Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the DOH

Introduction

One of the major challenges in the Philippine health sector is providing access to appropriate health facilities for the poor and the marginalized sector of the society. Recognizing this problem, one of the inaugural commitments of the Aquino administration is ensuring that quality and affordable care reaches each and every Filipino during his term. At the core of this commitment is the expansion of Pantawid Pamilyang Pilipino Program (4Ps), a conditional cash transfer (CCT) program targeting indigents who will be given cash conditional on utilization of maternal and child care services. Studies have shown that while cash transfer help overcome demand-side barriers to healthcare, it has to be complemented with supply-side strategies, like improvements in health facilities and training of health professional, for it to be effective (DFID, 2011).

Budgets for capital outlay have been sparse in the DOH budget from 2000 to 2006. Due to this, maintenance and upkeep of health facilities has been postponed which has resulted in deterioration of most health facilities. According to DOH, 892 RHUs (36% of total) and 99 public hospitals (14% of total) have yet to qualify for PhilHealth accreditation. In response to this, the new administration launched the Aquino Health Agenda (AHA) where one of the three strategic thrusts is improving access to quality hospitals and health facilities through upgrading of facilities.

There have been efforts that started in 2007 to bridge the gaps in health care delivery and utilization and eventually increase access to health facilities and services. The Department of Health (DOH) has included into the General Appropriations Program (GAA) funds for the Health Facilities Enhancement Program (HFEP) which aims to upgrade health facilities such as Health Centers, Barangay Health Stations (BHS) and Rural Health Units (RHUs) to sufficiently provide for emergency and primary care services. Another goal of the HFEP is to improve and upgrade facilities in government hospitals.

Since its implementation in 2007, budget for HFEP has increased from P43.5M in 2007 to P7.1B in 2011. The program has also expanded from initially targeting Local Government Units (LGUs) in F1 sites only to all provinces in the country. Despite these efforts, the Department of Budget and Management (DBM) has still received feedback regarding difficulties encountered by the DOH in implementing this program.

The *Improvement of the Implementation Procedures and Management Systems for Health Facilities Enhancement Grant of the DOH* study addresses the need to identify the difficulties encountered by the DOH in implementing the program for the efficient allocation of funds for facilities across the country. It assesses the indicators used in choosing which facilities should be targeted for upgrading to ensure equity in the allocation of funds. This study specifically aims to map and examine the rationale for the choice of facilities that will be upgraded through Health Facilities Enhancement Grant (HFEP). It also lays-out some policy options that can be considered to improve equity and efficiency in allocation of funds.

Description of Program: HFEP

The DOH implemented the HFEP with the main goal of improving the delivery of basic, essential and as well as specialized health services. The project envisions revitalization of primary health care facilities and the rationalization of the various levels of hospitals to decongestend-referral hospitals.[1] Facilities will be upgraded to make them more responsive to the "need" of the catchment area, to provide Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency and Newborn Care (CEmONC) services to the population, and to strengthen the health facility referral system or network.

Specifically, the objectives of the HFEP are as follows:

1. To upgrade/establish priority BHSs and RHUs nearest to the communities in order to provide services for BEmONC to reduce maternal maternity ratio (MMR); to establish strategically located blood service facilities and upgrade end-referral/training center for B/CEmONC personnel;

2. To upgrade government hospitals/health facilities in Provinces with approved Provincial Rationalization Plans of their Health Care Delivery System based on Health Needs and its Implementation Plans linked to Provincial Investment Plan for Health (PIPH) and Annual Operation Plans (AOPs); to meet DOH Licensing and PhilHealth accreditation requirements and provide quality and appropriate health services responsive to the priority health needs of the catchment population;

3. To upgrade Philippine National Police (PNP) clinics to Level 1 (primary) general hospitals; to upgrade government hospitals (including military and PNP hospitals) from Level 1 (primary) to Level 2 (secondary) in order to accommodate nursing students as base hospital; and if necessary to upgrade from Level 2 (secondary) to Level 3 (basic tertiary) hospitals to "gatekeep" and decongest higher level tertiary hospitals; for nursing affiliation in tertiary hospitals; and to provide services for CEmONC to reduce MMR; expand services of existing tertiary hospitals to provide higher tertiary care and as teaching, training hospitals.

The HFEP Budget

A separate line item was provided for the HFEP in the General Appropriations Act (GAA) beginning 2007. The HFEP was one of the priority programs of the DOH in 2007 in line with the health sector reforms. HFEP had a budget of P43 million at the start of the program in 2007. Of this, only P10 million was appropriated for Capital Outlay (CO) and the rest of the budget is for Maintenance and Other Operating Expenses (MOOE). In 2008, total budget increased to P1.65 billion, where P27 million was appropriated for MOOE and the rest for CO. MOOE appropriation has been steady at P27 million from 2008 to 2011, while the CO budget increased from P1.6 billion in 2008 to P7.1 billion in 2011 (see Table 1).

[1] DOH Department Order no. 2008-0162 entitled, "Guidelines and Procedures for the Implementation of the Government Hospital Upgrading Project under the CY2008 Health Facilities Enhancement Program Funds of the DOH" dated 7 July 2008.

Table 1. HFEP Budget, General Appropriations Act

	MOOE	CO	**TOTAL**
2007	33,530,000	10,000,000	**43,530,000**
2008	27,522,000	1,628,000,000	**1,655,522,000**
2009	27,522,000	2,045,726,000	**2,073,248,000**
2010	27,522,000	3,224,173,000	**3,251,695,000**
2011	27,522,000	7,116,387,000	**7,143,909,000**

