This policy brief aims to present the experience and lessons of the Zuellig Family Foundation (ZFF) in improving local health systems through leadership and governance interventions. It also identifies current policy issues and operational gaps on how local government units (LGUs) manage the local health systems.

The Foundation has been working to address health issues of the Filipino rural poor. Its intervention is providing health leadership and governance training to transform local chief executives into responsive health leaders. Some legislative recommendations are being proposed to accelerate policy support in making local health systems responsive in addressing inequities. These are the policy recommendations:

- **Revisit the Local Government Code or Republic Act (RA) 7160, particularly the ‘devolved setup’ on health.** This recommendation refers to strengthening the accountability and outlining the specific roles of the local leaders, sustainability measures and regulatory oversight in devolved areas; and increasing or exempting personnel salary cap to meet health workers-to-population ratio.

- **Revisit the Magna Carta for Public Health Worker’s Act (RA 7305) to reinforce benefits and security provisions that would ensure the safety and protection of health workers, particularly those deployed in geographically isolated and disadvantaged areas and localities with high violence risks.** The only way to have a more universal and uniform implementation of the law is to come up with a national policy with corresponding appropriation from the national treasury. A full review of existing policies, rules and regulations, with the end in view of coming up with revised guidelines on the implementation of RA 7305, must be made a priority.

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**The authors are ZFF’s policy associate, former monitoring and evaluation associate, and president, respectively.
• **Amend the Barangay Health Worker’s Act (RA 7883), particularly the granting of the hazard pay and rationalization of health manpower complement at the barangay level.** Considering the huge budgetary requirements, the following are recommended: 1) possible fund subsidy from the Department of Health (DOH) to the barangay health workers (BHW), like the subsidy local agriculture officers get from the Department of Agriculture; 2) rationalize the functions of the BHWs and the barangay nutrition scholars who may have overlapping functions.

• **Policy support to strengthen the integration of preventive and curative care at the provincial level.** This accelerates interventions focusing on the linkage of primary, secondary and tertiary levels of care at the provincial level.

**Current health system structure in the Philippines**

The DOH oversees the overall health sector performance while provinces, cities, and municipalities manage the local health system, including direct delivery of health services. Provinces are mandated to provide hospital services through provincial and district hospitals, while cities and municipalities are primarily tasked to provide public health programs through health centers and barangay health stations. The national government retained the responsibility for tertiary level and specialty hospitals (see Figure 1).

**Figure 1. Health service delivery under a decentralized system**

![Diagram](image)

*Source: Lavado and Pantig, 2009*

The 1991 Local Government Code (RA 7160) provides more autonomy to local government executives in the planning, resource allocation and service delivery, particularly in the health sector. Under the Local Government Code, health was the biggest service affected due to the extent and number of health
personnel, and facilities devolved (Atienza, 2004). It was also the most contentious. In fact, there were attempts from 1992 to 1995 to recentralize or suspend the devolution of health services. This was stopped following a veto of the proposed bill to recentralize health services by President Fidel V. Ramos.

With devolution, local political leaders are expected to become local health champions and drivers of change in their health systems. Conceptually, this setup provides clear assignment of responsibilities in the LGUs (see Table 1); however, this has not been translated into practice.

