

Pantig, Ida Marie T.; Lorenzo, Pauline Joy M.; Ramos, Tatum P.

Working Paper

Transitioning to a province-wide health system: Experience of the provinces of Bataan and South Cotabato

PIDS Discussion Paper Series, No. 2024-09

Provided in Cooperation with:

Philippine Institute for Development Studies (PIDS), Philippines

Suggested Citation: Pantig, Ida Marie T.; Lorenzo, Pauline Joy M.; Ramos, Tatum P. (2025) : Transitioning to a province-wide health system: Experience of the provinces of Bataan and South Cotabato, PIDS Discussion Paper Series, No. 2024-09, Philippine Institute for Development Studies (PIDS), Quezon City, <https://doi.org/10.62986/dp2024.09>

This Version is available at:

<https://hdl.handle.net/10419/311697>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

Transitioning to a Province-Wide Health System: Experience of the Provinces of Bataan and South Cotabato

Ida Marie T. Pantig, Pauline Joy M. Lorenzo, and Tatum P. Ramos



The PIDS Discussion Paper Series constitutes studies that are preliminary and subject to further revisions. They are being circulated in a limited number of copies only for purposes of soliciting comments and suggestions for further refinements. The studies under the Series are unedited and unreviewed. The views and opinions expressed are those of the author(s) and do not necessarily reflect those of the Institute. Not for quotation without permission from the author(s) and the Institute.

This study is carried out with support from the Technical Education and Skills Development Authority (TESDA).

CONTACT US:

RESEARCH INFORMATION DEPARTMENT
Philippine Institute for Development Studies

18th Floor, Three Cyberpod Centris - North Tower
EDSA corner Quezon Avenue, Quezon City, Philippines

publications@pids.gov.ph
(+632) 8877-4000

<https://www.pids.gov.ph>

Transitioning to a Province-Wide Health System:
Experience of the Provinces of Bataan and South Cotabato

Ida Marie T. Pantig
Pauline Joy M. Lorenzo
Tatum P. Ramos

PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES

August 2024

Abstract

The integration of different levels of local health systems into Province- or City-wide Health Systems (P/CWHS) in the Philippines is a reform that is designed to help the achievement of a responsive and efficient health system, financial and social risk protection, and better health outcomes. The majority of Universal Health Care Integration Sites (UISs) have already achieved the Key Result Areas (KRAs) for the Preparatory and Organized Levels. Using the case study approach, this study aimed to explore how local government units (LGUs) and other stakeholders have navigated through the transition process given existing policies and frameworks. It looked into the P/CWHS components and the experiences of the provinces of Bataan and South Cotabato in the integration process, and determined enabling and facilitating factors, innovations, and challenges. Enabling and facilitating factors include LGU initiative and appreciation of P/CWHS benefits; partnerships of provinces with national government agencies (NGAs), nongovernmental organizations (NGOs), development agencies, and private sector that provide technical and financial assistance; presence of legal instruments; and optimization of existing monitoring systems. LGUs have also carried out innovative practices such as documenting efforts during the initial stages and engaging development partners and NGOs that increase understanding of P/CWHS, help address challenging KRA and Health Care Provider Network (HCPN) requirements, and generally facilitate transition. Challenges have, nevertheless, been encountered. These obstacles include the limited awareness of the LGU roles and responsibilities, time and resource costs of requirements to fully integrate and transition, piecemeal understanding of P/CWHS and Universal Health Care (UHC) reforms among local leaders, lack of guidance on how the private sector can integrate, lack of technical assistance from the Central Office, and lack of interoperability of datasets from various health information systems of provinces. Given the findings, this study provides the following policy recommendations to scale up the integration efforts: ensure proper communication of accurate information to stakeholders; jumpstart discussions on private sector integration into the HCPN; implement, evaluate, and progressively enhance the financing reforms to be implemented; provide resources to augment LGU funding for transition requirements; and incorporate plans to ensure optimal participation of the population in the P/CWHS.

Keywords: UHC Law, province-wide health system, integrated health systems, health care provider network, inter-LGU cooperation

Table of Contents

1. Introduction.....	1
2. Review of Related Literature.....	3
3. Methodology	4
3.1. <i>Conceptual Framework.....</i>	4
3.2. <i>Research Design</i>	6
3.2.1. Case Studies	6
3.2.2. Document Review.....	8
4. Components of a Province-wide Health System (PWHS).....	9
4.1. <i>Establishment of a Health Care Provider Network (HCPN)</i>	9
4.2. <i>Management and Organizational Structure</i>	11
4.3. <i>Characteristics of Integration</i>	13
4.4. <i>Major Reforms in the Transition to a Province-wide Health System</i>	18
5. Status of Transition to PWHS: Bataan and South Cotabato	23
5.1. <i>Health Sector Profile of the Provinces of Bataan and South Cotabato</i>	23
5.2. <i>Transition to Province-wide Health System: Initial Phases</i>	25
5.3. <i>Health Care Provider Network (HCPN) Formation</i>	25
5.4. <i>Management Support Unit (MSU) Creation.....</i>	26
5.5. <i>Local Health System Maturity Level (LHS ML) Scorecard and Integration</i>	27
5.6. <i>Case Study Results: Experiences of Bataan and South Cotabato.....</i>	30
5.6.1. Service Delivery	33
5.6.2. Health workforce	34
5.6.3. Health Information System.....	34
5.6.4. Procurement and Supply Chain management.....	35
5.6.5. Financial Management.....	35
5.6.6. Unified Governance	36
6. Discussion.....	37
6.1. <i>Inter-LGU Cooperation towards PWHS: enabling and facilitating factors</i>	37
6.2. <i>Innovations for Inter-LGU cooperation towards PWHS</i>	39
6.3. <i>Challenges in the implementation of PWHS</i>	39
7. Conclusion and Policy Recommendation	42
Bibliography	44
Annexes.....	47

List of Tables

Table 1. Summary of components of an integrated health system	5
Table 2. Key Informant Interviewees	8
Table 3. List of Focus Group Discussion Participants.....	8
Table 4. Local Health Systems Maturity Level (LHS ML) Characteristics and Key Result Areas (KRAs)	15
Table 5. Major reforms in the Province- and City-wide Health System	19
Table 6. Health outputs and outcomes for Bataan and South Cotabato, 2022	25
Table 7. Number of KRAs achieved per level*, Bataan and South Cotabato	27
Table 8. Status of KRAs for Bataan and South Cotabato as of August 2023.....	27
Table 9. Summary of KII and FGD results per KRAs based on the WHO Health System Blocks	30

List of Figures

Figure 1. Theory of change for health system integration.....	6
Figure 2. Map of the study sites	7
Figure 3. Components of a Health Care Provider Network (HCPN).....	10
Figure 4. Reconstituted Provincial/City Health Board	12
Figure 5. Recommended Structure of the HSDD and HSSD of the P/CHO	12
Figure 6. Status of LHS ML Achievement by Characteristic for 71 UHC Integrated Sites as of August 15, 2023.....	18
Figure 7. Organization of the Philippine Health System after Devolution	23

List of Annexes

Annex A. KRAs with Means of Verification (MOV).....	47
Annex B. List of hospitals, infirmaries, and rural health units in the province of Bataan.....	51
Annex C. List of hospitals, infirmaries, and rural health units in the province of South Cotabato	52

Transitioning to a Province-Wide Health System: Experience of the Provinces of Bataan and South Cotabato

Ida Marie T. Pantig, Pauline Joy M. Lorenzo, and Tatum P. Ramos¹

1. Introduction

The enactment of Republic Act No. 11223, or the Universal Health Care (UHC) Act of 2019, signaled the Philippines to carry out key health sector reforms towards increasing healthcare access and equity in the country (Villaverde et al. 2022). To achieve this, the UHC Law directed the integration of the different levels of local health systems into Province- or City-wide Health Systems (P/CWHS). According to Section 19.6 of the UHC Act and its Implementing Rules and Regulations (IRR), the integration of local health systems will provide the “mechanism of cooperative undertakings among the LGUs to ensure the effective and efficient delivery of health services provided under Section 33 of RA 7160 (Local Government Code of 1991).”² Further, at the provincial level, Section 19.10 states that “municipalities and component cities shall endeavor to integrate their Municipal Health Offices, Component City Health Offices, Municipal Hospitals, Component City Hospitals, and LGU-managed health care providers with the Provincial Health Office, Provincial Hospital(s), and District Hospitals to constitute a province-wide health system.”³ The integration, however, retains the municipalities’ existing function over their respective health facilities and personnel under RA 7160 but will now be under the administrative and technical supervision of the Provincial Health Board. Prior to the UHC Reform, each municipality and component city would manage its own health system—including health workforce and capital investments in health—which has long been the source of the country’s fragmented health system and is likely the cause of inequities in access to quality and affordable health care in the country. Apart from minimizing the fragmentation among the different levels of LGUs, the P/CWHS also provides the platform for private sector participation through contractual arrangements with the public sector, or through other means, subject to existing laws and policies (Section 19.3).

The transition to a province- and city-wide health system (P/CWHS) requires the establishment of a Health Care Provider Network (HCPN) and the technical, managerial, and financial integration of the local government units (LGUs) under the province-wide health system (PWHS). The HCPN is a group of “primary, secondary, and tertiary care providers that offer comprehensive health care in an integrated and coordinated manner to their catchment population” (Villaverde et al. 2022, p.4). Inter-LGU integration, on the other hand, requires major stakeholders such as the provincial government and relevant offices, provincial health office, local chief executives of municipalities and component cities and their health offices, and human resources for health (HRH) and other health service providers.

¹ Consultant, Senior Research Specialist, Supervising Research Specialist, respectively, Philippine Institute for Development Studies. The authors were supervised by Dr. Marife Ballesteros and assisted by Jenica Ancheta in data analysis and administrative support during field work.

² Universal Health Care Act (RA. No. 11223) and its IRR

³ Universal Health Care Act (RA. No. 11223) and its IRR

The HCPN is founded on a strengthened and capable primary care system and guided by the Primary Health Care (PHC) approach. DOH defines primary care as “initial-contact, accessible, continuous, comprehensive, and coordinated care that is available and accessible at the time of need [...] and the ability to coordinate referrals to other health care providers in the health care delivery system, when necessary,”⁴ while PHC refers to a “whole-of-society approach that aims to ensure the highest possible level of health and well-being through equitable delivery of quality health services.”⁵ The HCPN has the Primary Care Provider Network (PCPN) at its base, which are composed of either public, private, or mixed public-private primary care providers offering people-centered, integrated, and comprehensive primary care services to the population.

As for LGU integration, the Department of Health (DOH) has developed the guidelines for the integration of LGUs into P/CWHS through DOH Administrative Order No. 2020-0021. Section VII.C provides the implementing mechanisms and specific guidelines on the characteristics of P/CWHS integration, which are (1) Managerial and Technical Integration, and (2) Financial integration. These characteristics are to be achieved according to different levels of progress: Level 1 for the Readiness of the P/CWHS, Level 2 for an Organized P/CWHS, and Level 3 for a Functional P/CWHS.⁶ The characteristics are guided by the (1) components of the WHO Health System Building Blocks Framework: Leadership and Governance, Financing, Health Workforce, Information, Medical Products, Vaccines and Technologies, and Service Delivery; (2) Characteristics based on Sections 41.4.c and 41.4.d of the UHC Act IRR describing the features of the P/CWHS that have achieved managerial and financial integration, and (3) Key Result Areas (KRAs) or the minimum outputs expected to be delivered by the P/CWHS that can facilitate the achievement of integration.

To monitor the progress of local health systems integration provided by the UHC Act, the Local Health Systems Maturity Level (LHS ML) is used as the framework that guides the categorization of different P/CWHS into the different levels through the achievement of the KRAs. DOH Department Memorandum No. 2020-0469 presents the LHS ML Monitoring Tool that list the KRAs to be achieved. An LHS is said to have achieved Preparatory Level (Level 1) if it has met all 16 Level 1 preparatory level KRAs, Organized Level (Level 2) if it has met all 36 Level 2 organizational KRAs, and Functional Level (Level 3) if it has met all 20 Level 3 functional KRAs.

With the formation of an HCPN and the inter-LGU cooperation and action required of local health systems to attain P/CWHS integration, the objective of this study is to explore how LGUs and all the stakeholders navigate through the process of transition. This study will explore the components of the P/CWHS such as the HCPN, its management structure, and the characteristics of integration and their level of implementation. Taking from the experience of our study sites—the provinces of Bataan and South Cotabato—this study will describe the experience of LGUs in their integration process and identify factors that enabled and facilitated integration. Lastly, this study will identify

⁴ DOH AO 2020-0024. “Primary Care Policy Framework and Sectoral Strategies” (page 2)

⁵ DOH AO 2020-0024. “Primary Care Policy Framework and Sectoral Strategies” (page 2)

⁶ Level 1 refers to achievements related to preparatory works and other supporting mechanisms that are needed to facilitate the integration of local health systems, including securing of legal and political support of stakeholders, setting of baseline and planning of development. Level 1 KRAs also involve organization of the management structure and the creation of the Special Health Fund. Level 2 refers to outputs that are important for the organization and management of integrated local health systems such as establishment of network of health facilities and services, linking of primary care provider networks to secondary or tertiary care providers, and other work related to the development of the Health Care Provider Network (HCPN). Level 3 looks at a functional health system after achieving all minimum outputs and continued monitoring of the functionality of the health system will be done.

the challenges encountered by LGUs in their integration and recommend possible actions to address the bottlenecks in local health system integration and transitioning to a P/CWHS. Section 2 provides a literature review on local health systems integration and is followed by a description of the methodology for this study in Section 3. This is followed by Section 4 which describes the components of the PWHS as proposed by the DOH. Section 5 presents the status of the study sites in the transition and the results of the case study, providing highlights of their experiences. Section 6 consolidates these findings and discusses the enabling and facilitating factors, innovations, and challenges. Section 7 concludes and recommends actions for future implementation.

2. Review of Related Literature⁷

Health system integration has been one of the key reforms being put forth believed to address health system fragmentation and to improve health outcomes (Robinson and Casalino 1996; Miller 1996; Maruthappu, Hasan and Zeltner 2012). Health systems are believed to operate as firms, and following economic theory, firms integrate to increase efficiency through economies of scale, improve their market power, and resolve transaction costs involved with multiple external suppliers (Laugesen and France 2014). Comparing the US model and the UK model, Laugesen and France (2014) find that while all three criteria should hold true, only the reduction in transaction costs remains as the main motivation for integration in these two health systems. The US has opted to integrate to contain the costs associated with the move from fee-for-service to standardized national service lists with fee schedules and diagnosis related groups (Laugesen and France 2014). In addition, integration promises reduced administrative costs, lower medical care prices, utilization and expenditures, and higher quality of care (Miller 1996). It is also believed that health systems integrate to address growing concerns with population aging, growing medical complexity, increasing rates of chronic diseases, and multimorbidity, in addition to rises in technological costs (Maruthappu, Hasan and Zeltner 2012). Integration, as defined by the WHO, is the concept of bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. WHO furthers that integration “is a means to improve the services in relation to access, quality, user satisfaction, and efficiency” (Gröne, Garcia-Barbero, & WHO European Office for Integrated Health Care Services. 2001, p.7).

Evidence on integrated health systems have been mixed. Quality of care is better in integrated health systems based on the systematic review done by Hwang et al. (2013). According to literature reviewed in their study, outcomes with respect to number of office visits, rate of admission, duration of stay, medication mistakes, clinical effectiveness, and rate of adverse health outcomes improved under integrated healthcare delivery systems (Hwang et al. 2013). Goniewicz et al. (2021) conducted a systematic and non-systematic review and content analysis, and they found integrated healthcare systems having a great role in countries in the European Union healthcare system reforms. Among the topics discussed in their study is healthcare integration between organizational, clinical, and individual levels of care with subthemes including aging patient, disease panorama, advancing technology, and commitments on services and supply. Feng et al.

⁷ Studies cited in this paper include evidence reviews, reviews of literature, or systematic reviews like that of Hwang et al. (2013), Goniewicz et al. (2021), Liljas et al. (2019), Dorling et al. (2015), Herndon (2001), etc. Please see references cited therein.

(2021), through their study on the effects of an integrated delivery system of a medical care group in Huzhou, China, found improvements in dimensions on breadth of diagnosis and treatment, patient satisfaction, surgical ability, and efficiency of diagnosis and treatment. The benefits of integration are also evidenced by reduced hospital admission rates and duration of stay for older adults (Liljas et al. 2019); enhanced health outcome for people with diabetes and reduced hospital admission rates (Dorling et al. 2015); and higher ratio of admissions between primary healthcare institutions and hospitals in a tight integration, and improved healthcare quality for people with diabetes and hypertension (Yuan et al. 2022). On the other hand, care quality was observed to be adversely affected due to physician's modifications in their care processes, increases in patients' post-procedure complications, and negative effects on quality and overall expenditure for each physician after vertical integration in the United States of America because of the integration's financial incentive structure that prevents allocation of expensive resources to relatively unprofitable procedures (Saghafian et al. 2023). Despite this, Saghafian et al. (2023) did find improvements in operational efficiency through increased throughput after integration.

To achieve integration, enabling and limiting factors come to play. Maruthappu, Hasan and Zeltner (2012) identified core factors that include adequate financing, changing clinical cultures, supportive regulation, and flexible administrative reorganization; enabling factors including IT infrastructure, clinical leadership, common values, and evaluation methods, and barriers to overcome which include involvement of primary, community and social care, identification of target population, leadership coalition, and funding realignment. Miller (1996) identified financing-related barrier which could limit integration, such as continuation of fee-for-service instead of capitation which has more incentive to coordinate, integrate and manage care across sites of care and keep hospital beds empty, not full. Herndon (2001), who relayed the situation in the United States of America, discussed the failures of integrated delivery systems in enhancing quality, giving uniform and integrated care, and reducing costs. He pointed out that the battlefield for the success of the systems is clinical integration wherein there should be shared clinical services, and continuity and less variation in care. Attention should be given to such obstacles.

Health systems transformation and not merely health systems strengthening is needed to make UHC work, and this involves actions such as transforming policy development and implementation, establishing public-private partnerships, transforming systems and processes, and adopting a systems lens (Michel, et al. 2019). With the multitude of aspects covered by integration, action from all actors is necessary. In addition, innovative approaches such as having a platform for cooperative partnership, such as the Philippines' PWHS, can facilitate the implementation of reforms and provide the avenue for training, testing initiatives, and performance assessment (Tumusiime et al. 2019).

3. Methodology

3.1. *Conceptual Framework*

The transition to a P/CWHS and the attainment of its health system goals rests on the inputs, interventions, attainment of expected outputs and intermediate outcomes. This study proposes a

theory of change based on a review of reports, policies, and literature on UHC, health system integration, and established frameworks for health systems. In this theory of change that was developed for this study, the inputs, based on the P/CWHS requirements, are: (1) the manuals, policies, frameworks, and guidelines developed by the DOH for the UHC and P/CWHS, (2) the current supply and the additional health care providers, and (3) the financing from national, local, and other (external) sources. These inputs, with the application of appropriate interventions, are expected to result to the following outputs: functional HCPN with unhampered patient care, efficiently financed local health system with delineated financing sources and purchasing arrangements, properly managed P/CWHS across technical, managerial, and financial aspects, and accomplished KRAs for full P/CWHS integration. For the interventions, we refer to the findings of Piquer-Martinez et al. (2024) on their systematic review of integrated health systems. Their review resulted to having identified the 11 components of an integrated health system common to published literature on the subject matter, summarized in Table 1. In addition, they emphasized that integration is not the end goal, but rather “a process to achieve other outcomes, such as integrated care or improved market performance of the system, and ultimately, a way to enhance health outcomes” (Piquer-Martinez et al. 2024).

