

PHILIPPINE HEALTH SECTOR REVIEW

Transforming the
Philippine Health Sector:
**Challenges and
Future Directions**



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Currency and Equivalent Units

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of March 28, 2011)

US\$1 = 43.47 PHP (Philippine Peso)

PHP1 = US\$0.0230

FISCAL YEAR

January 1 – December 31

Abbreviations and Acronyms

ADB	Asian Development Bank
AO	Administrative Order
ARMM	Autonomous Region of Muslim Mindanao
ASEAN	Association of Southeast Asian Nations
BBP	Basic Benefit Package
BFAD	Bureau of Food And Drugs
BHS	Barangay Health Station
BnB	Botika ng Barangay
BNB	Botika Ng Bayan
CHD	Center for Health Development
CHITS	Community Health Information Tracking System
CON	Certificate Of Need
CSR	Contraceptive Self-Reliance
DOH	Department Of Health
DOHLIS	Department Of Health Licensing Information System
DRG	Diagnosis-Related Group
DSWD	Department of Social Welfare and Development
EAP	East Asia and Pacific Region
EC	European Commission
EO	Executive Order
EU	European Union
FDA	Food and Drug Administration
FFS	Fee-For-Service
FHSIS	Field Health Service Information System
FP	Family Planning
GAA	General Appropriations Act
GDP	Gross Domestic Product

GGR	General Government Resources
GIDA	Geographically Isolated and Disadvantaged Areas
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HMO	Health Maintenance Organization
HOMIS	Hospital Management Information System
HSRA	Health Sector Reform Agenda
HSS	Health Systems Strengthening
ICD	International Classification of Diseases
ICU	Intensive Care Unit
ILHZ	Inter-Local Health Zones
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPP	Individual Paying Program
IRA	Internal Revenue Allotment
LCU	Local Currency Unit
LGC	Local Government Code
LGU	Local Government Unit
LMIC	Low and Middle Income Countries
MCH	Maternal and Child Health
MCP	Maternal Care Package
MDG	Millennium Development Goal
MIC	Middle Income Country
MIMAROPA	Mindoro, Marinduque, Romblon, Palawan
MMR	Maternal Mortality Rate
MNCHN	Maternal, Neonatal and Child Health And Nutrition
MOOE	Maintenance and Other Operating Expenses
MRP	Maximum Retail Price
NCD	Non-Communicable Diseases
NCHFD	National Center for Health Facilities Development
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NG	National Government
NGO	Non-Governmental Organization
NHA	National Health Accounts

NHI	National Health Insurance
NHS	National Health Service
NHTS-PA	National Household Targeting System - Poverty Alleviation
NSD	Normal Spontaneous Delivery
OBP	Outpatient Benefit Package
ODA	Official Development Assistance
OFW	Overseas Filipino Worker
OOP	Out-Of-Pocket
OTC	Over-The-Counter
PHILHEALTH	Philippine Health Insurance Corporation
PIPH	Province-Wide Investment Plan For Health
PITC	Philippine International Trading Corporation
PPP	Public/Private Partnership
PPP	Purchasing Power Parity
PRO	PhilHealth Regional Office
RA	Republic Act
RDF	Revolving Drug Funds
REO	Regional Economic Outlook
RH	Reproductive Health
RHU	Rural Health Unit
SHI	Social Health Insurance
SME	Small and Medium Enterprise
SOCCSKSARGEN	South Cotabato, Cotabato, Sultan Kudarat Sarangani, General Santos
SP	Sponsored Program
SWAp	Sector-Wide Approach
TB DOTS	Tuberculosis Directly Observed Therapy Short Course
THE	Total Health Expenditure
UC	Universal Coverage
UHI	Universal Health Insurance
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
WDI	World Development Indicators
WHO	World Health Organization

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Executive Summary

1. The Philippines health sector is at a critical stage in its transformation.

While the country has undertaken several significant health sector reforms in the past decades, a large unfinished policy agenda remains. The achievement of the health Millennium Development Goals (MDGs), especially among poor households, is at risk and there is a newly emerging challenge of addressing non-communicable diseases (MDG+). The overall health spending ratio (as a percentage of GDP and public spending as a percentage of total government spending) is one of the lowest in the Region with out-of-pocket (OOP) spending, a measure of financial protection, at over half of all health spending, well above the average for global comparators. It is within this context, that the Philippine Health Sector Review takes stock of health reforms implemented to date, and evaluates the impact of these reforms on health systems performance. Based on this evaluation, the Review identifies the challenges and future policy directions for accelerating the transformation of the Philippines health sector for improved health outcomes, financial protection of the population and consumer satisfaction.

I. THE MAIN FINDINGS OF THE REVIEW ARE:

A. Health Sector Performance

2. At the aggregate level, the Philippines has made steady and significant progress in its population health outcomes over the past several decades.

Life expectancy increased to 72 years in 2008, up from 53 in 1960. Childhood mortality also continues to decline in the Philippines. The infant and under-five mortality rate during the 2004-2008 period stood at 25 and 34 per 1,000 live births respectively. This is lower than the rates of 29 and 40 per 1000 live births in 2003 (NDHS, 2008, NDHS, 2003). The country is “on-track” to achieving Millennium Development Goal (MDG) 4, which calls for a two-thirds reduction in the under-five mortality rate over the period 1990-2015.

3. On maternal and reproductive health, progress has been less than expected and regional and income related disparities across all health outcomes are persistent and potentially widening. MMR has improved more slowly than expected (94 per 100,000 live births in 2008) and the country is not expected to reach the MDG 5 goal of three-quarters reduction in MMR between 1990

and 2015, as well as universal access to reproductive health services. According to the 2008 National Demographic and Health Survey (NDHS, 2008), child mortality indicators are four times higher among the lower income quintiles as compared with higher income quintiles. Life expectancy in some provinces of the Philippines (La Union) is similar to high middle-income countries such as Chile and Slovenia. In comparison, provinces such as Sulu and Tawi-Tawi have life expectancy levels similar to low-income countries such as Ethiopia and Guinea.

4. While there is an unfinished agenda with the MDGs, the burden of disease is rapidly changing in the Philippines and non-communicable diseases (MDG plus Agenda) are emerging as a health sector challenge.

Projections show that by 2030, NCDs will account for 85 percent of the disease burden in the East Asia Pacific Region. Currently, in the Philippines deaths from cardiovascular conditions are one of the top 10 causes of reported deaths. Moreover, injuries are also a major contributor and the number of road traffic accidents in the Philippines is increasing. Poor households are as vulnerable to NCDs as non-poor households are.

5. Financial protection from the costs of ill-health, a key outcome of the health sector, and measured in terms of out-of-pocket payments, is getting worse in the Philippines.

This is despite the implementation of universal health insurance (UHI). In 2009 (the last year for which comprehensive household level OOP data are available), the share of health spending in per capita expenditures was at its highest level in the past 18 years. Poor households in the Philippines are spending a higher share of their disposable income on health care as compared to the better off. While expenditures on drugs and medicines account for the biggest share for both poor and rich households, there is an increasing shift towards OOP financing hospital charges. Out-of-pocket spending as a share of total health spending is very high and has increased.

6. There are large income-related disparities in the utilization of health services.

For example, according to the NDHS 2008, skilled birth attendance among the highest income quintile is 94 percent as compared with 25 percent in the lowest income quintile. Only 13 percent of all births in the lowest quintile occur at the facility level compared with 84 percent in the highest quintile. Similarly, immunization coverage is only 70 percent among the lowest quintile as compared with 84 percent in the highest quintile. Some prominent reasons affecting the decision to seek care (in public and private facilities) include: (i) economic barriers, (ii) geographic distance, (iii) quality of care concerns such as the unavailability of drugs;

7. Health spending levels (3.9 percent of GDP in 2008) are below the average for comparable countries. On public spending as well, Philippines performance is below average as compared with other similar income countries. The Philippines spends only about 6.5 percent of total government expenditures on health (2008), as compared with an average of some 10 percent of total government expenditures in the East Asia and Pacific Region. Generally, with economic growth, public spending on health grows more than proportionately but this has not been the case in the Philippines where the overall share of public spending on health has grown very slightly at the national level and has been largely offset by a declining and stagnant trend among LGUs and PhilHealth. In fact, the elasticity of public spending on health to GDP from 1995 – 2008 was about 0.9, implying that if this trend continues the share of public expenditure on health to GDP will continue to decline.

8. Health insurance coverage in the country (based on the 2008 NDHS, is still low (42 percent overall and 38 percent PhilHealth)). Health insurance coverage among indigent households is only 20 percent. Moreover, health insurance coverage is no guarantee of financial protection and enhanced access to good quality health services. This is due to the limited nature of PhilHealth benefits and the difficulties in accessing these benefits.

B. Reasons for Gaps in Health Sector Performance

9. The Review finds that the Health Sector Reform Agenda (1998-2004) and the Fourmula 1 reforms (2005-2010) have made important contributions to the health sector but have fallen short in addressing many of the structural deficits in the health sector. These include:

a. *The continuing low levels, fragmentation and inequity in public financing.* There are multiple factors for this trend, including those that are outside the control of the health sector. First, the Government's revenue raising capacity is constrained and this limits how much resources the Government is able to raise to finance public expenditures for multiple sectors, including health, (ii) there is a large informal sector (almost 50 percent of the population) which means that mobilizing health sector resources from this group through enrollment into PhilHealth is a challenge, (iii) LGUs in underserved Regions face a fiscal constraint in financing health, and (iv) health financing is characterized by the co-existence of highly fragmented and sometimes overlapping streams of funding that run separately from and independently of each other (PhilHealth, DOH, LGUs). These financing "pools" vary in the way they are funded, in their approach to financing (whether premiums for health insurance or budget financing for health facilities), in their eligibility, in the services they cover and use.

b. *Limitations in PhilHealth's performance in implementing universal social health insurance and using health financing as a lever to drive health sector development.* The establishment of a single-payer system under the Philippines Health Insurance Corporation (PhilHealth) in 1995 was one of the important achievements of health reforms in the Philippines. The global experience with social health insurance (SHI) shows that a strong purchaser can act as a key change agent in the health sector, encouraging improved performance and accountability on the part of providers and ensuring equitable access to health services. Single-payer systems (such as PhilHealth) generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health expenditures, high levels of patient/consumer satisfaction and high performance on measures of access and quality. Moreover, in a highly decentralized system such as the Philippines, PhilHealth provides a unique policy instrument to centralize health financing and use these funds as a lever to drive health sector development (through appropriate benefits, payment mechanisms and incentives for providers). This expectation of a single-payer system being able to transform the health sector has largely remained unfulfilled.

c. *There are large gaps in service delivery capacity, particularly in some Regions. Often these are poor and underserved Regions in the country.* The population of the Philippines has grown considerably in the last two decades, and the health sector infrastructure has not kept up with these changes. While the private sector, which provides more than fifty percent of the service delivery infrastructure in the Philippines, has also grown, their preference has been for large towns and city centers. Rural areas still face a considerable challenge vis-à-vis geographic access and poor households living in rural areas are most affected by the gaps in service delivery. The recent NDHS notes that geographic access to service delivery has hardly improved in the last five years. Expanding health insurance coverage in these Regions without a proactive strategy to address capacity gaps will not improve service utilization, nor contribute to improved health outcomes.

d. *Gaps in the stewardship of the sector.* While the Department of Health (DOH) has been given the mandate for stewardship and oversight of the health sector, it has not been adequately empowered to enforce this mandate. For example, the stewardship of the DOH over LGUs is loosely defined and the DOH cannot require LGUs and the private sector to submit health sector data. This creates a huge challenge for the DOH to exercise its stewardship function. Despite these limitations, the DOH has done a remarkable job in taking forward stewardship of the sector especially vis-

à-vis LGUs. The DOH has adopted innovative institutional mechanisms such as LGU scorecards, Centers for Health Development, and the Province Wide Investment Plans to enhance LGU accountability for health sector goals. Considerable inroads have been made in public health, again using innovative instruments such as public health grants to LGUs. Nevertheless, the effective deployment of these instruments is hampered by data constraints. Some other areas of stewardship such as strategies for service delivery reforms for the public and private sectors, role of first contact care, pharmaceuticals and non-communicable diseases are yet to be addressed.

II. THE REVIEW PROPOSES THE FOLLOWING PRIORITY POLICY ACTIONS:

10. **Based on its evaluation of health sector performance, the Review proposes the following priority policy actions for consideration by the Government of the Philippines (GOP).** The main thrust of the priority actions are on improving financial protection and access to care by expanding health insurance coverage and holding PhilHealth accountable for its performance. The Review argues that, in this scenario, service delivery transformations complement the expansion of health insurance coverage and the revised regime of PhilHealth payment incentives for providers. A binding constraint in carrying out any of these priority policy actions is the tight macro-economic and fiscal context. This means that in the short term, increased budget allocations to the health sector will have to be obtained from improvements in *inter-sectoral efficiency at the national government level (reallocating resources from other sectors to health) as well as making sure that health sector resources are well spent (improved efficiency and equity of spending).*

a. ***Policy Priority # 1: Increase public financing (national government) on health within fiscal constraints and allocate for expanded PhilHealth coverage for the population while holding PhilHealth accountable for results.*** A recent universal health care costing exercise (World Bank, DOH, PhilHealth 2011) estimates that the total costs of expanding effective universal coverage (adequate financial protection) is approximately PhP 408.6 billion (US\$ 8.5 million) over the medium-term plan period (2012-16). This could result in a doubling of public spending on health as a share of GDP by 2016 (Baseline: 1.3% of GDP in 2009). This would not only expand coverage among the poorest households in the Philippines (5.2 million households targeted under the National Household Targeting System), but expand the depth and height of PhilHealth coverage to provide better financial protection and incrementally shift utilization to more cost-effective levels (first-contact care). To make the most efficient and equitable use of these resources, the

Review proposes that additional public financing for health is allocated for expanding PhilHealth coverage for indigent families (Sponsored program) and for the near poor informal sector. The Review argues that any additional contributions to PhilHealth for the sponsored program could be combined with a set of performance indicators to hold PhilHealth accountable for results.

b. *Policy Priority # 2: Undertake comprehensive reform of PhilHealth to make it an active and accountable purchaser in the health sector, setting the incentives and driving the process of service delivery transformations.*

The policy priority of increased health spending and expanded coverage will not work if PhilHealth does not transform itself into an active purchaser, able to use health financing as a policy lever to encourage public and private providers to provide accessible, high quality health services. The PhilHealth Board has to play a key role in this process, driving strategic directions of the Corporation, identifying performance accountability measures and service standards and holding the Corporation accountable for achieving the set performance targets.

c. *Policy Priority # 3: Support DOH in strengthening its stewardship function vis-a-vis service delivery transformation; improved regulation of facilities (public and private), improved oversight for key health sector inputs such as human resources and pharmaceuticals, strengthened data for decision-making and sector monitoring and performance management;*

d. *Policy Priority # 4: Enhance the focus on public health including NCDs or MDG+ (possibly through DOH managed performance-based grants to LGUs).*

INTRODUCTION

1. The Philippine Health Sector Review was undertaken upon the request of the Department of Health (DOH), the Philippines with the objective of providing an external evaluation of health reforms completed to date and identifying challenges and future policy directions. The Review documents progress to date on health reforms, evaluates the performance of the Philippines health sector in comparison to other countries and based on this analysis, highlights challenges and future policy directions. This Review uses the methodology used by the World Bank in similar health sector reviews undertaken in other parts of the world.

A. Structure of the Report:

2. Chapter 1 of the Report is an “Overview Chapter.” This chapter is for busy readers and highlights the main findings and policy directions elaborated in the remaining Chapters. Chapter 2 describes the socioeconomic and health sector context in the Philippines including the major health reforms completed in the Philippines to date, with a focus on the recent FOURMULA1 reforms (2005-2010). Chapter 3 assesses the performance of the Philippines health system against basic health system objectives of improving health outcomes, financial protection for the population and equity and access to health services. It assesses both the current situation and trends over time and compares the Philippines to other relevant comparator countries in Asia and globally. Based on the diagnosis in the previous chapters, Chapter 4 establishes the current policy reform baseline by summarizing the main strengths and weaknesses of the Philippines health sector and suggests possible future directions for health reform.

B. Methodological Constraints:

3. The work for the Review faced certain methodological constraints – namely the availability of up-to-date data and information on broad national aggregates including National Health Accounts (NHA), service availability and use. The team faced constraints in evaluating service availability and use in the public and private sector. For example, the team was not able to obtain data on bed to population ratios by region and provinces and average length of stay and occupancy rates for the different types of health facilities, nor data on outpatient

visits. There were, however, data available from micro studies that the team has exploited to the extent possible. Data on quality of care was also limited except from the Quality Improvement Demonstration Project (QIDS). Finally, no recent information was found on consumer responsiveness, the third major performance objective of health systems. A brief overview of datasets used for the various analyses is provided below:

Chapter 2: Socioeconomic, demographic and health sector context: UN reports, IMF and World Bank data and reports, DOH reports;

Chapter 3: Performance of the Philippines Health Sector: WHO data, World Development Indicators, Family Income and Expenditure Surveys (FIES) (2006, 2009), NDHS 2003 and 2008;

Chapter 4: Strengths and Weaknesses of the Philippines Health Sector and Future Policy Directions: Various studies carried out on the health sector in the Philippines (Health Financing Study, DOH and PhilHealth consultant reports) and internationally available literature.

Overview of the Report

I. THE PHILIPPINES TODAY: PROGRESS AND CHALLENGES

A. The Progress in Sector Reforms

1.1 The Philippines health sector has been experiencing waves of reforms since the 1990s. These reforms have been implemented to improve health outcomes, increase the financial protection of the population, and improve the quality and equity of health services delivery. The reforms are also consistent with global trends in moving towards universal health insurance coverage, decentralization of service delivery and strengthening the stewardship capacity of the health ministries. Box 1 outlines the major reforms implemented to date. As a result of these reforms: (i) the provision of health services has been largely decentralized to local government units (LGUs), (ii) the legal and institutional framework for the implementation of universal health insurance has been created, and (iii) the Department of Health (DOH) has been given the mandate to focus on policy-making, priority setting and other stewardship functions, including public health.

1.2 Because of the reforms, health insurance coverage has increased slightly in the Philippines, including for poor households. When the Philippines Health Insurance Corporation (PhilHealth) was established in 1995, health insurance coverage in the Philippines was entirely restricted to the formal sector and was around 30 percent. According to PhilHealth data, health insurance coverage was 76 percent of the population in 2008. According to the 2008 National Demographic and Health Survey, however, PhilHealth coverage is much lower (only 38 percent) and overall health insurance coverage is only 42 percent. To further encourage local governments to enroll indigent households into its Sponsored Program (SP), PhilHealth expanded health insurance benefits to include first contact services exclusively for SP members, outpatient treatment of tuberculosis and malaria, and normal deliveries in non-hospital health facilities; Government health centers including rural health units (RHUs) are accredited by PhilHealth to provide these services.

Box 1: A Snapshot of Health Reforms in the Philippines 1990-2009

1991: A landmark law transfers the management of public facilities in the Philippines to LGUs with the provinces typically responsible for managing provincial and sub-provincial hospitals and with cities and municipalities responsible for public health programs, city and municipal hospitals, and barangay health stations. However, the DOH eventually expands role beyond stewardship of the health system by assuming responsibility for the procurement of public health commodities such as vaccines and tuberculosis drugs and retaining a network of “DOH hospitals”.

1995: National Health Insurance Law is passed with the objective of scaling up the social insurance program (called Medicare and established in the 1960s) into a universal health insurance program. The Philippines Health Insurance Corporation or PhilHealth is established as the single purchaser in the health system and given the mandate to expand the formal health insurance program and implement mechanisms to enroll informal sector workers. A Government-financed indigent program (managed by PhilHealth) is established. It is mandated with achieving universal coverage by 2010.

1998: The Health Sector Reform Agenda (HSRA) is announced with the objective of focusing on full-scale implementation of the decentralization and universal health insurance reforms. The HSRA aimed at: (a) an enhanced social insurance program and expanding coverage of informal sector workers and the indigent as well as strengthening PhilHealth’s role as the health purchaser and addressing issues such as balanced billing by hospitals, (b) upgrading public health facilities to meet PhilHealth standards and introduce hospital autonomy, (c) more effective regulation of the private sector and stronger results orientation and coordination between DOH and LGUs in the delivery of health programs, and, (d) introducing necessary structures and processes among the various institutions such as DOH, LGU and private sector to strengthen local health sector planning.

2005. The Government launches “Fourmula 1 for Health.” FOURMULA 1 aims to achieve broad and comprehensive reform of the health system. It essentially builds upon the concepts outlined in the HSRA while providing a framework for accelerated action on the implementation of the reforms. It consists of the following areas:

- Health Financing: ensuring sustainable financing for the health sector, strengthening universal health insurance and building the capacity of PhilHealth to function as the main purchaser in the health system;
- Health Regulation: harmonizing and streamlining the licensing, accreditation and certification systems, ensuring the availability of quality and affordable medicines and the capacity building of regulatory agencies;
- Health Services Delivery: ensuring the availability of a basic and essential health services package, improving the quality of health services and intensifying current efforts to reduce public health threats;
- Good Governance: improving governance in local health systems, improving national capacities to manage and steward the health sector and developing a more rationalized and efficient national and local health system.

1.3 Overall public spending on health, especially public health interventions, has increased very slightly, and still remains on the low side due to limited PhilHealth and LGU expenditures on health. After declining in real terms for nearly a decade, the DOH budget has doubled its spending on health as a percentage of government expenditures. As a result, government expenditures on health have increased from 5 percent in 2002 to 6.5 percent in 2008. In particular, spending for public health interventions such as vaccines, anti-tuberculosis drugs, and the upgrading of government health facilities to provide emergency obstetric care has increased in the past two years. However, the increase has largely been limited to national government expenditures, while LGU expenditures on health have declined in real terms. In addition, PhilHealth’s share of health expenditures has hardly grown since it was established in 1995. In terms of overall trends, out-of-pocket spending in the Philippines has been increasing while public spending has been declining. This is contrary to the trends in other Asian countries.

1.4 Important progress has been made in laying the foundations for more systematic pharmaceutical policies and regulations. The prices of drugs in the Philippines have traditionally been high compared with other Asian countries (except Japan). Competition in the pharmaceutical industry has intensified in some segments of the market with local generics companies now accounting for nearly half of all the medicines sold. National government financing has been used in some initiatives to increase the availability of cheaper medicines. Village pharmacies, or “Botika ng Barangays”, selling predominantly over-the-counter drugs are being rolled out all over the country. There are, however, concerns with the lack of and sustainability of pharmacy supervision. The Bureau of Food and Drugs (BFAD) was recently converted to the Food and Drug Administration (FDA) with increased regulatory powers and resources.

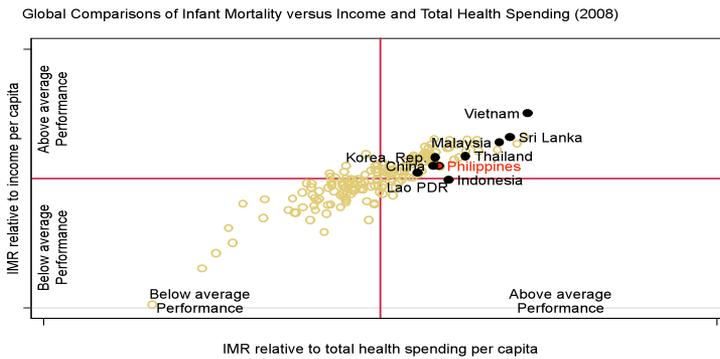
1.5 The DOH has initiated performance-based approaches with LGUs. DOH has developed a LGU scorecard that explicitly tracks and holds LGUs accountable for their performance on a set of health outcome, output, and governance indicators. It has guided LGUs to develop Provincial Investment Plans for Health (PIPH)¹ and City Investment Plans for Health (CIPHS). It has launched performance agreements with 16 provinces and is expanding these performance agreements to the rest of the provinces and major cities. The implementation of mechanisms to reduce fragmentation in the health services delivery system is important since a primary care system with referrals needs to be managed at the provincial (not LGU) level. Nevertheless, the data that are reported through the LGU scorecards are weak and there is no external verification process.

¹ The World Bank is supporting the development of PIPHS through the NSSHRP.

B. Health Sector Performance

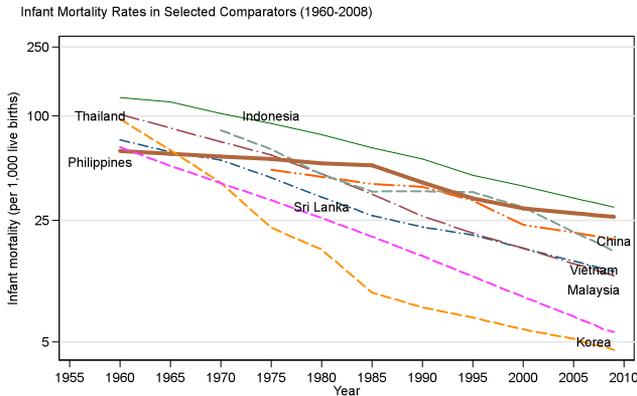
1.6 Health outcomes in the Philippines reveal a mixed picture. While the Philippines does well on indicators such as life expectancy and infant mortality in comparison to other countries of similar income and health spending levels, other countries have sustained greater improvements in these indicators over time (Figures 1.1 and 1.2). There are also large income-related health outcome inequalities. For example, the infant mortality rate (IMR) among the poorest quintiles is four times of those in the richest.

Figure 1.1: Infant Mortality Rate: Attainment relative to income



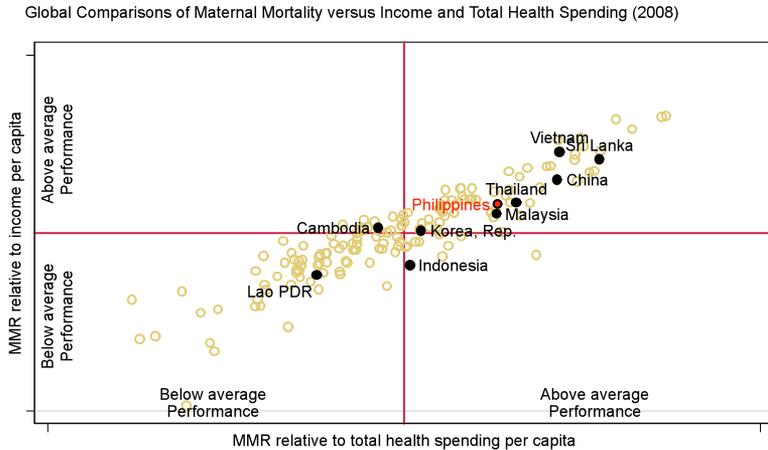
Sources: WDI;WHO
Note: Both axes current US\$

Figure 1.2: Infant Mortality Rates: 1960-2008



Source: WDI
Note: y-axis log scale

Figure 1.3: Maternal Mortality Rates



Sources: WDI/WHO
 Note: Both axis current US\$

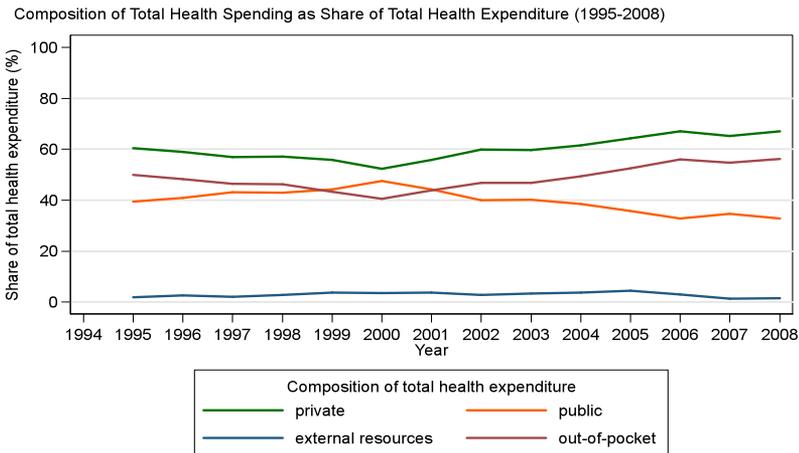
1.7 The Maternal Mortality Rate (MMR) in the Philippines is also on the low side in comparison to countries of similar income and health spending levels. However, because of slow declines, it is unlikely that the Philippines will achieve the MDGs on maternal mortality by 2015. There is large variation in fertility rates with the total fertility rate (TFR) for women in the highest income quintile at 1.9 compared with the 5.2 for women in the lowest income quintile (NDHS, 2008)

1.8 The burden of disease (BOD) in the Philippines is changing with almost 58 percent of total burden attributable to non-communicable diseases (NCD), and the health system is not fully equipped to deal with this new challenge. By 2030, it is projected that NCDs will account for 85 percent of the disease burden in the East Asia Pacific Region. Currently, in the Philippines deaths from cardiovascular conditions are one of the top 10 causes of reported deaths. Moreover, injuries are also a major contributor and the number of road traffic accidents in the Philippines is increasing. Treating NCDs can be expensive and requires longer and continuous interaction with the health system. Moreover, the continuum of care becomes even more important, and the Philippines health system has to gear up for addressing the next generation of challenges in the health sector, while addressing existing ones.

1.9 The financial protection of the population against the costs of ill health is worse than among comparator countries and deteriorating. Out-of-pocket payments (OOP) account for over half of all health spending in the Philippines and its share has been increasing (Figure 1.4). In 2009, the OOP share of non-food household consumption across all income classes was higher than in all previous years. Meanwhile, public spending on health in the Philippines is below the level of other comparator countries (Figure 1.5)

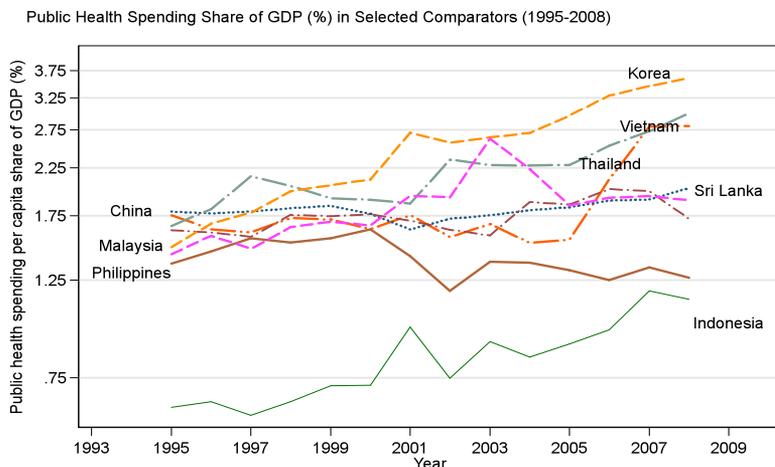
1.10 There are large income-related disparities in the utilization of health services. For example, skilled birth attendance among the highest income quintile in 94 percent as compared with 25 percent in the poorest quintile. Only 13 percent of all births in the lowest quintile occur at the facility level compared with 84 percent in the highest quintile. Similarly, immunization coverage is only 70 percent among the lowest quintile as compared to 94 percent in the highest quintile (NDHS, 2008).

Figure 1.4: Public and Private health spending in the Philippines, 1995-2008



Sources: WDI; WHO

Figure 1.5: Public Spending on Health as a percent of GDP in Selected Comparator (1995-2008)



Source: WDI
Note: y-axis log scale

1.11 There are capacity constraints as health sector inputs have not kept up with population growth. The bed-to-population ratio is roughly 1 per 1000 inhabitants, lower than in other East Asian countries such as China (2.6 beds per 1000 inhabitants), Vietnam (1.2 beds) and Thailand (2.2). Moreover, many of these hospital beds are clustered in large city centers and better-off LGUs. This is particularly true for private hospital beds, which account for approximately half of all hospital beds in the country. The availability of skilled health sector staff is also a problem, especially in the public sector. While the Philippines do not have a problem with the overall supply of doctors and nurses, there is large-scale out-migration. The Philippines is one of the largest suppliers of trained nurses in the world.

C. Key Challenges in Implementing a Strategy for Universal Access to Quality Health Services

1.12 A large percentage of poor urban and rural households are not enrolled in the PhilHealth Sponsored Program and enrollment does not guarantee service use. Enrolling poor households is one among many challenges. LGUs with limited fiscal capacity cannot afford the subsidized contribution requirements. Once poor families are enrolled, they face various barriers to accessing health services. These are related to: (i) lack of awareness of health insurance benefits and administrative procedures related to accessing benefits, (ii) lack of availability

of PhilHealth accredited facilities, and ensuring that accredited facilities provide quality care (convenient opening hours, no stock-outs for drugs and other medical supplies, medical equipment in working condition), (iii) cumbersome claims and reimbursement mechanisms, which means that it is not easy for health facilities to get reimbursed, (iv) the limited regulation of fees, as well as (v) the still very limited benefits package (for example outpatient drugs are not covered). PhilHealth has begun to address some of these barriers, but further action is needed.

