

Policy Analysis on Province-level Integration of Healthcare System in Light of the Universal Health Care Act

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ABSTRACT

Background. The enactment of the Universal Healthcare (UHC) Act affirms the commitment of the State to safeguard the health of all Filipinos. One of the objectives of the Act is to integrate the different local health systems at the provincial level in order to minimize fragmentation in the delivery of health services. This significant undertaking needs effective inter-sectoral collaborations of various stakeholders both at the local and national levels.

Methods. A systematic review of literature was conducted to generate evidence-based policy tools. A roundtable discussion (RTD) was organized in collaboration with the Department of Health (DOH) to frame the current issues of the devolved health system and the anticipated challenges surrounding the integration to the provincial level. Policy discussion was guided by specific operational concerns put forth by the DOH such as the roles and functions of key local actors, organizational models, and metrics of integration.

Results. Inputs in the proposed organogram for the province-level integrated health system and assessment tool for identifying readiness of provinces were discussed and agreed upon. Critical issues in the composition of the members of the Provincial Health Board (PHB) and the line of command among constituents were raised.

Conclusion and Recommendations. Eight consensus key policy recommendations have been identified. These could be translated into operational guidelines for the DOH, local government units (LGUs), and other related national government agencies (NGAs) in implementing the local health systems integration as prescribed in the UHC Act.

Key Words: Health Policy, Integrated Health Systems, Health Care Reform

INTRODUCTION

The organizational framework and local practices in the Philippine health system have been challenged by the fragmented status of Local Government Unit (LGU) health systems. There is a lack of horizontal and vertical integration^a in the current health system set-up.¹ The Health Sector Reform Agenda in 1999 attempted to facilitate integration through the creation of Inter-local Health Zones (ILHZs).² To some extent, several ILHZs may already function as

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^a A vertical relationship is between different levels of care while a horizontal relationship is between facilities providing the same level of care.¹

provincial service delivery networks (SDNs) but these are mostly limited to public facilities.³ Recently, the Philippine Health Agenda targeted the operationalization of SDNs in three regions during the first 100 days of the Duterte Administration.⁴ In 2017, the Department of Health (DOH) released Administrative Order 2017-0014 or the Framework for Redefining Service Delivery Networks to provide guidelines on the organization of SDNs.⁵ The latest attempt to establish SDNs used virtual integration^b of services, focusing mainly on reproductive health services, and other vertical programs such as maternal and neonatal care, adolescent care, among others. A contributing factor to fragmentation is the duplication of procurement services and infrastructure as influenced by the disconnected budget planning and procurement.⁶ There is also a lack of gatekeeping mechanisms with uncoordinated referrals consequently leading to the maldistribution of demand in hospitals.^{1,7} This is further complicated by the reported uncoordinated financing and lack of financial accountability among the LGUs.⁶

The Republic Act 12233, otherwise known as Universal Health Care (UHC) Act attempts to mitigate the fragmentation through (1) integration at the province-level, that would translate to continuous care and improved access to services; (2) incentivizing public and private linkages; and (3) rationalizing multiple payers for health at the province level by the establishment of a Special Health Fund (SHF).⁸

With the call for evidence-informed policy development, particularly in the macro-policy change in the health systems, the University of the Philippines Manila Health Policy Development Hub (UPM HPDH) in collaboration with the DOH, conducted a roundtable discussion (RTD) guided by scientific, legal, and expert evidence, intending to generate consensus policy recommendations. This served as input to the development of Implementing Rules and Regulation of the UHC Act.

METHODS

Pre-work research

A systematic review of literature was conducted to generate evidence for the policy brief, and other discussion points tackled in the RTDs. A search in the PUBMED library was done to answer questions related to the roles of local health system actors in health service delivery. The search using the keywords "Delivery of Health Care"[Mesh] AND "Philippines" produced 1,472 articles. "Delivery of Health Care"[Mesh] AND "Philippines" AND "decentralization" produced 10 articles. Of the 10 articles, eight articles were excluded after screening of titles, and one title was excluded after reviewing the abstracts. Due to the limited number of

articles, the documents' bibliographies were used to generate other references. To search for organizational design related to integrated health systems, the keywords "Delivery of Health Care, Integrated"[Mesh] AND "organizational design" were used. This generated seven articles. Five articles were excluded after screening of titles, and only one article was able to be accessed online.

