

Factors Influencing the Quality of Health Care Provisions on Local Government Units

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Abstract – This study addressed the problem of determining the services provided by the RHUs in the municipalities of Aliaga, Licab, and Quezon and the factors that influence the delivery of these services. With the use of the descriptive method and employing a set of questionnaire, it was revealed that the three municipalities provide primary health care services but lack facilities for Level 1 hospital. Further, the factors of inadequate facilities, personnel complement, and unsound fiscal management affect the delivery of health care services to the residents in the municipalities concerned. From these findings, it was recommended that there should be a policy of the lead agency, the Department of Health, to prescribe penalties for the local governments to at least compel them to achieve the least requirement for healthcare provision. The healthcare services should be insulated from political control for it can be used as a tool for political gains. Finally, this study should serve as a reference for future studies on health care, particularly for rural communities.

Keywords: healthcare, rural health, health facilities, health care services, local government unit

I. INTRODUCTION

A. Background

The health care system of the Philippines has evolved tremendously through the numerous challenges it had encountered. With the inception of decentralization in 1991 and the implementation of the Local Government Code, much of the power was vested on the fragile shoulders of local leadership. Most healthcare service expenditures have been devolved in these sub-national governments though licensure regulations, other public goods like immunization and control of communicable diseases are retained in the Department of Health.

In the last four decades after World War II (1945-1985), the healthcare system was controlled centrally. Then it was deconcentrated with the creation of eight(8) regional offices in 1958 and later expanded to 12 regional offices in 1972. The national agency for health located in the country's capital continued to provide resources, health policies, supervision of healthcare programme and healthcare facilities. Healthcare services were impeded at the community level due to the concentration of health workers in the urban centers and Manila[1].

Local government was allocated funds in the form of unconditional block grants, called Internal Revenue Allotments (IRAs). The funds that were allocated depended upon the population (50%), land area (25%) and rested divided equally among all local governments. The funds that were allocated are unrelated to either actual expenses or capacity to carry out their tasks or raise their resources; neither did they have any other conditions attached[2].

With decentralization in motion, the impacts on human resource were wide-sweeping the foundation of the relationship between the health care providers, their managers, and financiers. During the onset of devolution, healthcare provider and infrastructure were handed down to non-medical or non-health locally elected politicians and their administration. The Department of Health provided implementing rules and regulations in managing health in the local government units and series of health assemblies with their respective representatives to confer the responsibilities they would undertake, for there was no strategic plan for the introduction of devolution [3]. There were difficulties in hiring medical health workers for the local government units due to its great demand abroad. There was a loss in the career path as well. Before decentralization, a municipal health worker can pursue a career in provincial, national, regional and also up to the national level. Moreover, since the incorporation of health services was added, more frontline workload also expanded.

Meanwhile, many public hospitals in the urban areas continued to decline services and decay their facilities. The flight of healthcare workers was among the dilemmas faced by the public health management. Many are paid poorly which might have resulted in a high turn over of personnel even in areas needed of high technical skills [4].

The Department of Health, the lead agency for the provision of universal health care for the nation. It is mandated to formulate and develop national public health policies, guidelines, standards and manual of operations for health care services and programs; issuance of rules and regulations, licenses and accreditations; promulgations of national health standards, goals, priorities and indicators; development of special health programs projects and

advocacy for legislation on health policies and programs. The primary function of the Department of Health is the promotion, protection, preservation or restoration of the health of the people through the regulation and encouragement of providers of health and services [5].

Aside from being the regulator of all public health services and products, the DOH is the provider of special tertiary healthcare services and technical assistance to health providers and stakeholders. Its mission is "To guarantee an equitable, sustainable and quality public health for all Filipinos, especially the needy and poor, and to lead the quest for excellence in health." With the goal of becoming "A global leader for attaining better health outcomes, competitive and responsive health care system, and equitable health financing" by the year 2030.

The Philippines has evolved its health reforms through lesson and experiences from the past initiatives undertaken in the last 30 years. In 1979, it adopted the primary health care (PHC) which promoted participatory management of the local health care system. It was aimed to achieve health for all Filipinos by the year 2000. It focused on the delivery of eight essential elements of health care, including early prevention and control of prevalent health problems; the promotion of adequate food supply and proper nutrition; basic sanitation and proper amount of water; maternal and child care; immunization; prevention and control of endemic diseases; appropriate treatment and control of common diseases; and provision of essential drugs. To be able to implement PHC, EO 851 was issued in 1983 integrating public health and hospital services [6].

