Organizing Health Services Towards Universal Health Care

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The delivery of health services is fragmented into over 3,000 discrete units: 2,600 facilities at primary, provincial, regional and national levels and over 1,000 private facilities of which only the hospitals have been counted. (see figure 1) The public-private dichotomy seems to have evolved naturally from the Americal colonial model while the fracturing of the public health system is of recent origin namely, the enactment of the Local Government Code of 1991. This conferred the power and authority for health care services, including primary care and hospital services to specific LGUs, barangays, muncipalities and cities and provinces. The result is the absence of a unified, cohesive and logically organized health system, but instead "several autonomous organizational structures with the common thread being their concern with the provision of health goods and services."[1]

Primary Care

Primary health care is provided at 3 levels: over 15,000 Barangay Health Stations (BHS), close to 19,000 Rural Health Units (RHUs) or Urban Health Centers (HC), and over 300 Primary or District Hospitals (DOH BHFS, *Distribution*…). BHS and RHU services revolve mainly around the following: diarrheal disease, ARI, dental health, environmental health (specifically water and toilet), immunization, family planning, nutrition, prenatal and postnatal care, and TB control.[2] This health care provision has been described as "selective PHC," "vertical,"; i.e. aligned along programs, disease and interventions, not on people, doctor-centered, and "rationed" by availability of doctor, medicines and laboratory services.[3]

District system

The "district health office" was specified as such in 1987. The office exercised jurisdiction over district hospitals, municipal hospitals, rural health units, barangay health stations and all other Ministry units in the health district.[4]

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With devolution mandated in 1991, health districts were transferred to the jurisdiction of provincial governments where many did not thrive owing to the lack of funds and the departure of personnel.[5] Health districts were revived and rehabilitated as Interlocal Health Zones (ILHZ), i.e. a "clustering of a group of contiguous municipalities that have a core referral hospital and a number of primary level facilities such as RHUs and BHS."[5] According to the administrative order, ILHZs were designed to be venues for harmonizing preventive and curative care through integrated governance, management, financing, resource-sharing and provision of health services.

Referral hospital system. There are 4 hospital levels reflecting "graduated resource capacities and care capability": 41% are primary, 36% are secondary, 9% are tertiary, and 6% are quaternary.[1] In general, there are slightly more government beds for all levels, except for tertiary hospitals where private beds are the majority. The number of hospitals appears to be directly related to the size of the regional population. However, there are significantly less government hospitals in the more impoverished regions, belying the notion that "government hospitals are mechanisms for tempering inequity."[1]

General performance of health delivery organizations

Primary care. With primary care facilities widely dispersed and administered disparately, it is very difficult to get a picture of their functionality and viability. In 2003, Sentrong Sigla (SS) announced the percentage of facilities that met SS standards: 53% of health centers, 15% of district and provincial hospitals, and 3% of barangay health stations.[7] The SS Quality Assurance Program examined the delivery of basic services **-** EPI, Disease surveillance, Control of ARI, Control of Diarrheal Diseases, Micronutrient Supplementation/Nutrition, FP, TB control, STDs and HIV-AIDS, Environmental Health and Sanitation and Cancer control – as well as compliance with facility standards and regulation. However, we have no information whether any general assessment of Primary care provision is being done, whether or not via the SS QAP.

Inter Local Health Zones (ILHZ). 23 years after the concept of the district was laid down, the effort to "model" ILHZ consumes a lot of DOH and donor resources and effort. DOH targeted the modeling of about 152 ILHZ (calculated from NSCB) in 65 convergence sites. As of 2006-

