

Patterns and Challenges of Outpatient Services in Level I Government Hospital in Dinalupihan, Bataan: Basis for Operational Improvement Plan

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ABSTRACT

This study evaluated outpatient service utilization patterns and operational challenges in a Level I government hospital in Dinalupihan, Bataan, as basis for a Strategic Improvement Plan. A sequential explanatory mixed-method design, anchored in pragmatism, Donabedian's Quality of Care Model, and Systems Theory, was used. The quantitative phase retrospectively analyzed hospital records from January to December 2025, while the qualitative phase explored the experiences of healthcare workers and patients through interviews and phenomenological analysis using Colaizzi's method. Quantitative findings showed 33,838 outpatient consultations, with adult services comprising the largest share (34.3%), followed by pediatric (24.4%) and prenatal services

(16.0%). Injury of unspecified body region was the most frequent case type (31.1%), while October recorded the highest monthly patient volume (11.1%). Female patients had significantly higher monthly consultation volumes than males ($p < .001$). Qualitative findings revealed operational challenges, particularly insufficient doctors, high patient volume, prolonged waiting times, OPD-to-ER overflow, inadequate diagnostic equipment such as ultrasound, uncomfortable waiting areas, and patients leaving without being seen. Financial barriers, out-of-pocket expenses, inefficient referral mechanisms, RHU bypassing, and limited technology infrastructure contributed to fragmented service delivery. Despite these challenges, patients continued to use the hospital because consultations were free, PhilHealth coverage reduced financial burden, staff were approachable, and the facility was accessible. The findings indicate a structural capacity-demand mismatch and systemic coordination gaps. The proposed improvement plan prioritizes workforce optimization, infrastructure and equipment upgrades, digital and appointment-system integration, patient support, and strengthened RHU referral networks to improve efficiency, accessibility, continuity, and quality of outpatient care.

Keywords: *outpatient services, government hospital, service utilization, operational challenges, mixed-methods research, healthcare quality, patient flow, strategic improvement plan, referral system, Dinalupihan*

INTRODUCTION

The quality of the outpatient services represents one of the most visible indicators of the hospital's overall efficiency and responsiveness to the health demands of the community. Outpatient departments (OPD) serve as the most frequent point of contact between patients' and health care institutions, most specially in government hospitals that cater immense population with limited resources. This study explores the patterns and challenges of outpatient services in a Level I government hospital in Dinalupihan, Bataan

that shall be a basis for the development of a strategic development plan.

Globally, there has been a growing emphasis on improving outpatient service systems as healthcare continues to shift from inpatient to ambulatory and preventive care. The World Health Organization (WHO, 2021) notes that primary and outpatient care now accounts for significant portion of health services encountered worldwide driven by principles of universal health coverage and community-based health. In other countries, such as United Kingdom and Singapore, digital systems and patient-centered scheduling have been integrated to enhance outpatient service efficacy (Smith et al., 2020).

In the Philippines the passage of Universal Health care Law (Republic Act 11223) in 2019 mandates equitable access to quality health services for all Filipinos, which further emphasizes the need for efficient outpatient services operations as a gateway to broader health system reform (Department of Health, 2020). With this pathway, government hospitals, particularly Level I facilities undeniably play a vital role in providing essential outpatient services particularly to the underserved and vulnerable members of the community.

Several studies have investigated outpatient service delivery in both developing and developed countries. A study in India revealed that insufficient manpower and poor patient record management significantly affected outpatient efficiency (Kumar and Gupta, 2020). In the local arena, Mendoza and Dizon (2022) found that the most common barriers to smooth outpatient service delivery are delays in patient triage, documentation and laboratory turnaround time. Despite the availability of studies, most of them focus on operational audits and patient satisfaction surveys without integrating both the qualitative and quantitative perspective that would provide more comprehensive understanding of the outpatient service delivery dynamics.

This gap highlights the need for a mixed-method approach that examines not only the quantitative or measurable data but also the experiences and perception of both patients and healthcare workers. By integrating quantitative data and qualitative insights, this study seeks to bridge the divide between administrative data and human experience. With this approach, this study intends to delve into having a clearer understanding of how organizational, technical and interpersonal factors affects the outpatient service delivery in a level I government hospital.

The objective this study is to determine the patterns and challenges of outpatient service delivery in a Level I government hospital in Dinalupihan, Bataan and use the findings as basis for the developing a strategic improvement plan. Specifically, it aims to identify utilization patterns and performance trends in hospital's outpatient services, explores challenges encountered by both healthcare workers and patients and integrate these findings in a proposed data driven strategic improvement plan.

In summary, this study aims to transform empirical findings into actionable strategies for improving outpatient service delivery. By grounding its analysis in both data and experience it aims to promote evidence-based hospital management practices and promote accessible, efficient and people-centered outpatient services within the healthcare system of the Province of Bataan.

Review of Related Literature

Several studies about outpatient service delivery were already conducted in other countries. Most of these studies centered on patient satisfaction and its predictors in various healthcare settings. In a cross-sectional study conducted by Biya, M., et al. (2022), factors associated with prolonged OPD turnaround time were associated with place of residence, arrival time and even day of visit. Relative to this, Utino, L., et al. (2023) concluded that shorter waiting hours, drug availability, communication and privacy were key predictors of better perceived outpatient service delivery among public hospitals in Southern Ethiopia. In a similar study, Owusu, A.A., et al. (2024) identified waiting area comfort, signage, staff attitude and long waiting time as significant determinants of perceived quality of outpatient services in selected health facilities in Kumasi, Ghana. Aside from these studies, Mansilla, M.J., et al. (2024), arrived at the conclusion that scheduling optimization, workflow redesigning and other technical changes resulted to forty five percent reduction in OPD waiting time and

improvements at registration, triage and pharmacy points in a quasi-experimental quality improvement evaluation in Tanzanian public hospital.

In the local scenario, several studies also focused on the dynamics of services in the outpatient's departments. Several local students have documented long waiting hours, fragmented patient flow, and service inefficiencies. Cenizal (2019) found that patient spent an average of two hours completing triages and registration procedures in a time and motion study. In the same light, Barbadillo et al. (2024), noted that even in less crowded facilities consultation would take around twenty-nine minutes. Caguimbal (2017), in a system study at De La Salle University Medical Center identified long-waiting time average of one hundred minutes as the most critical operational issue at the outpatient department. Aside from time efficiency, other studies focused on other dimensions of outpatient service delivery. Dans et al. (2024) conducted baseline surveys across three primary care sites and concluded that there are significant differences in service utilization and health spending across urban, rural and remote areas. Divinagracia (2024) reiterated that patient satisfaction is not only influenced by waiting time but also by staff behavior and appointment system in a study conducted in level I private hospitals in Western Visayas.

Both local and international findings provide a vantage point for this study. Collectively, these studies underscore the universality of outpatient services challenges - the prolonged turnaround time, inefficient workflows, issues of resources, communication, and staff attitude. On the hand, these studies also provide valuable empirical references for examining outpatient services patterns and challenges. The review of both local and foreign literature underscores the need for strategic planning and data driven reforms in enhancing outpatient services delivery.

Philosophical Underpinning

This study is anchored on the pragmatic paradigm, which serves as the philosophical foundation for mixed-method research. Pragmatism emphasizes that the choice of research methods should be determined by the research problem itself. Pragmatism allows the combination of both qualitative and quantitative approaches to generate an in-depth understanding of the research issue (Creswell and Plano Clark, 2018).

Under the quantitative aspect, the study anchors from the positivist philosophy, which assumes that reality can be measured and explained through observation and statistical analysis. In this study, the patterns of outpatient service delivery- such as patient volume, turnaround time, case frequency and patient satisfaction are treated as measurable phenomena that can be analyzed to reveal trends and operational performance (Cohen, Manion, and Morrison, 2018)

In relation to the qualitative aspect, the study draws from the interpretivist or constructivist view, which holds that reality is socially constructed and best understood through the subjective experience of the individuals. This aligns with the study's exploration on the challenges encountered by both healthcare workers and patients as it seeks to comprehend their lived experiences, perceptions and contextual meanings (Lincoln, Lynham and Guba 2011)

By adopting pragmatism, this study acknowledges that neither quantitative nor qualitative methods alone are sufficient to fully understand the complex realities of outpatient service delivery in Level I government hospital setting. Instead, the integration of both methods provides a holistic understanding that can lead to a practical solution - in this case, a strategic improvement plan for outpatient services.

Theoretical Framework

This study is anchored on two complementary theoretical perspectives: *Donabedian's Quality of Care Model (1988)* and *Systems Theory (von Bertalanffy, 1968)*. These theories provide a holistic approach for understanding and analyzing the patterns and challenges of outpatient service delivery in government hospital setting. Both theories emphasized interrelated components that affect service quality making them highly relevant to the subject under study.

Donabedian's Quality of Care Model

Avedis Donabedian's *Quality of Care Model* (1988) is one of the most influential frameworks in research related to health services. The model conceptualizes healthcare quality in three interrelated dimensions namely, structure, process and outcome. *Structure* refers to the resources and organizational setting in which care occurs. Physical facilities, equipment, staffing, financing and policies are parts of the structure. In relation to this study, structure pertains to the hospital's manpower complement, facilities and administrative components that support the outpatient services.

Process, on the other hand involves the actual delivery of care- the interaction between patients and providers, including diagnosis, treatment, record management, and patient flow. Relative to this, for the outpatient department, process indicators include turnaround time, trigger systems, consultation procedures and referral mechanism. *Outcomes* represent the results of healthcare services, which can be measured in terms of patient satisfaction or health improvement. Within the bounds of this study, outcomes reflect on the effectiveness of outpatient services as perceived by both patients and healthcare providers.

Donabedian's model posits that high-quality care results well from well-structured systems that enable efficient processes leading to favorable outcomes (Donabedian, 2003). This theoretical perspective provides a scientific basis for evaluating how organizational factors (structure) and care processes influence service delivery outcomes. In this research the theory guides both the quantitative inquiry - patterns in utilization and performance metrics, and the qualitative inquiry-healthcare provider and patient experiences, ensuring that data collection and interpretation remain aligned with recognized dimensions of healthcare quality.

Systems Theory

Ludwig Von Bertalanffy originally developed the Systems Theory in 1968. According to this theory, organizations are composed of interrelated and interdependent parts that must function cohesively to achieve overall goals. In healthcare, hospitals are view as open systems that interact continuously with internal and external environments, such as patients, staff, policies and community health needs (Kast and Rozenweig, 1972).

Applying Systems Theory in this study, reiterates that the outpatient services operate as a subsystem within the larger hospital organization. Inputs such as human resources, equipment and patient flow enter the system; processes, such as consultations and diagnostics occur; and output such as treated patients and patient's satisfaction levels feedback into the system for continuous improvement. When any components of the system malfunctions, it creates a domino effect that affects the entire system. System Theory emphasizes interconnectedness and feedback as key principles in the development of the strategic improvement plan proposed in this study. By analyzing the outpatient services through a system approach, the researcher can identify which element would require restructure, redefining and redesigning.

The integration of Donabedian's Model and Systems Theory offers a comprehensive theoretical foundation. Donabedian's Model offers quality assessment framework which are the structures, processes and output. On the other end of the spectrum, Systems Theory explains the dynamics, interconnectedness and interdependence of these components. With these models combined, the study does not only investigate the patterns and challenges in the outpatient services but also the systemic relationships influencing the subject under study.

