E. Public hospital governance in the Philippines

A case study on health sector reforms

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Abstract

The Philippine health care system is characterized by a combination of public and private ownership of assets and services. Household utilization of these services is still largely dictated by the ability to pay, with the Government providing direct service (through its health facilities) or premium subsidies to poor households under PhilHealth (the social health insurance programme), and the private sector focusing on middle- and higher-income households. The purpose of this study is to determine how health sector reforms in the Philippines have affected hospital governance and delivery of services.

Hospital reforms in four facilities were studied: La Union Medical Center, Leyte Provincial Hospital, National Kidney Transplant Institute/Hemodialysis Center–Fresenius Medical Care Public–Private Partnership, and the Southern Philippines Medical Center. Several lessons and trends were drawn from these case studies.

The most profound health sector reform was the devolution of primary and secondary health services to local government units (LGUs) in 1992. Primary services refer to those provided in rural and city health units and barangay (village) health stations under municipal and city governments, while secondary services refer to those provided in district and provincial hospitals under provincial governments. The immediate effects of devolution were the rupturing of the referral system and the fragmentation of the financing of health services as the administrative, operational, and financial burden of devolved health facilities and programmes were turned over to LGUs while upper-level hospitals remained under the Department of Health.

All the reforms initiated in the case study hospitals responded to the need for a stronger financial base to support and sustain better services. The reforms were achieved primarily through the expansion of internally generated (non-budgetary) funds; initially through patient fees and increasingly through PhilHealth reimbursements. Almost all of the reforms that have succeeded are based on central PhilHealth financing, without which internal revenue generation (based on patients’ fees and other non-insurance sources) would be grossly inadequate.
In this regard, PhilHealth and participating hospitals need further strengthening to increase patients’ access to hospital services and utilization; make payment fair and efficient; and establish a provider payment process between funder (PhilHealth) and accredited providers (hospitals, physicians) that is transparent and fair.
Acronyms and abbreviations

BOT  Build-Operate-Transfer
DOH  Department of Health
IRA  internal revenue allotment
LGU  local government unit
LUMC  La Union Medical Center
NKTI  National Kidney Transplant Institute
PGLU  Provincial Government of La Union
PhilHealth  Philippine Health Insurance Corporation
PPP  public-private partnership
SPMC  Southern Philippines Medical Center
SSF  special service fee
1. Introduction

1.1 Country context

In the last three years, the Philippine economy has blossomed beyond expectations, but this growth is yet to be realized in better health service coverage and the health status of all Filipinos. As the country aspires to become a higher-middle income economy, policy-makers need to focus on more inclusive growth and stronger human development. In the health sector, this is daunting as the country faces a double-edged challenge: the coexistence of the unfinished public health agenda reflected in the Millennium Development Goals with the emergence of the demographic and health transition leading to a higher prevalence of non-communicable diseases (NCDs) and increasing hospitalization. NCDs are growing in part due to the ageing population, more rapid urbanization and congestion as well as work and lifestyle changes brought about by modernization and higher household incomes. Thus, even with the best of public health interventions, there will be even more demand on hospitals in the future. The governance and performance of hospitals, therefore, is a critical policy issue.

Geography and politics

With a total land area of 343 449 km², the Philippines is an archipelago and its 7107 islands pose a key obstacle to transportation and communication in health care, creating a sensible referral framework for health facilities, and establishing a rational logistics system for commodities. Within major and minor islands there are geographically isolated, depressed areas where indigenous and poor people live in ancestral domains and fragile communities, often eking out a living in the harshest conditions. In some of these areas, the 30-year Leftist insurgency and Muslim separatist movements persist, disrupting Government and community investments in economic and human development.

The Philippines regained democracy in 1986 when a people-power revolution overthrew the dictatorial regime of Ferdinand E. Marcos who ruled with his cronies for over two decades. Since then, national-, local- and village-level representatives have been directly elected by popular vote. In 1991, the Philippine Congress enacted the Local Government Code (R.A.
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7160), leading to the devolution of primary and secondary health services to 79 provinces, 143 cities, and 1484 municipalities.

Many non-governmental organizations are active in service delivery, sector advocacy and legislative monitoring. They include for-profit groups protective of professional and industry interests, business groups, civil society organizations, civil-servants’ associations, and Left-leaning pro-poor and anti-privatization lobby groups. Few formal opportunities exist for these disparate groups to achieve consensus on vital health-sector issues, and differences often boil over in street demonstrations. Indeed, reforms in the health sector are often hindered by protracted discussions.

Demography and economics

The Philippines is now the 12th largest country in the world. In 2010, the population reached 94.4 million, from around 36.7 million in 1970. The 2% annual population growth means that 1.9 million Filipinos are added each year. Limited economic prospects in rural areas often force people to troop to cities or to seek employment overseas, making many areas in the Philippines prematurely urbanized. About 49% of Filipinos now live in urban areas.

The population remains predominantly young, with 57% of the population below the age of 24. While total fertility rate has declined from 6.0 children per woman of reproductive age in 1973 to 3.3 in 2008, it remains one of the highest in Southeast Asia. Life expectancy at birth has also improved as the country addressed the major reasons for infant and child mortality and morbidity. These trends have led to a demographic transition, with a rising median age, declining dependency ratio and increasing proportion of elderly people (above 60 years old). With this demographic transition well underway, along with greater urbanization and Filipinos’ adoption of more modern diets and lifestyles, a health transition has also ensued. This is characterized by the falling – though still significant – burden of communicable diseases, and the rising burden of NCDs. The top ten major causes of mortality and morbidity now show a significant burden of NCDs such as hypertension, diseases of the heart and vascular system, malignant neoplasms, diabetes mellitus and renal diseases.
Until recently, economic growth in the Philippines has not been as rapid as the rest of East Asia. Because of the country’s high population growth, per capita income has virtually crawled at around US$ 2600 per year, putting the Philippines at the lower end of the middle-income bracket. The poverty rate has remained largely unchanged for decades: the figure marginally declined from 33.1% in 1991 to 28.6% in 2009 and 27.9% in 2012.

Part of the problem with poverty in the Philippines – and therefore people’s access to health services – is due to the economy’s weak ability to create jobs, especially for the poorest households. Philippine economic growth has been described by one local economist as “development progeria” – the marked ageing of its industrial (especially manufacturing) base, which has been stagnant for many years in terms of its share of gross domestic product (GDP) and productivity. The Philippines exports a significant number of its workers, rather than creating employment for them at home. The country has been highly reliant on overseas Filipino workers’ remittances, and on revenues from its highly lucrative business process outsourcing (establishment by large multinational companies of call centers offshore, e.g., the Philippines and India, to cater to the service needs of their customers) and other service industries. But in the process it has neglected its manufacturing sector, which is often a source of employment for the poor.

Fortunately, although challenges remain – especially on poverty reduction – the country’s macroeconomy has strengthened and stabilized. From a net external borrower of the International Monetary Fund, the Philippines has become a net external lender. The currency (Peso) has stabilized owing to massive foreign-exchange remittances. Gross international reserves are now at a very comfortable level (one year’s worth of imports). Economic growth over the past three years has been rapid, and the Government budget is now in surplus. The global rating agencies such as Standard and Poor’s and Fitch have conferred on the Philippines investment-grade status.

