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Working Paper

The state of health infrastructure investments in the Philippines and assessment of the Health Facility Enhancement Program (HFEP)

PIDS Discussion Paper Series, No. 2025-05

Provided in Cooperation with:

Philippine Institute for Development Studies (PIDS), Philippines

Suggested Citation: Tomas, Therese Jules P.; Carreon, Danielle Lois M.; Dagoy, Louie Iyar L.; Manuel, Aaron Carlos G.; Ulep, Valerie Gilbert (2025) : The state of health infrastructure investments in the Philippines and assessment of the Health Facility Enhancement Program (HFEP), PIDS Discussion Paper Series, No. 2025-05, Philippine Institute for Development Studies (PIDS), Quezon City, https://doi.org/10.62986/dp2025.05

This Version is available at: https://hdl.handle.net/10419/316186

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This study was carried out in collaboration with the Department of Health as part of the 2023 Advancing Health through Evidence-Assisted Decision with Health Policy and Systems Research Program.

CONTACT US:

RESEARCH INFORMATION DEPARTMENT Philippine Institute for Development Studies

18th Floor, Three Cyberpod Centris - North Tower EDSA corner Quezon Avenue, Quezon City, Philippines https://www.pids.gov.ph

publications@pids.gov.ph



(+632) 8877-4000

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PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES

April 2025

Abstract

The Health Facilities Enhancement Program (HFEP) is a capital investment grant administered by the Department of Health (DOH), designed to help local government units (LGUs) augment their health infrastructure, such as primary healthcare facilities, hospitals, and equipment. Over the past decades, HFEP has accounted for approximately 12% of DOH's total budget. Despite its scale and over a decade of implementation, systematic program evaluations remain limited. We used a mixed-methods approach to assess the various stages of program implementation: planning, budget allocation, execution, and monitoring and evaluation. At each stage, we identify critical challenges undermining the program's effectiveness. Our findings reveal long-standing inequities in grant distribution, with some LGUs receiving national funding despite not being among those with the greatest need. This study aims to provide insights to inform supply-side reforms, ensuring a more equitable and efficient allocation of national resources in a highly decentralized health system.

Keywords: Health Facilities Enhancement Program, health infrastructure, health capital expenditure, capital stock, health facilities, equipment

Executive Summary

The Health Facility Enhancement Program (HFEP) is a capital investment grant designed to support local governments and public hospitals in addressing the country's scarcity and maldistribution of health infrastructure. It is considered one of the major programs of the Department of Health (DOH). From 2008 to 2023, the national government spent PHP 190 billion on the program, accounting for about 12% of the total budget. In this report, we assessed the implementation of HFEP. We identified challenges to its successful implementation and in achieving its intended goals.

The state of capital infrastructure in the Philippines

Capital infrastructure still needs to be improved in the Philippines. Although the number of hospital beds has increased over the years, the bed-to-population ratio has declined to 0.93 beds per 1,000 people in 2024, falling below regional and global averages. This ratio lags the projected needs outlined in the Philippine Health Facility Development Plan (PHFDP), which is 2.5 beds per 1,000 population. Despite transitioning to an upper-middle-income country status, the bed-to-population ratio in the Philippines remains comparable to that of the world's poorest countries. Our analysis highlights that the shortage is particularly high in poorer provinces. Wealthier cities and provinces have better access to private hospital beds. Still, severe overcrowding remains a persistent issue in public hospitals, with bed occupancy rates surpassing 100%, a dangerous level that negatively impacts outcomes. Regarding primary care facilities, most local governments still fall short of the recommended ratio of one Rural Health Unit (RHU) per 20,000 population.

Capital expenditures on health

Recent trends suggest that the Philippines is progressing in capital investments. According to the Philippine National Health Accounts, capital spending on health has risen significantly in recent years, reflecting the government's commitment to addressing supply-side constraints in the health sector. From 2019 to 2023, the country's average capital spending on health was USD 15.8 per person, higher than lower-middle-income countries, according to WHO Global Health Expenditures. Public sector investments have primarily driven this increase.

Despite the decentralization of the health sector, the national government remains the main contributor of capital investments. The national government accounts for about 88% of the total capital spending on health. Capital spending on health of local governments accounts for a small share. From 2017 to 2023, LGUs allocated only 4.41% of their total capital expenditures to health spending. This reflects perhaps a lower priority set by most local governments for health investments. Local governments may be focusing their spending on other sectors. Wealthier local governments also tend to invest more in health infrastructure, while areas with higher poverty allocate less, further widening inequities in healthcare access.

Key Findings

Since its inception in 2008, HFEP has funded 42,439 capital investment projects in health, amounting to about PHP 190 billion. Our analysis shows that primary care facilities consistently received the most projects. Over the years, there were noticeable shifts in project distribution, with increased allocations for DOH and LGU hospitals in certain periods. These reflect the HFEP's evolving focus, aligning with policy shifts and the priorities of

different administrations. We examined various implementation stages to assess the program comprehensively, including program planning, budget allocation, construction, and monitoring and evaluation. Key findings are highlighted for each stage.

Per policy, the planning process of HFEP utilizes a bottom-up approach to ensure projects meet the population's needs. During the planning phase of HFEP, local governments are responsible for assessing and addressing gaps in health infrastructure. A common issue identified is the need for more technical guidance from local governments on health facility planning, resulting in inconsistent planning capacities across LGUs. Frequent changes in annual guidelines and documentary requirements complicate the process, leading to delays and inefficiencies. Political influences at the local level usually undermine the planning process, as local leaders often prioritize projects that need to align with national health agendas, resulting in resource mismanagement and deviations from planned capital investments.

Inequities in HFEP budget allocation remain a challenge. Despite the national program's intent for more equitable resources, *that is*, allocating resources to those with lower capacity, poorer local governments (as measured by poverty incidence in the municipality and LGU income per capita) do not consistently receive more grants, and evidence suggests that wealthier local governments tend to have higher per capita funding – as shown in our quantitative analysis. The National Allocation Framework (NAF) is meant to prioritize local governments with less capacity to receive HFEP grants to ensure equitable distribution of resources.

However, budget allocations are often subject to a legislative and political process that prioritizes different value systems, which are neither explicit nor documented. This results in inequitable allocation of HFEP resources and carries implementation challenges. While the political process can increase funding for LGUs, allowing them to invest in other initiatives, local governments may need help absorbing additional projects, especially those not originally part of the plan. Insufficient complementary resources, such as limited land for new buildings or inadequate staff to operate new facilities, are recurring challenges.

The management for HFEP implementation and procurement reflects limited technical capacity. Insufficiency and inefficiencies of funding also contribute to delays and underutilization of projects. High personnel turnover and inadequate technical guidance contribute to the delays. In our thematic analysis, key informants commonly note the need for additional human resources and budget to support newly constructed facilities. Poor absorptive capacity of grants, especially in less affluent local governments, further exacerbates these challenges. In contrast, a recurring theme in our qualitative analyses is that allocated grants are often deemed "insufficient," leading to incomplete projects or reduced project scope, particularly in poorer or geographically isolated LGUs.

How should the country move forward?

Long Term Recommendations

Changing the paradigm of how the national government approaches grants to local governments. The DOH should consider implementing "service grants" that provide comprehensive support to local governments, in addition to capital investment grants. Service grants include human resources, operational funding, and technical assistance. By adopting this integrated grant mechanism, the DOH can ensure local governments can implement and sustain

capital investments, maximizing their impact. This approach addresses staffing and equipment, resulting in more effective and sustainable healthcare delivery across all local governments.

An integrated planning framework would harmonize these programs, leading to more cohesive and efficient support for local health systems. In addition, the national government should sequentially phase its grants. For example, local government could receive a capital infrastructure grant to build new facilities in the first year. In subsequent years, additional grants could be provided to support staffing and operational needs to ensure the effective utilization of these new facilities.

Medium Term Recommendations

As the country moves towards province-wide health systems, the provision of HFEP grants should be patterned after the needs of the provinces. This means that planning for HFEP proposals must be conducted per province. Doing so will allow these health systems to prioritize areas with the least capacities (i.e., high poverty incidence, low public spending per capita, and high percentage share of GIDAs) and the highest gaps in health capital outlay. Provincial-level planning will ensure the availability of services and facilities within local health systems while strengthening the program's commitment to its existing equity framework, the NAF.

Leverage national resources to stimulate increased local government spending on capital investments in health through a more strategic mechanism. This can be operationalized by implementing the NAF envisioned in the PHFDP. It identifies local governments' required health infrastructure needs and aligns suitable grant mechanisms based on their capacity. For instance, local governments with higher capacity should provide counterpart funding with national government contributions. In contrast, those with limited capacity could receive more comprehensive grants to ensure equitable development across local governments.

Short Term Recommendations

Standardize requirements for project proposals. One of the challenges discussed in this paper is the changing annual guidelines for HFEP project proposals. Standardizing these guidelines or requirements will ensure that LGUs can meet them during the project planning season. This will also avoid constant changes in their project plans and existing facilities, thereby reducing costs in the long run. In addition, changes to the guidelines should also be paired with technical guidance to allow LGUs to adopt them. Providing an advance notice before implementing these changes will also give LGUs ample time to prepare their resources.

The national government should reconsider its approach to scaling up the construction of health facilities in underserved areas. The current design of the HFEP cannot keep pace with growing demand. To accelerate implementation, the government could broaden its existing bulk procurement mechanisms and explore public-private partnership (PPP) models, particularly for bulk contracting of infrastructure and services. While the HFEP Management Office, CHDs, and DOH Hospitals currently conduct bulk procurement, this method is limited to medical transport vehicles and select medical equipment.

Measure the program's success by outlining performance indicators vis-à-vis program objectives and health outcomes. Currently, assessments of HFEP are limited to the number of facilities built and the amount of funds that have been fully utilized. By measuring health

indicators such as service utilization (for example, through outpatient visits, immunization, assisted births, etc.), program implementers can see how government investments translate to improved health outcomes. This is especially important since the program's priorities evolve with leaders' health and development agenda.

Expand the portion of HFEP grants that can be used for maintenance and other operating expenses (MOOE) and other administrative overhead expenses. GAA Special Provisions only allow 1% of the total project budget for administrative overhead expenses such as hiring job order staff, transportation expenses, per diems, and more. However, our findings suggest that the insufficiency of human resources is one of the main reasons behind poor absorptive capacity. The national government should explore increasing the 1% cap to allow program recipients to hire more personnel to implement their projects. This will help resolve the inadequate supply of human resources at the back end of program implementation.

Provide guidelines on proposals that go through non-preferred routes. It is common among program recipients to deviate from the program's processes by directing their HFEP proposals to politicians, central DOH, or other offices that bypass the vetting process conducted at the CHDs. This practice interferes with HFEP's budget allocation as it risks moving funds from low-income and low-capacity LGUs to wealthier localities. It is, therefore, important to address this issue by providing clear and explicit mechanisms for returning these proposals to LGUs or referring them to the CHDs. Mechanisms to deter such practices should also be established to ensure that funding goes to the program's intended recipients.

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The State of Health Infrastructure Investments in the Philippines and Assessment of the Health Facility Enhancement Program^{*}

Therese Jules P. Tomas, Danielle Lois M. Carreon, Louie Iyar L. Dagoy, Aaron Carlos G. Manuel, and Valerie Gilbert T. Ulep[†]

1. Introduction

The Health Facility Enhancement Program (HFEP) is a capital investment grant that the Department of Health (DOH) provides to local governments and health facilities in the Philippines. Its primary goal is to address the shortage and unequal distribution of primary care facilities, hospitals, and medical equipment. Since its inception in 2008, the DOH has allocated PHP 190 billion to the program (Department of Health 2024). HFEP's share of the DOH budget has steadily grown from 8.77% in 2008 to 12.58% in 2022, at times surpassing 20% of the total DOH budget (Department of Budget and Management 2024).

The HFEP started in 2008, but a comprehensive evaluation of the program still needs to be improved. Lavado et al. (2012) and Picazo et al. (2016) observed improvements in healthcare access but also pointed out significant implementation challenges, including inequities and inefficiencies. Given the HFEP's evolving context and the operational changes over the past decade, a new assessment is necessary. As the Philippine healthcare system undergoes major reforms, such as the Universal Health Care Act of 2019 and the Supreme Court's Mandanas-Garcia ruling, reassessing the HFEP and reconsidering its role has become increasingly important.

This study has two main evaluation questions. First, it seeks to answer the question: *Is HFEP allocation equitable and efficient vis-à-vis LGU need and capacity?* The study answers this by analyzing HFEP administrative data and support datasets. The first question assesses whether the program meets its intended goals and whether national resources are distributed equitably and efficiently to local governments. Second, the study aims to provide a comprehensive process evaluation of the program by answering the following questions: What *are the challenges and issues in the program's key areas (planning, allocation, implementation, and monitoring and evaluation)?* The study maps out the program's processes using official documents and policies and interviews with select program implementers at different levels of governance (national, regional, and local).

^{*} This assessment was funded by the Department of Health

[†]TJT is a Research Analyst II, VGU is a Senior Research Fellow, DLC is a Senior Project Technical Specialist, LID is a Project Technical Assistant, and ACM is a Project Technical Specialist at the Philippine Institute for Development Studies. The authors would like to thank the administrative assistance of Jann Trizia B. Talamayan.

2. The Health Facility Enhancement Program

a. Brief overview of the program

The Health Facilities Enhancement Program (HFEP) is one of the major programs by the DOH. Established in 2008 by the DOH, HFEP aims to provide capital investment grants to local governments and public hospitals to construct or upgrade health infrastructure and procure medical equipment. From 2008 to 2010, the program allocated PHP 8.43 billion nationwide to improve public health facilities (Flavier et al. 2011). The key policy driving HFEP was the DOH's *Kalusugan Pangkalahatan* (KP). Under KP, the development and upgrading of the *supply side* was a critical part of the health reforms achieved through HFEP and the *demand-side* intervention through universal PhilHealth membership. Funding for these reforms was supported by the passage of the Sin Tax Law in 2014, which allocated excise taxes collected from tobacco and alcohol sales to the health budget and even supplemented the budget for HFEP projects. The HFEP began with a budget of PHP 0.5 billion in 2007, growing to PHP 25 billion by 2016, with continued increases in subsequent years (Dayrit et al. 2018).

The overall goal of HFEP is to improve healthcare access. The program addresses scarcity and maldistribution of health facilities and equipment by providing capital investment grants to local governments and public hospitals to build, upgrade, and develop their facilities. It prioritizes resource allocation to remote areas and those with high poverty incidence. In its early years, HFEP prioritized "those located in the National Anti-Poverty Commission's list of municipalities; those located in Department of Social Welfare and Development's Listahan, and those located in Geographically Isolated Disadvantaged Areas (GIDA) and Indigenous Cultural communities/ Indigenous Peoples areas (ICCs/IPS), especially those endorsed by the Bureau of Local Health Systems Development."³

In recent years, the National Allocation Framework (NAF), which outlined the gaps in health capital stock and identified priority local governments based on infrastructure gap and capacity, strengthened the program's commitment to equity, at least in policy.

HFEP's priorities are evolving. While its primary goal is improving healthcare access, leaders may adjust the program's objectives to reflect their health and development agenda. **Table 1** summarizes HFEP's annual priorities and how they are linked with each administration's health sector objectives.

