Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MAY 22 2020

ADMINISTRATIVE ORDER
No. 2020 - 0021

SUBJECT: **Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)**

I. BACKGROUND

The Department of Health (DOH) was reorganized in 1987 to integrate hospital and public health services at all levels of administration through Executive Order (EO) 119 or the Reorganization Act of the Ministry of Health and EO 292 or the Administrative Code of 1987. The structural organization followed a vertical flow of command with the DOH having the supervision and control over all health facilities and services through the Integrated Provincial Health Offices. With the implementation of Republic Act (RA) 7160 or the Local Government Code (LGC) in 1991, the governance over the Philippine Public Health System was divided between the National Government, through the DOH, and the Local Government Units (LGUs) consisting of Provinces, Cities and Municipalities. The LGUs are mandated to deliver primary and secondary care services through the rural health units/health centers (RHUs/HCs), and hospitals, respectively. The DOH, on the other hand, acts as the overall steward of the health system by setting the national policy direction, plan, technical standards and guidelines for health. The regulation of health services and products, as well as the management of specialized tertiary health care facilities remained with the DOH. The fragmentation of responsibilities and accountabilities in the public health service delivery system led to health system inefficiencies, such as lack of coordination across different levels of care, lack of continuity and presence of duplication in services provided, and failure to meet the demands and needs of clients.

In order to address the fragmentation of the health systems, and to promote cooperation among LGUs in addressing health issues at the local level, inter-local health zones (ILHZ) were established nationwide through EO 205 s. 2000 and was one of the key pillars of the Health Sector Reform Agenda (HSRA). Service Delivery Networks (SDNs) were also mandated by RA 10351 or the Sin Tax Law, and RA 10354 or the Responsible Parenthood and Reproductive Health Act to be established for an integrated, coordinated, and efficient provision of health care services. The AO 2017-0014 or the Framework for Redefining Service Delivery Networks provided the specific guidelines on the organization of the SDNs; while, AO 2018-0014 or the FOURmula One Plus for Health (F1*Plus*) further reiterated that the SDNs shall be engaged to deliver comprehensive package of health services.

With the passage of RA 11223 or the Universal Health Care (UHC) Act, the provision of continuous, coordinated and integrated care will be further facilitated through the integration of local health systems into Province-wide and City-wide Health Systems (P/CWHS). The law intends to address fragmentation issues in service delivery by

streamlining the management of the health system, rationalizing multiple payers of care, and linking public and private providers.

II. OBJECTIVES

The objectives of this Order are as follows:

A. To provide the general procedures and mechanisms by which LGUs (i.e. provinces, cities, and municipalities), national government agencies, and stakeholders can integrate local health systems into P/CWHS.

B. To provide the scope and minimum level of functionality of an integrated local health system.

III. LEGAL FRAMEWORKS

A. Section 13, Article X of the 1987 Constitution states that *"Local government units may group themselves, consolidate or coordinate their efforts, services and resources for purposes commonly beneficial to them in accordance with law"*.

B. Section 33, Article III of the Local Government Code (RA 7160) states that *"local government units (LGUs) may, through appropriate ordinances group themselves, consolidate, or coordinate their efforts, services, and resources for purposes commonly beneficial to them. In support of such undertakings, the local government units involved may, upon approval by the Sanggunian concerned after a public hearing conducted for the purpose, contribute funds, real estate, equipment and other kinds of property and appoint or assign personnel under such terms and conditions as may be agreed upon by the participating local units through Memoranda of Agreement."*

C. Section 19, Chapter V of the UHC Act provides that *"The DOH, Department of the Interior and Local Government (DILG), PhilHealth and the LGUs shall endeavor to integrate health systems into Province-Wide and City-Wide Health Systems"* while Section 19.6 of its IRR states that *"The DILG and the DOH shall facilitate the integration of local health systems into province-wide and city-wide health systems through a mechanism of cooperative undertakings among the LGUs to ensure the effective and efficient delivery of health services, provided under Section 33 of RA 7160"*.

IV. SCOPE OF APPLICATION

This Order shall apply to all offices and attached agencies under the DOH, all health care providers and facilities (public and private), other National Government Agencies (NGAs), Non-Government Organizations (NGOs), LGUs, health partners and donors, and all others concerned.

