



**Technical Assistance to the
Health Sector Policy Support Programme**

MANUAL for HEALTH REFORM COORDINATION
(Final Report)

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PREFACE

The attainment of the health system goals of: better health outcomes, more responsive health system, and more equitable health care financing can only be attained by a health system operating at the highest level. This can be achieved through partnership, collaboration, cooperation and joint efforts for health. Coordination is the key that holds together the joint efforts for health.

Cooperation at all levels of care is an imperative for all health workers from the barangay health stations (BHS) to the policy makers. Institutions have to align themselves to be able to collectively cope with the changing times, emerging and re-emerging health challenges and evolving technologies. Partners have to transcend their respective points of view in order to function as a body working towards common goals/objectives. The roles of the different stakeholders have to be determined and defined amidst the changing contexts and frameworks looking at the totality of activities towards a common end.

Priorities have to be set and re-ordered while redundancies are to be avoided. Attention is to be focused on the unserved and the underserved. Considerations have to be given to the health needs of the population at their most vulnerable stages of the life cycle. Coordination among partners in health enhance policy making, management capability for results and mutual accountability.

At the helm of all these efforts for health to achieve the health system goals of better health outcomes, more responsive care delivery system, and more equitable health care financing with focus for the poor is the Department of Health (DOH). With Fourmula One for Health as the main framework, DOH embarks in the implementation of health sector reforms.

This Manual for Health Reform Coordination aims to promote a common understanding of local health reform under Fourmula One for Health between and among local government personnel, Center for Health Development (CHD) staff and representatives in LGU as well as local health reform implementation coordinators (LRICs) and in the long term technical consultants.

This manual shall/can be used by the LRICs, DOH representatives (DOH-Rep) assigned in the provinces, cities, municipalities, any member of CHD, and technical consultants.

This manual consists of three (3) major sections. These are: Contextualizing Health Sector Reform, Implementing Health Sector Reform, and Coordinating the Health Sector Reform Implementation.

EXECUTIVE SUMMARY

This Manual for Health Reform Coordination aims to promote a common understanding of local health reform under Fourmula One for Health between and among local government personnel, CHD staff and representatives in LGU, local health reform implementation coordinators (LRICs) and technical consultants.

Health is a basic human right. The State protects and promotes the right to health of the people. The 1987 Constitution guarantees this basic human right.

The Local Government Code of 1991 – Republic Act No 7160 – provides genuine and meaningful authority to local governments giving them more power, authority, responsibilities and resources. This is the legal framework of all health efforts between/among health partners.

The Philippine Health System is basically a dual system in health service provision. On one end is the public sector composed of the Department of Health and the Local Government Units. At the other end is the private sector.

The Code however, initiated the fragmentation of the delivery of health services to the people on the public sector end. Before the devolution, the Department of Health was the financial and administrative authority over the entire health system. The exceptions to this were the chartered cities. After 1991 the health system operationally was divided into the municipal/city, province and the DOH administrations. Each body exercises financial and administrative authority over their respective areas. The DOH maintains its role as the steward of health of the country.

The Department of Health (DOH) is the lead agency for health, the steward of the health of the nation, with the major mandate to provide national policy direction, develop national plans, technical standards and guidelines on health.

The quest for the Healthy Filipino, Healthy Philippines continues amidst the challenges of emerging diseases like HIV-Aids, severe acute respiratory syndrome (SARS), bird flu and meningococemia among others.

Fourmula One for Health is the implementation framework for health sector reforms. It applies to the entire health sector and is designed to implement critical health interventions and programs, projects, activities at the national and local level as a single package backed by effective management infrastructure and financing arrangement.

The policy supports for sector reform are guided by Health Sector Reform Agenda (HSRA) and National Objectives for Health (NOH), the Sector Wide Approach for Health (SWAp), and the Sector Development Approach for Health (SDAH). The Fourmula One for Health synthesizes all of these policies.

The Province-wide Investment Plan for Health (PIPH) is the key instrument in forging the DOH-LGU cooperation for health, woven around the Fourmula One for Health and defines common goals.

The speed of the delivery of health packages/srvices is moderated by standards, regulations and national laws.

It is powered by PhilHealth claims of reimbursements, internally generated funds like local taxes, user fees and economic enterprise. From the national government financial support is through the internal revenue allotment (IRA), DOH regular budget, DOH counterpart to EC grant, national government subsidy for PhilHealth premium, foreign grants and loans.

Coordination is the key to health sector reform initiatives between/among health partners. It is basically a process of working together harmoniously, putting together all actions for health in one accord. It is necessary, an imperative for the health partner to attain cohesively the health system goals.

Coordination should be ruled by the framework of engagement such as shared vision for health, autonomous LGU partners, with focus for the unserved in diverging localities toward converging health outcomes. It works in an atmosphere of informed and enlightened public support establishing an open line of communication among partners through facilitative and enabling actions and informed gate keeping.

Coordination between/among the different partners and stakeholders became a necessity and imperative for the health sector to attain cohesively the goals of better health outcome, more responsive health delivery system and more equitable health care financing with focus for the poor.

The process of coordination involves consultations, dialogues, meetings and focus group discussion, trainings and workshops. It occurs in a network of agencies and communities.

As the delivery van weaves in and out of the community, monitoring and evaluation for equity and effectiveness (ME3) is done regularly.

Roadblocks are to be expected in the journey since there are political dynamics, geographical and cultural issues as well as the agendas of the health partners.

The Inter-Local Health Zone (ILHZ) is an innovative approach to the disparate and fragmented health system. The Local Government Code provides that “local government units may, through appropriate ordinances, group themselves, consolidate or coordinate their efforts, services and purposes commonly beneficial to them.” Section 33 – LGC 1991.

The Local Health System is like a delivery van of programs, projects, activities that is powered by the engine of Fourmula One for Health. While speed is of utmost importance it must be guided by vision/mission/goals moderated by the quest for quality and sustainability, tempered by standards, policies, rules, laws and regulations.

ACRONYMS

AO	Administrative Order
AOP	Annual Operations Plan
APP	Annual Procurement Plan
AS	Administrative Service
BAC	Bids and Awards Committee
BEmOC	Basic Emergency Obstetric Care
BFAD	Bureau of Food and Drugs
BHFS	Bureau of Health Facilities and Services
BHDT	Bureau of Health Devices and Technology
BHS	Barangay Health Station
BIHC	Bureau of International Health Cooperation
BLHD	Bureau of Local Health Development
BOQ	Bureau of Quarantine
BSP	Bangko Sentral ng Pilipinas
BS	Budget Support
BTC	Belgian Technical Cooperation
BTr	Bureau of Treasury
CBIS-MBN	Community-Based Information System – Minimum Basic Needs
CBMS	Community-Based Monitoring System
CHD	Centers for Health and Development
COA	Commission on Audit
COBAC	Central Bids and Awards Committee
CO	Central Office
CPD	Corporate Planning Department
CPR	Certificate of Product Registration
DBM	Department of Budget and Management
DBP	Development Bank of the Philippines
DOH	Department of Health
EC	European Commission
EO	Executive Order
EXECOM	Executive Committee
FACO	Foreign Assistance Coordinating Office
FICO/FIMO	Field Implementation and Coordination/Management Office
FICT	Field Implementation and Coordination Teams
FS	Finance Service
GPM	Generic Procurement Manuals
GTZ	German Technical Cooperation
HEMS	Health Emergency Management Staff
HHRDB	Health Human Resource Development Bureau
HPDPB	Health Policy Development and Planning Bureau
HRDU	Health Resource Development Unit
HSPSP	Health Sector Policy Support Programme
HSRA	Health Sector Reform Agenda
IAEB	Invitation to Apply for Eligibility and to Bid
ICC-CC	Investment Coordinating Committee-Cabinet Committee
IHSP	Integrated Health Planning System

ILHZ	Inter-Local Health Zones
IMCI	Integrated Management of Childhood Illness
IMS	Information Management Service
INAT	Integrated Needs Assessment Tool
IRA	Internal Revenue Allotment
IRR-A	Implementing Rules and Regulations
JAC	Joint Appraisal Committee
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau
LBP	Land Bank of the Philippines
LCE	Local Chief Executive
LGAS	Local Government Accounting System
LGE	Local Government Executives
LGU	Local Government Unit
LICT	Local Implementation Coordination Team
LRIC	Local Reform Implementation Coordinator
LS	Legal Service
LTO	License to Operate
M&E	Monitoring and Evaluation
MDFO	Municipal Development Fund Office
MDG	Millennium Development Goal
ME3	Monitoring and Evaluation System for Equity and Effectiveness
MESU	Municipal Epidemiological Surveillance Unit
MLGU	Municipal Local Government Unit
MMD-PLS	Materials Management Division-Procurement Logistics Service
MOA	Memorandum of Agreement
MOU	Memoranda of Understanding
MTPDP	Medium-Term Philippine Development Plan
NCDPC	National Center for Disease Prevention and Control
NCHFD	National Center for Health Facility Development
NCHP	National Center for Health Promotion
NEC	National Epidemiology Center
NEDA	National Economic Development Authority
NGAS	New Government Auditing System
NG-LGU	National Government-Local Government Unit
NGO	Non Government Organization
NHA	National Health Accounts
NHIP	National Health Insurance Program
NHPC	National Health Planning Committee
NNC	National Nutrition Council
NOH	National Objectives for Health
NSSHR	National Sector Support for Health Reform
NTP	Notice to Proceed
PAI	Philippine Administrative Issuance
PBD	Philippine Bidding Documents
PD-PLS	Procurement Division

PESU	Provincial Epidemiological Surveillance Unit
PhilHealth	Philippine Health Insurance Corporation
PIF	Performance Indicator Framework
PIPH	Province-wide Investment Plan for Health
PLGU	Provincial Local Government Unit
PMO	Project Management Office
PMU50	Project Management Unit for Pharma50
PNAC	Philippine National AIDS Council
PNDF	Philippine National Drug Formulary
POPCOM	Population Commission
PPMP	Project Procurement Management Plan
PRO	PhilHealth Regional Offices
PSD	Policy and Standards Development
RFQ	Requests for Quotation
RHU	Rural Health Unit
RICT	Regional Implementation Coordination Teams
RO	Regional Office
SDAH	Sector Development Approach to Health
SLA	Service Level Agreement
SMCT	Sectoral Management and Coordination Team
STI-HIV	Sexually Transmitted Infection – Human-Immunodeficiency Virus
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB-DOTS	TB Directly Observed Treatment - Short Course
TB	Tuberculosis
TF	Trust Fund
TWG	Technical Working Group
UNFPA	United Nations Population Fund for Population Activities
UNICEF	United Nations Children’s Emergency Fund
USAID	US Agency for International Development
WB	World Bank
WHO	World Health Organization
WHSM	Women’s Health and Safe Motherhood

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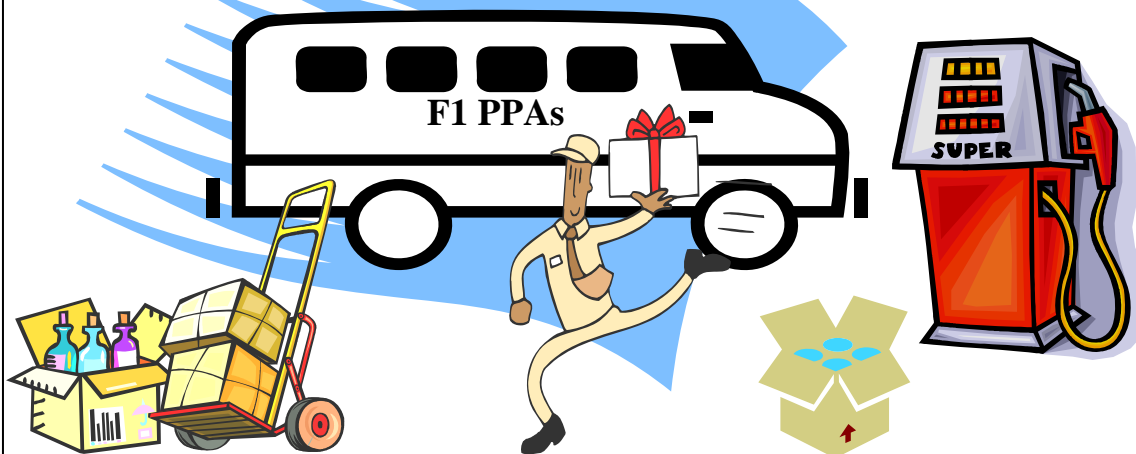
Attachments

- 1. Basic 7 Administrative Orders for Local Health Reform
- 2. Local Reform Implementation Coordinators Training (Powerpoint presentations)

SECTION I.

CONTEXTUALIZING HEALTH SECTOR REFORM

The Local Health System is like a delivery van of programs, projects, activities that is powered by the engine of Fourmula One for Health. While speed is of utmost importance it must be guided by vision/mission/goals moderated by the quest for quality and sustainability, tempered by standards, policies, rules, laws and regulations.



Health is a basic human right. The State provides and promotes the right to health of the people. It instills health consciousness among the people.

The 1987 Constitution, Article II, Section 15 states that the State shall protect and promote the right to health of the people and instill health consciousness among them.

The 1987 Philippine Constitution provided that the country would have decentralized governance through the provision of local autonomy. Article X of the Constitution on Local Government stated in Section 1 that the territorial and political subdivisions of the Republic of the Philippines are the provinces, cities, municipalities and barangays. There shall be autonomous regions in Muslim Mindanao and Cordillera; Section 2 states that the territorial and political subdivisions shall enjoy local autonomy.

Section 4 states that the President of the Philippines shall exercise general supervision over all local governments. Provinces with respect to component cities and municipalities with respect to component barangays shall ensure that the acts of their component units are within the scope of their prescribed powers and functions.

A. The Philippine Health System – A Dual System

The country health system is a dual system. It consists of the public sector and the private sector. The public sector is largely financed through a tax-based budgeting system at national and local levels. Health care is generally given free at the point of service. Recently, socialized user charges have been introduced for certain types of services. The private sector on the other hand consists of for-profit and non-profit providers. It is largely market-oriented and health care is paid through user fees at the point of service.

The public sector consists of the Department of Health (DOH), other national government agencies and the Local Government Unit (LGU). The DOH is the lead agency in health. Its major mandate is to provide national policy direction, develop plans, technical standards and guidelines on health. It is made up of the Central Office, regional offices known as Centers for Health Development, specialty hospitals, regional hospitals and medical centers. It also maintains provincial health teams made up of DOH representatives to the province/municipal and city.

The other end of the public sector is the local government unit by virtue of the LGC of 1991. LGU are in-charge of the provision of the direct health services at the primary, secondary and tertiary levels of health care. The province manages, supervise, maintains and finances the provincial and district hospitals. The municipality/city manages, supervises, maintains and finances the rural health units (RHU), health centers and barangay health station (BHSs). Under this set up, there is a local health board (LHB) chaired by the local chief executive (LCE). LHB serves as the health advisory body to the local executive and the Sanggunian or local legislative council.

The private sector includes for-profit and non-profit health providers. They provide health services in clinics and hospitals; manage health insurance, manufacture and distribute medicines, vaccines, medical supplies, and equipment. They also provide health and nutrition products, research and development, human resource development and other health related services.

B. The Philippine Health Situation – The Goals and the Challenges

Before the enactment and implementation of the Local Government Code (LGC) of 1991 the health system was a continuum of services of prevention, treatment, disease control at the barangay health station (BHS) and the rural health unit (RHU)/city health centers to the treatment and management at the provincial and district hospitals to the referral core/tertiary facilities. This continuum of care was financially, administratively and technically managed by the Department of Health (DOH).

With the implementation of LGC 1991, the whole health system was fragmented and distributed among the three levels of government. The municipal/city government took over the barangay health stations, rural health units/health centers; the province took charge of district and provincial hospitals. The local government unit (LGU) with the advent of devolution took over the administrative/financial authority over their respective facilities. DOH however retained the technical and regulatory supervision over some facilities and services.

The quest for HEALTHY FILIPINO, HEALTHY PHILIPPINES continues amidst the challenges of devolution in an evolving world of changing technologies, values and priorities, but with the constant threat of emerging diseases like HIV-AIDS, Severe Acute Respiratory Syndrome (SARS), bird flu, meningococcemia among others, the re-emerging diseases (TB resistant cases), environmental degradation (mosquito borne diseases), and poverty.

The Philippine health system has three primary goals that correspond to the goals of health systems as defined by the WHO. These goals are: *better health outcomes; a more responsive health system; and equitable health care financing.*

1. Better health outcomes

The health system's main purpose is the appropriate use and adequate provision for health care to ensure that all have quality care throughout their lifecycle.

Health Status of the Filipinos

Life Expectancy at Birth, Crude Birth Rate and Crude Death Rate

Filipinos are living longer now with an average life expectancy at birth of around 70.5 years in 2005. This may be attributed to the improving health status of the people and other socioeconomic factors.

Between the years 1980 to 2003, CBR (Crude Birth Rate) decreased from 30.2 to 20.6 births per 1000 population, while CDR (Crude Death Rate) decreased from 6.2 to 4.9 deaths per 1000 population.

Leading Causes of Mortality

Despite the positive developments in the life expectancy, Filipinos are still affected by a double burden of disease, both from infectious and non-infectious diseases.

Non-communicable diseases are responsible for majority of deaths in the country. The trends of the causes of death are from disease of the heart and malignant neoplasm which comprise more than a third of the total causes deaths. Meanwhile, deaths due to accidents doubled from 20.1 per 100,000 population in 1993 to 41.9 per 100,000 in 2003 (Philippine Health Statistics, 2003).

Deaths caused by communicable diseases have been reduced by more than half in the last twenty years. This is quite evident in the decrease of pneumonia deaths from 93.6 per 100,000 population in 1980 to 42.7 per 100,000 in 2000, a 54 percent reduction. Deaths from all forms of tuberculosis have also decreased by 40 percent in the last 2 decades. This is the result of more aggressive disease prevention and control efforts of the government and improvements in curative care.

Infant, Child and Maternal Mortality

The infant mortality rate (IMR) and child mortality rate (CMR) births in the Philippines have been declining through the years, but the rate of decline has slowed down during the 1980s. The IMR was estimated at 34 infant deaths per 1,000 live births between 1988 and 1992 then decreased to 29 per 1,000 live births between 1998 and 2003. The three most common causes of infant deaths are pneumonia, bacterial sepsis, and disorders related to short gestation and low birth weight.

On the other hand, CMR was estimated at 19 deaths between 1988 and 1992 then declined to 12 from 1993 to 2003. The most common causes of child mortality are pneumonia, accidents, and diarrhea.

Fourteen percent of all deaths in women aged 15-49 years are maternal deaths. The country's maternal mortality ratio (MMR) was estimated at 209 per 100,000 live births between 1987 and 1993 (NDHS 1993). This improved to 162 per 100,000 live births in 2006 (FPMCHP, 2006). Maternal deaths are mainly due to hypertension, postpartum hemorrhage and complications from abortions.

Leading Causes of Morbidity

As in the past, most of the 10 leading causes of morbidity are communicable diseases. The leading causes of morbidity included acute lower respiratory tract infection and pneumonia, bronchitis/ bronchiolitis, diarrhea, influenza, pulmonary tuberculosis, chickenpox, malaria and dengue fever from 1996 to 2006. Morbidity rates of these diseases have been observed to be declining over the last couple of years. Two of the top 10 leading causes of morbidity are non-communicable diseases which are hypertension and diseases of the heart.

Other infectious diseases such as rabies, malaria, filariasis, schistosomiasis, leprosy, dengue fever, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) remain relevant public health problems even though they are not leading causes of illness and death. Rabies incidence in the Philippines is the 6th highest in the world. Malaria is still the most common and persistent mosquito-borne infection in the country and drug resistant

cases are on the rise. Filariasis is the second leading cause of permanent disability among infectious diseases. Schistosomiasis remains endemic in the country although it has been eliminated in most South East Asian countries. And while leprosy has been considered as eliminated based on national prevalence levels, certain areas still have prevalence rates above the elimination target. Dengue fever is known to have sudden increases in the number of outbreaks within a year. There is no vaccine or specific drug regimen to cure it. HIV/AIDS prevalence is estimated to be low in the Philippines but, high risk behaviors appear to be increasing and could lead to high incidence over time.

Disasters and Emerging/Re-emerging Illness

The Philippines, being in the so-called Circum-Pacific belt of fire and typhoon, has always been subjected to constant disasters and calamities such as floods, typhoons, tornadoes, earthquakes, tsunamis, volcanic eruptions, drought, and flashfloods. Man-made disasters such as land, air and sea disasters, civil and armed conflict also take their toll in lives and properties.

The country is also threatened by emerging and resurgent diseases. Emerging infectious diseases are newly identified or previously unknown infections, such as severe acute respiratory syndrome (SARS), while re-emerging infections are secondary to the reappearance of a previously eliminated infection or an unexpected increase in the number of a previously known infectious disease, such as avian influenza, mad cow disease and meningococemia. Both types can cause serious public health problems if not contained as close as possible to its source.

2. More responsive health system

Patients and their families are entitled to respect and quality care. Respect is associated with treating a person with dignity, maintaining confidentiality of health information, and allowing an individual to participate in choices about his or her health. The health system should provide patients and their families greater public satisfaction in the overall performance of the health system.

Responsiveness of the Health System

Responsiveness of a health system is usually reflected in the overall level of satisfaction of the public with health facilities and services and other domains such as prompt medical attention, dignity, and basic amenities of health facilities.

Satisfaction with Health Facilities

In 2000, the Filipino Report Card on Pro-Poor Services showed that there was a high level of overall satisfaction with health facilities. Satisfaction was significantly higher for private facilities than government facilities. The former was rated as +100 while the government hospitals were rated +79, rural health units (RHUs) as +82 and barangay health stations (BHS) as +74. In the same

survey, government hospitals got higher ratings from the rural households and those from the lower socioeconomic class.

Private facilities, compared to government facilities, ranked superior on quality aspects, at par on convenience of location, and inferior on cost aspects. In other words, cost was the only categorical advantage of government facilities over private facilities. Health services provided by public facilities were used mainly by those who could not afford the widely preferred private services.

Prompt Attention, Dignity and Basic Health Facility Amenities

Meanwhile, according to the 2002 World Health Survey, 40 percent of persons who sought ambulatory care then assessed waiting time in ambulatory care facilities as moderate to very bad. More than a third of respondents who experienced hospital inpatient care rated health workers as moderate to very bad in terms of talking respectfully to patients and caregivers, while almost half rated cleanliness of hospitals as moderate to very bad.

3. Equitable health care financing

All individuals face financial risks due to health care costs. Equitable health care financing means that financial risks are distributed in a population based on an individual's capacity to pay rather than his or her risk of illness. In other words, a health system should ensure that an individual or family will not be forced into poverty because they paid for health care, or prohibited to avail of health care because of costs.

Equity in Health Care Financing

In 2004, a total of P165 billion was spent on health related expenditures. Of this, 52.8 percent or P97.5 billion was taken from private sources which include out-of-pocket, private insurance, health maintenance organizations, employee-based plans and private schools. Around 46.9 percent or P77.5 billion is primarily from out-of pocket which means that the burden of paying for health care is still predominantly shouldered by individual families instead of the government or insurance. National and local governments spent a total of P50.1 billion, or 30.3 percent of total health expenditures, while social health insurance paid P15.7 billion or 9.5 percent. Other sources accounted for 1.2 percent or P2 billion.

The above sources of funds reflect different insurance mechanisms with varying degrees of ability to pool resources and spread health risk. The individual family, through direct out-of-pocket expenditure, is the least effective and most inefficient health insurance institution. A family's income and size limit the resources that can be pooled for health expenses. And since members are often exposed to similar health risks, the family has limited risk-pooling capacity.

Until now, there has been limited progress made in expanding social risk pools (i.e. government budget and social insurance funds for health). In 1991, social risk pools financed only as much as 44 percent of total health spending.

On the average, families spend only 1.9 percent of their annual family expenditures on health care, based on a survey conducted in 2000. The average health expenditure amount of a family then was roughly P2,660 and ranged from P572 to P4,430. Of this amount, 46.4 percent was spent on drugs and medicines, 24.1 percent on hospital room charges, 21.7 percent on medical charges including the doctors' fees, 3.5 percent on medical goods, and 4.3 percent on combined expenses for dental charges, contraceptives, and other health services.

Access to and Quality of Health Services and Medicines

The attainment of better health status outcomes and, to a certain extent, responsiveness of the health system is affected by the accessibility and quality of health services and medicines.

Medical Attendance at Births and Deaths

In 2003, around 60 percent of all births were attended by a trained health professional in a health facility but the rest were delivered by *hilots* or unlicensed midwives and other untrained attendants (NDHS 2003). In the same year, around 34 out of 100 deaths from all causes and around 65 percent of deaths from certain conditions originating in the perinatal period were attended by a medical or health professional (PHS 2003).

Geographic Access of Health Facilities

Government primary health facilities are conveniently located as 94 percent of households are within 15-minute walking distance to a Rural Health Unit (RHU) or Barangay Health Station (BHS). However, these facilities were frequently bypassed resulting in overcrowding of higher level facilities that are supposed to be reserved for more specialized care.

Health Facility Utilization

The 2000 Filipino Report Card on Pro-Poor Services showed that 77 percent of households surveyed used health facilities of one type or another. Urban households tended to use health facility services more compared to rural households. Government facilities were more frequented than private facilities. Those who used the latter were predominantly rich households and urban respondents, although poor respondents reported using private facilities as well.

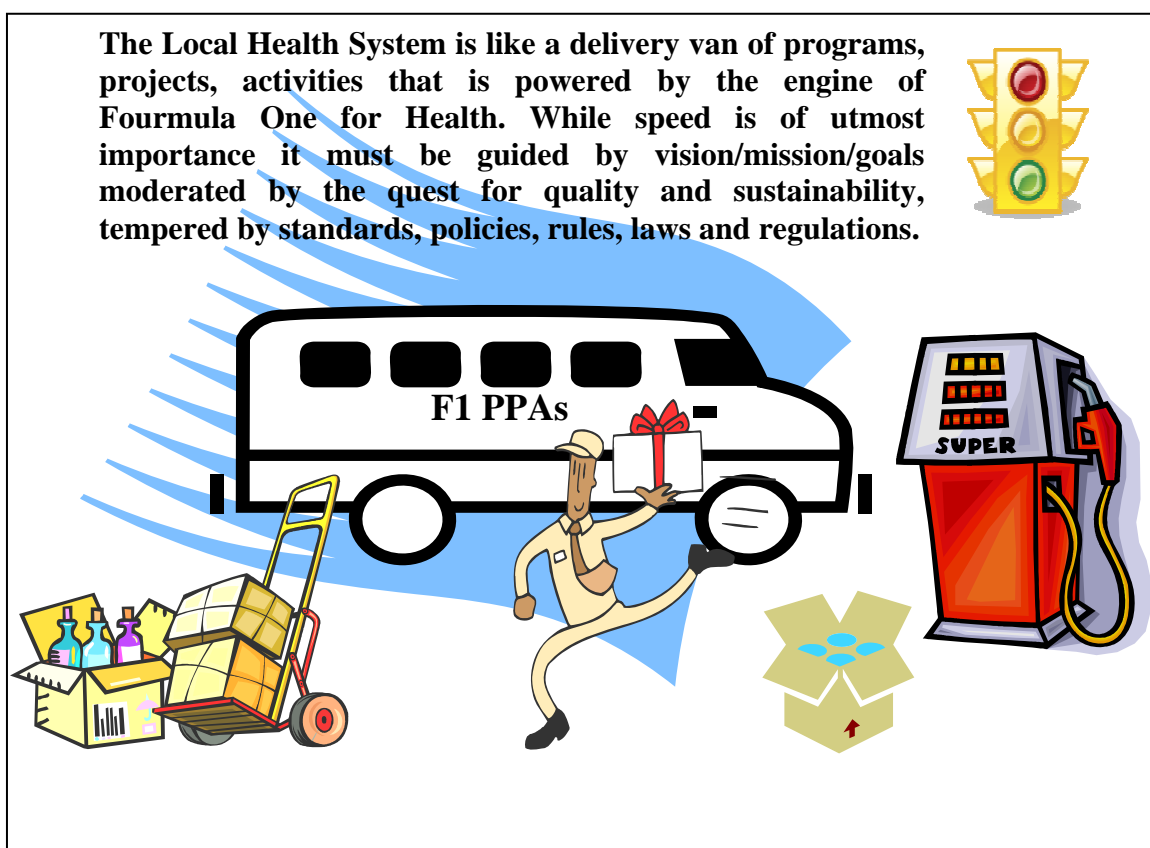
Access to low-priced quality Essential Medicines

In 2003, the Philippine pharmaceutical market was estimated to be P65 to 70 billion and accounted for roughly 45 percent of health spending. Despite the large pharmaceutical market, local drug prices are two to 30 times higher than in Canada or other neighboring Asian countries. This situation exists partly because low cost quality generic medicines comprise only 15 to 20 percent of the market while the rest are dominated by high-priced branded medicines. Furthermore, drug distribution is controlled by a few big distributors, mostly private

drugstores; 85 percent of all drugs sold in the country are dispensed from these private pharmacies.

SECTION II. IMPLEMENTING THE

HEALTH SECTOR REFORM



A. Policy Framework of Health Sector Reform

The health care system in the country is generally extensive. Access to health services especially by the poor is hampered by the financial, geographical and socio-cultural barriers.

Thus access, affordability and availability of health services to the people especially the poor have always been contentious issues.

To address these issues, reform in the country's health care system have been instituted in the past 30 years. Several laws, executive orders and policy issuances have addressed and are addressing these issues. Some of these are the following:

- Adoption of Primary Health Care in 1979
- Integration of public health and hospital services in 1983 by virtue of Executive Order 851
- Generics Act of 1988 (RA 6675)
- Local Government Code of 1991 (RA 7160)
- National Health Insurance Act of 1995 (RA 7875)

On July 21, 1991, the Senate and the House of Representative in Congress enacted Republic Act No. 7160, An Act Providing A Local Government Code of 1991. It provides genuine and meaningful autonomy to the local government. This shall enable them to attain their fullest development as well as to be self-reliant communities. The Code gives them more powers, authority, responsibilities and resources.

The Code requires all national government agencies to conduct regular consultations with local government units especially before any national program or project is implemented in the local community.

Community participation, collaboration and consultations at all levels are encouraged, from planning of any health initiative to resource sharing to actual implementation and monitoring and evaluation. Public-private cooperation is needed and encouraged. These activities are important, even an imperative especially in the delivery of the basic services.