The return of democracy through People Power Revolution had strengthened the call for local legal representation. Through Republic Act (RA) 7160 or the Local Government Code (LGC), the responsibility of health service provision was transferred to the local government units (LGU). The law intended to establish a more responsive, sensitive and accountable local government structure. On the other hand, this has resulted in fragmented administrative control of health services between the rural health units and hospitals and between the different levels of political structure [6]. Before this, the Generics Act was enacted in 1988 to ensure adequate supply, distribution, and use of generics that had improved access to affordable drugs and medicines.

In those times more than half of the population do not have health insurance coverage, especially the poor, self-employed and informal sector [6]. With these came the enactment of the National Health Insurance Act of 1995 or RA 9875 which aims to provide the citizenry a mechanism for financial protection with priority given to the underprivileged. This has created the National Health Insurance Program "which shall provide health insurance coverage and ensure affordable, acceptable, available and accessible health services for all citizens of the Philippines."

A significant unintended consequence of devolution was the interruption of the technical links between the rural health units in the municipalities and the primary and secondary referral facilities at the district and provincial levels.

Disruptions can also occur if the municipal government has disagreements with the provincial government. The absence of powerful central mechanisms to influence local government to invest in priority programs was also a significant handicap for service delivery at the local level

Then the "Comprehensive Health Care Agreements" have been developed in 1994. This is to provide an opportunity for the DOH and local government units to negotiate priority health investments on an annual basis. However, these agreements were rendered ineffective because they did not include incentives or punitive measures to ensure local government complied with the agreements. For example, when some local government units succumbed to local pressure and stopped providing contraceptives services, the center was not able to compel them to do so, even though these had been classified as priority services under the Health Care Agreement. Another major flaw in the Comprehensive Health Care Agreements was that they were between the province and the DOH, yet the producer of the deliverables was the municipality. Provinces were expected to negotiate performance agreements with their municipalities, but this often did not happen [7].

In 1999, the Health Sector Reform Agenda had been launched as a major policy framework and strategy to improve the way healthcare is delivered, regulated and financed. This is to address various decentralization problems. The HSRA noted a slight resurgence of certain diseases and persistent inequities in service access. It redefined itself as a health leader, enabler, and capacity builder, administering only certain services. It would primarily be responsible for setting national health policy and regulations and strengthening regulatory agencies, promote innovations and standards in health services, push for the greater fiscal autonomy of hospitals, secure funds for public health programs, and promote universal Insurance coverage. It brought all its interventions under one HSRA framework in all provinces. Coming up with the slogan cry of "*Kalusugan Para SaMasa*," it was aimed to implement the reform package in the convergence sites. The five reform areas are 1. Public health; 2. hospital; 3. local health systems; 4. health regulations and 5. health financing [8]. This was during the time that the DOH underwent a major organizational reform to pursue its new role as a result of the devolution. At the local level, the municipalities were joined together to form interlocal health zones (ILHZs) to optimize sharing of resources and maximize joint benefits from local health initiatives.

The department of health initiated the universal health care program or *Kalusugan Pangkalahatan* (KP) in 2011 to meet the ever-growing health needs of the country. There was a call

for partnership and support of the Local Government Units (LGUs), other national agencies, development partners, civil society organizations, non-government organizations and other stakeholders. The investment of the central government shall be complemented by the development partners and is expected of them to align their support in the thrust of the universal health care program. The development partners were encouraged to fill in health investment gaps and give assistance to the department and LGUs in capacity building, policy, research development, and systems strengthening.

In a sense, the LGUs were assigned greater health functions. They were also given autonomy to experiment or innovate in their service delivery and financing of health care services, which has both bad and good consequences. Though discussions on the benefits of decentralization have always obtained much attention, the quality of healthcare delivery in many localities is an issue that should not be taken for granted. Many improvements have been achieved in the recent development of the health care system of our nation, but much is still need to be done. The quality of healthcare services remains inconsistent across the country with the inefficient decentralization of healthcare functions and resources [9]. It is in this following context that this study was undertaken.

