Progress Report on Tranche Release

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Philippines: Health Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 17 October 2006)

Currency Unit	–	peso (P)
P1.00	=	$0.2000
$1.00	=	P50.00

ABBREVIATIONS

AO	–	administrative order
BFAD	–	Bureau of Food and Drugs
BHDT	–	Bureau of Health Devices and Technology
BHFS	–	Bureau of Health Facilities Services
CPG	–	clinical practice guideline
DOF	–	Department of Finance
DOH	–	Department of Health
HSDP	–	Health Sector Development Program
HSRA	–	Health Sector Reform Agenda
ILHZ	–	inter-local health zone
IPP	–	informal paying program
LGU	–	local government unit
MOA	–	memorandum of agreement
PHIC	–	Philippine Health Insurance Corporation
POGI	–	PHIC Organized Groups Initiative
SDAH	–	Sector Development Approach for Health
SP	–	sponsored program
UMIS	–	unified financial management information system

NOTES

(i) The fiscal year (FY) of the Philippines and Department of Finance ends on 31 December.

(ii) In this report, "$" refers to US dollars.

CONTENTS

I. INTRODUCTION

1. The Asian Development Bank (ADB) approved the Health Sector Development Program (HSDP) for the Philippines in December 2004.[1] The HSDP consists of (i) a program loan of $200 million and (ii) an investment loan of $13 million. The loans are closely linked: the program loan supports the financing of comprehensive sector reforms and the project loan supports reforms in selected provinces. Associated with the HSDP is an advisory technical assistance (TA)[2]—Support for the Health Sector Reform. The Department of Finance (DOF) is the Executing Agency, and the Department of Health (DOH) and the Philippines Health Insurance Corporation (PHIC) are the implementing agencies for the program loan. The DOH is the Executing Agency for the investment project and the associated TA.

2. The HSDP's goal is to improve people's health, especially the poor's, and to achieve the health-related Millennium Development Goals (MDGs). The HSDP supports the Philippines Health Sector Reform Agenda (HSRA) of 1999, to improve the efficiency and effectiveness of the health service delivery system, especially to meet the needs of the poor and the vulnerable, and to accelerate achieving the health-related MDGs.

3. The HSDP tackles the root causes of the HSRA's lack of substantial progress by putting in place incentives to change systems, processes, and rewards. The HSDP takes into account the lack of fiscal space available to the Government for investing in health and in poverty reduction, and proposes a refocus of health spending[3] and higher expenditures in areas that directly benefit the poor. The HSDP follows a strategy that invests in people and primary health facilities and focuses on cost containment and cost-efficiency. The envisaged policy actions and reform interventions emphasize performance-based resource allocation, increased accountability and good governance, and consumer participation.

4. The program loan supports the overall goal to promote cost-effective health interventions, rationalized health service delivery systems, and equity of health status through an integrated set of health sector reforms. The system-wide changes will largely concern improving the ways that HSRA reforms are implemented and managed at all levels in the health sector. The HSDP follows three fundamental objectives derived from the sector analysis and lessons learned: (i) improving focus on the poor and on primary health care, (ii) reforming sector organizations, and (iii) operationalizing regulatory reform and improving governance.

5. The program loan of $200 million from ADB's ordinary capital resources was designed to meet the estimated direct short- to medium-term costs of the reform program net of $280 million. The Government estimates that the reforms may eventually cost more than $2.2 billion. The program loan was planned for disbursement in two tranches of $100 million each, to be released upon reaching HSRA milestones. Upon loan effectiveness, the first tranche of $100 million was disbursed on 13 January 2005. The second tranche is due for release about 18 months after the first tranche, upon reaching the HSRA milestone for 46 policy actions (20

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

[2] ADB. 2005. *Technical Assistance to the Republic of the Philippines for Support for Health Sector Reform*. Manila.

[3] Total health spending was estimated at 3.2% of gross national product (GNP) in 2004, having decreased from 3.5% in 1997. A large portion of health care cost comprises household out-of-pocket expenditures (47.0%), while the public sector's share of total health expenditure (of 30.0%: 16.0% from national and 14.0% from local governments) has declined, and the national health insurance program share has increased only slightly (9.5% in 2004). Most public resources are allocated to curative health care, while 13% are spent on public health programs (National Statistics Coordination Board. 2004. *Philippines National Health Accounts*. Manila).

tranche-release triggers and 26 monitorable actions). The DOF and DOH have submitted a report showing that of the $100 million first-tranche release of the HSDP, almost 50% went to public health interventions and 50% to hospital services. These resources were allocated to non-salary recurrent categories of the 2005–2006 DOH budget. The DOH expects to use the second-tranche release of $100 million for similar activities to support the HSRA in the 2007–2008 budget.

II. STATUS OF SECOND-TRANCHE RELEASE POLICY ACTIONS

6. The HSDP has shown good progress since its inception. The DOH and the PHIC have complied with almost all 46 policy actions laid out for the second-tranche release. Of these policy actions, 20 are set as triggers for the second-tranche release and 26 as monitorable actions to be completed by the end of the HSDP. The Government has fully complied with 17 tranche-release triggers and substantially complied with the remaining three. (Appendixes 1 and 2 provide the status of all the tranche-release triggers and the monitorable actions.)

7. The policy matrix follows the DOH's five components of the HSRA of 1999: (i) health care finance reform, (ii) hospital reform, (iii) public health reform, (iv) regulatory reforms, and (v) local health system reform. For the policy matrix, an additional component was added to include some cross-cutting issues and was listed as item (vi) health sector governance.

A. Health Care Financing Reform

8. **Policy Actions in Full/Substantial Compliance.** Among the 13 policy actions, 4 are triggers for tranche release and 9 are monitorable actions. Of the tranche-release triggers, three are in full compliance and one is in substantial compliance. Of the monitorable actions, seven are in full compliance, one is in substantial compliance, and one is in partial compliance.

9. The policy actions were primarily to improve financial protection against illnesses. The policy actions stipulated (i) indigent coverage in the PHIC (sponsored program [SP]) through general tax revenues; (ii) informal sector coverage in the PHIC (informal paying program [IPP]) through risk-sharing groups (organized groups), and group risk-sharing by offering progressive premium charges based on earnings; (iii) enhanced package of reimbursable benefits offered to its beneficiaries; (iv) introduction of process measures such as the use of clinical practice guidelines (CPGs) to improve the quality of care by health providers; and (v) development of the medium-term plan for the PHIC, which included actuarial forecasts on revenues and payments.

1. Policy Action 1. PHIC submits confirmation of the inclusion of allocation for the sponsored program in the 2006 budget as submitted to Congress (fully complied with)

10. The PHIC has submitted to Congress a request for the 2006 budget to include the allocation of P4.2 billion (P2.9 billion more than in 2004[4]) to ensure coverage of the beneficiaries under the SP (Plan 5/25 includes 5 million indigent families or 25 million indigent people). For 2006, the Government generally faced budgetary constraints as Congress did not pass the 2006 budget and, as a result, the Government is operating on a reenacted 2005

[4] The PHIC requested P1.3 billion (2004) and P4.6 billion (2005) as the national Government's budgetary support for the SP to be included in the Government's Appropriation Act (GAA). The Department of Budget and Management released only a portion of the GAA approved national Government counterpart funds: P500 million (2000–2004), and P750 million (2005). The national Government continues to have arrears with the PHIC that reached P4.9 billion as of March 2006.

budget. However, Congress approved a supplemental budget of P2.9 billion for the PHIC SP. The Department of Budget and Management had released up to 68% of the requested budget as of March 2006, and the PHIC expects to receive the balance of funds before the end of the year. For 2007, the PHIC aims to propose an increased budget allocation of P3.9 billion as the national Government counterpart to ensure improved coverage of the indigents (expected to be at least 90% or 4.5 million indigent families). The PHIC is also advocating that local government units (LGUs) contribute resources toward their share of the subsidies.

11. The PHIC introduced the SP in 1997 and then increased the targeted population further in 2004 by introducing Plan 5/25, which stated the national Government's priority and commitment to insure the population through general tax revenue financing. The beneficiaries are the poor—25 million people or 5 million families (30% of the population). In 2000–2004, only 14% of indigent families were covered by the PHIC program. By 2005, the proportion of indigents enrolled under the PHIC increased to 50%. In 2006, the PHIC increased the coverage of the SP beneficiaries to enroll 4.5 million indigent families (90%). By the first quarter of 2006, the PHIC enrolled 3.4 million indigent families (68%), with plans to cover the additional indigent families before the end of 2006. The PHIC plans to cover at least 90% of the indigent families under the SP by early 2007 and has planned to cover 100% of the indigents by 2010. The PHIC has introduced a system to monitor the coverage of indigents in the program, despite the challenge of identifying the poor. The Government is advocating the use of community-based poverty tracking systems, although so far only 10% of LGUs have adopted the system, which is gradually gaining momentum.

