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Health Management: Strategies from Selected Cities

Virginia S. Pineda

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HEALTH MANAGEMENT: STRATEGIES FROM SELECTED CITIES

Virginia S. Pineda[1]

I. INTRODUCTION

Cities are currently facing the challenges of urbanization and devolution. Urbanization increases the demand for basic services and sanitation facilities. Devolution, on the other hand, gives cities and other local government units (LGUs) autonomy in the mobilization, allocation and utilization of resources. It involves the transfer of power, functions, responsibilities, programs and projects, personnel and assets, as well as their corresponding appropriations, from the National Government to the LGUs. If LGUs fail to mobilize, allocate, and utilize resources wisely to meet the increasing demand for health services, the health of the population would deteriorate.

Devolution has been met with perhaps the strongest resistance in the health sector. There were fears concerning the health workers' security of tenure, the financial and management capability of the LGUs to sustain the devolved facilities and functions, and the politicization of health services. Consequently, there have been moves for recentralization or suspension of devolution.

On the positive side, devolution can facilitate and improve health service delivery. With health workers under the jurisdiction of the LGUs, decision making is faster which allows immediate action on health needs and problems. Greater accountability to and closer association of the local officials with the people put them in the best position to undertake health programs that are locally responsive, relevant and innovative (Borlagdan, Gabronino, and Tracena, 1993).

As devolution proceeded, many local officials complained that the Internal Revenue Allotment (IRA) had been inadequate to cover for the devolved functions and responsibilities. The net transfer of resources (incremental IRA less cost of devolved functions) was negative in 26 out of 76 provinces and in some 20 percent of the 1,500 municipalities in 1993. Although provinces and cities received the same IRA, provinces shoulder 60 percent of the total cost of devolution of health services while cities shoulder only 2.5 percent (Manasan, 1995). Insufficiency and delay in releases of funds adversely affected the implementation of health programs and benefits of health personnel as well as the maintenance and operation of hospitals and other health facilities. Demoralization among devolved personnel, lack of medicines and supplies and deterioration of services in many of the hospitals turned over to provinces have been reported. Budget allocation for health was also eroded in LGUs where health was not a priority of the chief executives. While there are unmet needs in the health sector, total local government expenditures on health, on

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the aggregate, have been lower than what the government used to spend before devolution.

On the other hand, the Department of Health's Local Government Assistance and Monitoring Service (LGAMS) reported that in each of the many places where the health sector and the LGU have succeeded in forging a working relationship, there has been a marked improvement in community participation, closer coordination among the various agencies involved in health and health-related programs, more flexibility in program implementation, and better overall primary health care management. LGAMS was able to document LGU success stories under devolution, specifically, selected municipalities and provinces with innovative responses to devolution's transition problems.

This present study focuses on model cities – those that have exemplary health strategies that could help other cities cope with the demands of devolution and urbanization. Based on the recommendations of the NEDA Regional Offices, eight cities were selected for the case studies on the health sector. The cities have been winners in competitions for best-practice, such as the Galing Pook and Health and Management Information System (HAMIS) Awards.

The paper is organized as follows. The next section specifies the type of health services devolved to cities and those retained by the DOH. This is followed by a comparison of population, health expenditures and health performance of the selected cities before and after devolution. Section 4 presents the cities' various approaches in overcoming common constraints to health financing and service delivery and also their strategies related to systems/administration. The fifth section provides an evaluation of the applicability of the strategies and suggested improvements. The paper ends with some concluding remarks.

II. HEALTH SERVICES PROVIDED BY CITIES AND DOH UNDER DEVOLUTION

With decentralization, city governments will be responsible for the implementation of primary health care and other field health services, aid to puericulture centers, and provision of medical, hospital and other support services (which include primary, secondary and tertiary health services) in the following health facilities:

- Barangay health stations (BHS).
- Rural health units;
- City health offices; and
- City hospitals in highly urbanized cities (excluding those in the National Capital Region).

Primary health care includes health education; control of locally endemic diseases (such as malaria, dengue, schistosomiasis); expanded program of immunization (against tuberculosis, polio, measles, diphtheria, whooping cough, and tetanus); maternal and child health and family planning; environmental sanitation and provision of safe water supply; nutrition; treatment of common diseases; and supply

of essential drugs. It is usually provided by midwives and barangay health workers in Barangay Health stations (BHSs) or Rural Health Units. Secondary health care is given by physicians with basic health training. It is usually done in infirmaries, clinics or hospitals. Secondary level facilities can perform minor surgery and some simple laboratory examinations. Tertiary care is rendered by specialists in hospitals. Tertiary hospitals have staff and facilities to handle complicated cases, intensive and rehabilitative care, diagnosis, treatment, research and training activities.

The DOH retains the following functions, services, facilities, programs, personnel and assets:

- components of national programs which are funded from foreign sources;
- nationally funded programs which are in the process of being pilot tested or are in the process of being developed;
- health services and disease control programs covered by international agreements such as disease eradication programs and quarantinable diseases;
- regulatory, licensing and accreditation functions in accordance with existing laws such as Food, Drugs and Cosmetics Law and hospital licensing; and
- regional hospitals, medical centers and specialized health facilities.