1.13 Overall government spending on health remains on the low side.

Increases in public spending on health in the last few years have mainly taken place at the national government level, including through the expanded DOH public health program for LGUs (procurement of vaccines). Local government spending has stagnated in real terms over the last decade, which has important equity implications for the poor. As a share of total LGU spending, the contribution for health declined from 12 percent in 2002 to 9.5 percent in 2007. Cities and towns are spending less, with only 7.5 percent and 7.7 percent, respectively, of their total 2006 expenditures going on health. Since the Internal Revenue Allotment (IRA) and intergovernmental fiscal systems do not fully reflect fiscal capacity and need, many LGUs in reality have very limited fiscal space to finance any expenditure, whether in health or other sectors.

1.14 Poor households largely rely on public hospitals, whose quality of care is problematic and client responsiveness is low.

Consumer surveys conducted in 2005 and 2006 indicated that people chose private hospitals over public ones since they perceived the latter as providing better quality care. Due to financing barriers, however, poor people do not have access to private hospitals, creating inequity in access to care. Public hospitals (DOH and LGU) suffer from many problems, including inadequate financing, poor allocation of resources, lack of quality benchmarks and standards, and limited accountability. Access to good quality first contact care is also uneven, and when available, people often bypass first (primary care) level to seek care in hospitals, as there is no effective referral system and penalties are not applied for bypassing the less costly first contact level. Global experience shows that high utilization of good quality first contact care is equity enhancing and cost-effective for the health system.

1.15 PhilHealth is not, as yet, exploiting its potential as a major change agent in the health sector.

The global experience with social health insurance (SHI) shows that a strong purchaser can act as a key change agent in the health

sector, encouraging improved performance and accountability on the part of providers and ensuring equitable access to health services. So far, due to its limited purchasing power in the sector and institutional capacity, PhilHealth is not able to fully exploit this potential.

1.16 The quality of care in private hospitals is mixed, with some very high quality hospitals. Although largely perceived by the public as providing good quality care, available information shows that the quality of care in private hospitals is mixed. The Philippines has private health care facilities that are accredited by international organizations such as Joint Commission International. Nevertheless, there exist many small private facilities, including those serve the poor, where the quality of care is uneven and unregulated.

II. PRIORITY POLICY ACTIONS

1.17 The proliferation of reforms initiatives in the last two decades has resulted in a health system that is a sub-optimal combination, on both the financing and service delivery sides, of a partially implemented UHI approach and a National Health Service (NHS) model, both functioning in highly decentralized governance and intergovernmental fiscal structures. So far, these reform initiatives have not been able to effectively address some of the deeper structural problems in health services financing and delivery, namely:

- The continuing low levels, fragmentation and inequity in public financing;
- Limitations in PhilHealth's performance in implementing universal social health insurance and using health financing as a lever to drive health sector development;
- Gaps in service delivery capacity;
- Weak health sector stewardships vis-à-vis data for decision-making, sector monitoring and performance management, and strategies for hospitals, human resources, pharmaceuticals and supply chain management as well as public and private facilities regulation

1.18 Based on this analysis, the Review lays out priority policy actions for the Government to consider in developing a medium-term plan for the health sector. The main thrust of the priority actions are on improving financial protection and access to care by expanding health insurance coverage (universal health insurance) and holding PhilHealth accountable for its performance. In this scenario, service delivery transformations complement the expansion of health insurance coverage and revised PhilHealth incentives for health providers.

1.19 As the global experience shows, implementing universal health coverage reforms takes time and political commitment. Important enabling factors for these reforms are economic growth, formalization of the labor market, strong regulatory systems, high levels of societal solidarity and administrative and management capacity. Moreover, rarely have countries been able to achieve these changes through a “big bang” approach but rather through carefully sequenced incremental steps. The challenge for the Philippines health sector is, therefore, to identify a carefully sequenced roadmap that gets to the core of the structural problems, while taking into account the political and institutional realities of the country. In the following section, we highlight, based on analysis and available international evidence, some options for the Philippines to consider in developing such a roadmap. These include:

- (i) Increase public financing (national government) on health within fiscal constraints.
- (ii) Undertake a transformation of service delivery configurations in a context of public-private mix
- (iii) Support DOH in strengthening its stewardship function
- (iv) Enhance the focus on public health (MDG Plus)

Priority Policy Action # 1: Increasing Public Financing within fiscal constraints and allocating additional resources to expanded PhilHealth health insurance coverage against clearly defined and measurable performance indicators

1.20 The following are the main health financing challenges facing the Philippines: (i) How to raise enough revenues in a sustainable manner to provide the population with an adequate package of services and financial protection against catastrophic medical expenses in a tight macro-economic and fiscal context? (ii) How to manage these revenues to pool health risks in an equitable and efficient manner while reducing fragmentation? (iii) How to ensure that resource allocation and purchasing of health services promotes allocative and technical efficiency?

1.21 **Increasing Public Financing for Health within Fiscal Constraints:** One of the main findings of the Review is that public spending on health in the Philippines is way below comparator countries and is stagnant and declining. With such low levels of public budget allocation, the Philippines cannot expect to improve health outcomes and financial protection for poor households. Therefore, one way or the other, the country will have to increase public financing for health, while keeping in mind the macro-economic and fiscal context for increasing sector financing and ensuring that additional financing is sustainable.

The analysis conducted for this Review indicates limited public financing space in the medium-term to finance the health sector. Although the Philippines did not suffer as much as some other countries in the region during the recent global economic crisis and the economy has re-bounded, providing inclusive growth is still a challenge. Revenues as a share of GDP are low in the Philippines and the average elasticity of public spending on health to GDP is below 1. The prospects for raising additional resources through health sector specific resources such as earmarked taxes are limited. *In this context, the main tools for generating more fiscal space for health will be through improving the efficiency of public spending (inter and intra sectoral resource allocation).* A recent universal health care costing exercise (World Bank, DOH, PhilHealth 2011) estimates that the total costs of an expanded effective coverage under the National Health Insurance Program is approximately P408.6 billion (approximately US\$ 8.5 billion) over the medium-term plan period (2012-16). This could result in a doubling of public spending on health as a share of GDP by 2016 (Baseline: 1.3% in 2009). This would not only expand coverage among the poorest households in the Philippines (5.2 million households targeted under the National Household Targeting System, but expand the depth and height of PhilHealth coverage to provide better financial protection and incrementally shift utilization to more cost-effective levels (first-contact care). With the projected increases in health spending Philippines would move closer to the health spending ratios as a percentage of GDP in other comparator countries.²

1.22 In addition to government revenues (and efficiency gains), the other source of increased financing for health is the contributory regime under PhilHealth. The premiums could be adjusted based on household income and the definition of dependents could be adjusted (down to 18 years instead of 21). The premium payments for Overseas Filipino Workers (OFWs) could be increased as well. Improving collection from small and medium-enterprises will also help. Options under the Individual Paying Program (IPP) include: (i) making it mandatory, (ii) annual instead of quarterly IPP enrollment and (iii) cost-sharing (partial government, partial individual or in fact full government contributions, if fiscally affordable, as in Thailand for the premiums of the near poor self-employed and informal sector workers).

² The average for Southeast Asian countries (Indonesia, Malaysia, Philippines, Thailand and Vietnam) is 3.9 percent of GDP in the mid-2000s.

1.23 Allocating Additional Public Financing for Health: Given the mixed financing system, there are several options for the Philippines to consider in the allocation of increased public resources for health. One option is to channel the increased resources to LGU pools; the other to DOH managed health facilities and the third to the PhilHealth in the form of insurance premiums for the poor and near poor. Among the three, the pooling of funds within the PhilHealth is the best option from the perspective of generating a large risk pool with strong cross-subsidy arrangements. It would also mitigate the fragmentation in risk pools and increase PhilHealth's market power. This is of course contingent on PhilHealth being able to deploy the resources effectively to finance an expanded benefits package. In the highly decentralized context of the Philippines, additional allocations to LGU pools without changes in the Internal Revenue Allotment (IRA) is the least optimal option for efficient and equitable risk pooling and reduced fragmentation in financing.

1.24 Currently, the Sponsored Program (SP) for indigent families is financed from two pools (national government and LGU). To reduce the fragmentation in risk pools and clarify the role of LGUs vis-à-vis health financing and delivery, the Sponsored Program could be entirely financed from the national government pool. With the application of the National Household Targeting System, approximately 5.2 million families are identified for the Sponsored Program. A priority policy intervention is to enroll this group from national government funds. Moreover, financing from the national pool would be consistent with the fact that income redistribution is a national government priority. Universal application of the National Household Targeting System (NHTS) to target beneficiaries under the sponsored program will greatly enhance poverty targeting and reduce political interference in targeting. If the same premium for a very limited benefits package is applied (P1200), the costs are P6.2 billion (annual). If an improved benefits package is applied (full financial protection for hospitalizations, enhanced outpatient package with drugs), the premium would have to increase. Costs for five years (2012-16) are estimated at P107.6 billion (US\$ 2.2 billion).³ The national government could consider in the future, through the DOH, allocating premium money for the Sponsored Program to PhilHealth against clearly defined and measurable performance indicators to ensure that insureds receive the benefits mandated. Enhanced coverage under the SP also means that more women and children will have access to health insurance – a critical element for alleviating the economic barriers to achieving MDG 4 and 5.

³ World Bank. 2011. Preliminary estimates, Technical Working Group on Universal Health Care, Manila, Philippines.

1.25 As a next step, the Philippines could consider co-financing the premiums of the near-poor household as well (discussed earlier). Estimates indicate that if this twin approach is adopted by the country, technically by 2016, the country should be able to achieve universal health insurance coverage.

Priority Policy Action # 2: Undertake comprehensive reform of PhilHealth to make it an active and accountable purchaser in the health sector, setting the incentives and driving the process of service delivery transformations;

1.26 **Comprehensive Transformation of PhilHealth:** Pooling of revenues within PhilHealth and increased national government financing for SP will only have an impact if complemented by reforms in PhilHealth management, benefits package and purchasing arrangements. The National Health Insurance Law mandates PhilHealth to provide inpatient and outpatient benefits and emergency care, and any other benefits deemed cost-effective. Moreover, the NHIL states that in case of reserves exceeding the set ceiling (which is the case right now); PhilHealth shall use the additional funds to either increase benefits or lower contributions. Therefore, there are no barriers to PhilHealth incrementally expanding benefits, especially if these expansions are undertaken with appropriate actuarial estimates. The following changes to the existing benefits package are suggested based on the experience of other LMICs: (i) coverage for catastrophic (inpatient, acute) care with a flat co-payment per day of hospital stay (with exemptions for targeted populations such as poor households), coverage for first contact care with a system of referrals and outpatient drugs (with a co-payment for non-exempt families). Penalties for by-passing first contact care could include paying the full costs of service out-of-pocket.

1.27 **Strengthening Purchasing for Better Outcomes:** PhilHealth could be encouraged to incrementally shift away from paying exclusively on a fee-for-service (FFS) basis to more appropriate, prospective payment methods such as case-based payments (already piloted in maternity care, surgical contraception, and cataract surgery benefits and now being expanded by PhilHealth), capitation for health facilities (a very rudimentary version with allocations to LGUs has been implemented for the primary care benefits for SP members), global budgets, and performance-based payments (a pilot is being planned by PhilHealth). Other options include accelerating the piloting of the preferred provider model to address the problem of balanced billing. Finally, in a country where the private sector is so vibrant, PhilHealth could further improve its payment and contracting methods to attract private health providers as accredited PhilHealth providers. This will require creating a level playing field between public and private providers, which is not the case now since DOH and LGU facilities receive budget subsidies in addition to PhilHealth payments, and

user fees. Make accreditation (by PhilHealth) more independent, initially by de-linking the accreditation arm of PhilHealth from the contracting and payment arms. Incrementally look at options for third-party accreditation. Eliminate duplication between DOH licensing and accreditation including harmonizing reporting from health facilities.

Priority Policy Action # 3: Support DOH in strengthening its stewardship function especially on service delivery transformation; improved regulation of facilities (public and private), improved oversight for key health sector inputs such as human resources and pharmaceuticals and strengthened data for decision-making, monitoring and sector performance management;

1.28 **Transforming First Contact Care:** The Review highlights the fragmented nature of first contact care in the Philippines and yet, for indigent families, this is often the nearest available care. In the absence of good quality and easily accessible first-contact care, the tendency of the population is to seek care in more expensive, hospital settings. Moreover, as the Review mentions, the burden of disease is changing in the country, and for non-communicable diseases (NCDs), first-contact care is crucial for the prevention, early detection and treatment of NCDs such as cardiovascular diseases, diabetes and hypertension. Many countries (including in the East Asia Region) have adopted family medicine as a vehicle for transforming first contact care. The Philippines already has an Academy of Family Physicians and one option would be for the country to identify how it can use the existing health insurance system to encourage the development of private family medicine practices. In many countries where family medicine is gaining ground as the main source of first contact care, policy interventions have included: (i) ensuring an adequate supply of family physicians, (ii) giving existing doctors (general practitioners, pediatricians) a chance to retrain as family physicians, (iii) start-up funds to set-up family practices, and (iv) implementing a capitation payment system to family physicians depending on the number of patients enrolled. In some countries with advanced family medicine systems such as the UK, family practices are even acting as gatekeepers to secondary care.

1.29 **Transforming the Hospital Sector and developing a Hospital Strategy:** The Review describes the many challenges facing the hospital sector in the Philippines. It suggests future actions such as (i) based on international experience, developing a new vision for the configuration and role of the hospital system, including the relationship with first-contact care; (ii) a rapid assessment focusing on those regions with the lowest total hospital bed to population ratios and, (iii) based on international experience, developing a comprehensive model for public hospital autonomy. The Review argues that while these

transformations will take time and will require a phased approach, DOH could jumpstart the process by developing new licensing standards for hospitals in the Philippines. There is a need for human resource planning for specialized skills needed in the hospital workforce. While aggregate doctor and nurse numbers in the Philippines are at reasonable levels by regional and global standards, there are problems with shortages of particular medical specialties and allied health professionals in some parts of the country that affect access to essential care for particular conditions. Understanding and planning how to address these shortfalls will require coordination and partnership with the specialist health professional associations/societies. Irrespective of how the Philippines wishes to sequence hospital reforms, there will be a very strong role played by the DOH in terms of strategic vision and technical support to LGUs.

1.30 Managing Inputs – Human Resources and Pharmaceuticals: The DOH has made progress in both areas but human resources and pharmaceutical policies in the country are currently fragmented. A master plan for human resources has been developed, but it needs an update in the context of the strong private sector orientation and the demand for overseas workers. The implementation of the Magna Carta for health workers has been challenging and is a major factor in incentivizing service delivery in the public sector, particularly at the LGU level. Given the supply-side constraints, a policy is perhaps needed not simply on future expansions in the supply of health personnel, but how existing personnel in the public sector can be encouraged to perform better using the twin levers of incentives and accountability. The unavailability of medicines is one of the reasons why patients (even poor members of the PhilHealth Sponsored program) resort to higher priced private hospitals and self-medication. Moreover, concern over drugs is identified by poor households as a barrier to care, and the household expenditure analysis indicates that pharmaceuticals constitute a significant portion of household expenditures. An outpatient drug benefit package has already been developed by PhilHealth but is not being implemented. In the pharmaceutical sector, there are a range of issues related to the pricing of drugs, generic policies and policies to encourage competition.

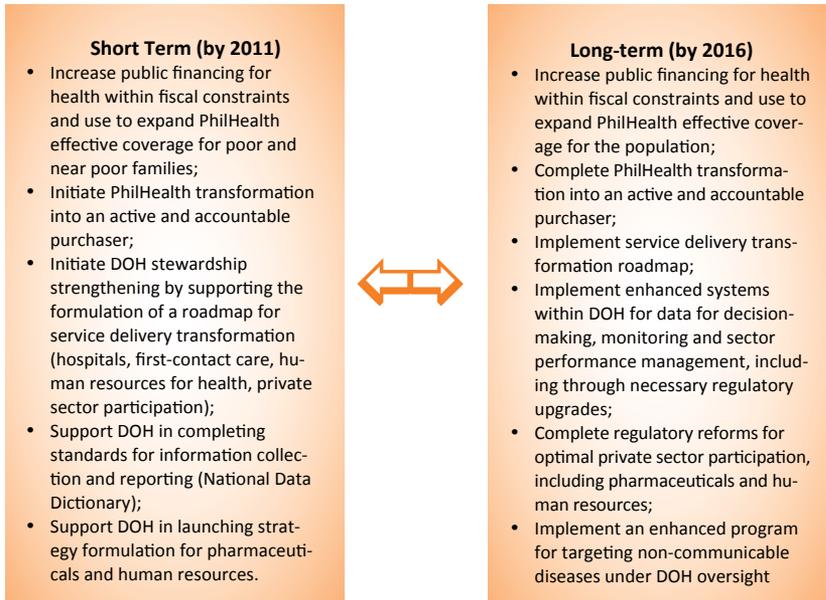
1.31 Addressing the Quality of Care: The Philippines health sector has many instruments to improve the quality of care – namely the DOH licensing system (mandatory), PhilHealth accreditation (voluntary to allow contracting by PhilHealth), and certification (awards such as *Sentrong Sigla*). The Review describes the limitations of each of these instruments and highlights how these can be used to further enhance quality of care. The licensing standards could be updated taking into account a new vision for the configuration of hospitals and health centers. The PhilHealth accreditation standards have already been upgraded with the application of the “bench book” but bench book standards

need to be synchronized with licensing standards. In some countries (Brazil), there are efforts to link payments to accreditation (pay-for-accreditation). PhilHealth could explore these models for possible application to the Philippines. Another key dimension of accreditation is that it tends to be conducted by a third-party (generally not the health insurance agency as in the case of PhilHealth). While in the case of the Philippines, accreditation by PhilHealth is reflective of the particular institutional context, one option for PhilHealth to consider is to separate the accreditation arm of PhilHealth from other parts, especially those responsible for paying providers.

Policy Priority # 4: Enhance the focus on public health including NCDs or MDG+ (possibly through DOH managed performance-based grants to LGUs)

1.32 Delivering Public Health Services: The Review shows that considerable progress has been made on public health under the FI reforms. In the context of a fragmented financing and service delivery arrangement, the DOH has made important choices to steer away from vertical programs and adopt a more integrated, health systems approach for addressing public health problems such as tuberculosis. The budgets for public health programs have also grown in the last few years. Nevertheless, the challenge remains how the country will begin to address non-communicable diseases using integrated health systems approaches. Global experiences in the successful implementation of NCD interventions highlight the importance of: (i) linking community-based interventions to first contact care to provide a continuum of NCD interventions, (ii) identifying critical social determinants of health that can impact behaviors such as smoking and poor diet, (iii) concerted macro-level public health interventions to complement micro interventions (e.g. tobacco control policy including the role of tobacco taxes).

Figure 1.6: Phasing of Policy Priorities



Socioeconomic and Health System Context

Box 2: Main Messages

- Overall, long-term demographic projections for the Philippines (up to 2045) indicate the Philippines is expected to have a favorable dependency ratio with a substantial young population that can contribute to economic development.
- The Philippines has a fast-growing urban population and the urbanization rate in the Philippines is not likely to decline in the near future.
- The population is aging, though and the Philippines is also experiencing the nutrition and epidemiological transitions. By 2030, the vast majority of the disease burden in the Philippines is expected to be driven by non-communicable diseases (NCD).
- Poverty rates and inequality in the country have further deteriorated and are exacerbated by the continuing high fertility rates – one of the highest among East Asian countries
- As in the case of most LMICs, the labor market in the Philippines is characterized by a large informal sector (estimated at almost 50 percent of the labor market) and a high number of small and medium-sized firms.
- The health financing system is based on a combination of general government revenues (GGR), social insurance contributions and OOP. Of these sources OOP accounts for more than half of total health expenditures. Social insurance expenditures are only on the order of 10 percent of THE, although this is an increase over the pre 1995 reform of NHI
- Approximately 60 percent of health services are delivered through the private sector and the remaining through a network of public sector health facilities. The DOH manages 70 hospitals and the remaining public sector delivery system is through the LGU (provincial and municipal hospital, city health facilities, rural health unit and barangay health stations). The LGU service delivery system is extremely fragmented with each level (province, municipality, city) managing their own facilities.
- The DOH is responsible for health sector regulation and public health functions.
- The Fourmula1 reforms have been instrumental in: (i) mobilizing additional resources for public health, (ii) implementing an innovative program for LGU accountability, and (iii) improving the coordination of external resources for the health sector.

2.1 This chapter discusses the overall socioeconomic, demographic and health system context in which the Philippine health sector operates, including an overview of the major health reforms implemented to date with a focus on the FOURMULA1 reforms (2005-10).

I. SOCIOECONOMIC CONTEXT

A. Population Dynamics and Geography

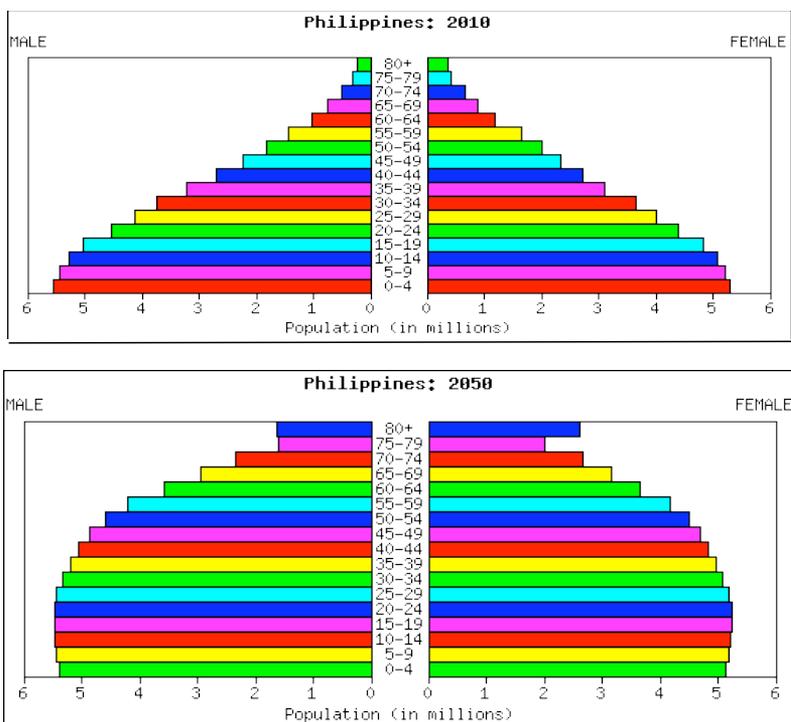
2.2 **With a population of 94 million people in 2010, the Philippines is the 12th largest country in the world.** The population is growing at a rate of 2.04 percent a year, which means that around 1.7 million Filipinos are added annually. While total fertility rate (the total number of children ever born to a woman) has declined to 3.0 children, it is still higher than most Asian countries. The Philippine population is forecast to hit 100 million in 2015, within the next presidential administration (2010-2016). By 2050, the population of the Philippines will be 146.1 million of which 18 percent will be above the age of 60 compared to 4.5 percent today (United Nations, 2008)

2.3 **Population density has visibly risen, from 224 people per square kilometer in 2000 to 273 in 2010.** Urbanization has also rapidly increased; as much as 64 percent of the population (2 out of 3) now live in cities, provincial capitals, “poblacion” (town centers), and other urban areas. The urbanization rate (3.7 percent per year) exceeds the population growth rate. The urban agglomeration is an important consideration not only from the viewpoint of health service delivery and disease transmission, but also from the perspective of expanding formal health insurance risk pools. These areas tend to attract formal-sector investments and labor employment, such as business-process outsourcing (“call centers”) and attendant service industries, manufacturing, and tourism.

2.4 **The country’s dependency ratio defined as the proportion of population 0-14 and 65 years and older to the working age population of 15-64 years, is 0.69.** While this looks low, the fact is that the Philippines still has a young population, with 37 percent of Filipinos (about 35 million) under the age of 15. If the age cohort of 15-24 (high school and college years) is included, then the “young” population increases to 43.4 percent of total population (or about 41 million in 2010). Under current social health insurance rules, non-working children of the PhilHealth members up to the age of 21 can be considered dependents.

2.5 About 4.5 percent of the population is senior, defined as those 60 years and over. The sizeable number of seniors (4.2 million in 2010) is important from a social-services policy perspective given the increasing number of social benefits that they are entitled to (Figure 2.1). A recent law provides the elderly population with automatic membership to the social health insurance program (PhilHealth), 20 percent discount on retail purchases and services including medicines, laboratory diagnostics, and hospitalization, and social pensions (grants) to the elderly poor. Those who are members of the mandatory social security funds in the government and private sectors receive pensions upon retirement (usually 65, although some opt to retire as early as 60 or after a certain number of years of service, depending on the pension plan they are enrolled in). PhilHealth provides automatic health insurance membership to its retirees (the non-paying members).

Figure 2.1: Population Pyramids for the Philippines, 2010 and 2050



Source: U.S. Census Bureau, International Data Base, 2010

2.6 From the perspective of health service delivery and health-insurance risk

pooling, the archipelagic nature of the country and the populations isolated in islands and mountains offer a difficult challenge. This isolation is worsened by frequent typhoons and flooding during the monsoon season (generally late June to October), and interrupted by occasional social disturbances (insurgency, politically motivated violence, and the like). The isolation is also highlighted by the fact that many of these areas are ancestral domains of indigenous peoples or otherwise poor Filipinos who have been historically disadvantaged, aside from having cultural and behavioral norms about health-seeking and treatment that is different from the mainstream.

2.7 As a coping mechanism for being geographically remote, local organized groups may set up health facilities that may not be optimally sized, or would confront logistics problems of resupply, or would face challenges of staffing given the natural hesitance of professional health workers to live away from the mainstream. While some of these problems can be addressed by greater communication and transport interconnectivity, the real costs of these obstacles have not been well appreciated by program planners and policy analysts who assume a neoclassical “central plan” framework for service delivery, budgeting, and financing that is used in conventional spatial economics. Official acceptance of the nature of “geographically isolated and disadvantaged area” (GIDA) has helped elevate this problem at the policy and planning level, but existing interventions still fall short of what the problem of geographic isolation requires.

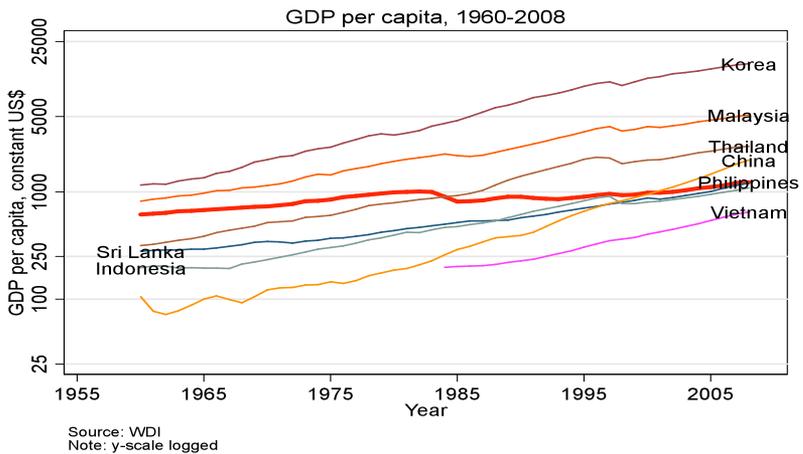
B. Macro-economic and Fiscal Situation and prospects

2.8 Conducive macro-fiscal conditions such as sustained economic growth, improvements in revenue generation, and sustainable levels of deficits and debt can be important for fiscal space considerations for any sector, including health. Even if the government health spending share of GDP remains unchanged (i.e., the elasticity is 1.0), if GDP in a country grows by 5 per cent per year in real terms then government health spending would also increase by 5 per year in real terms. In addition, periods of robust economic growth, rising national incomes, and macro-fiscal stability often result in an increase in the share of government resources devoted to the health sector.⁴

⁴ ADB (2006), *Measuring Policy Effectiveness in Health and Education*, Manila: Asian Development Bank.

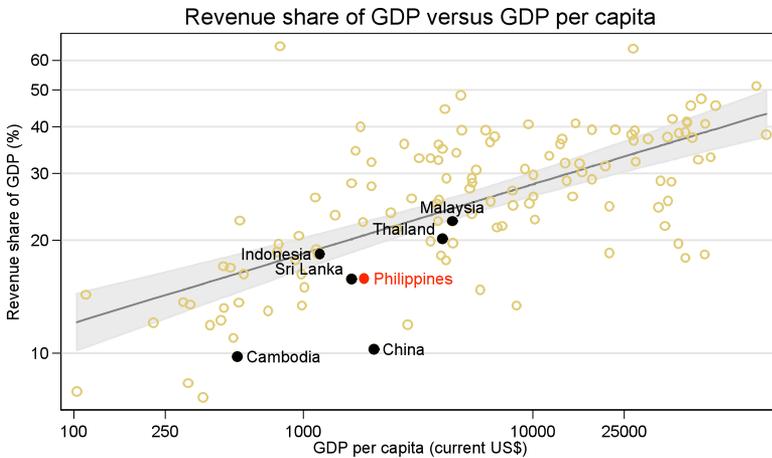
2.9 The Philippines is classified as a lower middle-income country with a GDP per capita of about US\$1,847 in 2008. The country has been a relative laggard in terms of economic growth, averaging only about 1.5 percent per year in per capita terms over the period 1960-2008. As a consequence, and as can be seen in Figure 2.2, the Philippines has been overtaken by several of its peers including China and Thailand both of which had lower per capita GDPs than the Philippines in the 1960s and 1970s. If current trends continue, Indonesia and Sri Lanka will also overtake the Philippines in GDP per capita terms in the next couple of years.

Figure 2.2: GDP per capita in Real terms, 1960-2008



2.10 Revenues as a share of GDP are low in the Philippines relative to other countries. The share of national government revenues in GDP in the country was about 16% in 2008 and continues to be relatively flat. This is low relative to the Philippines' income level (Figure 2.3). Indonesia, by way of contrast, has a higher revenue-to-GDP ratio. The average for lower middle-income countries is about 26 percent and that for the East Asia and Pacific (EAP) region is about 20 percent. Improvements in revenue collection efforts could constitute, in itself, an important source of fiscal space in the country.

Figure 2.3: Revenue Share versus GDP per capita



Sources: WDI; WHO
 Note: both axes log scale
 Data are for latest available year 2000-2008

2.11 The current global financial crisis has hit the Philippines hard.

According to the IMF GDP growth in the country was about 1.1 percent in 2009 (and roughly -1 percent in per capita terms), down from over 7 percent in 2007 and 3.7 percent in 2008.⁵ Growth rates are expected to rise to 7.0 percent in 2010 and 5 percent from 2011-2015.⁶ The global financial crisis has hit the Philippines relatively harder than some countries in the region such as China, Vietnam, and Indonesia, but less so than others such as Thailand, Malaysia, and Korea (Figure 2.4).

2.12 In addition to a dip in economic growth, revenues have declined and expenditures have increased in the country.

Public sector revenues and grants are expected to have declined to 20.7 percent of GDP in 2009, down from 24.1 percent of GDP in 2007.⁷ As a result of stimulus spending efforts, the public sector expenditure (excluding interest payments) share of GDP

⁵ The Philippines’ growth rate in 2009 is more than a full 3 percent points lower than was expected based on pre-crisis IMF forecasts.

⁶ IMF *World Economic Outlook* projections.

⁷ Although only part of this revenue decline is due to the crisis. Revenues have been declining since 2007 when tax cuts were introduced in the country.