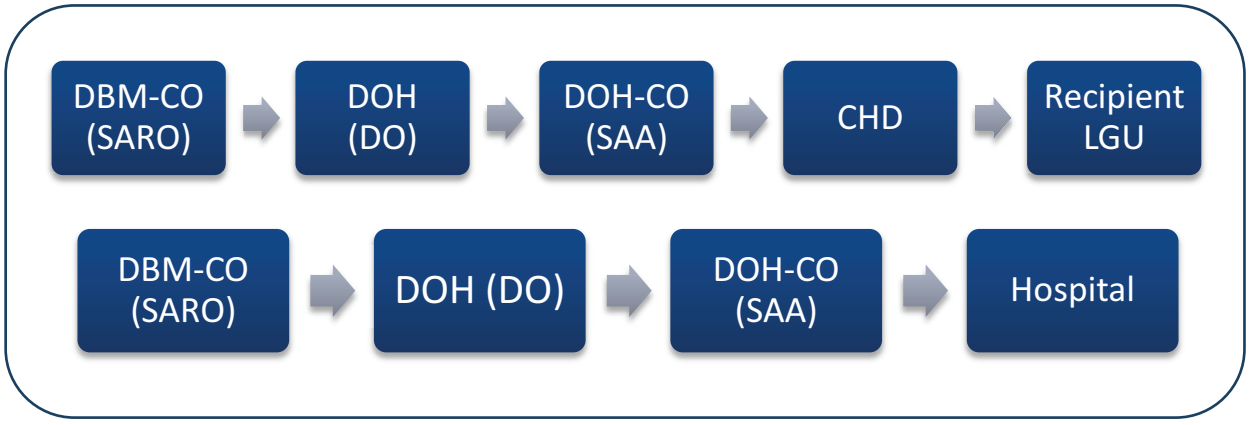
Source: General Appropriations Act, Department of Budget and Management, various years

Structure

Regulation and Oversight. The National Center for Health Facility Development (NCHFD) is tasked to provide coordination, technical assistance, capability building, consulting and advisory related to health facility development. NCHFD technical assistance ranges from planning, to operation and maintenance. It is composed of three divisions: the Technical Operations Division, Infrastructure and Equipment Division, and Management Systems Development Division. The Infrastructure and Equipment Division is the unit in charge of the HFEP.

Budget Releases. Once a request for facility is approved, a Special Allotment Release Order (SARO) is issued by the DBM. DOH then issues a Department Order indicating the guidelines for the release and utilization of funds for the recipient LGU or hospital.A Sub-Allotment Advice (SAA) is then released by NCFHD, through the Finance Service, to the CHD. The CHD then releases the fund to the Recipient LGU or hospital. In some instances, however, the SAA is released directly to the hospital. Figure 1 illustrates this process.

Figure 1. Flow of Budget Release



Sources of Fund

Aside from the GAA, other sources of fund for the HFEP include realignments from the Family Health Office (FHO), Katas ng VAT, and Congressional and Senate Initiatives. Table 2 shows that in 2008, 36% of HFEP spending comes from other sources; 25% of the total HFEP spending is from the Katas ng VAT, while Congressional initiatives comprise 8% and Senatorial iniatives 3%. In 2010, FHO realigned its budget of P503 million for the upgrading of BHSs and RHUs into BEmONCs and CEmONCs.

Table 2. Sources of Fund for HFEP

(in '000)	2007		2008		2009		2010	
GAA	**485,412**	**100%**	**1,267,522**	**64%**	**2,045,048**	**99%**	**3,181,676**	**86%**
Others			**702,400**	**36%**	**30,000**	**1%**	**503,000**	**14%**
FHO							503,000	14%
Katas ng VAT			496,000	25%				
Congressional Initiatives			148,400	8%				
Senate Initiatives			58,000	3%	30,000	1%		
Total	**485,412**	**100%**	**1,969,922**	**100%**	**2,075,048**	**100%**	**3,684,676**	**100%**

Issues

The Family Health Office realigned funds amounting to P503 million in 2010. This amount is for the construction and upgrading of RHUs and BHSs to provide BEmONC and CEmONC services. Although this is in line with FHO's MNCHN Strategy, the funds were realigned due to the facilities enhancement nature of the project, which is under the responsibility of NCHFD.

On average, funds from other sources comprise only 13% of the total HFEP funds. The existence of such funds mixes up the allocation criteria of DOH (refer to section on allocation below), which is supposedly based on "needs." This need is defined in the facilities rationalization plan prepared by each province.[2] Since congressmen and senators do allot funds to augment DOH's HFEP budget, there were cases that the criteria set by the DOH in choosing which facilities to upgrade were disregarded to accommodate their requests. Since it is identified that having those funds can politicize the allocation of funds, the process of accepting funds from other sources needs to be carefully reviewed.

[2] As of June 2011, only 52 provinces prepared a rationalization plan. These provinces are: Benguet, Mt. Province, Ifugao, Ilocos Norte, Pangasinan, Isabela, Nueva Vizcaya, Cagayan, Quirino, Nueva Ecija, Batanes, Cavite, Laguna, Batangas, Rizal, Quezon, Oriental Mindoro, Occidental Mindoro, Romblon, Palawan, Marinduque, Albay, Sorsogon, Capiz, Iloilo, Guimaras, Negros Oriental, Siquijor, Bohol, Cebu, Biliran, Southern Leyte, Leyte, Eastern Samar, Samar, Northern Samar, Zamboanga Sibugay, Zamboanga del Norte, Zamboanga del Sur, Misamis Occidental, Lanao del Norte, Misamis Oriental, Compostela Valley, Davao del Norte, North Cotabato, South Cotabato, Sarangani, Sultan Kudarat, Agusan del Sur, Dinagat Islands, and Surigao del Sur. There were cases, however, that HFEP funds were given to provinces with no rationalization plan to accommodate requests by politicians.

Planning and Budgeting

Request for Funding from HFEP. Department Memorandum (DM) 2010-0104 provides the process flow for the approval of HFEP allocation. According to the DM, all requests coming from LGUs, Office of the Secretary (OSEC) and DOH Hospitals shall be forwarded to the Center for Health Development (CHD). Hospitals under the DOH should directly forward their requests to the CHD, while LGU hospitals can submit their requests through their LGUs. The LGU will then pass a *Sanggunian Resolution* in connection to the request to the CHD. In some instances, requests are forwarded straight to the Office of the Secretary (OSEC) of the DOH or the Field Implementation Management Office (FIMO). In such case, the OSEC/FIMO will forward the request to the CHD for review and validation.

