

# Pangasinan

## Socio-Economic and Health Profile

With a land area of 536,818 hectares, Pangasinan is among the largest provinces in the Philippines. In 2000, the province had a total population of 2,434,086 with 477,819 households, 55% of whom lived in the rural areas. The population is mostly working age (15-64 years). Thirty-nine percent of the population belongs to the younger age groups. Pangasinan is classified as a first class province, with an average family income of P8,371, average family expenditures of P6,758.17 and annual regional per capita poverty threshold of P11,975.00. The employment rate in 2000 was 88%.

Pangasinan has 51 hospitals, 72% of which are privately owned. It has 6 district health offices, 68 rural health units, 414 barangay health stations, 52 botika sa barangay and 486 family planning clinics. Public hospitals are maintained by the provincial government while rural health centers as well as the city health offices are under the jurisdiction of the mayors. The district health offices are maintained by the provincial government.

The following are the vital health indicators in 2001:

Crude birth rate	20.6	per 1,000 population
Crude death rate	4.5	per 1,000 population
Infant mortality rate	12.3	per 1,000 livebirths
Maternal mortality rate	0.18	per 1,000 livebirths
Overall malnutrition rate	5.9%	with 95% moderately malnourished

## Convergence Experience

In 1996, Pangasinan was chosen to become a model for the LGU Performance Program (LPP) on family planning (Family Planning Technical Assistance Project) by the Management Sciences for Health (MSH) under Dr. Jose Rodriguez. Pangasinan's successful collaboration with the Catholic church in implementing the family planning program was replicated in 20 LGUs in the country.

In the later part of 1998, MSH technical assistance branched out to hospital reforms. Then with the opportunity, Pangasinan preferred to prioritize hospital reforms than develop inter-local health zones because hospitals are under the control and management of the provincial government. The provincial hospital in San Carlos City became the pilot health facility for such interventions and as part of the hospital reforms. A pooled drug procurement program for the hospitals was developed.

In 2001, the Health Sector Reform Technical Assistance Program (HSRTAP) of MSH under Dr. Benito Reverente, continued the health reforms in Pangasinan. Using a convergence framework, the first orientation workshop was held at the Star Plaza Hotel in Dagupan City on March 7-8, 2001. The workshop was attended by 48 people: 27 from

the provincial and municipal LGUs, 5 from DOH, 6 from PhilHealth, 2 from the Futures Group Inc., and 8 from MSH. Its purpose was to disseminate information about the convergence strategy, advocate the need for health sector reforms, and address various issues and concerns about the implementation of the HSRA convergence. As outputs, the participants identified the problems of the health sector, analyzed the actions that have already been taken, and developed the vision for health for 2004. Benchmarks, strategies and plans of action were also formulated during the workshop. As a follow-up activity, a Health Summit, was conducted in October 2001 to orient the local government executives on HSRA convergence.

Table 1. Issues Addressed during the First Convergence Workshop in March 2001, Province of Pangasinan.

<b>HSRA Component</b>	<b>IDENTIFIED /PROBLEMS</b>	<b>ACTIONS TAKEN</b>	<b>VISION FOR 2004</b>
<i>Hospital reforms</i>	<ul style="list-style-type: none"> <li>◆ ◆ dilapidated facilities</li> <li>◆ ◆ sustainability of hospital reforms</li> <li>◆ ◆ lack of manpower</li> <li>◆ ◆ need to increase utilization of hospitals</li> <li>◆ ◆ additional MOOE funding</li> <li>◆ ◆ poor quality care</li> </ul>	<ul style="list-style-type: none"> <li>○ ○ partial repair/request for funds</li> <li>○ ○ continuous QAC monitoring improved billing and collection procedure</li> <li>○ ○ maximized utilization of manpower</li> <li>○ ○ partial upgrading of equipments</li> <li>○ ○ automatic 10% increase in MOOE funds by LGUs</li> <li>○ ○ implement quality assurance program</li> </ul>	<ul style="list-style-type: none"> <li>➤ ➤ All hospitals SS and PhilHealth accredited</li> <li>➤ ➤ Fully autonomous provincial hospital</li> <li>➤ ➤ All 5 district hospitals financially viable</li> </ul>
<i>Social Health Insurance/Health financing</i>	<ul style="list-style-type: none"> <li>◆ ◆ lack of qualified/accredited health service providers</li> <li>◆ ◆ health as low priority of local chief executives</li> <li>◆ ◆ lack of understanding of health insurance</li> </ul>	<ul style="list-style-type: none"> <li>○ ○ Identification and communication of need to governor</li> <li>○ ○ PhilHealth presented Indigent program to SBs/SP</li> <li>○ ○ governor's commitment for 3000 indigent households</li> <li>○ ○ Tri-media campaign</li> </ul>	<ul style="list-style-type: none"> <li>➤ ➤ Coverage: 85% indigent population</li> <li>➤ ➤ All LGUs with Indigent Program</li> <li>➤ ➤ Expand benefit package</li> <li>➤ ➤ Increased awareness</li> <li>➤ ➤ '85% of public and private health service providers accredited</li> <li>➤ ➤ Increased share of health insurance in provincial health care expenditures</li> </ul>
<i>Drug management</i>	<ul style="list-style-type: none"> <li>◆ ◆ irrational drug use</li> <li>◆ ◆ delivery of drugs not according to</li> </ul>	<ul style="list-style-type: none"> <li>○ ○ Hospital and Provincial TCs selects and reviews, respectively, the type of drugs to be procured</li> </ul>	<ul style="list-style-type: none"> <li>➤ ➤ Cheap, appropriate, safe, effective drugs available thru Provincial Pooled Procurement Program- all 48 cities and municipalities,</li> </ul>

	<p>priorities</p> <ul style="list-style-type: none"> <li>◆ ◆ perception of poor quality of drugs procured</li> <li>◆ ◆ high drug prices in RHUs</li> <li>◆ ◆ no clear cut PHIC protocol on reimbursements</li> <li>◆ ◆ non-compliance with PHIC rules and regulations (generic O.R. and incomplete diagnosis)</li> </ul>	<p>by hospitals in accordance with the Provincial Drug Formulary</p> <ul style="list-style-type: none"> <li>○ ○ Memo to suppliers to deliver within 10 days after receiving POs.</li> <li>○ ○ purchase from qualified and accredited drug suppliers</li> <li>○ ○ random sampling testing of drug deliveries</li> <li>○ ○ tender management at the provincial level</li> <li>○ ○ procurement thru bidding</li> <li>○ ○ development of standard treatment protocols</li> <li>○ ○ PHIC protocol on payment of “generic” drugs generics</li> </ul>	<p>provincial bidding, municipal procurement</p> <ul style="list-style-type: none"> <li>➤ ➤ Computerized procurement system</li> <li>➤ ➤ Functional Therapeutic Committees in all hospitals</li> </ul>
<p><i>Local Health System</i></p>	<ul style="list-style-type: none"> <li>◆ ◆ fragmentation of health services</li> <li>◆ ◆ Inadequate management system</li> <li>◆ ◆ poor quality of services</li> <li>◆ ◆ career pathway disruption</li> </ul>	<ul style="list-style-type: none"> <li>○ ○ .orientation of LCE's regarding health system</li> <li>○ ○ introduction of inter-local health zone system</li> <li>○ ○ installation of CBHMIS</li> <li>○ ○ lobby more funds</li> <li>○ ○ availability of computers and training of staff on IT</li> <li>○ ○ seminar workshop on Total Quality Management</li> <li>○ ○ value formation seminars</li> <li>○ ○ QA for health personnel</li> <li>○ ○ referrals to DBM, CSC re salary grades and appointments</li> <li>○ ○ CME seminars</li> </ul>	<ul style="list-style-type: none"> <li>➤ ➤ 6 ILHZ functional <ul style="list-style-type: none"> <li>• • all catchment municipalities with indigent program</li> <li>• • with MOA's signed</li> <li>• • management -structure in place</li> <li>• • integrated planning</li> <li>• • information system</li> <li>• • referral system</li> <li>• • human resource program</li> </ul> </li> </ul>

From key informant interviews, it appeared that not all Mayors were receptive of the HSRA convergence because of differences in development priorities and availability of

budget. In the case of the pooled drug procurement, their contentions were: a) inadequate budget and b) late deliveries of drugs from the province. MHOs and other health workers were receptive of the HSRA convergence because they felt that the district health system before devolution is being revived. It provided a venue where their work-related concerns can be addressed.

