

Assessment of the Effectiveness of Medical and Surgical Missions in the Philippines

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I. INTRODUCTION

Medical/surgical missions are temporary health care services, of short duration, usually given free to underserved communities by the initiating or sponsoring entity. This sponsor may be a government unit or agency, a government official, a private philanthropic individual or group, a private non-government and non-profit institution or even a for-profit institution that uses its resources for a philanthropic purpose. Foreign-based organizations also conduct medical/surgical missions. These missions provide medical, surgical and dental services or a combination of services such as medical/surgical or medical/dental care.

More than 30 years ago, missions were already being conducted by civic organizations, professional groups, non-government organizations (NGOs) and local politicians to provide health services to poor areas. No official document has been

found formally endorsing these missions. The earliest reference appears in Department of Health (DOH) Order No. 184-A, s.1988 on the National Medical/Surgical Outreach Program which aimed to enhance health care services in the countryside through a series of medical/surgical outreach nationwide. Medical and surgical teams from DOH Metro Manila hospitals would be sent to host provincial hospitals to render medical consultations and perform surgical procedures that cannot be routinely done locally. The impact of such policy, however, was never evaluated, and despite an absence of policy evaluation, missions have become more frequent through the years.

In 2000, DOH Regional Offices reported a total of 398 medical missions, except for Regions V, VI and XII that did not provide information (Table 1). Cagayan Valley and Central Luzon attracted the most number of missions, followed by Northern Mindanao and Southern Mindanao. Far-flung and poor areas such as the Cordillera Autonomous Region, Eastern Visayas and the Autonomous Region of Muslim Mindanao do not seem to attract as many missions, despite these missions' stated objective of reaching out to underserved areas. In 2001, a database of institutions and individuals with interest, mandate or capacity to conduct missions yielded 974 names, out of which 170 were identified to have actually sponsored a mission.

TABLE 1: Number of Medical/Surgical Missions Held by Region, 1999-2000

Region	Medical/Surgical Missions	Population (In Million)	No. of Missions Per Population
I – Ilocos	10	4.2	1 per 420,000
II – Cagayan Valley	95	2.8	1 per 30,000
III – Central Luzon	111	8.0	1 per 72,000
IV – Southern Luzon	36	11.8	1 per 328,000
National Capital Region	19	9.9	1 per 523,000
V – Bicol Region	6	4.7	1 per 779,000
VI – Western Visayas	12	6.2	1 per 517,000

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Region	Medical/Surgical Missions	Population (In Million)	No. of Missions Per Population
VII – Central Visayas	7	5.7	1 per 814,000
VIII – Eastern Visayas	5	3.6	1 per 722,000
IX – Western Mindanao	12	3.1	1 per 258,000
X – Northern Mindanao	32	2.7	1 per 859,000
XI – Southern Mindanao	29	5.2	1 per 179,000
XII – Central Mindanao	n.a.	2.6	n.a.
XIII – CARAGA	13	2.1	1 per 161,000
Cordillera Autonomous Region	8	1.4	1 per 171,000
Autonomous Region of Muslim Mindanao	3	2.4	1 per 804,000
Total	398	76.5	1 per 186,000

Note: Total figures in the second and fourth columns exclude Central Mindanao. Sources: RHO/Pahunungod Database, 1999-2000; National Statistical Coordination Board, May 1, 2000.

II. DESCRIPTION OF MEDICAL/SURGICAL MISSIONS

A. Rationale of Missions

Most mission sponsors aim “to provide community service” (28.4% of the respondents) or “to conduct medical missions” as part of their overall program (17.1%), according to the 2001 Institutional Survey undertaken by the Center for Economic Policy Research (see below for details). A few have mandates to promote the welfare of specific population groups such as soldiers, military veterans and their dependents. Still others undertake missions as part of their larger social-upliftment mandate or as part of the evangelical call. However, others are involved in missions only peripherally, their central mandate being education, research and extension and professional development, business and finance or some other rea-

sons. This indicates that almost any organized group can mount a mission, provided it has the wherewithal to do so.

Most missions are conducted “to alleviate the health problems of the poor” or “to reach out to the poor”. However, these objectives are often combined with other reasons, such as “to promote the goodwill of the sponsoring institution or “to execute a program with a nongovernmental organization in an outreach community”. A small but disturbing number of sponsors were not able to articulate the ultimate purpose of their mission. None of the respondents, however, admitted conducting missions for extraneous purposes such as promoting a product or political objectives.

Multipurpose missions such as medical/dental/surgical (37.1%) and medical/dental (35.0%) appear to be more frequently held, compared to single-purpose ones such as medical (5.6%), surgical (4.2%) and dental (2.1%) missions. However, in terms of patients’ perception, single-purpose missions seem to be more important than multipurpose ones.

Box A summarizes the key steps in planning, implementing and monitoring missions in the Philippines.

Box A – Key Steps in Planning, Implementation and Monitoring of Missions

A medical/surgical mission involves a complex set of activities that must be organized well to achieve its intended purpose. Ideally, the mission must be planned way in advance. Planning involves, among others: (a) Obtaining a formal request from the local government unit (LGU). (b) Inquiry from the DOH, the Professional Regulations Commission and local medical and related professional societies on rules and regulations governing missions. This is important if foreign doctors are involved. (c) Coordination with co-sponsors and other groups on their committed resources, e.g., personnel, drugs and other inputs. (d) Finalization of the mission date and announcement of the date to the local community. (e) Orientation of mission staff and volunteers.

