

NEGROS ORIENTAL

Socio-Economic and Health Profile

Negros Oriental has a population of 1,124,000, a population density of 220 persons per square kilometer, and a population growth rate of 2.03% in 2000. About 95% of its population are Cebuano speaking; the rest speak Hiligaynon (Ilonggo). It has 20 municipalities and 5 cities. Two of the cities are classified as second class and 45% of LGUs are fourth and fifth class municipalities. It is a first class province with an annual income of over P30 million. The average annual family income is P49,403. The average poverty incidence is 40.6%, but there appears to be maldistribution of income as 80% of the population in rural areas is classified below the poverty line.

Health Sector Reform

Negros Oriental is one of eight pilot sites under the two-year Health Sector Reform Technical Assistance Project (HSRTAP) funded by the United States Agency for International Development (USAID). The experience in this province began with a convergence workshop held at the Bethel Guest House in Dumaguete City on April 19-20, 2001. The workshop succeeded in generating interest among major stakeholders that included 72 representatives from the national, regional and local health agencies, Philippine Health Insurance Corporation (PhilHealth) representatives, municipal/city public officials, support institutions, and health NGOs. With the use of participatory mechanisms, the various stakeholders crafted targets, strategies and health plans that were doable.

The workshop started by defining the policy environment and identifying problems and issues that affected the local health sector. The participants were briefed about the basic concepts of current initiatives that included the Health Sector Reform Agenda, the Health Passport Strategy and the Convergence Strategy. Together they defined an HSRA vision for Negros Oriental. This became the basis for a draft convergence plan. A group of Negros Oriental Health Sector Reform advocates was constituted to serve as strategy champions.

Gains in Health Financing

Community Financing - Peso for Health

The “Peso for Health Program” was implemented before PhilHealth approached the LGUs. It is community-designed, community-based and community-managed. Its implementation started in May 2000. The program aims to mobilize resources for sustainable health services, and strengthen health service delivery through community, LGUs, and hospital participation. The Peso for Health Program is open to any resident person certified by the LGU. Community resources from individual members’ minimal monthly contribution, LGUs’ fund support, and donor contributions are pooled to sustain community health care financing under the Fund Management Committee of the district health system. The Peso for Health Program will get 25% of LGUs’ pledges in the ILHZ.

Monthly contributions are based on A, B, and C categories with corresponding benefit packages as shown below.

Bracket	Premium/mo. (P)	Benefits
Category A	1.00	P200 benefit package for drugs/medicines plus discount in diagnostic services and other medical facilities
Category B	5.00	P1,000 benefit package for drugs/medicines plus discount in diagnostic services and other medical facilities
Category C	10.00	P2,000 benefit package for drugs/medicines plus discount in diagnostic services and other medical facilities

Drugs are prioritized in the coverage of the benefit package. Any remaining amount from the ceiling set per bracket will be utilized for hospital bills. The patient will pay only half (50%) of the excess bill. This covers all hospital services like medicines, inpatient and outpatient services/laboratory, diagnostic services (e.g., newborn screening), room accommodation, and emergency transport from the District Hospital to the Negros Oriental Provincial Hospital (NOPH). Identification cards are distributed to individual members. The card is non-portable and color coded by municipality (yellow, blue and green IDs). A member can avail of the benefit package only after six months and when the accumulated contribution has been paid.

Barangay health workers (BHWs), barangay officials, and assigned health workers of the program are the collectors of members' monthly contribution either cash, in kind or in service. The Fund Management Committee has P5,000 in petty cash every week. Expenses or charges from 2001 to the present has amounted to over P100,000. With 10,000 members, they now have P38,000 in the bank. Cash inflow vs. outflow is break-even. The program targets to reach P200,000 or 50,000 enrollees which is the critical mass. When they reach the critical mass, they would like to include OPD in the benefit package. Based on a rough estimate, the average cost per patient is approximately P900. This indicates that health care cost is almost doubled from January 2001 with an average of P500 for Bracket B. Latest records show approximately P650 out-of-pocket payment per member, mostly on obstetric and sometimes medical cases. Program records also reveal that health care cost of members normally did not exceed the ceiling of the benefit package. Members have difficulty making the yearly payment, especially if the family has many members enrolled in the program.

The advantages of the Peso for Health program are the following:

- • less bureaucratic
- • genuinely autonomous
- • community-based, owned and managed
- • cost sharing or responsibility sharing

- • accessible, available, acceptable and affordable
- • people empowerment is assured

The problems and limitations of the Peso for Health program include:

- • Miscommunication between members and program implementers. This is relative to limited funds to produce information materials like a brochure.
- • Irregular collection of monthly contribution of members. Not all contributions are collected by BHWs regularly, and there are cases when the remittance is in lump sum. Sometimes there are members who pay in advance, depending on the availability of cash.

Other provisions or policies of the program that are worth noting are:

- • for three months delay in the payment of contribution, the member can only avail of 50% of the benefits;
- • six months delay in payment means dropping of membership and requires re-enrollment; and,
- • benefits can only be availed of if the enrollee has been a member for six months.

There is a six-month grace period prior to availment of the benefit package because: a) this is a counter strategy to patients taking advantage of the benefit package; b) this helps to accumulate funds on the assumption that the number of enrollees is increasing; and, c) this makes sure that funds will not be exhausted.

There are many PhilHealth members who are Peso for Health members, but in the community, indigents depend on Peso for Health Program for health care financing. There is no double membership in the Indigency Program and Peso for Health Program since PhilHealth's Indigency Program is not present in Sta. Bayabas ILHZ.

PhilHealth Indigent Program

The target of the Indigency Program (IP) is that by year 2004, 25% of all LGUs will be enrolled in the program. As of May 2002, PhilHealth records show that 10 LGUs have enrolled in the program, which indicates 40% accomplishment of the target number of LGUs.

The program was presented initially at the regional level, which was attended by members of the Regional Development Council, DOH VII and Provincial Health Officials and Social Welfare Officers. The program was also presented to the League of Mayors at the provincial level, to the Sangguniang Panlungsod (SP) / Sangguniang Bayan (SB), Committee on Health, Health Officers and other LGU personnel assigned by the local chief executive to take charge of the program. Usually, the Municipal Health

Officers (MHOs) took the responsibility of initiating the adoption and facilitating program implementation in the LGU.

In Negros Oriental, the IP premiums are covered by municipal LGUs (MLGU). There is no provincial LGU (PLGU) counterpart due to differences in political party affiliation. The PLGU also wanted MLGUs to take the initiative in lobbying for the PLGU's counterpart. The Governor is very supportive of the Indigency Program but he has no control of the Sangguniang Panlalawigan. Majority of the SP members do not belong to the same political party. This was cited as a limiting factor in facilitating SP resolution to support legally the provincial government's partnership. It also entails cost sharing with municipal and city LGUs and the national government through PhilHealth.

PhilHealth key informants revealed, "although advocacy was properly handled, the former Vice-Governor who was the presiding officer of the Sangguniang Panlalawigan had his own program called Valencia Program, which he wanted the province to adopt." Amlan's enrollment to the program is an exemption because it has a counterpart from the province. It had successfully lobbied with the provincial government. Their resolution was passed after the May election last year, which was timely then since the former Vice-Governor did not win in the election.

PhilHealth then suggested to the PLGU to make one resolution for the adoption/implementation of the Indigency Program in Negros Oriental. However, the provincial administration prefers to do it on a per LGU basis like what Amlan did.

While there was some delay in acceptance of the PhilHealth indigent program in some municipalities in Negros Oriental, the experience in the municipality of Bindoy was different. In August 2001, the Management Sciences for Health facilitated the Health Sector Reforms orientation in Binata health district. Social health insurance was one of the priority interventions, which in turn encouraged Bindoy's Local Chief Executive and other local stakeholders to adopt the program. However, they found it difficult to market any program if constituents have to pay. This perception was based on their unfavorable experiences with PhilHealth's services (e.g., very bureaucratic, policy restrictions, issues on late reimbursements, low utilization rate, etc.).

To counter this, the Mayor and the officer in-charge of the Indigency Program of Bindoy took the lead in conducting IEC in different barangays with other local stakeholders, health workers and barangay officials. Advocacy through information dissemination per barangay has been effective. Indigency Program coverage, entitlements, benefits, processes, and cost sharing schemes were the focus when conducting IEC. Another strategy of the LCE in marketing the program is to emphasize to the constituents that health is not only a concern but also a responsibility of every individual. This has helped to persuade the people to contribute 50% of the total premium to sustain the program.

Another issue is that of affordability and sustainability. To address this, the Mayor of Bindoy conducted a comparative study on cost sharing for the Indigency Program

premium and capitation fund within a six-year period. It was presented to the different stakeholders in Bindoy and other LGUs in the health zone.

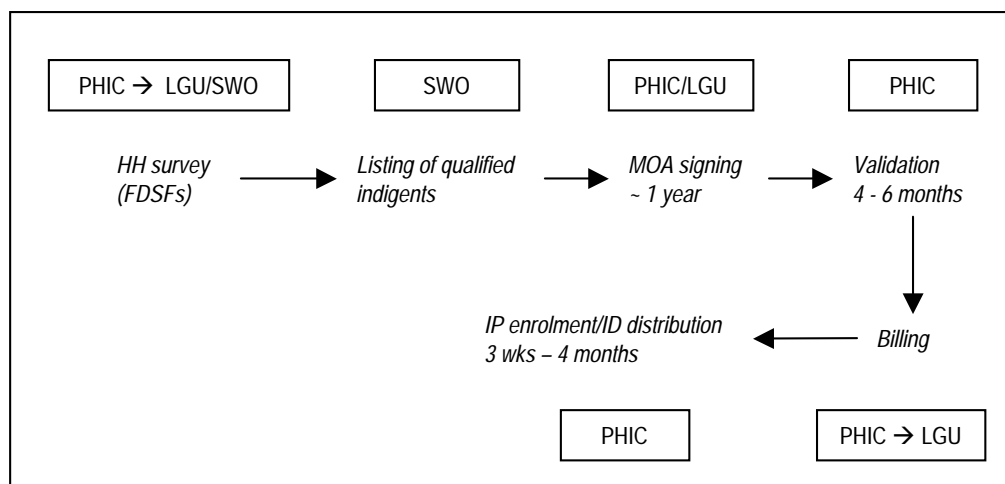
Bindoy relies on different fund sources for the Indigency Program premiums. These sources are the Municipal LGU (20% development fund), Barangay Internal Revenue Allotment (1% of Barangay IRA), Provincial LGU and households (enrolled indigent families). The proposed cost-sharing scheme of Bindoy applies to other 4th – 6th class municipalities because of the following features:

- • At P118.80 annual premium per enrollee, the Provincial LGU covers 50% share at P59.40 in the first year. The remaining half is equally divided by the Municipal and Barangay LGUs.
- • In the second year, the household-enrollee will have to contribute 50% of the total premium while counterparts from the three LGUs (province, municipal and barangay) will be reduced to half of its first year share.
- • To meet the premium contribution of P237.60 per enrollee for year 3, all counterparts from the four fund sources will be doubled (HH = P118.80, PLGU = P59.40, MLGU and BLGU = P29.70 each).
- • Sharing scheme for year 4 will reflect the same amount of HH contribution in year 3 (P118.80) but it accounts one third of the total premium (P356.40). LGUs' (province, municipal and barangay) counterparts will be doubled based from year 3.
- • Household contributions for succeeding years 5 and 6 remains the same, but it will account 25% (year 5) and 20% (year 6) of the total contribution. LGUs' shares will be increasing (see Appendix).