**Sector context**

The Philippine health care system is characterized by a mixed public/private ownership of assets and services. Household utilization of these services is still largely dictated by the ability to pay, with the Government
providing direct health services (through government-owned health facilities) or premium subsidies to poor households so that they can be members under PhilHealth (the social health insurance programme), and the private sector focusing on middle- and higher-income households. In effect, it is a dual health care system. Reforms in social health insurance are intended to reduce the adverse equity effects of such a system by providing choice to members and by reducing (if not outright eliminating) out-of-pocket payments by households at the point of service.

The Philippines is a major producer of health workers of different cadres and the official policy is to train staff to meet both domestic and external demand. The Professional Regulations Commission licenses around 2600 physicians, 650 dentists, 67,000 nurses, 3,900 midwives, 1,400 medical technologists and 1,200 pharmacists a year (NSO, 2011). While the health workers export policy seems well-intended, it has adverse consequences in the poor domestic retention rate.

Access to drugs remains difficult for poor households due to inappropriate financing (most drug purchases are funded out-of-pocket and bought at the point of need), procurement inefficiencies in the Government system, and an oligopolistic, private local production that is highly dependent on imported ingredients. Historically, the Philippines has had one of the highest retail prices of drugs in Asia. The Generics Drugs Law was passed in 1988 requiring providers to write out prescriptions in generics terminology, thereby giving consumers a choice of drugs to purchase and shifting the balance of power from doctors to pharmacists/consumers. However, it was not until the late 2000s that the generics drugs market blossomed and eased the supply problem, partly through parallel importation.

In terms of overall health financing, the percentage of total health expenditure to GDP has increased, but at 3.4% is still lower than the 5.0% prescribed by the World Health Organization, and lower than most middle-income countries. Per capita health expenditure has also increased, but out-of-pocket spending remains high as a percentage of total health expenditures (NSCB, 2013). Social health insurance spending has grown steadily, but is still low (around 10%) as a proportion of total health
spending. Government health expenditure has slightly increased since 2009, but the private sector remains the major funder of health.

2. Philippine hospital system

The Philippine hospital network is a mixed public and private system that relies on multiple payment flows, including the Government budget (for Department of Health (DOH) and local government hospitals); PhilHealth; modest private health insurance (health maintenance organizations (HMOs) and private indemnity health insurance); and out-of-pocket financing. In 2011, personal health care expenditures amounted to PHP 338.9 billion, the vast proportion of which was accounted for by out-of-pocket spending (67%), and less so by Government (12%), social health insurance (10%), and private health insurance along with the private expenditures of corporations and schools (10%) (NSCB, 2013).

The infrastructure and staff complement of the Philippine hospital system have not kept pace with population growth. The number of hospitals has remained almost unchanged at around 1700–1800 since the early 1980s, while hospital beds per 10,000 people fell from 18 in the 1970s to just 10 in 2000. This figure increased slightly to 12 beds per 10,000 people in 2010, but hardly reached the ratio established more than a generation ago.

In 2010, there were 1812 hospitals (730 Government and 1082 private). Private hospitals have historically outnumbered government hospitals, although their share of the total has been declining due to low investments. In the 1970s, private hospitals accounted for around 75%, but this share went down to 67% in the 1980s, and measures 60% at present. While private hospitals are more numerous, they tend to be smaller (45 beds on average) than Government hospitals (which average 67 beds). Thus, the ratio of private and public hospital beds is around 50:50. As smaller hospitals are being constructed by the Government to bring health facilities closer to the rural areas, their average number of beds has dropped from 122 in 1976 to 67 in 2010.

The distribution of hospitals across regions has not changed much. The National Capital Region and adjacent regions (Central Luzon and Calabarzon) account for the largest number of hospitals (34% of the total).
At the other end of the scale are the relatively deprived Autonomous Region of Muslim Mindanao, Caraga, Mimaropa and the Cordillera Autonomous Region that have only 12% of the total number of hospitals. Government hospitals can be further classified according to who owns and manages them. Out of the 1620 Government hospitals in 2011, 75 (4.6%) are DOH-managed; 572 (35.3%) are LGU managed; 5 (0.3%) are owned by state universities; 28 (1.7%) are military; and 4 (0.3%) are managed by other government agencies.

The most profound reform that has affected the government health service and financing system is the devolution of primary and secondary health services to LGUs in 1992 (under the Local Government Code R.A. 7160). Under devolution, LGUs are entitled to a set level of internal revenue allotment (IRA) based on certain socioeconomic indicators (LGU classification based on tax revenues, area, population size and poverty rate), which they then allocate to various social services including health. Under this setup, DOH retained its roles of stewardship, policy-making and regulation as well as the ownership and management of 72 retained regional and upper-level hospitals, 17 regional Centers of Health Development and a handful of attached agencies, notably the Food and Drug Administration.

The immediate effects of devolution were the rupturing of the referral system and the fragmentation of the financing of health services as the administrative, operational, and financial burden of devolved health facilities and programmes were turned over to LGUs, while upper-level hospitals remained under the DOH. Thus, the previously integrated public health and upper-level hospital services were de-linked, weakening the referral system that had been built up over the years under a centralized system. In many LGUs, the devolved functions required far greater budgets than the devolved fiscal resources allocated. Moreover, devolution also stultified the health services in LGUs that were simply suboptimally-sized, while it energized similar services in LGUs that were financially better off or had more enlightened local government executives. The lack of an inter-jurisdictional payment system for referrals and the mobility of patients as
well as the frequent bypassing of primary care and district hospitals has led to the further fraying of the financing and delivery system. This has manifested in overcrowded provincial and DOH hospitals, and under-utilized health centers and district hospitals. Data show that all secondary and tertiary Government hospitals are operating way above 100% capacity while many Rural Health Units and primary hospitals are under-utilized. The network model that existed prior to devolution – based in a district catchment area with a district health structure that responds to it – has all but disappeared. DOH has been heroically trying to cohesively reorganize service delivery networks, but with little visible success.

Instead of increasing the local financing of health services, devolution has also led to a decline in the share of local health financing to total health expenditure (NSCB, 2013). The short term of office of local officials (three years, plus the possibility of re-election) also means the near-impossibility of sustaining any gains in local health service delivery, which may not be followed up by the subsequent LGU executive. Many local executives did not prioritize financing health facilities, especially hospitals, which are deemed a drain on local financing. Indeed, quite a few of them successfully returned their hospitals to the DOH as “renationalized assets”.

3. Case studies of hospital reforms

3.1 La Union Medical Center

La Union is a geographically small province in the Ilocos Region (or Region 1), with a medium-sized population of 720 000. La Union Medical Center (LUMC), a 100-bed hospital, is one of six hospitals that were turned over to the provincial government when health services were devolved in 1992. Prior to devolution, LUMC – originally called Doña Gregoria Memorial Hospital (DGMH) – served as the district hospital for 10 municipalities with a combined population of around 400 000 (Astom, 2012). Under this un-devolved and centralized setup, it obtained its annual budget from the DOH to which it reported, and acted as one of two primary referral facilities in the province’s second congressional district, which was also its health district.

