# EXPANSION PLAN FOR PHILHEALTH PLUS
## (Outpatient Consultation and Diagnostic Package – OPB)

**PHILHEALTH PLUS EXPANSION PLAN**

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## I. INTRODUCTION/SUMMARY

This paper presents the PhilHealth Plus expansion plans of the different PhilHealth Regional Offices (PROs), which was the output in the PhilHealth Plus Assessment and Planning Workshop conducted in May 1, 2002 in Cebu City. The workshop was held with the following objectives:

1) assess the implementation of PhilHealth Plus,
2) assess implementation of, and participation in health sector reform strategy in convergence areas, and
3) plan for next steps in implementation and rolling-out of the Outpatient Consultation Diagnostic Package (OPB).

The working definition of PhilHealth Plus used in this workshop was the enhanced Indigent Program, which now includes Outpatient Consultation Diagnostic Package. Hence, the terms PhilHealth Plus and OPB were used interchangeably.

PhilHealth Plus is considered implemented in a local government unit (LGU) if these three conditions are present: 1) the indigents are enrolled (through Memorandum of Agreement between LGU and PhilHealth and payment of premiums), 2) at least one health center is accredited, and 3) an ordinance creating a PhilHealth Capitation Fund (PCF) has been passed by the local council.

The main output of the workshop was a regional OPB expansion plan, wherein using similar templates, each PhilHealth Regional Office targeted when the above three conditions will be present for each province and city. That is, each PRO developed a roll-out or expansion plan for the OPB.

The workshop was participated in by the Assistant Vice-President (AVP, the PRO head) and the Indigent Program Unit head of each PRO.

In preparation for this planning session, each PRO was asked to analyze its (the PRO's) strengths, weaknesses, opportunities, and threats (SWOT) with regards the implementation of the Indigent Program with the OPB. The SWOT analysis was intended to point out what needs to be done and to put problems into perspective. Moreover, it was also aimed to help the PRO focus in areas where it is strong and where the greatest opportunities lie.

The result of the SWOT analysis was summarized and presented to the participants in the May 1 activity. A copy of the presentation materials is in Annex A.

To further put the participants in the proper perspective as they develop their OPB roll-out plans, the Corporate Planning Department also presented an analysis of the performance of the different PROS in the implementation of the Indigent Program. Operational efficiency and equity in terms of member-to-bed ratio and member-to-rural health unit (RHU) ratio were found to be generally at acceptable levels. A copy of the complete presentation is in Annex B.

The provincial/city health officers of Misamis Occidental and Pasay City also gave a presentation on the implementation PhilHealth Plus in their respective localities, in the

context of other health reforms, through the convergence strategy. The Department of Health likewise made a presentation to give its perspective on the implementation of PhilHealth Plus. These presentations are in Annexes C and D.

The remainder of the body of this document consists of four parts:

i) a background on the Health Passport Initiative/PhilHealth Plus and OPB in the context of the Health Sector Reform Agenda and the Health Passport Initiative/PhilHealth Plus, and the rationale of crafting the PhilHealth Plus expansion plan
ii) Parameters of the expansion plan
iii) Summary of results and analysis
iv) the individual expansion plans of the PROs.

## II. BACKGROUND

The past two years saw the dawning of health sector reforms in the Philippines that aim to improve the way health care is delivered, regulated, and financed, in a devolved setting. The Department of Health (DOH) articulated these reforms in the Health Sector Reform Agenda which then was the DOH's flagship program. The reform has five major components: a) public health reform, b) local health systems reform, c) hospital reforms, d) regulatory reforms, and e) health financing reforms.

The Health Passport Initiative (HPI) was conceptualized to be the lynchpin of all the five reform areas. The principle was to obtain universal social health insurance coverage in a geographic area. This was expected to spur the other four reform areas. And furthermore, it was expected to have a "neighborhood" effect, i.e., the success in one area will make neighboring local government units (LGU) undertake similar reforms, until such time comes that all LGUs will be implementing the programs. The Outpatient Consultation and Diagnostic Benefit (OPB) Package of the National Health Insurance Program became the rallying point for the HPI. In the OPB, members can avail of consultation, diagnostic services, and preventive/promotive health services in LGU-owned rural health units or city health centers, and the LGU is paid for the services through capitation, or a fixed amount per member-family. The capitation payments can be used for the improvements of the health centers.

From this basic concept, innovations and new concepts, strategies, and ideas emerged, as new learnings were gained and as administration changed at the national level and in DOH and in PhilHealth. One such new strategy is the convergence strategy, also known as "Tulong-Sulong sa Kalusugan" in which all five reforms are deliberately undertaken in a particular LGU. With the HPI as the spearheading activity, the convergence strategy aims to generate the momentum that will ensure the irreversibility of the health reforms. The concept of the Health Passport Initiative itself evolved, and was renamed PhilHealth Plus, after PhilHealth took the lead from DOH.

A Health Passport/PhilHealth Plus Task Force was formed in PhilHealth to oversee all PhilHealth-related activities in the context of health sector reform, i.e. the social health insurance component of health sector reform. PhilHealth Plus was also seen as a step towards realizing a fully functional local health insurance office which the law provides to enhance all aspects of a social health insurance in a particular geographic area.

In the last meeting of the PhilHealth Plus Task Force in March 2002, at least two realizations were made:

1. That the enhanced Medicare para sa Masa in its entirety, i.e., the Indigent Program with OPB, is indeed the driver for health reforms.
2. That universal health insurance coverage and all the accompanying enhancements in the National Health Insurance Program to sustain the universal coverage, needs to be implemented first in one or two laboratory sites before it can be rolled out nationwide. That is, the concept of a local health insurance office as described in the law, is not ready for replication and in fact needs to be modeled first in one or two areas.

These two realizations imply that there are two tracks that PhilHealth can pursue:

1. **To roll-out PhilHealth Plus nationwide**. PhilHealth Plus, from this point (PhilHealth Plus Task Force meeting in Linden Suites on March 22, 2002), only refers to the enhanced Medicare para sa Masa. The current standard Medicare para sa Masa includes OPB, subject to capability of the LGU. Hence from this point in this paper, Medicare para sa Masa, even without the word "enhanced", would include the OPB.

2. **To model a local health insurance office (LHIO).** One or two sites to be treated as laboratory sites of the NHIP and the LHIO, with the aim of achieving the aim for NHIP in the national scale, in a smaller scale. The PhilHealth Plus Task Force agreed that this should be undertaken slowly but surely. Top management support will be solicited, and then resources will be devoted to this. The modeling of an LHIO will therefore be pursued with the sole objective of attaining the NHIP's goal, which is not only to achieve universal coverage, but also to ensure affordable, acceptable, available, and accessible health care services for all citizens of the Philippines. Even the choice of sites, therefore, will not be influenced by any external factor including politics.

The May 1 workshop was therefore conducted to pursue the first track. The expansion plans will be the baseline in monitoring and evaluating the progress of the geographic expansion of PhilHealth Plus/the OPB.

## III. PARAMETERS OF THE PHILHEALTH PLUS EXPANSION PLAN

**Scope and Limitaitons**

The PhilHealth Plus expansion plan developed by the different PhilHealth Regional Offices subscribes to the scope defined as the implementation of the OPB. The plan therefore works on achieving three milestones for every locality:

### 1 – Signing of an IP-OPB Memorandum of Agreement

New Indigent Program MOAs already contain a provision on the OPB, but for some MOAs that already have been signed prior to 2001, in the previous years, the OPB

provisions have not yet been included. Updating the new MOAs to include OPB would therefore be considered a new milestone.

**2 – Accreditation of RHU/Health Center**

**3 – Passage of Ordinance Creating PhilHealth Capitation Fund (PCF)**

Capitation, the payment to the health center through the LGU owning it, can only be released once this ordinance is passed by the local legislative body. OPB implementation, therefore, cannot be complete without this.

The first milestone is a prerequisite for the second and third. The second and third milestones, however, do not have to occur in any particular order. All three can be pursued simultaneously and therefore can all be accomplished at about the same period.

Each PhilHealth Regional Office (PRO) mapped out the implementation of the OPB in the LGUs within its jurisdiction, which is not identical with the political zoning. For instance, South Cotabato belongs to Region XI in the political zoning, but is covered by the PRO XII.

**Limitations of the Exercise**

This exercise was an initial attempt to coordinate the rolling out of the implementation of the OPB nationwide, after a period of advance implementation in selected sites. This concretizes the "neighboring effect" envisioned for the HPI.

It only covers the geographic expansion of the OPB and does not cover other forms of expansion and improvements such as expansion of benefits and customization of the benefit package.

