SOUTH COTABATO

Socio-Economic and Health Profile

South Cotabato is home to several indigenous peoples such as the T'boli, B'laan, Tagabili, Ubo and Tasaday. Muslim settlers arrived in the 15th century, while migrants from Luzon and Visayas came as part of a government program to develop Mindanao starting from 1939. These later settlements have been followed by successive migration waves and provide a dynamic force that has been a factor in the growth surge experienced by the province in the last decade

South Cotabato lags behind national averages in health. Leading causes of death in the province reflect the state of transition where infectious diseases are competing with chronic and lifestyle diseases within the top ten. It is worth noting that "assault" figures prominently in the top ten causes of mortality for the province, indicative of the volatile peace and order situation in Mindanao.

Table 1. Selected Socio-Demographic & Economic Indicators.

Indicator	1990	1995	2000
Total Population (in '000) Rank in Region 11	1073 2nd highest	673 2nd	689 3rd
Population Growth Rate Rank in Region 11	3.37 2nd	4.16 1st	2.24 1st
Population Density	143.7	176.1	243.5
	1990	1994	1997
Human Development Index Rank in Region 11	.548 2nd	.586 1st	.532 1st
Life expectancy at birth Rank in Region 11	Not available	64.9 2nd	66.3 2nd
School Enrollment Rate Rank in Region 11	Not available	70.9 2nd	72.0 3rd
Real per capita income (at 1994 prices) Rank in Region 11	Not available	12,285 1st	15,187 1st
Poverty Incidence* Rank in Region 11	54.8 1st or highest	41.3 4th or lowest	25.4 4th

Source: Time to Act: Needs, Options, Decisions, State of the Philippine Population Report 2000, Commission on Population, January 2001, pp. 83-87; [1]1980-1990, [2] 1990-1995, [3] 1995-2000

*Philippine Human Development Report 1997

Table 2. Selected Health Indicators: Mortality Rates.

Indicator	1990	1995
Infant Mortality Rate* Rank in Region 11	51.17 3rd	55.37 3rd

Philippine IMR	56.69	48.93
Under- 5 Mortality Rate* Rank in Region 11 Philippine U5MR	77.44 3rd 79.64	70.45 3rd 66.79
Maternal Mortality Ratio* Rank in Region 11 Philippine MMR	214.07 1st 209.00	196.97 1st 179.74

* Source: Time to Act: Needs, Options, Decisions, State of the Philippine Population Report 2000, Commission on Population, January 2001, p 88.

Table 3. Selected Health Indicators: Leading Causes of Deaths.

Condition	**1999**		**2000**	
	No.	Rate	No	Rate
Cerebrovascular Disease	211	10.7	108	5.3
Pneumonia	161	8.1	99	4.9
Pulmonary Tuberculosis	72	3.6	85	4.2
Malignant Neoplasms	112	5.7	70	NA
Other Heart Disease	8	0.9	56	2.8
Glomerular/ Renal Disease	55	2.8	49	2.4
Ischemic Heart Disease	8	0.4	48	2.4
Septicemia	65	3.3	47	2.3
Assault	108	5.5	36	1.8
Diabetes Mellitus	27	1.4	19	0.9

Source: ICHSP Project Status Report, Dec 2000

Table 4. Selected Health Indicators: Nutritional Status, 1998 (from the 5th National Nutrition Survey, FNRI 1998).

Indicator	South Cotabato	Region XI (mean)	Philippines (mean)
Children under 5 years			
I. I. Underweight	37.6	32.9	32.0
II. II. Wasted	4.8	5.3	6.0
III. III. Stunted	45.0	40.5	34.0
IV. IV. Vit. A deficient & low	24.1	35.6	38.0
V. V. Anemia Prevalence	21.9	27.5	31.8
Pregnant Women			
VI. VI. Vit. A deficient & low	8.9	21.3	22.2
VII. VII. Anemia Prevalence	34.2	49.5	50.7
Lactating Women			
VIII. VIII. Vit. A deficient & low	0.4	11.7	16.5
IX. IX. Anemia Prevalence	52.0	49.4	45.7

South Cotabato, as a participant in the Integrated Community Health Services Project (ICHSP) was included in the Local Health Accounts pilot phase as one of six provinces where local financial data was collected. Data from 1998 (see Table 5) shows that of the PhP 1,041, 443,300 the province spent for health care, 74% was spent for personal health care which are predominantly hospital expenses, 14.5% on public health care - rural health unit expenses and 11.5% on administrative and other expenses including research and training. Out of pocket expenses account for 64% of personal health care with all forms of insurance covering 10.4% of these expenses. The bulk of insurance coverage came from PhilHealth pegged at 88.6% of all insurance costs. Most of the out of pocket expenses (36%) were spent on government hospitals and medicines (32.5%), 12.5% went to non-hospital presumably private MDs and 9.7% to private hospitals. Data for the province's local health accounts for the year 2000 are available, but have not been released as of this time and would be useful in assessing progress in terms of financial goals for HSRA.

USES of Funds	SOURCES of Funds				
	National Gov't	Local Gov't	Mandatory Insurance	Local Hlth Insur	Private

		Prov'l	Mun'l	Medicare	EC*		OOP*	Insurance	Employer	Sc
Personal Health Care	1,980,186	43,114,876	77,662,663	71,015,028	4,998,546	0	493,140,588	4,116,970	69,810,334	4,
Government Hospitals	1,322,180	43,114,876	77,662,663	5,529,666		0	176,986,338			
Private Hospitals				65,485,362			47,679,639			
Non-Hospital MD	658,006						61,656,792			
Other Professionals					4,998,546		5,713,058	4,116,970	69,810,334	4,
Dental							14,272,563			
Traditional							26,512,205			
Home care (Drugs, Med. Durables)							160,319,993			
Public Health Care	22,156,804	15,943,348	113,005,379			0	0			
Other	16,615,203	19,796,655	62,729,290	12,128,995	769,697	0	0	8,042,430	0	
Administration	15,519,816	19,796,655	62,729,290	12,128,995	769,697			8,042,430		
Research & Training	1,095,385									
TOTAL	40,752,193	78,854,879	253,397,332	83,144,023	5,768,243	0	493,140,588	12,159,400	69,810,334	4,

Convergence In Health Reform

Health services in South Cotabato were seriously affected by devolution in 1992. Most of the LGUs were not ready to provide and manage health services. Personnel were demoralized. The referral system disintegrated -- "patients would go straight to the hospital without passing the health centers" -- and procurement of drugs and medications was affected. The LGUs were not prepared to accept the responsibility. Their health budgets only went to personnel services. As a result, there was physical deterioration of the health facilities and equipment since no funds could be allotted for maintenance and capital outlay.