2. Policy Action 2. PHIC board approves a new premium policy allowing progressive premium structure (fully complied with)

12. In 2006, the PHIC Board approved the increases in the premium rates proposed for self-employed professionals within the subgroup of the IPP—to P200 by October 2006 and to P300 by October 2007—to cross-subsidize the premiums of low-income families. The PHIC had offered a monthly premium of P100 per family since 1999, much lower than that charged to government and private employees (P625 average). The enrollment density rate (number of months of enrollment in 1 year) among government employees (12 months) and private sector employees (8 months) is better than that of the IPP enrollees (6 months). Overall, however, enrollment in IPP remains low (35%). Many in the high-income groups are likely to hold private health insurance (10% of the total health expenditure is contributed through private health insurance), as the PHIC benefits are not as attractive. In general, an improved benefit package is more likely to attract enrollment than a low premium. Most low-income groups are expected to be covered by the SP by 2007, but many who are just above the poverty bracket, but vulnerable to shocks, belong to the IPP and not the SP. The PHIC has proposed a gradual increase in the IPP premium rates for self-employed professionals to make the rates comparable to those paid by government employees. It is recommended that the PHIC bring the rates as close to the government and private sector premiums by 2008.

13. The IPP was introduced by the PHIC in 1999. The beneficiaries include the self-employed, doctors, lawyers, businessmen, farmers, and hawkers. Almost 23 million (28% of the population) fall under this subgroup but only 8 million (35%) were enrolled under the PHIC in 2005. The PHIC planned to give attention to improving enrollment. It launched the Kalusugan

Sigurado at Abot-Kaya in the Philippines (KASAPI)[5] program (which provides financial incentive for enrollees as well as improved advocacy campaigns among cooperatives and organized groups to limit adverse selection and promote risk-sharing), and initiated its pilot interventions in seven provinces.[6] The results from the pilot effort will help modify the KASAPI program before it is scaled up nationwide.

3. Policy Action 3: Based on a detailed cost database and analysis, the PHIC board approves a revised benefits package (fully complied with)

14. In 2006, the PHIC board approved the revised benefits package, which includes additional services such as outpatient care, maternity care, and public health interventions. This revised package is an improvement over the previous package[7] and will increase the cost of the benefits package annually by P750 million (or by only 4.3% more than the 2005 package). Most beneficiaries have a co-payment even though indigents receive free services at public health facilities. The accredited public hospital is reimbursed certain fixed fees, and primary medical care facilities receive capitation for providing services to the indigents. However, indigents have a co-payment at private facilities and often still have to pay for drugs and medicines, as most public health facilities have no available stock. Still, the PHIC offers a far too limited benefits package with a low ceiling. Households end up contributing as much as 47% (of total health expenditures) as out-of-pocket payment. In 2004, only 9.5% total health expenditure contributions were from the social health insurance system. The PHIC designed an information campaign to promote the improved benefits package among its beneficiaries and eligible providers.

4. Policy Action 4. PHIC publishes a performance report on the status of the use of the 10 clinical practice guidelines for quality assurance and accreditation (substantially complied with)

15. Although, the PHIC has not finalized the performance report, it has prepared a study to test the use of 10 CPGs at accredited hospitals, and the results are expected by the first quarter of 2007. This will ensure a standard set of treatment protocols followed by health providers for these 10 illnesses. The study's results are to be posted in newsletters and distributed to providers, users, and stakeholders. The CPGs are expected to improve the quality of health care. The PHIC is planning to introduce the use of CPGs as a process and outcome of care in its accreditation system. Current accreditation standards assess only minimum inputs (such as health staff, equipment, and building standards). The policy action is substantially complied with

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[5] KASAPI is embodied in PHIC Board Resolution 719 (September 2004). The PHIC Organized Groups Initiative (POGI) pilot was launched in 2003. Under this scheme, POGIs are formed with a minimum of 50 members (families), and the cooperatives act either as marketing agents or as premium collectors or both. However, the group size was considered too small and the group selection criteria not ideal. An independent evaluation of POGI suggested that it was not very effective and instead the KASAPI-recommended structure was formulated. KASAPI requires at least 1,000 members (families) through organized groups or cooperatives and requires that at least 700 are enrolled in the PHIC. KASAPI adds to POGI by selecting organized groups in a different way.

[6] As KASAPI requires at least 1,000 members in an organized group, only Ilocos Norte among the HSDP provinces was selected for the pilot effort. However, KASAPI is being piloted in seven provinces in Region I (Ilocos Norte), Region III (Central Luzon), Region IV-A (Southern Tagalog), Region VIII (Eastern Visayas), Region X (Northern Midanao), and CARAGA.

[7] Originally, the PHIC offered almost the same package of benefits to all its beneficiaries (except for overseas workers and indigents), and primarily reimbursed only inpatient services. Hence, access to services and quality of services was inequitable. In 2000, the PHIC also offered an outpatient diagnostic service package for indigent families (as capitation payment offered to accredited rural health units through LGUs). In 2003, the PHIC introduced certain outpatient services for all beneficiaries (including maternity care, tuberculosis directly observed treatment short course [TB DOTS], among others).

because PHIC started the study in 2006 and will be able to present/publish its results only in 2007. This exercise is under way with the assistance of ADB consultants (TA 4647).[8]

B. Hospital Reform

16. **Policy Actions in Full/Substantial Compliance.** Among the 11 policy actions, 4 are triggers for tranche release and 7 are monitorable actions. Of the tranche-release triggers, three are fully complied with and one is substantially complied with. Of the monitorable actions, all are fully complied with.

17. The policy actions were primarily to ensure efficiency and effectiveness of the health service delivery system and stipulated (i) improved accountability in the hospital's use of resources, (ii) improved efficiency in hospital management, and (iii) rationalization of hospitals based on needs.

1. Policy Action 1. The DOH designs a unified financial management information system for pilot-testing and enters into a memorandum of agreement with selected hospitals for test (fully complied with)

18. The DOH has designed, and is piloting the UMIS in five hospitals (a memorandum of agreement [MOA] was signed between five hospitals in 2006): three DOH national hospitals, one DOH provincial hospital (Ilocos Norte), and one LGU provincial hospital (Oriental Mindoro). After decentralization, financial flows from central to local governments and health providers were not recorded transparently. Resource leaks were reported and parallel and fragmented systems did not communicate between each other. The DOH planned to set up an integrated financial management system so that expenditures and earnings would be reported by public hospitals, and a system where financial data would be connected to hospital performance data. The results of this pilot effort indicated the need for a new framework that integrated existing systems (hospital logistics, procurement, financial and administrative information [HOMIS], logistics management information system [LMIS] and procurement and logistics management of drugs [Pharma-50]) into one system (UMIS), thereby eliminating data entry duplication and improving overall efficiency. The UMIS will ensure that (i) fund flows are transparent, (ii) hospital expenditures and revenues are tracked, and (iii) budgeting is performance-based. The pilot test is expected to be completed by March 2007, after which the UMIS will be revised before it is scaled up. The UMIS is expected to be scaled up at the public hospitals in the 16 convergence provinces identified by the DOH.

2. Policy Action 2: DOH issues an administrative order to adopt a policy on governing boards of all public hospitals (fully complied with)

19. The DOH has issued an administrative order (AO) in 2006 to adopt the policy on public hospital governing boards to ensure improved efficiency in hospital management. The AO compels all public hospitals to establish governing boards with consumer participation. The governing boards are expected to include at least three representatives from the business sector, and the community, including health professional organizations. This will increase hospital responsiveness to client needs and will pave the way to transform the hospital into autonomous economic units. The strategy will need to be evaluated and its results documented.

[8] ADB. 2005. *Technical Assistance to the Philippines for the Support for Health Sector Reform.* Manila.

3. Policy Action 3: DOH issues an AO to adopt performance-based allocation of (national) subsidies for 2006 (substantially complied with)

20. The DOH issued an AO in 2006 on the allocation of the national subsidies based on hospital service performance. The 2007 subsidies have already been budgeted and allocated to DOH hospitals on the basis of performance. Two issues were explored: (i) the use of national Government subsidies for the DOH-retained hospitals and (ii) the use of performance-based allocation of national Government subsidies. In the AO, the DOH proposed to (i) reallocate some resources to the DOH-retained hospitals in the regions (instead of in the capital) to benefit the poor, and (ii) contribute at least 5% of their maintenance and other operation expenses (MOOE) allocations to support priority essential HSRA programs in exchange for greater access to and more flexible use of user fees and PHIC reimbursements. The AO outlines performance criteria for resource allocation. The performance criteria require, among others, that (i) MOOE allocation to individual (DOH-retained) hospitals be conditioned on the proportion of surgical and special cases relative to their total caseload, (ii) MOOE be distributed on the basis of their performance of research and training, and (iii) MOOE be allocated on the basis of their ability to meet quality standards. The UMIS will help track the financial information and link it to service performance indicators at these DOH-retained hospitals.

