



# The Philippines: From Performance to Programs in the Health Budget

Jason Lakin, Ph.D.

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## INTRODUCTION

The Philippines undertook a wide range of performance-related budget reforms under President Benigno Aquino's government between 2010 and 2016. At the same time, the government reformed the excise tax on alcohol and tobacco to increase dedicated revenues for the health sector. These revenues were intended to support the government's universal health coverage agenda by channeling funds to PhilHealth, the national insurance agency. PhilHealth was founded in 1995, but its budget soared after the tax reform in 2012. Premium contributions (PhilHealth's principal source of revenue) in 2011 amounted to 33 billion pesos; by 2016, including a nearly 35 billion peso subsidy for indigent members from earmarked tax revenues, premium contributions were 104 billion pesos.<sup>1</sup> Earmarked revenues also flowed into the Department of Health's (DOH) budget directly to support infrastructure investment and hospital services for the poor.<sup>2</sup>

Enhanced revenues for health and the shift toward a performance framework may have created the conditions for improved health sector performance, but challenges remain. While PhilHealth has paid out most of its revenue toward medical claims, the DOH has faced some challenges in spending its enhanced budget. In 2016, total expenditure was approximately 87 percent of budget, and only about half of the targeted local health infrastructure was actually built.<sup>3</sup> Challenges in budget execution, as well as the fragmentation of the health system, the limits of PhilHealth coverage when compared to overall health spending, and longstanding inequities

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<sup>1</sup> Philippines Health Insurance Corporation (2011) *Kambyo/Shifting Gear: Philippines Health Insurance Corporation Annual Report 2011*. Manila. Available at: [https://www.philhealth.gov.ph/about\\_us/annual\\_report/ar2011.pdf](https://www.philhealth.gov.ph/about_us/annual_report/ar2011.pdf) (Accessed: 10 July 2018); and Philippines Health Insurance Corporation (2016) *Moving Forward Towards Health for All: Philippines Health Insurance Corporation Annual Report 2016*. Manila. Available at: [https://www.philhealth.gov.ph/about\\_us/annual\\_report/ar2016.pdf](https://www.philhealth.gov.ph/about_us/annual_report/ar2016.pdf) (Accessed: 10 July 2018).

<sup>2</sup> Kaiser, K., Bredenkamp, C. and Iglesias, R. (2016) *Sin Tax Reform in the Philippines: Transforming Public Finance, Health, and Governance for More Inclusive Development*. Washington, DC: The World Bank. Available at: <http://documents.worldbank.org/curated/en/638391468480878595/pdf/106777-PUB-PUBLIC-PUBDATE-7-26-2016.pdf> (Accessed: 10 July 2018).

<sup>3</sup> Development Budget Coordination Committee (Republic of the Philippines) (2017) *Year-End Report on the 2016 National Budget*. Available at: [https://www.dbm.gov.ph/wp-content/uploads/DBCC/2016/FY\\_2016\\_DBCC\\_Year-End\\_Report\\_092517\\_final\\_version.pdf](https://www.dbm.gov.ph/wp-content/uploads/DBCC/2016/FY_2016_DBCC_Year-End_Report_092517_final_version.pdf) (Accessed: 10 July 2018).

in the distribution of services, are partly responsible for stagnation in priority areas in the Philippines, such as reducing maternal and neonatal mortality.<sup>4</sup>

## PERFORMANCE WITHOUT PROGRAMS?

The Philippines presents a somewhat unique case of program budgeting. The decision to introduce programs came after nearly a decade of attempting to use performance information in different ways without budgetary programs. Programs were not initially seen as an essential ingredient in the performance system when the reform process started in 2007, but challenges arising from performance-oriented reforms led the country back toward program budgeting (known as Program Expenditure Classification, or PREXC) in 2015.<sup>5</sup> While PREXC started in 2015, it was not fully implemented until 2018. The 2018 budget presents both the older framework based around ministry outputs and the newer program approach.

An initial performance-oriented budget reform, the Organizational Performance Indicator Framework (OPIF), was piloted in 20 ministries in 2007. It created what were known as Major Final Outputs (MFOs) at the ministry level. The budget was organized around these MFOs. For example, in the Department of Health, one of its MFOs was “Hospital Services.” This was measured by indicators such as “number of out-patients managed” and “net death rate among in-patients.” There was no unified system of program budgeting at this point; some agencies had programs but the term “program” was not used consistently by agencies.

