

NUEVA VIZCAYA

Socio-Economic Profile

Nueva Vizcaya had a total population of 366,962 in 2000, a household population of 74,402 and average household size of about 5 persons. About 39% of the population belong to the younger group (<15 years). A third live in the urban areas of Bayombong, Solano and Bambang.

Administratively, the province of Nueva Vizcaya belongs to Region 2. It is divided into 15 municipalities and 275 barangays. It has one lone congressional district. The economy is basically agricultural with rice, onions, mangoes and vegetables as the main produce. The province is also known for its rattan products and rare species of orchids. Nueva Vizcaya is a 2nd class province with an income of P290,600,076.00 in 2001

Nueva Vizcaya has 1 regional hospital, 1 provincial hospital, 3 district hospitals, 1 municipal hospital, 15 rural health units and 108 barangay health stations. It maintains 97 doctors, 10 dentists, 118 nurses, 128 midwives, 35 nursing aides, 16 medical technologists, 25 sanitary inspectors and 1,200 *barangay* health workers. The province also has 1 private hospital and medical clinics that are concentrated in the Bambang-Bayombong-Solano towns. The province has about 333 traditional birth attendants (*hilots*).

The following were the vital health indicators in 2001:

Life expectancy	66.63 (male); 69.8 (female)
Crude birth rate	2.8 per 1,000 population
Crude death rate	20.5 per 1,000 population
Infant mortality rate	7.41 per 1,000 livebirths
Maternal mortality rate	0.26 per 1,000 livebirths

The leading causes of morbidity are communicable diseases (2582.1 per100,000 pop), cardiovascular diseases (2488.3 per 100,000 pop) and influenza (1996.43 per 100,000 pop). Majority of the people in Nueva Vizcaya die of cardiovascular diseases (80.97 per 100,000 pop), pneumonia (49.4 per 100,000 pop) and cancers (31.8 per 100,000 pop).

Background of Health Sector Reform

Devolution and Pre-Convergence. The provincial government's openness to the idea of participatory governance made Nueva Vizcaya, one of the 6 pilot sites of GOLD in 1995. This multi-sectoral program provided assistance to the provincial government during devolution, particularly on organizational development, planning and budgeting among others. In 1996, a societal mission-vision was developed for the province. Each department also had formulated its own specific vision-mission statement, which are now conspicuously displayed in each provincial office. During the last year of GOLD (1998), the governor requested for GOLD assistance on health management owing to the

numerous complaints being received by the governor's office. GOLD then focused on capacity-building, specifically in the training of trainers on organization development and quality assurance. This later led to the establishment of the Quality Services Improvement Program (QSIP) in the hospitals.

HSRA Convergence Strategy. In 2001, the Management Sciences for Health (MSH) under Dr. Benito Reverente came to the province to introduce the concept of convergence in health sector reform. The key informants surmised that Nueva Vizcaya was chosen as a convergence site because 1) it was a *Galing Pook* awardee in 2000, 2) it was cited for its outstanding local health board in 1995 and 1996, and 3) it performed well in the GOLD project (e.g., pioneered in *barangay* planning and budgeting; formulated the training modules for QSIP which was adopted in other sites).

The first convergence workshop was conducted at Villa Margarita Resort, Bayombong in July 2001. The workshop aimed to:

- • Identify health-related problems/issues in Nueva Vizcaya and the actions taken;
- • Orient key technical players on the HSRA, Health Passport Initiative and the Convergence Strategy;
- • Develop targets for Nueva Vizcaya by 2004 in the area of social health insurance, local health system, hospital reforms, drug management and public health;
- • Develop a draft convergence plan for Nueva Vizcaya;
- • Determine the next steps to sell the program to the LGUs; and
- • Organize the Nueva Vizcaya Health Sector Reform Advocates

There were about 95 participants in the workshop, which included the Chiefs of Hospitals, Provincial Health Officer, Municipal Health Officers, local government officials, representatives from the Department of Health, Philippine Health Insurance Corporation, Center for Health Development (Region 2), MSH and NGOs. The attendance of Health Secretary Manuel Dayrit and PHIC President Francisco Duque III made the convergence workshop in Nueva Vizcaya a memorable event. The Health Summit was also held along side the July workshop. The attending local executives agreed on the targets set earlier by the workshop participants.

Table 1. Issues addressed during the First Convergence Workshop in July 2001.