III. COMPARISON OF POPULATION, HEALTH EXPENDITURES AND HEALTH PERFORMANCE OF SELECTED CITIES

A. Population

The population of the cities ranged from about 88,000 persons to 247,000 persons in 1995, with Gingoog having the lowest and Butuan having the greatest population. (Table 1).

Puerto Princesa City had the highest increase in population at 41 percent between 1990 and 1995. In contrast, Olongapo City's population declined by 7 percent for the same period. This may be due to outmigration after the withdrawal of the U.S. Navy from Subic and the Mt. Pinatubo eruption. For the rest of the cities, the rise in population ranged from 5 percent to 19 percent between 1990 and 1995.

Table 1. Population of Selected Cities

City	Population		Percent Change
	1990	1995	
Puerto Princesa	92,147	129,577	40.62
Lapu-lapu	146,194	173,744	18.84
Cotabato	127,065	146,779	15.51
Naga	115,329	126,972	10.10
Butuan	227,829	247,074	8.45
Gingoog	82,582	87,530	5.99
Surigao	100,379	104,909	4.51
Olongapo	193,327	179,754	-7.02
PHILIPPINES	**60,703,206**	**68,616,536**	**13.04**

Source: 1997 Philippine Statistical Yearbook,
National Statistical Coordination Board

Lapu-lapu City was the most densely populated among the cities under study, with almost 3,000 persons per square kilometer in 1995. It is followed by Olongapo and Naga, each with over 1,500 persons per square kilometer. Puerto Princesa and Gingoog had the lowest density, with population per square kilometer of 62 persons and 216 persons, respectively, in 1995.

Table 2. Population Density and Land Area of Selected Cities

City	Density (persons/sq.km.)		Land Area (sq. km.)
	1990	1995	
Lapu-lapu	2,516	2,990	58.1
Olongapo	1,872	1,740	103.3
Naga	1,488	1,638	77.5
Cotabato	722	834	176.0
Butuan	433	470	526.3
Surigao	409	428	245.5
Gingoog	204	216	404.6
Puerto Princesa	44	62	2,106.7
PHILIPPINES	**202.3**	**228.7**	**300,000**

Source: 1997 Philippine Statistical Yearbook,
National Statistical Coordination Board

B. Health Expenditures and Mortality Rates

All the eight cities have lower infant and children mortality rates than the average for the Philippines in 1990 and 1995 (Tables 3-4). However, Surigao, Butuan and Puerto Princesa have higher maternal mortality rates than the national average for the same years. Nevertheless, they showed greater reduction in maternal mortality rates than the national average from 1990 to 1995 (Table 5).

The data on health expenditures and mortality rates (Tables 3-10) indicate a positive relationship between these two variables. The magnitude of the cities' expenditures depends on the extent of the health problem. Cities that have the highest (lowest) mortality rates also have the highest (lowest) health expenditures.

Puerto Princesa had the most substantial increase as well as the biggest health expenditure per capita in 1991 and 1994. The city aimed to reduce its mortality rates which were the highest among the selected cities in 1990 and 1995.

In Olongapo City, the share of health expenditures to total expenditures dropped significantly from 26 percent in 1991 to 8 percent in 1994. The city had the smallest increase in health expenditure per capita between 1991 and 1994. Although it had the highest health expenditure per capita in 1991, it ranked fifth only in 1994. It minimized its health expenditures considering that it had the lowest infant and child mortality rates in 1990 and 1995 and ranked third lowest in maternal mortality rate in 1995.

Likewise, Lapu-lapu City's low health expenditures may be associated with its having low mortality rates. The city had the second smallest increase as well as the lowest health expenditure per capita in 1991 and 1994. It had the second lowest infant, children, and maternal mortality rates in 1990 and 1995.

The cities may be deemed as good examples since they have been adjusting their expenditures to the severity of the problem – spending more when the problem is greatest and spending less when the health problem has been minimized.

IV. HEALTH CONCERNS AND STRATEGIES

A. Strategies for Coping with Deficiencies

In several cases, the cities have confronted the same constraints to health service delivery. These problems and the corresponding different approaches used by the cities in meeting them are as follows:

1. Insufficient Number of Barangay Health Stations

a. Conducting Outreach Activities in Rural Barangays

To deliver basic services to people who live far from government facilities, Gingoog City implemented the G-TIDA (Gingoog Total Integrated Development Approach) in December 1988. The G-TIDA is basically an outreach program to rural barangays. It is integrated since it provides health/medical, infrastructure and other services.

