Table 3. Ten Leading Causes of Mortality by Sex Number, Rate/100,000 Population & Percentage, 2000

Cause	Male	Female	Total Number	Rate	% of Total Deaths
1. Diseases of the heart	34,356	26,061	60,417	79.1	16.5
2. Diseases of the vascular system	27,197	21,074	48,271	63.2	13.2
3. Malignant Neoplasm	19,597	16,817	36,414	47.7	9.9
4. Pneumonia	16,549	16,088	32,637	42.7	8.9
5. Accidents	26,009	6,346	32,355	42.4	8.8
6. Tuberculosis, all forms	18,590	8,967	27,557	36.1	7.5
7. Chronic obstructive pulmonary diseases and allied conditions	10,770	5,134	15,904	20.8	4.3
8. Certain conditions originating in the perinatal period	9,083	6,015	15,098	19.8	4.1
9. Diabetes Mellitus	5,147	5,600	10,747	14.1	2.9
10. Nephritis, nephritic syndrome and nephrosis	4,642	3,321	7,963	10.4	2.2

Source: DOH Health Statistics

General Condition of the Health Sector. The health situation in the Philippines, however, is a result of several factors. The health outcomes reflect the quality and physical and financial accessibility of health care services. In the last decade there were two landmark legislations that changed the way health services were delivered and financed. The first legislation was the Local Government Code of 1991, which transferred the provision of direct health services from the national government to the local government units (i.e. provincial governments manage the provision of primary and secondary hospital services while the city and municipal governments provide primary health care services), and the second was the National Health Insurance Law in 1995, which aims to provide universal health insurance to all Filipinos. These two important legislations have affected the way health services are delivered, regulated and financed.

The rationale of developing and implementing Health Sector Reform Agenda (HSRA) in 1999 (20) was based on the problems in the health sector:

fragmented health care delivery system, poor financing mechanism for health and outdated and ineffective health regulatory mechanism. Much had been done since 1999 in terms of policies and pilot testing of models that will address the issues of improving the financing and delivery of health services. However, much work still needs to be done in terms of health regulation, surveillance, health human resource management and development, and monitoring and evaluation.

Structural Inputs to health Care

Technical Proficiency/Competence. This domain of quality care is partly ensured by the presence of regulatory policies that govern the health workers and operation of health facilities. For health human resources, this means license to practice granted by the Philippine Regulatory Commission after passing the board exam ((Table 4) of their respective profession. For physicians, there is also a specialty certification given by specialty board to those who underwent residency training after passing the written and oral examination. In addition, doctors and dentists also get accreditation from PHIC. (Table 5)

Table 4. Registered Health Professional, 1991 - 2000

PROFESSION	Grand Total 2000	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991
Dentistry	41,484	1,052	763	1,391	1,571	1,224	1,104	1,077	1,209	1,739	2,150
Dental Hygienist	6										
Medical Technology	40,879	1,821	1,689	1,686	1,463	1,344	2,169	2,135	1,345	1,620	1,509
Medical Laboratory Technician	3,323	95	85	68		69	73	103	61	75	58
Physician	95,016	2,174	2,276	1,812	1,876	2,208	2,176	2,558	2,809	3,119	1,41ɔ
Midwifery	129,532	1,738	2,278	3,503	4,018	6,291	8,833	8,022	9,677	7,399	6,681
Nursing	337,939	5,784	8,419	9,441	11,693	15,701	27,272	29,445	30,921	15,986	9,165
Nutritionist Dietitian	10,841	342	334	393	396	467	326	432	70	340	197
Dietitian	1,410										
Optometry	9,155	68	116	111	274	305	316	413	275	427	268
Pharmacy	44,316	1,622	1,987	1,702	1,447	1,296	1,498	1,621	1,107	1,155	1,359
Chinese Druggist	485										
Physical & Occupational Therapy	11,442	2,313	2,276	1,433	969	777	664	524	578	369	131
Physical Therapist	1,191	250	2,141	167	124	36	35	35	29	23	2.
Occupational Therapist	78		305								
Physical Therapy Technician	119										
Occupational Therapy Technician	4,034	627	448	461	470	597	466	556	409		
Radiologic Technologist	8,031	228	222	385	479	897	1,698	2,736	1,386		
X-ray Technologist	739,281	18,114	23,339	22,553	24,780	31,212	46,630	49,657	49,876	32,252	22,958