The Code also allows the LGUs to negotiate and secure grants for their programs and projects.

The organized Local Health Boards (LHB) – city, municipal, province – provide the venue for discussions, advocacies, advisories regarding the fiscal requirements needed to operate and maintain the local health system operations. Through this forum, inter-local health zones of health development may be created.

The Local Government Code (RA No. 7160) provides the legal framework for the process of coordination of all health efforts in the local community.

B. Health Sector Reform and the DOH

The Department of Health as the lead agency for health and the steward of the health of the nation continues to embark on the quest to strengthen the Philippine health system and make it a vehicle of change. In support of the commitment to attain the goals set in the Medium Term Philippine Development Plan (MTPDP) 2004-2010 and the Millennium Development

Goals of eradicating extreme poverty and hunger, improving access to health, education and other social services and attaining greater national development, DOH took the bold steps of reforming the health system delivery, regulation, financing and governance.

In the pursuit for a Healthy Philippines and Healthy Filipinos, DOH continues to forge, foster and enhance the cooperation and collaboration of all health partners – the LGU, other national agencies, development partners, private sector and the community. Fourmula One for Health was formulated and developed to become the new implementation framework for health sector reform. To achieve the goals of better health outcomes, more responsive health system and more equitable health care financing with focus for the poor, Fourmula One for Health has 4 major thrust. These are health care financing, health regulation, health service delivery and good governance.

Reference:

- Republic Act No. 7160: The Local Government Code of 1991
- The 1987 Philippine Constitution
- National Objectives for Health Philippines 2005-2010

C. Fourmula One for Health – Revving Up the Engine of Development for Health Sector Reform

FOURmula ONE for Health is adopted as the implementation framework for health sector reform. It is designed to implement critical health interventions as a single package, backed by effective management infrastructure and financing arrangements.

It applies to the entire health sector, to include the public and private sectors, national agencies and local government units, external development agencies, and civil society involved in the implementation of health reforms.

Over-all Goals and Objectives

Over-all Goals:

The implementation of FOURmula ONE for Health is directed towards achieving the following end goals, in consonance with the health system goals identified by the World Health Organization, the Millennium Development Goals, and the Medium Term Philippine Development Plan:

1. Better health outcomes;
2. More responsive health system; and
3. More equitable health care financing.

A. General Objective:

To undertake critical reforms with speed, precision and effective coordination directed at improving the efficiency, effectiveness and equity of the Philippine health system in a manner that is felt and appreciated by Filipinos, especially the poor.

B. Specific Objectives

Fourmula One for Health shall strive, within the medium term, to:

1. Secure more, better and sustained financing for health;
2. Assure the quality and affordability of health goods and services;
3. Ensure access to and availability of essential and basic health packages; and
4. Improve performance of the health system.

General Guidelines:

- A. FOURmula One for Health shall organize the critical reform initiatives into four implementation components, namely, Financing, Regulation, Service Delivery and Governance.
- B. The implementation of FOURmula One for Health shall focus on a few manageable and critical interventions. Such interventions shall be identified using the following criteria:
 1. *Doable given available resources* – Critical interventions identified for each component must be deemed doable given the available time, human and financial resources.
 2. *Sufficient groundwork and buy-in* – The chosen interventions must be backed by sufficient groundwork and buy-in from implementation partners, especially in the development of reform packages for local implementation.
 3. *Triggers a reform chain reaction* – These critical interventions must be able to trigger a chain reaction that will spur the implementation of other FOURmula One for Health interventions, within and across the four components.
 4. *Produce tangible results and generates public support* – These critical interventions must be able to show tangible results within the immediate and medium terms, which in turn generate support and cooperation from the public.
- C. The reforms shall be implemented under a sector-wide approach, which encompasses a management perspective that covers the entire health sector and an investment portfolio that encompasses all sources.
- D. The National Health Insurance Program (NHIP) shall serve as the main lever to effect desired changes and outcomes in each of the four implementation components, where the main functions of the NHIP including enrollment, accreditation, benefit delivery, provider payment and investment are employed to leverage the attainment of the targets for each reform components.
- E. The functional and financial management arrangements shall be defined in terms of specific offices having clear mandates, performance targets and support system, within well-defined time frames in the implementation of reforms within each component.

F. The selection of FOUR-in-One Convergence Sites shall be governed by the following criteria:

1. Willingness of the LGU to participate in the FOURmula One for Health implementation, in terms of:
 - a. willingness to provide the requisite counterpart resources, and
 - b. willingness to enter into formal national government to local government, inter-local government and government to private sector networking, partnership and resource sharing arrangements;
2. Presence of local initiatives or start-up activities relevant to FOURmula One strategies, to include, but not limited to: development of inter-local health zones, enrollment of indigents into social health insurance system, improvement in drug management systems, among others;
3. Relatively high feasibility of success and sustainability, to include factors such as capacity to enter into loans, capacity to absorb investments and sustain the reform process, etc.; and
4. Availability of funds from GOP and external sources for capital investment requirements.

FOURmula One for Health Component-Specific Objectives and Strategies

1. HEALTH FINANCING

The objective is to secure more, better and sustained investments in health to provide equity and improve health outcomes, especially for the poor. This is through:

- a. Mobilizing resources from extra budgetary sources
- b. Coordinating local and national health spending
- c. Focusing direct subsidies to priority programs
- d. Adopting a performance based financing system
- e. Expanding the national health insurance program

2. HEALTH REGULATION

To assure access to quality and affordable health products, devices, facilities and services, especially those commonly used by the poor, the following strategies are to be pursued:

- a. Harmonized streamlined, rational and client-responsive regulatory mechanisms
- b. On the demand side, a “seal of approval system” on health products, devices services or facilities shall be developed.
- c. Cost recovery with income retention for health regulatory agencies and other revenue-generating mechanisms shall be pursued to ensure financial sustainability. However, the use of retained revenues shall be backed by a rational and approved expenditure plan.
- d. The availability of low-priced quality essential medicines commonly used by the poor shall be assured.

3. HEALTH SERVICE DELIVERY

To improve the accessibility and availability of basic and essential health care for all, particularly the poor. This shall cover all public and private facilities and services, and will include the following steps:

- a. Basic and essential health service packages shall be made available in all localities while specific and specialized health services shall be made available by designated providers in strategic locations.
- b. The quality of both basic and specialized health service shall be assured
- c. Current efforts to reduce public health threats shall be intensified

4. GOOD GOVERNANCE IN HEALTH

To improve health systems performance at the national and local levels, FOURmula One for Health shall introduce interventions to improve governance in local health systems, improve coordination across local health systems, enhance effective private-public partnership, and improve national capacities to manage the health sector.

- a. Governance in local health systems shall be improved.
- b. National capacities to manage and steward the health sector shall be enhanced.
- c. The development of rationalized and more efficient national and local health systems shall be pursued through strengthening networking mechanisms and referral systems, sharing of resources, organizational transformation and restructuring; and capacity building, among others.

Reference:

- Administrative Order No. 2005-0023: Implementing Guidelines for Fourmula One for Health as Framework for Health Reforms. August 30, 2005
- Administrative Order No. 2007-0021: Harmonization and Streamlining of the Licensure System for Hospitals. June 6, 2007

Suggested Reading:

- Making Your Local Health System Work – A Resource book on the Local Health System Development by Dr. Eddie G. Dorotan and Dr. Zsolt Mogyorosy

D. Programs, Projects, Activities (PPAs), Carrying Out the Game Plan

The Local Health System delivery of programs, projects, activities is like a delivery van running on the engine of development Fourmula One for Health. While speed is of utmost importance it must be guided by vision/mission/goals, moderated by the quest for quality and

sustainability, tempered by standards, policies, rules, regulations, and laws. In all these health efforts, an partner, steward health.

F1 Projects Programs and Activities (PPAs)	
National Level	LGU Level
I. Health Financing	I. Health Financing

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The PPAs are organized according to the four pillars of Fourmula One namely, Health Financing, Health Regulation, Service Delivery, and Good Governance.

These PPAs are presented in a table form to show the PPAs to be accomplished at the national vis a vis the provincial level:

F1 Projects Programs and Activities (PPAs) for Health Financing

1. Expansion of National Health Insurance Program (NHIP) <ol style="list-style-type: none"> Attainment of Universal Coverage for Social Health Insurance Assurance of National Government Premium Counterpart Development and Implementation of Tool/s to Identify the Indigent Families for PhilHealth Sponsored Program Enrolment PhilHealth Accreditation of Facilities Expansion of PhilHealth Benefit Packages 	1. Facilitate the Expansion of National Health Insurance Program (NHIP) <ol style="list-style-type: none"> Support the Attainment of Universal Coverage for Social Health Insurance Assurance of Local Government Premium Counterpart Adoption of PhilHealth Approved Tool for Identifying Indigent Families and Ensured Enrolment to PhilHealth Hasten the PhilHealth Accreditation of Facilities Rational Use of PhilHealth Capitation and Reimbursement
2. Budget Reforms in DOH and Attached Agencies <ol style="list-style-type: none"> Development of the Health Sector Expenditure Framework (HSEF) Establishment of a System for Budget Allocation, Utilization and Performance Monitoring Mobilization of Extra-Budgetary Resources Coordination of National and Local Health Spending 	2. Increase in LGU investment for Health <ol style="list-style-type: none"> Increase Budget Allocation for Health Revenue Generation and Mobilization of Extra-Budgetary Resources Income Retention or Health Facilities
	3. Establishment of Local Health Accounts

The objective of Health Financing Reforms is to secure greater, better and sustained investments in health that would be able to provide equity and improved health outcomes especially for the poor.

Strategies under this reform component include: mobilizing resources from extra budgetary sources; coordinating local and national health spending; focusing direct subsidies to priority programs, adopting a performance based financing system, and expanding the national health insurance system.

PPAs under this reform component are to be implemented at the national and local levels.

For National Level

1. Expansion of the National Health Insurance Program (NHIP)

a. Universal Coverage for Social Health Insurance

Advocacy for increase in National Health Insurance Program (NHIP) membership and collection will be conducted by the Philippine Health Insurance Corporation (PHIC) better known as PhilHealth in order to attain the universal coverage for social insurance. This shall include social marketing strategies for increasing the enrollment of indigent families in the

Sponsored Program, increasing membership from the informal sector, increasing the membership of Overseas Filipino Workers (OFWs), improving the active membership of the Individually Paying Program (IPP), ensuring timely remittance of accurate premium contributions for the private sector employees, and continuously adjusting contribution schedule of the employed and the IPP for equity considerations.

b. Assurance of National Government Premium Counterpart

The DOH and PhilHealth shall develop mechanisms in ensuring financing for the national government counterpart of the PhilHealth premium for the enrollment of indigent families in the Sponsored Program through the General Appropriations Act and other funding mechanisms initiatives.

c. Development and Implementation of Tool/s to Identify the Indigent Families for PhilHealth Sponsored Program Enrolment

Advisory for the use of acceptable tool/s for the identification of indigent families shall be released by DOH and PhilHealth. The resulting database of indigent families shall be utilized as basis for the selection of families to be enrolled under the Sponsored Program.

d. PhilHealth Accreditation of Facilities

PhilHealth shall continue the accreditation of public and private hospitals and the primary level facilities such as the RHUs and BHS under the harmonized PhilHealth and *Sentrong Sigla* standards.

e. Expansion of PhilHealth Benefit Packages

The PhilHealth benefit packages shall be continuously enhanced to be respond to the needs of the members in a given locality and address the National Objectives for Health. However, steps must be taken to ensure that benefits remain within the range of targeted support value and are not prone to fraud and abuse. Clinical Practice Guidelines (CPGs) or treatment protocols for the management of patients shall also be developed to ensure rational administration of drugs, medicines and services and prevent excessive claims of health providers from the purchasers of health services such as PhilHealth and the general population.

2. Budget Reforms in DOH and Attached Agencies

a. Development of a Health Sector Expenditure Framework

A medium term Health Sector Expenditure Framework (HSEF) will be developed to facilitate linking budget allocation to performance. This will be the basis for planning, budgeting, utilizing funds and monitoring other project components, harmonized with DOH's own management processes.

b. Establishment of a System for Budget Allocation, Utilization and Performance Monitoring

Financing of health agencies and programs shall be shifted from historical and incremental budgeting system into one that is performance-based. Budget allocation and releases shall therefore be conditioned on the achievement of performance targets. Performance-based budgeting initiatives shall include the following:

- *Performance-based commodities allocation.* Public health commodities shall be given to LGUs which are willing to partner with the DOH in the implementation of priority public health programs such as disease eradication initiatives (e.g. Schistosomiasis, Filariasis); or intensified efforts for disease prevention and control (e.g. hepatitis B vaccine provision for LGUs with already high fully immunized children coverage). Incentives for performance shall be given to the LGUs based on achievement of clearly defined and measurable improvement in the delivery of selected public health programs and objectives. These awards may be linked to the LGU scorecard and to the development of “LGU League Tables” to publish the relative performance of LGUs in different priority areas of their public health responsibility. Performance-based allocations and awards for public health would be based on performance agreements between the DOH and participating LGUs.
- *Performance-Based Budgeting for DOH Retained Hospitals.* A fund pool contributed to by DOH retained hospitals for upgrading of hospital facilities and services shall be established. Access to this fund shall be competitively determined and will be based on compatibility with local health care networks, competitiveness with the private sector, and contributions to clinical research and training, and performance. Special consideration shall be made on how well a facility can recoup and sustain support for the recurrent cost implications of proposed upgrading or investments.

c. Mobilization of Extra-Budgetary Resources

The DOH shall lead in mobilizing extra-budgetary resources from official development agencies (ODA) and other donors through the principles of Sector Development Approach for Health (SDAH) which shall be utilized for health reforms at the national and local level. Additional resources for health shall be mobilized by increasing the revenue generation capacities of health agencies without compromising access by the poor. This shall include revenues from user-fee charges from personal health care and regulatory services and rationalized use of real property assets belonging to government health agencies. Health agencies and facilities with revenue generating capacities shall not only support its own requirements but also contribute to meet the needs of non-revenue generating priority programs. However, such mechanisms shall be designed and introduced in a way that do not penalize or restrain fiscal performance among revenue generating agencies.

d. Coordination of National and Local Health Spending

The DOH shall lead in coordinating national and local health spending especially in the implementation of national health programs and in the implementation of reform initiatives. This shall ensure that there shall be no duplication in health expenditure across all levels. Efforts to mobilize more investments for health shall be coupled with measures to improve efficiency in the system for maximizing the expected performance outputs using the available resources and properly distributing or allocating the resources where they shall yield the optimum health impact. Existing resources for health shall be focused on identified priority areas and programs specifically direct subsidies from national and local governments shall be focused on basic and essential health goods and services commonly used by the poor. The overall management of total health investments shall be undertaken through the principles of Sector Development Approach for Health (SDAH) where health resources shall be pooled and allocated rationally across all levels based on identified priority areas. The financing of F1

PPAs shall be jointly undertaken by the central and local government, PhilHealth, ODA and other partners. The mechanisms for mobilizing private sector resources shall likewise be undertaken.

For LGU Level

1. Facilitate the Expansion of the National Health Insurance Program (NHIP)

a. Support the Attainment of Universal Coverage for Social Health Insurance

Social marketing strategies shall be conducted among the LGUs to increase the enrolment of the indigent families to the Sponsored Program of the NHIP. The LGUs shall also assist in the implementation of social marketing strategies to increase the enrolment of the informal sector to the NHIP.

b. Ensure Local Government Premium Counterpart

The municipal, city and provincial LGUs shall ensure the allocation of budget from their IRA for the payment of their premium counterpart in the enrolment of indigent families to the Sponsored Program of PhilHealth. The LGUs may pursue legislation to peg a portion of their Internal Revenue Allotment (IRA) to enroll the indigents identified in the tool for identification of the poor.

c. Adoption of PhilHealth Approved Tool/s for Identifying Indigent Families

The LGUs shall adopt the PhilHealth approved tool for identifying indigent families for enrolment into the Sponsored Program of PhilHealth to ensure that the true poor families will be given financial risk protection from catastrophic illnesses through social health insurance.

d. Hasten PhilHealth Accreditation of Facilities

The municipal, city and provincial LGUs shall ensure that their facilities such as the RHUs and hospitals shall meet the accreditation criteria of PhilHealth for them to qualify for the release of capitation and reimbursement from PhilHealth.

e. Rational use of PhilHealth Capitation and Reimbursement

The municipal and city LGUs shall ensure that capitation from PhilHealth shall be spent rationally following PhilHealth policies for its utilization. The hospitals of LGUs shall also ensure that they are claiming appropriate reimbursement from PhilHealth based on benefit packages and treatment guidelines and that the reimbursements are properly utilized according to PhilHealth policy.

2. Increase in LGU Investments for Health

a. Increase Budget Allocation for Health

Advocacy for the increased health budget allocation for capital outlay, maintenance and other operating expenses (MOOE) and personal services from the IRA shall be conducted among municipal, city and provincial LGUs.

b. Revenue Generation and Mobilization of Extra-Budgetary Resources

The LGUs shall conduct revenue generation initiatives to sustain their financial

F1 Projects Programs and Activities (PPAs)	
National Level	LGU Level

resources for health such as collection of user-fee charges in health facilities without compromising the access of the poor and through the rationalized use of real property assets of health facilities such as establishment of income generating projects and economic enterprise within their areas of responsibility. The LGUs shall also be encouraged to mobilize extra-budgetary resources from donations, grants and loans coming from ODA and other partners in health. Other sources of financing for health can also be identified.

c. Income Retention of Health Facilities

Advocacy to policy makers at the LGU level to allow income retention and utilization among LGU hospitals and other health facilities through local legislation shall be conducted. This shall ensure availability and increase resources for the provision of health services in LGU health facilities until they achieve fiscal autonomy.

3. Establishment of Local Health Accounts

A Local Health Account which is a system of monitoring and tracking the sources and uses of health funds shall be established among LGUs. This shall serve as basis for planning and policy development to improve the investments for health at the local level.

F1 Projects Programs and Activities (PPAs) for Health Regulation

II. Health Regulation	II. Health Regulation
1. Upgrading, Harmonization and Streamlining of Regulatory Systems and Processes a. Establishment of a One-Stop Shop for Licensure of Health Facilities b. Automation of Regulatory Systems and Processes c. Introduction of Less Intensive, Less Frequent and Incentive-Based Regulatory Procedures d. Decentralization of Appropriate Regulatory Functions to Regional Offices and LGUs e. Strengthening of Enforcement Mechanism and Regulatory Oversight Functions of DOH	1. Enforcement of and Compliance to National Health Legislation, Policies and Standards a. Implementation and Enforcement of National Health Laws, Policies and Standards
2. Development of Quality Seals for Health Products, Food, Devices, Drug Establishments, Facilities and Services	2. Legislation and Localization of Regulatory Policies at the Local Level a. Enactment of Ordinances and Passage of Resolutions and Executive Orders
3. Harmonization of Systems and Processes of DOH Regulatory Offices with ASEAN Standards	
4. Improvement of the Availability and Access to Low-Cost and Quality Essential Medicines and Other Health Commodities a. Promotion of High Quality Generic Pharmaceutical Products b. Expansion of Pharmaceutical Distribution Networks c. Identification of Alternative Local and Foreign Sources of Low-Priced Quality Drugs and Medicines d. Development of Mechanisms for Pooled Procurement Among Health Facilities Across LGUs	3. Improvement of the Availability and Access to Low-Cost Quality Essential Medicines and Other Health Commodities a. Promotion of High Quality Generic Pharmaceutical Products b. Establishment and Operation of Pharmaceutical Distribution Networks c. Implementation of Pooled Procurement Among Health Facilities Across LGUs
5. Institutionalization of Cost Recovery, Revenue Enhancement Mechanisms for Health Regulatory Agencies a. Income Retention Policy b. Fee Restructuring	

Health regulation reforms aim to improve access of the poor to good quality and affordable health products, devices, facilities and services especially those commonly used by the poor. Strategies under this reform area include the harmonization of licensing, accreditation

and certification, development of “seal of approval” for quality assurance and the pursuit of revenue enhancement with income retention for health regulatory agencies.

The PPAs under health regulation for the national agencies and LGUs are discussed below.

For National Level

1. Upgrading, Harmonizing and Streamlining of Regulatory Systems and Processes

The regulatory systems and processes of the DOH need to be upgraded, harmonized, streamlined and simplified. In the process, personnel and manpower implements would be rationalized and dedicated to more productive activities. On the side of the regulated, this agenda would derive customer trust in the system and, ultimately, satisfaction on the regulatory services provided.

a. Establishment of a One-Stop Shop for Licensure of Health Facilities

In order to harmonize and streamline regulatory processes for health facilities, to reduce transaction costs and the costs of provision of regulatory services, and to increase customer trust and satisfaction, a One-Stop Shop System for the Licensure of Health Facilities shall be established at the DOH Central Office and the Centers for Health Development (CHDs). Initially the system shall include the licensure of hospitals, but would eventually cover other regulated health facilities that provide ancillary services, such as dialysis clinics, ambulatory surgical clinics, medical facilities for overseas workers and seafarers and similar health facilities.

In the One-Stop Shop Licensure System, a single license to operate shall be issued to the health facility, which would cover all services provided within the premises of the health facility, including diagnostic and other ancillary services. There shall be a single license application process and unified inspection of the health facility that shall be conducted by a composite team of professionals with the technical expertise to determine compliance to regulatory standards.

Another important feature of the One-Stop Shop Licensure System shall be the automatic renewal of license, in which the license to operate shall be renewed upon submission of required documents, without prior inspection of the health facility. Compliance to regulatory standards shall be determined during intensified monitoring visits by the regulatory officers from the CHDs and DOH regulatory bureaus. Automatic renewal of license shall necessitate a more intensive, less frequent regulatory procedures that focus more on providing incentives for timely submission of applications, such as discounts on license fees.

The implementation of the One-Stop Shop Licensure System shall be evaluated by 2009-2010. The system is expected to promote efficiency in health regulation, which shall in turn lead to the achievement of the F1 goals of responsiveness and client satisfaction.

The Bureau of Quarantine (BOQ) shall set up a One-Stop Shop for the issuance of Certificate of Compliance to Criteria for Establishments’ Sanitation and Employees’ Hygiene for all establishments located inside the perimeter of airports and seaports nationwide.

b. Automation of Regulatory Systems and Processes

Upgrading of regulatory systems and processes shall be realized through the establishment of a “central regulatory hub” that will facilitate transactions in the regulatory bureaus and improve their information management system. This shall entail software development for the automation of systems and procedures for the regulation of health products, food, devices, drug establishments and facilities. Automation will increase efficiency in the regulatory bureaus as well as client satisfaction through better, faster and more convenient public service.

For the Bureau of Health Facilities and Services (BHFS), there is the ongoing development and implementation of the computer-based Integrated Drug Test Operations and Management Information System (IDTOMIS). Its objective is to make efficient and effective the current systems and procedures for accreditation of drug testing laboratories and drug abuse treatment and rehabilitation centers through on-line application and payment systems, registration of clients, and verification and confirmation of drug test results through the development and implementation of computer-based systems.

The Bureau of Food and Drugs (BFAD) is currently undergoing automation of its regulatory systems and processes. Likewise, automation of its systems and processes is being proposed by the Bureau of Health Devices and Technology (BHDT) as well as the BOQ.

c. Decentralization of Appropriate Regulatory Functions to Regional Offices and LGUs

The decentralization of appropriate regulatory functions to CHDs and Local Government Units (LGUs) would help streamline regulatory systems and processes, to the benefit of both the government and the private sector, by improving efficiency and reducing the cost of regulation as well as reducing transaction costs incurred by the latter. Decentralization would also free-up resources that could be used to strengthen standards development, enforcement, surveillance and oversight functions of the DOH regulatory offices.

Decentralization to the CHDs shall initially be undertaken for the licensing process for hospitals and clinical laboratories. Other health facilities and other health regulatory functions shall be targeted later on, based on the evaluation of initial decentralization efforts. Similarly, the decentralization of selected regulatory functions to LGUs shall be based on the experience with decentralization to CHDs. In addition, a research study on the capacity of LGUs to undertake health regulatory functions shall be conducted. The data that will be obtained shall serve as basis for policy decisions on decentralization of regulatory functions to LGUs.

The Bureau of Quarantine shall decentralize appropriate regulatory functions to major quarantine stations nationwide.

In the background of decentralization, the DOH regulatory bureaus shall re-orient their organizational goals and functions, focusing more on regulatory standards development, supervision and monitoring, surveillance and oversight. They shall endeavor to build up the capacity of CHDs, other field units (i.e. quarantine stations) and LGUs to perform decentralized regulatory functions, particularly the training of personnel.

d. Upgrading of the Critical Capacity of Regulatory Agencies

The regulatory bureaus shall develop and implement their masterplans to upgrade laboratory equipment, services, systems and processes including the retooling and retraining of their health human resource.

e. Strengthening of Enforcement Mechanism and Regulatory Oversight Functions of the DOH

Legislation that will strengthen and expand the regulatory mandates of the DOH shall be proposed. In the background of decentralization of selected regulatory functions, the regulatory oversight functions of the DOH regulatory bureaus shall be emphasized in the proposed legislation, as well as in any policy initiatives on health regulation.

Outsourcing is the contracting out or buying in of goods or services from external sources, whether government or private, instead of the regulatory bureaus providing such services themselves. This can take the form of a regulatory bureau transferring the operation of a certain regulatory service to a private firm.

Initial efforts on outsourcing or contracting out of selected regulatory services to other government agencies or the private sector shall be evaluated for efficiency and effectiveness, particularly in terms of strengthening enforcement and promoting compliance to regulatory standards. The regulatory bureaus shall also determine which among their remaining regulatory functions may be outsourced or contracted out.

The presence of specialized service support systems and expert services is needed to assure continuous compliance with the technical requirements of the regulatory bureaus. There should be a regulatory mechanism to recognize or deputize specialized or expert service providers through accreditation or certification systems.

In order to promote geographic access to hospital facilities and to maximize the use of limited health resources, the DOH shall expand the scope of hospital regulation by controlling the establishment of new hospitals through the institution of the Certificate of Need as a requirement for the issuance of a permit to construct and license to operate a hospital. Similarly, there is a need to promote access to medical equipment to where they are needed most by coming up with a list of essential health technologies for each level of health care systems.

2. Quality Seals for Health Products, Food, Devices, Drug Establishments, Facilities and Services

The DOH regulatory bureaus shall develop an operational framework for the implementation of seal of approval system for health regulated products, devices, and facilities. The quality seal system is intended to take quality a notch higher than the regulatory requirements for the issuance of permits, licenses or authorization to enter the market. The quality seal issued for products, devices and facilities will serve as signal for the public as to conformance with internationally accepted standards of quality and that fair and ethical standards are met. The seal will enable the consumers to make informed decisions and demand quality health products, devices and facilities in a competitive market.

The Bureau of Quarantine has integrated all accreditation into a Unified Seal of Approval by subscription to the Hazard Critical Control Point (HACCP) and the Good Manufacturing Practice (GMP) since 2004. BoQ also developed the Quality Seals for Food Service Establishments within the perimeter of airports and seaports

The DOH and PhilHealth shall harmonize the Sentrong Sigla Certification (Phase II level 1) and the PhilHealth accreditation of Rural Health Units (RHU) and Barangay Health Stations (BHSs) by integrating PhilHealth accreditation standards for RHUs/BHSs into the basic certification standards of the *Sentrong Sigla*.

3. Harmonization of Systems and Processes of DOH Regulatory Offices with ASEAN Standards

Globalization has already facilitated economic exchanges including trade in health services and goods among countries. However, the currently different regulatory requirements of each country are viewed as technical barriers to trade. This lead the different countries to standardize their regulatory systems and processes within an agreed time frame known as the road map leading to ASEAN harmonization. Failure of the Philippines to harmonize their standards and processes will not protect the consumers from the possible dumping or entry of substandard or counterfeit products coming from other countries.

The BoQ has a long standing coordination and cooperation with 3 other ASEAN countries, Brunei Darussalam, Indonesia, Malaysia, and Philippines East Asia Growth Area (BIMP-EAGA). There is a continuous quarterly meeting in each country by rotation attended by representatives for their Customs, Immigration, Quarantine and Security (CIQS) since 1994.

For medical devices and equipment, the ASEAN countries are looking for integration measures on the regulatory systems and processes such as:

- A common submission dossier for product approval
- An abridged approval process for medical devices which Regulatory Authorities (RAs) of benchmarked counties or regional RAs have already approved
- A harmonized placement of medical devices into the ASEAN market based on common product approval process
- A formalized post marketing alert for defective or unsafe medical devices and equipment

Along these activities, the Philippine DOH joined the AHWP and worked in parallel with GHTEF on technical harmonization efforts.

4. Improvement of the Availability and Access to Low-Cost and Quality Essential Medicines and Commodities

According to the World Medicines Situation, a 2004 publication of the World Health Organization (WHO), only 66 percent of the country's population had access to essential medicines. Access is measured based on the estimated percentage of the population with access to at least twenty (20) essential medicines. The later must be continuously available and affordable at a health facility or medicine outlet, and within an hour's walk from the patient's home.

Access to essential life-saving drugs depends on the availability and affordability of such, especially in areas of high morbidity and mortality. Moreover, other factors also influence and have direct or indirect effects to access to essential drugs and medicines namely: rational selection and use of medicines, tailored procurement, sustainable financing and reliable health and supply systems (WHO).

In line and espoused within the National Objectives for Health to achieve the Medium Term Philippine Development Plan and Millennium Development Goals, the following interventions have been prioritized to achieve our envisioned goal of better health outcomes through the provision of essential drugs and medicines, especially for the poor and underserved.

a. Promotion of High Quality Generic Pharmaceutical Products

Promotion of high quality generic pharmaceutical products shall be pursued among producers, distributors, retailers, medical and dental practitioners and consumers. The Bureau of Food and Drugs (BFAD) shall ensure that generic pharmaceutical products are of high quality through their regulatory systems and processes. Rational prescribing of drugs and medicines among medical and dental practitioners shall be enforced according to the Pharmacy Law (RA 5921) and Generics Act (RA 6675). Rational drug use shall be promoted among patients and consumers of drugs and medicines to ensure safety and attainment of desired therapeutic effects. The advocacy for the establishment of functional therapeutic committees in government and private hospitals shall be strengthened.

b. Expansion of the Pharmaceutical Distribution Networks

On the objective of achieving availability and access to low-priced quality essential drugs and medicines commonly bought by the poor are enhanced, the intent is to saturate the market with low-cost essential drugs and medicines through the following strategies:

i. *Establishment of Botika ng Barangays (BnB)*

The BnB program seeks to make quality essential drugs and medicines more affordable and available to the Filipino people down to the Barangay level to the poorest of the poor. Regulatory requirements for establishing BnBs were streamlined for facility and seed capital investments were planned and provided for from the Department of Health (DOH) to assist Local Government Units (LGU) in pushing for and realizing the objectives of the Program.