The Philippines then introduced additional performance related-incentives for budget managers in 2011 and 2012, such as bonuses for achieving agency targets. Further reforms in 2013-14 involved restructuring of activities and projects and the introduction of Organizational Outcomes above the output level captured by MFOs. Performance indicators were published along with the budget in the General Appropriations Act starting in 2014. All of these indicators remained at the ministry level until 2015.<sup>6</sup>

Program budgeting (PREXC) was introduced in part to address accountability challenges of having performance measures at the ministry level. By breaking down the performance indicators further and assigning them to programs with specific program managers, it was expected to be easier to hold officials to account for budgets and performance. In addition, PREXC was meant to clarify the logical framework linking activities to outputs and outputs to outcomes, and to ensure that indicators and targets were clearly understood within government.

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<sup>4</sup> Panelo, C. I. A. *et al.* (2017) *THE CHALLENGE OF REACHING THE POOR WITH A CONTINUUM OF CARE: A 25-Year Assessment of Philippine Health Sector Performance*.

<sup>5</sup> Department of Budget and Management (Philippines) (2016) *Program Expenditure Classification (PREXC): The next phase of the Performance-informed budget*.

<sup>6</sup> Department of Budget and Management (Philippines) (2016) *Program Expenditure Classification (PREXC): The next phase of the Performance-informed budget*.

Finally, as mentioned above, while some ministries were using terms like “program” under the previous system, there was a lack of consistency in how ministries were reporting their budgets and the use of terminology. The Department of Budget and Management (DBM) felt that there was a need to standardize this through a revised classification.

However, it should be noted that not everyone in DBM supported the reform. Many felt that it had taken a lot of work to build the system around MFOs and that it was not worth creating additional upheaval to shift to programs. This is one reason why the PREXC reform launched in 2015 was not implemented until the 2018 budget.

## PROGRAM BUDGETING IN THE HEALTH SECTOR

### TYPES, NUMBER AND SIZE OF HEALTH BUDGET PROGRAMS

The Philippines health budget has eight operational programs and two administrative programs. The operational programs are further divided into 16 sub-programs. The administrative programs are the same as those that appear in other ministries and are intended to be consistent (in terms of activities covered) across all ministries.

Initially, the health department had considered having just five programs, but these were eventually expanded to eight. This was the result of the decision to split up one larger program, originally called “Support to Service Delivery.” This program was divided into four: the Health Systems Strengthening Program, the Public Health Program, the Epidemiology and Surveillance Program, and the Health Emergency Management Program. This decision was taken in order to make the budget structure more transparent, to provide more public visibility for public health and epidemiology activities, which were initially subsumed within it, and to facilitate alignment with the department’s existing organizational structure and ensure greater accountability.

Nevertheless, 84 percent of the 2018 budget goes to just three programs, and one of these, Health Systems Strengthening (HSS), takes nearly 40 percent of the total budget for the Department of Health. While it remains concentrated, the decision to split public health from health system support did contribute to diffusion of the health budget. Had this not been done, more than two thirds of the total budget would have gone to a single program, Support to Service Delivery, further reducing the value of the program level for expenditure prioritization. The Philippines does have a sub-program structure which would still support expenditure prioritization, but the current set of programs would have become sub-programs under this arrangement, reducing the visibility of government activity and the scope for making expenditure trade-offs.

Why is the Philippines health budget so concentrated? The largest program, the Health Systems Strengthening (HSS) program, is dominated by a massive infrastructure investment program targeting local health facilities, but

controlled centrally. Essentially, the Health Facilities Enhancement Program, which is an activity (not a budget program) within the Service Delivery sub-program of the HSS program, controls virtually the entire capital budget for the Department of Health. While there is a human resource component to the HSS program, it seems to operate as a separate initiative from this capital investment scheme. The large size of these schemes to support local health service delivery is a principal driver of concentration.

Understanding the purpose of each program is not straightforward in the Philippines. For example, the Philippines budget contains a program called the Health Facilities Operation program. What does this program do? Based on the name, it could support national or local facilities, or both, and it might be mainly focused on operations, or it might include staff costs as well. It has two outcome indicators in the budget: hospital infection rate, and the percentage of drug dependents completing treatment. Neither of these clarifies exactly what this program does.

When designing program structure, agencies are required to fill out a program profile (Form A) with information about program objectives, outputs and outcomes. These profiles do not appear in the actual budget documents, though they contain some information that other countries do include in their budgets, such as a narrative description of program objectives. This can be important to understand the scope and nature of each program.