Enrollment in PhilHealth Indigent Program

It took almost a year for most LGUs to accomplish the MOA from the time that the LGU passed the resolution. In the case of Zamboanguita (the first LGU to implement the IP), it only took two months to have their MOA signed. The normal timeframe after the MOA was signed to validation (verifying the list) is six months. Zamboanguita did the shortest period in four months.

Figure 1. Schematic Flow and Estimated Timeline of the IP Application Process.



PhilHealth provides family data survey forms (FDSFs) to LGU thru the Social Welfare Office (SWO). FDSF is patterned after the existing DSWD form. There is only one form used by PhilHealth and SWO in identifying qualified indigents. PhilHealth hires enumerators, usually BHWs to administer the FDSFs in the barangay. The survey is under the supervision of the Social Welfare Officer and the Barangay Chair. For LGUs that conducted their own survey, they just transferred their data to FDSFs and have their list of indigents. Certification of the Social Welfare Officer is sufficient for PhilHealth. Thus, there is no need to conduct another household survey. There are patients who approached to in-charge of the social health insurance (IP) for membership inclusion.

Verifying the list to ID generation/distribution took four months when the IDs were generated at the National Office. Recently, IDs have been made at the Regional Office, which shortened the timeline to three weeks (e.g., in the case of Bindoy). Bindoy targeted around 4,000 enrollees for this year with budget augmentation from the Binata ILHZ common health fund. As of June 2002 data, the LGU enrolled a total of 1,902 indigent families from all (22) barangays. Enrollment was carried on three batches with a total payment of P225,957.60 made to PhilHealth from the Municipal and Barangay LGUs share. A total of 196 applications have been submitted to PhilHealth for approval. The provincial counterpart (P200,000) is not yet released, but it will be used for additional enrollment to meet this year's target.

Table 1. Status of Indigency Program Enrollment, Contribution and Capitation Fund Received as of June 2002, Bindoy, Negros Oriental.

Batch no.	No. Of enrollees	Validity date	Amount paid to PHIC (PhP)	Capitation fund received (PhP)
1	784	2/16/02 – 2/15/03	93,139.20	107,146.67
2	898	4/16/02 – 4/15/03	106,682.40	
3	220	6/01/02 – 5/31/03	26,136.00	
Total	1,902		225,957.60	107,146.67

* Capitation fund received – initial and 2nd quarter of 2002.
Source: Bindoy LGU Indigency Program TWG record.

The benefit package offered to indigents under the program are categorized as regular benefits – refers to hospital benefit package that includes room accommodation, medicines, laboratory and x-ray services, doctors' fee with certain ceiling and the outpatient benefits are provided at the RHU level.

The PhilHealth National Office is also into private sponsorship. The Regional Office already identified and communicated potential benefactors including congressmen for sponsorship strategy. All congressmen in Cebu are interested, but only the second district has started implementing. So far, there is no response from private benefactors.

Policy restrictions limit PhilHealth to alternative ways in expanding coverage like allowing qualified indigents/clients to cover the P120 premium payment. The staff cannot do it since billing has to be done by LGUs as stipulated in the national policies and guidelines. Clients who do not qualify in the program will be classified as individual paying members with a monthly premium of P100.

There are four LGUs in Negros Oriental (Amlan, Bindoy, Dauin and Zamboanguita) that enrolled in the Indigency Program with a total of 6,063 active members. Three (3) LGUs are still in the survey stage of the application process and there are nine (9) LGUs with MOA on IP-OPB having a total commitment of 14,372 households.

PhilHealth Rural Health Unit Accreditation

Most LGUs wanted to avail of the out patient benefits (OPB) because of the capitation fund from PhilHealth to LGUs with accredited RHUs. Hence, LGUs wanted their RHUs to be PhilHealth accredited. PhilHealth representatives have visited and pre-assessed all RHUs in Negros Oriental. Now, they are working on the requirements for accreditation.

During the interview, some reasons for the delay of the approval of accreditation were as follows:

- • Policy restriction on equipment and laboratory apparatus limits accreditation approval of CHOs/RHUs, while only 10% - 20% of patients availed of laboratory services of the out patient benefit package due mostly from non-compliance with equipment and laboratory apparatus requirements, such as: centrifuge, test tubes for laboratory exams, urinalysis, CBC, fecalysis equipment, etc.
- • Another identified problem on accreditation is the failure of LGU-RHU applicants to comply with the requirement on one medical technologist per facility. Region VII is flexible on this particular requirement. The accreditation unit allows complementation of medical technologists among LGUs within a health zone. This is based on transitory provisions of the policy, which are applicable to hospitals and inter-local health zones. This has been to the advantage of Negros Oriental. With the

ILHZ, LGUs can share the services of the medical technologist, facilities and equipment within the catchment. This could be possible through a referral system. So, the medical technologist requirement is no longer a “must requirement” as long as they have an ILHZ, which has a referral facility (e.g., another RHU).

- • A MOA is a requirement for accreditation. Accreditation application may start as long as the Mayor signifies intention, even if there is no list of indigents. The MOA could be accomplished at the same time with accreditation application as long as the LGU has started the process of accomplishing it.

Up to the present, Negros Oriental has three (3) accredited RHUs in the municipalities of Ayungon, Bindoy, and Amlan. Willingness of the political structure, LCEs and health providers, particularly the Municipal Health Officers to upgrade the facility and comply with accreditation requirements, is considered as the main factor that facilitated accreditation. Policy restrictions on the part of PhilHealth, like strict implementation and compliance to accreditation standards, the top-down approach in policymaking and implementation, were identified as the main barriers to facility accreditation.

However, the respondents agreed that some RHUs were liberally approved by PhilHealth even if they failed to comply with equipment and laboratory requirements. Such consideration is based on the assumption that the capitation fund will be utilized for procurement of lacking equipment/laboratory apparatus.

The structural improvements of Amlan and Bindoy RHUs in the BINATA ILHZ are worth noting. Bindoy invested P200,000 in year 2000 and another P100,000 in the following year for RHU rehabilitation and upgrading of facility and equipment. The buildings were repainted, tiled flooring, new windows, landscaped RHU area, television, video-audio and karaoke sets used for IEC while clients are waiting. This shows significant improvement in providing access and better health services to the people.

Capitation Fund

Amlan is a fifth class municipality that was already accredited by PhilHealth and is now entitled to the capitation fund of the PhilHealth indigent program. The Municipal Health Officer admitted that they needed the fund badly because there was a cut in health budget caused by slashed internal revenue allotment of last year. Although she did not have a breakdown on the proposed expenditure for the fund, she believes that the fund will be helpful in terms of the following:

- • Additional budget for medicines
- • Upgraded facility
- • Better and more services available to people

The LGU enrolled its indigents on February 15, 2002 and the RHU is also PhilHealth accredited. In April 2001, the MOA was signed and the Provincial Government gave a counterpart, but it was withheld due to the election bond. The approach of Amlan was quite different from other RHUs in terms of payment for the IP enrollees. Each indigent

member is required to give a counterpart of P60 on installment at P10 per month for the premium to ensure sustainability of the program. Said mechanism also inculcates responsibility and ownership of each member. The LGU has a trust fund. They had a program before where people who want to be covered by the health support program contribute P10 per month. It will be used to sustain the Indigency Program if in case the LGU cannot afford to cover the premium.

It took about two months for the approval of Amlan's application for RHU accreditation. They applied last March 2002 and just received the PhilHealth accreditation certificate during the third week of May. The LGU has not received the capitation fund and based on PhilHealth feedback, it is still being processed at the regional office. They have not set the details on capitation fund utilization, but will prioritize procurement of drugs and equipment. They still have to comply the centrifuge and equipment requirements. The LGU is aware that the capitation fund is for health services. So deviating from the utilization of said fund is very remote.

Amlan RHU also continues to provide innovative services and introduced charges to these services to maintain sustainability of their operations. Innovative programs include women's health, newborn screening, rehabilitation, acupuncture and laboratory services like blood typing, blood count, blood sugar, urinalysis, cholesterol and sputum microscopy. They charge P40 for blood sugar and P70 for cholesterol examinations. They continue to provide consultation and medical services with minimum of 30 patients per day for consultation. There is no service charge for consultation, but they accept donations for facility maintenance. For minor surgery service, they charge or require the client to provide their own supplies for sutures.

To formalize charging for services, the MHO submitted to the LGU a proposal on the collection of minimal fee for services availed by non-members of the Indigent Program of PhilHealth.

Amlan has a track record of being recognized for their innovative services. The LGU received the Sentrong Sigla P1 million cash award prize. They used it in supplementing other health resource requirements. Seventy percent (70%) of the amount was used for drug procurement and the remaining funds for facility maintenance and repair.

Another innovative and community-based program implemented was the "Singko for Health Program" for medicines. It was patterned after the "Peso for Health Program." Each individual member contributes P5 per month. This is equivalent to P1,000 -ceiling of the benefit coverage for medicines. Now, they adopt a new policy with a ceiling of P 250 for first year of membership and P 500 for the second year. They had experienced before that funds were exhausted because members bought medicines for three months and they discovered dishonesty of some members.

Another is the Hospitalization Program, which gives P2,000 subsidy for indigents. LGU health program stakeholders are planning to establish a cooperative pharmacy. Prescriptions will be issued to clients but direct it to the pharmacy in order to provide

cheaper drugs and avoids dishonesty of Singko for Health members. Returns or consequences of their local efforts and health development initiatives are; a) minimized dole out at the RHU level (e.g. transportation fare of clients covered by health providers) and b) reduced RHU referrals to hospitals.

A similar experience can be seen in Bindoy. Just like the standard application procedure for accreditation, the LGU complied and submitted the requirements on November 25, 2001. It was not difficult for them to comply the requirements since their facility was already upgraded and SS certified, the RHU has an existing laboratory and medical technologist. RHU accreditation approval was in January 2002.

The LGU already received P107,146.67 as initial and 2nd quarter capitation fund on May 29 this year for the first 784 enrollees. What is certain in terms of its utilization and management for the moment is to follow the standard appropriation guideline set by PhilHealth, such as;

- • 20% for administrative cost (half of it or 10% of the total fund will be given to the doctor and the other 10% will be shared among the medical technologist, nurse and midwives), and
- • 80% for drugs, supplies and equipment

The LGU has not prepared the capitation fund utilization and program plan. So, the money is still intact. Hopefully within the third quarter of this year, the LGU will be able to prepare the program plan indicating the utilization and management of the capitation fund after the supplemental budget of P400,000 for equipment from the Congressman and another P400,000 for medicines will be exhausted. The P400,000 allocation for equipment will be used for the procurement of semi-automated analyzer, equipment for microscopy procedures and other laboratory equipment.

Patient's Experience on PhilHealth Indigent Program

Records show a high utilization rate based on number of households enrolled in the Indigency Program and indigent benefit claims. The total LGU investment is P254,640 for 2,122 households at P120 LGU counterpart for the premium per household. LGU investment is about 35% of members utilization cost, which is pegged at P730,011.65. Thus, there is no negative perception or losing end concept of LGUs on their investment to the program. On the contrary, it would mean loss for PhilHealth. The data further indicate that PhilHealth reimbursement is calculated at 68% of actual hospital charges (P1,073,249.47). This accounts for 32% loss or deficit of the claimant facility.

Interviews with patients admitted at Negros Oriental Provincial Hospital was also done. The PhilHealth member informant did not know the cost of his premium since it is the employer who pays it. One of the non-PhilHealth members had heard of PhilHealth in the hospital but did not know its details. The informant has limited knowledge on his benefits as a member. He cited hospitalization benefits like room accommodation and laboratory service fees, but he was unaware of the details of social health insurance

coverage and members' benefits. Most of them are aware of available health facilities accredited by PhilHealth. Government and private hospitals (District, Provincial and Medical Center) were enumerated as service providers accredited by PhilHealth. The respondent expressed dissatisfaction of PhilHealth's ceiling for patients' benefits, especially for medicines. Hospital pharmacy only allowed P1,700 for medicines and P250 room rate per day. He wanted that the ceiling and coverage be increased to minimize their financial burden on hospitalization.

