INTERNATIONAL BUDGET PARTNERSHIP
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Budget Credibility in the Philippines' Health Sector:

Regional Comparisons and Case Studies

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Paper

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GLOSSARY OF ACRONYMS

AOP – Annual Operational Plans
ARMM – Autonomous Region of Muslim Mindanao
BAC – Bidding and Awards Committee
BHUs – barangay health units
Bicam – Bicameral Conference Committee
BUR – budget utilization rates
CHDs – Centers for Health Development (regional DOH offices)
CI – congressional insertions
CO – capital outlays
CONAP – Continuing Appropriations
DBM – Department of Budget and Management
DOH – Department of Health
DOH-CO – Department of Health – Central Office
DOH-OSEC – Office of the Secretary, Department of Health
DPRI – Drug Price Reference Index
FAR – Financial Accountability Report
GAA – General Appropriations Act
GAARD – 'General Appropriations Act-as-Release Document' policy
GAB – General Appropriations Bill
GAS – General Administration and Support
HFDB – Health Facilities Development Bureau
HFEP – Health Facilities Enhancement Program
HOR – House of Representatives
LFP – Locally Funded Projects
LGUs – Local Government Units
LHSDA – Local Health System Development Assistance
MFO – Major Final Outputs
    MFO1 – Health Sector Policy Services
    MFO2 – Technical Support Services
    MFO3 – Hospital Services
    MFO4 – Health Sector Regulation Services
MOOE – appropriations for maintenance and other operating expenses
NCR – National Capital Region
OPIF – Organizational Performance Indicator Framework
P/CIPH – Province-wide and City-wide Investment Plans for Health
PAPs – programs / activities / projects
PBIS – performance-based incentive system
PHTLS – Provincial Health Leaders
PNF – Philippine National Formulary
PPBDC – Program Planning Budget Deliberation Committee
PREXC – Program Expenditure Classification
PS – personnel services
RHUs – rural health units
SAAODB – Statement of Appropriations, Allotments, Obligations, Disbursement, and Balances
SARO – Special Allotment Release Orders
SPFs – Special Purpose Funds
STO – Support to Operations
WFP – Work and Financial Plan

EXECUTIVE SUMMARY

Big increase in health funding, but…

Fueled by the introduction of a dedicated sin tax, the budget of the Philippines' Department of Health (DOH) rose almost five-fold between 2010 and 2018. These additional funds were primarily targeted for health insurance premiums for indigents and members of the informal economy, but a substantial amount (about 26% in 2018) was earmarked for public health programs and the enhancement of health facilities. Globally, as many countries strive to achieve universal health coverage by 2030, this massive influx of funding into the Philippines' health sector is typically celebrated as a critical victory towards improving health access.

Of course, for budgets to have an impact, the money must be spent. And, during this same period, the Philippines' Department of Health (DOH) struggled to utilize its full budget: **unused** DOH funds per year grew from 5.4 billion pesos in 2012 to 16.1 billion pesos (in 2016), before levelling off at 9 billion pesos in 2018 (Roxas, 2019).

The majority of the DOH budget is executed directly by the Office of the Secretary (DOH-OSEC), which includes regional DOH offices known as Centers for Health Development (CHDs). CHDs are responsible for the field operations of the Department, executing DOH-Central Office (DOH-CO) programs/activities/projects in each region, as well as coordinating with other agencies for health-related concerns and supporting health programs of Local Government Units (LGUs).

These regional CHDs exhibit considerable underspending, as well as a high degree of variation in their degree of budget credibility. Table EX-1 shows average expenditure (disbursement) in two ways – both including and excluding 2016, an election year with particularly low spending. The table demonstrates that capital expenditure (CO, capital outlays) is the main area of underspending, followed by maintenance and other operating expenses (MOOE). Capital expenditure levels are exceedingly low. Additionally, the data show surprisingly low levels of personnel services (PS) execution in the National Capital Region (NCR) and in Region IV-A.

The biggest area of underspending occurs in what is known in the Philippines as *Major Final Output 2 (MFO2): Technical Support Services*. Where does this money go? MFO2 allotments are for both maintenance and operations (53 percent) that are directed at training/capacity building and commodity support for public health programs, and capital outlays (47 percent) for the construction and enhancement of health facilities through the government's Health Facilities Enhancement Program (HFEP).

TABLE EX-1: Summary classification of regions by average disbursement rates, per expense class, 2015 to 2018

	Personnel Services (PS)		Maintenance and other operating expenses (MOOE)		Capital outlays (CO)	
	average w 2016	average w/o 2016	average w 2016	average w/o 2016	average w 2016	average w/o 2016
NCR	73%	73%	45%	50%	13%	17%
CAR	99%	99%	78%	77%	47%	57%
Region I	97%	96%	89%	88%	39%	42%
Region II	99%	99%	85%	87%	25%	22%
Region III	97%	97%	70%	71%	10%	12%
Region IV-A	68%	70%	41%	42%	36%	48%
Region IV-B	99%	99%	90%	91%	20%	11%
Region V	97%	99%	68%	68%	30%	37%
Region VI	102%	103%	62%	61%	8%	10%
Region VII	98%	98%	78%	77%	2%	1%
Region VIII	94%	92%	66%	67%	14%	17%
Region IX	97%	96%	65%	67%	7%	7%
Region X	98%	97%	64%	65%	9%	7%
Region XI	98%	99%	72%	76%	14%	17%
Region XII	98%	98%	74%	79%	17%	20%
Region XIII	96%	95%	57%	60%	30%	38%

Note:

High	*Average*	*Low*

What is at the root of regional underspending?

What are the drivers of this underspending? In order to better understand the causes of poor budget credibility in the Philippines' health sector, we undertook an analysis of five (of the total 15) regions with different spending patterns. Based on a review of documents and interviews, we conclude the following:

1. **All five CHD regional offices cited similar constraints to spending on technical support services or MFO2. Thus, variations in MFO2 CO disbursement rates must be driven by the varying intensity of these constraints within each region.** Further research would be needed to isolate the impact of these factors on spending outcomes.

2. **The following factors affect regional budget implementation, with varying intensity across regions:**

   (i) Congressional intervention in the identification of *Health Facilities Enhancement Program* projects per province or region, and the response of the CHDs to these insertions;

(ii) Unique supply-side constraints which have not been fully accommodated by the Health Department's central office (DOH-CO) policy – such as the need for different cost standards in different regions – notably, for example, in regions composed of island provinces where weather variability combined with topography are significant cost drivers;

(iii) Differences in the various CHDs' approaches to the execution of the capital budget, i.e., whether to offload implementation of infrastructure projects to local government units (LGUs), to the Department of Public Works and Highways (DPWH), or to carry them out directly;

(iv) Other differences in fund management capabilities, including the degree to which regional officials can effectively take advantage of mechanisms like pooled funding; and

(v) Though difficult to observe directly, the quality of oversight of the regional office of the Commission on Audit (which may determine whether and how a CHD director will redeploy savings).

3. **The factors above are, however, less significant than the degree to which regional CHDs have direct control over their budgets.** CHDs receive three types of funding. Regional office budget lines are directly released to and controlled by CHDs. But the other two types of funding (central office programs with "regional distribution" and "regional sub-allotments") are subject to more direct control by the central office in terms of their use and flow. "Regional sub-allotments" are effectively central spending that is offloaded onto regional offices during the year, disrupting their budget execution plans and leading to lower credibility.

4. **It is also possible that the health department has hit its overall absorptive capacity limit.** Put another way, there may be too much money for the DOH to handle efficiently or effectively.

Does this underspending matter? Do we really know?

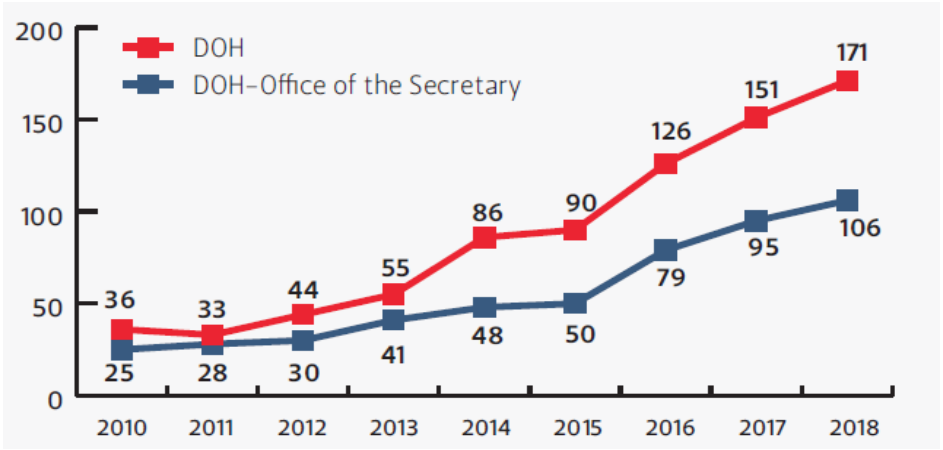
What impact does underspending have on service delivery measures? We find no impact of underspending on service delivery indicators, many of which are met at more than 100% of target, even when there is underspending. This suggests that indicators and targets may be inappropriate or insufficiently ambitious. These findings are consistent with others from the IBP credibility initiative, and the IBP Program Based Budgeting project, that raise questions about the degree to which performance indicators and targets are useful measures of government services in most countries. In any case, as the Philippines continues to roll out its approach to program-based budgeting, there is clearly scope for revisiting and improving upon the country's indicator framework.

1. MOTIVATION[1]

Between 2010 and 2018, the budget of the Department of Health (DOH) rose almost 5-fold from 36 billion in 2010 to 171 billion in 2018.[2] The primary driver of this increase was a 2012 reform of sin taxes which kicked in in 2014, providing the DOH with P30 billion in incremental funds, a figure that increased to P71.2 billion in 2018. The funds are primarily used for health insurance premiums for indigents and members of the informal economy – amounting to about 67% in 2018 - but a substantial amount (about 26% in 2018) is earmarked for public health programs and health facilities enhancement.[3] The Department has been struggling to utilize its budget however: between 2012 and 2018, unused DOH funds per year grew from 5.4 billion in 2012 to 16.1 billion (in 2016) then levelled off at 9 billion in 2018 (Roxas, 2019).

The DOH budget is executed by the Office of the Secretary (DOH-OSEC), attached agencies and attached corporations (Figure 1). In 2018, DOH-OSEC accounted for 62 percent of the total DOH Budget; attached agencies accounted for 0.71 percent; and corporations, 37.3 percent (of which 35.4 percent was released to the Philippine Health Insurance Corporation for the National Health Insurance Program.) In other words, after allocations to corporations, the DOH-OSEC accounts for roughly 99 percent of the total budget. Observed 'underspending' by the Department has to do with amounts released to DOH-OSEC.[4]

FIGURE 1: THE DOH BUDGET 2010 – 2018, IN BILLION PESOS



Source: DBM Budget Brochure 2018. Notes: DOH refers to the DOH-Office of the Secretary, Attached Agencies and Attached Corporations. DOH-OSEC includes the Central Office, Regional Offices, DOH Hospitals and Treatment & Rehabilitation Centers.

[1] Submitted by T. Monsod, with associates Jenah Flor Lagdameo, Zyraliyn Oblefias, Katherine Pilapil, Mia Soriano, and Anne Payumo.
[2] DOH Budget Briefer FY 2019 available at https://www.doh.gov.ph/sites/default/files/publications/2019-Budget-Briefer.pdf
[3] The implementing rules of the law require that 80% of the Sin Tax Incremental Revenue for Health is allocated to expenditure items related to Universal Health Care, programs contributory to the attainment of MDGs, and Health Awareness, while the balance of 20% is allocated for Medical Assistance and Health Facilities Enhancement.
[4] Appropriations to government corporations, once released, are booked as spent by the National Government.

The DOH-OSEC budget is shared by Central Office units (DOH-CO), Regional Offices, DOH Hospitals (Metro Manila, Special and Regional) and Treatment and Rehabilitation Centers (TRC), but the bulk of that budget – an average of 69 percent of new appropriations between 2015 and 2018 – is allocated to DOH-CO and Regional offices combined. [5] Prior to 2014, budgets for public health programs were assigned to DOH-CO, which sub-allotted amounts for the execution of these programs to the fifteen regional offices, also known as Centers for Health Development (CHDs). [6] (**Annex A**) However, in 2014, public health programs were required to have a regional breakdown and regional line items became part of the allotments directly available to CHDs from the Department of Budget and Management (DBM) at the beginning of the year, over and above their regular budget line items.[7] To provide a very rough idea of the resulting shift in the allotment of funds, amounts for DOH-CO accounted for about 71 percent on average of the Department's total expenditure program between 2008 and 2013 but about 43 percent on average between 2014 and 2018. [8]

DOH has cited several factors to explain its slow spending. It claimed that almost half of the health facilities enhancement funds in 2013 was unused owing to the requirements of disaster response (e.g. Bohol earthquake, Typhoon Haiyan, among other events) that occupied CHDs and Hospitals. Low obligations for the purchase of medicine and health facilities infrastructure and equipment in 2014 and 2015 were attributed to poor planning and management of procurement (e.g. weak staff capacities, problems in procurement scheduling, change in or incorrect technical specs and costing) as well as procurement bottlenecks (e.g. incidents of failed bidding; insufficient bidding requirements, delays in bidding). Difficulties in the hiring of doctors and nurses have also been cited to explain the underutilization of funds for human resources for health.

Less is known about the spending performance of the regional CHDs – hence this report. CHDs are responsible for the field operations of the Department, executing DOH-CO programs/activities/projects (PAPs) in each region, as well as coordinating with other Departments/offices and agencies for health-related concerns and supporting health programs of Local Government Units. Apart from providing a more complete picture of the absorptive capacity of the DOH, understanding CHD spending and the variations in spending rates across CHDs, and unpacking spending performance by PAP, can potentially help sort binding from non-binding constraints to DOH budget execution as a whole (e.g. to what extent operational innovations can facilitate spending given structural constraints) as well as provide a better appreciation for the effects of spending on service delivery goals, especially equity goals.

[5] Rough estimate by the author based on the average of new appropriations from 2015 to 2018.

[6] Excluding the Bangsamoro Administrative Region in Muslim Mindanao

[7] Specifically, three: Support to Regional Delivery of Services, Local Health Systems Development and Assistance (LHSDA), and Regional Health Regulations. More on this in Section II.

[8] This is a very rough estimate just to provide an idea of how the assignment of expenditures has shifted. This is based on the annual Budget of Expenditures and Sources of Finance (BESF) which is the only document that shows a summary of the expenditure program by department and region (i.e. Table B.8 or B.9). The portion to DOH-CO is assumed to be amounts listed under "Nationwide" and "Central", which would also include budgets of attached agencies (accounting for an insignificant portion) but not attached corporations (which are listed in a separate line item in said BESF Table). Amounts for CHDs would be as listed per region.

Methodologically, there was a choice between examining annual *obligations* or annual *disbursements* (relative to current year *allotments* [9]) as a measure of spending. On the one hand, budgeting in the Philippines has long been obligation-based, i.e. agencies propose an expenditure program based on amounts that can be contracted out rather than disbursed *per se*. The national expenditure program, defined as "the ceiling on the obligations that could be incurred by the government in a given budget year", is proposed to Congress by the President, which becomes the basis for a General Appropriations Act (GAA). The GAA has also been obligation-based therefore and, up to FY 2016, appropriations for maintenance (MOOE) and capital outlays (CO) had a two-year validity (e.g. if not released in the current year, or if allotments were not obligated, amounts could be authorized as Continuing Appropriations or CONAP in the succeeding year).[10] Thus "expenditures" has been, and continues to be, synonymous with "obligations" and budget execution by agencies has been measured using an obligation-based budget utilization indicator, i.e. current year obligations as a percentage of current year allotments.

On the other hand, concern for actual spending has been building since 2012[11] and a **disbursement-based budget utilization measure** (ratio of total disbursements, cash and non-cash, to total obligations for maintenance and capital outlays) was adopted in 2013 as a strategic performance indicator common to all departments/agencies under the government's performance-based incentive system (PBIS).[12] The PBIS was part of a broader set of reforms, started in 2011, to install an integrated and unified 'Results-based Performance management System' for the government, including major budget reforms to precisely "ensure faster and efficient budget execution and strengthen performance budgeting" so that "each peso spent is in line with approved appropriations and leading [sic] to measurable results". Among the other major reforms was the 'General Appropriations Act (GAA)-as-Release Document' policy (or GAARD), instituted in 2014, which "enabled the enacted Budget to serve as the allotment release document for the respective appropriations of agencies, except for those in the negative list…". That is, the GAA, itself, became an allotment order, "allowing agencies to enter into contracts and obligate funds on the first working day of the fiscal year".[13]

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[9] *Allotments* are "authorizations issued by the Department of Budget and Management (DBM) to an agency, through authority contained in the General Appropriations Act (GAA) or the release of a Special Allotment Release Order (SARO), permitting the agency to commit/incur obligation and/or pay out funds within a specified period of time, within the amount specified for the purpose indicated therein." (Glossary, BESF 2015 at https://www.dbm.gov.ph/wp-content/uploads/BESF/BESF2015/GLOSSARY.pdf). There are adjustments made to *authorized appropriations* as well as to allotments during the year so that, in the end, the relevant amount for which budget utilization is measured is *adjusted allotments.*

[10] *Continuing appropriations* are authorizations that support obligations (expenditures incurred and committed to be paid by the government) for a specific purpose or project, even when these obligations are incurred beyond the budget year (Glossary, BESF 2015). The GAA for FY 2013 and 2014 provided for a one-year validity, but the former was extended by Congress, and the latter was diluted as it allowed for payments for "unbooked obligations of prior years."

[11] This was not really a new concern. However, the tight fiscal space between 1987 and 2010 directed attention to the revenue side of the budget rather than the expenditure side. Fiscal space widened considerably after 2010, forcing into the spotlight budget execution problems. See Monsod 2015.

[12] Memorandum Circular No. 2013-01 and 2012-01-A Guidelines on the Grant of the Performance-Based Incentives for Fiscal Year 2013, p. 4, as amended. Accessed from https://www.officialgazette.gov.ph/downloads/2013/09sep/20130930-AO25-MC-2013-01-A.pdf *Non-cash disbursements* are the settlement of government obligations for non-cash transactions such as for "direct payments made by international financial institutions to suppliers and consultants of foreign assisted projects." See Glossary, BESF 2015.

[13] DBM 2014: pp. 8-11 (https://www.dbm.gov.ph/wp-content/uploads/Reports/_2014%20Annual%20Report%20as%20of%20oct%2027.pdf) Other reforms were the disaggregation of lump-sum finds, the introduction of cashless and checkless disbursement schemes, and procurement innovations.

Following from these efforts, DBM formally proposed legislation in 2017 to shift to an annual cash-based budget with a one-year validity.[14] The shift was expected to

> *"… speed up budget execution through prompt payment of goods and services delivered and rendered within the fiscal year, as well as improve* ***budget credibility*** *or the degree of deviation between what was planned and the actual spending in a fiscal year."* (DBM 2017 Annual Report, emphasis added) [15]

Even without a law, however, the DBM adopted a one-year validity of appropriations for FY 2017, which meant that unused appropriations and unobligated allotments reverted back to the General Fund by December 31 (i.e., rather than become CONAP for FY 2018). [16] The DBM continued to adopt this rule for FY 2018; and, for FY 2019, the President proposed the first-ever Cash-based National Budget to Congress. The FY 2019 budget did not pass as planned, however; Congress pushed back on the shift to a cash-based budget and removed some provisions, delaying the ratification of the GAA until February 2019.[17] In the end, the President reiterated the implementation of an "operational cash budget for FY 2019" in his April 2019 veto message but comprised, allowing the implementation of, and payment for, infrastructure projects to extend until December 31, 2020, "provided that the funds for such purpose are not obligated later than December 31, 2019."[18]

We assume an impending shift to cash-based programming and a continuing concern for budget credibility and, consequently, focus on disbursements, treating obligations as a driver of disbursements. The DOH itself is interested in disbursement rates, recognizing it as the main measure of absorptive capacity under a cash-based regime.[19] There is also a wider variation in disbursements than in obligations among CHDs, which is not unusual: commitments are easier to deliver than actual spending (e.g., it is enough to find a contractor; project implementation can commence much later).