The implementation of the mission itself involves: (a) Courtesy call to LGU or NGO hosts. (b) Physical exploration and assessment of the community and venue. (c) Organized registration and listing of patients. (d) Preassessment and identification of medical cases, patient screening and patient “clearance” for treatment. (e) Providers’ consultation and treatment of patients, including prescription and all necessary medical information that patients must do after the mission. (f) Referral to local doctors of surgical cases or patients who otherwise cannot be dealt with during the mission. (g) Medical and pharmacy recording and encoding of patients seen. (h) Provision of amenities (snacks) to patients seen.

Post-mission work usually involves: (a) Submission of patient lists and reports to government or NGO offices. (b) Financial liquidation of advances received or reimbursement of expenses incurred. (c) Post-assessment and follow-up of post-operative cases through feedback from district hospitals or local doctors on the referred cases. (d) General monitoring and evaluation.

B. Location, Duration and Frequency of Missions

Mission location is determined largely through consensus among mission sponsors (35.0%) or as an executive decision by the president, the executive committee, the social action director or the community extension service officer (25.9%). Although the sponsoring group invariably makes the final decision, the mayor/municipal council, the barangay chief/council or the rural health unit in the locality are usually consulted, although this is not a universal practice.

A mission sponsor may have a regular focus area to conduct missions, but this does not appear to be the rule. Rather, most mission sponsors (55.2%) reported conducting missions in different areas, depending on such key criteria as the needs of the beneficiaries and the request of the LGU. Among 143 respondents, 42.2% said they took into account the needs of beneficiaries, 24.5% said they responded to a specific LGU request and 12.4% mentioned area accessibility as an important consideration. These criteria are confirmed by barangay respondents who reported that the large population, the number of poor residents and inadequate medical

care in the barangay as the key factors in mission sponsors' choice of their locality. However, the barangay respondents also cited "LGU mandate" and "political considerations" as important determining factors.

Most missions are conducted on an annual basis (21.7%) or semi-annual basis (19.6%). Some sponsors do so as frequently as quarterly, monthly or 2-3 times a month, although not always in the same location. Others mount missions on a

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non-regular basis or as the need arises. Contrary to conventional wisdom, most missions do not occur during specific anniversaries, Christmas breaks or semestral breaks. Sponsors showed no preferred months or days to conduct a mission; timing is usually a function of the request of the LGU or the availability of resources, especially personnel. In most cases, however, missions occur at the height of the dry season, from March to June,

with April and May being the busiest months. Missions are usually held on weekends and may involve the Friday before or the Monday after.

Most missions are of short duration. A simple outreach to a sponsor's immediate vicinity or own locality may take half-a-day or one day at most, as for instance an urban hospital doing outreach work to a slum area. A major medical/surgical mission usually takes 2-3 days for a relatively accessible site. A remote site may take a week of mission work, with a significant amount of the time taken up by travel. In terms of venue, missions are usually held in the barangay or multipurpose hall, the health center, the school, the hospital, a covered court or the plaza.

II. EVALUATION STUDY OF MEDICAL AND SURGICAL MISSIONS

A. Objectives of the Study

In April 2001, the DOH's Essential National Health Research Program commissioned the Center for Economic Policy and Research (CEPR) to conduct a rapid assessment of medical and surgical missions in the Philippines. The increas-

ing frequency in the deployment of these missions as a health service delivery mechanism especially in underserved areas calls for objective information on whether missions are appropriate to the health needs of poor Filipinos, whether they are effective and whether they use resources well. Thus, the objectives of the study are: to describe the sponsors of missions and to build a typology of them; to analyze how such missions are operated by identifying their objectives, describing their mechanics and procedures, and establishing information on the costs they incur and the benefits they generate; and to assess their effectiveness by quantitative (resource use and costs) and qualitative means.

B. Methodology of the Study

The study involved desk research and primary data gathering. Desk research involved the analysis of the results of the survey of Ugnayan ng Pahinungod and DOH Regional Health Offices (RHO) on the occurrence of medical/surgical missions. The results of this analysis informed the subsequent surveys undertaken for this study, including the typology of mission sponsors and thus the sampling frame and the site selection. Individual names of institutions were downloaded from the mission sponsors' Internet websites or taken from the Commission on Higher Education or from specialty societies.

Subsequently, primary data were gathered through three surveys. On the basis of two criteria – number of missions conducted and the conduct of all three types of missions, i.e., medical, dental and surgical mission – four provinces were selected as survey sites: Cagayan and Zambales (in Luzon), Negros Occidental (in the Visayas) and Davao del Sur (in Mindanao). A random sample of barangays was selected from these provinces. The site visits were made from June to July, 2001. Table 2 provides a summary of the location and number of respondents of the three CEPR surveys.

Three inter-related surveys were undertaken. The CEPR survey of patient-beneficiaries generated information on the household profile mission beneficiaries, including socio-economic and demographic characteristics; the household's medical mission experience, including knowledge and actual use of mission services;

illness reported to these missions; patient compliance with mission provider's instructions; perceived improvement in health status after the mission; and problems encountered with the mission.