Donabedian's Quality of Care Model Systems Theory

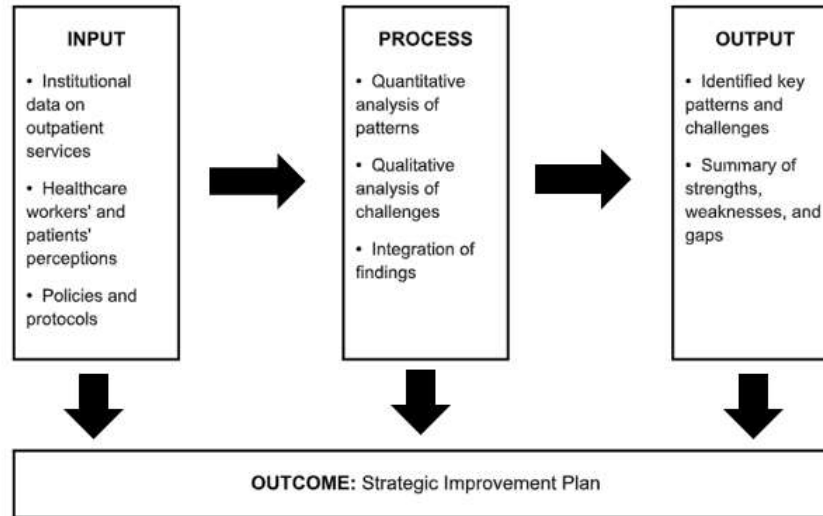


Figure 1. *Conceptual Framework*

Figure 1 represents the Conceptual Framework of the study. It utilizes the core concepts of Donabedian's Quality of care Model and von Bertalanffy's Systems Theory. As depicted in the figure above, relevant data to outpatient services delivery, healthcare workers and patients' perception and policies and protocols in the hospital constitute the input. These data are then processed through mixed-method approach, particularly the quantitative analysis of the patterns and qualitative analysis of the challenges. With the application of the mixed-method reattach design, patterns and challenges are to be uncovered alongside with the strength, weakness and gaps in the outpatient service delivery, thus- output of the study. The findings then from the quantitative and qualitative analysis shall be integrated to come up with a proposed strategic improvement plan which will be the penultimate output of this study.

Statement of the Problem

The general objective of this study is to identify and explore the patterns and challenges of outpatient services in a Level I Government hospital in Dinalupihan, Bataan.

Specifically, this study seeks to answer the following:

1. What are the patterns of out-patient services utilization in terms of:
 - 1.1 Patient volumes and case type
 - 1.2 Average turnaround time and consultation time
 - 1.3 Frequency of follow-up visits
 - 1.4 Availability of medical and support personnel?
2. What challenges are encountered by health care providers in rendering outpatient services?
3. What challenges are encountered by patients in accessing and receiving outpatient services?
4. How do the identified patterns relate to the challenges experienced in outpatient service delivery?

5. What strategic improvement plan can be proposed to enhance the efficiency and quality of outpatient services in the hospital?

Assumptions

The following are the assumptions in this study:

1. It is assumed that the out-patient service records and hospital data accurately reflect the actual patterns of services utilization and delivery in the facility.
2. It is assumed that the selected respondents will provide honest, accurate and unbiased responses during the conduct of the study.
3. It is assumed that the challenges identified respondents represent the real operational and experiential issues affecting outpatient service delivery.
4. It is assumed that both quantitative and qualitative data will complement one another, providing a comprehensive understanding of the outpatient services.
5. It is assumed that existing hospital policies, resource allocation and organizational structure influenced the patterns and challenges in outpatient service delivery.
6. It is assumed that the findings of this study can serve as a reliable basis for developing a strategic improvement plan that is relevant to a Level I Government Hospital.

METHODS

Research Design

This study will utilize a Sequential Explanatory Mixed-Method Design to investigate the patterns and challenges of outpatient services in a Level I government hospital in Dinalupihan, Bataan. The design involves two phases: a quantitative phase and a qualitative phase.

The quantitative phase will employ a retrospective descriptive approach, analyzing existing hospital records, reports and outpatient department statistics from January to December 2025. This phase aims to identify measurable trends in outpatient service delivery, including patient volume, case type, turnaround and consultation time, and frequency of follow-up visits.

The qualitative phase will start after quantitative results are analyzed and will employ phenomenological approach to explore the challenges and underlying factors affecting the identified patterns. Through focused group discussion and structured interview, this study will gather insights from healthcare workers and patient alike to explain issues, barriers and factors that affect outpatient service delivery.

The rationale for employing this mixed- method design is to integrate the strength of both quantitative and qualitative data, thereby complementing static trends with experiential insights. According to Creswell and Plano (2018), the sequential explanatory approach is appropriate when quantitative findings require further explanation through qualitative inquiry.

Research Site

The study will be conducted at Jose C. Payumo Jr. Memorial Hospital, located in Dinalupihan, Bataan. It is a Level I government hospital operated by the Provincial Government of Bataan under the supervision of the Provincial Health Office. The hospital provides both inpatient and outpatient services primarily to the municipality of Dinalupihan and Hermosa, two of the most populous areas in the province.

The facility houses several outpatient services such as general OPD, multi-specialty clinic for patients needing specialized care, animal bite treatment center and HIV/ STI treatment hub. The hospital serves as an important health care access for low-income population making it an appropriate setting for investigating outpatient service patterns and operational challenges.

The choice of this research site is justified by its very characteristics which is typical for a Level I government hospital setting in the Philippines. These characteristics includes limited resources, high patient volume and wide service coverage. Understanding its outpatient service patterns and challenges will contribution to formulating data driven strategies for hospital efficiency and quality improvement (Department of Health, 2022) Department of Health. (2022). *Philippine health facility development plan 2020-2040*.

Sample and Sampling Design

This study will employ two sets of samples corresponding to its sequential explanatory mixed-method design.

The study will use tool population sampling of all outpatient service records, reports, and monitoring data available from January to December 2025 for its quantitative or retrospective data. These include patient volume records, service logs, and turnaround time monitoring sheets. This non-probability method ensures comprehensive coverage of hospital outpatient data to accurately determine trends and patterns (Polit and Back, 2021)

On the other hand, the qualitative or prospective data of this study will be obtained through purposive sampling method. This means that participants who possesses significant knowledge and experience regarding outpatient service delivery will be purposely selected. The study will include healthcare workers who has been assigned at the outpatient department for at least three (3) years, while patient's respondents must be of legal age and have availed at least five (5) times. Furthermore, there will be ten (10) healthcare workers and (10) patients for interview and focus group discussion, as typically 10-15 participants are enough to reach data saturation (Creswell, 2014).

Research Instrument

The study will utilize two sets of instruments, corresponding to the quantitative and qualitative phases of the mixed-method design.

A researcher-developed data extraction form will be utilized for the retrospective quantitative phase of this research. The form will be designed to systematically gather relevant data from existing hospital records, logs, reports and monitoring sheets pertaining to outpatient services from January to December 2025.

The researcher-developed data extraction form will include the following variables: (1) Patient volume and case type - number and classification per month, (2) average waiting or turnaround time - total time from registration until consultation , (3) Consultation duration - length of physician patient interaction , (4) frequency of follow-up visits - average number of repeat consultation per patient , (5) staff availability - number and distribution personnel assigned in outpatient department, and (6) patient satisfaction data - extracted from available hospital survey results.

According to Polit and Beck (2012), the data extraction form ensures the standardized collection of numerical and categorical data from second day sources. It will be developed in alignment with hospital's outpatient reporting format to maintain data consistency and reliability.

For the qualitative phase of this study, a semi-structured interview guides will be used to explore the perceived challenges in outpatient service delivery. Separate guides shall be prepared for healthcare workers and patients, containing open-ended questions to elicit detailed narratives. Cl (2014) reiterated that the used of semi-structured interviews allows flexibility to probe deeper into response while maintaining focus to the study objectives. Interviews will be audio recorded and transcribed verbatim for analysis.

Validation of Research Instrument

The data extraction from shall undergo content validation by a panel of three (30 subject matter experts in the fields of hospital administration, nursing management and research methodology. They will

assess clarity, relevance and usefulness of each data item using a content validation index (CVI) rating scale. Ten with a CVI score of below 0.80 will be revised or discarded. The form will also be pretested using a small subset of outpatient records to check for ease of use and consistency in data entry.

The interview guides for the qualitative phase will be validated through expert review, approval from psychometrician and pilot testing. The same panel of experts shall evaluate the appropriateness and alignment of the interview questions with the study objectives. Additionally, the interview guides will also be subject to the review and approval of a registered psychometrician. After making necessary revisions, pilot interview will be conducted with one healthcare worker and one patient not included in the main study to determine the comprehensibility of guide questions and flow of the discussion.

Data Gathering Procedure

This study will employ the Sequential Explanatory Mixed-Method Design consisting of two phases: quantitative phase for the retrospective data analysis followed by qualitative phase through semi-structured interviews and focus group discussion.

Quantitative Phase

The first phase will involve retrospective analysis of existing outpatient department data from January to December 2025. Data will be extracted using the validated data extraction form developed by the researcher. The quantitative data will include the following variables: monthly patient volume and case type, average waiting and consultation time, frequency of follow-up visits, staffing and personnel availability and patient satisfaction data.

The researcher will coordinate with hospital records office, hospital data controller, hospital management information system and outpatient department to access the needed documents. Only aggregated and de-identified data will be recorded to ensure patient confidentiality and compliance with the Data Privacy Act of 2012 (Republic Act 10173).

Once extracted, the data will be encoded in a spreadsheet and analyzed using descriptive statistics to determine prevailing patterns and trends in outpatient service delivery. The findings from the quantitative phase will serve as the empirical foundation for the qualitative phase.

Qualitative Phase

After the analysis and understanding of the quantitative data, the qualitative phase will be conducted to explore the challenges and perception related to outpatient services. A semi-structured interview guide validated by experts and pilot-tested will be used to collect narrative data from the two groups of participants: (1) healthcare providers assigned at the OPD for at least three years and (2) patients who have availed OPD services at least five times within the past years.

Participants will be purposely selected based on their experience and relevance to the objective of the study. Before each interview, participants will be informed about the nature of the study, their rights, and voluntary nature of participation. A written consent shall be obtained from each participant before the interview commences.

Interviews will be conducted in a private and quiet room within the premises of the hospital to ensure confidentiality and comfort, each interview will last for at least 30-45 minutes and will be audio-recorded for accuracy. The recording will then be transcribed verbatim for thematic analysis.

Upon completion of both phases, the results will be integrated during the interpretation phase. Quantitative findings will prove the patterns in outpatient service delivery while qualitative findings will provide the challenges and factors influencing these patterns.

Ethical Considerations

This research shall adhere to the highest standards ethical standards as outlined by the National Ethical Guidelines for Health and Health Related research (2017) and the Data Privacy Act of 2012. As such, the searcher will ensure ethical clearance, informed consent, confidentiality, data security anonymity and withdrawal of participants will be accomplished.

Prior to data collection, an approval letter will be sought from the provincial health office, hospital ethics committee and other offices. Informed consent from all participants shall be obtained after orienting them about the purpose, nature and procedures of the study. To uphold confidentiality, names and identifiable details of participants and patients will not be recorded. Codes will be used in transcripts and datasets.

To ensure data security, all electronic files will be stored in password-protected devices and printed materials will be kept in locked cabinets accessible only to researcher. Furthermore, participants may withdraw from the study at any point without any consequences.

According to Polit and Beck (2021), these measures are needed to ensure that the study upholds principle of respect to person, beneficence and justice consistent with ethical research standards.

Data Analysis Procedure

This study will employ the Sequential Explanatory Mixed-Method Design consisting of two phase, quantitative phase followed by qualitative phase. The quantitative data shall be analyzed first to determine existing patterns in outpatient service delivery while the qualitative data will be analyzed using Colaizzi's (1978) phenomenological method to explore the challenges of healthcare workers and patients. The final step involves integration of both datasets to generate insights that will serve as basis for formulation of a strategic improvement plan.

Quantitative data derived from the researcher made data extraction form will be encoded and analyzed using the Statistical Package for the Social Sciences Version 27. The analysis will include descriptive statistics, trend analysis, and cross tabulation and correlation. The quantitative result will establish the patterns that reflect the outpatient service performance and will serve as foundation for the qualitative phase.

The qualitative phase will focus on explaining and deepening the understanding of the qualitative results through the experiences of healthcare workers and patients. Data from the interviews will be ascribed verbatim and will be analyzed using Colaizzi's (1978) seven-step phenomenological method. These steps are as follows:

1. **Familiarization.** The researcher will read all transcripts multiple times to obtain comprehensive understanding of participants' experiences.
2. **Extraction of significant statement.** Key sentences and phrases directly related to the challenges and experiences in outpatient will be identified.
3. **Formulation of meaning.** The researcher will interpret the meanings embedded in each significant statement.
4. **Organization into Theme Cluster.** Formulated meaning will be grouped into clusters, leading to the identification of major and subthemes.
5. **Development of Exhaustive Description.** All emerging themes will be synthesized into a full detailed description of participants experiences.
6. **Production of Fundamental Structure.** The exhaustive description will be reduced to a concise summary capturing the essence of phenomena
7. **Validation by Participants.** The researcher will return the findings to the participants for confirmation of accuracy and to ensure the authenticity of interpretations.

