

# Guidebook on Public–Private Partnership in Hospital Management





ADB

# **Guidebook on Public–Private Partnership in Hospital Management**

Asian Development Bank

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# Foreword

**P**artnerships may well be the order of the day. In the same way that the order of things in the universe is maintained by continuing action and reaction, governments certainly cannot survive on their own. Intrinsic in any state intervention is the element of people's participation.

This is the basis of public-private partnership (PPP). PPP embodies the strength of cooperation and the principle of shared governance. PPP is not an idea to be marketed and sold as if it is a sure-fire formula for something that has gone wrong. Instead, it is among the many strategies that nations can adopt as they pursue their national development goals. However, like many strategies, it may or may not work at all. Its success is dependent on several factors but experiences worldwide point to transparency as one of the most important determinants. Partners do not want to be treated with suspicion. Genuine partnerships require trust and openness.

Many countries are already seriously taking this path. Philippine President Benigno Simeon Aquino III has pronounced that "...they (private partners) will play a vital role in our administration's fulfillment of our Social Contract with our people." This declaration comes at the most opportune time as the country doubles its efforts in achieving Millennium Development Goals 4 (reduce child mortality by two-thirds) and 5 (reduce maternal mortality by three-quarters).

Why PPP for health? For one, it capitalizes on the essence of genuine partnerships. It motivates both the public and private sectors to work together toward the attainment of common public health goals, particularly those that impact most on mothers and their children. Second, PPP calls for deeper levels of transparency and operates in an arena where stakeholders share resources and risks. Third, PPP motivates partners to produce tangible results and cutting-edge solutions, ensuring better and more efficient public health services, financial viability, and sustainability. Finally, PPP calls for creativity. It explores the untested grounds and considers "out of the box" solutions.

To help implementers, particularly public agencies and local government units, the Asian Development Bank, through the technical assistance project PPP in Health (TA-7257 PHI), has developed this guidebook and another one titled, *Guidebook on Public-Private Partnership in Pharmacy*. This guidebook has been crafted from actual experiences on the ground as the Development Bank of the Philippines, the Department of Health, Philippine Health Insurance Corporation, and the Asian Development Bank worked with local governments in developing PPP projects in hospital management.

Having reliable and efficient hospital management services is an important cornerstone of public health service delivery. A PPP in hospital management tackles this requisite by ensuring that a private sector service provider will not only render services at all times but will also offer compassionate, safe, and affordable care, and demonstrate authentic corporate social responsibility.

It is hoped that this guidebook will assist you, our dear readers and implementers, in considering and developing PPPs in health projects, particularly as you work together in ensuring that our people will always have access to affordable and safe health care.



**Enrique T. Ona**

Secretary

Department of Health

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# Abbreviations

ADB	Asian Development Bank
APP	approved procurement plan
BAC	bids and awards committee
BOT	build–operate–transfer
CBHCP	Credit for Better Health Care Project
COA	Commission on Audit
DBP	Development Bank of the Philippines
DOH	Department of Health
GPPB	Government Procurement Policy Board
IRR	implementing rules and regulations
LGU	local government unit
M&E	monitoring and evaluation
OSS	organizações sociais de saúde (nonprofit social organizations)
PBD	Philippine bidding documents
PhilHealth	Philippine Health Insurance Corporation
PPP	public–private partnership
RA	Republic Act
SHCIP	Sustainable Health Care Investment Project
TOR	terms of reference

# Glossary

**Build–Operate–Transfer (BOT).** In the Philippines, the amended BOT Law (Republic Act 7718, July 1990) and its revised Implementing Rules and Regulations (IRR, 2012) provide the legal framework for public–private partnerships. The original BOT Law specified a set of processes to ensure that the government and the private proponent meet their obligations. However, the risk was with the private sector, while the government entity had assured returns (fixed fee, percentage, or both). The amended BOT Law provided a reasonable security package, clarified government support and incentives, liberalized the regulatory framework, provided and allowed private sector proponents to directly submit solicited and unsolicited proposals for infrastructure projects, provided a clear framework for structuring BOT contracts, and clarified the approval process.

There are several variations in the BOT scheme:

- (i) Build–operate–transfer,
- (ii) Build and transfer,
- (iii) Build–own–and–operate or build–operate–and–own,
- (iv) Build–lease–and–transfer,
- (v) Build–transfer–and–operate,
- (vi) Contract–add–and–operate,
- (vii) Develop–operate–and–transfer,
- (viii) Rehabilitate–own–and–transfer,
- (ix) Rehabilitate–own–and–operate, and
- (x) Other variations as may be approved by the President of the Philippines.

**Franchising** involves a franchisor–franchisee relationship built on standardized contractual arrangements. It requires (i) standardization of products and services; (ii) standardized procurement, packaging, and distribution; (iii) standardized accounting, billing, and payment system; and (iv) common branding.

**Joint ventures** involve sharing of profits, losses, and risks and are either corporatized (i.e., a joint-venture stock corporation is formed) or covered by an executive joint-venture agreement and public–private partnership (PPP) institutional arrangements. In a joint venture, the government agency contributes physical assets (e.g., building, land, hospital, facilities) and is a minority shareholder, but retains significant control over the use of the property. The government’s share generates income or dividends, and the agency may benefit from better market conditions in the future. Performance standards are established and monitored.

**Modalities.** PPP in hospital management may adopt different modalities (e.g., a joint venture), although the assumptions in this guidebook are based on a straightforward contracting scheme/arrangement where a government organization forges a partnership with a private sector entity through a hospital management contract. However, in any type or modality of a PPP in hospital management, due diligence must be exercised to ensure that both the clinical and administrative aspects of hospital management are clearly understood by all parties concerned. The PPP arrangement may cover both the clinical and administrative aspects or only one

of these areas. In both cases, the government entity must ensure that if it enters into a PPP arrangement, it is doing so with a clear understanding of what its roles are, the risks involved, the requirements of the arrangement, the extent of control that it is willing to share with its private sector partner, and similar considerations. The best financial arrangement should also be clearly identified (e.g., determining whether it is better to issue a straightforward management fee, opt for profit sharing, or adopt a mixture of both schemes).

**Municipal Development Fund (MDF).** The MDF is a special revolving fund that aims to establish an effective mechanism that would enable local government units (LGUs) to avail themselves of funds and local and international assistance for the implementation of various social and economic development projects. The MDF Office, under the Department of Finance, was created through Executive Order No. 41 to assume the administration of the MDF. The MDF Office, through its various programs, projects, and activities, provides assistance to LGUs in financing development projects, helps establish LGUs' creditworthiness, and promotes fiscal discipline.

**Priority Development Assistance Fund.** This is a funding mechanism in the Philippines released through the members of the House of Representatives. "This makes possible the implementation, in every congressional district, of small-scale but significant projects which cannot be part of large-scale projects of national agencies. These projects, which are generally in the form of infrastructure, health, education and social aid packages, directly touch the lives of district constituents."<sup>1</sup> While this source of funding is sometimes criticized for several reasons, among them the seeming lack of transparency in disbursements,<sup>2</sup> local governments should see this as a possible resource for the improvement of health facilities and services.

**Public–Private Partnership (PPP).** A PPP is a cooperative venture or contractual arrangement between public agencies and private sector partners toward clearly defined public or social needs. It utilizes built-in expertise, experience, and human resources available in the private sector in the provision of services that are normally the responsibility of government. PPP involves a sharing of resources, risks, and benefits between the public and private providers based on clearly defined terms of agreement. A PPP arrangement includes a financial arrangement that clearly defines how the initiative will be financed and whether financing will be shared. It needs a strong management information and monitoring system to support the definition of targets and performance evaluation.<sup>3</sup>

**RA 9184 and its Implementing Rules and Regulations (IRR).** The Government Procurement Reform Act (RA 9184), along with its IRR, are the most important reference documents in government procurement. The law, which took effect on 26 January 2003, provides for the standardization and regulation of the procurement activities of the government. The IRR, which took effect on 8 October 2003, initially covered public procurement, but was revised in 2008 to include procurement for foreign-assisted projects in agreement with various development partners. Hence, the Revised IRR of RA 9184 came into being on 22 July 2009.

<sup>1</sup> Message from the Speaker of the House, House of Representatives, Quezon City, Philippines. [www.congress.gov.ph](http://www.congress.gov.ph)

<sup>2</sup> The current administration has imposed new and stricter measures in the release and utilization of the funds through the National Budget Circular 537 issued in February 2012.

<sup>3</sup> ADB. 2011. *Public–Private Partnership in Health. Inception Report*. Manila. (TA 7257-PHI).

**Universal health care (UHC).** Universal health care is often defined as the state where all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, and where such access does not cause them to suffer financial hardship when paying for these services.<sup>4</sup> Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of the World Health Organization.

Meanwhile, the UHC Study Group in the Philippines defines UHC as “the provision to every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public.”<sup>5</sup> In tackling PPP under a UHC framework, “needs” are translated to “demands” so health planners and project implementers are on a common ground. This is particularly important in the feasibility study stage, where viability of PPP projects should be thoroughly scrutinized.

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<sup>4</sup> Adapted from pronouncements of the World Health Organization.

<sup>5</sup> Universal Health Care Study Group. [www.universalhealthcare.ph/history](http://www.universalhealthcare.ph/history)



# Program Overview<sup>6</sup>

## The Credit for Better Health Care Project

The Asian Development Bank (ADB) approved a loan to the Government of the Philippines, through the Development Bank of the Philippines (DBP), for the Credit for Better Health Care Project (CBHCP) (Loan 2125-PHI)<sup>7</sup> to help the country achieve the Millennium Development Goals (MDGs), specifically Goal 4 to reduce child mortality and Goal 5 to improve maternal health. The loan intends to address low and inefficient public expenditures in health care by mobilizing additional off-budget credit for pro-poor investment through a government financial intermediary (DBP), *leveraging private participation* and increasing allocations toward investment priorities. These priorities include maternal and child health services, control of communicable diseases, services to improve access to basic health care, and referral services including laboratory and other diagnostic services.

The CBHCP supports DBP's Sustainable Health Care Investment Project (SHCIP),<sup>8</sup> a credit facility established in 2007 to support the health sector reform agenda and implementation framework, FOURmula One for Health of the Department of Health (DOH). The project's expected impact is improved overall health status, especially in relation to MDGs, by (i) reduced under-5 child mortality rate and reduced infant mortality rate (MDG 4), and (ii) reduced maternal

mortality rate (MDG 5). Its outcome is increased use of basic health care and referral services by the poor, in general, and by women and children, in particular. It has four outputs: (i) upgraded LGU health services, (ii) *more efficient health delivery systems through public-private partnership (PPP)*, (iii) improved access to small-scale private providers, and (iv) enhanced institutional capacity for health sector lending. To manage the project, DBP has set up a project management office in its Program Development Department, headed by a project director and staffed by a project manager, an assistant project manager, and two project associates.

## ADB Technical Assistance Project: Public-Private Partnership in Health

An ADB technical assistance grant for PPP in health services was provided to DBP to support the sub-borrowers under CBHCP, including local government units and private providers, in enhancing modalities for PPP, including (i) innovative strategies to improve efficiency, access, and quality of services; (ii) assisting small-scale health providers with access to credit to support health-related MDGs; and (iii) mobilizing private resources for achieving the MDGs. The grant's impact is improved maternal and child health status by 2015 in the subproject sites through PPP, and its outcome is tested PPP modalities that will have demonstrated potential to increase the

<sup>6</sup> Mostly sourced (with minor editing done) from ADB. 2011. *Public-Private Partnership in Health. Inception Report*. Manila (TA 7257-PHI).

<sup>7</sup> ADB. 2009. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Administration of Grant Credit for Better Health Care Project*. Manila.

<sup>8</sup> SHCIP is available to local government units (LGUs) and the private sector through (i) direct retail lending for LGUs and larger private sector sub-borrowers and (ii) wholesale direct lending to accredited financial intermediaries (microfinance intermediaries, rural and thrift banks) for small private sub-borrowers. SHCIP is financed from DBP's own resources and supplementary funds of development partners and supports both capital investments and working capital.

use of maternal and child health care and referral services in the PPP subproject sites. The technical assistance (TA) has three outputs: (i) development and promotion of PPP modalities in the health sector, (ii) development of incentives and operational strategies for small-scale health providers in rural and underserved areas to obtain accreditation with the Philippine Health Insurance Corporation (PhilHealth), and (iii) development of a contracting modality for health services.<sup>9</sup> DBP is the TA executing agency, while DOH and PhilHealth are implementing agencies.

In the Philippines, the emerging PPPs in health include the following:

- (i) outsourcing of clinical or technical (ancillary) services to private enterprises and organizations;
- (ii) outsourcing of support services, including laundry, transportation, logistics, security, janitorial, and food and nutrition services;
- (iii) contracting out the direct provision of certain health services to a private provider (e.g., TB treatment, health education); and
- (iv) contracting or integrating private insurance schemes to cover specific populations, especially in low-income areas.

Three modalities for PPP in health are common in the Philippines: contracting out services, joint ventures, and franchising. Several models of contracting out to the private sector are available, such as the following:

- (i) collaboration initiated by private companies or nongovernment organizations to develop or deliver health services for specific public health maladies and diseases and/or to specific groups, such as the development of vaccine manufacturing, Tuberculosis–Directly Observed Treatment Strategy, maternal care, child health services, parasite control, malaria, and HIV/AIDS;
- (ii) contracting for integrating private insurance schemes to cover specific populations; and
- (iii) outsourcing clinical or technical (ancillary) services to private sector enterprises or organizations.

As part of the TA's outputs, a DOH Administrative Order for PPP in Health was drafted and eventually signed in 1 March 2012 (Annex 1).

## Challenges and Opportunities for Public–Private Partnership in Health

The promotion of PPP in the health sector faces a number of challenges, including the following: (i) a poor understanding of the concept of PPP; (ii) weak institutional capacity of public sector agencies to engage in PPP; (iii) PPPs being initially donor-driven and eventually losing momentum as interest dies down; (iv) political affinities and inability to sustain the PPP beyond the term of the LGU chief executive; (v) non-formal working arrangements between partners, which can result in limited support from one or both partners; (vi) peace and order issues in some places; (vii) limited sustainability of resources; (viii) lack of or weak monitoring; and (ix) prevalence of moral hazards and political influences and practices. In addition, there are numerous private parties that could benefit the public sector but hesitate to engage with public partners. There is, thus, an urgent need to strengthen the capacity of public agencies to manage PPP projects through activities such as drawing up PPP agreements, mentoring them in business planning, and providing support for monitoring and evaluation of the enterprise. There are vast opportunities for creating or expanding successful PPP models, but leadership is a key to success.

These challenges then provide opportunities for the development of PPP enterprises as well as knowledge management resources that will enable institutions to continuously capture lessons and insights from implementation. This guidebook is one of the resources that has been developed under the TA 7257-PHI package. Figure 1 shows an illustration of these knowledge management products.

<sup>9</sup> There had been revisions in the second and third TA outputs since the submission of the project inception report. Output 2 now focuses on providing technical assistance to PhilHealth in developing a global budget scheme and a monitoring and evaluation system while Output 3 focuses on capacity development.

**Figure 1: Knowledge Products Developed through ADB Technical Assistance for Public–Private Partnership in Health**

## 1. Printed Materials



- 1.1 Frequently Asked Questions on Public–Private Partnership (PPP) in Health
- 1.2 Guidebooks on PPP in Health
  - a. Guidebook on PPP in Pharmacy Services
  - b. Guidebook on PPP in Hospital Management
- 1.3 Resource Books
  - a. Resource Book on PPP in Birthing Homes
  - b. A Resource Book for Capacity Development (focus on Social Marketing and Knowledge Management)
- 1.4 Monographs
  - a. Brief on PPP in Health Applications
  - b. Legal and Policy Issues
  - c. Financing Options
  - d. Procurement Process
  - e. Social Marketing and Knowledge Management
- 1.5 Summary of Proceedings of the PPP in Health Manila 2012

## 2. Online Portals



PPP in Health Manila 2012 website:  
[www.pppinhealthmanila2012.com](http://www.pppinhealthmanila2012.com)

## 3. Audiovisual Presentation, “Partnerships for Health”



Note: The Frequently Asked Questions on PPP in Health, resources books, monographs, and the Summary of Proceedings of the PPP in Health Manila 2012 are part of the final report on the ADB technical assistance project, Public–Private Partnership in Health in the Philippines. Source: Asian Development Bank. 2012. *Public–Private Partnership in Health*. Final Report. Manila.





# I. Why This Guidebook?

This guidebook is intended to help government and public sector organizations in developing a public–private partnership (PPP) project or enterprise in hospital management. The lessons and insights shared here are based on actual experiences of a technical assistance team in Sarangani and Camarines Norte provinces (in the Philippines) in the development of PPPs in hospital management in the preparatory stage. While this guidebook is mostly based on experiences with local governments in the Philippines, readers from both the public and private sectors and outside the Philippines will find the insights that it contains to be useful, and in many instances, directly applicable.<sup>1</sup>

The development of a PPP in hospital management is a complex task. Hospital management considers the distinct separation of general administration from clinical management, with the former requiring experts in general management concerns such as finance, administration, and marketing, among others, while the latter in medical and clinical care matters. The two aspects must coordinate. The broad role of general management is to provide the needed supplies and ancillary services so that the clinical care staff can effectively and safely deliver health services.

This guidebook serves as a simple road map in the development of a PPP in hospital management. However, users can develop their own procedures based on local conditions and resources. The steps and procedures discussed here are not to be treated as absolute rules but rather as recommendations and “guideposts” meant to be further enhanced, modified, and customized according to the needs and aspirations of specific users.

This guidebook was specifically developed for organizations that wish to address public health care needs through the adoption of PPPs. It was developed with the hope that it will inspire and encourage more organizations toward the development and implementation of their own PPP programs and enterprises in health.

Further discussions on PPP in health are found in the annexes of the final report on the ADB technical assistance project, Public–Private Partnership in Health in the Philippines. For further information and support, readers may contact the Credit for Better Health Care Project (CBHCP) of the Development Bank of the Philippines or the Asian Development Bank.

This is an evolving document that may be continuously enhanced based on new lessons and experiences. Therefore, insights, comments, and suggestions that may help in making this document more useful and practical are welcome. Feedback may be sent through [emasaki@adb.org](mailto:emasaki@adb.org).

<sup>1</sup> The authors intended to make this guidebook as universal or generic as possible with a caveat that some assumptions and recommendations may not be legally applicable or consistent with policies of certain countries. Readers are advised to refer to their country regulations and practices in the adoption or application of PPP programs and projects.



## II. Reading Guide

**B**efore proceeding, users are encouraged to read Annex 2: A Simplified Tool for Determining Need for a Public–Private Partnership. This simple tool will help readers determine whether establishing a PPP in hospital management in their locality is the best solution for their identified needs and problems.

Having decided that a PPP in hospital management is a viable option, users will find it easy to navigate through this guidebook. The six-step process for developing a PPP project or enterprise in hospital management is explained in simple terms, supported by on-the-ground experiences of the local governments of Sarangani and Camarines Norte. Again, the six steps proposed may be adjusted or modified according to local needs and conditions.

The step-by-step manner by which the procedures are discussed does not necessarily mean that such steps must be strictly followed in the order that they are presented. For example, a user doing Step 1 (determine needs and review the hospital services in the area) may opt to simultaneously do Step 2 (identify stakeholders and their roles) as well. The steps are difficult to separate in a real-life situation, so users should not feel limited by the sequencing used in this guidebook.

The discussion in each step follows a simple flow. First, a description is given, with objectives and tools. This is followed by key activities and the expected outcome. The discussion in each step looks like this:

- 1.1 About This Step
- 1.2 Key Activities
- 1.3 Expected Outcome

The numbering of these three sections indicates the step, too. For example, **1.2 Key Activities** refers to the key activities in **Step 1** and **3.3 Expected Outcome** refers to expected outcome in **Step 3**.

The following markers and symbols will provide additional help in navigating the guidebook:




**Important reminders**





**Elaborations on certain sections**



**Best practices**

Content marked with  are **important reminders**. It's okay to quickly skim them on the first reading, but they should be read more thoroughly after finishing the section.

Content marked with  **elaborates on certain sections**. It may include definitions, recommendations for specific activities that can fulfill a particular goal, or suggested courses of action to deal with certain challenges.

**Good or best practices** from organizations that have already developed their PPPs in hospital management projects or enterprises are also shared here. These stories are in boxes and marked with .

You can see where you are in this guidebook by looking at the upper margins of the page. You can also flip back to the process illustration (Figure 2) on page 7.

Some terms are explained within the text while others are defined in the glossary. This guidebook also comes with several other knowledge products, such as the Frequently Asked Questions on PPP in Health, which are found in the annexes of the final report on the ADB technical assistance project, *Public-Private Partnership in Health in the Philippines*. Readers from Philippine LGUs will find it beneficial to refer to the *PPP Manual for LGUs: Developing PPP Projects for Local Government Units*, which can be accessed at [http://ppp.gov.ph/?page\\_id=5779](http://ppp.gov.ph/?page_id=5779)

# III. Developing a Public–Private Partnership in Hospital Management (Overview)

This section gives an overview of the steps involved in the development of a PPP in hospital management. As mentioned above, these steps are only meant as guide; users can apply them based on their local needs and conditions. Details are found in the next chapters.



## Step 1: Determine needs and review the hospital services in the area

The first step requires determining and understanding the main issues and problems related to the needs of an organization (or a local government) for hospital care and management services in a chosen site or area. These concerns will form some of the bases of the PPP in hospital management.

Having identified the problems, the organization will have to come up with proposed solutions, mainly through a market or a feasibility study. This step then involves a review of the supply and demand for hospital services in the hospital catchment area. A PPP in hospital management requires an organization to develop financial models to facilitate its decision making.

Consultations with affected sectors and a review of policies on PPP and hospitals may also be conducted in this initial step.



## Step 2: Identify stakeholders and their roles

Now that the organization knows what it wants to do, it should already have an idea of who are its stakeholders and their roles—for example, the department or ministry of health, social health insurer, audit commission, government bank, civil service commission or agency, PPP center or agency, provincial or district council, nongovernment organizations, hospital management operators and staff, local communities, and other institutions and groups. At this stage, the organization may conduct research, meetings, and consultations with stakeholders and prospective PPP partners. This is also a good time to research possible financing options.



### Step 3: Develop an implementation plan for the public–private partnership in hospital management

In this step, the organization embarks on the development of an implementation plan for the PPP modality chosen for the project. The plan should include the personnel and advisors to be involved in undertaking the process, the budget, and the time frame.



### Step 4: Develop a marketing and promotion plan

Here the organization develops a social marketing plan, which should include strategies for communications, stakeholder engagement, and capacity development (if desired). The social marketing and promotion plan should be based on the organization's aspirations and behavioral change targets.



### Step 5: Conduct procurement

Once the plan for the PPP in hospital management is in place, the organization should prepare for procurement. This step includes developing bidding documents, finalizing the terms of reference (TOR), and drafting the contract. This crucial step is the perfect time to ensure that the bidding documents clearly specify the procedures for bidding, evaluation and award, while the TOR and contract cover the details of each party's responsibilities, performance standards, monitoring and evaluation (M&E), and pre-termination, among others.



### Step 6: Implement the public–private partnership in hospital management (focusing on monitoring and evaluation)

This step involves the actual implementation of the PPP in hospital management. This is when the partnership between the public and private sector organizations becomes operational. It is the main phase of the PPP, as it is when the desired targets and deliverables are executed by the contracting parties in order to achieve the objectives and expected outcomes of the PPP. This is the centerpiece of the entire exercise.

Contract implementation requires an effective M&E system. In this step, the organization must have a framework and parameters for M&E and a team that will undertake the M&E activities. Some organizations establish an M&E unit while others simply assign specific personnel to do the job. It is important that the PPP contract provides measurable targets and procedures for measuring and reporting.

# IV. The Steps in Developing a Public–Private Partnership in Hospital Management

This section discusses the six steps in detail. Before proceeding, review the illustration in Figure 2 to gain a better understanding of how each step connects to the next one.

**Figure 2: Steps in Developing a Public–Private Partnership in Hospital Management**







## Step 1: Determine needs and review the hospital services in the area

### 1.1 About This Step

The first step requires determining and understanding the main issues and problems related to the needs of the organization (or the local government) in hospital management services in a chosen site or area. These concerns will form part of the bases of public–private partnership (PPP) in the hospital management project. For example, if the key problem is poor and unreliable hospital services in a particular locality, the PPP project should ensure that this problem is adequately addressed. Going further, the organization should also have an idea on the scope of the PPP enterprise—for example, whether it should begin with just one hospital or immediately establish PPPs in hospital management projects in the whole province or district.

Having identified the problems, needs, and goals, the organization will have to come up with proposed solutions through the conduct of a market study (or a full-blown feasibility study, if deemed necessary). This step then involves a review of the market or the area that will be covered by the PPP project. A market (or feasibility) study should include strong financial models, which will help to facilitate the decision-making process. Box 1.1 briefly shares an experience of the Sarangani local government unit (in the southern Philippines) during the initial phase of its project development.

To reiterate, it is very important for any organization to understand the market before establishing a business or enterprise. In the case of an organization or a local government hoping to establish a PPP in hospital management, it is crucial to understand the local hospital services environment and the requirements of the public health care system.

In this step, the organization should also look into the legal and policy framework of a PPP in a hospital management project. It should have strong legal bases for such an intervention. Prospective partners should look into and understand pertinent national and local regulations. In the Philippines, PPP project developers should look into the Build–Operate–Transfer (BOT) Law (Republic Act 7718), the Procurement Law (Republic Act 9184), Department of Health’s Administrative Order 2012-0004, and the local PPP code (if one exists).

Most, if not all, countries will also have pertinent laws related to the environment, social development, gender equality, and indigenous peoples. These policies must be reviewed, particularly during the feasibility study phase, and adhered to throughout the life of the project. PPP implementers and participants should recognize that any development intervention should respect the integrity of humans, nature, and the natural order of things.

Finally, consultations with affected sectors may also be conducted in this initial step and in Step 2.

### Box 1.1: Lessons from the Proposed Sarangani Medical Center (Philippines)

The Sarangani LGU—a Philippine LGU that intends to build the Sarangani Medical Center through a PPP—initially embarked on design works but eventually decided to conduct a feasibility study before proceeding. With the support of an ADB technical assistance team, it developed terms of reference in 2012 for the contracting of a feasibility study consulting group.



A team was eventually contracted and produced a draft feasibility study, in which two scenarios were recommended as the better alternatives for a PPP scheme: (i) outsourcing of most administrative staff (e.g., orderlies, security force, laundry staff) and of some medical-related personnel such as staff nurses; and (ii) a profit-sharing scheme. The feasibility study team eventually recommended the adoption of the profit-sharing scheme for the following reasons:

- (i) It would incur less additional cost for the Provincial Government of Sarangani.
- (ii) It would require less capitalization, thus lessening the amount to be borrowed by the provincial government and reducing the amortizations.
- (iii) Maintenance and repair of medical equipment would not burden the hospital administration since this would be handled by the partner service provider.
- (iv) It combines the income-generating and cost-saving features of the other scenarios while reducing the burden on hospital administration and the provincial government.

ADB = Asian Development Bank, LGU = local government unit, PPP = public-private partnership.  
Source: Infoshare Management Systems. 2012. Feasibility Study for the Development of a PPP Tertiary Hospital of the Provincial Government of Sarangani. First draft.

### What are the tools and requirements in this phase?

This step requires a good database on existing hospitals in the project area, maps, historical data on sales (e.g., services availed or paid for by patients), laws and regulations on PPP and hospital management (including local ordinances, if any), and other useful information on the health care industry in the locality. Box 1.2 shows some of the documents developed by two local governments as they planned for a PPP in hospital management.

### 1.2 Key Activities

The following are the expected activities in this step:

- conduct of a market study (or a full-blown feasibility study, if needed or desired);

### Box 1.2: Documents Created for Step 1

In Step 1, the local governments of Sarangani and Camarines Sur prepared the following documents:



- (i) Work Plan—road map toward preparing the business plan
- (ii) Request for Information—data checklist for preparation of the business plan
- (iii) Public-Private Partnership in Hospital Management Business Plan—completed business plan, which includes an estimation of capital, a guide to computing minimum capital, bond amounts, etc.
- (iv) Weighted Average Cost of Capital—suggested calculation of the weighted average cost of capital (to estimate the minimum required return on equity of companies engaged in hospital services)
- (v) Suggested Cost-Benefit Approach—guide to quantifying the social values of the project from the organization's point of view

- development of a business plan;
- consultations or focus group discussions with all stakeholders, including affected sectors and people (more discussions on this are in Step 2); and
- review of policies on PPP, PPP in health, hospitals, drugs and medicines, and if applicable, policies on environment, gender, indigenous peoples, and other social safeguards.