We proceed by using data obtained from DOH-CO to examine CHD disbursements relative to allotments for the years 2015 to 2018, in the aggregate and by general expense class: personnel services (PS), maintenance and other operating expenses (MOOE), and capital outlays (CO). We then select five CHDs with relatively high-, low- or

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[14] Annual appropriations would limit incurring obligations and disbursing payments for goods delivered and services rendered, inspected and accepted within the current fiscal year. Payments of these obligations shall be made until the Extended Payment Period or within three (3) months immediately succeeding the end of the preceding fiscal year (Glossary, BESF 2019 at https://www.dbm.gov.ph/wp-content/uploads/BESF/BESF2019/GLOSSARY.pdf))

[15] https://www.dbm.gov.ph/wp-content/uploads/Reports/2017-Annual-Report.pdf

[16] The DBM's initial attempt at limiting the availability of funds to only one year was for FY 2013 (Section 63 of the GAA) which was reiterated in the President's Affirmation Message. Due to the abolition of the Priority Development Assistance Fund – essentially a pork barrel fund - in the same year, Congress issued a resolution suspending the one-year availability of appropriations to allow using available 2013 PDAF including calamity funds in 2014. Section 17 of the 2014 GAA still referred to the same on-year availability although the provision was slightly relaxed, allowing for "payment of unbooked obligations incurred in prior years". in the 2015 and 2016 GAA, the availability period was reverted to two years (HPDP 2017).

[17] Among others, lawmakers perceived that having a cash-based budgeting system means less funds to build projects that may take more than one year to construct, implement, and pay for, like classroom buildings, health facilities, and irrigation projects, although the DBM explained this was not the case because such projects could obtain a multi-year obligational authority. See, among others, https://www.rappler.com/nation/209191-lawmakers-cross-party-lines-resolution-oppose-cash-based-budget-2019.

[18] The reason for the extension was the late passage of the FY GAA and the election ban in connection with the May 2019 elections. The President's veto message is available at https://www.officialgazette.gov.ph/downloads/2019/04apr/20190415-VETO-RA-11260.pdf.

[19] Sin Tax Law Incremental Revenues for Health Annual Report 2018, p. 9. https://www.doh.gov.ph/sites/default/files/publications/2018%20Sin%20Tax%20Incremental%20Revenue%20Report.pdf

average- levels of disbursements relative to allotments as subjects of case studies and unpack spending by P/A/P using data obtained from the CHDs directly and interviews with current and past CHD officials.

We find the following:

1. The sheer size of MFO 2 or Technical Support Services makes it the most relevant component of the CHD budget. Across the five CHDs studied, MFO 2 claimed the largest share of adjusted allotments among all PAPs, ranging from 85.1 percent to 90.4 percent, or an average of 87.1 percent. It also accounted for the largest share of current year unspent adjusted allotments for MOOE (average of 75.9 percent), CO (average of 96.9 percent) and in the overall (89.6 percent). MFO2 allotments are both MOOE outlays (roughly 53 percent on average), directed at training/capacity building and commodity support for public health programs, and CO outlays (47 percent on average), for the construction and enhancement of Health Facilities.

2. Constraints to MFO2 spending that were cited by the five CHDs are largely common constraints. Thus, variations in MFO2 CO disbursement rates must be driven by the **intensity** of these constraints. Specifically (i) differences in the intensity of congressional intervention in the identification of HFEP projects per province or region, and the response of CHDs to these insertions (such as in CHD VI or CHD I); (ii) unique supply-side constraints which have not been fully accommodated by DOH-CO policy (such as the need for different cost standards in CHD IV-B, composed of island provinces where weather variability combined with topography are significant factors); (iii) differences in a CHD's approach to the execution of CO outlays, i.e. whether or not to offload the funds for the implementation of infrastructure projects to LGUs or to the Department of Public Works and Highways (DPWH) (such as in CHD VI versus CHD IV-A) and (iv) other differences in CHD management, including the degree regional officials are able to leverage budget provisions, within audit rules, to the CHDs advantage (such as in CHD IV-A). Other contextual idiosyncrasies may be at play, such as the quality of oversight of the regional office of the Commission on Audit (which may determine whether and how a CHD director will redeploy savings). It is not possible to isolate the incremental effects of these factors per CHD studied in a *ceteris paribus* fashion however.

3. Zooming out, it seems to matter for CHD spending if allotments are for either (i) regular "regional offices budget line items", (ii) DOH-CO programs "with regional distribution" which DOH-CO units are in-charge, and (iii) sub-allotments from DOH-CO during the fiscal year. The first two are directly released to CHDs by the DBM, but CHDs have both allocative and disbursement control over the first item only; CHDs have no allocative control over the second. CHDs may have both allocative and disbursement control over the third item depending on what PAPs these are for. However, the third item is typically disruptive in any case since, by definition, sub-allotments are not anticipated or programmed into annual CHD workplans.

Of the total allotments CHDs receive, "regional offices budget line items" account for only (roughly) 23.3 percent.[20]

4. It also appears that, relative to factors that cause regional variations in spending, larger structural issues (such as the distinction between allocative and disbursement control) remain far more binding or influential to spending performance, limiting the ability of CHDs to disburse in the overall. In four years of CO disbursements by 16 CHDs (or 64 data points), there were only five instances when CO disbursements were greater than 58% of CO adjusted allotments.

5. It is also possible that DOH-OSEC has hit its absorptive capacity limit. Put another way, there may be too much money for the DOH-OSEC to handle efficiently or effectively.

The rest of this Report is organized as follows. Section II provides more context, describing how the DOH budget is prepared, while Section III describes the data and methods used. Section IV presents average disbursement rates per CHD for the period 2015 to 2018 in the overall and by general expense class, while Section V looks more closely at five CHDs which are identified as fast, slow or average spenders. Insights from the five case studies are consolidated and larger structural issues discussed in Section VI.

2. DOH BUDGETING PARAMETERS AND PROCESSES

The mandate of the Department of Health (DOH) is to "provide assistance to local government units (LGUs), people's organizations (POs), and other members of civil society in effectively implementing programs, projects and services that will [i] promote the health and well-being of every Filipino; [ii] prevent and control diseases among populations at risks; [iii] protect individuals, families and communities exposed to hazards and risks; and [iv] treat, manage, rehabilitate individuals affected by disease and disability."[21] This is based on the 1987 Constitution (Art II, Sec. 15), the 1987 Administrative Code (EO 292), and especially the Local Government Code of 1991 (Republic Act 7160), which devolved the management and delivery of basic health services to locally elected provincial, city and municipal governments. [22]

[20] The regional budget line items are (i) Support to regional delivery services, which accounts for almost 100% of STO allotments, or 5% of total AA; (ii) Local Health System Delivery Assistance (LHSDA) under MFO2.1, accounting for 19.6 percent of MFO2, or 17.1 % of total AA, and (iii) Regional health regulations, accounting for almost 100% of MFO 4 allotments, or 1.2 % of total AA.

[21] See various DOH Budget Briefers such as https://www.doh.gov.ph/sites/default/files/publications/2017-Budget-Briefer.pdf

[22] RA 7160 left the DOH with the following functions: (i) develop policies and standards for quality health, (2) regulate health facilities, products and services for safety and quality and (3) assist LGUs during emergencies, epidemics, pestilence and other widespread public health danger and assume direct supervision when necessary.

Operationally, DOH is guided by a 3-level hierarchy of outcomes, known as its Organizational Performance Indicator Framework (OPIF), which serves as the logical framework for results-oriented budgeting and performance management.[23] DOH's outcomes are **societal** ("poverty reduction and improved quality of life"), **sectoral** ("improved health status of the population", "desired population growth and distribution") and **organizational** (improved access to, and improved quality of, preventive primary health services, hospital services, health products/devices/facilities, and social health insurance), and strategies to achieve the third level of outcomes - organizational - are linked to what are called Major Final Outputs (MFOs).[24] MFOs are what departments and agencies are mandated to deliver to their external clients/stakeholders through programs/activities/projects (PAPs).[25]

In 2012, annual budget preparation and execution forms issued by the DBM were refined to be explicitly organized around agency MFOs and their respective performance indicators.[26] The MFOs of DOH are:

MFO1: **Health Sector Policy Services**, referring to the issuance, review, and updating of policies (such as policy issuances, plans and memoranda of agreements) that concern LGUs and other partners;

MFO2**: Technical Support Services**, referring to 'human resources for health' training/capacity building support for LGUs and other partners; funding support for health facilities and equipment (also known as the Health Facilities Enhancement Program or HFEP) intended for LGUs and other partners; and disease prevention and control, which is, primarily, the provision of commodities and services (vaccinations, doctors, nurses, midwife hours) to LGUs and other partners for various public health programs;

MFO 3: **Hospital Services**, referring to services of DOH hospitals and drug treatment and rehabilitation centers, which is measured by out-patients, in-patients, elective surgeries, emergency surgeries, and death rates; and

MFO 4: **Health Sector Regulation Services**, comprising licensing/regulation/accreditation, monitoring and enforcement.

These MFOs are PAPs under the "Operations" component of the DOH budget. Three other major components/PAPs are "General Administration and Support" (or GAS) and "Support to Operations" (or STO), which have performance indicators common to all agencies (such as budget utilization rates (BUR) under GAS), and "Locally Funded Projects" (or LFP). For FY 2018, the MFO classification was transformed into a *Program*

[23] DBM Circular Letter 2012-9 (https://www.dbm.gov.ph/wpcontent/uploads/Issuances/2012/Circular%20Letter/ CL%202012-9.pdf
[24] DOH Budget Briefer FY 2016, p. 4.
[25] Thus, the OPIF "focuses the efforts and resources of spending agencies on high impact PAPs at reasonable cost and quality." (DBM Circular Letter 2012-9).
[26] DBM 2012 Annual Report (https://www.dbm.gov.ph/wp content/uploads/Reports/2012%20Annual%20Report.pdf).

Expenditure Classification (PREXC) with organizational outcomes (OOs) rather than MFOs. For purposes of this report however, we retain the MFO Classification.[27]

2.1 DOH BUDGET PREPARATION AND CONSOLIDATION

The DOH OPIF does not indicate which MFO is more or less important or how funds are to be allocated across them, however. Rather, annual allocations per MFO are arrived at through an internal process of planning, negotiation and consolidation among DOH units, informed by budget parameters and budget estimates issued by DBM (Figure 2). [28]

In brief, between January and April of each year, DOH program units, particularly those with priority PAPs (e.g., included in the Budget Priorities Framework issued by DBM), formulate the details of the amounts estimated for the next fiscal year, covering ongoing/existing PAPs (considered Tier 1) and new and expansion PAPs (considered Tier 2).[29] In formulating proposals, program units are instructed to consider targets set under the *Philippine Development Plan* for the current 6-year plan period; the *National Objectives for Health*, which is a roadmap for Universal Health Care/SDGs for the plan period[30]; Province-Wide and City-Wide Investment Plans for Health (P/CIPH); Annual Operational Plans (AOP) of Local Government Units (LGUs), and other components of the National Budget Priorities Framework (e.g., focus on poorest 44 provinces, identified priority municipalities, and so forth).

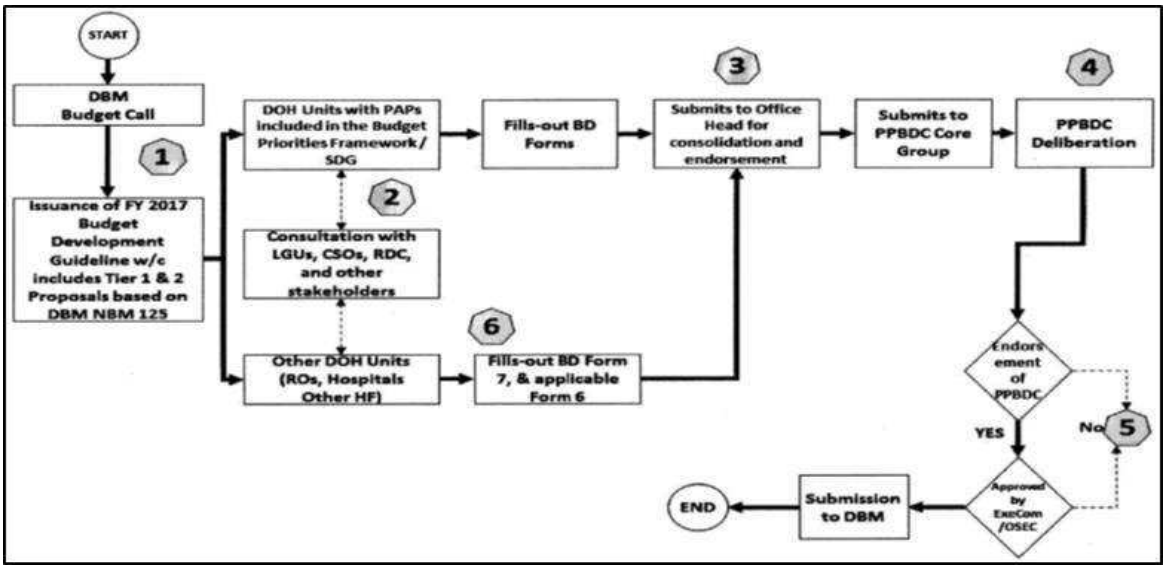
[27] The matching from PREXC to the MFO classification is explained in Annex D.

[28] This section highlights only the key features of the budget preparation process as described in DOH Department Memoranda Nos. 2015-0127, 2016-0073, and 2017-0037, which prescribe guidelines for the DOH FY 2016, 2017 and 2018 budget proposals, noting that the budget preparation process itself evolved during this short period.

[29] This two-tiered budgeting approach, introduced in FY 2015, separates the evaluation of agency proposals for: a) on-going/existing programs/projects under Tier 1; and b) for new proposals and the expansion of on-going/existing programs/projects, considered as Tier 2, in order "to decongest and systematize the decision-making process for these two different types of programs during budget Preparation" as well as "strengthen the top-down oversight in the whole budget cycle, i.e., from preparation to accountability." See DBM National Budget Memorandum No. 125, January 15, 2016 (https://www.dbm.gov.ph/wp-content/uploads/Issuances/2016/National%20Budget%20Memorandum/ NBM%20No.%20125 .pdf)

[30] The National Objectives for Health (NOH) provides guidance to all stakeholders and advocates in attaining the strategic goals of the Department of Health for the health sector. It sets all the health program goals, strategies, performance indicators and targets that can lead the health sector to achieve these strategic goals.

FIGURE 2: THE DOH BUDGET CONSOLIDATION AND APPROVAL PROCESS



(from Department Memorandum No. 2016-0073, for FY 2017)

Tier 1 proposals are typically assured, being the "bare-bones" budget which only provides funding for the cost of running existing programs.[31] Tier 2 items need to be justified in terms of impact, consistency with current priorities. and implementing capacity of the proponent unit.

All major programs are managed by DOH-CO units.[32] Budget levels for PS are largely fixed but levels for MOOE (e.g. including drugs/commodities for disease prevention and control programs, training outlays, doctors/nurses/midwives as human resources for health and so forth) are proposed based on estimated increases in target populations, inflation for indexed items (prescribed by DBM), and consultative inputs from CHD counterpart program coordinators and civil society organizations. Inputs from CHD counterparts are, in turn, expected to be based on actual need and area specific concerns, guided by P/CIPH, AOPs of LGUs, and consultative activities with LGUs.[33]

Proposals for CO or capital outlays (e.g., vehicle acquisition, land acquisition, ICT and facility upgrading / repair / construction) are 'optional'. However, since at least 2010, the Health Facilities Enhancement Program (HFEP) has been a key strategy ("improving access to quality hospitals/health facilities) toward Universal Health Care, constituting a major component of the DOH budget. HFEP involves funding assistance for infrastructure and

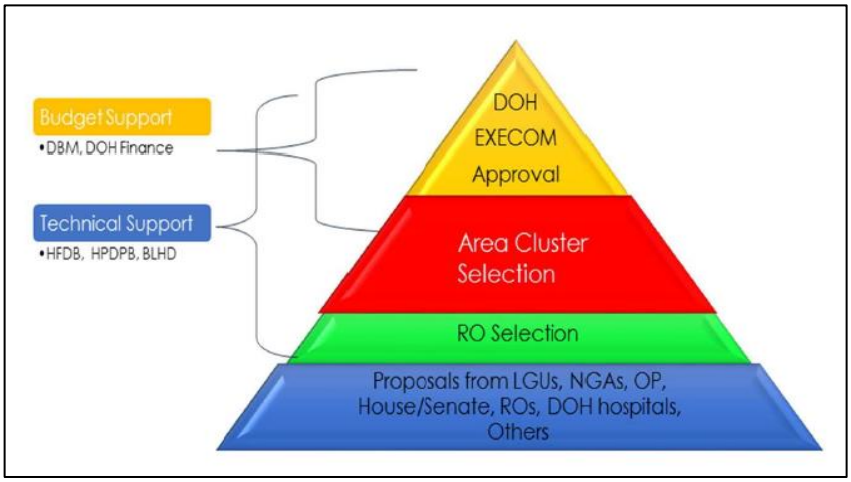
[31] DBM 2017. https://www.dbm.gov.ph/index.php/budget-documents/2017/guide-to-the-two-tier-budget-approach-2tba

[32] For instance, in 2017, priority PAPs included Family Health & Responsible Parenting; Expanded Program on Immunization; Elimination of Diseases; Other Infectious Diseases; Rabies Control; TB Control; Non-communicable diseases; Environmental and Occupational Health; National Health Insurance Program; Health Promotion; Human Resources for Health; Health Emergency; Dangerous Drug Abuse and Treatment- Central Office (Program); HFEP; and Pharmaceuticals.

[33] For FY 2017, CHDs were also instructed to provide justification for Tier 2 proposals for National Pharmaceutical Policy Development (including provision for drugs and medicines, medical and dental supplies to make affordable quality drugs available), Implementation of Doctors to the Barrios, and handful of programs that were included in the Budget Priorities Framework/SDGs (i.e. Elimination of Diseases, Rabies Control, Expanded Program on Immunization, TB Control, Other Infectious Diseases and Family health and Responsible Parenting.)

equipment of government facilities - particularly barangay health stations (BHS), rural health units (RHUs), district hospitals, provincial hospitals, DOH retained hospitals and specialty centers - and proposals may come from many quarters, including LGUs, national government agencies, Office of the President, Congress, DOH hospitals, CHDs themselves and others. CHDs are asked to validate all proposals based on parameters and guidelines issued by the Health Facilities Development Bureau (HFDB) at DOH-CO. The HFDB consolidates proposals and recommends the distribution of HFEP funds across CHDs. (Figure 3)

FIGURE 3: SCREENING PROCESS FOR PROJECT PROPOSALS UNDER HFEP



(From COA 2017, p.5)

CHDs thus play a supporting role in the MOOE and CO budget preparation of major national (central office) programs, and the portion of these budgets that is to be spent in each region is disaggregated and understood to be "for regional distribution", i.e., directly released by the DBM to CHDs. Each CHD consequently includes these amounts in their annual work and financial plans. However, the allocation and use of these program funds are largely prescribed by the DOH-CO office or bureau in charge of the program.

In contrast, CHDs play a major role for both the allocation and disbursement of what are known as "regional offices budget line items". These are, specifically, Support to Operations (STO), Local Health System Development Assistance (LHSDA) (under MFO2.1), and Regional Health Regulations (under MFO4).[34] These items are not typically included in the Budget Priority Framework.[35] CHDs are asked to provide justification for proposals (especially Tier 2 proposals) for these items.

In any event, all Tier 1 and 2 proposals submitted are vetted and consolidated by a *Program Planning Budget Deliberation Committee* (PPBDC), convened specifically by the DOH Secretary for budget preparation purposes.

[34] See footnotes 7 and 21.
[35] See DOH Budget Folio for FY 2018. Table 1 and Figure 2 on pp. 4 and 8 respectively.

