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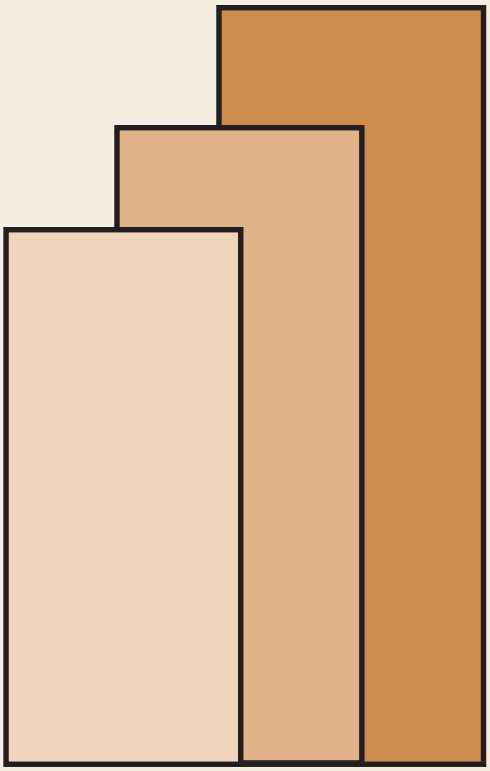
Eduardo P. Banzon et al.

DISCUSSION PAPER SERIES NO. 2014-49



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Assessing the Feasibility of Public-Private Partnerships in Health in the Philippines

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Abstract

The government has decided to utilize the Public-Private Partnership (PPP) Program, to help improve access to quality hospitals and health care facilities. This paper will look into the feasibility of implementing PPPs in the health sector. Review of literature, key informant interviews (KII) and focused group discussions (FGDs) were conducted for the study. The Philippine hospital system was reviewed using five performance criteria, namely improved health care access, equity, and quality, operating with maximum efficiency, and ensuring sustainability followed by the development of an assessment framework; the application of the said framework; and policy and program implementation recommendations for health PPPs.

In order to improve the feasibility of PPPs in the health sector, it is recommended that the government uses Public Private Investment Partnerships (PPIPs) as the definition for health PPPs, encourage public policy discussions on PPP and its relation to socio-economic development, and develop a comprehensive communications program for PPPs. It needs to rectify shortcomings in previous PPPs; and ensure absolute transparency and accountability in the entire PPP process. There is a need to amend the legal framework to ensure coherence of health PPPs. It should conduct joint capacity building initiatives; and develop and enforce an evidence-based decision making process for PPPs. It needs to strengthen implementation of monitoring and evaluation; and utilize the health system indicators in evaluation of PPPs. Finally, it should ensure universal PhilHealth membership to attract private sector.

Keywords: health, PPP, public private partnerships, public private investment partnerships, public private interactions

EXECUTIVE SUMMARY

The government has decided to utilize the Public-Private Partnership (PPP) Program, to help improve access to quality hospitals and health care facilities. This paper will look into the feasibility of implementing PPPs in the health sector. Review of literature, key informant interviews (KII) and focused group discussions (FGDs) were conducted for the study. The Philippine hospital system was reviewed using five performance criteria, namely improved health care access, equity, and quality, operating with maximum efficiency, and ensuring sustainability followed by the development of an assessment framework; the application of the said framework; and policy and program implementation recommendations for health PPPs.

In the Philippines, hospitals care can be physically inaccessible, particularly in the rural and poorer areas of the country due to the concentration of both public and private hospitals in developed areas brought about in part by the lack of a national hospital development plan. And while the enrollment of Filipinos in the Philippine Health Insurance Corporation (PhilHealth) has reduced financial hardships for patients undergoing hospital care; informal payments to doctors, varying prices of diagnostics and treatment, and non-compliance to the "no balance billing" or NBB policy continue to hound patients. NBB policy requires hospitals and doctors not to charge or bill PhilHealth member-patients over and above their PhilHealth payments or reimbursements and this was designed to ensure no out-of-pocket payments from the PhilHealth member-patients.

There is continuing quality concerns with equipment and facilities of government hospitals often decrepit and in a pitiful state that contribute to the public's negative perception of government hospitals. Generally, hospital equipment does not undergo maintenance, leading to full depreciation in a much shorter time frame. Quality of equipment is largely dependent on procurement, with suppliers providing warranties, installation, and maintenance only upon explicit inclusion in technical specifications. Indeed, inefficiency at the hospital level is usually related to financial procedures – procurement and budgeting in particular.

The following factors were determined as enabling factors in implementing PPP initiatives: a.) Contextual Framework, b.) Mutual Trust, c.) Policy and Regulatory Framework, d.) Institutional Framework, e.) Contract Management, and f.) Monitoring Framework. These enabling factors will comprise the assessment framework to determine the general feasibility of health PPPs.

The government justifies the policy paradigm of Public-Private Partnerships utilizing the social contract to provide access to health care and constitutional role of the private sector as a partner of the state. Indeed, the Department of Health (DOH) seeks to expand universal health care through PhilHealth and PPPs with PPPs expected to help hospitals be efficient and affordable. Unfortunately, these benefits are unknown to civil society, resulting in significant opposition from labor unions, patient groups, and health professionals.

The generation of mutual trust has been affected by accusations of corruption and arbitrarily ending contracts that had affected other PPP projects although the overall trust of the private sector in government is steadily increasing. There is a transparent and open policy and regulatory framework for PPP with the legal framework for the PPP program mainly based on the Amended Build-operate-transfer (BOT) Law (RA 7718). However, it has been argued that the BOT Law does not explicitly allow provision of clinical services as only infrastructure operations are included and not services such as hospital services.

DOH is considered a PPP implementing agency and has created a specific office for PPPs – the Center for Excellence in PPPs in Health (CE3PH). PhilHealth is presently not an active part of the

institutional framework and there is no regulatory body for health PPPs. CE3PH is a multidisciplinary team, composed of finance analysts, economists, lawyers, BOT specialists, information technology, engineering, and architecture experts. Although the high turnover of staff has reduced its overall effectiveness, CE3PH has more than adequately done scoping, contract structuring, and procurement management. It also conducts the monitoring and evaluation based on the Minimum Performance of Standards and Specifications (MPSS) manuals. The Commission on Audit (COA) retained the responsibility of auditing. Nonetheless, there is a need for the DOH to further market PPPs socially and legally acceptable in the health sector.

In order to improve the feasibility of PPPs in the health sector, it is recommended that the government uses Public Private Investment Partnerhships (PPIPs) as the definition for health PPPs, encourage public policy discussions on PPP and its relation to socio-economic development, and develop a comprehensive communications program for PPPs. It needs to rectify shortcomings in previous PPPs; and ensure absolute transparency and accountability in the entire PPP process. There is a need to amend the legal framework to ensure coherence of health PPPs. It should conduct joint capacity building initiatives; and develop and enforce an evidence-based decision making process for PPPs. It needs to strengthen implementation of monitoring and evaluation; and utilize the health system indicators in evaluation of PPPs. Finally, it should ensure universal PhilHealth membership to attract private sector.

OVERVIEW

The Philippine population has rapidly grown in the past decade with at least a fifth of the population still living in poverty as shown by the 2012 Family Income and Expenditure Survey (FIES)) estimates of a national poverty incidence among families at 22.3% with poverty rates as high as 46.9% in Autonomous Region of Muslim Mindanao (ARMM), and as low as 3.8% in National Capital Region (NCR) (National Statistics Coordination Board (NSCB), 2013).

The Philippine government spends only 3.6% of its gross domestic product (GDP) on health while continuing to use household out-of-pocket payments to fund over half of total health care expenditures. Although the 2011 Philippine National Health Account (NHA) report showed health benefit payments from the Philippine Health Insurance Corporation (PhilHealth) increasing by 15.1% and national government spending on health growing from PhP43.4 billion in 2010 to PhP 53.1 billion in 2011, out of pocket payments still accounted for more than half of the total health expenditures of the country (NSCB, 2013).

The devolution of the provision of public health care services to local government units (LGUs) by the Local Government Code of 1991 did provide space for LGUs to mobilize resources and undertake innovative approaches in addressing health-related problem but it has also fragmented health services, broke down the referral system, and varied the quality of health governance among the different LGUs and resulted to wide differences in spending for health, and comprehensiveness of services provided as local health systems were subjected to local health funding priorities and local-level political decisions.

Indeed, increasing population, persistent poverty and widening income gap exacerbated by inadequate government financing and the differential prioritization of health by devolved local governments had contributed to the failure of the government primary health care and hospital infrastructure to match the growth of the population (Department of Health (DOH), 2011).

In response, the national government decided to support the revitalization and rehabilitation of national and local government health units and through the Health Facilities Enhancement Program (HFEP); and the leveraging of expanded National Health Insurance Program (NHIP) enrolment and benefits to sustainably finance operations of government health facilities.

In addition to HFEP and NHIP, the government decided to utilize one its banner projects, the Public-Private Partnership (PPP) Program, to help fund the repair, rehabilitation and construction of selected priority health facilities in order to provide improved access to quality hospitals and health care facilities. PPPs will be one of the means to augment health services delivery in areas that currently have inadequate access to needed health services. PPPs are expected to improve the efficiency and thus lower the costs of delivering health services. In the process, the improved and expanded service delivery would redound to improved health outcomes. PPPs will help address issues of lack of resources, administrative roadblocks and inadequate management capacity. Bringing in the expertise and efficiency of the private sector are expected to significantly contribute in improving health outcomes.

OBJECTIVES

The objective of this paper is to study the feasibility of implementing PPPs in health.

Specifically, the study shall:

1. undertake an environmental scan of the prospects of PPP in the health sector

2. identify minor opportunities for PPP in DOH and LGU health facilities. These could be small-scale opportunities such as outsourcing (ancillary services in health centers hospitals), drug consignment, co-location schemes, networking and sharing of equipment, and the like.

3. identify major opportunities for PPP in DOH and LGU health facilities. These could be medium- to large-scale opportunities such as long-term leasing, concessions, build-operate-transfer schemes, hospital management contracting, health/clinical service contracting, joint ventures, and the like.

4. identify current constraints at the policy and programmatic level, and to sketch out a strategy of easing these constraints.

METHODOLOGY

A thorough literature search was undertaken using three search strategies, namely: filter/automated, manual, and ancillary search, to limit the scope of PPPs in the health sector, review best practice PPPs, identify enabling and disabling factors for PPPs, and to develop a feasibility assessment framework for the PPPs in health in the Philippines.

The desk review enabled a comprehensive stakeholder mapping; thereafter, key informant interviews (KII) and focused group discussions (FGDs) were conducted amongst key stakeholders to clarify and validate literature reviewed, to accumulate relevant experiences in relation to health PPPs, to enable an analysis of the Philippine PPP policies, to identify major roadblocks in the mainstreaming of PPPs in health, and to provide useful recommendations in expanding the PPPs in health businesses. Purposive sampling was used in the selection of the KII respondents and FGD participants. For the central government offices, those who are directly involved in PPP projects were invited to participate (DOH, PPP Center, and Center for Excellence in PPPs in Health). Local chief executives of LGUs who have participated or expressed interest in PPP projects were also included in the study. Private investors who have partaken in the government's PPP projects and those involved in the health care industry, NGOs, hospital chiefs, health care workers, and patient groups were also invited to participate as study participants. Of those invited for participation, only those who responded and agreed for interviews were included in the study.

Descriptive analysis of the different enabling factors was done to improve the assessment framework and the application of the said framework to identify how government can provide a more enabling environment for PPPs and provide recommendations for enhancing the national policy for health PPPs.

The study was submitted for ethics review with the University of the Philippines - Manila Research Ethics Board who then determined that the study complied with ethical research standards. All respondents and participants in the KIIs and FGDs were asked to sign consent forms that state the voluntary nature of the study, their privacy privileges, and the confidentiality of their participation.

SCOPE and LIMITATIONS

This study discusses the feasibility of Public-Private Partnerships in Health as a strategy to attain universal health coverage in the Philippines. Extensive literature review guided the development of interview and discussion questions. All types of PPP stakeholders were represented in the study. Participants were selected based on their knowledge of and potential or existing involvement with PPPs to varying degrees. However, only those around the greater Metro Manila area were mostly contacted due to

their availability as respondents. Furthermore, only those who agreed to be interviewed were included as study participants. Given the qualitative nature of the study, the responses of the stakeholders may not be representative of the thoughts and opinions of their peers. Caution should be exercised in generalizing the results of this paper.

