PN-ACU-525

A HANDBOOK ON INTER-LOCAL HEALTH ZONES

Department of Health
2002

This Handbook was completed and published through the assistance of
the United States Agency for International Development (USAID)
under contract with Management Sciences for Health, Inc.
(Contract No. HRN-I-00-98-00033-00, Delivery Order No. 804).
The views, expressions, and opinions contained in this report
are those of the authors and are not intended as statements of policy of USAID.

B

FOREWORD

The *"Handbook on Inter-Local Health Zone"* is the first of its kind published in the Philippines to serve as a basic guideline for implementers of local health systems. The publication of this handbook is in line with the Department of Health's thrust to develop the district health system in a devolved setting throughout the country.

This handbook was conceived as a management tool for local health officers, local government units executives and other officials, health personnel in the various levels of local government units, other government and non-government organizations and private entities in aid of the institutionalization of local health systems within the context of local autonomy through their collaboration and partnership.

In this spirit of optimism and confidence, we would like to thank the United States Agency for International Development (USAID), the Department of Health Bureau of Local Health Development (DOH-BLHD), the Institute of Health Policy and Development Studies of the National Institutes of Health UP Manila (IHPDS-NIH), the Management Sciences for Health (MSH), and our friends and supporters for helping bring this handbook into reality.

All of our collective efforts will hopefully contribute to the improvement of quality of care in health services, and the upliftment of the quality of life of our people achieved at the grassroots.

MANUEL M. DAYRIT, MD, MSc
Secretary of Health

ACKNOWLEDGEMENT

We wish to thank the United States Agency for International Development (USAID) for the full support and cooperation they extended to make possible the publication of this handbook on district health systems.

We are grateful to the directors of the Department of Health Centers for Health Development (CHDs), the Provincial Health Officers, and other health personnel of the case study areas in Kalinga, Pampanga, Bulacan, Negros Oriental and South Cotabato.

We would like to extend our gratitude to the Bureau of Local Health Development for their immeasurable support and the Institute of Health Policy and Development Studies of the National Institutes of Health, UP Manila for the immense input in the case studies.

Likewise we would like to express our sincere thanks to the following people who reviewed the Handbook and gave significant comments: Dr. Rosendo Capul, Dr. Maricar Bautista, Dr. John Wong, Dr. Melchor Lucas, Jr., of the Management Sciences for Health; Dr. Mario Villlaverde and Dr. Bernardino Aldaba of the Health Policy Development and Planning Bureau; Dr. Juanito Taleon, Dr. Regina Sobrepena, Mr. Jose Basa, Ms. Risa Yapchiongco of the Bureau of Local Health Development; Dr. Edgardo Sandig of the South Cotabato Provincial Office; Dr. Ruben Caragay of the UP College of Public Health; Dr. Teresita Bonoan of the CAR Center for Health Development; and Dr. Maria Consorsia Lim-Quizon of the Office of the Secretary of Health.

We are most especially grateful to the Management Sciences for Health team for making this project possible: to Dr. Eddie Dorotan for his clear vision and motivation, to Dr. Mary Angeles Pinero for her support and technical guidance, to Ms. Celia Marin for her

concern and facilitation of the administrative requirements of the project, to Dr. Leila Trinidad-Halum for the write-up and editing, to Ted Olavere for the artworks, and Lorenzo G. Ubalde for the handbook design and computer works.

GLOSSARY

District Health System

The World Health Organization defines the district health system as "a more or less contained segment of the national health system which comprises a well defined administrative and geographic area either rural or urban and all institutions and sectors whose activities contribute to improve health". It is subdivided into three levels of referral, namely primary (barangay health stations and rural health units), secondary (district/provincial hospitals) and tertiary (provincial and regional hospitals) that have distinct yet complementary functions.

Inter Local Health Zone and Inter Local Health System

The **Inter-Local Health Zone (ILHZ)** is the nationally endorsed unit for local health service management and delivery in the Philippines. This system is inspired by the concept of the District Health System (DHS), a generic term developed by the WHO to describe an integrated health management and delivery system based on defined administrative and geographical area known as ***health districts***. The DHS has been applied in many developed and developing countries throughout the world, primarily in countries where responsibility for health services has been decentralized from national to local health authorities.

The overall concept is the creation of an **Inter-Local Health System (ILHS)** by clustering municipalities into ILHZs. Each ILHZ has a defined population within a defined geographical area and comprises a central (or "core") referral hospital and a number of primary level facilities such as RHUs and BHS. In addition to govern

ment health services, ILHZs are inclusive of all other stakeholders and sectors involved in the delivery of health services or the promotion of health, including community-based NGOs. and the private sector (local and foreign).

Core Referral Hospital

The term core referral hospital indicates the main hospital for an ILHZ and its catchment population. Such hospital is the main point of referral for hospital services from the community, private medical practitioner, and public health services at Barangay Health Stations (BHS) and Rural Health Units (RHU). The minimum services provided at a core referral hospital include outpatient services, laboratory and radiological diagnostic services, inpatient care, and surgical services sufficient to provide emergency care for basic life threatening conditions, obstetrics and trauma.

Referrals to and from the core referral hospital are managed in accordance with a referral system that delineated the levels of diagnostic, surgical and medical services appropriate for the referral hospital and the other health service providers in the ILHZ. The core referral hospital may be a government or private facility.

ACRONYMS

BHS	Barangay Health Station
BHW	Barangay Health Worker
BLHD	Bureau of Local Health Development
BNS	Barangay Nutrition Scholar
CBHP	Community-Based Health Program
CDF	Countrywide Development Fund
CHD	Center for Health Development (formerly Regional Field/Health Office)
CHW	Community Health Worker
COH	Chief of Hospital
DHB	District Health Board
DHO	District Health Officer
DHS	District Health System
DOH	Department of Health
HDB	Health District Board
HMIS	Health Management Information System
IEC	Information Education Campaign
ILHD	Inter Local Health District
ILHS	Inter Local Health System
ILHZ	Inter Local Health Zone
IPHO	Integrated Provincial Health Office
IRA	Income Revenue Allocation
LGAMS	Local Government Assistance and Management Service
LGC	Local Government Code
LGU	Local Government Unit
LHB	Local Health Board
LIGA	Liga ng mga Barangay (Formerly ABC)
MHO	Municipal Health Officer
MOA	Memorandum of Agreement
MPDC	Municipal Planning and Development Council
NGO	Non Government Organization
NHI	National Health Insurance
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Officer
PO	People's Organization
RHU	Rural Health Unit
TMC	Technical Management Committee
WHO	World Health Organization

CONTENTS

Foreword i
Acknowledgement iii
Glossary v
Acronyms vii

Introduction 1

Chapter 1: General Principles

Definition of Inter-Local Health System . . . 7
The Importance of Establishing the Inter-Local Health System 8
Expected Achievement of the Inter-Local Health System . 8
Legal Bases for Establishing the Inter-Local Health System . 9
Guiding Principles in Developing the Inter-Local Health System 10
Composition of the Inter-Local Health Zone . . . 11
Critical Steps in Establishing the Inter-Local Health Zone . 12

Chapter 2: The Key Players

Local Health Officers 17
Local Chief Executives and Other Government Officials . 18
The District Health Team 19
The Community Health Workers 20
The Community Members 20
Non-Government Organizations and People's Organizations 21
Private Sector 22
Department of Health - Bureau of Local Health Development 23
Department of Health - Center for Health Development . 24
Provincial DOH Representative 25
Philippine Health Insurance Corporation . . . 26

Chapter 3: Preparatory Activities

Analysis of Data 29
Generate the Idea of Inter-Local Health Zone . . 31
Clustering of Municipalities 32

Chapter 4: Legal and Political Support

Legal Mandates 39
Advocacy and Social Marketing 41
Concretizing Agreements 42

Chapter 5: Organization of the Inter-Local Health Zone

The Inter-Local Health Board 50
The Technical Management Committee . . . 61

Chapter 6: Management of the Inter-Local Health Zone

Integrated Health Planning System 67
Improvement of Facilities 71
Health Referral System and Minimum Packages of Services . 73
Drug Procurement and Management System. . . 84
Health Human Resource Development . . . 91
Health Information System 92

Chapter 7: Resources for the Inter-Local Health Zone

Main Sources of Funds 104
Other Sources of Funds 109
Fund Management 116

Chapter 8: Monitoring and Evaluation

Quality Assurance 121
Sentrong Sigla Certification 123
PHIC Accreditation 125

Annexes

Annex	1	Health Sector Reform Agenda 1999	135
Annex	2	Health Covenant 1999	138
Annex	3	Presidential Executive Order No.205	143
Annex	4	Provincial Executive Order No.13 - s 2000, Province of Capiz	147
Annex	5	Provincial Administrative Order No. 99 - s 1999, Province of South Cotabato	152
Annex	6	Provincial Health Board Resolution No. 5 - s. 1999, Negros Oriental	156
Annex	7	Sangguniang Panlalawigan Resolution No. 678 - s. 2000, Negros Oriental	158
Annex	8	Sangguniang Bayan Resolution 274 - s. 2000, Municipality of Bayawan, Negros Oriental	160
Annex	9	Memorandum of Agreement for Inter-Local Health Zone of Bindoy, Ayungan and Tayasan in the Province of Negros Oriental	162
Annex	10	Agency Contact Information	177

Tables

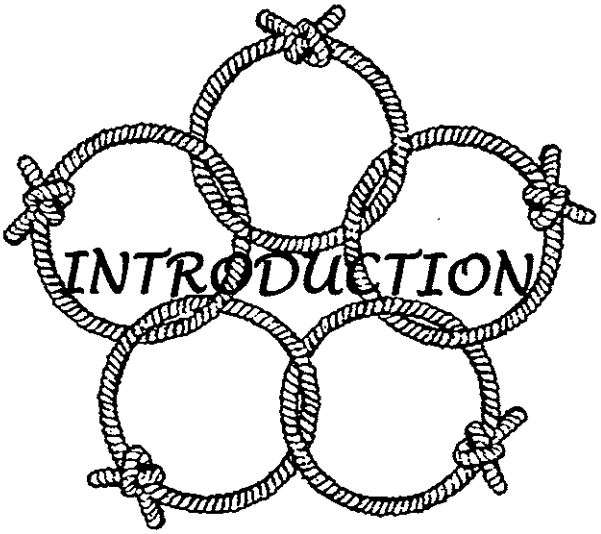
Table	1	Processes and Health Services Delivery Levels Involved in the Development of Integrated Health Plans	68
Table	2	Comparative Drug Prices of Parallel Drug Imports vs Local Branded Products	89
Table	3	LGU and PhilHealth Premium Payments for Indigent Members	106
Table	4	Expected Return on Investment for PhilHealth Capitation Fund	107
Table	5	Benefits of PhilHealth Medicare Para sa Masa Cardholders	108

Figures

Figure	1	Organizational Structure of the Health System - Pre Devolution	48
Figure	2	Organizational Structure of Health Services - Post Devolution	50
Figure	3	Lin'awa District Health Board Organizational Structure	51
Figure	4	Pampanga Unified Inter-Local Health Zone	55

Figure 5 Baliuag Unified Local Health System District Health Board Organizational Structure . 56
Figure 6 CVGLJ District Health Board Organizational Structure 57
Figure 7 Sta. Bayabas Inter-LGU Health System Organizational Structure . . . 59
Figure 8 Organizational Structure of Integrated Health System of South Cotabato . . 60
Figure 9 CVGLJ Health District Management Committee Organizational Structure . . . 62
Figure 10 Operational Framework to Support LAHDZs . 64
Figure 11 Development of the Strategic and Annual Health Plans 70
Figure 12 Flow of Referral of Patients . . . 76
Figure 13 Flow Chart of Referral System in Kalinga ILHZ . 77
Figure 14 Drug Management Cycle. . . . 84
Figure 15 Process Flow for Hospital Procurement in Pangasinan 86
Figure 16 CBMIS Updating Process: Malaybalay City . 94
Figure 17 Bago City CDSS 97
Figure 18 Quality Assurance Circle 122

References 179


INTRODUCTION

The World Health Organization (WHO) introduced the District Health System in 1983 to improve efficiency and effectiveness in the delivery of health services. As early as 1981, Executive Order No. 851 allowed for the arrangements of district hospitals, rural health units and barangay health stations into health districts. District Health Offices were further established in 1987 under Executive Order No. 119. Hospital and public health services were integrated at all levels of administration, including management and primary health care approach to the delivery of health services.

The District Health System was greatly affected by the implementation of the Local Government Code of 1991, otherwise known as R. A. 7160. The process of decentralization broke the chain of integration as a result of the separation of administrative control of health services between the Rural Health Unit (RHU) and hospitals. Major changes ensued in the delivery of health services, health personnel morale, and sustainability of gains previously made in the health sector. This resulted in the decline of quality and availability of government health services.

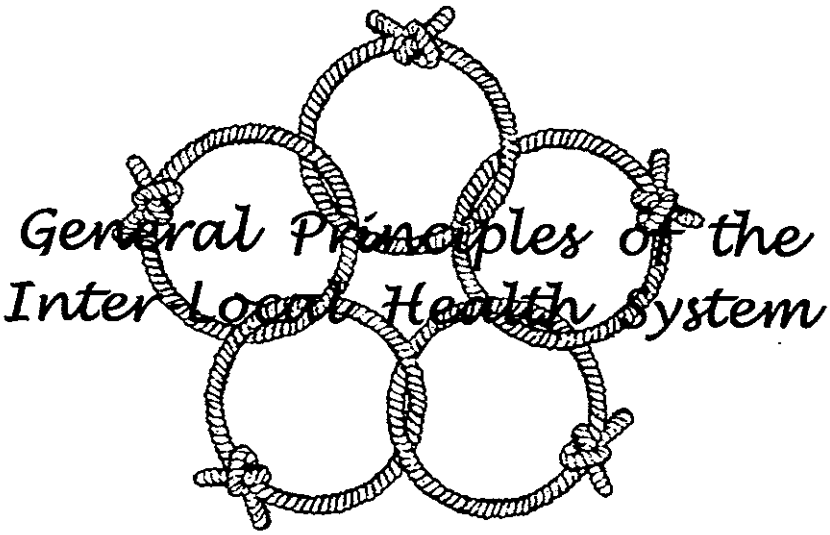
In its Health Sector Reform Agenda in 1999, the Department of Health (DOH) included the revitalization of the District Health System in response to the post-devolution difficulties encountered (see Annex 1). Under its new name, the Inter-Local Health System is deemed as the same mechanism that will mobilize the different stakeholders towards an integrated system of health development within the framework of inter-Local Government Unit (LGU) cooperation.

PREVIOUS PAGE BLANK

This handbook aims to provide basic information on Inter-Local Health System to researchers, health workers, Local Government Unit (LGU) managers, health policy makers, Department of Health (DOH) management and technical personnel. The discussion points in this handbook came from various concept papers, workshop outputs, policy papers, and the rich experiences of five LGUs in the case studies of Inter Local Health Zones.

As a guide, the handbook offers the minimum requirements in the establishment and management of Inter-Local Health Zones. The users of this handbook are encouraged to use their own creativity, resourcefulness and adaptability to suit the situation and specific needs of the areas and people involved.

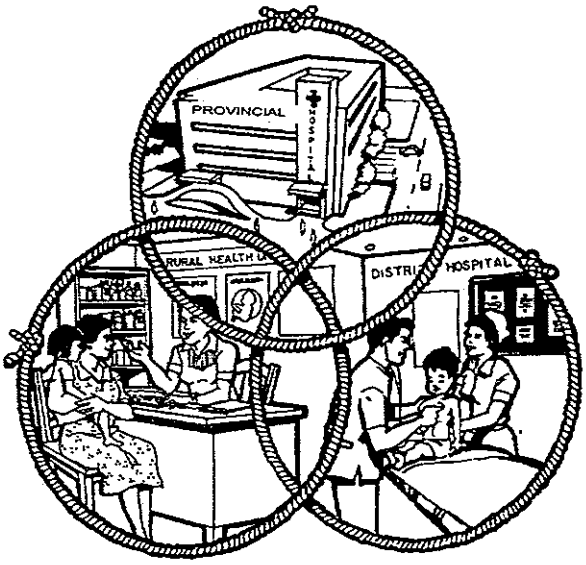
CHAPTER 1



Definition of Inter-Local Health System

It is a system of health care similar to a district health system in which individuals, communities and all other health care providers in a well-defined geographical area participate together in providing quality, equitable and accessible health care with ***Inter-LGU partnership*** as the basic framework.

The World Health Organization defines the District Health System (DHS) as "*a more or less contained segment of the national health system which comprises a well defined administrative and geographic area either rural or urban and all institutions and sectors whose activities contribute to improve health*". The DHS has been applied in many developed and developing countries throughout the world, primarily in countries where responsibility for health services has been decentralized from national to local health authorities.



The District Health System is subdivided intro three levels of referral namely primary (barangay health stations and rural health units), secondary (district/provincial hospitals) and tertiary (provincial/regional hospitals) that have distinct yet complementary functions.

PREVIOUS PAGE BLANK

The Importance of Establishing the Inter-Local Health System

Why is there is a need to establish the Inter-local Health System?

- There is a need to re-integrate hospital and public health services for a holistic delivery of health services.
- The Inter-Local Health System will identify areas of complementation of the stakeholders in the delivery of health services. These stakeholders include: LGUs at all levels, Department of Health (DOH), Philippine Health Insurance Corporation (PHIC), communities, Non-Government Organizations (NGOs), private sector, and others.

Expected Achievement of the Inter-Local Health System

The Inter-local Health System hopes to achieve the following:

- Universal coverage of health insurance
- Improved quality of hospital and Rural Health Unit (RHU) services
- Effective referral system
- Integrated planning
- Appropriate health information system
- Improved Drug Management System
- Developed human resources
- Effective leadership through inter-LGU cooperation
- Financially viable or self-sustaining hospitals
- Integration of public health and curative hospital care

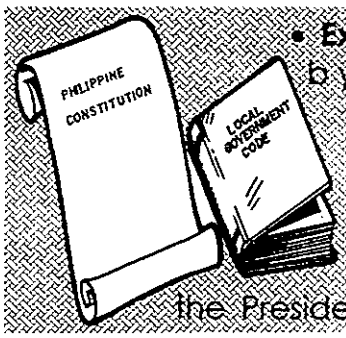
- Strengthened cooperation between LGUs and the health sector

Legal Bases for Establishing the Inter-Local Health System

- Article X, Section 13 of the **1987 Constitution** states *"local governments may group themselves, consolidate or coordinate their efforts, services and resources for purposes commonly beneficial to them."*

- The **Local Government Code of 1991** Section 33 states that *"local governments through appropriate ordinances **group themselves,** consolidate and coordinate their efforts, services and resources for the purpose beneficial to them. In support of such undertaking the local government involved, upon the approval of the Sanggunian concerned after public hearing conducted for the purpose, **contribute funds, real estate, equipments and other kinds of property and** appoint or assign **personnel** under the terms and conditions may be agreed upon by the participating local units through a memorandum of agreement."*

- The **Health Covenant** by the League of Provinces, signed March 1999 between the Secretary of Health and the Department of Interior and Local Government (DILG) articulates their commitment for the implementation of the District Health System (see Annex 2).



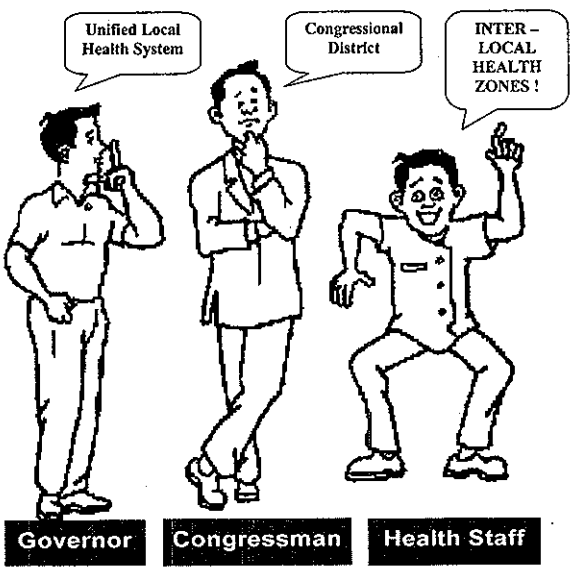
- **Executive Order No. 205**, signed January 2000 by the President provides for the creation of a national

Article X Section 13 of the 1987 Constitution and the Local Government Code of 1991 Section 33 suggest that cooperation among LGUs, therefore, is consensual or contractual in nature.

Health Planning Committee and the establishment of ***Inter Local Health Zones (ILHZ)*** throughout the country (see Annex 3).

Guiding Principles in Developing the Inter-Local Health System

- Financial and administrative **autonomy** of the provincial and municipal administrations **(LGUs)**;
- Strong **political support**;
- Strategic **synergies** and partnerships;
- **Community** participation;
- **Equity** of access to health services by the population, especially the **poor**;
- **Affordability** of health services;
- **Appropriateness** of health programs;
- **Decentralized** management;



In post-devolution Philippines,"health districts" have been variously referred to as Inter Local Health Districts (ILHD), Local Area Health Development Zone (LAHDZ), and Area Health Zone (AHZ). At the National level, Executive Order Number 205 of January 2000 established Inter-Local Health Zones (ILHZ throughout the Philippines. When all the ILHZs within a province are linked together, they form the basis of the province-wide Inter-Local Health System. In Region 3, this is called the Unified Local Health System.

- **Sustainability** of health initiatives
- Upholding of standards of **quality** health service

Composition of the Inter-Local Health Zone

- ***People*** – The number of people may vary from zone to zone. An ideal health district would have a population size between 100,000 and 500,000 for optimum efficiency and effectiveness (WHO, 1986). The population may vary further depending on the number of LGUs who will decide to cooperate and cluster.

> ***Health District and Congressional District.*** A health district is not synonymous to a political congressional district. Health districts may overlap congressional districts based on contiguity of cooperating municipalities for effective delivery and management of health services. A health district may comprise of only one large municipality, or several municipalities. It may also be a cluster of municipalities located in a small island.

- ***Boundaries*** – Clear boundaries between Inter Local Health Zones determine the accountability and responsibility of health service providers. Geographical locations and access to referral facilities such as district hospitals are the usual basis in forming the boundaries. However, flexibility regarding existing political, social and cultural borders would be best in order to ensure every person's access to health services.

- ***Health Facilities*** – A district or provincial hospital (referral hospital for secondary level of health care), a number of Rural Health Units (RHU), Barangay health stations (BHS) and other health services deciding to work together as an integrated health system.

- ***Health Workers*** – The right mix of health providers is needed to deliver comprehensive health services. The groups of health providers include the Department of Health , district hospital, Rural Health Units , Barangay Health Stations , private clinics, volunteer health workers, Non Government Organizations (NGO) and

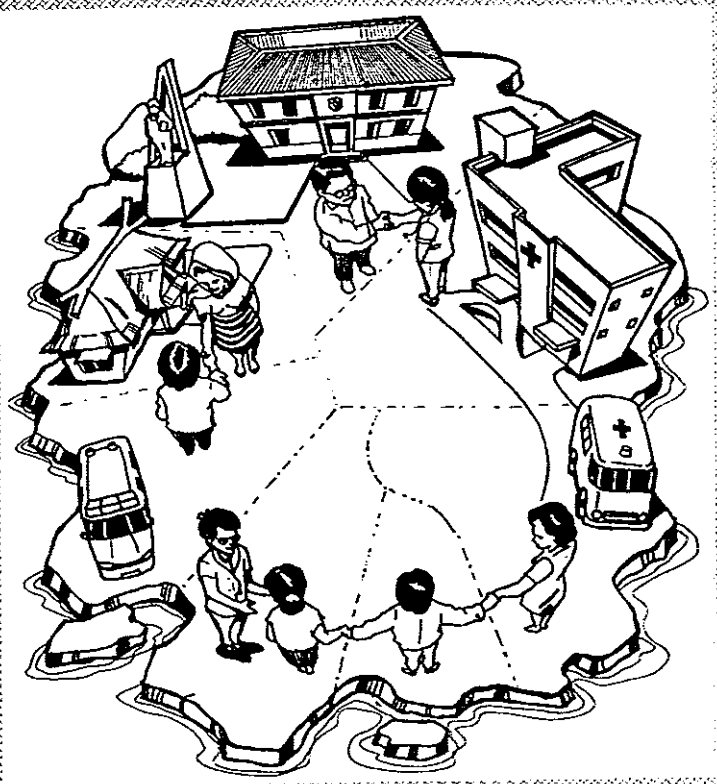
community-based organizations. Together, they form the ILHZ team to plan joint strategies for district health care.

Critical Steps in Establishing the Inter-local Health Zone

These are the critical points in making the ILHZ work:

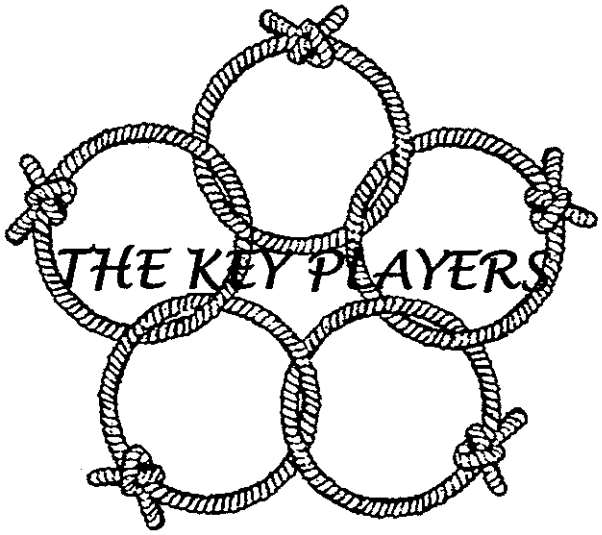
- Conduct a thorough **preparatory study** of the province regarding its health situation, geography, economic and socio-cultural dimensions, as well as its political dynamics;
- Put in place **policy and technical management structures**;
- Set up guidelines for **packages of services** at all levels (BHS, RHU and district hospital);
- Formulate an **integrated health plan**;
- Set up **health care financing** and cost-sharing schemes;
- Institute a mechanism for **local control** of financing and resource allocation;
- Improve BHS, RHU and district hospital **facilities** for primary and secondary levels of care;
- Strengthen a **two-way referral system** for patients' access to appropriate level of care in the various health facilities in the district;
- Adapt an appropriate **information system** for disease surveillance and support for planning and decision-making;
- Improve the **drug management system** for cheaper and quality drugs;
- Ensure effective **personnel development** and management;
- Ensure **quality assurance** of services through periodic systems review.

Each critical step will be described in the succeeding chapters. Significant experiences from the five ILHZ case studies will be cited to further illustrate some points.



An **Inter-Local Health System** is created by clustering municipalities into Inter-Local Health Zones through inter-LGU cooperation. Each ILHZ has a defined population within a geographical area, and comprises a central or core referral hospital and number of primary level facilities such as RHUs and BHS. Included in the ILHZ are other stakeholders and sectors in the delivery of health services or the promotion of health such as community-based NGOs and the private sector.

CHAPTER 2



PREVIOUS PAGE BLANK

In any endeavor, the most important component is the people. The Inter-Local Health Zone has an interesting diversity of key players or stakeholders.

The Local Health Officers

The local health officers are composed of the Provincial Health Officer of the Integrated Provincial Health Office, the Chief of Hospital of the Provincial Hospital, the Chiefs of the District Hospitals, and the Municipal Health Officers of the cooperating municipalities. They are the lead persons in the establishment, operations and management of health services of the ILHZ. The set up of the ILHZ gives the local health officers some form of fiscal autonomy, as district funds become available for health systems improvement. They play a major role in the planning, implementation, monitoring and evaluation of the delivery and management of health services in the ILHZ.

The Role of PHO in ILHZ:

The Provincial Health Office shall be the focal point for technical assistance for health services including administrative supervision of provincial and district hospital. It provides public health and management support for all levels of care. This includes technical supervision and monitoring and evaluation for public health programs. It shall be responsible for developing a province-wide human resource development plan, manage the integrated info database for the province and an integrated health plan. It coordinates with the DOH through the Centers for Health Development (CHD). The Governors and Mayors shall retain administrative control over the hospitals and RHUs respectively.

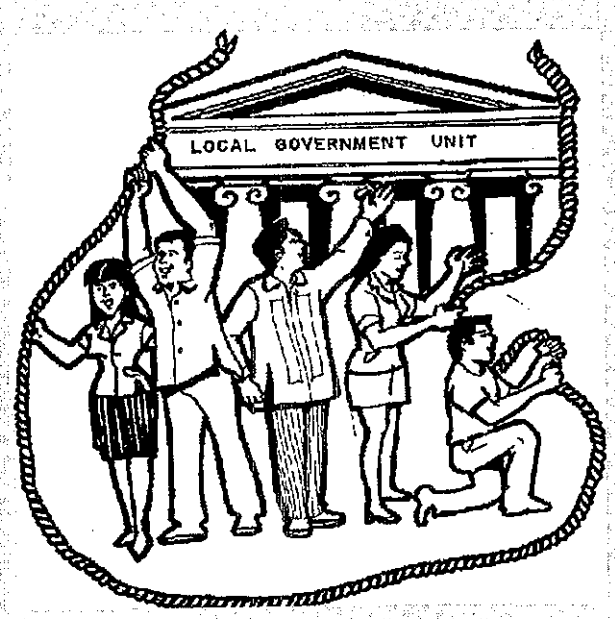
PREVIOUS PAGE BLANK

Local Chief Executives and Other Government Officials

The local chief executives involved in the Inter-Local Health Zone are the Provincial Governor and the municipal Mayors of the collaborating municipalities. Essential also to the ILHZ are the members of Sangguniang Panlalawigan, Sangguniang Bayan, and the Barangay Chairpersons. They ensure the institutionalization of the ILHZ in the area, and appropriate funds to support the delivery of health care. They also provide mechanisms to guarantee the sustainability of the ILHZ even after their terms of offices.

Good Health is Good Politics.

In Negros Oriental province, there exists a political tradition that health is an important component of governance. Congressman Emilio Macias, a doctor by profession, who previously served as Governor, was responsible for this legacy. The strong commitment to support the health sector continues among the local chief executives (LCEs) of the local government units. The idea of the health district system was already familiar to and supported by the LCEs of the province. They commit to provide financial support to improve health care delivery systems.



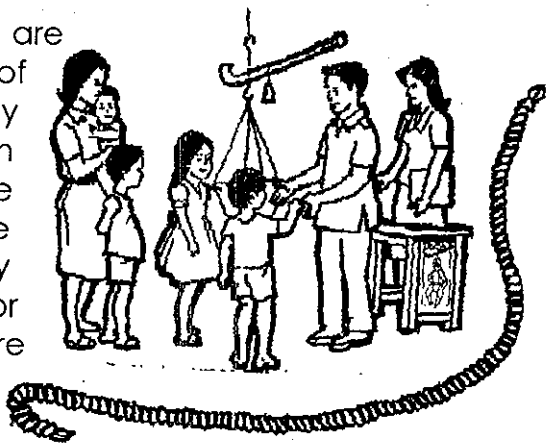
The District Health Team

This is the backbone of the Inter-Local Health Zone. The district health team is composed of all the health workers and support personnel in the district hospital, rural health units, municipal hospital, and barangay health stations. The right mix of health personnel is very important in providing comprehensive primary health care. They are concerned not only in treating patients, but also in the promotion and prevention aspects of health care.

The district health team is composed, therefore, of the doctors, dentists, nurses, midwives, as well as sanitary inspectors or environmental health officers. The support staff includes the laboratory and radiological service personnel such as the medical technologists and x-ray technicians. The health team also includes the management and administrative staff, the engineering staff and computer personnel, the cooks and laundry workers, the drivers, cleaners, gardeners and maintenance workers. All of them work harmoniously for the provision of quality health care.

The ***District Health Office (DHO)*** and the district hospital play a central role in the ILHZ. The hospital performs secondary health services while the RHUs and the BHS perform primary health functions. The provincial hospital performs the tertiary level of care. The district consolidates health statistics from the catchment area to be able to draw up a district health plan from inputs from the RHUs and other hospitals. All district plans are consolidated to formulate a provincial health plan. Strategic planning is done at the district and provincial levels. Each plan has a financial component. The DHO serves to link the municipalities and cities in the catchment area to the province.

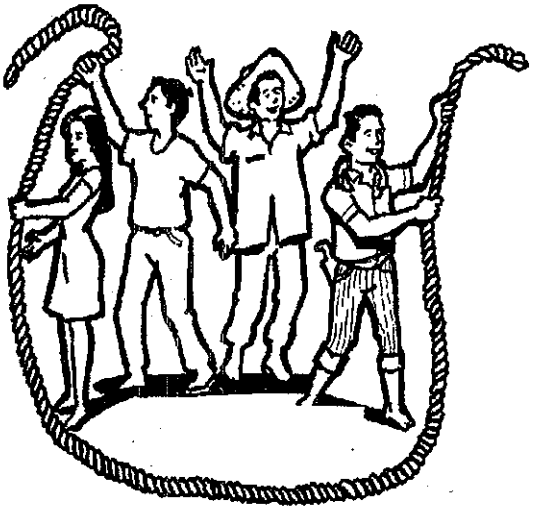
The Community Health Workers



The community health workers are the front liners in the delivery of primary health care. Every day they are directly in contact with their patients and clients, the community members. They are the conduits for the two-way channel of communication for the improvement of health care delivery.

The Community Health Workers may include the Barangay Health Workers (BHW), Barangay Nutrition Scholars (BNS), Community Volunteer Health Workers (CVHW), and traditional or indigenous healers. These health workers may be trained by NGOs, church-based groups, or by various government health institutions.

The Community Members

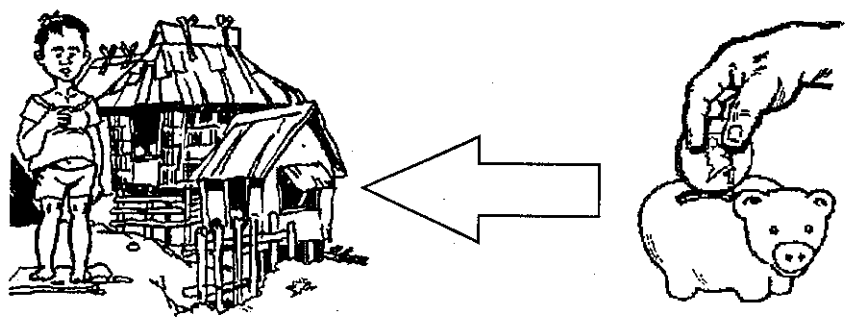


The community is the purpose and mission of the Inter-Local Health Zone. They are not merely the recipients of health care, but partners in the development and improvement of primary health care by actively participating in the planning, implementation and evaluation of health programs and projects. Through their initiatives and proactive stance, ***health in the hands of the people*** can, and will be fulfilled.