Another HSRA workshop for civil society was subsequently conducted in February 2002. The purpose of the workshop was to disseminate information about the health sector reforms being implemented in Pangasinan and to get the cooperation of the NGOs in implementing these reforms.

A Provincial Advocate Group (PAG) was organized in May 2002. The group goes from one municipality to another to sell the concept of HSRA convergence. The PAG is divided into three teams: *think tank* team (to generate goals and strategies), *resource* team (to provide relevant information to think tank team as well as to LGUs) and *spokespersons* team (to talk to the targeted clients).

### **Gains in Health Financing**

#### *Status of implementation*

Even before convergence, PhilHealth was already lobbying to the Mayors for the social health insurance of their constituents. It was during the Health Summit in Pangasinan in October 2001 when PhilHealth introduced the Indigency Program to the LGUs.

Pangasinan has lagged behind other provinces in Region 1 in the implementation of the Indigency Program. Out of the 48 municipalities and cities of Pangasinan, only 7 LGUs had current indigent membership. The latest statistics (as of July 2002) show a total of 8,869 families or approximately 20% of the 35,000 to 50,000 estimated total number of indigent families in Pangasinan have already been enrolled. Eighteen of the 48 LGUs have signified their intentions to sign a MOA with PhilHealth and the provincial government in April, 2002. A meeting with the second batch of 28 LGUs was scheduled for August 2002. Nevertheless, the Philhealth Manager claimed that Pangasinan has one of the “best of PhilHealth social health insurance in the Philippines” with Dagupan City having the highest utilization rates.

The PhilHealth manager emphasized that hospital reforms should go hand in hand with advocacy for social health insurance. As of July 2002, 44 of the 51 hospitals and clinics in the province have already been accredited by PhilHealth, which include 12 of the 15 government hospitals (including Region 1 Medical Center).

Table 2. Status of PhilHealth Implementation (*Medicare para sa Masa*), Pangasinan (as of July 2, 2002).

	MUNICIPALITIES	# OF TARGETTED ENROLEES (families)	DATE OF EFFECTIVITY	REMARKS

1	Dagupan City	4,852 490 157	0/16/98 6/16/00 3/16/01	Current membership
2	Sto Tomas	500	10/1/00	Current membership
3	Asingan	750	1/16/01	Current membership for 500 enrollees; 250 enrollees to be shouldered by provincial government
4	Bolinao	250	2/16/01	Current membership for 150 enrollees; 100 enrollees to be shouldered by provincial government
5	San Carlos City	1000	3/16/01	Current membership
6	Alcala	1000	4/16/02	Current membership ; appropriated P242.513 as per Res No 05-s-2002
7	Laoac	220	Not ascertain	Current membership
8	Mapandan	1000		
9	Mangaldan	1000		To issue certificate of availability of funds
10	Binmaley	1000		Requesting to enroll 500 more enrollees
11	San Fabian	1000		
12	San Manuel	500		Appropriated P40,000 as per Res No 10-s-2002
13	Bayambang	1000		
14	Basista	500		Appropriated P30,000 as per Res No 198-s-2002
15	Aguilar	500		Requesting to enroll 200 more enrollees
16	Bugallon	500		Requesting to enroll 500 more enrollees
17	Natividad	500		
18	Urdaneta City	500		Requesting to enroll 500 enrollees instead of 1000 because of budgetary constraints
19	Labrador	500		
20	Dasol	500		
21	Sual	1000		
<i>Total number of current members</i>		8,869		<i>Approximately 20% of the 35-50 thousand estimated total number of indigents in Pangasinan</i>

Table 3. List of PhilHealth-accredited Hospitals and Clinics, Pangasinan (as of July 2, 2002)

<b>Name of hospital</b>	<b>Type of hospital</b>	<b>Category</b>
Alaminos Doctors Hospital	Private	I
Asingan Medicare and Community Hospital	Government	I

Banez Clinic	Private	II
Bayambang District Hospital	Government	II
Bolinao Medical and Community Hospital	Government	I
Cuison Family Clinic and Hospital	Private	II
Dagupan Doctor Villaflor Memorial Hospital	Private	III
Dagupan Orthopedic Center	Private	II
Del Carmen Medical Clinic and Hospital	Private	I
Don Amadeo Perez Sr. Memorial Hospital	Private	II
Don Marcelo Chan Memorial Hospital	Private	I
Eastern Pangasinan District Hospital	Government	II
Espinoza-Rosario Hospital	Private	II
Holy Child General Hospital	Private	II
Labrador Community Hospital	Government	I
Lopez Family Clinic and Hospital	Private	I
Luzon Medical Center	Private	II
Mangatarem District Hospital	Government	II
Medical Centrum Dagupan Inc	Private	II
Nazareth General Hospital	Private	II
Nuestro Senor Sto Nino Hospital	Private	II
Pangasinan Center for Family Medicine Inc	Private	III
Pangasinan Doctors Hospital	Private	II
Pangasinan Medical Center	Private	III
Pangasinan Provincial Hospital	Government	III
Perpetual Help Hospital	Private	I
Pozurrobo Municipal Hospital	Government	I
Prudencio Medical Clinic	Private	I
Ramos Nursery and Childrens Hospital	Private	I
Region 1 Medical Center	Government	III
Rosario-Trino Medical Clinic	Private	I
Saballa-Rosario Hospital	Private	I
San Antonio de Padua Hospital	Private	II
Specialists Group Hospital and Trauma Center	Private	III
St Lucy's Cataract and Laser Eye Center	Private	ASC
Stella Maris Hospital	Private	II
Sto Nino Hospital	Private	I
Umingan Medicare and Community Hospital	Government	I
Urdaneta Sacred Health Hospital	Private	II
Velasquez medical Clinic	Private	I
Villasis Polymedic Hospital and Trauma Center	Private	II
Vigen Milagrosa Medical Center	Private	III
Western Pangasinan District Hospital	Government	II
Zaratan-Jimenez Clinic	Private	I

