

CHAPTER 7

IMPLEMENTATION ARRANGEMENT FOR KALUSUGAN PANGKALAHATAN

To address the call of universal health care (UHC) or *Kalusugan Pangkalahatan (KP)*, the government is organizing and maximizing all possible resources, and coordinating with partners to respond to this call. Partner institutions include those that have the machinery to reach most of the target population.

The Department of Health (DOH) shall spearhead the implementation of KP in several phases from 2011 to 2016 with the support of the Local Government Units (LGUs), other national agencies, development partners, civil society organizations, non-government organizations and other stakeholders.

Individuals and families who are beneficiaries of KP are encouraged to assert their rights and entitlements for quality health care services and facilities and cooperate in the implementation of health programs, projects and activities.

The investment of the government for the health sector shall be complemented by development partners. It is expected that development partners shall align and harmonize their support to the thrusts and directions of KP. Development partners can fill health investment gaps and assist the DOH and LGUs in capacity building, policy and research development and systems strengthening.

Coordination mechanisms shall be put in place to ensure that health partners and stakeholders are well consulted and properly informed on policy directions as well as in program and project development and implementation towards the attainment of KP.

7.1. KP PERFORMANCE TARGET

The National Objective for Health performance target from 2011 to 2016 is reflected in **Table 35**

TABLE 35. KP KEY PERFORMANCE TARGETS

	2011	2012	2013	2014	2015	2016
CHTs deployed, RNheals/ others deployed to achieve the MDGs	CHT and RN Heals as part of the SDN developed	50,000 12,000	100,000 22,500	100,000 22,500	100,000 22,500	100,000 22,500
Facilities upgraded to provide quality health services	Validation of health facility upgrading investment plans	1,377 RHUs 69 District Hospitals 72 Provincial and City Hospitals 8 DOH Hospitals	471 RHUs 243 District Hospital 55 Provincial and City Hospital 22 DOH Hospital	190 District Hospitals 6 City Hospitals 33 DOH Hospitals *Incentives to sustain delivery of quality care introduced	6 DOH Hospitals	Enhanced provision of health services in health facilities through improvement of processes and systems within the health facilities
Families covered by PhilHealth	All NHTS-PR are enrolled and eligible to the NHIP.	All NHTS-PR and informal sector are enrolled *catastrophic care package introduced	Universal Coverage *Catastrophic care package fully implemented	Universal Coverage	Universal Coverage	Universal Coverage

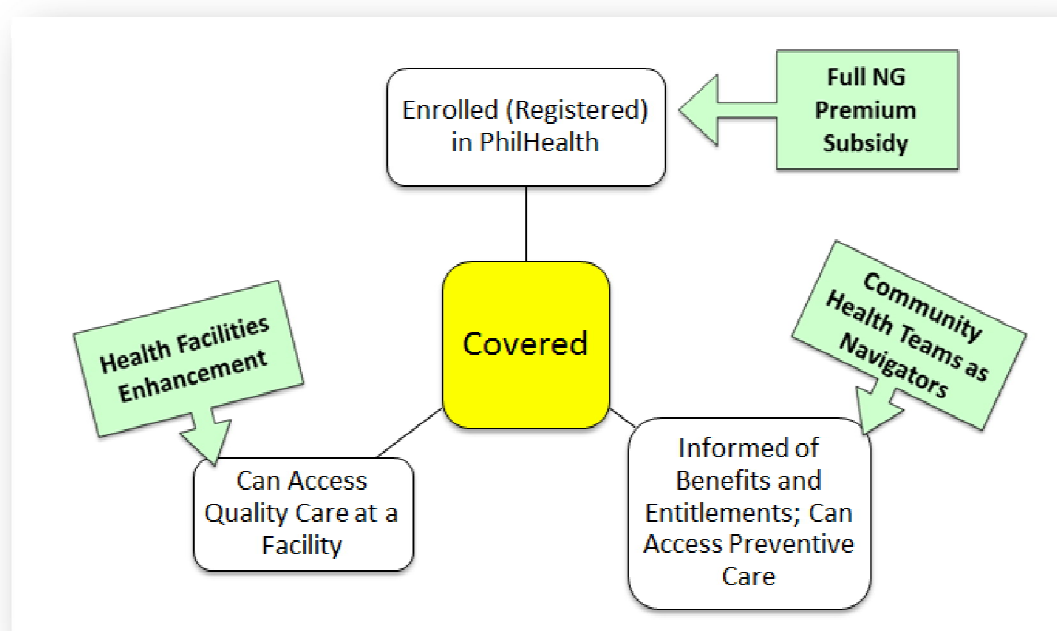
To improve financial risk protection, DOH will increase NHIP coverage by sustaining the enrolment of at least 5.3 M NHTS-PR poor households, with intention to expand to all 10.9 million NHTS-PR households. It will also improve benefits by implementing a no balance billing policy (i.e. no out of pocket charges) for members of the NHIP Sponsored Program. Twenty-three of the most common conditions for confinement are being considered under the scheme for PhilHealth Sponsored Program members admitted in government hospitals.