From the CHD, the requests are forwarded to NCHFD for further review before passing on to the ExeCom for approval. All requests that are forwarded to the NCHFD are also sent to the FIMO for monitoring of process. Upon approval, the requests are passed on to the Finance Service for fund processing. Lastly, from the Finance Service, approved requests/grants are sent to the requesting hospitals. Figure 2 summarizes the process flow for the approval of HFEP funding.

Before the memorandum was issued, NCHFD prepares a list of health facilities and asks CHDs to validate whether the list corresponds to the three HFEP criteria on BEmONC/CEmONC, provincial rationalization plan, and PIPH.

Figure 2. Process Flow of Approval for HFEP funding in 2010

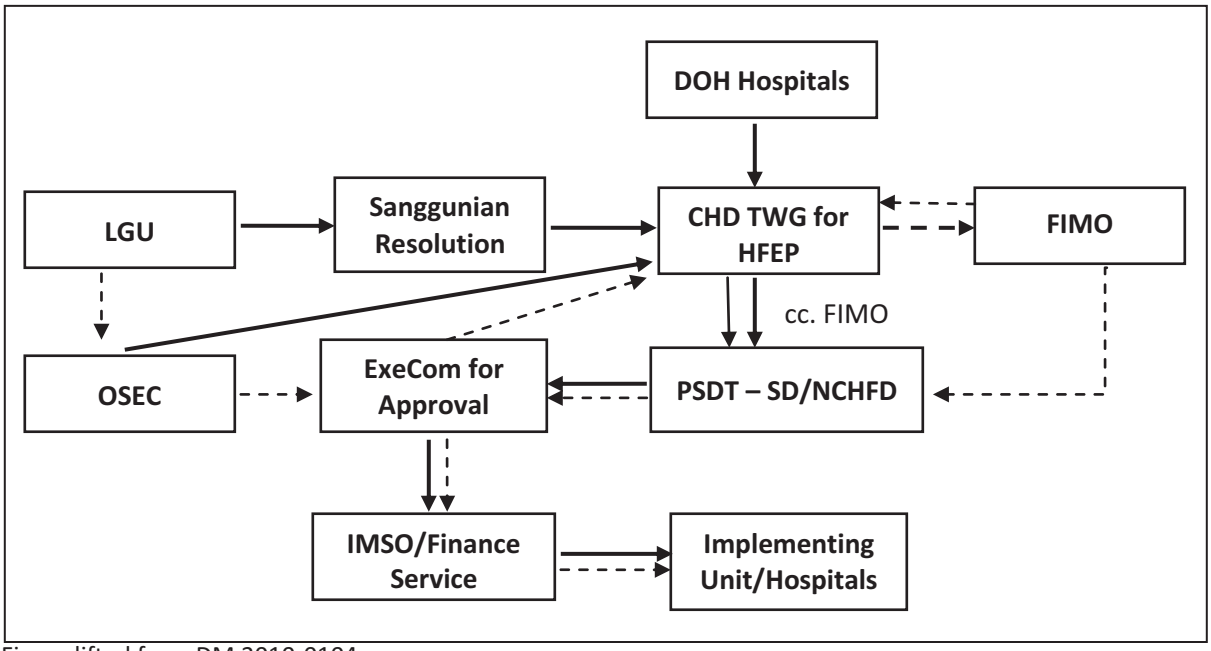


*Figure lifted from DM 2010-0104

Issues

This DM was released because it has been observed that requests from LGUs and DOH hospitals are addressed directly to the Office of the Health Secretary and other officials from the DOH. This is considered as a "non-preferred route" (route with- - -▸ in the figure above), which has been the practice despite the priority list that NCHFD has prepared.

The process flow outlined in Figure 2 makes the process more complicated. While the DM was explicit in stating that the preferred route is for LGUs to come up with a resolution and apply through their respective CHDs, allowing them to approach the OSEC directly can make the allocation of funds unfair. According to interviews, what happens in a typical "non-preferred" route is OSEC/NCHFD receive a call from the Congress asking them to allocate funds in their preferred localities. Thus, despite the presence of a criteria that serves as a basis for the allocation list, most of the time, this list gets set-aside to accommodate the requests of the Congress.

Budget Allocation

Criteria for Selecting Facilities. The CHDs are provided with criteria for rating the requests to ensure objectivity and fairness in assessing the requests. There are three main criteria – LGU Priority, CHD Review, and Plus Factor. Under each criterion, specific conditions with equivalent points each have to be met for approval of request. For the LGU Priority, a maximum of ten (10) points can be given if the LGU has allocated MOOE budget and Human Resources for the project; another ten points if there are LGU counterpart funds and; 15 points upon evaluating how responsive it is to the health situation status.

For CHD review, a maximum of 15 points can be given if it is within approved PIPH/AOP framework of the LGU. If it complies with the Certificate of Need (CON) and/or B/CEmONC standards/requirements, a maximum of ten points can be given and; another ten points if it is deemed "rational" by the CHD even if without Rationalization Plan (RatPlan) or not complying with RatPlan.

The Plus Factors requires that the request should have more than 85% LGU IP enrolment. The highest score for this condition is ten points. If there is a good track record in submitting reports/Fund Utilization Reports (FUR), a maximum of ten points can also be given and; another ten points if good financial management is in place.

Out of a possible 100 points, the total scores corresponding to each request shall be used by the ExeCom in deciding on the approval of requests. This criteria is summarized in the table below.