Two of the respondents have never heard of the Indigency Program and PhilHealth promotional activities. The other one had heard about it over the radio but not in Siaton. One non-PhilHealth member respondent wanted to enroll in PhilHealth social health insurance but cannot decide to be an individual paying member because she wants to consult first her husband. The other non-member wants to avail social health insurance but cannot afford to pay the premium. When she was informed about the Indigency Program, she wanted to avail it because hospitalization cost (particularly on medicines) is very expensive and too heavy for their pocket. Room accommodation and doctors fee are free. The hospital accepts donation but they buy medicines in hospital pharmacy and pay laboratory fees. Overall, PhilHealth members expressed dissatisfaction of the benefit package.

In Bindoy, people are no longer afraid to go to health facilities for treatment. They are aware of the social health insurance coverage, the benefit package and their entitlements. Hence, there is a gradual positive shift in their perception and practice on health care. Before they used to go to the RHU or hospital for severe illness or condition, but with the Indigency Program membership, they are aware of their entitlements and services, which consequently enabled them to avail both preventive and curative services. Constituents/IP enrollees' reactions;

- • Very happy
- • Very grateful/thankful
- • Proud (it was their first time to have an id)
- • There were questions on renewal and when others can avail the program

There are other LGUs in Negros Oriental that have a community based health insurance scheme. Ayungon has an endowment plan for indigent patients. It also has a community-based health financing program called "Sustainable Health Care Initiative of the People" or SHIP. The local officials under Mayor Edcel Enardecido initiated the program in 1999. It is the response of local officials to urgent needs for medicines and other health needs of their constituents. It is supported by 2 legal mandates, the SB Resolution No. 146 and Ordinance No. 8, which stipulates the adoption of a health care program – SHIP. Target beneficiaries are all Ayungon residents from 3 months old and above. Non-residents but working in the municipality either government or private employee may join the SHIP. Monetary involvement includes a lifetime membership of P20 and P50 for the annual contribution.

Benefit package of the SHIP health care financing program;

- • Free consultation by the MHO or any government doctor
- • Free medicines of not more than P1,000 prescribed by the physician at the OPD or during admission availed only once a year

Problems on the PhilHealth Indigent Program

Sustainability of the Indigency Program depends on utilization rate and the same membership over time. If utilization is low, it implies loss of LGU investment and a problem of the LGU. If utilization is high, it becomes a problem of PhilHealth. The experience of Bago City on low utilization rate based on actual servicing (P950,000 for 2 years) vis-à-vis the LGU investment for the Indigency Program (P6 million) also influenced the reluctance of Sta. Bayabas to adopt the program. Based on statistics, there are roughly about 4,000 admissions in all district hospitals and health providers have an apprehension that it would be a losing investment for LGUs to join the Indigency Program since the utilization rate is low. Thus, they are not receptive to the program.

There is no program sustainability if PhilHealth relies only on members' contributions. So, it is up to the national office on how to invest and implement mechanisms to sustain the program. The regional office is not allowed to invest, but being in the forefront of program implementation. It should be responsible of taking the initiative/s in developing sustainability mechanisms. The fund for the indigent program also depends on the timely remittance of the national government's share.

Limiting factors in implementing and sustaining the Indigency Program are: a) lengthy application process / tall bureaucracy. It takes about 1½ years for LGUs to enroll their indigents to the program. This will have an implication on indigents' timely service utilization, b) lack of manpower for groundwork activities and monitoring. PhilHealth's present structure limits extensive promotion and coverage of the Indigency Program, c) management and implementation of the program is only at the Regional Office. Thus, the service or field office has no direct involvement and hands on of the program.

Although all (7) staff of the Indigency Unit in the Regional Office are capable of presenting the program, still the ratio of staff over LGUs coverage is 1: 19, which is apparently high. There are areas where telecommunication and email are not available. So, physical presence of IP Unit staff is needed to follow-up LGU application and other program implementation activities. Ideally, there should be one service office for every ILHZ. This connotes additional staff requirement for ILHZs as PhilHealth desk officer or contact person. There are also other concerns that PhilHealth representative should address. However, field staff has/have some limitations and restrictions in program implementation. They need approval from the regional office. PhilHealth representative was hesitant in going with health providers, when in fact they should exert more effort in promoting the Indigency Program.

Some key informants made a comment that "PhilHealth's information campaign strategy is ineffective or inappropriate in a sense that they were so aggressive in membership campaign while the infrastructures are not ready."

Fund source of LGU for IP premiums is another big concern and issue of program sustainability. Cost sharing scheme can be a hindrance to program sustainability. Can the LGU/s afford, especially if reclassified into higher income class? Income classification of municipalities is not based on total income of LGU but on per capita income, which is population based. With the 50:50 cost-sharing scheme, the LGUs might discontinue their enrollment in the program. Financial incapacity of some LGUs to enroll all indigents and sustain program membership may result to political liability of the LGU. Hence, the program could not be sustained.

Unfavorable political environment is also a critical factor that attributes to Indigency program implementation and its sustainability. Differences in political party affiliation among local leaders at the provincial, city and municipal LGUs also affect the status and development of Indigency Program in Negros Oriental. Opportunity of politicians to take advantage of the program by issuing medicines charged to PhilHealth reimbursement. The Indigency Program has political connotations. Sometimes, LGUs feel that it becomes an obligation of the LGU/LCE to pay the excess bill of indigent PhilHealth member when hospitalized. This is a way of strengthening the dole out system, unless health is linked with socio-economic programs toward the direction of a holistic development approach. There has to be a livelihood program component to complement Indigency Program's sustainability.

The Provincial Administration's perception is that the Indigency Program is subsidizing PhilHealth members in the employed sector. Now the LCE would like to do it the other way -- let PhilHealth members of the employed sector subsidize the indigents. This is another adverse perception of PhilHealth social health insurance.

Other LGUs were encouraged to enroll in the Indigency Program because of the capitation fund. Some health providers prefer local/community health insurance for accessibility of funds, ease in processing and shorten the bureaucracy. The convergence strategy does not necessarily make things work on improving and sustaining the social health insurance. The key informant could not cite significant effect or impact of the convergence on this particular reform component. It may not work because of the attitude of politicians.

Gains in Hospital Reforms

Negros Oriental is one of the few provinces that have allowed public hospitals to retain their income for their use. Aside from the regular budget allocation from the province, the income earned by hospitals from user fees are plowed back to the hospital for their maintenance and operating expenses. At the outset of devolution when there were insufficient funds for hospital operations, then Governor Macias explored the possibility of allowing hospitals to keep their income. Provincial funds for hospitals were reduced to one half and there was need for an innovative scheme to be able to maintain hospital operations. Appropriate local legislation was passed - allowing the provincial treasurer to keep in trust funds generated by the hospitals at the provincial and district and community levels. Up to the present, user fees are remitted to the provincial treasurer and an accountant is assigned to keep records and keep track of all hospital remittance

forwarded to the Provincial Treasurer. The hospital makes periodic requests for release of funds and a budget sub-allotment is prepared and approved by the Sangguniang Panlalawigan. Each hospital has its own board that decides how the funds are to be spent.

The creation of hospital boards also prepared various sectors of Negros Oriental society for participation in district health boards. The hospital board is multi-sectoral in membership and has policymaking as well as financing functions. It approves the work and financial plan prepared by the hospital staff and disbursement by the province is in accordance with the approved plan and budget.

The multi-sectoral membership made hospital operations a joint concern and ensured transparency in budgeting and financing. Collaboration was also easier to pursue as various sectors contribute to meet hospital needs. In the provincial hospital, it is a common practice to donate in kind in the form of hospital equipment or undertake renovation of rooms. 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 like the Rotary Club undertake projects to benefit the hospitals. The Women's Auxiliary actively solicits donations for the hospital and religious groups like Sinag also do the same simultaneously with the performance of their religious ministry. The idea of inter-sectoral collaboration as espoused in the inter-local health zone concept was no longer a novel idea but an expansion of the hospital board concept. It was no longer difficult for the DOH through the regional office to promote the ILHZ. Various sectors of Negros Oriental society were already prepared and had previous experience with inter-sectoral collaboration. In terms of hospital reforms, the province had set the following targets for 2001-2004 for its eight hospitals:

- • Sentrong Sigla and PhilHealth accreditation
- • Creation of quality assurance committees
- • Financial autonomy
- • Availment of sub-allotment scheme
- • Generation of income equivalent to 40% of MOOE

Negros Oriental Provincial Hospital (NOPH)

The NOPH is the tertiary referral hospital for the province of Negros Oriental located in Dumaguete City. It also serves as the core hospital of the ILHZ composed of Dumaguete City and the municipalities of Dauin, Bacong, Sibulan, San Jose, Amlan and Valencia. It is accredited by both DOH and PhilHealth as a tertiary facility. It has authorized capacity of 250 beds. It serves not only the province but also some areas of the nearby provinces of Siquijor, Southern Cebu and Northern Mindanao.

It appears that many of their cases may be served by the lower levels of the health system. The referrals received increased from 675 in 1993 to 1,463 (116.7%) in 2000. This reveals 46% increase. It is interesting to note that throughout the period, majority (85% - 95.%) of the cases were referred by other hospitals/centers. The hospital staff

reported that many of the cases seen at the outpatient department, as well as birth delivery in the hospitals could be handled by the lower levels of the health system.

The facility registers an occupancy rate of 90% in 2001 with an average 5 days length of stay of patients. Total admissions last year was 16,824, out of which medical services accounted for 30% of total admissions. Hospital records shows that pediatrics and under five consultations were highest at the outpatient service department (OPD). Surgical and medical services ranked second and third in the OPD. The hospital had served a total of 68,638 OPD clients (data based on year 2001 record).

Acute respiratory infection and urinary tract infection rank first in consultation cases. Wounds with minor surgical interventions rank second, followed by ARI with pneumonia. Moderate to severe dehydration secondary to diarrhea is the top leading cause of discharges, followed by ARI with severe pneumonia. Pneumonia ranks third in leading causes of discharges, but it is the number one cause of mortality. Cerebro vascular disease is second followed by malignancies due to cancer.

The cost of maintenance is high vis-à-vis the perceived impact of prolonging the life of patients. This is cited as one of the impact programs of the former provincial administration, but it also raised a critical issue on sustainability based on economic analysis. From an objective perspective of economics and program sustainability, it is a losing venture of the LGU even if the machines/equipment were donations. The net income for dialysis is only P180-P200 while sustainability of hospital services is an important consideration for LGUs.

Fund allocation for medicines is 25% of total hospital budget. Dumaguete City has an endowment fund from the LGU for indigents' hospitalization financial assistance.

Among the problems identified in Negros Provincial Hospital are;

- • Personnel management. When they were devolved, they wanted to standardize operations. However, the Provincial Government cannot afford to hire the desired plantilla positions.
- • Inadequate resources for hospital operations and services to meet real demands of clients.
- • Despite its problems, the Negros Provincial Hospital has positive attributes:
- • Utilization of hospital income for its operations. It is now categorized as restricted fund for facility operations. Although users' fees were given back to the hospital, the funds were utilized by charging contract services. It should have been used for hospital operations improvement that would focus on maintenance, operations and ultimately provision of better services.
- • A Hospital Board sets policy, approves budget and monitors operations.