The program profile does not answer all the questions we may have about the Health Facilities Operation program, but it does clarify its scope. It is meant to cover “DOH regional hospitals, the 12 Metro Manila Hospitals, Treatment and Rehabilitation Centers, Philippines Blood Center and other blood service facilities and reference laboratories.” Although it would increase the volume of the budget to include such information, it is clear that users of the budget will have trouble understanding what programs do based only on the outcome/output indicators included. The Philippines program structure is also still clearly in transition. There are a number of program indicators that have targets but no baselines to understand how realistic the targets are. The budget does contain sub-programs, but there are no indicators or targets at sub-program level (though every sub-program should relate to at least one indicator, this is not made explicit in the budget documents).

Some analysts involved in designing the program structure in Philippines did consider having primary, secondary, and tertiary level services as the organizing principle for programs. However, they ultimately decided that it would not work well because they found that sub-programs they needed to maintain around specific disease areas, such as tuberculosis, would not fit under one of these programs. The tuberculosis sub-program provides support to facilities at all three levels and thus fits better under the Public Health program than it would under any a “level of care” logic. Of course, this determination rested on the DOH’s prior decision that tuberculosis should be treated as a sub-program, which would not necessarily be the case in other countries.

## PERFORMANCE INDICATORS

The shift to program budgeting in the Philippines has entailed the transformation of the indicator framework away from Organizational Outcomes and Major Final Outputs toward program-level outputs and outcomes. As 2018 is a transitional year, the budget contains both the old and the new indicator framework, which is somewhat confusing. In addition, because many of these indicators appear to be new, only some of them are presented with baselines alongside of their targets for 2018.

Focusing on the program outcomes and outputs, it appears that each program has one to three outcome indicators and one to three output indicators, with the exception of the Public Health program, which has nine outcome indicators, many of which relate to specific diseases such as malaria and filariasis (see Figure 1).

**FIGURE 1. PUBLIC HEALTH PROGRAM INDICATORS AND TARGETS, 2018**

PUBLIC HEALTH PROGRAM		
<b>Outcome Indicators</b>		
1. Percentage of external clients who rated the technical assistance provided as satisfactory or better		85%
2. Percentage of fully immunized children	45.6% (2015 FHSIS)	95%
3. Modern contraceptive prevalence rate	23.5% (2013)	32.5%
4. Number of malaria-free provinces	32 Provinces (2016)	Additional 13 provinces (cumulative: 45 provinces)
5. Number of filariasis-free provinces	35 Provinces (2016)	Additional 6 provinces (cumulative: 41 provinces)
6. Number of rabies-free areas	41 Areas (2016)	Additional 6 areas (cumulative: 47 areas)
7. Percentage of Anti-Retroviral Treatment (ART) eligible people living with HIV on ART	53% (December 2016)	90%
8. Treatment success rate for all forms of Tuberculosis	91% (2016)	90%
9. Premature mortality rate attributed to cardiovascular disease, cancer, diabetes, and chronic respiratory diseases	170 per 100,000 population (2015)	No annual target
<b>Output Indicators</b>		
1. Percentage of LGUs and other health partners provided with technical assistance on public health programs		80%
2. Average percentage of LGUs provided with at least 80% of commodities		80%

*Note: Column 1 is the baseline (which is missing in some cases) and column 2 is the target for 2018*

In setting their programs and indicators, the Department of Budget and Management encouraged line departments to draw on the Philippines National Development Plan 2017-22 (PDP) and the Sustainable Development Goals. There is some relationship between the indicators in the PDP and the Public Health program, but they are not an exact match. For example, the PDP has an indicator of “malaria prevalence decreased.” The Public Health program has an indicator for “number of malaria-free provinces.” The objectives behind these

indicators are related but could entail somewhat different strategies. Similarly, the PDP is focused on a decline in the number of new cases of HIV, while the budget is targeting an increase in the treatment of people already infected with the illness.<sup>7</sup>

It is not always clear how the outputs and outcomes are related, or how either is related to what the programs do. Returning to the outcome indicator for “number of malaria-free provinces,” the outputs that lead to this outcome (Figure 1) are the percentage of local government units provided with technical assistance and those provided with 80 percent of commodities (it is not clear what the denominator in this calculation is). While commodities are undoubtedly part of what is needed to contain malaria (and technical support may be useful), it seems unlikely that this fully illuminates the results chain the government intends to follow to achieve control of the disease.