Table 1. Summary of components of an integrated health system

Component	Description
Stakeholder management	Strategic engagement and alignment of all parties involved in healthcare and emphasizes the importance of strong relationships among actors
Adequate funding	Strategic allocation and management of financial assets to drive health integration; involves sourcing of funds, leveraging on incentives to steer integration
Technological connectivity	Creation and effective use of shared technological platforms and efficient sharing of vital information
Roles	Ensuring that every stakeholder understands their specific functions and responsibilities, therefore ensuring a harmonized approach to care
Governance	Involves crafting and implementing an organizational blueprint that consists of governing boards, leadership assemblies, and steering committees
Communication	Systemic and strategic interactions within the health system framework
Shared vision, values, goals, and trust	Highlights the importance of consensus and alignment among stakeholders
Context	Recognition of the need for adaptability and underscores the importance of tailoring health integration strategies to local conditions, market dynamics, or specific regional factors
Culture	Focus on cultivating a shared understanding of group dynamics, stories, and values
Community engagement	Proactive drawing of the broader community into the integration process
Co-location	Placing of health service providers in shared or nearby locations

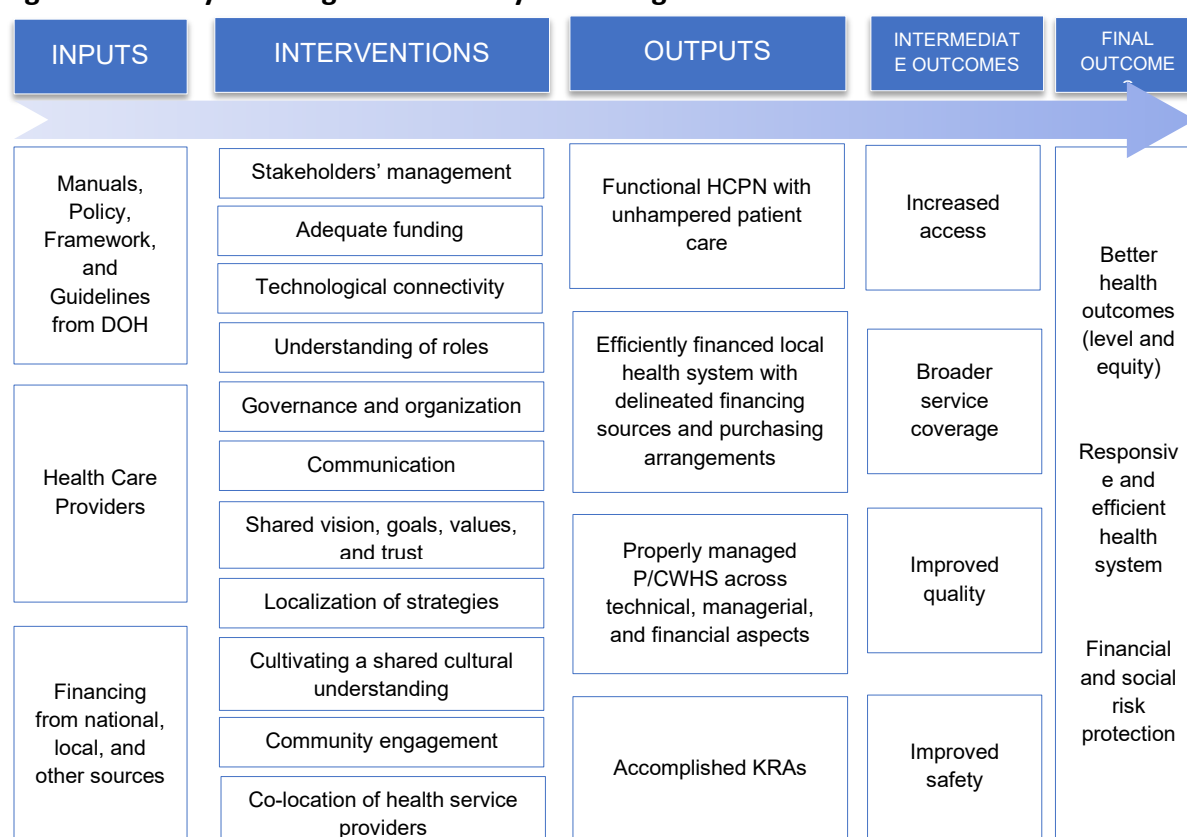
Source: Piquer-Martinez et al. 2024 (p. 2-4)

Upon achieving the outputs, the expected intermediate outcomes are based on WHO’s Health System Building Blocks framework, where upon strengthened system building blocks including Service Delivery, Health Workforce, Health Information System, Access to Essential Medicines,

Financing, and Leadership/Governance, the intermediate outcomes of increased access to the health system, broader service coverage, improved quality of care and safety are all achieved, leading to the final outcomes of better health (in terms of level and equity), responsive health system, and provision of financial and social risk protection. The building blocks are assumed to be embedded in the inputs and the application of interventions to build on the expected outputs of an integrated P/CWHS.

This framework is presented in Figure 1. It is important to note, however, that this study will only cover the inputs, interventions, and outputs component of the theory of change, as the review and assessment of the intermediate and final outcomes are outside the scope of this work.

Figure 1. Theory of change for health system integration



Source: Authors' rendition

3.2. Research Design

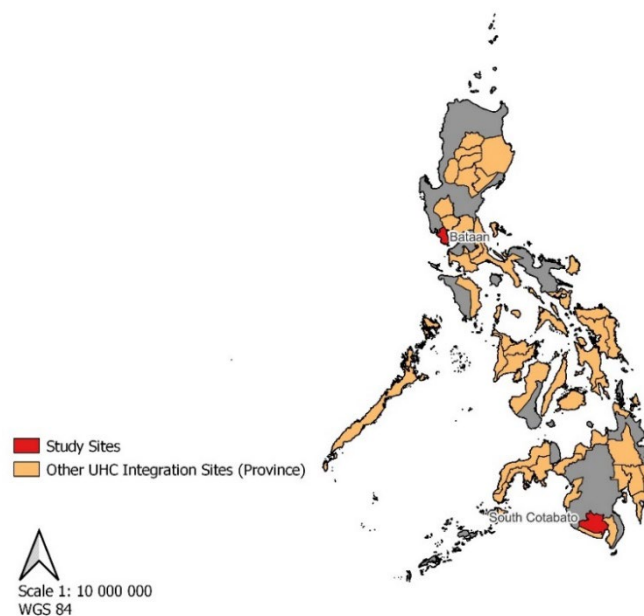
3.2.1. Case Studies

This study employed a case study approach and used various data collection methods like document review of pertinent reports and records, key informant interviews (KIIs), and focus

group discussions (FGDs). The case study approach aims to provide an in-depth understanding of an event or phenomenon in real-life situations (Crowe et al. 2011). Using this approach, the study will highlight and document the experiences of the identified study sites attaining their targets in relation to the integration of the health systems. The study also investigated the bottlenecks each province encountered and how they overcame these. This will provide better understanding of what provincial local governments experience in organizing the inter-local collaboration to attain the goals and objectives of the UHC Law.

3.2.1.1. *Study sites.* There were 58 UHC integration sites (IS) monitored as of the first assessment done by DOH in 2020. Out of the identified sites, 33 of which were classified in an advanced level, these are: Benguet, Isabel, Nueva Vizcaya, Quirino, Bataan, Tarlac, Batangas, Quezon, Oriental Mindoro, Masbate, Sorsogon, Aklan, Antique, Guimaras, Iloilo, Cebu, Biliran, Leyte, Samar, Zamboanga del Norte, Cagayan de Oro, Misamis Oriental, Compostela Valley, Davao del Norte, Sarangani, South Cotabato, Agusan del Sur, Agusan del Norte, Maguindanao, Valenzuela City, Parañaque City, Dagupan City, and Baguio City. Among the list, the DOH have identified the provinces of Bataan and South Cotabato as model provinces. Both provinces were pilot areas for the Service Delivery Network (SDN). Also, according to their LHS ML Scorecard for 2022, both provinces have achieved Level 1 (Readiness) Status by accomplishing all 16 KRAs. Both provinces are on their way towards achieving Level 2 status with ongoing works on the different KRAs on the organization of their P/WHs. Figure 2 describes the location of the selected study sites in relation to other provinces selected as UHC integration sites.

Figure 2. Map of the study sites



Source: Authors' rendition

3.2.1.2. *KIIs and FGDs*. KIIs and FGDs were part of the data collection for the case studies, Field visits for the conduct of the KIIs and FGD were done in September 2023-January 2024 in both study sites. Table 2 summarizes the key informant interviewees and Table 3 list the participants in the FGDs. The KIIs and FGDs aim to explore the enabling factors, innovative approaches, and the challenges that each player encountered in their transition to PWHS. The KII/FGD tool is outlined according to Roles and Responsibilities of the Respondent, Processes for the monitoring and establishment of the P/CWHS, and Issues and Challenges faced.

Table 2. Key Informant Interviewees

Province	Designation	Office
Bataan	Medical Officer IV	Central Luzon Center for Health Development (CHD)
	Provincial Health Officer II	Integrated Provincial Health Office, Bataan
	Municipal Health Office	Municipality of Samal, Bataan
South Cotabato	Regional Director	CHD XII
	Division Chief	CHD XII
	Nurse II	CHD XII
	Provincial Health Officer I/Focal person for UHC,	Integrated Provincial Health Office (IPHO), South Cotabato
	Nurse II/UHC Coordinator	Integrated Provincial Health Office (IPHO), South Cotabato

Source: Authors' summary

Table 3. List of Focus Group Discussion Participants

	Designation	Office
Bataan	OIC Immediate Past President	DOH Treatment and Rehabilitation Center Bataan Medical Society
	Training Specialist IV	Bataan General Hospital and Medical Center
	Hospital Administrator	Administrator - Bataan St. Joseph Hospital
South Cotabato	President	AMCHOP South Cotabato
	Hospital Administrator	Allah Valley Medical Specialist Center, Inc.
	Program Manager	Mahintana Foundation
	Medical Specialist	Dr. Arturo P. Pingoy Medical Center
	Medical Specialist II	South Cotabato Provincial Hospital

Source: Authors' summary

3.2.2. Document Review

Apart from the case studies, a review of documents related to UHC including policies and frameworks from the DOH on the establishment of the P/CWHS was done. These include, but are not limited to, DOH guidelines on the formation of the HCPN, integration of local health systems

into the P/CWHS, implementation of the LHS ML, annual LHS ML reports, and frameworks on key areas such as primary care, health promotion and private sector participation. Other documents include DOH publications on UHC, and joint memorandum circulars on P/CWHS financing. These documents were used in setting the model which a P/CWHS aims to achieve.

4. Components of a Province-wide Health System (PWHS)

A PWHS is characterized by an integrated local health system in which health service delivery to individuals and communities are provided in a continuous and integrated manner. For such undertaking, inter-LGU cooperation is imperative to ensure that LGUs complement an individual LGU's health operation. Under a PWHS, all health offices of the province, municipality, and component cities, including provincial, district and municipal hospitals and health centers, will be consolidated at the provincial level under the management and supervision of the Provincial Health Office. To operationalize a PWHS, the following implementing mechanisms shall be implemented: (1) establishment of a HCPN, (2) creation of the Management Structure of the PWHS, and (3) integration at the managerial, technical, and financial levels.⁸

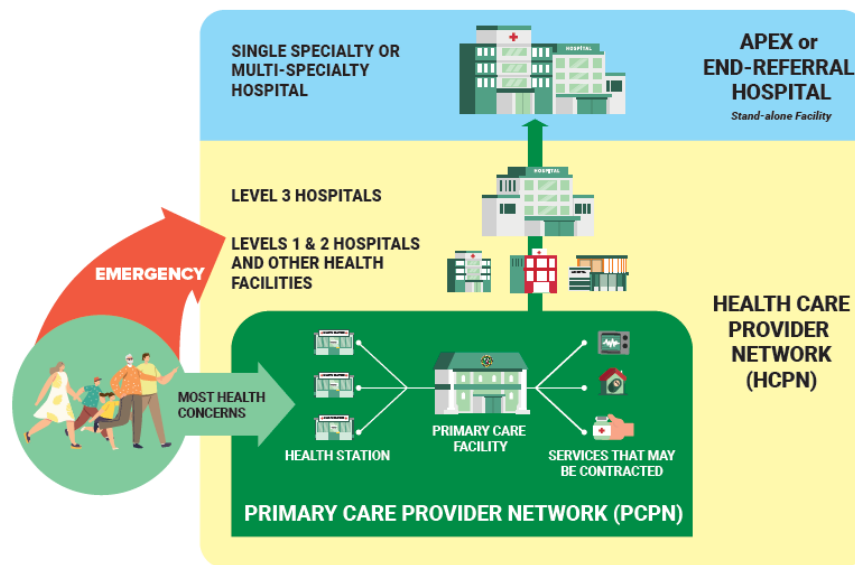
4.1. Establishment of a Health Care Provider Network (HCPN)

As defined, an HCPN “refers to a group of primary to tertiary care providers, whether public, private or mixed, offering people-centered and comprehensive care in an integrated and coordinated manner...Each HCPN shall have primary care provider network (PCPN) as its foundation and responsible for providing primary level of care. The PCPNs are coordinated groups of public private or mixed primary care providers that act as the navigator, initial and continuing point of contact of clients to the health care delivery system. Secondary and tertiary levels of care shall be provided by hospitals and other qualified health facilities.”⁹ Figure 3 illustrates the components of an HCPN.

⁸ DOH AO 2020-0021. “Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)”, page 4

⁹ DOH AO 2020-0021. “Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)”, page 4

Figure 3. Components of a Health Care Provider Network (HCPN)



Source: Image from DOH (2022). UHC in the Philippines: From Policy to Practice

An HCPN may be public, or the P/WHs itself, private, and mixed. In the case of a public HCPN, all public primary care providers and facilities are grouped into a PCPN and are linked to secondary and tertiary care providers within geographic or political boundaries. The HCPN is then linked to a DOH-determined apex or end-referral hospital. Primary care providers provide primary care services while hospitals and other qualified health facilities within the network provide inpatient care and/or outpatient specialty care services. In the absence of an LGU-owned higher level facility, the HCPN may link with a DOH hospital or a private hospital to complete its HCPN, taking consideration of proximity between facilities.

On the other hand, a private HCPN is market-based and does not limit its formation based on defined geo-political boundaries. PhilHealth contracts the private HCPN to provide individual-based health services at all levels of care. A private HCPN, however, may engage public service providers through contractual arrangements to complement the health services provided by the private HCPN. A third type is the mixed HCPN, where contractual arrangements between the public and private health care systems can be made to provide unavailable services or augment existing services within the network.

A key feature of the HCPN is network contracting, where DOH contracts the P/CWHS through a legal instrument to provide population-based health services and to ensure shared responsibilities and accountabilities among members of the health system. PhilHealth, on the other hand, contracts public, private, or mixed HCPNs for the delivery of individual-based health services.

As mentioned, the HCPN is rooted on the Primary Health Care (PHC) approach, which highlights people-centeredness in the individual's ability to make their own decisions on health and their well-being, provider preferences, and ensuring that every Filipino's right to quality, accessible, and affordable health care are upheld. PHC also highlights principles of equity and fairness, paving

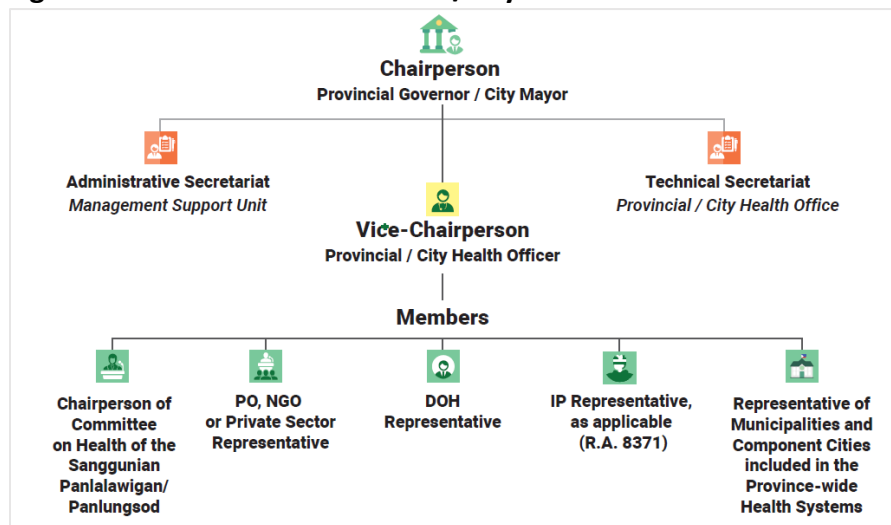
the way towards access and universality—all under the premise that all Filipinos have access to quality primary care services and are covered under the same set of benefits under UHC.

The establishment of the HCPN is guided by several documents such as DOH AO 2020-0019, or the “Guidelines on the Service Delivery Design of Health Care Provider Networks,” DOH AO 2020-0024, or the “Primary Care Policy Framework for Sectoral Strategies.” As for financing, public HCPNs and the PWHS are funded through the Special Health Fund (SHF), one of the key requirements for integration. The SHF is a pool of funds managed at the PWHS level through the Provincial Health Board and is intended for the provision of health services. Funds from national government grants, PhilHealth payments, LGU counterpart funding, and other external sources are pooled in the SHF and are used to fund the entire HCPN. PhilHealth pays based on contractual obligations with the PWHS through the All Case Rates (ACR)-based global budget mechanism for hospitals and through capitation under the Konsulta primary care benefit package for primary care provided by the PCPN. As of writing, the ACR-global budget payment mechanism is yet to be implemented in pilot sites, while PhilHealth guidelines on HCPN contracting is yet to be released. It is also through the accreditation guidelines and payment mechanisms where performance and compliance with standards and processes are anchored, as no other monitoring and performance tools for HCPN are currently provided by the DOH.

4.2. Management and Organizational Structure

With the Provincial Health Board (PHB) at the helm, the transition to a PWHS requires the reconstitution of the existing PHB. While the original members of the PHB based on the Local Government Code remains intact, additional members under the reconstituted PHB for the P/CWHS now includes (1) Indigenous Cultural Communities/Indigenous Peoples (ICC/IP) representative, as applicable, and (2) representative/s of municipalities and component cities in the PWHS (see Figure 4). Part of the responsibilities of the P/CHB include, but are not limited to: proposing annual budgets for health service delivery, advise the Sanggunian on local appropriations on public health, set overall policy directions and strategic thrusts, assume full responsibility on the management of the SHF, and ensure that the SHF is optimally utilized to achieve desired health outcomes, and exercise administrative and technical supervision over health facilities and health human resources.