Non-Government Organizations and People's Organizations

For over two decades now, in times of political turmoil and peace, many NGOs and POs have become catalysts for change in the arena of health. Through the Inter-Local Health Zone, collaboration and partnership between government and non-government organizations would be more substantial and institutionalized. The ILHZ has a greater participatory component since it allows NGOs and POs to become members of health boards that become the policy-making bodies of local health systems.

Sinangpad – unity in health care. In Kalinga, the Sinangpad is a federation of 24 non-government organizations formally linked to the ILHZ. The word sinangpad refers to a necklace of different beads and colors commonly worn in the cultural communities suggesting a sense of unity amidst differences. Through the Small Grants Scheme, the NGOs were able to work on specific community health projects. These diverse projects were school-based community health contests, health promotion approaches, Botika sa Barrio, Family Planning and Reproductive Health, medical and dental missions, community organizing and mobilization, Information-Education campaigns and preparation of community health plans.



In Negros Oriental, the ***Peso for Health*** Program, a community-based health-financing scheme, has given the members the opportunity to actively participate in many aspects in the delivery of health care.

Private Sector

The private sector refers to individuals or groups that collaborate with the local government units and heatlh personnel in the delivery of health services. This collaboration may be through personal services such as in medical-dental missions and health campaigns and projects, and also through financial assistance such as loans and grants for health projects and programs, given by local and foreign agencies.

Some private groups and donors contribute equipment or upgrade rooms in hospitals. Foreign funding agencies also provide the necessary funds to jumpstart the upgrading of health facilities and services. The creation of a health district system formalizes and strengthens the collaboration that already exists.

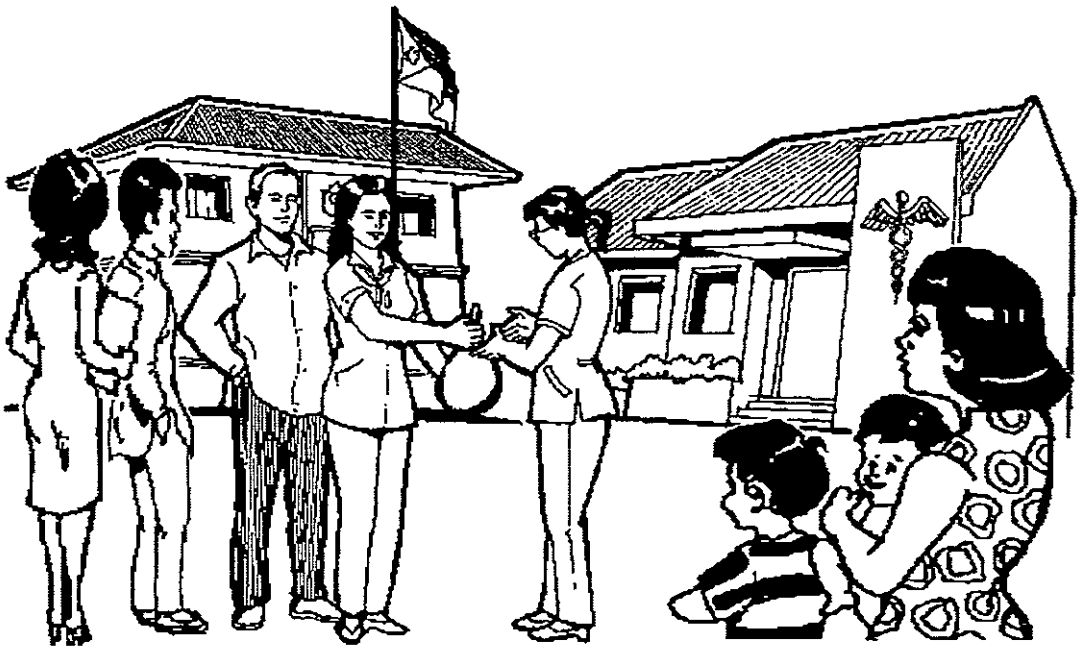
Through the Inter-Local Health Zone, private practitioners may have other venues for collaboration. Involvement in referral and health information systems may be explored. Private clinics and hospitals are also part of the Local Health System, and these can be used as referral facilities.

Department of Health - Bureau of Local Health Development

The Bureau of Local Health Development is the lead agency of the DOH in institutionalizing and developing local health systems. Its mission is to provide "technical leadership on local health systems for equitable and quality health care thru development of policies, frameworks, standards, guidelines, models, capacity and capability building and strategic alliances".

The three main goals of the BLHD are:

- To institutionalize local health systems within the context of local autonomy;
- To ensure and sustain quality of care in health services; and
- To develop mechanisms for inter-local government units (LGU) collaboration and partnership with other government and non-government organizations and private entities under a devolved system.



Through partnerships with other agencies that seek to uphold the goals of local health system development, the Bureau aims to provide better understanding of the local health systems and how they work within a devolved context.

Department of Health - Center for Health Development
(Formerly Regional Field/Health Office)

The role of Centers for Health Development of the DOH is to act as the main catalyst and organizer in the ILHZ formation. Its functions in line with this are to:

- Provide technical support and advocacy for development of local health management systems and their integration in the context of the ILHZ;
- Review and approve ILHZ proposals for funding aimed at strengthening the delivery of health services and supporting community-based initiatives;
- Integrate local health plans into regional plans; and
- Undertake monitoring of the development and implementation of ILHS.

Sentrong Sigla. The Sentrong Sigla Movement (SSM) is a nationwide initiative of the DOH in partnership with LGUs. It aims to improve health services and make them more accessible to local communities. SSM promotes devolution of health services and improved quality of services through active participation of all sectors in society. The Sentrong Sigla Team are at the DOH Central Office and Centers for Health Development. (See Annex 10 for Sentrong Sigla contact information).

Provincial DOH Representative

The provincial DOH representative is a member of the Provincial Health Board. In addition to this, his/her other responsibilities are to:

- Provide updates and advise ILHZ boards and municipal Local Health Boards on DOH policy guidelines and standards
- Coordinate with CHD for technical assistance on DOH policy matters
- Lobby and advocate CHD for funds for identified health activities of the ILHZ based on annual health plans
- Advocate for DOH program implementation with LGUs through ILHZ boards and municipal LHBs
- Provide regular reports to the CHD on health activities undertaken by individual ILHZ

Let's-DOH-It Rep. At the Bulacan Unified Local Health System, the DOH representative, Dr. Jason Galeon, is a true liaison between the provincial DOH resources and LGU operations. The roles and functions of the DOH representative are well understood by the municipal mayors, health officers, the Provincial Health Office, and by Dr. Galeon himself. Hence, he has become an effective coordinator of the functions of the two separate organizations. As a result, all the municipalities cooperate readily when Dr. Galeon collects data for consolidation. They also respond positively to scheduled meetings and common activities, so that ILHZ meetings are well attended. Even the Provincial Governor is very familiar with the DOH representative and his functions. The DOH representative, therefore, is an effective change agent that brings the DOH programs to the local health system areas.

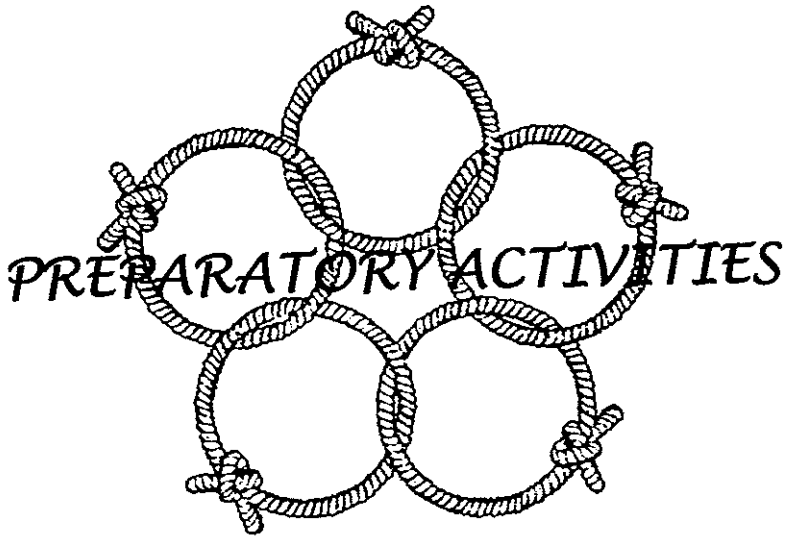
Philippine Health Insurance Corporation (PHIC or PhilHealth)

The Philippine Health Insurance Corporation is a key player in the financial sustainability of the ILHZ. The National Health Insurance Law of 1995, or RA 7875, mandates the PHIC to provide universal coverage of social health insurance to all, especially the poor through the implementation of the National Health Insurance Program.

PhilHealth's tasks then in ILHZ are the following:

- Increase coverage of Social Health Insurance by enrollment of the households to the PhilHealth at premium payment of P1, 188 per household. This will cover the formal sector, the informal sector, and the indigents.
- For the indigents program, PHIC will cover 90% of the premium while the LGU will shoulder 10% in 4th to 6th class municipalities. In the first two years it will be 50-50 sharing in the 1st to 3rd class LGUs (see Table 3 on page 106). T his means that LGUs only have to pay a premium of P118.80 per household in 4th to 6th class municipalities, and P594 per household for 1st to 3rd class municipalities.
- Increase benefits to PhilHealth cardholders to include hospitalization and outpatient benefits (see Table 5 page 108 for the detailed benefits.)
- Accredit facilities in RHUs and both government and private hospitals. (Accreditation requirements will be discussed in Chapter 8)
- Offer capitation funds in the amount of P300 per household to accredited RHUs. (see Table 4, page 107 for sample).
- Reimburse hospitals for inpatient services availed of by members, subject to certain ceiling amounts or caps.

CHAPTER 3

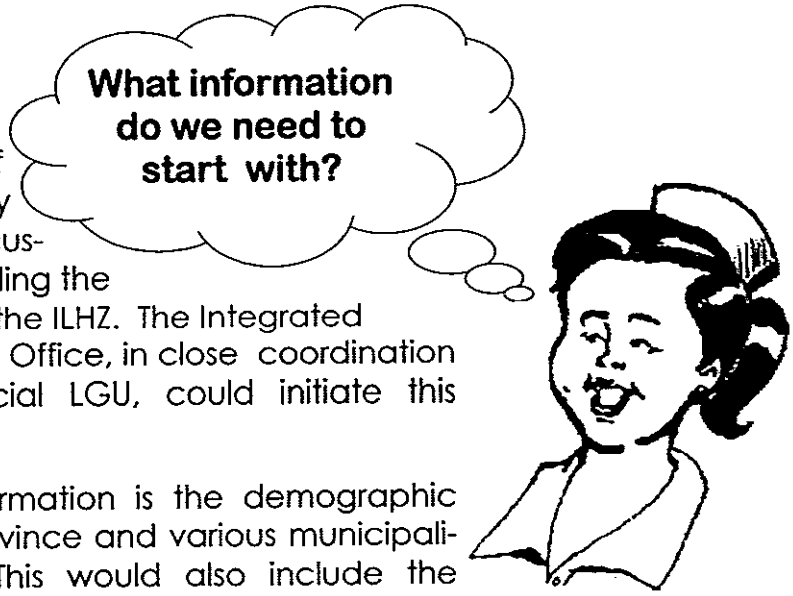


The first critical step in the formation of ILHZs is to undertake an extensive and meticulous pre-implementation preparation of all ILHZ stakeholders.

There are the three major preparatory activities:

- Analysis of data
- Generating the idea of ILHZ
- Clustering of municipalities

Analysis of Data



The gathering and analysis of data will greatly substantiate discussion points regarding the establishment of the ILHZ. The Integrated Provincial Health Office, in close coordination with the Provincial LGU, could initiate this activity.

The primary information is the demographic profile of the province and various municipalities involved. This would also include the economic and socio-cultural dimensions of the province. Coverage of the area should include both population and land size.

Next would be the health facilities and services available. How many BHS, RHUs and district hospitals are there in the area? Are there also community and specialized hospitals? How many private hospitals and clinics are in the vicinity? The census reports of the various facilities, including the provincial hospital, would provide information on the utilization rate of these facilities. The

PREVIOUS PAGE BLANK

reports would include bed occupancy rate, outpatient clinic census, as well as data from the laboratory, x-ray and pharmacy. Is the provincial hospital over utilized? Are the district hospitals underutilized?

Financial statements of the health facilities would show sustainability needs, and trigger discussions on fund sources. The data on personnel component of the facilities would reflect their adequacy and effectiveness in terms of number and level of competence, as well as indicate further training needs. Available previous patient surveys and other researches on quality assurance would be helpful.

The morbidity and mortality reports are very crucial. What are the most common illnesses, both acute and chronic? What are the most common causes of death? What are the reportable cases, infectious and communicable diseases? What health programs need to be intensified?

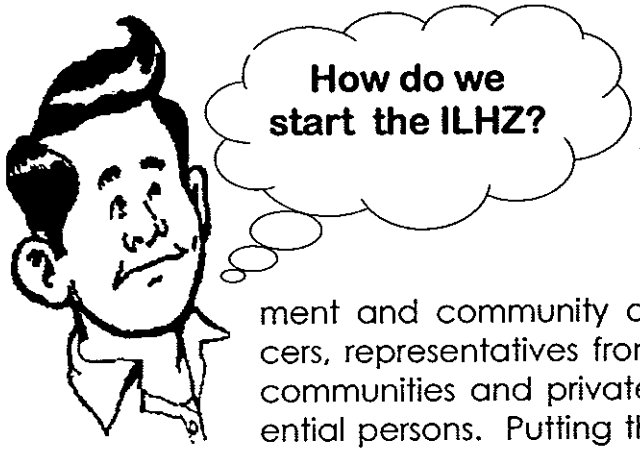
Data on transportation and communication flows are needed for identifying existing referral mechanisms. Which municipalities have ambulances or other vehicles? Are there two-way radios available at the LGU and/or the RHUs? Are the district hospitals also equipped with transport vehicles and radio communications?

Checklist of data in preparing the ILHZ

-] Demographic profile of province and municipalities (population and land size)
-] Economic and socio-cultural profile
-] Political affiliation of LGUs at all levels
-] Health facilities and services available (BHS, RHU, community/municipal hospital, district hospital, provincial hospital, specialized hospital, private hospitals and clinics)
-] Census reports of health facilities (bed occupancy rate, outpatient clinic census, laboratory, X-ray and pharmacy census)
-] Financial statements of health facilities
-] Personnel component
-] Satisfaction surveys (patients and employees)
-] Morbidity and mortality reports
-] Transportation and communication flows

Generate the Idea of ILHZ

The next major step is to generate the idea on the integration of health services at the local level thru inter-LGU cooperation.



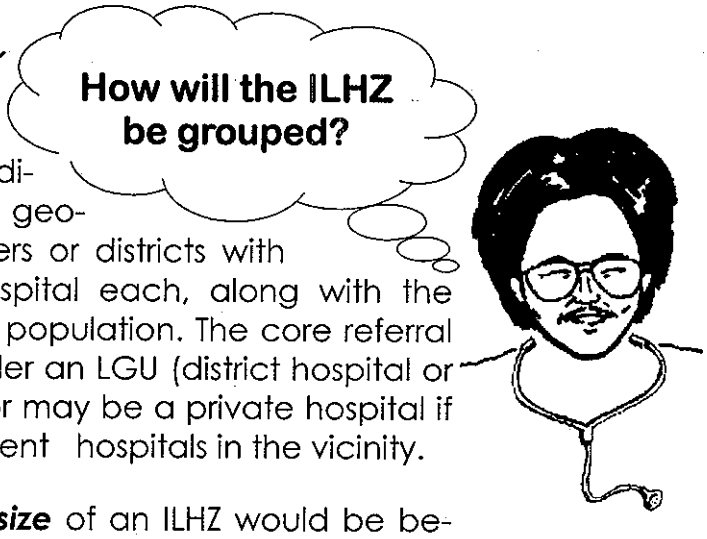
Once all the relevant data are gathered and analyzed, a seminar-workshop could be conducted. This would include the key players, namely the local government and community officials, local health officers, representatives from the NGOs in the area, communities and private sector, and other influential persons. Putting the idea in concrete form may entail developing a concept paper. Further discussions and workshops may be conducted to undertake consultation on the concept paper before the proposal is finalized.

It would be very helpful to include in the seminar-workshops a module on the Local Government Code, Section 17. This module would give the local chief executives, various government officials involved, as well as other stakeholders a basic understanding of the provision of devolution. This would indeed facilitate the establishment of the ILHZ in the area.

The South Cotabato Integrated Provincial Health Office (SCIPHO) conceptualized the Integrated Health System (SCIHS) after they identified factors in the derailment of their health services. The SCIPHO developed the concept paper and project proposals were submitted to funding agencies. Multi-sectoral consultations were conducted for this. Proposals for funding the Integrated Health System were prepared and submitted to the provincial government, DOH, USAID and AUSAID. The SCIHS was officially proposed to the provincial government at the Provincial Health Summit in 1999.

CHD 3 as process champion. In Bulacan and Pampanga, the active role of the DOH-CHD in functioning as the process champion in the formation of the ILHZ is notable. Their early recognition of fragmentation of the health care system and their ability to solicit the support of local chief executives in the area, especially the provincial governor proved to be valuable. The Baliuag Unified Local Health System concept was developed at the CHD level. Orientation of municipal local chief executives, local health board, and health staff at the regional and provincial levels on the Unified Local Health System was conducted by the CHD. The CHD also supported orientation live-in training for local health board members. PowerPoint presentation of health programs to local health board members were carried out by the CHD in every municipality.

Clustering of Municipalities



The next preparatory activity would be to divide the province geographically into clusters or districts with one core referral hospital each, along with the catchment RHUs and population. The core referral hospital could be under an LGU (district hospital or provincial hospital), or may be a private hospital if there are no government hospitals in the vicinity.

The ideal ***population size*** of an ILHZ would be between 100,000 to 500,000 (WHO, 1986). Based on the five case studies conducted, the manageable population coverage was largest at 277,384 in Baliuag, Bulacan, and smallest at 86,923 in

Kalinga. Land area was predominantly rural, and some areas were also rurban. ***Cities*** may be incorporated within the catchment area, as in Negros Oriental. The relatively inaccessible rural areas of Kalinga were the most sparsely populated at 50/sq km, and the most densely populated were the rurban areas of Pampanga and Bulacan, with population density at 1,000/sq km and 724.6/sq km respectively.

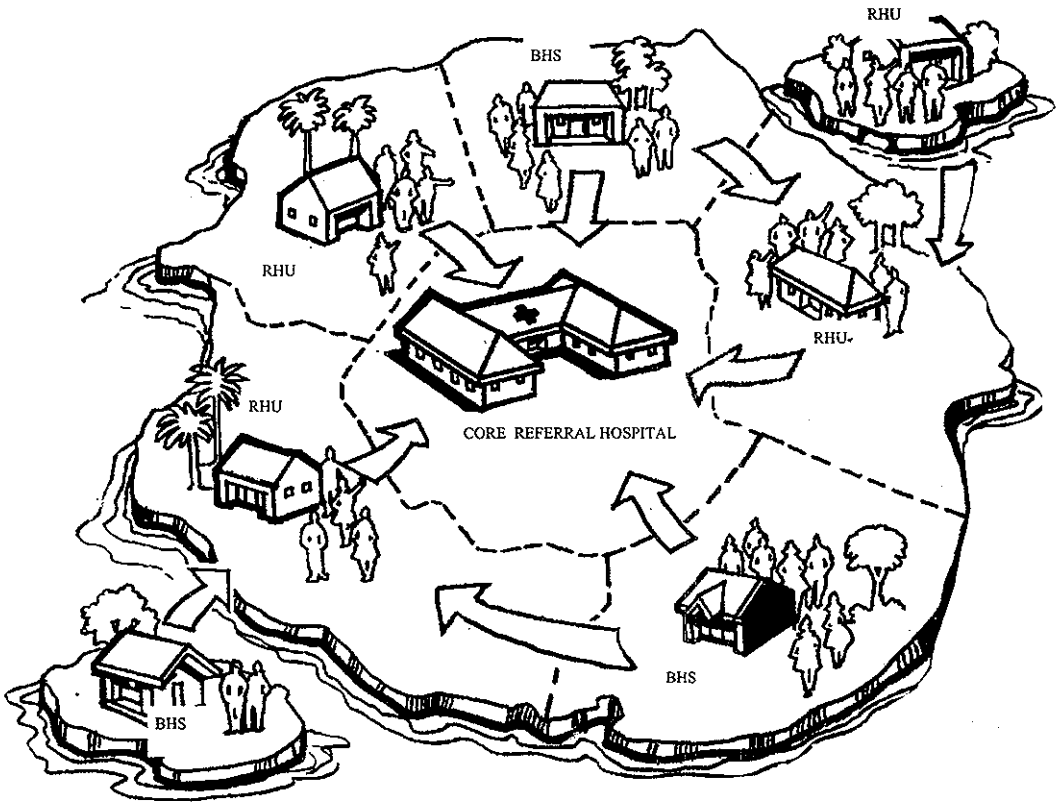
Geographical division could be the starting point for identifying the clusters of municipalities of the ILHZ. Variations in terms of number of component municipalities may depend on the catchment population of each core referral hospital. Geography, road networks, transportation and availability of other health services largely determine catchment areas. Other factors to consider are distance of the population bases from the core referral hospital, and the number and level of other hospital services within the area.

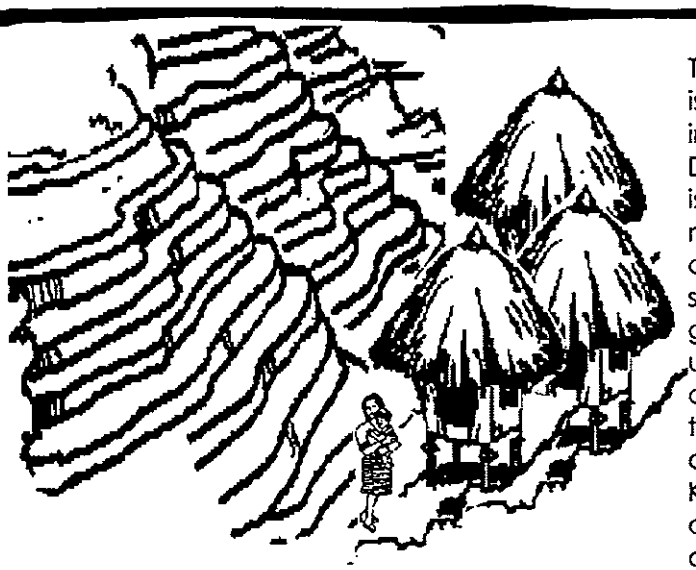
With data clearly presented, the concept of ILHZ ably generated, and clustering of municipalities adequately ground worked, the ILHZ is now ready to be launched.

Core Referral Hospital indicates the main hospital for an ILHZ and its catchment population. In accordance with a referral system in the ILHZ, such hospital is the main point of referral for hospital services from the community, private medical practitioner, and public health services at BHS and RHU. The minimum services provided at a core referral hospital include outpatient services, laboratory and radiological diagnostic services, inpatient care, and surgical services sufficient to provide emergency care for basic life threatening conditions, obstetrics and trauma. The core referral hospital may be a government (district or provincial) facility or a private facility. In Kalinga and Mexico, Pampanga, networking arrangements were made with a private hospital in each municipality to act as the core referral hospital for the municipal population.

The core referral hospital should be a secondary level facility capable of dealing with referral cases not within the capability of the RHUs. This must be in consultation with the LGUs concerned for other considerations and approval. Further discussions between the LGUs and health officers could emphasize on the government hospital sector due to its critical role in the health referral system of the ILHZ.

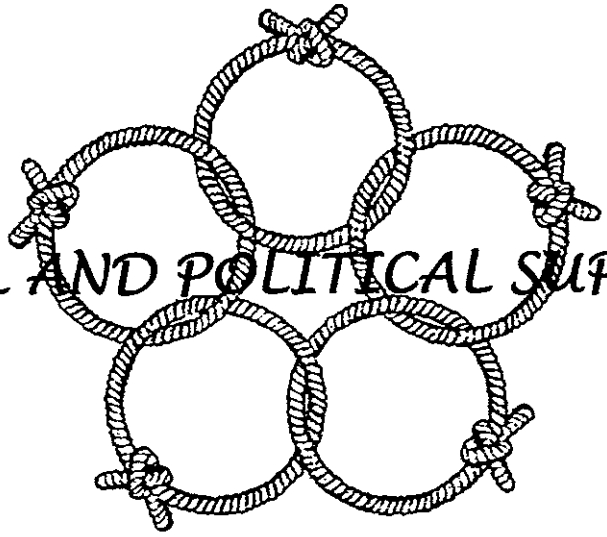
A very important consideration in clustering is the culture of the area, especially if there are several ***indigenous communities*** involved. ILHZs should therefore be geographically, culturally, socio-politically, and economically adaptable.





The ***Kalinga Province*** is an example of local indigenization of the District Health Zone. It is a unique case of modeling culturally and geographically sensitive local integrated health systems under a politico-administrative decentralized setting or devolution. The Kalinga Health Zones are quite different due to the terrain and cultural settings. The Balbalan-Bumilgan Health Zone is a one hospital-one municipality health zone. On the other hand, the Chico River District Health System is an integration of one municipality (Tinglayan) in Kalinga Province and two municipalities (Bontoc and Sadanga) in Mountain Province.

CHAPTER 4



LEGAL AND POLITICAL SUPPORT

PREVIOUS PAGE BLANK

For the ILHZ to take root, it is very important to institutionalize legal and political support. This would entail the following:

- Establishment of legal mandates,
- Advocacy and social marketing to stakeholders, and
- Concretization of agreements.

Legal Mandates

Once the concerned authorities are convinced regarding the Inter-Local Health System, it is imperative that local mandates be secured. These mandates institutionalize inter-LGU cooperation. Examples of the local mandates are: Executive Order of the Governor, Resolution from the Provincial Health Board, Resolution of the Sangguniang Panlalawigan, and Resolution of the Sanggunian Bayan (see Annexes 4, 5, 6 and 7 for the templates).

Of the ILHZ study sites, South Cotabato and Negros Oriental seem to have secured legal mandates at all levels. Resolutions were passed by the Provincial Local Health Board endorsing the DHS/ ILHS to the Sangguniang Panlalawigan. This institutionalized the district health system in the province. With the approval of this resolution by the Sangguniang Panlalawigan, the provincial governor was given authority to enter into a Memorandum of Agreement with the participating municipal governments, the Department of Health and the Integrated Provincial Health Office and other key stakeholders in the development of the district health system (see Annex 9 for the template).

The same process was done at the municipal level. The Local Health Board passed a resolution endorsing the district health system to the Sangguniang Bayan. The Sangguniang Bayan approved the said resolution, and another resolution was made to authorize the Municipal Mayor to enter into a Memorandum of

Agreement for the institutionalization of the district health system.

With the legal mandates in place, there is assurance that there would be no drastic changes in priority regarding health. Even if the local officials are replaced, the previous gains have been institutionalized in terms of local laws, ordinances and resolutions.

Here is a checklist of legal mandates of the Negros Oriental and South Cotabato ILHZ done in chronological order:

- Local Health Board resolution endorsing the adoption of the ILHZ
- Provincial Governor's Executive Order establishing the ILHS and creation of the ILHZ
- Sangguniang Bayan resolutions endorsing mayors to sign MOAs adopting the ILHS as the health management and delivery structure for the Province
- ILHZ MOAs signed between the Governor and mayors of component municipalities
- Provincial Development Council resolution for adoption and full implementation of the ILHS
- Sangguniang Panlalawigan resolution for adoption and full implementation of the ILHS

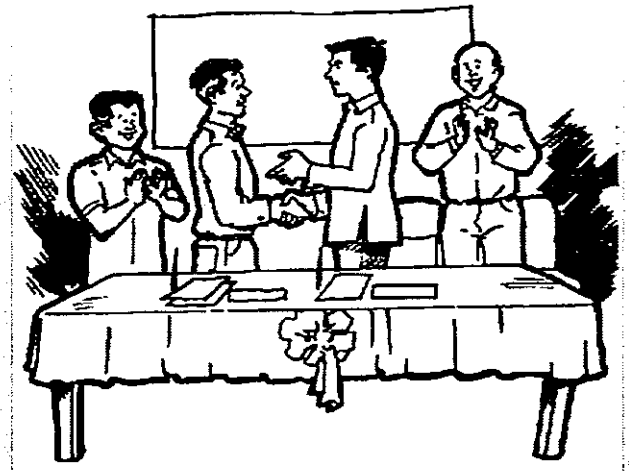
Additional legal and political mandates were provided in South Cotabato to ensure that the province has a lead role in facilitating the successful implementation of the ILHS. Establishment of province-level organizational support at the management and technical levels were granted by the following:

- Provincial Local Health Board resolution endorsing ILHZ board chairpersons and area coordinators for each ILHZ
- Provincial Governor's Administrative Order appointing ILHZ board chairpersons and area coordinators
- Official assignment of provincial health staff and provincial DOH representatives to individual ILHZs

Advocacy and Social Marketing

When the legal mandates are in place, it is time to advocate and orient Local Chief Executives and other government officials, health personnel and other stakeholders regarding the ILHS. Among the topics which need to be thoroughly discussed and understood are the following: basic concept of District Health System or Inter-Local Health System, the Local Government Code provisions on devolution and other issues on health, mechanism of partnership, possible areas of collaboration, political implications and financing options for sustainability.

The basic concept of the District Health System should be explained within the context of Health Sector Reform Agenda with



Social Marketing.
In **Pampanga** and **Bulacan,** CHD 3 carried out massive social marketing for the ILHZ formation. They developed Power Point presentations for local government executives and government managers to convince them on the importance of setting up and supporting ILHZs. These were greatly instrumental in winning over the governors and mayors, and supporting ILHZ development. These events were utilized to communicate advantages and disadvantages of setting up health districts as well as conveying that financial incentives were available to the local areas that were willing to initiate and operate ILHZs. **In South Cotabato,** sustained social marketing was valuable in the implementation phase. Tri-media, radio, local newspapers and other printed materials were used to disseminate information about the progress of the ILHS. They developed a weekly radio program where the Provincial Health Officer (PHO) discussed issues and addressed problems and criticisms of health care delivery.

focus on Local Health Systems Development (see Annex 1). This is an invitation for the LGUs to be advocates for health reform, by changing the way things are done in their respective LGUS under a devolved set-up.

A second round of more extensive and broader consultations would be necessary for advocacy to stakeholders. Discussions with health staff and IPHO staff may be conducted during meetings and even during fieldwork. There should be continuing dialogues with LGU officials and other officers involved. One-on-one discussions with managers and staff of private hospitals would strengthen networking.

Presentations at Local Health Board and Provincial Development Council meetings of the ILHS would further orient the officials involved. Active lobbying and engagement of Sangguniang Panlalawigan Committee on Health would enhance LGU cooperation.

Regular LGU meetings (Sanggunian, League of Mayors) may be used to disseminate information and lobby for endorsement of the proposed ILHZ. Social marketing of the ILHS would also include weekly radio programs on health to address continuing issues in ILHS implementation.

Concretizing Agreements

A Memorandum of Agreement is needed to be signed to concretize collaboration or cooperation. This agreement should articulate the functional relationship among the LGUs and other stakeholders their roles and responsibilities on the ILHZ. It would be a lot easier and faster to provide them with ***MOA templates*** (refer to Annex 9). Resolutions by the Sangguniang Bayan and Sangguniang Panlalawigan giving authority to the mayor and governor to enter into agreement are prerequisites before the final signing.

MOAs between the Mayors and the Governor include duties and responsibilities of the Provincial and Municipal LGUs and covered areas. These include:

- Establishment of the expanded Provincial Health Development Board and ILHZ Boards as the main health policy making bodies in the Province;
- Establishment of ILHZ monitoring and evaluation system;
- Formulation of cost-sharing mechanisms for the delivery of health services and exploration of local health financing schemes to improve delivery of health services;
- Exploration of networking and joint planning mechanisms for the development of human resources;
- Provision of essential packages of activity within component LGUs;
- Establishment of comprehensive health referral system; and
- Establishment of integrated health information, communication and transport systems.

In South Cotabato, the ILHZ was officially proposed during the Provincial Health Summit. This was done to ensure maximum exposure of ILHZ. There were 115 participants ranging form barangay to provincial officers, LCEs and Sanggunian representatives, health service providers from barangay to provincial levels, private medical sector and community-based NGOs, representatives from DOH at national and regional levels, and a number of provincial health officers from neighboring provinces. The Summit also provided a public forum for mayors and Governor to sign a ***Pledge of Support*** for the establishment and implementation of the ILHZ.

The legal and political pillars are now in place. We can thus proceed to organize the ILHZs.

CHAPTER 5

ORGANIZING THE INTER-LOCAL HEALTH ZONE

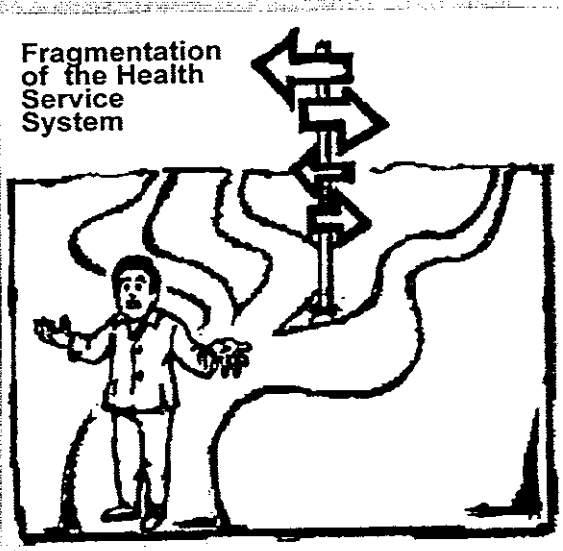
PREVIOUS PAGE BLANK

The daunting task of organizing the ILHZ would become a lot easier after we have grasped the background and development of ILHS in the Philippine setting.

The 1991 Local Government Code was passed effecting decentralization by devolution. That meant transfer of political and administrative powers to the local government at municipal and provincial levels. Under devolution, the municipal local government managed the public health units – the barangay health stations and the rural health centers, and in some areas, the municipal hospitals. On the other hand, the provincial local government took over the management of provincial and district hospitals.

The Organization of the Health System Before and After Devolution

The DOH found itself grappling with new roles in relation to local governments. Previous functions of planning, policy-making, program implementation, monitoring and evaluation could no longer be directly connected to the public health and hospital system. The process of devolution also unduly shifted the burden of responsibility for health to local government units. At that time, the LGUs did not yet have the technical capabilities and financial capacity to manage public health services and hospital operations. There was widespread confusion and demoralization among DOH personnel. They were mandatorily devolved or retained, but they encountered initial discrepancies in remuneration at the LGUs.