Table 1. LGU health service responsibilities

<table>
<thead>
<tr>
<th>LGUs</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Barangay (village)</td>
<td>• Health and social welfare services which include maintenance of barangay health center and day-care center (Section 17, b, 1, ii)</td>
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<td></td>
<td>• Services and facilities related to general hygiene and sanitation, beautification, and solid waste collection (Section 17, b, 1, iii)</td>
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<td>Municipality</td>
<td>• Health services which include the implementation of programs and projects on primary healthcare, maternal and child care, and communicable and non-communicable disease control services; access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated (Section 17, b, 2, iii)</td>
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<td></td>
<td>• Social welfare services which include programs and projects on child and youth welfare, family and community welfare, women’s welfare, elderly and disabled persons welfare; community-based rehabilitation programs for vagrants, beggars, street children, scavengers, juvenile delinquents, and victims of drug abuse; livelihood and other pro-poor projects; nutrition services; and family planning services (Section 17, b, 2, iv)</td>
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<td></td>
<td>• Solid waste disposal system or environmental management system and services or facilities related to general hygiene and sanitation (Section 17, b, 2, vi)</td>
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<td></td>
<td>• Infrastructure facilities intended primarily to service the needs of the municipality residents and are funded by municipal funds. These infrastructure include clinics, health centers and other health facilities necessary to carry out health services (Section 17, b, 2, viii)</td>
</tr>
<tr>
<td>Province</td>
<td>• Health services which include hospitals and other tertiary health services (Section 17, b, 3, iv)</td>
</tr>
<tr>
<td>City</td>
<td>All the services and facilities similar with the municipality and province (for city hospital) (Section 17, b, 4)</td>
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Recognizing leadership is the key to improving health systems and programs, ZFF embarked on a health leadership and governance program for mayors to help them understand their critical role in improving the health of their constituents. In 2008 the Foundation piloted its theory of change, the Health Change Model, highlighting the important role of public health leadership in the transformation of health system so it can have more poor-inclusive health services leading toward better health outcomes. The model was tested in 72 pilot municipalities nationwide with the following characteristics: income-poor, rural, had high maternal health burdens, and had local chief executives who expressed commitment in improving their local health systems.

The data show the dramatic improvements in rates of facility-based delivery (FBD) and skilled birth attendants (SBA), as well as the reduction of maternal mortalities in the prototype municipalities (see Figure 2). The data also show that over time, 75 percent of the pilot LGUs were reporting zero maternal death.

The significant decrease in maternal deaths resulted from interventions the mayors and their health teams had done and supported. Pregnant women were tracked by frontline health workers so they get the appropriate pre- and post-natal care. Through policies and incentives, they were also encouraged to prefer facility delivery assisted by a health professional.

Results of an impact evaluation of ZFF’s intervention in its prototype municipalities showed it was effective in bringing changes to leadership and governance, local health systems, and increasing use of maternal and child health services (Fajutagana, N., et al., 2016). The study specifically noted ZFF
coHORTS HAD MORE ACTIVE, EXPANDED AND CAPACITATED LOCAL HEALTH BOARDS (LHBs) IN TERMS OF HEALTH PLANNING AND MEETING THAN THE CONTROL GROUP OF NON-ZFF MUNICIPALITIES. MAYORS IN THE ZFF COHORTS WERE MORE AWARE OF MATERNAL AND CHILD HEALTH ISSUES, AND PARTICIPATIVE IN THE FORMULATION OF HEALTH PLANS. CLEAR PROCESSES FOR HEALTH PLANNING, INCLUDING THE PARTICIPATION OF LHBs AND OTHER STAKEHOLDERS AND USE OF HEALTH INFORMATION, WERE FOUND TO BE PRESENT IN THE ZFF COHORTS THAN IN NON-ZFF AREAS.

MATERNAL DEATHS IN ARMM PILOT MUNICIPALITIES

DELAY IN SEEKING MEDICAL CARE (FIRST DELAY)

While more mothers were found to be giving birth in health facilities, in far-flung, hard-to-reach villages, home births continue. Aside from the distance, the profile of mothers showed they belonged to indigenous communities and were considered high risk—too old or too young or have had too many pregnancies, and with pre-existing conditions such as heart problems. Other factors contributing to first delay were cultural and economic factors. Some cultural practices encourage women to give birth at home assisted by traditional birth attendants. Lack of money is also a common reason women prefer not to go to health facilities.

In this 2015 ZFF file photo, a pregnant mother is shown with her children in Bongao, Tawi-Tawi. Low income and other cultural factors resulted in pregnant mothers opting to deliver their babies in their houses.
Delay in reaching care (second delay) and delay in receiving care (third delay)

In an analysis of ZFF partner municipalities in the Autonomous Region in Muslim Mindanao (ARMM), most deaths occurred in hospitals. From 2012 to 2016, half of the deaths happened in the referral facilities and mainly caused by either pre-eclampsia and/or postpartum hemorrhage (see Figure 3).

