

In addition, concern had been raised over the migration of health workers, particularly nurses, to other countries like USA and UK. (24,25) Table 9 shows the number of nurses deployed from 1994 to mid 2003. The increasing demand for nurses abroad does not only mean that nurses are leaving the country but it also encourages doctors, other allied health professionals and even non-health professionals to study nursing and work abroad as nurses. One report stated that the Philippine Nurses Association estimated that around 2,000 doctors have enrolled in nursing schools throughout the country. On the other hand, the National Institute of Health Policy Development pegged the number closer to 3,000—double the number of licensed medical practitioners produced each year. One hundred physicians took the nursing boards in June 2002. (26) This problem will result not only to shortage of health professionals but will worsen the maldistribution of the health providers, thereby affecting the accessibility of Filipinos to health services.

Table 9. Deployment of Nurses from 1994 to 2003

YEAR	NUMBER
1994	6,699
1995	7,584
1996	4,734
1997	4,242
1998	4,591
1999	5,413
2000	7,683
2001	13,536
2002	11,911
July 2003	5,628
TOTAL	84,843

Source* POEA, Institute of Health Policy and Development Studies, 2004

Availability of Information for the Patients. Health information and dissemination has been one of the main features of all public health programs of the government. Countless resources have been spent to develop information and education (IEC) materials, train health providers and conduct information

campaign. As a result of re-engineering the Department of Health in 2000, the National Center for Health Promotion had been established to institutionalize health promotion and education services. In various government health offices, a health promotion officer is either hired or appointed to perform the important task of informing and educating the patients and the general public about health and health services.

The National Demographic and Health Survey in 1998 showed that Filipinos have quite high general awareness regarding health issues. As example, most household respondents say that they watch their nutrition or exercise to stay healthy. Similarly, a majority of household respondents are aware that smoking causes lung diseases such as cancer. Over 90 percent of respondents have heard of dengue fever and two-thirds of them say destroying the breeding sites of mosquitoes can prevent that dengue. There are however, misconceptions about leprosy and tuberculosis, with 21 percent of respondents knowing that leprosy is transmitted by skin and 11 percent by airborne droplets, and only one in six respondents knowing that a germ or bacteria cause tuberculosis. (27)

Procedural Guidelines in Providing Quality Health

Appropriateness, Effectiveness, Safety and Timeliness of Care. Various clinical guidelines and manual of operations have been developed by several bureaus/offices to ensure that delivery of care is appropriate, effective, safe and timely. These include a number of clinical practice guidelines for common diseases in the country, implementing manuals for different public health programs and referral system among the network of health facilities. As example, in the control and surveillance of Severe Acute Respiratory Syndrome, the DOH was able to set up the SARS Surveillance System 5 days after the WHO issued a global alert on the emergence of a new infectious disease called SARS. This was done in collaboration with other experts. (28) In addition, the technical working group on SARS was able to develop the Interim Clinical Guidelines on Severe Acute Respiratory Syndrome for Health Facilities two months after establishing the surveillance system. Technical capability of infectious experts in the country, appropriateness and effectiveness of interventions embodied in the clinical guidelines and timeliness of health care were the hallmarks of managing and controlling transmission of SARS in the Philippines. As a result of this, Philippines was in the WHO list of countries

with local transmission for only 2 weeks.

In addition to clinical guidelines, other equally important manuals and programs to ensure appropriateness, effectiveness, safety and timeliness of care include, among others, the 1) Hospital as Center of Wellness Program established in the hospitals by the National Center for Health Facilities Development; 2) the Maternal Mortality Review Manual developed by the National Center for Disease Prevention and Control which strengthens the referral system/linkages between health facilities at different levels to promote safe motherhood and prevent maternal deaths, and establishes the criteria for emergency referral to appropriate health facility; 3) the Quality Standards List for Health Facilities developed by the Bureau of Local Health Development for Sentrong Sigla certification; and, 4) the Benchbook for Quality Assurance developed by PHIC which links accreditation with quality of care measurements.

In contrast, there are also evidences that point out to inappropriateness of health services provided to patients. In a study conducted in 2001 to investigate the knowledge, attitudes and perspectives of Filipino private doctors on managing and treating tuberculosis, 87.9% of doctors interviewed diagnosed TB mainly through X-ray and usually treated their patients with inappropriate regimens of anti-TB drugs. Also, they did not follow up their patients, did not trace defaulters and did not identify the contacts of TB patients. (29)

Another evidence is provided by the utilization review conducted by Valera et al (30) which showed that based on bed occupancy rate and number of claims filed, 126 PHIC-accredited facilities were identified as outliers, i.e., these are the hospitals that have utilization rates significantly higher than their counterparts. Majority of these facilities are privately owned primary health facilities. Forty-eight percent (48%) of these outlier facilities had extremely disproportionate reimbursements for acute bronchitis. In addition, peer review committee found that in 33% of varied clinical cases examined and deliberated, 33% of therapeutic management was inappropriate and unnecessary. In terms of prescriptions from primary and secondary hospitals, there is an average of 3 drugs prescribed regardless of case and an average of 79% of these prescriptions are written in generics. Average consultation was found out to be 3.5 minutes.

