Ex post evaluation – Philippines

Sector: Basic health services (12220)
Project: Programme to support the Philippine Health Sector Reform Agenda, BMZ No. 2006 65 109*
Implementing agency: Department of Health, Philippines

Ex post evaluation report: 2019

		(Planned)	(Actual)
Investment costs (total)	EUR million	10.00	11.19
Counterpart contribution	EUR million	0.00	1.37
Funding	EUR million	10.00	9.82
of which BMZ budget funds	EUR million	10.00	9.82

*) Random sample 2017

Summary: This project supported the Philippine government in implementing its Health Sector Reform Agenda (HSRA). In order to strengthen the local governments responsible for providing healthcare to the population following the decentralisation in 1991, the FC loan funded measures to improve the provision of services. These measures included 12 sub-loans and performance-based grants to local government units, which funded measures to improve access to and improve the quality of health services in a total of 21 health facilities. The main investments were the structural renovation and partial extension of the existing facilities and the procurement of medical and non-medical equipment.

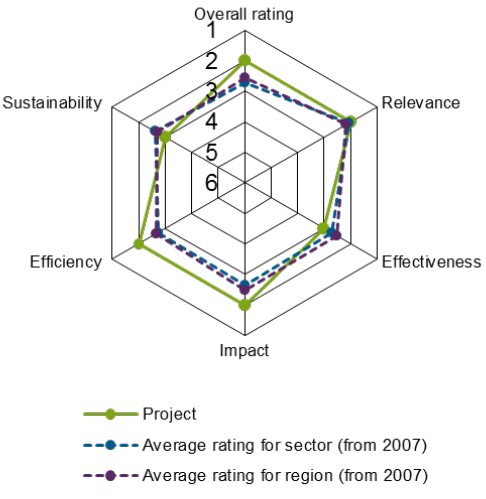
Development objectives: The objective at outcome level was to support the implementation of the Philippine health reform agenda and to improve the services provided by public health institutions. The objective at impact level was to contribute to improving the health of the population, especially the poor, and to contribute to achieving the health-related Millennium Development Goals.

Target group: The target group was the entire population of the participating local authorities and provinces, in particular the poorer population groups as these are primarily dependent on the services of the public health facilities.

Overall rating: 2

Rationale: The project was aligned with national strategies and took into account the support given to the reform programme by other donors. The decentralised strengthening of the services from public health facilities was of particular relevance to the poorer sections of the population. The effectiveness of the measures was reflected in the improved service offerings and the number of users at the facilities, which was mostly growing. In light of the complexity of the project and the reasonable overall costs, efficiency can still be rated as good despite the delay. The ex post evaluation also assessed the developmental impacts as positive, which are reflected in the improved health situation of the provincial population. Sustainability is assessed as satisfactory due to the risk of low operational budgets at municipal level.

Highlights: The funding concept, whereby loans were only granted to local authorities that made their own contribution, led to a significant increase in the investment volume due to the leveraging effect. The performance-based grant component to support the reform process has become a model for projects in other sectors (such as agriculture).



Rating according to DAC criteria

Overall rating: 2

Ratings:

Relevance	2
Effectiveness	3
Efficiency	2
Impact	2
Sustainability	3

General conditions and classification of the project

This programme supported the Philippine government in implementing its Health Sector Reform Agenda (HSRA). In order to strengthen the local governments responsible for providing healthcare to the population following the decentralisation in 1991, the FC loan funded measures to improve the provision of services. These measures included 12 sub-loans to local government units (LGU) and performance-based grants, which were used to invest in a total of 21 health facilities to improve access to and the quality of health services. The main investments were the structural renovation and partial extension of the existing facilities and the procurement of medical and non-medical equipment.

Relevance

The Philippine health reform agenda's three main pillars comprised i) improved access to high-quality public health services at a decentralised level; ii) improved coverage of the financial risks for the population through an increased use of the PhilHealth public health insurance system and improved service provision; and iii) achievement of the Millennium Development Goals (MDG) in the health sector.[1] At the time of the project appraisal (PA) in 2006, the Philippine health sector was making steady improvements, but the milestones set in the Philippine Mid-term Development Plan for 2004 on infant and maternal mortality were clearly missed. Based on the situation at that time, the population's health could only be improved and the MDGs achieved in 2015 with considerable additional efforts. A project intended to improve the quality of care for the population, especially the poor, by improving the services of public health service providers was therefore extremely relevant.