TABLE 2: Number of Respondents for the CEPR Surveys, 2001

<i>Province</i>	<i>Focus Barangays and Cities/Municipalities</i>	<i>Mission Sponsors' Institutional Survey (N=no. of institutions)</i>	<i>Patient-Beneficiary Survey (N=no. of households)</i>	<i>Barangay Survey (N=no. of officials and other key informants)</i>
Cagayan	Carig Norte, Tuguegarao	6	12	1
	Carig Sur, Tuguegarao		13	1
	Pussian, Alcala		21	2
Zambales	San Isidro, Castillejos	1	27	2
	Baloganon, Masinloc		27	2
Negros Occidental	Tabao Proper, Valladolid	1	20	2
	Isio, Cauayan		20	2
Davao del Sur	Mintal, Tugbok District, Davao City	2	20	2
	Sirawan, Toril District, Davao City		20	2
Others	Manila-based MSM Institutions, etc.	148	—	—
Total	8 barangays in 7 cities and municipalities	158	180	16

Source: This study.

The CEPR survey of sponsors of missions generated information on their institutional profile including name, contact address, institutional type, year of incorporation, mandate and institutional affiliation; mission activities including the type of

missions conducted; frequency of missions; rationale of these missions; institutional coordination and collaboration; location, timing and duration of the missions; mission operational policies and procedures; mission beneficiaries; the resources used in the conduct of these missions; and the problems faced by the institution in the conduct of missions.

The CEPR survey of municipal and barangay officials and medical practitioners generated information on the officials' knowledge of the operations of missions in their locality; their level of involvement in the choice of location, timing and venue of the missions; existence of local policies and procedures governing the conduct of these missions; general collaboration and participation before, during and after these missions; their perception on the beneficiaries of these missions; the resources used by the barangay in these missions; and the immediate benefits as well as long-term ripple effects of these missions on the locality.

C. Limitations of the Study

Respondents provided generally scanty data. Although the CEPR institutional survey generally received a good response rate from mission sponsors, data provided were not always complete. Only a few bothered to answer the sections on resource use and costs and on mission processes and procedures. The incompleteness of responses may be a reflection of poor record-keeping which, in turn, may be due to the lack of a systematic and regular reporting of mission work to a regulating or clearinghouse body. These institutions' poor process documentation may also reflect the absence of work standards that they are mandated to follow. Although the DOH has issued a department order on key aspects of mission work, the extent to which the order is being heeded is not known since enforcement capacity is weak, especially after health services were devolved to local government units.

III. KEY FINDINGS OF THE STUDY

The study's findings revolved around four key areas: (1) the immediate health benefits of missions, especially among the poor; (2) operational issues in the planning, implementation and monitoring of missions and the generally poor regulation

of these activities; (3) the large and often under-appreciated opportunity costs of missions; and (4) the potential negative ripple effects on the health system as a consequence of missions.

A. Health Benefits Among the Poor

Household Knowledge and Availment of Mission Services. True to their intention, missions mostly cater to the poor. The typical head of a household availing of mission services is a male, between 31-50 years old, who has at least finished high school. He is usually a laborer, a tricycle or jeepney driver or a farmer. Some household heads are so poor that they are completely dependent on other relatives. The typical household has an annual income of only P20,000 to P40,000, but the household is usually large with as many as 6-10 members. The crowding may explain the average household's proneness to contracting diseases, especially communicable ones. Around 15.6% of the household respondents said they had a household member who got sick during the last six months, usually from fever, flu, coughs and colds, asthma or a combination of symptoms.

Household respondents appeared to be knowledgeable about missions. Around 55.0% of them said the barangay health worker informed them of the mission, while 36.1% said it was the mayor or the barangay captain or other officials. Radio spots were also sources of mission information. Almost all (96.1%) beneficiaries reported availing of mission services in the last 2.5 years. Only 3.9% reported not availing, mainly because the respondent was not at home during the mission, or did not hear about the mission or did not have an illness.

Household knowledge about a mission and actual attendance varies by the type of mission sponsor or group. For instance, those knowing about a mission sponsored by a government official, politician or public figure are much more (4.4% of the respondents) than those actually using the services of such a mission (only 1.1%). (See Table 3). It may be that a politically-motivated mission only attracts persons who subscribe to the sponsoring political party, even if people knew that such a politician-sponsored mission is meant for all. On the other hand, actual

attendance at missions sponsored by specialty societies, religious groups and socio-civic groups is higher, even if these are not usually known as sponsors.

TABLE 3: Household Knowledge of and Actual Attendance in a Mission, 2001

Mission Sponsor or Group	Percent of Households Who Know Group as Usual Mission Sponsor (N=180)	Percent of Households Who Know Group as Regularly Conducting a Mission (N=180)	Percent of Respondents Who Actually Used Services of Mission Sponsor (N=180)
DOH	43.3%	28.3%	34.4%
Local Governments	25.0%	21.1%	26.1%
Dept. of National Defense	7.8%	6.7%	6.1%
Public figure/Gov't official	4.4%	3.9%	1.1%
Medical specialty societies	6.1%	4.4%	8.3%
NGOs (religious and socio-civic groups, and voluntary organizations)	2.9%	6.7%	12.2%
Don't know/ no response	10.5%	28.9%	11.9%

Missions vary in the health services they offer. Among household respondents, 61.1% received free medicines and vitamins; 28.3% had surgery; 7.8% received free medical check-up or consultation; and 2.2% were given prescriptions for medicines to be bought elsewhere. None reported being referred to a hospital or another health facility. The typical illnesses for which mission services were provided were dental; circumcision; cough, cold or fever; cataract or other eye problems; hypertension; asthma; wound dressing; pneumonia; and immunization (see Table 4). Less frequently mentioned medical conditions are allergies, arthritis, rheumatism, breast cancer, diarrhea, goiter, harelip, hearing problems, kidney problems, migraine, sinusitis and tuberculosis.