When health services were devolved to the provinces and municipalities, the Provincial Government of La Union (PGLU), like the other provinces,
found itself in grave difficulty meeting the finances needed for its provincial hospitals. Before these reforms, the PGLU spent 33% of its annual budget on its hospitals – PHP 35 million alone being incurred for the running of DGMH. However, this amount was deemed highly inadequate by the PGLU and the hospital managers themselves, who estimated that the hospital would need an annual budget of at least PHP 80–100 million to bring its services up to par for its volume of patients; meaning that it must earn an additional PHP 45–65 million a year from patients’ fees. This underfunding was reflected in the limited staffing resources (especially specialist physicians), the sorry state of its basic infrastructure and the absence of high-end diagnostic and treatment facilities.

The financing problem would have been addressed somewhat if the hospital had been able to retain patients’ fees. However, existing provincial policy dictated that all the funds generated by provincial hospitals had to be channelled to the Provincial General Fund, as was the practice in most LGUs in the Philippines. As a result, the hospital was unable to upgrade its diagnostic and therapeutic capacities. Staff were also poorly paid and some positions were unfilled.

In addition to the annual financing requirements of the provincial hospitals, the PGLU was also saddled with the administrative and operational burden of running the hospital. As a hierarchical unit of the Provincial Government, the hospital exhibited the usual problems associated with centralized management, which in turn were reflected in day-to-day problems such as poorly motivated and inadequate staff, weak information systems and severe delays in the procurement of hospital inputs, such as drugs. The hospital had difficulty recruiting qualified personnel because of the restrictions on salary levels which must follow provincial standards. The hospital was treated as just one of the units under the PGLU, and critical procurements were often delayed because of the high volume of provincial business transactions. Administrative, accountability and transparency structures and processes were inadequate, due to the low level of computerization in the PGLU as a whole.

In the late 1990s, the European Union (EU) chose the hospital as the site of an €11.3 million (PHP 650 million) hospital rehabilitation programme,
which triggered its policy and institutional reform programme spearheaded by the PGLU. The new buildings were turned over to the Provincial Government in December 2001. To manage this new facility, the PGLU committed to transform it from a hierarchical unit of the province into an economic enterprise and then eventually into a fully autonomous hospital. The Province’s vision for the hospital is for it to be run by professional managers working under the structure of a corporate economic entity – a vision that could not be realized if it stayed as an appendage of the provincial administrative structure.

3.1.1 Reforms undertaken

The Local Government Code permits LGUs to run their social services as economic enterprises i.e., revenue-earning entities. Following the PGLU’s vision, on 8 April 2002 the Philippine President Gloria Macapagal Arroyo formally closed all operations of the old hospital before opening the new and renamed La Union Medical Center. On 15 April, the President subsequently issued Executive Order No. 4 transforming LUMC into an economic enterprise for sustainability and development. Finally, LUMC was made an autonomous hospital through a special charter of Congress (Republic Act 9256) that was signed into law by the President in March 2004. With this law, LUMC became the first LGU hospital that was turned into a non-stock, non-profit local government-owned and controlled corporation. So far, it is still the only LGU hospital to have achieved this status.

The autonomization of LUMC entailed a range of reforms in governance and management, including: a change in vision and mission (as a multispecialty centre involved in training and research); the expansion of its mandate and catchment area (from a district to a provincial hospital); advocacy with the municipal mayors of the province; the formation of an independent board of trustees; the creation of management teams in various technical fields; the installation of human resources, financial, procurement and other support systems; the training and capacity-building of its staff; the acquisition of new medical technology through outsourcing and public–private partnership (PPP) arrangements; and the implementation of a socialized pricing structure as well as the more focused claiming of PhilHealth reimbursements.
3.1.2 Governance structure

The hospital’s enabling Act envisioned a governance structure that was transparent and accountable; with a wide latitude to carry out activities; efficient; and with a strong political will for change. Through its enabling Act, the hospital ceased to be a unit of the PGLU hierarchy and became an independent institution governed by a Board of Trustees, with the governor of the Province as the Chairman, the Vice Governor as Vice Chairman, and 15 others as Trustees. The Provincial Governor acting as Chairman of the Board was intended to ensure that the PGLU’s commitments, in terms of budgetary support (PHP 30 million a year), would continue.

As an autonomous hospital, LUMC is deemed to be a Government corporation owned and controlled by the province of La Union. Its charter makes it independent and flexible in making decisions pertaining to its institutional direction and operations. The changes in accountability and decision-making pertained to a wide range of functions including the hiring and firing of staff; the procurement of civil works, equipment, goods and services; fee setting and retention; the generation/mobilization and use of internally generated funds; and contracting arrangements e.g. entering into PPP.

The creation of the Board of Trustees means that the governance of the hospital and decisions about its strategic direction were moved from the Office of the Governor, which barely had time to deal with hospital issues in the past, to a dedicated number of Trustees selected for their knowledge of hospital development. The Trustees were selected from among Government and private sector leaders who were knowledgeable about health sector development. The initial key decisions made by the Board had to do with the review and approval of the hospital’s Economic Enterprise Sustainability Framework which covered:

- the finance and pricing strategy, which defined the overall resource mobilization of the hospital including PhilHealth reimbursements, patients’ fees and subsidies from the PGLU;
- human resources development and the alignment of staff and incentives along a corporate structure and culture, and the increase in the number of employees from 138 to 278 plus 48 others to implement improved career-path arrangements;
• administrative and operational computerization, including that of
the hospital’s accounting and financial system; and
• centralized procurement and supply chain management. The
Board and senior hospital managers were also mandated to
undertake advocacy work with municipalities whose constituents
will be using the newly corporatized hospital.

The day to day running of the hospital was assumed by a professional team
along with the 17 hospital committees mandated by the hospital’s enabling
Act, including the Committees on Staff Promotion and Selection, Training and
Research, Grievance and Ethics, Therapeutics, Utilization Review and Quality
Assurance, and others. The management team obtained Board approval
for the following key elements of hospital operations: i) joint venture (PPP)
agreements for access to medical equipment, including a haemodialysis
machine and laboratory equipment. Under these agreements, the private
investors place their machines on the hospital premises before paying the
staff, rent and other necessary costs and then share 15% of the revenues with
the hospital; ii) fee-setting and cost-recovery, which is based on the principle
of ability to pay, the implementation of payment in-kind or in-service, and
the subsidization of the poor; iii) other income-generating activities including
the operation of a pharmacy, the income from which augments the funds for
medicines for indigents; and iv) the installation of an integrated information
system which interlinks computers in billing and cashier sections for easy
monitoring of cash flow. LUMC has also installed the new Government
accounting system to ensure transparency and efficiency.

3.1.3 Results of reforms

LUMC was given the prestigious Gawad Galing Pook Award for excellence in
local governance in 2004, from among 189 entries nationwide. It is frequently
cited as a model for Philippine hospital autonomization and corporatization.
Among its key achievements have been the following: i) the total number
of patient discharges per year has increased from an average of 8 056 in
ii) within the same period, charity inpatients declined from 84.7% of the total
number discharged to 53.4% due to the enrolment of a significant number of
households under the PhilHealth Sponsored Program whose premiums are
subsidized by the Government; and iii) correspondingly, the proportion of
PhilHealth inpatients increased from 10.2–38.8%, while private pay patients
increased from 5.1–7.8%. Outpatient department patients increased from 23,856 in 2002 to 49,434 in 2008.