Table 3. Infant Mortality Rates

City	Infant Mortality Rates				
				Rank	
	1990	1995	% change	1990	1995
Olongapo	41.2	30.9	-25.0	1	1
Lapu-lapu	42.0	32.8	-21.9	2	2
Cotabato	45.0	36.1	-19.8	5	3
Surigao	44.3	36.3	-18.1	3	4
Butuan	45.9	36.7	-20.0	6	5
Gingoog	44.7	36.7	-17.9	4	6
Naga	49.6	42.2	-14.9	7	7
Puerto Princesa	52.7	44.8	-15.0	8	8
PHILIPPINES	**56.7**	**48.9**	**-13.8**		

Table 4. Child Mortality Rates

City	Child Mortality Rates				
				Rank	
	1990	1995	% change	1990	1995
Olongapo	54.0	40.2	-25.6	1	1
Lapu-lapu	55.1	43.0	-22.0	2	2
Cotabato	60.9	50.0	-17.9	3	3
Gingoog	61.1	50.2	-17.8	4	4
Surigao	61.8	50.8	-17.8	5	5
Butuan	65.0	52.2	-19.7	6	6
Naga	66.6	56.2	-15.6	7	7
Puerto Princesa	71.8	61.2	-14.8	8	8
PHILIPPINES	**79.6**	**66.8**	**-16.1**		

Table 5. Maternal Mortality Rates

City	Maternal Mortality Rates				
				Rank	
	1990	1995	% change	1990	1995
Naga	150.7	128.1	-15.0	1	1
Lapu-lapu	167.7	130.8	-22.0	2	2
Olongapo	184.0	138.0	-25.0	4	3
Cotabato	182.8	149.9	-18.0	3	4
Gingoog	190.3	156.1	-18.0	5	5
Surigao	237.7	194.9	-18.0	6	6
Butuan	251.3	201.0	-20.0	7	7
Puerto Princesa	253.1	215.1	-15.0	8	8
PHILIPPINES	**209.0**	**179.7**	**-14.0**		

Infant mortality: infant deaths per 1,000 live births;
Child mortality: number of deaths among children less than 5 years of age per 1,000 children of the same age range;
Maternal mortality: number of maternal deaths per 100,000 live births.

Sources: Herrin (1998) and National Statistical Coordination Board

Table 6. Health Expenditures and Ratio to Total City Expenditures

City	Health Expenditures (P)		Health Expenditures (P)/ Total Expenditures	
	1991	1994	1991	1994
Gingoog	2,295,264	10,774,523	0.06	0.09
Butuan	12,262,330	27,512,850	0.11	0.10
Cotabato	3,016,387	8,470,312	0.07	0.05
Naga	3,594,597	10,456,201	0.07	0.06
Puerto Princesa	6,512,001	20,119,268	0.07	0.05
Surigao	3,888,840	12,066,714	0.09	0.06
Lapu-lapu	2,821,137	6,099,927	0.07	0.04
Olongapo	18,764,434	23,586,670	0.26	0.08

Table 7. Ratio of Basic Health and Hospital Expenditures to Total Health Expenditures

City	1991		1994	
	Basic Health Exp./ Total Health Exp.	Hospital Exp./ Total Health Exp.	Basic Health Exp./ Total Health Exp.	Hospital Exp./ Total Health Exp.
Naga	0.48	0.51	0.41	0.59
Olongapo	0.44	0.56	0.41	0.58
Butuan	0.34	0.66	0.43	0.55
Puerto Princesa	0.96	0.00	0.74	0.17
Gingoog	0.97	0.00	0.61	0.05
Cotabato	0.75	0.24	0.95	0.00
Surigao	1.00	0.00	0.77	0.00
Lapu-lapu	0.65	0.00	0.88	0.00

Source: Local Government Audit Office (LGAO)

Table 8. Health Expenditures Per Capita, 1991 and 1994

City	Health Expenditures Per Capita (P)		Amount of Increase (P)	Rank	
	1991	1994		1991	1994
Puerto Princesa	61.51	160.21	99	2	1
Gingoog	27.46	124.54	97	6	2
Surigao	38.31	115.98	78	4	3
Butuan	52.96	113.20	60	3	4
Olongapo	95.01	111.99	17	1	5
Naga	30.58	83.96	53	5	6
Cotabato	22.86	56.46	34	7	7
Lapu-lapu	18.65	36.28	18	8	8

Table 9. Basic Health Expenditures Per Capita, 1991 and 1994

City	Basic Health Expenditures Per Capita		Amount of Increase (P)	Rank	
	1991	1994		1991	1994
Puerto Princesa	59.25	118.66	59	1	1
Surigao	38.31	88.98	51	3	2
Gingoog	26.65	76.15	49	4	3
Cotabato	17.25	53.59	36	5	4
Butuan	18.05	48.78	31	6	5
Olongapo	41.88	46.03	4	2	6
Naga	14.68	34.68	20	7	7
Lapu-lapu	12.04	31.76	20	8	8

Table 10. Hospital Expenditures Per Capita, 1991 and 1994

City	Hospital Expenditures Per Capita		Amount of Increase (P)	Rank	
	1991	1994		1991	1994
Olongapo	53.13	65.12	12	1	1
Butuan	34.91	61.97	27	2	2
Naga	15.55	49.27	34	3	3
Puerto Princesa	0.00	27.38	27	-	4
Gingoog	0.00	5.82	6	-	5
Cotabato	5.43	0.00	(5)	4	-
Surigao	0.00	0.00	0	-	-
Lapu-lapu	0.00	0.00	0	-	-

Source: LGAO

A G-TIDA core group, organized by the mayor, is responsible for planning, identification of the target barangays and the implementation of the outreach program. The core group is composed of the G-TIDA coordinator, the G-TIDA Secretariat, transportation coordinator, logistics coordinator, and specific service coordinators represented by the department heads of the concerned agencies.