Source: Professional Regulation Commission

Table 5. PHIC Accredited Health Providers by Specialization as of December 2004

SPECIALIZATION	NUMBER	SPECIALIZATION	NUMBER
General Practice	11216	ENT	313
Internal Medicine	2170	Orthopedics	228
Pediatric	1820	Rehabilitation Medicine	60
Surgery	1590	Pathology	67
Obstetric-Gynecology	1810	Occupational Medicine	21
Anesthesia	887	Urology	90
Radiology-Ultrasound	143	Dermatology	105
Family Medicine	353	Neurology	81
Ophthalmology	687	Neurosurgery	18
Dentistry	139	Emergency Medicine	16

For health facilities and services, there are separate licenses for building the facility and for operating it. In addition, for hospitals, three regulatory bureaus grant different licenses: Bureau of Health Facilities and Service issues the license for hospital services including clinical laboratory, Bureau of Food and Drugs provides the license for hospital pharmacy to operate and the Bureau of Health Devices and Technology grants the license for radiology services provided by the hospital. The presence or absence of the different licenses can affect the category of the hospital and its accreditation with PHIC. As example, a primary or secondary hospital can be classified as infirmary if licenses are not granted for pharmacy and radiology, or if the laboratory capability of the hospital is deemed inadequate. This reclassification will have an effect on the accreditation with PHIC and its reimbursement to services rendered by this particular facility. The licensing requirements for hospital has been updated in DOH Administrative Order number 147 series 2004. Aside from hospitals, there are also licensing requirements required for 16 other health facilities, including birthing clinics, dialysis centers, blood bank, newborn screening centers, kidney transplantation facility, drug testing laboratory, medical facilities for overseas workers and seafarers, health maintenance organizations, dental laboratory, ambulatory surgical clinics, HIV testing clinic, training laboratories, water testing centers, clinical laboratories and drug abuse treatment and rehabilitation centers.(9) Table 6 shows the regional distribution of licensed government and private hospitals in the

Philippines in 2003 while Table 7 shows the regional distribution of PhilHealth accredited facilities in 2004. One must note however that DOH and PhilHealth uses different terms for hospital categories. DOH uses infirmary, first level referral hospital, second level referral hospital and third level referral hospital while PhilHealth uses primary, secondary and tertiary level hospital. In addition, after getting a license from DOH, the health facilities will go through another evaluation to get PHIC accreditation. In 2003, there were 1719 health facilities licensed by DOH and if there were the same facilities in 2004, then only around 86% of these facilities became accredited with PhilHealth.

Table 6. Distribution of Licensed Hospitals by Service Capability, Year 2003

REGION	CLASSIFICATION	PRIMARY	INFIRMARY	SECONDARY	1ST LEVEL REFERRAL	2ND LEVEL REFERRAL	3RD LEVEL REFERRAL	TOTAL
CAR	Government	0	18	0	8	0	1	27
	Private	0	10	0	8	0	1	19
Region I	Government	0	18	0	13	0	6	37
	Private	0	48	1	27	3	5	84
Region II	Government	0	20	0	15	0	2	35
	Private	0	28	0	15	0	1	44
Region III	Government	0	12	0	34	2	5	53
	Private	1	36	3	25	4	5	74
Region IV	Government	0	47	0	45	3	2	97
	Private	0	52	1	90	23	8	174
Region V	Government	0	27	0	16	4	2	49
	Private	39	0	2	19	5	3	68
Region VI	Government	0	20	0	29	0	4	53
	Private	0	5	0	5	0	9	19
Region VII	Government	0	36	0	19	1	4	60
	Private	16	0	15	0	9	6	46
Region VIII	Government	0	34	0	13	1	1	49
	Private	0	12	0	10	1	1	24
Region IX	Government	0	17	0	7	0	1	25
	Private	19	2	1	14	3	1	40
Region X	Government	0	17	0	8	3	2	30

REGION	CLASSIFICATION	PRIMARY	INFIRMARY	SECONDARY	1ST LEVEL REFERRAL	2ND LEVEL REFERRAL	3RD LEVEL REFERRAL	TOTAL
	Private	7	33	2	15	2	5	64
Region XI	Government	0	11	0	4	2	1	18
	Private	68	1	16	1	4	3	93
Region XII	Government	0	14	0	7	1	1	23
	Private	1	41	1	22	4	3	72
CARAGA	Government	0	23	0	8	3	1	35
	Private	0	19	0	3	2	1	25
ARMM	Government	0	6	0	6	0	0	12
	Private	6	0	0	0	0	0	6
NCR	Government	0	7	0	15	4	25	51
	Private	0	21	0	51	10	31	113