In terms of financing, the hospital’s PhilHealth collections increased several-fold from PHP 1.1 million in 2002 to PHP 19.1 million in 2008. Moreover, total collections from all hospital services – inpatient as well as outpatient, pharmacy and diagnostic services – increased from PHP 11.1 million in 2002 to PHP 57.8 million in 2008.

From the point of view of the PGLU, which owns the hospital, the hospital autonomy given to LUMC has freed the LGU of day to day operating problems as well as from worries about fiscal issues concerning its management. From the point of view of the hospital management, LUMC’s conversion into an autonomous corporate entity has been helpful in obtaining greater management latitude through the exercise of hospital corporate powers; the acquisition of technical expertise in such areas as medical technology, organizational management and other scarce skills through hospital Board membership; entering into contracts and other legal transactions, especially with respect to the acquisition of medical equipment through PPP; greater leeway in managing employees, free from the constricting civil service regulations; and greater overall stability as hospital governance is shielded from changes in local administration and elections. From the point of view of the employees, the autonomy and improved financial position of the hospital has given them better working conditions, more stable jobs and better salary structures, relative to what they experienced before the autonomy.

3.2 Leyte provincial hospitals

Leyte is an island province in Eastern Visayas (or Region 8) with 40 municipalities and a population of 1.5 million in 2012. Although the province is politically independent, two cities are also within the province, Ormoc and Tacloban – a highly urbanized area. The Leyte Province inherited 12 public hospitals (nine district- or secondary-level and 3 community- or primary-level) when these were turned over by the DOH in 1992. Until the Province-wide hospital reforms were initiated in Leyte in the early 2000s, these provincial hospitals were operated and run independently by each hospital director, although they obtained their budget from the Provincial Government.
As in any province that inherited hospitals from the DOH, Leyte’s hospitals were poorly funded, mainly because the annual revenue the Province received from the national Government was not enough to fund the social and other services that the Province inherited. Moreover, Leyte Province is not wealthy and has few revenue sources. The Province was spending as much as a third of its IRA on running its hospitals, and the costs were increasing every year. In 2003, the provincial hospitals had combined running costs of PHP 227.3 million but were only collectively generating hospital revenues of PHP 7.3 million a year, necessitating a provincial subsidy of PHP 220.0 million. In the following year, the hospitals’ costs increased to PHP 233.8 million; and, although their revenues also increased to PHP 10.4 million, overall the subsidy required increased further to PHP 223.4 million.

The underfunding manifested itself in the poor condition of the hospitals, including dilapidated hospital buildings; poor facilities and services; a shortage of doctors who were poorly motivated and who were often nowhere to be found; poorly motivated hospital employees; and a lack of medicines and hospital supplies. Due to the bad reputation of these public hospitals, they tended to cater only to poor and lower-middle-class patients. And because of the worsening conditions of these hospitals, their overall census declined from 5867 people in 2003 to 5531 people in 2004.

The financial rescue and reform of the Leyte provincial hospitals focused on retaining medical doctors. In the view of the then-incoming Provincial Governor, hospitals cannot be sustained without doctors who are not only the medical providers but the generators of revenues through their services as well. This vision involved hiring full-time doctors and lessening the reliance on part-time private doctors, incentivizing doctors by maximizing the collection of PhilHealth reimbursements, and imposing reasonable fees on users, except the poor.

3.2.1 Reforms undertaken

There are two complementary flanks of the hospital reform programme in Leyte. The first is Leyte’s own provincial hospital reforms, i.e. financing and supply-side reforms (Petilla, 2013). The second involves reforms to the PhilHealth social health insurance programme, which now provides
premium subsidies to the poor and quickens the eligibility verification system so that members can access services and make reimbursement payments to the provincial hospitals more easily. These reforms are deemed innovative in the context of the Philippines. This is because they focused not on infrastructure (the usual starting point of many hospital upgrading programmes), but on building a self-sustaining system of health financing. This makes it possible for physician and human-resource improvements to be made on public hospitals without entailing direct budgetary infusion from the provincial treasury.

The Leyte provincial hospital reforms were initiated by Carlos Jericho L. Petilla when he became Governor in 2004 and was re-elected for another three-year term in 2007. A private-sector business manager by profession, he realized that the financial difficulties of these hospitals can only be addressed through more aggressive revenue generation, professional management and better incentives to doctors and staff. As soon as he assumed office, Governor Petilla created the Hospital Enhancement for Leyte’s Progress (HELP) programme in August 2004.

The first flank of this reform programme is fee-generation and the earmarking of funds for hospitals with set rules under the Office of the Governor for their distribution as staff incentives. This is supported by the Special Service Fee (SSF) scheme – a user-fee programme started in the Leyte Provincial Hospital in Candahug, Palo and then expanded to the other provincial hospitals to generate financing for the retention of doctors and upgrading of hospital services. To achieve this, patients are asked and assessed by a social worker whether they want to stay in the pay ward (PHP 800/day) or free ward, and whether they prefer the services of their personal doctor (for which they have to pay) or not. Poor patients, as determined by the social worker in the hospital, are not required to pay. Patients pay only to hospital cashiers, while payments to individual doctors are strictly forbidden (enforced via closed-circuit TV cameras in the hospitals). A patient who agrees to these terms signs a consent form and a hospital representative issues the corresponding SSF slip. All fees are standardized across all provincial hospitals (which were all secondary level), and collections are centralized in a single fund under the Provincial Government.
Other elements of this reform programme include formally allowing dual practice among doctors; the setting aside of private wards in Government hospitals where paying patients stay; the creation of a dedicated fund where hospital fees are collected; and the formulation of rules on how these funds should be used. As stipulated in a 2006 Provincial Board Resolution, the SSF revenues are distributed as follows: 70% for the attending physician, 20% for the support staff, and 10% for the Province (since the hospital continued to receive subsidies from the Province). Of the 20% given to support staff, 50% was allocated to the assisting physician, physician aides, operating room nurses, pharmacist and the chief of clinics.

Leyte’s resource mobilization programme for hospitals also involved the more focused claiming of PhilHealth reimbursements (hospital fees and professional fees), and the setting of rules for their use (rather than discretion). As stipulated in the Provincial Board Resolution, PhilHealth hospital income is distributed in a way that corresponds to the expenditure of each hospital. This benchmark amount is deducted from the gross income of the hospital to yield its net income: 50% of each hospital’s net income goes to the provincial coffers (since hospital staff remain provincial employees) and 50% goes to the hospital. Of the 50% retained by the hospital, 30% is allocated to maintenance and other operating expenses, 30% to capital outlay, and 40% to employee incentives. Of the 40% allocated to employee incentives, 20% is for hospital doctors and 80% is for nonmedical staff.

