CHAPTER 4

IMPROVING ACCESS TO QUALITY HOSPITALS AND HEALTH SERVICES

4.1. HEALTH FACILITIES

The Local Government Code of 1991 resulted in the devolution of health services to local government units (LGUs) that included among others the provision, management and maintenance of government health facilities (district hospitals, provincial hospitals, RHUs, BHS) at different levels of LGUs. Though most of health facilities are devolved, 70 hospitals scattered all over the country are retained by the central government (DOH retained hospitals).

Private sector plays a crucial role in the Philippine hospital system. As noted in the earlier chapter, they account for more than 50 percent of the total number of hospitals. Almost half of the population goes to private facilities for their health care needs. However, private hospitals cater more to the upper socio-economic quintiles and those covered by health insurance.

In 2009, the country licensed a total of 721 public and 1,075 private hospitals. In 2010, the total hospital beds are 98,155 (Department of Health, 2009). Of these, around half (50 percent or 49,372 beds) are in government hospitals (National Statistics Office, 2010). To ensure provision of quality services, 10,530 facilities have been accredited (n=1835) and issued with licenses (n= 8,695) to start their operations in 2008 (Philippine Health Insurance Corporation, Various years). Issuing documents and accreditation are vital processes in quality assurance and monitoring compliance to standards.

RHUs and BHS act as providers of public health services at the municipal and *barangay* levels. From 1996 to 2005, the number of RHUs was declining, and the number of BHS was stagnating. Thus, the number of government primary care facilities cannot cope up with the increasing population.

Data has shown that the poorest of the population are the main users of government health facilities, yet these health facilities have suffered neglect due to the inadequacy of health budgets. Lower levels of care were bypassed even for simple primary cases because of deteriorating quality,

TABLE 12. NUMBER OF RHU AND BHS, PHILIPPINES, 2005

Year	Number of RHU	Number of BHS
1996	2856	1709
1997	2405	13096
1998	1791	14267
1999	2121	14416
2000	2218	15204
2001	1773	15107
2002	1974	15283
2003	2257	14490
2004	2258	15099
2005	2374	15436

Source: Department of Health

lack of human resources, medical equipment and medicines (Department of Health, 2010). This is particularly disadvantageous to the poor who need the services the most.

KP shall reform the health care delivery systems by focusing on health facility enhancement and rationalization and development of integrated health service delivery network. A functional and complementary network between the different components of local health systems should be formulated and implemented to properly maximize the health resources of each health facility. The DOH budget shall allocate resources in health facility upgrading coupled with improving the systems for health facility operation and management. Health facility enhancement increase hospital revenue from NHIP benefits and other medical and non-medical revenue and sustain the health facilities in providing quality services especially to the poor.

NATIONAL OBJECTIVES FOR 2011-2016

OVERALL GOAL: Improved access to quality hospitals and health facilities by all Filipinos, especially the poor

Strategic Objective	Indicator	Data Source	Latest Baseline	2016 Targets
Access to quality health facilities and services, especially those commonly used by the poor is improved	% DOH retained hospitals upgraded/rehabilitated/constructed	DOH Report	10 (Upgraded 2010)	95
	% Provincial Hospitals upgraded/rehabilitated/constructed	DOH Report	25 (Upgraded 2010)	95
	% District Hospitals upgraded/rehabilitated/constructed	DOH Report	30 (Upgraded 2010)	95
	% RHUs upgraded/rehabilitated/constructed	DOH Report	30 (Upgraded 2010)	100
Quality of inpatient and outpatient care is improved	% DOH-retained hospitals with Center of Quality or Excellence Accreditation status or equivalent	PhilHealth Report	17 (May 2011)	100

