Completion Report

Project Number: 33278
Loan Number: 2136/2137
August 2014

Philippines: Health Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – Philippine peso (P)

		At Appraisal	At Program Completion
		19 November 2004	30 September 2013
P1.00	=	$0.0178	$0.02306
$1.00	=	P56.28	P43.365

ABBREVIATIONS

ADB	–	Asian Development Bank
BIHC	–	Bureau of International Health and Cooperation
DMF	–	design and monitoring framework
DOF	–	Department of Finance
DOH	–	Department of Health
EU	–	European Union
HOMIS	–	Hospital Management Information System
HSDP	–	Health Sector Development Program
HSRA	–	Health Sector Reform Agenda
ILHZ	–	inter-local health zone
LGU	–	local government unit
MDFO	–	Municipal Development Fund Office
MDG	–	Millennium Development Goal
NHIP	–	National Health Insurance Program
PHIC	–	Philippine Health Insurance Corporation (PhilHealth)
RCHSD	–	Resource Center for Health Sector Development
RHU	–	rural health unit
TA	–	technical assistance

NOTES

(i) The fiscal year (FY) of the government and its agencies ends on 31 December.
(ii) In this report, "$" refers to US dollars unless otherwise stated.

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CONTENTS

BASIC DATA

A. Loan Identification

1.	Country	Philippines
2.	Loan Number	2136/2137
3.	Program Title	Health Sector Development Program
4.	Borrower	Philippines
5.	Executing Agency	Department of Health
6.	Amount of Loan	$200,000,000 (Program) $13,000,000 (Project)
7.	Program Completion Report Number	PCR PHI-1459

B. Loan Data

1.	Appraisal	
	– Date Started	11 October 2004
	– Date Completed	15 November 2004
2.	Loan Negotiations	
	– Date Started	22 November 2004
	– Date Completed	22 November 2004
3.	Date of Board Approval	15 December 2004
4.	Date of Loan Agreement	10 January 2005
5.	Date of Loan Effectiveness	
	– In Loan Agreement	10 April 2005
	– Actual	12 January 2005
	– Number of Extensions	0
6.	Closing Date	
	a. Program	
	– In Loan Agreement	30 June 2007
	– Actual	30 June 2007
	– Number of Extensions	0
	b. Project	
	– In Loan Agreement	31 December 2011
	– Actual	16 May 2013
	– Number of Extensions	1
7.	Terms of Loan	
	a. Program	
	– Interest Rate	London Interbank Offered Rate
	– Maturity (number of years)	15
	– Grace Period (number of years)	3
	b. Project	
	– Interest Rate	London Interbank Offered Rate
	– Maturity (number of years)	26
	– Grace Period (number of years)	6

8. Disbursements

a. Dates

(i) Program

Initial Disbursement	Final Disbursement	Time Interval
13 January 2005	17 November 2006	22 months
Effective Date	**Original Closing Date**	**Time Interval**
12 January 2005	30 June 2007	29 months

(ii) Project

Initial Disbursement	Final Disbursement	Time Interval
15 May 2005	16 May 2013	96 months
Effective Date	**Original Closing Date**	**Time Interval**
12 January 2005	31 December 2011	95 months

b. Amount

(i) Program ($ million)

Tranche No	Date Disbursed	Amount
First Tranche	13 January 2005	100.000
Second Tranche	17 November 2006	100.000
TOTAL		200.000

(ii) Project ($ million)

Category or Subloan	Original Allocation	Last Revised Allocation	Amount Disbursed	Undisbursed Balance[a]
Civil Works	5.834	7.632	7.662	(0.029)
Equipment	2.546	1.798	2.267	(0.469)
Consulting Services	0.734	1.554	1.159	0.395
Training and Workshops	0.196	0.206	0.192	0.014
Research and Studies	0.215	0.250	0.251	(0.001)
Project Management	0.263	0.470	0.417	0.053
Interest During Construction	2.165	2.165	0.650	0.120
Unallocated	1.047	0.319		0.319
Total	13.000	13.000	12.598	0.402

( ) = negative

[a] Canceled on 16 May 2013.

9. Local Costs (Financed)

- Amount ($ million) 7.662
- Percent of Local Costs 59.3%
- Percent of Total Cost 42.7%

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	6.250	4.937
Local Currency Cost	17.080	12.980
Total	23.330	17.916

2. Financing Plan ($ million)

Cost	Appraisal Estimate	Actual
Implementation Costs		
Borrower Financed	10.330	5.318
ADB Financed	10.840	11.948
Other External Financing	21.170	17.266
Total		
IDC Costs		
Borrower Financed	0.000	0.000
ADB Financed	2.160	0.650
Other External Financing	0.000	0.000
Total	23.330	17.916

ADB = Asian Development Bank, IDC = interest during construction.

3. Cost Breakdown by Project Component ($ million)

Component	Appraisal Estimate	Actual
A. Investment Cost		
Civil Works	8.970	9.988
Equipment	3.920	2.550
Consulting Services	1.060	1.450
Training and Workshops	1.240	0.976
Social Marketing	0.500	0.088
Research and Studies	0.720	0.308
Project Management	1.310	1.906
Taxes and Duties	1.290	0.000
Subtotal	19.010	17.266
B. Contingencies.		
Physical Contingencies	0.650	0.000
Price Contingencies	1.510	0.000
Subtotal	2.160	0.000
C. Interest and Commitment Charges	2.160	0.650
Total	23.330	17.916

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants		
Project Operations Specialist (Individual)	16 Feb 2007	15 Apr 2010
Civil Works Specialist (Individual)	23 Aug 2007	30 Sep 2012
Medical Equipment Specialist (Individual)	8 Nov 2007	Contract terminated
Monitoring and Evaluation Specialist (Individual)	3 Dec 2008	30 Sep 2012

Item	Appraisal Estimate	Actual
Baseline Study (Firm)	Sept 2008	May 2009
Project Implementation Consultant (Firm)	6 Aug 2009	30 Apr 2010
End-Line Study cum preliminary impact assessment (Firm)	1 Jan 2012	30 Sept 2012
Feasibility Study for Ifugao (Individual)	15 May 2007	31 Dec 2008
Completion of Engineering Designs		
Detailed Architectural and Engineering Design for Oriental Mindoro Provincial Hospital Civil Works Contract (Firm)	30 Jan 2008	21 Jul 2008
Date of Award		
Resource Center for Health Systems Development 1	17 Apr 2007	17 Jun 2007
Resource Center for Health Systems Development 2	28 Mar 2008	15 Dec 2008
Site Development for Oriental Mindoro Provincial Hospital	20 Jun 2008	30 Oct 2008
Oriental Mindoro Provincial Hospital	20 Jun 2008	10 Mar 2009
Pinamalayan District Hospital, Oriental Mindoro	19 Jun 2009	26 Jun 2009
Roxas District Hospital, Oriental Mindoro	19 Jun 2009	25 Jun 2009
Gen. Roque B. Ablan Memorial Hospital – Phase 1	14 Jan 2008	14 Dec 2008
Gen. Roque B. Ablan Memorial Hospital – Phase 2	31 Jul 2009	12 Dec 2009
Bangui District Hospital, Ilocos Norte	14 Jan 2008	14 Dec 2008
Dingras District Hospital, Ilocos Norte	31 Jul 2009	15 Sep 2009
Nueva Era Rural Health Unit, Ilocos Norte	30 Aug 2007	5 Sep 2008
Dingras Rural Health Unit, Ilocos Norte	14 Dec 2007	14 Jan 2008
Mariano Marcos Memorial Hospital and Medical Center, Ilocos Norte	15 Jan 2009	10 Aug 2009
Batangas Regional Hospital, Batangas City	28 Sep 2009	28 Sep 2010
Veterans Regional Hospital, Nueva Vizcaya	25 Nov 2008	9 Jul 2009
Batangas Regional Hospital-2	12 Feb 2012	18 May 2012
Veterans Regional Hospital-2	12 Feb 2012	24 May 2012
Completion of Work		
Resource Center for Health Systems Development 1	10 Nov 2007	4 Jan 2008
Resource Center for Health Systems Development 2	15 Apr 2009	12 Jun 2009
Site Development for Oriental Mindoro Provincial Hospital	30 Dec 2008	18 Feb 2009
Oriental Mindoro Provincial Hospital	30 Mar 2010	22 Jul 2010
Pinamalayan District Hospital, Or. Mindoro	30 Sep 2009	15 May 2010
Roxas District Hospital, Oriental Mindoro	30 Sep 2009	15 May 2010
Gen. Roque B. Ablan Memorial Hospital – Phase 1	30 Dec 2009	15 Aug 2010
Gen. Roque B. Ablan Memorial Hospital – Phase 2	30 Dec 2009	23 Sep 2010
Bangui District Hospital, Ilocos Norte	30 Jun 2009	15 Oct 2009
Dingras District Hospital, Ilocos Norte	30 Jun 2009	22 Jul 2010
Nueva Era Rural Health Unit, Ilocos Norte	25 May 2008	12 May 2008
Dingras Rural Health Unit, Ilocos Norte	15 Apr 2008	28 May 2008
Mariano Marcos Memorial Hospital and Medical Center, Ilocos Norte	30 Sep 2009	25 Sep 2010
Batangas Regional Hospital, Batangas City	25 Jul 2010	16 Aug 2011
Veterans Regional Hospital, Nueva Vizcaya	30 Mar 2010	20 Dec 2011
Batangas Regional Hospital-2	30 Jun 2012	27 Jul 2012
Veterans Regional Hospital-2	30 Jun 2012	3 Aug 2012

Item	Appraisal Estimate	Actual
Equipment and Supplies		
Dates		
First Procurement	Q1 2006	Q1 2006
Last Procurement	Q4 2009	Sep 2012
Completion of Equipment Installation	Q1 2010	Sep 2012
Start of Operations		
Completion of Tests and Commissioning	Q2 2011	Sep 2012
Beginning of Start-Up	Q3 2011	Q4 2012
Other Milestones		
1st Reallocation		12 Apr 2006
Major Change in Scope and Implementation Arrangements		3 Jun 2009
2nd Reallocation		3 Jun 2009
3rd Reallocation		13 Oct 2011

Q = quarter

5. Project Performance Report Ratings

	Ratings	
Implementation Period	**Development Objectives**	**Implementation Progress**
From 1 December to 31 December 2004	Satisfactory	Satisfactory
From 1 January to 31 December 2005	Satisfactory	Satisfactory
From 1 January to 31 May 2006	Satisfactory	Satisfactory
From 1 June to 31 December 2006	Satisfactory	Highly Satisfactory
From 1 January to 30 June 2007	Satisfactory	Highly Satisfactory
From 1 July to 31 December 2007	Satisfactory	Satisfactory
From 1 January to 31 December 2008	Satisfactory	Satisfactory
From 1 January to 31 December 2009	Satisfactory	Satisfactory
From 1 January to 31 December 2010	Satisfactory	Satisfactory
From 1 January to 31 December 2011	On Track	On Track
From 1 January to 30 September 2012	On Track	On Track

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Loan Fact Finding	5–28 Apr 2004	2	6	i
Appraisal	18 Oct–3 Nov 2004	5	55	i, j, k, l
Inception Mission	4 Apr–29 May 2005	2	10	a,b,
Loan Review	3–14 Oct 2005	2	12	a,c
Loan Review	25 Apr–19 May 2006	5	44	a,b,c,g,g
Loan Review	16–27 April 2007	2	24	a,c,f
Loan Review	3–13 Oct 2006	3	15	a,k, g
Loan Review	22–26 Oct 2007	2	10	a,c
Consultation	14–15 Nov 2007	3	5	a, c, e
Preliminary Loan Review	2–30 Jul 2008	3	9	a,c
Midterm Loan Review	20 Oct–14 Nov 2008	3	47	a,a,c,d
Loan Review	19 Aug–3 Sep 2009	3	23	a,b,c
Loan Review	11 Feb–2 Mar 2010	3	18	a,b,c
Loan Review	24 Nov–7 Dec 2010	2	7	a,b
Loan Review	28 Apr–9 May 2011	2	12	a,b

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Loan Review	21 Nov–8 Dec 2011	2	11	a,b
Final Loan Review	14–26 Sep 2012	2	10	a,b
Program Completion Review	23 Jul–16 Aug 2013	3	19	b,h,i

a = health economist, b = national officer, c = project analyst, d = consultant (health economist), e = social development specialist, f = consultant (economist), g = consultant (health specialist), h = director, I = health specialist, j = housing and urban financing specialist, k = counsel, l = resettlement specialist.
Source: Asian Development Bank.

I. PROGRAM DESCRIPTION

1. The Government of the Philippines is committed to achieving the Millennium Development Goals (MDGs) by 2015. The health status of Filipinos has improved since the 1990s, but not enough to achieve all the health-related MDGs. According to the United Nations Children Fund, the child mortality rate fell from 80 per 1,000 live births in 1990 to 29 per 1,000 live births in 2010,[1] compared to a target of 27 by 2015, while the maternal mortality ratio fell from 209 per 100,000 live births in 1990 to 99 per 100,000 live births in 2010, compared to a target of 52.[2] Malnutrition remains high: 34% of children below five years of age were underweight (weight by age) in 1990, and 27% in 2008.[3] Preventable or easily treatable diseases continue to cause major mortality among the poor. The major public health service challenges include:[4] (i) low health spending, at 3.5% of gross domestic product; (ii) insufficient health insurance for the poor;[5] (iii) lack of preventive services; (iv) management of services following devolution;[6] and (v) lack of staff and services in rural areas.

2. In 2004, the government requested support from the Asian Development Bank (ADB) for the 1999 Health Sector Reform Agenda (HSRA) of the Department of Health (DOH).[7] The national HSRA was implemented in phases, with initial efforts directed to support local government units (LGUs) in 16 convergence sites.[8] ADB approved a program loan of $200 million and a project loan of $13 million for the Health Sector Development Program (HSDP) on 15 December 2004. The goals were to improve health status, especially of the poor, and meet the health-related MDG targets. HSDP was to help increase the use of health services by the poor by improving their quality, and making them affordable and financially sustainable. HSDP supported six reform areas: (i) health financing, (ii) hospital systems, (iii) public health programs, (iv) health regulations, (v) local health systems, and (vi) health sector governance reforms. The program loan supported 39 policy actions and 37 monitorable indicators of DOH, and closed in June 2007. The first tranche of $100 million was released upon loan effectiveness in January 2005, while the second tranche was released in November 2006.[9] As per plan, the project loan helped upgrade health services in three of the five selected provinces,[10] and supported the DOH Resource Center for Health System Development (RCHSD). The project loan closed in May 2013. Related technical assistance (TA) was also provided (paras. 44–45). HSDP was

[1] United Nations Children Fund (UNICEF) Maternal and Newborn Health Country Profiles: Philippines. http://www.unicef.org/eapro/MNH_Philip.pdf

[2] The Department of Health indicates that mortality is higher (221 per 100,000 live births in 2011) K. Alave. 2012. Maternal mortality rate rose in 2011, says DOH. *Philippine Daily Inquirer.* 18 June 2011.

[3] Food and Nutrition Research Institute, Department of Science and Technology. 2009. 7*th National Nutrition Survey*. Manila. UNICEF estimate is 21%, in Maternal, Newborn & Child Survival Country Profile: Philippines. http://www.childinfo.org/files/maternal/DI%20Profile%20-%20Philippines.pdf.

[4] Department of Health. 2004. *Implementing Guidelines for Refocusing Health Sector Reform Agenda Implementation.* Manila: Department of Health Administrative Order 174 s. 04.

[5] Government of the Philippines. 1995. *Establishment of Philippines Health Insurance Corporation (PhilHealth*). Manila

[6] Government of the Philippines. 1991. *Local Government Code*. Manila.

[7] ADB. 2004. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Philippines for the Health Sector Development Program.* Manila.

[8] LGUs comprise provinces, municipalities, and chartered cities, which were granted greater administrative autonomy under a devolved system as prescribed by the Local Government Code of 1991. The public provision of health services and administration of health facilities were correspondingly transferred from DOH to the LGUs. DOH retained direct control of selected tertiary-level hospitals.

[9] Asian Development Bank. 2006. *Progress Report on Tranche Release. Philippines: Health Sector Development Program.* Manila.

[10] Ifugao, Ilocos Norte, Nueva Vizcaya, Oriental Mindoro and Romblon.

implemented through the Department of Finance (DOF), DOH, the Philippine Health Insurance Corporation (PHIC) and LGUs. The design and monitoring framework (DMF) is in Appendix 1.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

3. The government continues to place a high priority on poverty reduction through the provision of health care for the poor, and to achieving the MDGs. The government recognizes that medical expenses can represent a significant burden for families and contribute to their falling into poverty. Poor quality health care also leads to considerable income erosion. To help address these challenges, the government formulated a comprehensive, national HSRA with six reform areas supported by the loan (para. 2).

4. The project preparatory TA for HSDP was implemented in two phases.[11] The first phase involved a comprehensive review of HSRA and the selection of five convergence sites. The second phase was concerned mainly with the preparation of a detailed project design. Extensive consultations were held with various stakeholders including DOH, DOF, the National Economic Development Authority, PHIC, LGUs, and partners. The project preparatory TA was much appreciated by the government as it supported the HSRA.

5. HSDP was fully in line with the HSRA, and was also in line with the government's overall aim to provide pro-poor services with a focus on maternal and child care, and achieve the MDG targets. While DOH and PHIC conceived and planned the program prior to the assumption of the loan, the time-bound program commitments associated with the loan catalyzed the process and facilitated the formulation and adoption of relevant policies. With subsequent changes in national and departmental leadership, the country's overall health policy agenda evolved. HSDP was suitably adjusted to conform to the changing policy environment,[12] while remaining consistent with subsequent government strategies for health sector reform, including FOURmula ONE for Health, and Universal Health Care.[13] Some of the policy actions required DOH administrative orders, but were subsequently made into more encompassing laws.[14] Despite the intervening changes in coverage and character, the stress on the original HSRA outputs was maintained, and HSDP, as a whole, continued to be relevant.

6. ADB's country strategy and program update (2004–2006) confirmed ADB support for HSRA, in particular for primary health care, women's health, and early childhood development.[15] Increased engagement with LGUs was also recognized as an important area of support following devolution in the Philippines. The design of the HSDP was in line with ADB's Policy for the Health Sector.[16] ADB was the first development partner to support the HSRA. With the

[11] ADB. 2002. *Technical Assistance to the Philippines for Preparing the Health Sector Development Project.* Manila.
[12] ADB. 2009. *Technical Assistance Completion Report: Support for Health Sector Reform in the Philippines.* Manila. (TA 4647-PHI). ADB. 2008. *Mid-Term Loan Review Mission: Health Sector Development Project in the Philippines*. Manila (Loan 2137-PHI).
[13] Administrative Order 2010-0036 (the Aquino Health Agenda: Universal Health Care).
[14] The concurrent Support for Health Sector Reform TA during this transition period supported capacity-building activities relating to eight specific DOH administrative orders (AOs): (i) inter-local health zones (AO 2006-0017), (ii) performance-based budgeting for health (AO 2006-0022), (iii) health financing (AO 2006-0023), (iv) drug reforms (AO 2006-0018), (v) performance-based budgeting for public hospitals (AO 2006-0027), (vi) clinical practice guidelines (AO 2006-0002), (vii) consumer participation (AO 2006-0020), and (ix) rationalization of health services (AO 2006-0029).
[15] ADB. 2003. *Philippines: Country Strategy Program and Update (2004–2006).* Manila
[16] ADB. 1999. *Policy for the Health Sector.* Manila.

participation of other development partners, DOH formed the Sector Development Approach for Health to better harmonize assistance.[17]

7. The project design proposed that LGUs in at least three project provinces would be selected on a competitive basis. However, despite major investment needs, LGUs in three provinces[18] could not afford the loan interest rate or meet financial standards. A change of scope was processed to include DOH-retained tertiary hospital services in two provinces,[19] and Batangas province, as these hospitals also provided basic health services for the targeted provinces, including Oriental Mindoro. However, it would have been better if LGUs had been able to access suitable loan funds to improve the capacity of primary health care services. DOH's Health Facilities and Enhancement Program came to complement the project's infrastructure investments. [20]

8. Consistent with the sector-wide span of HSRA, the scope of the project-related activities was extensive, and ambitious given the small size of the loan. Project implementation depended on the willingness and capacity of the participating LGUs, which all enjoyed administrative autonomy and had their own political dynamics. LGUs did request some adjustments that generally made the project investments more relevant to prevailing local conditions.[21] The underlying provincial investment plans for health were maintained, as well as rationalization plans that served as the basis for allocating provincial health resources and integrating government health facilities.

B. Program Outputs

9. The HSDP program and project are intertwined, with the program focused on the national-level policy setting and structural arrangements, and the project on piloting provincial-level implementation. Of the program loan's policy actions, 39 served as triggers for the release of tranches of the program loan—19 for the first tranche and 20 for the second tranche. The outcomes of the remaining 37 policy actions were monitored—11 for the first tranche and 26 for the second tranche. Policy actions were fully complied with and are listed in Appendix 2.

10. Baseline and project completion evaluations were conducted in 2007 and 2011.[22] These were based on a revised DMF that reflected the evolving DOH policy agenda and project activities.[23] The evaluation, using 58 indicators, compared data obtained from the three project provinces of Ilocos Norte, Ifugao, and Oriental Mindoro with those from the matched provinces of Cagayan, Kalinga, and Aklan. The evaluation focused primarily on management rather than services. Other data collected on the use of health facilities during 2005–2012 showed a positive trend. While the assessment was designed as an evaluation of the HSDP project sites, it also provided an insight into the implementation of the policy reforms.

