

# How budgeting practices on health-care equipment may fail government hospitals

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**N**ow that there are more poor Filipinos covered under the National Health Insurance Program, the expectation is that government hospitals must be ready to respond to the increasing demand for health services. One of the many ways of looking at hospitals' capability to deliver the needed health-care services is to assess what goes into hospitals' planning and budgeting processes.

This *Policy Note* takes a sneak peek at a small section of hospitals' budget: their capital outlay (CO)—specifically, equipment used directly in health-care service delivery—and how the current accounting process is a reflection of the state of government hospitals. Results are from a survey and a focus group discussion (FGD) with six local

government unit (LGU)-managed hospitals and two Department of Health (DOH)-managed hospitals conducted in the study “Analysis of the maintenance and depreciation costs of selected government hospitals” (Banzon et al. 2014).

## **Sources of government hospitals' budget**

In the Philippines, public hospitals are classified as either DOH- or LGU-managed hospitals.

The DOH currently funds and manages DOH-managed hospitals across the country. Based on the General Appropriations Act (GAA), which is approved by Congress each

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The authors are consultants of PIDS. The views expressed are those of the authors and do not necessarily reflect those of the PIDS or the DOH.

### Terms at a glance

Capital outlay (CO) – money used to either buy a fixed asset such as property, plant, and equipment, or to extend its useful life.

Internal revenue allotment (IRA) – funds allocated by the national government to a local government unit.

General Appropriations Act (GAA) – law that sets, among others, the Philippine government’s operating budget for each year.

Maintenance and other operating expenses (MOOE) – refers to expenditures to support the operations of government agencies such as expenses for supplies and materials; transportation and travel; utilities (water, power, etc.) and repairs, etc.

Depreciation cost – the straight-line depreciation method is used in calculating the costs of depreciation of property, plant, and equipment.

year, appropriations are released directly to DOH-managed hospitals. Such may also be augmented by suballotments from the DOH Central Office, hospital revenues, or net income from the Philippine Health Insurance Corporation (PHIC) reimbursements and user fees, and other special purpose funds (Lavado et al. 2010a).

Meanwhile, LGU-managed hospitals are managed at the provincial and city/municipal levels by their respective local chief executives, as mandated by the Local Government Code of 1991 (Herrera and Roman 2010). Funds for LGU-managed hospitals are sourced from the internal revenue allotment (IRA) and from the provinces’ and

municipalities’ funds and net income. They also receive transfers from the DOH and PHIC in the form of cash, hospital reimbursements, and capitation funds (Lavado et al. 2010b).

An income retention policy is deemed critical for the upkeep of hospital infrastructure and equipment. Since 2003, DOH-managed hospitals have been allowed to retain their income, of which at least 25 percent should be allocated to the purchase and upgrade of hospital equipment used directly in service delivery, while 75 percent may be used to cover for maintenance and other operating expenses (MOOE) and CO for other infrastructure and equipment.

No such blanket policy for income retention, however, holds for LGU-managed hospitals. While some LGUs have created special/trust funds that allowed their hospitals to retain income, most still pool hospitals’ revenues in a general fund without any guarantee that the money will be plowed back into the contributing hospitals (Herrera and Roman 2010).

Table 1 summarizes how government hospitals deal with their capital assets.

### *Existing budgeting practices of LGU- and DOH-managed hospitals*

At the level of government hospitals, findings from the FGD include the following:

- The use of historic budgeting, where a budget ceiling persists, largely influences budget preparation and planning.

- Budget preparation and planning, the most critical stages of the budget cycle, are highly steered and influenced by the hospital administration. Worse, because of poor data management and data utilization, arbitrary data are resorted to during these important budgeting stages.
- When budgeting, expenses for salaries and wages for personnel services are given the utmost priority. Thereafter, the remainder of the budget is allocated to other operational expenses of the hospitals.
- Based on the income retention policy, DOH-managed hospitals are given the flexibility to use a fourth of their income to fund capital investment. However, because the national government's GAA funding is claimed to be insufficient to cover for the personnel services and MOOE, the allowed 25 percent of hospitals' income is almost never spent on CO.
- In both types of hospitals, CO is not a permanent line item in the budget plans and instead is funded on a "as-needed basis" where no system is in place to objectively determine the authenticity and urgency of the needed capital asset. This subjects the funding for CO to political whims, as in the case of most LGU-managed hospitals.
- The selected government hospitals in this study complied with the standards set by the oversight agencies in relation to budgeting practices (such as the budget cycle and schedule, documentary requirements, and prescribed methods). However, they were only successful in standardizing the administrative side of budgeting, but sorely failed to address the technical aspect that could have made

**Table 1. How government hospitals deal with capital assets for health care**

Factors	DOH Hospitals	LGU Hospitals
Decisionmakers for funding of CO	Congress that approves the GAA	LGU's chief executive
Income retention policy	May retain at least 25% of their income for the purchase and upgrade of hospital equipment	Do not follow any blanket policy for income retention
CO as a line item in budget plans	CO is not a permanent line item in the budget plan	CO is not a permanent line item in their budget plan
Technical aspect of budget planning for health	Low	Low. Prescribed budget allocation is almost never met in terms of percentage of the IRA allotted for health
Existence of maintenance program for capital assets	None	None
Responsible for computing capital assets' depreciation costs	DOH-managed hospitals compute their own depreciation costs	Accounting office of the LGUs, not of the hospital, does the computing

Source: Summarized from Banzon et al. (2014)

budget planning and execution effective and efficient.