In the case of Bangsamoro Autonomous Region for Muslim Mindanao (BARMM), the adoption of the integrated P/CWHS shall be in accordance with Article IX, Section 22 of RA 11054 or the Organic Law for BARMM and subsequent laws and issuances.

V. DEFINITION OF TERMS

For purposes of this Order, the following terms are defined as follows:

A. Co-Ownership – refers to ownership of health facilities and services within a network by at least two or more juridical entities where the co-owners agree on their network shares.

B. Local Health System - refers to all health offices, facilities and services, human resources, and other operations relating to health under the management of the LGUs to promote, restore or maintain health.

C. Primary Care Provider – refers to a health care worker, with defined competencies, who has received certification in primary care, as determined by the DOH, or any health institution that is licensed and certified by the DOH.

D. Primary Health Care Approach - refers to the concept that promotes maximum community and individual participation in the planning, organization, operation, and control of health care services, making optimal use of available resources, and organized around the demands and expectations of the community, not merely on disease or financing.

E. Special Health Fund (SHF) – refers to a pool of financial resources at the P/CWHS intended to finance health services and health system operations.

VI. GENERAL GUIDELINES

A. The Province-wide Health System (PWHS) shall consist of the provincial, municipal and component city health offices, provincial, district and municipal hospitals, health centers, barangay health stations and other LGU-managed health facilities and services. The city-wide health system (CWHS) shall include the city health office, hospitals, health centers, barangay health stations and other city-managed health facilities and services of highly urbanized cities (HUCs) and independent component cities (ICCs).

B. The P/CWHS are integrated local health systems in which health care providers deliver continuous and integrated health services to individuals and/or communities in a well-defined catchment area. These health systems are forms of progressive cooperative undertakings among LGUs to complement the individual LGU's health operations.

C. The private sector shall be encouraged to participate in the integrated local health system through a contractual arrangement with the P/CWHS.

D. The P/CWHS shall be based on the Primary Health Care Approach that emphasizes strong primary care.

E. The provinces, HUCs and ICCs that committed to integrate shall create a SHF and strengthen their Provincial Health Office (PHO)/ City Health Office (CHO) by creating at least two divisions, namely, Health Service Delivery Division (HSDD) and Health Systems Support Division (HSSD).

F. In consideration of the size, population and geography of the province, a group of adjacent municipalities and component cities may form sub-provincial health systems for effective health service delivery and management of health systems.

G. The provisions stipulated in AO 2018-0014, "Strategic Framework and Implementing Guidelines for Fourmula One Plus (F1Plus) for Health," shall likewise be followed.

VII. SPECIFIC GUIDELINES/ IMPLEMENTING MECHANISMS

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

The HCPN refers to a group of primary to tertiary care providers, whether public, private or mixed, offering people-centered and comprehensive care in an integrated and coordinated manner. The HCPN shall ensure that its catchment population has access to all levels of care: (1) primary care; (2) secondary care; and (3) tertiary care.

Each HCPN shall have primary care provider networks (PCPNs) as its foundation and responsible for providing the primary level of care. These PCPNs are coordinated groups of public, private or mixed primary care providers that act as the navigator, initial and continuing point of contact of clients to the health care delivery system.

Secondary and tertiary levels of care shall be provided by hospitals and other qualified health facilities.

1. There are three types of HCPN, namely (see Figure 1):

   a. Public HCPN or the Province-Wide and City-Wide Health System (P/CWHS)
      i. A P/CWHS is created by grouping the public primary care providers and facilities into PCPNs that are linked to secondary and tertiary care providers within geographic or political boundaries.
      ii. In consideration of the size, population, and geography of the province, and based on the assessment and recommendation of the PHO, in collaboration with the Center for Health Development (CHD), a group of adjacent municipalities and component cities may form sub-provincial health systems for effective health service delivery and management of the health systems. The sub-provincial health system shall consist of the PCPN linked to a secondary or tertiary care provider. Existing cooperative undertakings such as ILHZ and SDN may transition to sub-provincial health systems.
      iii. The P/CWHS shall deliver both population-based and individual-based health services and shall be linked to at least one apex hospital. The hospitals or other qualified health facilities within the network shall provide outpatient specialty care and/or inpatient care services, while the primary care providers shall be responsible for primary care services.
      iv. In the case that there are no LGU-owned/managed secondary or tertiary care providers, the province/city may link with a DOH or private hospital to complete its HCPN provided that the hospital shall be of the level and service capability needed as identified by DOH standards. The proximity between facilities shall also be taken into consideration.
      v. The P/CWHS may engage private service providers, through contractual arrangements, to complement health services provided by public health facilities or to support in the management of the P/CWHS.