**The Contents of the Exapnsion Plan**

The expansion plans consist of three parts: 1) Current OPB Status in the Region, 2) Targets, and 3) Action Plan. The following is a summary of the contents of each part. A copy of the detailed guidelines and notes in accomplishing the templates is in Annex E.

**Part I. Current OPB Status in Region**

The template gives a list of provinces and cities within the region. The PRO filled up the templates to give the following information per province and city:

i. no. of LGUs with enrolled indigents
   - "no. of enrolled indigents" pertains to indigents with IDs. Some LGUs already have MOAs with PhilHealth, but enrollment has not yet taken place (i.e. identification of indigents, payment of premiums, and releasing of IDs)

ii. no. of LGUs in groundworking stage for OPB
   - pertains to any groundworking activity pertaining to OPB, such as presentation to the local chief executive, presentation to the Sangguniang Bayan, pre-assessment of RHUs

iii. no. of LGUs with IP-OPB MOA
   - pertains only to Indigent Program MOA that includes agreements on the OPB. An LGU may already have a MOA for IP that does not include

agreements on the OPB; this is particularly true for the MOAs that have been signed before 2000 when the OPB was not yet being implemented

iv. no. of LGUs with PCF Ordinance passed
v. no. of LGUs with accredited RHUs

**Part II. Targets**

In the guidelines, a reminder was given that this part pertains to targets and not mere projections. Projections was defined as forecasts that may be based on the natural course of things, as against targeting, wherein we take an extra mile or strategize in order to achieve the targets.

A. Bases for Targeting

The PRO-respondent lists here the bases used in setting the targets in II.C. The guidelines specifies that the current resources available to the PRO be considered, such as staff, equipment, and vehicles. The SWOT analysis earlier conducted is also considered here.

B. Strategies

The respondent is asked to enumerate and explain briefly the strategies PRO intends to employ in achieving the targets.

C. Targets for OPB Expansion in Region

The PRO is given a table with a list of provinces and cities in the region, and the following information on each province and city:

i. population
ii. poverty incidence, based on the regional poverty incidence data of NSO
iii. No. of LGUs (municipalities and cities) within each province or city

The respondent is then to fill up the following information for each province and city:

i. Target coverage of the Indigent Program, expressed as a cumulative percentage of the population, for years 2002, 2003, 2004, and beyond 2004.

The main target is to cover the entire poor population, hence the last entry for this should be equivalent to the given poverty incidence. For instance, if poverty incidence for a particular province is 54%, the target coverage should be increasing cumulatively from year to year until such time that 54% is covered, indicating that the entire poor population is already covered. Ideal is for the entire poverty incidence covered by 2004, but for some LGUs this may be unlikely. In such cases coverage for the entire poor population will have to be indicated under the column "beyond 2004". The respondents were asked to provide reasons for such cases.

ii. Cumulative target no. of LGUs to be implementing the OPB package, for years 2002, 2003, 2004, and beyond 2004

In the same manner as in item i above, the main target is to have all LGUs implementing the OPB package, hence the last entry for this should be equivalent to the total no. of

LGUs within the province. For instance, if a province has 14 municipalities and two cities (hence a total of 16 LGUs), at some point from 2002 to beyond 2004, all 16 LGUs must already be implementing the OPB.

**Part III. Action Plan**

The template again provides a list of provinces and cities within the jurisdiction of the PRO and a list of the LGUs (municipalities and cities) within each province. For each LGU, the following information is also given:

i. poverty incidence
ii. income class
iii. 2001 population (based on 2000 census)
iv. no. of households
v. no. of indigent households, as computed from the poverty incidence (no. of indigent households = no. of households x poverty incidence)
vi. no. RHUs, no. of accredited RHUs, no. of RHUs qualified for accreditation (if data is available)

The respondent is then to indicate the following in the templates:

i. at what stage the LGU is currently in, and
ii. action plan on a semestral basis from 2nd semester of 2002

The following activity and milestones are used as indicators:

1 - Groundworking for OPB
2 - IP-OPB MOA signed
3 - PCF Ordinance Passed
4 - RHUs Accredited (some LGUs may have more than one RHU, but for this plan's purposes, this refers to at least one RHU)

Note that groundworking for OPB may have not yet been done for some LGUs who are already implementing the Medicare para sa Masa.

Indicator nos. 2 to 4 do not necessarily have to be chronological. Ideal is to have them all simultaneously accomplished at the soonest time, but in some cases one may be easily accomplished but another may take time. For instance, an LGU may already have passed its PCF ordinance, but its RHU may not be ready for accreditation. On the other hand, the RHU may already be accredited, but the passage of the PCF ordinance may be taking time in the Sangguniang Bayan.

## IV. SUMMARY OF RESULTS AND ANALYSIS

This section summarizes and compares the PhilHealth Plus/OPB expansion plan developed by the different PhilHealth Regional Offices.

The individual expansion plans are in the last section.

Due to logistic and coordination lapses, the National Capital Region (NCR) group was not able to attend the PhilHealth Plus Assessment in Cebu City, nor was the unit able to fill its OPB expansion plan template.

**Current Status of OPB Implementation**

- PhilHealth Regional Offices IV-A and X are currently the most advanced in the implementation of the OPB, with the most number of LGUs with accredited RHUs and necessary ordinances and MOAs passed and signed (Table 1). This is so because each one has an entire province implementing the OPB: Laguna for Region IV-A and Bukidnon for Region X. The PCF Ordinance for Bukidnon was collective for the province instead of per municipality, hence the small no. of PCF ordinances for Region X.
- So far, only Region XI has no accredited RHU and no PCF Ordinance passed. Also, only three of 48 municipalities so far have MOAs for Indigent Program with OPB.

**Table 1. Current Status of OPB Implementation as of May 2002, per Region**

| REGION | TOTAL # OF LGUs | #of LGUs | | | | |
|---|---|---|---|---|---|---|
| | | With Enrolled Indigents | In Ground-working Stage for OPB | With IP-OPB MOA | With PCF Ordinance | With Accredited RHU/s |
| I * | 131 | | | | | |
| II | 87 | 52 | 31 | 0 | 4 | 4 |
| III | 130 | | 52 | 4 | 10 | 1 |
| IV-A | 94 | 42 | 55 | 48 | 48 | 26 |
| IV-B | 107 | 83 | 47 | 32 | 7 | 6 |
| V | 115 | 41 | 52 | 15 | 1 | 1 |
| VI* | 133 | | | | | |
| VII* | 132 | | | | | |
| VIII* | 143 | | | | | |
| IX* | 106 | | | | | |
| X | 132 | 47 | 34 | 31 | 8 | 30 |
| XI | 48 | 35 | 34 | 3 | 0 | 0 |
| XII* | 71 | | | | | |
| CAR | 77 | 73 | 24 | | | 2 |
| CARAGA* | 73 | | | | | |
| NCR | | | | | | |

* templates submitted but either incomplete or not properly filled

**Target Coverage and Target LGUs for OPB Implementation**

- Regions IV-A, IV-B, VII, X, and CARAGA are the only regions who are targeting more than 90% of LGUs to be implementing the OPB by 2004 (Table 2). It will be noted that these regions are also among those which recognize the resources they have (Table 3).

Those that these PROs intend to cover beyond 2004 are generally the LGUs whose current political figures are not receptive of the Medicare para sa Masa.

- Region I and IV-B intend to intensify OPB implementation in 2003, with a relatively small percentage only covered in 2002, to an about five-fold increase in 2003.
- Regions II, VI, IX, and CAR, on the other hand, target for an almost even increase in number of LGUs with OPB from year to year.
- About half of the regions aim for more than 50% of LGUs implementing OPB by end of 2003 while the other half's aim for 2003 did not reach 50%.
- CAR and Region II targeted for only less than 50% of LGUs implementing OPB by 2004.