![Figure 3. Proportion of Maternal Deaths by Place of Death in 16 Prototype ARMM Municipalities, 2012 - 2016](image)

Source: Municipal Field Health Services Information System

There was no effective referral system to ensure high-risk mothers give birth in the proper facility. While high-risk women were getting tracked, most of them gave birth in the RHUs, which have neither the capacity nor the mandate to handle complicated pregnancies since these cases require surgical procedures and blood transfusion. For example, municipalities in Tawi-Tawi did not have formal agreements with the referral facility, the Datu Halun Sahilan Memorial Hospital, to allow two-way communication, feedback and referrals. The next referral hospital after Datu Halun Sahilan Memorial Hospital is in Zamboanga City, which is about 15 hours by boat or around 45 minutes by plane.

Reducing deaths

Analyzing deaths using the Three Delays Model of (1) delay in deciding to receive care, (2) delay in reaching care, and (3) delay in receiving care showed reasons for first delay in prototype LGUs were distance, poverty and traditional beliefs.

Addressing first delay: Barangay strengthening

In ARMM, community organization and involvement should be the strategic focus, especially since health gains are not being sustained when there are changes in leadership—whether the mayor or the
municipal health officer (MHO). Pilot municipalities in Samar Island that are located in geographically isolated and disadvantaged areas (GIDAs) have shown successive declines in maternal deaths. A major factor for this is the strengthening of its barangay health systems.

Samar GIDA’s program for barangay strengthening is called “BIDA,” which stands for Bulig (help), Inspirasyon (inspiration), Dedikasyon (dedication), Aksyon (action). This has two categories: technical capacity and adaptive leadership.

Under technical capacity are:
- **Pregnancy Tracking System** capacity-building training for RHU staff and barangay health workers
- **EINC (Essential Intrapartum and Newborn Care)** technical skills training for RHU staff (doctor, nurse, and midwife) on the acute management of the third stage of labor, proper newborn care, and neonatal resuscitation
- **IMCI (Integrated Management of Childhood Illnesses)** training for BHWs: home remedies, and identification of danger signs, and the time to refer patients to the health facility

Under adaptive leadership is:
- **BHLMW (Barangay Health Leadership and Management Workshop)** training for barangay officials in which the objective is the activation and functionalization of Barangay Health Board (BHB)

The Barangay Health Leadership and Management Program of ZFF started in the second half of 2015 in the ARMM. With the inclusion of religious and community leaders, barangay captains and BHWs in the program, FBD and SBA deliveries are expected to further increase in ARMM, where FBD has shown successive increase: 50 percent in 2014, 59 percent in 2015, and 69 percent in 2016. However, this is still below the 90-percent national target. In Samar GIDAs, the mobilization of BHWs proved effective in increasing ante-natal care, which subsequently helped increase FBD and SBA.

**Addressing second and third delays**

In ARMM, it is important to have an active collaboration among the DOH-ARMM, the governor, the provincial health officer (PHO), and mayors and MHOs. Initially, pilot LGUs were focused on municipal health systems such that when a higher level of care, i.e. hospital care, was needed, and an integrated system was lacking, the mothers’ chances of dying remained high.

In Tawi-Tawi, a province under ZFF’s partnership with the United States Agency for International Development (USAID), provincial health leaders were engaged through the Provincial Leadership and Governance Program (PLGP). The province’s Datu Halun hospital continues to have a problem maintaining sufficient blood supply. And while it has shown improvements in the availability of medicines, it still needs to improve on its personnel, particularly having specialists available 24/7.

Continuing engagement with the province to strengthen their referral system with municipalities and improve hospital services is expected to yield more improvements in having functional referral systems between municipalities and the provincial referral hospitals, and addressing delays in reaching facilities and receiving quality care.
Addressing hospital deaths

Since most deaths occurred in hospitals and were caused by hemorrhage and pregnancy-induced hypertension, the Foundation’s intervention at the provincial level focused on strengthening hospital capacities. Under the PLGP, seven key monitoring indicators were chosen for inclusion to CEmONC (Comprehensive Emergency Obstetric and Newborn Care) Hospital Scorecard: 1) functional management committee, 2) regular maternal audit, 3) 24/7 obstetricians, 4) 24/7 blood availability, 5) 24/7 medicines availability, 6) point-of-care (POC) enrollment, and 7) no-balance billing as proof there is no out-of-pocket payment of patients.