ENVIRONMENTAL SCAN

The Philippine Hospital System

The hospital system is reviewed utilizing the five performance criteria, originally used by the US Agency for International Development (USAID) in the flagship project Health Systems 20/20, that describes an ideal health system would provide improved health care ***access, equity,*** and ***quality***, operating with maximum ***efficiency***, and ensuring ***sustainability.***

Access and equity overlap in the physical and financial aspects – physical access is the ability of a population to utilize health services based on geographical locations of hospitals; financial access is concerned with the availability of affordable health care, either for persons with the same need (horizontal equity) or persons with varying needs (vertical equity).

Quality, the third indicator, is determined by the fulfilment of patients' explicit and implied needs. The former can be measured by health indicators, as well as the actual conditions of health facilities, equipment, and personnel. Implied needs are largely perceptive, gauged by the degree of patient satisfaction.

Finally, efficiency and sustainability, which deal with management of resources, are jointly discussed. Efficiency is both distributing resources for maximum benefit to the system (allocative) and acquiring the best value for money (technical). The expected outcome of efficiency is sustainability, both institutionally and financially.

Low physical accessibility and geographical inequity

At present, hospitals care can be physically inaccessible, particularly in the rural and poorer areas of the country. The concentration of both public and private hospitals in developed areas is primarily due to the profit-seeking nature of private hospitals and the lack of a national hospital development plan.

At present, there are 1,824 hospitals in the Philippines, with 729 under public ownership, about 40 percent (Department of Health [DOH], 2012a). Public hospitals are categorized by management, with 70 retained by DOH and the remainder managed largely by Local Government Units (LGUs). Majority of private hospitals operate as for-profit institutions, with a significant concentration in Central Luzon and NCR, regions which are relatively wealthier. Thirty-four percent of all hospital beds are located in the NCR, where 12 percent of the nation's population reside. The establishment of private hospitals in areas with lower poverty rates is commonly seen as a measure to ensure steady income (Lavado, Sanglay-Dunleavy, Jimenez, & Matsuda, 2010).

Whether public or private, hospitals providing higher levels of care are mostly located in highly developed urban centers, whether in NCR or provincial capitals. The archipelagic nature of the country also means that populations of many islands are unable to access emergency health care immediately, and have to travel by boat to reach the nearest hospital. The unstable political situation has also contributed to the inaccessibility in some areas. For instance, the bed to population ratio of the ARMM is 0.17 for every

1000 people, a far cry from national average and the WHO recommendation of 2:1000 (Lavado, Pantig, Rosales, & Ulep, 2011).

The inaccessibility of hospitals due to maldistribution of hospital beds was openly acknowledged by the DOH. Though the DOH proceeded to regulate the establishment of new hospitals, requiring integration of these with provincial hospital development plans, there is no clear indication that provinces actually create and implement such plans (DOH, 2006). The lack of a national hospital development plan, along with the devolution of health care in the 1990s, only served to widen the disparities in access.

Aside from the lack of a national plan to set rational hospital catchments for non-urban areas based on travel time, the DOH was also limited by a lack of budget for capital outlay (CO). The budget process requires the DOH to seek approval from Congress for inclusion of CO for new and existing hospitals in general appropriations, with the building of a single hospital expected to cost between three to five billion (Calleja, 2014). Due to the expense involved, such allotments were highly unlikely to be passed into general appropriations.

Financial inaccessibility and inequity

While the enrollment of Filipinos in PhilHealh has reduced financial hardships for patients undergoing hospital care, formidable obstacles remain. Hurdles in government hospitals include informal payments to doctors, varying prices of diagnostics and treatment, and non-compliance to its "no balance billing" or NBB policy. NBB policy requires hospitals and doctors not to charge or bill PhilHealth member-patients over and above their PhilHealth payments or reimbursements. This was designed to ensure no out-of-pocket payments from the PhilHealth member-patients.

Private hospitals comprise 60 percent of all hospitals in the Philippines with for-profit hospitals competing with each other over specific segments of the market – the ABC socio-economic classes, estimated to be no more than 10% of the entire population (Africa, 2011). This divide between public and private hospitals and the people they provide care to is evident in health facility utilization rates - use of private hospitals increases from 5 percent in the lowest income quintile to 46 percent in the highest quintile (National Statistics Office, 2008).

In the same survey, it was estimated that thirty-nine percent of the population from the first four wealth quintiles visit Barangay Health Centers (BHCs), while 17.7 percent proceed to government hospitals. Only 14 percent of the same population group visit private hospitals (NSO, 2008). The socioeconomic disparity in facility utilization is acknowledged by the DOH, which concluded that the poorest Filipinos are the primary users of government health facilities (DOH, 2010a).

This indicates that private hospitals are utilized primarily by the non-poor, who are more likely to possess PhilHealth membership than patients in public hospitals (Lavado et al., 2010). Yet even if the poor are sponsored PhilHealth members, the aggregate financial support provided may still be inadequate to completely meet hospitalization expenses of the severely ill (Caballes, Söllner, & Nañagas, 2012).

The disparity between the support PhilHealth provides and the actual fees charged by hospitals is largely due to non-enforcement of the No Balance Billing (NBB) scheme, which was implemented begiining in late 2011. As late as July 2013, the NBB policy was reportedly only being implemented in eight DOH hospitals (GMA News Online, 2013). Many LGU hospitals have not yet complied, instead deciding to charge socialized rates for residents and full rates for non-residents (SunStar Iloilo, 2014).

Even in hospitals where the NBB policy is implemented, non-functional equipment and shortages in reagents and medicines may force poor patients to go elsewhere for specific services. The imposition of

informal charges in government hospitals is also a recurring problem, when low-paid health professionals demand a fee from the patient, to be paid directly to them. Furthermore, certain public facilities also continue to charge higher rates due to lack of regulation, passing on costs to patients to ensure commercial viability.

The additional costs incurred are considered part of out-of-pocket expenditures for health. From 2009 to 2013, out-of-pocket spending remained at 53 percent of total health spending, amounting to 83.9 percent of private sub-sector spending (Cetrángolo, Mesa-lago, Lazaro, & Carisma, 2013) signifying the lack of financial access of many to affordable needed health care services.

Perception of low quality in hospitals

Though hospitals had been required to comply with the Hospital Quality Assurance Benchbook since 2002 in order to be accredited or contracted by PhilHealth, equipment and facilities of government hospitals are still often decrepit state. Despite the poor quality of equipment and facilites, clinical indicators in government hospitals are generally within international standards. Nevertheless, the public's negative perception of government hospitals plays a significant decision-making role in patients seeking hospital care.

For the ***clinical*** indicators of quality, the net death rate and net nosocomial infection rate in DOH general hospitals are low (ranges of 0.0-1.43 and 0.0-0.58 respectively, though data is incomplete), and fall well within accepted standards (Bontile, 2013). The two indicators suggest that 72 hospitals under management by the DOH generally have quality clinical outcomes, although there are no existing comparable data on LGU hospitals, as well as data on other clinical indicators such as adverse drug reactions.

Bed occupancy rates and average length of stay (ALOS) are also quality ***service*** indicators in hospitals. For the former, the WHO standard is 80-85 percent. In the Philippines, at least 50 percent of hospitals at all levels exceeded individual bed occupancy rates. Majority of the excess beds are located in Level 1 hospitals, followed by Level 4. This overflow is particularly marked in some Level 4 hospitals, which not only exceed their authorized bed capacity, but also situate patients in hallways. In certain specialty hospitals, multiple patients share one bed (Bontile, 2013).

While national data on average length of patients' stay (ALOS) is unavailable, a study of five tertiary public hospitals pegged the ALOS at an average of 5 days. Obstetrics and gynecology ALOS averaged around 4 days, while pediatrics cases averaged 6 days (Tsilaajav, 2009). This is close to the average ALOS of Asian countries (6 days), although the data may not be comparable. In certain specialty hospitals such as the Philippine Orthopedic Center, the ALOS can be as long as 21 days, as patients seek to acquire funding to self-pay for expensive operations.

Institutionally, the quality of equipment and facilities in government hospitals vary greatly, ranging from from state-of-the-art to run-down. Generally, hospital equipment do not undergo maintenance, leading to full depreciation in a much shorter time frame (Banzon et al, 2014). Usually, the lack of an equipment management plan hampers the maintenance and repair of hospital equipment, as well as slowing down the procurement of vital spare parts and services to keep hospital operations at optimum.

Quality of equipment is largely dependent on procurement, with suppliers providing warranties, installation, and maintenance only upon explicit inclusion in technical specifications (Gepte, et al 2014). Recently, the Philippine General Hospital was cited by the Commission on Audit as having neglected maintenance, resulting in wastage of 115 million worth of equipment (rappler.com, Feb 17, 2014). The

presence of incompetent suppliers that cannot maintain equipment after procurement further aggravates this problem.

In order to support LGU hospitals improved the quality of their hospital equipment, the national government expanded the Health Facility Enhancement Program (HFEP), increasing the budget for capital outlay from Php 1.6 billion in 2008 to Php 7 billion in 2011. While HFEP is undoubtedly beneficial to local health facilities, there have been concerns about mismatches between the assistance provided and local needs, such as the absence of trained technicians. This indicates the necessity for a clear policy on allocating HFEP funds, as well as a monitoring and evaluation system (Lavado et al, 2011).

Aside from the dearth of technicians to operate and maintain x-ray, ultrasound, and other complex machines, there is also a lack of various other health professionals – doctors, dentists, and nurses – in government hospitals (Herrera, Roman, & Alarilla, 2010). The government has yet to implement measures to comply with the ideal nurse to patient ratio of 1:12 for hospital care. The significant global demand for health workers compromises quality as well; as experienced nurses leave for other countries, the hospital must invest time and effort in training new professionals again.

Aside from labor export, hospitals face other human resource concerns as well. In government hospitals, patients are usually managed by resident trainees, with minimal supervision from consultants. This management structure allows doctors to receive full time pay for part time work, with some even holding private practice in the public facility. Overall, the low compensation, lack of professional growth, and poor working conditions result in dissatisfied health personnel, reducing the quality of health service delivery in hospitals.

In sum, the decrepit nature of government facilities and myriad of human resource concerns are most problematic for the poor, who need health care the most (DOH, 2010). Moreover, the mere perception of poor quality can lead patients to utilize private care instead. This is particularly worrisome for lower income families, who may incur additional expenses and risk impoverishment. The recent trend of for-profit hospitals targeting poorer patients and succeeding (5 percent of the lowest income quintile utilized private hospitals, according to the 2008 NDHS) is cause for concern. The government must look into increasing patient satisfaction and responsiveness, as well as reducing waiting times for emergency and outpatient services.

Fiscal inefficiency and unsustainable fiscal policy

Inefficiency at the hospital level is usually related to financial procedures – procurement and budgeting in particular. Government hospitals are confronted with limited budgets, but usually are unable to link technical performance to costs. To resolve these issues, the DOH is currently proposing the corporatization of DOH-retained hospitals, to ensure fiscal discipline, and eventually, fiscal sustainability.

Although performance was linked to budget allocation of DOH hospitals as early as 2006, after the issuance of an Administrative Order on Performance-Based Budget (PBB), the PBB system needs reworking. The process is as follows: the DOH divides funding for hospitals' Maintenance and Other Operating Expenses (MOOE) into two portions, with 70 percent guaranteed to cover for overhead costs, and the release of the remaining 30 percent based on hospital performance, evaluated based on previously established performance measures.

However, it has been asserted that the PBB is conceptually flawed, as a punitive measure that restricts the 30 percent in case of poor performance, instead of providing a reward for greater efficiency. Furthermore, depending on the nature of the hospital, management can abide by the PBB as it is

advantageous to a low income setting, or ignore it altogether if the 30 percent lost is offset by income gains (Lavado, 2010). This indicates the need for the PBB to be reconstructed into a system that encourages efficient management, and with simple, relevant, and easily collected criteria.

Ideally, these criteria would also be utilized in the planning and budget preparation stages of government hospitals. At present, planning is often an extension of previous years' projects, while budgeting is done on an *ad hoc* basis, usually a re-enactment of the previous budget. Aside from the weak basis for planning, there is no oversight, nor are there national guidelines for budget preparation of hospitals. This in turn causes weak national monitoring of budget execution, partly due to differences in the reports or Statement of Allotment and Obligations and Balances (SAOB) of hospitals (Lavado, 2010).

