



**CENTER FOR LEGISLATIVE
DEVELOPMENT**

**Quality issues in the
delivery of health care
services:**

A Policy perspective

A study conducted by:

The Center for Legislative Development - Health Policy Network

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Abstract: Inequities in access to **quality health care** among Filipino patients are glaring. While a few health care facilities in Metro Manila can boast of meeting world class standards on quality care, many others suffer from dire lack of equipment and adequate staff. Such inequity is an extension of the serious imbalance in country's socio-economic development which favors the high income and urban-based population.

As an attempt to reverse this imbalance, Philippine legislators in the 1990's adopted the Local Government Code (the Code) to transfer the control and resources from the Manila-based central government to local government units (LGUs). The country also devolved the mandate and resources for the provision of health care services to the local government units (LGUs). This step created early optimism towards a nationwide and sustainable development. But some now view devolution as the major culprit in the deterioration of health care services as it resulted in the fragmentation of the country's health care system.

This study examines the issues and problems relating to equitable access to quality health care.

The Center for Legislative Development

The Center for Legislative Development is a non-government organization that was established in 1988 as a legislative development and training institution.

CLD is dedicated to the development of policies and legislation that promote equality, development and peace through genuine people's participation in the decision-making process.

CLD has worked on various issues that included local government decentralization and devolution of healthcare.

CLD initiated the Health Policy Network to facilitate sustained discussion among health care stakeholders on policy issues that affect the country's health care delivery system

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Executive Summary

Inequities in access to **quality health care** among Filipino patients are glaring. While a few health care facilities in Metro Manila can boast of meeting world class standards on quality care, many others suffer from dire lack of equipment and adequate staff. Such inequity is an extension of the serious imbalance in county's socio-economic development which favors the high income and urban-based population.

To reverse such imbalance, Philippine legislators in the 1990's adopted the Local Government Code (the Code) to transfer the control and resources from the Manila-based central government to local government units (LGUs). The country also devolved the mandate and resources for the provision of health care services to the local government units (LGUs). This step created early optimism towards a nationwide and sustainable development. But some now view devolution as the major culprit in the deterioration of health care services as it resulted in the fragmentation of the county's health care system.

This study examines the issues and problems relating to equitable access to quality health care. The reports of two internationally renowned quality assurance organizations on Philippine hospitals were reviewed for this current study. The International Nosocomial Infection Control Consortium (INICC) and the International Organization for Standardization (ISO) have earlier evaluated Philippine hospitals using their quality standards for certification.

In 2007, there were two ISO-certified Philippine hospitals - the Makati Medical Center and the National Kidney and Transplant Institute, indicating that they meet international quality standards for hospitals. The public hospital system, however, were cited for lack of efficiency and effectiveness. According to these studies, quality of care has deteriorated in terms of supplies, equipment, infrastructure, and technical quality.

In response, the DOH implemented an upgrading program of 96 LGU and DOH hospitals to meet:

- a. DOH licensing requirements;
- b. standards per category; and
- c. PhilHealth accreditation and subspecialty level as targeted under the Philippine Hospital Development Plan.

Under the program, the DOH upgraded its retained medical centers and regional hospitals in Luzon's subspecialty capabilities in heart, lung and kidney diseases.

The DOH also expanded in 2007 the scope of its hospital regulatory function by controlling the establishment of new general hospitals and requiring the establishment of Continuing Quality Improvement (CQI) Programs and Committees in all DOH hospitals. It also pursued performance-based hospital financing systems and initiated corporate restructuring, fiscal and managerial autonomy.

To strengthen its regional and local epidemiology surveillance capabilities, the DOH embarked on the establishment of the Philippine Integrated Disease Surveillance and Response (PIDSR).

Such institutional efforts according to DOH were marred by problems associated with the:

- a. Mass migration of nurses and doctors;
- b. Decline in health care spending; and
- c. Fragmentation of the country's health care delivery system.

Currently, a number of bills are pending in congress that intending to provide incentives to stimulate the delivery of quality health care in the rural areas. Some bills offer additional benefits to health workers and doctors to encourage them to practice in remote rural areas. Others seek to modernize the health care delivery system by establishing a comprehensive national health facilities program and revise the National Health Code. Other proposals aim to amend specific provisions of the Local Government Code (LGC) to revise the formula that determines the share of local government units (LGUs) in the country's tax revenues while others are advocating the return of devolved hospitals due to lack of funds. To arrest the impact of mass migration of nurses and doctors for better opportunities abroad, some are seeking cooperation from recruiting countries for various forms of paybacks and support programs.

Last year, policy makers took major steps that aimed to make quality health care accessible and affordable to Filipinos, particularly the poor. But already, questions are being raised whether such policy moves could indeed broaden access to a predominantly privatized health care system or would only serve as another dose of mere palliatives with only limited effects.

I. Introduction

A. Background

Despite vigorous health reform initiatives in the past, health authorities acknowledge difficulties in achieving its health care goals for the country.

The devolution of the health services in the early 1990s marked the most radical change that the government did in its attempt to make delivery of health care services more efficient and effective.

The implementation of the Local Government Code of 1992 (LGC) mandated the local government units (LGUs) to deliver health services to their constituents and to raise resources for this purpose so that services are brought closer and more relevant to the people. This prompted the Department of Health (DOH) to re-direct its efforts towards reforms and better coordination of health activities with the local governments.

In 1999, the DOH launched the Health Sector Reform Agenda (HSRA), which defined key reforms and strategies required to address inequity and inefficiency in the health sector.

The HSRA's goal was to improve the health status of all Filipinos through the implementation of reforms in five general areas: public health, hospitals, regulation, financing, and local health systems.

As its overall strategy for health sector reform, the DOH adopted the FourMula One for Health (F1) to achieve better health outcomes, more responsive health system and equitable health care financing.

F1 pursues critical reforms for a more, better and sustained financing, assuring quality and affordability through regulation and ensuring access and availability in service delivery and improving performance and governance. The reforms will contribute to the national goals of (i) increased financial protection for the poor from the costs of poor health, and (ii) improved public health outcomes, and (iii) increased responsiveness of the health system, especially in relation to conditions, diseases and services that are critical for the achievement of the health-related Millennium Development Goals. To realize its goals, the government acknowledged the need to increase investments for health.

B. Study Objectives

This study aims to:

1. Examine the policy issues that impede or facilitate the delivery of efficient, effective and quality health care services; and
2. Explore policy reforms that can best address policy issues in order to achieve efficient, effective and quality health care services

C. The Center for Legislative Development

The Center for Legislative Development is a non-government organization established in 1988 as a policy research and legislative development and training organization. CLD has worked on various issues that included local government decentralization and devolution of healthcare.

Recently, CLD started a network called the Health Policy Network that intends to gather health policy stakeholders for a sustained discussion on policy issues that affect the country's health care delivery system.

D. Framework of the Study

The ideal health system, according to the DOH, is one that is responsive to the needs of the population, especially the poor. The system should provide basic health and nutrition services through strong collaborative efforts of the national and local governments, the private sector and non-government organizations that ensure accessibility of affordable quality health services.