Identified issues/ problems	Actions taken	Vision for 2004
<p>I. Social Health Insurance</p> <ul style="list-style-type: none"> □ □ lack of local advocacy □ □ LGU financial constraints □ □ LGU political intervention in the 	<ul style="list-style-type: none"> ▪ Advocacy to municipal officials ▪ Regional PhilHealth office conducted IEC through radio ▪ Provincial 	<ul style="list-style-type: none"> ➤ ➤ full awareness about social health insurance ➤ ➤ all 15 municipalities enrolled in the Indigency

<p>selection of indigents</p> <ul style="list-style-type: none"> □ □ ineligible health facilities for (OPD) accreditation □ □ no PhilHealth service office (province) and service desk(municipality) □ □ low benefits provided by PHIC 	<p>government counterpart of PhilHealth premium</p> <ul style="list-style-type: none"> ▪ Gave feedback to Provincial and municipal DSWD ▪ requests for provincial PhilHealth from central office ▪ Pilot testing of PhilHealth 	<p>program with full LGU financial support</p> <ul style="list-style-type: none"> ➤ ➤ creation of a screening committee with proper classification of indigents/100% of indigents covered ➤ ➤ establishment of Philhealth provincial and municipal service offices ➤ ➤ upgrade benefits provided by Philhealth
<p>2. Hospital reforms</p> <ul style="list-style-type: none"> □ □ hospital budgetary problems □ □ patient financial resources □ □ weak referral system □ □ poor utilization of hospital resources □ □ external factors affecting hospital care 	<ul style="list-style-type: none"> ▪ lobbying to local boards ▪ strategic planning and annual budget review ▪ re-designed procurement system ▪ utilization of hospital income (NVPH) ▪ increase service fees ▪ enrolment in the indigency program ▪ advocacy on cost-sharing of resources ▪ IEC campaign ▪ outreach activities ▪ health board agenda 	<ul style="list-style-type: none"> ➤ ➤ Institutionalization of QSIP in all hospitals ➤ ➤ all hospitals able to generate and utilize revenues ➤ ➤ all public hospitals Philhealth accredited ➤ ➤ budget increase based on needs identification ➤ ➤ upgrading of NVPH to tertiary level

<p>3. Drug management system</p> <ul style="list-style-type: none"> □ □ high costs □ □ delayed procurement and delivery □ □ unnecessary and soon-to-expire drugs □ □ inadequate funds for drugs 	<ul style="list-style-type: none"> ▪ direct purchase ▪ creation of special procurement team ▪ early submission of the annual procurement plan ▪ A.O. empowering departments to reject donated expiring drugs ▪ increase funds for drugs 	<ul style="list-style-type: none"> ➤ ➤ 1.establish a cost-efficient drug procurement system ➤ ➤ Increase allocation for drugs by 50% from 2001 level ➤ ➤ Integrate 15 RHUs in the Provincial Therapeutic Committee
<p>4. Local Health System</p> <ul style="list-style-type: none"> □ □ inadequate information education campaign □ □ low budget for health services □ □ weak referral system □ □ politicized health services □ □ poor planning integration at the municipal level □ □ provincial health system differently organized 	<ul style="list-style-type: none"> ▪ household teachings, networking, tri-media campaign, program reviews ▪ fund raising, augmentation from CHD, proposals submitted to different funding agencies, increase in budget through LHB ▪ development of referral standard form, dialogue with hospitals and RHUs ▪ strengthening LHB, focus on QSIP, establishment of selection/promotion board, multisectoral involvement ▪ strategic LGU planning, setting 	<ul style="list-style-type: none"> ➤ ➤ establish 2 functional ILHZs ➤ ➤ All RHUs SS and Philhealth accredited ➤ ➤ 3. functioning referral and networking system

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In April 2002, the MSH initiated a program called *Lakbay Aral*. The purpose of this program was to expose local HSRA advocates to the results and processes used by other convergence areas in their pursuit of health sector reform. About 20 people from Nueva Vizcaya went to Capiz and saw for themselves the health developments in this area. Half of the participants were funded by MSH, the others were sent by the provincial government. The key informants who participated in the *Lakbay Aral* were very appreciative of their experiences that they expressed to have more of these type of learning opportunities. The lessons learned were in the areas of interpersonal relationships, human resources, material resources, service delivery, management and social health insurance. The group has submitted a report to the governor; but discussions about which issues to replicate in Nueva Vizcaya will still be done.

Gains in Health Financing

Status of implementation

As of May 2002, all the 15 municipal LGUs in Nueva Vizcaya have participated in the PhilHealth Indigency Program. For 2002, PhilHealth has targeted 20% of the total indigent households, of which 97.7% have actually been enrolled. Some municipalities like Bagabag and Bambang have exceeded their target for 2002. About 69% of the 18,000 indigent households targeted for 2004 have been covered. Except for Bayombong, Kasibu, Solano and Villaverde, the rest of the municipalities are now sharing 20% of the insurance premium.