Ultimately, the PPBDC decides which cluster (e.g., public health cluster, hospital cluster), and which office/unit in each cluster, gets what funds, and endorses a consolidated budget to the Executive Committee/Secretary. Endorsement from the PPBDC is based on the "completeness of the budget proposal details and the soundness of the proposal to attain health sector goals."[36]

The important take away from all this is that the budgets for major PAPs are under the control of DOH-CO - even though parts are 'for regional distribution" and directly released to CHDs - and only three budget line items are considered "regional offices budget line items", with CHDs exercising both allocative and disbursement control. HFEP is among the first type, a DOH-CO program with regional distribution. But because CHDs are responsible for validating all HFEP proposals, both DOH-CO and CHDs must deal with Congress during the budget legislation phase (addressed below).

Annex B provides an outline of DOH **Agency-Specific** (explained in the section III) Budget Line Items, where items highlighted in orange are the 'Regional Offices Budget Line Items.'

2.2 BUDGET LEGISLATION

There is a long way to go from the budget proposed by the DOH Secretary to DBM, to the DOH budget which Congress eventually approves.

First, based on budget ceilings and budget priorities, DBM continues to negotiate with DOH and other agencies until a consolidated budget is acceptable to the President - which is then submitted to Congress in July. Second, significant changes in the level and distribution of funds per PAP are bound to occur during what is known as the *budget legislation* stage – which involves public hearings by the Committee on Appropriations of the House of Representatives (House); approval of a General Appropriations Bill (GAB) by the House; transmission of the GAB to the Senate for hearings by the Senate Committee on Finance; approval by the Senate; and deliberations by a Bicameral Conference Committee (or 'Bicam'), composed of representatives from the HOR and Senate, to "harmonize" the different versions approved by the House and Senate. It is the Bicam version which is ultimately ratified by both HOR and Senate and sent to the President (who can then veto some line items).

During budget legislation, Congress engages the DOH Secretary, DOH-CO officials and CHD Directors tweaking the list of projects for funding - particularly projects under the HFEP - by realigning funds across the list of projects proposed (e.g. changing location or type of facility, etc.), or adding to the list by realigning funds away from other programs, typically to favor their respective congressional districts or home regions/provinces. Realignments by

[36] Department Memorandum No. 2016-0073. The PPBDC is supported by the Health Policy Development and Planning Bureau and the Financial Services Bureau. Existing local government facilities, private sector services, and other factors are presumably factored into proposals from DOH-CO and CHDs. Thus, national government outlays are supposed to supplement or complement these outlays.

Congress are known as "congressional insertions" (CI) and are often described by DOH officials as disruptive to budget execution because these may not be consistent with local or regional plans (e.g. for instance, there may already be an existing hospital close by but a Congressman wants another one in his district) and may not even be implementable (e.g.. there is no land available). But CI's are accepted/included into the DOH budget as part of the negotiation process - "if we don't give it, the budget won't be passed" – with the understanding that compliance (e.g. site availability, local government concurrence, etc) will be obtained or completed ex-post (i.e., after appropriations have been authorized.)

Thus, there are high opportunity costs associated with CIs. While discussing one possible reform in budget execution, one DOH official mentioned political PAPs and non-implementable PAPs in one breath:

> *"Non-implementable PAPs must be abandoned early so that funds can be used by other programs which are unfunded and needed…. We know early. Those political PAPs which comprise a huge part of the pie…. 'Early' means the first half of the year, or even earlier. You can even identify these a year before."*

3. DATA, METHODS

Review of CHD disbursements. To compare spending across CHDs, we use the Financial Accountability Report (FAR) No. 1: *Statement of Appropriations, Allotments, Obligations, Disbursement, and Balances* (SAAODB) obtained from the DOH-Central Office (DOH-CO). The DOH-CO consolidates FAR from all regions, excepting the Autonomous Region of Muslim Mindanao (ARMM), into one report. The SAAODB "reflects the authorized appropriations and adjustments, total allotments received including transfers, total obligations, total disbursements, and the balances of unreleased appropriations, unobligated allotments and unpaid obligations of a department/office/agency by source and by allotment class", with authorized appropriations classified as either *Current Year* appropriations or *Continuing* appropriations (known as CONAP). [37] The DOH_CO has the SAAODB for the years 2011 to 2018, however disbursement data appears only for the years 2015 to 2018. Hence our inter-CHD examination is constrained to these four years.

In the SAAODB, Current Year appropriations and CONAP are further unbundled into 'Agency-Specific Budget', 'Automatic Appropriations', and 'Special Purpose Funds', and, for each, total allotments received, obligations, disbursements, are accounted for. The **Agency-Specific Budget** refers to the GASS, STO, Operations (MFOs) and LFPs items earlier described. Automatic Appropriations are items such as debt service, retirement and life

[37] Commission on Audit and Department of Budget and Management (2013). Joint Circular No. 2013-1 (2013). Retrieved from https://www.coa.gov.ph/index.php/2013-06-19-13-06-41/issuances-of-other-agencies/category/168-joint-circular?download=77:coa-dbm-jc-no-2013-1-march-15-2013

insurance premiums, and special accounts in the general fund, that are covered by separate laws and made automatically available without being included in the GAA.[38] Special Purpose Funds (SPFs) are GAA items (e.g. pension and gratuity fund, miscellaneous personnel benefits, e-government fund, contingent fund, calamity fund) "for which recipient agencies have not yet been identified during budget preparation" and which shall be available for allocation to agencies "in addition to built-in appropriations, during budget execution."[39] For the period 2015 to 2018, Automatic Appropriations and SPFs to CHDs were largely for retirement and life insurance premiums, pension and gratuity fund, and miscellaneous personnel benefits.

It is the Agency-Specific budget that is salient to this study, therefore. Specifically, the Current Year agency-specific budget; allotments and disbursements out of CONAP are not examined. We note however that the CONAP budget would have been a factor in the execution of Current Year budget: since CONAP amounts lapse at the end of the second year, there would have been 'competition' in the execution of the two budgets for each of FY 2015, 2016 and 2017.[40] For these years, CONAP allotments represented between 10 and 13 percent of Total Adjusted Allotments.[41] In FY 2018, there was no longer any CONAP.

We compute average annual disbursement rates for the period 2015 to 2018, in the overall and by expense class, as follows:

- Total disbursement rate, i.e., total disbursements over total adjusted allotments;
- Personnel Services (PS) disbursement rate, i.e. PS disbursements over PS adjusted allotments;
- MOOE disbursement rate, i.e. MOOE disbursements over MOOE adjusted allotments; MOOE obligation rate, i.e. MOOE obligations over MOOE adjusted allotments, and
- CO disbursement rate, CO disbursements over CO adjusted allotments. [42]

For MOOE and CO, we also compute obligation rates (i.e. MOOE or CO obligations over MOOE or CO adjusted allotments), to see whether having an obligation-based budget and a 'two-year validity' on MOOE and CO outlays had any bearing on current year MOOE and CO disbursements.

We also show the average annual disbursements without FY 2016. The year 2016 was a Presidential election year and, typically, pre- and post- election peculiarities are the source of distortions in budget execution. Before a

[38] Automatic appropriations include special accounts for the Bureau of Quarantine and the FDA.
[39] Before 2014, SPFs included the PDAF which was basically pork barrel funds for members of Congress.
[40] For instance, during 2016, both the Current Year budget for 2016 and the CONAP from 2015 would have to be executed.
[41] 13 percent each for FY 2015 and 2016, 10 percent for FY 2017. Computed from DOH-CO SAAODB data.
[42] For DOH, MOOE includes drugs and medicines, scholarship grants, rents of buildings, and other "expenditure associated with maintaining the day-to-day operations of government operations such as expense for supplies, materials, transportation and utilities" (DOH, 2019). CO are "expenditure relating to acquisition of land or building, modification to existing infrastructure, and cost of planning and construction of new buildings". For DOH, this is primarily the construction or enhancement of health facilities, including the provision of equipment.

regular election, projects disbursements are suspended, that is, any public official or agency is prohibited from releasing, disbursing or expending project funds forty-five (45) days before a regular election unless an exemption is sought from election authorities. After the elections, a new president will typically direct his new cabinet to review the program and project allocations made under the previous administration before approving the release of said allocations, resulting in further distortions. A new president may also speed up spending on some campaign-related programs while suspending others.

We use the disbursement indicators to classify CHDs into fast-, slow- and average-spending CHDs (i.e., a higher disbursement ratio means faster spending) and to select CHDs for case studies.[43] Our selection is biased toward CHDs that provide some interesting variation and contrast in spending across expense classes and, everything else held fixed, toward heavily populated regions. We are also opportunistic and focus on CHDs which were the quickest to respond to our request for data, and we try to ensure that CHD selection spans the three major island groupings of Luzon, Visayas and Mindanao.

The question has been raised about why *adjusted allotments* are used as the base for computing CHD disbursement rates rather than *authorized appropriations*. From the CHD viewpoint, the answer is: adjusted allotments are the amounts that CHDs are ultimately accountable for spending; CHDs have no control over the differences between the two amounts. Differences arise due to (i) "negative list" items (i.e. items not released as part of the GAARD but for later release pending clearance or compliance with certain requirements) which ultimately fail to receive clearance from approving authorities and/or comply with requirements; (ii) adjustments to authorized appropriations, e.g., per special provisions in the GAA (including transfers to/from other department/agency "resulting to [sic] increase/reduction of appropriations"), or realignments of allotment classes, or releases to agencies from SPFs, Unprogrammed Fund and Automatic Appropriations; [44] and (iii) adjustments to allotments, such as "transfers to bureaus/regional offices/operating units" as well as "additional allotments received from central office/regional office/operating units. [45] All would be driven by DOH-CO and/or DBM, although CHDs may be involved with the first, e.g., HFEP infrastructure projects that fail to comply with requirements for the release of appropriations. In general, however, it is CI's that typically fail to comply.

In any case, it can be argued that CHDs are disadvantaged by the distinction: for FY 2017 and 2018, adjusted allotments among CHDs were higher than authorized appropriations by 50% and 150% respectively. This was primarily due to adjustments to appropriations from Special Allotment Release Orders (SARO), such as for the

[43] We use "fast" and "slow" rather than "high" and "low" because the latter is typically associated with absolute amounts rather than ratios, causing confusion. That is, a CHD with high disbursement rates may actually be spending much smaller absolute amounts versus a CHD with low disbursement rates.

[44] More precisely, *adjusted appropriation* is authorized appropriation while taking into account different adjustments such as allotment releases from Special Purpose Funds (e.g., Miscellaneous Personnel Benefits Fund, Pension benefits and Budgetary Support to GOCCs), grants/donations on top of the expenditure program, and transfers from/to other department or agency (COA and DBM, 2019).

[45] See DBM-COA Joint Circular 2013-1, Annex A. Also, Section 72 of the GAA General Provisions for Fiscal Year 2018 provides the Rules on Modification in the Allotment, as an example of the bases for adjustments.

HFEP, meaning additional HFEP projects/funds were assigned to CHDs during the year. To the extent that these additional/new amounts effectively disrupt the implementation of work and financial plans, such additions are likely to be considered a burden by CHDs and would be associated with lower budget credibility (i.e., lower probability of meeting both original and adjusted spending targets, c.p.)

For FY 2015 and 2016, adjusted allotments were 94% and 44% of authorized appropriations, respectively. The latter is explained by large transfers of appropriations to other agencies.

Annex C provides an illustration of adjustments from Authorized Appropriations to Adjusted Allotments for one CHD for FY 2017 and 2018.

CHD case studies. For the case studies, we use SAAODBs obtained from each CHD. [46] CHDs had disbursement data for 2014, hence case studies cover the period from 2014 to 2018. Additionally, the case studies drill down to the level of Programs, Activities and Projects (PAPs), which are divided into four (as earlier discussed): (1) General Administration and Support (GAS), (2) Support to Operations (STO), (3) Operations – further subdivided into four MFOs - and (4) Locally Funded Projects (LFP). To reiterate, the MFOs are MFO1 (Health Sector Policy Services) which focuses on the formulation, issuance, and dissemination of health care policies; MFO2 (Technical Support Services) which is training support, funding support (for HFEP), and disease prevention and control (commodities and services); MFO3, hospital services, and MFO4 licensing/registration/accreditation of health products, establishments, etc., and monitoring and enforcement.

We undertake interviews of CHD Regional Directors and staff to get their insights on drivers of disbursements. All Regional Directors are career executives, with previous appointments as Regional Directors in other CHDs or in DOH-CO. Key DOH-CO officials were also interviewed, namely the Undersecretary for Policy, the Assistant Secretary for Visayas and Mindanao, and the previous Director of Finance, now the Director of Administration. The first two had extensive experience as CHDs Regional Directors prior to their appointment at DOH-CO.

Validation. To validate our draft report, a roundtable discussion with DOH officials from central office and from case study regions was held on 17 July 2019.

[46] There are some discrepancies between the annual figures from the DOH-CO-consolidated SAAODBs and the CHD SAAODBs. These discrepancies are attributed to aggregation errors. The DOH-CO annual SAAODB is based on monthly SAAODBs received from CHDs. But the CHD annual SAAODB is based on quarterly SAAODBs which they submit to the DBM.

4. REGIONAL CHD DISBURSEMENTS OUT OF ADJUSTED ALLOTMENTS, 2015 TO 2018

4.1 TOTAL DISBURSEMENTS OUT OF TOTAL ADJUSTED ALLOTMENTS

Including fiscal year 2016 (an election year), the regional average is 53 percent, with disbursements as a percentage of adjusted allotments rates ranging from 37 percent to 71 percent **(Table 1).** Not including 2016, the regional average became 56 percent, with rates ranging from 44 to 75 percent.

At the **high end** of the range, with or without 2016, we find CHDs I, CAR and Region II. CHD I hits a high of 75 percent without 2016, an increase of 4 percentage points from its average with 2016. Regions IV-B may be considered a high-average spender with rates reaching 9 percentage points above regional average with 2016. At the **low end** we have CHDs NCR, IV-A and VI *with* or *without* 2016. NCR rates increase by 7 percentage points when 2016 is not included; IV-A rates increase by 5 percentage points.

CHDs which spend at the regional average, either with or without year 2016, are IX, XII and VII and XI.

TABLE 1: TOTAL DISBURSEMENTS TO TOTAL ADJUSTED ALLOTMENTS

	2015	2016	2017	2018	AVERAGE (with 2016)	AVERAGE (w/o 2016)
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
Region I	80%	58%	71%	75%	71%	75%
CAR	76%	59%	79%	61%	69%	72%
Region II	85%	62%	67%	53%	67%	68%
Region IV-B	76%	61%	62%	48%	62%	62%
Region V	53%	46%	53%	82%	58%	63%
Region XIII	61%	45%	55%	64%	56%	60%
Region VIII	55%	49%	45%	75%	56%	58%
Region IX	47%	58%	56%	60%	55%	54%
Region XII	68%	36%	49%	61%	53%	59%
Region VII	56%	43%	61%	43%	51%	53%
Region III	54%	43%	48%	56%	50%	53%
Region XI	62%	38%	48%	52%	50%	54%
Region X	57%	45%	46%	48%	49%	50%
Region VI	49%	43%	46%	39%	44%	45%
Region IV-A	45%	26%	12%	78%	40%	45%
NCR	69%	15%	16%	47%	37%	44%
Average	60%	45%	49%	59%	53%	56%

Note: Overall disbursement rates are:

Fast	*Average (+/- 2)*	*Slow*

Interestingly, two of the fastest spending CHDs, CAR and Region II, are relatively small by way of population and budget (Table 2). In contrast, the slowest-spending CHDs, IV-A, NCR and VI, are among the largest by way of population, with VI and IV-A receiving a budget whose rank (by size) is close to its rank by population. In general, CHDs have rankings by population and by budget that are within 3 rungs of each other. The exceptions are NCR, VIII and IV-B. NCR receives a budget ranked 11 rungs lower than its rank by population – owing to the fact that cities in NCR are better able to fund health from their own budgets and private service providers are also widely available[47] -- while VIII and IV-B each receive a budget ranked higher by 5 rungs. This seems to indicate that **size** may matter to the spending performance of CHDs, perhaps because of the political (e.g., associated with voter population) and administrative complications that accompany size. [48]

TABLE 2: REGIONS RANKED BY PUPULATION AND AVERAGE ADJUSTED ALLOTMENT

	Population	Population rank	Adjusted allotment (nominal average,2015-2018)	Budget rank
Region IV-A	14,414,774	1	1,686,453,464.48	4
NCR	12,877,253	2	1,084,426,848.94	13
Region III	11,218,177	3	1,688,370,556.78	3
Region VI	7,536,247	4	1,703,479,561.71	2
Region VII	7,396,903	5	1,829,757,504.42	1
Region V	5,796,989	6	1,515,714,974.64	5
Region I	5,026,128	7	1,398,991,930.84	7
Region XI	4,893,318	8	1,282,351,688.92	11
Region X	4,689,302	9	1,390,552,357.19	8
Region XII	4,545,276	10	1,303,675,530.22	10
Region VIII	4,440,150	11	1,454,101,186.41	6
Region IX	3,629,783	12	958,442,456.78	15
Region II	3,451,410	13	1,089,263,668.44	12
Region IV-B	2,963,360	14	1,338,355,795.48	9
Region XIII	2,596,709	15	962,949,264.74	14
CAR	1,722,006	16	764,150,309.05	16

[47] Comment by the DOH Undersecretary of Policy, during the roundtable discussion 17 July 2019. One of the bases for proposals is local investment plans for health and gaps in realizing these plans. If local governments can fund their plans, less is needed from the national government.

[48] We note a wide variation in per capita allotments. This is not an anomaly however since there is no presumption that equalizing per-capita allotments is an efficient way to allocate resources, nor that it translates into equitable access to health services. Funding proposals for public health programs are based on the needs of target population relative to what is available from LGUs. Thus, variation in per capita allotments are likely to be due to health demographics, geography, and institutional factors. Funding allocations are also driven by congressional insertions which are rarely based on health needs per se.

4.2 DISBURSEMENTS FOR PERSONNEL SERVICES (PS)

The regional average PS disbursement rate with or without 2016 is 94 percent. ***Including 2016***, rates range from 68 percent to 103 percent **(Table 3).** The CHDs with the highest PS disbursement rates (99 percent and above) are Regions VI, II, CAR and IV-B. The CHDs with lowest rates are IV-A and NCR, the largest in terms of population, coming in below 75 percent.[49] All other CHDs have disbursement rates between 92 and 98 percent.

Without 2016, rates range from 70 to 103 percent. The same four CHDs top the list but are now joined by CHD XI and V; the same two CHDs - NCR and IV-A- bottom out the list with averages below 75 percent.