Google search using the above keywords to augment the reference availability was also done, generating five official reports, and one DOH guidelines. Relevant laws were accessed through official websites of the national government agencies, yielding one Republic Act and one Administrative Order. In total, 16 full text records were included in the review.

Findings from the literature review framed the key points for policy discussion. Further, these served as inputs in crafting the policy brief presented in the RTD, including the proposed algorithm based on international scientific and legislative evidences.

Review of Literature

In Latin America, strategies to address fragmentation were identified through a series of multi-country consultations by the Pan American Health Organization (PAHO) leading to a draft position paper on Integrated Health Service Delivery Network (IHSDN). The public policy objective for implementing province-level integration is a design to meet each system's specific organizational needs. Hence, different attributes of an integrated health system were identified. Based on these attributes, milestones in integrating SDNs were thus developed to describe the progress to a fully integrated system.⁹ In the organizational setting and practices in the Philippines, the operational definition of each attribute must be clearly defined which will serve as criteria in assessing the readiness of provinces for integrations. This could serve as a guide for the Transitory Provision (Section 41) of UHC Law wherein "the National government shall provide technical and financial support to selected LGUs that commit to province-wide integration."⁸ The UPM HPDH-proposed algorithm in identifying provinces for integration is shown in Table 1.

This algorithm is adapted from three different frameworks: DOH guidelines on SDNs, ILHZs, and the PAHO model for IHSDN. The operational definitions for the criteria are examples of the usual steps taken by LGUs to solve or at least mitigate fragmentation issues in their jurisdiction. There is a need to identify the existing public and institutional instruments of the DOH and other related agencies as key actors of health so that their roles can be supported in the province-level integration. It is recommended that mechanisms be put in place to monitor the progress of health service integration within a province-level system.

One of the main determinants of the fragmentation of a decentralized health system is the organizational structure. The legal framework for the reform of the current health

^b Virtual integration refers to integration through relationships, not asset ownership, as a means for collaboration among system components.⁵

Table 1. UPM HPDH proposed assessment tool for PHO readiness for province-level integration

Domains	Essential Attribute	Levels of progress in the attributes that make up the Integrated Health Service Delivery Network (pts)	Operational Definition	Assessed # of Points
Model of Care	Population and territory	<ul style="list-style-type: none"> No definition of population/territory under its responsibility (0 pt) Defined population/territory under its responsibility, but with limited knowledge of the health needs of this population (1 pt) Defined population/territory under its responsibility, and extensive knowledge of the health needs of this population which determine the supply of health services (2 pts) 	Updated Barangay level statistics on health, facilities, environmental health	
	Service delivery	<ul style="list-style-type: none"> Non-existent, very limited or restricted to first level of care (0 pt) Includes all or most levels of care, but with high predominance of personal health services (1 pt) An extensive network of healthcare facilities that includes all level of care and provides and integrates both personal and public health services (2 pts) 	Satisfactory compliance to existing MOAs, existing inventory of operational needs such as infrastructure, human resources both public and private	
	First level of care	<ul style="list-style-type: none"> Predominance of vertical programs with no integration or coordination (0 pt) Acts as a gateway to the system but with very low capacity to resolve health problems and poor integration of services (1 pt) Acts as a gateway to the system, integrated and coordinates care, and meets the majority of the population's health needs (2 pts) 	Satisfactory compliance to existing MOAs	
	Specialized care	<ul style="list-style-type: none"> Deregulated access to specialists (0 pt) Regulated access to specialized care, but predominance of hospitals (1 pt) Delivery of specialized services is done preferably in non-hospital settings (2 pts) 	Satisfactory compliance to existing CPGs, existing polyclinics / specialized outpatient centers	
	Coordination of care	<ul style="list-style-type: none"> No coordination of care (0 pt) Existence of coordination mechanisms, but that do not cover the entire continuum of care (1 pt) Existence of coordination mechanisms throughout continuum of care (2 pts) 	Clear Policies and Procedures manual, compliance to existing MOAs on coordination, efficient and compliant referrals such as ILHZ/SDN coordination and referral documents	
	Focus of care	<ul style="list-style-type: none"> Centered on disease or program (0 pt) Centered on the person (1 pt) Centered on the person, the family, and the community (2 pts) 	PIPH should include foci on indigents, family, and community; Satisfaction level of residents, patients	
	Governance and strategy	Governance	<ul style="list-style-type: none"> No clear governance function (0 pt) Multiple instances of government that function independently of each other (1 pt) A unified system of governance for the entire network (2 pts) 	Clear Policies and Procedures manual
Participation		<ul style="list-style-type: none"> No instances for social participation (0 pt) Instances for participation are limited (1 pt) Broad social participation (2 pts) 	Clear Policies and Procedures manual with plantilla item; Satisfaction level of stakeholders	
Intersectoral Approach		<ul style="list-style-type: none"> No links with other sectors (0 pt) Links with other social sectors (1 pt) Intersectoral action beyond the social sectors (2 pts) 	Clear Policies and Procedures manual, PLHB includes MHO, members from other sectors; Investments in health-sensitive projects	

