



HOSPITAL ADMINISTRATION CHALLENGES IN SELECTED LOCAL PUBLIC HOSPITALS IN THE NATIONAL CAPITAL REGION

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Abstract

Patient safety remains a critical concern in public healthcare, where administrative, structural, and resource-related challenges may affect the quality of patient care and the reporting and accountability of medical errors. This study examined the challenges faced by hospital administration in selected local public hospitals in the National Capital Region (NCR), with particular emphasis on issues affecting patient care quality, barriers to error accountability and reporting, and differences in reported challenges across hospital affiliations. A quantitative, descriptive-correlational research design was employed. The study involved 30 purposively selected nurses from three local public hospitals in the NCR: Pasig City General Hospital, Pasig City Children's Hospital, and Mandaluyong City Medical Center, with ten respondents from each institution. Data were collected using a researcher-designed questionnaire consisting of demographic items, medical-error-related questions, patient-care indicators, and five-point Likert-scale measures of accountability and reporting barriers. Data were analyzed using frequency and percentage distributions, weighted means, and a two-sample t-test at the 0.05 level of significance. Results showed that hospital size and capacity were the most frequently reported issues affecting patient care quality, followed by financial support, technology, and infrastructure. Human resources, leadership and management, and quality of care were also identified as recurring concerns. Regarding accountability and error reporting, respondents agreed that fear of repercussions, blame culture, workload constraints, lack of standardized reporting systems, and bureaucratic reporting processes hindered effective reporting. The findings further revealed a significant



difference in reported administrative challenges according to hospital affiliation ($t = 3.18$, $p = .011$). The study concludes that hospital administration challenges are shaped by institutional and contextual conditions. Strengthening financial and human resources, modernizing infrastructure, promoting non-punitive safety cultures, improving leadership, and implementing standardized reporting systems are recommended to enhance hospital administration and patient safety.

Keywords: *Patient Safety; Hospital Administration; Medical Error Reporting; Accountability; Patient Care Quality; Public Hospitals; Healthcare Governance*



Introduction

Patient safety remains a central concern for healthcare systems worldwide, and Philippine public hospitals are no exception. Reducing and preventing medical errors — and the administrative failures that allow them to recur — requires understanding the systemic vulnerabilities and individual behaviors that give rise to them, as well as the barriers that keep such errors from being reported and addressed. This study investigated the administrative challenges facing hospital management in three local public hospitals in the National Capital Region (NCR): Pasig City General Hospital, Pasig City Children's Hospital, and Mandaluyong City Medical Center. It identified the issues most frequently affecting the quality of patient care, examined the barriers to error accountability and reporting, evaluated existing strategies and policies, and proposed evidence-based interventions to strengthen hospital administration and, by extension, patient safety.

Beyond identifying problems, the study sought to inform a more proactive culture of error prevention. Interprofessional collaboration and open communication recur throughout the literature as central to both preventing errors and building the kind of safety culture in which accountability and reporting can function. By examining prevalent issues, their effects on patient care, and the pathways — or lack of pathways — to accountability, this study aims to support initiatives that strengthen hospital administration and elevate healthcare standards in the NCR's local public hospitals.

Theoretical and Conceptual Framework

The study is grounded in Human Factors Theory, which holds that errors arise not solely from individual fault but from the interaction between people and the systems in which they work. Reason's (2016) "Swiss Cheese Model" illustrates this by representing a system's defenses as layered slices, each containing weaknesses; an error occurs when those weaknesses momentarily align across layers, allowing it to pass through every line of defense. Norman's (1988) related work on design similarly attributes most human error to poor system design rather than individual failing, and argues for interfaces and workflows that account for human cognitive limits. Carayon, Schoofs, Hundt, and Karsh (2014) apply this framing directly to healthcare, arguing that human-centered design of clinical systems is central to reducing error.

This is complemented by a systems-theoretic conceptual framework, which treats a hospital as an interdependent set of administrative, clinical, financial, and human-resource components that jointly shape organizational performance. Viewed this way, the six areas examined in this study — hospital size and capacity, financial support, human resources, technology and infrastructure, leadership and management, and quality of care — are not independent problems but interacting parts of the same system, and interventions aimed at one are likely to affect the others.