- For LGU-managed hospitals, the prescribed budget allocation (in terms of the percentage of the LGU's IRA for health) is almost never met.

#### *Maintenance and depreciation costs*

Based on how the Commission on Audit (COA) categorized capital assets, maintenance and depreciation costs are divided into three types: (1) building and physical plant (includes office building, hospital, health center, and other structures); (2) equipment and instruments (includes specific equipment



*DOH-managed hospitals have been allowed to retain their income, of which at least 25 percent should be allocated to the purchase and upgrade of hospital equipment used directly in service delivery. (Photo from the Health Systems Research Management Project of PIDS and DOH.)*

under office, equipment, furniture, and fixtures, machineries and equipment, and transportation equipment); and (3) other property, plant, and equipment.

*Maintenance cost.* The selected hospitals in the study did not report any method used to determine how to allocate the maintenance cost of their buildings, equipment, and other assets. Instead, a lump-sum budget is apportioned for the MOOE account, where the projected costs for repairs and maintenance are lodged, along with the following: traveling expenses, supplies

and materials expenses, utility expenses, communication expenses, etc. As hospitals use the historic budgeting method, the projection of the MOOE budget is based on previous budgets.

The COA does not have a prescribed method on the calculation of maintenance cost, neither does the Department of Budget and Management nor most accounting books. Thus, the definition of maintenance cost provided by Flessa (2009), who prescribes a standard maintenance cost of 5 percent of the original value of hospital buildings and equipment, is used to compute for the ideal maintenance cost and represented as a cost estimate.

Generally, hospitals have a very low budget utilization or actual expenditure for repairs and maintenance, with some reporting not to have spent anything at all for their maintenance. Their reported repairs and maintenance expenditure is only 0.17 percent to 2.58 percent of the budget for MOOE. The reported/actual figures are in no way near the standard cost of maintenance. In fact, the smallest difference between the actual and the estimate is seen in the case of one LGU hospital's maintenance cost for equipment and instruments, where the actual expenditure is merely around 50 percent of the standard cost.

Based on the actual hospital expenditures on repair and maintenance and results from the FGD, it can be construed that the selected hospitals do not have maintenance programs specific to their assets, especially the heavy equipment. While preventive and

corrective maintenance are included in the procurement of new equipment, the problem arises after the warranty period expires (where the supplier is no longer accountable for the maintenance of equipment).

*Depreciation cost.* Depreciation costs for the depreciable assets of LGU-managed hospitals are computed at the accounting office of the LGUs, except for one LGU hospital where a book on depreciation costs is produced monthly by the hospital. Meanwhile, DOH-managed hospitals compute their own depreciation costs.

Not all hospitals reflect depreciation in their financial report. It appears that the computations of depreciation costs are for mere compliance with COA rules and guidelines on accounting. Such failure to report the depreciation of capital assets overestimates the net income. This makes capturing the accurate costing of hospital services difficult.

Also, it takes some time for the list of depreciable assets to be transferred from the supply office to the accounting office for the depreciation computation.

All the selected hospitals reported that they have continued to use even the fully depreciated capital assets. Although hospitals are well aware of the protocol for handling fully dilapidated assets as stipulated by COA, the scarcity of resources compels them to continue utilizing these equipment until the

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latter have reached their operational limit and/or a replacement arrives. However, these do incur additional maintenance costs in terms of servicing the damage beyond their useful years and the replacement of their spare parts. Spare parts of outdated models turn out to be more expensive particularly when they are not easily available. In the end, health care is compromised by the obsolescence of the fully depreciated equipment.

All these confirm that depreciation costs are not being utilized as inputs to guide hospitals in capital management. For LGU-managed hospitals in particular, there is no incentive to track accurately the depreciation costs as they do not have control over the budget for capital expenditures. Meanwhile, DOH-managed hospitals give the least priority to funding for replacement and/upgrading of obsolete equipment despite the fact that they are required to submit their five-year development plan, including their anticipated CO or capital expenditure for the next five years.