21. The tranche-release trigger is assessed as substantially complied with because it was delayed. Policy action 3 stipulated that allocation of performance-based national subsidies be in operation by 2006. Since the AO was introduced in 2006, the DOH has prepared the basis for allocating the national subsidies to the DOH-retained hospitals based on performance starting 2007. This is consistent with the time frame of the regular budget cycle for the Government, where budget allocation, and preparation, and authorization were done in 2006 for the annual budget executed in 2007. The 2007 subsidies have already been budgeted and allocated for DOH hospitals on the basis of performance. The DOH plans to evaluate the allocation of national subsidies and to document its findings and share the results with beneficiaries and stakeholders through its website.

4. Policy Action 4. The DOH issues an AO to state a policy on rationalizing local public hospitals based on need (fully complied with)

22. The DOH has issued an AO in 2006 on Rationalization of the Health Care Delivery System, which states a policy to help local governments rationalize hospitals based on needs, and to build an adequate referral network. Local governments will be guided to take decisions on upgrading, merging, or downgrading health facilities (including small hospitals), and in building networks through contracting services between government and nongovernment providers. The AO will not only affect public hospitals but also private providers. Provinces are encouraged to develop province-wide health plans, which include primary care (clinics) and secondary care (hospitals). The plans are based on DOH guidelines on rationalizing the health care delivery system, which stipulates needs based on the number of hospital beds, the size of hospitals, the existence of private facilities, among others. Primary medical care will be encouraged, taking the pressure off hospitals. Hospitals will be providing secondary care (specialist care) instead of primary care. Investments in health facilities (including hospitals) will be based on population needs. This is a critical AO to improve planning and effectiveness of health service delivery and is expected to lead to efficiency gains.

C. Public Health Reform

23. **Policy Actions Fully Complied with.** Among the six policy actions, three are triggers for tranche release and three are monitorable actions. All policy actions are fully complied with.

24. The policy actions were primarily to ensure commitment to public health interventions through increased and continuous resource allocation for these interventions. The policy actions stipulated (i) public–private partnership in the delivery of reproductive health services and public health services, (ii) long-term budget planning and allocation to ensure continuity and reliability of resources for public health interventions, and (iii) availability of contraceptives.

1. Policy Action 1. The DOH issues an AO to adopt the revised expenditures targets for public health spending and hospital-based services (fully complied with)

25. The DOH issued an AO in 2006 on HSRA financing reform, which is a key element to shift DOH resources to public health through (i) the reallocation of DOH-retained hospital subsidies from DOH hospitals to public health interventions, (ii) resource allocation for public health commodities, (iii) performance-linked grants to LGUs, and (iv) development of public health service packages for various levels of (public) facilities. This AO provides guidelines on budget allocation and budget execution principles. (See policy actions C2.1, B.3 and E.1.2 in Appendix 2).

2. Policy Action 2. The DOH develops a framework to establish long-term performance-based budgeting for priority public health programs (fully complied with)

26. Through an AO in 2006, the DOH developed a framework with four pillars: (i) prioritizing public health programs, (ii) allocating resources for public health commodities, (iii) linking budget subsidies of DOH to specific performances of targeted public health reforms, and (iv) linking DOH assistance to LGU performance in public health programs. Priority public health programs are identified as vaccine-preventable childhood diseases, tuberculosis control, HIV/AIDS, reproductive health outcomes, and lifestyle and risk management. Localized elimination programs have been identified for schistosomiasis, filiarisis, leprosy, malaria, and rabies. After decentralization, public health service delivery was devolved to LGUs, resulting in a decline in national Government resources over the years and an expected increase in LGU resources. However, LGU resources are limited because of budget constraints or lack of commitment, and partnership with the national Government, particularly to subsidize public health commodities and reach the poor and underserved areas, is critical.

3. Policy Action 3. The DOH Revises the Philippines National Drug Formulary (PNDF) to include contraceptives (pills, injectibles, and intrauterine device [IUDs]) (fully complied with)

27. In 2006, the DOH supported the inclusion of pills and injectibles in the PNDF system of the DOH, and of IUDs and condoms in the essential device list of the Bureau of Food and Drugs (BFAD). Previously, contraceptives were not part of the Government's essential drug or device list or reimbursable commodities under the PHIC. Contraceptive prevalence remains low, and unmet needs are high (only 33% of married women use modern contraceptives), suggesting that modern contraceptives are either not available or affordable. However, the new Government policy to disallow national Government budgets to fund contraceptives will need to

be monitored closely, and the Government's partnering with local governments and with nongovernment agencies in planning, procurement, and distribution strongly promoted. The ready availability of contraceptives and their affordability are critical areas to be addressed by the DOH. The PHIC must place essential drugs and devices in its benefits package. The regulatory agencies' role in price regulation will make contraceptives affordable.

D. Health Regulation Reform

28. **Policy Actions Fully Complied with.** Among the six policy actions, three are triggers for tranche release and three are monitorable actions. All policy actions are fully complied with.

29. The policy actions aimed primarily to improve performance of health services. The policy actions stipulated (i) regulatory agencies to monitor quality standards in the market, such as in the provision of drugs, equipment, and services (health personnel, building, and equipment); (ii) bills drafted for Congress to provide more authority to regulatory agencies in regulating quality and price of drugs and medical equipment in the market; and (iii) harmonization of various standards and systems set-up for quality assurances.

1. Policy Action 1. The DOH drafts a bill for congress review proposing amendments of the mandates of DOH regulatory agencies to increase efficiency in health care provisions (fully complied with)

30. The DOH has issued three draft bills for Congress review to strengthen the authority and role of the regulatory agencies such as the BFAD, Bureau of Health Devices and Technology (BHDT), and Bureau of Health Facilities Services (BHFS).

31. Because regulatory controls are lacking, pharmacies overprice drugs, and drug quality varies across the country. The DOH drafted a bill to strengthen the role and authority of BFAD in regulating drug prices and controlling supply of counterfeit drugs. This bill gives BFAD the authority to suspend or revoke the registration of drug manufacturers and distributors and any other facilities used to produce, label, and distribute counterfeit drugs. The DOH drafted a similar bill to give BHDT the authority to close, suspend, or penalize manufacturers, assemblers, importers, exporters, distributors, installers and retailers who hold unregistered or unacceptable quality products that could cause harm, disability, injury, or death.

32. Given that several small health facilities are scattered throughout the Philippines, and many of them underused, the DOH improved the licensing standards to rationalize health services. The DOH drafted a bill to authorize BHFS to issue and revoke licenses of health service providers that do not meet people's needs, and to regulate fees (by developing fee schedules) for public and private providers.

2. Policy Action 2. The DOH issues an AO on certification mechanism for primary health care services providers based on service capacity and quality (fully complied with)

33. Through an AO in 2005, the DOH has harmonized its certification standards and the PHIC's accreditation standards, after which the PHIC's accreditation system was assigned responsibility for quality assurance (quality is currently measured as meeting minimum requirements). Harmonization was needed because DOH and PHIC standards differed although they had the same objective.

3. Policy Action 3. The DOH issues an AO and new regulations on drug management to reduce drug prices (fully complied with)

34. The DOH issued an AO in 2005 to reduce market drug prices, as BFAD will (i) authorize the registration of generic drugs, (ii) simplify the drug registration process, (iii) encourage pooled procurement so that DOH hospitals can engage in wholesale procurement of drugs, (iv) add generic prescription drugs to the *botika ng barangay* (community-based pharmacies) drug distribution, and (v) reduce pharmaceutical company transaction cost by allowing for automatic renewals of certification (these costs had been significant in increasing drug prices). Given the lack of regulatory controls, the Philippines faces high drug prices and variable access. By strengthening BFAD, drug prices are expected to be streamlined.

E. Local Health Systems Reform

35. **Policy Actions Fully/Substantially Complied with.** Among the six policy actions, three are triggers for tranche release and three are monitorable actions. Of the tranche-release triggers, two are fully complied with and one is substantially complied with. All the monitorable actions are fully complied with.

36. The policy actions were primarily to promote autonomy and incentives for improved local health service delivery.

1. Policy Action 1. The DOH, PHIC, and LGUs approve an MOA that commits to (i) establishing inter-local health zones (ILHZs), (ii) enrolling the poor in the 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 rural health units and barangay health stations (fully complied with)

37. The DOH, in partnership with the PHIC and LGUs, has approved an MOA (2006) whereby this partnership is formalized in the five ADB-funded HSDP investment project sites. The MOA stipulates (i) DOH's assistance to LGU in improving fiduciary controls, good governance, quality assurance, and indigent enrollment in PHIC; (ii) PHIC assistance to LGUs in securing universal health insurance coverage, especially of the informal sector population and the indigents, promotion of PHIC benefits, and accreditation of health facilities; and (iii) LGUs' cooperation in promoting the HSRA by helping set up enrollment centers for the PHIC, monitoring drug price and quality controls, practicing good governance, and allying with other LGUs and nongovernment sectors to improve health service delivery in the ILHZs that meet licensing and accreditation standards.