DOH hospital heads have also voiced concerns regarding the insufficiency of the budget allocated to cover capital outlay and MOOE. This is particularly evident in procurement, where a limited annual budget forces hospitals to procure goods in smaller quantities, leading to increased administrative costs and less discounts (Gepte et al, 2014). On the other hand, procurement in LGU hospitals is conducted by LGU Bids and Awards Committees. There is a pervasive belief that the LGU procurement process is replete with leakages from corruption and malversation, although proofs for these are mostly anecdotal in nature.

Aside from the intricacies of procurement, other unsustainable practices are widespread in state-run hospitals. The rechanneling of "savings" from MOOE to fulfil an unfunded mandate – benefits due to health workers from the Magna Carta of Public Health Workers – is often practiced. Instead of condoning the manipulation of funds at the hospital level, the government must exercise due diligence in locating funding for these benefits, perhaps from general appropriations of PhilHealth. Another inefficiency is the management of non-core sections (laundry, dietary, sanitation, motorpool, engineering, and waste disposal) that do not directly contribute to health outcomes, but increase overhead costs.

The policy of income retention that has been enacted in DOH hospitals needs clarification. Income retention increases fiscal discipline in the sense that the money at hand was earned by the hospital and will more likely be allocated efficiently. However, hospitals with high incomes may have their MOOE reduced, a form of penalty similar to the cut decreed by PBB (Lavado, 2011). Rules on how the retained hospital income will be used needs to be clarified, and the basis of the fee schedules and rartaes be made transparent. On a positive note, income retention does pave the way for the eventual corporatization of DOH hospitals.

Corporatization seeks not only to introduce fiscal reforms, but also institutional ones aimed at improving sustainability. For instance, in the present system, hospital chiefs serve until they reach retirement age. At times, those who reach retirement age are further retained with political appoinments as co-terminus officials. Oftentimes, this means intense reforms in the first few years, to be replaced by a conservative management style in the succeeding ones. Aside from that, the position is subject to political influences, with a subjective selection. Finally, the head of the hospital often a medical doctor, but must fulfil the additional roles of business manager, coordinator, and management team leader (Avestruz, 1995). In the corporatized setup, the hospital director would have a fixed term, would be accountable to a corporate board, and would have previous management experience.

In the entirely of the hospital system, factors discussed earlier – a dominant private sector in health, the fragmentation of the health system due to devolution, and the absence of an integrated referral and gatekeeping system – have a negative impact on hospital efficiency as well. Signs of this include the overcrowding of tertiary hospitals with cases treatable at the primary level, as well as "shopping" for specialists. Government hospitals must confront significant challenges both externally and internally in order to achieve fiscal efficiency and institutional sustainability.

Public-Private Partnerships (PPPs)

Defining PPPs

There is no single international definition of what constitutes a Public-Private Partnership (PPP). As the World Health Organization (WHO) states, "The term covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy setting prerogatives, contributions, and operational roles." (World Health Organization, n.d.) However, the two succeeding descriptions state that the partnership should ***serve public needs*** (either infrastructure or service) by taking advantage of ***private expertise*** and ***private capital***, identifying the partners' ***roles, risks, and benefits*** in a ***legal contract***.

"An innovative, long-term contractual arrangement for developing infrastructure and providing public services by introducing private sector funds, expertise, and motivation into areas that are normally the responsibility of government." – International Monterary Fund and United Nations Economic Commission for Europe (2012)

"A cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks, and rewards." - Canadian Council for PPPs (About PPP: Definitions, 2005)

Finally, the Asian Development Bank adds to the Canadian and IMF definitions, underscoring the need to specify the ***method of financing***, and the necessity of ***monitoring*** in PPPs: "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." (2008)

Public-Private Partnerships in Health

Due to the complexity of service delivery and the nature of health as a public good and social service, health-related PPPs differ greatly from PPPs in infrastructure, transportation, and telecommunication. The government, instead of individuals, acts as purchaser of hospital PPPs, which may add risk to the private partner. The purchaser identity also affects perception of the partnership – risks are political, not market-related, with health PPPs often eliciting firm ideological opposition. There is also unpredictability in determining the outputs (due to variations in disease and demographics), applicable technology, and difficulty in measuring the quality of health services. Finally, the investment profile (construction costs under 20 percent, health services around 65 percent, ancillary services for the remainder) poses a challenge in increasing efficiency gains through service provision (Downs, Montagu, da Rita, Brashers, & Feachem, 2013). All of these differences contribute to the difficulty of comparing non-health PPPs to health PPPs.

In the last two decades, numerous advocates have promoted Public-Private Partnerships as the "third way" for health, rather than a completely privatized or entirely state-run health system. The idea for PPPs originated from the growing concern that a private sector approach would not be entirely successful, and gained strength from closer collaboration between research and development of pharmaceuticals of public and private sectors. PPPs as a global strategy was then cemented when international donor groups (Global Fund, Rockefeller Foundation, Bill and Melinda Gates Foundation, among others) decided to utilize PPPs to answer the crises in HIV/AIDS, malaria, and tuberculosis (Barr, 2007).

Locally, there have been a significant number of projects in the PPP realm in recent years. Running parallel to global trends, most projects are primarily funded by international donor groups, with an emphasis on a specific disease (tuberculosis, malaria). Simultaneously, other PPPs were created to operate and manage facilities, or to increase access to a specific health service (Couttolenc, 2009). The concerns these early PPPs sought to address vary – from increasing insurance enrollment to providing public health services, from training of the health workforce to improving drug distribution.

The Department of Health acknowledges the versatility and diversity of these early PPPs, which "may range from health care provision to logistics management, from information and communication technology to capacity building of health providers." (DOH, 2010) However, many of these PPPs were non-contractual, with weak performance monitoring and accountability, and donor-driven, hence, unsustainable in the long term (DOH, 2012b). This has since led to efforts to institutionalize and formalize PPPs on a contractual basis, paving the way for sustainability and increased efficiency.

There is clearly a broad range of Public-Private Partnership options available in health care, beginning with contracts accomplished through traditional procurement to agreements where the private sector absorbs almost all the risk and accomplishes more roles originally in the public mandate. PPPs can be categorized into Public-Private Interactions (PPIs) and Public-Private Investment Partnerships (PPIPs).

Public-Private Investment Partnerships fulfil four requirements: 1. Accomplish construction of building, management of non-clinical services, and provision of clinical services, usually in a design-build-operate-and-finance (DBO/DBOF) model; 2. Provide for constant government ownership of assets; 3. Achieve risk transfer to the private sector; and 4. Indicate a long-term, shared investment (Global Health Group [GHG], 2010). Several contractual arrangements in the Philippine BOT Law (RA 7718) may be considered as PPIPs, including build-lease-and-transfer (BLT), build-operate-and-transfer (BOT), build-transfer-and-operate (BTO), develop-operate-and-transfer (DOT) and rehabilitate-operate-and-transfer (ROT). These five arrangements guarantee government ownership, and are long-term investments. Provided the government entity mandates delivery of clinical services and transfers risks to the private sector in the details of the contract, these would fall under the definition of PPIPs.

The professed purpose of PPIPs includes providing ***improved quality of care***, ensuring ***equity*** for the poor and marginalized, granting ***financial accessibility*** with cost neutrality for patients, and improving ***efficiency and sustainability*** through predictable government expenditures in health (GHG, 2010).

Several characteristics qualify what a Public-Private Investment Partnership (PPIP) should be. These include having a clear policy objective of Universal Health Coverage while using the Design Build Operate Deliver model. There is planned delivery of quality integrated clinical and non-clinical services. There is government ownership of assets with government review and independent monitoring. It is a long-term and shared investment with the risk of meeting service quality benchmarks transferred to private partners. There is cost neutrality to patients and predictable government expenditures with the patients not expected to bear any additional cost to patients utilizing health services. Equity of access for all and system-wide efficiency gains are explicit objectives.

PPPs that do not meet the above characteristics can be called Private Public Interactions (PPIs) or minor PPPs since they attend to smaller portions of health care service delivery – infrastructure, service, management, or concession type contracts. Similar to PPIPs, PPIs may be long-term, do not engage in any sale of assets, allocate risk appropriately, and maintain the government's role of reviewer and monitor. The difference lies in the overall impact that PPIs make. Unlike the systemic impact of PPIPs, PPIs are likely to be stopgap measures that address fragments of the real problem due to its small-scale nature.

OPPORTUNITIES for PPPs

Based on the categorization of into PPIP and PPIs, the various PPP opportunites are reviewed as to their applicability to the DOH or LGUs. However, it is reiterated that even as the national government and local governments (LGUs) may consider implementing PPIs as stop-gap measures, it is best that PPIPs be construed as the primary health PPP approach for both DOH and LGUs.

PPP contract options

Concession, a long-term contract that grants the private partner exclusive rights to operate, manage, and maintain a government asset, effectively transferring full responsibility to deliver health services and financial risk. Usually, the company pays the government for the right to operate, or remits a portion of income generated. There may also be a government investment subsidy to ensure commercial viability. This is the case in the concession contract of the Philippine Orthopedic Center (POC), which indicates that the DOH will grant the company a five-year subsidy period, providing an annual viability gap fund of 600 million Pesos. Concerns about concession contract include the complexity of contract, which must clearly stipulate that the private partner invest in necessary assets, even if the contract is almost finished, and possible regulatory capture, resolved by efficient regulation and policing. PPIPs are usually in the nature of concession contracts.

Co-location requires site sharing, either in the same building or compound. In this arrangement, two clinically independent hospitals, public and private, may share ancillary support. Benefits that accrue from co-location is the operation of idle assets, income generation through a lease fee, possibly a shared investment in technology, and extra capacity to manage peak demand. However, the public partner must ensure that it gets the best of the bargain – the lease payment should be significant and technology investments long-term. The perception of being short-changed emerged as a major stakeholder concern in the Philippine General Hospital – Faculty Medical Arts Building (PGH-FMAB) co-location project. Co-location contracts can not comply with the characteristics of PPIPs and thus are usually PPIs.

On the other hand, **Private Finance Initiatives (PFIs)** are contracts limited to construction of infrastructure, although they still seek to tap private expertise and capital. The private partner takes full responsibility for construction, reducing cost overruns and delays in the process. Afterwards, the public operates and manages the facility, providing health services and paying the private partner in annual instalments, similar to a lease. There may an option for the company to provide maintenance services, as well as non-clinical support. The local counterpart in the BOT law is the build-and-transfer (BT) agreement, which is being explored for the relocation of the National Center for Mental Health. Overall, the PFI concept, which originated from the UK, provides local governments with easier access to capital. However, numerous issues hound this contract category. It has been blasted as little more than an alternative form of procurement, bringing in no change in clinical efficiency. The government may be able to save on construction expenses, yet this is only 20 percent of the overall budget, 80 percent of which goes to operation and management. Finally, the technological inputs private partners provide tend to quickly become obsolete, which means the public shoulders the cost of replacement for these.

In contrast to PFIs, co-location, and concession agreements that utilize private capital, a **lease** underscores the role of private expertise. In a lease agreement, the private partner manages the hospital and provides clinical services. Contracts are often medium term and renewable, providing a strong incentive for efficient service delivery to maximize profit. Leases give the company considerable operating risk, although financial risk can be shared between partners, when the public purchases services. If new investments are to be purchased, the contracting authority finances it as well. Two

concerns often noted in lease contracts are the rapid depreciation of state-owned assets, and non-provision of agreed health services. To reduce this, the public can conduct regular monitoring and evaluation and more stringent regulation to ensure maintenance of facilities and equipment and timely delivery of quality services. Well-designed lease contracts can comply with the characteristics that define PPIPs.

The operational risk the private sector incurs in leases stands in contrast to **management contracts** (also called **franchise contracts** and **operations and maintenance contracts)**, where the company does not have to absorb risk. In a medium-term management contract, hospital management is partially or completely turned over to a private partner, which provides working capital only. In exchange, the public pays a fixed monthly fee, as inputs, not outputs, are purchased. However, the government authority can reduce risk and improve efficiency by linking performance to incentives and bonuses. Concerns include both too much private control (leading to displacement of government priorities of equity and access) and too little control (the inability to hire and fire personnel and subcontract hinders management reforms). A well written contract is key, in the same way that safeguards in it ensure equipment maintenance and verify private achievements for claiming of incentives. Locally, the Hemodialysis Center of the National Kidney Transplant Institute (NKTI) is operated by Fresenius under a management contract.

