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The Philippines Health System Review

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The Philippines Health System Review

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with an international editor. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems. They can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programs;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences between policymakers and analysts in different countries implementing reform strategies; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Western Pacific Country Health Information Profiles, national statistical offices, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to apobservatory@wpro.who.int. HiT profiles and HiT summaries are available on the Asia Pacific Observatory's web site at www.wpro.who.int/asia_pacific_observatory.

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List of abbreviations

ADB	Asian Development Bank
ADR	Adverse Drug Reactions
AIPH	ARMM Investment Plan for Health
AIPS	Annual Poverty Indicators Survey
AO	Administrative Order
AOP	Annual Operational Plan
APIS	Annual Poverty Indicators Survey
ARI	Acute respiratory infection
ARMM	Autonomous Region for Muslim Mindanao
ASEAN	Association of South East Asian Nations
BAC	Bids and Awards Committee
BFAD	Bureau of Food and Drugs, Philippines
BHC	Barangay Health Centre
BHDT	Bureau of Health Devices and Technology, DOH
BHFS	Bureau of Health Facilities and Services, DOH
BHW	Barangay Health Worker
BIR	Bureau of Internal Revenue, Philippines
BnB	Botika ng Barangay: DOH-led community based pharmacies
BNB	Botika ng Bayan: privately-owned flagship outlets of the Half-Priced Medicines Programme led by PITC Pharma
BOQ	Bureau of Quarantine, DOH
CALABARZON	Cavite, Laguna, Batangas, Rizal and Quezon
CAR	Cordillera Autonomous Region
CHC	City Health Centre
CHD	Centre for Health Development
CHED	Commission on Higher Education, Philippines
CHITS	Community Health Information Tracking System
CO	Capital Outlay
CON	Certificate of Need

CPR	Contraceptive prevalence rate
DALE	Disability-Adjusted Life Years
DBM	Department of Budget and Management, Philippines
DHS	District Health System
DILG	Department of Interior and Local Government, Philippines
DO	Department Order
DOF	Department of Finance, Philippines
DOH	Department of Health, Philippines
DOLE	Department of Labor and Employment
DOST	Department of Science and Technology, Philippines
DTI	Department of Trade and Industry
EENT	Eye, Ear, Nose, Throat
EmONC	Emergency Obstetric Care
ENT	Ear, Nose, Throat
EO	Executive Order
EPI	Expanded Programme on Immunization
EU	European Union
F1 for Health	FOURmula One for Health
FAP	Foreign-assisted projects
FDA	Food and Drug Administration, Philippines
FHSIS	Field Health Service Information System
FIC	Fully-immunized child
FIES	Family Income and Expenditure Survey
FPS	Family Planning Survey
GAA	General Appropriations Act
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
GNP	Gross National Product
GSIS	Government Service and Insurance System
HALE	Health-Adjusted Life Years
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organizations
HOMIS	Hospital Operations and Management Information System

HRH	Human Resources for Health
HSEF	Health Sector Expenditure Framework
HSRA	Health Sector Reform Agenda
HTA	Health technology assessment
ILHZ	Inter-Local Health Zones
IMS	Information Management Services
IPP	Individually-Paying Programme
IRA	Internal Revenue Allotment
LGC	Local Government Code
LGU	Local Government Unit
LTO	License to Operate
MCP	Maternity Care Package
MDG	Millennium Development Goals
MFO	Major Final Output
MHC	Municipal Health Centre
MIMAROPA	Mindoro, Marinduque, Romblon, Palawan
MOOE	Maintenance and Other Operating Expenses
MRDP	Maximum Retail Drug Price
NCDPC	National Centre for Disease Prevention and Control, DOH
NCHFD	National Centre for Health Facility Development, DOH
NCR	National Capital Region
NCWDP	National Council for the Welfare of Disabled Persons
NDCC	National Disaster Coordinating Council, Philippines
NDHS	National Demographic and Health Survey
NEC	National Epidemiology Centre, DOH
NEDA	National Economic Development Authority
NEP	National Expenditure Programme
NFA	National Food Authority
NGO	Non-government organization
NHIP	National Health Insurance Programme
NOH	National Objectives for Health
NSCB	National Statistical Coordination Board
NSD	Normal spontaneous delivery
NSO	National Statistics Office
OFW	Overseas Filipino workers