**TABLE 4: Usual Cases Seen as Reported by Households
and as Perceived by Barangays and Mission Sponsors, 2001**

Usual Cases Seen	According to Households (N=180)	According to Barangays (N=16)	According to Mission Sponsors (N=143)
Dental	26.7%	20.0%	5.7%
Circumcision	11.7%	12.0%	1.4%
Cough, cold, fever/URTI	10.6%	20.0%	14.9%
Cataract/ other eye problems	5.0%	4.0%	2.8%
Asthma	4.4%	0.0%	12.8%
Hypertension	2.8%	4.0%	4.6%
Wound dressing	2.8%	0.0%	0.0%
Immunization	2.2%	0.0%	0.4%
Others	33.8%	40.0%	57.4%

Quality of Care. Although no specific assessment of quality of care was made, results of the survey can provide indications of how well missions cater to patients' needs. Three indicators were examined: unserved patients, volume of patients per provider and patient compliance and continuity of care.

1. Unserved Patients. Results of both the institutional survey and barangay survey confirm that in some cases, demand for mission health services exceeds supply. Table 5 shows a sample of mission sponsors by the volume of patients seen (with cutoffs for "small", "medium" and "large" missions), and whether or not they were able to cater to all their patients. Of the 42 respondents that provided complete information on their patient load, 26 (or 61.9%) were able to accommodate all their patients. However, 16 of the sponsors (or 38.1%) admitted that not all of their visitors were served. Unserved patients appear to occur whether or not the mission is small, medium or large. These findings on unserved patients were confirmed by both sponsors and barangay officials. Among mission sponsors, 30.3% said they were not able to serve all patients while 8.2% had no response or did not know. Among the 16 barangay respondents, six (or 37.5%) reported a significant number of unserved patients, ranging from 20 to 620 per mission.

TABLE 5: Number of Unserved Patients as Perceived by Mission Sponsors, 2001

Mission Sponsor Respondents by Volume of Patient Visitors and Ability to Serve All Patients (N=42)	How Many Patient Visitors Go to Your Mission? (A)	How Many Patient Beneficiaries are Served in Your Mission? (B)	Estimated Number of Unserved Patients (A-B)
I. Missions that are able to serve all patients (n=26)			
Small missions (n=10)	30 to 150	30 to 150	-
Medium missions (n=7)	200 to 480	200 to 480	-
Large missions (n=9)	501 to 1,000	501 to 1,000	-
II. Missions that are not able to serve all patients (n=16)			
Small missions (n=3)	200 to 250	100 to 150	Around 100
Medium missions (n=10)	280 to 550	40 to 360	50 to 510
Large missions (n=3)	800 to 4,000	700 to 3,000	100 to 1,000

Note: Under I, small missions are defined as those with patient visitors from 1 to 150; medium, from 151 to 500; and large, from 501 and more. Under II, small missions are defined as those with patient visitors from 1 to 250; medium, from 251 to 600; and large, from 601 and more. Source: This study.

Mission sponsors who are not able to accommodate patients refer them to other medical institutions (37.8%), give them cash to purchase medicines or provide other forms of financial or assistance (7.7%). A few sponsors, however, simply instruct the patient to wait for the next mission (17.5%) or have no response at all, leaving the patient uncared for (27.3%).

2. *Volume of Patients Per Provider.* Based on available data of 10 mission sponsors, Table 6 shows the number of patients served per physician and nursing personnel per day of the mission. Each doctor or surgeon sees an average of 47 patients per day, ranging from 16 to 100. On the other hand, each nurse or medical aide sees an average of 40 patients per day, ranging from 13 to 75. The large vari-

ances in output per health personnel can be accounted for by factors such as patient caseload, type of patient seen (medical or dental or surgical), severity of illness treated, orderliness of the mission, bottlenecks (inadequacy of instruments) and distance of the mission site. The provision of an honorarium is also an important factor in personnel productivity. Some external factors, such as the devotion of the mission sponsor, or perceived politicization of the mission can also affect the performance of the health provider.

The large number of patients seen by each provider (especially those exceeding 50 a day) raises issues about quality of care of mission services, especially those providers seeing 50 or more patients a day. The limited number of providers and time during a mission tends to make providers work in a hurry, resulting in “depersonalized” consultation and treatment. There are currently no set standards with respect to this aspect of mission work, and could be developed through a more detailed time and motion study.

TABLE 6: Number of Patients Served Per Physician and Nursing Personnel Per Day, by MSM Institution, 2001

Mission Sponsor	No. of Patients Served Per Doctor and Surgeon Per Day	No. of Patients Served Per Nurse and Medical Aide Per Day
Code # 4	41	20
Code # 23	100	57
Code # 24	40	13
Code # 42	60	51
Code # 51	16	-
Code # 82	16	19
Code # 83	36	25
Code # 84	25	40
Code # 89	59	59
Code # 97	75	75
Average	47 (n=10)	40 (n=9)

3. *Patient Compliance and Continuity of Care.* A key issue in medical/surgical missions is whether patients follow doctor's instructions and whether they receive continuity of care after the mission ends. Most patient respondents (93.3%) said they followed the mission doctor's instructions; only 2.8% said they did not do so, due to financial constraints ("*walang pera*") or lack of follow up by the mission doctors. In fact, among all respondents who availed of mission services, 63.3% said they were not given post-mission care. The seriousness of the issue of continuity of care needs to be underscored since majority of poor households (53.9%) reported having a regular ("*suki*") doctor, with almost all of them being able to name and locate such a doctor. If this is the case, then a mission has a tendency to disrupt the care provided by the household's "*suki*" doctor.