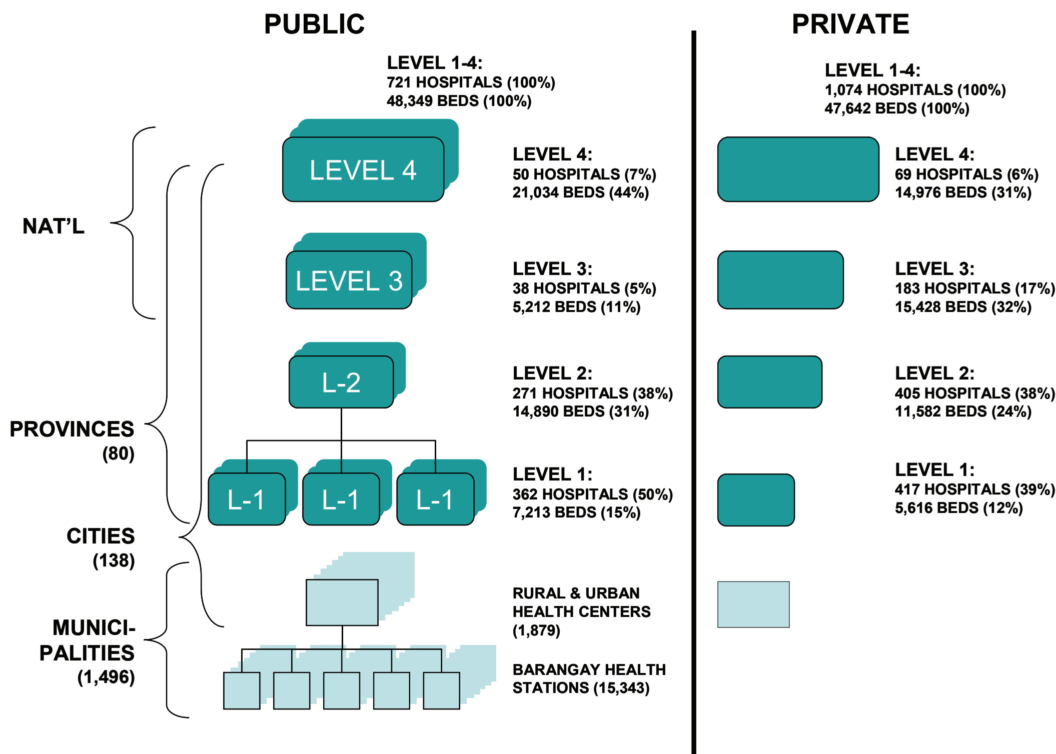

Figure 1. Levels of Health Care Delivery (*Source*: DOH Bureau of Health Facilities and Services)

2007, 83 of these ILHZ are reported to be functional.[8] Yet, despite some very promising practices in 5 provinces, enormous challenges persist, including the perennial insufficiency of human and physical resources, unstable political leadership of the Health Boards, misunderstandings about the role of the DOH, and insufficient management resources and capacity, including that of information.[5] These structural difficulties prompted the evaluator above to ask a basic question: do devolved health services have strategic advantage over other options of delivering health care services, in terms of providing equity and efficiency?

Patient responses and outcomes. According to the National Demographic and Health Survey (NDHS) 2008, 8% of Filipinos visited a health facility or sought consultation in a month, 3.9% in public facilities and 3.1% in private facilities. In terms of specific facilities, 34% went to RHU/BHS, 20% to private hospitals and 19% to private clinics. Reasons for consultation were illness/injury, 68%; and check up, 28%.

4% were confined in one year, 51% in public facilities, 48% in private. In terms of specific facilities, private hospitals accounted for 44% of inpatients, provincial and regional hospitals for 17% per level, and district hospitals, for 12%.

It is apparent that patients, even the poor are more inclined to seek care in private facilities and the only barrier seems to be cost. The cost of consulting in a private facility is 3 times that in public facility (PhP 2,864. vs. 1,051 while the cost of inpatient care in private hospitals is also 3 times that in public hospitals: (PhP 24,278. vs. 9,849.)[9]

For a middle income country, the fact that the Philippines is not meeting some of the health indicators associated with public health, such as immunization against measles in one-year olds and death rates associated with TB, indicates something amiss with the health system. This fact is emphasized in maternal mortality, the reduction of which is associated with a strong referral system at the district level.[10] Poor health outcomes are a function of the way health care services are organized and made available.

Recommendations

To address the problems wrought by the inherently disorganized health care delivery system, the following steps are being proposed:

I. Strengthen Primary Care to ensure responsiveness and sustainability

Devolution has caused the provision of primary care to be non-uniform, focused on a few vertical programs, and substandard in many cases. A strategic step towards strengthening is to reconfigure and implement a package of "Essential Services".