Review of Related Literature

Structural and resource-related factors. Hospital size and capacity shape service delivery in competing ways: larger facilities generally offer more advanced equipment, specialized staff, and a wider range of services, but are also more prone to overcrowding, longer wait times, and bottlenecks that strain patient safety; smaller hospitals, conversely, may be nimbler but constrained by limited resources and infrastructure (Smith, Johnson, & Williams, 2019). Financial support is a related and recurring constraint: public hospitals depend on a mix of government funding, insurance reimbursement, and patient revenue whose adequacy and stability vary considerably, and budgetary pressure forces trade-offs among competing services, infrastructure investment, and staff training (Brown, Garcia, & Martinez, 2019). Human resources are strained by staffing shortages, high turnover, and limited opportunities for continuing training, all of which increase workload and burnout among remaining staff



and threaten continuity of care (Johnson, Lee, & Nguyen, 2019). Technology and infrastructure gaps — outdated equipment, inadequate facilities, and limited access to modern clinical tools — compound these pressures and disproportionately affect underserved communities (Garcia, Rodriguez, & Lopez, 2019).

Leadership, management, and quality of care. Effective leadership and management shape organizational culture, staff morale, and ultimately patient outcomes; transformational leadership styles and adaptive, evidence-based management practices are associated with better alignment among frontline staff and more resilient organizations (Lee, Chen, & Wang, 2019). Quality-of-care initiatives — medication reconciliation, infection-control protocols, accreditation compliance, and the use of performance metrics — depend on this kind of leadership investment and on a systems-thinking approach that treats quality gaps as organizational rather than individual failures (Chen, Smith, & Johnson, 2019).

Nature and impact of medical errors. Communication breakdowns, medication errors, and diagnostic inaccuracies recur as the most commonly identified categories of medical error, both internationally and in Philippine-specific research (Santos, Cruz, & Reyes, 2019; Smith, Johnson, & Brown, 2018). International literature further documents surgical errors, healthcare-associated infections, and device-related technical errors as additional sources of harm (Chen, Lin, & Leong, 2020; Patel, Rajabzadeh, & Varghese, 2018). These errors carry consequences well beyond the immediate clinical event: prolonged hospital stays, escalating costs, and, in the most severe cases, preventable patient harm or death (Smith & Johnson, 2017; Gupta, Sharma, & Khan, 2020).

Barriers to error reporting and accountability. A consistent set of barriers keeps errors from being reported and addressed: fear of professional or legal repercussions, hierarchical structures that discourage frontline staff from raising concerns involving senior colleagues, and the absence of confidential, user-friendly reporting channels (Weingart, Smith, & Jones, 2018). These barriers sustain a culture of silence in which lessons from errors are not systematically captured or applied.

Safety culture, teamwork, and interprofessional collaboration. A strong safety culture — one built on open communication and a non-punitive, learning-oriented response to error — is associated with lower error rates and better reporting (Gonzales & Ramos, 2018). Effective interprofessional collaboration and clear communication among healthcare teams likewise reduce errors and improve patient satisfaction and outcomes, both in Philippine hospitals (Reyes, Cruz, & Santos, 2020; Smith, Clark, & Brown, 2018) and internationally (Weaver, Dy, & Rosen, 2019; Cohen, Rhydderch, & Kansal, 2019).

Legal and regulatory context. Philippine jurisprudence has progressively clarified hospitals' administrative and legal accountability for the conduct of their medical staff. In *Professional Services, Inc. v. Agana* (G.R. No. 126297/126467/127590, 2007), the Supreme Court held that a hospital may be held liable for a consultant physician's negligence under the doctrines of apparent or ostensible agency and corporate negligence, rejecting the argument that attending physicians are merely independent contractors beyond the hospital's control. *Casumpang v. Cortejo* (G.R. No. 171127, 2015) similarly held a hospital and its physicians accountable for a wrongful death arising from delayed and inaccurate diagnosis, reinforcing the standard of care owed to patients. Rulings on informed consent and professional competence (as raised in later disputes over unauthorized changes to surgical procedures) further underscore hospitals' duty to ensure that consent and scope-of-practice obligations are clearly documented. Separately, *Commissioner of Internal Revenue v. St. Luke's Medical Center, Inc.* (G.R. No. 195909, 2012) clarified that a non-stock, non-profit hospital engaged in profit-generating activity is subject to the preferential tax rate under Section 27(B) of the National Internal Revenue Code rather than full exemption under Section 30, underscoring the administrative importance of properly documenting income sources. Together, these cases situate the administrative challenges examined in this study within a legal environment that



increasingly holds hospitals — not only individual clinicians — accountable for patient safety and institutional governance.

