Where Have All the Patients Gone?

Dr. Roland Garcia is a young, newly licensed physician who was accepted for a tenured position in the local health department of the highly urbanized city of San Antonio. This was Garcia's first job; he was assigned to work in one of the city's 14 community health centers as a primary care provider, program manager, and health facility supervisor. In this capacity he had to ensure delivery of basic health services to a catchment population of 25,000 distributed in 10 villages; manage more than 50 local and national preventive, promotive and curative health programs; and oversee the work of 10 professional health staffers and another 20 volunteer health workers.

Three months into his new job, Garcia was confronted with a dilemma. He only saw about 20 patients daily, and his quarterly service coverage was below the target set for his unit, despite these services being offered for free most days of the week. While funding for health services was assured for the rest of the year, Garcia was aware that low program performance would reflect on his capacity as a health facility administrator, and would affect his prospects for tenure and promotion.

And so Garcia pondered how he should address his dilemma.

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San Antonio — A City of Contrasts

San Antonio City was a highly-urbanized city located in the capital region of the Philippines. It had a population of 392,869 distributed over 201 *barangay* (villages), and had a total land area of 18.50 square kilometers.[1] The city was known for its entertainment establishments, with a significant portion of the area's tourist attractions located in the city. San Antonio City's relative affluence — as could be gleaned from the many shopping centers, business-entertainment complexes, and high-rise buildings occupying more than half of the city's land area — allowed for a certain level of fiscal autonomy, with the local government able to provide funding for provision of basic services.[2]

The presence of many business establishments located in San Antonio City, coupled with the strategic location of ports for air, land, and water transport within the city, had attracted migrants in the city, resulting in the growth of pockets of informal settlements housing minimum-wage earners, the largest of which were those located along the two minor rivers.[3]

San Antonio City Health Department

The presence of the double-burden of disease — high illness and death from both infectious and lifestyle diseases — was present in the statistics reported by the San Antonio City Health Department. Over the years, tuberculosis and diarrhea ranked along with cancer, hypertension, and diabetes as the leading causes of morbidity and mortality affecting the population of San Antonio City.[4]

In recognition of this, San Antonio City had strengthened the delivery of basic preventive, promotive, and curative health services through its front-line cadre of professional and volunteer health workers strategically deployed in the city's 201 villages.[5] Through 14 community health centers, San Antonio City ensured that residents, especially the urban poor, could access free consultation, vaccination, prenatal care, nutrition monitoring and intervention, dental services, laboratory services, and disease prevention and control services.[6]

The management of health programs was lodged under the San Antonio City Health Department with technical and policy support from the Department of Health and other partner agencies. The department was headed by the city health officer, who was a tenured senior physician appointed by the city mayor. He was assisted by a team of supervisors representing the different professions (e.g., physicians, dentists, nurses, midwives, pharmacists, and medical technologists). Together, they facilitated the implementation of national and local health programs provided through the various community health centers.

Battleground: Area 5 Health Center

Area 5 Health Center, located in the area of one of the urban poor settlements in the city, was where Garcia was first assigned after being accepted in the local health department. The catchment area was comprised of the surrounding 10 villages with a total population of 25,000; 75% of these belonged to the urban poor. It was the only health facility in the area, with the next nearest facility — a private clinic — located in the neighboring district.

Like other community health centers in the city, Area 5 Health Center was tasked with the provision of basic promotive, preventive, and curative services to its area Monday through Friday, from 8 am to 5 pm (**Exhibit 1**). It was headed by a physician (Garcia), who was supported by 10 staff divided into three

functional groups: medical services (this was headed by Nurse Valeriana Santos, who was, in turn, assisted by three midwives); dental service (only one dentist was assigned in the health facility); and laboratory services (a medical technologist worked with a laboratory aide). In addition, 20 volunteer health workers — lay people trained in basic healthcare delivery — augmented the workforce of the health center (**Exhibit 2**).

Exhibit 1

Services offered by Area 5 Health Center

Maternal, Newborn, Child Health and Nutrition Services	Disease Control Services	Ancillary Services
• Prenatal consultation • Tetanus toxoid immunization • Iron and folic acid supplementation • Screening for sexually transmitted infections • Postnatal consultation • Iron and folic acid supplementation • Family planning • Newborn and child health • Newborn screening • Immunization • Growth monitoring • Care of sick infant and child • Nutrition • Nutrition counselling • Infant and young child feeding • Micronutrient supplementation • Supplemental feeding	• Communicable disease control • Diagnosis and treatment for tuberculosis, dengue, leprosy, sexually transmitted infections (including HIV), and soil-transmitted helminthiasis • Surveillance for vaccine-preventable diseases and other diseases of public health importance • Non-communicable disease control • Screening, diagnosis, and treatment for diabetes, hypertension, kidney disease, and stroke • Advice on smoking-cessation	• Dental services • Prophylaxis, including provision of fluoride to target population • Curative services, including tooth extraction and filling • Laboratory services • Blood typing • Complete blood count • Urinalysis • Fecalysis • Sputum microscopy • Environmental sanitation • Vector control • Water quality examination • Issuance of certificates for food establishments and to food handlers

Source: Philippine Department of Health. "2011-2016 National Objectives for Health. Health Sector Reform Agenda Monograph No. 12." 2011. Accessed 8 Sept. 2015. <http://www.doh.gov.ph/sites/default/files/7%20Chapter5.pdf>.