system is presented in the Universal Health Care Act (Section 2), stating the four key principles of the law, one of which is the State’s adoption of healthcare models that “provide all Filipinos access to a comprehensive set of quality and cost-effective promotive, preventive, curative, rehabilitative, and palliative health services.”⁸ This would entail a strong primary care health system with a gatekeeping mechanism

utilizing primary care providers, as stated in Section 4 (1) “with the primary care provider acting as navigator and coordinator of healthcare within the network” and Section 6 (c) where “the DOH and the LGUs shall endeavor to provide a healthcare delivery system that will afford every Filipino a primary care provider that would act as the navigator, coordinator, and initial and continuing point of contact in the

Table 1. UPM HPDH proposed assessment tool for PHO readiness for province-level integration (continued)

Domains	Essential Attribute	Levels of progress in the attributes that make up the Integrated Health Service Delivery Network (pts)	Operational Definition	Assessed # of Points
Organization and management	Management of Support Systems	<ul style="list-style-type: none"> • Non-integrated management of support systems (0 pt) • Integrated management of clinical support but without integration of administrative and logistical support systems (1 pt) • Integrated management of the clinical, administrative and logistical support systems (2 pts) 	Clear Policies and Procedures manual, e.g. ILHZ maternal and neonatal death review, periodic meetings between levels of care	
	Human Resources	<ul style="list-style-type: none"> • Insufficient for the needs of the network (0 pt) • Sufficient, but with deficiencies in the technical competencies and commitment to the network (1 pt) • Sufficient, competent, committed and valued by the network (2 pts) 	Existing contracts that meet minimal staff to population ratios	
	Information Systems	<ul style="list-style-type: none"> • No information system (0 pt) • Multiple systems with no communication among them (1 pt) • Integrated information system that links all network members with data disaggregated according to pertinent variables (2 pts) 	Fully functional and accessible Health Information System	
	Performance and Results	<ul style="list-style-type: none"> • No measurement of performance and results (0 pt) • Measurement of performance centered on inputs and processes (1 pt) • Measurement of performance centered on health outcomes and user satisfaction (2 pts) 	Clear Policies and Procedures manual; Good performance of local hospitals under provincial jurisdiction	
Financial allocation and incentives	Funding	<ul style="list-style-type: none"> • Insufficient and irregular (0 pt) • Adequate financing but with unaligned financial incentives (1 pt) • Adequate funding and financial incentives aligned with network goals (2 pts) 	PIPH endorsed by PLHB, with accompanying documents (1) pertaining to PLHB targets and goals, etc.; (2) ILHZs/ SDNs with common health trust funds; (3) updated financial statements	

Table 2. Supplementary proposed scoring guide for PHO readiness assessment for province-level integration

Points	Initial Assessment
0 to 9	Not ready, consider integrating with nearby PSDN approved by DOH CO and DOH CHDs / Regional Offices
10 to 20	Can be ready within three to four years, need extensive assistance from DOH CO and DOH CHDs / Regional Offices
21 to 28	Ready within 1 to 2 years, need incentives, coaching from DOH CO through DOH CHDs / Regional Offices
Points	Two-year Continuing Assessment
0 to 20	PSDN needs improvement to function efficiently, consider re-structuring, may need extensive support from DOH CO and others
21 to 22	PSDN functioning well, may need some support from DOH CO and others

health care delivery system.”⁸ These provisions mirror major aspects of Integrated Delivery Systems (IDS) for health.