Figure 2.4: Economic Growth Rates in the Philippines and Comparator Countries, Actual 1995 – 2009 and Projected 2010-2015

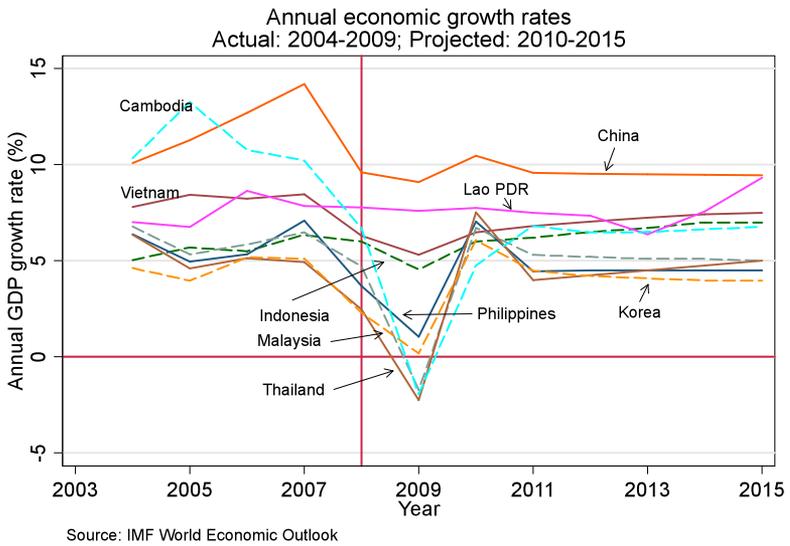
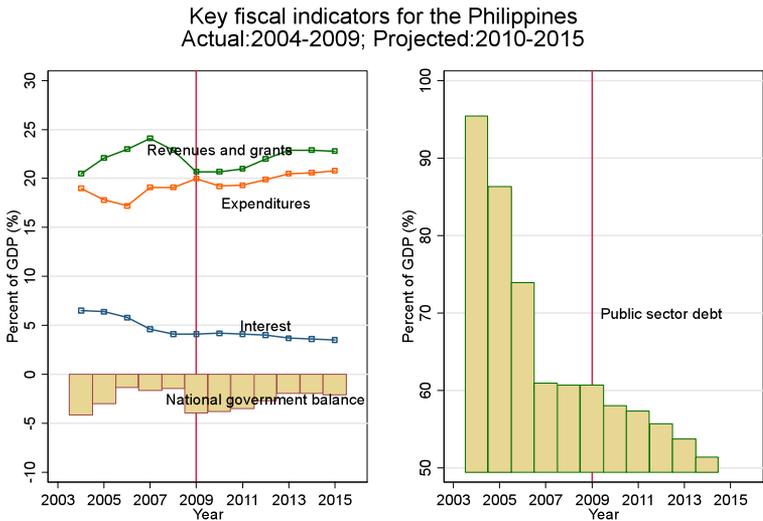


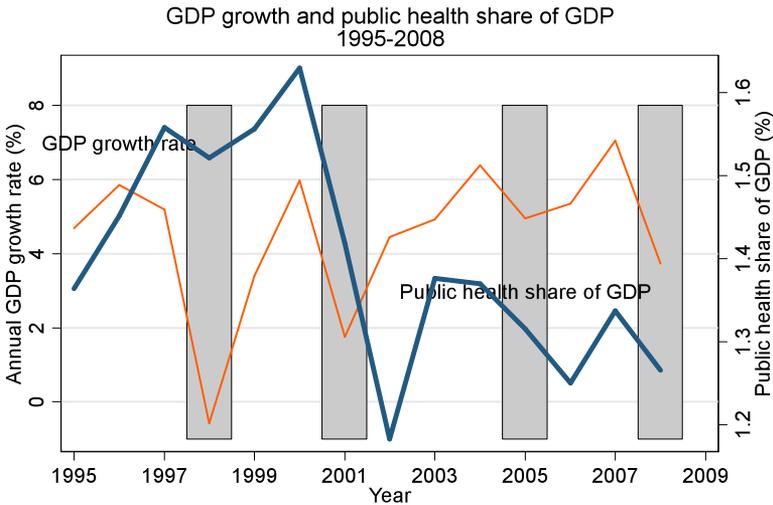
Figure 2.5: Key Fiscal Indicators for the Philippines, Actual 2004-2009, Projected 2010-2015



is expected to increase to 19.9 percent, up from about 19.3 percent in 2007 (Figure 2.5). As a result of stimulus spending and declining revenues, the public sector balance – has deteriorated in recent years. Total public sector debt levels are projected to remain at high levels -- 60.7 percent percent of GDP in 2009.⁸ In sum, the fiscal situation – although not dire – is expected to be tight in the country, at least for the near-to medium-term.

2.13 The macro-fiscal contextual ization of the health sector is important given that previous trends indicate some degree of pro-cyclicality in public expenditure on health in the country. Since 1995, and excluding the current crisis, economic growth declined in the Philippines on three separate occasions. The most severe was the decline of more than 5 percent points during the 1997-1998 Asian financial crisis. Growth rates in the Philippines declined by more than 4 percent points in 2001, and again in 2005 by about 1.4 percent points. On all three occasions, public health expenditure declined in real terms (Figure 2.6).

Figure 2.6: Economic Growth and Public Health Expenditures, 1995-2008



Source: IMF; WHO
 Note: Shaded bars are years when GDP growth declined by more than 1% point

⁸ The numbers are from IMF Article IV reports for the Philippines.

C. Labor market and poverty trends

2.14 The Philippine labor force reflects the slow transformation of the Philippine economy, which has grown more slowly than its East Asian neighbors. In 2008, there were 57.8 million Filipinos 15 years and above, 63.6 percent of whom (or 36.8 million) are in the labor force. The employment rate showed a marked improvement over the decade prior to the global economic crisis in late 2008, and this is reflected in the increase in the employment rate of 3.8 percentage points, from 88.8 percent at the beginning of the decade to 92.7 percent in 2008. Economic forecasts indicate that once the global economic crisis comes to an end, the country should revert back to its pre-crisis employment rate of around 93 percent.

2.15 However, the large number of people entering the labor force (about 1.3 million annually), and the country's low labor absorptive capacity, means that many cannot find work or are underemployed. Although the unemployment rate has declined, it is still high at 7.4 percent in 2008. This rate represents about 2.7 million people in the labor force without work, and not enjoying (together with their dependents) socially legislated benefits that come with employment, such as social health insurance. Moreover, of those who have work, a very high rate (19.3 percent or about 1 out of 5 employed persons) deemed themselves underemployed. These include people who are irregularly employed. The majority of the unemployed are youth in the age range 15-24 years.

2.16 There are no available estimates of those in the informal sector, although inferences can be made from other data, especially occupational groupings and number of employed workers per establishment. In terms of occupational groupings (Table 2.1), informal workers are most likely to come from laborers and unskilled workers (33 percent of total employment); agricultural workers (18 percent); service, and shop and market sales workers (10 percent); and traders and related workers (8 percent). Altogether, these occupations take up 69 percent of total employment, which reflects the high likelihood of informality in the economy. Informality can also be measured by unpaid family workers and own-account workers, the so-called “vulnerable employment.” In 2007, as much as 44 percent of males and 47 percent of females who were employed were in “vulnerable employment.”

Table 2.1: Employed Persons by Major Occupational Groups (In Millions), October 2005 and October 2007

Occupation	Oct. 2005		Oct. 2007	
	No.	percent	No.	percent
Government officials and staff	3.77	11.5	4.30	12.5
Professionals	1.39	4.2	1.59	4.6
Technicians and associate professionals	0.87	2.6	0.88	2.6
Clerical staff	1.47	4.5	1.74	5.0
Service workers and shop and market sales workers	3.04	9.3	3.45	10.0
Farmers, forestry workers, and fishermen/women	6.29	19.1	6.13	17.7
Traders and related workers	2.77	8.4	2.72	7.9
Plant machine operators and assemblers	2.55	7.8	2.35	6.9
Laborers and unskilled workers	10.62	32.3	11.24	32.5
Special occupations	0.14	0.4	0.15	0.4
Total	32.88	100.0	34.53	100.0

Source: Philippine Statistical Yearbook, 2009 (NSCB).

Note: Details may not add up to totals due to rounding.

2.17 A notable feature of the Philippine labor market is the high rate of Overseas Filipino Workers (OFW). Labor migration is an official government policy steered by the Philippine Overseas Employment Administration. The country is one of the largest exporters of land-based and sea-based workers in the world. Some 1.2 million land-and-sea-based workers were deployed in 2008 (double the figure from 0.6 million in 1991) and the trend is still rising, despite a blip from the recent global economic crisis. Estimates of the number of OFWs abroad are highly variable, ranging from 3 to 10 million. Philippine embassies and consulates counted as many as 2.3 million Filipinos working abroad in the 1990 census, but this is clearly an under-count.

2.18 Labor exports are important to consider in understanding the health sector because outbound workers entail a range of medical tests and clearances that crowd out the routine work of hospitals and clinics. Indeed an entire medical sub-industry has emerged just to cater to the laboratory and x-ray needs of these workers. Moreover, workers' remittances (about US\$17 billion annually) improve the housing conditions, nutritional and health status, and ability to pay for health care of their families left behind. Finally, while abroad,

workers may engage in risky health behaviors (unsafe sex leading to sexually transmitted infections, smoking, drinking, and over-eating), face occupational hazards, or experience depression from social isolation. If these workers get sick without adequate insurance coverage and are repatriated, the Philippine health system will end up caring for them.

2.19 The health and allied professions are a key exporter of manpower.

Table 2.2 shows the annual output of the health and allied professions in terms of the number of examinees of the Professional Regulation Commission and the number of passers, by type of profession. After a few years of domestic work experience, a significant number of these passers – notably nurses, physicians, and occupational and physical therapists – head for abroad. Thus, although the educational system can easily satisfy the staffing needs of the country’s health system as indicated by the large number of health professionals produced annually, opportunities abroad make it hard for the health system to keep its workers, unless working conditions and benefits come close to those available outside the country. As expected from an economy that produces so many tertiary-educated graduates, the rate of unemployment among this group is also high (39.4 percent). Indeed, the unemployment rate among this group is higher than the unemployment rate among those who merely completed primary school (13.6 percent).

2.20 The high unemployment and under-employment rates, and the large number of people entering the labor force every year, who cannot find jobs, largely explain the pervasiveness of poverty.

In 2006, 28.8 percent of the population fell below the national poverty line. This is largely unchanged from the poverty prevalence three years earlier (28.7 percent). Using an international poverty line of \$1.25/day, the poverty prevalence falls to 22.6 percent of the population. However, this rises to as much as 45.0 percent of the population if the international poverty threshold of \$2.00/day is used. The poverty gap, which measures the depth of poverty, has worsened from 7.0 percent in 2003 to 7.7 in 2006.

2.21 The poverty picture has not changed much over the past decade in terms of its magnitude and the groups falling into poverty.

The vulnerable groups include women (12.8 million poor in 2006), youth (5.9 million poor), children (14.4 million poor), senior citizens (1.3 million poor), urban dwellers (6.9 million poor), migrants and low-paid formal workers (3.2 million poor), farmers (2.1 million poor) and fishermen (0.5 million poor). Health and social services need to focus on these groups. The DSWD has recently come up with a national proxy-means test to identify poor households, but this needs to be harmonized with PhilHealth’s LGU-focused identification system for the indigent Sponsorship Program.

Table 2.2: Annual Output of Health Professions, 2007 and 2008

Professions	Schools		Examinees		Passers		Passing Rate (percent)	
	2007	2008	2007	2008	2007	2008	2007	2008
Dentists	35	33	1,681	1,626	581	654	34.6	40.2
Medical technologists	78	73	2,547	2,380	1,311	1,414	51.5	59.4
Midwives	288	337	6,579	7,337	3,498	3,881	53.2	52.9
Nurses	584	495	131,489	153,107	60,199	67,220	45.8	43.9
Nutritionists-dietiticians	43	40	567	523	320	273	56.4	52.2
Occupational therapists	19	20	179	169	77	82	43.0	48.5
Optometrists (4 years)	15	14	178	448	108	256	60.7	57.1
Optometrists (6 years)	9	9	87	98	60	66	69.0	67.3
Pharmacists	44	51	2,230	2,077	1,241	1,123	55.7	54.1
Physicians	51	49	4,889	4,406	2,930	2,565	59.9	58.2
Physical therapists	102	101	1,989	1,573	800	680	40.2	43.2
Physicians	51	49	4,889	4,406	2,930	2,565	59.9	58.2
Radiologic technologists	47	58	934	1,512	364	723	39.0	47.8
X-ray technologists	40	44	185	298	49	113	26.5	37.9

Source: Philippine Statistical Yearbook, 2009 (NSCB)

D. Epidemiological trends

2.22 The Philippines is going through an epidemiological transition. The morbidity data continue to highlight the predominance of communicable diseases such as respiratory tract infections, diarrhea, influenza, tuberculosis, malaria and dengue. Thus, eight of the top ten causes of morbidity are infectious diseases (Table 2.3). However, the burden of disease in the population is shifting towards NCDs. Five of the top ten causes of mortality are already due to NCDs (Table 2.4), and two

of the top ten causes of morbidity are also NCDs. These are cardio-vascular diseases (which combined have a mortality rate of 146.6 cases per 100,000 population), cancers/malignant neoplasms (48.5 per 100,000), and diabetes mellitus (19.8 per 100,000). Hypertension and diseases of the heart afflict a combined rate of 572 per 100,000 people. Accidents claim the lives of 41.3 per 100,000 people every year.

2.23 The aging population, a sedentary and stressful life brought about by modernization and congestion, as well as the increasing rate of risk factors such as smoking, obesity, blood sugar, and over-nutrition all contribute to the emergence of NCDs. Smoking is as pervasive as ever, especially among adolescents. The prevalence rate of smoking rose from 15 percent in 2003 to 22 percent in 2007. The prevalence rate of diabetes among adults (20-79 years old) is 7.6 percent. Hypertension afflicts 22.3 percent (more than 1 out of 5) of Filipinos.

Table 2.3: Top Ten Leading Causes of Morbidity, 2006

Causes of Morbidity	Total	Rate (per 100,000 pop.)
Acute lower respiratory tract infection and pneumonia	670,231	829
Diarrhea	572,259	708
Bronchitis, bronchiolities	538,990	690
Hypertension	408,460	523
Influenza	339,881	435
TB	132,725	170
Diseases of the heart	38,482	49
Acute febrile illness	25,400	33
Malaria	22,284	28
Dengue	15,279	20

Source: Philippine Statistical Yearbook, NSCB, 2009

Table 2.4: Top Ten Leading Causes of Mortality, 2004

Causes of Mortality	Total	Rate (per 100,000 pop.)
Diseases of the heart	70,861	84.8
Diseases of the vascular system	51,680	61.8
Malignant neoplasms	40,524	48.9
Accidents	34,483	41.3
Pneumonia	32,098	38.4
Tuberculosis	26,770	31.0
Symptoms, signs and abnormal clinical lab findings, not elsewhere classified	21,278	25.5
Chronic lower respiratory diseases	18,975	22.7
Diabetes mellitus	16,552	19.8
Certain conditions originating in the perinatal period	13,180	15.8

Source: Philippine Statistical Yearbook, NSCB, 2009

2.24 Poverty and genetics also contribute to NCDs, indicating the need for early detection through public health screening as well as health promotion and communication. These preventive programs have not been given much attention, and the few screening programs need to be scaled up. Poor households rarely have choices about healthy living and working quarters and healthy foods, and seldom have the opportunity for good exercise, especially if they live in unsafe, congested informal settlements. Thus, couching NCDs in terms of “lifestyle” change can be wrong-headed by blaming the victim, while understanding NCDs in the wider context of socioeconomic constraints can lead to more robust public health interventions. PhilHealth and other health insurance plans also need to be lobbied to provide cost-effective outpatient drug therapies for chronic diseases, given the rising prevalence of these conditions.

2.25 Globalization contributes to increasing public health risks. Despite the upsurge of avian influenza in East Asia in this decade, the Philippines remains free of bird flu, thanks to a variety of preventive measures revolving around early warning systems. The health authorities also handled the H1N1 epidemic quite well. HIV/AIDS prevalence remains below 1 percent, but the country needs to be more vigilant especially among the younger generation of Filipinos, overseas Filipino workers, tourists, sex workers, and men having sex with men.

2.26 Natural calamities also contribute significantly to the disease and injury burden. About 20 typhoons visit the Philippines each year, causing flooding, landslides, and other storm-related disasters. The archipelago forms part of the “Ring of Fire” volcanic and earthquake zone. In 2006, 459 occurrences of natural disasters were reported, affecting 2.5 million families and 11.2 million people. Some 376,118 houses were fully damaged and 848,842 were partially damaged. Cost of damage was estimated at Php 22.9 billion.

2.27 An Asian Development Bank (ADB) assessment noted that the country still lacks a comprehensive disaster response program. The reach of disaster relief is inadequate and disaster response efforts are often uncoordinated. Only about half of the eight million or so Filipinos affected by typhoons and other hydrologic events in rural areas receive assistance from the government and private relief institutions (ADB, 2007). Unfortunately, victims of these disasters also tend to be the poor who live in environmentally unsafe areas, often in makeshift dwellings. Disasters tend to quickly degenerate into epidemics, necessitating close coordination among disaster response teams and health professionals. The 2009 flooding following Typhoons Pepeng and Ondoy witnessed the emergence of a new epidemic on leptospirosis. The volume of rain and flooding are also a preview of the health risks associated with climate change.

II. ORGANIZATION AND FINANCING OF HEALTH SERVICES

2.28 The organization and financing of the Philippine health system has undergone changes consistent with the various reforms implemented over the years. The two main reforms that have drastically changed how the Philippines health system is organized and financed are the 1991 Local Government Code (LGC) and the 1995 National Health Insurance Law.

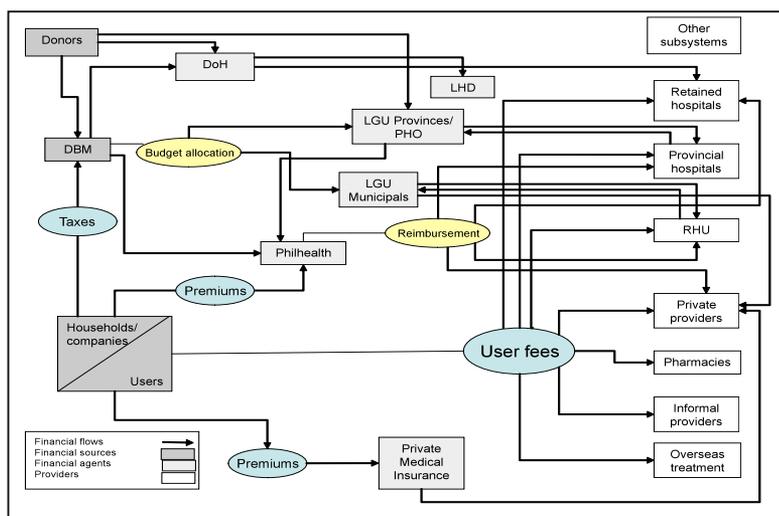
- a. **Local Government Code (LGC):** A landmark law, the Local Government Code (LGC), transferred the management of public sector health facilities to LGUs. It transferred health services up to the level of provincial and district hospitals to LGUs consisting of 81 provinces, 150 cities, and 1,500 municipalities. Devolution resulted in three administrative levels: central DOH in charge of regulation and provision of tertiary care (through retained hospitals); the provincial governments responsible for secondary care (provincial and district hospitals); and the municipal governments in charge of primary care. City governments inherited city health facilities. Some public health activities remained the responsibility of the central level with the support of regional units or Centers for Health Development.

- b. **The National Health Insurance Law:** The National Health Insurance Law (NHIL) was passed in 1995 with the objective of scaling the Medicare Program for those in the formal sector into a universal health insurance program. The Philippine Health Insurance Corporation (PhilHealth) was established as the single purchaser in the health system. It was given the mandate to expand the formal health insurance program and implement mechanisms to enroll informal sector workers. A government-financed indigent program was later established.

A. Health Financing System

2.29 Currently, the Philippines health system is financed from a mix of prepaid employer and employee health insurance contributions, contributions from the self-employed, general taxation revenues that cover health insurance contributions for the poor as well as budget financing for public facilities and out-of-pocket payments from patients. Health financing is characterized by the co-existence of highly fragmented and sometimes overlapping streams of funding that are run separately from and independently of each other, as shown in Figure 2.7. These financing “pools” vary in the way they are funded, in their approach to financing (whether demand/output- or supply/input-oriented), in their eligibility, in the services they cover and use.

Figure 2.7: Health Financing Flows in the Philippines



Source: HPDPB, DOH as cited in the draft Health Care Financing Strategy

2.30 Social Health Insurance (SHI) Program managed by PhilHealth: Since 1995, the Medicare Program has been rolled into PhilHealth. Contribution levels (2.5 percent of wages) have remained the same. The PhilHealth has introduced an Individual Paying Program (IPP) for the self-employed and those working in the informal sector. In 2003, the Government introduced the Sponsored Program (SP) for indigent families. The SP consists of the non-contributory arm of the Philippines health insurance program with premiums paid out of general budget revenues.

2.31 Consistent with the creation of the single-payer system, these contributions are pooled within the PhilHealth. According to the National Health Insurance Law, PhilHealth is required to provide inpatient and outpatient care, emergency and transfer services as well as any other care deemed cost-effective by PhilHealth. The full implementation of the Law has yet to happen. PhilHealth provides inpatient benefits for all its members (room and board, services of health care professionals, diagnostic, laboratory and other medical examinations, use of surgical or medical equipment and facilities, limited prescription drugs and inpatient education package). In addition to this inpatient package, PhilHealth has expanded outpatient benefits for SP members as well as introduced packages of services targeted to specific groups such as mothers and children, and patients suffering from TB (maternity and newborn care package TB package). PhilHealth currently does not cover outpatient pharmaceutical benefits for any of its members. PhilHealth pays for inpatient benefits using a fee-for-service (FFS) regime and hospitals are allowed to charge over and above the PhilHealth fees (balanced billing). For outpatient benefits, PhilHealth pays 300 pesos for each enrolled member as a type of capitation payment to LGUs to cover the costs of outpatient services. Per case payment has been developed for the maternity care package and selected surgical procedures (e.g. cataract). Members are entitled to obtain benefits from any PhilHealth accredited provider. Currently, PhilHealth does not implement contracts with providers specifying the quality and quantity of services to be purchased. The main criterion is PhilHealth accreditation. PhilHealth accredits public and private providers through its “Bench book,” a comprehensive set of structural and process indicators that facilities desiring to avail of PhilHealth reimbursements must meet.

2.32 Private Health Insurance: A voluntary private health insurance industry is organized along the lines of the United States model of health maintenance organizations (HMOs) and indemnity insurance plans. This “American system” provides demand-side financing, with clear rules on who is eligible for services and with a defined benefit package. It caters primarily to the better-off households in corporate employment.

2.33 General Budget Revenue Allocations to Health facilities and DOH (National Health Service): In addition to the flow of funds through the PhilHealth, the national government (NG) finances DOH hospitals and DOH public health programs. In turn, the DOH transfers funds largely for personnel and small amounts for other expenditures (MOOE) to DOH hospitals (supply-side subsidies). At the LGU level similarly, the LGUs make similar supply-side subsidies to LGU facilities for health personnel and other expenditures. At the level of the LGUs, financing is fragmented across provinces, cities and municipalities, with each LGU financing their own facilities. The government health system, in principle, provides care to everybody including public health, personal care, and the other health sector functions (research, surveillance, training, etc.).

2.34 Out-of-pocket household spending remains the most important and unmanaged stream of health financing. This demand-side financing is unpooled and spent at the point of service for all types of health goods and services. Although it represents the biggest share of financing, it is in principle “residual,” paying only what the government (DOH, LGUs), PhilHealth, and private insurance fail to cover. The large out-of-pocket payment can also be seen as the rate of un-insurance or under-insurance of households, or their poor utilization of (PhilHealth) insurance benefits. A small but significant stream of financing from donors has historically provided supply-side financing and expenditures mostly for public health programs in specific localities. Donors typically finance inputs such as drugs and other commodities, civil works, and technical assistance.

Table 2.5: Characteristics of Philippine Health Financing Systems

Systems	Size (PHP billion) in 2005	Funding	Side of Financing	Eligibility of Use (Targeting)	Services Covered
National Health Service (NHS) Type	NG – 19.9 LGU – 23.3	Tax > gov't Budget	Supply-side (inputs)	Unclear (Open to all)	All, but unclear benefits package. Implicit rationing ⁹
Donor assistance	Loans – 6.6 Grants – 2.3	Official development assistance	Supply-side (inputs)	Unclear (Open to all)	All, but mostly public health
Social Health Insurance (SHI)	PhilHealth – 19.3 EC – 0.6 ¹⁰	Social insurance premium ¹¹	Demand-side (outputs)	Contributing or sponsored members and dependents	Clear benefit package with ceilings per episode
Private voluntary health insurance	HMOs – 7.1 Other private HI – 4.3	Private health insurance Premium	Demand-side or outputs	Contributing members	Clear benefit package with ceilings per episode
	Self-insured employers & schools – 8.0	Own-funded	Mixed	Contributing members	Defined services
Household	87.5	Out-of-pocket	Mainly demand-side	Unknown	Residual – what above streams won't pay
Others (NGOs, CBOs)	2.1	Unknown	Probably supply-side	Unknown	Unknown

Source: This study using Philippine NHA data

⁹ No officially-sanctioned essential package of health services that defines the “benefit package.” Hence, services are “open-ended”.

¹⁰ This refers to the Employees Compensation program, which reimburses hospitalization and related benefits for occupationally-related injuries and other health conditions.

¹¹ Increasingly blended with tax-funded direct government subsidy for the premium contributions of indigents under the sponsorship program.

2.35 **Table 2.6 summarizes in detail the sources of health spending in 2008.** Some 67 percent of total health spending is private, while 56 percent of total spending (84 percent of private) comes from OOP, indicating the high level of inefficiency and inequity of the system. The government (including social health insurance) contributes some 33 percent, while social health insurance (PhilHealth and the much-smaller Employees Compensation Program for work-related injuries) accounts for some 8 percent of all spending (23 percent of public).

Table 2.6: Sources of Health Expenditures (Percent of Total), 2008

Funders	Share of Total
Public	33
of which:	
Social health insurance	8
Private	67
of which:	
OOP	56
Other private	11

Source: WHO, National Health Accounts, 2011.

B. Health Services Delivery

2.36 **Health service delivery in the Philippines is a mixed system** of government health facilities (DOH-owned, LGU-owned, and some hospitals having autonomy), private for-profit facilities (hospitals, physician clinics, and pharmacies), and a small number of non-profit private facilities run by non-governmental organizations (NGOs) and religious groups. The barangay (village) health station (BHS) is closest to the household. There were 16,219 BHSs in 2005 (Table 2.7), which means that about 37 percent of the barangays had a BHS (or roughly 1 BHS in 3 villages). Rural health units (RHUs) and city health centers are located in each town/city, with the larger towns/cities having more than one RHU or health center. There were 2,266 RHUs in 2007, which means about 1.4 RHUs per town.

Table 2.7: Government and Private Health Facilities, 2004-2008

Health Facilities	Year	Government	Private	Total
Barangay health stations	2004	15,099	-	15,099
	2005	16,219	-	16,219
Rural and city health units	2004	2,258	-	2,258
	2007	2,266	-	2,266
Hospitals	2004	657	1,068	1,725
	2007	701	1,080	1,781
Hospital beds	2004	41,933	40,947	82,880
	2007	44,714	45,420	90,134
Drug distributors	2004	3,078		
	2008	4,165		
Medical device distributors	2004	754		
	2007	1,004		

Source: Philippine Statistical Yearbook, 2009 (NSCB)

2.37 Private health clinics, diagnostic/imaging centers, and laboratories operate in larger towns. Retail pharmacies and drug stores are the main sources of prescription and over-the-counter drugs. These used to be simple single-proprietorships, but have been dominated by national retail pharmacy chains and franchises, which now account for about 60 percent of the market by value. In recent years, village and town pharmacies sponsored by the government (Botika ng Barangay; Botika ng Bayan) have been revived, and these have multiplied in poorer barangays lacking a private retail pharmacy all over the country under a DOH program, but most have low turnover and face difficulty with re-supply.

2.38 In 2009, there were 1,796 hospitals, divided 60 percent/40 percent between private and government, respectively, with an average size of 50 beds per hospital. The number of beds is shared almost equally between government and private hospitals, although private hospitals are typically smaller (average size of 42 beds) compared to government hospitals (average size of 64 beds). These averages mask the fact that private hospitals in particular are made up of a large number of very small hospitals and a small number of large hospitals.

C. Health Sector Governance and Stewardship

2.39 **The Department of Health (DOH) is the key health sector steward in the Philippines responsible for the oversight of the health sector.** The Secretary of Health is the head of the DOH. The DOH consists of 17 central offices, 16 centers for health development (CHDs) located in various regions, 70 DOH hospitals (retained hospitals) and four affiliated agencies

- a. **Office of the Secretary:** This is the office for the Secretary of Health and consists of the Health Emergency Management Staff; Internal Audit Staff, the Media Relations Group and the Public Assistance Group including three Zonal Offices of the DOH located in Luzon, Visayas and Mindanao. The Zonal Offices are headed by an Undersecretary and supported by an Assistant Secretary. These offices are mandated to coordinate and monitor the National Health Objectives and the Local Government Code with the various Centers for Health Development.
- b. **Sectoral Management Support Cluster:** This cluster is composed of the Health Human Resource Development Bureau and the Health Policy Development and Planning Bureau. This unit is responsible for functions such as policy-making and priority setting, including the generation of the evidence base for health reforms;
- c. **Internal Management Support Cluster:** This cluster is composed of the Administrative Service, Information Management Service, Finance Service and the Procurement and Logistics Service.
- d. **Health Regulation Cluster:** This is composed of the Bureau of Health Facilities and Services, Bureau of Food and Drugs (now called the Food and Drug Administration or FDA) and the Bureau of Health Devices and Technology.
- e. **External Affairs Cluster:** This unit is composed of the Bureau of Quarantine and International Health Surveillance, Bureau of International Health Cooperation.
- f. **Bureau of Local Development Health Program Development Cluster:** It is composed of the National Center for Disease Prevention and Control, National Epidemiology Center, National Center for Health Promotion and National Center for Health Facilities Development.
- g. **Center for Health Development:** Responsible for field operations of the Department in its administrative region and for providing catchment areas with efficient and effective medical services. It is tasked to implement laws, regulations, policies and programs. It is also tasked to coordinate with regional offices of the other Departments, offices and agencies as well as with the local governments.

- h. ***Attached Agencies:*** The PhilHealth is implementing the national health insurance law, administers the Medicare program for both public and private sectors. The Dangerous Drugs Board coordinates and manages the dangerous drugs control program. The other two agencies are Philippine Institute of Traditional and Alternative Health Care and the Philippine National AIDS Council.

2.40 PhilHealth: PhilHealth has the status of a tax-exempt government corporation attached to the DOH. The Secretary of Health heads the PhilHealth Board of Directors. The PhilHealth Board of Directors consists of 11 members of which seven are from government agencies and the remaining four are representatives from civil society (labor, employers, self-employed sector and providers). The President of the Philippines appoints the Members of the Board upon the recommendation of the Chairperson of the Board (Secretary of Health). The President of PhilHealth is appointed for a non-renewable terms of six years upon the recommendation of the Board. Even through the Secretary of Health is the head of the PhilHealth Board, on a day-to-day basis, PhilHealth has great management autonomy. PhilHealth can set its own salary scales (although there are limits built into the system) and can spend a maximum of 12 percent of its income from premium contributions on total expenses (Jowett and Hsiao, 2007). The PhilHealth is required by its law to establish local health insurance offices in each province or chartered city. These offices are responsible for the full range of functions such as recruiting new members, membership management, granting or denying accreditation, paying fees, and establishing referral networks with other units. The National Health Insurance Law of 1995 provides the guiding legal framework for PhilHealth on all elements of revenue raising, resource allocation and purchasing. It also provides the legal framework for financial management and reserve fund management for PhilHealth.

2.41 At the LGU level, health is managed through provincial, municipal and barangay local government offices. In general, LGUs have minimal institutional infrastructure to manage health. In addition to DOH, PhilHealth and LGU structures, there is a strong professional and civil society in the Philippines with a strong presence of the Philippines Hospital Association, the Philippines Medical Association to which the Philippines Family Medicine Association is linked.

D. Recent Reforms in the Philippines Health Sector

2.42 **To address some of the factors for the slow progress from decentralization and national health insurance implementation, in 1998, the DOH launched the Health Sector Reform Agenda (HSRA).** The HSRA had multiple objectives including: (i) an enhanced social insurance benefits package with a strategy to limit balance-billing and increased enrolment of the indigent and informal sector into the national health insurance program, and increasing financial protection of the poor and sick, (ii) supply side measures to upgrade public health facilities in all communities to meet PhilHealth’s accreditation standards, and to increase fiscal autonomy for public health facilities, (iii) more effective regulation of the private health sector and of drugs and commodities, to improve access to quality services and drugs (including generics) at competitive prices, (iv) stronger results-orientation and coordination between DOH and LGUs in the delivery of public health programs, (v) development of structured processes to increase coordination among neighboring LGUs, DOH and the private sector in planning local health systems. A phased implementation strategy was developed and a number of “convergence provinces” were identified.

2.43 **In 2005, the Government launched the FOURMULA1 (F1) reforms.** The F1’s general objective is to achieve critical reforms with speed, precision and effective coordination directed at improving the quality, efficiency, effectiveness and equity of the Philippine health system in a manner that is felt and appreciated by Filipinos, especially the poor. The specific objectives are: to secure more, better and sustained financing for health; to assure the quality and affordability of health goods and services; to ensure access to and quality of essential basic health packages; and to improve the performance of the health system.

2.44 **The core of F1 consists of the four technical components¹² and their respective subcomponents as follows:**

- **Health financing** – mobilizing resources from extra-budgetary resources; coordinating local and national health plans; focusing direct

¹² The World Health Organization (WHO) lists six components of a health system that are usually the subject of health sector reform: financing, human resources, service delivery, regulation, governance, and information system. In F1, human resource issues are subsumed under governance while information system issues are subsumed under service delivery. F1 combined public health and hospitals under service delivery and thereby reduced the technical focus areas from five under the earlier HSRA to four.

subsidies to priority programs; adopting a performance-based financing system; and expanding the national health insurance program.

- **Regulation** – harmonizing licensing, accreditation, and certification; issuance of quality seals; and assuring the availability of low-priced quality essential medicines commonly used by the poor.
- **Service delivery** – ensuring availability of providers of basic and essential health services in localities; designating providers of specific and specialized services in localities; and intensifying public health programs in targeted localities.
- **Governance** – establishing four-in-one advanced implementation sites; developing an LGU F1 for Health scorecard; and institutionalizing an F1 for Health expanded professional career track.