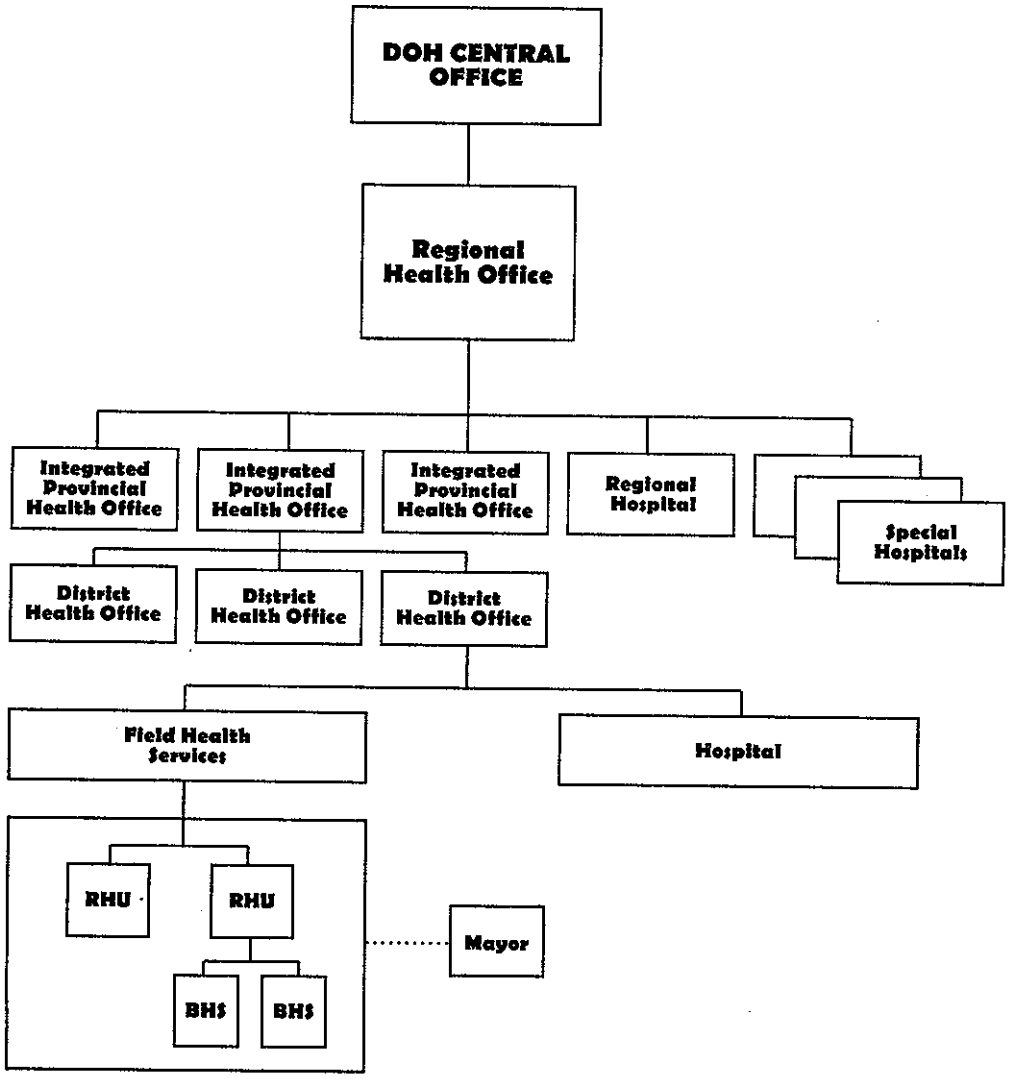


As a result, there was breakdown in referral system, health management information system, training and human resources development, and drug procurement system. The problem of fragmentation of the health service system was traced to the separate levels of political and administrative authority over health (see Figures 1 and 2 for the organization of health systems before and after devolution).

PREVIOUS PAGE BLANK

Figure 1

Organizational Structure of the Health System, Pre-Devolution



Providentially, the solution seemed to emanate from the Local Government Code itself! Section 33 of the LGC allowed inter-LGU cooperation through Memoranda of Agreement for mutually beneficial purposes and sharing of resources. Anchored on this provision, the DOH issued Executive Order 205 in January 2000, calling for the creation of the National Health Planning committee and the establishment of inter-local health zones throughout the country.

Armed with this proper perspective, we can now proceed to establish the ILHZ. The organizational stage requires the following output:

- The ILHZ Board
- The Technical Management Committee

Inter-LGU cooperation for mutually beneficial purposes and sharing of resources

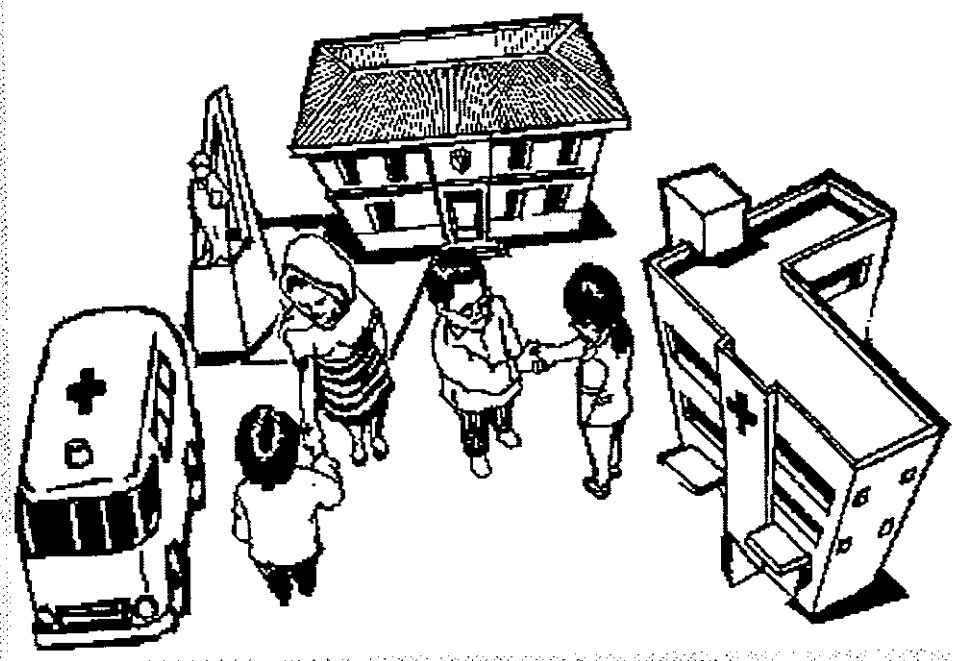
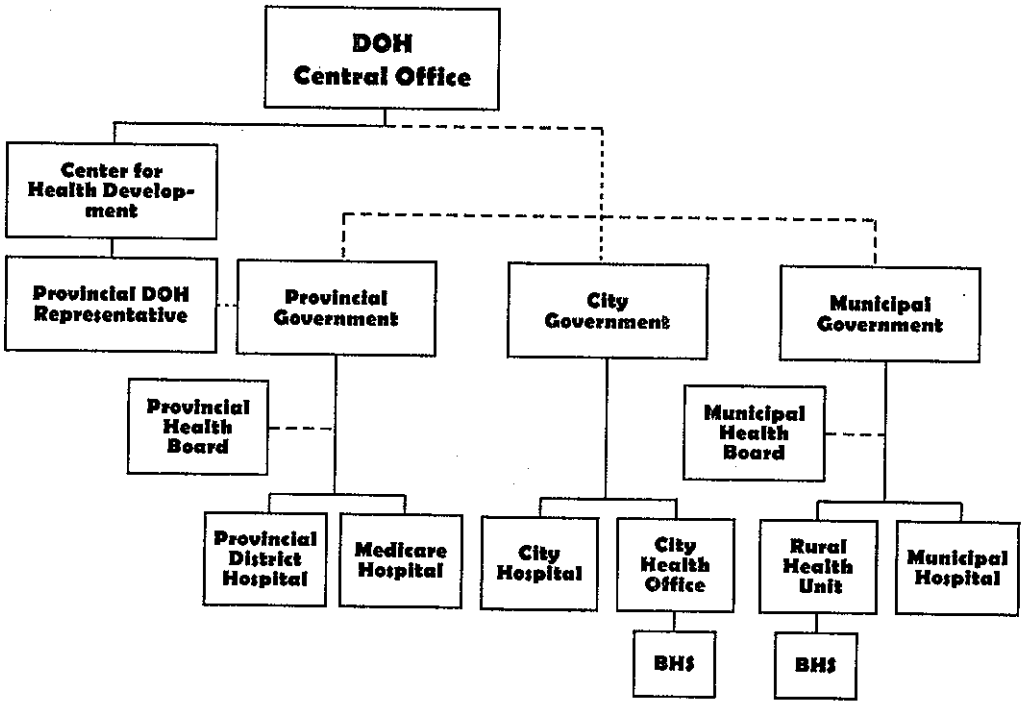
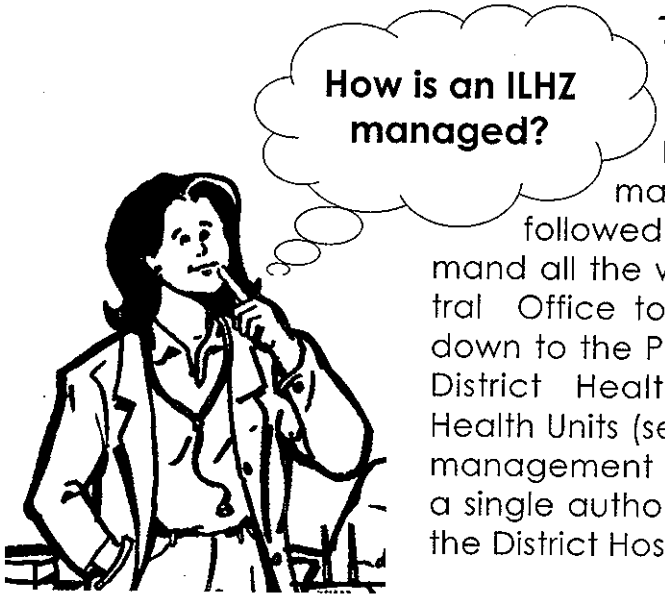


Figure 2. Organizational Structure of Health Services, Post-Devolution





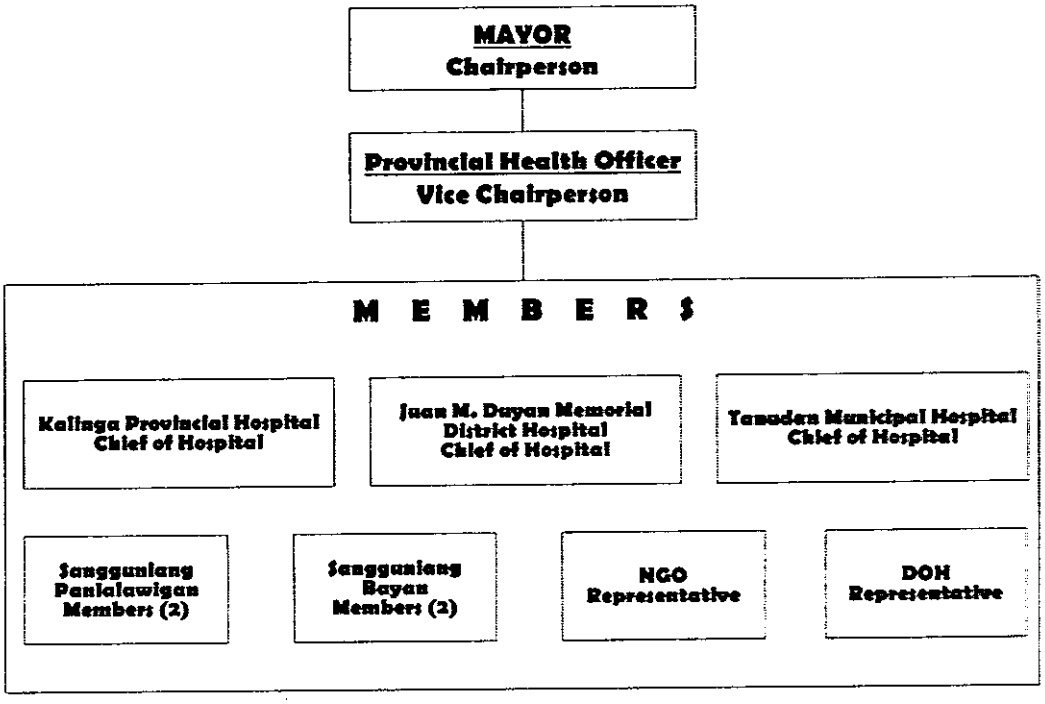
The Inter-Local Health Board

Before devolution, the management of the DHS followed a vertical flow of command all the way from the DOH Central Office to the regional offices, down to the Provincial Health Offices, District Health Offices and Rural Health Units (see Figures 1 and 2). The management of the DHO was under a single authority (that is, the Chief of the District Hospital).

Now; with the new ILHS set-up, one of the new important features of management is greater participation of the LGUs, the health sector, health insurance, NGOs and private sector and the community.

Establishing the ILHS would need a ***decentralized*** but ***unified*** management system. The first steps would be to organize an ILHZ policy board and a technical management committee to provide policy advice and technical assistance to the hospital and catchment RHUs. This ILHZ should be linked with existing health boards of the participating LGUs; that is, the provincial and municipal health boards. Establishment of ILHZ further facilitates linkages between the municipal and provincial decision-making bodies through the broad membership of ILHZ boards.

Figure 3. Lin'awa District Health Board Organizational Structure



Source: Provincial Health Office

Function of the ILHZ Board

The ILHZ Board is the policy and governing board that provides complementary policy advice to the health units of the area. Its main purpose is to facilitate inter-LGU cooperation and coordination.

While the provincial and the municipal health boards are the legally mandated health boards cited in the Local Government Code, the ILHZ Board is a voluntary, self-imposed structure of the cooperating LGUs. As such, the basic functions may not be necessarily the same as that of the provincial and municipal health boards. The functions, therefore, may vary based on the needs of the ILHZ, but the common ones are the following:

- To serve as technical and advisory committee to individual Sangguniang Bayan and health offices of component municipalities within ILHZ;
- To oversee and approve joint health planning and budgeting, inter-LGU sharing, and sharing of human resources;
- To advocate for municipal and provincial annual budgetary allocations;
- To determine additional funding requirements for health service management and delivery;
- To identify funding sources and advocate for funds;
- To oversee development and approval of ILHZ policies;
- To oversee monitoring and evaluation of public health and hospital services within the ILHZ; and
- To act as management board for the core referral hospital.

Functions of the South Cotabato LAHDZ Board:

These are the functions of the ILHZ in South Cotabato based on their needs and priorities:

- Oversee the development of an ILHZ integrated plan that shall contain among others the complementation of health services in both hospitals and RHUs targeting priority ILHZ concerns;
- Determine and approve the resource requirements for the operationalization of the plan and the necessary contributions from participating LGUs;
- Present the integrated plan to the provincial health board for concurrence and endorsement to the Sangguniang Panlalawigan and Sangguniang Bayan concerned for budget approval;
- Monitor the implementation of the integrated plan by the ILHZ management committee;
- Adoption of the NHI/community-based health insurance financing scheme;
- Adopt an effective drug management system (ex. bulk procurement);
- Adopt quality standards for health facilities and services;
- Formulate policies concerning referral system, manpower sharing, collective procurement system and health care financing;
- Advice on personnel requirements and recruitment;
- Identification and selection of members of the management committee; and
- Adoption of the National Health Insurance/community-based health insurance financing scheme.

Members of the ILHZ Board

Who heads the ILHZ or District Health Board? The Local Government Code under Section 102 mentions that the Municipal Mayor heads the Municipal Health Board, while the Provincial Governor heads the Provincial Health Board. Since the formation of the ILHZ is a contractual, consensual and voluntary partnership, the agreeing partners have absolute discretion regarding the management structure as well as membership of the board.

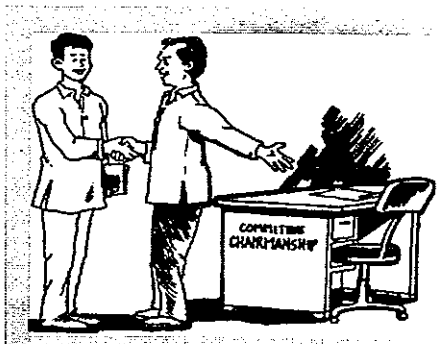
In the ILHZ case studies, most of the organizational set-ups have the provincial governor as head of the ILHZ board (see Figures 5, 6 and 7). One area agreed to have the Municipal Mayors rotate as the head (see Figure 4). Another area voted to have one Mayor as the head, since the status of their governor was still precarious at that time (see Figure 3). The composition of the ILHZ Board may again vary according to the area.

Members common to all the study areas are the following:

- Mayors of component municipalities
- Chief of core referral hospital
- Municipal health officers
- Representative from Sanggunian Panlalawigan
- Representative from NGOs active in health sector in each ILHZ
- Representative from DOH

Other members may be included:

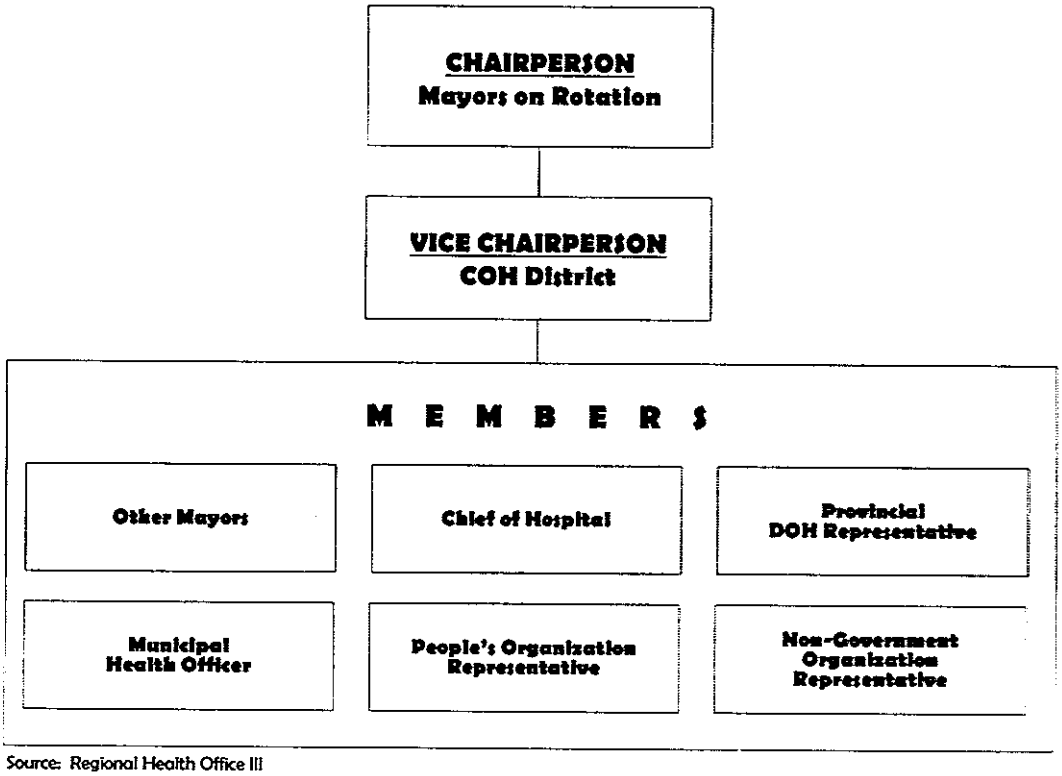
- Sanggunian Bayan member
- PHO representative
- Private medical sector
- Liga ng mga Barangay chairpersons
- Health insurance representative
- Representative from the patients



South Cotabato Political Dynamics and the Inter-Local Health Zone

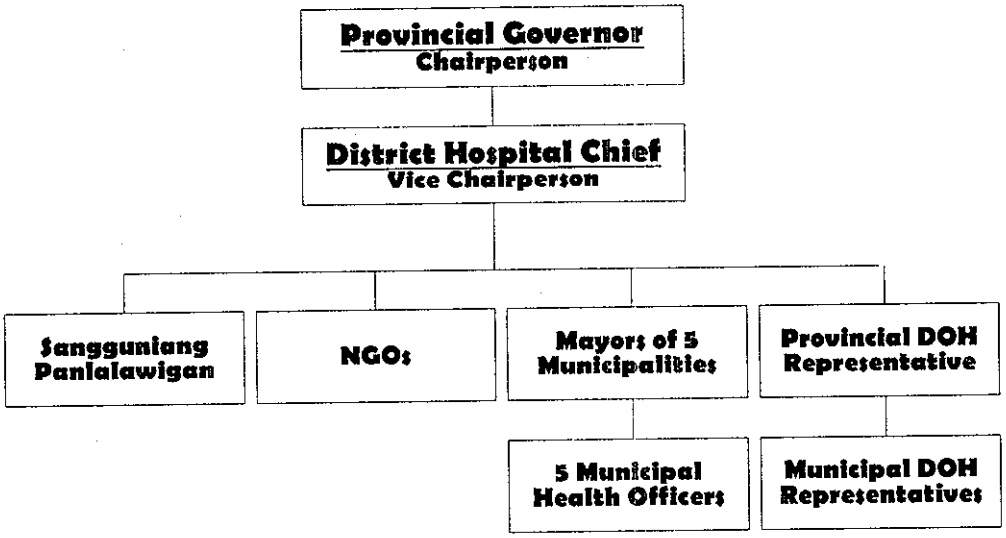
Membership in certain political parties do not mean the demise of certain programs sponsored by a previous administration. Gov. de Pedro's practice is to involve politicians from the opposition party by giving them committee chairmanships. The Chair of the ILHZ is usually someone from the opposition. Local legislation making is also a joint endeavor, and party lines do not affect legislative functions. *Governor de Pedro: "Here in South Cotabato, we forget the partisan issues in order to have continuity of the ILHZ. We have a policy here that whoever sits in power as governor would have to continue the program."*

Figure 4. Pampanga Unified ILHZ



Source: Regional Health Office III

Figure 5. Baliuag Unified Local Health System District Health Board, Organizational Strucrure



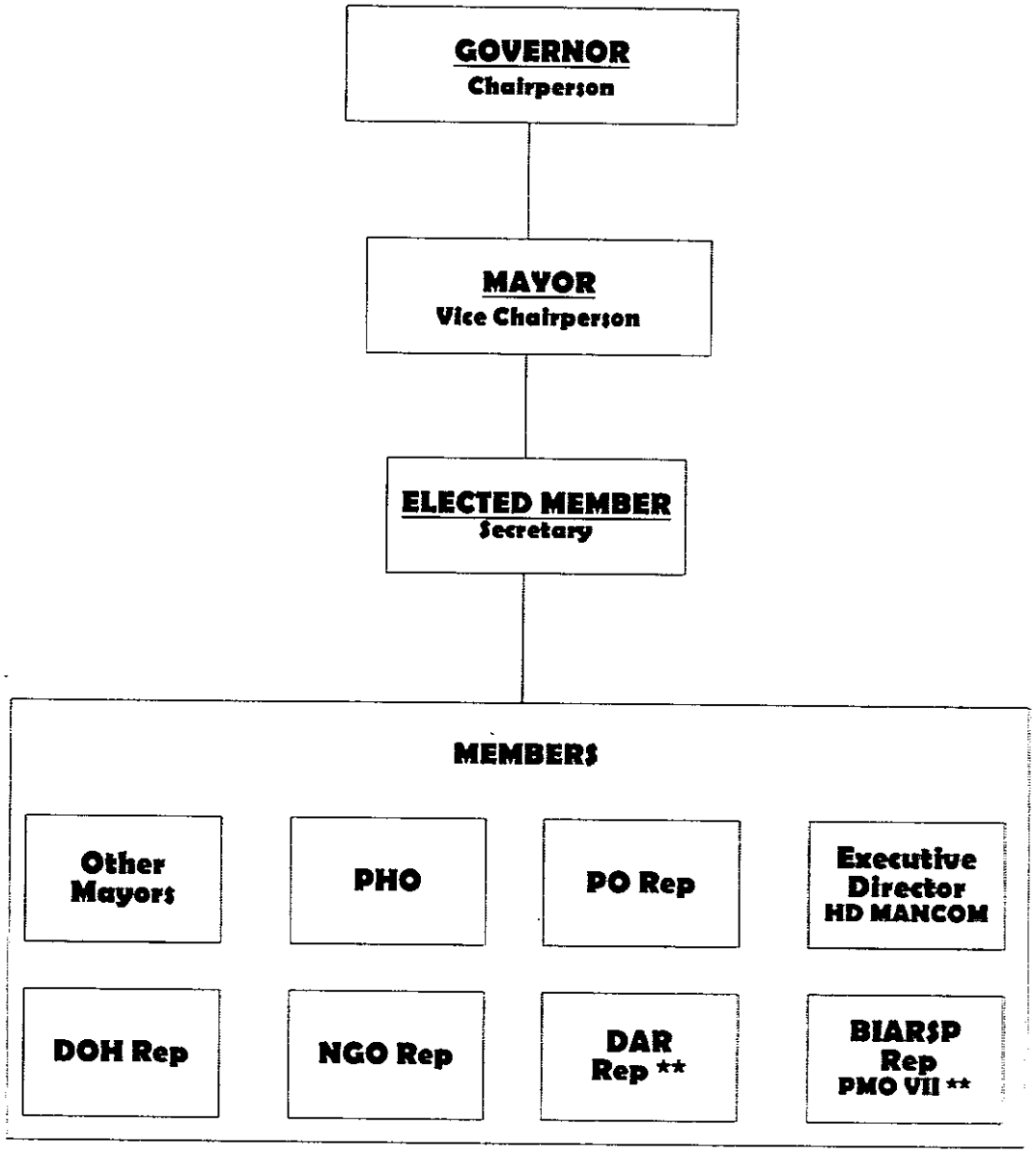
Source: Dr. Jason Galeon, DOH Representative

South Cotabato Provincial Technical Assistance Group (PTAG)

- Each ILHZ has assigned PTAG to provide technical assistance and act as link between component municipalities and the IPHO.
- Partnership between one provincial program coordinator and one provincially assigned DOH representative

The responsibilities of PTAG include undertaking technical supervision and monitoring of health service management and delivery; provision of assistance to develop and operationalize health policies of DOH, provincial and ILHZ; and participate in joint health planning, monitoring and evaluation activities.

Figure 6. CVGLJ District Health Board Organizational Structure



Source: Annual Report 2000,
Guihulngan District Hospital, Negros Oriental

** During Project Time

ILHZ Board and Provincial and Municipal Health Boards

In the present set-up, how do we link the ILHZ and the Provincial and Municipal Health Boards? The existing Provincial and Municipal Health Boards shall retain their functions as mandated by the Local Government Code. The Municipal Health Boards continue to meet regularly to discuss their internal affairs and support the action needed by the ILHZ.

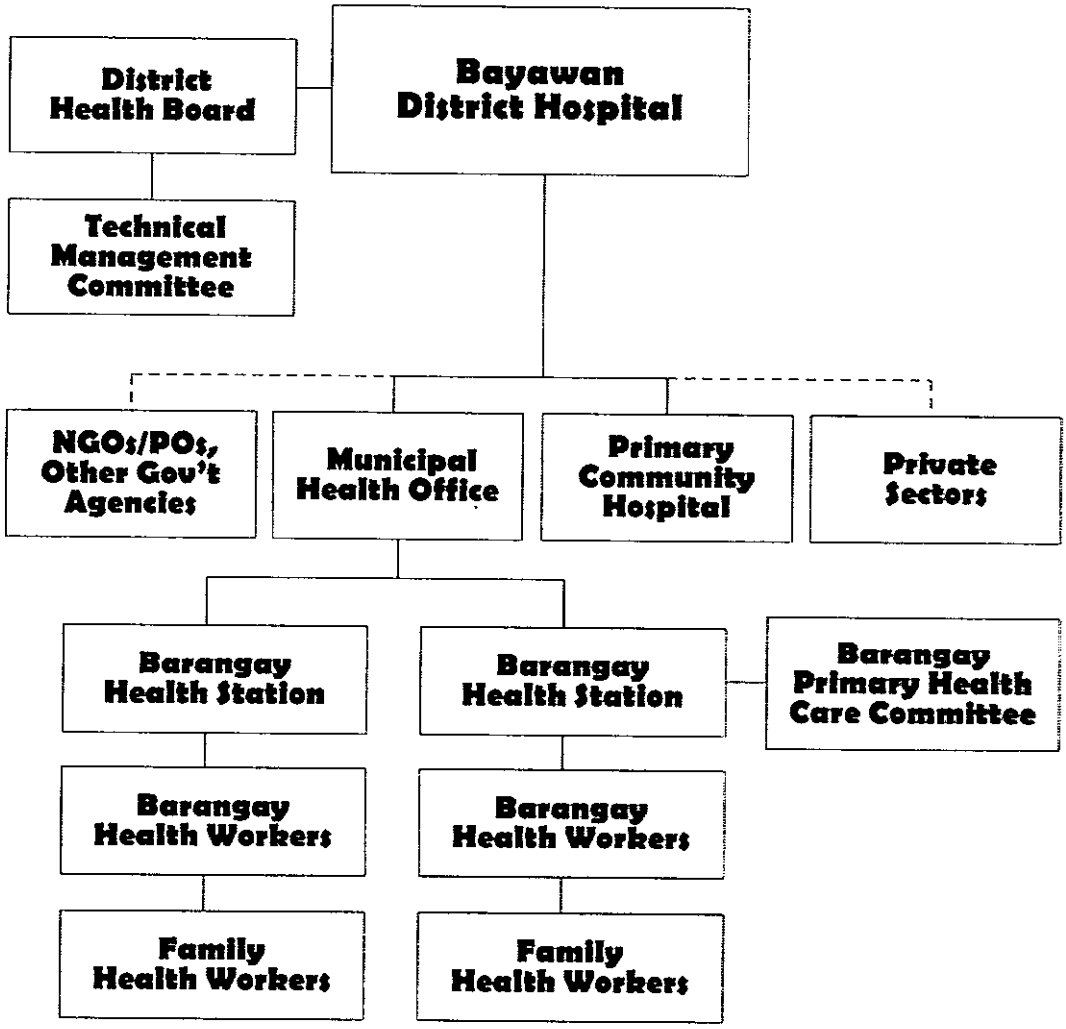
However, to ensure the connection to the different ILHZ Boards, the South Cotabato Provincial Health Board expanded its membership to include all the Chairpersons of Each LADHZ Board (see Figure 8).

ILHZ Coordinator

Each ILHZ has a designated coordinator, usually the chief of core referral hospital. Where there is no government core referral hospital, one MHO is designated. The responsibilities of the Coordinator are the following:

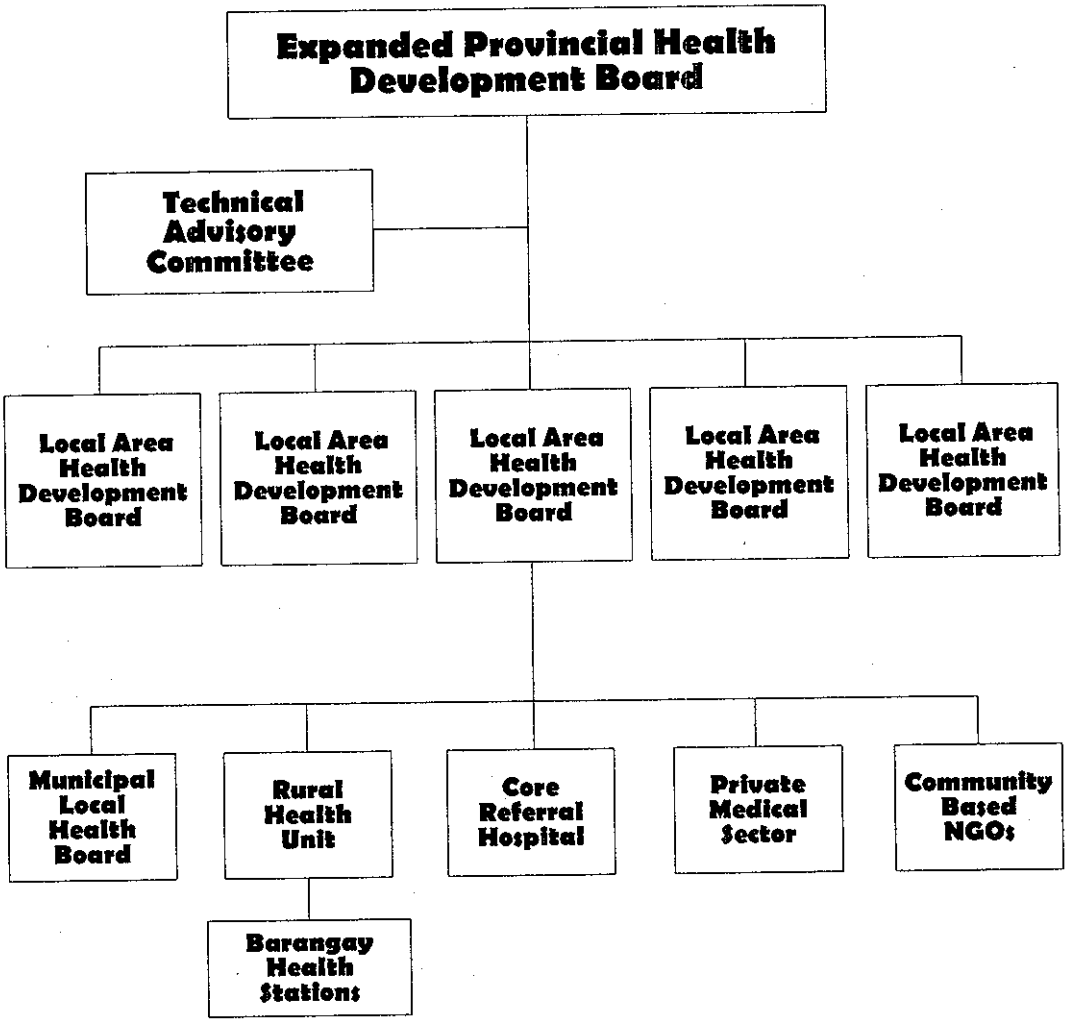
- Coordinate the development and institutionalization of the ILHS at the ILHZ level;
- Assist key municipal and NGO personnel to develop collaborative health management systems within the ILHZ;
- Coordinate the development and monitoring of implementation of ILHZ policies;
- Coordinate ILHZ planning, monitoring and evaluation activities and reporting;
- Advocate for ILHZ needs with component municipal Local Chief Executive (LCEs), Integrated Provincial Health Office (IPHO) and Center for Health Development (CHD); and
- Facilitate communication within the ILHZ and between the ILHZ, IPHO and CHD.

Figure 7. Santa Bayabas Inter-LGU Health System Organizational Structure



Source: District Health Hospital
Bayawan, Negros Oriental

Figure 8. Organizational Structure of Integrated Health System of South Cotabato



Source: The Best of Health 2000
Province of South Cotabato

The Technical Management Committee

The ILHZ Technical Management Committee is the technical arm of the policy board that will provide technical advice and recommendations to the board and catchment facilities (Please refer to Figures 9 and 10 for models of the Technical Management Committee). It manages the day-to-day operations of the health services and oversees the hospital and public health functions as well as the activities of the private sector, NGOs, and other government agencies.