Key emerging lessons

Lesson #1: Local leaders and health workers must be capacitated and supported to strengthen technical and governance capacity to address local health needs.

Health boards at the municipal and barangay levels must be functional if health issues are to be tackled and solved immediately. Also, programs and reforms will more likely generate the needed community and local legislative support when representation to the health boards are expanded to include budget officers, social workers, planning officers, and other socioeconomic sectors. Health proposals also become integrated with other sectors and the development plan. A formative evaluation of the Health Leadership and Governance Program showed three variables are significantly associated with leadership training (Wong, et al., 2016). These are (a) average number of LHB meetings conducted, (b) average number of LHB meetings conducted with documentation, and (c) number of health resolutions proposed by LHB and passed by Sanggunian Council that are monitored and evaluated by the LGU. The same study said LGUs that underwent training will be four times more likely to conduct LHB meetings than the control counterpart. It further said the functionality of the LHB was translated into the development of LHB-initiated municipal health action plans and approved by the Sanggunian Council in the LGUs with leaders who underwent the training. This indicates the need to provide capability-building for local chief executives and other LHB members and technical training for health staff.

Lesson #2: There must be available health facilities other than the RHU and these must be easily accessible to the people, especially those living far from the town center, where RHUs are usually located.

Those residing in far-flung villages cannot easily be convinced to get regular checkups in the health centers because of the distance, difficulties and costs the travel
would entail. For these cases, municipal governments must offer incentives that include monetary assistance, transportation facilities and even accommodation because for some patients—mothers, in particular—being away from their homes means having no one to look after the rest of their children and/or having no one to care for them in the health facility. By having a place to stay near the health center, a mother’s loved ones can accompany her. In many ZFF LGUs, maternal shelters were built near birthing centers.

In other cases, BHS were not able to provide complete primary care services to the community particularly in the far-flung areas (ZFF, 2014). This emphasizes the role of BHWs. A vital part of quality health service is competent workforce. It means importance and recognition must be given to health workers who continue to perform their duties even under hazardous working environments. This can be done by giving equal treatment in hazard pay, and other support programs. In 21 ZFF partner municipalities that were assessed, health workers were aware of the additional compensation to which they were entitled as stated in the Magna Carta for Public Health Workers. These include hazard allowance, subsistence allowance, longevity pay, laundry allowance and remote assignment allowance. However, not all municipalities are able to provide the full Magna Carta benefits. Only four municipalities were giving all the additional benefits, but none of the municipalities gave overtime pay and night shift differential (ZFF, 2011).

**Lesson #3: Linkage between preventive care and curative care must be strengthened.**

This means that for long-term sustainability, the governors and their health leadership team must have overall accountability for the provincial health indicators. There is a need for a provincial chief executive to be a health champion who will have oversight on the preventive care and not just curative care to make sure both systems are functional and linked. The concern with hospitals led the Foundation to work with governors in 2014. ZFF worked with 32 provinces, but concentrated on hospitals that had the most number of maternal deaths. Assessment conducted by the ZFF project team in these hospitals using the CEmONC guidelines showed its many challenges: lack of regular management committee meetings to know and discuss challenges; lack of reliable blood supply and obstetric medicines; and no OB gynecologist, and/or anesthesiologist present 24/7.
Policy recommendations

With the devolution, much emphasis has been placed on the importance of first-level health facilities such as the BHS and the RHU. However, inefficiencies inherent in the health system have dampened the implementation of crucial health interventions vital in local service delivery. In this regard, the following are recommendations for programs and policies to strengthen local health systems.

Revisit the Local Government Code particularly the ‘devolved setup’ on health.

The provision must outline the accountability and specific roles of the local chief executives, the sustainability measures, and the regulatory oversight in devolved areas. A regulatory oversight committee must be established to monitor local health systems development and performance of LHB as mandated by Local Government Code. The multisectoral oversight committee will be composed of the DOH, the Department of the Interior and Local Government, professional organizations and representatives from non-government and civil society organizations.