E. Health Financing Reforms under F1

2.45 **The main objectives of FOURMULA1 under health financing are:** ensuring sustainable financing, including mobilizing resources from extra-budgetary resources, focusing direct subsidies to priority programs and expanding the national health insurance program. F1 calls for increasing revenue generation capacities of health agencies without compromising the poor’s access to services. This may include revenues from income retention, e.g., user fees and charges for personal health care and regulatory services, and health facilities’ rationalized use of real property assets; social health insurance; and private sources such as corporate social responsibility (CSR) programs, and other forms of public/private partnerships. In order to achieve this goal, the following efforts are supported under FOURMULA1.

- **Reducing the Fragmentation in Financing at the LGU Level:** FOURMULA 1 carried out several initiatives to correct some of the inherent weaknesses of devolution. To ease the problems of service fragmentation, lumpiness of investment, and externalities (spill-over effects), some municipalities organized themselves into inter-local health zones (ILHZs) so that they can share resources and benefits together. As of end-2009, as many as 274 ILHZs have been organized in 72 provinces, although little has been done to empirically evaluate their effectiveness, impact, and sustainability.
- **Implementation of Province-Wide Investment Plans:** Until recently, there was little planning capacity for health in LGUs. This problem is being addressed with the roll-out of the Province-wide Investment Plans for Health (PIPH) (Table 2.8). The PIPH has become the principal instrument to coordinate and consolidate the fragmented strands of resource mobilization by the province as it lays out the multi-year

investment plan based on needs identified and the various financing sources (IRA, commodity self-reliance plans relying mostly on locally-generated revenues, reimbursements from PhilHealth, additional central government grants, LGU's own loans, commodity and in-kind support, and external assistance, if any). Lower-level localities are also undertaking their own city and municipal investment plans for health. It remains to be seen how far these local health investment planning initiatives can generate additional resources for health, allocate them properly, and result in a rationalized efficient service delivery system. To measure provincial health expenditures, Local Health Accounts are also being piloted in 11 provinces.

Table 2.8: Provinces with Province-wide Investment Plans for Health, by FOURMULA 1 Waves, 2005-2010

Region	F16	F15 + ARMM	F44
Cordillera Autonomous Region (CAR)	Ifugao, Mountain Province	Benguet	Abra, Kalinga-Apayao
Region I – Ilocos	Ilocos Norte, Pangasinan	-	Ilocos Sur, La Union
Region II – Cagayan Valley	Nueva Vizcaya	Isabela	Cagayan, Quirino
Region III – Central Luzon	-	-	Aurora, Bataan, Bulacan, Nueva Ecija, Pampanga, Tarlac
Region IVA – CALABARZON	-	-	Bataan, Cavite, Laguna, Quezon, Rizal
Region IVB – MIMAROPA	Oriental Mindoro, Romblon	-	Marinduque, Occidental Mindoro
Region V – Bicol	-	Albay, Catanduanes, Masbate, Sorsogon	Camarines Norte, Camarines Sur
Region VI – Western Visayas	Capiz	-	Aklan, Antique, Iloilo, Negros Occ., Guimaras
Region VII – Central Visayas	Negros Oriental	-	Bohol, Cebu, Siquijor
Region VIII – Eastern Visayas	Biliran, Eastern Samar, Southern Leyte	-	Northern Leyte, Northern Samar, Western Samar

Region	F16	F15 + ARMM	F44
Region IX – Zamboanga Peninsula	-	Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay	-
Region X – Northern Mindanao	Misamis Occidental	Lanao del Norte	Bukidnon, Camiguin, Misamis Oriental
Region XI – Davao	-	Compostela Valley, Davao Oriental	Davao del Norte, Davao del Sur
Region XII – SOCKSARGEN	North Cotabato, South Cotabato	Sultan Kudarat, Sarangani	-
Region XIII – CARAGA	Agusan del Sur	Surigao del Sur	Agusan del Norte, Surigao del Norte, Dinagat Island
Autonomous Region of Muslim Mindanao (ARMM)	-	Basilan, Maguindanao, Sulu, Tawi-tawi, Lanao del Sur	-

Source: DOH

- Patient classification** – In its desire to impose user charges for the non-poor as a way of mobilizing more funds for the health sector, F1 recommends client segmentation mechanisms and patient classification systems. These were done initially in localities that developed plans for contraceptive self-reliance (CSR) or CSR+ (contraceptives plus other health commodities). More than 300 municipalities now have CSR or CSR+ plans, which were capacitated to undertake proxy means testing using the results of the Living Standards Survey and applying them to their own specific populations. The same tool is being used in the identification and enrolment of indigents into the LGU-PhilHealth Sponsorship Program.
- Special Congressional funds for health** – Since 2007, the National Government through the DOH has leveraged LGUs to provide resources to specific public health programs through specially grant allocations. In 2007, Congress appropriated Php 150 million to be used by LGUs for family planning and reproductive health services. In the following year, Congress also appropriated Php 2 billion to be used by LGUs for MNCHN services. In both cases, the governing rules require that the LGU should first show that it has spent some of its own resources to these programs before it can access the Congressional

grants, to indicate that the LGU does consider these programs as a priority. As a result, the annual budgetary appropriations to the DOH have ballooned in recent years. This is an important development for it reinstates the DOH and the regional Centers for Health Development (CHDs) as key players in local health financing, an influence DOH lost with devolution.

- ***Giving Fiscal Autonomy to DOH Facilities:*** To address resource inadequacies, F1 has focused on turning health facilities into revenue-earning “economic enterprises,” which essentially entails making them fiscally and organizationally autonomous. All of the retained DOH hospitals have achieved fiscal autonomy, their income-retention capacity having been made possible through a special provision in the Annual General Appropriations Act. The next step for these facilities is to go for a full-blown hospital autonomy, with their own governing boards, essentially making them government owned and controlled corporations. LGU health facilities (RHUs, city health centers, and LGU-owned hospitals) do not yet enjoy fiscal autonomy, and the risk is that the additional resources they mobilize will just revert back to the LGU treasury and may not result in improved health services.
- ***Reducing the price of drugs:*** In the absence of PhilHealth covering pharmaceutical benefits, outpatient drugs are a major source of expenditures for households. The enactment in 2008 of the *Universally Accessible Cheaper and Quality Medicines Act* (RA 9502/2008) and in 2009 of the Food and Drug Administration Act (RA 9711), were important milestones in laying foundations for improving quality and reducing prices of medicines. The “Cheaper Medicines Act” confers on the President the authority to regulate the price of medicines and drugs and empowers the DOH Secretary to establish a drug price monitoring and regulation system. Pursuant to this Act, the President issued Executive (EO) Order 821 (made effective August 15, 2009) prescribing the maximum retail prices (MRP) for selected medicines that address some diseases which are common causes of morbidity and mortality in the country. The EO covered only five active pharmaceutical ingredients including some antihypertensive, antibiotics, and anti-ceroplastics/anti-cancer.
- ***Negotiated Prices for Drugs with Selected Manufacturers:*** Some manufacturers negotiated with the Government to reduce prices of selected products voluntarily, rather than fall under mandatory price regulations. The DOH approved voluntary price reductions of up to 50 percent for 16 molecules (or 41 drug preparations) in August

2009, and a further 97 products in 2010. However, voluntary price reductions apply only to the products of participating manufacturers, not to alternative suppliers of generic substitutes. The DOH has established a process for monitoring and evaluation of the impact of these measures.

- ***Implementation of Performance-Based Financing Approaches.*** In F1, performance based financing (PBF) means that budget allocations and releases will be conditioned on the achievement of performance targets. F1 aims to install a performance-based budgeting system for hospitals, public health facilities, and regulatory agencies, which necessitates reforms in the respective agencies' management and procurement system and implementation of a performance audit, and review system. DOH is now shifting to a contractual mode of dealing with LGUs. It enters into service-level agreement with an LGU when it provides resources to implement a component of the Province-wide Investment Plan for Health. The agreement specifies the rights and responsibilities of the DOH and LGU and the performance benchmarks to be used to measure compliance. This approach is in contrast to the previous unconditional provision of drugs and other inputs. DOH contracting of leptospirosis cases with a number of private hospitals also exemplifies the use of PBF in a public/private partnership arrangement.

F. Service Delivery Reforms under F1

2.46 The FOURMULA1 reforms also focused on service delivery reforms mainly with the objective of: (i) rationalizing and upgrading health facilities (DOH and LGUs), (ii) establishing small pharmacies to improve access to outpatient drugs, and (iii) strengthening public health interventions at the LGU levels.

- ***Rationalizing Health Facilities at the LGU level:*** To rationalize health facilities at the LGU level, DOH lobbied for the formulation of provincial health facility rationalization plans. These plans comprise six areas where the LGU should make strategic decisions: merger, conversion, or closure of the facility; civil works plan; procurement plan; staffing and human resource development plan; social marketing activities; and monitoring and evaluation. All of the 16 F1 priority provinces plus 1 roll-out province (Albay) and 1 volunteer province (Mindoro Occidental) have completed their rationalization plans.

- Health facilities development planning***—Despite the deficits in hospital beds, the national and local governments actually made major hospital investments in recent years. Since 2007, Php 6 billion were spent to upgrade hospitals, RHUs, and barangay health stations (BHS) all over the country. These include (a) in 2007, the upgrading of 32 primary hospitals to secondary or tertiary level; (b) in 2008, the upgrading of 34 BHSs and RHUs, upgrading of 131 primary and secondary hospitals, expansion of 10 tertiary hospitals, and the upgrading of 21 teaching and training hospitals and 6 specialty centers; (c) in 2009, the upgrading of 319 BHSs and RHUs to provide BEmOC and CEmOC services; upgrading of 171 primary and secondary hospitals and 14 tertiary hospitals; expansion of 10 teaching and training hospitals; and establishment of 2 additional specialty centers (regional heart/lung/kidney center and 1 geriatric center). Finally, subspecialty capabilities in heart, lung and kidney diseases are being established in five DOH regional hospitals.
- Implementation of Facility Upgrades for Improved Maternity Care:*** Facility mapping of BEmOC and CEmOC facilities in all F1 sites started in 2007, and based on this mapping, rationalization of facilities in some localities has been initiated. About 111 health facilities have been capacitated to provide BEmOC/CEmOC services nationwide. However, many hospitals that are currently used as referral centers still do not have the capacity to handle maternal and neonatal emergencies. Upgrading of hospitals to become basic and comprehensive emergency obstetrics and neonatal facilities is critical, and this should be coupled with providing transport mechanisms for referrals. The Mother-Baby Friendly Hospital Initiative is being revitalized in BEmOC and CEmOC facilities.
- Nationwide establishment of small pharmacies in barangays that do not have access to any commercial drug outlets.*** The village drug outlet is an old idea previously known as “Botika sa Barangay” in the 1970s. These outlets faded out of the scene in the 1980s and 1990s, but were revived during the current administration and renamed Botika ng Barangay (BnB). In 2004, DOH with the Philippine International Trading Corp. (PITC) launched the program to set up a network of BnB (one for every three adjacent barangays, targeting those without existing pharmacies) and the larger Botika ng Bayan or BNB (at least one for each town). These outlets are privately owned and operated pharmacies that sell low-priced generics or drugs acquired through PITC parallel importation or local procurement. Each BnB sells a selection from a list of around 35 OTC medicines and household

remedies, and 7 prescription drugs. By June 2009, a total of 13,498 BnBs were established nationwide, including those of two NGOs (892 of the Kabalikat ng Botika Binhi and 462 of the National Pharmaceutical Foundation).

- ***Creating “disease-free zones”*** – F1 sought to identify areas with major infectious and vaccine-preventable disease problems and target them for intensive campaign to eliminate the threats. The work of the Infectious Disease Office is deemed to be outstanding as it exceeded targets for disease elimination over the past five years. The approach is to eliminate diseases province-by-province, island-by-island.
- ***Intensifying disease prevention and control strategy*** – Under F1, DOH focused on priority disease control in areas highly prevalent in tuberculosis, HIV/AIDS, and other communicable illnesses, achieved mainly through the revitalized TB program that placed emphasis on public/private mix DOTS (PPMD) as a key strategy. The DOH lobbied LGUs to collaborate with local private groups (NGOs, churches, schools, businesses, and communities) for awareness-raising and capacity-building in TB case management, which came to be known as PPMD. Over a hundred PPMDs have been organized all over the country. National TB policies were also translated into implementable standards of service for implementation at the local level. For instance, the Manual of Operations assisted LGUs in standardizing TB case management and in considering financing options for both patients and providers. PhilHealth’s formulation and further improvement of the benefit package for TB diagnosis and treatment (TB DOTS) also helped.

G. Governance under F1

- ***A new strategy for Maternal and Newborn Health:*** DOH’s major achievement in F1 is the change in strategy from the risk approach to emergency obstetric care, as laid out in AO 29, s. 2008 on Maternal, Neonatal, Child Health, and Nutrition (MNCHN). The AO prescribes that mothers should go to the health facility to deliver, and it mandates the government to bring basic and comprehensive emergency obstetric care (BEmOC and CEmOC, respectively) up to speed to be able to cater to the new delivery requirement. ***DOH has developed a new framework of Health Promotion for Behavior Change***, with 15 health promotion and communication plans for priority health programs. DOH has also held strategic communication planning workshops, with support from USAID’s HealthPro Project. Increasingly, LGUs

are taking on the responsibility for health promotion, but this is going to be an uphill climb. Local health communications are still greatly dependent on the DOH's National Center for Health Communication and Promotion, which produces and distributes the IEC materials and determines messaging at the national level. As a result, the centrally designed messages may not be appropriate for local audiences due to cultural factors, necessitating local adaptation.

- ***Strengthening disease surveillance*** – Groundwork on the Philippine Integrated Disease Surveillance and Response (PIDSRS) started in 2007 to harmonize all existing disease surveillance systems. In the following year, the surveillance capability of LGUs was enhanced with the issuance of the guidelines to establish epidemiology and surveillance units (ESU) and training for all Regional ESUs in 2008. ESU networks are being institutionalized all over the country.
- ***Establishing four-in-one advanced implementation sites*** – F1 calls for provision of support in the four thematic areas of financing, regulation, service delivery, and governance in each of the provinces. The first wave started in 2005 in 16 F1 convergence sites; the second wave of 15 rollout provinces followed in 2007; the third wave of 44 provinces came through in 2008; and the 4 or 5 provinces in ARMM brings the total to 70. These first two waves of convergence sites were selected based on health needs, capacities, and political commitment to pursue F1 reforms with DOH.
- ***Participation mechanisms*** – The Local Health Board (LHB) is the technical body that serves as an advisory body on health matters to the local legislative body or “Sanggunian”. LHBs include private sector and NGO representatives. However, LHBs are known not to have worked well as indicated by the way health plans emanated from municipal health offices and LGU executives. Moreover, not all NGO representatives are adept at conveying the health needs of their communities, indicating the need to train them in that area.
- ***Inter-LGU coordination systems, i.e., inter-local health zones (ILHZ)*** – Devolution frayed the district health structure, which has been entrenched in almost all developing countries as a feasible planning unit for health financing and delivery. Many small municipalities lost the natural economies of scale and scope inherent in the district health structure, and with it, the referral structure within their former catchment area as well. The primary justification, albeit

often unarticulated, for the establishment of ILHZs among (adjacent) municipalities is to re-institute these lost economic dimensions through better coordination. Section 33 of the Local Government Code provides that “LGUs may, through appropriate ordinances, group themselves, consolidate or coordinate their efforts, services and purposes commonly beneficial to them.”

- ***National sectoral development approach to health (SDAH)*** – F1 prescribes that health investments will be undertaken using a sector-wide approach (SWAp) at the national and local levels. At the central level, in 2007 the DOH adopted the Sector Development Approach for Health (SDAH) as a governing principle of total health investments through the issuance of an AO; emphasized the leadership role of the government, and the desire to harmonize systems and processes. SDAH is the Philippine adaptation of SWAp that has been instituted in many developing countries to better plan and coordinate the investments sponsored by a plethora of sources. Although donors are a minor source of funding in the country’s health sector, the number of their activities is still forbidding. The policy framework for the implementation of SDAH was formulated in 2005, and increasingly the health sector has been recognized as the best managed among other development sectors in the country.
- ***Role of DOH regional offices*** – The role of the Centers for Health Development (CHDs) in the stewardship of health sector is not clearly spelled out in F1. Compared to the Department of Education that decentralized many of its functions to regional and provincial offices even if education services remained undeveloped, up until the last few years the DOH reluctantly decentralized similar functions to the Centers for Health Development (as its regional offices are called). Just after devolution was implemented, DOH established the ad hoc unit, the Local Government Assistance and Monitoring Service (LGAMS), rather than empower its CHDs to deal with issues and problems concerning LGUs in the early years of the devolution (Capuno, 2008). This attitude about the role of CHDs continues to this day, although decentralization earnestly begun over the past couple of years under F1 as DOH tasked CHDs with an increasing number of regulatory functions.

Performance of the Philippines Health System

Box 3: Main Messages

- *Health outcome indicators such as life expectancy at birth and infant and under-five mortality rates are improving. The Philippines is expected to reach the MDG 4 target for childhood mortality. It performs better than other comparable income and health spending countries on infant mortality and life expectancy.*
- *While maternal mortality has been improving and the Philippines has lower maternal mortality than other comparable income and health spending countries, its rates of reduction appear to be too low to achieve its MDG target.*
- *Inequalities in health outcomes are present across the board. While aggregate child mortality statistics have improved, the gap between the rich and the poor on this health outcome has widened. While life expectancy levels in some provinces (e.g., La Union) are similar to European country levels, in others (e.g., Tawi-Tawi and Sulu) life expectancy is similar to Sub-Saharan African countries.*
- *On overall health and public expenditure levels as well as public spending on health as a percentage of total government spending, the Philippines' levels are below the averages for its income comparators. The private and out-of-pocket (OOP) shares of total spending in the Philippines are one of the highest among comparator countries. Moreover, OOP spending levels have been increasing, despite SHI and universal coverage reforms. At the same time, public spending levels have declined.*
- *While the utilization of key services (ante-natal care, immunization) is improving, the improvements are not the same across all income quintiles. It is striking that the largest gains in utilization indicators are among the second lowest income quintile, which indicates that services are reaching the poor. However, the bottom quintile (generally the hardest to reach in any health system) are left out.*
- *Financial access to health services has improved in the last few years (2003-08) but remains a major factor for people not seeking health services in a timely manner.*

PERFORMANCE ASSESSMENT OF THE PHILIPPINES HEALTH SYSTEM

3.1 In this chapter, an assessment is made of the performance of the Philippines health system. Performance of a country's health system including its health financing functions of revenue collection, risk pooling, and purchasing should be evaluated in terms of final health system objectives of health outcomes, financial protection, and consumer responsiveness in the context of the intermediate outcomes of equity, efficiency and sustainability. However, as has been well articulated in the health systems strengthening (HSS) literature, such evaluations are extremely difficult for a variety of reasons including: definitional and measurement problems (e.g., measuring health outcomes, measuring the depth and breadth of health insurance coverage, etc.), attributing causality in a complex interactive system, separating demand from supply side factors, and controlling for the impacts of non-health systems' related factors such as education, water, sanitation, infrastructure, etc. It is thus extremely difficult in a country-specific only context to measure the performance of a health system and attribute such performance to specific health system features.

3.2 One useful technique that has been extensively employed to provide crude indications of a country's performance is to assess trends over time and benchmark a country's performance on readily measurable performance indicators and health systems inputs against other comparable income and health spending countries. This is generally done by estimating the average relationships for all countries globally and assessing the country in questions performance against global averages, keeping in mind that there is nothing right or wrong about a global average. Nevertheless, large deviations from the 'average' performance of comparators do provide some indications of areas that may require changes in health policies.

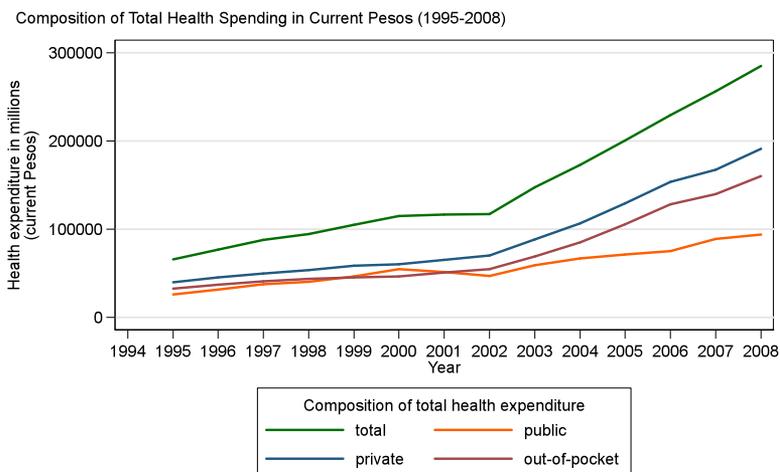
3.3 While some such comparative analyses have been done before for the Philippines, here we provide a comprehensive update of previous analyses for the latest available health spending and outcome information from the WHO National Health Accounts (NHA) data base, the World Bank's World Development Indicators (WDI) data base, and the IMF's latest Regional Economic Outlook (REO) and post financial crisis macroeconomic statistics as well as the recently published Philippines National Demographic and Health Survey (NDHS, 2008). The analysis for the Chapter has, nevertheless, been constrained by the limited data on service delivery (e.g., outpatient visits, hospital admission and occupancy rates for each province and public and private facilities). While these data exist, an additional data collection effort would have

had to be launched to collect updated information from each province. Since licensing of health facilities was decentralized to the provincial level (through DOH offices at the provincial level) in 2007, these data are not available in aggregate format at the national level.

I. TRENDS IN HEALTH SPENDING IN THE PHILIPPINES

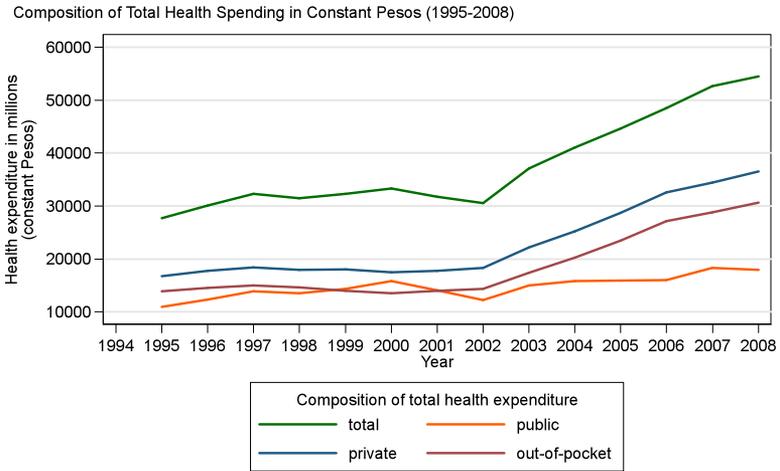
3.4 This section analyzes trends over time in total, public, private, and OOP health spending in the Philippines in constant and nominal local currency units (LCUs) and US\$ (in exchange rates and ‘international dollars’ which correct for cost-of-living differences using purchasing power parities – PPPs), total and per capita, and as a share of the overall economy (GDP). Various measures are used as there is no one overall ‘right’ way to measure health spending levels and trends within a given country. Each measure provides complementary information about health spending performance in terms of adjusting for various factors such as inflation, population, in absolute terms and as a share of the overall economy.

Figure 3.1: Health Spending in Nominal LCUs



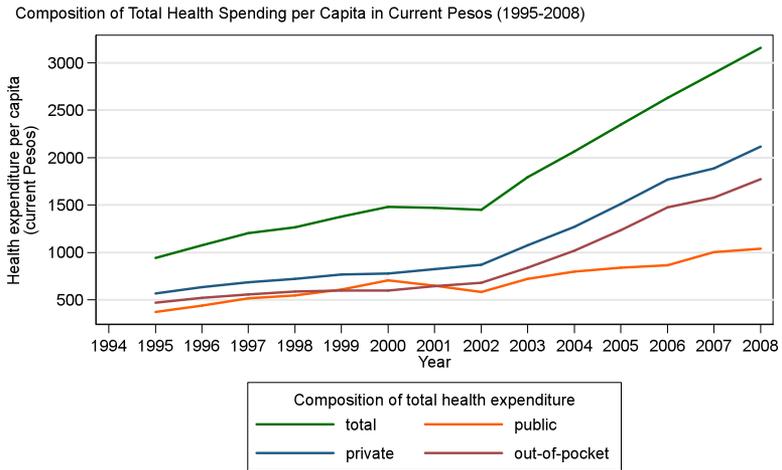
Sources: WDI; WHO

Figure 3.2: Health Spending in Constant LCUs



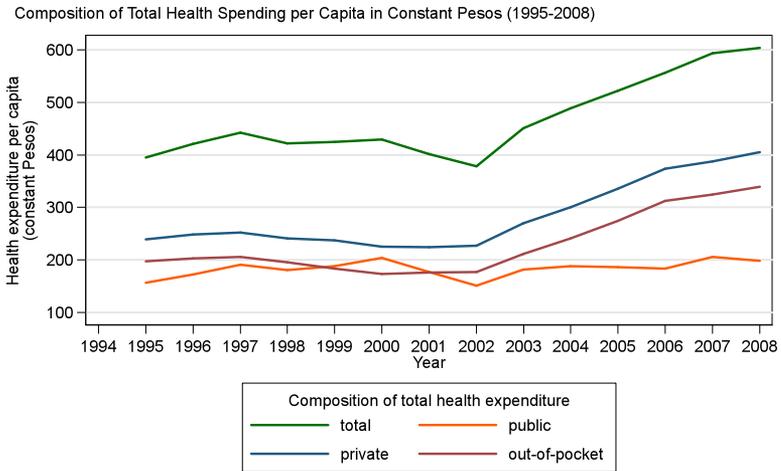
Sources: WDI; WHO

Figure 3.3 Per Capita Health Spending in Nominal LCUs



Sources: WDI; WHO

Figure 3.4: Per Capita Health Spending in Constant LCUs

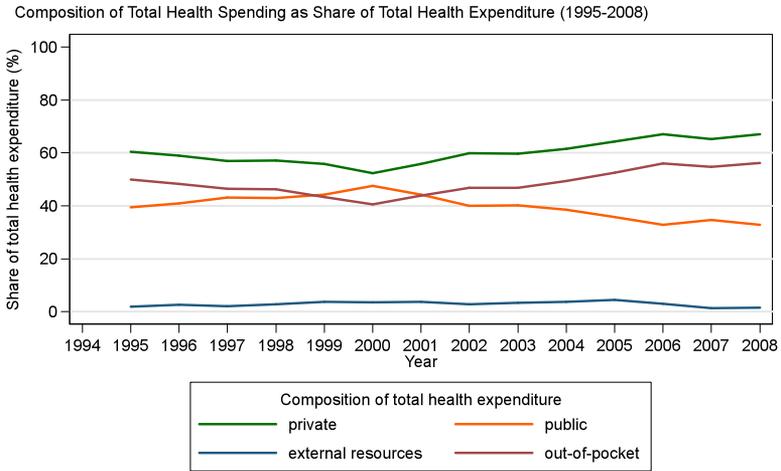


Sources: WDI; WHO

3.5 Figures 3.1 and 3.2 show the nominal and real 1995-2008 trends in total, public, private and OOP health spending in LCUs, while Figures 3.3 and 3.4 provide the same information adjusting for population growth. While the trend in the totals and its components are upward, of note is that in constant per capita LCU terms (Figure 3.4), public spending in 2008 is almost the same as it was in 2000.

3.6 These trends in absolute increases are further highlighted by looking at the changes in shares of spending as shown in Figure 3.5. Both sets of measures highlight the continuing and growing importance of private (67 percent in 2008 versus 60 percent in 1995) and OOP health spending (56 percent in 2008 versus 45 percent in 1995) as the major sources of health spending in the Philippines. Conversely, the public share is declining and accounting for a relatively smaller share over the entire 1995-2008 time period (33 percent in 2008 versus 40 percent in 1995), despite the push for universal coverage through the creation of PhilHealth in 1995. External assistance has been relatively stable over time, accounting for an extremely small share of the total.

Figure 3.5: Shares of Total Health Spending

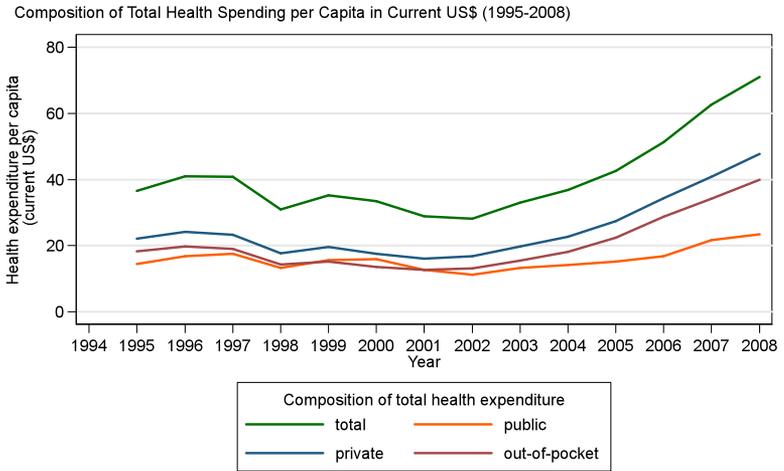


Sources: WDI; WHO

3.7 Moreover, while total spending increased by an average 12 percent per year between 1995 in nominal terms, it only increased by an average of 5.4 percent per year in constant terms, and after adjusting for the Philippines’ high rates of population growth only increased by 9.8 percent in nominal and 3.3 percent in constant per capita terms with most of these increases attributable to private/OOP spending. Below this growth is assessed relative to the growth of the overall economy, and public health spending is assessed as a share of the overall government budget.

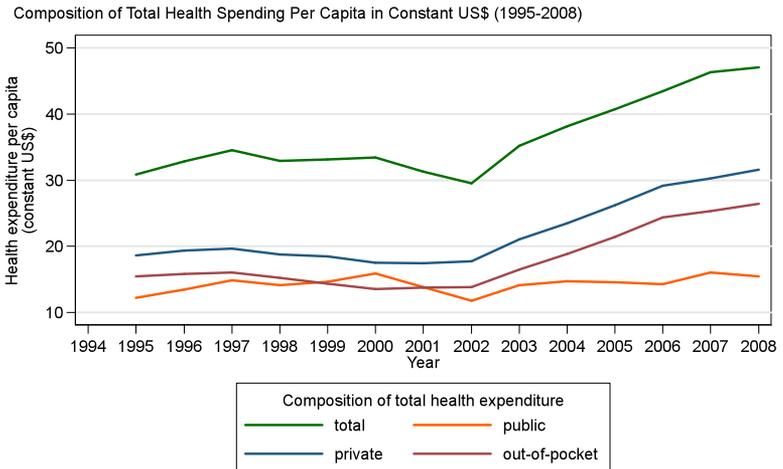
3.8 One can also evaluate health spending in a single numeraire currency such as \$U.S., which facilitates comparisons with other countries. Figures 3.6 – 3.9 show the trends in Philippines per capita health spending in nominal and constant exchange rate-based and international U.S. dollars.