- • Complementation from active NGOs and civic organizations.

Renovated private rooms thru the help of Women's Auxiliary Service, a non-government organization complementing health service delivery.

Networks with Dumaguete and Florida Rotary Clubs. These linkages enabled hospital management to access seven dialysis machines/equipment. The rationale for acquiring the equipment was based on the life saving impact and specialization of donor. Acquisition of said machines/equipment was during the former Provincial Administration. The equipment caused additional income to the facility, but the charge is low and liquidity of income posed an issue due to many outstanding debts. NOPH charges only P3,500 for first use compared to P5,500 (private facility) and P1,800 for re-use. So there is a big difference of service charge between government and the private facility.

- • Facilitating factors in implementing hospital reforms are; a) openness and cooperation of health management and providers to undertake reforms, and b) users fee utilization to augment hospital operations. The Provincial Government allows hospital income to be used by the facility to augment budget for hospital operations.
- • Sustainability through privatization/corporatization is not the goal of hospital management and staff. They adhere to sub-allotment in order to facilitate operations with some sense of autonomy and fiscal administration. The political leadership somehow supports this view.

Bais District Hospital

Bais District Hospital is categorized as secondary health facility operating a 50-bed capacity but with a budget of a 25-bed hospital. The facility has increased the number of beds to 150. It is operating beyond its capacity. Occupancy rate is 93%.

Hospital budget is sourced from the Provincial Government and Bais City Government. Provincial budget has been limited since devolution. At the outset, the former Chief of Bais District Hospital (Dr. Ely Villapando) had convinced Bais LGU to complement funds for hospital operations. Total hospital budget for this year is P20 million. The Provincial Government's share accounts 55% of the total budget (P11M), while Bais City LGU contributes P9 million. Hospital income is P 2.4 million, which is 12% of its total budget.

Two LGUs within Bais ILHZ pledged a total of P5 million for hospital improvement. The Local Chief Executive of Bais City pledged P2 million and P3 million from Tanjay City Mayor.

The facility has 12 well-trained doctors, but it is constrained by an inadequate budget for hospital operations. A limiting factor in hospital operations is lack of supplies, which is attributed to inadequate budget. Supplies are not available for local purchase, even if

patients are willing to buy it. Bais health providers work with PhilHealth. They exert more efforts compared to PhilHealth representatives. Key informants' remarks indicated inadequacy of PhilHealth's advocacy, "mahina [weak] compared to hospitals."

The hospital has adopted some strategies to increase its revenues and achieve sustainability. They are; a) increase hospital fees/charges (level with PhilHealth rate), b) billing of patients if they have money and c) Medicare para sa Masa or Indigency Program. RHUs are aggressive in promoting the Indigency Program. Most LGUs enrolled their indigents in the program. The District Hospital is banking on the Indigency Program as a means of increasing its revenues. Health providers at the facility are also encouraging indigents to enroll in the program. They are the prime advocates of the Indigency Program in their catchment thru the inter-local health system.

Limiting factors in implementing hospital reforms.

- • Inadequate budget for facility and equipment upgrading, and other hospital operations needs and requirements.
- • Patients' biased perception and preference. Patients prefer tertiary facility services especially for major operations. The District Hospital wants to increase surgical operations but patients prefer tertiary facility services preventing district hospitals from achieving their health delivery targets.

Bayawan District Hospital

Bayawan District Hospital is a secondary facility with a 50-bed capacity. The hospital is PhilHealth accredited catering to three municipalities in the southern part of the province.

The budget for fiscal year 1999 (P12,424,429) and 2000 (12,969,605) is almost the same, but there is a big difference from 2000 to 2001 and 2002. Capital outlay allocation for equipment, building and structure in two recent years caused a remarkable leap in hospital budget. Hospital budget for 2001 has increased by almost 42% of previous appropriation, and the increment for 2002 from last year is calculated at around 6%. Appropriation for maintenance and other operating expenses (MOOE) and personnel services has been increasing over the four-year period, except for 2000 budget, which decreased at a very minimal amount. This difference could be explained by the absence of allocation for monetization of leave credits in 2000, which costs more than the overtime line item budget, which the previous year did not have. The average increase of MOOE is calculated at 38% over the period. MOOE allocation for 2002 accounts almost 25% of the total hospital budget. It is 10% higher compare to 1999 statistics.

Fig. 2. Comparative detailed budget of Bayawan District Hospital, 1999–2002.
(Source: Bayawan District Hospital)

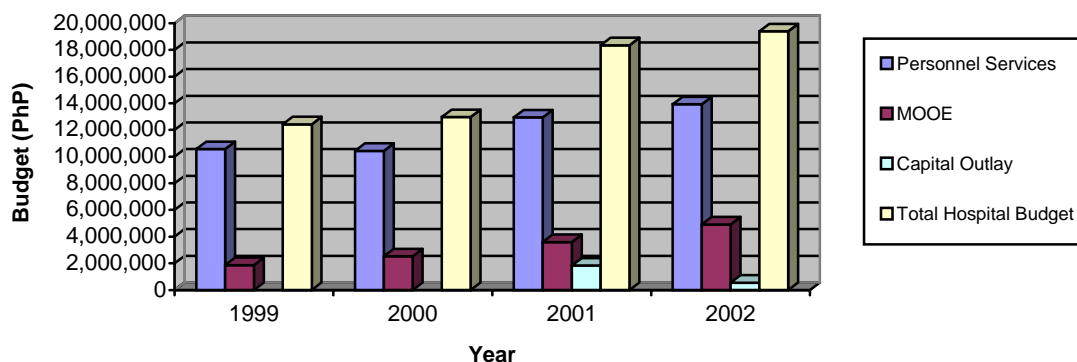


Table 2. Comparative budget of Bayawan District Hospital, 1999 – 2002.

YEAR	BUDGET(PhP)
1999	12,424,429
2000	12,969,605
2001	18,352,887
2002	19,386,781

Source: Bayawan District Hospital

Bayawan District Hospital has a higher budget compared to other hospitals in the province. The hospital has excess funds and the management is thinking of sharing part of it to other health units. This was a result of innovative financing strategy adopted by the hospital. The Chief of District Hospital recognized the “barter system” principle as part of the local culture. Thus, he took advantage of such practice but not thinking then that it would help in their dietary operations. Hospital management accepts goods in lieu of cash payment for hospital bill of patients. With this innovative strategy, the management established guidelines and came up with a list to identify the equivalent cost of local products.

The collection of some form of service fees has been established and the medical social worker has been instructed to explain the policy. The policy is no charity or free service, which is based on the premise that “if you value your life, you must be willing to give something.” They developed the promissory note as mechanism for installment/staggered payment of hospital bills or service charges. The hospital adopted a follow-up mechanism to ensure high turnover of promissory note payments. Payment may be made in cash, in kind or service. Payments in kind or goods and services are given their cash equivalence. The hospital staff buys patients’ goods or monetizes the services rendered by a patient’s watcher. An example cited was for caesarian. They ask patients if they can pay in kind like lechon or 10 kilos of sweet potato. This is a local strategy of

empowering the clients to be responsible of their health care needs and obligations. If all hospital managers have the same perception on the social responsibility of clients for their health care, then the Indigency Program is not an issue or an immediate option to increase hospital revenues while serving majority of indigents. Based on their experience, 70% of promissory notes were fulfilled and accomplished.

The “Peso for Health Program,” has been established as a local initiative of hospital management before HSRA convergence. It is a community health care financing program of Sta. Bayabas ILHZ.

It is the first district hospital of Negros Oriental that implemented the newborn screening. It is a locally initiated service at a cost of P500. The following are newborn screening related-activities;

- • Advise patients to follow the steps indicated in newborn screening
- • Encourage the community on cost sharing for newborn screening
- • Retrieval of statistics and program
- • Recording of all in-house deliveries

The hospital also adopted quality assurance activities and improvements made on the following: (a) implementation of the 5 S, and (b) conduct of monthly client evaluation survey on health personnel behavior and attitude.

A patient admitted at the hospital is also interviewed to give feedback about the hospital services. The patients and respondents were generally satisfied with the services provided by the facility. Patients expressed satisfaction for good doctors, caring health providers who attended to patients needs, cleanliness of the facility and availability of equipment. Another comment of clients was that most drugs were purchased outside.

The challenge taken by the hospital is to continue the social preparation of the patients in Bayawan through health providers’ advocacy. There is a call for strong willed health providers to encourage clients to pay for the services, as well as teach them how to earn money.

Siaton District Hospital

Congressman Lamberto L. Macias Memorial Hospital (Siaton District Hospital) is a secondary facility accredited by PhilHealth and Sentrong Sigla with 25-bed capacity. Occupancy rate is fifty 58%. It has a total workforce of forty-six employees, of which forty-two are permanent. The facility is the lead coordinating partner in the inter-local health system governed by the Siazam ILHZ Board.

The hospital has four doctors who served 16,605 patients in 2001. Outpatient services catered to 91% of total clients. Charity patients accounted for about 86%. The cost per patient discharged is calculated at P1,260.

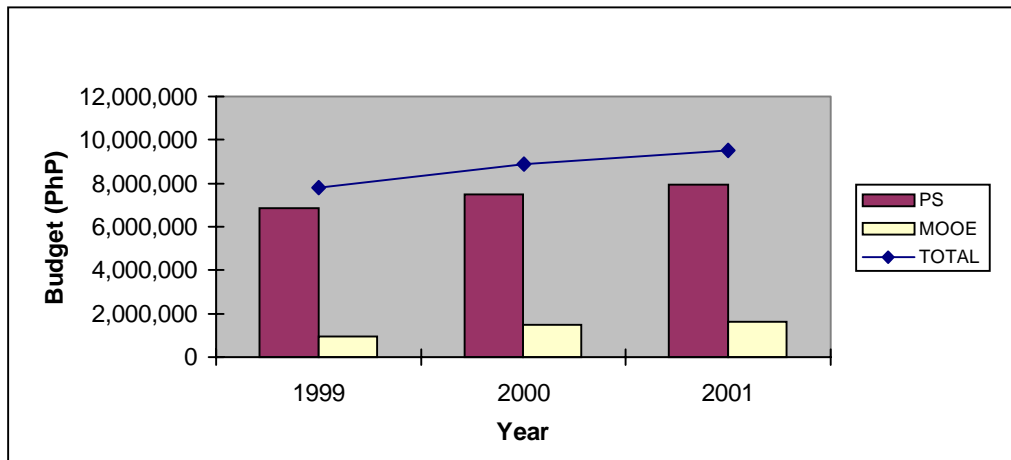
The hospital budget has increased over three years but actual expenditures exceeded the appropriation in the last two years. Total hospital budget has increased by 5% from the base year (1999) to 2000 and has doubled in the following year. Actual MOOE in 1999 is 12% of total expenditures, while the succeeding years indicate the same percentage calculated at 17%. Increase in hospital expenditures in 2000 is calculated at 14% from the base year. Operations cost in 2001 has increased by 7% from the previous year. Year 2001 indicated the highest income and its corresponding percentage over hospital operations cost. Increase in hospital income is pegged at 7% from 1999 – 2000 and has declined by 4% from 2000 – 2001. Based on the modal value, hospital income is 12% of the expenditures. Therefore, the gap of income over expenditures is high, which has an implication on the sustainability of hospital reforms.

Table 3. Comparative Hospital Budget, Expenditures, Income and Proportion of Income Over Expenditures of Siaton District Hospital, 1999 – 2001.