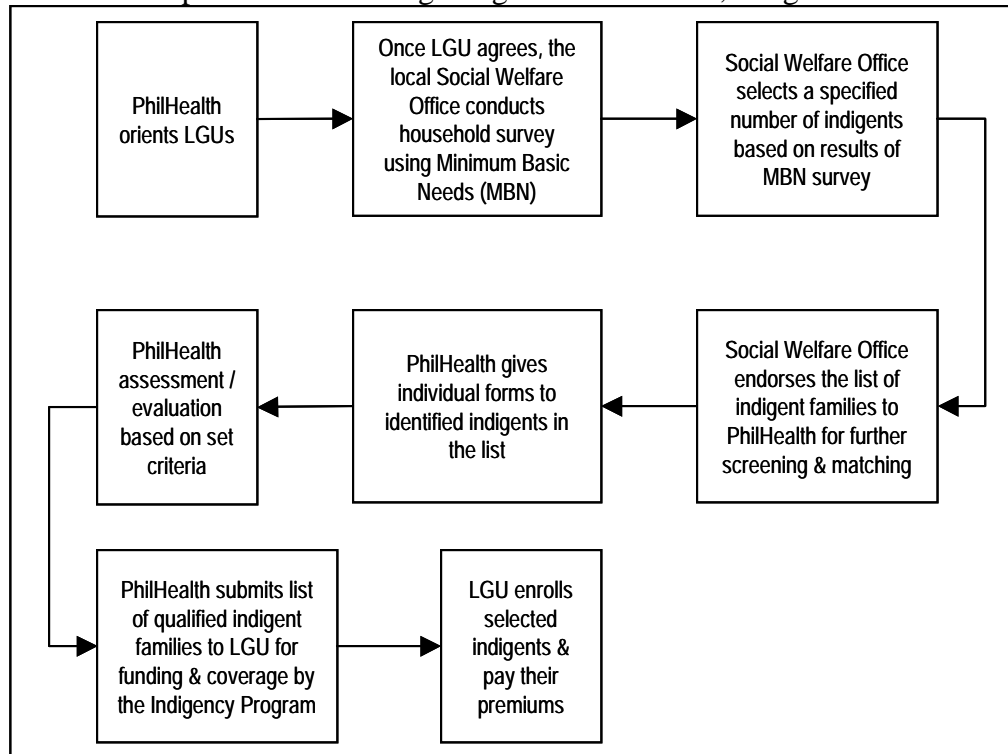
### *Process of implementation*

Lately, PhilHealth has focused on the selling of social health insurance to the different municipalities. PhilHealth uses 3 types of strategies. The *investment perspective*, which states that the premium per month (i.e., P118/ month) can be applied to the whole family, the *political perspective* states that the mayor's investment can gain for himself/herself political mileage and the *vice perspective*, which states that the personal burden of politicians in providing health assistance to their constituents can be minimized.

PhilHealth also applies “psychology” by sensing the needs of the Mayors (“*give them what they want to hear from you.*”).

Apparently, all Mayors in Pangasinan are convinced of the importance of the Indigency Program except for some forms of resistance, which were perceived to be financial. As an alternative approach, PhilHealth convinced the Mayors and the *Sangguniang Bayan* (SB) to realign their budgets allocated for emergency purposes into social health insurance premium appropriation. However, even with this strategy, LGUs found it difficult to follow PhilHealth’s suggestion because of the natural disasters that often visit the province. While some key informants would like to think that health is not really in the priority agenda of some LGUs, others believe that the implementation of the Indigency Program was also delayed by difficulties in identifying the indigent population.

Figure 1. Standard process of selecting indigent beneficiaries, Pangasinan.



Some indigent beneficiaries were found to be personal and political recruits (e.g., blood relations, party mates, friends). One of PhilHealth’s limitations was insufficient manpower to handle huge volume of clients from the region as well as the unavailability of accredited health providers in eastern and western Pangasinan.

What made these 18 mayors finally decide to join the Indigency Program? Apparently, the provincial intervention of sharing the premium with the municipal LGUs “broke the camel’s back”. The total premium per indigent family is P1,188 per annum. For 1<sup>st</sup>-3<sup>rd</sup>

class LGUs, the said amount is equally shared by PhilHealth and the LGU at 50:50 sharing arrangement. The 50-percent share of the LGU is further equally subdivided into provincial and municipal shares.

For 4<sup>th</sup> to 6<sup>th</sup> class municipalities, the sharing of premium is graduated: 90:10 for the first year; 80:20 for the second year; 70:30 for the third year till PhilHealth and the LGUs have equal shares of 50:50 in the 5<sup>th</sup> year. Mayors found this arrangement more viable except that problems may be expected to arise once premiums are raised in the second to the fifth years. For sustainability purposes, the provincial government made sure that there is a resolution that 1) authorizes the governor to enter into an agreement with PhilHealth; 2) authorizes, upon approval of the *Sangguniang Panglalawigan*, the appropriation of an annual allocation of funds for the provincial share of the insurance premium.

There is a view that the involvement of PhilHealth in the HSRA convergence should not be limited to the Indigency Program. It should be universal coverage catering to all sectors. The convergence should cut across all members, “otherwise class distinction is being promoted”.

Another come-on for Mayors is the idea of capitation. The RHU will receive capitation money from PhilHealth in the amount of P300 x number of enrolled indigents, given on a quarterly basis. Eighty percent of the capitation fund can be utilized for medicines, supplies and equipment. Ten percent can be appropriated as incentive for the health center staff. The remaining 10% can be used for non- medical services. The RHU should be PhilHealth-accredited in order to qualify for the capitation scheme. In May-June 2002, 5 RHUs qualified for PhilHealth accreditation. These RHUs are in Sto. Tomas, Basista, Alcala, Mangaldan and Laoac. However, these RHUs are not still receiving capitation. As a rule, capitation can be availed three months after the RHUs PhilHealth accreditation. In the case of Mangaldan, ID distribution shall be done on July 2002.

There seems to be some confusion with regard to capitation. The PhilHealth manager noted that there are no distinct rules and guidelines regarding capitation. For example, the Central PhilHealth Office says that PhilHealth funds should be released to the RHUs, but politicians insist that funds should be released to the LGUs.

A hospital capitation proposal was presented to the governor and the Sangguniang Panlalawigan in which hospital budgets will be used to buy insurance premiums. The capitation payments can then be used for the operations of the hospital. However, the use of hospital income to buy insurance premiums was perceived to be “risky” because of concomitant changes in the financial system if adopted. However, a provincial ordinance for capitation is under study.

#### *Progress of Implementation*

So far, the following have been the accomplishments in social health insurance and health financing (as of July 2002).

Table 4. Summary of Accomplishments in Social Health Insurance/Health Financing vis-à-vis Indicators of Improvement, Pangasinan, July 2002.

Indicators of Improvement	Accomplishment
Percent of indigents currently enrolled	8,869 families or approximately 20% of estimated total number indigent families in the province
Percent of LGUs participating in the Indigency Program	7 of the 48 LGUs (12.5%)
Percent of PhilHealth – accredited hospitals and clinics	44 of the 51 hospitals (86.2%) including 12 of the 15 government hospitals (plus Region 1 Medical Center)
Percent of RHUs accredited by PHIC	5 of the 48 RHUs (12.5%)
Funding of premium (ratio of prov:mun:Philhealth)	For 4 <sup>th</sup> -6 <sup>th</sup> class municipalities; 5:5:90
Social marketing of PhilHealth	Active: First batch of 18 municipalities have signed MOA; 2 <sup>nd</sup> batch of 28 municipalities will meet in Aug 2002
Utilization	Dagupan City has the highest utilization rate in the entire country.
Percent of RHUs receiving capitation	0%
Utilization of capitation funds	Not applicable
Non-PHIC financing schemes	0%

#### *Gaps and problems*

The gaps and problems in the implementation of the social health insurance in Pangasinan are summarized below.

- • 80% of total indigent families still to be covered
- • 87.5% of 48 LGUs has still to participate in the Indigency Program
- • 14% of 51 hospitals and clinics still to be accredited including 3 government hospitals
- • 90% of 48 RHUs still to be accredited by PhilHealth

Much still needs to be done to increase the coverage of the Indigency Program and to make it more functional.

#### *Propositions/suggestions*

- • Stronger advocacy to LGUs
- • Upgrading of district hospitals
- • Increase PhilHealth's human resource capabilities

## **Gains in Hospital Reforms**

### *Status of Implementation*

The Pangasinan Provincial Hospital (PPH), with its 150-bed capacity, was the target for hospital reforms even during the time of the LPP in Pangasinan. It was formerly the San Carlos District Hospital but was designated as the provincial hospital in 1997 after the former provincial hospital based in Dagupan City was re-nationalized.