According to the DOH, a measure of a responsive health system is its performance in meeting the people's expectations of how they should be treated by providers of health services. A health system's responsiveness covers respect for the dignity of the person, confidentiality of one's personal health information, and autonomy to participate in choices about one's own health. It also includes appropriate client orientation characterized by prompt attention in the provision of care, amenities of adequate quality, access to social support networks, and freedom to choose a health provider. An indicator of responsiveness includes the degree by which people are satisfied with the performance of the health system and the services it provides.¹

Measures of effectiveness

Accessibility, Availability, Affordability, and Acceptability are often used as measures to describe the effectiveness of health care service delivery.

¹ National Objectives for Health, 2005-2010, Department of Health.

Accessibility. A study by Melchor and associates (2001) defined **accessibility** as the ability of clients to get into a health facility at any time of need. Proximity of a primary health facility to the population and a system that would ensure a referral to an appropriate facility level are essential. An indicator of accessibility is the bed to population ratio. In 1989, the bed to population ratio was 1:707 while in 2005, the bed to population ratio is about 1:1000. More people continued to compete for a hospital bed as the number of government hospitals and facilities further dropped from 702 to 359 while private hospitals also dropped from 1,136 to 595 in 2007.

Proximity of government hospitals to population statistics reveals an unequal distribution of health facilities and hospitals across the regions since most of the government hospitals are located in the more developed regions.

Availability. Availability suggests that the expected health service is obtainable all the time in a given facility. Primary, secondary and tertiary level facilities are expected to have primary, secondary and tertiary level services respectively. Currently, in both national and local government units, 76 percent of the hospitals offer primary health care services. In government hospitals, barely 7 percent and 17 percent offer secondary and tertiary services respectively. Medical supplies (such as drugs and medicines) are available in the hospitals but at cost.

Affordability. Affordability implies that the health services are within the paying capacity of clients. Affordability is a relative concept and depends upon the paying capacity of the patient and the disease condition. A simple illness is a financial burden for a poor man, and for many of them, a catastrophic illness. In government hospitals that provide free care to all its constituents, affordability will not be an issue. But since patients purchase items that are not available in these hospitals, health care in government hospitals is becoming more and more of an out-of-pocket expense and may no longer be affordable to them.

Acceptability. Acceptability indicates that the quality of services is within the defined standards of care based on quality benchmarks as defined by either international or local standards.

Defining quality health care

Based on the foregoing discussion of measures of effectiveness of a health care delivery system, **quality health care** should likewise be characterized as both the **responsiveness** and **acceptability** of health services for all.

Health care policies should stimulate market responses to provide quality health care and enable access for all. And when the market fails, as it has in many instances, the government should be prepared to step in.

II. Review of the Philippine Health Care System

The Philippines health care delivery system consists of both the public and private sectors.

When health care devolution was implemented in 1992, many observed that the public sector health care service delivery became fragmented as the national government transferred to the local government units (LGUs) the mandate, manpower and infrastructure to provide health care services directly to their constituents.

The public sector has three largely independent segments or sets of providers:

- (1) national government providers, which include, hospitals run by national government agencies (e.g., hospitals of the Department of Health and the Department of National Defense), central and regional offices of the Department of Health;
- (2) provincial government providers, which include provincial hospitals, provincial blood banks and the Provincial Health Office; and
- (3) local (municipal or city) government providers, including rural health units or RHUs, city health centers and barangay health stations or BHSs. Each BHS is staffed by a midwife, and each RHU by a doctor, a nurse and midwives. Thus, primary, secondary and tertiary health care services are offered at different levels of the public health care sector.

The private sector in health care is composed of private foundations and for-profit-stock corporations. To a limited extent, non-government organizations (NGOs), and people's organizations (POs) also offer health care services that are mainly traditional and primary.

A. The Department of Health (DOH)

With devolution, the role of the Department of Health (DOH) was transformed from a sole provider of health services to that of a provider of specific health services and technical assistance for health to LGUs.

The DOH is mandated to serve as the national technical authority on health. As such, it is expected to define and formulate programs and strategies that ensure the highest achievable standards of quality healthcare, health

promotion, and health protection, on which local government units, non-government organizations, other private organizations, and individual members of civil society will anchor their own health programs and strategies (Executive Order 102, 1999).

The DOH was also mandated to maintain national health facilities and hospitals with modern and advanced capabilities to support local services. These health facilities and special hospitals should provide technical support to all rural health centers.

The DOH's current vision is to be "The leader of health for all in the Philippines". Its mission is to "guarantee equitable, sustainable and quality health for all Filipinos, especially the poor, and to lead the quest for excellence in health". The DOH had three major goals, namely: (1) better health for the entire population; (2) efficient and effective healthcare system; and (3) equitable health care financing.

'Formula One for Health' is DOH's current program of health reforms to achieve the three primary health goals. Vital reforms are organized into four major implementation components: health financing; health regulation; health service delivery; and good governance in health.

Formula One for Health has four general objectives: (1) health financing, to secure increased, better and sustained investments in health to provide equity and improve health outcomes, especially for the poor; (2) health regulation, to assure access to quality and affordable health products, devices, facilities and services, especially those commonly used by the poor; (3) health service delivery, to improve the accessibility and availability of social and essential health care for all, particularly the poor; and (4) good governance in health, aimed at improving health systems performance at the national and local levels.

As a result of devolution, the DOH relinquished its control of health care resource allocation functions.

The DOH retained control over the regional offices and health centers. The Bureau of Food and Drug (BFAD), the national agency responsible for the regulation of drugs and medicines, also remains under the administration of the DOH.

B. Local Government Units

The role of the LGUs in health care delivery had become more pronounced under a devolved set up. The LGUs became the main provider of health services and were made responsible for the operation of health facilities. The Philippines has 79 provinces, 1,496 municipalities, 117 cities and 42,435 barangays (DILG, 2007). The delivery of health services at various levels are shown below:

- a. Provinces – Provincial Health Offices; District Health Offices; Provincial Hospitals; and District Hospitals
- b. Cities – City Health Offices; City Hospitals and Rural Health Units
- c. Municipalities – Barangay Health Stations

With the bulk of expenditures in health transferred to LGUs, the problem now lies in the generation of financial resources to support these obligations. In this devolved setup, local units are assigned revenue-raising powers to source the financing of their responsibilities and obligations. The LGC expanded the assigned specific tax bases for LGUs. In principle, LGUs have the option of increasing their spending by raising their own tax revenue.

The Internal Revenue Allotment (IRA) is given to the LGUs to augment the budget of the local unit or to ensure a budget for the minimum deliverables of the LGUs. With all these financing options, LGUs are expected to be able to operate effectively and to efficiently provide the basic services devolved to them. LGUs are to act as economic managers, using their resources and capacity to provide social services for their people. They are expected to be self-reliant, sustainable, and financially independent from the national government.

C. The Private Sector

The private sector consists of a wide range of privately operated facilities, such as pharmacies, physicians in solo or group practices, small hospitals and maternity centers, diagnostic centers, employer-based outpatient facilities, secondary and tertiary hospitals, traditional birth attendants and indigenous healers. The private sector includes individual and corporate establishments engaged in health-related activities such as clinics, hospitals, health maintenance organizations (HMOs), pharmaceuticals and other health-related products. Private providers are predominantly located in highly urbanized areas.