As earlier mentioned, an organization that hopes to develop and implement a PPP in hospital management should first conduct a market study to determine if there is a strong need for such an enterprise or project. For example, a perceived inefficiency of public health care services is not enough to establish a PPP in hospital management. The organization should also develop a strong understanding of the hospital services in the locality, the needs of its

people, and its capacity to implement a PPP. Notes on the conduct of a market study are shared in Box 1.3.

Market studies are undertaken for different purposes, and the data collection methods to be used depend on the particular purpose and the type of information needed for the planned enterprise. (Annex 3 contains more detail on market studies. Additional notes on the development of a feasibility study are in Annex 4 while the likely tasks required in the development of a business plan are discussed in Annex 5.)

### Reasons for the Market Study<sup>2</sup>

The following summarizes the primary reasons for conducting a market study. An organization that wishes to establish a PPP in hospital management may refer to this list in evaluating the need for a market study.

#### Box 1.3: Notes on Market Study



Knowing the market's needs and how it is currently being serviced provides an organization with key information that is essential in developing its public–private partnership (PPP) and marketing plan. The organization is cautioned against spending a significant amount of money in launching a “new” enterprise with a limited market because of factors such as poor appreciation of demand, stiff competition, supply constraints, and other operational issues. The organization must assess its strategy and determine if there is indeed a market and significant need for a PPP in hospital management.

An interested organization should consider economic benefits and financial viability while considering a PPP option and drawing up a plan. Financial viability, in this context, refers to projects yielding a rate of return that exceeds the minimum level required by a private sector investor. Although the quality of health care services is important, the provision of competent health care services may not be maintained without

financial viability. Factors that may lead to financial viability include increased resource generation and efficient fund utilization. Furthermore, the presence of the private sector ensures that financial viability is always considered.

Conducting a market analysis will help an organization

- prepare itself when entering a PPP venture,
- launch the new PPP application, and
- start and comanage a PPP in hospital management.

At the completion of this step, the organization should be able to

- explain the concepts of a market study or analysis,
- determine if there is a need for the PPP enterprise,
- identify the market,
- analyze the current market, and
- gain insights on the PPP project's competitive advantage.

<sup>2</sup> Significant portions of this section were adopted from books and articles by A.B. Blankenship, W.D. Perreault, E.J. McCarthy, and C. McNamara.

**(i) Identifying opportunities to serve various groups of customers**

An organization may want to verify and understand the unmet needs of a certain market or group of customers. What do they want and what do they need? Some examples of useful data collection methods are focused group discussions, interviews of customers and investors, publications, other key library sources, and observation of clients' behaviors. Sources of information may include statistical reports from hospitals within the catchment area and those adjacent to it.

**(ii) Examining the size of the market (how many people have unmet needs?)**

As mentioned in the glossary, "needs" are translated to "demands" under a universal health care framework to help PPP project planners and developers in developing the financial projections.

An organization may want to identify various subgroups, or market segments, in that overall market along with their unique features and preferences. Useful data may be derived from analyzing demographic, health, socioeconomic, and technological trends. Useful statistics will include population–bed ratio, population growth rate, disease profiles and patterns, bed occupancy rate, employment rate, and social health insurance enrollment. A prospective PPP implementer may even observe each group for awhile to notice what they do, where they go, and what they discuss. It may be worthwhile to interview some members of each group.

**(iii) Determining the best array of services for the unmet needs of the target markets**

The organization may want to answer the following questions:

- What services and features will the PPP enterprise offer based on the disease profiles and other data gathered so far?
- What are the services that the operations can sustain?

Focused group discussions can be useful here. The participants can be asked about their preferred services and how their needs might be met by such services.

***Refining the array of services***

The array of services can be refined if the hospital will also cater to patients who can pay. Therefore, conducting research on willingness to pay will be beneficial, providing information that will be important in determining the price of services.

**(iv) Knowing and analyzing the competition**

An organization hoping to establish a PPP in hospital management should also examine their proposed services, products, marketing techniques, pricing, location, etc. vis-à-vis their competitors. Some useful sources for obtaining this information are hospital statistical reports filed with the country's department or ministry of health and financial statements filed with its government agency handling securities and exchange.

**1.3. Expected Outcome**

This step will give an organization a clear understanding of the hospital industry in the locality and help it to decide if it needs and can implement a PPP in hospital management. This also helps it determine the coverage of the prospective PPP: for example, will it begin as a one-hospital enterprise or cover a whole province or district? In the Philippines, local governments usually manage several hospitals, which often include a provincial hospital and several district hospitals. Therefore, another possibility to consider is the management of a hospital system which, though more complex, may have advantages for the province like economies of scale in terms of supplies or service quality standards.

The results of the market or feasibility study, the political will of the local leaders, and the interest of the private sector will all be of great benefit in determining the coverage and even the type of modality to be used.



## 2.1 About This Step

Setting up a public–private partnership (PPP) in hospital management is a complex task. In using the term “hospital management,” one must distinguish

general management from clinical management. General management requires experts in disciplines such as finance and administration, while clinical management calls for professionals with medical knowledge and expertise in clinical care. These



### Box 2.1: List of Likely Stakeholders in a Public–Private Partnership in Hospital Management

#### Who are the stakeholders?

Every social intervention has stakeholders. Stakeholders are organizations and individuals that may be significantly affected by the PPP or the project. In Step 2, it is critical that the organization carefully identifies the most important stakeholders. For example, if the purpose of the PPP is to acquire technical expertise, the major stakeholders will be hospital owners and operators rather than funding facilities. For the sake of discussion, stakeholders can be categorized into several groups. Below is a list of likely stakeholders, based on Philippine context.

#### Local government

- (i) Civil servants
- (ii) Elected officials

#### National government agencies

- (i) Department of Health
- (ii) Department of Interior and Local Government
- (iii) Commission on Audit
- (iv) Civil Service Commission
- (v) Department of Social Welfare and Development
- (vi) National Economic and Development Authority
- (vii) Philippine Health Insurance Commission
- (viii) PPP Center

#### Funding organization facilities and sources

- (i) Development Bank of the Philippines
- (ii) Countryside Development Fund
- (iii) Overseas Development Assistance; examples are the Asian Development Bank, the World Bank, the United States Agency for International Development, and Japan International Cooperation Agency

#### Private sector (corporate)

- (i) Hospital owners and operators
- (ii) Advisors
- (iii) Suppliers

#### Academe and other learning institutions

#### Civil society

- (i) Associations (e.g., Philippine Hospital Association)
- (ii) Nongovernment organizations and foundations

#### Media

#### Patients

- (i) Paying
- (ii) Nonpaying/indigent

two branches of management must always coordinate and work together. The broad role of general management is to provide all administrative support and ancillary services to enable the clinical care staff to effectively and safely deliver health services.

A hospital is thus a complex organization where people with different areas of expertise must work together as a team—and where the weakest link determines the quality of care in the facility. An organization that desires to improve hospital services through a PPP will therefore do well to identify and consider all the stakeholders in the undertaking, both within and outside the organization. This step also brings the organization into contact with people and institutions that can help it with enterprise development, licensing and legal requirements, financing options, and social marketing.

### What are the tools and requirements in this phase?

Stakeholder consultation requires a good planning phase that includes the development of an agenda. The agenda must focus on the particular concern of an office or institution. It will be worthwhile if a meeting of all stakeholders can be undertaken for transparency and in order to determine as many of the potential eventualities/effects of a PPP in hospital management as possible. Documentation of meetings is crucial. Pertinent materials and data must be available during discussions. Table 1, while not exhaustive, gives an idea on what are the essential information and documents that will help the PPP project developers.

**Table 1: Matrix of Document and Data Requirements for Step 2**

Source	Documents	Data
Local government	Pertinent local laws and regulations, local government development plans, directory of all stakeholders, financial statements of the public hospitals including PhilHealth reimbursements, etc.	Demographics of the province, present and projected; mapping of hospital facilities in the area (both public and private); inpatient and outpatient records; disease patterns
National government agencies	Pertinent national laws and regulations: Republic Acts, administrative orders, circulars, local ordinances, etc.	Disease patterns (to cross-reference or validate local data)
Funding organization facilities and sources	Requirements of funding facilities and agencies	Menu and features of funding mechanisms
Private sector (corporate)	Sample contracts or terms of reference, financial statements of private sector hospitals including PhilHealth reimbursements	Menu of services being provided, inpatient and outpatient records
Academe/Civil society	Policy papers, research work	
Media	News and feature articles, press statements	
Patients		Feedback on hospital services, feedback on PhilHealth membership, etc.

PhilHealth = Philippine Health Insurance Corporation.

## 2.2 Key Activities

This phase requires a thorough appreciation of the key stakeholders and their roles. The following activities may be done:

- (i) Identify stakeholders.
- (ii) Develop the agenda for consultation meetings.
- (iii) Conduct consultation meetings.
- (iv) Document discussions.
- (v) Review and analyze results.

Having identified the stakeholders, the organization can list their questions, concerns, and issues and develop the agenda for consultation meetings. These meetings, which can be done through either group discussions or one-on-one interaction, provide a perfect way to identify and get to know the PPP project's stakeholders.

The organization needs to prioritize the stakeholders with whom they should work, starting with the most critical. For example, it may not be logical to meet with potential bidders if the local leaders do not completely understand the need for a PPP in hospital management. Box 2.2 contains a few of the questions that the organization may raise before or during public consultations.

## 2.3 Expected Outcome

A PPP is a complex undertaking that needs to deal with a lot of stakeholders. For example, hospitals need to be licensed; therefore, the country's health department is a major partner and stakeholder. (The responsibility for the hospital license may depend on the form of PPP that an organization wants. For example, an organization may decide to offer a management contract only or undertake a joint venture.)

The identification process in Step 2 enables the organization to develop a stakeholder analysis. The stakeholder analysis is important in the development of the PPP as it allows project developers to understand the roles of prospective partners. The following discussion helps users to understand the role of likely partners and stakeholders.

Local government components are vital partners. In the Philippines, the Sangguniang Panlalawigan (Provincial Council) is one such a partner. It not only gives legitimacy to any PPP initiative but also the necessary budget support. Some Philippine governors have taken an initial step by convincing the council to enact a PPP code that is not limited to the health sector. Because PPP is a fairly new phenomenon for many local governments, members of the bids and

### Box 2.2: Guiding Questions for Stakeholder Consultation

Here are some questions to ponder during stakeholder consultations:

#### Why is there a need to improve hospital services?

The answer must be validated by data such as mortality rates, referrals to and from the hospital, availability and cost of services such as diagnostic procedures (x-rays, laboratories, etc.), and drugs (availability in the pharmacy, stockouts, etc.).

#### Will the public-private partnership improve services but raise prices?

There may be a tradeoff between cost and efficiency, with the private sector perceived as able to provide more efficient services, but in some instances at a higher price.



The role of the social health insurance system is, therefore, crucial.

#### How much of hospital operations will be funded by provincial funds, social health insurance, or other sources (e.g., congressional or government grants)?

Hospitals are costly enterprises and need a variety of funding sources.

#### What factors will determine the organization's access to financing?

Financing options will be determined by the organization's credit standing and capacity to pay, the financial viability of the project, the size of the financing requirement, and the risk appetite of financial institutions.



awards committees may have to undergo training on such matters as the Build–Operate–Transfer (BOT) Law or the Procurement Law. Chief executives of municipalities are also vital partners since they are in charge of public health services.

Social health insurance organizations are major partners. In the Philippines, PhilHealth is considered

as the key provider of universal health care, which private investors view as the primary mitigant to payment risks associated with catering to the needs of indigents. This may serve as a form of guarantee for the payment of management services.

Auditors may not be officially involved in the initial steps of developing PPP projects. However, the

### Box 2.3: The Importance of a Public–Private Partnership Code

While national laws such as the Philippines' BOT Law and Local Government Code provide strong policy bases for PPP projects, local governments hoping to develop PPP projects in health may consider passing a local PPP code. A PPP code provides a basis for the following:

- (i) adoption of PPP as a mode of development for the local government unit;
- (ii) creation of a regulatory authority for PPP projects;
- (iii) crafting of operative principles that will guide PPP projects in the province;



- (iv) legal framework and authority for entering into PPP contracts; and
- (v) creation of a PPP selection committee, which may be tasked with the selection of private partners for specific PPP projects and for project monitoring and evaluation.

Further discussions on the legal framework for PPP in health are found in a monograph authored by Atty. Bayani Agabin. This monograph is found in an annex of the final report on the technical assistance project, PPP in Health in the Philippines.

BOT = build–operate–transfer, PPP = public–private partnership.  
Source: Based on the authors' experiences with Philippine local governments through the Asian Development Bank Technical Assistance on Public–Private Partnership in Health and meetings with Alberto Agra (College of Law, Ateneo de Manila University).



organization will benefit by ensuring the participation of government auditors, even in an advisory capacity, to ensure that transactions are managed in a way that addresses typical audit issues (e.g., lack of feasibility study, sharing of revenues, etc.).

Personnel concerns invariably crop up when PPP initiatives are discussed. The local civil service commission can provide assistance regarding these concerns, including options for current staff who may be affected. Acceptance and ownership of the PPP initiative depends on allaying fears, real or imagined, of the provincial personnel.

Government financial institutions like the Development Bank of the Philippines have funds dedicated to the health sector (Box 2.4). Local governments in the Philippines have an advantage when dealing with government banks because, unlike in private banks, collateral is not required. The internal revenue allotments of local governments are guaranteed sources of loan payments. Government banks can also provide advice to interested partners. Each country will have its own financing facilities. PPP project developers are encouraged to look at the financing landscape diligently to avoid costly mistakes.

Depending on the modality that the organization hopes to develop (which should have been agreed upon already in Step 1), it may look at capital assets acquisition, such as the construction of a hospital building and purchase of hospital equipment. It also

needs to consider the human resources component, working capital for inventory buildup, and financing of receivables. The organization (and even its private partner) may consider several financing options, such as bank borrowing, securing of grants and overseas development assistance funds, use of financial instruments, and the Project Development Assistance Fund (see the glossary for a description of the fund). The organization may also consider accessing the Municipal Development Fund.

Should an organization consider bank borrowing, it should look into the requirements, which may include the submission of a local government resolution authorizing its borrowing and designation of authorized signatory to the loan, submission of financial statements for the last 3 years, and the other standard requirements.

The National Economic Development Authority in the Philippines has an office dedicated to PPP. There are prescribed processes that a proponent has to undergo depending on the form and amount of the PPP. (The amount determines whether a PPP initiative is a regional or national concern.) These national government organizations can provide technical assistance on the requirements of the process.

Private organizations and associations can also provide technical assistance to interested PPP project developers. (A directory of health- and PPP-focused organizations is in Annex 6.)

### Box 2.4: The Credit for Better Health Care Project

The Credit for Better Health Care Project (CBHCP) credit facility was established by the Development Bank of the Philippines (DBP) in 2007 to support the health sector reform agenda and implementation framework—FOURmula One for Health—of the Department of Health. The health sector reform program, and therewith the project, aims to support the government in attaining the Millennium Development Goals for maternal and child health as well as in improving access to affordable quality care, especially of the poor in underserved areas.

DBP aims to re-lend to subprojects for (i) improving quality of health services to attain health facility accreditation by the Philippine Health Insurance Corporation; (ii) addressing the gaps in access to basic health services (communicable disease control, woman and child health care, clinical care, ancillary services, and generic drugs); and (iii) improving efficiency in health service financing and delivery



through outsourcing, improving management systems, and other innovative strategies.

For local government, the maximum loan amount is 90% of the total project cost, with a loan term of up to 10 years (inclusive of a grace period of 6 months to 2 years in principal amount repayment). The loan can be secured by any or a combination of the following: deed of assignment of a specified portion of a local government's internal revenue allotment; real estate/chattel mortgage; government guarantees; hold out on deposits; and assignment of project income, purchase orders, and other collateral acceptable to DBP.

For more details on the CBHCP, please visit <http://www.dbp.ph/devbanking.php?cat=129>

Source: Credit for Better Health Care Project of the Development Bank of the Philippines.



### 3.1 About This Step

In this step, the organization embarks on the development of a detailed implementation plan for the public–private partnership (PPP) that includes a personnel component, policy initiatives (if these have not been done yet or need further work), budget, resource mobilization, and strategies.

The project’s impact on existing personnel should be considered in its transition strategy. As is often experienced in any transitory phase, the people must be adequately informed and consulted to lessen and manage their fears, if any. The organization should, therefore, develop a plan for the personnel who may be affected by the PPP arrangement. For example, they can be asked later on (e.g., prior to PPP implementation) to transfer to other departments in the hospital, offered an attractive early retirement package, or allowed the opportunity to be hired by the private partner. However, as in any form of organizational development process that involves staff movement, the necessary assessment of staff performance, aptitude, and career goals should be undertaken. A PPP can lead to efficiency and improvement in service delivery but it should not be undertaken at the expense of human resources. The discussion in Step 4 (development of a social marketing and promotion plan) addresses the

human component in the development of any PPP and provides insights on dealing with different perceptions on PPP in health interventions.

Monitoring and evaluation (M&E) could be an ideal role for some affected personnel, so the proponent can also consider setting up a PPP M&E committee, where these personnel will be able to find fulfillment as well as continue public service. (Further discussions on M&E are in Step 6.) The organization should have the corresponding budget to cover the benefits of those who will avail themselves of the retirement option as well as other contingencies.

#### What are the tools and requirements in this phase?

This step focuses on planning, human resources, and to some extent, resource mobilization (although this should have been widely discussed already in steps 1 and 2). This phase normally requires the following:

- (i) personnel records including performance evaluation reports,
- (ii) interview guidelines (in case the organization wants to conduct one-on-one interviews of affected personnel),
- (iii) planning tools, and
- (iv) laws and policies on civil servants.

## 3.2 Key Activities

This step may involve the following activities:

- (i) setting up a PPP committee or formalizing it (if this was not done in steps 1 or 2),
- (ii) holding planning meetings,
- (iii) assessing personnel resources and needs,
- (iv) promoting capacity development (if deemed necessary), and
- (v) developing criteria for the private sector partner.

A PPP committee should have already been set up, ideally from Day 1. The committee members can be composed of the provincial health officer, chief of hospital, provincial information officer, and other individuals who will be helpful in the planning stage. The PPP committee can be formalized through a local resolution or ordinance (depending on country requirements). Once the PPP is in place, the committee can be responsible for contract administration, monitoring, and evaluation. It can also provide technical support to the bids and awards committee.

Personnel resources should also be assessed so that the organization can determine who among its people can best fit the specific functions. The results of this can also help them determine if a capacity development intervention is necessary. Likewise, the activity can help them determine if advisors or consultants will be required.

The PPP committee can be designated to handle the following functions and tasks:

- (i) preparing feasibility studies and business plans;
- (ii) preparing tender documents;
- (iii) determining performance standards and economic parameters;
- (iv) drafting PPP contracts;
- (v) publishing bid invitations, schedules, and procedures\*;
- (vi) defining prequalification requirements\*;
- (vii) conducting pre-selection conferences;
- (viii) conducting selection processes\*;

- (ix) evaluating legal, financial, and technical aspects of proposals; and
- (x) preparing acceptance letters, recommendations, and contract awards.\*

Tasks with an asterisk (\*) may be done in coordination with or to support the bids and awards committee (BAC). Alternatively, a special BAC may be created solely for the PPP procurement. It can be eventually dissolved or some members may be invited to a permanent PPP committee. It is crucial to have a permanent and institutionalized committee that is composed of organic personnel (e.g., those with permanent or tenured positions) to ensure project efficiency, sustainability, and replication.

The planning meetings are the most important activities in this stage, as they are where the organization's plans are primarily drawn up and discussed. The plan should adequately cover all aspects of the development and implementation (particularly all the steps mentioned in this guidebook). The organization, when considering a PPP, should also consider capacity development activities, which will also require funding. The local governments that were being assisted during the development of this guidebook underwent capacity development training workshops on social marketing and knowledge management and worked with a team of consultants and advisors. The day-to-day work became a capacity development process in itself through constant sharing of knowledge and experiences.

The organization should also discuss criteria or standards for their prospective private partner(s). Key considerations are track record, length of time and extent of experience in the relevant specialization(s), and good financial standing. The winning bidder is expected to improve hospital services by ensuring availability of affordable, safe, efficient, and compassionate health care.

## 3.3 Expected Outcome

By the end of Step 3, the organization should have a completed implementation plan for the development of the PPP. (A sample implementation plan outline is in Annex 7.)



## Step 4: Develop a social marketing and promotion plan

### 4.1 About This Step

A local government hoping to establish a public–private partnership (PPP) in hospital management will most likely need to develop a marketing and promotion plan. In Step 4, the organization wants to find ways to convince its stakeholders to support public health goals through innovative interventions such as the establishment of a PPP. They need to rally the people behind their plans to be able to ensure successful implementation.

This step will allow the organization to position the PPP enterprise not as the product itself but as an effective way to pursue an objective (that is, achieving better health care for the people). Therefore, the positioning of the social marketing component of the PPP enterprise requires a more practical approach that focuses on the end product and its benefits, which is the provision of better and efficient health services to the general community. The insights in Box 4 are good starting points in crafting a social marketing plan.

#### Box 4: Communicating about Public–Private Partnerships in Health

##### What do we want to communicate?

Experts agree that public–private partnerships (PPPs) in health are better implemented by not selling the partnership itself. The concept of PPP is communicated only to the internal groups or public of participating government agencies, prospective private sector partners, and local government implementers. For the general public who will benefit from PPPs in health, it is the selling of the improved health services that is most important.

The long-term goal of behavior change—the changing of the mind-set of the general public that is desired by program managers—is therefore seen to be at the end of a spectrum of outcomes of the social marketing component, with the caveat that the success of any PPP enterprise should also be



measured by how it has effectively changed the behaviors of its intended beneficiaries (e.g., people patronizing the PPP hospital because they prefer its services and value its impact on their lives). This is the ideal situation, where the general community patronizes the health services provided through PPPs in whatever form and modality they have (e.g., even if they result in slightly higher costs).

The costs of health services, perceived by the masses (particularly indigents) as “free,” are actually being subsidized by the national government through social health insurance systems and other local and national programs. This should be communicated to the masses in understandable terms to disabuse the notion that health services for the poor are forms of “dole-out” programs.

continued on next page

Box 4 *continued*

In this context, proponents of PPPs in health, who tend to be the catalysts and designers of the program, should be presented as champions of improved and more efficient health services rather than reformists of the current system through a so-called partnership with the private sector.

PPPs in health should be seen as the means for better and efficient health services rather than an end itself.

This approach tends to defocus the public's incorrect perception that PPP is "privatization" and, therefore, would lead to higher costs of services. It also deflects the notion that government is abrogating its responsibilities to provide health services to the community to the private sector.

### What are the tools and requirements in this phase?

The physical and tangible changes that will be brought by PPPs in health (i.e., highly efficient hospitals) will be the primary focus of marketing and promotion. Local teams should develop and implement a simple but persistent campaign to inform the public about the improved services.

Communication and promotion tools may include face-to-face information drives led by the local executives and key public endorsers such as religious leaders, local officials, business leaders, media supporters, teachers, and other professionals and influencers in the community. Communication tools include printed materials such as leaflets, comics, and billboards; media campaigns through guest appearances in radio and TV programs; and the use of radio and TV plugs.

The support of local media is very critical in the information drive. The local PPP team should try to identify media personalities who can be endorsers of the PPP enterprise.

An orientation kit (printed and audiovisual materials) may be developed for the orientation of participating government agencies, prospective private sector partners, and local government units joining the program.

## 4.2 Key Activities

Step 4 involves the development of a social marketing plan, which should include plans for communications, audience analysis, message development, stakeholder engagement, and capacity development. In order to develop a social marketing plan, the organization should first determine the "publics" that it will be working and interacting with. (Remember that determining stakeholders—often referred to as the "publics" in social marketing—is part of Step 2.)

There are two levels of the "public" in the social marketing program. Foremost would be the internal groups of participating government agencies and international bodies providing financial and policy support. These may include, among others, organizations such as the Asian Development Bank and the United Nations Economic Commission for Europe. National government agencies and prospective private sector partners, such as hospital owners, hospital equipment manufacturers and suppliers, and hospital management groups, also fall into this level.

The "ground-level" public would include the political groups and individuals in the local government (i.e., mayors, officers and staff, and community leaders and/or councils); stakeholders such as nongovernment organizations, women's groups, businesses, schools, media practitioners, and youth; the patients or clientele of the health units; and the general public.

The sample matrix in Table 2 (based on the Philippine context) shows key activities.

**Table 2: Key Activities in Step 4**

Intended Audience	Content and Messages	Key Activities	Desired Output
<b>Inception or Introductory Stage</b>			
ADB, Development Bank of the Philippines, Department of Health, PhilHealth, National Economic and Development Authority; other institutional partners such as Commission on Audit and Civil Service Commission; prospective local government units and private sector partners	Description of PPP in health, benefits of PPP in health modalities, responsibility areas of partner agencies, terms of reference, monitoring and evaluation framework	Orientation	Clear understanding of PPP in health, acceptance of the program and its modalities, agreement on terms of reference, advocacy activities
PPP in health technical teams of LGUs	Social marketing, communication planning, public speaking, knowledge management, message development	Training	Clear understanding of PPP in health, skills to do social marketing and information campaign, development of key messages
Department of Health PPP in health team	PPP in health modalities, social marketing, communication planning, public speaking, knowledge management, message development, monitoring and evaluation framework	Training	General knowledge of PPP in health, core competence to provide technical assistance to LGUs and private sector partners
<b>Implementation Stage</b>			
PPP in health technical teams of LGUs	Information campaign	Face-to-face communication; radio and TV guest appearances; radio/TV plugs; billboards, leaflets, and comics	General knowledge of PPP in health, core competence to conduct the information campaign, information materials appropriate to the local level
Department of Health PPP in health team	Monitoring of PPP in health implementation	Evaluation reports	Core competence to assess and evaluate activities of the PPP in health LGUs and partners

ADB = Asian Development Bank, LGU = local government unit, PPP = public-private partnership.

### 4.3 Expected Outcome

This step leads to development of a social marketing plan, anchored on behavioral change aspirations. An ideal situation is where the general community patronizes the health services provided by government through PPPs, whatever forms and

modalities they have, and even if they will sometimes lead to slightly higher costs. As earlier mentioned, a PPP in health should be seen as the means for better and more efficient health services rather than an end itself. (Further notes on social marketing are in Annex 8.)



## Step 5: Conduct procurement

### 5.1 About This Step

This section deals with the procurement process of the public–private partnership (PPP) in hospital management services after the organization has specified its needs, determined its targets, defined the expected responsibilities of its prospective partner firm or individuals, and for its part, confirmed its own tasks attendant to the proposed PPP.

At the end of this step, the user or any organization requiring the services of a private sector partner in hospital management will be able to do the following:

- (i) Identify the most appropriate mode of procurement based on the specified needs, terms, and conditions of the proposed hospital management services.
- (ii) Customize a bidding document based on the features of the proposed PPP.
- (iii) Invite bids and conduct the bidding process.
- (iv) Evaluate bids and award contracts.
- (v) Troubleshoot cases related to bidders' submissions or bidding outcomes.
- (vi) Monitor the bidding, evaluation, and contract awarding activities to ensure compliance with the deadlines prescribed in the *Procurement Manual for Local Government Units*.

### What are the tools and requirements in this phase?

This step involves the preparation of all bid documents including the terms of reference (TOR) and contract. This step is crucial in that it is the perfect time to ensure that the TOR and contract—the most important documents in the development and implementation of any PPP project—will adequately cover relevant elements such as performance standards, monitoring and evaluation, and pre-termination. The organization should be able to customize its bidding documents based on the features of the proposed PPP.

Some organizations will require the advice and counsel of PPP, procurement, and health management specialists and lawyers. The local governments mentioned in this guidebook benefited greatly from the guidance and inputs of advisors who were part of an ADB technical assistance package that was designed to support the Philippine government in the development of different PPP in health projects.