Analysis of the usual caseload of missions can provide indications of whether MSMs can appropriately handle these health conditions or not. For instance, while dental extraction, cataract removal, wound dressing, circumcision and elective surgeries are "once-off" cases and can be properly dealt with in missions, many of the reported cases are chronic in nature – allergies, asthma, diabetes, hypertension, etc. – and require continuing care. The provision of immunization and other preventive health services could also turn problematic, especially if these mission services are not properly coordinated with local health or DOH programs mandated to do this. Spurts of tuberculosis care provided by missions through TB drugs may engender drug resistance, if the patient fails to complete the therapy and falls sick again after the mission has left. Finally, the generally poor referral reported in the survey could result in animosities with patients as well as with local providers.

In most cases, patients did not encounter problems in availing of the services of missions. However, a significant percentage of patient-respondents (28.3%) encountered problems, including the inadequacy of drugs, too many patients that led to long queues, disorderly service ("*hindi maayos na serbisyo*") probably due to the lack of a structured mission program and protocol, non-uniform services ("*hindi parehas na serbisyo*"), prescribing medicines for a fee and inadequate medical equipment and instruments.

Impact of Missions on Individual and on Public Health. Individually, some 63.3% of the patient-respondents noted the general improvement in their health status (“*bumuti ang kalusugan*”) after receiving services from a mission. An additional 8.9% of the respondents also recognized the positive contribution of missions, although they were less specific (“*nakatulong sa amin*”). Some 6.1% of the interviewees responded positively to the preventive/promotive health aspects of missions and now recognize the value of health (“*pinabahalagahan ang kalusugan*”). However, a disturbing 17.8% had no response to the impact of missions in their lives, possibly because they did not utilize, or did not get well from, mission services.

From a public-health point of view, health workers noted four specific social benefits. First, the immediate health intervention provided by missions, especially in calamity situations, can prevent the outbreak of an epidemic. This was cited by as many as seven mission sponsors. Second, missions provide medical specialists who otherwise are not available in the area. Third, the identification of early symptoms and risk factors during a mission can avert the development of more serious (and more expensive to treat) medical conditions later. Finally, missions can engender transfer of technology through the interaction of mission providers with their local counterparts. It covers not only the technical aspects of the provision of care (proper medical procedures, types of medicines prescribed and up-to-date professional practices), but the general exchange of ideas, problem-solving techniques, communication and ways of relating with clients. Close to half (43.8%) of the barangay respondents value this enhancement of the knowledge and skills of local medical practitioners brought about by missions.

Barangay and municipal officials generally approve of the conduct of missions in their locality. Fourteen of the 16 respondents (or 87.5%) think that missions positively affect health status and health practices through curative care (free consultations, medicines and operations), preventive and promotive care (the importance of personal hygiene and cleanliness of their houses and surroundings), general health information and education on how to avoid specific diseases and the need to seek medical care as soon as symptoms were felt. Support of missions by barangay respondents, however, was not universal. A few of them did not view

missions in a positive light principally because these only had limited beneficiaries and services and are only held seasonally or irregularly.

Mission Effectiveness. Table 7 shows the effectiveness ratings of missions from the points of view of mission sponsors and client barangays. Institutional self-rating of effectiveness is generally high: 23.1% of institutions surveyed rated missions in general as “excellent” in providing community benefits, while 35.0% rated them as “very good”. Most of the missions sponsors that rated themselves “very good” (20.3%) in providing community benefits are from the government, the 13.3% that rated themselves as “excellent” are also from the government.

less-than-compelling rating of missions may be due to these missions’ inability to address the full spectrum of health care or the total needs of their clients.

TABLE 7: Effectiveness Rating of Missions by Mission Sponsors and by Barangays, 2001

Rating	Mission Sponsor Self-Rating of Effectiveness in Providing Community Benefits (N=143)	Barangay Rating of Mission Sponsor in Treating Illness (N=16)	Barangay Rating of Mission Sponsor in Improving Health Care (N=16)	Barangay Rating of Mission Sponsor in Improving Quality of Life (N=16)
Excellent	23.1%	0.0%	0.0%	0.0%
Very Good	35.0%	50.0%	18.8%	12.5%
Good	18.9%	43.8%	62.5%	56.3%
Fair	4.9%	6.3%	18.8%	18.8%
Bad	0.0%	0.0%	0.0%	12.5%
No response	18.2%	0.0%	0.0%	0.0%

Barangays, however, are less convinced about the effectiveness of missions. Only 50.0% of the barangay respondents think missions are “very good” at treating

illness, while a much smaller 18.8% of them think they are “very good” at improving health care. None of the barangay respondents rated these missions as “excellent”. The majority think they are either “good” or just “fair” in these endeavors. The less-than-compelling rating of missions among barangay respondents may be due to these missions’ inability to address the full spectrum of health care or the total needs of their clients.

B. Operational and Regulatory Issues

Existence of Mission Operational Guidelines. Only 58.7% of the sponsors reported having mission guidelines and a smaller percentage (37.1%) reported having mission policies. (Most of the mission sponsors with operational guidelines and policies were established and began sponsoring missions in the 1990s.) Of those who do have operational guidelines, the high variability in their responses indicates the high variability of these procedures. These are disturbing indicators considering the increasing visibility of missions in the Philippines.

