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How Are Government Hospitals Performing? A Study of Resource Management in Government-Retained Hospitals

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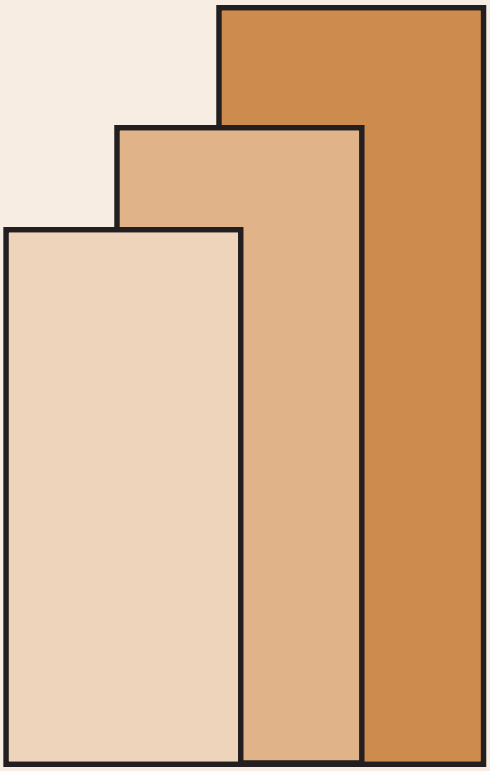
DISCUSSION PAPER SERIES NO. 2010-02



January 2010

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How Are Government Hospitals Performing?
A Study of Resource Management in DOH-retained Hospitals*

Rouselle F. Lavado, Abigail Barbara Sanglay-Dunleavy, Jeanette Jimenez, Yasuhiko Matsuda

ABSTRACT

The paper attempts to provide an overview of the hospital sector in the Philippines with particular emphasis on hospitals being managed by the DOH. The paper begins with an overview of the hospital sector in the Philippines, describing the size, location, and utilization of hospital services. To assess the efficiency and effectiveness of service delivery in DOH-retained hospitals, an analysis of resource management is undertaken by examining the sources of funds, planning and budgeting cycle, uses of funds, and monitoring set-up. The paper provides a critique of recent policies concerning hospitals as outlined in the Health Sector Reform Strategy. The last section concludes and provides some policy recommendations.

Keywords: health, health care, health sector, health care financing, health care reform, health expenditures, health facilities, health funds, health management, health services delivery, hospitals

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*The original research for this paper was conducted for a World Bank analytical study but the views and opinions expressed herein are solely those of the authors and do not reflect those of the World Bank.

EXECUTIVE SUMMARY

1. **Hospitals serve as the locus of health care delivery in the Philippines.** Survey data shows that most households go directly to hospitals for treatment of illnesses. With the breakdown of referral networks due to devolution, tertiary level hospitals which are designed to cater to more serious diseases are also accommodating cases that can be handled by lower level facilities. This leads to tertiary hospitals requiring more financial resources to be able to attend to all its patients.

2. **The Department of Health (DOH) spends more than half of its budget for the upkeep of its tertiary level hospitals.** In the 2007 GAA, allocations for hospitals comprised 61 percent of the DOH total budget of Php11.4 billion. A total of Php2.7 billion was appropriated for national hospitals while Php4.17 billion of appropriations were provided for health facilities under Center for Health Development (CHDs) such as regional hospitals and medical centers. These account for 24 and 37 percent of the DOH's total budget, respectively. Despite their crucial importance in the healthcare sector, there is little systematic understanding of how public hospitals utilize public resources. Since the budget flows directly to the DOH-retained hospitals, budget execution reporting and monitoring appears to be weak and so are the incentives and accountability structures to ensure that hospital services are affordable and of acceptable quality.

3. **The share of hospital allocation in the total DOH budget has been declining.** From the previous 60 to 66 percent recorded from 2003 to 2006, this figure declined to 59 percent in 2007. Although in nominal terms the allocation for hospitals in 2008 was at the same level as prior years, its share in the total DOH budget saw a marked decline in 2008 accounting only to 35 percent. This change reflects a shift in the priority of DOH from personal health care to public health programs.

4. **Payments to hospital personnel comprise the largest share of hospital budgets.** In 2008, personal services account for three-fifths of the budget. There has been a steady decline in the share of Maintenance and Other Operating Expenditures (MOOE) in the hospital budget, from the level of 44 percent in 2000, the share of MOOE declined to just 32 percent in 2008. From 2000 to 2008, MOOE declined by as much as 52 percent in real terms. Capital Outlay had been zero from 2001 to 2006, partly due to the fiscal crisis and the austerity measures imposed during this time. Capital outlay was only distributed to all hospitals in 2007 but such distribution was scaled back in 2008 with only 13 hospitals receiving CO appropriations.

5. **There appears to be no clear allocation criteria for hospital budget.** It used to be that the budgets are based on the number of hospital beds but as hospitals evolved with more complex composition of cases, this practice is not applicable anymore. Hospitals that cater to more complicated cases such as Medical Centers and Regional Hospitals receive lower per bed allocations than Extension and District Hospitals.

6. **Poorer regions are not receiving higher hospital subsidies**. In terms of poverty incidence, ARMM ranked the highest and at the same time received the least amount of subsidy allocation for its DOH-retained hospitals on a per capita basis. Conversely, NCR and CAR (Cordillera

Administrative Region), which both have relatively low poverty incidences, received the highest subsidy allocation on a per capita basis.

7. **There is no overall sector plan for hospitals sector**. Planning is a crucial stage towards determining a budget which will reflect the current needs of the hospitals. In the years before the implementation of F1, it appears that there was no clear plan for DOH-retained hospitals, which translated into a budget based on historical data, rather than the actual needs of the facility. At the hospital level, planning and budgeting seem to be also ad hoc and lacking in overall strategy. There are no oversight arrangements in terms of planning and budgeting, and no clear guidelines exist in budget preparation specifically designed for hospitals.

8. **Budget execution for hospitals lack oversight**. Reporting of actual budget execution is weak and the differences in the way reports/Statement of Allotment and Obligations and Balances *(*SAOBs) have been prepared makes monitoring more difficult. Based on a sample set of SAOBs prepared by MM hospitals, some accounts or line items are recorded differently across hospitals. There are also no reports on particular expenditure items such as procurement of medicines and hospital subsidies for service patients are not quantified. Although income utilization data are submitted by the hospitals, it is not analyzed.

9. **Unfunded laws distort reporting of uses of funds**. Mandating hospitals to provide Magna Carta benefits without giving them the appropriate budget and the restrictive regulation on the uses of funds push the hospitals to resort to report manipulation. Interviews with DBM-Central Office as well as DOH-Central Office Budget Division reveal that the reason for the high budget utilization rate is due to the use of savings as payment for magna carta benefits. Under RA 7305, or the Magna Carta of Public Health Workers, public health workers are entitled to, among others, subsistence allowance, laundry allowance, longevity pay, hazard pay, higher salary grade upon retirement, among others. Since its passage in 1992, government has not been able to fully provide for in the budget the payment of such benefits as prescribed in the law. Only the subsistence and laundry allowances are provided but these are not given in full, i.e. for subsistence allowance, of the Php1,500 under the IRR of the magna carta for health workers, only Php900/month is funded from the GAA while Php600/month from savings; for laundry allowance (Php150/month based on the IRR, only Php125/month is funded from the GAA while Php25/month is sourced from savings. Hazard allowances are budgeted but these are only for x-ray technicians. The rest of the benefits prescribed in the magna carta are not funded at all.

10. **Clear guideline in the rules behind income retention does not exist**. Starting 2003, DOH retained hospitals were able to retain its income by virtue of a special provision in the 2003 GAA. Instead of reverting the income back to Bureau of Treasury, hospitals are allowed to use income in augmenting its MOOE. Sources of hospital income are out-of-pocket payments, reimbursements from PhilHealth, and others, such as training fees, certification fees, PCSO, and rental income. Although all hospital directors that were interviewed agree that allowing income retention provided a good way of alleviating fund shortages, the current practice of cutting MOOE as income increases provide adverse effects in income collection efforts.
11. **There is lack of reliable data for measuring hospital performance**. Although the DOH mandates hospitals to submit reports on hospital activities, the reports are sometimes incomplete and lacking key components. In 2005, only 48 out of 66 submitted the Annual Statistical Report. NCHFD does not impose sanctions to the hospitals that did not submit the

reports. The last consolidated annual report was prepared in 2004. Statistical data from 2005 onwards were no longer prepared due to the resignation and retirement of key staff involved in the HOMIS. Since the data has not been consolidated since 2004, no pertinent analysis has been made on Hospital Statistical Report. At present, data from the report is used only as an input to DOH Annual Report. At the hospital level, collecting and using information for planning and budgeting purposes do not appear to be an important priority.

12. **The incentive structure of Central Office regulations is conflicting**. The DOH adopted *FOURmula ONE for Health* (F1) as the implementation framework for health sector reforms in August 2005. Among the budget allocation principles espoused in F1 is for subsidies to be allocated on the basis of capacity to generate revenues from operations. The budget for retained hospitals was easily identified as the source for such reallocation due to their potential of generating their own revenues. F1 also states that financing of health agencies and programs shall be shifted from historical or incremental budgeting system into one that is performance-based where budget allocations and releases are conditioned on the achievement of performance targets. A separate implementing guideline for performance-based budgeting (PBB) for DOH-retained hospitals was released subsequently on July 2006 where DOH splits funding for the hospital MOOE into several portions, the releases of which will be based on hospital performance relative to pre-agreed performance measures. However, while the F1 encourages hospitals to increase income collection, criteria for the release of MOOE under PBB requires hospitals to engage in activities that will dampen fee collections.

The way forward

1. ***A need for an overall plan for all DOH-retained hospitals cannot be overemphasized.*** Various plans have been drafted in different health sector reform strategies in the past but disconnect between the central office plan and the hospitals remain because agencies in charge of the implementation do not have a strong authority to implement reforms. A probable solution would be to have a hospital administrator within the DOH who will oversee the implementation of the hospital plan in all DOH hospitals. This administrator should be given the appropriate authority to give sanctions for non-compliance and provide rewards for good performance.

2. ***Using the number of beds as a basis for budget allocation needs to be revised.*** Before budget is allocated using the OPIF, there is a need to first reset the amount allocated to each hospital. This new allocation criterion should reflect the current status of each hospital. Aside from the size of the hospital, allocation should incorporate various activities of the hospital such as complexity of cases handled and the number of service patients served. It should also factor in equalization measures such as GDP and poverty incidence in the region where the hospital is located.

3. ***A clearer policy on income retention needs to be drafted.*** Hospitals should not be penalized for earning high incomes by cutting their MOOE allocation for the next year. Similarly, the DOH should ensure that poorer segments of the population will not be ostracized in public hospitals due to the pressure of increasing hospital income. One way of ensuring that hospitals earn, and the poor afford hospitalization, is the enrollment of the poor patient in the Indigent Program of Philhealth. The current set-up of DOH hospitals being funded by the national government and LGUs paying for PHIC premium is not incentive compatible since the LGUs can pass hospitalization cost to the national government even without PHIC cards. A short-run

alternative is for the national government to shoulder the PHIC premium of the poorest of the poor. In the long-run, management of hospitals, should be given back to LGUs, particularly those that are not special medical centers. This way, LGUs will have an incentive to increase their efforts not only in enrolling their poor constituents but also enticing those who are self-employed to join the program. This would also help equalize the unfair distribution of devolved functions among provinces where those who had a DOH funded hospital in their area are better-off compared to those who inherited all hospitals.

4. ***Magna Carta Benefits no longer funded by hospital savings.*** The current financial status of most hospitals suggests that they are already overstretched in meeting hospital operational expenses. Giving them the additional burden of shouldering the expenses to pay for Magna Carta benefits is likely to result in unequal compensation of hospital workers among DOH-retained hospitals. Since the law is already enacted and it has long been recognized that hospital workers are undercompensated, Magna Carta benefits should indeed be paid. Given that the national government budget cannot afford to pay for these benefits, a possible source is the professional fee reimbursement from Philhealth. Currently, these are used by some hospitals to provide honoraria to their workers. As opposed to the current practice of funding the benefits from PS or MOOE savings, professional fee reimbursements should be earmarked for Magna Carta benefits. It will also provide an incentive for hospital workers to encourage patients to enroll in Philhealth.

5. ***Data collection should be raised as a priority at the hospital level.*** A reliable set of data is needed before any performance benchmarking can be done. The DOH-CO should re-evaluate the reasons why HOMIS has not been successfully adopted by most hospitals. If indeed it was found that the absorptive capacity of DOH-retained hospitals to maintain a hospital database is low, simpler alternatives should be pursued. In the advent of information technology, manual tabulation of hospital statisticians should cease to be the status quo.

6. ***Rethinking performance based budgeting.*** While the idea behind PBB is promising, it is essential to determine how to implement the same given the prevailing incentive structure surrounding hospital managers and hospitals' information management capacities. DOH should re-examine the feasibility of the criteria used to assess the performance of hospitals. The incentive structure behind PBB should also be re-assessed so that it will actually reward good performers and steer those that are lagging behind toward better performance in a consistent manner.

1. INTRODUCTION

1.1. Hospitals serve as the locus of health care delivery in the Philippines. With 1,800 hospitals and over 87,000 beds, most households go directly to hospitals for treatment of illnesses. The Department of Health (DOH) spends more than half of its budget for the upkeep of its hospitals. In the 2007 General Appropriations Act (GAA), appropriations for hospitals comprised 61 percent of the DOH total budget of Php11.4 billion. A total of Php2.7 billion was appropriated for national hospitals while Php4.17 billion of appropriations were provided for health facilities under Center for Health Development (CHDs) such as regional hospitals and medical centers. These account for 24 and 37 percent of the DOH's total budget, respectively.

1.2. Although a significant portion of the DOH budget is allocated for hospitals, there is little systematic understanding of how public hospitals utilize public resources. Since the budget flows directly to the DOH-retained hospitals, budget execution reporting and monitoring at the central level appears to be weak and so are the incentives and accountability structures to ensure that hospital services are affordable and of acceptable quality.

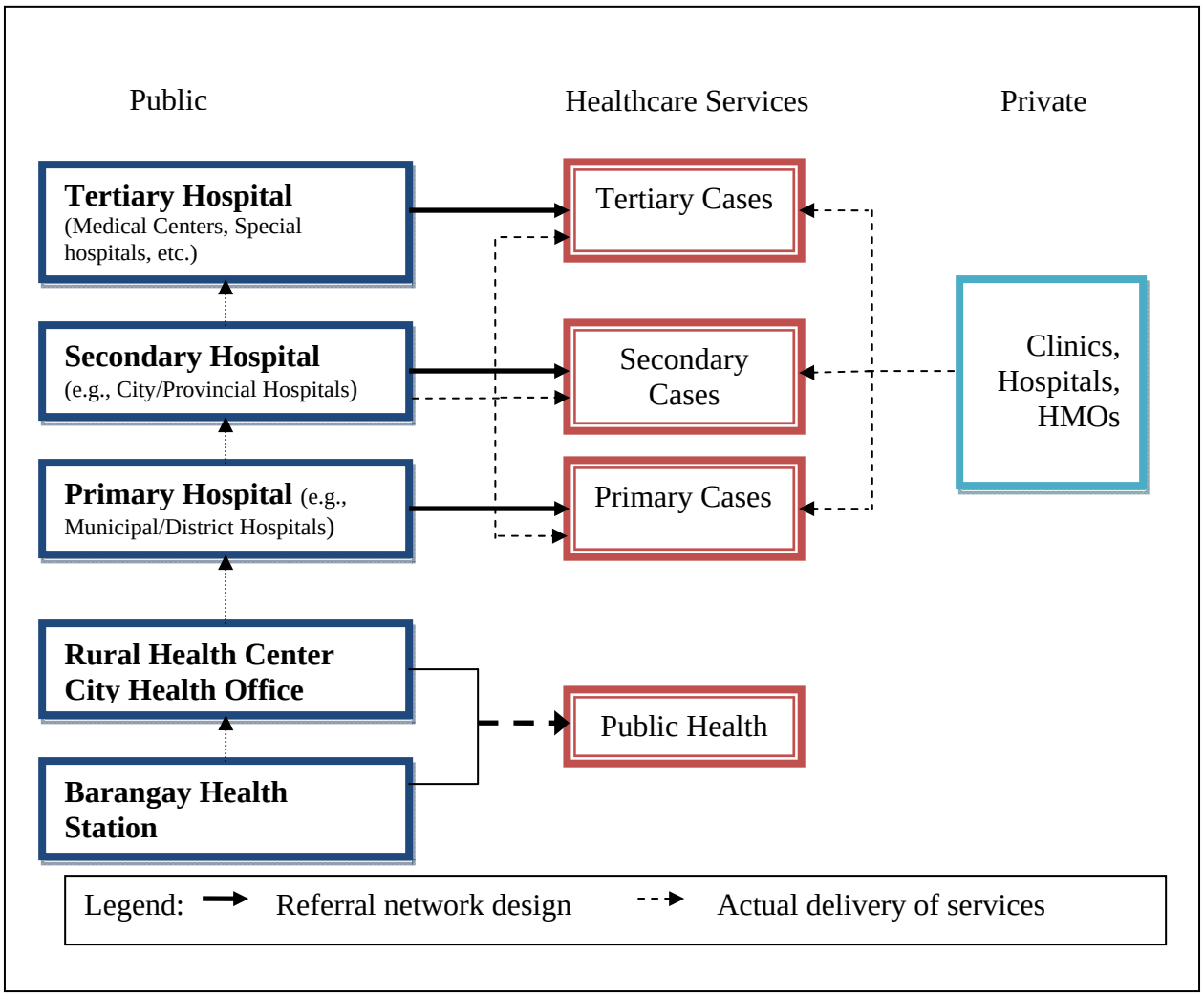
1.3. This paper attempts to provide an overview of the hospital sector in the Philippines with particular emphasis on the hospitals being managed by the DOH. To be able to assess the efficiency and effectiveness of service delivery in DOH-retained hospitals, an analysis of planning, budgeting, allocation and execution is undertaken through desk reviews and field visits to a sample of hospitals. This study aims to help in understanding whether or not government's initiatives to improve access to quality health care are having desired effects.