Statement of the Problem

This study sought to identify and analyze the challenges faced by hospital administrators in local public hospitals in the National Capital Region, evaluate existing strategies for addressing them, and develop evidence-based recommendations for their prevention and management. Specifically, it addressed the following questions:

1. What is the demographic profile of the respondents in terms of (a) hospital affiliation and (b) years of experience?
2. What issues affect the quality of patient care in the selected hospitals?
3. What challenges exist in accountability and the reporting of medical errors?
4. Based on the findings, what strategies may be proposed to address hospital administration challenges?
5. Is there a significant difference between the challenges reported and the respondents' hospital affiliation?

Hypothesis

H₀: There is no significant difference between the challenges in hospital administration and hospital affiliation.

H_a: There is a significant difference between the challenges in hospital administration and hospital affiliation.

Significance of the Study

The findings are intended to benefit nurses, by deepening their awareness of the frequency and causes of errors and equipping them with practical tools for prevention; hospital administrators, by informing targeted policies, interventions, and training initiatives; healthcare quality-improvement teams, by grounding their efforts in evidence specific to these institutions; medical educators, by informing curricula that better prepare future nurses; and healthcare researchers, by providing a basis for further inquiry into patient safety and hospital administration in the Philippine public-hospital context.

Scope and Delimitations

The study was delimited to three local public hospitals in the NCR — Pasig City General Hospital, Pasig City Children's Hospital, and Mandaluyong City Medical Center — and to the period from 2019 to the present. It focused on nurses' and, where noted, administrators' perceptions of hospital administration challenges, patient-care quality, and accountability; it did not extend to private hospitals or to facilities outside the NCR, and its findings are not intended to generalize beyond similar public-hospital settings.



Methods

Research Design

The study used a descriptive-correlational design, combining a survey approach — which provides a numeric description of the trends, attitudes, and perceptions of a sampled population (Creswell & Creswell, 2018) — with a correlational component examining whether differences in one variable (hospital affiliation) are associated with differences in another (the challenges reported), consistent with Leedy and Ormrod's (2015) treatment of correlational design.

Study Sites, Population, and Sampling

The study was conducted in three public hospitals in the NCR — Pasig City General Hospital, Pasig City Children's Hospital, and Mandaluyong City Medical Center — using purposive sampling to select participants with direct, relevant experience of hospital administration challenges and medical-error prevention.

Under this reading, ten nurses were purposively selected from each of the three hospitals, for a total sample of 30 respondents. Nurses were selected as the primary respondent group because of their frontline role in patient care and their direct exposure to the occurrence, consequences, and prevention of medical errors, as well as to the collaboration, communication, and safety culture within their respective institutions.

Research Instrument

Data were gathered using a researcher-designed questionnaire in four parts. Part I gathered the demographic profile of respondents (sex, age group, position or title, years of healthcare experience, years of experience at the current hospital, and hospital affiliation). Part II asked respondents to identify the medical errors they had encountered or observed. Part III asked respondents to describe the impact of these errors on patient care. Part IV used a five-point Likert scale to measure perceived barriers to error accountability and reporting — such as fear of repercussions and workload pressure — interpreted as follows: 4.21–5.00, Strongly Agree; 3.41–4.20, Agree; 2.61–3.40, Neutral; 1.81–2.60, Disagree; 1.00–1.80, Strongly Disagree.

The instrument was pilot-tested with 15 participants to assess clarity and comprehensibility, then reviewed by the researchers' adviser and subject-matter experts for content validity, reliability, and alignment with the study's objectives, in an iterative revise-and-refine process.

Data Collection Procedure

Data collection began with a formal request for cooperation, addressed to the administrators of the three participating hospitals and describing the study's objectives and title. Upon each hospital's endorsement, the questionnaire was administered to the selected respondents, combining quantitative ratings with qualitative, open-ended items. All 30 questionnaires were completed and returned, for a 100% retrieval rate. Qualitative responses were transcribed, coded, and thematically categorized; quantitative responses were subjected to statistical analysis. Ethical clearance was obtained from the Research Ethics Committee (REC) of each participating hospital, and the study protocol and instrument were additionally endorsed by the hospital respondents before submission to the Research Ethics Committee of Rizal Technological University (RTU-REC) for final clearance. Respondent confidentiality and anonymity were maintained throughout.



Statistical Treatment

Percentage distribution ($P = f/n$, where f is frequency and n is the total number of responses) was used to describe the demographic profile of respondents. Weighted mean ($w\bar{x} = \Sigma fx / \Sigma f$) was used to summarize Likert-scale ratings of perceived issues and barriers. A two-sample t -test was used to test whether the challenges reported differed significantly by hospital affiliation, with the decision rule based on the conventional $\alpha = .05$ significance threshold.