TABLE 3: PS DISBURSEMENTS TO ADJUSTED ALLOTMENTS

	2015	2016	2017	2018	AVERAGE (w/ 2016)	AVERAGE (w/o 2016)
Region VI	114%	100%	95%	99%	102%	103%
Region XI	100%	96%	98%	99%	98%	99%
Region II	100%	100%	97%	100%	99%	99%
Region V	100%	93%	98%	99%	97%	99%
CAR	99%	99%	98%	99%	99%	99%
Region IV-B	100%	100%	96%	100%	99%	99%
Region XII	99%	99%	96%	98%	98%	98%
Region VII	98%	97%	96%	99%	98%	98%
Region X	100%	102%	99%	92%	98%	97%
Region III	100%	100%	95%	95%	97%	97%
Region IX	92%	100%	97%	99%	97%	96%
Region I	88%	99%	100%	99%	97%	96%
Region XIII	93%	99%	95%	97%	96%	95%
Region VIII	84%	97%	96%	97%	94%	92%
NCR	87%	73%	32%	99%	73%	73%
Region IV-A	93%	61%	22%	95%	68%	70%
Average	96%	94%	88%	98%	94%	94%

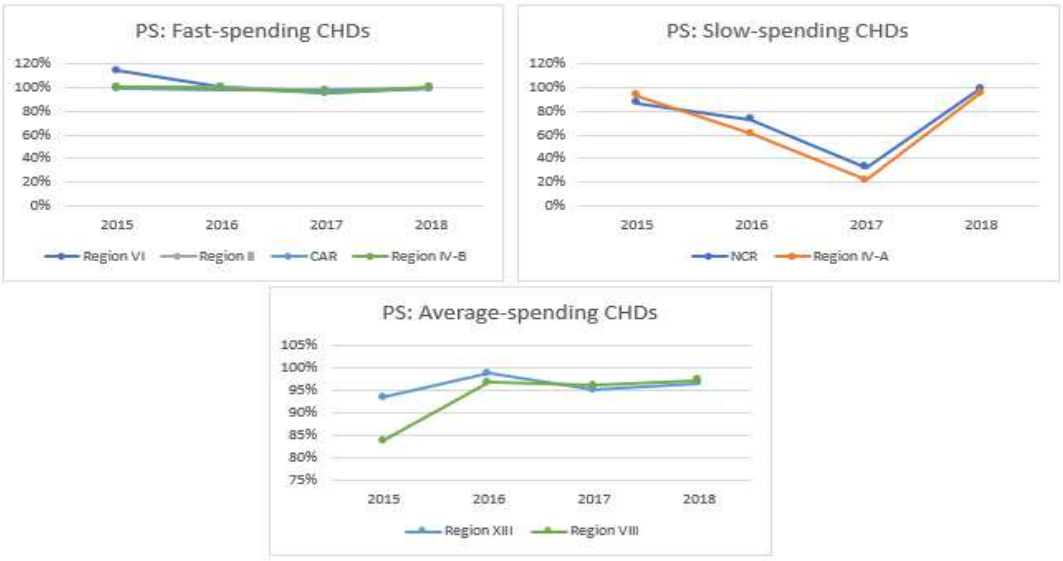
Note:

Fastest (99 and above)	*Average (+/- 3)*	*Slowest (below 75)*

[49] In the case study of CHD-IVA (Appendix IV), we found that the very low disbursement rate for 2017 (22%) was due to erroneous figures submitted by the CHD to DOH-CO. DOH-CO and DBM caught this ex-post but electronic files were not corrected formally (at least not the files provided to this team) because of implications on performance-based bonuses (already awarded). The low figure for NCR in the same year was not noted by DOH-CO nor further examined for any similar errors.

Figure 4 graphs PS disbursement rates of select fast PS-, slow PS- and average PS-spending CHDs.

FIGURE 4: PS DISBURSEMENT RATIOS OF FAST PS-, SLOW PS- AND SELECT AVERAGE PS-SPENDING CHDS



4.3 DISBURSEMENTS FOR MAINTENANCE AND OTHER OPERATING EXPENSES (MOOE)

Including 2016, the regional average for the MOOE disbursement rate is 68 percent, with rates ranging from 41 percent to 90 percent (Table 4)**.** The CHDs with the highest MOOE disbursement rates are IV-B, I and II; CHDs with the lowest rates are IV-A and NCR; CHD XIII is also relatively low. ***Without 2016***, the regional average increases to 69 percent, with rates ranging from 42 to 91 percent. The same CHDs top and bottom out the list. CHDs III, V, VIII and IX are within 3 percentage points of the regional average with or without 2016.

TABLE 4: MOOE DISBURSEMENTS TO ADJUSTED ALLOTMENTS

	2015	2016	2017	2018	average w 2016	average w/o 2016
Region IV-B	95%	87%	88%	89%	90%	91%
Region I	85%	90%	93%	86%	89%	88%
Region II	91%	78%	84%	85%	85%	87%
Region XII	83%	57%	78%	77%	74%	79%
Region VII	69%	80%	81%	82%	78%	77%
CAR	72%	79%	77%	82%	78%	77%
Region XI	60%	60%	79%	88%	72%	76%
Region III	60%	67%	72%	82%	70%	71%
Region V	53%	66%	75%	76%	68%	68%
Region VIII	58%	65%	62%	81%	66%	67%
Region IX	41%	61%	78%	80%	65%	67%
Region X	54%	63%	60%	80%	64%	65%
Region VI	49%	63%	75%	60%	62%	61%
Region XIII	59%	49%	58%	63%	57%	60%
NCR	66%	27%	23%	62%	45%	50%
Region IV-A	36%	37%	13%	79%	41%	42%
Average	62%	64%	67%	78%	68%	69%

Note:

Fastest	*Average (+/- 3 ppt)*	*Slowest*

Table 5 presents MOOE **obligation rates** for the period beginning 2014 and correlations with same and succeeding year MOOE disbursement rates.[50] On average, obligation rates are higher than disbursement rates by 23 percentage points (92% vs 69% respectively), with all but one CHD (CHD IX) obligating between 88 and 98 percent allotments on average. There is a stronger correlation between obligation and disbursement rates of the same year than between the obligation rate of one year and the disbursement rate of the next, i.e., MOOE disbursements from 2015 and 2018 follow MOOE obligations from 2015 to 2018 more closely than MOOE obligations from 2014 to 2017. Seven CHDs demonstrate the opposite, with four (highlighted in yellow) showing sharp differences, including NCR and IV-A, which were earlier identified with the lowest disbursement rates (marked orange). In any case, the same-year correlation of obligation and disbursement rates (44%) is not as strong as one would expect.

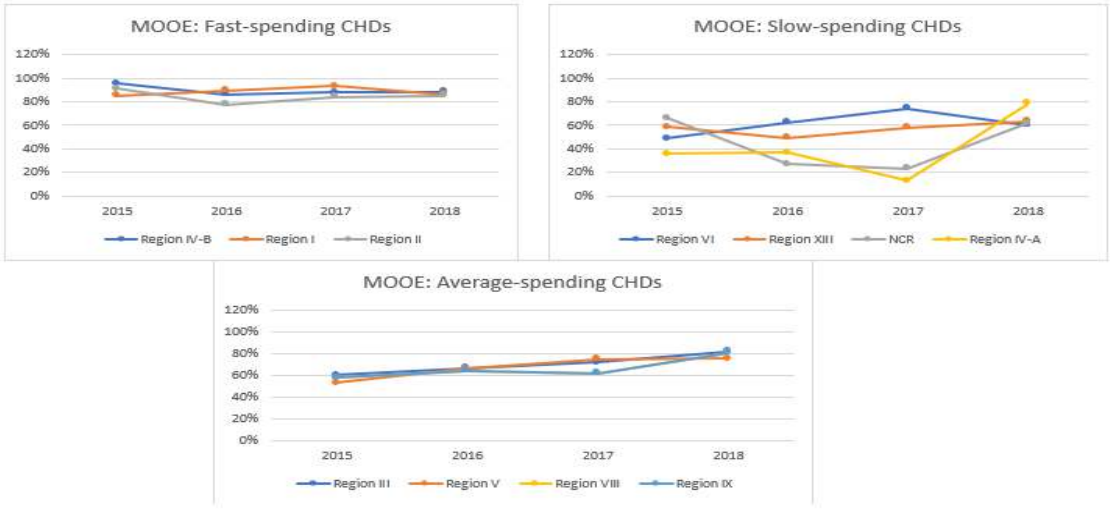
[50] As earlier mentioned, to see whether having an obligation-based budget and a 'two-year validity' on MOOE (and CO) outlays had any bearing on current year MOOE (and CO) disbursements.

TABLE 5: MOOE OBLIGATION RATES, 2014 TO 2018, AND CORRELATION WITH SAME AND SUCCEEDING YEAR DISBURSEMENT RATES

	2014	2015	2016	2017	2018	Average, 2015-2018	Correlation with **same year** disbursement rates, 2015-18	Correlation with **succeeding year** disbursement rates, 2014-2017
NCR	90%	88%	84%	95%	93%	**90%**	0.02	0.81
CAR	98%	88%	96%	98%	96%	**95%**	0.77	-0.23
Region I	86%	91%	94%	100%	96%	**95%**	0.78	0.13
Region II	92%	92%	84%	96%	97%	**92%**	0.56	0.07
Region III	93%	95%	97%	99%	99%	**98%**	0.89	0.99
Region IV-A	100%	96%	98%	100%	99%	**98%**	-0.06	0.47
Region IV-B	99%	98%	97%	100%	97%	**98%**	0.00	0.40
Region V	93%	89%	97%	99%	99%	**96%**	0.97	0.61
Region VI	81%	86%	91%	96%	95%	**92%**	0.84	0.54
Region VII	88%	74%	90%	95%	93%	**88%**	0.98	0.04
Region VIII	86%	82%	88%	96%	97%	**91%**	0.68	0.80
Region IX	74%	67%	91%	11%	95%	**66%**	-0.19	-0.37
Region X	94%	98%	96%	98%	95%	**97%**	-0.89	0.77
Region XI	84%	84%	78%	99%	95%	**89%**	0.88	0.53
Region XII	81%	83%	88%	96%	98%	**91%**	0.08	0.20
Region XIII	77%	100%	90%	92%	96%	**95%**	0.68	-0.55
Average	**89%**	**88%**	**91%**	**92%**	**96%**	**92%**	**0.44**	**0.32**
Nb: DOH-CO		85.5%	85.5%	92.9%	85.5%	**87%**		

Figure 5 graphs the MOOE disbursement rates of fast MOOE-, slow MOOE- and average MOOE-spending CHDs.

FIGURE 5: MOOE DISBURSEMENT RATIOS OF FAST MOOE-, SLOW MOOE-, AND SELECT AVERAGE MOOE-SPENDING CHDS



4.4 DISBURSEMENTS FOR CAPITAL OUTLAYS (CO)

Including 2016, the regional average for the CO disbursement rate is 20 percent, with rates ranging from 2 percent to 47 percent (Table 6). The regions with the highest CO disbursement rates are Regions CAR, IV-A, and I in that order, while the regions with the lowest rates are Regions VII, IX, X and VI. Regions IV-B and XII are within 3 percentage points of the regional average.

Without 2016, average disbursements rates generally improve, with increases ranging from 2 percentage points (e.g., CHD VI and III) to 12 percentage points (CHD IV-A), and the regional average increasing to 23 percent. The same three CHDs – CAR, IV-A and I, top the list, and with rates improving by 10, 12 and 3 percentage points respectively. The same four CHDs bottom out the list – VII, IX, X and VI – but IV-B comes very close after disbursement rates drop by 9 percentage points without 2016.

We note the very low rates across the board. In the four years presented for 16 CHDs, CO disbursement rates are greater than 58% only **5 times** (highlighted in yellow).

TABLE 6: CO DISBURSEMENTS TO ADJUSTED ALLOTMENTS

	2015	2016	2017	2018	average w 2016	average w/o 2016
CAR	70%	14%	73%	29%	47%	57%
Region IV-A	63%	0%	8%	72%	36%	48%
Region I	49%	30%	20%	56%	39%	42%
Region XIII	32%	8%	25%	57%	30%	38%
Region V	12%	9%	11%	88%	30%	37%
Region II	29%	32%	32%	7%	25%	22%
Region XII	8%	9%	5%	47%	17%	20%
Region VIII	7%	3%	14%	30%	14%	17%
NCR	41%	0%	0%	10%	13%	17%
Region XI	25%	5%	7%	19%	14%	17%
Region III	0%	3%	8%	27%	10%	12%
Region IV-B	0%	47%	16%	17%	20%	11%
Region VI	0%	2%	19%	12%	8%	10%
Region X	0%	13%	5%	17%	9%	7%
Region IX	0%	7%	0%	20%	7%	7%
Region VII	0%	3%	1%	3%	2%	1%
Average	21%	12%	15%	32%	20%	23%

Note:

High	*Average (+/- 3 ppt)*	*Low*

Table 7 presents CO o**bligation rates** for the period beginning 2014 and correlations with same and succeeding year CO disbursement rates. On average, CO obligation rates are higher than disbursement rates by a huge 59 percentage points (79% vs 20% respectively). But, in contrast to the MOOE case, there is now a stronger correlation between obligation rates in the current year and disbursement rates in the succeeding one. That is, CO disbursements from 2015 and 2018 follow CO obligations from 2014 to 2017 more closely than CO obligations from 2015 to 2018. Even then, however, the correlation rate of the former was not very strong (at 0.32).

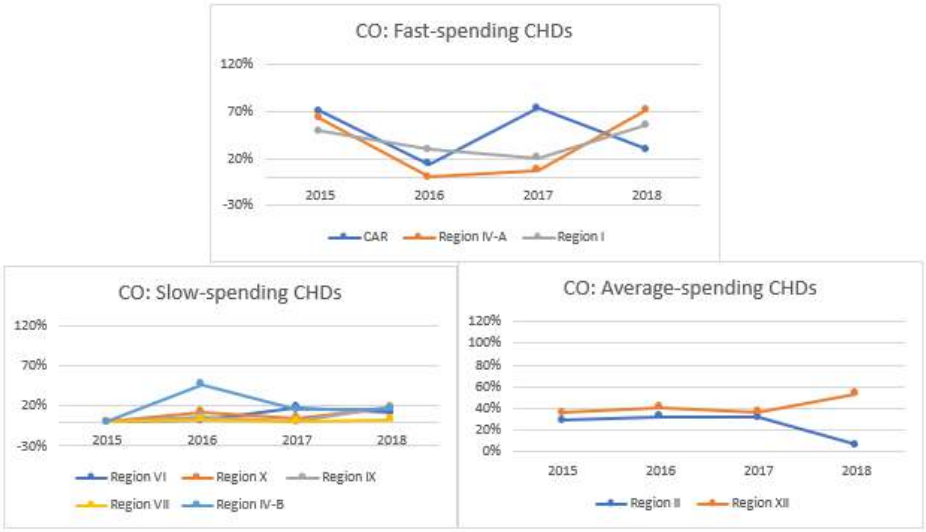
There is no discernable pattern among CHDs identified with high-, low- or average disbursement rates (marked, green, orange and blue).

TABLE 7: CO OBLIGATION RATES, 2014 TO 2018, AND CORRELATION WITH SAME AND SUCCEEDING YEAR DISBURSEMENT RATES

	2014	2015	2016	2017	2018	Average (2015-2018)	Correlation with **same year** disbursement rates, 2015-2018	Correlation with **succeeding year** disbursement rates, 2014-2017
Region IV-B	96%	99%	98%	100%	90%	**97%**	-0.01	0.61
Region IV-A	94%	87%	91%	100%	98%	**94%**	-0.16	0.91
Region V	91%	90%	88%	99%	94%	**93%**	0.18	0.97
Region XIII	57%	94%	86%	98%	88%	**92%**	0	0.08
Region XII	94%	90%	68%	100%	95%	**88%**	0.25	0.64
Region II	83%	70%	81%	98%	95%	**86%**	-0.38	-0.9
Region VIII	82%	79%	70%	80%	94%	**81%**	0.97	-0.04
CAR	55%	68%	73%	99%	74%	**79%**	0.45	-0.44
Region VII	88%	83%	45%	94%	92%	**79%**	-0.43	0.34
Region I	56%	58%	48%	99%	97%	**76%**	-0.01	0.76
Region XI	70%	69%	39%	94%	86%	**72%**	0.26	0.53
NCR	54%	50%	66%	96%	68%	**70%**	-0.75	-0.18
Region VI	84%	24%	57%	96%	97%	**69%**	0.9	0.15
Region X	85%	40%	46%	98%	89%	**68%**	0.31	0.09
Region III	88%	25%	61%	98%	81%	**66%**	0.56	0.53
Region IX	28%	49%	29%	70%	70%	**55%**	0.24	0.99
Average	**75%**	**67%**	**65%**	**95%**	**88%**	**79%**	**0.15**	**0.32**

Figure 6 graphs the CO disbursement rates of fast CO-, slow CO- and select average CO-spending CHDs. Wide swings are observed, such as between 2015 and 2016 (a sharp decrease) and then between 2017 and 2018 (a sharp increase) among the fast-spending CHDs.

FIGURE 6: CO DISBURSEMENT RATIOS OF FAST CO-, SLOW CO-, AND SELECT AVERAGE CO-SPENDING CHDS



We note that, on average, **MOOE and CO disbursement rates increased significantly in 2018 -** from 67 percent to 78 percent for MOOE, and 15 percent to 32 percent for CO, or an increase of 11 and 17 percentage points respectively. PS rates also went up by 10 percentage points. This coincides with the removal of the CONAP for FY 2018, owing to the adoption by DBM of a one-year validity of appropriations in FY 2017, as well as a 30 percentage point jump in CO obligations in FY 2017, most likely owing to the same rule; there does not seem to have been the same effect on MOOE obligation rates for FY 2017, but these were already at 91 percent in 2016. In any case, the absence of CONAP in the GAA for 2018 could have demonstrated the resolve of the DBM to enforce its rules, providing an incentive to CHDs to disburse at a faster rate in FY 2018.

4.5 FAST-, SLOW- AND AVERAGE SPENDERS

Table 8 consolidates the annual averages per expense class, with and without 2016.

Notable **fast-spending** CHDs are I, CAR and II, which were earlier identified by their overall disbursement rates, as well as IV-B, whose overall ranking is pulled down because of its slow spending on CO; otherwise it would be one of the fastest spending. CHD I's rates are consistently high, but below IV-B by one to three percentage points for

MOOE spending. CHD IV-B has the highest rates for MOOE disbursements but an average to low rate for CO spending.

TABLE 8: SUMMARY CLASSIFICATION OF REGIONS BY AVERAGE DISBURSEMENT RATES PER EXPENSE CLASS, 2015 TO 2018

	PS		MOOE		CO	
	average w 2016	average w/o 2016	average w 2016	average w/o 2016	average w 2016	average w/o 2016
NCR	73%	73%	45%	50%	13%	17%
CAR	99%	99%	78%	77%	47%	57%
Region I	97%	96%	89%	88%	39%	42%
Region II	99%	99%	85%	87%	25%	22%
Region III	97%	97%	70%	71%	10%	12%
Region IV-A	68%	70%	41%	42%	36%	48%
Region IV-B	99%	99%	90%	91%	20%	11%
Region V	97%	99%	68%	68%	30%	37%
Region VI	102%	103%	62%	61%	8%	10%
Region VII	98%	98%	78%	77%	2%	1%
Region VIII	94%	92%	66%	67%	14%	17%
Region IX	97%	96%	65%	67%	7%	7%
Region X	98%	97%	64%	65%	9%	7%
Region XI	98%	99%	72%	76%	14%	17%
Region XII	98%	98%	74%	79%	17%	20%
Region XIII	96%	95%	57%	60%	30%	38%

Note:

High	*Average*	*Low*

Notable **slow-spenders** are IV-A and NCR, but also VI. All three were among the slowest spenders based on overall disbursement rates, but the disaggregated picture indicates different proximate causes. IV-A and NCR are the slowest PS- and MOOE-spenders, but IV-A spends CO allotments quite fast. In contrast, VI is a fast PS spender, an average MOOE spender, and a slow CO spender.

All other regions may be considered **average spenders**. Notable are XIII, XII and VIII, which are located nearest the regional average based on their overall disbursement rates, as well as XI which is a low-average spender. By expense class, each demonstrates a mix of average, high-average and low-average spending. XII is an average CO-spender and a high-average PS- and MOOE-spender. VIII is an average PS- and MOOE-spender and a low average CO-spender. XIII is a very high-average CO spender, an average PS-spender, and one of the lowest MOOE-spenders. XI is an average MOOE-spender, a low-average CO-spender, but a fast-spending PS-spender.

To reiterate, the categorization above (fast-, slow-, average-) is based on the ratio of disbursements to adjusted allotments. It does **not** take into consideration **absolute levels** of PS, MOOE or CO disbursements per CHD. A fast-spending CHD may actually be spending a lower absolute level of disbursements than a slow-spending CHD.

5. UNPACKING DISBURSEMENT RATES: HIGHLIGHTS OF CASE STUDIES

We undertook **five case studies** (found in the appendices of this report), the highlights of which are discussed in this section. The regional central health departments (CHDs) that we explored include:

(i) **CHD I and IV-B, representing fast-spending regions:** CHD I's disbursement rates are consistently among the fastest, while IV-B's rates are fast except for its CO-spending. CHD I is average in size, while IV-B is considered small; both are in Luzon. Among the group of fast-spenders, there are no large regions nor regions outside Luzon;

(ii) **CHD IV-A and VI, representing slow-spending regions**: IV-A is the slowest PS- and MOOE-spender among CHDs but one of the fastest CO-spenders; VI is the fastest PS-spender but one of the slowest CO-spenders. Both are heavily populated, with IV-A located in Luzon (adjacent to Metro Manila) and VI in the Visayas; and

(iii) **XI is an average-spending region** in the overall, with average MOOE-spending, low-average CO-spending, but fast PS-spending. XI is in Mindanao and is considered average in size.

