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The Local Health Care System of the Province of Ilocos Sur, Philippines

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ABSTRACT

Health is fundamental to life. It is in this premise that efforts are being undertaken to improve the health system of every country. The focus of the study was on the different components of the Local Health Care System and the quality of health services of selected Rural Health Units and District Hospitals in the province of Ilocos Sur. The study revealed that the Administrative Capability along leadership and good governance is "moderate". Along the capability of health personnel in terms of ratio to total population, only two municipalities have the ideal number of doctors and nurses while only five municipalities have an ideal number of midwives. There is also a shortage of human resources for health, particularly doctors, in almost all the district hospitals. However, the limited number of nurses and midwives is compensated by the presence of contractual and volunteer nurses and midwives. In general, the clients expressed their satisfaction on the services provided. Suggestions were made largely on availability of free medicines, laboratory services, reduction of waiting time, and improvement of facilities. Efforts should be undertaken to ensure that programs and policies are implemented and objectives are reached through improved coordination across local health systems.

Keywords: public health, rural health units, district hospitals capability, services, quality

INTRODUCTION

In the Philippines, the Local Government Code of 1991 – Republic Act No 7160 – provides genuine and meaningful authority to local governments, giving them more power, authority, responsibilities, and resources. This is the legal framework of all health efforts between/among health partners.

System thinking is essentially part of the contemporary health care management and health system stewardship principles. It also provides a scientific methodology for understanding and dealing with complexities and changes. In the health sector, it is the totality of policies, programs, institutions, and actors that provide health care-organized efforts to treat and prevent disease. Defining it as a whole, health care system is a formalized, legally regulated financing and the provision of health services: including preventive, curative, and palliative interventions provided by health professionals. In other words, it is just how the health care of a certain population in a defined geographic location is being demanded, delivered, financed, organized, and utilized (Dorotan, 2005).

The Philippine Health System is basically a dual system in health service provision. On one end is the public sector composed of the Department of Health and the Local Government Units. At the other end is the private sector. The Code, however, initiated the fragmentation of the delivery of health services to the people on the public sector end. Before the devolution, the Department of Health was the financial and administrative authority over the entire health system. The exceptions to this were the chartered cities. After 1991 the health system operationally was divided into the municipal/city, province and the DOH administrations. Each body exercises financial and administrative authority over their respective areas. The DOH maintains its role as the steward of health of the country. The Department of Health (DOH) is the lead agency for health, the steward of the health of the nation, with the major mandate to provide national policy direction, develop national plans, technical standards and guidelines on health.

The quest for the Healthy Filipino, Healthy Philippines continues amidst the challenges of emerging diseases like HIV-AIDS, severe acute respiratory syndrome (SARS), bird flu and meningococcemia among others. In June 2005, "FOURmula ONE for Health (F1)2" was launched as the new health sector reform implementation framework. Through this new framework, doable and critical reforms will be undertaken with "speed, precision, and effective coordination" and are directed at improving the efficiency, effectiveness and

equity of the Philippine health system. The goals of this new approach, "better health outcomes, a more responsive health system, and more equitable health financing," are in consonance with the WHO health system goals, the Millenium Development Goals, and the Medium Term Philippine Development Plan. In more specific terms, the F1 aims to: ensure access to and availability of essential health packages; assure the quality and affordability of health goods and services; secure more, better and sustained financing for health; and improve performance of the health system within the medium term.

The core element of local or district health system is an integrated primary health care and its first referral hospital serving a well-defined population (Dorotan & Mogyorosy, 2005). The objectives of the Health Sectors include: improvement of the general health status of the population, reduction of morbidity and mortality from certain diseases, elimination of certain diseases, promotion of healthy lifestyle and environmental health, protection of vulnerable groups with special health and nutrition needs.

Public health providers offer medical services and are usually governed and regulated by the government through the Department of Health (DOH) or local government units (LGUs). Private providers, on the other hand, generally charge fees for services. The latter include both for-profit and non- profit organizations. However, there is a generally observed disparity in quality between the medical services from private and public providers.

The Rural Health Unit is the primary institution in the community responsible for the health promotion and prevention of illnesses. Its services are not only focused on the individual but to the entire family and the community.