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[17] Department of Health. 2005. Administrative Order No. 2005-0023. Implementing Guidelines for FOURmula ONE for Health as Framework for Health Reforms.
[18] Ifugao, Nueva Vizcaya, and Romblon.
[19] Ilocos Norte and Nueva Viscaya.
[20] DOH 2010. AO No. 2010-0036. The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos.
[21] The civil works allocations for Ilocos Norte were reapportioned such that a bigger share went to the upgrading of the provincial hospital. The civil works for the Mindoro Oriental provincial hospital and two district hospitals were drastically reduced, with the governor guaranteeing provision of LGU funds.
[22] ADB.2012. *End-line Survey cum Intermediary Impact Assessment Study, Health Sector Development Project.* Consultant's Report. Manila (Loan 2137-PHI).
[23] However, some indicators are related more to activities supported by other development partners than to project interventions.

1. Health Care Financing Reform

11. The National Health Insurance Program (NHIP) is a social health insurance program implemented by PHIC that aims to provide universal health insurance coverage that is affordable, acceptable, and accessible to all citizens. The NHIP reform aimed to expand insurance coverage to at least 85% of the population, with universal coverage of the poor and indigent, including those eligible under the subsidized premium program (identified by the national household targeting system for poverty reduction, and other "critical poor"). The NHIP reform also aimed to improve the benefit packages. The policy actions proposed to: (i) continue national subsidies of the NHIP premium for the poor; (ii) ensure that national funds are remitted in a timely fashion to PHIC; (iii) introduce progressive premium contributions based on ability to pay, in order to increase informal sector coverage; (iv) pilot a low health insurance premium for the poor and vulnerable who cannot benefit from government subsidies (about 25% of the population) using various group enrollments; (v) improve the benefit package for hospital services, catastrophic and expensive illnesses, maternal and child health, outpatient services, tuberculosis and other public health programs; (vi) introduce the use of clinical practice guidelines (CPGs); and (vii) conduct an information campaign, especially targeting the poor.

12. As reported by PHIC, in 2012, overall NHIP coverage reached 85%—up from 53% in 2010, and 72% in 2011.[24] All those in the lowest income quintile in the Philippines are automatically eligible for PHIC benefits, including government payment of premiums if registered as poor or identified through the sponsored program of local governments.[25] National and LGU support for the sponsored programs is growing, with a steep increase in national PHIC financing in 2012–2013. The drivers include the push for universal health care, a strong political commitment, good economic growth, and the recently introduced "sin tax".[26] Overall, it is evident that NHIP coverage and benefit packages have substantially increased, especially since 2010. HSDP helped build the foundation for NHIP.

13. Nevertheless, many of the poor and indigent still fail to benefit from the NHIP for a variety of reasons: (i) accredited services are not available; (ii) the poor are not informed; or (iii) other social and financial barriers. An assessment of the use of PHIC in HSDP hospitals was undertaken in 2010 by the project implementation consultant team,[27] which confirmed the relatively low use of PHIC benefits in project hospitals, and the limited benefit package and premium subsidy provided to poor patients. Social marketing efforts were undertaken at the project sites to address this. Field visits to Ilocos Norte and Mindoro Oriental confirmed that a substantial increase in utilization rates occurred since 2012, including for PHIC members.

14. PHIC generally increased its premium over time, but a flat rate was maintained for a few special groups, including overseas Filipino workers. Because the government maintained the health insurance premium payment subsidy, PHIC did not introduce a progressive premium contribution, and did not pilot limited premium payment for the poor and vulnerable. Benefit packages have improved for outpatient care, maternal care, tuberculosis control, and

[24] Dr. E. Ona, Health Secretary. 2012. Speech at the Wealth for Health Summit. July 31. http://www.doh.gov.ph/content/speech-health-secretary-dr-enrique-t-ona-wealth-health-summit.html

[25] Department of Health and Philhealth Office Order No. 2013-0031.Enrollment of Critical Poor under the Sponsored Program of the National Health Insurance Program at Point-of-Service. http://www.philhealth.gov.ph/joint_order/2013/jo2013_0031.pdf

[26] Presidential Communications Development and Strategic Planning Office. 2012. Sin Taxes. *Official Gazette.*19 September. http://www.gov.ph/sin-tax/

[27] A Caballes et al. 2012. Financial Protection Mechanisms for Inpatients at Selected Philippine Hospitals. *Social Science & Medicine*. 75(10):1820–1827.

catastrophic illnesses. In 2012, PHIC reconfirmed the use of CPGs for disease management.[28] However, these are not yet widely used except in major referral hospitals, and their cost reduction objectives have been more effectively addressed by the more recent introduction of case rate payments.

2. Hospital Reforms

15. The reforms sought to enhance the sustainability and efficiency of hospitals by: (i) restructuring them into corporations and supporting the participation of the private and nonprofit sectors; (ii) encouraging upgrading of lower-tier hospitals to provide better quality care, thereby relieving the stress on tertiary hospitals; (iii) ensuring the efficient provision of quality health services by linking hospital revenue and service quality; (iv) making hospitals financially autonomous, by allowing them to earn, retain, and use all their revenues; and (v) building the capacity of hospital administrators and strengthening corporate governance through the development of various guidelines, regulations, and accountability mechanisms.

16. The administrative orders for the establishment of boards for public hospitals, performance-based hospital allocations, and rationalization of local hospitals have been published. The project supported efforts to reorganize LGU hospitals to make them autonomous. The proportion of project hospitals with autonomy policies increased from 17% in 2007 to 25% in 2011. To convert LGU hospitals into so-called “economic enterprises”, officials were assisted in developing business plans.[29] The Oriental Mindoro provincial hospital has requested that DOH establish it as an economic enterprise, but the request was pending as of June 2014. Ilocos Norte established a hospital council to oversee provincial hospitals. Nationally, only the La Union Medical Center, a public hospital, has managed to establish a corporation, and serves as a model for others.

17. The chronic drug shortage is mainly caused by late release of funds and delayed procurement rather than lack of funds. The provincial hospital in Oriental Mindoro solved the problem by starting a central medical store in the hospital that operated as a consignment system, with private suppliers contracted to provide supplies for a fixed price and maintain store stocks; these are only paid for by the hospital when issued to the dispenser. The hospital management information system (HOMIS) upgrading continues to face difficulties, [30] including delays in procuring hardware, which resulted from the time taken to prepare specifications and evaluate bidding documents. DOH has issued a draft ordinance recommending the use of HOMIS in LGU hospitals, and on integrating information systems.[31]

18. The project design proposed upgrading LGU health facilities in up to five provinces, on a competitive basis. The less prosperous Romblon province did not meet financing requirements; Ifugao and Nueva Vizcaya opted out in view of the interest rate charged (up to 12%), while Ilocos Norte and Oriental Mindoro limited borrowing for the same reason (para 2). Six LGU health facilities were supported by the project: the Oriental Mindoro Provincial Hospital (30% of its civil works), the Governor Roque B. Ablan Sr. Memorial Hospital in Ilocos Norte, the Bangui

[28] PHILHEALTH Circular No. P54 . s-2012. http://www.philhealth.gov.ph/circulars/2012/circ54_2012.pdf
[29] Under the Local Government Code, the conversion of specific public services into “economic enterprises” was an acceptable option for the achievement of specific LGU objectives.
[30] The HOMIS modules and their corresponding content are as follows: Module 1: Admitting, Billing, Cashier, PHIC, Medical Records, Medical Social Service; Module 2: Wards, Laboratory, Pharmacy, Radiology, Emergency, Outpatient Department, Dietary and Other Ancillaries, Cost Centers; Module 3: Personnel Information System, Logistics Management Information System, Electronic New Government Accounting System.
[31] Integrating the Field Health Service Information System used by rural health units with HOMIS.

and Dingras District Hospitals in Ilocos Norte, and the Roxas District Hospital and Pinamalayan rural health unit (RHU) in Oriental Mindoro. A summary of civil works is in Appendix 3.

19. Due to the limited borrowing capacity of LGUs, a change in project scope was approved to upgrade the DOH-administered hospitals, which served as the referral facilities for project LGUs. DOH-administered hospitals typically have a low bed–population ratio and high bed occupancy (up to 200%). These hospitals needed to be upgraded, even with the upgrading of the LGU health facilities. The project supported civil works and equipment for Batangas Regional Hospital in Batangas City, and the Mariano Marcos Memorial Hospital and Medical Center in Ilocos Norte, and equipment for the Veterans Regional Hospital in Nueva Viscaya.

20. Delays in the design phase caused some delay in civil works, but all were completed within the original project period. Hospital directors also pointed out that the private wings supported under the project as a form of public–private partnership were affordable by PHIC patients, elevated the status of the hospital, helped retain staff and generated hospital revenues.

21. The quality of civil works was found to be generally sound when inspected, with few design flaws detected. Fixtures including taps and washbasins were not always of good quality, and a private wing had a sewage problem. Hospital directors noted that minor adjustments in the design were difficult to obtain. Several hospitals reported that some equipment was not delivered as per specifications, or was not of adequate quality.[32] Considerable time was spent in planning and procuring equipment, but there was insufficient attention to commissioning equipment. A summary of equipment is in Appendix 4.

22. Feedback from DOH and LGU officials indicates that the investments have largely been viewed as positive developments by local leaders, staff, and clients. While ADB-supported civil works were only a small part of the required investments, DOH and hospital directors noted that the ADB investment helped them leverage other funding. All new facilities have experienced a rapid increase in the number of outpatients and inpatients, in particular for obstetrics, paediatrics, and emergency services. These have in turn bolstered public health programs and motivated nearby municipalities to improve their health services. For financial and system-design reasons, DOH is reluctant to increase the official number of inpatient beds, which is often much lower than the actual number of beds, and determines hospital staffing and funding. As a result, hospitals depend on contractual staff paid from revenues. DOH wants to decongest hospitals and improve service delivery efficiency by RHUs. More effort is needed in preventive programs and system integration.

3. Public Health Reforms

23. The reforms were intended to the increase financial resources for and the effectiveness of DOH-supported public health programs (e.g. immunization, disease control and reproductive health), to be implemented by LGUs through multi-year, performance-based budgets. To improve equity and efficiency, DOH subsidies were to be allocated on the basis of the fiscal capacity of and poverty prevalence in LGUs, rather than on the basis of population.

24. Although public health programs were initially taken over by other development partners, the government asked the project to support maternal and newborn care. Three specific policy actions for reproductive health were approved. Service-level agreements have subsequently been adopted that indicate the outputs required from LGUs, for which fund releases are made

[32] Problems included unstable operating tables and defective endoscopic equipment.

through fixed or variable tranches. Despite problems involving delayed submission of liquidation reports, this initiative has been successful and has been taken up by other government agencies.

25. Reproductive health supplies were included in the Philippine National Drug Formulary. The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354), through its implementing rules and regulations, has provided for contraceptive supplies to be included in the National Drug Formulary upon approval of the Food and Drug Administration. The Act further defines the public provision of these commodities and related services. However, implementation of the Act has been blocked by legal action, and has yet to begin.

4. Regulatory Reforms

26. Focusing on the need to guarantee service quality following devolution, regulatory reforms were aimed at: (i) streamlining licensing and accreditation procedures for health facilities; (ii) strengthening primary health care services; (iii) ensuring an equitable and cost-effective distribution of primary care, hospitals and high-technology medical devices across the country; (iv) developing regulations and incentives to increase the availability of quality drugs at a lower price; and (v) strengthening the national disease surveillance system.

27. Policies regarding strengthening of DOH regulatory agencies, accreditation of primary care services, and improved drug management were enacted in line with the program requirements. DOH and PHIC have established a one-stop accreditation arrangement for health facilities. The number of PHIC-accredited services increased in the evaluated RHUs. From 2007 to 2011, accreditation rates for the out-patient primary care benefit package in RHUs increased from 75% to 95%, for the maternity care package from 10% to 30%, and for the tuberculosis package from 50% to 80% in project sites, with similar increases in control sites.

28. Support for Health Sector Reform[33] (para. 44) provided training on various aspects of drug management for the concerned LGU officials and staff. Likewise, the project helped draft the National Policy and Program on Pharmacovigilance (Administrative Order No. 2001-0009). Legislation enacted on 12 July 2011 has revitalized Food and Drug Administration and established an integrated drug policy, as contained in the Universally Accessible Cheaper and Quality Medicine Act of 2008 (Republic Act 9502), which includes measures for better drug management. The target of 10% lower prices for drugs is being realized with the establishment of generic drug shops. Only one hospital managed to set up a containment warehouse to overcome drug production constraints, after addressing several legal and financing barriers.[34]

5. Local Health Systems Reforms

29. The reforms sought to address the local health system fragmentation following devolution. Actions aimed to: (i) improve health facilities to conform to licensing and accreditation requirements; (ii) establish inter-local health zones (ILHZs) as autonomous entities, with support of PHIC accreditation criteria; (iii) integrate procurement and management of drugs; and (iv) conduct health information campaigns and outreach activities.

[33] ADB. 2002. Technical Assistance to the Philippines for Support to Health Sector Reform in the Philippines. Manila.
[34] Oriental Mindoro has established the *Botikang Panlalawigan ng Oriental Mindoro* specifically for the pooled procurement of drug supplies for the LGU's hospitals and health facilities.

30. The enhanced operations of ILHZs, including improvements in the referral system, were targeted by Support for Health Sector Reform TA (footnote 37) through a training module, and evaluated in the succeeding project implementation consultant contract under the project loan. The establishment of ILHZs has been broadly adopted,[35] but most of these have not achieved the desired level of functionality, except in the province of Oriental Mindoro. The Ilocos Norte LGU aims to merge existing ILHZs into a single Ilocos-wide system. LGUs face administrative, financial, legal and political challenges in working together to share resources. PHIC approved accreditation criteria and provision of financial incentives for local health systems, but ILHZ-based accreditation was not implemented as a result of political, legal and financial hurdles.

6. Health Governance

31. The reforms sought to improve health governance through three policies: (i) human resources for health; (ii) HSRA implementation; and (iii) consumer participation in the health sector. An HRSH master plan was developed by the DOH in 2005, in coordination with World Health Organization Western Pacific Regional Office. An electronic human resources for health registry has also been set up. The LGU scorecard was initiated, as part of DOH's Monitoring and Evaluation for Equity and Effectiveness (part of regulatory reform). Patient satisfaction is one of the categories rated with this tool. Patient Charters have been implemented in public hospitals, which use posters to help facility users to be familiar with patient care processes, administrative procedures and responsible persons.

32. According to the study by the Resources, Environment and Economics Center for Studies most hospital business plans were not approved by LGUs (para.16). However, over 75% of health facilities had a policy framework with detailed policy and guidelines for accountability. This is attributed to the existence of several accountability measures, such as those from the Commission on Audit, the Philippines' supreme audit institution. On the other hand, there were major weaknesses with gender disaggregation and reporting of health statistics.

33. The project supported the establishment of a RCHSD in DOH, which has been operational since 2009. It was intended to facilitate, broker, and provide multi-media resource on the latest knowledge and information on health sector reforms.[36] It initiated expenditure tracking, burden of illness and economic evaluations, health standards, and governance performance monitoring. RCHSD published health policy notes, which served to communicate the key policy concerns of the DOH. The office space was refurbished and computer equipment was installed at the designated area (of Building No. 3) at the DOH Central Office compound. However, at the time of evaluation, the Center's e-operations had been scaled down due to software problems.

C. Program and Project Costs

34. At appraisal, the reform program was estimated to cost $280 million. ADB's share of $200 million was fully disbursed in two tranches—the first tranche 1 month after board approval,

[35] An inter-local health zone is an organization of health facilities and provider that typically includes primary care providers, district hospitals and one provincial hospital, jointly serving a common population within a local geographic area under the jurisdictions of more than one LGU. ILHZ, as a form of inter-LGU cooperation, is established to assure the constituents access to a range of shared services, and manage limited resources for health efficiently and equitably.

[36] Department of Health, Philippines. 2008. *Operations Manual: Expanded Resource Center for Health Systems Development (RCHSD).* Manila.

and the second after about 22 months (10 months later than scheduled), following delayed but full compliance with second tranche conditions. The government used these funds to help finance parts of PHIC and HSRA. The DOH made investments totaling $1.282 billion during 2006–2012. As reported by DOH, the ADB support helped trigger major reforms in the health sector. However, DOH did not track the detailed financing of individual reforms.

35. At appraisal, project costs were estimated at $23.33 million, inclusive of taxes, duties, and physical and price contingencies. ADB's share was $13.0 million (55.7%), sourced from its ordinary capital resources. The government was to contribute $10.33 million (44.3%), including a DOH's share of $8.88 million (38.1%) and LGUs' share of $1.45 million (6.2%). The loan had a 26-year term, with a 6-year grace period, a commitment charge of 0.75% per annum, and interest rates in accordance with ADB's London interbank offered rate-based lending facility. Actual project completion costs were $17.92 million, $5.41 million lower than the appraisal estimate, due to adjustment in scope, savings and co-financing. ADB financed $12.60 million, 70.3% of the total cost, or 97% of its original commitment. The Government of the Philippines funded $5.32 million equivalent, 29.7% of the total cost, or 51% of its original commitment, in particular due to low LGUs financing. The project realized savings with respect to equipment, social marketing, studies, taxes and duties, and interest and commitment charges. Civil works, consulting services, and project management costs increased. Equipment for LGU hospitals was financed by a European Union (EU) grant instead of from the ADB loan.[37] Second, the ADB London interbank offered rate lending rate, including the 0.40% spread, was 3.96% at appraisal in 2004, reached a high of 5.36% in 2007, and was as low as 0.73% at project completion, resulting in savings in interest during construction of $1.5 million. Third, civil works unit costs increased due to various procurement delays and devaluation of the United States dollar, from $1=P56 to $1=P42 at completion. Project extension also drove up project management costs.

36. ADB approved three reallocations of loan proceeds during project implementation. The first reallocation in 2006 was to reduce civil works and add equipment. A second reallocation in 2009 increased the ADB share for civil works, and reduced the allocation for equipment. In October 2011, ADB approved the third reallocation to finance additional civil works, adjust civil works contracts for currency fluctuations, and procure additional medical equipment, using various project savings and contingencies.

D. Disbursements

37. Loan proceeds were disbursed in accordance with ADB's Loan Disbursement Handbook (2012, as amended from time to time). ADB provided an advance of $0.30 million to DOH in June 2005, $0.50 million to the Municipal Development Fund Office (MDFO) in August 2007, and $0.50 million to the MDFO in November 2009. The imprest account turnover ratio was consistently below 2, due to delays in project work and liquidation. ADB allowed the use of the statement of expenditures procedure for amounts below $200,000. Of the total disbursement of $12.60 million, $4.73 million (36.7%) was paid through the imprest account, $3.61 million (29%) through reimbursement and $3.61 million (29%) by direct payment. The remaining amount of $0.65 million was the capitalization of service charges. The unused imprest account balance of $0.259 million, with $0.016 million was refunded after loan closing.

[37] The on-lending interest rate from DOF to LGUs—up to 12% in the early phase of the project—made the loan less attractive, and LGUs instead employed the ADB funds as seed money to attract other financiers, in particular EU grants.

E. Program/Project Schedule

38. HSDP started on 12 January 2005, following ADB approval on 15 December 2004. The second tranche release of the program loan was delayed by 10 months. The project was extended once for 9 months due to a delay in planning the civil works and procurement of equipment. Robust disbursements began in 2007, after 2 years of implementation. Major reasons for delays included: (i) alignment of the project with FOURmula ONE for Health, and with the new grant project financed by the EU in 2006; (ii) delays in obtaining agreement with LGUs; (iii) weak monitoring of the project; (iv) systemic problems with consultant engagement; and (v) failed bids as a consequence of increasing construction costs, coupled with changing LGU leadership and their desire to revisit the Memorandum of Agreement[38] and scope of subproject investments. The HSDP implementation schedule is in Appendix 6.

F. Implementation Arrangements

39. DOF was the executing authority for the program loan. DOH and PHIC were to implement the policy actions. DOH was the executing authority for the project, with subloans intended for LGUs channeled through the DOF MDFO. The Bureau of International Health and Cooperation (BIHC) was responsible for project management and provided dedicated support for implementation. Provincial governors were the designated provincial project director, while provincial health officers were in charge of the local project management units. Decentralized procurement and implementation enhanced the capacity of LGUs and DOH-retained hospitals. Except for the imprest fund shortage during the peak of civil works construction, the project encountered no major issues in channeling funds to LGUs through MDFO.

G. Gender and Development

40. A gender analysis and strategy was prepared prior to appraisal. A poverty and gender specialist was to be engaged during implementation to assist DOH with the design of a community-based information system, and develop a national, sector-wide gender and development plan. However, the initial community focus of the project design and pre-appraisal was changed in support of six policy areas, with a focus on services. Several of the gender-responsive strategies proposed in the gender analysis and strategy were henceforth no longer applicable. The gender specialist was not engaged and the gender and development plan was not prepared. Towards program completion, DOH did prepare a sector-wide gender strategy and plan, and included gender actions in annual operational plans.

41. The DOH promoted gender and development sector-wide, through a focus on the workforce rather than the range of services and policies. Women's participation in management, workshop, training, and scholarships was high. Affirmative action targeting women also remained a high DOH priority, but more from a health needs than a gender perspective. Policy reforms included a wide range of gender supportive activities. Reproductive health services were improved for women in general and the Mangyan women in particular (para. 46). However, disaggregated data were not routinely reported, and the community-based information system that was to produce disaggregated data at community level is still in a pilot stage.

42. The multiple policy actions carried out under HSRA (Appendix 2) have no doubt led to improved access and affordability of health services, in particular for women and children.

[38] ADB. *Memorandum of Understanding of Final Review Mission, 14–26 September 2012*. Loan 2137-PHI: Health Sector Development Project (HSDP).

Facility-based data show increased use of targeted hospital services (Table 1, Appendix 7). This is partly attributable to the improved services, and partly due to expansion of PHIC, and will undoubtedly impact mortality. In view of the lack of a gender and development plan, gender consultant, and disaggregated monitoring, and less systematic effort in bringing gender dimensions in policies, the program is rated *unsatisfactory* from a gender perspective.