   b. Private HCPN
      i. The configuration of the private HCPN is driven by market-based forces and may not be limited to defined geo-political boundaries. It shall be

contracted separately by PhilHealth to provide individual-based health services at all levels of care, primary to tertiary.

ii. The private HCPN may engage public service providers, through contractual arrangements, to complement health services provided by private health facilities.

c. Mixed HCPN

Models for mixed HCPN shall be developed. Public and private entities shall have co-ownership of all health facilities and services in the network capable of delivering primary to tertiary care services

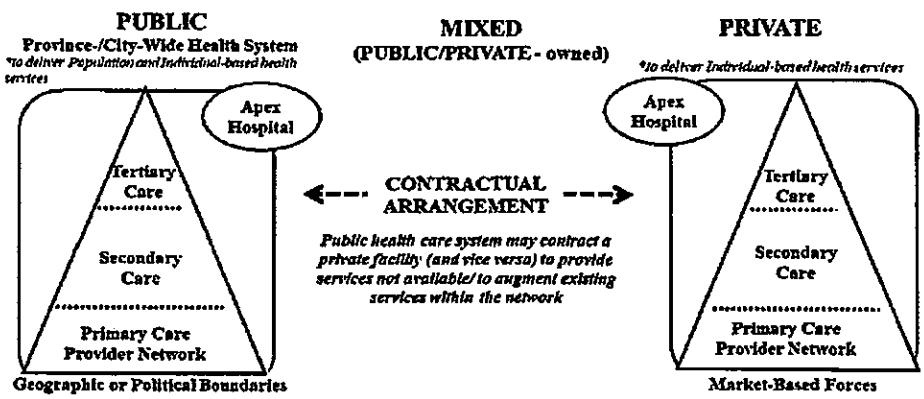

Figure 1: Types of Health Care Provider Network

2. Network Contracting

a. Population-based health services

The DOH shall contract the P/CWHS through a legal instrument to ensure shared responsibilities and accountabilities among members of the health system for the delivery of population-based health services, including those that impact the social determinants of health.

The following are the minimum components of a P/CWHS:

i. PCPN with patient records accessible throughout the health system. This network shall provide primary care services, serve as initial contact and navigator to guide patients' decision making for cost-efficient and appropriate levels of care, coordinate patients to facilitate two-way referrals and implement public health services;
ii. Accurate, sensitive and timely epidemiologic surveillance systems;
iii. Proactive and effective health promotion programs or campaigns; and,
iv. Timely effective and efficient preparedness and response to public health emergencies and disasters.

b. Individual-based health services

PhilHealth shall contract the public, private, or mixed HCPNs for the delivery of individual-based health services. The contracted networks shall have the following minimum components:

i. PCPN that is linked to secondary and tertiary care providers;
ii. Assurance of member access to all levels of the HCPN, including the use of digital technologies for health;
iii. Patient navigation and coordination system;
iv. Patient records management system, including electronic health records;
v. Provider payment mechanism;
vi. Proof of legal personality; and,
vii. Mechanism of pooled fund management within the network.

In addition, the following are the minimum requirements for contracting HCPNs:

i. All health care facilities within the network are licensed or accredited by the DOH, as applicable; and,
ii. All health care providers within the network executed or signed a performance contract with PhilHealth.

B. Management Structure of the P/CWHS

1. The Provincial/City Health Board (P/CHB) shall be the steward of the integrated local health system and responsible for setting the policy and strategic directions of the P/CWHS:

a. Composition of the P/CHB

Position	Province	HUC/ ICC
Chairperson:	▪ Provincial Governor	▪ City Mayor
Vice-Chairperson:	▪ Provincial Health Officer	▪ City Health Officer
Members:	▪ Chair of Committee on Health-Sangguniang Panlalawigan	▪ Chair of Committee on Health-Sangguniang Panlungsod
	▪ DOH Representative	▪ DOH Representative
	▪ PO, NGO or Private Sector Representative	▪ PO, NGO or Private Sector Representative
	▪ ICC/IP representative, as applicable	▪ ICC/IP representative, as applicable
	▪ Representative/s of municipalities and component cities included in PWHS	

The selection of the Indigenous Cultural Communities/Indigenous Peoples (ICC/IPs) representative shall be in accordance with Title II (The ICC/IP Representative) of the National Commission on Indigenous Peoples (NCIP) AO 3 series of 2018 or the "Revised National Guidelines for the Mandatory Representation of Indigenous Peoples in Local Legislative Councils and Policy-Making Bodies."