An interim committee composed of the Governor, member of the *Sangguniang Panglalawigan*, Provincial Health Officer, Population Officer, DOH representative, Chief of Hospitals, member of the media and NGO representative, was organized as the consultative body for hospital reforms. This group, many of whom are also members of the Provincial Health Board, formulated the policies for hospital reforms. Within the hospital, a Quality Assurance Committee (QAC) was created to oversee the implementation of the hospital reforms. Similarly, Quality Improvement Teams (QITs) were established in each hospital departments and sections.

The Pangasinan Provincial Hospital has maintained its classification as a tertiary health facility. It has visiting consultants from Villaflor Hospital (a private hospital in Dagupan City). It has also links with NGOs such as Rotary club for the polio campaign and the Engender Health for voluntary sterilization and management of post-abortion complication cases.

### *Process of Implementation*

At the beginning of the health initiative, a situation analysis was conducted by the PPH hospital staff to determine the problems that needed to be addressed. Using the Monitoring, Training and Planning (MTP) modules, the staff identified the following issues:

- • low morale/motivation of staff and other employees
- • need to improve quality of care
- • poor income generation
- • low cost-efficiency

To address the first issue, 5S technology seminars were conducted in all hospital departments. The seminar emphasized order and discipline in work. As a result, the hospital staff and employees developed higher motivation, stronger self-discipline and better relationships with patients and co-employees. The 5S was later institutionalized through the “Best Hospital Department Award”.

The creation of the QAC ensured that quality health services are provided by the hospital. In each department, there is a functional QIT that takes charge of identifying the problems confronted by the department. The QITs meet monthly to discuss the issues, make plans and solutions and submit their proposed plans to the QAC. The QAC also

meets monthly to monitor the submission of QIT reports, and to provide more viable solutions to the issues at hand. For example, the committee implemented color-coding as a means of controlling visitors and watchers of patients in the hospital.

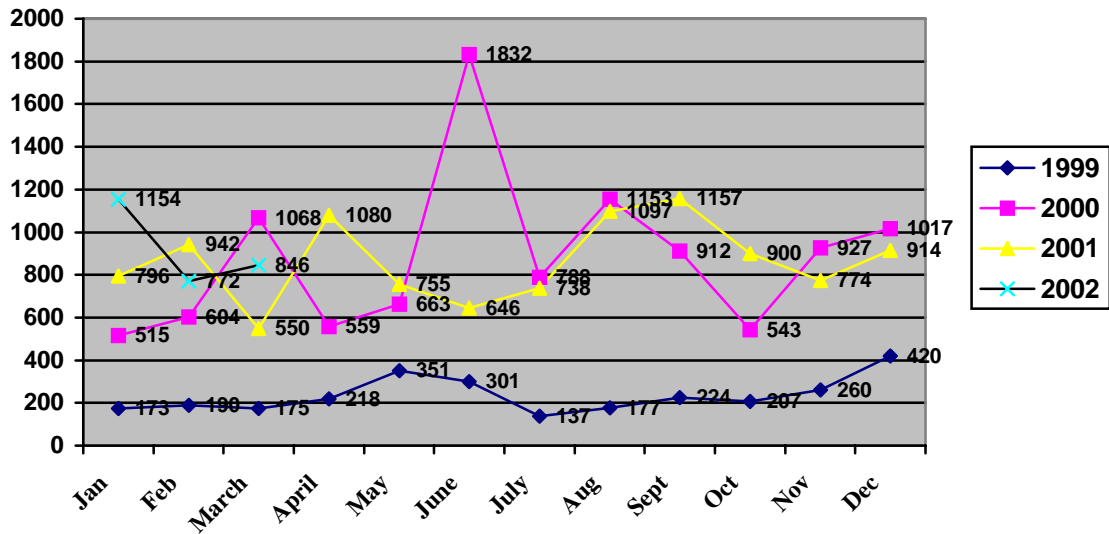
Among the various concerns of the hospital, shortening patient waiting time at the emergency ward was found most tenable. A time and motion study involving a review of emergency room (ER) policies, physical set-up, flowchart, and functions of hospital staff was conducted. As a result, the ER was separated from the OPD and a unidirectional flow of patients was implemented. Treatment flowcharts and time indicators were adopted while manpower was maximized. The outcome was the shortening of patient waiting time from 30 minutes to 5 -10 minutes.

Increasing hospital revenues was also a major concern. To generate higher income, a more efficient system of billing and collection of fee was instituted. The criteria for the availment of social services were reviewed, new policies on patient classification and discharge were adopted, and cost analysis was performed in each hospital cost center. For example, hospital clients were provided with annual ID cards, which classified them according to their ability to pay. Hospitals cost centers were given budget ceilings for operations and excess expenditures were noted. Prescribed drugs were sold at the 24-hour hospital pharmacy.

All these interventions resulted in an increase in hospital revenues from 2.4 million in 1998 to 10.5 million in 2000. Currently, the provincial hospital makes use of a portion of the income to upgrade its facilities and shares its revenues with the other 14 hospitals in the province.

To address low cost efficiency, several interventions were established, such as the development of a formulary. Hospital therapeutic committees were formed to determine the kinds of drugs to be purchased. Procurement of drugs and supplies was centralized (i.e., Provincial Pooled Procurement Program) and a constant monitoring of cost centers to ensure the efficient use of drugs and supplies was observed.

Figure 2. Average Monthly Collection ('000), Pangasinan Provincial Hospital, 1999-2002.



In July 1999, a *Big Bang Day* for the hospital was conducted resulting in better image for the hospital, cleaner hospital environment, and satisfaction and better work ethics among the employees. Other hospital reforms at the provincial hospital involved physical changes in the hospital environment like fencing, expansion of the ICU, renovation of the admitting area, putting a covered walk between admitting area and ER as well as some purchase of equipment and supplies for the laboratory. Patients who could not afford to pay were given the option to help in the beautification and cleaning of the hospital. Preventive and promotive health programs are now also being implemented. Regular customer satisfaction surveys are conducted to gather important feedback regarding policies and its implementation.

Recent discussions centered on plans to corporatize the provincial hospital or to make it a government foundation. There was hesitance on the part of the provincial government for reasons that are legal and political. The province, instead, proposed a 5-year experimental implementation for the corporatization (*fiscal autonomy* is the preferred term) of the hospital. (*If the move is successful, then (it) will be adopted; but if not, it will go back to the usual management system*). As part of the move for fiscal autonomy, a hospital income retention scheme was proposed to the provincial government where 50% of the excess income be reverted back to the hospital. However, this did not push through because of budget cuts in the internal revenue allotment (IRA) of the province. Currently, the province is looking at the way the Negros Oriental HSRA is implementing its hospital income utilization scheme.

There are other issues related to hospital reform in the provincial hospital:

- There is now a resolution that allows hospital doctors to do private practice after office hours.

- • PPH is preparing the wards for indigent patients under the Indigency Program. Pay wards are also being improved.

Currently, district hospitals are being groomed to replicate the success of PPH. The MSH facilitated the technology transfer in Bayambang and Western Pangasinan District Hospitals. PPH staff conducted 5S and QA seminars in the Urdaneta District Hospital.

Hospital reforms at the Bayambang District Hospital are being implemented. The hospital created its Vision-Mission statement where the hospital will become a “center of wellness”. Values formation workshops were conducted to develop committed and motivated health staff. Transparency was an essential component of management. The key informant was quick to add that these two reforms were hospital initiatives.