H. Conditions and Covenants

43. None of the covenants were modified during the project. The covenant for gender was not complied with. All other project conditions and covenants were substantially complied with, although there was some delay in the fielding of consultants and there were some selective issues with civil works and procured equipment. The submission of quarterly reports and audited project accounts was also delayed. The government did not submit consolidated audited project accounts for both DOH and MDFO (for LGU), because different agencies are usually audited by different set of Commission on Audit auditors. The auditor issued an unqualified opinion for five audit periods and a qualified opinion for three audit periods, and noted the project complied with the use of funds, imprest account, and statement of expenditure procedure. Compliance with loan covenants is in Appendix 8.

I. Related Technical Assistance

44. In addition to the project preparatory TA (para. 4), two stand-alone TAs were associated with HSDP and contributed to the project's objectives and activities. **Support for Health Sector Reform TA** (footnote 33). Implemented from September 2005 to August 2007, this TA supported DOH in HSRA policy development, capacity building and monitoring at the national and LGU levels. Three international and ten national consultants were engaged through a firm, supplemented with individual consultants. The TA developed several capacity-building packages to facilitate the adoption of FOURmula ONE for Health reform policies, and a set of tools and indicators to monitor and evaluate the implementation. The TA was rated *satisfactory*.

45. **Promoting Gender Equality and Women's Empowerment (Philippines Subproject): Indigenous Community Maternal and Newborn Care Program.** TA 6143 was funded by ADB's Gender and Development Cooperation Fund and the Technical Assistance Special Fund.[39] The Philippines subproject under this TA was implemented during August 2009 to September 2011. It was tailored to the needs and circumstances of the Mangyans of Oriental Mindoro. Its objectives were: (i) increased capacity of public health service workers to provide culturally appropriate services for Mangyan women and their families seeking maternal and newborn services, (ii) improved access by Mangyan women to quality maternal and new born care, and (iii) raised awareness among Mangyan families about the principles of safe motherhood. This included construction of *Balay Mangyan* birthing centers.[40] Prenatal visits and facility-based deliveries for Mangyan women have increased substantially, and Mangyan leaders and service providers appreciate the services.[41] Mangyan people are pleased with the services as can be seen from the busy wards in a YouTube video.[42] The project also supported capacity building for tuberculosis control campaign social marketing.

[39] ADB. 2008. *Regional Technical Assistance for Promoting Gender Equality and Women's Empowerment.* Manila.
[40] The Mangyan people are a unique indigenous group of about 100,000 people consisting of eight language subgroups. Mangyan women begin child bearing at very young age, and have Very high maternal and child mortality rates.
[41] ADB. 2011. Family Medicine Research Group. *Culture-Sensitive Maternal and Newborn Care Program: Experience with the Mangyans of Oriental Mindoro.* Consultant's Report. Manila (TA 6143-REG).
[42] http://www.youtube.com/watch?v=_d0AKqhSgNk&list=PLPclkF5Ezor8x6HWR0SM6CU1b_-HEKQ1Q&index=9

J. Consultant Recruitment and Procurement

46. At appraisal, consulting needs were estimated at 523 person-months (86 person-months of international and 437 person-months of national services) to support policy reforms and project implementation. An international firm was engaged for a total of 78 person-months of consulting services (24 person-months of international and 54 person-months of national services) to support policy reforms. A national firm was engaged to conduct baseline surveys (7 person-months) and completion surveys (7.9 person-months). A total of 161.5 person-months of individual national consultants were engaged to support project work, The underutilization of consulting services to support policy reforms was due to (i) the support of other development partners; and (ii) preliminary preparation of reforms by DOH. In contrast, more consultants were hired to support project work, including monitoring and evaluation, due to DOH implementation staff constraints. All consultants were engaged in accordance with ADB's Guidelines on the Use of Consultants. The executing authority's lack of familiarity with ADB's guidelines and internal approval process caused delays in engaging consultants. Consulting services are detailed in Appendix 9.

47. All procurement was undertaken in accordance with ADB's Procurement Guidelines. A total of 17 civil works packages for health facilities and resource centers totaling $10.0 million were procured under the project. The project experienced procurement delays as a result of (i) delays in the finalization of the subproject grant and loan agreement, and in preparation of architectural and engineering designs; (ii) changes in the scope of work; (iii) bid failures due to lack of bids or price escalation; (iv) delays in release of funds from MDFO; and (v) adverse weather. Medical and office equipment procured under the project (totaling $2.2 million) was for DOH-retained hospitals.

K. Performance of Consultants, Contractors, and Suppliers

48. The performance of the consultants was generally satisfactory. However, some design issues were noted in health facilities, including international standards not being followed in the construction of health facilities, in part because civil works involved upgrades of existing facilities. The performance of the civil works contractors was generally satisfactory. There were isolated reports of delays in construction and follow-up repairs, attributed in part to the late payment of contractors. The performance of suppliers of equipment, furnishings, and fixtures was less satisfactory. Some equipment for hospitals did not meet specifications or was found to be substandard after delivery. The DOH procurement process does not fully ensure procurement of appropriate equipment, such as a clear understanding of specifications with the end user, and proper commissioning of equipment before payment.

L. Performance of the Borrower and the Executing Agency

49. The performance of the borrower was satisfactory. Counterpart funds were provided on time. The borrower responded quickly and positively to specific recommendations made by ADB and BIHC for improving project implementation. MDFO adequately managed subloan funds for LGUs. The performance of the executing authority and LGUs was also satisfactory. The BIHC officials attended to all aspects of project implementation, including coordination with the concerned LGUs and DOH hospitals. The executing authority was also responsive to changes in the project environment, and helped in developing implementation alternatives. Efforts were made to address delays in procurement of consultant services. The executing authority was receptive to ADB's involvement, and helped facilitate the review missions

M. Performance of the Asian Development Bank

50. The performance of ADB was satisfactory. In the course of HSDP's implementation, 14 review missions were fielded and site visits were undertaken to gain first-hand information on the progress and issues of the subprojects. However, no ADB staff members with experience in health service delivery were included in these missions, which may have affected project oversight. Requests for modifications in scope, schedule, or allocations were promptly attended to. Through its gender fund, ADB also responded to the needs of the Mangyan people.

III. EVALUATION OF PERFORMANCE

A. Relevance

51. HSDP is considered *relevant*. It supported the government's HSRA for improving the health status of Filipino citizens, and in particular, the poor and vulnerable groups. The program-related policies were strategic in scope and timing. Many reforms became effective administrative tools, such as the LGU rationalization and investment plans, and some evolved into more far-reaching policies, as with the increased health insurance enrolment. Five out of 39 policy actions were premature, slow to be implemented or became less relevant over time, including progressive PHIC premiums, formation of ILHZ, hospital corporatization, clinical practice guideline-driven budgets, and performance-based budgeting of public health programs. The intervening changes in the national health policy agenda resulted in changes to the relative emphasis of the program outputs, but not its overall thrust and importance. The project helped pilot reforms in selected provinces, and mobilized other funding. The program was also relevant to ADB's country and sector development objectives.

B. Effectiveness in Achieving Outcome

52. HSDP is considered *effective*. Most HSDP policy actions and project activities were completed. The program played a major role in reforming the health sector. While changes in services stemming from the reforms were not immediate, the upgrading of hospitals and PHIC reforms led to an increased volume and range of services, in particular for women and children, as shown in the DMF in Appendix 1. However, the targets of immunization rate and contraceptive prevalence rate were not met. The use of public health services as a proxy for the availability and acceptability of services has also increased substantially in targeted facilities. Table 1, Appendix 7, provides details on utilization of health services. These changes are likely to have contributed to achievement of the health-related MDG targets at national and local levels.

C. Efficiency in Achieving Outcome and Outputs

53. The HSDP is considered *less efficient*. The supported reforms were well conceptualized, but the numerous subsequent adjustments made the sector reform process complex. For example, devolution and health financing reforms have made the financial administration of hospitals difficult. A further rationalization of the health system is urgently required to help improve sector performance. In HSDP, both program, tranche releases and project implementation experimented delays. In addition, during project implementation, there were delays in engaging consultants and in civil works. Based on the economic analysis (Appendix 10), the internal economic rate of return ranges from 12% to 54% for targeted health facilities.

D. Preliminary Assessment of Sustainability

54. The HSDP is considered *sustainable*. The government has rapidly increased budget support for PHIC to achieve universal health coverage. This is a major source of financing for health facilities, and allows DOH to better regulate the health sector. DOH will continue adjusting policies initiated with the support of HSDP as conditions evolve. The three project LGUs have plans to ensure the financial sustainability of project investments. Improved conditions have sharply increased the use of health facilities, thereby generating more revenue and improving service efficiency. On this basis, current revenue versus operating cost is calculated at 75% by 2015 (Appendix 10, table 4). Further expansion of PHIC is also contributing to the funding of these health facilities. DOH has been requested to re-categorize health facilities based on their actual bed capacity, so as to improve the quality of services and budget allocations. DOH envisions a further upgrading of health centers, which is expected to reduce overcrowding in hospitals and thereby reduce the unit cost of routine health services.

E. Impact

55. The upgraded hospitals are the most tangible contribution of the investment component to the LGUs and associated DOH hospitals. The evaluation by the Resources, Environment and Economics Center for Studies found that project sites demonstrated varying but overall consistent improvements in impact indicators. The maternal mortality ratio shows an increase in one location but this is likely a result of HOMIS improvements. DOH and LGU officials noted that the project provided valuable lessons in sector reforms and investments. Patients and staff were highly appreciative of the new or refurbished health facilities.

56. Many of the policies supported by HSDP have had definite impacts on the health sector. Some have been modified to be better attuned to more recent developments—such as the Health Facilities and Enhancement Program—and some have contributed significantly to new and more substantive legislation, such as the Universally Accessible Cheaper and Quality Medicine Act of 2008. Taken together with the related TA, HSDP has contributed to creating structures and systems to further HSRA, and thereby improve the health status of both direct recipients and the general population.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. OVERALL ASSESSMENT

57. HSDP is rated *successful*. Both the program and project are considered *relevant, effective, less efficient and sustainable*. While there were strategic adjustments, on the whole the reform program was implemented and further amplified in successive developments. A major concern is that the HSDP supported too many reform activities. However, it appears that this comprehensive support did play a critical catalytic role in achieving national health sector reforms. The project, given its relatively small size, is also considered ambitious and less attractive for LGUs because of the high on-lending rate. However, it helped improve health services, in particular for women and children; attracted additional funding; and helped formulate policy reforms.

B. LESSONS

58. HSDP supported the entire HSRA, with six reform areas, a large number of stakeholders, multiple levels, and intervening policy alterations, making it a complex undertaking. However,

the government reported that ADB's support for the entire reform program helped advance reforms. Nevertheless, careful consideration should be given to the scope of program support.

59. A high on-lending rate prevented the targeted provinces from participating. At appraisal, careful consideration needs to be given to the project's financial feasibility. Limited project funds could finance only about 30% of required investments in targeted health facilities. Although additional funding was mobilized to complete upgrading of these facilities, more detailed advanced planning could mitigate financing risks.

60. Design flaws resulted from the rehabilitation of existing facilities. Budget constraints may have led to the use of substandard materials. Some equipment was purchased that did not meet technical specifications. Further improvements can be made by improving specifications, adequately budgeting for works and equipment, and ensuring proper commissioning.

C. RECOMMENDATIONS

1. Program Related

61. Consulting services were effective and additional TA helped facilitate reforms and capacity building. However, ADB's review missions should have included a health specialist to provide comments on technical matters such as facility design and equipment. Program monitoring (not evaluation) was quantitatively weak, in particular with respect to gender. Arrangements need to be made prior to loan effectiveness to ensure adequate monitoring.

2. General

62. DOH may want to reappraise several of its major health system design features, including: (i) the technical and financial capacity of devolved health services at the municipal level; (ii) the design of ILHZs, which requires new legal, administrative, and financial arrangements; (iii) the feasibility of performance-based budgeting of public health programs; (iv) the allocation of funds and staff based on standard bed capacity rather than actual workload, even when adjusting for unnecessary bed occupancy or admissions; (v) the drug procurement systems, because lack of medicines is currently the major burden for the poor when entering a hospital, and in emergencies; (vi) the adequacy of current service standards, quality control systems, training; (vii) the increasing fragmentation of hospital financial management systems, (vii) the improvement in financing devolved health facilities in poor LGUs; and (viii) the acceleration of PHIC reforms, including improving benefits for the poor, simplified payments, and benefit monitoring.

63. Despite progress in attaining the health-related MDG targets, DOH reports slow progress in maternal mortality reduction. Women's health, full health coverage for the poor through PHIC, and quality improvement at all levels remain high priorities for future health sector investments in the Philippines.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/ Indicators	Baseline 2004	Completion 2011	Source
Impact Improve health status of the population, especially of the poor and achievement of health related Millennium Development Goals (MDGs).	Maternal mortality ratio reduced to 90/100,000 live births.	110 (73–160) (2005)	99 (66–140) (2010)	WHO
	Infant mortality rate reduced to 17/1,000 live births.	29	19 (2012)	Indexmundi
	Under-5 mortality rate reduced to 24/1,000 live births.	33	25 (2012)	Indexmundi
	Malaria cases reduced by half	50,850 (2005)	19,316 (2009)	WHO
Outcome Increase utilization of affordable and financially sustainable quality health services by the poor based on progressive implementation of the Health Sector Reform Agenda.	Proportion of children fully-immunized before age 1 is at least 95%	92%	79%	WHO
	Percentage of facility-based deliveries is at least 70% by 2010	44% (2008)	62%	NSO, DOH
	Contraceptive prevalence rate increased to 60% by year 2010	50%	48%	NSO 2002
	Proportion of Botikang Barangay per two Barangays has reached 84%	2% (2003)	59% (2009)	DOH
	Percentage of families enrolled in NHIP is at least 85%	59% (2003)	84% (2012)	DOH
Output **A. Health Financing Reform -** Financial sustainability of the national health insurance improved and insurance coverage of the poor extended. Per capita public spending on health	Information campaign on benefit package of sponsored program of PHIC conducted until end Proportion of provincial budget allocated to health is at least 15%		Yes	
	Proportion of provincial budget allocated to health is at least 15%	27%	27%	LGU Scorecard table 4, #20
	Percentage of families enrolled in NHIP is at least 85%	16% (2000)	84% (2012)	LGU Scorecard table 4, #20/DOH
	Percentage of all indigent families enrolled in NHIP is 100%		100%	WHO LGU Scorecard table 4, #20/DOH
B. Hospital Reform - Improved governance, operational efficiency, and service provision of public hospitals	Governing boards for public hospitals established based on DOH policy documented in administrative order in at least one hospital per province	60 Governing boards established	60 Governing boards established	Endline report
	Proportion of LGU hospitals with	No data	No data	Endline report

Design Summary	Performance Targets/ Indicators	Baseline 2004	Completion 2011	Source
	Continuing Quality Improvement program is 100% of LGU hospitals	available	available	
	Proportion of LGU hospitals with management information system implemented is 100% of LGU hospitals	25%	33%	Endline report
	Lower tier hospitals upgraded to provide better quality care by 2012	8 hospitals	8 hospitals	Endline report
C. Public Health Reform - Increased utilization of cost-effective public health programs and primary health care services	Proportion of LGU spending on health allocated to public health programs & activities is 15% of total budget for health for provinces and 45% for municipalities.	17.8% (Ilocos Norte), 13.2% (Ifugao), 44.5% (Oriental Mindoro)	Ilocos Norte 9.29% (for 7 municipalities with data)	Endline report
	At least 90% of all eligible RHU staff trained in management guidelines		No data available but ongoing	Endline report
	At least 90% of all eligible hospital staff in trained in CPGs		No data available but ongoing	Endline report
	Proportion of RHUs upgraded or physically improved is at least 80%		89%	Endline report
D. Regulatory Reform - Improved quality, accessibility, and safety of health care-related products, facilities, and services	Percentage of RHUs accredited by PHIC for OPB package is 80%	75%	95%	LGU Scorecard
	Percentage of BEMONC facilities accredited by PHIC for MCP package is 100%	10%	30%	LGU Scorecard
	Average bid price for selected essential drugs (i.e., Paracetamol) purchased by PHO is lower by 10% from the baseline	1.96%	1.88%	LGU Scorecard
	Proportion of drugs (i.e., Package 1) purchased through pooled procurement schemes is 100% at the provincial level		Total amounts purchased through pooled procurement scheme, Ilocos Norte P2.98 million, Or. Mindoro P6.3 million,	Endline report
	Median availability of selected generic medicine (public)	15.4% (public) 26.5%	No data available	WHO

Design Summary	Performance Targets/ Indicators	Baseline 2004	Completion 2011	Source
		(private)		
	Median consumer price ratio of selected generic medicine	(2001–2009) 6.4 (public) 5.6 (private)	No data available	WHO
E. Local Health System Reform - Rational delivery of local health services through formation of interlocal health zones (ILHZs) and private sector partnerships	100% of ILHZs have strategic business plans developed and operational		60% (among sample core-referral hospitals)	Endline report
	Proportion of health financing in participating municipalities that is under the authority or managed by the ILHZ board/fund should be at least 1% of their budgets (in-kind or cash)	70%	No data available	LGU Scorecard
	100% of ILHZs with formal referral system	50%	70%	LGU Scorecard
	At least one PPP in any public health facility with a private institution		Yes	
F. Health Sector Governance - Increased public accountability and improved organizational effectiveness of health service providers	At least 1 policy framework for accountability developed	0	Accountability policies built into existing policies of other agencies.	LGU Scorecard
	At least 1 joint policy framework developed for contracting with health facilities		PHIC developed 10 CPGs for accredited hospitals.	PHIC report
	At least 1 HMIS developed for improving the reliability of health data/information		One HOMIS developed	Endline report
	National resource center fully established by DOH by end 2011	No resource center established	1 resource center established	Endline report

BEMONC = Basic Emergency Maternal Obstetric and Neonatal Care, CPG = Clinical Practices Guidelines, DOH = Department of Health, HMIS = Health Management Information System, HOMIS = Hospital Management Information System, ILHZs = inter-local health zones, LGU = local government unit, MDG = Millennium Development Goal, NHIP = National Health Insurance Program, NSO = National Statistics Office, OPB = outpatient primary care benefit, PHIC = Philippine Health Insurance Corporation, PHO = provincial health office, PPP = public–private partnership, RHU = rural health unit , WHO = World Health Organization

Source: Asian Development Bank; Department of Health, Philippines.

PROGRAM POLICY MATRIX

Policy Actions	Monitorable Actions	Accomplishment
Actions Completed for First Tranche		
A. Health Care Financing Reform		
PHIC submits confirmation of the inclusion of the allocation for the sponsored program in the 2005 (2006) budget as submitted to Congress PHIC submits a Board resolution to review the policy and structure of premium payment for both the employed sector and the sponsored program. PHIC develops a plan to establish a routine process of review and adjustment of benefit packages aiming at cost-effectiveness.	PHIC submits a financing plan showing the proposed budgetary allocation of national government subsidies for sponsored program in 2005 (2006). PHIC issues a coordination plan for a DSWD and DILG-led regular national enumeration and ranking of all households by an appropriate poverty index developed in conjunction with existing initiatives such as those outlined in DILG Memorandum Circular 92-2003. PHIC submits a plan, for progressive premium contributions based on capacity to pay	PHIC Board Resolution 584 s 2003 (signed by the Board on 17 June 2003) approved P1.3 billion for FY2004 budgetary support for the sponsored program. PHIC Board Resolution 684 s 2004 (signed by the Board on 27 May 2004) approved P4.58 billion for FY2005 budgetary support for the sponsored program. In essence the sponsored program target population was increased (Plan 5/25). PHIC Board Resolution 799 s 2005 (signed by the Board on 9 June 2005) approved P4.2 billion for FY2006 budget support for the sponsored program. PHIC Board Resolution 902 s 2006 (signed by the Board on 15 June 2006) approved P3.9 billion for FY2007 budgetary support for the sponsored program. An issue paper was added to explain that the revised sponsored program (called Plan 5/25) would include all those identified as indigents in the country, including the poor who were initially added in the IPP. An LGU M&E computerized system was developed to monitor enrollment of the sponsored program. The M&E system acceptance certificate dated 9 August 2006 was signed by PHIC Management. PHIC Board Resolution 886 s. 2006 (signed by the PHIC Board on 23 February 2006) on approved implementation of the progressive premium contribution for self-employed professionals. PHIC Board Resolution 887 s. 2006 (signed by the Board on 24 March 2006) amended PHIC Board Resolution 886 s. 2006 and authorized PHIC management to identify higher-income professional

Policy Actions	Monitorable Actions	Accomplishment
		groups that would be covered. The Implementation Rules and Regulations of the National Health Insurance Act as amended by RA9241 2004 (page 25, section 28) described the premium sharing schedule for the indigent program. PHIC Board Resolution 735 s. 2004 (signed by the Board on 16 December 2004) approved the proposed contribution schedules for the employed sector, and adjusted the ceiling on the monthly salary that is subject to PHIC contribution. In 2006, salary cap was raised to P25,000, and in 2007, salary cap was raised to P30,000.
	PHIC prepares an action plan on information campaigns targeting the poor.	PHIC Board Resolution 917 s. 2006 (signed by the Board on 23 June 2006) approved the FY2006 Corporate Operating Budget of PHIC, including a budget allocation for the IEC Implementing Plan for the premium adjustment. Issue paper showed the IEC Plan on the progressive premium structure for the employed and IPP sectors, detailing the objectives, which included dissemination and/or consultation of the plan to the community.
	PHIC submits an action plan to develop a new insurance scheme for the informal sector through organized group program	PHIC Board Resolution 917 s. 2006 (signed on 23 June 2006) approving FY2006 corporate budget use for implementation of KASAPI. Study results were submitted through a report on Segmenting the Informal Sector with a view to adjusting premiums based on the ability to pay in the Philippines, conducted by S. Kwon, and funded with the support of GTZ (6 September 2005). PHIC Board Resolution 926 s 2006 (signed by the Board on 6 July 2006) approved the rationalization of PHIC benefits.
	.	The additional costs of the extended benefits package was estimated at P750 million (or $14.7 million) annually (as of 19 September 2006).