The current target is to establish one (1) BnB to serve three (3) adjacent barangays. And to date, there are more than 11,000 BnBs all over situated even in the most far flung areas of the country.

ii. *Parallel Drug Importation in DOH hospitals and in select LGU hospitals*

This refers to the importation of low-cost drugs and medicines into the country to be sold in legitimate drugstore outlets to compete with their exorbitantly priced counterparts. Currently, there are fifteen (15) essential drugs and medicines under the PDI that are sold in the 72 DOH hospitals and three (3) LGU hospitals.

iii. *Botika ng Bayan (BNB)*

The DOH together with the Philippine International Trading Corporation (PITC) launched in December 2004 the BNB project to set up a nationwide network of privately-owned and operated accredited pharmacies that sell low-priced parallel imported or generic drugs with the aim of competing with commercially priced drugs and medicines in the market. At least 1, 500 outlets have been opened so far.

iv. *The P100 Program*

This program is one of the newer strategies being implemented by the Department. This program has the main objective of ensuring access to drugs and medicines which are packaged within an affordability parameter of 100 pesos or lower. This program shall be piloted in 100 hospitals (DOH and LGU).

c. Identification of Alternative Local and Foreign Sources of Low-Priced Quality Drugs and Medicines

Alternative local and foreign sources of low-priced and quality essential drugs and medicines shall be identified. Parallel Drug Importation by the Philippine International Trading Corporation (PITC) of cheaper drugs and medicines of similar brands and therapeutic dose of that which is locally produced shall be carried on. This scheme shall challenge the local manufacturers to lower down the market prices of drugs and medicines.

d. Development of Mechanism for Pooled Procurement Among Health Facilities Across LGUs

Mechanisms for pooled procurement among health facilities across LGUs shall be developed for economies of scale through the execution of Memorandum of Agreements (MOAs) or Memorandum of Understanding (MOUs).

5. Institutionalization of Cost Recovery and Revenue Enhancement Mechanisms for Regulatory Agencies

Regulatory fees are drawn from the regulated entities in order to defray the cost of administration. This stems from the principle that the granting of a license to operate in a regulated market is a privilege and not a right. The fees to be derived should be commensurate to the administrative cost which necessitates the restructuring of current regulatory fees.

The Bureau of Quarantine has restructured its regulatory fees in 2005. This was followed by the BHFS in 2006, when it started to implement a rationalized schedule of fees for the regulation of health facilities. BFAD and BHDT shall also re-structure their own regulatory fees based on actual administrative costs.

The Bureau of Quarantine is mandated to retain and utilize at least fifty percent (50%) of its income by virtue of Republic Act 9271 of 2004.

DOH shall continue to push for the approval of the special provision on income retention and utilization by BFAD, BHDT and BHFS under the General Appropriations Act or its enactment in a republic act.

The BHFS shall continue to propose the implementation of the provision in Section 17 of the Hospital Licensure Act (Republic Act 4226) that allows the hospital licensing agency to retain funds collected from permit to construct, registration and license to operate fees for hospitals and other health facilities covered by R.A. 4226.

Income retention and fiscal autonomy, with appropriate control and auditing systems, is expected to result in better performance of the health regulatory bureaus.

For LGU Level

1. Enforcement of National Health Legislation, Policies and Standards

The LGUs may exercise their health regulatory functions through the localization, implementation and enforcement of national health legislation, policies and standards such as the Expanded Child Care Development, Asin Law, Food Fortification Law and Sanitation Code among others shall be pursued in public and private health facilities.

2. Legislation of Health Regulatory Laws and Policies at Local Level

The adoption and localization of national health regulatory laws and policies shall be pursued among LGUs through legislation, creation of resolution and executive issuances at the

municipal, city and provincial levels. The LGUs may also pursue local health policy development appropriate to their prevailing situation.

3. Improvement of the Availability and Access to Low-Cost Quality Essential Medicines and Other Health Commodities

The LGUs shall conduct promotion of high quality generic pharmaceutical products among physicians and consumers. Pharmaceutical distribution networks shall be established at the LGUs such as the *Botika ng Barangay*, *Botika ng Bayan* and Health Plus. Rational Drug use shall be promoted among consumers and advocacy to medical and dental practitioners on rational prescribing of drugs and medicines according the Pharmacy Law and Generic Act. Advocacy for the establishment of therapeutic committees in LGU and private hospitals shall be pursued. Development and implementation of mechanisms for pooled procurement among health facilities across LGUs shall also be advocated through the execution of MOAs and MOUs.

F1 Projects Programs and Activities (PPAs) for Service Delivery

F1 Projects Programs and Activities (PPAs)	
National Level	LGU Level
III. Service Delivery	III. Service Delivery
1. Public Health Development Program	1. Public Health Development Program
a. DisDisease-Free Zone Initiatives <ul style="list-style-type: none"> ▪ Filariasis Elimination Services ▪ Schistosomiasis Elimination Services ▪ Rabies Elimination Services ▪ Leprosy Elimination Services ▪ Malaria Control Services 	a. Disease-Free Zone Initiatives <ul style="list-style-type: none"> ▪ Filariasis Elimination Services ▪ Schistosomiasis Elimination Services ▪ Rabies Elimination Services ▪ Leprosy Elimination Services ▪ Malaria Control Services
b. Intensified Disease Prevention and Control <ul style="list-style-type: none"> ▪ Tuberculosis Control Services ▪ HIV/AIDS Control Services ▪ Dengue Control Services ▪ Emerging and Reemerging Infection Prevention and Control Services 	b. Intensified Disease Prevention and Control <ul style="list-style-type: none"> ▪ Tuberculosis Control Services ▪ HIV/AIDS Control Services ▪ Dengue Control Services ▪ Emerging and Reemerging Infection Prevention and Control Services
c. Improving Reproductive Health Outcomes <ul style="list-style-type: none"> 1. Child Health Programs <ul style="list-style-type: none"> ▪ Expanded Program on Immunization ▪ Breastfeeding Program 	c. Improving Reproductive Health Outcomes <ul style="list-style-type: none"> 1. Implementation of Child Health Programs <ul style="list-style-type: none"> ▪ Expanded Program on Immunization ▪ Breastfeeding Program

<ul style="list-style-type: none"> ▪ Integrated Management of Childhood Illnesses (IMCI) ▪ Nutrition Services <p>2. Maternal Health Programs</p> <ul style="list-style-type: none"> ▪ Safe Motherhood Policy ▪ Reproductive Health to Include Family Planning and Adolescent Health ▪ Maternal Nutrition 	<ul style="list-style-type: none"> ▪ Integrated Management of Childhood Illnesses (IMCI) ▪ Nutrition Services <p>2. Implementation of Maternal Health Programs</p> <ul style="list-style-type: none"> ▪ Safe Motherhood Policy ▪ Reproductive Health to Include Family Planning and Adolescent Health ▪ Maternal Nutrition
<p>d. Healthy Lifestyle and Management of Health Risks</p> <ul style="list-style-type: none"> ▪ Advocacy Campaigns for Risk Behaviors ▪ Water and Sanitation Programs ▪ Risk Factor Screening 	<p>d. Healthy Lifestyle and Management of Health Risks</p> <ul style="list-style-type: none"> ▪ Advocacy campaigns for risk behaviors ▪ Water and Sanitation Programs ▪ Risk factor screening
<p>e. Surveillance and Epidemic Management System</p> <ul style="list-style-type: none"> ▪ Creation and Strengthening of Epidemic and Surveillance Units ▪ Creation of Regional Epidemic Management Committee (REMC) ▪ Set up Surveillance Systems ▪ Linkage with Private Sector 	<p>e. Surveillance and Epidemic Management System</p> <ul style="list-style-type: none"> ▪ Creation and Strengthening of Epidemic and Surveillance Units ▪ Creation of Provincial Epidemic Management Committee (PEMC) ▪ Set up Surveillance Systems ▪ Linkage with Private Sector
<p>f. Disaster Preparedness and Response System</p> <ul style="list-style-type: none"> ▪ Advocacy for Safe Community and Safe Hospitals ▪ Establishment of Regional Health Emergency Network (RHEN) 	<p>f. Disaster Preparedness and Response System</p> <ul style="list-style-type: none"> ▪ Formulation of Health Emergency Preparedness and Response and Recovery Plan ▪ Advocacy for Safe Community and Safe Hospitals ▪ Establishment of Provincial Health Emergency Network (PHEN)
<p>g. Intensification of Health Promotion and Advocacy</p> <ul style="list-style-type: none"> ▪ Review of Health Promotion and Interventions Technology Upgrade ▪ Strengthening Health Promotion in Service Packages ▪ Integration of Patient Education in Clinical Practice Guidelines ▪ Creation of Health Promotion Foundation 	<p>g. Intensification of Health Promotion and Advocacy</p> <ul style="list-style-type: none"> ▪ Localization of Health Promotion and Advocacy Materials ▪ Behavior Change Communication (BCC) ▪ Intensification of Patient Education in Clinical Practice
<p>2. Health Facilities Development Program</p> <p>a. Rationalization of Local Health Facilities</p> <p>b. Health Human Resource Provision and Capability Building</p> <p>c. Integration of Wellness Services in Hospitals</p> <p>d. Hospital Development Plan</p>	<p>2. Health Facilities Development Program</p> <p>a. Rationalization of Local Health Facilities to Include BEmOC/ CEmOC</p> <p>b. Health Human Resource Provision and Capability Building</p> <p>c. Integration of Wellness Services in Hospitals</p> <p>d. Compliance to PhilHealth Accreditation Standards for Health Facilities</p> <p>e. Compliance to DOH Licensing Standards</p>

Public health and hospital reform pillars of the Health Sector Reform Agenda (HSRA) were merged under the health service delivery component of **F1**. Doing so highlights the continuum of care across all levels (primary, secondary and tertiary levels of care) shared by public and private health service providers.

The objective of service delivery reforms is to improve the accessibility and availability of basic and essential health care for all, particularly the poor. The following strategies shall be utilized: making available basic and essential health service packages by designated providers in strategic locations; assuring the quality of both basic and specialized health services and intensifying current efforts to reduce public health threats.

The national agencies shall pursue policies and standards development, monitoring and evaluation, leveraging and provision of technical assistance to improve service delivery at nationwide scale especially for public health development programs. The LGUs on the other hand, shall ensure the localization and implementation of health policies, programs and projects at the local level.

The PPAs under this reform are grouped into public health development programs and health facility development program as described below.

For National Level

1. Public Health Development Program

a. Disease-Free Zones Initiatives

The Disease-free zone initiative aims to “mop up” diseases such as leprosy, schistosomiasis, filariasis, rabies, and malaria in selected localities in support of the NOH goals to eliminate these diseases as public health problems. This would entail stratification of areas according to the burden of disease, validation of the status of potential disease-free areas, and identification of appropriate interventions. The DOH shall pursue policy and standards development, provision of technical assistance to improve service delivery at nationwide scale, monitoring and evaluation as well as bulk procurement of commodities necessary for the implementation of disease-free zones initiatives.

b. Intensified Disease Prevention and Control Programs

Intensified disease prevention control strategies shall be implemented to reduce morbidity and mortality from vaccine-preventable diseases, tuberculosis, HIV/AIDS, Dengue and emerging and re-emerging diseases such as SARS and avian influenza. These efforts are particularly geared toward the attainment of the MDG targets. DOH shall continue to provide policy directions, monitor program implementation and mobilize resources from budgetary and extra-budgetary resources to finance diseases prevention and control programs and conduct bulk procurement of commodities for the vaccine-preventable diseases, rabies, tuberculosis, HIV/AIDS and index cases of emerging and re-emerging diseases as necessary for distribution to appropriate facilities.

c. Improving Reproductive Health Outcomes

i. Child Health Programs

The Improvement of child health outcomes such as the Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR), Under 5 Mortality Rate and Child Mortality Rate (CMR) depend on the strengthening maternal and child health programs, development and implementation of new policies and standards, and ensuring availability and accessibility of public health commodities and services to include attendance during the delivery of neonates by skilled health professionals in health facilities; implementation of the Expanded Program on Immunization (EPI) through the administration of BCG, DPT, OPV and Hepatitis B vaccine; deworming, ferrous sulfate and Vitamin A to children; administration of tetanus toxoid to pregnant mothers for the protection of neonates from tetanus neonatorum; breastfeeding program; Integrated management of Childhood Illnesses (IMCI) and nutrition services among others.

ii. Maternal Health Programs

The improvement of reproductive health outcomes such as the Maternal Mortality Ratio (MMR), Total Fertility Rate (TFR), Contraceptive Prevalence Rate (CPR) depend on the strengthening of maternal health programs, development and implementation of new policies and standards, and ensuring availability and accessibility of public health commodities and services such as the provision of ferrous sulfate, Vitamin A, and tetanus toxoid; conduct of prenatal and postnatal check-ups and assistance during delivery by skilled health professionals and delivery in health

facilities capable of providing Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC); family planning; Contraceptive Self Reliance (CSR); adolescent health and other reproductive health initiatives as well as Maternal Nutrition among others.

The promotion of Safe Motherhood Policy that all pregnancies are high risk and maternal death reviews shall be considered for all maternal deaths. BEmOC and CEmOC facility mapping and upgrading shall be advocated by the DOH including the creation of Women's Health team, implementation of Contraceptive Self Reliance (CSR) and other Reproductive Health (RH) programs among LGUs.

d. Healthy Lifestyle and Management of Health Risks

The advocacy and promotion on healthy lifestyle for the prevention of cardiovascular diseases, diabetes mellitus, chronic obstructive pulmonary disease, breast and cervical cancers shall be intensified. Campaigns against risk behaviors such as physical activity, healthy diet and smoking cessation shall be promoted. Risk factor screening such as blood pressure monitoring, breast examination, digital rectal examination and others shall be advocated as part of routine examination of patients. Strengthening of networks with professional and other private groups shall be undertaken to set up local support and advocacy teams for Healthy Lifestyle campaigns. Advocacy for safe water and sanitation programs shall also be conducted.

e. Epidemic Management System

Threats of emerging and re-emerging infections such as Severe Acute Respiratory Syndrome (SARS) and avian influenza necessitates the creation and strengthening of the disease epidemiology and surveillance network through enhancing the epidemiology and surveillance units (ESU) at all levels of government units – municipal level (Municipal Epidemiologic and Surveillance Unit or MESU), city level (City Epidemiologic and Surveillance Unit or CESU) and at the level of the province (Provincial Epidemiologic and Surveillance Unit or PESU). Tracking of disease incidence as well as the development and implementation of prompt response shall be greatly facilitated by the institutionalization of ESU networks in all LGUs. Regional Epidemic Management Committee (REMC) shall be created at the regional level. In line with these initiatives, linkages with private sector practitioners who serve a significant part of the population shall be strengthened and be made more efficient.

f. Disaster Management System

Prevention of loss of lives during emergencies and disasters requires strengthening of health emergency and disaster preparedness, response system, rehabilitation and poison control across all levels. This shall be done through the organization, integration and coordination of the entire health sector for emergency and disaster preparedness and response, and by providing and augmenting the necessary logistic resources for effective and efficient response to the same. Regional Health Emergency Network (RHEN) shall be established at the regional level through memorandum of agreement (MOA) with different stakeholders for health. Policy formulation, advocacy and monitoring shall also be implemented for the promotion of Safe Community and Safe Hospitals.

g. Intensification of Health Promotion

- *Review of Health Promotion Interventions and Technology Upgrade.* Effective health promotion activities will save the government a substantial amount of money as people change their lifestyle and health-seeking behaviors. Thus, current health promotion interventions need to be reviewed and appropriate technology upgrades be undertaken.
- *Stronger Health Promotion in Health Service Packages.* Health promotion shall be strengthened and incorporated into health service packages. Aggressive promotion of F1 adoption to stakeholders, especially the LGUs and the public, will be undertaken.
- *Integration of patient education in Clinical Practice Guidelines.* Patient education shall be integrated into clinical practice guidelines to ensure that patients and their caregivers receive relevant information on disease causes, management, and prevention.
- *Creation of a Health Promotion Foundation.* A Health Promotion Foundation shall be established to facilitate health education and promotion activities. The start up fund for this foundation could be initially taken from revenues derived from excise taxes on alcohol and tobacco products.

2. Health Facilities Development Program

a. Rationalization of Health Facilities

Rationalization of the health facilities and services guarantees the delivery of good quality health care by providing appropriate access to the right facilities in the right places and with the right professionals. It also drastically limits the rapid rise in cost of the health care system by reducing excess capacity, particularly in expensive hospital facilities and concentrating services where it is most needed. Health costs are also reduced by coordinating a continuum of hospital, primary care and home based care, and removing wasteful duplication of services.

Health care facilities and health providers operating within a health care delivery system of a specific area shall follow a set of guidelines that would enable them to rationalize their facilities and services based on the health needs of the community they serve. This covers public and private health providers, national and local public hospitals, health centers and RHUs, and Basic and Comprehensive Emergency Obstetric Care facilities (i.e. BEmOC and CEmOC).

DOH shall pursue health mapping for public and private facilities to include BEmOC and CEmOC to ensure access of the population to health care services. Assistance for the establishment and operation of BEmOC and CEmOC facilities shall be provided among LGUs to include critical upgrading of facility and equipment and training of health human resource (HHR) complement.

b. Health Human Resource Provision and Capability Building

The DOH shall continue to augment necessary health human resource (HHR) at the local level when necessary through the implementation of the Doctors to the Barrios and Rural Health Practice Program, provision of a pool of Medical Specialist and provision of Medical Officers. The DOH shall also ensure health human resource capability building and venue for professional enrichment. DOH shall continue to provide policy direction for health human resource development through the implementation of the Health Human Resource Master Plan.

c. Integration of Wellness Services in Hospitals

Retained hospitals shall re-establish themselves as “Centers for Wellness,” to enable to them to provide promotive and preventive care to patients on top of curative care. There is a need to evaluate the previous implementation of this program in order to identify key areas for improvement.

d. Hospital Development Plan

DOH hospitals shall complement local health facility networks to protect the poor and exert pressure on the private sector to deliver competitively priced quality health care. This applies especially for specialty services if continued access to national subsidies were to be justified. Hospitals must also contribute to the production of health technology by conducting research and training. Retained health facilities need to be competitive and must undergo critical upgrading of infrastructure, staffing, and equipment in order to provide quality services to clients. A pool of funds shall be created for hospital upgrading from contributions by DOH hospitals and access to this fund shall be determined in a competitive manner with special consideration on how well the facility can generate and sustain support for the recurrent cost implications of proposed upgrading and investments.

For the LGU Level

1. Public Health Development Program

a. Disease-Free Zones Initiatives

The LGUs shall implement the policies, programs and initiatives to “mop up” diseases to include leprosy, schistosomiasis, filariasis, rabies, and malaria in support of the NOH goals to eliminate these diseases as public health problems. The LGUs may pursue local legislation of policies to support the disease-free zones initiative such as vaccinating all dogs to control rabies and regular clearing of waterways to remove breeding sites of mosquitoes harboring malaria among others. Awards and incentives for frontline workers and facilities may be develop to enhance the implementation of disease-free zone initiatives at the local level.

b. Intensified Disease Prevention and Control Programs

Intensified disease prevention control strategies shall be implemented among the LGUs to reduce morbidity and mortality from vaccine-preventable diseases, tuberculosis, HIV/AIDS, dengue and emerging and re-emerging diseases. Local legislation to facilitate the implementation of disease prevention and control programs as well as to provide incentives to health workers may be developed.

c. Improving Reproductive Health Outcomes

i. *Implementation of Child Health Programs*

The LGUs shall implement child health programs to include EPI, breastfeeding, IMCI, nutrition services, deworming, distribution of ferrous sulfate and Vitamin A and tetanus toxoid vaccination among others. The LGUs may legislate policies to increase the incentives and benefits of health workers to increase their morale in the implementation of child health programs and projects.

ii. *Implementation of Maternal Health Programs*

The LGUs shall ensure the implementation of maternal health programs such as the delivery of pregnant mothers in BEmOC and CEmOC facilities by skilled health professionals, conduct maternal death reviews, tetanus toxoid immunization, prenatal and post-natal check-ups, distribution of iron supplements to pregnant mothers and distribution of iron and Vitamin A to lactating mothers among others. The LGUs shall develop Women's Health Teams consist of physicians, nurses, midwives, trained traditional birth attendants and volunteer health workers to attend to deliveries and implement family planning and other RH programs. The LGUs may develop family planning, contraceptive self reliance and reproductive health ordinances among others to ensure the improvement of maternal health.

d. Healthy Lifestyle and Management of Health Risks

The LGUs shall implement programs and activities to promote healthy lifestyle for the prevention of cardiovascular diseases, diabetes mellitus, chronic obstructive pulmonary disease, breast and cervical cancers will be intensified. This shall include promotion of smoking cessation, diet, exercise, stress management, safe water, sanitation among others. The LGUs shall network with professional and other private groups in setting local support and advocacy teams for healthy lifestyle. The LGUs may develop Tobacco Control Ordinance and other ordinances to support the implementation of healthy lifestyle and the management of health risks.

e. Epidemic Management System

The disease epidemiology and surveillance networks shall be enhanced at all LGU levels to include PESU at the provincial level, MESU at the municipal level and CESU at the city levels including their close linkage and collaboration with the private sector min their localities. Provincial Epidemic Management Committees (PEMCs) shall also be established at the provincial levels.

f. Disaster Management System

The LGUs shall establish and strengthen their disaster management and response system at the municipal, city and provincial levels. The LGUs shall ensure the formulation of Health Emergency Preparedness and Response and Recovery Plan which shall incorporate LGU primary level and hospital facilities disaster preparedness. Provincial Health Emergency Network (PHEN) shall be established through memorandum of agreement with stakeholders for health at the provincial level. The LGUs shall also support the passage of ordinances and executive issuances to strengthen the disaster management system at the municipal, city and provincial levels.

g. Intensification of Health Promotion

- *Behavior Change Communication.* The promotion of behavior change for health shall be intensified to improve the health seeking behavior, attitude and values of the local population towards health and health related matters.
- *Localization of Health Promotion and Advocacy Materials.* Health promotion and advocacy materials shall be localized using the vernacular or dialect for easier understanding of the population in a particular area.

- *Intensification of Patient Education in Clinical Practice.* Patient education shall be incorporated in the treatment and management of patients in public and private health care facilities.

2. Health Facilities Development Program

a. Rationalization of Local Health Facilities to Include BemOC / CEmOC

Rationalization plan of LGU health facilities shall be developed and implemented to ensure that there is a continuum of care from primary, secondary and tertiary level. This shall cover the BHSs, RHUs, BEmOC and CEmOC facilities. The LGUs should ensure that core referral hospitals and CemOC facilities are offering regular and emergency services in a 24-hour basis. This shall entail the merging of adjacent facilities and their health human resource, facility level adjustment and reconfiguration including facility and equipment development. Facility mapping shall be conducted among LGUs to serve as basis for the rationalization plan. The LGUs may develop local ordinances to ensure the implementation of rationalization plans to optimize the utilization of health facilities.

b. Health Human Resource Provision and Capability Building

LGUs which are lacking in HHR shall be encouraged to develop mechanism to ensure the application, hiring and retention of necessary HHR to include legislation, executive issuances and memorandum of agreement for salaries and benefits. The DOH shall continue to assist LGUs lacking in necessary HHR through the Doctors to the Barrios and Rural Health Practice Program, pool of Medical Specialist and pool of Resident Physicians. The DOH shall also assist in the training and professional development of LGU HHR.

c. Integration of Wellness Services in Hospitals

The LGU hospitals shall provide promotive and preventive care to patients on top of curative care.

d. Compliance to PhilHealth Accreditation Standards for Health Facilities

The health facilities of the LGUs should be able to meet the accreditation standards of PhilHealth to ensure the release of capitation and reimbursements. LGU facilities may need to improve the health facilities and equipments, human human resource complement and training.

e. Compliance to DOH Licensing Standards for Health Facilities

The health facilities of the LGUs need to follow the licensing procedures and criteria of the DOH regulatory agencies to ensure the provision of quality services and to prevent legal encumbrances that may occur during the operation of their health facilities.

F1 Projects Programs and Activities (PPAs) for Good Governance

F1 Projects Programs and Activities (PPAs)	
National Level	LGU Level
IV. Good Governance	IV. Good Governance
1. National and LGU Sectoral Management a. Stewardship of National and Local Health Systems b. National Human Resources for Health Program c. Sector Development Approach for Health (SDAH) Implementation d. Monitoring and Evaluation of Health Reforms e. Philippine Health Information System	1. LGU Sectoral Management a. Local Health Systems Development b. Local Human Resource Strengthening c. Sector Development Approach for Health (SDAH) Implementation d. LGU Scorecard implementation e. Local Health Information System Development and Utilization
2. Internal Management a. Public Finance Management b. Procurement and Logistics Management c. Asset Management d. Internal Audit	2. Internal Management a. Public Finance Management b. Procurement Logistics Management c. Asset Management d. Internal Audit

The objective of good governance in health is to improve health systems performance at the national and local levels. **FOURmula ONE for Health** shall introduce cross-cutting interventions to improve governance of the national and local health systems, improve national capacities to manage and steward the health sector and pursue the development of rationalized and more efficient national and local health systems

Reforms in governance are categorized into the health sector management and internal management which are discussed in the following section.

For National Level

1. Health Sector Management

a. Stewardship Over National and Local Health System

Governance over the Philippine health system entails effective and responsive stewardship of national and local health systems. The development of rationalized and more efficient national and local health systems will be pursued through strengthening of networking mechanisms and referral systems, sharing of resources, organizational transformation and restructuring, and capacity building, among others.

The DOH shall lead the LGUs towards effective stewardship of their local health systems through the institution of health reforms at the local level. This shall be done through the establishment of FOUR-in-ONE convergence sites where all four reforms- health

financing, health regulation, health service delivery and good governance are implemented initially in 16 provinces then eventually in the rest of the country. The key elements in the implementation of these FOUR-in-ONE sites are: investment planning, service delivery flow and referral network in a province-wide system, formation of inter-local health zones leading to province-wide governance mechanisms and institutions for the health system, and, rationalization of central support to F1 convergence sites. A roll-out framework and plan shall be developed and implemented for the expansion of F1 convergence sites to other areas based on lessons learned from pilot convergence sites.

LGUs that may not yet have the capacity to adopt a convergence approach to implement health reforms shall be assisted in the development of functional inter-local health systems based on learnings derived from best practices. Improvement in the capacity of local health authority to manage and coordinate the functions of the local health system shall be pursued.

Promotion and advocacy for increased inter-LGU cooperation and coordination as well as public-private partnership shall also be intensified.

b. National Human Resource for Health Program

The Philippines is producing more and better human resources for health (HRH) compared to most Asian countries. Ironically, some areas in the Philippines suffer from lack of professional health providers. This partly due to the uneven distribution of HRH across the country and the large exodus of nurses and physicians in the last four years which is a phenomenon that is unparalleled in the migration history of the country. In lieu of this, an HRH Master Plan will be developed to mitigate this growing problem.

Technical leadership and management capability at the central and regional levels will be strengthened through retooling and retraining of central office and CHD personnel as well as tapping DOH representatives to serve as vital links to the LGUs.

- *Human Resource for Health (HRH) Planning and Production.* HRH Planning shall be done by getting the total workforce requirements and corresponding costs based on parameters like current population and population growth, current stock of HRH category and attrition rate, and preferred health worker to population ratio. It should then follow that the production of health manpower shall be based on the actual and projected requirements of the health delivery system.
- *Human Resource for Health Utilization and Placement.* A recruitment and selection system shall be developed based on actual job competencies. At the same time, rewards and incentive mechanism through a performance management system shall be developed to motivate health professionals to continue personal development and improve job performance. Actual career development and management shall be conducted to support health manpower through retention planning, individual career planning, career pathing and succession management. These processes shall also ensure that a qualified professional will be ready to continue the service of a vacated position.
- *Human Resource for Health Learning and Development.* Strategy driven, competency-based training and development interventions shall be aggressively pursued to equip HRH at the national, regional and local levels with knowledge, attitudes and skills required to carry out reforms in the country's health care system.
- *Human Resource for Health Information System.* Different HRH Information Systems shall be installed to capture employee information, support HRH Management and

Development systems, announce job vacancies in the health sector and generate baseline HRH data for use in planning. There is a need to communicate these health human resource thrusts and resources to both the health workers and the communities.

c. Sector Development Approach for Health (SDAH) Implementation

The Sectoral Development Approach (SDAH) is a major strategy to ensure that there is a coordinated national effort towards the thrusts and strategies of the country. This shall strengthen government leadership in implementing a health sector program where development partners cooperate and contribute according to priority thrusts. Effective donor and LGU coordination and harmonization of procedures shall be established.

d. Monitoring and Evaluation of Health Reforms

A monitoring and evaluation system shall be developed, tested, and applied in order to monitor F1 implementation of all stakeholders at all levels. This shall be called as the Monitoring and Evaluation for Equity and Effectiveness (ME3) which shall include scorecards for DOH central offices, CHDs, hospitals, LGUs and donor agencies. Monitoring and evaluation tools shall be developed through a consultative, iterative and objective process. Qualitative and quantitative means of evaluation shall be utilized.

To maximize the use of the monitoring and evaluation system and keep it responsive to changes during the medium term, there is a need to develop the monitoring and evaluation capabilities, including research skills, of DOH central office and CHD personnel.

e. Philippine Health Information System

Health information should be managed, disseminated and utilized effectively. In line with this, a Philippine Health Information Network (PHIN) shall be institutionalized which shall serve as the “data portal” or search engine system for all health information. Easily accessible data shall make not only health planning easier but also support cooperative efforts with partners. With both public and private sector using the same information source to monitor and plan, efforts and interventions shall become more complementary.

Efforts in this regard shall include harmonization of information systems of different stakeholders in health, and inclusion of information systems on human resource, vital registries and health statistics, disease surveillance, national and local health accounts, health regulations, and health facilities.

To maximize the use of the information system, the DOH as well as the other health sector stakeholders shall develop systems on knowledge management which includes not only information systems but also development of knowledge management oriented decision-makers, staff and processes.