**Table 2. Target Number of LGUs with OPB Package, by Region**

| REGION | TOTAL # OF LGUs | # OF LGUs WITH OPB PACKAGE | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2002 | | 2003 | | 2004 | | Beyond 2004 | |
| | | # | % | # | % | # | % | # | % |
| I | 131 | 9 | 7 | 53 | 40 | 90 | 69 | 131 | 100 |
| II | 87 | 4 | 5 | 18 | 21 | 30 | 34 | 87 | 100 |
| III | 130 | 4 | 3 | 38 | 29 | 74 | 57 | 130 | 100 |
| IV-A | 94 | 55 | 59 | 71 | 76 | 89 | 95 | 94 | 100 |
| IV-B | 107 | 12 | 11 | 69 | 64 | 99 | 93 | 107 | 100 |
| V | 115 | | | | | | | | |
| VI | 133 | 33 | 25 | 84 | 63 | 103 | 77 | 133 | 100 |
| VII | 132 | 21 | 16 | 104 | 79 | 125 | 95 | 132 | 100 |
| VIII | 143 | 19 | 13 | 42 | 29 | 74 | 52 | 143 | 100 |
| IX | 106 | 14 | 13 | 38 | 36 | 65 | 61 | 106 | 100 |
| X | 132 | 46 | 35 | 95 | 72 | 132 | 100 | 132 | 100 |
| XI | 48 | 18 | 38 | 30 | 63 | 46 | 96 | 48 | 100 |
| XII | 71 | 14 | 20 | 25 | 35 | 35 | 49 | 71 | 100 |
| CAR | 77 | 1 | 1 | 12 | 16 | 21 | 27 | 77 | 100 |
| CARAGA | 73 | 18 | 25 | 65 | 89 | 73 | 100 | 73 | 100 |
| NCR | | | | | | | | | |

* template submitted but incomplete

**Table 3. Bases for Targetting and Strategies, per Region**

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| Region I | Current Resources:<br>• # of staff : 13<br>• Equipment: 4 computers, 1 laser jet printer, 1 Ink jet printer | Coordinate with accreditation and quality assurance unit to fasttrack RHU accreditation and OPB implementation.<br>Negotiate with legislators and other private sponsors to extend financial assistance to LGUs with intention to adapt the indigent program.<br>Massive information and education campaign.<br>Monitor increase in benefit availment |

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| | | to encourage LGUs to renew/increase enrollment into the program. |
| Region II | Current Resources:<br>• 7 IPU staff<br>• Equipment: 3 computers, 1 printer<br>• 1 Vehicle | Embark into constant coordination with LCEs for program enhancement/sustainability<br>Present the program to congressmen, board members, and private organizations<br>Tri-media utilization<br>Giving plaques of appreciation to LCEs and advocates of the Medicare<br>Establish linkages with health officers and health committees. |
| Region III | Current Resources:<br>• 13 IPU staff<br>• Equipment : 4 computers, 1 HP Laserjet printer, 1 HP Deskjet colored printer | Teamwork<br>Service office quick access<br>Barangay sponsorship<br>IEC – barangayan<br>Tri-media approach<br>Techno-political skills of AVP and IPU personnel |
| Region IV-A | Current Resources:<br>• staff: IPU personnel<br>• Equipment : 2 computers, 1Printer<br>• Vehicles : as need arises | Establish contacts with different organizations<br>Follow up commitments<br>Encourage LCE on upgrading of their RHU to avail of OPB<br>Encourage private sector to sponsor indigent in their locality.<br>Give emphasis on OPB package during presentation to private, legislator and to Sangguniang Bayan or Panlalawigan. |
| Region IV-B | Current Resources:<br>• 5 IPU personnel (DMO III, MSO I, PDO I, Encoder I, Account Examiner I)<br>• Equipment : 3 computers, 1 HP 1100 printer, and 1 HP 4050<br><br>Data from National Statistic Office<br><br>Data from all social | Groundworking in the House of Representative<br>Intensive IEC/Introduction of the OPB and the Capitation Fund to all LGUs<br>Orientation up to the barangay level on the additional benefits for their enumeration<br>Orientation/IEC for NGOs and private sector for possible sponsorship<br>Encouragement for other LGUs through media coverage of ID distribution and MOA signing |

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| | welfare offices | Orientation regarding Plan 500 |
| Region V | Current Resources:<br>• 8 staff permanently assigned; 4 staff temporarily assigned<br>• Equipment : 3 computers, 2 Printers, 1 electric typewriter<br>• one vehicle (not for exclusive use of IPU)<br>• Other Resources : Approved budget for travel/ supplies and materials/marketing and promotions | Tap the PDAF fund of Congressmen.<br>Solicit private sponsorship through NGOs, NGAs, Pos. |
| Region VI | | |
| Region VII | Current Resources:<br>• 7 IPU staff | PDAF<br>private sponsorship<br>provincial sponsorship<br>barangay sponsorship<br>NGOs (BIARSP/foreign assistance) |
| Region VIII | | |
| Region IX | Current Resources:<br>• 7 IPU personnel<br>• Equipment : 4 units HP computers, 1 HP Laserjet 1100 printer, 1 Epson LQ-2180, 1 Epson LX-300+ | Advocacy was done to Region 9 Legislators last May 14-15, 2002, House of Representatives, QC. Majority are interested to join the program. Although some are requesting for the status and masterlist for their review<br>Persuade Provincial Governors to join the Indigent Program and help support the 4th-6th municipalities for funding<br>Information Campaign for LGUs under the servicing stage of the OPB Package to increase enrolment<br>IEC to beneficiaries for awareness of their benefits which will resort to greater utilization and give good impression to LCEs<br>Closely coordinate with accreditation unit for immediate RHU implementation |
| Region X | Current Resources: | Pro-active negotiations with LGUs |

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| | • staff: 8 (non-regular); 4 (detailed non-regular)<br>• Equipment: 3 computers, 3 laser jet printers | through forging close relationship based on trust and respect with Local Chief Executives and their advisers/consultants, and INTENSIVE RELENTLESS FOLLOW-UP of PROPOSALS.<br>Assist, in whatever way possible, the LGUs in planning for the improvement of their Health Care Delivery System with PhilHealth as the focal point.<br>On-time delivery and fulfillment of PhilHealth obligations.<br>Maintain an attitude of understanding and compromise with regards to the budgetary/financial constraints facing LGUs. |
| Region XI | Current Resources:<br>• 4 staff (with the inclusion of OPB and decentralization of ID generation, the unit cannot operate with just 4 staff)<br>• Equipment: 3 computers (2 for ID generation and 1 for reports)<br>2 Printers: one each for reporting and ID generation.<br>• Vehicles (2): the unit can use any of the vehicles of PRO XI upon request.<br>• Other Resources :<br>- flyers/brochures – flyers received from the Central Office are already integrated with the OPB package.<br>- coordination with service offices<br>- support from the AVP/management/ Central Office | Intensify partnership with DOH especially in advocating the program to the different LGUs.<br>Close coordination with service offices.<br>Additional power<br>Strengthen linkage with local government units and local chief executives.<br>Convince legislators to enroll into the program<br>Tap private donors to enroll indigents as their donation to the LGU is fully deductible from their taxable income.<br>Management to consider implementation of OPB even in non-priority areas – to exclude submission of letter of intent from LGU capacity to implement OPB lies strongly on capability of RHU |
| Region XII | Current Resources: | The Indigent Program Unit of PhilHealth |

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| | • staff: presently the Indigent Program Unit has only 10 staff covering its entire area of jurisdiction in PRO XII in-charge for networking activities<br>• Equipment: overhead projector<br>• vehicle: The Indigent Program Unit has no exclusive vehicle, instead the unit shared the use of two corporate vehicle which commonly used by five units of PhilHealth Regional Office XII | Regional Office XII is presently adopting an integrated approach and strategies in order to achieve peg targets vis a viz its program implementation in the area. The following strategies and approaches identified below are instrumental in the conduct of networking and establishing linkages to the concerned agencies, to wit:<br><br>1. Holding of meetings, orientation workshop, conferences and for a<br>2. Conduct of Massive Information Education Campaign (IEC) during the councilor's regular session<br>3. Conduct of Maximum Lobbying to Local Chief Executives and legislators<br>4. Pursuance of Private Sector Sponsorship wherein we tapped donors to shoulder the premium payment of indigents like in South Cotabato there were two foundations identified as donors. (First People Foundation of Norala and Tribal Leaders Foundation)<br>5. Pursuance of legislative sponsorship wherein we tapped the different representatives of Region 12 to enroll indigents via their soft fund known as Priority development Assistance Fund (PDAF) |
| CAR | 1. Current Resources:<br>• 9 staff<br>• Equipment: 4 computers, 1 laser jet printer (EPSON LQ 2180)<br>• Vehicles: 2 for the entire region<br>• Other Resources : manpower complement and support from the Accreditation and Quality Assurance Unit of PRO-CAR | PRO presented the OPB Package to the Provincial Officials of Ifugao Province, being one of the HSRA Priority Areas.<br>The OPB was presented and discussed during the Consultation Dialogues with Stakeholders conducted by PRO per province.<br>All priority areas (Plan 500 Areas) and all interested LGUs that expressed their intent to adopt the package were given a copy of the requirements.<br>PRO will visit the RHUs of Priority areas for preliminary evaluations. |

| REGIONS | BASES FOR TARGETTING | STRATEGIES |
|---|---|---|
| | 2. Administrative support from the PRO management. | |
| CARAGA | 1. Current Resources:<br>• 7 IPU staff<br>• Equipment: 1 laserjet 4050, 4 HP computers with LAN<br>• 2 Vehicles: 2x2 (Frontier and Hilander) | Conducted NHIP Convergence Meeting in every province and City in collaboration with CHD-DOH. All program stakeholders were invited such as Provincial Governor, Vice Governor, Provincial Administrator, Provincial Health Officer, MSWDO, MHO, and SB Member on Health<br>Present OPB during Sangguniang Panlalawigan, Sangguniang Panglunsod, Sangguniang Bayan Regular Session<br>Organized 6 OPB Teams composed of personnel from IPU, MCU, Training Specialist, Information Officer II, and Service Office In-charge. They will conduct initial groundworking and arrange with LGU a schedule for PhilHealth to present OPB during the regular session. Session will then be attended by IPU staff together with a non-IPU staff to maximize manpower and to train the later about marketing OPB |
| NCR | | |

## V. RECOMMENDATIONS

The following recommends some of the next step that need to be done from the development of the PhilHealth Plus expansion plan.

