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ISSUES & CONCERNS

The Management of Philippine Hospital Services Post Devolution:

Concepts, Strategies & Recommendations

Juan R. Nañagas, M.D.
Romeo M. Cruz, M.D.
George P. Purvis

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The Management of Philippine
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Concepts, Strategies and Recommendations

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Table of Contents

| | |
|--|-----------|
| EXECUTIVE SUMMARY | 5 |
| BACKGROUND & OBJECTIVES | 6 |
| 1 HOSPITALS AND THE HEALTH CARE SYSTEM CONCEPTS | 7 |
| A. Comprehensive Health Care System Based on PHC | 7 |
| B. Population and Levels of Care | 8 |
| C. Definitions of Levels of Care | 8 |
| D. Hospital Referral Systems and Feeder Networks | 9 |
| 2 PHILIPPINE HOSPITAL DATA AND STATISTICS | 13 |
| A. Health Facilities and Population | 13 |
| B. Hospital Facilities and Beds in the Philippines | 14 |
| C. Hospital and Medical Services in the Philippines | 15 |
| 3 HEALTH AND HOSPITAL SYSTEM ISSUES | 17 |
| A. Health System Concerns | 17 |
| B. Health System Issues and Key Questions | 21 |
| C. Hospital Services Development | 23 |
| 4 RECOMMENDATIONS | 27 |
| A. General Recommendations | 27 |
| B. Specific Findings and Recommendations | 30 |
| I. Retained Hospitals Findings and Recommendations | 30 |
| II. Devolved Hospitals Findings and Recommendations | 37 |
| III. Private Hospitals Findings and Recommendations | 42 |
| 5 HOSPITAL SECTOR DEVELOPMENT STRATEGIES | 47 |
| A. The Private Hospital Sector Development | 47 |
| B. The Devolved Hospital Sector Development | 47 |
| C. The Retained Hospital Sector Development | 47 |
| D. Strategy Paper for Philippines 2000 | 48 |
| 6 CONCLUSIONS | 55 |
| 7 BIBLIOGRAPHY | 57 |

Executive Summary

This paper discusses the key concepts, issues, strategies and recommendations surrounding the management of hospitals within a larger healthcare system, post devolution.

This paper strongly recommends that the hospital sector be aggressively managed by the Department of Health (DOH) if it is to make a significant contribution to the health of the people of the Philippines. This means that sufficient resources must be funneled into the hospital sector to allow it to grow and to develop, and be an integral and effective part of a larger healthcare system. If hospitals are to fulfill their vital role in assisting the process of improving the health of the people, it will be important for the DOH to provide policy framework and policy guidelines to the government. It is of equal importance that the DOH develop a strategy and a long term plan for the management of the forty-seven (47) retained hospitals which are critical national resource. This paper can provide the framework for discussion of the critical issues and possible policy recommendations of the DOH in the post devolution environment.

Following the presentation of the background and objectives of this paper is an overview (Section I) of the relationship between hospitals and primary health care (PHC), and outlines the role of hospitals in the larger health care system. The succeeding sections include the following:

Section II presents data on the scope and size of the private, devolved, and retained hospital sectors;

Sections III and IV discuss the various health, hospital and management system issues, concerns, and the general recommendations for the future management of the hospital sector based on the findings of HFDP studies on retained, devolved and private hospitals;

Section V outlines the hospital sector development strategies, with some conclusions on **Section VI** based from this exercise;

Section VII contains a bibliography of relevant articles, books, monographs, and other major papers which have been produced over the last ten years concerning the management of hospitals in the Philippines.

Any review and specific comments on this paper are encouraged and should be directed to Dr. Juan R. Nañagas, HFDP Project Director, Dr. Romeo M. Cruz, HFDP Project Manager, or George P. Purvis, HFDP Hospital Management Specialist.

Background

The Department of Health (DOH) is in the process of formulating health policy for the hospital sector. With these policy issues in mind, the Health Finance Development Project (HFDP) is submitting this paper to assist the DOH to think through some of the issues with regard to the role of hospital services post devolution. This paper is an attempt to pull together the findings of prior studies and prior background papers, as well as highlighting issues and concerns that have arisen since the initiation of the Health Finance Development Project, the Hospital Strategic Planning Process, and the Technical Working Group on Hospitals. The intended audience for the paper is the DOH leadership, the HFDP staff, other interested parties, and the hospitals themselves.

OBJECTIVES

1. To assist in the process of managing hospital services and programs, post devolution;
2. To outline the issues which are critical to the development of health policy for the hospital sector, post devolution;
3. To formulate the conceptual framework for the hospital sector, within the total healthcare system, including the role of the forty seven (47) DOH retained hospitals, the role of the 580+ devolved public hospitals, and the role of some 1200+ private hospitals;
4. To specifically focus on the role and the major issues surrounding the management of the 47 retained public hospitals, post devolution;
5. To present specific recommendations for action in the Hospitals Sector which the DOH may want to consider.

Hospitals and the Health Care System Concepts

As hospitals are only one component on the total health care and medical care system, it is important to be able to conceptualize how hospitals fit together with other components of the system. This section of the paper outlines the various levels of health and medical care, and types of hospitals (primary, secondary, tertiary), and presents the relationships of various types of hospitals to geographical population groupings.

A. Comprehensive Health Care System Based on Primary Health Care (PHC)

A conceptual model of a comprehensive health system based on the principles of PHC and taken out of the WHO publication, *Hospitals and Health for All* is similar to Figure 1 on this page.

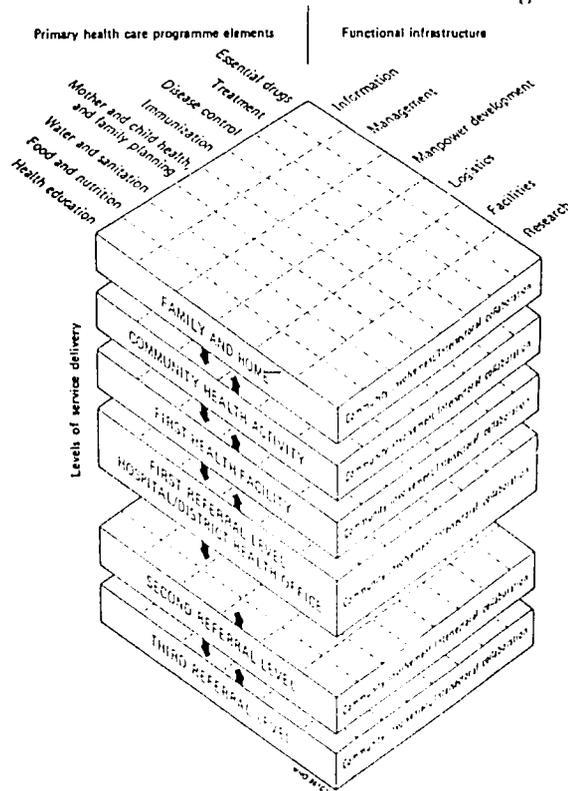


Figure 1

B. Population and Levels of Care

As hospital services are only one part of the total health and medical care system, we might conceptualize the relationship of population to level of health/medical care in Figure 2.

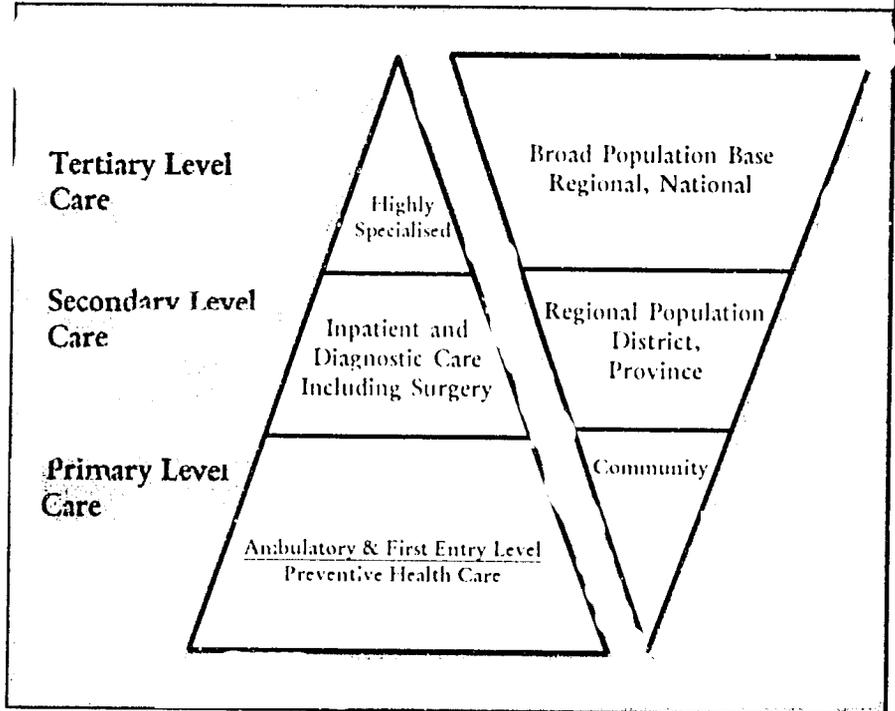


Figure 2

C. Definitions

With regard to specific definition of types of health/hospital care, we can supply the following international definitions:

1. Primary Health Care (PHC)

PHC is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC forms an integral function and main focus, of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health systems, bringing health care as close as possible to where people live and work.

Declared in Alma Ata in 1978, PHC refers to the philosophy that health care should

be available, adequate, accessible, affordable, and acceptable. PHC as a service delivery policy of the DOH shall permeate all strategies and thrusts of government health programs at the national, local and community levels, so that people can be active and self-reliant participants in the struggle for better health. Re-stated in the Philippines in the 1990's, Primary Health Care is "*Health in the Hands of the People.*"

2. Primary Medical Care

Basic or general medical care first sought by the patient for treatment of the simpler and more common illnesses. The primary care provider usually assumes ongoing responsibility for health maintenance for the patient, refers the patient to secondary and tertiary providers, and coordinates care for all of the patient's health problems. Primary care is most frequently associated

with the solo physician's office practice but is increasingly found in hospitals and team practice settings. (Examples of this type of care in a hospital setting might be performed in clinics conducted by OPD, ER, pediatrics, OB, internal medicine, and community health services).

3. Secondary Care

Services provided by medical specialists, such as cardiologists or urologists, who generally do not have first contact with patients. Patients are usually referred by primary care providers but sometimes by themselves. A substantial portion of community hospital services fall into this category. (Examples of this type of care in a hospital system might be performed by general surgery, ophthalmology, orthopedics, neurology, cardiology and hematology).

4. Tertiary Care

Services provided by highly specialized providers, such as neurosurgeons and oncologists, who frequently require highly sophisticated technological and support facilities, such as cardiac catheterisation and high-energy radiation therapy. University teaching hospitals and specialty hospitals and medical centers are examples of tertiary care providers. (Examples are oncology, OB-high risk, neonatology, cardio-thoracic surgery, plastic surgery, pediatric cardiology, hemophilia, genetics).

The preceding are international definitions, and should not be confused with the DOH designations for primary, secondary, and

tertiary hospitals, which classify hospitals according to equipment, instruments and physical plant, and types and number of physician specialists. The following are the Philippine hospital classifications according to DOH guidelines:

1. Primary Hospital is equipped with the service capabilities needed to support licensed physicians rendering services in medicine, pediatrics, obstetrics, and minor surgery.

2. Secondary Hospital is equipped with service capabilities needed to support licensed physicians rendering services in medicine, pediatrics, obstetrics and gynecology, general surgery, and other ancillary services.

3. Tertiary Hospital is fully departmentalized and equipped with service capabilities needed to support certified medical specialists and other licensed physicians rendering services in their fields, subspecialties, and ancillary services.

The DOH classifies hospitals according to equipment, instruments and physical plant, and types and number of physician specialists.

D. Hospital Referral Systems and Feeder Networks

In order to understand the hospital's role in the larger health and medical care system, it is important to document and visualize where patients come from and how they get into the hospital care system. Outlined below are examples of where patients come from and how patients select the appropriate place for treatment in the health/medical care system. Also presented are examples of a typical hospital referral systems and referral networks for primary, secondary, and tertiary care hospitals:

1. A study by Center for Research and Communications (CRC), presented in Figure 3, outlines which type of treatment or health professionals Filipinos would contact when an accident or illness occurs.
2. A typical acute care hospital feeder system might look like the following Figure 4.