The City conducts G-TIDA outreach activities usually once or twice a month. During the G-TIDA Day, the members of the team meet directly with the people and their leaders to discuss the needs and problems of the barangay. If problems cannot be solved immediately, they are referred to the appropriate agency. The G-TIDA team informs the people about the functions and services provided by each agency in the city so they would know which to approach for their specific needs.

The G-TIDA approach has contributed to the building of people's capabilities and participation in local governance. Encouraged and guided by the G-TIDA team, people in some of the far-flung barangays were able to install water pipes connected to a spring using their own local resources and relying on the bayanihan system.

Gingoog's outreach program is now on its tenth year of implementation. It has provided a means for delivering health services in areas without BHSs. Presently, all the fifty (50) Rural Barangays have BHSs manned by at least a barangay health midwife and volunteer health workers. During the early implementation of the program, the G-TIDA team stays for two days and one night in the barangay. However, as requests for outreach activities increased, the conduct of G-TIDA outreach is now limited to about one day per barangay.

The expenses incurred by the various agencies in providing services during the G-TIDA outreach are taken from their regular agency budgets. No new appropriations are provided except for the budget for overhead expenses like gasoline, transportation and food. In 1996 the city government appropriated P189,400 for G-TIDA.

b. Use of Barangay Halls and Rooms of Private Homes for BHS

Cotabato City aimed to provide a BHS for every barangay so that the people can have ready access to basic health services and facilities. However, the city's Office of Health Services (OHS) had very limited financial resources. Its regular budget was just enough to cover personal services and maintenance and operating expenses. In the city's experience, building cost for a concrete BHS is about P100,000. At most, the city could construct only three concrete BHS structures per year. Despite such constraint, the number of BHSs increased from only nine in 1990 to 35 in 1991.

The OHS overcame the lack of permanent BHS structures by using (free of charge) barangay halls and rooms or spaces in homes of concerned citizens as health stations. This strategy enabled the provision of a BHS for each of the city's 37 barangays. At present, Cotabato City has 37 BHSs and seven BHS extensions. Of these 23 are permanent structures constructed by the city while the rest are temporarily placed in barangay halls or private homes.

2. Inadequate Number of Health Personnel

a. Mobilization of Health Volunteers

The common approach to augment manpower is to mobilize volunteers. Cotabato City activated 100 volunteer health workers, mostly trained hilots, to assist the midwives in the BHSs. Similarly, Olongapo has about 300 health volunteers. For its rescue and emergency medical assistance program, Naga City has 400 trained first responders and emergency medical technician volunteers. The volunteers render free services so the cities save on salary expenses. As token of appreciation, Cotabato City gives each volunteer P500 cash gift during December, Olongapo entitles them to hospitalization benefits, and Naga provides them with uniforms, group insurance, and free food while on duty.

b. Organization of Women's Groups

Women proved to be valuable partners of the city governments in the health sector. Olongapo has its Balikatan Ladies of Olongapo Movement (BLOOM). The group has 6,000 members, most of whom are housewives in the community. Its members participate in the city's cleanliness drive and undertake various barangay projects. BLOOM members who also serve as health volunteers work without pay as nursing aides in the city hospital, assist the health workers in immunization drive, and in organizing and conducting health classes.

Similarly, Lapu-lapu City has its 'mothers support groups' which is composed of 410 members. Health personnel ask help from mothers during advocacy activities such as feeding the children during nutrition month.

Surigao City mobilized the largest number of women for health care. Its Primary Health Care Federated Women's Club (PHC) has over 12,000 members as of 1996. This represents about 63.2 percent of the 20,240 households in the city at that time.

The PHC is a people's organization initiated in 1986 by a City Health Office (CHO) midwife who conducted 3-day seminars on health matters and thereafter formed PHC Clubs. The CHO adapted and expanded this strategy all over the city. It appointed a coordinator whose task is to launch PHC clubs. In addition, it provides the training package and resource persons for the PHC classes. Upon completing the course, the participants form a PHC chapter (purok-level) and elect a set of officers.

As health volunteers, the PHC members are involved in the operation and maintenance of Barangay Health Stations (BHS) and feeding centers. They record immunization, bring the pregnant women for pre-natal check-up, assist in feeding the children, conduct health education activities, encourage and teach plant propagation to those who do not have herbal or vegetable garden, and do the necessary follow-ups, such as on children who have not been immunized. They have also learned to treat common illnesses and make herbal cough preparations and liniments. Since the PHC members work on a voluntary basis, this means for the CHO considerable savings on salaries and having thousands of health workers.

c. Involvement of Private Companies/Medical Practitioners

Lapu-lapu City asked private companies and institutions to adopt barangays which they can assist on health needs. They help through their doctors (retainers) who conduct regular monthly free clinic in the adopted barangays and through donating facilities or supplies. One company even handled fogging activities in the entire Lapu-lapu City. At present, ten private companies and five educational institutions have adopted 8 barangays.