It is not known what form these guidelines and policies take. As a matter of good practice, these should be in written form and disseminated by the mission sponsor to mission partners and providers. Of those who reported having guidelines, the steps summarized in Box A were deemed important as to be written in an operational manual.

Awareness of Relevant Laws and Regulations. Only 18.9% of mission sponsors are aware of specific government laws and administrative orders on the conduct of missions. In fact, as much as 63.6% of the institutional respondents claimed ignorance of these legal and regulatory instruments. Clearly, the regulation of medical and surgical missions in the Philippines leaves much to be desired.

Among the institutions that claimed knowledge of applicable laws, orders and circulars, the following were mentioned:

- Republic Act. No. 7846; Republic Act. No. 8172;
- Laws on physician licensing, medical specialties, patient safety and ethical practices in medicine;

- DOH Administrative Order 16-A s. 1998, Administrative Order 13-A, s. 1999 and Administrative Order 41-B, s. 1999 all of which defined the standard operating procedures with respect to request and approval of the holding of missions;
- Policy on foreign-sponsored missions requiring permit from the DOH and the Professional Regulation Commission;
- Philippine Medical Association administrative procedure from the Committee on Disaster and Relief Operations;
- Generic Drugs Law, Pharmacy Law (drug dispensing), Bureau of Food and Drug Administration policies; and
- the Local Government Act.

Level of Local Participation. From the point of view of barangay officials, the participation of local leaders and practitioners in missions is very active or moderately active; none of them admitted being inactive. Barangay perception of helpfulness varies highly from site to site, and from one partner to another. Among the barangay sites, Baloganon (in Masinloc, Zambales) and Mintal (in Davao City) appear to provide examples of good practices in the area of partner helpfulness. Their experiences need to be documented for wider-scale sharing with other mission sponsors and participants. It appears from Table 8, however, that helpfulness is highly correlated with the level of organization of the partners, i.e., the better organized the partners, the more helpful they are. Conversely, poorly organized partners also tend to be less helpful. The level of helpfulness and organization does not appear to be a function of the number of partners involved in the missions. There are sites with few mission partners but are not very organized; on the other hand, there are sites with quite a number of partners but are highly organized.

Mission sponsors generally provided lukewarm response with respect to their level of collaboration and coordination. Less than half (47.6%) admitted coordinating their mission work with other agencies or partners, while more than half (55.9%) admitted having collaborative relations with others. Curiously, these same institutions invoked the importance of coordination and collaboration in mission work. It is not clear, however, where the responsibility and locus of coordination or

collaboration should be. Many mission sponsors take the view that other agencies (DOH, local governments) should coordinate or collaborate with them, rather than the sponsors themselves taking a proactive stance in actively seeking the inputs of these partners. This is a contentious issue that needs further clarification.

Table 8: Barangay Perception of the Level of Helpfulness of Various Mission Sponsors in Missions, 2001

Organization	Isio	Tabao	Pussian	Carig	San Pablo	Baloganon	Mintal	Sirawan
Politicians					8		10	7
LGUs	4		8	8.5		10	8.5	8
Military	8.5	7	8			10	10	
Local private health providers	8	7						
Local gov't health providers	10							
DOH, DECS						10	10	
NGOs		8			8	10	9.5	6.5
Religious leaders						10	9	

Note: 1=least helpful; 10=most helpful. Source: This study.

C. Opportunity Cost of Missions

Missions entail a variety of inputs, incurred by both the sponsor itself as well as those by partners or co-organizers, e.g., drugs and supplies donated by other parties and volunteers' time. Analysis of available data from 15 mission sponsors indicates the large opportunity costs of these activities.

Personnel Costs. A medical mission usually consists of a team of doctors, nurses, medical aides and field guides. A surgical mission also includes surgeons.

In addition, there may be other trained providers such as pharmacists, interns, social workers and barangay health workers. The size of the mission is determined principally by the number of doctors in the mission team. Small missions usually involve 1-5 doctors; medium missions, 4-10 doctors; and large missions, 8-15 doctors. Mission personnel usually work as volunteers. However, many mission sponsors do provide an honorarium, the average per day being P930 for doctors, P930 for surgeons, P430 for nurses and P365 for medical aides.

Cost of Drugs and Other Supplies. In many cases, medicines, surgical and other medical supplies are donated by other parties, e.g., health care companies, the DOH, other government agencies and philanthropic organizations. For the most part, mission sponsors do not keep accurate and reliable records of the value of these donated inputs. However, based on incomplete information, the cost of medicines, surgical and other supplies could vary from P7,300 to as high as P100,000 per mission, depending on the volume of patients and the type of health services dispensed.

Other recurrent costs include medical instruments and apparatus, food and lodging for mission members, gasoline and other vehicle expenses, and food for selected patients. In general, mission sponsors keep poor track of these expenses but from three informants who provided data, the following can be gleaned: (1) Food for mission members is mostly donated by the local government unit (municipal or barangay council) or the hospital or health center where the mission is being held. Only three mission sponsors reported spending on food, with food allowance varying from P100 to P400 per person per day. (2) Board and lodging is, for the most part, the responsibility of the local government. In one case where the mission sponsor had to pay for this, an allowance of P150 per person per day was provided. (3) A gasoline allowance of P2,000 to P3,000 is usually provided for by the sponsoring institution, though sometimes, the local government unit shoulders this cost. Special arrangements may be resorted to where the local government unit vehicles are borrowed, with their own gasoline allowance. (4) Medical instruments and apparatus (weighing scales, sphygmomanometers, medical kits, thermometers) are usually solicited from mission partners. Foreign missions almost always bring their own equipment and apparatus.