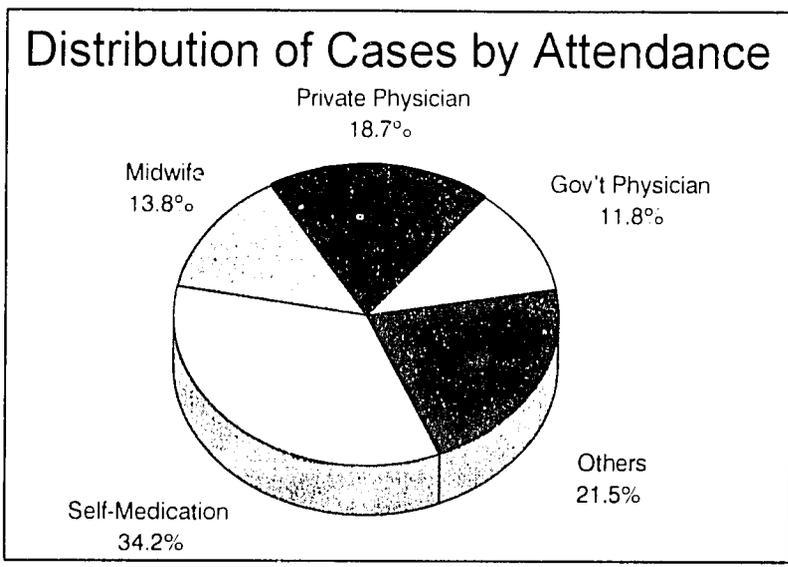


Figure 3

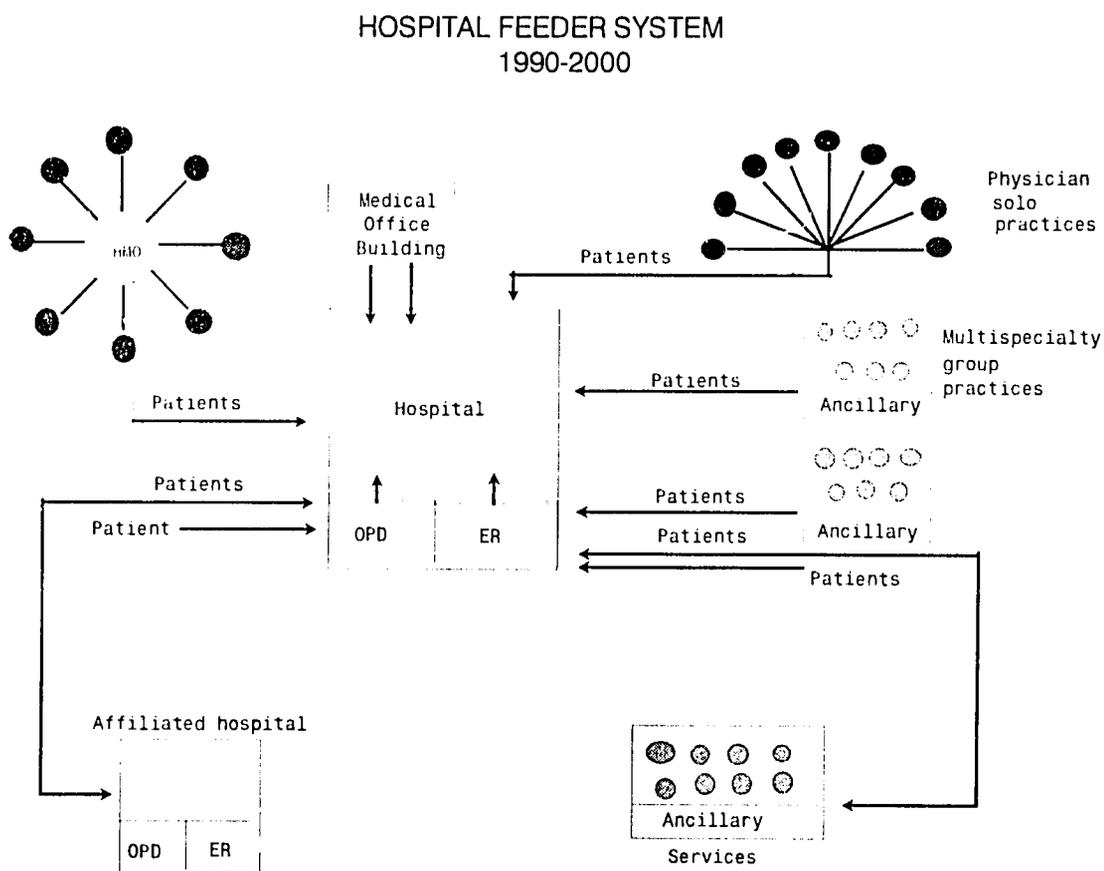


Figure 4

3. A typical rural/peri-urban/urban referral system, based on the WHO

concept of Hospitals at the First Referral Level, might look like Figure 5.

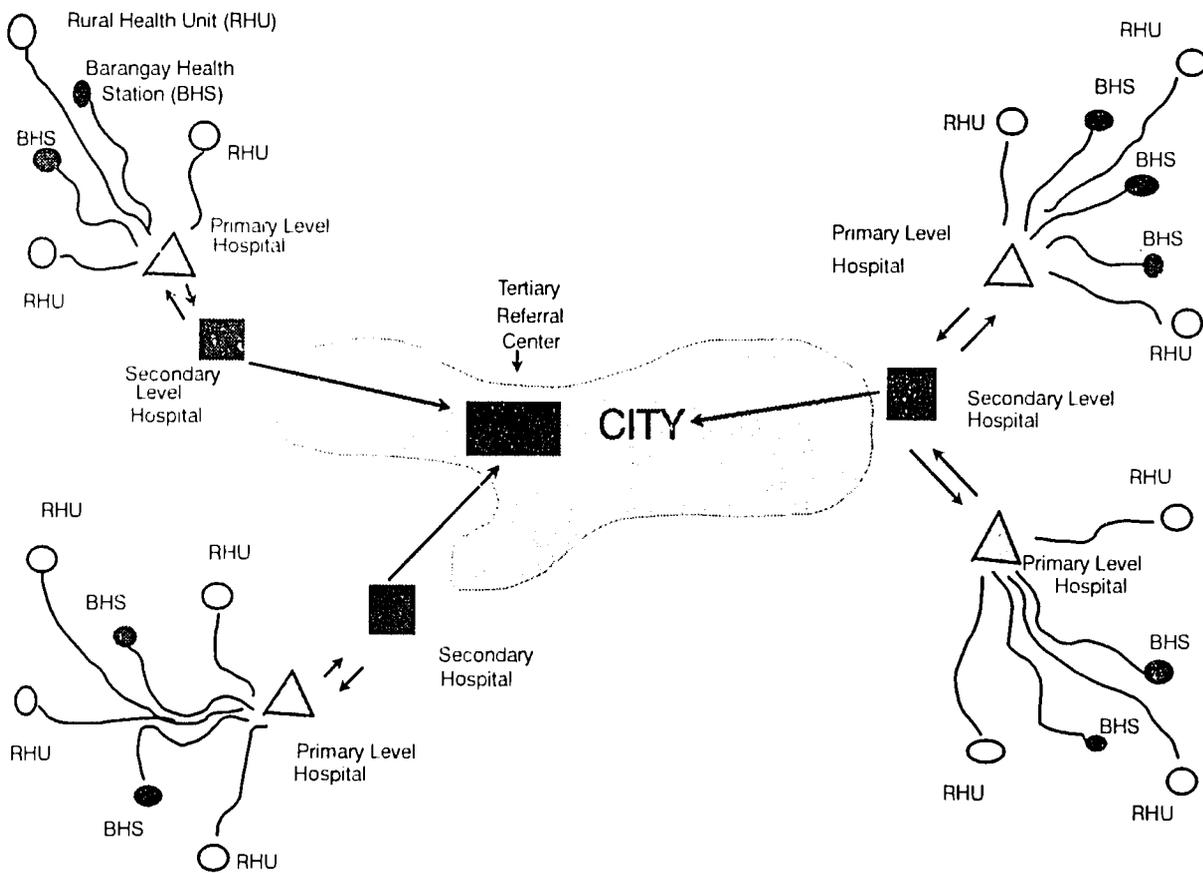


Figure 5

2

Philippine Hospital Data and Statistics

This section presents data from prior studies on hospitals in the Philippines as well as information on the type and location of hospitals, pre and post devolution.

A. Health Facilities and Population: Population Per Hospital Bed and the Share Owned by the Government

The study by Griffin in 1992 shows the Philippines has 647 people per hospital bed and that 53% of the hospital beds are owned by the government. As shown on the chart (Figure 6), the Philippines is in the middle of the distribution for Asian Countries.

A study by Solon, Gamboa, et. al., states "as of 1989, the Philippines had one bed for 707 people, an increase of one bed for 607 people in 1985. In terms of accessibility to government hospitals, 86.4% of the population lived within 17.5 km of a DOH hospital." Considering the large geographical dispersion of the Philippine Islands, this appears to be reasonable accessibility for such a large, dispersed population.

The 1992 study by Griffin shows that "private hospitals are widely distributed across the country, with only 11% located in Metro Manila. A third of

these private hospitals are tertiary hospitals. Metro Manila hospitals, both public and private account for only 10% of the total number of hospitals, but they comprise 34% of the country's total bed capacity. Forty six percent of Metro Manila Hospital beds are provided by the private tertiary hospital sector. Primary hospital beds are largely located outside Metro Manila. While only 24 % of Metro Manila hospitals are public, they account for 64% of total bed capacity. Government hospitals in Metro Manila, comprising 7.2% of the total public system, are large teaching and specialized institutions."

Figure 6

| Hospital Bed to Population Ratio In Selected Asian Countries & Percentage of Total Beds Owned by Government | | |
|---|--------------------|------------------------------|
| Country | Population Per Bed | Beds Owned by Government (%) |
| Bangladesh | 3589 | 85 |
| China | 465 | 100 |
| India | 1489 | 74 |
| Indonesia | 1743 | 69 |
| Korea | 558 | 18 |
| Malaysia | 435 | 86 |
| Myanmar | 1484 | 100 |
| Nepal | 4511 | 86 |
| Papua New Guinea | 772 | 100 |
| Philippines | 647 | 53 |
| Sri Lanka | 368 | 91 |
| Thailand | 665 | 90 |

B. Hospital Facilities and Beds in the Philippines

1. All Hospitals

The pie charts (Figure 7) present the distribution of public and private hospitals and hospital beds. Please note that Governments (LGUs and DOH) own 33% of the total hospitals but 54% of the total beds.

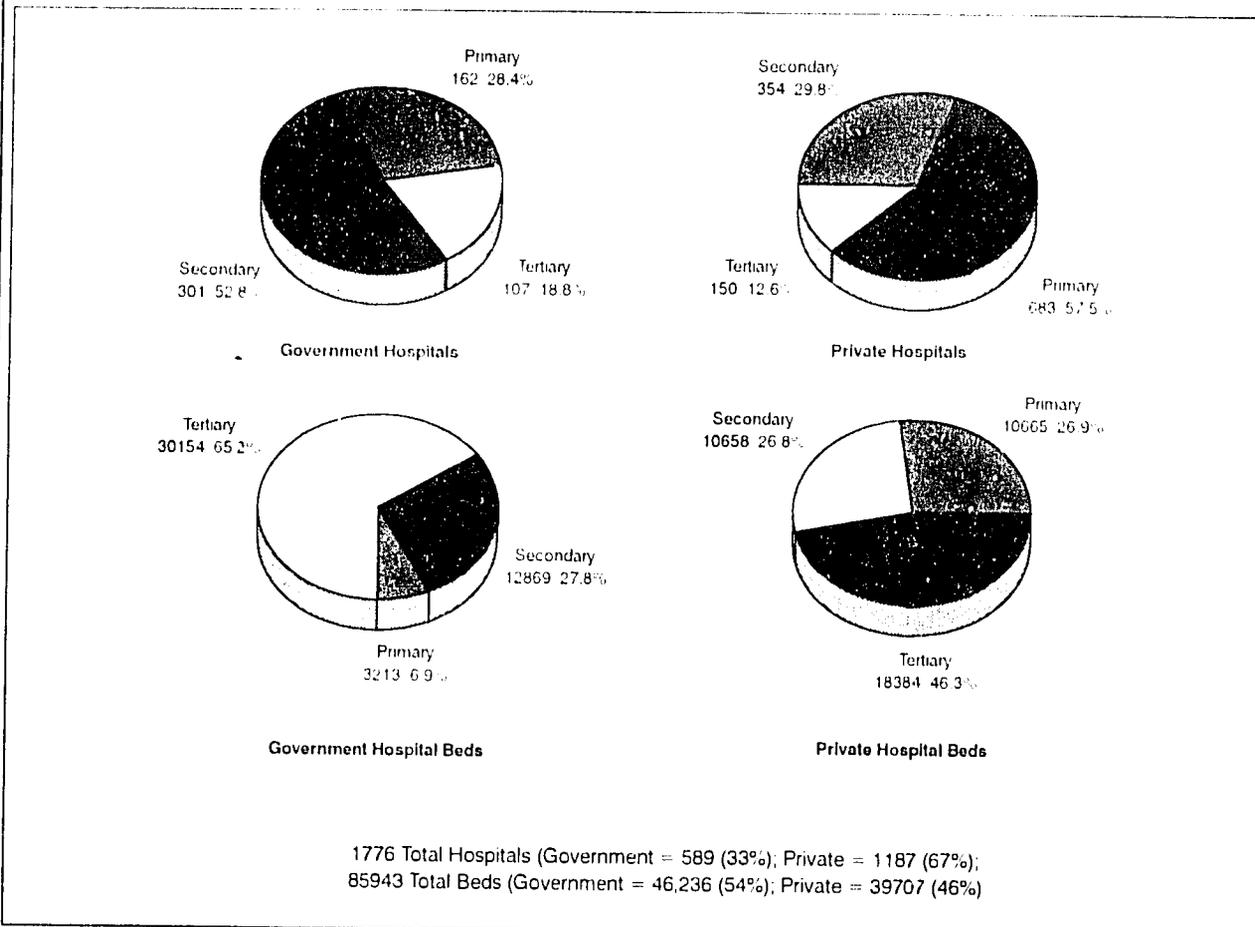


Figure 7

2. Private Hospitals

While there are 1187 private hospitals with 39,707 private hospital beds, the majority (58%) of private hospitals are small primary hospitals. Many of these small hospitals are not much more than health centers, and are not acute care institutions. These institutions are not capable of providing care for the more serious diseases requiring hospital care.