Figure 4. Reconstituted Provincial/City Health Board



Source: Image from DOH (2022). UHC in the Philippines: From Policy to Practice

To aid the health board in carrying out their additional roles and responsibilities under P/CWHS, the UHC Act directs the establishment of the Management Support Unit (MSU) that serves as the P/CHB's administrative secretariat. Part of the functions include providing assistance in the management of the SHF, administrative and technical support, and coordination with the P/CWHS stakeholders. The MSU is composed of an accountant, administrative officer, and liaison officer.

Apart from the MSU, the Provincial and City Health Offices (P/CHO) are also mandated to serve as the technical secretariat of the P/CHB. Based on the UHC Act, the P/CHO should be composed of two divisions: the Health Service Delivery Division (HSDD), in charge of health service delivery operations, and the Health Systems Support Division (HSSD), which manages financing, health information system, procurement, health human resources, and performance monitoring, among others. The specific tasks for each division are presented in Figure 5.

Figure 5. Recommended Structure of the HSDD and HSSD of the P/CHO



Source: Image from DOH (2022). UHC in the Philippines: From Policy to Practice

The reorganization and restructuring among health and non-health actors at the LGU level requires ordinances and/or resolutions from the Sangguniang Bayan or from the P/CHO, therefore institutionalizing the restructuring for P/CWHS. This also ensures that all members of the provincial board participate in the organization-related decision-making.

4.3. Characteristics of Integration

A P/CWHS is characterized by Managerial, Technical, and Financial Integration. The requirements for integration take reference from the UHC Act. All matters on the consolidation of resources (i.e., health facilities, human resources for health, health finances, health information system, health technologies, and equipment and supplies) refer to managerial integration. On the other hand, technical integration looks at the continuity of care across different levels of facilities, from primary to tertiary care. Requirements for managerial and technical integration are the following:

- a. Local ordinance(s) on (1) Integration of the municipalities' and component cities' local health systems to the province-wide health system and (2) Implementation of the province-wide and city-wide health systems¹⁰
- b. Unified governance of local health system¹¹
- c. Integrated management system, consisting of financing, human resources for health management and development, strategic and investment planning, information management, procurement and supply chain management, and quality assurance/improvement¹²
- d. Functional referral system¹³
- e. Functional disaster risk reduction management for health system
- f. Functional epidemiologic surveillance system, and
- g. Proactive and effective health promotion programs or campaigns¹⁴

Financial integration, on the other hand, looks into the pooling of funds exclusively for health service delivery under the supervision of the P/CWHS. The Local Investment Plan for Health (LIPH) and the Annual Operational Plan (AOP) will serve as the key tools in financial integration. Minimum characteristics for financial integration entail the following:

- a. Creation of Special Health Fund (SHF)¹⁵
- b. Issuance of health board resolution on the utilization of the SHF, in strict adherence with the national guidelines¹⁶
- c. Funds exclusively used for health systems and development

In general, the integration will take place in three phases: (1) Preparatory Works, which involves securing legal and political support of LGUs to integrate, setting the baseline, planning based on

¹⁰ Section 19, UHC Act (RA No. 11223) and its IRR

¹¹ Section 19, UHC Act (RA No. 11223) and its IRR

¹² Section 36, UHC Act (RA No. 11223) and its IRR

¹³ Section 6, UHC Act (RA No. 11223) and its IRR

¹⁴ Section 30, UHC Act (RA No. 11223) and its IRR

¹⁵ Section 20, UHC Act (RA No. 11223) and its IRR

¹⁶ Section 20, UHC Act (RA No. 11223) and its IRR

the assessment, organizing the management structure, and creating the SHF; (2) Organization of the P/CWHS, which involves establishing the network of health facilities and services, implementation of policies, plans, manuals, and other support mechanisms (i.e., referral system, DRRM-H system, epidemiologic surveillance system, etc.), contracting by DOH and PhilHealth, and P/CHB managing the SHF; and (3) Monitoring of the functionality of the local health system through the Local Health System Maturity Model. To assess health outputs and outcomes, the existing LGU Health Scorecard will remain in use.

As the general framework for monitoring and evaluation of LGUs in their integration progress, the Local Health System Maturity Level (LHS ML) will serve as the general framework and is based on the WHO Building Blocks for Health Systems, the characteristics of integration, and KRAs. The KRAs for the LHS ML are presented in Table 4. The KRAs are divided into 10 characteristics that are based on the six WHO Building Blocks for Health Systems (in parenthesis):

1. Unified Governance of the LHS (LG1)
2. Strategic and Investment Planning (LG2)
3. Financial Management (Fin1)
4. HRH Management and Development (HW1)
5. Information Management System (Info1)
6. Epidemiology and Surveillance System (Info2)
7. Procurement and Supply Chain Management (MPVT1)
8. Referral System (SD1)
9. DRRM-H System (SD2)
10. Health Promotion and Campaigns (SD3)

****LG:** Leadership and Governance; **Fin:** Financing; **HW:** Health Workforce; **Info:** Information; **MPVT:** Medical Products, Vaccines and Technology; **SD:** Service Delivery. These correspond to the WHO Health Systems Building Blocks which was used as the guiding framework for the KRAs.

For each of the characteristics, KRAs are identified by level of integration and are to be achieved by the P/CWHS. The KRAs are divided into three and correspond to the preparatory phase, organizational phase, and monitoring phase. For each KRA, one or more means of verification (MOVs) are identified as a way for the DOH to monitor the progress of the LGU. A list of the KRAs with MOVs is attached in Annex A.

Based on the FY 2023 LHS ML Mid-year Monitoring Report, 99.12% and 59.25% of the UHC Integration Sites (UIS)¹⁷ have already achieved all 16 KRAs for Level 1 and 36 KRAs for Level 2, respectively, while most UISs have ongoing efforts towards achieving all 20 KRAs for Level 3 status. While this achievement is already worth commending, not all UISs have equal footing in terms of integration. In addition, all other local health systems that are currently not UIS could learn from the process of the different LGUs that have initiated the integration process.

¹⁷ UISs are LGUs that have formally signified their intent to integrate into P/CWHS. In 2020, there were 58 UISs (per DOH DM no. 2020-0414) and an additional 13 UISs were approved by DOH in 2022 (per DOH DM no. 2022-0238). This number is based on all 71 UISs.

Table 4. Local Health Systems Maturity Level (LHS ML) Characteristics and Key Result Areas (KRAs)

Unified Governance of the LHS (LG1)	
KRA 1.1	Commitment to integrate local health systems (LHS) into Province-Wide/ City-Wide Health Systems (P/CWHS)
KRA 1.2	Presence of technical working group/s (or similar group/s) to assist the Provincial /City Health Board (P/CHB) on matters relating to the integration of LHS
KRA 2.1	Organized Province-Wide Health Systems (PWHS)
KRA 2.2	Expanded Membership and Functions of the Provincial /City Health Board (P/CHB)
KRA 2.3	Strengthened Provincial/ City Health Office (P/CHO)
KRA 2.4	Established Management Support Unit (MSU)
KRA 3.1	Institutionalized P/CWHS
KRA 3.2	P/CWHS contracted by DOH and PhilHealth
KRA 3.3	Monitoring of P/CWHS Performance
Strategic and Investment Planning (LG 2)	
KRA 1.1	Baseline assessment of LGUs' health systems capacity and corresponding investment needs for the Local Health Systems integration
KRA 2.1	LIPH as the strategic and investment plan of the Province-Wide/ City-Wide Health Systems (P/CWHS)
KRA 2.2	LIPH/ Annual Operational Plan (AOP) concurred by concerned Center for Health Development (CHD)
KRA 3.1	Analysis of LGU Commitment/ Counterpart vis a vis Actual Health Expenditure
Financial Management (Fin 1)	
KRA 2.1	Opening of Special Health Fund (SHF) Depository Bank Account
KRA 2.2	Presence of Separate SHF Book of Accounts at Provincial/ HUC/ ICC Level
KRA 2.3	Presence of Subsidiary Ledger for SHF in the Trust Fund of Component LGUs
KRA 2.4	Presence of Personnel in the Management Support Unit (MSU) to Assist the Board in the management of the SHF
KRA 3.1	Exclusive Use of SHF Budget for Health Programs, Projects and Activities within the P/CWHS
Human Resource for Health Management and Development (HW 1)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Human Resources for Health Management and Development System
KRA 2.1	Presence of Province-Wide/ City-Wide Health Systems (P/CWHS) Human Resources for Health (HRH) Plan
KRA 2.2	Updated National Health Workforce Registry (NHWR)
KRA 2.3	Presence of Harmonized HRH Management and Development System and HRH Performance Assessment System
KRA 2.4	Presence of DOH-PRC Certified Primary Care Health Workers
KRA 3.1	Creation of Permanent Plantilla Positions for HRH
KRA 3.2	Monitoring of P/CWHS Performance on HRH Management and Development
Information Management System (Info 1)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Information Management System
KRA 2.1	Presence of P/CWHS Health Information Management/ ICT Development Plan
KRA 2.2	Functional EMR System among Health Facilities within the P/CWHS
KRA 2.3	Engagements with Medical Specialists/ Facilities for the Provision of Telemedicine Services
KRA 2.4	Presence of Dedicated ICT Personnel in the P/CHO
KRA 3.1	Validated EMR System that Links the Members of the PCPN to Secondary and Tertiary Care Providers within P/CWHS
KRA 3.2	Monitoring of P/CWHS Performance on Information Management
Epidemiology and Surveillance System (Info 2)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Epidemiology and Surveillance System

KRA 2.1	Epidemiology and Surveillance Units (ESUs) with Dedicated Personnel Competent on Basic Epidemiology, Disease Surveillance and Event-Based Surveillance
KRA 2.2	Presence of Technical Guidelines/Manual of Operations on Epidemiology and Surveillance System
KRA 3.1	Full Implementation of the Epidemiology and Surveillance System Technical Guidelines/Manual of Operations
KRA 3.2	Monitoring of P/CWHS Performance on Epidemiology and Surveillance System
Procurement and Supply Chain Management (MPVT 1)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Procurement and Supply Chain Management System
KRA 1.2	Presence of a Pharmacy and Therapeutics Committee (PTC)
KRA 2.1	Presence of P/CWHS Procurement Plan
KRA 2.2	Presence of Technical Guidelines/ Manual on Harmonized Supply Chain Management System
KRA 2.3	Presence of Pharmacist/ Pharmacy Assistant
KRA 2.4	Presence of Dedicated Trained Personnel on Supply Chain Management in the P/CHO
KRA 3.1	Interoperable electronic supply chain/ logistics management system within the P/CWHS
KRA 3.2	Monitoring of P/CWHS Performance on Procurement and Supply Chain Management
Referral System (SD 1)	
KRA 1.1	Assessment of Existing Two-Way Referral System
KRA 1.2	Groupings/ Clustering of Health Care Providers and Facilities
KRA 1.3	Identification of Potential Apex Hospital/s
KRA 2.1	Presence of Technical Guidelines/ Manual on Referral System
KRA 2.2	Adoption and Implementation of Clinical Practices Guidelines (CPGs) and other Case Management Protocols in the P/CWHS
KRA 2.3	Presence of P/CWHS Health Facility Development Plan
KRA 2.4	Presence of Public Health Unit (PHU) in LGU Hospitals
KRA 2.5	Partnership with Apex Hospital/s
KRA 2.6	Registration of Indigents to a Primary Care Provider (PCP) within the P/CWHS
KRA 2.7	Presence of Technical Guidelines on Customer Feedback Mechanism
KRA 3.1	Monitoring of P/CWHS Performance on Referral System
KRA 3.2	Registration of all Constituents to a PCP within the P/CWHS
Disaster Risk Reduction Management in Health (DRRM-H) System (SD 2)	
KRA 1.1	Baseline Assessment and Gaps Analysis on the Implementation of the DRRM-H System
KRA 2.1	Organized Province-Wide/ City-Wide DRRM-H System
KRA 2.2	Monitoring of Province/ City-Wide Health System (P/CWHS) Performance on DRRM-H System
KRA 3.1	Advanced Province-Wide/ City-Wide DRRM-H System
KRA 3.2	Monitoring of P/CWHS Performance on DRRM-H System
Health Promotion Programs and Campaigns (SD 3)	
KRA 1.1	Baseline Assessment on Functional Health Literacy
KRA 1.2	Presence of a Health Promotion Committee (HPC)
KRA 1.3	Barangay Health Workers (BHWs) as barangay Health Promotion Officers
KRA 1.4	Implementation of Population-wide Health Promotion Programs
KRA 2.1	Presence of Health Promotion Unit (HPU) in the Provincial/ City Health Office (P/CHO)
KRA 2.2	Presence of P/CWHS Health Promotion Framework Strategy (HPFS)
KRA 2.3	Implementation of Population-wide Health Promotion Programs
KRA 3.1	Capacitated to Participate in the Health Impact Assessment (HIA) Review Process
KRA 3.2	Implementation of Population-wide Health Promotion Programs
KRA 3.3	Monitoring of the P/CWHS Performance on the Implementation of Health Promotion Programs or Campaigns

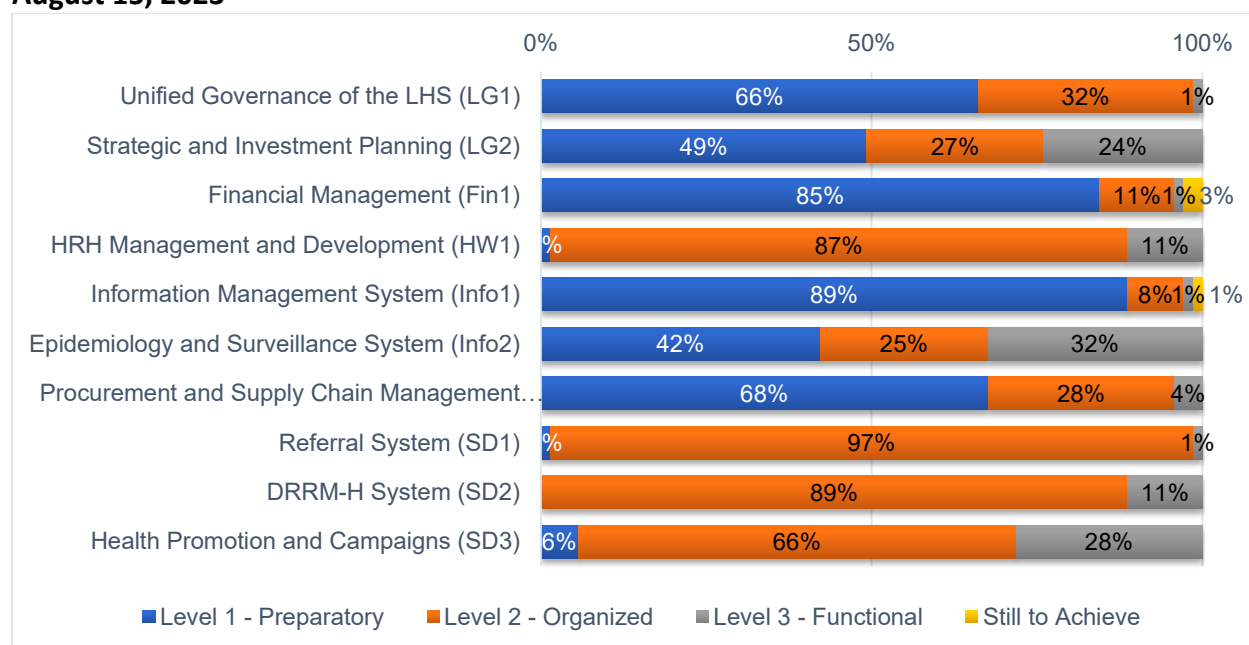
Source: Annexes A to F of DOH AO No. 2020-0037 entitled, "Guidelines on the Implementation of the Local Health Systems Maturity Level"

As of August 2023, all 71 UHC integration sites have achieved an average of 99% Preparatory Level 1 and an average of almost 60% for Organizational Level 2. In its 2023 Midyear Report for the LHS ML, the DOH reports that, as of August 2023, while 66 out of 71 sites have achieved Level 1, but only 19 sites have reached at least 70% of their Level 2 KRAs. Based on the targets, the DOH aims to have at least all the original 58 sites to achieve at least 70% of Level 2 KRAs in 2023. In 2024, DOH targets that at least 58 sites are able to achieve 100% of the Level 2 KRAs and at least 70% of the Level 3 KRAs, and that at least 58 sites are able to achieve 100% of the Level 3 KRAs in 2025 (Department of Health, 2023).

Figure 6 presents a summary of the status of LHS ML achievement by characteristic for all 71 UHC IS. It can be observed that majority of the sites have only achieved Preparatory Level 1 status and have not achieved Level 2 Organizational Status yet as of August 2023 for the following characteristics: Unified Governance of the Local Health System, Strategic and Investment Planning, Financial Management, Information Management System, and Procurement and Supply Chain Management. In the case of Information Management System, 89% of the sites have achieved Level 1 preparatory KRAs but have struggled in achieving Level 2 organizational status for the said characteristic. The same story goes for Financial Management, where 85% of the sites are still aiming to achieve all Level 2 KRAs.

As for HRH Management and Development, Referral System, Disaster Risk Reduction and Management for Health (DRRM-H) System, and Health Promotion and Campaigns, 66%-87% of the integration sites have already achieved Level 2 Organizational Status for these KRAs. Lastly, it can be observed that Epidemiology and Surveillance System has the highest share of integration sites that have already achieved Level 3 Functional status (32% of ISs), followed by Health Promotion and Campaigns (28%) and Strategic and Investment Planning (24%).

Figure 6. Status of LHS ML Achievement by Characteristic for 71 UHC Integrated Sites as of August 15, 2023



Source: LHS ML 2023 Mid-Year Report, Department of Health

4.4. Major Reforms in the Transition to a Province-wide Health System

Prior to the passing of the UHC Act and its accompanying reforms, the Philippines' health system has been organized and reorganized based on existing laws like the RA 7160, or the Local Government Code, and reforms such as DOH's Health Sector Reform Agenda 1999-2004, FOURmula One for Health 2005-2010, and Universal Health Care in 2010-2016. With these reforms, the transition to P/CWHS is not all new. Shifts in health information system has been evident in a pocket of capable LGUs where investments in interoperable electronic medical records have been made. LGUs may already be incorporating innovative procurement practices to ensure that medicine stock-outs are avoided. Barangay health workers (BHWs) and community health teams are already providing essential preventive health care services to the populations and serve as patient navigators. Under the P/CWHS, however, all these will instead be part of a system-wide reform and will be integrated under the stewardship of the Provincial Health Office.

Prior to UHC, the DOH calls the program managers, regional offices, and local government units to establish Service Delivery Networks (SDN) in UHC to streamline the service delivery modality of the different levels of health facilities¹⁸ and national health programs.¹⁹ The SDN serves as “an

¹⁸ Administrative Order No. 2012-0012 on “Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines” was issued to provide guidance on the service capability and levels of care of facilities, such as (1) Population Health Interventions, Primary Health Care and Primary Care through Rural Health Units, Barangay Health Stations, Primary Care Facilities, and Private Clinics and Infirmaries including Birthing Homes, (2) Emergency, Medical, and Surgical Intervention through Levels 1-3 General Hospitals and Specialty Hospitals, and (3) Other Health Facilities providing continuing care and follow-through consultations.