2. Internal Management

a. Public Finance Management

The financial management capacity at DOH central office and CHD levels shall be strengthened by developing a comprehensive and integrated financial management and information This shall be done through the computerization of budgeting and accounting systems, monitoring and evaluation of fund sources, and development of feedback mechanisms for fund utilization at all levels, and strengthened internal audit capacities. Such systems shall

include the Electronic National Government Accounting System (e-NGAS) and Medium Term Expenditure Framework (MTEF) among others.

b. Procurement and Logistics Management

The DOH procurement, logistics and warehousing management system shall be strengthened. This shall cover the inventory system, supply chain mechanism, efficient storage, database of goods and supplies with standard specifications, pooling, monitoring, and feedback mechanisms incorporated in the procurement systems, database of suppliers with performance monitoring, standardization of specifications and documents, and the implementation of ethical practices.

c. Asset Management

The DOH shall undertake a comprehensive and systematic process of effectively acquiring, maintaining, upgrading, operating and disposing its assets to maximize the utilization and worth of these assets.

d. Internal Audit

The systems and procedures for internal audit of DOH shall be strengthened to monitor the financial and internal operations and performance of the DOH to make sure that all resources are managed and utilized in accordance to prescribed laws and regulations.

For LGU Level

1. Health Sector Management

a. LGU Sectoral Management

The DOH shall lead the LGUs towards effective stewardship of their local health systems through the institution of health reforms at the local level. This shall be accomplished primarily through the establishment of FOUR-in-ONE convergence sites where interventions under all four F1 reform components: good governance, health regulation, health financing and health service delivery shall be implemented. Systems and processes for inter-LGU cooperation, public-private partnership and community participation shall be established.

b. Local Health Human Resource Strengthening

Parallel to national efforts, a local health human resource strategy shall be developed and implemented at the LGU level. Efforts shall include a development of a health professional development and career tract.

c. Sector Development Approach for Health (SDAH) Implementation

The establishment of effective donor and LGU coordination and harmonization of procedures shall be implemented at the local level.

d. LGU Scorecard Implementation

The LGU Scorecard system shall be developed and piloted in convergence sites to assess LGU performance during the medium-term. The LGU Scorecard shall not be limited to benchmarking the progress of site development but also may serve as basis for incentives. Monitoring and evaluation tools shall be developed through a consultative, iterative and objective process. Qualitative and quantitative means of evaluation shall be utilized.

e. Local Health Information System Development and Utilization

Local Health Information System shall be developed to provide accessible data for local health planning and policy development. This shall require harmonization of information systems of different stakeholders in the local health system, inclusion of information systems on human resource, vital registries and health statistics, disease surveillance, national and local health accounts, health regulations, and health facilities.

2. Internal Management

a. Public Finance Management

Advocacy and technical assistance for the improvement of public finance management among LGUs shall be done. This shall cover their budgeting and accounting systems, monitoring and evaluation of fund sources and development of feedback mechanisms for fund utilization among others.

b. Procurement and Logistics Management

The municipal, city and provincial procurement and logistics management system needs to be strengthened. The reform initiatives shall improve the inventory system and a supply chain mechanism, efficient storage, database of goods and supplies with standard specifications, pooling, monitoring, and feedback mechanisms incorporated in the procurement systems, database of suppliers with performance monitoring, standardization of specifications and documents, and the implementation of ethical practices.

c. Asset Management

The LGUs shall undertake a comprehensive and systematic process of effectively acquiring, maintaining, upgrading, operating and disposing its assets in the health facilities to maximize the utilization and worth of these assets.

d. Internal Audit

The systems and procedures for internal audit of LGUs shall be strengthened to monitor their financial and internal operations and performance so that all resources are managed and utilized in accordance to prescribed laws and regulations.

E. Pump Priming Fourmula One for Health – The Budget

There are two identified and specified sets of Fourmula One flagship programs and projects. These are the development of province-wide local systems in 16 initial convergence sites and the projects to build capacity to exercise effective leadership or stewardship over the health sector. To fund these two initiatives require large amount of financing which cannot be covered by the existing resources. Hence the need to reform the structure, allocation and execution of direct subsidies going to central and regional level health agency programs.

Such budget reforms include effective use of existing budget, prudent and judicious utilization of same. DOH within its limited resources will assert its technical leadership over the sector, flex its regulatory muscle and use targeted initiatives in focus in terms of grants in cash and in kind. It can also influence procurement practices and leverage payments for service.

The financing framework of F1 will be anchored on DOH budget reforms, policies that will direct DOH offices and attached agencies to prioritize activities related to health reforms and policies. This will also guide development partners in identifying priority areas for support as well as to oversight agencies in health and other related agencies in facilitating reform implementation in the DOH and LGU.

F1 financing framework shall be along the four pillars of reform – financing, regulation, service deliver and governance. National subsidies for health shall be based on the incremental influence over health sector performance and capacity to generate revenues for operations.

DOH budget shall be disbursed on the basis of scheduled performance benchmarks.

F1 financing strategy shall include adjusting DOH budget ceiling based on need, market demand and performance. Items critical to F1 implementation shall be protected from budget cuts and this shall be coordinated with DBM. Final cost and allocation shall be determined by the Sectoral Management Coordination Team (SMCT) based on a set of allocation criteria, subject to approval by DOH-EXECOM and reflected in the annual DOH budgets.

Budget structure shall be distinguished along the major functions: governance and management support; policy and standards development and technical assistance; health program implementation and coordination. Policy and standard development and technical assistance is further subdivided into standards development and technical assistance for regulation and standards and technical assistance for service delivery.

The financing of Fourmula One for Health implementation shall follow a two-pronged strategy.

1. The first one shall refer to the rational use of public subsidies, both national and local, and the increasing role of social health insurance in paying for the health services of the Filipinos. This shall likewise require aligning these resources to sustain the strategic thrust and programs of Fourmula One.
2. The other strategy shall entail using available resources, mainly those from the foreign assistance pipeline to pump prime Fourmula One for Health implementation in the immediate term.

The financing portfolio for health sector reform specifically Fourmula One for Health consists of the following:

- Grants – shall come from development agencies such as the European Union (EU), the German Technical Cooperation (GTZ), among others.
- LGU Counterpart – shall come from the respective Internal Revenue Allotments (IRA) and other revenue sources of the LGUs; or from loans that may be accesses from the Asian Development Bank (ADB) or the Kreditanstalt für Wiederaufbau (KfW) through the Municipal Finance Corporation (MFC), an attached agency of the Department of Finance, and other such development or commercial banks.
- National Government Counterparts – shall come in the form of technical assistance, training and capability building, systems development support, logistics support or other non-cash assistance from the Department of Health. One source identified for the National Government counterpart is the World Bank (WB), in the form of budget support loan.
- Other partners like the World Health Organization (WHO) and other United Nations-attached agencies, the United States Agency for International Development (USAID), the Japan International Cooperation Agency (JICA) and other funding agencies shall also be tapped for technical assistance and support.

Reference:

- Administrative Order 2005-0023: Implementing Guidelines for F1 for Health as Framework for Health Reforms. August 30, 2005
- Administrative Order 2006-0023: Implementing Guidelines on Financing Fourmula One for Health (F1) Investments and Budget Reforms. June 30, 2006

F. Planning the Province-wide Investment Plan for Health (PIPH) – The Roadmap

The road to the health sector goals of better health outcomes, more responsive health system and more equitable health care financing is long and winding. There are as many voices and agendas as there are health partners, working together in pursuit of these goals.

The Local Government Code of 1991 states that “the National Government shall ensure that decentralization contributed to the continuing improvement of the performance of local government units and the quality of community life.” LGC 1991 – Section 3 (m). Under Fourmula One for Health, DOH adopted the instrument Province-wide Investment Plan for Health (PIPH) to forge the DOH-LGU partnership. The PIPH serves as the roadmap in the road to Local Health System Development. With PIPH and AOP as the basis, the DOH-LGU partnership is forged through the Service Level Agreement (SLA) document, operating within the framework of Fourmula One for Health.

A plan prepared and adopted by the health sector led by LGUs within a province, agreed to be supported by DOH and its development partners in health. It defines the local health systems improvements to be attained in the province through the proposed application of public investments jointly funded by LGUs, DOH and development partners.

The basic framework is Fourmula One for Health

- To secure greater, better and sustained investments in health to provide equity and improved health outcomes especially the poor
- Improved access of the poor to good quality and affordable health products, devices, facilities and services
- Improved accessibility and availability of basic and essential services for all, particularly the poor
- Improved health system performance at the national and local level.

The Process of the Formulation of Province Wide Investment Plan for Health (PIPH):

- There are two (2) phases
 - Pre- Planning phase
 - Planning phase
- The planning process can be an initiative of the Center for Health Development (CHD) or the local government unit
- A Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) signed by DOH/CHD and LGU covers the planning process
- It expresses the formal agreement between DOH-CHD and LGU to conduct the formulation and development of the PIPH
- The Local Chief Executive issues an Executive Order/Office Order creating the PIPH/TWG team composed of provincial officers and staff. It defines the functions of the team.
- The CHD provides the technical assistance to LGU planning teams
- In the planning phase, health issues and concerns are identified and solutions are proposed.
- Resources – human, facilities, services, health goods and commodities and equipment as well as financial support are also identified

Governed by Section 33 of the Local Government Code, *Cooperative Undertakings Among Local Government Units*. - Local government units may, through appropriate ordinances, group themselves, consolidate, or coordinate their efforts, services, and resources for purposes commonly beneficial to them. In support of such undertakings, the local government units involved may, upon approval by the sanggunian concerned after a public hearing conducted for the purpose, contribute funds, real estate, equipment, and other kinds of property and appoint or assign personnel under such terms and conditions as may be agreed upon by the participating local units through Memoranda of Agreement.

The basic features of PIPH are:

- Defines common vision, mission, goals towards improved health of the community
- The key instrument in forging/strengthening DOH-LGU partnership for health
- Woven around the framework of Fourmula One For Health
- Participative approach
- Builds upon previous efforts and experiences of LGU-DOH collaboration and cooperation
- The roadmap to reach the goals of better health outcomes, more responsive health system and more equitable health care financing.
- Five year strategic policy and investment framework

- Well defined critical interventions and targets
- Interventions, targets and timelines linked to current sources and uses of funds, projected incremental revenue streams and sector-wide support fund partners
- Implemented through performance driven annual agreements
- Focus for the unserved and underserved communities
- Designed to be an integral part of the LGU development process

Expected Output:

- Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU). See Annex D
- Executive Order/Office Order creating the PIPH/TWG
- Province Wide Investment Plan for Health (PIPH) document
- Code of Conduct to govern National/Local Coordination and Priority Setting

Reference:

- Administration Order No. 2007-0034: Guidelines in the Development of the Province-wide Investment Plan for Health. October 15, 2007

G. Financing the Province-wide Investment Plan for Health (PIPH)

The health sector program of a province may be financed by various sources such as:

- PhilHealth claims of reimbursement
 - PhilHealth fee for service claims
 - PhilHealth capitation
- Foreign grants
- Loans
- National Government
 - Internal Revenue Allotment
 - DOH regular budget
 - DOH counterpart to European Community Grant (per Health Sector Policy Support Program)
 - National Government Subsidy for PhilHealth premiums
- Private Sector/Civil Society Organization (NGOs, etc)
- Internally – Generated Funds
 - User fees
 - Local taxes
 - Economic Enterprise and other revenue sources

These sources may be classified as either internally-generated or externally-generated. PhilHealth may be regarded as a third category:

1. Internally Generated

Internally generated funds for health may come from local taxes, user fees, economic enterprise, and other revenue sources.

Local Taxes

Some of local tax receipts may be earmarked for health.

User Fees and Other Charge

User fees for health services in government facilities, particularly government hospitals, are oftentimes reverted to the province's general funds. Some provinces, however, implement an income retention scheme to ensure that the income is used for hospitals.

Whether retained or not, it will be helpful to track the share of user fees in the total revenues of the facilities. This will be useful in planning and budgeting by estimating the operating expenses that can be covered by user fees.

Economic Enterprise and Other Revenue Sources

The LGUs, whether provincial (PLGUs) or municipal (MLGUs), may also put up some economic enterprise such as drugstores or canteens, usually within the health face facility premises, and income is earmarked for the facility or for health care needs.

2. Externally Sourced

Externally-sourced funding for the local health sector includes the national government, grants, and loans.

National Government

Internal Revenue Allotment (IRA)

A portion of the respective IRA of the provincial LGU (PLGU) and the municipal LGUs (MLGUs) are usually budgeted for health.

DOH Regular Budget

The Department of Health has been rendering support for non-devolved activities of LGUs, including but not limited to public health activities. These usually come in the form of technical support such as training and technical assistance through the DOH central office and the Centers for Health and Development, and in the form of medicines and supplies. DOH has also developed a performance-based resource allocation for public health outlined in Administrative Order No. 2006 0022.

DOH Counterpart to the EC Grant

For the 16 convergence sites receiving grant from the EC, the DOH will be providing a counterpart cash contribution.

National Government Subsidy to PhilHealth Premiums of Indigents

The law provides that premiums of PhilHealth indigent enrollees is shared by the national government and the local government. The sharing scheme depends on the income classification of the MLGU and the number of years the MLGU has been participating in the PhilHealth Sponsored Program.

Foreign Grants

Many multilateral and bilateral donors such as the Belgian Technical Cooperation (BTC), European Commission (EC), German Technical Cooperation (GTZ), Japan International Cooperation Agency (JICA), US Agency for International Aid (USAID), and the World Health Organization (WHO) provide grants to local governments to finance their health programs. Grants come in the forms of cash, in-kind items such as equipment and supplies, or technical support.

In the case of the 16 convergence provinces, the EC is providing cash grant as budget support, i.e., to finance the provinces' health investment plans that are based on the provinces' needs and designed according to the FOURmula ONE for Health framework. (As will be discussed in a later chapter, these are channeled either as direct budget support or through a World-Bank administered Trust Fund.) This is in keeping with the sector-wide approach and the devolution of health services to the local governments.

EC will likewise provide in-kind technical assistance.

Loans

The PLGU or the MLGUs may also source out loans to finance their health sector program. Possible sources of loans are:

- Commercial lending institutions;
- Government financing institutions such as the Land Bank of the Philippines (LBP) and the Development Bank of the Philippines (DBP); and
- Municipal Development Fund Office (MDFO) – This is an office under the Department of Finance that acts as conduit to foreign loans and assistance designed to finance local government development. For instance, specifically for the implementation of the PIPHS of the convergence sites, the Asian Development Bank and the KfW are providing loans to the LGUs through the MDFO. Annex B provides operational details in obtaining such loan from the MDFO.
- Private Sector, Civil Society Organizations – the private sector and civil society organizations can also be an important source of resources for the health sector of local governments.

3. PhilHealth Claims

Fee-for-Service Claims or Reimbursements – These are the benefit payouts for in-patient and selected outpatient benefits. A specific amount or a maximum amount is set for each type of service and for different categories of hospitals.

Most LGUs revert income from PhilHealth claims to the LGU's general fund, and this makes it difficult to track PhilHealth claims as a source of funding for health, and to track what particular items are financed by it. It is recommended that LGUs allow government hospitals to retain PhilHealth income. Even without such PhilHealth income retention scheme, however, LGUs should endeavor to track the income from PhilHealth claims and its share in hospital revenues.

Technically, PhilHealth claims in LGU hospitals are revenue source of the LGU and therefore can be classified under #1 above. In planning and budgeting, however, it is useful to estimate the expected expenditures and operating expenses that are covered through PhilHealth claims. For example, PhilHealth reimbursement can be identified as a source of funds for supplies for normal spontaneous deliveries by PhilHealth-covered patients.

Capitation payments – PhilHealth capitation is the payment to the MLGU of a fixed P300 per year per indigent family enrolled in the PhilHealth Sponsored Program. PhilHealth regulations require the capitation payment to be placed in a Trust Fund that is earmarked for provision of specific services including supplies in the MLGU-owned rural health units (RHUs). Unlike fee-for-service claims, therefore, it is easier to track what health investment items or operating costs are financed through PhilHealth capitation.

Reference:

- Fourmula One for Health Operations Manual for Convergence Provinces Implementation of Province-Wide Investment Plan for Health November 2007 Version 1.1

H. Guiding the Health Sector Reform Implementation – Tools / Instruments of Health Sector Reform Implementation

To ensure the attainment of the health sector goals and to guide the implementation of PIPH, some tools/instruments were developed. These are:

1. Annual Operation Plan (AOP)
2. Annual Procurement Plan (APP)
3. Human Resource for Health Management and Development (HHRMD)
4. Facility Rationalization Plan
5. Service Level Agreement (SLA) which serve as the binding mechanism between DOH and the province
6. Monitoring and Evaluation for Equity and Effectiveness (ME3)

1. The Annual Operation Plan (AOP)

The Annual Operation Plan (AOP) is a program specific plan of activities within the annual investment cost as reflected in the Province-wide Investment Plan for Health (PIPH) for all sources of funds that includes among other things; Provincial Local Government Unit (PLGU), Municipal Local Government Unit (MLGU), European Commission, DOH budget support, and PhilHealth.

- Annual thrust aligned with PIPH
- Specific objectives by PPA
- Activity specific
- Specified in the SLA
- Accompanied by APP (specifically the PPMP), Training Plan and a Financial Plan
- Refers to an LGU-approved and DOH-concurred Provincial Health Facilities Rationalization Plan (AO 29, s 2006)
- The AOP will contain
 - Activities per F1 Components
 - Time Frame
 - Targets
 - Resource Requirements with details of expense classification using New Government Accounting System (NGAS) per COA Circular No. 2003-001. June 17, 2003

Steps in Annual Operation Planning

The entire process should conform to the schedule of local investment planning in the Joint Memorandum Circular No. 1 of national oversight agencies.

To facilitate the LGU planning, the DOH releases regular advisories on the global priority PPAs whose priority implementation is necessary in identified LGUs/geographical areas to achieve National Objectives for Health and international commitments in the Millennium Development Goals.

It is recommended that the following sequence be followed in annual planning based on approved PIPH:

Local Identification/Prioritization of Health Problems/Priorities (barangay/municipality) (1)



Local Health System Aggregation of Problems/Priorities (ILHZ) and Resource Commitment (2)



Development of AOP based on Local Health Development System Plans by Technical Working Group (TWG) created by LCE to LICT (DOH Technical Support Packages considered) (3)



Presentation to LICT, approves recommendation of DOH/Development partner component to JAC, municipal LHBs, provincial Sanggunian (4)



Presentation to the Local Finance Committees prior to preparation of local appropriation (5)



Presentation of AOP (provincial/municipal components) to respective sanggunians (6)



DOH informed of approved AOP (7)



Annual Service Level Agreements developed by DOH based on approved AOP (8)



LICT concurs with SLA (9)



Implementation, Monitoring, Evaluation by local health systems (10)



Planning (11)

Reference:

- Administrative Order No. 2008-0003: Guidelines for the Preparation of Annual Operational Plan (AOP) for 2008 and Yearly Thereafter Based on the Province-wide Investment Plan for Health (PIPH) for the Fourmula One (F1) 16 Convergence and Roll-Out Sites and Other Provinces. January 7, 2008

2. Annual Procurement Plan (APP)

As a part of the Annual Operation Plan it contains all procurement activities of the whole province.

Some basic principles that should govern any procurement plan:

- Governed by provisions of Republic Act (RA) No.9184 known as the Government Procurement Reform Act and its Implementing Rules and Regulations (IRRA 9184)
- Republic Act 9284 brought about major changes in the rules and procedures of procurement. This in effect repealed pertinent provisions in Local Government Code on procurement.
- The Annual Procurement Plan (APP) shall contain all the procurement activities of the agency. It includes all programs, activities and projects that are considered essential in the discharge of its functions.
- All procurement shall be done through competitive bidding.
- Regarding projects all project procurements shall be included in the APP under the heading of Project Procurement Management Plan (PPMP)
- All procurements that include civil works, goods and services are covered by these principles
- Should there be alternative modes of procurement these will be governed by procurement guidelines from donor agencies.
- For procurement of drugs and medicines, the following requirements are to be observed in addition to these prescribed by RA 9184
 - a. Should be listed in the most recent Philippine National Drug Formulary (PNDF) Essential Drug List (Latest Edition Volume I Sixth Edition 2005)
 - b. Specifications in generic form as required in RA 6675 Section II of the Implementing Rules and Regulations
 - c. Bureau of Food and Drug (BFAD) Certification and Licenses
 - Valid and Current License to Operate (LTO)
 - Certificate of Good Manufacturing Practice (CGMP)

- Certificate of Product Registration (CPR)
- Always follow the principles of:
 - Transparency
 - Accountability
 - Equity
 - Efficiency
 - Economy

Reference:

- Updated Budget Operations Manual for Local Government Units – DBM publication
- Philippine National Drug Formulary (PNDF) Essential Drug List Vol.1 Sixth Edition 2005
- Administrative Order 2006-0018: Implementing Guidelines for the Philippine National Drug Formulary. May 8, 2006
- Administrative Order 2006-0009: Guidelines Institutionalizing and Strengthening the Essential Drug Price Monitoring System (EDPMS). February 14, 2006
- RA 6675 Generic Act

3. Human Resource for Health Management and Development (HRHMD)

For DOH-LGU-Inter-LGU cooperation and for coordination to be sustained and evolving, a long term process of institution building and organized learning is necessary. The continuing quest for excellence in health involves strengthening and capability building of skilled human resources through responsive and evolving competency based training program.

DOH through its Health Human Resource Development Bureau has developed a human resource for health management and development system package. This package of assistance is meant to assist LGUs in resolving issues related to human resource.

Through this package, DOH aims to

- Implement advocacy strategies for LGU, to adopt and implement its own human resource for health management and development
- Assist the LGU, in the development and implementation of its own human resource development program based on standards and policies of DOH/HHRDB
- Document such efforts of the LGU

The Human Resource for Health Management and Development package has six systems recommended for installation. The six systems are:

- Human Resource Planning
- Job-related Recruitment and Selection System/Targeted Selection System
- Performance Management
- Training and Development Needs Analysis
- Career Development and Management System
 - Individual Career Planning
 - Career Planning Charting
 - Succession Management

- Retention Planning
- Human Resource for Health Information System

While this system and subsystems are being proposed for adoption by the LGU, the latter may develop their own training plans based on the proposed systems and subsystems. They will be guided/assisted by the Center for Health Development (CHD) through its Human Resource for Health Development unit.

DOH looks at this systems and subsystems as the vehicle for the Fourmula One for Health Professional Development Career Track institutionalization. With the goals of better health outcomes, more responsive health system and more equitable health care financing as its focus, DOH aims to:

- Develop the managerial skills of local health supervisors and improve the technical competencies of field personnel in the medium term
- Expand the professional career paths of qualified local health personnel in the long term
- Develop a pool of career, experienced professionals from the devolved health units for placements in the DOH-Central Office and the CHDs

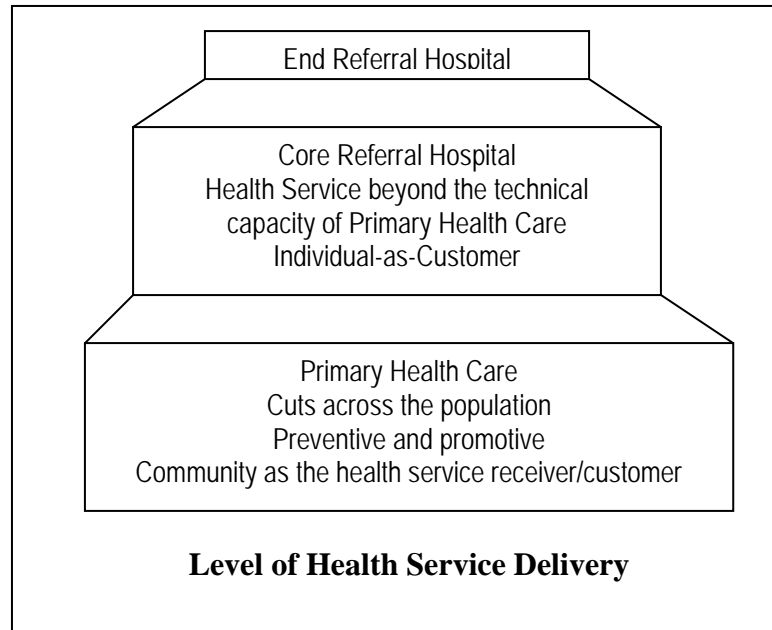
Reference:

- Fourmula One for Health Operations Manual for Convergence Provinces
Implementation of Province-Wide Investment Plan for Health
November 2007 Version 1.1

4. Facility Rationalization Plan

This is a critical subset of the Province-wide Investment Plan for Health (PIPH) that ensures the effectiveness, quality and continuum of health services. It ensures the consumer access to the right service at the right place at the right time. It assures continuing improvement of services through compliance to regulatory standards. It determines the key health facilities where best advantages can be met.

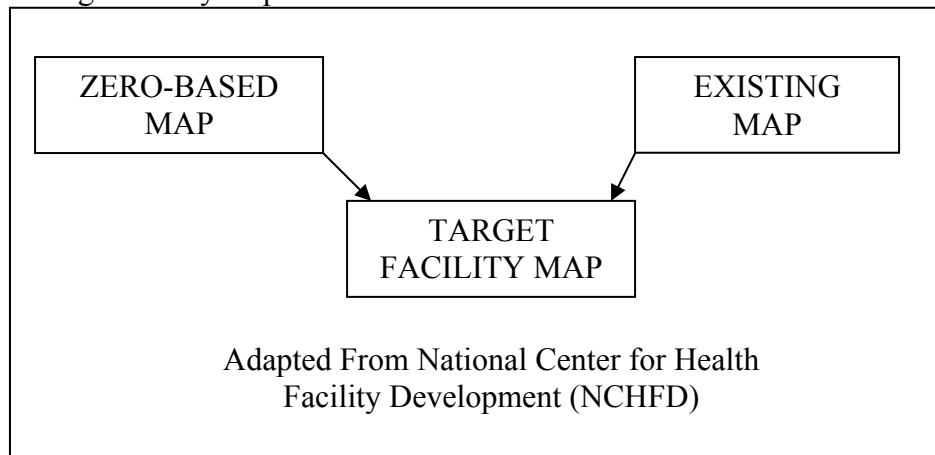
Levels of health service delivery is illustrated:



The Facility Rationalization Plan is:

- Participative, involving the entire network of a local health system starting with the community
- Done within the framework of the economic situation, geography, demography, health status and the political realities of the locality
- Long term (5-10 years) in nature
- In the health context, Formula One For Health
- Towards the goals of better health outcomes, more responsive health system, and more equity in financing, with focus for the poor
- There are several critical steps specific to the Rationalization Planning
 - Health Care needs analysis which is included in the total PIPH
 - Facility Mapping
 - Health Resource Needs Analysis including Facility Needs Assessment and Benchmarking against DOH standards

Facility Mapping exercise consist of drawing up a zero-based map and the existing map towards a target facility map



The existing facility map helps in

- Identification of strategically located health facilities
- Determining size and location of target clients, spot the public health provider network
- Defining service delivery gaps
- Identification of potential facilities to address the gaps
- Developing customized facility maps showing the referral network

The zero-based map

- No existing facilities
- Establish set criteria to situate ideal locations of specific types of facility such as
 - Distance/travel time from the catchment areas
 - Size of catchment population
 - Utilization rate
 - Special consideration for isolated communities and island communities

Reference:

- Administrative Order No. 2006-0029: Guidelines for Rationalizing the Health Care Delivery System Based on Health Needs. June 15, 2006

5. Service Level Agreement

The agreement is between DOH and the Province. It is prepared on an annual basis from 2007-2010. It is the binding mechanism between DOH and the province.

The features of the SLA

- Defines the outputs and expected performance milestones
- Features funds through European Communities grants; DOH counterparts and other funds from the national government.
- States the conditions/requirements for release of said funds
- For the Health Sector Policy Support Programme
 - There are two trenches; fixed and variable
 - SLA will indicate the amount and dates release of fixed allocation
 - 2007 fixed trench is released in two installments
 - For the variable trench the SLA will determine the maximum amount, the amount to be released will be determined by the milestones

See **Annex C** - Service Level Agreement Draft

6. Monitoring and Evaluation for Equity and Effectiveness (ME3)

A series of activities that will track down the implementation phase of the Annual Operation Plan within the bigger framework of the Province-wide Investment Plan (PIPH). The ME3 is formulated along the principle of the Fourmula One for Health. To be undertaken by the Local Implementation Coordinating Team (LICT). ME3 will help the LHSD stakeholders

to follow through the activities and outcomes vis a vis the inputs/resources interplay. The major instrument of the ME3 is the Annual Operation Plan (AOP). The output indicators were identified by the province in the AOP. The Province will design the data gathering methodology.

There are two phases in the ME3. They are the 1) major final output monitoring, and 2) the intermediate performance concerns (outcome monitoring).

Basically, it will highlight the activity and output as against the commodity, fund and other assistance utilization. It will identify the gaps and issues in the plan operation, and ultimately lead to finding the solutions to the issues identified.

In the short term, the ME3 will help decision makers to attend to the identified gaps and problems and institute/provide solutions to them. In the long term, as issues and gaps are identified and resolved, the goals better health outcomes, more responsive health system and more equitable health care financing are achieved.

Output Monitoring:

- Also referred to as program monitoring
- Focuses on the implementation issues, concerns and accomplishments of the PIPH.
- Tracks the progress of the implementation of the programs/projects/activities in the annual operations plan (AOP)

In evaluating the progress, it should be assessed if a) objectives and activities are technically sound; b) resources are adequately and timely provided for; c) implementation (structures and processes) is carried out effectively.

Outcome Monitoring:

- Focuses on measuring the intermediate outcomes
- Provides an overall picture of the level of health performance of the province
- Provides insight on how the different local initiatives or innovations of LGUs contribute to the overall improvement of health within their localities
- Measures how the different interventions expressed as health and health-related inputs, outputs and processes involved at the local level affects the attainment of intermediate and ultimately the final health system
- Links the outputs measured in output monitoring contribute to the overall improvements of the health outcomes in the province

The result of the outcome monitoring can be used by both the local and national government in assessing the current health system models and in developing relevant and appropriate response or support to further strengthen the LGU health system.