A consultation process must be undertaken in determining the appropriate number of members, particularly the representative/s of municipalities and component cities included in the PWHS, taking into consideration the quorum and manageability of board meetings, and size and geography of the province.

b. Functions of the P/CHB
   i. Propose to the Sanggunian concerned, in accordance with the standards and criteria set by the DOH, annual budgetary allocations for the operation and maintenance of health facilities and services within the province or city
   ii. Serve as an advisory committee to the Sanggunian concerned on health matters such as, but not limited to, the necessity for, and application of local appropriations for public health purposes
   iii. Consistent with the technical and administrative standards of the DOH, create committees which shall advise local health agencies on matters such as, but not limited to personnel selection, bid and awards, grievance and complaints, personnel discipline, budget review, operations review and similar functions
   iv. Set the overall health policy directions and strategic thrusts including the development and implementation of the integrated strategic and investment plans of the province-wide and city-wide health systems
   v. Oversee and coordinate the integration and delivery of health services across the health care continuum for province-wide and city-wide health systems
   vi. Assume full responsibility in the management of the SHF and ensure that the SHF is optimally utilized to help achieve the desired health outcomes
   vii. Exercise administrative and technical supervision over health facilities and health human resources within their respective territorial jurisdiction. This is to generally oversee the operations of the P/CWHS and ensure that they are managed effectively, efficiently, and economically but without interference with day-to-day activities. The health board may require the submission of reports, cause the conduct of management audit, performance evaluation, and inspection to determine compliance with policies, standards, and guidelines of the DOH, and take such actions as may be necessary for the proper performance of official functions. Such actions, however, shall not extend to appointment and other personnel actions which shall remain with the concerned LGU.

c. Meetings and Quorum
   i. The P/CHB shall meet once a month or as often as necessary.
   ii. A majority of the members of the board shall constitute a quorum, but the chairperson and vice-chairperson must be present during meetings where the Local Investment Plan for Health (LIPH), Annual Operational Plan (AOP), and annual budgetary proposals are being prepared or considered. The affirmative vote of a majority of all members is necessary to approve health systems plans and budgetary proposals. The affirmative vote of a majority of the members present is sufficient to approve matters relating to ordinary business.

d. Conduct of General Assembly

A General Assembly shall be conducted, at least twice a year, within the P/CWHS to provide the opportunity for all stakeholders to be informed and to discuss the developments and concerns on health services and management of the health system.

2. Creation/Strengthening of Support Units

   a. Management Support Unit (MSU). An MSU shall be created under the supervision of the P/CHB Board to serve as the Board's administrative secretariat and to assist in its operations. At the minimum, the MSU shall be composed of the following personnel: (1) Administrative Officer; (2) Accounting Clerk; and (3) Liaison Officer. Depending on the size of the province/city, the Board may decide to appoint, designate, or hire additional staff, as deemed necessary.

      The MSU shall perform its functions in close coordination with P/CHO, which shall serve as the technical secretariat of the Board. The functions of the MSU shall include, but not limited to:

      i. Provision of assistance in the management of the SHF:
         1) Preparation of the Board resolution on SHF budget.
         2) Ensuring that budgetary documents are approved and signed by the Provincial/ City Budget Officer, Treasurer and/ or Accountant.
         3) Preparation, submission, and reporting of financial status and physical accomplishments.
         4) Coordination with concerned LGU Budget Officer, Treasurer, Accountant and/ or Health Officer for the purpose of planning, budgeting, utilization, and liquidation.

      ii. Perform administrative and technical support:
         1) Documentation of Board meetings and other activities relating to the organization and functionality of the P/CWHS.
         2) Preparation and submission of reports to the Board, DOH and PhilHealth, among others, in close coordination with the P/CHO and other concerned LGU offices.
         3) Assist in the conduct of monitoring activities such as management audits and performance evaluation reviews.
         4) Preparation of other technical and administrative documents.