¹⁹ Department Memorandum No. 2014-0313 specified the implementation of the Service Delivery Networks for the Responsible Parenthood and Reproductive Health Act of 2012.

instrument to improve, strengthen service delivery, and ensure continuity of services for families, across political and geographical boundaries.²⁰”

DOH AO No. 2014-0046 defines an SDN as “a network of health facilities and providers within the province or city-wide health systems, offering a core package of health care services in an integrated and coordinated manner similar to the local health referral system” and “may be initiated or composed by both public and private hospitals and other health care facilities” (p.2). The SDN is clear on identifying the needs of the priority population groups as its starting point and ensuring that health facilities can serve their needs as well as the needs of the general population at different levels of care. These guidelines were revisited in 2017 with the issuance of AO No. 2017-0014, or the “Framework for Redefining Service Delivery Networks (SDN)” where additional guidelines on the following were provided: (1) models of care based on Primary Health Care approach, (2) integrated organization and management, and (3) mix of financing resources, among others. It can be gleaned from this issuance that the current PWHS under the UHC Act was heavily based on the enhanced SDN.

This section explores the major reforms under the PWHS categorized according to the WHO health system building blocks, which were used as the foundation of the Local Health System Maturity Model of the UHC Law. Since some of the reforms are founded on prior efforts such as the SDN and other efforts of individual local health systems, the transition to P/CWHS is not a radical shift for some aspects such as service delivery and human resources for health but are groundbreaking in terms of financing and governance. Table 5 summarizes these reforms.

Table 5. Major reforms in the Province- and City-wide Health System

Health System Building Block	Pre-UHC Law	P/CWHS
Service Delivery	<p>Municipalities and component cities in-charge of RHUs, BHSs and level 1 hospitals</p> <p>Provinces in-charge of district and provincial hospitals</p> <p>Public-private engagement through MOUs</p> <p>Patients seeking mostly curative care</p>	<p>HCPN managed at the provincial level with an established referral system and linked to an apex hospital</p> <p>PCPN as foundation and serves as gatekeeper and patient navigator</p> <p>Rooted in primary health care approach where both the sick and healthy populations seek care from their assigned primary care provider</p>
Health Workforce	<p>Component LGUs responsible for designing and implementing own organizational and staffing pattern</p> <p>DOH finances HRH through grants and augmentation program</p>	<p>Provinces tasked to monitor HRH to properly plan needs of province; Encouraging creation of permanent <i>plantilla</i> positions for HRH in the province</p>
Health Information System	<p>Interoperable health information system compliant with national</p>	<p>Additional requirement of telemedicine services;</p>

²⁰ DOH AO No. 2014-0046, “Defining the Service Delivery Networks (SDNs) for Universal Health Care or *Kalusugang Pangkalahatan*”

	eHealth standards; no link between RHU and hospital HISs	Electronic medical record system linking all levels of healthcare providers Linked information system for all aspects of health service delivery
Access to Essential Medicines	Component LGUs and DOH undertake procurement independently	Health system-wide procurement planning as imperative under interoperable electronic supply chain/logistics management system Creation of Special Bids and Awards Committee for Health
Financing	Independent LGU budgeting and funding except when under agreements with other LGUs for health service delivery Grants from DOH and payment from PhilHealth are directed to component LGUs	Budgeting and planning done at the HCPN level Special Health Fund as a pool of funds from all sources LGU counterpart funding to add to the SHF PhilHealth payments through prospective payment mechanisms to accrue to the SHF instead of going back to the municipality and component city
Leadership and Governance	Provincial health office manages provincial and district hospitals but without jurisdiction on affairs of lower-level health facilities	Rural health units, city and municipal health centers, and barangay health stations are led and supervised by the provincial government Involvement of non-health actors in decision-making Creation of new plantilla positions/designation of new staff for new offices and additional roles

Source: authors' compilation based on DOH AO No. 2014-0046 entitled, "Defining the Service Delivery Networks (SDNs) for Universal Health Care or Kalusugang Pangkalahatan," DOH AO No. 2017-0014 entitled, "Framework for Redefining Service Delivery Networks," DOH AO No. 2020-0019 entitled, "Guidelines on Service Delivery Design of Health Care Provider Networks," and DOH AO No. 2020-0021 entitled, "Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)"

For **service delivery**, SDN is based on the Primary Health Care Approach with strong emphasis on Primary Care. It also emphasizes the gatekeeping function of first-line providers who will also serve as the entry point to the different services across the SDN. All public health facilities should be part of the SDN and therefore establish a referral network with a defined catchment area or population determined by proximity and ease of travel rather than geopolitical boundaries. As for

the facilities, primary care service facilities serve as the entry point, while Level 1 or 2 hospitals serve as first-level referral unit. Level 3 DOH hospitals serve as Apex Hospitals.

The PWHS builds on the SDN setup. The PWHS is founded on the primary health care approach. Features such as partnership with apex hospitals from the private sector, manual on referral system, adoption and implementation of Clinical Practice Guidelines and other case management protocols, and the presence of health facility development plan are added to the existing SDN setup. In addition, the PWHS highlights major features on disaster risk reduction management in health (DRRM-H) and health promotion programs and campaigns (SD2 and SD3 characteristics in the LHS ML), requiring PWHSs to develop and establish systems for province-wide DRRM-H system through ordinances, trainings, ensuring inventory of health emergency commodities, establishment of Health Promotion Units, and implementation of population-wide health promotion programs, among others.

Human Resources for Health prior to UHC Law is based on the Local Government Code, where LGUs are responsible for designing and implementing their own organizational structure and staffing pattern. Additionally, DOH finances HRH through grants in line with the Local Investment Plan for Health (LIPH). Under a PWHS, while this guidance is still in place, provinces are tasked to monitor their HRH to properly plan the needs of the province. This includes having an updated HRH registry, a performance assessment system, and monitoring the performance of HRH management and development at the LGU. Aside from this, a PWHS also requires specific skills (i.e., primary care health workers) and are therefore encouraged to create permanent plantilla positions for HRH in the province, with the hopes of alleviating the persistent HRH challenges at local health systems throughout the country.

LGUs are required to operate an updated registry and health records of the individuals in their respective catchment area following the national eHealth standards to ensure interoperability across other catchment registries (**health information system, or HIS**). In addition to the HIS, the PWHS requires telemedicine services where engagement with medical specialists and practitioners offering such services will be necessary. Another critical requirement under the PWHS is the electronic medical record (EMR) system that links all levels of healthcare providers from the primary care provider network to the secondary and tertiary care providers within the PWHS—an investment that requires significant resources to implement.

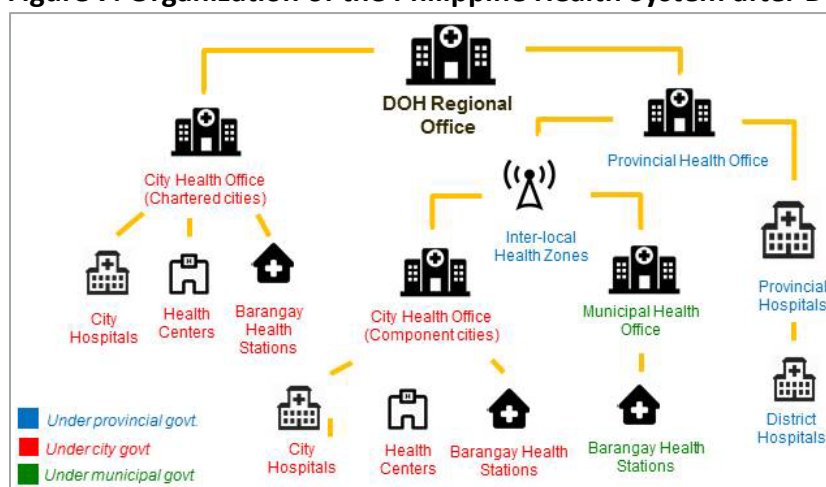
The WHO expounds **Access to Essential Medicines** building block to include medical products, vaccines, and technology. Facilitating factors include an operational supply chain management and procurement system, which are under the umbrella of Republic Act 9184, also known as the Government Procurement Reform Act. Prior to the UHC Act, both the LGUs and the DOH procure the supplies and the commodities necessary for the operation of the local health system and stockouts, supply chain, and procurement issues abound. With the PWHS, health system-wide procurement planning for medicines, vaccines and other health commodities as well as harmonized province-wide supply chain management system is now imperative, all under an interoperable electronic supply chain/logistics management system within the PWHS, will attempt to address the long-standing challenge of access to health commodities. In addition, dedicated personnel such as pharmacists/pharmacy assistants and supply chain management staff are also requisites under the PWHS.

Rules under the Local Government Code and the Procurement Law govern local health system **financing**—from planning, budget allocation, and utilization of funds. Each LGU level (i.e., province, municipality, and component city) are independent in terms of budgeting and funding and operate within their geographic boundaries except when under SDN agreements with other LGUs. Other sources of financing include national sources from the DOH that pour directly into DOH hospitals (also the Apex hospitals) and to LGUs through the provision of public health commodities, capital investments through the Health Facility Enhancement Program (HFEP), and HRH augmentation in LGU health facilities.

One of the major reforms under the PWHS is the pooling of funds from municipalities and component cities into the Special Health Fund (SHF) which will be under the management of the Provincial Health Board. Creation of the SHF and identifying the funds from municipalities and component cities that will be pooled into the SHF needs to be done as the PWHS will be managing the entire province's health system including service delivery, health workforce, HIS, and procurement and supply chain management, among others. Aside from pooled LGU funds, all DOH grants to all LGUs and all reimbursements from PhilHealth will be pooled in the SHF—funds that are traditionally managed and used by municipalities and component cities for their own local health system functions.

Lastly, one of the remarkable reforms in the PWHS is the shift in **leadership** and supervision of health facilities such as rural health units, city and municipal health centers, and barangay health stations (including city and municipal hospitals for some LGUs) from the city or municipal government to the provincial government under the provincial health office. Prior to the PWHS, the provincial health office manages provincial and district hospitals as well as the interlocal health zones/SDNs but has no jurisdiction on the affairs of the lower-level health facilities (Figure 7). With the PWHS, the health system is organized into a Health Care Provider Network (HCPN) that is composed of primary to tertiary level health care providers with the primary care provider acting as the navigator and coordinator for patients accessing care within the network. These facilities used to be under the supervision of either city, municipality, or province, but are all now integrated into a network under the PWHS. In addition, the management structure of the PWHS consists of the Provincial Health Board (PHB), which now includes representatives from the municipalities and component cities (referred to as the expanded PHB). The Provincial Health Office is now tasked to manage the health service delivery including facility operations and program implementation, health financing (planning and budgeting), HIS, procurement and supply chain management, and HRH, among others, of the entire province—a task that was then the responsibility of municipalities, component cities, and provinces based on their geographic jurisdiction. In turn, local chief executives and local health officers (i.e., municipalities and component cities) are now under the supervision and management of the provincial government through the Provincial Health Office.

Figure 7. Organization of the Philippine Health System after Devolution



Source: Image from Alliance for Improving Health Outcomes, Inc. (AIHO), The Philippine Health System in a Glance. March 2017.

Status of Transition to PWHs: Bataan and South Cotabato

This section presents the experience of the provinces of Bataan and South Cotabato in their transition to a PWHs. We begin by presenting the profile of their health sector and proceed with their accomplishments for the different components of the P/CWHS.

4.5. Health Sector Profile of the Provinces of Bataan and South Cotabato

The province of Bataan is a first-class province in Region III composed of 11 municipalities, one city, and 237 barangays. As of 2020, it has a total population of 853,373.²¹ There are two identified GIDA barangays in the province as of 2021.²² Bataan has 13 hospitals, five are public and eight are private. Out of the five public hospitals, three are Level 1 hospitals and are province-owned. The remaining two are DOH-retained: one Level 3 hospital (Bataan General Hospital and Medical Center) and one Level 1 hospital (Mariveles Mental Wellness and General Hospital). There are two infirmaries in the province (one public, one private), 24 RHUs, and 243 BHSs.²³ A list of health facilities in the province of Bataan is in Annex B.

The province of South Cotabato is also a first-class province in Region XII and is composed of 10 municipalities, one city, and 199 barangays. As of 2020, it has a total population of 975,476.²⁴ The province has classified 32 barangays in eight municipalities as GIDAs as of 2021.²⁵ The province has 13 hospitals, three are public and 10 are private. Of the three public hospitals, one is a Level 1 DOH-retained hospital, and the remaining two are Level 1 and Level 2 hospitals. Of the 10 private hospitals, seven are Level 1 hospitals and three are Level 2. There are nine infirmaries (three

²¹ Philippine Standard Geographic Codes, Philippine Statistics Authority. <https://psa.gov.ph/classification/psgc>

²² GIDA Dashboard, BLHSD-DOH. <https://tinyurl.com/ft8m4txz>

²³ DOH National Health Facility Registry. <https://nhfr.doh.gov.ph/Home> (as of March 5, 2024)

²⁴ Philippine Standard Geographic Codes, Philippine Statistics Authority. <https://psa.gov.ph/classification/psgc>

²⁵ GIDA Dashboard, BLHSD-DOH. <https://tinyurl.com/ft8m4txz>

public, six private), 11 RHUs, and 227 BHSs.²⁶ A list of health facilities in the province of South Cotabato is in Annex C.

A summary of the health outputs and outcomes for both study sites are presented in Table 6. It can be observed that for fully immunized children and skilled birth attendance, study sites performed better than the national average in 2022. This is the same trend for both maternal and infant mortality rate (MMR and IMR), both tracer indicators of the performance of the health system. However, MMR and IMR are lower in Bataan compared to South Cotabato. As for the ratio of HRH to population, the ratio of rural health physician (RHP) is better in Bataan than in South Cotabato, where one RHP caters to 19,825 population compared to 42,704 in South Cotabato. The same trend goes for dentist-to-population ratios. However, there are more nurses and midwives in South Cotabato relative to the population compared to Bataan. The number of barangay health workers are relatively less in both study sites compared to the national average, as presented in the BHWs-to-household ratios. Lastly, per capita spending for health, nutrition, and population in Bataan and South Cotabato are higher than the national average, at PhP 903 and PhP 887, respectively, compared to the national average of PhP 874.

²⁶ DOH National Health Facility Registry. <https://nhfr.doh.gov.ph/Home> (as of March 5, 2024). Excludes facilities in City of General Santos.

Table 6. Health outputs and outcomes for Bataan and South Cotabato, 2022

	Bataan	South Cotabato	National
Health Outputs			
Fully Immunized Children (0-12 months)	61.00%	68.51%	59.92%
Skilled Birth Attendance	97.95%	94.55%	92.95%
Maternal Mortality Rate (per 100,000 livebirths)	31.82	42.62	64.68
Infant Mortality Rate (per 1,000 livebirths)	3.82	9.25	10.36
HRH to Population Ratio			
MD (Rural Health Physician)	19,825	42,704	26,041
Dentists	57,949	85,407	57,630
Public Health Nurse	4,305	3,382	4,911
Midwives	4,330	3,096	5,074
Nutritionists	251,114	146,412	165,783
Medical Technologists	32,754	37,334	35,657
Sanitary Engineers	753,343	No data	2,936,112
Barangay Health Workers (per household)	156	109	88
Financing			
Health, nutrition, and population expenditure per capita	PhP 903	PhP 887	PhP 874

Source: Regional Field Health Service Information System (FHSIS), Region III and Region XII; Statement of Receipts and Expenditure, Department of Finance-Bureau of Local Government Finance.

4.6. Transition to Province-wide Health System: Initial Phases

In both provinces of Bataan and South Cotabato, the transition to a PWHS was prompted by the pronouncement of the provincial governor's intent to integrate upon the call of the DOH in 2019 and the passage of the UHC Act. The UHC Act was the main basis for the provinces' intent to integrate, and was complemented by their current health situation, adequate capacity of health workers, and interest from the local chief executives, among others. While LGU participation is not mandatory, all LGUs (municipalities and component cities) in both provinces also expressed their intent to integrate, thus establishing the PWHS.²⁷

As part of DOH support, orientations and financial support through the UHC grant was accorded to the provinces intending to integrate. The UHC grant is given to UISs for their use in setting up their HCPN, the MSU, and all other PWHS requirements.

4.7. Health Care Provider Network (HCPN) Formation

The province of Bataan has established a purely public HCPN with its 24 RHUs and two LGU-owned Level 1 hospitals. As of writing, the assigned apex hospital to the HCPN is Jose B. Lingad Memorial Hospital in Pampanga despite having DOH-retained Bataan General Hospital and

²⁷ Interview with CHDs.

Medical Center (BGHMC) in the province. This setup remains until BGHMC complies with all the requirements of an apex hospital. Under this setup, no Level 2 hospital part of the HCPN. It is also worth noting that four out of the 24 RHUs in the province were recently established in order to meet the demand in the province.

As for the PCPN, the PHO considers each RHU as one PCPN. While the latest four RHUs are being completed, the 20 existing RHU compose the province's HCPN. Being one of PhilHealth's sandbox sites for demonstration of UHC reforms, PhilHealth has already transferred their equivalent capitation payment to their SHF for their implementation of Konsulta in the PWHS.

The province of South Cotabato, on the other hand, has organized their HCPN and has developed their framework for establishing networks throughout the province. This framework covers the different referral streams given the distribution of their health facilities and the presence of GIDAs in the province. Similar with Bataan, the initial HCPN will be a purely public entity, relying on the province's health facility development plan to fill the gaps in facility-based service delivery.²⁸ As for the PCPN, each of the 11 LGUs in the province forms one PCPN. The case is different for PCPNs—the PHO recognizes the potential contribution of the private sector, particularly the primary care providers, in filling the gap in primary care service delivery. The PHO encourages the LGUs to go into contractual agreements with the private providers in the formation of their PCPNs.²⁹ Also a PhilHealth sandbox site, South Cotabato has likewise received their payment for the implementation of Konsulta and has been deposited in their SHF.

As of writing, both provinces have created their frameworks in establishing their PCPNs and HCPNs but it is recognized that both HCPNs are yet to be operationalized and policies on HCPN contracting by PhilHealth are yet to be released. A PhilHealth Circular on PCPN contracting arrangements in Konsulta Sandbox Sites,³⁰ however, has been released in 2023, thus prompting the transfer of fund from PhilHealth to the SHF of both Bataan and South Cotabato in late 2023.

4.8. Management Support Unit (MSU) Creation

The creation of Management Support Unit (MSU) can either be through creation of plantilla positions or designation of current employees. Part of the MSU is the creation of the Special Bids and Awards Committee (BAC) for health, where current employees will be designated to form the committee. This directive entailed the designation of non-health employees in the province such as accountants, budget and planning officers, and IT staff, among others.

South Cotabato was able to pass a resolution that designated current provincial staff as MSU members. On the other hand, Bataan, as of writing, is still in the process of having their board resolution on the creation and designation of MSU members passed. A unique practice observed in Bataan was the assignment of the Provincial Health Officer as a special member of the current BAC. It is recognized that the creation of a Special BAC for health would use up time and money resources and a compromise between the province, DBM, and COA was to assign the PHO as a special member of BAC.