**Refinement of Expansion Plans**

The expansion plan contained in this report is a first pass to developing such a roll-out plan. There is a need to review and correct inconsistencies in the figures contained in the expansion plans. If needed, the different PROs should be individually consulted and guided in the verification and refinement of their respective expansion plans. The NCR Group, having not been in the May 2002 assessment workshop, should be oriented on the process of developing the plan.

**Analysis of Expansion Plans**

The concerned PhilHealth units should also analyze the contents of the expansion plan including the bases for targeting and strategies identified by the PROs. These can serve as inputs in over-all planning for the Indigent Program and the National Health Insurance Program in general, including allocation of resources and expansion of benefits.

**Further Orientation and Training on the OPB**

It was apparent in the May 2002 assessment and workshop session that the different PROs, particularly the Indigent Program Units which market the OPB and the entire Indigent Program, still need further orientation regarding the OPB. Moreover, training on marketing such as presentation skills and negotiation skills will be very valuable. Capability building of these personnel is crucial to the roll-out of the OPB.

**Periodic Monitoring of Progress of OPB Expansion**

The expansion plan should serve as baseline for monitoring the actual progress of the OPB roll-out. Periodic review or evaluation of progress vis-à-vis the targets should be performed in order to identify areas that need to be acted upon.

# Part II

# THE EXPANSION PLAN OF EACH PHILHELATH REGIONAL OFFICE (PRO)

# ANNEXES

# Annex A
# Strengths, Weaknesses, Threats, Opportunities (SWOT) of the Indigent Program by the PhilHealth Regional Offices (PROs)

**SWOT**
**of the**
**INDIGENT PROGRAM**
**by the PROs**

## Strengths

- Program's appeal to the masses
- Indigent Program is included in the National Priority Plan of the government
- Established a healthy relationship and good rapport with LCEs
- Acceptance by most LGUs
- Increased benefits and introduction of OPB, Plan 500 and HSRA

## Strengths

- Full support from national government and management
- Decentralization of functions
- Existence of Service Offices
- Availability of IT equipment and sufficient logistics and supplies
- Good planning and execution of activities
- Hard-working, well-trained, diligent, dedicated and competent staff
- Effective and aggressive conduct of IEC/dialogues

## Weaknesses

- **Program Design**
  - Low utilization rate / availment of indigent members
  - Increase in premium contribution from 3rd year onwards of program implementation
  - No clear cut guidelines and policies for the implementation of OPB and on benefit availment / constant changes in policies
  - Rigid accreditation requirements
  - Benefit package not well responsive to the health care needs of indigents

## Weaknesses

- **Program Administration**
  - Database of enrolled indigents not updated
  - Unresolved issues on the duplicate PINs assigned to an indigent beneficiary
  - Delayed release of renewal ID cards from Central Office
  - Number of ID cards released by Means Test do not tally with the transmittal letters and actual number of ID cards screened at the PRO
  - Needs improvement in monitoring system of personnel activities and status of IP implementation
  - Lack or inadequate IEC activities and dissemination of Circulars
  - Giving wrong information to LGUs
  - Inability to collect LGU / Donor premium contributions on time

## Weaknesses

- **Admin Support**
  - Lack of manpower complement
  - Lack of transportation, IT equipment, and other presentation materials and supplies
  - Lack or insufficient training of personnel
  - Employment status of contractors has become an issue (not allowed cash advances, etc)

## Opportunities

**Partner Support**
- Active partnership with the LGUs and NGAs (DOH,DSWD and DILG)
- PDAF of legislators / private sponsorship
- JICA funding would upgrade 31 RHUs and some BHS and construct a 100-bed tertiary hospital in Cagayan
- Many LCEs are interested and supportive of the program
- Accredited hospitals and health care providers

- Plan 500 and HSRA
- Reclassification of LGUs, which brings about increase in the number of enrollees

- Information / Communication technology made other people aware of the program

- Enumeration fees for enumerators

## Threats

- **LGU**
  - Peace and order situation
  - Budgetary constraints of LGUs
  - Existence of private health insurance / own HI scheme by LGU
  - Too much politics / political indigents
  - Political instability
  - Geographical structure, remote areas and poor road condition
  - Increasing expectation of the LGUs towards the implementation of OP and Diagnostic Package
  - IP not a priority of some LGUs

## Threats

- **Providers**
  - Lack or no accredited health care providers in most areas where there are indigent members
  - Some hospitals deny indigent members for treatment
  - Poor hospital services and poor health facilities (hospitals and RHUs)
  - Lack of medicines and supplies in hospitals and RHUs
  - Fraud

- **Other Partners**
  - Slow-paced indigent identification by MSWDOs
  - Enumerators need appropriate training
  - Lack of incentives to those assisting in the identification / evaluation of indigents

- **Members**
  - Poor health seeking behavior of IP members

# Annex B
# The Indigent Program and the PhilHealth Regional Offices (PROs)

## The Indigent Program and the PROs: 2001

1

## Enrollment by PRO

| PRO | Est Active Members | Indigent Members | IPP Members |
|---|---|---|---|
| CAR | 128,446 | 19,985 | 16,089 |
| 1 | 272,936 | 39,917 | 32,978 |
| 2 | 153,147 | 29,821 | 12,355 |
| 3 | 726,378 | 97,996 | 110,695 |
| 4A | 704,527 | 33,624 | 52,466 |
| 4B | 308,138 | 61,918 | 60,265 |
| 5 | 239,149 | 34,180 | 21,425 |
| 6 | 657,112 | 68,233 | 31,201 |
| 7 | 577,942 | 12,063 | 47,262 |
| 8 | 207,646 | 33,948 | 16,740 |
| 9 | 279,926 | 18,854 | 59,322 |
| 10 | 414,896 | 30,102 | 85,679 |
| 11 | 535,503 | 35,366 | 83,663 |
| 12 | 175,068 | 25,918 | 43,230 |
| CARAGA | 170,969 | 40,512 | 41,542 |
| TOTAL | 5,551,784 | 582,437 | 714,912 |

2

## No. of LGUs Participating in the Indigent Program

| PRO | No. of LGUs participating | | | Average Participation (in months) |
|---|---|---|---|---|
| | Provinces | Cities/Municipalities | Districts (Congressmen) | |
| CAR | 6 | 70 | | 20 |
| 1 | 3 | 49 | 2 | 20 |
| 2 | 4 | 43 | 1 | 26 |
| 3 | 5 | 110 | | 15 |
| 4A | 1 | 49 | 4 | 13 |
| 4B | 4 | 72 | | 16 |
| 5 | 3 | 38 | | 26 |
| 6 | 4 | 85 | 1 | 28 |
| 7 | 1 | 28 | | 14 |
| 8 | 3 | 75 | | 16 |
| 9 | 1 | 45 | | 10 |
| 10 | 3 | 33 | 2 | 16 |
| 11 | 3 | 20 | 2 | 11 |
| 12 | 1 | 24 | | 15 |
| CARAGA | 4 | 67 | | 38 |
| TOTAL | 46 | 808 | 12 | 16 |

3

## Accredited Facilities

| PRO | No. of Hospitals | No. of RHUs |
|---|---|---|
| CAR | 49 | |
| 1 | 100 | |
| 2 | 62 | |
| 3 | 157 | |
| 4A | 117 | 12 |
| 4B | 100 | |
| 5 | 109 | |
| 6 | 76 | 12 |
| 7 | 83 | |
| 8 | 60 | |
| 9 | 68 | |
| 10 | 109 | |
| 11 | 108 | |
| 12 | 74 | |
| CARAGA | 45 | |
| TOTAL | 1,317 | 24 |