Results

Demographic Profile of Respondents

Thirty respondents participated in the study, drawn in equal numbers from the three participating hospitals.

Table 1. Distribution of Respondents by Years of Experience

Years of Experience	Frequency	Percentage (%)
Less than 1 year	4	13.33
1 to 5 years	10	33.33
6 to 10 years	14	46.67
11 years and above	2	6.67
Total	30	100.00

Issues Affecting the Quality of Patient Care

Table 2 presents respondents' weighted-mean (WM) ratings of six recurring issues affecting patient care quality across the three participating hospitals (labeled A, B, and C to protect institutional confidentiality), with verbal interpretation (VI): F = Frequent, MF = Most Frequent.

Table 2. Issues with the Quality of Patient Care, by Hospital

Statement	Hosp. A (WM)	VI	Hosp. B (WM)	VI	Hosp. C (WM)	VI
Hospital size and capacity	3.52	MF	3.78	MF	3.89	MF
Financial support	3.33	F	3.51	MF	3.56	MF
Human resources	3.12	F	3.25	F	3.33	F
Technology and infrastructure	3.33	F	3.53	F	3.55	MF
Leadership and management	3.01	F	3.24	F	3.42	F
Quality of care	3.00	F	3.14	F	3.25	F
Overall weighted mean	3.22	F	3.41	F	3.50	F

Hospital size and capacity were rated the most frequent issue at all three hospitals (WM 3.52–3.89), most pronounced at Hospital C. Financial support and technology and infrastructure were rated "Most Frequent" at

Hospitals B and C, respectively, but only "Frequent" at Hospital A, suggesting these pressures are felt unevenly across the three sites. Human resources, leadership and management, and quality of care were consistently rated "Frequent" across all three hospitals, with Hospital C rating every issue at least as severely as, and usually more severely than, Hospitals A and B.

Challenges in Accountability and Reportage

Table 3. Challenges in Accountability and Its Reportage, by Hospital

Statement	Hosp. A (WM)	VI	Hosp. B (WM)	VI	Hosp. C (WM)	VI
Fear of repercussions deters reporting	3.17	A	3.25	A	3.27	A
Blame culture hinders accountability	3.33	A	3.42	A	3.45	A
Time constraints/workload impede reporting	3.21	A	3.25	A	3.36	A
Lack of standardized reporting systems	3.11	A	3.46	A	3.51	SA
Reporting perceived as bureaucratic burden	3.05	A	3.28	A	3.27	A
Overall weighted mean	3.17	A	3.33	A	3.37	A

(A = Agree; SA = Strongly Agree.) All five statements were rated "Agree" or higher at every hospital, indicating a broad consensus that fear of repercussions, a culture that assigns blame to individuals rather than systems, workload pressure, and the absence of standardized reporting mechanisms all impede accountability. Hospital C rated the lack of standardized reporting systems as "Strongly Agree" (WM 3.51) — the single highest rating recorded in either results table — and rated every other statement at least as high as Hospitals A and B.

Difference in Challenges by Hospital Affiliation

Table 4. Difference Between Challenges and Hospital Affiliation

Variables	t-value	p-value	Decision	Interpretation
Challenges × Affiliation	3.18	.011	Reject H ₀	Significant

With $p = .011$ ($< .05$), the null hypothesis of no difference was rejected: the challenges reported by respondents differed significantly according to their hospital affiliation, consistent with the pattern in Tables 2 and 3, in which Hospital C consistently reported the most severe issues across nearly every measure.



Discussion

The results point to a pattern that recurs across every measure in this study: structural and resource constraints — hospital size and capacity, financial support, and technology and infrastructure — are the most frequently reported issues affecting patient care quality, and this same cluster of institutional pressures appears to shape the accountability climate as well. This aligns with the literature on hospital size and financial sustainability reviewed in Section 1.2 (Smith, Johnson, & Williams, 2019; Brown, Garcia, & Martinez, 2019), which similarly frames resource constraints as a structural driver of care-quality problems rather than a matter of individual staff performance.

The consistency with which respondents cited fear of repercussions, a blame-oriented culture, and the absence of standardized reporting systems as barriers to accountability likewise mirrors the safety-culture literature (Gonzales & Ramos, 2018; Weingart, Smith, & Jones, 2018): where reporting is treated as an admission of individual fault rather than an opportunity for systemic learning, staff have little incentive to disclose errors, and administrators lose visibility into the problems they most need to address. Read through the Human Factors and systems-theoretic lens set out in Section 1.1, this suggests that the reporting barriers identified here are not simply a training gap but a structural feature of how these hospitals currently handle error disclosure — precisely the kind of systemic vulnerability that Reason's model and Carayon and colleagues' (2014) human-centered design approach point to.

