A POSTSCRIPT on the:
"Improvement of the Implementation and Procedures and Management Systems for the Health Facilities Enhancement Grant of the Department of Health"

The DBM-PIDS Study on the "Improvement of the Implementation and Procedures and Management Systems for the Health Facilities Enhancement Grant of the Department of Health" provided the Department of Health significant findings which we can use to improve our delivery of services.

The study noted the following:

a. "…none of the HFEP guidelines explicitly mentioned any of these AOs in the guidelines for allocation and release of funds for HFEP";

b. Actual allocation of HFEP funds…"does not clearly show the link of HFEP allocation to needs specified by DOH policies on allocating based on needs";

c. "…simple correlation suggests that the allocation per capita and poverty incidence are not related"; and,

d. "…Correlation suggests that HFEP expenditure per capita and population are (sic) not statistically significant."

The DOH Centers for Health Development evaluates proposed Health Facilities Enhancement projects, and uses this list of criteria to screen and select facilities for inclusion:

1. Existing list of BEmONC facilities
2. Province's Rationalization Plan
3. Province Wide Investment Plans for Health (PIPH)
4. Annual Operation's Plan (AOP's)
5. DSWD-CCT areas

With the increase of Health Facilities Enhancement Program (HFEP) budget was the proportionate increase in the number of projects that were to be managed by DOH. The DOH Regional Cluster Heads were included in the screening and selection of HFEP 2011 projects, which has further aided the rational screening of HFEP projects.

The observed disconnect in the HFEP allocation by DOH and the actual needs of the provinces is admittedly an issue that the department needs to address. But one of the major reasons for this disconnect is based on the premise that capital infusion for the upgrading, repair, renovation, expansion or new construction of health facility buildings and procurement of hospital or diagnostic equipment is best allocated where their optimal use, adequate maintenance and sustainability are assured. And the potential for optimal utilization of the hospital, RHU or BHS is assured when LGUs or the existing health facility can assure the availability of adequate and appropriate human resources to operate the facility and provide the services funded by HFEP. Also, potential for optimal utilization is high when the facility or services are located strategically such that this can be accessed by various population groups instead of confined or authorized for a singular or small LGU.

With this, the potential for adequate maintenance of buildings and equipment and their sustainability is higher among LGUs or existing facilities that have track record for appropriating adequate funds for health care or hospital operations (MOOE) and among health facilities located in or near commercial areas where services, materials or networks for specialized services are more easily

accessed. A hospital administration's experience in improving schemes in healthcare financing and use of income, such as linkage with PhilHealth and other health insurance corporations, use of revolving funds and fees-for-services likewise indicate high potential for sustainability of HFEP investments.

Thus, even if the target population to be served or whose health status needs to be improved is located in a low income municipality, it is likely that the hospital to be built or upgraded would be the hospital in the urban zone nearest it and would be reflected as HFEP funds allocated to the provincial government or HFEP funds allotted to an existing DOH hospital. In a similar manner, the location of households or poor families qualifying for the CCT or conditional cash transfer from the DSWD may not be rendered feasible for construction of a BHS or hospital, and thus, the HFEP budget may be deemed better invested in one or several nearby *barangays* that are considered to be more topographically stable or in the mother RHU serving the community or households.

DM 2010-0104 which is about the HFEP guidelines being questioned, recommends that project proposals to be considered for HFEP funding are channeled through DOH-CHDs or Centers for Health Development. This is because the CHD is continually involved in the province-wide or city-wide planning for the rationalization of health care delivery. The Rationalization Plan (RatPlan) is a health sector development cum business plan proposed collegially by the province and its component municipalities and cities and the DOH. These RatPlan's prepared by the LCE's and endorsed by the CHD's are frequently used as reference to verify the accessibility and LGU commitments to maintain certain health facilities prior to firming up the HFEP project list to be funded.

The DOH uses the Rationalization Plans as the basis for allocating HFEP funds, and ideally all provinces in the country should now have their Rationalization Plans. Unfortunately, when provinces do not have RatPlan's, decisions on investments for the health facility is endorsed to the DOH EXECOM for further evaluation and approval.

In general, it is fair to say that the DOH has managed HFEP budget guided by procedures and policies that aim for allocative and technical efficiency with consideration to improve access to healthcare facilities nationwide, especially where these can impact on the achievement of Millennium Development Goals—which cover the very basic health needs of the poor. The DOH likewise admits to the fact that the degree of consistent execution of these written policies may sometimes vary in some offices or LGU's, and can be influenced by various interest groups.