Table 3. HFEP Criteria

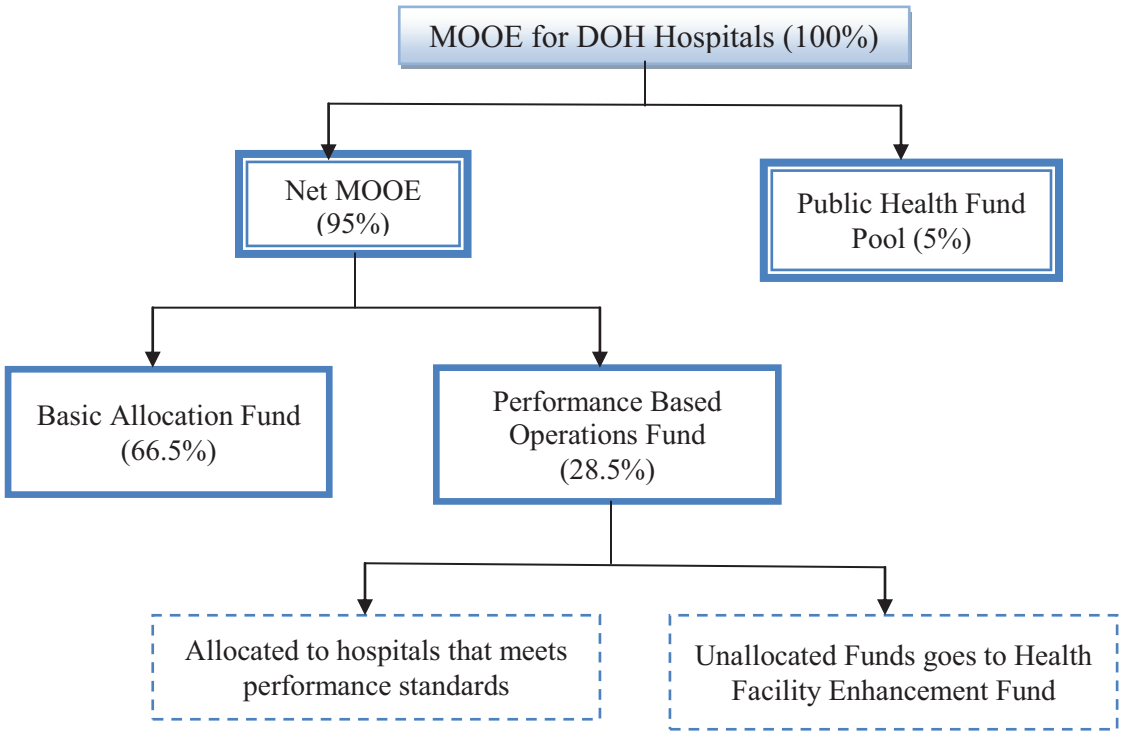
CRITERIA	DESCRIPTION	POINTS
LGU Priority	- LGU has allocated MOOE budget and Human Resources for the project	10
	- LGU counterpart funds	10
	- Responsive to health status situation	15
CHD Review	- Within approved PIPH/AOP framework of the LGU	15
	- Complying with the Certificate of Need (CON) and/or BEmONC/CEmONC standards/requirements	10
	- Deemed "rational" by the CHD if without RatPlan or not complying with the RatPlan	10
Plus Factor	- >85% LGU IP enrollment	10
	- Good track record in submitting reports/FUR	10
	- Good financial management in place	10
TOTAL		**100**

Source: DM 2010-0104

Defining "Need." Since 2006, DOH has embarked on major efforts in making sure that its funds are allocated efficiently and equitably. For the efficient allocation of funding for public health, Administrative Order no. 2006-0022 entitled "Guidelines for Establishment of Performance-Based Budget for Public Health" was passed. This AO aims to progressively allocate commodities for priority public health programs and to link budget subsidies of DOH offices to specific outputs and outcomes for targeted reforms in the public health programs. The AO lists down the guidelines for identifying the priority public health programs on the basis of burden of disease, equity, economic efficiency and cost effectiveness, and prioritizing health target diseases with the greater impact. For the progressive allocation of public health commodities, indicators such as population in need or at risk, and regional poverty indicators are used.

A separate AO was released on the guidelines for Performance-Based Budget (PBB) for DOH Hospitals (AO 2006-0027). PBB refers to the process by which DOH splits funding for the hospital MOOE into several portions, the releases of which will be based on hospital performance relative to pre-agreed performance measures (Figure 3). With this system, a hospital's budgetary allocation is linked to performance, therefore reducing the hospitals' dependence on subsidies and enhancing its internal funds generation. The AO stipulates that 70% of the MOOE for all hospitals will be provided to cover for overhead costs, but the remaining 30% will be given based on identified performance benchmarks. In case a hospital is not able to meet the target, the fund will be transferred to the Health Facilities Enhancement Fund which will be available on a competitive basis to hospitals which submitted proposals for infrastructure enhancement of upgrading.

Figure 3. Performance Based Budgeting of Hospitals



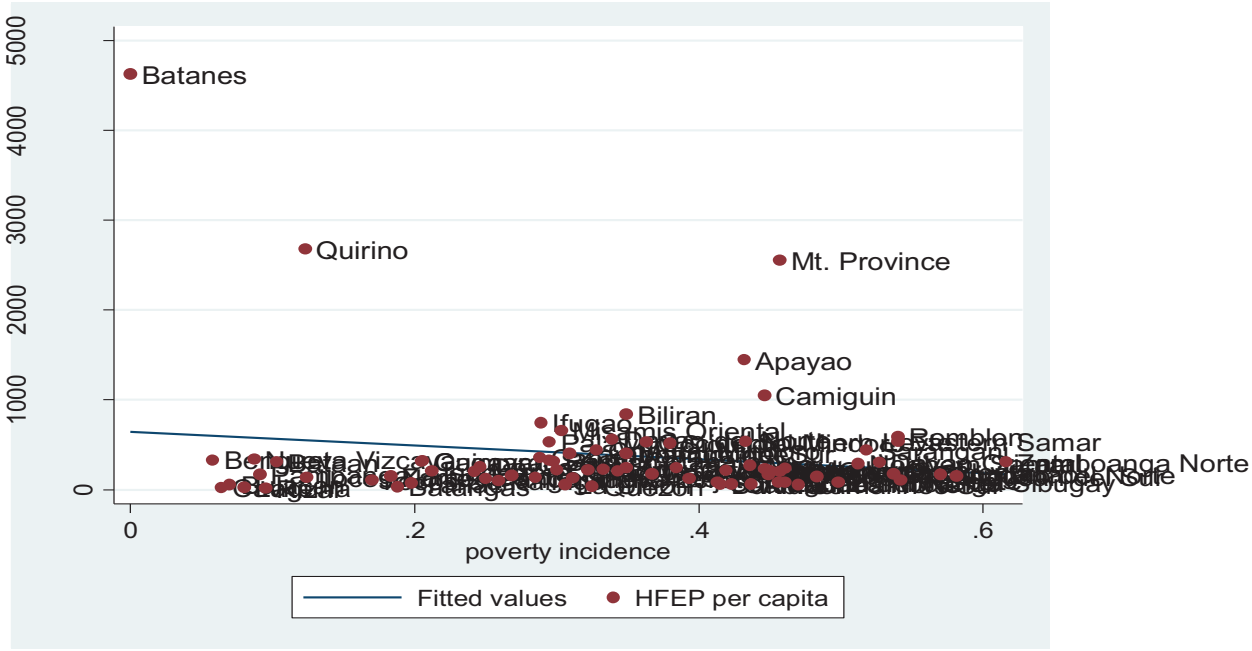
Not long after the signing of the two AOs, AO 2006-0029 entitled "Guidelines for Rationalizing the Health Care Delivery System Based on Health Needs" was signed. The AO provides the set of indicators to be used in rationalizing the health care delivery system. Indicators are both for health and non-health outcomes. The objective of the AO is to provide the mandate and directions for all DOH offices in developing the rationalization of health care delivery systems in the country.