Cost Per Patient. Cost data were generated for personnel and supplies (see Table 9). Personnel cost averaged P35 per patient, varying from P16 to P395 (the extreme high value due to the high honorarium provided by a Manila-based socio-civic organization to its participating surgeons). Supplies cost averaged P118 per patient, varying from P70 to P379. Overall, total cost per patient averaged P153, ranging from P70 to P379.

TABLE 9: Cost of Personnel and Medical Supplies Per Patient Served, by Type of Cost and by Mission Sponsor, 2001

MSM Institution	Personnel Cost Per Patient, in Pesos	Supplies Cost Per Patient, in Pesos	Total
Code # 4	P 43	n.a.	n.a.
Code # 23	P 16	P 58	P 74
Code # 24	P 54	P 73	P 127
Code # 26	n.a.	P 691	n.a.
Code # 42	P 23	P 81	P 104
Code # 51	P 19	n.a.	n.a.
Code # 82	P 395	n.a.	n.a.
Code # 83	P 48	P 116	P 164
Code # 84	P 46	P 333	P 379
Code # 89	P 23	P 47	P 70
Code # 97	P 18	n.a.	n.a.
Average (n=6)	P 35	P 118	P 153

Note: In this table, personnel refers only to doctors, surgeons, nurses and medical aides and excludes all other support staff (field guides, interns, social workers, etc.) Supplies refer only to medical and surgical supplies and reported cost for medical instruments and apparatus. Supplies exclude food, lodging, gasoline, vehicle costs, etc. for which information was mostly unavailable. The average was derived only from mission sponsors that provided complete information for both types of costs (n=6). Source: This study.

These cost data are not definitive but point the direction for more intensive work in this area. Cost data are important for more accurate budgeting and planning of resources and for providing information on alternative uses of resources.

For instance, what would be the total cost of a mission if all the volunteer personnel and donated supplies were paid? Although the cost of mission personnel are, in general, not incurred by the sponsoring institution, these still need to be reckoned as they entail opportunity costs. A DOH doctor participating in a mission as a volunteer may be reckoned as free by the mission sponsor, but s/he is being taken away from other tasks for which s/he is being paid by the government, and for which DOH patients are being denied care because the doctor is not there. The same is true with other health personnel.

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These volunteers, therefore, entail societal or opportunity costs when they perform mission duties, i.e., they are not free to “society” although they may be registered as such in the books of the mission sponsor. The principle of opportunity cost is not well-understood by mission sponsors, as gleaned from their responses. The DOH and other regulatory bodies need to inculcate this principle among them.

D. Potential Negative Ripple Effects of Missions on the Health System

Despite the immediate as well as medium-term benefits of missions, many mission sponsors and barangay respondents think that missions can, in the long term, undermine the development of a fully functioning and sustainable health delivery system. The critical negative consequences of missions cited by survey respondents were:

- (1) Dependency of patients – The results of the beneficiary survey indicates that as many as 25.6% of the respondents deemed missions necessary simply because they are free. An additional 7.2% noted passively that missions came along (“*yun ang dumating sa amin*”), while the rest cited no specific reason for preferring missions. Thus, close to a third (33.9%) could be considered “passive” in their attitude about medical/surgical missions. Encouraging the culture of dependency (cited by 15 mission sponsors) and discouraging patient self-reliance (cited by five mission sponsors) was seen

as a major problem with the increasing pervasiveness of missions in the Philippine health care system.

- (2) Weak targeting and “leakage” of free care - Operationally, dependency could worsen if patients are not properly screened in terms of indigency, which is the main thrust of missions. Although the mission sites appear to be geographically-targeted well, there were a considerable number of non-poor

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households in these areas, e.g., 8.3% of household heads attended or completed college. Interestingly, none of the mission sponsors cited specific individual or household targeting protocols to ensure that only the poor are provided free mission services or that the non-poor patients are excluded from free care. A few mission sponsors also cited undue wastage from free care, as when persons try to obtain free medicines even if they are not sick. The undue politicization of medi-

cal/surgical missions may also result in people with real health concerns being unable to obtain care, simply because they might think only those who will vote for the political sponsor are entitled to get care or they might be actively screened out by political functionaries.

- (3) Worsening relationship with local medical practitioners – Missions that are not properly coordinated with local medical practitioners tend to cause animosity. If the patient has capacity to pay, then the mission is seen as “stealing” patients from local practitioners. Moreover, if no proper referral is done, then the patient tends to get “dumped” on the clinics of local practitioners.
- (4) Drug resistance – Inadequate treatment in terms of duration and/or amount can lead to the development of bacteria that are resistant to the inadequate antibiotic. In the case of missions, the potential for this is great due to their sporadic and non-continuing nature. Giving free starter doses with no certainty of compliance with the treatment after these doses are consumed can lead to antibiotic resistance. This is particularly true in the treatment of TB.
- (5) Undue politicization of medical/surgical missions – Politicians often use these missions to gather support and “score points” in the communities,

both during and after an election season. The mission sponsor may also be misrepresented by the politician for his/her own ends. As one medical specialty group noted, mission “care-giving” could end up in “care-grabbing.”