To accelerate implementation, the Philippine government, along with the international donors involved in the health sector (WHO, EU, ADB, Germany and Spain), decided on extensive investment and technical support under the slogan "FOURmula ONE for Health". This was to be initiated in a few provinces and then extended to all provinces of the country. The strategy involved developing comprehensive solutions in the four components of funding, services, regulation and governance, and implementing them in a concerted campaign comprising all partners.

At the time of the PA, the Philippines had largely decentralised, and had established vertical financial equalisation, so that both the provinces and the municipalities had fixed allocations from central government. However, they were also assigned far-reaching tasks, particularly in the health sector, which were not fully covered by financial transfers. Since the municipalities mostly had no tax revenues of their own, the annual budgets were only sufficient to cover the running costs of the healthcare facilities, and there was a lack of funds for additional funding and investment needs. Even though the Department of Health had earmarked certain resources at central level for this purpose, they were not available to the municipalities to a sufficient extent or at the required time. It therefore made sense and was relevant to support the decentralised municipalities in question and to provide funds for infrastructure and equipment so that

[1] The United Nations MDGs were formulated in 2000 and included eight development goals for 2015. Goals in the health sector were: (i) reduce child mortality by two thirds between 1990 and 2015; (ii) combat HIV, Aids, malaria and other communicable diseases; (iii) improve maternal health with a view to reducing maternal mortality by two thirds and universal access to reproductive medicine.

they could improve the provision of healthcare services to the population at a decentralised level, which also meant the facilities could increase income from services reimbursed by PhilHealth. The impact chains underlying this project are thus broadly plausible.

Since too little had been invested in the hospital infrastructure before the decentralisation, and this had been exacerbated in part by the transfer of responsibilities to the decentralised structures, there was a big need for investment to equip public health facilities. The buildings were often in a poor condition and the equipment was outdated, which meant hospitals and public health stations provided poorer quality diagnoses and treatment. While wealthier patients were able to switch to private service providers, poorer patients did not have this option because of the lack of funds. Adequate hospital infrastructure and equipment were therefore basic prerequisites for providing the population with an adequate and high-quality range of government services in the health sector. This benefits the poor in particular as they do not have the means to switch to private service providers.

The project was aligned with national strategies, was part of the coordinated support framework of the donor community and was complementary to the measures of other donors, so as to avoid duplication.

Relevance rating: 2

Effectiveness

The objective at outcome level was to contribute to the implementation of the health reform agenda by improving public health services in the participating provinces.

To review this objective, four indicators were agreed which are suitable for assessing the improvement in the provision of services by the facility or LGU. However, the large number of other actors in the sector programme makes it difficult to determine how FC measures actually contributed to the implementation of the health reform agenda. Nevertheless, at the level of the health facilities or LGU, it is possible to adequately determine the extent to which FC measures specifically improved the health situation, so that the contribution actually made to implementing the health reform agenda can be derived from it and checked for plausibility in the context of the ex post evaluation (EPE).

Indicator	Status PA, target PA	Ex post evaluation
(1) Usage of hospitals participating in the programme (bed occupancy rate)	PA: The bed occupancy rate was between 56% and 162%; on average: 127%*. Target value: Bed occupancy rises to between 80% and 105%.	The bed occupancy rate was between 59% and 256%; on average: 167 %*.
(2) PhilHealth accreditation of participating hospitals	PA: -*** Target value: 100% of the participating facilities are accredited.	100% of the participating facilities have been PhilHealth accredited since 2014. The target value was therefore achieved.
(3) Total number of patient contacts in the programme hospitals	PA: -*** Target value: Patient contacts increased by 20%.	The target value was reached. The number of patient contacts per year increased by an average of 42% at the participating hospitals.

(4) Patients in secondary level hospitals are referred by primary health care facilities	PA: -*** Target value: 75%	The indicator cannot be operationalised because these figures are not systematically collected. Statements on the functionality of the reference system can be derived from data on indicators 1 and 3.

Source: Statistics of the health facilities, final review report 2017, GITEC Report 2015. 10 of the 21 facilities in 6 of the 12 LGUs were recorded and evaluated.

* The distortion of the indicator with bed occupancy rates above 100% was due to the fact the official bed occupancy rate (BOR) is measured by the number of licensed beds, but the larger hospitals have one to two times that number.