PhilHealth professional fees for doctors are distributed as follows: 20% goes to the Provincial Health Development Fund which was established to pool funds for the improvement of provincial hospitals, and 80% is a professional fee, of which 85% was given to the obstetrician/gynaecologist or other specialist (or 75% to a surgeon with assistant), 10% to the assisting doctor or nurse, 5% to the chief of hospital, and 10% for the pool to be used for other health workers.

The second flank of the hospital financing reforms in Leyte involved improving the management of PhilHealth members’ eligibility through the creation of a call centre called PhilHealth LINKS in 2010 in Tacloban – the regional centre of Eastern Visayas. This was also initiated by Governor
Petilla, through close coordination with the regional office of the PhilHealth. The PhilHealth LINKS call centre responds to the problem of protracted and often missed identification of PhilHealth members, especially those who were enrolled quickly under the premium subsidy programme and who have not received their membership cards.

A major problem of PhilHealth is the low demand for benefits by its members. The 2008 Benefit Delivery Review indicates that only 6.2% of PhilHealth members utilized their membership for inpatient hospitalization that year. This problem has been traced to many factors, for example, the cost of reaching members through information, education and communication campaigns is very prohibitive. Many new members, such as poor families whose premiums are paid for by the government under the Sponsored Program, were handed out membership cards which contained little information on how they should be used. Members often misplace the cards, or find it difficult to prove they are members because they are unable to produce birth certificates and meet other administrative requirements. PhilHealth’s policy on dependents is also extremely complicated (e.g. the children of single mothers are particularly disadvantaged, since single mothers and their children are not legally deemed “family”). Households are often unaware of the need to renew their membership annually, which may have lapsed as a result. Some hospitals prefer cash payments rather than delayed PhilHealth reimbursements and may intentionally control members’ access to benefits. Prior to the introduction of case rate payments, complicated PhilHealth rules on birth delivery – PhilHealth reimbursed delivery expenses only up to the fourth child, for example – also dis incentivi zed many health facilities from assisting PhilHealth members to claim such benefits.

To correct these problems, PhilHealth Region 8, through the intervention of the Leyte Provincial Governor, initiated the LINK call centre that members can contact to assist in the verification of their membership. The Province of Leyte pays for an employee (PhilLINK) stationed at the call centre who serves as the call-centre agent for all 12 hospitals of the Province. In addition, the Province pays for provincial employees (PhilHELP) stationed within the 12 hospitals, who assist members when they are admitted and provide information on their health insurance benefits until they are discharged with completed claims forms.
Call inquiries from across Leyte to PhilHealth LINKS have increased from 5815 in 2011 to 24 994 for the first six months of 2013. Correspondingly, during the same period, new members have increased from 4856 to 18 918. Largely because of this system, as much as 76% of the callers during the first six months of 2013 have been confirmed to be PhilHealth members – higher than the 74% in 2012. As a result, the PhilHealth claim rate by Leyte hospitals has improved dramatically. For instance, data from the Leyte Provincial Hospital in Palo showed that only 30% of the patient census in 2005 consisted of PhilHealth members. This proportion had increased to 75% by 2011.

3.2.2 Governance structure

The hospital reform programme was orchestrated under the Office of the Governor who created the Provincial Ad Hoc Committee on Health in August 2004 to implement the vision laid out in the HELP Program. The Committee met and drafted the necessary rules and guidelines on the sources and allocation of fee revenues and PhilHealth reimbursements; the training and study tours for medical and nonmedical hospital staff; the installation of a financial management information system; the acquisition of medical equipment; and the approval of hospital facility improvement plans. Consequently, the Committee became the de facto governing and decision-making body for the HELP Program. The rules and guidelines, in turn, were issued as Executive Orders, Provincial Resolutions or Provincial Board Ordinances by the Office of the Governor. For regional initiatives, the Office of the Governor works very closely with the Regional Office of PhilHealth. For example, on the LINKS call centre programme.

Health service devolution transferred the governance of hospital services from the national Government to provincial government units in 1992, which then funded them largely with meagre IRAs from the national Government. This left many hospitals under the de facto governance of individual directors. For many years, this governance function was passively dispensed by most LGUs that did not know what to do with these assets and deemed them financial liabilities. The Leyte hospital reforms are important in the Philippine context for two reasons. First, they were the first attempt to deal with hospital financing in a comprehensive and politically active manner, using the same governance function that has been
available to LGU executives since 1992. Thus, while the Leyte Governor did not acquire additional powers, he simply exercised the functions that the Local Government Code conferred on him, and which many similarly placed LGU executives have difficulty exercising. What does seem to set the Leyte Governor apart from the other provincial executives is his vision and technical knowledge of how to go about the reform programme.

Second, the Leyte reforms reorganized the governance of LGU hospitals from individual directors left mostly on their own, to a governance system resembling a holding corporation under the Office of the Governor, issuing policies and guidelines to be followed by all hospitals in the Province. It is also critical to note the importance of the common fund, obtained from all sources and retained by the Office of the Governor – i.e. 10% of the SSF, 20% of the PhilHealth professional fee revenues and a benchmark amount from the PhilHealth hospital reimbursement. This income is used as an equalization fund to ensure that the provincial hospitals do not develop in an unbalanced way. To sustain the impetus of the reforms and ensure that standards are commonly applied across all provincial hospitals, relevant provincial resolutions and ordinances have been passed. These also make certain that the reforms will continue beyond the term of office of the elected provincial officials.

3.2.3 Results of reforms

The positive impact of the reforms has been unmistakable. The overall budget of the 12 provincial hospitals increased from PHP 227.3 million in 2003 (at the start of the reforms) to PHP 272.2 million in 2012. During the same period, income generated from fees and PhilHealth reimbursements increased from a measly PHP 7.3 million to a whopping PHP 118.4 million. As a result, the level of provincial subsidy has declined from PHP 220.0 million to PHP 153.8 million as planned. The subsidy is expected to decline further to about PHP 100.0 million in 2013 as PhilHealth reimbursements increase. Also, as a result of more citizens being enrolled in PhilHealth, the revenues from the SSF have remained stationary at around PHP 4.0 million a year since 2011.

Doctors are now much better remunerated. There are no longer any vacancies for medical specialists in any of the provincial hospitals. Indeed,
there is a queue of doctors wanting to apply. Provincial doctors earn anywhere from PHP 40,739–162,169, probably the best-earning provincial government doctors anywhere in the Philippines.

Despite the increase in fees for those with ability to pay, overall hospital census among provincial hospitals has nearly doubled from 5,867 people in 2003 to 9,973 people in 2012. The patient profile has also changed: while only 29% of the patients were PhilHealth members in 2005, this had risen to as much as 74% by 2011. Primarily due to the hospitals’ better technical capacity and services, and much-improved physical amenities due to capital upgrading, referrals from Rural Health Units have increased from 849 patients in 2005 to 983 patients in 2011, while referrals to other hospitals declined from 337 to 293 patients over the same period, mainly because improvement in the hospital allowed it to provide services to these patients who used to be referred.

3.3 National Kidney Transplant Institute/Hemodialysis Center– Fresenius Medical Care

The National Kidney and Transplant Institute (NKTI) is one of the four apex and autonomous hospitals established by the then President Ferdinand Marcos in the early 1980s – all located within a kilometre-radius of each other in Quezon City’s central business district. Established in 1983, NKTI is a Government owned and controlled corporation that has evolved into one of the top kidney and liver transplant hospitals in Asia.