Figure 3.6: Nominal Per Capita Health Spending (US\$ Exchange Rates)



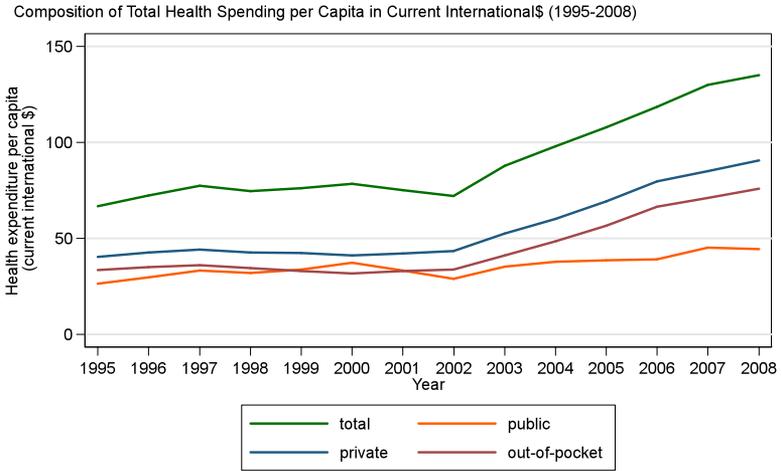
Sources: WDI; WHO

Figure 3.7: Constant Per Capita Health Spending (US\$ Exchange Rates)



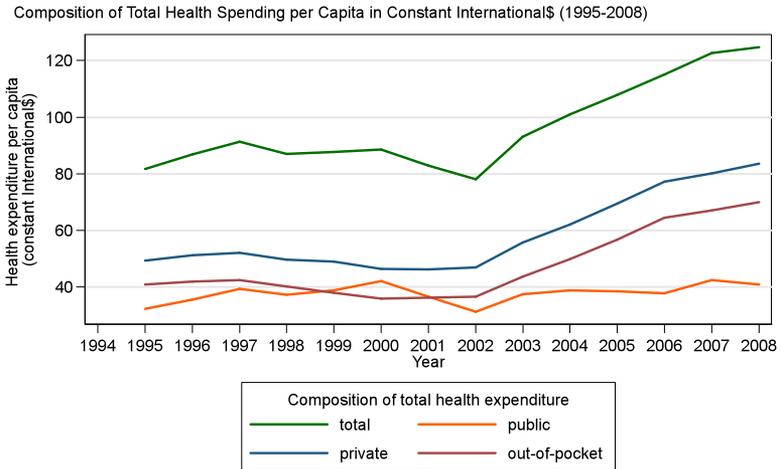
Sources: WDI; WHO

Figure 3.8: Nominal Per Capita Health Spending (US\$ PPPs)



Sources: WDI; WHO

Figure 3.9: Constant Per Capita Health Spending (US\$ PPPs)

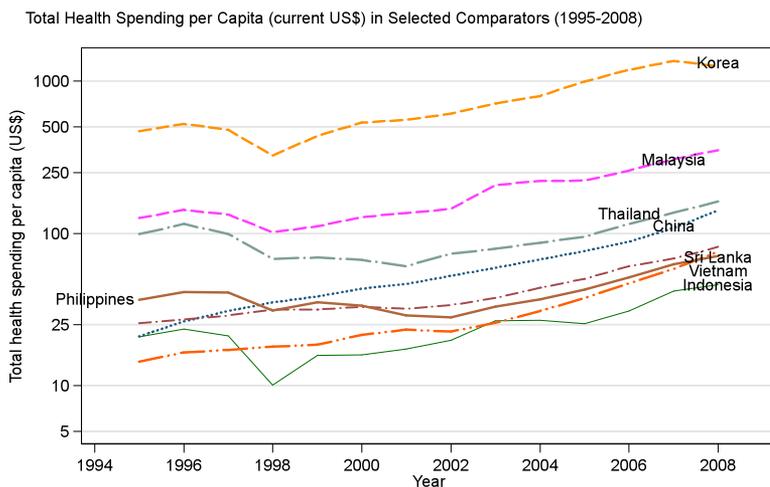


Sources: WDI; WHO

3.9 Analyzing Philippines expenditure trends in nominal and constant US\$ whether using exchange rates or PPPs provides a somewhat similar picture to the LCU analysis. In nominal exchange rate based US\$ spending increased from \$37 in 1995 to \$71 in 2008, a 94 percent increase, slightly less than the PPP increase from \$67 to \$135 of 100 percent. In constant exchange rate-based and PPP-based US\$ spending increased by about 52 percent. Interestingly, the US\$ comparisons, whether in exchange rates or PPPs generally indicate lower rates of increase in health spending then the per capita LCU comparisons.

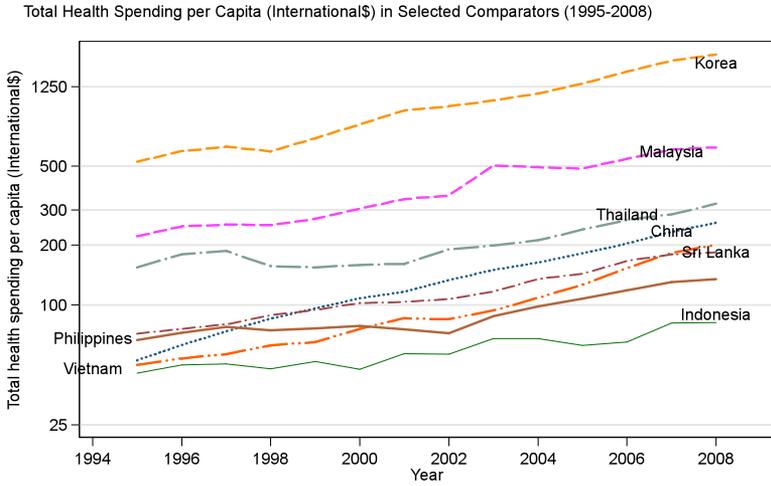
3.10 Figures 3.10 and 3.11 compare Philippines trends in nominal exchange rate and PPP-based US\$ health spending per capita over the 1995-2008 period with the trends in several other neighboring Asian countries -- China, Indonesia, Sri Lanka, Thailand, Korea, Malaysia, and Vietnam.

Figure 3.10: Nominal Per Capita Health Spending (US\$ Exchange Rates): Select Asian Comparators



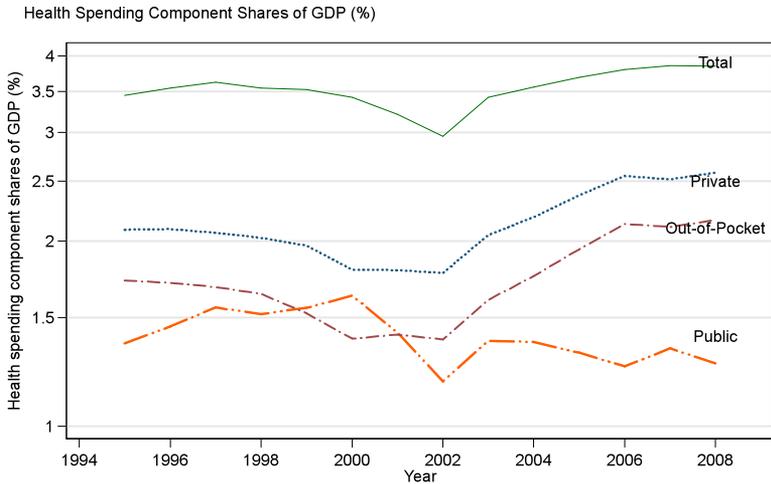
Source: WDI
Note: y-axis log scale

**Figure 3.11: Nominal Per Capita Health Spending (US\$ PPPs):
Select Asian Comparators**



Source: WDI
Note: y-axis log scale

Figure 3.12: Health Spending as a Share of GDP



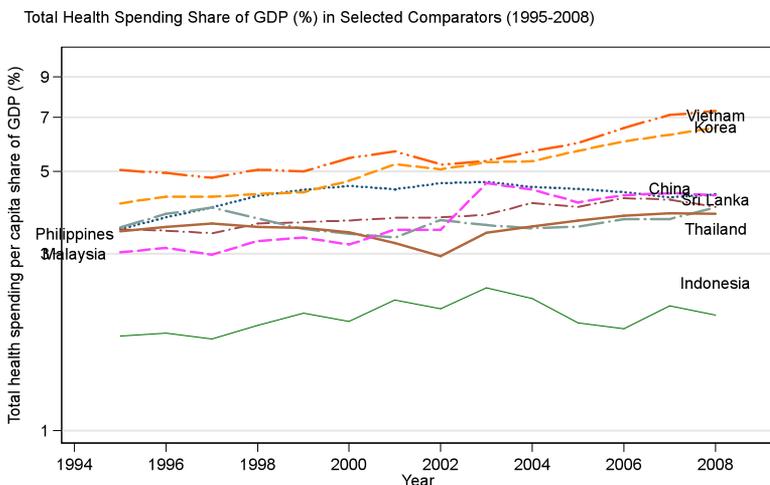
Source: WDI
Note: y-axis log scale

3.11 As shown in these figures, the rates of increase in Philippines per capita health spending, whether measured in exchange rate or PPP-based US\$, do not appear to be as rapid as in a number of neighboring countries. We now assess Philippines health spending trends when health spending is measured as a share of GDP.

3.12 Figure 3.12 shows for 1995-2008 the Philippines trends in total, public, private and OOP health spending as a share of GDP.

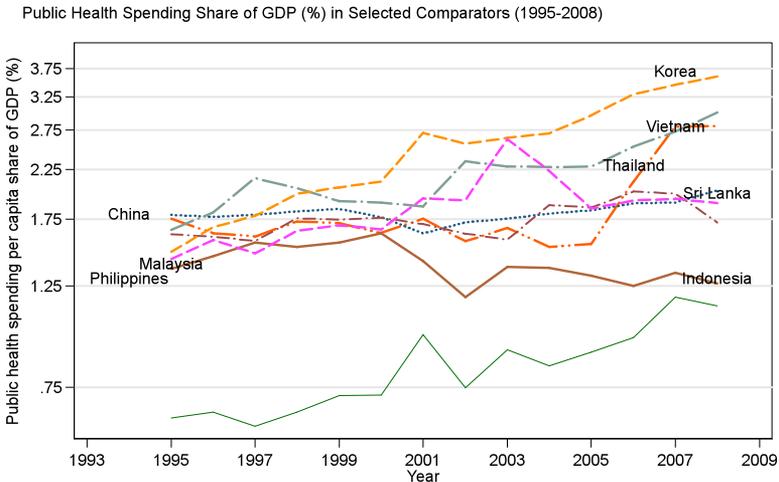
3.13 Total health spending as a share of GDP has increased slightly from 3.4 to 3.9 percent of GDP over the 1995-2008 time period. While spending as a share of GDP appears to have increased significantly in 2002, this appears to be largely a result of OOP spending. However, while as shown in Figure 3.13 and 3.14 below, compared to other neighboring Asian countries, the Philippines share of the economy devoted to health has not grown as significantly over this time period, the private and OOP shares have increased, while the public share as a percent of GDP has actually fallen from its 2000 level and is slightly below the level in 1995.

Figure 3.13: Total Health Spending as a Share of GDP: Select Asian Comparators



Source: WDI
 Note: y-axis log scale

**Figure 3.14: Public Spending on Health as a Share of GDP:
Select Asian Comparators**



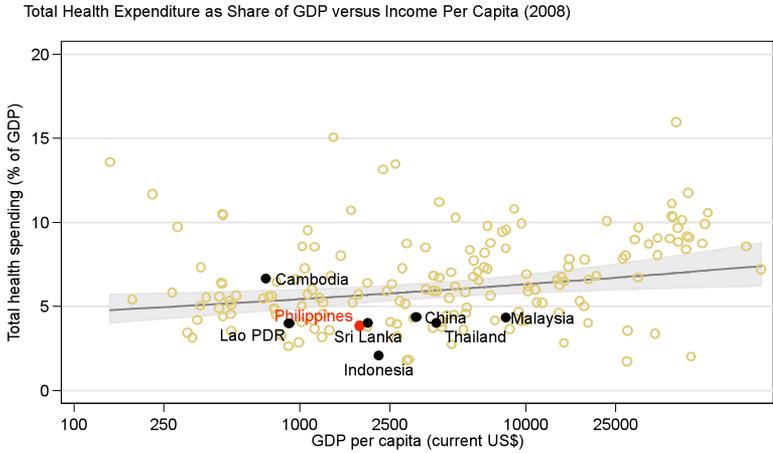
Source: VDI (updated as of October 8, 2009)
Note: y-axis log scale

II. GLOBAL COMPARISONS OF PHILIPPINES' HEALTH EXPENDITURES

3.14 **This section of the analysis compares various measures of total, public, private, and OOP health spending in the Philippines to the levels found in other comparable income countries based on average global relationships between the various health spending measures and per capita GDP.** Figures 3.15 – 3.17 provide global comparisons of total health spending to GDP as well as total health spending per capita measured both in exchange rate and PPP-based US\$. The global trend lines in all cases show the upward trends in health spending as countries get richer (i.e., health is a normal good), and based on all three measures, total health spending in the Philippines is lower than the levels found in other comparable income countries.

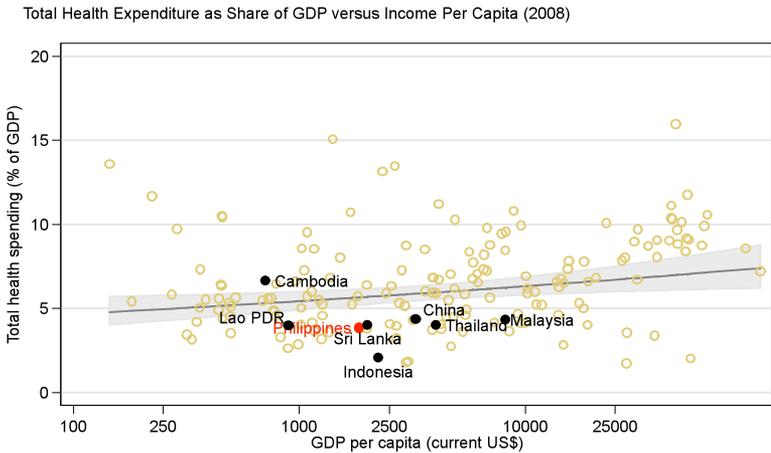
3.15 **Public expenditures on health can be measured in a variety of ways including: the public share of total health expenditures, as a share of GDP, per capita in exchange rates and PPP-based US\$, and as a share of the overall government budget.** Figures 3.18 – 3.22 display the global comparisons for these various measures of public spending on health. As in the case of total health spending, for every measure of public spending on health, the Philippines public spending measures are lower than other comparable income countries.

Figure 3.15: Global Comparisons of Total Health Spending to GDP



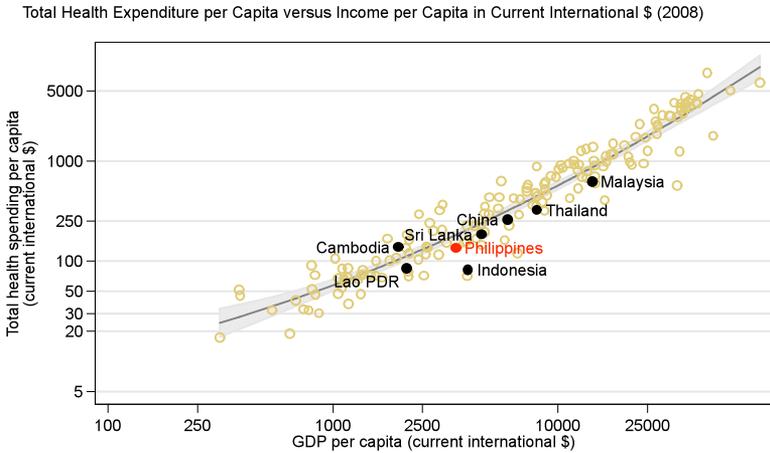
Sources: WDI; WHO
Note: x-axis log scale

Figure 3.16: Global Comparison per Capita Total Health Spending (US\$ Exchange Rates)



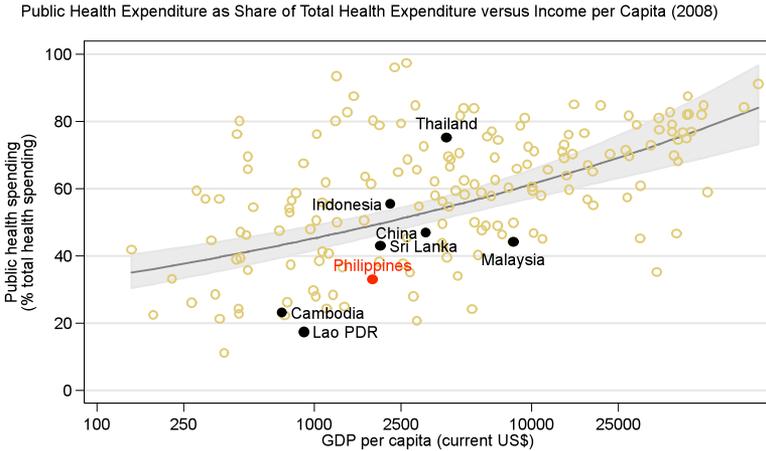
Sources: WDI; WHO
Note: x-axis log scale

Figure 3.17: Global Comparison of Per Capita Total Health Spending (US\$ PPPs)



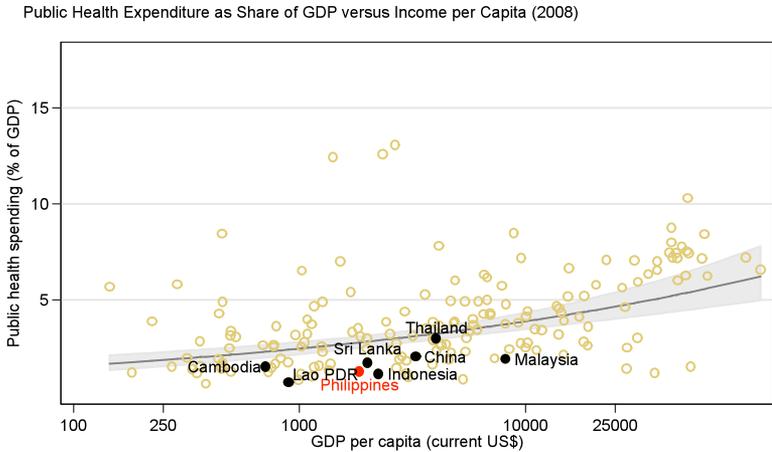
Sources: WDI; WHO
 Note: Both axis log scale

Figure 3.18: Global Comparison of Public Spending on Health as a Share of Total Health Spending



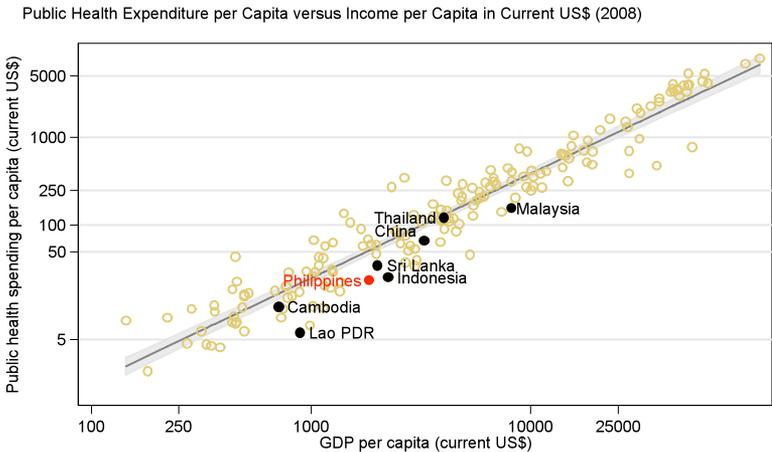
Sources: WDI; WHO
 Note: x-axis log scale

Figure 3.19 Global Comparison of Public Spending on Health as a Share of GDP



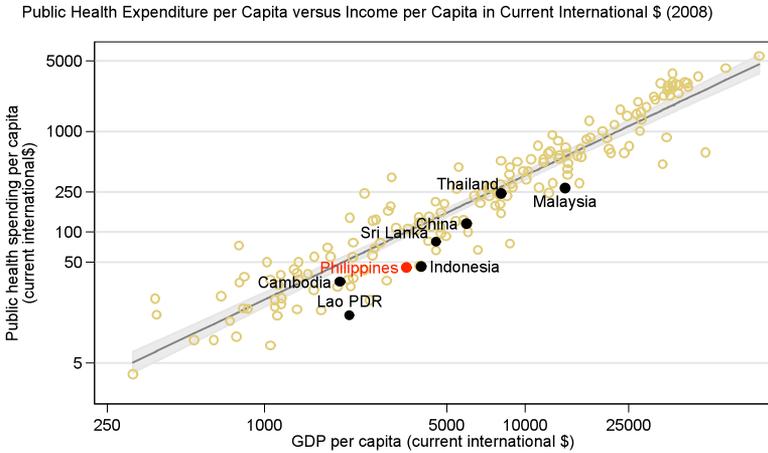
Sources: WDI; WHO
Note: x-axis log scale

Figure 3.20: Global Comparison of Public Spending on Health Per Capita (US\$ Exchange Rates)



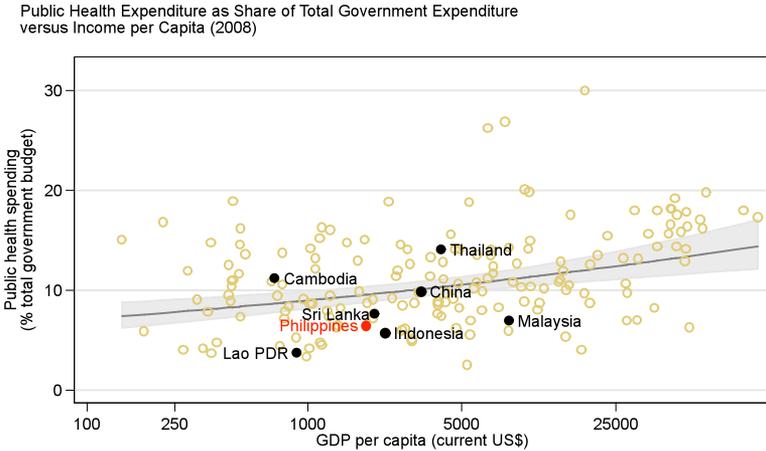
Sources: WDI; WHO
Note: Both axis log scale

Figure 3.21: Global Comparison of Public Spending on Health Per Capita (US\$ PPPs)



Sources: WDI; WHO
 Note: Both axis log scale

Figure 3.22: Global Comparison of Public Spending on Health as a Share of the Overall Budget

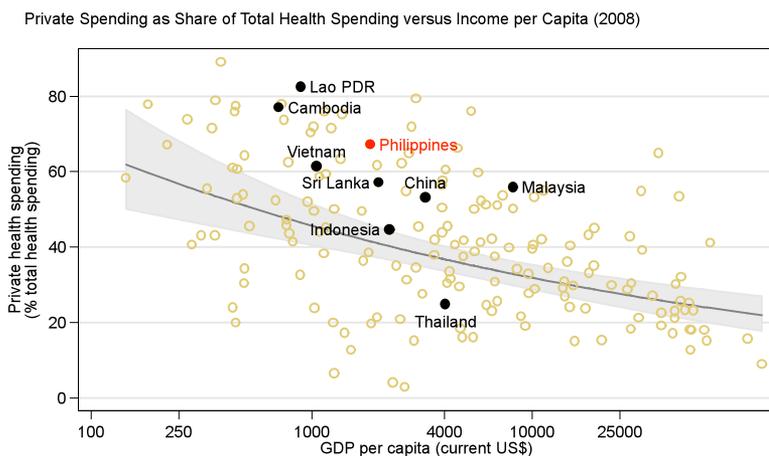


Sources: WDI; WHO
 NOTE: x-axis log scale

3.16 In the Philippines, private health spending, 84 percent of which is out-of-pocket, made up 67 percent of total health spending in 2008. Out-of-pocket spending is a crude indicator of financial protection and measures the amount of health spending for which there is no public and/or private risk pooling (i.e., prepaid ‘insurance’ coverage). While in and of itself, it does provide a crude measure of the level of financial risk faced by the population, when accompanied by more detailed analyses of spending at the household level by income quintile, these measures provide a comprehensive assessment of how well the Philippines performs vis-a-vis the financial protection and equity goals of health systems.

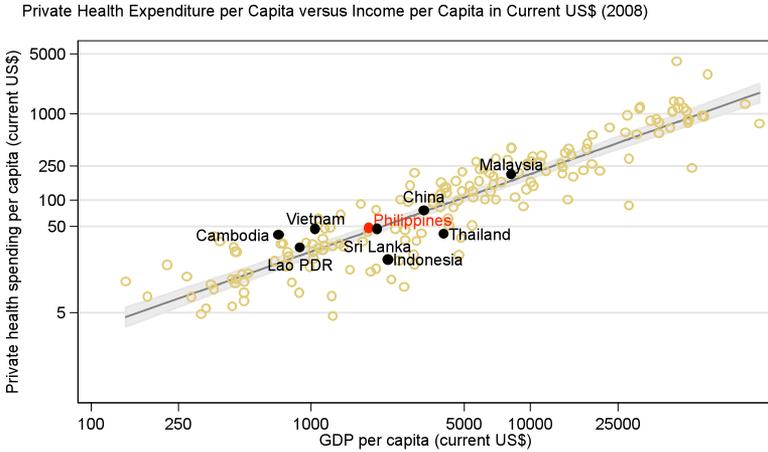
3.17 Figures 3.23 – 3.28 provide global comparisons of the private share, private spending per capita in exchange rate and PPP-based dollars, out-of-pocket spending as a share of total health spending and OOP per capita in exchange rate and PPP-based dollars. These global comparisons will be followed by a detailed analysis of household spending on health by income quintile from household surveys.

Figure 3.23: Global Comparison of Private Health Spending as a Share of the Total



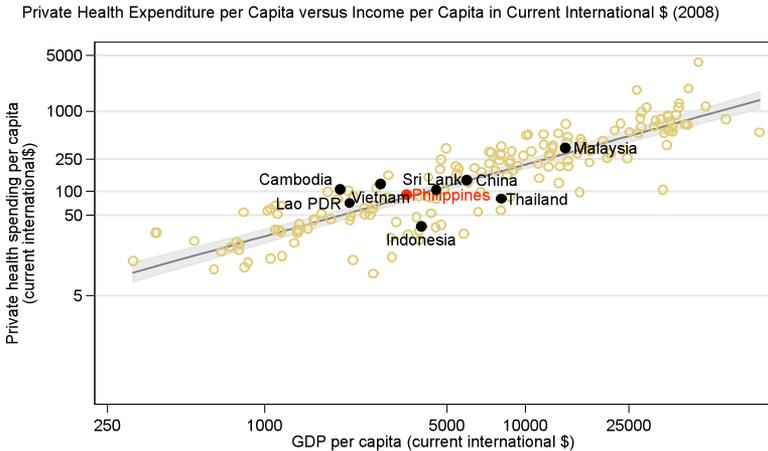
Sources: WDI; WHO
Note: x-axis log scale

Figure 3.24: Global Comparison of Private Health Spending Per Capita (US\$ Exchange Rates)



Sources: WDI; WHO
 Note: Both axis log scale

Figure 3.25: Global Comparison of Private Health Spending Per Capita (US\$ PPPs)



Sources: WDI; WHO
 Note: Both axis log scale

Figure 3.26: NGlobal Comparison of OOP as a Share of Total Health Spending

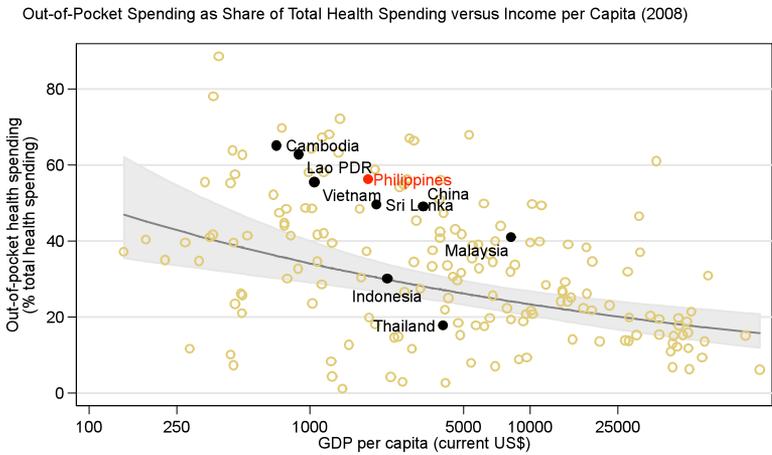


Figure 3.27: Global Comparison of OOP Per Capita (US\$ Exchange Rates)

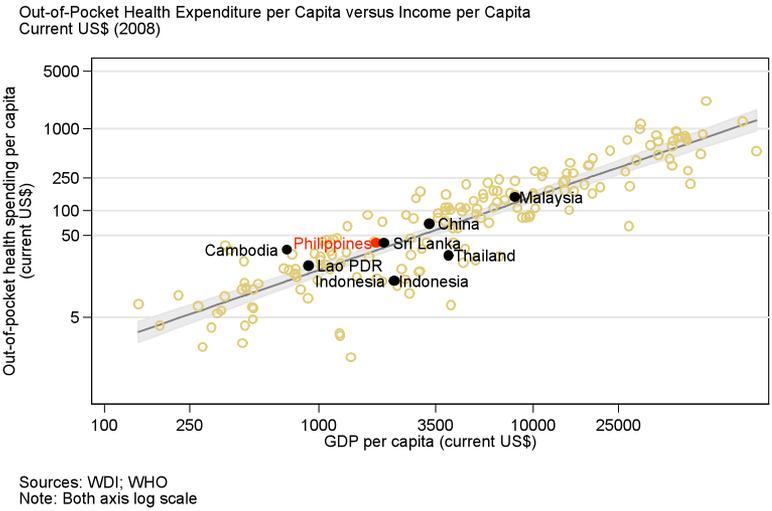
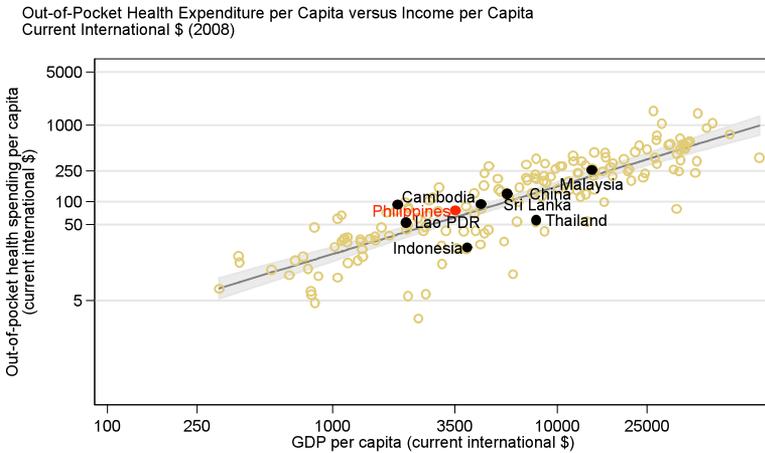


Figure 3.28: Global Comparison of OOP Per Capita (US\$ PPPs)



Sources: WDI; WHO
Note: Both axis log scale

3.18 **While total health spending in the Philippines and the public share are low, the private and OOP shares are very high, and both private and OOP spending per capita are at or slightly above the levels in global comparators, despite the overall low level of total health spending.** However, the very high out-of-pocket share coupled with the significant levels of out-of-pocket per capita spending are very troubling as it reflects a lack of risk pooling and financial protection for the population overall. However, to really understand the impact of these aggregate OOP figures in terms of financial protection, equity, and impoverishment, one needs to analyze household level data by income class (Section V of this Chapter).

III. HEALTH OUTCOMES RELATIVE TO INCOME (GDP), HEALTH SPENDING AND EDUCATIONAL LEVELS

3.19 **The Philippines has made steady and significant progress in its population health outcomes over the past several decades.** Life expectancy has been steadily increasing in the country to 72 years in 2008, up from about 53 years in 1960. The infant mortality rate (IMR) in 2008 was 26.5 per 1,000 live births. In the same year, the under-five mortality rate was 33.5 per 1,000 live births (Figure 3.29). The DHS confirms that child mortality continues to be on the decline in the Philippines. According to the DHS, the IMR and under-five mortality rates are currently 25 and 34 per 100,000 live births, as compared

with 29 and 40 respectively during the earlier period (2003 DHS). The country is “on-track” to achieving the Millennium Development Goal (MDG) 4, which calls for a two-thirds reduction in under-five mortality over the period 1990-2015. From a cross-country comparative perspective, the country’s 2008 infant mortality is below the average level of its income and health spending comparators (Figure 3.30).

Figure 3.29: Population Health Indicators in the Philippines, 1960-2008

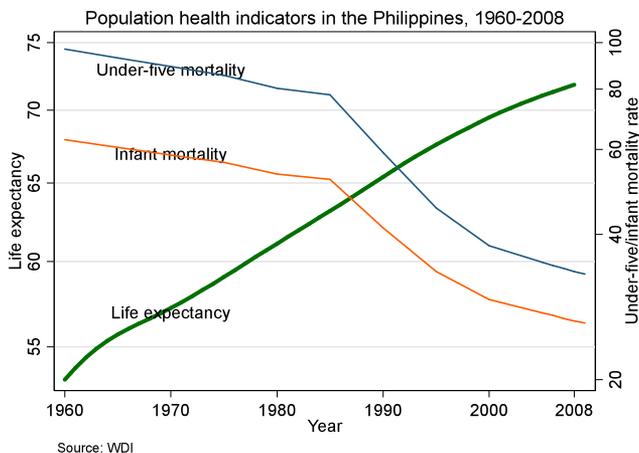
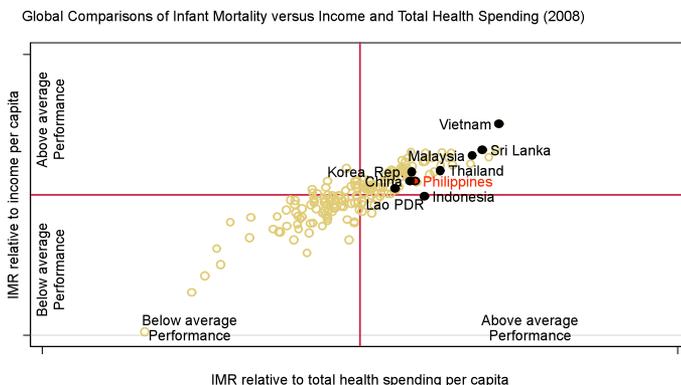
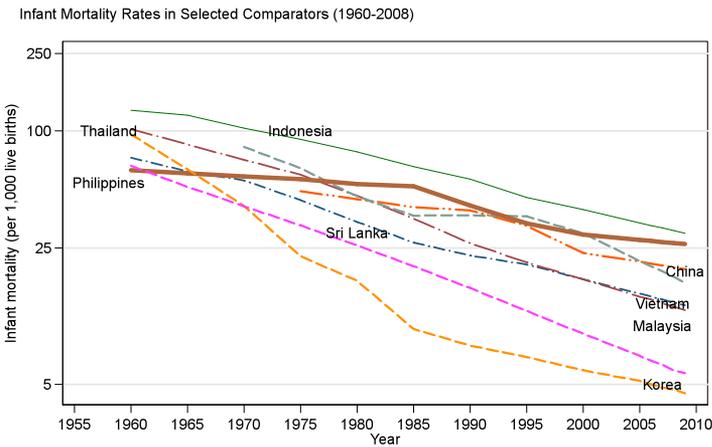


Figure 3.30: Global Comparison Infant Mortality Versus Income and Total Health Spending, 2008



3.20 **Despite being better than average with regard to the attainment of certain population health indicators relative to income, it is important to note that the Philippines has lagged some of its neighbors in trend improvements over time.** With regard to infant mortality, for instance, several countries in the region – including Korea, Thailand, Malaysia, and Sri Lanka – were worse than the Philippines in 1960 (Figure 3.31). By 2008, all of these countries had overtaken the Philippines. At current trends, Indonesia is poised to overtake the Philippines over the next couple of years in terms of its infant mortality rate.