	Number of provinces and large cities with at least one LGU-managed hospital with Center of Quality Accreditation	PhilHealth Report	10 (2010)	70
	% RHU/CHO with PhilHealth Accreditation	PhilHealth Report	59 (2010)	80
	% Government hospitals with PhilHealth Accreditation	PhilHealth Report	88 (2010)	95
	% DOH licensed private hospital with PhilHealth Accreditation	PhilHealth Report	91 (2010)	93
Availability of essential drugs and medicines in all levels of government health facilities is ensured	% Availability of essential drugs in health facilities at all levels according to the National Drug Formulary	Special Facility Survey	25.3 (2010)	80
Access to specialized services in sub-national health facilities is enhanced	No. of Subnational Facilities with specialized services for heart, lung and kidney	DOH Report	3 (Upgraded/established in 2010)	5
	No. of regional blood centers	DOH Report	3 (Upgraded/established in 2010)	9
	No. of Cancer centers	DOH Report	1 (Upgraded/established in 2010)	3
Governance, sustainability and fiscal autonomy of government hospitals are improved	Number of DOH hospital transformed into corporate hospital	DOH Report	4 (2010)	6
	Number of LGU hospitals with fiscal autonomy or with scheme for economic enterprise	DOH Report	1 (2010)	16
Client responsiveness of health facilities is improved	% Client Satisfaction Rate	Special Survey	83.2 (2010)	90

STRATEGIES FOR 2011-2016

- A targeted health facility enhancement program that shall leverage funds for improved facility capacity to adequately manage the most common causes of mortality and morbidity, including trauma;
- Provision of financial mechanisms drawing from public-private partnerships to support the immediate repair, rehabilitation and construction of selected priority health facilities;
- Fiscal autonomy and income retention schemes for government hospitals and health facilities;
- Unified and streamlined DOH licensure and PhilHealth accreditation for hospitals and health facilities; and
- Regional clustering and referral networks of health facilities based on their catchment areas to address the current fragmentation of health services in some regions.

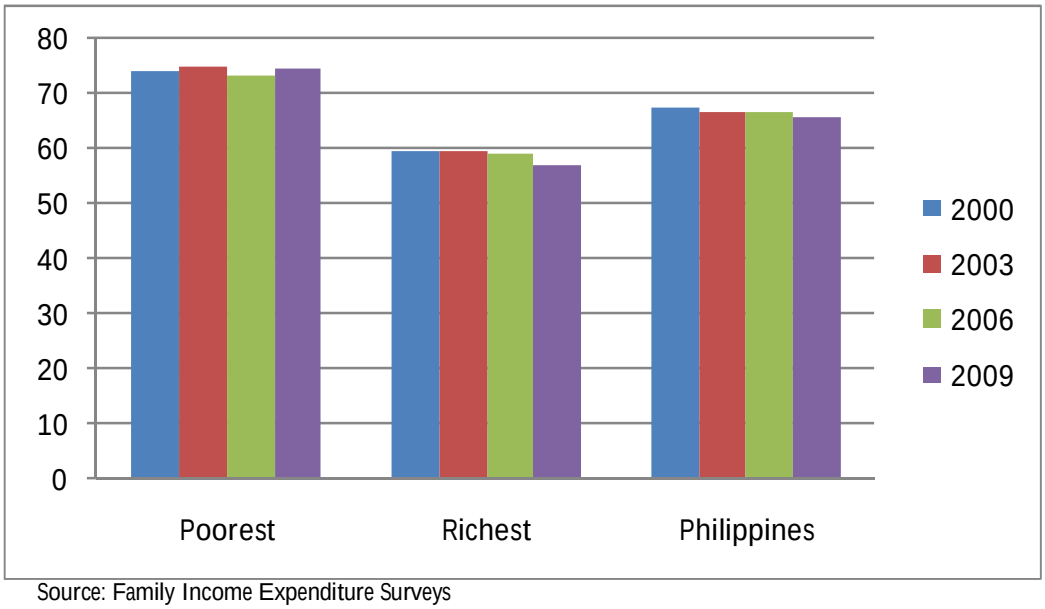
4.2. PHARMACEUTICALS

The purpose of the regulation of essential medicines is to ensure that no Filipino dies due to problems related to medicines. According to the World Medicines Situation, only 66% of the world population has access to essential medicines (World Health Organization, 2004). Lack of access to medicines as well as other problems like poor quality and irrational use, has impeded the achievement of the desired health status of the population. Access to or effective availability of essential medicines is influenced by the kind, price, and location of certain drugs, and also by the financing, payment, and organization of systemic actors who define what is offered and at what terms (Roberts, 2004).