OOP	Out-of-pocket
OPB	Outpatient Benefit Package
OPD	Outpatient department
OT	Occupational Therapist
OTC	Over-the-counter
OWP	Overseas Workers Programme
PCHD	Partnership in Community Health Development
PCSO	Philippine Charity Sweepstakes Office
PGH	Philippine General Hospital
PHC	Primary Health Care
PHIC	Philippine Health Insurance Corporation (Philhealth)
PHIN	Philippine Health Information Network
PHIS	Philippine Health Information System
PIDSR	Philippine Integrated Disease Surveillance and Response
PIPH	Province-wide Investment Plan for Health
PITC	Philippine International Trade Corporation
PMA	Philippine Medical Association
PNDF	Philippine National Drug Formulary
PNDP	Philippine National Drug Policy
PO	People's organization
PPP	Purchasing Power Parity
PRC	Professional Regulations Commission, Philippines
PSY	Philippine Statistical Yearbook
PT	Physical Therapist
PTC	Permit to Construct
PWD	People with disabilities
R&D	Research and Development
RA	Republic Act
RH	Reproductive Health
RHU	Rural Health Unit
SARS	Severe Acute Respiratory Syndrome
SDAH	Sector-wide Development Approach for Health
SOCCSKSARGEN	South Cotabato, Cotabato, Sultan Kudarat, Sarangani, General Santos City
Sp	Speech Pathologist

SP	Sponsored Programme
SPED	Special education
SRA	Social Reform Agenda
SSS	Social Security System
TB-DOTS	Tuberculosis Directly-Observed Treatment Short-course
TCAM	Traditional and Complementary/Alternative Medicine
TDF	Tropical Disease Foundation Inc.
TESDA	Technical Education and Skills Development Authority
THE	Total health expenditure
UN	United Nations
UP	University of the Philippines
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO	World Health Organization
VAT	Value Added Tax
WHO	World Health Organization

Abstract

Health status has improved dramatically in the Philippines over the last forty years: infant mortality has dropped by two thirds, the prevalence of communicable diseases has fallen and life expectancy has increased to over 70 years. However, considerable inequities in health care access and outcomes between socio-economic groups remain.

A major driver of inequity is the high cost of accessing and using health care. The Philippines has had a national health insurance agency – PhilHealth – since 1995 and incrementally increased population coverage, but the limited breadth and depth of coverage has resulted in high-levels of out of pocket payments. In July 2010 a major reform effort aimed at achieving 'universal coverage' was launched, which focused on increasing the number of poor families enrolled in PhilHealth, providing a more comprehensive benefits package and reducing or eliminating co-payments.

Attracting and retaining staff in under-served areas is key challenge. The Philippines is a major exporter of health workers, yet some rural and poor areas still face critical shortages. Inefficiency in service delivery persists as patient referral system and gatekeeping do not work well.

Successive reform efforts in financing, service delivery and regulation have attempted to tackle these and other inefficiencies and inequalities in the health system. But implementation has been challenged by the decentralized environment and the presence of a large private sector, often creating fragmentation and variation in the quality of services across the country.

Executive Summary

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTS examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

Section 1 introduces the country, its people and the political context, and briefly describes trends in health status. The Philippines is an archipelago of 7107 islands, subdivided into 17 administrative regions. A low middle-income country, its economy has not kept pace with its 'Asian Tiger' neighbours, and the benefits of growth have been inequitably distributed: average annual family income is as high as US$ 6058 in the National Capital Region (where Manila is located), while families in the poorest regions earn less than a third of this amount.

One break on the economy is the high population growth rate of 2% per year; the total population now stands at 94 million. Driving this is a high fertility rate of three children per woman. This average masks considerable inequalities between income groups, with the poorest women having on average almost six children, and the richest less than two.

The Philippines experienced dramatic improvements in levels of child and maternal mortality and communicable disease control during the second half of the twentieth century. However, gains have slowed in recent years, in part due to the poor health status of those on low-income and living in less developed regions of the country. Life expectancy in richer provinces is more than 10 years longer than in poorer ones.

Section 2 summarizes the organization and governance of the health system, including the underpinning governance and regulations. Under the current decentralized structure, the Department of Health (DOH) serves as

the principle governing agency of the health system, mandated to provide national policy direction and develop national plans, technical standards and guidelines on health.

Decentralisation was first introduced in 1991, when Local Government Units were granted autonomy and responsibility for their own health services, and provincial governments given responsibility for secondary hospital care. Initially, the quality of services deteriorated due to low management capacity and lack of resources. A health sector reform programme introduced in 2005 helped to address some of these issues and improve overall health sector performance. It focused on expanding public and preventative health programmes and access to basic and essential health services in underserved locations. However, the involvement of three different levels of government in the three different levels of health care has created fragmentation in the overall management of the system. Local and provincial authorities retain considerable autonomy in their interpretation of central policy directions, and provision of the health services is often subject to local political influence. As a result, the quality of health care varies considerably across the country.

Section 3 describes the financing of the health sector in the Philippines; it includes an overview of the system, levels of spending, sources of financing and payment mechanisms. It finds that total health expenditure per capita has grown slowly in real terms: by 2.1% per year between 1995 and 2005. Total health spending now stands at 3.9% of GDP – low compared to the Western Pacific regional average of 6.1%.

