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A Review of (Management Sciences for Health – Health Sector Reform Technical Assistance Project) MSH-HSRTAP Contributions to the Progress of Health Sector Reform Agenda (HSRA) Implementation

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Acronyms

ARMM	Autonomous Region of Muslim Mindanao
BFAD	*Bureau of Food and Drugs*
BLHD	Bureau of Local Health Development
CEO	chief executive officer
CHD	Center for Health Development
CLASP	Consolidated Licensing and Accredited Survey Program
CPG	clinical practice guidelines
DBM	Department of Budget and Management
DMS	drug management systems
DOF	Department of Finance
DOH	*Department of Health*
DOLE	Department of Labor and Employment
DOTS	directly observed treatment, short course
EO	executive order
EOP	end-of-project
GMA	Greater Medicare Access
HFDP	Health Finance Development Project
HOMS	Hospital Operations and Management Services
HP	Health Passport
HPI	Health Passport Initiative
HSRA	Health Sector Reform Agenda
ILHZ	Inter-local Health Zone
IP	Indigent Program
IPP	Individually-Paying Program
IRR	implementing rules and regulations
ITRMC	Ilocos Training and Regional Medical Center
IUD	intrauterine device
LGU	local government unit
LHAD	Local Health Assistance Division
LHS	local health system
MEWAP	Malaria Eradication Workers Association of the Philippines
MOA	memorandum of agreement
MSH-HSRTAP	Management Sciences for Health – Health Sector Reform Technical Assistance Project
NCHFD	National Center for Health Facility Development
NEDA	National Economic and Development Authority
NHIP	National Health Insurance Program
NOH	National Objectives for Health
PDI	parallel drug importation
PHIC/PhilHealth	Philippine Health Insurance Corporation
PHO	provincial health officer

PITC	Philippine International Trading Corporation
PM/RS	post-marketing and registration surveillance
PMTAT	Program Management Technical Advisors Team
QA	quality assurance
QMMC	Quirino Memorial Medical Center
RA	Republic Act
RD	regional director
RHU	rural health unit
RUV	relative unit value
SHI	social health insurance
STTA	short-term technical assistance
SV	support value
TA	technical assistance
TC	therapeutics committee
TCG	technical coordination group
TB	tuberculosis
USAID	United States Agency for International Development

Overview

This report reviews the contributions of Management Sciences for Health – Health Sector Reform Technical Assistance Project (MSH-HSRTAP) to the progress of the Health Sector Reform Agenda (HSRA) implementation.

While this report is written separately, it should be read in tandem with the report entitled ***A Review of the HSRA Implementation Progress*** by the same authors. After all, whatever progress was made in implementing HSRA owes to a large extent to HSRTAP efforts. Moreover, most of the obstacles and constraints faced by the Department of Health (DOH), Philippine Health Insurance Corporation (PHIC), and local government units (LGUs) in HSRA implementation were the same ones confronted by HSRTAP.

The main purpose of this review is to draw lessons for future technical assistance projects. The HSRTAP experience offers invaluable lessons on how donors might adjust to organizational and political changes with minimum deviation from the original policy objectives on which the technical assistance was originally based. It is hoped that with this experience, client-agencies will be better informed on how to tailor-fit external technical assistance for maximum effect.

This review utilized information from interviews with key informants representing the various client interests of DOH, PHIC, and LGUs. It examined data and documents, including the quarterly reports filed by HSRTAP, technical reports, and the allocation of technical assistance resources to the project's various support areas. Analysis of the information gathered revolved around the effectiveness of HSRTAP activities and outputs, both from a technical and a strategic sense. By technical, the review refers to the competence and soundness of HSRTAP advice and recommendations. By strategic, the review refers to whether such advice was effectively communicated and well placed to effect the appropriate policy action or decision.

The rest of the report is divided into six sections. Section 1 offers a summary of the progress of HSRA implementation. This mainly draws from the findings of the report ***A Review of the HSRA Implementation Progress***. Section 2 describes the nature of HSRTAP support and the implicit framework that guided this assistance. Here the review pointed out that while HSRTAP was initially designed as a client-driven and tailor-fit assistance project, it was flexible enough to adjust to changes in the client's organizational and political environment.

Section 3 summarizes the expected outputs and deliverables of HSRTAP. This section identifies how HSRTAP was able to remain consistent with the overall policy objectives it was designed to support and yet be flexible enough to adapt to changes. HSRTAP essentially had two sets of targets: one set is fixed – essentially a mirror image of HSRA objectives, and the other moving – quarterly set and monitored benchmarks and deliverables jointly determined with its clients.

The specific accomplishments of HSRTAP are summarized in Section 4. Here the review took a few steps back from the progress that was made in HSRA implementation to examine the technical assistance provided by the project, including allocation of project funds, consultants' time or level of effort, and the quality of technical reports provided. The review pointed out that on the whole, HSRTAP was able to maintain relatively high value for money but with some uneven application especially of its support to social health insurance (SHI) and DOH hospital reforms.

Section 5 briefly analyzes the effectiveness of HSRTAP contributions. This section deals with the strategic question *Did HSRTAP advice lead to the appropriate action or decision by the project's client?* A minor but related issue is whether the client perceived HSRTAP support as effective and useful. For this question, the review relied heavily on subjective information gathered from key informants. On the whole, the effectiveness of HSRTAP can be inferred by examining which reform area generated the most progress. One would then note that areas such as public health, health regulation (other than on drugs), and DOH hospital reforms have seen little progress.

Lessons for future technical assistance projects are summarized in Section 6. Here the review identified three sets of lessons: 1) the by-pass technology offered by convergence sites, 2) influencing the top from the bottom, and 3) tapping on a network of reform-minded professionals. The first set refers to work in convergence sites, defined by the HSRA implementation plan, as an effective by-pass technology that insulates health sector reform activities from political and organizational disturbances at the central level. The second set of lessons refers to using the experience and outcomes in convergence sites to influence or fuel continued support to HSRA activities at the central level. In other words, outcomes at the local level can help ward off tendencies at the top to ignore, if not reverse, health sector reforms. The last set of lessons has to do with the ability of technical assistance to tap into a local (as against foreign) network of reform-minded professionals to provide consultant services, discuss options, and examine project work.

Section 1

Summary of the HSRA Implementation Progress

A summary of the progress of HSRA implementation is offered to serve as reference in discussing the contributions of HSRTAP. The review of HSRA implementation progress found that while target activities and outcomes have largely been unmet, there has been significant progress in convergence site development (see Table 1). Progress in off-site reform areas has slowed down save for advances made in the National Health Insurance Program (NHIP). The least progress was found in crosscutting reform activities.

It must be pointed out, however, that HSRA implementation, while delayed and pursued at a much slower pace than planned, has gone beyond the critical first steps. What makes this accomplishment remarkable is that this was achieved under adverse conditions – disruptions owing to political change, severe budget cuts, and inadequate management infrastructure within DOH.