In 1993, the Department of Health (DOH) asked USAID to conduct a rapid appraisal assessment of South Cotabato. The DOH was planning to assist the province by extending technical assistance to strengthen the health delivery system from the barangay level to the hospital through the ICHSP project. Dr. Edgardo Sandig, South Cotabato's Provincial Health Officer (PHO), believes that the area was chosen for the project because of its big population, relatively good peace and order, reasonably good roads and the presence of an NGO network. A project proposal was prepared by the PHO, consisting initially of infrastructure and equipment needs. At the same time that ICHSP was being readied, LPP was also being launched in the province. South Cotabato was among the first twenty provinces selected for the LPP projects in the Philippines.

It was in the last quarter of 1997 that the DOH finally implemented ICHSP in South Cotabato and five other provinces with funding from AUSAID and Asian Development Bank. AUSAID was assigned to finance and assist South Cotabato. By this time, the focus of the project had changed to systems development in order to strengthen the management capacity of the LGUs at provincial and municipal levels. The goal of the ICHSP in South Cotabato was to "promote the well-being of the people of South Cotabato through a sustainable health care delivery system in full partnership with non-government organizations (NGOs) and the community". It has the following objectives and strategies:

Objectives

Revitalization of the health system through collaborative health focused management and delivery of health services within South Cotabato;
Improved access to an appropriate level of health care targeted at services that have the greatest health benefit for the population as a whole;
The efficient and effective allocation of resources based on strategic development plans and networks developed with the private medical and community-based NGO sector.

Strategies

Clustering of municipalities into five Local Area Health Development Zones;
Development of a management structure for LAHDZs and a supportive management structure at the provincial level;
Provision of a defined minimum package of activity for public health services, complimentary package of activity for core referral hospitals and tertiary package of activity for the provincial referral hospital;
Development of a well-functioning and comprehensive health referral system;
Strategically identified development requirements and implementation schedule for the integrated health system.

Sub-systems such as Integrated Health Planning, Health Care Financing, Health Delivery and Referral, NGO/ Community Mobilization, Human Resource Management and Development (HRD), Health Management Information, and Monitoring and Evaluation were set up, with manpower from the province assigned to these units. A series of planning and consultative meetings were conducted, spearheaded by the PHO and participated in by the LGUs, the Sanggunian Panlalawigan, the private sector, NGOs and the Chiefs of Hospitals of the district hospitals.

By June 1999, five Local Area Health Development Zones were organized in the province as the operating mechanism for the integration of the different components and sub-systems. This preceded the signing of Presidential EO 205, which mandated the organization of Inter-Local Health Zones throughout the country. The LAHDZ vary in terms of the number of component municipalities, the catchment population of each core referral hospital and the number and level of hospital services within each area. Catchment areas are generally determined by geography, road networks, transportation

and availability of other services. Local chief executives once informed of the goals and planned processes were generally supportive.

Table 6. The LAHDZ areas in South Cotabato , their core referral hospitals and Catchment areas.

LAHDZ	Catchment Areas	Core Referral/ District Hospital
Upper Valley LAHDZ 1	• Lake Sebu • Selected barangays of Surallah	Lake Sebu Government Hospital
LAHDZ 2	• Norala, Sto. Niño • Selected barangays from Surallah, Banga, and Sultan Kudarat	Norala Government Hospital
LAHDZ 3	• Surallah • Banga • T'boli	• Lariosa Private Hospital • Januaria Private Hospital • Edwards Evangelical Hospital
Lower Valley LAHDZ 4	• Koronadal,Tantangan, Tampakan • Selected barangays from Sultan Kudarat	South Cotabato Provincial Hospital
LAHDZ 5	• Polomolok, Tupi • Selected barangays from T'boli	Polomolok Government Hospital

* Excluding population of Barangay Ned that currently access hospital services in Sarangani and Sultan Kudarat
Source: (South Cotabato Provincial Health Office, 2000.)

The Convergence Strategy

The MSH Convergence strategy was launched in the province on June 14-15, 2001 during the South Cotabato Health Sector Reform Convergence Workshop. The participants to the workshop included Chiefs of Hospitals, Provincial Health Office staff, Municipal Health Officers, local government officials, representatives from the DOH, PHIC, CHD, MSH, NGOs and the private sector.

Participants to the workshop identified health problems and issues related to the implementation of health sector reform in the province. Current and planned actions were discussed together with strategies, activities and targets for each reform area for 2001-2004. Norala district (LAHDZ 2) was selected as the convergence area.

South Cotabato's Health Sector Reform Targets for the period 2001-2004 are as follows:

- Social Health Insurance
  - 60% of population Health Passport holder
  - 50% of Health Passport holders availing of increasing benefits
  - All health facilities PHIC accredited (4 government hospitals, 11 RHUs)
- Local Health System
  - 5 fully functional and provincially integrated LADHZ
  - All facilities Sentrong Sigla certified: 4 hospitals, 11 RHUs, and 25% of BHS
- Hospital Reforms
  - Fiscal autonomy for all public hospitals – income retention, sub-allotment
  - QA Benchbook fully implemented resulting in quality service provision
  - Hospitals upgraded – SCPH as medical center, NDH as secondary hospital
- Drug Management
  - Pooled procurement system for the province and all municipalities, provincial formulary developed
  - Five functional therapeutic committees
  - Essential and parallel import drugs available at health facilities
  - Fifty percent increase in knowledge, attitude and skills on RDU by consumers
  - Standard treatment guidelines
- Public Health
  - All 11 RHUs and 25% of BHS Sentrong Sigla certified
  - Ninety percent of households with safe water supply and sanitary toilets
  - Sixty percent of health personnel trained on IMCI
  - Decrease in the number of cases of infectious diseases: TB, DD, ARI, filariasis
  - Increasing budget for public health

The Convergence Workshop participants also made pledges and commitments. The LGU representatives (Tampakan Mayor Barroso, Surallah Mayor Bendita, Tupi Mayor Mariano, Norala Kagawad Cerveza) pledged to prioritize health and include budget allocations for enrollment of their constituents to the PHIC Indigency Program. Dir. Dolores Castillo of CHD Reg. XI pledged to provide technical and counterpart support to HSRA activities. She promised transparency and equity in the provision of support. Mr. Amario Morales of PHIC promised full support –funds, workforce and effort for HSRA. Dr. Edgardo Sandig of the IPHO said South Cotabato is committed to health reform and

to making devolution work in the province. He says the convergence workshop added flavor to something, which already existed. "Parang bibingka na linagyan ng mantekilya" ("like adding icing to a cake").