The major health financing concern in the Philippines is the high level of out-of-pocket payments, which account for 48% of total health expenditure. The Philippines has a national health insurance agency – PhilHealth – however the level of financial protection it provides is limited as patients are often liable for substantial copayments. In 2010, the newly-elected government launched a major reform effort aimed at achieving 'universal coverage' which focused on increasing the number of poor families enrolled in PhilHealth, providing a more comprehensive benefits package and reducing or eliminating co-payments. So far the results are promising. As of April 2011 almost 4.4 million new poor families had been enrolled in PhilHealth, equivalent to a 100 per cent increase in enrolment for the real poor. In 2011, PhilHealth introduced a no-balanced-billing policy for these sponsored households.

The fee-for-service payment system and the limited regulation of provider behavior have also contributed to financial burden on patients. Financial reform in the Philippines is made more complicated by the presence of a large private sector which has incentives towards over-provision. Thus, the introduction of reforms intended to provide stronger incentives for the rational allocation of resources is operationally challenging.

Physical and human resources available to the health sector are described in Section 4. There has been a general upward trend in the number of both private and government hospitals over the last 30 years, with the biggest growth noted in the 1970s, and a flattening off of growth in the last ten years. Most hospitals are privately-owned, though there are roughly equal numbers of public and private beds. The expansion of private hospitals has been principally centred in urban or near-urban areas leading to an inequitable distribution of health facilities and beds across the country.

The largest categories of health workers are nurses and midwives. Currently, there appears to be an oversupply of nurses relative to national needs – as many are trained with the intention of working overseas – and an underproduction in other professional categories, such as doctors, dentists and occupational therapists. In 2009, over 13 000 Filipino nurses took up positions overseas. Migration is internal as well as external – with a growing private sector absorbing an increasing number of health staff. HRH planning is thus particularly challenging in the Philippines.

Section 5 describes the health services delivery mechanisms, explaining the various facilities available at each level and the referral system. Public health services are delivered by Local Government Units, with the Department of Health providing technical assistance. In addition, specific campaigns and dedicated national programmes (such as TB) are coordinated by the Department of Health and the LGUs. Provincial governments manage secondary and tertiary level facilities, and the national government retains management of a number of tertiary level facilities. The private sector delivers services at all three levels of the system. Private primary services are provided through freestanding clinics, private clinics in hospitals and group practice or polyclinics.

Though a referral system which aims to rationalize heath care use has been in place since 2000, it is common practice for patients to bypass the primary level and go direct to secondary or tertiary level facilities.

Hospital admissions data from PhilHealth suggests that specialized facilities are continuously treating primary and ordinary patients. Dissatisfaction with the quality of services, lack of supplies in public facilities, and the absence of a gate-keeping mechanism are among the reasons that patients bypass lower levels of care.

The principle health care reforms are described in Section 6. Over the last 30 years a series of reform efforts have aimed to address poor accessibility, inequities and inefficiencies of the health system, with mixed results. The three major areas of reform are health service delivery, health regulation, and health financing. The service delivery component of the health sector reform agenda included provision of a multi-year budget for priority services, upgrading of the physical and management infrastructure at all levels, and the strengthening of technical expertise in the DOH.

Health financing reforms have focused on expanding health insurance – including a recent push toward universal health coverage as mentioned above. Experience from past reform efforts suggests that higher levels of enrollment of "sponsored" families (premiums paid by the government) has not automatically translated into greater use of services – most likely because of the concerns about service quality and high co-payments. The government is therefore now looking at options to reduce or eliminate co-payments. Attracting the self-employed has also proved a difficult challenge in the past.

Regulatory reforms were implemented in the pharmaceutical sector in the late 1980s. An essential drugs list was established, a Generics Act promoted and required greater use of generic medicines – 55-60% of the public now buy generics – and capacities for standards development, licensing, regulation and enforcement were strengthened at the Federal Drug Authority. In 2009, the DOH set maximum retail prices for selected drugs and medicines for leading causes of morbidity and mortality.

Section 7 presents an assessment of the Philippines health system against a set of internationally recognized criteria. It suggests that, despite important progress in improving health status, successive waves of reform – from primary health care to decentralization to the more recent health sector reform agenda – have not succeeded in adequately addressing the persistent problem of inequity. An independent and dominant private health sector, the disconnect between national and

local authorities in health systems management, and the absence of an integrated curative and preventive network have together had a negative impact on economic and geographic access to health care as well as its quality and efficiency. However, these issues are now attracting attention at the highest levels of government which suggests that the coming years present an important window of opportunity for reform.

1. Introduction

1.1 Geography and Socio-Demography

The Philippines is an archipelago in the South-East Asian region, located between the South China Sea and the Pacific Ocean. Across the South China Sea, to the west of Palawan Island, are the countries of Cambodia, the Lao People's Democratic Republic, and Viet Nam. China lies west of the Luzon coast while further north are Korea and Japan. Across sea borders in the south are Indonesia, Malaysia and Brunei. To the east of the Philippines lie the scattered island territories of Saipan, Guam, Micronesia, and Palau (Figure 1-1). The country is comprised of 7107 islands, of which Luzon in the north is the largest, where the capital city of Manila is located. To the south of Luzon are the Visayan Islands whose major city is Cebu. Further south is the second largest island, Mindanao, where Davao City is the main urban centre.