This study found, however, that none of the HFEP guidelines explicitly mentioned any of these AOs in the guidelines for the allocation and release of funds for HFEP.

Also, examination of the actual allocation of HFEP funds from 2007 to 2010, however, does not clearly show, the link of HFEP allocation to needs specified by DOH policies on allocating based on needs.

Allocation of HFEP Facilities by Poverty Incidence. Figure 4 shows the relationship between HFEP spending per capita and poverty incidence. HFEP per capita is computed by aggregating all the HFEP funds that went into the province from 2007 to 2010 and dividing this with provincial population. Batanes has the largest HFEP budget per capita, and has the lowest poverty incidence. Mt. Province, Apayao and Camiguin have fairly high HFEP per capita allocation at P2,500, with poverty incidence of 50%. However, a simple correlation suggests that the allocation per capita and poverty incidence are not related.

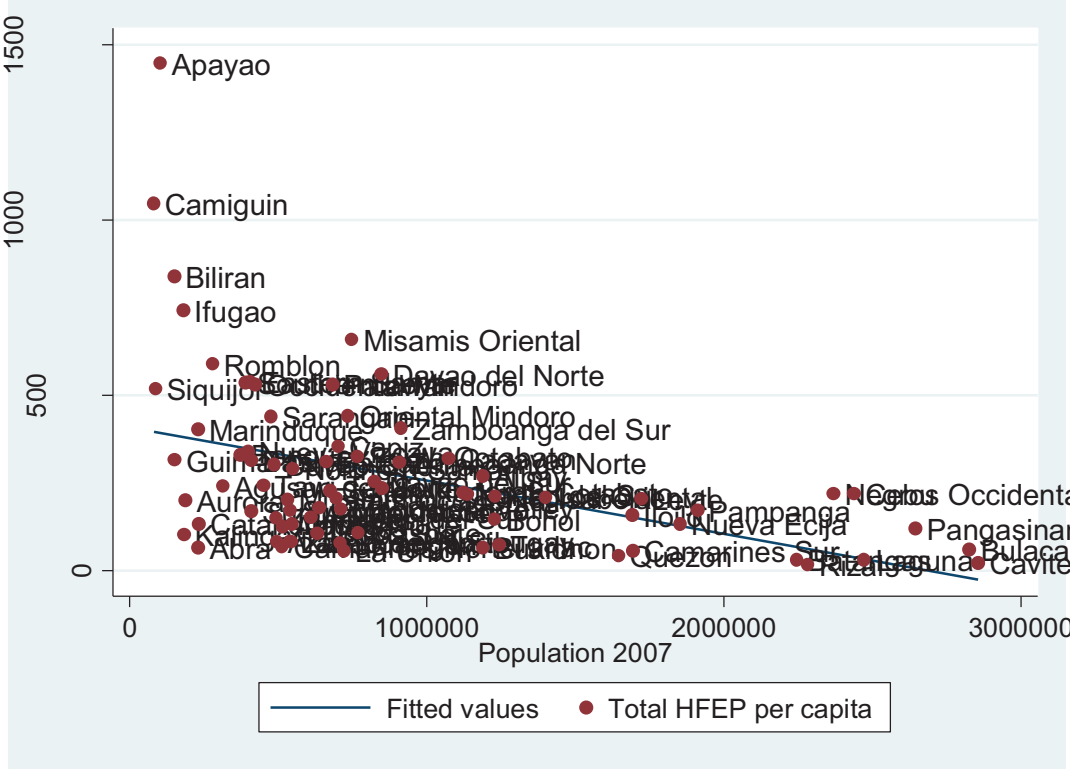
Figure 4. HFEP allocation per capita and poverty incidence



Correlation: R=-0.1720; p-value=0.1296 (not significantly correlated)

Allocation of HFEP Facilities by Population. The same story applies for HFEP spending per capita relative to population in the province (Figure 5). In fact, provinces with smaller population have more HFEP allocation per capita, such as the provinces of Apayao, Camiguin, Biliran and Ifugao, among others. Correlation suggests that HFEP expenditure per capita and population are not statistically significant.