A Provincial Health Summit was held in July 2001 where the local chief executives signed pledges of commitment to the strategies and activities put together during the convergence workshop. A third summit is being organized for the third week of July 2002 to coincide with the foundation day of the province.

Activities by the convergence group cited by Dr. Sandig/Dr. Magan are: assistance in health assessment, health planning, drug management (training/workshops), advocacy with PhilHealth and DOH in social health insurance, some activities for hospital reforms like the 5S, monitoring and improving local health systems, Lakbay Aral and regular monitoring/assessment of health situation/management in the province. Dr. Sandig and other health personnel of the PHO/hospital believe that the activities of the MSH are complementary to the programs of ICHSP. They also expressed that some health reforms have been initiated in the province even before the convergence program. However, MSH, according to them, has cemented whatever reforms have been initiated.

Gains in Health Financing Reforms

Social Health Insurance

In 1995, the law creating the Philippine Health Insurance Corporation (PHIC) was enacted. The law broadened insurance coverage to include the informally employed and indigent sectors, in addition to the formally employed sector already covered by the then Medicare Commission. PHIC Regional Field Offices (RFO) were established in 1998. South Cotabato was then under the Region 11 office. Advocacy and initial meetings for the PHIC Indigency Program were started by PHIC Central office staff at this time.

By 1998, all 11 towns of South Cotabato allotted funds for their indigents but these were not released due to the election ban on certain finances. On August 16, 1999, the Region 12 PhilHealth Office, now known as PhilHealth Regional Office (PRO), was established in Koronadal, South Cotabato. However, the "all out war" in Mindanao affected the drive to increase coverage. Differences of opinion between the PHO and PHIC also needed to be ironed out.

After conducting "massive information dissemination", with focus on the Indigency Programs in the local government units, seven towns from South Cotabato had MOA signings in October 1999. These were Banga, Norala, Tupi, Sto. Niño, Tampakan, Lake Sebu, and T'boli. The provincial government, under then Gov. de Pedro, provided P450,000 as initial allocation to be divided equally among each of the participating LGUs, which also provided their counterparts for additional enrollees to the program.

In 2000, two LGUs, Banga and Tampakan, signed the MOA for the Out-Patient Benefit Package (OPB)/Capitation Fund program. The two towns have since received their

capitation funds. Two more LGUs, Tupi and Norala, signified their intention for the same program.

The package requires coordination between the DOH, LGU, and PhilHealth. This is because the LGUs are responsible for upgrading facilities in order to make it PhilHealth accredited. DOH grants the Sentrong Sigla accreditation (which is part of the PhilHealth accreditation requirement) and PhilHealth will provide capitation.

Enrollment to the Indigency Program entails a length process that could take as long as 1 to 1 ½ years to complete. This has been met with consternation by local chief executives who have paid the premiums and built up people's expectations. There have been reports of IDs about to expire that have not been distributed. This is a serious hindrance to further expansion because local chief executives are now looking more closely into the returns on their "investments" in health and may decide that there are more attractive uses for their money.

PhilHealth RHU Accreditation for Outpatient Benefit Package and Capitation

With the assistance of ICHSP, the RHUs have been upgraded starting with those of Norala and St. Niño in the convergence area. At present, 10 RHUs have been accredited and only the Polomolok RHU has not yet received its PhilHealth accreditation.

By 2001, all 11 LGUs of South Cotabato have enrolled indigents from their communities. Even barangay chairmen (Norala) tapped their funds to enroll their indigents. However the two LGUs that wanted to participate in the OPB program for RHUs withdrew because they disagreed with the provision on honorarium that gives 10% of capitation funds to the Municipal Health Officer (MHO). This was interpreted as "double compensation" to the MHO who already gets a higher salary than the mayor because of the Magna Carta and other benefits for health personnel.

In one town (Norala), barangay chairmen are planning not to renew their enrollees next year despite the fact that the MHO has waived her part of the honorarium in favor of the LGU. The SB for health has already communicated their queries and objection to the above provision to the PHIC central office. The PHO maintains that this should be seen as an incentive for the MHO similar to the sharing of fees under the former Medicare Program rather than as "double compensation."

In June 2001, Pres. Gloria Macapagal Arroyo, in her State of the Nation Address (SONA), announced her target to enroll about 17,000 households in each province in PhilHealth's indigent program. At present, PRO 12 has accomplished about 58% of its SONA commitment. (PhilHealth staff argue that if their earlier accomplishments were counted, then they have already exceeded their target.) Seven other towns have already applied for the RHU accreditation/OPB program although only four of these have enacted an ordinance in support to the program.

Facilitating Factors

The PhilHealth Regional Office says it has no difficulty implementing the indigent program in South Cotabato. The advocacy efforts of the PHO and partner NGOs has kept the PRO busy trying to cope with the demands for enrollment. The following factors facilitate implementation of social health insurance in South Cotabato:

Early and sustained advocacy from several sectors including CHD Region 11, Provincial Health Officer, Provincial Governor and PHIC central office. This is supplemented by active information dissemination of PRO 12 through regular radio programs, newsletter (*Sprikitik*), LGU orientation, and posters. Consultative fora with stakeholders and translation of materials to the local language have helped communicate goals and processes of the program. There is good coordination with other agencies like DOH, PHO, DSWD and LCEs/LGUs and support from NGOs in advocacy like ICHSP, MSH.

Political and technical support starting with the pro-active indigent officer and staff/leadership of the PHIC Regional Manager, together with support from the Technical Working Group (TWG) of the province as well as at the municipal level. In one town (Norala), the TWG meets monthly and has been very instrumental in enticing the mayor and barangay chairmen to provide funds for enrolling indigents. Provincial, LAHDZ, and municipal health boards have worked together to pass the needed resolutions and budget allocations.

The enabling environment of a relatively stable peace and order situation and good dynamics between the health leaders and politicians. Health workers and local politicians say that “politics is only during the election; pagkatapos ng election magkasama na ulit” ("after the elections, we're all friends again").

Setting up a User’s Fee System

To help ensure sustainability of services, the province implemented a User’s Fee System in 1996. Fees collected for similar services were set based on level of care, so that the lowest cost would be at the Rural Health Units (RHUs), followed by the District Hospitals and the most expensive would be those at the Provincial Hospital. The ordinance implementing this system was hotly debated at the Sangguniang Panlalawigan and in the public hearing that followed. The winning argument in favor of the fees, however, was the observation that even those who can afford to pay avail of government health services.