Reference:

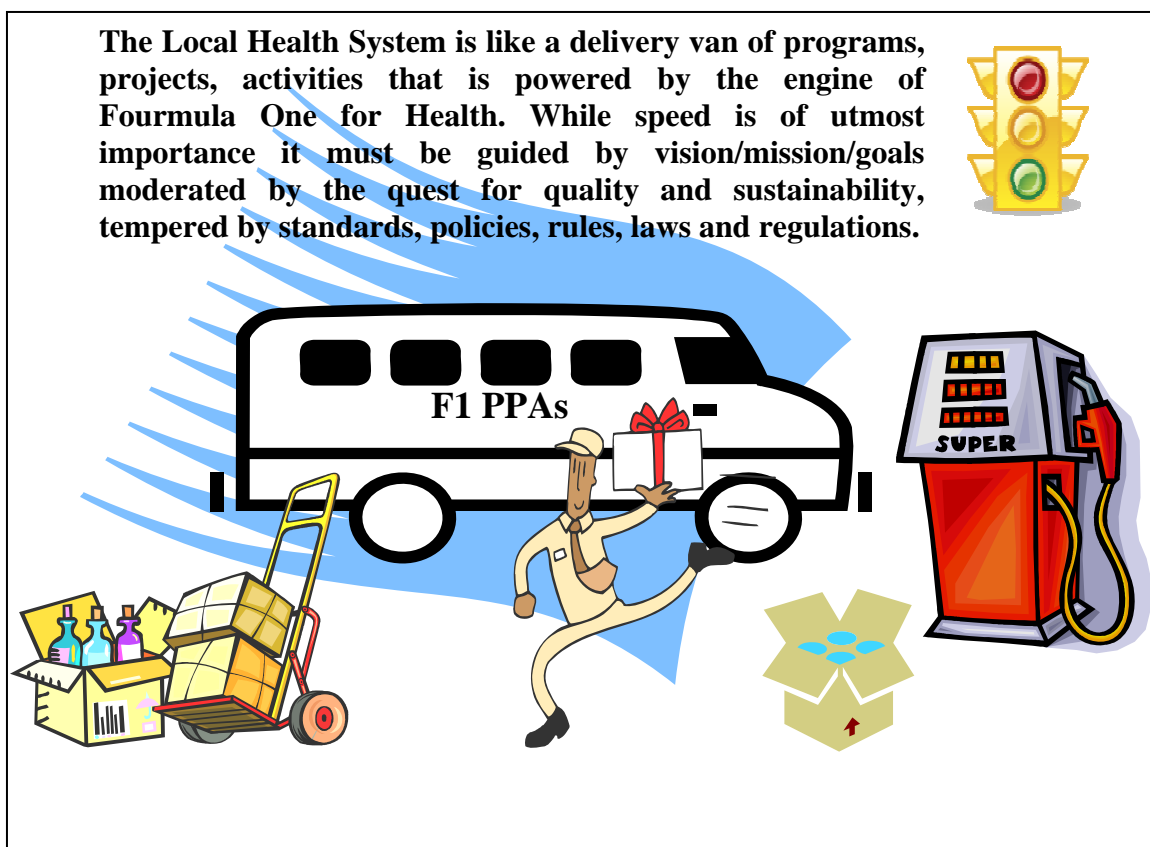
- Fourmula One for Health Operations Manual for Convergence Provinces Implementation of Province-Wide Investment Plan for Health November 2007 Version 1.1

Local Health System Development and the Department of Health

There are variations in health of different localities because of wide variation in population, sizes and densities, poverty incidence, levels of socio-economic development, degrees of urbanization exposure to health risk among others. Variation in health is also affected by the performance of health providers as well as the priorities of governments.

In spite of these variations in health and the factors affecting health, DOH continues to steer the sector to improve the local health status in particular and the national health status in general. Continuous development of LGU led health system is a priority for the Department of Health.

SECTION III.
COORDINATING THE
IMPLEMENTATION OF
HEALTH SECTOR
REFORM



A. Working Together - Coordination A Key to Health Sector Reform Initiatives

In the light of a possible disharmony in the delivery of health services, amidst the challenges, continuing coordination between/among agencies becomes a necessity. Coordination is basically a process of working together harmoniously, putting together all actions for health in one accord in an atmosphere of mutual respect of the boundaries of authority and autonomy towards the goals of better health outcomes, more responsive health system, more equitable health care financing, with focus for the poor.

The paper presents the efforts of coordination along the line of coordination as a process in a network of stakeholders of the community, government agencies, private sector and development partners. It will follow the roadmap of reform concepts with Fourmula One for Health as the engine of development amidst the realities of the roadblocks that may impede the development process.

B. Framework of Engagement for Coordination

All efforts of coordinating the initiatives of the health sector from the DOH to the barangays, the public-private cooperation and development partners shall be done along the framework of engagement for coordination.

1. Shared Vision for Health

The Local Health System is like a delivery van of health goods, services and facilities that is powered by FOURMULA 1 FOR HEALTH. While speed is of utmost importance, it must be guided by vision/mission/goals; moderated by the quest for quality and sustainability; tempered by standards, policies, rules, laws and regulations. In all these endeavors, DOH is an active partner, the steward for HEALTH, sharing the same vision, mission, and goals.

The continuing maintenance and running of the LGU-driven van in the context of Local Health System Development is supported by DOH actions.

2. Autonomous Partner Local Government Unit

The Local Government Unit (LGU) is an autonomous entity responsible to its constituency. Chapter 1 Section 2 of the Local Government Code clearly states that the territorial and political subdivisions of the state enjoy genuine and meaningful local autonomy to enable them to attain their fullest development as self reliant communities. The Local Chief Executive (LCE) exercises general supervision and overall control of all programs, projects, services of the local government.

On the other side of the fence is the Department of Health (DOH), which is the lead agency in health. It is mainly responsible for the development, implementation of national policies and plans, regulations, standards, and guidelines related to the health sector. DOH as the lead agency for health has no administrative or financial authority over the LGU. It is mainly the steward for the health sector.

The tension between the autonomy on one hand and stewardship on the other has created invisible walls and doors between/among provinces, cities, municipalities, and DOH. To breakdown the walls, open the doors is the challenge. Focused, result-oriented and progressive coordination between the LGUs and DOH is an avenue for the continuing partnership for health.

3. Unserved and Underserved Focus

A health system's overriding goal is to improve the health of the entire population throughout one's life cycle from womb to tomb. A health system must be accessible, available and affordable to all sectors of the society.

However, the 2000 Filipino Report Card in the Pro-Poor Services showed that 77% of the surveyed household used health facilities of one type or another. Urban households tended to use health facilities more compared to rural households.

Thus all LGU-DOH collaboration and cooperation shall focus on efforts to reach the unserved and underserved.

4. Diverging Localities, Converging Health Outcomes

The delivery of the basic goods, commodities, services (including health) to a community is largely shaped by the geography of a locality. It is influenced by the culture, traditions, and priorities of the people. Along the way of the delivery developments like urbanization, Overseas Filipino Workers (OFW) phenomenon, environmental concerns, digitalization “cellularization” of communities can post some roadblocks. And further down the road are the political dynamics, capacity and capability of the people and their hierarchy of value.

These are the realities albeit challenges that affect health system. Challenges that confront both the LGU, that delivers the health services; and the DOH that provides the standard policies to support the system.

C. Harmonizing Health Sector Reform Initiatives– DOH Policy Issuances

There are some policy issuances that cover the continuing efforts of the Department of Health (DOH) to attain the goals of better health outcomes, more responsive health care delivery system and more equitable health care financing, in partnership with the local government unit (LGU), the private sector, and other health partners. These are the Health Sector Reform Agenda (HSRA) and the National Objectives for Health (NOH); that later evolved into the Sector Development Approach for Health (SDAH). The latter further evolved into the Fourmula One for Health.

The National Objectives for Health is a statement of the national goals and objectives, summarized as follows:

- Prevention and control of diseases and promotion and protection of health
- Eradication and control of infectious diseases; major chronic illnesses and injuries
- Promotion of healthy lifestyle and health seeking behaviors

The Health Sector Reform Agenda (HSRA) describes the major strategies, organizations and policy changes, and public investments needed to improve the way health care is delivered, regulated and financed. It tackles reform in five areas: local health systems, public health programs, hospital systems, health regulations and health financing. Ultimately these reform will lead to significant improvements in health status through greater and more effective coverage of national and public health programs, to increased access to health services especially by the poor and disadvantaged and to reduce financial burden on individual families.

Executive Order 521, issued on March 22, 2006 directed the Secretary of Health “shall steer the implementation of health reform. He shall formulate the blueprint for implementing health sector reform throughout the country in accordance with the Medium Term Philippine Development Plan for 2004-2010.” Invoking this order, DOH started on the Sector Development Approach for Health (SDAH) as the management approach to make genuine health sector reform happen. It aims to bring about an environment where all significant funding for the sector support the sector policy and expenditure program. The aim is to reduce fragmentation of support of partners and increase impact in health sector development. (See Annex B - Executive Order 521)

DOH adopted SDAH as the vehicle for sector wide approach for health development towards the goals of better health outcomes, more responsive health system and more equitable health care financing with focus for the poor. Some features of SDAH:

- Sector wide approach
- DOH and the attached agencies; PhilHealth, POPCOM, NNC; in the leadership role
- Department of Budget and Management (DBM) and Department of Finance as oversight bodies
- LGU as owner of health program
- Strengthened planning capabilities at the local, regional and national level
- Strengthened leadership, coordination and management
- Harmonized technical assistance (TA) processes and procedures
- Coordinate resources
- Common expenditure program, efficient mobilization and utilization of development assistance fund
- Common monitoring and evaluation for equity and effectiveness (ME3)

Formula One for Health is adopted as the implementation framework for health sector reform. It is designed to implement critical health interventions as a single package, backed by effective infrastructure and financing arrangements.

It applies to the entire health sector, to include the public and private sectors, national agencies and local government units, external development agencies, and civil society involved in the implementation of health reform. This serves/will serve as the framework for health planning at the local government unit.

Section 33 of the Local Government Code of 1991 provides for the cooperative undertakings among local government units. It states, “Local government units may, through appropriate ordinances group themselves, consolidate, or coordinate their efforts, services and resources for purpose commonly beneficial to them.” Based on this mandate the local government units may individually or collectively do some health planning for the delivery of health service to their constituents. (See Annex A)

The planning process may be initiated upon the invitation of the Centers for Health Development (CHD) or upon the initiative of the Local Chief Executive. The CHD and the LGU upon consultation with all sectors will decide if the planning process will be done individually by barangay, city, municipality, province, CHD and private sector. A technical working group (TWG) may be created, with each body sending a representative.

Reference:

- Administrative Order 2007-0038: Adopting the Sector Development Approach for Health (SDAH) in the Implementation of Formula One (F1) for Health. November 15, 2007

D. The Network of Stakeholders

Coordination operates in a network of cooperation and collaboration between/among national, regional and local agencies. Each agency has its own specific roles and functions in a framework of financial, administrative and technical authority. Coordination ensures that the network is a web of efficiency, effectiveness and high level of performance, towards the attainment of the goals of better health outcomes, more responsive health system, and more equitable health care financing with focus for the poor.

The network of stakeholder is composed of:

- Department of Health (DOH)
 - Central Office
 - Center for Health Development (CHD)
 - Field Implementation Management Office (FIMO)
 - Philippine Health Insurance Corporation (PhilHealth)
 - Population Commission (POPCOM)
 - National Nutrition Council (NNC)
- Local Government Units
 - Municipal/City
 - Province
 - Barangay
- Civil Society

- Development Partners
- Consumers/Community

Department of Health

The Department of Health is the lead agency for health, the steward of the health of the nation, with the major mandate to provide national policy direction, national plans, technical standards and guidelines on health.

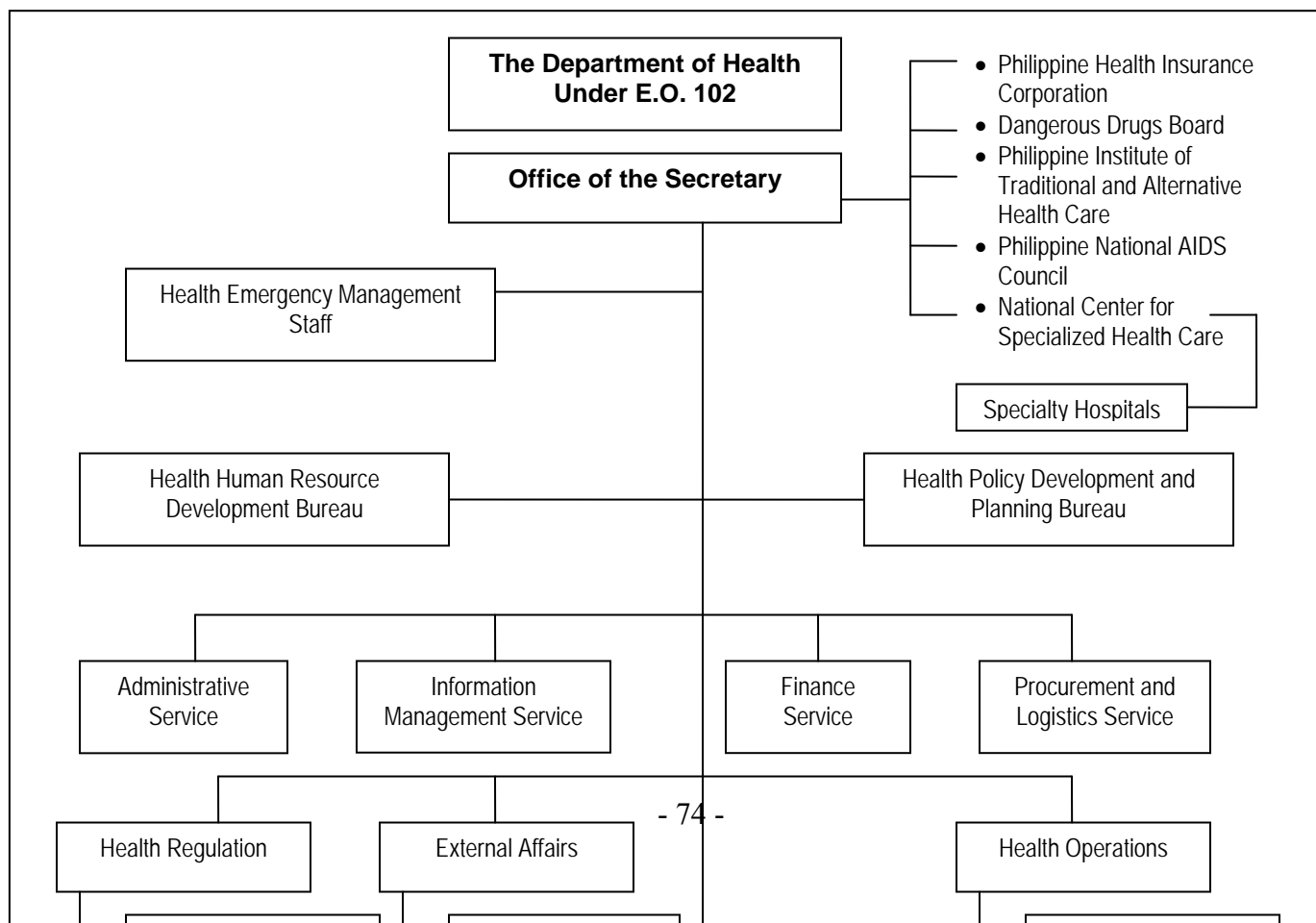
Central Office mainly deals with

- Development and implementation of health policies, standards, rules and regulations that will govern all health efforts to attain better health outcomes, more responsive health system and more equitable health care financing.
- Develop manuals of operation, guidelines that will help partners in health service delivery
- Develop technical assistance packages to capacitate partner agencies
- Act as a leader advocate for health promotion efforts
- Develop and execute DOH budgets
- Create a climate of pursuit of excellence in all levels of health care delivery
- Overall supervision of DOH retained tertiary hospitals
- Administers emergency response services upon the direction of the President in consultation with the LGU concerned
- Regulation/Certification of facilities, resources, authorities providing health services for the people

DOH as the Lead Agency for Health Sector Reform

Department of Health (DOH) and the Attached Agencies:

By the virtue of Executive Order 102 the organogram of the DOH



Centers for Health Development

- Center of knowledge, expertise and influence on local health system development
- Principal regional technical agencies for DOH efforts and support to local health system development
- Bridge between LGU and DOH Central Office; PhilHealth, National Nutrition Council and POPCOM

Field Implementation Management Office (FIMO)

- Will provide strategic leadership, management and coordination of field implementation, consolidation of annual plans and projects
- Leadership in health emergencies
- Oversight monitoring and evaluation, technical supervision, quality assurance of DOH hospitals
- Facilitation of experience exchange
- Elevation to DOH-EXECOM of field implementation issues and concerns

DOH Retained Hospitals

- Core referral or end referral hospital in their respective inter-local health zone
- Participates actively with LGU's efforts in their areas of operation particularly in the establishment of inter-local health zones

Philippine Health Insurance Corporation (PhilHealth)

Health Care Financing is about determining who should pay for what health services so that health care can be adequately provided, efficiently delivered and equitably distributed.

The objective of financing reform under Fourmula One for Health is to secure better, more and sustained investments in health to provide equity and improved health outcomes especially for the poor.

PhilHealth, the Philippine Health Insurance Corporation, is in the forefront of health care financing. It is identified as the major lever to effect desired changes and outcomes

National Health Insurance Program (NHIP) refers to the compulsory health insurance program of the government instituted under Republic Act No. 7875 which aims to implement a universal health insurance system and provide universal access to affordable, acceptable, efficient and effective health care services for all citizens of the Philippines. NHIP is alternatively known as the Medicare Program established under Republic Act 6111.

Some basic PhilHealth functions:

- Continuing enrollment of members
- Accreditation of health facilities/services
- Payment of service providers
- Collection of premiums

Target Population

- Formally employed sector

- Individual paying members
- Informal sectors
- Families of OFWs
- Special Focus for the Poor/indigent

Areas of Concern

- Enrollment/increased enrollment of the indigent to the program
- Ensured budget allocation of LGU for premium counterpart of enrolled indigents to the sponsored program of PhilHealth
- Accreditation of LGU health facilities like RHU, hospitals to PhilHealth according to its set standards
- LGU ensures that these health facilities follow PhilHealth standards
- PhilHealth ensures release of capitation fund and reimbursement based on set criteria
- LGU ensures rational use of capitation and reimbursement funds

Population Commission (POPCOM)

- Coordinate the national population management policy and program to support identified priorities in local health system development

National Nutrition Council (NNC)

- Coordinate national nutrition policies and programs to support identified priorities in local health system development

Local Government Units (LGUs)

- Front liners in the race to achieve better health outcomes through a more responsive health service delivery
- Form the core of service delivery force that is available and accessible to all members of the community especially the poor
- Ensure that the basic essential health service packages are being delivered to its constituents
- Organize themselves to Inter-Local Health Zones that will integrate the implementation of Fourmula One health reform strategies.
- Enact the necessary legislative issuances (ordinance, resolutions, etc.) in support of Fourmula One implementation at the local level.
- Provide counterpart funds for implementing and sustaining their investment plan
- Promote and advocate for the implementation of Fourmula One as the health sector reform implementation framework in their respective localities.

Municipal Government/Municipal Health Office (MHO)

- First contact point in the chain of service delivery including acute and emergency care, chronic care, rehabilitative care
- Focus on disease prevention and control strategies like disease surveillance, case findings, immunization, information education and advocacy campaigns among others.

Provincial Government/Provincial Health Office (PHO)

- Focus on the curative health care requiring 24-hour health attendance

- Operates within the framework of accepted Clinical Practice Guidelines (CPG) or diagnostic related groups (DRG)
- Serves as a steward of health in the province
- Facilitates and coordinates all health and health related efforts between/among municipalities and cities even between provinces
- Assumes the technical leadership in all health matters cutting across boundaries in the province

Civil Society

- Health provider
- Provides feedback – positive and negative
- Assistance in terms of health goods, funds, and other services
- Assist the DOH and the LGUs in achieving desired health objectives.
- Help point out people's health needs, particularly those of the vulnerable groups and bring to the attention of the LCEs and/or LIC Teams such felt needs.
- Contribute towards enhancing the equity, accountability and transparency of Fourmula One Implementation at the Four-in-One Convergence sites.

Development Partners for Health

The daunting task of steering the highly decentralized and fragmented local health system in the midst of declining health budget requires innovative approaches, creative solutions and new capacities. The health sector operation is basically funded by the national and local government budgets, social health insurance, out of pocket monies. This is further augmented by external assistance both financial and technical.

The Community

The community has many faces. It can be a partner/ally in all health efforts to achieve the goals of better health outcomes, more responsive health system and more equitable health care financing. It can assume the face of a critic in the ways and means of the health care delivery to the community. It can be an advocate giving valuable health assistance to information and advocacy campaigns. At any given time the community can be an individual, a couple or a family or household. The community may access the health service in the form of a preventive service like pre-natal or immunization, or as a patient seeking treatment for cough and cold, or an individual seeking advice on promotive health care like a healthy lifestyle.

Besides being a consumer of health goods, services and facilities, the community can also be another health provider.

In all these, the community is exercising its basic right to health

Community participation in the network of coordination is viewed from the following perspective:

- The community as a provider of health services at household level
- The community as a support group and forming group of health advisers/counselors like a diabetes club: senior citizen group
- Community participation in the form of membership in the local health board, thereby participating in the discussions, decisions about health
- Participate in monitoring the local health system, operation and development.

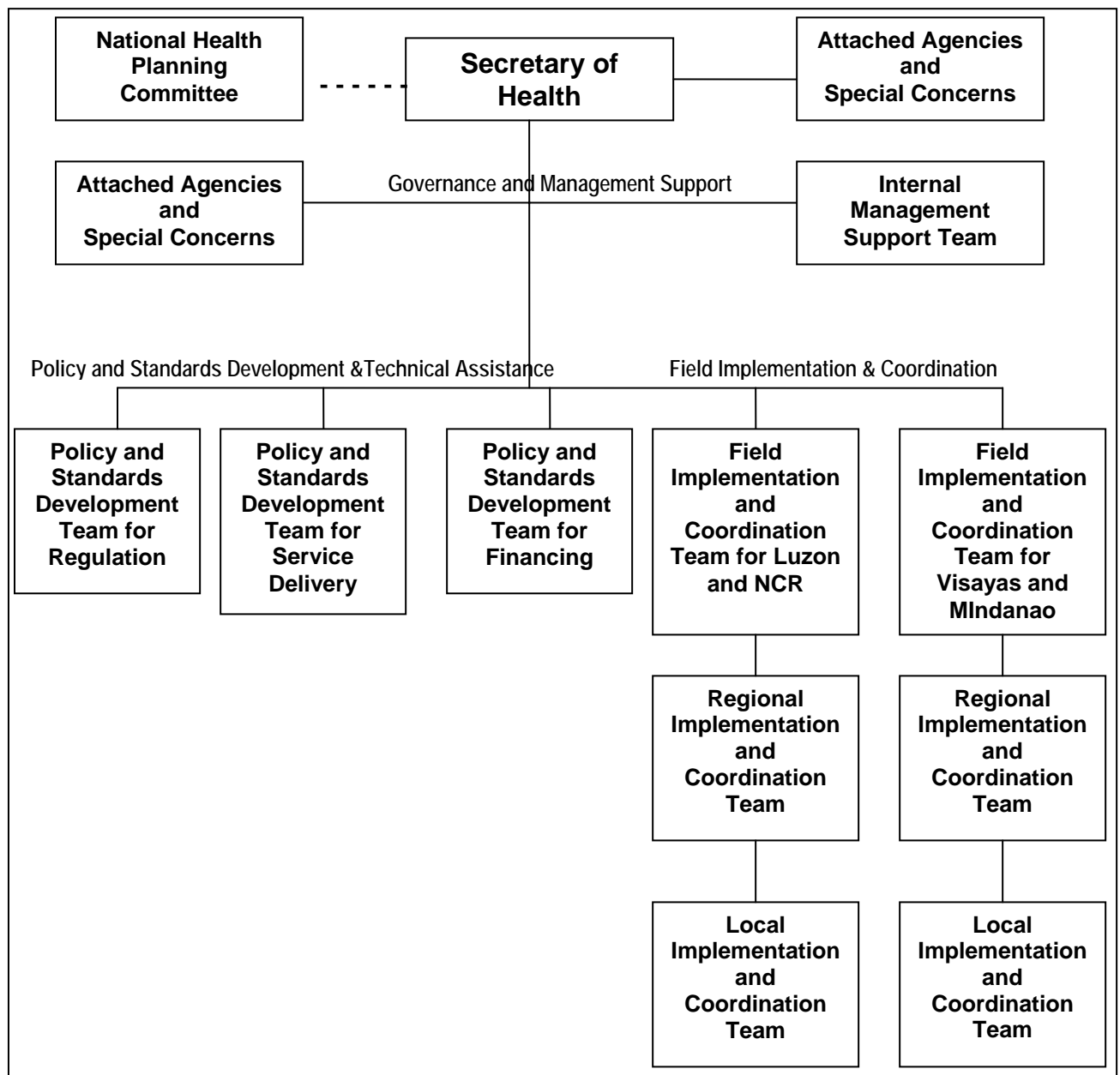
- Empowered they can become very powerful partners in health

Reference:

- Administrative Order No. 2005-0023: Implementing Guidelines for Fourmula One for Health as Framework for Health Reforms. August 30, 2005
- Administrative Order No. 2006-0020: Guidelines for Evaluation of Consumer Participation Strategies in Fourmula One for Health. June 13, 2006

E. Managing the Health Sector Reform Implementation – DOH Functional Management Arrangement

By the virtue of DOH Department Personnel Order 2005-1862, for the implementation of Fourmula One for Health at the DOH level the following functional Management Structure was adapted:



1. The **Secretary of Health** is the overall lead in the nationwide implementation of FOURmula One for Health.
2. The **Executive Committee (EXECOM)** provides policy directions for implementing Fourmula ONE for Health. The EXECOM is chaired by the Secretary of Health and composed of all undersecretaries, assistant secretaries, the President and Chief Executive Officer of PhilHealth, and selected Directors in the DOH.

3. The **National Steering Committee for Health (NSCH)** acts as the overall coordinating body to oversee and ensure adherence by all concerned stakeholders to a comprehensive, integrated and strategic policy framework and plan for health. In particular, the NSCH shall perform the following specific functions:
- Provide strategic directions to enhance implementation of health reform policies and strategies
 - Strengthen partnership among stakeholders particularly the Local Government Units (LGUs), concerned NGAs, NGOs, private sectors and civic groups under the SDAH framework
 - Mobilize resources to implement and institutionalize critical programs, projects and activities both at the national and local levels as embodied in their respective Investments Plans; with the end-view of further enhancing local government capability, responsibility and accountability relative to the delivery of basic health services
 - Assess and evaluate overall progress of implementation as well as the performance of stakeholders
 - Perform other functions as may be deemed necessary by the NSCH Chairperson

The NSCH is composed of:

Chairperson: Secretary of Health

Vice-Chairperson: Secretary of the Department of Interior and Local Government

Members:

Secretary of the Department of Budget and Management

Director General of the National Economic and Development Authority

President and Chief Executive Officer of Philippine Health Insurance Corporation

President, League of Provinces of the Philippines

President, League of Municipalities of the Philippines

President, League of Cities of the Philippines

One (1) representative from Non-Government Organization (NGO)

One (1) representative from a private sector/professional organization

World Health Organization Country representative (as a representative of development partners)

4. As shown in the previous figure, Fourmula ONE for Health at the national level is organized into three (3) major clusters with their respective component teams:

- **Governance and Management Support Teams** – Two teams assist and provide support to the Secretary of Health in the governance and management of Fourmula ONE for Health, operating directly under the Office of the Secretary:
 - a. The **Sectoral Management and Coordination Team (SMCT)** ensures that all four thrusts of Fourmula ONE for Health are effectively coordinated, synchronized, and properly monitored.
 - i. This team consists of the:
 - Health Policy Development and Planning Bureau (HPDPB)
 - Bureau of International Health Cooperation (BIHC)
 - Bureau of Local Health Development (BLHD)
 - Health Human Resource Development Bureau (HHRDB)
 - ii. This team's counterpart offices in PhilHealth are:
 - Corporate Planning Department (CPD)

- Foreign Assistance Coordinating Office (FACO)
 - iii. The SMCT is responsible for the overall development, monitoring and coordination of policies, mechanisms and guidelines for the health sector, encompassing financing, regulation, service delivery and governance concerns as approved by the EXECOM. This includes concerns in rationalizing public subsidies in health and the management and implementation of the needed DOH budget reform required in the course of implementation of Fourmula ONE for Health.
 - iv. The SMCT also coordinates and manages inputs to the Field Implementation and Coordination Teams from the other Fourmula ONE for Health management teams concerning policies, standards and technical assistance related to financing, service delivery, regulation, and governance.
- b. The **Internal Management Support Team (IMS Team)** is responsible for implementing DOH financial, procurement and logistics management reform, including building the information and communication technology infrastructure and other management support service.
 - i. This team is composed of the:
 - Finance Service (FS)
 - Materials Management Division (MMD-PLS)
 - Information Management Service (IMS)
 - Administrative Service (AS), including Legal Service (LS)
 - Central Bids and Awards Committee (COBAC), including Procurement Division (PD-PLS)
 - ii. The Internal Management Support Team focuses on the administration of the DOH's finance and logistics management, and oversees the development of information and communication technology (ICT) requirements of Fourmula ONE for Health implementation.
 - iii. As a special committee, the COBAC, including the Procurement Division-PLS oversees the procurement management reform.
- **The Policy and Standards Development and Technical Assistance Teams (PSD Teams)** focuses on the provision of technical guidance and policy support for implementation at the field level. A Policy and Standards Development Team for each major function is assigned to develop policies and standards, and provide technical assistance to field level implementation in areas of regulation, service delivery, and financing.
 - a. **The Policy and Standards Development Team for Health Regulation (PSD Team for Regulation)**
 - i. The PSD Team for Regulation consists of the:
 - Bureau of Food and Drugs (BFAD)
 - Bureau of Health Facilities and Services (BHFS)
 - Bureau of Health Devices and Technology (BHDT)
 - Bureau of Quarantine (BOQ)
 - Project Management Unit for Pharma50 (PMU50)
 - ii. The PSD Team for Regulation exercises its mandate and function to ensure the quality and affordability of health products and services. This pertains to the development of policies, standards and guidelines, as well as technical

capability for regulating health products, including drugs and medicines, and health facilities and services, in tandem with the accreditation and quality assurance systems of PhilHealth.