To improve access to modern health facilities, DOH will upgrade a total of 2,552 government health facilities nationwide in order to close the upgrading gap by 2016. The upgrading will make these facilities compliant with DOH and PhilHealth standards by ensuring that RHUs meet accreditation, district, provincial and city hospitals fulfill the licensing and accreditation standards and for DOH facilities to become modern medical

centers. The upgraded facilities will also be monitored for quality improvements and assisted to attain long term financial sustainability.

Lastly, KP will implement focused public health services in order to prevent families, especially the poor, from falling ill or injured. In order to do this, DOH will assist LGUs in deploying 100,000 Community Health Teams (CHT) and 22,500 RNheals to: engage families and provide information; assist in health risk assessment and health use plan development; and facilitate use of services and provide basic services (see **Figure 49**).

FIGURE 49. KP INTERVENTIONS TO ADDRESS CHALLENGES TO UNIVERSAL HEALTH CARE



It can be expected that by 2016, there is universal PhilHealth coverage, improved access to modern health facilities and quality services and MDG targets are achieved. These can be expected to improve financial risk protection, improve access to quality health services, reduce costs, and more importantly, save the lives of thousands of mothers and children and increase the productivity of future generations of Filipinos.

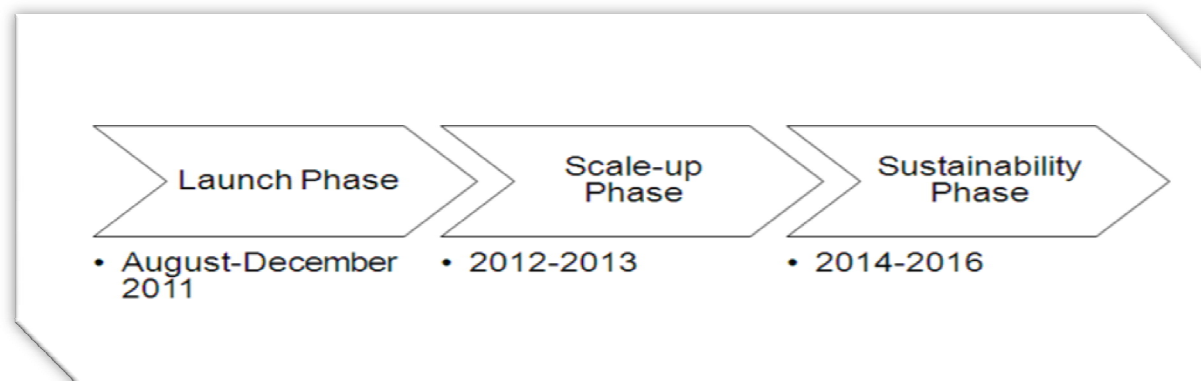
In particular, poor Filipino families will be aware that they are protected from vulnerabilities since they are:

1. enrolled in the NHIP;
2. assigned to a CHT;
3. linked to designated health facilities and providers that are KP compliant;
4. not charged for use of health services; and
5. provided with free public health services (e.g. vaccinations, TB DOTS, family planning).