Table 1. Summary of HSRTAP implementation progress

REFORM AREA	MAIN FINDINGS
Convergence site development	
• Number	Number of sites for convergence development may have been overestimated. Demand from LGUs seems high enough but capacity to supply required TA, training, and critical investments limited
• Site development – primary	Complete convergence not achieved; HP as an integrating instrument not pursued. PhilHealth Plus is promising but not focused on convergence sites. Full integration into an insurance package constrained by financial and actuarial risks
• Site development – expansion	First steps initiated; follow-through uncertain owing to budget cuts, unclear mandate of LHAD, and incompatibilities in the CHD organization
Cross-cutting reforms	
• Reengineering	Phase 2 on hold. Political support from key reengineering consultants (now DBM and DOLE secretaries) not harnessed against MEWAP concerns
• Finance and budget	Performance-based budgeting not in place possibly because the concept is not effectively communicated in operational or practical terms
• Legislative action	Bills drafted and submitted but not given priority
• Implementation management unit	Ad hoc LHADs in regions. TCG at central office meets regularly but mandate not clear and without authority to discipline reform effort. Progress of implementation not monitored by DOH top management
• Procurement reforms	Systems still evolving; initial efforts reduced TB drug prices, but delays in procurement. Re-centralization of procurement planned next year

Table 1. Summary of HSRA implementation progress (cont'd.)	
REFORM AREA	**MAIN FINDINGS**
Hospitals	
• Upgrading	Some upgrading; priorities not followed, not linked to hospital reforms nor to presence of convergence sites
• Systems	Systems that built upon HFDP technology refined and introduced
• Mandate	EO for corporatization submitted this year; status not clear
• Cost recovery	Limited by DOF and DBM restrictions
• Quality assurance monitoring	PHIC accreditation, no CPGs introduced
• Corporatization	Awaiting EO for QMMC and ITRMC; proposal to set up an independent Philippine Hospital Authority or Commission now being revived by hospital chiefs
Local health systems development	
• Health boards activated	Limited activities off-site; no monitoring of progress of this activity at the central level
• ILHZ initiated	Limited activities off-site mainly those initiated by LHADs; BLHD seems overwhelmed
Public health programs	
• Technical leadership	Loss of skilled staff owing to turnover and reassignment
• Multi-year disease control bill	Drafted, but rejected by NEDA; DOH staff unable to defend concept
• Public health CPGs	Guidelines present, compliance not monitored
• NOH targets	No prevalence surveys since baseline
NHIP	
• Enrollment	Indigent Program enrollment under GMA 500 exceeded, but only 47% of HSRA target met. Mechanisms to enroll individual paying members not yet effective. Development in convergence sites not tapped for IPP enrollment.
• Support value (SV)	Ceilings increased, SV computation being debated
• Outpatient service package	Package launched, more in pipeline
• QA measures	No CPGs, no drug price reference
• Financing	Indigent premium subsidies not secured, contributions not progressive
• Program administration	Still no IT system; subcontracting key function; reorganization pending
OVERALL	**Implementation activities ongoing but not in all areas; poor coordination across five reform areas; budget does not reflect expressed priorities. There is an impression that nobody is on top of everything.**

The Framework of HSRTAP Support

As a preamble to its quarterly report, HSRTAP defines itself as "*technical assistance support to the Health Sector Reform Agenda, which the Department of Health has launched as its flagship program*." The framework of support implied by this definition is that HSRTAP will work with DOH in implementing HSRA. This seems to be the typical role assumed by previous programs related to health sector reform such as the Health Finance Development Project (HFDP). Hence, the success or failure of HSRA begins and ends with the effectiveness with which DOH performs the lead role in undertaking reforms.

In the same preamble, HSRTAP also defines for itself a much more progressive position with respect to health sector reforms. It declares that "*the purpose of the assistance, therefore, is to create and ensure irreversible momentum in the process of reforming the health sector, as articulated in the DOH Health Sector Reform Agenda, so that the reforms would continue even if there was a change in political and administrative leadership*."

In the course of defining and implementing reforms, political and administrative conditions in DOH changed. Consequently, HSRTAP switched from the support role articulated in the first definition to one more progressive, as in the second definition. Prior to the change in administration in 2001, HSRTAP was a client-driven facility working closely with DOH top leadership who championed health sector reforms. The key contribution of HSRTAP during this period was that it pushed for and facilitated the development of the HSRA implementation plan built around the strategic concepts of convergence site development, the Health Passport (HP), and irreversible momentum for health sector reforms.

The new DOH administration ushered in by the political change in 2001 did not push for HSRA implementation as much as its predecessor did. Its reluctance to assume leadership over the reform program slowed down, if not stopped, progress especially in reform areas like public health, health regulations, DOH hospital reforms, and crosscutting reforms particularly DOH reengineering and budget and finance. The impact of poor leadership in these areas was so pronounced because these were far removed from where the action was ongoing – convergence site development.

The convergence site development strategy allowed HSRTAP to play a more progressive, if not lead, role in HSRA implementation. Because it had assumed for itself the HSRA implementation plan, which called for the implementation of the five reform areas in a convergence site, HSRTAP effectively by-passed the choke point served by the DOH central office. Hence, the progress of HSRA implementation is more evident in the primary convergence sites of Capiz, Bulacan, Pangasinan, Negros Oriental, Misamis Occidental, Neuva Vizcaya, South Cotabato, and Pasay City.

The key lesson here is that HSRTAP was designed with a two-pronged technical assistance framework compatible with the convergence strategy of HSRA implementation. As a *support project* it facilitated the development of the HSRA implementation strategy and plan, and as an *implementation catalyst*, it pushed for convergence site development in the target primary sites by working collaboratively with LGUs, DOH, and PHIC field staff.

Section 3

The Expected Outputs and Deliverables of HSRTAP

HSRTAP support is driven by two sets of targets. One set is fixed and identical to HSRA targets; the other is variable and jointly determined by DOH, PHIC, and USAID. At the start of the project, there were seven end-of-project (EOP) deliverables. In April 2001, these deliverables were amended in order to define them more clearly, especially after PhilHealth adjusted the baseline figures on which these deliverables were based. In June 2002 when the end date of the project was extended to November 30, 2002, four more EOP deliverables were added. The deliverables are as follows:

1. NHIP benefit package improved to include both inpatient and outpatient services, including TB DOTS (tuberculosis directly observed treatment, short course), family health services, family planning, and reproductive health services

2. NHIP benefits package improved to cover an average 70 per cent support value of hospitalization costs

3. NHIP spending increased from PhP 4.2 billion (1997) to at least PhP 10 billion (2002)

4. NHIP coverage increased from 36 million or 47 per cent of total population (2000) to 50.6 million or 65 per cent of total population (2002)

5. Guidelines and manuals of operation for financial management and other management systems for local health facilities developed

6. Each region will have an expansion plan for PhilHealth Plus (formerly the Health Passport Initiative)

7. At least one province, city or large municipality in each of the 16 regions is implementing PhilHealth Plus, with quantitative targets for PhilHealth Plus membership and health facilities with *Sentrong Sigla* (Center of Vitality Program) certification set and agreed upon by health care stakeholders in the LGU under the leadership of the local chief executive working for universal coverage

8. Each of the eight convergence sites will have a tracking system for outpatient benefits utilization

9. Overall design developed, and pilot testing of outpatient family planning and TB DOTS benefits initiated

10. At least one inter-local health zone in each of the eight convergence sites will be implementing the four health reforms being supported by the project in an integrated fashion

11. Overall plans for PhilHealth's management information systems development (including organizational development requirements) developed and initiated

The nature of the target accomplishments of HSRTAP is identical to that of the desired outcomes articulated in the HSRA implementation plan of DOH. It is tempting to compare these targets with what has actually been accomplished by DOH and then declare HSRTAP a failure owing to shortfalls. But as HSRTAP stated in its working philosophy, "*it is going to operate purely as a technical assistance project, and serve as catalyst, consultant, and advisor rather than as direct implementor*." The HSRA monograph estimates that a huge amount of financial, technical, and political resources would have to be mobilized for these accomplishments to be realized, and the resources available to HSRTAP are nowhere near these requirements. But for whatever reason these target accomplishments were assumed by HSRTAP, it is clear from hindsight that HSRTAP served to steer project activities in the same direction as HSRA.

In the course of project implementation, the so-called EOP deliverables were revised. For example, target NHIP spending was reset to at least PhP 10 billion (at least PhP 15 billion in the original target). Population coverage was reduced to 65 per cent from the previous target of 67 per cent. PhilHealth Plus replaced the Health Passport. But despite these changes, the character of HSRTAP adopting for itself the goals of HSRA implementation remained.