4

## Claims Processing

| PRO | Total No. of Claims Received | Number of Claims Received | | Total No. of Claims Returned/ Denied | Number of Claims Returned/Denied | |
|---|---|---|---|---|---|---|
| | | IPP (not all PROs have breakdown for IPP) | Indigent Members | | IPP (not all PROs have breakdown for IPP) | Indigent Members |
| CAR | 33,989 | - | 2,481 | 7,798 | - | 893 |
| 1 | 57,904 | - | 3,578 | 9,871 | - | 256 |
| 2 | 28,056 | 1,575 | 1,006 | 6,727 | 524 | 200 |
| 3 | 111,642 | - | 4,831 | 7,701 | - | 447 |
| 4A | 118,360 | - | 2,323 | 8,460 | - | 221 |
| 4B | 60,354 | 5,224 | 3,252 | 8,319 | 1,002 | 429 |
| 5 | 69,134 | 5,854 | 5,136 | 11,041 | 1,452 | 669 |
| 6 | 104,200 | - | 4,522 | 18,624 | - | 867 |
| 7 | 128,170 | - | 1,216 | 14,121 | - | 75 |
| 8 | 30,615 | 1,456 | 1,461 | 4,620 | 295 | 336 |
| 9 | 40,661 | 4,788 | 1,673 | 8,122 | 1,104 | 411 |
| 10 | 106,852 | - | 3,232 | 15,282 | - | 379 |
| 11 | 136,308 | - | 3,605 | 13,480 | - | 466 |
| 12 | 93,127 | - | 2,323 | 12,030 | - | 273 |
| CARAGA | 36,709 | 722 | 2,000 | 4,565 | 155 | 344 |
| TOTAL | 1,156,081 | 19,619 | 42,639 | 150,761 | 4,532 | 6,166 |

5

## Collection and Benefit Payment

| PRO | Amt of LGU premium collected | Total Benefit payments (Desk Report) | Amount of Benefit Payments (Desk Report) | | Capitation |
|---|---|---|---|---|---|
| | | | IPP (not all PROs have breakdown for IPP) | Indigent Members | |
| CAR | 1,687,991.85 | 159,721,914.90 | - | 6,836,376.68 | |
| 1 | 6,663,619.80 | 260,917,872.84 | - | 12,846,830.53 | |
| 2 | 3,428,964.17 | 112,877,033.66 | 5,850,087 | 3,663,706.50 | |
| 3 | 6,059,189.44 | 579,901,118.85 | - | 19,855,145.10 | |
| 4A | 5,823,461.14 | 545,580,390.90 | - | 8,130,668.70 | 964,061.00 |
| 4B | 9,982,127.71 | 257,691,350.49 | 21,027,754 | 8,687,980.32 | |
| 5 | 1,982,940.14 | 244,061,288.33 | 18,077,807 | 12,473,197.79 | |
| 6 | 5,825,091.84 | 607,176,634.85 | - | 14,177,589.46 | 3,120,759.00 |
| 7 | 1,208,807.74 | 627,147,205.98 | - | 3,619,739.26 | |
| 8 | 3,106,824.40 | 125,384,767.46 | 6,933,381 | 3,579,848.96 | |
| 9 | 961,282.85 | 134,226,024.26 | 5,702,577 | 3,473,855.69 | |
| 10 | 2,902,781.53 | 377,349,375.79 | - | 5,924,628.48 | |
| 11 | 3,168,876.70 | 503,301,992.61 | - | 10,557,945.13 | |
| 12 | 471,262.40 | 288,328,181.52 | - | 3,919,144.62 | |
| CARAGA | 1,047,198.82 | 125,494,239.37 | 3,982,648 | 4,813,833.78 | |
| TOTAL | 54,320,420.53 | 4,949,149,391.81 | 61,574,155 | 122,480,391.00 | 4,084,820 |

6

## Budget and Human Resource

| PRO | 2001 Budget (Admin. Expense) | Budget for Technical Labor/Contractors | No. of Technical Staff/Contractors (Filled positions) |
|---|---|---|---|
| CAR | 12,306,800 | 6,116,944 | 47 |
| 1 | 20,996,620 | 9,517,612 | 83 |
| 2 | 11,702,420 | 5,777,005 | 52 |
| 3 | 30,351,064 | 14,560,998 | 132 |
| 4A | 19,404,563 | 10,789,689 | 89 |
| 4B | 16,817,390 | 8,457,161 | 71 |
| 5 | 15,620,011 | 6,917,391 | 67 |
| 6 | 16,865,992 | 9,017,349 | 73 |
| 7 | 22,168,695 | 9,498,447 | 78 |
| 8 | 12,680,346 | 3,777,082 | 48 |
| 9 | 14,103,760 | 7,763,379 | 59 |
| 10 | 25,763,131 | 13,386,416 | 109 |
| 11 | 20,856,140 | 10,283,018 | 83 |
| 12 | 17,545,342 | 9,412,069 | 82 |
| CARAGA | 13,855,751 | 5,232,929 | 45 |
| TOTAL | 271,038,025 | 130,507,489 | 1,118 |



## LGU Participation

| PRO | % prov participating | % cities/mun participating |
|---|---|---|
| CAR | 100.00 | 90.91 |
| 1 | 60.00 | 37.40 |
| 2 | 100.00 | 49.43 |
| 3 | 71.43 | 84.62 |
| 4A | 33.33 | 52.13 |
| 4B | 66.67 | 67.29 |
| 5 | 50.00 | 33.33 |
| 6 | 66.67 | 63.91 |
| 7 | 25.00 | 21.21 |
| 8 | 50.00 | 52.45 |
| 9 | 16.67 | 42.45 |
| 10 | 50.00 | 25.00 |
| 11 | 75.00 | 41.67 |
| 12 | 20.00 | 33.80 |
| CARAGA | 100.00 | 91.78 |
| TOTAL | 58.97 | 51.20 |

- **7 of 15 PROs exceed the national average for both indicators**
- **CAR, 2 and CARAGA have all the provinces participating**
- **CAR, 3 and CARAGA have almost covered all cities/municipalities in their regions**



## Fund Utilization

| PRO | Amt of LGU premium collected | Amount of Benefit Payments (Desk Report) |
|---|---|---|
| | | Indigent Members |
| CAR | 1,687,991.85 | 6,836,376.68 |
| 1 | 6,663,619.80 | 12,846,830.53 |
| 2 | 3,428,964.17 | 3,683,706.50 |
| 3 | 6,059,189.44 | 19,855,145.10 |
| 4A | 5,823,461.14 | 8,130,668.70 |
| 4B | 9,982,127.71 | 8,687,980.32 |
| 5 | 1,982,940.14 | 12,473,197.79 |
| 6 | 5,825,091.84 | 14,177,589.46 |
| 7 | 1,208,807.74 | 3,519,739.26 |
| 8 | 3,106,824.40 | 3,679,848.96 |
| 9 | 961,282.85 | 3,473,858.69 |
| 10 | 2,902,781.53 | 5,924,528.48 |
| 11 | 3,168,876.70 | 10,557,945.13 |
| 12 | 471,262.40 | 3,919,144.62 |
| CARAGA | 1,047,198.82 | 4,813,833.78 |
| TOTAL | 54,320,420.53 | 122,480,391.00 |

- **Only PRO 4-B paid benefits within the LGU premium it collected for the year**
- **PROs 5 and 12 paid as much as 6 and 8 times more than they collected from the LGUs**



## Supply

| PRO | # of RHUs | IP members | Ratio |
|---|---|---|---|
| 4-A | 12 | 30,868 | 2,572:1 |
| 6 | 12 | 22,124 | 1,844:1 |
| Total | 27 | 53,776 | 1,992:1 |

- **Conventional ratio is 4,000 households : 1 RHU, therefore the RHUs implementing the OPB package are adequate in meeting NHIP needs**



## Supply

| PRO | members (all) per hospital | HH to bed ratio | Ideal density-adjusted ratio |
|---|---|---|---|
| CAR | 2,621 | 75 | 60 |
| 1 | 2,729 | 84 | 259 |
| 2 | 2,470 | 84 | 83 |
| 3 | 4,627 | 127 | 333 |
| 4A | 6,022 | 170 | 185 |
| 4B | 3,081 | 109 | 185 |
| 5 | 2,194 | 92 | 214 |
| 6 | 8,646 | 164 | 250 |
| 7 | 6,963 | 129 | 293 |
| 8 | 3,461 | 100 | 138 |
| 9 | 4,117 | 155 | 153 |
| 10 | 3,806 | 121 | 155 |
| 11 | 4,958 | 152 | 148 |
| 12 | 2,366 | 76 | 142 |
| CARAGA | 3,799 | 137 | 155 |