An IDS is an organization that according to Shortell et al. (1993) “aims to provide a continuum of services to a defined population, and is willing to be held clinically and fiscally accountable for the outcomes and the health statuses of the populations served.”¹⁰ As a representative of the State, the province is directed to adopt the aforementioned principles of the UHC Act. In effect, the province-level health

system becomes an IDS in itself. This is further supported by Section 19 of the Act, wherein the province, through its Provincial Health Board (PHB), is in charge of a network of facilities, exercising administrative and technical supervision over health facilities within its territorial jurisdiction; and Section 20, where all resources intended for health services will be managed by the province-level health system.

An IDS is usually organized into sub-units, such as health districts.¹¹ This concept was introduced by DOH post-devolution through the district health systems.¹² These subunits have been described to have a dual nature, both from a structural perspective: “a network of facilities where services are delivered to patients” and from a managerial perspective: “being in charge of enhancing an epidemiological picture of health and health needs of the local population” and “adopting planning and investment policies to match those needs with appropriate services.”¹¹

The RTD aimed to identify and situate the fragmentation issues in the Philippine health system and discuss how these should be addressed in preparation for the province-level integration. From these, organizational structure and corresponding roles of Provincial Health Officers (PHOs) and Municipal Health Officers (MHOs) in integrated SDNs must be designed. Proposed milestones and organizational structure were used as discussion points in the policy RTD.

From the deliberation of the DOH as the primary agency and the UPM HDPH as the research team, the following were the identified discussion questions that the RTD sought to answer:

1. What are the current roles and mandates of PHOs, MHOs, the Health Boards, and Local Chief Executives (LCEs) in providing health services at the local level?
2. What additional roles/functions would the PHOs, health boards, and LCEs would have with the proposed integration?
3. What are possible models of staffing / table of organization of PHOs and corresponding reporting lines that could be adopted?
4. What milestones are useful to measure towards full integration?
5. What specific supportive actions / reforms are needed within the DOH Centers for Health Development (CHDs)/ Regional Offices (ROs)?

Conduct of RTD

The UPM HDPH in collaboration with the DOH conducted a RTD on the Universal Health Care Act entitled “Moving towards province-level integration through the Universal Health Care Act” on January 10, 2019, at the Board Room, PGH, Manila. This was the third in a series of RTDs that aimed to discuss the strategic reforms and policy implications of the UHC Act, specifically on the effects of the province-level integration on current organizational structures within LGUs, the DOH, and other sectors such as private primary care providers.

A total of 48 participants representing various sectors and agencies at the national and local levels attended in the third RTD. The diversity of expertise and experiences of the participants brought wide-ranging insights into the discussion, arriving at consensus policy recommendations on local health systems integration.

To provide background knowledge to all the participants, the UPM HDPH Chair, presented a policy brief highlighting the existing policies and structure of the health system and a proposed reorganized structure of PHB and criteria in determining the readiness of provinces for reintegration. To deepen the understanding of the participants on the policy issue, three speakers coming from the DOH, provincial, and municipal LGUs presented evidences. The speaker from the Bureau of Local Health Systems and Development of DOH gave an overview of the fragmentation of the health system, and what efforts are needed to mitigate this. In particular, the speaker provided the participants a policy background on the ILHZ and SDN initiatives. While for the ground experience, the PHO of Bataan shared efforts of the provincial government to establish and implement the SDN initiative as directed by the DOH. Specific efforts of Bataan were narrated, from mapping out and reaching out to all service providers in their jurisdiction, developing guidelines and protocols through extensive stakeholder and

expert consultation, and finally the pilot implementation of their SDN. On the other hand, a former MHO focused on the frontline challenges faced by municipalities during integration. He presented the administrative and technical complexities involved in establishing their ILHZ. He also briefly discussed the possible concerns of MHOs as they play the role of primary care navigator and coordinator as prescribed by the UHC Act.

Crafting policy paper

The policy paper was crafted from the review of literature and thematic analysis of the RTD with the discussion questions as the sub-themes. To ensure that consensus policy recommendations were attained, the draft paper was circulated among all the participants for comments and/or approval. Revisions from the consolidated inputs were done as necessary.

RESULTS AND DISCUSSION

Current roles and mandate of PHOs, MHOs, health boards and LCEs in the local health system

Based on the LGU Code of 1991, the roles of the MHOs, PHOs, and LCEs take on the responsibility of delivering health services at the local levels. In the current devolved setup of the Philippine health system, primary level of services is coursed through health centers controlled by the municipalities, secondary level services through the local hospitals, while the national agency for health – the DOH, provides tertiary level services through retained regional hospitals and specialized centers.