In addition to the aforementioned reference materials, the organization should have a bids and awards committee (BAC). In the Philippines, a BAC was created under Republic Act (RA) 9184 with an adequately staffed secretariat performing the



functions enumerated in the same RA. To support the BAC and its secretariat during relevant procurement activities such as the pre-procurement conference, pre-bid conference, and bid evaluation, the end-user representatives are expected to form part of the team of resource and technical persons. If the organization is not equipped with the skills necessary to prepare the bid documents and other materials required for procurement, technical advisors could assist the team to facilitate the process.

In the Philippines, the following materials will be very useful during this step:

- (i) *Handbook on Philippine Government Procurement*
- (ii) Procurement manuals for the local government units
- (iii) *Revised Implementing Rules and Regulations (IRR) of RA 9184*
- (iv) *Commission on Audit's Guide in the Audit of Procurement*
- (v) *National Economic and Development Authority Guidelines and Procedures for Entering into Joint Venture Agreements between Government and Private Entities*
- (vi) *ADB's Procurement Guidelines*
- (vii) *ADB's Public-Private Partnership Handbook*

Step 5 also requires a review of laws and regulations (local and national) governing PPPs, health, health insurance, and auditing. The following are some of the policies and laws that must be reviewed:

- (i) Streamlining of Licensure and Accreditation of Hospitals (Department of Health Administrative Order 2011-0020)
- (ii) Hospital Licensure Act (RA 4226)
- (iii) Philippine Medical Act (RA 2382)
- (iv) An Act Prohibiting the Detention of Patients in Hospitals and Medical Clinics on Grounds of Nonpayment of Hospital Bills or Medical Expenses (RA 9439)
- (v) An Act Prescribing Forty Hours a Week of Labor for Government and Private Hospitals or Clinic Personnel (RA 5901)
- (vi) PhilHealth [Philippine Health Insurance Corporation] Law or 7875 (amended by RA 9241)
- (vii) Pharmacy Act (RA 5921)

- (viii) Magna Carta of Public Health Workers (RA 7305)
- (ix) Rural Health Unit Act (RA 1082)
- (x) BOT [Build-Operate-Transfer] Law or RA 7718
- (xi) Procurement Law of RA 9184
- (xii) Local Government Code or RA 7160

While the documents and laws listed here are relevant to PPPs in the Philippines, readers from other countries may easily contextualize these references based on their own policy environment.

## 5.2 Key Activities

The following key activities make up the complete procurement procedure after the terms of reference and other bid documents are finalized:

- (i) preparation of the invitation to bid/request for expression of interest and the bidding documents,
- (ii) conduct of pre-procurement conference,
- (iii) publication or posting of the invitation to bid,
- (iv) issuance of the bidding documents,
- (v) conduct of the pre-bid conference,
- (vi) issuance of bid bulletins, where necessary,
- (vii) submission of bids by interested bidders,
- (viii) opening of bids,
- (ix) conduct of bid evaluation and post-qualification,
- (x) preparation of bid evaluation report,
- (xi) preparation of BAC Resolution to Award,
- (xii) approval of the BAC Resolution to Award,
- (xiii) issuance of the Notice of Award and the draft contract,
- (xiv) winning bidder's submission of performance security,
- (xv) approval of the signed contract, and
- (xvi) issuance of Notice to Proceed to the winning bidder.

Further details on the activities are found in Annex 9.

The organization, at this stage, is expected to already have set up a legal team working with the BAC to ensure that the bid documents cover all aspects of the operations and management of the hospital. This team is expected to conduct desktop research, workshops/writeshops, and meetings and

consultations with the law departments or sections of various government agencies. Aside from the organizations listed in Step 2, project developers in the Philippines need to touch base with the Department of Justice and the Department of Interior and Local Government. It must be reemphasized that it is crucial to consult the Department of Health, and possibly medical associations, regarding latest policy issuances and development of the health profession.

### 5.3 Expected Outcome

At the end of Step 5, the organization will have developed comprehensive bid documents. (A sample contract template is in Annex 10.) The contract becomes one of the bases for the development of the monitoring and evaluation system, which is discussed in Step 6.

The organization should be able to develop the following documents in this step:

- (i) terms of reference (TOR) for the proposed PPP,
- (ii) approved procurement plan,
- (iii) purchase request specific to the package for bid,
- (iv) bidding documents for the organization or local government as developed by the Government Procurement Policy Board (GPPB), and
- (v) contract for the proposed PPP.

Some of the outputs are described below.

#### Terms of Reference

When the need for the hospital management services of a private sector partner has been identified, a TOR becomes necessary to enable the procurement team to initiate its activities. Without a TOR, the BAC secretariat could not prepare the invitation for bids or the appropriate bidding documents. The TOR describes the specifications of the goods and services required by the end user, as in the case of procurement of goods or civil works. The TOR guides the prospective bidders in deciding whether they should bid and, if so, up to what price ceilings they would submit their offers. (Depending on the PPP modality, the bidders may have the option to quote

a specific amount for their professional services, a certain percentage that it is willing to share to its government partner, e.g. 10% of net income, or a combination of both.) The TOR should be thorough enough to make it easy for the bidder to fully understand what the organization needs.

In addition to the standard background and rationale, the TOR should indicate the following:

- (i) detailed specifications of the required services;
- (ii) qualifications and experience of those expected to perform the services;
- (iii) financial capacity required of the firm or individuals expected to perform the services;
- (iv) target schedule for completion of the required services;
- (v) expected outputs, documents, or reports, if any; and
- (vi) payment terms, where applicable.

#### Annual Procurement Plan

The BAC will require that an approved procurement plan (APP) be available before acting on any bidding package. No procurement can be undertaken unless it is provided for in the APP. The BAC secretariat prepares the APP based on the procurement management plans of the various units or offices within the organization. It is treated as a procurement planning document that is linked to the agency's budget plan and is updated once the organization's budget appropriation ordinance becomes final. Ideally, the APP should contain the same information as that in the procurement management plans of the organization's various units or offices, as follows:

- (i) information on whether the activity will be contracted out or implemented by administration,
- (ii) magnitude of the contract,
- (iii) procurement method to be adopted,
- (iv) time schedule for the procurement activities, and
- (v) estimated budget for the bid package.

If the existing APP of the organization has not yet incorporated the need in hospital management services, it must be updated to ensure the



### Box 5: Sample Provisions in a Public–Private Partnership in Health Terms of Reference

In one of the local governments assisted by the ADB project PPP in Health (TA 7257-PHI), the following provisions in its draft terms of reference signaled how the bidding document in hospital management services could be customized:

- (i) The organization requires a qualified group of individuals or firm that can provide expertise in hospital operations, marketing, communications, and community development.
- (ii) The qualified group of individuals or firm is required to ensure the availability of quality medical care and services on competitive terms.
- (iii) The qualified group of individuals or firm is required to submit a technical proposal on how they plan to operate and manage the hospital as well as how they intend to promote and market the services being offered by the hospital to the community.
- (iv) The qualified group of individuals or firm shall be responsible for the selection, hiring, and training of the necessary personnel to manage the hospital.
- (v) The local government offers three modes of compensation from which the interested bidders can choose: reimbursement, management fee, or markups.
- (vi) The bidder is required to submit a price proposal for the local government's share of the revenue derived from the hospital management services.
- (vii) The bid shall be evaluated based on the bidder's track record, financial capability, and proposed revenue share to the local government.

procurement activity is acceptable to the reviewing authorities. Keep in mind that the Commission on Audit (COA) contract review includes verification of the existence of an approved APP with its supporting documents. The APP is one of the basic elements in COA's audit of procurement, during which the auditor will verify the completeness of the required information.

#### Purchase Request

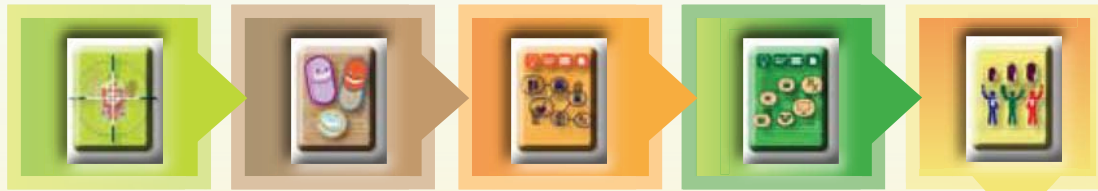
This is a standard government document to support undertaking the procurement activities, including the preparation of bidding documents, inviting bids for the required services, and the eventual bid evaluation and contract award. As in the case of the APP, the BAC normally would not act on a proposed bid package without an approved purchase request. In hospital management services, the purchase request could be written as follows: "procurement of hospital management services from a private sector partner." A draft of the TOR could be attached in case the approving authority of the purchase request asks for one.

#### Bidding Documents

The GPPB has developed a set of Philippine bidding documents (PBDs) for the following requirements of the organization using the competitive bidding process:

- (i) Procurement of consulting services
- (ii) Procurement of goods
- (iii) Procurement of infrastructure services

The latest (4th) edition of these documents was prepared in December 2010 for mandatory use of all government agencies in accordance with RA 9184. Because there are no PBDs in hospital management services, the organization may develop a bidding document for that purpose, using as reference the existing PBDs. The closest reference are the PBDs for procuring consulting services, but BAC members should take note of the conditions described in the TOR. Where applicable, the provisions in the PBD could be lifted, and customization could be done where needed. (Further details on the bidding documents are found in Annex 11.)



## Step 6: Implement the public– private partnership (focusing on monitoring and evaluation)



### 6.1 About This Step

When public–private partnership (PPP) contracts have been signed, monitoring and evaluation (M&E) will ensure that parties are living up to their ends of the contract and the endeavor is achieving its intended purpose. The *ADB Public–Private Partnership Handbook* mentions three general forms for monitoring PPP initiatives:

- (i) Use of a contract monitoring unit, usually a unit formed within a government unit if a separate regulator is not present. The contract has to contain measurable targets and procedures for measuring and reporting. The unit has to develop a procedures manual for verifying performance against the contract and for responding to any contract deviation. If payments are part of the contract, a method for ascertaining the basis for payments, making payments, reporting, and accounting for payments made is also necessary.
- (ii) If a government regulator exists, they should perform the same functions but against existing sector regulations.

- (iii) A third option is to contract independent auditors, who can be from either the public or private sector. (In the Philippines, the Philippine Council for Accreditation of Health Organizations may be contacted as an independent auditor.)

Government regulatory bodies may focus on hospital performance and their M&E departments can develop monitoring tools for PPPs in health initiatives. However, their assessments are usually performed only once a year; thus, they may be inadequate for monitoring day-to-day performance of an innovative setup such as a PPP in hospital management in the local governments. The assessment indicators can be discussed with the PPP committee.

A PPP in hospital management is usually intended as part of a schema or logical framework (logframe) designed to achieve a goal or impact on health in a particular locality or province (Table 3).

The relationship between the columns is illustrated in Table 4.

**Table 3: Sample LogFrame Matrix for a Public–Private Partnership in Hospital Management**

Project Summary	Indicators Measurement of the performance of the project objectives and outputs  Effect Indicator: A quantitative measure for effects generated by the project	Means of Verification Sources of data for verifying indicators	Assumptions Conditions important for project success, but not controllable by the project
<b>Overall Goal</b> Longer-term development goal			
Necessity of the project (Impact of the project)			
<b>Project Purpose</b> Direct effects of the project (positive changes for the target group/area)			
<b>Outputs</b> Goods and services created by the project			
<b>Activities</b> Actions required for achieving “outputs”	<b>Inputs</b> Physical, financial, and human resources to carry out project activities		<b>Pre-Conditions</b> Conditions to start the project

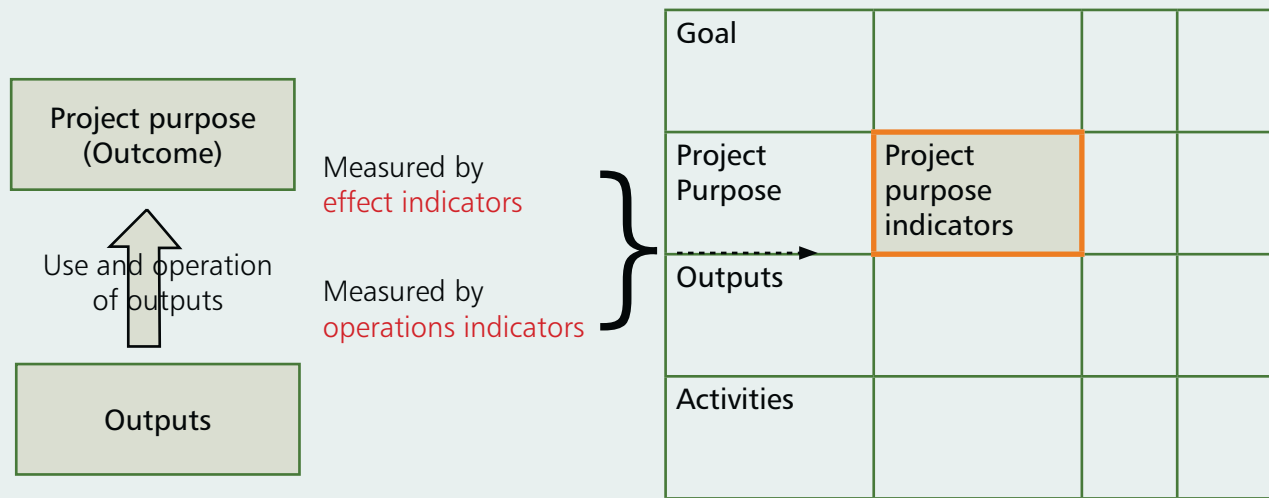
Source: ADB. 2007. *Guidelines for Preparing a Design and Monitoring Framework*. Manila.

**Table 4: Sample LogFrame Matrix for a Public–Private Partnership in Hospital Management Showing Relationships**

Project Summary	Indicators	Means of Verification	Assumptions
Overall Goal THEN			
Project Purpose IF THEN			AND IF
Outputs IF THEN			AND IF
Activities THEN	Inputs		AND IF IF Pre-Conditions

Source: ADB. 2007. *Guidelines for Preparing a Design and Monitoring Framework*. Manila.

**Figure 3 Logic of Operation/Effect Indicators**



Source: ADB. 2007. *Guidelines for Preparing a Design and Monitoring Framework*. Manila.

**Box 6: Statements of Goal, Purpose, and Outputs for a Public-Private Partnership in Hospital Management (Sample)**

**Overall goal:** Improved maternal mortality rate

**Project purpose:** Provide quality general management and clinical management services to provincial hospital/s especially maternal and child health services.

**Project output:** Hospital managed by a private entity

- Activities:**
- (i) Conduct a needs assessment of hospital services
  - (ii) Institutionalize and document management practices
  - (iii) Provide appropriate quality levels for hospital services
  - (iv) Monitor hospital operations



Performance indicators for project purpose or outcome include both operation and effect indicators. An operation indicator is a quantitative measure of the operational status of the project outputs, while an effect indicator is a quantitative measure of effects generated by the project (Figure 3).

Box 6 shows examples of goal statement, purpose, outputs, and activities when a logical framework is applied to a PPP in hospital management. However, the organization must bear in mind that hospital management is much more complex than straightforward outsourcing of services such as hospital administrative services. The organization and the chosen hospital manager must agree on indicators for both general and clinical management. The considerations in Box 6 are just examples. Bear in mind that the process of formulating an M&E program is the focus here.

Moving further, a framework for a PPP in hospital management may look like the one in Table 5.

**Table 5: Logical Framework for a Public–Partnership in Hospital Management with Sample Considerations**

Project Summary PPP— Hospital Management	Indicators	Means of Verification	Assumptions
<b>Overall Goal</b> Improved maternal mortality rates	Maternal mortality rate	Hospital records	Births in the hospital contribute to a major portion of births.
<b>Project Purpose</b> Provide quality general management and clinical management services to provincial hospital(s), especially maternal and child health services.	(i) Net death rate from deliveries, cesarean sections (ii) Net death rate for children under 5 (iii) Infection rates (iv) <i>PhilHealth Benchbook</i> indicators <sup>a</sup> (Philippine context)	Census from patient charts	Local and external physicians will agree to management setup and indicators.
<b>Outputs Functioning</b> Quality hospital management services provided by a private entity	(i) Contract signed (ii) No non-conformances to contract agreements (iii) Hospital performance indicators	(i) Document copy (ii) Reports (iii) Visual inspection	Both local and external physicians will agree to management setup.
<b>Activities</b> (i) Determine needs and review the hospital services in the area. (ii) Identify stakeholders and their roles. (iii) Develop an implementation plan for the PPP. (iv) Develop a social marketing and promotion plan. (v) Conduct procurement. (vi) Implement the PPP.	<b>Inputs</b>		(i) Health department, social health insurance, and audit commission approval of setup (ii) Less than 80% social health insurance enrollment and global budgeting <sup>b</sup> used.
			<b>Pre-Conditions</b> Provincial government decision to pass a PPP code or resolution through the local council

PPP = public–private partnership.

<sup>a</sup> The *Benchbook* features a list of standards for improving the quality of care in all health care organizations in the Philippines. It goes beyond the usual emphasis on structures (e.g., facilities and equipment) by providing process and performance standards such as waiting time for procedural treatments and business processes. Source: Philippine Health Insurance Corporation (PhilHealth).

<sup>b</sup> A “global budget scheme” is now being developed by Philippine Health Insurance Corporation. This scheme is a modified approach to health financing where accredited health care providers with good performance can negotiate an advance payment for the costs of providing specific packages of medical benefits based on a predetermined and fixed budget. Once implemented, it encourages good performers to continue improving their health services and facilities with the promise of advance payments.

The shaded cell in Table 5 contains indicators that are critical in monitoring how the hospital is performing and consequently how the PPP is faring. Partners need to agree on performance indicators, examples of which are listed below (under tools and requirements).

### What are the tools and requirements in this phase?

There are a number of hospital performance indicators that can be used. The World Health Organization mentions several dimensions that need to be covered:<sup>3</sup>

- (i) **Clinical effectiveness**—technical quality, evidence-based practice and organization, health gains, outcomes (individual and community)
- (ii) **Patient centeredness**—responsiveness to patients; client orientation (prompt attention, access to social support, quality basic amenities, choice of provider); patient satisfaction; patient experience (dignity, confidentiality, autonomy, communication)
- (iii) **Production efficiency**—resources; finance (financial systems, continuity, wasted resources); staffing ratios; technology
- (iv) **Safety**—patients and providers, structure, process
- (v) **Staff**—health, welfare, satisfaction, development (e.g., turnover, vacancy, absences)
- (vi) **Responsive governance**—community orientation (answers to needs and demands), access, continuity, health promotion, equity, ability to adapt to the evolution of the population's demands (strategy fit).

A sample M&E form, adopted from a Department of Health form, is in Annex 12. There is also a hospital monitoring tool produced by a foreign-funded project in 2002.<sup>4</sup> It is extensive and uses a grading system to rate a hospital's performance. The *PhilHealth Benchbook*, familiar to many provincial hospital managers, also monitors service quality and can be used as a basis for M&E for quality of service. There are commonalities in the dimensions that these tools cover. However, the provincial government should bear in mind that contract terms, which are not included in the existing monitoring tools, must be included in the monitoring for the PPP in hospital management.

The sample management monitoring tool in Annex 12 includes both general management and clinical management aspects of hospital management. The goal of general management (administration, finance, marketing, etc.) is to ensure that the clinical staff can deliver clinical services without any problems. Failure to do so will result in inadequate or inefficient clinical services (e.g., lack of drugs and medicines, lack of supplies, unnecessary referrals, etc). Clinical and medical services are also monitored to ensure that a certain level of service quality is maintained. Their indicators include infection rates, net death rates, etc. Good hospital management is thus a marriage of good general and clinical management, and most monitoring tools include aspects of both.

## 6.2 Key Activities

After the preparation of a logical framework and an agreement on the hospital performance indicators to be used, the two parties must also agree on the tools for monitoring. It is understood that the contract

<sup>3</sup> World Health Organization, Regional Office for Europe. 2003. *Measuring Hospital Performance to Improve the Quality of Care in Europe: A Need for Clarifying the Concepts and Defining the Main Dimensions*. Report on a World Health Organization Workshop, in Barcelona, Spain, on 10–11 January.

<sup>4</sup> Management Sciences for Health. 2002. *Hospital Reforms: The Hospital Performance Monitoring Tool*. Health Sector Reform Technical Assistance Project.



should be a part of the guide for the development of an M&E system. The PPP organization then needs to set up the M&E team, conduct meetings, develop an M&E reporting system, and implement the monitoring system.

### 6.3. Expected Outcome

The M&E framework and parameters will provide information on how the PPP initiative is performing, using hospital performance indicators as one set of indicators.

The M&E results should provide bases for continuous improvements and enhancements. The success of any PPP model relies significantly on how well an organization responds to the need for changes and performs corrective measures when needed. Successful models should also be sustained and eventually replicated.

Case profiles of PPPs in hospitals and hospital management in other countries are in Annex 13.

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**Annex 1**  
**Department of Health Administrative Order**  
**on Public–Private Partnerships in Health**  
**(No. 2012-0004)**



Republic of the Philippines  
Department of Health  
**OFFICE OF THE SECRETARY**

MAR 0 1 2012

**ADMINISTRATIVE ORDER**No.2012- 0004**SUBJECT: Policy Framework for Public-Private Partnerships in Health****I. BACKGROUND AND RATIONALE**

In pursuit of the objectives of Universal Health Care or “Kalusugang Pangkalahatan (KP)”, as defined in Administrative Order No. 2010-0036 (The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos), the Department has committed to engage in more Public-Private Partnerships (PPPs) specifically to enable physical improvements in government health facilities. PPPs have also been looked upon by no less than the President of the Republic as a key national development instrument, the furtherance of which is therefore a priority of all government agencies, including the Department of Health.

The private sector is deemed to have intrinsically better capabilities in some areas, such as more timely financing, operational efficiency, highly-responsive services, and even dominant market presence. If optimally harnessed, more cooperative undertakings with the private sector may help significantly address some of the constraints and inefficiencies inherent in public-only provision of health services.

The Philippine government has long recognized the advantage of adopting PPPs in public sector undertakings, especially for large-scale priority infrastructure developments. The mechanisms for the latter had been laid out in the Republic Act 7718, otherwise known as the Amended BOT Law. While the latter account for several possible variants of PPPs, the included listing is still not exhaustive. Separate guidelines for Joint Ventures, another PPP modality, have been drawn up by the National Economic and Development Authority (NEDA).

The local PPP experiences in the health sector have thus far been varied. While many such endeavors have been documented, most of these have been found to be non-contractual in nature (with consequent minimal accountabilities and performance references), and many have been unsustainable. It also remains to be determined if existing and upcoming PPPs in health substantially address the fundamental UHC goal of enhanced access to health care for the country’s poor. All these assume greater significance in the light of the reported United Nation’s consideration of the Philippines as the Center of Excellence for PPPs in Health.

It is apparent from the foregoing that while the national policy on PPPs has been set, much remains to be clearly delineated and effectively adapted for health services. This Administrative Order has therefore been crafted in order to better define the applicability and prioritization of the relevant policies, streamline their implementation, and enable the continuing evaluation of PPPs in the health sector.

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## II. SCOPE AND COVERAGE

This issuance shall apply to the entire health sector, from both the public and private sectors, the DOH bureaus, national centers, hospitals, and attached agencies especially Philippine Health Insurance Corporation (PhilHealth), which are involved in the support for and provision of health services.

## III. GOAL AND OBJECTIVES

### A. Goal

The establishment of Public Private Partnerships is to be encouraged and sustained in the areas of health care where these most contribute to the achievement of “*Kalusugan Pangkalahatan*”, and thereby ensure equitable access and better outcomes for disadvantaged Filipinos.

### B. Objectives

The DOH aims to:

1. prioritize PPPs that meet national and local government objectives of addressing adequately the health service needs of the poor ;
2. promote and provide a focused approach that harmonizes the existing PPP-applicable legal and administrative mandates as well as internal strategies and procedures;
3. foster a culture that engenders transparency, fairness, and robust competition;
4. develop and integrate in the overall PPP efforts, incentives, which are aligned with both departmental goals and expected health outcomes; and
5. continually assess the collective experiences on PPPs in the health sector so as to be able to adapt public policies and approaches to new developments and needs to sustain accessibility to quality healthcare.

## IV. DEFINITION OF TERMS

1. **Health sector** – refers to health systems, including all institutions, organizations, enterprises and entities, involved in actions that protect, promote or advance the health status of individuals or populations; conceptually includes all aspects of society that influence health status but operationally focuses on those entities specifically organized to provide or govern the provision of health services and goods.
2. **Public sector** – refers to health providers (individual practitioners, health centres, hospitals, organizational units, agencies) within the rules and regulations of the government and all providers under the administration and control of the DOH, other national agencies (DepED, DOLE, DND, etc) or local governments (provincial, city or municipal governments).
3. **Private sector** – refers to health providers and facilities (individual practitioners, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government;



includes the drug and pharmaceutical industry, non-government organizations, as well as proprietary enterprises providing health services as part of their activities.

4. **Public-Private Partnership (PPP)** – a cooperative venture between the public and private sectors, built on the expertise of each partner, that best meet clearly defined public needs through the appropriate allocation of resources, risks and rewards.
5. **“Kalusugan Pangkalahatan” (KP)** – a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform; intended to ensure that the poor are given financial risk protection through enrolment in PhilHealth and that they are able to access affordable and quality health care and services in times of need.

#### V. GENERAL GUIDELINES

Cognizant of the still under-tapped potential offered by PPPs in expanding the provision, particularly in capital-intensive areas, of health services, the DOH will adhere to the following guiding principles to both facilitate and regulate these engagements:

- A. **Consistency of Priorities:** PPPs in the health sector which are in line with key national, DOH, and even LGU developmental priorities will be favoured, in terms of the administrative, technical and operational support that may be provided by the DOH.
- B. **Synergized Strategies:** All the relevant KP-related strategies, the implementation of which will cultivate an environment which is supportive of PPPs, are to be given more emphasis by the DOH.
- C. **Comparative Advantage:** The DOH will actively promote the adoption of PPPs in health in areas where these are deemed to be the most meritorious option for the implementation of specific health programs or services.
- D. **Sector Coordination:** The DOH will coordinate with the other concerned national government offices and agencies, LGUs and private institutions and organizations so as to expedite the processing and functioning of priority PPPs in health.
- E. **Fair Competition:** To ensure a level playing field, as well as to be aligned with the nationally-defined strategy, contractual PPPs, entered into following a competitive bidding process, will be preferentially encouraged.
- F. **Transparent Processes:** An informational and procedural clearing system will be established, which will be made accessible to all health-related PPP stakeholders.
- G. **Conditional Incentives:** Technical, material, or financial incentives are to be developed and provided which are in concordance with both KP objectives and strategies as well as actual PPP performance vis-a-vis intended population health outcomes.

- H. **Continuing Appraisal:** The DOH shall establish a repository of Health PPP performance and experiences, and utilize the data so collated to effectively fine-tune the relevant policies and procedures.