1.4. The study is composed of five parts. Section 2 provides an overview of the hospital sector in the Philippines, describing the size, location, and utilization of hospital services. Section 3 focuses on the budget execution of DOH-retained hospitals. It begins with a description of trends in DOH budget for hospitals. Then it looks at financing arrangements, highlighting the sources of funds, planning and budgeting cycle, uses of funds, and monitoring set-up. Section 4 provides a critique of recent policies concerning hospitals as outlined in the Health Sector Reform Strategy. The last section concludes and provides some recommendations that can be gleaned from the study.

2. HOSPITAL SECTOR IN THE PHILIPPINES: A BRIEF OVERVIEW

2.1. *Delivery of healthcare services* in the Philippines is provided both by public and private providers (Figure 2.1). It is designed as a referral network, wherein Barangay Health Stations (BHS), manned by Barangay Health Workers (BHWs), serve as the base.[1] They report to City Health Offices (CHOs) or Rural Health Units (RHUs) usually located in a city or a town poblacion. CHOs/RHUs are usually staffed by a physician, nurses, a sanitary inspector, trained midwives, affiliated traditional birth attendants and BHWs. RHUs refer patients to primary hospitals, usually composed of 25 beds. Large provinces usually have secondary hospitals usually composed of provincial and city hospitals. Final referral hospitals are composed of medical centers, regional hospitals, and specialty care hospitals. With the devolution of health services in 1992, the referral network failed to work as envisioned. For instance, tertiary hospitals normally attend to all the cases, even primary ones.

Figure 2.1: Healthcare Service Delivery in the Philippines



[1] A barangay is the smallest political unit in the Philippines.

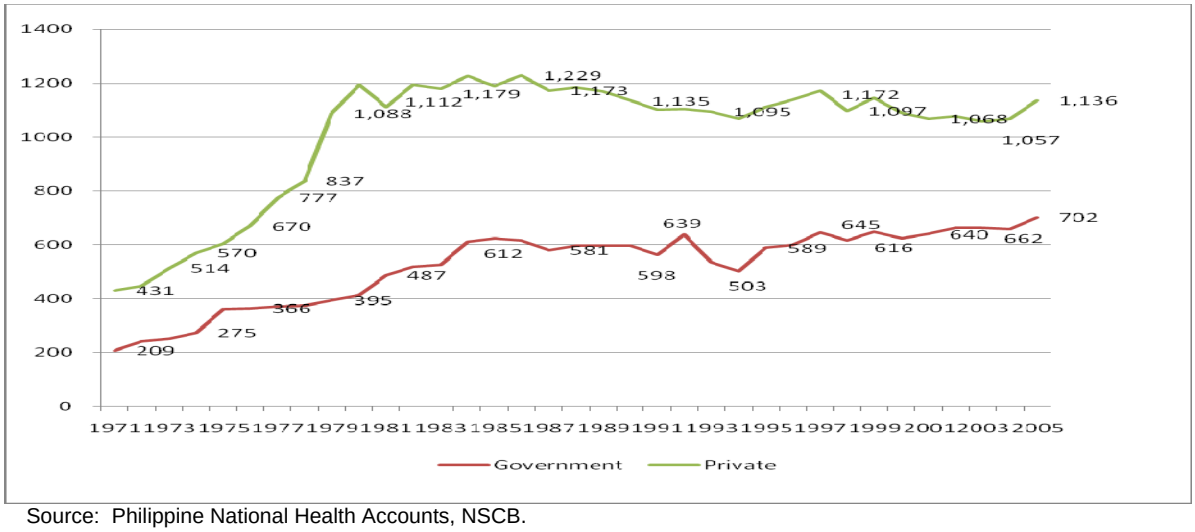
2.2. *Number of Hospitals*. A total of 1,578 hospitals were registered with the DOH as of 2007. Public hospitals (including corporate and local government hospitals) account for only 39 percent of the total number of hospitals but are usually bigger than private hospitals and have a higher number of beds (Table 2.1). It is worth noting that there are more secondary hospitals than primary level hospitals. From 1971 to 2005, the total number of public and private hospitals grew by 236 and 164 percent, respectively (Figure 2.2).

Table 2.1: Number of Hospitals by Ownership and Classification, 2007

Ownership	Number of Hospitals	% of Total
Government	*617*	*39.10%*
Primary	294	*18.63%*
Secondary	238	15.08%
Tertiary	85	5.39%
Private	*961*	*60.90%*
Primary	361	22.88%
Secondary	396	25.10%
Tertiary	204	12.93%
TOTAL	**1,578**	**100.00%**

Source: Department of Health

Figure 2.2: Number of Hospital, Public and Private



Source: Philippine National Health Accounts, NSCB.

2.3. *Hospital Size*. Hospitals in the Philippines are relatively small. Sixty-five percent of all hospitals have 50 or fewer beds (Figure 2.3). On average, government hospitals are composed of 62 beds while private hospitals have 38 beds. In the early 1970s, public hospital beds outnumbered private hospital beds by a big margin (Figure 2.4). But this gap has been narrowing as the number of private hospital beds has been catching up with the number of public hospital beds. In 2005, the gap was minimal at 342. Government bed capacity decreased particularly after the devolution of hospitals to local governments. With the passage of the Local Government Code in 1991, the powers and responsibilities of the central government were passed to local government units. The DOH devolved its hospitals, provincial and district offices, and the staff of these offices to the provinces. The municipalities were given the responsibility of providing basic health services through Rural Health

Units and *Barangay* Health Stations while the cities were in charge of health offices in the city. Out of 639 public hospitals, only 45 remained under the DOH as national government facilities in 1992.[2]

Figure 2.3: Number of Hospitals by Number of Beds, 2007

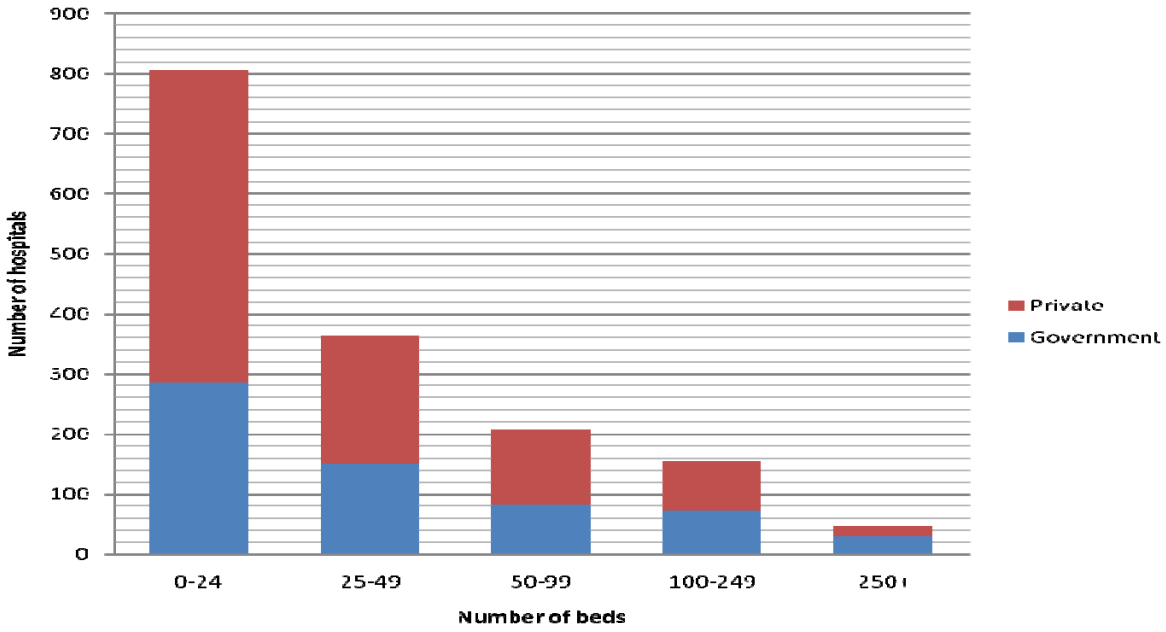
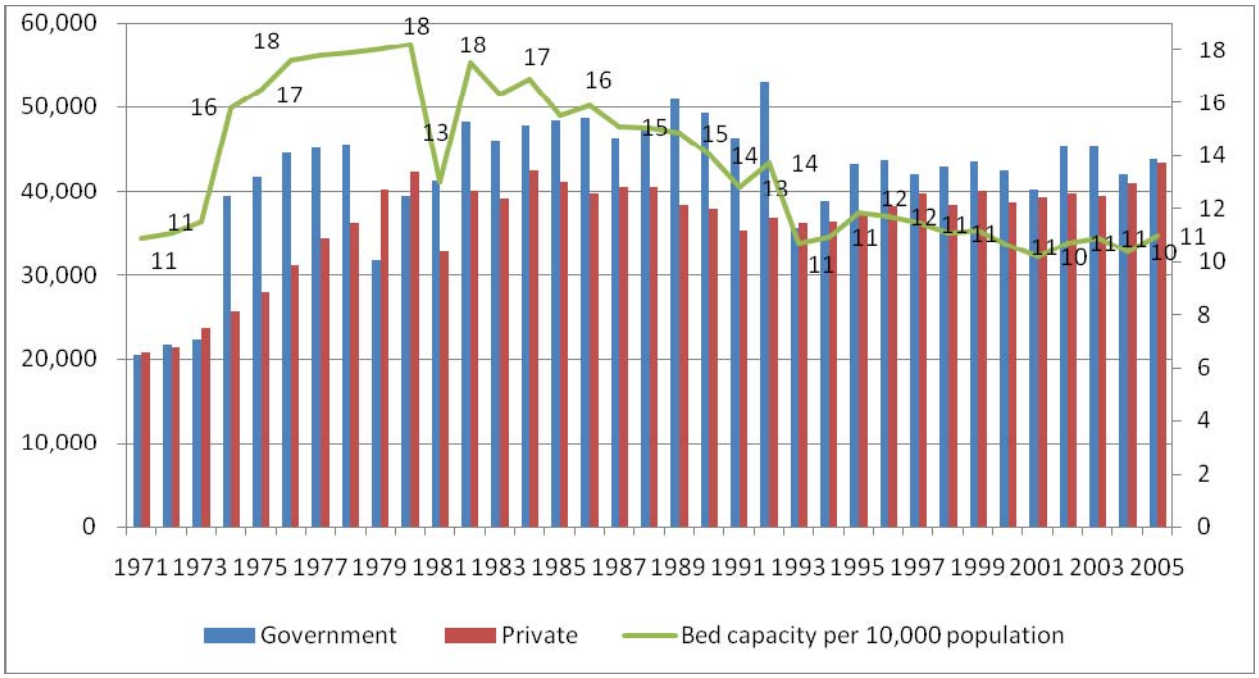


Figure 2.4: Number of Hospital Beds, Public and Private

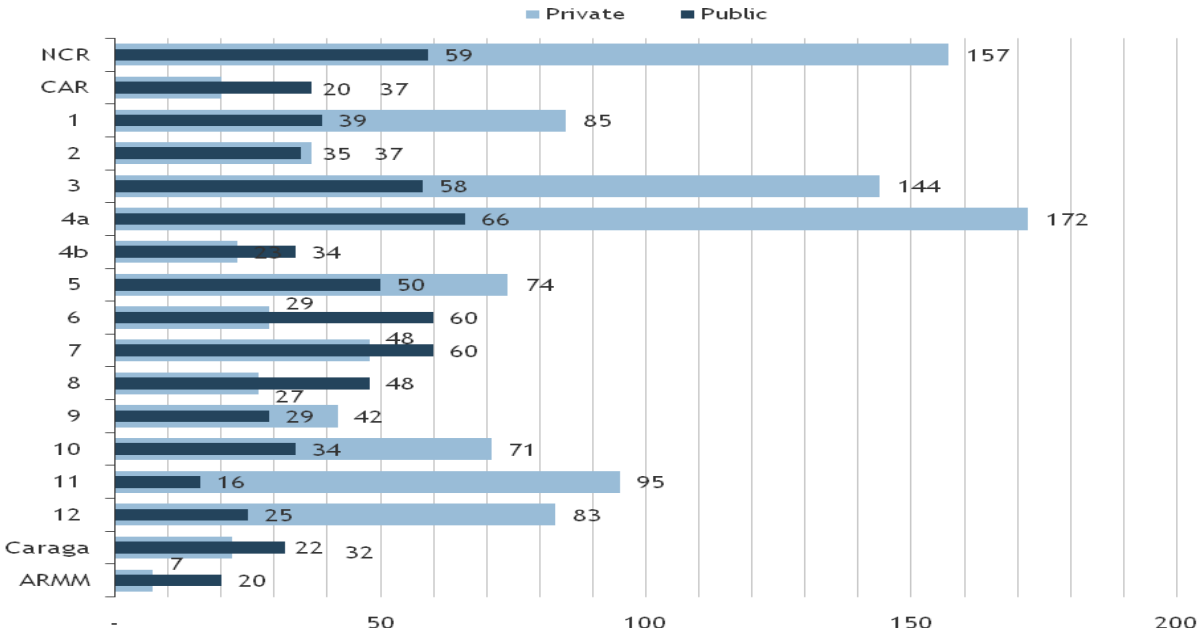


Source: Philippine National Health Accounts, NSCB.

[2] There are currently 72 hospitals under the DOH. It is composed of the original 45 retained hospitals, 21 re-nationalized hospitals such as Veterans Regional Hospital and Region 1 Medical Center, and 6 newly established hospitals such as Talisay District Hospital and Conner District Hospital.

2.4. *Regional Distribution.* There is a higher concentration of private hospitals in highly urban regions such as the National Capital Region (NCR), Region 4a (CALABARZON), and Region 11 (Davao Region). In these regions, private hospitals greatly outnumber public hospitals. But in the poorer regions such as Cordillera Autonomous Region (CAR), Caraga and Autonomous Region of Muslim Mindanao (ARMM), there are more public hospitals than private hospitals.

Figure 2.5: Number of Hospitals by Type and Region, 2005



Source: Philippine Statistical Yearbook, 2007

2.5. *Hospital Utilization*. Among the factors that affect the utilization of health facilities are geographical barriers, cost of medical care and demography. The 2003 National Demographic and Health Survey shows that among those who utilized any health care facility in the preceding six months, 52 percent came from the urban areas and 48 percent from the rural areas.

2.6. The type of health facility utilized also depends on the wealth level of households. The poorest and poorer quintiles tend to utilize public facilities while the richer quintiles utilize private clinics and hospitals (Table 2.2).

Table 2.2: Utilization of Health Facilities by Wealth Quintile, 2003

	Poorest	Poorer	Middle	Richer	Richest
Any health facility	18.4	21.1	20.6	20.2	19.7
Barangay health station	28.2	27.6	21.4	14.9	7.9
Rural health unit/urban health center	20	24.4	23	21	11.7
Municipal hospital	19.2	26.4	19.8	22.4	12.2
District hospital	21.3	23.4	22.5	18.3	14.4
Provincial hospital	16	26	20.7	21.5	15.8
Regional hospital/public medical center	19.8	20.5	20.6	20	19.1
Private clinic	7.5	13	18.2	27.1	34.1
Private hospital	4.5	8.9	16.6	24.7	45.3
Other	22.9	19.8	19.8	21.3	16.3

Source: Authors' calculations based on the 2003 National Demographic and Health Survey.

2.7. Public hospitals are used basically for treatment and laboratory, and to some extent, for check-ups and maternal care. It is highly probable that the poor utilizing hospitals for these services are suffering chronic diseases. *Barangay* health stations (BHS) and rural health units (RHU) are utilized primarily for immunization, family planning, health education and maternal care. Private clinics and hospitals are utilized for the same purpose as public ones (Table 2.3). There are, however, a considerably higher percentage of patients seeking immunization, family planning, health education, and maternal care in private facilities compared to public hospitals. Given the figures in Table 2.2, it can be inferred that the rich people prefer private clinics and hospitals even for services that can be offered by the *barangay* health station and the rural health unit for free or for a minimal fee. These trends confirm the findings of Solon, et al. (1998) that low-income families are capturing public subsidies for primary health through public health facilities.[3]

Table 2.3: Uses of Facilities, 2003

Uses of Facilities	Treatment	Check-up	Lab.	Immunization	Family Planning	Health Education	Maternal Care	Others
Barangay health station	26.6	30.8	10.9	56.3	61.6	51.7	44.1	22.8
Rural health unit/ urban health center	18.3	21.1	9.1	29.1	23.8	20.2	21.1	15.3
Municipal hospital	5.4	4	6.9	1.5	2.2	2.8	3.2	2.6
District hospital	4.5	3.2	6.4	1	1.5	2.3	3.6	4.8
Provincial hospital	7.5	5.3	11.2	2	1.8	3.7	4.9	7
Regional hospital/ public medical center	4.8	3.6	8.1	1.3	1.1	1.9	4.5	5.6
Private clinic	17.4	19.1	20.3	5.3	4.9	9.4	9.6	15.2
Private hospital	13.8	11.9	26	3.2	2.8	7.3	7.7	10.4
Other	1.8	1.2	1.1	0.3	0.3	0.6	1.3	16.3

Source: Authors' calculations based on the 2003 National Demographic and Health Survey

[3] Solon, Orville, Gertler, Paul, and Alabastro, Stella (1998): *Insurance and Price Discrimination in the Market for Hospital Services in the Philippines*. Quezon City: University of the Philippines.

2.8. *Summary*. With the breakdown of referral networks, tertiary- level hospitals which are designed to cater to more serious diseases are also accommodating cases that can be handled by lower-level facilities. This leads to tertiary hospitals requiring more financial resources to be able to attend to all its patients. Aside from being more expensive, the current arrangment leads to overcrowding of tertiary facilities, which entails longer waiting time for patients. This mismatch in the capability of tertiary facilities and the severity of cases they cater to makes costs of seeking health care higher not only for the facilities but for the patients as well. The health system is therefore plagued with many challenges that undermine its efficiency. The next section looks at how resources are being used, highlighting the process in which budgets are prepared, allocated and utilized by the final referral centers among public facilities, the DOH-retained hospitals.