Policy Actions	Monitorable Actions	Accomplishment
		Philippine Board Resolution 605 s. 2003 dated September 4, 2003 signed by PHIC Board approved the PHIC Development Plan for 2004–2012. PHIC MTPs (2004–2007 and 2008–2012) estimated the costs of new benefits packages dated 19 September 2006. However, the MTP were incomplete and required further work.
	PHIC develops an action plan for a feasibility study on coverage of the five most frequent catastrophic illnesses requiring hospitalization	PHIC Board Resolution 880 (singed by the Board on 23 February 2006), and 921, 923, 924 s. 2006 (signed by the Board on 6 July 2006) accepted the extension of the benefit package. The revised benefits package included coverage for Avian Influenza, and outpatient coverage for HIV/AIDS, and malaria and maternity care package for the third normal spontaneous delivery
	PHIC submits an implementation plan for the clinical pathways for five high-cost volume cases, and their use in accreditation, and post-payment auditing of claims.	PHIC prepared 10 treatment protocols. PHIC prepared a study proposal to test the utilization of the 10 CPGs (26 September 2006). The terms of reference for the study were approved by PHIC management. The study proposal was accepted by PHIC management on 26 September 2006. An ADB TA consultant was slated to help conduct the study, which was to be conducted during September 2006 to February 2007, with results published in newsletters and shared with stakeholders and providers by March 2007. Following dissemination, PHIC planned to regularly review the claims that would be filed by the participating hospitals for adherence to the CPGs. The hospitals were to be informed of the review results. Health Technology Assessment Forum newsletter (Volume 4 no. 1, 2006) published the description of the 10 CPGs that were to be used for accredited hospitals: pediatrics community acquired

Policy Actions	Monitorable Actions	Accomplishment
		pneumonia, acute appendicitis, hypertension, dyspepsia, acute bronchitis, adult asthma, community acquired pneumonia in adults, urinary tract infection, acute gastroenteritis, maternity care. In addition, the newsletter set out the PHIC plans for disseminating these 10 CPGs in the accredited hospitals. The status of CPG use in the accredited hospitals was to be published in a subsequent newsletter and PHIC website after the CPGs were tested under policy action A.4.
	PHIC issues an implementation plan for the use of 10 CPGs in all accredited hospitals as criteria for accreditation and quality assurance	
B. Hospital Reforms		
DOH develops an action plan to prepare standard guidelines to institutionalize governing boards, including ways to select and train board members and terms of reference of governing boards. Governing boards must include consumer representatives and develop an annual business plan.	DOH develops a set of waste management guidelines	Administrative Order no. 02 s. 2005 (24 August 2005) signed by the Secretaries of the DENR and DOH on Policies and Guidelines on Effective and Proper Handling, Collection, Transport, Treatment, Storage and Disposal of Health Care Wastes.
DOH issues an AO setting out a policy for a unified management information system (UMIS), including systematic monitoring and evaluation of finances and management of all public hospitals	The DOH budget in the 2005 General Appropriations Act submitted to Congress gives authority to DOH hospitals to retain and use revenues.	Administrative Order no. 002 s. 2006 (23 January 2006) signed by Secretary of Health, DOH on the establishment of the continuing quality improvement (CQI) program and committee in DOH-retained hospitals. PHIC circular no. 12 s. 2006 (10 April 2006) signed by the officer-in-charge of PHIC on a requirement for continuous quality improvement program in accreditation of hospitals.
DOH submits a plan and terms of reference to develop a policy framework for performance-based allocation of subsidies to DOH hospitals		
DOH submits draft guidelines on rationalizing LGU hospitals, based on need, using objective criteria such as utilization rate and geographic access.		Administrative order no. 0007 s. 2006 (28 April 2006) signed by the Secretary of Health, DOH on Guidelines in Establishing Governing Boards for Augmenting Management Capacity of Public Hospitals. Administrative order no. 0027 s. 2006 (signed on 12 July 2006) by Secretary of Health, DOH on Implementing Guidelines for Performance-based budgeting for DOH retained hospital.
	DOH submits guidelines on basic principles to earn, retain, and use revenues.	Administrative order no. 0029 s. 2006 (15 June 2006) signed by Secretary of Health, DOH on Guidelines for Rationalizing the Health Care

Policy Actions	Monitorable Actions	Accomplishment
		Delivery System based on health needs. This policy action was substantially complied with, because with the introduction of the Administrative order in 2006, DOH had prepared the basis for allocating the national subsidies to the DOH-retained hospitals on a performance basis in 2007. The 2007 subsidies were budgeted for DOH hospitals on a performance basis. Memorandum for the Guidelines on the Revenue Retention prepared by DOH on 27 February 2006, whereby certain guidelines were recommended for change from that proposed under the Joint circular 2003-1 by DOH, DBM, and DOF prepared on Implementation of the Guideline on Revenue Retention. A comparative analysis of human resources in 30% of DOH hospitals was completed on 10 June 2006.
C. Public Health Reforms		
DOH issues an administrative order to adopt the revised expenditures targets for public health spending and hospital-based services (Tranche release policy action) DOH develops a framework to establish long term performance-based budgeting for priority public health programs. (Tranche release policy action) DOH drafts a bill for Congress review to institutionalize long-term performance-based budgeting for priority public health programs DOH revises the PNDF to include contraceptives (pills, injectibles, and intrauterine devices). (Tranche release policy action) DOH issues an administrative order on partnerships with the private sector for delivery of public health programs, specifically tuberculosis (TB) and family planning	DOH submits an action plan to set a national target for increasing the share of public health expenditures for public health programs.	Administrative order no. 0023 s. 2006 (30 June 2006) signed by the Secretary of Health, DOH on Implementing Guidelines for Financing HSRA (FOURmula ONE for Health) Investment and Budget Reforms. Administrative order no. 0022 s. 2006 (12 July 2006) signed by the Secretary of Health, DOH, on Guidelines for Establishment of Performance-based budgets for public health. Performance was to be considered under three-categories: baseline public health commodity fund intended for public health commodities (e.g. vaccines, tuberculosis drugs); public health program funds intended for policy and systems development and for the provision of TA from DOH to LGUs and health sector partners (e.g. surveillance systems strengthening); and public health development fund intended for savings generated or unallocated from the public health program fund

Policy Actions	Monitorable Actions	Accomplishment
DOH and selected private health organizations signs an MOA on public–private partnerships on TB and women's health and safe motherhood programs.		grant and loan inputs from ODA and funds shifted from hospitals towards preventive and promotive services, and used for LGU incentives (refer to Policy action B.3.). Some public health performance-based indicators were identified as: coverage under the expanded program for immunization, tuberculosis prevalence, contraceptive prevalence, under-5 mortality, infant mortality, maternal mortality.
	DOH issues administrative order to make a policy statement for contraceptive self-reliance strategy, targeting poor women.	Draft Bill submitted to Congress on 27 April 2006 for Institutionalization of Performance-based budgeting for Public Health Programs, Appropriating Funds Therefore and for other purposes. PNDF (sixth edition) included pills and injectables as of 3 April 2006. Medical Device List (of the Bureau of Food and Drugs) included IUDs and condoms as of 8 May 2006.
	DOH issues a plan setting out policy for reviewing the current primary health care services and recommending necessary adjustments	Administrative Order no. 008 s. 2006 (10 May 2006) was signed by the Secretary of Health, DOH, on Guidelines of Public–Private Collaboration in Delivery of Health Services, including Family Planning for Women of Reproductive Age. Administrative Order no. 154 s. 2004 (14 June 2004) was signed by the Secretary of Health, DOH, on Implementing Guidelines for the Creation of National and Regional Coordinating Committee on Public–Private Mix on Tuberculosis Directly Observed Treatment Short Course Package. An MOA was signed among the PNGOC, PCCI and DOH on 19 May 2006 with the objectives of a sustained reduction in Filipino women's risk from dying due to maternal causes and increasing the share of private sector provision in total population-wide coverage of essential health services for women of reproductive age.

Policy Actions	Monitorable Actions	Accomplishment
		An MOA was signed between the Philippines Coalition Against Tuberculosis, Foundation for Innovative New Diagnostics, Global Alliance for TB-Drug Development, Department of Science and Technology, and DOH on 24 March 2006 on Understanding to the Objective of Accelerating the Discovery and Development of new TB tools, diagnostics, and anti-TB drugs.
D. Health Regulatory Reforms		
DOH drafts a bill for Congress review proposing amendments of the mandates of DOH regulatory agencies to increase efficiency in health care provision. (Tranche release policy action) DOH and PHIC review and updates administrative issuances and circulars on licensing and accreditation standards of health facilities. DOH issues an administrative order on certification mechanism for primary health care services providers based on service capacity and quality (Tranche release policy action) DOH issues an administrative order and new regulations on drug management in order to reduce drug prices. (Tranche release policy action) DOH and PHIC establish a regularly updated and published drug price reference and/or monitoring system, involving related public and private agencies, consumer organizations, and the academe, among others. DOH and PHIC reviews and issues department orders and circulars in updating PNDF based on the needs of drug management needs of PHIC benefit packages and LGUs	DOH develops an action plan to review and revise the existing laws (e.g., Hospital Licensing Act, Food and Drug Regulation Act), and proposes amendments. DOH submits an action plan to strengthen DOH's certification guidelines for primary health service providers based on service capacity and quality	Draft Bills were submitted by DOH to Congress on 27 April 2006 (and received on 10 May 2006), but Congress has not reviewed the bills by September 2013. The bills were on strengthening the regulatory capacity of the BFAD by amending the Republic Act, and appropriating funds; therefore, rationalizing and strengthening the regulatory power of the state over radiation medical and health-related devices through the creation of the Bureau of Devices and Radiation Health and appropriating funds; therefore, enhancing the regulations of health facilities and health services, strengthening the Bureau of Health Facilities and Services and appropriating funds therefore. DOH issued a department memorandum 0026 s. 2006 (9 February 2006) on the dissemination of administrative order no. 2005-0029 and other administrative orders related to the regulation of health facilities and services. Joint Memorandum circular no. 2 s. 2006 (23 February 2006) between DOH and PHIC on Adoption of a Policy Harmonizing *Sentrong Sigla* certification standards and PHIC accreditation standards for rural health units and/or health centers. Administrative Order no. 0031 s. 2005 (signed by the Secretary of Health on 7 December 2005) on Guidelines and Procedures for the Issuance of the Principle Certificate of Product Registration and the Listing of Identical Drug Products based on the

Policy Actions	Monitorable Actions	Accomplishment
	DOH develops an action plan to develop guidelines to improve controls over drug prices.	Identity of Manufacturers and Pharmaceutical formulation. Administrative Order no. 009 s. 2006 (14 February 2006) signed by the Secretary of Health, DOH, on Guideline on Institutionalizing and Strengthening the Essential Drugs Price Monitoring Systems. Administrative Order no. 0018 s. 2006 (8 May 2006) signed by the Secretary of Health, DOH, on Implementing Guidelines for the PNDF system.
E. Local Health Systems Reform		
DOH issues guidelines on (i) ILHZ governance, (ii) resources sharing arrangements among participating LGUs, (iii) promotion of core referral system, (iv) pooled procurement of drugs, (v) promoting private–public partnerships, and (vi) development of strategic business plans for health services delivery. DOH submits standard MOA on establishment of ILHZ. DOH develops guidelines for incentives for sustaining effective operations of ILHZs	At least three ILHZ's business plans in project provinces developed for 2006. DOH issues an administrative order to approve incentive schemes supporting sustainable operations of ILHZs	MOA signed between DOH, PHIC and LGUs on Establishing ILHZs, enrolling the sponsored program beneficiaries, and upgrading strategic health facilities to meet accreditation and licensing requirements and DOH certification standards for RHU/BHS (23 March 2006 for Nueva Vizcaya and Romblon, 31 March 2006 for Ifugao, 15 May 2006 for Oriental Mindoro, and Ilocos Norte). Three business plans were delivered for two ILHZs in Oriental Mindoro and one ILHZ in Ilocos Norte (24 September 2006) by DOH. Administrative order no. 0017 s. 2006 (3 August 2006) signed by the Secretary of Health, DOH, on Incentive Schemes Framework for Enhancing Inter-LGU Coordination in Health through ILHZ and ensuring their sustainable operations. Draft bill submitted to Congress on 26 April 2006 on providing for the Institutionalization of the Local Health System by establishing ILHZs, creating the governance structure of the same, and for other purposes. ILHZ system proposal was developed in 2001. Two of the five HSDP provinces had established ILHZ in 2000 (Romblon), 2003 (Oriental Mindoro), one (Ilocos Norte) established an ILHZ in 2005, and one (Nueva Vizcaya) established ILHZ in 2006. All

Policy Actions	Monitorable Actions	Accomplishment
		these provinces had an MOA signed between provincial and municipal governments. However, Ifugao did not establish an ILHZ but instead established district health systems in 2003, because it has a small and sparsely distributed population. For Part (i): PHIC Board Resolution no. 918 s. 2006 (6 July 2006). PHIC circular 11 s 2003 on accreditation of BHS/RHUs under ILHZ.
	To convert EO 205 (1999) that mandates (a) DOH and DILG to form national health planning committee and (b) ILHZ into a Republic Act, DOH submits a draft plan for a Congress review.	For Part (ii): DOH requested exemption on legal basis. (Letter of Secretary of Health to ADB received on 2 May 2006). DOH Resolution 36-26 s 2006. The policy action is substantially complied because part (ii) was not possible to follow through due to legal restrictions in the Philippines.
F. Improving Health Sector Governance		
DOH develops an action plan and TOR to conduct a comprehensive need assessment and develop a capacity development plan, and distribution of health human resources. DOH initiates an executive order to establish a process whereby short- and medium term plans of DOH and LGU health agencies are reconciled with updated HSRA. DOH develops a framework for consumer participation in planning and evaluating health sector activities and performance; and standard instrument to measure consumer participation	DOH issues the first update of short- and medium-term plans for DOH and project provinces in support of HSRA implementation. (Tranche release policy action)	Comprehensive Health Human Resource master plans (2006–2011, 2011–2020, and 2020–2030) were submitted by DOH on November 2005. DOH submitted on 20 September 2006 an update on the short (2006–2007)- and medium (2006–2010)-term plans that included the national plans for health service delivery, health regulations, health financing, and health governance in support of HSRA implementation. Administrative Order 0020 s. 2006 (13 June 2006) on Guidelines for Evaluation of Consumer Participation Strategies in HSRA (FOURmula ONE for Health).
	DOH through a consultation process with relevant stakeholders develops a standard instrument for measuring the effectiveness of consumer participation, and tests and approves it. (Tranche release policy action	Community consultations took place in May 2006. First tranche release of $100 million was used during 2005–2006 towards HSRA activities, and most of it was shared between public health and hospitals. Second tranche of $100 million was planned to be

Policy Actions	Monitorable Actions	Accomplishment
	DOF and DOH shall submit a report on the investment in the health sector, including proceeds of the program loan in support of the HSRA and policy implementation	used during 2007–2008 for similar HSRA activities.
Actions Completed for Second Tranche		
A. Health Care Financing Reforms		
PHIC submits confirmation of the inclusion of the allocation for the sponsored program in the 2006 budget as submitted to Congress. PHIC board approves a new premium policy allowing progressive premium structure. Based on a detailed cost database and analysis, PHIC board approves a revised payment package. PHIC publishes a performance report on the status of the utilization of the 10 CPGs for quality assurance and accreditation	PHIC submits their financing plan, which allocates subsidies for the sponsored program in 2006. PHIC submits a board-approved MTP for 2005–2012 including an actuarial forecast of revenues and payments. PHIC develops LGU database monitoring participation in sponsored program and a mechanism of improved targeting, monitoring and evaluation, and tests it in three project LGUs. PHIC board approves a progressive premium contribution scheme based on individuals' capacity to pay for poor households under the poverty line that are ineligible for the sponsored program. PHIC concludes designed information campaign. PHIC board expands PHIC Organized Groups Interface for national implementation. PHIC and organized groups in informal sector develop an MOA in all HSDP provinces to implement an Organized Group Program. PHIC publishes a report on status of CPG use in accredited hospitals.	This was successfully implemented, with the initial sponsored program national financing counterpart sourced from the World Bank. In 2013, the sponsored program adjusted the enrollee selection criteria, in coordination with the Conditional Cash Transfer program of the Department of Social Welfare and Development, as well as increased budget appropriation from the national government. In 2012, there was an attempt to increase premium rates for the self-employed, those who pay individually and overseas workers by 100%, as specified in PHIC Circular no. 57 (series of 2012). However, due to public opposition, this was partially rescinded, with premiums for the self-employed and individually paying members set at P1,800 (from P2,400), and those for overseas workers at P1,200. PHIC has since increased benefit payments and developed new packages, having implemented case rate payments for some 20 conditions and Z benefits for so-called catastrophic conditions (e.g., dialysis and chemotherapy). The CPGs have been published but have been of limited utility as PHIC does not require compliance with these for reimbursements. The reimbursement issue has been bypassed by the implementation of case rates (under which some of the conditions with CPGs belong). Benchbook quality accreditation standards have additionally required locally developed CPGs. Nonetheless, actual CPG utilization and consequent quality improvement remain to be determined.
B. Hospital Reforms		
DOH designs a unified management information	DOH issues an administrative order to implement	HOMIS was expanded to provide additional

Policy Actions	Monitorable Actions	Accomplishment
system for pilot testing and enters into an MOA with selected hospitals for test. DOH issues an administrative order to adopt a policy on governing boards of all public hospitals. DOH issues an administrative order to adopt performance-based allocation of subsidies for 2006. DOH issues administrative order to state a policy on rationalizing local public hospitals based on need.	the public and private hospital waste management guidelines. DOH completes a human resource assessment for 30% of DOH hospitals. DOH evaluation report on progress and experience of corporatizing the two selected DOH hospitals. DOH implements guidelines on revenue retention for DOH hospitals. DOH submits three LGU ordinances authorizing provincial hospitals to earn, retain, and use their revenues. DOH issues an administrative order on implementation of continuing quality improvement (CQI) and use of monitoring tools in all DOH hospitals. PHIC endorses CQI as criteria for accreditation of all hospitals. DOH completes the performance evaluation system. DOH submits an action plan to assess hospital staff requirements based on expected case load and service volume, identify training requirements, and design hospital staff performance evaluation system	financial management capabilities, including the generation of PHIC claims. Currently, a Unified Health Management Information System is being developed by DOH that will integrate the different information management systems and hopefully provide more comprehensive and timely data for decision making. A governing board was adopted in just one hospital (Quirino) outside of the four DOH corporate hospitals (Heart Center, Lung Center, National Kidney and Transplant Institute, and the Children's Medical Center). There is by December 2013 pending legislation to convert selected DOH hospitals into government corporations, which would have their own boards. Performance-based budgeting for hospitals was initiated but not sustained as conditions for performance payment were found to be restrictive (i.e., rather than separate additional financing for good performance, hospitals received lower maintenance and other operating expense funds, with the balance received later in the year contingent on performance). Rationalization and eventually investment plans were used extensively by LGUs. These became the basis for DOH's allocation of resources for LGU health infrastructure upgrading under the current Health Facilities Enhancement Program.
C. Public Health Reforms		
DOH issues an administrative order to adopt the revised expenditures targets for public health spending and hospital-based services. DOH develops a framework to establish long term performance-based budgeting for priority public health programs. DOH revises Philippines National Drug Formulary to include contraceptives (pills, injectibles, and IUDs).	DOH drafts a bill for Congress review to institutionalize long-term performance-based budgeting for priority public health programs. DOH issues an administrative order on partnerships with the private sector for delivery of public health programs, specifically TB and family planning. DOH and selected private health organizations sign an MOA on public–private partnerships on TB and women's health and safe motherhood programs.	Service Level Agreements were adopted that indicate the outputs required from LGUs, for which fund releases are made either by fixed or variable tranches. Despite problems (primarily from delayed submission of liquidation reports), this initiative has been relatively successful and has therefore been taken up by other national government agencies. The Responsible Parenthood and Reproductive Health Act of 2012, or Republic Act 10354, through its implementing rules and regulations, has additionally specified that contraceptives and IUDs

Policy Actions	Monitorable Actions	Accomplishment
		will be included in the PNDF upon approval of the FDA. The act further defines the public provision of these medications and related services even at the village level. However, the implementation of the act has been hindered by a suit filed with the Supreme Court.
D. Regulatory Reforms		
DOH drafts a bill for Congress review proposing amendments to the mandates of DOH regulatory agencies to increase efficiency in health care provision DOH issues an administrative order on a certification mechanism for primary health care services providers based on service capacity and quality. DOH issues an administrative order and new regulations on drug management in order to reduce drug prices	DOH reviews administrative order revising licensing and accreditation standards and criteria to support reforms. DOH issues guidelines for the selected, most frequently used drug groups	Republic Act 9711, or the Food and Drug Administration Act of 2009, was to further strengthen the capacities of the FDA (originally BFAD). A "one stop shop" provider accreditation system for DOH and PHIC has been established. The "Universally Accessible Cheaper and Quality Medicine Act of 2008", or Republic Act 9502 came to define drug policy and regulation. The corresponding IRR was contained in the joint Administrative Order (2008-01) issued by the DOH, Department of Trade and Industry (DTI), Intellectual Property Office (IPO), and the (then) Bureau of Food and Drug. In 2011, the DOH issued administrative order 2011-0012 that contained the implementing guidelines on electronic drug price monitoring system, in compliance with the joint administrative order. Nonetheless, the actual effectiveness of this system remains to be determined.
E. Local Health System Reform		
DOH, PHIC and LGUs approve an MOA that commits to (i) establishing ILHZs, (ii) enrolling the poor in PHIC indigents program, (iii) setting up enrollment centers, and (iv) upgrading strategic health facilities to meet PHIC accreditation and licensing requirements and DOH certification standards for RHUs and BHSs. LGUs sign an MOA to establish ILHZs in at least three of the 13 areas identified by DOH in five project provinces. To issue licensing and accreditation of ILHZ as an integrated network including private health services providers (system accreditation), PHIC approves	At least three ILHZ's business plans in project provinces developed for 2006. DOH issues an administrative order to approve incentive schemes supporting sustainable operations of ILHZs. To convert EO 205 (1999) that mandates DOH and DILG to form national health planning committee and ILHZ into a Republic Act, DOH submits a draft plan for a Congress review.	While ILHZs have been broadly adopted, most of these have not achieved the desired level of functionality. There are administrative as well as legal hurdles to resource sharing among LGUs, which is a prerequisite to achieving operational synergies and effectiveness.