Four municipalities (Aritao, Bambang, Dupax del Sur and Bagabag) have signed a contract with PhilHealth for Phase II OPBP. These municipalities have PhilHealth-accredited RHUs but PhilHealth is still waiting for the remittance of the premium payment to qualify them for the capitation scheme.

Table 2. Status of PhilHealth Implementation (as of June 2002).

	Municipalities	Class	# of nrolees (as of july 2002)	Target HHs for 2002 (Phase I)
1	Alfonso Castaneda	5 th	82	164
2	Ambaguio	5 th	218	436
3	Aritao	4 th	731	1220
4	Bagabag	4 th	1158	1244
5	Diadi	5 th	429	528
6	Dupax del Sur	4 th	984	1000
7	Dupax del Norte	4 th	930	930
8	Kayapa	4 th	360	720
9	Quezon	5 th	430	454
10	Sta Fe	5 th	1500	1500

11	Bambang	3 rd	1595	1592
12	Bayombong	3 rd	1000	845
13	Kasibu	4 th	480	480
14	Solano	2 nd	731	1,040
15	Villaverde	4 th	245	245
16	Barangay Poblacion North, Solano	2 nd	50	50
	Total number of current members		12,159	
	Total number of potential members			12,448

In terms of health provider accreditation, the only private polyclinic in Nueva Vizcaya has already been certified by PhilHealth. Except for the Kasibu Municipal Hospital, all other government hospitals in the province have received PhilHealth recognition.

Table 3. List of PhilHealth- Accredited Hospitals and Clinics, Nueva Vizcaya (As of July 2002).

Name of hospital	Type of hospital	Category
Medical Missions Group	Private	II
Veterans Regional Hospital	Government	III
Nueva Vizcaya Provincial Hospital	Government	II
Kayapa District Hospital	Government	I
Dupax Sur District Hospital	Government	I

Process of implementation

According to the Region 2 PhilHealth manager, it was not easy convincing the LGUs to participate in the Indigency program. Aside from the financial aspect, many of the mayors were not aware of the social health insurance. Admittedly, one reason was PhilHealth's inability to provide adequate information to the LGUs owing to the distance between Tuguegarao, where the regional office is, and Nueva Vizcaya. To make the program more responsive, PhilHealth established its provincial service office in Nueva Vizcaya in February 2002. Since then, massive information on the PhilHealth thrusts and programs were effectively disseminated to the LGUs.

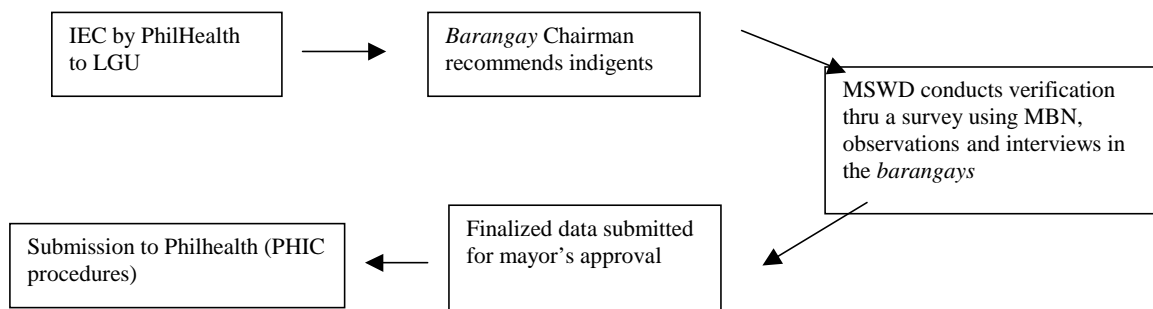
There were individual visits to the LGUs. The strategy was to identify a point person who is close to the Mayor, convince this person about the PhilHealth indigency program, and then approach the Mayor through this contact person who, in turn, helps in endorsing the program to the local executive.

A plus factor for the Indigency Program was the support provided by the provincial government in terms of office space, moral support, resolutions adopting the program as well as allocation of funds for the program. Among the barrier factors were the (a)

financial constraints of LGUs, (b) indigency program not being a priority of the LGU, and (c) identification of indigents.

There were issues in the implementation of the Indigency Program in indigenous communities. Indigenous households cannot satisfy PhilHealth's requirements of a marriage contract and a birth certificate because these practices are not within the tribal culture. This creates a problem for PhilHealth in Nueva Vizcaya because of the large proportion of the indigenous population in the province.