      iii. Coordinate with the necessary P/CWHS stakeholders

      To ensure proper accountability, the Board shall either designate or appoint existing plantilla personnel from the Provincial/ City Government as part of the MSU.

   b. Provincial/City Health Office. The PHO/CHO shall act as the technical secretariat of the Health Board, in close coordination with the MSU. The PHO/CHO assisted by the Assistant Provincial/ City Officers, shall be responsible for the technical integration and supervision of the P/CWHS. To support its operation, the following shall be undertaken:
      i. Establishment of at least two technical divisions, namely:

1) Health Service Delivery Division (HSDD) - This Division shall manage the health service delivery operations of PCPNs, hospitals, and other health facilities, and oversee the implementation of public health programs including health promotion, epidemiologic surveillance and disaster risk reduction and management for health. This shall be headed by the Assistant Provincial/City Health Officer.

2) Health Systems Support Division (HSSD) - This Division shall manage the health financing (planning and budgeting), health information system, procurement and supply chain for health products and services, local health regulation, health human resource development, and performance monitoring, among others, in close coordination with the concerned offices of the provincial/ city government. This shall be headed by an Officer of the same level as the Assistant Provincial/City Health Officer.

An enabling ordinance shall be passed to create the Assistant Provincial/City Health Officer and another official of equivalent rank, as well as other necessary staff needed per division, as plantilla items if not yet present. Until such time that the plantilla positions have been created, existing personnel may be designated/ detailed.

In addition, the PHO/CHO shall have an administrative unit to render administrative-related support.

ii. A Technical Management Committee (TMC) may be created to supervise the operations of each sub-provincial health system, as applicable. At the minimum, each TMC shall be composed of technical staff from the member health facilities, DOH representatives of the municipal/ component city, patient representative and others, and shall be assisted by administrative staff designated by the participating provincial, city or municipality. Its functions shall include:

1) Initiate participatory health care needs assessment and integrated health planning for both hospital and RHUs/HCs at the sub-provincial health system
2) Supervise navigation, coordination, and referral across component facilities and ensure compliance with the referral system protocol
3) Recommend policies and guidelines for the establishment of management support systems such as strategic and investment planning, referral system, HRH development, logistics and supply chain, and information systems
4) Advocate the approval of funds pertaining to the provision of health services
5) Monitor and evaluate the integration of public health and hospital services within the sub-provincial health system
6) Submit necessary reports and health data to the PHO

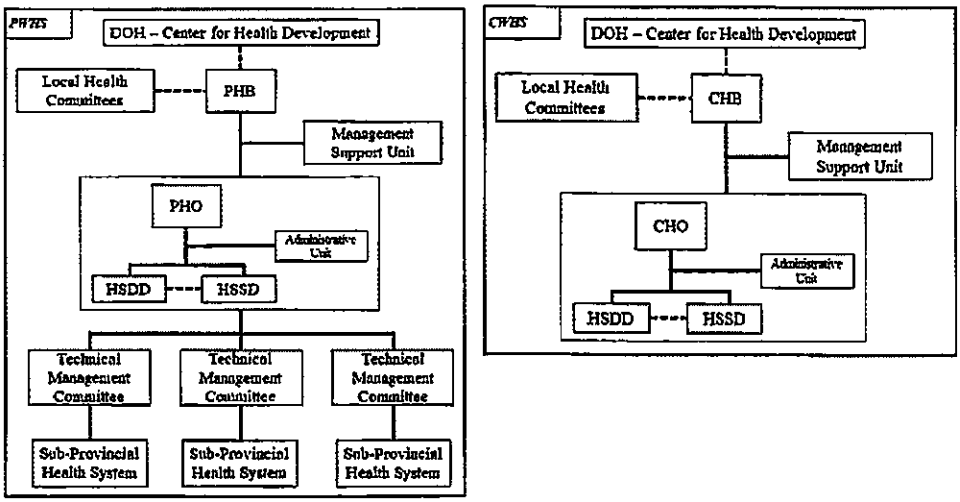

Figure 2: Structure of Support Units: P/CWHS (Note: Figure 2 reflects the summary of the relationship among the different support units.)

iii. The municipal/ component city health boards shall retain their existing composition and functions as stipulated in the LGC

C. Characteristics of P/CWHS Integration

At the minimum, the integrated local health systems shall be characterized by the following:

1. Managerial and Technical Integration. Managerial integration refers to the consolidation of administrative, technical and managerial functions of the P/CWHS over its resources such as health facilities, human resources for health, health finances, health information systems, health technologies, and equipment and supplies; while, technical integration refers to the functional and efficient linking of health service provision from primary to tertiary care, when appropriate, across different levels of facilities, care settings, across a comprehensive spectrum of care with primary care as the foundation and intersectoral participation as one of its key principles.