Acceptability of Care to Patient. The Quality Standards List for Health Facilities that is used as a guideline for Sentrong Sigla accreditation includes the presence of client satisfaction feedback system as one of the requirements. (31) Moreover, the PHIC Benchbook on Quality Standards identifies criteria that will promote patient's rights and organizational ethics. One of the criteria that this quality guidelines focus on is securing patient's informed consent prior to initiation of care. (32)

. In early 2000, The World Bank commissioned a national client satisfaction survey to look at various social services provided by the government. From this survey, the Filipino Report Card on Pro-Poor Services was developed. The Report Card noted that mainly those who cannot afford private services use public health facilities. Compared to government health facilities, respondents of the survey rank private facilities superior in all quality aspects i.e. care, facilities, personnel, medicines and convenience. In addition, government primary facilities are deemed to have low quality. The survey shows lowest satisfaction for frontline Barangay health station (village health centers) and rural health units. In this facilities, diagnosis is poor, medicines and supplies are inferior and often unavailable, personnel are often absent and perceived as having no medical and people skills, waiting time is long, schedules are inconvenient and the facilities are rundown (33).

On the other hand, in a study done in 2001 to assess the implementation of Sentrong Sigla, Lamberte (34) found that in 4 or 5 out of the 10 provinces that were assessed, the health providers perceived a marked improvement in client-provider inter-action, client satisfaction, and clients' asking questions when Sentrong Sigla standards and procedures are implemented.

Consumer participation. The Hospital as Center of Wellness Program of NCHFD, the Quality Standards List of BLHD and the Benchbook of PHIC promote client participation in health service provision. Presently, however, there is paucity of evidence on how well or how much clients or consumers are participating in the health services that they received.

Attainment of the Goals of the Health System

With different structural and procedural inputs to the health care system and with varying degree of their implementation, how far has the health care system in the Philippines gone in achieving the health system goals of attaining the optimum improvement in the health status of the Filipino people

and making the health system responsive?

In terms of improving the health status of Filipinos, evidences showed that:

Firstly, in the World Health Report 2000, the WHO used disability-adjusted life expectancy (DALE) to assess the overall health status of the population in order to compare the performance of attaining health among the 191 member countries. The Philippines ranked 113 in terms of level of health attainment and but ranked 50 in terms of health inequality in attaining health. (7)

Secondly, in the Philippine Progress Report on the Millennium Development Goals (35) the National Economic and Development Authority noted that 1) malnutrition still poses a major threat to the Filipino Child's survival with only a slight 17.25% decline in the prevalence of underweight pre-school children 0-5 years old from 34.5% in 1990 to 32% in 1998; 2) a significant decline in under-5 mortality from 80 per 1000 livebirths in 1990 to 48 in 1998; and, a slow decline in maternal mortality rate from 209 per 100,000 livebirths in 1990 to 172 in 1998. Poor improvements in some of health related MDGs mean doubling of current efforts particularly in order to attain the goal for maternal mortality.

Lastly, the Statistical Indicators on Philippine Development 2004 (36), an instrument that tracks and monitors the achievement of Medium Term Philippine Development Plan, showed that crude death rate improved at a minimal pace between 2001 and 2003 from 5.83/1000 to 5.72/1000 population. Similarly, crude birth rate in the same period showed modest decline from 26.2/1000 to 25.2/1000 population. In contrast, various essential public health programs showed declining coverage: the number of TB cases provided full coverage of directly observed treatment declined from 107,000 in 2001 to 83,000 in 2002; the percentage of women with three or more pre-natal visit showed a downward trend from 62.9% in 2001 to 60.5% in 2002; the percentage of women with at least one-post partum visit declined slightly from 70% to 60% in the same assessment period.

In terms of responsiveness of the health system, i.e. how the system performs relative to non-health aspects like respect for the person, confidentiality, autonomy, prompt attention, quality of amenities, access to social support network and choice of provider, there seems to be evidences of improvement in Philippine health system. In WHO World Report 2000, the

country ranked 49 in terms of level of achieving responsiveness and ranked 48 in terms of distribution of the responsiveness of health system across the country. (7)

In addition, the National Demographic and Health Survey in 1998 provide evidence in improving responsiveness when it reported the unmet need for family planning services has declined from 26% in 1993 to 20% in 1998. Data from the 1993 NDS show that 26 percent of currently married women were in need of services, compared with 20 percent in the 1998 NDHS. (27)

V. CONCLUSIONS

The Philippine health care system seems to be achieving the two goals of health care system that are directly affected by the different dimensions of quality of health care, i.e. attaining optimum health for the population and making the health care system responsive. In terms of gains, this health system has adequate structural inputs: 1) despite the accelerating exodus of health professionals to other countries, there is still enough health providers at present albeit maldistributed in favor of urban centers; 2) the presence of preventive and screening services all over the country helped in the on-going efforts to prevent and control diseases, disabilities and deaths; 3) health facilities are present in every locality; and, 4) health information is readily available to most Filipinos. In addition, policies and programs to improve the processes in delivering health services have been put in place: e.g. PHIC Benchbook on the Performance Improvement of Health Services and the Philippine in Health Quality Program.