³ DO No. 2016-0110 Guidelines for the Preparation for Availment and Processing of DOH HFEP Projects for FY 2016, DO No. 2017-0112 Guidelines for the Preparation and Selection of Projects for HFEP 2017, AO No. 2019-0048 Guidelines for Accessing and Processing of Project Proposals for HFEP 2019

Year	Priorities	Health Agenda and/or Objectives		
2011- 2012	BHS; RHU; and LGU Hospitals	Aquino Health Agenda (AHA) to achieve Universal Health Care (UHC)		
2013	BHS, RHU, LGU Hospitals, DOH Hospitals, and Hospital Development	 AHA to achieve UHC Ensure the achievement of the health system goals of better health outcomes, sustained health 		
2014	BHS, RHU, LGU and DOH Hospitals, Dialysis Clinics, Blood Service Facilities, Psychiatric Facilities and Treatment, and Rehabilitation Centers	financing and a responsive health system to ensure all Filipinos have equitable access to affordable health services		
2015	BHS, RHU, Government Hospitals, DOH Facilities and grounds, and other Government Health Facilities			
2016	BHS, RHU, Government Hospitals, DOH Facilities & ground, and other Government Facilities	 Kalusugan Pangkalahatan (KP) / UHC Improving primary health facilities to 'gatekeep' and deliver preventive health service Improving quality of LGU hospitals to comply with DOH licensing and PhilHealth accreditation requirements as quality referral centers Decongest DOH Hospitals to be able to provide quality tertiary care and specialized treatment 		
2017	BHS, RHUs, UHCs, LGU Hospitals, DOH Hospitals, Drug Abuse Treatment and Rehabilitation Centers, Quarantine Stations, Reference Laboratories, ARMM Health Facilities, Health Facilities in GIDA and with ICC/IPs,	 Philippine Health Agenda (PHA) 2016 through the Philippine Health Facility Development Plan (PHFDP) 2017-2022 Eliminating white elephant HFEP projects Improving RHUs, UHCs, and BHJS in their gatekeeping and delivery of preventive and promotive health services accessible to the people Improving the quality of hospitals owned by LGUs and their compliance with the DOH licensing and PhilHealth accreditation Upgrading DOH Hospitals and other NGA healthcare facilities Ensuring the availability of specialty care at the regional level Establishing and/or upgrading other government health facilities (i.e. drug abuse treatment and rehabilitation centers, quarantine stations, and reference laboratories) 		
2018	BHS, RHUs, UHCs, LGU Hospitals, DOH Hospitals, NGA Hospitals, Specialty Care at the regional level, Drug Abuse Treatment and Rehabilitation Centers, Quarantine Stations, Blood Service Facilities and Reference Laboratories	 FOURmula One Plus (F1 plus for Health) and PHFDP 2017-2022 Improving health facilities previously funded through HFEP but non-functional due to incomplete construction, inadequate utilities, and lack of equipment (granted that end-users have enough resources to maintain the HFEP project) Improving RHUs, UHCs, and BHS in their gatekeeping and delivery of preventive and promotive health services accessible to the people Improving the quality of hospitals owned by LGUs and their compliance with the DOH licensing and PhilHealth accreditation requirements Upgrading DOH Hospitals and other NGA healthcare facilities 		

Table 1. HFEP Priorities, by Administration (2011-2023)

		Ensuring the availability of specialty care	at the
		regional level	
		 Establishing and/or upgrading other 	health
		facilities (i.e. drug abuse treatment	t and
		rehabilitation centers, quarantine stations,	blood
		service facilities, and reference laboratories)
2019	BHS, RHUs, UHCs, City Health Offices,	UHC and F1 plus for Health	
	(CHOs), LGU Hospitals, Motor Vehicles	HFEP utilized project prioritization through	project
		prioritization	
		Priority 1 – Priority 5	
2020	BHS, RHUS, MTVs for LGU Hospitals	UHC and F1 plus for Health	
	and DOH Hospitals, City Health Offices	 Improve the country's overall health system 	goals
	(CHOS)	Improve nealth outcomes	
		Provide financial risk protection	and
2024			
2021	BHS, RHUS, POlyclinics, LGU Hospitals,	UHC, FI plus for Health, and PHFDP	
	DOH Hospitals, COVID-19 laboratories		
	and quarantine facilities, whys,		
2022	RUS RUUS Rehalining LCU Hagnitals		
2022	BRS, RROS, POlyclinics, LGO Rospitals,		
	and Dialysis Contars Burgau of		
	Quarantine Military Hospitals		
	Molecular Laboratories Drug Abuse		
	Treatment and Rebabilitation Centers		
	Mega Health Centers DOH Central		
	Office medical equipment and MTVs		
	COVID-19 laboratories and guarantine		
	facilities. Multi-year Obligation		
	Authority (MYOA) projects of Apex		
	Hospitals, and monitoring of HFEP		
	projects		
2023	BHS, Super Health Centers, RHUs,	PHFDP and UHC	
	Polyclinics, LGU Hospitals, DOH		
	Hospitals, Military Hospitals, State		
	Universities, Drug Abuse Treatment		
	and Rehabilitation Centers (DATRCs),		
	Specialty Centers, MYOA projects of		
	Apex Hospitals; medical equipment		
	and MTVs		

Source: Author's illustration of the 2011 to 2023 annual HFEP implementing guidelines (DOH 2024) and HFEP Performance Audit Report (COA 2017).

The DOH developed implementing and availment guidelines, which align the HFEP priorities with the administration's health agenda. In 2008, HFEP focused on upgrading primary care facilities, such as BHSs and RHUs, to provide Basic and Comprehensive Obstetric and Newborn Care services and strengthen facility referral networks (see Annex 1 for a summary of HFEP objectives).⁴ From 2016 to 2018, under the "Kalusugang Pangkalahatan" initiative of the Aquino Administration, the HFEP aimed to improve primary care facilities, assist LGU hospitals in meeting licensing standards, and decongest DOH hospitals. During this period, HFEP priorities alternated between primary care facilities and hospitals, emphasizing

⁴ DOH DO No. 2008-0162. Guidelines and Procedures for the Implementation of the Government Hospital Upgrading Project under the CY2008 Health Facilities Enhancement Program Funds of the DOH.

completing unfinished HFEP projects in 2018. Following the enactment of the UHC Law in 2019, primary care facilities, particularly super health centers and those with in-house ancillary services like laboratories and pharmacies, became the primary focus of HFEP funding. However, implementing the Mandanas Ruling has shifted the focus from LGU-owned primary care facilities to DOH-retained hospitals. LGUs in Categories 2-4 of the NAF are already excluded from the 2024 HFEP guidelines, signaling a continued shift in funding priorities as health devolution progresses.

Since its inception, the national government has allocated PHP 200 billion for the program. The HFEP is one of the highest-budgeted projects of the DOH, which accounted to 11% of the total DOH budget in 2022 and 2023 (DBM 2023). Investments increased significantly from 2008 to 2018, reaching about 29% of the total DOH budget. However, HFEP spending from the onset of the pandemic until 2021 resulted in a drastic decline to less than 6%.⁵ This reduction can be attributed to shifting government priorities, budget reallocations, and the impact of COVID-19. Political leadership and policy direction changes are crucial in determining the program's annual budget allocations. Figure 1 shows the percent share of HFEP in the DOH's yearly total budget. The HFEP budget consistently formed a larger portion of the total budget (around 30%).





Source: Authors' analysis and illustration of the 2008-2023 General Appropriations Act (GAA) (Department of Budget and Management 2024).

⁵ Computed from GAA allotments.



Figure 2. Share of HFEP Appropriations to total Capital Outlay Appropriation

Source: Authors' analysis and illustration of the 2008-2023 General Appropriations Act (GAA) (Department of Budget and Management 2024).

The analysis of HFEP data from the DOH from 2008 to 2022 reveals an emphasis on strengthening Primary Health Care (PHC). While LGU and DOH hospitals received notable funding during specific years, primary care facilities (e.g., RHUs, BHSs) have dominated the program, representing 62% of the total projects (see Figure 3).



Figure 3. Share of HFEP Project Type

Source: Authors' analysis and illustration of the 2008-2022 HFEP Administrative Data (DOH 2024a).

HFEP efforts have increasingly focused on refurbishing and fully equipping health facilities. Although construction increased markedly in 2015-2016, repair and renovation activities maintained a stable share in the program. The introduction of land ambulance procurement in 2019 reflects the program's expansion to address the logistical needs of HFEP recipients. In 2021-2022, we observed a shift in emphasis toward equipping (see Figure 4).



Source: Authors' analysis and illustration of the 2008-2022 HFEP Administrative Data (DOH 2024a).

3. Methodology/assessment framework

This mixed-methods study includes both quantitative and qualitative components. For the quantitative portion, we analyzed municipal-level HFEP obligations and disbursements data requested from DOH, along with auxiliary datasets from the Philippine Statistical Authority (PSA), municipal socio-demographic variables, and financial data from the Bureau of Local Government and Finance (BLGF), to identify trends and concentrations in HFEP disbursements. Additional analyses of infrastructure data from Hospital Statistical Reports (HSR) were generated to supplement the incomplete facility-level data of HFEP. We then triangulated the results to determine whether HFEP funds were allocated and disbursed equitably and efficiently.

For the qualitative portion, we conducted semi-structured key informant interviews with 28 national and local offices involved in HFEP implementation. These interviews spanned various governance levels, including the HFEP Management Office under the DOH and local governments, which are primary beneficiaries and end-users of HFEP grants. Provinces were selected based on economic status, and urban and rural municipalities were chosen within each province. We reviewed official HFEP documents from its inception in 2008, including DOH implementing guidelines and policies, the Philippine Health Facility Development Plan, Commission on Audit reports, and the Devolution Transition Plan.

4. Capital investments for health

Capital investments for health involve funding for constructing and upgrading healthcare facilities and purchasing medical equipment. These investments are critical because they improve access, quality of care, and health outcomes. In this section, we assess the state of capital investments for health in the Philippines, including the governance and institutional arrangements, the current health infrastructure stock and distribution, and the spending on capital infrastructure.

Adequate and equitable capital investments improve health outcomes. Capital investments are linked to better health outcomes because they are a prerequisite for providing quality health services (Mallick and Amo-Adjei 2021). Building healthcare facilities, procuring medical equipment, and using up-to-date information and communication (ICT) systems enable health facilities to respond to the population's needs. Valdivia (2002) examined the health reform of Peru in the 1990s. The government created new public health facilities that focused on the poor urban districts of Peru, making health services more accessible to poor families and increasing spending on preventive and primary healthcare services. (Hati and Mamujer 2013) found that poor health infrastructure leads to poor health outcomes in India. Capital investments reduce congestion at higher healthcare facilities and improve primary, preventive, and curative care delivery (Valdivia 2002).

In many health systems, especially those with decentralized regimes, capital investment grants are commonly provided to local or sub-national governments to support infrastructure development, public services, and economic growth. These grants aim to address regional disparities and promote equitable access. Effective governance of these grants requires clear guidelines, robust monitoring and evaluation frameworks, and accountability mechanisms to ensure funds are used efficiently and align with national priorities. While financing approaches vary, they often include a mix of direct allocations, matching funds, and performance-based incentives designed to encourage efficient resource use, foster local government ownership, and build capacity.

Country	Definition and governance/financing mechanics
India	The National Health Mission (NHM) provides financial support to various states across India. Under the program, states are tagged as either high-focus states- identified as states with weak health infrastructure and poor health (based on life expectancy, fertility rates, child and maternal mortality indicators) or non-focus states. The former can spend up to 33% of their NHM funds on infrastructure, while the latter may only spend up to 25%. State infrastructure spending is guided by population norms for public health facilities, with facility density increasing in difficult/tribal and hilly areas.
South Africa	The execution of provincial health budgets is up to the discretion of provincial governments in South Africa's decentralized regime. However, around 20% of these budgets are from conditional grants from the national government, which are designed to protect spending on specific programs. This implies less flexibility for provinces as these conditional grants are meant to be spent on priority services. Major conditional grants for health have commonly been related to HIV/AIDS interventions, national tertiary services, and health infrastructure. Beyond health, major conditional grants include infrastructure and housing.
Australia	Australia's National Health Reform Agreement aims to improve health outcomes nationwide by providing funds for public hospital services delivered through emergency departments, hospitals, and community health settings. Although the funding comes from the federal government, states (or territories) can determine the services and functions provided in their areas. As system managers of public

Table 2.	. Examples of health systems that provided capital investment grants to sub	-national
	units.	

	hospitals, states are responsible for the planning and implementing their system- wide public hospital services.
Nigeria	The National Health Act of 2014 (NHA 2014) earmarks 1% of Nigeria's federal revenues for the Basic Healthcare Provision Fund (BHCPF), which aims to improve service quality at the primary level. The BHCPF differs from the intergovernmental transfers, which are provided to state ministries as unconditional block grants. Unlike these transfers, the NHA 2014 requires states to provide a 25% counterpart for the BHCPF.
Canada	The Canada Health Transfer (CHT) is a major health program by the federal government that grants funding to the provinces and territories of Canada. It ensures access to quality health services across regions by allocating funding on a per capita framework, providing more resources to areas with a smaller population and lower tax income. These grants ensure that the federal government provides monetary assistance to regions and territories with a smaller capacity. Although the CHT is not directly aimed at enhancing healthcare facilities, the grants allow healthcare providers to expand their facilities.

Sources: Ministry of Health & Family Welfare (2020); James et al. (2018); Australian Government Department of Health and Aged Care (2024); Ibrahim et al. (2023); Mou (2021).

a. Governance and institutional arrangements

The Philippines operates with a high degree of decentralization. Local governments (*that is*, provinces, municipalities, barangays/villages) are responsible for ensuring the availability of health infrastructure in their localities. They are mandated to construct, manage, and maintain health infrastructure. Section 17 of the Local Government Code (LGC) of 1991 explains the duties of an LGU at different levels. Barangays maintain their health facilities, such as health centers and barangay health stations (BHS). Such facilities offer basic services related to maternal and newborn care, family planning, nutrition, dental care, immunization, and patient referral. Barangay officials also provide services and construct facilities that promote general hygiene and sanitation within their catchment areas. Barangay Health Workers (BHW) work at the BHS to ensure service provision (RP 1991).

Municipal and city governments are expected to provide primary health care services, such as maternal and child health, and control and prevent communicable and noncommunicable diseases (Section 17, LGC of 1991). Municipal and city governments are responsible for procuring medical equipment and drugs and building and maintaining the infrastructure and PHC facilities (e.g., Rural Health Units/City Health Units). They hire doctors, public health nurses, midwives, dentists, medical technologists, and sanitary engineers or inspectors to man, operate, and maintain their primary healthcare facilities. Provincial governments provide primary healthcare services, but their main function is to provide hospital care through their infirmaries, district hospitals (usually Level 1), and provincial hospitals (usually Level 2).⁶ However, most highly urbanized cities (31 cities) provide PHC and hospital services for their constituencies.

⁶ Level 1 hospitals (or first-level referral hospitals) are non-departmentalized hospitals that provide clinical care and manage prevalent diseases in a locality. Level 2 hospitals (or second-level referral hospitals) are departmentalized hospitals that provide similar services as Level 1 hospitals but with additional treatments such as surgical procedures and intensive care (BHFS Administrative Order No. 70-A S. 2002, January 3, 2002, January 03, 2002)

Figure 5. Hierarchy of Facilities



Source: Author's illustration

LGU Level	Expenditure Assignment	Source				
Province	Hospitals and other tertiary health services	Sec.17 b (3)				
City	All services of the province and municipality	Sec. 17 b (4)				
Municipality	Primary health care	Sec. 17 b (2)				
	Maternal and childcare					
	Communicable and non-communicable disease control					
	services					
	Access to secondary and tertiary health services					
	Purchase of medicines, medical supplies, and equipment					
	Health centers and health facilities					
Barangay	Health services, including Barangay Health Centers	Sec. 17 b (1)				
	General hygiene and sanitation					

Source: Authors' illustration of the Local Government Code (RP 1991).