Religious and socio-civic group, cooperatives, and educational institutions identified as NGOs number more than 500 and are mostly engaged in community-based activities, with health programs as either the main work focus or one of the components of integrated development initiatives. There were around 200,000 traditional healers and around 5.65 traditional medicine practitioners per barangay.

III. Measures of Quality of Health Care Service Delivery

The DOH has categorized the primary, secondary and tertiary levels of health care into two major health service delivery areas. These are the hospital services and the public health services. This study initially focuses on the quality of health care service delivery in hospitals.

A. The Philippine Hospital System

The hospital system, as an integral part of health care delivery in the Philippines, is composed of the public and private hospital sectors, classified into primary, secondary and tertiary levels according to their service capabilities. Reforms in the hospital sector are directed towards the development of a Philippine Hospital System that includes 1,127 licensed hospitals, of which, 1,061 are private hospitals and 66 are government owned. Among the government hospitals, 72 are DOH hospitals, 5 are military hospitals and 590 are local government hospitals. Total hospital beds in the Philippines is 85,040 with 45,395 (53 percent) of these beds in government hospitals. The 72 DOH hospitals have a total number of beds reaching 23,755, about 28 percent of the total beds in the country (BHFS 2003).

The country has an average ratio of 1,000 people per hospital bed. Based on the licensing report on the number of beds according to category of health facilities, the government owns most of the beds in infirmary facilities and in the first and third level referral hospitals while the private sector owns most of the beds in birthing homes, second level referral hospitals, and acute, chronic and custodial psychiatric care facilities.

Past efforts to integrate the dual hospital system into a cohesive one has not been successful. The interface between the public and private hospital systems needs to be further elucidated and the areas of engagement strengthened.

B. Measures of Quality

Hospitals that aim for quality health care go through rigorous procedures using internationally acceptable standards. Some forge partnerships with external agencies that had gone through thorough licensing and accreditation to ensure that they could carry out the task of delivery of quality health care. To accredit partners, a list of requirements is presented to the medical institutions to check their capability to deliver optimal health care on a consistent basis. Their record on improvement, experience and attainment of expertise are examined to ascertain their achievement levels.

The Department of Health (DOH) is tasked to grant licenses to hospitals

according to service capabilities on an annual basis. Specialized bureaus of the DOH check compliance with standards on personnel, equipment and physical environment.

The Philippine Health Insurance Corporation (PHIC) accreditation enables participation in the National Health Insurance Program and claim reimbursements for health services rendered to eligible members. Requirements for PHIC accreditation include DOH licensing for the past three years, acceptance of NHIP programs on quality assurance and utilization review and operation of Internal Quality Assurance Programs, Therapeutics committee and Infection Control Committee.

Accreditation by the Joint Commission International is recognized as a gold seal of service quality and patient safety. It is granted by the international affiliate of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the agency charged with accrediting US hospitals.

Recognition in the international arena is also provided via ISO 9001 Certification, an international quality management framework that is applied to hospitals as a whole or to component service units of institutions.

On the part of the medical practitioners, licensing for doctors, nurses and other staff is provided by the Philippine Regulatory Commission while specialty certifications are provided by individual specialty societies. A systematic approach to assess a medical doctor's professional competence and conduct is through credentialing which includes a review of relevant academic training, experience, licensure, certification and registration to practice. Another method is through privileging which is the process by which a hospital determines what procedures may be performed and which conditions may be treated by each physician, based on his established qualifications. These credentialing and privileging mechanisms ensure the continuing technical proficiency of and adherence to ethical standards by medical doctors, and thus, promotes the quality and safety of patient care.

Externally and internally-driven Quality Improvement (QI) programs prompt the improvement of the design, documentation, implementation and monitoring of hospital processes and their efficiency. QI programs are initiated by external regulatory agencies like the PHIC and through institutional collaboration with the Philippine Society for Quality in Healthcare (PSQua).

Within the medical organizations, the conduct of peer audits, sentinel event monitoring, the tracking of Hospital Quality Indicators and launch of Quality Circles are ways by which self-improvement are undertaken.

Another indicator of quality is patient participation. As vital partners for growth and quality management, Patient Education Programs are carried out, empowering patients to demand quality service and safety. Feedback mechanisms through e-newsletters and web-based forums are new venues for active engagement of patients in the care process. Other forms used in Patient Rights Programs are individual counseling and group sessions.

Country Performance in the Achievement, Maintenance and Continuous upgrading of Quality Health Care

The following assessments were taken from various reports and studies that reveal positive and negative marks in the delivery of health care in the country.

International Nosocomial Infection Control Consortium (INICC)

The International Nosocomial Infection Control Consortium (INICC) used a sampling of Philippine hospitals to track infection rates. The sampling revealed favorable results as it indicate the Philippine hospitals in the lower range, an excellent indicator of patient care and safety.

From an INICC low of 1.7 to a high of 12.8, sample Philippine hospital scored a low of 1.9 in the monitor for Foley catheter-associated infection. From an INICC low of 7.8 to a high of 18.5, the studied hospital manifested a low 8.9 in blood stream infection. In ventilator-associated infection, with a low of 10.0 and a high of 52.7, the count for the model hospital was 13.2.

Joint Commission International:

In 2003, St. Luke's Medical Center became the first accredited hospital by the Joint Commission International (JCI), the international arm of the US-based Joint Commission for the Accreditation of Healthcare Organizations. The accreditation puts this Philippine hospital at par with the best in the world.

ISO certification

As of 2007, there are two ISO-certified Philippine hospitals - the Makati Medical Center and the National Kidney and Transplant Institute. Accreditation with the two groups is currently being sought by other Philippine medical institutions.

The 18 Health Maintenance Organizations (HMOs) operating since 1981 has also made quality health care a major goal. Awareness of hospitals of length-of-stay issues from HMOs and the Philhealth has upped the bar for efficiency in processes. It has also affected hospital compliance with documentary requirements for speedy claims processing.

Disparate quality and cost, patient preferences

However, a study² on efficiency and effectiveness of the public hospital system found disparities between public and private hospitals. The study made in 2000 revealed that the average length of stay for DOH and LGU facilities at all levels are longer than in similar private facilities.

The DOH and LGU facilities tend to have more medical and non-medical personnel. The ratio of medical to non-medical personnel is 1:5 in DOH tertiary facilities (1:3 in private tertiary facilities). The average cost per patient day in DOH and LGU primary and secondary facilities are higher than in similar private facilities.

The Filipino Report Card (World Bank 2000) showed that among 1,200 sample households, respondents ranked private facilities as superior on quality aspects, at par with government facilities on convenience of location, and not as good on patient cost aspects (cost of medicines and supplies, cost of treatment, and flexibility of payment). This implies that patient cost is the only categorical advantage of government facilities over private facilities. In terms of client satisfaction, the Report also states that “overall satisfaction” or “appreciation” of health facilities was significantly higher for private facilities than government. Government hospitals get higher ratings from rural areas and among the lower classes.