Municipalities provide primary health care services under the local health system through the MHO, which is under the administrative supervision of the mayor. The MHO provides services such as health promotion, preventive care, and primary care services.¹³ The MHO renders direct community-level health services through barangay health stations (BHS) supervised by a Rural Health Midwife. A collection of BHS would report to their main primary care facilities such as Rural Health Units, supervised by a physician, the MHO. Provinces provide secondary care through provincial and district hospitals and are mandated to coordinate health delivery of municipalities and member cities. Secondary care services include outpatient specialty referrals or inpatient management of patients, both acute and emergency care. Some district and provincial hospitals also provide primary care services such as immunization services through outpatient departments.¹⁴ Direct administrative supervision of provincial and district hospitals are under hospital chiefs, who then report to the PHO and the governor. The primary funding sources for all of these services are the municipal and provincial governments. Local Health Boards, which are found both at the municipal and provincial level, aim to help LCEs mainly by assisting them in health policy formulation.

Additional roles for PHOs, health boards, and LCEs

This new environment of a province-level health system and the premium placed by the UHC Act on the continuity of person-centered services that is person-centered highlights the need for managers or health system coordinators with the technical capacity to coordinate the different parts of the integrated health system. This role as a health system coordinator would organically be placed on the PHO. As discussed by the participants, there are tendencies for some PHOs to only focus on the management of province-managed hospitals, neglecting other aspects of the health system. This must change with the province-level integration, especially monitoring and evaluation of projects and programs. The PHO must also lead in the development and creation of protocols, especially on referrals (out and back) and transfers between service providers. Given their control over the SHF, PHBs would receive some regulatory roles, including contracting service providers. This and other levers available to PHBs that can be used to manage the performance of the health systems must be identified.

Possible models of staffing and reporting lines for PHOs

Based on the review of literature, the proposed approach to the organizational design for the province-level integrated health system would closely resemble the development of an IDS. The critical first step is to have a clear definition of a population or juridical territory. Fortunately, DOH has initiatives that attempt to define local population or territory coverage in the hopes of mitigating the fragmentation of health service delivery through ILHZ and SDN.

The main difference between the ILHZ and SDN is the recognition of geopolitical boundaries. The ILHZ relies on inter-LGU cooperation, wherein in the primary coordinating unit is the municipality. Dividing the province into clusters or districts takes into account the geography and proximity of service providers wherein a cluster of municipalities would be the aimed result.¹² Therefore, there is a possibility that a MHO may assign its population to a hospital in another municipality. On the other hand, SDNs explicitly state that the defined catchment area would be determined by proximity and ease of travel relative to the service providers usually within the LGU. It is important to note that both ILHZ and SDN frameworks refer to the following as crucial factors to consider: geography, proximity, road networks, transportation means, and socio-cultural appropriateness when defining a population or catchment area.

Once a population is defined, the organization of the rest of the components of the province-level integrated health system would follow. Figure 1 shows the proposed organogram adopted from IDS organizational design concepts.

As stated in the UHC Act, Section 19, the topmost authority is the PHB, which is accountable for the integration of health services at the province-level. It is recommended to be headed by the governor and composed of representatives from (1) each SDN committee; (2) member municipalities, (3) private-public partnership; (4) private sector; (5) DOH CHD / Regional Offices, among others. To form a governing board that is sensitive to a whole-of-society approach, the PHB may also include representatives from other sectors such as non-government organizations

