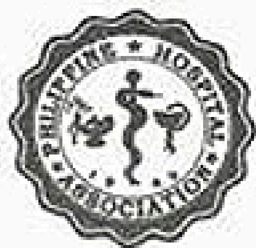

Philippine Hospital Association

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May 19, 2015

HONORABLE JANETTE P. GARIN
Secretary
DEPARTMENT OF HEALTH

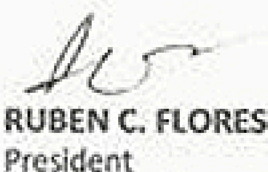
Dear Hon. Secretary Janette P. Garin;

As you are well aware of by now, the issues surrounding AO 2012-0012 have resulted to some amount of agitations among hospitals. Not all hospitals are similarly situated. While others reluctantly complied substantially, there are many who, much as they wanted to, could not do so within the time frame set. This even with the moratorium that will be expiring in August 15, 2015. As the deadline nears, the cries have consistently escalated wherefore, out of despair, there are talks of employing measures that can be interpreted as confrontational. In the case of the Philippine Hospital Association, it opts to take the more sober approach of engaging those concerned in productive dialogues.

The nation-wide roadshow-dialogues conducted by the BHFS with hospitals recently should confirm the points we raised in our position paper.

It is for this matter that PHA, in behalf of its member-hospitals, respectfully reiterates its position on the matter as attached to this letter.

Respectfully yours,



RUBEN C. FLORES
President

Received by:
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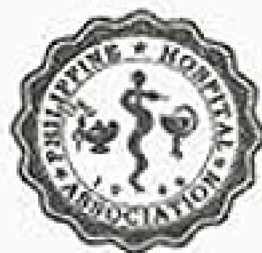
19 MAY 2015



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May 19, 2015

RE: POSITION PAPER OF PHILIPPINE HOSPITAL ASSOCIATION ON HOSPITAL RECLASSIFICATION

The problems and debates on Hospital reclassification are not the reclassification per se but stem from the downgrading of capability and incomplete payment by Philhealth and the imposition of additional requirements by BHFS that are found to be unsuitable by the majority of the PHA member-hospitals such as:

1. Restricting the ***relative unit value*** of a case that a hospital level can perform.
2. ***Incomplete reimbursement*** for Infirmary institutions by Philhealth.
3. ***Unequal case rate*** payment between different level of Health care institution
4. Mandatory requirement for a ***Dental Clinic*** in the hospitals.
5. Excessive requirement of ***Medical Technologists*** manpower in secondary level Laboratory and tertiary level ;laboratories.
6. Mandatory requirement of ***Masters of Hospital Administration (MHA***) degree for hospital administrators.
7. Mandatory requirement of ***Teaching and Training capability*** for a hospital to be qualified as level 3 Hospital
8. Mandatory requirement for a ***Hemodialysis*** for level 3 hospital
9. Requirement of ***ambulatory Surgical clinic*** for a level 3 hospital.

Our Position on the issues are as follows:

1. We agree that an ***operating room*** is necessary for a health institution to be called a hospital. Therefore nomenclature change is legally correct.
2. ***No downgrading of Capability***. The reclassification is only on nomenclature. The reclassified hospital did not lose any capability from what they were capable of. One example is secondary level hospital that was reclassified to level 1 hospital. This hospital can still perform the same intestinal surgeries (RVS 200 and above)that it used to do despite the reclassification. Philhealth should not look at the imperfect classification but on the capability of the institution for the kind of operation that it can perform
3. Infirmary / Primary Health Care Institution should ***be paid the whole reimbursable amount*** and not only 70%.
4. The ***case rate payment*** of Normal deliveries should be the same regardless on whether the procedure was done in a birthing home or in a hospital.
5. ***Dental clinic*** for hospitals should be optional based on need of the community (dental clinic to population ratio). If DOH insists on requiring dental clinic in hospitals then the services should be reimbursed by PHIC. Dental Care is as important as renal, cardiac, intestinal or pulmonary care. Good Dental health is the first requirement for good

nutrition and good nutrition is a requirement to good health. But there is an excess supply of dentist and dental clinics in most communities that the mandatory requirement for installation of a dental clinic in a hospital is inordinate.

6. The requirement of one ***Medical technologist*** per Laboratory Department (5 Depts in one Lab) per shift would need a minimum of 15 Medtechs (3 shifts x 5) to be compliant to operate a secondary level laboratory. This is not only impossible, given the low number of Graduates in Medical technology in the country, but also non feasible because it actually need at least 300 bed capacity hospital to provide work and pay for the salary of such a big number of Med Techs. Moreover it is not necessary because the new Laboratory machines are user friendly and does not require specialized skill. The time needed to perform lab procedures are significantly faster than older technology. One medtech can do multiple task so that one (1) medtec per shift (3 medtechs/ 24 hours) should be enough for a 100 bed or less hospital.
7. Requirements for a ***Masters of Hospital Administration (MHA***) degree for hospital administrators should be applied prospectively. This is because no study has ever been made to prove that an experienced administrator without MHA degree is less than capable to run a hospital than an MHA degree holder. In fact, compliance to the Guidelines in the Benchbook provided by Philhealth should be enough for effective administration and provision of quality hospital care by an administrator who is a non MHA degree holder. Prospective application of the requirement is just and reasonable for the present Hospital Administrators who do not have time and opportunity to go back to formal schooling. Status Quo is hereby requested for present administrators who cannot find time , energy and opportunity to go back to school.
8. ***"Teaching and training capability"*** is a special function (not the main function) of a hospital. Therefore a hospital with teaching and training capability should be given a special Classification. we suggest the following terms:

Level III - Non Teaching Non Training /Service Hospital

Level III - Teaching And Training Hospital

9. The ***"Dialysis clinic"*** requirement in a tertiary hospital should be deleted because dialysis clinics can be established even outside of a hospital. Even a level one hospital can put up a Dialysis Clinic. The construction is dictated by "need" in a catchment area. Therefore, it is not a "must have " capability of a level 3 hospital. This should be considered as "other services" which has a bearing only as an additional capability but not a requirement for purposes of classification.
10. ***"Ambulatory Surgical clinic"*** requirement for a level 3 hospital should be deleted for the simple reason that any operating room (therefore any hospital) can perform ambulatory surgery. This will all dependent on the case requirement and/ or the wish of the patient. Even a non hospital health institution can put up an "ambulatory surgery clinic". This should be considered as "other services".
11. The ***Moratorium*** given for the hospitals to upgrade their facilities will end on August 15, 2015. Many infirmaries were able to upgrade to level 1 classification but others are still in the process. We hereby appeal for the extension of the Moratorium for a period of atleast one (1) year. Favorable action on this appeal will result to better implementation of "Universal Health Care"..

The nation-wide roadshow-dialogues conducted by the BHFS with hospitals recently should confirm the points we raised.

It is our prayer that the foregoing shall be given utmost consideration.

Thank You.

JAIME ALMORA
Head-PHA TASK FORCE DOH

JESUS JARDIN
Head-PHA TASK FORCE PHIC