Finally, there are **service contracts** which are often accomplished through traditional procurement of services under the Government Procurement Reform Act (RA 9184). Private partners participate in the public bidding process to provide specific services to a health facility, incurring minimal risk in the process. After the contract is awarded, the public proceeds to pay fixed compensation for services rendered. In this form of PPP, the authority must have the capacity to administer multiple contracts, as well as place a strong monitoring and evaluation system in place to be assured that the private contractor is not cutting corners. Both management and service contracts are essentially PPIs.

Service contracts are often small scale in terms of financial investments and risk transfer can still be high impact projects especially if it provides a service that is otherwise not available. These contracts include outsourcing of ancillary services refers to contracting with a private sector to provide non-health support services such as dietary, laundry, security, and janitorial services. In a study by Juban *et al* (2012), it was shown that around 20 out of the study sample of 28 hospitals in the Philippines have contracted out their non-clinical services.

Government health care providers can engage in these kinds of partnerships to be able to focus management's attention to more critical aspects such as health service provision. And since the success of these partnerships depends on the quality of the contracts and the capacity of hospital administrators to implement it, the government can (1) create a model or template contract for each service which can be easily adopted by health care providers and (2) additionally, it can mandate the use of the said contract without much iteration to enforce a minimum standard.

Another type of service contract is the outsourcing of ancillary clinical services such as pharmacy, diagnostics, and laboratory services are common forms of PPPs. In the study of Juban *et al.* (2012), 19 out of 28 surveyed hospitals have outsourced some of their clinical ancillary services to the private sector.

The Local Government of Makati cited the following reasons that prompted it to outsource the pharmacy services of Ospital ng Makati through a PPP arrangement: 1) the inefficient procurement process led to stock outs, forcing patients to buy from drug outlets outside the hospital; 2) the expiration of medicines in stock resulting from bulk procurement which management results to in order to get discounts; and 3) pilferage due to poor monitoring in public institutions. The partnership was able to

provide added manpower and information system for the pharmacy. The government was also able to save money because it only pays for dispensed medicines.

The Luis Tirso Rivilla General Hospital in Paniqui, Tarlac meanwhile outsourced their laboratory services and diagnostic imaging modalities primarily because of lack of capital. The hospital just started operating in July and has yet to see the impact of the arrangement.

Finally, clinical services can be contracted out to private health care providers. Such is the case of when Tarlac launched the Linaw Tanaw Program, a comprehensive plan to forward ophthalmologic services. The local government funded and built the Tarlac Eye Care Center and invited private practitioners to provide ophthalmic surgery. The PhilHealth reimbursements are shared to the private medical practitioners and the eye center. The come-on for these private practitioners is that these are patients which would otherwise not have sought treatment for cataract, thus a professional fee less than what they are charging in private practice seems acceptable. The result was increased access to quality ophthalmologic services, at no cost to patients and revenue generation for the government.

CONSTRAINTS ASSESSMENT

Assessment Framework

In 2011, ADB commissioned The Economist to evaluate the PPP-readiness of countries in the Asia-Pacific. Each country was scored based on six key categories: 1) legal and regulatory framework, 2) institutional framework, 3) operational maturity, 4) investment climate, 5) financial facilities, and 6) sub-national adjustment factor. The Philippines was categorized as "emerging PPP market" and ranked 8th out of 16 countries with an index score of 49.8 (with 100 being the ideal environment for PPPs). The poor institutional capacity and problematic dispute-resolution was cited as reasons for the failure of PPPs to be scaled up in the country (The Economist, 2011).

Based on the Economist report and an extensive literature review of best practice PPPs, the following factors were deemed as enabling factors in implementing PPP initiatives:

Contextual Framework. There should be a clear understanding of the purpose of the partnership (ADB, 1999), responsive to current health delivery problems and should also be able to integrate well with the health systems of a country.

Mutual Trust. Trust between the sectors involved is central to the success of partnerships. It is important to have transparency of records and to allow for open communication between the public and private entities (UCSF, 2010).

A complete understanding of PPPs includes providing incentives to the private sector because government needs to acknowledge that they are business entities with business objectives (Hodge, 2011). It is important for government to realize that private investors will want decent returns from their investment, and this can be done by ensuring a sure revenue stream and in some instances providing fiscal support in the form of subsidies, guarantees, or tax breaks.

Policy and Regulatory Framework. A legal framework that adequately protects the interests of both the public and private sector is a necessary prerequisite to the PPP agenda (Nikolic and Maikisch, 2006). In the 2011 Infrascope report of the Economist Intelligence Unit on the environment of PPPs in the Asia-Pacific, they identified 4 indicators of a sound legal framework:

consistency and quality of PPP regulations, PPP selection and decision making, openness of bids and contract changes, and dispute resolution mechanisms.

Institutional Framework. Central coordination and support by a third party agency is an important part of PPP project development. In an analysis of best practice PPP Centers such as Infrastructure UK, Partnerships British Columbia, and Australian PPP Forum, the following were noted to be functions of a PPP Center: quality control, policy advocacy, technical assistance, project promotion, contract management, standardization and dissemination (GHD, 2012).

Contract Management. A contract that provides a middle ground between the public and private sector is a necessary factor that determines the success of a partnership. According to Nikolic and Maikisch (2006), in the implementation phase of PPPs it is important to develop a contract that addresses foreseeable risks and has a detailed quality and performance standard and targets. According to Jamali (2004), a contract should clearly articulate the purpose of the partnership and provide a clear delineation of targets and goals with specific reporting and record keeping requirements. Contracts must concretize the benefits for both public and private sectors: decent returns for the private sector and quality service delivery for the public sector. Since PPP contracts are usually long term, they are often incomplete. Proper contract management should include provisions for contract negotiations (Jamali, 2004).

Monitoring framework. An integral part of PPP success involves independent monitoring and evaluation of projects (UCSF, 2010) so that appropriate adjustments can be made. There should be clear quantitative and qualitative standards by which the relevance and success of PPPs are evaluated.

The above enabling factors will comprise the assessment framework to determine the general feasibility of health PPPs.

Feasibility Assesment and Discussion

Contextual framework

Prior to the utilization of the PPP process, a clear understanding of the rationale for its use is necessary. This calls for an extensive policy debate on the matter, comparing PPP programs to modes where state funding prevails. As for health, individual PPIPs must be responsive to the service delivery problems previously discussed, and integrate well with the country's existing health system to be considered successes.

The Philippine government justifies the policy paradigm of Public-Private Partnerships through various avenues. First, there is President Aquino's Social Contract – a commitment to the Filipino people. In the economic aspect, the government promises impartiality and transparency, conditions conducive to growth and competitiveness of businesses, and accountability to the public and protection of public interest (Government of the Philippines, 2010). Secondly, it returns to the 1987 Constitution, where "the State recognizes the indispensable role of the private sector, encourages private enterprise, and provides incentives to the needed investments." The private sector is considered a "partner in development," although this is not explicitly written in the Constitution. Based on this role, Public-Private Partnerships shall introduce finance, technology, and innovation for greater efficiency gains, and accelerated provision of public services, leading to rationalization of the government budget to allocate limited resources for social services (Canilao, 2011).

Utilizing the social contract and constitutional role of the private sector, the PPP flagship program to accelerate infrastructure development is the driving force of the Philippine Public Investment Program, which in turn supports the Philippine Development Plan 2011-16 (PPP Center of the Philippines, 2012). Since PPP programs existed as early as the 1990s, the rationale for use of PPP is widely accepted, despite the continuing lack of formal discussions on PPP and other policy actions available to the government. In the 2010 State of the Nation Address, however, the President pointed to the unlimited needs and limited funding as the reason for use of PPP, not only in infrastructure and transport, but also in social development. Essentially, the bottom line is that PPPs are justified by the budget deficit, and can free up fiscal space and enable the government to realign money.

This is the same motivation given by top executives at the Department of Health. In the discussion concerning the Philippine hospital system, it was noted that many regions had a deficit in the bed-to-population ratio. At present, the national rate (1:04 beds per 1000 population) is half of the WHO recommendation, indicating a huge infrastructure gap. If the DOH were to double the number of DOH-retained general hospitals (excluding LGU hospitals), at Php 1 billion for capital outlay of each hospital, the amount to be requested from general appropriations would amount to 51 billion, excluding maintenance, operating and other expenses (MOOE) and personal services (PS). Yet this Php 51 billion would result in a net addition of only 12,500 more beds, increasing the national rate to 1.18. At that rate, a massive amount – Php 350 billion, equal to 15 percent of the national budget – is necessary to reach the recommended bed to population ratio. Citing the impossibility of Congressional approval for such an amount, the DOH turns to Public-Private Partnerships in the long term.

Moreover, the DOH seeks to expand universal health care through PhilHealth and PPPs. The current strategy is providing universal coverage through insuring the poor – Php 35 billion from the incremental revenue of the Sin Tax Law was allocated to pay for the PhilHealth membership of 14.7 million families. Since the coverage is available, the next step would be to cover the hospital infrastructure gap with PPPs to expand, modernize, enlarge, and equip hospitals. In effect, the improved environment for health PPPs is made possible by the substantial infusion in PhilHealth funds. Aside from funding, the government also owns land and employs numerous health professionals. All these can be used as leverage to incentivize the private sector to build a hospital via PPP, and comply with the PhilHealth No Balance Billing policy for indigents.

Since the health is accessed by people through PhilHealth, hospitals must be able to run efficiently and provide affordable care at the same time. This has led to governance reforms through corporatization, in order to resolve the perennial issue of inefficiency. Hospital bureaucracy will be slashed, a board of directors introduced, and the facility would earn from PhilHealth through volume, and receive government incentives based on performance. In a similar manner, PPP hospitals are no longer limited to the budget subsidy provided by DOH. Health PPPs would also remove the inefficiencies of government procurement, not only because the entire process is designed for transparency, but also because it is improbable for a corrupt official to ask for kickbacks from the privately funded partnerships.

Significant increases in the quality of outputs are also anticipated in PPPs, from a reduced hospital stay to improved facilities, resulting in enhanced service provision.

Health PPPs are presented as a way to correct the dominance of the private sector and reduce inequity in health. At present, the poor are forced by overcapacity and poor public quality to go to private hospitals, where they are kept hostage by exorbitant rates. Health PPP contracts can ensure that the poor have increased access by prescribing a minimum number of beds reserved for indigents and PhilHealth patients. Through lowering the market cost of hospital stay to predetermined rates, privately-run hospitals will have to lower their rates as well to compete with government PPIPs. The concept of a market

"mirror" is very similar to parallel drug importation, and results in a net benefit for both those subsidized by PhilHealth and the middle class.

Yet most of these benefits are unknown to civil society, resulting in significant opposition from labor unions, patient groups, and health professionals. The leftist Makabayan bloc equates PPPs in health with privatization, asserting that the constitutional right to equitable and accessible health care will be trampled upon, further disenfranchising the poor (Torres-Tupas, 2014). The slightly more moderate Alliance for Progressive Labor also labelled PPPs in general as mere "build-operate-transfer on steroids" that would result in more outsourcing and contractualization of work, aside from making public services more expensive and prohibitive (Alliance of Progressive Labor, 2011). Even the administration's leftist coalition partner Akbayan expressed alarm early on, exposing most PPPs as privatization in the guise of "constructive partnerships," leaving services inaccessible to minimum-wage earners while enriching corporations, citing the privatization of water services (Akbayan Partylist, 2010). The DOH countered by pointing out that these failures in the past – unsolicited proposals, airports, water, and tollways – provided valuable lessons to the present PPP, cited the reversion of PPP hospitals to the government, and reiterated their control over corporate greed.

However, this answer has not been acceptable, and the Makabayan bloc filed a Supreme Court petition to stop the privatization of the Philippine Orthopedic Center early in February 2014. The core argument against health PPPs stems from a rights-based approach, as the 1987 Constitution degrees that the State shall "protect and promote the right to health of the people," which is interpreted accordingly as state provision of health care (SC petition). (The second core argument concerning the legality of a PPIP in relation to the BOT Law will be discussed in the section ***Policy and regulatory framework***.) In sum, civil society and progressive groups continue to resist most government efforts in health PPPs, beginning from management contracts such as the National Kidney and Transplant Institute (NKTI) Dialysis Center to full-blown PPIPs, and maintain that health care must be publicly provided. The government must work to increase public and civil society awareness of the benefits of health PPPs through a comprehensive communications program.