3. PLANNING AND BUDGETING IN DOH-RETAINED HOSPITALS

The DOH Budget

3.1 The DOH budget has been increasing nominally for the past three years. From the 2003 General Appropriations Act (GAA) to the 2008 GAA, the nominal DOH budget increased by as much as 103 percent from Php9.28 billion to Php18.91 billion. In real terms, this translates to an increase of 55 percent from Php8.15 billion in 2003 to Php 12.3 billion in 2008 (in 2000 constant prices). On a per capita basis, the DOH budget has been steady at about Php111 to 116 million, but it suddenly jumped in 2007 and 2008 to Php129 million and Php209 million, respectively (Table 3.1).

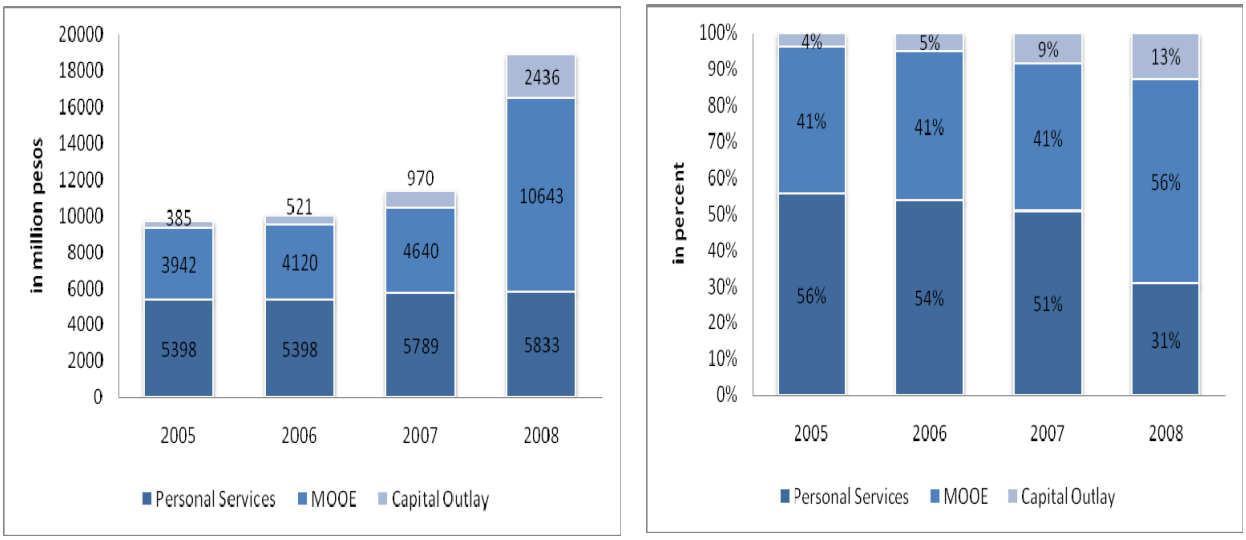
Table 3.1: DOH Budget, Nominal and Real Values

In million pesos	2003	2004	2005	2006	2007	2008
Nominal	9,281	9,281	9,725	10,038	11,399	18,912
Real	8,156	7,696	7,492	7,279	8,039	12,345
Per Capita	113	111	114	116	129	209
As % to GDP	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%
As % to Total	1.1%	1.1%	1.0%	1.0%	1.0%	1.5%

Source: General Appropriations Act, table pertains to Department of Health-Office of the Secretary budget only; Based on 2000 constant prices

3.2 Most of the increase in the 2008 budget is attributed to the increase in Maintenance and Other Operating Expenditure (MOOE) and Capital Outlays (CO). MOOE increased to Php10.64 billion in 2008, more than double its allocation in 2007. This is due to increases in its service delivery programs such as disease prevention and control, and family health including family planning. For its part, CO's share in the total budget rose from 9 percent in 2007 to 13 percent. The increase in CO is attributed to the significant amount of appropriation provided to the Health Facilities Enhancement Program. Details of the budget are presented in Figure 3.1.

Figure 3.1: Breakdown of DOH Budget



Source: General Appropriations Act, table pertains to Department of Health-Office of the Secretary budget only

Budget for DOH-Retained Hospitals

3.3 Appropriations for hospitals and medical centers are lodged under activities related to health operations for special hospitals and medical centers in Metro Manila and operations of CHDs for regional hospitals. Funds are directly released to the hospitals since regional hospitals, medical centers and special hospitals are authorized to undertake bulk procurement of drugs, medicines, medical and dental supplies, equipment and instruments as prescribed under the special provisions of the GAA.

3.4 The share of hospital allocation in the total DOH budget has been declining. From the previous 60 to 66 percent recorded from 2003 to 2006, this figure declined to 59 percent in 2007 and then to 35 percent in 2008. Although in nominal terms the allocation for hospitals in 2008 was at the same level as prior years, its share in the total DOH budget saw a marked decline in 2008. This change reflects a shift in the relative priority of DOH from personal health care to public health programs (Table 3.2).

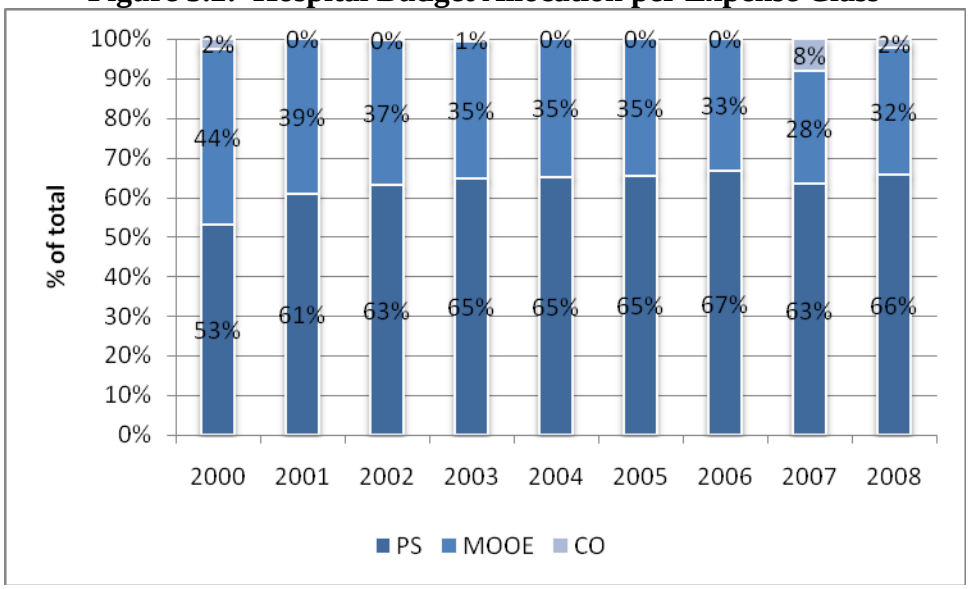
Table 3.2: Budget for DOH Retained Hospital, Nominal and Real Values

In million pesos	2003	2004	2005	2006	2007	2008
In Nominal Terms:						
Total Budget for Hospitals	6,119	6,084	6,099	5,997	6,777	6,594
Total DOH Budget	9,281	9,281	9,725	10,038	11,399	18,912
In Real Terms:						
Total Budget for Hospitals	5,377	5,045	4,699	4,349	4,779	4,304
Total DOH Budget	8,156	7,696	7,492	7,279	8,039	12,345
% Allocation for Hospitals	*66%*	*66%*	*63%*	*60%*	*59%*	*35%*

Source: General Appropriations Act, various years

3.5 In terms of allocation per expense class, Personal Services comprises the largest share of the budget (Figure 3.2). There has been a steady decline in the share of MOOE in the hospital budget, from the level of 44 percent in 2000, the share of MOOE declined to just 32 percent in 2008. CO, which from 2001 to 2006 had been zero, was at its highest in 2007 accounting for 8 percent of the budget.

Figure 3.2: Hospital Budget Allocation per Expense Class



Source: General Appropriations Act, various years

Financing Arrangements of DOH-Retained Hospitals

3.6 *Types of Hospitals.* There are eight types of hospitals: Special Hospital-Regular, Special Hospital-Mental, Medical Center, Regional Hospital, District Hospital, Extension Hospital, Research Hospital and Sanitaria Hospital. The types of hospitals are based on the disease they treat and geographic location. The special hospitals-regular are those that cater to patients who require specialist care, for instance, obstetrics and gynecology for Fabella Hospital, and infectious diseases for San Lazaro Hospital. On the other hand, special hospitals-mental address the needs of the mentally ill. Sanitaria hospitals provide care to patients with leprosy. Research hospitals such as Schistosomiasis Control and Research Hospital and Research Institute for Tropical Medicine are mainly dedicated to research of specific diseases. Medical Centers are general hospitals with various specialty departments usually located in Metro Manila and other urban capitals of various provinces. Extension hospitals were created as annexes of medical centers. The last two types of hospital pertain to its geographic location: regions and congressional districts. This classification of hospitals by type is usually not reflective of the service capability of the hospital.

3.7 *Hospital Classification*. An alternative way of categorizing hospital is through the classification used for licensing hospitals as specified in AO 29 s. 2005.[4] This classification is based on the service capability of the hospital where the highest level offers the highest level of care. Level 1 hospital provides initial clinical care and management to patients requiring immediate treatment as well as primary care. Level 2 are non-departmentalized hospitals which provide clinical care and management on prevalent diseases in the locality. Level 3 are departmentalized hospitals capable of managing particular forms of treatment, surgical procedure and intensive care. Level 4 refers to teaching and training hospitals (with at least one accredited residency training program for physicians) providing clinical services provided in a Level 3 hospital as well as sub-specialty clinical care. All DOH-retained hospitals fall under either Level 3 or 4.

Structure

3.8 *Regulation and oversight.* The National Center for Health Facility Development (NCHFD), a unit in DOH, is tasked to oversee the operations of DOH hospitals both retained and corporate. It is comprised of three divisions, the Technical Operations Division, Infrastructure and Equipment Division and Management Systems Development Division. The general function of the NCHFD is to, among others, formulate policies, plans and programs on health facilities design, operation and management and hospital corporate restructuring. It gives technical assistance to all stakeholders regarding health facility development and hospital corporate restructuring, as well as nurturing and helping transformed DOH Hospitals into government-owned corporate hospitals to sustain its operations.

3.9 The Management System Development Division is the unit in charge of establishing the national hospital data bank on performance indices, as well as developing/updating hospital indicators. The NCHFD is headed by a director and is comprised of 41 technical plantilla positions, where only 31 were filled as of 2008.

3.10 In the implementation of Fourmula One for Health (F1), Field Implementation Management Offices (FIMO) were created to coordinate with CHDs and DOH-retained hospitals within their catchment areas.[5] FIMOs are headed by an Undersecretary or an Assistant Secretary. Three zonal clusters (Luzon, Visayas, Mindanao) were formed where CHDs and hospitals should report. The 12

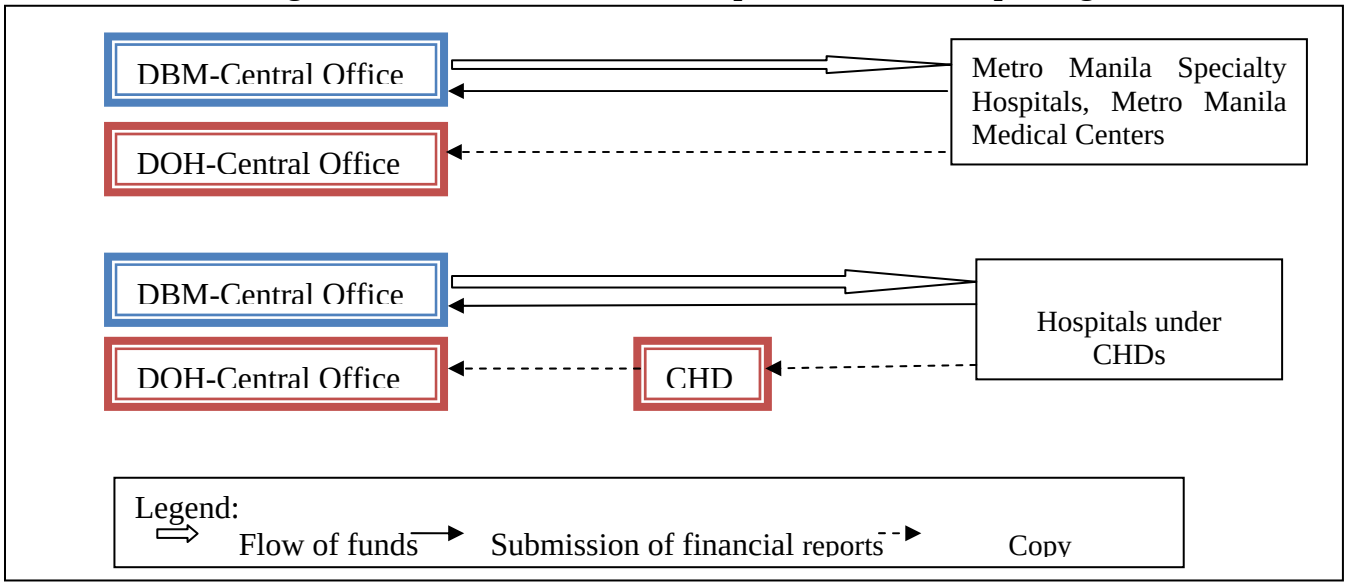
[4] Administrative Order No. 2005-0029 dated December 12, 2005 "Amendment to Administrative Order NO. 147 s. 2004: Amending Administrative Order No. 70-A series 2002 re: Revised Rules and Regulations Governing the Registration, Licensure and Operation of Hospitals and other Health Facilities in the Philippines."

[5] DOH Administrative Order No. 2008-0005 dated 12 March 2008, *Functional Arrangement for Managing Field Implementation in support of Health Sector Reform Efforts*

special hospitals and 4 corporate hospitals in Metro Manila (MM) are under the Office for Special Concerns (OSC) which serves the function similar to FIMO. These FIMOs/OSC are in charge of monitoring and evaluating hospitals.

3.11 *Budget Releases.* Fund releases for MM specialty hospitals are from the Department of Budget and Management (DBM) Central Office. A division under Budget Management Bureau (BMB) B handles the day-to-day coordination with these hospitals, with each of the staff handling about 2 hospitals. Regional hospitals coordinate with their respective DBM regional offices. As with other agencies, hospitals are covered by the annual national budget circulars pertaining to the guidelines on the release of funds for a particular year. The basis for comprehensive releases is the Agency Budget Matrix, where 50 percent is released without needing clearance while the remaining 50 percent is released through Special Allotment Release Order (SARO) after the agency performance review.

Figure 3.3: Flow of Release of Hospital Funds and Reporting



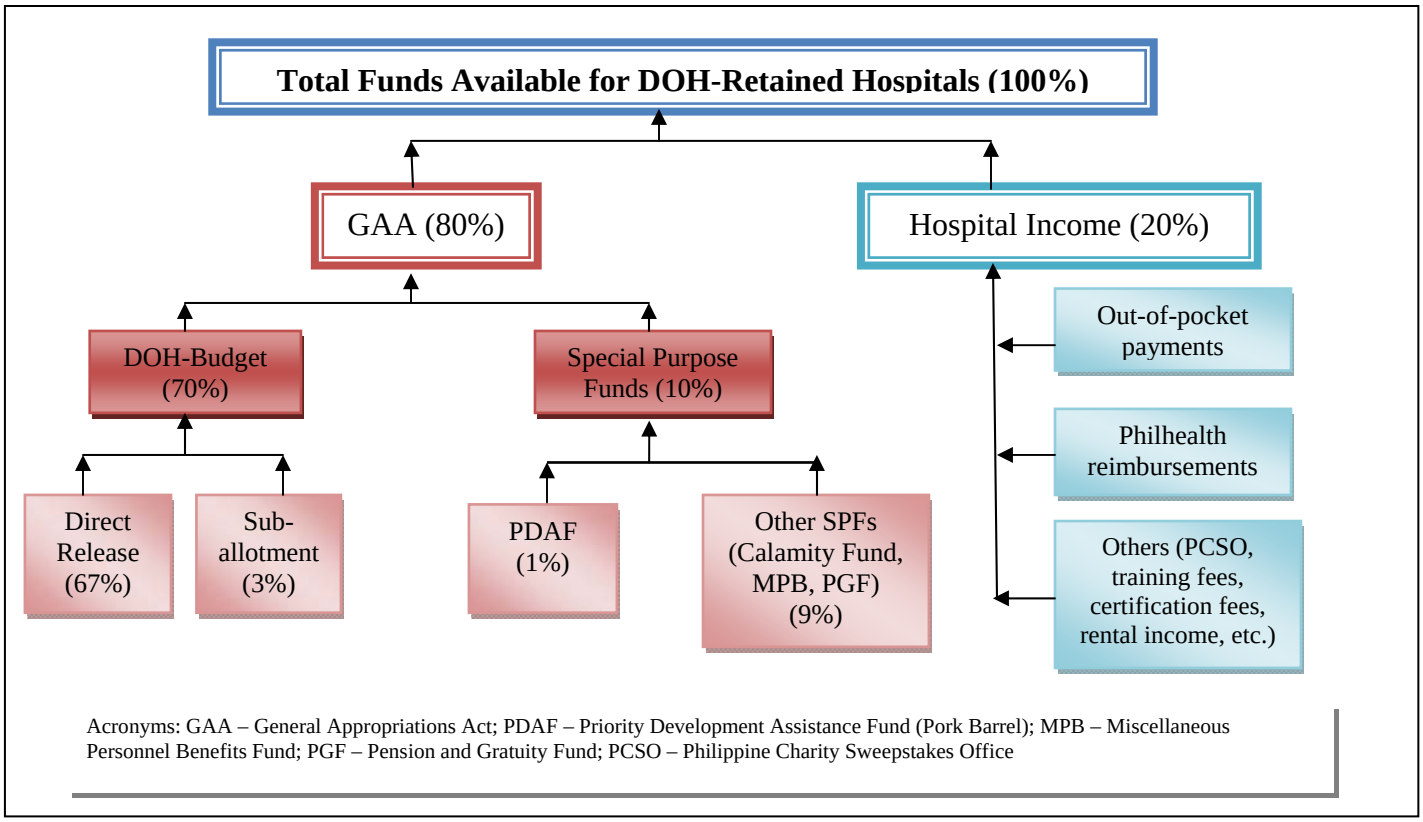
Financing and Sources of Funds

3.12 *Fund Sources.* Besides the regular appropriations hospitals receive from the GAA, hospitals augment their resources through transfers from the Central Office (sub-allotments or SAAs), releases from the Priority Development Assistance Fund (PDAF), other special purpose funds (SPFs), and their respective net income (mainly from fees charged to the patients).