HSRTAP support for the realization of HSRA outcomes was organized into annual rolling plans monitored on a quarterly basis with clear performance benchmarks. These plans were a product of the collaborative work of DOH, PHIC, participating LGUs, and USAID. This feature provided much flexibility but also made it almost impossible to employ the target-versus-accomplishment approach in evaluating HSRTAP support. As project management admitted, the annual work plan was a "work in progress." This meant that target outputs may be dropped (e.g., development of business plans for hospitals targeted for corporatization) while new ones are introduced (e.g., drafting of executive orders [EOs] for the corporatization of Ilocos Training and Regional Medical Center [ITRMC] and Quirino Memorial Medical Center [QMMC]). Outputs may be completed but not utilized owing to changes in priorities (e.g., operations manual for the Health Passport). Other outputs may be completed but may have to await action by DOH or PHIC (e.g., drug reference pricing).

The long list of expected outputs for the two-year project life shown in Annex Table 1 provides sufficient information on the level of understanding, skill, and effort necessary to accomplish these targets. The first work plan developed for drug management systems had

well-defined technical outputs that are linked to HSRA objectives specific to pharmaceutical regulation. Activities and outputs were clearly organized around Bureau of Food and Drugs (BFAD) capacity building, enhancement of standard setting, licensing and surveillance, influencing the price of drugs via competition promotion, and procurement systems reforms at the central and local levels.

The work plan for hospital reforms focused on the corporatization of targeted hospitals – options and models for corporatization, establishment of legal basis for corporatization, governance structures, and capacity building in the areas of financial management, quality assurance, cost control, and revenue retention. Considering the controversy in and the level of resistance expected of the hospital corporatization strategy, the plan was thin on advocacy and constituency building for this component. While hospital corporatization met heavy resistance at the DOH and LGU levels, HSRTAP hospital reform planning had sufficient flexibility to transform its outputs in the areas of financial management, quality assurance, and revenue retention that remained useful especially to hospitals in convergence sites.

The work plan developed for social health insurance confused activities with outputs. For example, it listed meetings and discussions as outputs. It also missed out on a number of key outputs like a technical definition of the Health Passport Initiative (HPI) and yet proceeded to target the development of an HPI implementation plan. Perhaps because PHIC remains highly centralized, the plan for social health insurance proposed activities and outputs directed towards development of central level policies. What was missed was an attempt to focus reform activities on premium collection, social marketing of the indigent (IP) and individually-paying (IPP) programs, and design of new benefit packages and capitation payment schemes in the context of convergence site development and HPI. From the plan, one gets the impression that the Health Passport was treated as a project independent of other activities rather than as a strategy to bind all NHIP reform initiatives. The Health Passport Manual developed jointly by HSRTAP, DOH, and PHIC failed to provide the technical definition and requirements of HPI (see related comments in the HSRA progress review).

The local health systems development work plan paid sufficient attention to the systems development's advocacy and facilitation role rather than to delivering technical advice. While the plan mentioned joint planning exercises that linked all reform areas together, there were no cross-references made with other reform area work plans. Efforts to synchronize activities as well as delivery of technical assistance were not evident in the plan.

The work proposed by HSRTAP was to be undertaken in five phases. The startup phase (June to September 2000) aimed to get the project organized. The consultant mobilization phase (October to December 2000) was set to identify, select, and contract consultants. The peak performance phase of 12 months (January to December 2001) was the period for much of the ground breaking work. The consolidation phase (January to June 2002) presumably was set to prepare and market lessons, especially in convergence site development. The last phase (July to September 2002) was earmarked for housekeeping and other project exit requirements. This meant the project had only been given less than two years to accomplish

its targets. With the political change in 2001, HSRTAP only had a little over a year of intensive hard work to accomplish what it did. It is unfortunate that the peak performance phase was shortened and pushed much later, leaving little time for the consolidation phase.

Section 4

The Accomplishments of HSRTAP

Overall Contribution to HSRA Implementation

A comparison of HSRA targets (which HSRTAP claimed are the expected results of its support) with actual accomplishments of HSRA implementation thus far is summarized in Table 2. It is difficult to determine how much of the progress of HSRA implementation can be attributed to HSRTAP support. At the time of the review the outcomes/results of only seven deliverables were available. The paucity of available information limited the review to making inferences on the extent of HSRTAP contributions in terms of the way the project had applied its technical and financial resources. The rest of the review examined whether the pattern of resource utilization varied consistently with observed variations in HSRA implementation.

Three clues, however, allow one to infer the extent of HSRTAP contribution. One, the observed pattern is that HSRA reform areas not supported by HSRTAP posted the least progress. Of course HSRTAP could simply have been discriminating at the beginning by choosing to support reform components with high level of difficulty or areas where reform directions were not clear. But by supporting or focusing its attention on convergence sites HSRTAP could not have, by definition, ignored all five HSRA reform areas.

The second clue is that HSRTAP, apart from the resources and people it offered, effectively served as a venue for reform-minded professionals in and outside San Lazaro Compound to discuss, consider, monitor, and offer suggestions to further HSRA implementation even when leadership at the DOH top management was lacking. The fact that little documentation of the progress of HSRA implementation exists outside the files of HSRTAP indicates how well this venue was served by the project.

Another indication of the effectiveness of the facility the project offered is alluded to by the admission the Secretary of Health made during the November 7, 2002 workshop on the progress of HSRA implementation. In his closing remarks, the Secretary cited three occasions where he had to seriously consider HSRA. First, when he studied the HSRA monograph and implementation plan during the time he assumed the position as Secretary of Health. Second, when he joined the Nueva Vizcaya convergence workshop. And third, when he had to make sense of the presentations and proceedings of the November 7 workshop. The project contribution had little to do with the fact that HSRTAP initiated all three events. What really underscored the contribution of the project was that even with the admission that DOH top leadership neither pushed for nor blocked implementation efforts, progress has been made. What the Secretary of Health referred to as serendipity could very well have been

the HSRTAP facility. A notable effort of HSRTAP was to provide a "communication handle" for HSRA implementation – *"Tulong-Sulong sa Kalusugan "* (literally help-push for health).

The third piece of evidence is the working relationship between HSRTAP and the local executives as well as health professionals in the convergence sites. HSRTAP staff, especially those working on local health systems, drug management systems, and local hospital systems reforms are perceived not only as promoters of HSRA but as partners in advancing local health interests. This role has even led a number of DOH regional people to raise the concern that HSRTAP staff had a tendency to jump right into the convergence site without coordinating with or requiring the participation of Center for Health Development (CHD) staff.

Table 2. Expected results of HSRTAP support and HSRA implementation outcomes

EXPECTED RESULTS	OUTCOMES
1. NHIP benefit package of inpatient and outpatient services, including TB DOTS, family health services, family planning and reproductive health services	• Outpatient benefit package covering general consultation and diagnostic services (chest X-ray, sputum examination, complete blood count, urinalysis, and fecalysis) via capitation fund of PHIC-accredited RHUs • Expanded outpatient package that includes visual acetic acid test for cervical cancer, blood pressure monitoring, annual digital rectal examination, body mass index determination, breast examination, counseling for smoking cessation and lifestyle modification is now available in 75 LGUs • As of June 2002, 213 RHUs and city health centers in 139 cities and municipalities have been accredited as providers of outpatient benefit package (PhilHealth Plus). 75 of these centers are already actively providing the benefit to indigent members on a capitation fund basis • Medicines/drugs (including for TB) not yet covered by PhilHealth • Family planning services covered by PhilHealth are only sterility procedures such as vasectomy and tubal ligation; others such as pills, condom, IUD insertion, gels, and injectables are not covered
2. NHIP support value of at least 70%	• PHIC is still unable to present a clear estimate of support value benefits, but benefits have steadily increased since 1999 • Clinical practice guidelines (CPGs) and drug price reference are not yet enforced • Relative unit value (RUV) system used for the computation of compensation for treatment and procedures/ operations is constantly updated for optimal benefits • PHIC covers only drugs/medicines used during hospitalization; no coverage for home medicines

