

TYPE OF DOCUMENT:	PROJECT SUMMARY (ABRIDGED)
PROJECT TITLE:	Financing the Health Sector Reform Project (HSRP)
IMPLEMENTING AGENCY:	Department of Health (DOH)
FUNDING SOURCE:	KfW
PERIOD OF LOAN AVAILMENT:	2007-2011

## ANALYSIS OF HEALTH SECTOR PROBLEMS AND OPPORTUNITIES

The ailing Philippine health setting has set the challenge for the Health Sector Reform Agenda (HSRA). Major health improvements have been evident during the last few decades, but their pace and scope is now at risk of being overwhelmed by a growing population, a constrained economy, and the various challenges to service delivery. While infant mortality and maternal mortality rates—the classical indicators for health service quality—have declined since 1985, they are still too high (44.3 IMR per 1000 live births, and 172 MMR per 100,000 live births; DOH 1999b) compared to Thailand and Singapore.

### **Leading Causes of Illnesses and Deaths**

The leading causes of morbidity from communicable diseases are diarrhoea, pneumonia, bronchitis, tuberculosis, malaria, and sometimes, measles and dengue outbreaks. Leading non-communicable causes of morbidity are diseases of the heart, hypertension, accidents, and malignant neoplasms. The leading causes of mortality of non-communicable diseases are heart and vascular diseases. Among the communicable diseases, pneumonia, tuberculosis, and diarrhoea still remain in the top 10 causes of mortality, although deaths due to diarrhoea have considerably declined in the past five years. An increasing trend in deaths due to diabetes mellitus, accidents and injuries has also been noted.

### **Causes of Declining Health Status**

According to the World Bank (1998), while the health status has improved in the Philippines, it remains unsatisfactory compared to other middle-income countries in the region. The declining rate of improvement in health status in the country has been partially traced to inadequacies in the financing of health care. Overall spending for health has improved slightly over the past 10 years, but remains insufficient. In 1997, about 3.5% of gross national product (GNP) was spent on health care (up from 3% in 1991), but is still below the WHO benchmark of 5%. Per capita spending for public health is less than P300 per year, which is less than half the recommended level for low-income countries. Almost half of the money spent on health came from direct out-of-pocket payments by individuals. Social health insurance contribution to health care spending was less than 10% from 1991-2000, although it has been steadily growing in the past three years. More than 70% of health expenditure was spent on personal health care, and only 13% was spent on public health care.

Although this is the typical pattern found everywhere, the governmental health sector expenditure pattern in the Philippines shows considerable imbalances between what is spent on personal/curative care relative to the overhead expenditure. Not enough is allocated for public health and preventive care services like family planning or reproductive health. The devolution of 1991 resulted in the fragmentation of the public health care delivery system, with DOH retaining responsibility for administration of tertiary hospital, while provincial governments took over the management of secondary and the so-called primary hospitals, and municipal and city governments inherited the responsibility for managing RHUs and BHSs providing some public health services and limited primary clinical care. For many local governments, the devolution of health care became burdensome as it became evident that their respective revenue allotments were insufficient to cover the cost of the devolved services. Provincial governments bore the brunt of the burden as they took over the operation of the more costly hospital services and absorbed the cost of past irrationalities in investment in too many hospitals, some of which were poorly located and poorly maintained even prior to devolution. A reallocation of resources towards more spending on preventive care is only realistic if the quality of care in hospitals can be improved and basic care unnecessarily served at hospital level shifted towards health centers and RHUs.

### **The Health Sector Reform Agenda**

In 1999, the DOH formulated and adopted the HSRA, which is composed of five inter-dependent reform pillars: (1) health financing, (2) public health, (3) local health systems development, (4) hospital development,

and (5) regulations. A review of the HSRA implementation indicated that while target activities have largely been unmet, there has been significant progress in some specific areas of concern, such as the convergence sites. However, while the HSRA implementation has been delayed and pursued at much lower pace, it has been taken beyond the critical initial implementation phase. The HSRA requirement in terms of budget, human resource and organizational capacity is so huge which made it very difficult for the DOH to lead and support the reform process.