7.2. PHASING OF KP IMPLEMENTATION

The implementation of KP shall be undertaken in three phases namely Launch Phase, Scale-up Phase, and Sustainability Phase as shown in **Figure 50**.

FIGURE 50. KP IMPLEMENTATION ROAD MAP



7.2.1. PREPARATORY AND LAUNCH PHASE (JANUARY TO DECEMBER 2011)

The Preparatory and Launch phase shall take place from January to December 2011 and it is expected that by the end of December 2011, at least the 2.3 million beneficiary families of the DSWD's Pantawid Pamilyang Pilipino Program (4Ps) are enrolled to the NHIP, provided information and guidance on NHIP benefit availment, and assigned and navigated to the public health and outpatient (OP) services that provide quality services with adequate supply of public health commodities and drugs. The 4Ps beneficiaries shall have access to inpatient services provided by upgraded hospitals with adequate supply of drugs and supplies.

7.2.1.1. The Interventions to be implemented for the KP thrust on financial risk protection:

1. Enrol 4.89 million of the poorest NHTS-PR households, including those who are beneficiaries of the 4Ps, into the NHIP sponsored program;
2. Train 10,000 RNheals nurses as trainers and supervisors to capacitate existing community-level workers (e.g. BHWs, BNS, *Barangay* officials) with community health team (CHT) functions;
3. Secure drugs, medicines, and supplies for DOH-retained hospitals serving NHTS-PR families (including 4Ps beneficiaries) for implementation of the "no balance billing" policy;
4. Consolidate inputs supporting local implementation of KP into one instrument and negotiation process by which to leverage better health performance from Provinces and Independent Cities through a system of Province- or City-wide agreement for KP
5. Amend the National Health Insurance Act (RA 7875, as amended) Implementing Rules and Regulations to define a new sponsored program that provides for a population based national local premium counterpart scheme that maximizes enrolment of poor families by earmarking national

subsidies for the NHTS-PR households with LGUs subsidizing both NHTS-poor households and LGU-identified poor;

6. Establish an NHIP membership services program that shall include, among, others, the provision of critical NHIP information to families such as their benefits and entitlements, their assigned primary providers, and the network of hospitals that can provide them inpatient services;
7. Implement a new NHIP Outpatient Benefit Package with No Balance Billing (OPB-NBB), based on a review of the implementation of PhilHealth Circular No. 40, s, 2000;
8. Implement a new NHIP Inpatient Benefit Package with No Balance Billing (IP-NBB) that draws from the experience of DOH and PhilHealth in NBB implementation;

7.2.1.2. The interventions for the KP thrust on health facilities enhancement shall include the following:

1. Upgrade 20 percent of DOH-retained hospitals, 46 percent of provincial hospitals, 46 percent of district hospitals, and 51 percent of RHUs to ensure that the poorest 5.2M NHTS-PR families shall have access to better quality inpatient and outpatient care;
2. Procure and distribute treatment packs for hypertension and diabetes to the RHUs for the use of 4Ps beneficiaries;
3. Develop a clear framework, objective criteria and transparent process in determining the necessity for providing assistance - a menu of options for the delivery of HFEP assistance, including mechanisms such as grants, central procurement, budget subsidy, etc.; and
4. Synchronize the procurement and logistics cycle with NG and LG procurement systems

7.2.1.3. The Intervention for the KP thrust on attaining health-related MDGs includes the following:

1. Procure and distribute public health commodities to RHUs serving 4Ps beneficiaries for the attainment of health-related MDGs; and
2. Develop budget execution plans for each CHD, including operational plans for implementing the MDG breakthrough strategy in the 12 priority areas.

7.2.2. SCALE-UP PHASE 2012-2013

The Scale-up phase shall take place from January 2012 up to December 2013 with the following interventions.

7.2.2.1. The Interventions to be implemented for the KP thrust on financial risk protection are as follows:

1. Roll-out a new sponsored program with full national government premium subsidy to 5.2 million poorest families listed in the NHTS-PR at PhP 2,400.00 per family.
2. Ensure membership services to NHIP members; and
3. Introduce the new OPB and IP packages with No Balance Billing, including catastrophic care coverage by 2013.