RESULTS AND DISCUSSION

Integration of the results will follow the explanatory approach online by Creswell and Plano Clark (2018). The quantitative finding will answer what patterns exist while qualitative findings derived from Colaizzi's analysis will answer why these patterns occur and how healthcare workers and patients experience them. The integration findings shall lead to the formulation of strategic improvement plan for outpatient service delivery.

Table 1. *Demographic profile of outpatients by sex*

Month	Male (n)	Female (n)	Total (n)	% Male	% Female	Mean Monthly	SD	Min (Month)	Max (Month)
JAN	810	1,084	1,894	42.8%	57.2%				
FEB	755	974	1,729	43.7%	56.3%				
MAR	761	1,029	1,790	42.5%	57.5%				
APR	681	860	1,541	44.2%	55.8%				
MAY	648	876	1,524	42.5%	57.5%				
JUN	574	773	1,347	42.6%	57.4%				
JUL	648	954	1,602	40.4%	59.6%				
AUG	768	1,098	1,866	41.2%	58.8%				
SEP	760	1,161	1,921	39.6%	60.4%				
OCT	913	1,285	2,198	41.5%	58.5%				
NOV	747	937	1,684	44.4%	55.6%				
DEC	456	631	1,087	41.9%	58.1%				
Male						710.08	±116.29	456 (Dec)	913 (Oct)
Female						971.83	±179.83	631 (Dec)	1,285 (Oct)
Total						1,681.92	±284.15	1,087 (Dec)	2,198 (Oct)
Sex Ratio (F:M)									1.37:1

Table 1.1 reveals that a clear pattern emerges where women consistently sought outpatient care more often than men throughout 2025. Of the 20,183 total consultations recorded, nearly 58% came from female patients (11,662), while males accounted for just over 42% (8,521). This translates to roughly 137 women for every 100 men seeking care at the hospital. This gender gap was not just a one-time occurrence, it held steady month after month. The proportion of female patients ranged from a low of 55.6% in November to a high of 60.4% in September, showing that women's higher utilization of outpatient services was a persistent trend rather than an occasional spike.

When it came to peak demand, both men and women followed a similar rhythm. October emerged as the busiest month for both sexes, with 913 male and 1,285 female consultations. December, on the other hand, saw the lightest patient load, with numbers dropping to 456 for men and 631 for women, likely reflecting the holiday season's effect on healthcare-seeking behavior.

Accordingly, female patient volumes showed more variability from month to month, as reflected in the higher standard deviation (±179.83) compared to males (±116.29). This suggests that women's decisions to seek outpatient care may be more influenced by seasonal changes, social factors, or other external circumstances than men's, (Barasa & Virhia, 2022).

Hence, it reflects how traditional gender roles shape health-seeking behavior, with women seeking

care more proactively.

Table 1.2. *Demographic profile of outpatients by patient's category*

Patient Category	Annual Total (n)	% of Total
Total OPD Consultations	33,838	100.0%
<i>Breakdown by Category</i>		
OPD - Adult	11,620	34.3%
Pedia	8,271	24.4%
PNCU (Prenatal)	5,421	16.0%
Senior	2,932	8.7%
Postnatal	2,285	6.8%
PNCU - Teen	1,084	3.2%
Ortho	936	2.8%
ENT	730	2.2%
Surgical	559	1.7%

Note. PNCU = Prenatal Care Unit; ENT = Ear, Nose, and Throat; Ortho = Orthopedics; OPD = Outpatient Department.

Table 1.2 depicts the demographic profile of outpatients according to patient category. A total of 33,838 consultations were recorded for the year 2025. Among these, Adult OPD comprised the largest share with 11,620 cases, accounting for 34.3% of all consultations. This was followed by Pedia with 8,271 (24.4%) and PNCU (Prenatal) with 5,421 (16.0%). These three categories represented nearly three-fourths (74.7%) of the total patient volume, indicating that general adult care, pediatric services, and maternal health are the hospital's primary service areas.

Conversely, specialized services such as Surgical (1.7%), ENT (2.2%), and Ortho (2.8%) recorded the lowest utilization rates. This supports the claim of Reyes et. al, (2023) that mentioned, limited availability of specialized services may be due to a lack of equipment, facilities, or trained staff. Patients needing these services are often referred to larger hospitals in nearby cities. Some community members may also choose not to seek these services because they do not see them as necessary or prefer other forms of care.

Indeed, the distribution emphasizes the need for the hospital to prioritize resource allocation toward high-demand categories while the hospital should examine whether low utilization of specialized care stems from lack of awareness, affordability issues, or referral practices, and respond accordingly.

Table 1.3. *Demographic profile of outpatients by case type*

Rank	Case Type	Frequency	% of Total OPD	ICD-10 Code
1	Injury of unspecified body region	10,534	31.1%	T08-T14
2	Reproductive health services (Prenatal)	5,421	16.0%	Z30-Z39
3	Urinary system diseases	3,161	9.3%	N30-N39
4	Acute lower respiratory infections	2,653	7.8%	J20-J22
5	Influenza and pneumonia	1,187	3.5%	J10-J18
6	Hypertensive diseases	1,109	3.3%	I10-I15
7	Other viral diseases	683	2.0%	B25-B34
8	Intestinal infectious diseases	613	1.8%	A00-A09

9	Acute upper respiratory infections	586	1.7%	J00-J06
10	Diabetes mellitus	570	1.7%	E09-E14
	Total cases	26,517	78.4%	

Table 1.3 presents the ten most frequently occurring case types among outpatient consultations, with 26,517 cases or 78.4% (cumulative) of the total OPD volume. This finding suggests that a relatively narrow set of health conditions comprises the majority of the hospital's clinical workload, thereby providing a clear direction for resource prioritization.

Foremost among these is injury of unspecified body region, which ranked first with 10,534 cases, representing nearly one-third of all consultations. This disproportionately high prevalence points to potential underlying community safety issues, including road traffic accidents, occupational hazards, or domestic incidents, warranting further epidemiological investigation.

Similarly, reproductive health services, specifically prenatal care, ranked second with 5,421 cases. This finding corroborates the earlier observed by Laza et al., (2026) which noted that female predominance among outpatients and reinforces the hospital's pivotal function in maternal and child health service delivery.

Furthermore, respiratory infections emerged as a significant disease cluster. Acute lower respiratory infections, influenza and pneumonia, and acute upper respiratory infections collectively constituted a substantial proportion of consultations. Given their seasonal nature, these conditions necessitate proactive surge capacity planning.

Moreso, the presence of hypertensive diseases and diabetes mellitus, though comprising smaller percentages, signals the growing burden of non-communicable diseases. These chronic conditions require long-term management protocols and lifestyle interventions.

Thereby, the hospital must adopt a multifaceted operational strategy that addresses trauma care, maternal health, infectious disease control, and chronic illness management to effectively respond to the community's prevailing health needs.

Table 2.1. *Level patterns of out-patient services utilization in terms of monthly patient volume*

Month	Patient Volume	% of Annual Total	Descriptive Measure	Value
January	3,269	9.7%	Mean Monthly	2,819.83
February	2,908	8.6%	Median	2,833.50
March	3,233	9.6%	Standard Deviation	±542.94
April	2,606	7.7%	Minimum (Month)	1,780 (Dec)
May	2,478	7.3%	Maximum (Month)	3,761 (Oct)
June	2,117	6.3%	Range	1,981
July	2,759	8.2%		
August	3,000	8.9%		
September	3,218	9.5%		
October	3,761	11.1%		
November	2,709	8.0%		
December	1,780	5.3%		

Note. No unique mode was identified for monthly volume as all values were distinct.

It can be gleaned on Table 2.1 the monthly distribution of outpatient. Patient volume fluctuated considerably throughout the year, with October recording the highest number of consultations at 3,761, representing 11.1% of the annual total.

In contrast, December registered the lowest volume with 1,780 consultations, accounting for only 5.3% of the yearly figure. The mean monthly volume was 2,819.83, while the median stood at 2,833.50, indicating a relatively symmetrical distribution. However, the standard deviation of ± 542.94 reflects substantial variability across months. The range of 1,981 further demonstrates the disparity between peak and off-peak periods. This seasonal pattern marked by a significant drop in December and a surge in October which suggests that in the Philippine setting, external factors such as long holiday breaks, the rainy season, and community festivities often influence when and whether people seek healthcare, (Pajaron & Vasquez, 2023), with some delaying visits during celebrations and others coming in during disease outbreaks brought by changing weather.

Understanding these seasonal trends can guide the hospital in preparing for changes in patient volume, such as through flexible staffing and timely procurement of supplies, especially ahead of the rainy months when respiratory and waterborne illnesses are more prevalent.

Consequently, the hospital must develop strategies to manage these fluctuations, including surge capacity planning for high-demand months and efficient resource allocation during lean periods to ensure uninterrupted service delivery.

Table 2.2. *Level patterns of out-patient services utilization in terms of consultation time by service area*

Month	ER Patients (n)	ER Average Time (min)	OPD Patients (n)	OPD Average Time (min)	MC Patients (n)	MC Average Time (min)	Birth Cert Patients (n)	Birth Cert Average Time (min)
January	1,134	13	4	10	0	—	0	—
February	1,142	13	3	3	0	—	0	—
March	—	—	—	—	—	—	—	—
April	627	7	17	14	0	—	0	—
May	665	15	14	3	0	—	0	—
June	1,211	12	9	3	0	—	0	—
July	1,350	13	12	5	0	—	0	—
August	1,192	12	11	7	0	—	0	—
September	1,029	13	9	3	0	—	0	—
October	1,111	10	9	7	0	—	0	—
November	1,121	10	9	6	0	—	0	—
December	1,137	10	9	8	0	—	0	—
Total	12,319	—	106	—	0	—	0	—
Overall average	—	11.6	—	6.3	—	—	—	—

Note. March 2025 data is unavailable. MC = Medical Certificate; Birth Cert = Birth Certificate. Dashes (—) indicate no data available as no patients were recorded in these categories. ER = Emergency Room; OPD = Outpatient Department. Average times are computed from reported daily averages per month; actual patient-level waiting times may vary. Overall average represents the mean waiting time across all available months.

Table 2.2 illustrates the average turnaround and consultation times across four service areas from January to December 2025. The emergency room recorded the highest patient volume with 12,319 consultations, averaging 11.6 minutes per patient.

In contrast, the outpatient department had only 106 patients recorded, with an average time of 6.3 minutes. The medical certificate and birth certificate services showed zero patients across all months, indicating either these services were not offered, not tracked, or captured under other reporting categories.

Monthly ER times ranged from 7 minutes (April) to 15 minutes (May), while OPD times ranged from 3 minutes (February, May, June, September) to 14 minutes (April). March data was unavailable.

The emergency room consistently managed a substantial patient load with relatively efficient turnaround times, suggesting that current protocols and staffing levels are adequate for acute care demands. Conversely, the notably low OPD utilization raises concerns about service accessibility or patient referral patterns, which may indicate either underutilization due to systemic barriers or the possibility that patients bypass OPD in favor of emergency services.

This finding substantiates with Serafica et al., (2025) who reported that institutional barriers limit outpatient service uptake or community members habitually seek care through emergency channels. This calls for an in-depth examination of referral networks and operational models to enhance patient navigation and guarantee that each care setting serves its intended population effectively.

Table 2.3. *Level patterns of out-patient services utilization in terms of emergency department visits*

Category	Frequency
Adult ED Visits	27,406
Pediatric ED Visits	22,693
Total ED Visits	50,099

Note. ED = Emergency Department

Table 2.3 shows the breakdown of emergency department visits by patient category. Out of 50,099 total ED visits, adults accounted for 27,406, while pediatric patients made up 22,693. This means adults comprised nearly 55% of all emergency cases, with children representing the remaining 45%.

The gap between adult and pediatric visits is notable but not overwhelming. Adults seek emergency care more often, possibly due to work-related injuries, chronic conditions, or lifestyle factors. However, the high number of pediatric visits is almost half of all ED cases which is found to be equally significant. Children clearly represent a major portion of the emergency caseload.

This distribution has practical implications for the hospital. This evidence consistent with Berg et al. (2023) which confirmed that staffing patterns, equipment needs, and training requirements differ between adult and pediatric emergency care. The hospital cannot afford to neglect either group. Pediatric cases demand specialized knowledge, child-sized equipment, and age-appropriate protocols, Onyejesi et.al, (2025). Adult cases involve different clinical presentations, medication dosages, and treatment pathways.