3. Public Hospitals

a. Devolved Hospitals

The chart (Figure 8) shows that there are approximately 580 devolved public hospitals and the majority of these (57%) are secondary type institutions, 31% are primary, and 12.5% are tertiary hospitals. The distribution of retained hospitals is also shown and is discussed on the next page.

b. Retained Hospitals

The DOH has 47 Retained Hospitals with 20,948 Beds and they are distributed as follows:

- (1) Four specialty hospitals (Heart, Lung, Kidney, and Childrens) with 953 beds;
- (2) Five special hospitals (Maternity, Orthopedic, National Childrens, Mental, San Lazaro) with 7750 beds;
- (3) Two research hospital with 75 beds (1 in Metro Manila and 1 in Leyte del Norte);
- (4) Nine medical centers (3 in Manila, 6 in Regions) with 3,150 beds;
- (5) Three district hospitals in Manila with 150 beds;
- (6) Fourteen regional hospitals (2 Manila, 12 in Regions) with total of 3950 Beds;
- (7) Eight sanitaria with 4920 Beds (1 each in Manila, Palawan, Camarines Sur, Iloilo City, Cebu City, Sulu, Zamboanga del Sur, and Sultan Kudarat).

The retained hospital are some of the best and the most expensive hospitals in the country, and are geographically dispersed nationwide, with a central core in Metro Manila. With devolution, the retained hospitals are in need of a new

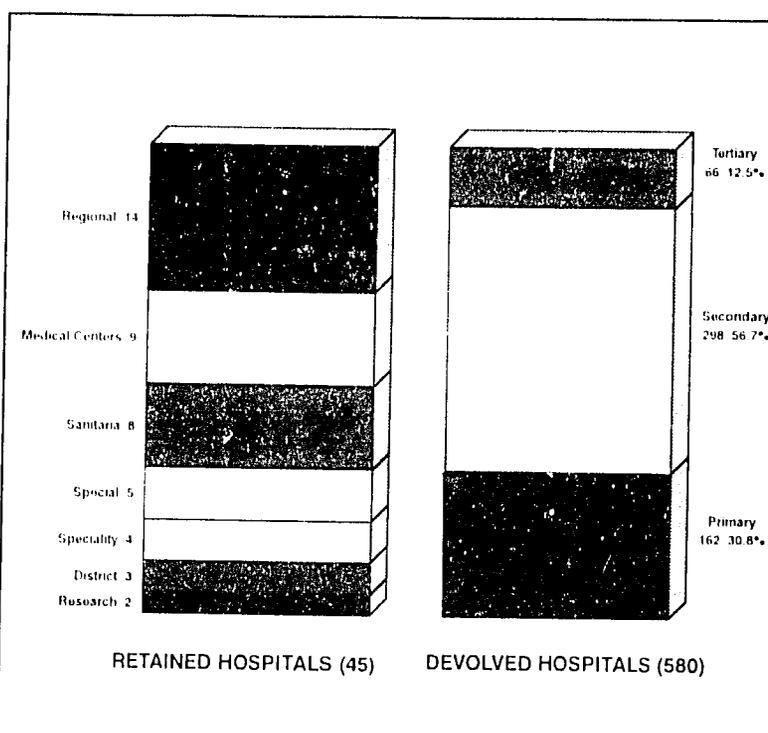


Figure 8

management and organizational structure which better suits the needs of a smaller, more efficient hospital system.

C. Hospital and Medical Services Within the Philippines

While it is not possible to secure data on the type and quantity of services provided by all hospitals (public and private) in the Philippines, it is possible to secure these data for DOH facilities. If we assume that the private hospital market is relatively similar in its type and distribution of services, we can get some idea of how hospital services (admissions, patient days, out-patient visits, length of stay, etc.) are utilized and what type of medical services (OB, SURGERY, MEDICINE, etc.) are consuming what percentage of hospital resources.

Philippine Hospital Data and Statistics

1. Hospital/Medical Services DOH (1990)

A recent analysis of some of the DOH data on type of services provided in all (primary, secondary, tertiary) public hospitals are presented in (Figure 9):

hospital beds in the Philippines, not 40% as commonly quoted.

d. Length of Stay (LOS) is 4.95 days overall with 5.7 days LOS in Primary, 5.3 days LOS in Secondary, and 4.91 days LOS in Tertiary Hospitals. LOS for private patients in government hospitals is significantly less than for public patients with the same diagnosis.

| <u>TYPE OF SERVICE</u> | <u>TOTAL NO. OF PATIENT DAYS</u> | <u>% OF TOTAL</u> |
|------------------------|----------------------------------|-------------------|
| Medicine | 3,026,126 | 38.8% |
| Surgery (Peds) | 130,166 | 1.7% |
| Surgery (Adult) | 773,656 | 9.9% |
| Obstetrics | 842,156 | 10.8% |
| Gynecology | 222,343 | 2.8% |
| Pediatrics | 1,537,105 | 19.7% |
| Newborn | 605,751 | 7.8% |
| Genito-Urinary | 124,314 | 1.6% |
| EENT | 69,162 | 0.9% |
| Others | 471,788 | 6.0% |
| Total | 7,802,567 | 100.0% |

e. Hospital length of stay in public hospitals are still long by international standards and long in comparison to private hospitals in the Philippines. These could be reduced to effectively reduce costs and allow treatment of more patients by public hospitals.

f. Over-utilization and mis-utilization of public hospitals and hospital beds is apparent, and there is a need for stronger utilization review, case management, and managed care programs in public hospitals.

Figure 9

As expected, these percentages vary greatly by type of hospital (primary, secondary, tertiary).

2. Items of Note:

- a. Public Hospitals had 1,575,183 admissions, treated 7,434,527 out-patients, and performed 514,644 surgeries in 1990.
- b. Medical patients consume roughly 39% of the beds and Surgery 12% of the beds.
- c. Maternity beds, including newborns, consume approximately 20% of the

g. Expensive tertiary public hospitals are being utilized to treat primary cases, e.g. normal delivery, and through education and utilization controls, more of these primary cases could be done in less costly primary and secondary hospitals.

h. Medicare expenditures could be reduced with changes in benefit rules to favor out-patient treatment instead of in-patient treatment, especially in primary hospitals.

3

Health & Hospital System Issues

A. Health System Concerns

1. The Need for Hospital Services

The Philippines is rapidly moving into a demographic and epidemiological transition with respect to trends in diseases, mortality and morbidity. With the success of PHC and other public health programs the trend is and will be away from communicable diseases (infectious, parasitic, and nutritional) and toward the chronic and degenerative diseases (cardiovascular, malignancies, and trauma). This section of the paper documents this transition, and outlines some of the issues

facing the DOH and hospitals during the coming period.

a. The Epidemiological Transition

With the push toward more Primary Health Care, the mortality and morbidity trends are away from the communicable diseases and will be toward the chronic and degenerative diseases. The aging of the population, with increases in life expectancy will result in more demand for hospital services. This trend is presented clearly on the graph (Figure 10) below and on the following page (Figures 11 and 12).

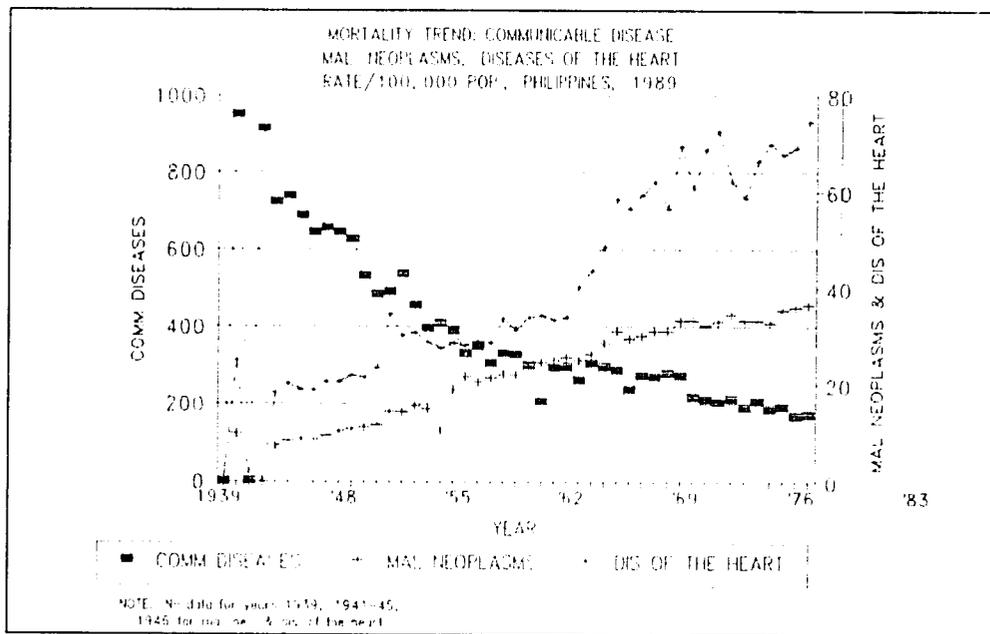
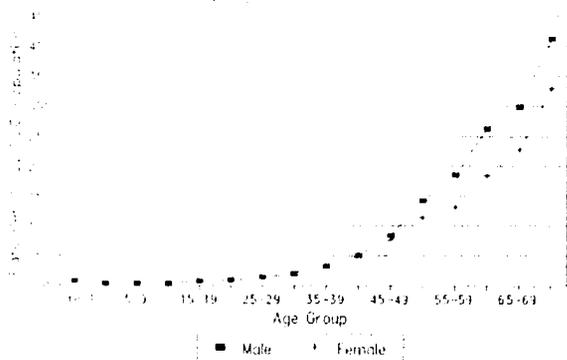


Figure 10

Death Rate from M. Neoplasms, 1988
By Age and Gender

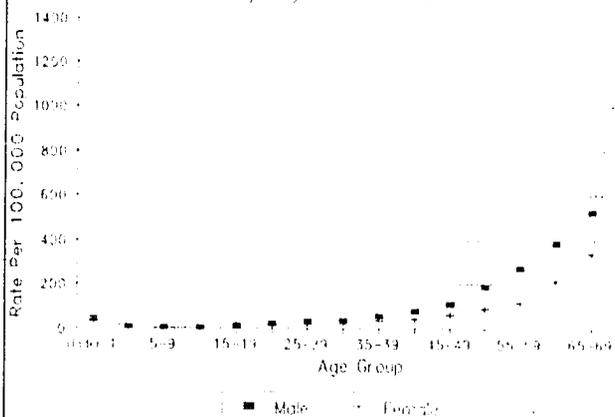


Source: DOH, Philippine Health Statistics, 1988 as reported in Ferrin, Russo and Pons (1992)

Figure 11

The probable effect of these trends for hospitals and hospital care in the future will result in the need for more intensive services, and more high technology services, which are the more expensive side of hospital delivery. Increasing degenerative and chronic diseases, will most probably require Philippine hospitals, both public and private, to move toward more high technology treatment at significantly higher cost.

Death Rate from Heart Diseases, 1988
By Age and Gender



Source: DOH, Philippine Health Statistics, 1988 as reported in Ferrin, Russo and Pons (1992)

Figure 12

b. Population and Levels of Care

Outlined below are tables (Figures 13, 14, 15) presenting the number of primary, secondary, and tertiary hospitals by ownership and region, as well as population per bed ratios for all hospitals and for tertiary hospitals. These data are presented to give some perspective on the size and location of hospitals throughout the Philippines.

Figure 13

| Distribution of Licensed Hospitals, by Category & by Ownership Philippines 1990 | | | | | | | | |
|--|---------|--------|-----------|--------|----------|--------|-------|--------|
| Agency/Sector | Primary | | Secondary | | Tertiary | | Total | |
| | No. | Beds | No. | Beds | No. | Beds | No. | Beds |
| Public | 165 | 3,225 | 306 | 13,104 | 115 | 31,352 | 586 | 47,681 |
| LGUs | 10 | 210 | 9 | 470 | 4 | 800 | 23 | 1,480 |
| DND/DOJ | 1 | 50 | 16 | 1,604 | 3 | 975 | 20 | 2,629 |
| SCUs | 6 | 165 | 1 | 50 | 2 | 1,149 | 9 | 1,364 |
| DOH | 148 | 2,800 | 280 | 10,980 | 106 | 28,428 | 534 | 42,208 |
| Private | 632 | 9,732 | 349 | 10,357 | 139 | 16,809 | 1,120 | 36,889 |
| TOTAL, Phils. | 797 | 12,948 | 655 | 23,461 | 254 | 48,161 | 1,706 | 84,570 |

Source of Basic Data: DOH, BLK & HOMs

Taken from "National Hospital Services Development Plan - ADB"

Few reliable international standards for forecasting demand for hospital services are available, and attempts to forecast population is also an imprecise science. Previous attempts by other countries to forecast the need for hospital beds by type (primary, secondary, tertiary) using future population estimates has proved unsuccessful. However, these data and these ratios can provide an indication of possible underserved areas of the country.

These Data and Trends Suggest the Following:

1. There could be a need for more secondary and tertiary hospitals and fewer primary hospitals as PHC becomes more widespread and has wider coverage, and as the population grows and the epidemiological shift takes effect.
2. Primary hospitals, as a hospital classification, are not hospitals in the acute care definition normally used for hospital care. These could be reclassified as Health Centers, which is the WHO designation for primary care facilities which also have a few in-patient beds. However, these primary care hospitals do fulfill a definite need, and now with devolution are the responsibility of the LGU's.
3. With devolution and the LGC, each province and each region will be in a better position to forecast their own needs for primary, secondary, tertiary services. Attempting to forecast needs for hospital beds by Primary, Secondary, Tertiary care services is not very effective and is seldom used for any decision making with regard to where hospitals will be built or which hospitals

| Distribution of Hospital Beds and Population Per Bed By Region and By Ownership Philippines, 1990 | | | | |
|---|-------------------------|---------|--------|--------------------|
| Region | Number of Hospital Beds | | | Population Per Bed |
| | Public | Private | Total | |
| CAR | 1,480 | 1,062 | 2,542 | 451 |
| NCR | 19,212 | 9,361 | 28,573 | 277 |
| 1 | 1,805 | 1,711 | 3,516 | 1,010 |
| 2 | 1,713 | 686 | 2,399 | 976 |
| 3 | 3,245 | 2,669 | 5,914 | 1,048 |
| 4 | 2,965 | 3,872 | 6,837 | 1,209 |
| 5 | 2,204 | 1,982 | 4,186 | 934 |
| 6 | 2,715 | 1,959 | 4,674 | 1,154 |
| 7 | 3,192 | 2,618 | 5,810 | 791 |
| 8 | 2,030 | 624 | 2,654 | 1,151 |
| 9 | 2,065 | 914 | 2,979 | 1,060 |
| 10 | 2,225 | 2,558 | 4,783 | 734 |
| 11 | 1,505 | 4,611 | 6,116 | 729 |
| 12 | 1,325 | 2,262 | 3,587 | 884 |
| Philippines | 47,681 | 36,889 | 84,570 | 718 |

*Sources of Basic Data: DOH, BLR & HOMS
Taken from "National Hospital Services Development Plan - ADB"*

Figure 14

might be closed or relocated.