The national government sets national health policies, standards, and guidelines. The DOH is the technical authority on health. The DOH provides technical assistance to LGUs through capacity-building initiatives, including training, logistical support, and grants, to help carry out their devolved functions. Under the UHC Act of 2019, the role of DOH has expanded to include supporting LGU health capital investments and financing population-based services. As part of its regulatory function, the DOH issues licenses to hospitals, which have been in place since 1965.⁷ The more recent licensing requirements for primary care facilities began in 2020.⁸

⁷ Republic Act No. 4226. An Act Requiring the Licensure of All Hospitals in the Philippines and Authorizing the Bureau of Medical Services as the Licensing Agency.

⁸ Public and private Primary Care Facilities obtain a License to Operate by complying with facility standards set by the Department of Health. These facilities are assessed based on the following criteria: personnel, physical facilities, equipment and instruments, service delivery quality improvement activities, information management, and environmental management, with consideration to their assigned services. At the minimum, PCFs should offer medical consultation and minor surgical services and are not allowed to outsource these services (AO No. 2020-0047. Rules and Regulations Governing the Licensure of Primary Care Facilities in the Philippines).

Under the Universal Healthcare Act (RA No. 11223), local governments and the national government maintain the same function, with provinces and cities responsible for health service delivery through health care provider networks (HCPNs) composed of integrated Province and City-Wide Health Systems. These local health systems consist of private and/or public healthcare providers that ensure continuity of care from primary to tertiary health care and the delivery of individual- and population- based services. Within these local health systems, primary care facilities (managed by local government units) serve as the first point of care and help the population navigate the network. Meanwhile, Apex Hospitals are DOH-determined and -owned hospitals that provide specialty and tertiary services within the local health system (DOH 2020a). The national government provides guidelines, standards, and technical assistance (through the Local Health Systems Maturity Level) to guide LGUs in developing their network (DOH 2020b)The responsibility to construct, procure, and maintain health capital expenditures remains within the purview of the LGUs, consistent with their mandates in the Local Government Code.

b. Current stock of health facilities

Ownership of healthcare facilities in the Philippines varies by level of care. Primary healthcare services, delivered through BHS and RHUs, are predominantly owned and managed by LGUs. Lower-level hospitals (Level 1 and Level 2), which provide higher-level/curative care, are a mix of LGU and private ownership. Most referral and specialty hospitals (Level 3) are owned by the national government and private sector, with only a small number managed by LGUs, primarily in highly urbanized cities. **Error! Reference source not found.** shows the n umber of health facilities by ownership as registered in the National Health Facility Registry.

	LGU		National (DOH)		Private	
	Counts	Beds	Counts	Beds	Counts	Beds
Barangay Health	25,327**	144	594	0	N/A	N/A
Stations*						
Primary Care Facilities	2,878	196	136	0	2671	24
Rural Health Units**	2,513	152	129	0	N/A	N/A
City Health Office***	51	0	0	0	N/A	N/A
Gen. Clinical Lab.	291	43	7	0	2,639	24
Med. Outpatient Clinic	1	0	0	0	32	0
Municipal Health Office	22	1	0	0	N/A	N/A
Infirmaries	320	4,727	42	784	293	3,999
Level 1 Hospital	293	14,173	20	2,085	469	15,046
Level 2 Hospital	40	5,343	11	2,617	317	25,328
Level 3 Hospital	11	2,811	45	20,898	64	15,210

Table 4. Number of health facilities by type and ownership

Source: Authors' analysis and illustration of 2024 National Health Facility Registry (NHFR) (DOH 2024h) Note: Hospitals that do not have declared service capabilities in the NHFR were not included in the table above. *BHS without specified ownership by either LGU or National were assumed to be owned by LGUs

following LGC of 1991. ** RHUs without specified ownership by either LGU or National were assumed to be owned by LGUs following GC of 1991. *** CHOs are all assumed to be owned by LGUs

The number of hospital beds has been increasing, but the growth needs to keep pace with the rising population. Data from the National Health Facility Registry of DOH shows a steady increase in hospital beds. However, population growth has outpaced this increase, causing the

bed-to-population ratio to decline from 1.4 in 1990 to 0.93 in 2024. The bed-to-population ratio significantly decreased between 2012 and 2013. The rise in hospital beds since 2012 is primarily driven by private sector investments, with private beds taking up 51% of the total beds available in the country. The bed-to-population ratio remains below regional averages compared to Vietnam's 2.6 beds per 1,000 population (2014) and Malaysia's 1.8 beds per 1,000 population (2017). The country's bed-to-population ratio is significantly less than the global average of 2.8 beds per 1,000 population in 2017.





Source: Authors' analysis and illustration of 2000-2015 Philippine Statistical Yearbook (PSY) (PSA 2024a) and 2021-2024 NHFR (DOH 2024g).

Note: The number of beds for 2016-2020 is interpolated. Old versions of NHFR do not have data on the number of beds.

Figure 7. Bed-to-population ratio vs. GNI per capita



Source: Authors' analysis and illustration of the 2024 Global Health Observatory data (WHO 2024b)

The disparity in bed-to-population ratios across provinces in the Philippines highlights stark inequities in healthcare access. There is only one hospital bed per 1,000 people in the Philippines, far below the needed supply to meet growing demand. The Philippine Health Facility Development Plan (PHFDP) suggests that the country needs to increase its bed-to-population ratio to 2.7 beds per 1,000 people.

Figure 8 shows the bed-to-population ratio is much higher in highly urbanized cities, first-class municipalities, and affluent provinces. In contrast, poorer cities and provinces lag far behind. The data reveals significant disparities in the bed-to-population ratio across provinces and highly urbanized cities in the Philippines, with the national standard being one (1) bed per 1,000 population. While LGUs like Batanes and the cities of Iloilo and Manila exceed this standard, many provinces, such as Sulu, Leyte, and Basilan, fall well below, with ratios as low as 0.03 to 0.33 beds per 1,000 population. Private hospital beds are concentrated in wealthier areas, reflecting a market that caters to those who can pay. Although public hospital beds help offset the lack of private beds in less affluent areas, many low-income provinces still lack any hospital beds, and the overall share of public beds remains low across income classes, deepening socio-economic inequities in healthcare access.

Many provinces in the Philippines need access to hospital care. Our analysis shows that out of 116 provinces and highly urbanized cities, 22 lacks public level 1 hospitals, and 28 lacks level 2 hospitals. While the PHDP and the creation of provincial healthcare networks under the UHC Act (2019) aim to establish primary care and Level 1 and 2 hospitals across provinces, the absence of hospital infrastructure remains challenging, particularly in less affluent provinces. The lack of hospital infrastructure in less affluent provinces underscores disparities in healthcare access and highlights the need for targeted capital investments. The concentration of higher-level hospitals in wealthier, urbanized cities may further widen the gap in healthcare accessibility between urban and rural populations. **Figure 8** shows the disparity of the bed-to-population ratio across provinces and HUCs.

Figure 9 illustrates the relationship between the bed-to-population ratio and the poverty incidence. The scatter plot suggests an inverse relationship between the two variables, with a red dashed curve indicating a trend where areas with lower poverty incidence generally have a higher bed-to-population ratio.

Figure 8. The bed-to-population ratio on public vs. private and level 1 vs. level 2 beds, by provinces and HUCs





Source: Author's analysis and illustration of 2024 NHFR (DOH 2024h)



Figure 9. Bed-to-population ratio and poverty incidence by provinces and HUCs

Source: Authors' analysis of 2024 NHFR (DOH 2024h) and 2023 Official Poverty Statistics (PSA 2024b) Note: The bed-to-population ratio is computed using 2024 NHFR and 2024 population projections.

Overcrowding in public hospitals is due to insufficient capital investments. Analysis of the Hospital Statistics Report of DOH, the average median average bed occupancy rate (BOR) in public hospitals⁹ exceeded 100% capacity from 2017 to 2019. During 2020-2021, BOR declined, likely due to the pandemic, where COVID-19 wards were heavily utilized while non-COVID wards saw less demand. It is well-documented that BOR exceeding 85% can negatively impact hospital outcomes (National Institute for Health and Care Excellence 2018). **Table 5** shows the BOR in Philippine hospitals, disaggregated by ownership and capacity level.

⁹ Bed occupancy was defined as the percentage of in-patient hospital beds occupied, calculated by dividing the number of occupied beds by the average number of hospital beds. Evidence suggests that hospitals with average bed occupancy levels exceeding 85% are likely to experience regular bed shortages, periodic bed crises, and an increased incidence of healthcare-acquired infections.

	Public			Private		
Year	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
2017	117.96	118.35	103.52	65.52	65.34	61.87
2018	119	119.41	116.27	64.86	66.5	58.84
2019	128.81	135.04	121.1	69.39	70.24	63.12
2020	75.7	77.72	75.08	44.37	43.87	39.1
2021	75.16	69.64	62.32	38.11	39.51	33.31
2022	93.14	95.36	89.57	39.09	38.6	33.76

Table 5. Bed occupancy rate (2017-2022)

Source: Authors' analysis of 2017-2022 Hospital Statistical Report (HSR) (DOH 2024e)

Many Filipinos need access to primary healthcare facilities. RHU and BHS provide primary health care services. The PHFDP targets establishing one RHU per 20,000 people. However, data from the provinces and HUCs indicate a substantial gap between this target and the current availability of facilities (see **Figure 10**). The law requires that each barangay has a BHS. Yet, according to the 2024 National Health Facility Registry (NHFR), only 22 provinces and HUCs have achieved a ratio of one or more BHS per barangay. Although there are 44,000 barangays nationwide, only 25,327 BHS exist. Only 17 provinces have met the target of one RHU per 20,000 people.





Source: Authors' analysis and illustration of 2024 NHFR (DOH 2024h). Note: Including city health offices and municipal health offices

c. Capital expenditure for health

In the Philippines, capital investments have increased over the years. Public investments play a role in building a network of physical assets, including economic infrastructure (roads, airports, and electric utilities) and social infrastructure (such as schools and hospitals). Historically, public investment in the Philippines has been among the lowest in the region, particularly over the past two decades. The Philippine public capital stock trails behind ASEAN economies, with a 30% capital stock gap compared with the ASEAN average (International Monetary Fund 2019). In recent years, the government has significantly increased spending on roads, bridges, air and seaports, and other large-scale projects. Public infrastructure investment rose from an average of 3% of GDP during 2011–2016 to over 5% in 2020 (IMF 2020).



Figure 11. ASEAN Capital investments (public and private)

Source: Authors analysis and illustration of 2000-2020 Investment and Capital Stock Dataset (ICSD) (IMF 2024).

Capital spending on health has increased in recent years. Over the past decade, health spending has increased in nominal and constant terms, accompanied by a rise in health capital spending. In 2023, current health expenditure per capita (i.e., non-capital expenditures) increased to 14% from 7.5% the previous year (see Figure 12). This indicates a shift towards greater investment in health infrastructure.



Figure 12. Philippine Capital Health expenditure as a share of total health expenditures

Source: Authors' analysis and illustration of 2014-2023 Philippine National Health Accounts (PNHA) (PSA 2024c). Note: Figures are rounded off.

In per capita terms, capital spending for health in the Philippines is higher than in lowerincome countries, likely due to a ramp-up of investment in recent years. Analyses of the WHO data show that, from 2019 to 2022, the Philippines spent an average of around USD 14 per capita for capital investments on health, compared to USD 10-12 per capita in other lowermiddle-income countries. Although the available data does not distinguish between public and private capital spending on health, evidence postulates that the public sector is the primary driver of this growth. Public spending on health per capita has increased from 30 USD in 2012 to 78 USD in 2022, even after adjusting for population growth and inflation.



Figure 13. Capital spending on health (2019-2022)

Source: Authors' analysis and illustration of 2019-2022 Domestic General Government Health Expenditure (GGHE-D) (WHO 2024a).

Health infrastructure, such as hospital buildings, is the primary focus of spending with increased spending on digital assets. We observed a steady increase in capital spending for health and saw a steady increase from 2014 to 2022, with a noticeable spike in 2018, followed

by an increase in 2023. While infrastructure has been the dominant focus, investment for other key areas, such as medical equipment, also increased in 2018 and 2019, and intellectual property products, such as computer software and databases, experienced an increase in investments in 2023.

Evidence suggests that the national government remains the primary driver of public spending on capital investments for health. Despite the Supreme Court's Mandanas Garcia ruling, there is no indication of slowing down.¹⁰ Strong indicators of increase in public capital investments for health are seen through the time series of (1) the median age fixed assets of private and public facilities and their respective (2) financial leverage ratio.



Figure 14. Capital expenditure on health by type (in nominal terms)

Source: Authors analysis and illustration of 2014-2024 NHA (PSA 2024c).

The increased public capital investments in recent years are evident in the decreasing average age of public fixed assets.¹¹ Analysis of hospital financial statements from 2017 to 2020 shows that the median age of public fixed assets has steadily decreased by a with the exception of the 1.9 percentage point uptick in 2020 (see Figure 15).¹² The decreasing average suggests that public hospitals can replenish their capital assets. This contrasts with the trend for private hospital assets over the same period, as the increasing average age suggests that hospital fixed assets are depreciating faster and might require reinvestment.

We disaggregated the median age of fixed assets for private and public hospitals. Public hospitals are further disaggregated into LGU and DOH facilities. We noticed a consistent declining trend for DOH hospitals, from 7.63 years in 2017 to 5.85 years in 2020. The mean

¹⁰ Mandanas-Garcia Ruling of the Supreme Court, Mandanas et al. v. Ochoa, Jr. et al., (G.R. Nos. 199802 and 208488, July 03, 2018).

¹¹ Age of fixed assets is calculated from the accumulated depreciation over annual depreciation expense.

¹² The decline in public hospitals' median age could be partly explained by the nominal increase of HFEP allocations. DBM GAA data shows that HFEP appropriations as share of (1) total DOH appropriations and (2)

age of fixed facilities of LGU facilities, on the other hand, steadily increased and peaked at 12.42 in 2020. We note that this increase needs to be validated whether it is an artificial increase or due to the limitations of the Hospital Statistical Report (HSR) dataset.

Year	Private	Public (LGU)	Public (DOH)
2017	11.08	5.54	7.63
2018	11.56	6.09	6.90
2019	11.75	6.35	6.42
2020	10.70	12.42	5.85

Table 6. Hospital average age of plant (median), 2017 – 2020

Source: Authors' analysis and illustration of the 2017-2020 Hospital Statistical Reports and Financial Statements (DOH 2024d).

In examining the financial health of Philippine hospitals, results show that the median total liabilities of public hospitals relative to total assets are lower than the median figures for private hospitals. Financial leverage (the ratio of total liabilities over total assets) measures the hospitals' risk appetite for asset expansion through debt. Median samples of private hospitals show that they are more likely to do this than public hospitals.



Figure 15. Hospital Financial Leverage (median), 2017 – 2020

Source: Authors' analysis and illustration of the 2017-2020 Hospital Statistical Reports and Financial Statements (DOH 2024d).

Recent figures show that, on average, in 2020, private hospitals had debt equivalent to 54% of their total assets compared to 42% for public hospitals. While the financial leverage ratio gap between the two is decreasing (from a 21 percent gap in 2017 to a 12 percent gap in 2020), public hospitals median is still relatively smaller.



Figure 16. DOH and LGU Financial Leverage (median), 2017-2020

Source: Authors' analysis and illustration of the 2017-2020 Hospital Statistical Reports and Financial Statements (DOH 2024d).

The financial leverage ratio of DOH hospitals remained relatively stable throughout the years, hovering at 14 to 15%. This may be due to the expected annual subsidy that DOH hospitals receive from the national government, making them less reliant on loans. This can be contrasted to the trend for LGU facilities, from 41 percent in 2017 to a drastic thirty-percentage-point increase to 71 percent in 2020.