There were also issues related to the selection of indigent beneficiaries where mayors and *barangay* chairmen tend to select their friends and relatives as indigent beneficiaries. Based on interviews with the Municipal Social Worker of Bagabag, the following processes were followed for the selection of indigents:



According to the MSWD, an eligible household must have: an annual income of P8,000 or less; an unemployed family head; a large household size; and, presence of out-of-school children.

Indigent cardholders interviewed in Bagabag confirmed the conduct of the house-to-house interview by the MSWD. The beneficiary-respondents also admitted that they were not initially aware of the benefits and procedures of being PhilHealth members. A number did not know that they could be reimbursed for medicine costs. Others learned that they could avail themselves of free health service only during time of release from the hospital. In such cases, the families have already spent some amount of money for the hospitalization of their kin.

For Phase II OPBP, the absence of medical technologists in many RHUs, which should have qualified them to become Sentrong Sigla and PhilHealth, accredited institutions, served as an impediment. Nevertheless, an arrangement with PhilHealth was made for neighboring RHUs to share one person in charge of laboratories.

The PhilHealth office in Nueva Vizcaya will be conducting orientation programs to NGOs like the Rotary Club for possible sponsorship in the outpatient benefit package, and to business establishments for the health insurance of their employees.

Progress of implementation

A summary of the accomplishments in social health insurance/ health financing vis-à-vis some indicators of improvement is shown below (as of July 2002):

Table 4. Summary of Accomplishments in Social Health Insurance/ Health Financing vis-a-vis Indicators of Improvement, Nueva Vizcaya, July 2002.

Indicators of Improvement	Accomplishment
Percent of indigents currently enrolled	97.7% of targeted indigent households in 2002; 69% of the 18,000 indigent households targeted for 2004
Percent of LGUs participating in the Indigency Program	100%
Number of PhilHealth - accredited hospitals and clinics	4 of the 5 hospitals/polyclinics (1 private, 4 government)
Percent of RHUs accredited by PHIC	4 of the 15 RHUs (27%)
Funding of premium (ratio of prov:mun:Philhealth)	For 11 municipalities: 80:10:10 For 4 municipalities: 90:5:5
Social marketing of PhilHealth	Active with the establishment of a provincial service office
Utilization	According to the chiefs of hospitals, the PhilHealth Indigency program is a major source of income for the hospitals.
Percent of RHUs receiving capitation	0% but expects to start as soon as remittance is given by end of July
Utilization of capitation funds	Not applicable
Non-PHIC financing schemes	none

Gaps and problems

As far as the 2004 vision is concerned, about 31% of the targeted indigent population has still to be covered. Eleven of the RHUs still need to be PhilHealth-accredited to qualify them for the capitation program. Similarly, one government hospital needs to be accredited by PhilHealth.

A culture-sensitive policy must be formulated by PhilHealth to ensure that the indigenous population (“poorest of the poor,” “most marginalized sectors of society”) is covered by the government health insurance.

Gains in Hospital Reforms

Status of implementation

Several changes and improvements during devolution were implemented as part of the hospital reforms. For one, the Bambang District Hospital was designated as the Nueva Vizcaya Provincial Hospital (NVPH) when the former provincial hospital based in Bayombong was re-nationalized in 1995. Second, hospitals were given autonomy in governance since 1995-96. Previously, the provincial and district hospitals were under the supervision of the Provincial Health Office (PHO), today, they are accountable to the Office of the Governor. Preventive health became the major thrust of the PHO, while hospitals took charge of the curative health services.

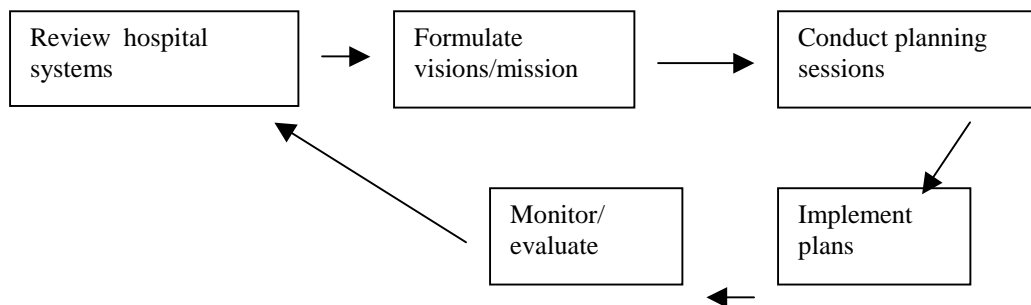
Another major development in hospital reforms was the establishment of the Quality Services Improvement Program (QSIP) in 1998. The QSIP has 5 members, including the chiefs of hospitals. It formulates the internal policies of each hospital, takes charge of organizational development and quality assurance, monitors the implementation of these policies and makes recommendations to the Provincial Health Board if the policy affects the whole province. Service audit teams (SAT) in each hospital were also organized.