Figure 1-1 Map of the Philippines

The Philippines has a total land area of 343 282 square kilometers, and a coastline stretched to 36 289 kilometers. Its terrain is mostly mountainous, with narrow to extensive coastal lowlands. It has a tropical and maritime climate, characterized by relatively high temperatures, high humidity and abundant rainfall. Its lowest temperatures are recorded in mountain areas at between 15.6 °C (60 °F) and 21.1 °C (70 °F) during the months of December, January and February. The highest temperatures of up to 35 °C (95 °F) occur during the dry season from December to May. The country's rainy season is from June to November, although a significant part of the country experiences continuous rainfall throughout the year.

Because of its location in the typhoon belt of the Western Pacific, the Philippines experiences an average of twenty typhoons each year during its rainy season. In addition, the country is along the "Pacific Ring of Fire", where large numbers of earthquakes and volcanic eruptions occur. These factors combine to make the country one of the most disaster-prone areas of the globe.

In 2007, the total population reached 88.57 million, distributed among the island groups of Luzon, Visayas and Mindanao. The projected population for 2010, based on National Statistics Office's (NSO) 2000 national census, is 94.06 million, making it the 12th most populous country in the world. Rapid urbanization in the Philippines, particularly in Metropolitan Manila, continues to create problems such as housing, road traffic, pollution and crime. The urban population has doubled in the past three decades, from 31.8% in 1970 to 50.32% in 2008, while the rest of the population remains in rural, often isolated areas (Table 1-1).

Table 1-1 Population/demographic indicators,1970-2007 (selected years)

Indicator	1970	1980	1990	2000	2005	2007	2008
Total population	36 684 486	48 098 460	60 703 206	76 504 077	--	88 574 614[a]	--
Population, female (% of total)	44.7	49.8	49.6	49.6	--	--	--
Population growth (average annual %)	3.1	2.7	2.4	2.4	2.0	2.0	--
Population density (persons/sq. km)	122	160	202	225	260	260	--
Fertility rate, total (births per woman)	6.0	5.1	4.1	3.5	--	3.3[b]	--

Indicator	1970	1980	1990	2000	2005	2007	2008
Crude birth rate (per 1000 population)	25.4	30.3	24.8	23.1	20.1[c]	20.1[c]	--
Crude death rate (per 1000 population)	6.4	6.2	5.2	4.8	5.1[c]	5.1[c]	--
Sex ratio	99	101	101	101	101	101	--
Age dependency ratio	94.6	83.2	75.1	69.0	73.0[d]	--	68.3
Urban population (% total population)	31.8	37.3	47.0	48.0	--	--	50.3
Simple literacy rate (%) (10 years & above)	--	--	89.9	92.3	93.4[d]	--	--

Notes: a - as of Aug. 1, 2007; b - as of 2006; c - as of 2005; d - as of 2003.
Sources: PSY 2008, NSCB; NDHS 1993-2008, NSO & Philippines in Figures 2009, NSO.

A population growth rate of 2.04% annually is linked to a high average fertility rate of three children per woman of child-bearing age. The highest population growth rates are observed in some of the most economically-deprived areas of the country, such as the Bicol and Eastern Visayas Regions.

The majority of the population consists of Christian Malays living mainly on the coastal areas. In the 2000 census, the NSO reported that 92.5% of the population is Christian, 81.04% of which is Roman Catholic. Muslim minority groups, comprising 5.06% of the household population, are concentrated in Mindanao, while tribes of indigenous peoples are found in mountainous areas throughout the country. There are approximately 180 ethnic groups in the country, each representing their own language group. The most widespread group is the Tagalog, accounting for 28% of the household population. Other ethnic groups include Cebuano, Ilocano, Ilonggo, Bisaya, Bicol and Waray. The official languages in the Philippines are Filipino, which is derived from Tagalog, and English, both widely used in government, education, business and the media. Administrative regions are areas covered by regional subdivisions (or offices) of different departments and bureaus of the national government. They are composed of provinces located in the different island groups as follows (corresponding full names are in Box 1):

Luzon – NCR, CAR, I, II, III, IV-A, IV-B, V
Visayas – VI, VII, VIII
Mindanao – IX, X, XI, XII, XIII, ARMM

Box 1 The 17 Administrative Regions of the Philippines

Region	Region Name	Region	Region Name
NCR	National Capital Region	VI	Western Visayas
CAR	Cordillerra Administrative Region	VII	Central Visayas
I	Ilocos Region	VIII	Eastern Visayas
II	Cagayan Valley	IX	Zamboanga Peninsula
III	Central Luzon	X	Northern Mindanao
IV-A	CALABARZON	XI	Davao Region
IV-B	MIMAROPA	XII	SOCCSKSARGEN
V	Bicol Region	XIII	CARAGA
		ARMM	Autonomous Region in Muslim Mindanao