** The value relates to the expanded bed capacity after completion of the infrastructure investment.

*** Participating facilities had not yet been designated at the time of the PA.

Indicator (1) shows that the average occupancy rate of the participating facilities (in terms of bed occupancy rate) rose from an average of 127% to 167% between 2009 and 2017. But if one looks at individual facilities, the picture is nuanced. In the larger hospitals (more than 50 beds), occupancy rates rose from 135% to 176% between 2009 and 2017. As the hospital staff also reported, these facilities are being used very well and some are already on the verge of being overutilised. Thanks to the improved and expanded services that can be offered after the renovations/new buildings, the facilities, in particular the Category I to III hospitals, provide not only improved services for the population but also a more attractive offer for private patients, which in turn has a positive impact on revenues and therefore on the hospitals' economic viability.

In the smaller health facilities (5 to 25 beds), the occupancy rate fell from 80% in 2012 to 68% in 2017. But this cannot be attributed to the poor quality of these facilities, rather to the stricter licensing system for health facilities, which has led to a reduction in licensed services and an increase in the number of referrals to the next higher level (see also below).

The use of the supported facilities, as measured by patient contacts (indicator 3), is good overall and a 20% increase in the target value compared with 2009 was achieved almost everywhere for 2017, except in one of the smaller facilities. Interestingly, the number of patients increased throughout almost the entire period up to 2013/14. Although this trend continued in the larger facilities (level I from 50 beds), a declining trend was observed in the smaller facilities. According to the facility managers, this is due to the stricter licensing system and the increased standards for service offerings as well as the consequent downgrading in some facilities (e.g. Carmaran and Bato from "level I" to "Infirmary"). As with the bed occupancy rate, the statistics on patient numbers also show that smaller facilities do not tend be used to capacity, while the larger facilities with their large number of services are visited by many more patients.

This trend also allows conclusions to be drawn about the functionality of the referral system. Even though there is virtually no data on the number of referrals from one level to the next, the high and sometimes even excessive utilisation of the large hospitals and the normal to low utilisation of the small facilities indicate that the referral system does not function sufficiently well. As reported by the heads of the facilities, the system whereby complex cases which cannot or should not be dealt with in the respective institutions are referred to the next higher level does work well. However, many patients arrive at level I and II hospitals who decide to go there directly, and without making a "detour" via small health stations. A reverse referral virtually never occurs, not even in non-complex cases. "Patient´s choice" was cited by hospital staff as the reason. The other economic reason might be that every additional patient means additional income. So the conclusion with regard to the functioning of the referral system is that it works from the bottom up, but not in the opposite direction. Overall, the current system does not therefore produce an optimal balance in the use of facilities at different levels.

All participating facilities were accredited by PhilHealth at the time of the EPE.[2] This means that a certified treatment standard can be offered at the same time that the treatment services of PhilHealth members are covered by the insurance. Indicator (2) is therefore deemed to be achieved. Investment from the project has led to an improvement and, in most cases, an expansion of the range of services offered at the participating facilities, which opens up a wider range of services to patients and allows the facilities to increase

[2] See PhilHealth website:https:\\gis.philhealth.gov.ph.

their income from the services reimbursed by PhilHealth. In addition, the number of PhilHealth members rose from 74% in 2010 to 94% in 2018 of the total eligible population due to extensive packages of measures under the Health Reform Agenda.[3] But despite the steady and successful expansion, the PhilHealth system is very complex and often unclear, both on the supply side (licensing processes, reimbursement procedures, etc.) and the demand side (scope of service package, support options for the poor, etc.) and, as a result, has led to health services not being sufficiently used.

Effectiveness rating: 3

Efficiency

The project was implemented by the Ministry of Health (implementing agency), as the specialist representative ensuring the medical quality and relevance of the measures implemented, and the Ministry of Finance (borrower), which was responsible for granting and forwarding the loans. In addition, the municipal regional authorities were involved in the implementation as end customers of the loans. This organisational structure was very complex and new for the implementing offices of the respective ministries. This led to delays, particularly at the start of the project, but then worked quite well in the implementation stage after the corresponding structures had been developed with the support of the implementation consultant. It was highly likely that efficiency was increased by the municipalities' own contribution and the fact that most of this was loans. This ensured that the planned infrastructure was very close to real needs and that there was interest at implementation level in the cost-efficient implementation of the funds. The implementation was efficient based on the extensive approval process and the clearly structured criteria for the respective individual projects by the Ministry of Finance and the Ministry of Health, with the support of the implementation consultant and final FC approval. The tendering and award processes were carried out by the respective municipalities in line with national rules and closely monitored by the implementation consultant. To compare and evaluate the bids, benchmark values were used, e.g. for construction costs/m²; the construction was supervised by the municipalities, which contributed to the project's efficient implementation overall.