The Technical Management Committee is composed of the technical staff from the RHU and hospital personnel. These are the following:

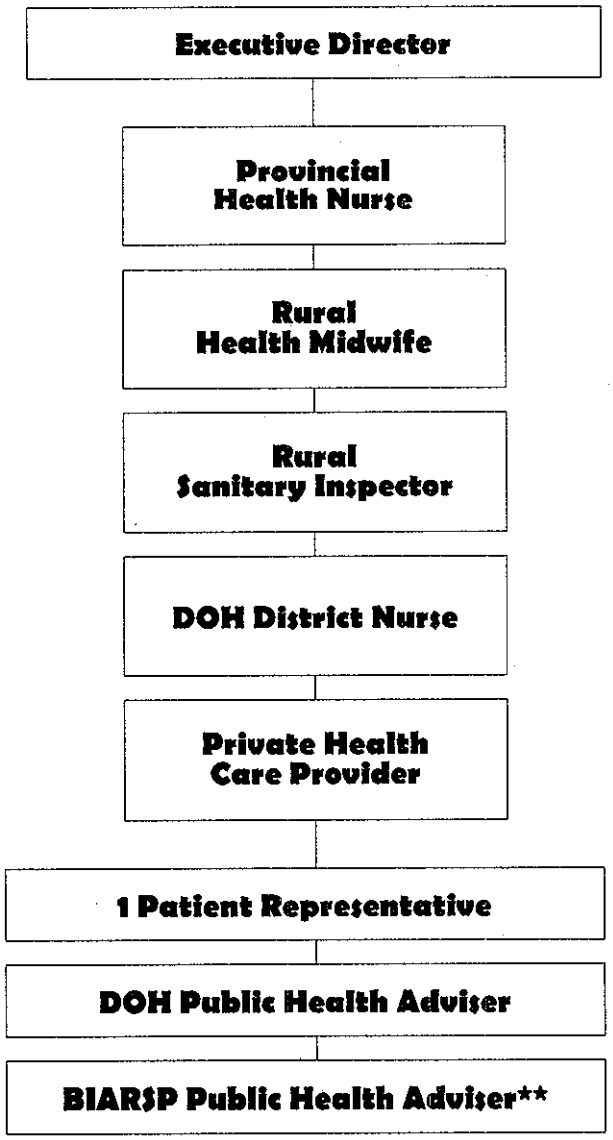
- Chief of hospital (of the core referral hospital)
- Municipal Health Officers of the participating LGUs
- Chief nurse
- Pharmacist
- Representative of each category of RHU personnel

Other members may include the representatives from DOH, IPHO NGO or patients. The Committee may be assisted by the administrative staff designated by the participating LGUs on a part-time or full-time basis.

The Coordinator of the Technical Management Committee is usually the chief of hospital of the core referral hospital, but s/he may also be chosen from the RHU or a primary hospital.

The membership, again, will vary depending on specific needs. There should be a balance between team size and effectiveness.

Figure 9. CVGLJ Health District Management Committee Organizational Structure



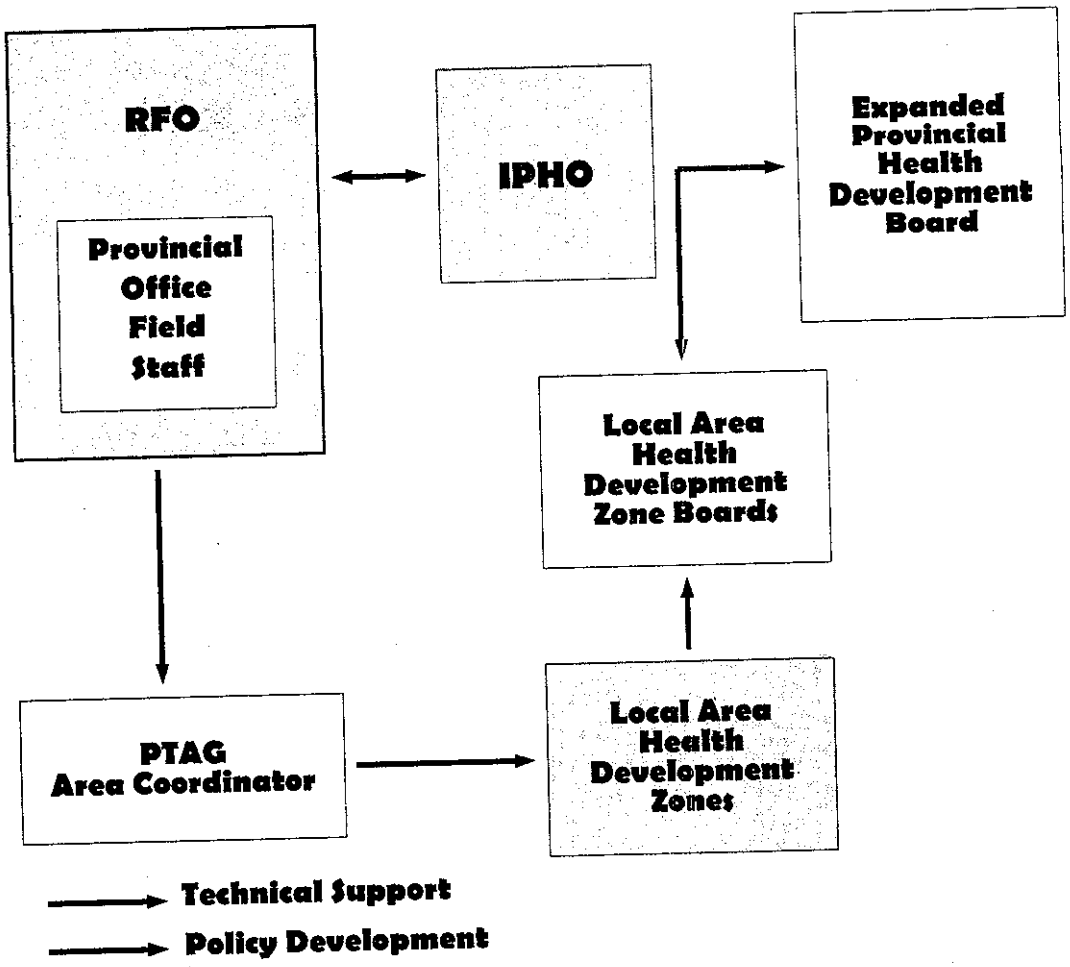
**During Project Time

Source: Annual Report 2000, Guihulngan District Hospital, Negros Oriental

The functions of the Technical Management Committee are to:

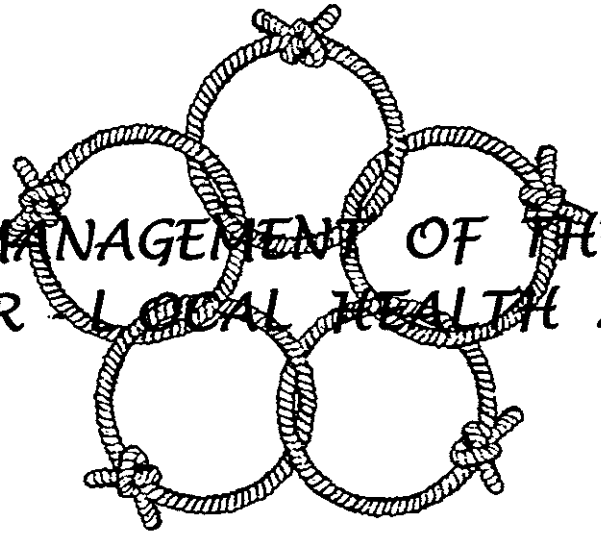
- Act as secretariat to the ILH Board;
- Establish health data based information system of the health zone;
- Initiate integrated planning;
- Develop ILHZ work and financial plan and identify priority areas for funding;
- Prepare the development of a heath zone health insurance scheme with preference to the low income population through the indigence component of PhilHealth;
- Set up a minimum package and a complementary package of health services for hospitals, RHU and BHS;
- Put up a disease surveillance sentinel site;
- Recommend to the Board policies and guidelines for referral system, manpower sharing, health care financing, collective procurement system, utilization of hospital income, and quality assurance standards;
- Initiate periodic assessment of health programs and hospital performance;
- Recommend appropriate health manpower training; and
- Manage the health zone trust fund.

Figure 10. Operational Framework to Support LAHDZ



Source: The Best of Health 2000
Province of South Cotabato

CHAPTER 6



MANAGEMENT OF THE INTER - LOCAL HEALTH ZONE

Integrated Health Planning System

The ***Integrated Health Planning System (IHPS)*** of the DOH was developed to facilitate the health planning activity of the LGUs. It is intended for the use of health workers and LGU planning staff at all levels (barangay, municipal, district and provincial). It encourages the actual participation of NGOS, POs and other concerned sectors involved in health services development. The IHPS is lodged at the Health Policy Development and Planning Bureau of the DOH.

The IHPS was designed to strengthen the partnership of the DOH and LGUs for devolution and the efficient implementation of the re-integration of health services. The IHPS also supports the establishment of the District Health System (DHS) or Inter-Local Health Zone (ILHZ) in the context of local autonomy and inter-local government cooperation.

The IHPS advocates for a three-year ***strategic planning*** at the district/ILHZ level, and likewise at the provincial level, especially in cases where districts have not yet been formed. It involves ***annual planning*** at three levels of health service (municipal, district/ILHZ, and provincial levels). It also offers an approach to health planning at the barangay level. Individual facilities, i.e., RHUs and hospitals, may also formulate their own strategic plans (see Table 1 and Figure 11).

The final output is an ***Integrated Annual Health Plan.*** The public health and hospital services are integrated into a district health planning process wherein the RHUs that comprise the health district/ILHZ jointly plan with the district hospital. The identified health district vision, mission and goals are adopted as a common basis for the individual annual plan for each hospital and RHU in the ILHZ. The integrated work and financial health plan would also be the basis for disbursing funds of the ILHZ budget either from regular funds, grants, common fund and other sources.

The Provincial Health Office reviews the plan and consolidates it with other plans of the ILHZ including those of the Provincial Hospital and the Provincial Health Office. This will now become the Integrated Provincial Health Plan. Copies of these will be submitted to the CHDs and most especially to the Provincial Planning and Development Office for its integration to the Provincial Development Plan of the province.

Table 1. Processes and Health Services Delivery Levels Involved in the Development of the Integrated Health Plans

Health Services Delivery Level	Process	Output
PHO	- Strategic Planning - Annual Planning - Integration	- Integrated Provincial Strategic Health Plan - Integrated Provincial Annual Health Plan
ILHZ	- Strategic Planning - Annual Planning - Integration	- Integrated ILHZ/ District Strategic Health Plan - Integrated ILHZ/ District Annual Health Plan
RHU/Hospital	- Strategic Planning (optional) - Annual Planning - Integration	- Municipal Strategic Health Plan (optional) - Integrated Municipal Annual Health Plan

The development and integration of health plans is essential in strengthening inter-LGU cooperation and collaboration in the ILHZs. As a built-in quality of the planning process, integration is manifested specifically in:

- Adoption of a unifying ***vision*** at the district, provincial or city level to achieve which services and facilities must contribute their share;

- Adoption of facility-level or service-level ***mission*** that translates into action the determinants of the vision;

- Consistency between the situation analysis of external and internal environment that affects the entire planning area (i. e., district/province/city);

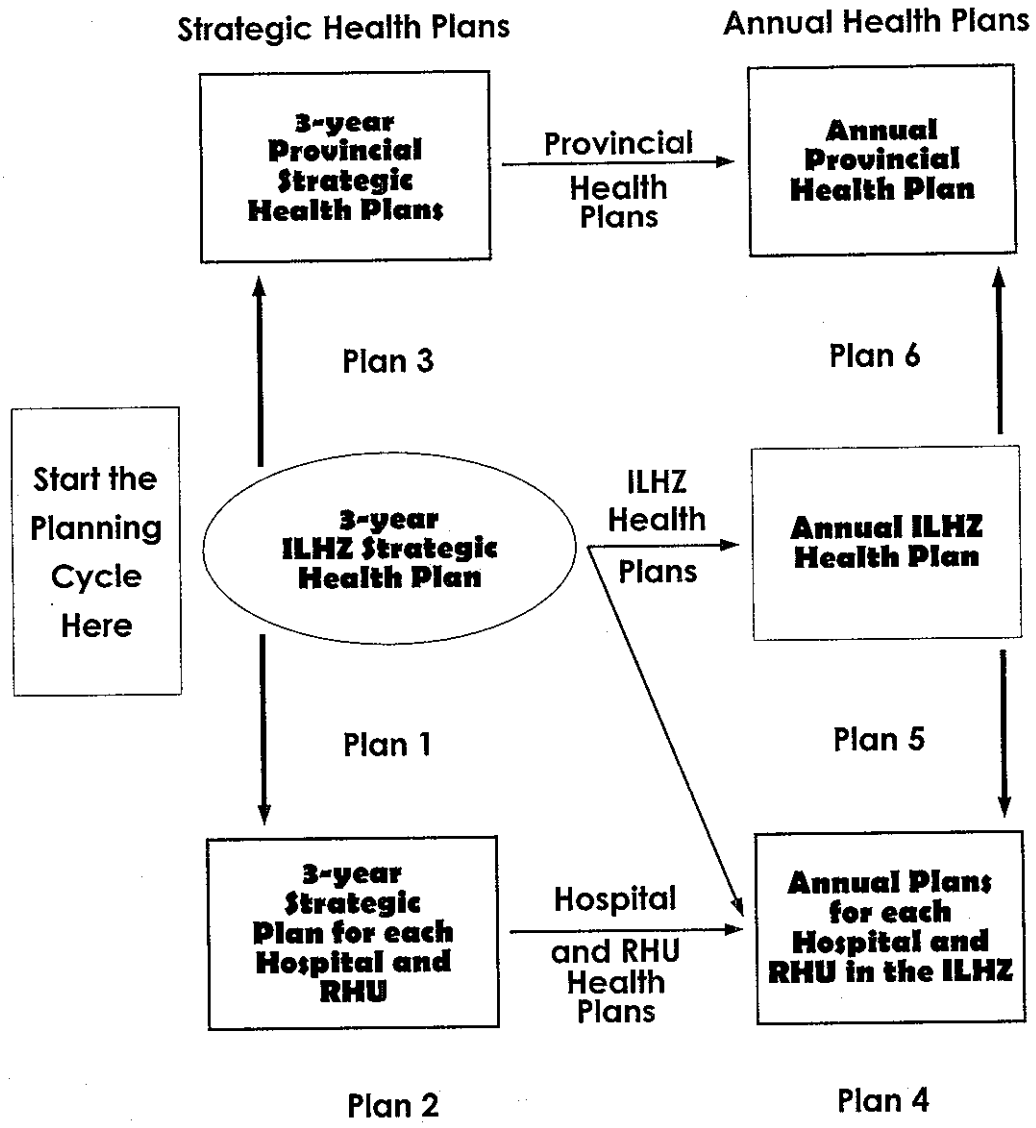
- Clear definition of roles of each level of service/facility, including other stakeholders, through discussion of organizational structure, relationships and coordination mechanisms particularly during the strategic planning workshop; and

- Consolidation of data/plans whenever possible at the next higher level.

The respective area managers usually initiate the strategic health planning, i.e., the Provincial Health Officer at the provincial level, or the District Chief of Hospital at the district level.

Participation of key stakeholders in health services delivery is very crucial at the planning stage. This is to generate co-ownership of the plan, and ultimately their commitment in carrying out its implementation. The key stakeholders will include representatives from the government health facilities, aw well as local chief executives and members of the local health boards, private sectors, non-government organizations (NGOs) and people's organizations (POs).

Figure 11. Development of the Strategic and Annual Health Plans



Vision and Mission of ILHZ. The drafting of the Lin-awa Zone Health Plan was the significant result of creating the health zone such that the three municipalities and the province can share their common vision, mission and objectives. These were formulated in a planning workshop shortly after the ILHZ was constituted.

Vision: to become a self-reliant, healthy and productive people in the Lin-awa Zone having access to Quality and affordable health services provided by competent health workers, fully supported by a strong inter-LGU partnership and in collaboration with other GOs, NGOs POs and the community.

Mission: to provide quality health care services to people in the Lin-awa Zone in a culture of caring, teamwork and professionalism.

Improvement of Facilities

In implementing the plan for the ILHZ, the initial consideration should be the improvement of facilities.

Health facilities must be upgraded to meet quality standards of DOH and accreditation requirements of PhilHealth to ensure access of health services by the poor both in the hospital and RHUs.

Buildings like clinics, hospitals and district offices are necessary to provide health care, but are very expensive to construct and maintain. Clear capital work plans should document all the health service buildings in the district, the physical state of each, the im-

mediate, medium- and long-term needs for renovating existing buildings or building new ones, and the budget allocation for immediate and medium-term building activities.

Each health facility should have an inventory of essential ***equipment*** for primary health care. Each ILHZ should have a capital equipment plan, which details acquisition and replacement of capital equipment such as x-ray machines, etc.

Vehicles are crucial to the ILHZ. Vans, ambulances, and even motorized bancas for the coastal barangays, are essential in community outreach, as well as referral. Acquisition and maintenance are very important; therefore the ILHZ should have clear transport policies and a transport management system. The transport policy should state what vehicles are to be used for, who should drive them, what records and logbooks should be kept, and procedures for repairs and maintenance. The transport management system should ensure that vehicles are only used for their intended purpose, serviced regularly, repaired promptly, and use acceptable amounts of fuel and oil.

Communication facilities enable better sharing of ideas, knowledge, feelings and thoughts with each other, and better interaction with the communities served. Proper and efficient communication includes the use of the telephone, radiophone and fax machine. If setting up this communication infrastructure is quite frustrating for rural areas, the ILHZ level may help alleviate this situation.

Health Referral System and Minimum Packages of Services

Health referral is a set of activities undertaken by a health care provider or facility in response to an inability to provide the necessary intervention to a patient's need, whether it is real or perceived need. Referral involves not only direct patient care but support services as well (e.g. transport to move patient from one facility to another).

The ILHZ provides the strategic framework for the development of a functional two-way referral system. Individual ILHZs are the basis for developing a referral system at the local level. An agreed referral system is required between the individual ILHZs and the provincial tertiary referral hospital, and this in turn becomes the basis for defining a province-wide health referral system. The health referral system is a ***key integrating factor*** for the ILHS.

What are the major effects of deficiencies in the health referral system?

- There is wastage of scarce health resources through duplication of services and under-utilization of primary and secondary government hospital services. This results in decreased efficiency.
- There is an increase in preventable morbidity and mortality due to lack of appropriate services, delayed referral, and poor referral communications. This results in decreased effectiveness.

A well functioning comprehensive two-way health referral system requires the following features:

- Defined levels of care and a mix of services for each level of care (packages)

- Agreed roles and responsibilities of key stakeholders
- Agreed standard case management protocols (treatment protocols and guidelines – for doctors)

In Kalinga, the referral system does not follow the regular chain due to proximity, availability of transportation, and quality of health services. The Tabuk based provincial hospital and RHUs are accessible to those in nearby areas since transportation and road networks are available. Time to reach these facilities is between 30 minutes to one hour, or even shorter in the case of BHS. But due to lack of road networks in other municipalities, travel would take a day or two, and even hiking at some parts of the route on dirt road until the point where transportation is available. For easier and more accessible referrals, Tinglayan municipality deemed it necessary and convenient to join the nearby municipalities of Mountain Province, with Bontoc General Hospital as core referral hospital.

The framework of a two-way health referral system should include a defined package of services provided at different levels of care. It should encourage an environment in which the core referral hospital is viewed as a community resource. It should be responsive to local situations, while being part of overall province-wide referral system. If possible, it should be inclusive of the private medical sector and NGOS involved in the provision of community-based health care. Needless to say, it should include a properly functioning communication and transport system (telephone, radiophone, ambulance, etc.)

For the referral system to function, the lower levels, especially the health centers, should be manned by competent personnel whose roles and functions are clearly defined. This is to avoid duplication, and also to ensure that the range of services that need to be delivered are in fact delivered. Otherwise, self-referral based on perceived inadequacy in the lower levels will perpetuate the vicious cycle of self-referral to hospitals which are already over-burdened and under-staffed.

It is important for health centers to refer only those patients for whom secondary or tertiary care is essential. In general, referral from a health center to higher levels should occur in the following situations:

- When a patient needs expert advice;
- .When a patient needs a technical examination that is not available at the health centers'
- When a patient requires a technical intervention that is beyond the capabilities of the health center; and
- When a patient requires in-patient care.

Figure 12 shows the general flow of referral of patients, while Figure 13 illustrates a more detailed referral flow chart used in the Kalinga ILHZ.

Figure 12. Flow of Referral of Patients

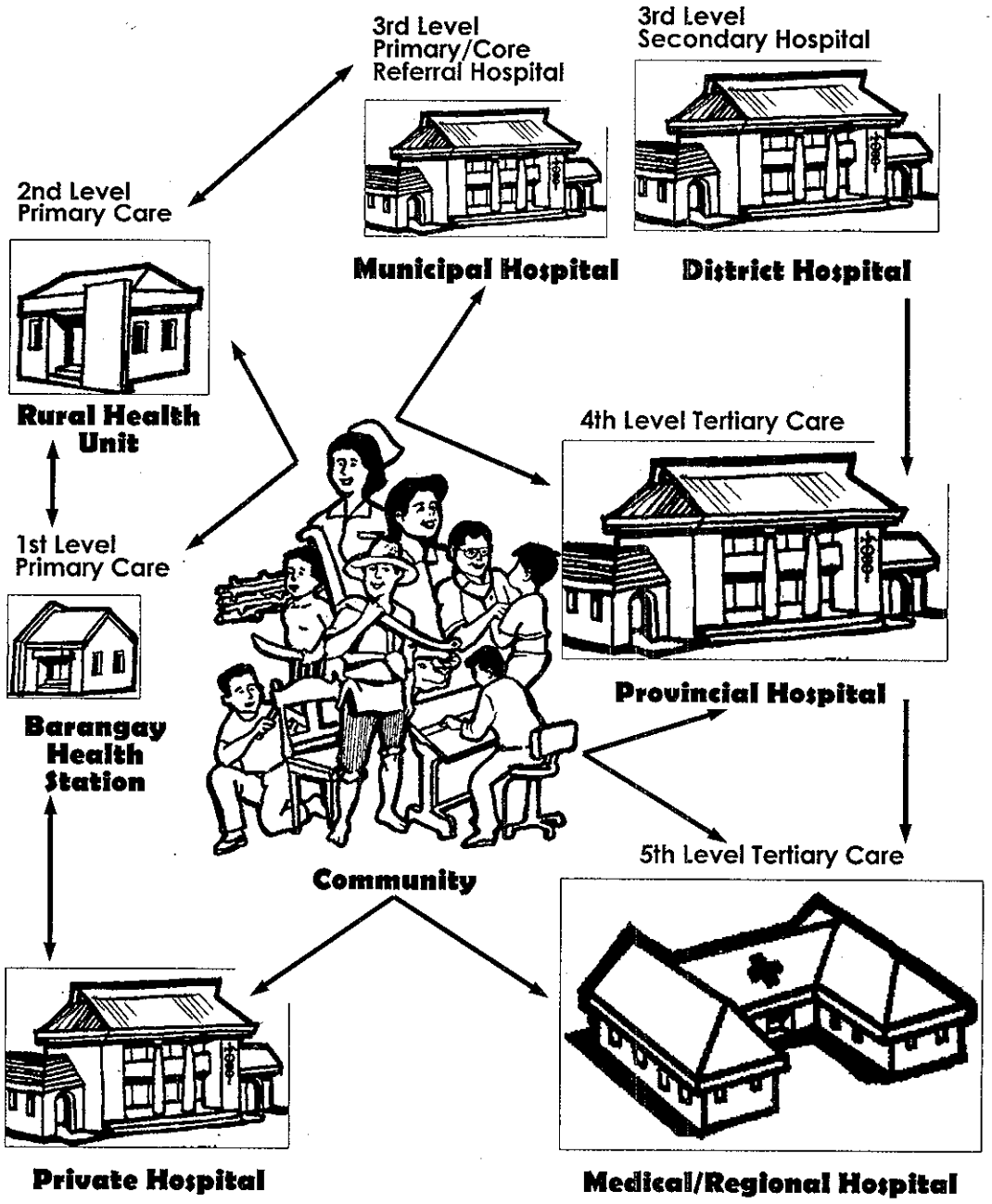
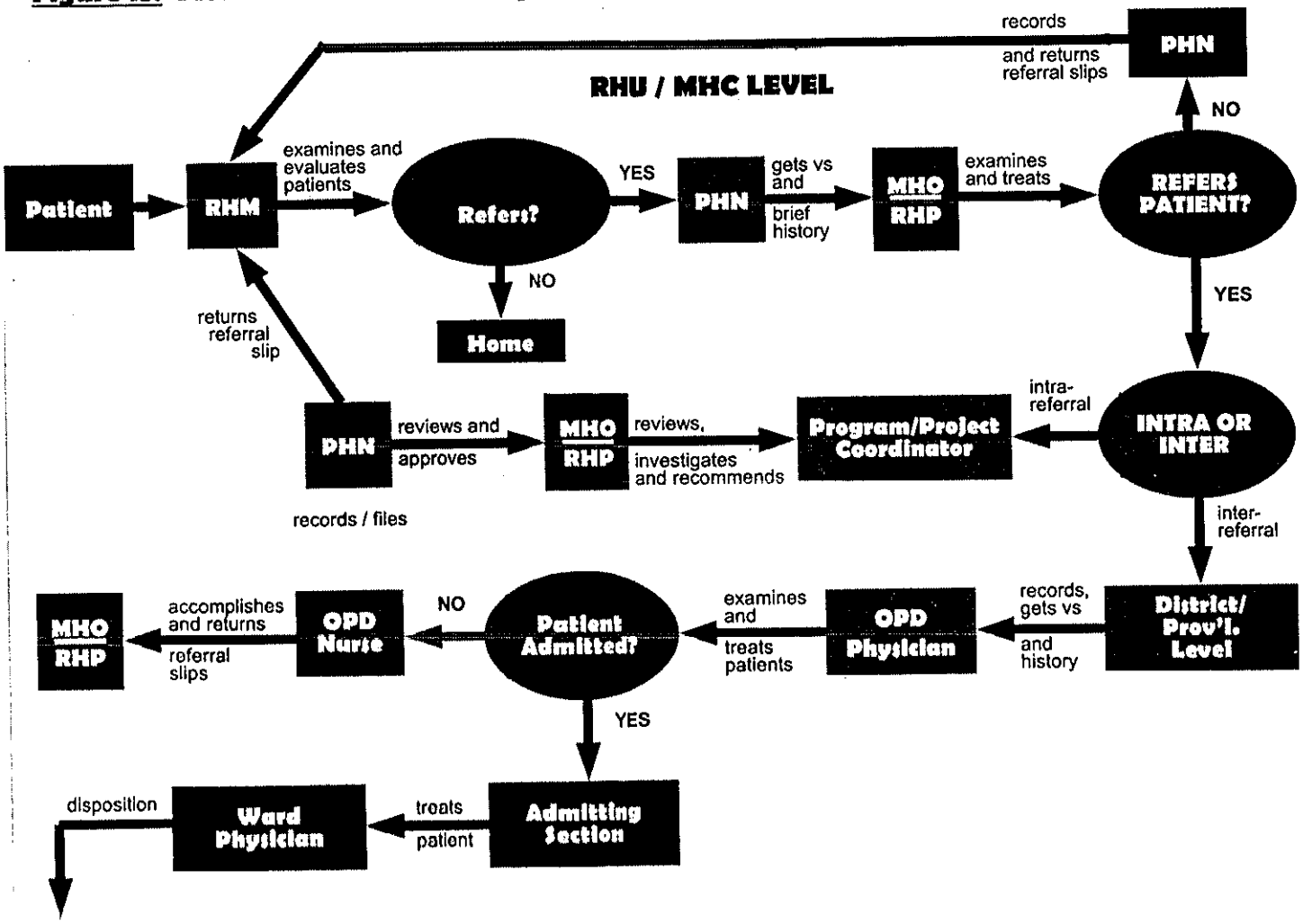
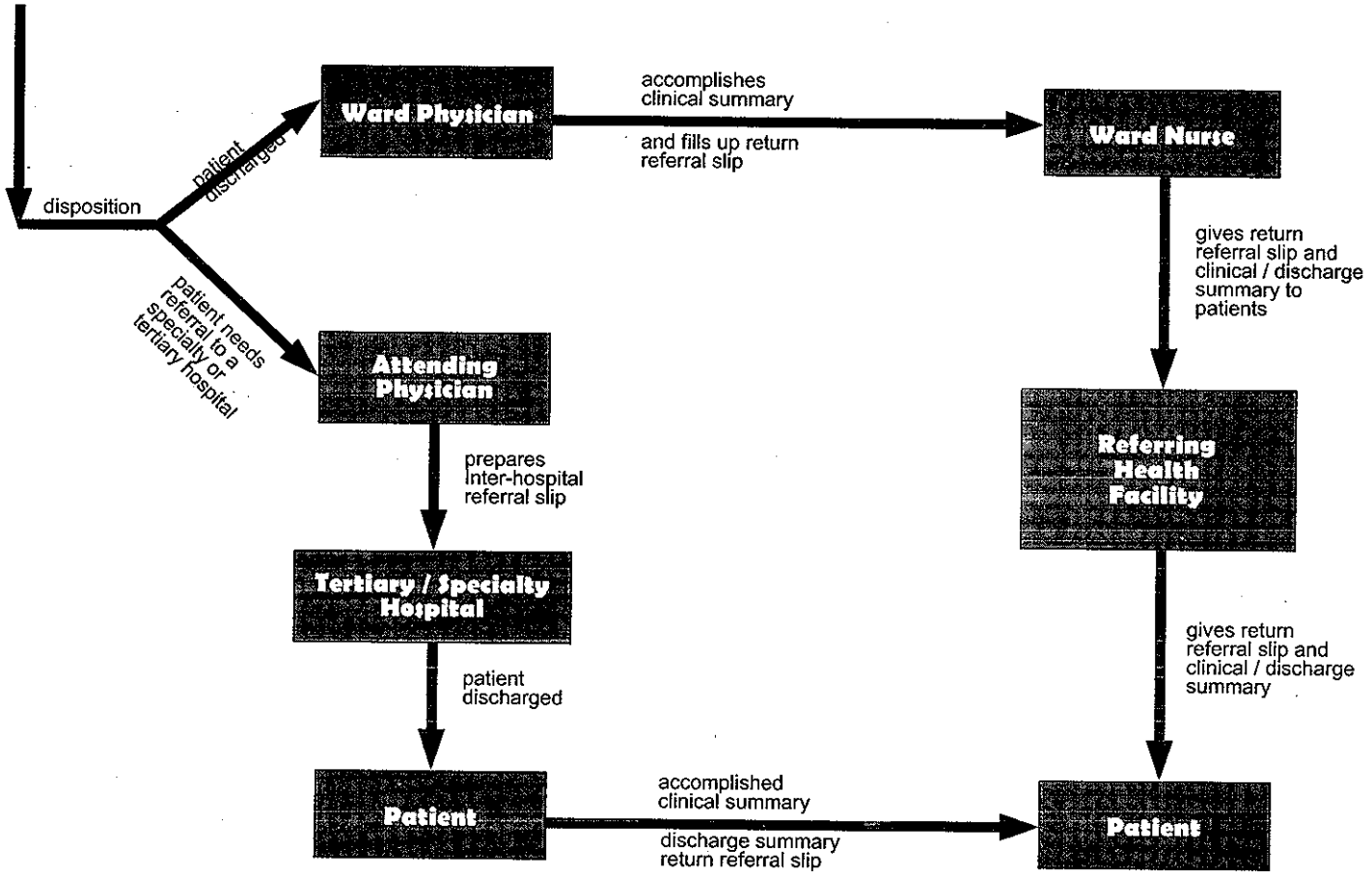


Figure 13: Flow Chart for Referral System in Kalinga ILHZ



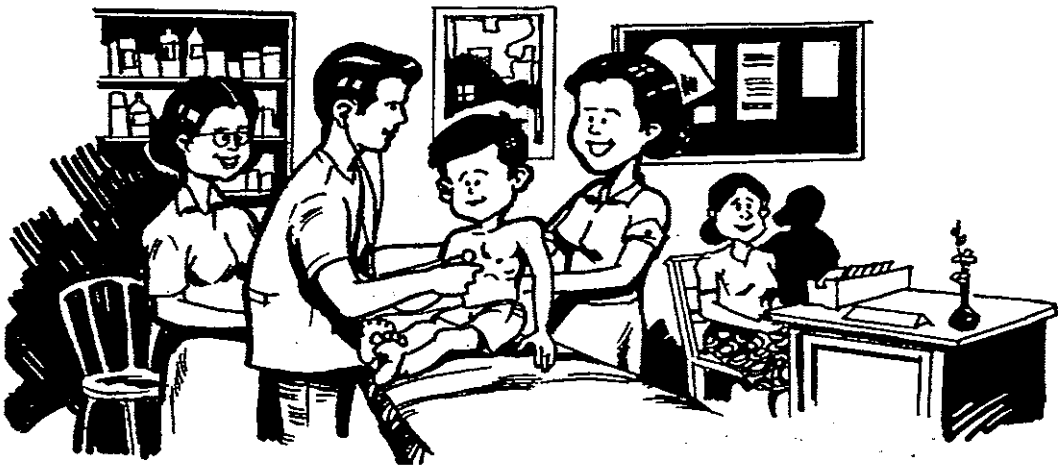

disposition
patient discharged
patient needs referral to a specialty or tertiary hospital
Ward Physician
accomplishes clinical summary
and fills up return referral slip
Ward Nurse
gives return referral slip and clinical / discharge summary to patients
Referring Health Facility
gives return referral slip and clinical / discharge summary
Attending Physician
prepares Inter-hospital referral slip
Tertiary / Specialty Hospital
patient discharged
Patient
accomplished clinical summary
discharge summary return referral slip
Patient

Minimum Packages of Services

The rationale for defining essential packages of health care services for the ILHZ is to ensure that the limited health resources are targeted towards provision of essential health activities. This results in improved health status of the community and the cost-efficient use of health care resources. Another reason for setting minimum and complementary packages of services at all levels is to ensure appropriate services are provided at different levels of the referral facilities.

Each ILHZ should conduct a review of the organization and composition of health services available in their catchment area. Public health facilities, namely the Barangay Health Stations, Rural Health Units and hospitals manage a mix of communicable and non-communicable diseases. They render symptomatic and definitive treatment, as well as preventive and promotive services.

At the main RHU centers, simple laboratory examinations such as urinalysis and fecalysis are performed. The district hospitals provide pharmacy, laboratory and x-ray services aside from in-patient and outpatient services. These services are usually categorized into general medicine, pediatrics, surgery, and obstetrics and gynecology that secondary and tertiary hospitals provide. Most core refer-



ral hospitals are licensed either as primary or secondary level hospitals. Some core referral hospitals are also the provincial hospitals.