B. Objectives

This study aimed to determine the kind of services provided by rural health units in the municipalities of Aliaga, Licab, and Quezon and the factors that influence the delivery of these services.

The objectives of this study were:

1. To determine whether the RHUs in the municipalities of Aliaga, Licab, and Quezon provide the following services:

- 1.1. Dental
- 1.2. Maternity
- 1.3. Laboratory
- 1.4. Pharmacy

2. To determine the effects of the following factors on the quality of health care service delivery in the local governments.

- 2.1. Facilities
- 2.2. Personnel Complement
- 2.3. Fiscal Management

C. Theoretical Framework

This study rests on the Maslow's need theory. According to Maslow, when a human being ascends the levels of the hierarchy having fulfilled each need, one may eventually achieve self-actualization. In this study, quality health provision is important to achieve a low mortality rate.

However, the need for good health is difficult to achieve because in most public health facility there is lack of enough infrastructures such as wards, maternity wards, and insufficient lab parameters to provide required services to the patients.

Maslow constructs a hierarchy of human needs from the lowest which is physiological needs, self-esteem needs and topped with self-actualization. The physiological needs are those needs that help a person to be in the comfortable state in which his body is in a good state to enable him to perform well. After being physiologically fulfilled, a person will need a safe surrounding that will ensure his security. Then he ascends to the need to be loved and be shown a sense of belonging. Because of the attainment of love and belonging, the individual will develop a sense of self-esteem, self-respect, and competence and this finally leads to self-actualization where an individual knows himself better and know what he wants to do with his lives [10].

In this study, health care needs to be served well so that patients will feel they are given due care and attention. The attainment of good health is a basic need that once fulfilled will lead to the fulfilment of the other higher needs.

II. METHODOLOGY

This part discusses the research design, tools of research, and treatment of data.

A. Research Design

The study employed the descriptive method using the questionnaire as the main tool for data gathering. The descriptive method was used in describing systematically the delivery of healthcare services in the three towns of Nueva Ecija. Aside from the questionnaire, interviews and observations were also done to follow up responses to the questionnaire.

Primary data were gathered using a set of questionnaire. The questionnaire was of the check-list type for the convenience of the respondents and for ease in collating the data. According to Kothari (2004), primary data is that which is collected afresh and for the first time happens to be original [11]. The researcher also observed the way clients were being handled in the health centers and the kind of services they received.

B. Study Locale and Respondents

The study was conducted at the Rural Health Units of Quezon, Aliaga, and Licab. All are municipalities under the 1st Congressional District of the Province of Nueva Ecija.

The respondents in the study consist of all staff of the Rural Health Unit of the respective municipalities, working under various areas. These include doctors, nurses, and laboratory staff. Thus, the respondents consist of the entire population of health staff in the RHUs of the three towns. According to Mugenda & Mugenda (2003), a population is an

entire group of individuals, events or objects with some common observable characteristics [12].

C. Data Collection and Analysis Technique

Permission to administer questionnaires was first sought from the RHU chief of every town involved in this study. When granted, the questionnaires were administered to the RHU staff on their break time. The researcher waited for the questionnaires to be accomplished.

Data from questionnaires were analyzed using percentages. The results were interpreted in the light of the concepts and principles of health care services.

III. RESULTS AND DISCUSSION

This section presents and interprets the data gathered from the questionnaire administered to the respondents.

A. RHUs' Services

The data in Table 1 shows that of the three (3)

TABLE I
SERVICES RENDERED BY RHUS

Services	Aliaga	Quezon	Licab
Dental	✓	✓	✓
Maternity	✓	✓	✓
Laboratory	✓	✓	✓
Pharmacy	✓	x	x

Municipalities, Aliaga's RHU provide all the basic services for a rural health unit; namely, dental, maternity, labor and pharmacy. The other two municipalities, Quezon and Licab, do not operate a pharmacy.

The Revised Organizational Structure and Staffing Standards for Government Hospitals released in 2013 provides for other facilities Level 1 hospitals should acquire, namely, an operating room with standard equipment and provision for sterilization of equipment and supplies, a post-operative recovery room, and an isolation facilities with proper procedures for the care and control of infectious and communicable diseases as well as for the prevention of cross infections.

It matters for the RHUs in Licab, Aliaga, and Quezon to acquire these facilities as. Ideally, residents in the community should be able to conveniently and confidently access services such as primary care, dental care, emergency care, and behavioral health for their overall physical, social, and mental health status.