Table 2. Expected results of HSRTAP support and HSRA implementation outcomes (cont'd.)	
EXPECTED RESULTS	**OUTCOMES**
3. NHIP spending increased from PhP 6 billion (1997) to at least PhP 15 billion (2002)	• The share of social health insurance to the total national health expenditures increased to 6.88% in 2000 from 4.83% in 1999 • PhilHealth spent approximately PhP 4 billion in benefit payments in the first semester of 2002, and an estimated PhP 10 billion on benefits by the end of 2002
4. NHIP coverage increased from 38.16 million or 50% of total population (2000) to 53.65 million or 67.5 % of total population (2002)	• PHIC has already met 71% of the 2002 target.
5. Guidelines and manuals of operation for financial and other management systems for local health facilities developed	• Guidelines and manuals of operation have been completed for financial and other management systems for local health facilities such as Operational Plan for Local Health Systems Development, Manual on Inter-local Health Zones, Convergence Work Plans, Case Studies on Model Local Health Systems, Drug Management Manual, LGU Guide to PDI from PITC, Hospital Financial Management, Guidebook to LGU Hospital Boards, Therapeutics Committee Manual, etc.
6. Health Passport Initiative expansion plan for each region	• Overall plan for HPI and operations manual were completed; initially introduced to Capiz and Pasay City; but HPI was abandoned and no expansion plan for each region was done • Health Passport Initiative was replaced by PhilHealth Plus
7. Health Passport Initiative in at least one province, city or large municipality for each of the 16 regions: • At least 85% of population in each LGU are holders of health passports; • At least 80% of all health facilities in each LGU are *Sentrong Sigla*- accredited.	• Only 8 convergence sites were supported by MSH-HSRTAP; other expansion sites were organized by BLHD • Health Passport was initially introduced to Pasay City and Capiz, but abandoned and replaced by PhilHealth Plus • Enrollment in PhilHealth Plus was focused on indigents, but none of the sites reached the 85% target enrollment • Not all RHUs in the convergence sites are *Sentrong Sigla*-accredited

Technical Reports of HSRTAP[1]

An important input of HSRTAP to HSRA implementation is the technical recommendations the project made based on the studies it contracted out. A brief review of these technical reports organized around the reform areas is presented in Annex Table 2.

A number of reports only recently completed (that is, after August 2002, the cut-off period for this review) was not covered by this review. Among the notable reports on the drug management system work that were missed were the final versions of the drug procurement manual, training for therapeutics committee's manual, and the Region 10 drug management system assessment reports. For hospital reforms, this review missed out on an important document detailing the process of and basis for the draft executive orders for the corporatization of ITRMC and QMMC.

A key issue here is for DOH, PHIC or even LGUs to adopt the manuals and technical reports produced by the project. By the closing time of the project, HSRTAP has developed a package of technical documents that can serve as guidelines or templates for future HSRA implementation. This package has been turned over to DOH and PHIC for adoption.

Two documents were produced for overall HSRA implementation concerns – the HSRA implementation plan and the reengineering plan. The HSRA implementation plan eventually became Administrative Order No. 37 series 2001. As for the reengineering plan, only the central office phase was carried out; the rest has been put on hold owing to political constraints. Ironically, the political capital generated by having the reengineering plan developed has not been exploited by DOH. The main consultants who helped craft the reengineering plan now lead the Department of Budget and Management (DBM) and the Department of Labor and Employment (DOLE).

The inhouse work on drug management systems represented value for money as far as HSRTAP work is concerned. In hospital reforms, much of the technical work on corporatization – asset valuation, legal mandate and options, business plan preparation – has yet to generate impact. But as pointed out earlier, the work on capacity building in financial management, quality assurance, revenue retention, etc. managed to find audience in convergence sites.

The templates, manuals, and technical reports on local health systems alone did not capture the real contribution of HSRTAP to local health systems development – the interpersonal interactions and relationships that built confidence and trust. In contrast, much of the technical work on social health insurance focused on the policy concerns of PHIC. It is unfortunate that very little technical work was devoted to developing or even testing out

[1] Charlie Stover of Management Sciences for Health suggested that the review note a number of points regarding project documentation and dissemination. Technical work drew heavily from previous work (HFDP and MSH work in Kenya) to save time and valuable resources. Moreover, a formal process of documentation and dissemination is scheduled at the end of the project. Project documents have been made available in CD-ROM as well as through a website to be implemented by DOH, USAID, and MSH.

social insurance packages, payment systems, quality assurance, and enrollment schemes in convergence sites.

Application of Project Resources

An analysis of the way HSRTAP applied technical resources and project funds helped establish the efficiency with which the project provided support to HSRA implementation. The project's full-time inhouse technical staff represented the base level of technical effort the project applied in the reform areas it supported. Apart from this, the project contracted the services of consultants to provide additional technical inputs.

Table 3 shows how consultant time, measured in number of days, has been allocated to four reform areas. The allocation pattern that emerged is surprising. The local health systems component that directly supported convergence site development – the key strategy of HSRA implementation – received only 20 per cent of contracted consultant services. Of course, one might add to this allocation part of the efforts allocated for hospital reforms and drug management systems that had to do with convergence site development.

Table 3. Level of effort* of HSRTAP *consultants, by reform area

REFORM AREA	LEVEL OF EFFORT (No. of days)			
	Consultant Agreement	Sub-contract	Purchase Order	Total
Social health insurance	267	568	81	916
Hospital reforms	338	0	0	338
Drug management systems	177	132	0	309
Local health systems	48	280	83	411
Health sector reform management support	56	0	22	78
TOTAL	886	980	186	2,052

On the other hand, the social health insurance component got 45 per cent of contracted consultant time. It should be noted that given the technical reports produced, consultant time allocated to social health insurance focused on PHIC policy issues that did not immediately impact on convergence site development. There are a number of reasons that may explain this seemingly inefficient use of technical resources. For one, the inhouse technical staff for local health systems, drug management systems, and hospital reforms were probably much more competent so that additional consultant time was not necessary. For another, the technical concerns confronted by social health insurance development were probably much more difficult.

A similar pattern was observed when project expenditures were sorted according to target outcome areas as shown in Table 4. After taking out project management, which includes full-time technical staff working on the four reform areas, half of the remaining expenditures was found to be allocated to health care financing.

Table 4. Project expenditures by target outcome*		
TARGET OUTCOMES	EXPENDITURE (PhP)	PER CENT SHARE (%)
Family planning	49,400.80	0.07
Drug management	4,356,760.50	6.52
Community health development	4,661,344.50	6.98
Health care financing	11,374,943.00	17.03
Institutional development	629,836.88	0.94
Program management	45,442,928.00	68.03
Other outcomes	285,280.72	0.43
TOTAL	66,800,494.40	100.00

* The categories in this table are those used by HSRTAP to manage its finances. The expenditure allocations for these categories were derived from the project's financial management records.

While only less than 1 per cent of project spending was targeted to family planning, one can argue that spending for drug management, community health development, health care financing, and institutional development pushes more effectively for reproductive health objectives. Procurement reforms also facilitate value for money in the procurement of contraceptives. The local health systems established in convergence sites provide the necessary infrastructure for pursuing the same reproductive health goals.

A much finer breakdown of expenditures by specific project activity is shown in Table 5. Project management including general administration, finance management, personnel management, logistics, and coordination with USAID and client-agencies ate up 55 per cent of project expenditures. Some 28 per cent of project funds were spent as technical assistance to DOH, PHIC, and LGUs. The remaining 17 per cent of project funds were spent on activities like financial systems development, costing and rate setting capacity, advocacy and social marketing, organizational development, governance concerns, improved drug management, assessment of local health systems, development tools, coordination activities for local health systems, local health systems financing, operations research, Health Passport (2%), and technical exchange.