Aside from the upgrading of hospital equipments and facilities, and cleaning and beautification of the hospital premises, inter-hospital sharing of manpower and material resources was also considered a major development in health service delivery. The provincial hospital shares its facilities, manpower and supplies with the 3 district hospitals, and vice versa.

MSH has conducted training workshops on 5S and drug management review for the hospital staff.

Process of Implementation

The following steps were pursued by the Service Audit Teams to improve the hospital: From a review of the hospital systems, vision-missions were formulated. Then, a planning session was conducted to set up the specific objectives and action plans. The implementation of the plans were monitored and evaluated through customer satisfaction surveys and public consultations.



In February 2002, mayors and *barangay* officials were invited to attend a public consultation meeting. In their situational analysis, the participants perceived NVPH as

“clean”, “accessible”, “with available water and well-kept surroundings”, “respectful staff” and where “*barangay* official recommendees were well taken cared of”. The problematic issues related to the lack of specialists, lack of medicines/selling of medicines by doctors, poor facilities and equipments, non-implementation of hospital benefits for *barangay* officials, among others. Some recommendations were suggested to resolve these issues.

\Customer satisfaction surveys (both from staff and patients/watchers) were also done to identify strong and weak areas in the hospital system. In March 2002, the hospital staff did an evaluation of the NVPH. The “good” points were the increasing hospital budget, cleanliness and beautification of the hospital. The “bad” points included: lack of computer training for administrative personnel, poor dietary program for patients, poor waste management, complaints against some hospital personnel and complaints against the hospital leadership.

Similarly, the referral system with the Rural Health Units was strengthened. In a meeting with MHOs, there was an agreement that 2 referral slips will be issued to the patient by the RHU. The RHU is to pick up from the hospital the feedback slip. However, the key informants reported that up to the present, this referral system has not been working as desired.

Hospital income retention scheme is currently being discussed by the QSIP. A drug supplementation program is also being proposed. A pharmacy cooperative will be established either within the provincial hospital or outside the premises of the hospital. The drug supplementation program will provide drugs and medicines that are not sold in the hospital pharmacy. This plan will still be discussed by the provincial health board.

The chiefs of hospitals expressed excitement about the financial management training that will be conducted by MSH.

Progress of Implementation

The QSIP was instrumental in enhancing the image of the hospitals and their respective personnel through quality standard protocols and customer satisfaction surveys. Developed protocols to remind the personnel of their tasks and responsibilities were posted in strategic places within the hospital. These protocols include admissions, disease management, supply management, recording and ER management.

Feedback on the 5S was positive. The key informants claimed that the training on 5S changed their attitudes about work, aided them in systematizing and “cleaning up” their tasks and made them “constructively critical” about their relationships with their co-employees and clients.

As a result of better working conditions, provincial hospital revenues increased from P2.7 million in 1997, to P3.3 million in 1998, P4.2 million in 1999, P4.6 million in 2000 and P5.5 million in 2001. Hospital income in the district hospitals has also exceeded their yearly quota in 2001. The key informants attributed the increase in revenues to the

acquisition of new equipments, QSIP, increase in number of indigents and the campaign made by the province regarding hospital charges.

Table 5. Hospital Revenues of District Hospitals, Nueva Vizcaya, 2001.

Hospital	Target for 2001 (PhP)	Actual Revenues (PhP)	Excess (PhP)
Kasibu MH	300,000	326,000	26,000
Kayapa DH	500,000	579,000	79,000
Dupax Sur DH	1.4 M	1.7 M	3 M

A summary of the accomplishments in hospital reforms vis-à-vis some indicators of improvement is given below (as of July 2002):

Table 6. Summary of Accomplishments in Hospital Reforms vis-a-vis Indicators of Improvement, Nueva Vizcaya, July 2002.