4. The Retained Hospitals, which are mostly Medical Centers and Regional Hospitals offering primary, secondary, and tertiary care could begin to restrict their effort toward the more serious cases and try to ensure that most of the primary and secondary care is performed by the devolved hospitals.
5. Public hospitals in the devolved sector could focus on primary and secondary care only, leaving expensive tertiary care to the regional hospitals, medical centers, and specialty hospitals.
6. The most expensive specialized tertiary care could be left to private hospitals and to the national specialty public hospitals in Manila and similar centers, one each in the Visayas and Mindanao. The government could limit funding to "high tech" equipment as is required at the Regional Hospitals and Medical Centers.

Figure 15

| Distribution of Tertiary Hospitals & Beds By Region & By Ownership Philippines, 1990 | | | | | | | |
|--|------------|--------|---------|--------|-------|--------|-----------------------|
| Region | Government | | Private | | Total | | Population Per Bed |
| | No. | Beds | No. | Beds | No. | Beds | |
| CAR | 4 | 650 | 2 | 243 | 6 | 893 | 1,283 |
| NCR | 28 | 18,252 | 42 | 7,426 | 70 | 25,678 | 309 |
| 1 | 8 | 1,150 | 5 | 466 | 13 | 1,616 | 2,197 |
| 2 | 4 | 800 | 1 | 100 | 5 | 900 | 2,601 |
| 3 | 8 | 1,600 | 13 | 890 | 21 | 2,490 | 2,490 |
| 4 | 10 | 1,250 | 18 | 1,549 | 28 | 2,799 | 2,953 |
| 5 | 6 | 1,150 | 8 | 495 | 14 | 1,645 | 2,377 |
| Luzon | 68 | 24,852 | 89 | 11,169 | 157 | 36,021 | 926 |
| 6 | 9 | 1,350 | 10 | 1,495 | 19 | 2,845 | 1,895 |
| 7 | 7 | 1,225 | 14 | 1,711 | 21 | 2,936 | 1,564 |
| 8 | 7 | 875 | 2 | 225 | 9 | 1,100 | 2,777 |
| Visayas | 23 | 3,450 | 26 | 3,431 | 49 | 6,881 | 1,895 |
| 9 | 5 | 600 | 1 | 25 | 6 | 625 | 5,054 |
| 10 | 8 | 1,000 | 8 | 625 | 16 | 1,625 | 2,160 |
| 11 | 7 | 1,000 | 9 | 1,080 | 16 | 2,080 | 2,143 |
| 12 | 4 | 450 | 6 | 479 | 10 | 929 | 3,413 |
| Mindanao | 24 | 3,050 | 24 | 2,209 | 48 | 5,259 | 2,719 |
| Philippines | 115 | 31,352 | 139 | 16,809 | 254 | 48,161 | 1,260 |

Sources of Basic Data: DOH, BLR & HOMS

Taken from "National Hospital Services Development Plan - ADB"

B. Health System Issues and Key Questions

This section of the paper outlines some overall health system issues and questions as they relate to the management of hospitals. These issues include the following: (1) resource allocations; (2) health hospital services; and (3) standards, licensing/regulation (SLR). Most of the key questions included in these paper were voiced out by DOH key officials during the numerous workshops organized to present the findings of HFDP-financed studies on hospitals.

1. Resource Allocations

The first major issue has to do with the percentage of total health expenditures being allocated to hospitals. The available data are presented in Figure 16.

The recent study by the World Bank presented data on the distribution between

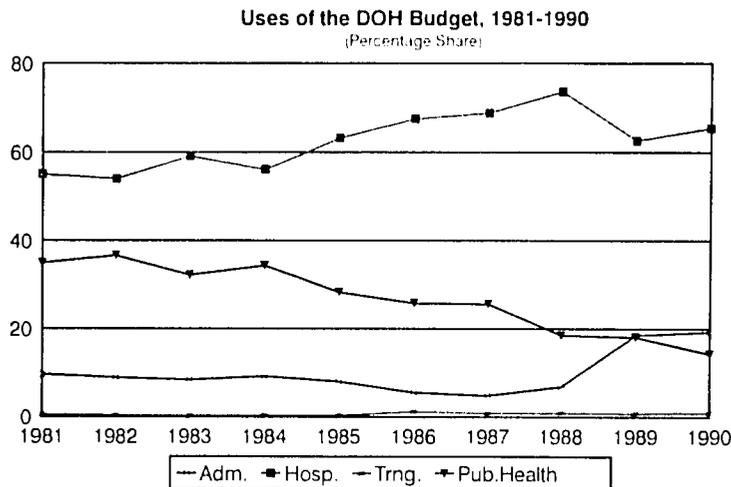
| Share of Hospitals in Total Public Recurrent Health Expenditure (percent) For Selected Countries | | | |
|--|----------------|---------|-----------------|
| Country | Hospital Share | Year | Source |
| Bangladesh | 61 | 1987 | Griffin 1989 |
| Brazil | 68 | 1984 | |
| China | 61 | 1987 | Fiedler 1987 |
| Colombia | 67 | 1984 | |
| El Salvador | 62 | 1985 | Kutzin 1989 |
| Indonesia | 37 | 1985-86 | |
| Jamaica | 72 | 1986-87 | Newbrander 1987 |
| Kenya | 73 | 1985-86 | |
| Mexico | 58 | 1986 | ADB 1987 |
| Papua New Guinea | 46 | 1975 | |
| Philippines (see Note [a]) | 55 | 1981 | OECD 1987 |
| | 71 | 1985 | |
| Sri Lanka | 70 | 1986 | |
| Turkey | 63 | 1987 | |
| OECD mean | 54 | 1980s | |

Note: [a] Excludes health expenditures by public sector other than Ministry of Health.

Source: World Bank sector reviews and appraisal reports.

Figure 16

hospitals and public health. Unfortunately, changes in accounting practices occurred during this period and the reliability of the data has been questioned. The data presented on Figure 17 are for discussion purposes only.



Source: World Bank (1990) and Commission on Adult Government (1986, Philippines).

Figure 17

Key Questions:

Under devolution, it will be more difficult to measure and to monitor these relationships. The present administration has reviewed the allocation to various sectors in the health areas and has made plans for reallocation among the various components. However, a number of questions on post devolution should be considered:

1. *What is the proper allocation to hospitals?*
2. *How will this be measured, and who will be responsible for monitoring it?*
3. *How will the DOH know if LGU overspend on hospitals and underspend on PHC?*

2. Health/Hospital Services

a. *Clinical Services*

The recent World Book Report states "that governments have a fundamental responsibility for ensuring universal access to an essential package of clinical services, with special attention to reaching the poor. The choice of services to be included in such a package for each country will be strongly influenced by information on the distribution of disease and the relative cost-effectiveness of clinical institutions. A minimum package of clinical services could reduce the present burden of disease by about one-quarter in low-income countries and by about one-tenth in middle-income countries. This package is affordable - but only if governments carry out significant health-financing

The recent World Book Report states "that governments have a fundamental responsibility for ensuring universal access to an essential package of clinical services, with special attention to reaching the poor."

reforms that will affect the roles of insurance and of user charges."

Key Questions:

1. *What will be the minimum package of clinical services that the DOH will sponsor?*
2. *How can more cost recovery and user fees be effectively introduced into the system?*

b. *District Level System*

With devolution, the prior working relationships between hospitals and the rest of the health system has undergone major change. The district health system, as designed by WHO, was the original focal point in bringing health and hospitals together. The Chief of the district hospital was previously, also the District Health Officer. PHC and hospital activities often worked together to provide the most effective range of programs. The district hospitals are now under the provincial office, but the municipal health officers report to the mayors. This may lead to a breakdown in the district level health system.

Key Questions:

1. *What will the future district level system look like?*
2. *Will the focus now change to the provincial level?*
3. *How will PHC and hospital fit together in the new national system?*
4. *How will the regional level systems function, and will the DOH retained hospitals play the major role?*
5. *How will the H.E.A.D. Zones effectively operate at the district level?*

3. Standards/Licensing/Regulation (SLR)

With devolution, the role of the DOH in standards, licensing and regulation has increased significantly. While the DOH has set standards and licensed hospitals, radiology units, laboratories, blood banks, and clinics in the past; the oversight and regulations of these institutions has been lax. The perception of a double standard has existed between private and public activities. In addition to past practices, new forms of health care organizations, Health Maintenance Organizations (HMO) have developed and are now being licensed.

The increasing cost pressures of hospital care around the world has brought a number of changes in the management of hospital and medical services.

Key Questions:

1. How will the DOH's strategy change with regard to SLR?
2. How will the DOH regulate the growing HMO movement?

C. Hospital Services Development

1. Recent International Trends in Hospital Care

The increasing cost pressures of hospital care around the world has brought a number of changes in the management of hospital and medical services. These international trends are listed below and strategies need to be developed to effectively handle these in the Philippine setting.

- a. *Trends away from costly in-patient stays to more out-patient treatment*

- b. *Trends toward more one-day and more out-patient surgery*
- c. *Reduction in the length-of-stay in hospitals*
- d. *Increasing intensive care treatment and intensive care beds*
- e. *Trends toward more utilization review of ancillary services (laboratory, radiology, etc.)*
- f. *Development of utilization review of drugs and medicines*
- g. *Trends towards managed care concepts including strong utilization review and case management*
- h. *Development of Health Maintenance Organizations and stronger interest in health prevention programs.*
- i. *Trends towards integrating quality assurance and cost management programs*
- j. *Trends toward hospitals as the center of the health care system, and PHC programs being conducted out of the hospital.*

2. Hospital Costs and Efficiencies

The area of cost reduction, cost control, methods improvement, work simplification, productivity and cost management has not been developed to any great degree in the Philippine setting. More attention needs to be focused on setting standards both on the operational side (facilities, equipment, technology, personnel, materials) as well as on the utilization side (LOS, UR, Outpatient vs. In-Patient treatments).

3. Fees, Pricing and Revenues

The area of revenue enhancement, setting fees, using cost based pricing and other hospital finance considerations have not

been well developed in the Philippine public hospital system. The emphasis has always been on budget control and not cost control or revenue maximization. With the new 20% revenue retention allowance of the GAA, this will need a great deal more effort. On the other hand, public hospitals can look forward to Sec. 35 (*Fee-for-Service Payments and Payments in General*) of the recently passed R.A. 7875

the IRR on such provision is put into effect. Public hospitals will need to begin to see costs/costing/pricing as part of the model outlined below (Figure 18):

4. Capital Development

Public hospitals have had little capital funds for facilities, maintenance and equipment over the last five years. Building and equipment are in a serious state of disrepair and often are dysfunctional. Major efforts will need to be made over the next five to ten years to bring hospitals up to a satisfactory level of operations. While two previous attempts have been made to get assistance from/through the ADB this has never been implemented. The Health Facilities Enhancement Bill is a start in this direction, but even greater capital demands will be needed over the next few years as building and equipment deteriorate under devolution and LGU, non-management of these areas.

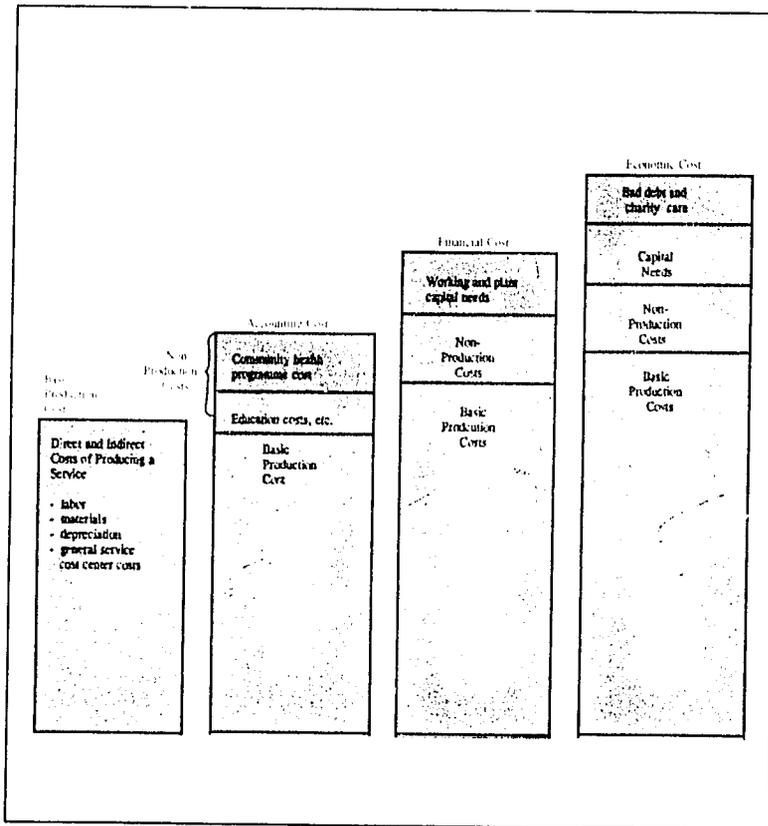


Figure 18

or the National Health Insurance Law states that "... Charges paid to public facilities shall be allowed to be retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to defray operating costs other than salaries, to maintain or upgrade equipment, plant or facility, and to maintain or improve the quality of service in the public sector," once

years. Little has been done in the areas of management development, human resource development, financial management, hospital information system, preventive maintenance, materials management, and hazardous waste management. All of these areas are in serious need of development. The recent Hospital Budget Reviews by the DOH highlighted a number of problems within all of these areas. Hospital administration, as opposed to clinical administration, needs to become a profession in the Philippines.