During the first few years of NKTI’s operation, it had five haemodialysis machines used by inpatients and outpatients. In response to the rising number of dialysis patients, NKTI purchased 16 additional machines in 1998 through public bidding using the hospital’s budget for capital outlay. In 2000, four additional haemodialysis machines were purchased. These 20 machines provided 144–180 haemodialysis sessions for patients on twice-a-week treatments. At this scale, NKTI’s Hemodialysis Center was the largest in the country. But, at this capacity, the hospital was still turning away three new dialysis patients each day. However, in the wake of the Asian financial crisis during the late 1990s/early 2000s, the DOH was unable to increase the capital and recurrent budget of the hospital, as was also the case with the other DOH-retained hospitals.
The increasing demand for haemodialysis procedures coupled with the hospital’s financial difficulties, led to an impending vicious cycle of worsening services. An analysis of the problem showed that the daily pressures on the capacity of the Hemodialysis Center were creating frequent equipment breakdowns which caused logjams in maintenance, repair and other technical support (Riego-Javier, n.d.). Owing to the complex and protracted government bidding and procurement procedures, response times for repair and replacement of spare parts (usually 2–3 days) worsened, leading to the cancellation of treatments. Emergency cases could not be accommodated immediately due to the lack of machines; or, when they were given priority, other patients had to be dislodged from their original schedules, causing patient dissatisfaction. Due to increasing demand, the hospital warehouse became unable to accommodate all the necessary supplies to support haemodialysis services, leading to further delays. The staff were also showing fatigue as they had to juggle patients with whatever equipment was available, and staff turnover was becoming a problem. The hospital’s ownership of the equipment became a major management burden, and their replacement added to the problem due to the overall freeze in capital outlay.

The dilemma of increasing patient load and zero capital financing led the hospital’s management and Board to consider other options aside from the traditional financing of investments. In 2001, according to hospital administrators (led by Dr Aileen Riego-Javier, Executive Director), the expansion of the hospital’s Hemodialysis Unit became an essential and immediate priority of NKTI. The hospital management, working with the hospital Board, developed the following objectives: i) to expand the provision of haemodialysis services with a total of 31 machines, increasing the number of slots to 372 per week, for patients on twice-weekly treatments; ii) to establish a world-class haemodialysis centre in the country, with a separate facility for inpatients and another facility for outpatients; iii) to provide the best quality of haemodialysis treatment at an affordable cost; and iv) to provide a regular training programme for the hospital’s haemodialysis nurses along with technicians from other Government hospitals.
3.3.1 Reforms undertaken

To solve the problem of the high costs of new equipment and sustaining supplies for 180 haemodialysis sessions per day, in addition to removing the responsibility for maintenance and repair from management, the hospital embarked on a PPP arrangement with an external partner via public bidding. The PPP strategy follows the national Government’s Build-Operate-Transfer (BOT) or long-term lease approach that was being applied in large infrastructure projects but had not been tried in the health sector. The legal framework for this reform in service delivery and financing had already been established under R.A. 6957 (BOT Law), as amended by R.A. 7718, which authorized the financing, construction, operation and maintenance of infrastructure projects, including health, by the private sector.

The BOT scheme is a type of financing for long-term Government infrastructure projects, which sees the Government providing a lengthy concession to a private partner that arranges the building, operation and eventual transfer of the infrastructure. In return, the Government agrees to pay an annual unitary payment to the private partner until the concession ends. Hospital BOT, or its other variants, is a form of performance-based financing, since the concession agreement specifies the benchmark that the contractor is legally obligated to meet in exchange for the payment from Government.

The NKTI Hemodialysis Center is a PHP 54 million facility constructed as a PPP between NKTI and its private partner, Fresenius Medical Care. NKTI had a minimum equity contribution of 20% and Fresenius Medical Care put up 80%. The contract period initially ran for five years (2003/04–2007/2008) but has since been extended for another five years (2009–2013). Fresenius supplied and replaced the Center’s haemodialysis machines including state-of-the-art water treatment and dialysis reprocessing technology; provides service technicians at all times; and ensures the around-the-clock availability of supplies. NKTI, in turn, pays the lease provider a fee per treatment in accordance with the pre-agreed lease payment schedule. It also meets the space, staff and utility requirements; monitors the partner’s quality performance in accordance with international standards; and ensures compliance with relevant Government regulatory health policies.
3.3.2 Governance structure

The BOT/PPP was put in place largely by the NKTI management team based on the decisions of the autonomous hospital Board. Would NKTI have succeeded in formulating and carrying out the Hemodialysis Center PPP if it were not autonomous? Hospital administrators have reported that its autonomy has allowed managers and Trustees to be more open-minded about potential options and more flexible in negotiations with potential offerors. Autonomous hospitals can also exercise greater latitude in terms of the size and modality of procurements and contracts, which non-autonomous hospitals cannot. Moreover, by delegating governance and decision-making to the Board of Trustees, the DOH has been able to devote more of its time to other pressing matters in the health sector.

However, as the following case study (Southern Philippines Medical Center) shows, the lack of hospital autonomy is not a complete deterrent to hospital reforms. Certain reforms can still be carried out even if the hospital is not autonomous, provided it has visionary leadership, adequate technical capacity to formulate and implement the reforms, and set rules and guidelines on how specific reform measures and operational aspects are to be achieved. Hence, while autonomy can be a facilitating factor for reforms, it is not the only key that can unlock potential innovations.

The major change in accountability and decision-making that resulted from this BOT/PPP reform is the delegation of day-to-day management of haemodialysis – equipment acquisition, procurement of supplies, scheduling of preventive maintenance, training of haemodialysis nurses – to the private-sector partner (Fresenius), based on the contract that both parties signed. In other words, the contract became the governing instrument for the reforms to take place. To make such an arrangement work requires a strong and high-level regulatory and monitoring capacity within the hospital. It is not clear, however, whether this is a governance or a management responsibility, although it does seem to be dispensed by both.

3.3.3 Results of reforms

NKTI was able to acquire the latest haemodialysis technology and expand its services to more patients at the same cost of treatment and less risk to the Government – such as the risk of project non-completion. The project was
formulated and awarded in a short time (about two years). Thanks to more machines and greater reliability, haemodialysis treatment has been extended to more Filipinos. From 2007–2010, the total number of dialysis patients reached 27,522, or around 6880 a year (or 19 a day). Access among those with a limited ability to pay has been enhanced – the fee at NKTI (around PHP 2000 per week) is still far more competitive than those in the private sector (around PHP 4000 per week). The PPP has also intensified nurses’ training programmes and improved the rotation of nursing staff. Nursing staff turnover has also been controlled. Finally, while the hospital’s annual Government budget has remained fairly constant since 1998, hospital fee revenues have increased dramatically and haemodialysis revenues have consistently outpaced the payment made to the PPP partner since the scheme started.