## VI. SPECIFIC GUIDELINES

- A. The determination of health programs or services which are to be given precedence, in terms of DOH-provided support, for PPP establishment shall be based on:
- 1) KP goals and strategies
  - 2) Other DOH-set priority areas
- B. The Department shall comply with the following legal and administrative instruments and frameworks in the promotion, implementation, and evaluation of PPPs:
- 1) RA 6957, as amended by RA 7718 (BOT Law) and its Implementing Rules and Regulations
  - 2) RA 9184 (Government Procurement Reform Act)
  - 3) Batas Pambansa Blg. 68 (Corporation Code of the Philippines)
  - 4) RA 7160 (Local Government Code)
  - 5) EO 292 (Administrative Code of the Philippines)
  - 6) EO 226 (Omnibus Investment Code of 1987)
  - 7) NEDA Joint Venture Guidelines and Procedures
  - 8) NEDA Investment Coordination Committee (ICC) Guidelines
  - 9) Commission on Audit (COA) Guidelines
  - 10) Other related legal and administrative issuances
- C. Even as the DOH assumes the lead in the establishment of strategic PPPs in the health sector, it shall coordinate with, as well as provide any necessary assistance, to the following entities:
- 1) Public-Private Partnership Center of the Philippines, NEDA for medium to large-scale health PPPs
  - 2) LGUs and Local Development Boards for LGU-initiated PPP endeavors
  - 3) Development partners, financial institutions, NGOs and other parties interested in PPPs
- D. The DOH shall endeavor to ensure that the financial environment for health-related activities is conducive to private sector participation by:
- 1) Progressively increasing, in coordination with PhilHealth, membership in the social health insurance system, with particular emphasis on attaining universal coverage of the poor
  - 2) Putting in place more adequate and timely reimbursement mechanisms, also in coordination with PhilHealth
  - 3) Streamlining the PhilHealth accreditation of qualified health service facilities and providers
  - 4) Promoting efficiency and responsiveness among public providers of health services by encouraging their assumption of greater administrative and fiscal autonomy
- E. Suitability, transparency and fair competition in the establishment of PPPs in health are to be advanced by the adoption of the following:
- 1) Determination of the applicable clinical, administrative, and economic norms for PPP undertakings
  - 2) Publication of user-friendly procedural guides

- 3) Declared partiality for solicited bids in the setting up of PPPs
  - 4) Development and dissemination of performance standards
  - 5) Endorsing the inclusion of public disclosure clauses in PPP contracts
- F. Assessment as well as incentives schemes are to be developed and are to be premised on:
- 1) The commitment by the Department to provide substantial technical, material, and financial support (through conditional grants or soft loans) as additional incentive mechanisms
  - 2) The actual incentive mix is to be pre-determined for targeted types of or desired outcomes for PPPs
  - 3) A system for periodic monitoring and evaluation is to be set-up purposely for both exclusive as well as comparative appraisal of PPPs in health
  - 4) Regular publication of the performance assessments of initiated PPPs

## VII. ROLES AND RESPONSIBILITIES

### A. DOH, through the following offices, shall:

- 1) Office of the Secretary
  - a. Provide policy directions for and ensure the Department's sustained commitment to PPPs for the health sector
  - b. Commit resources to support the PPP undertakings of the Department
  - c. Develop and implement the corresponding organizational framework, inclusive of lines of accountability, in support of the PPPs for health effort
- 2) PPP Task Force
  - a. Serve as the point group for PPPs in the DOH
  - b. Assume all the responsibilities for PPPs as listed in Department Personnel Order No. 2010-5150
  - c. Support the establishment of the DOH Center for Excellence on Public-Private Partnerships in Health (DOH-CEP3H), which will eventually take over the Task Force's responsibilities as well as become the primary office concerned with the PPP-related initiatives and activities of the DOH
  - d. Provide the primary link to the external network of government agencies and private entities which are involved or interested in PPP undertakings in health
  - e. Recommend to the Secretary appropriate PPP measures for the furtherance of the UHC/KP goals and strategies
- 3) DOH Bureaus, Agencies, Hospitals, and other subsumed offices, particularly Center for Health Development (CHD)
  - a. Identify and develop priority areas in their corresponding fields of operations where PPP arrangements will be appropriate
  - b. Collaborate with the pertinent DOH offices, government agencies as well as private entities in the planning, implementation, and monitoring of PPPs in health



- B. Philippine Health Insurance Corporation (PhilHealth) shall:**
- a. Ensure effective coverage of social health insurance through expanded enrollment of the sponsored and informal sector, widely accessible accredited facilities and better support value
  - b. Develop the contracting modality, case-based payments and other measures for timely and efficient payments of providers.
- C. Local Government Units (LGUs) are encouraged to:**
- a. Consider the option of PPP whenever appropriate for the implementation of their Province-wide Investment Plan for Health (PIPHs)
  - b. Transfer more governance and fiscal responsibilities and capacities to their health facilities to enable these specifically to retain and appropriately utilize generated revenues
  - c. Adopt the appropriate incentive systems for developing and sustaining local PPPs in health
  - d. Coordinate with DOH agencies in the development, implementation, and monitoring of local PPPs in health
  - e. Utilize the guidelines and other instruments provided by DOH for the local development of PPPs in health
- D. Other Government Agencies, Development Partners, and Private Sector Organizations are advised to:**
- a. Align their objectives and PPP-related activities so as to be consistent with KP goals and strategies
  - b. Coordinate with the DOH and concerned government agencies in the development, implementation, and monitoring of PPPs in health.

#### VIII. REPEALING CLAUSE


The provisions of previous Orders and other related issuances inconsistent with or contrary to the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

#### IX. IMPLEMENTATION

The Implementing Rules or equivalent guidelines in line with this Order shall be developed within three months.

#### X. EFFECTIVITY

This Order shall take effect immediately.

  
ENRIQUE T. ONA, MD, FPCS, FACS  
Secretary of Health

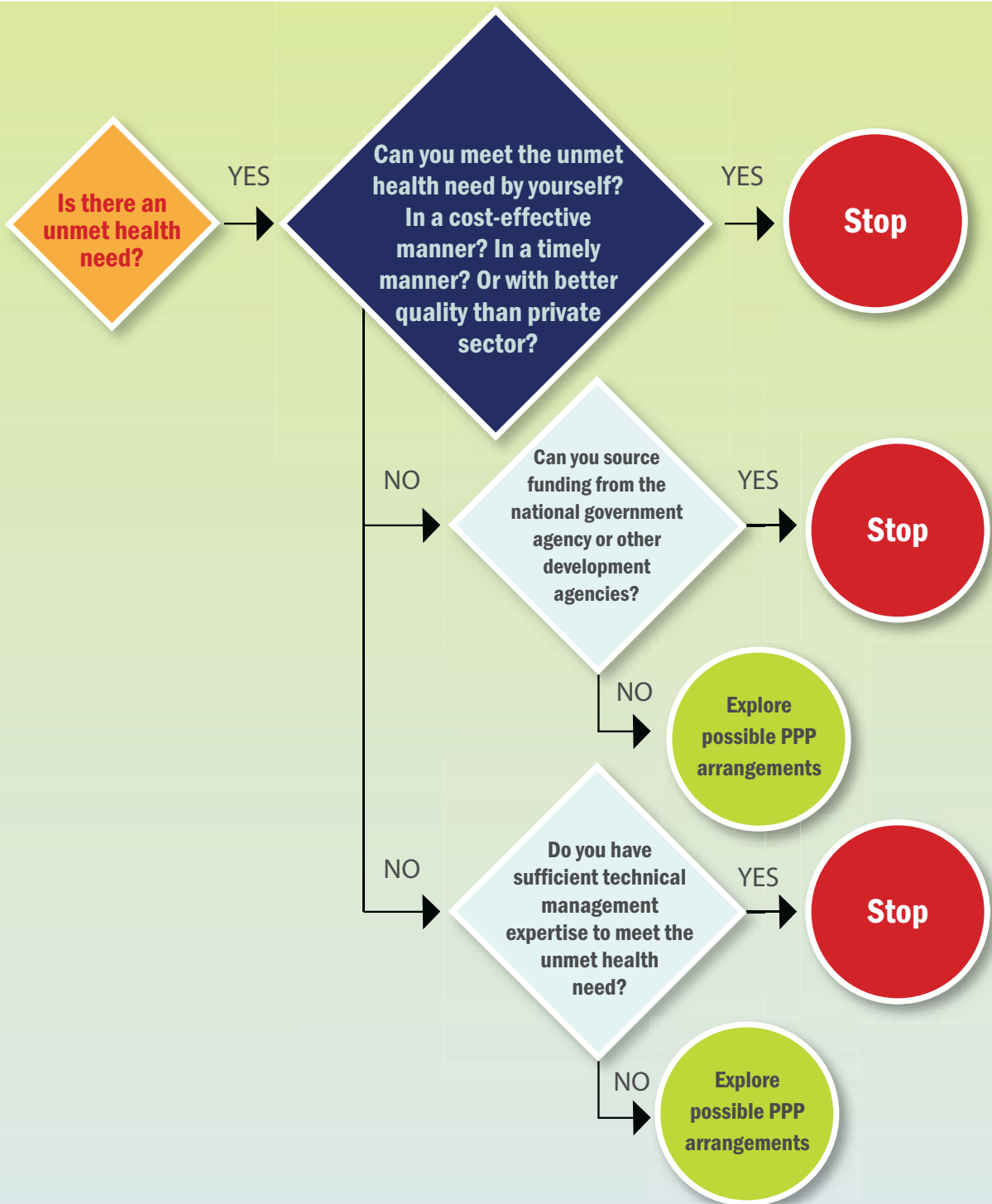
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# Annex 2

## A Simplified Tool for Determining Need for a Public-Private Partnership

Figure A2: A Simplified Tool for Determining Need for a Public-Private Partnership



## Understanding PPP and Selected Modalities

A good operational definition of public–private partnership (PPP) is “a project that proportionally apportions the risks and rewards to the government and private entity partners.” As practiced, a PPP can be considered

- (i) a tool for government governance or management;
- (ii) a novel approach to delivering government goods and services;
- (iii) a tool for development; and
- (iv) a less controversial phrase for privatization or contracting out.

PPPs recognize that governments and private entities have certain advantages relative to one another in performing specific tasks. For example, government is very effective in mobilizing resources for the poor, while a private enterprise is very successful in fostering innovation and efficiency. In bringing government and private enterprise together in a PPP, it is hoped that the advantages of each can be synergistically harnessed to provide services and products that neither one can do very well alone.

The flowchart here provides a simple way to help an organization or local government determine if it should pursue a PPP project. Because of the uniqueness and potentially politically risky consequences, it is advised that PPP be entertained only as a solution for current unmet health needs or foregone care.

PPP is not recommended if the organization is able to meet this unmet need with its own resources, or if it could access national government resources.

Further, PPP is recommended only if the private sector is able to deliver goods and services that are more cost-efficient or timely, or that have better

results, than if the organization were to undertake the delivery of the same goods and services.

PPP is useful if the organization will benefit from improved technical and managerial capabilities in meeting unmet health needs, such as managing the professional and supplier accreditation process, enforcing clinical practice guidelines, credentialing personnel, handling mortalities and morbidity conferences, monitoring disease trends, controlling healthcare-associated infections, managing assets and finances, and others.

### Using This Tool

After going through the flowchart, the organization should consider the suitable PPP modality. Table A2.1 summarizes the common modalities and their features.<sup>1</sup>

#### Service Contracts

Under a service contract, the government organization (e.g., local government) hires a private company to deliver specific tasks or services for a specified time period. The private partner must perform the service(s) at the agreed price and must meet performance or deliverable standards set by the government partner. Generally, competitive bidding procedures are the best way to award service contracts, as competitive bidding mimics the open market in a time limited and controlled manner.

Under a service contract, the compensation for the private partner is fixed; therefore, the private partner can increase its profit only if it can reduce its operating costs. Often, this incentivizes the private partner to save costs instead of introducing efficiency innovations, as service contracts are usually of short duration, typically 1 year. To prevent providers from cutting corners, the organization needs to invest in a comprehensive monitoring and evaluation (M&E) system. With proper M&E, this profit incentive based

<sup>1</sup> Table A2.1 and the accompanying text were compiled by Hilton Lam for ADB TA 7257-PHI: PPP in Health and sourced from the following publications: Quium, A. 2011. *A Guidebook on PPP in Infrastructure*; UNESCAP. European PPP Expertise Centre. 2011. *The Non financial benefits of PPP: An Overview of Concepts, and Methodology*; Tain, F. and D. Bendahmane. 2001. *Public–Private Partnerships: Mobilizing Resources to Achieve Public Health Goals*. United States Agency for International Development, BASICS II Project, the Environment Health Project, UNICEF, and the World Bank. [www.ehproject.org/PDF/Joint\\_Publications/JP002CAHandPmPhlEn.pdf](http://www.ehproject.org/PDF/Joint_Publications/JP002CAHandPmPhlEn.pdf); McKee, M. 2006. *Public–Private Partnerships for Hospitals*. *Bulletin of the World Health Organization*; Lim, M.K. 2004. *Transforming Singapore Health Care through PPP*; UNECE. 2008. *Guidebook on Promoting Good Governance in PPP*; and Palmer, K. 2000. *Contract issues and financing in PPP-PFI*. CEPA.

**Table A2.1: Public–Private Partnership Modalities**

PPP Type	Capital Investment	Recommended Years of Partnership	Operations and Management	Outcomes Monitoring and Evaluation	Risk Assumed by LGU	Competitive Pressure	Problems and Challenges
Service contract	Government organization/ Local government	Annual	Government organization/ Local government	Government organization/ Local government	Low	High	Local government unit (LGU) must be able to administer multiple contracts simultaneously. LGU must have strong contract policing powers and political will.
Management contract	Government organization/ Local government	3 to 5 years	Private	Government organization/ Local government	Low to moderate	High during bidding	Private sector partners usually encounter problems with LGU budgetary process, staff hiring and firing.
Lease contract	Government organization/ Local government	3 to 5 years	Private	Government organization/ Local government	Moderate	High during bidding	Issues of low maintenance of infrastructures and equipments
Concessions	Private	10 to 25 years	Private	Government organization/ Local government	High	Moderate during bidding	LGU must be powerful enough in ensuring reasonable fees and quality outcomes
Build–operate–transfer	Private	10 to 25 years	Private	Government organization/ Local government	High	Low	Issues of inefficiencies and low innovations

behavior of the private partner can be controlled and eventually channeled into greater efficiencies and innovations through a longer-term contract or preference for continuance of existing contracts.

Service contracts are usually most suitable where the service can be clearly defined in the contract, the level

of demand is reasonably certain, and performance can be monitored easily. Service contracts provide a relatively low-risk option for expanding the role of the private partner. Service contracts can lead to a quick and clear impact on system operation and efficiency. Service contracts are often short-term, allowing for repeated competition in the sector.



### **Management Contracts**

A management contract expands the service contract to include some or all of the management and operations of the government service (i.e., hospital management). Although the ultimate responsibility for service provision remains with the government partner, daily management control and authority are assigned to the private partner. In many cases, the private partner provides working capital only and does not finance the whole investment. Most management contracts are for 3 to 5 years.

Typically, the private partner is paid a predetermined amount for personnel and other anticipated operating costs. To provide an incentive for performance improvement, the contractor is awarded an additional amount for achieving certain targets or a bigger share of the profits. The private partner interacts with the patients while the government partner is responsible for setting hospital vision and missions, and service fee schedules.

The key advantage of a management contract is that many operational gains that result from private sector management can be achieved without transferring government assets to the private partner. These contracts are relatively easy to develop and can be less controversial than outright privatization.

However, if the private partner does not have control over personnel hiring and firing, and of subcontract negotiations, there is a risk that the private contractor will not be able to achieve deep and lasting change. However, if given too much control, there is also the risk that the private partner may take actions that are contrary to government social sensibilities such as equality, gender equality, pro-poor bias, etc. If the private partner is paid a portion of profits or given an incentive payment, safeguards are required to prevent overstatement of achievements. Government must also make sure that the private partner does not under-invest in asset maintenance, as the assets are provided by government, and not purchased by the private partner.

### **Lease Contracts**

Under a lease contract, the private partner is responsible not only for the government service in its entirety

but also undertakes obligations relating to quality and service standards. The private partner provides the service at its expense and risk. The duration of the leasing contract is typically for 3 to 5 years and may be renewed for up to 20 years. Responsibility for service provision is transferred from the government partner to the private partner, while the financial risk for operation and maintenance may be shared between the public and private partners.

Under lease contracts, the private partner's profits are dependent on the sales volume and cost performance. Therefore, there is strong incentive for the private partner to achieve higher levels of efficiency and sales, unlike in the service contracts, which are usually very limited in duration. The principal risk of lease contracts is the possibility that the private partner may not deliver the required services and/or at the required quality. Therefore, the contract should contain appropriate grievance, appeal, and termination provisions. In this setup, the government partner focuses on regulatory issues while the private partner takes on the service delivery issues.

### **Concessions**

A concession makes the private partner (concessionaire) responsible for the full delivery of services in a specified area, including all capital investments, almost like a geographically delimited monopoly. Although the private partner operator is responsible for providing the assets, such assets are publicly owned even during the concession period.

The concessionaire collects the payments directly from the service end users. The fee schedule is typically established by the concession contract, which also includes provisions on how it may be changed over time. A concession contract is typically valid for 10 to 15 years and renewable up to 30 years so that the operator has sufficient time to recover the capital invested and earn an appropriate return over the life of the concession. The government organization may contribute to the capital investment cost, if necessary. This can be an investment “subsidy” to achieve commercial viability of the concession. Alternatively, the government organization can be compensated for its contribution by receiving a portion of the incomes generated.

Concessions are an effective way to attract private finance required to fund new construction or rehabilitate existing facilities. A key advantage of the concession arrangement is that it provides incentives to the operator to achieve improved levels of efficiency and effectiveness since gains in efficiency translate into increased profits and return to the concessionaire. The transfer of the full package of operating and financing responsibilities enables the concessionaire to prioritize and innovate as it deems most effective.

Key drawbacks include the complexity of the contract required to define the operator's activities. The government organization needs to upgrade its regulatory capacity in relation to fee schedules and performance monitoring. Further, the long term of the contracts (necessary to recover the substantial investment costs) complicates the bidding process and contract design, given the difficulty in anticipating events over a 10 to 15 year period. This drawback may be countered by allowing a periodic review of certain contract terms in the context of the evolving environment.

There is additional risk that the operator will only invest in new assets where it expects payback within the remaining period of the contract unless provisions for these events are set out in the contract. Because of the long-term, comprehensive nature of the contracts, they can be politically controversial and difficult to organize. It can also be argued that concessions go against open competition given the limited number of qualified operators for a major infrastructure network. The government partner must make sure that the concessionaire will not have an opportunity to become a full monopoly, and provide measures to allow additional operators into the market when necessary. Failure in regulating and policing may lead to the phenomenon of regulatory capture in the concession area.

### **Build-Operate-Transfer**

Build-operate-transfer (BOT) and similar arrangements are a kind of specialized concession in which a private partner or consortium invests and develops a new infrastructure project or a major component of a government project according to performance standards set by the government.

Under a BOT, the private partner provides the capital required to design, build, and operate the new facility. The private partner owns the assets for a period set by the contract—sufficient to allow the developer time to recover investment costs through user-fee charges. The government partner agrees to subsidize the operations, usually in the form of a purchase guarantee or tax holiday. As most BOTs are greenfield endeavors, this is to assure the private partner of recovering its costs during operation in exchange for undertaking the risks of investing and operating in an untested field. A difficulty emerges if the government partner has overestimated demand and finds itself purchasing output under such an agreement when the demand does not exist. BOTs generally require complicated financing packages to achieve the large financing amounts and long repayment periods required. As such, the government partner should put in safety features that would prevent the emergence of regulatory capture.

At the end of the contract, the government partner takes over ownership of the assets, but can opt to contract the operation to the same private partner or to a new contractor or partner.

BOTs have a project-specific application so they are potentially a good vehicle for a specific investment, but with less impact on overall system performance. However, because the scope of BOTs are usually very expansive, and often only one private partner is negotiated to provide the service, a form of "state-sanctioned" monopoly is put into place. As such, wastage, poor quality, and minimal innovation may result if measures to infuse competition are not pre-set.

### **Hybrid Arrangements**

Contract arrangements that incorporate different characteristics of a range of contract types can also be developed. Called "hybrid" arrangements, these bring together the attributes most suitable to a particular project's requirements and the operating conditions. Hybrid arrangements provide a tailored solution—in terms of scope and risk-sharing—that is most directly suitable to the project at hand. Obviously, the variations are endless; here are a few examples:

- (i) a **management contract plus** arrangement, in which the performance-related element

**Table A2.2: Extent of Investment for Selected Public–Private Partnership Modalities**

PPP Modality	Political Will	Capital Requirements	PPP System Issues (operational requirements)
Service contract	Low	High	Low
Management contract	Moderate	Moderate	Moderate
Lease contract	Moderate	Moderate	High
Concessions	High	Low	High
Build–operate–transfer	High	Low	High

of the management contract is substantial enough to transfer real risk. For instance, the payment of bonuses to the management contractor might be linked to achieving increases in the operating cash flow of the utility by a predetermined amount. To achieve the bonus (if sufficiently large), the contractor may put additional inputs at risk to achieve the cash flow outputs.

- (ii) a **lease plus** arrangement, which allows shared responsibility for investments. Under a standard lease, the contracting authority retains full responsibility for undertaking and financing new investment, even though the operator may be in a better position to manage new construction and some other investment obligations.

In some cases, the operator is given limited investment responsibility, such as an extension of network service coverage in certain areas. Alternatively, the operator and contracting authority may reach an agreement to cofinance investments.

Table A2.2 provides a quick look at the extent of investment (stake) that is needed in the selected types of modalities for PPP in health.

As with all PPP modalities, political will, capital requirements, and PPP system issues must be dealt with.

Political will is an inverse function of the level of change to be brought about by the PPP. As such, service contracts, which do not change the status quo much, require only low-level political will. Meanwhile, concessions and BOTs, which give the private partner a significantly more visible role, will require higher levels of political will.

From the government partner’s point of view, the capital requirements are inversely proportional to the level of change. If the government entity sticks with the status quo, then the organization or local government is essentially responsible for capital and operational expenditures. As such, service contracts require more capital from the organization than the more sophisticated types of PPPs, such as concessions and BOTs. However, as private partners take on more of the public sector’s responsibilities, the government partner will need to invest more in the M&E system to ensure that quality outcomes are achieved, the poor are not taken advantage of, and targets are honestly achieved.

# Annex 3

## Notes on Conducting a Market Study<sup>1</sup>

The internet is a good source of further readings on market study and research. Below are bite-sized chunks of information sourced by the authors to help readers begin their journey in market study and establishment of the public–private partnership (PPP) in hospital management.

### How to Conduct Market Research

It is important to establish clear goals for the market research activity that an organization hopes to undertake. The organization must define what it needs to know and why. Once it has already established its goals, it is important to develop a strategy and select techniques that it will use to gather data. The two broad types of research that an organization can use are primary and secondary research. They are explained below.

#### Primary research

Primary research is original information gathered through a user's (e.g., local government's) own efforts (or its authorized research company) to respond to a specific question or set of questions. This information is normally gathered through surveys, observation, or experimentation.

The following are examples of questions that can be addressed through primary research:

- (i) Who are the PPP's expected customers and how can the proposed enterprise reach them?
  - Customer profiles
  - Prospective business locations
  - Marketing strategies
- (ii) Which products and services do these buyers need or want?
- (iii) What factors influence the buying decisions of these customers?
- (iv) Price, service, convenience, branding, etc.
- (v) What prices should the organization set for the products and services?
  - Customer expectations
- (vi) Who are the likely competitors, how do they operate, and what are their strengths and weaknesses?

Primary research can be time consuming and expensive, especially if not performed by the organization. The results also may not be available immediately. Nevertheless, this type of research allows the user to target desired groups (such as its target customers or the geographic market for the PPP enterprise) and tailor its research instrument to answer specific questions. Moreover, if done by the organization itself, it allows cost savings and deeper knowledge and appreciation of the intended market.

Surveys are the most common way to gather primary research. Surveys can be conducted:

- (i) **through direct mail.** Direct mail is handed out in the place of business or mailed out (with survey forms returned in person or via mail) and has high effectiveness, but follow-up reminders may be needed.
- (ii) **over the telephone.** This method can be more cost-effective, but may not be an easy way to reach participants compared with direct mail (some individuals do not favor telephone interruptions).
- (iii) **on the web or via e-mail.** This method allows participants to complete the survey on their own time with little effort, and is cost-effective
- (iv) **in person.** In-person surveys can be conducted through personal interviews or focused group discussions. They can be flexible because the interviewers can ask follow-up questions or change the focus of the survey immediately, but they may be tedious or time consuming to invite participants.

<sup>1</sup> Significant portions of this section were sourced from articles by J.C. Levinson, E.J. McCarthy, C. McNamara, and W.D. Perreault.

When designing a research questionnaire, the organization should follow these tips:

- (i) Keep it short and simple.
- (ii) Ensure it is visually appealing and easy to read.
- (iii) Organize the questions so they move from general questions to more specific questions.
- (iv) Ensure questions are brief and easily understood.
- (v) Avoid leading questions, questions with ambiguous words, and questions that are too difficult to answer.
- (vi) Ensure that the response scales to be used are logical with categories that are mutually exclusive.
- (vii) Pre-test the questionnaire to identify potential problems.

The internet is a good resource for sample questionnaire questions that can be customized to suit the organization's particular research needs. There are also firms that can create and conduct surveys online.

Some organizations are reluctant to ask their customers to complete a questionnaire because of inconvenience. This can be addressed by offering respondents token incentives such as hospital vouchers for specific services or small gifts.

Credible information on prospective buyers can often be obtained without engaging them directly. Interviewing the organization's employees can provide excellent insights, as they are in constant contact with the prospective buyers and can provide information such as

- (i) customer profiles,
- (ii) goods and services that customers demand,
- (iii) satisfaction with price levels and quality of service, and
- (iv) experiences with competitors in the locality.

### **Sources of help with market research**

A local business school or small business development center can help an organization with conducting its own market research. University or college students may be a good source of labor for telephone or other types of interviews.

## **Secondary research**

Secondary research utilizes existing resources like company records, surveys, research studies, and books, and applies the information gathered to answer the questions formulated by the research team or the organization. It is normally less time consuming and less expensive than primary research.

While secondary research is less targeted than primary research, it can yield valuable information and answer some questions that are not practical to address through primary research (such as assessing microeconomic conditions) or questions that may make customers uncomfortable if asked directly (such as those about age and income levels).

The following are examples of questions that can be addressed through secondary research:

- (i) What are the current economic and/or socioeconomic conditions that the proposed PPP enterprise is operating in? Are these conditions changing? (international backdrop, e.g., MDG goals and/or commitments, national public health goals, provincial and local economic and/or socioeconomic conditions)
- (ii) What trends are influencing the industry that the PPP in hospital management will operate in? (consumer preferences, technological shifts, and prices for goods and services)
- (iii) Are there other markets for the products or services that could help the organization grow its business?
- (iv) What are the demographic characteristics of the target customers or where do they live? (populations, age groups, income levels, etc.)
- (v) What is the state of the labor market in the province and/or district and/or area? (e.g., How many people have the skills that the PPP in hospital management requires? How much should the organization expect to pay for public employees who opt for early retirement to join the private sector partner?)
- (vi) What is the projected supply of equipment, services, and supplies that are needed for the proposed PPP enterprise?

This question should be a little easier to answer than the demand questions. The projected supply is the amount an organization can obtain of the goods or the amount of the service(s) it can provide, within a given time period. Limitations on this will include the suppliers' manufacturing capacity, suppliers' ability to provide equipment, and the personnel (e.g., what scope of services can the staff realistically provide in 1 month?).

Existing records of private operators (and even those of publicly operated hospitals) such as sales invoices, receipts, and formal complaints are important secondary resources that organizations can use. Most often, these records shed light on the same issues that an organization seeks to address through primary research. Therefore, an examination of those records should first be done before considering a customer survey or other form of primary research. Some specific examples of using existing data include

- (i) examining sales receipts to find trends in the demand for particular services (e.g., handling of cardiovascular diseases, caesarean deliveries, etc.);
- (ii) cross-referencing sales receipts with customer addresses or products and services to determine the effectiveness of advertising; and
- (iii) compiling complaints to determine areas for improvement in customer service, pricing, or products, and services offered.

Another key secondary resource is statistical data from official statistics providers and other organizations. These statistics, in turn, can feed into analytical papers and market profiles that can help to put the numbers in context.

Identifying statistics and analysis that can help an organization with its business decisions can be difficult, and some datasets are expensive to purchase. There are, however, a number of quality statistics and analytical resources available to any organization and/or local government, as well as guidance to help it make sense of all the materials available.



# Annex 4

## Notes on the Development of a Feasibility Study<sup>1</sup>

### What Is a Feasibility Study?

A feasibility study is designed to provide an overview of the primary issues related to a business idea. The purpose is to identify any “make or break” issues that would prevent your business from being successful in the marketplace. In other words, a feasibility study determines whether a business idea, such as a public–private partnership (PPP) in hospital management, makes sense.

A thorough feasibility analysis provides a lot of information necessary for the business plan. For example, a good market analysis is necessary in order to determine the project’s feasibility. This information provides the basis for the market section of the business plan.

Because putting together a business plan is a significant investment of time and money, you want to make sure that there are no major roadblocks facing your business idea before you make that investment. *Identifying such roadblocks is the purpose of a feasibility study.*

A feasibility study looks at three major areas:

1. Market issues
2. Organizational and technical issues
3. Financial issues

### Typical Sections of a Feasibility Study

The list below shows the typical sections of a feasibility study. This list will help an organization that hopes to conduct a feasibility study for a PPP enterprise.