Therefore, the nearly equal split between adult and pediatric visits suggests the emergency department must maintain competency in both areas. Neither group can be treated as a secondary priority. This is particularly important during peak hours or seasonal surges when both adult and pediatric patients may arrive simultaneously.

Table 2.4. *Level patterns of out-patient services utilization in terms of availability of medical and support personnel*

Category	Indicator	Frequency	Percentage
Personnel expenditure	Total Personnel Expenditure	₱9,329,431.85	100.0%
	Wages,Salaries,Benefits, Allowances	₱9,329,431.85	100.0%
Support services	Total Tests Performed	297,934	100.0%
	Clinical Chemistry	110,131	37.0%
	Immunology/Serology	77,369	26.0%
	Hematology	68,152	22.9%

	Urinalysis	22,365	7.5%
	X-Ray	17,983	6.0%
	Fecalysis	1,934	0.6%
	Blood Units Transfused	539	0.2%
Surgical operations	Total Operations Performed	507	100.0%
	Cesarean Delivery	297	58.6%
	Cesarean Delivery with BTL	58	11.4%
	ORIF (Open Reduction Internal Fixation)	47	9.3%
	Open Cholecystectomy	46	9.1%
	TAHBSO (Total Abdominal Hysterectomy with BSO)	18	3.6%
	Thyroidectomy	18	3.6%
	Exploratory Laparotomy	10	2.0%
	Modified Radical Mastectomy	7	1.4%
	Removal of Implant	6	1.2%

Note. BTL = Bilateral Tubal Ligation; BSO = Bilateral Salpingo-Oophorectomy; ORIF = Open Reduction Internal Fixation; TAHBSO = Total Abdominal Hysterectomy with Bilateral Salpingo-Oophorectomy. Data on headcount by job category was not available at the time of data collection.

Table 2.4 presents data on level patterns of out-patient services utilization in terms of availability of medical and support personnel. Total personnel expenditure amounted to ₱9,329,431.85, covering wages, salaries, benefits, and allowances. However, specific headcount by job category was not provided, limiting the analysis of staffing distribution.

Among support services, clinical chemistry accounted for the highest volume with 110,131 tests (37.0%), followed by immunology/serology with 77,369 (26.0%) and hematology with 68,152 (22.9%). these three categories collectively represented 85.9% of all laboratory procedures, indicating heavy reliance on diagnostic testing. x-ray (6.0%), urinalysis (7.5%), fecalysis (0.6%), and blood transfusions (0.2%) comprised the remaining services.

In terms of surgical operations, a total of 507 procedures were performed. Cesarean deliveries dominated with 297 cases (58.6%), followed by cesarean with BTL at 58 (11.4%). These two procedures alone accounted for 70.0% of all surgeries, underscoring the hospital's primary role in maternal and obstetric care. Other procedures such as ORIF (9.3%), open cholecystectomy (9.1%), and TAHBSO (3.6%) were performed with notably lower frequency.

Nevertheless, the absence of disaggregated staffing data constrains any meaningful evaluation of whether this level of spending adequately supports the overwhelming demand for obstetric surgeries and laboratory diagnostics, which together dominate the hospital's service profile, (Jones, 2025).

The data illustrates that the hospital's focus on obstetric services and laboratory diagnostics. It can be inferred that the hospital's substantial personnel expenditure of ₱9,329,431.85 reflects a considerable investment in its workforce.

Table 3. *Comparison between monthly patient volume between male and female patients*

Group	*n	M	SS	s ²	SD	
Male	12	710.08	154,609	14,055	118.56	
Female	12	971.83	344,553	31,323	177.06	
Result	s_p²	SE	*t*	df	t-critical	*p

22,689.21	61.49	-4.26	22	±2.074	< .001
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Note. An independent samples t-test was conducted to compare monthly outpatient consultation volume between male (M) and female (F) patients.

Table 3 provides the data on comparison between monthly patient volume between male and female patients. Results revealed a statistically significant difference in monthly volume between males ($M = 710.08$, $SD = 118.56$) and females ($M = 971.83$, $SD = 177.06$), $t(22) = -4.26$, $p < .001$.

The decision to reject the null hypothesis indicates that female patients had significantly higher monthly consultation volumes than male patients. $\alpha = .05$, two-tailed. M = Mean; SS = Sum of Squares; s^2 = Variance; SD = Standard Deviation; s_p^2 = Pooled Variance; SE = Standard Error; t^* = t-statistic; df = Degrees of Freedom; $t_{critical}$ = Critical t-value. The null hypothesis is therefore rejected.

This data supports the claim of Jalo et.al, (2025) that women are generally exhibit more proactive healthcare-seeking behaviors compared to men.

Thus, women consistently used the hospital's outpatient services at higher rates than men throughout the entire year of 2025. This pattern is statistically significant, meaning it is a genuine trend rather than a random occurrence.

Statistical Treatment of Data

Descriptive statistics were primarily employed to summarize the demographic and utilization patterns of outpatient services. Frequency counts, percentages, and ranking were used to present the distribution of patients by sex (Table 1.1), patient category (Table 1.2), and case type (Table 1.3), as well as emergency department visits (Table 2.3). These measures allowed for the identification of the most and least utilized categories and the most prevalent health conditions.

Moreso, measures of central tendency (mean, median) and variability (standard deviation, range, minimum, maximum) were computed to describe monthly patient volume (Table 2.1), consultation times across service areas (Table 2.2), and support service and surgical operation volumes (Table 2.4). These descriptive statistics provided a comprehensive overview of service utilization patterns and operational efficiency.

For inferential analysis, an independent samples t-test was employed to determine whether the observed difference in monthly patient volume between male and female patients was statistically significant (Table 3). Descriptive statistics including mean, standard deviation, variance, and sum of squares were computed for each group, while inferential statistics such as the t-value, degrees of freedom, and p-value were reported to support the comparison. The t-test results allowed for the rejection or acceptance of the null hypothesis, confirming whether the observed gender disparity in outpatient utilization represented a genuine pattern rather than a random occurrence.

Step 1: Acquiring familiarity with the data

After a thorough review of all seven interview transcripts, the researcher have gained a comprehensive understanding of the healthcare providers' experiences in the outpatient department (OPD) of a Level I Government Hospital in Dinalupihan, Bataan. The data revealed multiple interconnected challenges affecting both healthcare providers and patients in accessing outpatient services.

Step 2: Extracting significant statements (verbatim)

Table 4. *Challenges are experienced by healthcare rendering and of patients in accessing outpatient services*

Participant	Verbatim Statement
P1	"Ang nagiging problema po namin pagka Monday is talagang marami yung population, Doc, umaabot po ng 50 tapos iisa po yung consultant natin."

Participant	Verbatim Statement
	"Ang nagiging problema lang po namin talaga sa OPD kami na nakiki ay first hand sa mga pasyente is yung ah lack of ano po ng consultant. Kulang po talaga sila." "Kailangan naming i-repair sila sa another hospital para sa mga kagaya ng ultrasound po kasi hindi po available sa atin 'yun." "Sa laboratory naman po ah so far naman po na natutugunan ng hospital natin 'yung ah mga laboratory na kailangan ng mga buntis natin." "Yung ultrasound kung dito na po sa hospital natin gagawin mapapadali po siguro para sa mga buntis natin."
P2	"Ah sa tingin ko po hindi po tama yung ah kumbaga po hindi po capacity ng ganong patient yung bilang po ng doctor. Kasi po commonly ah pagka weekdays po umaabot po ng 70 plus ah yung mga patient po natin." "Yung ibang doctor po kasi ah minsan po isa or dalawang doctor po yung nagche-check up sa OPD tapos yung ibang pasyente po natatagalan pong maghintay." "Sa tingin ko po factor din po yun. Ah kaya nagtatagal? Yes po." (referring to doctor's time per patient) "Kailangan po siguro ng ah health teaching na yung ganong case po ay pwede naman po sila ng week days yung oras po ng sa vaccine po natin." "Madalas po sa OPD binabayaran po yun ng pasyente." (referring to laboratory services)
P3	"Una po siguro po importante din yung cooperation po ng RHU kasi meron pong mga cases na pang RHU lang kagaya po ng CF and colds." "May time po na umaabot kami ng 100 plus doc per day." "May mga umuwi na hindi nagche-check up. Yes po doc. Marami din po yung mga hindi nakapaghintay na patient." "Kapag halimbawang mahaba yung oras ng case nila [sa OR], naiinip yung mga pasyente. Kahit na sabihin namin na ganitong oras yung sinabi ni Doc pero minsan hindi man dumadating si Doc ng ganong time." "Hindi po. May ano parang kulang po doc. Kulang po tayo sa doktor para matugunan po lahat nung kailangan ng mga pasyente na magpapa-check up." "Sana po madagdagan po yung doctor natin especially I para po hindi loaded yung sa isang araw." "Yung waiting area po natin minsan halimbawa sobrang ano po yung araw naitan po sila nagsisitaasan yung Opressure yon kaya ang tendency yung iba napupunta sa ER." "Yung sa area namin doc parang hindi siya okay na ano yung pagkakatayo po. Ngayung umuulan so tumutulo meron po do meron is merong kwarto na tumutulog pa rin pero naaanuhan pa naman po."
P4	"Yung mga um challenges na na-encounter ko po yung kapag po naiinip na po sila yung pasyente wala na po silang tigil sa pagtatanong kung wala pa bang doktor, anong oras po magsisimula." "Yung challenges naman sa mga equipments po natin sa ospital may mga may mga equipments po kasi na talagang mahirap pong i-provide natin kasi nasa level 1 OPD po tayo." "Nag-i-improvise po tayo gamit ang swero or kayaman po yung sa may kapag ka po may sira yun sa pangsiliip po ng sa sa tenga." "Kailangan ko pa po ng computer. Isa pa pong computer para po mas mas mabilis po yung facing ng pasyente na kasi isa lang po yung gumaga ng computer." "Yung pagbibigay po ng reseta natin is naka-print na rin po para po hindi na po babalik si pasyente para para magtanong ano po daw ang basa dito."

Participant	Verbatim Statement
P5	"Yung sa timbangan po medyo ano na po kasiing scale natin pati po yung sa baby." "Hindi [tama ang patient ratio] ... umaabot kami ng 300 to 400 a day [sa animal bite center]." "Yung mga pasyente nagmamadali pero na-handle naman po na papauwi sila lahat ng nababakunahan ng antiabis." "May bayad 'yung gamot natin, Doc pero mas mura. Kumpara po sa labas ah ang range niya is PH55 pag regular patient Mas mura tayo compare sa mga animal bite center sa labas." "Sana magkaroon ng free although mahirap maging posible Sana magkaroon yung social worker natin ng assistant. Hindi naman po karamiha n ng pasyente eh humihingi ng tulong pero sana yung mga talagang walang pangbakuna, pang-injection eh mabigyan natin ng suporta."
P6	"Pwede rin din doc kasi po minsan po ang pasyente po ang doktor po natin na halimbawa isa lang po siyang ganon ang dami tulad po ng IM isa lang po kasi ang IM natin ngayon. So dinadagsa po siya ng mga pasyente." "Umaabot po kami ng kulang 50 sa kanya pa lang po. Yun pong iba nai inip lalo na po ang mga senior natin. Naiinip po then umaalis po." "Yun pong sao pag Monday po marami po talagang pasyente kasi naiipon po mula yung Sabado Linggo."
P7	"Siguro doc unang-una ito yung pinakamalapit sa kanila ... nakikita din po nila yung quality ng pagka-assess sa kanila ng mga doctor." "Kaya po parang gusto man po nilang pumunta din sa ibang doctor wala ka lang wala lang din silang pera para po sa private." "Hindi po cover ni PhilHealth yung bakal medyo malaki pong malaking gastos para sa kanila tapos kaya nagpo-prompt din sila na imbes na apa-opera, semento na lang po ganon." "Yung schedule po kasi ng natin for OR is puno parang hanggang August, September meron na po." "Mas sasapat po siya siguro do kung pwede tayong magdagdag ng kahit isa pang IM para sa mga adult medical natin po." "Nakakaapekto din yung paghihintay since yung mga consultant natin ... sila din po yung nag-o-opera. So ang schedule po is opera bago checkup." "Yung waiting area po nila tapos additional doctor kahit siguro yun sa IM po yun. Tapos availability po minsan ng laboratory din po." "Yung ultrasound kung magkakaroon po tayo malaking bagay din po yun."