However, the gaps far outweigh the gains that have been achieved. Although the structural inputs are present, there is a need to constantly update and improve them. For example, preventive and screening services must be updated regularly according to the latest evidences. Also, the issue of distributing these inputs equitably across the country needs to be addressed. The policy to promote equitable distribution of health providers and facilities must be put in place.

Moreover, the processes of delivering health services require a lot of improvement. Although the policies and programs to ensure that health services are appropriate, effective, safe, timely, acceptable to clients and promote their participation, measures that providers are actually following

these policies and programs must be monitored and evaluated.

As a result of these gains and gaps, there are patchy improvements in the health status and responsiveness of the health system. Moreover, the rate of success in achieving these goals of the health care system has been slow and uneven.

VI. RECOMMENDATIONS

In order to capitalize on the present gains and put on considerable efforts to address the gaps in ensuring the quality of health care in the Philippines, the Department of Health in coordination with the different stakeholders in the health sector must orchestrate the following strategies:


- Develop and implement policies that will ensure equitable distribution of health human resource and facilities. E.g. area or unit-based licensing and accreditation policy
- Promote a culture of research at all levels of health care system not only pursuing clinical research but also operations and systems researches. The results of these researches must be translated and used in updating and improving health policies and programs.
- Establish a seamless quality measurement and reporting system, which will capitalize on the gains of implementing the Philippine Quality in Health Program and the Benchbook on the Performance Improvement of Health Services and will involve the participation of private providers, the academic and research institutions and civil society. This quality measurement and reporting system must be an integral part of the Monitoring and Evaluation System of the Health Sector.
- Concomitant to the development of seamless quality measurement and reporting system is establishing the quality indicators at all levels of health care and improving the process recording, reporting and utilization of these data. These indicators must be linked to the achievement of health care system goals of improving health status and promoting responsiveness.

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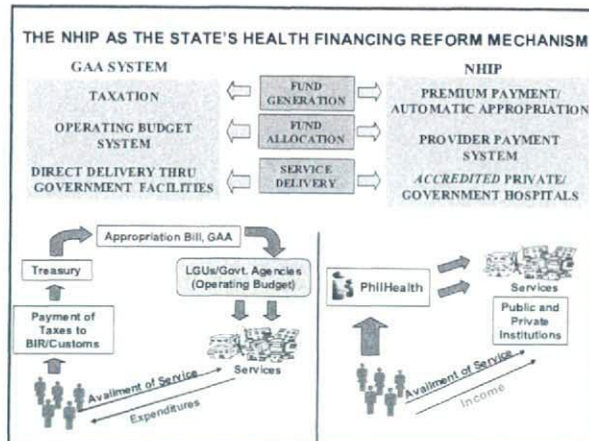
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The National Health Insurance Program (NHIP) in Health Financing Reforms

Val S. Valila, CPA
Vice-President for Membership and Marketing

PHILIPPINE HEALTH INSURANCE CORPORATION



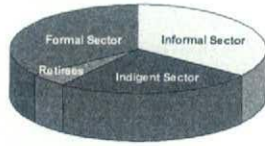
Social Solidarity and Universal Coverage

Compulsory coverage of the employed sector

Coverage of the self-employed or informal sector

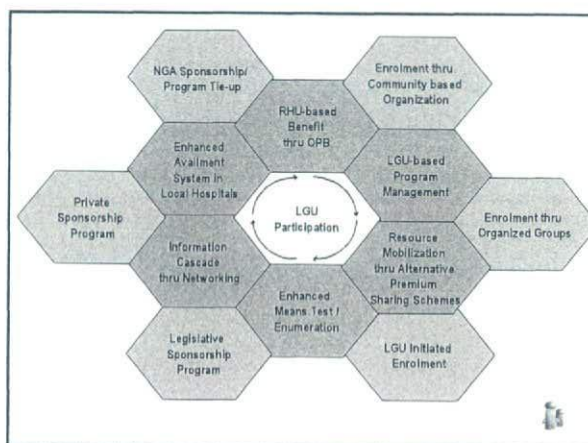
Free lifetime coverage of the retirees

Free coverage of the poor in partnership with LGUs which provide counterpart financing