   Minimum Characteristics:
   a. Local ordinance(s) issued on the:
      i. Integration of the municipalities' and component cities' local health system to the province-wide health system; and,
      ii. Implementation of the P/CWHS;

   b. Unified governance of the local health systems

   c. Integrated management systems:
      i. Health Financing;
      ii. Human Resources for Health Management and Development;
      iii. Strategic and Investment Planning;
      iv. Information Management System;
      v. Procurement and Supply Chain Management System; and,

vi. Quality Assurance/ Improvement System;

d. Functional referral system;

e. Functional Disaster Risk Reduction and Management for Health (DRRM-H) system;

f. Functional epidemiologic surveillance system; and,

g. Proactive and effective health promotion programs or campaigns

2. Financial Integration. Financial integration refers to the consolidation of financial resources exclusively for health services and health system development under a single planning and investment strategy by the P/CWHS, i.e. LIPH and AOP.

Minimum Characteristics:

a. Creation of SHF

b. Health Board Resolution on SHF budget and allocation

c. Funds exclusively used for health services and health system development

D. Implementation Arrangement

The following are the specific phases and strategies which are deemed essential in the success of the integration of the local health systems into P/CWHS. The different phases and strategies outlined herein may not necessarily follow the same order.

1. Phase 1: Preparatory Works

a. Getting the commitment
   i. Secure the legal and political support of the provinces, HUCs, ICCs, component cities, and municipalities to integrate their local health systems. This involves engaging the LGUs through advocacies and orientations on UHC Act, F1 Plus for Health, and other national policy goals and directions.
   ii. Formalize the LGU commitment to collaborate with other LGUs.

b. Setting the baseline. Conduct of thorough assessment on the state of the local health system which includes, among others:
   i. Inventory and mapping of service availability and readiness of public and private health facilities;
   ii. Assessment of capacities and training needs of health care providers;
   iii. Population profiling and risk stratification; and,
   iv. Presence/Functionality of management support systems, such as a referral system, DRRM-H system, epidemiologic surveillance system, information system, health promotion programs, and campaigns, among others.

c. Plan development. Based on the results of the assessment;

i. Formulate the LIPH and annual operational plans in accordance with the existing guidelines on the development of the LIPH and its corresponding AOPs. These plans shall be approved by the P/CHB.

d. Organizing the management structure. Organize/ Strengthen policy and technical management structures, such as:
   i. Additional member/s to the P/CHB and creation of its MSU;
   ii. Establishment of at least two technical divisions in the P/CHO; and,
   iii. Creation of the technical management committee, as deemed necessary.

e. Creation of SHF

2. Phase 2: Organization of the P/CWHS

a. Establish the network of health facilities and services
   i. Clearly identify the health facilities and services that will form each PCPN. The geographical division of a province may serve as the basis for identifying the group of public or private primary care providers in adjacent municipalities and/ or component cities that will compose the PCPN. The number of member municipalities and/ or component cities shall depend on the proximity and access to the secondary or tertiary level of care.

      A group of public or private primary care providers within the territorial jurisdiction of the HUC/ICC can be considered as a PCPN.

   ii. Linking the PCPN to secondary or tertiary care providers.
   The secondary or tertiary care providers shall serve as the referral facilities of the PCPN. Geographical characteristics, road networks, availability of transportation facilities, and availability of health services shall be considered in choosing the referral facilities of the PCPN. A MOA shall be entered into by the PCPN members and their referral facilities.

   iii. Identification of apex hospital.
   The DOH shall provide the list of apex hospitals wherein the P/CWHS can link for specialty care services. A MOA shall be entered into by the P/CWHS with their identified apex hospital/s.

   iv. Compliance of health facilities and providers to licensing, accreditation and certification requirements.

b. Implementation of policies, plans, manuals and other support mechanisms for the organization of the integrated management support systems such as referral system, DRRM-H system, epidemiologic surveillance system, information system, health promotion programs, and campaigns, among others.

c. P/CWHS contracted by DOH and PhilHealth.

d. SHF managed by the P/CHB.