The rationale for the fees therefore was for those who are able to pay to do so in order to help support those who cannot. The truly indigent are certified by a social worker and are exempted from paying fees, but only after being informed of the amount that the government has spent for their care. The PHO wants the people to know the extent of support being extended to them. There were initial reports of a reluctance to pay, but with consistent implementation and continuous explanations through the media, these have diminished.

Data at the RHU level shows that the fee system needs to be built up for it to substantially contribute to the sustainability of services. At the Sto. Niño RHU, records for laboratory

fees from January to May 2002 showed a total collection of P1,040. Income from medical certificates during the same period was P1,360. There does not appear to be a clear-cut accounting system. In the town of Norala, records were not available, although fees have been collected.

This is an innovative feature of the HSRA implementation in South Cotabato that needs to be better documented. Health providers have the sense that there has been no decline in service utilization despite the implementation of the fee system, but this needs to be validated.

Integration of Services, a Cost- and Resource-Sharing Mechanism

Since the Norala RHU is walking distance from the District Hospital, one of the ways conceived to make the delivery of services more efficient was the integration of the laboratory services. The RHU laboratory would be integrated with that of the District Hospital. This would minimize duplication of services while still ensuring access to clients. One of the hurdles that had to be overcome was the PHIC accreditation of the RHU, which was required to provide laboratory services. The PHIC guidelines were modified to accommodate this situation. Under discussion are the handling of income and delineation of lines of responsibility of the laboratory between the RHU and the Hospital management.

This same mechanism is under negotiation between the RHU and District Hospital in LAHDZ 1 (Lake Sebu). Negotiations for cost sharing are also on-going with the province of Sultan Kudarat in LAHDZ 4 because the referral hospital (the Provincial Hospital) there serves several barangays of that province.

Retention of Income

The PHO has been advocating for the income retention of devolved hospitals since 1999 in order to augment appropriations for Maintenance, Operating and Other Expenses (MOOE). This is particularly true for the LAHDZ referral hospitals whose smaller budgets (compared with the Provincial Hospital) are eaten up by personnel salaries and benefits. The current discussions center on setting up a trust fund where the retained income would be used as a revolving fund for the hospital.

The PHO, however, realizes that for this scheme to be viable, the quality of services needs to be improved in order to attract a larger client base for the district hospitals. For the last three years, the occupancy rate of the Norala District Hospital has, in fact, been declining. While discussions regarding the financial management of the potential funds from income retention are on going, equal attention to improving the services at the hospital must be given. There is also a need to "market" the district hospitals to encourage utilization.

An observation made is that the perennial lack of medicines serves discourages PhilHealth cardholders from patronizing the district hospital. These clients would prefer to go to a private hospital where medicines are always available so that there will be no

out-of-pocket expense on their part. The drugs will be charged to their PhilHealth plan. At the Norala District Hospital, because medicines are not available, clients need to buy their own and then have to go through the reimbursement process at PhilHealth.

Community-based Health Financing

Together with the Davao Medical School Foundation's (DMSF) Institute of Primary Health Care, the PHO set up the "Barangay Maibo Bulig-Bulong Program" in Tantangan in 1996. Seed money from the DMSF and contributions from the members help support hospitalization and other health needs. However, this project seems to have been superceded by the PHIC Indigency Project. Members to this community-based financing program avail of their benefits only after PHIC benefits have been exhausted. Some mechanism to link the two insurance schemes should be worked out to improve efficiency and coverage.

Gains in Hospital Reforms

As of 1998, the province had 22 hospitals, of which 5 are government (4 primary, the District Hospitals, and 1, the Provincial Hospital, secondary) and 17 are private (15 Primary, 1 Secondary and 1 Tertiary). With help from the Investment Plan of the Governor's office and the ICHSP, government hospital facilities have been upgraded (ER, new OPD building, OR expansion, district hospital renovation). The wards have been improved with the help of private institutions. The PHO established an "Adopt a Room" program accessing support from private groups. In the planning stage, with funds already allocated from the province, is the construction of 50 beds for a private ward in the hospital.

This is expected to increase hospital revenue. Training programs have been started with the medical internship, Family Medicine Residency programs. Eleven private consultants have been hired on an honorarium basis in Surgery, OB, Pediatrics Medicine, Family Medicine, Pathology, and EENT to augment the hospital staff. The goal is for the Provincial Hospital to be a Regional Medical Center under local government management.

The LAHDZ system has facilitated the linkages between the RHUs and the hospitals. User charges, where district hospitals charge lower rates than the provincial hospital and RHUs charge even lower rates than district hospitals for the same services, are expected to decentralize the management of primary and secondary cases and encourage the utilization of the RHUs and district hospitals. This is supported by a strict referral policy. The sign "No referrals, No Consultation" is posted in all facilities.

According to the MHO and the District Chief, although initially resisted and ignored by the people, the people are now following proper referral. Accordingly, it has had a significant impact on the attitude of the patients and the types of disease being handled at different health facility levels. However, according to the SB for health in Norala, some people still cannot follow the logic of the referral system especially if the patient lives near the hospital.

A Quality Assurance program was started last year after the chief nurse, hospital administrator and the chief of clinic attended a training workshop on QA. The following achievements through the efforts of the three-man QA team are:

a. a. Echo of the training to the LGUs/District health

b. b. Establish quality circle in the LGUs/District health and each section of hospitals

c. c. Each section circles identified their problems then present it to a bigger circle led by the hospital management. The problems identified are prioritized and solutions are discussed

Table 7. Examples of Problems and Solutions addressed during Quality Circle Discussions.

Problem	Solution
long waiting period of patients for consultation in ER and OPD, understaffing and work overload for physicians	hiring of consultants and doctors; doctors work schedule organized so they come to clinic on time
delays in operation/procedures in ER/OR due to lack or insufficient supplies	budget of supplies for the two sections was increased
lack of anesthesiologist in the hospital	government negotiated with the private anesthesiologists and secured an agreement for government to pay for services to indigent patients for a fixed rate of P2,000.00 per case

d. d. Inclusion of QA in weekly management meetings

e. e. Values orientation to the staff (with emphasis on being conscientious and awareness of the needs of the patient/watchers and other staff)

f. f. Emphasized cleanliness in the hospital

The QA program has been echoed to the district hospitals but has not yet been implemented outside the Provincial Hospital. The province is supporting the residency training and other higher short course training of hospital personnel to upgrade their staff and as an incentive for them.