Develop and provide an organic Essential Health Package (EHP)

Primary care or Essential care was originally defined in the Alma Ata declaration as "Essential health care based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[11] EHPs of varying sizes and composition have been proposed for countries, including those reconstructing from war and conflict, without much success.[12] This failure has been attributed to the failure to recognize that EHPs are inherently "value" laden and that where values conflict they could distort the package, prolong its implementation and eventually affect its viability. Another lesson is that the enabling conditions for the realization of the package are vital: "good technical and management training for the eventual providers of essential services, adequate resource levels, consistent allocative decisions, sound professional tools made available across services (information, relevant guidelines for action, realistic targets, functioning monitoring mechanisms), and effective incentives."[12] Chile's EHP and the way it was processed is a notable precedent in this regard: there was no preset package but an organic one that assimilated people's demands and needs; packages were developed for both primary and secondary levels; citizens and public officials were involved in discussions on the benefits and costs of the package; and the package is periodically subject to evidence-based reviews.[13]

In response to the most pressing health problems affecting most Filipinos, including those in the Millennium Development Goals (MDGs), an Essential Health Package has been proposed to the WHO that consists of services around 8 areas: Maternal and Newborn Care, Reproductive Health, Child Health and Nutrition, Communicable Diseases, Noncommunicable Diseases, Mental Health, Acute Care and Oral Health.[14] The package is based on studies in rural and urban communities. It specifies services at 3 levels – BHS, RHU/HC, and District hospitals – and specifies the required personnel, essential medicines and diagnostic examinations per level. The package describes facilitating factors as well as obstructing factors, and was projected to cost PhP 1,379.00 per capita.[3]

The EHP is not conceived to limit services but to serve as starting points for patient-centered care. The Primary Health Care principle of putting people "in the center" implies going beyond simple health care provision to address peoples' needs, foster enduring relationships between providers and patients, and relate to people not as objects of care but as partners in managing their health and community.[13] Person-centered care, which is equity taken to the individual level, has been shown to increase patients' trust and compliance, improve treatment effects, strengthen integration of preventive and promotive care, and promote better quality of life.[13]

Our proposal is to pilot the EHP and EHP process in 6 or so provinces prior to cascading it. The first step is to build consensus and support for the EHP nationally and in the pilot provinces. It is necessary to get the buy-in of critical stakeholders - patients, providers, and policymakers across LGUs, DOH, Philhealth and other funders. The next step is to put in the necessary human and logistical requirements and assure continuing funding. The last step is to implement and assess.

Enable primary care teams to develop primary care network and select patients for referral to the primary care hub, the district hospital

The complex and social nature of many health problems requires solutions coming from other health workers as well as from nonhealth sectors. This requires a multidisciplinary primary care team that is closely linked with other community resources and able to tap into these resources as often as necessary. Health-related human resources include laboratories, pharmacies, health specialists, shelters, transport drivers, drug rehabilitation centers, etc. Nonhealth human resources include parents, teachers, social welfare agencies, credit facilities, lawyers, law enforcement, employers, etc. Broad linkages are necessary for the comprehensive management of social health problems but also serve to engender intersectoral support for health.

Simultaneously with building bridges to the community, the primary care team acts as gatekeeper identifying those patients requiring more technical diagnosis and care and channeling them to the hospital system, via the district hospital. Based on the roles and capacities delimited by the EHP, the primary care team will manage patients and refer them to the upper levels accordingly.

Our recommendation is to include these "broadening" and "filtering" functions of the primary care team when they are selected and trained.

II. Expedite the establishment and/or functioning of the district system or Interlocal Health Zones (ILHZ) as the key link between the Primary System and the Hospital system

The gatekeeping and filtering functions of several primary care teams will converge on the district facility and system. Though the district facility was originally conceived to deconcentrate from a centralized system,[11] the same is being used inversely to integrate the primary care and hospital systems. The district health system has been proven to be essential and effective in localities where multiple stakeholders, but particularly different configurations of local chief executives, endeavored to rise above LGU political boundaries and jointly managed what are incipient