3. Phase 3: Monitoring of the functionality of the integrated local health system.

To track the level of integration of the local health systems, the local health system maturity model shall be used. In addition, the LGU Health Scorecard shall be utilized to monitor health outputs and outcomes.

E. Performance Monitoring and Accountability

For better execution of policies and programs in the DOH, AO 2019-0003 or the F1 Plus Monitoring and Evaluation (M&E) System and related issuances shall be used as a guide to ensure that DOH programs, projects, and activities are being implemented in accordance with the directions and goals of F1 Plus for Health. In addition, a separate order shall be issued by the DOH on the monitoring and evaluation of the integrated local health systems through the local health system maturity model.

VIII. ROLES AND RESPONSIBILITIES

A. Department of Health (DOH)

1. Field Implementation and Coordination Team (FICT) – shall oversee the integration of local health systems through the Centers for Health Development

2. Centers for Health Development (CHDs)

   a. Provide or facilitate the necessary technical support identified in the LIPH, and advocate the development of integrated management systems

   b. Review the LIPH and AOP, and recommend proposals for assistance aimed at strengthening the delivery of health services and integration of the P/CWHS

   c. Monitor the development and implementation of the systems integration through the creation of a core group composed of personnel from CHD units.

3. Bureau of Local Health Systems Development (BLHSD) – shall formulate policies and standards relating to strategic investment planning and strengthening of local health systems

4. The following Central Office Bureaus and Attached Agencies shall focus on the development of standards and guidelines, the establishment of support mechanisms, provision of technical assistance and capacity building activities, and/or monitoring the implementation/ presence of integration characteristics:

   a. Health Emergency Management Bureau (HEMB) for the functionality of the Disaster Risk Reduction Management for Health (DRRM-H) System;

   b. Epidemiology Bureau (EB) for the functionality of the epidemiologic and disease surveillance system;
   c. Health Promotion Bureau (HPB) for the implementation of proactive and effective health promotion programs or campaigns;

   d. Health Facility Development Bureau (HFDB) for the development of health facilities standards and health care provider network service delivery design;

e. Knowledge Management and Information Technology Service (KMITS) for the functionality and interoperability of health information systems;

f. Health Human Resource Development Bureau (HHRDB) for the crafting and implementation of the National Health Workforce Support System, including the HRH Master Plan;

g. Health Facilities and Services Regulatory Bureau (HFSRB) for the development of licensing and regulatory systems for health facilities and services, including that of the primary care facilities;

h. Health Policy Development and Planning Bureau (HPDPB) for the formulation of the national health policies and directions, and integrated health planning and resource allocation;

i. Disease Prevention and Control Bureau (DPCB) for the primary care service packages and standards, delineation of individual-based and population-based health services, and development of clinical practice guidelines, in coordination with medical societies; and,

j. PhilHealth for the formulation of guidelines on benefit packages, standards on HCPN contracting, and establishment and maintenance of SHF utilization tracking system, in coordination with the DOH.

B. Department of Interior and Local Governance (DILG) - shall make available support mechanisms, such as policies, to facilitate the integration of local health systems into P/CWHS. They shall likewise ensure that the monitoring and evaluation of the integrated local health systems are included in the Seal of Good Local Governance.

C. Local and International Health Partners – shall align all their objectives, initiatives, and programs/projects with the integration of local health systems

D. Local Government Units (LGUs)

1. Lead the integration of local health systems into P/CWHS

2. Provide the needed resources, including funds, and support mechanisms to make managerial, technical and financial integration possible and sustainable

3. Ensure proper complementation of efforts at the local level

4. Monitor the development and implementation of the systems integration, together with concerned DOH-CHD

IX. TRANSITORY PROVISION

For local health systems that did not commit to the integration, existing mechanisms shall still be in effect.

X. SEPARABILITY CLAUSE

If any part or provision of this Order is rendered invalid, by any court of law or competent authority, the remaining parts or provisions not affected shall remain valid and effective.

XI. REPEALING CLAUSE

All Orders, rules, regulations, and other related issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XII. EFFECTIVITY DATE

This order shall take effect immediately.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

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MAY 26 2020
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