The implementation timeframe was originally planned from 2006 to 2011, but was then extended to the start of 2017. Despite the clear deviation from the original planning, the timeframe can still be considered appropriate and justifiable for the implementation of this complex project. Matters could have been accelerated by more frequent progress checks on the part of FC, as only two progress checks were carried out on site during the entire implementation period (in 2010 and 2015).

Consulting costs rose by almost 94% due to the additional time required, but also due to the need to expand the scope of duties. Nevertheless, the total costs for the international consultant are very low at 7.8% of the FC funds. The average price per square metre for buildings was between EUR 250 and 350 and is reasonable in view of the standard achieved. Overall, the production efficiency is rated good.

The funding concept developed at the start of the programme, which was based on the fact that only municipal authorities willing and able to make their own contribution receive funding, proved to be very efficient. The loan funds received from central government were transferred by the Municipal Development Office of the Ministry of Finance to the local level as a loan/grant mix, which divided the costs between national and local government agencies and measured the municipalities' own contribution against their financial capacity or income class. Besides the technical aspects, proof of their own contribution and the ability to repay the loans were the most important criteria in the evaluation of the applications. Ultimately this approach resulted in 25% of the funds of the individual projects implemented being financed by the municipalities' own funds. The leveraging of equity applied by this financing mechanism led to an increase of almost 20% in the investment volume originally available for infrastructure and equipment, which must be seen as a positive outcome in terms of allocation efficiency. The loan was already being repaid at the time of the EPE and is within the contractually agreed timeframe. Another positive aspect with regard to allocation efficiency is that poorer sections of the population in particular benefit from the insurance benefits. Furthermore, performance-based grants for investment in additional construction measures and

[3] See PhilHealth Statistical Reports in 2010 and 2018.

equipment were awarded to the LGUs, which served as an incentive and motivation for implementing the HSRA and developed models for other projects.

Efficiency rating: 2

Impact

The project's ultimate development objective was to contribute to improving the health of the population in the participating provinces. The indicators for the ultimate objective set at the appraisal were that the MDGs of maternal and child mortality should be achieved in the participating LGUs. In principle, these are suitable indicators. But under the EPE, trends related to morbidity and the field of maternal and child care should also be considered to be able to check the plausibility of the contribution made by the FC measure to the change in the overall situation.

Indicator		2007	2010	2012	2013	2014	2015	2016
(1) Infant mortality rate (less than 26.7 deaths per 1,000 live births)	National	9.2	8.69	8.68	8.13	8.3	7.91	8.15
	Programme provinces	6.98	5.5	7.2	7.05	5.99	5.73	5.74
(2) Child mortality rate under 5 years (19 deaths per 1,000 live births)	National	N/A	N/A	11	10.8	11.65	10.93	11.49
	Programme provinces	N/A	N/A	9.97	10.11	8.53	7.7	6.72
(3) Maternal mortality (less than 52 deaths per 100,000 live births)	National	60	65	64.76	69.88	73.89	73.63	66.51
	Programme provinces	77.5	73.12	76.1	74.02	73.47	106.97	67.91
(4) Percentage of specialist-assisted births	National	32.8	43.23	67.64	74.79	81.22	85.5	88.67
	Programme provinces	36.62	44.59	61.89	71.03	73.02	76.80	89.49
(5) Postnatal care (with at least 2 postnatal visits)	National	N/A	53.33	52.71	61.48	65.28	61.82	60.97
	Programme provinces	N/A	53.71	58.97	68.72	70.8	69.75	66.87

Source: Field Health Service Information System Annual Reports 2009-2016.

Looking at the health situation at the level of the participating programme provinces, infant mortality has fallen by 18% since 2007 and child mortality by 33% since 2012. The result was within the targets for MDG 4, which set a maximum of 19/1,000 live births for infants and 26.7/1,000 live births for children under five years of age. Maternal mortality has also improved and fallen by 12% since 2007 in the participating provinces, but does not meet the MDG target of less than 52 deaths per 100,000 live births.