3.13 To give an illustration of how much the distribution is in terms of fund sources, actual data on obligations were used covering 2007 appropriations while actual data on hospital income were sourced from 2006 figures.[6] Of the total available funds for DOH-retained hospitals, about 80 percent are from the GAA while 20 percent were from hospital income. The funds from the GAA come from two sources, 70 percent of which are from the DOH budget while 10 percent are from various special purpose funds. Out of the funds sourced from the DOH budget, 67 percent are directly allocated to the hospitals while 3 percent are from sub-allotments from the central office. As for the 10 percent coming from special purpose funds, 9 percent are from personnel-related SPFs, e.g., miscellaneous personnel benefits fund (MPBF), pensions and gratuity fund (PGF), and the calamity fund while 1 percent are from the PDAF. Hospital income, on the other hand, comprises 20 percent of the total funds available for hospitals.

[6] During the time of the preparation of this report, data on hospital income were not yet completed.

Figure 3.4: Sources of Funds



3.14 *Sub-allotments from the Central Office.* Transfers from the Central Office through Sub-Allotments (SAA) are sourced from various funds from the DOH-CO such as: DOH Indigency Fund; ASEAN Fund; Dengue Fund; National AIDS STD Prevention and Control Program (NASPCP Fund); National Epidemiology Center (NEC Fund); Philippine National AIDS Council (PNAC) Fund; and Health Emergency Management Staff (HEMS)/Quick Release Fund. In 2007, a total of Php244.37 million was transferred from DOH-CO to the MM Specialty Hospitals and Regional Hospitals. These transfers are usually requested by the hospitals from the Central Office to fund staff trainings and are counted as MOOE. In 2007, there were just two hospitals that requested for SAA to augment their PS, namely, National Center for Mental Health and Basilan Provincial Hospital.

3.15 *Priority Development Assistance Fund (PDAF).* These are provided by various members of Congress as contributions to a hospital of their choice and counted as MOOE in the hospital budget. These funds usually cover the treatment and/or hospitalization of indigents. However, according to DOH, the use of PDAF funds for hospitalization requires prior endorsement by the congressman who donated the PDAF in the first place. Contributing congressmen are not necessarily from the particular district where the hospital is situated. MM Specialty Hospitals and hospitals situated in urban areas, such as the hospitals in Central Visayas and Davao CHDs, cornered 66 percent of the total PDAF contributions nationwide.

Box 3.1: PDAF Releases

Funds coming from PDAF comprise a very small part of hospital budgets. Flows are usually intermittent, usually reaching its highest levels during election years. The process starts with signing a Memorandum of Agreement between a legislator and a hospital. Then, the Congressman writes to DBM to request a particular amount be allocated to the hospital. DBM will then issue a SARO to the hospital followed by a notice of cash allocation.

The hospital requires a letter of endorsement signed by the office of the congressman to ensure that the fund is tapped only by his constituents. The hospital will then deduct the amount stated in the endorsement letter from the account of the congressman. The PDAF fund is usually used to pay for drugs, supplies and laboratory procedures for specific patients. To ensure transparency, the hospitals regularly issue a notice of liquadation of each fund. In some hospitals such as Davao Regional Hospital and Davao Medical Center, liaison officers of legislators have designated offices within the hospital to make it easier for their constituents to acquire a letter of endorsement.

The SARO has a validity of two years. In cases where the PDAF is not yet fully exhausted by that time, hospitals usually forge an internal arrangement with the legislator. Hospitals vow to attend to their constituents until the full amount of the unused PDAF is exhausted and in return legislators permit them to use the fund for other purposes.

3.16 *Various Special Purpose Funds (SPFs).* As with other government agencies, Personal Services expense of hospitals is augmented by various SPFs such as automatic appropriations for Retirement and Life Insurance Program (RLIP) Miscellaneous Personnel Benefit Fund (MPBF), and Pension and Gratuity Fund. In 2007, the Calamity Fund[7] was a major source of capital outlay for hospitals. The allocation provided to MM Specialty Hospitals was in response to the destruction brought about by typhoon Milenyo which struck in 2006. As much as Php81.35 million which is 62 percent over the total regular appropriation for CO for MM Specialty hospitals were distributed in 2007. Hospitals under the Bicol CHD received the largest amount of calamity fund at Ph129.5 million in response to the numerous typhoons that battered the Bicol Region in 2006.

3.17 *Hospital Income.* Sources of hospital income are out-of-pocket payments, reimbursements from PhilHealth, and others, such as training fees, certification fees, PCSO, and rental income. Out-of-pocket payments came from hospital fees that are charged to pay patients and some service patients. PhilHealth reimbursements are payments to hospital by PhilHealth for the services it rendered to its members and dependents. Another source of income is training fees from schools that are affiliated with the hospital. Minor sources of income include rent income, proceeds from the sale of hospital therapeutic products, prosthetic appliances and other medical devices, and diagnostic fees. The hospitals also obtain income from activities that are non-hospital related such as charging rent to commercial establishments that operate businesses within the hospital premises.

3.18 *Hospital Fees.* Unlike before where services in public hospitals were virtually free, hospitals nowadays can only provide free room and board and waiver of professional fees for its service patients (See Box 3.3). All other services in the hospital, for instance laboratory and radiology procedures, require payment of fees. Aside from these fees, patients shoulder the full amount of room and board as well as professional fees.

[7] These funds are provided only for the relief, reconstruction, rehabilitation and other works and services, in connection with a calamity which occurred during the budget year.

3.18.1 *Retention of Net Income.* Starting 2003, DOH-retained hospitals were allowed to retain its income by virtue of a special provision in the 2003 GAA,[8] which provided that at least 25 percent of the income would be used to purchase and upgrade hospital equipment used directly in the delivery of health services. The remaining 75 percent or less was supposed to augment MOOE and capital outlay whether infrastructure or necessary equipment not directly used for direct health services.[9] Payment of salaries and other allowances could not be sourced from the retained hospital income.

3.18.2 The provision of income retention was carried over to the 2005 and 2007 GAA (2006 budget was re-enacted 2005). Except for hospitals belonging to the CHDs of Zamboanga Peninsula and SOCCKSARGEN, the rest recorded a significant increase in income since 2003. In the first year of its implementation, total net income of all DOH-retained hospitals increased by 42.6 percent to Php1.18 billion from Php0.83 billion (Table 3.3). This surge in income was maintained in the next years with income rising by 26 percent annually from 2004 to 2005, but the growth tapered in 2006 with net income rising by just 6.4 percent.

Table 3.3: Net Income of DOH-Retained Hospitals

Year	Net Income	% YoY Increase
2000	646.05	
2001	737.00	14.1%
2002	829.30	12.5%
2003	1,182.29	42.6%
2004	1,489.25	26.0%
2005	1,876.49	26.0%
2006	1,997.34	6.4%
2007	954.50	Up to June 30 only

Source: National Center for Health Facility Development

3.18.3 With the increase in net income, hospitals were able to have more funds for equipment purchase and infrastructure. In fact, hospitals' own income became the primary funding source for capital outlay (Table 3.4). Hospitals had not been provided with regular capital outlay in the budget from 2004-2006. It was only in 2007 and 2008 GAA that a total of Php559.0 million and Php156.0 million, respectively, for capital outlays were appropriated.

[8] Under Special Provision No. 6 of the DOH Appropriations under the FY2003 GAA (RA 9206), provides that: *"6. Use of Income. All income of special hospitals, medical centers, institute for disease prevention and control and other national government hospitals of the DOH shall be retained and constituted as a trust fund for the use of hospitals, medical centers, institute for disease prevention and control and other "DOH-retained" national hospitals. PROVIDED, that at least twenty five percent (25%) of the said income shall be used to purchase and upgrade hospital equipment used directly in the delivery of health services; PROVIDED, FURTHER, that no amount of the said hospital income shall be used for the payment of salaries and other allowances."* In FY 2008 GAA (RA 9498), these ceilings were removed.

[9] DOH Department Circular No. 377-A s. 2003 dated November 10, 2003.

Table 3.4: Capital Outlay, by funding source

	From GAA	From Net Income
2003	35.0	496.6
2004	-	491.5
2005	-	506.7
2006	-	279.6
2007	559.0	-
2008	156.0	

Source: National Center for Health Facility Development

3.18.4 However, the percentage share of equipment purchase and infrastructure vis-à-vis the total fund utilization of net income has been decreasing (Table 3.5). Together with the increase in net income, the share of MOOE has increased to as much as 86 percent in 2006 from the 2003 level of 58 percent. According to NCHFD, this is due to variations in hospitals' priority needs. The reasons cited are: DOH hospitals are major recipients of Foreign Assisted Projects (FAPs) for upgrading of hospital equipment, hence, there is less need for procurement of hospital equipment; and most DOH hospitals need more augmentation of MOOE than capital outlay for their operations.[10]

Table 3.5: Utilization of Net Income for DOH Retained Hospitals

Year	MOOE	Equipment	Infrastructure
2003	58%	41%	1%
2004	67%	29%	4%
2005	73%	25%	2%
2006	86%	11%	3%

Source: National Center for Health Facility Development

[10] Implementation of the Guidelines on Revenue Retention for DOH Hospitals, prepared by NCHFD, September 2007

Box 3.2: Sources of Income at Davao Medical Center

Davao Medical Center (DMC) was the highest income earner in 2006 at Php 110.24 million. It surpassed even Metro Manila specialty hospitals like East Ave Medical Center (Php 103.35 million), Quirino Memorial Medical Center (Php 99.37 million) and Jose Reyes Memorial Medical Center at (Php 98.69 million).

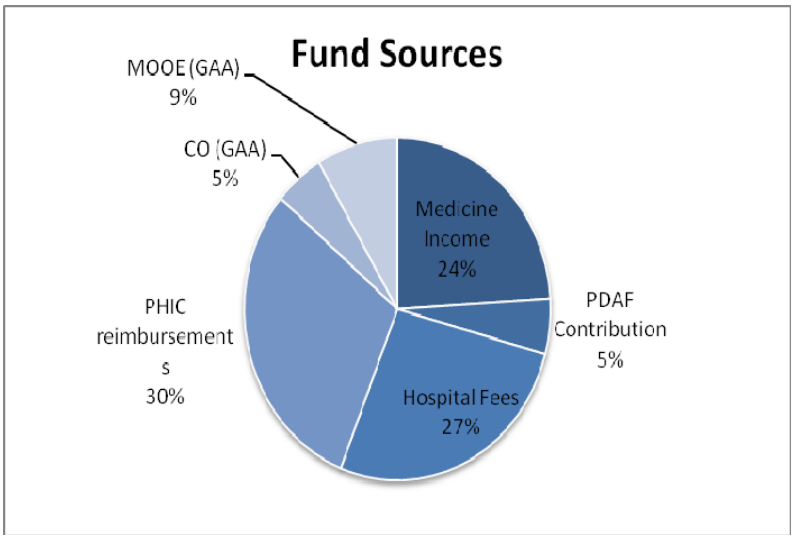
Top Hospital Income-Earners for 2006

Hospital	Net Income 2006
Davao Medical Center	110.24
East Avenue Medical Center	103.35
Quirino Memorial Medical Center	99.37
Jose R. Reyes Memorial Medical Center	98.69
V. Sotto Sr. Memorial Medical Center	96.85
Davao Regional Hospital	91.00

Source: National Center for Health Facility Development

Sources of funds aside from the national government budget allocation of DMC were Philippine Health Insurance Corporation (PHIC) reimbursements, hospital fees, PDAF contributions, out-of-pocket payments, and income from medicine sales.

Sources of Funds, Davao Medical Center



Source: Budget Reports, Davao Medical Center

PhilHealth

PhilHealth was the largest source of fund aside from that given by the government. The continuous increase in income since 2000 has been attributed to the increase in enrollment rate to PHIC. This is primarily due to the joint efforts of local governments and hospital employees in promoting PHIC. DMC employees and physicians have incentives to campaign for PHIC due to the honorarium they receive in correspondence to the number of PHIC patients they serve. This honorarium comes from the professional fees reimbursements that are divided among the employees. Also, PHIC provides financial security to the hospital by ensuring a continuous cash flow. Since collection of reimbursement takes a maximum of 45 days, if transmittals of reimbursements are done on a regular basis, constant cash inflow is expected as well.

Patients themselves are encouraged to enroll in PHIC due to its evident benefits in DMC. For most illnesses, patients can be assured of zero or very minimal out-of-pocket payments.

Box 3.2: Sources of Income at Davao Medical Center, continued

PDAF contributions

DMC has the highest PDAF contribution in all retained hospitals in 2007. It received a total of Php 25.5 million contribution which covers cost of medicine, supplies and laboratory fees for the indigent constituents of congressmen which allocated PDAF funds at DMC.

PDAF in Mindanao is highly concentrated in DMC with a share of 71.2 percent in 2007. Even congressmen from different districts allocate PDAF to the hospital. A breakdown of 2007 PDAF contribution among Mindanao Hospitals is presented in the table below:

PDAF Contribution in Mindanao

Mindanao Hospital with PDAF	% Share within Mindanao
Davao Medical Center	71.2
Davao Regional Hospital	17.5
Cotabato Regional & Medical Center	4.7
Northern Mindanao Med. Ctr.	3.8
Zamboanga City Med. Ctr.	1.4
Labuan Public Hospital	1.1
M. H. Ramiro Sr. Regl. Trng. & Teaching H.	0.3

Source: DBM website

DMC is a popular recipient of PDAF probably due to the extensive service offerings. Legislators are enticed to earmark funding to DMC because it serves as a one-stop-shop for health care, especially in a region deprived of health facility choices. It might be viewed that it is more efficient to put a large sum of money in one hospital which caters to most illnesses rather than distribute small amounts among many hospitals.

PDAF may be small in terms of its share in the total funding but it plays a crucial role in financing the hospital bill of the poor. PDAF guarantees cost recovery for supplies, medicines and laboratory fees utilized in treating service patients.[a] Thus, PDAF serves as an alternative to MOOE as a source of hospital bill subsidy.

Out of Pocket Payments

Another fund similar to PDAF but unique to DMC is *LINGAP*. This program is a direct monetary subsidy provided for by the city mayor of Davao. A 24-hour office was set-up within the DMC compound to augment the ability of Davao residents to pay their hospital dues. *LINGAP* spends Php 300 to 500 thousand daily to subsidize healthcare costs. Other sources of out-of-pocket income are paying patients of DMC as well as remaining charges for Class C service patients.

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[a] PDAF devoted for medical expenses constitutes the Congressional Medical Assistance Program (CMAP).

Box 3.3: Charging of Service Patients

Following the mandate of charging patients based on their capacity to pay,[a] the hospitals segregate patients into: Class A, B, C1, C2, C3, and D. Class A and B patients are required to pay the full amount of hospital bill including room and board and professional fees. Patients classified as C and D are given free hospital accommodation and waiver of doctor's fees. For drugs, supplies, radiology, laboratory, and other ancillary services, Class C patients are subject to graduated discounts while Class D patients receive those for free, subject to availability.[b]

Each hospital has a Medical Social Service section which is in charge of assessing the financial status of patients. The social worker interviews the patient using a uniform questionnaire to estimate the total monthly income of the patient's family. Per capita income is derived and then compared to the per capita poverty threshold of the area after which the patient will be assigned a classification.

It should be noted that even if a patient is classified as Class D, he may still incur hospitalization expenditures when drugs and services are not available in the hospital. When the radiology or laboratory services are available in other hospitals, the patient asks a referral from the Medical Social Service so that they can still avail of the discount. In cases where the service and drugs are not available in a government facility, the patient has to pay the full amount to private hospitals or commercial pharmacies. To be able to pay, the patient may opt to seek the help of PCSO or his/her congressman through PDAF.

Subsidies to charity patients comprise a substantial amount of hospital expenditures. In Davao Regional Hospital, subsidy to drugs for indigent patients alone amounts to Php 9 million per year. Also, a patient may be classified as Class C1 upon admission but upon discharge may ask to be re-classified as Class D. Hospitals usually get their funding for indigents from their trust funds for drugs and MOOE and PDAF for laboratory, x-rays, and other ancillary services.

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[a] DOH Administrative Order No. 51-A series 2000 issued on 12 October 2001, *Implementing Guidelines on Classification of Patients and on Availment of Medical Social Services in Government Hospitals*, pursuant to Republic Act No. 747 of 1954, *An Act to Regulate fees to be charged Against Patients in Government and Charity Clinics Classifying patients according to their Financial Condition*.

[b] Class C is further subdivided to C-1, C-2, and C-3. Class C-1 patients are those with monthly per capita income are 180-220 percent of the per capita poverty threshold of the area. Class-2 patients' per capita income falls within 140-179 percent while C-3 patients have equal to or less than 140 percent of the threshold. Those classified under Class D have estimated per capita income below the threshold. Class C-1 are subject to 75 percent discount, C-2 are given 50 percent, while C-3 patients are asked to share any amount they can afford.

Planning and Budgeting

3.19 *Budget Preparation.* The DOH proposed a new budget structure for the 2008 budget that is compatible with F1 as the health sector reform implementation strategy. This new structure is consistent with the OPIF, clearly reflecting resources allocated for specific programs, by geographic areas, and is expected to foster fiscal accountability among all DOH units.

3.20 Prior to the preparation of the 2008 budget, budget levels for CHDs were pre-determined during high-level meetings based on the ceilings provided by the DBM. These levels were then relayed to the CHDs, which then notify the retained hospitals to adjust their budget based on their respective programmed ceilings.

3.21 The process for budgeting was changed for the preparation of the 2008 budget. DOH issued a department order (AO 2008-0005) for all hospitals to submit a budget proposal to its respective Field

Implementation and Coordinating Office (FICO).[11] This budget proposal is formulated without considering a ceiling and is based on the hospitals' perception of actual spending needs. It is reviewed by the respective cluster heads who recommend a budget to be deliberated at the executive level. This budget is presented to the DOH Secretary after which, submitted to DBM's Bureau A. DOH technical staff are tasked to defend the budget. This cluster[12] approach only started last year (for the 2008 budget).