Legend:

P1	Nursing Attendant	P2	OPD Nurse
P3	Nurse/Staff		
P4	Nurse/Staff		
P5	Nurse (Animal Bite)	P6	OPD Nurse
P7	Senior Nurse		

Step 3: Formulating Meaning

Theme	Meaning	Description	Verbatim Evidence
Theme 1: inadequate healthcare workforce	Meaning 1.1 - insufficient number of consultants/doctors	The hospital experiences a critical shortage of medical doctors, with only one consultant handling 50+ patients on peak days. This creates a mismatch between patient volume and provider capacity.	"Ang nagiging problema po namin pagka Monday is talagang marami yung population, Doc, umaabot po ng 50 tapos iisa po yung consultant natin." (P1)

Theme	Meaning	Description	Verbatim Evidence
Theme 2: inadequate medical equipment and diagnostic services	Meaning 1.2 - single specialist coverage	Specific departments like internal medicine operate with only one doctor, leading to patient congestion and prolonged waiting times. The OR schedule conflict further reduces doctor availability for OPD consultations.	"Pwede rin din doc kasi po minsan po ang pasyente po ang doktor po natin na halimbawa isa lang po siyang ganon ang dami tulad po ng IM isa lang po kasi ang IM natin ngayon." (P6)
	Meaning 1.3 - imbalanced patient-to-doctor ratio	Patient loads reach 70-100+ per day with only 1-2 doctors, far exceeding reasonable capacity. It results in patients leaving without being seen and increased stress on healthcare workers.	"Ah sa tingin ko po hindi po tama yung ah kumbaga po hindi po capacity ng ganong patient yung bilang po ng doctor. Kasi po commonly ah pagka weekdays po umaabot po ng 70 plus ah yung mga patient po natin." (P2)
	Meaning 2.1 - absence of essential diagnostic equipment	Ultrasound services are unavailable at the hospital, requiring patients to seek services elsewhere. It leads to additional burden, costs, and delays for pregnant patients requiring this essential diagnostic tool.	"Kailangan naming i-repair sila sa another hospital para sa mga kagaya ng ultrasound po kasi hindi po available sa atin 'yun." (P1)
	Meaning 2.2 - equipment malfunction and improvisation	Essential diagnostic tools (e.g., otoscope, ophthalmoscope) are either broken or unavailable, forcing staff to improvise using alternative methods (e.g., using IV fluids for eye flushing).	"Nag-i-improvise po tayo gamit ang swero or kayaman po yung sa may kapag ka po may sira yun sa pangsiliip po ng sa sa tenga." (P4)
Theme 2: inadequate medical equipment and diagnostic services	Meaning 2.3 - need for updated equipment	Broken or outdated equipment such as weighing scales (including baby scales) affect service delivery quality.	"Yung sa timbangan po medyo ano na po kasing scale natin pati po yung sa baby." (P4)
	Meaning 2.4 - limited technology infrastructure	Only one computer serves the OPD with two doctors, creating inefficiencies in patient processing, recording, and prescription writing.	"Kailangan ko pa po ng computer. Isa pa pong computer para po mas mas mabilis po yung facing ng pasyente na kasi isa lang po yung gumaga ng computer." (P4)
Theme 3: facility infrastructure challenges	Meaning 3.1 - inadequate waiting area	The waiting area has poor physical conditions including excessive heat, insufficient seating, and exposure to weather elements, negatively affecting patient comfort and potentially causing health complications (e.g., elevated blood pressure in seniors).	"Yung waiting area po natin minsan halimbawa sobrang ano po yung araw nainitan po sila nagsisitaasan yung Opressure yon kaya yung iba napupunta sa ER." (P3)
	Meaning 3.2 - structural deficiencies	The OPD area has structural issues including leaking roofs during rainy seasons, compromising patient care environment.	"Yung area namin doc parang hindi siya okay ... ngayung umuulan so tumutulo meron po do meron is merong kwarto na

Theme	Meaning	Description	Verbatim Evidence
			tumutulong pa rin pero naanuhan pa naman po." (P3)
Theme 4: long waiting times and patient throughput issues	Meaning 4.1 - patient congestion on specific days	Mondays see the highest patient volume due to accumulation over weekends, with OBs reaching 50+ patients and total OPD reaching 70-100+.	"Yun pong sao pag Monday po marami po talagang pasyente kasi naiipon po mula yung Sabado Linggo." (P6)
	Meaning 4.2 - doctor availability conflicts	Consultants who also perform surgeries prioritize OR operations before OPD consultations, causing unpredictable delays and patient frustration.	"Yung mga consultant natin ... sila din po yung nag-o-opera. So ang schedule po is opera bago checkup." (P7)
	Meaning 4.3 - patients leaving without being seen	Due to long waiting times, many patients leave without receiving care, representing service delivery failure.	"May mga umuwi na hindi nagche-check up. Yes po doc. Marami din po yung mga hindi nakapaghintay na patient." (P3)
	Meaning 4.4 - variable consultation Duration	Different doctors have varying consultation speeds, with some taking longer per patient, contributing to overall delays.	"Sa tingin ko po factor din po yun. Ah kaya nagtatagal? Yes po." (P2)
Theme 5: financial	Meaning 5.1 - out-of-pocket expenses for	While consultations are free, patients must pay for laboratory services and medications, creating financial barriers for economically disadvantaged patients.	"Madalas po sa OPD binabayaran po yun ng pasyente." (P2)
	Meaning 5.2 - cost implications of external referrals	Patients needing services unavailable at the hospital (e.g., ultrasound, surgical implants) must seek external providers, incurring additional costs and logistical difficulties.	"Kailangan naming i-repair sila sa another hospital para sa mga kagaya ng ultrasound po kasi hindi po available sa atin 'yun." (P1)
	Meaning 5.3 - PhilHealth coverage gaps	Surgical implants/materials (like surgical steel) are not covered by PhilHealth, causing patients to opt for less effective but more affordable alternatives (e.g., cement instead of proper implants).	"Hindi po cover ni PhilHealth yung bakal medyo malaki pong malaking gastos para sa kanila ... semento na lang po ganon." (P7)
	Meaning 5.4 - need for social welfare support	There is a perceived need for additional social worker support to assist indigent patients with medication and vaccine costs, particularly for animal bite treatment.	"Sana magkaroon yung social worker natin ng assistant. ... Sana yung mga talagang walang pangbakuna, pang-injection eh mabigyan natin ng suporta." (P5)
Theme 6: inter-system coordination and referral challenges	Meaning 6.1 - RHU referral pattern	Patients bypass Rural Health Units (RHUs) due to absence of doctors and come directly to the hospital for cases that should be managed at the primary care level (e.g., coughs, colds).	"Una po siguro po importante din yung cooperation po ng RHU kasi meron pong mga cases na pang RHU lang kagaya po ng CF and colds." (P2)

Theme	Meaning	Description	Verbatim Evidence
	Meaning 6.2 - patient preference due to quality of care	Despite challenges, patients choose the hospital due to perceived better quality of service, approachable staff, and no doctor's fees compared to private facilities.	"Siguro doc unang-una ito yung pinakamalapit sa kanila ... nakikita din po nila yung quality ng pagka-assess sa kanila ng mga doctor." (P6)
	Meaning 6.3 - misconceptions about urgency	Some patients lack understanding of what constitutes an urgent case, leading to inappropriate use of OPD services for non-urgent conditions (e.g., animal bites arriving late at night).	"Kailangan po siguro ng ah health teaching na yung ganong case po ay pwede naman po sila ng week days yung oras po ng sa vaccine po natin." (P2)
Theme 7: patient education and health literacy gaps	Meaning 7.1 - limited understanding of service schedules	Patients lack awareness of appropriate times to seek services, contributing to congestion and inefficient service utilization.	"Okay naman po lahat ng ano dito wala naman pong problema kaya lang po kailangan po talaga maaga po talagang pumupunta." (P3)
	Meaning 7.2 - need for health teaching	There is an identified need for better health education regarding appropriate care-seeking behavior, including when to visit RHUs versus the hospital.	"Kailangan po siguro ng ah health teaching na yung ganong case po ay pwede naman po sila ng week days yung oras po ng sa vaccine po natin." (P2)
	Meaning 7.3 - patient-driven referral patterns	Patients recommend specific doctors to others based on perceived quality and demeanor, creating uneven patient distribution across days.	"Ganitong araw magaling doctor na ganun, mabait, mahinahon." (P1)
Theme 8: impact on patient health outcomes	Meaning 8.1 - deferred care due to waiting	Patients unable to wait become lost to follow-up, potentially compromising their health outcomes.	"Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka m sa iba ka magpapa-check up dahil minsan talagang masakit na eh." (Pt1)
	Meaning 8.2 - health deterioration during waiting	Seniors and other vulnerable patients experience health deterioration (elevated blood pressure, stress) while waiting in uncomfortable conditions.	"Yung waiting area po natin minsan halimbawa sobrang ano po yung araw nainitan po sila nagsisitaasan yung Opressure yon kaya yung iba napupunta sa ER." (P3)
	Meaning 8.3 - emergency room overflow	Patients who become distressed while waiting in OPD require emergency department transfers, creating additional burden on the hospital system.	"Yung iba napupunta sa ER." (P3)

The findings depicted a critical capacity-demand mismatch at this Level I Government Hospital, where severe workforce shortages, inadequate equipment, and facility deficiencies create a cascade of service delivery failures that disproportionately affect vulnerable populations. Despite these systemic challenges, patients continue to choose this hospital due to financial necessity and perceived quality of care, (Divinagracia & Guevarra, 2024) creating a paradox where service inadequacies are tolerated because alternatives are either unaffordable or inaccessible, compromising patient health outcomes and perpetuating an unsustainable cycle of care discontinuity.

Step 4: Organizing formulated meanings into theme clusters

Theme Cluster	Meaning	Description	Verbatim Evidence
A. resource limitations	1. inadequate healthcare workforce	The hospital suffers from a critical shortage of medical doctors, with only one consultant handling 50+ patients on peak days and single specialists (e.g., Internal Medicine) creating bottlenecks. OR schedule conflicts further reduce OPD availability.	"Ang nagiging problema po namin pagka Monday is talagang marami yung population, Doc, umaabot po ng 50 tapos iisa po yung consultant natin." (P1); "Pwede rin din doc kasi po minsan po ang pasyente po ang doktor po natin na halimbawa isa lang po siyang ganon ang dami tulad po ng IM isa lang po kasi ang IM natin ngayon." (P6)
	2. insufficient medical equipment and diagnostic services	Essential diagnostic equipment (ultrasound) is unavailable; existing tools (otoscope, ophthalmoscope) are broken requiring improvisation; only one computer serves OPD; weighing scales (including baby scales) are outdated.	"Kailangan naming i-repair sila sa another hospital para sa mga kagaya ng ultrasound po kasi hindi po available sa atin 'yun." (P1); "Nag-i-improvise po tayo gamit ang swero or kayaman po yung sa may kapag ka po may sira yun sa pangsiliip po ng sa sa tenga." (P4); "Kailangan ko pa po ng computer. Isa pa pong computer para po mas mas mabilis po yung facing ng pasyente na kasi isa lang po yung gumaga ng computer." (P4)
B. patient access barriers	3. facility infrastructure deficiencies	The waiting area has poor physical conditions including excessive heat, insufficient seating, and exposure to weather elements. The OPD area has structural issues including leaking roofs during rainy seasons.	"Yung waiting area po natin minsan halimbawa sobrang ano po yung araw naitan po sila nagsisitaasan yung Opressure yon kaya yung iba napupunta sa ER." (P3); "Yung area namin doc parang hindi siya okay ... ngayung umuulan so tumutulo meron po do meron is merong kwarto na tumutulog pa rin pero naaanuhan pa naman po." (P3)
	4. OR schedule congestion affecting OPD availability	OR schedules are fully booked months in advance (August-September), and surgeon-consultants prioritize OR operations over OPD consultations, causing unpredictable delays and patient frustration.	"Yung schedule po kasi ng natin for OR is puno parang hanggang August, September meron na po." (P7); "Yung mga consultant natin ... sila din po yung nag-o-opera. So ang schedule po is opera bago checkup." (P7)
	1. financial constraints	While consultations are free, patients must pay for laboratory services and medications out-of-pocket, creating financial barriers for economically disadvantaged patients.	"Madalas po sa OPD binabayaran po yun ng pasyente." (P2); "Kaya po parang gusto man po nilang pumunta din sa ibang doctor wala ka lang wala lang din silang pera para po sa private." (P6)
	2. geographic distance to other facilities	Tertiary hospitals with comprehensive services are located far from Dinalupihan, making them less accessible for	"Mas malapit po kasi to tsaka mas madali po puntahan kung sakaling yun po manganganak na." (Pt5); "Siguro doc unang-una ito yung pinakamalapit sa kanila." (P6)