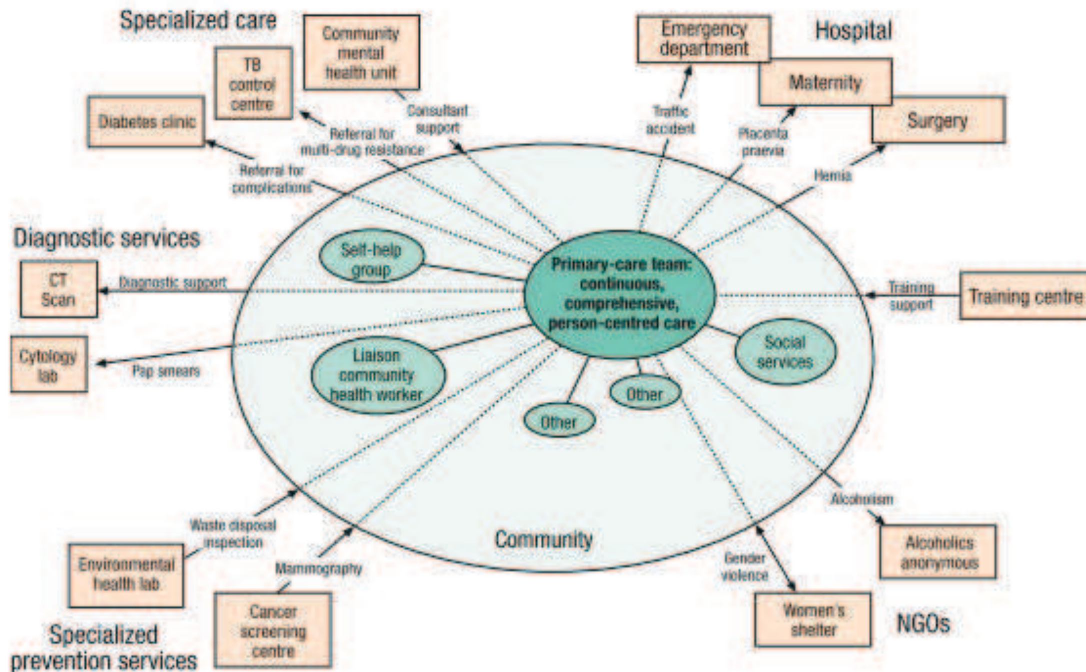

Figure 2. Primary Care as a hub of coordination: networking with the community served and other partners

forms of district systems under devolution.[5] Though the formation process is arduous and the new district systems continue to be buffeted by all sorts of political, financial and administrative challenges, the pivotal role of district systems need to be asserted and institutionalized for the long term integrity and viability of the health system. This is important for municipalities and cities where barangays are decisive.

Reinstitutionalize the District Health system through political and financial support through the province

The original concept of the district health system flowed from an emphasis on autonomy through decentralization (not devolution):

"A district health system based on primary health care is a more or less self-contained segment *of the national health system*. It comprises first and foremost a well-defined population, living with a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district whether governmental, private or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other sectors. It includes self-care and all health workers and facilities, up to and including the hospital at first referral level and appropriate laboratory, other diagnostic and logistic support services. Its component elements need to be well-coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activites."[11]

Anchored on the principles of Primary Health Care, district health systems are expected to incorporate the guiding principles of equity, accessibility, emphasis on promotion and preventions, intersectoral action, community development, decentralization, integration of health programs, and coordination of separate health services.[11] Under the present conditions of unfettered LGU autonomy, the integration role of district health system becomes imperative, where integration is defined as "the process of bringing together common functions within and between organizations to solve common problems, develop a commitment to a shared vision and goals, and, using common technologies and resources, achieve health goals for the community."[11] Three elements of integration are particularly vital: integration of service tasks, e.g., providing primary preventive and outreach services from hospitals; integration of management and support functions, e.g., planning, budget, communication, training, transport, quality assurance and research; and integration of organizational components, e.g., putting in place a coordinating mechanism like a council that ensures that discrcete parts of the system -human, physical and financial-are harmonized.[11]

Our propoposal is to support the provincial governments' assertion of their power and authority to revitalize and strengthen the district health system in both rural and urban settings. DOH must mobilize human,

technical, political, and funding resources to re-establish the place of district system in the whole delivery system.