Source: BHFS-DOH

Table 7 PhilHealth Accredited Facilities by Classification and Category, 2004

Region	Total # of Accredited Facilities	Class		Category		
		Public	Private	Primary	Secondary	Tertiary
CAR	46	29	17	30	14	2
PRO I-	102	35	67	48	38	16
PRO II	59	28	31	28	27	4
PRO III	171	52	119	33	113	25
PRO IV-A –	120	38	82	33	62	25
PRO IV-B	103	42	61	43	51	9

PRO V	100	36	64	63	21	16
PRO VI	53	36	17	23	22	8
PRO VII	92	46	46	42	30	20
PRO VIII	64	44	20	36	24	4
PRO IX	70	28	42	41	25	4
PRO X	109	33	76	58	34	17
PRO XI	107	16	91	73	21	13
PRO XII	81	17	64	46	30	5
CARAGA	52	30	22	35	10	7
NCR	178	51	127	31	73	74
TOTAL	1507	561	946	663	595	249
Per cent		37.3%	62.7%	44%	39.4%	16.5%

Source: PHIC. Note: PhilHealth Regional Offices (PRO) have similar configuration as NSCB regions except PRO I, IV-A, IV-B, IX, X and NCR. .

In 1998, the Department of Health further went a step further by establishing the certification of public health facilities under its Quality Assurance Program, more popularly called Sentrong Sigla (Centers of Vitality) Movement. This Program has 2 major strategies: certification of public health facilities using DOH criteria, and capability building to install, knowledge, attitude and skills in the same public health facilities on continuous quality improvement. Although the first strategy had been started and still on-going, the Philippine Quality in Health Program 2003-2007 will focus on 3 layers of ensuring quality of care: 1) enforcing mandatory licensing of health facilities and services; 2) accreditation with PHIC and other Professional Associations; and, 3) Sentrong Sigla Certification, which will now be awarded not only to public health facilities but also to private units. (22) Currently, 1371 or 58% of the Rural Health Units or Health Centers are Sentrong Sigla (SS) Certified, 770 or 56% of these are being managed by the more affluent local government units. (23)

Preventive/ Screening Services. The preventive health services in the Philippines are deeply rooted in the delivery of different public health programs delivered by the City/Municipal Health Offices. These services include immunization, environmental sanitation like water testing and analysis, prenatal and post-natal care, preventive dentistry, promotion of healthy lifestyle and proper nutrition and health information campaign for priority public health programs like

family planning, control of infectious diseases like TB, leprosy, STD/HIV and endemic diseases like malaria and dengue. These are mainly provided by the network of government facilities, from the Barangay Health Stations to Provincial Health Office. Despite the availability of these services however, reports from essential public health programs were not always encouraging. As example, Figure 3 shows a decreasing trend in the proportion of children under 1-year old who have been immunized against measles from 1999 to 2002
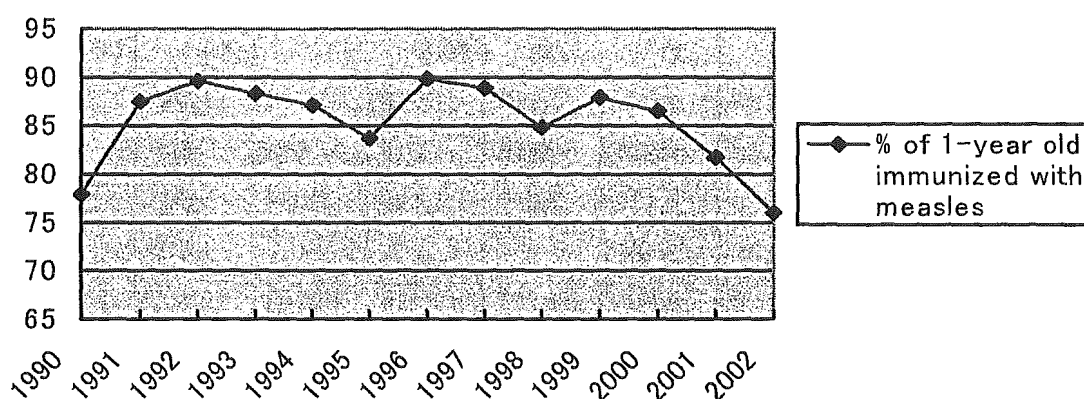
(Source: DOH- National Epidemiology Center)

Figure 3. Proportion of under 1-Year Old Immunized Against Measles in Percent

Screening services include sputum smear, blood smear for malaria, skin smear for leprosy, Pap smear, cancer screening in hospitals and newborn screening exams in accredited facilities. Primary health facilities including the RHUs and Health Centers in can provide basic screening like sputum smear for TB, blood smear for malaria and skin testing for leprosy but facilities that provide services like HIV, drug testing and newborn screening are required to secure license and accreditation from the Bureau of Health Facilities and Services.