On the other hand, the MSH provided trainings and assistance to the Bayambang District Hospital with regard to the following:

- • Establishment of 5S and Quality Assurance programs
- • Creation of a hospital therapeutic committee
- • Financial management
- • Information management

After the devolution, the Bayambang District Hospital maintains an informal relationship with the rural health centers. Resources from the district hospital were shared with the RHUs like kelley pads, cord clamps and Betadine. Dental chairs were procured through NGO's and other foundations. In general, there was no resistance from the MHO's regarding the maintenance of the pre-devolution relationship. The resistance came from the Mayors but “it was necessary to play politics with the mayors to win their cooperation”.

At the Western Pangasinan District Hospital in Alaminos, a Quality Assurance Committee (QAC) has already been established. MSH provided trainings on 5 S, problem management and financial management. So far, the QAC was able to accomplish the following: 1) hospital problem identification, prioritization of identified problems and charting of solutions; 2) efficient system in monitoring patients and watchers through provision of IDs; 3) improvement of the system of billing and collection of fees; 4) organization of a Hospital Therapeutics Committee (*although not yet as functional as desired*); and 5) cleaning and beautification of surroundings.

There were observations that the reforms at the Bayambang and Western Pangasinan District Hospitals are “snail-paced” as compared to the developments at the PPH when it was just starting. A key informant from one of the targeted districts claimed that it was because “*what has been done to the provincial hospital in the past is not being done in the district*”, referring to the support given to the PPH by the province and MSH-USAID. (“*There is no regular monitoring from MSH*”).

In the Urdaneta District Hospital (UDH), a seminar on 5 S was conducted in September 2001 by MSH and PPH. Immediately after, 9 committees were organized, namely; 1)

Quality Assurance, 2) Therapeutics, 3) Disaster Control, 4) Grievance and Promotions, 5) Infection Control, 6) Management Staff, 7) Outreach Program, 8) Voluntary Blood Donation, and 9) Waste Management.

The initial achievements at the UDH include:

- • Establishment of hospital cost centers (e.g. OPD services).
- • Collection of hospital fees
- • Converting unpaid hospital bills of indigent patients into services rendered to the hospital, mostly in the cleaning and beautification of the facility

The hospital has improved its income -from P700,000 in 1998 to P1.2 M in 2000. The Urdaneta District Hospital has also:

- • Allowed the practice of private doctors/specialists in the hospital. The MOA was signed between the Chief of Hospital and Private Practitioner/Consultant.
- • Allowed the regular monthly visit of a surgeon from the Regional Hospital to provide surgical services to patients.
- • Improved the image of hospital (e.g. staff attitude, cleanliness and beautification). The Chief of Hospital required all staff to do something for beautification (e.g. planting) at least five minutes before reporting to their official station.
- • Acquired funds from the province for the renovation of some parts of the hospital.
- • Requested the Provincial Government to have their share of the hospital's excess income. They were required by the LGU to submit a proposal/plan indicating the details of fund utilization.
- • PhilHealth Indigency Program is still in the MOA signing stage.

*Progress of Implementation*

The following have been the accomplishments in hospital reforms (as of July 2002).

Table 5. Summary of Accomplishments in Hospital Reforms vis-à-vis Indicators of Improvement, Pangasinan Provincial Hospital, July 2002.

Indicators of Improvement	Accomplishments
Establishment of financial management systems	Training on financial management Establishment of cost centers Improvement of billing and collection Review of patient classification Systematic record-keeping
Income generation	Increase in hospital income from 2.4 M in 1999 to 10 M in 2000
Income retention	Proposal was approved by the governor but still to be implemented

Income utilization	Some income were used to 1) upgrade facilities; 2) purchase drugs 3) as incentives to hospital personnel in the form of monetization of credit leaves; 4) share funds with 14 other hospitals
Fiscal autonomy	Under experimentation
Quality assurance	Training on 5S; improved work attitudes Establishment of a QAC Committee Establishment of QITs in each hospital department Establishment of hospital therapeutic committee Improvement of operational systems Upgrading of facilities Improvement of surroundings Pooled drug procurement Increase in cost-efficiency in all departments
SS/PHIC facility upgrading	PPH is SS and PHIC-accredited; some district hospitals are not PHIC-accredited
Upgrading in hospital classification	PPH already a tertiary level hospital
Technology transfer	Technology transfer in 3 district hospitals
Networking with private sector	Has work agreement with Villaflor Hospital and NGOs like the Church, Rotary Club and Engender Health

### *Gaps and problems*

The major gap in the implementation of hospital reforms in Pangasinan relates to the establishment of full fiscal autonomy for the provincial hospital. While hospital income increased five-folds since 1999, much of the money goes back to the province. Another setback relates to the upgrading of the district hospitals to make them Sentrong Sigla and PhilHealth accredited.

### *Propositions/suggestions*

Implementation of the hospital retention and utilization scheme.

## **Gains in Drug Management Systems**

### *Status of Implementation*

Problems related to limited financial resources, shortages of drugs and supplies in government hospitals, varied prices of drugs purchased by the health and non-health sectors in many LGUs, as well as non-compliance to the Philippine National Drug Formulary (PNDF) prompted the province of Pangasinan to create and implement a Provincial Pooled Procurement Program (PPPP) in 1998. The purpose was to ensure quality and procure drugs systematically at lower costs.

With the help of MSH, the provincial government organized a series of meetings with hospital chiefs, General Services Office (GSO) staff, hospital staff, and suppliers to draft a provincial pooled procurement system. Hospital (HTC) and provincial therapeutics committees (PTC) were organized. The HTC reviews the annual procurement plans of the 14 hospitals and oversees the quality of drugs delivered to these health facilities. The PTC in turn, reviews the drugs requested by the hospitals to be purchased and sees to it that drugs procured are in accordance with the provincial drug formulary (PDF), which is a subset of the national drug formulary (PNDF).

#### *Process of Implementation*

The provincial pooled procurement scheme abides by the following process. The process starts with hospitals preparing their annual procurement plans using VEN and ABC value analysis. The hospital staff makes use of their morbidity/mortality statistics to determine common cases treated in the hospital after which they assess these cases based on standard protocols and clinical practice guidelines. They, then, use the VEN analysis to classify the drugs according to their therapeutic value (vital, essential and non-essential). Vital drugs are given priority in the purchase. The ABC value analysis determines which of the procured drugs have highest costs. Class A products are those that make up 75% to 80% of total costs; Class B represent the middle 10-15% while those in the C category represent about 10%. Since Class A items are expensive, highest priority is given to their management.