Year	Hospital Budget (PhP)	Hospital Expenditures (PhP)	Hospital Income (PhP)	Income/Expenditures (%)
1999	7,967,287	7,801,909.94	974,370.46	12
2000	8,381,770	8,897,809.54	1,183,170.60	13
2001	9,219,795	9,524,971.20	1,131,539.95	12

Source: Cong. Lamberto L. Macias Memorial Hospital, Siaton

Figure 3. Comparative Detailed Expenditures of Siaton District Hospital, 1999-2002.



The key informant cited that the former provincial administration prioritized health in the development agenda. Health providers gained favorable support as well. The current provincial administration continued previous development efforts. The facility is the only hospital in health zone.

Four medical outreach activities were conducted, bringing medical consultation and treatment, circumcision and dental extractions to local communities. It is one of hospital's support services to rural health units.

The hospital pharmacy operates with 10% mark up on the cost of drugs and supplies. Pharmacy income is kept as a trust fund. There is a plan of the ILHZ Board to standardize service charges. The hospital collects lower fees than other health facilities. The issue on sustainability is self-sufficiency, but the key informant's point of view was that "they need to maintain balance, where the Provincial Government should allocate regular budget and whatever excess operations costs will be covered by the trust fund. It is difficult to adopt privatization.

The facility has not accepted payment in kind because they find it difficult to convert goods into cash. However, they would like to implement the service program and payment in kind. These matters are subject for discussion in their next ILHZ Board meeting.

PhilHealth reimbursement is quite okay and up to date based on their normal reimbursement process. They are less likely to complain compared to private health facilities. However, in the case of Siaton, the hospital management is struggling on PhilHealth categorization of health facilities vis-à-vis their compliance to all requirements for accreditation, except for the non-functional incubator. The hospital is categorized as primary, so they raised this issue to PhilHealth.

The hospital like other hospital in Negros Oriental Has been conducting quality improvement activities like; a) survey of patients in assessing the quality of services provided, b) health education for patients, which is an activity to attract patients, and c) cost-cutting measures in operations expenditures (e.g. light and water).

During the interview with patients, all respondents were satisfied of hospital services in terms of the following citations; a) health providers attend immediately to their needs, b) available medicines in the pharmacy, c) regular rounds of doctors and other hospital staff to check and monitor patients, d) good attitude of health providers, and e) clean facility. However, they made a comment that the hospital lacks the capability for major surgical operations. Likewise one of the informants expressed discontentment of hospital service since there was no regular monitoring and follow up of health providers to patients.

In the experience of Siaton, a strong political will of provincial administration to support hospital reform initiative was instrumental in implementing reforms. The former Governor ensured that that hospital income will be given back to the facility for other hospital operations needs and requirements (usually medicines and supplies). The strong cooperation and support of health providers were also considered to be very important.

Bindoy District Hospital

Not to be outdone, Bindoy District Hospital has also made significant improvements. The hospital is licensed by the DOH as secondary health facility but accredited by PhilHealth

as primary hospital. It has 25-bed capacity, of which 15 are charity beds and ten are Medicare. Occupancy rate is pegged at 67%. Total manpower complement registers 29 personnel, of which 3 are doctors and 5 of the staff accounts to LGU'S augmentation. Like any other government and LGU operated hospitals, majority of Bindoy District Hospital's clientele are indigents.

The improvements done were:

- • Physical improvement as reflected with the new and spacious OPD and waiting room, spacious District Health Office, improved ventilation (repaired windows, electric fans, repaired pumping station, repainting of hospital buildings, rooms were repaired, and constructed new kitchen for watchers).
- • 5 S orientation meeting was conducted.
- • Improved work flow/patient flow thru signages and flow charts in the emergency room and other areas of the hospital.
- • Acquisition of beds for the recovery room.
- • Manpower complementation (medical technologist from the RHU also renders service in the hospital when the facility's medical technologist is absent). However, this has been practiced even before the convergence.
- • Improved hospital services by providing surgical operations, mostly minor surgeries and seldom for major operations. The hospital management and staff also conducted outreach activities, bringing consultation, dental, and minor surgical services in far-flung barangays. These medical outreach activities are part of the hospital's support mechanisms to inter-local health systems and the convergence, with the support of local chief executives and rural health units.

Revenue enhancement has been one of the objectives of the hospital management even before the convergence. The dole out system was discouraged but there was minimal increase in hospital income. There was a move to increase service charges and adopt uniform rates for services in all government/LGU-managed hospitals in the province. However, said move was pending due to policy and legal requirements and processes. All hospitals have been allowed to retain and use their income, but experience revealed restrictions to some extent on regular budget appropriation. Matters related to income retention and utilization have been discussed by the Hospital Board.

Quality Improvement Strategies

In Negros Oriental, all hospitals have systems on quality assurance. All key personnel had attended training on quality assurance intervention. The following activities are undertaken; a) waste management / segregation of wastes, b) instituted the 5 S, c) implements Public Service Excellence Program (institutional - involving all health service providers to be client friendly, signage/flow charts and shorter waiting time

Survey tool for total quality improvement (leadership, client, process improvement, standards and measurements). A survey was conducted to patients per section after implementing reform interventions. At first, clients expressed inadequate services, no linens and longer waiting time. Thus, they install television sets as health information medium for health programs. However, NOPH has only one OPD physician, so this intervention did not actually shorten the waiting time but diverts clients' patience through health education and other media programs.

One client survey done indicated patients complaining about health providers' behavior or attitudes. But health providers just laughed off the results. There was no follow-up survey that was conducted.

Gains in Drug Management Systems

The province set the following targets for 2001-2004 to establish an effective and efficient drug management system through the following:

- • Pooled/bulk procurement
- • Parallel drug importation
- • Adequate budget for drugs
- • Affordable, adequate, quality and timely drugs

The budget for drugs and medicines is about P 5.5 million. It is insufficient to meet real demands. The budget is not enough to purchase the annual provincial requirement and budget release is done every quarter. Allotment for the first quarter is usually released in March or early second quarter. The process restrains the procurement of drugs and supplies and the problem is most acute during the first quarter.

In order to decrease the cost of medicines and supplies, the method and process of pooled procurement is being formulated and refined in the province. Bulk procurement started two years ago for hospitals. They experienced failures before but they're learning through time and experience. The LGU encountered a problem last year when there was a medical alert on Philippine Pharma Wealth. This in turn encouraged them to facilitate bulk bidding, streamlining the facility and process as well. With the ILHZ, they can expand it to include RHUs whose funds come from the municipalities.

To ensure that only qualified bidders participate, some bidding requirements are enforced like; a) Mayor's permit, b) DTI permit, c) Certification from BFAD, d) Certificate of Good Manufacturing Practice, etc. The award is usually given to the lowest bidder, but there are also cases where the award is not given to the lowest bidder when consideration is given on the quality of products.

The IPHO is making representation with the Provincial Administration for direct purchase of drugs and if through pooled procurement, the process should be revised and shortened. There are also proposals to solve pharmacy inventory stock out. Ideally, the purchase request is prepared and processed when the pharmacy is at the critical inventory

level, pegged at 50% stocks. However, procurement based on critical inventory level is difficult to follow in the hospital because of high and erratic demands of patients.

One of the problems identified regarding drug utilization is the poor prescription of generic drugs by doctors. Hospital health providers are not patronizing branded drugs but they cater to doctors' preference based on their clinical experience. Doctors are not favorable to generic drugs because of the following reasons; (a) substandard drugs of fly by night suppliers, (b) difficulty of doctors in memorizing the long list of generic drugs and (c) issue on the length of drug validation if they send samples to BFAD. During the interview however, the respondents agreed that the supposed adverse findings and effects of substandard or less quality drugs are undocumented experiences and may just be personal perceptions of clinical practitioners and clients. Doctors do not prefer the lowest bidder after adopting stricter requirements; instead they recommend three branded drugs per illness/disease based on their preference.

Doctors have a strong position on their preference, considering that they are in the frontline and if they prescribe substandard drugs to patients who will eventually die; consequently they will take the burden of liability to patients, not anybody else in the Provincial Government. The Provincial General Services Office (PGSO) also gives the benefit of the doubt on this issue because even housewives and common people have their own preference on the kind of drugs they want to take. However, patient preference is also attributable to doctors' preference. The PGSO has no capacity to convince doctors to use less expensive or lower cost drugs because the latter have the medical knowledge and technical capability.

Another way of procuring drugs at lesser cost is through the Parallel Drug Importation Program of the DTI and DOH. The goal of PDI is good but in reality it takes time before purchase orders are served. Siaton placed two orders but has not received any of their orders. Negros Oriental is discouraged about parallel drug importation due to delayed delivery, which took six months. Bayawan is an exception because they ventured on PDI. They just received their orders. But in other towns, more than 6 months had passed that they have not received drugs ordered through parallel importation.

Emergency purchase of drugs is done if the prescribed drugs are not available in hospital pharmacy. The cost is doubled and increases the financial burden of patients.

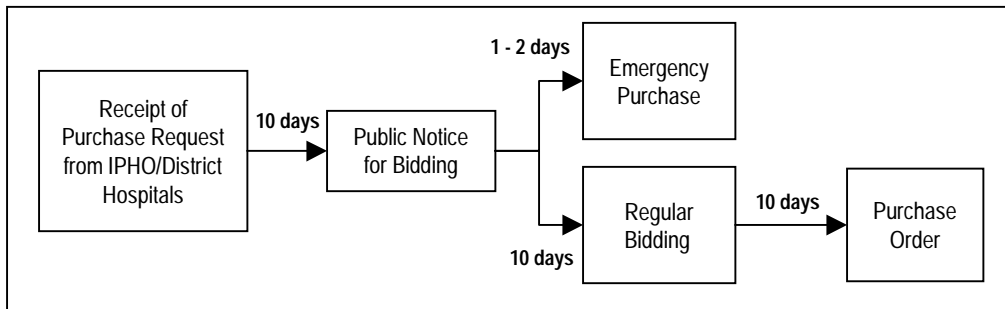
Just like in other provinces, the drug procurement process tends to be a long process. Before, the requisitioning officer decided where to purchase drugs and supplies, even if it is the highest bidder.

Most of the hospitals in Negros Oriental including Bindoy District Hospital is into pooled procurement. Drug purchase is based on the annual procurement plan, which is done by quarter, depending on the available/allocated budget. Appropriation for 2001 and 2002 is just the same at P460,000 per year. Bindoy's pooled procurement process and experience is the same with the Provincial and other District Hospitals. Bidding is associated with price monitoring viable for 6 months. Each hospital submits purchase request/s to the

Provincial General Services Office (PGSO). It took 2 – 3 months that purchase requests are served to the hospital. In principle, bulk procurement is associated with price monitoring.

Drug procurement is based on the annual procurement plan of each hospital, the Philippine National Drug Formulary and DOH -BFAD. The annual procurement plan limits purchase of drugs but the LGU is flexible in giving allowance to new drugs.

Figure 4. Minimum Timeline of Bulk Procurement Process at the PGSO.



The minimum timeline of bulk procurement process at the PGSO will take more than 30 days on the average. Sometimes bulk procurement took 4 to 5 months. The most common reason for the delay is in the process of going after the signatories. Before, it took three to four months (3 – 4 mos.) from the start of drug purchase request to delivery. The whole process is now reduced to two (2) months.

The PGSO admitted that they have not perfected the bulk drug purchase. They had several bulk biddings for drugs and supplies of hospitals, but they experienced failure due to the following factors/attributes;

- • Pre-qualification of bidders is patterned from the DOH requirements, which is not very strict as long as the bidder is DOH accredited.
- • Doctors' preference on drug distributors and suppliers. Awarded bidders were not acceptable by hospital doctors.
- • The price index they conducted was a failure.