Basic health and nutrition services, such as low-cost good quality medicines, maternal care are among the essential social services that constitute vital Rural Health Unit (RHU) in interventions aimed at raising productivity, reducing poverty and promoting social justice. In this light, the status of RHU must be intensified to attain the country's vision of health for all Filipinos and continue its mission of ensuring the accessibility and quality of health care to improve the quality of life of all Filipino, especially the poor.

In inter-local health zones, core referral hospitals are critical to an integrated health service delivery. First level referral hospitals are non-departmentalized hospitals that provide clinical care and management on the prevalent diseases in the locality. They provide ancillary (clinical laboratory, radiology, pharmacy) and administrative services and also provide nursing care for patients who require care for 24 hours or longer.

Since the RHU and District Hospital facilities are more accessible to household and are mostly visited by the poor, improving their status will also improve the delivery of services. It is in this premise that the researcher conducted this study to determine the status of the Local Health Development System of the Province. The result of the study will enhance awareness of the LGU and Provincial Office as to the status of the Local Health Care System of the RHUs and District Hospitals in terms of governance and stewardship; resource generation and financing; and service delivery. Being aware of the status, measures will be undertaken to improve the status of RHU thereby improving the delivery of health care service. Once the delivery of health care services is improved, the total population will benefit from it. They will be able to access quality and affordable health services.

FRAMEWORK

The Local Government Code of 1991, also known as R.A. 7160, which took effect on January 1, 1992, mandating the devolution of some basic services and facilities from the national government to the local government units one of which is health services under the Department of Health. It aims to heighten people access to decision-making process doing away with the traditional red tape of having to go all the way up to the central authorities for action or authority to perform appropriate action, decongest the central government of certain functions that could well be done at the lower levels, and make decisions more responsive to the needs of the people.

The law uprooted decades of highly centralized decision-making that hindered and placed upon the local officials in major portion of the responsibility for modernization of the local communities. The code primarily aims to increase people's access to decision and policy making process and enables the pole to end their passivity, thus, making them truly self-reliant as well as enabling them to achieve maximum freedom and peace and order. The delivery of basic services to the local government units, including appropriate personnel, assets, equipment, programs, and projects finally took effect.

The promulgation of the code was actually in accordance to a 1987 constitutional provision that declared that the state shall ensure the autonomy of local governments. It was towards operationalizing this policy that the constitution mandated Congress to legislate a Local Government Code that would devolve substantial, political and administrative authorities to local government units long held hostage by the central authorities from Manila

(Brillantes, 1999). The enactment of the code was welcomed by most sectors of society. It finally transferred the responsibility for the delivery of basic services to the local government units, including appropriate personnel, assets, equipment, programs and projects.

In the past, most LGU's were heavily dependent on the national government in terms of their financial and physical needs. Power was greatly concentrated in Manila which dictated and told what project is needed by the communities. It was a top-to-bottom approach trying to determine people's needs and in the delivery of their basic needs. In terms of planning the development needs of local government units, the central government called the shots affording little opportunities for the people to plan and participate in decision-making. Most political historians agree that the Philippines have a long tradition of centralized government. Ever since the arrival of the Spaniards in 1521, the Philippine Islands have always been ruled from the national capital, Manila, to appoint that because of the excessive centralization, it has been derisively referred to as "Imperial Manila" (Brillantes, 1999). Thus, the enactment of Local Government Code elicited hope for most sectors of society.

Decentralization is claimed to be a means of bringing government "closer to the people", to enhance responsiveness of services through local participation, better information, and greater accountability. However, it also carries with it particular demands in that, the LGUs are expected to allocate and spend for basic health services and facilities. Financial expenditures are at the core of health responsibilities of local executives, because in the absence of these resources, critical health supplies for low-income populations would be limited and health outcomes would be affected (Lee et al., 2011).

The Department of Health was most affected in scale and scope of resources, powers and responsibilities because of the devolution. With the passage of the code, a number of local special bodies were created to encourage citizen participation, one of which is the Local Health Board. Local Health Boards were designed to be the main mechanisms for broader community participation and involvement in Local Health Development. Thus the LGC enunciates that there shall be established a Local Health Board in every province, city or municipality. This actually springs from a constitution mandate under Article II, Section 15 which provides that the state shall protect and promote the right health of the people and instill consciousness among them.