2. Policy Action 2: LGUs sign an MOA to establish ILHZs in at least 3 of the 13 areas identified by DOH in 5 project provinces (fully complied with)

38. LGUs of the five HSDP provinces have signed an MOA to form three ILHZs. The DOH is encouraging LGUs to ally with adjacent ones and thereby share in the management and financing of the health delivery system. The standards stipulated in the MOA for the formation and functionality of the ILHZ are (i) population-wide health improvement and coverage with public-health interventions, (ii) continuity in meeting individual patient care needs across different levels of health services, and (iii) efficient use of scarce resources for health. After decentralization, health delivery management and financing became fragmented. Provincial and district hospitals are under the governors' authority although DOH-retained hospitals also exist

in several provinces and are independent of the provincial health system. Often, provincial hospitals either run in parallel to the DOH-retained hospitals, offering the same services but not coordinating with them, and often DOH-retained hospitals crowd out provincial hospitals. The mayors, however, have the authority to manage the primary health care system (rural health units, barangay health system, and public health interventions). The ILHZs will promote cooperation between primary care centers and hospitals. The DOH, in partnership with the LGUs, will evaluate the ILHZs' functionality, and the results will help modify and scale up ILHZs to the 16 convergence provinces.

3. Policy Action 3. To issue licensing and accreditation of ILHZ as an integrated network including private health service providers (system accreditation), (i) the PHIC approves accreditation criteria for local health systems, and (ii) the DOH approves licensing standards for ILHZ (substantially complied with)

39. The PHIC has approved accreditation criteria for local health systems and has prepared a resolution to issue group accreditation to the ILHZs. The National Health Insurance Act of 1995 provides the PHIC with the authority to accredit health care providers (hospitals, primary care facilities, and private providers) and thereby permit them to participate in the PHIC program. As accreditation is for reimbursement purposes, the PHIC can extend this privilege to ILHZs as an integrated network. Accreditation is, therefore, an appropriate instrument to sustain and institutionalize ILHZs.

40. The DOH has requested exemption from pursuing part (ii) of the policy action (Appendix 3). Under Republic Act 4226—the Hospital Licensure Act of 1954, which sets the mandate for the licensure of all hospitals—separate licenses are required for each hospital. Therefore, legally a group license cannot be provided to an ILHZ[9] and so compliance was not possible and not necessary. Further, practically, it is not necessary to license ILHZ as a group because (i) under the Philippines health regime, there is no need and no means for licensing primary health care providers, (ii) an ILHZ comprises not only hospitals but mostly primary health care providers, (iii) hospitals under ILHZ are all licensed individually, and (iv) ILHZ's individual members are licensed to the extent that they are so required under the Philippines laws.

41. The policy action is substantially complied with, given that the PHIC fulfilled part (i) of the policy action, while the DOH was unable to fulfill part (ii) because of legislative constraints.

F. Health Sector Governance

42. **Policy Actions in Full Compliance.** Among the four policy actions, three are triggers for tranche release and one is a monitorable action. All policy actions are fully complied with.

43. The policy actions were primarily to address some of the health governance issues pertaining to human resources, national and local government medium-term frameworks, and improvement of monitoring and evaluation systems by engaging civil society.

[9] It is not necessary to license an ILHZ as a group because (i) under the health regime, there is no need and no means for licensing primary health care providers, (ii) an ILHZ comprises not only hospitals but mostly primary health care providers, (iii) hospitals under ILHZ are all licensed individually, and (iv) ILHZ's individual members are licensed to the extent that they are so required under the law.

1. Policy Action 1: DOH develops a comprehensive plan for health human resource assessment and capacity development and approves it (fully complied with)

44. The DOH has developed and approved an overall 25-year national framework whereby short- (2006-2011), medium- (2011-2020), and long-term (2021-2030) plans are to be prepared. The DOH has prepared the short-term plans, which stipulate strategies to (i) rationalize on the basis of skills mix and skills need and redistribute to address inequities and gaps, (ii) manage and monitor deployment of health human resources locally and emigration of health workers, and (iii) institutionalize health human resource management units. In the medium term, attention will be given mainly to developing partnerships between government and nongovernment agencies and providers, setting up a human resource database, and monitoring the quality of performance. In the long term, attention will be given mainly to provider satisfaction and improved monitoring and evaluation of the health human resource systems in place. The five HSDP provinces, as well as some provinces among the 16 convergence provinces, have prepared their plans. The plans aim to improve the effectiveness and efficiency of the health delivery system, and to improve governance, financial management and procurement systems, and health human resource planning needs assessment. After decentralization, the roles of the central, provincial, and local administrative levels of government changed. The DOH is now responsible for policy formulation, coordination, monitoring, and service delivery through DOH-retained hospitals. The regional health departments are responsible for monitoring, and addressing inequity in, health outcomes, and local governments are mainly responsible for health service delivery. The changing skills mix required by these various levels needs to be addressed. The country has difficulty retaining health professionals (many nurses and doctors are migrating in response to international shortages). Many health positions therefore remain unfilled, with few incentives to attract professionals to remote and underserved areas. The Government has a mandate to address these challenges for an improved and effective health delivery system.

2. Policy Action 2. DOH issues the first update of short- and medium-term plans for DOH and the project provinces in support of HSRA implementation (fully complied with)

45. The DOH has prepared a short- (2006–2007) and medium-term (2006–2010) plans to implement the HSRA. The updated national plan provides a 5-year HSRA reform program with cost estimates at P42.5 billion, as well as a short-term (2006–2007) reform package costing P16 billion. Most of the funding goes to service delivery reforms. In view of the challenges of decentralization and inequity in health outcomes, the DOH initiated the HSRA in 1999. Devolution as per the Local Government Code of 1991 fragmented the health service delivery system, and administrative and financial responsibilities are shared among central, provincial, and local authorities, without effective coordination and cooperation mechanisms. Public health programs suffered most. The budget deficit of the national Government and declining public sector resources aggravated the situation. The HSRA was introduced to help streamline the health service delivery system with a comprehensive program covering five broad areas of reform:[10] (i) providing fiscal autonomy to hospitals, (ii) securing funding for priority public health programs, (iii) promoting the development of local health systems and ensuring their effective performance, (iv) strengthening capacities of health regulatory agencies, and (v) expanding coverage of the national health insurance program. The HSRA was expected to improve the

[10] The HSRA does not include two priority areas: human resource development and improving the health information systems.

efficiency of the health service delivery system by integrating health care promotion and prevention, improving referral links, reducing the need for hospitalization, and thereby improving the allocation and use of resources.

3. Policy Action 3: The DOH through a consultation process with relevant stakeholders develops a standard instrument for measuring the effectiveness of consumer participation, and tests and approves it (fully complied with)

46. The DOH has developed a strategy to engage civil society in decision making and monitoring of health delivery. While it was developing the strategy, DOH consulted extensively with provincial and district health offices, hospitals, and health facilities; and representatives from nongovernment organizations, civil society, and organized consumer groups. The DOH strategy includes (i) establishing a consumer feedback mechanism (e.g., complaint desk at LGUs, consumer satisfaction surveys); (ii) introducing mechanisms to assess consumers' ability to pay; (iii) transparency in sharing health inputs, outputs, and outcome information with consumers (e.g., displays through websites, health facility information board, community forums); (iv) consumer partnership in health service delivery (e.g., partnership with NGOs, community mobilization, and community voluntary workers); and (v) civil society engagement in planning, policy development, implementation, and monitoring of performance. The DOH will accelerate this function in its medium-term plans (2006–2010).

III. PROGRAM IMPLEMENTATION

47. ADB was the first development partner to provide comprehensive support for the HSRA, with other development partners joining later. In July 2005, the DOH formed the Sector Development Approach for Health (SDAH) to bring all development partners together. The DOH has received substantial support for the HSRA for 2007–2011. Besides resources received from the Government, whose 2007 budget is expected to increase by P1 billion for DOH and by P2.7 billion for PHIC, additional resources are expected from development partners such as the United States Agency for International Development (USAID) ($125 million), the World Bank ($110 million), the European Commission (EC) (€40 million), (German Bank for Reconstruction [Kfw]) ($12.5 million), and others (German Agency for Technical Cooperation [GTZ], the Government of Belgium, and the Japan International Cooperation Agency [JICA]).

48. In July 2005, the new secretary of DOH introduced a refined set of priorities by revising the HSRA (FOURmula-One or F-1 for health): (i) health care finance reform, (ii) health service delivery strengthening, (iii) governance reforms, and (iv) regulation reforms. It also adds a principle for cross-cutting themes.