The aim of defining an appropriate mix of services for different levels of care is to avoid duplication. The practical way to minimize the degree of duplication is to strengthen the capacity of the immediate lower level of care to provide the expected services. This will then allow for the more specialized services at each higher level to be the main focus of their activity.

Ultimately, though, a degree of duplication will always be present. People exercise their right to choose, within reason, to whom they will go for health care.

Packages of essential services have been developed in South Cotabato. These are:

- A ***Minimum Package of Activity (MPA)*** for primary health care services;
- A ***Complementary Package of Activity (CPA)*** for core referral hospitals; and
- A ***Tertiary Package of Activity (TPA)*** for the provincial government referral hospital.

The ***Minimum Package of Activity for Primary Health Care Services*** focuses on ***health promotive and preventive*** activities while ensuring that a basic level of curative service is available. Services are variously provided in the home, BHS, RHUs and, to some extent, private medical clinics. The package at the municipal level is broader than at the barangay level. This includes environmental sanitation, basic laboratory services, curative services provided by medical officers, and health service management.

Minimum Package of Activity for Primary Health Care Services

- Pre natal care
- Normal delivery and post partum care
- Immunization
- Family planning
- Nutrition (Vitamin A and Iron supplementation)
- Growth monitoring
- Control of communicable diseases (e.g. ARI, TB, DD, STD, malaria)
- Control of non-communicable diseases (e.g. related to diet, alcohol, tobacco)
- Minor surgery (e.g. suturing, drainage of abscess, circumcision)
- Dental health
- Appropriate referral to referral hospitals or specialist physicians
- Environmental health services
- Basic laboratory services
- Health promotion and education
- Management of public health services, coordination with NGOs and the private medical sector, participation in ILHZ management
- Training of human resources
- Supervision of health services and human resources within the municipal catchment area

The ILHZ may contain several private and government hospitals (community hospital, district hospital) but one ***core referral hospital*** is designated for each area. The core referral hospital services complement activities provided at the primary level. This package focuses primarily on a higher degree of curative services that cannot be managed at the primary level. These services are provided on an ***emergency basis*** or upon ***referral from a primary level*** of care (BHS, RHU or community hospital).

Complementary Package of Activity for Core Referral Hospitals

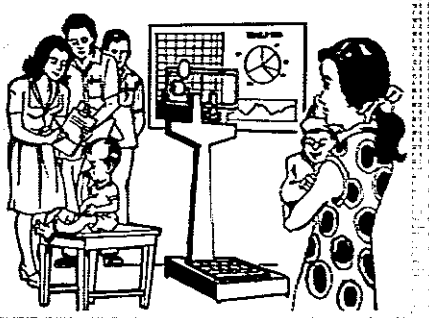
- Outpatient consultations for patients referred from the primary level
- Inpatient medical and surgical care
- Emergency room care
- Minor surgery (excision, placental extraction, suturing, D and C)
- Anesthesia
- Major emergency surgery (caesarian section, trauma surgery, appendectomy)
- Complicated deliveries
- Basic orthopedics (e.g. setting of simple fractures)
- Nutrition services
- Referral of more urgent cases to a higher level of care
- X-ray
- Laboratory services
- Blood transfusion
- Pharmacy services
- Management of hospital services and participation in ILHZ management
- Public health promotion and education
- Coordination with public health services, NGO and the private medical sector
- Transport and communication linkages with other levels of care

Tertiary Package of Activity for Provincial Government Referral Hospitals. This package provides additional services such as medical specialist, surgical and allied health services, more complex diagnostic services, and blood banking. More complex hospital care is given for cases that cannot be managed at the core hospitals. Health services at specialist levels are provided for those referred from RHUs.

Tertiary Package of Activity for Provincial Government Referral Hospital

- Pediatric, surgical, medical, orthopedic, obstetric and gynecology depar ments
- Expanded surgical capability (e.g. craniotomy, orthopedics, burns)
- Intensive care, neonatal intensive care, coronary care
- Ophthalmology
- Rehabilitative medicine (physiotherapy, occupational therapy)
- A full range of dental services
- Advanced diagnostics (e.g. x-ray, ultrasound, laboratory)
- Public health laboratory (e.g. malaria, schistosomiasis, water analysis, referral laboratory for RHUs and core referral hospitals)
- Blood bank and transfusion services
- Medical social services, veterans, and senior citizens medical services
- Pharmacy services
- Dietary and nutrition services
- Wellness Center Program
- Hospital administration and management services
- Emergency transport
- In-house engineering and maintenance

South Cotabato Health Referral System Manual. The province of South Cotabato has developed and published its own comprehensive Health Referral System Manual. This discusses the operational framework of the referral system, and defines all levels of health facilities. The implementation of the referral system in each of their LADHZ is well described and illustrated. There are samples of Referral Forms, Logbook Entries, and indicators for monitoring and evaluation. Packages of services are discussed per level of care. Policies, guidelines and procedures for proper referral are delineated. A very comprehensive section is that of Management/Treatment Protocol. This includes emergency cases, emergency drugs, infection control measures, and treatment protocol for cases of tetanus, malaria, dengue, animal bites and diarrhea.

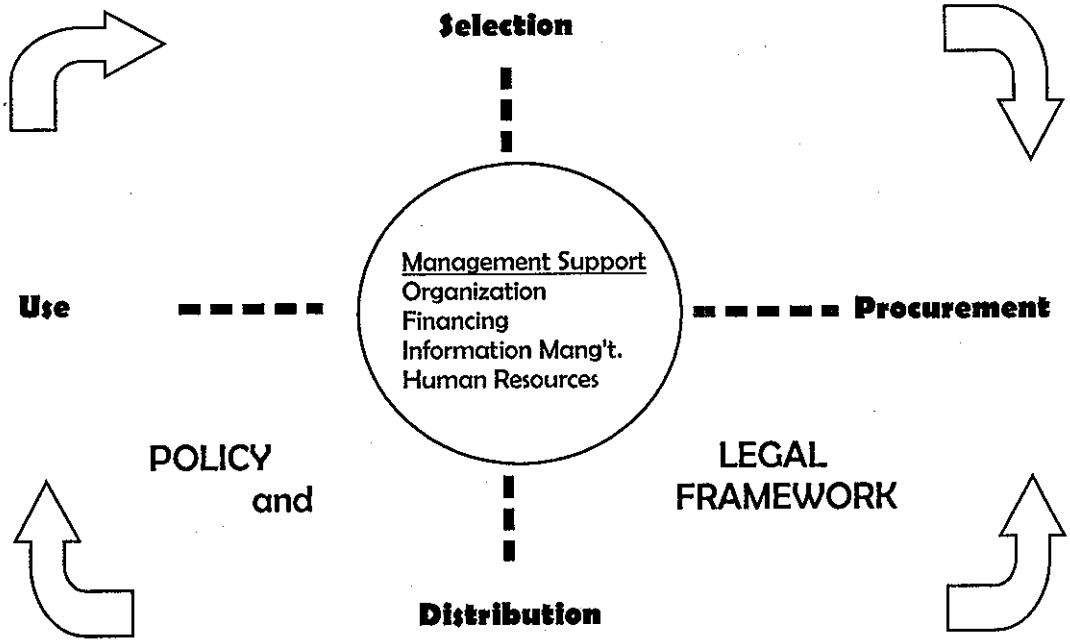


Drug Procurement and Management System

There were many changes in drug procurement and management attributed to the devolution of health services to the LGUs. The hospitals and RHUs had no standard list of essential drugs to procure. There were a lot of costly emergency purchases of drugs due to lack of planning. Branded names were preferred to generic drugs. All these were due, not only to lack of technical capability on the part of the LGUs, but also to bureaucracy and corruption.

The drug management cycle consists of: selection, procurement, distribution and use (see Figure 14). The cycle functions if there is effective management support, and if a policy and legal framework is provided as well.

Figure 14. Drug Management Cycle



The following are issues and concerns in drug management:

- What drugs are to be used? These may be from the **Philippine National Drug Formulary (PNDF)**, a Hospital/District and Provincial Formulary, and/or the Standard Treatment Guidelines.
- Are the drugs available? Do the RHUs and hospitals have a sufficient volume? Are these high quality but low priced and therefore affordable? How is the procurement system?
- How can these drugs be procured effectively and efficiently? The selected drugs should be procured in the right quantities, at the lowest possible prices, within acceptable limits of quality at the right time, from properly accredited suppliers, and in the most efficient measures.
- Are these drugs used rationally or appropriately in the hospitals by prescribers, dispensers, and patients?
- How can these procured drugs be delivered in the right quantities, to the right places, at the right time?

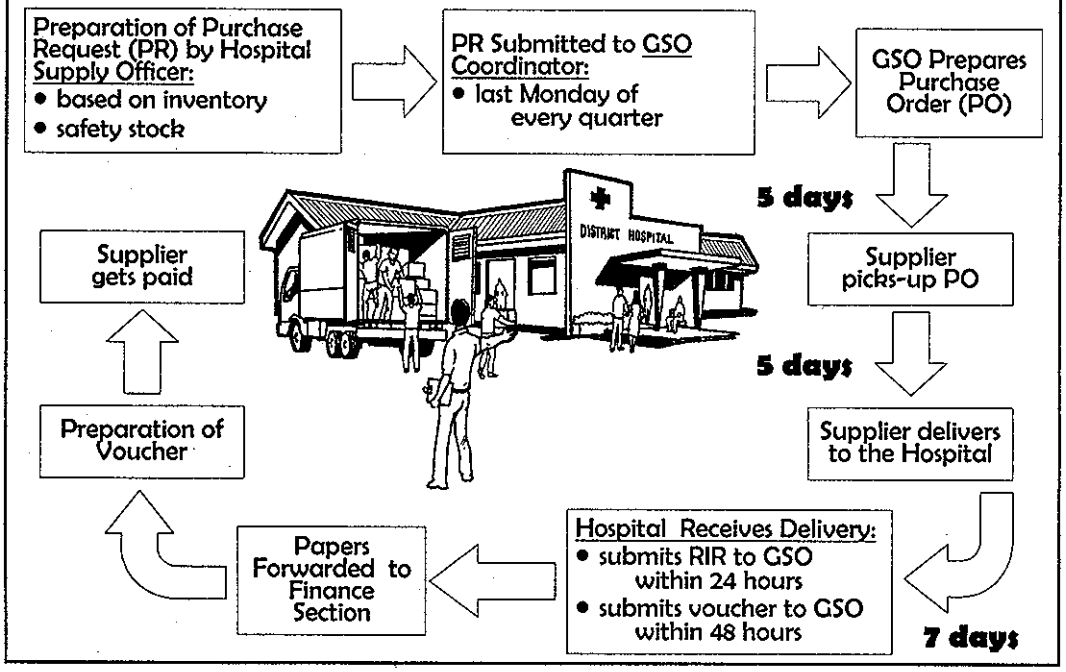
Measures are undertaken by the Bureau of Food and Drugs regarding the safety and efficacy of these drugs.

Models of Drug Management Reforms

- Provincial Formulary in Pangasinan
  - Provincial and all district hospitals only procure drugs found in the **provincial formulary**
- Pooled procurement in Pangasinan
  - **50% reduction** in drug prices
- Parallel drug importation in Capiz
  - About P1 M worth of imported drugs at an average price that is **47% less** than the usual local prices

Several LGUs have adopted drug management reforms to address these questions. In Pangasinan, a ***Provincial Formulary*** is being used to select drugs for procurement. The provincial and all district hospitals only procure drugs that are found in the provincial formulary. The drug requests of hospitals of the province are pooled and bid out together. This has resulted in 50% reduction in drug prices (see Figure 15 of Process Flow for hospital procurement). This has resulted in 80% reduction in drug prices. The province of Capiz has utilized ***parallel importation of drugs***. On the average, the imported drugs are 47% less than the usual local prices (See Table 4 for comparative prices).

Figure 15. Process Flow for Hospital Procurement in Pangasinan



Bulk or Pooled Procurement

Devolution of hospitals resulted in the centralization of the procurement process in the provincial governments through the General Services Office (GSO). The circuitous procurement process, with about 40 signatures and initials, has become a major problem to devolved hospitals. Furthermore, many of these hospitals are located far from the provincial capitals, making communication, coordination and follow-up of purchases very difficult. All these result in shortages in drugs and medical supplies.

The provincial pooled procurement program observes the following principles:

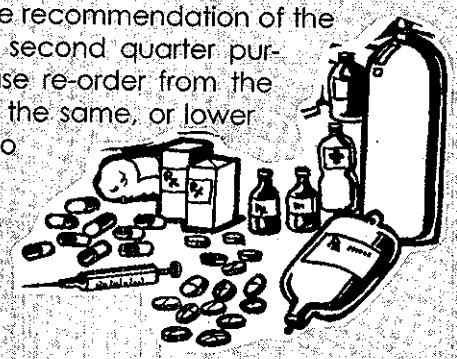
- Purchases are conducted by generic name or international nonproprietary names in accordance with the Generics Act of 1988.
- Purchases are limited to a list of essential drugs selected by the Hospital's Therapeutic Committee and reconciled by the Provincial Therapeutic Committee according to the provincial formulary.
- The provincial formulary is based on the Philippine National Drug Formulary (PNDF).
- The procurement program pools the needs of all the province's hospitals to achieve higher volume and cheaper prices through economies of scale.
- The province accepts bids from pre-qualified suppliers in good standing with good manufacturing practices (GMP) to ensure product quality, service reliability and financial viability.
- The prices from successful suppliers are valid for a period of 12 months, which allows the province to maximize their purchases.
- Hospitals place quarterly purchase requests based on the information provided by their inventory control system and available

funds, thus avoiding stockouts.

- To ensure the most efficient use of the available funds, hospitals will prioritize their requests using the VEN and ABC tools. VEN analysis classifies drugs into vital, essential, and nonessential, according to their therapeutic value, or on how critical the drug is for treating common diseases. In ABC analysis, the items are ranked according to their annual value in Philippine pesos. Managers may therefore focus first on high-cost items when considering ways to reduce procurement costs. Category A includes items that make up 75-80% of the total cost. Category B represents the middle 10-15%, while C represents about 10%.

With the implementation of the pooled procurement system, the province was able to procure drugs and medical supplies at much reduced prices. This enabled the province to realize sizeable savings and revenues. Hospitals are now able to efficiently procure needed pharmaceuticals with limited resources and are assured of having stocks of essential drugs every quarter (Please refer to Annex 10 for MSH-IFPMAP contact information).

Negros Occidental Drug Procurement System. The simplified drug procurement model developed combines options to allow the shortest processing and at the same time achieve the procurement objectives. The quarterly bulk purchase avoids the repetitive procurement process of each hospital. Under this mode, majority of items will be on public bidding, while selected items, will either be procured from direct manufacturers and exclusive distributors subject to the recommendation of the Provincial Therapeutic Committee. The second quarter purchase will utilize the concept of purchase re-order from the preceding quarter's winning suppliers, at the same, or lower selling price. These re-orders will have to be done within 90 days of the last quarter's Purchase Orders. New items not procured on the previous quarter will be procured either through public bidding, direct manufacturers, or exclusive distributors.



Parallel Drug Importation

In the Philippines, good quality drugs are priced beyond the capability of the patients to pay for them. However, these same drugs are sold in other countries at prices several times lower than in the Philippines. One way to solve this problem is to import these drugs into the Philippines from a country where it is priced lower.

Parallel importation refers to the importation, without authorization of the patent holder, into a country of a product from a third country, where this product has been marketed by the patent holder.

Table 2. Comparative Drug Prices of Parallel Drug Imports vs. Local Branded Counterparts

Generic/Brand Name	Price of Local Branded Counterparts in Private Drug Outlets A	Price of Parallel Drug Imports in the 7 DOH Hospitals B	Price Difference (A-B) C	% Savings (C/B) x 100% D
Salbutamol (Ventolin/Ventorlin) 100 mcg/dose x 200 MDI	294.75	197.60	97.15	49.16%
Beclomethasone (Becloforte/Becoride) 250 mcg inhaler	831.00	532.50	298.50	56.06%
Atenolol (Tenormin) 50 mg tablet	17.75	9.05	8.70	96.13%
Cotrimoxazole (Bactrim) 800 mg SMZ + 160 mg TMP tablet	24.10	5.10	19.00	372.55%
Cotrimoxazole (Bactrim) 400 mg SMZ + 80 mg TMP tablet	13.50	2.80	10.70	382.14%
Cotrimoxazole (Septrin/Septran) 200 mg SMZ + 40 mg TMP/5 ml susp. 50 ml bot.	82.68	67.60	15.08	22.31%
Glibenclamide (Daonil) 5 mg tablet	7.75	3.10	4.65	150.00%
Nifedipine (Adalat Retard) 20 mg capsule	34.15	5.75	28.40	493.91%

The Philippine International Trading Corporation (PITC), an attached agency of the Department of Trade and Industry (DTI), is the sole entity authorized by the DOH to conduct parallel importation of drugs (see Annex 10 for PITC contact information).

There are several advantages in procuring through the PITC:

- The DOH does not have to go through the tedious bidding process. The PITC is responsible for conducting its own bidding and/or canvassing from among possible suppliers in order to select the appropriate party who can provide prices and terms most advantageous to the government.
- The LGU will be assured of value for money. Competitive prices will be charged at actual reasonable costs of the specific drugs and medicines. Unnecessary middlemen, distribution and other facilitation charges previously passed on to the government will be avoided. Budgetary allocations and funding will be maximized, as larger quantities may be purchased as a result of lower per unit prices.
- The LGU will not be required to pay in advance. Reasonable payment terms such as credit of from 30 to 60 days and non-requirement of dollar payments may be negotiated.
- The LGU will be assured of quality products. These are sourced only from reputable suppliers with the necessary cGMP/WHO certifications, undergo the standard laboratory testing process of the BFAD, and are properly registered before delivery to the users.
- Logistics, warehousing and delivery services will be provided, thus the LGU does not have to contract a third party for these services.
- Government revenues will be assured through full declaration of duties, value-added, city and other taxes. In addition, PITC pays out dividends to its mother company, reverting part of its revenues to the National Government.

Since the last quarter of 2000, PITC has sold parallel drug imports to about 40 DOH hospitals, and to the hospitals of the province of Capiz. About 30 DOH hospitals are now offering quality, low-cost drugs to their patients.

Health Human Resource Development

The Health Personnel Management System must make health workers feel cared for and supported. It must ensure that:

- Enough staff are available to provide services in the district
- The right mix of different types of health workers is present in the district
- People carry out their duties for which they are employed
- People can take leave without services shutting down
- Training opportunities are available for people to develop further skills and improve qualifications
- People are happy and motivated in their work.

Performance Management System

This involves a continuing process of clarifying the employee's assignments, guiding them towards improved performance and encouraging them to work with zeal and confidence, thereby improving individual and organizational productivity.

The Sangguniang Panlalawigan of Kalinga authorized the setting up of a ***Health Human Resources Management Center*** at the office of Health Services. This would look into health manpower capacities, recruitment, deployment, training and development in an attempt to de-politicize and instead professional the health staff.

Job-Related Recruitment and Selection System

This ensures an improved hiring system especially in government employment where the merit and fitness are valuable, and provides equal employment opportunities to all citizens, regardless of sex, geographical and cultural origin, physical condition, political leanings and social or economic status.

Training and Development

Upgrading of skills and competencies is very important for the health personnel's career path. Several training modules are available. This could be in-house training within one of the ILHZ facilities, RHU personnel's tour of duty in the district hospital, or distance training. Regional hospitals may become the venue for upgrading the clinical skills of the ILHZ physicians. The DOH Health Human Resource Development Bureau and Training Service, and DOH attached agencies may conduct training seminars from time to time at the national and regional levels, which may be open to LGU participants.

Health Information System

Improvement of the existing field health information system must be done to be responsive to local planning, monitoring, referral and disease surveillance. The system incorporates both the manual and electronic approach of data gathering and integration. This would also require investing in equipment such as telephones, computers and printers, software (programs), and training of personnel involved in the information system.

The Health Information and Management System is one of the weak areas of the ILHZ. Therefore, there is still a great need to invest in and develop appropriate health information systems at different levels and health facilities of the ILHZ.

At present, the functioning health information systems being imple-

mented are the following:

- The ***Field Health Service Information System (FHSIS)*** is a facility-based information system that records clients who are provided health services at the health facility level.

- The ***Community-Based Monitoring and Information System (CBMIS)*** complements the FHSIS since it helps identify clients with unmet needs who do not visit the health facility. It keeps track of these clients until they are provided the necessary health services.

- The ***Hospital Operation and Management Information System (HOMIS)*** is utilized in retained and devolved hospitals.

A simple but effective information system at the RHU would include the following data plastered on the walls of the clinic or the BHS: the community it serves, the major health problems in the community, trends in health problems seen at the clinic, people's satisfaction with its services, up-to-date pictures, charts and maps. All these show that the RHU staff knows the people they serve, and whether the clinic is meeting the community's priority health needs.

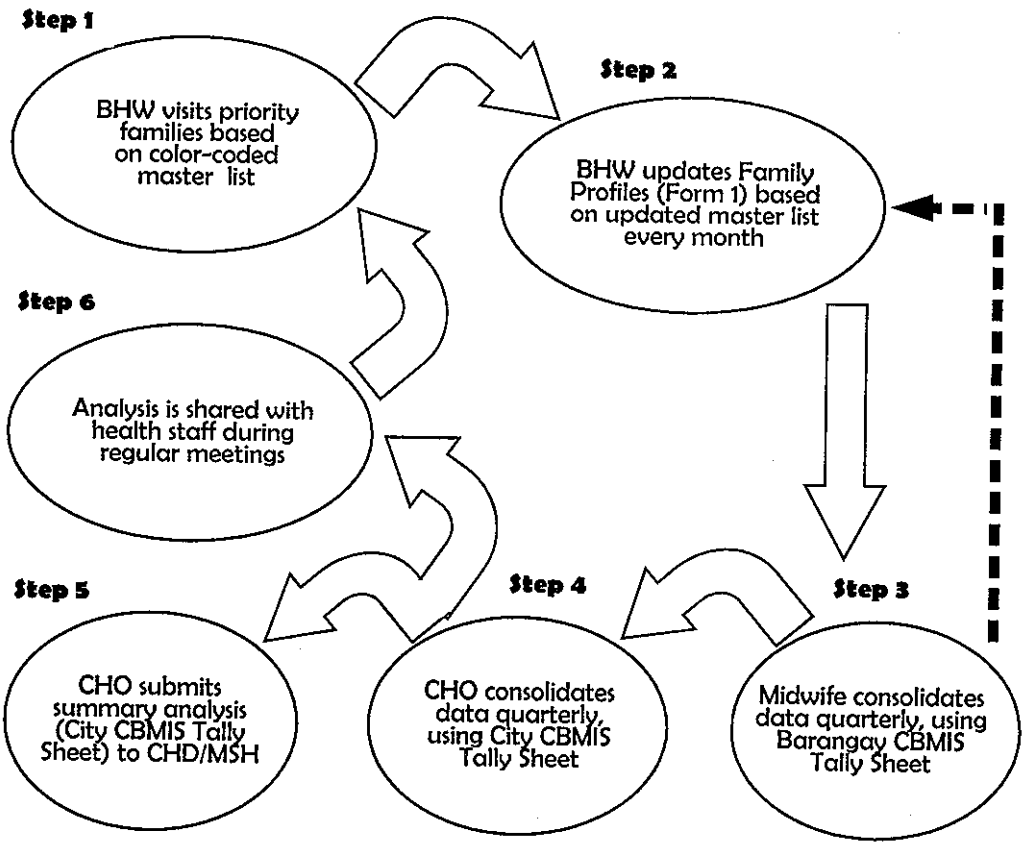
Community-Based Monitoring and Information System (CBMIS)

At present, a national health information system is used to determine targets for specific health services as a fixed proportion of a projected population. While this system is useful for allocating supplies, it is not a very reliable basis for calculating rates of achievement. The system reports only those who actually go to government health facilities. It does not give an accurate picture of coverage rates. Many families, particularly those in economically depressed, hard-to-reach areas, lack information about or access to basic health services.

The DOH introduced the CBMIS in 1996 in the province of Pangasinan and Iloilo City. The earlier version focused on family planning, while the new one evolved to cover child survival services. These services include tetanus toxoid vaccination for pregnant women to protect newborns from tetanus, immunization, and vitamin A supplementation.

Malaybalay City CBMIS. Malaybalay City in Bukidnon province has a CBMIS for identifying and prioritizing women and children who have unmet needs for family planning and selected maternal and child health services. The BHW has a ***color-coded master list*** of individuals for each barangay. Figure 16 illustrates the updating process.

Figure 16. CBMIS Updating Process: Malaybalay City



The ***CBMIS*** enables health service providers (government and

private) to systematically identify, categorize, and prioritize clients, particularly women and children, for specific health services. It provides the basis for planning and implementing interventions that use available resources more effectively.

Planning involves making a ***spot map*** of communities with poor access to health services, underserved populations, or relatively high numbers of families in need of public health services.
The community health volunteers (BHW and CVHW) are assigned a number of households to survey. A ***Family Profile*** is completed for each family. This will identify the target clients who are in need of appropriate health services. This form is updated at least monthly as health services are provided.

The supervisor/midwife then totals the data of the Family Profiles on the ***Barangay Tally Sheet*** for every barangay. This will provide the midwife an overall picture of the status of target clients and their service needs in the entire barangay. It is basically the tool for planning, implementation of appropriate service delivery interventions, and tracking of clients with unmet needs. The information regularly generated in this form will give the health care providers an indication of the effectiveness of their service delivery interventions.

The ***Municipal or Catchment Tally Sheet*** records barangay totals and percentages so health personnel can compare problems and accomplishments of different barangays. This would provide the midwife an overall picture of the status of target clients and their service needs in her entire catchment area, and therefore help her in prioritizing which barangay needs immediate health interventions.

Midwives issue ***"call cards"*** to clients and families that identified with unmet needs or health services. The call card specifies what services are needed, and when and where to get them. The call card, therefore, invites the clients to visit the health fa-

cility and avail of the health services which they immediately need.

The CBMIS data may be used to complement the DOH's Field Health Service Information System target client list. It is expected that the CBMIS will be used in more than 200 municipalities and component cities by 2002.

Community-Based Disease Surveillance System (CDSS)

Bago City in Negros Occidental set up a community-based disease surveillance system (CDSS) in 2000. This system would enable local health managers to respond to outbreaks immediately, reducing the burden of communicable diseases on the population. This would also help local health workers assess the adequacy of preventive measures, such as immunization and micronutrient supplementation. In addition, the system would inform local politicians about the region's health problems, encouraging them to further support health programs and services.

Bago City's CDSS is designed to monitor the occurrence of 13 diseases, including acute flaccid paralysis, animal bites, dengue hemorrhagic fever, diarrheal disease, diphtheria, measles, meningococcal disease, neonatal tetanus, non-neonatal tetanus, pertussis, cholera (suspected/confirmed), typhoid fever (suspected/confirmed), and viral hepatitis (A and B). The CDSS

is intended to:

- Provide early warning about disease outbreaks;
- Formulate and carry out appropriate and timely interventions;
- Determine trends of diseases under surveillance;
- Describe the demographic characteristics of identified cases;
- Assess the effectiveness of health interventions using the

community-based monitoring and information system (CBMIS) Bago City has implemented as a complementary data gathering system; and

Generate information that can be used to lobby for more support for health.

Figure 17 illustrates how this system works.

Community-Based Disease Surveillance (CDSS) for LGUs. The Program Management Technical Advisors Team (PMTAT) of Management Sciences for Health (MSH) provided technical assistance in setting up Bago City's CDSS. The City Health Officer and PMTAT visited the Epidemiology and Disease Surveillance Unit of ***Paranaque City***, the only LGU in the country with a computerized CDSS, to observe and learn about its system. Bago City Health Office then held a five-day training course on the CDSS for its health staff of doctors, nurses and midwives. The course included training in the use of ***Epi Info*** for database management and analysis. The group agreed to adopt the worksheets developed by Paranaque City. Based on Bago City's experience and recommendations, PMTAT, together with the ***DOH National Epidemiology Center*** and the Infectious Disease Surveillance and Control Project, developed a training course to prepare LGUs to set up a basic disease surveillance system and conduct outbreak investigations

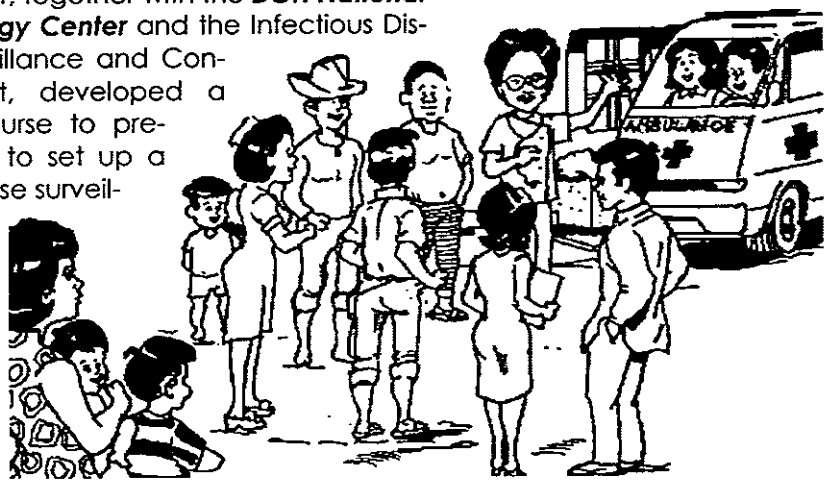
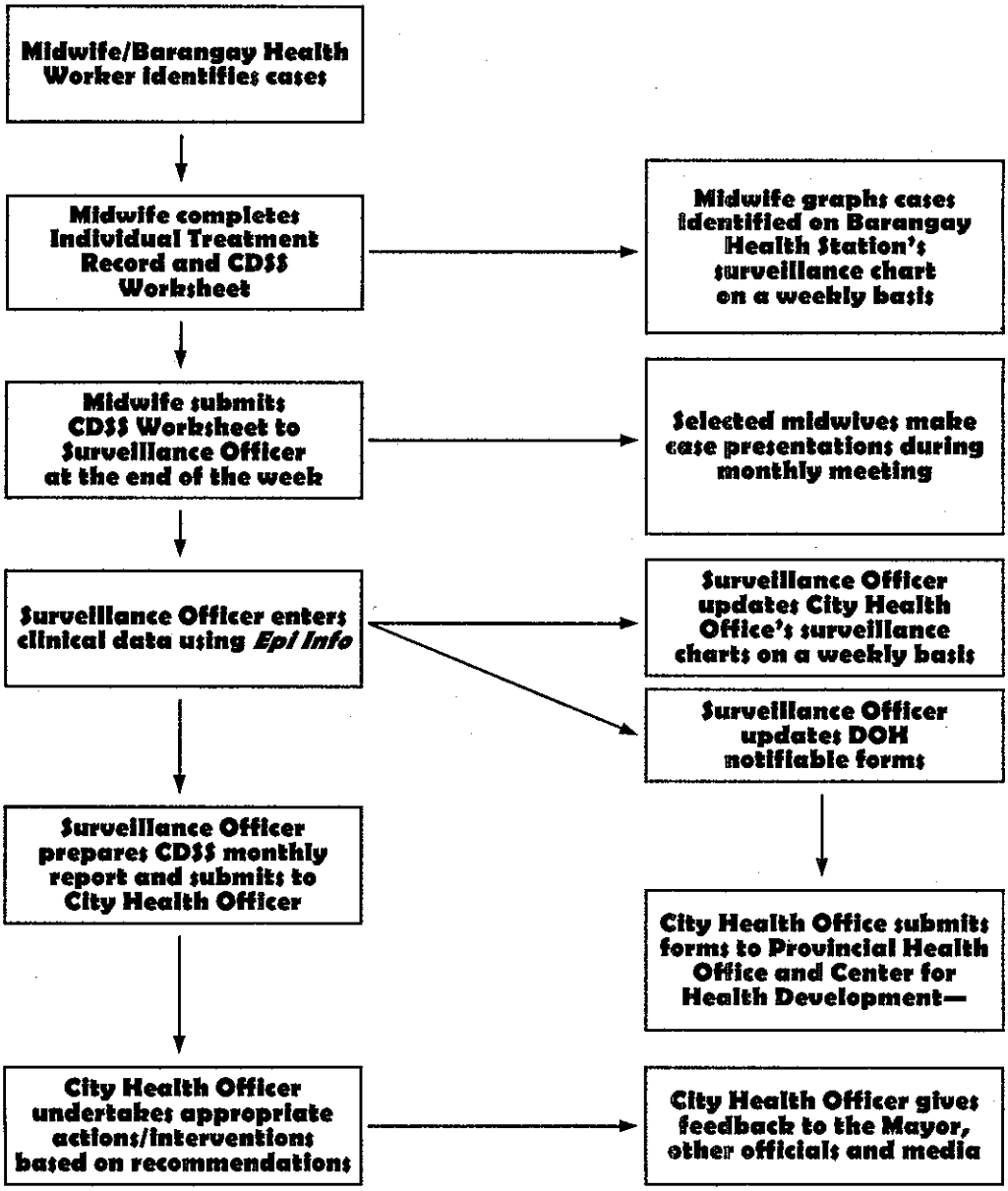


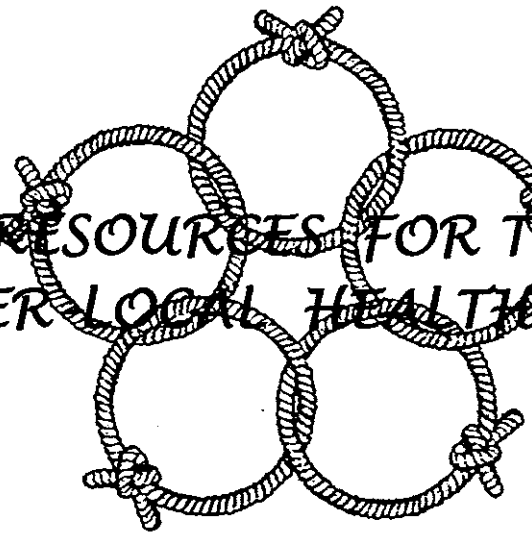
Figure 17. Bago City's CDSS



HIS in Negros Oriental. Better information sharing among parts of the health district system has been achieved through the forum provided for discussion and joint activities. Computers to input information have been procured, but there is no adequate computer program yet to enable more sophisticated forms of information sharing. ***ICDT*** and ***Lucena*** programs, which are very basic, are already available. However, the lack of telephones in the area hampers communication and information sharing.

HIS in South Cotabato. Integrated health information system is already computerized at the ILHZ level. Two RHUs have begun the development of client profiles. The Provincial LGU has hired a data encoder to assist the rural health staff with data entry. The Provincial HMIS point persons have assisted rural health staff through training, trouble-shooting and management of the database. The core referral hospital has included procurement of computer system in budget to support the hospital info system. One municipal LGU will procure a computer system. Discussion and consultation would be needed regarding the inclusion of health data from the private and NGO sector.