The PHO is implementing preventive maintenance with support from ICHSP by training maintenance crew in the hospitals as well as in the RHUs. A preventive maintenance team will be pooled in the province and will be provided with knowledge and logistics to repair and maintain medical equipment. A workshop and spare parts depot is also being

established in the hospital. A mechanism is in place for immediate purchase for spare parts using cash advance for parts not more than P40,000.

The development of clinical protocols was started only this year involving all consultants and some MHOs. Each department identified the most common causes of mortality and morbidity and each specialist conducted workshops to develop disease management guidelines. The flow of patients from presentation till admission and discharge is analyzed. Referrals are also discussed in the process; as they are strictly enforced from the BHS, to the RHUs, district hospital and provincial hospital. Treatment protocols are in accordance also with the hospital formulary.

The Department of Health with the support of ICHSP included South Cotabato in the implementation of an electronic management information system program. At present the provincial hospital has installed computers in the sections of admission, billing, records, cashier and social services. A central server/office is provided in the provincial hospital. Encoding of the past record is on going and new patients/records are both recorded on paper and in the computer. Double recording is necessary since the program has no back-up capabilities yet. In the district hospitals, a stand-alone computer is installed.

Some problems noted with this program are: (a) most staff are not computer literate, (b) no budget for repairs/maintenance of CPUs, (c) No back-up server, (d) duplication of work (double recording), (e) No local technician trained for computer repair, (f) when a computer/program crashed, it took three months before it was addressed, (g) the system is currently limited to the provincial hospital.

Initially though its functions/effects are noticeable. Records for the sections with installed programs can be easily accessed and retrieved for patient care or to make reports. Some bills with very minimal assessment but with many services provided to the patient have been monitored. These cases have been brought to the attention of the management because they may not have been assessed correctly. But the program head was not yet satisfied with the project, especially with the current funding support phasing out next year.

Gains in Drug Management Systems

Dr. Sandig acknowledges the workshops/support conducted by the MSH for the drug management reforms. Procurement of drugs and other health supplies have been fast-tracked by reducing signatories and the process has been streamlined. The Therapeutic Committees have been strengthened. A Hospital formulary was created in accordance with the national formulary. Drugs were classified into VEN (Vital, Essential and Necessary). Through ICHSP, seed money was provided for the Provincial hospital (P300,000) and the district and municipal hospitals (P100,000) for these activities.

The province has worked out a bulk procurement system for its hospitals and increased the budget for drugs. In principle, each hospital is asked for a list of drugs and supplies it needs for one quarter. The Therapeutics committee of each unit/ hospital assesses its needs. These lists are consolidated and bid out by the provincial government. The results

of the bidding are sent back to the hospitals that decide whether the winning brands and amounts are acceptable. Delays occur when the hospitals prefer a more expensive brand than the lowest bid (usually generic), which the Provincial General Services Office will, of course prefer. Meetings and discussions are held to reconcile these differences. Allocations for one quarter are thus usually available about 6 months after they are requested.

Until this system can be ironed out, it is unlikely that the RHUs will choose to join in the bulk procurement process since at the moment they are able to secure their needs within a few days of request since they only need a few signatures from their municipal offices. Some LGUs have also expressed their preference for specific suppliers who may not be the same as the provincial suppliers.

Other possible interventions to reduce delays would include considering only DOH accredited suppliers in the bidding process, and ordering during the period when there is still budget available for the drugs. The PHO also needs to make the doctors understand that their drug "preferences must match government resources".

Parallel drug importation process has been attempted but delivery has been delayed. It was learned that the problem is BFAD's requirement of a Certificate of Product Registration (CPR). This is not required in international bidding and the process to secure one is lengthy. This creates a bottleneck, which slows down the parallel import. Orders placed in October 2001 were finally delivered only this June 2002.

A Cooperative Pharmacy, a project of the federation of Barangay Health Workers (BHWs) was set up on March 11, 1996. It is located in the provincial hospital itself and is being supported by the province but is run as a private entity. The PHO and other officials were not included in management to avoid conflicts of interest but they may be members of the cooperative. Not faced with the government accounting rules, the pharmacy is able to procure medicines in a short time and canvass and secure consignment with drug companies. Being run by a cause oriented group, the cooperative marks up a small profit only, thus lowering the selling price. For example, the private pharmacy sells IV fluids for P70 while the cooperative store prices it at P35 only. If the hospital lacks some supplies they turn to the store, which extends them credit. The store has existed for six years and has provided dividends to its members and even scholarships for the children of BHWs. They also provide health assistance to their members.

Faced with a recurrent problem of lack of medicines, a revolving drug fund for hospitals was set up in February 1999 with assistance from ICHSP. The fund provides seed money for the hospitals to secure medicines during an emergency. Patients pay on cash basis. The payment is returned to a Trust Account managed by the Provincial Treasurer's Office so it can be "revolved" when the next emergency arises. However, this is only a back up to the regular procurement process.

Dr. Sandig says that the drug procurement program has to date not necessarily decreased prices and still needs a lot of work.

Gains in Local Health Systems Development

Plans for an Integrated Health System had been laid out in South Cotabato long before the health sector reform agenda launched by former Secretary of Health Alberto Romualdez, Jr. in 1998. There were already consultations with the local chief executives and MHOs on improving health care and referrals. These consultations were mostly initiated by the PHO. The PHO believed in the motto " initiative to initiate." LCEs were motivated to sign up because of their desire to improve the access and quality of health services at the provincial ("to decongest the provincial hospital") and municipal ("'yung kaya sa RHU, dapat sa RHU na" -- "what can be done at the RHU level should be done at the RHU") levels. The Zone formation also created a somewhat bandwagon effect because the mayors did not want to be seen as "napag-iwanan" or left behind by the rest of the province. The potential for attracting donor funding by being a pilot area was also a factor.

In 1999, during an LPP Provincial Health Summit, the Local Area Health and Development Zone System for South Cotabato was organized. The LCEs agreed with the option to organize a local health care system in their district. Support from agencies such as AUSAID, the province and DOH was secured and the implementation is on going.

The province has well laid out plans for their health system. Roles and responsibilities are carefully defined for each level of care and each level of management. Primary, secondary and tertiary packages of care have been described to clarify access, referral and provision of services. What is even more impressive is that all these are documented and disseminated at the RHU, LAHDZ and provincial levels. A Referral Manual has been developed for the purpose. The Manual contains the policies, guidelines, procedures and forms needed for the referral process.

Interviews with health providers show that they are aware of these policies and their role in implementing them. They have used the LAHDZ meetings as opportunities to discuss modifications to these policies and thresh out problems and issues that arise during actual case management.