Indeed, the modernization of the Philippine Orthopedic Center, which is the banner PPP project of the DOH, strikes some stakeholders as ironic because it is a super specialty center that would only cater to a specific population and that it will not contribute to the intended goal of meeting the health-related MDG goals. *"If the focus is on decreasing maternal mortality, then we should have started with Fabella. But, the DOH envisioned a tri-medical integrated complex of San Lazaro, Fabella and Jose Reyes. Since this is a bit more complicated, they decided to use POC as the pilot project of PPP." (Stakeholder #7)*

According to Nishtar (2004), PPPs should not be seen as outcomes in themselves and it is important for PPPs "not just to exist in form but to contribute to improvements in health outcomes". The POC situation illustrates a lack of clear contextual framework for PPPs. *"PPPs are temporizing… What about primary health? We can't even declog our hospitals." – (Stakeholder #5)*

How well it integrates into the health system is a different issue all together. Although there is a road map to improve primary health services in the different localities, there hasn't been much progress in terms of access to essential health care services. Households have already been shown to go directly to tertiary hospitals even for check-ups and treatment that can be handled by primary and secondary health facilities (Lavado *et al.*, 2010). The pursuit of modernized public hospitals without an improvement in primary health care facilities will only further fragment the health system.

Mutual trust

To successfully generate mutual trust and respect between public and private partners, a culture of integrity, transparency, and open communication is necessary, with both sectors fulfilling their contractual duties. Trust is vital for success in PPIPs - the government must create a business atmosphere that declares its readiness to engage the private sector, and operate in the framework provided by national laws. Conversely, companies should not only be ready to partner with the public sector, but to do it with integrity and in good faith. However, the Philippine government has been plagued with accusations of corruption and arbitrarily ending contracts, while private partners have maximized legal loopholes or even ignored contract provisions for larger profit margins.

The metro rail transit (MRT)-3 PPP is an example of the difficulties in partnership, both for the public and private sectors. The MRT was awarded to Metro Rail Transit Holdings Inc. (MRT Holdings) as a BOT in 1997, but was replete with inefficiencies, including overcapacity, long waiting and queue times, breakdown of trains, and petty crimes (Cruz, 2014). This is partly due to the obsolete information technology (IT) signaling system, lax requirements in the maintenance provider's contract, and the absence of contract renegotiation, which could increase the minimum number of trains (18) to meet increasing demand (23 trains). In fact, the corporation did not fulfill its contractual obligation to find a new maintenance provider after the expiration of the previous repair subcontract. Yet after the DOTC bid out the maintenance contract, the government was charged of conducting it without the company's consent, leading system breakdowns (Orias, 2014). In 2011, a renegotiation of the contract was announced but for unstated reasons, did not materialize (Montecillo, 2011). The deficiencies on the private partner's side reinforce the view that companies are profit-seekers before service providers, and will only provide what is required by the contract.

In the same year, MRT Holdings repeatedly proposed the procurement of additional vehicles through PPP, at no additional cost to the government, but the DOTC did not respond to these proposals (Villanueva, 2014). Then in mid-2013, there was an accusation of an attempted extortion of Php1.2 billion from Czech train manufacturer Inekon, in exchange for a guarantee of the contract (Camus, 2013). Finally, the DOTC procured 48 train vehicles from CNR Dalian of China but this was put on when in 2014, a Makati court issued a Temporary Restraining Order in their favor of MRT Holdings who argues that they did not violate the contract and should continue to retain a preferential right to supply rail vehicles (ABS-CBN News, 2014). As seen here, questions of corruption and breach of legal contracts are issues that must be resolved in PPPs.

The MRT 3 case is no worse than the Ninoy Aquino International Airport (NAIA) 3 case, another controversial PPP which resulted in a Php17 billion suit against the government, pending at the World Bank International Center for Settlement of Investment Disputes (ICSID), an autonomous international institution that conducts conciliation and arbitration. The failure of the NAIA 3 PPP points to several factors that reduce private sector trust in government – corruption, political maneuvering, and ambiguity in provisions of the Anti-Dummy Law that restrict foreign ownership.

Setting these incidents aside, the overall trust of the private sector in government is steadily increasing. This was evident even in late 2012, when the Macquarie Group of Australia announced its desire to invest $600 M in a PPP due to "strong economic growth and sound prospects for economy" (GMA News, 2012) In 2013, when a number of PPPs were bid out, private investors exhibited high confidence in the government as exhibited by their interest and participation. For the automated fare collection system of the MRT and LRT, five groups submitted bids, while all seven pre-qualified groups in the Mactan-Cebu International Airports joined the bidding (DOTC, 2013).

Internationally, the Philippines is in a strong position as well, with the three major credit raters (Fitch Ratings, Standard & Poor, and Moody's) raising the nation to investment grade. The Philippines' strong growth prospects – such as a jump to 59th in the Global Competitiveness Index –are coupled with

the already accelerating gross domestic product, outpacing most of the Asia-Pacific region by mid-2013 amid the poor global outlook (Remo & Montecillo, 2013). This is matched by the local confidence in the government – the Employees Confederation of the Philippines hailed PPPs as spurs for manufacturing and employment, and called for further acceleration of these projects for the private sector to match government spending (Magkilat, 2014).

Conversely, the government puts significant trust in the private sector, with major pronouncements on PPP by the President himself, as well as key Cabinet members. Last year, the private sector was hailed not only as the engine of economic growth but also as a powerful driver of reform, as it benefits from social and economic stability (DBM, 2013). This invites companies to serve as "reform constituencies" that actively participate in co-governance. Another paradigm shift is the inclusion of the academe, civil society, communities and other non-government groups in the private sector. This assertion is crucial, as it treats brings in more stakeholders in a partnership, and indicates a government commitment to open communication and transparency.

In communicating with private investors, banks and development partners, the PPP Center adheres to the principle of consultative and systematized partnerships, and is now strengthening dialogue (Austria, 2012). To increase feedback from prospective bidders, the government usually provides for a longer period prior to bidding. Unfortunately, this time frame has not been institutionalized, though, leading to the perception of government inefficiency when a project is "delayed" for additional feedback. The premium put on communication means that private concerns are appropriately addressed, and if necessary, modifications introduced to the contract (de la Maza, 2014). Flexibility also prevailed when Typhoon Yolanda entered the country a day before the closing of bid submission for a major PPP, leading to a few days' extension. However, if public consultations were to take place prior to the launch of the bid documents, this would further drum up private sector interest and promote transparency.

Transparency in the PPP process is generally compliant with Procurement Law (RA 9184), with majority of project documents posted in the PPP Center website. These include project-specific documents, like presentations to potential investors and official communications (Invitation to Qualify and Bid, memoranda, bid bulletins, and Notice of Award). This will reassure civil society that fears over privatization, reduced access, and greater inequity is unfounded.

Based on the FGDs, most stakeholders understand that PPPs pertain to long term and high-risk contracts where government partners with the private sector to deliver health services via sharing of expertise. But there was a clear misunderstanding of the finer details of the partnership. More often than not, stakeholders consider the mere presence of a public and private entity in a project a public-private partnership; the role could be as minor as technical assistance or as major as program implementer. Indeed, several respondents see PPPs as privatization.

Nonetheless, although PPPs are generally seen as beneficial given that "the government cannot do it all," acknowledges a public official, some respondents expressed their concerns that PPPs have a potential to increase the cost of health care and decrease access to health services thus further disenfranchise the poor, and may even cause unemployment for government workers. Still, majority of stakeholders accepted it as a strategy to move towards UHC, by addressing infrastructure gaps and improving the delivery of needed health care services.

On the other hand, it was raised that PPPs may not be doable in the health sector because of the perceived "unattractiveness" of public hospitals to private investment partly due to unreliable and not so secure revenue flows.

Policy and regulatory framework

The third requisite in PPP programs is the presence of a policy and regulatory framework that provides adequate protection of public interest yet attracts the private sectors. The consistency and quality of PPP regulations across the board is considered as well as decision-making in specific PPP projects. The transparency in changes to the contract, both before and after the signing, and dispute resolution mechanisms are necessary as well. Fortunately, the present policy environment is transparent and open.

The legal framework for the PPP program is comprised of the amended Build-Operate-Transfer (BOT) Law (RA 7718) and its revised Implementing Rules and Regulations (IRR), the Government Procurement Reform Act (RA 9184), and other related laws including the Local Government Code (RA 7160), charters of Government Owned and Controlled Corporations (GOCCs), negotiated and lease contracts (EO 301 s. 1987), joint ventures (EO 423 s. 2005), Alternative Dispute Resolution (EO 78 s. 2013) and legal mandates of national implementing agencies and sectoral regulatory agencies. The BOT Law and its IRR outline the government approval process and the variants of BOT, indicating the allowable of government support and ensuring reasonable rate of return for private partners. The Procurement Law decrees the possible modes of procurement, and sets public bidding as default procedure. Finally, the other laws provide the guidelines on inter-agency coordination and had streamlined the PPP process.

However, despite the thoroughness of the policy and legal framework, it may not necessarily be a perfect fit for health PPPs and PPIPs. This weakness was exposed in the Makabayan bloc's petition for a Temporary Restraining Order at the Supreme Court, citing unconstitutionality and that the BOT Law does not explicitly allow provision of clinical services with the law limited to the only the operation of infrastructure and not of facilities like hospitals. The National Union of People's Lawyers further contend that the IRR of the BOT is invalid, as it overreaches the scope of the law itself. Specifically, it is argued that the Philippine Orthopedic Center as a BOT cannot include provision of clinical services for this is an inappropriate extension of the definition of "operation of infrastructure" to include health care provision.

This deficiency in the existing BOT Law emphasizes the need for amendments, if health PPPs are to be pursued. An alternative action is the creation of a new law specifically for health PPPs, an option that is bolstered by the fact that the intricacies of health PPPs – unpredictability of demand and difficulty in measuring quality of services – are difficult to include in BOT Law amendments. Another alternative is to continue the argument that the current DOH administrative orders (AOs) are sufficient for the establishment of health PPPs. These DOH AOs include the Aquino health agenda: universal health care (AO 2010-0036) as well as the policy framework for PPPs in health (AO 2012-0004).

The UHC AO specifies how UHC can benefit from the revitalized PPP program, specifically in the repair, rehabilitation, and construction of priority facilities, services that need heavy capital investments. It also encourages Centers for Health Development to provide policy directions to facilitate health PPPs. The PPP policy framework AO provides for the consistency of priorities (DOH favors PPPs relevant to national and DOH priorities), synergized strategies (DOH emphasizes KP strategies that improve the PPP environment), comparative advantage of PPPs (DOH promotes PPP use in areas where they provide relatively more benefits), and sector coordination. It also mandates that in dealing with the private sector, there should be fair competition, transparent processes, conditional incentives, and continuing appraisal of PPP projects' performance. The last four guidelines support the Procurement Law that has set public bidding as default procedure; and the BOT Law's provisions on monitoring and evaluation, and incentives for the private partner.

With regards to incentives to the private partner, the BOT Law allows corporations to register their investments with the Board of Investments (BoI), in order to receive specified incentives stipulated in the Omnibus Investment Code of 1987 (EO 226). Upon inclusion in the Investment Priorities Plan,

enterprises are entitled to an income tax holiday ranging from three to six years, duty free importation of capital equipment and spare parts, and a five-year additional deduction for labor expenses (50 percent of labor wages are untaxed), among others. Non-fiscal incentives allow for employment of foreign nationals, simplification of customs procedures, and unrestricted use of consigned equipment. The private partner is fully responsible for registering with the BoI. Additional incentives may be granted by local government units (LGU) while the DOH is currently developing health-related technical and material incentives in accordance with KP objectives and PPP performance.

Compared to the straightforward policy framework, the relations between government, private partner, and sectoral commissions are more complicated in the regulatory framework. In particular, regulation in PPP becomes more important when the market is a natural monopoly or when the company possesses significant market power, and the rights and obligations of a concession agreement depend on regulatory interpretation. A regulator typically establishes standards for services, regulates rates, establishes market rules for the sector, monitors performance of regulated entities, and arbitrates related disputes (Smith, 2011).