Theme Cluster	Meaning	Description	Verbatim Evidence
		patients who need advanced care.	
	3. limited diagnostic services requiring external referrals	Patients needing services unavailable at the hospital (e.g., ultrasound) must seek external providers, incurring additional costs and logistical difficulties.	"Kailangan naming i-repair sila sa another hospital para sa mga kagaya ng ultrasound po kasi hindi po available sa atin 'yun." (P1); "Yung ultrasound kung magkakaroon po tayo malaking bagay din po yun." (P7)
	4. lack of social welfare support for indigent patients	There is a perceived need for additional social worker support to assist indigent patients with medication and vaccine costs, particularly for animal bite treatment.	"Sana magkaroon yung social worker natin ng assistant..... Sana yung mga talagang walang pangbakuna, pang-injection eh mabigyan natin ng suporta." (P5)
C. service delivery inefficiencies	1. Patient congestion on peak days	Mondays and Wednesdays see the highest patient volume due to accumulation over weekends and patient preferences for specific doctors. OBs reach 50+ patients and total OPD reaches 70-100+.	"Yun pong sao pag Monday po marami po talagang pasyente kasi naiipon po mula yung Sabado Linggo." (P6); "May time po na umaabot kami ng 100 plus doc per day." (P3)
	2. long waiting times due to doctor-patient ratio	With only 1-2 doctors serving 70-100+ patients daily, waiting times are extensive. Some patients report half-hour waits as "long," while others accept full-day commitments.	"Ang dati ko pong na-encounter yung sa triads. Matagal po talaga naghihintay. Opo. Siguro kalahating oras kami." (Pt6); "Sa panganganak ko ... kahit maaga kang nagpa-record hapon ka po talaga mag hanggang hahapunin ka na." (Pt6)
	3. patients leaving without being seen	Due to long waiting times, many patients leave without receiving care, representing service delivery failure and lost opportunities for care.	"May mga umuwi na hindi nagche-check up. Yes po doc. Marami din po yung mga hindi nakapaghintay na patient." (P3); "Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka m sa iba ka magpapa-check up dahil minsan talagang masakit na eh." (Pt1)
	4. OR conflicts delaying OPD consultations	Consultants who also perform surgeries prioritize OR operations before OPD consultations, causing unpredictable delays and patient frustration. Patients wait for doctors who are delayed due to extended OR cases.	"Kapag halimbawang mahaba yung oras ng case nila [sa OR], naiinip yung mga pasyente. ... minsan hindi man dumadating si Doc ng ganong time." (P3); "Yung mga consultant natin ... sila din po yung nag-o-opera. So ang schedule po is opera bago checkup." (P7)
	5. inefficient patient processing	Only one computer serves the OPD with two doctors, creating inefficiencies in patient processing, recording, and prescription writing. No printer for clear prescriptions causes patient confusion and returns.	"Kailangan ko pa po ng computer. Isa pa pong computer para po mas mas mabilis po yung facing ng pasyente na kasi isa lang po yung gumaga ng computer." (P4); "Yung pagbibigay po ng reseta natin is naka-print na rin po para po hindi na po babalik si

Theme Cluster	Meaning	Description	Verbatim Evidence
D. system coordination gaps			<i>pasyente para magtanong ano po daw ang basa dito." (P4)</i>
	1. bypassing RHUs despite available services	Patients bypass Rural Health Units (RHUs) due to absence of doctors and come directly to the hospital for cases that should be managed at the primary care level (e.g., coughs, colds).	<i>"Una po siguro po importante din yung cooperation po ng RHU kasi meron pong mga cases na pang RHU lang kagaya po ng CF and colds." (P2); "Meron pong mga cases na pang RHU lang." (P2)</i>
	2. lack of effective referral systems	Referral mechanisms between facilities are inefficient. Patients often self-refer to the hospital without proper coordination with RHUs, and referral documentation is not streamlined.	<i>"Kasi po doc kailangan po dito para po na yung kalimbawa may problema sa akin, madali po akong i-transfer." (Pt3); "Yung suggestion ko lang po bale yung doktor sa Triads siguro kapagka kinailangan ni OPD ng doktor ah padala." (Pt2)</i>
	3. inconsistent doctor availability	Doctor availability is inconsistent, with some days having no OPD doctor, forcing OPD patients to seek care in the ER. This creates a cascade effect where ER becomes overwhelmed.	<i>"May pagkakataon na wala eh. Kaya napupunta OPD sa ER tapos pagtoxic si ER medyo yung pasyente nagbo-volume." (Pt2); "Minsan hindi man dumadating si Doc ng ganong time." (P3)</i>
E. patient health literacy and behavior	1. misunderstanding of urgency levels	Some patients lack understanding of what constitutes an urgent case, leading to inappropriate use of OPD services for non-urgent conditions (e.g., animal bites arriving late at night thinking it is urgent).	<i>"Kailangan po siguro ng ah health teaching na yung ganong case po ay pwede naman po sila ng week days yung oras po ng sa vaccine po natin." (P2); "May mga nagpupunta pong gabing-gabi ah akala po nila yung case nila is urgent." (P2)</i>
	2. poor understanding of appropriate service utilization	Patients lack awareness of when to visit RHUs versus the hospital, and have limited understanding of appropriate care-seeking behavior, contributing to congestion.	<i>"Meron pong mga cases na pang RHU lang kagaya po ng CF and colds." (P2); "Kailangan po siguro ng ah health teaching." (P2)</i>
	3. word-of-mouth doctor recommendations causing uneven demand	Patients recommend specific doctors to others based on perceived quality and demeanor, creating uneven patient distribution across days. This contributes to congestion on certain days and underutilization on others.	<i>"Ganitong araw magaling doctor na ganun, mabait, mahinahon." (P1); "Nagkakaron po kasi ng endorsement from patient to another patient. Sasabihin nila yung ganitong araw magaling doctor." (P1)</i>
F. impact on staff and patients	1. staff stress and burnout from workload	Healthcare workers face overwhelming workloads with 70-100+ patients daily and only 1-2 doctors. Staff experience	<i>"Yung mga um challenges na na-encounter ko po yung kapag po na naiinip na po sila yung pasyente wala na po silang tigil sa pagtatanong kung wala pa bang doktor."</i>

Theme Cluster	Meaning	Description	Verbatim Evidence
		stress from managing patient expectations, frustrations, and high patient volumes.	(P4); <i>"May time po na umaabot kami ng 100 plus doc per day."</i> (P3)
	2. patient frustration and verbal complaints	Patients express frustration through verbal complaints, questioning doctor availability and waiting times. Some patients use harsh language, reflecting dissatisfaction with service delivery.	<i>"Wala na po silang tigil sa pagtatanong kung wala pa bang doktor, anong oras po magsisimula."</i> (P4); <i>"Yung mga nakakapagsalita na po sila na hindi maganda."</i> (P4)
	3. health deterioration during waiting	Seniors and other vulnerable patients experience health deterioration (elevated blood pressure, stress) while waiting in uncomfortable conditions. This results in some patients requiring emergency department transfers.	<i>"Yung waiting area po natin minsan halimbawa sobrang ano po yung araw naitan po sila nagsisitaasan yung Opressure yon kaya yung iba napupunta sa ER."</i> (P3); <i>"Naiinip lalo na po ang mga senior natin."</i> (P6)
	4. lost opportunities for care	Patients unable to wait leave without being seen, representing lost opportunities for care and potentially compromised health outcomes. These patients may seek care elsewhere or defer treatment entirely.	<i>"May mga umuwi na hindi nagche-check up. Yes po doc. Marami din po yung mga hindi nakapaghintay na patient."</i> (P3); <i>"Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka m sa iba ka magpapa-check up dahil minsan talagang masakit na eh."</i> (Pt1)

The data show just how tightly connected everything is at this hospital. Too few doctors, broken equipment, cramped waiting areas, and poor coordination between health centers all feed into one another, creating a cycle that is hard to break.

When there are not enough providers, patients pile up, wait times stretch, people get sicker while waiting, some give up and leave, and the staff get burned out. At the same time, money problems keep patients coming back because this is the only place they can afford, even if it means putting up with long lines, heat, and confusion about where to go or when to show up, (Chen, 2022). It is a tough spot where people tolerate the struggles because they do not have better options, and that tolerance, in turn, takes away any pressure to fix what is broken.

Step 5: Describing the Phenomenon

Exhaustive description of challenges in outpatient services

The outpatient services at this Level I Government Hospital in Dinalupihan, Bataan, are characterized by a complex interplay of resource limitations, access barriers, service inefficiencies, and systemic gaps that collectively compromise both healthcare delivery and patient experience.

From the healthcare provider perspective

Providers are caught in a perfect storm of overwhelming patient volumes (70-100+ patients daily with only 1-2 doctors), inadequate infrastructure (leaking roofs, uncomfortable waiting areas, insufficient computers), and limited diagnostic capabilities (ultrasound unavailable, broken equipment requiring

improvisation).

This situation is exacerbated by the dual role of consultants who must prioritize surgical operations before OPD consultations, creating unpredictable delays and patient frustration. Staff witness patients leaving without care, seniors experiencing health deterioration during extended waits, and families struggling with out-of-pocket expenses they cannot afford. The emotional toll manifests in staff burnout, while professional frustration stems from providing suboptimal care due to resource constraints.

From the patient perspective

Patients face multiple barriers to accessing outpatient services. They endure long waiting hours in uncomfortable conditions (heat, overcrowding) that can actually worsen their health (elevated blood pressure in seniors). Financial constraints force difficult choices: patients must pay for laboratory services and medications even though consultations are free, and when specialist services are unavailable (ultrasound), they must travel elsewhere and incur additional costs.

Surgical patients face additional burdens when implants are not PhilHealth-covered. The lack of social welfare support leaves the most vulnerable without access to life-saving treatments like rabies vaccines. Despite these challenges, patients continue to choose this hospital because of perceived quality of care, approachable staff, and the absence of doctor's fees compared to private alternatives.

Systemic interactions

The challenges are not isolated but interconnected. Inadequate workforce leads to longer waiting times, which combines with poor facility conditions to cause health deterioration. Financial barriers compound the problem when patients must choose between seeking care elsewhere (with associated costs) or waiting in the OPD. The bypassing of RHUs due to absent doctors shifts the burden to the hospital, while the lack of patient education perpetuates inappropriate service utilization.

The absence of ultrasound creates a referral cascade that delays care for pregnant patients. OR schedule conflicts demonstrate how one department's operations directly impact another's service delivery.

Core patterns

- Mondays and Wednesdays show peak patient volumes (50+ OB patients, 70-100+ total patients) due to weekend accumulation and patient preferences for specific doctors.
- Specific groups are disproportionately affected like seniors experience greater health risks during waiting, pregnant women face ultrasound access issues, and indigent patients face medication and laboratory cost barriers.
- Consultations are free but laboratory and medications require payment; diagnostic services are limited (no ultrasound, broken equipment); surgical consultations are delayed by OR schedules.
- Patients bypass RHUs and directly seek hospital care, despite RHU availability, due to previous negative experiences and perceptions of better quality.

Thereby, it can be inferred that the outpatient department at this government hospital is caught in a difficult cycle that affects everyone involved. Providers are stretched thin seeing over a hundred patients a day with just one or two doctors, working with broken equipment, and trying to keep things running in a cramped, leaky space. They watch patients walk away without being seen, seniors get worse while waiting, and families struggle to pay for labs and medicines.

Meanwhile, Pavia (2024) affirmed that patients line up before sunrise, wait for hours in the heat, and often spend their whole day just to see a doctor. They pay what they can for tests and prescriptions, but when they need something like an ultrasound or surgery, they have to go elsewhere and spend even more.

Despite all of this, they keep coming back not because they want to, but because this is the only place they can afford and the staff actually treat them decently. It is a tough reality where people accept poor conditions because they do not have any other choice.