With the lessons learned at the initial phase of HSRA implementation, the DOH formulated the Formula One for Health (F1), a strategy that stresses four sets of instruments—(1) service delivery, (2) regulation, (3) health care financing, and (4) governance—that must be effectively applied in order to influence the performance of a highly decentralized public health care system and local health care markets. Hence, meeting national targets such as those in the National Objective for Health (NOH) and the Millennium Development Goals (MDG) must now be seen in the context of using these instruments to influence the behaviours of target beneficiaries, public and private health care providers, and suppliers of other health goods and commodities.

Basically, F1 took off from the HSRA but with deliberate focus on the most critical, achievable, doable and high-impact reform initiatives that can be undertaken in the next five years. Since the issuance of AO 23, s. 2005, two sets of F1 flagship projects have been identified and specified: (1) development of province-wide local health systems in 16 initial convergence sites; and (2) projects to build capacity at the national level to exercise effective leadership or stewardship over the health sector. Initial estimates suggest that existing resources are not sufficient to support the requirements of these projects. And, in the process of prioritizing and then identifying funding sources for F1 investments, it became clear that there was an urgent need to reform the structure, and allocate and execute direct subsidies going to central level health agencies and programs.

DOH is developing a framework for financing critical F1 investments in the context of budget reforms over the next five years based on the Medium-Term Health Sector Expenditure Framework. To maximize the resources being invested in the health reform initiatives, the DOH adopted the Sector Development Approach (SDAH) for health, or more commonly known as Sector-Wide Approach (SWAP). Using the SDAH as the measure to implement the F1, it is envisioned to move the F1 programs towards a broader support from all sources of funding, make the sector coverage more comprehensive, align ongoing and future projects with the SDAH, develop or harmonize common processes and procedures, and strengthen the leadership of the DOH in the health sector.

## THE PROPOSED PROJECT

### **Objectives**

The proposed project will aim at contributing to the improvement of the health status of the population and the achievement of health-related MDGs through improvement in the quality and access to better health care services, particularly the poor and other marginalized and vulnerable population groups. The project will implement a package of activities that will generate lessons and foster the ongoing reform especially in selected F1 convergence sites.

The project's purpose is to improve the physical and functional design as well as the distribution of the health care delivery system taking into account available and existing health services in both public and private sectors using the F1 framework. The expressed intent of the national policy is geared towards ensuring the availability and accessibility of affordable, good quality health goods and services.

### **Brief Description**

#### *Convergence sites*

The DOH is currently developing the National Investment Plan (NIP) for health composed of flagship programs and projects aimed at attaining the goals of the F1: (1) more equitable financing for health care, (2) better health outcomes, especially in the health-related MDGs, and (3) more responsive health system. To

ensure that targets will be met, sixteen (16) provinces are partnering with the DOH to achieve these goals at the local level. These provinces are referred to as FI provinces or convergence sites. They were identified using a set of economic and health indicators. After the initial 16 F1 provinces have started implementation, identification and PIPH formulation of the next set of F1 roll out provinces will already start.

The initial F1 provinces have already prepared their PIPH and will start implementation towards the later part of 2006. The preparation of the PIPH is a thorough process undertaken by the respective provinces and DOH. Subsequently, the PIPH submitted by the provinces are reviewed and recommended for approval by the Joint Appraisal Committee (JAC) led by the DOH and composed of representatives from other relevant government agencies and the donor agencies.

#### *PIPH financing*

The PIPH will be financed through: (1) national government counterpart, (2) grants from donor agencies such as but not limited to the EC, and (3) LGU counterpart from MDFO or other financing facility.

The proposed KfW loan will be used to provide additional funding for on-lending to the initial 16 F1 convergence sites and other additional roll-out provinces. Participating LGUs will utilize this loan to finance their LGU counterpart in the F1 implementation at the provincial and municipal level. The KfW loan will be an additional loan funds to an existing loan window at the MDFO supported by the Asian Development Bank. The LGU loan facility will enable the participating LGUs to put up their share of resources needed to fully finance their five-year province-wide investment plan which as stated above will be funded through various sources, such as DOH budget and grants from various donor agencies. The loan facility will be executed and managed by the Municipal Development Fund Office (MDFO) of the Department of Finance.