CHAPTER 7



RESOURCES FOR THE INTER LOCAL HEALTH ZONE

PREVIOUS PAGE BLANK

The prohibitive cost of health services requires that scarce resources be efficiently utilized to obtain maximum benefits. The establishment of the ILHS will promote the integration of the curative and preventive services that will integrate comprehensive package of services to address priority health concerns in the area.

For the LGUs, the ILHZ scheme will work tremendously to their favor. There is cost sharing among member LGUs that will make it financially easier for poor LGUs to attend to their health problems. During outbreak of epidemics, LGUs will find it easier to cooperate with one another to address common health problems. There is sharing of human resources and expertise to help them improve their health facilities to be able to provide quality service to their constituents. There are more opportunities for generating external funding as organizational capabilities are improved and better solicitation skills are developed.

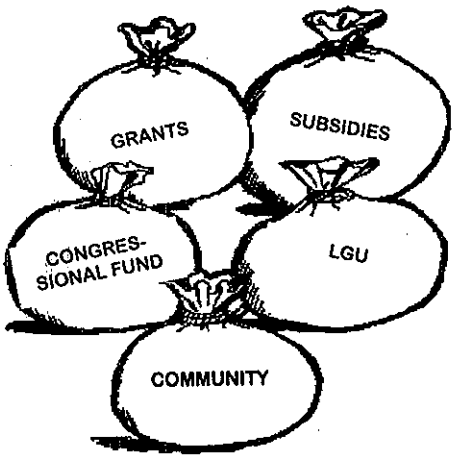
There is also greater sustainability of health programs as community organizations learn to set up their own health care financing schemes. When people share their income to get a health service, they are more inclined to take care of their health.

Good health is good politics. Once people begin to attribute their good health to success of the social programs of the local chief executives (LCEs), there will be better support for health as it becomes an indicator of good performance of local politicians.

PREVIOUS PAGE BLANK

Main Sources of Funds

- Regular budget of the LGUs for hospitals and RHUs
- 20% development funds of LGUs
- Augmentation and subsidies from DOH/CHD
- Congressional Funds
- Health Insurance Scheme through PhilHealth Plus



Regular Budget and 20% Development Funds of LGUs

The local governments get a share of the Internal Revenue Allotment (IRA) based on the gross national internal revenue tax collection preceding the current fiscal year. Locally generated incomes are in the form of local taxes, fees and charges, as well as real property taxes. A portion of this regular budget is allotted by the LGU for the RHUs and hospitals.

The ILHZ board may establish a ***common health fund*** from the LGU appropriations of member municipalities in the catchment area, in addition to funds from other sources like foreign funding. A ***trust fund*** may be created for the specific purpose of the ILHZ.

Augmentation and Subsidies from DOH/CHD

Augmentation and subsidies may come from the DOH Central Office or the Center for Health Development. Foreign funding may be channeled through the Bureau of International Health Cooperation.

DOH Augmentation Funds. The Kalinga and South Cotabato ***Integrated Community Health Services Project*** was conceptualized in 1995 to install and implement subsystems in the context of the District Health System. The province became the recipient of a grant form the DOH (through a soft loan from the Asian Development Bank) and a grant from the Australian Agency for International Aid (AUSAID). The augmentation funds from the DOH, through the CAR Regional Health Office, helped to stir the enthusiasm of the provincial and municipal governments to participate in organizing the district health zones. One half of the funds was released to the three RHUs of the Lin-awa Health Zone. The other half went to the province, specifically for the provincial hospital and two other hospitals in the ILHZ.

Congressional Funds

Another source of funding is through tapping the Priority Development Assistance Project (PDAP) Fund of members of both Houses of Congress. Usually the members of the House of Senate have P100 Million each per year, while the members of the House of Representatives each have P50 Million annually.

Health Insurance Scheme Through PhilHealth

This is through the enrollment of indigents and self-employed group to PhilHealth. This will allow cost recovery of budget for health in the hospital and RHUs through the reimbursement scheme and capitation fund, which can be spent to further improve health services in both facilities. But more importantly, this will increase access of health services by the poor.

PhilHealth's Universal Health Insurance Coverage has three components: Financing, Access, and Delivery.

Financing is through payroll deduction of the formal sector (government and private employees), NGO and LGU subsidies for indigents, informal sector premiums, interest income of reserves, and consolidation of community, NGOs and charitable funds.

Access is through the ***PhilHealth Plus (or Plan 500)***. The key design elements are:

- Universal coverage in a well-defined area
- Number and specific sites chosen for "neighborhood" effects among others
- Comprehensive benefits for card holders including services from DOH programs, PhilHealth benefits, and LGU health services

The objective of the PhilHealth Plus (or Plan 500) initiative is to develop a critical mass of areas with universal coverage of social health insurance by 2004. This means 32 provinces and 32 cities or 4 areas per region by 2004. One of the strategies is to enroll at least 85% of families in each area in the National Health Insurance Program. This will be done by assisting LGUs to access additional funding sources for indigent and informal sectors, and to integrate local health insurance schemes with the NHIP for efficiency and sustainability.

Table 3. LGU and PhilHealth Premium Payments for Indigent Members

LGU Income Classification	Year	Ratio	PhilHealth Share	LGU Share
1st to 3rd	1st onward	50:50	P 594.00	P594.00
4th to 6th	1st and 2nd	90:10	P1,069.20	P118.80
	3rd	80:20	950.00	237.60
	4th	70:30	831.60	356.40
	5th	60:40	712.80	475.20
	6th onward	50:50	594.00	594.00

Delivery of PhilHealth Plus (or Plan 500) outpatient benefits is through PhilHealth accredited RHUs with outpatient benefits and government and private hospitals.

The ***Indigent Program (Medicare Para sa Masa)*** is a component of

the National Health Insurance Program that provides for social health insurance for the indigent sector.

As a joint undertaking of the LGU and PhilHealth, premium payments for the indigent members (P1, 188 per household annually) are shared by both parties. Sharing is determined by the LGU's income classification, as shown in Table 3.

Table 4. Expected Return on Investment for PhilHealth Capitation Fund

Amount Allotted (Investment)	4th-6th class municipality (On 1st and 2nd years)			1st-3rd class municipality		
	Premium Share of LGU (10% of P1, 188)	No. of HH	Capitation (No. of HH x P300)	Premium Share of LGU (50% of P1, 188)	No. of HH	Capitation (No. of HH x P300)
P500, 000	P119	4,209	P1, 262,626	P594	842	P252, 525
P1, 000,000	P119	8,418	P2, 525,253	P594	1,684	P505, 051
P3, 000,000	P119	25,253	P7, 575,758	P594	5,051	P1, 515,152

Indigent members and their beneficiaries are entitled to the Medicare benefits enjoyed by regular (employed sector) members. In addition, they may avail of an outpatient consultation and diagnostic package, which is exclusively for indigent members. The outpatient benefit package includes primary consultations and diagnostic examinations.

The ***PhilHealth Plus Capitation Fund*** recognizes the role of the local

Table 5. Benefits of PhilHealth *Medicare Para Sa Masa* Cardholders

Rural Health Units Benefits (Outpatient Services)	Hospital Benefits	
	Inpatient Services	Outpatient Services
Doctor's consultation fee Laboratory • Complete blood count • Fecalysis (stool examination) • Urinalysis Laboratory Chest X-ray (or referral to hospital for Chest X-ray)	Room Drugs and medicines X-ray, laboratory, etc. Doctor/s consultation fee Others: Operating room, Surgeon, Anesthesiologist	Chemotherapy Hemodialysis Radiotherapy Cataract extraction Minor surgical procedures performed in an operating room complex Surgical family planning procedures (vasectomy, tubal ligation)

government both as a financial intermediary and provider of health service.

Capitation refers to the scheme of paying the RHU for specific services it provides for a particular period. PhilHealth shall release the capitation amount of Three Hundred Pesos (P300) per household annually to the RHU, through the municipal/city government. This is based on the number of enrolled indigent households in the LGU concerned (e.g. 2,000 households for Municipality X: 2,000 x P300 = P600, 000.00 for one year).

Any savings from the agreed amount will be credited to the benefit of the RHU. Through the capitation scheme, the LGU is assured of a return on investment and automatic access to national gov-

ernment subsidy (see Table 4).

The LGU in turn is responsible for setting up the PhilHealth Capitation Fund through the passage of an ordinance. It should upgrade or enhance the administrative and operational capabilities of its local health facilities to conform to accreditation standards.

In case of deficiency in medical equipment or temporary inability by the RHU to deliver a particular service (e.g. lack of X-ray in the RHU), the patient shall be referred to another accredited outpatient health care provider (government or private). That particular service shall be paid at the expense of the RHU.

The capitation payment scheme will therefore help LGUs upgrade their health facilities and services. Furthermore, the gate keeping functions of RHUs will minimize over-utilization of hospital facilities and avoid unnecessary confinements and denial of hospital claims.

Other Sources of Funds

- Cost-sharing
- Revenue Enhancement
- Utilization of Income
- Community-based Health Insurance
- Bulk Procurement System of Drugs and Supplies
- Establishment of Cooperatives
- Grants
- Fund Raising

Cost-sharing of LGUs

LGUs may pool financial resources, manpower and equipment in an ILHZ to address priority health problems (ex. rabies control, dengue) and during disasters and calamities.

Under a cost-sharing scheme, the participating LGUs put up funds from their own budgets and other funds as their counterpart to match the community contribution.

For municipal LGUs to consider cost-sharing, they need to know the following: current capabilities of the hospital; gaps between current and required services; plans to close these gaps; and funding requirements. The most important issue of concern is how to determine a fair and equitable formula or mechanism to identify LGU cost-sharing responsibilities.

Health Care Financing in Kalinga. Initially, the member LGUs in the Lin-awa Zone adopted co-sharing of costs in common medical mission projects, without any transfer of funds, but by merely using their respective budget allocation for health. Later on a Trust Fund was established. The Lingap sa Mahirap program and the DSWD have been sources of support for indigents. The Ambigatton (meaning "morning star") Cooperative Pharmacy was organized at the provincial level for health care financing in the purchase of medicines. The province also launched community based health insurance schemes managed by the BHW for payment of *piso-piso araw-araw* (one peso daily) or P30 monthly. Other schemes were the Medical Assistance Fund, and the Barangay Health Workers Multipurpose Cooperative.

Cost Sharing in Negros Oriental ILHZ. In Sta. Bayabas Inter-LGU Health System, the three participating LGUs agreed to put up a common health fund. The amounts pledged reflect the financial position of each of the three areas. Bayawan, recently converted into a city, paid the highest contribution at 42%. Sta. Catalina was next with 31%. Basay, a 4th class municipality and the poorest among the three, paid the least (27%). The ILHZ/District Health Board met to decide on how the common fund should be allocated among the components of the Sta. Bayabas ILHS. The Peso for Health Program got the highest percentage of funding at 25%. The Board explained that the unused portion of the LGU contribution would remain with the common fund if the community does not utilize them, whereas the PHIC premium has to be renewed every year for members to be covered. However, they were willing to enroll Peso for Health members when the PHIC is ready with a capitation scheme. The other top priority programs and their corresponding share from the common fund are as follows: Health Information System – 20%, Human Resource Development Program – 15%, Monitoring and Evaluation – 12%, Primary Health Care – 10%.

Revenue Enhancement and Cost Recovery Systems

Hospitals and even RHUs can further improve their income through proper rate setting of services, effective billing and collection and patient classification. This will allow for the facilities to be self-

Hospital Reforms in Pangasinan. Gov. Victor E. Agbayani sought technical assistance from the DOH and the US Agency for International Development (USAID) to increase the efficiency and improve the quality of delivery of hospital services in Pangasinan. The Pangasinan Provincial Hospital in San Carlos City was chosen as the pilot hospital. As a result of the pilot study, the hospital income jumped from a mere ***P2.4M in 1998 to P10.5M in 2000.*** Upcoming improvements include: National Health Insurance Program, and Hospital Management Systems (continued Quality Assurance Program, Financial Management, Logistics Management, and Rational Drug Use).

sustaining without neglecting their social responsibility.In order to improve the efficiency of hospital services delivery, hospital reforms were initiated at the Pangasinan Provincial Hospital in San Carlos City. The Provincial Hospital is the core referral hospital for its catchment area of 8 municipalities, 14 Rural Health Units, and one Community Hospital. These were the reforms adopted:

- ***Efficient billing and collection.*** This entailed the customization of collection and billing procedures.
- ***Patient evaluation and classification.*** This was done by the Medical Social Worker. Proper patient evaluation required documents like family social case done by the social worker. The patient was subsequently classified (A, B, C1, C2, C3, D).
- ***Improvement of financial management system.*** Quality assurance included improved response to treatment at the Emergency Room from 30 minutes to 5-10 minutes. Work-up for patients for elective surgery were done on outpatient basis, rather than as inpatients. Changing of dressings, Doppler ultrasound procedures, etc. were also charged.
- ***Establishment of corporate accounts***
- ***Marketing of services to the community.*** Marketing was conducted to NGOs and some LGUS.

Income Retention. Negros Oriental is one of the few provinces that have allowed public hospitals to keep their income held in trust by the Provincial Treasurer. Aside from the regular budget allocation from the province, the income earned by hospitals from users fees are plowed back to the hospital for their maintenance and operating expenses.

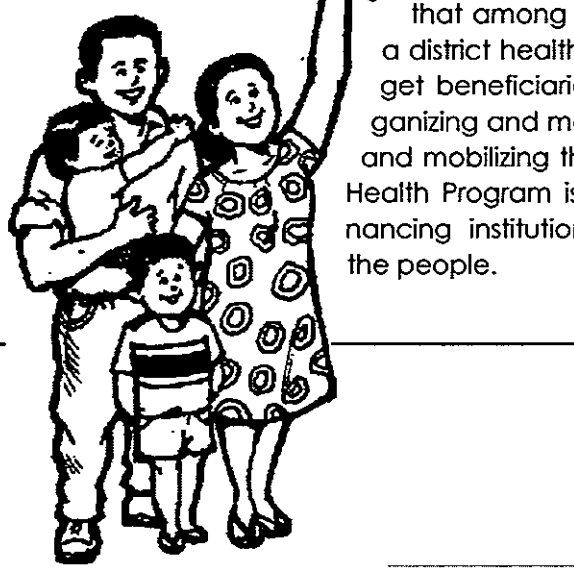
When Congressman Macias was still the Governor, he asked the Sangguniang Panlalawigan to endorse this scheme by passing a resolution. Since then, all hospitals under the jurisdiction of the province were allowed to keep their income.

Up to the present, the users fees are remitted to the Provincial Treasurer. An accountant is assigned to keep records and keep track of all hospital remittance forwarded to the Provincial Treasurer. The hospital then makes periodic requests for release of funds.

Utilization of Income

Certain mechanisms have been put in place to support the local health systems. Hospitals and RHUs can be allowed to use their income to augment for the limited budget for operation and to further improve their facilities and services.

Community HMO. The ***Peso for Health Program*** in Negros Oriental is a community health care financing institution organized and managed by the people. It is a community funded integrated hospital and public health service program. All it takes is P10 to enroll a family, after which each family member chooses to pay P1, P5, or P10 as monthly contribution and avail of corresponding benefits. Members are also entitled to the expanded benefit package of newborn screening, emergency transport service (for referrals), safe motherhood services (home-based delivery package), maternal and child care services (Caesarian section package), growth monitoring (health and nutrition), micronutrient supplementation (iron, iodine), and essential drugs for integrated management of childhood illnesses. Dr. Fidencio Aurelia of the Guihulngan and Bayawan District Health Offices conceptualized the program in 1990. He perceived that among the necessary steps in setting up a district health system are: identification of target beneficiaries (the poorest of the poor), organizing and motivating the target beneficiaries, and mobilizing them to participate. The Peso for Health Program is indeed a community health financing institution organized and managed by the people.



Community-based Health Insurance

There are various models of community-based health care financing. These have been experimented and developed by different groups such as NGOs, POs, and LGUs.

One model of community-based health insurance is the Peso for Health Program in Negros Oriental. This program is tailor-fit to work under an ILHZ structure. The multi-level responsibilities begin with the family health worker (FHW) who, after undergoing basic training in health care, becomes the point person in the family. The FHW keeps records and remits monthly contributions of the family members. The BHWs supervise and monitor the activities of the FHWs.

The RHUs market the program and mobilize community participation. The district provides administrative and technical support services to the various field units, while the PHO provides a support package for community health and development.

Bulk or Pooled Procurement System of Drugs and Supplies

Bulk procurement of drugs can lower cost that allow for more drugs to be available for the same budget. Hospitals also can increase their income through their pharmacies with more drugs available to the patients (This section has been previously discussed in Chapter 6).

Grants

The provincial and municipal governments may avail of foreign grants through governments (e.g. USAID and AUSAID) as well as private institutions. Local grants and loans are also available from business and other organizations.

Establishment of Cooperatives

Several multi-purpose cooperatives have been established mainly or partially to cover the health care needs of the members. These cooperatives may set up a cooperative pharmacy, or create a health fund for community-based health programs.

Fund Raising

Fund raising activities are conducted sporadically for specific health projects. Private groups, both local and overseas, generously contribute to the construction or renovation of clinic or hospital rooms and wings. They also donate medical equipment and supplies.

Negros Oriental Donors. The provincial hospital receives donations in kind in the form of hospital equipment, or donors undertake renovation of rooms. The hospital officials do not receive cash but simply become the recipients during the turnover of rooms or equipment for hospital use. Private donors, religious groups and organizations undertake projects and solicit donations to benefit the various hospitals. These are the Rotary Club, the Men and Women's Auxiliary and the religious group Sinag, simultaneously with the performance of their religious ministry.

Fund Management

All funds may be deposited to the ILHZ account and disbursed in accordance with the integrated work and financial plan. The common health fund should be deposited under one collaborating LGU as agreed upon by the participating LGUs. The Technical Management Committee manages this common health fund.

The ILHZ Health Board and the Technical Management Committee (TMC) shall maintain separate books of account and keep financial records available anytime for monitoring and auditing by an authorized agency. The TMC shall submit a financial statement and narrative report.

Management of ILHZ funds must abide by sound accounting procedures and the Commission on Audit rules and regulations.

In Negros Oriental, the Sta. Bayabas Inter-LGU Health System and the Bindoy-Ayungon-Tayasan ILHZ has formulated clear guidelines for ILHZ fund management:

- The Local Government Units shall establish a Common Health Fund which may include: Individual LGU Appropriation to the Trust Fund, Drugs Revolving Fund, Health Insurance Fund, DOH Assistance to Local Government Unit Fund, Community Health Care Financing Fund, and other (Private Sectors) contributions.

- All funds shall be deposited as "Trust Funds" ***exclusively*** for the use of the ILHZ. The ILHZ "Trust Funds" must be disbursed based on the Integrated Work and Financial Plan.

- These funds shall be transferred by the participating LGUs and must be deposited under one collaborating LGU for convenience and practical purposes, as agreed upon by the participating LGUs.
- The Common Health Fund shall be managed by the ILHZ

Fund Committee, designed and established by the ILHZ/ District Health Board in accordance with the Philippine Laws.

- The ILHZ/District Health Board members, upon presentation of the ILHZ Work and Financial Plan, shall agree upon the amount and frequency of appropriation to the "Trust Fund". However, the individual LGU appropriation shall be commensurate to the individual LGU financial capacity.

- The ILHZ through the ILHZ/District Health Board and the Technical Management Committee, shall:

  (a) Maintain separate books of account to record all sources and disbursement of funds for the system;
  (b) Keep the financial records from the date of the signing of contract for auditing purposes; and
  (c) Make available all the financial records at any time for monitoring and auditing purposes by legally authorized agency.

- The Technical Management Committee shall submit a financial statement including narrative report, the utilization of the revolving fund, every month commencing on the date of its implementation. The said reports shall be submitted to the ILHZ/District Health Board and Provincial Health Board not later than two (2) weeks after the end of each month.

SEC Registered ILHZ. The CVGLJ Inter-LGU Health System model in Guihulngan, Negros Oriental has been registered with the Securities and Exchange Commission. The Board has opened a bank account for the common fund. In its Articles of Incorporation, fund management specified the following:

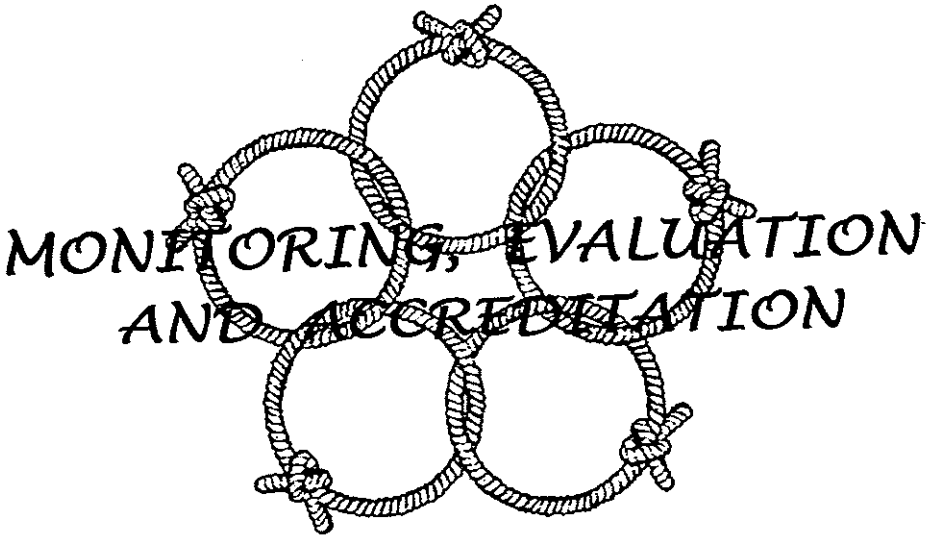
- The association shall derive from the Provincial and Municipal LGUs funds which shall constitute a common trust fund to include: the individual LGUs appropriation to the Trust Fund, the Drug Revolving Fund, the Health Insurance Fund, the DOH Fund, and others (private donations).

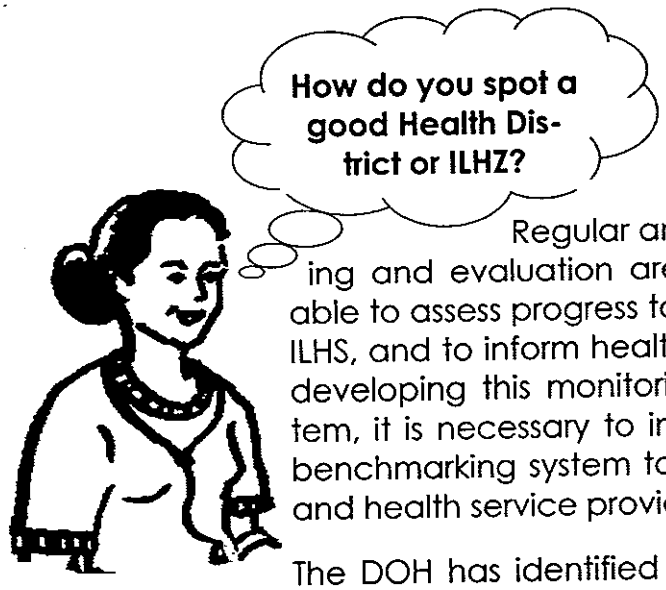
- All funds shall be deposited as trust funds exclusively for the use of CVGLJ Inter-LGU Health Zone, Inc.

- The common Trust Fund shall be managed by the Board of Trustees in accordance with the existing accounting procedures and Commission of Audit rules and regulations.

- Disbursements – Withdrawal from Health Zone Funds, whether by check or any other instrument, shall be signed by the Treasurer and/or President. If necessary, the Board of Trustees may designate other signatories.

CHAPTER 8





Quality Assurance

Regular and appropriate monitoring and evaluation are very important to be able to assess progress towards a fully functional ILHS, and to inform health planning activities. In developing this monitoring and evaluation system, it is necessary to include indicators and a benchmarking system to guide decision-makers and health service providers.

The DOH has identified a number of indicators to measure initial establishment of ILHZs. Each ILHZ should also develop its own monitoring and evaluation system. This should identify a number of process and outcome indicators for the ILHS. The indicators would emerge as the process of consultation with decision-makers and LGU officials progresses.

Internal monitoring and evaluation may be done in each ILHZ in collaboration with a partner NGO, as is being done in Kalinga and Negros Oriental. External monitoring is conducted by the DOH through the CHD.

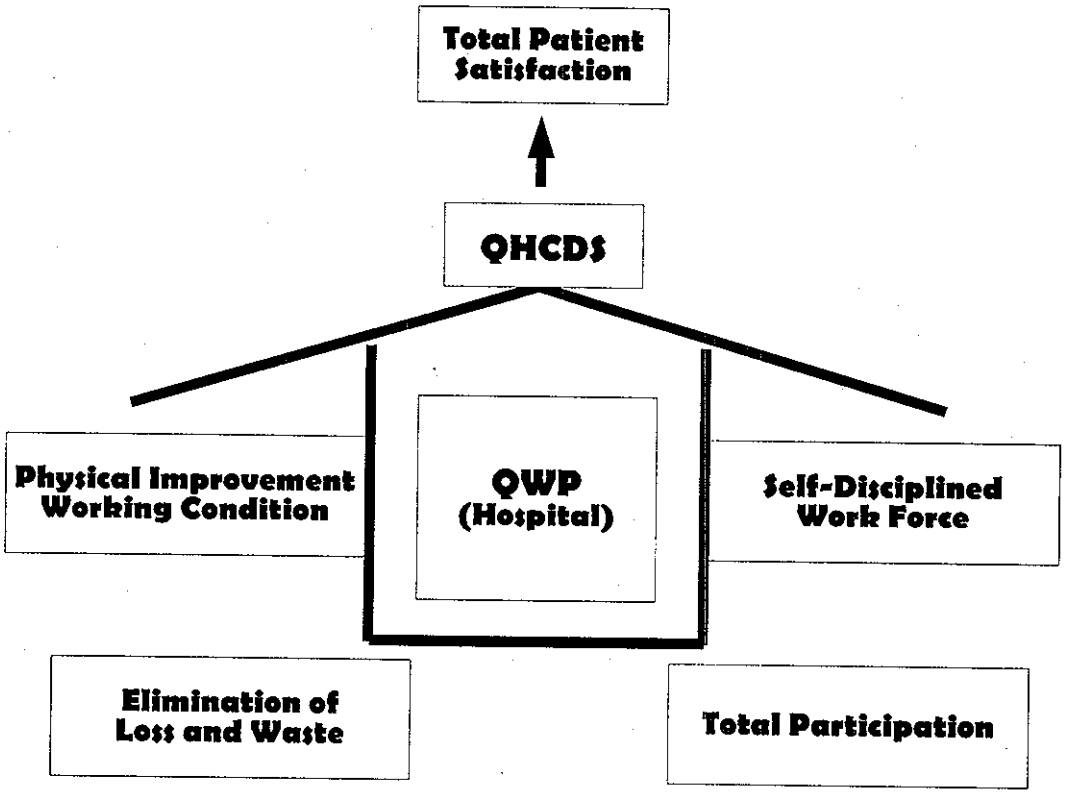
A good health district or ILHZ is easy to spot. It is a district in which the health services are geared up to meet the primary health care needs of the population.

These are the qualities of a good ILHZ:

- Services must meet the needs of the population.
- Service is efficient – fast and streamlined.
- Services are accessible, both physically and financially.
- The personnel are friendly and courteous.
- Services are equitable.
- There is Inter-LGU cooperation.

These criteria should be monitored and evaluated regularly in the field, and within the health facilities. Patient surveys, focus group discussions, formal and informal interviews, and personnel performance evaluation may be conducted by the management, or in collaboration with NGOs.

Figure 18: Quality Assurance Circle

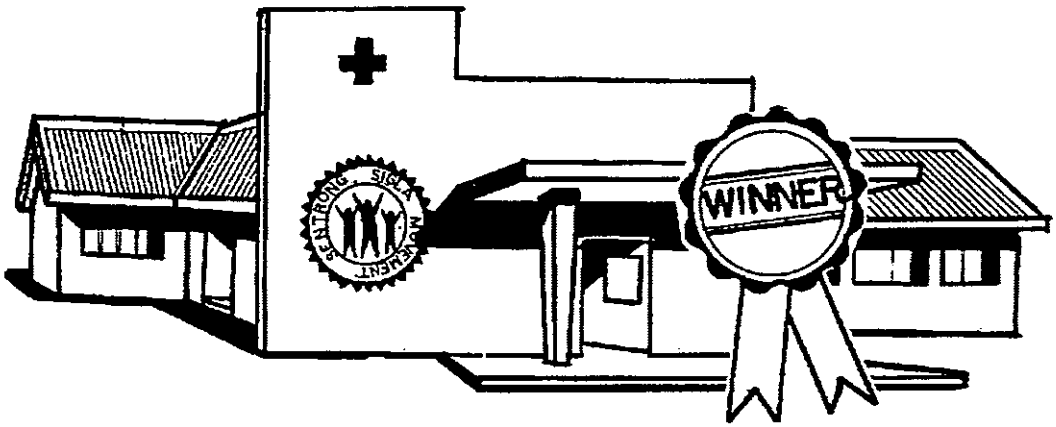


The Lin-awa Health Zone in Kalinga was piloted for the Benefit Monitoring and Evaluation Program which monitors the progress of the District Health System, and the Performance Management and and Evaluation System which evaluates the performance of the health workers. The RHO monitored the planning processes at the LGU, fund releases, liquidation, and schedule of future releases.

Sentrong Sigla Certification

The ***Certification and Recognition Program (CRP)*** is the main component of ***The Sentrong Sigla Movement (SSM)***. It develops and promotes standards for health facilities, and also recognizes LGUs and certifies health facilities that meet requirements and standards to deliver quality health care. It covers health facilities like hospitals, rural health units/health centers and barangay health stations. The SS Seal is the proof of certification. The facility and its staff will eventually be introduced to the continuous quality improvement (CQI) tools and techniques in order to maintain its standards.

Sentrong Sigla Quality Standards List for Health Facilities contains the recommended standards and requirements for providing quality services, based on existing national program guidelines of the DOH. There are Standards Lists developed separately for Barangay Health Stations, Rural Health Units/Health Centers, and Hospitals (provincial and district hospitals).



The list is for the use of service providers or health facility staff, local health managers, LCEs, and quality assessment teams and other users interested and involved in improving the quality of services being provided in that facility. With the list, the user will be able to assess if his/her facility meets the quality standards for providing health services or if not, what improvements are needed to meet the standards.

The focus of certification standards will be "inputs" such as basic infrastructure, equipment, drugs, medicines and supplies, and training that demonstrate "preparedness" or "readiness" of facilities and staff to provide the services. "Process" standards include attitude and behavior of health workers, health human resources, health information system, and community interventions.

Sentrong Sigla Quality Assurance Program

- Sets and updates standards and requirement for quality health services in government health facilities
- Supports continuing efforts for quality assurance
- Conducts semestral evaluation of the facilities with SS seal
- Removes from the facility the SS seal if it fails to maintain the standards for two consecutive evaluation periods
- Assess the following areas for quality :
    1. Infrastructure/amenities
    2. Services
    3. Attitudes and behavior of health workers
    4. Human resources
    5. Equipment
    6. Drugs, medicines and supplies
    7. Health Information System
    8. Community intervention

For the RHUs and BHS, the health programs or categories initially included are the following:

- Expanded Program on Immunization (EPI)
- Disease Surveillance
- Control of Acute Respiratory Infections (CARI)
- Control of Diarrhea Diseases (CDD)
- Micronutrient Supplementation/Nutrition
- Family Planning Program
- Tuberculosis (TB) Control Program
- Sexually Transmitted Diseases/Acquired Immunodeficiency Syndrome (STD/AIDS) Prevention and Control Program
- Environmental Health and Sanitation Program
- Cancer Control Program: Cervical Cancer Screening Program

PHIC Accreditation

Health insurance through the PHIC is the most sustainable funding scheme for the ILHZ. It is very important, therefore, that the key players involved (LGUs, district health team, PHO, DOH-CHD, NGOs, the community and the private sector) work together to attain and maintain PHIC accreditation for all the health facilities in the ILHZ (see Annex 10 for PHIC contact information).

The following are checklists of requirements for initial accreditation of Rural Health Units (as Outpatient Healthcare Provider), primary hospital, secondary hospital, and tertiary hospital.

Rural Health Unit (Outpatient Healthcare Provider)

Clinic Facilities

A. General Infrastructure

- Building (concrete, semi-concrete or wood; old structure, renovated or new structure)
- Sanitation and safety standards (water supply, electric power, covered garbage containers with color-coded segregation)
- Clinic condition (receiving area, sign boards of RHU and "PhilHealth Medicare sa Masa" provider, seats at waiting area, lighting, examination room with privacy, examination table with clean linen, cleaning supplies for the facility and clinical instruments))
- Current photographs of RHU façade and other facilities (optional)

B. Equipment and Supplies

- Microscope. Centrifuge, counting chamber
- Laboratory reagents and supplies
- Stethoscopes, sphygmomanometer, weighing scales (Beam scale and Ming scale), speculums (large and small)
- Clinic supplies
- List of available drugs in RHU
- Covered pan and stove
- Patient record forms, inventory logbooks
- Decontamination solutions

C. Clinic Staff

- Complete list and current photographs of staff with respective designations
- Physicians, nurses, midwives and medical technologists with their PRC No. and validity, PHIC No. and validity
- Organizational chart of the RHU

Service Capability

- Medical consultation in: Pediatrics, Internal Medicine, OB-Gyn, Minor Surgery
- Current standard operating procedure
- Flow of activities when the patient visits the health center
- Diagnostic services
    - ✓ Laboratory examination (CBC, urinalysis, fecalysis, sputum microscopy)
    - ✓ Chest X-ray examination referral

Quality Assurance Activities (optional)

- Quality Assurance documents (quality assurance handbook, mission/vision, annual report, action plans)
- Leadership capability (medical management, financial management, regular staff meetings on clinic management)
- Process control based on standards
    - ✓ Posters on treatment protocols for diarrhea, rabies, pneumonia, etc.
    - ✓ Patient education (brochures, mothers' classes)
    - ✓ Referral forms
    - ✓ Training on rational drug use
- Human resource management
- Quality improvement procedures (satisfaction surveys among patients and employees, utilization of individual care plans, management information system)

Other Requirements

- PhilHealth application form
- Remittance form I
- Accreditation fee

Note:

- In LGUs with more than one RHU or Health Center (HC) that

could not comply with the requirements of one licensed medical technologist and one functional microscope per RHU/HC, this may be accredited provided there is a ***Referral System*** with a DOH-licensed laboratory facility owned and managed by the LGU not exceeding thirty minutes in travel time.

- In an LGU with an available X-ray facility, the said facility should be duly licensed by the DOH.