Further, with the enactment of the Local Government Code, a Local Health Board is supposed to be constituted to provide technical assistance to the Local

Sanggunian on health matters, including those pertaining to financial allocations. As stated in the Legislative Agenda, the best way to secure the people's right to health is to ensure the delivery of health services. Health service is defined as the output of managing the resources invested for health by an individual or an institution such as the government, the private sector and other alternative organization. The delivery of health care services to the rural areas is a major challenge to all health practitioners in order to achieve the goal of primary health care. With respect to allocation, utilization and disbursements of funds, the financial statements and records attest to the efficiency and effectiveness of the financial control system (Anagaran et al., 2010).

Department of Health, Rules and Regulations Implementing the Local Government Code mandates that the Local Health Boards were designed to propose to the Sangguniang concerned annual budgetary allocations for the operation and maintenance of health facilities and services within the province, city or municipality as the case may be. Local Health Boards also serves an advisory committee to the Sanggunian, for and application of local appropriations for public health purposes. Finally, consistent with the technical and administrative standards of the Department of Health, create committees which shall advice local health agencies on matters such as, but not limited to, personnel selection and promotion bids and awards, grievance and complaints, personnel discipline, budget review, operations review and similar functions (Anagaran et al., 2010).

The provision of basic health care services has been at the center of discussion on the merits of devolution. A major concern is the inability of local governments to absorb the costs of devolved health functions owing to problems in the transfer of corresponding financial resources. Simply put, the allocation of the Internal Revenue Allotment did not consider the distribution of the burden of devolved functions across LGUs so that more than a few provincial and municipal governments ended up with disproportionately greater additional expenditures than incremental income from IRA.

In response, the Department of Health (DOH) launched the Health Sector Reform Agenda (HSRA)1 in 1999. The goal of the HSRA was to improve the health status of all Filipinos through the implementation of reforms in five general areas: public health, hospitals, regulation, financing and local health systems. Fourmula One for Health is the implementation framework for health sector reforms. It applies to the entire health sector and is designed to implement critical health interventions and programs, projects, activities at the national and local level as a single package backed by effective management infrastructure and financing

arrangement. The policy supports for sector reform are guided by Health Sector Reform Agenda (HSRA) and National Objectives for Health (NOH), the Sector Wide Approach for Health (SWAP), and the Sector Development Approach for Health (SDAH). Instead of five reform areas described in the HSRA, the FOURmula One for Health reforms are now packaged into four distinct components: Health Service Delivery, Health Regulation, Health Finance, and Good Governance in Health.

Further, interest in the area of quality arose when researchers, health advocates, and program managers observed that clients often received inadequate care and that legitimate constraints inhibited the delivery of high-quality services. Health care services is the totality of all services rendered by the various health discipline or health practitioners. It is also considered as a great help to make an individual, family as well as the community have a healthful living. The services include the promotion of health, prevention of illnesses and prolonging life. The different health care services are Mother's class, training of barangay health workers, training of barangay disaster brigade, home visits and herbal gardening.

Reforms in health service delivery are aimed at improving the accessibility and availability of basic and essential health care for all, particularly the poor. Public primary facilities are perceived as being low quality, hence they are frequently bypassed. Clients are dissatisfied due to long waiting times, perceived inferior medicines and supplies, poor diagnosis resulting in repeated visits, and personnel who are not always available, especially in rural areas, and are perceived to lack both medical and people skills. The result is that secondary and tertiary facilities are inundated with patients needing primary health care. Since public primary facilities are more accessible to households and are mostly visited by the poor, improving their quality, particularly those services demanded by the poor, would improve their health. Furthermore, referral mechanisms among different health facilities across LGUs need to be strengthened (Dorotan, 2005).

Overall, the Local Government Code fundamentally changed the management and funding mechanisms of health service delivery. Many authors report that most LGUs, specifically provinces and municipalities, throughout the Philippines have been constrained from performing their health responsibilities effectively, due to their insufficient resources relative to the devolved health tasks, absence of or weak basic organizational structures for health, inadequate capability-building support from the DOH and dearth of accountability mechanisms. Still, some provinces and cities have effectively carried out their mandated health responsibilities and are making good progress on health outcome indicators such

as facility based delivery and decrease in the infant and maternal mortality rates.