The shift in HSRTAP attention from centrally-based initiatives to convergence site development cannot be readily inferred from the spending allocation shown in the two previous tables. Hence, the review presented in Table 6 the allocation of funds spent as technical assistance to LGUs. Much of the expenditures were spent on primary convergence sites like Pangasinan, Negros Oriental, Capiz, Misamis Occidental, and South Cotabato. What is surprising is the relatively low level of spending for Pasay City (where the Health Passport was launched), Nueva Vizcaya, and Bulacan which are primary convergence

*Table 5. Project expenditures by activity**		
ACTIVITY	**EXPENDITURE (PhP)**	**PER CENT SHARE (%)**
Project general administration	13,832,690.00	20.71
Project finance management	785,889.50	1.18
Project management personnel	10,544,519.00	15.79
Project management logistics	3,412,049.80	5.11
Project administrative meetings	1,560,236.90	2.34
Technical coordination and supervision	5,859,914.50	8.77
Coordination with USAID	683,736.38	1.02
Coordination with other client-agencies	688,349.00	1.03
Coordination with other projects	253,553.16	0.38
Coordination with DOH	1,851,641.80	2.77
Coordination with PHIC	804,685.50	1.20
Policy, legal, regulatory component	1,085,528.80	1.63
Financial systems development	624,175.81	0.93
Costing and rate setting capacity	156,966.20	0.23
Advocacy and social marketing	231,931.92	0.35
Organizational development	514,009.50	0.77
Governance concerns	92,779.55	0.14
Physical plant, equipment upgrading	1,275.75	0.00
Improved drug management	1,625,854.00	2.43
Assessment of local health systems	1,000,000.00	1.50
Development of tools	68,682.00	0.10
Organization and coordination of local health systems	254,094.72	0.38
Local health systems financing	30,207.939	0.05
Operations research	325,600.00	0.49
Health Passport	1,374,738.90	2.06
Development of field office	62,264.99	0.09
Technical exchange	599,060.75	0.90
Communications	38,476.62	0.06
Technical assistance to DOH	3,991,289.30	5.97
Technical assistance to PHIC	8,995,522.00	13.47
Technical assistance to LGU	5,429,324.50	8.13
Others	21,445.36	0.03
TOTAL	66,800,494.15	100.00

* Mr. Stover of MHS questions how these categories were developed, and how the funds were allocated to these categories. With the other tables, the categories and allocation of funds were directly derived from the financial recording system of the project. The pattern shows an uneven application of funds. However, Mr. Stover insists that all four reform areas supported by the project received more or less equal resources since "1) each of the four technical areas had a manager and an assistant who focused on their area of expertise, at both the central level and at the convergence sites; 2) each team had lead responsibility for two convergence sites; and 3) the technical teams used consultants wherever possible as 'extenders' (to permit more work to get done), and to accomplish highly specialized technical work (such as actuarial studies)."

Table 6. Project expenditures by LGU/location		
LGU/LOCATION	MEAN EXPENDITURE (PhP)	PER CENT SHARE (%)
Pangasinan	1,727,957.00	2.59
Nueva Vizcaya	463,971.00	0.69
Baguio	57,735.04	0.09
Bulacan	460,142.10	0.69
Pasay City	400,471.70	0.60
Palawan	283,084.20	0.42
Catanduanes	129,659.30	0.19
Capiz	1,204,776.00	1.80
Negros Oriental	1,581,499.00	2.37
South Leyte	42,580.22	0.06
Western Mindanao	25,421.54	0.04
Misamis Occidental	866,934.80	1.30
South Cotabato	719,666.80	1.08
North Cotabato	51,016.93	0.08
ARMM	2,964.38	0.00
CARAGA	48,060.79	0.07
Manila	29,509.62	0.04
Project Office (including Boston)	58,705,044.00	87.88
TOTAL	66,800,494.00	100.00

sites[2]. Perhaps this pattern suggests that there could very well be substantial economies gained from learning from convergence site development. If so, the experience in the eight primary convergence sites could significantly reduce the cost required to push convergence development in the expansion sites identified by DOH.

Another interesting pattern of expenditures is shown in Table 7. In its first work plan, HSRTAP expected high effort levels during the so-called peak performance phase from Quarter 3 to Quarter 6. The pattern shown in Table 7 is indicative of the extent of the delay and disruption caused by the change in the political administration in early 2001. Project expenditures remained relatively flat from the first to the fifth quarters of operations. Only after the sixth quarter did expenditures pick up, presumably owing to stepped-up efforts in convergence site development. The delays show that what was planned to be the consolidation phase had been shortened.

Table 7. Project expenditures by quarter, 2000 – 2002		
QUARTER	EXPENDITURE (PhP)	PER CENT SHARE (%)
QI	7,529,621.70	11.84
Q2	6,873,874.50	10.81
Q3	7,414,474.30	11.65
Q4	7,239,758.30	11.38
Q5	7,337,034.10	11.53
Q6	8,346,372.30	13.12
Q7	9,524,602.60	14.97
Q8	9,351,301.50	14.70
TOTAL	63,617,039.30	100.00

[2] One explanation offered was differences in transport cost.

Section 5

Perceived Effectiveness of HSRTAP Contributions

A convenient way to summarize the effectiveness of HSRTAP contributions is to consider the perception of the client-agency. Here DOH regional directors (RDs) were selected as the appropriate respondents since they are able to keep abreast with central level concerns and presumably have a better appreciation of developments at the convergence site level[3]. Moreover, the CHD staff have been identified as a key player who should assume HSRTAP-like functions in developing the targeted expansion sites.

Ten of the 14 RDs interviewed identified the existence of HSRTAP support in their respective regions. The respondents were asked to rate what they perceived to be the effectiveness of HSRTAP support in the areas of social health insurance, drug management systems, local health systems, and hospital reforms.

Table 8 shows the subjective ratings of the effectiveness of HSRTAP support to social health insurance expansion. Considering that most of the project work on SHI was directed at PHIC, the respondents gave relatively high ratings – three of the RDs even rated social health insurance support as being very effective. But when asked which particular HSRTAP consultants provided SHI support, many of the RDs actually referred to HSRTAP consultants on local health systems.

Table 8. Perceived effectiveness of HSRTAP support to social health insurance

EFFECTIVENESS OF SHI SUPPORT	FREQUENCY (n=10)	PER CENT (%)
Not effective	0	0
Somewhat effective	3	30
Effective	3	30
Very effective	3	30
No answer	1	10
TOTAL	10	100

Another surprise in the perceived effectiveness rating had to do with drug management systems support shown in Table 9. The ratings given to this reform area is relatively lower than that given to social health insurance. But the discussions revealed that some RDs had regional procurement in mind rather than procurement for the convergence sites.

[3] Mr. Stover of MSH disagrees with this approach. He argues that "the DOH regional directors were not directly involved in convergence site activities, nor in central level activities. They are the least informed people to make realistic assessments of the value of STTA, or of the impact of the reforms." He adds, "Even if all regional directors said that the work was not effective, I wouldn't believe it. If the governors said the same thing, I certainly would."

The ratings given to local health systems support are similar to that for social health insurance (see Table 10). This is not at all surprising since the indigent program enrollment and the ILHZ are the two components that have been converged the most.

Like the case of drug management system, hospital reforms support was given relatively lower ratings (see Table 11) owing to the confusion over HSRTAP support to hospitals in the convergence sites and to the corporatization drive for DOH hospitals.