- b. **The Policy and Standards Development Team for Health Service Delivery (PSD Team for Service Delivery)**
 - i. The PSD Team for Service Delivery consists of the:
 - National Center for Disease Prevention and Control (NCDPC)
 - National Epidemiology Center (NEC)
 - National Center for Health Facility Development (NCHFD)
 - National Center for Health Promotion (NCHP)
 - Health Emergency Management Staff (HEMS)
 - Philippine National AIDS Council (PNAC) Secretariat
 - Population Commission (PopCom)
 - ii. The PSD Team for Service Delivery ensures the development of policies, standards and guidelines for health programs and the provision of technical assistance to health service providers. This shall include development of disease surveillance systems, program design for essential health packages and specialized health services, health promotion and advocacy, and upgrading of health facilities, among others.
- c. **The Policy and Standards Development Team for Health Financing (PSD Team for Financing)**
 - i. The PSD Team for Financing is led by the Philippine Health Insurance Corporation (PhilHealth) and works with the Health Policy Development and Planning Bureau (HPDPB) of the DOH for purposes of coordinating health policy and planning.
 - ii. The PSD Team for Financing ensures that the NHIP is further strengthened by expanding social health insurance coverage, improving benefits, and leveraging provider payments on quality of care.
 - iii. The PSD Team for Financing coordinates with the PSD Team for Regulation with regards to the harmonization of regulatory systems and processes.
- **The Field Implementation and Coordination Teams (FIC Teams)** focus on the Fourmula ONE for Health implementation and coordination in their respective geographic assignments – one for Luzon and NCR and one for the Visayas and Mindanao.
 - a. The FIC Teams provide over-all coordination of the Centers for Health Development (CHDs), PhilHealth Regional Offices (PROs), POPCOM Regional Offices and retained DOH health facilities in their area. Each team also initiates and maintains the development of the regional coordinating facility involving government health offices such as the DOH-CHD, PRO, and the POPCOM Regional Office, other government agencies, NGOs, the private sector and other stakeholders at the regional level.
 - b. The FIC Teams oversee and coordinate implementation of Fourmula ONE for Health in partnership with the LGUs, the private sector and other government agencies, in consonance with the principle that reform implemented and operated in a decentralized manner brings results closer to the people.

- c. The FIC Teams deal with technical supervision and coordination of the implementation activities of Fourmula ONE for Health at the local level, specifically, development of FOUR-in-ONE Convergence Sites and institutionalization of LGU governance management structures.
 - d. The FIC Teams promote and ensure the quality of the services provided for by the DOH retained hospitals in support of, and within, the context of local health system development.
5. As shown in the figure above, the LICT shall collaborate closely with the Field Implementation Office through the Regional Implementation Coordination Teams. More specific functions of the FICO and the RICT are as follows:

Field Implementation and Coordination Office (FICO)

- A Field Implementation and Coordination Office headed by the Undersecretary/Assistant Secretary are established to provide overall coordination and technical supervision of the implementation of F1.
- As the over-all coordination in the area, FICO undertakes the following activities:
 - a. Organization of Regional Implementation and Coordination Teams (RICTs) in each of the region;
 - b. Conduct of periodic RICT meetings to monitor progress of F1 implementation;
 - c. Development of a mechanism for RICTs to institutionalize participation of other government agencies, non government organization (NGOs) and the private sector and other stakeholders, for the comprehensive and efficient implementation of Fourmula One in their areas; and
 - d. Development of systems to ensure that all policies, plans and programs of all health actors and stakeholders in their area contribute relevantly to the fulfillment of F1 goals and its flagship programs, projects and activities for service delivery, financing, regulation and governance.
- The FICO oversees and coordinates implementation of Fourmula One in consonance with decentralization through the:
 - a. Development and implementation of the following policies, plans, programs relevant to political and socio-economic conditions in their area, and targeted to specific health players and stakeholders in their area:
 - i. Consolidated Area/Regional Investment Plan for Health to support F1 Convergence Sites and Roll-Out Sites
 - ii. Communication/Advocacy Plan
 - iii. Consolidated Area Human Resource Development Plan
 - iv. Consolidated Area Policy and Research Agenda
 - v. Documentation on Best Practices (e.g. role of NGO/civil society)
 - vi. Consolidated Area Monitoring and Performance Evaluation Reports
 - vii. Consolidated Area Rationalization Health Facilities Plan
 - viii. Consolidated Area Technical Assistance Packages
 - b. Identification of core roles and responsibilities of other government agencies, LGUs, NGOs, private sector and other stakeholders for the accomplishment of F1 goals in the area; and
 - c. Ensuring the execution of Memoranda of Agreements (MOAs), Memoranda of Understanding (MOUs) or such similar instruments to be consistent with the plans and activities of all health players for F1 in the area.

- The FICO ensures quality of service provided by DOH retained hospitals in the context of local health system development, specifically:
 - a. Developing a plan that would rationalize current and future hospital service delivery involving public and private hospitals in each region, consistent with mandated requirements on rationalizing health facilities;
 - b. Ensuring that all public and private hospitals in their geographic assignment are licensed and accredited, and acquire all existing and appropriate quality seals;
 - c. Ensuring an effective referral system at all levels of health care thru an integration of hospital and public health package of services in their area.
- For an effective technical supervision of the implementation of F1 activities, the FICO shall:
 - a. Define and develop technical assistance (TA) packages for specific F1 convergence site development tasks, institutionalization of LGU governance management structures, and other TA packages required for F1 in their area. TA package may be in the form of training modules (face to face or web based), study tours, protocols for structured field supervision, educational publications, and other forms appropriate to the geographical areas;
 - b. Develop capacity of RICTs to deliver such TA packages to LGUs through the LICTs;
 - c. Implement a monitoring and evaluation system on performance of RICT teams, which includes quarterly progress report to the stakeholders and other partners; and
 - d. Make important decisions and take necessary actions to promptly and effectively carry out F1 implementation activities. The FICO head may determine important matters that require actions/decisions by EXECOM, and/or the Secretary of Health with the concerned officials or key staff within the DOH as well as other government agencies. A quarterly Progress Report shall be submitted by the FICO Head and/or as necessary to the EXECOM.

Regional Implementation and Coordination Teams (RICTs)

- RICTs shall be headed by the Undersecretary or Assistant Secretary of the concerned regional area.
- The RICTs shall be composed of all heads of DOH-CHDs, Medical Centers and Regional Hospital, PhilHealth Regional Officers (PROs), POPCOM and NNC, and other government agencies, LGUs, NGOs, private sector and civil society in the region.
- The CHD director of the region shall be the co-chair of the RICT.
- The roles and responsibilities of the RICTs shall include the following:
 - a. Ensure development and implementation of programs and activities based on defined F1 flagship programs particularly in F1 convergence sites and roll-out sites;
 - b. Ensure provision of technical and manageability capability to all LGUs, NGOs and other health players in the region based on a defined package of health support services by regional personnel;
 - c. Develop strategies to ensure that all health facilities, products and services within the region are licensed and accredited with quality seal;

- d. Develop a mechanism or regular venue for participation of all health players in the region for the regional planning, budgeting, monitoring activities, performance evaluation, and other relevant activities;
- e. Ensure that performance of each LGU in the region are monitored and evaluated using the LGU scorecard;
- f. Develop institutional incentives and other mechanisms to sustain quality performance in the delivery of health care services;
- g. Conduct studies on the market, health need requirements of the population served by DOH hospitals; effective and efficient development of DOH hospital rationalization plan;
- h. Ensure successful and timely completion of all F1 reform implementation in F1 convergence sites in the region; and
- i. Facilitate development of F1 Roll out strategy Plan in coordination with other DOH units.

Reference:

- Fourmula One for Health Operations Manual for Convergence Provinces Implementation of Province-Wide Investment Plan for Health November 2007 Version 1.1
- Administrative Order 2005-0023: Implementing Guidelines for Fourmula One for Health as Framework for Health Reform. August 30, 2005
- Administrative Order No. 2006-0020: Guidelines for Evaluation of Consumer Participation Strategies in Fourmula One for Health. June 30, 2006
- Administrative Order 2007-0037: Creation of the National Steering Committee for Health (NSCH)

F. Coordinating the Health Sector Reform Initiative, Processes, Coordinators, Flow of Activities and Other Concerns

The process of coordination is continuing, open, progressive, result/output oriented, focused with common framework and sustained. There is an open line of communication, mutual respect between/among coordinating bodies working towards a common goal and objective. Book 1 Section 3 (k) of the Local Government Code states “the realization of local autonomy shall be facilitated through improved coordination of national government policies and programs and extensions of adequate technical and material assistance.”

These are instruments of unity in an otherwise fragmented system.

- Consultation is the process of coordination whereby the stakeholders for health can/may ask each other or seek each other’s opinion/advice in some health/health related issues/concerns. This process can also be an avenue for classification of some mutual concerns
- Dialogue – basically a conversation or process where two or more persons sit down and discuss/talk about health situation, problems, gaps in the health system. Maybe formal or informal.

- Meetings/focus group discussion – it is usually a formal process with a specific agenda and topics for discussion. The agenda may be for information, resolution of issues, planning for planning, information, education or advocacy. There is a facilitator/moderator to guide/put in focus the discussion. Or a chair is elected/appointed to lead the meeting. A secretary to take notes/minutes of the meeting is also needed. The minutes/summary of the meeting is provided to the participants in the meeting.
- Training/workshop – usually conducted to develop the knowledge, attitude/skills among the participants. It is guided/framed by general/specific objectives, methodology and schedule, and expected output. At the end of the process it is expected that a critical mass of personnel has acquired the expected knowledge, attitude and skills.

At any given time, the coordination of all health efforts may result into report of health situation, planning for health/health plan, policy proposals/recommendations, development of manual of operations for any of the pillars of the Fourmula One for Health. It may also be an avenue for information, education and advocacy for health/health campaigns.

Through these processes of coordination the efforts for health reform will be progressive, focused and result-oriented.

The process of coordination may result in any one of the following: manuals/development of manuals; policy proposals/recommendations; health situation; critical mass of trained personnel and/or advocates; or health plans

The Coordinator - Person Responsible For Coordination

Any of the following personalities may be assigned as point person for coordination

- Local Reform Implementation Coordinator (LRIC) per Program Technical Assistance to Health Sector Policy Support Programme
- DOH Representatives (DOH-Rep) assigned in the provinces, cities, municipalities
- Provincial Health Team Leader (PHTL)
- Any member of the CHD from the Director down to the line of organization
- Technical Consultants (time bound)

Walking the Talk of Coordination

a. At the Center for Health Development (CHD)

- Courtesy Call to the Director of the CHD
- Purpose of call/visit
- Gets the perspective of the Director in the Formula 1 For Health: Local Health System Development in the region and the province
- Specific instructions/directions from the Director
- Meeting with CHD Management Team upon request or upon invitation of the Director
- Director may appoint the contact person/s in CHD
- Request for CHD documents like
 - CHD Annual Report
 - CHD Annual Operation Plan/Budget
 - Regional Health Situation

Output:

1. Letter of introduction/Office order to province of assignment
2. Perspective of the region health situation vis a vis province of assignment
3. Line of communication/delineation of functions/duties and responsibilities identified, processed and established.

This introduction process shall take place within a period of one to two weeks.

b. At the Local Government Unit**Province/City/Municipality**

- Courtesy Call with letter of introduction or office order or both of them from the CHD
- State purpose of visit/call
- Get the Local Chief Executive perspective in the status/progress of the local health system development; the existing LGU/DOH interaction/relationship; inter-LGU cooperation/collaboration especially on health matters
- Request for letter of introduction to the different offices of the LGU with permission to access the following:
 - Annual Operation Plan/Budget
 - Province-wide Investment Plan for Health
 - Annual LGU Accomplishment Report
 - With special focus in health
- Network of offices to visit:
 - Vice Local Chief Executive
 - Sanggunian member especially on health
 - Members of the LHB

c. Other Government Agencies:

- Philippine Health Insurance Corporation (PhilHealth)
- Population Commission (POPCOM)
- National Nutrition Council (NNC)
- Tertiary Core Hospital
- Provincial Hospital
- District Hospital
- Barangay Health Station (BHS)
- Rural Health Unit/Health Center

In all these facilities request will be made for:

- Accomplishment Report
- Problem/Issues
- Referral System
- Other documents per need basis

d. Community

- People's Organization
- Non-Government Organization

At any given time, coordination may mean:

- Advocacy for health
- Facilitator/moderator in meetings, dialogues, orientation sessions, seminars
- Conduit of information exchange between CHD, LGU
- Conduit of technical assistance from CHD to LGU
- Catalyst of local health system development
- Gate keeper of actions/efforts between CHD and LGU
- Storehouse of best practices, success stories, failed efforts in the locality

Output:

- Connectivity with LGU/other government agencies / People's Organization/community established
- Perspective of local health situation: local health system is obtained
- Coordination embedded in LICT/LHB/ILHZ

Pointers for Coordination

For coordination to be progressive/result-oriented, reflection, action and reflection are needed.

Before Coordination:

- Decide on the purpose of coordination activities
- Decide on the subject matter for discussion or resolution
- Identify issues and concerns to be resolved
- Reflect and analyze on the above

During Coordination:

- Introduction
- State purpose or reason for the visit
- Listen more, talk less, take notes
- Listen for undertones
- Be explicit, clear, concise
- Be friendly, diplomatic, non-threatening, not imposing
- Before ending the coordination, recapitulate or summarize what transpired in the meeting.

After the Coordination:

- Write a complete report with recommendations if required or needed
- Report submitted to CHD

Feedbacks:

- Should be timely
- Should be evidence based
- Should be specific and focused in the issue, concern, needs

Two Notebooks

To make the coordination process progressive, focused, result-oriented it is suggested that there will be

- The Agenda
- The Compendium

The AGENDA

- Planned activities for the month
- People to see and meet
- Facilities to visit
- Purpose of the activities
- Result/Output of the activities
- Will be by days, by weeks

The COMPENDIUM

- A compilation of experiences, activities, initiatives meetings and other efforts to attain the health goals.
- Compilation of success stories, best practices, failed efforts that will be fed back to CHD, LICT, LHB
- Compilation of issues and concerns
- Reference materials, agenda for meetings
- May be in picture

G. The Roadblocks and Overcoming Them

Along the road of local health system development, roadblocks are inevitable and unavoidable. These obstacles are the challenges that development partners, DOH-LGU, private and other public sector face in the quest for the attainment of the goals of more responsive health systems towards better health outcomes through more equity in health care financing. Some of these roadblocks are:

- Political dynamics in the LGU
- Availability of resources
- Management capacities
- Resistance to change
- Environmental concerns

The local government unit operates along the spectrum of interaction between the executive body in one end and the legislative body in the other end. The executive body directs and operates the delivery of goods and services to its constituents at the same time managing the bureaucracy like the revenue collections, fund mobilization and utilization. On the other hand, the legislative body – municipal/city, provincial – councils take care of the enactment of ordinances including the budget that form the framework along which the government operates, thus enabling desired health sector policies to operate. In the process of the budget

preparation, submission to the legislative council to the enactment of the budget ordinance down to approval and finally execution, a lot of give and take dynamics may take place; and political agendas somehow affect the executive legislative agenda. Some health program/projects may be adversely affected. Some funds for health may be used for activities short in health outcome but long in political sound bites. (Ex: free clinics)

It is a fact that some if not most local government units operate on an annual budget. As such, there are instances when many programs/projects and services compete for the meager resources. Lack of funds is a common enough reason for non-delivery of basic services (what is needed is long-term investment planning which a PIPH can bring about).

Along the same reason of lack of funds are the lack of road infrastructures, facilities, equipment and transport system which impede development in the locality. Environmental concerns like pollution and deforestation form another roadblock.

These are but some of the many roadblocks along the avenue of health service delivery. The function of coordination is to work through this maze of obstacles to forge collaboration between and among partners. However, even among the partners/stakeholders, there are also hidden agenda that can hinder effective coordination and collaboration.

Lack of defined roles and functions, can also be a roadblock. Coordination is meant to pave the way for harmonized, seamless relay of activities toward the goal of effective health service delivery. Therefore, it is imperative that coordinating bodies are conscious of the relay and knowing when and where its role and function ends and another begins. There are many stakeholders in the delivery system as there are many agenda. Coordination efforts may get lost in the din of voices and network agenda.

The roadblocks can be overcome by:

1. Informed and Enlightened Public Support

The people are major stakeholders in health. In all health endeavors the community is a vital partner. The public must know their responsibility in all health efforts. Their role especially in disease transmission, prevention, and control is critical. Public support is a vital determinant from policy, program and project development to implementation.

Community-based approaches owned by the people empowers them and therefore assure the sustainability of health activities.

Thus informed and enlightened public support must be actively pursued, nourished, and nurtured in any LGU-DOH coordination.

2. Connectivity Between/Among Partners maybe Formal or Informal

This is the continuing pursuit of an open line of communication between/ among partners. It may be along a vertical line or a horizontal line. It may be formal or informal. In this framework of engagement, the vertical line follows a formal set up since this will be dealing with relationship from the appointing authority down the line of supervision. This deals mostly with administrative concerns. The horizontal line of connectivity is between and among the people working on the ground, from the people receiving the service to the people

providing the service directly or indirectly. It is an endeavor that maintains an open line of communication in an atmosphere of objective non-judgmental listening, keen observation and pro-active actions.

3. Facilitative and Enabling Actions

The process of coordination involves any or a combination of consultation, orientation, seminars, dialogues, meetings, focused group discussion among others. These activities provide avenues for interaction between and among members of the community. They provide opportunities for identification of health issues and concerns and factors affecting these concerns. Through all these processes the community is enabled to change from observer/receiver to be one of the active participants or even leaders in the attainment of health objectives.

On the other hand, coordination processes operate along a two-way street. DOH also learns from local community experiences. These experiences the DOH can/may explore and exploit for the greater good of all partners concerned.

4. Informed Gate keeping

Autonomy somehow created invisible doors and walls, between/among communities, between local government unit and central agencies. As LGUs continue to pursue self-reliance, the delivery of health services continues. But over the emerging and re-emerging diseases (TB, HIV-AIDS, Meningococemia, SARS), lifestyle changes, environmental degradation, and poverty. These problems/challenges know no walls or doors. These are the realities on the ground.

Coordination between/among LGUs, DOH and LGU entails a lot of gate keeping efforts. For gate keeping to be successful, a lot of listening, observing, and action is needed. But all these must be based on facts, evidence based knowledge and fingertip knowledge of the regional, national and local health situations.

H. Directing Health Sector Reform – The Cascade of Policy Issuances

As DOH continues to steer the health system of the country, definite courses of actions are pursued, to guide and direct present and future actions for health. Policies in support of the health system goals, are formulated, developed and implemented. These policies are guided by international policy declarations, national laws, executive orders and administrative orders. It must be emphasized that the Philippines is an endorser/participant/advocate to all these policy support papers, using them as framework for major policy issuances.

Below are some example of policies that guide and direct the DOH in directing and steering the health system in the country:

1. Millennium Development Goals (MDG)
2. Paris Declaration on Aid Effectiveness
3. Medium Term Philippine Development Plan (MTPDP)
4. Abstract of the Philippine Health Laws
5. Executive Orders (EOs)
6. Other Issuances
7. Administrative Orders (AOs)

1. Millennium Development Goals (MDG)

In September 2000, at the United Nations Millennium Summit, world leaders agreed to a set of time bound and measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. Placed at the heart of the global agenda, they are now called the Millennium Development Goals (MDGs). The Summit's Millennium Declaration also outlined a wide range of commitments in human rights, good governance and democracy.

At the International Conference on Financing for Development in Monterrey, Mexico, earlier this year, leaders from both developed and developing countries started to match these commitments with resources and action, signaling a global deal in which sustained political and economic reform by developing countries will be matched by direct support from the developed world in the form of aid, trade, debt relief and investment. The MDGs provide a framework for the entire UN system to work coherently together towards a common end. The UN Development Group (UNDG) will help ensure that the MDGs remain at the centre of those efforts. On the ground in virtually every developing country, the UN is uniquely positioned to advocate for change, connect countries to knowledge and resources, and help coordinate broader efforts at the country level.

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop global partnership for development

2. Paris Declaration on Aid Effectiveness

On March 2, 2005, (91) countries, which includes the Philippines, 26 multinational agencies and 14 civil society organizations, come out with a policy statement on aid effectiveness.

The declaration has five (5) equally important pillars:

- Country ownership
- Alignment with country strategies and priorities

- Harmonization among development partners and with country systems
- Managing for results rather than inputs and outputs
- Mutual accountability

3. Medium Term Philippine Development Plan (MTPDP)

This is the Philippine policy paper that guides the development and implementation of the national development plans, programs, strategies for pro-poor economic development and growth. It mainstreams the Millennium Development Goals (MDGs) and affirms the country's commitment to the said goals.

Among the plan's priority goals in health are the following:

- Child health and nutrition will be given greater emphasis with the "Bright Child Campaign"
- Micronutrients supplementation will be vigorously pursued
- Public health programs to curd and prevent major illnesses
- Provisions of Affordable Medicine
- Primary prevention on drug addiction through advocacy and IEC activities, as well as secondary (treatment) and tertiary (rehabilitation) care services will be established in all regions

4. Philippine Health Laws

Promotive Programmes/Services

a. Specific disease and conditions

- Republic Act No. 9288 – An Act Promulgating A Comprehensive Policy and A National System for Ensuring Newborn Screening
- Republic Act No. 8504 – An Act Promulgating Policies and Prescribing Measures for Prevention and Control of HIV/AIDS in the Philippines, Instituting a Nationwide HIV/AIDS Information and Educational Program, Establishing a Comprehensive HIV/AIDS Monitoring System, Strengthening the Philippine National AIDS Council, and for Other Purposes
- Republic Act No. 7885 – An Act of Advance Corneal Transplantation in the Philippines, Amendment for the Purpose Republic Act No. 7170, otherwise Known as the Organ Donation Act of 1991
- Republic Act No. 8191 – An Act Prescribing Measure s for the Prevention and Control of Diabetes Mellitus in the Philippines, Providing for the Creation of a National Commission on Diabetes, Appropriating Fund therefore and for Other Purposes
- Republic Act No. 7846 – An Act Requiring Compulsory Immunization Against Hepatitis B for Infants and Children Below Eight (8) years old
- Republic Act No. 124 AN Act to Provide Medical Inspection of Children Enrolled in Private School, Colleges and Universities in the Philippines

b. Surveillance Over Quality of Health Care and Hospital Care

- Republic Act No. 7160 – The Local Government Code of 1991, Title V, Sections 102-105

- Republic Act No. 4226 – An Act Regulating the Licensure of All Hospitals in the Philippines and Authorizing the Bureau of Medical Services to Serve as Licensing Agency
 - Republic Act No. 4688 – An Act Regulating the Operation and Maintenance of Clinical Laboratories and Requiring the Registration
 - Republic Act No. 123 – The Basic Quarantine Law of 1947
 - Republic Act No. 9271 0 An Act Strengthening the Regulatory Capacity of the Department of Health in Quarantine and International Health Surveillance, Repealing for the Purpose Republic Act No. 123 of 1947, as Amended
- c. Specific Services for Specific Group/Sector: Senior Citizens; Women; Children; Handicapped, etc.
- Republic Act No. 9257 – An Act Granting Additional Benefits and Privileges to Senior Citizens Amending for the Purpose Republic Act No. 7432, otherwise Known as “An Act to Maximize the Contribution of Senior Citizens to Nation Building, Granting benefits and Special Privileges and for other purposes”(Expanded Senior Citizens Act 2003)
 - Republic Act No. 8980 – An Act Promulgating a Comprehensive Policy and a National System for Early Childhood Care and Development (ECCD), Providing Funds therefore and for Other Purposes
 - Republic Act No. 7305 – Magna Carta for Public Health Workers
 - Republic Act No. 7394 – The Consumers Act of the Philippines
 - Republic Act No. 7600 – The Rooming-in and Breastfeeding Act of 1992
 - Republic Act No.7719 – An Act Promulgating Voluntary Blood Donation, Providing for an Adequate Supply of Safe Blood, Regulating Blood Banks and Providing Penalties for Violation thereof/National Blood Service Act of 1994
 - Republic Act No. 349 – An Act to Legalize Permission to Use Human Organs or Any Portions of the Human Body for Medical, Surgical, or Scientific Purposes, Under Certain Conditions
 - Republic Act No. 7170 – An Act Authorizing the Legacy of Donation of All or Part of a Human Body After Death for Scientific Purposes
 - Republic Act No. 7883 – Barangay Health Worker’s Benefits and Incentive Act of 1995

Advocacy for Promotive Health; Safety

- Republic Act No. 9211 – An Act Regulating the Packaging , Use, Sale, Distribution and Advertisement of Tobacco Products and for Other Purposes (Tobacco Regulation Act of 2003)
- Republic Act No. 8423 – An Act Creating the Philippine Institute of Traditional and Alternative Health Care (PITAHC) to Accelerate the Development of Traditional and Alternative Health Care in the Philippines, Providing for a Traditional and Alternative Health Care Development Fund and for Other Purposes/Traditional and Alternative Medicine Act (TAMA) of 1997

Social Financing of Health Care; Health Insurance; Health Service

- Republic Act No. 4110 – Establishing a Reproductive Health care Act, Strengthening its Implementing Structures, Appropriating Funds therefore, and for Other Purposes
- Republic Act No. 7875 – An Act Instituting a National Health Insurance Program for All Filipinos and Establishing the Philippine Health Insurance Corporation for the Purpose/National Health Insurance Act of 1995
- Republic Act No. 9241 – An Act Amending Republic Act No. 7875, Otherwise known as “An Act Instituting a National Health Insurance Program for All Filipinos and Establishing the Philippine Health Insurance Corporation for the Purpose”
- Republic Act No. 8976 – An Act Establishing the Philippine Food Fortification Program and for Other Purposes
- Republic Act No. 8172 – An Act for Salt Iodization Nationwide (ASIN)

Public Health Threats Drugs, Smoking, etc.

- Republic Act No. 3720 – An Act to Ensure the Safety and Purity of Foods, Drugs and Cosmetics Being Made Available for the Public by creating the Food and Drug Administration which shall Administer and Enforce the Laws Pertaining thereto
- Act No. 3573 – An Act Providing for the Prevention and Suppression of Dangerous Communicable Diseases and for Other Purposes
- Republic Act No. 6675 – An Act to Promote, Require and Ensure the Production of an Adequate Supply, Distribution, Use and Acceptance of Drugs and Medicines Identified by their Generic Names
- Republic Act No. 9165 – An Act Instituting the Comprehensive Dangerous Drugs Act of 2002, Repealing Republic Act No. 6462 Otherwise Known as the Dangerous Drugs Act of 1972, as Amended, Providing Funds therefore and for Other Purposes

Practice of Profession

- Republic Act No. 2382 – Medical Act of 1959
- Republic Act No. 4491 – An Act to Regulate the Practice of Dentistry in the Philippines and for Other Purposes/Philippine Dental Act of 1965
- Republic Act No. 5527 – An Act Requiring the Registration of Medical Technologist, Defining their Practice, and for Other Purposes/Philippine Medical Technology Act of 1969
- Republic Act No. 5680 – Philippine Physical and Occupational Therapy Law
- Republic Act No. 5921 – An Act Regulating the Practice of Pharmacy and Setting Standards of Pharmaceutical Education in the Philippines and for Other Purposes
- Republic Act No. 9173 – An Act Providing for a More Responsive Nursing Profession, Repealing for the Purpose Republic Act No. 7164, Otherwise Known as “The Philippine Nursing Act of 1991” and for Other Purposes
- Republic Act No. 7392 – Philippine Midwifery Act of 1992
- Republic Act No. 7431 – An Act Regulating the Practice of Radiologic Technology Defining its Powers and Functions and for Other Purposes/Radiologic Technology Act of 1992

During the LHB/LICT/ILHZ regular meetings, coordination can/may be in the form of advocacy for LGU resolutions or ordinances adopting the above mentioned laws. Pooled procurement for drugs and medicines, procurement of quality generic drugs, can be some inter-local health zone initiatives. Smoke-free zones, support for breastfeeding, and women's health can also be a subject for resolution and/or ordinances. Programs for malaria, schistosomiasis, filariasis control and prevention with corresponding budget support can also be some inter-local health zone actions.

The LHB/LICT/ILHZ are rich grounds for discussion of health issues and concern and fora for health initiatives.

Reference:

- Philippines Midterm Progress Report in the Millennium Development Goals 2007 National Economic and Development Authority (NEDA) Publication
- Abstract of the Philippine Health Laws 2006

5. Executive Orders

- Milk Code of 1986 (Executive Order 51): provides for safe and adequate nutrition of infants through breastfeeding and ensuring the proper use of breast milk substitute and supplements
- Executive Order No. 521 - Abolishing the National Health Planning Committee

6. Other Issuances

- A Gender and Development (GAD) Budget Policy provides allocation of at least 5 percent of national and local government budgets for gender and development
- Philippine National Development Plan for Children ("Child 21"): a strategic framework that guides stakeholders in planning programs and interventions that promote and safeguard the rights of Filipino children in the 21st century

7. DOH Administrative Orders

- Administrative Order 2005-0023: Implementing Guidelines for Fourmula One for Health as Framework for Health Reform. August 30, 2005
- Administrative Order 2006-0009: Guidelines Institutionalizing and Strengthening the Essential Drug Price Monitoring System (EDPMS). February 14, 2006
- Administrative Order No. 2006-0017: Incentive Scheme Framework for Enhancing Inter-LGU Coordination in Health through Inter-Local Health Zone (IHLZ) and Ensuring their Sustainable Operations. August 3, 2006
- Administrative Order 2006-0018: Implementing Guidelines for the Philippine National Drug Formulary. May 8, 2006
- Administrative Order No. 2006-0020: Guidelines for Evaluation of Consumer Participation Strategies in Fourmula One for Health. June 30, 2006
- Administrative Order No. 2006-0023: Implementing Guidelines on Financing Fourmula One for Health (F1) Investments and Budget Reform. June 13, 2006
- Administrative Order No. 2006-0029: Guidelines for Rationalizing the Health care Delivery System Based on Health Needs. June 15, 2006

- Administrative Order 2007-0021: Harmonizing and Streamlining of Licensure System for Hospitals. June 6, 2007
- Administration Order No. 2007-0034: Guidelines in the Development of the Province-wide Investment Plan for Health. October 15, 2007
- Administrative Order 2007-0037: Creation of the National Steering Committee for Health (NSCH)
- Administrative Order No. 2008-0003: Guidelines for the Preparation of Annual Operational Plan (AOP) for 2008 and Yearly Thereafter Based on the Province-wide Investment Plan for Health (PIPH) for the Fourmula One (F1) 16 Convergence and Roll-Out Sites and Other Provinces. January 7, 2008
- Draft for Approval: Administrative Order Guidelines in DOH Support to Local Health Systems Development under Fourmula One for Health

I. Advocating For Inclusion of Proposed Health Executive Agenda for Legislation in Local Legislative Agenda as Sanggunian Resolutions or Ordinances

The DOH is proposing some laws for enactment in the 14th Congress. These proposals cover the four pillar of Fourmula One. These proposed bills can/may be presented to the local council/sanggunian for enactment into ordinances. They can/may also be subject of board resolutions endorsing them to the local councils or even Congress.