Figure 3.31: Infant Mortality Rate Trends, 1960-2008



Source: WDI
Note: y-axis log scale

3.21 **A somewhat similar picture emerges for life expectancy, which has increased from 53 years in 1960 to 72 years in 2008.** As shown in Figure 3.32 improvements in the Philippines have been somewhat less impressive than for some of its neighboring Asian countries, but for its income and health spending levels, as shown in Figure 3.33 it performs better than global comparators. Such results may well be related to education and other life style and social factors as opposed to the performance of the health care delivery system per se.

Figure 3.32: Life Expectancy in Select Asian Countries, 1960-2008

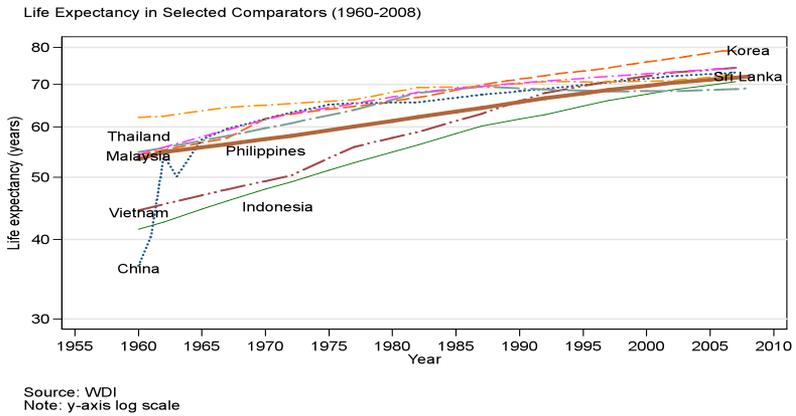
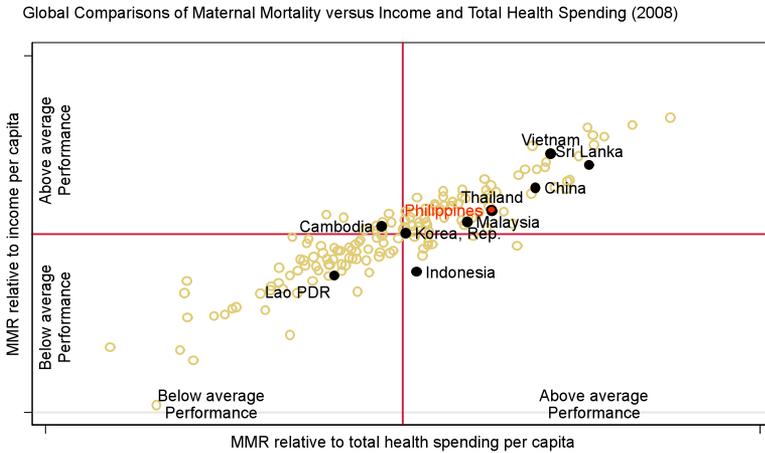


Figure 3.33: Global Comparisons of Life Expectancy Based on Income and Health Spending, 2008



3.22 While the Philippines health system appears to perform well in terms of infant mortality and life expectancy, the results for maternal mortality are more mixed. Given the problems in obtaining consistent MMR data even within, much less across, individual countries, only a global comparison is undertaken for 2008, a year for which consistent data for all countries were

Figure 3.34: Global Comparisons of Maternal Mortality Based on Income and Health Spending, 2008



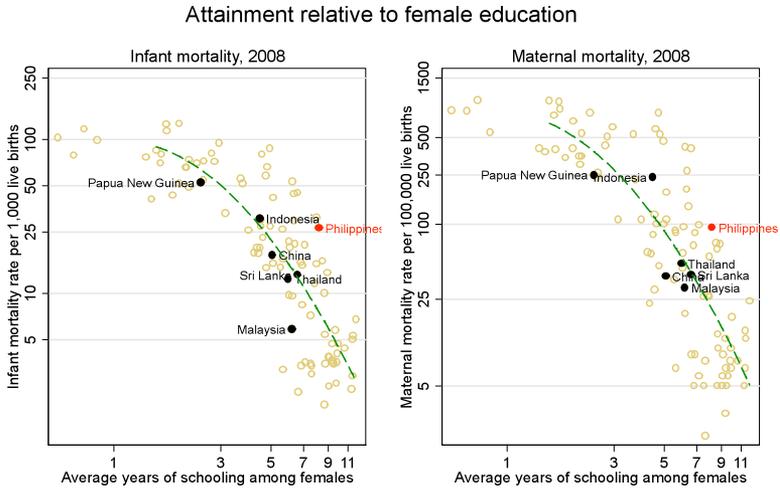
Sources: WDI:WHO
 Note: Both axis current US\$

developed by WHO, UNICEF, the World Bank, and UNFPA. As shown in Figure 3.34 the Philippines for its income and health spending levels performs somewhat better than the comparator ‘average’, but, as discussed above, its rates of decline are insufficient for achieving the MDG 5 goal.

3.23 While the Philippines performs better than its peer group averages for its income and relatively low health spending levels on infant and maternal mortality, when one takes into account its relatively high education levels, a different picture emerges. Figure 3.35 shows infant mortality and maternal mortality relative to female education attainment. The relative performance of the Philippines is quite poor: both infant and maternal mortality rates are much higher than the levels that would be expected on average in countries with the Philippines’ high level of female education attainment.

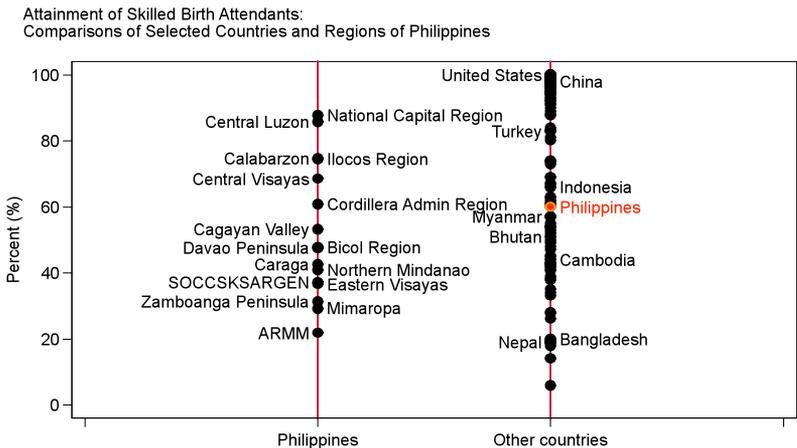
In Figures 3.36-3.37, a key proxy indicator for maternal health outcomes is evaluated in terms of the utilization of skilled birth attendants. This shows that utilization (overall) is similar to the levels of Myanmar and as in the case of health outcomes, there is substantial variation in use across the regions, with some regions such as Central Luzon having high utilization, while others such as ARMM having extremely low utilization similar to the levels of Nepal and Bangladesh. For its income and health spending levels (Figure 3.37), Philippines performance is about average for its health spending level but worse than average for its income level.

Figure 3.35: Infant and maternal mortality relative to female education, 2008



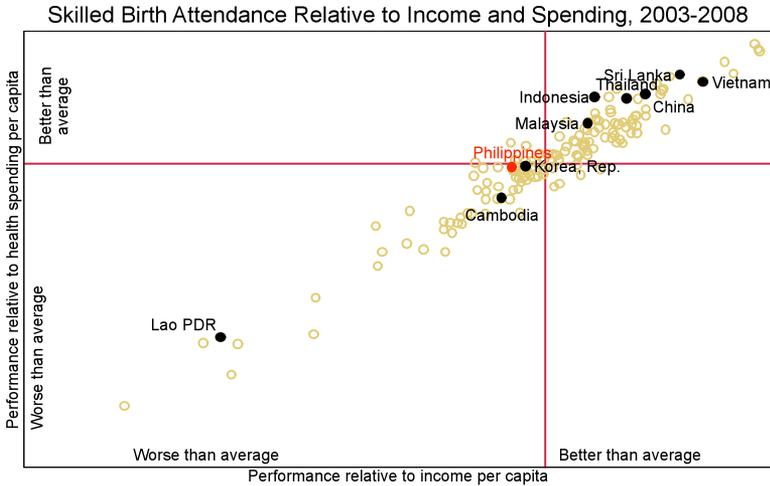
Source: VDI; Edstats (2010)
 Note: Education attainment data are for 2000
 Note: Both axes log scale

Figure 3.36: Use of Skilled Birth Attendants within the Philippines and for Select Asian Countries



Source: WHO; NDHS 2008
 Note: A skilled birth attendant is an accredited health professional including midwife, doctor, and nurse

Figure 3.37: Global Comparisons of Use of Skilled Birth Attendants Based on Income and Health Spending



Source: World Development Indicators (2010), WHO (2010), & Royal Monetary Authority (2009)
 Note: both axes log scale
 Data are latest available year 2003-2008

IV. HEALTH SECTOR INPUTS

3.24 **The performance of the Philippines health system is also contingent on the numbers, distribution, organization, and management of health sector inputs including facilities and manpower in addition to logistics, information systems, etc.** Here the Philippines health system is compared in terms of manpower and hospital beds and assessed relative to other Asian and global comparators. Relative to other countries the Philippines tends to have more health workers per capita. Indeed the Philippines exports large numbers of skilled health workers all over the world, resulting in large worker remittances that support the Philippines economy. Figure 3.38 shows the trends in physician population ratios from 1960 – 2008 for the Philippines and select Asian comparators, while Figures 3.39 – 3.41 provide global comparisons for the latest available year for three different WHO classifications of health workers – (1) physicians; (2) physicians, nurses, and midwives; and (3) physicians, nurses, midwives, dentistry, and pharmaceutical personnel. In all cases the Philippines numbers for its income and health spending levels are higher than most global comparators as has been the increase in the physician stock over the last 50 years. Of course as discussed elsewhere in this analysis, there are important questions of distribution and quality.

Figure 3.38: Physician Population Ratios in Select Asian Countries: 1960 – 2008

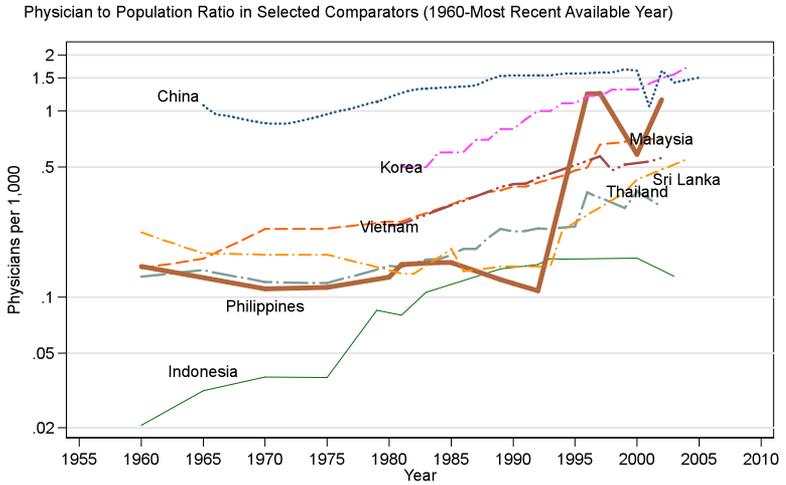


Figure 3.39: Global Comparison of Physician to Population Ratios Relative to Health Spending and Income in Select Asian Countries

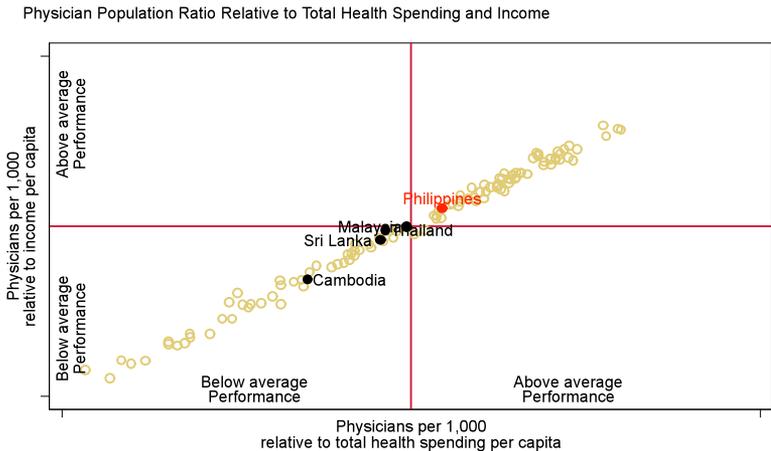
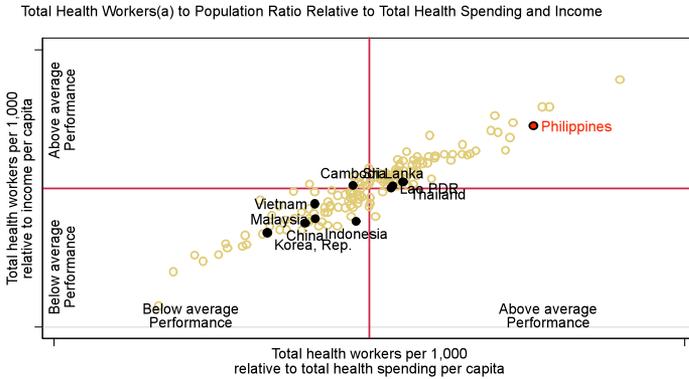
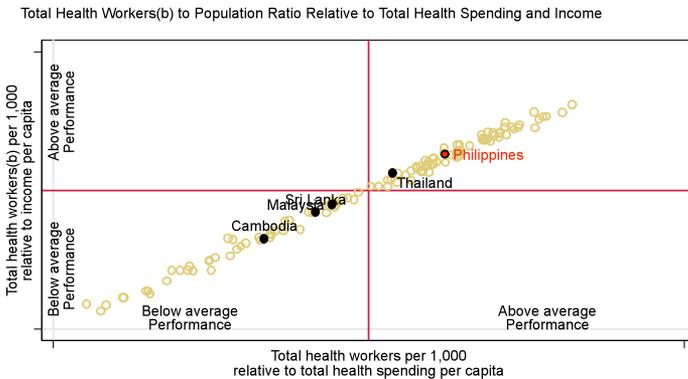


Figure 3.40: Global Comparison of Physicians, Nurses and Midwives Relative to Health Spending and Income in Select Asian Countries



Sources: WDI;WHO
 Note: Total health expenditure and GDP per capita data are for 2008.
 Number of total health workers is estimated by using the most recent available year from 2000 to 2008.
 Total health workers(a) include physicians,nurses, and midwives.

Figure 3.41: Global Comparison of Physicians, Nurses, Midwives, Dentistry and Pharmaceutical Personnel Relative to Health Spending and Income in Select Asian Countries

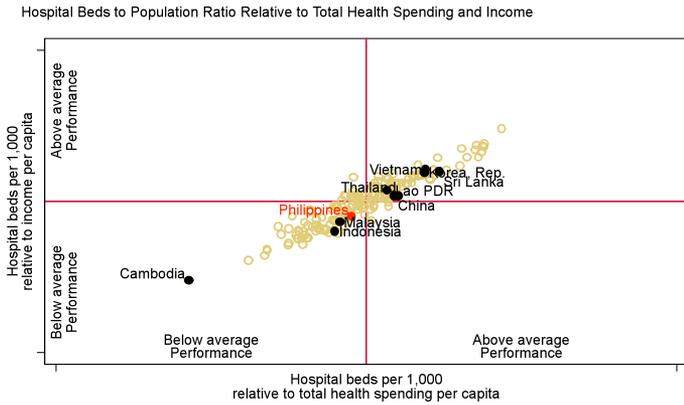


Sources: WDI;WHO
 Note: Total health expenditure and GDP per capita data are for 2008.
 Number of total health workers is estimated by using the most recent available year from 2000 to 2008.
 Total health workers(b) include physicians,nurses, and midwives,dentistry and pharmaceutical personnel

3.25 As in the case of manpower, while the number of hospital beds may be indicative at an aggregate level of an important health sector input, organization, distribution, staffing, management and quality are also critical factors that determine the performance of this critical health subsector. As can be seen in Figures 3.41 and 3.42 the Philippines in aggregate has less beds

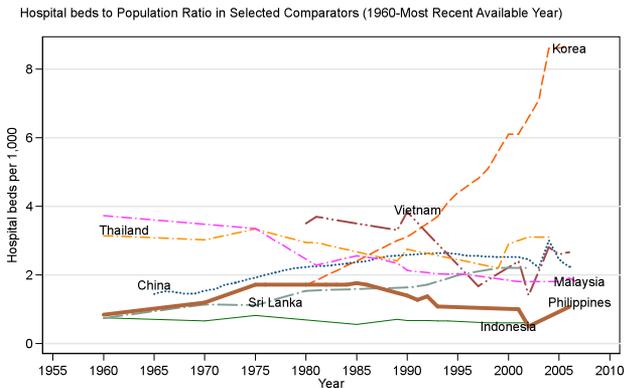
per capita than other Asian and global comparators and has had slower growth over the past several decades. However, despite the low numbers, the fact that hospital occupancy rates in the Philippines are low (for example a recent report shows that hospitals in Metro Manila have an average occupancy rate of 60.5 percent which is well below the level of 80 percent generally considered an efficient level), suggests that this most expensive health sector input is not being used in an optimal manner.

Figure 3.42: Global Comparison of Hospital Beds to Population Ratio Relative to Total Health Spending and Income in Select Asian Countries, Latest Year Available



Sources: WDI/WHO
 Note: Beds and GDP per capita data are for the latest available year.

Figure 3.43: Global Comparison of Hospital Beds to Population Ratios in Select Asian Countries: 1960 – 2008



Source: WDI
 Note: Philippines data are from 1960 to 2006

V. HOUSEHOLD-LEVEL ANALYSIS: EQUITY, FINANCIAL PROTECTION AND ACCESS TO HEALTH SERVICES AT THE HOUSEHOLD LEVEL

3.26 **In the absence of a full medical insurance coverage, having one sick household member can imply catastrophic expenditures, which can push some households to fall into poverty.** Huge out-of-pocket expenditures (OOP) can lead to lower living standards in the short-run and in the long-run, threaten the stability of households. While the research on poverty is quite abound, little research has looked into the role of catastrophic expenditure in poverty in the Philippines.

3.27 **The share of health spending in per capita household expenditures is at its highest level.** OOP payments in 2009 comprise 2.20 percent of per capita expenditures, the highest share in the past 21 years. There was a decrease in OOP shares from 1997, which coincided with the establishment of PhilHealth in 1995. In 2000, the health expenditures of the poorest two quintiles reached their lowest level, which again coincided with the introduction of PhilHealth Sponsored Program. This might imply that for those years, poor households were able to receive better financial protection. By 2009, however, the burden of OOP for the poorest quintile was almost back to its pre-PhilHealth level, while the rest of the quintiles exhibited their highest OOP shares among all survey years.

Table 3.1: Expenditure Shares of Out-of-Pocket Payments

	1988	1991	1994	1997	2000	2003	2006	2009
OOP payments as a percentage of total household expenditure								
Mean	1.48%	1.50%	1.83%	1.74%	1.57%	1.76%	2.16%	2.20%
Median	0.52%	0.52%	0.59%	0.56%	0.38%	0.53%	0.57%	0.56%
Concentration Index	0.0981	0.0913	0.1383	0.1485	0.1941	0.1778	0.2098	0.2320
Income Quintile								
Poorest 20%	1.11%	1.12%	1.26%	1.16%	0.91%	1.10%	1.22%	1.17%
2nd poorest	1.34%	1.34%	1.56%	1.40%	1.18%	1.44%	1.59%	1.61%
Middle	1.42%	1.45%	1.65%	1.65%	1.48%	1.70%	2.10%	2.01%
2nd richest	1.54%	1.61%	1.97%	1.95%	1.83%	2.15%	2.69%	2.73%
Richest 20%	1.90%	1.87%	2.56%	2.47%	2.42%	2.67%	3.45%	3.78%

Source: Author's calculations based on Family Income and Expenditure Survey

3.28 **Expenditures on drugs and medicines account for the biggest share of total medical expenditures for both poor and rich households.** Poor households spent a major portion of their OOP expenses on drugs

and medicines with the proportion decreasing by 15 percentage points from 1997 to 2009. The decrease in drug expenses shifted to payments for hospital room charges. On the one hand, this could be construed as a sign that poorer households were shifting away from self-medication but on the other hand, this could also mean that PhilHealth was not providing enough coverage for inpatient benefits. Richer households were also spending the largest portion of their OOP on drugs, which has also been declining in the past ten years. Unlike poorer households, they shifted to higher medical charges implying that richer households were selecting more expensive providers. (Figure 3.44- 3.45).

Figure 3.44: Composition of Medical Expenditures for Poorer Quintiles

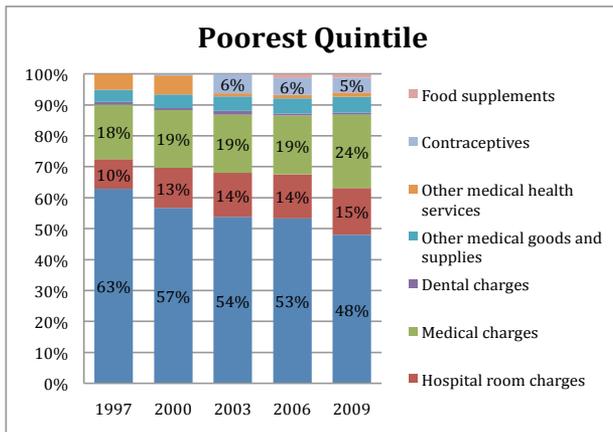
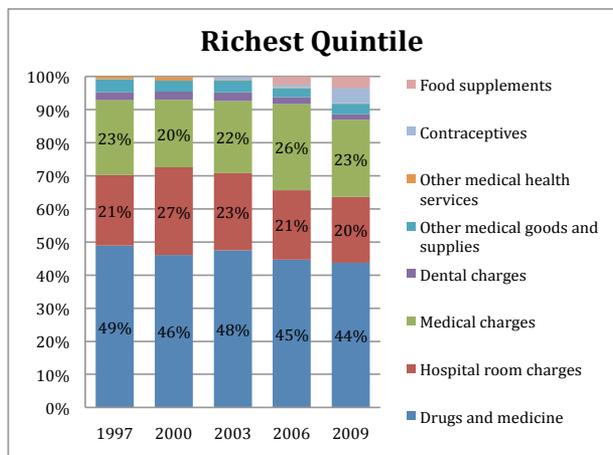


Figure 3.45: Composition of Medical Expenditures for Richest Quintiles



3.29 Excessively high expenditure on health payments can push some households into poverty. The basic premise is spending a huge proportion of the household budget on health care payments deprives the household of the consumption of other goods and services. For instance, almost five percent of households in the Philippines spent 10 percent of their total expenditures on health care in 2009. While this is low compared to countries like Vietnam and Bangladesh with 15 percent of household falling in this threshold (O'Donnell, et al, 2008), this is alarming for the Philippines because headcount trends were increasing at all expenditure thresholds despite the declaration of PhilHealth of almost universal health insurance coverage (PhilHealth, 2010).

Table 3.2 Percentage of Households Spending 5-25 percent of Total Expenditures on Health Care

Threshold	1988	1991	1994	1997	2000	2003	2006	2009
5%	5.79%	6.24%	7.89%	7.60%	7.06%	7.85%	10.45%	10.47%
10%	2.26%	2.57%	3.37%	3.42%	3.19%	3.56%	4.91%	5.10%
15%	1.27%	1.38%	1.93%	1.82%	1.80%	1.99%	2.83%	2.99%
20%	0.75%	0.75%	1.22%	1.07%	1.12%	1.20%	1.79%	1.95%
25%	0.44%	0.52%	0.80%	0.67%	0.75%	0.75%	1.17%	1.28%

Source: Author's calculations based on Family Income and Expenditure Survey

3.30 Despite the PhilHealth Sponsored Program, there remain households from the poorest quintile incurring catastrophic expenditure on health care.

While the Sponsored Program appeared to have contributed to lower percentages of catastrophic expenditure for poorest households in 2000 and 2003, its impact seems to have waned (Table 3.2). The health insurance law mandates that all indigents should be covered by health insurance but the persistence of poorest households with catastrophic expenditure seem to suggest the following; there was mis-targeting of the poor or benefits are not enough to cover medical expenses.

3.31 Poorest households might be foregoing care. A major limitation of the Family Income and Expenditure Survey is it only reported household expenditures on healthcare; it did not capture incidence of illnesses in the households.¹³ This limits that analysis because it will not be able to capture households foregoing health care or the extent of incomplete care that some

¹³ An alternative would have been the Annual Poverty Indicator Survey (APIS). A main limitation of APIS is its level of aggregation of expenditure items, which makes it difficult to conduct catastrophic expenditure analyses.

households resort to. A simple tabulation of households not incurring any health expense is presented in Table 3.3. It shows that the poorest two quintiles, which normally are the most vulnerable to illnesses, comprise the majority of those reporting zero spending on health care. The extent of these households foregoing care needs to be examined in future studies.

Table 3.3: Percentage of Households Spending Not Incurring Health Care OOP

	1988	1991	1994	1997	2000	2003	2006	2009
Poorest 20%	23.54%	24.33%	26.40%	25.45%	22.70%	32.35%	30.65%	18.78%
2nd poorest	19.88%	20.57%	20.06%	20.67%	21.42%	22.71%	21.05%	13.22%
Middle	19.40%	19.05%	18.46%	19.30%	18.84%	18.05%	18.78%	9.55%
2nd richest	18.78%	18.03%	17.94%	18.86%	19.55%	14.44%	15.16%	7.61%
Richest 20%	18.39%	18.03%	17.14%	15.71%	17.49%	12.46%	14.36%	5.72%

VI. HOUSEHOLD ACCESS TO HEALTH SERVICES AND FACTORS AFFECTING HEALTH-SEEKING BEHAVIOR

3.32 **The recent DHS 2008 provides information to evaluate household access to health services (specifically maternal and child health services).** A comparison of the 2003 and 2008 DHS shows that during this period access to basic health services has improved for all groups. However, the gap in access to health services across income groups has widened. For example, the percentage of women who delivered in a facility has hardly changed for the lowest income quintiles, while it seems to have changed a bit more for the second lowest income quintile. This raises some questions regarding the targeting of health interventions and whether DOH and PhilHealth interventions under the new mother and newborn health program is able to reach the lowest income quintiles (Table 3.4) (Manasan, 2010).

Table 3.4: Place of Delivery, 2003-2008

Wealth Index Quintile	Health Facility		Home	Other/ Missing	Total	Percentage Delivered in a Health Facility
	Public Sector	Private Sector				
2008 NDHS						
Lowest	11.5	1.5	86.8	0.2	100	13.0
Second	26.9	7.1	65.5	0.6	100	34.0
Middle	33	15.3	51.5	0.2	100	48.3
Fourth	39	29.7	30.9	0.4	100	68.7
Highest	29.4	54.5	15.8	0.2	100	83.9
Total	26.5	17.7	55.5	0.3	100	44.2
2003 NDHS						
Lowest	9.2	1.2	88.7	0.8	100	10.4
Second	20.4	4.4	74.3	0.8	100	24.8
Middle	32.2	11.1	56.2	0.4	100	43.3
Fourth	37.6	22.2	39	1.3	100	59.8
Highest	31.5	45.5	22.6	0.2	100	77.0
Total	24.2	13.7	61.4	0.7	100	37.9

Source: 2003 and 2008 NDHS

Similarly for other key indicators such as fully immunized children, the percentage has increased from 70 percent in 2003 to 80 percent in 2008, but the lowest income quintiles continue to lag behind. While in 2003, 55 percent of children in the lowest income quintile were fully immunized, these numbers have only increased to 63.9 percent. In comparison, for the second lowest income quintile the improvements are more substantial – from 69 percent in 2003 to 82 percent in 2008. The numbers for all other income groups have also improved during this period (Table 3.5) (Manasan, 2010).

Table 3.5: Percentage of Children Vaccinated, 2003-2008

Wealth Index Quintile	All ¹	No Vaccination
2008 NDHS		
Lowest	63.6	13.4
Second	81.6	5.7
Middle	82.3	2.0
Fourth	89.4	2.0
Highest	87.1	1.5
Total	79.5	5.6
2003 NDHS		
Lowest	55.5	15.1
Second	69.3	5.7
Middle	77.8	5
Fourth	72.4	4.4
Highest	83.0	2.2
Total	69.8	7.3

1. BCG, measles, and three doses each of DPT and polio vaccine (excludes hepatitis B)

Source: 2003 and 2008 NDHS

3.33 The percentage of mothers of under-five children reporting difficulties in accessing health services has not changed much between the two surveys.

In 2003, 77 percent of the surveyed population reported at least one problem in accessing care. This has reduced to 74 percent in 2008. For the lowest income quintile however, the change is very marginal (94 percent reported difficulties in 2003 as compared with 92 percent in 2008). Among different factors, in 2003, 67 percent had cited getting “money for treatment” as a barrier to accessing health care (Table 3.6). In 2008, this has decreased significantly to only 55 percent. This indicates that financial access to health services has substantially improved in the last few years. Geographical access, on the other hand, hardly changed from 27.2 percent citing “distance to health facility” as a deterrent in 2003, while 27.4 percent cited it in 2008. In addition to the NDHS, the Quality Improvement Demonstration Project (QIDS) has also carried out micro-level analyses of health-seeking behavior among households. The data from the QIDS study shows that among a cohort of children under five living in the Visayas region and Camiguin, 42 percent of sick children were not treated in any type of health facility. The children who did visit a health facility were just as sick as those who did not, and in the case of both, the average travel time to facilities was the same – indicating that geographical proximity was not the main reason. The major reason seemed to be on the demand side (affordability of care, lack of awareness and socio-cultural preferences). (QIDS, 2007)

VII. SUMMARY

3.34 **This section of the analysis has analyzed health spending in the Philippines, compared spending levels to other comparable countries, and attempted to assess value for money in terms of health outcomes and financial protection/equity.** In addition the configuration of the Philippines health system is compared to other Asian and global comparators.

3.35 **In terms of health spending, total and public health spending are low relative to other comparable countries irrespective of how it is measured. However, both private and OOP spending are at or well above the global comparator averages.** Public spending is low on all accounts in terms of absolute per capita levels, as a share of GDP, as a share of the total, and as a share of the overall government budget. Since 1995, public spending on health has increased less rapidly than GDP, while private spending has been increasing significantly faster. The private share of the total health spending is high, and OOP is substantially higher than the levels found in global comparators. OOP has increased over time overall and for all income groups including the poor, raising troublesome questions about the health financing system's performance with respect to its financial protection and equity objectives. This is particularly vexing in light of the 1995 legislation to provide universal health insurance coverage to the entire Philippines population through Phil Health.

3.36 **For its low spending levels and income, health outcomes are generally better than comparable income and health spending countries.** However, improvements over time have been much less impressive, and the Philippines is unlikely to achieve its MDG 5 goal. Similarly, for its very high female education attainment levels, both infant and maternal mortality are much worse than comparators. Thus, with respect to maximizing health outcomes, allocative efficiency, financial protection, and equity, serious challenges remain.

3.37 **With respect to the service delivery system, issues of distribution, quality, and management aside, the Philippines appears to be well endowed with health manpower relative to other comparators.** However, there is serious mal-distribution in health personnel. It has a low hospital bed to population relative to other global comparators. While overall national hospital occupancy rates are rather varied, especially in provincial level LGU hospitals, some LGU hospitals, particularly those with less than 50 beds, often have occupancy rates of only 40 percent. This raises questions of distribution, equity, efficiency, and quality.