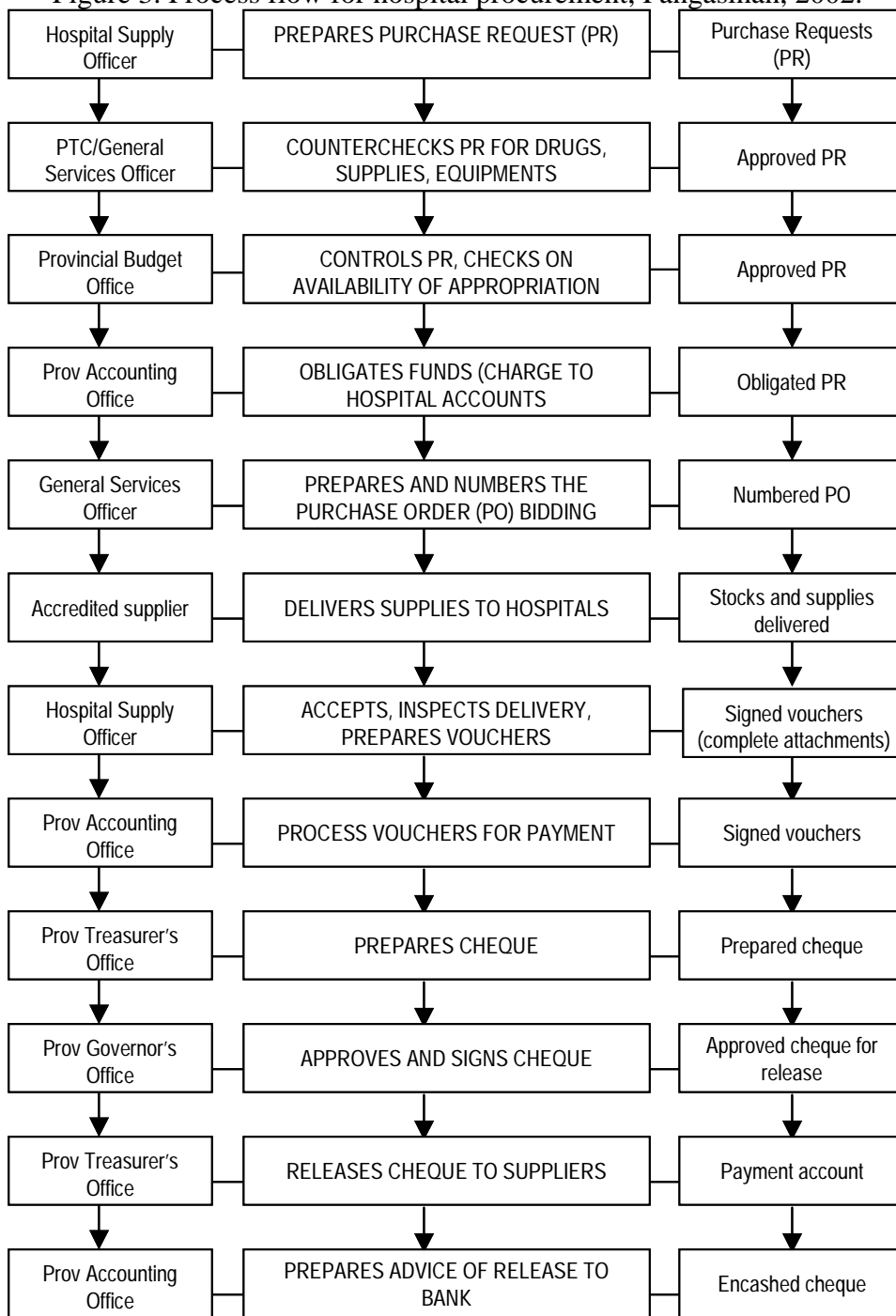
In July of each year, the hospitals then submit their annual procurement plans to PTC and GSO. PTC reviews the plans for compliance with PDF, checks specifications for the bid and forwards the approved plan and specifications to GSO. The GSO consolidates the plans from 14 hospitals, prepares and processes all tender documents and undertakes the bidding process. The Provincial Pre-qualification, Bids and Awards Committee (PBAC) select the winning bids based on price, lead time, product quality, and past supplier performance. The entire bidding process is completed by the end of the year. Then the GSO notifies hospitals about the winning bidder/s.

In the last Mondays of every quarter, purchase requests from each hospital are submitted to the GSO coordinator where this office prepares purchase order (PO). Purchase requests are based on the hospital procurement plan, inventory management spreadsheets and availability of funds as evidenced by a bank statement or deposit slips. The LGUs provide the funds for medical supplies (General Fund), which in many cases are dependent on the timely release of the LGU's IRA; funds for the purchase of drugs come from the Trust Fund (financed by the sale of drugs in each hospital). The hospital supply officer, therefore, prepares two sets of purchase requests: one that is charged to the General Fund, and the other, to the Trust Fund. The quantity requested for a particular product follows a formula where the maximum stock level (MSL), stock on hand and stock on order is taken into consideration.

The GSO consolidates all purchase requests from the 14 hospitals. Each winning supplier will receive a number of POs depending on the Purchase Request (PRs) of the 14 hospitals. The GSO issues the POs to the suppliers selected by the PBAC, and to the

second supplier if the first supplier is unable to deliver. Signed by the Governor, the POs are ready for pick up by the supplier 5 working days after the PRs are received by the GSO.

Figure 3. Process flow for hospital procurement, Pangasinan, 2002.



The supplier then picks up POs within 5 working days. The suppliers are given up to 7 days to deliver the goods to the hospital. The supply officer and hospital auditor inspects the medical supplies while the pharmacist and the hospital auditor inspects the delivered drugs. The Supply Officer prepares the Receiving and Inspection Report and submits a copy to the GSO within 24 hours from receipt of deliveries. The Supply Officer also submits the voucher, signed by the hospital chief, accountant and auditor, to the GSO within 48 hours. Papers are forwarded to finance section. If the products are unacceptable, the end user (pharmacist or medical technologist) submits a completed Product Problem Report Form to the HTC and GSO. The HTC documents and researches the complaint and informs the GSO of the batch number (Figure 4)

The LGU pays the suppliers on a quarterly basis after having the documents pass through relevant departments in the LGU.

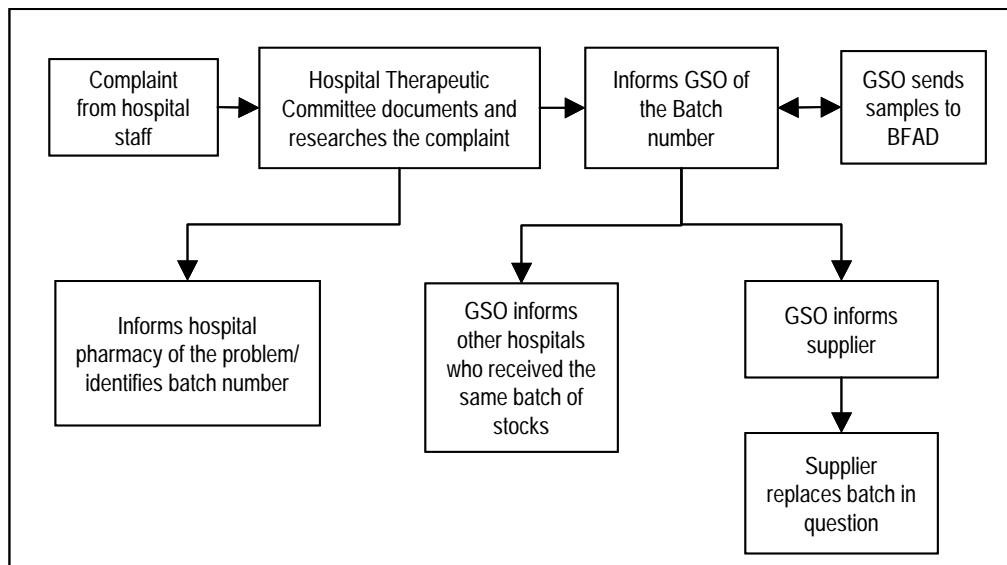


Fig 4. Action Steps for Suspected Quality Problems, Pangasinan, 2002.

With the pooled procurement program in the 14 hospitals, drugs were bought at much reduced prices, about 46.5% on the average lower in 2001 compared with 2002 prices. It was noted that drug suppliers have dropped their prices in order to compete with the parallel drug importation.

Quality drugs were assured because only bids of suppliers accredited by DOH were entertained. Hospital staff learned to prioritize their drugs into vital, essential and non-essential. There was proper procurement of drugs by the GSO using a new set of drug supply contract and bidding documents as well as the avoidance of the more expensive emergency purchase of medicines and supplies. Hospitals learned to make use of a common inventory control system, which aids in what drugs to order, when to purchase the same and how many of the said drug should be ordered.

Table 6. Comparison of Drug Prices, Pangasinan, 1999 - 2002.