Yet the regulatory framework in the Philippines is anything but ideal. Often, there is a failure to regulate, or worse, regulation that consistently favors the stand of corporations. For instance, the Energy Regulatory Commission (ERC) was the subject of much discussion in early 2014, as a government regulator that rubber-stamped electricity rate hikes without exercising due diligence in investigating the sudden spike in price and market manipulation. The ERC explained that the commission is subject to the fluctuating prices at the Wholesale Electricity Spot Market, and only approved the incremental nature of the increase, and not the increase itself, which would be automatically computed (Anonuevo, 2014). Civil society groups retorted that there is regulatory capture, as the ERC is impotent to halt a tariff hike of Asia's most expensive electricity rate, affecting customers and discouraging manufacturing (Kritz, 2013).

Another notable failure of regulation is the privatization of the waterworks of the National Capital Region (NCR) in 1995. Originally hailed as the model for water privatization across the globe, it has resutled to increased rates and larger debt burdens. The latter is caused by Maynilad Water's non-payment of concession fees, despite increasing unauthorized collections from consumers. On the other hand, from 1997 to 2012, the Metropolitan Waterworks and Sewerage System (MWSS) Regulatory Office continuously approved rate hikes without questioning estimation errors and demanding accountability for inefficient operations. This has led to water costs at least 600 times more expensive than they were prior to privatization. It was only in 2013 that NCR's water regulator elected to cut rates charged by concessionaires, after a periodic rate-rebasing review was conducted. The MWSS cited "disallowances in operating and capital expenditures," explaining that numerous cash advances and expenses were not substantiated. This was immediately followed by objections from the concessionaires, which both filed dispute notices to initiate arbitration (Balea, 2013).

In order to improve regulation, the government established a Php 30 billion contingency fund, a "Risk Management Program" to fulfill PPP agreements made in case of a breach and increase investor confidence. Reasons for a potential breach may include the failure to implement necessary regulations stipulated in contracts, such as rate increases. Yet the National Economic and Development Authority (NEDA) justifies this item in general appropriations as a fund not to be used, but only to attract investors in PPP projects as part of good governance (Remo M. V., 2014). This action is part of the government's policy to introduce regulatory risk protection, as announced by the President to investors in 2010 (Aquino, 2010).

Institutional Framework

Simultaneous with the policy and regulatory frameworks, PPPs operate in an institutional framework as well. Well-defined responsibilities of government agencies are necessary, with these roles clearly documented. As much as possible, the mandates of the different actors should not overlap, in order to reduce confusion. Agencies can either be an implementing, regulating, reviewing, or coordinating bodies. Finally, the agencies ought to receive adequate funding and external support in order to fulfill their obligations.

At the national level, the institutional setup categorizes agencies involved in PPP into various categories – contracting or implementing agencies (IA), regulatory bodies, review and approving bodies, and a coordinating and monitoring agency, the PPP Center. Implementing agencies are the sectoral agencies, such as the DOH, which has created a specific office for PPPs – the Center for Excellence in PPPs in Health (CE3PH). Local Government Units (LGUs) and Government Owned and Controlled Corporations (GOCCs) that wish to utilize PPPs are also considered IAs. However, the PhilHealth Insurance Corporation (PhilHealth) is presently not an active part of the institutional framework and there is no national regulatory body or sectoral regulator in health. PPPs must also pass through review and approval prior to bidding, specifically through the local development councils, the Department of Budget and Management, the Department of Finance, the Inter-agency Investment Coordination Committee, and the NEDA Board, which is chaired by the President.

In the DOH, the CE3PH is mandated to ensure the effective and efficient implementation of DOH PPPs and act as clearinghouse for collecting experiences, analyses, and dissemination of best practices (DOH, 2012). The CE3PH was established from the DOH PPP Management Office (PPPMO) in March 2012, which was preceded by the PPP Task Force, created in December 2010. The latter was previously responsible for contract promotion, capacity building and technical assistance to LGUs and DOH hospitals, policy development, and development of monitoring and evaluation tools (DOH, 2010b). Since the AO creating CE3PH barely touches upon its specific role, in "effective and efficient implementation of health PPPs," it is safe to assume that the center took over these functions, serving as the de facto contract management unit of the DOH.

The CE3PH is a multidisciplinary team, composed of finance analysts, economists, lawyers, BOT specialists, information technology (IT), engineering, and architecture experts. Most of the team comes from the private sector, though some have relevant government credentials. However, the high turnover of specific experts such as architects has reduced overall effectiveness. The CE3PH invests significant effort in determining the viability of specific projects, to identify whether PPP is the ideal option. Its experts in IT, engineering, and architecture provide a second opinion, balancing out the perspective of the bidding corporations.

On the other hand, the Public-Private Partnership Center (PPPC) serves as a coordinating and monitoring agency for all PPPs, regardless of sector. The PPP Center was originally the BOT Center under the Department of Trade and Industry, until it was designated as an attached agency of NEDA in September 2010 with expanded mandate and functions. Presently, the PPPC assists IAs by assisting them address impediments in implementation of PPP programs, provides technical assistance and capacity development, recommends PPP policies and guidelines, monitors and facilitates implementation of PPP projects, manages a central database, and administers the Project Development and Monitoring Facility (PDMF) (PPP Center, 2010). It is worth noting that the roles of the CE3PH mirror that of the PPP Center.

The PPPC is divided into five operational offices – the PDMF service, the legal service, policy formulation and evaluation service (PFES), project development service (PDS), and capacity building service (CBS) and knowledge management service. The PDMF is a fund allocated for the preparation of business case, pre-feasibility and feasibility studies, and bid documents of PPP projects. The PDMF is a revolving fund that is replenished by the winning bidder of the last PPP (de la Maza, 2014). PDS provides

technical assistance to IAs, ensuring proper preparation and bidding, while CBS trains IAs that have not yet developed PPPs. Lastly, the PFES and legal service attempt to strengthen existing laws and issuances for a conducive policy environment for PPPs (PPP Center Philippines, 2010).

Financially, both the PPPC and CE3PH are well supported by their parent agencies. The DOH Secretary has allotted latter a total of Php 3 billion for the modernization of 25 regional hospitals, while the PPPC budget for 2014 is equivalent to Php 85.5 million (Official Gazette, 2013). The 3 billion pesos would cover conduct of feasibility studies, engagement of legal, financial, and other advisers, but not payments to private investors. The Undersecretary for Health in the NCR and Southern Luzon currently heads CE3PH who in turn reports to the Office of the Secretary.

The PPPC continually provides in-house technical assistance to CE3PH in the different steps in the preparation of a PPP proposal, as well as hiring external consultants, or Transaction Advisers (TA), through the PDMF mentioned earlier. As the PDMF is transparent and well managed, international donors such as the Canadian and Australian governments have contributed funding to it. It also enhances the investment environment and helps develop a robust pipeline of viable, well-prepared PPP projects. The PDMF has nine consulting firms on retainer, and the PPP Center bids out the task of conducting a feasibility study and other pre-investment activities to them. Afterwards, the selected TA reports its findings to CE3PH.

The PPPC has a Strategic Support Fund, which pays for right of way acquisition (ROWA) and related costs, including resettlement, and the cost of designing, building, and delivering a PPP project (Austria, 2012). This is in contrast to the previous investment environment, where the private company was required to shoulder ROWA costs on its own. Aside from these funds that contribute to market development, the PPPC also lends media assistance, particularly for reassuring the public that no privatization will occur, and conducts PPP roadshows to present a "menu" of PPP projects to foreign and local investors.

Concerning LGUs, both the PPPC and CE3PH are involved in expanding capacity. The PPPC program is available for both national agencies and LGUs, and covers the whole PPP project cycle; while the CE3PH training is specific to health, applied to LGUs, LGU hospitals, and DOH hospitals, and usually emphasizes the creation of performance-based contracts and contract management. Trainings are need-based, with customized content and actual outputs reflective of local needs. However, there is some overlap in the trainings, as both seek to enhance LGUs' institutional capacities in PPP project development and implementation.

Though the learning-by-doing approach of the PPPC and CE3PH have been considerably successful, actual PPP contracts remain absent due to the reluctance of companies to invest in a politically risky contacts, given that the election cycle for LGUs is a mere three years. Additional limitations are the vulnerability of LGU bureaucracies to corruption, as well as the local mindset that contracts can be ready-made, "one size fits all." This is impractical as the PPP process itself resists fixed templates, adapting each project to the needs of the IA and the strengths of the private partner.

Two groups of key actors remain conspicuously absent in the PPP scene – Centers for Health Development (CHDs) and DOH attached agencies, including PhilHealth and the Food and Drugs Administration. Although CHDs are in fact encouraged to assist in PPP policy development, and to submit proposals as well, their involvement has been limited. The participation of PhilHealth into the institutional framework should also be strengthened.

Aside from institutional clarity, political interventions in the PPP process must be reduced, and eliminated if possible. The case of Dr. Jose Fabella Memorial Hospital is telling – originally planned to be

a build-and-transfer PPP, the initial studies revealed that it was not feasible. However, when the DOH bid out the construction of Fabella as funded from general appropriations, the DOH was restrained by the NEDA and Department of Finance, which recommended that the agency revisit the outline business case and course the construction through PPP. The reverse was the case in the Vaccine Self-Sufficiency Program (VSSP) PPP amounting to Php 400 million, when it was recommended that funding be sourced from general appropriations instead.

Contract Management

The fifth requisite for successful PPPs is capacity of the public sector to perform contract management. Contract management covers four phases namely a.) project preparation, where the Value for Money (VfM) analysis, engineering design and draft contract are accomplished; b.) pre-construction and construction, with Engineering, Procurement, and Construction (EPC) appraisal of subcontractor; c.) operations; and d.) asset transfer. In the second and third stages, monitoring and evaluation are conducted based on Minimum Performance Standards and Specifications (MPSS), with one manual each for construction and operations. If necessary, amendments can be made to the contract or financial model at any time, due either to force majeure, a major change in the law, or the economic environment (GHD Pty Ltd, 2013). ***Monitoring and evaluation*** will be discussed in the following section.

As the contract management unit of DOH, the CE3PH, together with transaction advisers provided by PPPC, conducts scoping and contract structuring as part of the project preparation stage. Scoping is a concept originating from the UK, New Zealand, and Australia, where the project proponent obtains a diagnosis on various issues including Financial (determining value for money or VfM), Market demand (ensuring economic sustainability based on the predicted demand and local PhilHealth enrollment), environment and existing infrastructure, and unique characteristics of the hospital being scoped. Consistent with international literature, a hospital chief supportive of PPP is crucial to PPP development, working as a champion for the PPP.

A scoping exercise with positive outcomes results in the creation of NEDA Investment Coordination Committee (ICC) ready Project Evaluation Forms, and the development of an attractive business case for private investors. Contract structuring is crucial in this stage, requiring an intimate understanding of the financial and social value, and risks inherent in PPP agreements. The contract is adequately designed by the CE3PH to effectively manage the regulatory, financial, and other risks, consequently maximizing the project's value to investors and the government. Minimizing risk is not simply passing on all the risk to the private sector, but identifying the most appropriate party to reduce the risks and assigning that government agency or private investor the action plan to mitigate damage once the event has occurred.

After scoping and contract structuring, the project then undergoes reviews from other agencies, such as the local Development Council (Regional, Provincial, Municipal, and City), the Environmental Management Board (EMB) of the Department of Environment and Natural Resources, the Department of Budget Management, the Department of Finance, and the Office of the Solicitor General (OSG). These government agencies and groups will issue necessary certificates and endorsements, prior to submission of the DOH proposal to the NEDA ICC. The proposal and requirements will then be reviewed and evaluated by the ICC Secretariat, Technical Board, Cabinet Committee, and finally, the NEDA Board. However, the process and procurement is different for unsolicited proposals involving novel technologies, which undergo a competitive "Swiss challenge".

After confirmation of approval, the CE3PH once again enters the scene, conducting procurement in accordance with the Procurement Law. The DOH convenes the Bids and Awards Committee (BAC) to prepare the tender and bid documents, while advertising the Invitation to Bid (ITB). Bid documents are

issued to investors who purchase them, and a pre-bid conference is held to clarify inquiries and solicit further comments from the prospective bidders. A bid submission date is set, wherein bidders are responsible for submitting three envelops – qualification documents, technical proposal, and financial proposal. The three-envelope system ensures that ability and technical capacity of the winning bidder is evaluated prior to the bid offer. The procurement and project preparation conclude with the issuance of Notice of Award (NOA) to the winning bidder.