49. The HSDP investment project is within the SDAH framework. The project therefore works closely with other partners (government and development agencies) to support the HSRA in selected HSDP sites. The investment provided by loan proceeds considers the SDAH recommendation, whereby the province-wide investment plan for health for each of 16 convergence sites is assessed using agreed criteria, and financing mobilized and allocated collaboratively for the various capital and recurrent investment needs.

50. The HSDP investment project primarily supports local government needs in the health sector but finances national and local government activities. The project supports financing by (i) onlending resources for capital investment in the health sector through the Municipal Development Fund Office (MDFO) of the DOF, and (ii) ongranting resources through DOH for

local government non-capital spending to strengthen health service delivery and to implement the HSRA. Three provinces (Ilocos Norte, Oriental Mindoro, and Ifugao) have requested assistance, one province (Nueva Vizcaya) has declined assistance, and one (Romblon) may not have the fiscal capacity to borrow. The DOH is in dialogue with more provinces within the 16 convergence sites to determine if they have an interest in borrowing. The project helps strengthen the health service delivery system through an agreement reached with the LGUs on following a rationalized framework for health service delivery, investing in rehabilitating or constructing rural health units and district and provincial hospitals. The project has worked closely with local governments to build capacity for planning and management. It has also helped build systems such as the UMIS in public hospitals in provinces, train local governments in understanding HSRA, and develop partnerships and agreements between central and local governments to commit to the HSRA.

51. The TA has helped the DOH and the PHIC promote the program loan agenda. It will help the Government reform policy by guiding the HSDP investment project. It is working closely with other development partners in preparing guidance and training for DOH national and regional staff to promote the HSRA.

IV. CONCLUSION

52. The Philippines has generally made good progress in health sector reform. The HSDP has made substantial progress in addressing the needs of the poor and the vulnerable. All the 46 policy actions (20 tranche-release triggers and 26 monitorable actions) for the HSDP second-tranche release have been complied with. Of the 20 tranche-release triggers, 17 are fully complied with and 3 substantially complied with, and of the 26 monitorable actions, 24 are fully complied with, 1 is substantially complied with, and 1 partly complied with.

V. THE PRESIDENT'S DECISION

53. In view of the substantial progress made in implementing the HSDP and satisfactory compliance with the second-tranche policy actions, the President has authorized the release of the second tranche of the HSDP loan. Accordingly, pursuant to established procedures, the release of the second-tranche release in the amount of $100 million will be effected not less than 10 working days after the circulation of this progress report.

SUMMARY OF THE STATUS OF TWENTY TRANCHE POLICY ACTIONS FOR THE SECOND TRANCHE RELEASE

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
A. Health Care Financing Reform		
1. The Philippines Health Insurance Corporation (PHIC) submits confirmation of the inclusion of allocation for the sponsored program in the 2006 budget as submitted to Congress.	Fully complied with.	The PHIC Board has submitted to Congress the 2006 budget request for P4.2 billion for the Sponsored Program. National Expenditure Program (from the Department of Budget and Management to the Congress) FY2006 includes the PHIC request for (additional) resources for the Sponsored Program in the amount of P2.9 billion (as P1.3 billion had been approved for the regular Sponsored Program).
2. PHIC Board approves a new premium policy allowing progressive premium structure.	Fully complied with.	The PHIC Board had introduced the Individually Paying Program (IPP) for the self employed and informal sector groups in 1999, with a monthly premium of P100 per family for all within the group. This group includes those who are self employed and working as professionals (e.g., doctors, lawyers), however, they still pay a very low premium. In 2006, the PHIC Board approved staggered implementation of the progressive premium for the self employed professionals, and increased their monthly contributions to P200 effective 1 October 2006, and P300 effective 1 October 2007.
3. Based on a detailed cost database and analysis, PHIC Board approves a revised benefits package.	Fully complied with.	On 6 July 2006, the PhilHealth board took a number of resolutions to improve the benefit package: (i). requiring sufficient regularity in premium contribution for the availment of dialysis, chemotherapy and radiotherapy benefits by individually paying members, starting 1 January 2007. (ii). Amending payment for surgical procedures for fair and equitable utilization of benefits, effective 1 January 2007. (iii). Approving outpatient HIV and AIDS benefit, this benefit was implemented 6 July 2006. (iv). Approving a tiered payment of professionals based on their credentials and technical competence. (v). Approving the maternity package for the third normal spontaneous delivery, this benefit was implemented 6 July 2006. (vi). Approving the outpatient malaria benefit package, effective 1 October 2006.

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
		(vii). Approving the newborn care benefit package, this benefit was implemented 6 July 2006. (viii). Approving the further rationalization of PHIC benefits, starting 1 January 2007. The additional costs for the extension of the benefit package are estimated at P750 million ($14.7 million) yearly. Comparing to the costs of the benefit package in 2005, this is an increase of 4.3%.
4. PHIC publishes a performance report on the status of the utilization of the 10 clinical practice guidelines (CPGs) for quality assurance and accreditation.	Substantially complied with.	The PHIC will display the results among the providers and stakeholders though the PHIC newsletter and website, before formalizing the use of CPGs as quality assurance tool for accrediting public and private providers. The policy action is substantially complied with, due to the delay in its implementation. Although, the PHIC has initiated the study in 2006, it will be able to present/publish its results only in 2007. This exercise is underway with the assistance of ADB supported consultants (TA4647).
B. Hospital Reforms		
1. The Department of Health (DOH) designs a Unified Financial Management Information System (UMIS) for pilot testing and enters into a Memorandum of Agreement (MOA) with selected hospitals for test.	Fully complied with.	In cooperation between the IT unit of the DOH and external domestic expertise a UMIS was designed and approved by DOH. The MOA was signed between five hospitals, and the UMIS is being pilot tested in 1 provincial hospital, and 4 DOH retained hospitals (one of which is in the province of Ilocos Norte). The UMIS will integrate the existing systems (HOMIS, LMIS and Pharma-50) into one system, thereby eliminating data entry duplication, and improving the overall operational efficiency.
2. DOH issues an Administrative Order (AO) to adopt a policy on governing boards of all public hospitals.	Fully complied with.	The issuance of the AO compels all public hospitals to establish governing boards with client participation. The governing boards are expected to include at least three representatives from the business sector, and the community, including from medical and professional organizations. This will increase hospital responsiveness to client needs, and will pave the way for a future transformation of the hospital to autonomous economic units.
3. DOH issues an AO to adopt performance-based allocation of (national) subsidies for 2006.	Substantially complied with.	The DOH developed an AO whereby defining the intentions to allocate hospital resources based on hospital service performances. The

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
		AO outlined performance criteria for resource allocation. The performance criteria included (i) maintenance and other operations expenses (MOOE) allocation to individual hospitals be conditioned on the proportion of surgical and special cases relative to their total caseload, (ii) MOOE be distributed on the basis of their performance of research and training, and (iii) MOOE be allocated on the basis of their ability to meet quality standards. Subsidies will be allocated on performance basis in 2007. This policy action is substantially complied with, given the delay in its implementation from 2006 to 2007. With the introduction of the AO in 2006, DOH has prepared the basis for allocating the national subsidies to DOH retained hospitals on performance basis in 2007. The 2007 subsidies have already been budgeted for DOH hospitals on performance basis.
4. DOH issues an AO to state a policy on rationalizing local public hospitals based on need.	Fully complied with.	The AO on Rationalization of the Health Care Delivery System may be considered to be one of the most important AOs. This AO will not only affect public hospitals but also affect private providers. Provinces are encouraged to develop health plans for the whole province for primary care facilities as well as secondary care (hospitals). The plans will be based on guidelines of DOH with regard to the number of hospital beds, the size of hospitals, the existence of private facilities, etc. Based on these, investment plans will refurbish (or build new) needed hospitals. Primary medical care will be stimulated taking the pressure away from hospitals, and hospitals will provide secondary care (specialist care) instead of primary care.
C. Public Health Reforms		
1. DOH issues an AO to adopt the revised expenditures targets for public health spending and hospital-based services.	Fully complied with.	The AO on HSRA financing reform is a key element to support the shift of DOH resources towards public health, such as the reallocation of DOH retained hospital subsidies from DOH hospitals to public health interventions; public health commodities; performance-linked grants to LGUs; development of public health service packages for each level of (public) facilities. This AO provides guidelines on budget allocation and budget execution principles. (refer to policy action C2.1 in Appendix 2).