The study revolved around the paradigm below:

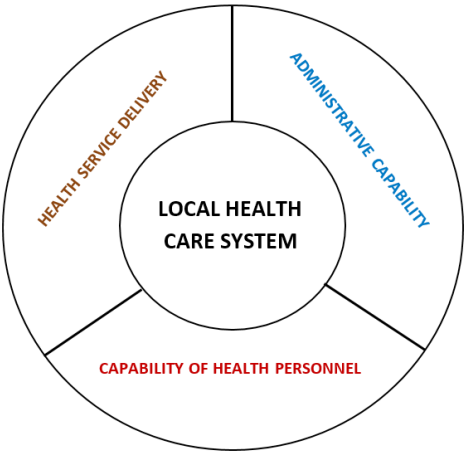

Figure 1. Local Health Care System Paradigm

OBJECTIVES OF THE STUDY

This study focused on the assessment of the Local Health Care System of the different Rural Health Units and District Hospitals of the Province of Ilocos Sur. It determined the different components of the Local Health Care System namely good governance and stewardship, health service delivery, health regulation and financing and resource generation, as stated in the Fourmula One of the Department of Health. Self-Rating of Health Workers On Attitude and Behavior towards their clients was also elicited. The quality of health services was also looked into in terms of accessibility, availability of service, provision of care, health personnel- client interaction.

METHODS

This study used the quantitative and qualitative method to gather data as the two approaches are complimentary and can give an accurate reflection of reality. For the quantitative data, a questionnaire checklist formulated by the researcher based on the DOH Quality Standard Test and the Benchbook on Performance Improvement of Health Services of the Philippine Health Insurance

Cooperation, was used to determine the capability of the RHUs and District Hospital.

The respondents of this study were the personnel holding a permanent position which includes the Municipal Health Officer, nurses, and midwives of the Rural Health Unit and the Chief of Hospital, Administrative Officer, Nurses and Nursing Attendants of the District Hospitals.

Records review was utilized to assess the impact on the general health status in terms reduction of maternal mortality rate, infant mortality rate and morbidity rate. Supporting documents for the annual budget for health was taken from the Budget office of the province.

Further, a qualitative approach, Focus Group Discussion (FGD) was used to assess the quality of health care services by the facility. FGD was done on one District Hospital and one Rural Health Unit. The following selection criteria were used to identify the client-respondents: 1) A regular patient of the facility and 2) Must be in the facility at the time of the data gathering.

Discussion was conducted with a group of six clients and the topic revolved on the questions of accessibility, availability of services, provision of care and health personnel-client interaction. Answers to the topic were from the perspective of their individual experience and opinion.

The purpose of the study was explained to all participants and were assured of strict confidentiality. Likewise, they were given the option of not participating in the study if they wanted. Data gathered were treated and analyzed using the following statistical tools: Frequencies, Mean, Multiple Regression and Correlation Analysis.

To ensure that ethical considerations were made, the facility was coded while the identity of the participants were kept confidential.

RESULTS AND DISCUSSION

On Good Governance And Stewardship

In general, Capability of the RHUs and District Hospitals along leadership and good governance and stewardship is “Moderate”. The highest mean level is along the conduct of evaluation of periodic performance of the health staff and orientation program of new personnel that covers the essential components of the service being provided.

On the other hand, the least mean score is along developing activities with at least two civil society organizations in the local health system, an exit interview is

conducted for personnel who resigns or retire from service and the health facility identifies priority programs to be implemented and proposed to the local health board.

Health Governance is mainly two-tiered (provincial and municipal level). The Provincial Governor is the central authority for health care in the province. The municipal mayors are expected to support and implement health programs and projects. However, the health facility is empowered to identify its own priority programs basing from the needs of their clients.