In the middle two stages, Pre-construction and construction and Operation, the CE3PH is in charge of contract or project administration. This refers to ad hoc duties involving changes in the signed contract or base case financial model, which may be modified due to refinancing of the project, implementation of previous agreements on sharing of profits from refinancing, or restructuring of the contract following a change in legislation or force majeure (natural disasters, war and terrorism, etc.) prevent fulfillment of the original contract. Amendments are made possible by proposals to the joint governing council, in order to keep abreast with existing technology.

Other non-routine activities under contract management are dispute resolution, asset turnover at the end of the contract, and Major Adverse Government Action (MAGA) (GHD Pty Ltd, 2013). Administration also includes numerous routine activities, including appraisal of progress during construction, continuing VfM analysis, and monitoring to ensure the Minimum Performance Standards and Specifications (MPSS) review are met. In repeated non-compliance of the latter, a MAGA can be triggered. Both the MPSS and MAGA are linked to monitoring and evaluation, and will be discussed in the succeeding section.

The possible deficiency in contract administration is the existing fragmentation of contract management among several agencies, due to policy and legislative gaps. There is ambiguity in the BOT Law and IRR concerning the roles of the different agencies particularly if the PPP project necessitates a change in the contract or financial model. Presumably, the original actors – OSG for legal implications of contract change, DOF for commercial model – need to give their approval to the modifications, but this is not explicitly stated. As the IA, the DOH is the contract administrator, although the PPP Center's role as monitor and coordinator is not formalized in event of these changes. It would be beneficial if the PPP Center would consistently be kept appraised of these matters, considering that it is tasked to manage a database on existing PPPs.

Previously, the other weak link of contract administration is dispute resolution, with loopholes leading to ambiguity and suits in court and other international arbiters (Economist Intelligence Unit, 2011). However, the government has since mandated the inclusion of the Alternative Dispute Resolution (ADR) process in all PPP contracts (EO 78 s. 2012) and centralized all ADR workings in the Office for Alternative Dispute Resolution (EO 97 s. 2012). The ADR is promoted as an effective tool to achieving speedy and impartial justice outside the clogged court dockets, and contributes to a more attractive climate for private investment. This is particularly useful because corporations are uncomfortable or perhaps distrustful of filing suits in government courts, preferring to use international arbitration (Smith, 2011). Because of this, the ADR not only increases mutual trust but also strengthens the regulatory framework, paving the way for mediation and conciliation between disagreeing parties.

Monitoring framework

Monitoring and evaluation, as a crucial part of contract management, is strengthened by the presence of clear quantitative and qualitative standards to measure success of PPP projects. Monitoring and evaluation by an independent third-party is preferable, utilizing both project specific performance indicators.

In the CE3PH, monitoring and evaluation are accomplished in-house, based on the Minimum Performance of Standards and Specifications (MPSS) manuals, which vary from contract to contract. The MPSS in a contract can be either an operations manual, a construction manual, or both, depending on the type of PPP utilized. The construction manual contains indicators relating to outputs (infrastructure quality, timeliness of delivery, and compliance with technical specifications), while the operations manual is linked to clinical outcomes and standard of care in the hospital. Among the previously accomplished health PPPs, there are no financial indicators.

As previously indicated, the MPSS indicators are tied to the performance of the company. If the MPSS requirements are not fulfilled, the investor will be fined for non-compliance. However, once the total non-compliance exceeds a specified level, an official warning would be issued by CE3PH. If not rectified, this is followed by probation status. Finally, a Major Adverse Government Action (MAGA) may be enforced by the DOH. Both the context and violations which would cause MAGA are explicitly stated in the contract; in case of such an event, management control and the entire hospital facility will be promptly surrendered to the government.

In previous PPPs, the Commission on Audit (COA) retained the responsibility of auditing. COA is also tasked to audit the PDMF and SSF, funds under the PPP Center, revenue of the IA, equity contribution and funding support of the IA, and contingent liabilities of the government. Special Purpose Vehicles created expressly for a PPP project are not exempt from the COA audit. In the previous audits, COA recommended several actions, including the issuance of receipts by the government partner, then remitting the private company afterwards in compliance of bookkeeping rules. Interestingly, while COA cites pharmacy consignment tracts as unlawful, the same contracts, when renamed "drug supply continuity contracts" were approved without hesitation. This indicates the need for the DOH to further market PPPs to the bureaucracy as socially and legally acceptable, particularly since COA rules allow for very strict or liberal interpretations, depending on the auditor.

On the other hand, auditing is not a government role in the POC project. The DOH did not consider this necessary, as the roles of financing and management are completely borne by the private partner. However, the COA is concerned that the POC contract does not allow for auditing, as the auditing agency maintains that the government should always have a share in the revenue, even in a PPP. The exact role of COA must therefore be clarified prior to finalizing other PPP contracts. The powers of the regulator and the auditor have to be clearly reconciled with the existing PPP program, as overlaps may prove detrimental in the long run, muddling institutional roles and reducing investor confidence. Capacity must be developed in the PPP Center or COA to conduct PPP audits.

In conducting monitoring and evaluation, the CE3PH has strengthened its institutional memory, leading to prompt identification of health PPP best practices and potential shortcomings. The DOH now treats unsolicited proposals originating from the private sector with a warranted amount of caution, to ensure that the public receives the most advantageous deal possible. Imperfections in previous PPPs have also aided the CE3PH in improving contracts. For instance, the PPP contract in Jose Reyes Memorial Medical Center was unduly burdensome to the government, even increasing the hospital debt from indigents' use of equipment, with contract guaranteeing profit to the investor. Nowadays, the clauses no longer guarantee profits, only providing for the No Balance Billing policy, essentially transferring all financial risk. Potential conflicts of interest of health professionals, who may be able to earn more using older technology than the one undergoing PPP, also need to be appropriately managed.

In summary, the current context properly situates health PPPs to potentially address budget and health system concerns. However, there is mixed signals in the assessment of how the private and public sectors trust each other given the experiences in non-health PPPs. There is clarity in over-all PPP policy and regulatory framework but there is need to clarify if health PPPs, particularly those involving the

provision of clinical services is covered by existing laws. There is a robust institutional framework but there is need to explicitly bring in PhilHealth as part of the framework. Capacity in contract management had been built up but there is a need to strengthen monitoring capacity particularly the monitoring of compliance with the NBB policy of PhilHealth. Health PPPs are feasible in the current setting with substantial space for improving their feasibility if the subsequent recommendations are acted upon.

RECOMMENDATIONS

1. Revise the definition of Health PPPs

In its Administrative Order 2010-0036, the Department of Health called for greater partnership with the private sector to meet the Aquino health agenda to achieve universal health care for all Filipinos. The administrative order used the term PPP, defined as "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. This partnership may range from health care provision to logistics management, from information and communication technology to capacity building of health providers" and indicated their participation in projects requiring large capital. The definition is general and does not contextualize its relationship to health. Adopting the terms of PPIPs and PPIs may delineate the scale and requirements of various projects, highlighting its relevance and importance.

2. Amend the legal framework to ensure coherence of health PPPs

Depending on the results of the pending case at the Supreme Court, the DOH can either call for amendments to the BOT Law or draft its own health PPP law, to account for provision of health care. The latter option is justifiable, since health PPPs vary drastically from the infrastructure and utility counterparts. The roles of various institutions – PPP Center in contract management, COA in auditing PPPs – remain vague and must be clarified as soon as practicable.

3. Encourage public policy discussions on PPP and its relation to socio-economic development

At present, the PPP program is considered a development strategy; however, PPPs are not policy in themselves, but the means to fulfilling a strategy or policy. The mainstream view is that the PPP program will stimulate socio-economic development, yet the program cannot guarantee inclusive growth due to the current political and economic conditions.

A thorough, macro-level discussion on PPP and its impact on society is necessary, as well as debate about the pros and cons of collaborating with the private sector, the adequacy of public safeguards, and the link between prevailing neoliberal ideology and the reshaping of public institutions. In considering public interest in PPP, the government must not limit itself to the services the public receives, but must also consider the economic benefits of individuals hired by PPP projects. The economic environment for these persons must be taken into consideration, in order to ensure that the state and the public's interests are held above that of the private investors.

4. Develop a comprehensive communications program for PPPs

The resistance of specific segments of civil society to health PPPs stems from ideological differences; however, this will likely be appropriately resolved by involving stakeholders of hospitals about to undergo PPP. Dialogue with affected health professionals and staff would significantly reduce the opposition. Since public trust in PPPs has significantly deteriorated due to the outright privatization of

basic utilities and the subsequent failure of regulation, the government must reassure the public that these failures would not be repeated.

5. Rectify shortcomings in previous PPPs

The government must not only design future PPPs for success, but also correct the mistakes and outright failures in the past. This will convince the public of government sincerity in securing people's interests, and the investors of good faith in entering into new PPP deals. Abrogated contracts can be reversed, while regulators can enforce more strictly the provisions underlined in previous contracts. Trust that was lost in previous deficiencies can be regained, and the public good guaranteed.

6. Ensure transparency and accountability in the entire PPP process

Concomitant with a marketing program for the public is the provision of total transparency and accountability in PPPs. The government has promised to treat different public sectors as stakeholders in the PPP process, yet this has yet to be proven by action. The DOH should formulate a public disclosure policy that allows for health professionals to be kept abreast of developments in PPP projects, and reiterate its commitment to good governance principles in the development, construction, and operation of PPPs.

7. Conduct joint capacity building initiatives

As there is currently some duplication in training, the CE3PH and capacity building service of the PPP Center can jointly develop and administer capacity building to DOH hospitals, Centers for Health Development and LGUs. This would eliminate the duplication of roles, intensify the training for the potential end user, and increase the possibility of PPP uptake in LGUs due to the stronger support available. CHDs in particular must be encouraged to develop PPPs that address the specific needs of their locality, such as training for midwives.

8. Develop and enforce an evidence-based decision making process for PPPs

If unviable projects are entered into the PPP pipeline, these will likely result in failure of bidding, refinancing to the detriment of the government, or bankruptcy of the investor. In the long run, none of these options are beneficial to the government. There is a need to secure the decision making process from political interventions, which may be attained through institutionalizing the decision process. Definite, predetermined indicators will greatly assist in resisting reversal of the DOH's previously agreed decisions.

9. Strengthen implementation of monitoring and evaluation

In past PPPs, the monitoring and evaluation framework has not been thoroughly emphasized, leading to unfulfilled obligations on both the public and private sector sides. This has traditionally led to disagreements between the partners in the PPP. To resolve this, monitoring and evaluation must be strengthened. The DOH can explore the possibility of assigning this responsibility to an independent third party, or conducting it jointly with the private investor. Either way, strict enforcement of the contracts' incentives and penalties would induce better performance. The role of the COA in auditing PPPs must also be clearly defined under the law and IRR.

10. Utilize the health system indicators in evaluation of PPPs

It is believed that PPPs will increase the quality, efficiency, and sustainability of government hospitals. However, the remaining indicators of access and equity must be retained. The DOH may provide strong argument for PPPs if research proves that the poor have increased access to health care as a result of PPPs. Furthermore, this must be followed by efforts to either adopt PPPs to scale up access of poorer regions and rural areas to hospital care, or increasing general appropriations for hospital buildings these areas.

11. Ensure universal PhilHealth membership to attract private sector

Most PPPs in health are rooted in the fact that PhilHealth will pay the entire bill of patients. Health PPPs are then automatically more attractive in areas with high employment and PhilHealth enrollment, such as NCR and Central Luzon. It is evident that 100% PhilHealth enrollment is necessary for PPPs to work, both for ensuring equitable access of the poor to such services and attracting the private sector to earn profits through the volume of health services provided. With the expanding population coverage of PhilHealth converting charity patients into insured patients with third party payors, maintaining government ownership of the assets no longer automatically translate into a lack of financial viability brought about by the requirement of the old Hospital law (Republic Act 1939) to maintain 90% of government hospital beds as charity beds.