6. Sanitaria Hospital Development

The special administrative, political and medical problems of the sanitaria need to be addressed. The inability to discharge "non-active" patients due to socio-economic problems needs to be addressed. The DOH spends \$4 million a year in this area, when these funds are critically needed in other areas. These institutions could better serve the public as general acute care hospitals.

7. Output From Budget Review Meetings

Outlined below are a number of issues that have arisen in the budget review meetings which will need to be discussed within the context of an operational planning for hospitals:

- a. *Lack of standard definitions for statistics, financial and operating ratios, and input/output relationships.*
- b. *Inconsistencies in collection and reporting of key statistical indicators.*
- c. *Lack of operating standards and large variation in cost per unit for similar types of hospitals.*
- d. *Lack of systematic budget presentations and review.*
- e. *Failure to involve all levels of management and administration in the budget process.*
- f. *Little or no follow-up after the budget year begins in order to track performance of individual hospitals.*
- g. *Inability to recognize outstanding performance, and reward accordingly, as well as applying lessons learned to other hospitals.*
- h. *Inability to determine poor performance of individual hospitals and to secure assistance towards improving weaknesses.*
- i. *No systematic performance review in order to develop acceptable levels of management performance.*
- j. *Poor coordination between DBM, COA, and HOMS in order to resolve financial and management issues.*

4

Recommendations

This section includes the specific recommendations which have come out of HFDP studies, the strategic planning process for hospitals, and the Technical Working Group. A list of HFDP studies from HFDP Program Areas on Devolution and Standard, Licensing and Regulation are enumerated below:

1. Private Hospitals Study
2. Hospital Devolution Study
3. Retained Hospitals Incentive Study
4. Health Prevention, Promotion, PHC in Hospitals
5. Management/Ownership Innovations for Devolved Hospitals
6. Computerized Hospital Information System Demonstration
7. Task Order Assistance for Devolved Hospitals
8. Revenue Enhancement for Retained Hospitals Demonstration
9. Retained Hospitals Strategic Planning Process
10. Development of Operating and Technical Manuals

Outlined in this section are some general recommendations culled from the above mentioned studies. These recommendations as guides may prove useful in the formulation of policy recommendations and/or strategies in the management of hospitals in the light of recent developments.

A. General Recommendations:

i. Organization and Management

1. The DOH should continue the process of devolution by decentralizing and delegating the management and operations of the twelve (12) Regional Hospitals, the five (5) Regional Medical Centers, and the seven (7) Sanatoria to the Regional Field Offices. This should be completed in conjunction with increasing levels of authority and autonomy by hospital chiefs.
2. The DOH should move towards management of the forty seven (47) DOH hospitals as a "hospital system."
3. The DOH should develop a central "Hospital Planning, Policy, and Development Board" to oversee long term financial development, policy, personnel and planning of the forty five (47) retained hospitals.
4. The DOH should initiate plans to move toward increasing levels of financial and management autonomy and eventual privatization of the four (Heart, Lung, Kidney, Children's) Specialty Hospitals in Manila.
5. The DOH should turn all of the sanatoria into acute care general hospitals, should develop a special task force for the management of the sanatoria, and should work toward reduction in cost of the institution treatment of leprosy.

Recommendations

6. The DOH should encourage the development of local health/hospital advisory boards, made up of a wide representation from the community, at each regional hospital, medical center, as well as all provincial, district and municipal hospitals.

ii. Insurance/Managed Care Development

1. The DOH should push for National Health Insurance as well as an increasing number of prepaid health insurance programs nationwide.

2. The DOH should develop closer management coordination with the PMCC to ensure stronger "managed care" programs including continuity of Medicare benefits and hospital cost containment efforts (Utilization Review, reduced LOS for in-patients, case management, more out-patient procedures vs. in-patient treatment).

3. The DOH should push for strengthening of the Medicare Policy and Procedures to control fraud and abuse and to speed up payments of valid claims to providers.

iii. Finance, Budget and Capital

1. The DOH should move toward greater cost sharing with patients and continue policy efforts to increase revenue retention, (from existing GAA of 20% to 100%) and revenue enhancement, including increased efforts at improved pricing, billing and collection activities in public hospitals with the major goal being the movement of these hospitals toward long term financial self-sufficiency, with decreasing levels of government financing.

2. The DOH should develop operational, financial and efficiency standards for DOH hospitals and improve the budget review process.

3. The DOH in conjunction with Philippine Hospital Association (PHA), should improve and standardize the definition, recording, the collection and reporting of hospital statistics, income, expense and other key hospital data.

4. The DOH should increase the standardization of reporting and coordination between HOMS and BLR.

5. The DOH should continue efforts toward developing policy proposals on the capital development for hospitals (Health

Facilities Enhancement Bill) within the context of an overall development plan, including manpower implications and work towards annual allotments to public hospitals for capital needs.

6. The DOH should consider focusing its initial capital expenditures to improving basic services like water, back-up power system, waste disposal system.

7. The DOH should continue its policy of no new DOH public hospitals being built during the 1992-1998 period.

8. The DOH should continue to encourage innovations in the privatization and joint public-private partnerships in the ownership, organization and management of devolved public hospitals.

"The DOH should develop operational, financial and efficiency standards for DOH hospitals and improve the budget review process." Budget Review Workshop

Recommendations

iv. Personnel Human Resources

1. The DOH should continue to push for full implementation of the Magna Carta in the devolved public hospitals.
2. The DOH should initiate a major management development program for hospital chiefs.
3. The DOH should increase levels of training for all employees.

v. Standards, Licensing and Regulation

1. The DOH should review and revise the SLR standards for hospitals including a move from a one year to a two year inspection period.

2. The DOH should develop policies and programs for closer supervision, regulation and licensure of Health Maintenance Organizations (HMOs).

vi. Other

1. The DOH should continue the development of programs to encourage the development of health, education, health prevention and health promotion in all hospitals (*Retained, Devolved, and Private*).

The sections which follow outline the specific findings and specific recommendations of the major hospital studies.



Specific Findings and Recommendations

1. Retained Hospitals' Study, Including Hospital Budget Reviews; and Revenue Retention/Enhancement Study - Findings and Recommendations

Background

Devolution has significantly re-defined the role of the key players within the health care delivery system. Before, the national government owned and managed all public hospitals, the 1991 Local Government Code (LGC) requires the transfer of ownership, management and operation of around 580 hospitals to local government units. These leaves only 47 hospitals under the direct care of the DOH. With the seemingly lessened load, as far as supervised health institutions is concerned, the perception is that the DOH has more resources to improve the operations of its remaining hospitals.

The *Retained Hospital Study* conducted by the Health, Education and Welfare Specialists (HEWSPECS) during the period July-October 1993 was done primarily to review and assess the management and operation, including the initial effects of devolution, on retained hospitals. The study covered 38 of the 47 retained hospitals, all of the acute care hospitals and 2 of the 8 sanitarium. The study reviewed operational, statistical, and budget data, as well as management, organizational, planning and control systems. Each hospital

chief, as well as selected patients were interviewed to assess attitudes and opinions about problems, perceptions, and possible improvements. In addition to this study,

hospital budget reviews were conducted on two different occasions, a review of revenue retention regulations was conducted, and a pilot demonstration project at two DOH hospitals on the area of revenue enhancement was initiated.

Since the study was done only in the first three months after the implementation of the LGC, no clear effect of devolution on retained hospitals could yet be

determined. However, this early, DOH retained hospitals are already providing some form of assistance to devolved hospitals. Retained hospital officials (and staff) continue to clamor for some autonomy in managing these health institutions. Their belief is that some policy changes may have to be made for their hospitals to operate more efficiently and effectively. Adjustments are also warranted in the financial systems of retained hospitals to generate funds which will support operation improvements. However, in spite of deficiencies in facilities (particularly the hotel aspects of hospital care) and financial resources, patient-respondents were generally satisfied with the services rendered by retained hospitals.

The study recommends a number of policy and operational changes to improve

The study recommends a number of policy and operational changes to improve the efficiency and effectiveness of retained hospitals. Policy changes are basically being proposed in the areas of budget, audit and civil service.

Specific Findings and Recommendations

the efficiency and effectiveness of retained hospitals. Policy changes are basically being proposed in the areas of budget, audit and civil service. Amendment of restrictive policies in these areas will help hospitals meet the minimum requirements of standards and licensing. Operational changes, on the other hand, include the development of appropriate planning methods, re-orienting personnel to perform efficiently, defining hospital performance standards, improvements in the communications system, and data and information exchange.

Another suggestion was for DOH and retained hospital officials to find ways to improve the financial viability/performance of retained hospitals. Efforts should specifically focus on revenue enhancement and revenue retention, including improved pricing of services, better billing and collection efforts to screen out non-indigent taking advantage of free services.

The complete range of findings, conclusions, and recommendations of these studies are documented in separate reports. Outlined below are the major findings and recommendations from these studies which are relevant to the management of the DOH retained hospitals post devolution.

Major Findings:

The major findings (*Retained Hospitals' Study, Revenue Retention/Enhancement Study and Budget Review Workshop*) are presented under each management area:

1. Hospital Operations and Services

a. The large majority of the patients interviewed were satisfied with the

services they received, and signified a willingness to pay some amounts for services received.

b. A clear DOH policy or a set of DOH shared values on what constitutes a well managed or efficient hospital does not exist.

c. Hospital chiefs find it extremely difficult to maintain cleanliness and service delivery due to inadequate water supplies, insufficient back-up power system and unsatisfactory waste disposal systems.

d. Networking between hospitals, while generally appreciated, is not extensively practiced outside the national capital region NCR.

2. Hospital Budget, Planning, and Revenue Systems

a. Hospital managers feel that operating budgets and staffing levels are wholly inadequate for the required service demands which leads to unavailability of equipment, medicines and supplies; and this results in poor service, long waiting times, and lack of medicines and supplies for patients.

b. Hospital budget planners are not well trained on cost-based planning methods and are not able to prepare effective, rational budget proposals that reflect the real financial needs of the hospital.

c. Hospital chiefs experience undue restrictions on the management of procurement systems and funds due to auditors who impose too many and often contradictory requirements.

d. At most hospitals, only the budget

 "A clear DOH policy or a set of DOH shared values on what constitutes a well managed or efficient hospital does not exist." - Retained Hospital Study

Specific Findings and Recommendations

officer, in consultation with the chief of hospital, prepare the budget plans. Few hospital chiefs involve the unit directors in the budget process which leads to more effective planning and control.

e. Hospital chiefs feel strongly that there is a need for retention and use of retained income to augment current appropriations.

f. The existing GAA Special Provision on the "use of (20%) of the actual excess income between the immediate past year and the year before that may be used to fund deficiencies in maintenance and other operating expenses" is unclear and is in need of an IRR (*Revenue Retention Study*).

g. The existing practices

ii. DOH retained hospital with respect to pricing, costing, billing, and collection of fees is ineffective, and inefficient and not presently designed to optimize hospital revenues (*Revenue Enhancement*).

h. Standard definitions for hospital utilization, statistics, financial, operating ratios, unit costs, efficiency measures, and other input/output indicators do not exist, hence are not used in budget presentations to any great degree making it impossible to determine performance differences between hospitals (*Budget Reviews*).

i. There are high levels of inconsistency between collection and reporting of statistical indicators and cost data (*Budget Reviews and Retained Hospital Study*).

j. There are few effective operating standards, and large variations in cost per unit for similar types of hospitals, e.g. food costs, making it impossible to compare performance between hospitals (*Budget Reviews and Retained Hospital Study*).

k. Hospital budget presentations do not follow a systematic managerial format, and little trend analysis or variance analysis is completed, making it difficult or impossible to determine superior or sub-standard performance (*Budget Reviews*).

3. Hospital Personnel Practices

a. All retained hospitals claimed to be understaffed, but few formal staffing standards exist, making it difficult to draw objective conclusions on the extent of understaffing.

b. Overly restrictive enforcement of the attrition law and the absence of a rational staff recruitment and promotion process makes it difficult for hospitals to replace key personnel who have resigned or retired.

c. The process for dismissing ineffective or unproductive personnel is very difficult, and there is a lack of legal support when hospital chiefs attempt to correct performance problems or discharge employees.

d. Not all public health workers have received benefits due them under the Magna Carta for Public Health Workers.

"There is a lack of policy coherence and coordination among oversight agencies (BLR/DOH, DBM, COA) to ensure that public hospitals comply with licensure equipment and staffing standards."

Specific Findings and Recommendations

4. Hospital Standards, Licensure, and Regulation

- a. There is a lack of policy coherence and coordination among oversight agencies (BLR/DOH, DBM, COA) to ensure that public hospitals comply with licensure equipment and staffing standards.
- b. The renewal period for licensure is too short and a great deal of management time is spent on these activities with little result.