The following strategies were identified to improve the bulk bidding process of drug procurement;

- • Require a certificate of good manufacturing practice to eliminate fly by night suppliers.
- • Disallow bidders supplying substandard drugs.
- • PGSO is in the process of developing stricter guidelines. They will endorse it to the Sangguniang Panlalawigan for the resolution to make it legal, with a safety net

committee that will defend the LGU against suppliers' accusations on strict bidding requirements.

- • Recommendation of the Provincial Therapeutics Committee.

The Hospital Therapeutics Committee

All district and provincial hospitals have their respective therapeutics committee and established hospital drug formulary. Although the hospitals have their existing committee, revitalization was done with the technical assistance of the MHS-HSRTAP. Strengthening of the Therapeutics Committee was legally supported by an executive order, stipulating the organization, functions, responsibilities and scope. A training course was conducted. A series of seminars on rational drug use, review on drug utilization and a seminar workshop with 7 points recommendation were conducted as part of health sector reform – technical assistance interventions to improve drug management system. Generic drug utilization was encouraged during the seminar.

The committee decides and recommends drugs to be purchased and stocked in hospital pharmacy. It requires doctors to submit the list of drugs used in their prescriptions based on the ten leading causes of mortality and morbidity, as well as the standards on clinical guidelines. Doctors and committee members calculate their drug requirement based from the standard clinical guidelines using mortality and morbidity statistics. The essential drug list is a requirement for drug purchase request. The Hospital Therapeutics Committee also initiated a policy on routing of prescription through hospital pharmacy. This policy is supported by a Sangguniang Panlalawigan resolution.

The Provincial Therapeutics Committee is responsible for rational drug selection and procurement. Majority of the members of the Provincial Therapeutics Committee are doctors. The members of the Provincial Therapeutics Committee:

Chair	Provincial Administrator
Co-chair	Integrated Provincial Health Officer (Dr. Ely Villapando)
Members	Prov'l. General Services Officer, Prov'l. Accountant, President of the Medical Society, Prov'l. Pharmacist, Chief of District Hospitals, Supervisor of 6 Community/Primary Hospitals (Calamboyan, Amio, Nabilog, Tayasan, Pacuan, Inapoy and Luz Sikatuna), BFAD and NGO representatives.

The Negros Oriental Provincial Hospital Therapeutics Committee is developing the treatment guidelines that will serve as standards on the uniformity of treatment and minimize treatment variation. All department heads of hospitals have to sit down for finalizing the treatment guidelines. This is viewed as an improvement in effect of capability building interventions (e.g., training).

The Bayawan District Hospital Therapeutics Committee conducts regular meeting to discuss issues and concerns in drug management system, pharmacy inventory and ensures that the essential drug list is followed. Procurement is based on the PNDF and essential drug list. The hospital drug formulary is also established. Choosing of drug brands is

based on the clinical experience of doctors on drugs prescribed for certain disease/s and length of drug's effect to patients. They purchase branded and generic amoxicillin. Patients' choice on the brand of amoxicillin prevails even if doctors prescribe and advocate the generics.

Members of the Therapeutics Committee prefer branded drugs, especially those who are also connected with the private hospital. They have their own undocumented experiences indicating that branded drugs are more effective than generic drugs. As cited by some doctors in local health zones, "drug companies' promotional strategies have nothing to do with doctors' perception on branded drug preference." Promotional activities of drug companies in the area are very minimal since the campaign for generic drug utilization.

Problems and Solutions Associated with Drug Management System

The identified gaps/problems/issues/concerns on drug management system are: (a) lack of drugs and supplies due to limited budget, and (b) lengthy procurement process/tall bureaucracy. The bottleneck in drug procurement was cited at the PGSO. The process involves 56 signatories, which they now reduced to 39. This is indicative of the tall bureaucracy in the LGU, which leads to the delay of drug procurement.

The mode of procurement through bulk bidding has been a problem. Only 15% of their purchase requests were awarded during their bidding before. It took several months for re-bidding of remaining requests. Thus, the hospital management recommends direct purchase of drugs instead of the normal bulk bidding process. They do not trust some drug companies and prefer direct purchase from credible distributors.

Proposals to improve the Therapeutics Committee operations include; a) multi-stakeholder membership with equal representation of medical and non-medical members in the Therapeutics Committee and b) develop a policy to counter doctors' preference. In Bayawan, they implement the drug utilization program by monitoring doctors' prescriptions, assess and make feedback.

Gains in Inter-Local Health Systems

The network of Inter-local Health Zones in the province of Negros Oriental is referred to by its old name "district health system." As early as 1981, Executive Order 851 created health districts where the district hospital exercised supervision over all field health units. The rural health units (RHUs) and specialized field health units served as the outpatient components of the district hospital. The barangay health stations (BHS) served as extension of the RHUs. The same EO merged the PHO and provincial hospital and integrated the promotive, preventive, curative and rehabilitative components of health services. In 1987, the District Health Office (DHO) was created by Executive Order 119 and patterned after the World Health Organization model.

The district is defined 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 health

district system consists of a large variety of interrelated elements that contributes to health in homes, schools, workplace and communities through the health and other sectors. It is described "a smallest manageable health unit in areas small enough to be managed without being hampered unnecessarily by bureaucracy yet large enough to make it feasible to include most of the ingredients required for self reliant health care. (WHO, 1997)."

The district health system sought to achieve the following outcomes:

- • Unity of command
- • Holistic approach in health care
- • Two-way referral system
- • Sharing of facilities in manpower
- • Constant monitoring and evaluation of service coverage (hospital and public health) through district wide program review
- • Updating of health information system
- • Knowledge by the district health office of the health status of the entire catchment area
- • Integrated and realistic approach to planning and program implementation
- • Allocation of budget for hospitals and catchment RHUs to district health office

The leaders of the health sector in the Negros Oriental explained that they really never broke away from the spirit of the district system, despite the onset of devolution that has been viewed as responsible for the fragmentation of the local health system.

Congressman Emilio Macias II, a doctor by profession and one of the leading exponents of devolution became Governor of the province during the transition to a devolved setting. He was committed to a strong health sector by virtue of his profession and to devolution as shown by his political record. He would not allow any of these two ideas to flounder as he was convinced that health, his centerpiece program, should continue to remain strong. Also, major stakeholders in the health sector of the province who held important positions realized the importance of maintaining links with one another despite the fragmented organizational structure that devolution brought about. Other health professionals (nurses, doctors, etc.) in the province would explain that they had a health sector alliance that included various types of health workers that was organized before devolution and continued to function after devolution. The health sector in Negros Oriental manifests certain characteristics of maturity as evidenced by the close cooperation with their strategic partners.

The Goretti Foundation, a church-based NGO together with the provincial government and some municipal governments took note of the need for collaboration in health and with encouragement from the DOH undertook advocacy work for ILHZ. Silliman University is also an active partner in community health research and social mobilization. Foreign funding agencies like the Belgian Integrated Agrarian Reform Support Program (BIARSP) and the USAID took interest in the integrated health delivery system and provided some funds for some components of the projects. The Negros Oriental

Provincial Health Board passed Resolution No. 5 in 1999 recommending the development of six district health systems province wide and the formation of the corresponding inter LGU District Health Board.

Negros Oriental has organized six ILHZs that are also known as district health systems or Inter-LGU Health Systems. The five districts and their corresponding catchment areas and population size as of 2001 are as follows:

CVGLJ District Health System (19.7%)

a. Canlaon City	44,073
b. Vallehermoso	35,242
c. Guihulngan 1	49,536
d. Guihulngan 2	38,922
e. La Libertad	35,604
f. Jimalalud	25,288
Total population	228,665

Sta. Bayabas District Health System (17.4%)

a. Sta. Catalina	74,833
b. Bayawan City 1	59,588
c. Bayawan City 2	48,729
d. Basay	19,429
Total population	202,549

Binata District Health System (9.8%)

a. Bindoy	31,370
b. Ayungon	41,709
c. Tayasan	40,000
Total population	113,079

Mama Bata Pa District Health System (23.9%)

a. Mabinay 1	33,999
b. Mabinay 2	33,931
c. Manjuyod	37,773
d. Bais City	71,795
e. Tanjay 1	32,566
f. Tanjay 2	36,693
g. Pamplona	30,777
Total population	277,534

NOPH District Health System (21.3%)

a. Dumaguete City	109,427
b. Datuin	22,285
c. Bacong	21,833
d. Valencia	22,816
e. Sibulan	36,658
f. San Jose	17,875
g. Amlan	17,082
Total population	248,026

SIAZAM Inter-local Health Zone (7.76%)

a. Siaton	68,794
b. Zamboanguita	21,227
Total population	90,021

Certain mechanisms have been put in place in support of the local health systems. Public health programs are handled by the RHUs and the barangay health stations supported by the municipalities while a community health care financing has been put in place through the Peso for Health initiative. The regulatory and technical functions are implemented by the DOH through the regional office that has been renamed as the “Center for Health Development.” The district health system provides the organizational structure for integration of the local health system.

Organizational Structure and Management Procedures

In terms of the organizational structure and management processes, the ILHZ board is the unifying and coordinating body composed of representatives from LGUs that contribute to the health zone operation:

- • Provincial LGU representative
- • Sangguniang Panlalawigan (SP) representative of the health zone
- • IPHO
- • Municipal LGU
- • Association of Barangay Captains (ABC) President
- • DOH representative
- • Health insurance organization
- • CHO
- • MHO
- • NGO/PO representative

According to the standard template of ILHZs in Negros Oriental, the ILHZ or district health board shall have financial and policy-making functions to supplement existing LGU policies. New ILHZ policies shall be presented and approved by the provincial

health board and the Sangguniang Panlalawigan. It also approves the integrated health work and financial plan.

The ILHZ technical committee is composed of the technical staff from the RHU and hospital personnel and assisted by the administrative staff designated by participating LGUs on a part time or full time basis. Other members may include the DOH representative or the patient representative. Technical assistance is provided by the DOH and MSH. Meetings are convened on a monthly basis to discuss the operations of the ILHZ based on the approved health work and financial plan. It initiates a participatory health needs assessment that becomes the basis of an integrated zonal plan for both the district hospital and the RHUs. It also sets minimum standards for health services at all levels in conformity with national health policies. It also plans a system of pooling human resources to attend to leave of absence, retirement, etc.

The other local health boards (Municipal Health Board and the Provincial Health Boards) mandated by the Local Government Code continue to exist. The municipal health boards continue to meet regularly to discuss their internal affairs and support or action needed by the ILHZ. The Provincial Health Board also retains its function mandated by law. The PHO and the SP member in the ILHZ present the district work and financial plan to the Provincial Health Board once a year.

There is a separate District Hospital Health Board that is responsible for assuring quality care and services in the district hospitals. It approves the hospital budget and helps the Governor with the financial management of the hospital. It ensures the participation and financial support from the LGUs and the community for hospital services. The Inter District Hospital conference and the bi-annual review led by the PHO have become the inter-zonal conference and participation has been enlarged to include public health staff to be able to discuss ILHZ related issues and problems. Issues that cannot be solved locally are elevated to the Provincial Health Board for deliberation. Matters that require action of the Sangguniang Panlalawigan are accordingly elevated to the SP for endorsement or adoption of a resolution.

Each LGU member of the ILHZ is expected to implement its share of responsibilities contained in the memorandum of agreement (MOA).

- • The municipality with the help of its local health board is responsible for formulating and implementing an integrated municipal health plan using the framework identified in the Provincial/District Health Plan and based on analysis of relevant information. It implements projects of the Integrated District Health Plan; enforces regulatory measures at the municipal level; manage, finance and maintain municipal health facilities; promote health together with NGOs and the private sector; and conduct research for improvement of health services. It commits to maintain one functioning RHU per 10,000 to 20,000 population and one BHS for every 3,000 to 5,000 population. It maintains the road network to facilitate referral among health facilities and provides transportation and communication facilities for emergency

cases. It provides financial and technical support for volunteer health workers like BHWs and provides financial assistance to existing health projects.