The Philippines is one of the biggest pharmaceutical markets in the ASEAN region, next to Indonesia and Thailand. Sales of pharmaceuticals in the Philippines are estimated at Php100 billion annually, with 70 percent being accounted for by multinational firms (Reyes, 2010). Out of total sales, 63 percent comes from a major pharmaceutical chain, 17 percent comes from the combined sales of all other small independent pharmacies, 7 percent comes from private hospitals, 2.5 percent comes from public hospitals, 10 percent comes from other private outlets, and 0.5 percent comes from other public outlets (Picazo, 2012).

Drugs in the Philippines are more expensive than in other countries in Asia, and it is the major source of out-of pocket health expenditures. Analyses of various rounds of Family Income and Expenditure Surveys reveal that almost 66 percent of total health out-of-pocket can be accounted for pharmaceutical expenditure. **Figure 10** shows that the share of medicine expenditure is higher among the poorer quintiles (National Statistics Office, Various Years).

FIGURE 10: SHARE OF MEDICINES IN THE TOTAL OUT-OF-POCKET IN PERCENT, PHILIPPINES, 2000-2009



Source: Family Income Expenditure Surveys

The catastrophic and impoverishing effects of high cost of medicines led the national government to mitigate the drug prices. In the recent decade, different laws were enacted which aim to promote generics and increase supply of cheaper medicines. The Generics Act (RA 6675), the Cheaper Medicines Act (RA 9502) and the executive order requiring maximum retail prices for a number of drugs intend to improve accessibility to affordable quality medicine.

Another landmark law is Republic Act 9711 or the Food and Drug Administration Act of 2009 which strengthens the regulatory capacity of the DOH to ensure the quality of medicines and other health products.

The government made efforts to make drugs accessible especially in local communities by building drug outlets known as *Botika ng Baranggay* and *Botika ng Bayan* (**Table 13 and 14**).

TABLE 13: NUMBER OF *BOTIKA NG BARANGAY*, PHILIPPINES, 2005-2010

Year	Cumulative number of *Botika ng Barangays* (BnBs)
2005	2977
2006	7392
2008	10996
2009	13498
2010	16350

Source: PIDS study on Cheaper Medicine

TABLE 14: NUMBER OF *BOTIKA NG BAYAN*, PHILIPPINES, 2006-2010

Year	Cumulative number of *Botika ng Bayan* (BNBs)
2006	1,258
2007	1,605
2008	1,923
2009	2,195
2010	2,256

Source: *Botikang Bayan* Secretariat, PITC. www.botikangbayan.com.ph

In addition to *Botika ng Barangay, Botika ng Bayan* (BNB), the flagship outlets of the Cheaper Medicine Program were also established. BNB uses franchising as way to diffuse the drug stores in municipalities. The eligible applicants are NGOs and cooperatives; trade and labor unions or employees' associations; corporate foundations and religious groups; senior citizens and women's groups; and sole proprietorships, partnerships and corporations (Picazo, 2012). Treatment packs for selected NCDs shall be procured and distributed at RHUs for the use of the 4Ps beneficiaries (DOH DO 2011-0188).

The irrational use of medicines is another factor that affects access to medicines. The problem stems from medicines that are inappropriately prescribed, dispensed or sold, and from patients who fail to take their medicines properly. Overutilization, misuse, or underutilization of medicines poses health hazards and results to wastage of limited resources.

The DOH therefore aims to improve the safety and quality, access and availability, and rational use of medicines and to ensure accountability and health systems support by concerned agencies.