Table 9. Perceived effectiveness of HSRTAP support to drug management systems

EFFECTIVENESS OF DMS SUPPORT	FREQUENCY (n=10)	PER CENT (%)
Not effective	0	0
Somewhat effective	3	30
Effective	5	50
Very effective	1	10
No answer	1	10
TOTAL	10	100

Table 10. Perceived effectiveness of HSRTAP support to local health system

EFFECTIVENESS OF LHS SUPPORT	FREQUENCY (n=10)	PER CENT (%)
Not effective	0	0
Somewhat effective	4	40
Effective	2	20
Very effective	3	30
No answer	1	10
TOTAL	10	100

Table 11. Perceived effectiveness of HSRTAP support to hospital reforms

EFFECTIVENESS OF HOSPITAL REFORMS SUPPORT	FREQUENCY (n=10)	PER CENT (%)
Not effective	0	0
Somewhat effective	4	40
Effective	4	40
Very effective	1	10
No answer	1	10
TOTAL	10	100

While one respondent consistently refused to rate HSRTAP support, no one perceived project assistance as ineffective. On the average, RDs rated the four types of HSRTAP support as *effective.*

To sum up, the review asked the RDs if they would endorse an extension of HSRTAP. It was felt that this question would indicate whether the RDs thought that such support would continue to be useful. The tally in Table 12 shows that nine out of the 10 RDs recommended an extension of HSRTAP.

Provincial health officers (PHOs) of Bulacan, Capiz, Negros Oriental, and Misamis Occidental were likewise interviewed. Responses to the same set of questions asked of regional directors were fairly similar – HSRTAP assistance especially to local health systems, DMS, and indigent program enrollment was perceived to be highly effective. But

one particular PHO raised an important qualification with regard to the role played by the project. The basic elements of health sector reform have already been recognized at the local level even before the convergence site strategy was implemented. What HSRTAP did was to validate and subsequently facilitate among local chief executives and health officials a deeper understanding of the interrelationships of reform components.

Table 12. Endorsement of HSRTAP extension

RECOMMEND EXTENSION	FREQUENCY (n=10)	PER CENT (%)
Yes	9	90
No	1	10
TOTAL	10	100

Section 6

Lessons for Future Technical Assistance for Health Sector Reform

This section summarizes the lessons for future technical assistance for health sector reform by identifying the features of HSRTAP that helped secure its effective contributions to HSRA implementation. The review pointed out five critical elements: 1) convergence strategy, 2) demand-driven support, 3) having fixed targets but with flexible deliverables, 4) the project as a venue for reform discussions, and 5) top management that is committed to health sector reforms.

Convergence strategy

Although much more time and resources should have been spent on the convergence strategy, its work in the eight convergence sites delivered the goods for HSRTAP. At the site level, the key elements of HSRA were much more observable and real. Even with only a little over a year's worth of work, the outcomes of building ILHZ, expanding IP enrollment, reforming local hospital systems, and managing local drug procurement have already been felt. But perhaps more importantly, the convergence strategy pursued by HSRTAP mitigated the adverse impacts of political and administrative changes at the national level. Moreover, the results of convergence site development effectively provided evidence that even a timid DOH top leadership cannot ignore.

Demand-driven project

The initial demand for HSRTAP support came from DOH top management that was committed to pursue health sector reforms. This demand was articulated in HSRA and its implementation plan. Hence, the project was tailor-fit to meet such demand. But while priorities of DOH top management have changed, HSRA continues to be valid (and was declared as such by DOH) so that HSRTAP remained relevant and useful. Furthermore, HSRTAP recognized that HSRA served client-agencies other than DOH, specifically LGUs, PHIC, and even legislators. This provided the opportunity for the project to continue its work by directing its support to these other clients.

Fixed targets, flexible benchmarks

A key feature of the way HSRTAP was designed is that it adopted for itself the very outcomes that HSRA wanted to produce. This allowed the project to steer itself in the direction of HSRA objectives even in a rapidly changing political environment. On top of this the project built for itself some room for flexibility to adapt to such changes. Of basic importance here is the rolling annual plan with quarterly set and monitored benchmarks jointly determined with client-agencies. This approach, which builds upon the experience with previous USAID projects like the Child Survival Project and the Health Finance Development Project, became more effective when coupled with close interaction between the project and its clients.

Venue for reform-minded health professionals

Beyond its staff and consultants, HSRTAP also effectively served as a venue for reform-minded health professionals in and outside its client-agencies to discuss, debate, and monitor the progress of HSRA implementation. In doing so, the project was able to sustain the constituency behind HSRA. Moreover, the project can be seen as a facility that supports health sector reform champions in and outside government.

Project management committed to reforms

Finally, the drive behind the project could not have been sustained without managers who were committed to HSRA. It is not too difficult to discern the extent of this commitment. One simply has to read the overview section of every quarterly progress report of the project, which without fail provides insightful accounts of the changing political environment and how HSRTAP managed to cope with these changes without diverting the project away from its original course.

Annex A

Expected Outputs of HSRTAP Activities

Annex Table 1. Expected outputs of HSRTAP activities stated in the first HSRTAP work plan	
AREA	**FIRST YEAR EXPECTED OUTPUTS**
Drug Management Systems	• Proposal for a revised BFAD rules and regulations • Proposed organizational structure of BFAD with proposed operational plan and manual of procedures • Training kits and resource speakers for newly deployed personnel • Proposal for a revised post-marketing and registration surveillance (PM/RS) system for safety and quality • Operations manual for PM/RS • Drug regulatory information, database, and processes in the Internet • Therapeutics committee training design and training manual • Training for therapeutics committees • Pharmacoeconomics and pharmacoepidemiology manuals • Core courses for pharmacoeconomics and pharmacoepidemiology • Drug Information Center network and database • Review of cross-country experience in parallel drug importation • BFAD seal of excellence certification scheme • Options for compulsory drug licensing • Report on the viability of the existing hospital pharmacy retail system • DOH drug procurement manual and drug supplier accreditation manual • Online drug procurement system • Drug reference price study • Assessment reports of drug management systems in convergence sites • Establishment of therapeutics committees in convergence sites • Improved LGU drug management system • Assessment reports of drug management systems of 6 hospitals targeted for corporatization • Improved hospital drug management
Hospital Reforms	• Guidelines for establishing hospital boards • Training and orientation of hospital boards and chief executive officer (CEO) • Human resources management manual • Establish 5 Ss (Sort, Systematize, Sweep, Standardize, Self-discipline) and total quality management approaches to quality assurance • Business plan format for 6 hospitals targeted for corporatization • Financial management manuals for corporate hospitals • Costing tool and software

Annex Table 1. Expected outputs of HSRTAP activities stated in the first HSRTAP work plan (cont'd.)	
AREA	**FIRST YEAR EXPECTED OUTPUTS**
Social Health Insurance	• Health Passport strategy plan • Organize technical working group for health passport • Technical working group and task force meetings • Launching of advanced implementation site plan • Orientation sessions • Operations manual for Health Passport • Replication tools for Health Passport • Health Passport implementation and monitoring plan • Organize task force for PHIC reorganization • Report recommendations for organizational change • Report recommendations for successful procurement of PHIC information technology • Report needs/gap analysis of PHIC organization • Report recommendations for contribution ceilings • Report recommendations for fund sources • Report enforcement of compliance and collections • Report recommendations on implementation and evaluation of capitation schemes • Report on evidence-based treatment protocols • Report on marketing strategy for IP and IPP • Performance indicators for PHIC
Local Health Systems	• Case studies on local health system models • Rapid assessment tool for ILHZ • User-friendly planning manual • Meta-analysis of health referral studies • User -friendly health referrals manual • Workshop on district health financing • Review of health information systems software • Health information system software for ILHZ • Templates for MOA resolutions and ordinances • Development of advocacy strategy and materials • Training for ILHZ advocates • Operational plans for ILHZ • ILHZ with health board organized • Technical management committees in ILHZ organized • Integrated planning conducted interfacing with Health Passport, drug management system, and health reforms • Fund management manuals • Technical exchange visits • Regional technical summits