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
2. DOH develops a framework to establish long-term performance-based budgeting for priority public health programs.	Fully complied with.	The AO on framework provides guidelines to prioritize public health programs, commodities and development by establishing special funds for these areas. Subsidies will be linked to specific outcomes, including functional inter-local cooperation.
3. DOH revises Philippines National Drug Formulary (PNDF) to include contraceptives (pills, injectibles, and intra-uterine device (IUDs)).	Fully complied with.	Contraceptives (pills and injectibles) were included in the PNDF system, while IUDs and condoms were included in Bureau of Food and Drugs (BFAD) list of medical devices.
D. Health Regulation Reforms		
1. DOH drafts a bill for Congress review proposing amendments of the mandates of DOH regulatory agencies to increase efficiency in health care provisions.	Fully complied with.	The draft bills stipulated areas for strengthening capacity and authorizing the regulatory agencies to enforce quality assurance.
2. DOH issues an AO on certification mechanism for primary health care services providers based on service capacity and quality.	Fully complied with.	Through this AO, certification and accreditation standards are harmonized between DOH and PHIC, and its responsibility for quality assurances (at this time quality is measured as meeting minimum requirements) left with the accreditation system of the PHIC.
3. DOH issues an AO and new regulations on drug management in order to reduce drug prices.	Fully complied with.	The AO provides guidelines to define basic necessities among generic and branded drugs and establishes a system and an organization to reduce drug prices, monitor drug prices and inventories of such drugs. It also provides specific guidelines with criteria for various actors.
E. Local Health Systems Reform		
1. DOH, PHIC and local government units (LGUs) approve a MOA, which commits to (i) establishing inter-local health zones (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 rural health units (RHUs) and barangay health stations (BHSs).	Fully complied with.	The MOA stipulates: (i) DOH's assistance to LGU in improving fiduciary controls, good governance, quality assurance, and indigent enrollment in PHIC; (ii) PHIC assistance to LGUs in securing universal health insurance coverage, especially of the informal sector population and the indigents, accreditation, and promotion of PHIC benefits; and (iii) LGUs confirmation on coordination and partnership for HSRA, supporting the implementation of a provincial-wide investment health plan, helping set up enrollment centers for the PHIC, monitoring drug price and quality controls, good governance practices, and partnership with

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
		other LGUs and nongovernment sectors to form alliances for improved health service delivery in the inter-local health zones. MOA was signed between central and local governments of all five HSDP project provinces.
2. LGUs sign MOA to establish ILHZ in at least three of the thirteen areas identified by DOH in five project provinces.	Fully complied with.	The standards stipulated in the MOA for the formation and functionality of the ILHZ are (i) population-wide health improvement and coverage with public-health interventions; (ii) continuity in meeting individual patient care needs across levels of health services; and (iii) efficient use of scarce resources for health. MOA for at least three ILHZ formation was signed between governors and mayors of all five HSDP project provinces.
3. To issue licensing and accreditation of ILHZ as an integrated network including private health service providers (system accreditation), (i) PHIC approves accreditation criteria for local health systems and (ii) DOH approves licensing standards for ILHZ.	Substantially complied with.	For Part (i): PHIC Board has approved accreditation criteria on accreditation of BHS/RHUs under ILHZ. For Part (ii): DOH requested exemption on legal basis. The policy action is substantially complied because part (ii) was not possible to follow through due to legal restrictions in the Philippines.
F. Health Sector Governance		
1. DOH develops a comprehensive plan for health human resource assessment and capacity development, and approves it.	Fully complied with.	The DOH has prepared the short-term plans, which stipulate strategies to (i) rationalize on basis of skills mix and skills need and redistribute to address inequities and gaps; (ii) manage and monitor deployment of health human resources locally, and emigration of health manpower; and (iii) institutionalize health human resource management units.
2. DOH issues the first update of short- and medium-term plans for (i) DOH and (ii) project provinces in support of HSRA implementation.	Fully complied with.	The updated national plan provides a 5-year HSRA reform program with cost estimates at P42.5 billion, as well as a short-term (2006–2007) reform package costing P16 billion. Most of the funding goes to service delivery reforms. Similarly the five HSDP project province plans provide reform programs, investment cost estimates and management systems.
3. DOH through a consultation process with relevant stakeholders develops a standard instrument for measuring the effectiveness of consumer participation,	Fully complied with.	DOH through a consultative process with stakeholders developed an AO on consumer participation institutionalizing the HSRA strategy for consumer participation, the

Policy Actions under Health Sector Development Program for Second Tranche Release	Status of Compliance	Description of Status of Policy Actions
and tests and approves it.		Assessment tool as well as regular evaluation of effectiveness of consumer participation. Based on the concepts of the World Bank's publication, *World Development Report 2004* the tools are focused on client voice, client choice and participation as well as provider accountability. The HSRA strategies establish feedback mechanisms, improve purchasing power of poor, provision of health information, support to consumer production of health services and client participation in decision-making.

ADB = Asian Development Bank, AO = administrative order, BFAD = Bureau of Food and Drugs, BHS = barangay health station, CPG = clinical practice guidelines, DOH = Department of Health, FY = fiscal year, HSRA = health sector reform agenda, ILHZ = inter-local health zones, IPP = individually paying program, IT = information technology, IUD = intra-uterine device, LGU = local government unit, MOA = memorandum of agreement, MOOE = maintenance and other operations expenses, PHIC = Philippine Health Insurance Corporation, PNDF = Philippine National Drug Formulary, RHU = rural health unit, UMIS = unified management information system.
Source: ADB. 2004. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Republic of the Philippines for the Health Sector Development Program.* Manila.

SUMMARY OF THE STATUS OF 46 TRANCHE POLICY ACTIONS FOR THE SECOND TRANCHE RELEASE

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
A. Health Care Financing Reforms		
1. PhilHealth submits confirmation of the inclusion of allocation for the sponsored program in the 2006 budget as submitted to Congress. (Tranche release policy action).	Fully complied with.	PHIC Board Resolution No. 799, s. 2005 (signed by PHIC Board members on 9 June 2005) budget request for 2006 in an amount of P4.2 billion for the Plan 5/25 Sponsored Program; National Expenditure Program (from the Department of Budget and Management to the Congress) FY2006 includes the PHIC request for (additional) resources for the Sponsored Program in the amount of P2.9 billion (as P1.3 billion had been approved for the regular Sponsored Program); PHIC Board Resolution No. 902, s 2006 (signed by PHIC Board members on 15 June 2006) budget request for 2007 in an amount of P3.9 billion for the Sponsored Program.
1.1. PhilHealth submits their financing plan, which allocates subsidies for the sponsored program in 2006	Fully complied with.	PHIC issued certificate on 2 September 2005 for P2.9 billion (out of the P4.2 billion) for the Sponsored Program, and included it in the National Expenditure Program for FY2006.
2. PhilHealth Board approves a new premium policy allowing progressive premium structure. (Tranche release policy action).	Fully complied with.	PHIC Board Resolution 886 s. 2006 (signed by the PHIC Board on 23 February 2006) on approving the implementation of the progressive premium contribution for the self-employed professionals. PHIC Board Resolution 887 s. 2006 (signed by the Board on 24 March 2006) amending PHIC Board Resolution 886 s. 2006 and authorizing PHIC management to identify professions by professionals in higher income groups to be covered thereby. The Implementation Rules and Regulations of the National Health Insurance Act as amended by RA9241 2004 edition page 25 section 28 describes the premium sharing schedule for the indigent program. PHIC Board Resolution 735 s. 2004 (signed by the Board on 16 December 2004) approving the proposed contribution schedules for the employed sector adjusting the ceiling on the monthly salary that is subject to PHIC contribution. In 2006, salary cap is raised to P25,000, and in 2007, salary cap is raised to P30,000.
2.1. PhilHealth board approves a progressive premium contribution scheme based on individuals' capacity to pay for poor households under the poverty line but ineligible for sponsored program.	Fully complied with.	PHIC Board Resolution 584 s 2003 (signed by the Board on 17 June 2003) approving 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) approving P4.58 billion for FY2005 budgetary support for the Sponsored Program. In essence the Sponsored Program target population was increased (Plan 5/25).