²⁸ Interview with South Cotabato PHO

²⁹ Interview with the PHO

³⁰ PhilHealth Circular No. 2023-0008. "Implementation of a Primary Care Provider Network (PCPN) Contracting Arrangement through the Konsulta Package in Sandbox Sites/Networks (Revision 1)"

4.9. Local Health System Maturity Level (LHS ML) Scorecard and Integration

Table 7 shows the status of KRA achievements for Bataan and South Cotabato as of August 2023. Both study sites have already achieved Level 1 Preparatory Status while South Cotabato has already achieved more than 70% of their Level 2 Preparatory KRAs, beyond what was required of the UHC IS for 2023. On the other hand, Bataan is on its way towards achieving its targets as it currently stands at 53% for its Level 2 KRAs. Lastly, while not necessarily required given the milestones for 2024-2025, both study sites have already achieved Level 3 Functional Level KRAs as of 2023.

Table 7. Number of KRAs achieved per level*, Bataan and South Cotabato

	Level 1 - Preparatory	Level 2 - Organizational	Level 3 - Functional
Bataan	16 (100%)	19 (53%)	1 (5%)
South Cotabato	16 (100%)	29 (81%)	6 (30%)

*as of August 2023

Source: LHS ML 2023 Mid-Year Report, Department of Health

Table 8 details the status of the study sites by KRA. The DOH uses a traffic light system which assesses how the UHC ISs have achieved the KRAs: green for *achieved*, yellow for *ongoing*, and red for *not yet started*. This color-coding system also allows for easy tracking of UHC characteristics and KRAs that have been achieved or are yet to be achieved.

Table 8. Status of KRAs for Bataan and South Cotabato as of August 2023

LHS ML CHARACTERISTICS and KRAs		Bataan	South Cotabato
Unified Governance of the LHS (LG1)			
KRA 1.1	Commitment to integrate local health systems (LHS) into Province-Wide/ City-Wide Health Systems (P/CWHS)	Achieved	Achieved
KRA 1.2	Presence of technical working group/s (or similar group/s) to assist the Provincial /City Health Board (P/CHB) on matters relating to the integration of LHS	Achieved	Achieved
KRA 2.1	Organized Province-Wide Health Systems (PWHS)	Ongoing	Achieved
KRA 2.2	Expanded Membership and Functions of the Provincial /City Health Board (P/CHB)	Achieved	Achieved
KRA 2.3	Strengthened Provincial/ City Health Office (P/CHO)	Achieved	Achieved
KRA 2.4	Established Management Support Unit (MSU)	Achieved	Achieved
KRA 3.1	Institutionalized P/CWHS	Not yet started	Achieved
KRA 3.2	P/CWHS contracted by DOH and PhilHealth	Ongoing	Ongoing
KRA 3.3	Monitoring of P/CWHS Performance	Not yet started	Ongoing
Strategic and Investment Planning (LG 2)			
KRA 1.1	Baseline assessment of LGUs' health systems capacity and corresponding investment needs for the Local Health Systems integration	Achieved	Achieved
KRA 2.1	LIPH as the strategic and investment plan of the Province-Wide/ City-Wide Health Systems (P/CWHS)	Achieved	Achieved
KRA 2.2	LIPH/ Annual Operational Plan (AOP) concurred by concerned Center for Health Development (CHD)	Ongoing	Achieved

KRA 3.1	Analysis of LGU Commitment/ Counterpart vis a vis Actual Health Expenditure	Ongoing	Achieved
Financial Management (Fin 1)			
KRA 2.1	Opening of Special Health Fund (SHF) Depository Bank Account	Achieved	Achieved
KRA 2.2	Presence of Separate SHF Book of Accounts at Provincial/ HUC/ ICC Level	Ongoing	Achieved
KRA 2.3	Presence of Subsidiary Ledger for SHF in the Trust Fund of Component LGUs	Ongoing	Ongoing
KRA 2.4	Presence of Personnel in the Management Support Unit (MSU) to Assist the Board in the management of the SHF	Ongoing	Achieved
KRA 3.1	Exclusive Use of SHF Budget for Health Programs, Projects and Activities within the P/CWHS	Not yet started	Achieved
Human Resource for Health Management and Development (HW 1)			
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Human Resources for Health Management and Development System	Achieved	Achieved
KRA 2.1	Presence of Province-Wide/ City-Wide Health Systems (P/CWHS) Human Resources for Health (HRH) Plan	Achieved	Achieved
KRA 2.2	Updated National Health Workforce Registry (NHWR)	Achieved	Achieved
KRA 2.3	Presence of Harmonized HRH Management and Development System and HRH Performance Assessment System	Not yet started	Achieved
KRA 2.4	Presence of DOH-PRC Certified Primary Care Health Workers	Achieved	Achieved
KRA 3.1	Creation of Permanent Plantilla Positions for HRH	Not yet started	Ongoing
KRA 3.2	Monitoring of P/CWHS Performance on HRH Management and Development	Not yet started	Ongoing
Information Management System (Info 1)			
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Information Management System	Achieved	Achieved
KRA 2.1	Presence of P/CWHS Health Information Management/ ICT Development Plan	Ongoing	Achieved
KRA 2.2	Functional EMR System among Health Facilities within the P/CWHS	Ongoing	Achieved
KRA 2.3	Engagements with Medical Specialists/ Facilities for the Provision of Telemedicine Services	Not yet started	Ongoing
KRA 2.4	Presence of Dedicated ICT Personnel in the P/CHO	Achieved	Achieved
KRA 3.1	Validated EMR System that Links the Members of the PCPN to Secondary and Tertiary Care Providers within P/CWHS	Not yet started	Not yet started
KRA 3.2	Monitoring of P/CWHS Performance on Information Management	Not yet started	Not yet started
Epidemiology and Surveillance System (Info 2)			
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Epidemiology and Surveillance System	Achieved	Achieved
KRA 2.1	Epidemiology and Surveillance Units (ESUs) with Dedicated Personnel Competent on Basic Epidemiology, Disease Surveillance and Event-Based Surveillance	Ongoing	Achieved
KRA 2.2	Presence of Technical Guidelines/Manual of Operations on Epidemiology and Surveillance System	Ongoing	Achieved
KRA 3.1	Full Implementation of the Epidemiology and Surveillance System Technical Guidelines/Manual of Operations	Ongoing	Achieved
KRA 3.2	Monitoring of P/CWHS Performance on Epidemiology and Surveillance System	Ongoing	Ongoing
Procurement and Supply Chain Management (MPVT 1)			

KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Procurement and Supply Chain Management System	Achieved	Achieved
KRA 1.2	Presence of a Pharmacy and Therapeutics Committee (PTC)	Achieved	Achieved
KRA 2.1	Presence of P/CWHS Procurement Plan	Achieved	Achieved
KRA 2.2	Presence of Technical Guidelines/ Manual on Harmonized Supply Chain Management System	Ongoing	Achieved
KRA 2.3	Presence of Pharmacist/ Pharmacy Assistant	Achieved	Achieved
KRA 2.4	Presence of Dedicated Trained Personnel on Supply Chain Management in the P/CHO	Achieved	Achieved
KRA 3.1	Interoperable electronic supply chain/ logistics management system within the P/CWHS	Not yet started	Achieved
KRA 3.2	Monitoring of P/CWHS Performance on Procurement and Supply Chain Management	Not yet started	Achieved
Referral System (SD 1)			
KRA 1.1	Assessment of Existing Two-Way Referral System	Achieved	Achieved
KRA 1.2	Groupings/ Clustering of Health Care Providers and Facilities	Achieved	Achieved
KRA 1.3	Identification of Potential Apex Hospital/s	Achieved	Achieved
KRA 2.1	Presence of Technical Guidelines/ Manual on Referral System	Achieved	Achieved
KRA 2.2	Adoption and Implementation of Clinical Practices Guidelines (CPGs) and other Case Management Protocols in the P/CWHS	Achieved	Achieved
KRA 2.3	Presence of P/CWHS Health Facility Development Plan	Ongoing	Ongoing
KRA 2.4	Presence of Public Health Unit (PHU) in LGU Hospitals	Achieved	Achieved
KRA 2.5	Partnership with Apex Hospital/s	Not yet started	Ongoing
KRA 2.6	Registration of Indigents to a Primary Care Provider (PCP) within the P/CWHS	Achieved	Achieved
KRA 2.7	Presence of Technical Guidelines on Customer Feedback Mechanism	Ongoing	Achieved
KRA 3.1	Monitoring of P/CWHS Performance on Referral System	Not yet started	Ongoing
KRA 3.2	Registration of all Constituents to a PCP within the P/CWHS	Achieved	Achieved
Disaster Risk Reduction Management in Health (DRRM-H) System (SD 2)			
KRA 1.1	Baseline Assessment and Gaps Analysis on the Implementation of the DRRM-H System	Achieved	Achieved
KRA 2.1	Organized Province-Wide/ City-Wide DRRM-H System	Ongoing	Ongoing
KRA 2.2	Monitoring of Province/ City-Wide Health System (P/CWHS) Performance on DRRM-H System	Achieved	Achieved
KRA 3.1	Advanced Province-Wide/ City-Wide DRRM-H System	Ongoing	Ongoing
KRA 3.2	Monitoring of P/CWHS Performance on DRRM-H System	Ongoing	Ongoing
Health Promotion Programs and Campaigns (SD 3)			
KRA 1.1	Baseline Assessment on Functional Health Literacy	Achieved	Achieved
KRA 1.2	Presence of a Health Promotion Committee (HPC)	Achieved	Achieved
KRA 1.3	Barangay Health Workers (BHWs) as barangay Health Promotion Officers	Achieved	Achieved
KRA 1.4	Implementation of Population-wide Health Promotion Programs	Achieved	Achieved
KRA 2.1	Presence of Health Promotion Unit (HPU) in the Provincial/ City Health Office (P/CHO)	Achieved	Achieved
KRA 2.2	Presence of P/CWHS Health Promotion Framework Strategy (HPFS)	Achieved	Achieved
KRA 2.3	Implementation of Population-wide Health Promotion Programs	Ongoing	Ongoing
KRA 3.1	Capacitated to Participate in the Health Impact Assessment (HIA) Review Process	Not yet started	Not yet started
KRA 3.2	Implementation of Population-wide Health Promotion Programs	Not yet started	Not yet started
KRA 3.3	Monitoring of the P/CWHS Performance on the Implementation of Health Promotion Programs or Campaigns	Not yet started	Ongoing

Source: LHS ML 2023 Mid-Year Report, Department of Health

For Bataan, a significant portion of KRAs (at least Level 2) for the following characteristics have been attained: Unified Governance of the LHS (LG1), Strategic and Investment Planning (LG2), HRH Management and Development (HW1), Procurement and Supply Chain Management (MPVT1), Referral System (SD1), and Health Promotion Programs and Campaigns (SD3). For South Cotabato, almost all characteristics have achieved at least Level 2 status, with continuing and ongoing work towards achieving all KRAs for Referral System (SD1). We also take note that for Bataan, most of the characteristics with ongoing work towards achieving Level 2 status are on the following: Financial Management (Fin1), Information Management System (Info1), Epidemiology and Surveillance System (Info2), and Referral System (SD1). We also consider that efforts towards achieving Level 3 status are not considerable at this point since these milestones are set for 2024.

4.10. Case Study Results: Experiences of Bataan and South Cotabato

The following section will describe the LHS ML status of both study sites and their experiences in achieving these indicators. As presented in the previous sections, it can be gleaned that the LHS ML component of the transition to P/CWHS is the sole component with a metric that allows for monitoring and comparison among LGUs. Table 9 below summarizes the experiences of Bataan and South Cotabato in working towards attaining the different KRAs required for the transition and is grouped according to the themes following the health system building blocks as prescribed by the WHO. For each theme, the LHS ML report status for each province is presented and is supplemented with results from the key informant interviews and the focus group discussions. The succeeding section will expound on these findings.

Table 9. Summary of KII and FGD results per KRAs based on the WHO Health System Blocks

Theme	Bataan		South Cotabato	
	LHS ML Report Status	Interview and FGD Results	LHS ML Report Status	Interview and FGD Results
Service Delivery				
Established referral system	Partially completed: Done - Referral System Manual, adoption of clinical practice guidelines done; Purely public HCPN, no private sector participation; Ongoing - Partnership with apex hospital	Adapted referral manuals from the Central Office and PCPN program-specific referral system.	Partially completed: Done - Referral System Manual, adoption of clinical practice guidelines done; Purely public HCPN, no private sector participation; Ongoing - Partnership with apex hospital	Adapted referral manuals from Central Office and will use the implementation of Sandbox to test the system.
Health Promotion Framework Strategy	Achieved: Presence of health promotion unit, health promotion strategy	Done	Achieved: Presence of health promotion unit, health promotion strategy	Done

Implementation of Population-wide Health Promotion Programs	Ongoing: Implementation of population-wide health promotion programs	For implementation	Ongoing: Implementation of population-wide health promotion programs ongoing	For implementation
Epidemiologic system	Ongoing: Manual of Operations on Epidemiological Surveillance System (ESS) and designation of dedicated personnel for Epidemiology and Surveillance Unit (ESU)	Ongoing	Done: Manual of Operations on Epidemiological Surveillance System (ESS) and designation of dedicated personnel for Epidemiology and Surveillance Unit (ESU)	Achieved
Organized DRRM-H system including available emergency health commodities, DOH-trained HERT	Ongoing: DRRM-H system	Adapting DRRM-H manual from Central Office to fit the province needs & context.	Ongoing: Organized DRRM-H system ongoing	Aside from manuals, there is a need for training & some of these trainings are specialized that they need to coordinate with Central Office & NDRRM.
Human Resource for Health				
HRH Plan	Not started: HRH Plan, updated workforce registry, Harmonized HRH management system and HRH performance assessment system	On-going development of HRH Performance System at the Province Level.	Done: HRH plan, performance assessment system in place	CHD XII assisted the province in drafting their HRH Plan thru series of workshop. Other development partners also provided capacity building activities for the HCWs. Province assigned a TWG for this characteristic.
Presence of primary care health workers	Done: Presence of primary care providers	Current HCWs	Done: Presence of primary care health workers	Current HCWs
Health Information System				
ICT Development Plan	Done	Adapted from COH template	Done	CHD XII assisted the province in drafting their ICT plan thru series of workshop. Province assigned a TWG for this characteristic.

Functional EMR	Done: Electronic medical records (EMR) available to RHUs links with district hospitals; provided by third party	Contracted another service provider (DCI) instead of using the iClinicSys (DOH-sponsored) due to lack of technical support. Previous projects with development partners also developed systems that connect their BHCs to RHUs.	Done: EMR available and linked across health facilities	There are initiatives in the public HFs while the private HFs are required by DOH to contract service provider to report notifiable diseases/10 common diseases which they submit directly to DOH. [FGD]
Provision of telemedicine	Done: Engagement with medical specialists for telemedicine services	Public Hospital continued to provide this service even after the pandemic. [FGD]	Not Done: Engagement with medical specialists for telemedicine	Not provided
Procurement and Supply Chain Management				
Procurement Plan	Done: Procurement plan and dedicated personnel on SCM	Submitted	Done: Procurement plan and dedicated personnel on SCM	Submitted
Manual on Harmonized SCM System/Electronic SCM system	Ongoing: Manual on Harmonized SCM System still being developed	Manuals were adapted from the national manual from Central Office. CHD III needs to provide training for this.	Done: Manual on Harmonized SCM System done	CHD XII provide capacity building in setting up this system.
BAC for Health	Functional	Due to staff & training requirements for a separate BAC, Bataan assigned the PHO as member of BAC and created a TWG & secretariat for health to facilitate procurement processes.	Functional	Created a UHC BAC separate from the province BAC. This is under the HSSD Division of PHO South Cotabato.
Issues on stock-outs			Functional	Partnered with private sector/foundation to address stock-outs in public HFs including hospitals. [FGD]
Financing				
Opening of SHF Depository Bank account	Done: SHF bank account	Completed	Done: SHF bank account	Completed
Creation of SHF Book of Accounts	Done: Book of accounts available	Completed	Done: Book of accounts available	Completed
Creation of Subsidiary Ledger for SHF in	Ongoing: SHF trust fund, subsidiary ledger created	On-going had to be fast-tracked due to	Ongoing: SHF subsidiary ledger creation ongoing	On-going

the Trust Fund Component of LGUs		PCPN sandbox implementation		
Strategic and investment planning	Done: Local Investment Plan for Health (LIPH) and Annual Operational Plan (AOP) part of usual process even before transitioning to PWHS	They have separate focal person/team from the municipal to provincial level. The PHO had to revise and update their LIPH and AOP because they are selected as one of the sites to pilot Konsulta under PhilHealth PCPN Sandbox. They haven't finalized the strategies on how each municipality contribute to the SHF.	Done: LIPH, AOP done; LGU counterpart in finances agreed upon and initiated	Province consolidates the plans from different municipalities and present this to the PHB for approval. Municipalities already contributed to the SHF as seed money. This will be combined with the funds that will be frontloaded by PhilHealth PCPN Sandbox.
Governance and leadership				
SP Resolution/EO on LGU's commitment to LHS integration and organization into PWHS	Done: LGUs intent to integrate resolution done	Signed resolutions	Done: LGUs intent to integrate resolution done	Signed resolutions
Provincial Ordinance on the establishment and operationalization of the PWHS	Not done: Province-wide health system yet to be formally established	On-going work at Provincial Board [PHO].	Done: Ordinance created	The Governor assigned a dedicated staff from the Legal Office to assist in the drafting of necessary MOAs/MOUs that helped in the buy-in of LCEs.
MOU among LGU, DOH, and PhilHealth on LHS integration	Completed	They renewed the MOA with LGUs to include in the PhilHealth.	Completed	Private partners assisted in drafting the MOAs that helped in the buy-in of the LCEs.
EO or AO on creation of TWG and other units required for the PWHS	Completed	Assigned TWGs and focal persons	Done: Integrated Province-Wide Health System with "UHC Provincial Health Board"; Established Management Support Unit (MSU)	Assigned TWGs and focal persons

Source: Authors' summary

4.10.1. Service Delivery

For the referral system, both provinces have connected their public health facilities from their barangay health centers (BHCs) to rural health units (RHUs) to Province/District Hospitals. They adapted manuals from DOH Central Office and are currently working on their systems to engage the APEX hospitals in their regions. In fact, according to the interview with CHD II, the Bataan

IPHO have utilized their existing program-specific referral systems in family planning and maternal and child health to meet the requirements of the referral system demanded by the UHC Law. However, both the provinces of Bataan and South Cotabato have yet to formally integrate the private health facilities to their HCPN.

On the creation of health promotion strategy and its population-wide implementation, both provinces have already created and submitted their health promotion framework strategies to DOH. However, they have yet to implement any of the planned activities.

