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How are DOH hospitals funded?

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Background

When health services were devolved in 1992 under the Local Government Code (LGC), it had the unintentional consequence of breaking down the referral network among health care service providers. As a result, hospitals became the locus of health care delivery in the Philippines. Various health surveys show that patients routinely bypass basic health care service providers[1] and health centers, and instead go straight to hospitals even for the simplest of health concerns.[2] Tertiary hospitals,[3] for instance, which are designed to cater to more serious diseases, are also accommodating cases such as immunization and malnutrition that can be handled by lower level facilities. Because of this, hospitals now require more financial resources to be able to attend to all their patients.

As of 2009, there was a total of 1,822 licensed public and private hospitals with the Department of Health (DOH). Of this number, public hospitals accounted for only 40 percent. Despite this marginal share, public hospitals serve the most number of patients. On average, government hospitals are bigger in size with 68 beds per hospital as opposed to private hospitals with only 44 beds. The final referral center among public health facilities are the DOH hospitals. Thus, DOH

[1] This pertains to barangay health stations (BHS) manned by barangay health workers (BHW). A barangay is considered as the smallest political unit in the Philippines.
[2] Among these surveys are the Filipino Report Card, National Demographic and Health Survey, and the PIDS-UNDP Local Services Delivery Survey. Basic health care service providers pertain to barangay health stations (BHS) and rural health units (RHU).
[3] Hospitals can either be private or publicly owned and classified as either Level 1 (primary and infirmary), Level 2 (secondary), or Levels 3 and 4 (tertiary). Levels 3 and 4 hospitals are facilities offering the highest level of health care service delivery.

PIDS Policy Notes are observations/analyses written by PIDS researchers on certain policy issues. The treatise is holistic in approach and aims to provide useful inputs for decisionmaking.

This *Notes* is largely culled from PIDS Discussion Paper No. 2010-02 titled "How are government hospitals performing? A study of resource management in DOH-retained hospitals" by the same author, and refers to the data that are more complete in said Discussion Paper. The author is Senior Research Fellow at the Institute. The views expressed are those of the author and do not necessarily reflect those of PIDS or any of the study's sponsors.

Table 1. DOH budget for hospitals, nominal and real values (in million pesos)

	2003	2004	2005	2006	2007	2008
In nominal terms						
Total budget for hospitals	6,119	6,084	5,099	5,997	6,777	6,594
Total DOH budget	9,281	9,281	9,725	10,038	11,399	18,912
In real terms[a]						
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

[a] adjusted for inflation, at constant 2000 prices
Source: General Appropriations Act, various years.

hospitals carry the brunt of public health care service delivery in the Philippines.

To date, there are 67 DOH hospitals.[4] Historically, the DOH spends more than half of its budget for the upkeep of these hospitals. From 2003 to 2007, the budget for DOH hospitals accounted for 60 percent or more of the total budget. However, in 2008, a shift in priority of the DOH from personal health care to public health programs saw a drastic decline of allocation for DOH hospitals to just 35 percent of total budget (Table 1). The DOH budget accounts for as much as 70 percent of hospitals' total fund. Given the DOH hospitals' status of referral-of-last-resort for public health facilities and patients' preference for hospital treatment over other health facilities, the tightening of budget support from DOH is a serious concern. A hospital under DOH management would now have to contend with less financial support for an ever-expanding demand on its services.

It now becomes vital for the government to determine whether or not DOH hospitals are using their limited resources in an efficient manner. Unfortunately, despite the crucial importance of DOH hospitals in the health care sector, there is little systematic understanding on how public hospitals utilize these public resources. How do DOH hospitals allocate their budgets? What can be done to improve the efficiency of spending in DOH hospitals? If the DOH budget for hospitals declines further, can DOH hospitals survive?

This *Policy Notes*, an extract from a previously released Discussion Paper titled, "How are government hospitals performing? A study of resource management in government-retained hospitals," will center on the budget sourcing and allocation process of DOH hospitals. The purpose of this analysis is to raise understanding of issues surrounding the sector and outline recommendations for more informed policy decisions on health sector design and implementation.

Inefficiencies in allocation from GAA

Of the total available funds for DOH hospitals, about 80 percent are from the General

[4] This number pertains to the number of retained hospitals in 2010. During the study period (2003–2008), there were 72 hospitals which included the original 45 hospitals retained under DOH after devolution, the 21 renationalized hospitals such as the Veterans Regional Hospital and Region 1 Medical Center, and six newly established hospitals such as the Talisay District Hospital and Conner District Hospital.