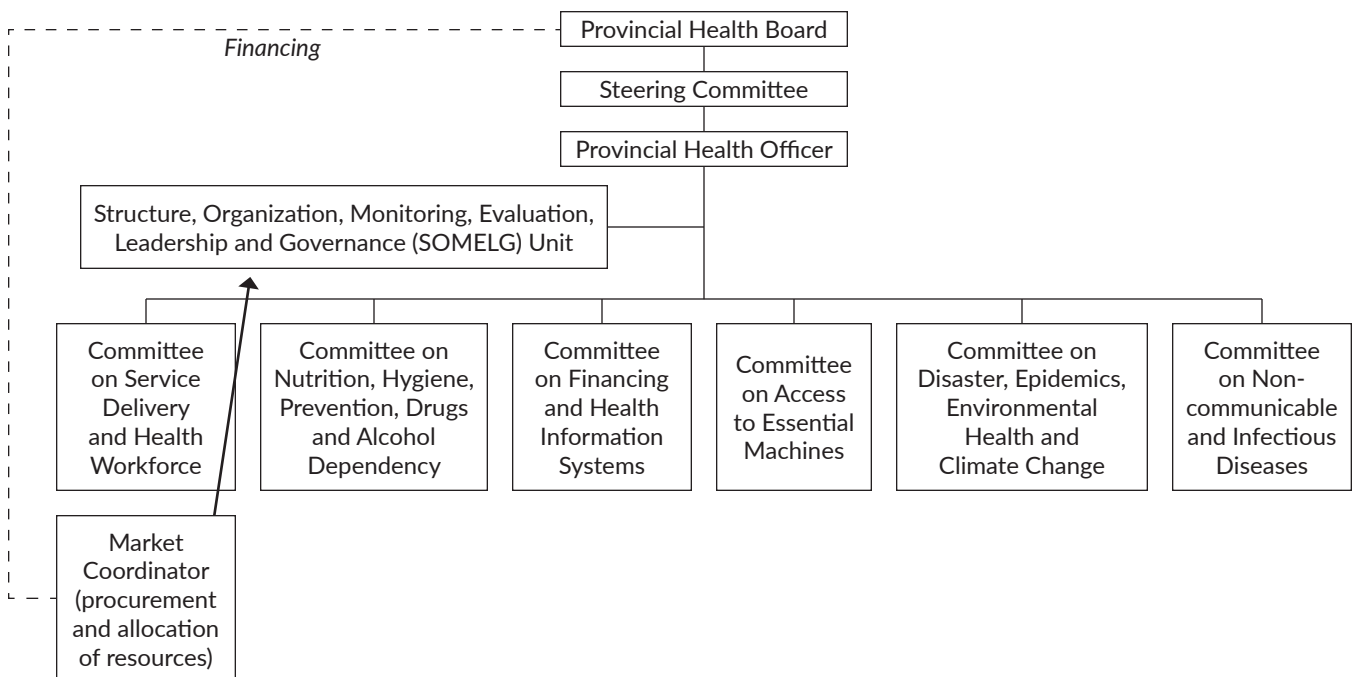


Figure 1. UPM HDPH proposed organogram of the province-level integrated health system.

as they see fit. The board will approve policies and plans that are formulated with the help of a Steering Committee.

The Steering Committee may be composed of the PHO, and heads of the Structure, Organization, Monitoring, Evaluation, Leadership, and Governance (SOMELG) Unit and the heads of all the committees. It serves as an advisory council to the PHB, tasked with the creation of the provincial-level health plan. The functions of the Steering Committee are similar to the function the Technical Management Committee of an IHLZ, wherein the committee (i) oversees joint health planning between regions/territories, (ii) formulates policy recommendation, and (iii) develops investment plans. The Committee will also oversee the implementation of health services through the PHO, as the focal person in implementing health programs. The PHO will also monitor and evaluate program performance with the help of the SOMELG Unit of a specific province. Financial management of resources for health may be done through market coordinators that are assigned per province.

The market coordinator will review and recommend to the PHB the request for resources of all the technical committees of their province based on the committee performance. Given the budget negotiation between committees and the market coordinator, the coordinator would have a quasi-managerial role. The PHB will download health resources from the SHF to the market coordinators who have to ensure equitable resource distribution to each committee, adequate to attain optimal performance. As resource allocation is need- and performance-based, the market coordinators will be working closely with the SOMELG Unit which consolidates performance reports of all committees within a territory. In general, the SOMELG Unit and the Market Coordinator handle the two managerial components of an IDS sub-unit: defining health needs and assessing health outcomes of an area, and adopting investment policies that satisfy the health service needs. By identifying gaps and needs that would have the most impact on the performance of a province, and assigning sufficient and cost-efficient resources to mitigate these, the SOMELG Unit and the market coordinator can help maximize the utilization of limited resources for a province.

While a specific organizational structure cannot be mandated by the future IRR because of the LGU Code, suggestions may be made, especially following the prescription of UHC Act where province-level networks will be the center of health service provision and accountability.