In terms of establishing the epidemiologic systems, the South Cotabato already have their Manual of Operations for Epidemiological Surveillance System (ESS) and have established their designated personnel for their Epidemiological and Surveillance Unit (ESU). The province of Bataan has a different experience as they were still on the works of drafting their ESS and ESU. The COVID-19 pandemic made way for the partnership between private and public health facilities in South Cotabato. They have developed the eReferral System that facilitated the transfer of patients and ensured zero-payments. With this system, the South Cotabato LGU and private hospitals have a MOA that the public hospitals can transfer patients to private hospitals if they cannot provide the service that the patients need. The private hospitals will submit billing statements to the Provincial LGUs and the LGUs will process these for payment. However, this endeavor was only implemented during the special emergency under the COVID-19 pandemic and has not been extended to be implemented under PWHS.

For organizing the DRRM-H system, both provinces have already adapted the manuals shared to them by DOH Central Office. However, during the interviews, respondents from both provinces shared that they still need specific training from experts from DOH & National Disaster Risk Reduction and Management Council (NDRRMC).

4.10.2. Health workforce

Another KRA that is essential to the UHC implementation is setting up the province's human resource for health. While both provinces have updated their healthcare workers registries and HRH plans, the province of Bataan have yet to harmonize their HRH performance assessment system during the interview last year. This is different in South Cotabato, wherein they have established their HRH performance assessment system with the help of CHD XII. Moreover, they have development partners who assisted them not only in the creation of HRH plans but also provided support on capacity building activities.

4.10.3. Health Information System

One of the KRAs for a functional health information system is an ICT development plan. Interview respondents from both provinces shared that they adapted the ICT plan shared by the DOH Central Office. In fact, the CHD XII aided South Cotabato thru series of workshops and assigned a TWG in their Regional Office to assist the provinces in achieving this specific requirement.

Both study sites also reported that they have functional electronic medical records (EMR) systems that connect their RHU patient records to their district hospitals. For Bataan, instead of relying on

the DOH-provided electronic medical record system, they opted to invest in a privately provided health information system that links RHUs, health centers, and public and private hospitals to ensure continuous patient journey and to facilitate report generation and claims filing for PhilHealth. They previously relied on the DOH-provided EMR but there was a lack of technical support during failures aside from the unfriendly user interface according to an interview. With their new system, the LGUs are expected to share in the investment and its operations and maintenance. South Cotabato, on the other hand, also has its own in-house system for the health profiling of their constituents, a system that is outside of what the DOH can provide now. A representative from the CHD XII Office shared during an interview that the health facilities need to update in their accreditations, licenses, and SOPs, as well as refresher courses of the healthcare workers before they can integrate them in the system. During the FGD session with hospital representatives in Bataan, one of the representatives from a major public hospital in the province shared that they continue to provide telemedicine services even after the pandemic.

4.10.4. Procurement and Supply Chain management

Interview results from both provinces supported their LHS ML Status report on the KRAs related to the submission of their procurement plans and assignment of personnel for supply chain management (SCM) system. However, the Province of Bataan have not yet harmonized their SCM System Manual, unlike South Cotabato. According to the interview with the CHD III representative, they have already disseminated the national manual from DOH Central Office but they have not conducted a workshop with PHO yet.

Both study sites have devised a way to achieve the KRA for BAC for health. Both Bataan and South Cotabato recognized the difficulty in creating a separate BAC because it requires specialized training and additional manpower. To achieve this KRA in Bataan, the LGU decided to assign the PHO as BAC member and designated a TWG and secretariat to facilitate all health-related procurement processes of the province. In South Cotabato, they created a UHC BAC Unit under the HSSD Division of the PHO for procurements related to health.

To address issues in priority medicine stock-outs in the GIDA areas of South Cotabato, they have a long-standing partnership with Mahintana Foundation that addresses this specific issue. The Foundation supplement the supply of essential medicines in health facilities situated in hard-to-reach communities during instances of stock-outs.

4.10.5. Financial Management

Both study sites reported that they already established their depository bank accounts for the SHF. They are finalizing the subsidiary ledger for the SHF Trust Fund Component.

In terms of strategic and investment planning, they already submitted their LIPH and AOP for PWHs. Both are implementation sites for PhilHealth PCPN Sandbox. For South Cotabato, they already established a mechanism for contribution per municipality since last year. During the interview with South Cotabato PHO and CHD XII, it was mentioned that the South Cotabato LGU did not rely solely on PhilHealth payment frontloading, but they also established a contribution mechanism from all participating LGUs to jumpstart the SHF. A representative from the CHD XII

shared that they: "require the different LGUs to provide seed money and pool it under the special health fund." In South Cotabato, an SP resolution was passed wherein all 11 local government units in the province will be contributing PhP 5.00 per individual to the SHF on the first year of implementation, and this increases in increments of PhP 5.00 per year until the fifth year of implementation. The pooled funds in the SHF will then be used to fund the entire HCPN's operations. It also serves as an equalizing factor, where the richer LGUs will be subsidizing the poorer LGUs since the planning and funding will be done at the PWHS level. The LGUs were also made to understand that operating under a network (both the HCPN and the smaller PCPN) means that the LGUs and their health facilities will be operating alongside other facilities in other LGUs, thus the imperative for shared sources of financing. This is different from the case of Bataan, wherein they have not finalized the mechanisms on how municipalities and component cities will contribute to the SHF yet.

4.10.6. Unified Governance

Both sites have completed the resolutions for LGU commitment resolutions and tripartite agreement between DOH, PhilHealth and LGU. The Province of Bataan is still finalizing the Provincial Ordinance in establishing and operationalizing PWHS. During the interview with PHO, the document is already at the PB. During the interview with Provincial Administrator of South Cotabato, she shared that the Governor assigned a dedicated staff from Legal Office to assist in the creation of necessary MOAs and ordinances to entice Mayors in participating in the PWHS.

Both provinces have assigned TWGs and focal persons per KRA to facilitate the process of integration PWHS. Majority of the members of these focal groups come from PHO and Finance/Accounting Offices of these Provinces. One of the innovative approaches common in the study sites is having a dedicated point person in ensuring that all KRAs are accomplished—a work that includes cooperating with DOH, PhilHealth, Provincial Governor, LCEs of component cities and municipalities, health care providers from public and private health facilities, medical societies, development partners, and non-profit organizations. This is mainly the work of the Provincial Health Officer and the provincial health office (PHO), but since majority of the work required for the transition involves legislation and/or executive action, the Legal Offices of the Provinces have also been heavily involved and have significantly contributed to ensuring that all required legal documents have been accomplished. Within the PHO, key point persons for the health system building blocks are also designated and are tasked to coordinate with their counterparts at the CHD. Regular meetings also play an important role in the continuous work towards integration, especially during the start of the COVID-19 pandemic which was also the year when most of the milestones were expected to be achieved.

According to a CHD Region III representative, for each KRA, they have a focal person who is tasked to monitor and provide technical assistance to the provinces and municipalities. For example, the unified governance KRAs are assigned with a representative from BLHSD, HRH KRAs with the HRDU, information system with KMITS, epidemiological surveillance with their RESU, and health promotion KRAs with their HFDU, to name a few.

On the other hand, representatives from CHD XII shared that for each UHC characteristic, they hired additional PDOHO/DMOs who work with PHOs. They also hired personnel to assist the

PHO in the LIPH information system. To encourage close coordination of the regional focal person with the province and municipalities from both provinces, they maximized the use of online platforms and instant messaging to receive immediate feedback from the Regional Offices. In South Cotabato, the representative from the Provincial LGU shared that their Governor assigned a legal officer that will assist in the drafting of necessary MOAs/MOUs, ordinances, MOPs, and other pertinent documents aside from the PHO. The PHO South Cotabato representative shared during the interview that one of their subunits, the Health Facility Unit, developed a one-page monitoring tool to assess the readiness and status of the health facilities. This unit goes to all BHS, RHUs, and public hospitals and uses the information gathered in the achievement of the KRAs related to health facilities and service delivery.

5. Discussion

6.1. Inter-LGU Cooperation towards PWHS: enabling and facilitating factors

For this section, we draw from the experience of the two study sites: the provinces of Bataan and South Cotabato in highlighting the enabling factors for the smooth transition to PWHS.

One of the factors that facilitated the inter-local integration in health is the **LGU's initiative and appreciation of its benefits**. Both provinces have the same favorable experience in setting up their PWHS for the SP Resolution signing, reconstitution of the Provincial Health Board to include LCEs of all municipalities and component cities, and strategic planning through the three-year Local Investment Plan for Health (LIPH) and Annual Operational Plan (AOP). At the onset of the integration, all component cities and municipalities of both provinces agreed and expressed their intent to integrate into PWHS, thus facilitating the transition. The driving factor for the compliance of the local chief executives is the provisions in the UHC Act that explicitly envision a province- or city-wide health system that integrates all components of the local health system. FGD responses from both provinces also highlighted that since it was the direction that their LCEs took, they must abide to this. LGU's initiative and appreciation of the benefits of the PWHS is seen as one of enablers of a successful inter-local integration on health, and the dual roles of the politicians, such as lawyer-mayors or doctor-mayors, also contributed to the better understanding and appreciation of the law. This is also manifested through the active participation in CHD activities like orientations and meetings. In fact, a representative from the CHD III reiterated that "the awareness of the ILHZ and SDN complements the transition to the HCPN and eventually to the PWHS. It somewhat builds up to the previous systems." This is seconded by the South Cotabato PHO wherein she shared that their experience with HCPN/PCPN and SDN helped them get familiarized with the process of transition to PWHS of the UHC.

The transition to the new health system will not materialize without the **partnership between the aspiring provinces with NGAs, NGOs, development agencies, and private sector** that provided technical and financial assistance in the integration. The technical guidance and expertise from the Department of Health through the Center for Health Development (CHD) regional offices in Region III and Region XII are facilitating factors not only in dissemination policies from the Central DOH Office but also in the activities that they conduct to ensure that the LGUs will have a full understanding of the process and benefits of integrating to PWHS. The CHDs provide

technical guidance, orientations, and trainings on the documentation requirements for strategic plans and frameworks (i.e., HRH, health facility, SCM, DRRM-H), to the PHO, thus enabling and empowering them to cascade the information to the LCEs, municipal and city health officers, and all other health care providers in their provinces. This cascading of information also leads to conversations on the different reforms which helps all stakeholders in understanding the different requirements for integration.

The Province of Bataan has long been in partnership with USAID's ProtectHealth, providing them with technical assistance on financing even before the start of the integration under UHC. The province has partnered again with ProtectHealth USAID to develop its HCPN in four barangays by training its BHWs as health system or HS navigators. The HS navigators are responsible for in-patient referrals from BHC to RHU and even to their district hospitals. It also used the systems developed in disease-specific projects with USAID to incorporate UHC-related activities (expanded referral system). This also contributed to the province being considered as one of the sites for the Sandbox project of PhilHealth. Aside from that, the PHO of Bataan shared during the interview that the province received assistance from USAID ProtectHealth in achieving its KRAs in the financial integration and guided them in drafting their inter-LGU MOA. They also partnered with a research group from a prominent university to jumpstart their electronic medical records (EMR) system. It also has a partnership with WHO which enables achievement of some PWHS KRAs even prior to signing of the UHC Law in 2019.

For the Province of South Cotabato, the Association of Municipal and City Health Officers of the Philippines (AMCHOP) and ReachHealth helped them in achieving the targets for HCPN transition. They also have a long-standing partnership with the Mahintana Foundation, a local organization in Mindanao, which provided technical inputs and assistance in accomplishing the requirements for the following KRAs: managerial/legal and supply of medical supplies, while their project with WHO helped them in drafting their LIPH. Mahintana Foundation, a non-profit based in South Cotabato, has been a crucial partner of the province in medicines augmentation in the rural health units and public hospitals. USAID's ProtectHealth was also part of the initial stages of UHC Integration in South Cotabato, providing information dissemination work to the LCEs on the reforms under UHC and eventually enticing them to participate in the transition to PWHS.

Other enabling factors for the transition of both Bataan and South Cotabato in PWHS were the presence of legal instruments that are integral in ensuring the confidence and continued participation of municipalities and cities in their respective PWHS. Having to complete the necessary ordinances, policies, and other executive actions laid out the ins and outs of the inter-local set-up that helped in the buy-in of the chief executives of the municipalities and cities being integrated. The expertise of these external partners also helped in communicating the different aspects of the reform to all stakeholders. They are also part of their UHC TWG and have provided the technical and operational expertise that has facilitated the integration.

Lastly, both provinces **maximized their existing monitoring systems to facilitate the attainment of KRAs needed for the full transition to PWHS**. For example, the CHD Region XII shared that South Cotabato is already conducting their bi-annual assessment using the LGU Health Scorecard. The MOVs submitted by the province for the LGU Health Scorecard complimented the achievement of some KRAs of the PWHS.

6.2. Innovations for Inter-LGU cooperation towards PWHS

Interviews also showed that LCE buy-in remains an integral part in the implementation of the PWHS. **Leveraging on development partners to guide LGUs in understanding the PWHS was crucial in having them agree to integrate.** Long-standing partnership with development partners played an integral role in the initial stages as they were able to conduct information sessions with the LCEs on how the UHC would work under a PWHS, particularly on the financing aspect. In addition to the initial work, having a development partner within reach made it possible for the provinces to request for assistance on KRAs and HCPN requirements that were challenging for the provinces during the course of the transition. In return, development partners provide the needed technical assistance which helps provinces attain their transition goals. Aside from development partners, tapping the expertise of NGOs also facilitated the transition for South Cotabato. While their partnership with Mahintana Foundation has been ongoing for years, their involvement under PWHS began with their participation as UHC TWG member in the PHB and are now exploring ways to expand their contribution as provider of stop-gap measure for the stock-out of medicines and supplies. Their crucial role in the initial stages of the integration can possibly develop into a larger role as they plan to expand their services from having select RHUs as beneficiaries to having the entire HCPN (and possibly extending to the private sector) as part of their scope. Having development partners and NGOs as part of the transition provided the appropriate support that enabled the LGUs to understand the integration and eventually agree to transition to a PWHS.

As for South Cotabato, during the initial stages of the transition, **the PHO endeavored to document all the work required and published this** through the support of UP Mindanao. Their “UHC Manual and Facilitator’s Guide” documents their plans, frameworks, and implementation guide, and compiles all the documentation requirements included in the LHS ML. This document will serve as their guide in cascading the information to all component LGUs, particularly the stakeholders such as health care providers in the municipalities and cities. Having this documented will allow for easy transition across administrations. However, while this is integral in the development of the PWHS, the implementation aspects of the PWHS such as ensuring the smooth flow of the referral system and the distribution of the SHF funds to different LGUs are yet to be part of this document.

6.3. Challenges in the implementation of PWHS

The main challenge in the initial stages of implementation of the PWHS was the **limited awareness on the roles and responsibilities of the municipalities and component cities in the PWHS** leading to hesitations in participation from the local LCEs’ perspective. Intensive orientations and workshops were needed to inform and educate to have the LGUs commit to shift to PWHS. In South Cotabato, they needed the orientation provided by a development partner which was the steppingstone towards having all the LGUs commit to transition to PWHS. As both study sites are now working towards achieving their Level 3 Functional status, the continued interest and understanding of the roles and responsibilities of the different stakeholders of the

PWHS must be sustained as more discussion and decision-making are required at the level of each KRA in the LHS ML.

Another challenge mentioned during the interviews and focus group discussions was **time and resource costs of requirements to fully integrate and transition to province-wide health system**. For a fully functioning PWHS, hiring of additional personnel, training, and creation of special committees are expected. Given that allocation of healthcare workers across the country is already poorly distributed, provinces especially in far-flung areas will have a difficult time filling these positions and meet the corresponding health service demands of these provinces. This is the case in Bataan wherein the LGU still find it difficult to recruit doctors and other healthcare workers, particularly in far-flung areas. This is the reality despite having the guidelines and strategies for HRH management and development. The MHO from Bataan mentioned that the integration will require them to hire additional staff. This is on top of the training requirements for both existing and new staff to train, which is deemed costly on their part. Aside from that, the integration of health system increases their workload as health service provider. According to the MHO of Bataan interviewed, they are required to reach certain targets in consultation, dispensed medicines, test conducted, etc. on top of the administrative tasks (creation of manuals, ordinances, meetings/trainings, etc.).

Another issue that province faced during the transition to PWHS is the piecemeal (vs. systemic) understanding of PWHS and UHC reforms (particularly financing reforms) among local leaders leading to misinterpretation of health systems integration. The financial integration aspect of the PWHS is identified as a major challenge for both Bataan and South Cotabato, despite being identified as provinces with best practices in terms of transitioning to PWHS. The issue of cost sharing, decision making on procurement, and prioritization of projects were raised by the mayors during the meetings of the PHB. This led to the delay in signing of inter-LGU MOA and passing of ordinance for the establishment of PWHS for both provinces. According to the Provincial Administrator of South Cotabato, the major issue raised by the mayors was about their capacity to fulfill the contributions to SHF. This bred hesitations among LCEs in taking part of the PWHS. In fact, the CHD XII representative shared the sentiment from the mayors' preference on direct downloading of fund to municipalities than thru the Provincial Government: "*iniisip nila na bakit pa namin ilagay sa special health fund na ima-manage ng provincial health board, na pwede naman diretso.*" This is the same sentiment shared by the Bataan MHO interviewed: "as a 4th class city will have a hard time fulfilling the financial aspect of the PWHS".

Aside from that, the novelty of the concept of SHF and the numerous health financing reforms in PhilHealth for UHC (i.e., payment schemes under Konsulta and Konsulta+SDGs, global budget for hospitals) resulted to a weak understanding of how the SHF can help serve the purpose of the PWHS. Based on the interviews, there seems to be an understanding that the SHF will be operating under pre-UHC health financing programs such as PhilHealth reimbursement for inpatient admissions and outpatient benefit packages. While the reforms in UHC involve prospective payments, this does not seem to be the understanding of most stakeholders as they still expect reimbursements from PhilHealth. These reimbursements will be used to pay the HRH and the facilities, and given the understanding that these reimbursements, regardless of the source municipality or component city, will all accrue to the PWHS-managed SHF, the LGUs now believe that they will not have enough resources to pay and incentivize their HRH.

Provinces can potentially experience losses if there are discrepancies in the actual reimbursements by PhilHealth and the total amount the LGU covered for the patients thru the zero-payment schemes. According to an interviewed Provincial Administrator from South Cotabato, if they will not receive the full amount from PhilHealth, the province will incur potential losses. They find that the Law seems to be vague in terms of the percentage that PhilHealth will reimburse to SHF and health professionals for a health service delivered. This is backed up by the insight shared by a representative from CHD XII that even the MHOs were lukewarm on the reimbursement rates their HFs will receive from PhilHealth since the reimbursements will be consolidated at the province level through the SHF.