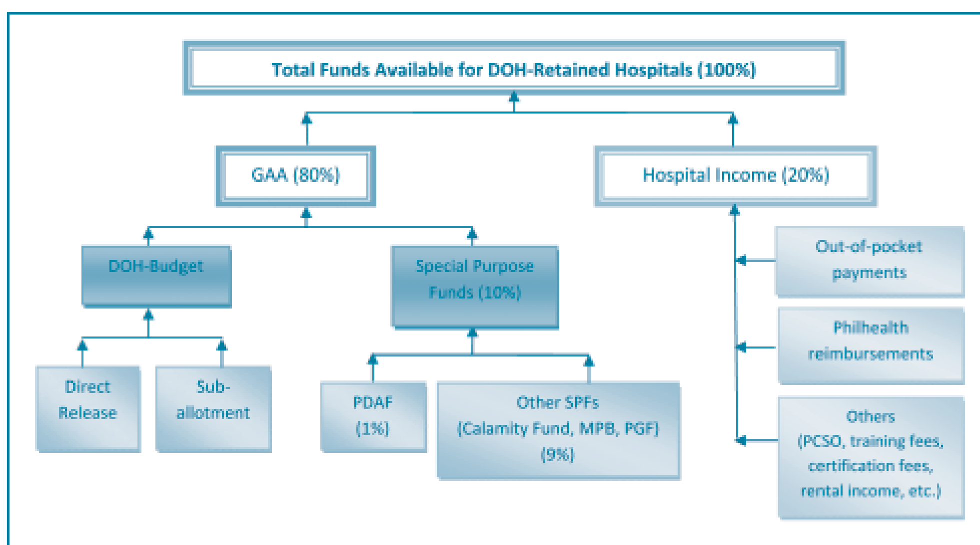
Appropriations Act (GAA) while 20 percent are from hospital income (Figure 1). The 80 percent GAA funds are sourced from the following: 70 percent from the DOH budget and 10 percent from various special purpose funds (SPFs). More specifically, out of the funds sourced from the DOH budget, 67 percent are directly allocated to the hospitals while 3 percent are suballotments (SAA)[5] from the DOH Central Office. As for the 10 percent coming from special funds, 9 percent are from personnel-related SPFs and 1 percent is from the Priority Development Assistance Fund (PDAF).

Unfortunately, as per the analysis done by this study for each source, inefficiencies in resource management can already be detected from the allocation of GAA funds, to wit:

Budget from DOH-Central Office. Payments to hospital personnel comprise the largest share of total budget appropriated to DOH hospitals. In 2008, personal services (PS) accounted for three-fifths of the budget. There has been a steady decline in the share of Maintenance and Other Operating Expenses (MOOE) in the total hospital budget, from a level of 44 percent in 2000 to just 32 percent in 2008. From 2000 to 2008, MOOE declined by as much as 52 percent in real terms. Capital outlay (CO) had been zero from 2001 to 2006, partly due to the fiscal crisis and the austerity measures imposed during this time. Allocation for CO was resumed in 2007, but

[5] SAA are transfers usually requested by the DOH hospital from the DOH Central Office to fund staff trainings and are counted as Maintenance and ther Operating Expenditure (MOOE).

Figure 1. Sources of funds



Acronyms: GAA – General Appropriations Act; PDAF – Priority Development Assistance Fund (pork barrel); MPB – Miscellaneous Personnel Benefits Fund; PGF – Pension and Gratuity Fund; PCSO – Philippine Charity Sweepstakes Office

this was scaled back in 2008, with only 13 hospitals receiving CO appropriations.

It is unclear what criteria are used for the allocation of 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 no longer applies. Analysis of the budget from 2000 to 2008 based on three possible criteria—hospital bed capacity, geographic character (population and regional poverty incidence), and the number of poor patients served—shows inconsistencies. This raises the question on 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.

The reality is that prior to the implementation of Formula One for Health (F1), the framework for health sector reforms, the DOH had no clear plan for the hospitals left under its care after devolution.

Budget from PDAF. Allocation of PDAF to hospitals is ad hoc. Congressmen are allowed to contribute their PDAF to any hospital of their choosing, regardless of whether a particular health facility is located in the district where they serve. Since allocation of PDAF is subject to the "whim" of congressmen, this usually means that PDAF goes to the biggest hospitals which attract a lot of patients. From 2000 to 2008, for instance, PDAF went to relatively richer, highly urbanized hospitals and medical centers in the National Capital Region (NCR), Central Visayas, and Davao. On the other hand, PDAF is low or nonexistent in health facilities located in the poorer regions of Caraga, Cagayan Valley, Northern Mindanao, Ilocos, Zamboanga Peninsula, Northern Mindanao, and SOCCSKSARGEN. If allocated in a more systematic manner, without political subjectivity, PDAF could have supplemented the MOOE of hospitals located in poorer regions in dire need of additional resources.