ONE FUND, ONE BENEFIT

RICH YOUNG HEALTHY **POOR OLD SICK**



PhilHealth "Medicare para sa Masa" COVERAGE

A.O. 277
The Lowest 25% of the Population



- Identification is thru the CBIS-MBN/FDSF of the Local Social Welfare Office
- Coverage shall include the member and his/her qualified dependents:
 - Legitimate spouse
 - Children below 21 years old
 - Children 21 years old and above but are suffering from congenital illness
 - Parents who are 60 years old and above

HOSPITALIZATION PACKAGE

Benefit Items	Hospital Category		
	Primary	Secondary	Tertiary
1. Room and Board	120	220	345
2. Drugs and Medicines			
Ordinary Case	1,500	1,700	3,000
Intensive Case	2,500	4,000	9,000
Catastrophic Case	—	8,000	16,000
3. X-Ray, Laboratory Etc.			
Ordinary Case	350	850	1,700
Intensive Case	700	2,000	4,000
Catastrophic Case	—	4,000	14,000
4. Operating Room			
Ordinary Case	385	670	1,060
Intensive Case	0	1,140	1,350
Catastrophic Case	0	2,160	3,490
5. Professional Fees			
Ordinary			
G.P.	600	600	600
Specialist	1,000	1,000	1,000
Intensive			
G.P.	900	900	900
Specialist	1,500	1,500	1,500
Catastrophic Case			
G.P.	900	900	900
Specialist	1,500	1,500	2,500
6. Surgeon			
Ordinary Case			
Intensive Case			
Catastrophic Case			
7. Anesthesiologist			
Ordinary Case			
Intensive Case			
Catastrophic Case			

PhilHealth-LGU Premium Sharing				
Annual Premium of P 1,188 per family				
LGU Income Classification	Year	Ratio	National Govt. Share (Annual)	Local Govt. Unit Share (Annual)
1 st to 3 rd	n/a	50:50	P 594.00	594.00
4 th to 6 th	1 st & 2 nd	90:10	1,069.20	118.80
	3 rd	80:20	950.40	237.60
	4 th	70:30	831.60	356.40
	5 th	60:40	712.80	475.20
	6 th onwards	50:50	594.00	594.00

UNIFIED HOSPITALIZATION PACKAGE			
Benefit Items	Hospital Category		
	Primary	Secondary	Tertiary
1. Room and Board	120	220	345
2. Drugs and Medicines			
Ordinary Case	1,500	1,700	3,000
Intensive Case	2,500	4,000	9,000
Catastrophic Case	—	8,000	16,000
3. X-Ray, Laboratory Etc.			
Ordinary Case	350	850	1,700
Intensive Case	700	2,000	4,000
Catastrophic Case	—	4,000	14,000
4. Operating Room			
RUV of 30 and below	385	670	1,060
RUV of 31 to 80	0	1,140	1,350
RUV of 81 and above	0	2,160	3,400

Benefit Items	Hospital Category		
	Primary	Secondary	Tertiary
5. Professional Fees, per single act of treatment			
150/day for General Practitioners (G.P.) and 250/day for Specialist but not to exceed the following			
Ordinary			
G.P.	600	600	600
Specialist	1,000	1,000	1,000
Intensive			
G.P.	900	900	900
Specialist	1,500	1,500	1,500
Catastrophic Case			
G.P.	900	900	900
Specialist	1,500	1,500	2,500
6. Surgeon			
per single act of treatment			Maximum of P16,000 @ 40/RUV
7. Anesthesiologist			Maximum of P5,000 @ 40/RUV

Expanded Benefits

Focus on Curative and Preventive Care

Phase 1 - Curative Care

Hospitalization Program thru Accredited Hospitals
1,502 Hospitals (95%) Accredited Nationwide

Phase 2 - Preventive and Promotive Services

Outpatient Consultation and Diagnostic Benefit Package thru Accredited Rural Health Units, Health Centers and Authorized Hospitals
(274 accredited RHUs/HCs nationwide)

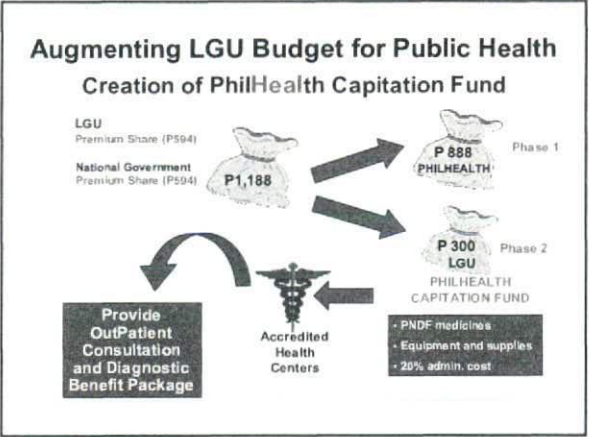
•Primary consults

•Laboratory fees for:

Chest X-ray
CBC
Fecalalysis
Urinalysis
Sputum Microscopy

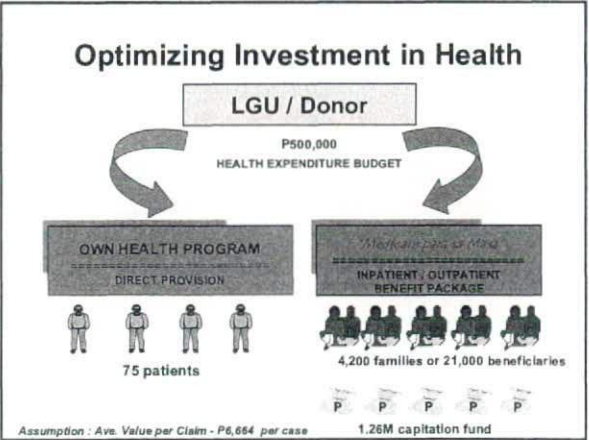
•Preventive Services

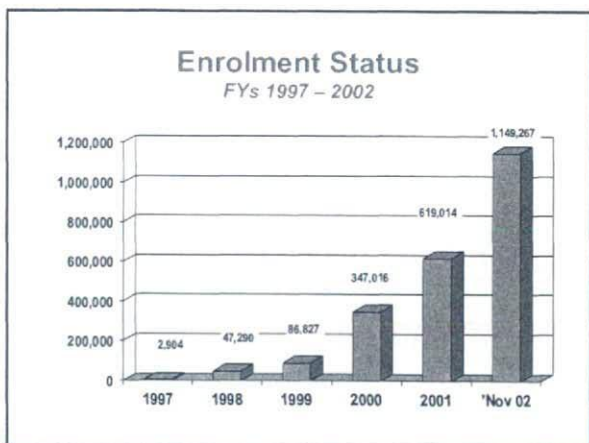
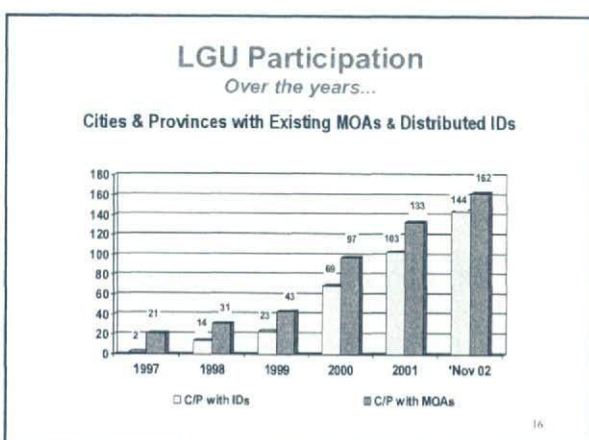
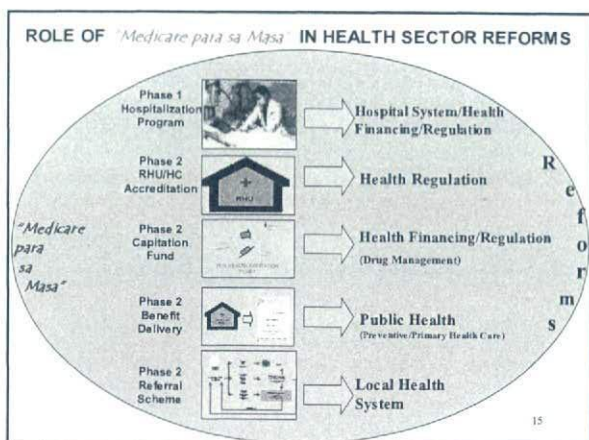
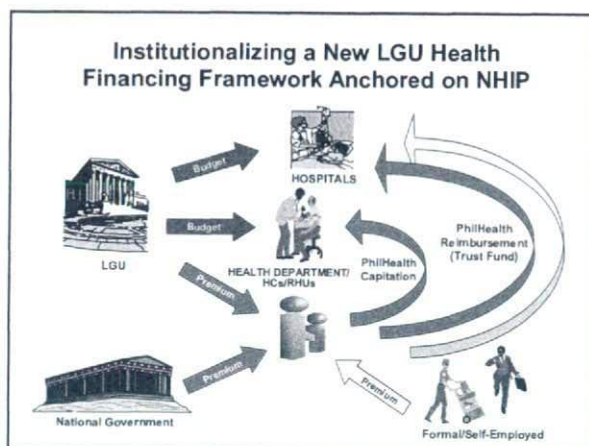
Visual aortic acid screening
Regular BP measurements
Digital rectal exam
Body measurements
Clinical breast exam
Counseling for smoking cessation
Lifestyle modification counseling