Indicators of Improvement	Accomplishments
Establishment of financial management systems	0%
Income generation	Provincial hospital revenues increased from 4.2 m in 1999, 4.6 m in 2000 and 5.5 m in 2001. Hospital income in the district hospitals have exceeded their yearly quota in 2001
Income retention	0%
Income utilization	0%
Fiscal autonomy	0%
Quality assurance	Upgrading of facilities, cleaning and beautifying the surroundings, regular conduct of customer satisfaction surveys and public consultations, application of 5S
SS/PHIC facility upgrading	All 4 government hospitals are SS-accredited. Except for Kasibu, all other hospitals are PHIC accredited.
Upgrading in hospital classification	0%
Technology transfer	Simultaneous training on 5S and drug review in all 4 hospitals
Networking with private sector	0%

Gaps and problems

From the list of accomplishments, some gaps and problems in implementation can be identified. Gaps in financial management are obvious as there has been no training of hospital staff in this aspect. A good financial management system can improve further the income generating capacity of the hospitals. Upgrading of the facilities and eventually a

better image for the hospital are also dependent on improved hospital income. Efforts should be made to commence training on financial management for hospital leaders and staff.

Gains in Drug Management Systems

Before 2000, drug purchase in Nueva Vizcaya was included in the procurement of provincial supplies by the General Supply Office (GSO). This procedure was regarded as long and arduous. Numerous complaints from the health sector were received especially with regard to the timely delivery and high costs of drugs and supplies.

In December 2000, the governor issued Executive Order # 145 creating the Provincial Committee on Awards (PCOA) to handle the procurement of drugs, supplies and equipment for the provincial health office and the 4 hospitals. PCOA is composed of the Provincial Administrator as chairman, and the provincial treasurer, budget officer, accountant, provincial health officer, chiefs of hospitals, general services officer and PCOA-Technical Committee (PCOA-TC) head as members. A representative of BFAD and the Commission on Audit were designated as observers. A provincial pooled procurement program in Nueva Vizcaya is therefore in place. Municipal LGUs have not yet availed themselves of the pooled procurement.

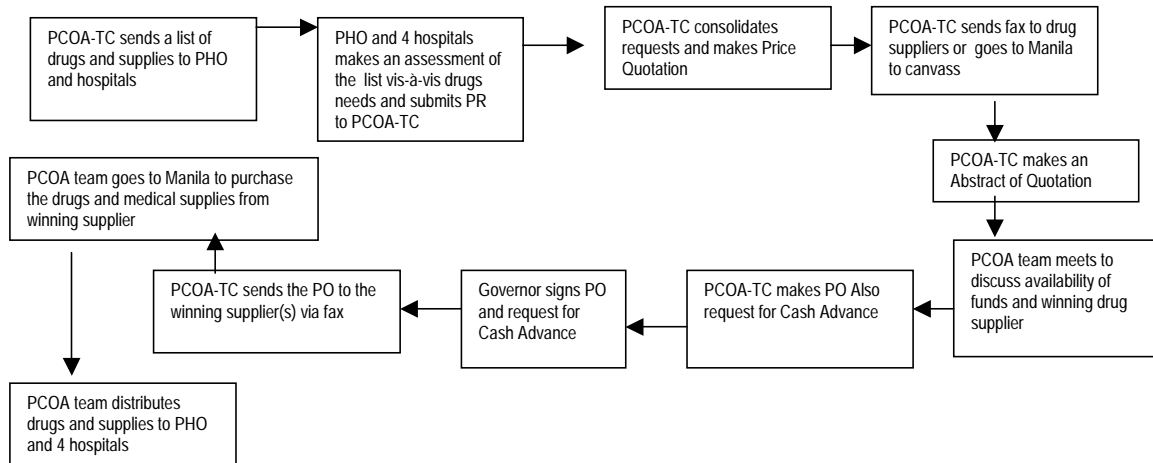
Recently, the Provincial Therapeutics Committee (PTC) composed of chief of hospitals was re-activated.

Process of implementation

The pooled procurement process in Nueva Vizcaya starts with a purchase request (PR) from the PHO and the 4 government hospitals. The PCOA-TC provides these units with the *Uniform List of Drugs (ULD)*, a consolidated list of previously purchased drugs and supplies. The Provincial Health Office (PHO) and hospital therapeutics committee of each hospital (HTC) go through the list and notes which of these drugs and supplies will be needed for the next quarter. The HTC may also indicate which other drugs not found in the ULD may be needed to be purchased. The PR will then be forwarded to the PCOA-TC for consolidation.

Once consolidated, the PCOA-C makes a Price Quotation Form. The form is sent by fax to the drug suppliers in Nueva Vizcaya and Manila to be filled up by the latter, or the team goes to Manila to do the canvassing of drug prices. Normally, about 15 drug manufacturers, distributors or retailers are consulted. Once the prices are in, an Abstract of Price Quotation, which includes the list of drugs to be procured together with their quoted prices is made. The whole group of PCOA members then meets to determine adequacy of funds vis-a-vis amount of drugs to be procured by PHO and the 4 hospitals. They also decide from which supplier to purchase the drugs. The supplier with the lowest price is taken except if complaints against the quality of drugs given by this supplier in the past were previously lodged. In which case, the award is given to the supplier with the second lowest price.