1.2 Economic Context

The Philippines is considered a low middle-income country, with a per capita income of about US$ 1620 in 2007 according to the World Bank. In 2009, its GDP amounted to almost Php 7.67 trillion or US$ 159.3 billion (Table 1-2). About 55.15% of its GDP comes from service industries, while industry and agriculture contribute 29.93% and 14.92% to GDP, respectively. Agriculture remains the major economic activity, with rice and fish the leading products for local consumption, while mining is an important source of export earnings. Manufacturing, previously a major economic activity, has been on the decline over the last two decades. Services and remittances from overseas Filipino workers (OFWs) are a major source of national income, comprising 13.45% of the country's GDP for the year 2009.

Table 1-2 Economic indicators, 1970-2007 (selected years)

Indicator	Year	Value
GDP (in million Php, at current prices)	2009	7 669 144
GDP, PPP (current international $)	2007	144 060 000 000
GDP per capita (in Php, at current prices)	2009	83 155
GDP per capita, PPP (US$)	2008	1866.00
External debt outstanding (million US$, at current prices)	2008	54 808
Value added in industry (% of GDP)	2009	29.93
Value added in agriculture (% of GDP)	2009	14.92
Value added in services (% of GDP)	2009	55.15
Net factor income from abroad (% of GDP)	2009	13.45
Labor force (total)	2008	37 058 000
Poverty incidence (% population)	2006	32.90
Gini coefficient	2006	0.46
Employment rate (%)	2009	92.40
Unemployment rate (%)	2009	7.60
Underemployment rate (%)	2009	19.80
Official exchange rate (US$ to Php)	2009	48.14

Sources: NSCB, 2009; Philippines in Figures 2009, NSO; United Nations Data Retrieval System, 2010.

Table 1-3 Average annual family income per region in Philippine Peso (Php), 1988-2006

Region	1988	1991	1994	1997	2000	2003	2006
NCR	79 314	138 256	173 599	270 993	300 304	218 000	310 860
CAR	33 838	58 985	74 669	112 361	139 613	126 000	192 126
Ilocos (I)	34 031	56 678	66 125	102 597	120 898	102 000	142 358
Cagayan Valley (II)	32 939	50 850	68 851	86 822	108 427	99 000	142 770
C. Luzon (III)	46 855	76 203	94 092	133 130	151 449	138 000	197 640
S. Tagalog (IV)	37 978	68 960	87 627	132 363	161 963	--	--
CALABARZON (IV-A)	--	--	--	--	--	158 000	209 749
MIMAROPA (IV-B)	--	--	--	--	--	84 000	108 946
Bicol (V)	26 570	39 823	54 167	77 132	89 227	94 000	125 184
W. Visayas (VI)	31 164	47 723	64 078	86 770	109 600	98 000	129 905
C. Visayas (VII)	27 972	45 255	57 579	85 215	99 531	102 000	144 288
E. Visayas (VIII)	25 345	38 475	49 912	67 772	91 520	84 000	125 731
Zamboanga (IX)	31 984	42 622	50 784	87 294	86 135	75 000	125 445
N. Mindanao (X)	35 801	45 179	63 470	99 486	110 333	91 000	141 773
Davao (XI)	37 132	51 722	71 177	94 408	112 254	100 000	134 605
C. Mindanao (XII)	35 090	44 398	61 282	81 093	90 778	--	--
SOCCSKSARGEN (XII)	--	--	--	--	--	85 000	113 919
CARAGA (XIII)	--	--	52 982	71 726	81 519	78 000	118 146
ARMM	--	43 677	51 304	74 885	79 590	67 000	88 632
PHILIPPINES	40 408	65 186	83 161	123 168	144 039	148 000	172 730

Source: NSCB, 2010.

From 2006-2012 the country averaged just under five per cent annual GDP growth (albeit with some major fluctuations), at par with the region (ADB 2011). The Gini coefficient decreased from 0.49 in 1997 to 0.46 in 2006, indicating that great economic inequality persists. Employment rates were below 90% in the years 2000 to 2005, but have risen to 92.4% in 2009. The underemployment rate, on the other hand, was 19.8%.

As of 2006, the National Capital Region (NCR) had the highest average annual family income of Php 310 860 (US$ 6058) (Table 1-3). Region IV-A and the Cordillera Administrative Region (CAR) are also among the highest earning regions. Conversely, the poorest region based on average annual family income is the Autonomous Region in Muslim Mindanao (ARMM), whose families earn less than a third of those in NCR, followed by Region IV-B and Region XII.

1.3 Political Context

Since 1897, the Philippines has had seven constitutions. The latest ratified by referendum in 1987 and now in effect, established a republican government patterned after that of the United States with a strong executive branch, a bicameral legislature, and an independent judiciary under a supreme court.