Enhanced Benefits at Reduced Premium						
PhilHealth-LGU Premium Sharing Annual Premium of P 1,188 per family						
LGU Income Classification	Year	Annual	Local Govt. Unit Share (in pesos)			
			Net Annual Share	Net Annual Share Per Capita*	Net Monthly Share Per Capita*	
1 st to 3 rd	n/a	594.00	294.00	58.80	4.90	
4 th to 6 th	1 st & 2 nd	118.80	59.40	11.80	0.94	
	3 rd	237.60	118.80	23.76	1.98	
	4 th	356.40	178.20	35.64	2.97	
	5 th	475.20	237.60	47.52	3.96	
	6 th onwards	594.00	294.00	58.80	4.90	

* for a family of 5





EXPANSION STRATEGIES

Increase LGU Sign-Up through OPB Implementation

Strategy 1

As of November 2002, there are 326 LGUs that have signed MOAs with PhilHealth.

Tie - up with Legislative Sponsors

Strategy 2

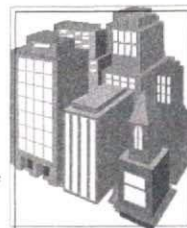


- To date, there are 52 Legislators who have signed MOAs with PhilHealth
- There are now 110,245 enrolled families or 551,225 beneficiaries under the PDAF Program in 213 LGUs nationwide

19

Tie-up with Private Sponsors

Strategy 3



- As of November 2002, there are 30 various Sponsors who have signed MOAs with PhilHealth
- There are 15,000 covered families or 75,000 beneficiaries under the Private Sponsorship Program in 16 LGUs nationwide

20

Tie-up with NGAs

Strategy 4

TARGET



- 536 Agrarian Reform Communities
- 500,000 Families nationwide
- 500,000 Coconut Farmers

21

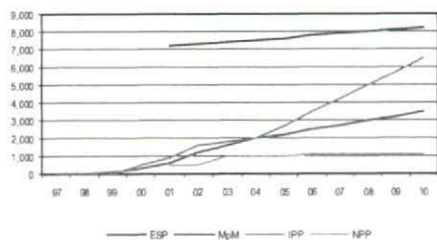
Other Enrollment Programs

TARGET



- Enrolment of Barangay Officials and Volunteers
- Enrolment of Indigenous Peoples
- Enrolment of Basic Sectors

22

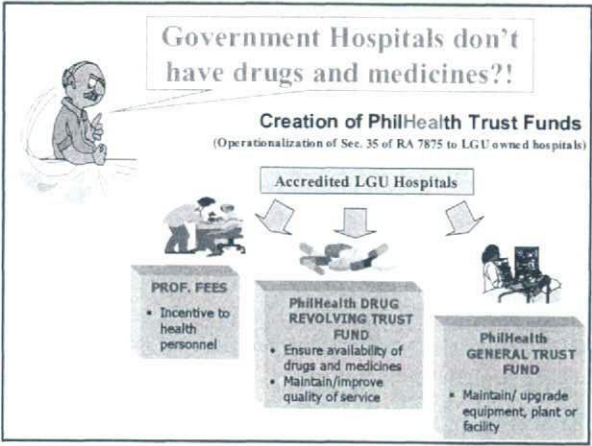


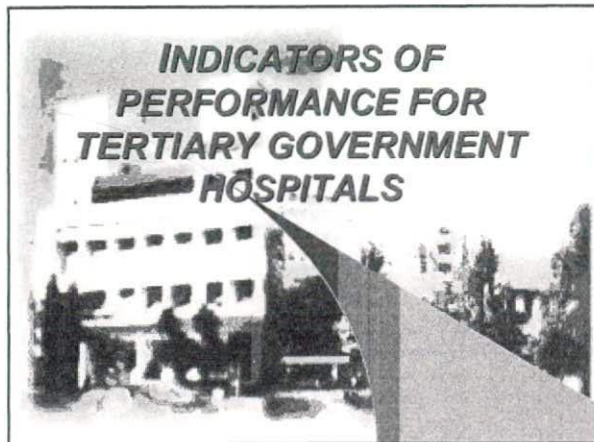
23



MARAMING SALAMAT!

24





"Performance indicators are employed to monitor, assess and improve existing health systems."