3.22 After DBM determines the allocable amount in the budget and provides DOH with additional budget beyond its ceiling, a set of criteria is recommended to serve as basis for allocating amounts to service delivery, regulation and governance. A sub-allocation criterion, divided into three parameters namely, efficiency, quality and service delivery, for hospitals is also set to distribute the service delivery allocation. Except for the allocation for capital outlays, the additional budget for hospitals can only be used for MOOE, e.g., direct patient care such as drugs, medicines, medical supplies, laboratory reagents.

3.23 The DOH-Budget Office is starting to consolidate the reports of actual expenditures on an annual basis (previously it was quarterly but not all hospitals submitted in a timely manner). Although there is a reporting template, oftentimes there are mistakes in filling it up because the staff in the hospitals lack adequate training to do so.

3.24 In principle, the budget planning process within DOH hospitals can be characterized as following bottom-up needs approach. The planning cycle usually starts with the DBM budget call in May where DBM sets the ceiling for MOOE of each hospital. The Executive Committee of each hospital will conduct a budget preparation workshop where each department will present an outline of all their needs. Based on the budget ceiling and projected income, the Executive Committee will allocate the budget based on the priorities of the department. Planning for each line item is usually based on historical data.

Issues

3.24.1 *No overall sector plan for hospitals sector.* Planning is a crucial stage towards determining a budget which will reflect the current needs of the hospitals. In the years before the implementation of F1, it appears that there was no clear plan for DOH-retained hospitals, which translated into a budget based on historical data, rather than the actual needs of the facility.

3.24.2 Planning and budgeting in the hospital level seems to be ad hoc and lacking in overall strategy. There are no oversight arrangements in terms of planning and budgeting at the hospital level, and no clear guidelines exist in budget preparation specifically designed for hospitals.

Budget Allocation

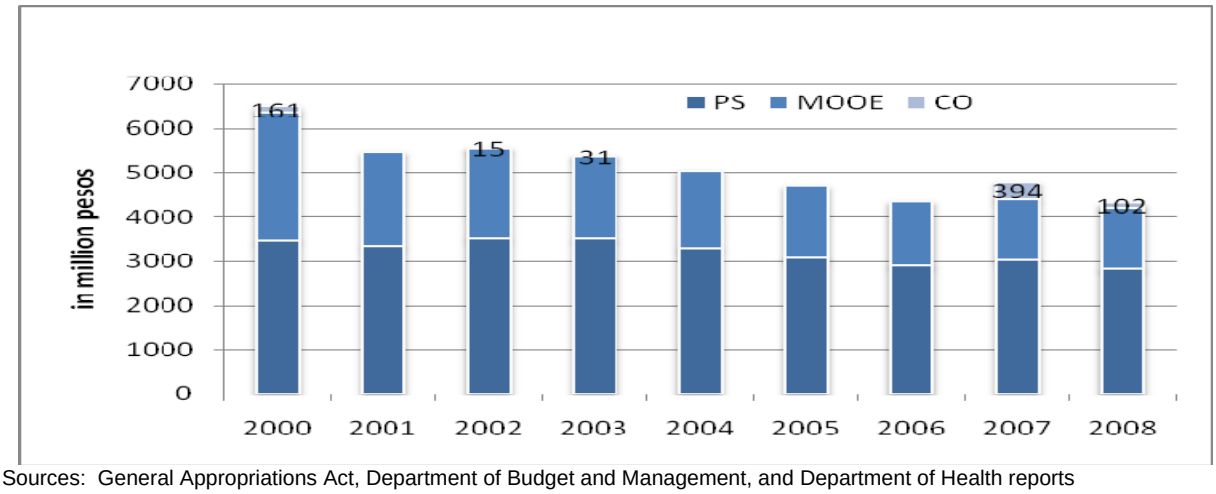
3.25 *Per expense class.* Budget allocation per expense class has been declining in real terms with MOOE suffering the steepest decline (Figure 3.5). From 2000 to 2008, MOOE declined by as much as 52 percent in real terms. Personal Services has been steady but recorded a decline of 18 percent from 2000 to 2008. From 2001 to 2006, there were no capital outlays recorded partly due to the fiscal crisis

[11] Field Implementation and Coordination Office was re-organized to Field Implementation Management Office in March 2008. DOH Administrative Order No. 2008-0005 dated 12 March 2008, *Functional Arrangement for Managing Field Implementation in support of Health Sector Reform Efforts.*

[12] The CHDs and the corresponding DOH Retained Hospitals within their respective catchment areas are grouped into Luzon, Visayas, and Mindanao and NCR clusters.

and the austerity measures imposed during this time. Capital outlays were distributed to all hospitals in 2007 but this was scaled back in 2008 with only 13 hospitals receiving CO appropriations.

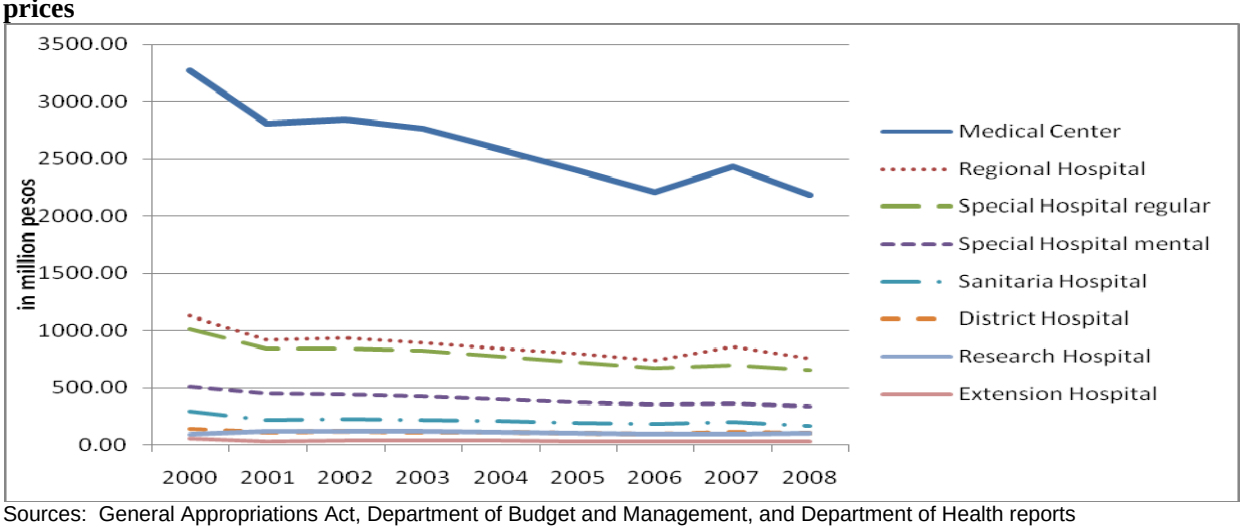
Figure 3.5: Budget Allocation of DOH-Retained Hospitals by Expense Class, in constant 2000 prices



Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

3.26 *Per type of hospital*. Although in nominal terms the hospital budget has been stable, in real terms it has been on a downtrend (Figure 3.6). Average year-on-year decreases in allocations are largest for Sanitaria and Extension Hospitals at 6 percent followed closely by Medical Centers, Special Hospital Regular and Mental at 5 percent. From 2000 to 2008, only Research Hospitals received a one percent increase in average allocation. The spike in 2007 budgets reflected the increase in capital outlay allocation that year.

Figure 3.6: Budget Allocation of DOH-Retained Hospitals by Type of Hospitals, in constant 2000 prices

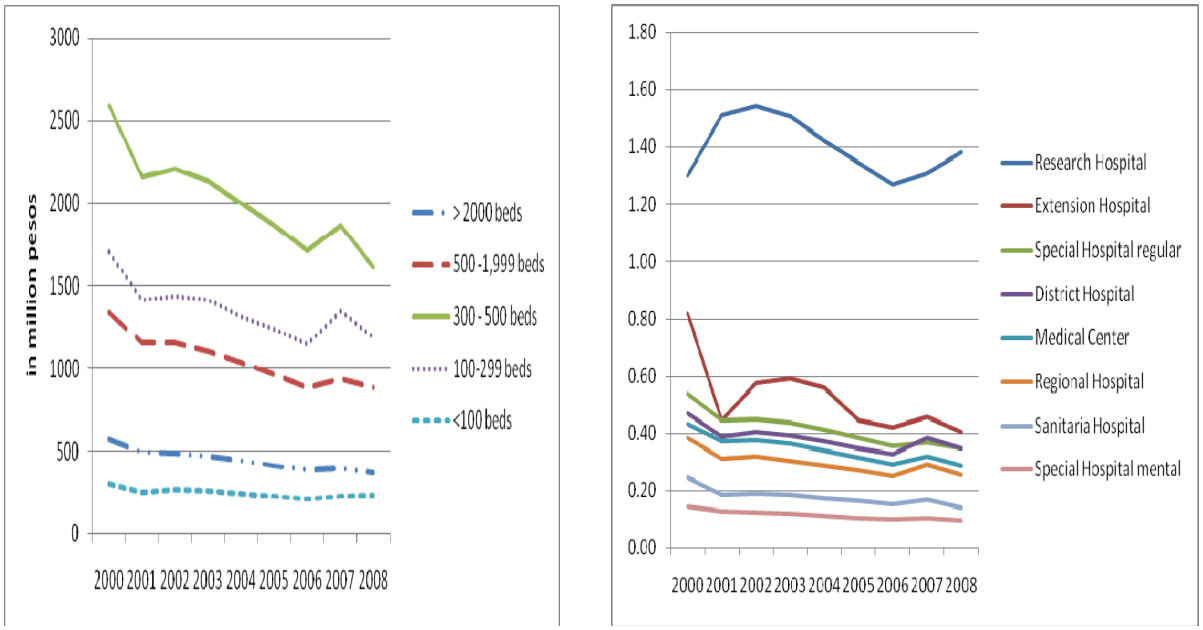


Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

3.27 *Per bed capacity*. Although hospitals with the least number of beds receive the smallest allocation, it does not follow that those with most beds receive the largest budget. Since hospitals with more than 2000 beds are mental and sanitaria hospitals, their allocation are reasonably lower compared to other hospitals. For hospitals with 100 to 1,999 beds (composed mostly of Medical Centers, Regional Hospitals and Special Hospitals-Regular), allocation seems to favor mid-size hospitals with 300-500 beds. When segregated per hospital type, indeed, Mental and Sanitaria hospitals receive the

lowest allocation on a per bed basis. It is interesting to note, however, that hospitals that cater to more complicated cases such as Medical Centers and Regional Hospitals receive lower per bed allocations than Extension and District Hospitals. Research hospitals appear as an outlier in the figure since a significant portion of their budget is spent on research related endeavors (Figure 3.7).

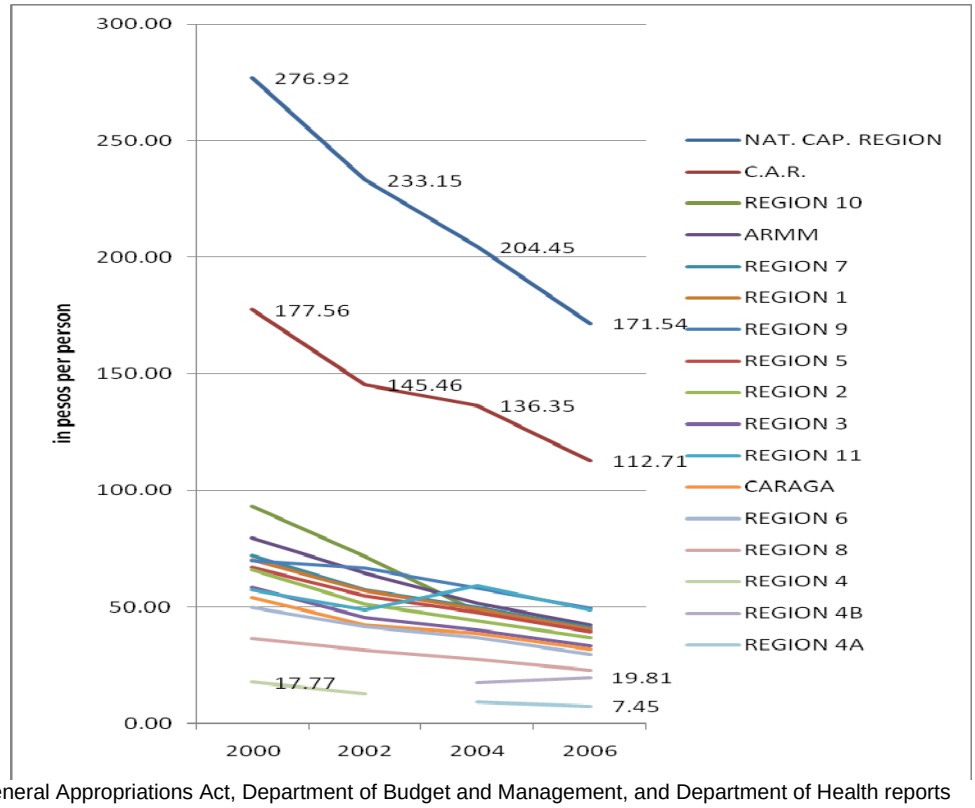
Figure 3.7: Budget Allocation of Per Bed by Type of Hospitals, in constant 2000 prices



Sources: General Appropriations Act, Department of Budget and Management and Department of Health reports

3.28 *Per Region.* When hospital budgets are divided by the population of the region where the hospitals are located, it can be inferred that residents of NCR and CAR receive significantly higher hospital subsidy per capita compared to other regions. Although budgets per region have seen a marked decline in real terms since 2000, residents of NCR received 23 times more hospital subsidy than Region 4A residents in 2006. All other regions received an average of 30 to 40 pesos per person in 2006 compared to 50 to 70 pesos in 2000.

Figure 3.8: Budget Allocation of DOH-Retained Hospitals by Region, in constant 2000 prices



Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

3.29 *Number of service patients.* The relationship between MOOE and the number of service patients that were given discounted/free services in the hospital is ascertained using data from a sample of ten hospitals in 2007 (Table 3.6). To account for the graduated fee schedule for service patients, individual weights were assigned to C1, C2, C3, and D patients.[13] Comparison of the numbers of service patients served and MOOE rankings for selected[14] hospitals indicate that the hospital with the highest MOOE subsidy does not necessarily provide its services for the most number of service patients.

[13] The weights used were: C1=0.25, C2=0.50, C3=0.75, and D=1.
[14] Only these hospitals provided data for service patients in the 2007 Hospital Statistical Yearbook.

Table 3.6: Budget Allocation and the Number of Service Patients

Name of Hospital	Total Service Patients (weighted)	Rank (Service Patients)	MOOE 2007	Rank (MOOE)
Natl. Center for Mental Health	5288.25	9	112.851	1
San Lazaro Hospital	16649	2	101.747	2
East Avenue Medical Center	13540.5	3	94.457	3
Davao Medical Center	35766.5	1	49.874	4
Quirino Memorial Medical Center	9281.75	6	44.447	5
National Children's Hospital	6691.5	8	34.605	6
J. Lingad Memorial Gen. Hospital	13270.75	4	34.241	7
Dr. Jose N. Rodriguez Mem. Hospital (gen)	7810	7	31.892	8
"Amang" Rodriguez Med. Center	11710	5	17.716	9
Valenzuela General Hospital	1998	10	15.052	10

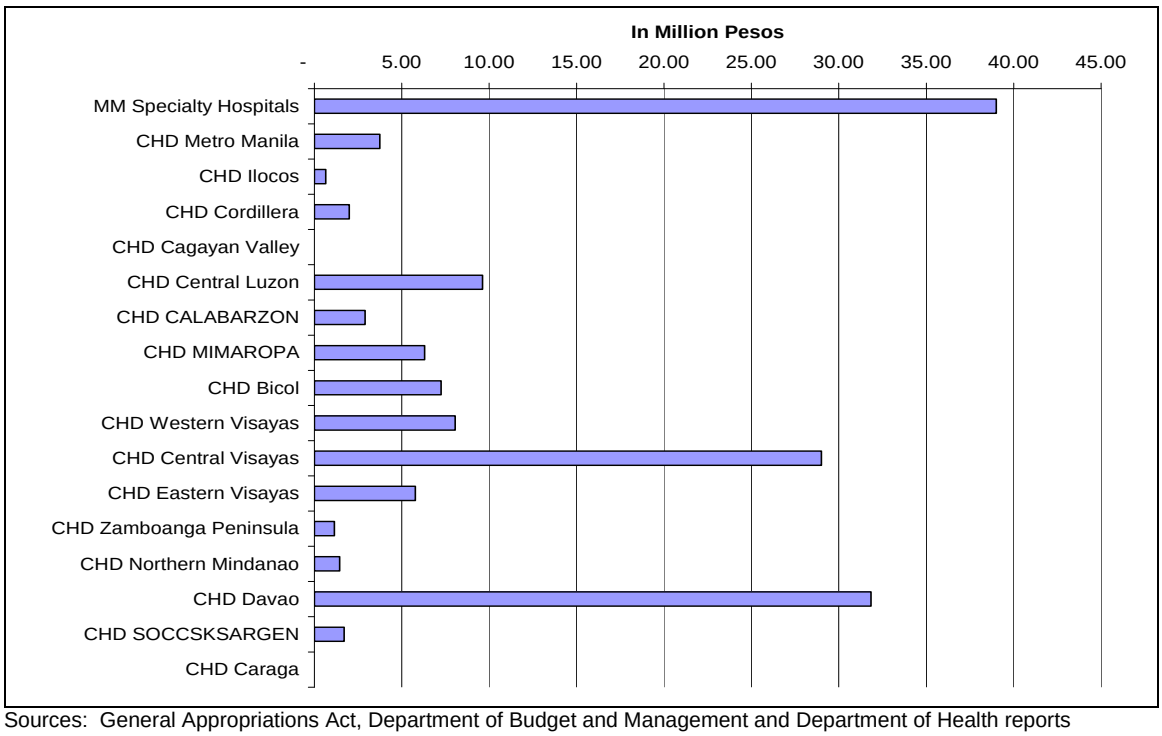
Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

Issues

3.29.1 *No clear allocation criteria for regular budget.* Although hospital budgets have been decreasing in real terms, the distribution of hospital budget by type and by region has not changed. This raises the question whether or not prioritization is done across types of hospitals or by regions. It is also not clear whether or not efficiency in the use of resources is an allocation criterion.