One of the recognized needs is the addition of personnel dedicated to establishing and maintaining coordination between different service providers. Outputs for this coordinator might include the development of protocols, of coordination mechanisms between specialists, and establishment of appropriate clinical guidelines for the specific province. Outcomes to be improved could include indicators for cases managed at the appropriate level of care, patient waiting times and the like. There might be a need to move

away from the notion that only medical doctors should be the de facto facility heads, and the focus on getting professional managers who can work within an integrated environment. Further, health care professional to population ratios and continuing education requirements of these professionals need to be updated and strictly reinforced.

There was consensus that while the municipalities should relinquish their health-related plantilla items to their provinces, the budget for these should remain with the municipalities to use as they see fit. Another issue that needs to be addressed is the extent of involvement of the PHB with the inclusion of the private sector in the SDN. There was consensus that private sector involvement is vital to the success of these province-level integrated SDNs, and that the PHB relationship with the private sector should not be limited to "purchaser-subcontractor", but could also be as partners in delivering healthcare services through a Public-Private Partnership (PPP) body. These highlight the need to set clear roles of the private sector within the province-level SDN and how will this be manifested in the composition of the PHB.

Measuring progress towards full integration

The UPM HPDH recommended looking at the lessons learned by the Pan American Health Organization (PAHO) in creating province-level integrated health systems and SDNs. The PAHO has identified attributes of an integrated SDN, and these attributes can be both used as criteria to determine which provinces to prioritize in implementing province-level integration, as well as integration milestones (Table 2). Because of the UHC Act, eventually, all provinces must have province-level integrated health systems. Some specific attributes were given importance by the discussants, such as the governance aspect. Specifically, ensuring full support from the provincial governor for initiatives related to the integration process. This is important because accountability for health outcomes post-integration would fall squarely on the governor and the PHB. Playing a crucial role in facilitating private sector cooperation, regulation control could also be used to both invite cooperation at the province level and promote the responsible use of resources and administrative power.

There were concerns from the participants that there will be no control over how the province spends the SHF. It is therefore emphasized that while the PHB has full discretion on fund utilization, the Board has to abide by the Provincial Investment Plan for Health (PIPH). Therein, the DOH through the CHDs / Regional Offices can provide oversight given that they are partners in the creation and approval of the PIPH. Further, key performance indicators (KPI) for SDNs can be included in the PIPH. This can serve as a guide in implementing respective projects under the SHF. The KPIs could include targets for the scope of coverage of services, the target population size, and profile, the quality of services, the cost of providing services, the service delivery time

and the reliability of services.¹⁵ For provinces with weak or underperforming fiscal governance, a temporary preventive measure may be that payments to the province-level SDN members can be temporarily paid by DOH or PHIC directly to the facility, until such a time when the provinces prove their fiscal management worthiness.

According to the study of Garand et al. (2016) on the framework of the government-sponsored health insurance program, performance monitoring is needed to assure the provision of Universal Health Care coverage, so indicators should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). Long-term effectiveness, client satisfaction, and client value are the key drivers for evaluating performance. It entails the measurement of service coverage, patient's satisfaction, as well as health outcomes.¹⁶

The RTD participants agreed that it is crucial to first identify and address fragmentation issues in current SDNs before finalizing the shift in the integration of health systems. Failure to do so could place the province-level integrated health systems at risk of the following: (a) Resistance to change by those who are content with the status quo; (b) Potential job losses arising from the integration of administrative, IT, HR, procurement, planning, and other services; (c) Insufficient levels of skills and competencies among hired staff; (d) Political interference from those who would prefer to maintain their authorities under the current fragmented health delivery system; and (e) Failure to obtain the appropriate financial support.

Browne et al. (2007) proposed a consolidated model based on different approaches to measure progress of network integration.¹⁵ The model closely resembles an Input-Process-Outcome logic model wherein the network should be first measured by its observed structural inputs: the agencies involved, services types, etc. An example of the structural inputs measured would be the presence or absence of services or facilities in each province-level health system and comparing it to the primary care guarantees by the government. The output would be the quality of the network or partnership in terms of functionality. This can be measured by the presence of policy instruments or institutional mechanisms such as contracts with private service providers. It could also be done through self-assessment or third party evaluation. Finally, the outcomes are measured from dual perspectives-both the patients and the agencies themselves. For example, outcome measurement could include service inaccessibility such as long waiting lists, late referrals, loss of continuity of care, unnecessary repetitions of record taking, and low client satisfaction scores.¹

Categories of shared data at the national-, provincial-, and health provider network-level must be clearly defined, as to facilitate effective integration as well as for monitoring performance and determining payments. Concerns were raised on the major data gap from the clinics of private physicians. It was suggested that provisions within the IRR include requirements for private clinics to share data

to the government as a requirement for accreditation and subcontracting by the province-level integrated health system.