The executive branch through the national government agencies and local government units exercises administrative and/or regulatory authority over the health system as a whole. The legislative branch influences the health system in two ways: a) by approving the annual budgets of national health agencies and institutions; and b) by individual congressmen allocating their "development funds" (PDAF or "pork barrel") to specific health institutions for various purposes. The judiciary affects the health system in both the government and private sectors when it renders decisions in legal disputes involving health agencies, institutions and individuals.

1.4 Health Status

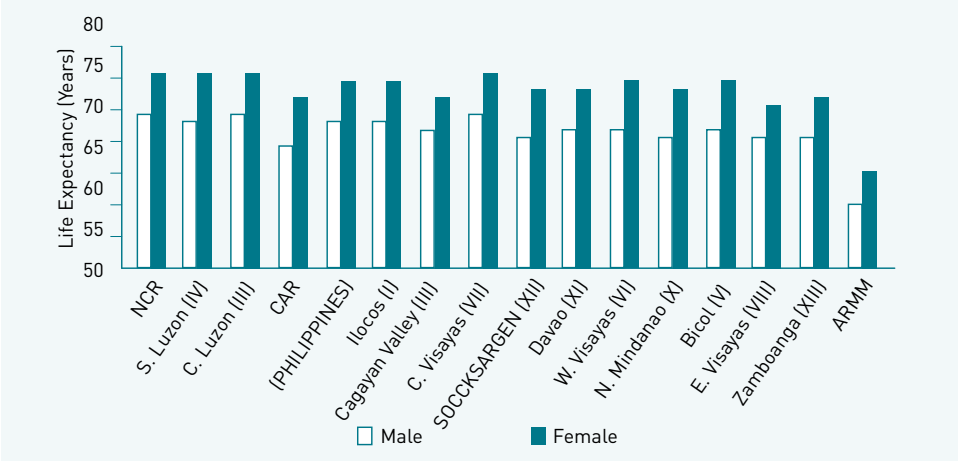
Philippine health status indicators show that the country lags behind most of South-East and North Asia in terms of health outcomes. While rapid improvements were seen during the last three decades, these have slowed in recent years.

Women tend to live longer than men by five years, while average life expectancy at birth for both sexes was about 72 years in 2007. There are also variations in projected life expectancy at birth across different regions. As noted in Figure 1-2, Regions III, IV, NCR and VII had the highest life expectancy for both men (67-69 years) and women (74 years) in 2005. By contrast, ARMM had a life expectancy of 58 years for men and 62 years for women, reflecting the difficult living conditions brought by armed conflict, poverty, poor nutrition and lack of health care.

Both disability-adjusted life expectancy (DALE) and health-adjusted life expectancy (HALE) are measures of the equivalent number of years expected to be lived in full health. In 1999, the DALE for Filipinos was approximately 57 years for men and 61 years for women; in 2007, the HALE was 59 years for men and 64 years for women.

The leading cause of death in the Philippines is heart disease, with rates steadily rising from 70 per 100 000 population in 1997, to 90 per 100 000 population in 2005 (Table 1-4). This is followed by vascular diseases and malignant neoplasms (or cancer), with mortality rates of 63.8 and 48.9 per 100 000 population, respectively.

Figure 1-2 Projected life expectancy at birth by region, 2005



Notes: S. – Southern; C. – Central; W. – Western; N. – Northern; E. – Eastern; Regions are sequenced according to average annual family income as of 2003, with NCR having the highest and ARMM, the lowest.
Source: PSY 2008, NSCB.

Communicable diseases continue to be major causes of morbidity and mortality in the Philippines. As shown in Table 1-4 and 1-5, infectious diseases such as tuberculosis and pneumonia are leading causes of death. Malaria and leprosy remain a problem in a number of regions of the country. Also shown in the tables is the prevalence of non-communicable diseases, such as diseases of the heart, diabetes mellitus and cancers. The National Nutrition and Health Survey in 2003-2004 revealed the prevalence rates of risk factors for cardiovascular diseases, such as coronary artery disease, stroke and peripheral arterial disease (Table 1-6). Of the 4753 adults who participated in the nationwide study, 60.5% were physically inactive, and 54.8% of women were obese. Among males, 56.3% have a history of smoking. Alcohol intake among adults had a prevalence of 46%. These are only a few of the risk factors that contribute to the rising incidence of non-communicable diseases in the country.

The rise in non-communicable diseases along with the existing prevalence of infectious diseases indicates the Philippines is in an epidemiologic transition characterized by a double burden of disease. This disease pattern indicates that even as degenerative diseases and other lifestyle-related illnesses are increasing, communicable diseases are still widely prevalent.