### **Policy recommendations**

Decisions on what capital asset to buy or upgrade ought to depend on which one will give the highest profitability. Intelligent

investment decisions must also be based on numerical data from costing studies on accurate financial reports. This process is called *capital budgeting*. There are different methods used in capital budgeting but ultimately, these methods would have the same set of data requirements—acquisition cost and cash inflow from an investment, operating expenses, refurbishments, repairs, and maintenance costs.

Such process is not seen in the case of government hospitals, where the decision to fund CO lies outside the hospital administration. For LGU-managed hospitals, the decision lies with the local chief executive; for DOH-managed hospitals, their GAA is subject to the approval of Congress.

While DOH-managed hospitals have opportunities to propose their annual budget for CO based on a five-year development plan and operational expenses based on historical data, they may be constrained by budget ceilings. Often, not all proposed capital assets from the development plan end up being procured. Even a budget proposal that is tediously crafted and within the ceiling provided, and its need for CO duly justified, may still be either changed or disapproved during deliberations in Congress.

More appalling is the case of LGU-managed hospitals, where political personalities change often and is worsened by the hospitals' inability to retain their income. Thus, these hospitals, which do not have control over

their budget and CO, lack any incentive to go through thorough budget planning nor to aim for an effective and efficient budget utilization.

These are many ways that hospitals' lack of incentive can manifest itself. First, there is the poor data management and data utilization at the level of the hospitals. This is vastly observed in the quality of data retrieved by the hospital survey tool. Data required for capital budgeting are either unavailable, outdated, or in forms that are not readily usable. Hospitals do not give any premium on precision and accuracy in their data as most do not even have a digitized inventory of capital assets.

Second, how the budget is being used and what it pays are indicative of the budgetary system's failure to drive any improvement in government hospitals' performance. The budget allocated for hospitals is primarily an input-based payment where money flows to the physical resources of hospital operations—CO, personnel services, and MOOE, with personnel services being given the highest priority. In this condition, oversight agencies cannot oblige hospitals to perform because hospitals will ultimately argue that the budget allotted for their operations is barely sufficient. Government hospitals will settle with aiming to sustain hospital operations, instead of delivering the "promised" quality care.

In gist, the obvious recommendations here are: (1) to formulate the proper guidelines

and protocols for budgeting and maintenance of capital assets, including the adoption of a standard maintenance cost of 5 percent of the original value for hospital buildings and equipment and (2) to vigorously implement the New Government Accounting System *straight line depreciation method* in calculating the costs of depreciation of property, plant, and equipment.

However, beyond all of these are the policy recommendations on the following:

- *Capital investment fund.* It is easy for hospitals to be highly reliant on the government's Health Facilities Enhancement Program (HFEP)<sup>1</sup> for funding of their CO while they utilize their income to augment their budget for MOOE.

It is recommended instead that the DOH converts the HFEP into a long-term capital investment fund where access to the fund would require the submission of long-term capital investment plans with corresponding maintenance programs. There shall be a regular reporting system that would monitor and evaluate the effectiveness of the CO investment including financial, clinical care, and quality of care measures.

- *Public-private partnership (PPP) arrangements for hospital equipment.* Consider expanding existing hospital-specific outsourcing approaches in hospital diagnostics into a PPP scheme wherein a private partner will be brought in to invest in the hospital equipment of all DOH-managed hospitals for a defined period of time. The



*When budgeting, government hospitals give utmost priority to expenses for salaries and wages for personnel services. (Photo from the Health Systems Research Management Project of PIDS and DOH.)*

same PPP scheme can also be adopted by an LGU for all its hospitals. The private sector partner must be responsible for procuring and installing new equipment and for ensuring that there is preventive, corrective, and restorative maintenance of said equipment. Replacement/upgrade of obsolete equipment as well as “safety net” provisions on downtime will be part of the arrangement.

- *Output-based payment of DOH/other government hospitals.* To be able to demand quality health-care services from DOH-managed hospitals and other government hospitals, incentives must be in place. Linking money to performance by shifting from input-

<sup>1</sup> This is the former administration's program for the upgrading of health facilities. An evaluation of the program has been conducted by PIDS. For a summary of the results, see Picazo et al. (2016).

to output-based payment is an effective incentive. Through an output-based payment, funds become tied to predefined performance measures. The output needs not be limited to quantity outputs but should also include quality-based outputs such as improved recovery time of patients and responsiveness to patient needs.

Similarly, the global budget payment program (GBPP) should also turn PHIC's payment program into an output-based one. However, PHIC may have to review this program to ensure that the GBPP payment rates are able to cover the operational expenses and fund part of the needed capital investments of hospitals.

- *Improved data management and utilization.* Government hospitals should see the value of investing in information technology to make critical hospital operations, such as budgeting and financial management, more efficient. There is a need to digitize financial processes/workflows and data capture so as to make information readily accessible to decisionmakers. This will improve hospital management choices, particularly in financial management. 

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