7.2.2.2. The intervention to be implemented for the KP thrust on Health Facility Enhancement shall focus on the closure of the upgrading gap for local health facilities and DOH-retained hospitals so that the 10.8 million poor households in the NHTS-PR shall have access to improved quality of health services. The health facilities for upgrading in 2012 are listed below.

1. 25 DOH-retained modern medical centers financed through public private partnerships;
2. 27 provincial hospitals;
3. 118 district hospitals; and
4. 973 RHUs accredited to at least provide the new OPB package.

7.2.2.3. The MDG related interventions to be implemented for the KP thrust include the following:

1. Implement the MDG breakthrough strategy by focusing resources and efforts in the 12 areas with the highest concentration of NHTS poor, women with unmet need for family planning, mothers giving birth outside facilities, children not fully immunized, children not given Vitamin A supplementation, and adults who are TB smear positive; and
2. Mobilize at least 100,000 Community Health Teams (CHTs) to be trained and supervised by 21,070 RNheals nurses.

7.2.3. SUSTAINABILITY PHASE (2014-2016)

The sustainability phase shall take place from January 2014 to December 2016; the execution of KP budgets shall be done in the context of an expenditure framework that sets milestones for KP implementation, which include the interventions below.

- 7.2.3.1. The Interventions to be implemented for the KP thrust on financial risk protection:
1. Sustain coverage of at least 10.8M NHTS-PR families in the NHIP; and
 2. Continue enhancement of the OPB and IP packages with no balance billing.
- 7.2.3.2. The intervention to be implemented for the KP thrust on Health facility Enhancement shall focus on the sustained provision of quality care at DOH-retained and local health facilities upgraded through HFEP.
- 7.2.3.3. The MDG related interventions to be implemented for the KP thrust shall cover the following:
1. Deploy CHTs and RNheals to serve at least the 10.8 M NHTS-PR families; and
 2. Attain health-related MDGs by 2015.

The DOH shall oversee and guide the implementation of the KP implemented via total market approach with the local government as stewards of health in the provinces and cities. The total market approach shall ensure that all partners in the local market shall be mobilized from both the public and private sector. The development partners shall provide technical assistance and continue to support the implementation of the KP.

7.3. COST OF KP IMPLEMENTATION

The implementation of the KP shall require an estimated cost of *PhP*512.19B from all funding sources (DOH, LGU, PHIC, PCSO, development partners and private investments via PPP). The budget shall include a total of P111.66B for preventive and promotive programs and services, P92.6B for health facility upgrading, P263.42B for reducing financial risks of health care use (includes PhilHealth premiums and hospital operations). Additional P44.51B will be required to support policy, regulatory and sectoral management.

TABLE 36. TOTAL KP REQUIREMENTS IN *PHP* BILLION (2013-2016)

KP Thrust	Cost items	2013	2014	2015	2016	TOTAL
Attaining MDGs	Preventive and promotive programs and services	26.33	27.36	28.43	29.54	111.66
Financial risk protection	NHIP premium for primary and hospital care including catastrophic care	12.63	12.63	12.63	12.63	50.51
	Hospital operations	50.21	52.17	54.20	56.32	212.91
Health facilities enhancement	Construction and rehabilitation of health facilities	19.42	63.80	5	5	92.60
Policy support, regulatory and sectoral management	Regulatory unit operations	10.50	10.91	11.33	11.77	44.51
Total		119.09	166.25	111.59	115.26	512.19

7.4. STEWARDS AND PARTNERS FOR THE KP IMPLEMENTATION

7.4.1. THE DEPARTMENT OF HEALTH

The DOH is the steward of the whole health sector. The DOH primary role is to lead the country towards the attainment of the universal health goals. In order to ensure that the LGU goals are aligned with the national goals for health, the DOH and its attached agencies shall guide the implementation of *Kalusugan Pangkalahatan* in the provinces and cities. This is achieved by providing the LGUs with technical assistance, developing guidelines and policies.