3.29.2 *Ad hoc allocation of PDAF to hospitals.* It is not clear how PDAF funds are allocated across regions. Apparently, PDAF funds, which comprise 8% of the total available funds for hospitals, reach the relatively richer, highly urbanized CHDs such as NCR, Central Visayas and Davao. PDAF funding is low or nil in CHDs in poorer regions such as Caraga, Cagayan Valley, Northern Mindanao, Ilocos, Zamboanga Peninsula, Northern Mindanao, and SOCCSKSARGEN. Distribution of these funds is subject to the whim of the congressmen and usually goes where there are big hospitals which attract lots of patients. If allocated in a more systematic order, without political subjectivity, it could have supplemented the MOOE needs of the poorer regions in dire need of additional resources.

Figure 3.9: Levels of PDAF allocation



Sources: General Appropriations Act, Department of Budget and Management and Department of Health reports

Budget Execution

3.30 *Reporting.* DOH-retained hospitals submit Budget Execution Documents (BEDs) and Budget Accountability Reports (BARs) to their respective counterparts at the DBM-CO and DBM-RO. Statements of Allotments, Obligations and Balances (SAOBs) are submitted to DBM, COA and DOH-Central Office Budget Division. The reports submitted to the DBM are used as basis for the Agency Performance Review (APR) which is conducted in the middle of the year to ascertain the level of releases for the remainder of the year. Monthly SAOBs submitted by the hospitals are compiled by DBM-CO and DOH-CO Budget Division. No analysis is done for these monthly reports except for the preparation of the APR.

3.31 *Budget Utilization Ratios*. In the aggregate, DOH-retained hospitals showed high budget execution ratios in the years covered in this analysis. Allotments for all expense class were fully released by the end of the year. Its PS appropriations were fully obligated while its MOOE was 99 percent obligated. Among the types of hospitals, only special hospital-regular and sanitaria hospitals had obligation ratios less than 100 percent, at 99 and 98 percent, respectively. Similar with other government agencies, total capital outlay program of all DOH-retained hospitals was only 34 percent obligated due to long procurement cycles.

Table 3.7: Budget Utilization per Hospital Type

Type of Hospital	Appropriations		Allotments Released		Actual Obligations		% Allotted		% Obligated*	
	MOOE	CO	MOOE	CO	MOOE	CO	MOOE	CO	MOOE	CO
Special Hospital regular	283.20	32.87	280.38	32.87	279.03	6.92	99%	100%	100%	21%
Special Hospital mental	143.06	17.14	153.06	17.14	152.79	16.96	107%	100%	100%	99%
Medical Center	964.08	316.30	977.76	312.30	958.50	128.13	101%	99%	98%	41%
Research Hospital	35.21	3.00	35.21	3.00	35.48	-	100%	100%	101%	0%
Regional Hospital	354.42	134.70	354.42	132.60	351.78	11.28	100%	98%	99%	9%
District Hospital	39.53	24.60	41.08	24.60	38.93	4.32	104%	100%	95%	-
Extension Hospital	11.44	-	11.44	-	11.43	-	100%	-	100%	-
Sanitaria Hospital	85.05	31.00	83.77	31.00	84.51	4.47	98%	100%	101%	14%
Total	1,879.55	517.63	1,908.35	511.53	1,883.69	172.10	102%	99%	99%	34%

Sources: General Appropriations Act, Department of Budget and Management and Department of Health reports
* Actual Obligations divided by Allotments released

3.32 *Utilization of PDAF Funds.* PDAF is an additional MOOE for hospitals. But unlike regular MOOE, its execution is quite low with only 71 percent obligated by year-end (Table 3.8). The percentage of appropriations obligated is especially low for extension hospitals, district hospitals, and special hospital regular.

Table 3.8: PDAF Utilization per Hospital Type

Type of Hospital	Appropriations	Allotments Released	Actual Obligations	% Alloted	% Obligated
Special Hospital regular	12.36	12.36	4.21	100%	34%
Special Hospital mental	-	-	-	-	-
Medical Center	102.18	102.18	68.44	100%	67%
Research Hospital	-	-	-	-	-
Regional Hospital	24.01	28.16	25.15	117%	105%
District Hospital	3.20	3.20	0.69	100%	22%
Extension Hospital	0.50	0.50	0.10	100%	20%
Sanitaria Hospital	8.20	8.20	7.55	100%	92%
Total	150.45	154.60	106.13	103%	71%

Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

Issues

3.32.1 *Lack of oversight with regards to budget execution for hospitals.* Reporting of actual budget execution is weak and the differences in the way reports/SAOBs are prepared makes monitoring more difficult. A sample set of SAOBs prepared by MM hospitals showed that some accounts or line items were recorded differently across hospitals. There were also no reports on particular expenditure items

such as procurement of medicines and hospital subsidies for service patients were not quantified. Although income utilization data are submitted by the hospitals, it is not analyzed.

3.32.2 *Payment of magna carta benefits distorts hospitals' use of funds reporting.* Interviews with DBM-Central Office as well as DOH-Central Office Budget Division revealed that the reason for the high budget utilization rate was the use of savings as payment for *magna carta* benefits. Under RA 7305, or the Magna Carta of Public Health Workers, public health workers are entitled to, among others, subsistence allowance, laundry allowance, longevity pay, hazard pay, higher salary grade upon retirement, among others. Since its passage in 1992, however, successive governments have failed to fully provide for in the budget the payment of such benefits as prescribed in the law. Only the subsistence and laundry allowances[15] are provided and only partially; for subsistence allowance, of the Php1,500 under the IRR of the magna carta for health workers, only Php900/month was funded from the GAA while Php600/month from savings; for laundry allowance (Php150/month based on the IRR, only Php125/month was funded from the GAA while Php25/month was sourced from savings. Hazard allowances were budgeted but these were only for x-ray technicians. The rest of the benefits prescribed in the *magna carta* were not funded at all.[16] An analysis of *magna carta* payments for MM hospitals is presented in Box 3.5.

[15] Subsistence allowance or meal stipend of at least Php50/meal or Php1,500/month; laundry allowance equivalent to Php150/month; and hazard pay of 25% of actual present salary for SG 19 and below and Php4,989.75 for SG 20 and above.

[16] "An Assessment of the Implementation and Budgetary Requirements of the Magna Carta for Government Workers (Draft Final Report)", by Drs. M. Garcia and E. Cabegin (2008)

Box 3.5: Payment of Magna Carta Allowances for MM Hospitals

Based on the total figures gathered from the Statement of Allotments, Obligations and Balances (SAOB) of MM specialty hospitals, it appears that only 11 percent of the obligated hazard pay and 92 percent of obligated subsistence and laundry allowances were covered by appropriations in 2007. In total, the budget may have only covered 65 percent of the implemented *magna carta* benefits, the rest of the funding requirements were sourced through savings.

The team tried to compare amounts of obligations vis-à-vis appropriations for *magna carta* benefits but it was difficult to do so since the recording of these transactions were not uniform across hospitals. Some hospitals (e.g. Quirino MMC, Tondo MC, National Children's Hospital, San Lazaro Hospital and Amang Rodriguez MC) reflected equal levels of appropriations and obligations, while other hospitals reported higher levels of obligations vis-à-vis appropriations. The latter included the amounts of savings used to cover for the *magna carta* benefit paid. For example, East Avenue MC's SAOB indicated that it was able to obligate Php18.04 million for payment of its subsistence and laundry allowance, Php7.47 million higher than the appropriated Php10.56 million. This way of recording suggested the amount of savings used since there were no other sources of funds to cover these benefits. Of the 12 MM specialty hospitals, only five recorded its obligations this way.

Comparison of Appropriations and Obligations for Provision of Magna Carta Benefits for MM Specialty Hospitals (2007), in thousand pesos

	Appropriations (In '000)			Obligations (In '000)			Difference (In '000)		
Name of Hospital	Hazard	Sub. & Laundry	Total	Hazard	Sub.& Laundry	Total	Hazard	Sub & Laundry	Total
Jose R. Reyes MMC	877	14,504	15,381	3,422	19,307	22,728	(2,545)	(4,803)	(7,347)
Rizal Medical Center	438	7,213	7,651	1,090	6,039	7,129	(652)	1,174	522
East Avenue MC	803	10,566	11,369	-	18,036	18,036	803	(7,470)	(6,667)
Quirino Memorial MC	321	7,337	7,658	321	7,337	7,658	-	-	-
Tondo Medical Center	292	5,097	5,389	292	5,097	5,389	-	-	-
Dr. Jose Fabella MH	877	12,884	13,761	18	17,062	17,080	859	(4,178)	(3,319)
National Children's Hosp.	365	5,351	5,716	365	5,351	5,716	-	-	-
Natl. Ctr. for Mental Health	1,607	24,412	26,019	44,122	21,644	65,766	(42,515)	2,768	(39,747)
Philippine Orthopedic Ctr.	877	13,553	14,430	17,183	17,153	34,336	(16,306)	(3,600)	(19,906)
San Lazaro Hospital	657	10,987	11,644	657	10,987	11,644	-	-	-
Res. Inst. for Tropical Med.	219	5,541	5,760	219	-	219	-	5,541	5,541
"Amang" Rodriguez MC	-	4,247	4,247	-	4,247	4,247	-	-	-
Total	7,333	121,692	129,025	67,690	132,259	199,948	(60,357)	(10,567)	(70,923)

Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

The biggest difference in terms of obligations vs. appropriations was the National Center for Mental Health. Only 4 percent of its hazard pay was funded. This meant a large difference of Php42.51 million between the appropriation and the obligation. On the other hand, its SAOB reveals that it had Php41.43 million of unobligated allotment under its *Salaries and Wages-Regular*. With no other sources besides this, it can be implied that the funding gap for the *magna carta* benefit was sourced from this activity. The same is also the case for East Avenue MC where only 63 percent of the implemented *magna carta* benefits, e.g. subsistence and laundry, and hazard, were provided for in the budget. As for the source of the savings, based on the SAOB, there was an unobligated balance of Php9.71 million under *Salaries and Wages-Regular*. Again, these unobligated alloments may have been used to cover the Php7.47 million funding gap for the payment of *magna carta* benefits. The possible source of funds as well as the respective amounts unobligated from these sources are presented in the table below.

Box 3.5: Payment of Magna Carta Allowances for MM Hospitals, continued

Funding Gap in the Provision of Magna Carta Benefits for MM Hospitals (2007), in PhpM

	Funding Gap	Possible Source of Funds	Amount of Unobligated Allotment
Jose R. Reyes Mem. Med. Ctr.	(7,347)	Salaries & Wages - Regular	19,907
East Avenue Medical Center	(6,667)	Salaries & Wages - Regular	9,706
Dr. Jose Fabella Mem. Hospital	(3,319)	figures presented in the SAOB were not broken down	Not available
Natl. Center for Mental Health	(39,747)	Salaries & Wages - Regular	41,432
Philippine Orthopedic Center	(19,906)	data on allotments not consistent with DBM	Not available

Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

Based on the sample above, it can be gathered that unobligated allotments of salaries and wages from unfilled plantilla positions in the hospitals are the main sources of "savings" for payment of *magna carta* benefits. Data on filled and unfilled positions reveal that those with high funding gaps are those that have higher than average level of unfilled plantilla positions. For example, unfilled positions account for 17.6 percent of the total plantilla positions at the National Center for Mental Health. This means that 349 positions were vacant at this hospital and this would have allowed them to accrue savings for payment of *magna carta* benefits. It is also possible that savings from MOOE were used to cover for these benefits as well. But because of the different ways these MM specialty hospitals record their SAOBs, it is difficult to ascertain if indeed this has been the case.

Filled and Unfilled Positions of MM Specialty Hospitals (2007)

HOSPITAL	No. of Positions			% Unfilled to Total
	Filled	Unfilled	Total	
Jose R. Reyes Memorial Medical Center	1,108	64	1,172	5.5%
Rizal Medical Center	546	57	603	9.5%
East Avenue Medical Center	1,024	57	1,081	5.3%
Quirino Memorial Medical Center	530	19	549	3.5%
Tondo Medical Center	377	37	414	8.9%
Dr. Jose Fabella Memorial Hospital	917	143	1,060	13.5%
National Children's Hospital	398	41	439	9.3%
National Center for Mental Health	1,632	349	1,981	17.6%
Philippine Orthopedic Center	990	112	1,102	10.2%
San Lazaro Hospital	815	76	891	8.5%
Research Institute for Tropical Medicine	411	61	472	12.9%
Amang Rodriguez Medical Center	338	12	350	3.4%
Total	9,086	1,028	10,114	10.2%

Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

Monitoring and Control

3.33 *Hospital Operations and Management Information System (HOMIS).* HOMIS is a computer-based system that was created by the NCHFD to systematically collect, process, store, present and share information in support of hospital functions. There were three planned modules under HOMIS, namely: Patient Management; Services Provision; and Administration. The components of each of these modules are as follows:

Table 3.9: Planned Modules under HOMIS

Patient Management	Services Provision	Administration
- Outpatient and emergency room consultations, admission, discharge, billing, payment - Medical records - PHIC claims processing - Medical social services and referral system requirements	Provision of clinical services to the patient throughout hospital stay: i.e., nursing care or ward, pharmacy, laboratory, radiology, dietary, central stock room and other ancillary services	- Budgeting - Obligations Accounting - Procurement Management - HR Management - Materials Management - Fixed Assets Management - General Ledger, Accounts Payable

Source: Department of Health

3.34 *Hospital Statistical Reports* are supposed to be generated through HOMIS by each of the hospitals and are submitted to NCHFD on a quarterly, semi-annual, and annual basis. Hospital statisticians and medical records officers are in charge of putting together these reports (see Box 3.6). These reports are normally submitted in hard copies and are sent by mail or by courier.

3.35 NCFHD used to validate the data submitted by the hospitals but due to manpower constraints, this responsibility was transferred to the respective Field Implementation Management Offices in the regions. NCHFD is just tasked to monitor the hospitals' compliance in submitting the reports. However, in cases where the hospitals do not submit their reports, NCHFD does not impose sanctions.

3.36 *Income Utilization Reports.* Under the guidelines[17] issued relative to the implementation of the income retention provision in the GAA, DOH-retained hospitals are required to submit two reports, namely: Quarterly Report of Estimated Income Collection and Utilization; and Status of Actual Quarterly Income Collection and Utilization. The circular specifies that these reports be submitted to DBM CO/RO concerned, copy furnished the DOH-Office of the Secretary and Regional Directors.

[17] DOH-DOF-DBM Joint Circular No. 2003-1 dated 16 July 2003, *Guidelines on the Retention and Use of Hospital Income Pursuant to Special Provision No. 6 of the DOH Appropriations under the FY2003 General Appropriations Act, RA No. 9206*

Table 3.10: Sources of Hospital Income and Allowable Items for Utilization

Hospital Income	Utilization
1. Hospital fees 2. Medical, dental laboratory fees 3. Rent income derived from the use of hospital equipment/facilities 4. Proceeds from the sale of hospital therapeutic products, prosthetic appliances and other medical devices 5. Diagnostic examination fess 6. Donations in cash from individuals or non-government organizations that are satisfied with hospital services, which are in turn given as assistance to indigent patients	1. For purchase of hospital equipment 2. For upgrading of hospital equipment 3. For augmentation of MOOE requirements 4. For other purposes

Source: Department of Health

3.37 The Chief of Hospital, upon the recommendation of the Hospital Executive or Management Committee in a form of resolution, approves the utilization of income. This resolution contains data on income collection by the hospital and the purposes for which it will be utilized. Hospitals are required to submit a Quarterly Report of Estimated Income Collection and Utilization, and a Status of Actual Quarterly Income Collection and Utilization to the DBMCO/RO and copy furnished the NCHFD at the DOH central office.

3.38 *Statement of Allotment and Obligations and Balances (SAOBs).* Hospitals, as with the rest of the government agencies, submit SAOBs to the DBM, COA and DOH budget division. MM Specialty Hospitals submit their respective SAOBs to the DBM-Central Office while hospital facilities under CHDs submit their SAOBs to the DBM-RO in charge. Consolidation of all these SAOBs is done at the DOH-CO which then submits the consolidated report to DBM. DBM-CO, on the other hand, does not have data on the SAOBs received from the regions nor does it attempt to consolidate these data.

3.39 *PhilHealth Monthly Hospital Report.* PhilHealth requires a monthly report from its accredited hospitals which has to be submitted within the first ten days of the month. It is a concise two-page report containing information on discharges, average length of stay, daily census of patients, common causes of confinement, surgical procedures, the number of deliveries, adverse drug reaction, mortality census, and referrals. Unlike the Hospital Statistical Report submitted to the NCHFD which details all the activities of the hospital, PhilHealth reports focus only on Philhealth members.

Issues

3.39.1 *Incomplete or no reports submitted.* Although there were required templates to be submitted, the reports are sometimes incomplete and lacking key components, e.g. *financial data,* personnel etc. There were relevant parts of the report missing, most importantly death rates, nosocomial infection rate, unfilled medical prescriptions, among others. As of 2005, only 48 out of 66 submitted the Annual Statistical Report. NCHFD does not impose sanctions to the hospitals that did not submit the reports.

3.39.2 *Statistical data has not been consolidated since 2004.* The last consolidated annual report was prepared in 2004. Statistical data from 2005 onwards were no longer prepared due to the resignation and retirement of key staff involved in the HOMIS. It was also gathered that there was insufficient budget to acquire new computers to maintain the system. The hospitals continue to submit these reports to NCHFD and these reports are filed in magazine boxes and are no longer processed.

3.39.3 *No analysis made on the data.* Since the data has not been consolidated since 2004, no pertinent analysis has been made on Hospital Statistical Report. At present, data from the report is used

only as an input to DOH Annual Report. The statistical report template contains very rich information which could be used to analyze hospital performance in greater depth. For example, it could be a very important source of information for benchmarking performance in accordance to Performance Based Budgeting.