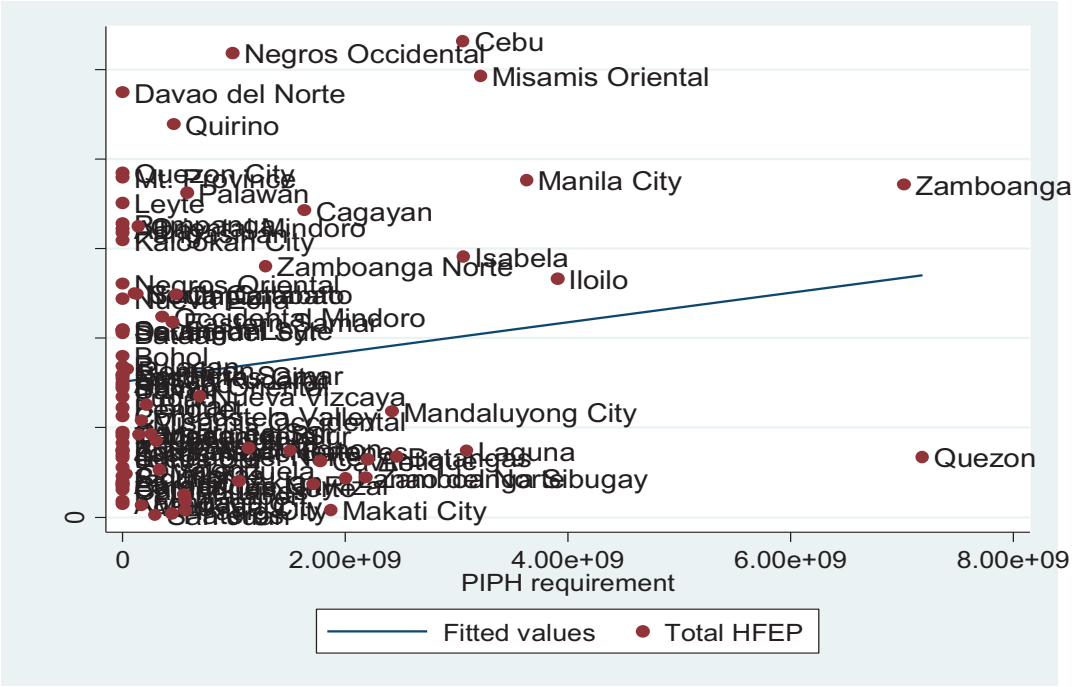
Figure 5. HFEP Allocation per Capita and Population



Correlation: R= -0.3514; p-value=0.0015 (not significantly correlated)

Allocation of HFEP Facilities by PIPH requirement. Figure 6 shows the relationship between Total HFEP Expenditure and a province's PIPH requirement. A province's PIPH requirement somehow indicates a certain level of need in the province and one of the three major criteria for HFEP allocation. Though it seems that Zamboanga del Sur received appropriate HFEP budget, correlation suggests that PIPH requirement and total HFEP expenditure are not statistically significant.

Figure 6. Total HFEP Expenditure and PIPH Requirement



Correlation: R=0.1692; p-value=0.1151 (not significantly correlated)

Annex 1 and 2 presents a disaggregation of HFEP funds by fund source: GAA, FHO for BEMoNC/CEMoNC, Katasng VAT, Congress and Senate Initiatives. The same trend remains that there are no correlations between HFEP funds allocated per province to PIPH requirement, poverty incidence, and population per capita. The highest recipient of HFEP from GAA appears to be Cebu, however, it was Quezon Province and Zamboanga del Sur with highest PIPH requirements. Batanes and Quirino received higher HFEP funds from GAA despite their relatively low poverty incidence compared to other regions. There was a significant negative correlation between population and HFEP allocation per capita. However, the relationship runs counter to expectations—the more populous the province is, the less allocation it receives from HFEP GAA funds.

The same trend of no correlation is observed for allocation of funds for BEmONC and CEmONC facilities. The provinces who were able to receive the highest allocations were Davao del Sur, Davao Oriental, Davao del Norte, Occidental Mindoro, Compostela Valley, Romblon, and Oriental Mindoro. On the other hand, Katas ng VAT benefitted the following provinces: Camiguin, Ifugao, Mt. Province, Guimaras, and Albay.

Senate initiatives were partial to only a handful of provinces, namely, Zamboanga del Sur, Batangas, Nueva Ecija, Negros Oriental, Camiguin, Ilocos Norte, and Oriental Mindoro. Despite non-submission of PIPH estimates which is one of the criteria in the HFEP guidelines, the provinces of Camiguin, Ilocos Norte, and Oriental Mindoro were allocated good sums of funds from Senate Initiatives.

Similarly, Congressional funds only benefitted five provinces—Manila City, Quirino, Catanduanes, Albay, and Ilocos Sur. It should again be noted that Albay and Ilocos Sur did not submit PIPH to DOH.

Discussion

In this study's review of AOs, DOs, and DMs issued by DOH, it appears that there was no reference made by HFEP guidelines to the AOs issued by DOH on defining need and rationalization of health facilities. For instance, it was not evident what the link of HFEP is to the Health Facilities Enhancement Fund mentioned in the performance-based budgeting AO on hospitals. Also, while AO 2006-0029 clearly outlines what the definition of need should be, the DM issued on the criteria and process flow does not appear to be consistent with the definition of need in the AO.

According to DOH, the funding priority for 2007 and 2008 were Levels 1 and 2 hospitals to serve as base hospital for nursing students. This was following the pronouncement of the previous administration that the government will provide training hospitals for nursing students. For 2009, BHS and RHUs were included in the priority to decongest DOH tertiary hospitals. Levels 1 and 2 hospitals that were identified for BeMONC conversion were prioritized for regions with high maternal mortality rates. It should be noted that it was only in 2010 that allocations were based on clear criteria specified in administrative orders (AO 2009-0022 and AO 2010-0006).

As such, it is no surprise that when allocations from 2007 to 2010 were plotted with PIPH, poverty incidence, and equity, there seems to be no structured allocating mechanism for HFEP. While this is true for all funding sources, the gap is greater for HFEP funds that were funded by congressional and senate initiatives that appear to benefit only a handful of provinces. Since the goal of the HFEP from 2007-2010 was to reduce maternal mortality, identification of facilities for funding was geared towards reduction of travel time to health facilities, which might not equate with the poverty incidence in the provinces. According to DOH, the plan for 2011-2012 is to saturate all the upgrading needs for BEmONC and CEmONC, and 2013 onwards will focus on upgrading Levels 3 and 4 hospitals where poverty incidence and other socio-economic indicators will be considered in identifying priority facilities.