Once approved by the whole team, the PCOA-TC prepares a Purchase Order (PO) and a request for Cash Advance, which are then signed by the governor. The PO is then faxed to the winning supplier to make sure that stocks are ready once the PCOA team goes back to Manila to pick-up the goods. Back in Nueva Vizcaya, the boxes of drugs are immediately distributed to PHO and the 4 hospitals.



An interview with the Chiefs of Hospitals showed a positive regard on the system of drug procurement by the province. They commented that the present system has solved the problem of delay in the delivery of drugs and medical supplies (*drugs are delivered in the same quarter unlike before when 1st quarter PRs are delivered in the 3rd quarter*). They had occasional problems with the quality of some drugs, but according to them the PCOA-TC has shown responsiveness with regard to their complaints. They hoped that the reactivation of the Provincial Therapeutic Committee would help solve the problem on the quality of drugs procured.

Other key informants however expressed concern about the system of procurement because “they are not following COA procedures.” The governor and the provincial administrator were quick to say that their legal office approved the present system. Still others worried about the possible loss that may result by having the PCOA team carry a large sum of cash about PhP800,000 per travel while doing their purchase in Manila.

The province is hesitant to participate in the parallel drug importation (Pharma 50) since “current costs of drugs and medicines are similarly cheap.” Some key informants observed a policy conflict between the government’s generic drugs policy and the parallel drug importation because the latter pushes for branded drugs. They were questioning its legality in reference to the generics law.

Other developments include: procurement review workshop – November 2001; Drug Use review - December 2001 until first quarter of 2002; and, Orientation of PDI – last quarter of 2001.

Progress of Implementation

A decrease of at most 45% in the prices of some drugs was noted between the 2nd and 3rd quarter purchase in 2002. A random sampling of drug prices is shown below.

Table 7. Comparison of Drug Prices, Nueva Vizcaya,- 2nd and 3rd Quarter, 2002.

Name of Drug	3 rd Qtr (Peso)	2 nd Qtr (Peso)	Decrease in drug price (%)
Salbutamol nebulas 2mg/2.5ml	23.20	23.20	-
Ampicillin 500mg mg vial	11.00	11.00	-
Chloramphenicol 250 cap 1 gm vial	93.00	125.00	(32.00)
Ascorbic acid 500mg tabl	92.00	100.00	(8.00)
Paracetamol 100 mg/ml	9.75	10.50	(0.75)
Penicillin G Na 1 million units	10.50	11.00	(0.50)
Gentamacin sulfate 80 mg vial	10.00	9.20	0.80
Rifampicin 200 mg susp 60 ml	43.50	42.00	1.50
Methylergometrine maleate 200 mg amp	28.00	28.00	-
Hydrocortisone vial	35.00	62.48	(27.48)
ATS 1500U	85.00	85.00	-
Nalbuphine 10 mg amp	88.70	136.00	(47.30)
Cefuroxime 750 mg vial	140.00	140.00	-
Mefenamic acid 500 mg tab	85.00	90.00	(5.00)
Cotrimoxazole 400 mg/80 mg tab	90.00	90.00	-
Amoxicillin 500 mg cap	175.00	185.00	(10.00)

A summary of accomplishments in drug management is given below (as of July 2002).

Table 8. Summary of Accomplishments in Drug Management vis-a-vis Indicators of Improvement, Nueva Vizcaya, July 2002.

Indicators of Improvement	Accomplishments
Functioning therapeutics committees	With newly reactivated provincial therapeutics committee With functional hospital therapeutics committee
Pooled drug procurement program	With pooled drug procurement program
Reduction in costs of drugs	Reduction in costs of drugs by at most 45% in 3 rd quarter compared to 2 nd quarter prices
Assurance of drug quality	Training in drug utilization review End-user complaints are acted upon by PCOA

Timely delivery of drugs	Delivered within the quarter
Purchase from accredited suppliers	Procures from DOH accredited suppliers
Provincial drug formulary	None
Inclusion of municipal LGUs in pooled drug procurement	0%

Gaps and problems

To ensure the purchase of quality drugs, the PTC should become fully functional. A provincial drug formulary should also be created. As in many other provinces, the inclusion of the municipal LGUs in the pooled procurement program is still absent.

Gains in Inter-Local Health Systems

Nueva Vizcaya maintains a single inter-local health zone (ILHZ) with the Provincial Health Board as the governing body. Stakeholders in Nueva Viscaya decided not to organize more than one ILHZ because 1) the present system of having expanded provincial health board is already effective, 2) referral hospitals are concentrated in one area, 3) linkages, coordination and communication among RHUs and the district/community hospitals are functioning and 4) population of Nueva Vizcaya is small.