The proposed bills are:

1. Health Financing
 - Amendment of the Local Government Code
 - An Act Defining the Offenses and Abuses Against the NHIP
2. Health Regulation
 - An Act Strengthening the Regulatory Capacity of BFAD
 - Amendment of the Consumer Act
 - Senate Bill NO. 1658 – An Act to Provide For Quality Affordable Medicines
 - House Bill No. 2844 – An Act Providing For Cheaper Medicines
 - Milk Code Amendment
3. Health Service Delivery
 - Amendment of the Disease Notification Act of 1929
 - Amendment to the Midwifery Act RA 7392

- An Act to Effectively Instill Health Consciousness through Picture Based Health Warnings in Tobacco Products
- An Act Expanding the Promotion of Breastfeeding – Senate bill No. 1698
- House bill No. 1427 – An Act to Promote and Support Breastfeeding as An Essential Component of Family Planning and Responsible Parenthood
- Amendment to the Firecrackers Law
- Hospital Corporate Restructuring

4. Governance

- Institutionalizing of Inter-Local Health Zones
- An Act Institutionalizing the Philippine National Health Research System, etc.
- Government Compensation and Classification Act of 2007
- Amendment of the Medical Act of 1959 – An Act Regulating the Education and Licensure of Physicians and their practice of Medicine in the Philippines, Repealing for the Purpose of RA 2382
- Amendment of the Pharmacy Law

Proposals for Local Legislation:

1. Health Financing

- Local legislation to earmark a portion of their IRA for health and to help in the attainment of Universal Coverage
- Local legislation on the income retention of hospitals and other health facilities

2. Health Regulation

- Adoption & localization of National Health regulatory Laws
 - Enactment of Ordinances & passage of resolutions
 - Enforcement of National Health regulatory Laws (i.e. BFAD law, Price Act, Asin Law, etc)
- Local Support to Botika ng Barangays and Botika ng Bayans

3. Health Service Delivery

- Local Legislation to eliminate rabies infection in the community (e.g. mass vaccination of dogs and impounding of stray dogs)
- Local ordinance on breastfeeding with the following provisions:
 - More breastfeeding rooms to be put up in malls, supermarkets, fast food chains and work places
 - Health workers shall encourage and promote breastfeeding
 - Arrange trainings on breastfeeding
 - Engage in massive promotion and support projects regarding breastfeeding
 - Establishment of community support groups that aid pregnant and new mothers
 - Monitor & report Milk Code violations
 - Ban milk companies from supporting their activities

- Disallow health workers from promoting infant formula
- Prohibit marketing materials of infant formula
- Local ordinance to support proper nutrition in the households by planting vegetables and PITAHC recommended medicinal plants in the backyard
- Local legislation on additional appropriations for Contraceptive Self Reliance and repro health
- Local legislation on tobacco control (e.g. no smoking in restaurants and public utility vehicles, tobacco advertisement ban, etc)
- Local ordinance that all pregnant mothers will deliver in health facilities assisted by trained health professionals
- Local ordinance to retain the income of local government hospitals or corporate restructuring of local government hospitals

4. Governance

- Local legislation on the networks and sharing of resources of the inter local health zones
- Local legislation on the provision of benefits and incentives for barangay health workers

The Inter-Local Health Zone: Trailblazing the Path of Inter-Local Coordination and Cooperation

With the devolution and subsequent initial fragmentation of health services gaps and problems were observed. As the LGUs grappled through the issues and concerns, they noticed that it was much easier to observe and work around the framework of financial and administrative authority. But the challenge of diseases, emerging and re-emerging diseases, and other health issues know no financial and administrative boundaries. One or two cases of measles in one barangay can easily jump over the boundary to another community.

GLOSSARY

The following terms and concepts were used in this report and were defined as follows:

Adjusted or Standardized Rates – To render the rates of 2 communities comparable, adjustment for the difference in age, sex, race and any other factors which influence vital events have to be made.

2 methods:

a.) By applying observed specific rates to some standard population

b.) By applying specific rates of standard population to corresponding classes or groups of the local population

Annual Operation Plan (AOP) – specifies the program/projects/activities covered by the Service Level Agreement within the annual investment cost as reflected in the five (5) year Province-wide Investment Plan for Health (PIPH) for all sources of funds (PLGU, MLGU, European Commission, DOH-budget support, PHIC and others).

Attack Rate (AR) – A more accurate measure of the risk of exposure. Useful in epidemiological investigations

Attended – refers to the cases given medical care at any point in time during the course of the illness which directly caused death. Medical care may either be provided directly by a medical doctor or indirectly by allied health care providers, i.e., nurses and midwives who are under the direct supervision of medical doctor. Otherwise, case is categorized as “*death unattended*”.

Barangay – is the basic political unit in the Philippines. It serves as the primary planning and implementing unit of government policies, plans, programs, projects and activities in the community. It serves as a forum wherein the collective views of the people may be expressed and considered and where disputes may be amicably settled.

Barangay Health Station – provide health services at the barangay level. Usually manned by a midwife or a community/barangay health worker. It is the first contact of the community in terms of health services. Usually renders preventive and promotive health service and attend to emergency cases.

Birth Order – is the numerical order of a child in relation to all previous pregnancies of the mother.

Birth Weight – is the first weight of the fetus or newborn obtained after birth.

Case Fatality Ratio (CFR) – Index of the killing power of a disease. It is influenced by incomplete reporting and poor morbidity data.

Center for Health Development – regional health offices covering several provinces. Re-configured to be center of knowledge expertise and influence in local health system development

City – consist of more urbanized and developed barangays, serves as a general purpose government for the coordination and delivery of basic, regular services and effective governance of its inhabitants within its territorial jurisdiction.

Coordination – A process of working together harmoniously, putting together all actions for health in one accord with mutual respect for one another

Crude Birth Rate (CBR) – is the measure of one characteristic of the natural growth or increase of a population.

Crude Death Rate (CDR) – is a measure of one mortality from all causes which may result in decrease of population.

Crude or General Rates – These rates are referred to all the total living population. It must be presumed that the total population was exposed to the risk of the occurrence of the event.

Death – is the permanent disappearance of all evidence of life at any time after live birth has taken place (post natal cessation of vital functions without capability of resuscitation).

DOH Representative – DOH personnel designated and delegated to perform DOH functions with the LGU at the city, municipal and provincial level

Early Neonatal Death – is the death among live births during the first 7 days of life.

Fetal Death – is the death prior to the complete expulsion or extraction of a product of conception from its mother, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Fetal Death Rate (FDR) – Measures pregnancy wastage. Death of the product of conception prior to its complete expulsion, irrespective of duration of pregnancy

Health Initiative – introductory step or self-reliant enterprise related to health. A process by which laws may be introduced or enacted directly by the will of the people.

Health Sector Reform Agenda (HSRA) – describes the major strategies, organizational and policy changes and public investments needed to improve the way the health care is

delivered, regulated and financed. It tackles reforms in five areas; local health system, public health programs, hospital systems, health regulations and health financing

Incidence Rate (IR) – Measures the frequency of occurrence of the phenomenon during a given period of time. Deals only with new cases

Infant Mortality/Death – is the death of an infant under one year of age.

Infant Mortality Rate (IMR) – Measures the risk of dying during the first year of life. It is a good index of the general health condition of a community since it reflects the changes in the environmental and medical conditions of a community.

Inter-LGU coordination in health – Actions of two or more LGUs to implement jointly common set of policies, programs, projects or activities for a common vision/goal/objective

Inter-Local Health Zone (ILHZ) – Organized arrangement of operation of an array and hierarchy of health providers and facilities which includes primary health care providers, core referral hospital and end referral hospital that jointly serve a common population within a geographical area under the jurisdiction of more than one local government

Late Fetal Death – is the death of fetus with 28 or more completed weeks of gestation.

Late Neonatal Death – is the death among live births after the 7th day but before completed days of life.

Live Birth – is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not umbilical cord has been cut or the placenta is attached; each product of such birth is considered liveborn.

Local health actions – Activities, initiatives, efforts intended to improve the health status of a country. Such actions may include disease prevention, disease surveillance and control, disease management or treatment, health information health education and advocacies, emergency and disaster management enactment/implementation of health/health related ordinances/laws/ standards/regulation

Local Health Authorities – Different health offices in the province, city, municipality which are mandated to perform public health

Local Health Board – composite body of the Local Chief Executive, the health officer, chairman of the committee on health, the representative for the private sector or non-government organization and representative of the Department of Health.

Local Health System – All organizations, institutions and resources devoted to undertaking local health actions. (World Health Organization Report 2000)

Local Health System Development – Progressive and positive change in the local health system in the form of improved performance or structural/process reform, or enhanced capacities towards attaining better health outcomes, more responsive health system and more equitable health care financing

Local Implementation and Coordination Team (LICT) – refers to the team responsible for over-all implementation of Fourmula One for Health activities in their respective local government units or F1 Convergence Sites. It shall be composed of the provincial Health Officer, Sangguniang Panlalawigan Chairman of the Inter-Local Health Zone (ILHZ) and Provincial Health Team Leader.

Local Reform Implementation Coordinator (LRIC) – refers to the person assigned and based in a specific province in F1 Convergence Sites. Working with the LICT, assists the provinces and component municipal LGU of inter-local health systems in ensuring that PIPH and the AOP are based on health sector reforms and Fourmula One for Health Strategy in implementing reforms. Also foster liaison among the different stakeholders in the health sector.

Maternal Mortality/Death – is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any caused related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Maternal Mortality Rate (MRR) – It measures the risk of dying from causes related to pregnancy, childbirth and puerperium. It is an index of the obstetrical care needed and received by the women in a community.

National Objectives for Health (NOH) – compendium of all goals, strategic thrust and targets set for the health sector for the medium term. Updated and published every six (6) years.

Neonatal Death – the death among live births during the first 28 completed days of life.

Neonatal Death Rate (NDR) – Measures the risk of dying during the 1st month of life. May serve as index of the effects of prenatal care and obstetrical management on the newborn.

Network – A group of systems of related or connected parts; system of elements that cross in the manner of thread – a web, group of health related system both public and private bound together by a common vision of healthy Philippines: Healthy Filipino

Networking – Exchange of ideas, information in services among groups, individuals

Place of Occurrence – refers to the place where the vital events took place.

Prevalence Rate (PR) – Measures the proportion of the population which exhibits a particular disease at a particular time. This can only be determined following a survey of the population concerned. Deals with total (old and new) number of cases.

Private Sector – refers to health providers and facilities (individual practitioners, clinics, hospitals, facilities, drug outlets) regulated under existing laws but otherwise operating outside the ownership and management of the government. It includes the drugs and pharmaceutical industry, non-government organizations and other enterprise.

Proportional Mortality (PM) – Shows the numerical relationship between deaths from a cause (or groups of causes), age (or groups of age) etc. and the total number of deaths from all causes in all ages taken together. Not a measure of risk of dying.

Province – composed of cluster municipalities, or municipalities and component cities, and a political and corporate unit of government, serves as a dynamic mechanism for development processes and effective governance of its inhabitants within its territorial jurisdiction.

Province-wide Investment Plan for Health (PIPH) – a plan prepared and adopted by LGUs within a province and agreed to be supported by DOH and its development partners in health that defines local health systems improvements to be attained by the province through the proposed application of public investments jointly funded by LGUs, DOH and development partners

Provincial Health Team Leader (PHTL) – DOH representative in the province designated as the team leader supervising the DOH representative province wide

Public Sector – refers to health providers (individual practitioners, health centers, hospitals, organizational units, agencies) operating within the rule and regulation of the government and all providers under the administration and control of the Department of Health and other national agencies as well as the local government units.

Rate – In Vital Statistics, a rate shows the relationship between a vital event and those persons exposed to the occurrence of said event, within a given area and during a specified unit of time. It is evident that the person s experiencing the event (the numerator) must come from the total population exposed to the risk of same event (the denominator).

Ratio – It is used to describe the relationship between two (2) numerical quantities or measures of events without taking particular considerations to the time or place. These quantities need not necessarily represent the same entities, although the unit of measure must be the same for both the numerator and denominator of the ratio.

Rural Health Unit – provides basic health services to several barangays, manned by a sanitary inspector, a midwife, a nurse, a dentist and a physician. Provide preventive, promotive and curative health care. It supervises the operation of the barangay health station.

Sector Development Approach for Health (SDAH) – a way of organizing the planning and management of international and national support for the health sector. The basic principle is that the significant funding should help health sector policy and expenditure program under government leadership. This entails common approaches and progressively relying in government procedures to disburse and account for all funds. The donors give up the right to select projects but in return they get a chance to contribute to the development of the health sector strategy and to the allocation of resources.

Sector Wide Approach (SWAp) – process guided by the Paris Declaration on Aid Effectiveness and anchored on government ownership, harmonization of process, alignment, managing for results and mutual accountability.

Service Level Agreement (SLA) – refers to the agreement signed by the Department of Health, and the Province defining the output and performance milestones to be reached, the amount of funds to be provided through the EC grant, DOH counterpart contribution, other health sector grant that may arise during the PIPH, other support from the DOH and the national government, and the conditions and requirements pertaining to the release of funds.

Specific Death Rate – Describes more accurately the risk of exposure of certain classes or groups to particular diseases. To understand the forces of mortality, the rates should be made specific provided the data are available for both the population and the event in their specifications. Specific rates render more comparable results and thus, reveal the problems of public health.

Specific Rate – The relationship is for a specific population class or group. It limits the occurrence of the events to that proportion of the population definitely exposed to it.

Total Fertility Rate (TFR) – refers to the number of children a woman would have by the time she reaches age 50 under a given fixed fertility schedule. It is sometimes referred to as completed family size. It is the average number of births per 100 females aged 15-49 years.

Usual Residence – refers to the place where the person habitually or permanently resides.

ANNEXES

ANNEX A **LEGAL FRAMEWORK**

Local Government Code of 1991
Republic Act No. 7160

BOOK I – General Provisions

SEC.2. *Declaration of Policy*

(a) It is hereby declared that the policy of the State that the territorial and political subdivisions of the State shall enjoy genuine and meaningful local autonomy to enable them to attain their fullest development as self-reliant communities and make them more effective

partners in the attainment of national goals. Towards this end, the State shall provide for a more responsive and accountable local government structure instituted through a system of decentralization whereby local government units shall be given more powers, authority, responsibilities, and resources. The process of decentralization shall proceed from the National Government to the local government units.

(c) It is likewise the policy of the State to require all national agencies and offices to conduct periodic consultations with the appropriate local government units, nongovernmental and people's organizations, and other concerned sectors of the community before any project or program is implemented in their respective jurisdictions.

SEC.3. *Operative Principles of Decentralization*

(f) Local government units may group themselves, consolidate or coordinate their efforts, services, and resources for purposes commonly beneficial to them;

(g) The capabilities of local government units, especially the municipalities and barangays, shall be enhanced by providing them with opportunities to participate actively in the implementation of national programs and projects;

(l) The participation of the private sector in local governance, particularly in the delivery of basic services, shall be encouraged to ensure the viability of local autonomy as an alternative strategy for sustainable development; and

(m) The National Government shall ensure that decentralization contributes to the continuing improvement of the performance of local government units and quality of community life.

SEC.17. *Basic Services and Facilities.* (a) Local government units shall endeavor to be self-reliant and shall continue exercising the powers and discharging the duties and functions currently vested upon them. They shall also discharge the functions and responsibilities of national agencies and offices devolved to them pursuant to this Code. Local government units shall likewise exercise such other powers and discharge such other functions and responsibilities as are necessary, appropriate, or incidental to efficient and effective provisions of the basic services and facilities enumerated herein.

(1) For Barangay:

(ii) Health and social welfare services which include maintenance of barangay health center and day-care center;

(iii) Services and facilities related to general hygiene and sanitation, beautification, and solid waste collection;

(2) For a Municipality:

(iii) Subject to the provisions of Title Five, Book I of this Code, health services which include the implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services, access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated;

(viii) Infrastructure facilities intended primarily to service the needs of the residents of the municipality and which are funded out of municipal funds including but not limited to, municipal roads and bridges; school buildings and other facilities for public elementary and secondary schools; clinics, health centers and other health facilities necessary to carry out health services; communal irrigation, small water impounding

projects and other similar projects; fish ports; artesian wells, spring development, rainwater collectors and water supply systems; seawalls, dikes, drainage and sewerage, and flood control; traffic signals and road signs; and similar facilities;

SEC.18. *Power to Generate and Apply Resources.* - Local government units shall have the power and authority to establish an organization that shall be responsible for the efficient and effective implementation of their development plans, program objectives and priorities; to create their own sources of revenues and to levy taxes, fees, and charges which shall accrue exclusively for their use and disposition and which shall be retained by them; to have a just share in national taxes which shall be automatically and directly released to them without need of any further action; to have an equitable share in the proceeds from the utilization and development of the national wealth and resources within their respective territorial jurisdictions including sharing the same with the inhabitants by way of direct benefits; to acquire, develop, lease, encumber, alienate, or otherwise dispose of real or personal property held by them in their proprietary capacity and to apply their resources and assets for productive, developmental, or welfare purposes, in the exercise or furtherance of their governmental or proprietary powers and functions and thereby ensure their development into self-reliant communities and active participants in the attainment of national goals.

SEC.23. *Authority to Negotiate and Secure Grants.* - Local chief executives may, upon authority of the sanggunian, negotiate and secure financial grants or donations in kind, in support of the basic services or facilities enumerated under Section 17 hereof, from local and foreign assistance agencies without necessity of securing clearance or approval therefore from any department, agency, or office of the national government or from any higher local government unit: Provided, That projects financed by such grants or assistance with national security implications shall be approved by the national agency concerned: Provided, further, That when such national agency fails to act on the request for approval within thirty (30) days from receipt thereof, the same shall be deemed approved.

The local chief executive shall, within thirty (30) days upon signing of such grant agreement or deed of donation, report the nature, amount, and terms of such assistance to both Houses of Congress and the President.

SEC.33. *Cooperative Undertakings Among Local Government Units.* - Local government units may, through appropriate ordinances, group themselves, consolidate, or coordinate their efforts, services, and resources for purposes commonly beneficial to them. In support of such undertakings, the local government units involved may, upon approval by the sanggunian concerned after a public hearing conducted for the purpose, contribute funds, real estate, equipment, and other kinds of property and appoint or assign personnel under such terms and conditions as may be agreed upon by the participating local units through Memoranda of Agreement.

CHAPTER 4

SEC.34. *Role of People's and Non-governmental Organizations.* - Local government units shall promote the establishment and operation of people's and non-governmental organizations to become active partners in the pursuit of local autonomy.

SEC.35. *Linkages with People's and Non-governmental Organizations.* - Local government units may enter into joint ventures and such other cooperative arrangements with people's and non-governmental organizations to engage in the delivery of certain basic services, capability-building and livelihood projects, and to develop local enterprises designed to improve productivity and income, diversify agriculture, spur rural industrialization, promote ecological balance, and enhance the economic and social well-being of the people.

SEC.36. *Assistance to People's and Non-governmental Organizations.* - A local government unit may, through its local chief executive and with the concurrence of the sanggunian concerned, provide assistance, financial or otherwise, to such people's and non-governmental organizations for economic, socially-oriented, environmental, or cultural projects to be implemented within its territorial jurisdiction.

Title Five LOCAL HEALTH BOARDS

SEC.102. *Creation and Composition.* -

(a) There shall be established a local health board in every province, city, or municipality. The composition of the local health boards shall be as follows:

(1) The provincial health board shall be headed by the governor as chairman, the provincial health officer as vice-chairman, and the chairman of the committee on health of the sangguniang panlalawigan, a representative from the private sector or non-governmental organizations involved in health services, and a representative of the Department of Health in the province, as members;

(2) The city health board shall be headed by the city mayor as chairman, the city health officer as vice-chairman, and the chairman of the committee on health of the sangguniang panlungsod, a representative from the private sector or non-governmental organizations involved in health services, and a representative of the Department of Health in the city, as members; and

(3) The municipal health board shall be headed by the municipal mayor as chairman, the municipal health officer as vice-chairman, and the chairman of the committee on health of the sangguniang bayan, a representative from the private sector or non-governmental organizations involved in health services, and a representative of the Department of Health in the municipality, as members.

(b) The functions of the local health board shall be:

(1) To propose to the sanggunian concerned, in accordance with standards and criteria set by the Department of Health, annual budgetary allocations for the operation and maintenance of health facilities and services within the municipality, city or province, as the case may be;

(2) To serve as an advisory committee to the sanggunian concerned on health matters such as, but not limited to, the necessity for, and application of local appropriations for public health purposes; and

(3) Consistent with the technical and administrative standards of the Department of Health, create committees which shall advise local health agencies on matters such as, but not limited to, personnel selection and promotion, bids and awards, grievance and complaints, personnel discipline, budget review, operations review and similar functions.

SEC.103. *Meetings and Quorum.* –

(a) The board shall meet at least once a month or as may be necessary.

(b) A majority of the members of the board shall constitute a quorum, but the chairman or the vice- chairman must be present during meetings where budgetary proposals are being prepared or considered. The affirmative vote of all the majority of the members shall be necessary to approve such proposals

SEC.105. *Direct National Supervision and Control by the Secretary of Health.* - In cases of epidemics, pestilence, and other widespread public health dangers, the Secretary of Health may, upon the direction of the President and in consultation with the local government unit concerned, temporarily assume direct supervision and control over health operations in any local government unit for the duration of the emergency, but in no case exceeding a cumulative period of six (6) months. With the concurrence of the government unit concerned, the period for such direct national control and supervision may be further extended.

ANNEX B

Executive Order No. 521

MALACAÑANG PALACE

Manila

EXECUTIVE ORDER NO. 521

ABOLISHING THE NATIONAL HEALTH PLANNING COMMITTEE

WHEREAS, Executive Order No. 205 dated 31 January 2002 created a National Health Planning Committee;

WHEREAS, there is a need to strengthen line accountabilities rather than dilute them through a proliferation of interagency committees;

NOW, THEREFORE, I GLORIA MACAPAGAL-ARROYO, by virtue of the powers vested in me by law, do hereby order:

SECTION 1. The National Health Planning Committee created by Executive Order No. 205 is hereby

abolished.

SECTION 2. The Secretary of Health shall steer the implementation of health reforms. He shall formulate the blueprint for implementing health sector reforms throughout the country in accordance with the Medium-Term Philippine Development Plan for 2004-2010.

SECTION 3. Executive Order No. 205 is hereby repealed.

SECTION 4. This Executive Order shall take effect immediately.

Done in the City of Manila, this 22nd day of March, in the year of Our Lord, Two Thousand and Six.

(Sgd.) **GLORIA MACAPAGAL – ARROYO**

By the President:

(Sgd.) **EDUARDO R. ERMITA**
Executive Secretary

ANNEX C

SERVICE LEVEL AGREEMENT

This Service Level Agreement is made and entered into on this ____ day of May 2008 by and between the following parties:

The Department of Health, a national governmental agency created under the laws of the Republic of the Philippines with principal office address at San Lazaro Compound, Sta. Cruz, Manila Philippines, represented by the Secretary of the Department of Health, Francisco T. Duque III, MD, MSc, and hereinafter referred to as the **DOH**;

- and -

The Provincial Government of South Cotabato, a Local Government Unit (LGU) established and existing under the laws and regulations of the Republic of the Philippines with principal office address at Provincial Capitol, Koronadal City, South COTabato represented by Honorable Governor Daisy A. Fuentes, hereinafter referred to as the **Province**;

NOW, THEREFORE the parties hereto agree as follows:

WHEREAS, Republic Act 7160 otherwise known as the 1991 Local Government Code mandated for the devolution of the delivery of health services and facilities as one of the basic functions and responsibilities of all Local Government Units (LGUs) at all levels;

WHEREAS, the “*FOURmula One for Health*” (F1) has been adopted as the implementation framework for health reforms of the DOH and is designed to undertake critical reforms with speed, precision and effective coordination with the goal of improving the efficiency, effectiveness and equity of the Philippine Health System for all Filipinos, especially the poor;

WHEREAS, the reforms are implemented under a Sector-wide Development Approach for Health (SDAH), a sector-wide approach which encompasses a management perspective and coordination requirements that covers the entire health sector and an investment portfolio that encompasses all sources;

WHEREAS, the DOH, being the technical resource, catalyzer for health policy, and advocate for health issues on behalf of the health sector commits to the principles and conditions in Health Services Delivery, in Health Care Financing, in Good Governance for Health and in Health Regulation;

WHEREAS, DOH Administrative Order 2005-0023 otherwise known as the Implementing Guidelines for *FOURmula ONE* for Health as Framework for Health Reforms has been adopted at the national and local levels;

WHEREAS, the Government of the Philippines has mobilized resources for *FOURmula One for Health* implementation in 16 *FOUR-in-ONE* Convergence Sites, including a grant from the European Commission and government contribution through a loan from World Bank, in addition to other grants and loans available to these Convergence Sites

WHEREAS, the Province of South Cotabato has been chosen as one of the *FOURmula ONE* for Health Convergence Sites for its capacity to absorb investments and sustain the reform process, among others;

WHEREAS, the Province of South Cotabato has prepared a Province-Wide Investment Plan for Health (PIPH) which has been reviewed with the Joint Appraisal Committee (JAC) of the Department of Health (DOH) and modified following the recommendations of the JAC as contained in the supplemental plans (costed operational plan, procurement, training and rationalization plans) that have been approved by the JAC for implementation during the first Service Level Agreement.

WHEREAS, the DOH and the Province of South Cotabato have signed a Memoranda of Agreement (MOA) dated 14 December 2006, in order to help achieve the objectives of *FOURmula one for Health*;

NOW, THEREFORE, and in consideration of the foregoing premises, the parties hereto agree as follows:

ARTICLE I **The Program**

1.1 Coverage

The Service Level Agreement covers the management and implementation of the Province-Wide Investment Plan for Health (PIPH) for 2008. Attached hereto and form an integral part of this Service Level Agreement are: i) Supplemental plans to the PIPH consisting of the operations plan with a procurement plan and a training plan for the PIPH for 2008; and a preliminary health facility rationalization plan; and ii) program indicators and milestones for 2008.

1.2 Expected Outputs

The Service Level Agreement will focus on the following outputs:

- i. Annual Operations Plan for 2008 for the PIPH that is costed and endorsed by the Joint Appraisal Committee. The Annual Operations Plan should contain:
 - o A detailed procurement plan for 2008 that conforms with the requirements of RA 9184
 - o A Training Plan for 2008 that conforms to the Guidelines developed by the DOH Health Human Resource Development Bureau (HHRDB)

- ii. A detailed Rationalization Plan for facility refurbishment for 2007-2010, including facility mapping for Women's Health and Safe Motherhood facilities, that conforms to the guidelines developed by the National Center for Health Facility Development (NCHFD) and the National Center for Disease Prevention and Control (NCDPC), and is endorsed by the Joint Appraisal Committee.
- iii. A Public Finance Management Plan
- iv. Confirmed program indicators and data sources for tracking provincial program accomplishments from 2007-2010, endorsed by the Joint Appraisal Committee and approved by the Health Policy Development and Planning Bureau.

Milestones and means of verification of the above outputs are attached as Attachment 3 of this Service Level Agreement.

Details of the execution of the program are contained in the FOURMula ONE for Health Operations Manual for Convergence Provinces, hereinafter referred to as the F1 Operations Manual for Convergence Provinces.

1.3 Program Funding

The implementation of the PIPH shall be funded by various sources, as indicated in the PIPH, in the Operations Plan, and in the F1 Operations Manual for Convergence Provinces. These sources include a grant from the European Commission in the form of direct budget support (*through a World-Bank Administered Trust Fund*), and support from the DOH central office consisting of 1) direct cash counterpart to the EC grant, and 2) in-kind support through the regular DOH budget, to be provided through the central office and through the Center for Health Development (CHD).

The EC grant consists of a fixed tranche and a variable tranche. The fixed tranche of the 2008 EC grant and the direct cash counterpart of the DOH will be released in two installments as indicated in Article III of this Service Level Agreement.

The variable tranche of the EC grant will be released during the first semester of 2009 and the amount will be dependent on the achievement of performance milestones during year 2008, as also indicated in Article III of this Service Level Agreement.

ARTICLE II Program Implementation Arrangements

2.1 The DOH shall:

- a) Authorize the Province to manage the grant funds and DOH counterpart funds as it implements the PIPH to produce the deliverables and outputs indicated in this Service Level Agreement and with the F1 Operations Manual for Convergence Provinces.
- b) Provide logistical and technical support to the Province for the overall planning, management, and coordination of PIPH activities and operations, including but not limited to public health programs, based on the agreed Program Milestones described in Annex A to ensure smooth and efficient implementation of the Province-Wide Investment Plan for Health.
- c) Ensure, through the Field Implementation Coordinating Office (FICO) and the CHD, verification and validation of submitted accomplishment reports prior to processing of grant releases.
- d) Ensure timely release of funds to the Province based on the Program Milestones and verified physical, financial, and technical accomplishment reports.
- e) Provide other forms of assistance essential for the effective implementation of the PIPH.

2.2 The Province shall:

- a) Implement all activities under the Annual Service Level Agreement following the DOH FOURmula ONE for Health implementation guidelines (DOH Administrative Order 2005-0023) and the F1 Operations Manual for Convergence Provinces.
- b) Carry out with due diligence all activities stipulated in the PIPH and supplemental plans as modified and approved by the Joint Appraisal Committee for implementation during the first Service Level Agreement period;
- c) Prepare and submit to the DOH Program Monitoring Reports as described in the F1 Operations Manual for Convergence Provinces.