Policy Actions	Monitorable Actions	Accomplishment
accreditation criteria for local health systems and DOH approves licensing standards for ILHZ		
F. Improving Health Sector Governance		
DOH develops and approves a comprehensive plan for health human resource assessment and capacity development DOH issues the first update of short- and medium-term plans for DOH and project provinces in support of HSRA implementation. Through a consultation process with relevant stakeholders DOH develops a standard instrument for measuring the effectiveness of consumer participation, and tests and approves it	DOH reviews administrative order on CQI and in participating provinces, supports the implementation of CQI programs. DOF and DOH shall submit a report on the investment in the health sector, including proceeds of the program loan in support of the HSRA and policy implementation.	A Human Resources for Health (HRH) master plan was developed by the DOH in 2005, in coordination with the World Health Organization – Western Pacific Regional Office. An electronic HRH has also been set up. The HSRA reform program was subsequently modified, to FOURmula ONE for Health, and, in 2010 to the Universal Health Care policy of the DOH. The latter policy frameworks are consistent with HSRA, but identify different priorities. The LGU scorecard was initiated, as part of DOH's Monitoring and Evaluation for Equity and Effectiveness. Patient satisfaction is one of the categories rated in this tool. Patient's Charters have been implemented in government hospitals, which, through posters, allow facility users to be familiar with administrative procedures as well as the responsible offices and persons. The actual effectiveness of these interventions remain to be determined

AO = Administrative Order, BFAD = Bureau of Food and Drugs, CPG = clinical practice guidelines, DBM = Department of Budget and Management, DENR = Department of Environment and Natural Resources, DILG = Department of Interior and Local Government, DOH = Department of Health, DSWD = Department of Social Welfare and Development, EO = Executive Order, FDA = Food and Drug Authority, FY = fiscal year, GTZ = German Technological Cooperation, HSDP = health sector development program, HOMIS = hospital management information system, HSRA = Health Sector Reform Agenda, HRH = human resources for health, IEC = information, education, and communication, ILHZ = inter-local health zone, IPP = Individually Paying Program , KASAPI = Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance, LGU = local government unit, M&E = monitoring and evaluation, MOA = memorandum of agreement, MTP = medium-term plan, ODA = Official Development Assistance , PCCI = Philippine Chamber of Commerce and Industry, PHIC = Philippine Health Insurance Corporation, PNDF = Philippine National Drug Formulary, PNGOC = Philippine Non-Government Organization Council, RA = Republic Act, TB = tuberculosis;
Source: Asian Development Bank

SUMMARY OF CIVIL WORKS

Name of Health Facility	Amount (in Php)	Scope of Work
Nueva Era Rural Health Unit	11,549,186	Construction of a new building Construction of a 3-chamber septic tank, vault for sharp objects, perimeter fence and canal lining and/or drainage Development of basement as parking area
Dingras Rural Health Unit	4,981,756	Site development Construction of a new building Construction of a 3-chamber septic tank, vault for sharp objects, fence and canal lining and/or drainage.
Bangui District Hospital	22,073,615	Bed capacity increased from 25 to 40 beds Construction of two-story pay ward and quarters building Repair of the out-patient department building and extension of operating room/delivery room/emergency room Major repairs on the existing main building Site development works; relocation of existing entrance gate and provision of concrete driveway Construction of waste collection unit, placenta pit and vaults for sharp objects Construction of canal linings and/or drainage for the new building.
Dingras District Hospital	22,845,421	Increase bed capacity from 25 to 50 beds Construction of additional pay ward, doctors quarters, and dining room and/or kitchen Repair of existing out-patient department and/or laboratory and/or radiology departments Completion of delivery and operating room Construction of dietary and/or laundry and linen building Construction of waste collection unit, placenta pit and vaults for sharp objects) Site development works—road network at the back portion of the hospital compound; Construction of miscellaneous structures (repair of dietary facility; tile and plumbing works; faculty quarters; carpentry works; roof repair; painting works; and ceiling, door and window repairs) Upgrading of electrical system.

Name of Health Facility	Amount (in Php)	Scope of Work
Gen. Roque B. Ablan Sr. Memorial Hospital	63,577,405	Completion of the unfinished 3-story building to accommodate an additional 50 beds for pay wards and ICU for surgical and pediatric care and supply and installation of elevator Completion of repair and/or repartitioning of existing OPD, laboratory and radiology Extension and/or construction of a 2nd floor for the laboratory and/or radiology departments to accommodate pay consultation rooms, doctors' quarters, and conference rooms Construction of emergency ramp Construction of waste water treatment plant, placenta pit and vaults for sharp objects. Repair of existing two-story pay ward building Construction of new one-story ER building Repair of existing labor and/or delivery room and nursery complex Construction of a linen and laundry section Repair of existing doctors quarters Construction of miscellaneous structures (storm drainage, pavements, canal linings, path) Electromechanical facilities Slope protection in areas prone to erosion
Pinamalayan Community Hospital	27,598,521	Site development Rehabilitation of existing administrative building Renovation of existing pediatric and isolation building Construction of new 35 beds ward building Construction of morgue Construction of maintenance building Construction of electrical building Water system Partial rehabilitation of existing laboratory and/or business and administration building Utility building
Roxas District Hospital	16,380,867	Site development Rehabilitation of existing administrative building Renovation of existing pediatric and isolation building; Construction of new 35 beds ward building Construction of morgue Construction of electrical building and improvement of electrical system Water system Renovation of women's health facility Construction of an administrative building Surgical ward Dietary building Utility building
Oriental Mindoro Provincial Hospital	179,640,416	Site development Construction of new 200 bed provincial hospital building with complete support facilities Water system Construction of perimeter fence Construction of Mangyan ward

Name of Health Facility	Amount (in Php)	Scope of Work
		Exterior water and sewer Utility building (pump & compressor room, medical gas room) Engineering and maintenance.
Mariano Marcos Memorial Hospital and Medical Center	12,589,694	Expansion and renovation of three-story OB-ER, admitting and diagnostic center
Batangas Regional Hospital	28,878,837	Completion of OR/DR & pediatric complex and mechanical gas piping system
Veterans Regional Hospital	48,320,962	Construction of a four-storey trauma center; Site development Improvement of electrical system Improvement of electro and/or mechanical system
Resource Center for Health Sector Development 1	5,150,212	Construction of resource center
Resource Center for Health Sector Development 1	7,495,415	Construction of second resource center

DR = delivery room, ER = emergency room, OB = obstetric, OR = operating room, OPD = out-patient department;
Source: Asian Development Bank.

SUMMARY OF PROCURED EQUIPMENT

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
I. Medical, Dental and Laboratory Equipment					
Anesthesia Machine	2010	1	1,800,000	1,800,000	MMMHMC
Pulse Oximeter	2010	5	28,000	140,000	MMMHMC
IV Infusion Pump	2010	2	56,700	113,400	MMMHMC
Cardiac Monitor	2010	2	147,500	295,000	MMMHMC
Electrocautery Machine	2010	1	225,000	225,000	MMMHMC
Ventilator Machine	2010	1	980,000	980,000	MMMHMC
Fetal Monitor	2010	1	157,000	157,000	MMMHMC
Examining Table	2010	4	18,500	74,000	MMMHMC
Steam Autoclave Sterilizer	2010	2	128,000	256,000	MMMHMC
Delivery Table	2010	2	98,400	196,800	MMMHMC
Diagnostic Set	2010	2	44,175	88,350	MMMHMC
OR Light	2010	1	890,000	890,000	MMMHMC
Defibrillator	2010	2	585,000	1,170,000	MMMHMC
Laryngoscope	2010	2	21,455	42,910	MMMHMC
Emergency Cart	2010	2	109,800	219,600	MMMHMC
Nebulizer	2010	3	2,498	7,494	MMMHMC
BP Apparatus	2010	6	5,242	31,452	MMMHMC
Mechanical Bed	2010	10	29,335	293,350	MMMHMC
Anesthesia Machine	2011	2	895,000	1,790,000	VRH
Cautery Machine	2011	1	280,000	280,000	VRH
Mobile C-Arm Imaging System	2011	1	2,978,000	2,978,000	VRH
Bedside Monitor	2011	1	715,000	715,000	VRH
Mobile X-ray	2012	2	2,377,000	4,754,000	VRH
Laparoscopy for surgery with Video System	2012	1	6,100,000	6,100,000	VRH
Mobile LED Light	2012	3	170,000	510,000	VRH
Weighing Scale (Pediatric)	2012	3	2,757	8,271	VRH
Weighing Scale (Adult)	2012	3	9,800	29,400	VRH
Ultrasound Machine	2012	1	1,910,000	1,910,000	VRH
Defibrillator	2012	4	310,000	1,240,000	VRH
Autoclave Steam (heavy duty)	2012	1	472,000	472,000	VRH
Instruments for ER	2012	1	99,900	99,900	VRH
Suction Machine (heavy duty)	2012	2	107,500	215,000	VRH
Wheelchair	2012	5	4,800	24,000	VRH
Anesthesia Cart	2012	3	85,000	255,000	VRH
Emergency Cart	2012	6	61,000	366,000	VRH
Nebulizer	2012	15	2,050	30,750	VRH

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
Negatoscope (with two films)	2012	10	15,140	151,400	VRH
Laundry Trolley	2012	5	37,150	185,750	VRH
Patient Bed with Side Table	2012	50	27,800	1,390,000	VRH
Orthopedic Bed with Balkan Frame	2012	10	67,140	671,400	VRH
Stretcher Bed with Rail	2012	15	34,880	523,200	VRH
ECG Machine with Built-in Reader	2012	6	25,794	154,764	VRH
Stretcher Bed	2012	6	89,500	537,000	MMMHMC
Suction Machine	2012	1	70,000	70,000	MMMHMC
Weighing Scale (Adult)	2012	1	14,200	14,200	MMMHMC
Weighing Scale (Neonate)	2012	2	5,800	11,600	MMMHMC
Ultrasound Machine with 2D Echo	2012	1	4,900,000	4,900,000	MMMHMC
Emergency OR (Major Set)	2012	2	230,000	460,000	MMMHMC
Emergency OR-CS Set	2012	2	95,000	190,000	MMMHMC
Operating Table	2012	6	290,000	1,740,000	BRH
Delivery Table	2012	2	325,000	650,000	BRH
Portable OR/DR Lights	2012	6	80,000	480,000	BRH
Anesthesia Machine	2012	2	585,000	1,170,000	BRH
Cardiac Monitor	2012	4	116,000	464,000	BRH
Pulse Oximeter	2012	8	32,000	256,000	BRH
Suction Machine	2012	7	9,150	64,050	BRH
Bililight (Blue Light)	2012	2	33,000	66,000	BRH
Incubator (Transport)	2012	3	260,000	780,000	BRH
E-Cart (Stainless Steel)	2012	2	39,500	79,000	BRH
Infusion Pump	2012	3	42,000	126,000	BRH
Injection Pump	2012	3	42,000	126,000	BRH
Bassinet	2012	10	12,280	122,800	BRH
Beds (Manual)	2012	30	19,000	570,000	BRH
Mechanical Ventilator	2012	3	880,000	2,640,000	BRH
OR Light (Mounted)	2012	6	72,000	432,000	BRH
Incubator (Standard)	2012	3	213,000	639,000	BRH
Mechanical Ventilator	2012	1	880,000	880,000	BRH
Pediatric Electrocardiograph Machine with Analyzer	2012	1	60,000	60,000	BRH
Mobile X-ray Machine	2012	1	1,200,000	1,200,000	BRH
Fetal Doppler (Portable)	2012	2	30,000	60,000	BRH
Video Endoscope System	2012	1	3,000,000	3,000,000	BRH
Mechanical Ventilator	2012	2	880,000	1,760,000	BRH
Endoview, Videoscope System	2012	1	3,000,000	3,000,000	BRH
Ultrasound Machine	2012	1	4,000,000	4,000,000	BRH
Examination Light	2012	7	20,500	143,500	MMMHMC
Scrub Sink	2012	1	450,000	450,000	MMMHMC

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
Suction Machine	2012	5	70,000	350,000	MMMHMC
Transport Incubator	2012	3	280,000	840,000	MMMHMC
Weighing Scale (Adult)	2012	15	14,200	213,000	MMMHMC
Weighing Scale (Neonate)	2012	5	5,800	29,000	MMMHMC
Delivery Room Set	2012	8	43,000	344,000	MMMHMC
Dilatation and Curettage Set	2012	8	12,000	96,000	MMMHMC
Patient/Nurse Call System	2012	1	888,524	888,524	MMMHMC
Bubble CPAP	2012	3	280,000	840,000	MMMHMC
ER/OR Major Set	2012	2	137,210	274,419	MMMHMC
Stretcher Bed	2012	8	50,850	406,800	MMMHMC
Mechanical Ventilator	2012	2	1,638,000	3,276,000	MMMHMC
Hemodialysis for Neonate	2012	2	747,500	1,495,000	MMMHMC
Laryngoscope set, neonate	2012	5	17,500	87,500	MMMHMC
Baby Bassinet	2012	10	9,989	99,890	MMMHMC
Pulse Oximeter (Portable)	2012	3	28,788	86,364	MMMHMC
Suction Machine (Heavy Duty)	2012	2	27,700	55,400	MMMHMC
Operating Microscope	2012	1	1,450,000	1,450,000	VRH
Instrument Cabinet	2012	5	28,500	142,500	VRH
Medicine Cabinet	2012	2	26,500	53,000	VRH
Suction Machine, heavy duty	2012	6	65,000	390,000	VRH
Instruments for ER	2012	9	99,500	895,500	VRH
Flexible Fiber Choledochoscope	2012	1	1,200,000	1,200,000	VRH
Autorefractor Keratometer	2012	1	714,000	714,000	VRH
Slit Lamp	2012	1	696,300	696,300	VRH
Anesthesia Machine	2012	2	1,050,000	2,100,000	VRH
Cautery Machine	2012	2	280,000	560,000	VRH
Mobile LED Light	2012	1	170,000	170,000	VRH
Defibrillator	2012	5	310,000	1,550,000	VRH
Central Monitor with 12 units Patient Monitor	2012	1	1,405,000	1,405,000	VRH
Dry View Printer	2012	1	799,900	799,900	VRH
Fetal Monitor	2012	4	512,000	2,048,000	VRH
Hand-held Pocket Doppler	2012	6	27,500	165,000	VRH
Instruments for ER	2012	5	99,500	497,500	VRH
Neonatal Hearing Screening	2012	2	339,400	678,800	VRH
Neonatal Weight	2012	2	21,800	43,600	VRH
OR Table for DR	2012	1	158,000	158,000	VRH
Patient Bed	2012	19	22,714	431,566	VRH
Pulse Oximeter	2012	3	62,000	186,000	VRH
Radiant Warmer	2012	1	474,400	474,400	VRH

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
Sliding Automatic Transfer Stretcher	2012	13	236,500	3,074,500	VRH
Suction Machine, heavy duty	2012	11	65,000	715,000	VRH
Ultrasound Machine	2012	1	2,680,000	2,680,000	VRH
Ultrasound Machine with Elastography	2012	1	3,498,000	3,498,000	VRH
Cautery Machine	2012	3	350,000	1,050,000	VRH
Sub-total			**65,181,821**	**100,183,804**	
II. Office Equipment					
Digital Duplicator (High-end)	2006	1	1,095,000	1,095,000	HPDPB
Airconditioner (Window type)	2006	1	23,000	23,000	HPDPB
Airconditioner (Window type)	2006	1	23,000	23,000	BIHC
Airconditioner (Split type)	2006	1	52,000	52,000	BIHC
Airconditioner (Split type)	2006	1	52,000	52,000	BIHC
Binding Machine	2006	1	20,000	20,000	BIHC
Paper Shredder	2006	1	21,000	21,000	BIHC
Multimedia Projector	2007	1	43,000	43,000	BIHC
Multimedia Projector	2007	1	43,000	43,000	HPDPB
Electronic Whiteboard	2007	1	100,000	100,000	HPDPB
Facsimile Machine	2008	2	8,000	16,000	BIHC
Facsimile Machine	2008	1	8,000	8,000	BIHC
Paper Trimmer	2008	1	5,200	5,200	HPDPB
Cabinet Type Aircon (3 Toner)	2012	2	87,954	175,908	VRH
Cabinet Type Aircon (5 Toner)	2012	5	120,054	600,270	VRH
Sub-total			**1,701,208**	**2,277,378**	
III. Furniture and Fixtures					
Filing Cabinet	2006	6	7,200	43,200	BIHC
Filing Cabinet	2006	6	7,200	43,200	BIHC
Conference Table	2006	6	3,200	19,200	HPDPB
Executive Chair	2006	15	3,880	58,200	HPDPB
Computer Chair	2007	5	2,605	13,025	BIHC
Computer Table	2007	5	1,760	8,800	BIHC
Computer chair	2008	7	1,350	9,450	HPDPB
Visitor Chair	2008	6	1,270	7,620	HPDPB
Sofa	2008	2	5,980	11,960	HPDPB
Bookshelf	2008	2	6,500	13,000	HPDPB
Sub-total			**40,945**	**227,655**	
IV. Communications Equipment					
Microphone with Speaker/amplifier	2010	1	94,000	94,000	BIHC
LCD TV	2010	1	97,500	97,500	BIHC

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
LCD TV	2010	1	97,500	97,500	HPDPB
PA System	2012	1	64,995	64,995	MMMHMC
Sub-total			**353,995**	**353,995**	
V. Information Technology Equipment					
Laser jet Printer (B&W)	2006	2	40,600	81,200	BIHC
Laser Printer (colored)	2006	3	39,500	118,500	BIHC
Midrange Server	2006	1	759,840	759,840	HSDP
Workstation	2007	6	53,150	318,900	BIHC
Laptop	2007	2	69,000	138,000	BIHC
Inkjet Printer (colored)	2007	1	16,200	16,200	BIHC
Workstation	2007	4	129,500	518,000	HPDPB
Laptop	2007	1	128,500	128,500	HPDPB
Inkjet Printer (colored)	2007	1	18,500	18,500	HPDPB
Flatbed Scanner	2007	1	4,500	4,500	BIHC
Workstation	2007	4	135,000	540,000	HPDPB
Workstation	2007	4	135,000	540,000	HPDPB
Video Conferencing Camera	2008	1	1,444,000	1,444,000	HPDPB
Digital Tabletop Microphone		5	55,000	275,000	HPDPB
Power Amplifier		1	70,000	70,000	HPDPB
Capture Card		1	36,000	36,000	HPDPB
Laser jet Printer (colored)	2008	1	17,289	17,289	HPDPB
Wireless Router	2008	1	15,000	15,000	HPDPB
Laser Printer (colored)	2008	2	38,000	76,000	HPDPB-RLC
Colored Inkjet Printer	2008	1	20,000	20,000	HPDPB-RLC
NS Switch Port	2008	1	50,000	50,000	HPDPB-RLC
LAN Cabling	2008	1	130,000	130,000	HPDPB-RLC
UPS	2008	15	13,000	195,000	HPDPB-RLC
Inkjet Printer (colored)	2008	1	181,000	181,000	HPDPB
Paper Trimmer/Cutter	2008	1	5,200	5,200	BIHC
DVD Writer	2008	2	3,488	6,976	BIHC
Workstation	2009	40	70,854	2,834,173	BIHC
Laser Printer (black & white)	2009	11	28,237	310,610	BIHC
Flatbed Scanner	2009	1	36,273	36,273	BIHC
Broadband Wireless Router	2009	2	14,531	29,061	BIHC
Power Amplifier	2010	1	28,000	28,000	BIHC
Channel Mixer	2010	1	13,000	13,000	BIHC
2-Way Speaker with Stand	2010	1	20,000	20,000	BIHC
Dual 15 Graphic Equalizer	2010	1	16,000	16,000	BIHC
Microphone	2010	2	1,500	3,000	BIHC
Cable Connectors and Accessories	2010	1	14,000	14,000	BIHC

Particulars	Year Acquired	Qty.	Unit Cost (in PhP)	Amount (in PhP)	Recipient Entity
UPS 1KVA	2011	1	23,696	23,696	HPDPB
UPS 700 VA	2011	40	12,000	480,000	BIHC
Desktop	2012	25	31,225	780,625	MMMHMC
Computer & Peripherals	2012	3	25,000	75,000	MMMHMC
Desktop	2012	15	47,800	717,000	
LAN Cabling	2012	1	2,800,000	2,800,000	
Sub-total			**6,789,383**	**13,884,044**	
TOTAL			**74,067,352**	**116,926,876**	

2D = 2-dimensional, B&W = black and white, BIHC = Bureau of International Health and Cooperation, BP = blood pressure, BRH = Batangas Regional Hospital, CPAP = continuous positive air pressure, CS = caesarian delivery, DR = delivery room, ECG = electrocardiogram, ER = emergency room, HPDPB = Health Policy Development and Planning Bureau, IV = intravenous, KVA = kilovolt-amps, LCD = liquid crystal display, LED = light emitting diodes, MMMHMC = Mariano Marcos Memorial Hospital and Medical Center, NS = name service, OR = operating room, PA = public address, UPS = uninterruptible power supply, VA = volt ampere, VRH = Veteran's Regional Hospital;
Source: Asian Development Bank.