NATIONAL OBJECTIVES FOR 2011-2016

OVERALL GOAL: Improve the safety and quality, access and availability, and rational use of medicines and ensure accountability and health systems support by concerned

Strategic Objectives	Indicator	Data Source	Latest Baseline	2016 Targets
Access and availability of medicines is improved	% Population with access to affordable essential drugs	DOH Program Report	73 (2009)	95
	% market share of generics	PHAP	40% (2009)	>65%
Safety and quality is improved	% Incidence of counterfeit medicines	FDA	45* (Jan to Nov 2009)	24**
	% Drug manufacturing facilities with quality seal	FDA	20 for cGMP (2009)	100
	Number of ADRs reported per 1 million population	FDA	3,866 reported ADRs (Jan-Nov 2009)	To be determined

*30 out of 67 drugs tested are counterfeit medicines
** computed at 10% reduction annually

STRATEGIES FOR 2011-2016

- Strengthen education and advocacy campaigns to increase local acceptability of generic medicines.
- Enhance the monitoring and regulatory functions of the NCPAM.
- Improve the efficiency of existing institutions such as the FDA, the BNBs and BnBs and their coordination with other stakeholders such as MeTA.
- Gather relevant data for the formulation of evidence-based solutions in addressing the problem of irrational drug use and other barrier to drug access
- Sustain and manage the implementation of the law in the LGUs particularly the exercise of regulation by FDA representatives in provinces and cities, as well as the investments for the management, drug procurement, and construction of new BnBs.

4.3. HEALTH HUMAN RESOURCES

Human resources for health (HRH) is defined as the group of individuals in the formal and informal health sector that seek to protect, promote, and improve population health, equitable distribution and mobilization, and strategic utilization in order to meet the health system's goals (World Health Organization, 2006).

The Philippines produces human resources for professional and non-professional fields, and is at the forefront of global human resource exchange, especially in the health sector. The country is known as "the leading exporter of nurses and the second major exporter of physicians" (WHO 2009).Human resources include the following: doctors, nurses, midwives, nutritionist and other health professionals. **Table 15** shows the type of health human resources available and their corresponding employment category. For most part of the decade, the country experienced increasing migration of its health professionals, with a consequent shortage of HRH in the country.

TABLE 15. DISTRIBUTION OF SELECTED HEALTH PROVIDERS ACCORDING TO EMPLOYMENT CATEGORY OF AFFILIATION

Category	Doctor	Nurse	Midwife	Dentist	Nutritionist / Dietitian	Pharmacist	Occupational Therapist	Med Tech	Physical Therapist	Total
No Information	5,953	9,936	7,953	902	403	1,931	67	2,438	181	**29,764**
Permanent Full-Time	2,963	13,114	4,881	580	428	812	22	1,813	196	**24,809**
Permanent Part-Time	861	188	20	20	14	15	1	29	10	**1,158**
Contractual	1,305	1,965	535	31	20	53	1	144	27	**4,081**
Visiting Consultant	2,041	4	4	25	0	0	0	0	2	**2,076**
Casual	24	646	363	11	5	29	4	46	18	**1,146**
Volunteer	10	998	57	0	0	1	0	5	2	**1,073**
Multiple Affiliations	3,622	498	272	96	37	107	1	215	12	**4,860**
TOTAL	**16,779**	**27,349**	**14,085**	**1,665**	**907**	**2,948**	**96**	**4,690**	**448**	**68,967**

However, even with the increasing migration of health professionals, the most recent WHO report on the country concludes that there is still a high unemployment rate for health professionals despite the large number of vacancies in rural areas. Factors suspected in this deficiency include emigration of Filipino health workers, a weak HRH information system, and the existing condition wherein health workers flock to already crowded urban areas, leaving rural areas unmanaged by physicians (Lorenzo, 2007).

Data on health workers in the public sector show that the concentration of health workers is highly variable across regions (**Table 16**). The number of health professionals in the public sector per 100,000 population is high in regions like NCR and CAR, while there is a noticeable scarcity of health professionals relative to the population size in regions like ARMM.