The progress of the province to achieve full integration will be determined by the actual presence of health structures both public and private. As stated by a participant, health service provision is some sort of monopoly. Creating a health provider network from scratch is hard to do, especially if there is an existing informal network. Thus, these informal networks need to be studied as to where possible, which informal member can be integrated into the formal system.

Reforms within DOH CHDs and identified supportive actions

The participants discussed the reforms and policies needed to help the LGUs transition to province-level integration. There were concerns about the staffing needs of a strengthened primary care system. There might be duplication in some areas, while a shortage in others. By strengthening the PSDN, DOH CHD / Regional offices can finally do away with parallel PHO structures and instead, focus on monitoring and evaluation, and higher-level policy creation and implementation. The province-level integration is also an opportunity to mitigate problems of the segmented health system such as hiring practices that are politically driven and not merit-based.

Capacity building of local executives and health managers at the provincial level could also be headed by the DOH CHD / Regional offices. Governors might benefit from coaching programs to facilitate commitment to health. Another consideration to explore is providing continuing professional education for health managers. This could target PHOs to capacitate them to manage the province-level system, focusing on skillsets important for monitoring and evaluation.

The DOH CHD / Regional offices would also take part in monitoring provincial health systems, as the closest form of oversight for province-level health systems. Roles and competencies of Development Management Officers (DMO) could be redefined. Their focus can be redirected to facilitating coordination between the LGUs and DOH CHD / Regional offices, as well as coaching and monitoring of local health system actors. Participants noted that health information systems should also aid in monitoring. Data should be packaged in such a way that it will be naturally used for contracting services, determining performance and accountability.

CONCLUSION AND RECOMMENDATIONS

The organizational shift of the health system framework to the province level would change the current landscape of human and financial resources, roles, and program management. There was a consensus that fragmentation issues of the current health systems of our LGU should first be addressed and best practices of other countries considered,

relevant to our local settings. Evidence-based strategies and approaches in health system integration aim to mitigate future gaps and challenges. Hence, the proposed tools for assessment were presented. Further, to minimize political interference in delivering quality and equitable health services among all constituents, clear and mutually exclusive roles must be crafted in a manner that will maximize efficiency in functions and processes.

Based on the review of literature and multi-sector policy discussion, the following key recommendations are presented:

1. Adoption of the PAHO attributes for integrated SDNs could be used to determine priority provinces for the implementation of province-level integration. Governance, health information systems, and the presence of adequate health resources could be prioritized. Consider the proposed assessment tool for PHO readiness and its identified milestones (Table 1). Implement only in provinces assessed to be ready (Table 2).
2. The focus of DOH CHDs/ Regional offices could be redirected to capacity building and performance monitoring for provincial health systems (i.e. marketing, financing, contract management, IT system, etc.).
3. Establish mechanisms to strengthen the participation of private sectors in the province-level integrated system. Two main mechanisms are identified by the group: (1) through contracting out of selected health services and (2) via health infrastructure development using public-private partnerships.
4. There are gaps in health data from the private facilities since they do not have the same data submission requirements as that of the public sector. Require private clinics to share data with the government to be accredited and subcontracted by the province-level integrated health systems.
5. Clear delineation of roles in the management and supervision of the provincial health system between provincial DOH offices and provincial health offices be prioritized to avoid overlaps and inefficiencies.
6. Prescribing a specific organizational structure might not be possible because of the LGU Code, but an organogram (Figure 1) is proposed as a rudimentary guide. Further, PHOs might have to dedicate staff for the sole purpose of establishing and maintaining coordination mechanisms between service providers of the integrated health system.
7. Ensure that PHOs are capable of managing a province-level integrated health system, and are not limited to managing province-controlled hospitals. Special focus should be placed on technical skills on monitoring and evaluation of projects and programs.
8. The PHB will possess regulatory functions after integration. It is important to identify potential overlaps in regulatory functions among the PHB, PhilHealth, and DOH.

Statement of Authorship

All authors participated in data collection and analysis, and approved the final version submitted.

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