A. Capability of the Health Personnel of Rural Health Units

Table 1

Administrative Capability of the Rural Health Units along Capability of the Health Personnel in terms of Ratio to Total Population

RHU Facility	Total Population	Medical Doctor (Ideal Ratio 1MD:20,000)	Public Health Nurse (Ideal Ratio 1PHN:20,000)	Rural health Midwife (Ideal Ratio 1 Midwife:5,000)
1	26,967	1:26,967	2:26,967	6:26,967
2	29,912	1:29,912	1:29,912	6: 29,912
3	45,036	2:45,036	2:45,036	8: 45,036
4	25,858	1:25,858	1:25,858	6:25,858
5	11,594	1:11594	1:11,594	3:11,594
6	15,290	1:15,290	1:15,290	10:15,290
7	38,768	1:38,678	2:38,768	6:38,768

At the Primary Level, the health needs of a 20,000 population should be catered by one (1) Medical Doctor and one (1) Public Health Nurse while one (1) Midwife for every 5,000 population. However, it can be gleaned from the table that the ideal ratio for a medical doctor and a public health nurse to the population is not followed in some facilities.

This may be attributed to the fact that some doctors find these areas unattractive due to long irregular working hours, isolation from medical colleagues and the absence of incentives to stay in these areas. Newly- trained doctors face radically different choices of where and how to practice. Further, new doctors are much less likely to enter solo practice and are more likely to take salaried jobs in group medical practices, clinics and health networks. However, the ideal Midwife ratio

of 1: 5,000 is observed by the 5 Rural Health Units.

B. Capability of the Health Personnel of District Hospitals

Table 2

Administrative Capability of the District Hospitals along Capability of the Health Personnel in terms of Population Served

Core Referral Hospital	Population Served	Number of Doctor	Number of Nurses	Number of Nursing Attendant
A	**88,583**	3	8	6
B	**64,570**	3	6	2
C	**133,539**	6	12	9
D	**116,234**	5	6	2
E	**18,741**	2	3	4
F	**23,588**	3	6	5
G	**100,521**	8	13	11

The highest number of population served by a district hospital is 133,539 with only six Medical Doctors, 12 Nurses and nine Nursing Attendants.

The shortage in human resources for health, particularly doctors, is a well-known fact. Seventy percent of all health professionals are working in the private sector addressing the needs of about 30% of the population while 30% of health workers employed by the government are addressing the health needs of the majority of Filipinos. The public health sector is unable to hire health professionals because they rely on LGU or national government allocation.

Moreover, there is a limited number of permanent nurses and midwives to serve the population. However, their services are supported by the presence of contractual and volunteer nurses and the current program of the Department of Health which is the Nurse Deployment Program, formerly known as the RN Heals. One facility claims to have six visiting consultants.

The lack of doctors and nurses to cater to the needs is supported by the claims of long waiting time by the clients and the unavailability of medical check-up when the doctor is out for seminars, training, meetings and other reasons.

This scenario may bring about a lesser health personnel-client interaction, shorter time allotted for physical examination and visiting hours thereby contributing to poorer diagnosis, management and treatment.

Table 3

Administrative Capability of the Rural Health Units and District Hospitals along Finance and Resource Generation

Finance and Resources Generation	A X DR	B X DR	C X DR	D X DR	E X DR	F X DR	G X DR	Overall X DR
1. The health facility ensures yearly increase in the health budget approved by the Sangguniang Bayan for priority program/projects.	1.73 (VL)	2.00 (Lo)	0.33 (VL)	2.00 (Lo)	0.75 (VL)	1.25 (VL)	1.07 (VL)	1.30 (VL)
2. The health facility has tapped resources for health services from sources other than the regular budgets support of the Local Government Unit (LGU).	1.64 (VL)	2.20 (Lo)	2.33 (Lo)	2.40 (Lo)	1.00 (VL)	1.50 (VL)	1.27 (VL)	1.76 (VL)
3. The health facility has the revenue generation schemes and utilizes the income to support the improvement of health services delivery and the maintenance of health facility.	1.73 (VL)	2.20 (Lo)	2.67 (Mo)	2.40 (Lo)	1.00 (VL)	1.00 (VL)	1.27 (VL)	1.75 (VL)
4. The health facility is accredited by Phil Health for outpatient benefit package.	2.45 (Lo)	2.80 (Mo)	1.33 (VL)	2.80 (Mo)	1.00 (VL)	0.63 (VL)	1.87 (Lo)	1.84 (Lo)
5. The health facility advocates the sponsored program of Phil health to their Local Health Unit.	2.55 (Lo)	2.80 (Mo)	3.00 (Mo)	2.80 (Mo)	1.00 (VL)	1.75 (VL)	1.87 (Lo)	2.25 (Lo)
6. The health facility utilizes the capitation fund for the improvement and maintenance of health service delivery.	1.73 (VL)	2.40 (Lo)	0.00 (Lo)	2.60 (Lo)	1.00 (VL)	1.13 (VL)	1.60 (VL)	1.49 (VL)
7. There is appropriation of staff development program which includes continuing education of the staff and other activities to ensure the mental and physical fitness of the staff.	1.91 (Lo)	2.00 (Lo)	3.00 (Mo)	2.20 (Lo)	0.75 (VL)	1.00 (VL)	1.67 (VL)	1.79 (VL)
Overall Mean	**1.96 (Lo)**	**2.34 (Lo)**	**1.81 (Lo)**	**2.46 (Lo)**	**0.93 (VL)**	**1.18 (VL)**	**1.51 (VL)**	**1.74 (VL)**