The percentage breakdown of assets, revenues, and expenses for government and private hospitals in 2020 shows that government hospitals tend to rely more on subsidies and invest a greater share in land and infrastructure (see Table 7). Analysis of NHFR data shows that government facilities allocate 20.82 percent of their capital outlay to buildings and infrastructure, while private hospitals allocate around 34.50 percent. This is consistent with the HFEP allocation, wherein capital outlay is mostly directed to DOH hospitals.

Government hospitals have higher proportions of cash reserves and inventories but spend less on salaries and hospital supplies. Private hospitals generate more revenue from hospital fees and other sources, while government facilities rely on subsidies. Private hospitals also allocate more to property, equipment, and utilities and spend a higher percentage on wages and professional fees, making them more dependent on operational revenues.

Veriable median	Government	Private
variable, median	n = 560	n = 846
Total assets (%)		
Cash or Equivalent	27.25	13.53
Receivables	16.66	15.98
Inventories	12.98	7.19
Property and Equipment	43.06	61.71
Investment	0.06	1.60
Revenues (%)		
Hospital fees	35.13	54.73
Government subsidies	49.60	1.58
Other revenues	15.28	43.69
Expenses - Personnel Cost (%)		
Salaries and Wages	47.85	53.84
Direct benefits and allowance	35.92	12.55
Professional fees	16.24	27.60
Expenses - Maintenance and Other Ope	rating Expenses (MOOE) (%)	
Utilities	12.78	22.92
(Electricity, Water, Rent)		
Hospital Supplies	80.61	66.75
(Drug and medicines, Medical, Dental,		
Lab, Food, and Other)		
Training	0.91	1.06
Marketing	0.07	0.62
Maintenance	5.64	8.65
Expenses – Capital Outlay (CO) (%)		
Capital Outlay	20.82	34.50
(Building and Infrastructure)		
Capital Outlay	68.19	61.37
(Medical Equipment, Furniture and		
Fixtures, Vehicles)		
Capital Outlay	10.99	4.13
(Health Information Systems, Others/		
Miscellaneous)		

Table 7. Median Percentage Breakdown of Government and Private Hospitals (assets, revenues, and expenses, 2020)

Source: Authors' analysis and illustration of the NHFR and 2017-2020 Hospital Statistical Reports and Financial Statements (DOH 2024f, 2024d)

Note: Some figures might not total to 100 percent due to decimal point rounding.

LGU's low share of capital spending on health relative to total capital spending reflects their investment priorities. Table 8 indicates that LGUs' overall capital outlay per capita has increased steadily from 2017 to 2023, and the portion allocated to capital spending on health remains relatively low. Of the total LGU capital outlay during this period, only 4.41% is dedicated to health.¹³ This suggests that, despite growing total capital expenditures, local governments prioritize other sectors over health in their capital investment decisions.

¹³ Using data from BLGF share of health capital outlay in the total capital investment expenditures per year are the following:

^{2.15% (2017), 1.91% (2018), 1.51% (2019), 11.22% (2020), 8.90% (2021), 3.16% (2022),} and 2.02% (2023).

Evidence suggests that the national government remains the primary driver of public spending on capital investments. Despite the Supreme Court's Mandanas Garcia ruling, there is no indication of slowing down.¹⁴

			-				
	2017	2018	2019	2020	2021	2022	2023
Capital spending on health per capita (in PHP)*	277.2	309.4	168.2	144.07	166.34	278.37	293.4
Local	12.64	14.19	12.07	32.79	35.31	42.32	22.75
National**	264.5	295.3	156.1	111.28	131.03	236.05	270.65
Total capital spending of local governments per capita (in PHP)	588	741.4	796.9	292.32	396.59	1336.99	1125.17
% share of health capital spending of local governments to total local government capital spending	2.15%	1.91%	1.51%	11.22%	8.90%	3.17%	2.02%

Table 8. Capital spending of local governments

Source: Authors' analysis and illustration of Statements of Receipts and Expenditures (SRE) (DOF 2024b), General Appropriations Act (GAA) (DBM 2024), and Public Infrastructure Expenditure (HOR 2021).

Note: *Capital Outlay Appropriations of the Office of the Secretary of Health and Health Capital Outlay Expenditures of Local Government Units. **Capital Outlay Appropriations of the Office of the Secretary of Health in GAA per capita

Available data reveals a glaring disparity in health capital spending among local governments, with some provinces and HUCs allocating significantly higher per capita expenditures than others. This wide variation suggests uneven prioritization of health infrastructure across local governments, potentially leading to unequal access to healthcare services and resources. The disparity in health capital outlay expenditures is stark, with per capita spending ranging from PHP 485 in the City of San Juan to as low as nearly PHP 0 in Camarines Sur. This vast difference highlights significant inequities in local government investment in health infrastructure across provinces and cities. Capital spending on health also shows a high degree of socio-economic gradient. Figure 17 shows that local governments with higher poverty incidence are more likely to have lower capital spending on health.

¹⁴ Mandanas-Garcia Ruling of the Supreme Court, Mandanas et al. v. Ochoa, Jr. et al., (G.R. Nos. 199802 and 208488, July 03, 2018).





Source: Authors' analysis and illustration of Statements of Receipts and Expenditures (SRE) (DOF 2024b).

An increase in government revenue does not translate to higher capital spending on health in a more decentralized regime. This has huge implications because of the Mandanas-Garcia Ruling. Examining the behavior of local government in a more centralized regime, we explored the relationship between capital spending on health and local revenue sources in cities and municipalities. This has huge policy implications. Because of the Mandanas ruling, national/DOH support for capital investments in health will decline, and national tax allotment (NTA) will increase. Our findings are encapsulated in **Table 9** as follows:

	All	Cities	Municipalities
Total revenue	0.23***	1.21***	0.31***
	[0.06]	[0.45]	[0.12]
Interaction terms with revenue share	S		
NTA	0.06	0.57***	-0.03
	[0.04]	[0.20]	[0.05]
Local tax	0.06	0.09	0.03
	[0.05]	[0.18]	[0.05]
Local non-tax	0.08	0.14	0.04
	[0.05]	[0.19]	[0.05]
Other national transfers	-0.008]	-0.14	-0.05
	[0.05]	[0.24]	[0.06]
Aid/grant	0.03	-0.08	0.02
	[0.05]	[0.19]	[0.04]

Table 9. 0	Capital Si	pending or	Health	and Local	Revenue	Regre	ssion A	Analy	sis
	suprior Sp	SCHAILE OF	incarti		ILC VCHIAC	NUSIC	JJIOI	THUI Y	313

Source: Author's analysis, results of a fixed effects model

Note: The regression exercise was based on the model/equation depicted below. *i* refers to the municipality/city and j the year (2017... 2021). With the log-log specification, the β is interpreted as the elasticity of capital spending on health in relation to municipal/city revenues. We also examine the source of local revenue in relation to capital spending on health by introducing interaction terms of the shares of each revenue source, *Sh* with log overall revenue. In the event of perfect fungibility of municipality/city revenue, we should find that $\partial_y = 0$, for all revenue composition, *r*. The control variables, X_{it}, include household size, under-five population, the share of the elderly population, and poverty incidence. τ is the time as a binary (or dummy) variable. The study aims to examine the causal effect of local revenues on capital spending on health by incorporating ϕ_i

$$logCH_{ij} = a + \beta logR_{ij} + \sum_{r=2}^{6} \partial_r Sh_{rt} logR_{it} + \rho X_{it} + \varphi_i + \tau_j + e_{ij}$$

The overall impact of capital spending increases across all local governments is that a 1 percent increase in the share of revenues results in a 0.27 percent increase in capital spending on health. This indicates a positive but moderate influence. In cities, a 1 percent increase in revenue leads to a 1.3 percent increase in capital spending on health, showing a strong link between revenue growth and health spending. A 1 percent increase in NTA share is associated with a 0.60 percent rise in capital spending, suggesting that funding sources play a significant role in cities. The effect is weaker in municipalities, as a 1 percent increase in revenue leads to just a 0.33 percent increase in capital spending on health. Unlike in cities, the type of funding source has less impact on spending decisions.

5. Findings

This section presents our findings using the assessment framework outlined in the methodology, which captures the various stages of implementing the HFEP. This framework allows us to evaluate the program comprehensively across its implementation phases—planning, budget allocation, construction and procurement, monitoring, and evaluation. Each phase is assessed for efficiency, equity, and transparency. The planning stage involves the initial needs assessment and resource planning, where local government and public hospitals submit project proposals. Budget allocation follows, guided by equitable distribution principles, but is subject to legislative changes. During the construction and procurement stage, we analyze budget utilization and challenges faced in project implementation. Monitoring and evaluation ensure that projects progress as intended, and funds are utilized.







a. Planning Stage

In policy, local governments are expected to use bottom-up budgeting to determine their health infrastructure needs. This approach involves assessing local health service gaps

through consultations with health officers, medical center chiefs, local executives, and other stakeholders, ensuring alignment with the national health agenda and current administration directives. The PHFDP 2020-2040 provides direction in determining the health infrastructure needs of the LGUs. A localized version of the PHFDP, the Regional Health Facility Development Plan (RHFDP), is crafted by the CHDs to guide the LGUs in their planning activities. This identifies gaps in the health infrastructure at the regional level and helps prioritize investments in areas that lack sufficient healthcare services, thus informing LGUs on which types of facilities (e.g., primary care, hospitals, specialty centers) are needed to meet local health demands (DOH 2020c). With the PHFDP and RHFDP, the LGUs are also guided by the target facility to barangay/population ratio of 1 BHS per barangay and 1 Health Center (RHU and DHC) per 20,000 population set by the DOH. They also consider health outcomes in the FHSIS¹⁵ to determine their disease incidence and prevalence-relevant indicators of local investment needs. These assessments are then integrated into Local Investment Plans for Health (LIPH), Annual Operation Plans (AOP), or Hospital Development Plans as HFEP project proposals. Once signed by local chief executives and health officers, these proposals are submitted to DOH Regional Offices (CHDs).¹⁶ LGUs implement and procure HFEP projects by entering a Memorandum of Agreement (MOA) with the CHDs, following a checklist of documentary requirements set by the HFEP-MO of DOH.¹⁷

The DOH issues comprehensive policies through annual implementation guidelines and development plans to assist LGUs as they enhance their healthcare facilities under HFEP (DOH 2020c, 2024b). These documents clearly outline the roles and responsibilities of the involved agencies like CHDs as they guide their respective localities; however, implementation challenges still arise, particularly when the program managers involved are overburdened with responsibilities in all stages of the program.

Key Challenges

CHDs offer limited technical guidance in planning, hindering LGUs' ability to fully utilize HFEP in their localities. DOH Central Office and CHDs, along with their respective RHFDP, provide technical assistance and training to guide LGUs and hospitals in preparing their plans¹⁸. Also, DOH-owned hospitals may offer project recommendations for LGU-owned health facilities within their respective service delivery networks. However, some local governments need more technical guidance from CHDs (CP8 2024; TP1 2024). While other LGUs find the guidance adequate, uneven distribution of training opportunities has led to disparities in skill levels and competencies among staff in different health facilities.

"We need to be trained by the HFEP of the region and guided on the checklist and selfassessment tools so that if we have a system, we could partner with them, visit different facilities, and help them with their assessments and self-assessment checklists. Or with the reports, the ones they need." -CP8

"The technical capability might not be sufficient. We will still acquire technical capability, like how the DOH hospital imposed the 'green hospital' concept. I don't think it has been properly communicated to the local level. Do you get my point? Many things

¹⁵ AO No. 2020-0022. Guidelines on the Development of Local Investment Plans for Health (LIPH).

¹⁶ Ministry of Health for LGU Health Facilities under BARMM.

¹⁷ AO No. 2019-0048. Annex C: HFEP form No. CHKL-2019-002. Guidelines for the Implementation of HFEP FY 2019.

¹⁸ AO No. 2023-0009. Guidelines in the Implementation of Projects Funded Under HFEP FY 2023.

are being introduced now that some LGUs are unfamiliar with because they need more knowledge on the matter. We need to strengthen that." -TP1

HFEP recipients face challenges getting their proposals approved due to inconsistent annual implementation and availment guidelines. While the national health agenda guides the planning stage, it is heavily influenced by these yearly guidelines, which outline national health priorities and specify resource requirements for HFEP projects, such as human resources and lot ownership. However, many study participants reported difficulties adhering to these guidelines due to frequent changes in the requirements each year (CP5 2024; CP6 2024). Some of these changing policies also come from changes in the DOH's facility accreditation requirements, such as changes in room sizes and the addition of facilities like wash areas and minor surgical rooms. Although these requirements influence the way end-users spend their program allocations, these regulations are only adopted in HFEP's yearly availment guidelines and are not created by the HFEP Management Office. Nevertheless, these inconsistent guidelines lead to confusion and inefficiencies in the planning process, resulting in delays in compliance, challenges in site readiness, and duplication of efforts. To illustrate the difficulties faced by implementing units, **Table 10** outlines the significant annual changes in the HFEP availment guidelines based on documents provided by the HFEP Management Office.

"One challenge for the LGU is the constant changes. For example, when this was first built, they didn't say a dedicated room for the pharmacy was needed. Suddenly, they asked for a minor surgical room, which wasn't previously required. We got delayed because we had to improvise. Before, they didn't require a washing area in every corner, but now they are asking for one here and there. It's fine on my part, but not financially." -CP6

"If we really want to avail of the project, we have to find a way because we have no choice but to follow the guidelines, or else we won't get it. Even if the mayor questions it and says there are too many requirements and constant changes, there's no choice." -CP5

riscal feat	Basic Documentary requirements
	for project proposal
2016	-Proof of ownership of lot or project location (land title, deed of donation, usufruct agreement, etc.)
	-5-10-year hospital development plan
	-Standard infrastructure plans (scope of works, technical specifications, bill of
	quantities, DAED, detailed estimates for implementation, etc.)
	-Commitment to and evidence of availability of health human resources for
	operationalization of the health facility being granted funds.
2017	-Similar documentary requirements with the previous FY
	Additional: For all equipment project proposals: Specific name of equipment items,
	purpose, technical specifications, quantities and budgetary cost estimate
2018	-Similar documentary requirements with the previous FY
	Additional: Laws for the establishment of new hospitals and other facilities managed
	and operated by the LGU

Table 10. Documentary Requirements for Project Proposal (Fiscal Year 2016-2024)Fiscal YearBasic Documentary requirementsfor project proposal

2019	-Similar documentary requirements with the previous FY
	Additional:
	For LGU hospitals entailing increase in bed capacity: A Sanguniang Bayan/
	Panlalawigan Ordinance on the provision of additional MOOE and human resources
	For equipment proposals: should not list any specific brands/products in the proposals
	Removed: requirement to comply to laws for establishment of new LGU facilities
2023	-Similar documentary requirements with the previous FY
	Additional:
	For all Infrastructure Projects under New Construction: All implementing units are
	advised to follow BERDE Green Building Rating Scheme (GBRS) Version 4.0.0 or other
	updated framework User Guidelines in planning, construction and operations.
	For Land Acquisition: Technical description of lot and Market Value of lot from the
	Assessor's Office
2024	-Similar documentary requirements with the previous FY
	Additional:
	For all infrastructure project proposals: Certificate of site readiness and Soil boring
	test/Geotechnical test (for structural design of 3-storey and above)
	For all equipment project proposals: Certificate of site readiness
	For land acquisition proposals: Photocopy of tax declaration and tax clearance from
	the local registry and land acquisition for the construction of the extension facility/
	annex building shall be adjacent to the main health facility.
	For medical transport vehicles: follow the Guidelines in the Allocation of Ambulances
	of the DOH.

Source: Authors' illustration of 2016-2023 Implementation Guidelines and Guidelines on the Availment and Prioritization of HFEP Projects (DOH 2024c).