Facilitate and support the establishment of well functioning District Hospital

The district hospital is defined as a hospital at the first referral level that is responsible for a defined geographical area with a defined population and governed by a politico-administrative organization. District hospitals generally serve communities of 50,000-500,000. In some countries, an intermediate facility between the primary care center and district hospitals exists serving populations of 10,000 to 50,000. The physical scale of the hospital is established on the basis of a determination of the number of beds required and a suggestion for the minimal hospital area per bed.[11]

District hospitals perform a wide array of functions, in addition to the provision of first referral level care, including public health functions and training and research. The essential services provided at this level are: Medicine, Surgery, Pediatrics, Obstetrics and Gynecology and Dentistry; which are supported by: Anesthesia, Radiology, and the Clinical laboratory.[11]

District hospitals play a critical role in providing timely medical care, including surgery for the conditions that typically account for a large share of the population's disease burden, such as surgery for complications of childbirth. Surgery for these and other conditions is most effective when provided at the district level, particularly in the poorest countries. Proper performance of their functions actually increase the over-all cost effectiveness of health care. Yet district hositals are typically underfunded and suffer deficiencies in quality.[15]

Our proposal is to integrate the rehabilitation and strengthening of district hospitals as part of the entire district system. Such strengthening can be piggybacked on current efforts to improve health care and hospital facilities under the Province-wide Investment Planning for Health (PIPH). However, beyond the physical infrastructure, continued human, political and funding support must be assured.

III. Integrate all referral hospital services – public and private – and align with the principles of Universal Health Care

Hospitals, especially large hospitals, are often perceived by the public to be the epitome of the health care system, associated with dramatic interventions in life-and-death conditions, imposing buildings, high technology gadgets, and the availability of, purportedly, the best specialist doctors. Financially they account for about 50% of over-all health care expenditure, and organizationally dominate the rest of the health care system.[16] Yet, the roles of hospitals are changing dramatically with changes in emergency and patient care, workforce configurations, patient expectations of quality care, etc.[17] Hospitals need to "work with each other, …integrate with communities they serve by moving from a typical technocratic planning model to a more sophisticated discussion with the public and other stakeholders,…and respond much more dramatically to changes in public expectation and in the practice of medicine."[17] Referral hospitals (secondary and tertiary) can be seen as the "capstone" of the referral pyramid, neither too heavy nor too light or the levels below them will lose cohesion. A restructuring of referral hospitals is necessary to improve appropriate referral and utilization, especially by remote and rural populations; to transform the inappropriate use of referral hospitals as primary health care providers; to improve efficiency; and to provide much better outreach and support to lower levels of care.[18]

With the involvement of all stakeholders, develop a unified policy framework

A unified policy framework that would clarify the goals and roles of government and private hospitals is necessary to prevent further fragmentation of the hospital system and to align them with national goals and policies on equity.[1,19]

Although both public and private facilities are generally described as belonging to general categories (primary, secondary, tertiary and quaternary) based on the degree of departmentalization and specialization, the delineations are not always distinct and tertiary hospitals are known to provide primary care. Meanwhile, other hospital varieties, such as ambulatory and 5-bed hospitals, require a reworking of the concept.[1] Defining the content of hospital packages – such as what they did in South Africa[18] – rationalizes the system while informing all stakeholders.

Our proposal is for the DOH to develop a unified concept and framework of the hospital system and its different components, public-national, public-provincial and private/nongovernment to guide the rationalizing and unifying process.

Continue efforts to integrate nationwide hospitals and hospital services

The fragmented operation of Philippine hospitals, which resulted in ineffectiveness, inefficiency and inequity, requires extensive integration mechanisms, some of which are already being done, e.g. sharing of resources between private and public hospitals, and coordinated referral systems.[19] Coordinating bodies have also been proposed, such as a hospital development commission for regulation, and a health services and technology assessment authority for information.[1]

The Secretary of Health, Sec. Ona, has mentioned the "clustering of health facilities as a health governance intervention directed at improving the capacities of health facilities across the region and beyond."[20] This is indicative