4.21-5.00	Always (A)	Very High(VH)
3.41- 4.20	Often (O)	High (H)
2.61-3.40	Sometimes (So)	Moderate (Mo)
1.81-2.60	Seldom (Se)	Low (Lo)
1.01-1.80	Never (N)	Very Low (VL)

It can be inferred in Table 3 that the overall rating of the facilities along Finance and Resource Generation is very low. Emphasis is made on the item that the health facility is not insured of a yearly increase in the health budget approved for priority program/projects.

The results imply that there is a need to strengthen the capacity of the health facility to generate more funds for the operation and maintenance of health facilities and services. This is anchored on the objective of the Fourmula One

for Health to rationalize the source of financing, create an effective financial management system, institutionalize revenue enhancement measures and performance-based budgeting system, and the need to increase the coverage of the National Health Insurance Program (DOH).

Self Rating of Health Workers On Attitude and Behavior

On Exhibiting Technical Competence in Articulating Information to Patients

The health workers still feel inadequate on interpersonal skills such as being a good listener, maintaining a two-way communication, and giving appropriate instructions. It can also be noted that almost all of the health workers rated themselves the lowest on the item that the "facility staff spend a minimum of then minutes with each client in history taking, examination, treatment, and health education. This finding may be attributed to the fact that the health worker-client ratio is not being observed in some municipalities, thus, the quality time spent with the client is compromised due to increased workload.

Further, the findings imply that client centeredness is a factor in the health service delivery. Attitude and behavior play an important factor in the treatment outcome of the patients.

On Caring and Gender Sensitive

The respondents rated themselves "Moderate" on the item caring and gender sensitive as supported. This implies that the health workers still feel the need for gender sensitivity training which will enhance their skill and attitude in caring for clients across all gender.

On Culture Sensitive

The health workers still feels the need to improve on being culture sensitive, especially on respecting patient's needs that are influenced by culture and religion, providing for patient's needs that are influenced by culture and religion, and offering choices/ options to patients.

Quality of Health Service Delivery of the Facility as Rated by the Clients

Understanding the client's perception on having used a service helps reflect the gap between the expected service and the experience of the service from the client's point of view.

Based from the results of the Focus Group Discussion among the clients currently availing of the health services, the following were elicited:

On Accessibility. The health facility may not be near to their residence but it is the only facility where they can avail of services.

Although the district hospitals are government funded, it does not ensure that services are free. The patients still claim that they still have to shell out money for their hospitalization.

On Availability of services. Laboratory services for Complete Blood Count and Urinalysis were not available in the RHU as these are being done in the district hospital except for one Municipality wherein such services are available.

The study also revealed that drugs are available in the facility but there are instances when there is lack of supply so they have to buy medicines from drugstores.

In the district hospitals, the patients can utilize their PhilHealth membership to pay for their medicines but non-PhilHealth members have to pay their medicines and services before discharge. In one district hospital, they can replace the medicines they have been given.

It is also elicited that consultations are done on a daily basis at the RHU except in instances that the MHO is not around due to training, seminars, and for other reasons. In this case, clients are not seen by a doctor in the facility. This is due to the existence of only one MHO per RHU. However, the nurse and midwives still provides immediate care to the patient.