Table 3.6: Problems in Accessing Health Care, 2003–2008

Wealth Index Quintile	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concern there may not be a female provider	Concern no provider available	Concern no drugs available	At least one problem accessing health care
2008 NDHS									
Lowest	16.1	74	57.8	56.1	31.8	29.6	54	71	92.3
Second	10.1	65.4	34.4	31.5	22.1	22.2	46.1	59.1	85.5
Middle	8.3	59.7	26.4	25.7	19.5	16.7	36.1	46.6	78.6
Fourth	5.2	48.4	17.2	17.3	16.5	12.9	32.9	40.2	69
Highest	5.2	38.2	12.9	12.8	13.8	10.1	23.4	30	57.2
Total	8.4	55.1	27.4	26.5	19.8	17.3	36.8	47.2	74.6
2003 NDHS									
Lowest	22	87.1	59.1	57.1	44	31.5			93.5
Second	12.7	80.1	33.8	32.5	28.8	20.9			87.1
Middle	8.4	73	22.2	20.3	25.2	18			80.8
Fourth	7.5	62.9	18.7	17.4	25.5	18.5			73.6
Highest	6.8	45.6	13.6	12	22	17.2			59.7
Total	10.7	67.4	27.2	25.6	28.1	20.5			77.1

Source: 2003 and 2008 NDHS



Strengths and Weaknesses of the Philippines Health System and Future Reforms

Box 4: Main Messages

- *By adopting the National Health Insurance Act in 1995, the Philippines took a bold step towards the implementation of UHI.*
- *The UHI system in the Philippines is facing obstacles due to: (i) low levels of public financing for health (ii) slow progress in expanding the breadth (number of people enrolled) depth and height (benefits package) of SHI coverage (iii) limited progress on reforming the service delivery system, and (iv) challenges in the governance and management of PhilHealth. Moreover, the health system is currently an inefficient mix of a Social Health Insurance system and a National Health Service type of system.*
- *Looking forward, the main goal of the Philippines Government needs to be to make some decisions regarding how to address the health system's basic structural problems with the objective of improving health sector performance.*
- *To embark on this path, the following actions are proposed:*
 1. *Increase public financing for health. In light of fiscal space considerations, increased financing is likely to come from improved inter and intra-sectoral reallocation of national government (NG) funds for health.*
 2. *The priorities for increased NG financing are to enhance PhilHealth enrollment under the subsidized regime (indigent program) and to provide partial sufficient subsidies and enrollment incentives for the near poor households who do not qualify for the indigent program. Families eligible for the indigent program will be identified using the National Household Targeting System.*
 3. *PhilHealth will take responsibility for strengthening revenue collection and the financial sustainability of the contributory regime by: (i) adjusting premiums to household income as well as inflation, (ii) eliminating collection evasion especially among small and medium-enterprises.*
 4. *PhilHealth will revise its Benefits Package (BP) to improve health outcomes, provide real financial protection to the population and promote allocative and technical efficiency (e.g. enhanced coverage for hospital care, outpatient benefits with a referral, results-based provider payment systems).*
 5. *PhilHealth will fully exploit its freedom to contract with private providers and create an enabling environment for greater private sector participation.*
 6. *PhilHealth governance and management will receive the highest attention (from the President's office) and performance indicators will be introduced for tracking PhilHealth performance, initially for the SP.*
 7. *Based on international experience, DOH will provide leadership for the development and implementation of a service delivery transformation plan for improving access, quality and efficiency in the sector*
 8. *DOH will implement an enhanced public health and preventive health care package (including NCDs)*
 9. *DOH will strengthen its role in regulation, and information collecting, processing and use.*

STRENGTHS AND WEAKNESSES OF THE PHILIPPINES HEALTH SYSTEM AND OPTIONS FOR FUTURE REFORMS

4.1 This Chapter assesses the Philippines' reform efforts in the context of the global evidence base on "successful" health-care reforms. It considers some of the contextual issues that the country will face in the future and how these could influence the implementation of planned reforms. Generally, future reforms need to be based on building on the strengths of the current system, while at the same time dealing with its weaknesses in the context of expected future demographic, epidemiological and economic changes. In effect, the basic strengths and weaknesses of the system define the current health policy reform baseline.

4.2 The various reform initiatives in the last two decades have resulted in a health system that is a combination, on both the financing and service delivery sides, of a partially implemented universal health insurance (UHI) approach and a National Health Service (NHS) model, both functioning in highly decentralized governance and intergovernmental fiscal structures. So far these reform have not effectively addressed deeper structural problems namely: *the continuing low levels, fragmentation and inequity in public financing for health, limitations in PhilHealth performance in the implementation of universal social health insurance, gaps in service delivery capacities, weak stewardship at all levels of the health system, particularly with regards to data for decision-making, monitoring and sector performance management, outdated or non-existent strategies in hospitals, pharmaceuticals and supply-chain management, public and private sector regulation and public health.*

4.3 The broader context within which future health sector reforms are likely to take place have favorable and not-so-favorable elements. Factors that are likely to favor speedy implementation of health reforms, including social health insurance, are: (i) a generally favorable dependency ratio for the next 25 years, which gives the Philippines the opportunity to capitalize on its potential "demographic bonus" if it can productively employ its growing working age population, (ii) education/literacy levels are high relative to other comparable countries, (iii) urbanization is a growing phenomenon, and (iv) there exists good information technology (IT) development capacity, reasonably reliable and priced connectivity and communications, and a population familiar with computers and programming, (v) high human resource capacity in DOH and PhilHealth that can be galvanized for reforms.

4.4 **The not-so-favorable elements include: (i) the demographic, epidemiological and nutrition transitions, including the progressively aging population will put pressure on health care costs, especially since demands from this group for more health care are likely to increase in the future, (ii) the macro-fiscal environment within which the health sector operates is tight, (iii) poverty continues to be a persistent problem, (iii) the population growth rates in the Philippines are among one of the highest in the Region, and mitigate against rapid scale-up of poverty alleviation efforts, (iv) the informal labor market is still quite large.**

4.5 **In this context, the Review identifies four priority policy actions for consideration by the GOP.** Each of these priorities are further discussed in the context of strengths and weaknesses of the Philippines health sector:

- (i) Increase public financing (national government) on health within fiscal constraints and allocate for expanded PhilHealth coverage for poor and near poor families. Hold PhilHealth accountable for results, starting with the Sponsored Program;
- (ii) Undertake comprehensive reform of PhilHealth;
- (iii) Support DOH in strengthening its stewardship function, especially vis-à-vis service delivery transformations (hospitals, first-contact care, public-private partnerships and regulating the private sector); and
- (iv) Enhance the focus on public health, especially non-communicable diseases.

THE GLOBAL EVIDENCE BASE ON SUCCESSFUL HEALTH-CARE REFORMS

4.6 **While the evidence base on “good practices” in health reforms is far from complete, in recent years, the World Bank and other organizations such as the OECD have made a systematic effort to put together the main lessons learned.** The World Bank’s recent study, “Good Practices in Health Financing: Lessons from Low- and Middle-Income Countries” identified 15 “enabling factors based on nine “good practice” case studies (Chile, Colombia, Costa Rica, Estonia, the Kyrgyz Republic, Sri Lanka, Thailand, Tunisia and Vietnam). These identified factors are consistent with those in a previous Bank study that identified the key enabling factors in high-income countries (Gottret and Schieber, 2008).

Table 4.1: Enabling Conditions for Health Reforms

<ul style="list-style-type: none"> • Institutional and societal factors • Strong and sustained economic growth • Long-term political stability and sustained political commitment • Strong institutional and policy environment • High levels of population education 	<ul style="list-style-type: none"> • Implementation Factors • Coverage changes accompanied by carefully sequenced health service delivery and provider payment reforms • Good institutional systems and evidence-based decision-making • Strong stakeholder support • Efficiency gains and co-payments used as financing mechanisms • Flexibility and mid-course corrections
<ul style="list-style-type: none"> • Policy factors • Commitment to equity and solidarity • Health coverage and financing mandates • Financial resources committed to health, including private financing • Consolidation of risk pools • Limits to decentralization • Primary Care (First Contact Care) Focus 	

4.7 Another recent World Bank publication, *Governing Mandatory Health Insurance* (Gottret et al, 2008) responds to the lack of information concerning the key government factors that affect the operation of mandatory health insurance (MHI) funds. While much of the information to date in the global literature has focused on issues such as setting premiums, benefits and coverage rules, very little is known about governance issues such as supervisory boards, regulations, auditing and accountability. These factors influence performance significantly and require inclusion within a broader agenda of health reforms. The study lays out in detail the major factors underlying coherent governance and accountability. The study also highlights good practices for implementing MHI governance and accountability principles based on case studies (Chile, Estonia and the Netherlands) and other global experience. It makes observations regarding governance and accountability in the context of unitary (single-payer) and multiple competing funds and the role of health care providers.

- *Number of Insurers:* In a context where there are multiple and competing insurers in the health system, external oversight mechanisms need not pay great attention to efficiency and management but rather focus more on consumer protection, inclusiveness and maintaining competition through relevant anti-trust regulation. By contrast, countries with

a single health insurer require external oversight mechanisms that make the insurer accountable for integrity, quality and productivity;

- *Provider-Payer Relationship.* The effect of including providers' representatives in decision-making bodies such as the Board of health insurance funds depend on whether this relationship is antagonistic or collaborative. When providers are direct employees of insurers, negotiations and oversight need to address civil service and labor regulation issues. Countries with independent providers need governance mechanisms for transparent negotiations over prices and payment mechanisms.

Table 4.2: Governance Factors Related to Mandatory Health Insurance

Dimension	Features
<ul style="list-style-type: none"> • Coherent decision-making structures 	<ul style="list-style-type: none"> • Responsibility for mandatory health insurance (MHI) objectives must correspond with decision-making and capacity in each institution involved in the management of the system. • All MHI entities have routine risk assessment and management strategies in place. • The costs of regulating and administering MHI institutions are reasonable and appropriate
<ul style="list-style-type: none"> • Stakeholder participation 	<ul style="list-style-type: none"> • Stakeholders have effective representation in the governing bodies of MHI
<ul style="list-style-type: none"> • Transparency and information 	<ul style="list-style-type: none"> • The objectives of MHI are formally and clearly defined. • MHI relies upon an explicit and appropriately designed institutional and legal framework • Clear information, disclosure and transparency rules are in place • MHI entities are subject to minimum requirements with regards to protecting the insured
<ul style="list-style-type: none"> • Supervision and Regulation 	<ul style="list-style-type: none"> • Rules on compliance, enforcement, and sanctions for MHI supervision are clearly defined • Financial management rules for MHI entities are clearly defined and enforced • The MHI system has structures for ongoing supervision and monitoring in place
<ul style="list-style-type: none"> • Consistency and stability 	<ul style="list-style-type: none"> • The main qualities of MHI system are stable

I. HEALTH FINANCING IN THE PHILIPPINES— STRENGTH AND WEAKNESSES

- 4.8 The three key functions of the health financing system are to:
- (i) Raise *sufficient and sustainable* revenues *efficiently* and *equitably* to provide individuals with a package of health services that improves health outcomes as well as provides financial protection against the costs of ill-health;
 - (ii) Manage health sector resources to pool health risks *equitably* and *efficiently* so that individuals are provided with “insurance” coverage against unpredictable, catastrophic medical care costs; and
 - (iii) Purchase of services to assure *allocative* (purchasing the right service) and *technical* (purchasing in the right way to maximize the use of inputs) efficiency (Gottret, Schieber and Waters, 2008, Gottret and Schieber, 2006).

Enabling conditions for optimal implementation of these functions in the health sector include: *a growing economy, a large formal labor market, administrative capacity for tax collection, a good regulatory and oversight structure and an appropriate incentive system* (Hsiao and Shaw, 2007, Gottret and Schieber, 2006).

A. Strengths of the Philippines Health Financing System:

4.9 **As Chapter 3 (Performance of the Philippines Health Sector) shows that for its income and health spending levels, at the aggregate level the Philippines performs relatively well in terms of key health outcome indicators such as infant mortality and life expectancy.** Health spending appears sustainable, and in fact, is below the average for other middle-income countries, including many in the East Asia Region. Overall, public spending on health is very low relative to other comparable income countries. Recent efforts to increase public spending (DOH allocations) have targeted public health interventions. These interventions are generally cost-effective and pro-poor. From 2004-2006, actual DOH allocations remained largely unchanged (in the range of 10-11 billion pesos) and declined as a share of overall actual national government expenditures (from 1.26 percent in 2004 to 1.01 percent in 2006), consistent with trends inferred from analysis of prior NHA data. However, since 2007, national government allocations to DOH have increased to 13.4 billion pesos in 2007 and 14.6 billion pesos in 2008. In 2009 and 2010, this trend continued.

4.10 **The Philippines took a bold step in 1995 to create the legal framework for expansion of a single-payer health insurance system to achieve universal health insurance coverage.** This also created a strengthened legal basis for

larger risk pools – generally considered a good health financing policy from the perspective of efficiency and equity. The passage of the NHIL in 1995 has made the Philippines one among a small number of middle-income countries legislatively committed to providing universal health insurance coverage through a mandatory health insurance system. In principle, the entire population of the Philippines is eligible for coverage through PhilHealth. Single-payer systems (such as PhilHealth) generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health expenditures, high levels of patients/consumer satisfaction and high performance on measures of access and quality (American College of Physicians, 2008).

4.11 Through its program for indigent families (Sponsored Program), the country has greatly advanced the topic of universal health insurance coverage and access to health services within the political agenda at the national and LGU levels. This has helped secure more funding for health insurance coverage for poor families. PhilHealth also has its own source of financing through premium contributions, which provide a more stable source of financing compared with annual budget allocations that are vulnerable to changes in Government priorities (Jowett and Hsiao, 2007). Special efforts have been made by PhilHealth to enroll the self-employed and informal sector workers (Individual Paying Program), adjust the salary cap under the employed program (regular increases) to bring contributions more in line with ability to pay, and enhance outpatient benefits for poor families. Recently, PhilHealth has undertaken numerous reforms to expand its provider network, simplify administrative procedures and improve benefits. As per the National Health Insurance (NHI) Law, PhilHealth is allowed to contract with public and private providers, as long as providers meet licensing and accreditation criteria of the DOH and PhilHealth (informed choice clause in NHI Law). This is also a strength because in many countries, mandatory health insurance funds such as PhilHealth are not allowed to selectively contract, thereby mitigating the effects of using financing as a lever to drive health sector improvements on the provider side.

4.12 With the establishment of PhilHealth, the previously fragmented functions of accreditation and claims management (which the Philippines Medical Care Commission used to manage), enrollment, collection of contributions and claims processing (which was managed by the Government Service Security System and the Social Security System) were integrated into one organization (PhilHealth), thereby contributing to less administrative fragmentation.

4.13 PhilHealth is vested full powers, as per the NHI Law to administer the NHI Program and formulate and implement policies for sound administration of the program, as well as set the necessary standards, rules and regulations for quality of care, appropriate utilization of services, fund viability, member satisfaction and overall achievement of Program objectives.

In the last few years, PhilHealth has taken steps to streamline the claims management system and reduce the backlog of claims, and be more responsive to providers and beneficiaries. In the last few years, PhilHealth has taken steps to further develop its health management information systems (HMIS) with the objective of improving the identification of the eligible population under the Sponsored Program, consolidating and analyzing the data in the existing accreditation standards and the soon to be implemented Bench-book, and there are pilots underway for hospitals to computerize eligibility checking.

B. Weaknesses:

4.14 The Philippines health sector continues to face significant challenges with regard to sustainable health financing. The main challenges are: (i) the continuing low levels of public financing, (ii) high OOP, (iii) stagnant levels of LGU and PhilHealth financing and poor allocative efficiency for LGU spending, (iv) fragmentation in financing with some resources allocated as demand side subsidies to PhilHealth but the bulk of the resources allocated through traditional input-based budgets at the LGU level. Although the various reform agendas to date (HSRA, F1) have identified these health financing problems, little progress has been made. (Table 4.3). The problems that have been particularly hard to address are the low levels, inequity and fragmentation in financing and PhilHealth performance.

Table 4.3 Assessment of Health Financing Under F1

Key Result Areas	Achievements and Remaining Gaps
Ensuring sustainable financing, including mobilizing extra-budgetary resources	<ul style="list-style-type: none"> * Low level of health spending persists. * Devolution fragments health spending; inequities persist across LGUs. * Lack of income retention in most health facilities disincentivizes extra-budgetary resource mobilization.
Focusing direct subsidies to priority programs	<ul style="list-style-type: none"> * Major achievement in focusing “Congressional insertion” budgets to priority programs, but local absorption of available resources is a challenge.

Key Result Areas	Achievements and Remaining Gaps
Expanding the national health insurance program	<ul style="list-style-type: none"> * Slow expansion of coverage to the poor, and the Sponsored Program is subject to leakage and under coverage, and LGU financing is unsustainable. * Historical PhilHealth problems persist (no fee regulation; low support value and balance-billing causing high out-of-pocket spending; employer arrearages; adverse selection in Individually Paying Program; poor benefit delivery resulting in low utilization rates). * Slow pace of reforms in provider payment system and contracting. * Slow upgrade of information technology (outdated, manual, individual claims processing) resulting in slow payment to providers and other inefficiencies.

Source: This study

1. *Low levels, Fragmentation and Inequity in Health Financing*

4.15 **In 2005 at the beginning of F1, the Philippines spent only some 3.5 percent of its GDP on the health sector while other Southeast Asian countries spent, on average, about 4-5 percent.** This number has grown very slowly (there has been slight increase in national government financing for DOH) but the shares (percentages) between government, social insurance, private insurance and private OOP have hardly changed. In fact, as the Review points out, private OOP spending is growing in the Philippines.

4.16 ***Fiscal Space and Health Spending.* The low levels of public spending on health are partly related to fiscal space issues in the Philippines.** Fiscal space for health refers to the ability of a country to increase public spending for health without jeopardizing the government’s long-term fiscal sustainability (Heller 2006). From a *macro-fiscal perspective*, the prospects of availability of additional public resources for health in the Philippines have been traditionally low. As Chapter 2 showed, the revenue to GDP ratio in the Philippines is below the average for other middle-income countries, including in East Asia, and the health sector has not been traditionally accorded a high priority – as indicated by the low elasticity of public spending on health. Moreover, with over 50 percent of the labor force of the country working in the informal sectors, it has been hard to mobilize resources from this group through PhilHealth’s Individual Program. In most LMICs such as the Philippines, achieving universal coverage has required long periods of time, and substantial dependence on general budget revenues to finance universal health insurance coverage (Langenbrunner and Somanathan, 2010, Gottret and Schieber 2006).

4.17 **Overall trends in DOH, LGU and PhilHealth Financing:** After declining in real terms for nearly a decade, the DOH budget has increased its spending on health as a percentage of government expenditures. As a result, government expenditures on health have increased from 5 percent in 2002 to 6.5 percent in 2008. In particular, spending for public health interventions such as vaccines, anti-tuberculosis drugs, and the upgrading of government health facilities to provide emergency obstetric care has increased in the past two years. However, the increase has largely been limited to national government expenditures, while LGU expenditures on health have declined in real terms. In addition, PhilHealth's share of health expenditures has hardly grown since it was established in 1995 (this is discussed in greater details in the next section).

4.18 **Inequity in LGU Financing and Absorption Capacities** – LGUs are at different states of natural endowments, economic development, and institutional capacities. This affects their revenue-raising capacities as well as the ability to absorb resources. Moreover, the inequity in the internal revenue allotment (IRA) among provinces, cities, and municipalities translates into highly variable health services. Changes in the IRA are beyond the control of the DOH and require intervention at a higher level of government. Wide regional and provincial variation in LGU health spending occur mainly because of LGUs' heavy reliance on IRA, which does not take account health needs. The inequities in LGU allocation are exacerbated by the fact that highly urban cities can generate additional resources from their large tax base (property and business taxes) while poor, rural municipalities and provinces cannot do the same. Because the IRA allocation favors cities, there has been a flurry of municipalities wanting to be cities. The proportion of the IRA going to health is not nearly enough to fund the cost of devolved health functions, a situation that has left many health facilities in a poor state of repair.

4.19 **Fragmentation in Financing** -- Devolution has led to the fragmentation of service delivery as public health functions and primary care (the responsibility of municipalities) were de-linked from primary and secondary hospitals (the responsibility of provinces) which were in turn de-linked from tertiary and national referral hospitals (the responsibility of DOH). The lack of inter-jurisdictional payment systems for referrals, the mobility of patients, and frequent bypassing of primary care and district hospitals to start with, has led to the fraying of the financing and delivery system, manifest in overcrowded provincial and DOH hospitals, and underutilized health centers and district hospitals. The "network model" that existed prior to devolution – based on the district catchment area and district health structure that responds to it – has all but disappeared.

4.20 **Recent efforts under FI** – Fourmula 1 carried out several initiatives to correct some of the inherent weaknesses of devolution. To ease the problems of service fragmentation, lumpiness of investment, and externalities (spill-over effects), some municipalities have organized themselves into inter-local health zones (ILHZs) so that they can share resources and benefits together. As of end-2009, as many as 274 ILHZs have been organized in 72 provinces for various reasons, although little has been done to empirically evaluate their effectiveness, impact, and sustainability.

4.21 **Until recently, there was little planning capacity for health in LGUs. This problem is being addressed with the roll-out of the Province-wide Investment Plans for Health (PIPH).** The PIPH has become the principal instrument to coordinate and consolidate the fragmented strands of resource mobilization by the province as it lays out the multi-year investment plan based on needs identified and the various financing sources (IRA, community self-reliance plans relying mostly on locally-generated revenues, reimbursements from PhilHealth, additional central government grants, LGU's own loans, commodity and in-kind support, and external assistance, if any). Lower-level localities are also undertaking their own city and municipal investment plans for health. It remains to be seen how far these local health investment planning initiatives can generate additional resources for health, allocate them properly, and result in a rationalized efficient service delivery system. To measure provincial health expenditures, Local Health Accounts are also being piloted in 11 provinces. By August 2011, local health accounts are expected to be completed for all provinces.

2. Limited Expansion and Implementation of the PhilHealth-managed National Health Insurance Program

4.22 **Another critical element of limited health spending is the extremely slow growth of the National Health Insurance Program.** PhilHealth claims that approximately 86 percent of the population has PhilHealth coverage (as of February 2010). However, other sources of data contradict this number, as does the very low percentage share of PhilHealth expenditure (8% of total health expenditures in 2008). The PhilHealth estimation of 86 percent is not based on an actual count of members, but is rather an estimate on the basis of the number of paying members times the average size of the Filipino household (5.9 members if the 2003 Family Income and Expenditure Survey is used, PhilHealth's actuarial model uses 4.4). A new 2009 estimate of PhilHealth coverage based on extracted membership data from PhilHealth and using the 2.6 dependency ratio shows that PhilHealth beneficiaries only number 55 million (approximately 60 percent of the population). The DHS estimates coverage at 38 percent (NDHS, 2008). Of this total, it is estimated that 14 million indigents are now covered,

leaving 15 million without health insurance, while 41 million non-indigents are now covered, leaving 20 million non covered. This means that PhilHealth faces the challenge of expanding health insurance coverage for indigents and non-indigents.

4.23 Enrollment under the Sponsored program for indigent families has grown in recent years, but not to the extent of providing coverage for all indigent households. The politicization of the targeting and membership identification at the LGU level contributes to program difficulties. While the national government and PhilHealth have tried to incentivize LGU participation through financially co-sponsoring the program, implementing an earmarked allocation to LGUs for the sponsored program as well as returning a portion of the insurance premiums to LGU in the form of capitation payments for primary health care, LGUs have been slow on the uptake. Another challenge under the SP is delayed accreditation by PhilHealth of LGU health facilities, which means SP expansions are not synchronized with the availability of services. Only 48.9 percent of the 2,226 Rural Health Units (RHUs) in the country are accredited by PhilHealth. Even for RHUs that already have accreditation, the annual renewal of accreditation is considered too frequent

4.24 Despite PhilHealth's best efforts, enrollment in the Individual Paying Program remains below expectations. In many MICs, the size of the non-poor self employed and informal sector workers is 30-40 percent of the population and over 50 percent of the labor force. Generally, willingness to pay for health insurance is low in this population due to lack of understanding about risk and insurance and the availability of low-cost public sector services. Moreover, for health insurance agencies, enrollment costs can be high (Hsiao, 2006). Nevertheless, given that this population is healthy, enrolling this group into PhilHealth will greatly enhance risk-pooling. From the industry and labor market perspective the large number of small size of firms in the Philippines also poses a problem for PhilHealth. Employers have not enrolled a large number of formal sector workers, which is quite problematic as this group is cross-subsidizing the higher needs groups. Health insurance premiums are often a burden for small and medium enterprises (SME), and these firms evade such payments. As will be discussed later (in the options section), there is perhaps a need for the Philippines to reconsider its strategy for enrolling informal sector workers and the self-employed as well as improve enforcement regarding formal sector workers enrollment.

4.25 Contributions from Paying Members: The low ceiling or cap on contributions (Php 30,000) means that those in the upper salary bracket contribute proportionately less than what they can afford (a fixed amount of Php 9,000 per year), thus dramatically reducing the progressivity and amount of total contributions. Moreover, the contribution ceiling is frequently not

adjusted for inflation, implying that progressivity is eroded annually by price increases. Premiums for informal workers under the IPP and indigents are flat (Php 1,200 per year) and rarely adjusted for inflation, thus promoting unfairness in contributions. Also surprising is the case of the Overseas Workers program with the lowest flat premiums (Php 900), despite OFW's generally having higher ability to pay. Evasion is reportedly a major issue, especially among small shops and businesses. In 2007, the Office of the Actuary estimated that collection efficiency is as low as 30 percent: that is 70 percent of those who should be contributing are not doing so (Jowett and Hsiao, 2007).

4.26 *PhilHealth Benefits Package:* PhilHealth and their dependents continue to be underinsured due to the low support value and restricted benefits of PhilHealth. The ceilings on PhilHealth reimbursements are low and there are no restrictions on balanced billing, i.e., whatever portion of the total hospital bill that PhilHealth will not shoulder has to be borne by the patient. PhilHealth's support value averaged only 62 percent in 2004. This has been eroded, based on later support value estimates made in 2009, with the inpatient support value as low as 34.4 percent (Solutions, Inc, 2009). The support value for Metro Manila (NCR) PhilHealth patients is particularly low at 23.8 percent reflecting the more expensive and higher levels of care that patients obtain in NCR. The prevalent system of balanced billing has from the start precluded PhilHealth from providing serious financial protection. As a result, OOP is higher for those with PhilHealth insurance than those with no insurance coverage (according to the DHS per capita expenditures for those with PhilHealth insurance was PHP 16,711 inpatient/year), while private insurance (PHP 28,532) is higher than for those without any coverage (PHP 10,702). The extremely limited outpatient benefits encourage the use of more expensive covered inpatient benefits and reduce the cost-effectiveness of PhilHealth benefits.

4.27 *The benefits under PhilHealth are quite restricted. Drugs for chronic diseases are not covered.* Costs of outpatient care (except under specified treatment such as TB DOTS) and physician visits are not reimbursable either. As mentioned earlier, in recent years, benefits have been added (TB DOTS in government health facilities, maternity care package in accredited centers, permanent methods of contraception and capitated outpatient benefits package for indigents seeking care in RHUs under the Sponsored program). However, these additions have tended to fragment the benefits package, and there has not been an across-the-board robust improvement in the package over the years. More seriously, since PhilHealth benefits are for the most part only for inpatient hospitalization, the tendency is to get patients confined, even if more cost-effective outpatient management of care is available.

4.28 ***Weak Provider Payment and Contracting Systems.*** The methods by which providers are paid and the levels of payment have important implications for cost, quality and access (Langenbrunner and Somanathan, 2010). Even under the fee-for-service (FFS) payment system, PhilHealth does not actively negotiate more reasonable prices with providers based on patient volumes. In contrast to the Maximum Retail Price for drugs recently imposed under the Cheaper Medicines Act, there has not been a similar policy initiative to control hospital and physician fees and balanced billing practices. Moreover, while most private health maintenance organizations (HMOs) in the country (with much smaller membership bases as compared with PhilHealth) typically negotiate with providers based on volume, PhilHealth has no such systematic practices and instead is a passive price-taker, resulting in significant economic rents being recouped by (private) hospitals and physicians.

4.29 **Recently, PhilHealth has officially declared per case payment as the desired provider payment system, in lieu of the current FFS system.** Following this, Kwon (2008) provided the roadmap towards per case payment, which should be inclusive of all types of cost (professional fee, room and accommodation, diagnostic services, operating room and drugs). Nevertheless, the future shift to case based payments could engender a different set of problems such as the substitution of unregulated sectors (e.g. outpatient home care which is outside the case-based payment system) for the regulated ones, patient selection and under-provision of care, and DRG creep (providers selection of diagnosis groups that yield higher reimbursement). Moreover, DRGs are still a fee-for-service payment system, albeit bundled. It still requires the systematic application of negotiated annual caps to control volume and shift the risk of overprovision to providers. It also requires sophisticated methods for tracking poor quality of care and holding providers accountable for performance. Currently, PhilHealth systems are not geared to tackle these possible negative impacts of case payment implementation. Finally, pay-for-performance (P4P) where some portion of provider payments are linked to performance is still a new concept in PhilHealth and will be piloted in the coming months. As in the case of case-based payment, the effective implementation of P4P within PhilHealth providers will require strong health information systems and capacity, on the side of both PhilHealth and providers to effectively track performance indicators. Few providers have this capacity right now.

4.30 ***Governance and Management of PhilHealth:*** A systematic review of strengths and weaknesses of PhilHealth governance and management has never been undertaken, although various assessments of PhilHealth have alluded to these problems. This section highlights the limited available information on this topic since it is a critical element of any roadmap for the comprehensive transformation of the PhilHealth. In the future, a full governance assessment of

PhilHealth could be undertaken to identify main factors and remedial measures. The limited information available indicates that governance and management of the PhilHealth suffers from various weaknesses. A recent study of PhilHealth highlights the difficulties that members experience in accessing health insurance benefits due to administrative complexities and the lack of streamlined procedures. The completion of PhilHealth paperwork to access benefits is complicated for poor households and those living in rural areas. Beneficiaries are not able to utilize the benefits once they arrive in a health facility because of incomplete documentation. It is perhaps due to these reasons that 63 percent of PhilHealth users reported not claiming the benefit. While the NHIL is quite clear on the scope of benefits PhilHealth is expected to provide as well as the ceiling on the reserves and how resources over and above the reserve ceiling are to be used (by increasing benefits or reducing the contributions of members), in reality PhilHealth currently has reserves over and above the ceilings set in the Law.

4.31 Claim submission and processing systems in PhilHealth are cumbersome and cause delays for providers and reduce their incentive to be part of the PhilHealth provider network (Streveler 2010). PhilHealth's huge reserves of more than P100 billion in light of the very limited benefits, poor financial protection and large numbers of uncovered poor people undermine public confidence in PhilHealth, where 6 months of reserves are more typical for a social insurance program. These problems are not lacking technical solutions but require strong governance, management and organizational change within PhilHealth for implementation. The PhilHealth Board needs to lead this reform agenda.

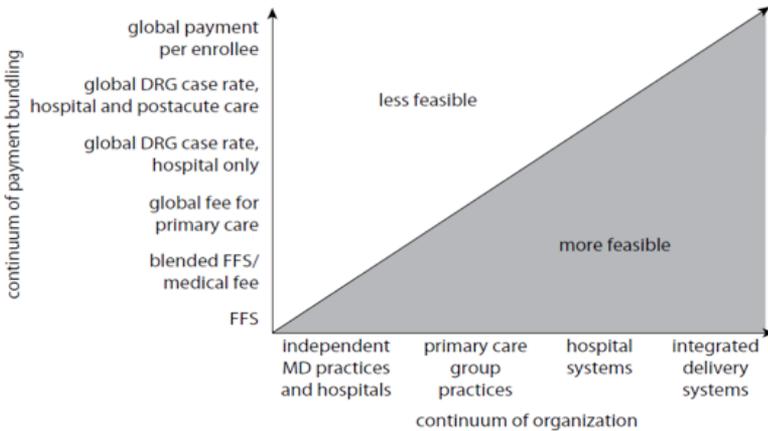
II: HEALTH SERVICES DELIVERY AND REGULATION STRENGTHS AND WEAKNESSES

4.32 As Table 4.1 shows, successful implementation of universal health insurance reforms need to be accompanied by carefully sequenced health service delivery reforms (Gottret, Schieber, and Waters, 2008). This is due to the following reasons: (i) expansion of health insurance coverage, especially for the underserved population and poor people immediately creates the demand for health services, and yet in most MICs the health services serving these groups (usually public) are plagued by many problems including health workers shortages, long waiting time, limited bed capacity, lack of training. This means that unless service delivery reforms are addressed, the newly covered individuals will not have easy access to health services (OECD, 2008), (ii) another key feature of the implementation of UC is the increasing shift from the Government directly financing hospitals and health centers (supply-side subsidies) to directly financing the insurance premiums for poor families (demand side subsidies), and (iii) health facilities (including public facilities) being financed by health

insurance agencies under contractual arrangements described in the earlier section, including sophisticated provider payment systems such as capitation, global budget and case-based payments (Hsiao and Shaw, 2007).