5. Hospital Facilities and Equipment

- a. In most hospitals critical equipment is unserviceable, non-functional, outdated, and obsolete, and a rational, effective system for disposal and replacement does not exist.
- b. The process of replacing critically needed facilities involves getting approval from those who lack the necessary technical skills to understand the need for those facilities.
- c. The process of maintenance of equipment and buildings is grossly underfunded and under managed, and preventive maintenance programs in most hospitals do not exist.

6. Research and Development

- a. Retained hospitals are a fertile ground for research, but due to inadequate policy directions, and lack of program support (training, facilities, funds) very little is being done.
- b. Many hospitals consider research and

information dissemination on health promotion and health education to be a low priority as financial support is not available.

7. Hospital Relations with Regional and Central Offices

- a. Many hospital chiefs feel that the intervention of the regional health offices in the day-to-day operations of the hospital is another unnecessary bureaucratic layer.

- b. Documents sent to the central office frequently get lost, mislaid or relayed too late, for required action or response.

- c. Central office makes too many demands on field staff to provide information or data which is already contained in official reports routinely submitted.

- d. A number of issuances, particularly those dated before 1991, are no longer consistent with the new thrusts of the DOH and the Local Government Code and need to be revised.

"Many hospitals consider research and information dissemination on health promotion and health education to be a low priority as financial support is not available."
Retained Hospitals Study

Major Recommendations:

The major recommendations from these studies (*Retained Hospitals' Study, Revenue Enhancement/Retention Study, Budget Review Workshop*) are as follows:

1. Hospital Operations and Services

- a. The DOH should allow Hospital Chiefs more autonomy in managing the affairs of the hospital, particularly in the areas of:

- i. contracting of services
- ii. hiring of contractual

Specific Findings and Recommendations

- or institutional workers*
- iii. *appointment of personnel up to level 2*
- iv. *grant of authority to travel to hospital personnel*
- v. *bidding and procurement*
- vi. *disciplinary measures for erring personnel*
- vii. *accreditation of affiliates*
- viii. *renovation and repair of infrastructures and equipment*

Central office intervention should be in the areas of:

- i. *licensing and standards formulation*
- ii. *appointment of chief of hospital*
- iii. *national health planning and policy formulation*
- iv. *training of senior staff/personnel*
- v. *monitoring of the hospital's performance and evaluation*

Regional/district office intervention should be limited to:

- i. *monitoring and evaluation of hospital performance*
- ii. *licensure inspections and standards enforcement*
- iii. *planning, budget review and approval/endorsement*

b. The DOH should establish a clear policy on the expected parameters of hospital performance and promote the development of a set of shared values and standards among all hospital managers and staff concerning what constitutes effective and efficient service performance.

c. The DOH should initiate more management training and management development for hospital managers and increase training for support staff.

d. The DOH should develop Operational and Technical Manuals, references in managing day-to-day operations (e.g. personnel, auditing rules and regulations).

e. The DOH should transform DOH hospitals into Centers of Wellness and Centers of Excellence.

• The DOH should develop Operational and Technical Manuals, references in managing day-to-day operations (e.g. personnel, auditing rules and regulations).

2. Hospital Budget, Planning, and Revenue Systems

a. The DOH should organize a "Group" of Hospital Policy, Planning and Development which would oversee the development of the retained hospitals as a "hospital system" for the 47 acute care hospitals. This group should also coordinate planning and budget development which

highlights efficiency and effectiveness in hospital systems management as well as overall management development of the hospital managers.

b. The DOH should develop a clear policy for hospital cost-sharing to motivate the public who can pay, to pay for hospital care. Pricing should be socialized and screening of indigents should be improved. DOH should set goals on the level of cost recovery and develop simple mechanisms for setting fees.

c. The DOH should ensure that budget provisions be adequate to meet service targets. Provisions should be made to enable hospitals to raise their own resources through revenue generation measures and to retain that revenue.

Specific Findings and Recommendations

d. The DOH should implement training in budget preparation and control for all hospital managers and ensure that department directors are involved in the budget preparation and budget control process.

e. The DOH should develop hospital financial, efficiency, staffing, and operational standards to be used in the budget review process. This would allow the DOH to compare the efficiency of similar types of hospitals and determine respective levels of performance for hospital managers.

f. Auditors assigned to hospitals should be given policy regulations and training as a group, on hospital policies, systems and hospital operational issues. This would enable them to perform their tasks without curtailing the efficiency and effectiveness of hospital service delivery.

g. The DOH should initiate public discussion on the possibility of reverting to the pre-martial law fiscal year of July-June. The current calendar year cycle is not in tune with government cash flows, resulting in perennial deficits in the first quarter while the fourth quarter is awash with funds.

h. The DOH should develop and implement an effective IRR for the retention of hospital revenues under the special provision of the GAA. (*Revenue Retention Study*)

i. The DOH should permit the retained hospitals to improve revenues through the implementation of improved pricing, costing, billing, collection systems. This should include the ability to set their own prices, based on cost and market conditions,

determine their own private/charity bed mix, and to pursue aggressive collection procedures for patients who can pay for services. (*Revenue Enhancement Demo*)

3. Hospital Personnel Practices

a. The DOH should improve the level of training among regional hospitals and medical centers.

b. The DOH should develop clear guidelines on the role of the regional hospitals in relation to the devolved hospitals, especially in the areas of training, standards development, and improvement in operating systems. This should be incorporated into the Comprehensive Health Care Agreements (CHCA's).

c. The DOH needs to ensure that DBM and COA requirements are in line with the BLR/DOH requirements for levels of staffing

in various departments in order to meet licensure regulations.

4. Hospital Standards, Licensing and Regulations

a. The DOH should review and revise, if necessary, the SLR function for hospitals.

b. The DOH should seriously consider 2-year inspection period for hospitals.

5. Hospital Facilities and Equipment

a. The DOH needs to push for a Health Care Facilities Enhancement Plan within the context of an overall development plan to improve the processes for acquisition and replacement of equipment and facilities, as well as ensuring that retained hospitals are

"The DOH should develop and implement an effective IRR for the retention of hospital revenues under the special provision of the GAA." Revenue Retention Study

Specific Findings and Recommendations

able to meet minimum standards for licensure in the equipment area, as well as manpower needs associated with this equipment.

b. The DOH needs to significantly improve the funding and the management of the preventive maintenance of hospital equipment and facilities.

6. Hospital Research and Development

a. The DOH should improve research capabilities of retained hospitals in conjunction with the DOH program on essential national health research. In developing a research agenda for hospitals, greater attention should be given to the non-clinical aspects of care.

7. Hospital and Regional and Central Office Relationships

a. The DOH should strive towards improving the responsiveness of the regional and central office to the needs and concerns of the retained hospitals, i.e. "The field first."

b. The DOH should review the following issuances for consistency with the new Local Government Code as well as the new thrusts of the DOH.

✓✓ Administrative Order No. 15 s. 1981 - Guidelines and Policies on Patients Admission in Hospital

✓✓ Ministry Circular No. 111 s. 1986 - Destruction of Used Empty Vials of Drugs in Government Hospitals

✓✓ Administrative Order No. 151-A s. 1981 - Standard Operating Procedures on Request for Repair, Installation, Maintenance of Ministry of Health X-ray Machine and other electro-medical equipment.

✓✓ Administrative Order 72 s. 1989 - Complaints and Grievances in the Hospital Setting

✓✓ Administrative Order 107 s. 1980 - Implementation of Manual for Medical Records Procedures

✓✓ Administrative Order No. 54 s. 1982 - Policies/Guidelines/Procedures on Mail Operations

✓✓ Department Circular 162-A series of 1989 which requires medical certificate issued by government hospitals to be attested by higher official seem to be an unnecessary step and casts doubts on the integrity of the medical official signing the medical certificate.

✍ "The DOH should strive towards improving the responsiveness of the regional and central office to the needs and concerns of the retained hospitals, i.e. "The field first". Retained Hospitals Study

II. Devolved Hospitals Study - Findings and Recommendations

Background

Devolved Hospitals Study was conducted by the Economic Development Foundation (EDF) from June to October 1993. The findings and recommendations were reported in a workshop in January 1994. The study reviewed twelve (12) devolved hospitals (1 each for provincial, district, and municipal) located in the provinces of Quezon, Negros Occidental, Western Samar, and Zamboanga del Sur. Key LGU officials, devolved hospital staff, and NGO's were interviewed to determine problems, issues, and concerns which had risen as a result of devolution and which were affecting the delivery of hospital and health services.

As expected by LGU and DOH officials, the transition period from a centralized to a devolved set-up was wrought with problems and confusion on how newly devolved hospital should operate. Local health boards were still groping with their new found role, and the Magna Carta for Public Health Workers (MCPHN) although clear in its "content" was not considered in the drafting of the LGC, thus creating confusion particularly in the provision of benefits. Security of tenure of health workers is threatened and opportunities for career development under the devolved setup is limited. There are not enough funds to cover the cost of devolution. As a result of the shortfalls in the LGUs operating budgets, local chief executives had to cut down their support to the devolved units. According to the study, one that clearly stands out amidst all these problems is

the administrative system, cumbersome procedures for procurement, and fund processing for medicines and medical supplies. The study noted that following devolution, the procurement and voucher processing became centralized at the provincial government offices and it often takes at least 15 signatures before the much needed drugs and medical supplies are purchased. This often produces unusually long lead times (3-6 months) and results in many hospitals running out of medicines and supplies.

According to the study, one that clearly stands out amidst all problems (under the devolved set-up) is the administrative system, cumbersome procedures for procurement and fund processing for medicines and medical supplies.

The findings suggest immediate action in the areas of improving Internal Revenue Allocation (IRA) distribution, simplification of procurement and funds processing and payment of Magna Carta benefits. Insufficient funding is also expected to continue as a major hindrance in the smooth operation of these devolved hospitals. LGUs will have to be innovative by adopting new approaches to the

management and operation of the health delivery system. The study recommends that the DOH and the Department of Interior and Local Government (DILG) should continue strong technical assistance to LGUs. Their recommendations will play a major role in addressing many operational concerns arising from devolution.

The complete range of findings, conclusions, and recommendations are documented in a separate report. In addition to the study, a *Workshop for Devolved Hospital Administrators* from Regions VI, VII, and VIII was carried out in Cebu in October 1993. The findings and recommendations of this workshop are also included in this section. Outlined below are the major findings and recommendations which are relevant to the

management of the devolved hospital sector and which may need further policy development.

¶ **Major Findings**

1. Transition Phase

a. The early administrative transition phase of devolution is completed. The transfer of people was completed, but issues surrounding facilities, and equipment to the LGU's still need some finalization.

b. Devolution is marked by opportunities as well as threats. Some provinces are improving housing and other benefits as well as increasing funds for medicines and supplies, while other provinces are reducing funding to hospital and limiting benefits to health personnel.

c. Substantial improvements in health service delivery are expected. After an initial period of familiarization and start up problems, the LGU's expect to see significant improvements in health services.

d. There is confusion as to the functions of Provincial Health Officers (PHO) and District Health Officers (DHO). Under the devolved set-up, PHOs and DHOs have no direct administrative supervision over the Rural Health Units (RHU). Furthermore, PHO supervision over health offices of component cities and municipalities is perceived as non-functional as these areas are now under local health executives not directly accountable to the province.

e. LGUs were not adequately prepared for devolution, and lack the necessary technical

and management skills by LCE to effectively operate hospitals under devolution.

f. Capital funds over the previous five year period have been severely limited, leading to deterioration of facilities and equipment.

g. The national vision for health, developed by the DOH, was not effectively communicated to LGUs. Thus, few local health plans developed by LGUs are often inconsistent with national health goals.

2. Character of Devolved Hospital Operation under LGU

a. Internal Revenue Allotments (IRA's) to most provinces are inadequate to finance devolved hospital operations. The initial formula spelled out in the LGC resulted in significant shortfalls in hospital operating budgets, especially MOOE.

b. Health service delivery is hampered by cumbersome LGU administrative systems and procedures for procurement. The lack of autonomy with respect to fund disbursement, absence of clear cut policies for fund releases, and "red tape" in the release of supplies, drugs and materials, resulted in shortages which severely affected the quality of health service.

c. The integration of public health programs and hospital services is uncertain. As provinces and municipalities develop their own health priorities, the linkage between hospital activities and public health programs weakened.

d. The local health boards (LHB's) of provinces and municipalities are not functioning effectively as designed under the LGC and in most cases are not operational.

"The lack of autonomy with respect to fund disbursement, absence of clear cut policies for fund releases, and "red tape" in the release of supplies, drugs and materials, has resulted in shortages which has severely affected the quality of health service."

Furthermore, chiefs of municipal and district hospitals are not members of the local health boards. Their non-inclusion in the health boards also weakens the local health system.

e. Transition problems (hiring, replacement and absorption) related to personnel include the following:

i. *Appointments are handled at the provincial capitol where political interference/patronage became the order.*

ii. *Vacant positions were dropped and renewal of appointments not permitted.*

iii. *Recruitment of non-qualified health personnel.*

iv. *The non compliance by LCE's to the rights and benefits of health workers under the Magna Carta of Public Health Workers caused low morale.*

v. *Security of tenure is threatened by the pending reorganizations at the LGU level.*

vi. *Devolution has limited the career development opportunities for medical personnel, as well as limiting funds for education and training.*

f. Health and hospitals are not a priority of some LGU's.

g. Hospital referral systems was adversely affected by devolution as patients move from district to provincial to regional hospitals to secure unavailable medicines and supplies.

There is a general opinion of a significant drop in the occupancy rate of some district hospitals as no medicines are available. (This still needs to be verified with actual data, not yet available).