Similarly, we have seen that the Health Facilities Enhancement Program (HFEP) receives nearly the entire capital budget for the DOH and constitutes a large share of the Health Services Strengthening program. However, when we look at the output and outcome indicators for this program, they do not seem to relate to capital investment at all (see Figure 2 below). It appears that the HFEP has its own indicator framework that is not connected to the HSS program under which it falls.<sup>8</sup>

## FIGURE 2. PERFORMANCE INDICATORS FOR HEALTH SYSTEMS STRENGTHENING PROGRAM, 2018

HEALTH SYSTEMS STRENGTHENING PROGRAM		
Outcome Indicators		
1. Percentage of public health facilities with no stock-outs		30%
2. Human Resource for Health (HRH) to Population Ratio	16 HRH: 10,000 Population (2016)	17 HRH: 10,000 Population
Output Indicators		
1. Percentage of LGUs provided with technical assistance on local health systems development		80%
2. Percentage of priority areas supplemented with Human Resource for Health from DOH Deployment Program		100%

Note: Column 1 is the baseline (missing in most cases) and column 2 is the target for 2018

An additional challenge around performance indicators is that a very large share of the DOH budget is distributed to regional facilities, and most program activities consist of transfers. While most of the output targets in the budget relate to actions that the national government takes to support local governments (such as the technical assistance output indicator in Figure 2), most of the outcome indicators require action to be taken by local

<sup>7</sup> National Economic and Development Authority, R. of the P. (2017) *PDP Results Matrices 2017-2022 - The National Economic and Development Authority*. Available at: <http://www.neda.gov.ph/pdp-results-matrices/2017-2022/> (Accessed: 26 April 2018).

<sup>8</sup> Commission on Audit (Philippines) (2017) *Health Facilities Enhancement Program: Implementation Gaps Impacting on the Efficient, Economical and Effective Provision of Health Facilities and Equipment Necessary for PhilHealth Accreditation and Licensing Audit Highlights*.

agencies that actually provide health services, but over which DOH has limited control. Part of clarifying the logical framework behind the indicator framework is to clarify how such outcomes are to be achieved in a decentralized context where recent evidence suggests that local governments have not always prioritized health expenditure.<sup>9</sup> Currently, local government performance generally is tracked through a scorecard system by the Department of the Interior and Local Government, but this system does not incorporate sector-specific performance targets such as those under DOH.

Program performance indicators are meant to operate in tandem with the government's Performance-Based Bonus scheme, which incentivizes public servants to achieve targets aligned with the targets of the ministry they work for. It would appear that this system has raised awareness of ministry targets, but it may also encourage public servants to try to limit their responsibility to areas over which they have greater control and can therefore ensure that they receive a bonus. This is a well-known pathology of indicator systems and runs counter to ideas about encouraging professionalism and "self-enlarging jobs" that encourage workers to take on more rather than less responsibility.<sup>10</sup>

## COST ALLOCATION

Allocating costs properly across programs drawing on common staff and other inputs has been a challenge in the Philippines, as in most countries undertaking program budgeting. The Philippines has two administrative programs (general administration and support, and support to operations). There has been an attempt to standardize what is included in these programs across ministries, though it remains a work in progress to ensure that all ministries are allocating the same costs to administration and support.

Some of the remaining operational programs do not appear to have any personnel costs, even though they likely do require staff to implement. None of the sub-programs under the Public Health program have personnel costs. In some cases, this could be because the national government is making transfers of commodities to regional units and those units are contributing staff time. However, under the Public Health program, most of these sub-programs involve only a single budget line for the central office in Manila. It is not clear where the staff time for these sub-programs is allocated. It may be that they are all under the Public Health Management sub-program, rather than divided across the remaining substantive sub-programs (e.g., Family Health, National Immunization, etc.). If so, however, most of this sub-program's staff costs are allocated to regional offices, creating a disconnect

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<sup>9</sup> Panelo, C. I. A. *et al.* (2017) *THE CHALLENGE OF REACHING THE POOR WITH A CONTINUUM OF CARE A 25-Year Assessment of Philippine Health Sector Performance*.

<sup>10</sup> Tandler, J. and Freedheim, S. (1994) "Bringing Hirschman Back In: A case of bad government turned good," in Rodwin, L. and Schoen, D. A. (eds) *Rethinking the Development Experience*. Washington D.C.: The Brookings Institution, pp. 176–209.

between the allocation of staff and that of commodities/operating costs for specific interventions, which suggests that proper cost allocation at program and sub-program level remains to be achieved in the Philippines.