- (6) Dependency of local government units – Missions may undermine the capacity of local government units to address key public health concerns in their locality on a sustainable basis. LGU expectations of the periodic visits of missions may make them less responsible to their constituents’ health needs as more and more of their mandated functions are usurped by these missions. Ideally, missions should complement LGU and DOH health services which could be achieved if these missions focus on the provision of medical skills and services that the LGU cannot provide. The danger, however, is when these missions substitute for LGU health services or begin to evolve as a parallel health service delivery system.

IV. CONCLUSIONS AND RECOMMENDATIONS

- (a) Overall policy context: The increasing proliferation of medical/surgical missions calls for a proper review of the role of missions in the context of overall health service delivery to the poor. This study has shown that missions do have a role to play in the provision of care especially to disadvantaged Filipinos. However, they involve significant resources and considerable opportunity costs. They also engender significant negative ripple effects that, in the long-term, may damage efforts by the DOH and local government units to achieve sustainable health services. Thus, there is a need to strategically focus the work of missions so that they can complement the work of the DOH and local government units, and do not substitute for them instead, or worse, become a parallel health delivery system.
- (b) Lack guidelines and knowledge of relevant laws: A mission is a complex undertaking, involving quite a number of stakeholders and beneficiaries. Not all mission sponsors currently have a structured program with established rules, policies and procedures to mount these activities. Knowledge of existing laws, administrative orders and circulars pertaining to missions is generally weak among sponsors. (The laws, administrative orders and

circulars pertaining to mission work are, themselves, not contained in a single publication, making it difficult for existing and would-be mission sponsors to familiarize themselves with their contents.) Their level of collaboration and cooperation with other agencies is also very weak, although there are shining exceptions to good collaboration and cooperation. At present, almost any person or institution can mount a mission.

- (c) Opportunity cost of missions: Most mission sponsors are not aware of the opportunity cost of mounting a mission since most mission personnel go as volunteers or are paid modest honoraria, and most supplies are donated or solicited from partners. However, so-called free resources have alternative uses, e.g., a vacated DOH health facility whose personnel have gone on a mission are unable to cater to clinic patients who go there that day. While missions do provide health services to usually underserved areas, it remains to be shown whether these are the most cost-effective means of addressing the health needs of the poor.
- (d) Continuity of care: Discontinuity of health services and disruption were cited as frequent problems arising from missions, especially with respect to chronic cases or cases for which the mission has no wherewithal to offer. Referral and coordination with local health providers is usually done by missions, but not universally so. In not a few cases, some patients were simply left behind for a local practitioner or the patient's "*suki*" doctor to care for. Finally, there are concerns raised with respect to missions' tendency to engender drug resistance.
- (e) Sustainability of missions: The missions' tendency to encourage dependency of patients and stunt the development of sustainable local health systems were recognized as major weak points of missions. Conceptual notions of integrating mission work into the existing health delivery system were broached by key informants but so far, there are as yet no concrete proposals to operationalize this approach.
- (f) Focus on measurable impact: Given the above concerns about missions' actual as well as opportunity costs, disruptive effects on local health service delivery and sustainability, it is important to focus the work of missions on those for which they can show measurable impact. Provision of care to "once-

off” cases (harelip, circumcision, tooth extraction and other dental procedures, cataract removal and other ophthalmic cases, and elective surgeries) appear to be the areas where mission services are called for since these services are not usually available in the localities, and for which mission sponsors have comparative advantage. Most medical cases and diseases for which the DOH and the LGU have existing health programs, however, are difficult to justify as the purview of mission work, since little measurable impact can be shown and since beneficiaries, though poor, appear to have “*suki*” doctors and mission “poaching” of patients can create animosity in the local health environment.

- (g) Politics: Majority of the missions are sponsored by well-meaning institutions and individuals, both in the government and the private sector. However, there are quite a few that are often used by politicians for reasons that are less-than-philanthropic. Adding political color to these missions tends to make them counter-productive because it distracts health professionals’ focus on providing care. It may also discourage patients from utilizing their services, especially if these patients see themselves as subscribing to a party different from the political sponsor. Mission sponsors unanimously endorse the need to de-politicize health care for the poor.
- (h) Excess demand for mission services: Although the majority of missions are able to cater to all their clients, a significant number have unserved patients. To avoid this, it is necessary for mission sponsors to undertake better planning and needs identification, better dispensing of medicines and better targeting of the truly sick and needy. So far, aside from the demographic and location targeting, no mission has reported a thorough mechanism of targeting (individual) indigents, which has been suggested as one approach of solving the occurrence of excess demand.
- (i) Reporting, monitoring and evaluation: Data-gathering on all fronts, but especially on inputs (resources use and costs), the effect of interventions (number and profile of patients served) and impact (longer term benefits on the household) is poorly developed in most mission sponsors. There is virtually no post-mission evaluation that is undertaken. Most of these weaknesses are simply a function of the absence of a body or agency (DOH or

local government unit) or clearinghouse of “industry or trade organization” to which missions are mandated, to report their activities. Thus, there has not emerged a systematic and regular monitoring of missions work.

- (j) Development of good practices and enforcement of standards: Despite their rather long history and pervasiveness, mission sponsors have not documented – much less shared with others – good practices on the conduct of missions. There are individual cases of documented institutional practices and processes, but there is no “industry-wide” set of standards. DOH itself has issued a department order on the proper conduct of missions but enforcement appears to be weak.

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