- **It appears that the accredited bed capacity of hospitals is more than adequate to meet NHIP demand in most of the PROs.**
- **Insufficiencies in some PROs are at minimum levels.**



## Cost of operations

| PRO | Cost per enrollee | Labor cost per enrollee |
|---|---|---|
| CAR | 95.81 | 47.62 |
| 1 | 76.93 | 34.87 |
| 2 | 76.41 | 37.72 |
| 3 | 41.78 | 20.05 |
| 4A | 27.54 | 15.31 |
| 4B | 54.58 | 27.45 |
| 5 | 65.31 | 28.92 |
| 6 | 25.67 | 13.72 |
| 7 | 38.36 | 16.43 |
| 8 | 61.07 | 18.19 |
| 9 | 50.38 | 27.73 |
| 10 | 62.10 | 32.26 |
| 11 | 38.95 | 19.20 |
| 12 | 100.22 | 53.76 |
| CARAGA | 81.04 | 30.61 |
| TOTAL | 48.82 | 23.51 |

- **PROs 6 and 4A seem to have operated at the least cost among the PROs. Labor costs per member are also the least.**



## IPP and IP RTH

| PRO | % RTH IPP | % RTH IP |
|---|---|---|
| CAR | | 35.99% |
| 1 | | 7.15% |
| 2 | 33.27% | 19.88% |
| 3 | | 9.25% |
| 4A | | 9.51% |
| 4B | 19.18% | 13.19% |
| 5 | 24.80% | 13.03% |
| 6 | | 19.17% |
| 7 | | 6.17% |
| 8 | 20.26% | 23.00% |
| 9 | 23.06% | 24.57% |
| 10 | | 11.73% |
| 11 | | 12.93% |
| 12 | | 11.75% |
| CARAGA | 21.47% | 12.20% |
| TOTAL | 23.10% | 14.46% |

- **PROs 7, 1, 4A and 3 register lower than double digit proportion RTH/denied for indigent claims among the PROs**



## Assumptions & Caveats

- **Where there are no ideal or conventional figures to compare with, national averages are maintained as ideal. Better than average will appear as green else yellow.**
- **Density-adjusted household : bed ratios are used and considers dispersion of household or population density in regions**
- **Member, enrollee and household are used as units and is used interchangeably here**
- **For benefits vis-à-vis LGU premium, ideal is spending within the collected premium**
- **Some PROs have not segregated IPP**

**Annex C**
**LGU Experiences on the Convergence Strategy and PhilHealth Plus: Pasay City and Misamis Occidental**

## 1. Pasay City

**PASAY CITY HEALTH OFFICE**

**PHILHEALTH PLUS**

**MILESTONES..**

**Pasay City**

**Gateway**

**to the**

**Philippines**

**In the City…**

- **TOTAL LAND AREA: 18.5 Sq. Kms.**
- **City Proper – 5 sq. kms.**
- **CAA, NAIA, Villamor Airbase – 9.5 sq. kms.**
- **Reclamation Area – 4 sq. kms.**

**In the City…**

| Year | Population Size | Pop. Density |
|---|---|---|
| 2002 | 422,599 | 22,843/ sq.km. |
| | 84,520 HH | |

**Urban Poor Population: 134,985 (32% of TP)**
**26,997 Households**

**UHNP MBN Survey (1999) 72,505 (17.15% of TP)**
**14,501 Households**

**In the City…**

- ✓ Barangay : 201 Zone : 20
- ✓ Districts : 7 ( for religious purposes)

San Jose, San Isidro Labrador, Sta Clara de Montefalco, San Rafael,

San Roque, San Juan Nepomuceno, and Our Lady Of Airways.

2 ( for political/health purposes)

Districts I and II

**Total Labor Force**

| | |
|---|---|
| 290,000 | income earners |
| 246,000 (85%) | employees, laborers ( receiving salaries or wages) |
| 44,000 (15%) | self-employed |
| Average Family income | P 12,000.00 |
| Employment rate | 84.4% |
| Unemployment rate | 15.6% ( 1997) |

## Health Resources

Health Resources

| | | | Number | Bed |
|---|---|---|---|---|
| ✓Facilities | | | | |
| ✓Health Centers | | | 11 | |
| ✓Lying-in-Clinic | | | 1 | 25 |
| ✓Social Hygiene Clinic | | | 1 | |
| ✓Employees' Clinic | | | 1 | |
| ✓Laboratory Services | | | 12 | |
| ✓Hospitals: | LGU | 1(PCGH) | | 150 |
| | Nat'l Gov't. | 1(VAB) | | 150 |
| | Private | 1 (MSH) | | 152 |
| | | 1 (SJDH) | | 220 |
| ✓Bed Population Ratio (1:589) | | | | |
| ✓Private Medical and Dental Clinics | | | 104 | |

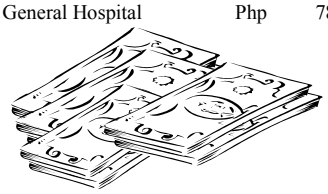
**CHO WORKFORCE RATIO / TOTAL = 178**

| | | | | |
|---|---|---|---|---|
| Physicians | = | 24 | = | 1 : 17,576 |
| Dentists | = | 19 | = | 1 : 22,201 |
| Nurses | = | 23 | = | 1 : 18,340 |
| Midwives | = | 53 | = | 1 : 7,959 |
| Nutritionist | = | 3 | = | 1 : 140,607 |
| Med-tech | = | 8 | = | 1 : 52,728 |
| S. I. | = | 10 | = | 1 : 42,182 |
| Lab. Aides | = | 10 | = | 1 : 42,182 |
| Pharmacist | = | 2 | = | 1 : 421,821 |
| BNS | = | 25 | = | 1 : 16,872 |
| BHW | = | 350 | = | 1 : 1,205 |
| Admin/Gen Services | = | 30 | | |

Budget for Health for the Year 2002

✓City Health Office for Public Health Php 59 M

✓Pasay City General Hospital Php 78 M



## Awards/Recognition:

**11 Health Centers are certified Sentrong Sigla**
**7 HC are national awardees**


| 1999 | 2000 |
|---|---|
| *San Isidro H.C. | *Dona Marta H.C. |
| *Mia H.C. | Leveriza H.C. |
| *Malibay H. C. | |
| *Main H. C. | 2001 |
| *Cuyegkeng H. C. | Kalayaan H.C. |
| *San Pablo H. C. | |
| Ventanilla H.C. | |
| M. Dela Cruz H.C. | |

## Pasay City Health Initiative

- December 9, 1997 – Sangguniang Panlungsod passed an approved resolution (No. 978-S-1997) adopting the National Health Insurance Program R.A. 7875
- February 2000- Signing of MOA for Indigency Program
- March 2000- Enrolment of Indigents
- June 2000- Launching of Health Passport

**Health Passport Initiative**

**Launched**

**at Cuneta Astrodome-**

**June 23, 2000**

**•August 11, 2000 MOA with Philhealth adopting Outpatient Benefit Package**

Primary consult

Laboratory examinations

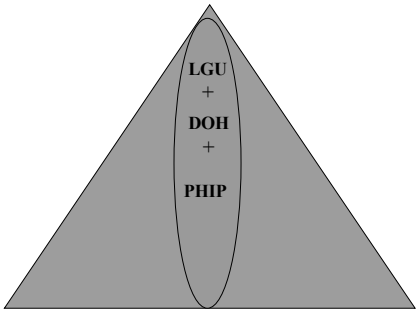
- CBC and Platelet count
- Fecalysis
- Urinalysis
- Sputum Microscopy
- Chest x-ray (Pasay City General Hospital)

Implementation: October 1, 2000

Budget allocation for Indigency Program

| | | |
|---|---|---|
| 1998 | P 2M | |
| 1999 | P 4M | |
| 2000 | P 4M | 6,849 HH |
| 2001 | P 5M | 8,561 HH |
| 2002 | P 6M | 10,273HH |

Preparations for Health Passport Initiative




**FOUR WINGS PREPARATION**

**11 Health Centers are Sentrong Sigla Certified**

**7 National Awardees**

**Procurement of medicines/drugs**

**DOH augmentation of other logistics**

**Procurement of equipment /supplies for HC laboratories**

**Capability Building of Medical Technologist at PCGH**

**Regular schedules of MT's assignments**

**Personnel oriented on "Medicare Para sa Masa"**

**Seminar/Workshops conducted Updates, re-orientation**

**Referral System in placed Secondary level –PCGH Tertiary level – UP-PGH**

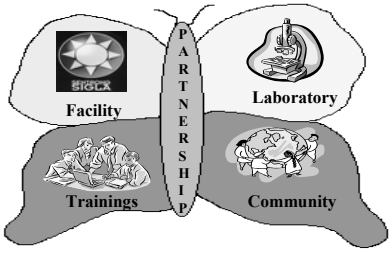
**Enrolment for the Indigency Program using Philhealth "Means Test" and their FDSF conducted by the DWSD.**