## PROGRAMS AND ORGANIZATIONAL STRUCTURE IN THE PHILIPPINES

Programs were created very recently in the Philippines in part to address the accountability challenges of the previous performance system, in which it was felt that it was not clear who was responsible for delivering on specific goals.<sup>11</sup> In order to clarify accountability lines, a partial overlap between the health department's structure and its programs was introduced. Facilitating the link between programs and organizational accountability is also one of the reasons why the number of programs in the ministry was ultimately expanded beyond the initial proposal (from five to eight programs, as we saw above).

In designing programs and sub-programs, proposals that involved major organizational changes to the DOH were not adopted. One early idea was to have only two programs in DOH: preventive and curative. Another proposal would have created five programs, elevating immunization to the program level, but without policy and regulation as two separate programs. This approach would have brought together support to hospitals at national level with support to hospitals at local level and social protection.

Ultimately, the sub-program structure of the DOH was organized mainly to be consistent with the organizational structure of DOH. For example, the Epidemiology and Surveillance program was separated from a larger program, in part to accommodate the Epidemiology Bureau within the Department of Health (DOH). The programs and the directorates within the DOH also appear to align in the case of health emergencies and planning, in spite of minor semantic differences. Nevertheless, there are 20 departments in the DOH central office and only ten programs (including the two administrative support programs), so these departments must be combined in various ways to link to the program structure. It is not clear exactly how. This may be partially achieved through sub-programs, but it is not obvious from the names of the sub-programs, and the Philippines budget provides very little information about what sub-programs are meant to do.

In defining the program structure, stakeholders raised some concerns that key activities and agencies in the health sector were not visible in the budget and were therefore left without clarity about their budgets. One such case raised by hospital administrators was the budget for national reference laboratories. In principle, these laboratories are funded from the overall budgets for hospitals, with some support from other programs. But there was concern that this created uncertainty about laboratory budgets and extra work for program managers to determine their allocations. So an additional activity was created—Operations of National Reference

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<sup>11</sup> Department of Budget and Management (Philippines) (2016) *Program Expenditure Classification (PREXC): The next phase of the Performance-informed budget*.

Laboratories—within the Health Facilities Operation program to ensure that these institutions were visible and received adequate funding.

## OVERSIGHT OF BUDGET PROGRAMS

In terms of the role of oversight actors, there is some evidence that legislators do review program performance when they undertake budget hearings, and may even amend the budget programs beyond just amending the appropriation levels. Legislators prefer detailed information below the program level, including local projects and activities, as they can identify specific items of concern at that level. They also prefer very specific indicators and targets. The Senate’s Legislative Budget Research and Monitoring Office has lauded the indicators in the Public Health program for being the only indicators specific enough for effective oversight. These indicators are disease specific and they are also defined in terms of regional coverage; these characteristics presumably allow legislators to more directly connect the program to the concerns of their constituents.

In 2017, the Commission on Audit (COA) established a Performance Audit Office to build the COA’s profile around performance auditing. This has resulted in performance audits in the health sector, including a 2017 published audit of the Health Facilities Enhancement Program.<sup>12</sup> This audit does include a review of performance indicators, including an assessment of the quality and appropriateness of the specific measures. However, the HFEP is not a budget program, and it remains to be seen if COA will undertake similar audits at the level of budget programs in the future.

## PROCESS OF PROGRAM DESIGN AND REVIEW

In the Philippines, designing programs and sub-programs has been a responsibility largely left to the departments, while the decision on how to measure performance has involved more back and forth between the line agencies and the Department of Budget and Management. The National Economic and Development Authority, which is responsible for national development planning, was also consulted. The DBM provided general guidance, such as that programs should group together activities and these must be related to the department’s overall mandate, but it did not try to micro-manage this process. This was done in part to reduce resistance to the reform from ministries, many of whom had resisted previous rounds of performance-oriented reform.

The DBM held workshops to provide guidance and encourage reflection, while still allowing departments to design their own program structure. They used these workshops to encourage managers to see the new program structure as a means to improve management and an opportunity to better defend their budgets during the

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<sup>12</sup> Commission on Audit (Philippines) (2017) *Health Facilities Enhancement Program: Implementation Gaps Impacting on the Efficient, Economical and Effective Provision of Health Facilities and Equipment Necessary for PhilHealth Accreditation and Licensing Audit Highlights*.

budget process. Interestingly, in some cases, these workshops were the first time that planning and budget officials within the same agency had ever met, suggesting that, if nothing else, the process of designing programs did help to start new conversations. One challenge that the DBM faced, however (which was particularly relevant for health), was that many departments were flush with cash and did not feel pressure to prioritize expenditure or improve management the way they may have in a tighter fiscal situation. As a general matter, it would seem logical that incentives for performance are stronger when there is less funding to go around.