Name of Drug	1999	2000	2001	2002	2001-2002 %decrease in drug price
Salbutamol nebulas 2mg/ml	P36.00	20.00	25.00	16.62	50%
Ampicillin 500mg mg vial	35.00	14.00	14.40	10.60	36%
Chloramphenicol 1 gm vial	80.00	23.93	21.90	13.75	59%
Ampicillin 1 gm vial	109.00	65.00	30.00	14.50	107%
Paracetamol 30 mg amp	32.00	18.05	23.00	16.50	39%
Oxytocin 10 U amp	78.00	25.20	23.75	18.00	32%
Gentamacin sulfate 80 mg amp	89.00	14.20	12.50	9.50	32%
Hyoscine N-butyl bromide 20 mg amp	47.00	30.00	20.00	13.75	45%
Methylergometrine maleate 200 mg amp	60.00	14.10	22.00	16.50	33%
ATS 1500U	55.00	50.00	117.50	110.00	7%
Nalbuphine 10 mg	79.80	85.00	91.20	60.00	52%
Cefuroxime 750 mg	360.00	128.35	157.00	70.00	124%
Mefenamic acid 500 mg cap	500.00	166.66	124.50	92.00	35%
Cotrimoxazole 400 mg/80 mg cap	634.00	69.00	117.00	92.00	27%
Amoxicillin 500 mg cap	850.00	179.49	222.00	187.00	19%

As expressed by the GSO, there were still delays in the delivery of drugs by the supplier despite the installation of a systematized procurement system. In many cases, the winning supplier/s did not have immediate stocks. Delays were also caused by the inability of the hospitals to submit their requests on time. While the procurement system was considered “ideal”, district hospitals claimed that (a) requested drugs and medical supplies are not delivered in full, (b) some drugs have doubtful quality (although still subject to testing, the results of which takes time), and (c) procurement is based on lowest bids, not on the quality of drugs.

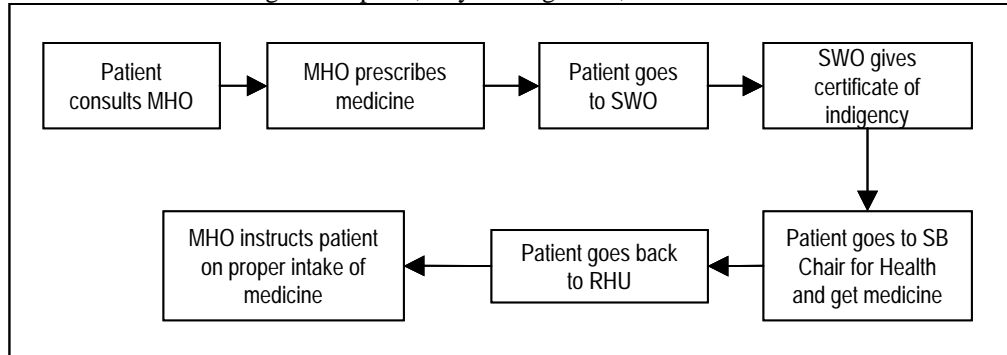
The Provincial Health Office has thought of ordering their drugs via the parallel drug importation scheme (PDI). A trial purchase was made in the early part of 2002 but delivery took a longer time (*“we ordered in January; the drugs came in June”*).

The province has not mainstreamed the LGUs for pooled procurement (*“Drug is the biggest policy of LGUs”*). The Governor did not purposely convince the Mayors to join the provincial pooled procurement because of political reasons. Mayors have their own suppliers of drugs. Drug procurement has been done every quarter at the municipal level. RHUs rely on BFAD accreditation of supplier as their basis for assuring the quality of drugs.

There is a common practice in many LGUs where RHU patients get their drugs from the Municipal Hall rather than from the RHU. In Bayambang, for example, the MHO prescribes the drugs to the patients, then the patient goes to the Social Welfare Office to

get an approval of indigency, then proceeds to the Office of the Sangguniang Bayan – Chair on Health Committee where the drugs are dispensed. To assure safety and regulate the validity of drug dispensing, the patient is asked to go back to the RHU for further instructions on the intake of medicine. The risks involved in this practice are 1) when the patient does not go back to the RHU for final MHO approval and 2) when the wrong, inappropriate drug is given to the patient. The PHO is trying to suggest a win-win strategy, proposing that all vitamins will be taken cared of by Mayors while drugs and medicines will be handled by MHOs.

Figure 5. Process Flow of Drug Prescription, Bayambang RHU, 2002.



### Progress of Implementation

The following were the accomplishments in drug management as of July 2002.

Table 7. Summary of Accomplishments in Drug Management vis-à-vis Indicators of Improvement, Pangasinan, July 2002.

Indicators of Improvement	Accomplishments
Functioning therapeutics committees	With functional 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 46.5% in 2002 compared to 2001 prices
Assurance of drug quality	Training in drug utilization review Drugs purchased according to PDF Pharmacists assure quality of drugs Conducts testing of drugs
Timely delivery of drugs	Still problematic
Purchase from accredited suppliers	Procures from DOH accredited suppliers; procures some drugs from PDI
Provincial drug formulary	Existing PDF; based on PNDF
Inclusion of municipal LGUs in pooled drug procurement	0% but there is continuing advocacy

### *Gaps and problems*

- • problems related to quality of some drugs
- • delay and non-full delivery of drugs to the hospitals
- • inclusion of municipal LGUs in the provincial drug procurement

### *Propositions/suggestions*

- • More intensive training on quality control of drugs
- • More intensive advocacy of pooled drug procurement to municipal LGUs
- • More stringent criteria in the selection of bidders to include adequacy of stocks
- • Thorough study of benefits derived from PDI

## **Gains in Local Health Systems**

### *Status of Implementation*

In Pangasinan, the old district health system is being maintained despite devolution. Relationships between the district office and member LGUs are present though informal with no MOA to cement these partnerships. The six district health systems are sustained mainly through funds from the provincial government.

The Bayambang Health District (BHD) is the pilot area for the Interlocal Health Zone. The Bayambang District Health District includes the following LGUs: Bayambang, Basista, Alcala, Malasiqui, Sto Tomas and Bautista. It was chosen because it was able to maintain informal relationships with its catchment municipalities. A MOA has already been drafted but is still under study by the provincial government.

Another consultative meeting with LGUs and health workers will be conducted on July 2002 to discuss the ILHZ framework for Pangasinan.

### *Process of Implementation*

Meetings with MHOs and Mayors were done regularly at the Bayambang Health District (BHD). The District Hospital has continued to share with the RHUs whatever resources it gets from external donors (e.g. PCSO). The LGUs and the district hospital have been complementing each other in terms of manpower resources, medicines and supplies. RHUs refer their patients to the District Hospital.

Local executives in the district have already discussed the possibility of forming an ILHZ. A MOA has already been drafted and is still under study by the provincial government. There is a plan to organize a District Health Board with the District Hospital Chief as Chair and Mayors, MHOs and an NGO as members. The political dynamics of having two congressmen within the health district was perceived both as a positive and negative factor for the ILHZ governance.

The RHUs within the district are *Senrong Sigla* accredited, but there is still a need to upgrade their facilities. At the Bayambang RHU, the laboratory is being improved to get

PhilHealth accreditation. RHU 1 sought assistance from the PCSO for facility upgrading. However, they have difficulty recruiting a medical technologist because they could only promise P7,000 a month as remuneration for the medical technologist.

Aside from Sto Tomas, a 4<sup>th</sup> class municipality who has enrolled its constituents in PhilHealth way back in 2000, the Mayor of Bayambang was among those who planned to enroll 1000 families in the PhilHealth Indigency Program with supporting Sangguniang Bayan resolution. An NGO was willing to cover the premium for 1,000 indigent families years before but PhilHealth did not agree because of the absence of guidelines.