When Garcia first arrived at the health facility, he was welcomed by Santos, who was the most senior person in the area at that time. She gave Garcia a briefing on the health status of the communities under the jurisdiction of the health center, and offered a walk-through of the existing procedures and protocols in place at the facility. Garcia's first impression of Santos was that of a strong-willed woman who knew her stuff, which was to be expected given her length of experience in the community. Other health workers often joked around that Santos could literally be considered one of the pillars of the health center, having witnessed its conversion from a single-room wooden structure into its bungalow-type, multi-room concrete form.

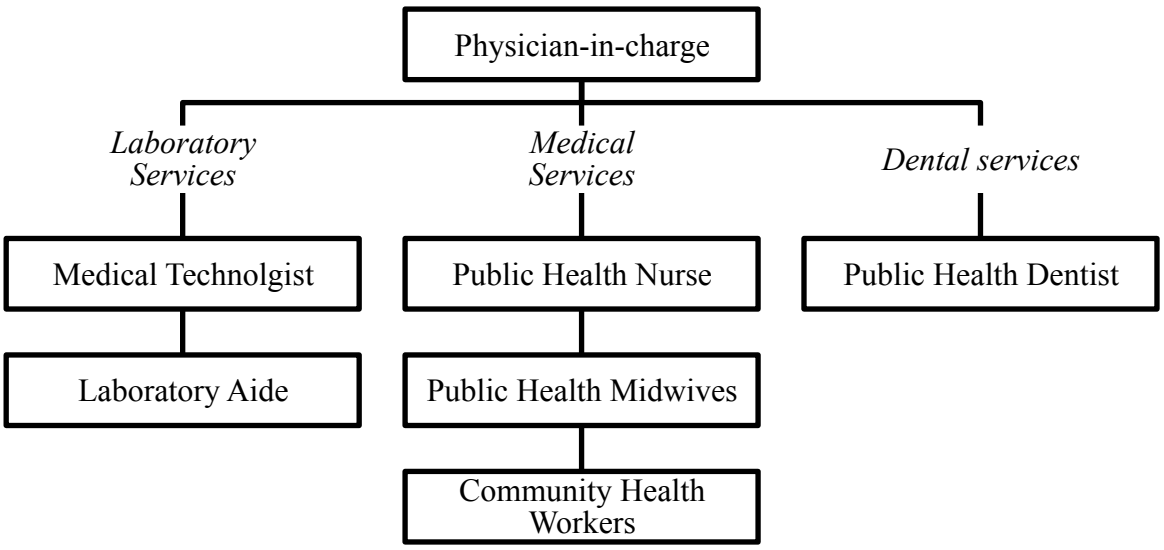
Garcia also somewhat expected this of Santos as, during his orientation, he was told that the second-in-command in any of the city's health center was the nurse. While physicians provided the

general direction in the implementation of programs and projects, the nurse was expected to operationalize it. Thus, Garcia felt relieved of some of his initial anxiety given his inexperience.

On his third month on the job, Garcia was surprised when he reviewed their patient census for quarter, and found that he was seeing, on average, only about 20 patients per day. This was far from the reported hundreds of patients who were traveling to community health centers daily because they could not afford to pay out of pocket for basic health services in private clinics. Stated another way, a facility staffed with 10 health workers was catering to only about two patients an hour for a regular working day.

Exhibit 2

Organizational Chart of Area 5 Health Center



Source: Created by the author of the case.

This situation also had an impact on the health center's performance. As part of a national effort to ensure the delivery of basic health services especially to the poor, provision of services was routinely monitored on a quarterly basis to find out if the target population was being served adequately. Overall, Area 5 Health Center was only reaching about half of the expected figures for the quarter (**Exhibit 3**), for example, on average, only about half (or less) of pregnant women were receiving prenatal care, and roughly the same number of infants were being given vaccines.