1. Introduction, Profiles, and Scope of Study
2. Market Aspects
  - 2.1 General market description
  - 2.2 Site analysis

- 2.3 Potential public–private partnership models and/or schemes
- 2.4 Marketing and social marketing plans

3. Technical Considerations

- 3.1 Architectural and structural considerations (i.e., whether the PPP in hospital management will involve construction and/or renovation)

- 3.2 Information technology and equipment

- 3.3 Health aspects

- 3.4 Other considerations

4. Organizational Development

- 4.1 Organizational capacity analysis

- 4.2 Operational scenarios (e.g., PPP operations and management)

5. Distribution and Processing Analysis

- 5.1 Map of distribution locations

- 5.2 Supply outlook

6. Financial Considerations

- 6.1 Scenario building

- 6.2 Project cost

- 6.3 Source of funds

- 6.4 Basic assumptions

- 6.5 Viability criteria

- 6.6 Financial analysis

7. Overall Feasibility Evaluation

- 7.1 Summary and conclusions

- 7.2 Recommendations

### Environmental and Social Considerations

The feasibility study stage is the perfect time to look at the environmental and social considerations in a planned PPP project, particularly if there is a need to construct a new hospital building or complex or significantly renovate an existing facility. There may also be social and cultural considerations

<sup>1</sup> This section benefited mostly from the articles of D.E. Gumpert, H.J. McLaughlin, W.R. Osgood, and J.L. Pope. The definition of a feasibility study was lifted from University of Wisconsin Center for Cooperatives, [www.uwcc.wisc.edu/manual/chap\\_5.html](http://www.uwcc.wisc.edu/manual/chap_5.html)



depending on the location of a proposed PPP project. For example, some hospitals in Oriental Mindoro, Philippines, have built special *Mangyan* wards, in consideration of the *Mangyan* people who inhabit the province and are among the major indigenous groups in the Philippines.

Below are some of the Philippine environmental regulations that may cover PPP in health projects. Other countries will have their own environmental policies.

- (i) Philippine Constitution (Sec. 16 Art. II)
- (ii) Philippine Environmental Impact Statement System (PEISS)
  - Presidential Decree (PD) 1151 (1977), PD 1586 (1978), Presidential Proclamation 2146 (1981)
  - DENR Administrative Order (DAO) 21 (1992), DAO 96-37 (1996)
  - DAO 03-30 (2003) further strengthens PEISS
  - Department of Environment and Natural Resources Memorandum Circular (DENR MC) 14 (2010)
  - DENRMC 05 (2011) incorporates disaster risk reduction and climate change
  - Scoping as a requirement
  - Major categories of projects:
    - ECPs—environmentally critical projects
    - ECAs—within environmentally critical areas (ECPs and ECAs require Environmental Compliance Certificate)
  - Important considerations under the (environmental impact statement) EIS System
    - EIS—required for ECPs (120 days)
    - IEE—initial environmental examination for ECAs (caveat: an environmental impact statement may be required later on) (75 days)
    - Accreditation of preparers
    - Accountability of proponents and preparers
    - Public participation and social acceptability

- Environmental Monitoring and Guarantee Fund
- EMF—Environmental Management Fund
- EGF—Environmental Guarantee Fund (for rehabilitation and compensation for damages)
- Review costs
- Filing fee: P310.00
- Processing fee: P1,750.00
- Legal and research fee: P70.00
- Other costs to be determined
- CNC—Certificate of Non-Coverage, if the project is deemed as falling outside the Environmental Impact Statement System
- (iii) Policies governing health care waste management
  - Joint DENR–Department of Health (DOH) AO 02 (2005) Policies and guidelines on management, treatment, and disposal of health care wastes
  - Republic Act (RA) 4226 Hospital Licensure Act
  - DOH AO 70-A Revised Rules and Regulations for RA 4226
  - PD 856 (Code on Sanitation of the Philippines)
  - DOH Dept. Circular 156-C (1993)
  - DOH Memo No. 1-A (2001)
  - RA 6969 An Act to Control Toxic Substances and Hazardous and Nuclear Wastes (1990)
  - RA 9003 Ecological Solid Waste Management Act (2000)
  - RA 8749 Clean Air Act (1990)
  - Guideline on the incineration of hospital wastes (Supreme Court Ruling on DENR MC 05 (2002) Clarificatory Statement)
  - RA 8275 Clean Water Act (2004)
  - PD 984 Pollution Control Law
  - DAO 35 Revised Effluent Standards
  - PD 813, Executive Order 927, Laguna Lake Development Authority Board Resolution 408 (2011)—clearance process for projects within Laguna Lake

## Market Research and Feasibility Study

Market study has been discussed in Step 1 and in Annex 3. In a nutshell, market research is often recommended as the first step in a feasibility study. One must not think of market research as highly sophisticated, expensive, and complicated. It can be very much a “do-it-yourself” thing.

Market analysis results in information about the market potential, which provides the basis for accurate sales forecasts and your marketing strategy. Its basic components include the following:

- (i) an estimate of the size of the market for the product/service,
- (ii) projected market share,
- (iii) information about your target market, and
- (iv) analysis of the competition.

Market research involves activities designed to obtain data about the market, and falls into two main categories: *Primary research*, which involves collecting new data through market surveys and other field research (specific studies that are conducted on behalf of a company), and *secondary research*, which includes gathering pre-existing information from published sources.

In addition to conducting research, it is valid to rely somewhat on an organization’s own opinions and observations, especially if it is involved in its local community. No one knows a community like the people who have spent their lives there. However, it is important to back up the organization’s opinions with data and research. Gut feelings are not enough to take to the bank. Resist the temptation to look only for data that confirm your opinions.

All this information goes into estimating the sales that will be achieved during the first few years of operation. The rest of the feasibility study and business plan is built upon these estimates. Because it is one of the principal tools for determining whether

the business will work, an investment in market research is worthwhile. The quality of information in the market analysis depends on the amount of energy that went into obtaining it.

An organization needs to be as specific as possible about the dimensions (size, trends) of the opportunity that the enterprise faces. Since a new business does not have a track record, the research must be thorough to enable the organization to make realistic sales estimates.

In the market analysis section of the feasibility study, an organization must determine whether adequate demand exists for its proposed products or services.

### From feasibility to planning

Feasibility studies require a lot of hard work, and the market analysis research is the most difficult part of the process. If the study indicates that the PPP business idea is feasible, the next step is the development of a plan or a business plan. The business plan continues the analysis that the organization has begun at a deeper and more complex level, building on the foundation created by the feasibility study.

The following are some of the important reasons why a feasibility study is done:<sup>2</sup>

- (i) gives focus to the project,
- (ii) narrows alternatives,
- (iii) surfaces new opportunities,
- (iv) enhances the probability of success by addressing factors early that could affect the project,
- (v) provides quality information for decision making,
- (vi) helps in securing funding, and
- (vii) helps to increase investment in idea.

### Financial issues<sup>3</sup>

Once the marketing, organizational, and technical analyses have been completed, the third and final step of a feasibility analysis is to look at financial issues.

<sup>2</sup> Adopted from a presentation of A. Davis, Market Analysis and Feasibility Studies, University of Kentucky.

<sup>3</sup> University of Wisconsin Center for Cooperatives.

The list of considerations below should help identify key issues that will require additional research.

Note that some of the areas below—specifically revenue projections—are directly based on the market analysis (the first step in the feasibility study), in which a proponent estimates the amount of product or services that they can sell. If that part

of the feasibility study is not done thoroughly, the financial analysis will be inadequate.

A strong financial analysis is one of the backbones of a good feasibility study. A good feasibility study will give the organization a clear idea whether the proposed PPP in hospital management is a sound business idea.

**Table A4: Key Areas in Financial Analysis**

<b>Start-Up Costs</b>	These are the costs that will be incurred in starting up a new business, including capital goods such as land, buildings, equipment, etc. The business may have to borrow money from a lending institution to cover these costs.
<b>Operating Costs</b>	These are the ongoing costs, such as rent, utilities, and wages, that are incurred in the everyday operation of a business. The total should include interest and principal payments on any debt for start-up costs.
<b>Revenue Projections</b>	These can be based on how a proponent will price his goods or services. He may assess what the estimated monthly revenue will be.
<b>Sources of Financing</b>	If the proposed business will need to borrow money from a bank or other lending institution, the proponent may need to research potential lending sources.
<b>Profitability Analysis</b>	The “bottom line” for the proposed business. Given the costs and revenue analyses, the proponent may ask the following questions: <ul style="list-style-type: none"> <li>(i) Will the public–private partnership business bring in enough revenue to cover operating expenses?</li> <li>(ii) Will it break even, lose money, or make a profit?</li> <li>(iii) Is there anything we can do to improve the bottom line?</li> </ul>

Source: University of Wisconsin Center for Cooperatives. 1998. *Cooperatives: A Tool for Community Economic Development*. Madison. [www.uwcc.wisc.edu/manual/chap\\_5.html](http://www.uwcc.wisc.edu/manual/chap_5.html)

# Annex 5

## Developing a Business Plan: List of Tasks

Developing and implementing a public–private partnership (PPP) project requires the preparation of a business plan. This entails the following:

### 1. Data gathering

#### 1.1 Catchment area characteristics

- a. Bed-to-population ratio (relative to government target of 1:500)
- b. Relative income profile
- c. Health conditions (how do health indicators compare with targets, such as Millennium Development Goals)
- d. Utilization rates of hospitals that cater to the catchment
- e. Disease profile (e.g., of hospitals in representative markets)
- f. Unmet needs of the catchment area

#### 1.2 Case rates (published by the country's social health insurance provider)

#### 1.3 Project cost<sup>1</sup>

- a. Building construction (requires a decision on capacity based on the gap between current and projected bed-to-population ratio)
- b. Land development costs
- c. Building services and equipment
- d. Medical equipment (requires a decision on service level of the hospital based on disease profile and other unmet needs that the hospital intends to address)
- e. Capital costs<sup>2</sup>

### 1.4 Project funding

- a. Own funds
- b. Grants available from national government (subject to negotiations between the local government and national government agencies such as the department of health)
- c. Loans
- d. Other sources

### 2. Development of assumptions about the future performance of the hospital under a likely scenario (i.e., base case)

#### 2.1 Income statement assumptions

- a. Bed occupancy rate (BOR), disease profile, and average length of stay (ALOS) (developed from catchment area data analysis)
- b. Inpatient volume = (number of beds x 365 x BOR/ALOS)
- c. Outpatient volume = (inpatient volume x outpatient)/inpatient ratio<sup>3</sup>
- d. Revenue per inpatient (derived by applying case rates and historical payments of PhilHealth [Philippine Health Insurance Corporation] to the disease profile, weighted by the disease distribution)
- e. Revenue per outpatient (derived by assuming a percentage of inpatient revenue)<sup>4</sup>
- f. Personnel costs and other operating costs<sup>5</sup>
- g. Depreciation<sup>6</sup>

<sup>1</sup> Estimates on costs of construction, land development, building equipment, and services can be based on country estimates (e.g., data from the health department). For these assumptions, data came from *Budgetary Requirements for Construction of Hospitals and Other Health Facilities*, as of June 2010, National Center for Health Facility Development.

<sup>2</sup> A local government may use 20% of total personnel costs and other operating costs (based on *Costing Study for Selected Hospitals in the Philippines*, which analyzed the operating performance of selected Level 3 public hospitals). This may be subjectively adjusted downward for sub-Level 3 hospitals.

<sup>3</sup> The local government may use 3.2, the average outpatient/inpatient ratio of Batangas Regional Hospital, Gov. Roque Ablan Sr. Memorial Hospital, Mariano Marcos Memorial Hospital and Medical Center, Oriental Mindoro Provincial Hospital, Ifugao General Hospital, and Veterans Regional Hospital (all from the Philippines).

<sup>4</sup> Local government may use approximately P2,000.00/outpatient as a subjective estimate (based on Philippine currency and market conditions).

<sup>5</sup> Local government may access Department of Health (DOH) estimates (e.g., *FOURmula One for Health Operations Manual for Convergence Provinces* provides DOH estimates of these costs).

<sup>6</sup> An examination of selected private hospital companies indicates these to range from 10 years (for equipment) to 30 years (for buildings).

- h. Management fees (to be paid to PPP partner)<sup>7</sup>
  - i. Taxes (30% statutory income tax rate)
- 2.2 Balance sheet assumptions
- a. Cash<sup>8</sup>
  - b. Accounts receivable<sup>9</sup>
  - c. Inventory, other assets, and accounts payable<sup>10</sup>
3. Preparation of the base case forecasted income statements, balance sheets, and cash flow statements based on the assumptions developed above
  4. Calculation of the project's internal rate of return (using the year-to-year changes in net equity)<sup>11</sup>
  5. Comparison of the IRR with the minimum return (or cost of equity) required by private investors<sup>12</sup> (to determine if PPP options, other than management contracts, can be considered)
  6. Sensitivity analysis to determine how the project performs under less or more favorable scenarios than envisioned in the base case
  7. Calculation of expected project IRR (by judgmentally applying probabilities to each scenario)

<sup>7</sup> A reasonable estimate to use is 5%.

<sup>8</sup> An acceptable convention is 2%–5% of total revenues.

<sup>9</sup> This can be based on a weighted average of the collection periods assumed for private- and public-paying patients. Local government may use cash or 30 days for private-pay patients, and 90 days for public-pay patients (the latter being subject to the length of the reimbursement period of say, PhilHealth).

<sup>10</sup> Based on financial statements analyzed by the technical assistance team, private hospitals maintain inventories, other assets, and accounts payable equivalent to about 5%, 1%, and 16% of revenues, respectively.

<sup>11</sup> This method assumes that the project is 100% funded by equity.

<sup>12</sup> Anecdotally observed by the technical assistance team to be 15%–25%, based on comments from private companies in roundtable discussions and other meetings. The capital asset pricing model provides an alternative for estimating the cost of equity; for example, using a risk-free rate of 4.86% (the yield on the benchmark 10-year Philippine peso bond on 17 August 2012), a conventional market risk premium of 6%, and an observed beta of 0.60 for Asian companies engaged in hospital operations yields a cost of equity of 8.5%.

# Annex 6

## Directory of Health, Development, and Public–Private Partnership–Focused Organizations

### **Access Health International**

Address: Head office – 3053 P Street, NW  
Washington, DC 20007, United States  
E-mail: [info@accessh.org](mailto:info@accessh.org)  
Website: [www.accessh.org/Home](http://www.accessh.org/Home)

### **American Public Health Association**

Address: 800 I Street, NW  
Washington, DC 20001-3710, United States  
Tel: +1 202 777 APHA  
Fax: +1 202 777 2534  
Website: [www.apha.org](http://www.apha.org)

### **Asian Development Bank (ADB)**

Address: ADB Headquarters  
6 ADB Avenue, Mandaluyong City 1550, Philippines  
Tel: +63 2 632 4444  
Fax: +63 2 636 2444  
Website: [www.adb.org](http://www.adb.org)

### **Asian Institute of Management (AIM)**

Address: Eugenio Lopez Foundation Building  
Joseph R. McMicking Campus  
123 Paseo de Roxas  
Makati City 1260, Philippines  
Tel: +63 2 892 4011 to 23  
Fax: +63 2 867 2114  
Website: [www.aim.edu](http://www.aim.edu)

### **Association of Asian Pacific Community Health Organizations (AAPCHO)**

Address: *Oakland Office*  
300 Frank H. Ogawa Plaza Suite 620  
Oakland, CA 94612, United States  
Tel: +1 510 272 9536  
Fax: +1 510 272 0817

#### *Washington, DC Office*

1400 Eye Street, NW, Suite 910  
Washington, DC 20005, United States  
Tel: +1 202 331 4607  
Fax: +1 202 296 3526  
Website: [www.aapcho.org](http://www.aapcho.org)

### **Australian Trade Commission**

Address: Head office, Level 23 Aon Tower  
201 Kent Street  
Sydney NSW 2000, Australia  
Tel: +61 2 132878  
E-mail: [info@austrade.gov.au](mailto:info@austrade.gov.au)  
Website: [www.austrade.gov.au](http://www.austrade.gov.au)

### **Board of Investments (BOI)**

Address: Industry and Investments Building  
385 Senator Gil Puyat Avenue  
Makati City 1200, Philippines  
Tel: +63 2 891 2116  
Fax: +63 2 895 8322  
Website: [www.boi.gov.ph](http://www.boi.gov.ph)

### **CFP Strategic Transaction Advisors**

Address: 14th Floor, Net Cube Center  
3rd Avenue, Bonifacio Global City  
Taguig 1634, Philippines  
Tel: +63 2 479 5436  
Fax: +63 2 478 5401  
E-mail: [inquiry@cfpstrategic.com](mailto:inquiry@cfpstrategic.com)  
Website: [www.cfpstrategic.com](http://www.cfpstrategic.com)

### **Commission on Audit (COA)**

Address: Commonwealth Avenue  
Quezon City 880, Philippines  
Tel: +63 2 931 7592 / +63 2 951 1341  
Website: [www.coa.gov.ph](http://www.coa.gov.ph)

### **Daewoo International Corporation**

Address: 84-11(Yonse Severance Building)  
Namdæmunno 5(o)-ga, Jung-gu  
Seoul 100-753, Republic of Korea  
Tel: +82 2 759 2114  
Fax: +82 2 753 9489  
Website: [www.daewoo.com/english/index.jsp](http://www.daewoo.com/english/index.jsp)

**Deloitte**

Address: *Global office*  
 30 Rockefeller Plaza  
 New York 10112-0015, United States  
 Tel: +1 212 492 4000  
 Fax: +1 212 489 1687  
 Website: [www.deloitte.com](http://www.deloitte.com)

**Department of Health (DoH), Philippines**

Address: San Lazaro Compound, Tayuman  
 Sta. Cruz, Manila, Philippines 1103  
 Tel: +63 2 743 8301 to 23  
 Fax: +63 2 711 6744  
 Website: [www.doh.gov.ph](http://www.doh.gov.ph)

**Department of the Interior and Local Government (DILG), Philippines**

Address: A. Francisco Gold Condominium II  
 EDSA corner Mapagmahal Street  
 Diliman, Quezon City 1100, Philippines  
 Tel: +63 2 925 0330 / +63 2 925 0331  
 Fax: +63 2 925 0332  
 Website: [www.dilg.gov.ph](http://www.dilg.gov.ph)

**Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)**

Address: Friedrich-Ebert-Allee 40  
 53113 Bonn, Germany  
 Tel: +49 228 44600  
 Fax: +49 228 4460 1766  
 Website: [www.giz.de/en](http://www.giz.de/en)

**Development Bank of the Philippines (DBP)**

Address: Sen. Gil J. Puyat Avenue corner  
 Makati Avenue  
 Makati City, Philippines  
 Mailing Address: P.O. Box 1996, Makati Central  
 Post Office 1200 Makati City, Philippines  
 Tel: +63 2 818 9511 to 20 / +63 2 818 9611 to 20  
 E-mail: [info@devbankphil.com.ph](mailto:info@devbankphil.com.ph)  
 Website: [www.dbp.ph](http://www.dbp.ph)

**DLA Piper Australia**

Address: Level 38, 201 Elizabeth Street  
 Sydney NSW 2000, Australia  
 Tel: +61 2 9286 8000  
 Fax: +61 2 9283 4144  
 Website: [www.dlapiper.com/home.aspx](http://www.dlapiper.com/home.aspx)

**Ernst & Young**

Address: 9/F, SGV Building II, 6760 Ayala Avenue  
 Makati City 1226, Philippines  
 Website: [www.ey.com](http://www.ey.com)

**European Network of Safety and Health Professional Organizations**

Address: The Grange, Highfield Drive  
 Wigston, Leicestershire LE18 1NN  
 United Kingdom  
 Tel: +44 (0) 116 257 3100  
 Fax: +44 (0) 116 257 3101  
 E-mail: [secretariat@enshpo.org](mailto:secretariat@enshpo.org)  
 Website: [www.enshpo.eu](http://www.enshpo.eu)

**European Union (EU)**

c/o Council of the European Union  
 Rue de la Loi / Wetstraat, 175  
 B-1048 Brussel, Belgium  
 Tel: +32 2 281 6111  
 Fax: +32 2 281 7397  
 Website: [www.europa.eu](http://www.europa.eu)

**Fortman Cline Capital Markets**

Address: 7/F Liberty Center Building  
 104 H.V. dela Costa Street  
 Makati City 1227, Philippines  
 Tel: +63 2 491 7366  
 Fax: +63 2 844 2232  
 Website: [www.fccm.asia](http://www.fccm.asia)

**GE Healthcare**

Address: Asia Pacific Headquarters GE Healthcare  
 298 Tiong Bahru Road #12-01, Central Plaza  
 Singapore 168730  
 Tel: +65 62918528  
 Fax: +65 62777688  
 Website: [www3.gehealthcare.com/en](http://www3.gehealthcare.com/en)

**Handicap International**

Address: 27 Broadwall, London SE1 9PL  
 United Kingdom  
 Tel: +44 (0) 870 774 3737  
 Fax: +44 (0) 870 774 3738  
 E-mail: [info@hi-uk.org](mailto:info@hi-uk.org)  
 Website: [www.handicap-international.org.uk](http://www.handicap-international.org.uk)

**Health Canada**

Address: Health Canada, 0900C2, Ottawa  
Ontario K1A 0K9, Canada  
Tel: +1 613 957 2991  
Fax: +1 613 941 5366  
Toll free: 1-866-225-0709  
E-mail: [info@hc-sc.gc.ca](mailto:info@hc-sc.gc.ca)  
Website: [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)

**Healthscope Medical Solutions Corporation**

Address: 804 West Tower, Philippine Stock  
Exchange Centre  
Exchange Road, Ortigas Center  
Pasig City 1605, Philippines  
Tel/Fax: +63 2 621 9529  
Website: [www.healthscopemed.com/home/](http://www.healthscopemed.com/home/)

**Health Solutions Enterprises Inc.**

Address: G/F Tao Corporate Center  
2291 Don Chino Roces Avenue  
Makati City, Philippines  
Tel: +63 2 836 5858 to 62  
Fax: +63 2 836 5863  
Website: [www.taocommunity.com/company/healthsolutions](http://www.taocommunity.com/company/healthsolutions)

**ICANSERVE Foundation Inc.**

Address: Unit 2302, Medical Plaza Ortigas Building  
San Miguel Avenue, Ortigas Center  
Pasig City 1605, Philippines  
Tel: +63 2 636 5578  
E-mail: [info@icanservefoundation.org](mailto:info@icanservefoundation.org)  
Website: [www.icanservefoundation.org](http://www.icanservefoundation.org)

**International Federation of Health and Human Rights Organizations (IFHHRO)**

Address: PO Box 1693, 1000 BR Amsterdam,  
The Netherlands  
E-mail: [ifhhro@gmail.com](mailto:ifhhro@gmail.com)  
Website: [www.ifhhro.org](http://www.ifhhro.org)

**International Finance Corporation (IFC)**

Address: Headquarters  
2121 Pennsylvania Avenue, NW  
Washington, DC 20433, United States  
Tel: +1 202 473 3800  
Fax: +1 202 974 4384  
Website: [www.ifc.org](http://www.ifc.org)

**International Health Terminology Standards Development Organisation (IHTSDO)**

Address: Rued Langgaardsvej 7, 5te, 5A56,  
2300 Copenhagen S, Denmark  
Tel: +45 36 44 87 36  
Fax: +45 44 44 87 36  
E-mail: [info@ihtsdo.org](mailto:info@ihtsdo.org)  
Website: [www.ihtsdo.org](http://www.ihtsdo.org)

**Japan International Cooperation Agency (JICA)**

Address: Nibancho Center Building 5-25  
Niban-cho, Chiyoda-ku  
Tokyo 102-8012, Japan  
Tel: +81 3 5226 6660 to 63  
Website: [www.jica.go.jp/english/index.html](http://www.jica.go.jp/english/index.html)

**KfW Development Bank**

Address: KfW Bankengruppe,  
Palmengartenstraße 5-9  
60325 Frankfurt am Main, Germany  
Tel: +49 69 74 31-0  
Fax: +49 69 74 31-29 44  
E-mail: [info@kfw.de](mailto:info@kfw.de)  
Website: [www.kfw.de/kfw.de-2.html](http://www.kfw.de/kfw.de-2.html)

**Ministry of Health, Cambodia**

Address: No. 151–153 Kampuchea Krom Boulevard  
Phnom Penh, Cambodia  
Tel: +855 23 722873 / 880261 / 881405 / 881409  
Fax: +855 23 426841 / 722873 / 880261 / 366186  
Website: [www.moh.gov.kh](http://www.moh.gov.kh)

**Ministry of Health, Myanmar**

Office Building 4 Zabuthiri Township 10528  
Yangon, Republic of the Union of Myanmar  
Website: [www.moh.gov.mm](http://www.moh.gov.mm)

**Ministry of Health, Indonesia**

Address: Jl H.R. Rasuna Said, Blok X.5 Kav. 4-9  
Jakarta, Indonesia  
Tel: +62 21 520 1590  
Fax: +62 21 520 3874  
E-mail: [adminkes@depkes.go.id](mailto:adminkes@depkes.go.id)  
Website: [www.depkes.go.id/en/index.php](http://www.depkes.go.id/en/index.php)



**Ministry of Health, Viet Nam**

Address: 138A Giang Vo, Ba Dinh  
Ha Noi, Viet Nam  
Tel: +84 4 6273 2273  
Fax: +84 4 3846 4051  
E-mail: byt@moh.gov.vn  
Website: www.moh.gov.vn

**Ministry of Public Health, Thailand**

Address: Tivanond Road, Nonthaburi 11000  
Thailand  
Tel: +66 2 590 1000  
Website: www.eng.moph.go.th

**National Alliance for Hispanic Health**

Mailing Address: 1501 16th Street NW  
Washington, DC 20036-1401, United States  
Tel: +1 202 387 5000  
Fax: +1 202 797 4353  
Website: www.hispanichealth.org

**National Economic and Development Authority (NEDA)**

Address: 12 Saint Josemaria Escriva Drive  
Ortigas Center, Pasig City  
Philippines  
Tel: +63 2 631 0945 to 56  
Website: www.neda.gov.ph

**National Kidney and Transplant Institute (NKTi)**

Address: East Avenue, Diliman  
Quezon City 1101, Philippines  
Tel: +63 2 981 0300 / +63 2 981 0400  
Fax: +63 2 922 5608 / +63 2 928 0355 (PRO)  
E-mail: pro@nkti.gov.ph  
Website: www.nkti.gov.ph

**Pan American Health Organization (PAHO)**

Address: Regional Office of the World Health  
Organization  
525 23rd Street, NW  
Washington, DC 20037, United States  
Tel: +1 202 974 3000  
Fax: +1 202 974 3663  
Website: www.paho.org/usa/

**Philippine Health Insurance Corporation (PhilHealth)**

Address: Citystate Centre, 709 Shaw Boulevard  
1603 Pasig City, Philippines  
Tel: +63 2 441 7444 / +63 2 441 7441  
Website: www.philhealth.gov.ph

**Philippine Hospital Project Development Corporation**

Address: Head Office  
2205 Phil AXA Life Tower  
Sen. Gil Puyat Avenue, corner Tindalo Street  
Makati City, Philippines  
Tel: +63 2 843 1022 / +63 2 887 0117  
Fax: +63 2 843 1021  
E-mail: info@vamedphd.com  
Website: www.vamedphd.com

**Philips Healthcare**

Address: 620A Lorong 1  
Toa Payoh  
Singapore 319762  
Tel: 1800-PHILIPS  
Fax: +65 6255 4853  
Website: www.healthcare.philips.com/ph\_en

**PRISM International (Professional Records and Information Services Management)**

Address: 4700 West Lake Avenue  
Glenview, IL 60025, United States  
Tel: +1 847 375 6344  
Fax: +1 847 375 6343  
E-mail: info@prismintl.org  
Website: www.prismintl.org

**Public-Private Partnership Center**

Address: NEDA sa QC, EDSA, Diliman  
1103 Quezon City, Philippines  
Tel: +63 2 990 0721 / +63 2 929 8593 to 94  
Website: www.ppp.gov.ph

**The American Chamber of Commerce of the Philippines**

Address: 2/F Corinthian Plaza  
Paseo de Roxas, CPO Box 2562  
Makati City 1229, Philippines  
Tel: +63 2 818 7922 to 13  
Fax: +63 2 811 3081  
E-mail: amcham@amchamphilippines.com  
Website: www.amchamphilippines.com/index.php

**The Forum for Family Planning & Development, Inc.**

Address: Room 305, Ang Bahay ng Alumni  
Ramon Magsaysay Avenue, UP Campus  
Diliman, Quezon City, Philippines  
Tel: +63 2 426 5484  
Fax: +63 2 436 3269  
E-mail: [forum4fp@forum4fp.org](mailto:forum4fp@forum4fp.org)  
Website: [www.forum4fp.org/index.html](http://www.forum4fp.org/index.html)

**The World Bank**

Address: 1818 H Street, NW  
Washington, DC 20433, United States  
Tel: +1 202 473 1000  
Fax: +1 202 477 6391  
Website: [www.worldbank.org](http://www.worldbank.org)

**UK Trade & Investment**

Address: Headquarters  
1 Victoria Street  
London SW1H 0ET  
United Kingdom  
Tel: +44 (0)20 7215 5000 / +44 (0)207 333 5442 /  
+44 (0)845 539 0419  
Website: [www.ukti.gov.uk/home.html?guid=none](http://www.ukti.gov.uk/home.html?guid=none)

**United Nations Economic Commission for Europe (UNECE)**

Address: Palais des Nations  
CH-1211 Geneva 10, Switzerland  
Tel: +41 (0) 22 917 4444  
Fax: +41 (0) 22 917 0505  
E-mail: [info.ece@unece.org](mailto:info.ece@unece.org)  
Website: [www.unece.org](http://www.unece.org)

**United States Agency for International Development (USAID)**

Address: Office of Press Relations Ronald Reagan  
Building  
Washington, DC 20523-0016, United States  
Tel: +1 202 712 4320  
Fax: +1 202 216 3524  
Website: [www.usaid.gov](http://www.usaid.gov)

**World Health Organization (WHO)**

Address: Avenue Appia 20  
1211 Geneva 27, Switzerland  
Tel: +41 22 791 2111  
Fax: +41 22 791 3111  
Website: [www.who.int/en](http://www.who.int/en)



# Annex 7

## Sample Implementation Plan Outline

**Name of Project: Public-Private Partnership in Hospital Management**

Name of Hospital/Medical Center and Location: \_\_\_\_\_

Date: \_\_\_\_\_

**1. Goals and Strategies**

**Statement of the Problem**

In [state date covered], we identified that [state problems here in hospitals and/or hospital services and other related concerns]

When we analyzed these data, they clearly demonstrated that [state findings and analysis of data].