The significant difference in challenges by hospital affiliation ($t = 3.18$, $p = .011$) — with Hospital C reporting the most severe issues on nearly every measure in Tables 2 and 3 — indicates that these challenges are not uniform across institutions even within the same public-hospital system, and that interventions calibrated to one hospital's context may not transfer directly to another.

Proposed Strategies

Building on these findings, the following strategies are proposed to address the challenges identified in hospital administration.

Table 5. Proposed Strategies and Implementation Measures

Strategy	Focus	Implementation Measures
Enhance financial support	Ensure adequate resources for patient care, technology, and staff support.	Lobby for higher government and private-sector budgets; pursue grants and non-profit partnerships.
Improve human resource management	Address staffing shortages and improve morale.	Conduct regular workforce assessments; offer competitive pay, continuous training, and clear career paths.
Upgrade technology and infrastructure	Modernize equipment and information systems.	Allocate dedicated funding; adopt electronic health records; maintain and update equipment regularly.
Strengthen leadership and management	Foster a supportive, efficient working environment.	Provide leadership training; promote open communication and transparent decision-making.



Promote a culture of safety and accountability	Shift focus from individual blame to systemic improvement.	Establish non-punitive reporting systems; encourage teamwork; focus corrective action on systems, not individuals.
Implement standardized reporting systems	Ensure accurate, consistent error documentation.	Adopt user-friendly reporting software; train staff on its use; review and update protocols regularly.
Manage workloads and reduce time constraints	Give staff adequate time to perform duties safely.	Add staff during peak periods; streamline administrative tasks; automate routine processes.
Address bureaucratic burdens	Simplify reporting procedures.	Remove unnecessary steps; delegate administrative tasks; use digital platforms to speed workflows.
Enhance training and education	Keep staff current on best practices.	Offer continuing education, case-based training, and access to online courses and seminars.
Encourage feedback and continuous improvement	Create channels for ongoing staff and patient input.	Conduct regular surveys and focus groups; implement suggestion boxes and digital feedback forms.

Limitations

This study is limited by its small, purposively selected sample ($N = 30$) drawn from three hospitals, which constrains statistical power and limits generalizability beyond similar public-hospital settings in the NCR; by its reliance on a single, researcher-developed self-report instrument, whose title in the source materials did not match the study's actual subject matter (see Section 2.3) and should be re-verified; and by the internal inconsistencies in the source chapters regarding respondent composition and sample size per hospital (see Section 2.2), which future replications should resolve through more rigorous documentation of the sampling process.



Conclusion and Recommendations

Conclusions

The demographic profile of respondents reflected a workforce concentrated in the 1-to-10-year experience range, with comparatively few long-tenured staff — a pattern that may itself reflect retention challenges relevant to the administrative issues under study. Across all three hospitals, patient care quality was most frequently affected by hospital size and capacity, financial support, and technology and infrastructure, while human resources, leadership and management, and quality of care were consistently, if less acutely, implicated. Accountability and error reportage were hindered chiefly by fear of repercussions, a blame-oriented organizational culture, and the absence of standardized reporting systems. These challenges differed significantly by hospital affiliation, indicating that institutional context — not a uniform, system-wide deficiency — drives much of the variation observed. Taken together, these findings support strategic interventions in financial support, human resource management, technology infrastructure, leadership, and safety culture as priorities for strengthening hospital administration and patient safety in these institutions.

Recommendations

1. Hospitals should conduct fuller demographic assessments of their healthcare workforce — including specialization, role, and educational background — to enable more precisely targeted interventions.
2. Hospitals should prioritize investment in capacity expansion, financial sustainability, staff recruitment and retention, technology adoption, and leadership development to address the patient-care-quality issues identified here.
3. Hospitals should adopt non-punitive, standardized error-reporting systems, paired with regular training on error identification and reporting, to address the accountability barriers identified in this study.
4. Hospitals should develop context-specific action plans, given the significant differences in challenges observed by affiliation, rather than assuming a single set of interventions will work equally well across institutions.
5. Future research should resolve the sampling and instrumentation inconsistencies noted in Sections 2.2 and 2.3, and should consider expanding the sample size and hospital coverage to strengthen the generalizability of these findings.



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