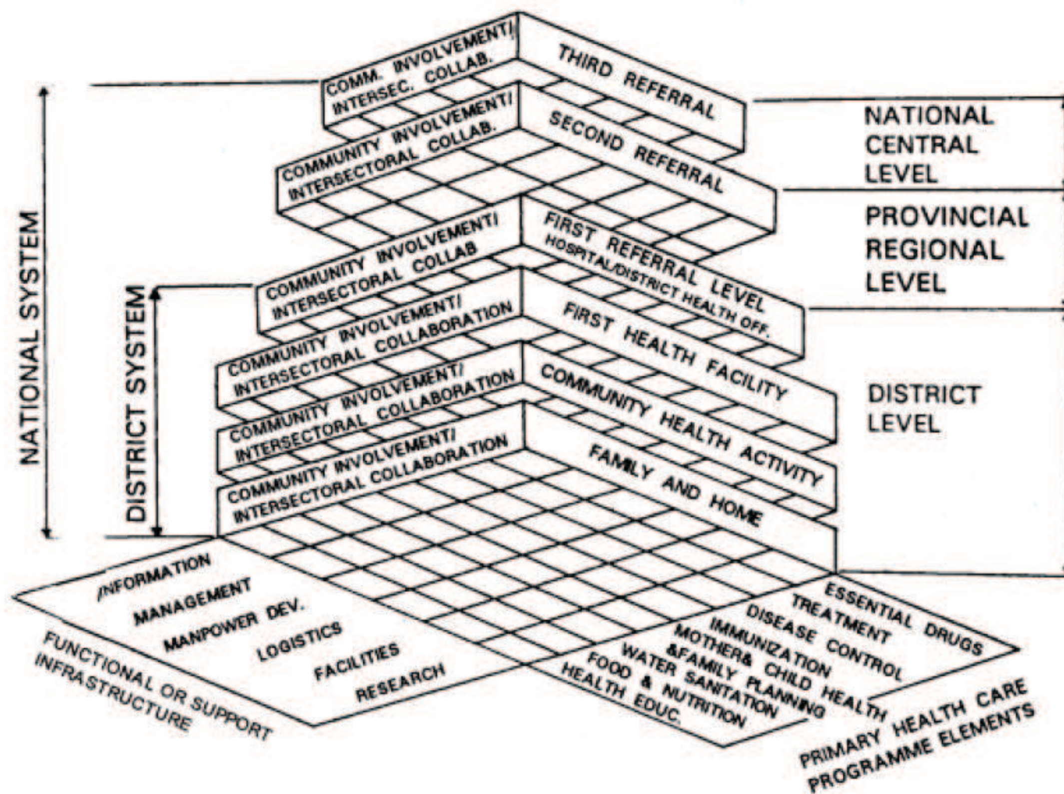

Figure 3. Model of health system based on Primary Health Care

of DOH's willingness to assume a stronger role in health system integration.

Our proposal is for DOH to study the viability and appropriateness of the different unifying mechanisms proposed.

IV. DOH must act decisively to address structural barriers to the rationalization and integration of the health system.

Below is a model of the health system and its different levels:

The recommendations raised - which include developing an Essential Health Care Package, strengthening the District system and hospital, and integrating the hospital system - cannot be effectively undertaken or sustained if two structural features of the system: devolution and privatization are not strategically addressed. Patchwork remedies, such as the establishment of additional structures to coordinate and harmonize fragmented function will merely add to the work and complexity, and result in further ineffectuality and inefficiency.

We propose a serious rethinking of devolution, which, is woven not just into the Local Government Code, but into the 1987 Philippine Constitution. Decentralization is proposed by experts as a policy mechanism to achieve a specific objective, e.g. efficiency, effectiveness, political democracy, etc.[21] However, in the Philippines, devolution is not just a means; it is an end in itself.

Sec. Ona's concept of "regional clustering," which falls within the framework of both the LGC and Constitution bears serious support.

We also propose serious thinking of public-private partnership, which is ubiquitous in all the levels of health care, but bears attention given the poor's growing predilection for private care in the light of poor public health. There is much scope to support private initiatives and public-private collaboration, but the bottomline is to prevent excessive profit making on health, further fragmentation of services, and wider disparities in health care.

To summarize, DOH needs to properly organize and manage health care levels in all parts of the system "so that people get the services they need when they need it, in ways that are user friendly, achieve the desired results, and provide value for money."[22]

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