Note: The guidelines for fiscal years 2020-2022 did not outline specific documentary requirements.

Local politics undermines the participatory nature of the planning process. Per policy, the planning process must consider local health situations because HFEP augments health service delivery through capital investments. However, it is common among the interviewed sites for their local government leaders to push for their health projects and agendas that may not be consistent with the LIPH, PHFDP, or the LGU's AOP (AP4 2024; AP7 2024).

"There are proposals lodged directly with the central office, to the president, or the secretary. When lodged with the secretary, they are sent down to the CHD for validation, but still, we wonder why there is an additional budget here that did not go through the project vetting and screening process." -AP4

"[City 1] encounters political backing or interventions, especially during budget planning and hearings. Some politicians send requests that sometimes contradict the priorities of the LGU or the city health office. It depends on what the politician wants. Almost all politicians in [City 1] are very active, so our projects involve politicians. That's why I gave a high percentage because nearly all our projects are influenced by politicians." AP7

Hutchcroft (2012) notes that such a political process at the planning stage may be attributed to local government politicians in the Philippines being motivated by reelection opportunities. With money going to their localities, Local Chief Executives (LCEs) may exercise their discretion over expenditure to favor highly visible projects, thus undermining national-level projects. AP2 (2024) also highlights this issue.

"When the DOH regional office told me that they're going to put a super health center, I said that when I chose different municipalities, [Mun 1] was one of the priority areas. We put one super health center there, but now he wants to make it a hospital. We are trying to convince him that we cannot do that, but he wants to have a hospital in the area. Sometimes the provincial level and municipal level have different perspectives. So, there are differing opinions regarding the construction of one facility. The municipality insists this is what they want, but it's not feasible or practical." -AP2

While HFEP's participatory planning process allows for a localized solution to various health system issues, it increases the risk of mismanagement of funds, particularly when political interventions occur. The process obstructs national plans and causes delays, where realignment or modifications in the proposals might happen. For instance, there were some projects requested by a legislator with the assurance of the LGU counterpart as lot ownership. However, the proposed sites are not suitable because the lots are too small, prone to flooding, and affected by road widening, which has led to changes in the original proposal (COA 2017). Political interventions often neglect the PHFDP, LIPH, and AOP, interrupting the referral network in their area. Furthermore, deviating from the localities' health plans compromises the sustainability of the health programs and projects.

b. Budget Allocation Stage

HFEP project proposals from the LGUs are subject to initial screening by the CHDs, reviewed by the HFEP-MO, and integrated into the NEP by DBM. As shown in Figure 19Figure 19, the budget allocation stage starts with the screening process, where CHD vets the proposals adhering strictly to the criteria set by the HFEP-MO.¹⁹ Meanwhile, Medical Center Chiefs of DOH-owned Hospitals evaluate their submissions. This initial screening ensures all HFEP projects are aligned with the PHFDP 2020-2040 and the UHC Act of 2019 before being consolidated by the HFEP-MO. The HFEP-MO then reviews all proposals and provides the year's approved projects. The approval process is guided by the NAF. This framework assesses the capacity and gaps of LGUs in delivering health services, measured using public spending per capita, the presence of geographically isolated and disadvantaged areas (GIDAs), and the poverty incidence in each locality. The NAF framework categorizes LGUs from Category 1 (high gap, low capacity) to Category 4 (low gap, high capacity), with priority funding given to those in Category 1.

¹⁹ AO No. 2023-0008. Annex A: Basic Documentary Requirements. Guidelines on the Availment and Prioritization of Projects for HFEP FY 2024

Figure 19. Overall Availment Prioritization Process



Source: Authors' analysis and illustration of the Guidelines on the Availment and Prioritization of HFEP Projects for FY 2024 (DOH 2023)

Note: *Health Policy and Infrastructure Development Team; **Regional Field Implementation and Coordination Teams; ***Health Facility Development Bureau

Figure 20 illustrates the NAF and how it determines the categories of HFEP end-users. This approach promotes equity by prioritizing funding for sites needing additional capital to improve their public health facilities. Under this framework, more capable public health facilities receive less funding and lower priority, ensuring that grants are directed towards areas with the most urgent needs for facility upgrades. This allocation framework is consistent with HFEP's vision of achieving health equity and improving healthcare access.

Figure 20. National Allocation Framework (NAF)

	Low Capacity	High Capacity
High Gap	Low Capacity High Gap Category 1	High Capacity High Gap Category 3
Low Gap	Low Capacity Low Gap Category 2	High Capacity Low Gap Category 4

Source: Figure lifted from Philippine Health Facility Development Plan (PHFDP) (DOH 2020c).

The NAF addresses the gaps in health infrastructure development by prioritizing underserved localities and promoting a transparent selection of priority projects that align with the country's development plans. Simultaneously, it aims to establish an efficient allocation of capital investments. NAF was created with devolution in mind, as the Mandanas-Garcia Ruling in 2018 reaffirmed the process of transferring executive functions and responsibilities LGUs beginning 2022. The Devolution Transition Plan (DTP) of DOH²⁰ underscores the importance of applying NAF since HFEP began its partial devolution to provinces, cities, and municipalities listed in Category 4 in 2022, followed by Category 2 in 2023 and Category 3 in 2024. HFEP continues to provide capital investments for LGUs classified under Category 1, DOH Hospitals, and other healthcare facilities (i.e., Blood Centers, National Reference Laboratories, and Drug Abuse Treatment and Rehabilitation Centers).

Utilizing the NAF has the potential to address health inequities across provinces. NAF groups LGUs into four (4) categories based on three parameters: (i) local government resource through public spending per capita; (ii) presence of GIDAs across areas and (iii) measuring levels of household income through poverty incidences (DOH 2020c). Measuring these parameters to determine priority recipients of HFEP enables the program to reduce these health infrastructure inequities across the country. The inception of NAF highlights the development of HFEP in addressing health gaps in the country. Before its inception, HFEPMO's review process consisted of using DSWD's *Listahanan* and the list of municipalities under the National Anti-Poverty Council for vetting all HFEP projects²¹. With NAF, HFEP now can prioritize and target funding to areas with wide health gaps to improve health care access.

Before NAF, DOH used the Criteria for Rating Requests in 2010 for HFEP. It was created because the DOH observed that some LGUs and DOH Hospitals do not follow the correct (or preferred) route for requesting HFEP funds as established in the guidelines. DOH addressed this issue by implementing the Criteria for Rating Requests²² and providing it to the Regional CHDs as a checklist when reviewing the requests submitted by LGUs and DOH Hospitals. The criteria aimed to promote impartiality when approving HFEP projects by ensuring the requests are objectively screened for feasibility and equity.

Figure 21 depicts the criteria for how CHDs rate the proposals of LGUs and DOH Hospitals.

CRITERIA	POINTS	DESCRIPTION	REMARKS (if less than allotted points, write
	10	-LGU has allocated MOOE	Teasony
		budget and Human Resources	
LGU Priority	10	for the project.	
	10	-LGU counterpart funds	
	15	-Responsive to Health Status	
	15	-Within approved PIPH/AOP	
		framework of the LGU	
	10	-Complying with Certificate of	
		Need (CON) and/or	
CHD Review		BEmONC/CEmONC	
		standards/requirements	
	10	-Deemed "rational" by the CHD	
		if without RatPlan or not	
		complying with RatPlan	
	10	->85%LGU IP enrollment	
	10	- Good track record in	
Plus Factor		submitting reports/ FUR	
	10	- Good Financial Management	
		in Place	
TOTAL	100		

Figure 21. Criteria for Rating Requests

Source: Figure lifted from the Department Memorandum (DM) 2010-0104 (DOH 2010).

²⁰ DOH: Devolution Transition Plan 2022-2024

²¹ DOH AO No. 2016-0045: Guidelines for the Preparation and Selection of Projects for HFEP FY 2017

²² DOH D.M. 2010:0104: Process Flow for Approval of HFEP Fund Allocation

The budget appropriation of HFEP is determined through a legislative process. Once the list of HFEP projects is finalized, it is submitted to the Department of Budget and Management (DBM) for inclusion in the National Expenditure Program (NEP). The NEP provides the yearly budget proposals of all government entities and programs for the succeeding fiscal year, which will be reviewed by both the House of Representatives and the Senate. The House of Representatives initially reviews the NEP through the Appropriations Committee, where amendments are incorporated into the General Appropriations Bill (GAB). This bill is then presented to the rest of the House members. Meanwhile, the Senate conducts its deliberations to propose amendments to the bill. The amendments from both chambers are reconciled through a Bicameral Conference Committee, which finalizes the bill. Once ratified, it becomes the General Appropriations Act (GAA), the revised budget for the Philippine government for the given year. The GAA contains the revised budget of the Philippine government for the given year.²³ Once the GAA is enacted into law, DBM releases the budget to the DOH Central Office in preparation for sub-allotment. The GAA serves as a reference for HFEP end-users to determine how much funding they will receive and what projects have been approved by HFEP-MO.

Key Challenges

Transparency could be further improved. HFEP budget allocations are expected to be evidence-based and grounded on equity. However, budget allocations undergo legislative and political processes, which may prioritize different value systems that are neither explicit nor documented. According to the annual implementing guidelines of DOH, approved projects are submitted to the HFEP-MO for final deliberation to ensure alignment with the PHFDP 2020-2040. Also, the DOH issued Department Memorandum DM 2010-0104²⁴ to outline the approval process for HFEP projects and, in 2010, introduced Criteria for Rating Requests to ensure equitable distribution of HFEP funds. However, interviews reveal that some CHD personnel are unaware of these guidelines. In certain cases, requests bypass the standard HFEP process, with local executives directing proposals straight to DOH. Representatives may also secure HFEP funding for their constituents during budget allocations. **Figure 22** shows the general process of HFEP implementation, with the different actors involved in budget allocation. Solid arrows represent the approval route of the HFEP project as described in DOH policies. Broken arrows indicate non-traditional routes of project requests during the political and legislative process.

²³ Official Gazette: Article VI: Legislative Department, 1987 Constitution of the Philippines

²⁴ DOH D.M. 2010:0104: Process Flow for Approval of Health Facility Enhancement Program (HFEP) Fund Allocation

Figure 22. Process Flow of HFEP Approval



Source: Figure lifted from the Department Memorandum (DM) 2010-0104 (DOH 2010)

These multiple non-traditional routes of allocating HFEP funds can be avoided by reinforcing the principle of transparency in the program. Similarly, the Commission on Audit's (COA) performance audit report on HFEP conducted in 2017 provided a similar recommendation by highlighting the need of collecting immediate feedback from end-users and improving HFEP's procurement to ensure that projects and allotments will be provided based on the end-users' needs and absorptive capacity (COA 2017). These suggestions have merit as it mirrors the difficulties end-users have experienced when receiving grants from HFEP (AP4 2024; TP7 2024).

"The LGUs within our region that are end-users of HFEP always bring up the issue on transparency. They always ask for clarification when they receive a lesser amount from what they've originally proposed or when they've completed their submission, but they've received no updates on the status of their request from the [DOH] Central Office." – AP4

"We don't know if and when [our projects] will get approved. We only get the confirmation of its approval once it's released in the GAA." – TP7

These multiple routes during the budget allocation may veer from the envisioned objective of the National Allocation Framework to facilitate equity.

Table 11 **Table 11** shows the percentage distribution of HFEP projects by given appropriation in recent years. Analysis shows that Category 2 (low capacity, low gap) consistently receives the highest shares across all project categories for the three years. It remains disproportionately high compared to Category 1 (low capacity, high gap). Ideally, more funding should go to the first category, but it received less than 16% for hospitals and equipment in 2021 and 2022, indicating underinvestment relative to its needs. Although Category 4 (high capacity, low gap) should be the lowest on the priority list regarding appropriations, its percentage share constantly exceeds that of Category 3 (high capacity, high gap) projects. It even saw an increase in funding for equipment by almost 30% and BHS/RHU by 25% for 2022.

The minimal allocations for Category 3 suggest that these facilities' needs are not adequately addressed. The table shows that funding appears inequitable and misaligned with the NAF

prioritization. This is true, particularly for Category 1 and 3 facilities, which still need to be funded as both categories have limited increases over the years.

2020			2021			2022		
BHS/	Llocaital	Fauinmont	BHS/	Hereitel	Fauinmont	BHS/	Llocnital	Fauinmont
RHU	позрітаї	Equipment	RHU	Equipment	RHU	ноѕрітаї	Equipment	
29.76	23.93	24.33	13.48	16.05	14.07	22.08	15.46	15.73
42.38	49.08	42.79	47.48	42.14	43.70	45.51	42.61	39.73
12.20	14.11	13.17	19.11	15.38	17.37	12.28	16.84	14.64
15.67	12.88	19.71	19.92	26.42	24.86	20.12	25.09	29.91
100%	100%	100%	100%	100%	100%	100%	100%	100%
	2020 BHS/ RHU 29.76 42.38 12.20 15.67 100%	2020 BHS/ RHU 29.76 23.93 42.38 49.08 12.20 14.11 15.67 12.88 100% 100%	2020 BHS/ RHU Hospital Equipment 29.76 23.93 24.33 42.38 49.08 42.79 12.20 14.11 13.17 15.67 12.88 19.71 100% 100% 100%	2020 2021 BHS/ RHU Hospital Equipment BHS/ RHU 29.76 23.93 24.33 13.48 42.38 49.08 42.79 47.48 12.20 14.11 13.17 19.11 15.67 12.88 19.71 19.92 100% 100% 100% 100%	2020 2021 BHS/ RHU Hospital Equipment BHS/ RHU Hospital 29.76 23.93 24.33 13.48 16.05 42.38 49.08 42.79 47.48 42.14 12.20 14.11 13.17 19.11 15.38 15.67 12.88 19.71 19.92 26.42 100% 100% 100% 100% 100%	2020 2021 BHS/ RHU Hospital Equipment BHS/ RHU Hospital Equipment 29.76 23.93 24.33 13.48 16.05 14.07 42.38 49.08 42.79 47.48 42.14 43.70 12.20 14.11 13.17 19.11 15.38 17.37 15.67 12.88 19.71 19.92 26.42 24.86 100% 100% 100% 100% 100% 100%	2020 2021 2022 BHS/ RHU Hospital Equipment BHS/ RHU Hospital Equipment BHS/ RHU Equipment BHS/ RHU Equipment BHS/ RHU 29.76 23.93 24.33 13.48 16.05 14.07 22.08 42.38 49.08 42.79 47.48 42.14 43.70 45.51 12.20 14.11 13.17 19.11 15.38 17.37 12.28 15.67 12.88 19.71 19.92 26.42 24.86 20.12 100% 100% 100% 100% 100% 100% 100%	2020 2021 2022 BHS/ RHU Hospital Equipment BHS/ RHU Hospital Hospital Hospital 29.76 23.93 24.33 13.48 16.05 14.07 22.08 15.46 42.38 49.08 42.79 47.48 42.14 43.70 45.51 42.61 12.20 14.11 13.17 19.11 15.38 17.37 12.28 16.84 15.67 12.88 19.71 19.92 26.42 24.86 20.12 25.09 100% 100% 100% 100% 100% 100% 100% 100%

Source: Authors' analysis and illustration of 2020 to 2022 HFEP Administrative Data (DOF 2024a).

The evidence indicates that HFEP does not specifically target poorer local governments. The distribution of HFEP funds across municipalities and cities shows a relatively even allocation across different poverty quintiles, suggesting a lack of focused effort to prioritize poorer areas. For instance, the percentage of municipalities that received HFEP funding does not significantly differ across the various poverty quintiles, with even the wealthiest municipalities receiving comparable funding levels to poorer ones. Similarly, when examining HFEP-funded primary care facilities, the distribution again shows no strong bias towards poorer municipalities. This illustrates that the allocation of resources under the HFEP may not be adequately aligned with poverty incidence.