4.33 **As Figure 4.1 shows, there is a close relationship between the types of provider payment reforms that can be implemented and the organization of service delivery systems.** For example, to get the benefits from a global budget or case-based payment system, health facilities must have the autonomy to determine how budgets are allocated and the control over staffing ratios and hiring and firing. Therefore, in most countries implementing social health insurance, reform of the service delivery systems has followed hand-in-hand with the financing reforms (Gottret, Schieber and Waters, 2008). Like the expansion of coverage to the self-employed and informal sector workers, reform of the service delivery sector is difficult and requires attention to the political, institutional and capacity-building elements of the reforms.

Figure 4.1: Provider Payment Mechanisms and Health System Organization



Source: Guterman et al. 2009.

Note: DRG = Diagnosis-related group; FFS = fee for service.

A. Strengths of the Philippines Health Services Delivery and Regulatory Systems

4.34 Health services are decentralized which, in principle, means that the delivery of services can be adapted to local conditions to improve effectiveness and consumer satisfaction. At an aggregate level, there is enough health manpower in the country to meet the service delivery needs of the population. The private sector health services delivery network is strong and provides more than 50 percent of health services in the country. To mitigate against some the challenges of a decentralized health services delivery system DOH has implemented a set of incremental reforms, especially under FI. These reforms aim at rationalizing the planning of service delivery at the provincial level (province wide investment plans), and create LGU accountability for minimum service delivery standards (LGU scorecards). As a next step, DOH is using the LGU scorecards to implement performance-based financing interventions to incentivize infrastructure improvements and more delivery of public health interventions. The importance of health facility autonomy is recognized and these reforms have been piloted among a small group of DOH and provincial hospitals. All DOH hospitals have at least partial autonomy, in that they are allowed to retain income from PhilHealth. This has already made a big difference in how effectively health sector resources have been mobilized by hospitals to improve service delivery. There are important pilot interventions under reproductive, maternal and new born health which have aligned demand (PhilHealth benefits for maternal and new born health) and supply side elements (upgrading of Rural Health Units to enable them to obtain PhilHealth accreditation) to comprehensively address the problem of maternal health.

4.35 Various information systems are available (Community Health Information Tracking System or CHITS, Hospital Management Information Systems or HOMIS, Field Health Services Information systems and the new information systems for health facility licensing called DOHLIS). As Table 4.3 shows, important interventions have been adopted on intensifying public health programs. Concerning pharmaceuticals, the Cheaper Medicine Act and the executive order on Maximum Retail prices of five active drug ingredients has potentially improved the accessibility of drugs, especially for the poor. There is a network of village and municipal drug outlets (Botiga ng Barangay and Botika ng Bayan), which also potentially improves access to drugs.

4.36 Regulation is a critical element of managing service delivery. To fast-track licensing, under FI, DOH licensing of health facilities was delegated to DOH Regional Offices. There has been some harmonization of PhilHealth accreditation and DOH licensing systems. The concept of quality seals (*Sentrong Sigla*) is well-established in health centers Table 4.4).

Table 4.4: Assessment of Health Service Delivery Under F1

Key result areas	Achievements and Remaining Gaps
Intensifying public health programs	<ul style="list-style-type: none"> * Major achievements in reducing health threats in avian influenza, A(H1N1), malaria, leprosy, filariasis, and others * TB case-finding and cure rates have improved, but disease burden is still high. * HIV/AIDS prevalence remains low, but increasing in some most at-risk groups; health promotion has stalled. * Maternal mortality ratio remains high owing to inadequate facilities for emergency obstetric care; being addressed with recent AO on maternal, neonatal and child health and nutrition. * Local immunization programs maintain high rates, but doubts are being cast on the integrity of the (national) cold chain owing to its break-up in the wake of devolution. * Family planning and reproductive health all but ignored by the National Government due to political pressures from pronatalist advocates. Reproductive health bill languishes in Congress.
Ensuring availability of health facilities	<ul style="list-style-type: none"> * General inability of the health system to expand to take account of large annual addition of population. * Number of hospitals (public and private) is stagnant; bed/population ratio has declined to a dangerously low state, although F1 witnessed slight increase. * Number of RHUs also stagnant; number of BHSs increasing but not fast enough.
Designating providers of specialized services	<ul style="list-style-type: none"> * Outsourcing of leptospirosis treatment to private hospitals at the height of Typhoons Ondoy and Pepeng illustrates benefits of public/private partnership (PPP). * PPP in family planning and reproductive health mainly donor-driven; DOH or LGU-initiated PPP stymied by government’s lukewarm policy on FP/RH in this decade. * PPP in tuberculosis treatment needs major expansion. PPP in HIV/AIDS has top-down approach (emanating from central DOH under vertical program), rather than bottom-up approach (emanating from LGUs). * Philippines has no tradition of direct budgetary subvention to nonprofit facilities, although health service contracting is legally allowed.
HIS development	<ul style="list-style-type: none"> * Integrity of FHSIS has been eroded by devolution; national service utilization and coverage data are hard to come by.

Source: This study

B. Weaknesses

4.37 Hospital bed capacity in the Philippines is below the average for East Asian countries and below the rates of other MICs such as China and Thailand. The capacity gaps are most prevalent in rural and hard to reach areas, which means that the gaps in service delivery most affect poor families that live in these areas. Few new hospitals and hospital beds are being added, and the hospital system is being over-run by population growth, the rise of non-communicable diseases, and the frequency of accidents, other trauma and an aging population. Public-private partnerships are often limited to medical imaging. Inequity and variance is growing between the well-endowed private sector and autonomous government hospitals that are able to pass the highest levels of global accreditation and ill-endowed public and private hospitals.

4.38 The majority of the public hospitals system (with the exception of a few DOH managed centers of excellence in Manila) have not undergone systematic investment and upgrading since before devolution, even though the population has grown, and the role of hospitals has changed substantially in the past 25-30 years. Under “Formula 1”, provinces have received financing to upgrade parts of their hospitals. In most provinces, funds available for investment are limited, and upgrading has focused mainly on minimum standards for emergency obstetric services. Provinces have been asked to prepare rationalization plans for the hospitals in their area as a pre-requisite for investment, in an attempt to ensure new investment is consistent with efficient, sustainable operation of hospitals. However, the available investment resources are too limited to finance major expansions and upgrading of hospital capacity in areas that need increased capacity. In spite of DOH efforts to insist on rational investment criteria, external intervention in hospital investment continues to undermine these efforts, leading to a non-sustainable investment that is not consistent with a high quality, modern hospital system. There is a need for nationwide analysis of the gaps in hospital capacity and planning for how to fill these – through a combination of public and private sector investment.

4.39 Concerning hospital autonomy, Some central hospitals have GOCC status. DOH retained hospitals were given some fiscal autonomy since 2004. However, an accountability framework for GOCC hospitals and fiscally autonomous DOH hospitals was not put in place before they were given autonomy. Many LGU hospitals do not have fiscal autonomy and are not able to retain PhilHealth revenues. The hospital autonomy framework is not comprehensive: there are gaps in relation to autonomy over personnel and capital investment, gaps in relation to information systems for performance monitoring, weak accountability framework and gaps in policies for financing

social functions of the hospital more explicitly. The DOH has begun to develop some of the building blocks for increasing the accountability of hospitals through attempts to develop a hospital score card. However, because of the lack of robust hospital information systems in most hospitals, the basic foundations for a hospital score card are not yet in place.

4.40 Private hospital capacity is concentrated in Metro Manila and other major metropolitan areas. A substantial share of private hospital beds is found in very small hospitals. Many if not most of these are probably not functioning at the standards usually expected for secondary care hospitals. However, “inflation” of the categories of hospital license has occurred to such an extent that it is difficult to assess how much private hospital capacity exists at secondary and tertiary levels in the Philippines, in the sense in which secondary and tertiary levels are understood internationally. Inflation in the categorization of hospitals is motivated by in part by the payment system used by PhilHealth (and HMOs/private health insurers) which pays at higher rates for tertiary level hospitals, even for the same procedure. The fact that PhilHealth (and HMOs/private health insurers) only cover drugs and diagnostic tests for inpatients may be driving unnecessary hospital admissions in low-level hospital facilities for patients who could be diagnosed and treated in outpatient settings. The fact that PhilHealth sets reimbursement ceilings per hospitalization and permits hospitals to balance-bill means that patients are not protected from catastrophic costs. It also means that hospitals are not subject to pressures to minimize costs and increase efficiency. Patient choice is not an effective driver of hospital efficiency, because patients have limited scope to compare prices for hospital treatment. There is good evidence that PhilHealth reimbursement leads to inflation in private hospital costs.

4.41 As is the case in many countries, patients routinely bypass first-contact care to seek care in more expensive hospital settings. First-contact (primary care) in the Philippines is largely perceived to be providing public and preventive, rather than curative, services and therefore patients prefer to seek care at the next levels.

4.42 There are shortages in the availability of physicians and nurses despite the fact that the Philippines is one of the largest exporters of health personnel in the world. The *Magna Carta* for health workers, which was created to provide incentives for health workers has reduced financing flexibility for LGUs, and created inequities vis-à-vis both national and LGU levels and distorted incentives for health and other local workers. Dual practice of public physicians and balanced billing affects public sector access, efficiency and overall health system and OOP costs.

4.43 Despite the recent efforts (cheaper drugs and village pharmacies), access to drugs for poor populations is still a problem. The lack of availability of medicines is one reason why patients (even poor members of the PhilHealth Indigent Program) resort to higher priced private hospitals and self-medication. Moreover, there is a lack of confidence in the quality of cheap generics on the part of doctors and many patients. This lack of confidence in generics is one of the main reasons why the pharmaceuticals market remains segmented – doctors prescribe by brand and patients who can afford to, prefer to purchase higher-priced brands, which they perceive to be higher quality. Provinces and municipalities are, on average, paying 3-4 times international reference prices for generic drugs. Some LGUs are buying branded generics at 13-40 times international reference prices, and originator brands at 60-70 times international reference prices. Selection of medicines by LGU hospitals often shows signs of poor practice, with clear instances of inappropriate influence by the pharmaceutical industry on selection of drugs for the hospital formulary.

4.44 While information and data management systems are in place at the LGU, hospital and RHU levels (HOMIS, CHITS), there is a very serious deficit in the available information for monitoring the performance of the service delivery system, which affects the capacity of DOH in policy formulation in this important area. The information that is collected is not shared, analyzed and used effectively.

Table 4.5: Assessment of Health Regulation Under F1

Key Result Areas	Achievements and Remaining Gaps
Upgrading, harmonizing and streamlining licensing, accreditation and certification	<ul style="list-style-type: none"> * Major achievement in decentralization of licensing and related functions to DOH regional offices (CHDs). * Some harmonization in accreditation systems of PhilHealth and DOH but duplication of processes continues. * Certificate-of-Need in hospitals probably ill-advised given large health-facility backlog, and unresolved issues in licensing regime that allow very small facilities with inadequate capacity, to be licensed as hospitals. * Pro-business thrust of reforms still has to yield new private and LGU investments in health.

Key Result Areas	Achievements and Remaining Gaps
Developing quality seals	<ul style="list-style-type: none"> * Quality seals well-established in health centers, but impact evaluation is needed. * Incremental addition of PhilHealth benefits leads to “incremental accreditation” which can be onerous and costly.
Improving capacity of regulatory agencies	<ul style="list-style-type: none"> * Capacity-building needs of new FDA identified, but FDA implementing rules and regulations still to be done. * No long-term strategy for the hospital sector; strategy for DOH retained hospitals still to be developed.
Improving availability of low-cost quality medicines	<ul style="list-style-type: none"> *Major achievement in the passage of Cheaper Medicines Act and signing of Executive Order No. 821 prescribing Maximum Retail Price of five active drug ingredients and voluntary price reduction of 16 others in 2009 and a further 97 others in 2010, but impact evaluation needed. * Revival of village and municipal drug outlets (Botika ng Barangay, Botika ng Bayan), but ill-served regions need more outlets; turnover is low, resupply is difficult, record-keeping is poor and pharmacy supervision is infrequent in most BnBs. * Increasing market share of generic drugs, though not possible to attribute this to Government action, and prices remain high. * Public sector availability of essential medicines is low and procurement prices in most LGUs too high.

Source: This study

C. Future Policy Directions:

Future Policy Directions

Priority Policy Action # 1: Increasing Public Financing within *fiscal constraints* and allocating additional resources to expanded PhilHealth health insurance coverage against clearly defined and measurable performance indicators

4.45 The Philippines will have to simultaneously address the problem of large OOP, low health insurance coverage and the fragmentation in health financing. Increasing public financing is one option but will have to be done while improving the base efficiency of the current system and without resorting to excessive public borrowing. Additional revenues need to be raised equitably and efficiently (Gottret and Schieber, 2006).

4.46 In this context, as discussed in more detail below, the Government has the following fiscal options.

4.47 *Re-prioritization of health within the Government Budget:* Given that the shares of public spending on health relative to total health and total government expenditures and GDP in the Philippines are lower than other comparable global and EAP countries, there may be scope for increasing allocations for health. In general, there is a very wide variation in the extent to which health is prioritized by governments across countries, even among countries at similar income levels. Economic growth tends to be associated with not only a higher overall level of resources but also a higher *share* of public resources devoted to health.¹⁴ The Philippines has been atypical in this regard: its public share of health spending has remained fairly stagnant, even declining somewhat over time. Indonesia's case is more typical of developing countries: public expenditures on health as a share of GDP have been trending upwards as the country has grown.

4.48 *New Health Sector Resources:* Another possibility is to explore new health-specific resource generation options (earmarked taxes) which can be used to create fiscal space for the health sector. From an economic perspective, earmarking is often viewed as a constraint on fiscal policy-making. In addition, there are examples where earmarked funds have been diverted to other activities especially in poor governance setting. Common earmarked taxes in the health sector include: (i) payroll taxes as social insurance contributions, (ii) taxes on alcohol and tobacco, other.

4.49 “Sin taxation”, i.e., taxes on the consumption of tobacco and alcohol, are often considered to be beneficial not only from a public health perspective but also from an economic perspective. Thailand, Australia, the US, and Korea, are examples of countries that have successfully implemented earmarked taxes on tobacco and used the revenues for public health purposes. **Whether taxes**

¹⁴ ADB (2006), *Key Indicators: Measuring Policy Effectiveness in Health and Education*, Manila: Asian Development Bank; Empirical evidence suggests the importance of other factors such as the prevalence of corruption, ethno-linguistic fractionalization, and average education levels in the population as determinants of the extent to which health is or is not prioritized by governments.

on alcohol and tobacco can and should be increased and/or earmarked for health in a country is dependent on many economic and political conditions that will determine: whether increasing taxes will raise total tax revenue and by how much (i.e., what is the elasticity of demand); whether there will be an impact on employment; whether the taxes will disproportionately impact the poor; and whether earmarking tax revenues for the health sector is politically feasible.^{15, 16}

4.50 The Philippines has earmarked a portion of incremental revenues from VAT for health. In 2006, the country raised the VAT tax rate from 10 percent to 12 percent. As part of the stipulated increase, there was a provision made that 4 percent of the incremental VAT revenues (with a 3-year lag) would be earmarked for LGUs to sponsor health insurance coverage for the indigent.¹⁷ In addition, beginning in 2006, 20 percent of incremental VAT collections were to be utilized for “investments in social services and government capital expenditures.”^{18, 19} This amount was to increase by 5 percent every year, until 50 percent of the incremental VAT resources were used for such investments by 2010. The availability of these additional VAT resources may have been one of the reasons why DOH allocations have registered increases in recent years. The Philippines has also earmarked a portion of excise taxes on tobacco and alcohol for health, and more specifically for health insurance financing and disease prevention.²⁰

¹⁵ Chantornvong, S, J Collin, R Dodgson, K Lee, D McCargo, D Seddon, P Vaughn, and G Woelk (2007), “The Political Economy of Tobacco Control in Low-Income and Middle-Income Countries: Lessons from Thailand and Zimbabwe,” *Bulletin of the World Health Organization*, 78(7): 913-919.

¹⁶ Hu, T and Mao, Z. 2002. Economics analysis of tobacco and options for tobacco control: China case study. HPN Discussion Paper, Economics of Tobacco Control Paper No. 3. Washington, D.C.: The World Bank.

¹⁷ Department of Finance (2005), *Briefer on VAT Reform Law*, available online at <http://www.vatreform.gov.ph>.

¹⁸ Ibid.

¹⁹ Newhouse, D and D Zakarova (2007), “Distributional Implications of the VAT Reform in the Philippines,” *IMF Working Paper WP/07/153*, Washington, DC: International Monetary Fund.

²⁰ Amendment to Republic Act No. 8240 of the Philippines’ tax code

Table 4.6: Fiscal space for health at a glance for the Philippines

Fiscal Space Source	Key Information	Prospects for Fiscal Space
Macroeconomic conditions	GDP growth rates (reduced from 7% to 1% between 2007 and 2009), declining revenue shares and low elasticity of public expenditures on health to GDP limit likelihood of additional public resources for health, but will rebound in 2011 to 7% with IMF estimates of 5% per year to 2015	Moderate
Re-prioritization of health in the government budget	Public spending on health is low relative to revenue efforts in the country and relative to the regional average. There are indications that the priority accorded to health may be increasing	Moderate
Health sector-specific resources	Philippines currently earmarks excise taxes on tobacco and alcohol for health as well as a portion of incremental revenues from VAT. Gaining further fiscal space from increased SHI contributions is unlikely given large informal sector	Limited
Health sector-specific grants and foreign aid	ODA for health is 2.9% of total health spending. External dependence is relatively low and irregular and likely to remain so given current global economic crisis	Limited
Efficiency gains	Improvements in revenue collection efforts and governance, better allocation of health resources, quality improvements and more cost-effective interventions could create additional resources for health	Good

Source: Tandon and Regondi, 2010

4.51 The Philippines has one of the lowest excise taxes for tobacco in the region.²¹ The World Bank's International Comparison Program estimates that the average price level on tobacco, alcohol, and narcotics is one of the lowest in the region: the price index for the Philippines in 2005 was 35 compared to the global average of 100, and lower than comparators such as Indonesia, Thailand, and Vietnam. The country has a non-indexed four-tier tobacco tax system that differentiates between low-, medium-priced, high-priced and premium brands. This tax structure makes tobacco taxation in the Philippines less regressive than a unitary tax. *One policy option could be to increase taxes only for high-priced and premium brands and use the additional resource to finance health.* This could increase state revenues while maintaining the pro-poor nature of the current tax structure on tobacco. From a public health perspective, however, this could cause some concern for those who would argue that the poorer wealth quintiles would be incentivized through lower prices to keep consuming cheap, perhaps low-quality tobacco.

4.52 Increasing the Efficiency of Health Spending: Fiscal space can, in effect, also be realized by improving the efficiency of existing outlays in health as well as for all other public sector spending. Efficiency, broadly defined for any generic production system, implies choosing and utilizing inputs so as to attain the maximum possible output(s) at least cost. Two components of efficiency are generally differentiated: *technical efficiency* implies attaining the most output from a given set of inputs; *allocative efficiency* implies choosing the optimal set of inputs, given their prices, in order to attain the maximum output at least cost (Tandon and Regondi, 2010). The PhilHealth benefits package and provider payment methods are key mechanisms to improve cost-effectiveness and value for money. Reducing duplication in financing can also enhance efficiency and here there is a need to think about how to best allocate health sector resources: through demand side or supply side subsidies and the tradeoffs in doing so. These topics are discussed in greater details in the next sections. ***Taking these various fiscal dimensions into account the Review proposes the following health financing actions to address the low levels, inequity and fragmentation in health financing:***

4.53 Increase National Government Financing for Health: As discussed above a recent review by the World Bank (Public Expenditure Review) recommends increasing national government (NG) transfers to the social sectors (health and education) through improvements in inter-sectoral resource allocation and strengthened revenue collection. According to the Public Expenditure Review,

²¹ Taxes in the Philippines fall below the international recommendations that tobacco taxes make up two-thirds to four-fifths of retail price.

public spending on health could increase by almost 0.7 percent of GDP each year during the next plan period (2011-2016), resulting in a potential doubling of public financing.²² A recent DOH, PhilHealth and World Bank costing exercise for universal health care identifies the costs of expanding effective coverage to the population. The total costs over five years for the subsidized regime (poor and near poor) are P218.6 billion and the total costs for the combined subsidized and non-subsidized regime is P408.6 billion over five years (2012-2016). The expansion of the identified benefits package will provide greatly enhanced financial risk protection to all Filipinos and create a cost-effective base for shifting to outpatient/first contact care. Nevertheless, the implementation challenges associated with the model are also large, will require a significant effort on the part of PhilHealth (through provider payment reforms) and a transformation of the public sector service delivery structures (DOH, LGU).

4.54 *Allocating Additional Public Financing for Health:* Given the mixed financing system, there are several options for the Philippines to consider in the allocation of increased public resources for health. One option is to channel the increased resources to LGU pools, the other to DOH managed health facilities and the third to the PhilHealth in the form of insurance premiums for the poor and near poor. Among the three, the pooling of funds within the PhilHealth is the best option from the perspective of generating a large risk pool with strong cross-subsidy arrangements. It would also mitigate the fragmentation in risk pools and increase PhilHealth's market power. This is of course contingent on PhilHealth being able to deploy the resources effectively to finance an enhanced benefits package. In the highly decentralized context of the Philippines, additional allocations to LGU pools without changes in the Internal Resource Allocation (IRA) is the least optimal option for efficient and equitable risk pooling and reduced fragmentation in financing.

4.55 *Currently, the Sponsored Program (SP) for indigent families is financed from two pools (national government and LGU).* To reduce the fragmentation in risk pools and clarify the role of LGUs vis-à-vis health financing and delivery, the Sponsored Program could be entirely financed from the national government pool. Moreover, financing from the national pool would be consistent with the fact that income redistribution is a national government priority. Universal application of the National Household Targeting System – (NHTS) to target beneficiaries under the sponsored program will greatly enhance poverty targeting and reduce political interference in targeting. According to the Department of Social Welfare and Development (DSWD), there are an estimated 5.2 million

²² The average for Southeast Asian countries (Indonesia, Malaysia, Philippines, Thailand and Vietnam) is 3.9 percent of GDP in the mid-2000s.

indigent families in the Philippines. The recent cost estimates indicate that national government coverage of the 5.2 million households identified through the NHTS will cost P107.6 billion over 5 years. In terms of expenditures as a percentage of GDP, the estimates are an annual increase of national government allocation of approximately .11 -.16 percent of GDP each year (.11 in 2012, and then .16 each year onwards).²³ The national government could consider in future, through the DOH, allocating premium money for the Sponsored Program to the PhilHealth against clearly defined and measurable performance indicators to ensure that insurees receive the benefits mandated. Enhanced coverage under the SP also means that more women and children will have access to health insurance – a critical element of alleviating the economic barriers to achieving MDG 4 and 5.

4.56 As a next step, the Philippines could consider co-financing the premiums of near poor households (discussed below). Estimates indicate that if this twin approach is adopted by the country, technically by 2016, the country should be able to achieve universal health insurance coverage.

4.57 *Strengthen the Contributory Regime under PhilHealth:* With an estimated 50 percent of the labor force in the informal sector, mobilizing additional health sector resources is a challenge. For those self-employed and informal sector workers who are currently not under the IPP PhilHealth, one could consider different options. One option (similar to Thailand) is to enforce participation (since the NHIP is a mandatory program) and complement with a partial subsidy scheme through general budget revenues for near poor households. This has fiscal implications and given the limited fiscal space in the Philippines will have to be carefully phased. Another option is to adopt a differentiated strategy for incentivizing enrollment through: (i) using private and social marketing methods to increase enrollment (this would address the fact that understanding of health insurance is a barrier to enrolment), (ii) designing an attractive benefits package at affordable prices, and consider different benefit packages for different enrollee groups, (iii) marketing the benefits to larger groups, such as through cooperative, (iv) marketing the product alongside complementary products such as microcredit (Hawkins, 2006). For the group of self-employed and informal sector workers who do not qualify under the NHTS, PhilHealth could consider subsidizing enrollment through a cost-sharing arrangement against a lower-cost benefits package. This was the approach adopted in Colombia in its attempts to reach universal coverage (Hsiao and Shaw, 2007).

²³ World Bank, DOH, PhilHealth. 2011. Preliminary Estimates: Costing the Aquino Health Agenda/Universal Health Care, Manila, the Philippines.

4.58 In addition to government revenues (and efficiency gains), the other source of increased financing for health is the contributory regime under PhilHealth. The premiums could be adjusted based on household income and the definition of dependents could be adjusted (down to 18 years instead of 21). The premium payments for Overseas Filipino Workers (OFWs) could be increased as well.

Priority Policy Action # 2: Undertake comprehensive reform of the PhilHealth to make it an active and accountable purchaser in the health sector, setting the incentives and driving the process of service delivery transformations;

4.59 *Benefits package reform must be PhilHealth's number one priority.* PhilHealth needs to build on its recent efforts in benefits package expansion by including outpatient benefits for all paying members, including outpatient pharmaceutical benefits with a co-payment (indigent program excluded), as well as a flat co-payment for all hospitalization (indigent program excluded). Enhancing and refocusing the PhilHealth benefits package is necessary not just from the perspective of financial protection and health outcomes but also from attracting and retaining paying members that feel they are getting good value for money for their contributions. PhilHealth could consider differentiated benefits package for different groups of members (a basic package for those under the Sponsored program and the sandwich population and an enhanced benefits package for other members. Alternatively, PhilHealth could maintain a single benefits package for all (equity principle). In this situation, those who can afford will have the choice to purchase additional private voluntary insurance. Irrespective of whether PhilHealth chooses differentiated or a single package, actuarial estimates of an upgraded package must be completed and applied to the premium rates for all members.²⁴

4.60 *Implement Performance-Based Approaches for Governance and Management of PhilHealth.* Consistent with the performance-based approaches adopted increasingly by other countries and the DOH, one option would be to finance the premium contributions for indigent families based on approved performance indicators by the Board of Directors. These could be consistent with PhilHealth's Medium-term Plan and encourage PhilHealth to work towards goals in the medium-term.

²⁴ An actuarial estimate of an expanded benefits package to provide effective health insurance coverage to all Filipinos was recently completed and preliminary estimates are available. See World Bank, DOH and PhilHealth UHC Costing references in the Review. Annual updates of this base model will occur.

4.61 ***Implement Speedy Modernization of PhilHealth information Systems.*** Improved and computerized information systems are key interventions to improve transparency and governance in the health sector. PhilHealth could consider the creation of a Core Business Process Improvement Group that would be the focal point for these organizational modernization activities. Its responsibility would be the continual improvement of PhilHealth core processes. A new system, which automates more of the adjudication process of individual claims, is needed. Today each claim is touched far too many times (estimates range from 8-11 human “touches” per claim) and thus the cost of the processing of claims is high. This fact today is not so crucial, since today’s claims have a relatively large face value (given that most are hospital inpatient claims), but as the tide of small amount claims for outpatient services and retail pharmacy claims begins, the existing system will be quickly swamped and the cost per claim of those claims will be very high. Thus it must become the computer which becomes the arbiter of the simple claim, with complex claims (perhaps 5 percent of the total) being routed to “human eyes” for adjudication. In addition, the means of transmission must become electronic, not paper-based. This means that most/all of the “attachments” to today’s claims will be absent – birth certificates, marriage licenses, individual invoices for services, etc. Overall the process must be changed fundamentally. The lead time for the design of such a system is at least 3 years, so PhilHealth should prepare now for systems to be in place at that time. The cost of the design, development, testing and rollout of the new claims system will be large. Therefore, it would not be prudent to implement it in each of the existing PROs. Instead, it has been suggested (Streveler, 2007-06, Streveler, 2007-07) that PhilHealth consider consolidating its processing centers to a small number (3-4) across the country. In that way the sophisticated software and equipment at the Center can be afforded given the volume of claims that each super-center would need to process, and thus the economy-of-scale would make sense.

Priority Policy Action # 3: Support DOH in strengthening its stewardship function especially on service delivery transformation; improved regulation of facilities (public and private), improved oversight for key health sector inputs such as human resources and pharmaceuticals and strengthened data for decision-making and monitoring and sector performance management;

4.62 **The Review describes the many challenges facing the hospital sector in the Philippines.** It suggests future actions such as (i) based on international experience, developing a new vision for the configuration and role of the hospital system, including the relationship with first-contact care; (ii) a rapid assessment focusing on those regions with the lowest total hospital bed to population ratios and, (iii) based on international experience, developing a comprehensive model for public hospital autonomy. The Review argues that while these transformations will take time and will require a phased approach, DOH could jumpstart the

process by addressing gaps in underserved parts of the country through LGU-DOH, and public-private partnerships, developing a revised configuration of health facilities in the Philippines and updating licensing standards to reflect the new standards. While aggregate doctor and nurse numbers in the Philippines are at reasonable levels by regional and global standards, there are problems with shortage of particular medical specialties and allied health professionals in some parts of the country that affect access to essential care for particular conditions. Understanding and planning how to address these shortfalls will require coordination and partnership with the specialist health professional associations/societies. Irrespective of how Philippines wishes to sequence hospital reforms, there will be a very strong role played by the DOH in providing stewardships for the process and technical support to LGUs.

2. Transforming First Contact Care

4.63 The Review highlights the fragmented nature of first contact care in the Philippines and yet, for indigent families, this is often the nearest available care. Moreover, as the Review mentions, the burden of disease is changing in the country, and for non-communicable diseases (NCDs), first-contact care is crucial for the prevention, early detection and treatment of NCDs such as cardiovascular diseases, diabetes and hypertension. Many countries (including in the East Asia Region) have adopted family medicine as a vehicle for transforming first contact care. The Philippines already has an Academy of Family Physicians and one option would be for the country to identify how it can use the existing health insurance system to encourage the development of private family medicine practices. In many countries where family medicine is gaining ground as the main source of first contact care, policy interventions have included: (i) ensuring adequate supply of family physicians, (ii) giving existing doctors (general practitioners, pediatricians) a chance to retrain as family physicians, (iii) start-up funds to set-up family practices, and (iv) implementing a capitation payment system to family physicians depending on the number of patients enrolled. In some countries with advanced family medicine systems such as the UK, family practices are even acting as gatekeepers to secondary care.

3. Addressing the Quality of Care

4.64 The Philippines health sector has many instruments to improve the quality of care – namely the DOH licensing system (mandatory), PhilHealth accreditation (voluntary to allow contracting by PhilHealth), and certification (awards such as *Sentrong Sigla and Gaaling Pook*). The Review describes the limitations of each of these instruments and highlights how these can be used to further enhance quality of care. The licensing standards could be updated taking into account a new vision for the configuration of hospitals and health

centers. The PhilHealth accreditation standards have already been upgraded with the application of the “bench book” but bench book standards need to be synchronized with licensing standards. In some countries (Brazil), there are efforts to link payments to accreditation (pay-for-accreditation). The PhilHealth could explore these models for possible application to the Philippines. Another key dimension of accreditation is that it tends to be conducted by the third-party (generally not the health insurance agency as in the case of PhilHealth). While in the case of the Philippines, accreditation by PhilHealth is reflective of the particular institutional context, one option for PhilHealth to consider is to separate the accreditation arm of PhilHealth for other parts, especially those responsible for paying providers.

4. Improved Regulation and management of critical health system inputs (human resources and pharmaceuticals)

4.65 The DOH has made progress in both areas but human resources and pharmaceutical policies in the country are currently fragmented. A master plan for human resources has been developed, but it needs an update in the context of the strong private sector orientation and the demand for overseas workers. The implementation of the Magna Carta for health workers has been challenging and is a major factor in incentivizing service delivery in the public sector, particularly at the LGU level. Given the supply-side constraints, a policy is perhaps needed not simply on future expansions in the supply of health personnel, but how existing personnel in the public sector can be encouraged to perform better using the twin levers of incentives and accountability. The unavailability of medicines is one of the reasons why patients (even poor members of the PhilHealth Sponsored program) resort to higher priced private hospitals and self-medication. Moreover, concern over drugs is identified by poor households as a barrier to care, and the household expenditure analysis indicates that pharmaceuticals constitute a significant portion of household expenditures. An outpatient drug benefit package has already been developed by PhilHealth but is not being implemented. In the pharmaceutical sector, there are a range of issues related to the pricing of drugs, generic policies and policies to encourage competition.

Policy Priority # 4: Enhance the focus on public health including NCDs or MDG+ (possibly through DOH managed performance-based grants to LGUs)

4.1 The NHI Law states that the PhilHealth will be eventually responsible for public and preventive health care services. However, given the urgent priorities in PhilHealth to expand coverage, enhance the accreditation of facilities and overhaul the organization and management systems of PhilHealth to tackle the increased load, a phased approach could be adopted to integration of the preventive and public health services in the PhilHealth benefits package. The experience with SHI in the East Asia and Pacific Region (EAP) indicates that public health is normally financed through general budget revenues in order to ensure universal coverage. In the Republic of Korea and Japan, services for health promotion and prevention of disease are not covered by health insurance but directly by Government. The DOH has already launched a work program in this area, and additional DOH resources are already allocated for LGU public health grants. This program could be further strengthened and expanded to also directly target non-communicable diseases (NCDs).

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