Annex Table 1. Expected outputs of HSRTAP activities stated in the first HSRTAP work plan (cont'd.)	
AREA	**SECOND YEAR EXPECTED OUTPUTS**
Drug Management Systems	• Training kits and resource speakers • Evidence-based standards development manual • Therapeutics committee trainings • Economic analysis integration study • Operations research on the consumer reporting system • Social marketing manual • One course on social marketing • Social marketing trainings • Information, education, and communication materials • Operations research on the "seal of excellence" system • Refined "online" drug procurement system • Evaluation report • Marketing plans for the government retail pharmacy system • Quarterly drug price index • Reports on the analysis of the hospitals' drug management systems • Therapeutics committees organized • Hospital drug management systems reports • Assessment reports on drug system of 8 LGUs • Improved LGU drug management • Monitoring reports • Final report • Quarterly review meetings • Bibliography on drug management systems • Midterm evaluation report on DOH's drug management reforms • Evaluation report of MSH's technical assistance to DOH's drug management reforms
Hospital Reforms	• Hospital assets and liabilities listed • Certificates of registration issued by the Securities and Exchange Commission • Hospital boards established and oriented to their roles and functions • CEO knowledgeable of their authority and limitations • Human resources management training conducted • Quality assurance committee oriented on 5 Ss and total quality management • Business plans of second batch of hospitals completed • Selected hospital personnel trained on financial management and information system • Systems and quality improvement in other public hospitals practiced • Hospital Operations and Management Services (HOMS) and hospital leaders aware of the process of corporatization • Coordination between HOMS, hospitals, other stakeholders • Project evaluation

Annex Table 1. Expected outputs of HSRTAP activities stated in the first HSRTAP work plan (cont'd.)	
AREA	**SECOND YEAR EXPECTED OUTPUTS**
Social Health Insurance	• Orientation sessions • Launch HP in 8 LGUs • Monitoring and evaluation of HPI • HP as PhilHealth Program • HP expansion plans • Recommendations on IT and organization to support HP efforts • Recommendations on ceilings • Recommendations on sourcing of additional funds • Recommendations on compliance and collection • Recommendations on reference pricing • Recommendations on evidence-based treatment protocols • Implementation of IP and IPP marketing strategies • Impact assessment of HSRTAP
Local Health Systems	• Technical manual of operation • Rapid assessment tools distributed • Review of ILHZ tools • Review of templates • ILHZ advocates identified • Training needs analysis • ILHZ advocacy and management skills training design and modules • Training courses conducted • LGU sites identified • Assessment for ILHZ conducted • Materials on the conceptual framework and organization/management of ILHZ provided • Templates for resolutions and ordinances provided • MOA templates provided • Launching and ceremonial signing • Inter-local health board organized • Technical management committee organized • Integrated planning conducted with interfacing of Health Passport, drug management systems, and hospital reforms • Fund management for common fund, matching grants, and external assistance • Advocacy materials and ILHZ tools provided for reproduction • Technical exchange visit • Local health system summit