In general, the following could explain the perceptions noted by the respondents in the above report:

1. poorly equipped and poorly staffed local government hospitals (provincial and district hospitals);
2. congested regional and national hospitals (due to patients by-passing primary and secondary level facilities);
3. inadequate hospital networking and patient referral systems;
4. heavy reliance on direct subsidies from national and local governments; and
5. uncoordinated implementation of public health programs in hospitals (HSRA Monograph 1999).

While there are a number of leading government hospitals offering quality specialized services, particularly in urban areas like the NCR, the private hospital sector is generally perceived as more advanced and client-centered, thus much of the reform efforts in the past focused on developing and upgrading systems among government hospitals to make them more responsive to their clients' needs and expectations.

² Solon, Fajutrao, C. Tan, and C. Almario, *Quality, Cost and Competitiveness of Government Hospitals (2000)*

In another study³, the impact of devolution on the quality of health was examined and found that:

1. Quality of care declined in terms of supplies, equipment, and infrastructure because of decreased funds for maintenance and other operating expenses (MOOE) and almost nonexistent funds for capital outlay
2. Devolved hospitals have deteriorated, due to rising costs
3. Regional and national hospitals, owing to the unmet health demands at the local level, are congested
4. Networking and patient referral systems between national and local, and between public and private, hospitals are inadequate.
5. Government hospitals still rely heavily on direct subsidies from national and local governments,
6. Only one-third of the total number of hospitals and about one-half of hospital beds are public.

IV. National Objectives for Health

Accomplishments Prior to the NOH

The objectives of hospital reforms of the DOH focused on addressing the disparity between public and private health facility performance as well as rural-urban inequities. Towards these ends, the DOH implemented the following prior to the implementation of the F1:

1. Rational upgrading of LGU and DOH hospitals, which includes upgrading of equipment in selected provincial and district hospitals, and the upgrading of selected DOH regional hospitals and medical centers to sub-specialty capabilities in heart, lung, and kidney diseases.
2. Expanding hospital financing mechanisms to ensure fiscal autonomy for government hospitals, such as the expansion of revenue enhancement and income retention and improvements in hospital financial management systems.

Ninety per cent of DOH hospitals and some LGU hospitals like Pangasinan Provincial Hospital, Misamis Oriental Provincial Hospital, Bukidnon DOH regional hospitals and medical centers Provincial Hospital, Silay Provincial Hospital, carried out the following revenue enhancement strategies:

³ Cielo Magno (2002)

- Establishment of revolving funds from revenue generating areas (e.g. pharmacy, laboratory);
- Increase PhilHealth reimbursements by advocating voluntary and NGO sponsored enrollment and making the hospitals attractive to PhilHealth members (in 2004 , 46 percent of the total MOOE of DOH hospitals was reimbursed from PHIC);
- Generate income from private wards;
- Implementation of proper patient classification to identify truly indigent patients as recipients of government subsidy or private sector sponsorship;
- Establishment of innovative income generating activities that are non-patient care sources such as renting out available spaces for medical clinics or commercial establishments
- Resource sharing with LGUs (e.g. city government subsidies)

Income retention was implemented in DOH hospitals since 2003 through a special provision in the annual General Appropriations Act. This strategy has resulted in a 20 percent increase of income compared with the preceding year in 33 out of 68 DOH hospitals, raising a cumulative income of 1.2 billion pesos from January to December 2003 (NCHFD). In 2004, cumulative hospital income reached 1.5 billion pesos or an increase by 25 percent compared to previous year's income.

Among local government hospitals, varied strategies are employed through the resolutions of their respective Sangguniang Panlalawigan. The provincial hospitals in Pangasinan and Misamis Oriental were allowed to retain their income above a set target, the provincial hospital in Capiz was allowed to place income in a trust fund while Bulacan Provincial Hospital was allowed to retain income but budget was not increased.

3. Restructuring LGU hospitals into a corporate set-up was undertaken in La Union Medical Center and Benguet General Hospital with DOH technical assistance.

4. Strengthening government and private hospital networking toward a Philippine Hospital System.

There are some existing public-private networks for patient referrals. St. Luke's Medical Center and National Children's Hospital in Quezon City have an agreement to share in the use of specialized diagnostic equipment. Other hospital networks were formed for training and research, like those involving the Iloilo Provincial Hospital and the Iloilo Doctor's Hospital, and the hospital network of the Metro Manila DOH hospitals.

Through the Integrated Community Health Service Program (ICHSP), the DOH developed a manual on the Inter-Local Health District Referral System. The manual offers the standard two-way referral system which is now institutionalized in six ICHSP pilot provinces in various regions.

5. Integrating public health program concepts into hospital services by creating a Public Health Unit in 13 hospitals to coordinate all the public health programs being implemented in their hospitals.

Majority provided comprehensive health care services that included promotive and preventive health services through the implementation of the hospitals as Centers of Wellness Program. The revenue enhancement program has greatly contributed in converting a number of hospitals into Centers of Wellness specifically in the context of a clean and green and culture friendly hospitals. Likewise, the Mother-Baby Friendly Hospitals Initiative (MBFHI) is being continued. In the year 2002, there were 1,427 MBFHI certified hospitals, 757 (68 percent) out of the 1,110 private hospitals and 670 (98 percent) out of 686 government hospitals.

According to the DOH, the enabling factors that facilitated the attainment of the above hospital reforms are: (1) political will of local chief executives; (2) effective managerial skills of hospital chiefs; (3) government hospital's felt need to survive fiscal difficulties; (4) support of the private sector to government initiatives; and (5) strong sense of social responsibility.

However, despite these positive developments, there remain to be major challenges that would affect the expedient and effective implementation of reforms in the hospital sector. Some of the challenges identified are the following:

1. Establishing legal mandate for structural reforms.

A number of legal options were explored (i.e. passage of congressional legislation and executive orders), however, appropriate adoption or approval has yet to be realized. For instance, in May 2004, the Executive Order for the conversion of ITRMC and QMMC into a government owned and controlled corporation was presented to the Presidential Committee on Effective Governance (PCEG). The Committee referred the issue to Congress for the amendment of the hospital's legal charter.

2. Change management challenges for the required reforms.

This includes overcoming unfounded fears on threats to security of tenure or plain resistance to change on the part of health workers and providers.

3. High cost and limited technical expertise for hospital reforms.

The government has no funds to address needed upgrading in infrastructure, equipment and manpower. To illustrate, the cost of backlog and proposed infrastructure projects of DOH hospitals is about 3 billion pesos. This includes projects under the 2004 Zero Infra Backlog, Fire Safety Projects for compliance with the Fire Code of the Philippines and the proposed mental health facility projects (NCHFD 2004). The cost of unimplemented laws regarding upgrading, re-nationalization and establishment of hospitals is 4 billion pesos (NCHFD2005).

Most DOH hospitals monitored were not able to implement their action plan pertaining to hospital reforms due to inadequate technical knowledge or skills. Most of the hospitals that were provided with technical assistance were the ones able to accomplish their plans.