Bibliography

ABS-CBN News. (2014, February 4). Makati court halts MRT-3 expansion project. Retrieved from http://www.abs-cbnnews.com/business/02/04/14/makati-court-halts-mrt-3-expansion-project

Africa, T. (2011, March 11). Family Income Distribution in the Philippines, 1985-2009: Essentially the Same. Retrieved from http://www.sws.org.ph/pr20110321%20-%20Family%20Income%20Distribution%20by%20Mr%20Tomas%20Africa_FINAL.pdf

Akbayan Partylist. (2010, October 7). Statement of Akbayan on President Benigno Simeon Aquino's 100 days in Office. Retrieved from https://www.facebook.com/notes/akbayan-partylist/statement-of-akbayan-on-president-benigno-simeon-aquinos-100-days-in-office/10150105596668625

Alliance of Progressive Labor. (2011, March 8). World March of Women. Retrieved from www.apl.org.ph/?p=1007

Anonuevo, E. P. (2014, January 25). *ERC chief says regulator approved staggered Meralco rate hike, not increase itself*. Retrieved from Interaksyon.com: http://www.interaksyon.com/business/79391/erc-chief-says-regulator-approved-staggered-meralco-rate-hike-not-increase-itself

Aquino, B. (2010, November 18). Speech, PPP conference: Infrastructure Philippines 2010.

Asian Development Bank. (2008). *Public-Private Partnership Handbook.* Manila: Asian Development Bank.

Asian Development Bank. (2013). *Guidebook on public–private partnership in hospital management.*

Austria, S. A. (2012, May 17). The Philippine PPP Program .

Avestruz, F. (1995). *A Study of Philippine Hospital Management Administrative Systems.* Philippine Institute of Development Studies.

Balea, J. (2013, September 12). *First time: MWSS cuts water rates*. Retrieved from Rappler.com: http://www.rappler.com/business/industries/208-infrastructure/38745-first-time-mwss-reduces-water-rates

Banzon et al (2014, unpublished) *Analysis of the Maintenance and Depreciation Costs and Other Requirements of Selected Government Hospitals*

Barnes, J. (2011). *Designing Public-Private Partnerships in Health [primer]*. Bethesda, MD: SHOPS Projects, USAID

Barr, D. A. (2007). A Research Protocol to Evaluate the Effectiveness of Public–Private Partnerships as a Means to Improve Health and Welfare Systems Worldwide. *American Journal of Public Health, 97*(1), 19-25. doi:doi:10.2105/AJPH

Bontile, H. L. (2013, July). Performance of DOH-retained Hospitals in the Philippines. Philippine Institute of Development Studies.

Caballes, A., Söllner, W., & Nañagas, J. (2012). Financial protection mechanisms for inpatients at selected Philippine hospitals. *Social science and medicine, 75*(10), 1820-7. doi:doi: 10.1016/j.socscimed.2012.07.027

Calleja, N. P. (2014, February 15). *All 72 DOH-run hospitals candidate for PPP*. Retrieved from Philippine Daily Inquirer: http://newsinfo.inquirer.net/578114/all-72-doh-run-hospitals-candidate-for-ppp

Camus, M. (2013, July 23). MRT head Vitangcol goes on leave. Retrieved from http://newsinfo.inquirer.net/450751/mrt-head-vitangcol-goes-on-leave

Canadian Council for Public-Pirvate Partnerships. (2005). *About PPP: Definitions.* Retrieved from The Canadian Council for Public-Pirvate Partnerships: http://www.pppcouncil.ca/resources/about-ppp/definitions.html

Canilao, C. (2011, November). Investing in our future through Properly Prepared Projects (PPPs). PPP Center of the Philippines.

Cetrángolo, O., Mesa-lago, C., Lazaro, G., & Carisma, S. K. (2013). *Health Care in the Philippines.* Pasig City, Philippines: Friedrich Ebert Stiftung. Retrieved from www.fes.org.ph/modules/download_gallery/dlc.php?file=36

Couttolenc, B. F. (2009, March 23). Public-Private Partnerships in Health in the Philippines: Assessment and Way Forward.

Cruz, R. G. (2014, February 6). Lawmakers call for review of MRT contract. Retrieved from http://www.abs-cbnnews.com/business/02/06/14/lawmakers-call-review-mrt-contract

DBM. (2013, September 13). *Speech of DBM Secretary Abad, Philippine Economic Briefing.* Retrieved from PPP Center: http://ppp.gov.ph/?p=16463

de la Maza, A. (2014, February 11). *Five lessons emerging countries should learn from the Philippine PPP program.* Retrieved from Infrastructure PPP World: http://infrapppworld.com/2014/02/five-lessons-emerging-countries-should-learn-from-the-philippine-ppp-program.html

Department of Health [DOH]. (2012a). *List of DOH licensed health facilities.* Retrieved from Bureau of Health Facilities and Services (DOH): http://bhfs.doh.gov.ph/images/listing/hospital/final_list2012.pdf

DOF. (2011). *Privatization and the PPP Program*. Retrieved from Department of Finance: http://www.dof.gov.ph/?page_id=1318

DOH. (2006, March 13). Guidelines for the Issuance of Certificate of Need to Establish a New Hospital. Manila: Department of Health.

DOH. (2010a, December 16). *Aquino Health Agenda: Achieving Universal Health Care for all Filipinos.* Retrieved from Department of Health: http://www.doh.gov.ph/sites/default/files/Aquino%20Health%20Agenda%20-%20Universal%20Health%20Care.pdf

DOH. (2010b, December 1). Creation of a Task Force for the Coordination, Monitoring and Evaluation of Public-Private Partnerships in Health.

DOH. (2012, March 2). Establishment of the Office of the DOH - Center of Excellence on PPPs in Health (CE3PH) at the NKTI Diagnostic Center.

DOH (2011) *Kalusugang Pangkalahatan: Annual Report for 2011*.

DOH (2011O National Objective for Health 2011-16. Manila, Philippines. DOH.

DOH. (2012b, March 1). Policy Framework for Public-Private Partnerships in Health.

DOTC. (2013, November 28). *High turnout in Mactan-Cebu International Airport bid signals investor confidence in PPP program*. Retrieved from The Official Gazette.

Downs, S., Montagu, D., da Rita, P., Brashers, E., & Feachem, R. (2013). Health System Innovation in Lesotho: Design and Early Operations of the Maseru Public Private Integrated Partnership. *Healthcare Public-Private Partnerships Series, No.1, First Edition, March 2013*. San Francisco: The Global Health Group, Global Health Sciences, University of California, San Francisco and PwC.

Economist Intelligence Unit. (2011). *Evaluating the environment for public-private partnerships in Asia-Pacific:: The 2011 Infrascope.*

Gepte et al (2014, unpublished) *Review of Procurment in the DOH.*

GHD Pty Ltd. (2013, January). Policy brief: Contract management.

Global Health Group [GHG]. (2010). *Public-Private Partnerships for Health: An Atlas for Innovation.* University of California - San Fernando.

GMA News. (2012, September 25). Australia's Macquarie placing $600M in PHL's PPP projects. Retrieved from http://www.gmanetwork.com/news/story/275547/economy/finance/australia-s-macquarie-placing-600m-in-phl-s-ppp-projects

GMA News Online. (2013, July 13). Poor Pinoys to get free PhilHealth benefits starting in August. Retrieved from http://www.gmanetwork.com/news/story/317332/news/nation/poor-pinoys-to-get-free-philhealth-benefits-starting-in-august

Government of the Philippines. (2010, July 25). *A Social Contract with the Filipino People*. Retrieved from The Official Gazette.

Herrera, M. E., Roman, F. L., & Alarilla, M. C. (2010). *Overview of Health Sector Reform in the Philippines and Possible Opportunities for Public-Private Partnerships.* Asian Institute of Management. Retrieved from www.aim.edu/files/download/131

Juban et al (2012). A Description of Existing Public-Privat Partnerships in DOh-retained Tertiary Hospitals in NCR and Selected Secondary and Tertiary Hospitals in Key Cities Outside NCR

Kritz, B. (2013, December 30). *Jericho Petilla: Regulatory capture personified*. Retrieved from Manila Times: http://www.manilatimes.net/jericho-petilla-regulatory-capture-personified/64100/

Lavado, R. F., Pantig, I. M., Rosales, K. T., & Ulep, V. G. (2011). *Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the DOH.* Philippine Institute of Development Studies.

Lavado, R. F., Sanglay-Dunleavy, A. B., Jimenez, J., & Matsuda, Y. (2010, January). How Are Government Hospitals Performing? *A study of resource management in DOH-retained hospitals*. Philippine Institute of Development Studies. Retrieved from Philippine Institute of Development Studies.

Magkilat, B. (2014, January 6). Manufacturing, PPP to cure high unemployment. Retrieved from http://www.mb.com.ph/manufacturing-ppp-to-cure-high-unemployment/comment-page-1/

Manila Bulletin. (2010, November 20). Scrapping of Laguna project stuns Belgian firm. Retrieved from https://ph.news.yahoo.com/scrapping-laguna-project-stuns-belgian-firm.html

Montecillo, P. (2011, August 12). Gov't to renegotiate MRT 3 contract. Retrieved from http://business.inquirer.net/12231/gov%E2%80%99t-to-renegotiate-mrt-3-contract

National Statistical Coordination Board. 2013. Philippine MDG Watch. http://www.nscb.gov.ph/stats/mdg/mdg_watch.asp

National Statistical Coordination Board. 2013. Philippine national health account 2012.

National Statistics Office. (2008). *Philippines National Demographic and Health Survey 2008.* Retrieved from Demographic and Health Surveys Program (USAID): dhsprogram.com/pubs/pdf/SR175/SR175.pd

Official Gazette. (2013). General Appropriations Act, FY 2013. *108(1)*.

Orias, E. (2014, February 12). MRT accuses DOTC of BLT violations in buying 48 coaches. Retrieved from http://www.malaya.com.ph/business-news/news/mrt-3-accuses-dotc-blt-violations-buying-48-coaches

Oteyza, K. C. (2013, September). *Gov't urged to focus on investment partnerships in health*. Retrieved from 11th Development Policy Research Month, Philippine Institute of Development Studies: http://dirp4.pids.gov.ph/DPRM/dprm11/?p=373

PPP Center. (2010). *Mandate and Functions.* Retrieved from PPP Center Philippines.

PPP Center of the Philippines. (2012, May). The Philippine Public-Private Partnership Program.

PPP Center Philippines. (2010). *Organizational Structure*. Retrieved from PPP Center Philippines.

Rappler.com. (2013, September 11). *Northrail contractor got paid $129 million more*. Retrieved from Rappler.com: http://www.rappler.com/nation/38685-government-overpaid-northrail-contractor

Remo, M. V. (2014, January 3). *Gov't allots P30B as PPP backup kitty*. Retrieved from Inquirer.net: http://business.inquirer.net/158655/govt-allots-p30b-as-ppp-backup-kitty

Remo, M. V., & Montecillo, P. G. (2013, October 3). PH secures 3rd investment grade rating from Moody's. Retrieved from http://business.inquirer.net/145921/ph-secures-3rd-investment-grade-rating-from-moodys

Richter, J. (2004). Public-private partnerships and Health for All: How can WHO safeguard public interests? *Globalism and Social Policy Programme*. Ministry for Foreign Affairs, Finland.

Smith, A. (2011, November). Policy, legal, and regulatory frameworks for successful PPPs.

SunStar Iloilo. (2014, Februrary 7). Defensor seeks full implementation of 'No Balance Billing'. Retrieved from http://www.sunstar.com.ph/iloilo/local-news/2014/02/07/defensor-seeks-full-implementation-no-balance-billing-327080

Torres-Tupas, T. (2014, February 3). SC urged to stop privatization of Philippine Orthopedic Center. Retrieved from http://newsinfo.inquirer.net/573180/sc-urged-to-stop-privatization-of-philippine-orthopedic-center

Tsilaajav, T. (2009, March). Costing study for selected hospitals in the Philippines. European Commission .

United Nations Economic Commission for Europe. (2012). *Capacity building programme on Public-Private Partnerships.* Retrieved from United Nations Economic Commission for Europe: http://www.unece.org/fileadmin/DAM/ceci/images/ICoE/Introductionppp.pdf

Villanueva, M. (2014, February 24). 'Last two minutes'. Retrieved from http://www.philstar.com/opinion/2014/02/24/1293843/last-two-minutes

World Health Organization. (n.d.). *Public-Private Partnerships for Health*. Retrieved from World Health Organization: http://www.who.int/trade/glossary/story077/en/