APPRAISAL AND ACTUAL PROJECT COSTS

($ million)

Item	Appraisal			Actual		
	Foreign Exchange	Local Currency	Total	Foreign Exchange	Local Currency	Total
A. Investment Cost						
Civil Works	0.000	8.970	8.970	0.000	9.988	9.988
Equipment	2.550	1.370	3.920	2.267	0.283	2.550
Consultant Services	0.730	0.330	1.060	1.159	0.291	1.450
Training & Workshops	0.200	1.040	1.240	0.192	0.784	0.976
Social Marketing	0.000	0.500	0.500	0.000	0.088	0.088
Research and Studies	0.220	0.500	0.720	0.251	0.057	0.308
Project Management	0.260	1.050	1.310	0.417	1.489	1.906
Taxes and Duties	0.000	1.290	1.290	0.000	0.000	0.000
Subtotal	3.960	15.050	19.010	4.287	12.980	17.266
B. Contingencies						
Physical Contingencies	0.130	0.520	0.650	0.000	0.000	0.000
Price Contingencies	0.000	1.510	1.510	0.000	0.000	0.000
Subtotal	0.130	2.030	2.160	0.000	0.000	0.000
C. Interest and Commitment Charges	2.160	0.000	2.160	0.650	0.000	0.650
Total Cost	6.250	17.080	23.330	4.937	12.980	17.916

Source: Asian Development Bank.

PROGRAM IMPLEMENTATION SCHEDULE

Component/Major Activity	Year							
	1	2	3	4	5	6	7	8
	2005	2006	2007	2008	2009	2010	2011	2012
Component 1: Capacity Building for Health Sector Reform Agenda								
Financing and Regulatory Reforms								
Program Design								
Training Implementation (Local and Intl.)								
Installation and Updating								
Public Health Program								
Program Design								
Pilot-Testing								
Evaluation								
Expansion								
Component 2: Hospital and Local Health Systems								
Inter-local Health Zone Organization								
Health Sector Reform Comprehensive Plan Development								
Availment of Matching Grant Program Assistance								
Design of Specific Reforms								
Implementation of the Reform Plan								
Upgrading/construction of facilities								
Procurement of equipment								
Training/staff development activities								
Installation of systems								
Establishment of public-private partnership								
Compliance with Social Security certification, Philippine Health Insurance Corporation accreditation, and licensure requirements								
Social marketing								

Component/Major Activity	Year							
	1	2	3	4	5	6	7	8
	2005	2006	2007	2008	2009	2010	2011	2012
Evaluation of pilot innovations								
Expansion of innovations in other areas								
Component 3: Strengthening Department of Health/Centers for Health and Development (CHD) Institutional and Regulatory Capacity								
Policy review and revision								
Protocols and standards development								
Reengineering/reorganization of CHD								
Staff development/retooling (national and regional)								
Automation of regulatory systems								
Consultative meetings/technical conferences								
Procurement of testing equipment								
Upgrading of Regional Hospital (Region 2)								
Setting up of Resource Information Center								
Research and Special Studies								
Project Management								
Project Team Mobilization								
Setting up of Project Management Offices								
Project Monitoring and annual planning								
Baseline, Midproject, and end of project evaluation								

Planned
Actual

SUMMARY OF GENDER EQUALITY RESULTS AND ACHIEVEMENTS

I. Program Description

1. The Health Sector Development Program (HSDP) design supports three fundamental objectives of the Health Sector Reform Agenda (HRSA): (i) improve the focus on the poor and primary health care, (ii) support structural reform of health sector organizations, and (iii) implement regulatory reforms and improve governance. The theme of HSDP is gender and development (with no subtheme).

2. The HSDP program was expected to contribute to the improvement of the health status of the population of the Philippines, particularly the poor and other vulnerable groups, through implementation of a package of reforms to improve the quality of health services, and facilitate their availability to the poor. For women in particular, improved health status and reduced fertility through enhanced family planning and reproductive health services are anticipated to improve individual productivity. HSDP was to facilitate the empowerment of poor, marginalized, and vulnerable groups by supporting their participation on local health boards.

3. Five project provinces were preselected: Ifugao, Ilocos Norte, Nueva Vizcaya, Oriental Mindoro, and Romblon. Of these, Ilocos Norte and Oriental Mindoro were selected for major project activities. Additional project support was provided to hospitals retained by the Department of Health (DOH) in Batangas, Nueva Vizcaya, and Ilocos Norte. Beneficiaries were mostly lower-income groups, particularly women of reproductive age, children, and indigenous people. Total direct project beneficiaries are estimated at close to half a million people.

4. The report and recommendation of the President covenant on gender stated that the government would ensure that the project is implemented in accordance with the Asian Development Bank Policy on Gender and Development (1998) and take all necessary actions to encourage women living in the project provinces participate in planning and implementation of the subprojects.[1] Furthermore, the government would (i) make every effort to identify and assign suitable qualified women to undertake project implementation activities at national or provincial levels; and (ii) cause DOH to monitor the effects of the project on women through collection and compilation of gender-disaggregated data, where relevant, including in the resettlement plans for the subprojects and the project performance monitoring system established for the project.

5. In the targeted provinces, males outnumber the females but have a shorter life expectancy. Women outperform men in education at all levels. Families are engaged in multiple, small-scale enterprises (other than farming or employment) that help sustain their households. While the economic activities of men comprise the major source of household income, women's activities also contribute significantly to total household income. Regular employment is usually outside the home, but women's mobility is hampered by household responsibilities. Opportunity is hampered by a lack of resources for initial investment. In most households, women do the budgeting and manage finances. In times of emergency or shortages, women seek loan sources. Women perform most of the voluntary work in the communities such as village health workers.

[1] ADB. 2004. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Philippines for the Health Sector Development Program.* Manila.

II. Gender Analysis and Program Design Features

A. Method

6. Prior to appraisal, and in line with the Summary Poverty Reduction and Social Strategy, a gender analysis and strategy was developed, including a gender-responsive strategies matrix. Workshops, household surveys and focus group discussions were conducted. To ensure that the gender and development (GAD) perspective and strategies were included in the national HSRA, a poverty and gender specialist was to be engaged during implementation. The main tasks of the specialist were to: (i) assist DOH with the design of a community-based information system (CBIS), and (ii) develop a national GAD plan for the health sector, with specific GAD indicators and reporting requirements. The matrix was based on the project design at that time of pre-appraisal, which emphasized community actions for health empowerment of the poor. A GAD plan was to be prepared at the start of the project. However, the project design was subsequently changed in support of six policy areas with a greater focus on services, and an overall GAD plan was not prepared. Instead, each province was to engage a gender specialist as part of a package of consulting services and develop its own GAD plan. Several of the gender-responsive strategies proposed in the gender analysis and strategy were no longer applicable and gender specialists were not engaged (please see para. 13). Towards program completion, the National Economic Development Authority issued instructions to develop a sector-wide Gender Strategy and Action Plan, and engaged a consultant. An international consultant subsequently developed a national gender action plan for the health sector, with a strong focus on gender benefits of programs.

B. Gender Issues

7. In the Philippines health sector, gender issues include (i) the relatively poor health status of women compared to men, despite their longer life expectancy; (ii) unequal social relations between women and men that affect access to health services; (iii) lack of specific services that address the needs of women provided in an appropriate manner (e.g., privacy, female staff); (iv) the burden of child care and households chores, which fall mainly on women; and (v) a hierarchical health work force that is predominantly female, but with men dominating management positions (albeit with some exceptions).

8. While total fertility rates (TFRs) in the 1970s were around six children per woman in many Asian countries, these declined rapidly with increasing income, education and availability of family planning services. However, the 2011 TFR in the Philippines was 3.7 children per women, one of the highest in Asia; the fertility rate is three times higher among women in the lowest income quintile compared to the highest quintile, and twice as high in poor provinces. A high fertility rate is associated with high maternal mortality ratio, which is in 2011 estimated at between 99 and 211 maternal deaths per 100,000 live births, compared to a target of 52.[2] The infant mortality rate for the poorest quintile is double that of the richest quintile, while under-five mortality for the poorest quintile is triple that of the richest quintile. Anemia affects mostly women. Sexually transmitted diseases are not satisfactorily controlled. Many risk factors for the rapid spread of HIV/AIDS are present and the country is seeing a late HIV epidemic.

9. The majority of poor women deliver their children at home with traditional birth attendants. With a national contraceptive prevalence rate of only 48% (with some estimates reporting a much lower rate), there is high unmet demand for family planning, in particular

[2] UNICEF. 2011. *Philippines. Maternal and Newborn Health Country Profiles.* New York

among the poor. In 2012, the Philippines ranked 114th out of 188 countries on the gender inequality index.[3]

10. A range of issues relating to access to health services for both men and women were identified during project preparation including (i) time, cost, and safety of transport; (ii) lack of a particular needed service; (iii) lack of free and affordable medicine; (iv) lack of information on services and fees; (v) overcrowded health facilities and long waiting hours; (vi) lack of 24-hour services; (vii) lack of trust in the health care providers, in particular at primary care level; and (viii) poor attitude of health providers and bad impressions of facility.

11. Constraints specific to women included: (i) difficulty in attending clinics due to housework, income generating activities, and child care; (ii) lack of and high costs of transport; (iii) preference for female providers; (iv) lack of privacy; and (v) neglect of illness in the early stages.

C. Program Design Features

12. The overall goal of the HSDP was to make quality health care accessible and affordable for the poor, meet the health needs of women and involve men in the process of meeting these needs. However, the HSDP goal did not explicitly target women. Implicitly, and as described, HSDP's goal of poverty reduction includes promoting equity for and among women. The design considered strategies and options that (i) meet the health needs of poor women at all stages of their life cycle; (ii) make available information, options and choices for women to enable them to make their own decisions; and (iii) make maternal health care and reproductive health a concern and responsibility of both women and men. It was less specific in terms of opportunities for female staff and managers.

13. The HSDP strategy provided key measures but not a comprehensive sector analysis, strategy and plan from a gender perspective. The HSDP did not include, in its final design, several measures shown in the matrix concerning (i) CBIS, (ii) dedicated birthing and lying-in clinics, (iii) conversion of selected health facilities to women's centers, (iv) capacity building for women leaders and entrepreneurs, and (v) seed funds for community-based projects managed by women. This change in design, from a community focus to a policy focus, did not result in a reformulation of the gender strategy based on the new design. However, other strategies, such as (i) capacity building for barangay health workers and family health volunteers in improved primary health care, particularly women's and reproductive health; and (ii) gender awareness and sensitivity among community members through inclusion of gender messages in information, education, and communication materials and training were implemented by the project.

14. Since 2010, driven by the National Economic Development Authority, DOH developed a strong emphasis on GAD in the entire sector, but this was not specifically linked to general DOH policies and programs. National health sector programs push for investment in women's health to benefit women specifically, and for family health and poverty reduction benefits. Some programs within DOH (e.g., women's health and safe motherhood programs) have very strong pro-women goals and objectives, while other reform programs are less gender specific but are expected to be gender-responsive. It appears that the GAD opportunities in various policy reforms were not clearly articulated.

[3] United Nations Development Program. 2013. *Human Development Report.* New York

D. Overall Assessment of Gender-related Achievements

15. Achievements and shortcomings in the project are listed in Table A7.1. Key features include:

(i) a focal point in DOH was only identified after program completion, and not in the provinces;
(ii) the project's focus on women's specific health needs, particularly maternal and reproductive health care, and the affirmative actions to address these needs, contributed in highlighting women's health care concerns as a high priority of the DOH. Many of these affirmative actions are integrated in the health sector reforms (Table A7.2) and are envisaged to further contribute to addressing women's health needs in the future;
(iii) the participation of women in workshop, training, and scholarships was high at about 64%;
(iv) women occupy many management position in DOH, but not the top positions;
(v) gender issues were included in annual operational plans;
(vi) disaggregated data were not routinely reported for services unless these were specific obstetric and gynecological services;
(vii) training statistics show disaggregation by gender, but were not systematically collated; and.
(viii) the CBIS eventually designed to produce these data remains in a pilot stage.

E. Gender Equality Results

1. Participation, access to project resources, and practical benefits

16. Participation of female managers and staff in the health sector is generally strong. However, monitoring of GAD indicators for staff in the sector is patchy, perhaps because gender, particularly in terms of equal opportunity among staff, is not seen as a major issue in the health sector. However, data for training attendance are disaggregated. By project end, women comprised 64% of 4,347 DOH and local government units (LGUs) staff trained on several topics such as (i) health sector reform and sustainable financing training course, (ii) health policy development and management, and (iii) case management.

17. Official data show increased use of services of targeted facilities, particularly for women and children (Table A7.1). This can be attributed in part to improvement of services, and in part to expansion of the Philippine Health Insurance Corporation (PHIC). The project contribution to improvement of services varies considerable by hospital, depending on the level of investment. Data for services specific to women and children are available for hospitals, but general admission and outpatient data are not yet submitted in disaggregated form by many facilities. Based on field visits and reports, there has been a substantial improvement in access to health care, but in particular after program completion, once policies have taken effect. In particular, maternal care has become much more affordable for women, and midwives are better paid. This will further reduce mortality over time. Family planning continues to be less accessible for the poor and rural women. A major remaining challenge is improving access to quality health care in rural health centers, which has improved much less than hospital services as a result of staff constraints.

Table A7.1: Utilization Trends in Selected Project Hospitals Statistics

	2005	2006	2007	2008	2009	2010	2011	2012
Total Admissions	29,864	29,549	27,767	30,988	29,196	32,756	35,250	37,147
Obstetric patients PHIC OMPH	627	799	733	823	981	1,080	1,622	2,184
Obstetric patients PHIC MMHMC	956	780	1,751	842	989	1,558	1,719	1,762
Pediatric patients PHIC OMPH	236	371	354	389	946	1,204	2,015	2,158
Pediatric patients PHIC MMHMC	778	1,149	1,557	1,296	1,401	2,026	2,191	1,996
Total deliveries 5 hospitals	9,781	9,673	10,499	10,497	10,802	10,521	10,959	12,634
Total outpatients 4 hospitals[a]	175,040	152,440	148,010	153,969	159,093	153,802	150,587	160,071

MMHMC = Mariano Marcos Memorial Hospital and Medical Center, OMPH = Oriental Mindoro Provincial Hospital, PHIC = Philippines Health Insurance Corporation.
[a] Hospitals outpatient attendance decreases as services in basic facilities are expanded.
Source: Asian Development Bank.

2. Strategic Changes in Gender Relations

18. Since 2010, DOH is placing emphasis on the gender aspects of health. This began with an emphasis on the workforce, rather than policy and services. Table A7.2 summarizes gender progress and shortcomings in reforms relating to HSDP. Much of this was implicit rather than specifically targeted as GAD.

3. Contribution of Gender Equality Results to Program Outcome

19. HSDP had a limited focus on gender equality, but is likely to have helped improve the program outcome. Programs targeting benefits for women were already prioritized prior to HSDP, and incorporated in the sector reforms. HSDP helped improve the program outcome for women as follows:

(i) a large number of female staff and health workers (64% of 4,347 participants) were trained (e.g. on health care techniques, particularly women's health and reproductive health) to enhance their capacity to provide health services,;
(ii) special interventions, such as expansion of insurance coverage for the poor, inclusion of maternal care in insurance package, and automatic coverage of eligible obstetric patients, benefited poor women in particular.
(iii) special attention for *Mangyan* (ethnic women) through interventions such as development of culturally sensitive maternal and newborn services, construction of Mangyan birthing facilities, among others, helped increased benefits for all women, and
(iv) a disaggregated CBIS was introduced.

III. LESSONS AND RECOMMENDATIONS

20. **Lessons**

(i) The HSDP had GAD as a theme, a GAD assessment was done, and a GAD strategy was prepared. The Summary Poverty Reduction and Social Strategy and covenants re-affirmed the emphasis on GAD. However, the gender responsive strategies were not adopted when the project design was changed, a GAD plan was not prepared, and a gender specialist was not appointed. Future projects should ensure that a Gender Action Plan is adopted and is aligned with project outputs, and that a gender specialist is hired to ensure its implementation.

(ii) The HSDP gender strategy featured several rather radical strategies that were not acceptable to DOH. The gender strategy should have been formulated and finalized with the DOH, based on a thorough gender analysis of the health situation and key gender issues in the sector.

(iii) The gender strategy of developing a disaggregated CBIS is a very complex and long-term undertaking. This should have been considered as a separate project.

21. **Recommendations**

(i) Any health sector reform agenda should include a gender analysis and action plan.

(ii) A careful analysis should be done of the relevance, relative importance, and feasibility of addressing various gender issues. Given resource and time constraints, and opportunity costs, clear choices need to be made regarding the most important feasible actions that will yield the greatest result.

(iii) Priority may be given to gender actions that yield tangible results for women, such as improving health services delivery in a gender perspective.

(iv) As part of gender analysis, a careful assessment should be done of the capacity and willingness of the executing authority to implement GAD.

(v) Suitable arrangement should be made to ensure implementation; sensitization and motivation of project management unit staff at during project preparation.

(vi) GAD should be fully integrated in the project design, specific, and have realistic targets.

(vii) Affirmative action specifically targeting benefits of women (such as health facility design to enforce privacy, adjusted opening hours,) should be considered and given priority where justifiable in the project design.

(viii) The Asian Development Bank should provide more hands-on gender supervision and support for programs, including field visits and participation in training activities.

Table A7.2: Health Sector Reforms and Gender Benefits

Pillar	Reforms	Gender Benefits
Health Care Finance Reform.	Social health insurance reforms aim to expand PHIC coverage to at least 85% of the population, with universal coverage of the poor, and improved benefit packages. Actions include (i) continue national subsidies of the health insurance premium for the poor; (ii) ensure that national funds are remitted to PhilHealth on a timely basis; (iii) introduce progressive premium contributions based on ability to pay to increase informal sector coverage; (iv) pilot a low health insurance premium for the poor and vulnerable who cannot benefit by law from government subsidies (about 25% of the population), using group enrollment; (iv) improve benefit package for hospital services, catastrophic and expensive illnesses, MCH, outpatient services, tuberculosis and other public health programs; (v) conduct an information campaign, targeting the poor in particular.	The PHIC coverage for the poor was expanded, and the benefit package for the poor improved, in particular also for outpatient care and maternal and child care. For the poor and vulnerable who, by law, cannot benefit from PHIC, a low health insurance premium was proposed. Following LGU initiatives, the national government is providing PHIC premium payments for the poor in the PHIC's sponsored program. In November, 2012, the DOH, PHIC, and DSWD issued a joint order that mandated the automatic PHIC enrolment for the beneficiaries of the *Pantawid Pampamilyang Pilipino* (Conditional Cash Transfer) Program. GAD benefits are: pregnant women shall get pre-natal care; child birth is attended by skilled and/or health professional, with mothers receiving post-natal care in accordance with standard DOH protocols, and; parents and/or guardians shall attend responsible parenting sessions. The recently adopted no-balance-billing policy of the DOH and PHIC ensures that eligible obstetric patients are automatically enrolled in the sponsored program and will not have to pay any premium or out-of-pocket expenses in government facilities Phil Health has introduced case rates as the primary payment system, for which the earlier developed maternity package served as the benefit template.
Hospital reforms	The reforms will enhance the sustainability and efficiency of hospitals by (i) restructuring them into corporations and supporting participation of the private and nonprofit sector; (ii) encouraging the upgrading of lower tier hospitals to provide better quality care, thereby relieving the stress on regional hospitals; (iii) ensuring that quality health services are provided cost effectively by linking hospital revenue to quality of services; (iv) making hospitals financially independent, allowing them to earn, retain and use all their revenues; and (v) building capacity of hospital administrators and developing good corporate governance through various	Increased PHIC coverage, coupled with income-retention mechanisms in government hospitals, has resulted in the expansion of services, particularly maternal care. As PHIC has also mandated quality standards, this has also resulted in improved patient care. The push for facility-based deliveries across the country has further contributed to expanded services and use, as also reported in the HSDP sites. Increased facility capacity and use has also affected lower-level facilities (e.g., RHUs and free-standing birthing units). HSDP-linked TA[a] also developed

Pillar	Reforms	Gender Benefits
	guidelines, regulations and accountability mechanisms. Various management tools such as business plans, continuing quality improvement programs and clinical protocols will be introduced. Subsidies will become performance-based rather than facility-based.	culturally-sensitive maternal and newborn services for the Mangyan people in Mindoro, inclusive of the construction of Balay Mangyan birthing centers, with 117 Mangyan deliveries at designated facilities over a 6-month period.
Public Health Reforms	The reforms will increase financial resources for, and effectiveness of, primary health care. Public health programs such as immunization, the tuberculosis program and the reproductive health and family planning program will be supported by DOH and implemented by LGUs through multi-year, performance-based budgets. To improve equity and efficiency, DOH subsidies will be allocated on the fiscal capacity of and poverty prevalence in LGUs, rather than according to population.	Service Level Agreements have been adopted that indicate the outputs required from LGUs—such as reproductive health services—for which fund releases were made to the participating LGUs. Despite problems, primarily resulting from delayed submission of liquidation reports, this initiative has been relatively successful and has therefore been taken up by other national government agencies. The PNDF (sixth edition) has included pills and injectables as of 3 April 2006. The Medical Device List (of BFAD) included IUDs and condoms as of 8 May 2006.
Local Health Reforms	Fragmentation of local health systems following devolution needs to be addressed. The reforms will include (i) improving health facilities to conform to licensing and accreditation requirement, (ii) establishing ILHZs as autonomous entities with support of PhilHealth accreditation criteria, (iii) integrating procurement and management of drugs, and (iv) conducting health information campaigns and outreach activities.	Improvements in birthing facilities have resulted from a confluence of favorable factors: facility-based delivery policies of LGUs, facilitated accreditation, and enhanced PHIC reimbursement arrangements and service requirements. These have resulted in expanded and improved maternal health services in HSDP sites. Better management of drugs has led to improved access to and affordability of medicines, and benefited women. Health information campaigns and outreach activities are also expected to particularly benefit poor women.
Regulatory Reforms	Health-related regulations are updated to address requirements related to devolution. Focusing on the need to guarantee quality of services, regulatory reforms will (i) streamline licensing and accreditation procedures for health facilities; (ii) ensure an equitable and cost-effective distribution of primary care, hospitals and high-technology medical devices across the country; (iii) develop regulations and incentives to make quality drugs more available at a lower price, promote generic drugs, and use an	Several recent and related policies, such as the Universally Accessible Cheaper and Quality Medicine Act of 2008 and FDA Act of 2009 have improved the accessibility and regulation of pharmaceutical products. While not differentially more beneficial to women, these nonetheless enable improved access to quality drugs, particularly for poor women.