Performance indicators provide quantitative information to help make decisions on the following:

- ◆ Choosing the best treatment option
- ◆ Evaluating the quality of patient care
- ◆ Formulating policies and procuring suitable equipment

Six Facets of Hospital Evaluation

- Access to care
- Appropriateness of care
- Effectiveness of care
- Technical proficiency
- Continuity of care
- Patient satisfaction

Acute Health Care Services Project, 1997

a. Access to care

- ◆ Occupancy Rate
- ◆ Implementing Beds
- ◆ Total Admissions
- ◆ Average Number of In-Patients

b. Efficiency

- Average Length of Stay in Days (ALOS)
- Turn-over Rate
- Total Expenditure to Total Admission Ratio
- Budget Utilization

c. Effectiveness of care

- ◆ Gross Death Rates under 48 hours
- ◆ Net Death Rates beyond 48 hours
- ◆ Crude Death Rate
- ◆ Caesarian Section Rates

Definition of Terms

- **In-patient day:** unit of measurement denoting lodging facilities provided rendered to one inpatient between the census taking hour on two succeeding days
- **Percentage Occupancy:** ratio of actual patient days to maximum patient days as determined by bed capacity during any given period of time
- **Average Length Of Stay:** is the average # of days of service rendered to each patient discharge during a given period of time
- **Turnover interval (Performance per Bed):** indicator of efficiency of utilization of beds, measures the # of patients that occupied the bed for a given period of time

Definition of Terms

- **Gross Death Rate:** Total deaths within a period divided by total discharges including deaths. Gives a rough indication of the cases the hospital is attending to or of the efficiency of the services the hospital provides
- **Net death Rate:** Total deaths among patients who have been in the hospital for more than 48 hrs for a given period divided by total discharges
- **Caesarian Section Rate:** Total CS for a given period divided by total OB discharges. A high CS rate may be indicative of a referral hospital or overutilization by practitioners for material reasons

Foreign Benchmarks

Are not applicable due to:

- ✓ Difference in Patient Case Mix
- ✓ Variability in Disease Patterns
- ✓ Facilities & Equipment Complement
- ✓ Socio-Cultural-Economic Factors
- ✓ Knowledge & Expectations of Patients

Statistics of Access to Care Indicators of Model Tertiary Government Hospitals

Access to Care	Mean	Std Dev	Std Error
Imp. Beds	325.82	197.04	56.88
Occupancy Rate	106.71	23.15	6.68
Total Admission	20086.03	8725.81	2518.92
Number of In-Patients	337.76	198.83	57.40

Statistics of Efficiency Indicators of Model Tertiary Government Hospitals

Efficiency Indicators	Mean	Std Dev	Std Error
Length of Stay in Days	4.94	0.83	0.24
Turnover Rate	63.28	20.58	5.94
Total Expense to Admission Ratio	P 10124.46	P11048.71	P 3189.49
Budget Utilization	92.65%	5.30%	1.53%

Statistics of Effectiveness of Care Indicators of Model Tertiary Government Hospitals

Effectiveness Indicators	Mean (%)	Std Dev	Std Error
Net Death Rate (>48 hrs)	3.246	0.775	0.224
Gross Death Rate	5.823	1.478	0.427
Death Rate <48 hrs	2.565	0.859	0.248
Caesarian Section Rate	15.91	0.622	0.180

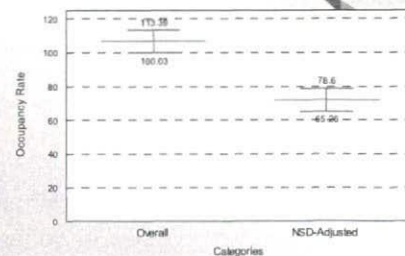
Comparison between non-adjusted & NSD adjusted indicators (for Access & Efficiency)

Indicator	Non-adjusted	NSD adjusted
Occupancy Rate	106.71	71.93
Total admission	20,086.03	14,148.44
Ave in-patient	337.76	234.38
ALOS	4.94	6.43
Turn-over Interval	69.90	40.83
MOE Expenditure per Patient	2781.39	4199.13
Budget Utilization	92.65%	

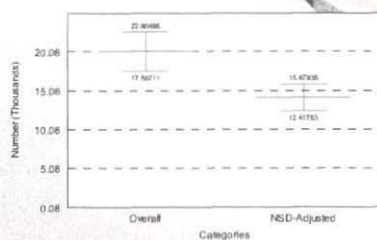
Comparison between non-adjusted & NSD adjusted indicators
(for Effectiveness)

Indicator	Non-adjusted	NSD adjusted
Death rate <48H	3.25	4.96
Death rate >48H	2.57	4.05
Gross Death Rate	5.82	9.94
Medicare %	7.96	13.87
Caesarian Section Rate	15.91	

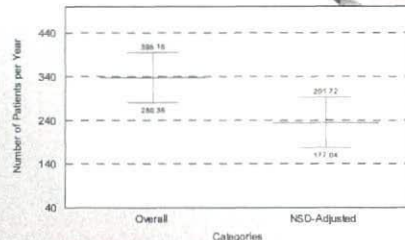
Performance Indicators
According to Overall and NSD-Adjusted
Occupancy Rates