The DOH has restructured itself to respond to the implementation of KP and achievement of the KP goals. The Center for Health Development (CHD) is responsible for meeting the KP performance targets in their respective provinces and cities and shall provide technical assistance to provinces and cities as they implement the three KP thrusts. The CHD shall manage the resources and leverage resources with the LGU for performance with respect to the KP implementation. The CHD shall sustain current efforts in the delivery of priority public health services throughout the region while applying increased effort in selected provinces/cities under the MDG breakthrough strategy and monitor the performance of provinces and cities in the region with respect to KP implementation. The CHD and the DOH ARMM are the stewards at the regional level. They shall be the key partners in working with the LGUs and other partners at the local level for the improvement of health outcomes.

The national public health programs should sufficiently complement the expansion of the national health insurance coverage in order to improve health outcomes, increase financial protection from costs of care and enhance responsiveness of the health care system. The Technical Clusters based at the Central Office shall provide technical support to KP implementation. They shall consolidate the national level performance regarding KP targets on NHIP, Health facilities enhancement and MDGs. These clusters shall consolidate overall resource requirements to implement KP from all sources, including the General Appropriations Act (GAA), NHIP, and Foreign Assistance Projects (FAPs) and ensure that the technical assistance capacities, packages, and tools are available to support the requirements in the implementation of KP. They shall develop measures and a collection, validation, and reporting scheme for monitoring the performance of KP implementation and shall also determine national level targets with area, regional and provincial breakdowns for KP implementation.

Resource mobilization for the KP implementation shall be conducted by the DOH. These shall include consolidation of the annual budget execution plans; performing timely and regular monitoring of budget expenditures through the Expenditure Tracking System (ETS); and facilitating the timely release of funds and delivery of commodities to CHDs. Guidelines shall be developed for the engagement and deployment of

doctors to the barrios (DTTBs), RNheals nurses, midwives and other personnel in support of KP implementation.

The CHDs shall be assisted in the operationalization of the new HFEP and a new approach to province-wide agreements for KP performance and implementation. A new method in validating service delivery outcome measures shall be developed including, among others, modern family planning (MFP) use, facility based deliveries, TB case detection and cure and developing a sustainable approach to secure access to essential lifesaving medicines for NHTS-PR families.

7.4.2. LOCAL GOVERNMENT UNITS (LGUs)

The LGUs are the local market stewards and shall ensure total market approach and mobilization of all partners for improved health outcomes. The LGUs shall formulate and implement the Province-wide Investment Plan for Health (PIPH) in the provinces and City-wide Investment Plan for health (CIPH) in the cities. The PIPH and CIPH shall help the provinces, cities, and municipalities to work as one unified health system and facilitate the achievement of the health goals and serve as the vehicle for implementing health reforms at the provincial and city level. In the next six years, the DOH will focus on improving the quality of the local health information systems in the LGUs and on institutionalizing the system. This includes the refinement of the LGU scorecard and its data collection and feedback system. Furthermore, analysis of certain weak and strong provincial areas will be made in order to provide better and more equitable services.

7.4.3. NATIONAL GOVERNMENT AGENCIES (NGAs)

The national agencies with the mandate to reduce poverty and serving the poorest of the poor of this administration shall be important partners in improving health outcomes. The national agencies with their own competencies and resources can contribute in the implementation of health sector reforms in the provinces and cities. The health stewards, the DOH and the LGUs, shall collaborate with the national agencies that will facilitate the achievement of the goals of KP.

Partnership with the Department of Social Welfare and Development (DSWD) shall primarily be done in reaching the poor families. The DOH coordinates with the DSWD through the CCT 4Ps program in reaching the poorest and marginalized sector that have the most needs. Providing the quality services and reducing financial risk protection shall be in coordination with the DSWD, in determining the poor through the NHTS. The intervention of deploying Doctors to the *Barrio*, RNheals, midwives and the CHT shall ensure that the CCT families will have an assigned health worker that will ensure proper health information and service provision.