Pillar	Reforms	Gender Benefits
	equitable fee schedule for drugs and services; and (iv) strengthen the national disease surveillance system.	
Governance Reforms	HSDP supported the development of a Resource Center for Health Systems Development, which was established in DOH and has been operational since 2009. It initiates capacity-building and knowledge-sharing activities such as expenditure tracking, burden of illness and economic evaluations, health standards, and governance performance monitoring.	Tracking reforms and conducting special evaluations can have a major impact on improving access for poor women through subsequent adjustments. However, it appears that knowledge dissemination is limited, and that the connection between studies and policy actions is not that strong. The LGU scorecard was initiated as part of DOH's Monitoring and Evaluation for Equity and Effectiveness. Maternal Health is one area included in this tool, which tracks skilled birth attendance, facility-based deliveries, contraceptive use, and the functionality of community health teams. Benchmarks are provided against which provincial data can be compared, and recommendations for improvement are provided. The project provided local training for 4347 DOH and LGU staff, 64% of whom were female. The health sector has a good representation of female managers.

[a] ADB. 2008. Regional Technical Assistance for Promoting Gender Equality and Women's Empowerment. Manila.
BFAD = Bureau of Food and Drugs, DOH = Department of Health, DSWD = Department of Social Welfare and Development, FDA = Food and Drugs Authority, GAD = gender and development, HSDP = Health Sector Development Project, ILHZ = inter-local health zone, IUD = intrauterine device, LGU = local government unit, MCH = maternal and child health, PHIC = Philippine Health Insurance Corporation, PNDF = Philippine National drug Formulary, RHU = rural health unit, TA = technical assistance;
Source: Asian Development Bank.

COMPLIANCE WITH LOAN COVENANTS

<table>
<tr><th>Nature of Covenants</th><th>Reference in Loan Agreement</th><th>Status of Compliance</th></tr>
<tr><td>The Borrower shall cause the Project to be carried out with due diligence and efficiency and in conformity with sound administrative, financial, engineering, and environmental and health practices.</td><td>Article IV, Section 4.01 [a]</td><td>Complied with.</td></tr>
<tr><td>In carrying out of the Project and operation of the Project facilities, the Borrower shall perform, or cause to be performed, all obligations set forth in Schedule 6 to this Loan Agreement.</td><td>Article IV, Section 4.01[b]</td><td>Complied with.</td></tr>
<tr><td>The Borrower shall make available, promptly as needed, the funds, facilities, services, land and other resources, which are required, in addition to the proceeds of the Loan, for the carrying out of the Project.</td><td>Article IV, Section 4.02</td><td>Complied with.
The following fund allotments (in PhP million) were released for the Project:
<table><tr><td>Year</td><td>GOP</td><td>LP</td></tr><tr><td>2005</td><td>11.658</td><td>18.815</td></tr><tr><td>2006</td><td>55.925</td><td>81.075</td></tr><tr><td>2007</td><td>36.930</td><td>99.355</td></tr><tr><td>2008</td><td>3.980</td><td>29.014</td></tr><tr><td>2009</td><td>37.147</td><td>47.665</td></tr><tr><td>2010</td><td>33.220</td><td>60.601</td></tr><tr><td>2011</td><td>56,149</td><td>141,720</td></tr></table></td></tr>
<tr><td>In carrying out of the Project, the Borrower shall cause competent and qualified consultants and contractors, acceptable to ADB, to be employed to an extent and upon terms and conditions satisfactory to the Borrower and ADB.</td><td>Article IV, Section 4.03 [a]</td><td>Complied with.</td></tr>
<tr><td>The Borrower shall cause the Project to be carried out in accordance with the plans, design standards, specifications, work schedules and construction methods acceptable to ADB. The Borrower shall furnish, or cause to be furnished, to ADB, promptly after their preparation, such plans, designs standards, specifications and work schedules, and any material modifications subsequently made therein, in such detail as ADB shall reasonably request.</td><td>Article IV, Section 4.03 [b]</td><td>Complied with.</td></tr>
<tr><td>The Borrower shall ensure that the activities of its departments and agencies with respect to the carrying out of the Project and operation of the Project facilities are conducted and coordinated in accordance with sound administrative policies and procedures.</td><td>Article IV, Section 4.04</td><td>Complied with.</td></tr>
<tr><td>The Borrower shall take all action which shall be necessary on its part to enable SPE to perform its obligations under the Implementation Agreement, and shall not take</td><td>Article IV, Section 4.05</td><td>Complied with.</td></tr>
</table>

<table>
<tr><th>Nature of Covenants</th><th>Reference in Loan Agreement</th><th>Status of Compliance</th></tr>
<tr><td>or permit any action which would interfere with the performance of such obligations.</td><td></td><td></td></tr>
<tr><td>The Borrower shall exercise its rights under the Subsidiary Loan Agreement and shall cause SPE to exercise its rights under the Sub-loan Agreements, in such a manner as to protect the interests of the Borrower and ADB and to accomplish the purposes of the Loan.</td><td>Article IV, Section 4.06 [a]</td><td>Complied with.
Provisions for such are indicated in the SPGLAs.</td></tr>
<tr><td>No rights or obligations under the Subsidiary Loan Agreement shall be assigned, amended, abrogated or waived without the prior concurrence of ADB.</td><td>Article IV, Section 4.06 [b]</td><td>Complied with.

This provision is stipulated in the SPGLA for the LGUs.</td></tr>
<tr><td>The Borrower shall (i) maintain, or cause to be maintained, separate accounts for the Project; (ii) have such accounts and related financial statements audited annually, in accordance with appropriate auditing standards consistently applied, by independent auditors whose qualifications, experience and terms of reference are acceptable to ADB; (iii) furnish ADB, as soon as available but in any event not later than 6 months after the end of each related fiscal year, certified copies of such audited accounts and financial statements and the report of the auditors relating thereto (including the auditors' opinion on the use of the Loan proceeds and compliance with the covenants of this Loan Agreement, as well as on the use of the procedures for the Imprest Accounts and statement of expenditures, all in the English language; and (iv) furnish to ADB such other information concerning such accounts and financial statements and the audit thereof as ADB shall from time to time reasonably request.</td><td>Article IV, Section 4.07 [a]</td><td>Complied with.

<table>
<tr><th rowspan="2">APA FY</th><th rowspan="2">Date of Receipt</th><th colspan="2">Audit Opinion</th></tr>
<tr><th>DOH</th><th>MDFO</th></tr>
<tr><td>2005</td><td>30-Jun-06</td><td>U</td><td></td></tr>
<tr><td>2006</td><td>24-Jul-07</td><td>U</td><td></td></tr>
<tr><td>2007</td><td>30-Jun-08</td><td>U</td><td>U</td></tr>
<tr><td>2008</td><td>01-Jul-09</td><td>U</td><td>U</td></tr>
<tr><td>2009</td><td>07-Jul-10</td><td>Q</td><td>U</td></tr>
<tr><td>2010</td><td>11-Aug-11</td><td>Q</td><td>U</td></tr>
<tr><td>2011</td><td>13-Jul-12</td><td>Q</td><td>U</td></tr>
<tr><td>2012</td><td>Jul-13</td><td>U</td><td></td></tr>
</table>
U - unqualified
Q – qualified

The Project did not submit a consolidated APA to include both the DOH and LGU component, which prevented an overall presentation of the financial status of the Project.
Qualified opinion was due to (i) inconsistency in recording of expenditures; (ii) timing in recording of transactions, (iii) delayed implementation which resulted to additional cost to Government.</td></tr>
<tr><td>The Borrower shall enable ADB, upon ADB's request, to discuss the Borrower's financial statements for the Project and its financial affairs related to the Project from time to time with the Borrower's auditors, and shall make necessary arrangements for any representative of such auditors to participate in any such discussions requested by ADB, provided that any such discussion shall be conducted only in the presence of an</td><td>Article IV, Section 4.07 [b]</td><td>Complied with.</td></tr>
</table>

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
authorized officer of the Borrower unless the Borrower shall otherwise agree.		
The Borrower shall enable ADB's representatives to inspect the Project, the goods financed out of the proceeds of the Loan, and any relevant records and documents.	Article IV, Section 4.08	**Complied with.** Inspection of goods financed out of the loan proceeds was regularly carried out during review missions..
The Borrower shall ensure that the Project facilities are operated, maintained, and repaired in accordance with sound administrative, financial, engineering, environmental, business, and maintenance and operational practices.	Article IV, Section 4.09	**Complied with.** Regular inspection and monitoring visits were conducted by the HSDP/PMO Civil Works Specialist.
Procurement of goods and services shall be subject to the provisions of the "Guidelines for Procurement under Asian Development Bank Loans" dated February 1999 (hereinafter called the Guidelines for Procurement), as amended from time to time, which have furnished to the Borrower.	Schedule 4, para. 2	**Complied with.**
Fielding of Consultants: The selection, engagement and services of the consultants shall be subject to the provisions of this Schedule and the provisions of the "Guidelines on the Use of Consultants by Asian Development Bank and its Borrowers" dated April 2002, as amended from time to time, which have been furnished to the Borrower and DOH.	Schedule 5, para. 2	**Complied with delay.**
PROJECT IMPLEMENTATION Project Executing Agency, Project Director and Technical Coordinator DOH shall be the Project Executing Agency and shall provide overall guidance for Project implementation. The UPMD in BIHC shall be responsible for the overall management and coordination of the Project, including recruitment of consultants, organization of capacity building and training activities under the Project, and monitoring and evaluation of the Project. The UPMD shall be assisted by consultants recruited under the Project in the day-to-day implementation of the Project at the national level. UPMD shall provide support to SPE with respect to subloan assessment and administration.	Schedule 6, para. 1	**Complied with**
DOH's Undersecretary for External Affairs shall appointed as the Project Director. The Director of the Health Policy Development and Planning Bureau of DOH shall be the overall	Schedule 6, para. 2	**Complied with.**

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
Technical Coordinator for the Project. The head of UPMD shall be the Project Manager		
Project Steering Committee The Borrower shall establish the PSC to provide overall policy guidance to the Project. The PSC shall be chaired by the Secretary of the DOH and shall include representative from DOF, SPE, PhilHealth, NGOs, relevant profession associations, private health care providers and consumer groups. The PSC shall meet at least once every three months. The Borrower shall ensure that the PSC is maintained throughout the Project Implementation period, with composition and terms of reference satisfactory to ADB, unless otherwise agreed between the Borrower and ADB.	Schedule 6, para. 3	**Complied with.**
Implementation Arrangements at the Provincial Level (a) The Borrower shall cause the Project provinces to establish provincial steering committee and PMUs to be responsible for Implementation of the Project at the Provincial Level. The Provincial Steering Committee shall have responsibility to oversee the planning and implementation on the ILHZs, and determine the required level of investments and allocation of cost among the participating LGUs. The Provincial PMUs shall be headed by a permanent staff of the Health Office of the respective Project provinces and assisted by the consultants to be recruited under the project. The Provincial PMUs shall be responsible for ensuring coordination between UPMD and the Project provinces, providing technical advice to the provincial steering committees and monitoring, evaluation and auditing of the Project activities at the provincial level. (b) In the Project provinces, the respective provincial governors shall be the provincial project coordinator and shall head the provincial steering committee concerned. The Provincial project coordinator shall assign a permanent staff of the respective Provincial Health Office to head the provincial PMU concerned. (c) The provincial project director shall facilitate the establishment of an ILHZ within the project province concerned. Each ILHZ shall have an ILHZ Board and permanent secretariat which shall jointly responsible for preparation of Annual Operational Plans comprising a plan of	Schedule 6, para. 4	**Complied with.**

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
action, a program of activities and financial plan to be submitted to the UPMD through the provincial project coordinator and copied to the Health Policy Development and Planning Bureau of DOH through the Provincial Health Office concerned. In additions, the ILHZs shall prepare, or cause to be prepared, approve and oversee implementation of ILHZ business plans. The ILHZ board shall consist of the mayors of the participating LGUs concerned, heads of hospitals and rural health units within such LGUs representatives of private health providers and community members.		
The Borrower shall not change the Project Manager or the Provincial project coordinators without prior approval of ADB and ensure that the staff of UPMD and the provincial PMUs are transferred no more than once in two years.	Schedule 6, para. 5	**Complied with.**
Selection Criteria for LGUs 6.The Borrower shall ensure that SPE sub-lends the proceeds of the loan to eligible LGUs or groups of LGU who meet the following selection criteria. The LGU or groups of LGU concerned shall: (i)be located and have Subproject proposal in one of the project provinces; (ii)Demonstrate financial capacity to borrow based on the borrowing capacity certified by DOF or shall be able to grant other collateral acceptable to SPE and ADB; (iii)Demonstrate that it can generated surplus income for the next three (3) years including sub[project expenses, by providing revenue and expenditure projections endorsed by the LGU insurer concerned or a qualified accountant acceptable to SPE; (iv)Have no adverse reports from its banks and suppliers; (v)Have clearly defined needs for investment in health care services, as evidenced by a business plan for one or more ILHZ and supported by a resolution of the Local Development Council; (vi)Where the investments involved civil works, have nationally of locally owned government land for the site of the works; (vii)Demonstrate interest in and commitment to the project, expressed in a letter of intent from the provincial governor and/or mayors concerned confirming that the respective LGUs will participate, modify, and adjust its health planning and health care management system, if recommended under the project;	Schedule 6, para. 6	**Complied with.**

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
(viii)Have the technical and administrative capacity to undertake institutional capacity building and subproject management; (ix)Have the capacity and willingness to contribute equity; and (x)Demonstrate willingness to establish ILHZ board.		
The Borrower shall ensure that the sub-loans are provided to eligible LGUs with respect to: (a)Subprojects that (i) are identified as priority investments in an ILHZs business plan as approved by the UPMD, and (ii) involve procurement of equipment and/or civil works for the construction rehabilitation or upgrading of local public hospitals, rural health units, barangay health stations or other health facilities acceptable to ADB; and (b)Establishment and operation of the ILHZs within the project provinces.	Schedule 6, para. 7	**Complied with.**
The Subloans shall have a term of up to 15 years, including a grace period of 3 years, and bear interest determined at market rates.	Schedule 6, para. 8	**Complied with.**
The Borrower shall ensure that no disbursement is made from the Loan account for any subproject-related expenditure that was not incurred through procurement methods included in this Loan Agreement.	Schedule 6, para 9	**Complied with.**
Counterpart Funds Without prejudice to Section 4.02 of the Loan Agreement, the Borrower shall ensure that necessary budgetary allocations are made to enable DOH to effectively implement the HSRA, in general and the Project in particular.	Schedule 6, para. 10	**Complied with.**
Environment The Borrower shall ensure that (i) an environmental assessment is carried out for each Subproject in a participatory manner as part of the planning process of the Subprojects; (ii) based on such environmental assessments, an EMP; (iii) an environmental impact assessment, where necessary, is undertaken for each Subproject and submitted to ADB for concurrence prior to Subproject approval; (iv) adequate environmental mitigation measures are incorporated into all Subproject design, construction, operation, maintenance and monitoring arrangements in accordance with Borrower's environmental laws, regulations, and standards and ADB's Environment Policy (2002); and (v) mitigation measures and monitoring plans required in the Sub-project EMPs are implemented effectively and in a timely manner satisfactory to ADB.	Schedule 6, para. 11	**Complied with.** Feasibility studies for Ilocos Norte and Oriental Mindoro provided environmental assessment of the Sub-project Appraisal Reports. ADB provided measures and recommendations on the environmental analysis. ADB approved the environmental assessment reports for Ilocos Norte and Oriental Mindoro.

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
Land Acquisition and Resettlement (a)The Borrower shall ensure that the Subproject sites or land donated voluntarily by the current owners for the benefit of the Subprojects are not being used or occupied by informal settlers. Any adverse impact on such informal settlers shall be avoided or appropriately mitigated in accordance with the Resettlement Framework prepared for the Project. (b)In the event that land acquisition and/or involuntary resettlement are required for any Subproject, the Borrower shall ensure, and cause the SPE and LGUs to ensure that: (i) such land acquisition and involuntary resettlement are undertaken in accordance with the Borrowers applicable laws and regulations, ADBs Involuntary Resettlement Policy (1995) and Projects Resettlement Framework as agreed between the Borrower and ADB, and disclosed to public in accordance with the relevant procedures of ADB; (ii) where necessary, resettlement plans acceptable to ADB are prepared, with appropriate participation and disclosure to the affected people, and submitted for ADBs approval; (iii) measures indicated in such resettlement plans are duly carried out prior to award of the respective civil works contract, and (iv) all compensation payments and resettlement assistance are provided to the affected people prior to displacement and/or dispossession.	Schedule 6, para. 12	**Complied with.** No land acquisition or resettlement involved under the project.
The Borrower shall ensure that, in accordance with ADBs Policy on Indigenous Peoples (2003) and the Indigenous People Framework (IPF) prepared for the Project, (i) adverse impacts on indigenous people (IP) are avoided or adequately mitigated in a timely manner; (ii) IP are provided with opportunities to benefit from the Project in an equitable sustainable manner; (iii) affected IP are adequately consulted and provided with full opportunity to participate in the planning and implementation of any mitigation and enhancement measures; (iv) sufficient budget is made available and funds are disbursed in a timely manner for effective implementation of the IPF and any IP development plan that may be required; and (v) implementation of the IPF and development plans are monitored and reported to ADB through quarterly progress reports.	Schedule 6, para. 13	**Complied with.**
Gender and Development	Schedule 6,	**Not complied with.** While targeting

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
The borrower shall ensure that the Project is implemented in accordance with ADB's Policy on Gender and Development (1198) and take all necessary actions to encourage women living in the Project provinces to participate in planning and implementation of the Subprojects. furthermore, the Borrower shall (i) make every effort to identify and assign suitable qualified women to undertake Project implementation activities at national or provincial levels; (ii) cause DOH to monitor the effects of the Project on women through collections and compilation of gender-disaggregated data, where relevant, including in the resettlement plans for the subprojects and the project performance monitoring system established for the Project.	para. 14	women in services and training was adequate, overall monitoring of gender impact was unsatisfactory.
Public Campaigns The Borrower shall ensure that DOH assists the participating LGUs to design and conduct public campaigns in the Project provinces to emphasize the benefits of the Project and stimulate community participation in its implementation.	Schedule 6, para. 15	**Complied with.**
The Borrower shall ensure that (i) the PPMS contains data and information on each health sector reform area, relevant management data and detailed financial data documenting Project's progress and adherence to principles of good governance; (ii) achievement is checked against performance targets set by DOH at the beginning of each year; (iii) the performance parameters include activities and outputs realized vis-à-vis plans and targets, independently verified physical accomplishments, and actual costs against budgeted amounts; (iv) specific monitoring forms are developed and used to monitor progress and accomplishments; and (v) PPMS is designed to enable prompt remedial action. Evaluation of the Project shall be carried out primarily through a set of baseline and end-of-project surveys. A general population-based poverty survey shall be conducted on the current status and outcome of HSRA initiatives in all Project provinces to validate the indicative levels of outcome and impact indicators reflected in the log frame. In addition, a survey at the end of the project shall be undertaken to evaluate the impact of the Project on the overall health status in the Project provinces at the time.	Schedule 6, para. 16	**Complied with.**
Project Reviews:	Schedule 6,	**Complied with.**

Nature of Covenants	Reference in Loan Agreement	Status of Compliance
The Borrower and ADB shall jointly undertake annual review missions to (i) monitor progress of Project implementation; (ii) identify areas of concern; and (iii) suggest remedial actions, if needed.	para. 17	Review missions were regularly conducted, at least once or twice a year.

ADB = Asian Development Bank, APA = annual project audit, BIHC = Bureau of International Health Cooperation, DOH = Department of Health, HSDP = health sector development program, HSRA = Health Sector Reform Act, ILHZ = inter-local health zone, IP = indigenous people, IPF = indigenous peoples framework, LGU = local government unit, NGO = non-government organization, PMO = project management office, PPMS = project performance monitoring system, PSC = project steering committee , SPE = special purpose entity, SPGLA = Subproject Loan and/or Grant Agreement; UPMD = unified project management division;
Source: Asian Development Bank.

CONSULTING SERVICES INPUTS

Table A9.1 Summary of Consulting Services (Firm; in person-months)

Positions	
International Consulting Firm	
1. Health Sector Reforms Consultants	
International	
a. Team Leader (Health System Governance Specialist)	18.0
b. Hospital Organization and Management Specialist	6.0
National	
c. Deputy Team Leader (Hospital Organization and Management Specialist)	18.0
d. Finance and Health Economics Specialist in Local Health System and Hospital	9.0
e. Hospital Drug Management and Quality Assurance Specialist	9.0
f. Health Management Information Specialist	9.0
g. Social Marketing and Community Participation Specialist	9.0
Subtotal International Consulting Firm	**78.0**
National Consulting Firms	
2. Baseline Survey Consultants	7.0
a. Team Leader (Biostatistician and/or Epidemiology Expert)	
b. M&E/Public Health Expert	
c. Health Financing and Economics Expert and/or Health Systems Reform Specialist	
d. Social Services and/or Community Development Expert	
e. Training and Process Documentation Expert	
3. Endine Study Consultants	
a. Team Leader (Biostatistician and/or Epidemiology Expert)	2.4
b. Post Project Evaluation and/or Impact Assessment Expert	1.0
c. Health Financing Specialist and Health Systems Reform Expert	0.5
d. M&E and/or Public Health Reform Specialist	1.0
e. Social Services and/or Community Development Expert	1.0
f. Training and Process Documentation Expert	2.0
Subtotal National Consulting Firms	**14.9**
Individual National Consultants	
1. Medical Equipment Specialist	0.0
2. Project Operations Specialist	39.0
3. Civil Works Specialist	51.0
4. M&E Specialist	46.0
5. FS Team for Ifugao	19.5
6. DAED for Oriental Mindoro	6.0
Subtotal	**161.5**
Total (International+National)	**254.4**

DAED = detailed architectural and engineering design, FS = feasibility study, M&E = monitoring and evaluation;
Source: Asian Development Bank.