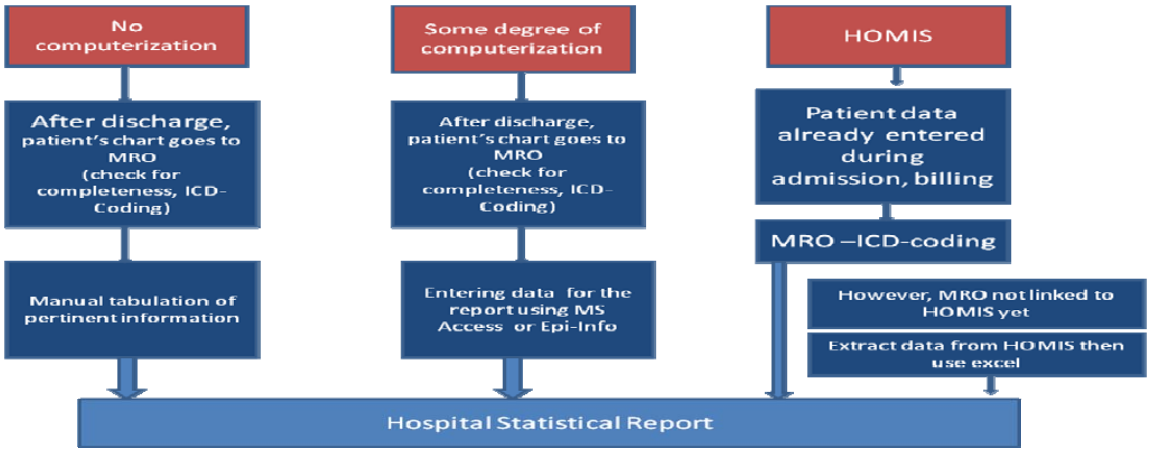
3.39.4 *As of the second quarter of 2008, there were still hospitals that did not submit income utilization reports to NCHFD for 2007.* Initially lack of clarity in the joint circular as to where in DOH the reports should be submitted led to not all income utilization reports being submitted to NCHFD even though they were put in charge of collecting these reports. Later a DOH Memorandum[18] clarified this matter, but compliance remained partial. These reports were typically received in hard copies and are sent through fax, mail or courier.

Box 3.6: Preparation of the Hospital Statistical Report

Hospitals are required to submit Hospital Statistical Report to NCHFD every quarter. The report contains detailed demographic data, bed capacity and occupancy, hospital operations, services of laboratory, radiology, dietary and pharmacy departments, the number of charity patients, staffing pattern, manpower development, research conducted, committees formed within the hospital, financial data, and public health programs implemented.

A large part of the report covers hospital operations based on the data generated by the medical records section. After a patient has billed out, the chart will be brought to the medical records section for safe keeping. Before charts are stored, they are checked for their completeness and the patient's disease is coded according to the International Classification of Diseases (ICD). Data required by the report are then encoded. Some hospitals use software such as MS Access or Epi-Info to encode the data while others manually tabulate them using ledger books. In hospitals using HOMIS, the medical records section is normally not yet linked to the system so the data for the report are still processed using MS Excel.

How is the data for Hospital Statistical Report generated?



Other sections of the report require input from other hospital departments. Data on daily census and occupancy rates are collected by the nursing service, surgical operations from operating room department, and activities of the emergency room from the ER department. Different departments involved in the report preparation are presented in the table below.

[18] Memorandum No. 40, s. 2004 dated April 15, 2004, *"Submission of Hospital Income Utilization Reports Pursuant to DOH-DBM-DOF Joint Circular No. 2003-1 Implementing the Special Provision No. 6 of the DOH Appropriations under the GAA FY 2003"*

Box 3.6: Preparation of the Hospital Statistical Report (continued)

Components of Hospital Statistical Report

Report Component	Department Responsible for the Data
Demographic data	Medical Records Section
Bed capacity and occupancy	Nursing Service
Hospital Operations	
-services rendered	Medical Records Section
-condition on discharge	Medical Records Section
-average length of stay	Medical Records Section
-twenty leading causes of morbidity	Medical Records Section
-twenty leading causes of mortality	Medical Records Section
-nosocomial infection rate	Infection Committee
-surgical operations	Operating Room Department/ Medical Records Section
-emergency room services	Emergency Room Department/ Medical Records Section
-outpatient	Outpatient Department/ Medical Records Section
Other Hospital Services	
-laboratory	Laboratory Department
-radiology	Radiology Department
-dietary	Dietary Department
-pharmacy	Pharmacy Department
Medical Social Service	Social Services Section
Staffing Pattern	Personnel Section
Manpower Development	Training Office
Research Conducted	Personnel Section/Training Office
Committees	Medical Director's Office
Financial Data	Budget Section
Programs Implemented	HEPO

After the statistician has collected data from different departments, she then consolidates the report and produces quarterly, semi-annual, and annual reports.

4 HOSPITALS AND HEALTH SECTOR REFORM

Health Sector Reform Strategy

4.1 *FOURmula ONE for Health.* The DOH adopted *FOURmula ONE for Health* (F1) as the implementation framework for health sector reforms in August 2005.[19] It covers four instruments namely: health financing; health regulation; health service delivery; and good governance in health. Among the strategies to implement financing reforms in the health sector is to adopt a performance-based financing system. Under this scheme, financing of health agencies and programs shall be shifted from historical or incremental budgeting system into one that is performance-based where budget allocations and releases are conditioned on the achievement of performance targets.

4.2 As follow-on to the DOH Administrative Order (AO) for the implementation of F1, AO No. 2006-0023 was issued on June 2006 to provide guidelines on financing F1 investments and budget reforms. This AO recognized that existing resources were not sufficient to support full implementation of the F1 framework. There was an apparent need to reform the structure, allocation and execution of direct subsidies going to the central and regional level health agencies and programs and a new budget structure was proposed to distribute the existing programs and projects under the current DOH budget structure according to three major functions: governance and management support; policy standards and development and technical assistance; and health program implementation and coordination. Among the budget allocation principles espoused in the AO is for subsidies to be allocated among the F1 instruments on the basis of capacity to generate revenues from operations. The budget for retained hospitals was easily identified as the source for such reallocation due to their potential of generating their own revenues. Capital outlay or funds for facility upgrading was also proposed to be pooled and be competitively accessed through submission of proposals.

Performance-based budgeting

4.3 As for budget execution, it was proposed that DOH budgets should be disbursed on the basis of scheduled performance benchmarks that were consistent with the Organizational Performance Indicator Framework (OPIF). On the performance benchmarks for hospitals, the pooling of a portion of MOOE for a performance-based fund was proposed. The performance standards would be based on service classification, quality of care, utilization rates, social support and efficiency measures, and a rationalized plan for the utilization of revenues.

4.4 A separate implementing guideline for performance-based budgeting (PBB) for DOH-retained hospitals was released subsequently on July 2006.[20] PBB refers to the process by which DOH splits funding for the hospital MOOE into several portions, the releases of which will be based on hospital performance relative to pre-agreed performance measures. The objective is to link budgetary allocation to performance, and to lessen the hospitals' dependence on subsidies and enhance its internal funds generation, specifically from social insurance reimbursements, user fee charges, and other extra-budgetary support.

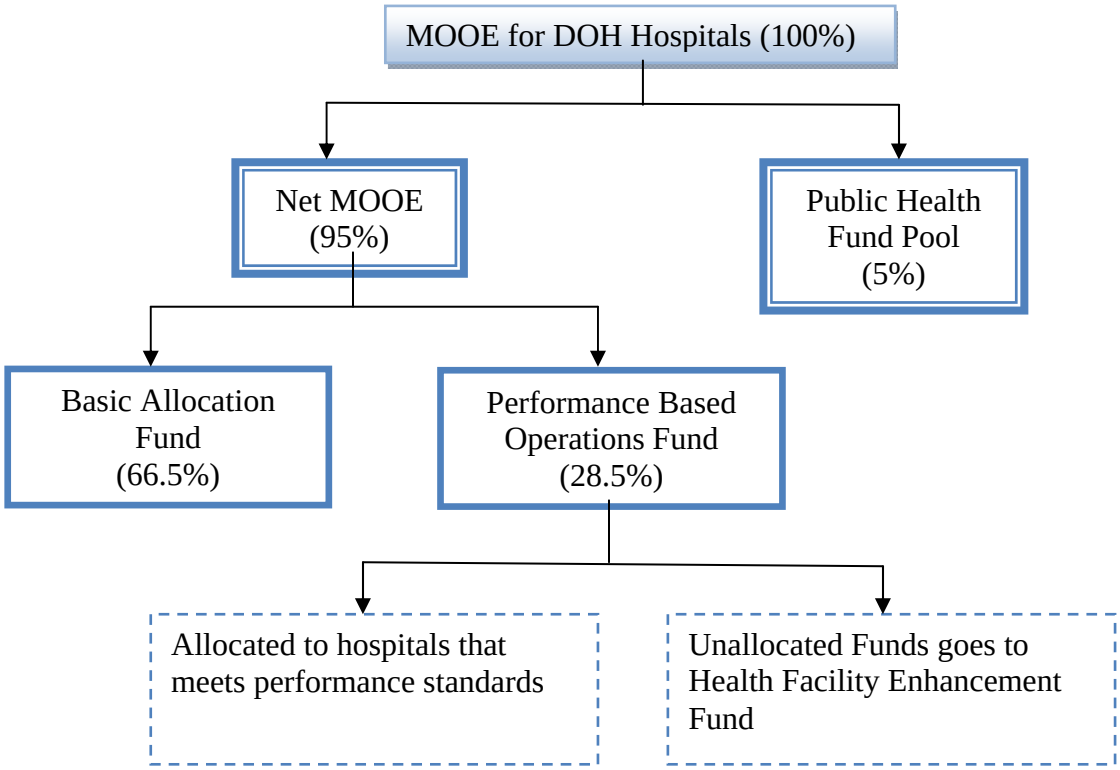
4.5 The AO on PBB stipulated that a fixed amount of 5 percent of MOOE for DOH hospitals would be automatically allocated to the Public Health Fund Pool to finance public health programs of F1. The remaining 95 percent of MOOE would then be divided into Basic Allocation Fund (BAF) and

[19] DOH Administrative Order No. 2005-0023 dated 30 August 2005, *Implementing Guidelines for FOURmula ONE for Health as Framework for Health Reforms*

[20] DOH Administrative Order No. 2006-0027 dated 12 July 2006, *Implementing Guidelines for Performance-Based Budgeting for DOH Retained Hospitals*

Performance Based Operations Fund (PBOF). The BAF would equal 70 percent of net MOOE (or 66.5 percent of total MOOE), not linked to performance benchmarking. This is to ensure that hospitals are capable of covering their overhead cost. The remaining 30 percent of net MOOE (or 28.5 percent of total MOOE) would constitute PBOF linked to performance benchmarks. In case a hospital was not able to reach the performance targets, the fund would be transferred to the Health Facility Enhancement Fund (HFEF). This fund would be available on a competitive basis to hospitals which submitted proposals for infrastructure enhancement or upgrading.

Figure 4.1: Performance Based Budgeting of Hospitals



4.6 It is worth noting that the issuance of the AO on PBB for hospitals is one of the prior actions for the release of the second tranche of a US$200 million ADB loan for the health sector. An AO to set out a policy for a unified management information system (UMIS), including systematic monitoring and evaluation of finances and management of all public hospitals, was among the actions completed for the first tranche of the loan as well.[21] It was later mentioned in the ADB progress report[22] that "the 2007 subsidies have already been budgeted and allocated to DOH hospitals on the basis of performance". A design of the UMIS was approved by DOH and pilot testing proceeded in 4 DOH retained hospitals. The UMIS was expected to integrate the existing systems (HOMIS, LMIS and Pharma-50) into one system, thereby eliminating data entry duplication, and improving the overall operational efficiency.

4.7 It has been several years since the AO on F1 and the introduction of PBB in hospitals. Changes in the budget structure was implemented for the proposed 2008 budget while implementing bed capacity

[21] Philippines Health Sector Development Program, Reports and Recommendations to the President-PHI-33278.
[22] Philippines Health Sector Development Program, Progress Report on Tranche Release-PHI-33278 (November 2006).

became the basis for hospital budget allocation, from the previous authorized bed capacity. However, other areas mentioned in the AO, most importantly, performance-based budgeting for hospitals had not been implemented as of 2008 balthough according to the AO, the period for implementation should have been CY2006-2010.

Issues with Performance Based Budgeting

4.8 *Conceptual flaw*. Given that at present, there is no criteria used for allocation of budget among DOH hospitals, it is indeed a good step that a framework for assigning budget based on performance is being implemented. Unfortunately, however, the design of PBB with respect to the DOH-retained hospitals was conceptually flawed. First, a specific parameter of the PBB as designed could either discourage some hospitals from trying to generate their own incomes, at least on the margin, or lead them to downplay the performance incentives (i.e., the marginal addition to the MOOE allocation) if they were capable of generating sufficient amounts of own income to compensate for the foregone MOOE allocation. Second, the PBB design was rather punitive in nature and could negatively affect the performance of those hospitals that failed to meet the performance targets, without necessarily encouraging better performance by the rest.

4.9 Given the resource scarcity in the health sector, the DOH has been reallocating its budget away from those hospitals capable of generating their own incomes to other programs like public health and social insurance. The parameters for PBB incorporate criteria which might lead to further reduction in hospital income such as increasing the number of indigent patients. Thus, if a hospital had a significantly higher income compared to its MOOE, it might not be enticed to adhere to the PBB since the amount withheld is only 28.5 percent of MOOE. When a hospital has significantly higher MOOE subsidy compared to its income, it will likely choose to adhere to PBB but it might not exert additional efforts to raise higher income. This is because higher income will lead to lower MOOE.[23] Thus, although the logic of linking funding to performance is attractive, the underlying incentive structure might have been overlooked when the PBB mechanism and its criteria were designed.

4.10 To illustrate, Table 4.1 presents income and MOOE subsidy for two regional hospitals: Batangas Regional Hospital (BRH) in Region 4-A and Davao Regional Hospital (DRH) in Region 11. The two hospitals provide an interesting contrast in income generation and MOOE allocations. BRH receives higher MOOE subsidy because its authorized bed capacity is 250 beds compared to 200 beds of DRH. Data on implementing bed capacity show, however, that DRH is in fact using 300 beds as opposed to BRH's 200 beds in its actual operations. Despite its lower budget and more beds to attend, DRH earns a higher income—65 million pesos more than BRH in 2006. And while BRH's income amounts to only 65 percent of its MOOE subsidy, DRH's income is almost three times more than its subsidy in 2006. Since BRH is highly dependent on MOOE subsidy, it is beneficial for the hospital to adhere to PBB so that its full MOOE budget will be released. In the case of DRH, however, it may be easier for the hospital to raise the amount that will be withheld through income generation than actually complying with PBB criteria.

[23] Regressions ran by the Team show that if a hospital's income increases by 1 million last year, MOOE for the following year will decrease by Php 137,700 (see Annex A).

Table 4.1: A Case of Two Hospitals

	2003	2004	2005	2006
Batangas Regional Hospital				
Income	11.62	15.82	24.94	25.13
MOOE subsidy	40.84	40.84	40.84	38.79
Income/MOOE subsidy	0.28	0.39	0.61	0.65
Davao Regional Hospital				
Income	27.57	36.28	67.82	91.00
MOOE subsidy	33.89	33.89	33.89	32.20
Income/MOOE subsidy	0.81	1.07	2.00	2.83

Sources: General Appropriations Act, Department of Budget and Management, and Department of Health reports

4.11 There is also a fundamental flaw in the PBB process that it appears as if it is a punishment rather than an incentive to perform better. When the hospitals perform well, they receive their budget which was originally due to them. But if they did not perform well, their budget will be cut which might take them farther away from the performance of other hospitals in the succeding year. Reducing MOOE allocations, even in a relatively small amount, is likely to disrupt hospital operations given the reality that all hospitals generally spend nearly 100% of their MOOE allocations and that only a third of the hospitals generate enough of their own incomes to fully cover their MOOE subsidy.

4.12 PBB Criteria. Table 4.2 presents the key performance benchmarks for 2008 to 2010. Based on a survey of available DOH reports and interviews with medical directors, statisticians, and record officers, the Table also provides a list of probable sources of data for each criterion.

Table 4.2: Allocation Criteria for Hospitals

Criteria	Availability
Efficiency Parameters	
• Case mix and occupancy rates based on most recent BHFS license	Report for Philhealth
• Networking arrangements established with private and public facilities	Hospital Stat Report-referral/ Report for Philhealth
• Cost per bed day vs. licensing category	Hospital Stat Report-finance
• Capability to handle complex cases, ancillary services including medical imaging and specialized laboratory procedures	Hospital Stat Report-hospital operations
Quality parameters	
• Decreasing nosocomial infection rate	Hospital Stat Yearbook-hospital operations
• Net death rates within internationally accepted standards	Hospital Stat Yearbook-hospital operations
• Effective hospital CQI activities	?
• Minimal adverse drug reactions/medication error rates	Report for Philhealth
• Increasing percentage of filled or decreasing or zero % of unfilled prescriptions by hospital pharmacy	Hospital Stat Report-pharmacy
• At least 50% of MOOE used for drugs and supplies	?

Criteria	Availability
• Client satisfaction and responsiveness (waiting time for ER, OPD and elective surgeries)	?
Social support parameters	
• Increasing percentage of Philhealth enrolled indigent patients against total admissions	Hospital Stat Report-Demographics/Report for Philhealth
• Increasing % of internally generated funds used for indigent patients against total budget	?
• Increasing ratios on quantified free service over total gross revenue	?

4.13 Of the 14 criteria that are proposed for 2008 to 2010, only four are readily available from the hospitals (Table 4.3). The Hospital Statistical Report template asks for information on networking arrangements but very few hospitals tabulate referrals for all patients. Usually, only those patients that go through assessments at the medical social service department are asked for referral letters. There are some criteria that are difficult to measure such as effective CQI activities and medication error rates. The guideline was not very clear on how it will define "effective". Although it would be ideal to obtain information on medication error rates, it is almost never reported. Other criteria are possible to measure but it will entail very high cost. For instance, to detect nosocomial infection, a hospital needs a special culture in their laboratory and a very competent infection committee. Client satisfaction and waiting time needs a staff dedicated to monitoring and timing each hospital procedure. Medical directors expressed that such exercise is currently not a major priority given very limited budget from the government.

4.14 The criteria on percent of internally generated funds used for indigent patients and increasing ratios on quantified free service are currently not yet collected by hospitals. Given that a number of retained hospitals claim that a substantial portion of their MOOE goes to writing-off of indigent's hospital bills, it would be ideal if this is indeed quantified.