Budget Execution

Fund Releases. In the normal course of fund release, after the GAA is ratified, DBM issues a SARO that will authorize the release of funds for HFEP. DOH then issues a Department Order that provides an outline as to how the fund will be utilized. The DO will go through different bureaus in DOH because it has to be signed by various authorities, including the Secretary of Health. After this, the finance office will issue sub-allotment orders to CHDs and hospitals. Only when they receive their SAAs could they start entering into contracts with suppliers.

It takes an average of 200-310 days from the date the GAA was signed to the release of SAA (Table 4). Fund release was longest in 2009 with 310 days and it has improved in 2010 with 200 days. In 2008, HFEP budget that came from the GAA line item budget was released within the year. Delays were mostly found on funds sourced from congress and senate initiative. The main source of delay is mostly from the time the GAA was passed to the time DBM issued a SARO, which, in 2008 took as long as 400 days in issuing the SARO for a Senate funded initiative.

The GAA was passed in March for 2008-2009 and in February in 2010. When cases like this happen, the common practice is to base the appropriation for the first quarter to the previous year's. Thus even if the GAA was not yet enacted, there will be funds that can be used by the department. This is the reason

why there were cases when the DO was issued before the SARO. On average, the DO was issued 5 days earlier in 2008, 133 days earlier in 2009, and 44 days earlier in 2010.

The time it took the finance office to issue SAAs ranges from 36 days in 2008 to 192 days in 2009. Details of the specific batches with their specific dates of issuances are presented in Annex 3.

Table 4. Average Number of Days of Release of Funds

	GAA to SAA	GAA to SARO	SARO to DO	DO to SAA
2008	**281**	**251**	**(5)**	**36**
GAA	170	181	(20)	10
Congressional Initiatives	283	248	(27)	62
Senate Initiatives	400	342	8	50
Katas ng VAT	270	232	18	21
2009	**310**	**246**	**(133)**	**192**
GAA	310	246	(133)	192
2010	**200**	**187**	**(44)**	**57**
GAA	200	187	(44)	57

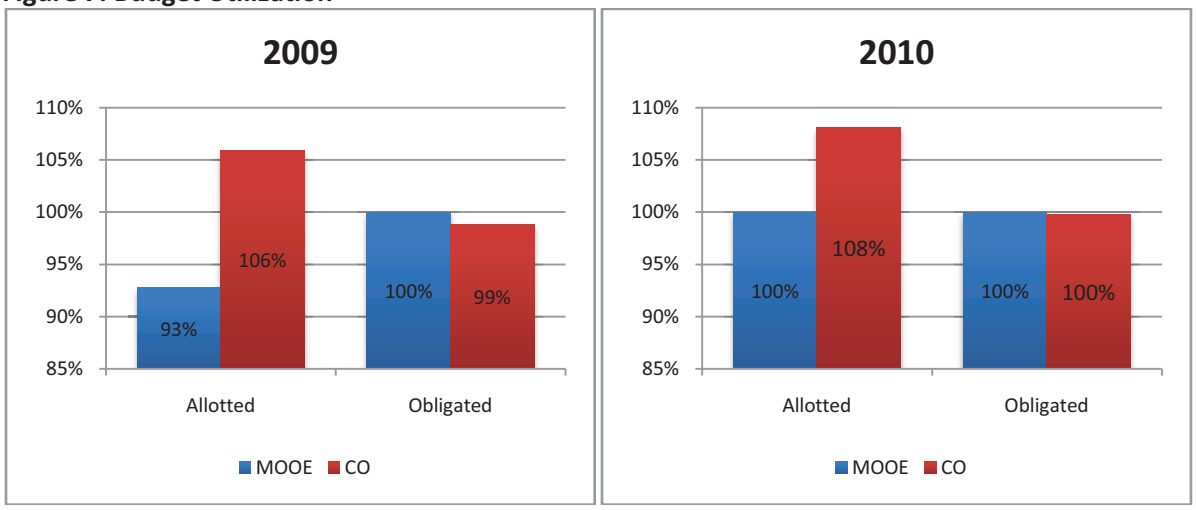
Fund Utilization. On the whole, the HFEP showed high utilization rates for years 2009-2010. Table 5 shows that actual allotment available is greater than the amount appropriated and a 99%-100% utilization rate for actual obligations is observed. Disaggregating by expense class, utilization rate for allotted MOOE in 2009 is only at 93%, and that utilization rate for allotted CO for 2009 and 2010 exceeded 100%. Of the total allotment released, all showed 100% utilization rates, except for CO in 2009, at 99%.

Table 5 HFEP Appropriations, Allotments, and Obligations

	Appropriations			Allotment Released			Actual Obligations		
	MOOE	CO	Total	MOOE	CO	Total	MOOE	CO	Total
2009	27,522,000	2,045,726,000	2,073,248,000	25,522,000	2,166,175,000	2,191,697,000	25,522,000	2,141,175,000	2,166,697,000
2010	27,522,000	3,224,173,000	3,251,695,000	27,522,000	3,485,773,000	3,513,295,000	27,522,000	3,477,733,591	3,505,255,591

Source: General Appropriations Act (GAA) and Status of Appropriations, Allotments and Obligations (SAAOB), Department of Budget and Management

Figure 7. Budget Utilization



**% Alloted is derived by dividing Allotment Released by Appropriations; % Obligated is derived by dividing Actual Obligations by Allotment Released.

Issues

There were many instances where the DOs were issued way before the SAROs were released. It is important that DOH-CO has a SARO on hand since it could not predict how much will be issued by DBM in one Batch. Should the guideline contains amounts higher than the SARO, this could pose a problem. A particular example cited was the case when DOH has to realign its savings from other Bureaus to HFEP because one province already entered into a contract even when the SARO was not issued. To resolve this, NCHFD resorted to realigning funds from DOH-CO.

During the period covered by the study, the bidding and awarding of contract is done by each and every LGU who received the HFEP funds. The NCHFD saw some inefficiencies in this process and is currently revising their guidelines to conduct bulk bidding and procurement at the CHD level.