**Project Goal**

To address the above problems, we intend to [state project goals] by [state key project strategy]. We hope to achieve this within [state length of implementation of date range]. We plan on implementing this beginning [state date of project commencement].

**Description of Strategy**

We will [state key strategies and describe them].

[You may also indicate important support strategies such as the need for permitting, policies, etc. and offer certain caveats and assumptions.]

**2. Approach**

The first area to be considered is most likely the selection of project team members. In the matrix below are columns for the names, suggested departments, and likely roles. (Note that the organization has the prerogative to decide which departments and what roles are necessary. The entries below are just examples.)

PPP Project Team Members		
Name	Department	Role in the Team
	Planning and Development	Project Manager
	Provincial/Local Health Office	Assistant Project Manager
	Bids and Awards Committee	Advisor – Procurement
	Hospital Administration – Clinical	Advisor – Clinical/Medical
	Hospital Administration – Administration and Finance	Advisor – Hospital Administration
	Nursing	Advisor – Nursing
	Pharmacy	Advisor – Pharmacy
	Laboratory and Diagnostics	Advisor – Laboratory and Diagnostics

	Finance/Accounting	Advisor – Finance and Administration
	Hospital Administration – Nutrition and Ancillary Services	Advisor – Nutrition and Other Auxiliary Services
	Planning and Development	Advisor – Monitoring and Evaluation
	Provincial/Local Information Office	Advisor – Communications/Social Marketing
	Information Technology	System Analyst/Management Information Systems (MIS) Specialist
	Local Government/Local Health Office	Secretary/Administrative Assistants and Other Support Staff

### 3. Threats and Obstacles to Implementation

In this section, you may enumerate the likely or possible threats and obstacles in the implementation of the PPP project. Please note that the entries in the worksheets below are just examples.

1. Additional staff needed (mention these staff members, if applicable)
2. "Buy-in" from staff
3. Approvals and/or permitting issues

In the next section, you may enumerate the expected implementation steps.

Implementation Steps		
Activity (e.g., data collection, staff training, development of bid document forms, bidding and procurement, awarding, etc.)	Persons Responsible	Deadline

You may then create a snapshot of the social marketing and communications strategy. Again, the data and entries below are just examples. Refer back to the section on **Step 4** for helpful tips and insights.

<b>Communications and Social Marketing Strategy</b>			
<b>Target Audience</b> (Who are the stakeholders for the PPP project)?	<b>Strategy</b>	<b>Timelines/ Deadlines</b>	<b>Persons/Departments Responsible</b>

#### 4. Project Schedule

For this section, you may develop a matrix that shows the estimated project schedule.

<b>Project Schedule</b>			
<b>Component</b>	<b>Activities</b>	<b>Timeline</b>	<b>Remarks</b>

#### 5. Project Budget

As in any project, implementers should determine resources needed (both human and capital) and their estimated costs.

<b>Resources Needed</b>	
<b>Items/Resources</b>	<b>Estimated Costs</b>

## 6. Performance Indicators

There should also be a system through which the PPP team can monitor and evaluate their progress. Here, you can develop a performance indicator matrix. You can monitor progress by indicating actual progress, rate/percentage of accomplishment, or simply saying “yes” (for finished tasks) or “no” (for unfinished tasks). You may add another column for longer tasks and activity updates.

Performance Indicators	
Tasks/Activities	Remarks/Rating or “Yes”/“No”

## 7. Supplementary Information

This is not a required section but may be useful, particularly if there are complex permitting procedures that the organization or local government unit (LGU) needs to go through. In the case of Philippine LGUs, the second table below shows levels of approval for LGU projects.

Permits Needed			
Permits Needed/Approval Issues	Person Assigned	Date Approval Requested	Date Approval Obtained

### Levels of Approval of Local Government Unit Project (for Philippine PPP Projects)

Levels	Description
<b>President</b>	<ul style="list-style-type: none"> <li>All build-operate-own projects and other schemes not defined in Section 2 of RA 7718, subject to the recommendation of the National Economic and Development Authority board’s Investment Coordination Committee</li> </ul>
<b>Investment Coordination Committee</b>	<ul style="list-style-type: none"> <li>Local projects costing above P200 million</li> <li>All unsolicited proposals regardless of project cost</li> </ul>

<b>Regional Development Council</b>	<ul style="list-style-type: none"><li>• Local projects costing above P50 million up to P200 million</li></ul>
<b>City Development Council</b>	<ul style="list-style-type: none"><li>• Local projects costing up to P50 million</li></ul>
<b>Provincial Development Council</b>	<ul style="list-style-type: none"><li>• Local projects costing above P20 million up to P50 million</li></ul>
<b>Municipal Development Council</b>	<ul style="list-style-type: none"><li>• Local projects costing up to P20 million</li></ul>

Source: Section 2.7 of RA 7718 of the Philippines.





# Annex 8

## Notes on Social Marketing



Source: Unknown. Lifted from MacFadyen et al. (1999) and Scott (2005), found at [www.sswm.info](http://www.sswm.info)

### Social Marketing<sup>1</sup>

Social marketing is the use of commercial marketing techniques to promote the adoption of behavior that will improve the health or well-being of the target audience or of society as a whole. Social marketing is not a stand-alone awareness raising tool; it is rather a framework or structure that combines classic promotional tools with knowledge from many other scientific fields such as economy, psychology, sociology, anthropology, and communications theory to understand how to influence people's behavior. Improving the current situation regarding sanitation and water in your area is very much connected with changing or adapting behaviors of the local community. By applying social marketing principles, you can positively influence current behaviors and therefore improve the well-being of the local community.

### What Is Social Marketing?<sup>2</sup>

Social marketing is similar to conventional marketing, but the end goal is not to sell a product to make profits, but to achieve a social benefit (e.g., improvement of health, conservation of resources) for society.

Social marketing is not easy to implement and involves changing intractable behaviors in complex economic, social, and political climates, often with very limited resources. When social marketing is successful, people will start to spread the message about a certain product, behavior, or technology themselves.

Though there exist numerous definitions of social marketing, this section is based on the following definition:

*Social marketing (for example, in the context of health) is the use of commercial marketing*

<sup>1</sup> Notes compiled by S. Keller and M. Kropac. Social Marketing (RR).

<sup>2</sup> Adapted from MacFadyen, L., M. Stead, and G. Hastings. 1999. *A Synopsis of Social Marketing*. Stirling, United Kingdom: Institute for Social Marketing. [www.sswm.info](http://www.sswm.info); and Scott, B. 2005. *Social Marketing: A Consumer-based Approach to Promoting Safe Hygiene Behaviours*. Leicestershire, United Kingdom: WELL. [www.sswm.info](http://www.sswm.info)

*techniques to promote the adoption of behavior that will improve the health or well-being of the target audience or of society as a whole.*

For instance, improving the current situation regarding hospital services can be connected with the behaviors of the local community. By applying social marketing principles, one can efficiently change the current behavior and therefore improve the health or well-being of the local community.

## Some Fundamental Marketing Principles<sup>3</sup>

The following marketing principles are critical to the success of social marketing campaigns:

- Understand your audience—their needs, wants, barriers, and motivations.
- Be clear about what you want your audience to do—changes in knowledge and attitudes are good only if they lead to action.
- Understand the concept of exchange—you must offer your audience something very appealing in return for changing behavior.
- Realize that competition always exists—your audience can always choose to do something else.
- Be aware of the “4 Ps” of marketing and how they apply to your program.
- Understand the role that policies, rules, and laws can play in efforts to affect social or behavioral change.

## Marketing Mix—The 4 Ps<sup>4</sup>

Marketing strategies are developed around the structure of the basic “4 Ps” framework: product, price, place, and promotion. An understanding of the 4 Ps allows the development of the appropriate product, at the right price, easily available through strategic sales placement, and known about through promotion, which also aims to enhance desire. Sometimes, a fifth P (policy) is used.

### Product

The social marketing “product” is not necessarily a physical offering. A continuum of products exists, ranging from tangible, physical products (e.g., hospital equipment), to services (e.g., treatment of cardiovascular diseases), practices (e.g., regular check-ups) and finally, more intangible ideas (e.g., good health).

When the “product” is behavior, there may be associated physical products necessary to allow this behavior change (e.g., PPP in hospital facilities) that need to be considered.

Before being able to design a product, the targeted consumers must be aware that they have a problem and that this can be addressed by a product: for example, the product “hospital equipment” can address the problem of “cardiovascular disease.” Particularly in health programs, it is not easy to achieve this kind of awareness. A lot of demand creation needs to be done in cases where the cause and effect of products are not easily recognizable.

### Price

Behavior change itself may have no price tag. However, associated products that make it easier can come at a price. These products need to be available at an affordable price to the target audience.

While the price is often an important contributor to the viability of a behavior change program, it is rarely the most important factor ruling product uptake (as many assume), even when very poor people are targeted. However, subsidies or incentives may be necessary in some cases to boost social marketing interventions.

### Place

The products required for behavior change need to be available and accessible in places for the target audience in order to make behavior change truly

<sup>3</sup> Adapted from Turning Point Social Marketing National Excellence Collaborative. *The Basics of Social Marketing: How to Use Marketing to Change Behavior*. <http://socialmarketingcollaborative.org/smc/basics.html>

<sup>4</sup> Adapted from Scott (2005).

possible. For example, the urban and rural poor need hospital facilities nearby in order to change their practices (e.g., avoiding consultation with doctors). People will go to doctors if they can consult them in nearby hospitals. Especially with new technologies, this “P” tends to be very challenging as a whole new supply chain needs to be built.

## Promotion

Having a product available in the right place, for the right price, is the precondition to start with the promotion of your “product.” However when your “product” is a new behavior or social norm, promotion tends to be quite difficult. Awareness needs to be raised, and a desire to adopt the new behavior created. This is done via promotion based upon an understanding of the motivations of the target audience and knowledge of their primary and trusted channels of communication.

## The 5th P: Policy

In the case of social marketing programs, a 5th “P” may be applied: policy. Policy can be used to make the unhealthy behavior harder, such as requiring local governments to build hospitals and clinics within the locality. Policy can also make the desired behavior easier; for example, by subsidizing the social health insurance of constituents. An enabling policy or institutional environment can also be vital for sustaining behavior change in the longer term.

## Social Marketing—Not Just Promotion!

Many behavior change programs target only the fourth “P”: promotion. However, if the products necessary to allow behavior change are not available in the right places at the right price, then behavior change will be incredibly difficult to achieve.<sup>5</sup> So social marketing is always a combination of all four Ps: **product, price, place, and promotion.**

## The Six Phases of a Social Marketing Process<sup>6</sup>

Implementing a social marketing strategy involves the following six phases:

### PHASE 1: Describe the Problem

At the beginning of this process, you must clearly describe the problem that will be addressed and a compelling rationale for the program. These are to be based on a thorough review of the available data, the current literature on behavioral theory, and best practices of programs addressing similar problems. This can, for example, be done through an analysis of strengths, weaknesses, opportunities, and threats (SWOT analysis), which will help you to identify the factors that can affect the program development. Finally, you will develop a strategy team to help develop and promote the program.

### PHASE 2: Conduct the Market Research

Social marketing depends on a deep understanding of the consumer. In this phase, you will research exactly who your target audience is, and what makes different consumer groups, or “segments,” alike and different from one another.

This research is important, because you will need to approach different consumer groups in different ways to be successful. If you do social marketing for sanitation, for example, you will not be very successful if you only have one standard product, at one given price, available only at one place that is promoted in only one way (e.g., through radio campaigns). You will need to segment your consumers into different groups you want to target, because those groups will have different needs and priorities in regard to sanitation. With market research, you aim to get inside the consumers’ heads, understanding what they want in exchange for what your program wants them to do, and what they struggle with in order to engage in that behavior. The objective of the research is to determine the following:

<sup>5</sup> Scott (2005).

<sup>6</sup> Adapted from Turning Point Social Marketing National Excellence Collaborative. *The Manager’s Guide to Social Marketing, Using Marketing to Improve Health Outcomes from the Social Marketing*. Washington, United States. [www.turningpointprogram.org](http://www.turningpointprogram.org)

- (i) how to cluster your target audience into useful segments,
- (ii) which target audience segments are most ready to change their behavior, and
- (iii) what they want or need most in order to do that.

### PHASE 3: Create the Market Strategy

The centerpiece of your social marketing program is to articulate what you want to achieve and how you will do it.

Based on the research findings, begin by selecting a target audience segment and the desired behavior to be promoted. Afterwards, specify the benefits the target audience will receive for changing or adopting this behavior. The target audience should really care about these benefits. You may also specify key barriers that the program will help the target audience overcome in order to perform the desired behavior.

### PHASE 4: Adapt Your Marketing Mix

To be successful, you will need to adapt a different marketing mix for all the identified segments from your market research:

- (i) You will have different **products** for different consumer groups,
- (ii) which will come at different **prices**,
- (iii) that will be available at different **places**, and
- (iv) you will reach them with a combination of different communication tools (**promotion**).

Depending on the scope of your program and your available resources, you will also need to work on the policy level and train your staff to be able to conduct your social marketing campaign.

These processes and considerations involve keeping on strategy and ensuring that each intervention addresses the respective target benefit or barrier, and is accessible and appropriate for the target audience. You will have to develop a plan, timeline, and budget

for each of the proposed interventions, and highlight where key partners and stakeholders are needed and how to engage them. At the end of this phase, you should have a comprehensive work plan that describes and ties together all the pieces.

### PHASE 5: Plan Monitoring and Evaluation

Social marketing is based on an iterative design model, so monitoring data are used to both ensure the program is being implemented as planned and to examine whether your strategy and tactics are suitable or need tweaking. You will also consider if environmental factors (such as policies, economic conditions, new programs, structural change, or improvement) have changed in ways that affect your program. You will have to design a research plan to evaluate the effects or outcomes of the social marketing program. This should involve examining whether

- (i) desired effects were achieved,
- (ii) observed effects can be attributed to your program, and
- (iii) the underlying logic of the intervention and its relationship to desired effects are sound.

### PHASE 6: Implement the Intervention and Evaluation

Finally, after all the planning, you are ready to implement the program and the evaluation.

This phase walks through steps for launching the program; producing materials; procuring needed services; sequencing, managing, and coordinating the respective interventions; staying on strategy; fielding the evaluation; capturing and disseminating findings and lessons learned; and modifying activities as warranted.

Your monitoring plan should be alerting you to any issue that requires urgent attention or modification. Staying on top of important stakeholder and partner perspectives and concerns is an important function during this phase.

# Annex 9

## Key Activities during the Bidding Process

### Preparation of the Invitation to Bid/ Request for Expression of Interest and the Bidding Documents

The invitation to bid/request for expression of interest and the draft bidding documents are usually prepared by the organization's procurement office or the bids and awards committee (BAC) upon receipt of the finalized terms of reference (TOR). Where a prior shortlisting of interested firms is required, a request for expression of interest is prepared, not an invitation to bid. Where shortlisting has been done, the bidding document is prepared.

At this stage, the type of bidding document to prepare (whether for procurement of goods, infrastructure services, consulting services, or any other form of services) and the mode of procurement to utilize (whether through competitive bidding, shopping, direct contracting, or any other alternative method) are first confirmed through the approved procurement plan (APP) and the approved purchase request as earlier described. Once it is confirmed that the proposed procurement is provided for in the APP and it has a corresponding approved purchase request, the procurement office picks the appropriate template from among the Philippine bidding documents (PBD) of the Government Procurement Policy Board (GPPB), or customizes one where needed. **Where a template is used, bear in mind that the decision to provide the specifics that are called for in the bid data sheet, special conditions of contract, and other sections of the bidding documents that are allowed to be modified remains with the procuring agency.**

The draft bidding document for this type of public-private partnership (PPP) in hospital management could be drawn from GPPB's PBD for consulting

services. Customization could be made once the TOR has been finalized, particularly the selection criteria and rating system, terms of payment, and the manner by which award would be made. The procurement process requires a prior eligibility check of interested bidders for shortlisting purposes and a short list of five will be selected from among those who expressed interest. The bidding documents will only be issued to the shortlisted consultants.

Ideally, the bidding documents should be prepared by a group of individuals from the BAC, the technical working group, BAC secretariat, end users, and technical experts. **As a rule, the bidding document should be finalized before the advertisement of the invitation to bid/request for expression of interest.**

### Conduct of Pre-Procurement Conference

The pre-procurement conference is a forum where all those concerned with the subject for bidding are called to discuss the details of a particular procurement. It is conducted by the BAC to ensure the readiness of the organization in procuring the required services. Items discussed during a pre-procurement conference include the TOR, mode of procurement, procurement timelines, budget availability, approved budget for the contract, bid evaluation procedure, draft contract, and the bidding document as a whole. While this conference is not required for consulting services worth 1 million Philippine pesos (P) and below, BACs are encouraged to conduct one in case there is complexity in the TOR or in any of the arrangements called for bids. **The pre-procurement conference should be held before the advertisement or posting of the invitation to bid/request for expression of interest to allow time to prepare amendments to the invitation or the bidding documents.**

### **Publication or Posting of the Invitation to Bid/ Request for Expression of Interest**

The invitation to bid/request for expression of interest may be advertised through the newspaper, the organization's website, Philippine Government Electronic Procurement System's (PhilGEPS) website, or in any conspicuous place within the organization's premises. A continuous period of 7 calendar days is required for website posts, starting from the date of advertisement. For Northern Samar's hospital management services, the organization's initial preference was to post the advertisement only through PhilGEPS, but it later decided to advertise through a national daily to help ensure wider dissemination and better competition. The same approach could be made for the organization's hospital management services.

### **Issuance of the Bidding Documents**

Bidding documents are treated as confidential documents prior to the official date of release. However, they should be ready for issuance on the first day of advertisement. While the implementing rules and regulations (IRR) of Republic Act (RA) 9184 allows a procurement process of 60 calendar days from the date of advertisement up to the bid opening date, the organization has the flexibility to determine a shorter period. In the case of Northern Samar's hospital management services, the duration is proposed to be shortened from 60 days to about 50 days given the organization's ability to expedite the eligibility screening activity.

For monitoring purposes, the BAC secretariat should keep a record of all those who purchased or were issued bidding documents. This record helps the end user and the BAC estimate the number of prospective bidders, and to ascertain the likelihood of a failed invitation in the event of a non-response.

### **Conduct of Pre-Bid Conference**

The pre-bid conference is a forum wherein the procuring office and the prospective bidders meet to discuss the package required for the bid. This

is done at least 12 days before the date of bid submission, during which technical and other knowledgeable persons should be present to ensure a thorough discussion. The BAC secretariat is expected to document the minutes of the pre-bid conference, which could also serve as the reference for subsequent preparation of a bid bulletin. The pre-bid conference should not be concluded without the BAC discussing the bid evaluation procedure. A pre-bid conference is required for consulting contracts with approved budget for the contract of at least P1 million.

### **Issuance of Bid Bulletins**

Clarifications made during the pre-bid conference are normally issued through bid bulletins; so are clarifications or further amendments of the bidding documents after the pre-bid conference. Bid bulletins should be issued at least 7 days before the bid submission date and should also be posted on the same website where the invitation to bid was advertised. A bidder who submitted its bid before the issuance of a bid bulletin should be allowed to modify its bid.

### **Submission of Bids**

Bidders should submit their bids on or before the date and time specified. Bids submitted after the specified deadline shall not be accepted by the BAC. The BAC secretariat should mark bid submissions with the date and time of receipt to ensure that no prompt bidder complains that a late bid was accepted.

### **Bid Opening**

The BAC should open the bids on the date and time specified for the same. The bids should not be opened without the BAC chairperson or the vice chair, and without a quorum of the members. All BAC members present during the bid opening should initial every page of the original copies of the bids received and opened. The BAC secretariat should document the minutes of the bid opening as well as the names and number of bidders whose bids were not accepted due to late submission.

## Conduct of Bid Evaluation and Post-Qualification

The following shows the bid evaluation procedures as specified in the bidding documents for a prospective PPP in hospital management project in the Philippines:

### What to do when no bidder meets the minimum required rating

- (i) The bid evaluation team presents its findings to the BAC.
- (ii) The BAC declares the bidding a failure through a resolution and decides the conduct of rebidding.
- (iii) The end user or the procurement office reviews the TOR and the terms and conditions of the concluded bidding, and determines areas that need to be amended.
- (iv) Rebidding shall be advertised using an amended TOR and bidding documents.
- (v) Bidders who participated during the first bidding shall be allowed to submit new bids.
- (vi) In case a second bidding failure occurs, the local government may enter into negotiated procurement with a legally, technically, and financially capable hospital operator, provided the original terms and conditions of the first bidding are maintained.

### What to do when the prospective awardee fails post-qualification

- (i) The bid evaluation team presents its findings to the BAC.
- (ii) The BAC shall notify the post-disqualified bidder, citing the grounds for its post-disqualification.
- (iii) The post-disqualified bidder shall be given the option to request reconsideration within an acceptable period, but the bid evaluation team may proceed to undertake post-qualification of the next ranked bidder.
- (iv) If the request for reconsideration of the post-disqualified bidder is accepted by the BAC, the concerned bidder shall be recommended for award.

- (v) If the request for reconsideration of the post-disqualified bidder is not accepted by the BAC and the next ranked bidder passes post-qualification, it shall be recommended for contract award.
- (vi) In case the next ranked bidder fails post-qualification, the procedure shall be repeated for the remaining bidders that met the minimum required rating until one is determined for contract award.

## Preparation of the Bid Evaluation Report

The bid evaluation report is prepared to document the entire procurement activity from planning up to the recommendation for award. It shall be signed by all members of the bid evaluation team and submitted to the BAC for review and eventual preparation of the BAC Resolution to Award. The features of the bid evaluation report for the hospital management services should include the following:

- (i) Description of the bidding package
- (ii) Narration of the schedule of activities from publication of the advertisement to the date of actual bid evaluation
- (iii) Number of bidders who purchased bidding documents against those who submitted bids
- (iv) Late bids that were returned unopened, if any
- (v) The forms and amounts of the submitted bid securities
- (vi) Outcomes of the prequalification process
- (vii) Outcomes of the price evaluation
- (viii) Outcomes of the post-qualification
- (ix) Recommendation for award

## Preparation of the BAC Resolution to Award

The BAC Resolution to Award (RTA) is drafted by the BAC secretariat after a review of the bid evaluation report. If the bid evaluation report is found to be in order, the BAC confirms the bid evaluation report through its RTA and transmits the same to the local chief executive for approval. The local chief executive has 7 calendar days to act on the BAC resolution.



## Issuance of the Notice of Award and Contract

The Notice of Award and the contract are issued to the winning bidder after the local chief executive approves the BAC resolution. At the same time, the losing bidders are also informed of the bidding outcomes.

## Procurement Monitoring

Procurement monitoring reports are expected of all procuring entities, some of which are even required for submission to the GPPB.

## Winning Bidder's Submission of Performance Security

Upon acceptance of the Notice of Award and contract signing, the winning bidder should furnish the organization with the required performance security within 10 business days. The performance security provides the organization the winning bidder's guaranty to perform its contractual obligations and could be forfeited in case of breach of contract. The organization should not accept a deficient performance security regardless of the amount of deficiency. The same security should be released by the organization after the winning bidder fulfills its contractual obligations.

## Contract Approval

Upon the winning bidder's submission of the required performance security, the BAC secretariat transmits the contract documents to the local chief executive for approval along with the bid evaluation report, the BAC Resolution to Award, and the certificate of funds availability. The local chief executive then issues

the Notice to Proceed to the winning bidder along with a copy of the approved contract.

## Issuance of Notice to Proceed

The Notice to Proceed usually signals the effective date of the contract. It should be issued by the local chief executive to the winning bidder within 3 days from contract approval. The IRR of RA 9184 provides for no more than 7 days from the issuance of the Notice to Proceed for the contract to become effective.

## Contract Implementation

Contract implementation is a joint responsibility of the contracting parties. Both the organization and the winning bidder are expected to perform their contractual obligations without delay to achieve the objectives of the project.

## Contractor's Performance Evaluation

To assist the BAC in maintaining a roster of hospital managers, the hospital administrator, through assigned personnel, is encouraged to implement a contract performance monitoring and evaluation system. The instrument should be designed to ascertain whether the hospital manager's contractual obligations have been met, taking note of the relevant contract provisions as the monitoring criteria. Feedback shall be given to the BAC, with the BAC secretariat keeping a record not only of the well-performing hospital managers but also those who require performance upgrading. This information will be useful for future procurement of similar services for the remaining hospitals in the province.

# Annex 10

## Sample Contract Template on Public–Private Partnership in Hospital Management

*NOTE: This is a sample bid document for a PPP in hospital management services. Users, with the assistance of lawyers or legal counsel, will find this useful in the crafting of the bid document. However, not all provisions or sections in typical PPP bid documents are provided here due to space limitation. Moreover, the provisions stipulated here may not be legally applicable in or compliant with specific policies of certain countries. Readers are advised to refer to their country regulations and practices in the adoption of some or all of the provisions in this document. Text inside the square brackets “[ ]”, except when the bracket indicates the abbreviation of terms or encloses additional information, should be replaced by the users, depending on their context. For example, “[name of procuring entity]” means the user should remove the brackets and replace it with the name of the organization that is conducting the bid for the PPP in hospital management services.*

## ***Section I. Notice of Eligibility and Short Listing***

[Date]

[Name and Address of Short-Listed Consultant]

Dear [Addressee]:

1. The [name of Procuring Entity] (hereinafter called “Procuring Entity”) has received financing (hereinafter called “funds”) from [name of Funding Source] (hereinafter called the “Funding Source”) toward the cost of [name of project]. The Procuring Entity intends to apply a portion of the funds in the amount of [amount of approved budget for contract (ABC)\* in words and figures] to eligible payments under the contract for [name of contract] for which the bidding documents are issued. [*\*Note that users of this document can use abbreviations if such terms have been indicated in a glossary and list of abbreviations. They must be spelled out in the document in the first instance they were used.*]
2. The Procuring Entity now invites bids to provide the following Consulting Services: [short description of objectives and scope of the project]. More details on the services are provided in the Terms of Reference for the project.
3. The Consultant shall be selected and employed in accordance with [evaluation procedure] procedures as described in the Bidding Documents.
4. This notice has been addressed to the following short-listed consultants:  
  
[List of short-listed consultants]
5. It is not permissible for you to transfer this invitation to any other consultant.
6. The Bidding Documents shall be available at [address] during [office hours, e.g., 8:00 a.m. to 5:00 p.m.].
7. **Select one of the following two (2) paragraphs and delete the other:**<sup>1</sup>
  - a) ***If the Procuring Entity intends to open the Pre-Bid Conference to all interested Bidders:***  
  
The [name of the Procuring Entity] will hold a Pre-Bid Conference on [time and date] at [location for Pre-Bid Conference], which shall be open to all interested parties.