Process of Implementation

The governor stressed that convergence occurs within the Provincial Health Board (PHB). All health issues are discussed and resolved through the PHB. The current Provincial Health Board, now called the Expanded Provincial Health Board (EPHB) is composed of 45 members from different relevant departments and LGUs. The expansion from the original 5 members as mandated by the Local Government Code was for the purpose of formulating effective, efficient and timely health policies and programs. The expansion also made health decision-making participative and consultative since the inclusion of MHOs from the 15 municipalities made sure that voices from the grassroots are heard, thereby making the implementation of the policies more effective at the municipal and barangay levels. The board has since become the policy making body for health in the province. The Department of Health proclaimed the Nueva Vizcaya Provincial Health Board as the Most Outstanding Health Board in 1995 and 1996.

Progress of Implementation

A summary of accomplishments in inter-local health zones is shown below (as of July 2002):

Table 9. Summary of Accomplishments in Inter-Local Health Zones vis-a-vis Indicators of Improvement, Nueva Vizcaya, July 2002.

Indicators of Improvement	Accomplishments
Number of ILHZs established vs targets	One ILHZ out of the 2 ILHZs targeted for 2004
With signing of MOA	No MOA
With District Health Board	With Expanded Provincial Health Board
Sharing of non-monetary resources	Sharing of resources among provincial and district hospitals; no sharing between hospitals and RHUs, or among RHUs.
Functional referral system	Not fully functional
Networking (NGOs, private sector, inter gov't agency)	Exist through the EPHB
Cost sharing	0%
Common fund	0%

Gaps and problems

The provincial government seems bent on maintaining only one ILHZ because of geographical, demographic and administrative reasons. A more formal mechanism like a MOA to cement the relationships may be needed to foster cooperation and sharing among municipal LGUs.

The key informants suggested that a district hospital be established somewhere in the north. They were eyeing at the DOH building in Diadi. However, the costs of establishing a district hospital need to be considered.

Best Practices

Among the HSRA convergence components in Nueva Vizcaya, best practice can be seen in the are of social health insurance. All 15 municipalities of the province are now participating in the PhilHealth Indigency Program. Eleven are on their third year; four are in the first year of implementation. Nueva Vizcaya is also one of the few provinces that have started getting access to PhilHealth's Out Patient Benefit Package with the MOA signing between PhilHealth and four municipalities in May 2002. Actual implementation of the capitation scheme is expected to commence in early August 2002.

The provincial drug procurement program can also be considered as best practice since it has solved the problem of delay in the delivery of drugs to the hospitals. Moreover, the Expanded Provincial Health Board is also recognized as a good example of participatory governance. The present system of local health governance institutionalized several programs and activities like the QSIP and PCOA. NGOs and groups like the Association of MHOs, Kabalikat, and other civil society groups also got the chance to contribute to improving the health of the people.

Lessons Learned

There are several lessons that can be learned from the experience of Nueva Vizcaya in health sector reform.

One, a dedicated service-conscious political leadership is an essential component of any health reform. Nueva Vizcaya has a governor who is pioneering, committed, transparent and consultative.

Two, the shape and content of the HSRA reforms may vary in each locality depending on ecological and social factors as well as felt needs and motivations of the local governments. Nueva Vizcaya has shown distinctiveness in the way they look at ILHZs and implement their drug procurement system. The EPHB has also been proven to be of utmost value in the management of health in the province.

Three, with an expanded PHB, health decision-making has become consultative and participatory.

Four, sustainability of health reforms should always be factored in. The governor assured sustainability by creating a system of governance (e.g., EPHB) in the event of change in political leadership.

Conclusion

The selection of Nueva Vizcaya as a convergence site is laudable in the sense that it can be a model for the implementation of HSRA in small, less populated areas. Its mechanisms for reform are simple and pragmatic. These include its system of drug procurement, the expanded provincial health board, and the format for a province-wide ILHZ.

Overall, the implementation of the various components of the HSRA in Nueva Vizcaya is improving except perhaps for the establishment of two ILHZs as envisioned for 2004. The present thinking is focused on making the province-wide ILHZ more functional through the EPHB.

HSRA Convergence has been very helpful in –

- • Emphasizing the integrated, collaborative character of health sector reform;
- • Providing direction to the ongoing health reforms in the province; and,
- • Systematizing the details for the implementation of health reforms.

In the words of the governor, the HSRA convergence cemented the loose ends of the reforms that the local government has been endeavoring to put in place.