4. Difficulties in establishing an integrated hospital information system for efficient and effective planning and decision-making.

The NCHFD has the mandate to develop mechanisms for the improvement and standardization of definitions, recording, collection and reporting of hospital statistics from the national and local government and private hospitals. The Integrated Hospital Operations and Management Program (IHOMP) is a computerized routine data collection system linking patient-based information with hospital performance indicators to better aid research, training, service, planning, policy formulation and decision-making. It is envisioned to link with the different service components of the hospital to facilitate a more systematic cost analysis of hospital service delivery for better implementation of quality management programs. The NCHFD required the implementation of these manual standards prior to the use of the computerized version of said standards which is the Hospital Operations and Management Information System or HOMIS. The use of the HOMIS has been limited to DOH and some LGU hospitals due to budgetary constraints. The lack of information on aggregate hospital incomes (broken down into various sources) has led to an inaccurate picture of health service status in the country and inefficient hospital planning and budgeting as well as inappropriate costing and pricing of services.

The NOH for the Delivery of Services in Hospitals

The DOH goals and targets in the delivery of hospital services are shown in the Table below:

Goal: An efficient, effective and integrated delivery system for hospital services to achieve better and equitable health outcomes is instituted

National Objectives for 2005 - 2010

Objective	Indicator	Target	Baseline Data and Source
Client-responsiveness and quality of service in hospitals are improved	Percentage of clients satisfied with health services in public hospitals	70 percent of clients	59 percent of clients <i>3rd Quarter 2005 Social Weather Station Report</i>
	Percentage of public and private hospitals compliant with DOH standards for Continuous Quality Improvement (CQI)	70 percent of hospitals complying with 80 percent of the DOH standards for CQI	To be determined
	Percentage of public and private hospitals with PhilHealth accreditation	Not less than 93 percent of government hospitals	93 percent of licensed public hospitals
		Not less than 89 percent of private hospitals	89 percent of licensed private hospitals <i>PhilHealth 2004</i>
Access to specialized services in sub-national health facilities is improved	Number of Clinical Practice Guidelines (CPGs) developed and linked to hospital financing	40 CPGs (10 each for 4 major specialty areas)	9 CPGs <i>NCHFD, 2003</i>
	Number of specialized centers/services established in public hospitals	5 regional hospitals and medical centers with subspecialty capabilities in heart/lung/kidney diseases are developed 5 national reference laboratories for different specialized fields are operationalized Development of national and sub-national blood centers, trauma centers, burn centers and cancer centers is initiated	
	Utilization rate of specialized health services among indigent sector	To be determined	To be determined
Efficiency in public hospitals is improved	Percentage of public hospitals implementing performance-based financing scheme for patient care services and activity-based financing for special programs	100 percent of DOH hospitals and at least 50 percent of ILHZ core referral hospitals in convergence sites	To be determined
	Percentage of public hospitals implementing proper costing and pricing of health goods and services	100 percent of DOH hospitals and at least 50 percent of ILHZ core referral hospitals in convergence sites	14 DOH hospitals and 3 LGU hospitals are implementing unit costing <i>NCHFD, 2004</i>
Governance of public hospitals is effective	Percentage of public hospitals with corporate restructuring mechanisms	72 DOH hospitals 17 Provincial hospitals	4 specialty hospitals 1 LGU hospitals <i>NCHFD, 2004</i>

Quality issues in delivery of health care services: A policy perspective

	Percentage of public hospitals with fiscal autonomy	100 percent of DOH hospitals and 50 percent of provincial/district hospitals in convergence sites	100 percent of DOH hospitals and none among LGU hospitals <i>NCHFD, 2004</i>
	Percentage of public hospitals with rationalized hospital development plan	100 percent of DOH hospitals and 100 percent of convergence sites	2 DOH hospitals with rationalized hospital development plan <i>NCHFD, 2004</i>
A seamless healthcare delivery system is ensured	Integrated two-way referral system among public-private and national-local health facilities	100 percent of DOH hospitals and at least 50 percent of ILHZ core referral hospitals in convergence sites with integrated two-way referral system	1 DOH hospital have two-way referral system NCR DOH hospitals have an established networking system <i>NCHFD, 2003</i>
	Integrated hospital database network and reporting system	All DOH hospitals and all convergence sites have unified hospital database network and reporting system	17 DOH Hospitals and 20 LGU Hospitals are implementing Integrated Hospital Operation and Management Program <i>NCHFD, 2003</i>
	Integrated public health concepts in hospital care services	All hospitals (DOH, LGU and private hospitals) in all convergence sites implements a comprehensive health care services that included promotive and preventive health services	Mother Baby Friendly Hospital Initiative was fully implemented in 68 percent of private hospitals and 98 percent of government hospitals in 2002. <i>NCHFD, 2003</i>

Strategic Thrusts for 2005-2010

- **Rationalizing and upgrading provincial and district hospital facilities and services** in parallel with developments in regional and national hospitals
- **Expanding performance-based hospital financing systems** in national and local government hospitals
- **Pursuing corporate restructuring, fiscal and managerial autonomy or other appropriate institutional and organizational structures** to improve governance and financing mechanisms of national and local government hospitals
- **Enhancing hospital networking and referral system** encompassing public-private as well as national-local inter-phasing of health services
- **Expanding integration of appropriate public health concepts into hospital services**

Progress of F1 Implementation

In its annual report, the DOH reported the following accomplishments in the implementation of F1 in 2005-2007:

1. Rationalizing and upgrading hospital facilities and services

Several foreign assisted projects are being implemented to help in the development of the different national health facilities which include upgrading of hospital facilities to: (a) meet DOH licensing requirements; (b) meet standards per category; (c) meet PhilHealth accreditation and (d) subspecialty level as targeted under the Philippine Hospital Development Plan. One of these projects is the Hospital Development Project, an Austrian funded project, which entails supply of equipment to selected hospitals.

As of the end of 2005, there were 96 recipient hospitals, 50% of which were LGU Hospitals. Continuous monitoring of preventive maintenance scheduled

in all regions is also being done. The upgrading of Emergency Rooms of 35 re-nationalized DOH and selected LGU hospitals was done through the upgrading of selected hospital equipment. 14 of said hospitals have undergone complete delivery, installation and commissioning of said equipments. Delivery and installation of equipment for the upgrading of the Zamboanga City Medical Center, Zamboanga del Sur Provincial Hospital and Margosatubig Regional Hospital, under the auspices of the Spanish Government were also completed.

The “Development of Subspecialty Capabilities in Heart, Lung and Kidney Diseases in Selected DOH Medical Centers/Regional Hospitals in Luzon, Visayas and Mindanao” aims the following: (a) developing regional counterparts of the Philippine Heart Center, National Kidney and Transplant Institute and the Lung Center of the Philippines, (b) installation of the remaining equipment (MRI, bi-plane catheterization laboratory, mobile C-arm), and (c) training of CathLab team from Davao Medical Center at the Philippine Health Center which is ongoing. The program completed the installation of 40 slices of CT scan, Gamma Camera and single plane catheterization laboratory diagnostic xray for angiography at the Phil Heart Center. Sites preparation at the Vicente Sotto Medical Center, Bicol Regional Teaching and Training and Davao Medical Center are ongoing. Ambulances were also turned-over to 72 DOH hospitals. In 2007, there is an ongoing hospital upgrading of 15 DOH and four military hospitals amounting to Php 285 million and Php 45 million for 43 LGU hospitals. Evaluation of three LGU hospitals for upgrading from primary to secondary care and ten LGU and two military hospitals from secondary to tertiary care with a total funding requirement amounting to Php 300 million was done.