### **Components and Outputs**

#### ***Component 1: Strategic Investment in Local Health Systems Reform and Development***

This component is designed to provide support to the development and implementation of province-wide investment plans that will facilitate the inter-dependent and simultaneous implementation of the four core reform packages at the local level and rationalize the development of local health systems and facilities so that the full range of essential health and medical services is assured at all times in the targeted convergence sites. Specifically, this component seeks to achieve the following objectives and targets:

- Upgrading of core referral hospitals to meet licensure and accreditation standards for secondary care or first-level referral facility, enhancement of their capacity for specialty care in the four basic specialties, and minimization of redundancies by converting some hospitals into specialty outpatient clinics or merging them with RHUs or with the core referral hospital as warranted;
- Upgrading of RHUs to meet SS standards and enhancing their diagnostic and treatment capacities for primary curative care (with special emphasis on TB-DOTS) and essential public health services (with special emphasis on Emergency Obstetric Care and reproductive health);
- Improvement of BHS responsiveness as frontline health service providers for the poor and marginalized population groups and enhancement of their public health capacities and referral efficiencies;
- Securing financing for health care by expanding social health insurance coverage of the indigent and the informal sector, promoting performance-based budgeting and fiscal autonomy for public hospitals, and progressively increasing budget support and/or expenditures for essential public health services; and
- Securing availability of affordable drugs at all times in all public health facilities through national drugs policy, pooled recruitment, and revolving drug funds, among others.

#### ***Component 2: Development of LGU Performance Benchmarks***

Given the various stages of development within the health sector, several tools for monitoring and evaluation have already been developed. These tools are used to monitor performance in terms of policy, program and project implementation. Health related indicators are also spread out in various tools that

measure performance of government programs on poverty reduction. These indicators measure performance levels relative to inputs, outputs and outcome policies, programs and projects.

Monitoring and evaluation (M&E) forms part of a process whether for the development or implementation of a policy, program or project. Within the framework of F1 for Health, the 4-in-1 sites serve as the venue for the integration of all reform efforts (in terms of financing, regulation, governance and service delivery). This integration is essential in achieving synergy of outcomes that would contribute to improving health status of the local populace. Serving as the springboard of implementing reforms at the local level is the 4-in-one sites investment planning process. Currently, the field is saturated with current and proposed indicators that would measure the performance within the sector. The challenge therefore in developing an M&E framework for the 4-in-one sites plan implementation is striking a balance on the following measures:

- Whether to maintain a few or comprehensive list of indicators;
- Whether to adopt new indicators or work on what is available; and
- Whether to focus on inputs, outputs or outcome indicators.

Specifically, the project will formulate and recommend a framework that would facilitate the monitoring of the progress of implementing health reforms within the 4-in-one sites. This framework should consider the lessons learned from the planning process and targets set in the Province-wide Investment Plans for Health (PIPH).

F1 for Health proposes the development and adoption of an LGU Scorecard that would track improvement in the health systems performance both at the national and local level. Specifically, the Scorecard would monitor the progress made in localities and present a comparative performance of these localities (i.e., internal benchmarking). It can be utilized by the LGU to elicit feedback for self management or assessment purposes and ensure public accountability. At the national level, it can be used to monitor local outcomes for potential unit of action. This would facilitate identification of potential contagion in the efficiencies in the local health systems so that provision of the appropriate support can be made by the DOH and the local government.

## **Investment Plan**

...

## **Financing Plan**

...

## **Implementation Arrangements**

The DOH will be the implementing agency for the project loan. In particular, the Sectoral Management and Coordination Cluster through the Bureau of International Health Cooperation (BIHC) shall be responsible for the overall management of the project. The BIHC will be assisted by a team of management consultants as necessary.

The DOH and the MDFO will develop and agree on coordination mechanisms to ensure that project activities are implemented in accordance with the plans approved for each participating province...

At the provincial level, a Provincial Project Management Committee Team (PPMT) shall be responsible for the implementation of LGU-specific projects with the provincial governor as provincial project director. He or she shall be assisted by teams of management and technical consultants.

## **Implementation Plan**

Detailed project implementation plan shall be synchronized with the PIPH implementation of the provinces that will avail of the KfW loan. An accompanying operational plan shall be formulated annually to reflect the progress as well as the remaining activities to be undertaken by the province to achieve their set targets.