However, interest in the LAHDZ needs to be sustained, particularly when external funding support ends. Already there are reports that some mayors have not been attending LAHDZ meetings because they do not see any benefits going to their municipalities. At least one LCE has complained that some of the promises for their area have not been fulfilled.

Gathering Data for Decision-making

The PHO is completing a study to identify the specific catchment areas of the referral hospitals and RHUs in order to rationalize the areas of responsibility of these units. With this study, they will be able to address the concerns of people from Tupi, for example, who prefer to go to the Provincial Hospital as it is more accessible to them than their assigned referral hospital in Polomolok. They will also be able to determine the extent to

which a neighboring LAHDZ or province should be involved in cost-sharing depending on the proportion of their constituents who are availing of services in a given health unit.

Another study being undertaken is the review of the impact and successes of the health zones. Meetings and resolutions are being documented to determine how responsive the system has been to identified needs and problems.

One problem that may need to be addressed is meeting people's expectations. A health provider in the pilot district claims that the expansion to other districts has contributed to the slowing down of reforms in their area. He is apprehensive that their reform model was not perfected yet but is already being carried out in other areas. Also the support initially aimed for the pilot areas was spread thinly to other districts. Discussions, particularly about funding support and allocation, need to realistically couch so that people will have reasonable expectations of the initiatives.

Health is Good Politics

Most of the health reforms in the province have been made possible through the support of the provincial health board, which conducts discussions of the health issues and recommends ordinances and even funding for health activities. The former governor expanded the health board to fifteen members including other stakeholders for health not identified in the law. It was also instrumental in the following health reforms/activities: formalization of inter-local health zones, indigent health insurance, drug procurement, cooperative pharmacy, hospital infrastructure enhancement (provincial counterpart funding), health summit, health advocacies, increase health budget and hiring of health personnel

Health managers believe that the former governor (Gov. de Pedro) supported all the needed reforms in health and other sectors being one of the authors of the Local Government Code when he was in Congress. He wanted decentralization to succeed in his province.

Another factor was the multi-pronged strategy employed by the PHO to get the SP members on his side. Dr. Sandig says he makes it a point for health to be always in the news and gives interviews and press conferences on a regular basis. When nothing is happening, he makes things happen, such as the holding of a rally for the recent Garantisadong Pambata campaign to drum up interest in the activity. This brings health concerns to the top of people's awareness.

A second strategy is to give the SP members important roles to play in health activities and decision-making. Each LAHDZ is organized so that an SP member is its head, with the District Hospital Chief as the coordinator. During LAHDZ meetings and functions, Dr. Sandig plays up the role of the SP members, which they recognize as important to their constituency building. The experience of SP Siapno, the author of the controversial User's Fee Ordinance, who won by more than 20,000 votes during the last elections, shows that "health is good politics".

A third strategy is to organize study tours for the SP Board members to "broaden their horizons". That way, they become advocates for health themselves. The current governor, Gov. Daisy Avance-Fuentes has made health her priority program and has continued and even expanded the health programs of her predecessor. She says she has seen the benefits and determines her "politics based on need and not along party lines". Her concern, building on the momentum generated by the strengthening of local health systems and the hospital reforms, is to provide an integrated preventive health care program that would incorporate strategies for nutrition, immunization, and healthy lifestyles among others.

The Private Sector

The province has tapped its private sector in many ways. Among the most notable has been the involvement of the private hospitals as the referral hospital for the Surallah, Banga, T'boli area (LAHDZ 3). The relationship with these hospitals apparently started even before the HSRA, with lump sum funding from the CHD, Region XI to support the care of indigent patients. The province has also solicited ambulances from the PCSO for these private hospitals.

Private practitioners in the province have also been recruited to serve as consultants on an honorarium basis to supplement the hospital staff at the Provincial Hospital and the Norala District Hospital. However, even this support may not be enough. The doctor who has been recruited to serve at Norala as regular staff, appears to be having second thoughts and is considering changing to part-time status so he can develop his practice elsewhere. Since the hospital is struggling to be upgraded to a secondary hospital, it is important to attract competent staff to meet the minimum requirements for this level. Other incentives may need to be given.

Through a small grants component, the ICHSP provides P 400,000 – 500,000 as support for NGOs to engage in projects on community health development, health promotion, and community mobilization for health. These initiatives in 28 barangays help to broaden awareness regarding health and to engage people in a health activity. Examples of these community-based projects include: Botica ng Barangays, Healthy Barangay Project, IEC campaign for Voluntary Blood Donation, Training on diarrhea management for Cholera-prone barangays, Linis Kalusugan Program, and Iodized Salt Drive among others.

Health Summits

To show the importance of health care in the province, the province through the PHO with the support from the office of the governor launched a health summit in 2000. Now on their third consecutive year of the summit, the activity showcases the best practices in South Cotabato and enjoins all the health stakeholders in working for the health plan of the province. During the summit best practices are awarded and there is keen competition among the LAHDZs for the awards.

Best Practices

There are a number of possible best practices for the province of South Cotabato. The province takes pride in its well-developed LAHDZ system that has operationally led to a better referral system, the integration of services to minimize duplication and reduced cost without sacrificing access or quality and closer links between the health sector and other stakeholders. The "secret is in maintaining strong links with the LGUs."

The province can also be cited for its innovations in health financing - the user's fee system and its aggressive push for the PHIC's Indigency Program. It may be one of the few provinces where all municipalities have enrolled indigents and where the municipal counterpart matches or exceeds that of the province. There is a strong partnership among the PRO, the PHO and the political leaders of the province that has created a bandwagon for the Indigency Program. The LAHDZ is an important factor in this strong partnership. Other notable consequences of drug management systems intervention is the strengthening the hospital therapeutics committees and reduction of signatories, which shortened the procurement process.

While not strictly speaking a best practice in the sense that it is not entirely replicable, the province serves as example of how a dedicated and committed health sector can work in a devolved setting. Under the able stewardship of Dr. Sandig, the province has weathered changes in political leaders, the "all out war" in Mindanao, the Abu Sayyaf terrorism on top of the challenges brought about by decentralization. Data from the Provincial Hospital's Cost of Operations and Maintenance as well as its utilization rates (see Figures 2 and 3) show how the hospital exemplifies the province's health sector's growth since devolution.

Lessons Learned

Roles and Expectations of Stakeholders

The PHO has mastered the art of partnership, within and outside the health sector. In its manuals and documents, the roles of stakeholders are explicitly stated. One key stakeholder, however, that is not always considered is the DOH Regional Office. The Regional Office appears to have taken an active role in the early stages of ICHSP implementation when the proposal was being prepared and negotiations with the Central Office and AusAID were being carried out. Its role was identified in terms of providing technical support to the province.