Title V of the 1991 Local Government Code provides for the establishment of a LHB in every province, city or municipality. One of its major functions is to propose to the Sanggunian concerned the allocation of budgetary resources for health-related facilities and activities within the municipality, city or province, as the case may be.

One of the major reasons for the weak local policy support for health programs is the low allocation of budgetary requirements. This policy option seeks to increase the role and functionality of the LHB through the proposed amendment in the 1991 Local Government Code which will include the following:

1) to specifically provide for a regular appropriate health budget; and

2) to include in the composition of the LHB, the provincial/city/municipal budget officers, planning and development coordinators and other department heads deemed necessary to push the health sector agenda to ensure funding of health-related projects in the local plans/annual investment and development programs.

LGU’s capacity to hire to meet the DOH standard of health workers-to-population ratio has been restricted due to personnel salary (PS) cap limitations. Such restrictions and/or their appropriateness should be checked and reassessed. The possible options would be to increase PS cap to hire additional health workers and/or exempt PS cap on devolved functions (ULAP, 2016).

Amend the Barangay Health Worker’s Act (RA 7883), particularly the granting of hazard pay and rationalization of health manpower complement at the barangay level.

At present, there is low compliance in granting the incentives and benefits of BHWs as stipulated in RA 7883, in particular, the hazard pay (amount determined by the LHB).

Considering the huge budgetary requirements, the following are recommended:

1) possible fund subsidy from the DOH to the BHWs (just like the Department of Agriculture’s subsidy to the agricultural officers at the local level); and

2) rationalization of the functions of the BHWs, who are also community-based health volunteer workers and may have overlapping functions, as well as standard/recommended ratio to the number of households/population or per barangay basis.
Amend the Magna Carta for Public Health Worker’s Act (RA 7305), particularly the universal and uniform implementation of the law.

As stated in the Department of Budget and Management and DOH Joint Circular No. 1, s. 2012, the implementation of RA 7035 is subject to the availability of funds. Thus, LGUs actually have some leeway as to how much and what specific provisions of the law will be prioritized. As LGUs vary in their financial capacity, this resulted in an uneven implementation of the law, not only across, but also within municipalities. The only way to have a more universal and uniform implementation of the law is to come up with a national policy with corresponding appropriation from the national treasury. A full review of existing policies, rules and regulations, with the end in view of coming up with revised guidelines on the implementation of RA 7305, must be made a priority.

There is also a need to revisit the law to reinforce benefits and security provisions that could ensure the safety and protection of health workers particularly those deployed in challenging areas like in GIDAs and localities identified as high risk for violence.

Implementation of the Magna Carta for Public Health Workers should be monitored and evaluated by the Management Health Workers Consultative Council. There is a need to reactivate this council at the national, regional and other appropriate levels to ensure the full implementation of the law and to recommend amendments of the law when necessary.

Policy support to integrate primary, secondary and tertiary levels of care

This accelerates interventions to focus on the linkage of promotive, preventive, curative and rehabilitative programs at the provincial level. The governors and their health leadership team must have overall accountability for the provincial health indicators.

There is a need for a provincial chief executive to be a health champion who will have oversight on the preventive care and not just curative care to make sure both systems are functional and linked. This is consistent with the pending health bill authored by Senator Joseph Victor “JV” Ejercito. Chapter IV Section 22 of the bill, “Universal Health Care for All Filipinos Act of 2016,” states the need to establish a “Network of Health Service Providers.” Specifically, all health facilities encompassing primary to tertiary care within a provincial jurisdiction are mandated to form a single network for purposes of effective referral system. The network shall be responsible for ensuring efficiency in using resources and establishing strategically located specialty centers to avoid redundant one-stop shops, and facilitate cross-subsidization of operational costs and the setting up of referral protocols including transport and accommodation services.

However, the bill must also include standardized monitoring process and establishment of an inter-sectoral oversight committee, which takes the lead in monitoring the local health systems performance and development of the annual performance report.
References


Union of Local Authorities of the Philippines (2016). *Addressing Health Devolution Gaps and Mainstreaming the Philippine Health Agenda to Local Governments*.