Recommendations:

1. LGUs and Devolved Hospitals

1. LGUs should accept their new responsibilities and begin to allot more time, effort, and resources to the management of devolved hospitals.

a. *LGUs should improve systems and procedures in the procurement of drugs and medical supplies to hospitals. LGUs should consider the return of some accounting and procurement functions to the hospitals.*

b. *Revise and review guidelines for the Magna Carta for health workers.*

c. *LGUs should develop an agreement for the substitution of Municipal Health Officers-on-Leave.*

d. *LGUs should strengthen the function of LHBs to include both health and hospital regulatory functions, financial management of hospital income (through a trust fund) and recommendations on uses of funds.*

e. *Strong advocacy by LHBs for a larger health budget to include capital funds for facilities improvements.*

"LGUs should accept their new responsibilities and begin to allot more time, effort, and resources to the management of devolved hospitals."
Devolved Hospitals Study

Specific Findings and Recommendations

2. Rationalize devolved hospitals — relative to their local conditions:

a. Health officials should intensify lobbying efforts for health/hospitals so these are included in the list of LGU priorities.

b. Establish district hospital/health boards which will address specific concerns at the district level and to link up with provincial health issues. The establishment of the district hospital/health boards should be done through a MOA with the provincial and municipal governments.

c. There should be common rules and regulations on selection procedures (e.g. representative from the hospitals and LGUs) following criteria similar to CSC requirements.

d. LGUs should strengthen Pharmacy and Therapeutic committees:

- Publish competitive prices, results of DOH bidding and recommend accredited suppliers.
- Bulk purchase of large quantity items
- Furnish copies of National Drug Formulary
- Return some procurement activities to the hospitals

e. Health services should be integrated at the provincial and district levels. This could be done if provincial and district health officers are made responsible for

all the promotive, preventive, curative and rehabilitative health services in their catchment areas. PHOs should also have oversight functions over district and municipal health officers.

3. Need for LGUs to acquire critical knowledge in hospitals:

a. LHBs should undergo orientation on:

- the national health vision and strategies
- the concept and importance of integrating public health and hospital services

b. Orientation activities must be given to devolved hospital personnel on how the LGU administrative systems operate. Concerned LGU staff should be oriented so they will understand the nature of hospitals.

4. Need for LGUs to acquire knowledge in financing their health requirements:

a. The LGUs should start looking at alternative financing, management, and organizational schemes (e.g. contracting, cooperatives, joint public-private partnerships, LGU-LGU collaboration).

b. Some LGUs may want to consider having private firms own and/or operate hospitals.

c. LGUs should consider the allocation of hospital income under a special trust revolving fund scheme.

d. LGUs should evaluate the revenue generating capabilities of their hospital and start instituting reforms:

- Seek authority or legal basis for increasing hospital fees through

"Orientation activities must be given to devolved hospital personnel on how the LGU administrative systems operate. Concerned LGU staff should be oriented so they will understand the nature of hospitals."

provincial/municipal council resolutions.

- Pricing of hospital services should be adjusted to bring fees at par with costs incurred.
- Improve billing and collection activities.

2. DOH and Devolved Hospitals

1. DOH residual responsibility over devolved hospitals

a. *DOH should propose guidelines in budget preparation and allocation*

- Budget proposal should be well-documented and justified.
- Provide LGUs with an optimum budget level for hospitals of different sizes and services to help LGUs in programming budget for hospitals.

b. *DOH should propose to LGUs that they develop a 5-year development plan for hospitals.*

c. *The Oversight Committee on Decentralization (OCD), through the DILG and the DOH, must continue to monitor and address the negative outcomes of devolution, including:*

- Inequitable IRA distributions.
- Non-payment of Magna Carta benefits.
- Procurement of medicines and supplies.

d. *The DILG should work with the DOH in capability building assistance to LGU's. Training and educational programs in a number of health and management area need to be conducted. Parallel to this, the DOH must*

start building up the technical competencies of its representatives to the local health boards so they can assist the LGUs effectively and report accurately on the progress of provincial health activities.

e. *The DILG, working with the DOH, will need to initiate measures and recommend systems improvements to simplify the funds allocation and procurement process for devolved hospitals. This may require establishing a sub-allotment system or some other mechanism to ensure timely allocation of budget funds to hospitals.*

f. *The DOH will have to develop stronger oversight processes and improved standards, licensing, and regulation activities which will need to include effective quarterly reporting systems to ensure that public health and hospitals are working together at the municipal, district, provincial, and regional levels.*

g. *DOH should extend technical assistance to LGUs in developing a hospital facilities and equipment improvement plan based on DOH licensing standards. The DOH should bring forth legislation to provide capital equipment funds for maintaining and upgrading devolved hospital facilities and equipment.*

h. *The DOH, through the use of the CHCA's, should encourage provinces to increase allocations to hospitals for improving services. The CHCA's are presently not being used for hospital services development.*

The OCD, through the DILG and the DOH, must continue to monitor and address the negative outcomes of devolution, including:

- Inequitable IRA distributions.
- Non-payment of Magna Carta benefits.
- Procurement of medicines and supplies.

III. Private Hospitals Study - Findings and Recommendations

Background

The private hospital sector plays a crucial role in health maintenance and the delivery of medical services. The sector accounts for majority (66%) of licensed hospitals and about half of the total number of hospital beds in the country. In 1993, there were 1,117 licensed private hospitals of which 12% (141) were tertiary hospitals and 32% (353) were secondary hospitals. Primary hospitals numbered 623 or 56% of the total.

The *Private Hospital Incentive Study* was conducted by Joaquin Cunanan & Co., Management Consulting Services between July-December 1993, and the results were reported out in a workshop in January 1994.

The study, using a combination of primary and secondary research, surveyed thirty (30) private hospitals (profit and non-profit, rural and urban, primary, secondary and tertiary), the results of which were used to get indications of operating and financial characteristics. In addition, interviews were made with representatives of hospital and doctors' organizations, government agencies, and academe. The study looked into the rationale for giving incentives to private hospitals and identified as well, existing and potential disincentives.

According to the study, the sector generated direct employment to no less than 70,000 people, total investment of about P12.5 billion and taxes paid reached P234 million. In terms of indigent served, private hospitals assisted some 11 million patients and

outpatients in 1992, with service valued at P1.8 billion, which could be viewed as savings to government in terms of the opportunity cost of providing health services. Assuming no private sector investments in hospitals, the government would have to invest this amount to deliver health services to the people.

The complete range of findings, analyses, conclusions and recommendations are documented in a separate report. Outlined

below are some of the salient findings and recommendations for the private hospital sector and may need further policy development.

¶ Major Findings

A. Some Characteristics of Private Hospitals

1. Data and Statistics

a) Private hospitals play a key role in the provision of hospital services in the country:

- As of 1993, 1,117 licensed private hospitals accounted for 66% of the country's total hospitals.
- The 40,861 private hospital beds nationwide represented 48% of total beds available.
- Breakdown by category of licensed private hospitals, 1993: 56% (or 623)—primary; 32% (or 353)—secondary; 12% (or 141)—tertiary.

b) Private hospitals are not homogenous in terms of service capabilities: a primary hospital has markedly different capabilities from a tertiary one. Even within the same category level, capabilities vary significantly.

The Private Hospital Incentive Study looked into the rationale for giving incentives to private hospitals, and identified as well, existing and potential disincentives.

2. Financials

a) Low profitability for all private hospitals using 1992 experience: i.e.

- (1) return on assets (ROA)—1.9%;
- (2) return on equity (ROE)—3.3%;
- (3) net income margin (NIM)—2%.

In comparison, private educational institutions had ROA of 9%; ROE of 13.1%; and NIM of 10.1%.

b) The higher the hospital category, the lower the operating profit margins. The ratio of operating expenses to operating revenues:

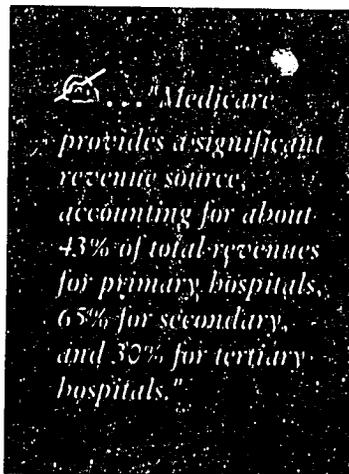
- (1) primary hospitals—62%
- (2) secondary—82%
- (3) tertiary—88%.

c) ROE for tertiary hospitals was only 5% compared to 10% and 13% for primary and secondary hospitals, respectively. The low payback for tertiary hospitals is due to low margins and a large capital base which is composed mostly of land, building, and equipment.

d) Total asset investments of all private hospitals in 1992 estimated at 12.57 billion. Average fixed asset per bed increases, the higher the hospital category:

- (1) primary— 125,000
- (2) secondary— 250,000
- (3) tertiary— 500,000.

f) Medicare provides a significant revenue source, accounting for about 43% of total revenues for primary hospitals, 65% for secondary, and 30% for tertiary hospitals.



g) Major operating expenses, as percentage of total expenses:

- (1) salaries: 34%-36%
- (2) medical & hospital supplies: 18%-33%
- (3) utilities: 7%-9%

h) The higher the hospital category, the bigger the percentage of bad debts to total revenues:

- (1) primary—8.8%
- (2) secondary—18%
- (3) tertiary—18.34%

i) Factors contributing to bad debts:

- (1) patient's inability to pay—41%
- (2) unpaid Medicare claims due to disallowances or incomplete documents—21%
- (3) unpaid emergency cases—18%

3. Management

a) Managerial capacities and performance are uneven. Primary hospitals and small secondary hospitals generally have informal operating systems while Tertiary hospitals have more formal operating systems and employ professional managers.

B. Economic and Social Contributions of Private Hospitals

1. Estimated total direct employment generated: 68,241.

2. Estimated total taxes paid, 1992: 263.6 million; broken down into:

- (a) income tax— 131 million
- (b) local taxes— 34.6 million
- (c) customs duties, taxes— 98 million

Specific Findings and Recommendations

3. Estimated total number of indigents served in 1992 on an outpatient and inpatient basis: 10.86 million, broken down into 2.67 million IP's and 8.19 OP's. The quantified cost of inpatient services rendered to indigents is about 1.8 billion.

4. This charity care relieves government of the burden of establishing hospitals to serve the indigent. If there were no private hospitals at all and government were to establish exactly the same private hospitals as are now existing (assuming they are all needed), total capital investment required would be about 12.5 billion and total annual operating expenses estimated at 3.36 billion per year.

5. Private hospitals are major player in bringing hospital services to rural areas since 62% of all rural-based hospitals are private hospitals.

4. No comprehensive or integrated government plan or policy defining the role of private hospitals in the overall health care system exists.

D. Incentives to Private Hospitals

1. An amount of 50 subsidy per bed for charity patients in private hospitals in underserved areas is the present policy. However, the amount is deemed no longer realistic since it has not been adjusted since 1981.

2. Discounts to private hospitals on power rates do exist. However, this discount is assured only in Meralco franchise areas. Hospitals outside of Meralco are not assured of such privilege since some electric cooperatives do not recognize it.

3. R.A. 7600 gives incentives to all government and private institutions for promoting breast

ES... "Private hospitals are major player in bringing hospital services to rural areas since 62% of all rural-based hospitals are private hospitals."

feeding and rooming-in practices. Private hospitals which incur expenses in complying with the law may deduct twice the amount for income tax purposes.

C. Disincentives to Private Hospitals

1. The "no-deposit law" for emergency cases contributes to the problem of bad debts, particularly since the term "emergency" is not well defined.

2. DOH licensing standards are deemed restrictive and unreasonable. There is uneven application of the standards, with government hospitals favored, and a double standard may exist.

3. Taxes and duties on medical equipment, supplies and medicines are a financial burden. Hospitals are taxed at 35%—the same as other profit institutions—while educational institutions are taxed only 10% and cooperatives are exempt. Hospitals have the added burden of having to provide free services to indigents but are taxed disproportionately.

ES Recommendations

1. The DOH should support legislation that allows private hospitals incentive(s) to perform legally mandated "public functions":

a. Government requires hospitals to perform public functions (e.g. treating indigents under "no-deposit rule") with no corresponding financial incentive. Although the bad debts arising from the "no-deposit" law are tax-deductible for income tax purposes, the hospitals still incur a net loss since the tax benefit is less than the amount of the bad debt.

b. Government should consider additional incentives to allow hospitals to recover the costs incurred when rendering these mandated functions. Examples are: allowing tax credit equivalent to the value of the bad debts; allowing actual cash reimbursement for indigents; or developing regulations to allow preferential credit terms from lenders.

2. The requirement for hospitals to allocate at least 10% of their authorized bed capacity for charity patients represents income lost to hospitals as private hospitals could use these charity beds for paying patients. This 10% requirement should be reviewed and improved for the present day financial environment.

3. The government should encourage smaller hospitals (i.e. primary and secondary) to improve their managerial and operating systems capabilities. The hospital operating and technical manuals that DOH developed and printed under HFDP auspices can be useful tools in the achievement of this recommendation. This should be a BLR requirement. Training should be a joint undertaking of the DOH,

... "The government should continue encouraging the growth of NHI and the Medicare Program and other third-party health insurance schemes. This would allow more people to be covered by such schemes, and the exposure of hospitals to bad debts would decrease."

the PHA and should be part of the continuing educational programs.

4. The government should define its policies and strategies concerning the private hospital sector over the long term. This articulation should include the role and development thrusts of private and public hospitals.

5. The DOH should review existing DOH hospital licensure standards taking into account, among others, hospital categories, service capabilities, quality, and geographical location, as well as reviewing the one-year review process, with a recommendation to move to a two-year review process.

6. The government should support the development of new and innovative financing schemes for hospitals, similar to tax-exempt hospital bonds, which would reduce capital costs for hospital.