Step 6: Identifying fundamental structure

Fundamental structure of challenges in outpatient services. The challenges experienced in outpatient services at this Level I Government Hospital represent a *complex adaptive system problem* where multiple interrelated factors create persistent service delivery failures. The fundamental structure can be understood through four interconnected dimensions:

1. Capacity-demand mismatch

The hospital operates with resources designed for a significantly lower patient volume than it actually serves. This mismatch manifests at multiple levels:

- human resources - 1-2 doctors serving 70-100+ patients daily
- physical infrastructure - Inadequate waiting areas for patient volume
- diagnostic capacity - Essential equipment (ultrasound) absent; existing equipment broken
- technological infrastructure - Single computer for documentation and encoding

This capacity-demand gap created a cascade of problems: long waits → patient frustration → health deterioration → patients leaving without care → ER overflow → increased system burden.

2. Financial access barriers

While consultations are free at this government hospital, the following cost points create access barriers:

- laboratory services (out-of-pocket)
- medications (out-of-pocket, though lower than private)
- external referral costs (ultrasound, tertiary care)
- surgical implants (not Phil health-covered)
- animal bite vaccines (out-of-pocket for non-indigent)

This led to a tiered access system where the poorest patients may be unable to complete their care episodes, leading to partial or incomplete treatment.

3. Systemic coordination failures

The hospital operates within a broader health system that is poorly integrated.

- RHUs are bypassed due to absent doctors, shifting primary care burden to the hospital
- Referral mechanisms between facilities are inefficient
- OR and OPD schedules conflict, creating cascading delays
- Social welfare support for indigent patients is insufficient

This means patients face a disconnected system, with the hospital absorbing functions that should be served at lower levels of care.

4. Quality-perception paradox

Despite significant challenges, patients continue to choose this hospital because of the following reasons:

- Perceived quality of care is higher than RHUs.
- Staff are perceived as more approachable.
- There are no doctor's fees (unlike private facilities).
- It is geographically accessible.

This paradox represents a delicate balance: patients tolerate suboptimal conditions because they perceive the hospital as their best available option, creating a captive patient population that perpetuates the

high demand.

The fundamental challenge is the gap between the hospital's operational capabilities and its actual patient population needs and expectations. This gap encompasses the following:

- inability to perform essential diagnostics (ultrasound)
- inability to provide timely consultations
- inadequate patient care environment
- limited support for indigent patients
- insufficient providers for patient demand

This capability gap is not merely a resource problem but a structural problem embedded in the Level I hospital designation, financial constraints, and systemic integration failures.

The most significant consequence of these challenges is discontinuity of care where patients receive partial care, experience delayed care, leave without being seen, or must face multiple facilities to complete their care journey. For pregnant women, this fragmentation includes travel for ultrasound; for surgical patients, this includes seeking implants elsewhere; for all patients, this includes paying separately for laboratory services.

The current system, while resilient enough to continue functioning, operates at the expense of staff well-being, patient satisfaction, and potentially health outcomes. The pressure will likely increase as population grows and service expectations rise, making this unsustainable without significant intervention.

Step 7: Validating the Findings

All seven participants (7/7) consistently identified long waiting times as a primary challenge. Six out of seven participants (6/7) agreed on insufficient doctors and high patient volume as critical issues. Four out of seven participants (4/7) acknowledged financial barriers as a significant concern. Three participants (3/7) reported patients leaving without being seen and staff approachability as notable factors. Two participants each identified ultrasound unavailability, equipment issues, facility problems, RHU bypassing, OR scheduling conflicts, and computer/technology needs. One participant suggested the need for computer and printer improvements, so the researcher revised the findings to include limited technology infrastructure as a distinct theme.

Accordingly, the participants themselves validated the challenges by offering various proposed solutions. Four out of seven participants (P2, P3, P4, P7) raised concern for additional doctors, especially in Internal Medicine. Two participants (P1, P7) called for establishing ultrasound services. Two participants (P3, P7) pointed out the need for an improved waiting area. Two participants (P2, P3) emphasized better RHU cooperation and referral systems. One participant (P4) raised the need for adding a computer and printer. One participant (P5) proposed social worker support and free vaccines for indigent patients. One participant (P7) proposed OR/OPD schedule improvement and laboratory availability. One participant (P4) emphasized for equipment repair and replacement. Two participants emphasized improving facility infrastructure, so the researcher revised the findings to include facility infrastructure challenges as a distinct theme.

Step 1: Acquiring familiarity with the data

After thorough review of six interview transcripts from patients and their companions who have utilized outpatient services, the researcher noted a comprehensive understanding of the patient perspective on outpatient care delivery. The data showed both satisfaction with certain aspects (staff approachability, free consultations, PhilHealth coverage) and significant challenges (long waiting times, facility discomfort, doctor availability, financial barriers). These findings directly inform the strategic improvement plan.

Step 2: Extracting significant statements (verbatim)

Table 5. *Proposed Strategic Improvement Plan for Outpatient Services*

Participant	Verbatim Statement
Pt1	"Yung mga nakaraan na una po medyo mabilis. Depende naman po sa pasyente pag marami po medyo matagal." "Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka m sa iba ka magpapa-check up dahil minsan talagang masakit na eh." "Eh libre po diyan eh. M libre. Pin po may bayad sa iba mga private may bayad. M kaya nagtyaga po." "Aun po sa yung sa pag-checkup nga dapat medyo talagang mabilis. Kaya lang wala pong magagawa dahil maraming tao naaksidente pa."
Pt2	"Yung una doc b ah ano tayo eh ah dahil walang pera. Mm. dahil umasa tayo sa libre mga ganun po." "Yung suggestion ko lang po bale yung doktor sa Triads siguro kapagka kinailangan ni OPD ng doktor ah padala kasi may pagkakataon na wala eh. Kaya napupunta OPD sa ER tapos pagtoxic si ER medyo yung pasyente nagbo-volume."
Pt3	"Maayos naman po. Ah okay naman po yung mga ano mga doktor at saka." "Hindi naman po doc kasi po maaga po ako." "Hindi naman po kasi talaga po akong kwan number two. Number two na ah kaya mabilis." "Kasi po doc kailangan po dito para po na yung kalimbawa may problema sa akin, madali po akong i-transfer." "Okay naman po lahat ng ano dito wala naman pong problema kaya lang po kailangan po talaga maaga po talagang pumupunta."
Pt4	"Actually po maganda po yung customer service po ng mga nurses and doctors po dito sa JC Payumo..... mabilis po yung responde po nila sa mga pasyente po nila." "Mabilis po yung checkup, mabilis po yung pila. Hindi niyo po kailangan maghintay ng sobrang tagal po." "Wala naman po kasi po ah base po sa experience ko po ah wala naman po akong nakitang problema po sa mga out patient po na pumupunta po dito sa hospital po."
Pt5	"Sa pagpapa-check up po ayos naman po. Ano lang po ah mainit lang po sa hantayan pero ano naman po kasi libre checkup lang naman po." "Wala naman po. Mabait naman po hanggang sa utility nurse hanggang sa doctor po." "Mas malapit po kasi to tsaka mas madali po puntahan kung sakaling yun po manganganak na."
Pt6	"Ang dati ko pong na-encounter yung sa triads. Matagal po talaga naghihintay. Opo. Siguro kalahating oras kami." "Kasi po ano katulad po niyan pagka wala pong talagang pera agag dito po kasi pagka inano niyo po sa Phil Health M zero balance po talaga at malaking tulong naman po kasi talaga sa amin." "Sa panganganak ko ... yun lang din pagka talagang hindi mo pagka hindi ka malapit ng manganak M kahit maaga kang nagpa-record hapon ka po talaga mag hanggang hahapunin ka na." "Sa akin po okay lang naman yung ano nila yung sa mga doctor po yung ano ko lang katulad nito mainit na ... wala po talagang aircon ... isa lang gumagana."

Legend:

Pt1	Patient 1
Pt2	Patient 2
Pt3	Patient 3
Pt4	Patient 4
Pt5	Patient 5
Pt6	Patient 6

Step 3: Formulating meanings

Theme	Meaning	Description	Verbatim Evidence
Theme 1: workforce and service efficiency	patient volume impacts waiting time	High patient census directly causes delays in service delivery. With only 1-2 doctors serving 70-100+ patients daily, waiting times are extensive and often unpredictable.	"Pag marami po medyo matagal" (Pt1)
	OPD-ER overflow issues	When OPD lacks doctors, patients spill over to the Emergency Room, creating a cascade effect where ER becomes overwhelmed and emergency care quality is potentially compromised.	"Napupunta OPD sa ER" (Pt2); "Pagtoxic si ER ... nagbo-volume" (Pt2)
	cross-departmental resource sharing needed	There is a recognized need for cross-departmental doctor sharing to address OPD shortages, particularly drawing from ER/Triage staff when OPD lacks physician coverage.	"Yung doktor sa Triads siguro kapagka kinailangan ni OPD ng doktor ah padala" (Pt2)
Theme 2: patient strategies for access	early arrival to secure timely service	Patients employ strategies to manage long waits, primarily arriving extremely early to secure low queue numbers, which allows them to be seen earlier in the day.	"Maaga po ako ... number two kaya mabilis" (Pt3); "Kailangan talaga maaga pumupunta" (Pt3)
	full-day commitment required	Even with early registration, consultations often occur in the afternoon, requiring patients to commit their entire day to seeking care—a significant burden for working individuals and families.	"Hahapon ka na" (Pt6)
	acceptance of limitations due to cost	Patients tolerate service limitations, discomfort, and long waits because they have no alternative—private care is unaffordable and they depend on free government services.	"Eh libre po diyan eh ... kaya nagtyaga po" (Pt1); "Walang pera ... umasa tayo sa libre" (Pt2)
Theme 3: infrastructure comfort	heat and inadequate cooling in waiting area	The waiting area suffers from excessive heat, with no air conditioning and limited electric fans—only one unit functioning. This physical discomfort compounds the challenge of long waits.	"Mainit lang sa hantayan" (Pt5); "Mainit na ... wala pong aircon ... isa lang gumagana" (Pt6)
Theme 4: financial factors	free consultations as primary driver	The absence of consultation fees is the main reason patients choose and remain loyal to this hospital, despite significant service challenges. The hospital serves patients who cannot afford private care.	"Eh libre po diyan eh" (Pt1); "Walang pera ... umasa tayo sa libre" (Pt2)
	Phil health coverage provides significant relief	PhilHealth coverage ("zero balance") provides substantial financial relief for patients, reducing out-of-pocket expenses and making hospital care more accessible to indigent populations.	"Zero balance po talaga" (Pt6)
Theme 5: quality/staff factors	positive staff attitude compensates for deficiencies	Staff approachability, kindness, and quick response partially offset other service deficiencies. The positive reputation of	"Maganda ang customer service ... mabilis ang responde" (Pt4); "Mabait naman po hanggang sa

Theme	Meaning	Description	Verbatim Evidence
		staff contributes to patient loyalty and continued hospital choice.	utility nurse hanggang sa doctor" (Pt5)
Theme 6: geographic/site factors	proximity and accessibility drive hospital choice	Geographic proximity, ease of access, and referral capability to higher-level facilities are key factors in hospital selection. Patients choose this facility because it is conveniently located and can facilitate transfers when needed.	"Mas malapit po kasi to tsaka mas madali po puntahan" (Pt5); "Kailangan dito para ... madali akong i-transfer" (Pt3)
Theme 7: service gaps	patients leave without being seen	Some patients abandon care altogether due to long waits, leaving without being seen and potentially compromising their health outcomes. This represents a significant service delivery failure.	"Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka" (Pt1); "Matagal po talaga naghihintay" (Pt6)
	inconsistent waiting times	Waiting times are highly variable and often extensive, with some patients reporting half-hour waits as "long" while others accept full-day commitments as normal. This inconsistency creates patient uncertainty.	"Matagal po talaga naghihintay ... kalahating oras" (Pt6)
	service can be adequate at certain times	Some patients experience efficient service and report positive experiences, suggesting that service quality may vary significantly depending on patient volume, timing, and specific circumstances.	"Mabilis po yung checkup, mabilis po yung pila. Hindi niyo po kailangan maghintay ng sobrang tagal" (Pt4); "Wala akong nakitang problema" (Pt4)

The table illustrates that patients at this government hospital have figured out that showing up before sunrise is the only way to get seen, yet even that does not guarantee a quick visit, many end up waiting until afternoon, spending their whole day just to see a doctor.