B. Factors Affecting the Delivery of Services

1) *Completeness of Facilities:* Table 2 shows that except for two respondents, the rest believe that the dental, maternity, laboratory, and pharmacy facilities of the RHUs are partially

complete. Only one reckoned that the RHUs maternity facilities are complete and another one who believed that the laboratory facilities are complete.

It is important to note that rural residents often experience barriers to healthcare that limit their ability

TABLE II
COMPLETENESS OF FACILITY

Services	Not Complete	Partially Complete	Complete
Dental	0	48	0
Maternity	0	47	1
Laboratory	1	46	1
Pharmacy	1	47	0

To obtain the care they need. One of these is the lack of health care facilities that will address their needs for prevention of diseases and detection and treatment of diseases.

The rural health units are providing partially complete facilities. Laboratories are at the minimum required level but with no accreditation from the Department of Health except for Licab which has the complete laboratory set up but they lack space. They lack other test parameters that physician could use to better assess patients' condition. This affects the service delivery of the physician and results in the patient seeking free or low price laboratory test provided by the pharmaceutical commercial stores which they periodically hold.

All the RHUs have birthing wards which are attended by licensed midwives. These birthing clinics can only accommodate those mothers whom had previously delivered and not first-time mothers. This is due to complications that may occur with the mother and child.

All municipalities have their dental services which are adequately manned by a licensed dentist.

2) *Personnel Complement:* Table 3 shows that the Municipality of Aliaga employs the most number of personnel numbering 24, of which 14 or 53.30% are contractual. The same holds through for

TABLE III
PERSONNEL COMPLEMENT IN THE RHUS

Municipality	Total No.	Permanent	Contractual	Percent of Contractual Personnel
Aliaga	24	10	14	53.30%
Quezon	15	7	8	58.30%
Licab	9	9	0	0%

The municipality of Quezon of its 15 personnel, 8 or 58.30% are contractual. In contrast, the municipality of Licab has all its nine personnel on permanent status.

The adequacy of personnel is a factor to consider in providing quality service to patients. If the health facility could not provide efficient and effective services, the healthcare problem of the municipality will

3) *Fiscal Management*: Be critical. The problem may even be compounded by the lack of permanent employees working as contractual employees come and go having no security of tenure.

Aliaga's political problem, the Executive, and Sangguniang Bayan conflict affect the allocation of funds for its RHU. This is signified by 20 or 83.3% of its 24 respondents who said funds are poorly allocated for salaries and 13 or 54.16% who claimed poor allocation for equipment. Since 2016 they have to work with the same budget allocation since its council does approve the local chief executive's proposed budget.

TABLE IV
FISCAL MANAGEMENT OF RHU IN ALIAGA

Response	Salary	Percentage Salary	Equipment	Percentage Equipment
No allocation	0		0	0
Poorly allocated	20	83.3%	13	54.16%
Partially Allocated	1	4.1%	0	0
Adequately Allocated	3	12.5%	11	45.83%
Total	24	100	24	100

Indeed, rural residents often experience barriers to healthcare that limit their ability to obtain the care they need. For the rural residents to have sufficient healthcare access, the necessary and appropriate services must be available and obtainable promptly.

IV. CONCLUSIONS AND RECOMMENDATIONS

From the above findings, the following conclusions were drawn:

1. The three municipalities provide basic healthcare services but lack facilities for Level 1 hospital.
2. The factors of inadequate facilities, personnel complement and unsound fiscal management affect the delivery of quality health care services to the residents in the municipalities concerned.

V. RECOMMENDATIONS

From the conclusions drawn, the following recommendations were proposed.

1. There should be a policy of the lead agency, in this case, the Department of Health, to prescribe penalties for the local governments to at least compel them to achieve the least requirement for healthcare provision.
2. LGUs should have a program of providing continuous training for municipal health officers for better management of staff and facility.
3. There should be a review of the provision of the local government code for the management of healthcare service. The healthcare services should be insulated from political control for it can be used as a tool for political gains and affects greatly in political turmoil.
4. The study should serve as a basis for future researches on other aspects of healthcare services. To make the study accessible, it should be submitted to the already existing Information Computer Technology or eGovernance.

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