When the DOH originally proposed its indicator framework, it had many more indicators than the DBM was willing to accept and had to prioritize among them. The program profile form (Form A, discussed above) requires departments to limit their outcome and output indicators to three. With eight programs, this would have meant no more than 24 outcome and 24 output indicators for DOH, for a total of 48. But the DOH's original proposal was closer to 70 indicators.

This reflects a common tension globally in the design of performance indicators, which is disagreement over the extent to which the indicators chosen for the program budget should be a subset of a larger indicator set used for internal management purposes. Many managers in the Philippines wanted to include all performance indicators used by the department in the program budget to enhance their profile, including those used for internal management. DBM advised managers against this, encouraging them to maintain a larger set of internal indicators linked to a reduced set of external-facing indicators that would not overwhelm budget users.

In the end, all but one of the DOH programs has three or fewer of each type of indicator (except for Public Health, as we have seen). While trying to limit the total number of indicators, DBM has also taken the view that every sub-program should have an indicator, and this has led to more indicators where there are more sub-programs (Public Health has eight sub-programs). DBM also encouraged DOH to focus on interventions rather than commodities, as their original indicator proposals were more oriented toward sharing of commodity inputs. As we saw above, however, this guidance has not necessarily resulted in coherent indicator hierarchies within programs. More work will need to be done to clarify the logical framework behind the indicators that have been chosen (or behind a revised set of indicators).

## APPROPRIATION AND CONTROL

As of 2018, programs are not yet being used to appropriate or control funds in the Philippines. Appropriation is done at the activity level, limiting freedom for implementers to shift funding within programs. Changes at the activity level require authorization from the Office of the President. In addition, the detailed notes in the General Appropriation Act also put extensive limits on how funds may be used at the scheme or initiative level in a number

of cases. The existence of numerous schemes within the budget thus creates additional rigidities during budget implementation.

## CONCLUSION

The Philippines is an unusual case in that the decision to introduce programs came after a decade of attempting various other performance-oriented budget reforms. While programs were not initially seen as essential to performance-influenced budgeting, over time, the Department of Budget and Management came to feel that budget programs were needed to create an intermediate level of accountability, where budgets could be managed against outputs and outcomes. This reform started several years ago, but 2018 is the first year in which these programs appear in the General Appropriation Act. It is therefore too early to draw conclusions about how the system will work. Nevertheless, this assessment suggests that there will be a need to further refine the program structure over time. More public information is needed about the nature of each program, the role of sub-programs, and the logic behind program indicators (as well as a clearer link between sub-programs and the indicator framework). Fortunately, some of this information already exists internally, and can simply be published, though further refinement will likely still be needed. Of course, for program budgeting to be truly meaningful, programs, rather than activities, will also eventually need to be used for appropriation and control.

## ANNEX 1. INTERVIEWS

The author thanks the following for generously agreeing to be interviewed for this project, as well as respondents wishing to remain anonymous. No one other than the author is responsible for any errors of fact or interpretation. Rose Nierras, Grace Tan and Maria Paz (Marichi) De Sagun also helped to facilitate contacts with many respondents.

1. **Omi Castañar**. Executive Assistant IV. Office of Undersecretary Laura B. Pascua. Department of Budget and Management.
2. **Jaker de Claro**. OIC Division Chief of Corplan. Philippines Health Insurance Corporation. (Written communication).
3. **Dr. Jaime Galvez Tan**. Former Secretary of Health. Department of Health.
4. **Allan Millar**. Consultant for Health Systems Strengthening, Logistics and Supply Chain. Department of Health.
5. **Atty. Alex Padilla**. Former President and CEO. Philippines Health Insurance Corporation.
6. Eireen Palanca. Director III. Legislative Budget Research and Monitoring Office. The Senate. (Written communication).
7. **Frances Rose Elgo-Mamaril**. Chief, Health Planning Division. Health Policy Development and Planning Bureau. Department of Health.
8. **Bruce Stacey**. Former Senior Budget Advisor, Philippines Department of Budget and Management. AusAid.
9. **Rolando Toledo**. Director, Fiscal Planning and Reforms. Department of Budget and Management. Group interview with members of Fiscal Planning and Reforms: Ms. Nanette Cabral (Division Chief in charge of Department of Health), Ms. Clarissa Bautista, Ms. Gillian C. Servida, Mr. Robin T. Gumasing and Mr. Imman Van B. Valerio.