The Lapu-lapu City CHO has also involved private medical practitioners from the Mactan Doctors Organization and nurse-volunteers from the Mactan Community Hospital in the immunization program. It provides vaccines for the group during their collaborated immunization program. Moreover, it also requests the said doctors and nurse-volunteers to set aside time for rendering free services to the barangays. Currently, 50 doctors and about 100 nurse-volunteers give free services to the barangay people.

d. Hiring of Temporary/Part-Time Health Personnel

To reach more people and to serve them better, the Cotabato City OHS's target was to have one midwife stationed in every barangay. However, the regular budget could not finance the employment of additional permanent midwives. To solve this problem, the strategy was to hire casual midwives and get their salary from the 20 Percent Development Fund. Thus, the city was able employ 37 casual midwives for its 37 barangays and other casual personnel for the Main Health Center starting in 1993. Salary expenses for these personnel totalled 2.5 million yearly.

For its Satellite Clinics Project which is financed also by the 20 Percent Development Fund, Puerto Princesa City hired five doctors on a contractual and part-time basis. At present, it has five strategically located satellite clinics. Each doctor stays for two days per week in the satellite clinic assigned to him. For the rest of the week, he is free to work in hospitals or engage in private practice. The city government pays each doctor a monthly salary of P10,000.

The schedules of the doctors in the satellite clinics are synchronized to maximize their availability. For example, in one satellite clinic, the doctor's schedule is Monday and Tuesday. In the nearest satellite clinic, the doctor's schedule is Thursday and Friday. In this way, during days when the doctor assigned to a satellite clinic is not scheduled to come, the patient can go to the other satellite clinic and avail of another doctor's services.

3. Lack of Emergency Medical Assistance

a. Emergency Rescue Naga (ERN)

The Naga City government initiated the establishment of the ERN under its Disaster Preparedness Program in April 1991. The ERN is a quick response unit led by the Naga City Hospital personnel. It provides emergency medical assistance, rescue services, and transport to a hospital. It also gives medical back-up assistance to events and conducts regular training on Disaster Preparedness and Management to ERN volunteers and various groups.

The ERN has two telephone hotlines and two VHF controls. Its volunteers are equipped with beepers. Average ERN response time is 3-5 minutes within the city proper and 30 minutes for the farthest mountain barangays some 17 kilometers away. As the ERN has become metro-wide, calls come not only from Naga City but also from neighboring municipalities. Within Metro Naga, an extensive radio network was set up linking all offices of the mayor, the ambulances, and the police and fire stations. Handheld radios were also distributed to key personnel of each LGU. Of the 14 LGUs comprising Metro Naga, only four have fire protection bureaus and five have ambulances. Making the ERN metro-wide enabled sharing of these limited facilities and magnified their benefits.

ERN's core staff includes one paramedic, a driver, and the volunteers. Regular hospital staff, numbering 40, are on call. ERN has 400 trained First Responders and Emergency Medical Technician volunteers. Its participating partners include the Philippine National Police, Bureau of Fire Protection, City Disaster Coordinating Council, Task Force COMET (for calls involving peace and order problems), and other civic organizations which are equally prepared to serve in case disaster strikes.

ERN started with only one ambulance. Currently, its facilities consist of three ambulances, one all-terrain rescue vehicle and one rubber boat stationed at its base at the Naga City Hospital, and a trauma van posted at the Naga City Bureau of Fire Protection. All ambulances are on call 24 hours a day manned by a crew of three on each vehicle. The city government's expenditures on ERN totalled P150,000 for 1997.

For 1996, the ERN responded to 2,257 emergency and transport cases or an average of 6.2 trips per day. It has provided valuable rescue services during calamities. For example, when Super Typhoon Rosing struck Naga in 1996 and floods rose to more than five feet, ERN rescued and evacuated about 310 families or more than 1,700 persons from flood-prone areas to higher levels and to wind-safe buildings. In recognition of its exemplary performance, ERN was honored with several awards. These include the Galing Pook Award (Top Twenty) in 1994, Disaster Management Award (Regional Level 1995 and 1996, National Level 1995) and Alay Buhay Award (given by the Department of Health in 1996).

b. Puerto Princesa City's Satellite Clinics

The city has five strategically located satellite clinics to serve far-flung rural barangays with no access to health services. The clinics handle emergency cases and simple illnesses. For more serious and complicated cases, they are equipped with ambulances to bring the patients to the hospitals.

In the absence of telephones, the satellite clinics use radio communication equipment. Each barangay and tribal community is provided with hand-held radio (VHF transceivers). Emergencies are reported to the barangay chairman who calls the nearest satellite clinic for an ambulance and health personnel. If patients require hospitalization, radio communication enables the clinic to make an advance call to the receiving hospital. This gives the hospital time to prepare and have a team of medical personnel ready for the coming of the patient from the rural barangay.

Each satellite clinic is manned by two midwives, a radio operator, a driver, and a utility man. A doctor stays for two days per week and a dentist comes every two weeks. To accommodate patients who are too weak to move or are in need of further observation or awaiting transport, each clinic is equipped with 4-5 beds. These patients are confined in the clinics for about one to three days.

From 1993-1997, the clinics have served an average of 47,000 patients per year. Most of the cases attended to were respiratory infections and other simple illnesses. The clinics serve as vital link to the city's referral system. They resulted in the increase in emergency cases and decline in the number of patients with simple illnesses going to the hospitals.