**Enrolment was transferred to the City Health Office**

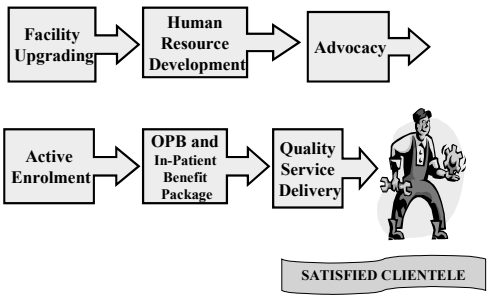
**ACTIVE ENROLMENT**

**Barangay Dialogues, Community Assemblies, Coordination with NGOs and other GOs**

**All 11 health centers accredited by Philhealth**




Strategy




**UTILIZATION**

| LGU | MEDICAL CONSULTATION | % | LABORATORY | % |
|---|---|---|---|---|
| PASAY CITY | 3,783 | 52.26 | 857 | 22.65 |

**Number of Families Enrolled to date: 8,413**

## Issues and Concerns

Enrolment assumed by the CHO

Distribution of IDs by Health Personnel even on Saturdays and Sundays

Low ceiling per capita income/annum prescribed by Philhealth

Ratio of MTs assigned in health centers (1MT:2 HC)

Fast turn-over of Personnel

Late renewals of IDs ( temporary certificate issued by CHO)

## Tulong-Sulong sa Kalusugan Convergence Workshop

Social Health Insurance

- HI coverage for 15,000 indigents HHs by 2004 (100% urban poor)
- 100% of all business establishments are Philhealth registered
- Increased enrolment of IPP by 20% in 2004
- Expanded benefits to indigent
- Monitoring systems installed in all health centers
- Permanent functional Philhealth office

PLEDGE OF COMMITMENT TO THE HSRA

TARGETS OF PASAY CITY BY 2004

SIGNED BY CITY AND BGY. GOV'T. OFFICIALS

## MESSAGE

TO PHILHEALTH:

VISIBILITY in ALL Cities and Municipalities!

TO DOH:

Continue your valuable SUPPORT!

TO our co-public health workers!

JUST DOH IT!

TO MSH:

Thank you for your vital assistance!

MARAMING SALAMAT
PASAY CITY
PHILHEALTH PLUS

2. Misamis Occidental

**TULONG-SULONG SA KALUSUGAN**
## Health Sector Reform Agenda
## Misamis Occidental

## SOCIAL INSURANCE REFORM AREA

## STATUS OF IMPLEMENTATION

A. Getting to know Misamis Occidental

B. Health Sector Reform Agenda Convergence Planning

C. Status of LGU-PHIC Implementation

C.1. Indigent Program OPB

C.2. Success Factors in Program Implementation

**1.** Coordination/Cooperation – LGU-DOH-PhilHealth

**CHAMPS –** PhilHealth personnel member of the CHAMPS team together with the other health personnel.

**Health Sector Reform Advocates** – PhilHealth personnel member of he HSRA advocates.

SS Certification first then PhilHealth accreditation

**2.** Accessibility – PhilHealth Satellite office within the Hospital campus.
**3.** Prioritization – Claims from the government hospitals are given attention first.
**4.** Indigent counterparting – ABC President of Aloran, Misamis Occidental convinced indigents to counterpart for the PhilHealth premium in the amount of P40.00/indigent.
**5.** Pre-processing center – Presence of PPc in Ozamiz to cut short the length of time in the processing of PhilHealth claims.
**6.** One-stop shop – At the ground floor of Regional PhilHealth Office, CDO, there's an available desk/area wherein in formations like claims, Ids & other services are rendered to a client without going up.

C.3. Problems, Issues and Recommendations

1. Processing of claims take more than 30 days

   RECOM – IEC on the areas/items that cause the delay
   - Strengthened the PPC

2. PhilHealth beneficiaries not fully aware

   RECOM – IEC – to bring their Ids during hospitalization

3. IDs – Barangay Captain Based
   In some areas, the barangay captains keep IDs. The PhilHealth holder will get it during hospitalization.

   RECOM – IEC – The IDs are PhilHelth beneficiaries' property. It should be PhilHealth beneficiary-based.
   - masterlisting of the PHIC beneficiaries should always be available in the health facility.

4. Some consultants are not PHIC accredited.

   RECOM – IEC campaign for accreditation

5. Medicines not adequate in the hospital pharmacy

   RECOM – establishment of public pharmacy
   - drug purchase through PDI and bulk procurement
   - made tie-up pharmacy with cheaper prices of drugs.

What was the **RESULT?**
Targets are identified per reform areas such as

**SOCIAL HEALTH INSURANCE**

- Quality health services available and accessible to NHIP members and dependents
- Collecting agencies present in every city/municipality
- Efficient and prompt processing of claims by PhilHealth within one month (30 calendar days)

**LOCAL HEALTH SYSTEM**

- 100% of the LGU's have effective and efficient local Health system implementation – 4 functional Inter-Local Health Zones.

**HOSPITAL REFORMS**

- Self-sustaining hospital operations: income generation and retention.
- Upgraded therapeutic and diagnostic capabilities of 6 Public hospitals.

**DRUG MANAGEMENT SYSTEM**

- Functional and empowered Therapeutic Committees in hospital and health facilities.
- Proper prescribing and dispensing practices.
- Available cheaper quality drugs through Parallel Drug Imports and provincial bulk/pooled Procurement systems.

**PUBLIC HEALTH**

- All RHUs facilities SS certified and PhilHEalth accredited.
- 20% of the total budget of the municipalities allotted for health and health related activities.
- Enactment and enforcement of legislative health ordinances.

How far have we gone in **HSRA?**

1. Public Health
   8 RHUs are Sentrong Sigla certified

| | |
|---|---|
| Aloran | Jimenez |
| Bonifacio | Plaridel |
| Calamba | Sinacaban |
| Clarin | Tudela |

   Certification for Sapang Dalaga, Lopez Jaena and Baliangao in the 2nd quarter 2002.

   2 CHOs certified Oroquieta and Tangub

   for certification – this year – Ozamiz City

**WHEN?** HSRA started in Misamis Occidental on August 23-24, 2001 Convergence Planning was done at Tangub City attended by:

1. LGUs – Governor Loreto Leo S. Ocampos (Provincial Governor), Mayors, SB Chair on Health, developed health personnel

2. DOH – Undersecretary Dr. Milagros Fernandez, CHD X, Regional Director Marietta C. Fuentes and personnel

3. NGOs – Dr. Josefina Dignum – PMA President

4. PhilHealth personnel headed by PhilHealth President Duque.

Republic of the Philippines
**PHILIPPINE HEALTH INSURANCE CORPORATION**
PhilHealth Regional Office 10
Oroquieta City Service Desk

**PROVINCE OF MISAMIS OCCIDENTAL INDIGENT PROGRAM**
**And RHU ACCREDITATION STATUS**
**As of April 29, 2002**

| LGU | NEGOTIATION STATUS | ENROLMENT STATUS | | RHU ACCREDITATION STATUS |
|---|---|---|---|---|
| | | ENROLLED | TARGET FOR ENROLMENT | |
| CITY | | | | |
| Ozamiz | Retrieval of SP resolution | | 2,000 HH | No application yet |
| Tangub | | 1,185 HH | 2,000 HH | Approved |
| Oroquieta | | 1,000 HH | | Approved |
| MUNICIPALITIES | | | | |
| Aloran | Enumeration for 2nd batch | 100 HH | 2,000 HH | For inspection |
| Baliangao | Retrieval of Budget Certificate | | 500 HH | No application yet |
| Bonifacio | Validation for 2nd batch | 2,240 HH | 2,240 HH | PHIC accreditation/servicing |
| Calamba | Validation for 2nd batch | | 1,000 HH | Approved |
| Clarin | Enumeration | | 1,000 HH | Approved |
| Concepcion | Retrieval of SB resolution | | 1,000 HH | No application yet |
| Don Victoriano | Enumeration | | 1,000 HH | No application yet |
| Jimenez | Validation | | 1,200 HH | For inspection |
| Lopez Jaena | Enumeration | 2,000 HH | 1,000 HH | For inspection |
| Panaon | Enumeration | | 500 HH | No application yet |
| Plaridel | Validation | | 3,000 HH | Approved |
| Sapang Dalaga | Enumeration | | 1,000 HH | No application yet |
| Sinacaban | Validation | | 500 HH | No application yet |
| Tudela | Enumeration | | 1,000 HH | For inspection |
| **TOTAL ENROLLED** | | 6,625 HH | | |
| **TOTAL TARGET** | | | 21,140 HH | |

**Annex D**
**Presentation of the Department of Health in the PhilHealth Plus Assessment Workshop**

## Recommended Action Points to Strengthen NHIP

1. Intensify and make more appropriate information dissemination
   - LGUs (especially on capitation and PhilHealth accreditation)
   - Health providers (requirements for accreditation and claims)
   - Clients/members (laymanized orientation)
2. Make advocacy style more strategic

## Recommended Action Points to Strengthen NHIP

3. Improve PhilHealth support services, i.e.,
   - more accessible desks for inquiry with trained manpower
   - more accessible payment centers in rural areas
   - improved claims processing
4. Make available disaggregated data on population and membership for a specific LGU that will be useful for the LGU's planning and policy decisions.