ARTICLE III

Resources and Financial Obligations

3.1 Resources from EC and DOH

- 3.1.1 The Province shall receive about PhP 87,252,197.00 of support from the EC and the DOH, broken down as follows:

Table 1. EC Grant and DOH Support to Province, 2008

	Amount	Notes
EC Grant, and DOH Counterpart 2008		
Fixed Allocation	20,255,019	
DOH Counterpart to EC Grant	6,300,721	
Total EC Grant and DOH Counterpart	26,555,740	Total Grant Possible
Variable Allocation	3,616,968	Maximum amount - the amount to be released in 2008 depending on achievement of performance during year 2007 as described in Article 3.1.3 of this Service Level Agreement
Other support from National Government , 2007		
DOH Support from regular Budget	31,142,209	Indicative amount of in-kind support
Nat'l Gov't. Counterpart to PhilHealth premiums	25,937,280	
Total Other Support from National Government	57,079,489	

- 3.1.2 The fixed EC grant and DOH counterpart allocations for 2008 will be released in two installments according to the schedule indicated in Annex A of this Service Level Agreement.
- 3.1.3 The variable EC grant and DOH counterpart allocations for 2008 will be released during the first semester of 2009, according to achievement of performance targets for 2008 as follows:

Target	% share of Total variable allocation (EC Grant and DOH counterpart)	% Share of Column 2
(1)	(2)	(3)
Service Delivery		
1. Completion of Rationalization plan for	20%	Completion of

health care facilities for 2008-2010 that has been concurred with LCE's and is JAC endorsed and DPOH approved, by 01 December 2008		rationalization plan on or before 01 December 2008 – 100% (also a requirement for the release of 2009 fixed tranche)
Financing		
2. Identification of Indigent families through any PhilHealth-approved means testing mechanism	15%	Achievement before 31 December 2008-100% households in 4 th and 5 th class municipalities
3. Enrollment in 2008 of at least as many indigent families enrolled in 2007. All enrolled families in 2008 must be in the list of indigent families identified through the any PhilHealth-approved means testing mechanism	15%	Achievement of 100% of target or more: 100% Achievement of 80% to 99% of target: 50%
4. Submission of JAC \-endorsed and DOH – approved operations plan for 2008 with procurement plan and training plan	10%	Submission on or before 31 August 2008-100%
5. Submission of Public Finance Management Plan for 2008	10%	Submission on or before 31 July 2008-100%
6. Balanced Financial Statement o\for First Three Quarters of 2008	10%	Submission of Balanced Financial Statement as of 30 September 2008 on or before 01 December 2008-100%
7. Use of new chart of accounts according to LGAS for 2008	10%	Use of new chart of accounts – 100%
8. Consolidation of 2007 data for performance indicators in Attachment 3	10%	2007 data collected on or before 31 August 2008-100%

3.1.4 Release of funds shall conform with the procedures in the F1 Operations Manual for Convergence Provinces.

3.2 The DOH shall secure the timely release of the EC grant proceeds (through regular government funds flow procedures (through the World Bank-administered Trust Fund procedures) and the DOH counterpart to the EC grants.

3.3. The Province shall:

- a) Manage the program resources and ensure the delivery of inputs (e.g. rehabilitation works, equipment, capacity building, etc.) to the lower levels of local government.
- b) Maintain adequate Financial Management records and systems for the Service Level Agreement. The Financial Management System will comply with that of the DOH and the Program Donors as described in the F1 Operations Manual for Convergence Provinces.
- c) Contribute to and facilitate monitoring, evaluation, and audit activities that will be conducted in the course of the programme, as described in the F1 Operations Manual for Convergence Provinces.

d) Refund expenditures disallowed by audit.

**ARTICLE IV
Miscellaneous**

4.1 Mutual Obligations

The DOH and the Province agree to perform, fulfill, abide by and submit to any and all of the provisions and requirements and all matters related, contained or expressed or reasonably inferred from this Service Level Agreement Document. All unobligated amounts shall be applied according to modalities determined by the DOH in consultation with the funding donors. The Province shall abide by the decisions of the DOH in this regard.

4.2 Service Level Agreement Period

The DOH and the Province agree that the Service Level Agreement herein described shall be implemented from May to December 31 2007.

4.3 Notices

All notices called for by the terms of this Service Level Agreement shall become effective only at the time of receipt thereof and only when received by the parties to whom they are addressed:

For the DOH:

The Secretary of the Department of Health

For the Province:

The Governor

4.4 Integration

The DOH and the Province agree that this Service Level Agreement expresses and integrates all agreements, promises and covenants of the parties and supersedes all prior negotiations understanding and agreements, whether written or oral and that no modification or alteration of this Service Level Agreement shall be valid or binding on either party unless expressed in writing and executed with the same formality as this Service Level Agreement.

**ARTICLE V
Effectivity**

This Agreement shall take effect on the date of the signing hereof by the parties concerned and shall be terminated upon satisfactory fulfillment of all the terms and conditions embodied herein. Any modification or amendments to this Agreement as proposed by either party shall mutually be agreed upon in writing by all the parties hereto.

IN WITNESS WHEREOF, the parties have hereunto set their signatures this ____ day of _____ 2007, _____ City.

DEPARTMENT OF HEALTH

PROVINCE

Secretary of Health

Governor

Signed in the Presence of :

Undersecretary of Health – FICO

Provincial Health Officer

ACKNOWLEDGMENT

Republic of the Philippines)
City/Municipality of)
X-----X

BEFORE ME, this ____ day of _____ 2007, in the City of _____ personally appeared the following persons:

Name	CTC No.	Place/Date Issued
1.	_____	_____
2.	_____	_____

all known to me to be the same persons who executed the foregoing instrument and signed their signatures above and acknowledged to me the due execution hereof is their free and voluntary act and those of the offices they represent.

This instrument consisting of _____ () pages signed on each and every page by the parties and their witnesses and sealed with my notarial seal.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal.

Doc. No. _____
Page No. _____
Book No. _____
Series of 2006

**Schedule of Fund Releases of Fixed Tranche of EC Grant and
DOH Counterpart to EC Grant, 2007**

Installment	Corresponding Amount in Philippine Peso (Php)			Expected Date of Application	Required Documents
	EC Grant, Fixed Allocation	DOH Counter part to EC Grant, Fixed Allocatio n	Total		
1 st Installment				___ March 2007	<ol style="list-style-type: none"> Notarized Service Level Agreement, with the following attachments: <ul style="list-style-type: none"> Operations Plan 2007 with Training Plan and Procurement Plan Preliminary Rationalization Plan for Health Care Facilities Separate Books of Accounts (subsidiary ledgers)
2 nd				June 2007	<ol style="list-style-type: none"> Request for 2nd Installment

Installment	Corresponding Amount in Philippine Peso (Php)			Expected Date of Application	Required Documents
	EC Grant, Fixed Allocation	DOH Counter part to EC Grant, Fixed Allocation	Total		
Installment					<ul style="list-style-type: none"> 2. Revised and JAC-approved operations plan with training plan and procurement plan (if JAC required for the specific province) 3. Public Finance Management Plan 4. Facility Mapping and Identification of “Non-Problematic” Hospitals, i.e., hospitals that can be refurbished without major issues from stakeholders, including CEmOCs and BEmOCs

Attachment 1
Operations Plan with Procurement Plan and Training Plan

Attachment 2
Preliminary Health Facilities Rationalization Plan

Attachment 3
Program Indicators and Milestones

INDICATORS/DELIVERABLES	MILESTONES		MEANS OF VERIFICATION
	31 May 2007	01 Dec 2007	
1. Operations Plan for 2007 and 2008, including Procurement Plan and Training Plan	Final Operations Plan (including Procurement Plan and Training Plan) for 2007	Operations Plan (including Procurement Plan and Training Plan) for 2008	JAC endorsed, DOH-approved
a. Public Finance Management (PFM) Plan	Final PFM Plan		
b. Health Care Facility Rationalization Plan - Needs Assessment Conducted and Facilities Identified for refurbishment	Priority "Non-problematic" facilities for refurbishment identified, including Comprehensive Emergency Obstetric Care (CEmOC) Facilities and Basic Emergency Obstetric Care (BEEmOC) Facilities	Final facility rationalization plan 2008-2010 concurred with local chief executives	JAC endorsed, DOH-approved
4. Compliance with LGAS		Financial records use new chart of accounts	
5. Increased access for the poor - % of indigent families enrolled in PhilHealth	Poor identified using methodology acceptable to PhilHealth and JAC	Increase in number of indigent families enrolled from 2007 to 2008 by 1,000 families	
6. Baseline data on: a) TB Cure Rate b) % of Fully Immunized Children c) % of Children Given Micronutrient Supplementation d) % children exclusively breastfed for six months e) % facility-based deliveries f) % of HH with Access to Potable Water g) % of HH with Access to Sanitary Toilets	For all: Baseline data collected and validity checked	For all: Yearly targets for 2008-2010 Set	Verified by Provincial Health Office, FICO and CHD

INDICATORS/DELIVERABLES	MILESTONES		MEANS OF VERIFICATION
	31 May 2007	01 Dec 2007	
<p><i>h) Stock-out Rates of the following drugs at RHUs and secondary hospitals:</i></p> <ul style="list-style-type: none"> <i>a. amoxicillin/cotrimoxazole</i> <i>b. Drugs for PTB</i> <i>c. Drugs for Diarrhea</i> <p><i>i) % surgical cases in secondary/tertiary hospitals</i></p> <p><i>j) Ratio of primary and secondary case mix in hospitals</i></p> <p><i>k) Ave Length of Stay by Hospital Category</i></p> <p><i>l) Bed occupancy rate by hospital category</i></p> <p><i>m) Hospital Net Death Rate</i></p> <p><i>n) Utilization rate in RHUs</i></p> <p><i>o) % of SS-certified RHUS</i></p> <p><i>p) % of PhilHealth-accredited private and government hospitals</i></p> <p><i>q) % of RHUs accredited for OPB</i></p> <p><i>r) % of health facilities that are PhilHealth accredited for TB DOTS</i></p> <p><i>s) % of target CEmOC and BEmOC facilities designated as such and PhilHealth-accredited for Maternal Care Package</i></p> <p><i>t) Compliance to PhilHealth capitation guidelines</i></p> <p><i>u) % of Magna Carta benefits implemented</i></p> <p><i>v) % of Total LGU Budget allocated for health</i></p>			

$\mathbf{t}, \mathbf{d}, \mathbf{f}$

MEMORANDUM OF AGREEMENT

This Memorandum of Agreement, hereinafter referred to as **MOA**, made and entered into this ____ day of _____, 2006 at Manila, Philippines, by and between:

the **DEPARTMENT OF HEALTH (DOH)**, a national government agency created and existing under the laws of the Republic of the Philippines with principal office address at San Lazaro Compound, 3rd Cruz, Manila herein represented by **FRANCISCO T. DUQUE III, MD, MSc**, in his capacity as the Secretary of the Department of Health, and hereinafter referred to as the **DOH**;

cruc:

The Provincial Government of BILIRAN, a Local Government Unit established and existing under the laws and regulations of the Republic of the Philippines, with principal office address at Provincial Capitol, Naval, Biliran, represented by **HONORABLE ROGÉLIO J. ESPINA**, in his capacity as the Provincial Governor, as duly authorized by the Sangguniang Panlalawigan Resolution No. 247 dated Dec. 5, 2016, hereinafter referred to as the **Provincial Government**:

WITNESSETH

WHEREAS, the Philippine Constitution of 1987 mandates the State to adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and social services available to all people at affordable cost;

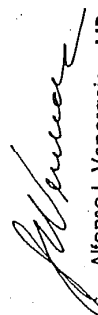
WHEREAS, Republic Act 7160 otherwise known as the 1991 Local Government Code mandated for the devolution of the delivery of health services and facilities as one of the basic functions and responsibilities of all Local Government Units or LGUs at all levels;

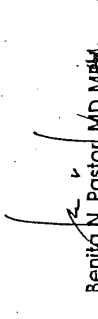
WHEREAS, the **FOURmula One for Health (F1)** is adopted as the implementation framework for health reforms of the DOH and is designed to undertake critical reforms with speed, precision and effective coordination, with the goal of improving the efficiency, effectiveness and equity of the Philippine Health System for all Filipinos, especially the poor;

WHEREAS, the *Formula One for Health* aims to attain better health outcomes, more responsive health systems and equitable health care financing through action on four critical components: Health Care Financing, Health Regulation, Health Services Delivery and Good Governance for Health;

WHEREAS, the reforms are implemented under a Sector-wide Development Approach for Health (SDAH), a sector-wide approach which encompasses a management perspective and coordination requirements that covers the online health sector and an investment portfolio that encompasses all sources;

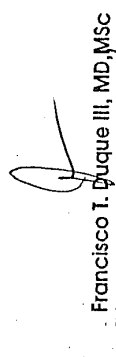
1. Jeune fille de Paris
 2. Jeune fille de Paris


Alfonso I. Veneracion, MD
Provincial Health Officer II


Benita N. Pastor, MD, MPH
Director IV, CHD-Eastern Visayas


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Hon. Rogelio J. Espina
Governor


Francisco T. Duque III, MD, MSc
Secretary of Health

WHEREAS, Administrative Order 2005-0023 otherwise known as the Implementing Guidelines for **FOURmula ONE for Health** as Framework for Health Reforms shall be adopted at the national and local levels;

WHEREAS, the DOH, being the technical resource, catalyzer for health policy, and advocate for health issues on behalf of the health sector commits to the principles and conditions in Health Services Delivery, in Health Care Financing, in Good Governance for Health and in Health Regulation;

WHEREAS, FOUR-in-ONE Convergence Sites will be established to undertake integrated implementation of **FOURmula ONE for Health** components in appropriately delineated localities or inter-local health zones

WHEREAS, the Government of the Philippines has mobilized resources for Fourmula One for Health implementation in 16 **FOUR-In-ONE** Convergence Sites, including a grant from the European Commission and government contribution through a loan from World Bank, in addition to other grants and loans available to these Convergence Sites

WHEREAS, the Province of **BILIRAN** has been chosen as one of the **FOURmula ONE for Health** Convergence Sites for its capacity to absorb investments and sustain the reform process, among others;

WHEREAS, the Provincial Government of **BILIRAN**, by virtue of the Sangguniang Panlalawigan Resolution No. 267, Series of 2006, is given the authority to enter into a MOA with the Department of Health;

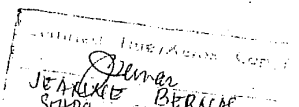
WHEREAS, the Provincial Government in partnership with the DOH and other key stakeholders do hereby adhere to an integrated implementation of health reforms and the SDAH;

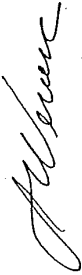
WHEREAS, the Provincial Government in partnership with the DOH commits to attain the Millennium Development Goals and **FOURmula ONE for Health** goals.

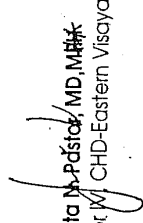
NOW THEREFORE, in consideration of the foregoing premises, and by way of formalizing and confirming the commitment of the Provincial Government and the Department of Health, the parties hereby mutually agree to enter into agreement in accordance with the terms and conditions hereunder set forth.

1. GENERAL PRINCIPLES

- 1.1. This MOA defines the general roles and responsibilities of both the Department of Health and the Provincial Government in implementing the activities of the **FOURmula ONE for Health** initiative. Further, this agreement aims to ensure and strengthen collaborative linkages with other Local Government Units, Civil Society Organizations, other National Government Agencies, and other development partners through the generation, mobilization and allocation of resources towards achieving the targeted goals of **FOURmula ONE for Health**.

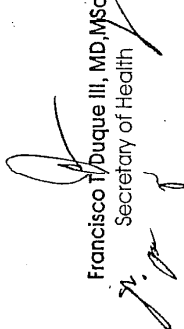

Jehanne Berina


Alfonso I. Veneracion, MD
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Benita N. Pastor, MD, MPH
Director of CHD-Eastern Visayas


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Hon. Rogelio J. Espina
Governor


Francisco T. Duque III, MD, MSc
Secretary of Health

1.2 The implementation of **FOURmula ONE for Health** will be as contained in the Province Wide Investment Plan for Health (PIPH), as modified following recommendations of the Joint Appraisal Committee (JAC) composed of government agencies and development partners, and including supplemental plans (operational plan, rationalization plan, training plan, public finance management action plan). The PIPH, including the supplemental plans, will be updated annually and shall undergo the review process of the JAC. The latest approved PIPH shall be hereby referred to as the "approved PIPH."

1.3 The specific roles and activities of the DOH and the Province in relation to the contents of the approved PIPH will be defined in an annual Program Contract, herein referred to as the Annual DOH-Province Program Contract. The Annual DOH-Province Program Contract will also define the outputs and performance milestones to be reached, the amount of funds to be provided from the EC grant and the DOH's counterpart contribution, and the conditions and requirements pertaining to the release of said funds.

1.4. The Parties shall at all times take all actions necessary to cooperate with each other and perform their respective duties and obligations in order to, among others:

1.4.1. Improve the efficiency and effectiveness of the health care delivery system through a comprehensive approach to health system development at the local level, through the attainment of the following specific objectives:

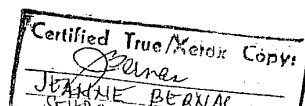
i. improve the capacities of communities, NGOs and LGUs in the province to properly execute the provision of health services.

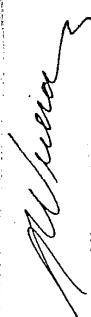
ii. develop, and implement the following thrusts of F1:

(a) Financing – universal social health insurance (SHI) coverage; rational use of government subsidies and other resources generated by the local health facilities;

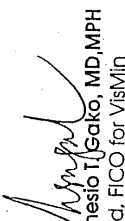
(b) Regulation–licensing, accreditation, and certification of health facilities, availability of affordable quality drugs and medicines, and implementation of health and health-related laws;

(c) Service Delivery – province declared a Disease-free Zone for specific diseases (e.g. rabies, malaria, leprosy, schistosomiasis, filariasis, etc.); reduced Infant Mortality Rate, Under 5 Mortality Rate, and Maternal Mortality Rate; increased coverage for health promotion, and disease

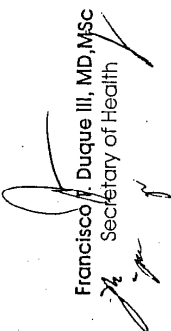



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Secretary of Health

prevention and control; optimized health facilities and service delivery; and

- (d) Governance– promoted inter-LGU cooperation thru mechanisms such as Inter-Local Health Zone (ILHZ); improved management support systems such as planning, health human resource, networking, information, procurement, logistics, and financial management.

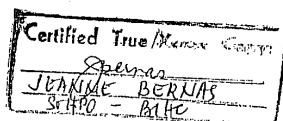
- iii. strengthen DOH capability at the national and regional levels to implement and support the said **FOURmula One for Health** thrusts and to provide policy direction and technical support to LGUs, NGOs and community groups in planning and implementing health programs and services.

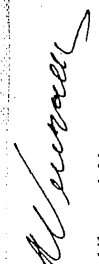
- 1.4.2. Make available, promptly as needed, resources required to carry out the **FOURmula ONE for Health** initiatives, such as funds, facilities, manpower, land, and others.
- 1.4.3 Carry out periodic monitoring and evaluation of the implementation of the approved PIPH.
- 1.4.4 Participate on a regular basis in meetings convened by the JAC to review progress of implementation of **FOURmula One for Health**.

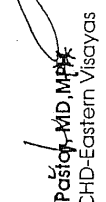
2. RESPONSIBILITIES OF THE PROVINCIAL GOVERNMENT


The Provincial Government hereby adheres to an integrated implementation of **FOURmula One for Health** components as embodied in the approved PIPH and commits to the principles and conditions herein set forth and to this end shall:

- 2.1. Take the lead in prioritizing and implementing the approved PIPH;
- 2.2. Issue the necessary administrative and technical instructions on the manner, scope and other operational details governing the proper execution and implementation of all activities identified in the approved PIPH;
- 2.3 Comply with the requirements of the Annual DOH-Province Program Contract and Program Operations Manual to be developed for **FOURmula One for Health** implementation in Convergence Sites, as set forth in Sec. 3.5 of this Agreement;
- 2.4 Mobilize participation and involvement of various local government units within the Province in carrying out local initiatives or activities relevant to **FOURmula ONE for Health** strategies, to include, but not limited to:

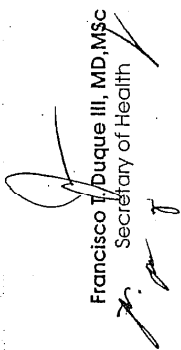



Alfonso I. Veneracion, MD
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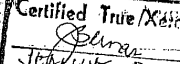

Hon. Rogelio J. Espina
Governor

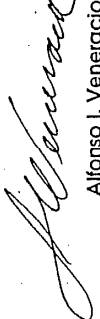

Francisco T. Duque III, MD, MSc
Secretary of Health

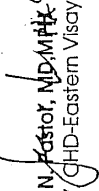
- i. secure increased, better and sustained financing for health;
 - ii. assure the quality and affordability of health goods and services;
 - iii. ensure access to and availability of essential and basic health packages; and
 - iv. improve performance of the health system
- 2.5 Institutionalize national and local government and private sector networking, partnership and resource sharing arrangements;
- 2.6 Enhance the capacity of LGUs to manage the investments and sustain the reform process;
- 2.7 Contribute to and facilitate monitoring, evaluation, and audit activities that will be conducted in the course of the programme; and
- 2.8 Provide office accommodation of reasonable standard for experts that may be provided by the European Commission.


3. RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH


- 3.1 Provide regularly updated policies to ensure directions and sustained implementation of health sector reforms.
- 3.2 Facilitate the review and approval of the Province's Operational Plan, Financial Plan, Procurement Plan, Training Plan, Rationalization Plan, and other required documents.
- 3.3 Facilitate mobilization of resources to sustain health sector reforms.
- 3.4 Provide appropriate technical assistance and training, systems development, and logistics support to build and sustain LGU capacity for implementing **FOURmula ONE for Health**.
- 3.5 Provide a Program Operations Manual that describes the implementation and management procedures, including financial management, procurement and reporting requirements for the program. This Manual is to guide the province and the LGUs in improving health delivery and meeting the terms of the Annual DOH-Province Program Contract. The DOH will consult with LGUs regarding the provisions of the Manual.
- 3.6 Evaluate, process, document, and advocate best practices that can be replicated, adapted by the local government.
- 3.7 Establish and implement in collaboration with the Province yearly benchmark and performance assessments.

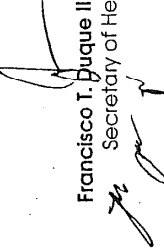
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JACKIE BEAYAS
SRHD - BIRAC


 Alfonso I. Veneracion, MD
 Provincial Health Officer II


 Benita N. Pastor, MD, MPH
 Director IV CHD-Eastern Visayas

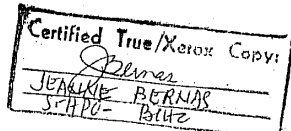

 Asec. Nemesio T. Gako, MD, MPH
 Hqd. FICO for VisMin


 Hon. Rogelio V. Espina
 Governor


 Francisco T. Duque III, MD, MSc.
 Secretary of Health

4. FINANCING

- 4.1. Financing portfolio for FOUR-in-One Convergence Sites shall consist of the following:
 - 4.1.1 Grants from the European Community (EC) and other donors assisting specific convergence sites.
 - 4.1.2 Local government unit sources such as the respective Internal Revenue Allotments (IRA) and other revenue sources of the LGUs, or from loans such as those that may be accessed through the Municipal Development Fund Office (MDFO)
 - 4.1.3. DOH counterpart to the EC grant, which is sourced from a national government loan from the World Bank
 - 4.1.4 National Government counterpart funds from the Regular Budget of DOH and Philippine Health Insurance Corporation (PHIC)
 - 4.1.5 In-kind technical assistance and support from other partners such as other donors (e.g. USAID, WHO, JICA, GTZ, BTC) and civil organizations.
- 4.2 The EC grant will be provided to the Province as **budget support** channeled through the DBM utilizing regular government funds flow procedures. The details of this funding modality will be provided in the Program Operations Manual.
- 4.3 EC grant funds and DOH counterpart contribution will be released to provinces as fixed allocations (released on the basis of milestones for completion of activities and outputs in the PIPH), and as variable allocations (released on the basis of performance). The DOH is developing a monitoring and evaluation and performance evaluation system to provide the basis for the release of performance-linked allocations. The Program Contract will define the basis for release of both fixed and variable allocations. Release of fixed allocations will include a mobilization payment, and initial payments based on completion of start-up activities.
 - 4.3.1 The amount of the fixed allocation of EC grant funds and DOH counterpart contribution per province will be specified in the Program Contract. The amount will be based on explicit criteria related to the population, poverty incidence and health need of the province, also taking account of other sources of grant funds provided to the province for financing of **FOURmula ONE for Health** activities in the approved PIPH.
 - 4.3.2 The amount of the variable allocation will be defined in advance in the Program Contract. The release of the variable allocation will be based on annual performance against the objectives stated in the Program Contract.



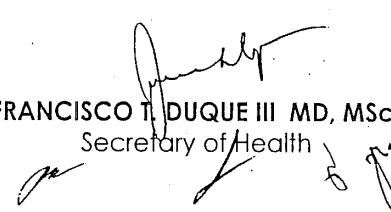
5. EFFECTIVITY AND AMENDMENTS TO THIS AGREEMENT

- 5.1. This agreement shall become effective once signed by both parties and endorsed by the mayors and local health boards and shall continue to become effective within the duration of the implementation of **FOURmula ONE for Health** strategy in accordance with the schedules and corresponding annual plans and financing arrangements.
- 5.2. In the event that the Provincial Government fails to achieve annual benchmarks and performance evaluation or otherwise fails to satisfy its obligation under this Agreement the DOH may reduce, suspend or cancel further funding of the **FOURmula ONE for Health** activities in the Province.

In witness whereof, the Parties hereto have caused this Agreement to be signed in their respective names in Manila, Republic of the Philippines, as of the day and year written above:

For the Department of Health (DOH)

For the Provincial Government



FRANCISCO T. DUQUE III MD, MSc,
Secretary of Health

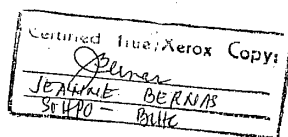

HON. ROGELIO J. ESPINA
Governor

Signed in the Presence of:


Benita N. Pastor, MD, MPH
Director IV, CHD-Eastern Visayas


Alfonso I. Veneracion, MD
Provincial Health Officer II


Assistant Secretary Nemesio T. Gako, MD, MPH
Head, Field Implementation & Coordination Office (FICO)
For Visayas and Mindanao

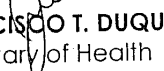


ACKNOWLEDGEMENT

Republic of the Philippines

City of MANILA

Before me, this 24 JAN 2007 day of MANILA, 2006 in the City of _____, Philippines, personally appeared:


FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

CTC# 10472545
Issued at: Dagupan City
Issued on: 11 January 2006

HON. ROGELIO J. ESPINA
Governor

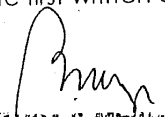
CTC# 09794507
Issued at: NAVAL, BILIRAN
Issued on: 01-02-06

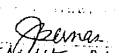
Known to me to be the same person who executed the foregoing instrument, and they acknowledge that the same is their free and voluntary act and deed.

This instrument consisting of 8 pages on which the acknowledgement is written has been signed on each and every page thereof by the parties and their instrument witness.

WITNESS MY HAND AND SEAL, at the place on the date first written above.

DOC.: 288
Page No. 78
Book No. 10
Series of 2007


BUENAVENTURA S. MEDINA, JR.
NOTARY PUBLIC
UNTIL DECEMBER 31, 2007
PTR. NO. 548065C 3-16-06


JEANETTE BERNAS
SILAPO - BILIRAN

LOCAL REFORM IMPLEMENTATION COORDINATORS TRAINING

Note: Click the links below to access powerpoint presentations:

- Overview of the Philippine Health System. Click [here](#)
- Department of Health (DOH) Philippines. Click [here](#)
- Financing the F1 for Health through SDAH. Click [here](#)
- Monitoring Evaluation for Equity and Effectiveness. Click [here](#)
- Fourmula One for Health PPAs. Click [here](#)
- Rationalization of Health Care Facilities Based on Needs. Click [here](#)
- Rationale for Establishing EmOC Facilities. Click [here](#)
- DOH LRICs Orientation Seminar. Click [here](#)
- Fourmula 1 Your Roadmap to Health. Click [here](#)
- Implementing Health Reforms Through Fourmula 1 for Health. Click [here](#)
- F1 for Health Operations Manual for Convergence Provinces. Click [here](#)
- Financial Management for EC Grant Convergence Sires. Click [here](#)
- PFM for Health Sector Reform Agenda. Click [here](#)
- General Guidelines for PIPH. Click [here](#)
- MDG Status Report 2007. Click [here](#)
- Medium Term Philippine Development Plan 2004-2010. Click [here](#)
- National Objectives for Health. Click [here](#)
- Health System and the Cycle of Health System Reform Based on International Experience. Click [here](#)

ATTACHMENTS

Basic 7 Administrative Orders for Local Health Reform

1. Administrative Order No. 2006-0017: Incentive Scheme Framework for Enhancing Inter-LGU Coordination in Health through Inter-Local Health Zones (ILHZ) and Ensuring their Sustainable Operations. August 3, 2006
2. Administrative Order No. 2006-0022: Guidelines for Establishment of Performance-Based Budget for Public Health. July 12, 2006
3. Administrative Order No. 2006-0023: Implementing Guidelines on Financing Fourmula One for Health (F1) Investments and Budget Reforms. June 30, 2006

Administrative Order No. 2005-0023: Implementing Guidelines for Fourmula One for Health (F1) as Framework for Health Reforms. August 30, 2005

4. Administrative Order No. 2006-0018: Implementing Guidelines for Philippine National Drug Formulary System. May 8, 2006

Administrative Order No. 2006-0009: Guidelines Institutionalizing and Strengthening the Essential drug Price Monitoring System (EPDMS). February 14, 2006

5. Administrative Order No. 2006-0029: Guidelines for Rationalizing the Health Care Delivery System based on Health Needs. June 5, 2006
6. Administrative Order No. 2006-0002: Establishment of the Continuing Quality Improvement (CQI) Program and Committee in DOH Hospitals. January 23, 2006
7. Administrative Order No. 2006-0020: Guidelines for Evaluation of Consumer Participation Strategies in Fourmula One for Health. June 13, 2006

Local Reform Implementation Coordinators Training (Powerpoint presentations)

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