	Poorest 20th	Second	Third	Fourth	Top 20th	All municipalities/ cities
2008	5%	2%	3%	1%	1%	2%
2009	12%	10%	10%	5%	2%	8%
2010	15%	15%	16%	13%	14%	14%
2011	34%	50%	49%	54%	35%	45%
2012	22%	24%	35%	26%	26%	27%
2013	48%	36%	32%	30%	31%	35%
2014	51%	53%	56%	52%	53%	53%
2015	24%	17%	27%	34%	25%	25%
2016	87%	82%	84%	83%	80%	83%
2017	51%	53%	44%	42%	40%	46%
2018	70%	67%	62%	67%	67%	66%
2019	62%	54%	49%	43%	49%	51%
2020	47%	43%	43%	51%	44%	45%
2021	50%	40%	32%	25%	28%	35%
2022	59%	57%	52%	58%	48%	55%

Table 12. Percentage of Municipalities/Cities that received HFEP

Source: Authors' analysis and illustration of 2008-2022 HFEP Administrative Data (DOH 2024a).

	Poorest 20th	Second	Third	Fourth	Top 20th	All Provinces/ HUCs
2008	0%	40%	100%	80%	100%	50%
2009	20%	45%	78%	73%	75%	60%
2010	9%	46%	67%	50%	60%	47%
2011	33%	64%	72%	88%	88%	73%
2012	57%	100%	100%	84%	100%	92%
2013	19%	47%	37%	32%	44%	36%
2014	8%	67%	79%	81%	86%	63%
2015	13%	38%	47%	33%	53%	35%
2016	56%	77%	82%	76%	74%	73%
2017	36%	90%	95%	95%	100%	82%
2018	48%	95%	95%	95%	96%	85%
2019	58%	75%	95%	75%	83%	76%
2020	55%	84%	60%	90%	100%	77%
2021	46%	86%	62%	89%	90%	73%
2022	42%	77%	73%	81%	76%	69%

Table 13. Percentage of Provinces/HUCs that received HFEP-funded LGU Hospitals

Source: Authors' analysis and illustration of 2008-2022 HFEP Administrative Data (DOH 2024a).

	Deerest					All
	20th	Second	Third	Fourth	Top 20th	municipalities/
	2011					cities
2008	2%	0%	0%	0%	0%	0%
2009	7%	6%	5%	3%	1%	4%
2010	7%	11%	10%	10%	11%	10%
2011	29%	45%	41%	47%	31%	39%
2012	8%	10%	18%	15%	15%	13%
2013	41%	33%	28%	29%	30%	32%
2014	38%	46%	50%	44%	40%	43%
2015	14%	13%	23%	32%	21%	21%
2016	81%	79%	80%	79%	76%	79%
2017	34%	39%	28%	27%	23%	30%
2018	57%	59%	53%	62%	58%	58%
2019	47%	45%	41%	36%	44%	43%
2020	36%	36%	34%	44%	32%	36%
2021	32%	28%	18%	17%	17%	23%
2022	31%	38%	38%	47%	32%	37%

Table 14. Percentage of Municipalities/Cities with HFEP-Junueu DHS/RHC
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Source: Authors' analysis and illustration of 2008-2022 HFEP Administrative Data (DOH 2024a).

HFEP appropriations for BHS and RHU show inequitable distribution, failing to prioritize municipalities with higher poverty incidence. The figure below shows the relationship between HFEP appropriations per capita and poverty incidence specifically for BHS and RHU. The plot shows a relatively flat trend line (dashed red line), indicating little to no strong correlation between poverty incidence and HFEP appropriations per capita. This suggests that HFEP funds for BHS and RHU are distributed somewhat uniformly across municipalities, regardless of their poverty levels. From an equity standpoint, the distribution of HFEP appropriations per capita for BHS and RHU appears to be inequitable. Ideally, municipalities with higher poverty incidence, which likely have greater healthcare needs, should receive higher per capita funding. However, the flat trend line in the scatter plot suggests that poverty incidence does not significantly influence the allocation of funds, meaning that poorer municipalities are not being prioritized.





Source: Authors' analysis and illustration of SRE (DOF 2024a) and Official Poverty Statistics (PSA 2024b).

Poverty Incidence (%), 2021

However, when considering LGU income per capita, greater inequities become apparent. The scatterplot shows the relationship between HFEP appropriations per capita and total income per capita across various regions in 2022. While the trend line suggests a positive but modest correlation—indicating that local governments with higher income per capita receive slightly more HFEP appropriations per capita—the overall distribution reveals significant disparities in funding allocation.



Figure 24. HFEP Appropriations per Capita and Total Income Per Capita by municipalities/cities

Source: Authors' analysis and illustration of SRE (DOF 2024b).

Municipalities and cities with higher incomes are likely to receive higher appropriations per capita. There is a positive and statistically significant relationship between per capita of the two variables. As total income per capita increases by 1 percent, so do the per capita HFEP appropriations by 0.88 percent. While income is a factor in determining HFEP appropriations, other unobserved factors might also be at play.

Local health systems have the potential to benefit from additional capital investments from political and legislative processes during national budget allocation; however, without proper coordination, they can cause challenges in project implementation when local authorities are unaware of additional funding. Additional projects resulting from the legislative and political process can benefit localities by providing LGUs with increased funding, which they can use for other local programs and initiatives. When health is a priority for a local chief executive, LGUs may receive sufficient funding to ensure the completion and functionality of their facilities by lobbying their HFEP projects. However, LGUs may face challenges in absorbing these additional projects. Issues such as the lack of available land for new buildings or inadequate staff to operate new facilities can create significant hurdles. Sometimes, when a medical transport vehicle (MTV) is provided that the recipient did not request, LGUs may struggle to license or fully operate the vehicle due to manpower shortages. As described by AP7 (2024):

"The responsibilities of LGUs on the preventive maintenance of equipment and MTVs are in the Deed of Donation (DOD). Ideally, if the LGU fails to comply with the requirements for the equipment and MTVs, it'll be turned over back to DOH. However, this has not occurred yet within NCR and we provide considerations when it does. For example, the DOD states that when an ambulance has still not been licensed within 6 months from the turnover [to LGUs], we'll have to revoke the DOD and retrieve the ambulance. What DOH does instead is they ask for a justification why the LGU has not been able to provide the license, and we let them recommit to the DOD until they're able to license the MTV" – AP7

Our findings highlight the role of political and legislative processes and the importance of power dynamics in increasing capital investments for local governments, which were reinforced by local government executives we interviewed (CP4 2024; TP8 2024).

"For a [health] program to be implemented properly, a good relationship between the Medical Health Officer (MHO) and the mayor is important. If they do not get along, the programs will be politicized" - CP4

"In my 18 years of service, I realized that there should be a political backing of the programs that you want to implement. Without those, it will be useless and nothing." – TP8

HFEP end-users often need to reprioritize their projects due to budget cuts, requiring LGUs to adapt to the reduced budgets they receive. Because of budget cuts, local governments and hospitals commonly experience limitations on the number and scope of projects they can pursue each fiscal year. Despite the urgency of their proposals, there is no guarantee that the end-users will receive the full amount they request. As a result, priority projects are often replaced by more financially feasible ones. LGUs split project implementation into phases or focus on projects that fit within their allocated budget. CHDs often assist LGUs in being strategic with their requests, maximizing the list of HFEP projects they submit to their DOH-RO or CHD in hopes of securing more funding. One respondent described the submission process for HFEP projects as a "wish list" with the hope of obtaining adequate resources. This challenge was reinforced during our interviews with local governments. Improving the transparency in the approval process would remedy this issue. This improvement can allows LGUs to forecast the exact or approximate amount of funding they will receive and minimize the inefficiencies caused by operating on a tight budget (AP4 2024; AP8 2024; TP10 2024).

"We do consultations with our proponents, and we notify them from the start that they need to include the most prioritized projects in their [HFEP] proposals. This is one of the techniques we use in anticipation of budget cuts. We inform them of this budget ceiling that exist, and they respond to our advice when we coordinate with them." – AP4

"It's easy to request projects in HFEP but you can't expect them to be approved. You'll have to push through with whatever projects that'll be approved. That's why we call it the 'HFEP wish list'. We call it a wish list because once a project is not approved on your first submission, you'll just include it again in the next one." -AP8

"We submitted a proposal for a Super Health Center worth PHP 20 million in 2022 because it was included in our medium-term plan. When the project got approved and appeared in the GAA, the budget was cut down to PHP6.5 million" – TP10

Some end-users are not aware that NAF guides HFEP disbursements. Although the NAF is essentially the allocation framework for HFEP, interviews with program implementers reveal a lack of awareness about what it is. This lack of understanding prevents LGUs from fully maximizing their annual budgets, as they are unsure of how much support they can receive from HFEP. Consequently, instead of allocating funds to other local projects, LGUs may need to set aside contingency budgets for health infrastructure projects that may or may not be covered by HFEP. Furthermore, their limited knowledge of NAF hinders their ability to prepare for the program's devolution (AP2 2024; TP7 2024).

"I don't know how they allocate; I have no idea how they even consider comparing one project to another we just wait for the final list of projects for the year" -AP2

"I don't have any idea regarding the National [Allocation Framework]" – TP7

A respondent from a CHD and LGU supports the finding that high-capacity health facilities still receive HFEP funding. This presents a challenge for the implementing units that fall under the lower categories (Category 1 and 2), as the budget that should have been allocated for them is also divided amongst resourced and well-capacitated end-users (AP1 2024; AP7 2024).

"In my own opinion at first, I thought that the funding in NCR will be affected because of the National Allocation Framework. Out of the 17 LGUs in NCR, 8 are under Category 3 which is high capacity and high gap, and 9 of them are under Category 4, high capacity and low gap, which are not priorities of NAF. However, when the funds were sub-allotted during 2022-2023, it had almost no effects because the cities still received some funds. Although the budget that they received was limited but I think it still causes delays because under NAF Categories 3 and 4 are not priorities and should not have received any funding according to the PHFDP 2020-2040" – AP7

"At the local level, there are request for facilities and equipment. When it can't be approved, we request it to our legislative representatives so that it will be directly sent to DOH, even though we're a high-capacity low gap category, we still receive some HFEP assistance and even some Barangay Health Stations (BHS) if a congressman is able to lobby through them [DOH]" – AP1

The lack of understanding on what NAF is puts poor LGUs at a disadvantage. When HFEP grants are allocated to richer LGUs, budget is moved from an area with a higher need to a well-resourced LGU. In the long run, this budget inefficiency worsens the disparate quality of health service across the country. The catchment population of these low-income areas suffers from their lack of access to health services- a challenge that Universal Healthcare, through the HFEP, could have addressed.

c. Construction and Procurement Stage

Upon the approval of the General Appropriations Act, money is released to various government agencies for use and implementation. The DOH sub-allots the HFEP funds to the program's implementing units- CHDs, MOH-BARMM, and DOH hospitals - following the

sub-allotment guidelines set by the Department of Budget and Management.²⁵ Once money is received, these program implementers, through their Bids and Awards Committees, conduct procurement activities for projects under their jurisdiction. However, funds for infrastructure projects may also be downloaded from CHDs to local governments through a Memorandum of Agreement (MOA)²⁶ between the LGU and the DOH.

Table 15. Requirements for Downloading Funds to LGUs for Implementing Infrastructure Projects**15 lists** the LGU requirements for said MOA overtime. Alternatively, money may be transferred from the implementing units to other government agencies (such as the Department of Works and Public Highways) under GAA Special Provisions.²⁷ or through a Joint Memorandum Circular.²⁸ This transfer is, likewise, based on an agency's performance records and implementation capacities.

Table 15. Requirements for Downloading Funds to LGUs for Implementing Infrastructure Projects

Implementing Year	LGU requirements
	 Known track record of LGU to implement infrastructure projects; Assessment of the current capacity of LGU to complete the project successfully within a reasonable period of time;
2016	• Review the financial liabilities of the LGU with regard past DOH funding assistance;
	• Justification of the need of DOH regional office to authorize HFEP project procurement and implementation by the LGU; and
	• Plan of action of DOH regional office to monitor LGU implementation of the HFEP infrastructure projects devolved to LGUs
	 Known track record of LGU to implement infrastructure projects; LGU's Seal of Good Governance or Seal of Good House Keeping Assessment of the current capacity of LGU to complete the project.
2017	successfully within a reasonable period of time;
	funding assistance;
	the HFEP infrastructure projects devolved to LGUs
2018	 Good track record of LGU to implement infrastructure projects as evidenced by full liquidation documents and no Commission on Audit (COA) audit findings in previous HFEP projects;
2018	 LGU's Seal of Good Governance or Seal of Good Housekeeping; Assessment of the current capacity of LGU to complete the project successfully within a reasonable period of time;

²⁵ National Budget Circular (NBC) No. 583 dated 4 January 2021.

²⁶ Annex C – Sample Template for the Memorandum of Agreement (MOA) between CHDs and LGUs from AO No. 2023-0009 Guidelines on the Implementation of Projects Funded Under the HFEP FY 2023 and Annex C.1 Checklist of Documentary Requirements Before Entering into a MOA from AO No. 2019-0048 Guidelines for the Implementation of the HFEP FY 2019.
²⁷ Special Provision No. 6 of the FY 2024 GAA

²⁸ DPWH-DOH Joint Memorandum Circular (JMC) No. 01, series of 2024 Guidelines on the Implementation of FY 2024 General Appropriations Act Special Provision No. 6 on Department of Health (DOH) - Health Facilities Enhancement Program (HFEP) Projects

	 Review of financial liabilities of the LGU with regards to past DOH funding assistance; and
	\cdot Plan of action of DOH RO to monitor LGU implementation of the HFEP
	infrastructure projects devolved to LGUs
	\cdot Capability to implement the project by administration or contract and in
	accordance with the design, plan, specifications, and such other standards
	and policies of the DOH;
2019 - 2021	 No COA audit findings in previous HFEP project/s;
	· Good track record in implementing infrastructure projects as evidenced
	by full liquidation documents;
	 Seal of Good Local Governance or Seal of Good Financial Housekeeping
	· Capability to implement the project by administration or contract and in
	accordance with the design, plan, specifications, and such other standards
	and policies of the DOH;
	 To commit to the cost of maintenance and repairs thereof;
	· To ensure that the funds appropriated to them shall be released during
2022 2022	the fiscal year to be deposited in a trust fund and shall be made available
2022-2023	for disbursement for the purpose specified until December 31, 2024
	· Submit to the CHD the documentary requirements for the Commission
	on Audit (COA) inspection and assessment;
	· Good track record in implementing infrastructure projects as evidence by
	full liquidation documents; and
	 Seal of Good Local Governance or Seal of Good Financial Housekeeping
	historian of 2016 2022 UEED Implementation (Widelines (DOU 2024s)

Source: Author's illustration of 2016-2023 HFEP Implementation Guidelines (DOH 2024c).

LGUs have consistently been assessed based on their track record and capacity to implement a project. This capacity includes timeliness in terms of project accomplishment and absorptive capacities measured through fund utilization. The consistency of these requirements incentivizes LGUs to conduct both their HFEP and non-HFEP projects efficiently to be able to manage their own HFEP funding.