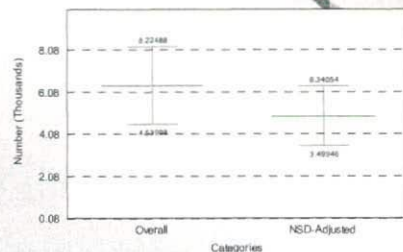
Performance Indicators
According to Overall and NSD-Adjusted
Mean Total Admission



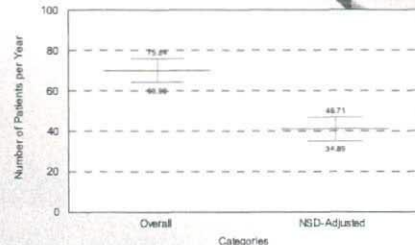
Performance Indicators
According to Overall and NSD-Adjusted
Mean Number of Patients Per Day



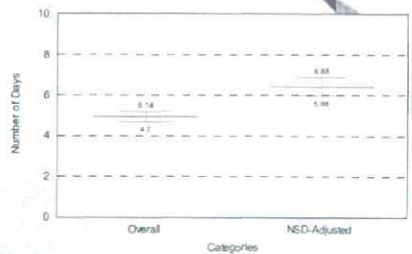
Performance Indicators
According to Overall and NSD-Adjusted
Mean Total Discharges



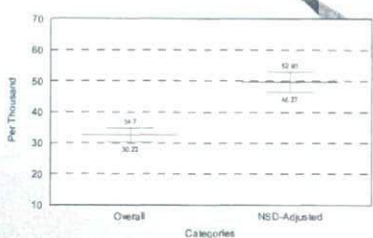
Performance Indicators
According to Overall and NSD-Adjusted
Patient Turnover



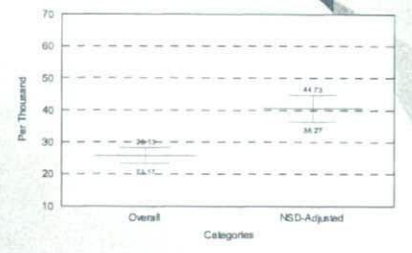
Performance Indicators
According to Overall and NSD-Adjusted
Average Length of Stay



Performance Indicators
According to Overall and NSD-Adjusted
Gross Death Rate



Performance Indicators
According to Overall and NSD-Adjusted
Net Death Rate Beyond 48 hours



Performance Indicators
According to Overall and NSD-Adjusted
Crude Death Rate



Comparison between some US Industry
Averages & NSD Adjusted Rates


Indicator	Overall	NSD-Adjusted
Occupancy Rate	71.93	71.93
ALOS	5.18	5.88
Expenditure per day	101.24	101.24
Net Death Rate	2.5%	4.05%
Medicare %	47.9%	13.87%

Its Utility in
the Local
Setting?

How to Use the Indices


INDICATOR	LEVEL
ACCESS TO CARE	
Occupancy Rate	71.93
Average In-Patient per Day	234.38

How to Use the Indices



INDICATOR	LEVEL	Hospital 1
ACCESS TO CARE		
Occupancy Rate	71.93	77.48
Average In-Patient per Day	234.38	252.46


How to Use the Indices



INDICATOR	LEVEL	Hospital 1	% Adequacy
ACCESS TO CARE			
Occupancy Rate	71.93	77.48	107.72
Average In-Patient per Day	234.38	252.46	107.71

$$\% \text{ Adequacy} = \frac{\text{Hospital Indicator Level}}{\text{Recommended Standard Level}} \times 100$$


How to Use the Indices



INDICATOR	LEVEL	Hospital 1	% Adequacy
ACCESS TO CARE			
Occupancy Rate		48	107.72
Average In-Patient		252.46	107.71
Average Access to C			107.71


If we apply this approach to the other facets...

How to Use the Indices




INDICATOR	LEVEL	Hospital 1	% Adequacy
EFFICIENCY			
ALOS (Days)	6.43	8.24	78.03
Turnover Interval (Perf. per Bed)	40.83	43.98	107.71
MOE Expenditure/Patient (%)	4199.13	4375.11	95.98
Budget Utilization	0.93	0.92	99.30
Efficiency Score			95.26

How to Use the Indices



INDICATOR	LEVEL	Hospital 1	% Adequacy
EFFECTIVENESS OF CARE			
Death Rate Under 48 Hrs.	4.96	4.60	107.83
Death Rate Beyond 48 Hrs.	4.05	3.76	107.71
Total Death Rate	9.01	8.37	107.65
Caesarian Section Rate	15.91	9.84	61.85
Effectiveness Score			96.26

How to Use the Indices



INDICATOR	Hospital 1
Average Access to Care Score	107.71
Efficiency Score	95.26
Effectiveness Score	96.26
CS Adjusted Effectiveness Score	107.73
Total Hospital Score	99.74