As case studies were being undertaken, it became apparent to us that the sheer size of MFO 2 or Technical Support Services made it the most relevant component of the CHD budget. Across the five CHDs studied, MFO 2 claimed the largest share of adjusted allotments among all PAPs, ranging from 85 percent to 90 percent, or an average of 87 percent (Table 9). It also accounted for the largest share of unspent adjusted allotments for MOOE (80 percent), CO (96 percent) and in the overall (89 percent) (Table 10). As earlier described (and see Annex B), MFO 2 components are Human Resource Development (MFO 2.1) which has no CO outlays and is primarily training and capacity building support, and Disease Prevention and Control (MFO 2.3) which has both MOOE (e.g. commodity support for LGU public health programs) and CO outlays (the HFEP). [51]

[51] MFO 2.2 is "Health Care Assistance", i.e. health premium payments for indigents, which is no longer released to CHDs but released directly to the Philippine Health Insurance Corporation.

TABLE 9: AVERAGE MFO2 ADJUSTED ALLOTMENTS AND DISBURSEMENTS AND SHARES IN TOTAL CHD ADJUSTED ALLOTMENTS AND DISBURSEMENTS, 2014 TO 2018

CHD	Category	Average MFO2 AA	Average share of MFO2 AA to Total CHD AA	Average MFO2 disbursement	Average share of MFO2 disbursements to Total CHD Disbursements	Average share of MFO2 disbursements to Total CHD AA
CHD1	fast	1,135,791,761	88%	773,653,235	86%	62%
CHD IVB	fast	1,083,058,619	90%	630,116,409	87%	56%
CHD IVA	slow	1,423,258,582	85%	575,110,357	85%	33%
CHD VI	slow	1,333,227,752	87%	516,573,601	83%	33%
CHD XI	average	1,095,403,886	85%	511,291,300	82%	41%
Average		**1,214,148,120**	**87%**	**601,348,980**	**85%**	**45%**

Source: Appendices I to V

TABLE 10: MFO2 UNSPENT ADJUSTED ALLOTMENTS (AA) AND SHARE TO TOTAL PAP UNSPENT AA, BY EXPENSE CLASS, BY CHD, 2014-2018

CHD	PS		MOOE		CO		TOTAL	
	Average unspent MFO2 AA (nominal)	Average share to total PAP unspent AA	Average unspent MFO2 AA (nominal)	Average share to total PAP unspent AA	Average unspent MFO2 AA (nominal)	Average share to total PAP unspent AA	Average unspent MFO2 AA (nominal)	Average share to Total PAP unspent AA
CHD1	2,227,839.0	20%	70,467,011.0	85%	289,443,676.0	100%	362,138,526.0	91%
CHD IVB	2,459,201.5	66%	46,500,828.4	75%	579,521,907.0	99%	452,942,209.8	95%
CHD IVA	21,759,507.5	29%	458,685,784.8	77%	369,386,778.2	92%	848,148,225.2	82%
CHDVI	3,074,614.5	10033%[52]	293,353,295.9	84%	520,226,240.1	95%	816,654,150.4	90%
CHD XI	349,330.1	16%	124,953,974.9	76%	458,809,280.8	93%	584,112,585.7	89%
Average	**6,698,970** [53]	**33%**	**198,792,178.98**	**80%**	**443,477,576.42**	**96%**	**612,799,139.42**	**89%**

Source: Appendices 1 to V

The focus of the case studies naturally became MFO2 disbursements, therefore. In particular, the MOOE and CO (i.e. HFEP) disbursements under MFO2 – the highlights of which are presented below. A description of PS disbursements was annexed in each case study.

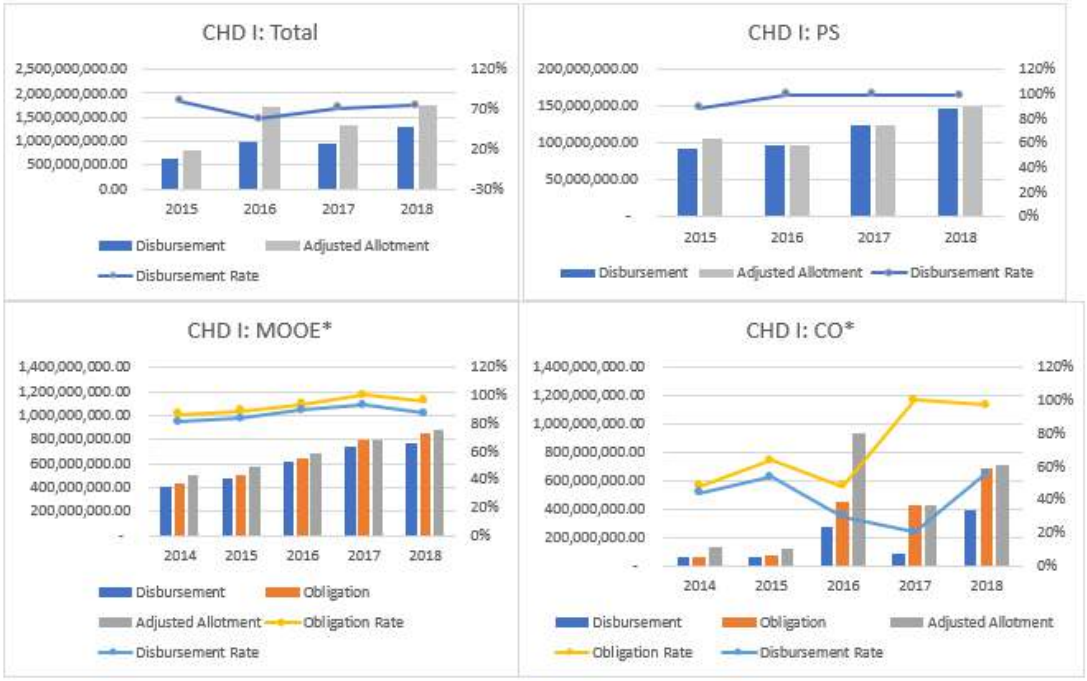
[52] Due to one year when PS spending for STO was greater than what was allotted, reducing total unspent on PS and distorting subsequent ratios (e.g. ratio of unspent PS for MFOs to Total PS unspent) See footnote Appendix Table A3.4.

[53] This amount and the next (average share to total unspent AA) excludes the figures for CHD VI.

5.1 CHD I – fast-spending (Appendix I)

Figure 7 presents the levels of disbursements and allotments, and disbursement rates over time of CHD 1 by expense class. There is a drop in total disbursement rates from 2015 to 2016, but it turns out that this is due to allotments increasing faster than disbursements. That is, disbursements more than double in that year, but allotments more than triple because of a sharp increase in CO allotments. Overall disbursement rates pick up in 2017 and hold steady in 2018, at a higher level of both MOOE and CO allotments. The increase in the level of CO disbursements in 2018 is particularly notable: a 32 percent increase from absolute levels in 2016, and a near five-fold increase from absolute levels in 2017.

FIGURE 7: CHD 1: DISBURSEMENT RATES, LEVELS OF DISBURSEMENTS, AND LEVELS OF ADJUSTED ALLOTMENTS BY EXPENSE CLASS



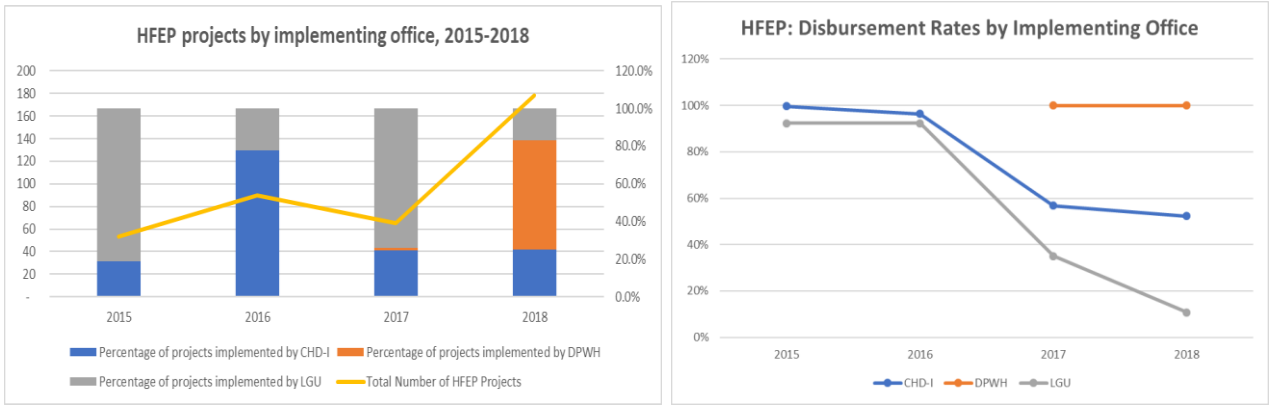
Source: Appendix Figures A1.5 and A1.14

2017 obligation rates may be one factor in the 2018 CO disbursement performance of CHD 1. CHD I seems to be one of the handful of regions which demonstrated an increase in CO obligation rates of 50 percentage points or more in FY 2017, i.e., from 48 percent in 2016 to 99 percent in 2017; CHD I went on to demonstrate a 36 percentage point increase in CO disbursement rates between FY 2017 and FY 2018, i.e., from 20 percent to 56 percent respectively. (Other CHDs with notable increases in 2017 CO obligations, e.g., CHD VII, IX, X and XI (refer

again to Tables 7 and 8) registered increases between 2 and 20 percentage points. Differences may be due to a wide range of factors including the portfolio of HFEP outlays obligated in 2017.)

CHD I officials owe the relatively high CO and MOOE disbursement rates to a combination of political savviness and good tracking and monitoring systems. The former refers to the ability of the regional director to engage congressmen, governors and other political stakeholders in the region before the budget is passed - to try and accommodate or reconcile their proposed projects with provincial and regional plans to rationalize health facilities – reducing possible disruptions to budget execution. The latter refers to hands-on monitoring of HFEP projects by and with CHD engineers, facility heads, Provincial Health Leaders (PHTLS) [54] and DPWH; outsourcing to DPWH seems to have mattered for the improvement of CO disbursement rates in 2018 **(Figure 8).** Tracking of MOOE funds is also led by the CHD regional director, together with the Management Support Services Division. The flow of commodities in and out of warehouses is also tracked.

FIGURE 8: HFEP PROJECTS



Source: Appendix Figures A1.15 and A1.17

However, the average annual CO disbursement rate of CHD I is still just 41 percent, quite low even though it is one of the highest among the 16 regions. This indicates that **structural impediments may be binding to capital outlay (CO) spending performance across all regions.** Common impediments identified by CHD-I include (i) the slow release of funds from national offices (referring to CO funds which are not immediately allotted with the GAA, including sub-allotments from DOH-CO), (ii) congressional insertions, or CI, (notwithstanding any political savviness the CHD may have), (iii) governance problems, i.e. conflicts among elected political stakeholders, (iv) poor site preparation, (v) failed or late bidding, (vi) coordination problems, e.g. between LGUs and DPWH and (vii)

[54] PHTL serves as the supervisor to the DOH Representatives in the province. The PHTL ensures that the roles and functions of the CHD are being implemented in his/her assigned provinces.

spillover effects from the delayed construction of facilities to the delayed disbursement for equipment for those facilities.

In brief, CO funds that are not immediately released with the GAA are either HFEP projects that were not compliant at the time but now are, funds that have been realigned from other units for newly identified projects, or funds that DOH-CO cannot disburse – which are then 'sub-allotted' from DOH-CO to CHDs. The obvious problem with these late PAP funds is that there is a far less chance that these can be utilized on time (given procurement timelines, etc.). More generally, sub-allotments and the like tend to disrupt the execution of other parts of the CHD budget; CHDs have little control over when funds will come nor how much will be involved, yet they are given the job of disbursing them.[55]

CIs are also disruptive (and can be the reason for sub-allotments) because CI's make changes to PAPs proposed by local governments through CHDs. And when elected politicians of a province or district – Congressman, Governor, Mayor - are not allied, problems escalate. For instance, all HFEP projects require the concurrence of Governors or Mayors. But even after concurrence has been secured, a Congressman may block the project, insisting that another project (in a different location) be executed instead.

HFEP projects require properly titled land. But titling problems may be due to poor due diligence by proponents (such as for CI projects) or may simply arise during budget execution (a challenge by a private-individual ex-post, for instance). Failed or late bidding may also be due to low contract price (e.g. the bid price of Barangay Health Units (BHUs) does not include the transportation costs), among other reasons; coordination problems between implementing agencies – such as between LGUs and DPWH to whom a CHD may outsource the execution of HFEP projects to – may lead to delayed disbursements (such as when LGUs and DPWH cannot agree on terms of engagement, which is what happened in 2017.) Then, if the construction of a facility has been delayed, the purchase of equipment for it will also be delayed.

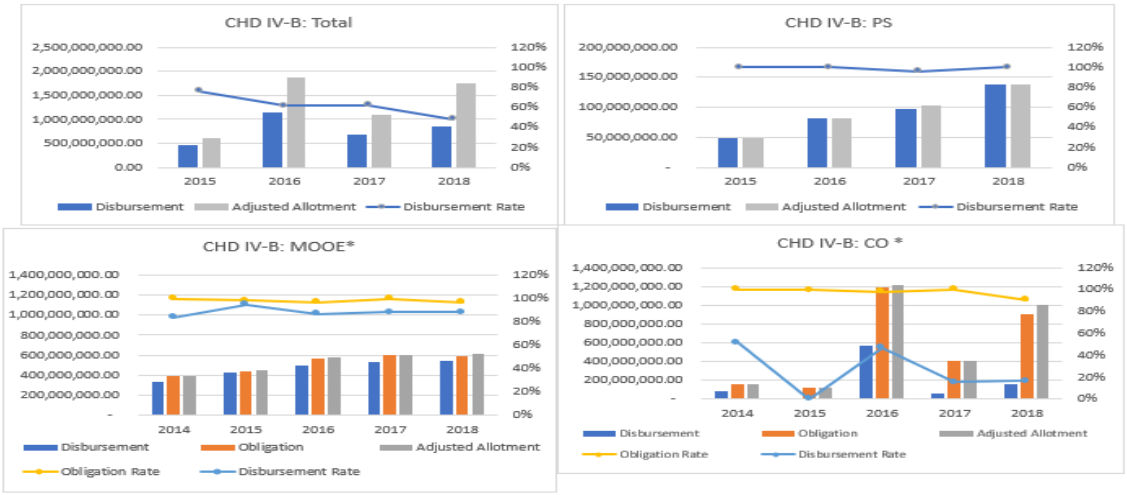
CHD-I also notes that the price ceilings and technical specifications prescribed in the Drug Price Reference Index (DPRI) and the Philippine National Formulary (PNF) respectively, contributes to shortfalls in the disbursement of MOOE funds (which is at 87 percent on average). The DPRI is set at the median value of the prevailing prices of most of PNF medicines; this will be too low in some instances or at some locations, causing a failed bid for drugs/medicines. There are also cases when the technical specification for drugs cannot be met by suppliers.

5.2 CHD IV-B – fast-spending (Appendix II)

[55] An example is given by CHD VI that, in 2018, the last sub-allotment advice (SAA) received for MOOE was dated December 3, and for CO, dated October 26, leaving little time to disburse funds.

CHD IV-B is also able to absorb regular increases in PS and MOOE allotments over the period; the MOOE disbursement rate of CHD IV-B is stable and high. However, its absorption of CO is weak, reflected in CO disbursement rates which are erratic and low. (Figure 9)**.** There is only one year – 2016 – when there was a relatively large amount of disbursements recorded; CO allotments and obligations were also at their highest levels in this year (for CHD IV-B, obligations are typically at or near 100% of allotments). However, the strong CO showing in 2016 did not carry over to 2017 or 2018; CO disbursements fell sharply in 2017 despite the very high levels of obligations in the previous year and inched up only slightly in 2018.

FIGURE 9: CHD IV-B: DISBURSEMENT RATES, LEVELS OF DISBURSEMENTS, AND LEVELS OF ADJUSTED ALLOTMENTS BY EXPENSE CLASS



Source: Appendix Figures A2.6 and A2.10

CHD IV-B attributes its good MOOE spending performance to a sound monitoring and evaluation system. As for CO disbursements, the CHD claims that the main impediment is the dearth of suppliers willing to participate in CO biddings by local government units. However, this is driven by the failure of DOH-CO procurement policy to take account of the unique topography and weather variability of CHD IV-B and what this means for cost standards.

Specifically, MIMAROPA consists of island provinces with weather variability, which drives up the cost of shipping/transporting materials and equipment. But these additional costs are not reflected in standard procurement prices nor in bigger procurement budgets, set by DOH-CO, which Local Government need to abide by. Even when a bid is successful, difficulties in transporting materials and equipment amount to delays in the completion of infrastructure projects. Delays in infrastructure projects then cause delays in the disbursements for equipment - as mentioned in the CHD I case, equipment purchases cannot be completed unless the equipment is properly delivered and installed - in what can be described as a domino effect.

CHD IV-B tries to mitigate this situation by taking on the bidding for LGU HFEP projects in addition to the projects that it handles. In the short run this may help, but suppliers from Manila are likely to encounter at least some of the same shipping problems in the longer run. The other alternative - partnering with DPWH - is no longer considered, however, because of the CHD's experiences with poor quality, high costs and late delivery of DPWH-implemented health facilities.

The sustainable solution would be for contract prices to properly reflect the unique additional costs associated with the geography of MIMAROPA. This decision has not yet been made by DOH-CO, which decides on the level and allocation of funds across programs, however. In short, the problem is in procurement policy that has not yet been corrected.

"Political issues" – referring to CIs - are also an impediment. Some projects approved via CI do not have readily available land and typically do not have approved technical (architectural and engineering) plans. Thus, the CHD must begin from scratch and make plans for projects they did not even propose. To provide an example, no new barangay health stations were proposed for one province in FY 2018. However, when the 2018 General Appropriations Act (GAA) was approved, P15 million was appropriated for the construction of six barangay health stations in that province.

Political pressure may also be behind allocations that are centrally approved but which are not appropriate for the region, i.e., for instance, the allotment of funds for 43 land ambulances, after CHD IVB had proposed a budget for sea and land ambulances; more land ambulances are simply not useful. However, in this case, DOH-CO only has standards for land ambulances; there are no standards for air/sea ambulances.[56] Thus, just like in the earlier matter (of a dearth of bidders), the problem is a policy that has not yet been corrected.