They put up with the heat, the long lines, and the uncertainty because they simply cannot afford to go anywhere else, and the staff's kindness, (Butalid et. al., 2024) along with free check-ups and PhilHealth coverage, make the struggle feel worth it somehow, even when they leave without being seen or wonder if things will ever get better.

Step 4: organizing formulated meanings into theme clusters

Theme Cluster	Meaning	Description	Verbatim Evidence
A. Workforce and service efficiency	OPD doctor shortages and ER-OPD overflow	The OPD faces critical doctor shortages, with inconsistent physician availability forcing patients to spill over to the Emergency Room. This creates a cascade effect where ER becomes overwhelmed, potentially compromising emergency care quality. Cross-departmental resource sharing is needed to address staffing gaps.	"Napupunta OPD sa ER ... pagtoxic si ER medyo yung pasyente nagbo-volume" (Pt2); "Yung doktor sa Triads siguro kapagka kinailangan ni OPD ng doktor ah padala" (Pt2); "Pag marami po medyo matagal" (Pt1)
B. Patient strategies for access	early arrival and full-day commitment	Patients employ coping strategies to manage long waits, including arriving extremely early to secure low queue numbers and committing their entire day to	"Maaga po ako ... number two kaya mabilis" (Pt3); "Kailangan talaga maaga pumupunta" (Pt3); "Hahapon ka na" (Pt6); "Eh

Theme Cluster	Meaning	Description	Verbatim Evidence
		seeking care. They accept these burdens because private alternatives are unaffordable, tolerating service limitations due to cost constraints.	libre po diyan eh ... kaya nagtyaga po" (Pt1); "Walang pera ... umasa tayo sa libre" (Pt2)
C. Infrastructure comfort	inadequate waiting area conditions	The waiting area suffers from excessive heat with no air conditioning and only one functioning electric fan. This physical discomfort compounds the challenge of long waits, affecting patient satisfaction and potentially contributing to health deterioration during extended waiting periods.	"Mainit lang sa hantayan" (Pt5); "Mainit na ... wala pong aircon ... isa lang gumagana" (Pt6)
D. Financial factors	free consultations and Phil health coverage	The absence of consultation fees is the primary reason patients choose and remain loyal to this hospital. PhilHealth coverage ("zero balance") provides significant financial relief, reducing out-of-pocket expenses and making hospital care more accessible to economically disadvantaged populations who cannot afford private care.	"Eh libre po diyan eh" (Pt1); "Walang pera ... umasa tayo sa libre" (Pt2); "Zero balance po talaga" (Pt6)
E. Quality/staff factors	positive staff attitude and approachability	Staff approachability, kindness, and quick response partially offset other service deficiencies. The positive reputation of nurses and doctors contributes to patient loyalty and continued hospital choice, with patients reporting respectful treatment from utility nurses to physicians.	"Maganda ang customer service ... mabilis ang responde" (Pt4); "Mabait naman po hanggang sa utility nurse hanggang sa doctor" (Pt5)
F. Geographic/site factors	proximity and referral capability	Geographic proximity and ease of access are key factors driving hospital choice. Additionally, the hospital's ability to facilitate referrals to higher-level facilities when needed provides patients with a sense of security, knowing they can be transferred quickly if complications arise.	"Mas malapit po kasi to tsaka mas madali po puntahan" (Pt5); "Kailangan dito para ... madali akong i-transfer" (Pt3)
G. Service gaps	long waits and patients leaving unseen	Patients experience highly variable and often extensive waiting times, with some reporting half-hour waits as long while others accept full-day commitments. Some patients abandon care altogether due to long waits, leaving without being seen and potentially compromising their health outcomes, showing a significant service delivery failure.	"Matagal po talaga naghihintay ... kalahating oras" (Pt6); "Eh minsan po talagang minsan hindi ka makapaghintay, aalis ka" (Pt1); "Mabilis po yung checkup, mabilis po yung pila" (Pt4)

Step 5: Describing the phenomenon

Patients' journey and experiences

Patients seeking outpatient services at this Level I Government Hospital navigate a complex experience shaped by several interconnected factors:

Patients choose this hospital primarily due to financial accessibility (free consultations, PhilHealth coverage, "zero balance") and geographic convenience (proximity, ease of access, referral capability). As one patient stated, "Eh libre po diyan eh ... kaya nagtyaga po"—patients tolerate service limitations because of cost advantages. The alternative like private clinics with fees is simply not an option for many: "dahil walang pera ... umasa tayo sa libre."

Meanwhile, patient waiting times are highly variable but often extensive. Strategies for managing waits include arriving extremely early to secure low numbers—"number two kaya mabilis." However, even with early arrival, consultations often occur in the afternoon, requiring full-day commitment: "kahit maaga kang nagpa-record hapon ka po talaga." Some patients report half-hour waits as "matagal," while others accept longer waits as inevitable.

Moreover, patients consistently note discomfort in the waiting area, "mainit lang sa hantayan," "wala pong aircon," "isa lang gumagana." This physical discomfort compounds the challenge of long waits, affecting patient satisfaction and potentially health outcomes.

Patient reports on staff are predominantly positive, "maganda ang customer service," "mabait naman po," "mabilis ang responde." This positive staff attitude appears to partially offset other service deficiencies and contributes to patient loyalty.

Consequently, critical pattern identified is the overflow of OPD patients to the Emergency Room when OPD lacks doctors: "may pagkakataon na wala eh. Kaya napupunta OPD sa ER." This creates a cascade effect where ER becomes overwhelmed ("pagtoxic si ER"), potentially compromising emergency care quality.

Some patients leave without being seen due to long waits: "hindi ka makapaghintay, aalis ka." This represents a significant service failure—patients in pain or with urgent concerns abandon care, with unknown consequences for their health.

Step 6: Identifying Fundamental Structure

The fundamental structure of improvement needs for outpatient services at this Level I Government Hospital in Dinalupihan, Bataan, revealed two interconnected sets of core strategic issues: patient-driven factors and system-driven factors.

Among patient-driven factors, primary motivation for choosing the hospital is rooted in free consultations, PhilHealth coverage, and economic necessity, meaning service improvements must maintain or enhance affordability; secondary motivation includes proximity, referral capability, and staff approachability, which are geographic and relational advantages that should be leveraged; patient behavior involves early arrival to secure a place and acceptance of full-day commitments, suggesting demand management strategies should align with patient patterns; and patient tolerance for discomfort due to cost advantage indicates that physical environment improvements may increase satisfaction without reducing demand.

On the system-driven side, doctor availability is inconsistent with OPD-ER overflow and cross-department needs, requiring staffing optimization across OPD and ER; waiting time is variable and often extensive, necessitating process redesign for patient flow; the physical environment suffers from inadequate cooling and poor comfort, demanding infrastructure improvements; while staff quality is generally positive and should be maintained and strengthened.

Three causal loops perpetuate these challenges: the overflow cycle where OPD lacks doctors, patients go to ER, ER becomes overloaded, emergency care quality is compromised, staff burnout increases, and more efficiency challenges emerge; the patient tolerance cycle where patients choose the hospital for cost and accept long waits, patient volume remains high, no pressure for improvement exists, and the status quo is maintained; and the resource constraint cycle where limited hospital resources lead to insufficient doctors, long waits, patients leaving unseen, compromised health outcomes, more return visits needed, and higher volume.

Step 7: Validating the Findings

All six patients (6/6) consistently identified long waiting times as a primary challenge, with one patient specifically reporting half-hour waits as "matagal." Five out of six patients (5/6) acknowledged financial factors—free consultations, PhilHealth coverage, and economic necessity—as the primary driver of hospital choice.

On the other hand, four patients (4/6) cited infrastructure comfort issues, particularly heat in the waiting area with inadequate cooling. Three patients (3/6) reported positive staff interactions as a compensating factor for other deficiencies, while two patients (2/6) identified geographic proximity as a key factor in hospital selection. One patient (Pt2) raised the issue of OPD-ER overflow and cross-departmental doctor sharing as a needed intervention, so the researcher revised the findings to include workforce optimization strategies addressing ER-OPD coordination. One patient (Pt4) reported efficient service with no problems, indicating that service quality may vary significantly depending on timing and patient volume, leading the researcher to include inconsistent service quality as a finding. One patient (Pt1) suggested that health education and managing patient expectations could improve satisfaction, so the researcher revised the findings to include health education and patient empowerment as a distinct theme. Similarly, one patient (Pt3) emphasized the importance of referral capability as a factor in hospital choice, leading the researcher to include strengthening referral pathways as a strategic priority. One patient (Pt6) highlighted that morning registration often means afternoon consultation requiring full-day commitment, so the researcher revised the findings to include patient burden and full-day commitment as a significant access barrier.

CONCLUSIONS

1. Based on the demographic profile of outpatient services, female patients consistently outnumbered males, with adult, pediatric, and prenatal care comprising the majority of consultations while specialized services remained underutilized. Injuries, reproductive health, and urinary system diseases dominated the case types, with the top ten conditions representing a concentrated disease burden that demands focused clinical and operational attention.
2. The level patterns of outpatient services utilization revealed considerable monthly fluctuations, with patient volume peaking in October and reaching its lowest point in December, reflecting a seasonal trend with significant variability. The emergency room handled the highest patient volume with relatively efficient consultation times, while the outpatient department remained markedly underutilized. Emergency department visits were nearly evenly split between adults and pediatric patients, indicating a balanced demand for acute care across both age groups. In terms of personnel and support services, laboratory diagnostics and cesarean deliveries dominated service activities, confirming the hospital's heavy reliance on diagnostic testing and obstetric surgical capacity.
3. There is statistically significant difference in monthly outpatient consultation volume between sexes, with female patients demonstrating consistently higher utilization than their male counterparts.
4. The outpatient department at this government hospital is caught in a difficult cycle where too few doctors, broken equipment, and cramped, leaky facilities force patients to wait for hours in the heat, pay for labs and medicines they cannot afford, and sometimes leave without ever being seen. Providers are stretched thin, patients have no other affordable option, and the whole system just keeps running on sheer tolerance rather than real solutions, affecting seniors, pregnant women, and the poorest folks the hardest.
5. Patients keep coming back to this hospital because the consultations are free, PhilHealth helps cover their bills, and the staff treat them with kindness, yet they endure long waits in unbearable

heat, spend entire days just to see a doctor, and sometimes leave without being seen at all because they simply have no other affordable option.

Recommendations

1. The hospital should strengthen its outpatient services by allocating more staff and clinic spaces for adult, pediatric, and prenatal care, while forging referral partnerships with nearby provincial hospitals for surgical and specialized cases. It should also work with the Local Government Unit (LGUs) and barangay health workers to implement injury prevention campaigns and enhance reproductive health and urinary disease management at the community level.
2. The hospital should adopt a flexible staffing scheme and implement surge protocols during peak months like October to avoid service disruptions, while maximizing the use of December lean periods for staff training and equipment maintenance. It should also review OPD referral mechanisms to decongest the emergency room, facilitate both adult and pediatric emergency competencies are maintained, and conduct a workforce audit to align staffing with the heavy demand for laboratory and obstetric services.
3. The hospital should launch a targeted men's health program in collaboration with barangay health centers and local workplaces to encourage male residents to seek early outpatient consultation and address the significant gender disparity in service utilization. Concurrently, it should sustain and strengthen its reproductive and maternal health services to accommodate the continued high volume of female patients who rely on the hospital for their healthcare needs.
4. The hospital needs to start by fixing the most urgent problems like bring in more doctors, get an ultrasound machine, repair broken tools, and make the waiting area bearable with fans, proper seating, and shade—while also working with RHUs to reduce unnecessary referrals, teaching patients when to visit the health center versus the hospital, and helping indigent families access medicines and PhilHealth coverage they are entitled to.
5. The hospital should roll out changes in stages like start right away with fans, AC repairs, doctor sharing between OPD and ER, and priority for seniors and pregnant women. Then build an appointment system with text reminders, train staff in customer service, and strengthen referral links. Later on, push for better PhilHealth coverage, set up medicine access programs, and teach the community when to use RHUs versus the hospital; and finally, renovate the waiting area, hire more staff, and put a proper management system in place, with clear goals like cutting wait times from over 30 minutes to under 20, reducing the number of patients who leave without being seen, and making sure patients actually feel heard and cared for.

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