Indigents at the Bayambang LGU were identified through the Office of the Municipal Social Welfare. The Mayor created a committee composed of the MHOs, social welfare workers and Barangay Chairmen to do the selection of indigents. A Minimum Basic Needs survey was conducted to identify indigent families based on DSWD criteria, then the list was submitted by the Social Welfare Officer to the Office of the Mayor and PhilHealth.

The criteria for selecting indigents are based on socio-economic indices, such as, household income (ultra poor – P5,000 and below monthly family income for a minimum of 6 children; poor – P5,000 to P6,000/ monthly income); families with irregular income; and type and physical structure of the house (temporary, small, and the like).

Based on PhilHealth policy, 20% to 25% of the population represents the target coverage for the Indigency Program. However, the LGU cannot afford to cover the premium of about 10,000 indigent families. Instead, the LGU opted to enroll 10 percent of its indigent population (or 1,000 families). So far, about 773 indigent families in Bayambang were identified and additional families are being recruited to complete the target of 1,000 indigent beneficiaries.

The factors that facilitated LGU involvement in social health insurance were:

- • Health was a political promise of the Mayor in the last elections
- • Governor's support to LGUs for the Indigency Program
- • Sangguniang Bayan resolution to support the social health insurance implementation
- • Three barangays allocated budget from their IRA for the social health insurance premium of their constituents
- • It was a way of minimizing the burden of LGU in assisting indigents for their hospitalization
- • Incentives related to capitation. If the RHUs will be PhilHealth accredited, they will receive P600,000 capitation fund from PhilHealth out of their P1,200,000 premiums/investment.

Among the HSRA reforms, the ILHZ was the least developed in Pangasinan. The key informants felt that the Negros Occidental model was quite difficult to adopt in Pangasinan. Unlike Negros Occidental, Pangasinan does not have the financial resources

from the DOH Regional Field Office, equivalent of their premium from the LPP Base Grant and a counterpart from the Provincial Government. The availability of these funds enticed municipal LGUs in Negros Occidental to invest for their own interlocal health system.

Resistance on the part of the Pangasinan local executives was partly financial and partly political. Mayors were perceived to have other priorities. They have their own turf and seemed more interested in developing a health facility that they could call their own “legacy to the people” (e.g., building a community hospital or buying their own drugs and supplies). For political reasons, even the Governor does not want to impose on the mayors the idea of cost sharing. Instead, the Governor would like to strengthen integrated planning, referral systems as well as information systems.

*Progress of Implementation*

The following were the accomplishments with regard to the establishment of inter-local Health Zones in Pangasinan (as of July 2002).

Table 8. Summary of Accomplishments in Inter-Local Health Zones vis-à-vis Indicators of Improvement, Pangasinan, July 2002.

Indicators of Improvement	Accomplishments
Number of ILHZs established vs. targets	Identified 1 out of 6 potential ILHZs; Bayambang District Office not yet fully functional
With signing of MOA	No MOA signing yet
With District Health Board	Still in the planning
Sharing of non-monetary resources	Sharing of supplies, drugs and manpower among LGUs in the Bayambang district; other district offices (e.g. Western Pangasinan District Office) claimed to have the same arrangement
Functional referral system	Functional with some feedback mechanisms
Networking (NGOs, private sector, inter gov't agency)	NGO in the planned District Board; assistance from PCSO
Cost sharing	0%
Common fund	0%

*Gaps and problems*

The establishment of an ILHZ is perhaps the biggest gap in the implementation of HSRA in Pangasinan. Only one ILHZ has been identified yet it has not started functioning as desired. The biggest stumbling block relates to the type of ILHZ to be established in the

province. The ongoing deliberations have delayed the signing of the MOA. As expressed by the governor, integrated health zone planning will be the main core of the collaboration. The implementation of a cost-sharing scheme among member LGUs may have to remain in the background.

### *Suggestions*

- • Develop a more relevant ILHZ framework for Pangasinan.

### **Best Practices**

Pangasinan's strengths are its hospital reforms, specifically in terms of quality assurance and revenue generation. Another strength is its pooled drug procurement program for government hospitals, which resulted in significant cost savings for the province.

The discretion and prudence being shown by the provincial government in instituting the health reforms was well noted. While it might have delayed the implementation of some of the HSRA Convergence components, the circumspecting attitudes of the provincial officials provided some assurance that the health initiatives are sustainable and culture-sensitive.

To pursue health reforms in Pangasinan, the following are in the pipeline:

- • A consultative meeting with LGUs and health workers in July 2002 to discuss the ILHZ framework for Pangasinan.
- • A meeting with 28 LGUs in August 2002 to discuss participation in the PhilHealth Indigency Program.

### **Lessons learned**

Several lessons can be learned from the experience of Pangasinan in health sector reform.

One, there should be a prime mover who could motivate people, initiate the activities and sustain the momentum for reforms. In the case of Pangasinan, the prime mover is the Governor.

Two, despite having a prime mover, the role of an external body like MSH cannot be at all ignored. MSH has provided substance and direction to HSRA.

Three, the motivations and the political will of the local governments to implement health sector reform is very crucial. Mayors and the local council are the final decision-makers for any reform that is implemented in their locality.

Four, competent and committed technical people and dedicated, reform-oriented program managers are needed for the successful implementation of reforms. In Pangasinan, the provincial HSRA advocates served as a major push factor for the reforms to trickle to the grassroots.

Five, for reforms to succeed, the approach should be consultative and participatory. The local culture as well as the sentiments of the local people should be considered. The provincial government and PhilHealth showed sensitivity in dealing with the mayors and local health workers (e.g., drug procurement, social health insurance). At the same time, MSH was very careful not to impose any intervention that the locals may not consider suitable to their conditions (e.g., corporatization, ILHZ)

Six, patience and a well-thought out strategy can bring about a more positive impact in the long term. The Governor was restrained and deliberate in his ways. He made sure that health reforms can be sustained.

### **Conclusion**

Great strides have been attained to improve the health system in Pangasinan. The implementation of the HSRA has brought about quality and cost-efficiency in the provision of health services at the provincial hospital. While the HSRA Convergence emphasized the integrated character of the 5 HSRA components, much has still to be done to make the blueprint work in Pangasinan.

## **Appendix 1. List of Key Informants, Pangasinan.**

1. Chief Nurse (San Carlos Provincial Hospital)
2. Chief of Bayambang District Hospital
3. Chief of Urdaneta District Hospital
4. Head of GSO
5. Indigent patients (San Carlos Provincial Hospital)
6. Management financial analyst (San Carlos Provincial Hospital)
7. Mayor, Bayambang
8. Medical Social Worker (San Carlos Provincial Hospital)
9. MHOs, Bayambang RHU I and II
10. MSWD, Bayambang
11. PhilHealth Region I manager
12. Provincial Health Officer
13. Provincial Planning Officer
14. Sanggunian for Health Bayambang
15. Supply officer (San Carlos Provincial Hospital)

## References

"Pangasinan Health Sector Reform Convergence Workshop Output." Management Sciences for Health, 2001.

"Site Plan for the Province of Pangasinan (Update of the HSRA Convergence Workplan January-June 2002)." Management Sciences for Health, 2001.

*Livebirths, Total Deaths, Infant Deaths and Maternal Deaths*, Province of Pangasinan, 2001.

*Facts and Figures*, CY 2000 Pangasinan.

"Comparative Results Hospital Income January 1999-March 2002." Slide presentation.

"Philippine Health Insurance Corporation Indigent Program Unit Medicare Para sa Masa. Total Members per Municipality per Effectivity Dates."

"Pooled Pharmaceutical Procurement in Pangasinan." Technical Notes 2, 2001.