In 2007, a total of 22 MOA between LGU Hospitals and DOH-CHDs regarding hospital upgrading was reviewed. The DOH expanded the scope of hospital regulation by controlling the establishment of new general hospitals through the institution of the Certificate of Need as a requirement for the issuance of a permit to construct and LTO to promote geographic access to hospital services and to maximize the use of limited health resources. The implementation of Quality Improvement Program in the delivery of health services is embodied in the draft AO which will require the establishment of Continuing Quality Improvement (CQI) Programs and Committees in all DOH hospitals. CQI in DOH health facilities will ensure all stakeholders the availability of quality and cost effective health services through a qualified, diverse and multidisciplinary network of services in DOH hospitals.

Since 2002, all DOH hospitals have been allowed full income retention and utilization as initial steps towards fiscal autonomy. With the continuous implementation of a Special Provision in the General Appropriations Act, DOH hospitals generated a total of P1.489B in CY 2004 as compared to

P1.182B in 2003. This amount is expected to increase by 14% in 2005. The use of hospital income had contributed significantly to a more responsive delivery of quality health services since funds are readily available for day-to-day operations and the purchase of hospital equipment, as well as priority projects for hospital infrastructure development. Parallel to these activities on hospital reforms, correlated activities are continuously done to ensure that the DOH policy on social responsibility for indigents and safeguarding patient's rights are being enforced.

The DOH continues to augment the human resources for health of the LGUs through the following programs: A total of 134 scholars under the Pinoy MD Medical Scholarship Project are currently enrolled in various medical schools (52 for Academic Year 2006-2007 and 82 for Academic Year 2007-2008); a team (one surgeon and one anesthesiologist) was deployed in Bohol Hospital under the Specialists to the Province Program was implemented to facilitate the deployment of Medical Specialists to the hospitals of the LGUs; a total of 101 Medical Specialist II and 48 Medical Specialist III deployed in various hospitals nationwide under the Medical Pool Deployment Program and a total of 56 Rural Health Physicians were also deployed to doctorless municipalities under the DTTB Program.

A. Enhancing hospital networking and referral system

For 2005, 24 DOH retained hospitals and 4 LGU hospitals were assessed for IHOMP-readiness. Among the DOH hospitals, 4 were installed with HOMIS Module I and are maintaining the operation of the software, 6 were recommended for installation of Module I, and 14 were subject to revisit. Subsequently, only 3 of the recommended 6 hospitals were able to have Module I installed, the 3 others were not able to install the system due to budgetary

constraints for the procurement of required hardware. The LGU hospitals were subject for revisit to determine their readiness for the implementation of the system. In 2007, only two LGU provincial hospitals of tertiary care categories were assessed to determine its readiness for the implementation of the HOMIS.

B. Expanding integration of appropriate public health concepts into hospital services

Groundwork activities for the establishment of the Philippine Integrated Disease Surveillance and Response (PIDSR) System was done in 2005 to strengthen the regional and local epidemiology surveillance capabilities. Likewise, the Field Health Service Information System (FHSIS) which is a vital health data source was being strengthened. To prepare the country for

infection control, a National Standard on infection control that is followed and implemented by all health care facilities was needed.

In 2005, preparatory activities for the establishment of the Hospital Infection Control Program were conducted: Standards in Infection Control for health care facilities were finalized, printed, published and presented before the Philippine Hospital Association; Tools for hospital infection control for administrators and health care workers were also formulated; Draft standards underwent review by stakeholders; Hospital Survey and Needs Analysis, planning and training preparation; Training on “The Impact of Emerging and Re-emerging Infectious Diseases on Hospital Infection Control and Occupational Health and Safety.”

In 2007, the PIDSIR was initiated through the AO No. 2007-0036 to harmonize and strengthen the various infectious disease surveillance systems in the country and respond effectively to the threat of emerging and re-emerging infectious diseases. The PIDSIR guidelines included strengthening and establishment of Regional and Local Epidemiology Surveillance Units, renewal of hospital license, infectious diseases reporting and development of the manual of operating procedures. To strengthen the FHSIS, workshop was conducted to come up with guidelines, identification of a national minimum data set requirement, establishment of data collection, flow of reporting and identification of the core set of indicators.

In 2004, Administrative Order No. 168 “The National Policy on Health Emergencies and Disaster” was issued to guide the health sector in ensuring preparedness and response during emergencies as well strengthen its capability to respond during disasters and emergencies. A draft IRR for this issuance was developed in 2005 which included the following: a) Directory of Services for Emergency Management/Disaster, b) Organizational Chart of Disaster Management Plan applicable to any hospital, c) Statistical Report on Disaster Management, d) Assessment of Health Facility in Securing and Protecting Critical Infrastructure, e) List of Drugs and Equipment for Major Disasters and Resource List for Chemical Disaster, f) Standard Design for Specialized Area, g) Essential Equipment needed in Emergency Room. A meeting with other offices (HEMS, BHFS, BHDT, NCHFD) on the delegation of roles and responsibilities was also conducted.

The organization, integration and coordination of the entire health sector for emergency/disaster preparedness, providing and augmenting the necessary logistic resources for effective and efficient response were done. Full operation of the 24-Operation Center which monitors, coordinates and facilitates immediate response to health related emergencies and disasters was maintained by monitoring 593 emergencies and disasters from January to December 2007. Issuance on the AO No. 2007-0018, National Policy on

the Management of the Dead and Missing Person during Disasters and Emergencies, that serve as a guide to an efficient and well coordinated action in managing dead and missing persons during emergencies and disasters was approved and a manual of operation was being finalized. The resolution concerning the Issuance of Certificate of Presumptive Death for Missing Persons during Disasters which will facilitate the issuances of necessary certificate required for the processing of claims of benefits for the bereaved families during emergencies and disasters was developed and submitted to the National Disaster Coordinating Council.

The Health Promotion (HP) Plan which addresses information, education and communication part of the specific delivery package, identified activities that would create the supportive environment, encourage stakeholders, community participation and standardize or improve service delivery was developed. A task force was organized to work for the creation of a HP Foundation, access funds from the sin tax and develop criteria for the selection of projects to be funded under the foundation.

V. Issues and Policy Initiatives

Mass Migration of Nurses and Doctors

The mass exodus of nurses and doctors overseas threatens to cripple the country's health system. More than 100,000 nurses have left since 1994. Over the past six years, thousands of doctors have left, lured by high salaries overseas and pushed by political and economic instability at home. Government figures report that 2,908 Filipino nurses left for 21 countries in the first quarter of 2002. In the previous year, 13,536 nurses left for 31 countries. The annual outflow of Filipino nurses is now three times greater than the annual production of licensed nurses of 6,500 to 7,000 year. Some say much more than 14,000 leave each year for better pay and opportunities.