---

<sup>1</sup> May be deleted if the ABC is less than [1 million pesos] where the Procuring Entity may not hold a pre-bid conference. (Replace the figure in brackets with the appropriate amount.)

***b) If the Procuring Entity intends to limit the Pre-Bid Conference to Bidders who have purchased the Bidding Documents:***

The *[name of the Procuring Entity]* will hold a Pre-Bid Conference on *[time and date]* at *[location of Pre-Bid Conference]*, which shall be open only to interested parties who have purchased the Bidding Documents.

Yours sincerely,

---

*[Signature, name, and title of the Procuring Entity's Representative]*

## *Section II. Eligibility Documents*

### **Notes on the Eligibility Documents**

This Section provides the information necessary for prospective bidders to prepare responsive Eligibility Documents in accordance with the requirements of the Procuring Entity.

The provisions contained in this Section are to be used unchanged. Additional information or requirements specific to each procurement shall be specified in the eligibility document sheet (EDS).

### **1. Eligibility Criteria**

- 1.1. The following persons/entities shall be allowed to participate in the bidding for Consulting Services:
  - (a) Duly licensed Filipino citizens/sole proprietorships;
  - (b) Partnerships duly organized under the laws of the Philippines and of which at least sixty percent (60%) of the interest belongs to citizens of the Philippines;
  - (c) Corporations duly organized under the laws of the Philippines and of which at least sixty percent (60%) of the outstanding capital stock belongs to citizens of the Philippines;
  - (d) Cooperatives duly organized under the laws of the Philippines, and of which at least sixty percent (60%) interest belongs to citizens of the Philippines; or
  - (e) Persons/entities forming themselves into a joint venture, i.e., a group of two (2) or more persons/entities that intend to be jointly and severally responsible or liable for a particular contract, provided that Filipino ownership or interest thereof shall be at least sixty percent (60%). For this purpose, Filipino ownership or interest shall be based on the contributions of each member of the joint venture as specified in the joint venture agreement (JVA).
- 1.2. When the types and fields of Consulting Services involve the practice of professions regulated by law, those who will actually perform the services

shall be [*nationality*] citizens and registered professionals authorized by the appropriate regulatory body(ies) to practice those professions and allied professions specified in the EDS.

- 1.3. If the Request for Expression of Interest allows participation of foreign consultants, prospective foreign bidders may be eligible subject to the qualifications stated in the EDS.
- 1.4. Government corporate entities may be eligible to participate only if they can establish that they (a) are legally and financially autonomous, (b) operate under commercial law, and (c) are not dependent agencies of the Government of the Philippines or the Procuring Entity.

## 2. Eligibility Requirements

- 2.1 The following eligibility requirements shall be submitted on or before the date of the eligibility check specified in the Request for Expression of Interest and Clause 5 for purposes of determining eligibility of prospective bidders:

- (a) Class “A” Documents

### Legal Documents

- (i) Registration certificate from Securities and Exchange Commission (SEC), Department of Trade and Industry (DTI) for sole proprietorship, or Cooperative Development Authority (CDA) for cooperatives, or any proof of such registration as stated in the EDS.\* [*All names of organizations indicated here are based in the Philippine context; they may be replaced with the relevant government organizations. This note applies throughout the whole document.*]
- (ii) Mayor’s permit issued by the city or municipality where the principal place of business of the prospective bidder is located.

### Technical Documents

- (iii) Statement of the prospective bidder of all its ongoing and completed government and private contracts, including contracts awarded but not yet started, if any, whether similar or not similar in nature and complexity to the contract to be bid, within the relevant period provided in the EDS. The statement shall include, for each contract, the following:
  - (iii.1) the name and location of the contract;
  - (iii.2) date of award of the contract;
  - (iii.3) type and brief description of consulting services;
  - (iii.4) consultant’s role (whether main consultant, subcontractor, or partner in a joint venture);

- (iii.5) amount of contract;
- (iii.6) contract duration; and
- (iii.7) certificate of satisfactory completion or equivalent document specified in the EDS issued by the client, in the case of a completed contract.
- (iv) Statement of the consultant specifying its nationality and confirming that those who will actually perform the service are registered professionals authorized by the appropriate regulatory body to practice those professions and allied professions in accordance with Clause 1.2.

Financial Document

- (v) The consultant's audited financial statements, showing, among others, the consultant's total and current assets and liabilities, stamped "received" by the [*name of relevant agency such as "Bureau of Internal Revenue"*] or its duly accredited and authorized institutions, for the preceding calendar year, which should not be earlier than two (2) years from the date of bid submission

(b) Class "B" Document

A valid JVA, in case a joint venture is already in existence. In the absence of a JVA, duly notarized statements from all the potential joint venture partners shall be included in the bid stating that they will enter into and abide by the provisions of the JVA in the instance that the bid is successful. Failure to enter into a joint venture in the event of a contract award shall be grounds for the forfeiture of the bid security. Each partner of the joint venture shall submit the legal eligibility documents. The submission of technical and financial documents by any of the joint venture partners constitutes compliance.

- 2.2 In the case of foreign consultants, the foregoing eligibility requirements under Class "A" Documents may be substituted by the appropriate equivalent documents, if any, issued by the foreign consultant's country.
- 2.3 The eligibility requirements or statements and all other documents to be submitted to the Bids and Awards Committee (BAC) must be in English. Classes "A" and "B" documents in other languages must be translated into English and certified by the appropriate embassy or consulate in the Philippines and must accompany the eligibility requirements under Classes "A" and "B" Documents if they are in another language.
- 2.4 Prospective bidders may obtain a full range of expertise by associating with individual consultant(s) and/or other consultants or entities through a joint venture or subcontracting arrangements, as appropriate. However, subcontractors may only participate in the bid of one short-listed consultant. Foreign Consultants shall seek the participation of [*nationality*] Consultants by

entering into a joint venture with, or subcontracting part of the project to, [nationality] Consultants.

- 2.5 If a prospective bidder has previously secured a certification from the Procuring Entity to the effect that it has previously submitted Class “A” Documents, the said certification may be submitted in lieu of the requirements enumerated in Clause 2.1.

### **3. Format and Signing of Eligibility Documents**

- 3.1 Prospective bidders shall submit their eligibility documents through their duly authorized representative on or before the deadline specified in Clause 5.\* *[\*The clause numbers may change depending on the final Bid Document that an organization will use. This note should be applied throughout the whole document.]*
- 3.2 Prospective bidders shall prepare an original and copies of the eligibility documents. In the event of any discrepancy between the original and the copies, the original shall prevail.
- 3.3 The eligibility documents, except for unamended printed literature, shall be signed, and each and every page thereof shall be initialed, by the duly authorized representative(s) of the prospective bidder.
- 3.4 Any interlineations, erasures, or overwriting shall be valid only if they are signed or initialed by the duly authorized representative(s) of the prospective bidder.

### **4. Sealing and Marking of Eligibility Documents**

- 4.1 Unless otherwise indicated in the EDS, prospective bidders shall enclose their original eligibility documents described in Clause 2.1 in a sealed envelope marked “ORIGINAL – ELIGIBILITY DOCUMENTS.” Each copy shall be similarly sealed, duly marking the envelopes as “COPY NO. \_\_\_ - ELIGIBILITY DOCUMENTS.” These envelopes containing the original and the copies shall then be enclosed in one (1) single envelope.
- 4.2 The original and the number of copies of the eligibility documents as indicated in the EDS shall be typed or written in indelible ink and shall be signed by the prospective bidder or its duly authorized representative(s).
- 4.3 All envelopes shall
  - (a) contain the name of the contract to be bid in capital letters,
  - (b) bear the name and address of the prospective bidder in capital letters,
  - (c) be addressed to the Procuring Entity’s BAC specified in the EDS,
  - (d) bear the specific identification of this Project indicated in the EDS, and



- (e) bear a warning “DO NOT OPEN BEFORE...” the date and time for the opening of eligibility documents, in accordance with Clause 5.

4.4 If the eligibility documents are not sealed and marked as required, the Procuring Entity will assume no responsibility for their misplacement or premature opening.

## **5. Deadline for Submission of Eligibility Documents**

Eligibility documents must be received by the Procuring Entity’s BAC at the address and on or before the date and time indicated in the Request for Expression of Interest and the EDS.

## **6. Late Submission of Eligibility Documents**

Eligibility documents submitted after the deadline for submission and receipt prescribed in Clause [clause number] shall be declared “Late” and shall not be accepted by the Procuring Entity.

## **7. Modification and Withdrawal of Eligibility Documents**

7.1 The prospective bidder may modify the eligibility documents after they have been submitted, provided that the modification is received by the Procuring Entity prior to the deadline specified in Clause 5. The prospective bidder shall not be allowed to retrieve the original eligibility documents, but shall be allowed to submit another set equally sealed, properly identified, linked to the original bid marked as “ELIGIBILITY MODIFICATION,” and stamped “received” by the BAC. Modifications received after the applicable deadline shall not be considered and shall be returned to the prospective bidder unopened.

7.2 A prospective bidder may, through a letter of withdrawal, withdraw eligibility documents after they have been submitted, for valid and justifiable reason, provided that the letter of withdrawal is received by the Procuring Entity prior to the deadline prescribed for submission and receipt of eligibility documents.

7.3 Eligibility documents requested to be withdrawn in accordance with this Clause shall be returned unopened to the prospective bidder concerned. A prospective bidder may also express the intention not to participate in the bidding through a letter which should reach and be stamped by the BAC before the deadline for submission and receipt of eligibility documents. A prospective bidder who withdraws eligibility documents shall not be permitted to submit another set, directly or indirectly, for the same project.

## **8. Opening and Preliminary Examination of Eligibility Documents**

8.1 The Procuring Entity’s BAC will open the envelopes containing the eligibility documents in the presence of the prospective bidders’ representatives who choose to attend, at the time, on the date, and at the place specified in the EDS. The prospective bidders’ representatives who are present shall sign a register evidencing their attendance.

- 8.2 Letters of withdrawal shall be read aloud and recorded during the opening of eligibility documents, and the envelope containing the corresponding withdrawn eligibility documents shall be returned unopened to the withdrawing prospective bidder. If the withdrawing prospective bidder's representative is present during the opening, the original eligibility documents and all copies thereof shall be returned to the representative during the opening of eligibility documents. If no representative is present, the eligibility documents shall be returned unopened by registered mail.
- 8.3 A prospective bidder determined as "ineligible" has [*insert number of days in word and figure*] calendar days upon written notice or, if present at the time of the opening of eligibility documents, upon verbal notification, within which to file a request for reconsideration with the BAC, provided that the request for reconsideration shall not be granted if it is established that the finding of failure is due to the fault of the prospective bidder concerned. The BAC shall decide on the request for reconsideration within [*insert number of days in word and figure*] calendar days from its receipt. If a failed prospective bidder signifies his or her intent to file a request for reconsideration, in the case of a prospective bidder who is declared ineligible, the BAC shall hold the eligibility documents until such time that the request for reconsideration or protest has been resolved.
- 8.4 The eligibility documents envelopes and modifications, if any, shall be opened one at a time, and the following read aloud and recorded:
- (a) the name of the prospective bidder,
  - (b) whether there is a modification or substitution, and
  - (c) the presence or absence of each document in the eligibility documents vis-à-vis a checklist of the required documents.
- 8.5 The eligibility of each prospective bidder shall be determined by examining each bidder's eligibility requirements or statements against a checklist of requirements, using nondiscretionary "pass/fail" criterion as stated in the Request for Expression of Interest, and shall be determined as either "eligible" or "ineligible." If a prospective bidder submits the specific eligibility document required, he or she shall be rated "passed" for that particular requirement. In this regard, failure to submit a requirement, or an incomplete or patently insufficient submission, shall be considered "failed" for the particular eligibility requirement concerned. If a prospective bidder is rated "passed" for all the eligibility requirements, he or she shall be considered eligible to participate in the bidding, and the BAC shall mark the set of eligibility documents of the prospective bidder concerned as "eligible." If a prospective bidder is rated "failed" in any of the eligibility requirements, he or she shall be considered ineligible to participate in the bidding, and the BAC shall mark the set of eligibility documents of the prospective bidder concerned as "ineligible." In either case, the BAC chairperson or duly designated authority shall countersign the markings.

## 9. Short Listing of Consultants

- 9.1 Only prospective bidders whose submitted contracts are similar in nature and complexity to the contract to be bid as provided in the EDS shall be considered for short listing.
- 9.2 The BAC of the Procuring Entity shall draw up the short list of prospective bidders from those declared eligible using the detailed set of criteria and rating system to be used specified in the EDS.
- 9.3 Short-listed consultants shall be invited to participate in the bidding for this project through a Letter of Invitation to Bid issued by the BAC of the Procuring Entity.
- 9.4. Only bids from short-listed bidders shall be opened and considered for award of contract. These short-listed bidders, whether single entities or joint ventures, should confirm in their bids that the information contained in the submitted eligibility documents remains correct as of the date of bid submission.

## *Section III. Eligibility Data Sheet*

### **Notes on the Eligibility Data Sheet**

This Section is intended to assist the Procuring Entity in providing the specific information and requirements in relation to corresponding clauses in the Eligibility Documents, and has to be prepared for each specific procurement.

The Procuring Entity should specify in this Section the information and requirements specific to the circumstances of the Procuring Entity, the processing of the eligibility, and the rules that will apply in the determination and evaluation of eligibility.

In preparing this Section, the following aspects should be checked:

- (a) Information that specifies and complements provisions of the Eligibility Documents must be incorporated.
- (b) Amendments and/or supplements, if any, to provisions of the Eligibility Documents as necessitated by the circumstances of the specific procurement must also be incorporated.

## Eligibility Data Sheet

Eligibility Documents	
1.2*	<i>State the types and fields of Consulting Services that will be performed in relation to the Project and the appropriate regulatory body(ies), if any.</i>
1.3	<p><i>Select one, delete the other.</i></p> <p><i>If foreign participation is not allowed: No further instructions.</i></p> <p><i>If foreign participation is allowed: Foreign consultants may be eligible to participate in this Project, subject to the following qualifications:</i></p> <p style="margin-left: 40px;">(a) The consultant must be registered with the SEC and/or any agency authorized by the laws of the Philippines.</p> <p style="margin-left: 40px;">(b) When the types and fields of consulting services in which the foreign consultant wishes to engage involve the practice of regulated professions, the foreign consultant must be authorized by the appropriate government professional regulatory body specified in Clause 1.2 to engage in the practice of those professions and allied professions: <i>Provided, however,</i> that the limits of such authority shall be strictly observed.</p>
(i)	<i>List any additional acceptable proof of registration or state “No Additional Requirements.”</i>
(iii)	The statement of all ongoing and completed government and private contracts shall include all such contracts within <i>[state relevant period]</i> prior to the deadline for the submission and receipt of eligibility documents.
(iii.7)	<i>State acceptable proof of satisfactory completion of completed contracts.</i>
4.2	Each prospective bidder shall submit one (1) original and <i>[insert number of copies required]</i> copies of the eligibility documents.
4.3 (c)	<i>State the Bids and Awards Committee of the Procuring Entity concerned with the Project.</i>
4.3 (d)	Operation and Management of <i>[name of hospital]</i>

5	<p>The address for submission of eligibility documents is <i>[insert address]</i>.</p> <p>The deadline for submission of eligibility documents is <i>[insert time and date]</i>.</p>
8.1	<p>The place of opening of eligibility documents is <i>[insert address]</i>.</p> <p>The date and time of opening of eligibility documents is <i>[insert time and date]</i>.</p>
9.1	<p>Similar contracts shall refer to <i>[insert description of similar contracts or state "No further instructions"]</i>.</p>
9.2	<p>The criteria and rating system** to be used by the BAC for the short listing of eligible firms includes (i) experience of the firm (and its associates in case of joint venture) that is similar in nature and complexity of the proposed project = 50%; (ii) qualifications of the principal and key staff who may be assigned to the job vis-à-vis the extent and complexity of the undertaking = 30%; and (iii) job capacity to undertake the project in relation to its current workload = 20%.</p> <p>Details are as follows:</p> <p>(a) Applicable experience for the last 5 years = <b>50 points</b>, broken into</p> <ul style="list-style-type: none"> <li>(i) <b>30 points</b> for ongoing and completed services or projects <b>similar</b> to the project under consideration</li> <li>(ii) <b>20 points</b> for ongoing and completed projects <b>related</b> to the project under consideration</li> </ul> <p>(b) Qualifications of the principal and key staff who may be assigned to the project under consideration = <b>30 points</b>, broken into</p> <ul style="list-style-type: none"> <li>(i) Education = <b>10 points</b></li> </ul> <p style="padding-left: 40px;">Example:</p> <p style="padding-left: 80px;"><i>10 points may be given to a staff who has a master's degree</i> (points to be determined by the BAC and PPP Team)</p> <ul style="list-style-type: none"> <li>(ii) Work experience = <b>20 points for individual involvement in similar or related projects</b></li> </ul> <p style="padding-left: 40px;">Examples:</p> <p style="padding-left: 80px;"><i>20 points may be given to a staff who has 10 years or more</i> <i>15 points may be given to a staff who has 5 to 9 years</i> (points to be determined by the BAC and PPP Team)</p>

	<p>(c) Job capacity = <b>20 points</b></p> <p>Examples:</p> <p><i>0-1 ongoing project = 20 points</i></p> <p><i>2 ongoing projects = 15 points</i></p> <p><i>3 ongoing projects = 10 points</i></p> <p><i>4 ongoing projects = 5 points</i></p> <p>(points to be determined by the BAC and PPP Team)</p>
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\*Certain sections of the original document have not been included so the numbering system shows some gaps.

\*\*The criteria and weights indicated here are based on the Philippine context; users may develop their own criteria and scoring guidelines.

# Annex 11

## Other Procurement Documents<sup>1</sup>

### Handbook on Philippine Government Procurement

This document is a compilation of Republic Act (RA) 9184 with its implementing rules and regulations (IRR) with additional references as follows:

- (i) Government Procurement Policy Board (GPPB) Resolution 01-2004 on bids and awards committee composition for local government units
- (ii) *Guidelines for Contract Price Escalation*
- (iii) *Uniform Guidelines for Blacklisting of Manufacturers, Suppliers, Distributors, Contractors and Consultants*
- (iv) *Guidelines on Termination of Contracts*
- (v) *Guidelines on the Use of an Ordering Agreement under the Government Procurement Reform Act*
- (vi) GPPB Resolution 07-2005 regarding rules on the adjustment of the Approved Budget for Contract
- (vii) *Revised Guidelines on the Extension of Contracts for General Support Services*
- (viii) *Guidelines on Implementation of Infrastructure Projects Undertaken by the AFP Corps of Engineers*
- (ix) *Revised Guidelines for the Implementation of Infrastructure Projects by Administration*
- (x) *Guidelines in the Determination of Eligibility of Foreign Suppliers, Contractors and Consultants to Participate in Government Procurement Projects*
- (xi) *Guidelines for Legal Assistance and Indemnification of the Bids and Awards Committee Members and its Support Staff*
- (xii) *Revised Guidelines on Index-Based Pricing for Procurement of Petroleum, Oil and Lubricant Products*
- (xiii) *Guidelines on Procurement of Water, Electricity, Telecommunications and Internet Service Providers*
- (xiv) *Implementing Guidelines on Agency-to-Agency Agreements*
- (xv) *Implementing Guidelines for Lease of Privately Owned Real Estate*
- (xvi) *Guidelines on Non-Governmental Organization Participation in Public Procurement*
- (xvii) *Guidelines in the Procurement of Security and Janitorial Services*

This handbook is highly recommended for use as it contains not only the Government Procurement Reform Act or RA 9184, but also its IRR and some guidelines that are deemed relevant to the proposed outsourcing of hospital management services.

### Procurement Manuals

These documents describe the step-by-step procedures to be observed by the organization when procuring goods, infrastructure services, or consulting services. For the proposed outsourcing of hospital management services, the suggested reference document is Volume 4 of the local government units' (LGU) *Procurement Manual for Consulting Services*.

### RA 9184 and Its Implementing Rules and Regulations (IRR)

The Government Procurement Reform Act or RA 9184, along with its IRR, is the most important reference document in government procurement. The law, which took effect on 26 January 2003, provides for the standardization and regulation of government procurement activities. The IRR, which took effect on 8 October 2003, initially covered public procurement but was revised in 2008 to

<sup>1</sup> Note that while these documents are based on the Philippine context, many of them may be similar to procurement documents used in other countries.



include procurement for foreign-assisted projects in agreement with various development partners. Hence, the Revised IRR of RA 9184 came into being 22 July 2009.

### **Commission on Audit's Guide in the Audit of Procurement**

The Commission on Audit (COA) memorandum dated 14 January 2010 issued this guide to help its personnel make their audit activities responsive to the requirements of procurement laws and regulations. However, this could also be a useful reference for LGUs to anticipate the extent of auditorial review concerning procurement. Familiarity with this document helps ensure compliance with audit requirements and therefore minimize audit findings. COA's reference in developing the audit criteria in this guide are RA 9184 and GPPB's related issuances at the time the guide was developed.

### **National Economic and Development Authority's Guidelines and Procedures for Entering into Joint Venture Agreements between Government and Private Entities**

These guidelines do not cover LGUs but are nonetheless useful in case the organization intends to

promulgate one through its ordinance mechanism. In August 2010, Camarines Sur issued an ordinance prescribing guidelines and procedures for entering into joint venture agreements with the private sector based on these guidelines.

### **ADB Procurement Guidelines**

ADB's procurement guidelines would be relevant for the organization that intends to finance its PPP in health project through a loan under the Credit for Better Health Care Project. Otherwise, the *Procurement Manual for LGUs* will serve as the basic reference for the organization's procurement in the manner prescribed under RA 9184.

### **ADB Handbook on Public-Private Partnership**

This is good reading material to fully understand what PPPs are; how to structure a PPP project; what PPP options are available; what preparation is required to implement a PPP activity; how to handle the procurement, contracting, and implementation of the PPP activity; and how to monitor and report on the results of the contract implementation.

# Annex 12

## Sample Monitoring and Evaluation Form<sup>1</sup>

### HOSPITAL MANAGEMENT MONITORING REPORT For the Month \_\_\_\_\_ Year \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Address: \_\_\_\_\_  
Region: \_\_\_\_\_

**(Please complete all items. Write “N/A” if not applicable.)**

#### 1. General Information

##### 1.1 Classification

**Service Capability:** General

- Level 1 Hospital
- Level 2 Hospital
- Level 3 Hospital (non-teaching and non-training)
- Level 4 Hospital (teaching and training)

##### 1.2 Bed Capacity/Occupancy:

Authorized bed capacity \_\_\_\_\_ beds  
Actual/Implementing beds \_\_\_\_\_ beds

Bed occupancy rate (BOR) for the month based on authorized beds \_\_\_\_\_ %  
*Total inpatient service days for the period \* /{(Total no. of authorized beds) x (Total days in the period)} x 100*

\*This BOR is for a certain period – usually a calendar year but one can calculate for a month to compare month-to-month variations, for example.

##### 1.3 Bed Count:

Number of beds per service based on actual bed capacity

##### *No. of Beds*

No. of beds per classification:

Pay \_\_\_\_\_  
Service \_\_\_\_\_  
No. of beds per service:  
Medicine \_\_\_\_\_  
Obstetrics \_\_\_\_\_  
Gynecology \_\_\_\_\_  
Pediatrics \_\_\_\_\_  
Surgery \_\_\_\_\_  
Pedia \_\_\_\_\_  
Adult \_\_\_\_\_

Others: Specify \_\_\_\_\_

**TOTAL** \_\_\_\_\_

(Note: In the Philippine context, “pay beds” are usually found in single or private and semi-private rooms. “Service beds” usually refer to ward beds and assigned to different specialties. As this is a sample M&E form only, there can be other classifications that are not seen here. The number of beds per service should be the total of all the beds in these services.)

<sup>1</sup> Modified from Philippines Department of Health Management Monitoring Tool.

## 2. Public–Private Partnership (PPP) Hospital Management Data

### 2.1 PPP Hospital Management Data: General

PPP Hospital Management Name : \_\_\_\_\_

Contract valid until <Date \_\_\_\_\_>

License valid until <Date \_\_\_\_\_>

### 2.2 Summary of Personnel: Please attach.

Are all pharmacists licensed and meet minimum requirements? Yes \_\_\_ No \_\_\_

Based on licensing standards, does it have a complete staffing complement?

Yes \_\_\_ No \_\_\_

### 2.3 Hospital Management Operations

(Note: In the Philippine context, the hospital management operation section may refer to the scorecard. It is a rating system where owners and managers can see how the hospital is faring regarding the different categories of hospital management or operations such as governance, finance, human resources, and other areas.)