Utilization rates appear to be high but it should be noted that this stops at the level of the central office giving sub-allotment to CHDs/hospitals. Monitoring of obligation of HFEP funds at the LGU level was a responsibility of the CHDs. Thus, unless the CHD submits its financial report, the Central Office will not know the fund utilization of HFEP. What the Central Office monitors, through the Infrastructure Division of NCHFD, are physical accomplishment report of each facility on reported percentage completion (for infrastructure project) and procurement/delivery status (for equipments).

Monitoring and Control

As part of HFEP Monitoring and Reporting, CHDs are in charge of conducting regular monitoring of Hospital Upgrading Projects for both DOH and LGU hospitals as well as other health facilities. CHDs are also tasked to submit Quarterly Status Reports of physical and financial accomplishment to the Field Implementation and Management Office (FIMO) and providing a copy of which to the NCHFD. Once consolidated, the DOH, through the NCHFD, submits these Quarterly Status Reports to the Presidential

Management Staff, the National Economic Development Authority and other requesting agencies. Sub-allotment Utilization Reports are also submitted by the CHD to the Finance Service.

As mentioned earlier, the Infrastructure Division of NCHFD collects information on percentage completion of infrastructure projects and procurement/delivery status of equipments funded by HFEP. Using this data as proxy for fund utilization, Table 6 shows that a total of 63% of obligated funds in 2009 should have been utilized as of June 2011. Table 7 shows that for HFEP projects in 2010, 6% of the obligated funds are under pre-procurement, 36% are currently undergoing procurement, 34% are currently being delivered equipments and infrastructure projects that are being implemented, while 12% are delivered equipments and completed infrastructure projects. A problem with using this data as proxy is 27% of obligated funds in 2009 and 13% for 2010 are unaccounted for since there appears to be no status report for these projects.

Table 6. Physical Accomplishment Report, 2009

2009	Amount	PERCENT OF OBLIGATIONS
Completed Infra	889,802,000	41.07%
Delivered Equipment	481,895,000	22.24%
On-going Construction	195,170,000	9.01%
On-going Delivery		
TOTAL AMOUNT ACCOUNTED IN PHYSICAL ACCOMPLISHMENT REPORT	1,566,867,000	
ACTUAL OBLIGATIONS	2,166,697,000	

Table 7. Physical Accomplishment Report, 2010

2010	AMOUNT	PERCENT OF OBLIGATIONS
A. PRE - PROCUREMENT		6.21%
Infrastructure	177,590,000	
Equipment	40,013,000	
B. PROCUREMENT		35.68%
Infrastructure	789,538,875	
Equipment	461,168,875	
C. IMPLEMENTATION/DELIVERY		33.56%
Infrastructure	886,033,500	
Equipment	290,371,250	
D. COMPLETED		11.74%
Infrastructure	136,585,000	
Equipment	275,101,500	
TOTAL AMOUNT ACCOUNTED FOR IN PHYSICAL ACCOMPLISHMENT	3,056,402,000	
ACTUAL OBLIGATIONS	3,505,255,591	

Source: Infrastructure Division, NCHFD.

Discussion

A clear monitoring and reporting system for the HFEP does not seem to exist. There is a need to monitor the hospitals and health facilities upgraded in each province for effective allocation of funds. As of June 2011, DOH has given the task of conducting quarterly monitoring to the ExeCom and regional office.

Since one of the bottlenecks in monitoring has been lack of personnel, DOH has allocated some funds to hire more engineers and architects who will monitor facilities and equipment in HFEP. DOH representatives or provincial health teams will also be deployed by CHDs to assist in HFEP monitoring.

Other efforts being finalized is the use of web-based tracking system where information will be uploaded by LGU/CHD engineers so that the Central Office will receive a real time update on HFEP. This effort will be spearheaded by IMS with inputs from the CHDs.

While efforts to use the internet to have a real-time update is laudable, past experience has shown that even when online programs for monitoring and evaluation were developed, it has rarely been used due to problems in interconnectivity and difficulties encountered by CHDs/LGUs in using the program. Rather than developing a new monitoring tool, a more cost-efficient alternative that could be considered is to create a module in the Expenditure Tracking System currently being rolled-out by the Planning Division of Health Policy Development and Planning Bureau (HPDPB). This alternative will also make sure that the physical update will be tied with HFEP fund release updates.

One of the main problems that surfaced is unclear definition of roles of Infrastructure Division of NCHFD, CHDs, and FIMO in monitoring of HFEP projects in 2007-2010. DOH is currently coming up with a Department Order that will explicitly define their roles. DOH has also made HFEP implementation a priority by assigning an overall national HFEP coordinator in the Health Services Delivery Cluster.

The Way Forward

Recommendations

The results of the study suggest:

- *A clearer policy on allocation of HFEP funds needs to be drafted.* The department memorandum on HFEP allocation should be made consistent with the DOH reform agenda of rationalizing health facilities based on health needs. A good program to emulate will be allocation method of the MNCHN program (Annex 4).
- *A need for securing a sustained funding source for HFEP*. Improvements in health facilities are critical in the implementation of the Aquino Health Agenda. Allocation of some HFEP funds in the past appears to have been influenced by requests from some politicians during budget deliberations. According to interviews, these requests were mostly accommodated to ensure funding for the program in the future. Moreover, presence of other fund source, particularly congress and senate initiatives, divert the resources away from provinces who might need upgrading of facilities most. It may be more equitable if reliance on funding the project from such initiatives will be minimized and the source of fund for HFEP be guaranteed from its line item budget in the GAA. Also, one way of assuring that funds get allocated to facilities that are in pipeline for upgrading is to explicitly write the facilities as line item under HFEP in the GAA, especially for higher level facilities that will require substantial budgets.
- *A need for establishing a monitoring and evaluation plan for HFEP*. The monitoring system from 2007-2010 has unclear assignment of responsibilities as to who monitors fund utilization of HFEP. The recent initiative of DOH in issuing a Department Order that will clearly define the delineation of roles of different agents involved in HFEP is a step in the right direction. Existing budget utilization tracking systems such as the Expenditure Tracking System should also be utilized by the monitoring and evaluation group in ensuring that the policy makers in the Central Office receives real-time information on fund utilization and physical accomplishment of HFEP recipients.