With fewer doctors and nurses, people complain of long waits to get treatment. More women must give birth without the help of a doctor, nurse or midwife. In the provinces, treatable emergencies such as meningitis or strokes are often fatal, because there are no specialists to treat them. In Zamboanga del Norte, the wealthy travel hundreds of kilometers to bigger cities to seek treatment for life-threatening illnesses. Because of the distance, however, some do not survive the trip.

The exodus of nurses is not expected to let up because demand from developed nations is increasing, as their populations grow older. The government also encourages Filipinos, including medical professionals, to

work abroad, because they send back billions of dollars to the country annually.

A number of policy experts have sounded off the alarm regarding future impact of the current wave of health workers' exodus.

Concern is also rising about a shortage of quality nurses in the Philippines. According to Dr. Marilyn Lorenzo, a professor at University of the Philippines College of Public Health, there are enough number of nurses in the country, but there is a shortage in terms of quality. The ones who leave are the skilled and experienced nurses. Most of those who continue to remain are relatively unskilled and inexperienced, and are expected to go overseas after a year or two of gaining experience. This poses serious implications for the quality of health care that they provide.

In the Philippines, there are only about 33,000 nurses employed. The government is the single biggest employer of nurses and pays better than private hospitals, but it has not opened new positions and average nurse-to-patient ratios are far from ideal - 1:30 to 1:60.

Overseas, the monthly pay for nurses ranges from 3,000 to 4,000 U.S. dollars a month, compared to the 169 dollar average pay in most Philippine cities. In rural areas, nurses receive lower, ranging from 75 to 95 dollars a month.

As a result of migration, former DOH undersecretary Dr. Jaime Galvez Tan said that at least 200 hospitals closed in the Philippines over the past five years and 800 more hospitals partially closed, one wing or one ward each. Most of these hospitals were in the poorest districts of the country. The reason is simply that the registered nurses and doctors left the hospitals. As a result, Filipinos dying without medical attention reverted back to its 1975 level of 70 percent.⁴

Declining Health Spending

Since 1999, national health care spending continued to increase in nominal terms but there was a decline in the percentage share of total government spending on health. The total health expenditure of the country reached P180.8 billion in 2005, growing at a slower rate of 9.4 percent compared to 11.9 percent growth in 2004. The share of health expenditure to GDP was lower at 3.3 percent in 2005 and still below the 5 percent standard set by the World Health Organization (WHO) for developing countries. On the other hand, the share of health expenditure to GNP remained at 3.1 percent which is within the National Objectives for Health (NOH) target of 3-4 percent.

⁴Dr. Jaime Galvez Tan, Former Undersecretary of the DOH, 2006.

Subsequently, the share of government on health expenditure declined to 29 percent which is below the target of 40 percent based on the Health Sector Reform Agenda (HSRA). Also, the government's target to depend less on out-of-pocket payments and provide more social health insurance is still far from being realized as the share of out-of-pocket payments even increased to 49 percent while the share of social insurance payments increased only slightly to 11 percent in 2005. Based on the HSRA, the target for out-of-pocket is 20 percent while the target for social insurance is 30 percent.

The share of the local government in health care spending continued to increase in nominal terms after the devolution, particularly starting in 1993. The local government expenditures increased in nominal terms from 7.0 percent of total government expenditures in the 1985-1991 period, to 14.7 percent in the 1992-1997 period. However, subsequent years show that local government spending on health declined. Recent figures reveal that spending declined by 6.1 percent or around Php1.5 billion in 2005. Declines were noted in all the uses of fund - personal health care, public health care and other services. Expenditure on public health care remained the largest share of local government expenses on health at 46.5 percent.

The share of local governments in health expenditures has increased right after devolution. However, the LGUs are spending less than what the national government used to spend for local health services before devolution. Such reduction in spending in health resulted to a marked decline in the quality of health services.

Sources of Healthcare Funds in the Philippines

SOURCE OF FUNDS	AMOUNT (in million pesos)		% Share to Total	Growth Rate (in percent)
	2004 ^{1/}	2005		
GOVERNMENT	50,792	51,922	28.72%	2.2
National	26,019	28,651	15.85%	10.1
Local	24,772	23,271	12.87%	(6.1)
SOCIAL INSURANCE	15,935	19,899	11.01%	24.9
PhilHealth (Medicare)	15,481	19,253	10.65%	24.4
Employees' Compensation	454	646	0.36%	42.4
PRIVATE SOURCES	96,616	106,848	59.11%	10.6
Out-of-Pocket	77,524	87,508	48.41%	12.9
Private Insurance	4,084	4,344	2.40%	6.4
HMOs	7,079	7,082	3.92%	*
Employer-Based Plans	5,903	5,755	3.18%	(2.5)
Private Schools	2,026	2,158	1.19%	6.5
OTHERS	1,953	2,102	1.16%	7.7
ALL SOURCES	165,295	180,772		9.4

1/ Revised
* Less than 0.1 percent

Source: National Statistical Coordination Board

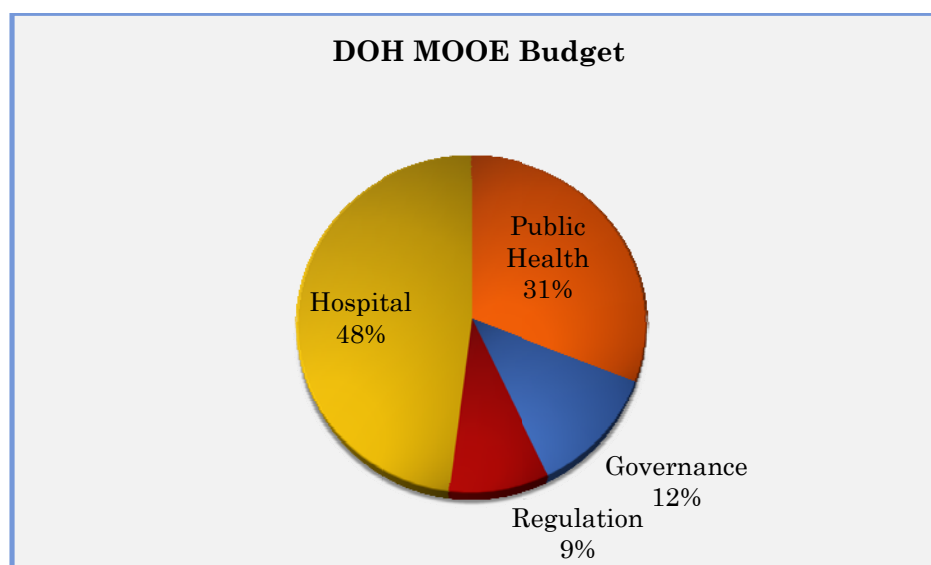
On the other hand, the national agencies received decreasing budget allocations since 1998. However, budget increased in 2002. The 2007 DOH budget is P11.4B, an increase of P1.9B compared with the CY 2006 budget. The spending of DOH and its attached agencies decreased by 10.8 percent, from Php15.4 billion in 2004 to Php13.8 billion in 2005. Consequently, spending on public health care increased by 16.8 percent while spending on personal health care and other services exhibited declines of 13.4 percent and 19.8 percent, respectively in 2005.