Garcia immediately convened a meeting with his professional staff to discuss the situation, and their general response was that this was the level of performance of the health facility for the past several years. They contended that this was evidence that the community was either generally healthy, or that most of the residents preferred to receive care from a private practitioner. Garcia, however, felt otherwise as he knew that his catchment center was an urban poor settlement. While consultation in the lone private clinic in his area cost less than a dollar, this amount still meant much for poor families and also did not cover medicines and diagnostic services. Thus, the argument that people preferred the

private provider had no basis. In addition, to say that the people in the area were generally healthy was not supported by reports received from hospitals indicating that people in Area 5 were being hospitalized for cases such as dengue, diarrhea, and pneumonia.

Exhibit 3

Performance of Area 5 Health Center for Selected Health Services

Performance indicator	Target[7]	Accomplishment
Proportion of pregnant women who had four or more prenatal visits	90%	53%
Proportion of pregnant women given at least two doses of tetanus toxoid	80%	36%
Proportion of pregnant women given complete iron and folic acid supplementation	80%	56%
Proportion of post-partum or lactating women given vitamin A supplementation	80%	47%
Proportion of married women age 15 to 49 years who were using (or whose partner was using) any modern family planning method	65%	11%
Proportion of infants who received one dose of BCG, three doses each of OPV and Pentavalent vaccine, and one dose of measles-containing vaccine before reaching one year old	90%	59%
Proportion of infants exclusively breastfed from birth to six months of age	60%	37%
Proportion of sick children given vitamin A capsule	100%	27%

Source: Created by the author of the case.

Resolved to get to the root cause of the problem, Garcia scheduled meetings with leaders of the community in Area 5 to seek their feedback. He wanted to refer to customer satisfaction surveys, but this mechanism was non-existent in his facility.

After two weeks of talking with community leaders and officials, Garcia was beginning to appreciate why service utilization in his health facility was low.

First, he was told that patients were confused as to the hours of operation of the health facility. When Garcia responded that his center was open during regular office hours, he was told by members of the community that there were times in the past when they lined up very early only to be told that consultation would begin at 10 a.m. as the physician was coming in late, or that children brought in for immunization would have to come back another day as the nurse assigned to provide vaccines called in sick.

Second, waiting time was excruciatingly long, with some patients staying in the facility for about three hours to obtain the service they required. This was especially difficult for parents who had to fetch children from daycare or had to cook dinner for children coming from school.

Finally, even though the facility was small, navigating it was difficult for most patients. They did not know who to approach first or where they should proceed after being registered for the day. And even when they already had their queue number, knowing when they were called and where to proceed was also not clear.

Conclusion

Garcia sat in his office, thinking about what to do. Clearly, the contention of his staff that low utilization of their health services only pointed to either a healthy or an affluent population were both incorrect. His rounds in the community highlighted three problems with service provision that were affecting the patient's experience of care in the community health center.

There were two interrelated products of this dilemma. As a public institution, Garcia felt that his facility was not being responsive to the needs of its constituency. On the other hand, low service utilization could result in a poorer health status for the population.

Garcia also realized that his public health facility's failure to attain its service targets would have an effect not only on his own, but the entire professional staff's opportunities for retention and promotion. Comparing notes with other physicians, he found out that his health center was among the low-performing health facilities in the city in terms of coverage for essential health services.

Garcia knew he needed to resolve the issue, he just did not know how.

Endnotes

1 Philippine Statistics Authority. “PSGC Interactive: Pasay City.” Makati City: Philippine Statistics Authority. 1 May 2010. Accessed 8 Sept. 2015. <http://www.nscb.gov.ph/activestats/psgc/municipality.asp?muncode=137605000&regcode=13&provcode=76>.
2 Pasay City Public Information Office. “Pasay is 2nd nationwide in local revenue collection efficiency.” 13 April 2013. Accessed 8 Sept. 2015. <http://www.pasay.gov.ph/News/04-13-2013.html>.
3 Galing Pook Foundation. “Best Practices in Local Governance 2006: Harnessing the Family for the MDGs. Pasay City, Philippines.” 2006. Accessed 8 Sept. 2015. <http://unpan1.un.org/intradoc/groups/public/documents/eropa/unpan029100.pdf>
4 Pasay City UHDS Project TWG. “City-wide Investment Plan for Health 2010-2015.” 2010.
5 Galing Pook Foundation. “Best Practices in Local Governance 2006: Harnessing the Family for the MDGs. Pasay City, Philippines.” 2006. Accessed 8 Sept. 2015. <http://unpan1.un.org/intradoc/groups/public/documents/eropa/unpan029100.pdf>.
6 Pasay City UHDS Project TWG. “City-wide Investment Plan for Health 2010-2015.” 2010.
7 Department of Health. “Field Health Service Information System Indicator Metadata.” 2013.
8 Department of Health. “2011-2016 National Objectives for Health. Health Sector Reform Agenda Monograph No. 12.” 2011. Accessed 8 Sept. 2015. <http://www.doh.gov.ph/sites/default/files/7%20Chapter5.pdf>