TABLE 16. NUMBER OF HEALTH PROFESSIONALS IN THE PUBLIC SECTOR, BY REGION, PHILIPPINES, 2008

Area	Frequency			Per 100,000		
	Doctors	Nurses	Midwives	Doctors	Nurses	Midwives
Philippines	2,838	4,576	17,473	3.2	5.2	19.7
NCR	590	723	1,135	5.1	6.3	9.8
CAR	89	131	637	5.9	8.6	41.9
Region 1	159	259	1,014	3.5	5.7	22.3
Region II	97	196	839	3.2	6.4	27.5
Region III	278	441	1,662	3.1	4.9	18.3
Region IV-A	238	472	1,818	2.0	4.0	15.5
Region IV-B	83	142	555	3.2	5.5	21.7
Region V	157	273	1,072	3.0	5.3	20.6
Region VI	234	401	1,775	3.4	5.9	26.0
Region VII	177	328	1,534	2.8	5.1	24.0
Region VIII	155	201	904	4.0	5.1	23.1
Region IX	100	203	697	3.1	6.3	21.6
Region X	138	241		3.5	6.1	
Region XI	75	127	743	1.8	3.1	17.9
Region XII	113	114	615	3.0	3.0	16.1
Region XIII	79	114	615	3.4	5.0	26.8
ARMM	76	130	507	1.8	3.2	12.3

*Calculated using Philippines Statistical Yearbook 2010

To address the inadequate distribution of HRH in the country, the CHTs together with the registered nurses, through the RNheals program, will be deployed to provide families with health information and guide them to the assigned health facilities and preferred referral facility. The range of information can include health risks, the needed services to address the risks, the available providers (including their location, services, costs, operating hours and level of quality) and their benefits or entitlements. Furthermore, families will also be guided on how to access services and how to finance the cost of care, particularly in terms of availing of NHIP benefits. The CHTs will be recruited from among community health volunteers such as *barangay* health workers, *barangay* nutrition scholars and *barangay* officials.

In addition, deployment programs such as Doctors to the Barrios (DTTB), DTTB-Leaders for Health (DTTB-LHP), Rural Health Team Placement Programs (RHTPP), and Specialist to the Provinces (STTP) will be enhanced.

NATIONAL OBJECTIVES FOR 2011-2016

OVERALL GOAL: Guarantee adequate supply and equitable distribution of human resources for health in the country.

Strategic Objectives	Indicator	Data Source	Latest Baseline	2016 Targets
HRH supply is adequate and distribution of HRH is equitable	Number of CHTs and RNheals deployed to achieve the MDGs	DOH Program Report	0 CHTs 0 RNheals (2010)	100,000 CHTs 22,500 RNheals
	Number of doctors, other allied health professionals and midwives deployed in the areas of need	DOH Program Report	80 DTTBs 50 each (Dentists, Med Techs and Nutritionist-dietitian) 175 Rural Health Midwives (RHMs) (2010)	300 DTTBs 1,000 other allied HRH 3,000 RHMs
	% Filled-up positions based on approved staffing	DOH Program Report	80% authorized (2010)	100%
Capacity of health work force to support national and local health systems is enhanced	Number of certificate courses leading to post-graduate program	DOH Program Report	1 (2010)	2
	Number of HRH systems and programs institutionalized	DOH Program Report	4 (2010)	6

STRATEGIES FOR 2011-2016

- Deploy CHTs and RNheals to the communities and enhance existing deployment programs such as the Doctors to the Barrios (DTTB), DTTB-Leaders for Health (DTTB-LHP), Rural Health Team Placement Programs (RHTPP), and Specialist to the Provinces (STTP) aligning them to KP objectives
- Through the HRH network, make health science education more community-oriented through a unified community-based curriculum that produces a broad range of health workers with competencies that are relevant to the country's needs
- Prioritize the reduction of the percentage of vacancies of HRH in rural health facilities and other areas and also strengthen the capability of human resources to support national and local health systems
- Constantly update and utilize the National Database on Selected Human Resources for Health Information System (NDHRHIS) as a tool to address the inequitable HRH distribution
- Enhance personnel administration systems and processes to effect improvement of health workforce outcomes through incentive mechanisms