Partnership with the Department of Education (DepEd) shall primarily be for ensuring the good health and nutrition of school children. Good health and effective education goes hand in hand in health and

development. School health programs are ideal vehicles to link the health, education and sanitation sectors in order to achieve better results in poverty reduction, development and good health. The coordination with DepEd shall be on the integration of simple evidence-based measures into the daily school routine to improve health in the school such as hand washing, tooth brushing and deworming which are components of the DepEd Essential Health Care Package.

Partnership with the Department of Interior and Local Government (DILG) shall include coordination with local government units to ensure total market mobilization for health at the LGU levels in the implementation of the three thrusts of the KP.

Partnership with the Department of Labor and Employment (DOLE) shall help in ensuring health in the workplaces, in the families of the employed and in the community where the worksite is provided, and that with quality care contributes to the KP goals.

Partnership with the National Economic and Development Authority (NEDA) and Department of Finance (DOF) shall facilitate the mobilization of development partners and other resources in support to the KP implementation.

Partnership with the Department of Budget and Management (DBM) shall result in resource mobilization in support to KP implementation and in the effective and efficient execution of the GAA.

7.4.4. DEVELOPMENT PARTNERS

The Development Partners (DP) shall provide official development assistance consistent with the national thrusts and directions for health. The DPs shall align and harmonize their systems and processes with government procedures and institutional reform processes and cooperate in the establishment of mechanisms to track development assistance for the KP and ensure the sustainability and institutionalization of assistance projects to appropriate agencies and offices.

The Development Partners (DPs) assist the DOH and LGUs through provision of technical assistance and resources through grants or loans. The collaboration between the DOH, LGUs and development partners is based on the Sector Development Approach for Health (SDAH). Through the SDAH, the DOH coordinates with the development partners and the national government to ensure the effective implementation of programs to improve health outcomes. The DOH, LGUs, and development partners interact through various institutionalized mechanisms, which allow the implementation of SDAH. The Bureau of International Health Cooperation (BIHC) coordinates and facilitates efficient and effective implementation of foreign-assisted projects. The DOH through BIHC has collaborated with the international organizations and development partners namely: UN Organizations (World Health Organization, United Nations Children's Fund and United Nations Population Fund); multilateral agencies (World Bank and Asian Development Bank) and

bilateral agencies (US Agency for International Development, European Union Delegation, Japan International Cooperation Agency, Agencia Española de Cooperación Internacional para el Desarrollo, Australian Aid for International Development) among others.

7.4.5. PRIVATE SECTOR

One major approach in achieving maximum results in the present administration is in public and private partnerships. The private sector includes professional groups like medical, nurses, midwives and other paramedical groups, companies and pharmaceutical groups. The private sector is considered an integral part of the health sector. They are responsible for the production of health goods and services that will be of use to both health providers and consumers. The private sector guidelines and protocols in the provision of health services meet the standards set by the government. Public-Private Partnership for health (PPP) is an agreement between the government and the private sector. They serve as a venue in which the manner of support needed to achieve the health outcomes desired by the country is discussed. The private sector contributes to the partnership through the sharing of expertise and knowledge and its resources. PPPs are most evident at the local level where direct provision of services is implemented. The private sector works within the stewardship of the public sector. The private sector can be a provider of health services, provider of human resources, and provider of technical assistance to improve the health systems.

7.4.6. NON-GOVERNMENT ORGANIZATIONS (NGOs) AND PEOPLES ORGANIZATIONS (POs)

NGOs and POs also contribute to the health service delivery through program development, management, policy advocacy, resource mobilization and local service delivery. They provide enormous support to the system by reaching underserved areas and extending coverage in high-risk areas. These groups have the capacity to organize and mobilize communities and can serve as effective advocates of health programs at the national and local levels, as well as being direct providers of services in areas where government services are inadequate.

7.4.7. COMMUNITY HEALTH TEAMS (CHTs)

The Community Health Team (CHT) guarantees that every family in the community is periodically visited and attended by health providers as part of the government's efforts to achieve *Kalusugan Pangkalahatan*. The CHT Mobilization teams will do a nationwide door-to-door visit to reach all families, especially the poorest Filipino households, identified through the DSWD's National Household Targeting System (NHTS). The CHT Mobilization aims to link these families to health service providers, provide basic preventive/promotive health services when needed, and deliver key health messages. Health education and information in maternal and child care, adoption of a healthy lifestyle, and utilization and availing of NHIP benefits are among the key messages that will be disseminated, not only to NHTS poorest families but to each household in the community.