It is also worth noting that one municipality has added an MHO in order to solve the unavailability of the doctor.

Furthermore, the clients' waiting time is dependent on the number of clients seeking consultation that day. When asked if they were made to wait merely because the staff are writing or transferring notes, doing reports or other tasks not directly related to patient care, almost all the respondents answered yes but it is worth noting that one client said in one of the facility that one client stated that she is waiting for more than four hours just for a doctor to see her sick child. The reason could be the number of health care provider in those mentioned service delivery places and the variety of activities they have in their respective areas.

On Provision of Care. All of the respondents answered that the RHU personnel showed mastery and expertise in doing their work. However, they claimed that they did not assure privacy and confidentiality of given information at all times.

They also claimed that they explained the effects of some of the drugs but not the side effects of their medicines

This is may be similar to the study of Melesa et al. (2014) that clients were not satisfied with the provision of information about the hospital services and their health problems.

On Health Personnel-Client Interaction. The clients claimed that the personnel treated them well. However, one client answered that she did not feel welcome when she entered the RHU premises but would not elaborate.

Choices and options regarding patient's care were not also given. This may be attributed to the way the health personnel examined the clients wherein they don't spend enough interaction to discuss patient's conditions and available care.

In general, the clients expressed their satisfaction on the services provided. Suggestions were made largely on availability of free medicines, laboratory services, reduction of waiting time, improvement of facilities such as comfort rooms and ventilation in the hospitals.

Aspects related to providers' technical competence during consultations including further information on why the patient had sought consultation, supplied with a description of the nature of the health problem, offered choices on management of patients' illness, detailed explanation on the effects, and side effects of the drugs, a thorough physical examination had been conducted and an advice had been offered and respect for patients' privacy were not rendered to the clients.

CONCLUSIONS

In terms of good governance and stewardship, the different RHUs and district Hospitals performed at an average level. While on health service delivery, there is a shortage of human resources for health, particularly doctors, in almost all the RHUs and district hospitals. However, the limited number of nurses and midwives is compensated by the presence of contractual and volunteer nurses and midwives of the DOH Nurses Deployment Program and Registered Midwives. With respect to finance and resource generation, the health facilities were rated very low. The health workers rated themselves in their attitude and behavior towards their dealings with their clients as "Moderate". In general, the clients expressed their satisfaction on the services provided. Suggestions were made largely on availability of free medicines, laboratory services, reduction of waiting time, improvement of facilities such as comfort rooms and ventilation in the hospitals.On aspects related to providers' technical competence during consultations including further information on why the patient had sought consultation, supplied with a description of the nature of the health problem, offered choices on management of patients' illness, detailed explanation on the effects and side effects of the drugs, a thorough physical examination had been

conducted and an advice had been offered and respect for patients' privacy were not rendered to the clients.

RECOMMENDATIONS

Based on the conclusions drawn, the following recommendations are forwarded for consideration:

1. Leadership and Good Governance in Health. In terms of managerial structure, the DOH and the LGUs may converge their efforts to ensure that the program and policies are implemented and objectives are reached through improved coordination across local health systems. The management structure is expected to account for the monitoring and implementation of the national, regional and local levels. The health facility with the involvement of the civil society should be empowered through participatory form of governance to identify its own priority projects basing from the health needs of their clients;

2. Capability of Health Personnel. The Provincial and Local Government Unit through the initiative of the health facility should continuously assess the competencies of their health workers and develop their personal and professional competencies through seminars and training programs. Focus should be done on health promotion and disease prevention to decrease the number of clients having illnesses especially on life-style related diseases;

3. Health Regulation. The approach should focus on the supply and demand of the health facilities. A harmonized and streamline system and process should be implemented for a more rational and client responsive health regulation;

4. Health Financing. To secure more, better, and sustained investment in health to provide equity and improve health outcomes, especially the poor, this can be carried out through revenue-generating initiatives, efficiency in mobilizing investments, performance-based financial system, and further strengthening of the National Health Insurance Program by expanding enrollment coverage, improving benefits and leveraging payments on quality of care.