However, the physical distance between the province and the Regional Office, and the limited manpower of the region has prevented regular interaction between the two. In the light of South Cotabato being a pilot province for the HSRA, upscaling of the HSRA would have benefited from a stronger participation of the region in the province's implementation so that the region would also have learned from the process. At this stage of implementation, South Cotabato would now be in the position to help the Regional Office in providing assistance to other areas for HSRA.

There is a need to clarify and be transparent about fund allocations so that stakeholders are not disappointed. The early promise to provide a certain amount of money to the convergence site that was not fulfilled has led to the disillusionment of some of the LAHDZ 2 members. There is a need to renew commitments and rekindle the enthusiasm for the LAHDZ. Perhaps the presentation of data showing the improvements that have resulted from the reforms will help in this process.

Social Health Insurance

A common observation is the lengthy PHIC procedures that lead to delays in utilization of benefits both for the Indigency Program and the Out-Patient Benefit Package/ RHU Capitation Fund Scheme. It is imperative that PHIC shorten the processing time by the decentralization of most functions/processes from national to regional. PHIC stands to lose the momentum and interest of its advocates if it does not deliver on time. It will also find it difficult to convince new enrollees as word of mouth spreads about its problems.

There is a need to address the concerns regarding the use and monitoring of the capitation fund while there are still only a limited number of RHUs availing of this. The problems will compound as more and more RHUs operate by capitation.

PHIC needs to develop and put in place its monitoring and evaluation systems for the Indigency Program and the OPB package as soon as possible. The data generated from this would inform both policy and process as well as provide evidence that PHIC is fulfilling its mandate. Local/ provincial, regional and central PHIC databases need to be electronically linked to facilitate enrollment and availment of benefits.

Drug Management

One of the key challenges to the PHO is to ensure the availability of medicines in the district hospitals. The current mechanisms being used by the province are not sufficient to either bring down drug prices or ensure supply. There is a need to increase the revolving funds for immediate drug procurement. There is a need to re-examine the policy on end-user preference, as this appears to cause delays in the procurement system. The promise of PDI has been delayed in South Cotabato.

Link between Systems Improvement and Public Health Programs

The Convergence Strategy is intended to bring out improvements in public health program implementation through the strengthening of local health systems, although there is no explicit technical assistance for public health programs. This means that there is a need to allow time for the system changes to take root before public health program changes can be seen.

South Cotabato, as one of the pilot HSRA provinces, bears the burden of this expectation. Its local systems have been strengthened and the fruits are being anticipated. The province has set as its public health goals a decline in cases of selected diseases and an increase in the public health budget, aside from Sentrong Sigla accreditation of its health

facilities and provision of safe water and toilets. The expressed interest of Governor Fuentes in preventive health measures needs to be tapped even as the province builds upon its LAHDZ systems to achieve these goals.

The province, through its ICHSP has singled out TB, DD, CVD and Mental Health as sentinel conditions to illustrate the public health effects of these system improvements. Improvements in TB-DOTS Cure Rates (from 38% in 1999 to 70% in 2000) shows that they seem to be going in the right direction but more time is needed to see whether these changes are sustained.

The province has expressed the need for better indicators that would reflect the improvements in the health system that has affected public health programs.

CONCLUSION and RECOMMENDATIONS

The concept of the convergence strategy is that each of the sector reforms are interlinked within local health systems, such that simultaneous improvements in each reform area would lead to a synergistic improvement in the system that would be greater than the sum of the individual interventions. This vision is on its way in South Cotabato with its strong LAHDZ systems, its burgeoning health finance mechanisms and the continuing quality improvements in its hospitals. However, there is a need to address its drug management problems and strengthen the system links with public health programs. With the phasing out of donor support, South Cotabato has to prove that it has achieved the “irreversible momentum” needed for it to pursue the reforms on its own.

The province would benefit from a network of provinces and other local government units, which have operating ILHZs so that they can continue to share experiences and learn from each other. There is deep appreciation for the “lakbay aral” which has served as both an advocacy and training opportunity. In the same way, the province intends to continue its Health Summits where its municipalities and LAHDZ interact and share best practices and lessons learned.

There is a need to continue and strengthen further partnerships outside the health sector including those with political leaders, PHIC, the NGOs and the private sector. This has served the province well and will continue to do so. At the same time, the province needs to rekindle its ties with the DOH Regional Office so that it can both assist and be assisted in HSRA implementation.

Appendix 1. South Cotabato Provincial Hospital, Occupancy Rates and Budget, 1990-2000.

Figure 1. South Cotabato Provincial Hospital Occupancy Rates, 1990-2000.