The Construction and Procurement Stage is concerned with fund utilization. Aside from the implementing units, Health Offices (Provincial, City, or Municipal) also play a critical role in ensuring that the budget is used as intended. Yearly Implementing and Availment Guidelines²⁹ delegate the procurement of medical transport vehicles and select equipment to the HFEP-MO, CHDs, and DOH Hospitals to cut costs. Given the program's budget limitations, HFEP must have mechanisms to leverage economies of scale. To guide the implementation of HFEP projects, the DOH also has procurement guidelines for motor vehicles,³⁰ and planning and design guidelines³¹ for health facilities. Generally, these policies

²⁹ AO No. 2019-0048 Guidelines for Accessing and Processing of Project Proposals for HFEP 2019 and AO No. 2020-0062 Guidelines for the Implementation of Projects Funded Under the HFEP FY 2020

³⁰ AO No. 13 and Budget Circular No. 2019-3: Guidelines to Implement the centralized Procurement of Government Motor Vehicles pursuant to AO No. 14, 2. 2018

³¹ A.O. No. 2016-0042 Planning and Design Guidelines for Hospitals and Other Health Facilities, A.O. 2020-0047-A Planning and design Guidelines for Primary Care Facility, DOH AO 2020-0011 Guidelines in the Implementation of the Unified Color, Signage Features, and Design of the Identified Interior Spaces for Health Facilities Enhancement Program (HFEP)- funded and coordinated Health Facilities and Medical Transport Vehicles, A.O. No. 2016-0042 Planning and Design Guidelines for Hospitals and Other Health Facilities and A.O. 2020-0047-A Planning and design Guidelines for Primary Care Facility.

focus on patient movement, space utilization, zoning, maintenance, material specifications, sanitation, utilities, and more.

Key Challenges

Implementing HFEP projects increases the demand for an already insufficient pool of human resources. CHDs are assigned as the DOH's regional managers, implementing arms, and procurement entities. In addition to technical assistance, screening HFEP proposals, and implementing HFEP projects, CHDs conduct on-site inspections and prepare monthly status reports for the HFEP-MO and the Health Facility Development Bureau. Despite this, interviews with the regional offices reveal that they only have a limited number of staff to accomplish these functions (AP4 2024; AP7 2024).

To resolve staffing issues, the HFDB can provide CHDs with financial assistance to hire additional technical personnel using a portion of the program's MOOE budget (DOH 2018)Nevertheless, CHDs encounter other issues with their technical personnel, such as high turnover rates due to a lack of job security. When CHDs cannot hire additional staff, their existing personnel take on multiple roles in implementing the program, causing delays in their office's other operations. Ideally, different employees oversee planning, monitoring, and validation.

"HFEP really hire as augmentation to our team because there are so many projects. But lately as years go by, the Central Office no longer sub-allots big amounts of money to hire technical staff or technical workers to implement the programs and still, regional offices receive big grants... Yes, there is difficulty in absorbing the additional funds received by the region every year because we are not hiring... the region's budget is not big when it comes to hiring technical [staff] because HFEP is not only our technical program"- AP4

"... ideally a different person is assigned to planning, another to monitoring and supervision of the projects. But here, you are the one planning, you are also the one monitoring, and you still manage until the end of the project. In a district, there are more than 10 or more than 15 projects that is handled by one engineer. He oversees planning as well as supervision when there is construction ongoing..." – AP7

Every HFEP project requires an additional human resource for health (HRH). When local governments cannot provide HR counterparts for their projects, implementing units cannot proceed with their procurement activities. Before turnover, end-users are obligated³² to have available human resources to guarantee a project's maintenance and functionality. However, many end-users have underutilized HFEP-funded facilities and equipment due to inadequate HRH (CP6 2024; CP8 2024).

"... we already lobbied last year for the creation of positions because it can't be that the staff here is also the staff there. The staff will be divided once the [facility] is operational there. So, we inserted in our AOP the creation of positions- additional nurses, doctors,

³² Annex A: Sample Template for Deed of Donation (Equipment) from AO No. 2023-0009 Guidelines on the Implementation of Projects Funded Under the HFEP FY 2023

midwives, and admin staff... Aside from the AOP, we write letters to mayor, directly-"Dear Mayor, in line with the coming super health center, we need the following positions." That's the counterpart of LGU, to provide sufficient funds for the creation of position- COS or permanent"- CP6

"HRH is our priority, Ma'am. Because even if we have the infrastructure and the equipment, but we do not have enough personnel, the facility is ghosted. There is no one, so who will man the facility?" – CP8

Data from DOH suggests evidence of poor absorptive capacity. Since the program's inception, the majority of municipalities have experienced poor absorptive capacity as indicated by an overall absorptive capacity index³³ below (see Figure 25). However, data suggest that LGUs' absorptive capacities do not vary with their socioeconomic status or income. Based on the key informant interviews, program implementers claim that the insufficient supply of human resources influences their absorptive capacity throughout the phases of program implementation. At the back end, LGUs lack technical personnel to manage project implementation, such as engineers and architects to oversee actual facility construction and approve architectural plans. Some municipalities also noted the lack of administrative staff at their MHOs to facilitate the necessary documents for project implementation. To resolve this, Section 6 of the 2019 GAA Special Provisions authorizes the DOH to use no more than 1% of the project budget for administrative overhead expenses such as hiring job order staff. While this helps address staffing challenges, the overall low budget for overhead expenses under the program remains an issue. At the front end, LGUs also lack the human resources to manage their facilities and equipment. LGUs and hospitals hire additional healthcare workers to operate their facilities and equipment to address absorption issues. Although engaged through Job Orders and Contract of Services (COS), these additional HRH augment health service delivery in these areas. However, poorer LGUs do not have the budget to hire additional staff and depend only on DOH-deployed nurses, midwives, and doctors. The lack of health and medical staff is counterproductive to the goal of HFEP because, although there are additional spaces and equipment, health services remain deficient as there are no personnel to provide them (AP6 2024; CP6 2024).

"HFEP [grants] are intended for infrastructure and equipment, we cannot use it for additional staff. There is a certain percentage of the total amount released to us that can be used for administrative overhead. We are exploring to use that for consultancy and hiring of contract of service. "- AP6

"Given the devolution, of course the MHO and PHN will have bigger administrative responsibilities. We are already the ones creating the budget for health, we are also making the project proposals for training that we did not use to do prior to devolution and at the same time, DOH programs are getting bigger. Of course that will entail

³³ In the context of HFEP, the overall absorptive capacity index (OACI) measures an LGU's ability spend their allotted HFEP budget. OACI is computed through the following formula: (Obligation/Allotment)/(Allotment/Appropriation). An index greater than 1 means that an LGU can absorb more funds than what they were allotted, while an index equal to 1 means that an LGU can absorb exactly the budget they received. Lastly, an OACI below 1 means poor absorptive capacity of an LGU (Palma, Alexander Michael G. (2001): Assessment of the Absorptive Capacity for Government and Donor Funding: The Case of the DOH, PIDS Discussion Paper Series, No. 2001-04, Philippine Institute for Development Studies (PIDS), Makati City)

administrative supervision. So, it is a big challenge for the MHO to do administrative work and patient consultations." -CP6





Source: Authors' analysis and illustration of 2008-2022 HFEP Administrative Data (DOH 2024a).

HFEP grants are inadequate for completing project proposals. Although the HFEP accounts for almost 30% of the annual DOH appropriations, the program's funds are still limited to accommodate all funding requests. As a result, HFEP end-users often deal with insufficient budgets for their proposed projects (AP6 2024; CP8 2024).

"Actually, like our proposal this 2024, it is around 500 million or 546 million if I am not mistaken, but we were only given 100 million"- AP6

"... our super health centers are supposed to be worth 200 million. That was what we proposed in 2022 during the funding year. But when it was approved as GAA, [the budget] was slashed to 6.5 million only"- CP8

Budget insufficiency is especially burdensome for poorer and isolated LGUs. While highincome localities and income-generating hospitals can financially compensate for the insufficiency, many LGUs experience delays and underutilization of their projects. In some cases, an infrastructure project may be finished based on the contractor's scope of work. Still, it remains unfunctional due to a lack of utilities such as water and electricity. The situation is worse for GIDAs, where transportation considerations drive construction and procurement costs (AP2 2024; AP3 2024).

"Since the HFEP could not also maximize the grant to the hospital, still the hospital needs to generate more income so that it can also help hand in hand with the HFEP because the HFEP funds are not really enough to cover all the needs of the hospital"-AP3

"... for example, the cost is 1.2 [million] for one infrastructure. If within the city land, it is okay. But here, you need to travel the construction materials. Just with transporting the construction materials, the budget will no longer be enough. Sometimes you can finish the infrastructure given the budget but there is no paint, not enough doors, no tiles. Then we get asked by the engineers why are we asking for a big budget? If we say we need 1.7 million, but we are only given 1.2, that is on them. Give us 1.2 although [the project] will not be finished so we would have to put it under completion in the next planning period so we can receive the remaining amount. But by then, the cost of construction materials might have gone up."- AP2

Barangay Health Stations							
	2010	2012	2014	2016	2018	2020	Total
Construction	1,669,389	953,183	1,236,521	1,350,628	1,311,499	1,207,896	1,312,329
Construction and equipping	-	1,000,000	578,956	955,263	751,332	-	856,341
Equipping	-	8,692	69,787	267,736	129,416	104,445	153,684
Repair and renovation	537,159	1,049,844	840,172	648,345	807,471	494,029	718,883
Repair, renovation, and equipping	1,024,417	738,354	405,812	774,781	761,527	344,349	614,989
Total	780,557	961,517	519,616	758,951	1,048,741	259,794	741,847

Table 16. Unit Cost Per Facility Type by type of project

		Rural H	lealth Units				
	2010	2012	2014	2016	2018	2020	Total
Construction	1,906,846	1,658,503	1,754,732	5,180,130	8,725,287	1,403,287	5,432,442
Construction and equipping	1,375,344	754,346	2,535,101	1,930,674	7,247,981	-	2,706,491
Equipping	425,251	306,340	228,905	324,202	1,017,094	216,800	332,267
Repair and renovation	1,559,640	1,903,191	1,292,676	2,175,327	2,618,701	1,343,454	2,005,204
Repair, renovation, and equipping	680,713	1,124,936	866,532	1,421,466	3,301,256	802,894	1,488,245
Total	1,215,598	1,301,349	871,829	2,066,485	3,607,744	533,803	1,796,554

LGU Hospitals							
	2010	2012	2014	2016	2018	2020	Total
Construction	15,190,083	13,169,192	10,486,360	26,598,691	20,429,080	3,587,948	14,759,944
Construction and equipping	-	4,511,317	6,725,391	8,741,587	13,224,095	-	8,522,145
Equipping	23,971,068	1,971,379	1,379,291	3,615,828	3,044,148	4,758,355	3,554,735
Others	-	-	9,797,042				9,797,042
Repair and renovation	7,131,840	7,657,627	5,727,504	6,417,937	10,864,668	5,012,832	7,590,570
Repair renovation and equipping	6,945,610	4,706,369	6,913,548	5,032,346	15,521,975	11,264,561	9,781,697
Total	8,178,580	6,851,174	5,493,689	6,213,824	11,504,552	5,451,261	7,505,917

Source: Author's illustration of 2008-2022 HFEP Administrative Data (DOH 2024a).

LCEs and medical center chiefs (MCC) seek public and private support. Because HFEP projects are capital investment projects, LGU or hospital revenues may still be insufficient to finish a project. In such cases, many LCEs and MCCs write letters to their congressional representatives requesting funding support, while some even send letters to the Office of the President. Other municipal health officers also request for funds from other National Government Agencies such as the Philippine Charity Sweepstakes Office and the Department of Public Works and Highways. There are also a few who write to various political parties to solicit funding for their health infrastructure projects.

"In their political party, our congressman has funds as well as our governor. They use that to support any problem that we may have. The nice thing is... our mayor is a doctor" -CP4

"He [medical center chief] will ask for assistance from other government offices or institutions for funding support, like what was mentioned earlier, we have budget from the Office of the President... We are identified as a specialty center. However, on that year, the fund was not given to us so we sourced out and strategized to lobby to some funding agencies or to political personnel to help us augment manpower, equipment and even out infrastructure projects." – CP2

The interviewees, however, mentioned that they do not always receive a positive response from the abovementioned offices. In that event, LGUs also seek support from the private sector through non-government organizations and private individuals.

d. Monitoring and Evaluation Stage

HFEP-MO involves multiple stakeholders, including end-users, to track the status of their projects. The HFEP-MO is mandated to conduct onsite inspections, provide a review of the program, and submit progress reports to the DOH Central Office. To do so, the HFEP-MO manages the Physical and Financial Performance Real-Time Report (PAFFPR)³⁴, an online tool that allows all end-users to update and view the progress of their HFEP projects. It provides the physical status and budget utilization reports for HFEP projects, requiring end-users to input the total amount spent on their projects, determine what items the funds have been spent on, and track the type of projects that are being implemented. PAFPRR is submitted through Google Sheets, and all end-users submit their reports on the 10th of each month for review and consolidation of HFEP-MO. **Table 17** describes the roles of each stakeholder in the monitoring of HFEP.

Stakeholders for M&E	Roles and Responsibilities	I	Monitoring Tools
HFEP-MO	o Monitors the performance of contractors or	0	PAFPRR
	suppliers of HFEP and validates their submitted	0	Contractor's
	reports	Pe	rformance
		Εv	aluation System
		(C	PES)
		0	Notice to Explain
		(in	case of project
		de	lays or failure of
		im	plementing units
		to	submit reports)

Table 17. HFEP Monitoring Stakeholders

³⁴ https://sites.google.com/view/hfep-rpmu

HFEP-MO Technical Staff	 Technical staff per region consisting of architects and/or engineers along with the Development Management Officers (DMOs) to conduct on-site inspections to validate the project reports Collaborates with CHDs and DOH Hospitals 	o ins	On-site spections
HFEP MO- Performance Management Unit (HFEP-MO PMU)	 o Provides the PAFPRR reports to the Health Policy and Infrastructure Development Team (HPIDT) o Manages the PAFPRR reports through Google Sheets to ensure access within DOH and keep track of the progress of projects o Submits quarterly, annual, and year-end reports of the PAFPRR documents to the DOH Executive Committee o Adopts a geo-tagging system in reference to the PAFPRR to determine the location of HFEP projects 	0	PAFPRR
Field Implementation and Coordination Team (FICT)	o Manages the appropriate actions needed on delayed projects or reported complaints that is flagged by COA	0	Not indicated
Centers for Health Development	 Monitors the status of all HFEP projects within their region and routinely monitors the PAFPRR in collaboration with HFEP MO PMU 	0	PAFPRR
(CHD)	 o Evaluates the site readiness of end-users for health facilities o Aids the CHD Director in case of slippage and termination of contracts o Attend meetings regarding the PAFPRR reports as needed by the Central Office o Conducts on-site inspections to validate the progress reports and the reports submitted by the contractor/suppliers o Cites and requires the suppliers or contractors to apply the necessary revisions or changes once discrepancies are found 	0 ins	Onsite spections
DOH Healthcare Facilities	 The regional implementing arm of HFEP MO to supervise the implementation of HFEP within DOH healthcare facilities 	0	PAFPRR
	 Monitors the status of all HFEP projects within their hospitals and routinely monitors the PAFPRR in collaboration with HFEP MO PMU Attend meetings regarding the PAFPRR reports as needed by the Central Office 	o ins	Onsite spections

o Conducts on-site inspections to validate the progress reports and the reports submitted by the contractor/suppliers

o Cites and requires the suppliers or contractors to apply the necessary revisions or changes once discrepancies are found

Source: Author's illustration on latest monitoring and evaluation measure pursuant to DO 2023-0009 (DOH 2023).

Before PAFPRR, HFEP-MO utilized various tools to monitor projects. The D.M. 2013-0216 instructed all Regional CHDs to focus their efforts on monitoring HFEP projects and ensure its alignment with Kalusugan Pangkalahatan. As a result, a monitoring tool developed by the UP School of Economics was created to standardize all monitoring reports. End-users also utilized the HFEP Project Monitoring Tool³⁵ by the National Center for Health Facility Development (NCHFD).³⁶ An additional tool from the Internal Audit Service was also used to supplement monitoring efforts. These reinforced the importance of monitoring HFEP projects.