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
		PHIC Board Resolution 799 s 2005 (signed by the Board on 9 June 2005) approving 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) approving P3.9 billion for FY2007 budgetary support for the Sponsored Program. Issues paper is added to explain that the revised Sponsored Program (called Plan 5/25) now includes all those identified as indigents in the country, and that includes the poor who were initially added in the IPP.
2.2. PhilHealth conducts a market segmentation study on the informal sector.	Fully complied with.	Study results 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 Prof. Soonman Kwon funded through the support of GTZ (6 September 2005). PHIC Board Resolution 886 s 2006 (see Policy action 2).
2.3. PhilHealth develops local government units (LGUs) monitoring and evaluation system of sponsored program	Fully complied with.	Study results submitted through a report on Sponsored Member's Aggregated Reporting Technology by Robert Brent P. Lipke – ADB TA consultant (7 July 2006). LGU Monitoring and evaluation (M&E) computerized system (called the SMART) was developed to monitor enrollment of the sponsored program. The M&E system acceptance certificate dated 9 August 2006 was signed by PHIC Management.
2.4. PhilHealth concludes designed information campaign.	Substantially Complied with.	PHIC Board Resolution 917 s 2006 (signed by the Board on 23 June 2006) approving FY2006 Corporate Operating Budget of PHIC which includes budget allocation for the Information, Education, Communication (IEC) Implementing Plan for the premium adjustment. Issues paper shows the IEC Plan on the progressive premium structure for the employed and IPP sectors detailing the objectives to include the premium schedule and premium rate to be communicated to the community. The Policy action is substantially complied with, because although the campaign is designed, it is not concluded. However, the campaign plans have been submitted, the campaign budgets have been approved and the campaign is expected to be conducted in January 2007. This exercise is underway with the assistance of ADB supported consultants (TA4647).
3. Based on a detailed cost database and analysis, PhilHealth Board approves a revised benefit package. (Tranche release policy action).	Fully complied with.	PHIC Board Resolution 926 s 2006 (signed by the Board on 6 July 2006) approving the rationalization of PHIC benefits. PHIC Board Resolution 880 (signed by the Board on 23 February 2006), and 921, 923, 924 s. 2006 (signed by the Board on 6 July 2006) accepting the extension of the benefit package. The revised benefits package

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
		includes coverage for Avian Influenza, and outpatient coverage for HIV/AIDS, and malaria and maternity care package for the third normal spontaneous delivery. The additional costs of the extended benefits package is estimated at P750 million (or $14.7 million) annually (as of 19 September 2006).
4. PhilHealth publishes a performance report on the status of the utilization of the 10 clinical practice guidelines (CPGs) for quality assurance and accreditation. (Tranche release policy action).	Substantially Complied with.	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 was approved by PHIC management. The study proposal was accepted by PHIC management on 26 September 2006. The study will be conducted between September 2006 to February 2007, and the results of the study will be published in newsletters and shared with stakeholders, and providers by March 2007. Following dissemination, PHIC plans to regularly review the claims that will be filed by the participating hospitals for adherence to the CPGs. The results of this review will be fed back to the hospitals. The Policy action is substantially complied with, because PHIC has initiated the study in 2006, and will be able to present/publish its results only in 2007. This exercise is underway with the assistance of ADB supported consultants (TA4647).
4.1. PhilHealth publishes a report on status of CPG use in accredited hospitals.	Fully complied with.	A Health Technology Assessment Forum newsletter Volume 4 no. 1, 2006 published the description of the 10 CPGs to be used for accredited hospitals later, and these are: pediatrics community acquired pneumonia, acute appendicitis, hypertension, dyspensia, 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 will be published in a subsequent newsletter and PHIC website after the CPGs have been tested under policy action A.4.
5.1 PhilHealth submits a Board-approved Medium Term Plans (MTPs) for 2005-2012 including actuarial forecast on revenues and payments.	Partially Complied with	Philippine Board Resolution 605 s. 2003 dated 4 September 2003 signed by PHIC Board approving the PHIC Development Plan for 2004–2012. PHIC MTP (2004–2007 and 2008–2012) estimated the costs of new benefits packages dated 19 September 2006. The Policy action is partially complied with, because the MTP is still a draft that requires further refinement, and then to be presented to the Board for approval. The exercise is underway with the assistance of ADB supported consultants (TA 4647), and the PHIC Board approval expected towards the end of 2006.

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
PhilHealth board expands PhilHealth Organized Groups Interface (POGI) for national implementation.	Fully complied with.	PHIC Board Resolution 917 s. 2006 (signed on 23 June 2006) approving FY2006 corporate budget use for implementation of KASAPI. An issues paper was prepared explaining the reason to move from POGI to KASAPI.
6.1 PhilHealth and organized groups in informal sector develop MOA in all Health Sector Development Program (HSDP) provinces to implement POGI	Fully complied with.	MOA was signed on the organized group partnership between PHIC and the CARD Mutual Benefit Association (including for Oriental Mindoro and Romblon—2 HSDP project sites) in enrolling IPP (September 2005); MOA was also signed with the organized group partnership between PHIC and Rural Green Bank CARAGA Inc. (microfinance group) for enrolling IPP (10 July 2006); MOA was also signed with the organized group partnership between PHIC and *Taytay sa Kauswagan* Inc. for enrolling IPP (25 October 2005)
B. HOSPITAL REFORMS		
1. DOH designs a UMIS for pilot testing and enters into a MOA with selected hospitals for test. (Tranche release policy action).	Fully complied with.	MOA was signed with: (i) four DOH retained hospital directors and DOH in the first half of 2006, and (ii) one provincial hospital (Oriental Mindoro) between Governor, Province, and DOH on 27 March 2006.
1.1. DOH issues an AO on implementation of continuing quality improvement (CQI)	Fully complied with.	AO no. 002 s. 2006 (23 January 2006) signed by Secretary of Health, DOH on the establishment of the continuing quality improvement program and the CQI committee in DOH retained hospitals.
1.2. PhilHealth endorses CQI as criteria for accreditation of all hospitals.	Fully complied with.	PHIC circular no. 12 s. 2006 (10 April 2006) signed by officer-in-charge of PHIC on requirement for continuous quality improvement program in accreditation of hospitals.
2. DOH issues an AO to adopt a policy on governing boards of all public hospitals. (Tranche release policy action).	Fully complied with.	AO 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.
2.1. DOH evaluation report on progress and experience of corporatizing the two selected DOH hospitals	Fully complied with.	Evaluation report submitted by DOH on 16 March 2006 on Progress and Experience of Corporatizing Quirino Memorial Medical Center, and Ilocos Training and Regional Medical Center.
3. DOH issues an AO to adopt performance-based allocation of (national) subsidies for 2006. (Tranche release policy action).	Substantially Complied with.	AO 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. This policy action is substantially complied with, since with the introduction of the AO in 2006, the DOH has prepared the basis for allocating the national subsidies to the DOH retained hospitals on performance basis in 2007. The 2007 subsidies have already been budgeted for DOH hospitals on performance basis.

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
3.1. DOH implements guidelines on revenue retention for DOH hospitals.	Fully complied with.	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.
3.2. DOH completes a human resource assessment for 30% of DOH hospitals.	Fully complied with.	A comparative analysis of human resource in 30% of DOH hospitals was completed on 10 June 2006.
4. DOH issues AO to state a policy on rationalizing local public hospitals based on need. (Tranche release policy action).	Fully complied with.	AO no. 0029 s. 2006 (15 June 2006) signed by Secretary of Health, DOH on Guidelines for Rationalizing the Health Care Delivery System based on health needs.
4.1. Provincial ordinances from three HSDP provinces authorizing their (provincial) hospitals to earn, retain and use their income	Fully complied with.	Provincial Ordinances no. 0321-2006 for Ifugao (on 22 May 2006), no. 005-2003 for Oriental Mindoro (on 4 August 2003), and no. 107-2003 for Romblon (21 July 2003).
5.1 DOH issues an AO to implement the public and private hospital waste management guidelines.	Fully complied with.	AO no. 02 s. 2005 (24 August 2005) signed by the Secretaries of the Department of Environment and Natural Resources (DENR) and DOH on Policies and Guidelines on Effective and Proper Handling, Collection, Transport, Treatment, Storage and Disposal of Health Care Wastes.
C. PUBLIC HEALTH REFORMS		
1. DOH issues an AO to adopt the revised expenditures targets for public health spending and hospital-based services (Tranche release policy action)	Fully complied with.	AO no. 0023 s. 2006 (30 June 2006) signed by the Secretary of Health, DOH on Implementing Guidelines for Financing HSRA (FOURmula-One) Investment and Budget Reforms.
2. DOH develops a framework to establish long term performance-based budgeting for priority public health programs. (Tranche release policy action)	Fully complied with.	AO 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 would be considered under three-categories: (i) baseline public health commodity fund intended for public health commodities (e.g. vaccines, TB drugs), (ii) public health program funds intended for policy and systems development and for the provision of technical assistance from DOH to LGUs and health sector partners (e.g., surveillance systems strengthening), and (iii) public health development fund intended for savings generated or unallocated from the public health program fund grant and loan inputs from ODA and fund 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 have been identified as: coverage under the expanded program for immunization (EPI), TB prevalence, contraceptive prevalence, under-five mortality, infant mortality,