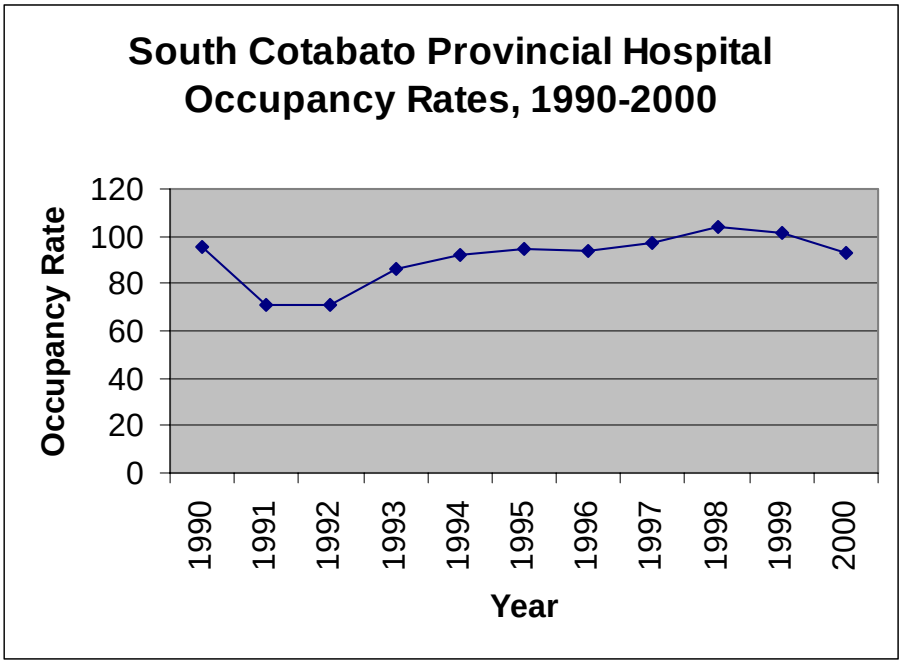
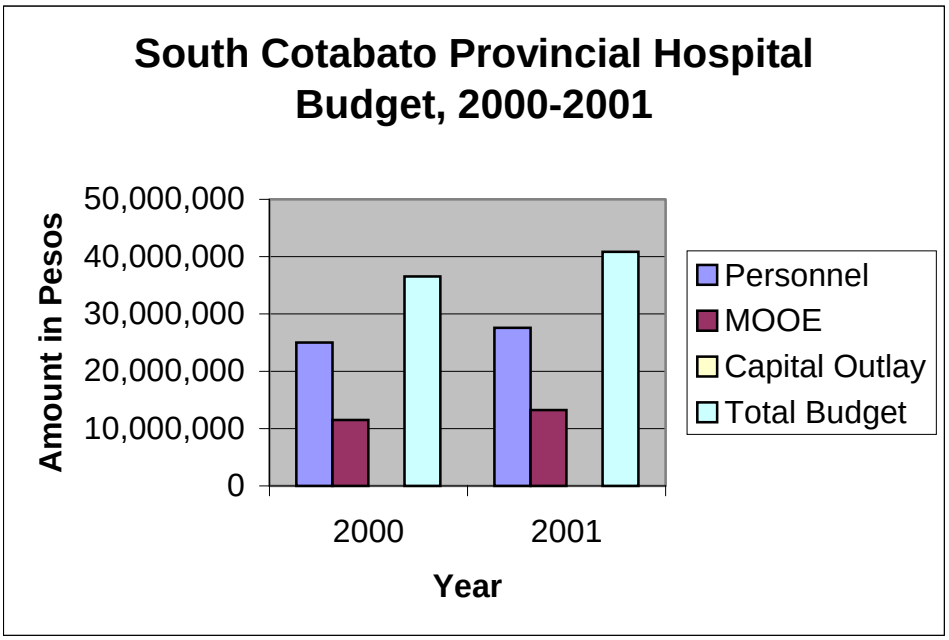
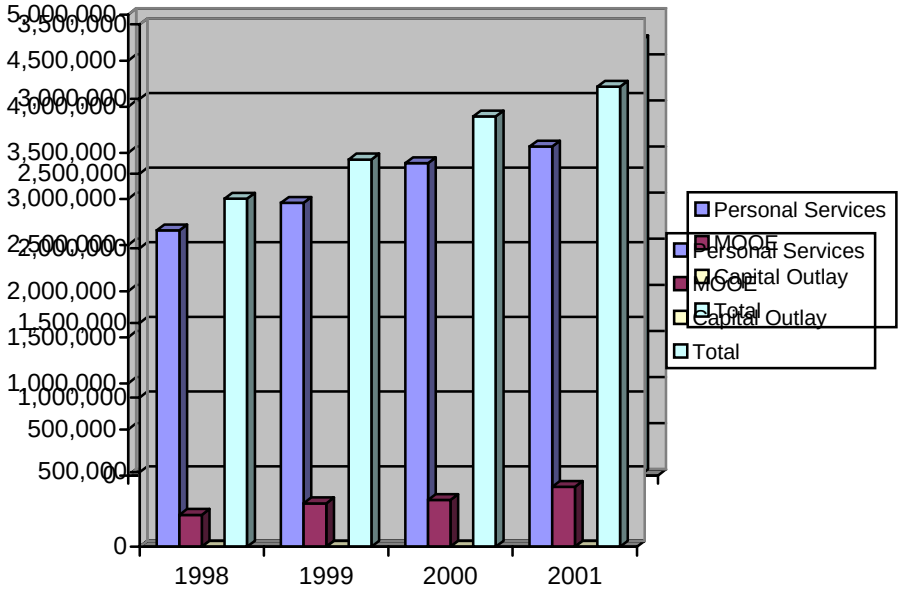


Figure 2. South Cotabato Provincial Hospital Budget 2000-2001.



Appendix 2. Norala and Sto. Niño Health Budgets, 1998-2001.

Total Health Budget of Norala, South Cotabato, By Appropriation, 1998-2001



Health Budget of Sto. Niño, South Cotabato, By Appropriation, 1998-2001

Appendix. List of Interviewees, South Cotabato.

Gov. Daisy Fuentes	Governor, South Cotabato
Dr. Edgardo Sandig	Provincial Health Officer, Chief of Provincial Hospital
Mr. Eduardo Siapno	SP for Health
Dr. Louella Estember	Provincial DOH Rep, Chief, Technical Division
Dr. Emilio Arenas	Prov'l Dentist, Point Person for Health Planning
Ms. Luz Decio	DOH Rep-LAHDZ 3, NGO &Community Dev't Point Person
Ms. Dinah Poral	DOH Rep, LAHDZ 5, Child Health Point Person
Mr. John Salcedo	ICHSP, Project Health Officer
Ms. Rosalina Jaictin	Human Resource Development Point Person
Ms. Lorna Lagos	Health Financing Point Person
Ms. Nelvie Capiz	Process Documentor
Ms. Lucheria Larong	Midwife 4, Provincial Health Office, Technical Division
Dr. Alicia Magan	PH-Chief of Clinics (QA Member)
Ms. Brigido Usita	Provincial Hospital (PH) Administrator, (QA Member)
Ms. Elena Arciaga	HOMIS
Ms. Vilma Ligo, RN	QA Lead person, Provincial Hospital Supply Officer
Mr. Ramon Aristoza	PHIC Vice-President, PRO XII Regional Director
Dr. Antoinette Ladio	PHIC Accreditation Officer
Mr. Amario Morales	PHIC Indigent Officer
Ms. Emily Bismar	PHIC Dev't Management Officer, Indigency Program
Ms. Merle Sabog	Head, PHIC Membership & Collection Unit
Dr. Gonzalo Braña	Norala District Health Officer
Dr. Lamelita Amido	Norala MHO
Ms. Elsie Cervesa	Norala Councilor for Health
Dr. Ervin Luntao	Mayor, Sto. Niño
Dr. Evelyn Diosana	MHO of Sto Niño
Hon. Nema Cornejo	Vice-Mayor, Tupi
Dr. Apolinar Hatulan	MHO of Tupi
DOH Regional Office, Davao City	
Dr. Mary Joan Bersabe	CHD XI, Chief, Technical Division
Dr. Rose Padilla	Regional Point Person for Social Health Insurance