Primary, Secondary and Tertiary Hospital

Physical Plant and Environment

1. Building
2. Sanitation and Safety Standard
3. Sewage Disposal

Hospital Beds – list of hospital's beds per room and current rates

Manpower Complement (Fulltime, Part Time and Visiting)

- Complete list and current photographs of staff with respective designations
- Physicians, nurses, midwives and medical technologists with their PRC No. and validity, PHIC No. and validity
- Organizational chart

1. Medical Service
   - ✓ Consultants (General Surgery, Sub-Surgical Specialty, OB-Gyn, Pediatrics, Internal Medicine, Pathology, Radiology, Dental, Others)
   - ✓ Residents
2. Nursing Service
   - ✓ Registered Nurse
   - ✓ Registered Midwives
   - ✓ Nursing Aides

3. Pharmacist
4. Laboratory and X-ray
   - ✓ Medical Technologist
   - ✓ X-ray Technologist
5. Dentist
6. Dietitian and Kitchen personnel (updated health certificate)
7. Administrative Service
8. Others

Clinical Facilities

- Emergency room
- Doctor's/Consultation office
- Clinical laboratory (License No. and validity)
- X-ray facility (License No. and validity)
- Pharmacy (License No. and validity)
- Dental room
- Drug room
- Labor room
- Delivery room
- Nursery room (No. of bassinets and incubators)
- Operating room (Minor OR and Major OR)

Equipment

Complete list of existing functional or serviceable equipment, apparatuses and instruments under each facility

Clinical Service

- General Medicine
- General Surgery
- Orthopedic Surgery
- Ophthalmology
- Otolaryngology

- Anesthesia
- OB-Gyn
- Pediatrics
- Dermatology
- Others

Records

- Admission and discharge records (prescribed logbook and computerized)
- Patient's chart
- Laboratory logbook
- X-ray logbook
- OPD logbook
- Outpatient surgical logbook
- Mandatory monthly hospital reports

Quality Assurance Program of the Institution

- Plan
- Mission and Vision
- Personnel Responsible for the Program
- Activities
- Minutes of Meeting

Other Requirements

- List of current hospital service charges
- PhilHealth application form
- Duly notarized Warranties of Accreditation
- Remittance Form I
- Accreditation fee
- Current photographs of hospital façade and other facilities (optional) – ER, Laboratory, Pharmacy, X-ray, DR, Recovery Room, Isolation Room, CR, Business Office, Nurses Station, CSS, ICU (secondary and tertiary)

- DOH License
- PHA/PHAP Certificate of Membership
- SEC License/ DTI Certificate/ CDA Certificate
- Ancillary Licenses and validation (Laboratory, X-ray, Hospital Pharmacy)
- Current standard operating procedures
- List of available emergency drugs (primary hospital)
- Training certificate in General Surgery of Resident Surgeon (secondary hospital)
- Sanitary permit of Dietary Section (tertiary hospital)
- Therapeutics Committee members and activities (secondary and tertiary hospitals)
- Antimicrobial resistance surveillance program (names of personnel involved, or names of members of Infection Control Committee and activities) – tertiary hospital

ANNEXES

PREVIOUS PAGE BLANK

Annex 1
Health Sector Reform Agenda 1999

Health Sector Reform Agenda
Philippines, 1999-2004

The health of Filipinos has significantly improved over the last 50 years. However, many challenges still remain for the health sector to effect further health gains.

Large variation in health status persists across population groups, income classes and geographic areas. People have unequal access to health services owing to physical and financial barriers.

Curative care facilities are unable to effectively meet health needs because their capacities are either inadequate or inappropriate. Inadequate funding and management systems have limited the impact of programs designed to address public health threats. The effectiveness of the decentralized primary health care delivery system has been compromised because of the lack of coordination and cooperation among local government units. The ability of government to effectively regulate the quality and cost of health services and health products remain weak. While resources for health remains inadequate, the funding that is available is inefficiently generated and inequitably spent.

In order to address these problems, the agenda for health sector reforms have been developed. The health Sector Reform Agenda (HSRA) describes the major strategies, organizational and policy changes and public investments needed to improve the way health care is delivered, regulated and financed.

The five major reforms stipulated in this document seek to undertake the following:

Provide fiscal autonomy to government hospitals. Government hospitals must be allowed to collect socialized user fees so they can reduce the dependence on direct subsidies from the government. Their critical capacities like diagnostic equipment, laboratory facilities and medical staff capability must be upgraded to effectively exercise fiscal autonomy. Such investment must be cognizant of complimentary capacity provided by public-private networks. Government hos-

pitals are expected to be more competitive and responsive to health needs.

Secure funding for priority public health programs. Multi-year budgets must be provided to eliminate or significantly reduce the burden of infectious diseases as public health problems. Investments must be undertaken to effectively address emerging health concerns and to advance health promotion and prevention programs. The management capacity and infrastructure of public health programs must be upgraded, as well as technical leadership over local health systems.

Promote the development of local health systems and ensure its effective performance. Local government units must enter into cooperative and cost sharing arrangements to improve local health services. Funds must be secured to upgrade local health facilities and build local human resource capacities. Participation of the private sector and volunteer groups must be tapped for more effective performance. Appropriate mechanisms for sustainability and continued delivery of quality care must be developed and institutionalized.

Strengthen the capacities of health regulatory agencies. This is to ensure safe, quality, accessible, and affordable health services and products. Weaknesses in regulatory mandates and enforcement mechanisms must be effectively addressed. Appropriated legislation must be enacted to fill regulatory gaps. Public investments must be made to upgrade facilities and manpower capability in standards development, technology assessment, and enforcement.

Expand the coverage of the National Health Insurance Program (NHIP). Social health insurance must expand to extend protection to a wider population especially the poor. Health insurance benefits must be improved to make the program more attractive. Improved benefits and services will be used to aggressively enroll members. Adequate funding must be secured for premium subsidies need to enroll indigents. Effective mechanisms must be developed to cover and service individually paying members. Appropriate mechanisms to ensure quality and cost effective services must be developed and introduced.

As envisioned, these five reform areas are highly interdependent, complementary and therefore expected to be implemented as a package.

Ultimately, the HSRA aims to improve the health status of the people through greater and more effective coverage, of national and local public health pro-

grams; increase access to health services especially by the poor; and reduce financial burden on individual families. The Health Sector Reform Agenda shall be the catalyst that will bring the country toward the realization of a shared vision of health for all Filipinos.

Annex 2
Health Covenant 1999

GOVERNORS' WORKSHOP ON HEALTH: PARTNERSHIP FOR DEVOLUTION

THEME: KALUSUGAN PARA SA MASA

Westin Philippine Plaza, Pasay City
March 9-10, 1999

RECOGNIZING the vision of His Excellency, President *JOSEPH EJERCITO ESTRADA* of providing quality health service for all as a fundamental human right of every person, specially the unserved, underserved, and the underprivileged sectors of our society, and of ensuring that the devolution of the basic health service delivery, facilities, and other resources to the local government units (LGUs), shall be more fully and effectively implemented, the League of Provinces of the Philippines (LPP) in partnership with the Department of Health (DOH) and the Department of the Interior and Local Government (DILG). Conducted the *GOVERNORS' WORKSHOP ON HEALTH* in order to formulate the requisite plans, policy reforms, and implementing strategies to achieve a truly meaningful partnership in devolution among the providers of basic health services;

REALIZING the urgency and the priority considerations for attaining the goals and objectives of a partnership for devolution through LGU-DOH-DILG cooperation in health service delivery, the *GOVERNORS' WORKSHOP ON HEALTH* developed a program of action on coordination and re-integration of health services that is designed to be specific, measurable, attainable, realizable and time-bound;

COGNIZANT of its roles and responsibilities in achieving the national targets to provide quality health services for all Filipinos, the participants to the Workshop hereby commit and pledge by undertaking a solemn covenant on the following:

1. To achieve a unified integrated health care delivery system at the local level by the year 2000, and thereafter;

2. To discuss and agree on national health objectives to be implemented by the LGUs in collaboration with the DOH and other government and private sector entities;

3. To develop a three-year (3) strategic plan for health;

4. To promote innovative strategies and approaches for basic health service delivery for all by the LGUs;

5. To formulate a partnership mechanism among the LGUs, National Government Agencies (NGAs), through the DOH and the DILG, and the private sector to support local health service delivery systems;

6. In line with the principle that authority must be coupled with corresponding responsibility and accountability, the National Government, through the DOH, DILG and other concerned agencies, shall promote policies, programs and projects to enhance local autonomy in implementing health service programs and projects;

7. Accordingly, it is imperative to agree on adequate resources to be transferred to the LGUs by the National Government to enhance local government capability relative to the delivery of basic health services, subject to the guidelines and criteria to be formulated by the DOH and DILG, in consultation with the LGUs, through the LPP and ULAP;

8. To ensure the organization and/or re-activation of existing Local Health Boards (LHB) at every local government level (province, city, and municipality) and their active involvement in the policy formulation and program and project implementation of health services;

9. To oversee the development and implementation of a monitoring, reporting, and evaluation system for all the projects and activities lined up for an integrated and unified health service delivery program;

10. As a result of this Workshop, certain key concerns were raised to ensure the partnership for devolution of the DOOH and the LGUs and the efficient implementation of the re-integration of health services at a local, inter-LGU level. A draft **Executive Order** directing the LGUs to establish Inter-Local Health Zones through Inter-Local Government Cooperation defining their Mechanisms, the Governing Structures, the power and functions of the zones and the funds and resources of such an arrangement will be submitted to the Office of the President for approval, with the endorsement of the DOH and DILG and the LPP.

11. To ensure the implementation of all the foregoing guiding principles, the provinces (with their respective component cities and municipalities) shall, subject to the guidelines, parameters and standards for action, strategic and program thrusts formulated by the DOH and DILG, in consultation with the LPP and the Union of Local Authorities of the Philippines (ULAP), submit the following:

(a) An annual Provincial/City Health Plan that functionally merge, as a unified plan for implementation at the local levels, he priority programs and projects to be implemented within every calendar year. The first Annual Health Plan referred to in the preceding paragraph 11 (a) shall be submitted not later than April 30, 1999;

(b) An annual planning schedule, including the proposed budgetary contributions, technical assistance and manpower inputs of the NGAs and LGUs, for specific priority programs and projects, to be implemented every calendar year, shall be established;

(c) For purposes of ensuring adherence to appropriate guiding principles and coordinated planning and implementation of annual priority programs and projects, a National Health Planning Committee (NHPC) shall be convened at the initiative of

the DOH and DILG, with representation from the LPP and ULAP prior to the commencement of the annual planning calendar and cycle at the provincial/city levels.

12. The meetings of the National Health Planning Committee shall be held during the period of the budget call of the DBM in order to assure inclusion in the preparation of the annual General Appropriations Bill (GAB) Budget of DOH, beginning CY 2000 and every succeeding fiscal year, to adequately meet the funding requirements for the proper implementation of the consolidated National and Local Health Plans.

    The National Health Planning Committee shall formulate the annual planning guides that shall serve as the unifying principles for ensuring that there will be functional merger of the annual priority programs and projects of the national and local governments that shall be carried out at the provinces with their component cities and municipalities.

    Annexed hereto are the mechanisms of partnership among the DOH, DILG, and LGUs (ANNEX A), which shall be used as the terms of reference for annual health planning and budgeting activities as agreed upon during the Governors' Workshop on Health. This annual planning and budgeting event shall be held at least six months prior to the budget call issued by the DBM.

13. It is clearly understood that continuing consultations on and periodic evaluations of the various aspects and implications of the inter-governmental relationships and undertakings between the LGUs and the NGAs, through the auspices of the DOH and DILG, and among LGUs shall be held in order to thresh out problems that may arise, challenges that need to be overcome and opportunities that may have to be pursued.

WE, THE INSTITUTIONAL PARTICIPANTS AND STAKHOLDERS OF THIS GOVERNORS' WORKSHOP FOR HEALTH, HEREBY ADOPT THIS HEALTH COVENANT '99 AND THROUGH OUT AUTHORIZED OFFICERS AFFIX OUR RESPECTIVE SIGNATURES TO THIS *"GOVERNORS*

WORKSHOP ON HEALTH: PARTNERSHIP FOR DEVOLUTION" HELD ON MARCH 9-10, 1999 AT THE WESTIN PHILIPPINE PLAZA AND AGREE TO SUBMIT THIS COVENANT TO HIS EXCELLENCY, PRESIDENT JOSEPH EJERCITO ESTRADA, THE OVERSIGHT COMMITTEE FOR LOCAL GOVERNMENT, THE CHAIRMEN OF THE RESPECTIVE COMMITTEES ON HEALTH OF BOTH HOUSES OF CONGRESS, AND TO THE DEPARTMENT OF BUDGET AND MANAGEMENT.

APPROVED THIS 10TH DAY OF MARCH 1999 IN THE CITY OF PASAY.

ALBERTO G. ROMUALDEZ, JR., M.D.
Secretary
Department of Health

RONALDO V. PUNO
Undersecretary
Department of the Interior and Local Government

GOV. JOSE D. LINA, JR.
National President, League of Provinces of the Philippines
And President, Union of Local Authorities of the Philippines

Annex 3
Presidential Executive Order No. 205

MALACANANG
MANILA

BY THE PRESIDENT OF THE PHILIPPINES

EXECUTIVE ORDER NO. 205

PROVIDING FOR THE CREATION OF A NATIONAL HEALTH PLANNING COMMITTEE (NHPC) AND THE ESTABLISHMENT OF INTER-LOCAL HEALTH ZONES (ILHZs) THROUGHOUT THE COUNTRY, AND FOR OTHER PURPOSES

WHEREAS, the 1987 Constitution provides that the State shall promote and protect the general well being of the citizens;

WHEREAS, R. A. 7160, otherwise known as the 1991 Local Government Code mandated for the devolution of the delivery of the health services and facilities as one of the basic functions and responsibilities of all the local government units or LGUs at all levels;

WHEREAS, Sec 33 of R. A. 7160, further provides that LGUs may "group themselves, consolidate their efforts and services and resources for purpose commonly beneficial to them where they may, upon approval of the sanggunian concerned, ... xxx ... under such terms and conditions as may be agreed upon by the participating LGUs through a Memorandum of Agreement";

WHEREAS, through the initiative of the League of Provinces of Philippine (LPP), in coordination with the Department of Health (DOH) and the Department of Interior and Local Government (DILG), a "Health Covenant 99" was forged among the above-mentioned stakeholders and participants of the "Governors' workshop on Health: Partnership for Devolution", held last March 9-10, 1999 at Pasay City, with the main objective of achieving an integrated health care delivery system at the national and local levels by the year 2000 and thereafter;

WHEREAS, based on the Health Covenant, and as agreed upon by the participants of the said Workshop, foremost of the major recommendations, specified therein to meet the objectives set forth were as follows (1) the creation of 3 National Health Planning Committee (NHPC) to oversee and ensure adherence by all LGUs and concerned stakeholders to appropriate guiding principles and coordinated planning and implementation of a comprehensive and integrated National and Local Health Plans as well as priority programs and projects by all LGUs through their Local Health Board (LHB); (2) the establishment of "Inter-Local Health Zones" throughout the country through Inter-Local Government Cooperation defining their mechanisms, governing structures, powers and functions and funds and resources; and (3) the reactivation and strength-

ening by the LGUs of their respective Local Health Boards (LHBs).
NOW, THEREFORE, I, JOSEPH EJERCITO ESTRADA, President of the Republic of the Philippines, by virtue vested in me by the Constitution and the laws, do hereby order

Section 1, Declaration of Policy. It is the policy of the State that full integrated delivery and development of health care services throughout the country must be promoted, encouraged, and ensured, especially for the poor and marginalized sectors of society. Towards this end, the State shall provide for the participation and active involvement and collaboration of all Local Government Units (LGUs) together with the major stakeholders, particularly with the Department of Health (DOH) and the Department of Interior and Local Government (DILG) with the main objective of achieving an integrated health care delivery system at the national and local levels by the year 2000 and thereafter.

Section 2. Organization of the National Health Planning Committee (NHPC). The National Health Planning Committee, herein referred to as NHPC, is hereby constituted to serve as the overall coordinating body to oversee and ensure adherence by all LGUs and concerned stakeholders to appropriate guiding principles and coordinated planning and implementation of a comprehensive and integrated National and Local Health Plans and priority programs and projects by all LGUs through their Local Health Boards (LHBs).

Section 3. NHPC Composition. Within one (1) month after the approval of this Executive Order, the NHPC shall be convened and composed of the following:

1. Secretary of the DOH	-	Chairman
2. Secretary of DILG	-	Co-Chairman
3. National President of the League of Provinces	-	Vice-Chairman
4. Executive Secretary	-	Ex-Officio Member
5. Chairman of Senate Committee on Health	-	Ex-Officio Member
6. Chairman of House Committee on Health	-	Ex-Officio Member
7. Secretary of the DBM	-	Member
8. Two (2) representatives from the private sector	-	Member

A Secretariat shall be organized to provide support to the NHPC. The DOH Secretary shall designate his Undersecretary to act as head of the NHPC Secretariat. The members of the Secretariat shall be composed of the following: Official representatives from the DOH, DILG, Union of Local Authorities of the Philippines, (ULAP), League of Cities, League of Municipalities, and Liga ng mga Barangay.

Section 4. NHPC Functions. Aside from the main responsibilities of the NHPC mentioned under Section 2 hereof, it is likewise expected to perform the following specific functions.

1. Ensure and sustain the agreements reached during the Governors' Workshop for Health" held last March 9-10, 1999, especially the recommendations specified under the "Health Covenant 99", as well as in the workshop outputs which are both made an integral part of this Executive Order.

2. Promote policies, programs and projects on health to enhance local autonomy in planning and implementing an integrated health care delivery system and an integrated health plan at the national and local levels;

3. Formulate a partnership mechanism among all the LGUs, concerned National Government Agencies (NGAs), through the DOH and DILG, and the private sector, NGOs and civic groups to support the local health service delivery systems;

4. Ensure that all LGUs shall prioritize the reactivation and strengthening of the LHBs as an initial move in making decentralized health services work;

5. Recommend specific and adequate resources both in cash and in kind to be allotted to the LGUs by the concerned NGAs (i.e. DOH and DILG) to enhance local government capability, responsibility and accountability relative to the delivery of basic health services prior to the commencement of the annual planning calendar and budget cycle at the national, provincial and city levels, subject to the guidelines and criteria to be formulated by the NHPC in consultation with the LGUs, through the LPP and ULAP, and to ensure its inclusion in the preparation of the Annual General Appropriation Act (GAA) budget of DOH and DILG beginning CY 2000 and every succeeding fiscal year for proper implementation of the consolidated National and Local Health Plans;

6. Act as the over-all coordinating body for all local health boards (LHB) and ensure the organization and/or reactivation of all LHBs at every local government level as well as their active involvement in the policy formulation and program planning and implementation of health services;

7. Formulate the annual planning guides, standards and format that shall serve as the integrating principles for ensuring that there will be functional merger of the annual priority health programs and projects of the national and local governments that shall be carried out at the provinces with their component cities and municipalities and highly urbanized cities (HUCs). These Provincial/ HUC Health Plans shall be submitted to the NHPC, copy furnished the Office of the President not later than forty-five (45) days after the signing of this Order;

8. Recommend to the President an initiative scheme package for outstanding LGUs with the best local health plan implemented at their respective LGUs, including a health insurance scheme particularly to the 100 poorest families in every province and city;

9. Submit a semi-annual and year-end report to the Office of the President, and;

10. Perform other functions that may be designated by the President or/and may be deemed necessary by the NHPC Chairman.

Section 5. Establishment of the Inter-Local Health Zones. For the effective delivery of integrated health care and ensure smooth coordination between and among cities, municipalities and barangays, and pursuant to Section 33 of RA 7160, there are, hereby established Inter-Local Health Zones (ILHZ) throughout the country whose organization is to be assisted by the DOH and DILG. These Inter-Local Health Zones comprise a well-defined population (by level of government in a rural or urban area, and all institutions and sectors whose activities contribute to improved health care delivery in that zone. The composition functions and required resources of these ILHZs shall be approved by the NHPC upon endorsement by the Provincial Governor or City Mayor.

Section 6. Integrated Provincial/City Health Plan. In accordance with the guidelines promulgated by the NHPC, every municipality, component city and highly urbanized city through their respective local health boards must develop their own health plan which shall be integrated into an Inter-Zonal Health Plan incorporating two (2) levels of health stations, with catchment populations. These Inter-Zonal Health Plans shall be aggregated into a Provincial/ City Health Plan taking into account the actual needs and available resources of their LGUs in relation to the national health objectives. All Provincial/City Health Plans shall be submitted to the NHPC on the date prescribed by the committee.

Section 7. Funding. All Governors, City and Municipal Mayors, through their respective Sanggunians, shall provide specific budgetary appropriations under their approved local development plan for the proper implementation of their respective health plans. As a counterpart support from the National Government, the DOH and other concerned NGAs shall likewise allocate and devolve funds to augment local funds intended for this purpose, as provided for under Article 31 of the IRR of R. A. 7160, subject to the guidelines and criteria to be set by operations of the NHPC of the NHPC Secretariat beginning CY 1999 and thereafter.

Section 8. Inter-Agency Coordination. All concerned Departments and other attached agencies, LGUs, GOCCs, and other instrumentalities of the government are hereby directed to cooperate and give their full support to the NHPC, ILHZS and LHBs to ensure the effective performance of their functions.

Section 9. Effectivity. This Order shall take effect immediately.

DONE in the city of Manila, this 31st day of January 2000.

(SGD) JOSEPH EJERCITO ESTRADA

Annex 4
Provincial Executive Order No. 13

CREATING THE CAPIZ INTEGRATED HEALTH SERVICES COUNCIL, COORDINATING COMMITTEE, TECHNICAL COMMITTEE AND FIELD MONITORING COMMITTEE UNDER THE CAPIZ INTEGRATED HEALTH SERVICES DEVELOPMENT PROGRAM

WHEREAS, the Province of Capiz in line with its priority agenda for the improvement of health services and facilities launched the Capiz Integrated Health Services Development Program;

WHEREAS, a Memorandum of Agreement was signed between participating agencies for the implementation of this Program;

WHEREAS, there is necessity for the issuance of an executive order for the operationalization of the said Program in the Province of Capiz.

NOW THEREFORE, I, VICENTE B. BERMEJO, Governor of the Province of Capiz, by virtue of the powers vested in me by law and consonant with the Memorandum of Agreement entered into by participating agencies, NGOs and the Province of Capiz on March 11, 2000, create the Capiz Integrated Health Services Council, Coordinating Committee, Technical Committee and Field Monitoring Committee under the Capiz Integrated Health Services Development Program.

Section 1. ***The Program and its Objectives.*** The Capiz Integrated Health Services Development Program has the following objectives:

- To establish areas for convergence of health services and cooperation among the stakeholders in the health sector through integration of all health care programs for a more efficient, effective and comprehensive health care delivery system;
- To organize local health zones involving the hospitals, the local government units and the private sector with each local health zones working together to address specific problems within their zones with the Capiz Integrated Health Services Council acting as umbrella organization to coordinate policies, mobilize resources and synchronize project implementation;
- To institutionalize a rational and efficient referral system between the different levels of health care providers;

- To promote setting up of alternative community-based health financing mechanisms in order to provide health insurance coverage for the majority of the Capicenos;

To upgrade hospital services and facilities to cater to the needs of more affluent patients thereby increasing revenues to subsidize indigent patients

Section 2. ***The Capiz Integrated Health Services Council.*** The Capiz Integrated Health Services Council shall be composed of the following:

1. Governor	Vicente B. Bermejo	Chairman
2. Congressman 1st District	Mar Roxas	Member
3. Congressman 2nd District	Vicente Andaya	Member
4. Vice Governor	Victor Tanco	Member
5. City Mayor	Antonio del Rosario	Member
6. Board Member (Chair Health)	Antonio Arciga	Member
7. SP Member (Chair Health)	Geronimo Arcenas	Member
8. LMP- Capiz President	Felipe Barredo	Member
9. Department of Health	Dir. Lydia D. Ramos or rep	Member
10. NGO- Capiz Medical Society President	Dr. Cesar Yap	Member
11. NGO- Capiz Blood Council	Dr. Charlie Robles	Member
12. NGO- GRF Dinggoy Roxas Health Program	Judy Roxas	Member
13. NGO- Community Barangay Health Worker	Salvacion Baria	Member
14. Civic Club – Rotary Metro Roxas	Angelo Hidrosollo	Member
15. Chairmen of Five Zone Management Board	Mayors	Members

Section 3. ***Functions and Responsibilities of the Council.*** The Council shall have the following functions and responsibilities.

1. Formulate health-related policies, mobilize resources, synchronize and monitor the implementation of programs and projects. Specifically, it shall draft guidelines and monitor the activities of the local health zones, the referral system, the policy on cost-recovery scheme and initiate a community-based health insurance system. It shall also insure the efficient and effective implementation of other health programs and projects for each of the local health zones.

2. Provide venue to evolve mechanisms for inter-LGU, inter-agency and multisectoral collaboration on health-related initiatives within the respec-

tive local health zones respecting the autonomy of each of the collaborating entities.

Section 4. ***The Coordinating Committee.*** The Coordinating Committee membership shall be composed of the Chairman of the Technical and Field Operations and Monitoring Committees. Additional members from the Provincial Government, City Health Office, NGOs and DOH shall be appointed by the Council.

Section 5. ***Functions and Responsibilities of the Coordinating Committee.*** The Coordinating Committee shall assist the Council in conceptualizing programs, enforcing policies and allocating resources.

Section 6. ***The Technical Committee.*** The Membership shall be appointed by the Council.

Section 7. ***Functions and Responsibilities of the Technical Committee.*** The Technical Committee that shall design and review processes and conducts program evaluation.

Section 8. ***The Field Operations and Monitoring Committee.*** The membership of the Field Operations and Monitoring Committee shall be appointed by the Council.

Section 9. ***Functions and Responsibilities of the Field Operations and Monitoring Committee.*** The Field Operations and Monitoring Committee shall gather feedback, conduct researches and survey, prepare process documentation and keep a database of health related information.

Section 10. ***The Zone Management Boards.*** The following shall be the composition of each of the five (5) Zone Management Boards:

ZONE MANAGEMENT BOARD – I (Roxas City, Panay, Ivisan, Panit-an)

- Mayors of Roxas City, Panay, Ivisan and Panitan
- 3 Rural Health Physicians
- 1 City Health Officer
- 1 Chief of Hospital
- 4 Private Sector

ZONE MANAGEMENT BOARD – II (Pilar, Pres. Roxas, Pontevedra, Maayon)

- Mayors of Pilar, Pres. Roxas, Pontevedra and Maayon
- 4 Rural Health Physicians

- 2 Chiefs of Hospital
- 4 Private Sector

ZONE MANAGEMENT BOARD – III (Dao, Dumarao, Cuartero)

- Mayors of Dao, Dumarao and Cuartero
- 3 Rural Health Physicians
- 2 Chiefs of Hospital
- 3 Private Sector

ZONE MANAGEMENT BOARD – IV (Mambusao, Jamindan, Sigma, Sapian)

- Mayors of Mambusao, Jamindan, Sigma and Sapian
- 4 Rural Health Physicians
- 2 Chiefs of Hospital
- 4 Private Sector

ZONE MANAGEMENT BOARD – V (Tapaz, Dumalag)

- Mayors of Tapaz and Dumalag
- 2 Rural Health physicians
- 1 Chief of Hospital
- 2 Private Sector

The mayor of the municipality where the District Hospital of the Province is located shall automatically be the chairman of the Zone Management Board in their respective local health zone.

Section 11. ***Functions and Responsibilities of the Zone Management Board.*** The following are the functions and responsibilities of the Zone Management Board.

1. Periodically meet to share experiences and discuss programs and policies for adoption and implementation in their respective health zones.

2. Recommend to the Council, policies and programs they deemed appropriate for their local health zone.

3. Mobilize and manage local resources as counterpart to the external resources that will be provided by the Council. Programs and projects adopted by the Zone Management shall then be implemented by their respective Zone Action Teams.

Section 12. ***Meetings.*** The regular meeting of the Council shall be once every quarter, at its principal office, or any other venue which will be determined by the Chairman. Special and Emergency meetings shall be called by the Chairman as need arises.

The regular meeting of the Zone Management Board shall also be once every quarter and shall follow the same procedures of the Council, except for exercising the power to amend the Memorandum of Agreement.

The Coordinating, Technical and Field Operations and Monitoring Committees shall meet once every month and/or as need arises.

Section 15. ***Effectivity.*** This shall take effect immediately.

Done in the City of Roxas on August 14, 2000.

VICENTE B. BERMEJO
Governor

Annex 5
Provincial Administrative Order No. 99

Republic of the Philippines
Province of South Cotabato
OFFICE OF THE PROVINCIAL GOVERNOR
Koronadal, South Cotabato

ADMINISTRATIVE ORDER NO. 99
Series of 1999

ESTABLISHING THE LOCAL AREA HEALTH DEVELOPMENT ZONES AND HEALTH BOARDS IN THE PROVINCE OF SOUTH COTABATO AND LIWISE DESIGNATING THE CHAIRPERSONS AND COORDINATORS OF EACH LOCAL AREA HEALTH DEVELOPMENT ZONE FOR ITS IMPLEMENTATION

WHEREAS, the Province of South Cotabato aims to improve the efficiency and effectiveness of the health care delivery system through the Integrated Health System;

WHEREAS, the honorable members of the Sangguniang Panlalawigan of South Cotabato have passed and approved Resolution No. 67 Series of 1999, endorsing the adoption and full implementation of the proposed Integrated Health System and the establishment of the five (5) Local Area Health Development Zones (LAHDZ);

WHEREAS, the establishment of these Local Area Health Development Zones will re-establish the linkages and cooperation between the Provincial Government and municipalities and NGOs which has been greatly affected by devolution;

WHEREAS, the foregoing premises considered, the Provincial Government of South Cotabato, desires to establish the five (5) LAHDZ) and likewise designating the Chairpersons and Coordinators for each area to hasten its implementation.

NOW, THEREFORE, I, HILARIO L. DE PEDRO III, Governor of

the Province of South Cotabato, by virtue of the powers vested in me by law, do hereby order:

1. There is hereby established five (5) Local Area Health Development Zones (LAHDZ) under the proposed Integrated Health System and likewise designating the Chairpersons and Coordinators in these areas:

LADHZ No. 1 – LAKE SEBU AREA

Chairperson -	Hon. Eduardo Biadoma Member – SP Committee on Health
Coordinator -	Dr. Mila Quinton Medical Officer V Lake Sebu Hospital

Functions of An Area Health Board

Functions of individual Area Health Boards would be determined by its members. The following functions are presented as a guide.

1. *Oversee development and maintenance of an integrated health management information system for each area.*
2. *Endorse an integrated area health plan to the Expanded Provincial Health Development Board (see below)*
3. *Determine additional funding requirements for area health plans, identify funding sources and advocate for funding.*
4. *Advocate for SB approval of individual municipal health budgets.*
5. *Undertake joint IIRMD planning as appropriate within the area.*
6. *Define, monitor and evaluate implementation of an integrated health referral system for the area.*
7. *Monitor and evaluate public health and hospital services within the area.*
8. *Develop and monitor implementation of area health policies.*
9. *Serve as a technical and advisory committee to individual Sanggunian and health officers of component municipalities.*
10. *Act as the advisory board of the core referral hospital.*
11. *Develop a disaster response team for the area.*

Health and health-related policies that could be developed for each area include:

- Integrated health management information system
- Integrated health planning
- Health care financing (e. g. agreed user-charges for government health facilities and services; cost-sharing mechanisms for core referral hospital; social health insurance schemes)
- Personnel relief and exchange between public health and hospital staff (e. g. MHO/physician; public health nurse/hospital nurse, rehab workers)
- Orientation of new health staff (this could include the private sector as appropriate)
- Agreed two-way health referral system for the area (public and private)
- Private sector access to the government hospital facilities and services
- Quality assurance of health services
- Integrated collective procurement system
- Management of community grievances and complaints against health services.

LADHZ No. II – NORALA AND STO. NINO AREA

Chairperson -	Hon. Antonio Damandaman SP Member – Committee on Health
Coordinator -	Dr. Conrado Brana Chief of Hospital Norala Hospital

LADHZ No. III - SURALLAH, BANGA AND T'BOLI AREA

Chairperson -	Hon. Nenita Jarabelo Vice Chairperson – SP Committee on Health
Coordinator -	Dr. Rolando Arrojo Municipal Health Officer Municipality of Surallah

LADHZ IV – KORONADAL, TAMPAKAN AND TANTANGAN AREA

Chairperson -	Hon. Eduardo Siason Chairperson – SP Committee on Health
Coordinator -	Dr. Edgardo Sandig Provincial Health Officer

LADHZ V – POLOMOLOK AND TUPI AREA

Chairpersons -	Hon. Jose Madanguit and Hon. Eduardo Pescadero Members – SP Committee on Health
Coordinator -	Dr. Rogelio Aturdido Medical Officer V Polomolok Hospital

2. This order shall take effect immediately.

Done at Koronadal, South Cotabato this 1st day of June in the Year of Our Lord Nineteen Hundred and Ninety Nine.

(SGD) HILARIO L. DE PEDRO III
Provincial Governor

Annex 6
Provincial Health Board Resolution

Republic of the Philippines
Negros Oriental Provincial Hospital
Health Board
Dumaguete City

EXCERPTS FROM THE MINUTES OF THE MEETING OF THE NEGROS ORIENTAL PROVINCIAL HEALTH BOARD DATED DECEMBER 14, 1999 AT THE OFFICE OF THE PROVINCIAL HEALTH OFFICER.

Provincial Health Board Resolution No. 5, S. 1999

Whereas, health is everybody's concern and the most effective way of achieving health goal is to build partnership among the various stakeholders for no one can ensure better health in solitude.

Whereas, the framework for political decentralization had little regard for the technical elements crucial to the proper functioning of basic health services.

Whereas, DOH sees the District Health Development as a major initiative of LGUs across the country in the new century.

Whereas, the development of health district by LGUs is allowed for in the Local Government Code of 1991, Section 33, and inter LGU cooperation supported by Article X, Section 13 of the 1987 Constitution which states that " Local Government may group themselves, consolidate or coordinate their efforts, services and resources for purpose commonly beneficial to them in accordance with the law".

Whereas, the Objective of the Inter LGU Health System is to ensure and strengthen collaborative linkages between LGUs/NGOs through the generation, mobilization and allocation of essential resources for sustainable hospital and field health services for the attainment of "Health in the Hands of the People" by the year 2020;

Whereas, inter LGU cooperation is mutually beneficial, consensual or contractual in nature and the local autonomy of the contracting local governments are not legally reduced nor expanded.

Whereas, the resultant consolidation is not a new political subdivision which would have the same powers and features of local government but rather focus on health programs and projects addressing health related issues and concern.

Whereas, a typical district could involve three to five municipalities which contains a district hospital, a number of rural units, barangay health stations and other services deciding to work together as an integrated health system.