5.3 CHD VI – slow-spending (Appendix III)

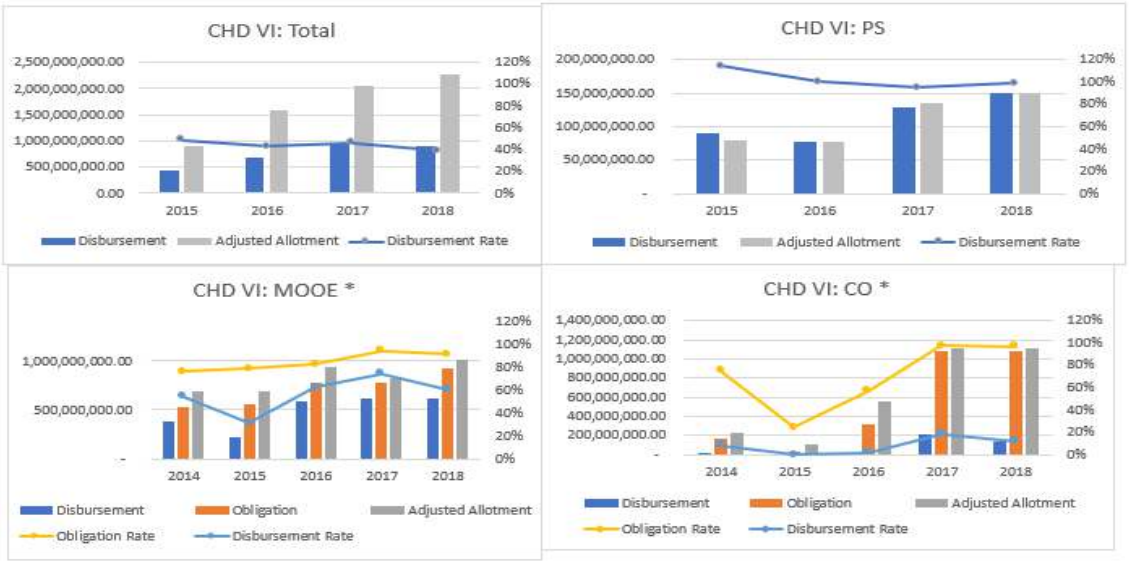
CHD VI has been able to steadily increase its absorption of PS and MOOE allotments over the period, which is reflected in stellar PS disbursement rates, although not MOOE disbursement rates (Figure 10). It turns out that, despite maintaining respectable levels of MOOE disbursements from 2016 and 2018, MOOE rates are not that good because MOOE allotments increased faster than disbursements over the period. In any case, CHD VI identifies issues related to price ceilings and technical specifications prescribed in the DPRI and PNF (earlier mentioned for CHD I) as contributing to shortfalls in the disbursement of MOOE funds; overly high amounts set by DOH-CO for trainings and seminars, which typically lead to savings (which the CHD may or may not be able to

[56] Standard setting for facilities, including sea/air ambulances is a function of DOH-CO. Currently, CHD IV-B is coordinating with DOH–CO as well as with religious institutions to obtain air and sea ambulances.

redeploy[57]); and procurement rules that enable delays. An example of the latter is the 60-day grace period for delivery of goods, which suppliers can easily game, by asking for an extension or change order as late as the 59th or so day, disrupting the process and, at worst, triggering a whole new round of bidding.

CO allotments have not been absorbed well by the CHD, however. CO allotments shot up four-fold in 2016 and then doubled again in 2017, even though actual disbursements hardly moved in 2016 and increased to just 19% of allotments in 2017 (before falling back again in 2018).

FIGURE 10: CHD VI: DISBURSEMENT RATES, LEVELS OF DISBURSEMENTS, AND LEVELS OF ADJUSTED ALLOTMENTS BY EXPENSE CLASS



Source: Appendix Figures A3.6 and A3.12

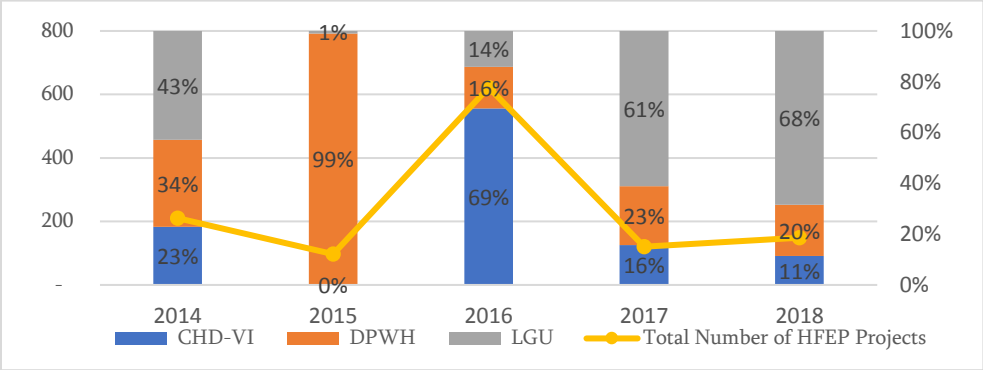
Two related factors seem to be most salient to explain the CO disbursement showing of CHD VI. First, HFEP projects are procured and implemented either by the CHD, DPWH, or an LGU; the decision to download funds to DPWH or LGU is made by the CHD. While there may be efficiency gains or even political gains from downloading funds DPWH and LGUs[58], the CHD gives up control over disbursements when projects are outsourced. However, if a loss of control over disbursements also means being able to focus on an enabling role to LGUs (rather than having to directly bid out and manage infrastructure projects) then the trade-off may be well worth it for CHDs.

This is the case for CHD VI. CHD VI prefers to outsource projects to LGUs or DPWH, arguing that infrastructure management (including supervising architectural or engineering work) is simply not among the core skills of

[57] Better explained in section E, CHD XI, below.
[58] Political gains may be realized if the preference of politicians as to project implementer – a DPWH district office, the provincial government, or the CHD - is accommodated.

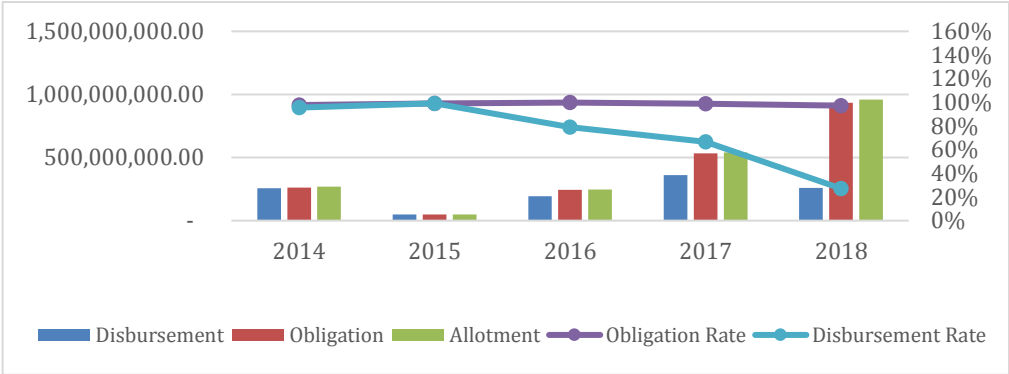
health/medical personnel. Thus, from a 43% (LGU)-34% (DPWH) -23% (CHD) split in the implementation of HFEP projects in 2014, the split has become 68% (LGU)- 20% (DPWH) – 11% (CHD) in 2018 (Figure 11). The trade-off, however, has been decreasing disbursement rates among implementing LGUs starting 2015 (Figure 12), and overall CHD CO disbursement rates and absolute levels of CO disbursements staying low and flat in both 2017 and 2018 (refer again to Figure 9). CHD VI still prefers this arrangement, preferring to support LGUs to expand their own absorptive capacities.

FIGURE 11: CHD VI HFEP PROJECTS BY IMPLEMENTING OFFICE, 2014-2018



Source: Appendix III, Figure A3.13

FIGURE 12: LGU HFEP PROJECTS IN REGION VI, 2014-2018



Source: Appendix III, Figure A3.14

The second, and related, factor is CIs, which CHD VI seems to be a major recipient of.[59] Quite apart from disturbing the rational distribution of health facilities, CIs in the region have also seriously challenged LGU capacities – as Figure 10 above demonstrates.

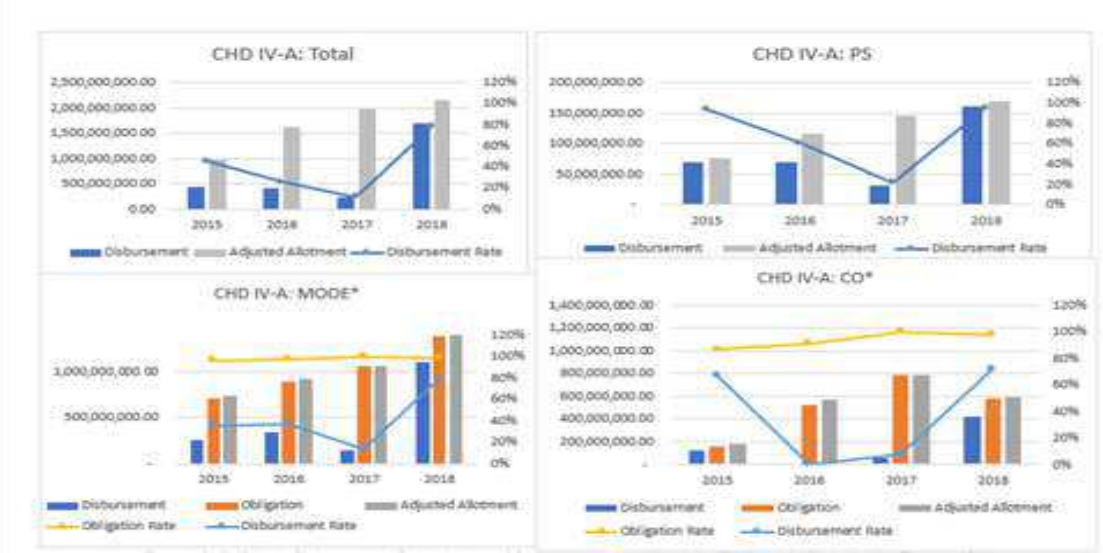
Other CO-related problems include the absence of land titles for HFEP projects ((that is, lack of project preparation, typically for CIs), coordination problems between suppliers and LGU proponents, delays in construction that spillover to delays in purchases of equipment, and the matter of sub-allotments and the difficulties arising from having to disburse these with little warning. As an example, in 2018, the last sub-allotment advice or CO was dated October 26, leaving very little time for CHDs to disburse these funds. The same thing happened for MOOE, where the last SAA in 2018 was dated only December 3. Sometimes program managers are not informed by DOH-CO that they will be given a sub-allotment.

5.4 CHD IV-A – slow spending (Appendix IV)

Total disbursements of **CHD IV-A** declined steadily while its allotments increased from 2015 to 2017 (Figure 13). This happened on all fronts: PS, CO and MOOE (although there is a slight improvement in MOOE disbursements in 2017). Then, in 2018, there was a significant kick in fund absorption: MOOE disbursement rates rose to 79% in 2018, more than double the 37% registered in 2016 and quadruple the 17% rate in 2017. CO disbursement rates also recovered to 72.2% in 2018, from lows of 0% and 7.6% in 2016 and 2017, and more than matching the 2015 rate of 67.1% but at allotment levels three times the level in 2015. And for both MOOE and CO, absolute levels of disbursements increased. While this kick was not enough to pull the CHD's ranking up from among the lowest during the period, the shift in performance is remarkable.

[59] Large amounts of CI have been given for at least one province – Antique – the home region of one Senator, whose term was ending and who is now the Representative of Antique. See Appendix Figure A3.15.

FIGURE 13: CHD IV-A: DISBURSEMENT RATES, LEVELS OF DISBURSEMENTS, AND LEVELS OF ADJUSTED ALLOTMENTS BY EXPENSE CLASS



Source: Appendix Figures A4.6 and A2.12

For CHD IV-A, the sharp improvement in fund absorption in 2018 cannot be explained by the previous year's obligations *per se,* since MOOE and CO obligation rates have been, at least since 2015, consistently high (i.e., above 90 percent). Instead, the impressive performance in 2018 seems to be due to structural budget reforms *combined* with new leadership which was able to leverage those reforms. Structural budget reforms refer to the removal of CONAP in 2018 - in anticipation of cash-based budgeting, as earlier mentioned - combined with the implementation of the new PREXC budget structure for DOH, featuring pooled funds (e.g. for public health management), an important mechanism.[60] Leadership refers to a new regional director appointed to CHD VI in the first quarter of 2018, who was well-known to have the knowledge and understanding of internal budget processes and technicalities, including procurement and auditing parameters, so as to be able to effectively capitalize on the opportunities presented by pooled funds and cash-based budgeting policies.[61]

Consequently, CHD IV-A was able to speed up procurement and disbursements.[62] Beginning the 2nd quarter of 2018, CHD IVA undertook bids, short of awards and - in an innovation - without specifying the source of funds for these bids, advertising only that the purchase would be completed "upon availability of funds." When funds did

[60] As described in Annex D, under the PREXC structure, soft components of public health programs (such as personnel services, policy development, provision of technical assistance, and training and monitoring) were pooled under one item called 'Public Health Management' so that funds may be more fungible across public health programs for these expense items.

[61] Pooled funds, or the "one fund" rule, is consistent with cash-based budgeting and execution and is an important mechanism because programs will typically not proceed at the same time. When funds are not pooled, the typical practice is to assign activities to specific allotments - sometimes, just to consume those funds - and, if activities cannot be identified, or if activities are not yet scheduled, to let those funds remain idle. Under a 'one fund' rule, funds can be deployed for activities that are ready to go.

[62] This section draws heavily from an interview with CHD IVA Regional Director Eduardo Janairo, 1 July 2019 who assumed office in the 2nd quarter of 2018.

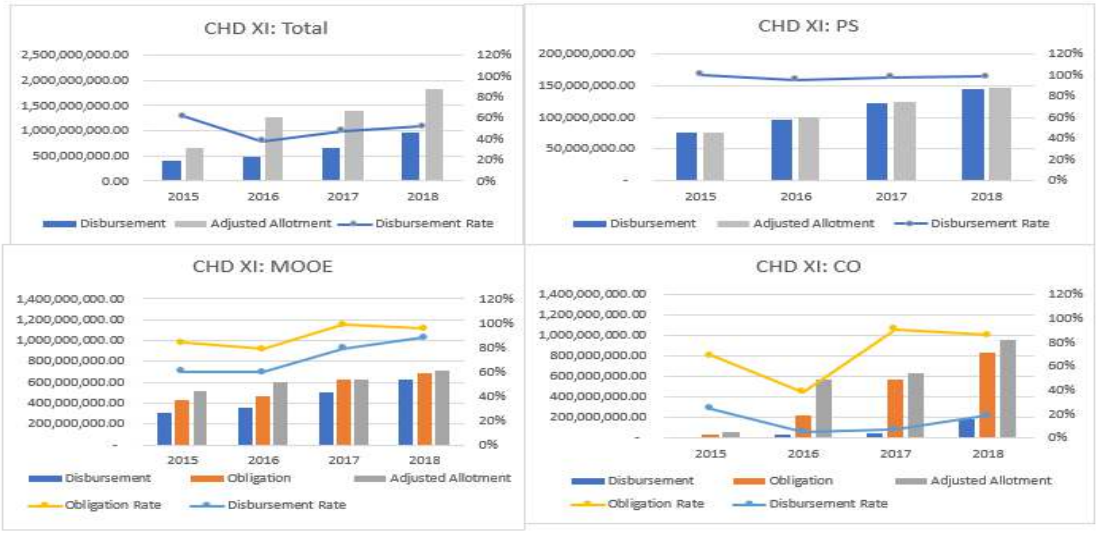
become available – whatever cash was made available first - the management team would then decide which contract to complete and fund first based on all the listings before them.

Other operational actions undertaken by the new CHD VI director to improve budget execution were (i) the maximization of the Work and Financial Plan (WFP) as a tool, including quarterly (and not just annual) WFPs; (ii) strict, close and proactive monitoring and enforcement of HFEP projects; and (iii) a redistribution of infrastructure contracting away from DPWH (due to high costs and poor quality) and back toward the CHD and LGUs. In 2017, almost 100% of HFEP projects were under the ambit of DPWH. This was corrected in 2018 and 2019 moving most projects back to the CHD.

5.5 CHD XI – average-spending (Appendix V)

The absolute levels of PS and MOOE disbursements of CHD XI have increased at the same pace as allotments, resulting in PS disbursement rates remaining steady at a high of 100% and MOOE disbursement rates increasing from 60% in 2015 to 88% in 2018 (Figure 14)**.** Where the CHD has had difficulty is with the absorption of CO allotments: only about P13.9 million was spent out of P55.9 million allotted in 2015, a level that increased to P30 million out of P569 million allotted in 2016, and P43 million out of P630 million allotted in 2017. Note that there was a 10-fold increase in CO allotments from 2015 to 2016, and another increase in 2017, even though disbursement levels were hardly rising. In 2018, spending quadrupled to P179.6 million, but allotments also increased by 50 percent to P931 million.

FIGURE 14: CHD XI: DISBURSEMENT RATES, LEVELS OF DISBURSEMENTS, AND LEVELS OF ADJUSTED ALLOTMENTS BY EXPENSE CLASS



Source: Appendix Figures A5.6 and A5.12

For this CHD, current year CO disbursements seem to have been helped along by previous year CO obligations (also Figure 12). It also seems like the 10-fold increase in allotments in 2016 was simply overwhelming and that it, along with the continuous increase in allotments afterwards, had more to do with the new political context than anything else. Region XI is the home region of the incumbent President of the Philippines who took office in 2016 and who directed attention to the region (and to Mindanao more generally) by, among others, having Davao (a province in Region XI) as an informal alternative to Metro Manila as his seat of government.

The greater attention and PAP funds directed at Region XI has become a double-edged sword, however, because (as already mentioned) politically driven PAPs disturbed the rational allocation of funds for the region. There were situations where the preparatory work for a HFEP project was complete (e.g. having secured a resolution from the local government, the commitment of the governor, validated land titles, and so forth), only to have a Congressman derail it by wanting another type of facility or another location. CI requests also involved requests to the DOH Secretary for the realignment of funds - funds for a CT scan costing 40M here, or for wheelchairs worth 6M there – each relatively small on their own but which, when added up, amount to a significant amount of 'sub allotments' that a CHD needs to disburse. Political PAPs comprise "a huge part of the pie". Some PAPs are identifiable as non-implementable even before the GAA is passed.

Thus, in the view of CHD XI, difficulties in CO absorption are primarily procurement-related – "procurement is the culprit here" – which includes the complications and delays brought about by CIs. Other procurement-related problems include:

(i) Legally prescribed rules, such as the 60-day grace period for a supplier to deliver goods, which suppliers abuse, e.g., writing to the CHD on the 50th day to request for a change order. A change in this manner may be disallowed by auditors (from the Commission on Audit) ex-post, however. Thus, the purchase is either cancelled and a new bid conducted, or an extension is given to suppliers to deliver what was exactly procured;

(ii) Internal coordination issues, e.g., inefficient scheduling and inability to obtain a quorum for meetings or inspections of the Bidding and Awards Committee (BAC). By law, a procuring entity must establish a BAC composed of at five or seven permanent officers, the Chair of which is at least a 3rd ranking permanent official (e.g. Assistant Secretary) and two others at least 5th ranking permanent officials. BACs are ad hoc, therefore, and personnel cannot be pulled out of divisions at a moment's notice. If a quorum is not formed, deliveries, inspections and acceptance of goods are all delayed;

(iii) Delays in infrastructure spending which cause delays in equipment spending. Equipment cannot be delivered, inspected, nor accepted (and paid) if the facility is not ready.

(iv) High cost standards issued by DOH-CO, particularly for MOOE items – training, supplies – which invariably leads to savings, after bidding drives down costs; what are savings looks like 'underspending'. Technically, savings can be redeployed for a similar activity – another training, more supplies - but it depends on how fast the CHD can pivot in order to redeploy savings. Also, redeploying could be interpreted as "technical malversation" depending on the judgement of the regional Commission on Audit. DBM's approval must also be sought for a redeployment of funds across programs or units.

It is only the first item above that is a procurement issue *per se* however – and one which may be mitigated by stronger enforcement (e.g. blacklisting a supplier) but is better cured by a reform in legal rules. To the extent that the composition and procedures of the BAC are provided in minute detail in the implementing rules of the law (with very little maneuvering room), the second one may also be driven by legal rules. However, it may also be a problem that can be mitigated with a deeper bench of high-ranking officials who are proficient in procurement.

The third and fourth are policy issues. Funds for equipment need not be proposed in the same year as the construction or renovation of the facility (a reform that is now being implemented apparently). Clearer guidance on the extent savings can be redeployed can be issued.

6. LINKING DISBURSEMENTS TO SERVICE DELIVERY TARGETS AND OTHER STRUCTURAL ISSUES

The preceding sections indicate factors that weigh heavily in explaining CHD disbursement performance, namely,

1. **The performance of MFO2**, Technical Support Services, which is the most relevant part of the CHD budget, based on sheer size. Across the five CHDs studied, MFO2 claimed the largest share of adjusted allotments, ranging from 85 percent to 90 percent, or an average of 87 percent as well as the largest share of unspent adjusted allotments for MOOE (80 percent), CO (96 percent) and in the overall (89 percent). MFO2 has both MOOE and CO components. MOOE spending (53 percent) is for training and capacity building support, as well as for commodity support to LGU health programs. CO spending is for infrastructure and equipment under the HFEP (47 percent). CO outlays perform worse, with an average disbursement rate of 25.4 percent, against an average MOOE disbursement rate of 66.2 percent.