Accessibility of Health Services There is a network of public health facilities managed and operated by local government units that makes health services available to every locality in the country. These include Barangay/village health stations, city/municipal health offices, provincial health offices and public (both local and national) hospitals. The public health network is complemented by private health facilities. Table 8 shows the number of health facilities, both public and private, from 1995-2003 showing an increasing number of facilities through the years. Although 65% of the hospitals

all over the country are privately owned, these facilities only provide 47% of the total hospital beds. This means that most of the private facilities are small and provide infirmary, primary and secondary care. As of 2003, there was roughly 1 bed per thousand populations. However, this ratio changes if computed per service capability of the hospital. In addition, the hospital bed to population ratio is also higher in the urban compared to rural areas.

Table 8. Health Facilities in the Philippines 1996-2003

FACILITY	1996	1997	1998	1999	2000	2001	2002	2003
Hospitals	1,738	1,817	1,713	1,794	1,712	1,708	1,738	1719
Government	600	645	616	648	623	640	661	662
Private	1,138	1,172	1,097	1,146	1,089	1,068	1,077	1057
Rural Health Units	2,856	2,405	...	...	...	1,879		
Barangay Health Stn.	17,090	13,096	14,267	14,416	15,204	15,107	15,343	

Source: NSCB Statistics for years 1996-2002. 2003 data from DOH-BHFS.

In terms of health work force, the country had 95,016 doctors, 41,484 dentists, 337, 939 nurses and 129,532 midwives, as of 2000. Of these, 3% of doctors, 4.7% of dentists, 1.4% of nurses and 12.7% of the midwives work for the government. This means that there are 805 persons per doctor, 1844 persons per dentist, 226 persons per nurse and 590 persons per midwife. If computed per locality these ratios will be higher for rural areas. Reports showed that there are not enough health providers in the country. Figure 2 shows the trend of births attended by skilled health personnel. Although there is an upward trend for the last 11 years, deliveries attended by skilled health providers remain below 70%.
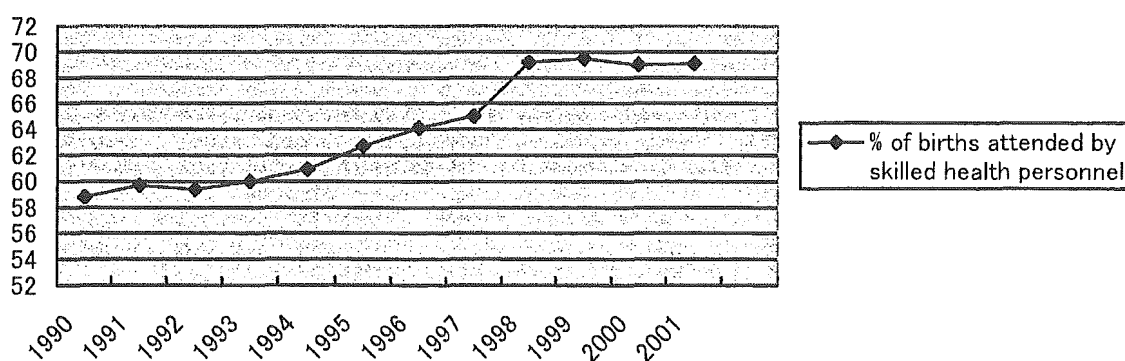
Source: DOH- National Epidemiology Center

Figure 2. Proportion of Births Attended by Skilled Health Personnel, 1990-2001 (%)

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 maldistibuted 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 responsivess.
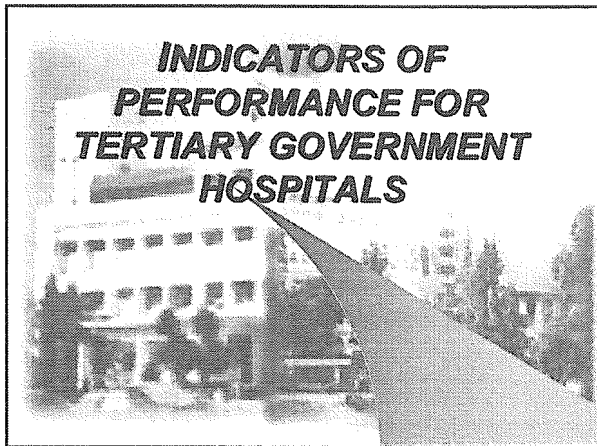
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INDICATORS OF PERFORMANCE FOR TERTIARY GOVERNMENT HOSPITALS

"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

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a. Access to care

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

b. Efficiency

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

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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