If one compares the provincial averages with the national averages, it is clear that infant and child mortality rates in the provinces in 2016 were below the national averages. Although the maternal mortality rate in the programme provinces was even higher in 2007 than nationally, the rate had largely converged in 2016. Even though this development cannot be attributed exclusively to the project due to the large number of influences, it can nevertheless be used as an indicator that the sector reform programme was successful in these provinces.

As shown in the table above, the proportion of specialist-assisted births improved from 37% in 2007 to 89% in 2016, and postnatal care in the programme provinces steadily increased from 54% in 2010 to 67% in 2016. This trend is directly linked to the establishment and improvement of decentralised health centres and maternity wards, which was promoted under the project and the health reform agenda. In terms of

birth control and the fertility rate as well, decentralised agencies made an important contribution; the fertility rate at national level fell from 3.5 in 2003 to 2.7 in 2017.

The development and implementation of the "Performance-Based Grant" component, in which grants to individual LGUs were linked to specific performance in the health sector, was a novelty in the cooperation between national structures of the Ministry of Health and local administrations. It has evolved into a very innovative and effective tool and has also become a model for other projects beyond the scope of the project.

Impact rating: 2

Sustainability

All the health facilities funded by the project were in operation at the time of the EPE, and the unused premises noted in the final review are now being used as planned. The hospitals in Lanao del Norte and Zamboanga, which were still unfinished at the time of the final review, are also fully operational and used for the intended purposes. There were no serious negative effects on efficiency and sustainability because of the delay in the completion and commissioning of the hospitals in Lanao del Norte, since the deviations from the original plans included an increase in the square metres built and the additional costs incurred were fully borne by the municipal authority in question.

Moreover, the procured medical equipment (ultrasound equipment, monitors for intensive care units, incubators, equipment for operating theatres, etc.) and the procured equipment (beds, wheelchairs, laboratory accessories, office equipment and generators) were, with a few exceptions, in regular use and in a good state of repair. There are maintenance contracts for larger devices.

The quality of construction and execution can be described as appropriate given the investment costs/m². However, with regard to any foreseeable weaknesses with maintenance and repair, it was too low; in some cases, a certain deterioration was already clearly visible (especially in buildings that had been used for more than six years). Despite complying with Ministry of Health regulations, weaknesses in the infrastructure planning process were noted, some of which had the effect of reducing the sustainability of investments and, in some cases, resulted in major repairs only a few years after completion.

After construction measures are completed for hospitals or health stations, these fall completely under the responsibility of the municipal administration in question and it is their responsibility to provide the necessary funding for operations. However, the budgets provided for them by central government and their own tax revenues, which are usually quite limited, do not increase to the same extent as the number and services offered by the health facilities. This is a major challenge for most municipalities and often leads to the underfunding of the facilities, especially since the provision of funds is usually based not only on technical and medical necessities, but is also dependent on the respective provincial government’s priorities and party-political considerations. While funds were usually provided by the provincial government for acute repair needs or in the event of natural disasters, budgets for running costs (wages, salaries, maintenance and upkeep) were rarely in line with needs or demands. Overall though, sustainability in terms of maintenance and upkeep can only just be rated as satisfactory. Nonetheless, the quality and attractiveness of public buildings could be significantly improved if the maintenance of these buildings were also adequately addressed, as demonstrated, and impressively so, by facilities in the private sector.

An external risk and an additional burden in terms of sustainability are common with natural disasters such as typhoons, tsunamis and earthquakes. After the devastating typhoon Yolanda in 2013 in particular, many lessons were learned and corresponding disaster preparedness plans were developed, which now have to be implemented by all regional administrations.

Sustainability rating: 3

Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being **relevance, effectiveness, efficiency** and **overarching developmental impact**. The ratings are also used to arrive at a **final assessment** of a project's overall developmental efficacy. The scale is as follows:

Level 1	Very good result that clearly exceeds expectations
Level 2	Good result, fully in line with expectations and without any significant shortcomings
Level 3	Satisfactory result – project falls short of expectations but the positive results dominate
Level 4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
Level 5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
Level 6	The project has no impact or the situation has actually deteriorated

Rating levels 1-3 denote a positive assessment or successful project while rating levels 4-6 denote a negative assessment.

Sustainability is evaluated according to the following four-point scale:

Sustainability level 1 (very good sustainability): The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The **overall rating** on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a "successful" project while rating levels 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally "successful" only if the achievement of the project objective ("effectiveness"), the impact on the overall objective ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (level 3).