For 1997, the budget for the satellite clinics project is P6.2 million. The project was one of the Top 20 Galing Pook Winners in 1996.

4. Financial Constraint and Augmentation

a. Barangay Funds for Health

Olongapo requires its barangays to allocate 5 percent of their Internal Revenue Allotment (IRA) to health and welfare. Drug allocation to the barangays are sourced from this fund. In Cotabato City, the barangays also finance the medicines. In the case of Lapu-lapu City, the barangays provide the allowance for barangay health workers. Depending on its budget, the allowance ranges from P400 to P1,500 per month. Sourcing funds from the barangays reduces the financial burden on the cities and encourages greater involvement of the barangay officials in health matters and in monitoring the activities of the Barangay Health Workers (BHWs).

b. 20 Percent Development Fund

Cotabato City and Puerto Princesa City used the 20 Percent Development Fund for their projects, hiring of temporary health personnel and satellite clinics respectively, which cannot be financed from their regular budget.

c. Contributions

Financial constraints were somehow alleviated by contributions. In Surigao City, BESIG (Barangay Environmental and Sanitation Implementation Group) members contribute their labor while the government provides funds for small infrastructure projects, such as construction of health stations and feeding centers. The city's PHC Federated Women's Club obtained P1.5 million for the construction of its training center from a senator's Countrywide Development Fund

Under the share-food project of a Butuan City barangay, well-to-do families sponsor malnourished children for three months. During this period, the sponsoring family feeds a child every meal.

In Lapu-lapu City, private companies and congressmen contribute for the milk feeding of pre-schoolers and Grade 1 pupils while a food manufacturer regularly gives noodles for children's feeding. They also donate facilities or supplies to barangays.

B. Strategies Related to Systems/Administration

1. Regular Visitation/Interaction with the Barangay People

To identify the people's needs and ways of improving the delivery of health services, the Lapu-lapu City Health Officer toured all the barangays for one month. He traced the city's low performance in the Expanded Program of Immunization (EPI) and the peoples' limited access to health services to the absence of a specific schedule for immunization and the doctors' visits as well as the people's lack of interest. The CHO therefore set a permanent schedule for the immunization and the doctors' visits and encouraged the people to go to the BHSs and avail of health services. As a result, Lapu-lapu was awarded the "Most Accelerated City in EPI" in 1991. Currently, the city health officer goes to the barangays three to four times a week to check on the status of programs being implemented. The mayor also visits the barangays with him about three to four times a month.

The Lapu-lapu City health officer also conducts barangay assembly every quarter. He presents the current health programs and projects initiated by the government and solicits from the community their health problems and priorities. Through the assembly, the community participates in coming up with solutions to address its problems.

In the case of Olongapo City, the mayor goes to the barangays with all the department heads to actually see the people's situation and needs. All the 17 barangays are visited within one quarter. During the barangay consultations, the people tell the mayor their problems and needs. The department head concerned is tasked to take action and start working on them the following day. People report to the mayor in case the problems remain unsolved.

2. Integrated Approach

Gingoog City opted for an integrated approach for its outreach program to deliver various services to its rural barangays. Its officials recognize that there are problems which cannot be solved by one agency alone but by several agencies working together. One example is the malnutrition problem. The City Health and Social Welfare personnel address this problem by feeding malnourished children, teaching mothers proper nutrition, and educating people about family planning. People from agriculture are also needed to teach people how to plant and grow nutritious food. Infrastructure services are also required for the construction of health centers and water system. Thus, Gingoog's G-TIDA involves various service agencies delivering a variety of services to the barangays.

Olongapo City strengthened the linkage between health and sanitation by integrating its environmental management program with health activities. The CHO plays a major role in the city solid waste management project. Its sanitary inspectors regularly inspect their assigned areas and issue citation tickets (fines) to residents and owners of business establishments who violate sanitation ordinances (such as having unclean premises and putting out garbage outside of the scheduled collection time). The combination of health and environmental management resulted in the reduction of the occurrence of sanitation related diseases. such as typhoid fever and paratyphoid infections which declined from 75 percent in 1988 to 9 percent in 1995 per 100,000 population.

3. Clustering of Barangays

For more effective supervision and monitoring, the Cotabato OHS grouped its 37 barangays into seven clusters. Each cluster is headed by a coordinator who supervises and monitors the activities of their respective BHSs and barangay midwives. Dividing the work of supervision and monitoring of the 37 barangays among seven coordinators facilitated these tasks. Focusing on only a few barangays enabled the coordinators to immediately respond to the problems and needs of the barangays.within their respective clusters.

4. Planning, Monitoring and Evaluation of Programs and Activities

a. Seminars/Workshops

Butuan City Nutrition personnel and DILG staff conduct nutrition program planning seminars with barangay leaders. They compare the nutritional status of the puroks in the barangay and guide the leaders in making their own plans for each quarter by asking them to identify problems, think of solutions, identify funding if needed, assign people to handle the problems, and make time table.