7. The government should continue encouraging the growth of NHI and the Medicare Program and other third-party health insurance schemes. This would allow more people to be covered by such schemes, and the exposure of hospitals to bad debts would decrease.

5

Hospital Sector Development Strategies

With Devolution, the Philippine Hospital System is broken into three distinctly different sectors (private, devolved and retained) with different needs, different issues, and different goals. If management of hospitals post devolution is to be effective, it needs to address the issues of all three of these groups. Outlined below are some of the issues which have previously been identified, and which will need to be further developed and refined within a strategic planning process:

A. Private Hospital Sector Development

1. Long Term Financial Viability
2. Incentives for Private Hospital Development
3. Disincentives presently in the Regulatory Systems
4. Medicare Improvement and Expansion
5. HMO and Private Insurance Development
6. Recruitment and Retention of Skilled Manpower

B. Devolved Hospital Sector Development

1. The Effects of Devolution
2. The Role of the District Hospital
3. The Role of the Provincial Hospital
4. Short Term and Long Term Financial Viability

5. Improvements in Quality Assurance Activities
6. Relationships with the Regional Hospitals
7. Integration of Hospitals and Public Health/PHC
8. Recruitment and Retention of Skilled Manpower

C. Retained Hospital Development

1. The Role of the Regional Hospital after Devolution
2. The Relationship with the Regional Office
3. The Relationship with the Central Office
4. Integration of Health Prevention, Promotion, PHC
5. Specialty Hospital Development
6. Special Hospital Development
7. Sanatoria Development
8. The DOH Hospitals as a Hospital System
9. Leadership and Management Development
10. Quality Assurance Improvement
11. Long Term Financial Viability
12. Recruitment and Retention of Skilled Manpower

The Retained Hospital Strategy Paper beginning on the next page is a major beginning effort to focus the retained hospitals in a specific direction.

TOWARDS HEALTH IN THE HANDS OF THE PEOPLE: POSITIONING FOR HOSPITAL PERFORMANCE

A DEPARTMENT OF HEALTH STRATEGY PAPER FOR PHILIPPINES 2000 FOR THE HOSPITAL SECTOR THIRD DRAFT June 1994

As outlined in The Philippine Hospital Strategic Planning Workbook, "a Mission statement should outline in one or two paragraphs what business you are in, who your clients are, what services you provide, and why you are in business". The outputs of the Tagaytay workshop produced the following:

I. MISSION STATEMENT

In partnership with the people, the mission of public hospitals is to provide accessible, equitable, quality, humanistic, compassionate, responsible, affordable and cost effective health promotion, prevention, rehabilitative and curative hospital care, to the general public with a focus upon the medically indigent. DOH hospitals also have a major mission in medical research and serve as training centers for medical education.

A Vision statement is focused upon "what we would like to become at some distant point in the future, what type of organization we would like to and how do we visualize the organization's capabilities at some future date." The outputs of the Tagaytay workshop produced the following:

II. VISION STATEMENT

The DOH Hospital System is a public, diversified, integrated healthcare service, education, and research organization providing a full range of health and medical services. These services are provided through a network of health prevention and curative hospital programs which work in close coordination with community and Local Government Units, private hospitals, NGO's, and national and local public health and PHC programs. The DOH hospitals will be cultural friendly and practice "Hospital Pinoy Style" and will become "Centers of Excellence" and will become trainers and models of hospital systems, programs and services for Local Government Units as well as private hospitals. Hospitals will increasingly become "Centers of Wellness" with more programs in health prevention, health promotion, and Primary Health Care, and will continue their strong role in medical education and research.

An environmental assessment is necessary to look both inside the organization at our strengths and weaknesses as well as looking outside the organization at the opportunities and threats facing us. The results for the DOH Retained Hospital Sector, as highlighted in various workshops are as follows:

III. A. ENVIRONMENTAL ASSESSMENT (INTERNAL TO THE DOH)

STRENGTHS

1. Strong leadership with clear vision
2. Trained, professional, dedicated staff
3. 47 Good Institutions with wide range of programs and services
4. Large training capability
5. Ability to access and mobilize outside funds
6. Responsive programs and services
7. Networking among some hospitals
8. Strong secondary and tertiary IP programs
9. Abundance of data generated, collected, and reported
10. Strong bulk purchasing programs

WEAKNESSES

1. Leadership is PHC oriented
2. Bureaucratic structure with much inertia
3. Outdated, poorly maintained buildings and equipment
4. Limited research capability
5. Limited resources (less than 3% spent on Health)
6. Front line services ER/OPD perceived as poor
7. Poor communication between other hospitals
8. Few health prevention and promotion programs
9. Data not used for decision making
10. Inadequate drugs and medical supplies

III.B. ENVIRONMENTAL ASSESSMENT (EXTERNAL TO THE DOH)

OPPORTUNITIES

1. Strong media relations environment
2. Devolution: fewer hospitals to manage

THREATS

1. Changing political environment
2. Devolution: less control over hospitals

Development Strategies

- | | |
|--|--|
| <ol style="list-style-type: none"> 3. Public support for hospitals 4. Movement toward more Privatization 5. Foreign funding of equipment/facilities 6. Networking between LGU and DOH hospitals 7. Legislative support for Health 8. National political stability 9. Availability of supply of medical manpower 10. Support of professional societies 11. National Health Insurance | <ol style="list-style-type: none"> 3. Hospital services eroding and quality declining 4. Energy and power crisis and economic uncertainty 5. Inability to maintain equipment/facilities 6. Epidemiological transition to high cost degenerative diseases and chronic care 7. Legislative unresponsiveness for Hospital capital needs 8. Local political instability 9. Brain drain and medical skills being exported 10. Elitist attitudes of professional societies 11. Hyper critical media |
|--|--|

The result of the S.W.O.T.'s is the establishment of the 8-10 critical issues facing the DOH Hospital Sector. The major issues outlined below are drawn from a number of sources:

IV. CRITICAL ISSUES FOR THE FUTURE

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. DEVOLUTION - How will the DOH hospitals relate to the devolved hospitals and Local Government Units with respect to regulation, programs, services, quality assurance, equipment, drugs, medical supplies, training, education, disaster management and a host of other issues. 2. FINANCIAL VIABILITY - How will the DOH hospitals become more financially self-sustaining and generate more of their own operating and capital funds. 3. CAPITAL NEEDS - Where will the capital come from to replace existing buildings and | <p>equipment, as well as fund new capital needs, and how can hospitals convince the DOH leadership of this need and get legislators to fund these needs.</p> <ol style="list-style-type: none"> 4. PERSONNEL AND MANAGEMENT - How can the DOH attract and retain critical medical and management skills, ensure personnel/people "empowerment," develop optimal staffing levels, and improve the management skills of hospital managers. 5. GOVERNANCE AND MANAGEMENT OF RETAINED HOSPITALS - How will the DOH govern and manage the 47 Retained |
|---|--|

Development Strategies

Hospitals, as a centralized "hospital system" with standardized services and programs, or with a "decentralized" regional structure and regional hospital boards which focused more on local regional needs.

6. **DRUGS AND MEDICAL SUPPLIES** - How will the DOH ensure that adequate funding will be available for drugs and medical supplies.
7. **SERVICE/PROGRAM IMPROVEMENT** - How will the DOH improve front line services (ER/OPD), ensure continued quality assurance improvements of In-Patient curative programs, disaster, epidemic and trauma management and integrate health prevention, promotion, and PHC programs into the hospitals.
8. **MANAGEMENT/HOSPITAL INFORMATION SYSTEMS** - How can the DOH update and improve information

systems and ensure information is used to facilitate decision making.

9. **MEDICAL EDUCATION/RESEARCH** - How can the DOH continue its role in medical education and research, and how can these programs be improved.
10. **HOSPITAL LICENSING AND REGULATION** - How can the DOH improve the licensing and regulation process for hospitals.
11. **NATIONAL HEALTH INSURANCE** - How will NHI change the management of DOH facilities and services.

With the identification of the key issues, we are able to move to the development of strategies to mobilize people and resources to effectively manage these issues in the future. Outlined below are possible strategies highlighted from a number of sources:

V. DEVELOPMENT OF KEY STRATEGIES

1. Decentralize the governance and management of hospitals to the regional level, and develop more autonomy in hospital operations, finance, and management.
2. Develop Revenue Enhancement and Revenue Retention Programs and allow hospitals more latitude in pricing bed mix, billing and collections in order to improve services to the indigent and improve the long term financial viability.
3. Develop a National Health Facilities Enhancement Bill for a five year program of capital funding, and strengthen relationships with the international donor community and convince donors of the benefits of long term funding of capital needs.
4. Implement fully the Magna Carta for Health

workers and push for continued improvements, staffing levels and in wages and benefits.

5. Implement management development and management training programs on a wide scale for local, regional and DOH central office hospital managers and parallel improvement in training for all staff.
6. Provide leadership to Devolved hospitals and LGU's in improving hospital programs and services through increasing levels of training and education.
7. Secure technical assistance in quality assurance to improve front line services as well as in-patient services, and to develop effective computerized Hospital Information Systems for decision making.

Development Strategies

8. Focus increasing attention to implementation of health prevention, promotion, and PHC programs in all DOH hospitals and assist the devolved hospital in also becoming "Centers of Wellness".
9. Improve training programs in medical education and research capability by securing additional funding from international donors.
10. Increase networking between DOH hospitals, devolved hospitals, private hospitals and local

NGO's to develop more effective networks for medical referrals, equipment, maintenance, bulk purchasing, education, and training programs.

11. Increase planning for National Health Insurance and its effects on DOH hospitals.

The result of a number of individual strategies should be a generalized Strategy Statement which clearly outlines the direction over the future period.

VI. STRATEGY STATEMENT

The DOH Hospital Sector will move toward a decentralized organizational structure with more autonomy in governance, management, operations, finance, programs, and services at the regional level. It will become a partner with Local Government Units and become a trainer and model of hospital programs and services for devolved hospitals. It will move toward more revenue enhancement, including revenue retention, and will make hospitals more fiscally responsible for generating some of their own funds. The DOH hospitals will become "Centers of Excellence" and focus more resources into maintenance of buildings and equipment, and will update technological capabilities to meet the demands of the epidemiological transition and the care of degenerative and chronic diseases in an appropriate and cost effective way. Hospitals will practice "Hospital Pinoy Style", will increasingly become "Centers of Wellness" with more programs in health prevention, promotion, and Primary Health Care, and will strengthen their role in medical education and research.

VII. SETTING GOALS AND OBJECTIVES

The goals of the DOH Hospital Sector are as follows:

1. **DEVOLUTION:** To work closely with Local Government Units and Devolved Hospitals to develop effective and efficient health and hospital programs and services in the areas of quality assurance, the provision of efficacious drugs and medical supplies, maintenance of buildings and equipment, training and education of medical personnel, management systems, and health prevention, promotion, and PHC programs.
2. **GOVERNANCE AND MANAGEMENT:** To improve the governance and management

of the DOH hospitals through the decentralization of authority and responsibility to the regional level with increased levels of autonomy to local hospital directors, and the creation of a central group for "Hospital Planning, Policy and Development."

3. **REVENUE ENHANCEMENT:** To develop effective policy measures which support the improvements in hospital revenues through revenue retention, pricing, billing, collection, and other revenue enhancements.
4. **CAPITAL NEEDS:** To improve the quality

Development Strategies

of buildings and equipment and to replace equipment and upgrade technology as needed.

5. **PERSONNEL:** To fully implement the Magna Carta for Health Workers and to improve training and education of medical personnel through people empowerment.
6. **MANAGEMENT DEVELOPMENT:** To improve the quality of management and supervision by implementing management training, education, and performance review for all hospital managers.
7. **HEALTH PREVENTION, PROMOTION, PHC:** To implement health prevention, promotion, and Primary Health Care programs and to ensure that all hospitals become Centers of Wellness.
8. **DRUGS AND MEDICAL SUPPLIES:** To improve the procurement and availability of efficacious drugs and medical supplies at all hospitals.
9. **SERVICES AND PROGRAMS:** To improve front line services (ER/OPD) and improve quality assurance programs in all areas.
10. **MAINTENANCE OF BUILDINGS AND EQUIPMENT:** To improve the quality and quantity of maintenance of buildings and facilities, and to implement and improve preventative maintenance of equipment.
11. **HOSPITAL INFORMATION SYSTEM:** To implement a computerized hospital information system for management decision making in all DOH hospitals.
12. **MEDICAL EDUCATION/TRAINING/RESEARCH:** To improve the quality of medical education, training, and research.
13. **STANDARDS, LICENSING, AND REGULATION:** To improve and facilitate the process of licensing and regulation of hospitals.
14. **NETWORKING:** To implement increased levels of networking between hospitals in the areas of medical referrals, blood supply, equipment utilization and maintenance, procurement of drugs and supplies, education and training.
15. **DONOR RELATIONSHIPS:** To improve and increase the intensity of communication with the international donor community.
16. **NGO RELATIONSHIPS:** To improve the relationship and communication with NGOs.

6

Conclusion

The major objective of this monograph is to provide information, strategies and recommendations to assist the DOH in its task of managing the Philippine Hospitals Post Devolution. As highlighted in the executive summary: "If hospitals are to fulfill their vital role in assisting the process of improving the health of the people," then the DOH must develop effective policies and policy guidelines for the hospital sector, both public and private. The process of devolution has produced a number of new issues, problems and opportunities for the DOH. If the experience of other countries is taken into account, it means that the process of devolving and decentralizing health/hospital service "into the hands of the people" will take many more years and will continue to dominate the DOH policy agenda for years to come. It is hoped that the findings and recommendations in this monograph prove helpful to the DOH, the provincial governors, and the hospitals themselves.

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