3.4 Southern Philippines Medical Center

The Southern Philippines Medical Center (SPMC) is a tertiary referral hospital in Davao City – the largest metropolitan area in Mindanao, the Philippines’ second largest island. It is one of 72 hospitals retained by the DOH when health services were devolved in 1992, and serves as the regional hospital for the Davao Region, an agriculturally rich area. It has an authorized bed capacity of 600 but its average inpatients per day reach 1107 – a bed capacity exceeding 226%. The outpatient department attracts, on average, 1096 patients per day.

Like most large retained DOH hospitals, it is not autonomous and has faced financial difficulties for many years. It has not received a budget for capital outlay over the past three years (2010–2012), even though its patient-load increases every year. Its recurrent budget barely increased from PHP 250 million in 2011 to PHP 261 million in 2012. Given the more pressing needs of the DOH, it did not seem likely that the hospital would get relief from its financial problems with help from the national Government. The zero capital outlay meant the hospital was not able to improve and upgrade much-needed diagnostic and therapeutic equipment, much of it in bad condition. Given its sizeable patient-load, drug shortage was also common.

In 2008, the hospital conducted a stocktaking exercise which identified revenue generation, through the maximization of PhilHealth benefits, as
the key strategy to get out of its financial difficulties (Vega, 2013). This would also pave the way for the hospital’s future of efficient, effective and sustainable service delivery based on medical upgrades and much-improved human resource development. The chain of problems originated with the poor morale of employees, most of whom deemed claims-filling to be an additional and needless task, used as they were to passively receiving DOH subsidies and not having to actively earn it, as is the case with health insurance reimbursements. This staff attitude resulted in inaccurate data, miscoding and the computation of claims. This arose, in turn, from inadequate receipts; poor and unreadable penmanship, especially of doctors; a lack of information among doctors and nurses about the benefits of PhilHealth claims; a lack of knowledge among billing clerks on claim preparation, prescriptions using non-PNDF (Philippine National Drug Formulary) which PhilHealth does not pay, and the use of non-standard paper. The combined effect of these problems was a high rate of “return to hospital” claims, many of which were denied payment by PhilHealth. Poor collection followed, setting off a vicious chain ending with ill-incentivized workers.

3.4.1 Reforms undertaken

Three interrelated reforms were undertaken at the SPMC: hospital financing reforms to increase the revenue flow; the adoption of drug consignment as a system of accessing drugs from the private sector; and PPP as an approach to greater access of diagnostic technologies. To break the chain of low finances due to a lack of claims submitted to PhilHealth, the hospital management adopted a multi-pronged approach to maximize health insurance reimbursements, thereby significantly increasing the flow of revenues needed to improve the running of the hospital. First, management decided to gradually increase the number of PhilHealth billing staff from 7 to 40; provide regular training to appropriate doctors and nurses in ICD-10 – a standard for medical diagnosis and billing codes endorsed by the World Health Assembly; and assign three doctors as medical adjudicators. Second, all nurses were trained in the precise charging of supplies for procurement, to be reflected in costs. Third, a quality assurance system was put in place for documents to be near-perfect (“PhilHealth friendly”); increase compliance among doctors and nurses, while improving the legibility of their penmanship; and make all PhilHealth computations accurate.
To address the recurrent problem of drug shortages, the hospital pioneered a drug consignment system in which private pharmaceutical suppliers placed their inventories in the hospital and SPMC merely paid for what it consumed on a periodic basis. Thus, there was no upfront cash payment involved, and the hospital management was freed of the inventory task and stock-out problem.

To have access to modern medical equipment without resorting to large upfront investment, the hospital management adopted an innovative PPP involving a publicly bid, multiyear (usually 3–5 years) consignment of medical equipment through unit-cost-per-test payment to the private partner. These were put in place for new chemistry and immune-assay analyzers (at an estimated cost of PHP 14.8 million), two haematology analyzers (at an estimated cost of PHP 6.0 million), dialysis machines (at an estimated cost of PHP 14.0 million), computed radiography and digital radiography equipment (at an estimated cost of PHP 35.0 million), and 50 mechanical ventilators (at an estimated cost of PHP 77.4 million). The hospital also entered into publicly bid lease-to-own partnerships (usually within 5 years) with the private sector which covered: a 16-slice computerized tomography (CT) scan (at an estimated cost of PHP 31.0 million); and a 128-slice CT scan (at an estimated cost of PHP 77.0 million).

3.4.2 Governance structure

The hospital remained non-autonomous before, during and after the reforms. Its governance structure remained the same – as a DOH-retained hospital. This case study shows that the reforms were facilitated by strong, visionary leadership (the hospital Director was in the private sector before going into the Civil Service) rather than an explicit change in institutional governance. However, the contracts with private suppliers (pharmaceutical and equipment consignments) became the basis of the governance structure. It also helped that there was strong agreement among hospital managers on what needed to be done as well as the approach to get there. Finally, the hospital rules and guidelines on PhilHealth claiming and reimbursement as well as PPP/consignment provided the institutional basis on how to implement the reforms.
3.4.3 Results of reforms

The reforms have resulted in an increase in the proportion of PhilHealth-covered patients, from 32% in 2008 to 44% in 2012. Correspondingly, PhilHealth reimbursements have increased dramatically from PHP 170.4 million in 2008 to PHP 436.9 million in 2012. Due to the 156% increase in PhilHealth reimbursements, the hospital has been able to embark on a large-scale capital investment programme including: the upgrading of two pay wards; the construction of a new pay ward and nurse station; the upgrading of the PhilHealth service ward; improvement in the specialty wards (obstetrics/gynaecology; ear, nose and throat; internal medicine; pediatrics); the installation of a pneumatic tube to carry drugs and other vital supplies around the hospital; the improvement of the halal dietary provision; and the construction of the canopy and façade of the hospital complex.

The drug consignment system has solved the problem of chronic drug shortages in the hospital. Private suppliers appear to be happy with the arrangement, mainly because the hospital is now generating large revenues from PhilHealth reimbursements and is able to pay for the drugs consumed by patients. A Department of Health Administrative Order has been drafted for the adoption of drug consignment nationwide among Government hospitals, based on the pioneering experience of the SPMC. In 2011, the system was recognized as a health-market innovation with an award from the Philippine Institute for Development Studies, and has since been replicated in other Government hospitals.

4. Environment affecting public hospital governance

4.1 Internal environment

Active and visionary leadership and management is the most critical element of hospital reforms. Where this is missing, reforms cannot be initiated and sustained. Given a reform- or health-unfriendly leader, Filipino Civil Servants in the health sector tend to simply wait out the end of the tenure of the political leader or the reassignment of the appointed officer.
All the reforms detailed in these case studies relate to financial difficulties. While PhilHealth reimbursements have become more available, many hospital directors and local government executives are ill-equipped to understand and deal with the intricacies of a third-party payment system — they would rather rely on budgetary subsidies. Many of the internal environmental constraints in public hospitals could be addressed if only their leaders understood the nexus of health insurance and reforms, e.g. the purchasing of health services, new provider payment system and revised administrative procedures.

Success in hospital reforms hinges on the good relationship between local government executives and LGU hospital directors. The short-lived and frequent changes in local government due to elections every three years are a constraint in this regard. A constitutional amendment has been proposed by several groups to resolve this, but the situation is not likely to be altered any time soon.