Expenditure of DOH Agencies by Use of Funds

Year	AMOUNT (in million pesos)				PERCENT SHARE		
	Personal	Public	Others	TOTAL	Personal	Public	Others
2004 ^{1/}	10,204.7	2,034.8	3,185.7	15,425.2	66.2	13.2	20.7
2005	8,833.8	2,375.8	2,554.9	13,764.5	64.2	17.3	18.6
2004-2005 Growth Rate	(13.4)	16.8	(19.8)	(10.8)			

Source: Department of Health
1/ Revised

Provision of hospital services continues to get the biggest share of the MOOE budget. For 2007, Hospital Services get 48%, Governance gets 12%, Public Health 31%, and Regulation 9%. Health facilities are costly to maintain and the DOH has 67 retained and renationalized hospitals being managed and maintained nationwide.



Re-nationalization of some hospitals

Despite the extensive devolution that took place in the health sector, there is a noticeable trend of re-nationalizing some hospitals. The DOH continues to retain tertiary hospitals that are fully departmentalized and equipped to treat most ailments. From 54 in 2000 and 65 in 2005, the number rose to 67 in 2007 because the DOH regularly “brings back to the fold” other hospitals that have been re-nationalized by Congress. The re-nationalization of these hospitals resulted in the DOH putting 48% percent of its budget into the maintenance of these hospitals. This explains the continuous increase in the budget of the DOH, despite the devolution of its personnel.

As a consequence of the national subsidy for these hospitals (which are usually in the urban centers), a spatial bias has formed against rural and municipal health centers—the very ones which should have received bigger budgets, since these are where the more numerous but economically deprived members of society access health services.

Lack of coordination

One of earlier studies cited that devolution has aggravated the lack of coordination between LGUs. In the health sector, this lack of coordination results in free riding and negative externalities. The health of an individual affects the health of other individuals. Therefore, the quality of health of individuals in a municipality influences the health of adjacent municipalities. The healthcare services that a municipality provides have positive externality on the health status of individuals in the other municipalities. In this case, health becomes a public good. This results in under provision of healthcare and free riding of some municipalities.

The quality of health care in the Philippines is largely defined by both national and global market forces and the policies that facilitate the achievement of their interests. Thus, efforts to improve quality health care should focus on policy reforms that will regulate the interests of such market forces to have positive impact in quality health care service delivery.

Fragmented health care system

The current health care system is far from being seamless. Health providers that are supposed to focus on providing tertiary and secondary care provide primary care health services. This may be attributed to the failure of the primary and public health care services to deliver quality health care services.

Mass Migration of Nurses and Doctors

Doctors find it more financially rewarding to work abroad as a nurse rather than as a doctor. The broad principles enunciated by the Global Commission on International Migration are well accepted by many governments, but they have not been applied to the health professionals. According to this group:

Migration should be by choice. In other words, poor doctors and nurses in developing countries should not be goaded to migrate because of the impoverished conditions that they face in their own local job markets. But if the choice is really for them to earn better in developed industrial countries, there must be a recognition that beyond individual benefits and costs of migration are social benefits and costs. There are bills in the Philippines today that will require state university and college graduates of nursing to stay for at least two years.

LGUs' Dependency on the IRA

The failure of local government to maintain the devolved hospitals, the decline in the quality of healthcare services, the inability of LGUs to sustain their technical personnel, and the inability to shoulder the required costs can all be attributed to lack of funds by the LGUs and/or the low priority they put on health because they had to fund so many unfunded mandates transferred to them after the devolution.

As has been clearly presented, the Internal Revenue Allotment (IRA) of the LGUs is not enough to cover the whole cost of devolution. Nevertheless, the purpose of the IRA is not to fully cover the total cost of devolution, but to simply augment the budget of the local government. Despite the fact that the power of the LGUs to source its own funds was expanded by the Local Government Code of 1991, most of the LGUs particularly the low income class municipalities and provinces are IRA dependent. Although a growing number of LGUs (mostly cities and first class municipalities and provinces) have been able to raise their local revenues, source international assistance and design more efficient programs of delivering services, the majority of the LGUs are very much dependent on the IRA and lack the capacity to source and mobilize their own funds, the funds that are needed to address their responsibilities.

Because of insufficient financial resources, the LGUs cannot maintain the health facilities and technical personnel devolved to them, which are essential to the delivery of quality health care services

Re-nationalization of Hospitals

The re-nationalization of some hospitals is a result of the lack of budget of some of the LGUs to efficiently manage these medical centers. However, not all cases of re-nationalization are due to fiscal incapacity. Some cases are just the result of politics, especially when the congressional representative of the district and the elected officials of the LGU have different political affiliations.

Congressional representatives have been filing bills to re-nationalize some hospitals so that the local government will lose control of the health services provided by these hospitals. Re-nationalization of devolved hospitals was resorted to by legislators who were at odds with local authorities in their home districts.⁵

There is an increasing number of rich LGUs (cities and provinces) that have been setting up LGU-run hospitals to cater to the health needs of their constituents. However, the provision of social services depends not on what is needed but on what activities will get greater mileage for the political career of government officials. Most appointments for position in the local government are based not on merit and credibility, but on the personal relationship of individuals to local leaders. As a result, individuals without enough competence and skills are made to manage the delivery of hospital services.

Policy initiatives

A number of legislative initiatives are pending at the Philippine congress that seeks to address the problem in quality health care delivery. There are bills that aim to provide incentives and additional benefits to barangay health workers and rural health doctors. Others aim to address the modernization of the health care delivery system. There are bills that suggest the formulation of a National Health Code, and a comprehensive national health facilities program. A particular bill tries to address the lack of operational budget of hospitals by authorizing government hospitals to utilize all their income for their maintenance and operating expenses.

There are bills that attempt to re-nationalize hospitals that were devolved to the LGUs. There are two possible reasons for this. One is that LGUs lack the capability to maintain the hospitals. The second is politics.⁶

⁵ Dr. Juan Antonio Perez III, former director of the Local Government Assistance and Monitoring Service of the Department of Health.

⁶ Cielo Magno, *Impact of Devolution on Health Services*, 2002.

Some bills aim at amending the revenue sharing in the Local Government Code of 1991. Several proposals try to utilize other variables to allocate the IRA, such as poverty incidence and the initiatives of local government to collect local taxes. These formulas attempt to address the problem of the LGUs' dependency on the IRA and to factor in the LGUs' fiscal capacity and needs. Some bills have the tendency to duplicate and supercede the tasks that were already devolved to the LGUs. These bills should be reviewed very carefully to continuously push for genuine local autonomy.

Another proposal is having a provision in the LGC requiring LGUs to allot a specific percentage amount to health care (similar to the Gender and Development Fund and the SK Fund). This way, health is prioritized in its planning and budgeting processes.

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