7.4.8. INDIVIDUALS AND FAMILIES

Individuals and families are included as important stakeholders for health since they are the direct beneficiaries of the KP being implemented. The responsibility of upholding the health of individuals and families does not solely fall upon the government and health care providers. Instead, the individuals and families themselves have the responsibility to care for their personal health and maintain healthy communities. Hence, it is important to involve them in decision-making processes through membership in health-related groups or structures. The individuals and families are empowered through participation in the decision-making for their own health care, planning and review of health service delivery, development, implementation and evaluation of health policies, strategies and programs. This enable effective strategies for improving health services from the standpoint of clients, providers, and policy makers.

7.5. COORDINATION MECHANISM FOR THE KP

A coordination mechanism to ensure total sector mobilization in attaining the KP goals shall be put in place at all levels. The public and private sector work together in improving the health outcomes. The private sector is mobilized with the stewardship of the public sector. Partners from the different sectors are involved in the resolution of issues and decision-making processes. Through this approach, the various stakeholders contribute their resources to include time and effort and their knowledge and experiences.

The stewards in promoting health in the Philippines are the Department of Health (DOH) and Local Government Units (LGUs). DOH and LGUs mobilize and coordinate with the national agencies, development partners, private sector, professional groups, non-government organizations (NGOs), people's organizations (PO), and individuals and families to achieve maximum results of the health reforms.

Coordinating mechanism with the development partners are conducted as follows:

1. Joint Assessment and Planning Initiative (JAPI). This is a multi-sectoral body composed of representatives from the DOH, other government agencies, international donor partners, and civil society. The JAPI serves as venue for partners to evaluate progress of reform implementation and recommend future actions at policy and strategic levels.
2. Joint Appraisal Committee (JAC) is another multi-sectoral body which reviews the national health reform efforts and the Provincial and City Investment Plans for Health
3. Health Partners Meeting (HPM) is conducted every two months to discuss operational issues or concerns in the implementation of reforms.
4. Technical Assistance Coordination Team (TACT) guarantees that the technical assistance provided by the partners is aligned with the sector program. This ensures that the manner of support given by the partners is complementary and is not duplicated.
5. Technical Coordination Meetings (TCM) ensures the monitoring and evaluation of foreign assisted project's performance indicators at a regular basis including the monitoring for the implementation

of strategies and activities under the project. It is in this venue that foreign assisted project and issues and concerns are also discussed and provided with resolutions together with all implementing partners.

Partnerships for health shall be performance-based and partners in health align and work together in achieving the national objectives for health. The monitoring and evaluation framework of DOH shall be made relevant to the parameters set for the KP. This would enable the DOH to manage and track health outcomes at the national and local levels. The Local Government Unit Scorecard (LGU Scorecard) shall measure the overall performance of provinces and their respective LGUs and track health outcomes in the provinces and cities. The Donor Scorecard shall measure the performance of development partners based on Sector Development Approach for Health (SDAH). The Performance Governance System scorecards at the central office, Centers for Health Development and hospitals shall measure the performance of the DOH Central Office, CHDs and hospitals in their contribution to the overall health outcomes.

All these can be achieved by laying down the necessary building blocks for an effective partnership. First, an environment that is conducive to collaboration should be fostered. A supportive and nurturing environment is central to managing and sustaining any partnership. Effective exercise of the leadership and stewardship role of the DOH is necessary to manage the wide array of stakeholders given the decentralized nature of the health system. Comprehensive policy frameworks should be supported with clear strategic directions that can be implemented at various levels. This creates involvement among various stakeholders. Second, institutional support systems have to be in place. This includes:

1. Systems and operating procedures for program and project management;
2. Financial and logistics management;
3. Sharing of information through updated and relevant information databases;
4. Clear reporting and feedback mechanisms; and
5. Functional monitoring and evaluation systems that would encourage the stakeholders to attain mutual goals.