The Cotabato OHS conducts semi-annual and annual review of its programs, activities and performance. Through the workshops, the OHS staff and health workers learn of better ways of doing things as they listen to lectures, interact with each other, share their experiences, problems and solutions. The workshops therefore serve as effective monitoring and management tool.

b. Regular Meetings

In Surigao City, the PHC chapter monthly meetings provide the means for identification and discussion of community needs and problems, solutions, development projects, and plans at the purok level. To ensure prompt action and accountability in implementation, the PHC uses a monitoring chart specifying the problems or needs, the steps required, the persons responsible for each step, the target completion date, and what has been accomplished.

Monthly staff meetings, in addition to report submission, are also conducted in Olongapo City to monitor, compare and evaluate performance in the barangays. Likewise, health personnel and workers in each of Lapu-lapu's eight districts and nutrition workers in each of Butuan's ten barangay clusters also hold monthly meetings for the same purpose. Accordingly, causes of low accomplishments are identified and appropriate actions are undertaken, resulting in better performance.

c. Community Data Board

Surigao City's sustained implementation of the community data board enables it to know the health status of each household and identify their needs. Each household is represented in the community data board by a small hut. The hut shows the house number, the name of the family head, the health concerns, and the period covered (first to fourth quarter). For comparison purposes, the previous year's quarterly performance is included as baseline data.

The community data board is updated every quarter through a survey of all the households. The survey inquires on health concerns, such as pregnancies (pre/post-natal), immunization and nutrition status of children, garbage disposal, water source, occurrence of diseases, PHC health insurance membership, and availability of toilet, herbal and vegetable garden.

For each health concern, the health worker and the assisting mothers assign a colored circle to indicate health status. The colors, their meanings, and some examples of their application in different health concerns are as follows.

COLOR	MEANING	EXAMPLE
Blue	Not applicable	Nobody is pregnant in the household
Yellow	Improving	Degree of malnutrition changed from severe to mild
Green	Safe	Children are fully immunized
Red	Danger	No PHC health insurance

By looking at the red circles, the health personnel are alerted on the needs of each household. The concerns of the purok can also be prioritized according to the number of red circles. The top problem is identified as the health concern with the most number of red circles. Comparison with the previous quarter will also show where performance has improved or deteriorated.

5. Recognition of Outstanding and Worst Performers

In Surigao City, outstanding performances are recognized based on how the PHC chapters or members conduct health-related programs, projects and activities, such as the most number of babies immunized and the most number of sanitary toilets constructed. Awards are given to the Ten Outstanding PHC Chapters, Five Outstanding Workers, and Outstanding Couple during the PHC annual convention. The awardees receive prizes in cash and in kind.

Butuan City conducts an annual contest for the most outstanding barangay, known as the "SEARCH FOR BULAWANONG (GOLDEN) BARANGAY". Every quarter, the performances of the barangays are evaluated using various criteria, such as primary health care activities, food production and livelihood programs. Prizes for the winning barangays range from P50,000 to P100,000. The city also ranks barangays in terms of malnutrition rate and announces the poor performers in the barangay captains' meetings. The problems of these barangays and appropriate actions to deal with them are discussed accordingly.

Recognition of outstanding and worst performers motivates barangay leaders and constituents to give their best performance and cooperation in the implementation of programs and projects.

V. APPLICABILITY AND SUGGESTED IMPROVEMENTS

Gingoog City's outreach method of providing health services is useful as temporary measure for coping with the problem of insufficient BHSs. The long-term solution is to provide additional BHS to reach all the barangays. People benefit from the curative and preventive health services provided during an outreach visit but there are health services which have to be done on a regular basis. The G-TIDA approach may be adopted by cities while they are in the process of setting up additional BHS structures or while looking for a facility to house, even temporarily, additional BHSs. To sustain health activities initiated by the outreach team, the CHO could train people from the areas visited as health workers and nutrition scholars. In addition, it could also form and mobilize people's organizations.

Cotabato City's strategy of using barangay halls and rooms or spaces in private homes as a facility for additional BHS is a sort of progression from the G-TIDA method. This enables regular provision of health services rather than a one-shot approach. Another alternative is to rent a space for the BHS. Since the barangay will be the beneficiary of the BHS, the OHS, through the mayor or sanggunian, could ask the barangay officials to take the lead in finding a suitable place for a BHS.

Equally important as having a BHS facility is the availability of health personnel or workers to deliver health services. Mobilization of volunteers and mothers in particular is a good way of supplementing health manpower resources which result in considerable savings in salaries. Likewise, Lapu-lapu City's utilization of free services of private medical practitioners and of doctors of private companies is costless.

The hiring of part-time doctors, as practiced by Puerto Princesa, enables provision of curative services in the barangays. BHS personnel are mostly midwives which mainly focus on preventive health. The experience of the city shows that the availability of doctors in the satellite clinics reduced the number of patients going to the hospitals for consultation and minor illnesses. The city's strategy may also be extended to other health personnel, such as dentists and medical technologists. Barangays may contribute for the salaries of part-time doctors and other health personnel. The latter may serve the barangays on a rotation basis.