HFEP has developed a rigorous monitoring system over the years to keep track on the program's multiple projects. It can be observed that the monitoring system HFEP has created evolved since its inception. It led to the creation of sub-teams within HFEPMO, involving and making end-users accountable for their respective projects, and providing an online avenue for all stakeholders involved to monitor and report the status of their HFEP projects conveniently and efficiently. End-users have reported that they've consistently complied with the monthly submission of reporting, along with collaborating closely with their counterparts from HFEPMO or with their respective regional CHD.

"In terms of monitoring, our local engineers collaborate closely with engineers from DOH to monitor the HFEP projects in our region. We constantly provide updates and report all the issues we face during implementation, and we all try to figure out a way to ensure that the projects are completed on time." – AP2

"The monitoring of HFEP in our health facility involves coordination of personnel from different departments. Not only do we involve our project engineer but we also include our accounting department to determine the total amount of resources disbursed for HFEP and assess our actual levels of accomplishment. We photocopy our documents and we upload it online." – AP8

HFEP already has a comprehensive monitoring system in place, it just needs to improve its implementation to ensure that what's being reported by end-users mirrors the actual accomplishment reports on the ground and are verified by monitoring units under HFEPMO and Regional CHDs.

³⁵ Part I: Roster Questionnaire, National Health Facility Survey, DOH D.O. 2013-0216

³⁶ The monitoring report included reports on the physical infrastructure progress, the functionality of equipment and newly constructed buildings, and the capacity of end-users to provide human resources for their HFEP projects

Key Challenges

There is heavy reliance on self-reported physical and financial reports from end-users which can lead to discrepancies in the final accomplishment reports. Although the annual guidelines assign CHDs to conduct on-site inspections and validate LGU progress reports, there is an overdependence on the submission of PAFPRR to determine the progress of HFEP projects³⁷. PAFPRR utilizes self-reporting by both LGUs and DOH Hospitals. While this may result in more accurate reports, this puts HFEP projects at risk of biased reporting on their actual status.

In recent years, there have been reports concerning unfinished and underutilized HFEP projects despite close monitoring of end-users. Uncompleted projects within the given implementation timeline, procurement of faulty equipment or vehicles, negative slippage, and unutilized health facilities due to inadequate resources persist. In 2022, an HFEP project for a regional hospital that could have increased the bed capacity from 450 to 1,050 total beds was found unfinished. The contractor still received payments equivalent to PHP338.782 million because they reported finishing 53.91% of the work. It was later confirmed by the DOH monitoring team that the actual accomplishment was only at 14.68%.³⁸ This incidence emphasizes the importance of properly implementing the program's M&E framework- weak monitoring and evaluation opens the program to project mismanagement and funding misuse.

HFEP does not have an assessment tool to determine if the projects are producing the program's desired outcomes. Outcomes assessment is a significant section of the monitoring and evaluation process to ensure that the program is achieving its objectives. When asked how they evaluate their HFEP projects, LGUs and DOH Hospitals only rely on their own internal evaluation tools. HFEP projects are reviewed through their own performance management system or through their own internal committees that assess the structural integrity and equipment of their respective health facility. However, these monitoring mechanisms do not look at the outcomes resulting from the program (AP4 2024; AP7 2024).

"...we also have our SPMS (Strategic Performance Management System) which includes the OPCR (Office Performance Commitment and Review). Through the OPCR, we determine if our HFEP projects are aligned with the goals of our agency such as reaching the target completion and budget utilization. This serves as our form of monitoring and evaluation." – AP4

"We have an FEMS, Facilities and Equipment Maintenance Section, so we have a check and balance system in determining the effects of the projects. Once we the project is complete, they will be the ones to evaluate it and conduct their inspection". -AP7

Even though end-users exhibit initiative in evaluating their HFEP projects, the lack of a standardized evaluation tool cannot determine the impacts of the constructed facilities and procured equipment. Respondents have claimed that the construction or enhancement of

³⁷ COA identified that the monitoring of HFEP projects is an issue, citing the lack of a sustained monitoring component and inadequate personnel from the DOH Regional Offices to monitor the projects have led to discrepancies in HFEP's implementation (Performance Audit Report 2017-05: Health Facilities Enhancement Program: Program Implementation Gaps Impacting on Efficient, Economical and Effective Provision of Health Facilities and Equipment Necessary for PhilHealth Accreditation and Licensing (COA 2017). ³⁸ DOH loses PHP338 million due to alleged hospital project irregularities in Albay (Labalan 2024).

their HFEP-funded facilities have enabled them to accommodate more patients after the project's completion, however, they were not able to provide the research team with any data regarding their claims (TP8 2024; TP11 2024).

"In terms of the number, I don't have yet the number but really those birthing facilities are of good use, put into good use and not only the pregnant women during their prenatal check-up are given services in those facilities but also during the intrapartum, postpartum and, we use the facility for vaccination, implementation of the catchment area. So, there are numerous benefits that were derived out of this project." – TP8

"...because of HFEP we're able to cater to more patients and improve the quality of service because of the improvements in our facility. Regarding the estimate of how many more patients we were able to accommodate, I don't have the data for that..." – TP11

The Commission on Audit (COA) has corroborated this finding on their Audit report on HFEP in 2017. COA flagged the same issue on the lacking assessment tool for HFEP as DOH's report on the Kalusugan Pangkalahatan 2010-2016: An Assessment Report³⁹ only included the total number of health facilities constructed under the HFEP budget. The report mirrors the findings of this study pertaining to the absence of an evaluative tool to determine if HFEP is achieving its desired health outcomes. Despite COA's report on this issue, no developments in the guidelines were applied in the succeeding years after the publishing of the report.

Some contractors or suppliers do not provide their obligation on preventive maintenance for procured medical equipment. HFEP guidelines concerning the installation of medical equipment notes that suppliers or contractors have an obligation to successfully install the procured equipment, correct any issues if there is any defective material, and conduct preventive maintenance within a warranty period. These suppliers and contracts must also train the end-users' personnel on how to operate and maintain the equipment. However, some respondents have experienced some issues with their contractor or supplier. One respondent reported that their supplier simply left them with the delivery of their procured equipment (AP3 2024).

"...HFEP just donates the equipment, and the supplier will do the rest. They'll let the supplier do the rest so whatever the supplier will tell you that's regarding the scope of their work then you have no choice because they're coordinating directly with the Central Office. If the supplier says preventive maintenance is not included, then you have a hard time arguing with them because you're not the one who's engaging with them." -AP3

Given this issue, end-users develop their own preventive maintenance measures for their HFEP projects. A respondent from a CHD noted that they build the capacity of LGUs to conduct their own maintenance. Similarly, a respondent from a DOH Hospital revealed that they form a team of engineers that specialize in specific fields to guarantee the longevity of their HFEP projects (AP3 2024; AP4 2024).

³⁹ The outcome indicator that DOH used to evaluate the accessibility and quality on the provision of health services were the (i) increase of PhilHealth-accredited RHUs for Primary Care benefit, (ii) increase on the number of beds within government health facilities, and (iii) the increase in the number of licensed government hospitals, (Health Facilities Enhancement Program: Program Implementation Gaps Impacting on the Efficient, Economical and Effective Provision of Health facilities and Equipment Necessary for PhilHealth Accreditation and Licensing, (COA, 2017)

"We notify the HFEP recipients that they need to institutionalize a maintenance program for their facilities. We assist LGUs within our region to build their capacity on preventive maintenance for their medical equipment." -AP4

"We have a team of engineers that consist of different fields of expertise such as civil engineers, electrical engineers, and mechanical engineers to main the buildings, even the elevators. We also have a bio-med engineering team for our medical equipment. We send them to trainings, and they also facilitate the trainings of other bio-med staff from other regions." – AP3

Although end-users are eventually required to maintain the equipment on their own, the lack of preventive maintenance offered by the supplier or contractors can pose a challenge for the quality and longevity of the procured medical equipment.

HFEP challenges revolve around inconsistency in policy implementation, inequitable resource allocation, insufficient technical and human resources, vulnerability to political influences, and weak monitoring systems. These issues collectively hinder the program's ability to achieve its goals, especially in undeserved regions. In identifying key challenges of HFEP in sequential phases (planning, budget allocation, construction and procurement, monitoring and evaluation), the next section highlights our general recommendations.

Conclusions and Recommendations

The Health Facilities Enhancement Program (HFEP) has significantly improved capital infrastructure in many public facilities. However, this report identifies several general findings that could help shape public policy to improve the program further:

- 1. Although HFEP has increased investment, there has not been a corresponding rise in hospital beds relative to the growing population. This is reflected in the declining bed-to-population ratio and severe overcrowding in public facilities, with bed occupancy rates exceeding 100%. While HFEP funding has largely focused on equipment acquisition and facility refurbishment—important for enhancing the quality of care—these investments may not be sufficient to expand capacity in public hospitals and primary care facilities.
- 2. Capital investments under HFEP are primarily structured as "passive" grants, unlike traditional infrastructure grants in many decentralized regimes that are tied to performance. While the national government has continued to increase its investments, local governments' capital spending on health remains relatively low, accounting for only 2% of their total capital expenditures, with no indication of an increasing trend. As a result, these national grants often substitute rather than complement local government investments, failing to incentivize additional local government spending. Thus, the primary driver of capital investments remains the national government, whose contributions have steadily increased.
- 3. Although HFEP's policies aim for a more equitable allocation by prioritizing local governments with limited resources, our analysis suggests that the distribution of HFEP grants remains inequitable. This raises concerns about whether HFEP's allocation framework and overall design can effectively address the maldistribution of health facilities.

- 4. **HFEP faces various operational challenges, from planning and budget allocation to implementation.** These challenges are linked to the varying resource capacity of local governments. This limited capacity includes insufficient human resources—both at the back end to implement the project and at the front end to staff and manage facilities and equipment once procured or constructed. These constraints often result in poor absorptive capacity and operational inefficiencies.
- 5. Although HFEP has strong monitoring and evaluation mechanisms, implementing these mechanisms still needs improvement. Centers for Health Development (CHDs) are assigned to conduct on-site inspections and validate LGU financial and physical reports. The program relies heavily on LGUs' self-reported progress without these checks. While this may result in more accurate reports, it leaves the program with insufficient and inconsistent financial data.

How should the country move forward?

Long Term Recommendations

Changing the paradigm of how national government approaches grants to local governments. The DOH should consider implementing "service grants" that provide comprehensive support to local governments, in addition to capital investment grants. Service grants include components such as human resources, operational funding, and technical assistance. By adopting this integrated grant structure, the DOH can ensure local governments can implement and sustain capital investments, maximizing their impact. This holistic approach addresses staffing and equipment, resulting in more effective and sustainable healthcare delivery across all local governments.

An integrated planning framework would harmonize these programs, leading to more cohesive and efficient support for local health systems. In addition, the national government should sequentially phase its grants. For example, local government could receive a capital infrastructure grant to build new facilities in the first year. In subsequent years, additional grants could be provided to support staffing and operational needs to ensure the effective utilization of these new facilities.

Medium Term Recommendations

As the country moves towards province-wide health systems, the provision of HFEP grants should be patterned after the needs of the provinces. This means that planning for HFEP proposals must also be conducted per province. Doing so will allow these health systems to prioritize areas with the least capacities (i.e., high poverty incidence, low public spending per capita, and high percentage share of GIDAs) and the highest gaps in health capital outlay. Provincial-level planning will ensure the availability of services and facilities within local health systems while strengthening the program's commitment to its existing equity framework, the NAF.

Leverage national resources to stimulate increased local government spending on capital investments in health through a more strategic mechanism. This can be operationalized by implementing the NAF envisioned in the PHFDP. It identifies local governments' required health infrastructure needs and aligns suitable grant mechanisms based on their capacity. For instance, local governments with higher capacity should provide counterpart funding with

national government contributions. In contrast, those with limited capacity could receive more comprehensive grants to ensure equitable development across local governments. **Short Term Recommendations**

Standardize requirements for project proposals. One of the challenges discussed in this paper is the changing annual guidelines for HFEP project proposals. Standardizing these guidelines or requirements will ensure that LGUs can meet them during the project planning season. This will also avoid constant changes in their project plans and existing facilities, thereby reducing costs in the long run. In addition, changes to the guidelines should also be paired with technical guidance to allow LGUs to adopt them. Providing an advance notice before implementing these changes will also give LGUs ample time to prepare their resources.

The national government should reconsider its approach to scaling up the construction of health facilities in underserved areas. The current design of HFEP, which is reflected in its capital investments—cannot keep pace with growing demand. The government could expand its existing bulk procurement initiatives and explore the possibility of bulk contracting. Even though the HFEP Management Office, CHDs, and DOH Hospitals currently conduct bulk procurement, this method is limited to medical transport vehicles and select medical equipment.

Measure the program's success by outlining performance indicators vis-à-vis program objectives and health outcomes. Currently, assessments of HFEP are limited to the number of facilities built and the amount of funds that have been fully utilized. By measuring health indicators such as service utilization (for example outpatient visits, immunization, assisted births, etc.), program implementers can see how government investments translate to improved health outcomes. This is especially important since the program's priorities evolve with leaders' health and development agenda.

Expand the portion of HFEP grants that can be used for maintenance and other operating expenses (MOOE) and other administrative overhead expenses. GAA Special Provisions only allow 1% of the total project budget to be used for administrative overhead expenses such as hiring of job order staff, transportation expenses, per diems, and more. However, our findings suggest that the insufficiency of human resources is one of the main reasons behind poor absorptive capacity. The national government should explore increasing the 1% cap to allow program recipients to hire more personnel that will implement their projects. This will help resolve the inadequate supply of human resources at the back end of program implementation.

Provide guidelines on proposals that go through non-preferred routes. It is common among program recipients to deviate from the program's processes by directing their HFEP proposals to politicians, central DOH, or other offices which bypasses the vetting process conducted at the CHDs. This practice interferes with HFEP's budget allocation as it risks moving funds from low-income and low-capacity LGUs to wealthier localities. It is, therefore, important to address this issue by providing clear and explicit mechanisms on returning these proposals to LGUs or referring them to the CHDs. Mechanisms to deter such practices should also be established to ensure that funding goes to the program's intended recipients.

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7. Annexes

Annex 1. Objectives of HFEP 2008

No.	HFEP Specific Objectives
1	Upgrade priority Barangay Health Stations (BHS) and Rural Health Units (RHUs) to
	provide Basic Emergency Obstetric and Newborn Care (BEmONC) services for the
	reduction of maternal mortality
2	Upgrade government hospitals and health facilities in provinces to make them more
	responsive to the health needs of the catchment population.
3	Upgrade lower-level facilities to be able to accommodate nursing students and to
	establish gate-keeping functions to avoid congestion in higher level hospitals
4	Expand the services of existing tertiary hospitals to provide a higher tertiary care and

as teaching, training hospitals

Source: Author's illustration of Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the DOH (DOH 2011).



Annex 2. BHS to Barangay Ratio by UHC Integration Sites

Source: Authors' analysis and illustration of the 2020-2024 Department Orders and NHFR (DOH 2024h).



Annex 3. RHU to Population Ratio by UHC Integration Sites

Source: Authors' analysis and illustration of the 2020-2024 Department Orders and NHFR (DOH 2024h).

Annex 4. Level 1 Beds by UHC Integration Sites



Source: Authors' analysis and illustration of the 2020-2024 Department Orders and NHFR (DOH 2024h).





Source: Authors' analysis and illustration of the 2020-2024 Department Orders and NHFR (DOH 2024h).