Another issue that was identified during the interviews and group discussions was the roles and responsibilities of the private sector are vague in the UHC policies and guidelines and there is limited expertise and guidance from DOH on how the private sector can integrate. The hesitations from the private sector stemmed from the issues of the pooling of their professional rates and PhilHealth reimbursements in the SFH. Aside from the fact that the consultation rates set by public health facilities tend to be lower compared to the private HFs rates, the doctors from the private sector wary on the concept that all reimbursements from PhilHealth will course through the province, which are prone to delays. Aside from that, private practitioners are wary about joining the PWHS because they need pool their PhilHealth reimbursements to the SHF where they do not have control on how the funds will be utilized. The CHD III shared that aside from the issues on low PF repayments rates, the role of private hospitals in the PWHS including the cost sharing mechanisms are not clear nor there are guidelines/policies about this. Moreover, the involvement of the private sector in health service delivery is not fully optimized. At present, their participation was limited to membership in various TWGs related to the transition to PWHS. However, their integration into the PCPN and HCPN is yet to be established. Although there are already existing MOAs on referral to higher private facilities from the primary care facilities in the selected study sites, a seamless integrated private health care facility in the HCPN is yet to happen. These existing MOAs came about due to the need during the COVID-19 pandemic that required both public and private health facilities to make arrangements to meet the extraordinary demands for hospital care and were just carried over as part of the initial work in HCPN.

There was also lack of expertise and technical assistance from the Central Office. CHDs were tasked to disseminate policies and guidelines from the Central Office. They also provided technical assistance for this. But there is specific training and orientations that the Central Office needs to do to help the implementors at the local level. The provinces are just adapting the manuals coming from the Central Office. According to the CHD XII interviewed, the meetings that they provided were basically about cascading policies and guidelines from DOH. The PHO from Bataan shared that they needed technical person experts in UHC implementation to assist them. The long lull in implementation caused by the recent pandemic also did not help the cause of faster integration of the provinces. The CHD Region III representative shared that they receive various requests from provinces for re-orientation for the workshops and training they already conducted.

Lastly, another issue that LGUs encountered in achieving KRAs was related to integrated and interoperable health information systems. The DOH implements the use of iClinicSys as a platform for EMR information systems. However, many LGUs tend to get other service providers because of the technical glitches and lack of timely technical support for the DOH-sponsored information system. The use of different information systems per provinces eventually led to the challenges in interoperability of datasets submitted to DOH and can further affect the other processes like delay PhilHealth reimbursements, among others.

7. Conclusion and Policy Recommendation

With full implementation of PWHS planned by 2025, UHC integration sites are putting in extra effort to achieve full functional status as soon as possible. Our study sites have additional burden being identified as PhilHealth PCPN Sandbox sites where they will serve as demonstration sites in 2024 and will need to be partially functional and are able to meet the requirements for operating a PCPN. Given this circumstance, both Bataan and South Cotabato have established their PCPNs which serve as the base of their HCPN. However, what we observe as limited in terms of achievement is the networking aspect of the integration since each of the municipalities and component cities correspond to one PCPN, thus expecting little or no inter-LGU cooperation in ensuring the completeness of the primary care services required of PCPNs under the PWHS.

As for the LHS ML, based on the latest update, majority of the UIS are on their way towards completing Level 2 requirements and are now working towards achieving Level 3 requirements in 2024. Integration areas that have achieved high completion rates for Level 2 among the UIS include Referral System, DRRM-H System, Health Promotion and Campaigns, and HRH Management and Development. On the other hand, the following areas seem to be a challenge for most UIS: Unified Governance of the LHS (LG1), Financial Management (Fin1), Information Management System (Info1), Epidemiology and Surveillance System (Info2), and Procurement and Supply Chain Management (MPVT1). While the numbers show that there is a high level of achievement, the issues and challenges on the ground seem to contradict these numbers. For example, while 87% of UIS have achieved Level 2 status in HRH Management and Development, these requirements are mostly documentation and planning, and the persistent issues of lack of HRH and its maldistribution remain. The heavy investment requirement for information management system also remains a challenge, and some UIS are still having issues with gathering consensus through an SP Resolution on PWHS integration.

To scale up the integration efforts for the UIS and future provinces intending to integrate, the following are the policy recommendations of this study:

- **Ensure proper communication of accurate information to stakeholders.** Majority of the issues on the hesitation of LGUs to integrate stems from their lack of accurate information on why there is a need to integrate. While the UHC Act set the foundation, the technical expertise necessary to convey this high-level information is needed to make all stakeholders understand the process and the goal. There seems to be inadequate information shared to the PHOs in terms of the need to integrate into inter-LGU networks, and on how the new financing reforms will work under the PWHS. In addition, local chief

executives and stakeholders with differing backgrounds may have different interpretation and appreciation of the provisions of the law—public officials with law background may be interpreting the law differently compared to those with medical background, creating biases among stakeholders. With the sharing of accurate information, collaborating with local chief executives, the provincial governor, health care providers, and the private sector will be enabled, thus facilitating the integration to PWHS.

- **Jumpstart discussions on private sector integration into the HCPN.** Based on the experience of the study sites, the hesitation of the private sector stems from the financing issues. As private entities, their concern is to ensure that their operations are sustained through revenues and that their HRH is compensated adequately. With the SHF and pooling of funds, and the limited information available on the new provider payment reforms, the private sector does not find any incentive to participate in the HCPN. In order to jumpstart the discussions, stakeholders including the PHO need to be well-informed of the new PhilHealth payment reforms, as well as the potential gains of the private sector joining in the HCPN.
- **Implement, evaluate, and progressively enhance the financing reforms to be implemented in the PWHS.** Financing is one of the main drivers of integration. With the lack of clarity on how the SHF can be maximized and the delay in the implementation of PhilHealth financing reforms, there has been limited information on the effectiveness as incentive measures and the implementability of these reforms. Ensuring that consistent evaluation and enhancement of new provider payment schemes and benefit packages are done can help guarantee the achievement of the goals of integration.
- **Provide resources to augment LGU funding for transition requirements.** Resource constraints were identified as one of the issues that hamper integration due to the multitude of investment requirements for the transition. The national government through the DOH should provide support to the LGUs such as sponsoring trainings for establishment of special BAC, for the expected additional role of BHWs and other health care providers in patient navigation and preventive health care, and health information systems. The provision of augmentation can be through grants distributed through an allocation framework that favors the low-resource provinces while forgoing support to well-off provinces.
- **Incorporate plans to ensure maximized participation of the population in the PWHS.** The people are at the heart of the PWHS. The shift to a PWHS requires a paradigm shift in the way that people access the health system—from seeking care at the outpatient department of a Level 3 hospital due to proximity to asking the patient to instead seek care from an RHU that is farther from their residence and likely does not have a doctor on duty daily. Communicating the reforms on PhilHealth inpatient and primary care benefit packages to both the population and the health care providers need to be done properly to ensure maximum efficiency in the use of health services without excessively prescribing laboratory and diagnostic tests to the population. Inviting the BHWs to support in

communicating the preventive care aspect of the PCPN to entice the population to be part of the system is crucial and can help ensure that the population—both the sick and the healthy—are part of the integrated health system and therefore help in attaining the goals of UHC.

Bibliography

- Crowe, S., K. Cresswell, A. Robertson, G. Huby, A. Avery, and A. Sheikh. 2011. The case study approach. *BMC Med Res Methodol*, 11(100). doi:<https://doi.org/10.1186/1471-2288-11-100> (accessed February 29, 2024).
- Department of Finance-Bureau of Local Government Finance. 2022. Statement of Receipts and Expenditures. <https://blgf.gov.ph/lgu-fiscal-data/> (accessed April 17, 2024).
- Department of Health. 2023. Local Health Systems Maturity Levels Mid-Year Report FY 2023. Manila: Bureau of Local Health Systems Development, Department of Health. https://drive.google.com/file/d/1UL5Ps8sw2R-NFCKm1Wn2dP54AmuDcoBv/view?usp=drive_link (accessed on January 30, 2024).
- DOH National Health Facility Registry. <https://nhfr.doh.gov.ph/Home> (accessed March 5, 2024).
- Dorling, G., T. Fountaine, S. McKenna, and B. Suresh. 2015. The evidence for integrated care. McKinsey&Company. <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/The%20evidence%20for%20integrated%20care/The%20evidence%20for%20integrated%20care.ashx> (accessed on March 1, 2024).
- Feng, W., X. Feng, P. Shen, Z. Wang, B. Wang, J. Shen, and X. Shen. 2021. Influence of the integrated delivery system on the medical serviceability of primary hospitals. doi: 10.1155/2021/9950163. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8356014/> (accessed on February 29, 2024).
- Gröne, O., M. Garcia-Barbero, & WHO European Office for Integrated Health Care Services. 2001. Integrated care: a position paper of the WHO European Office for Integrated Health Care Services. *International journal of integrated care*, 1, e21.
- Goniewicz, K., E. Carlström, A.J. Hertelendy, F.M. Burkle, M. Goniewicz, D. Lasota, J.G. Richmond, and A. Khorram-Manesh. 2021. Integrated healthcare and the dilemma of public health emergencies. *Sustainability* 2021, 13 (4517), pp. 1-13. <https://doi.org/10.3390/su13084517>. <https://www.mdpi.com/2071-1050/13/8/4517> (accessed on February 29, 2024).

- Herndon, J.H. 2001. Integrated health systems: Success or failure?. *Clinical Orthopaedics and Related Research*, 391, pp. 284-287. https://journals.lww.com/clinorthop/fulltext/2001/10000/integrated_health_systems__success_or_failure_.34.aspx (accessed on February 29, 2024).
- Hwang, W., J. Chang, M. LaClair, and H. Paz. 2013. Effects of integrated delivery system on cost and quality. *The American Journal of Managed Care*, 19(5), pp. e175-e184. <https://thepcc.org/sites/default/files/resources/Effects%20of%20Integrated%20Delivery%20System%20on%20Cost%20and%20Quality.pdf> (accessed on March 2, 2024).
- Laugesen, M. J. and G. France. 2014. Integration: the firm and the health care sector. *Health Economics, Policy and Law*, 9(1), pp 295-312. doi:10.1017/S1744133114000139 (accessed April 15, 2024).
- Liljas, A.E.M., F. Brattström, B. Burström, P. Schön, and J. Agerholm. 2019. Impact of integrated care on patient-related outcomes among older people – A systematic review. *International Journal of Integrated Care*, 19(3), pp. 1-16. DOI: <https://doi.org/10.5334/ijic.4632>. <https://storage.googleapis.com/jnl-up-j-ijic-files/journals/1/articles/4632/submission/proof/4632-1-17635-1-10-20190724.pdf> (accessed on February 29, 2024).
- Maruthappu, M., A. Hasan, and T. Zeltner. 2015. Enablers and Barriers in Implementing Integrated Care. *Health Systems & Reform*, 1(4), pp. 250-256. DOI: 10.1080/23288604.2015.1077301 (accessed April 15, 2024).
- Michel, J., B. Obrist, T. Bärnighausen, F. Tediosi, D. McIntyre, D. Evans, and M. Tanner. 2020. What we need is health system transformation and not health system strengthening for universal health coverage to work: Perspectives from a National Health Insurance pilot site in South Africa. *South African Family Practice*. DOI: 10.4102/safp.v62i1.5079 (accessed February 19, 2024).
- Miller, R. H. 1996. Health System Integration: A Means to an End. *Health Affairs*, 15(2), pp 92-105. <https://doi.org/10.1377/hlthaff.15.2.92> (accessed April 15, 2024).
- Piquer-Martinez, C., A. Urionagüena, S.I. Benrimoj, B. Calvo, S. Dineen-Griffin, V. Garcia-Cardenas, F. Fernandez-Llimos, F. Martinez-Martinez, M.A. Gastelurrutia. 2024. Theories, models and frameworks for health systems integration. A scoping review. *Health Policy*. <https://doi.org/10.1016/j.healthpol.2024.104997> (accessed on March 4, 2024).
- Robinson, J. C. and L.P. Casalino. 1996. Vertical integration and organization al networks in health care. *Health Affairs*, 15(1), pp. 7-22. <https://doi.org/10.1377/hlthaff.15.1.7> (accessed April 15, 2024).

- Saghafian, S., L.D. Song, J.P. Newhouse, M.B. Landrum, and J. Hsu. 2023. The impact of vertical integration on physician behavior and healthcare delivery: Evidence from gastroenterology practices. National Bureau of Economic Research Working Paper 30928. https://www.nber.org/system/files/working_papers/w30928/w30928.pdf (accessed on March 2, 2024).
- Tumusiime, P., A. Kwamie, O.B. Akogun, T. Elongo, and J. Nabyonga-Orem. 2019. Towards universal health coverage: reforming the neglected district health system in Africa. *BMJ Global Health*. https://gh.bmj.com/content/bmjgh/4/Suppl_9/e001498.full.pdf (accessed February 19, 2024).
- Villaverde, M., K. Ronquillo, N. Espiritu II, and J. Adora. 2022. Universal Health Care in the Philippines: From Policy to Practice. https://www.researchgate.net/publication/362689163_Universal_Health_Care_in_the_Philippines_From_Policy_to_Practice (accessed on February 29, 2024)
- World Health Organization. 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization. https://cdn.who.int/media/docs/default-source/service-availability-and-readinessassessment%28sara%29/related-links-%28sara%29/who_mbhss_2010_cover_toc_web.pdf (accessed on February 1, 2024).
- Yuan, S., F. Fan, and D. Zhu. 2022. Effects of vertical integration reform on primary healthcare institutions in China: Evidence from a longitudinal study. *International Journal of Health Policy and Management*, 11(9), pp. 1835-1843. doi:10.34172/ijhpm.2021.93. https://www.ijhpm.com/article_4099_bf184ea865a7195a33ebe121c5a0c938.pdf (accessed on March 1, 2024).

Annexes

Annex A. KRAs with Means of Verification (MOV)

Unified Governance of the LHS (LG1)	
KRA 1.1	Commitment to integrate local health systems (LHS) into Province-Wide/ City-Wide Health Systems (P/CWHS) 1. Signed Sanggunian Panlalawigan/ Panlungsod (SP) Resolution or Executive Order (EO) expressing LGUs' commitment to LHS integration 2. Signed and notarized Memorandum of Understanding (MOU) among the Province/City Government, DOH and PhilHealth describing the specific commitments of parties to implement LHS integration
KRA 1.2	Presence of technical working group/s (or similar group/s) to assist the Provincial /City Health Board (P/CHB) on matters relating to the integration of LHS 1. Signed EO or Administrative Order (AO) on the creation of the TWG and their functions relating to the LHS integration
KRA 2.1	Organized Province-Wide Health Systems (PWHS) 1. Signed and notarized Inter-LGU Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU)
KRA 2.2	Expanded Membership and Functions of the Provincial /City Health Board (P/CHB) 1. Signed EO on expansion of membership and functions
KRA 2.3	Strengthened Provincial/ City Health Office (P/CHO) 1. Signed Ordinance or EO reflecting the creation of the HSDD and HSSD, and its corresponding functions 2. Signed Ordinance on the creation of positions (if not yet existing) or EO/Office Order on the designation of personnel (if already existing)
KRA 2.4	Established Management Support Unit (MSU) 1. Signed EO establishing an MSU with personnel composition and their respective roles and Responsibilities
KRA 3.1	Institutionalized P/CWHS 1a. Signed Provincial Ordinance providing for the establishment and operationalization of the PWHS, including its management support systems 1b. List of component LGUs that committed to the integration with signed ordinance on PWHS establishment and operationalization, including its management support systems 2. Signed City Ordinance providing for the establishment and operationalization of the CWHS, including its management support systems
KRA 3.2	P/CWHS contracted by DOH and PhilHealth 1. Signed and notarized Terms of Partnership (TOP) between the P/CHB and DOH-Center for Health Development (DOH-CHD) for population-based health services 2. Signed and notarized contract between the P/CHB and PhilHealth for individual-based health services
KRA 3.3	Monitoring of P/CWHS Performance 1. P/CWHS Annual Accomplishment Report
Strategic and Investment Planning (LG 2)	
KRA 1.1	Baseline assessment of LGUs' health systems capacity and corresponding investment needs for the Local Health Systems integration 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 2.1	LIPH as the strategic and investment plan of the Province-Wide/ City-Wide Health Systems (P/CWHS) 1. Signed Provincial/ City Health Board (P/CHB) Resolution or Executive Order (EO) on the adoption of the LIPH as the strategic and investment plan of the P/CWHS
KRA 2.2	LIPH/ Annual Operational Plan (AOP) concurred by concerned Center for Health Development (CHD) 1. LIPH concurred by concerned Regional Director as reflected in the LIPH appraisal checklist 2. AOP concurred by concerned Regional Director as reflected in the AOP appraisal checklist
KRA 3.1	Analysis of LGU Commitment/ Counterpart vis a vis Actual Health Expenditure 1. Report on committed Province/HUC/ICC counterpart fund vs appropriated budget for health vs actual health expenditures, prepared by the Provincial/ City Accountant and noted by P/CHO
Financial Management (Fin 1)	
KRA 2.1	Opening of Special Health Fund (SHF) Depository Bank Account 1. Signed Provincial/ City Health Board (P/CHB) Resolution on the opening of an SHF depository bank account in an authorized depository bank based on existing Department of Finance – Bureau of Local Government Finance (DOF-BLGF) guidelines 2. Signed Sanggunian Panlalawigan/ Panlungsod (SP) Resolution endorsing the P/CHB Resolution on the opening of SHF depository bank account 3. Bank Certification on the presence of the SHF depository bank account
KRA 2.2	Presence of Separate SHF Book of Accounts at Provincial/ HUC/ ICC Level 1. Certification from the Provincial/ City Accountant on the presence of a separate book of accounts for SHF, including subsidiary ledgers for each fund source
KRA 2.3	Presence of Subsidiary Ledger for SHF in the Trust Fund of Component LGUs 1. List of component LGUs that have subsidiary ledger for SHF in their Trust Fund as certified by the LGU Accountant
KRA 2.4	Presence of Personnel in the Management Support Unit (MSU) to Assist the Board in the management of the SHF 1. Copy of Executive Order (EO) or Office Order designating or appointment letter hiring the MSU personnel
KRA 3.1	Exclusive Use of SHF Budget for Health Programs, Projects and Activities within the P/CWHS