Whereas, the common approach in the organization and management is the formation of an inter-LGU District Health Board composing of the representatives from participating municipalities, health services and other organizations.

"NOW THEREFORE, on motion by Dr. Mary Angeles Pinero, duly seconded by Hon. Bienvenido Yap and approved by all members present, the Provincial Health Board, hereby resolves, to recommend to the Sangguniang Panlalawigan of Negros Oriental, through the Provincial Governor, Hon. George P. Arnaiz, the development of six District Health System province wide and the formation of a corresponding inter LGU District Health Board.

Attested:

HON. GEORGE P. ARNAIZ
Chairman, Provincial Health Board

(SGD.) FILEMON B. FLORES, MD, MHA
Vice Chairman, Provincial Health Board

(Sgd.) Hon. Bienvenido F. Yap

(Sgd.) Ely Villapando, MD

(Sgd.) Mary Angeles P. Pinero, MD, MPH

(Sgd.) Marichi c. Bolangaita,MD, MPH

(Sgd.) Msgr. Merlin Logronio

(Sgd.) Jocelyn C. Cadimas,RN, MPH

Members:

Annex 7
Sangguniang Panlalawigan Resolution

SP Resolution No. 678, Series of 2000
(Authorizing the Governor to enter into a MOA for the Sta. Bayabas Inter-LGU Health System)

S. 2000

Res. No. 678

Republic of the Philippines
Province of Negros Oriental
OFFICE OF THE SANGGUNIANG PANLALAWIGAN
Dumaguete City

EXCERPT FROM THE JOURNAL OF THE SANGGUNIANG PANLALAWIGAN

Date: October 27, 2000 – 3:07 P.M. Classification: _____

RECORD OF ATTENDANCE:
Hon. Edgar Y. Teves
Vice-Governor and Presiding Officer
Present

Hon. Melimore C. Saycon	- Present	Hon. Bienvenido F. Yap, Sr.	- Present
Hon. Jose A. Baldado	- Present	Hon. Orlando V. Remollo	- Absent
Hon. Serafin R. Albito	- Present	Hon. Rutillo A. Cabusog	- Present
Hon. Edmund T. Nalam	- Present	Hon. Rolando O. Gaga-A (LNMB)	- Present
Hon. Lorenzo C. Dy	- Present	Hon. Juan Miguel G. Romero (SK)	- Present
Hon. Saleto J. Erames	- Absent	Hon Napoleon E. Villegas, Jr. (PCL)	- Absent

RESOLUTION NO. 678

"In the interest of public service,

"On motion of Honorable Member Yap, seconded by Honorable Member Cabusog, the Sangguniang Panlalawigan

"RESOLVES, To authorize Honorable Governor George P. Arnaiz to enter into and sign for and in behalf of the Province of Negros Oriental the Memorandum of Agreement with the Municipalities of Sta. Catalina, Bayawan and Basay (Sta. Bayabas) represented by the respective Municipal Mayors, the Department of Health represented by the Regional Director, the Provincial Health Office represented by the Provincial Health Officer, the Bayawan District Hospital represented by the Chief of Hospital, and the St. Goretti Foundation, Inc. represented by the President, in connection with the

collaborative linkages between LGUs/NGOs/DOH/POs/Private Sectors through the generation, mobilization and allocation of essential resources for sustainable hospital and public health services for the attainment of "Health in the Hands of the People" by the Year 2020.

"Approved."

I hereby certify to the correctness of the above-quoted resolution.

GEOFFREY P. VILLAHERMOSA
Board Secretary

EDGAR Y. TEVES
Vice-Governor of Negros Oriental
Presiding Officer

Annex 8
Sangguniang Bayan Resolution

SB Resolution No. 274, Series of 2000
Municipal Government of Bayawan
(Authorizing the Mayor to enter into a MOA for the Sta. Bayabas Inter-LGU Health System)

Republic of the Philippines
PROVINCE OF NEGROS ORIENTAL
MUNICIPALITY OF BAYAWAN
Office of the Municipal Council

EXCERPTS FROM THE MINUTES OF THE REGULAR SESSION HELD BY THE MUNICIPAL COUNCIL OF BAYAWAN, NEGROS ORIENTAL ON JUNE 20, 2000 AT 10:00 A.M. AT THE SESSION HALL.

Present:

Hon. German P. Sarana, Jr.	Vice-Mayor, Presiding
Hon. Rene R. Gaudiel	Councilor
Hon. Joselito C. Bito-on	-do-
Hon. Peter Paul F. Renacia	-do-
Hon. Rowena T. Cabanban	-do-
Hon. Antonio B. Villamil	-do-
Hon. Eustaquia T. Elnar	-do-
Hon. Guillermo A. Dino	-do-
Hon. Samuel T. Quindo	-do-
Hon. Hearty N. Soldevilla	Executive Vice-President, Liga ng mga Barangay
Hon. Fred Ian T. Trayvilla	SK Federation President

Absent: None

RESOLUTION NO. 274

"WHEREAS, on November 29, 1999, the Local Government Units of Sta. Catalina, Bayawan and Basay together with the provincial government in a General Assembly, formally launched the Inter Local Health Zone. (District Health System and the PESO FOR HEALTH PROGRAM).

"WHEREAS, the Inter Local Health Zone had an acronym of STA. BAYABAS Health

System representing STA. – Sta. Catalina, BAYA – Bayawan, BAS – Basay.

"WHEREAS, it was pledged that good, harmonious, better cooperation and support among the involved and committed Local Government Units was the primary feature of the Health Covenant 99 towards sustainable health service for all constituents.

"WHEREFORE, on motion of Honorable Councilor Renacia and jointly seconded by Honorable Councilor Quindo and Honorable Councilor Elnar, the Council

"RESOLVED, to adopt as it hereby adopts the principles and objectives as well as confirm the signature affixed in the Health Covenant 99 Declaration, held on November 29, 1999 at Bayawan Auditorium, Bayawan, Negros Oriental, Philippines.

"RESOLVED FURTHER, To authorize, as it hereby authorizes the Municipal Mayor, Honorable Ernesto T. Tijing to enter into a memorandum of agreement with the concerned LGUs and the Province of Negros Oriental which Memorandum of Agreement shall later on be approved and ratified by the perspective Sanggunian.

"Adopted."

I hereby certify to the correctness of the foregoing resolution.

Attested:

German P. Sarana
Vice-Mayor
Presiding

Approved: _____
(Date)

Ernesto T. Tijing
Mayor

Copy for:
The Honorable Mayor Ernesto T. Tijing, this municipality

CC:
The Honorable Provincial Board, Dumaguete City

Annex 9
Memorandum of Agreement

MEMORANDUM OF AGREEMENT

FOR

INTER LOCAL HEALTH ZONE

(BINDOY, AYUNGON, TAYASAN)
NEGROS ORIENTAL, PHILIPPINES

LIST OF ACRONYMS

ABC	Association of Barangay Captains
ABHP	Area-Based Health Plan
BDH	Bindoy District Hospital
BHS	Barangay Health Station
BHW	Barangay Health Worker
BPHCC	Barangay Primary Health Care Committee
BNS	Barangay Nutrition Scholar
CA	Catchment Area
CHCA	Comprehensive Health Care Agreement
COA	Commission on Audit
COH	Chief of Hospital
CPH	Community Primary Hospital
DOH	Department of Health
DOH-CHD-VII	Department of Health Center for Health Development VII
DHO	District Health Office
DHB	District Health Board
EDF	Economic Development Fund
FHW	Family Health Worker
HESF	Human Ecology Safety Fund
HRDP	Human Resource Development Program
HRMD	Human Resource Management and Development
IRA	Income Revenue Allocation
ILHZ	Inter Local Health Zone
LGC	Local Government Code
MCPHW	Magna Carta of Public Health Workers
MHO	Municipal Health Officer
MOA	Memorandum of Agreement
MOOE	Maintenance and Other Operating Expenses
MSH	Management Sciences of Health
MSW	Medical Social Worker
NGO	Non Government Organization
NHI	National Health Insurance
P-LGU	Provincial Local Government Unit
PHC	Primary Health Care
PHN	Public Health Nurse
PO	People's Organization
QAP	Quality Assurance Program
RFO VII	Regional Field Office VII
RHM	Rural Health Midwife
RHU	Rural Health Unit
SP	Sangguniang Panlalawigan
SB	Sangguniang Bayan
TMC	Technical Management Committee
WFP	Work and Financial Plan

MEMORANDUM OF AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This agreement entered into and executed by and between:

The **PROVINCIAL GOVERNMENT of NEGROS ORIENTAL**, a Local Government Unit established and existing under the laws and regulations of the Republic of the Philippines, with office address at Dumaguete City, Capitol Compound, represented herein by **HON. GEORGE P. ARNAIZ**, Provincial Governor, and hereinafter referred to as the PROVINCIAL LGU;

-And-

The **MUNICIPAL GOVERNMENT of AYUNGON**, a Local Government Unit established and existing under the laws and regulations of the Republic of the Philippines, with office address at Ayungon, Negros Oriental, represented herein by the Mayor, **HON. EDSEL ENARDECIDO** hereinafter referred to as the "MUNICIPAL LGU" of Ayungon, Negros Oriental;

-And-

The **MUNICIPAL GOVERNMENT of BINDOY**, a Local Government Unit established and existing under the laws and regulations of the Republic of the Philippines, with office address at Bindoy, Negros Oriental, represented herein by the Mayor, **HON. VALENTE YAP** hereinafter referred to as the "MUNICIPAL LGU" of Bindoy, Negros Oriental;

-And-

The **MUNICIPAL GOVERNMENT of TAYASAN**, a Local Government Unit established and existing under the laws and regulations of the Republic of the Philippines, with office address at Tayasan, Negros Oriental, represented herein by the Mayor, **HON. GEORGITA MARTINEZ** hereinafter referred to as the "MUNICIPAL LGU" of Tayasan, Negros Oriental;

-And-

The **DEPARTMENT OF HEALTH (DOH)**, a government agency created and existing under the laws of the Republic of the Philippines with principal office address at San Lazaro Compound, Sta. Cruz, Manila herein represented by **DR. DAVID JOAQUIN LOZADA, JR., MPA, CESO IV** in his capacity as the Director of the DOH Center for Health Development VII, and herein referred to as the "DOH";

-And-

The **PROVINCIAL HEALTH OFFICE**, a government office, under the provincial LGU, established and existing under the laws and regulations of the Republic of the Philippines, with office address at National Highway, Piapi, Dumaguete City and represented herein by **DR. FILEMON B. FLORES**, Provincial Health Officer II, and herein referred to as the "PHO";

WITNESSETH THAT:

WHEREAS, the Mayor of Bindoy, by virtue of the Sangguniang Bayan Resolution No. ___ series of 2000, is given the authority to enter into a MOA with other LGUs (Provincial, Ayungon, Tayasan);

WHEREAS, the Mayor of Ayungon, by virtue of the Sangguniang Bayan Resolution No. ___ series of 2000, is given the authority to enter into a MOA with other LGUs (Provincial, Bindoy, Tayasan);

WHEREAS, the Mayor of Tayasan, by virtue of the Sangguniang Bayan Resolution No. ___ series of 2000, is given the authority to enter into a MOA with other LGUs (Provincial, Bindoy, Ayungon);

WHEREAS, the Governor of Negros Oriental, by virtue of the Sangguniang Panlalawigan Resolution No. ___ series of 2000, is given the authority to enter into a MOA with Municipalities of Bindoy, Ayungon, Tayasan;

WHEREAS, R.A. 7160 known as the 1991 Local Government Code mandated for the devolution of the delivery of the health services and facilities as one of the basic functions and responsibilities of all the Local Government Units or LGUs at all levels;

WHEREAS, all parties respect and acknowledge the principle of partnership and cooperation as inscribed in **Art. X, Section 13 of the Constitution**, which states: *"Local Governments may group themselves, consolidate or coordinate their efforts, services and resources for purposes commonly beneficial to them in accordance with the law"*; **Art. 61, Sec. 33 of the Local Government Code (LGC)** states: *"Local Government Units may through appropriate ordinances, group themselves, consolidate or coordinate their efforts, services and resources for purposes commonly beneficial to them"*;

WHEREAS, Executive Order 205 "Providing for the creation of a National Health Planning Community (NHPC) and the Establishment of Inter-Local Health Zones (ILHZs) throughout the country, and for other purposes", Sub-section 2 "The establishment of Inter-Local Health Zones throughout the country, through Inter-Local Government Cooperation defining their mechanisms, governing structures, powers and functions, funds and resources";

WHEREAS, a **"Health Covenant 99"** was forged among the stakeholders and participants of the "Governors' Workshop on Health: Partnership for Devolution", held last March 9-10, 1999 at Pasay City, with the main objective of achieving an integrated health care delivery system at the national and local levels by the year 2000 and thereafter;
WHEREAS, Resolution No. 5 Series of 1999, of the Negros Oriental Provincial Health Board, recommending the development of six (6) District Health Systems province wide and the formation of a corresponding Inter-Local Government Units (ILGU) District Health Board was duly approved on March 10, 2000 in a Sangguniang Panlalawigan Regular Session;

WHEREAS, all parties agree that the resultant consolidation would not be a new political subdi-

vision which will have the same power and features of local governments;

WHEREAS, DOH, PROVINCIAL, MUNICIPAL LGUs. PHO and the BDH have signified their willingness to cooperate and pool their human, technical, financial, material and other essential resources to implement the Inter LGU Health System of BINATA, consisting of the municipalities of Bindoy, Ayungon, Tayasan, in the Province of Negros Oriental'

WHEREAS, all parties agree to observe the guidelines for the management of the Inter LGU Health System, the Technical Management Committee shall produce other operating and implementing guidelines with the assistance of the Management Sciences for Health and other consultants as needed;

WHEREAS, the contracting members of the cooperating LGU shall agree amongst themselves the mechanism of management with regards to the amount and frequency of contributions to a common health fund;

WHEREAS, all parties agree in good faith, to have an effective and efficient Inter Local Health Zone consultation processes in keeping with the tenets of democracy;

WHEREAS, all parties respect the autonomy of the Local Government Units, in so far as their internal affairs are concerned;

WHEREAS, all parties commit themselves to respect these principles in order to create a favorable environment for community health development;

NOW, THEREFORE, for and in consideration of the foregoing premises and by way of formalizing and confirming their commitment, the parties hereby mutually agree to enter into agreement in accordance with the terms and conditions hereunder set forth.

I. OBJECTIVES OF THE INTER-LGU COOPERATION

1. The general objective of this cooperation is to ensure and strengthen collaborative linkages between LGUs/DOH/NGOs/POs/Private Sectors and other National Agencies through the generation, mobilization and allocation of essential resources for sustainable hospital and public health services for the attainment of "Health in the Hands of the People" by the year 2002.

2. In particular, the signing parties, through this cooperation, shall organize and implement by means of an Inter-Local Health Zone Board and an Inter-Local Health Zone Technical Management Committee, to wit:

    a) Assess health situation in the ILHZ and identify prevailing health problems that need to be addressed;

    b) Review in a participatory manner the management service output and extent of coordination provided by all BHS, Rural Health Units, Primary Community

Hospitals and Health District Hospital;

c) Assess existing manpower supply and capabilities to include BHW and Hilots and implement training activates that would upgrade technical and institutional capabilities;

d) Assess rehabilitation/construction of facilities and availability of basic equipment and supplies at all levels;

e) Review drug procurement system of essential drugs, as to price, quality and conformity to the National Drug Formulary of the Generics Law and the bulk procurement of the province;

f) Strengthen the continuity of health care service delivery by utilizing a functional two-way referral system;

g) Establish an Integrated District-Wide Health Information and Management System through Computerization Network and Community-Based Health Data Boards;

h) Prepare the development of a Health Zone Health Insurance Scheme with preference to the low-income population through the indigency component of the National Health Insurance and Community-Based Health Insurance Program;

i) Adopt and implement the "Sentrong Sigla" or "Center of Wellness" of the Department of Health focusing and working towards Improved Quality of Services;

j) Encourage partnership among Local Government Units and networking between line-agencies, the communities and Non-Government Organizations (NGOs) or People's Organizations working in the Inter-Local Health Zone.

II. ORGANIZATIONAL STRUCTURE AND MANAGEMENT PROCESSES

1. The Inter-Local Health Zone Board shall be the unifying and coordinating authority composed of a representative of each LGU/unit that contributes in the Health Zone operation: Provincial LGU, SP representative of the Health Zone, IPHO, Municipal LGU, ABC President, DOH representative, Health Insurance Organization, COH, MHO, NGO and PO representative of each municipality.

    a. The Inter-Local Health Zone Board shall have financial and policy making authority complementing to existing policies of cooperating LGUs. New Inter-Local Health Board policies shall be presented and approved by the Provincial Health Board and the Sangguniang Panlalawigan respectively.

2. Inter-Local Health Zone Technical Management Committee shall be composed of technical staff representing various categories of RHU and hospital personnel assisted by administrative staff designated by participating Provincial, Municipal LGU on a part time/full time basis. Other members can also be included like DOH representative, patient representative. DOH and MSH shall assist technically the ILHZ Technical Management Committee.

    a. The Inter-Local Health Zone Technical Management Committee initiates a participatory health needs assessment and integrated zonal planning for both hospital and Rural Health Units.

    b. They shall hold monthly management meetings, and shall be fully responsible in the operationalization of Inter Zonal activities based on the approved Integrated Health Work and Financial Plan.

    c. Minimum staff the TMC shall be composed of at least CHO, 2 Medical Officers (1 Hospital/1 RHU), 1 IPHO Technical Staff, 1 PHN, 1 RSI, 1 RHM, 1 Chief Nurse, 1 DOH representative, 3 MSW, 1 Pharmacist, 1 Med. Tech. Administrative Support Staff will include: 1 Records Clerk. 1 Administrative Clerk, 1 Statistical Aide, 1 Utility Worker. They shall be selected by the ILHZ Board basing on a set of criteria.

    d. Set the standards for the minimum package of health services at all levels (BHS, RHU, Primary Community Hospital and District Hospital) in conformity to National Health Policies.

    e. Plan a system of manpower pooling to ensure continuity of service in cases of leave of absence, retirement or deaths.

3. In relation to Municipal Health Boards. These boards shall maintain their functions and regular meetings to discuss their internal affairs but also to include zonal issues and proposals previously discussed by the Inter-Local Health Technical Management Committee for information and support from the respective LGU.

4. In relation to Provincial Health Board. The Provincial Health Board shall maintain its functions. The PHO and a Sangguniang Panlalawigan member who participate in the ILHZ shall present the District Work and Financial Plan to the Provincial Health Board once a year together with the ILHZ Board and TMC Chairs.

5. In relation to District Hospital Health Board. A channel of responsibility between:

    a. The District Hospital Health Board shall ensure quality care and services, to endorse the hospital budgetary requirements and to help the Governor with the financial management of the hospital.

    b. The District Hospital Health Board and TMC, shall as well ensure participation and

financial support of the participating catchment area LGUs and community in the hospital organization of services.

6. In relation to Inter District Hospital conference and the bi-annual Program Review led by the PHO. These conferences become progressively the Inter Zonal Conference, broadening the participating members from hospital staff to public health staff and other stakeholders, Issues and problems common to Inter-Local Health Zone shall be discussed.

   a. Policies, issues and concerns that cannot be solved locally and which therefore needs higher approval shall be brought to the Provincial Health Board for deliberation and shall be covered by Sangguniang Panlalawigan Resolution.

   b. The frequency and content of the meetings shall be defined in consultation with the other Inter-Local Health Zone.

Manpower: requirements, salaries and benefits

1. All administrative and technical personnel from participating LGUs shall receive their regular salaries from their respective unit or agency including the legal allowances;

2. The Municipal health Office Staff Personnel shall continue implementing the DOH Health Programs and activities covered in this Memorandum of Agreement;

   a. Said unit shall consist of at least the following personnel: **for each RHU**: 1 MD, 1 PHN, 1 RHM, 1 Medical Technologist, 1 Sanitary Inspector, 1 Dentist and 1 Utility Worker; **for each BHS**: 1 RHM, assisted by Barangay Health Workers and Family Health Workers. All the mandatory positions shall be filled up. Other personnel can be assigned upon justified request by the TMC in accordance with the District Health System standard;

   b. All Rural Health Unit personnel shall receive their regular salaries from their respective LGU including the legal allowances, with the objective to fully implement the *Magna Carta of Public Health Workers* benefits as mandated by law.

3. The Provincial government guarantees the presence of a minimum standard manpower complement for the Bindoy District Hospital providing a minimal but sufficient number of Medical, Nursing and Administrative personnel to ensure the functionality of the hospital;

   a. All District Hospital personnel shall receive their regular salaries from the Provincial Government including the legal allowances, with the objective to fully implement the *Magna Carta of Public Health Workers* benefits as mandated by law.

III. OBLIGATIONS AND RESPONSIBILITIES

Other Institutional roles and responsibilities

1. The Local Government Units, Municipal level with the assistance of its corresponding Local Health Board will be responsible for the following:

    a. Formulate and implement an Integrated Municipal Health Plan within the framework of the Provincial/District Health Plan and considering the local health situation, based on among others, analysis of collected relevant information;

    b. Implement programs and projects of the Integrated District Health Plan that are applicable to the Municipality;

    c. Implement the regulatory measures formulated at national and provincial level, and propose and implement whatever other needed regulatory measures for the municipality;

    d. Manage and finance the operation of the Municipal Health Office, including hospitals owned by them: construct, repair or renovate such facilities as necessary;

    e. Promote coordination among health-related sectors in activities for health promotion and protection at municipal level, including the private sector and non-government health organizations;

    f. Conduct research for more effective health care delivery.

1.1 The Local Government Units, Municipal level shall also assume the following roles and responsibilities:

    a. Accept as a goal the existence of one totally functioning RHU per 10,000 to 20,000 population and 1 BHS for every 3,000 to 5,000 population;

    b. Improve and maintain the road network to facilitate access/referral to/from the BHS, RHU and the District Hospital, and when necessary provide existing transport and communication facilities for medical and surgical emergencies;

    c. Provide financial and technical support to vital community volunteer health workers (BHW, BNS);

    d. Provide financial assistance to existing health programs/projects.

2. The Provincial Government will be responsible for the following:

a. Formulation and implementation of the provincial/district policies and plans within the framework of the national health policies and plans, and considering the provincial health situation;

b. Provide administrative and technical assistance to District Hospital and technical supervision, support and coordination to Inter-Local Health Zone;

c. Manage and finance the provincial/district and community hospitals to meet standards
for hospital licensing and accreditation requirements of PhilHealth;

d. Collection/consolidation and analysis of health information from the municipal and component city levels, and submission of required reports to the Department of Health;

e. Promote coordination among health-related sectors in activities for health promotion and protection at the provincial/district level, including the private sector and non-government health organizations;

f. Promote/conduct training and research for more effective health care delivery;

g. Provide financial assistance in Strengthening Inter-Local Health Zone Development;

h. Conduct semi-annual assessment of health program and hospital service output by Inter-Local Health Zones;

i. Reinforce through legislation the compliance to the standards and regulations of the Sanitation Code of the Philippines.

2.1 The Provincial Government through the Provincial Engineer's Office shall improve the geographical accessibility of the Zonal Health Facilities, improving the road conditions and eventually providing transport and communication facilities for medical and surgical emergencies;

2.2 Provide and assist the Municipalities with resources to fulfill their obligations in the health sectors and communities.

3. The DOH-Center for Health Development VII and its DOH representatives in the field shall be responsible for the following:

a. Management of specified tertiary medical care facilities and specialized health facili ties
intended to serve for proper referral system;

b. Technical supervision of local health services and coordination to Provincial/ Municipal Health Boards and Inter Local Health Zone Boards;

c. Extension to Local Government Units of technical, logistic and financial advisory support services;

d. Formulation and overseeing the implementation of health regulatory measures;

e. Collaborate with sectors concerned in the formulation and implementation of human resource policies and plans;

f. Mobilize sources of funds and technical cooperation for health development purposes, both internal and external;

g. Promote/conduct research for more effective health care delivery.

3.1 The DOH, directly or through its Center for Health Development VII and its DOH representatives in the field shall:

a. Be in constant dialogue and coordination with the Inter-Local Health Zone Technical Management Committee, play the lead role in the technical coordination of the health programs;

b. DOH-LGU Comprehensive Health Care Agreement (CHCA) shall be maintained. Participating LGUs shall prepare their individual Area-Based Health Plan (ABHP). Thereafter, this ABHP shall be consolidated at district level in order to present an Integrated Comprehensive Health Care Agreement (ICHCA) to the DOH Center for Health Development VII. Special attention should be given by the DOH to the timely delivery of vaccines and other supplies in adequate quantities for effective and efficient implementation of the LGU performance project;

c. Establish a Trust Fund for grants from DOH Central Office and other related agencies,
with specific guidelines, for community-based health development projects;

d. Assist the Local Government Units in its efforts to generate, mobilize and allocate resources, and likewise, find a sufficient number of qualified personnel for the Inter Local Health Zone;

e. Participate in the Local Government Units Training Needs Assessment, and make suggestions to the TMC meetings for the selection of health staff and personnel to be trained.

Management of LGU Common Health Funds

1. The Local Government Units shall commit themselves to support progressively their individual LGU Health Budget every year. The LGU shall also seek to increase the percentage of funds allocated for the MOOE. This effort shall be commensurate to the individual LGU financial situation and existing distribution patterns.

2. The Local Government Units shall establish a Common Heath which may include: individual LGU Appropriation to the Trust Fund, Drugs Revolving Fund, Health Insurance Fund, DOH Assistance to Local Government Unit Fund, Community Health Care Financing Fund, and other (Private Sectors) contributions.

    a. All funds shall be deposited as "Trust Funds" exclusively for the use of Bindoy Inter-Local Health Zone.

    b. The Inter-Local Health Zone "Trust Funds" must be disbursed based on the Inte grated Work and Financial Plan.

    c. These funds must be deposited under one collaborating LGU as agreed among participating LGUs.

    d. The Common Health Fund shall be managed by the Inter-Local Health Zone Technical Management Committee designed and established by the Inter-Local Health Zone Board members, upon presentation of the Inter-Local Health Zone Work and Financial Plan. However, the individual LGU appropriation shall be commensurate to the individual LGU financial capacity.

Accounting and Financial Monitoring/Evaluation

1. The Bindoy Inter-Local Health Zone through the Inter-Local Health Board and the TMC, shall maintain separate books of account to record all sources and disbursement of funds for the system.

2. The Bindoy Inter-Local Health Zone through the Inter-Local Health Board and the TMC, shall keep the financial records from the date of the signing of contract for auditing purposes.

3. The Bindoy Inter-Local Health Zone through the Inter-Local Health Boards and the TMC, shall make available all the financial records and at any time for monitoring and auditing purposes by legally authorized agency.

4. The TMC shall submit a financial statement including narrative report, the utilization of the revolving fund, every month commencing on the date of its implementation. The said reports shall be submitted to the LGU District Health Board and Provincial Health Board not later than 2 weeks after the end of each month.

Projects Monitoring/Evaluation

1. Baseline Data Gathering and other surveys especially dealing with the socio-economic profile should assess the achievement towards the goal and objectives of the Inter-LGU Health System.

2. St. Goretti Foundation shall conduct monitoring and periodic evaluation of the project which is independent to that of the Provincial Health Office and Department of Health activity.

3. The Supervisory and Monitoring functions of the PHO/DOH/St. Goretti Foundation, Inc. shall be maintained at all levels of the Inter-LGU Health Systems.

IV. AMENDMENTS AND EFFECTIVITY

1. The majority of parties hereto may, upon mutual agreement, amend, alter, or modify this Memorandum of Agreement by and through a written addendum duly signed and acknowledged by the parties.

2. This Memorandum of Agreement shall take effect upon signing of all parties and shall remain in full force and effect, unless sooner revoked or terminated by mutual agreement of parties.

IN WITNESS WHEREOF, of the parties have been hereto set their hands on this _____ day of _____, 2000 in Ayungon, Negros Oriental.

PROVINCIAL GOVERNMENT OF NEGROS ORIENTAL
By:

HON. GEORGE P. ARNAIZ
CESO IV
Provincial Governor

DEPARTMENT OF HEALTH
Center for Health Development VII
By:

DR. DAVID J. LOZADA, JR. MPA,
Director

MUNICIPALITY OF AYUNGON
By:

HON. EDSEL ENARDECIDO
Mayor

PROVINCIAL HEALTH OFFICE
By:

DR. FILEMON B. FLORES, MHA
Provincial Health Officer II

MUNICIPALITY OF BINDOY
By:

HON. VALENTE YAP
Mayor

MUNICIPALITY OF TAYASAN
By:

HON. GEORGITA MARTINEZ
Mayor

Signed in the presence of:

_____ _____

ACKNOWLEDGEMENT
Republic of the Philippines
Municipality of _____, S.S.
At the Municipality of Ayungon, _____, 2000 personally appeared:

HON. MAYOR EDSEL ENARDECIDO with Residence Certificate No. _____
Issued at _____ on _____, 2000.

HON. MAYOR VALENTE YAP with Residence Certificate No. _____
Issued at _____ on _____, 2000.

HON. MAYOR GEORGITA MARTINEZ with Residence Certificate No. _____
Issued at _____ on _____, 2000.

HON. GOV. GEORGE ARNAIZ with Residence Certificate No. _____

Issued at _____ on _____, 2000.

DR. DAVID JOAQUIN LOZADA, JR. MPA, CESO IV with Residence Certificate No. _____ Issued at _____ on _____, 2000.

DR. FILEMON B. FLORES, MHA with Residence Certificate No. _____
Issued at _____ on _____, 2000.

Known to me to be the same in person who executed the foregoing instrument of the Memorandum of Agreement, which consist of thirteen pages, including the page on which that acknowledgement is written and signed on every page by the parties executing this instrument and their witnesses and sealed with my notarial seal and said parties acknowledge to me that the same is their free acts and deeds.

Doc. No. _____
Page No. _____
Book No. _____
Series of _____

Annex 10
Agency Contact Information

- **Philippine Health Insurance Corporation (PHIC)**
  Accreditation Department
  12th Floor, City State Centre Bldg., 709 Shaw Blvd.
  Oranbo, 1600 Pasig City
  Tel No. (632) 637-6265; (632) 637-9999 loc 1215, 1216
  Telefax (632) 637-2527
  E-mail: Accre@philhealth.gov.ph

- **Philippine International Trading Corporation (PITC)**
  Philippines International Center
  46 Sen. Gil J. Puyat Avenue
  1200 Makati City, Metro Manila
  Tel Nos. (632) 845-4776; 845-4376 loc 303
  Fax Nos. (632) 845-4473; 845-4476, 845-4363
  E-mail: pitc@info.com.ph; pitcccin@info.com.ph

- **Sentrong Sigla Movement**
  1st Floor, Bldg 3, Department of Health Central Office
  San Lazaro Cpd, Rizal Avenue, Sta.Cruz, 1003 Manila
  Tel No. (632) 743-8301 loc 1308, 1309
  Telefax (632) 711-6285; 7818977

- **Management Sciences for Health**
  Room 502, Ma. Natividad Building
  470 T.M. Kalaw St., corner Cortada St.
  1000 Ermita, Manila, Philippines
  Tel. No. (632) 400-2914; 400-2894
  Fax No. (632) 522-6243
  E-mail: localhlth@msh-hsrtap.com.ph

REFERENCES

PREVIOUS PAGE BLANK

The Arayat Unified Local Health System in Pampanga, 2001, Management Sciences for Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

The Baliuag Unified Local Health System in Bulacan, 2001, Management Sciences for Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

Community-Based Monitoring and Information System: A User's Manual, 2001, Management Sciences of Health – Integrated Family Planning and Maternal Health Program (IFPMHP), Manila.

Comparative Analysis of Five Inter-Local Health Zones: Current Practices, Policy and Program Directions, 2001, Management Sciences for Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

Convergence Orientation and Planning Workshop, 19 September 2001, Cebu Plaza Hotel, Cebu City, Philippine Health Insurance Corporation and Department of Health, Philippines.

Establishing the Inter-Local Health System in South Cotabato, Integrated Community Health Services Project (AusAID Assisted), 2000, Department of Health.

Health Referral System Manual, Province of South Cotabato, Philippines, 2001, Integrated Provincial Health Office, South Cotabato, Philippines.

Health Sector Reform Agenda, Philippines (1999-2004), Monograph Series No. 2, 1999, Department of Health, Manila, Philippines.

The Integrated Health Planning System (IHPS) Manual, (no date) Department of Health, Manila, Philippines.

King, TL, Drug Management systems Reforms, (no date) Bureau of Food And Drugs.

Lin'awa Health Zones in Kalinga, 2001, Management Sciences for

 PREVIOUS PAGE BLANK

Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

Local Area Health Development Zones (LADHZ) in South Cotabato, 2001, Management Sciences for Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

A Local Government Units' Guide to the Purchase of Parallel Drug Imports from the Philippine International Trading Corporation, (no date) Department of Health and Department of Trade and Industry, Manila, Philippines, and Management Sciences for Health, Manila.

Nolledo, JN (Ed.) The 1991 Local Government Code with Basic Features, 1991, Philippine Graphic Arts, Inc., Caloocan City.

Outpatient Consultation and Diagnostic Package Manual through the PhilHealth Capitation Fund, (no date) Philippine Health Insurance Corporation.

Philippine Health Insurance Corporation Accreditation Department.

The Pocket Guide to District Health Care in South Africa. http://www.hst/org.za/isds/pocket/pock1.htm

Practical Guidelines on Health Referral under the District Health System, 2000, Integrated Community Health Services Project, Department of Health, Manila, Philippines.

Provincial Pooled Procurement Program for the Province of Pangasinan (Procedures Manual for the Purchase of Drugs and Medical Supplies), 2000, Management Sciences of Health – Integrated Family Planning and Maternal Health Program (IFPMHP), Manila.

Quality Standards List for Barangay Health Stations Level 1, Certification and Recognition Program, Sentrong Sigla Movement, 2000, Department of Health, Manila, Philippines.

Quality Standards List for Rural Health Units and Health Centers Level 1, Certification and Recognition Program, Sentrong Sigla Movement, 2000, Department of Health, Manila, Philippines.

Sta. Bayabas and CVGLJ: Inter-LGU Health Systems in Negros Oriental, 2001, Management Sciences for Health - Health Sector Reform Technical Assistance Program (HSRTAP), Manila.

Updates from the Field: Best Practices, Using the Community-Based Monitoring and Information System to Help Reduce Unmet Needs, No. 4 Series of 2001, http://www.msh.org.ph

Updates from the Field: Technical Notes, Expanding the Delivery of Health Services through Community-Based Monitoring and Information System, No. 1 Series of 2001, http://www.msh.org.ph

Updates from the Field: Technical Notes, Pooled Pharmaceutical Procurement in Pangasinan, No. 2 Series of 2001, http://www.msh.org.ph

Updates from the Field: Technical Notes, Setting Up a Community-Based Disease Surveillance System, No. 4 Series of 2001, http://www.msh.org.ph

Vicente, WC, Referral System Protocol, 1999.