## 3. Hospital Scorecard

HOSPITAL SCORECARD		
	YES	NO
<b>I. HEALTH REGULATION AND GOOD GOVERNANCE</b>		
<b>1. Licensing and Accreditation</b>		
License/Permit to operate		
Social insurance or equivalent accreditation		
Specialty/Subspecialty accreditation		
Others (ISO, Joint Commission International, Accreditation Canada, others)		
<b>2. Compliance with Financial Regulations</b>		
Updated funding agency reporting		
Auditing agency recommendations addressed and/or implemented		
Internal financial audit $\geq 2x/yr$		
Government procurement process compliance		
<b>3. Good Governance</b>		
a. Patient welfare		
Facility accessible by public transport		
Efficient triage and prompt attention		
Clean, adequately ventilated waiting areas		
Waiting time within reasonable duration		
Patient recording system allows easy retrieval and continuity of care and avoids duplication and loss		
Anti-red tape processes implemented		
Patient assistance unit resolved $\geq 90\%$ of cases		

<b>HOSPITAL SCORECARD</b>		
	YES	NO
<b>b. Administrative functions</b>		
Risk management (identification, assessment, control)		
Integrity development action plan		
Competency-based promotion program		
Grievance committee resolved $\geq 90\%$ of cases		
Bioethics committee resolved $\geq 90\%$ of cases		
<b>II. FINANCIAL RESOURCE MANAGEMENT</b>		
<b>4. Fund Management</b>		
Working financial plan timely prepared		
Working financial plan implemented within target		
Funds utilized as scheduled		
<b>5. Health Financing (Cost/Patient/Day)</b>		
a. Maintenance and other operating expense (MOOE) per inpatient day = $\frac{\text{MOOE}}{\text{Inpatient days}}$		
b. Budget* per inpatient day = $\frac{\text{MOOE} + \text{sub-allotment} = \text{income utilized for MOOE}}{\text{inpatient days}}$		
c. Total budget* per inpatient days = $\frac{\text{MOOE} + \text{sub-allotment} = \text{income utilized for MOOE} + \text{fiduciary}^*}{\text{inpatient days}}$		
*endowments, trust funds, cash donations, and cash equivalents		
<b>6. Percentage of Subsidized Service =</b>		
$\frac{\text{total cost of service}^* - \text{patient service collection}^{**}}{\text{total cost of services}} \times 100$		
* Total cost of service = total expenses excluding personnel services		
**Patient service collection includes PhilHealth and out of pocket; excludes personnel services		
<b>7. Social Health Insurance Coverage, Reimbursements, and Claims</b>		
a. Percent (%) of patients covered by social health insurance = $\frac{\text{No. of patients covered by social health insurance}}{\text{total discharges}} \times 100$		
b. Percent (%) of social health insurance reimbursement as per operational income = $\frac{\text{social health insurance reimbursement}}{\text{operational outcome}} \times 100$		
*income from day to day operations		
c. Percent (%) social health insurance reimbursement as per charges = $\frac{\text{social health insurance reimbursement}}{\text{total charges of social health insurance patients}} \times 100$		
d. Returned to Hospital (RTH) claims = $\frac{\text{RTH claims}}{\text{total claims}} \times 100$		
<b>8. Property Management</b>		
a. Capital outlay		
Hospital on titled government estate (documents on file)		

<b>HOSPITAL SCORECARD</b>		
	YES	NO
Property Procurement/acquisition according to current government rules, policies, and guidelines		
No condemned building > 3 yrs		
Abandoned unfinished building construction > 5yrs		
<b>b. Property disposal</b>		
Property for disposal (%) = $\frac{\text{depreciation cost of property for disposal} \times 100}{\text{current assesses value of total inventory}}$		
<b>9. Other Sources of Funding</b>		
Income from estate or building (space rental/lease, parking fee)		
School affiliations (medical, nursing, allied health specialties) > 5		
Number of nongovernment organizations (NGOs) providing financial support > 5		
<b>III. SERVICE DELIVERY</b>		
<b>A. Medical Surgical Services and Outcomes</b>		
<b>10. Clinical Departments/Services</b>		
<b>a. Major departments/services</b>		
Internal medicine		
Pediatrics		
Surgery		
Obstetrics and gynecology		
<b>b. Other services/subspecialties</b>		
Anatomical and clinical pathology		
Anesthesia		
Cardiology		
Dental medicine		
Dermatology		
Emergency Medicine		
Endocrinology		
ENT-HNS		
Family medicine		
Hematology		
Gastroenterology		
Geriatrics		
Immunology		
Nephrology		
Neonatology/Perinatology		
Neurology (Neuroscience)		
Neurosurgery		
Nuclear medicine		
Oncology		
Ophthalmology		
Orthopedics		
Pediatric surgery		

HOSPITAL SCORECARD		
	YES	NO
Plastic and reconstructive surgery		
Pulmonary medicine		
Psychiatry		
Radiology and other imaging services		
Radiotherapy		
Rehabilitative and occupational medicine		
Rheumatology		
Toxicology/Detoxification		
Tropical and infectious diseases medicine		
Urology		
<b>11. Occupancy Rate</b>		
a. Based on authorized bed capacity		
b. Based on implementing bed capacity		
<b>12. Average Length of Stay*</b>		
*excluding psychiatric/custodial cases		
<b>13. Percent (%) Discharged, Improved, and Recovered Patients</b>		
$\frac{\text{number of discharged, improved, and recovered}}{\text{total discharges}} \times 100$		
*total discharges refers to all discharges regardless of outcome		
<b>14. Death Rates:</b>		
a. Gross death rate	$\text{Gross death rate} = \frac{\text{all deaths}}{\text{total discharges}} \times 100$	
b. Net death rate (1 point)	$\text{Net death rate} = \frac{\text{all deaths} > 48 \text{ hrs}}{\text{total discharges} - (\text{deaths} < 48 \text{ hrs})} \times 100$	
c. Maternal death rate (0.5 pt)	$\text{Maternal death rate} = \frac{\text{maternal death rate}^*}{\text{total obstetrics discharges}} \times 100$	
*includes deaths during pregnancy and within 42 days after delivery		
*includes deaths during pregnancy and within 42 days after delivery		
d. Infant death rate (0.5 pt) (deaths up to 1 year of age)		
Formula 1:	$\text{Infant death rate} = \frac{\text{all deaths of infants}^*}{\text{total discharges}} \times 100$	
Formula 2:	$\text{Infant death rate} = \frac{\text{all deaths of infants}^*}{\text{total infant discharges}} \times 100$	
e. Neonatal death rate (deaths up to 28 days)		
Formula 1:	$\text{Neonatal death rate} = \frac{\text{all deaths up to 28 days}}{\text{total discharges}} \times 100$	
Formula 2:	$\text{Neonatal death rate} = \frac{\text{all deaths up to 28 days}}{\text{total neonatal discharges}} \times 100$	

HOSPITAL SCORECARD		
	YES	NO
<b>B. ANCILLARY SERVICES</b>		
<b>15. Pharmacy Service</b>		
a. Pharmacy management		
Generics Act and Cheaper Medicines Act implementation		
Licensed pharmacist(s) available 24/7		
Proper medicine storage (air conditioned, no direct sunlight)		
Annual review and update of in-house formulary		
No expired medicines		
b. Pharmacy counter throughout		
Formula 1:	$\frac{\text{total number of filled prescriptions} \times 365}{\text{number of pharmacy personnel}}$	
Formula 2:	$\frac{\text{average number of daily prescriptions}}{\text{number of pharmacy personnel}}$	
c. Unfilled prescriptions		
	$\frac{\text{total filled prescriptions} \times 100}{\text{total prescriptions}}$	
<b>16. Diagnostic and Other Ancillary Services:</b>		
a. Radiologic sciences and other diagnostic imaging		
X-ray		
Fluoroscopy		
Ultrasound		
CT scan		
Magnetic resonance imaging (in-house and outsourced services)		
b. Laboratory service capability		
Tertiary level clinical laboratory		
Direct Observation Treatment Short Course center		
Drug-testing unit		
Routine histopathology		
Needle aspiration biopsy service		
Frozen section biopsy service		
Immunochemistry (in-house or outsourced)		
Autopsy service (in-house or outsourced)		
c. Laboratory daily throughout		
	$\frac{\text{total number of procedures}^*}{\text{total number of laboratorial staff}^{**}} / \text{day}$	
*Total number of procedures = anatomic + clinical pathology procedures		
**Includes pathologists, lab aides, morticians; excludes clerical staff		
d. External quality assurance program (EQAS)*		
Bacteriology		
Chemistry		
Hematology		
*If not done annually, use the latest EQAS in a particular section		

<b>HOSPITAL SCORECARD</b>		
	YES	NO
<b>17. Blood Bank Service</b>		
a. Blood bank capability		
EQAS most recent rating: excellent, very good, or passed		
Rational Blood Use Act implemented		
Mass blood donation monthly (MBD)		
Blood center		
b. Voluntary blood donation		
% Voluntary donors = $\frac{\text{number of voluntary donors}}{\text{total number of donors}} \times 100 =$		
*Directed and nondirected pre-transfusion and replacement donors		
c. Blood utilization		
% Blood utilization = $\frac{\text{No. of units of red blood cells (RBC) served} \times 100}{\text{number of blood units collected}}$		
d. Packed red cell: White blood (WB) ratio (0.3 pt)		
Pack red cell: WB ratio = $\frac{\text{No. of units of packed red blood cells (PRBC) served}}{\text{No. of units of WB served}}$		
<b>18. Social Service</b>		
a. Percentage of classified patients within 24 hours		
$\frac{\text{number of patients classified within 24 hours} \times 100}{\text{total inpatients}}$		
b. Percentage of patients counseled*		
$\frac{\text{number of counseled patients} \times 100}{\text{total inpatients}}$		
* patients requiring psychosocial counseling and follow-up		
c. Percentage of patients provided financial assistance		
$\frac{\text{number of patients provided financial assistance} \times 100}{\text{total patients classified}}$		
<b>IV. PATIENT SAFETY</b>		
<b>19. Safety Precautions</b>		
a. Patient and personnel precautions		
Protective gear (gowns, masks, gloves)		
All patients properly identified		
Correct specimen collection, labeling, transfer, and storage		
Proper handling and disposal of secretions and other biohazards (infectious, toxic, or radioactive-contaminated substances)		
Isolation/reverse isolation precautions		
b. Safe medications, materials, and reagents		
Therapeutics committee meets regularly		
Updated antibiogram		
Updated material safety data sheet (MSDS)		
Guidelines on materials reuse (instruments, containers)		
No expired reagents and supplies		
c. Equipment safety		



<b>HOSPITAL SCORECARD</b>		
	YES	NO
All medical equipment in good working condition		
Preventive maintenance, calibration, and controls done by qualified personnel		
<b>20. Sentinel Events</b>		
All medication errors timely managed and reported		
No bed fall		
No needle prick injuries		
No slipping accident		
<b>21. Adverse Events</b>		
All adverse drug reactions timely managed and reported		
All transfusion reactions timely managed and reported		
<b>V. CONTINUING QUALITY IMPROVEMENT</b>		
<b>22. Continuing Quality Improvement Program</b>		
Clinical practice guidelines, pathways, and flow charts in all units		
Regular audits (medical, nursing, administrative)		
<b>23. Comprehensive Quality Nursing Care</b>		
Number of needs per critical care nursing staff per shift $\geq 3$		
Number of supervising nurses per shift $\geq 4$		
Daily ward inspection by supervisor		
All charting and documentation completed at end of shift		
Daily patient hygiene and interaction		
<b>24. Engineering and Motor Pool Preventive Maintenance</b>		
Periodic infrastructure preventive maintenance and repairs		
All office equipment in good working condition		
All ambulances in good running condition		
All other transport vehicles in good running condition		
<b>25. Customer–Institutional Relations</b>		
Quarterly collation of patient satisfaction survey $\geq 75\%$		
Quarterly collation of personnel satisfaction survey $\geq 75\%$		
Amicable and collaborative relationship with local government		
Citation or recognition by a patient advocacy group		
<b>VI. CLEAN AND SAFE ENVIRONMENT</b>		
<b>26. Cleanliness and Orderliness</b>		
Daily housekeeping		
Adequate bathing and washing facilities		
Gender sensitive sanitary toilets with provisions for children		
No undue pollution (noise, smoke, dust, foul odor)		
<b>27. Hospital-Acquired Infection</b>		
Hospital acquired infection (HAI)* rate		
$\frac{\text{number of HAI}}{\text{number of inpatients}} \times 100$		
*nosocomial, health facility-acquired, or health care-associated infection		

<b>HOSPITAL SCORECARD</b>		
	YES	NO
<b>28. Safe Water and Proper Waste Management</b>		
Safe drinking water		
Adequate water supply for washing and bathing		
Alternative water supply		
Quarterly water analysis		
Proper waste management (segregation, recycling, disinfection, proper disposal)		
Sewage treatment plant		
<b>29. Hospital Disaster Preparedness and Response</b>		
a. "Hospital Safe from Disaster" Program		
Accessible and safe location (public transport, directional signage, peace and order in vicinity)		
Visible signage in strategic places		
Functional infrastructure (grills, ramps, adequate emergency exits, wide stairs and corridors free from obstructions)		
Emergency power source for high-risk areas (generator, emergency lights with backup battery)		
b. Disaster preparedness and response protocol (for fire, earthquake, typhoon, flood, epidemics, power shortage)		
Fire safety/earthquake precautions (fire safety cabinets, no electrical wire overloading, fire extinguishers in every unit, fire water reservoir, fire and smoke detection system, sprinkler system, illuminated exit signs)		
Feasible containment and evacuation plans		
Training and capability-building exercises (drills 1–2x/yr)		
Functional organizational structure (coordinator, marshals, evacuation team, fire brigade)		
Logistics management budget provisions		
<b>VII. EDUCATION, TRAINING AND RESEARCH</b>		
<b>30. Manpower Development and Training</b>		
Staff development program—quarterly in-house activities		
Mandatory pre-employment orientation and training		
Continuing medical education (in-house postgraduate courses)		
≥85%of graduate residents pass specialty board examination(s)		
All residents' score ≥75 in in-service examinations		
<b>31. Public Health Education and Advocacy</b>		
Patient/Caregiver counseling (Mothers' Class, Diabetics Club)		
Posters in strategic places		
Lay seminar/workshop/lectures 2x/year		
Video presentations in public places (e.g., outpatient department waiting areas)		
Mass media (television, radio advocacy programs)		
<b>32. Research</b>		
Staff's initiative in-house research ≥1/yr		
Participates in interhospital/interagency research projects		
Health system research adapted by hospital ≥1/yr		

<b>HOSPITAL SCORECARD</b>		
	YES	NO
Trainees' research output = 1 research/resident		
Research read or published in international or local forum* ≥50%		
*includes in-house scientific paper presentation		
<b>VIII. INNOVATIVE PROGRAMS</b> (Projects that improve hospital operation or service delivery, introduce care using good clinical practices, and thus serve as pilot and model for other institutions). List any innovative programs and assign one point per project; maximum of 3 items.		

# Annex 13

## Case Profiles of Public–Private Partnerships in Hospitals and Hospital Management Projects

This section profiles two public–private partnership (PPP) projects in hospitals and hospital management. The third case profile shared here, while not strictly a case study on a particular hospital, gives a very insightful analysis on PPP in hospitals in São Paulo, Brazil.

### Case Profile 1: Royal Women’s Hospital, Australia<sup>1</sup>

The new Royal Women’s Hospital was officially opened by Victorian Premier John Brumby in July 2008, marking the beginning of the next phase of this successful Public–Private Partnership (PPP) Project.

Bilfinger Berger Project Investments leads the private sector Royal Women’s Health Partnership (RWHP) consortium which has financed, designed, built and will now maintain the A\$250 million Melbourne hospital for the next 25 years. RWHP also includes builder Baulderstone Hornibrook and Facilities Manager United Group Services.

The Project is a prime example of the benefits of the PPP process.

“This is a model PPP Project: delivered on time and on budget,” explains Bilfinger Berger Project Investments’ Project Director, Graham Whitson. “Its success is a direct result of Bilfinger’s model of active leadership and partnership approach. We have been leading the consortium since the early tender phase and will continue to be involved over the long term

operation phase of the Project. This is our strategy on all our 22 PPP projects worldwide.”

The Project has

- been awarded a number of international Project Finance awards since 2005,
- accommodated over 600 design changes, at no extra cost,
- consulted with stakeholders and users through the project phases, and
- incorporated an extensive commissioning and transition process for staff and users.

The PPP process will mean that the hospital staff can focus on provision of clinical care and patient outcomes, while the private sector ensures the appropriate maintenance of infrastructure for long-term use.

The 160-bed nine-storey specialist hospital for women and newborn babies includes a 5-level underground carpark and a new 88-bed Frances Perry House private hospital. It will provide world-class facilities and deliver high-quality patient services in a family friendly and homely environment. It includes 50% of all rooms as single bed rooms, large birthing suites and an innovative interior design, based on extensive stakeholder consultation.

Approximately 12,000 operations and 11,000-day procedures will be performed in the hospital each year, while an extensive range of outpatient, women’s health, pregnancy day-care and breastfeeding education, and support services will be provided.

<sup>1</sup> Bilfinger. Royal Women’s Hospital Project Profile. [www.pi.bilfinger.com/projects/by-region/australia/royal-womens-hospital](http://www.pi.bilfinger.com/projects/by-region/australia/royal-womens-hospital); and State Government of Victoria, Department of Human Services. 2008. *World Class Royal Women’s Hospital Opens*. Victoria, Australia. [www.health.vic.gov.au/archive/archive2010/humanservicesnews/jul08/open.htm](http://www.health.vic.gov.au/archive/archive2010/humanservicesnews/jul08/open.htm)

## Case Profile 2: Teaching Hospital in Kuantan, Malaysia<sup>2</sup>

With 300 beds and capacity for 735 students, this impressive new facility will feature various medical disciplines including surgical and medical subspecialties such as internal medicine, surgery, oncology, cardiology, neuroscience, obstetrics, gynecology and pediatrics. It will also serve as the primary clinical and tertiary facility for the Medical Faculty of the International Islamic University Malaysia's (IIUM) teaching hospital.

The IIUM is being developed by Peninsular Medical SdnBhd (PenMedic), a wholly-owned subsidiary of Ahmad Zaki Resources Berhad (AZRB).

After an open tender in May 2010 issued by the Public Private Partnership Unit (3PU), a unit under the Prime Minister's Department, AZRB was awarded the contract in September 2011. Under the 25-year concession, PenMedic will build the hospital within 3.5 years and maintain it for 21.5 years, with the responsibility for design, build, lease, maintenance and transfer, as well as asset management services.

Building work was expected to begin in January 2012 and completion expected in 2015, after which Malaysia's Ministry of Higher Education and IIUM will pay PenMedic the construction cost and maintenance services through monthly availability charges and asset management services charges.

## Case Profile 3: Public–Private Partnership in Hospitals in São Paulo, Brazil<sup>3</sup>

In the late 1990s the state of São Paulo was completing construction of a number of new hospitals in underserved poor neighborhoods. State authorities faced a dual challenge. First, they wanted to avoid the governance problems—particularly

the lack of incentives and accountability for performance—widespread in directly managed public hospitals operated by the State. São Paulo considered this a low-performing and unworkable hospital governance form.

Second, although they envisioned a reform model endowing hospital management with greater autonomy, they were concerned about developing effective accountability arrangements via contracting. In particular, they wished to avoid the shortcomings of existing contracting arrangements for private hospitals. As practiced, contracting was passive and poorly managed, and there was no accountability. The contract was a weak form of contract management referred to as an “agreement” (*convenio*), which is a legal arrangement to distribute budgets to private hospitals traditionally, and often politically, linked to the public system. The only requirement was to provide information on service volume for payment purposes.<sup>4</sup> Performance targets, however defined, were not specified.

### A public–private partnership model to improve governance

The São Paulo government opted to turn over the new hospitals to private nonprofit operators to address the problems described above. The PPP model it chose included an open competition to identify the best operators to take over the facilities.<sup>5</sup> The winning operator would enter into a 5-year renewable operating contract with performance specifications, which in turn were linked to payments.

The contractual agreement specified provisions regarding the use and maintenance of the newly built facility by the operator. Bidders were required to organize their operations as nonprofit social organizations, or *organizações sociais de saúde* (OSSs)—a new form of “public interest” organization created by law in 1998. Significantly, the OSSs were incorporated under civil law, which made them

<sup>2</sup> PricewaterhouseCoopers. 2012. *Build and Beyond: Bridging the Gap: Meeting the Challenges of Healthcare Development in South East Asia*. [www.pwc.com.au/industry/healthcare/assets/Bridging-the-gap-Feb12.pdf](http://www.pwc.com.au/industry/healthcare/assets/Bridging-the-gap-Feb12.pdf)

<sup>3</sup> La Forgia, G., and A. Harding. 2009. Public–Private Partnerships and Public Hospital Performance in São Paulo, Brazil. *Health Affairs*. 28(4). pp. 1114–1126. <http://content.healthaffairs.org/content/28/4/1114.full>

<sup>4</sup> Government uses a treatment- and procedure-based rate system to pay private hospitals. Hospitals report admissions per procedure group and additional services provided beyond a standard package.

<sup>5</sup> During the early years of reform implementation, selection of operators was through a semicompetitive process involving certification by the state.

legally independent and therefore not bound by public contracting, civil service, or procurement laws. Because only nonprofit organizations could bid, operators are universities and philanthropic organizations that already operate other hospitals.<sup>6</sup>

Between 1998 and 2005 São Paulo ran competitive bidding for 16 new facilities. The facilities are general hospitals, averaging 200 beds and offering basic specialties: surgery, gynecology and obstetrics, internal medicine, pediatrics, and psychiatry. All maintain intensive care and neonatal units. Each facility offers emergency care, and most provide outpatient care. All are located in low-income neighborhoods in heavily urbanized municipalities on the periphery of the City of São Paulo.

Because the operators are private, they naturally have full managerial autonomy in decision making on inputs, managerial processes, and the day-to-day operations of public facilities.<sup>7</sup> They are held accountable to the state government (and their boards) via performance contracts. The state has surrendered hierarchical control and direct management of tasks such as human resource management and input procurement. It assumes more arm's-length responsibilities related to contract negotiation, management, and performance monitoring.

## Results: Impact on Efficiency and Quality

### Efficiency

PPP hospitals are markedly more efficient, performing better than the unreformed hospitals in a number of areas, including bed turnover rate (annual number of discharges per bed), bed substitution rate (average number of days a bed remains unoccupied between patients), bed occupancy, and length of stay (Exhibit 1). As measured by discharges per bed, the PPP hospitals were significantly more productive for general ( $p < 0.01$ ), surgical ( $p < 0.05$ ), and clinical

( $p < 0.05$ ) discharges. Discharges in obstetrics/gynecology (OB/GYN) departments per bed were higher, but only marginally significant ( $p < 0.10$ ). The group comparison study revealed that, consistent with international best practices, PPP hospitals use about one-third fewer physicians (full-time equivalent;  $p < 0.05$ ) and one-third more nurses (full-time equivalent;  $p < 0.10$ ) than directly managed facilities. This more appropriate staff mix likely contributes to these efficiency findings.

The Data Envelopmental Analysis results confirm those from the comparative evaluation. PPP hospitals were found to be significantly more efficient than directly managed hospitals. In fact, the latter require approximately 60% more resources than the PPP hospitals to produce a comparable output.

*(As this material had been lifted from a study by La Forgia and Harding, many sections have not been shared here, for brevity. The following part summarizes the findings.)*

### Key reform ingredients

This reform merits attention from policy makers seeking to improve performance of public hospitals. The PPP-based model enabled a clear separation of financing from provision of care in a way that allowed the government to move from being a “dumb provider” to a “smart purchaser.” The reform allowed private, nonprofit organizations to assume management of all operational aspects of public hospitals. Although the property and physical assets remained public, and PPP facilities serve “public” patients residing in poor neighborhoods where the facilities are located, provision is private and funded under contractual agreement with the State of São Paulo. The mission of the public hospitals remains intact.

Although the public mission (and ownership) was preserved, the structures, governance, and financing systems of traditional government-operated

<sup>6</sup> State Law 846, Chapter 1, Article 1. Selection criteria included at least 5 years' experience in operating a hospital and possession of a governance board.

<sup>7</sup> A table summarizing the characteristics of hospitals is available as an online supplement at <http://content.healthaffairs.org/cgi/content/full/28/4/1114/DC1>

## Exhibit 1 Comparison of Selected Quality and Efficiency Indicators, Hospitals under OSS and Direct Administration Arrangements, São Paulo State, Brazil, 2003

Indicator	PPP hospitals (N = 12)	Directly managed hospitals (N = 12) <sup>a</sup>
	Mean	Mean
Quality		
Mortality rate		
General*	3.3	5.3
Surgical*	2.6	3.6
Clinical	11.6	12.0
Pediatric		2.6
Efficiency		
Descriptive statistics		
Bed turnover rate***	5.2	3.3
Bed substitution rate***	1.2	3.9
Bed occupancy rate**	81	63
Average length-of-stay**	4.2	5.4
Average length-of-stay (surgery)*	4.8	5.9
Discharges per bed		
General***	60	46
Surgical**	71	44
Clinical**	86	53
OB/GYN* (n = 20)	96	58
Hours (full-time equivalent) <sup>b</sup>		
Physician**	143	203
Nurse	54	41
Auxiliary	234	257
Annual spending (thousands of reais)		
Per bed	177	187
Per discharge**	2.9	4.3

Notes: OSS is *organizações sociais de saúde* (nonprofit health organization). PPP is public–private partnership. OB/GYN is obstetrics/gynecology.

<sup>a</sup> For descriptive statistics and hours, n = 10.

<sup>b</sup> Total hours divided by 40.

\* $p < 0.10$  \*\* $p < 0.05$  \*\*\* $p < 0.01$ .

Source: La Forgia, G. and B. Couttolenc. 2008. *Hospital Performance in Brazil: The Search for Excellence*. Washington, DC: World Bank.

hospitals were radically altered. The PPP model applied a set of alternative arrangements that, taken together, fashioned an environment of performance-oriented incentives and accountability. Managers responded through applying more effective managerial processes to human resources, procurement, and financial management. This in turn contributed to higher production, productivity, and quality, and to lower unit costs than in traditional public hospitals.

Our research suggests that the entire package of governance reforms is necessary and needs to be durable. We identify five essential, closely linked components of this package.

- (i) **Autonomous authority.** This has three aspects. First, autonomy gave managers the decision-making authority to run their facilities. Managers are free to manage their budgets and inputs (human resources, drugs, and supplies) as they see fit to meet performance targets. The second aspect entailed protecting facilities from political interference. Finally, the OSS (or its board) is entrusted with fiduciary responsibility and provides oversight of operations while safeguarding against political meddling.
- (ii) **Flexible human resource management.** Most public hospital staff in Brazil are civil-service employees. Rigid rules govern all human resource processes. The PPP model freed the hospitals from these rigidities. Managers made use of the flexibility of private contract law to recruit qualified personnel who fit the organizational culture. They also displayed a willingness to dismiss nonperforming personnel.
- (iii) **Strategic purchasing.** The management contract and performance-based financing were key ingredients of the robust accountability framework. The state government

used both as a means to implement “intelligent purchasing.”<sup>8</sup> Contractual terms defined hospitals’ roles and responsibilities, preserved their public mission, conveyed physical plant and equipment to the OSS, stipulated payment, and specified service types and corresponding performance targets and reporting requirements. Linking financing to contractual terms created strong incentives for compliance with performance targets.

- (iv) **Contract monitoring and enforcement.** Weak contract management has been the “Achilles’ heel” of PPPs in developing countries.<sup>9</sup> The state established three main monitoring mechanisms: a contract-management unit that reviews and analyzes hospital data and negotiates budgets with PPP hospitals; annual audits conducted by the State’s Comptroller General; and an independent Commission that reviews contract compliance annually. But contracts are meaningless unless enforced. The State has shown a willingness to enforce contractual provisions by not increasing the budget of any hospital in deficit, withholding funds from facilities that fail to achieve performance targets or fulfill reporting requirements, and canceling a contract for a persistent nonperformer.
- (v) **Information and transparency.** Information flows underlie financing, purchasing, contract monitoring, and enforcement. Over time, the state established a robust process for managing information flows. In addition to mandating information systems, the state pioneered the use of standardized cost-accounting systems in PPP facilities. Using costs as a basis of budget negotiations is revolutionary for the public sector in Brazil. Finally, the State places much information in the public domain.

<sup>8</sup> Preker, A. 2005. Managing Scarcity through Strategic Purchasing of Health Care. In Preker, A., and J.C. Langenbrunner, eds. *Spending Wisely: Buying Health Services for the Poor*. Washington, DC: World Bank. pp. 23–46; and State Law 846, Chapter 1, Article 1. Selection criteria included at least 5 years’ experience in operating a hospital and possession of a governance board.

<sup>9</sup> La Forgia, G., P. Mintz, and C. Cerezo. 2005. Is the Perfect the Enemy of the Good: A Case Study on Large Scale Contracting for Basic Health Services in Rural Guatemala. In La Forgia, G., ed. *Health Systems Innovations in Central America: Lessons and Impacts of New Approaches*. Washington, DC: World Bank. pp. 9–48; and Loevinsohn, B., and A. Harding. 2005. Buying Results? Contracting for Health Service Delivery in Developing Countries. *The Lancet*. 366(9486). pp. 676–681.



### *Insights for other developing countries*

Governments in Moscow, Mumbai, Manaus, and many other places face similar problems, and sources of problems, in their public hospitals. As in Brazil, the problems are often grounded in rigid and politicized governance arrangements. Many have attempted to improve hospital performance without addressing this underlying problem, with almost universally disappointing results. For these countries, the Brazilian PPP model is well worth considering.

This model requires the establishment of a long-term contract covering hospital services, which involves public officials in new and complex performance monitoring and verification. Many countries, especially low-income countries, would find this element of the reform challenging. Furthermore,

the São Paulo reform allowed only nonprofit organizations to run PPP hospitals. These organizations have social missions more closely aligned with the government's goals in the sector; thus, this choice was seen as reducing opportunism as well as being politically palatable. OSSs, unfortunately, have little access to capital, so this PPP model could not be used to expand capital in the sector. Even if capital is not a goal, many countries might not have a vibrant nonprofit hospital sector, which would limit the application of this model. Furthermore, the Brazilian PPP model has been evaluated only when applied to new hospitals, leaving open the question of how it would work with existing public hospitals—which constitute the bulk of the hospital sector in developing countries. However, we may learn more soon, since the state of São Paulo and a municipality in that state recently moved to apply the model to two existing hospitals.

## Guidebook on Public–Private Partnership in Hospital Management

The Universal Declaration of Human Rights proclaims that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.” The guarantee of good health for its people is therefore every government’s aspiration. Public–private partnerships (PPP) in health offer effective and sustainable solutions where the private sector and government can work together to bring long-term benefits to the people.

This guidebook offers readers a guide for the development of a PPP in hospital management through six simple, customizable steps. It looks at hospital management as an important component of well-rounded health care systems. Through PPPs in hospital management, people will have increased access to effective, affordable, and compassionate health care services.

### About the Asian Development Bank

ADB’s vision is an Asia and Pacific region free of poverty. Its mission is to help its developing member countries reduce poverty and improve the quality of life of their people. Despite the region’s many successes, it remains home to two-thirds of the world’s poor: 1.7 billion people who live on less than \$2 a day, with 828 million struggling on less than \$1.25 a day. ADB is committed to reducing poverty through inclusive economic growth, environmentally sustainable growth, and regional integration.

Based in Manila, ADB is owned by 67 members, including 48 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance.

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