Table A9.2 Summary of Consulting Services (Individual; in person-months)

Position	Appraisal		Actual	
	International	Local	International	Local
Improving Health Sector Governance				
Organizational Development Specialists	20	14	6	18
Social Marketing & Health Promotion				9
Social Health Insurance Reforms				
Social Health Insurance Specialists	15	46		
Health Financing Specialists	4	18		
Health Financing Specialists	1	18		
Health Care Purchasing				
Social Health Insurance Specialists	2	6		
Social Health Insurance Specialists	1	3		
Local Health Systems Development				
Health Economists	4	12		9
Health Economists	1	12		
Health Contract Law Specialists	1	6		
Health System Governance			18	
Hospital Reforms				
Health Management Specialists	9	43		9
Health Planners	3	5		
Public Health Program Reforms				
Public Health Specialists	2	12		
Public Health Specialists	2	12		
Community Participation Specialists	2	12		
Health Facilities Planners	2	12		
Health Regulation Reform				
Quality Assurance Specialists	2	12		9
Health Systems Analyst	2	6		
Health Economists (Pharmacology)	2	12		
Health Economists (Pharmaceuticals)	2	12		
Sub total consultants health sector reforms	**77**	**389**	**24**	**54**
ILHZ Implementation Team				
Medical Equipment Specialist				0
Project Operations Specialist				39
Civil Works Specialist				51
M&E Specialist				46
FS Team for Ifugao				19.5
DAED for Oriental Mindoro				6
Sub-total ILHZ Implementation Team		**48**		**161.5**
Baseline Survey Consultant				7
Endline Survey Consultant				7.9
To be determined	**9**	**116**		
Total	**86**	**437**	**24**	**230.4**

DAED = detailed architectural and engineering design, FS = feasibility study, ILHZ = inter-local health zone, M&E = monitoring and evaluation;
Source: Asian Development Bank.

ECONOMIC RE-EVALUATION

1. The economic viability of the Health Sector Development Program (HSDP) was re-evaluated at its completion in September 2012, taking into account the changes in certain conditions and assumptions used in the report and recommendation of the President,[1] and in the feasibility study reports that were separately prepared for each health facility covered and funded under a technical assistance (TA) grant provided by the Asian Development Bank (ADB) to support the implementation of both the program loan and investment loan. These changes included the location of hospitals, scope of work, construction period, project costs and benefits, prices of outputs and inputs, operation and maintenance costs, and cost-sharing arrangements.

2. The economic re-evaluation of the project focused only on the newly constructed and renovated and/or rehabilitated health facilities of participating local government units (LGUs) as well as health facilities that are managed by the Department of Health (DOH). These DOH-retained hospitals serve as core-referral hospitals in LGUs covered by HSDP and were not originally counted in the list of project beneficiaries. The re-evaluation excluded the civil works subprojects undertaken at the main office of the DOH (i.e., the Research Centers for Health Sector Development).

A. Background

3. The HSDP, a $13.0 million investment loan from ADB, is a component of the much larger Health Sector Development Program loan approved in December 2004. During the course of its implementation, the project underwent three loan re-allocations. The first re-allocation took place in 2006, in which the executing authority proposed (i) an overall reduction in the allocation for civil works that would affect only the DOH-retained hospitals; (ii) an increased allocation for equipment from the unallocated portion of the loan; and (iii) retained the allocations for research and studies, social marketing and interest/commitment charges. On 3 June 2009, a second re-allocation of the $13 million loan proceeds was approved by ADB to components and categories of the project that had insufficient allocations. This second re-allocation, with concomitant changes in ADB local-cost financing, the ADB civil works financing percentage and project cost sharing between ADB and the Government of the Philippines was intended to implement additional civil works during the remaining 2 years of project life. The project financed about $7.18 million in civil works, $1.80 million under the DOH component and $5.83 million under the LGU component. It supported the construction and/or rehabilitation of resource and learning centers at the DOH, three DOH-retained hospitals serving as core referral hospitals for Project-assisted LGUs, three hospitals in Oriental Mindoro, and three hospitals and two rural health units (RHUs) in Ilocos Norte.

Table A10.1: Name and Location of Health Facilities by Province and Jurisdiction

Health Facility	Location	Jurisdiction
1. Nueva Era Rural Health Unit	Nueva Era, Ilocos Norte	LGU of Nueva Era
2. Dingras Rural Health Unit	Dingras, Ilocos Norte	LGU of Dingras
3. Bangui District Hospital	Bangui, Ilocos Norte	LGU of Ilocos Norte
4. Dingras District Hospital	Dingras, Ilocos Norte	LGU of Ilocos Norte
5. Gen. Roque B. Ablan Sr. Memorial Hospital	Laoag City, Ilocos Norte	LGU of Ilocos Norte
6. Pinamalayan Community Hospital	Pinamalayan, Oriental Mindoro	LGU of Oriental Mindoro

[1] ADB. 2004. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Philippines for the Health Sector Development Program.* Manila.

Health Facility	Location	Jurisdiction
7. Roxas District Hospital	Roxas, Oriental Mindoro	LGU of Oriental Mindoro
8. Oriental Mindoro Provincial Hospital	Calapan City, Oriental Mindoro	LGU of Oriental Mindoro
9. Mariano Marcos Memorial Hospital and Medical Center	Batac City, Ilocos Norte	DOH
10. Batangas Regional Hospital	Batangas City, Batangas	DOH
11. Veterans Regional Hospital	Bayombong, Nueva Vizcaya	DOH

DOH = Department of Health, LGU = local government unit;
Source: Asian Development Bank.

4. The objective of the project loan was to provide more affordable and better quality health care, and thus increase utilization through cost savings and health sector reforms that would enhance outputs, in six areas: (i) rationalizing health care financing and increasing health insurance coverage of the poor; (ii) improving governance, operational efficiency, and service provision of public hospitals; (iii) increasing utilization of improved public health care services; (iv) strengthening regulatory functions for improved quality, efficiency, and safety; (v) promoting service integration in local health systems; and (vi) promoting organizational effectiveness and public accountability in the health sector. Economic analysis of the project focuses on the benefits of increasing the proportion of the population with access to quality health care, improvement of the referral system and organizational reform of the management system toward integrated care. At inception the loan was envisaged to benefit over 725,000 people in selected LGUs in the Philippines by upgrading local health care services and facilities and increasing access to care. Changes in scope have led to the development of hospital and RHU infrastructure benefiting a catchment population of 5.3 million people.

B. Cost–Benefit Analysis

5. The quantitative cost–benefit analysis for the project follows the methodologies outlined in ADB's Guidelines.[2] The period of analysis covered 25 years and was carried out in constant 2013 dollar prices. Key assumptions include:

(i) **Project costs**. Base investment costs are in constant 2013 dollar prices. Taxes and duties account for a small proportion of the project costs. Incremental recurrent costs are calculated for the 20 years following the implementation period. The financial costs of the subprojects considered in the analysis were the actual construction and equipment cost outlays as well as the projected operation and maintenance costs based on acceptable engineering and hospital management standards during the entire 20-year economic lives of the sub-projects. These were the same capital and operating expenditure items used in the economic re-evaluation but were now valued in terms of their economic, shadow or accounting equivalents using the different conversion factors discussed above**.**

(ii) **Economic cost of labor.** The opportunity cost of labor or the shadow wage rate (SWR) for both urban and rural adults was calculated at $6.67 per day. The prevailing unskilled labor wage rate in each site was adjusted by a SWR factor of 0.60 to arrive at the economic wage rate of labor. Furthermore, subsidies and taxes and interest payments were excluded from the analysis. The financial prices of all other commodities and services were assumed to be equivalent to their economic prices.

[2] ADB. 1997. *Guidelines for the Economic Analysis of Projects. Manila; ADB. 2000. Handbook for the Economic Analysis of Health Sector Projects*. Manila.

(iii) **Project development period and economic life**. Physical construction of the subprojects took place 6–8 months from the date of contract award. The full development was assumed to be attained 2–3 years after construction when average bed occupancy rates match pre-construction bed occupancy rates. The project economic life was assumed to be 20 years following the construction phase.

(iv) **Economic analysis**. The measures of project worth used include the economic internal rate of return (EIRR) and the net present value (NPV). These were calculated from the incremental cash flows of benefit and cost streams. The economic opportunity cost of capital was assumed to be 12%. Most health project analyses tend to use 3% as a discount factor; therefore, future benefits are likely to be given greater value. To harmonize this analysis with other project appraisal in non-health sectors, a higher discount rate is used.

C. Project Benefits

6. Only the direct economic benefits accruing from the upgraded or reconstructed health facilities were considered in the economic re-evaluation. These were the user fees levied by the subprojects on the subproject beneficiaries, savings in medical expenses, savings in transport cost, and economic benefits derived from reduced morbidity and mortality.

(i) **Savings in transportation expenses.** Patients and their caregivers have an incentive to use the closest medical facilities, provided these offer the same quality of service. The upgrading of the Governor Roque B. Ablan Sr. Memorial Hospital and RHUs, for instance, would lure patients to use medical care in these public hospitals rather than going to the regional hospital in La Union or Baguio City, or to the provincial and private tertiary or secondary hospitals in Laoag City. As such, the differences in transportation cost were also counted as benefits directly accruing to the economy. The majority of the respondents walk to go to the nearest health facility, with 69.5% in the project sites and 56.4% in control sites using this form of transport. It is assumed that those seeking inpatient and outpatient services would have paid a transport cost of $20 per visit, which is avoided with development of project facilities.

(ii) **Reduced or foregone income due to reduced morbidity.** Based on the prevailing morbidity rates in the service areas of the subprojects, the potential impact of the incremental investments on the provincial and district hospitals and selected RHUs could be measured in economic terms by estimating the number of working days saved due to disease avoidance and valuing these using the corresponding economic wage rates. It was generally assumed that an individual may be able to save an average of 4 working days per year due to improved health, which is multiplied by the opportunity cost of labor (estimated using an average wage rate of $7.6/day for economically active adults). The economic value of labor productivity loss was calculated by adjusting the financial value of wages by a conversion factor of 0.6 to account for factors such as the unemployment rate.

(iii) **Reduced or foregone income due to reduced and/or delayed mortality.** Improved delivery of health care services that comes with upgraded facilities creates opportunities to generate savings from reduced mortality. The project had the overall objective of supporting the target of infant mortality of 17/1,000 live births by 2010, and reducing maternal mortality rate to 90/100,000 live births by 2010. The end-of-project survey found that the maternal mortality rate (MMR)

in project areas increased from 54.03 per 100,000 live births in 2007 to 56.04 in 2011. Likewise, the MMR increased in control areas surveyed that were not within project areas. The infant mortality rate IMR also increased between 2007 and 2011 for project and control areas.[3] The project completion evaluation indicated that qualitative consultations with key health staff revealed these increases may be attributed to improved reporting and recording. A small reduction in mortality (3%) is assumed for the cost–benefit analysis. Premature mortality is valued using the human capital approach where foregone income is discounted into a present value. It is estimated the average age of premature maternal mortality is 25 and a total of 40.5 years of productive work are foregone. Based on average wage of $6.67 per day and shadow wage factor of 0.6, 22 days of work per month, 11 months of work per year, and a discount rate of 3 percent, the present value of foregone income is estimated to be $28,444. The value of premature mortality in infants is estimated to be $30,697, and "other" mortality, where 3 years of premature mortality were estimated, is $3,437.

(iv) **Savings in medical expenses**. Public hospitals have comparatively lower rates than private or higher-tiered public hospitals. With improved facilities and services, target beneficiaries would be encouraged to avail of preventive or curative care services in these public hospitals in anticipation of the savings that would be obtained for the same service in privately-run facilities. Cost savings were not collected in the completion survey and are omitted from the cost–benefit analysis.

[3] ADB.2012. End-line Survey cum Intermediary Impact Assessment Study, Health Sector Development Project. Consultant's Report.Manila (Loan 2137-PHI).

Table A10.2: Cost–Benefit Parameters

Hospitals and RHUs	Unit	Batangas RH	MMMH &MC	Vete-rans RH	GRBA SMH	Bangui DH	Dingras DH	Dingras RHU	Nueva Era RHU	OMPH	PIN DH	Roxas DH	Total
Baseline[a]													
Catchment Population	No.	2,359,980	562,713	449,710	296,910	52,121	110,900	37,153	7,428	882,602	279,303	216,802	5,255,623
Annual Births	No.	58,528	13,955	11,153	7,363	1,293	2,750	921	184	21,889	6,927	5,377	130,339
Maternal Mortality	No.	58	14	11	7	1	3	1	0	22	7	5	129
Infant Mortality	No.	1,097	262	209	138	24	52	17	3	410	130	101	2,444
Other Mortality	No.	13,005	3,101	2,478	1,636	287	611	205	41	4,864	1,539	1,195	28,961
First Year Utilization													
Obs. and Gyn. Inpatients	No.	1,251	1,236	1,759	4,466	160	77	2	1	1,826	531	582	11,891
Pediatrics Inpatient	No.	499	800	921	2,105	342	764			1,174	557	2,127	9,289
Others Inpatient Treated	No.	1,460	5,715	1,665	6,544	562	2,207	9	7	1,850	866	2,795	23,680
Outpatients Treated	No.	2,085	4,507	628	642	235	102	220	152	517			9,088
Decreased Disease Burden[b]													
Maternal Mortality	No.	4	4	5	13	0	0	0	0	5	2	2	36
Infant Mortality	No.	25	3	2	2	0	1	0	0	5	2	1	41
Other Morbidity	No.	146	572	167	654	56	221	1	1	185	87	280	2,368
Other Mortality	No.	29	114	33	131	11	44	0	0	37	17	56	474
Annual Economic Value													
Maternal Mortality	$	93,825	92,700	131,925	334,985	12,000	5,775	150	75	136,950	39,825	43,650	891,860
Infant Mortality	$	748,500	91,399	73,045	48,226	8,466	18,013	6,035	1,207	143,358	45,366	35,214	1,218,828
Other Morbidity	$	3,130	12,253	3,570	14,029	1,205	4,732	19	15	3,966	1,857	5,992	50,769
Other Mortality	$	146,000	571,500	166,500	654,354	56,200	220,700	900	700	185,000	86,600	279,500	2,367,954
Transport Cost	$	105,900	245,160	99,460	275,140	25,980	63,000	4,620	3,200	107,340	39,080	110,080	1,078,960
Total Economic Benefits	**$**	**1,097,355**	**1,013,012**	**474,499**	**1,326,734**	**103,851**	**312,220**	**11,724**	**5,197**	**576,614**	**212,728**	**474,437**	**5,608,370**

DH = district hospital, Gyn. = gynecological, MMMH&MC = Mariano Marcos Memorial Hospital and Medical Center, Obs. = obstetric, PIN = Pinamalayan, RH = rural hospital; RHU = rural health unit;

[a] Birth rate of 24.8/1000, maternal mortality rate of 99/100,000 live births, infant mortality rate of 18.75/1000 live births, crude death rate of 99/100,000 (assumes 3% reduction in catchment burden of disease, increased use of health services by 1%).

Source: Asian Development Bank.

D. Economic Internal Rate of Return

7. The Economic Internal Rate of Return (EIRR) is estimated to be 14.7% and the economic net present value (NPV) $13.3 million. This EIRR is likely to underestimate total economic benefits flowing from the project. A number of other factors need to be considered, including improved efficiency in health systems, reinforcement of decentralization and local capacity, and medical cost savings.

Table A10.3: Cost–Benefit Projection
($ million)

Year	Investment Cost	Recurrent Cost	Reduced Mortality Benefits	Reduced Morbidity Benefits	Avoided Transport Costs	Net Benefits
2005	3.12					(3.12)
2006	3.03					(3.03)
2007	2.95					(2.95)
2008	2.87	0.00	0.03	0.00		(2.84)
2009	2.81	0.00	0.03	0.00		(2.78)
2010	2.79	0.01	0.47	0.00	0.01	(2.32)
2011	6.46	0.14	4.07	0.00	0.01	(2.52)
2012	6.33	0.16	4.91	0.00	0.10	(1.48)
2013	6.22	0.22	5.44	0.00	0.87	(0.12)
2014		0.23	5.50	0.00	0.99	6.26
2015		0.23	5.55	0.01	1.10	6.43
2016		0.23	5.61	0.01	1.11	6.49
2017		0.24	5.66	0.01	1.12	6.55
2018		0.24	5.72	0.01	1.13	6.62
2019		0.24	5.78	0.01	1.14	6.69
2020		0.25	5.83	0.01	1.15	6.74
2021		0.25	5.89	0.01	1.17	6.82
2022		0.25	5.95	0.01	1.18	6.88
2023		0.26	6.01	0.01	1.19	6.94
2024		0.26	6.07	0.01	1.20	7.02
2025		0.26	6.13	0.01	1.21	7.09
2026		0.27	6.19	0.01	1.23	7.15
2027		0.27	6.25	0.01	1.24	7.23
2028		0.27	6.32	0.01	1.25	7.30
2029		0.28	6.38	0.01	1.26	7.37
2030		0.28	6.44	0.01	1.28	7.45
2031		0.28	6.51	0.01	1.29	7.52
2032		0.29	6.57	0.01	1.30	7.60
2033		0.29	6.64	0.01	1.31	7.67
2034		0.29	6.71	0.01	1.33	7.75
TOTAL	**36.56**	**6.00**	**142.67**	**0.13**	**26.17**	**126.40**
EIRR						**14.7%**
NPV			12%			**$13.30**

( ) = negative;
Source: Asian Development Bank.

E. Financial Sustainability Analysis

8. The project's recurrent costs include staff costs, procurement of medical supplies and ongoing support for facilities developed under the project. These costs were estimated for each facility (Table A10.4). Only the proposed user fees from patients for the different hospital services and procedures are considered as incremental revenues. On this basis, the increased revenues cover cost increases after 2023. Before this point, the government is expected to subsidize costs for the poor through the Philippine Health Insurance Corporation.

Table A10.4: Incremental Hospital Revenue and Recurrent Costs

Year	Hospital Revenue ($)	Personnel Costs ($)	Maintenance and Other Operating Expense ($)	Other ($)	Net Cost ($)	Cost Recovery (%)
2008	556	5,208	6,649	16,916	28,217	2%
2009	2,690	20,832	26,594	23,958	68,693	4%
2010	152,486	65,181	70,088	126,506	109,288	58%
2011	3,315,630	1,553,542	1,080,882	1,306,310	625,103	84%
2012	3,815,670	1,908,468	1,583,838	1,321,447	998,084	79%
2013	4,371,439	2,912,652	2,002,727	1,741,172	2,285,111	66%
2014	5,031,160	3,058,285	2,107,462	1,800,022	1,934,608	72%
2015	5,135,016	2,990,329	2,107,462	1,775,603	1,738,378	75%
2016	5,261,541	2,990,329	2,124,919	1,766,708	1,620,415	76%
2017	6,032,650	3,139,845	2,228,647	1,829,035	1,164,878	84%
2018	6,155,318	3,139,845	2,197,803	1,818,691	1,001,022	86%
2019	6,282,858	3,139,845	2,209,696	1,810,447	877,130	88%
2020	7,055,971	3,296,838	2,361,692	1,877,073	479,632	94%
2021	7,200,105	3,296,838	2,301,846	1,867,362	265,940	96%
2022	7,349,419	3,296,838	2,342,211	1,853,130	142,761	98%
2023	8,273,417	3,461,680	2,545,895	1,923,002	(342,840)	104%
2024	8,445,828	3,461,680	2,470,957	1,912,618	(600,573)	108%
2025	8,618,104	3,519,803	2,509,974	1,729,131	(859,195)	111%
2026	9,060,561	3,634,764	2,744,155	1,762,306	(919,336)	111%
2027	9,268,617	3,715,621	2,713,908	1,751,265	(1,087,823)	113%
2028	9,459,075	3,739,961	2,714,583	1,786,391	(1,218,140)	115%
2029	9,553,666	3,777,360	2,741,728	1,804,255	(1,230,322)	115%
2030	9,649,202	3,815,134	2,769,146	1,822,298	(1,242,625)	115%
2031	9,745,694	3,853,285	2,796,837	1,840,521	(1,255,051)	115%
2032	9,843,151	3,891,818	2,824,806	1,858,926	(1,267,602)	115%
2033	9,941,583	3,930,736	2,853,054	1,877,515	(1,280,278)	115%
2034	10,040,999	3,970,044	2,881,584	1,896,290	(1,293,081)	115%

( ) = negative;
Source: Asian Development Bank.

F. Conclusions

9. The HSDP was expected to yield an economic rate of return of about 28% at inception through: resource cost savings, and productivity benefits from a population in better health. The reevaluation has resulted in a lower, but still positive NPV for the project. Reasons for the downward revision include:

(i) certain administrative and accounting and auditing protocols at the LGU level slowed procurement of civil works and cash releases for planned subproject activities;
(ii) lack of trained design and construction engineers at the local level;
(iii) the propensity of local chief executives and the LGU councils to exert influence on or alter firmly drawn-up construction and facility upgrading plans;
(iv) absence of truly functional inter-local health zones in the project provinces, in terms of having (a) integrated local health plans, (b) effective referral and counter-referral systems, (c) universal coverage of health insurance, (d) improved quality of hospital and rural health unit services, (e) appropriate data from health information systems, and (f) suitable drug management system;
(v) lack of transformative participation of local chief executives in HSDP-provinces and management of HSDP supported hospitals in instituting quality hospital management systems and operating procedures,
(vi) lack of complementary support for the project's infrastructure and development support components;
(vii) low absorptive capacity and inability to provide timely equity and/or counterpart contributions of targeted LGU-beneficiaries; and
(viii) long review and approval process for technical and engineering plans, as well as for the bid documents.