2. **For CO/HFEP disbursements within MFO2, political and procurement-related factors** such as:

    a. **Congressional insertions and attendant complications**. The unpredictability of CIs disrupts budget execution, not to mention the rational deployment of health infrastructure spending. Complications relate to the absence of requirements (including available land, basic plans, and concurrence of local governments), the late release of funds due to the absence of these requirements, the lack of capacity for LGUs to manage the procurement of CI projects assigned to them (CHD VI, IV-B), sometimes the lack of capacity of the CHD to absorb sharp increases in funds (CHD XI). CIs which require a realignment of funds by the DOH Secretary, e.g., for new equipment, will also disrupt CHD operations as these items amount to insertions in the work and financial plans of CHDs.

    b. **Population size** of regions, which may be salient because of political interests as well. Quite apart from the larger range of health-related threats that comes with a larger population (all other factors fixed), if size is equated with voter population, then these regions would be more attractive to politicians who would be inclined to sponsor their own projects in the region, interfering with smooth budget execution.

    c. **Whether and to whom – LGUs, DPWH - HFEP funds are downloaded for implementation**. The performance/capacities of LGUs and regional DPWH varies across regions just as the propensity of CHDs to download funds to them does. But the data indicates that the decision to download funds, and to which implementer, matters to the pace of HFEP disbursements.

    d. **Failed or late bidding** due to, among others, low contract prices (in turn due to the non-inclusion of transportation costs and other special considerations in prices), or late releases of HFEP funds or sub-allotments from DOH-CO, which means procurement will start too late;

    e. **Legally prescribed procurement rules** which are, inadvertently, easy for suppliers to manipulate, such as the 60-day grace period for a supplier to deliver goods;

    f. **Other procurement-related problems** such as internal inefficiencies of the BAC; coordination problems between LGUs and DPWH, or between CHDs and DPWH; spillover effects from the delayed construction of facilities which in turn delay the completion of procurement for equipment;

3. **For MOOE disbursements, specific procurement policy-related factors**, such as (i) price ceilings and technical specifications for drugs prescribed in the DPRI and PNF which are too low or stringent and which result in failed bids for drugs/medicines, and (ii) savings from the procurement of training and supplies

(the cost standards of which are set at DOH-CO and which are relatively high) that are mistaken for underspending. However, the latter is also related to whether and how savings can be redeployed, which, in turn, seems to depend on how fast a CHD can pivot, the CHD's risk appetite for the redeployment of funds (e.g., given that redeployment may be viewed as 'technical malversation' by the local Commission on Audit), and external factors such as the appreciation of redeployment of savings by the local Commission on Audit;

4. **New budget execution protocols** such as (i) the shift by DBM to a one-year validity of appropriations in 2017 (and the removal of CONAP in 2018) in preparation for cash-based budgeting which seemed to have pushed both MOOE and CO disbursements in 2018 (as well as CO obligations in 2017 – which would have also pushed CO disbursements in 2018), and, in at least one CHD, (ii) DOH's new PREXC budgeting structure in 2018 which featured pooled funds, combined with CHD leadership well-versed in internal budget processes and technicalities able to leverage the flexibilities presented by pooled funds[63] and cash-based budgeting policies. It should be noted that past year CO obligations seem to help push current year CO disbursements in at least some CHDs;

5. **For both MOOE and CO, the matter of *sub-allotments* from DOH-CO to the CHD** – the amounts involved, the timing, the lack of warning – and the implications on a CHDs work plans and, consequently, spending performance.

How have CHD MOOE and CO disbursement rates affected the achievement of service delivery targets? **It turns out that service delivery targets have been achieved in any case**. Annual physical targets associated with MOOE spending for four CHDs have been met 100 percent or more (from 2014 to 2017), although annual MOOE disbursement rates (for MFO 2.1 and 2.3) have ranged from 45 percent to 90 percent, and 28 percent to 71 percent on average, respectively (Table 11). Annual physical targets for HFEP, i.e. "number of LGUs and other health partners provided with health facilities", have likewise been met at rates near 100% - except for one year for CHD I and two years for CHD IVA - with little correlation to current year disbursement or obligation rates (Table 12). It is also unclear whether or how the achievement of service delivery targets is linked to the achievement to "equitable access" indicators (e.g., among others, one barangay health station per barangay) and onwards to larger sector outcomes (e.g., out of pocket expenditures for health reduced, 24/7 access to health services, universal health insurance coverage, lower malnutrition rates, etc.).[64]

[63] Flexibilities such as, among others, being able to redeploy savings from training procurement across public health programs since soft components for public health programs are now pooled. Refer to footnotes 60 and 61.
[64] See Annex Figures E.1 and E.2 for barangay health station indicators.

TABLE 11: MOOE PERFORMANCE INDICATORS AND DISBURSEMENT RATES, 2014 - 2017

CHD	Performance Indicators	2014		2015		2016		2017		DR (annual average)
		Targets	%	Targets	%	Targets	%	Targets	%	
CHDI	HRH trained	2,791	227%	5,968	119%	3,042	109%	2,730	90%	90%*
	Training days delivered	187	243%	386	126%	132	137%	202	102%	
	Commodities/ services provided to LGUs	1,809,372	110%	2,373,812	100%	3,403,560	108%	3,630,088	109%	71%**
CHD IVB	HRH trained	1,251	107%	672	107%	1,430	100%	1,365	109%	91%*
	Training days delivered	232	104%	113	101%	33	100%	38	161%	
	Commodities/ services provided to LGUs	1,557,028	99%	2,435,589	96%	1,821,063	100%	2,596,798	153%	84%**
CHD VI	HRH trained	11,226	158%	23,243	133%	16,569	106%	6,662	115%	61%*
	Training days delivered	615	130%	1,162	88%	760	104%	482	118%	
	Commodities/ services provided to LGUs	2,235,070	107%	3,255,765	104%	4,553,726	108%	2,460,598	132%	28%**
CHD IVA	HRH trained	8,751	105%	5,532	236%	9,824	172%	9,959	126%	45%*
	Training days delivered	1,400	105%	732	101%	598	111%	546	120%	
	Commodities/ services provided to LGUs							4,561,952	118%	31%**

Source: Appendix I-IV Tables.

(Notes: HRH: human resources for health; Commodities/services include vaccinations and hours of doctors/nurses/midwives; * MFO2.1 MOOE annual average disbursement rate; ** MFO 2.3 MOOE annual average disbursement rate.)

TABLE 12: PHYSICAL CO/HFEP TARGETS, % ACHIEVED, OBLIGATION AND DISBURSEMENT RATES, 2014-2017

	2014				2015				2016				2017			
	Targets	% met	OR	DR	Targets	% met	OR	DR	Targets	% met	OR	DR	Targets	% met	OR	DR
CHD 1	32	94%	56%	42%	34	0%	56%	51%	75	100%	48%	29%	29	100%	99%	20%
CHD IVB			96%	50%			96%	0%			98%	47%	10	740%	100%	16%
CHD VI	83	124%	84%	8%	58	103%	84%	0%	98	112%	57%	2%	23	213%	96%	19%
CHD IVA	112	121%	94%	0	24	42%	94%	73%	45	20%	91%	0%	67	107%	100%	8%

Source: Table 7 and Appendix I-IV Tables

(Notes: Target: "Funding Support: Number of LGUs and other health partners provided with health facilities"; % achieved: actual/target * 100%; OR: obligations/AA; DR: disbursements/AA. No targets are indicated for CHD IVB for years 2014-2016)

The list of factors above suggests that improvements in procurement policy and management, especially protocols involving political PAPs (e.g., whether and when to re-obligate funds if some are non-implementable) and the redeployment of savings, can loosen up bottlenecks in budget execution. The full implementation of cash-based budgeting policies and the flexibilities offered by the new DOH PREXC budget structure also promise to facilitate the budget credibility.

However, the list also suggests more fundamental "assignment" problems that need to be confronted, specifically: (a) whether or not to keep the execution of health infrastructure works in-house or to outsource it to DPWH and LGUs (or under what conditions these should be) and (b) the assignment of allocative and disbursement control over funds for major public health PAPs between DOH-CO units and CHDs. The latter problem seems to be at least as critical as the former since both MOOE and CO spending are affected. For the five case study CHDs, for instance, the average disbursement rate of "regular regional offices budget items" – over which CHDs have both allocative and disbursement control – is 77 percent, almost 20 percentage points greater than the average disbursement rate for "DOH-CO budget items with regional distribution" - at 58 percent – over which CHDs only have disbursement control. Moreover, it looks like, on average, a greater share of transfers or sub-allotments in adjusted allotments tends to lower the proportion of allotments that is disbursed of that item per year (Table 13).[65]

[65] From all accounts, timeliness also plays a big part in this, i.e. whether sub-allotments or supplemental funds come in the latter half of the year or not, but we are unable to further disaggregate this from the data.

TABLE 13: BY TYPE OF BUDGET ITEM: Average adjusted allotments (AA), share in total AA, transfers, share of transfers in AA per item, unspent AA, share in total unspent AA, and disbursement rates for 5 case study CHDS, 2014-2018

PAP	Adjusted Allotments (AA)	Share in Total AA	Transfers from DOH-CO	Share of transfers in AA per item annual average	Unspent AA	Share in Total unspent AA	Disbursement rate, average
Regular "Regional Offices Budget Items"	***295,741,595***	***22%***	***12,972,073***	***4%***	***79,886,526***	***11%***	***77%***
Support to Operations (STO)	64,979,882	5%	3,772,467	5%	9,857,437	2%	84%
MFO 2.1.3 (Local Health Systems Development Assistance)	214,877,196	15%	9,174,661	3%	66,859,748	9%	66%
MFO 4: Health Sector Regulation Services	15,884,517	1%	24,945	0%	3,169,341	0%	79%
DOH-CO budget items "with regional distribution"	***1,099,199,198***	***78%***	***379,320,929***	***34%***	***601,849,440***	***90%***	***58%***
General Administration and Support (GAS)	16,086,205	1%	14,513,484	74%	13,069,290	2%	55%
MFO 1: Health Sector Policy Services	11,277,536	1%	9,023,332	75%	4,721,327	1%	58%
MFO 2..1.1 (Human Resources for Health	24,212,637	2%	11,691,037	67%	702,590	0%	84%
MFO 2.1.2	339,262,527	24%	84,972,407	30%	88,660,684	10%	78%
MFO 2.3 Disease Prevention and Control	635,795,760	46%	184,382,919	28%	456,576,117	72%	36%
MFO 3: Hospital Services	5,319,221	0%	5,387,802	94%	3,901,646	1%	42%
Locally Funded Projects (LFP)	67,245,311	4%	69,349,949	100%	34,217,785	5%	52%
Note: Totals for case study CHDs	*1,394,940,793*				*681,735,966*		
Note: Correlation coefficient with Disbursement Rate				-.50			

Source: Various tables, Appendices I-IV

A review of functional assignments between DOH and other agencies and among DOH units is bound to have important implications not only for the speed of spending but also the *quality* of spending – at least, the efficient use of public funds for health. For one, efficiency and accountability gains are promised with expenditure assignments that are more closely based on principles of comparative advantage and fiscal federalism and which are duly supported by both allocative and disbursement control over funds.[66] But efficiency gains may also arise from a redeployment of DOH resources more generally, e.g., DOH's own 'human resources for health' from the supervision of civil infrastructure works to the formation, coordination and regulation of public-private 'service

[66] For instance, a well-known decentralization theorem (Oates 1972) is that public services are provided most efficiently "by the jurisdiction having control over the minimum geographic area that would internalize benefits and costs of such provision". The assignment of revenue powers should then match expenditure functions.

delivery networks" (functional networks of health facilities) within provinces. Spending pressures may be eased if DOH could better unload the implementation of devolved functions to LGUs or increasingly outsource functions to the private sector.[67]

This highlights the distinct possibility that DOH-OSEC is very close to hitting its absorptive capacity limit and that, even as there is room to expand spending capacities by improving procurement and financial management, other mechanisms may be required so that greater returns in terms of desired health outcomes can be obtained for every public peso spent. Indeed, the very weak link between PAP physical targets and spending levels (and between physical targets and health agenda outcomes) indicates the presence of deeper structural issues in the sector (quite apart from budget execution bottlenecks.) Panelo et. al. (2017) discuss, for instance, how social health insurance and the public delivery system, accounting for just 37 percent of total health spending (in 2014), are unable to leverage funds for performance of the entire health system due to their being highly fragmented:

"While national government accounts for 11 percent of total health care spending, this fund is spent on various stand-alone programs. The 13 percent share of LGUs is spent by 81 provinces, 143 cities, and 1,459 municipalities, each managing its own fund independently and addressing a widely heterogeneous set of local health issues. While the social health insurance share has moderately increased to 14 percent, its influence over both the public and private health care delivery sector becomes weaker as it introduces more and more benefit packages, all funded by a fixed budget envelope."

Thus, even if there are enough public funds to provide for those who cannot pay for their own health care owing to inequities, the ineffective application and use of public funds has instead resulted in inefficiencies (e.g. from lack of risk-pooling) and persistent inequities (as the poor are crowded out from public subsidies due to poor coordination, overlapping or incomplete coverage of priorities, and problematic and inconsistent targeting across 'depositories') (Panelo et. al. 2017).

In short, improving budget credibility by improving spending capacities is but one factor to achieving desired health outcomes. More fundamental challenges to the health sector, such as the ones described in Panelo et. al. (2017), will have to be addressed.

[67] Picazo, et. al (2015) point out that limited in-house capacity for HFEP (e.g. not enough engineers and architects to design facility upgrading, not enough Central Office Bids and Awards Committees, insufficient technical personnel to monitor the pace of facility upgrading) could have been addressed by pooling multiple projects into large packages that could then have been outsourced.

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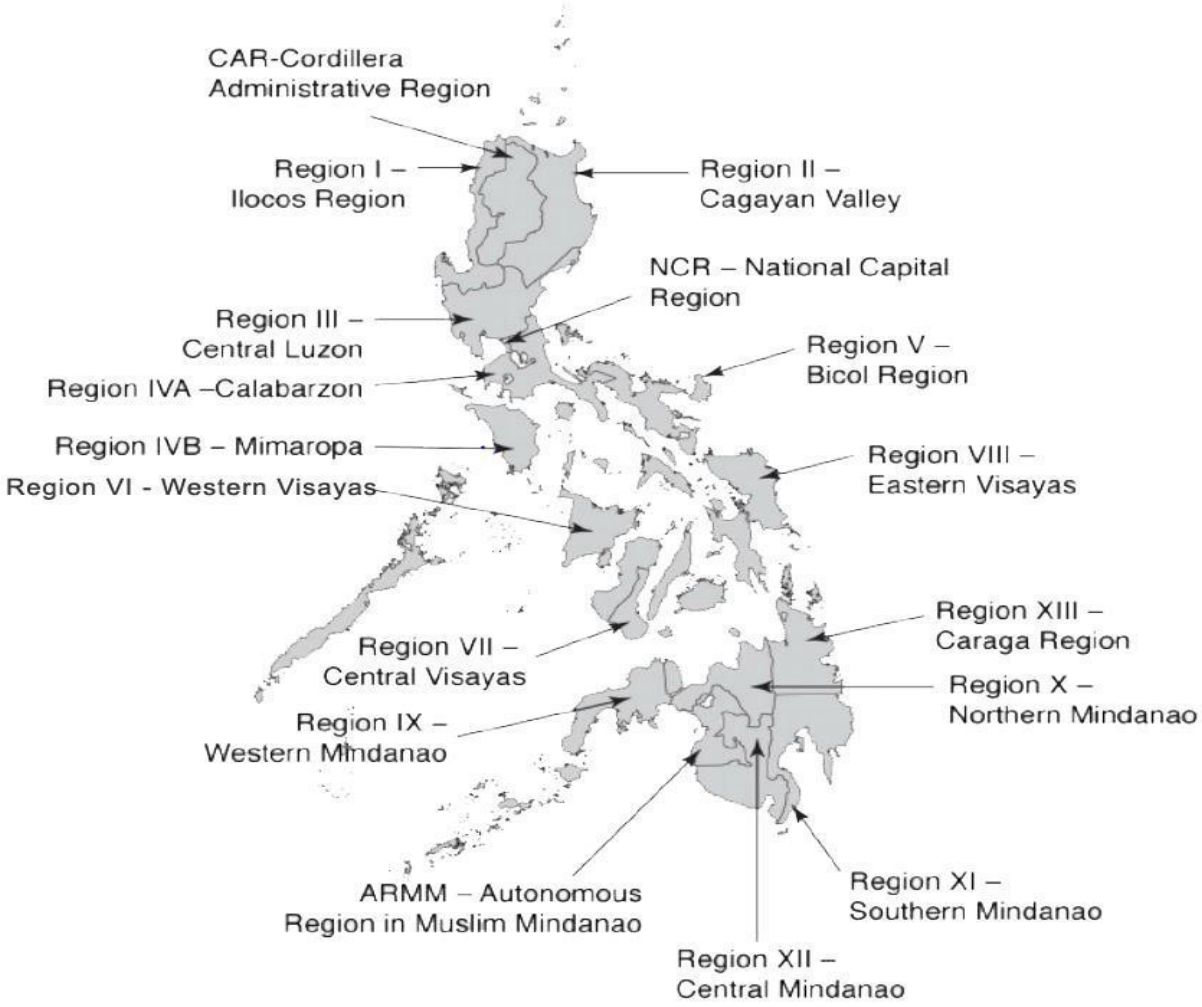
ANNEX A. REGIONAL MAP OF THE PHILIPPINES



ANNEX B. OUTLINE OF THE DOH AGENCY-SPECIFIC BUDGET

Agency-Specific Budget Line	Details/Notes
A. General Administration and Support	
B. Support to Operations (STO)	
Health Information Systems and Technology Development	
Support to regional delivery services	PS, MOOE and CO for CHDs
C. Operations	
MFO 1: Health Sector Policy Services	
MFO1.1 Formulation and Development of National Health Policies and Plans including Essential National Health Research	1.1.1 Development of Policies, Support Mechanisms and Collaboration for International Health Cooperation; 1.1.2 Health System Development Program; 1.1.3 Formulation of Policies, Standards, and Plans for Hospital and other Health Facilities; 1.1.4 National Pharmaceutical Policy Development; 1.1.5 Public Health Development Program including Formulation of Public Health Policies and Quality Assurance; 1.1.6 Health Policy Development including Essential National Health Research
MFO 2: Technical Support Services	
MFO2.1 Human Resource Development (HRD)	MFO2.1.1 Health Human Resource Policy Development and Planning for LGU and regional support
	MFO2.1.2 Implementation of the Doctors to the Barrios and Rural Health Practice Program (i.e. deployment of Physicians, nurses, and midwives to 4th to 6th class municipalities or Conditional Cash Transfer (CCT) areas, where lacking)
	MFO2.1.3 Local Health System Development Assistance (LHSDA) Local health efforts intended to improve health status of local population. Serves as the focal point for convergence and inter-LGU cooperation
MFO2.2 Health Care Assistance	MFO2.2.1 Subsidy for health insurance premium payment of indigent families to the National Health Insurance Program; MFO2.2.2 Assistance to Philippine Tuberculosis Society (PTS); MFO2.2.3 Assistance to Private Sector Health Centers
MFO2.3 Disease Prevention and Control	
	MFO2.3.1 Epidemiology and Disease Surveillance To strengthen the technical capacity of CHDs in relation to field health information system, epidemiologic surveillance and control, and health status assessment of populations.
	MFO2.3.2 Elimination of Diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis
	MFO2.3.3. Rabies Control Program mass dog vaccination, impounding, establishment of a central database system