High budget execution, poor planning

In the aggregate, DOH hospitals showed high budget execution ratios in the years covered in this analysis. Allotments for all expense categories were fully released by the end of the year. The PS appropriations were fully obligated while the MOOE was 99 percent obligated. The total capital outlay program of all DOH-retained hospitals, on the other hand, was only 34 percent obligated due to long procurement cycles. A probable reason for the high budget utilization rate was the use of savings as payment for *magna carta*[6] benefits.

Compared to the utilization of DOH funds, meanwhile, PDAF execution rate is quite low,

[6] Under Republic Act 7305, or the *Magna Carta* of Public Workers, public workers are entitled to several benefits (subsistence and laundry allowances, hazard pay, retirement, etc.). Since the law's passage in 1992, however, the government has failed to fully provide in the budget the payment of such benefits, forcing hospitals to fund the gap through savings elsewhere (usually salary and wages).

with only 71 percent by year-end. The percentage of appropriations obligated is especially low for the following types of government hospitals: a) extension hospitals, b) district hospitals, and c) special hospital-regular.

But it is not budget execution that is the main concern in the utilization of funds in DOH hospitals. With scarcity in resources, it is hardly surprising that DOH hospitals have high utilization rate. What the study actually shows as the two areas of concern in the use of funds in DOH hospitals are planning and monitoring.

Lack of planning. In principle, the budget planning process within DOH hospitals can be characterized as following the bottom-up needs approach. In practice, however, it is less clear how hospitals plan their budget. Planning and budgeting at the hospital level seems to be ad hoc and lacking in overall strategy. There are no oversight arrangements, with no clear guidelines existing in budget preparations specifically designed for hospitals.

Poor monitoring. Planning and budget preparation is poor because there are gaps in monitoring and reporting in hospitals. Reports such as Budget Execution Documents (BEDs), Budget Accountability Reports (BARs), and Statement of Allotments, Obligations, and Balances (SAOBs) are sometimes incomplete, inconsistent, and often flawed. Accurate decisions in budget allocation are difficult to make when the data are flawed and their integrity compromised.

The way forward

As shown earlier, the GAA is not the only source of funds for DOH hospitals. Hospital income, which accounts for 20 percent of DOH hospitals' budget, is derived from out-of-pocket payments of patients, PhilHealth[7] reimbursements, and other sources such as training fees, certification fees, Philippine Charity Sweepstakes Office (PCSO) donations, and rental income. However, this money is not enough to finance MOOE and CO, the two expenditure items that barely receive budget support from the DOH. An analysis of the MOOE coverage ratio in the study shows that in the four years since income retention was allowed, only 33 percent of hospitals can cover MOOE subsidy through income. Thus, DOH hospitals must learn to better manage the resources they receive to maintain the depth (variety) and quality of their services.

Improvement in resource management in DOH hospitals, however, is not a burden to be carried by DOH hospitals' management alone. The government, the DOH hospitals' biggest donor and supervisor, and whose mandate is to provide affordable and quality health care to all its citizens, must bear equal, if not greater responsibility.

To this end, what should be done?

[7] The Philippines' national health insurance program.

Revise the basis for DOH budget allocation. Before a budget is allocated using the Organizational Performance Indicator Framework (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 with consideration to its various activities such as the complexity of cases it handles and the number of service patients it serves.

Provide clear guidelines for PDAF allocations. To prevent arbitrary allocations of the PDAF, clear guidelines must be made. One restriction worth considering is the allotment of PDAF within the districts being served by the congressmen making the PDAF contributions, to ensure that poorer regions with smaller hospitals will also receive additional funding support.

Require that Magna Carta benefits no longer be 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 hospitals. An alternative source of fund is the professional fee reimbursement from PhilHealth as opposed to the current practice of funding the benefits from PS and MOOE savings. It will also provide incentive for hospital workers to encourage patients to enrol in PhilHealth.

Provide training in planning and budget preparation for hospital personnel. Hospital personnel must be trained in planning and budget preparation so that resources are not only used efficiently but also effectively. The DOH should provide a manual outlining in detail budget preparation specifically designed for hospitals. This type of trainings also increases awareness and appreciation for proper monitoring for performance appraisal.

Underscore the need for an overall plan for all DOH hospitals. Various plans have been drafted in different health sector reform strategies in the past. A "disconnect" between the Central Office plan and the hospitals, however, remains because agencies in charge of the implementation do not have a strong authority to implement reforms. A possible 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 noncompliance and provide rewards for good performance.

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