	1. P/CHB Resolution on the approval of budget for priority health programs, projects and activities within the P/CWHS 2. Approved Work and Financial Plan (WFP) of the P/CWHS for the SHF 3. Signed SHF Budget Utilization Report
Human Resource for Health Management and Development (HW 1)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Human Resources for Health Management and Development System 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 2.1	Presence of Province-Wide/ City-Wide Health Systems (P/CWHS) Human Resources for Health (HRH) Plan 1. HRH plan of the P/CWHS signed by Provincial/ City Health Board (P/CHB)
KRA 2.2	Updated National Health Workforce Registry (NHWR) 1. Signed NHWR Update Report
KRA 2.3	Presence of Harmonized HRH Management and Development System and HRH Performance Assessment System 1. Signed Executive Order (EO) or P/CHB Resolution on harmonized competency-based HRH management and development system, and HRH performance assessment system, including grievance redress mechanism
KRA 2.4	Presence of DOH-PRC Certified Primary Care Health Workers 1. List of DOH-PRC Certified primary care health workers in public primary care facilities
KRA 3.1	Creation of Permanent Plantilla Positions for HRH 1. Signed Provincial/ Municipal/ City Ordinances on the creation of plantilla positions for HRH based on gaps/needs identified
KRA 3.2	Monitoring of P/CWHS Performance on HRH Management and Development 1. Reports related to Human Resources for Health Management and Development System
Information Management System (Info 1)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Information Management System 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 2.1	Presence of P/CWHS Health Information Management/ ICT Development Plan 1. Health information management/ ICT development plan of the P/CWHS signed by P/CHB
KRA 2.2	Functional EMR System among Health Facilities within the P/CWHS 1. Submitted reports to DOH and PhilHealth through EMR
KRA 2.3	Engagements with Medical Specialists/ Facilities for the Provision of Telemedicine Services 1. Signed and notarized Memorandum of Agreement (MOA)/ Service Level Agreements (SLA) between the P/CHB and medical specialists/ facilities for the provision of telemedicine services
KRA 2.4	Presence of Dedicated ICT Personnel in the P/CHO 1. Signed office order designating or appointment letter hiring a dedicated ICT personnel in the P/CHO
KRA 3.1	Validated EMR System that Links the Members of the PCPN to Secondary and Tertiary Care Providers within P/CWHS 1. Reports related to Information Management System
KRA 3.2	Monitoring of P/CWHS Performance on Information Management 1. Report on percent of security incidents and personal data breaches detected and responded to in a timely manner 2. Report on percent of health facilities providing telemedicine services
Epidemiology and Surveillance System (Info 2)	
KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Epidemiology and Surveillance System 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 2.1	Epidemiology and Surveillance Units (ESUs) with Dedicated Personnel Competent on Basic Epidemiology, Disease Surveillance and Event-Based Surveillance 1. Signed Ordinance or Executive Order for the creation of Provincial/City ESU (P/CESUs) 2. Signed Executive Order or Office Order designating or appointment letter hiring personnel for the P/CESU 3. List of dedicated P/CESU staff with training certificate/s issued by Epidemiology Bureau (EB) / Regional ESU (RESU) 4. List of LGU hospitals within the P/CWHS with signed Ordinance, Executive Order or Hospital Order on the establishment of Hospital Epidemiology and Surveillance Unit (HESU) and updated hospital organizational structure reflecting the HESU
KRA 2.2	Presence of Technical Guidelines/Manual of Operations on Epidemiology and Surveillance System 1. Provincial/City Health Board-approved technical guidelines/manual of operations on epidemiology and surveillance system
KRA 3.1	Full Implementation of the Epidemiology and Surveillance System Technical Guidelines/Manual of Operations 1. Budget allocation for the implementation of epidemiology and surveillance system technical guidelines/manual of operations as reflected in an ordinance or work and financial plan.
KRA 3.2	Monitoring of P/CWHS Performance on Epidemiology and Surveillance System 1. Timely and complete submission of Field Health Services Information System (FHSIS) as prescribed in the FHSIS Manual of Operations. 2. Timely and complete submission of Case-based Surveillance Reports and complete and accurate surveillance databases through Philippine Integrated Disease Surveillance and Response (PIDSR) as required in the PIDSR Manual of Procedures. 3. Approved and signed notifiable disease surveillance reports, as needed 4. Epidemiologic/ Outbreak reports, as needed
Procurement and Supply Chain Management (MPVT 1)	

KRA 1.1	Baseline Assessment, Gaps Analysis and Investment Needs for the Development and Strengthening of the Procurement and Supply Chain Management System 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 1.2	Presence of a Pharmacy and Therapeutics Committee (PTC) 1. Signed Provincial/ City Health Board (P/CHB) Resolution or Executive Order (EO) on the creation of the PTC with clearly defined functions relating to procurement and supply chain management system of the P/CWHS
KRA 2.1	Presence of P/CWHS Procurement Plan 1. Signed procurement plan on medicines, vaccines and other health commodities of the P/CWHS
KRA 2.2	Presence of Technical Guidelines/ Manual on Harmonized Supply Chain Management System 1. P/CHB approved technical guidelines/ manual on the implementation of the harmonized supply chain management system
KRA 2.3	Presence of Pharmacist/ Pharmacy Assistant 1. List of existing licensed pharmacist/ pharmacy assistant (LGU-hired and DOH-deployed) vis-à-vis list of health facilities within the P/CWHS
KRA 2.4	Presence of Dedicated Trained Personnel on Supply Chain Management in the P/CHO 1. Signed office order designating or appointment letter hiring dedicated personnel on supply chain management in the P/CHO 2. List of dedicated supply chain management personnel with certificate/s on supply chain management
KRA 3.1	Interoperable electronic supply chain/ logistics management system within the P/CWHS 1. Report generated through an electronic supply chain/ logistics management system
KRA 3.2	Monitoring of P/CWHS Performance on Procurement and Supply Chain Management 1. Report on the availability of essential medicines in all public health facilities as represented by % of public health facilities with no stock-outs 2. Report on near-expiry medicines, vaccines and health commodities, including the batch number/ lot number, and name of manufacturer and distributor/ supplier
Referral System (SD 1)	
KRA 1.1	Assessment of Existing Two-Way Referral System 1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)
KRA 1.2	Groupings/ Clustering of Health Care Providers and Facilities 1. List of grouped/ clustered RHUs/Health Centers and their referral hospitals
KRA 1.3	Identification of Potential Apex Hospital/s 1. List of potential Apex Hospital/s of the P/CWHS
KRA 2.1	Presence of Technical Guidelines/ Manual on Referral System 1. Provincial/City Health Board (P/CHB)-approved technical guidelines/ manual on implementation of the referral system
KRA 2.2	Adoption and Implementation of Clinical Practices Guidelines (CPGs) and other Case Management Protocols in the P/CWHS 1. P/CHB-approved compendium of CPGs and other case management protocols adopted and implemented in the P/CWHS
KRA 2.3	Presence of P/CWHS Health Facility Development Plan 1. P/CHB-approved Health facility development plan of the P/CWHS
KRA 2.4	Presence of Public Health Unit (PHU) in LGU Hospitals 1. List of LGU hospitals within the P/CWHS with signed Executive Order (EO) or Hospital Order on the creation of PHU
KRA 2.5	Partnership with Apex Hospital/s 1. Signed Memorandum of Agreement (MOA) with Apex Hospital/s
KRA 2.6	Registration of Indigents to a Primary Care Provider (PCP) within the P/CWHS 1. List of indigents registered to a PCP
KRA 2.7	Presence of Technical Guidelines on Customer Feedback Mechanism 1. P/CHB-approved technical guidelines on customer feedback mechanism, including standard form and data utilization mechanisms
KRA 3.1	Monitoring of P/CWHS Performance on Referral System 1. Reports related to Referral System
KRA 3.2	Registration of all Constituents to a PCP within the P/CWHS 1. List of constituents registered to a PCP
Disaster Risk Reduction Management in Health (DRRM-H) System (SD 2)	
KRA 1.1	Baseline Assessment and Gaps Analysis on the Implementation of the DRRM-H System 1. Accomplished Baseline/ Assessment Report or Situational Analysis Report or other similar reports
KRA 2.1	Organized Province-Wide/ City-Wide DRRM-H System 1. Ordinance or P/CHB Resolution on the organization of DRRM-H System in P/CWHS 2. Office Order designating or appointing the DRRM-H Manager 3. P/CWHS DRRM-H Plan is approved and disseminated as evidenced by: a. Approved and signed DRRM-H Plan b. Documentation of planning activities and dissemination activities on the DRRM-H plan 4. Health Emergency Response Team (HERT) organized and trained on minimum trainings for the P/CWHS as evidenced by: a. Office Order organizing the HERT for Public Health and Hospital b. Certificate of Completion/ Participation (COC/COP) of HERTs on DRRM-H Trainings 5. Essential health emergency commodities (HECs) available and accessible as evidenced by inventory of HECs and /or other supporting documents 6. Functional Emergency Operation Center (EOC) as evidenced by: a. Office Order on activating an EOC with functional command and control, coordination and communication based on Code Alert level, as needed b. Emergency Operations Center Report as needed

KRA 2.2	<p>7. Local government investment plan earmarking budget for the DRRM-H System and its operations</p> <p>Monitoring of Province/ City-Wide Health System (P/CWHS) Performance on DRRM-H System</p> <p>1. Program Implementation Review (PIR) Reports issued annually reflecting the recommendations/ concerns raised during the previous PIR, as well as actions taken</p>
KRA 3.1	<p>Advanced Province-Wide/ City-Wide DRRM-H System</p> <p>1. P/CWHS DRRM-H Plan is updated and tested as evidenced by: a. Updated and tested DRRM-H Plan b. Documentation of drills and exercises applied in updating of DRRM-H Plan</p> <p>2. HERT sustained for the P/CWHS as evidenced by: a. Certificate of Completion/ Participation of HERTs on DRRM-H Trainings b. Deployment/ Mission order on HERT mobilization including "report from the field by the HERTs" as needed</p> <p>3. Executive Order/ Office Order on the organization of the following Health Clusters with members/ representatives, identified roles and responsibilities and rules of engagements, including accomplishment reports from each cluster as needed</p> <p>4. MOA/MOU specifying resource sharing and/or mobilization for service delivery in emergencies/ disasters</p> <p>5. Approved final report on major emergencies and disasters, as needed</p> <p>6. Office Order authorizing members of DRRM-H Program Management Team with defined roles and responsibilities</p> <p>7. Appropriation ordinance or approved work and financial plan reflecting budget allocation for the sustainable implementation of DRRM-H System and its operations</p>
KRA 3.2	<p>Monitoring of P/CWHS Performance on DRRM-H System</p> <p>1. Budget utilization reports on the implementation of the DRRM-H System and its operations</p> <p>2. Documentation of lessons learned, best practices and innovations on DRRM-H institutionalization</p>
Health Promotion Programs and Campaigns (SD 3)	
KRA 1.1	<p>Baseline Assessment on Functional Health Literacy</p> <p>1. Baseline Assessment Report or Situational Analysis Section of the Local Investment Plan for Health (LIPH)</p>
KRA 1.2	<p>Presence of a Health Promotion Committee (HPC)</p> <p>1. Signed Executive Order (EO) on the creation of the HPC with clearly defined functions relating to the implementation of proactive and effective health promotion programs and campaigns</p>
KRA 1.3	<p>Barangay Health Workers (BHWs) as barangay Health Promotion Officers</p> <p>1. Signed SP Resolution on the strengthened role of BHWs as barangay health promotion officers and members of the P/CWHS Primary Care Provider Network</p>
KRA 1.4	<p>Implementation of Population-wide Health Promotion Programs</p> <p>1. Accomplished copy of the self-appraisal checklist (DM-2021-0068) for at least one (1) HPFS priority area</p>
KRA 2.1	<p>Presence of Health Promotion Unit (HPU) in the Provincial/ City Health Office (P/CHO)</p> <p>1. Signed Ordinance or EO on the creation of the HPU in the P/CHO</p>
KRA 2.2	<p>Presence of P/CWHS Health Promotion Framework Strategy (HPFS)</p> <p>1. Signed SP Resolution adopting the HPFS (2021-2030)</p>
KRA 2.3	<p>Implementation of Population-wide Health Promotion Programs</p> <p>1. Accomplished copy of the self-appraisal checklist (DM-2021-0068) for at least three (3) HPFS priority areas</p>
KRA 3.1	<p>Capacitated to Participate in the Health Impact Assessment (HIA) Review Process</p> <p>1. List of P/CHB members with a certificate of completion in at least one (1) learning module on reviewing HIA reports and Public Health Management and Mitigation Plan</p>
KRA 3.2	<p>Implementation of Population-wide Health Promotion Programs</p> <p>1. Accomplished copy of the self-appraisal checklist (DM-2021-0068) for at least seven (7) HPFS priority areas</p>
KRA 3.3	<p>Monitoring of the P/CWHS Performance on the Implementation of Health Promotion Programs or Campaigns</p> <p>1. Annual accomplishment report on health promotion program implementation submitted to DILG and DOH</p> <p>2. Compendium of policies, programs and campaigns implemented, including documentation of community action and social mobilization initiatives within the P/CWHS</p>

Source: LHS ML 2023 Mid-Year Report, Department of Health

Annex B. List of hospitals, infirmaries, and rural health units in the province of Bataan

Health Facility	City/Municipality	Classification
<i>Hospital</i>		
1 BATAAN GENERAL HOSPITAL AND MEDICAL CENTER	CITY OF BALANGA (CAPITAL)	Government
2 MARIVELES DISTRICT HOSPITAL	MARIVELES	Government
3 MARIVELES MENTAL WELLNESS AND GENERAL HOSPITAL	MARIVELES	Government
4 ORANI DISTRICT HOSPITAL	ORANI	Government
5 BALANGA MEDICAL CENTER (BMCC) CORPORATION	CITY OF BALANGA (CAPITAL)	Private
6 BATAAN DOCTOR'S HOSPITAL AND MEDICAL CENTER	CITY OF BALANGA (CAPITAL)	Private
7 BATAAN PENINSULA MEDICAL CENTER	DINALUPIHAN	Private
8 BATAAN ST. JOSEPH HOSPITAL & MEDICAL CENTER CORP.	CITY OF BALANGA (CAPITAL)	Private
9 CENTRO MEDICO DE SANTISIMO ROSARIO, INC.	CITY OF BALANGA (CAPITAL)	Private
10 ISAAC AND CATALINA MEDICAL CENTER	CITY OF BALANGA (CAPITAL)	Private
11 JOSE C. PAYUMO JR. MEMORIAL HOSPITAL	DINALUPIHAN	Private
12 MAHESECO MULTIPURPOSE COOPERATIVE	MARIVELES	Private
13 ORION ST. MICHAEL HOSPITAL, INC.	ORION	Private
<i>Infirmery</i>		
1 BAGAC COMMUNITY AND MEDICARE HOSPITAL	BAGAC	Government
2 MT. SAMAT MEDICAL CENTER, INC.	PILAR	Private
3 SANTO ROSARIO MATERNITY AND MEDICAL CLINIC	DINALUPIHAN	Private
<i>Rural Health Unit</i>		
1 ABUCAY RURAL HEALTH UNIT	ABUCAY	
2 BAGAC RURAL HEALTH UNIT	BAGAC	
3 BALANGA CITY HEALTH CENTER I	CITY OF BALANGA (CAPITAL)	
4 BALANGA CITY HEALTH CENTER II	CITY OF BALANGA (CAPITAL)	
5 BALANGA CITY HEALTH CENTER III	CITY OF BALANGA (CAPITAL)	
6 BALANGA CITY HEALTH CENTER IV	CITY OF BALANGA (CAPITAL)	
7 BALANGA CITY HEALTH CENTER V	CITY OF BALANGA (CAPITAL)	
8 BALANGA CITY HEALTH OFFICE	CITY OF BALANGA (CAPITAL)	
9 COLO RURAL HEALTH UNIT II	DINALUPIHAN	
10 DINALUPIHAN RURAL HEALTH UNIT 4	DINALUPIHAN	
11 DINALUPIHAN RURAL HEALTH UNIT 5	DINALUPIHAN	
12 DINALUPIHAN RURAL HEALTH UNIT 6	DINALUPIHAN	
13 DINALUPIHAN RURAL HEALTH UNIT III	DINALUPIHAN	
14 HERMOSA LYING IN AND HEALTH CENTER	HERMOSA	
15 LIMAY RURAL HEALTH UNIT	LIMAY	
16 MARIVELES RURAL HEALTH UNIT I	MARIVELES	
17 MARIVELES RURAL HEALTH UNIT II	MARIVELES	
18 MARIVELES RURAL HEALTH UNIT III	MARIVELES	
19 MARIVELES RURAL HEALTH UNIT IV	MARIVELES	
20 MORONG RURAL HEALTH UNIT	MORONG	
21 ORANI RURAL HEALTH UNIT	ORANI	
22 ORION RURAL HEALTH UNIT	ORION	
23 PILAR RURAL HEALTH UNIT – LT. JUAN ALDABA MEMORIAL HEALTH CENTER	PILAR	
24 POBLACION RURAL HEALTH UNIT I	DINALUPIHAN	
25 SAMAL RURAL HEALTH UNIT	SAMAL	

Source: DOH National Health Facility Registry. <https://nhfr.doh.gov.ph/Home> (accessed March 5, 2024).

Annex C. List of hospitals, infirmaries, and rural health units in the province of South Cotabato

	Health Facility	City/Municipality	Classification
Hospital			
1	NORALA DISTRICT HOSPITAL	NORALA	Government
2	SOCCSKSARGEN GENERAL HOSPITAL	SURALLAH	Government
3	SOUTH COTABATO PROVINCIAL HOSPITAL	CITY OF KORONADAL (CAPITAL)	Government
4	ALLAH VALLEY MEDICAL SPECIALISTS CENTER, INC.	CITY OF KORONADAL (CAPITAL)	Private
5	BONTUYAN MEDICAL HOSPITAL, INC.	POLOMOLOK	Private
6	DANTOM DOCTORS HOSPITAL	BANGA	Private
7	DR. ARTURO P. PINGOY MEDICAL CENTER	CITY OF KORONADAL (CAPITAL)	Private
8	HERAMIL HOSPITAL	POLOMOLOK	Private
9	HOWARD HUBBARD MEMORIAL HOSPITAL	POLOMOLOK	Private
10	LANDERO CLINIC AND HOSPITAL	SURALLAH	Private
11	LARIOSIA CLINIC AND HOSPITAL, INC.	SURALLAH	Private
12	SOCOMEDICS MEDICAL CENTER, INC.	CITY OF KORONADAL (CAPITAL)	Private
13	SURALLAH COMMUNITY HOSPITAL	SURALLAH	Private
Infirmary			
1	LAKE SEBU COMMUNITY HEALTH CARE COMPLEX (GONO MULUNG)	LAKE SEBU	Government
2	POLOMOLOK MUNICIPAL HOSPITAL	POLOMOLOK	Government
3	ROEL I. SENADOR MD MEMORIAL HOSPITAL	TUPI	Government
4	CLINICA LUNTAO, INC.	SANTO NINO	Private
5	DR. FRANCISCO C. PARCON CLINIC AND HOSPITAL	BANGA	Private
6	DR. ROGELIO M. GARCIA MEMORIAL HOSPITAL	TUPI	Private
7	JANUARIA MARCIAL MEMORIAL HOSPITAL	BANGA	Private
8	MOOREHOUSE MISSION HOSPITAL, INC.	T'BOLI	Private
9	ZMK DOCTORS CLINIC AND HOSPITAL	SANTO NINO	Private
Rural Health Unit			
1	BANGA RURAL HEALTH UNIT	BANGA	
2	KORONADAL CITY HEALTH OFFICE	CITY OF KORONADAL (CAPITAL)	
3	LAKE SEBU RURAL HEALTH UNIT	LAKE SEBU	
4	NORALA RURAL HEALTH UNIT	NORALA	
5	POLOMOLOK MUNICIPAL HEALTH OFFICE	POLOMOLOK	
6	SANTO NIÑO RURAL HEALTH UNIT	SANTO NINO	
7	SURALLAH RURAL HEALTH UNIT	SURALLAH	
8	T'BOLI RURAL HEALTH UNIT	T'BOLI	
9	TAMPAKAN RURAL HEALTH UNIT	TAMPAKAN	
10	TANTANGAN RURAL HEALTH UNIT	TANTANGAN	
11	TUPI RURAL HEALTH UNIT	TUPI	

Source: DOH National Health Facility Registry. <https://nhfr.doh.gov.ph/Home> (accessed March 5, 2024).

NOTE: List excludes facilities from City of General Santos