	MFO2.3.4 Expanded Program on Immunization Provides routine immunization to children and mothers to prevent vaccine preventable diseases.
	MFO2.3.5 TB Control scaling-up and sustaining coverage of DOTS implementation, ensuring provision of quality TB Services
	MFO2.3.6 Other infectious diseases and emerging and re-emerging diseases including HIV/ AIDS, dengue, food and water borne diseases Diagnostic, treatment, and preventive health services
	MFO2.3.7 Environmental and Occupational Health Reduction of human exposures to various environmental hazards n
	MFO2.3.8 Non-Communicable Disease Prevention and Control
	MFO2.3.9 Family Health and Responsible Information and services for the couples of reproductive age.
	MFO2.3.10 Operation of the PNAC Secretariat
	MFO2.3. 11 Health Promotion Information dissemination and continuous health information through health-enhancing activities
	MFO2.3.12 Health Emergency Management including provision of emergency drugs and supplies
	MFO2.3.13 Health Facilities Enhancement Program (for facilities of LGUs and other health sector partners) [HFEP] New facilities or the upgrading of existing public health facilities such as barangay health stations, rural health units/ health centers, LGU and DOH hospitals
	MFO2.3.14 Quick Response Fund
MFO 3: Hospital Services	
MFO3.1 Operation of National, Special and Regional Centers/Hospitals	MFO3.1.1 National Voluntary Blood Services Program and Operation of Blood Centers; MFO3.1.2 Operation of Special Hospitals, Medical Centers and Institutes for Disease Prevention and Control; MFO3.1.3 Operation of Regional Medical Centers, Sanitaria and Other Hospitals
MFO3.2 Operation of Dangerous Drug Abuse Treatment and Rehabilitation Center	MFO3.2.1 Treatment and Rehabilitation Center Treatment and management drug abuse cases in 13 DOH-Treatment and Rehabilitation Centers & Community-based drug rehab
MFO 4: Health Sector Regulation Services	
MFO4.1 Regulation Functions	MFO4.1.1 Regulation of Health Facilities and Services; MFO4.1.2 Regulation of Devices and Radiation Health MFO4.1.3 Regulation of Food and Drugs, including Regulation of Food Fortification and Salt Iodization; MFO4.1.4 Operation of Satellite Laboratories MFO4.1.5 Quarantine Services and International Health Surveillance MFO4.1.6 Regional Health Regulations
F. LOCALLY FUNDED PROJECTS	

ANNEX C. ILLUSTRATION: FROM *AUTHORIZED APPROPRIATIONS* (GAA) TO *ADJUSTED ALLOTMENTS* FOR FY 2017 AND 2018

ANNEX TABLE C.1: DOH-REGION IV-B, APPROPRIATIONS AND ALLOTMENTS (CURRENT YEAR 2017)

	APPROPRIATIONS				ALLOTMENTS				
	Authorized Appropri-ation	Adjustments (Transfer To/From Realignment)		Adjusted Appropri-ations	Allotments Received	Adjustments (Withdrawal, Realignment)	(Transfe r to)	Transfer from	Adjusted Total Allotments
		Outside Dept.	Within Dept.						
Grand Total (Current Year 2017)	1,300.41	-	431.98	**1,732.39**	1,345.66	- 0.00	- 1.35	357.17	**1,701.48**
PS	352.62	-	123.05	**475.68**	397.88	9.66	-	37.23	**444.76**
MOOE	545.29	-	148.69	**693.98**	545.29	- 9.66	- 1.35	159.70	**693.98**
CO	402.50	-	160.24	**562.74**	402.50	-	-	160.24	**562.74**

**in millions*

Source: SAAODB 2017

ANNEX TABLE C.2: DOH-REGION IV-B, APPROPRIATIONS AND ALLOTMENTS (CURRENT YEAR 2018)

	APPROPRIATIONS				ALLOTMENTS				
	Authorized Appropriat ion	Adjustments (Transfer To/From Realignment)		Adjusted Appropri-ations	Allotments Received	Adjustments (Withdrawal, Realignment)	Transfer to	Transfer from	Adjusted Total Allotments
		Outside Dept.	Within Dept.						
Grand Total (Current Year 2018)	470.73	983.15	307.66	**1,761.53**	1,458.11	-	- 1.00	304.42	**1,761.53**
PS	94.92	7.01	49.85	**151.78**	106.17	3.23	-	42.39	**151.78**
MOOE	375.80	-	236.06	**611.87**	375.80	- 3.23	- 1.00	240.29	**611.87**
CO	-	976.15	21.74	**997.89**	976.15	-	-	21.74	**997.89**

**in millions*
Source: SAAODB 2018

ANNEX D. MAPPING THE CHD FY 2018 PREXC BUDGET INTO MFO LINE ITEMS

In 2015, DBM sought to further strengthen performance-informed budgeting by shifting the structure of the budget from a 'MFO' classification to a **Program Expenditure Classification (PREXC)**. PREXC organizes all recurring activities and projects under programs, and further under *organizational outcomes (OO).* PREXC would allow monitoring and evaluation of agency performance to be at the program level, "providing better information for planning, prioritization and management by agencies." [68]

One key change was the separation of *hard* components (e.g. procurement of commodities such as drugs and medicines) from soft components (personnel services, policy development, provision of technical assistance, and training and monitoring.) Soft components of public health programs were then pooled under one item called 'Public Health Management', leaving the hard components in their respective program line items (i.e., TB Control, Rabies Control, National Immunization, Family Health, Elimination of Diseases, Other Infectious Diseases, and Environmental & Occupational Health). [69] As a result,

"certain Budget Line Items have significantly decreased but only because of integration of certain funds in other line items intended for public health management, health research, training, health promotion, medical assistance program, and operations of national reference laboratories (DOH, n.d.)".

For comparability with previous years, we reclassified the items found in the DOH-CO FY 2018 SAAODB back to their 'MFO' line items. The reclassification is not perfect however precisely because of the pooling that occurred, e.g. into "Public Health Management".

The mapping is presented below. [70]

	FY 2018 SOAADB PREXC CLASSIFICATION	MFO CLASSIFICATION for FY 2018
		MFO1 Health Sector Policy Services
	International Health Policy Development and Cooperation	Development of Policies, Support Mechanisms and Collaboration for International Health Cooperation

[68] https://www.dbm.gov.ph/index.php/performance-management/program-expenditure-classification-prexc/prexc-briefer

[69] Department of Health (n.d.). Retrieved from: https://www.doh.gov.ph/sites/default/files/basic-page/PrExC%20Brochure_1.pdf

[70] As formulated and implemented by case study writers Jenah Flor Lagdameo, Zyralyn Oblefias, Katherine Pilapil and Mia Soriano.

	NA	Health System Development Program including Policy Support
	Health Facility Policy and Plan Development	Formulation of Policies, Standards, and Plans for Hospital and other Health Facilities
	Pharmaceutical Management	National Pharmaceutical Policy Development including provision of drugs and medicines, medical and dental supplies to make affordable quality drugs available
	NA	Public Health Development Program including Formulation of Public Health Policies and Quality Assurance
		Health Policy Development including Essential National Health Research
		MFO 2 Technical Support Services
		Human Resource Development
		Health Human Resource Policy Development and Planning for LGU and regional support
	Human Resource for Health (HRH) Deployment	Implementation of the Doctors to the Barrios and Rural Health Practice Program
	Local Health Systems Development and Assistance, Health Emergency Preparedness and Response, Human Resources for Health (HRH) and Institutional Capacity Management, ***Public Health Managemen***t, Health Sector Policy and Plan Development, Health Sector Research Development	Local Health System Development Assistance
		Health Care Assistance
	Assistance to Philippine Tuberculosis	Assistance to Philippine Tuberculosis Society (PTS)
	NA	Assistance to Private Sector Health Centers
		Disease Prevention and Control
	Epidemiology and Surveillance	Epidemiology and Disease Surveillance
	Elimination of Disease such as Malaria, Schistosomiasis, Leprosy and Filariasis	Elimination of Diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis
	Rabies Control	Rabies Control Program
	National Immunization	Expanded Program on Immunization
	TB Control	TB Control
	Prevention and Control of Other Infectious Disease	Other infectious diseases and emerging and re-emerging diseases including HIV/ AIDS, dengue, food and water borne diseases

	Environmental and Occupational Health	Environmental and Occupational Health
	Prevention and Control of Non-Communicable Diseases	Non-Communicable Disease Prevention and Control
	Family Health, Nutrition and Responsible Parenting	Family Health and Responsible Parenting
	Operation of PNAC Secretariat	Operation of the PNAC Secretariat
	Health Promotion	Health Promotion
		Health Emergency Management including provision of emergency drugs and supplies
	Health Facilities Enhancement Program	Health Facilities Enhancement Program (for facilities of LGUs and other health sector partners)
	Quick Response Fund	Quick Response Fund
		MFO 3 - Hospital Services
	Operation of Blood Centers and National Voluntary Blood Services Program	National Voluntary Blood Services Program and Operation of Blood Centers
		Operation of Special Hospitals, Medical Centers and Institutes for Disease Prevention and Control
		Operation of Regional Medical Centers, Sanitari and Other Hospitals
	Operation of Dangerous Drug Abuse Treatment and Rehabilitation Centers	Operation of Dangerous Drug Abuse Treatment and Rehabilitation Center
		MFO 4 - Health Sector Regulation Services
	Regulations of Health Facilities and Services	Regulation of Health Facilities and Services
	NA	Regulation of Devices and Radiation Health
		Regulation of Food and Drugs, including Regulation of Food Fortification and Salt Iodization
	Provision of Quarantine Services and International Health Surveillance	Quarantine Services and International Health Surveillance
		Regional Health Regulations

ANNEX E. SELECTED HEALTH INDICATORS BY REGION

ANNEX TABLE E.1: NUMBER OF REGISTERED LIVE BIRTHS AND RATES BY REGION (USUAL RESIDENCE OF MOTHER): 2016

(Rate per 1,000 population)

Region	Number	Rate
Region VII	145,550	*19.2*
Region V	116,092	*18.9*
Region X	89,359	*18.7*
Region XI	90,828	*18.0*
Region IV-A	251,344	*17.5*
NCR	219,936	*17.2*
Region III	191,245	*17.0*
Region XII	78,919	*16.8*
Region IX	63,556	*16.6*
Region II	58,490	*16.5*
Region VIII	74,725	*16.2*
CAR	29,285	*16.1*
Region XIII	44,135	*15.9*
Region I	82,206	*15.8*
Region IV-B	48,888	*15.5*
Region VI	114,774	*14.7*
ARMM	31,067	*8.2*
Philippines	1,731,289	*16.8*

Source: Table 9.3, 2018 Philippine Statistical Yearbook

ANNEX TABLE E.2: NUMBER OF REGISTERED DEATHS AND RATES BY REGION (USUAL RESIDENCE): 2016

(Rate per 1,000 population)

Region	Number	Rate
Region I	35,666	*6.9*
Region VI	51,256	*6.6*
Region VII	47,937	*6.3*
Region III	68,757	*6.1*
NCR	76,839	*6.0*
Region II	20,952	*5.9*
Region V	36,228	*5.9*
Region XI	29,260	*5.8*
Region IV-A	82,764	*5.7*
Region X	26,070	*5.5*
Region XIII	14,939	*5.4*
Region VIII	23,821	*5.2*
Region IV-B	16,105	*5.1*
Region XII	22,115	*4.7*
CAR	8,329	*4.6*
Region IX	17,457	*4.6*
ARMM	3,236	*0.9*
Philippines	582,183	*5.6*

Source: Table 9.4, 2018 Philippine Statistical Yearbook

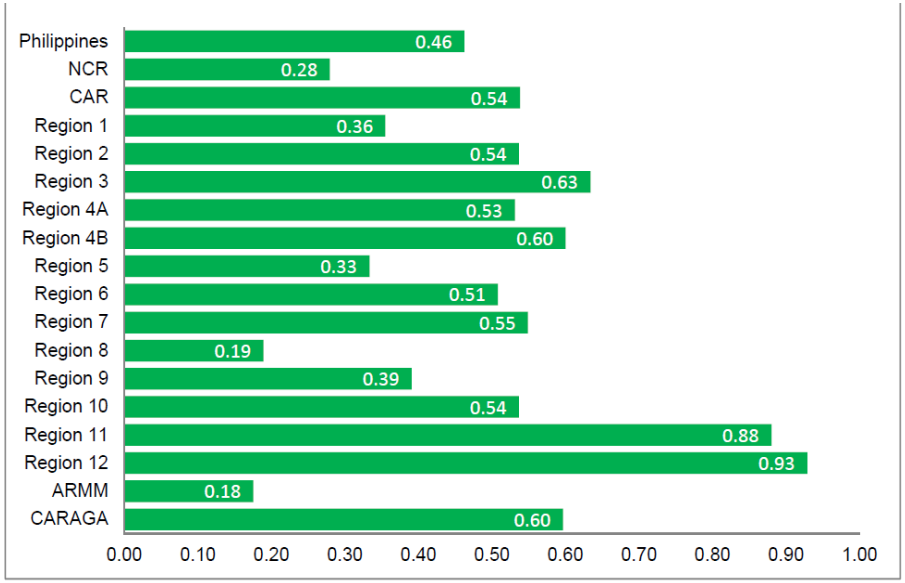
ANNEX TABLE E.3: PREVALENCE OF MALNUTRITION AMONG CHILDREN 0-60 MONTHS OLD BY REGION: 2015

Region	Form of Malnutrition (in percent)			
	Underweight	Stunting	Wasting*	Overweight*
	2015	2015	2015	2015
NCR	15.2	25.2	6.4	6.0
CAR	16.8	36.8	4.4	3.2
I - Ilocos Region	19.4	31.5	6.7	3.2
II - Cagayan Valley	19.9	28.8	7.1	3.8
III - Central Luzon	16.7	22.9	7.5	5.9
IV-A CALABARZON	19.0	27.7	7.6	4.9
IV-B MIMAROPA	31.6	40.7	9.6	3.2
V - Bicol Region	28.5	40.2	8.1	2.6
VI - Western Visayas	26.5	39.9	6.3	3.3
VII - Central Visayas	22.8	37.7	6.9	2.6
VIII - Eastern Visayas	30.0	42.1	8.4	2.3
IX - Zamboanga Peninsula	21.5	38.1	7.1	2.6
X - Northern Mindanao	20.8	37.0	3.9	1.9
XI - Davao Region	20.8	31.6	6.5	2.7
XII - SOCCSKSARGEN	26.0	40.2	6.9	2.7
XIII - Caraga	23.9	36.3	8.1	1.6
ARMM	25.0	45.0	8.2	4.1
Philippines	21.6	33.5	7.1	3.8

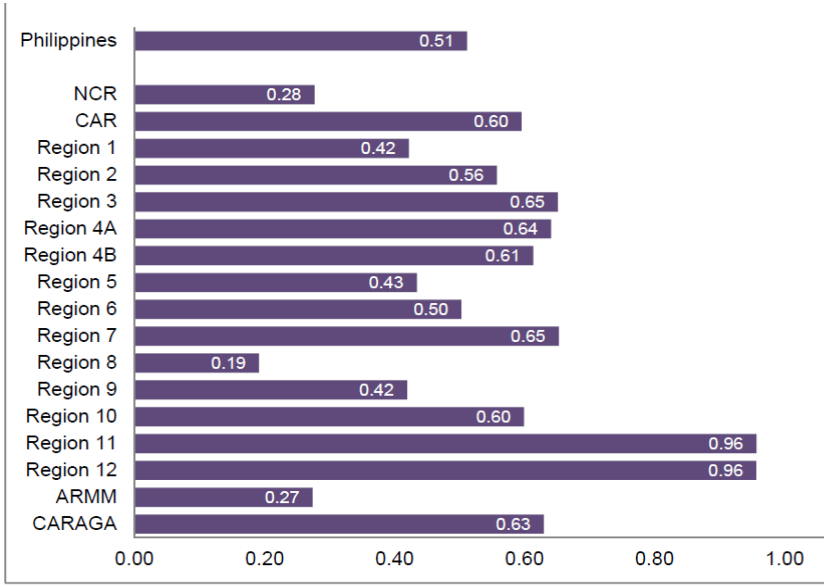
**weight-for-height*

Source: Table 9.26, 2018 Philippine Statistical Yearbook

ANNEX FIGURE E.1: Ratio of number Barangay Health Stations (BHS) to number barangays, by region, 2015 and 2018*



2015

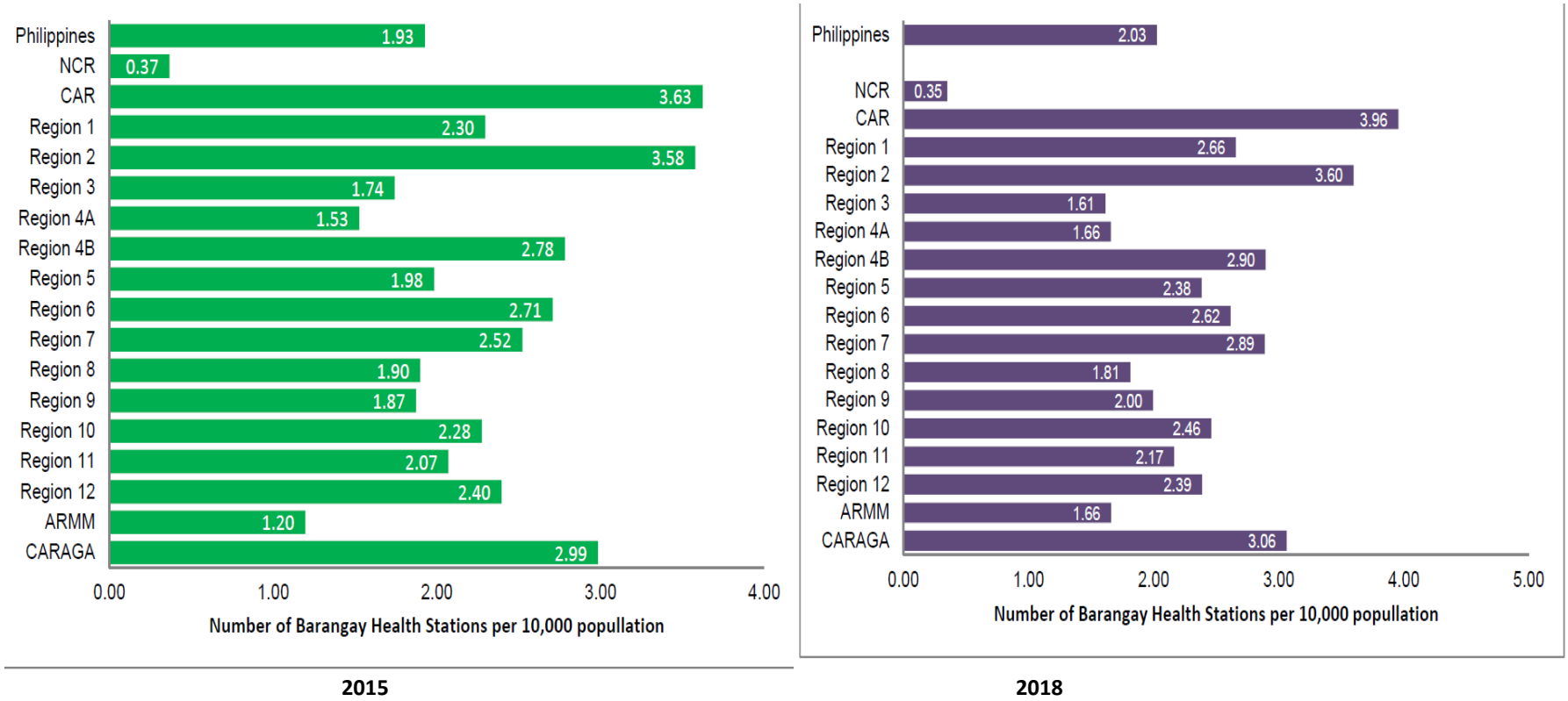


2018

Source: FHSIS Annual Reports 2015 and 2018 (https://www.doh.gov.ph/publications)

(*Notes: the target under the Philippine Health Agenda Target is 1:1, meaning 1 BHS for each Barangay. In this table, the **distribution** of BHSs is not known.)

ANNEX FIGURE E.2: Number of Barangay Health Stations (BHS) per 10,000 population, by region, 2015 and 2018



Source: FHSIS Annual Reports 2015 and 2018 (https://www.doh.gov.ph/publications)
(*Notes: the target under the Philippine Health Agenda Target is 1 BHS per 2,000, or 5 for 10,000 populations.)