4.15 Spending at least 50 percent of MOOE for drugs and supplies is not relevant anymore. Hospitals have been allowed to set up trust funds for medicines so the MOOE is not used to purchase pharmaceutical products anymore. Hospital officers interviewed also raised concern that the criteria on increasing percentage of PhilHealth enrolled indigent patients against total admissions is beyond the hospital's span of control. A hospital cannot choose which patients will go to their hospital and they cannot discriminate against those who do not have PhilHealth cards.

Table 4.3: PBB Criteria vis-à-vis Feasibility

READILY AVAILABLE	DIFFICULT TO MEASURE	NOT YET COLLECTED
• Capability to handle complex cases, ancillary services including medical imaging and specialized laboratory procedures • Case mix and occupancy rates based on most recent BHFS license ▪ Increasing percentage of filled or decreasing or zero % of unfilled prescriptions by hospital pharmacy ▪ Cost per bed day vs. licensing category	▪ Effective hospital CQI activities ▪ Minimal adverse drug reactions/medication error rates	▪ Increasing percentage of internally generated funds used for indigent patients against total budget ▪ Increasing ratios on quantified free service over total gross revenue
REQUIRED BUT USUALLY NOT REPORTED	EXPENSIVE TO MEASURE	NOT RELEVANT/BEYOND HOSPITAL CONTROL
▪ Networking arrangements established with private and public facilities	▪ Decreasing nosocomial infection rate ▪ Client satisfaction and responsiveness (waiting time for ER, OPD and elective surgeries)	▪ At least 50% of MOOE used for drugs and supplies ▪ Increasing percentage of Philhealth enrolled indigent patients against total admissions

4.16 *Data.* Collection of data needed for PBB is also plagued with many issues. Ideally, hospital data should be culled from HOMIS. It is, however, very expensive to have the infrastructure required by HOMIS and running HOMIS would entail additional personnel to encode data in the system. Those hospitals with a functioning HOMIS lament that the system is not user-friendly and not tailored to the peculiarities of each hospital. Thus, most hospitals produce data through manual calculations.

4.17 Other problems in data collection are incomplete medical charts submitted by residents and consultants and lack of support from management in requiring other departments to submit their data. There is also lack of manpower due to rationalization so rather than analyzing data for planning purposes, the statistician is relegated to other tasks such as encoding the chart. Despite the requirement of incorporating a statistician in the standard hospital staffing pattern for the implementation of Integrated Hospital Operations and Management Program (IHOMP),[24] there still remain many hospitals with no plantilla positions for statisticians. In these hospitals, clerks or administrative aides are tasked to prepare the statistical report.

4.18 There is also lack of training for statisticians. Even for the 2007 report preparation, there was still confusion as to the proper definition of the variables used in the report. The NCHFD has been trying to address this problem by conducting yearly trainings since 2005. A manual on Hospital Statistical Report preparation is also currently in the project pipeline.

4.19 Another problem raised by statisticians is the different format and definition of variables in the DOH and PhilHealth reports. Since PhilHealth reports are relatively shorter and disbursements are dependent upon their submission, it is prioritized over the Hospital Statistical Report. Most statisticians also expressed their frustration with preparing the report required by DOH because they rarely receive feedback regarding the quality of the report and its intended use.

[24] Administrative Order No. 44-A s. 1999, *Guidelines for the implementation of the INTEGRATED HOSPITAL OPERATIONS AND MANAGEMENT PROGRAM (IHOMP) within the Philippine Hospital System.*

5. CONCLUSIONS

4.2 The main purpose of undertaking the study was to provide a brief analysis of the planning, budgeting, and budget execution systems among DOH hospitals. To undertake the study, a situational analysis of the hospital sector was conducted through desk reviews and field visits to a sample of hospitals. Among the issues that need to be highlighted are:

- *Breakdown of referral networks.* Utilization of final referral hospitals for primary and secondary cases leads to a more expensive health system.
- *Lack of overall plan for the hospital sector*. At both the central office and the hospital level, planning appears to be ad hoc and there is no oversight arrangement in the budget preparation. Annual budgets that are drafted are therefore not well linked to priorities.
- *Antiquated basis for budget allocation*. The hospital budgets used to be estimated based on the number of hospital beds but as hospitals evolved with more complex composition of cases, this practice is no longer adequate for estimating hospitals' resource requirements.
- *No clear guideline in the rules behind income retention.* Although all hospital directors that were interviewed agreed that allowing income retention provided a good way of alleviating fund shortages, the current practice of cutting MOOE as income increased induces adverse effects in income collection efforts.
- *Perverse effects of unfunded mandates.* Mandating hospitals to provide *Magna Carta* benefits without giving them the appropriate budget and the restrictive regulation on the uses of funds push the hospitals to resort to gaming such as report manipulation or deliberate under-staffing to generate "savings" for benefit payments to the existing staff.
- *Lack of reliable data for measuring hospital performance*. Although the DOH mandates hospitals to submit reports on hospital activities, the current practice of data collection is questionable. Collecting and using information for planning and budgeting purposes does not appear to be an important priority at the hospital level.
- *Conflicting incentive structure of Central Office regulations*. While the F1 encourages hospitals to increase income collection, criteria for the release of MOOE under PBB requires hospitals to engage in activities that will dampen fee collections.

The way forward

The results of the study suggest:

- *A need for an overall plan for all DOH-retained hospitals*. A need for an overall plan for DOH-retained hospitals cannot be overemphasized. Various plans have been drafted in different health sector reform strategies in the past but disconnect between the central office plan and the hospitals remain because agencies in charge of the implementation do not have a strong authority to implement reforms. A possible solution would be to have an Undersecretary-level hospital administrator within the DOH who will oversee the implementation of the hospital plan in all DOH hospitals. This administrator should be given the appropriate authority to give sanctions for non-compliance and provide rewards for good performance.
- *Using the number of beds as a basis for budget allocation needs to be revised*. Before budget is allocated using the OPIF, there is a need to first reset the amount allocated to each hospital. This new allocation criterion should reflect the current status of each hospital. Aside from the size of the hospital, allocation should incorporate various activities of the hospital such as complexity of cases

handled and the number of service patients served. It should also factor in equalization measures such as GDP and poverty incidence in the region where the hospital is located.

- *A clearer policy on income retention needs to be drafted*. Hospitals should not be penalized for earning high incomes by cutting their MOOE allocation the next year. At the same time, DOH should ensure that the poorer segments of the population will not be ostracized in public hospitals due to the pressure of increasing hospital income. One way of ensuring that hospitals earn and the poor afford hospitalization is the enrollment of the poor patient in the Indigent Program of PhilHealth. The current set-up of DOH hospitals being funded by the national government and LGUs paying for PHIC premium is not incentive compatible since the LGUs can pass hospitalization cost to the national government even without PHIC cards. A short-run alternative is for the national government to shoulder the PHIC premium of the poorest of the poor. In the long-run, management of hospitals, should be given back to LGUs, particularly those that are not special medical centers. This way, LGUs will have an incentive to increase their efforts not only in enrolling their poor constituents but also enticing those who are self-employed to join the program. This would also help equalize the unfair distribution of devolved functions among provinces where those who had a DOH funded hospital in their area are better-off compared to those who inherited all hospitals.

- *Funding for Magna Carta benefits does not need to come from hospital savings.* The current financial status of most hospitals suggests that they are already overstretched in meeting hospital operational expenses. Giving them the additional burden of shouldering the expenses to pay for *Magna Carta* benefits is likely to result in unequal compensation of hospital workers among DOH-retained hospitals. Since the law is already enacted and it has long been recognized that hospital workers are undercompensated, *Magna Carta* benefits should indeed be paid. Given that the national government budget cannot afford to pay for these benefits, a possible source is the professional fee reimbursement from PhilHealth. Currently, these are used by some hospitals to provide honoraria to their workers, while in some hospitals it is not clear where these funds are spent. As opposed to the current practice of funding the benefits from PS or MOOE "savings," it might be better if professional fee reimbursements are earmarked for *Magna Carta* benefits. It will also provide an incentive for hospital workers to encourage patients to enroll in Philhealth.

- *Data collection should be raised as a priority at the hospital level.* A reliable set of data is needed before any performance benchmarking can be done. The DOH-CO should re-evaluate the reasons why HOMIS has not been successfully adopted by most hospitals. If indeed it was found that the absorptive capacity of DOH-retained hospitals to maintain a hospital database is low, simpler alternatives should be pursued. In the advent of information technology, manual tabulation of hospital statisticians should cease to be the status quo.

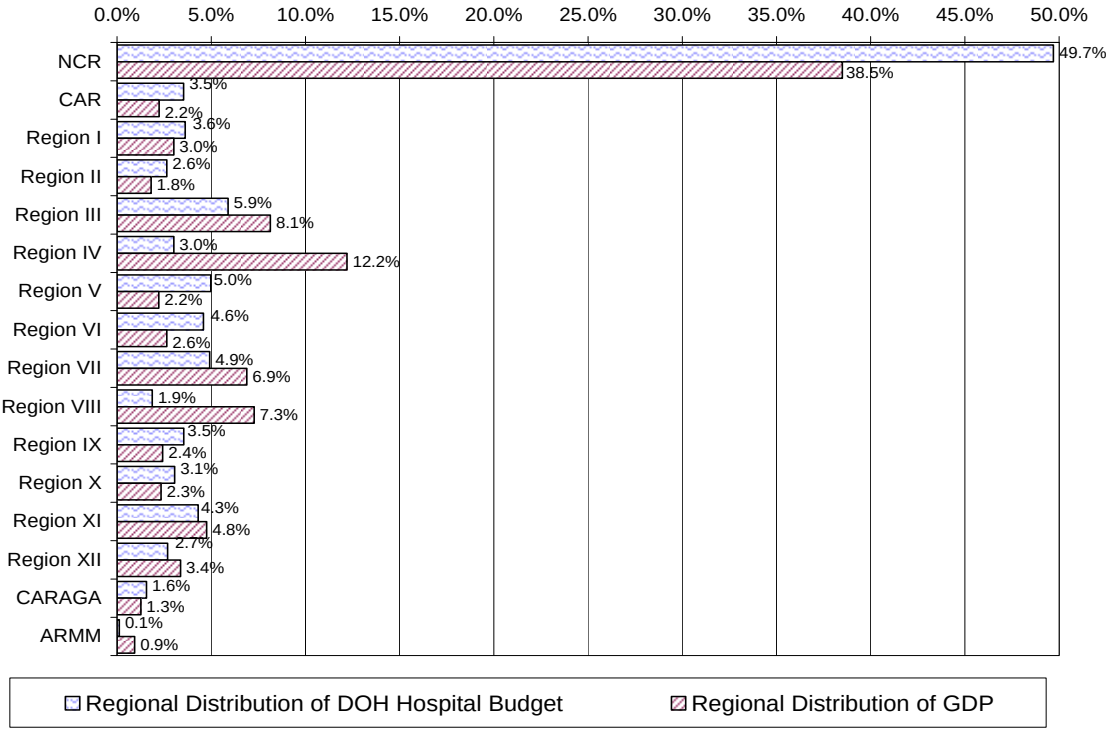
- *Rethinking performance based budgeting*. While the idea behind PBB is promising, the trick is in how to operationalize the concept given the prevailing incentive structure surrounding hospital managers and hospitals' information management capacities. DOH should re-examine the feasibility of the criteria used to assess the performance of hospitals. The incentive structure behind PBB should also be re-assessed so that it will actually reward good performers and steer those that are lagging behind toward better performance in a consistent manner. The current set-up of releasing budget for good performers does not seem to be a reward and not releasing budget for those that are not performing well is a punishment which will entail high costs because they will lag behind farther in the future.

Annex A: What is the basis of budget allocation?

Is it based on regional GDP?

Geographic distribution of the DOH hospital budget is highly skewed in favor of those located in the National Capital Region (NCR) or Metro Manila, which together receive almost 50 percent of the total hospital budget. The rest of the allocation for hospitals is distributed to the other 15 regions, where Regions III (Central Luzon) and VI (Western Visayas) receive the 2nd (5.9%) and 3rd (5.0%) highest allocation among regions. The ARMM (Autonomous Region of Muslim Mindanao), Caraga and Region VIII (Eastern Visayas) receive the lowest allocation at 0.1%, 1.6% and 1.9%, respectively.

Regional Distribution of Hospital Budget (including GOCC hospitals) vs. Regional Distribution of GDP, as percent to total, CY2007

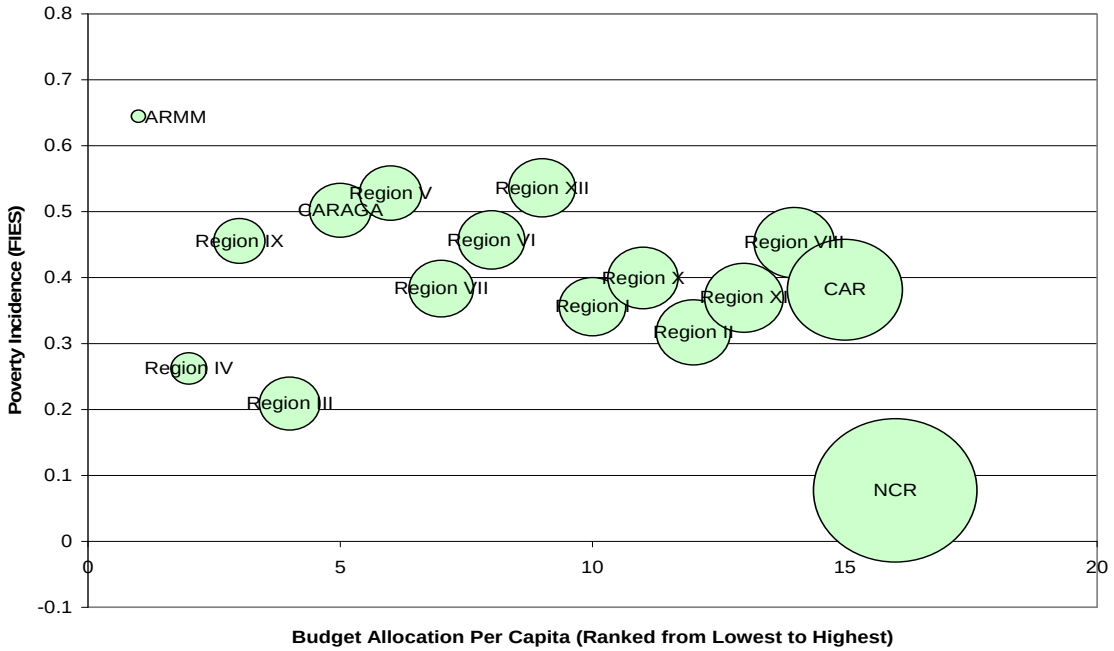


There is a significant correlation (0.95) between the regional distribution of GDP and that of the hospital budget, but this accounts for mainly the significant amount of budget allocation for high-income NCR and the meager allocation for ARMM, which has the lowest regional GDP. Once these outliers are removed, the correlation will be less significant at 0.18, since high-income regions like Region IV (Calabarzon and MIMAROPA) and Region VII (Central Visayas) receive low subsidy allocations.

Is it based on poverty incidence?

In terms of poverty incidence, ARMM ranked the highest and at the same time received the least amount of subsidy allocation for its DOH-retained hospitals on a per capita basis. Conversely, NCR and CAR (Cordillera Administrative Region), which both have relatively low poverty incidences, received the highest subsidy allocation on a per capita basis. The rest of the regions, except for Region IV, generally received almost the same amount of subsidy allocation on a per capita basis regardless of its poverty incidence.

Poverty Incidence vs. Regional Budget Allocation for Hospitals (including GOCC hospitals) Per Capita, CY2007



Source: Estimation of Local Poverty in the Philippines (NSCB), NSO Data

Is it based on income-generating capacity?

There is a high correlation (0.97) between the distribution of hospital budget and that of hospital income which shows that budget allocations are provided regardless of the income generating capacity of a hospital. This implies that DOH-retained hospitals receive their operating budgets every year regardless of hospital performance.

Empirical Findings

The authors estimated the determinants of MOOE using fixed effects panel regression. A balanced panel was constructed using data for 66 hospitals from 2003 to 2008. The relationship estimated was:

$$MOOE_t = a + b_1 Y_{t-1} + b_2 MOOE_{t-1} + year\ dummies$$

where

$MOOE_t$ = Maintenance and Operating Expenditures at year t

Y_{t-1} = Hospital income the previous year

$MOOE_{t-1}$ = Maintenance and Operating Expenditures

Summary of Results

	Coefficients (standard errors)
Y_{t-1}	-0.1377* (0.0283)
$MOOE_{t-1}$	0.5286* (0.1267)
Year is 2004	0.2811 (0.8655)
Year is 2005	0.7321 (0.8222)
Year is 2006	0.1208 (0.7832)
Year is 2008	1.2945 (0.8871

*significant at 1% level of significance

Results indicate that all things held constant, if a hospital's income increases by 1 million last year, MOOE for the following year will decrease by Php 137,700. The results also confirm that budget determination is indeed historical. An increase in MOOE last year will lead to an increase in MOOE of Php 529,700 the following year.

Annex B: Can DOH-Retained Hospitals survive on their income alone?

An MOOE coverage ratio is used to illustrate the current level of the hospitals' income-generating capacity. This ratio reflects how many times hospital income could cover the MOOE subsidy. For example, a ratio of less than 1, e.g. 0.95 would mean that there is only enough income to cover 95 percent of MOOE subsidy. This ratio offers an explanation of how much dependence hospitals have on government support for its operations. It is also a good revenue performance indicator since it can compare relative income generating capacities across hospitals. It should also be highlighted, however, that the MOOE subsidy from the government does not necessarily reflect the actual funding requirement of the hospital that will allow it to maintain the current level of services.

The average MOOE coverage ratio of all retained hospitals is shown in the table below. From only 50 percent of MOOE that can be covered by income in 2003, the coverage has increased to 101 percent in 2006. However, the average is pulled up by one hospital with very high ratio (S. Isabela Hospital). Even four years after income retention was allowed, only 33 percent of hospitals can cover MOOE subsidy through income.

MOOE Coverage Ratio

Year	MOOE Coverage Ratio	Number of Hospitals >1
2003	0.5160	8
2004	0.6337	15
2005	0.9017	25
2006	1.0576	27

Source: Authors' calculation based on NCHFD data