Annex B

Review of HSRTAP Technical Reports

Annex Table 2. Review of HSRTAP technical reports	
REFORM AREAS	**REMARKS**
OVERALL HSRA IMPLEMENTATION ISSUES	
• **Overall Implementation Plan for the Health Sector Reform Agenda (2001-2004)**	
• **Department of Health Reengineering Monograph**	
DRUG MANAGEMENT SYSTEMS	
• **Review of the DOH Therapeutics Committee Manual**	• The review resulted in improvement of the manual's content and format, thereby increasing its usefulness as a reference for TCs.
• **A Local Government Unit's Guide to the Purchase of Parallel Drug Imports from the Philippine International Trading Corporation**	• The manual provides a useful guide for proper selection of drug products to be procured, and quantifying volume requirements. It also lays out the step-by-step procedures in procuring parallel drug imports through the method of direct negotiation. Additionally, it includes a simple methodology for assessing the use of PDI by prescribers, dispensers, and consumers.
• **A Monitoring and Evaluation System for LGU Drug Management System Reforms and A Course Syllabus for 'Monitoring and Evaluating Drug Management System Reforms'**	• A monitoring and evaluation system that will be used in tracking the improvement of drug management systems in the eight convergence sites. Initially, a single training course was proposed; however, the team deemed it more effective to conduct a series of training courses in each convergence site using the monitoring-training-planning (MTP) method. The courses will be conducted together with members of the pool of DOH regional TC trainers to train them in the use of the method. It is expected that this technology transfer will allow the regional TC trainers to implement what they have learned in the other convergence sites.
• **A Report on the Philippine Health Insurance Corporation Drug Price Reference Index**	• A theoretical model was developed by MSH-HSRTAP and was approved by PHIC. Unfortunately, DOH was able to supply only partial price data from the hospitals and drugstore chains. Thus, reference prices could not be computed based on the approved model.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **A Report Reviewing Current Policy Papers on Contraceptive Prescribing and Tariffs**	• A review of literature revealed that numerous studies had been done on this subject. Most of the recommendations of these studies still remain to be implemented. Hence, it was felt that developing another policy paper on contraceptive prescribing requirements and tariffs would have limited usefulness. Instead, attention should be devoted to implementing the recommend-ations of prior studies.
• **Protocol for the Rapid Assessment of the Pharma 50 Project (RAP50)**	• Because of the growing popularity of parallel drug importation as a strategy to lower the cost of drugs, it is important that a protocol be developed to assess patients' access to PDI drugs so that the success of Pharma 50 can be measured more completely. • The focus of the assessment is patients' access to PDI drugs. It specifically determines the percentage of the quantity of a prescribed drug presented for dispensing that is actually dispensed in the health facility. This indicator measures the ability of a patient to purchase the needed quantity of drugs for his/her condition. It is also a valid measure of the availability of drugs in health facilities.
SOCIAL HEALTH INSURANCE	
• **Health Passport Initiative Manual**	• This was developed collaboratively by DOH and PHIC with technical assistance from HSRTAP. The manual defines the roles and functions of PHIC, the central and field offices of DOH, and LGUs in implementing HPI. • It discusses the relationship of HPI to HSRA and describes the ground working, capacity-building, developmental, and sustaining activities in Health Passport areas.
• **A Report on the Organizational Review Component of the PhilHealth Organizational Restructuring Study**	• The PHIC Organizational Restructuring Study is needed to achieve the reform objective of securing the viability of NHIP through sound administration and governance, sufficient funding, and effective controls. • The study provides the basis for designing the appropriate organizational form for PHIC to enable it to attain universal coverage and achieve the goals of the national social health insurance program.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **Expanded Health Passport Operations Manual**	• The HP Operations Manual has been expanded to include the roles and responsibilities of DOH and participating LGUs in addition to those of PHIC. • The expanded manual has been thoroughly discussed with and validated by central and regional staff of DOH and PHIC, and several LGUs such as Pangasinan, Capiz, and Pasay City.
• **Handbook on the Capitation Payment Mechanism for the Outpatient Benefit Package of PhilHealth**	• The completed manual has incorporated the results of the discussion on the preliminary version with PhilHealth. • The draft has been submitted to a foreign consultant for review and recommendations for further improvement.
• **Draft of the Handbook on PhilHealth Plus**	• This manual reflects PhilHealth activities, which may be independent of other health reform initiatives. It focuses on the attainment of universal health insurance coverage in a geographic area, and incorporates templates for marketing the program to LGU executives. The contents of the manual support a more realistic view of the LGU budgets vis-à-vis the LGUs' participation in the Indigent Program.
• **Final Report: Actuarial Study on the Planned Changes/ Enhancements in the National Health Insurance Program**	• The study developed financial projections for NHIP for the years 2003 to 2012 to model the effect of proposed benefit enhancements, considering increased population coverage and changes in the contribution structure. Four benefit enhancements were considered: outpatient medicines, expanded maternity benefit, immunization and nutrition supplements, and family planning.
• **Final Report: Strategic Options for the Use of Clinical Practice Guidelines (CPGs) for the Philippine Health Insurance Corporation**	• The use of CPGs is one tool for a health insurance agency to promote cost-effective and quality care as well as achieve operational efficiency. • This study sought to examine the perceptions and attitudes of professionals towards CPGs as well as assess the impact of CPG use in achieving operational efficiencies and lowering reimbursement costs. The study gathered data using focus group discussions.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **Final Report: Alternative Financing Sources for PhilHealth's Indigent Program**	• Recommends three options to reduce the burden of insurance premium on LGUs: 1. Begin increasing premium share of 4th-6th class municipalities from 10- 50% in five years beginning from five years of enrollment, instead of from two years of enrollment as what is currently in the Implementing Rules and Regulations (IRR) of Republic Act (RA) 7875. This option will only require an amendment of IRR. 2. The same as No. 1, but with the LGU share being shared equally with PhilHealth as a corporation, thereby further reducing the LGU share by half. This will require amendment of RA 7875. 3. The same as No. 1, but with the premium share of the 4th-6th class municipalities increasing only up to 20% instead of up to 50%. To take effect, this will also need an amendment of RA 7875.
• **Final Report: Consolidated Licensing and Accreditation Survey Program (CLASP) Systems Design for Policy Implementation**	• DOH and PhilHealth undertook licensing and accreditation activities separately, using seemingly identical survey criteria but arriving at different decisions. The purpose of this study is to rationalize and harmonize the licensing and accreditation system in the country in the context of PhilHealth's adoption of its new quality assurance Benchbook.
HOSPITAL REFORMS	
• **Alternative Models for Corporatizing Government Hospitals**	• Initial legal research indicated that the conversion of a government hospital into a public corporation requires legislation. Given that the enactment of a bill and its passage into law is a very protracted process, it was deemed necessary to identify alternative options to corporatization as a mechanism for granting fiscal and management autonomy to public hospitals in order to hasten the attainment of the envisioned reforms.
• **A Guidebook for LGU Hospital Boards**	• The guidebook discusses such core topics as the rationale for establishing hospital boards, basic roles and responsibilities of hospital boards, and recommended processes and procedures for selecting hospital board members.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **A Guidebook for LGU Hospital Boards**	• The guidebook was adapted from the Hospital Governing Board Handbook developed by an MSH project in Kenya. Certain sections of the handbook were revised to suit Philippine conditions. The current draft has incorporated the comments of the Pangasinan Provincial Hospital Core Group.
• **Documentation of Issues and Concerns on Corporate Restructuring of Government Hospitals**	• The various issues that have been raised against the corporatization of public hospitals and the responses to these issues have been organized into a document. The document likewise clarifies official DOH policies regarding hospital corporatization and its various implications. The speakers' bureau organized by DOH to advocate for hospital corporatization will use this document as its standard reference text to ensure consistent responses to issues raised by different sectors against the conversion of public hospitals into corporate entities. It will also provide the framework for the formulation of a communication and advocacy plan for hospital corporatization.
• **Draft Guidebook for Organizing DOH Hospital Boards**	• The manual was drafted by MSH-HSRTAP and is patterned after the *Handbook for Hospital Board Members* prepared by the Kenya Ministry of Health and MSH. • The guidebook is one of the corporate tools being prepared by HSRTAP to assist DOH pursue major hospital reforms. It has been submitted to the DOH National Center for Health Facility Development (NCHFD) and two retained hospitals for review and comments, and will be finalized based on comments and recommended modifications received.
• **A Guidebook on the Preparation of a Hospital Strategic Business Plan**	• MSH-HSRTAP, in collaboration with the staff of QMMC and ITRMC, developed a manual that contains useful guidelines on how to prepare a sound hospital strategic business plan. • It is designed for DOH and LGU hospitals intending to convert into autonomous institutions.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **Guidelines for Determining Patients' Ability to Pay**	• The guidebook recognizes that there are no hard and fast rules to assess a patient's capacity to pay. The ultimate decision is left to the judgment of the responsible hospital staff. The guidebook merely provides the tools and techniques to aid in the decisionmaking process. • HSRTAP assisted DOH-NCHFD in developing the guidebook by providing resource materials, particularly on the experiences of local public hospitals and hospitals in other countries in classifying patients according to capacity to pay. • The new guidelines are included in the Medical Social Workers Patient Classification System, which is currently undergoing review by DOH.
• **Draft By-laws for the Hospital Medical Staff**	• HSRTAP has completed drafting a set of medical staff by-lawss intended for use by public hospitals operating as autonomous entities. • These by-laws were patterned after those developed by the Kenya Ministry of Health and MSH.
• **Final Draft of the Financial Management Manual**	• The financial management manual will be very useful for public hospitals that will operate as government corporations. It has been designed to provide both accounting and financial information needed by health care managers to fulfill the organization's mission and purpose. • A copy of the final draft has been submitted to DOH-NCHFD. NCHFD will organize a technical working group, composed of representatives from selected DOH hospitals, to review the draft manual.
• **Revised Financial Assessment Tool**	• The financial assessment tool is used by the NCHFD staff as one of the means to determine whether a retained hospital has the potential for corporatization. • This tool, developed by DOH with MSH-PMTAT assistance, provides a sound methodology for evaluating the financial accomplishments and capabilities of a hospital but needs to be simplified for easier use.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
LOCAL HEALTH SYSTEMS	
• **Operational Plan for Local Health System Development (2001-2004)**	• The plan is a tool that BLHD can use to fulfill its mandate of advocating for and supporting the formation of local health systems, and in coordinating the implementation of HSRA in the convergence sites. The plan focuses on the setting of goals and targets, and in organizing and scheduling of BLHD activities in the areas of concern. • The plan was developed by in-house HSRTAP consultants in full collaboration with BLHD key technical staff.
• **Manual for Organizing and Conducting Convergence Workshops (for use by DOH central and regional staff and provincial health office staff)**	• This manual was developed to prepare the DOH central and regional staff as well as provincial health office staff to assume the responsibility of organizing convergence workshops. This manual is deemed important for DOH in meeting the target of establishing 64 health sector reform convergence sites by 2004.
• **Making District Health Care Work: An Outline of a Manual on Inter-Local Health Zones (District Health System in a Devolved Setting)**	• This manual is intended for easy use by provincial health officers, district health chiefs, municipal health officers, and DOH central and regional staff in organizing and establishing functional inter-local health zones in the country.
• **A Handbook on Inter-local Health Zones**	• The handbook was conceived as a management tool for local government unit executives and other officials, health personnel in various levels of local government, DOH field personnel, other government and non-government organizations as well as the private sector in the institutionalization of local health systems within the context of local autonomy through inter-local partnerships and collaboration. • The handbook was developed through a series of activities that started with the Case Studies on Five Inter-Local Health Zones by the Institute of Health Policy and Development Studies at the National Institutes of Health, UP Manila. A seminar- workshop on making district health care work was subsequently held, which generated recommendations to further improve the inter-local health systems.

Annex Table 2. Review of HSRTAP technical reports (cont'd.)	
REFORM AREAS	**REMARKS**
• **Manual on the Financial Management of the Common Fund of Inter-local Health Zones (ILHZs)**	• A user-friendly manual on the financial management of the common fund of inter-local health zones based on the experiences of functional inter-local health zones. • This manual is designed for the use of local chief executives, LGU financial managers, and inter-local health zone policy makers and managers in effectively and efficiently managing the funds contributed by participating LGUs to improve health service delivery and financing in an inter-local health zone. • It discusses the governance structure and processes of sourcing, utilizing, and administering the common fund of an inter-local health zone.
• **A Report on the Status of HSRA Implementation in Each of the Eight Convergence Sites**	• Although progress was generally achieved in all sites, levels of achievement across reform areas and among sites varied considerably. Not a single site has come close to implementing all the reforms in an integrated manner as to be able to demonstrate the direct benefits that can be derived from implementing the reforms, namely increase in the quantity and quality of service provision, and health care financing