Table 1-4 Main causes of death, 1997-2005 (selected years)

Region	Rate per 100 000 population (Rank)						
	1997	1999	2000	2002	2003	2004	2005
I. Communicable diseases							
Pneumonia	43.1 (3)	44.0 (4)	42.7 (4)	43.0 (4)	39.5 (5)	38.4 (5)	42.8 (4)
Tuberculosis, all forms	32.2 (6)	38.7 (6)	36.1 (6)	35.9 (6)	33.0 (6)	31.0 (6)	31.2 (6)
II. Noncommunicable diseases							
Diseases of the heart	69.8 (1)	78.4 (1)	79.1 (1)	88.2 (1)	83.5 (1)	84.8 (1)	90.4 (1)
Diseases of the vascular system	54.1 (2)	58.4 (2)	63.2 (2)	62.3 (2)	64.0 (2)	61.8 (2)	63.8 (2)
Malignant neoplasms	37.5 (5)	45.8 (3)	47.7 (3)	48.8 (3)	48.5 (3)	48.5 (3)	48.9 (3)
Chronic lower respiratory diseases	---	---	---	---	23.3 (8)	22.7 (8)	24.6 (7)
Diabetes Mellitus	9.4 (9)	13.0 (9)	14.1 (9)	17.5 (9)	17.5 (9)	19.8 (9)	21.6 (8)
Chronic obstructive pulmonary diseases & allied conditions	16.5 (7)	20.3 (7)	20.8 (7)	24.3 (7)	---	---	---
III. External causes							
Transportation accidents	39.9 (4)	40.2 (5)	42.4 (5)	42.3 (5)	41.9 (4)	41.3 (4)	39.1 (5)

Region	Rate per 100 000 population (Rank)						
	1997	1999	2000	2002	2003	2004	2005
IV. Others							
Certain conditions originating in the perinatal period	---	17.1 (8)	19.8 (8)	17.9 (8)	17.4 (10)	15.9 (10)	14.5 (9)
Nephritis, nephrotic syndrome & nephrosis	9.4 (10)	10.1 (10)	10.4 (10)	11.6 (10)	---	15.8 (10)	13.0 (10)
Ill-defined & unknown causes of mortality	---	---	---	---	---	25.5 (7)	---
Symptoms, signs & abnormal clinical, laboratory findings, NEC	---	---	---	---	26.3 (7)	---	---
Other diseases of the respiratory system	9.7 (8)	---	---	---	---	---	---

Source: FHSIS, DOH, 2009.

Table 1-5 Main causes of morbidity, 1997-2005 (selected years)

Region	Rate per 100 000 population (Rank)						
	1997	1999	2000	2002	2003	2004	2005
I. Communicable diseases							
Acute lower respiratory tract infection & pneumonia	908.1 (3)	829.0 (3)	837.4 (3)	924.0 (1)	861.2 (1)	929.4 (1)	809.9 (1)
Bronchitis/bronchiolitis	939.4 (2)	917.0 (2)	891.7 (2)	792.4 (3)	771.4 (3)	861.6 (2)	722.5 (2)
Influenza	673.5 (4)	658.5 (4)	641.5 (4)	609.3 (4)	550.6 (4)	454.7 (4)	476.5 (4)
TB respiratory	189.8 (6)	165.7 (6)	142.2 (6)	143.7 (6)	117.9 (6)	272.8 (6)	134.1 (6)
Malaria	89.3 (7)	66.6 (8)	52.0 (8)	50.3 (8)	36.5 (8)	23.8 (9)	42.3 (8)
Chickenpox	46.8 (9)	46.2 (9)	31.3 (10)	36.0 (9)	33.4 (9)	56(7)	35.3(9)
Dengue fever	--	--	--	--	--	19.0(10)	23.6(10)
Measles	--	30.5 (10)	31.4 (9)	31.0 (10)	32.6 (10)	--	--
Typhoid & paratyphoid fever	23.1 (10)	--	--	--	--	--	--
II. Noncommunicable diseases							
Hypertension	272.8 (5)	366.7 (5)	408.7 (5)	383.2 (5)	415.5 (5)	409.6 (5)	448.8 (5)
Diseases of the heart	82.7 (8)	69.4 (7)	60.4 (7)	65.7 (7)	38.8 (7)	44.4 (8)	51.5 (7)
IV. Others							
Acute watery diarrhoea	1,189.9 (1)	1,134.8 (1)	1,085.0 (1)	913.6 (2)	786.2 (2)	690.7 (3)	707.6 (3)

Source: FHSIS, DOH, 2009.

There is a slowing trend of reduction in child mortality, maternal mortality, as well as other indicators. This may be attributable to the poor health status of lower income population groups and less developed

regions of the country. Of grave national and international concern is the relatively high maternal mortality ratio of 162 per 100 000 live births (Table 1-7). Given this figure, it is unlikely that the 2015 target will be met for the Millennium Development Goals (MDG), which is to reduce maternal mortality ratio by three-quarters. The MDG targets for under-5 mortality and infant mortality are 18.0 and 19.0 deaths per 1000 live births, respectively. The downward trend appears to show that the MDG targets are achievable.