- • The province will formulate and implement the provincial/district policies and plans in support of national health policies after an analysis of existing health conditions. It provides administrative and technical assistance to district hospitals and ILHZs. It manages and finances provincial/district and community hospitals to meet PhilHealth requirements. It collects and analyzes health information from the lower levels and submits reports to the DOH. It promotes coordination among various sectors for health promotion. It conducts or promotes training and research for better health services. It provides financial assistance to ILHZs and conducts semi-annual assessment of ILHZ health programs. It recommends the passage of laws to comply with the Sanitation Code of the Philippines and it improves roads and provides transport and communication facilities to improve access to health facilities. It assists municipalities to fulfill their health roles.
- • The DOH through the Center for Health Development Region 7 and DOH representatives manages tertiary and specialized health facilities; provides technical supervision of local health services; extends technical, logistic and financial advice to LGUs; formulates and oversees implementation of health regulations; collaborates with other sectors to formulate and implement human resources policies and plans; mobilizes external and internal funding for health development; and conducts/promotes research for better health services. The DOH through its representatives should maintain constant dialogue with ILHZs to play a lead role related to technical coordination; establish a trust fund for community health projects from DOH and other agencies; assist the LGUs in generating and allocating resources and find qualified personnel for ILHZs; participate in LGU training needs assessments and make the necessary recommendations.

Management of Health Funds

LGUs shall commit to progressively increase their health budget every year and increase percentage allocated to MOOE, commensurate to the LGU financial position. The LGU will contribute the equivalent of 1% of the 20% economic development fund but taken from the general fund based on budget of the preceding years. The ILHZ board shall establish a common health fund from the LGU appropriation of member municipalities in the catchment area in addition to other funds from other sources like foreign funding.

There may also be a health insurance fund, DOH grants, community financing fund and other private sector contribution. All funds may be deposited to the ILHZ account and disbursed in accordance to the integrated work and financial plan. The common health fund should be deposited under one collaborating LGU as agreed upon by participating LGUs and managed by the ILHZ Technical Management Committee. 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.

Monitoring and Evaluation

The PHO, DOH and an NGO shall perform supervisory and monitoring functions at all levels of the ILHZs. The St. Goretti Foundation, a private entity monitors and evaluates periodically the ILHZ in Bayawan independent of the same function performed by the PHO and DOH. The NGO presumably performs the role of an independent auditor that is capable of assuming an outsider or a client's perspective in making its evaluation. Baseline and other surveys should assess achievement in terms of ILHZ objectives.

CVGLJ District Health System

The CVGLJ ILHZ is made up of Canlaon City, Vallehermoso, Guihulngan, La Libertad and Jimalalud and located in the northern part of Negros Oriental with an extensive land area of 930.4 sq.km. The municipalities/city in the district belong to different income levels with Canlaon as a third-class city; Guihulngan, a second class municipality; Vallehermosa and La Libertad, both fourth class municipalities and Jimalalud, a fifth class municipality and the poorest of all. The top five leading causes of morbidity are ARI, diarrhea, skin disorder, malnutrition, skeletal disorder while the top five causes of mortality are cardio-vascular diseases, tuberculosis, pneumonia, malnutrition and hemorrhage.

The CVGLJ ILHZ is the first to be organized in Negros Oriental and serves as a model for the other health zones. Initial talks between the health sector and political leaders were held to explore the mechanics of forming an ILHZ. During this period, the Belgian government through its Belgian Integrated Agrarian Reform and Support Project (BIARSP) was looking for a project to fund in agrarian communities. DOH identified Negros Oriental as a possible recipient of foreign funding and the possibility of BIARSP funding for the formation of the ILHZ was explored. The local LGUs seized the opportunity to upgrade health facilities in their respective areas.

Chair:	Governor or his representative (automatic)
Vice Chair:	Mayor (chosen)
Secretary:	Elected member
Members:	Other mayors
	PHO
	DOH Representative (province)
	NGO representative
	PO Representative
	Executive Director (Health District MANCOM)
	DAR Representative
	Belgian Integrated Agrarian Reform and Support Project (BIARSP)
	Project Management Officer (during project time)

The CVGLJ health zone's vision is to create a healthy and empowered ILHZ community through integrated quality health services that are accessible, affordable and sustainable

have been adopted in other health zones. The composition of its District Health Board has served as model for other ILHZs in the province.

The main function of the District Health Board is policy making and overseeing the finances of the district. Its specific functions include:

- • Setting up a health district organizational chart,
- • Formulating policies toward an integrated health care system
- • Approving an integrated health work and financial plan,
- • Creating a common health fund,
- • Acting as communication channel for health services,
- • Appointing or dismissing MANCOM members,
- • Holding monthly management meetings with partners or as needed for the proper operation of a health district.

The board also takes up matters related to requests for capital outlay (vehicles, renovation, etc.), distribution of ILHZ personnel, training programs and approves the district strategic plan drawn from inputs from its constituent units (hospitals and public health facilities). A district health management committee (MANCOM) has been created to assist the ILHZ board and its members are representatives of various positions from the health sectors

The function of the MANCOM is to provide technical assistance to the District Health Board to manage the day-to-day operations of the health services and to oversee the hospital and public health functions as well as activities of the private sector and other government agencies. It also provides advice regarding health personnel matters and manages the health zone trust fund. In addition, the members of the MANCOM are also responsible for the rehabilitation of facilities, community organizing, health information, referral, supervision, monitoring and evaluation, training, drugs and supply management, health insurance and general management.

The ILHZ board maintains a common health fund derived from BIARSP funds and contribution from the participating municipalities. The CVGLJ district has been registered with the Securities and Exchange Commission and the board has opened a bank account for the common fund. The board has the power to decide how the funds are to be disbursed.

**Health District Budget for 2000, CVGLJ District Health System,
Negros Oriental, 2000**

1. PERSONNEL SERVICES	
Honorarium for MANCOM for 12 months (12 members)	252,000.00
Honorarium for District board for 12 months (6 members)	86,400.00
Utility worker	25,080.00

<u>Sub-total</u>	P 363,480.00
2. MOOE	
Operating expenses	95,000.00
Purchase of emergency drugs and medicines	120,000.00
Other services	21,520.00
<u>Sub-total</u>	P 236,520.00
3. Capital Outlay	
Health insurance	600,000.00
Drug recycling	1,000,000.00
<u>Sub-total</u>	P1,600,000.00
Total	P2,200,000.00

Source: CVGLJ Inter-LGU Health Zone Profile, Negros Oriental, 2001

The district hospital is the Governor William Villegas Memorial Hospital and is located in the municipality of Guihulngan. It is accredited by DOH as a secondary hospital, but only as a primary hospital by PhilHealth. It has an authorized capacity of 75 beds but implements only 50 beds because of resource constraints. The occupancy rate showed a steady decrease from 103 % in 1992, 94.36% in 1995, 80.19% in 1997 and 68% in 2000. The average occupancy rate was 34 patients per day and the average length of stay per patient was 4 days. Some residents in Vallehermosa prefer to go to the San Carlos City Hospital, which is nearer their place than Guihulngan. It is cheaper for them to go to San Carlos and they also think that it has better facilities.

STA. BAYABAS ILHZ

The STA. BAYABAS district covers within its catchment area the municipalities of Sta. Catalina and Basay and Bayawan City. It is located in the southern part of Negros Oriental. The district hospital compound in Bayawan also serves as the district health office. The district's adult population is made up of seasonal agricultural workers or *sacadas* employed in the nearby sugar facilities, small farmers and fishermen.

The ILHZ in STA. BAYABAS was set up by Dr. Fidencio G. Aurelia, the Bayawan District Hospital chief. Given his experience in setting up the ILHZ in Guihulngan, he improved on the previous strategies to set up the STA. BAYABAS ILHZ with the use of his social marketing skills. He was successful in making each of the three LGUs pass a resolution to authorize their mayors to join the ILHZ collaboration. The Sangguniang Bayan of Bayawan, Basay and Sta. Catalina met in joint session on August 8, 2000 at the Bayawan Market Social Hall to adopt the draft of the memorandum of agreement for the creation of the STA. BAYABAS district health system. Subsequently, all the three areas agreed to put up a common health fund with their contribution being determined by their income and type of LGU. Bayawan City contributed P200,000, Sta. Catalina contributed P150,000 and Basay contributed P130,000 with total initial contribution amounting to P480,000. Bayawan City as the site of the district hospital acts as trustee of the fund.

The absence of foreign funding at the setting up stage makes the STA. BAYABAS model different from the CVGLJ model. While foreign funding is perceived to have jumpstarted the ILHZ in Guihulngan, STA. BAYABAS has successfully launched its ILHZ by relying on goodwill and funds from the LGUs within its catchment area. Foreign funds came later when the STA. BAYABAS ILHZ has stabilized. The local health fund has been augmented by foreign funds from the Matching Grant Program that contributed P500,000 per municipality to improve family planning and maternal and child health services.

The Bayawan District Hospital serves as core referral hospital of the STA. BAYABAS convergence area that networks with RHUs (Bayawan RHU I, Bayawan RHU II, Sta. Catalina RHU, Basay RHU), their BHS network as well as nearby primary hospitals (Kulombayan Primary Hospital and the Amio Primary Community Hospital). The top five causes of morbidity are gastro-intestinal disorders, bronchitis, ARI, pneumonia and UTI. The top causes of mortality are pneumonia, gastroenteritis, meningitis, and tuberculosis. The District Health Board has the same composition as CVGLJ and is also referred to as the Expanded Hospital Health Board.

The St. Maria Goretti Foundation has been designated as the NGO representative in the ILHZ board and has been given the monitoring and evaluation function. The health workers themselves do internal monitoring, while Goretti, which looks at the implementation of the health agenda and action plan, also does external monitoring. A Technical Management Committee (TMC) made up of health providers has been formed to be fully responsible for the operational management of the district health system.

BINATA ILHZ

The BINATA ILHZ is composed of three municipalities: Bindoy, Ayungon and Tayasan. The total district/health zone population is 110,165. Their health needs are being served by a district and primary hospitals, 3 RHUs, 30 BHSs and 2 private clinics. Even prior to the formation of inter-local health zones, the features of the former district health system were evident under a devolved setting. The organizational linkages were further reinforced through USAID's Local Partnership Project (LPP) Matching Grant Program. The formation of the BINATA inter-local health system and the health sector reform convergence strategy enabled the LGUs to commit resources to health as part of a holistic and integrated approach. The local health officers at the province and district levels met with the local chief executives to forge agreements for a better and improved local health system.

The formation of the BINATA ILHZ was supported by local legislation from each member LGU. Resolution No. 72, series 2000 of Bindoy authorized its mayor to enter into a memorandum of agreement with the provincial government and the municipal governments of Ayungon and Tayasan to form a partnership and cooperate for the establishment of an inter-local health zone. The Sangguniang Bayan from each municipality passed and approved a Board resolution to adopt and support the BINATA ILHZ. Resolution No. 63, series 2001 (Bindoy, appended document) is a legal evidence

of LGU's commitment to an integrated health care system within a health zone. The formal signing of the ILHZ Memorandum of Agreement was on February 6, 2002.