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
		maternal mortality.
2.1 DOH drafts a bill for Congress review to institutionalize long-term performance-based budgeting for priority public health programs.	Fully complied with.	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.
3. DOH revises Philippines National Drug Formulary (PNDF) to include contraceptives (pills, injectibles, and IUDs). (Tranche release policy action)	Fully complied with.	PNDF (sixth edition) included pills and injectibles as of 3 April 2006. Medical Device List (of BFAD) included IUDs and condoms as of 8 May 2006.
4.1 DOH issues AO on partnerships with the private sector for delivery of public health programs, specifically tuberculosis and family planning	Fully complied with.	AO no. 008 s. 2006 (10 May 2006) 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. AO no. 154 s. 2004 (14 June 2004) signed by the Secretary of Health, DOH, on Implementing Guidelines for the Creation of National and Regional Coordinating Committee on Public-Private Mix on DOTS.
4.2 DOH and selected private health organizations signs a MOA on public-private partnerships on tuberculosis and women's health and safe motherhood programs.	Fully complied with.	MOA was signed between Philippines Non-Government Organization Council (PNGOC), Philippines Chamber of Commerce and Industry (PCCI) and DOH on 19 May 2006 on Goal of Sustained Reduction of Filipino Women's Risk from Dying due to Maternal Causes and to the Objective of Increasing the Share of Private Sector Provision in total Population-wide coverage of Essential Health Services for Women of Reproductive Age. MOA was signed between Philippines Coalition Against Tuberculosis (PhilCAT), Foundation for Innovative New Diagnostics (FIND), 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 REGULATION REFORMS		
1. 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)	Fully complied with.	Draft Bills submitted by DOH to Congress on 27 April 2006 (and received on 10 May 2006), but Congress has not reviewed the Bills to date. The Bills were on (i) Strengthening the Regulatory Capacity of the BFAD by amending republic act, and appropriating funds thereof; (ii) Rationalizing and Strengthening the Regulatory Power of the State over radiation medical and health-related devices to the creation of the Bureau of Devices and Radiation Health and appropriating funds therefore; (iii) Enhancing the Regulations of Health Facilities and Health Services, Strengthening the Bureau of Health Facilities and Services and appropriating funds thereof.

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
1.1. DOH and PHIC review and updates administrative issuances and circulars on licensing and accreditation standards of health facilities.	Fully complied with.	DOH issued a department memorandum 0026 s. 2006 (9 February 2006) on the dissemination of AO no. 2005-0029 and other AO's related to the regulation of health facilities and services.
2. DOH issues an AO on certification mechanism for primary health care services providers based on service capacity and quality (Tranche release policy action)	Fully complied with.	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/health centers.
3. DOH issues an AO and new regulations on drug management in order to reduce drug prices. (Tranche release policy action)	Fully complied with.	AO no. 0031 s. 2005 (7 December 2005) signed by the Secretary of Health, DOH, on Guidelines and Procedures for the Issuance of the Principle Certificate of Product Registration and the Listing of Identical Drug Products based on the Identity of Manufacturers and Pharmaceutical formulation.
3.1. DOH and PHIC establish a regularly updated and published drug price reference/monitoring system, involving related public and private agencies, consumer organizations, and the academe, among others.	Fully complied with.	AO 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.
3.2. DOH and PHIC reviews and issues department orders (DO) and circulars in updating PNDF based on the needs of drug management needs of PHIC benefit packages and LGUs	Fully complied with.	AO no. 0018 s. 2006 (8 May 2006) signed by the Secretary of Health, DOH, on Implementing Guidelines for the PNDF systems.
E. LOCAL HEALTH SYSTEMS REFORMS		
1. DOH, PHIC and LGUs approve a MOA, which 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 rural health units (RHUs) and *Barangay* Health Stations (BHSs) (Tranche release policy action).	Fully complied with.	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).
1.1. At least three ILHZ's business plans in project provinces developed for 2006.	Fully complied with.	Three business plans were delivered for two ILHZs in Oriental Mindoro and one ILHZ in Ilocos Norte (24 September 2006) by DOH.
1.2. DOH issues an AO to approve incentive schemes supporting sustainable operations of ILHZs	Fully complied with.	AO no. 0017 s. 2006 (3 August 2006) signed by the Secretary of Health, DOH, on Incentive Schemes Framework for Enhancing Inter-LGUs coordination in Health through ILHZ and ensuring their sustainable

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
1.3. 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	Fully complied with.	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.
2. LGUs sign MOA to establish ILHZ in at least three of the 13 areas identified by DOH in five project provinces. (Tranche release policy action)	Fully complied with.	ILHZ system proposal was developed in 2001. Two of the five HSDP provinces (Romblon and Oriental Mindoro) had established ILHZ between 2000-2003, one (Ilocos Norte) established ILHZ in 2005, and one (Nueva Vizcaya) established ILHZ in 2006. All these provinces had a MOA signed between provincial and municipal governments. However, Ifugao did not establish ILHZ but instead established district health systems in 2003, because it has a small and sparsely distributed population.
3. To issue licensing and accreditation of ILHZ as an integrated network including private health services providers (system accreditation), PHIC approves accreditation criteria for local health systems and DOH approves licensing standards for ILHZ. (Tranche release policy action)	Substantially Complied with.	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. 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. HEALTH SECTOR GOVERNANCE		
1. DOH develops a comprehensive plan for health human resource assessment and capacity development, and approves it. (Tranche release policy action)	Fully complied with.	A comprehensive Health Human Resource master plans (2006–2011, 2011–2020, and 2020–2030) were submitted by DOH on November 2005.
2. 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)	Fully complied with.	DOH submitted on 28 July 2006 the 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. Short-term (2006-07) plans for the 5 HSDP provinces were submitted on 31 July 2006.
3. 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)	Fully complied with.	AO 0020 s. 2006 (13 June 2006) on Guidelines for Evaluation of Consumer Participation Strategies in HSRA (FOURmula-one for health). Community consultations took place in May 2006.

Triggers and Monitorable Actions	Status to date	Documents Supporting Policy Actions
4.2 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	Fully complied with.	First tranche release of $100 million was used between 2005–2006 towards HSRA activities, and most of it was shared between public health and hospital. Second tranche of $100 million is planned to be used between 2007–2008 for similar HSRA activities.

02 May 2006

MR. DAVID GREEN
Officer-in-Charge
Social Sector Division (SESS)
Southeast Asia Department
Asian Development Bank (ADB)
Mandaluyong City

Dear Mr. Green:

We would like to request that the ADB Policy Loan provision (E. 3) on licensing and accreditation of Inter-Local Health Zones (ILHZs) as an integrated network be revised ***to omit requirement for DOH to license ILHZ*** and ***to omit provision for DOH to approve licensing standards for ILHZ*** because of the lack of necessary and current legal basis for such action. The DOH request considers the following:

(1) The Department of Health (DOH) through its various regulatory offices is currently licensing the various health facilities and services found in ILHZs. The purpose of licensing is to protect and promote the health of the people by ensuring the right to safety and to quality health service.

(2) DOH Administrative Orders (AOs) Nos. 147, s. 2004, and 29 s. 2005, provide the implementing rules and regulations (IRR) for RA 4226 also known as the "Hospital Licensure Act" . These Orders provide for the registration, licensure ad operation of hospitals and other health facilities in the Philippines.

(3) Section 13 of R.A. 4226, which provides that, each hospital or any branch thereof shall be licensed separately may impede enforcement of licensing standards for a group of public and private health facilities forming an ILHZ.

(4) The more appropriate instrument to sustain and institutionalize ILHZ as an integrated network is the Accreditation Process, which is based on quality processes, and which is done by the Philippine Health Insurance Corporation (PHIC). The accreditation is done for reimbursement purposes, and PHIC can extend the same to the ILHZ as an integrated network that includes private health service providers.

The DOH Executive Committee (Execom) has thus resolved (see attached resolution) that the Policy conditionality (E 3), as revised should thus more appropriately require only: ***The accreditation of ILHZ as an integrated network including private health services providers (system accreditation). PHIC approves accreditation criteria for inter- local health zone system.***

Your favorable and immediate attention to our request will be highly appreciated.

Thank you.

Very truly yours,

FRANCISCO T. DUQUE, III, MD, MSc
Secretary of Health

Republic of the Philippines
Department of Health
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Department of Health Executive Committee
RESOLUTION NO. 36 – 26
Series 2006

"RESOLVED, that Executive Committee of the Department of Health (DOH) approve, as it hereby approves to pursue the track for Inter-Local Health Zone (ILHZ) system accreditation by the Philhealth and request to dispense with the ILHZ system network licensing requirements presented in the Asian Development Bank policy loan conditionality due to inconsistency with current legal mandates for licensure."

Approved at the regular Executive Committee Meeting of DOH on March 23, 2006, at OSEC Conference Room, Building 1, 2nd floor, San Lazaro Compound, Sta. Cruz, Manila.

APPROVED BY:

HON. MARGARITA M. GALON
Undersecretary of Health

HON. ALEXANDER A. PADILLA
Undersecretary of Health

HON. ETHELYN P. NIETO
Undersecretary of Health

HON. JADE F. DEL MUNDO
Undersecretary of Health

HON. LORNA O. FAJARDO
Officer-In-Charge, PHIC

HON. MARIO C. VILLAVERDE
Assistant Secretary of Health

HON. DAVID J. LOZADA, JR.
Assistant Secretary of Health

HON. NEMESIO T. GAKO
Assistant Secretary of Health

HON. FRANCISCO T. DUQUE III
Secretary of Health

ATTESTED BY:

DR. ROBERT LOUIE P. SO
Head, Executive Assistant