Governance is often thought of only in terms of the institutional structure that is put in place. But governance also includes, perhaps more importantly, the rules and regulations that are created and agreed upon by stakeholders to guide their relationship and way of doing things. This is true whether the instrument is a contract, a memorandum of understanding, a provincial or municipal ordinance, or an internal directive. Indeed, it is these instruments of governance that may be more important and lasting than the new personnel appointed or the new structures put in place.

4.2 External environment

Changes in demand are being brought about by a growing population, changing demographic and health transition which alter the burden of disease, at the same time as rapid migration from rural to urban areas and persistent poverty lead to significant uncompensated care – all take their toll on hospital governance and management. Changes in supply brought about by new technologies and medicines, new business formats and operating arrangements, new information technology, a mobile and often vocal health workforce, and medical tourism – these, too, impinge on hospital operations. But many hospital managers may not be able to
think through these demand and supply challenges and propose strategic solutions.

The Government’s response to these challenges is often to regulate, as indicated by the number of DOH Administrative Orders (AOs). While services have long been devolved, a “delivery mentality” lingers at the heart of the DOH which often manifests in control and micromanagement. As a result, many of the AOs do not get implemented at the local or hospital levels, and are sometimes viewed by local health officials as nuisance. Indeed, some of the AOs have no teeth, since DOH may not have a mechanism for their effective enforcement. An alternative paradigm of educating, skilling, facilitating and leading LGUs and hospitals (boards, directors, staff) needs to take root, but is often constrained by capacity weaknesses at the centre.

5. Conclusions and recommendations

While full hospital autonomy is an ideal governance structure that Government hospitals aspire to, it is clear that smart administrators can still introduce a lot of innovation and reforms within their own powers as defined by devolution. This is clearly the case with the Leyte Provincial Hospitals and SPMC, which operate within the parameters of their structures, yet are able to achieve the types of successes that elude others.

5.1 Governance structure and key reforms affecting performance

For LGU hospitals, the locus of reforms is in the office of the incumbent governor or mayor of large cities/municipalities which own the hospital assets (e.g. LUMC, Leyte Provincial Hospitals). In the case of DOH-retained hospitals, the hospital director and his team are the key reform leaders, as is the case at NKTI and SPMC.

Due to the short tenure of elected local officials, hospital reforms can be difficult to sustain unless the official who championed the reform programme gets re-elected, or a party colleague who thinks similarly becomes the next LGU executive. This has certainly been the case with LUMC and the Leyte Provincial Hospitals. It also helps if the reform programme is laid out formally in LGU ordinances or resolutions so that it is institutionalized.
The support of health leaders (provincial/municipal health officials, hospital directors and doctors practicing in the affected health facilities) is important. All of these case studies on hospital reforms were initiated in response to a need for a stronger financial base to support better services and to sustain them. Given the limited fiscal space that each of the hospitals faced, the reforms were achieved primarily via the expansion of internally generated (non-budgetary) funds – initially through user fees and increasingly through PhilHealth reimbursements. The reforms centred on rule setting – around fee schedules, the retention and allocation of revenues, the continued infusion of budget subsidies, and the need to protect vulnerable people or charity referrals – as well as on establishing support systems for information technology (LUMC, NKTI, SPMC).

In hospitals that required large investments in technology, PPP arrangements were put in place (NKTI, SPMC, LUMC). The PPP approach allowed Government health facilities to benefit from the advantages inherent in the private sector, which they would have missed had they continued to operate within the bounds of a hierarchical budgetary and performance structure. The PPP instrument (contract) spelled out the legally binding roles and responsibilities of the partners as well as the governance structure of the partnerships.

All of the reforming sites enjoyed fiscal autonomy (LUMC, NKTI, SPMC, the Leyte Provincial Hospitals) which were used not only to generate much-needed resources but to incentivize workers and managers, based on strict internal rules and regulations.

5.2 Strengths and good practices

The use of provincial ordinances and resolutions and, in the case of LUMC, an Executive Order and a Congressional Act, has made it possible for reform programmes to straddle political administrations. Given the fractious democracy and short political tenures in the Philippines, this is an important element of any hospital reform programme.

Competitive PPP is increasingly being used as a means of acquiring sophisticated medical technology in Government hospitals, sometimes at zero cost (in the case of consignment). Best practice documentation should
be institutionalized so that cross-institutional learning can occur and innovations implemented widely.

Almost all of the reforms that have succeeded are anchored on the centrality of PhilHealth financing, without which internal revenue generation (based on user fees and other non-insurance sources) would be grossly inadequate. In this regard, PhilHealth and participating hospitals need further strengthening to focus on increasing patient utilization and access to hospital services, making fair and efficient the level of payment and supporting the provider payment process.

In the few hospitals that undertook revenue improvement, the budget subsidy – whether from the DOH to its retained hospitals, or the provincial government to its LGU hospitals – was maintained until the hospitals were able to be self-sustaining. To achieve such degree of financial predictability, good negotiation using solid information is needed between the fund-holders and the fund-recipients.

Internal capacity strengthening, especially in information technology, is an essential ingredient of hospital reforms (especially in SPMC, LUMC and NKTI). Without it, reforms in finance and procurement cannot succeed. Given the Department of Budget and Management and Civil Service restrictions on the number of staff in Government hospitals, management should find alternative ways to plug this much-needed gap, either through outsourcing or part-time workers.

5.3 Challenges and recommendations

The lack of an overall Government strategy for tertiary care service delivery is an important constraint of a more comprehensive hospital reform programme in the Philippines. The governance and financing reform initiatives are far too few, relative to the total number of facilities, and the efforts are rather sporadic and not coherently packaged as an entire reform programme. The few that have succeeded or are struggling rely heavily on leaders/advocates with individual vision, rather than a Government wide recognized necessity to change.
Part of the sporadic nature of hospital reforms is the lack of critical hospital information resulting from the overall weakness of information systems. Although hospitals submit their annual capacity and operating profiles to the DOH, these are not encoded, aggregated and analyzed. Senior policymakers are disadvantaged in not having useful information that would help them to see the hospital sector in its entirety. As a result of this gap, plans and decisions are often made on a case by case basis.

Sceptics within government hospitals who are affected by the reform programme can be its most vociferous critics. Hospital reform initiatives in the Philippines are often met with demonstrations and other public displays of resistance; frequently abetted by advocacy groups that the disgruntled employees seek as allies or champions. The most difficult challenge is how to win over the media and other populist actors that are sceptical of hospital reforms and prefer the traditional approach of simply increasing Government budgets for hospitals.

In future, the challenge will be how to finance and provide services for both communicable and non-communicable diseases, which calls for the strengthening of both public health and hospital systems. Hospital governance reforms are a key ingredient in strengthening hospitals. While a few reforms are underway, they have been sporadic because of resistance within and outside the hospitals. Part of this resistance can be addressed in the short-term by greater information on key decisions, dialogue or mediation. But over the long-term, education of key decision-makers within the affected hospitals is critical, including their exposure to similar reform programmes elsewhere in the world. More research, documentation and sharing of experience should be undertaken.

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