## Recommended Action Points to Strengthen NHIP

5. (for LGUs) Involve PhilHealth in all health-related planning
6. Model LGUs' best practices on Health Passport/PhilHealth Plus as it relates to improvement of health care delivery.
7. Emphasize use of capitation as LGU health care financing scheme for improvement of health service delivery in an inter-local health zone.

## Recommended Action Points to Strengthen NHIP

8. Aim for the realization that social health insurance is the driver for other health sector reforms, i.e., public health, hospital improvements, drug management, local health system.

**Annex E**

# Guidelines and Some Notes in Accomplishing the OPB Expansion Plan

## I. Current OPB Status in Region

Column: with enrolled indigents

i. Pertains to no. of LGUs with enrolled indigents. "Enrolled indigents" pertains to indigents with IDs, not merely IP MOA. Please note in remarks whether some of the indigents are sponsored by the province or any other entity or sponsor other than the municipality/city.

Column: (1) in groundworking stage for OPB

i. As the column title implies, this pertains to any groundworking activity pertaining to OPB (e.g.p resentation to LCE, presentation to SB, pre-assessment of RHU). Please note in mind that this is different from groundworking for enrolling indigents. For instance, a municipality may have enrolled its entire indigent population but so far no form of discussion or presentation on OPB has been made to the LCE or any health official.

Column: (2) with IP-OPB MOA

i. As the column tiotle also implies, this pertains to MOA for OPB. Again, an LGU may already have an IP MOA but none yet for OPB. Although standard MOA now is with OPB, LGUs with previously-signed IP MOAs do not have the provisions of OPB in their MOAs.

## II.A. Bases for Targeting

List here the bases to be used in coming up with the targets in II.C. One basis should be the *current* level of resources. This has been placed as # 1 basis. Please identify the current resources your PRO has in relation to OPB expansion.

Please bear in mind that targets are not necessarily the same as projections. Projections may be based on the natural course of things. In targetting, we do things to achieve the targets.

## II.B. Strategies

Enumerate and explain briefly the strategies to be used by the PRO in order to achieve the targets in II.C.

## II.C. Targets for OPB Expansion in Region

Column: Poverty Incidence

i. The poverty incidence entered here is according to the regional poverty incidence data from NSO. This is what PMG used in all its circulars. The figure, being a regional average, will likely not reflect the true poverty incidence in some provinces.

ii. If you have another data source of poverty incidence for a particular data source, you may change the poverty incidence entry but be sure to indicate your official source. If there is no official source, just please don't change the poverty incidence entry and just remark that the estimated true poverty incidence is far from the regional average.

Column: % of population covered by IP (2002, 2003, 2004, beyond 2004)

i. Percentage indicated year by year must be cumulative. Also, percentage pertains to % of population. Hence, maximum % that must appear must be equal to the poverty incidence (in which case, it means the entire poor population is already covered).

Example:

| | Poverty Incidence | % of population covered by IP | | | |
|---|---|---|---|---|---|
| | | 2002 | 2003 | 2004 | beyond 2004 |
| Province W | 40% | 10% | 25% | 40% | |
| Province X | 55% | | 10% | 20% | 55% |
| Province Y | 30% | 30% | | | |
| Province Z | 74% | | | | 74% |

In the example above, the PRO intends that all of 40% poor in Province W is covered by year 2004. In Province X which has no indigent enrollment so far, the LGU believes it can make the LGUP enroll 10% of its indigents next year, and another 10% the following year; the entire poor population can only be covered completely beyond 2004. For Province Y, the 30% poor has

already been covered, or is about to be covered this year. For Province Z, the PRO believes the Indigent Program can be implemented only after 2004.

ii. Special Cases:

There may be unique cases in some LGUs. Just please provide a note on the special case. For example, in some LGUs, the current enrollment has already exceeded the poverty incidence, such as reflected in the following:

| | Poverty Incidence | % of population covered by IP | | | |
|---|---|---|---|---|---|
| | | 2002 | 2003 | 2004 | beyond 2004 |
| Province A | 40% | 65% | | | |
| Province B | 25% | 25% | 35% | | |

In the above, poverty incidence in Province A is only 40%, but 65% of the population is already enrolled in the IP (hence this 65% has been classified as poor in the means test and poverty incidence record is then incorrect). In Province B, all the 25% poor are already currently enrolled, but the PRO knows form its negotiations that the LGU still intends to enroll 10% more next year and all candidates will likely pass the means test.

iii. Unless the poverty incidence has already been exceeded, or there already is an intention in the part of the LGU to enroll more than what is indicated in the poverty incidence, it may be good to target only a maximum of that indicated it the poverty incidence, as it is in (i).

iv. There may be other special cases other than that exemplified in (ii), just please indicate a brief remark on the special case.

Equivalent No. of HH

v. You will notice that there is an extra row (highlighted) for equivalent no. of households. A figure here will automatically appear when you enter a percentage above it, indicating to the equivalent no. of households for the percentage that you will enter. This is only meant to guide you by giving you a picture of how many households the target percentage translates to.

If you are not using a computer and just entering the percentage on the hard copy, you may ignore this row.

Column: | No. of LGUs with OPB Package |

i. The target no. of LGUs with OPB must also be cumulative. For example:

| | No. of LGUs | No. of LGUs with OPB Package | | | |
|---|---|---|---|---|---|
| | | 2002 | 2003 | 2004 | beyond 2004 |
| Province W | 13 | 2 | 5 | 10 | 13 |
| Province Z | 24 | | | | 24 |

ii. Please note that what is being targeted here is no. of LGUs with OPB Package. It is likely the case that all municipalities in a province may be adopt the indigent program already but their facilities are not yet capable of rendering the OPB. IN the example above, 10 of LGUs in Province W may already be adopting the IP by year 2003, but only 5 of these are likely to be ready for OPB by 2003. Hence 5, and not 10, is entered in the box.

For Province Z, many LGUs may have the capability to implement the OPB in terms of facilities, but enrollment to the IP by any municipality is not expected until after 2004, hence OPB cannot be implemented until then.

## III. Action Plan by LGU (Municipality or City)

i. The data on RHUs is meant to guide you in planning for expansion: those with qualified RHUs may take less time to have the RHU accredited and have the PCF ordinance passed than those which are not. The data here is according to what you submitted to the PMG. No entry means you were not able to submit the data. You may or may not fill in the blank entries. You are only required to fill in the columns from "Current Status" to "Action Plan (2002 onwards)"

ii. The Legend Code used as follows is NOT CHRONOLOGICAL.

1 – Groundworking for OPB
2 - IPB-OPB MOA signed
3 – PCF Ordinance Passed
4 - RHU accredited

That is, an LGU may already have had its RHU pass the PhilHealth accreditation, but the PCF Ordinance has not yet been passed. Also, some may be, and in most cases are, carried out simultaneously. Having RHUs accredited before PCF Ordinance is passed, however, should be reflected only until 2002 since the actual case may already be known by now. In planning for 2003 onwards, however, it is ideal to target to have the PCF ordinance passed and RHUs accredited almost at the same time.

Example:

| | Current Status | ACTION PLAN | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2002 | 2003 | | 2004 | | beyond 2004 |
| | | 2nd sem | 1st sem | 2nd sem | 1st sem | 2nd sem | |
| Province J | 1,2,3,4 | | | | | | |
| Province K | | 1 | 2,3, 4 | | | | |
| Province L | 1,2,4 | 3 | | | | | |
| Province M | | 1 | | | | | |

In the example above, Province J has already complied all the four indicators. Province K is on the OPB groundworking stage and is likely to have the OPB MOA passed, the PCF Ordinance passed, and the RHU accredited by early next year. Province L has already passed the OPB MOA and the PCF ordinance, but is still complying with some requirements for RHU accreditation.