The ILHZ organizational structures were formalized one month after the MOA was signed in March 2002 and 18 members were made to constitute the ILHZ board. Like other Negros Oriental district boards, the overall/honorary chair is the governor while the co-chair/acting chair is the Sangguniang Panlalawigan member. One of the 3 LCEs serves as vice chair while the other 2 are members. The other members are: the Sangguniang Bayan Health chair of the 3 LGUs, Chief of Bindoy District Hospital, MHOs, resident physician of Nabilog Community Primary Hospital, representatives from the religious sector, IPHO, DOH, Hospital (District chief nurse) and NGO. The board functions as the coordinating and policymaking body of the health zone, while the execution and management of health reforms are under the Technical Management Committee (TMC). The BINATA TMC was formed by the ILHZ Board. It is chaired by the Chief of Bindoy District Hospital, with the 3 MHOs as vice chair and 17 other health service providers from the staff of the hospital and RHUs as members.

A common health fund was created with the LPP-MGP providing P500,000 for each member municipality for a total of P1.5 million and a counterpart contribution of P150,000 from each of the 3 municipalities amounting to P450,000. The money is deposited in a trust account of Bindoy, the depository LGU and its mayor and treasurer are authorized by the BINATA ILHZ to do business transactions related to fund management and safekeeping.

Various local stakeholders of BINATA ILHZ implement the agreed activities. An important activity is the on-going community-based monitoring and information system in every barangay for each LGU. The training of BHWs on the proper conduct of the CBMIS and family planning have been done and has become a continuing activity of the health zone. Part of the common health fund has been utilized for CBMIS training of BHWs. The ILHZ is also responsible for the complementation of resources in terms of manpower and services within and among the health zone members.

The following constitute the gaps and bottlenecks in implementing the ILHZ:

- • The hospital is not ready in terms of resources (budget, manpower, logistics, etc.) to cater to Indigency Program enrollees.
- • The hospital management does not admit any patient, including indigents, without any deposit. This policy was adopted by hospital management to ensure that patients would comply with PhilHealth requirements for the hospital to avail of PhilHealth reimbursement. Based on their experience, there were patients that never returned to the hospital to settle their bills.
- • Some health providers manifest an indifferent attitude toward patients.

It is proposed that there should be an upgrading of hospital facility, equipment and services and additional hospital staff should be hired. There should also be a leveling off among LGUs, the PhilHealth personnel and hospital staff to iron out differences and improve organizational effectiveness.

The public health programs in the BINATA health zone have been improved with the accreditation of 3 RHUs by PhilHealth. These public health facilities are able to provide outpatient services to all types of patients including the indigents. The solid waste management program has also been incorporated as part of public health. Furthermore, a community based monitoring information system (CBMIS) has also been put in place to watch out for the outbreak of epidemics and other illnesses.

Provincial Referral System

The first workshop conference on strengthening the referral system was on February 20 – 22, 2002. The referral system is one of the nineteen (19) concerns and areas identified for hospital reforms. The objective of the activity was to come up with a comprehensive and improved healthcare delivery system.

The most recent update of the draft of the referral system was presented and some important points were discussed. The issues were; a) flow from MHO to RSI, b) flow of patients at the BHS and RHU/CHO (change RSI in line with PHN/RHN), c) policy on direct or walk-in patients from municipalities, a referral is required by Negros Oriental Provincial Hospital and District Hospitals, City and Municipal Health Offices and d) flow chart of patient in the ILHZ referred for treatment or laboratory examination and refining the system further to minimize discomfort to the patient.

The reason for referral is limited resources and services in a referring unit. One limiting factor cited by the MHO within the Bais ILHZ is the preference of the patient to go to the provincial hospital instead of the district hospital in their ILHZ. They cited comparative advantage of NOPH over the District Hospital in terms of available services, doctors, medicines and supplies. Likewise, it also redounds to patients' preference. They don't like transferring from one referral facility to another co-referral facility (e.g., from the District Hospital to NOPH). On the contrary, Bais District Hospital has the technical capability compared to other District Hospitals. It has twelve well-trained doctors. It took time convincing the MHO to change her and clients' frame of mind on facility preference vis-à-vis the developed referral system.

It was emphasized that one of the pillars of the health sector reform is decentralization of health care delivery system. Local health facilities need to be upgraded to solve congestion at the NOPH, which caters referrals from six municipalities within the Dumaguete ILHZ and the whole province. With this strategy the preference of patient to go to the provincial hospital might decline.

Best Practices

Negros Oriental sets the pace in the establishment of inter-local health zones as the whole province has been subdivided into 6 zones. Its success in the creation of effective structures in its local health system is due to the following factors:

- • The legal framework is well defined, as there are resolutions at all legislative levels from the Sangguniang Panlalawigan to the Sangguniang Bayan to support the health district system and establishment of the Provincial Therapeutics Committee.
- • There is financial support from the LGUs that have contributed to the common health funds that support the activities of the health district system. There is a tradition and a culture that health is a priority and politicians outdo each other to present more innovative schemes to promote health.
- • The various health boards at all levels are operational. The Provincial Health Board meets regularly to take up province-wide concerns; the health district boards are active and have set up common funds to run their operations; the hospital boards perform policy and financial functions; the local health boards at the municipal level continue to meet to discuss local concerns.
- • Hospitals are given some form of financial autonomy as they are allowed to keep their income. The hospital boards approve a work and financial plan to determine hospital expenditures. The user fees in the hospitals are kept in trust by the Provincial Treasurer and supplemental budgets are approved by the SP to enable the hospitals to access these funds.
- • There is NGO and PO support for the ILHZs as shown by their active membership in the various boards. In Negros Oriental, the NGOs do not only perform medical missions. The health workers alliance is active in promoting the interests of the health workers while the Gorette foundation performs monitoring and training functions. Various rooms in the provincial hospital have been renovated from contributions from civic organizations and private individuals.
- • There is community health financing into the health district concept among the major stakeholders from the form of the Peso for Health. It is an innovative program that is affordable and enables poor members who have no money to contribute in kind to pay their monthly contributions. It encourages people to take care of their health, since they are made to cover part of the costs through their contributions.
- • Requiring certificate of good manufacturing practice as one of the criteria for supplier accreditation is considered a good practice in drug procurement to get rid of fly by night suppliers and ensure quality of drugs.

Conclusion and Recommendations

While Negros Oriental is successful in organizing its inter-local health zones, in achieving some form of fiscal autonomy for its hospitals in doing pooled drug

procurement and in creating community-based health financing scheme, its weakest link in its convergence strategy is its PHIC Indigent Program.

Challenges for the PHIC Indigent Program

With the successful implementation of small scale and community managed social health insurance in the province of Negros Oriental, there are so many challenges for PHIC. There seems to be a need to establish strong inter-local health zone (ILHZ) interface with PHIC to facilitate a well-coordinated program implementation. The STA. BAYABAS health zone is a strong ILHZ but there is no Indigency Program in the area because there is no guideline interfacing the Peso for Health and Indigency Programs. LCEs are not convinced of the Indigency Program.

Extensive advocacy on social health insurance/IP coupled with RHU accreditation to increase coverage must be undertaken. This challenge requires management complementation between Regional and Provincial Field Service Offices and additional staff to conduct orientation and other information dissemination activities, monitor and follow-up LGUs on their applications. Although PHIC presented the program to all LGUs since 1999, still there is a need for another presentation to the new set of elected officials. Demonstrate success stories to encourage other political leaders is also part of the advocacy challenge.

It was also found out that majority of PhilHealth members and beneficiaries are not aware of their benefits and privileges. Hence, there is a call for intensive information dissemination on members' benefits and privileges. Dr. Espallardo cited a strategy on addressing the aforementioned concern by printing the benefits and privileges of members at the back of PhilHealth member's identification card.

There is also a need to adopt the bottoms-up approach in program implementation in order to come up appropriate interventions and effective policies. The regional office should not wait for the national office in taking the initiative/s for program sustainability. It should also be allowed to introduce modification into the Indigent Program for smoother and sustainable implementation, such that:

- • Lobby LGUs' proposal for amendment of the law on step increment of premiums cost sharing scheme. Majority of LGUs are apprehensive on their capacity to cover the 50:50 cost sharing in the 5th or 6th year. In the case of Cebu for instance, Glaxo Drug Company is willing to cover 2,000 families but the LGU refused it because of sustainability issues/concern.
- • Interface mechanism of enrolling Peso for Health members in the Indigency Program. The District Health Officer of STA. BAYABAS is working on it. Re-insurance schemes should be liberally adopted to supplement and not monopolize social insurance activities.

- • Advocate on improvement of health facilities first before Indigency Program enrollment. It happened in one district that the LGU is entitled to the capitation fund but the LGU cannot utilize the money because there is no accredited facility.

Based on the experience of the province, the strong advocacy of health providers is also instrumental in encouraging the LGUs to participate in the PHIC Indigent Program. At the start, all district hospitals were downgraded by PHIC; thus each district hospital tried to improve and upgrade their facility. It caused strained relationship between PHIC and hospital management and health providers, which affects the attitude and extent of advocacy efforts of health providers on the Indigency Program.

In the experience of Amlan, the members' and barangays' counterpart for the premium may also be adopted to instill a sense of responsibility to the beneficiaries of the program. Bindoy and Amlan indigents and barangays have their counterparts for the premiums in order to sustain the program. The municipality of Bindoy has developed a cost sharing scheme for the next 5 years of implementing the PHIC indigent program. The cost sharing scheme was designed to make the program sustainable with emphasis on self-reliance on the part of the patient and local government

Policy Directions of the Province on PHIC Indigent Program

With the cited scenario, the Provincial Government with City and Municipal LGUs are now conceptualizing their own local health financing scheme (e.g. they generate PhP15 million and at the same time expanding benefit package). They feel that if they manage their own resources, they can facilitate the process and ease service utilization. This will minimize the lengthy process of PHIC. Moreover, the money is with them (PLGU), not with PHIC and will revolve within the province. However, there is an apprehension on the sustainability of local health financing since local investment is limited and rates on investment are low.

Appendix 1. Key Informants and FGD Participants, Negros Oriental.

PHIC Region 7

1. Ms. Jenet Ann R. Ayson, Indigency Program Unit
2. Ms. Flavia U. Aranas, Indigency Program Unit
3. Dr. Agnes Dizon, Accreditation Unit
4. Mr. William Chavez, AVP/Regional Manager
5. Mr. Paul Oyales, Service Field Officer, Negros Or.

IPHO

6. Dr. Ely Villapando, Integrated Provincial Health Officer and Chief of Provincial Hospital
7. Dr. Virgilio Cines, Chief, Bais District Hospital
8. Dr. Ma. Elizabeth Sedilio, Municipal Health Officer, Tanjay
9. Ms. Emalyn M. Gadingan, Chief Nurse, MOPH

PGSO

10. Atty. Ismael Martinez, Provincial General Services Officer

STA. BAYABAS ILHZ

11. Dr. Fidencio Aurelia, Chief, Bayawan District Hospital
12. Ms. Flor Pagaduan, Program Officer, Peso for Health
13. Ms. Sabina Valde, Client informant/wife of patient
14. Mr. Leonardo Valde, Client informant/patient
15. Dr. Victor O. Nuico, Municipal Health Officer, Sta. Catalina
16. Dr. Jacqueline Ann Borja, Municipal Health Officer, Valencia
17. Dr. Edalin L. Dacula, RHP, Bayawan
18. Dr. Estephen S. Estacion, Municipal Health Officer, Bayawan
19. Ms. Helen Gagoa, Chief Nurse
20. Ms. Lucia C. Canto, President, Federation of BHWs

SIAZAM ILHZ

21. Dr. Sozelon Zerrudo, Chief, Siaton District Hospital
22. Ms. Rica Gaga-a, Chief Nurse
23. Ms. Donna Villadolid, DOH Representative
24. Ms. Jocelyn Ege, Administrative Assistant, ILHZ