The providers of emergency medical assistance, Naga and Puerto Princesa can learn from each other. Puerto Princesa could follow Naga City's mobilization of volunteers for handling emergencies. On the other hand, the latter may consider stationing of ambulances in strategically located barangays as done in Palawan's satellite clinics (or in the farthest barangays). In this way, the ambulance need not come from the city proper but any ambulance nearest to the place of emergency can respond immediately, thus saving travel time.

The cities in the case studies provide free services and medicines in their health facilities (BHSs and satellite clinics) and in the use of ambulances. In some cases, they were able to obtain financial and in-kind contribution from individuals or private companies. One possible source of funds is cost-recovery, specifically, charging fees for medicines, use of ambulances, and medical services. Only those which are really indigent may be exempted from payment. This requires a system for determining the people's capability to pay.

VI. CONCLUDING REMARKS

Like all local government units, the subject cities in the case studies faced the challenge of devolution. They were also confronted with various constraints to delivery of health services. Because of their ability to overcome these limitations and make devolution work to their advantage, they can be considered as model cities for others to emulate.

Devolution is a step towards the fulfillment of the DOH's vision of "Health in the Hands of the People" by the year 2020. In the course of devolution, the government devised various measures to assist the LGUs. To advise the LGUs on health plans and budget, the 1991 Local Government Code provides for the creation in every LGU of a Local Health Board (LHB) composed of local chief executives and health officers, representatives from the DOH and the private sector or non-governmental organization. To ensure the speedy resolution of devolution-related issues and personnel problems, Transition Action Teams (TATs) at the provincial and regional levels have also been created. The DOH also established the Local Government Assistance and Monitoring Service (LGAMS) to attend to local government concerns. It also provides for Comprehensive Health Care Agreements (CHCAs) wherein priority health programs are implemented with DOH assistance and LGU counterpart.

A number of studies have identified some remaining issues that should be addressed so that devolution could work well (Legaspi (1995), Brillantes (1997), and Gaffud (1997), as cited by Herrin (1998)). Specifically, the following are needed: resolution of the issue of the inequitable distribution of IRA shares vis-a-vis devolution burdens (IRA reallocation bills are currently pending in Congress); technical assistance to LGUs in exploring alternative schemes for raising additional financial resources and in improving their capability in the management of devolved hospitals; greater participation of NGOs and POs (people's organizations) in local special bodies; and development of alternative modes of inter-governmental cooperation to deal with issues of service delivery and monitoring that cuts across jurisdictional boundaries and to consolidate and strengthen efforts in advocacy and social mobilization.

On the part of the DOH, it could jointly undertake with the LGUs revenue enhancement projects in devolved hospitals and other facilities just as it has done in its retained hospitals, such as the Rizal Medical Center in Pasig City and the Ilocos Regional Hospital in La Union. It could provide technical assistance in improving pricing, billing and collection systems of devolved facilities. Moreover, the DOH could help enhance the LGUs' capability in managing devolved facilities through continued trainings of concerned LGU officials and personnel.

The model cities provide some useful ways for dealing with the devolution issues. In general, their leaders and health officers promoted good management by interacting with the people and finding out their needs and problems. To alleviate financial constraints, they obtained financial and other forms of assistance from private companies, congressmen, and civic-minded individuals. Furthermore, they encouraged people participation in delivery of services by mobilizing volunteers, women's groups, and private medical practitioners. Inter-LGU cooperation was also achieved in the provision of emergency rescue services in the case of Naga City's ERN which has evolved into a Metro-Naga activity involving a total of 15 LGUs.

With the political will of leaders, commitment of health officers, and people participation, as exemplified by the model cities, together with national government support in terms of DOH assistance and equitable IRA distribution, and given sufficient time for adjustment, devolution could work well and result in the improvement of health service delivery to the people.

REFERENCES

Asis, M. "Community-based Initiatives in Health: Development, Growth and Transformation". Department of Health (DOH)-Health and Management Information System (HAMIS) Occasional Paper No. 8. Manila: DOH-HAMIS, 1994.

Borlagdan, S., Gabronino, G., and Tracena, A. "Health Service Delivery: Issues, Problems, and Prospects of Devolution". Philippine Journal of Public Administration. Vol. XXXVII, No. 1, January 1993.

Briones, R., Rodriguez, A., and R. Teh, Jr. "The Regulatory Environment in the Health Care Sector. PIDS Discussion Paper No. 95-30. Makati: PIDS. 1995.

Herrin, A. Beyond 2000: "An Assessment of the Health, Nutrition and Education Sectors, 1992-1996". Forthcoming PIDS Discussion Paper.

Local Government Assistance and Monitoring Service (LGAMS). Devolution Matters: a Documentation of Post-Devolution Experiences in the Delivery of Health Services. Manila: Department of Health (DOH). No Date.

LGAMS. "Health Services and Local Autonomy". Manila: DOH. No Date.

Manasan, R. "Fiscal Decentralization: The Early Years of Code Implementation". PIDS Development Research News. Vol. XIII, No. 4. July-August 1995.

National Statistical Coordination Board. Philippine Statistical Yearbook. Makati: NSCB, 1997.

Quieta, R. "Health Strategies and Interventions: Extended Case Studies on Good Health Care Management in the Philippines". DOH-HAMIS Occasional Paper No. 9. Manila: DOH-HAMIS, 1994.