5. Health Service Delivery. The Rural Health Unit should maintain occasional hours during evenings and weekends to accommodate clients who are unable to consult or visit during regular clinic hours. The facility should provide services

during non- traditional hours at least once per month, considering clients who may not be available during regular office or work hours. For hospitals and clinic hours, services, and the whereabouts of staff should be posted in strategic area readable by all clients and service providers. Client waiting time must be as brief as possible. They should be seen by health staff within 30 minutes of registration. The LGU may take into consideration its population and health worker ratio in order to meet the needs of its constituents. Furthermore, the improvement of the physical infrastructure focusing to meet the growing population of the province should be prioritized to ensure efficiency and effectiveness of services;

6. On the Quality of Health Service Delivery, health workers should be client centered by exerting effort to explain and understand patient's concern even when they cannot be resolved as it results to decrease in anxiety. Greater participation by the patient in the encounter improves satisfaction, compliance, and outcome treatment; and

7. A follow-up study using other variables and a more in-depth analysis should be undertaken.

LITERATURE CITED

Acas, M. L. (1999). *Health Services in the Tertiary Provincial Hospitals of Region I: Five Years Before and During the First 5 Years of Devolution*. Unpublished Doctoral Dissertation, UNP.

Anagaran, et al. (2010). *Functionality of the Municipal Health Board in the Advocacy of Pulmonary Tuberculosis Control Program in Selected Municipalities of Ilocos Sur*. Unpublished Undergraduate Thesis, University of Northern Philippines.

Banan, V. M. (2003). *The Comprehensive Agrarian Reform Program in the Province of La Union*. Unpublished Dissertation, University of Northern Philippines.

Canawati. Retrieved from http://www.upd.edu.ph/-surp/about_surp/2003-canawati.pdf

Chaisorn, C. (2006). *Assessment of the Community Radio Program in Thailand*. Unpublished Dissertation, University of Northern Philippines.

Classification of Provinces and Municipalities in the Philippines. Retrieved from http://www.zamboanga.com/z/index.php?title=Classification of_Provinces%2C_Cities%2C_and_Municipalities_in_the_Phil

Dorotan, E., & Mogyorosy, Z. (2005). *Making Your Local Health Sytem Work*, A Resource Book on the Local Health System Development.

Inspection Tool for Level 1 Hospitals. Retrieved from www.doh.gov.phil

Laolakha, S. (2008). *Assessment of the Community Hospitals in Chainat Provine, Thailand*, Unpublished Dissertation, University of Northern Philippines.

Lee, R.B., Nacionals, L.P., & Pedroso, L. (2009). The Influence of Local Policy on Contraceptive Provision and Use in Three Locales in the Philippines, *Reproductive Health*.

Melese, T., Gebrehiwot, Y., Bisetegne, D., & Habte, D. (2014). Assessment of client satisfaction in labor and delivery services at a maternity referral hospital in Ethiopia. *The Pan African medical journal*, 17.

National Health Plan. Retrieved from www.doh.gov.phil

Provincial Health Office. (2009). Field Health Services Information System Annual Report, Ilocos Sur

Provincial Health Office. (2010). Field Health Services Information System Annual Report, Ilocos Sur

Provincial Health Office. (2011). Field Health Services Information System Annual Report, Ilocos Sur

Provincial Health Office. (2012). Field Health Services Information System Annual Report, Ilocos Sur

Quality Assurance Program Benchbook Philippine Health Insurance Corporation, pdf. (n.d.). Retrieved on November 25, 2013

Quality Standard List for Rural Health Units. Retrieved from www.doh.gov.phil

Quality Standard List for District Hospitals. Retrieved from www.doh.gov.phil

Manual of Procedures for Hospitals. Retrieved from www.doh.gov.phil

Valdez, L.G. (1999). *Comparative Effectiveness of the Zanjeras and the NIA-Participatory Approach program in Ilocos Norte*. Unpublished Dissertation, University of Northern Philippines.

World Health Organization. (n.d.). WHO_MBHSS_2010Section1_web.pdf

World Bank. (2011). *Philippine: Study on Local Service Delivery*. Retrieved from http://openknowledge.worldbank.org/handle/10986/12469 on December 15, 2013