Table 1-6 Risk Factors affecting health status

Disease	Basis	Year	Prevalence, >20 years old (%)
Diabetes	FBS > 125 mg/dL or history or use of anti-diabetes medication	2003	4.6
Stroke	History	2003	1.4
Hypertension	BP or history	2003	22.5
Smoking, males	History	2003	56.3
Smoking, females	History	2003	12.1
Alcohol intake, adults	History	2000	46
Obesity, general	BMI ≥ 30	2003	4.8
Obesity, males	Waist-hip ratio → 1.0	2003	12.1
Obesity, females	Waist-hip ratio → 0.85	2003	54.8
Physical inactivity, adults	History	2003	60.5

Source: NSCB, 2010. Note: FBS - Fasting Blood Sugar

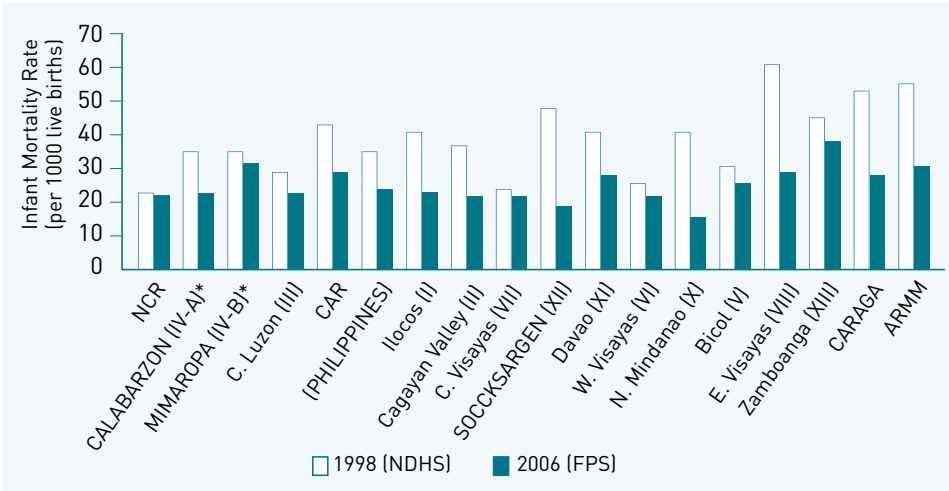
Disaggregation of indicators according to socio-economic groups and geographic areas reveals a wide disparity in health between high and low income groups as well as urban and rural dwellers. Figure 1-2 and Figure 1-3, which show the life expectancy at birth and infant mortality rate by region, respectively, reveal that highly developed areas such as the NCR and adjacent regions have relatively good health status while the less developed regions such as the Bicol Region, the Eastern Visayan provinces and the ARMM lag behind. Some proxy indicators also show that health outcomes are grossly inequitable. For example, as of 2008 the total fertility rate for women in the highest income quintile is about two, while women in the lowest quintile bear five children during their reproductive years (Figure 1-4).

Table 1-7 Maternal and child health indicators, 1970-2008

Indicator	1970	1980	1990	2000	2005	2008
Adolescent pregnancy rates (per 1000 women ages 15-19)	56	55	50a	53b	54c	--
Infant mortality rate, per 1000 live births	63	63	57	35d	29e	25
Under-5 mortality rate, per 1000 live births	--	--	54f	48d	40e	34
Maternal mortality rate, per 100 000 live births	--	182	181	172d	162c	--
HIV, no. of seropositive cases	--	--	66	123	210	342

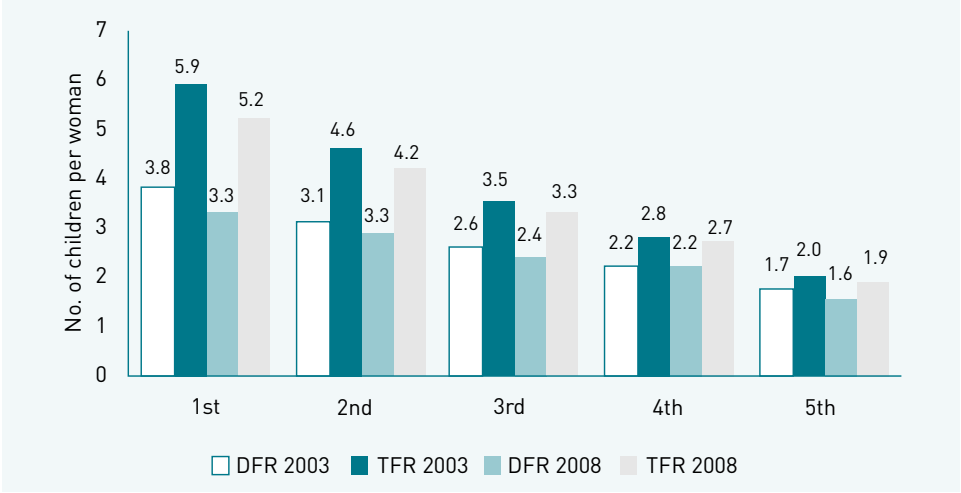
Source: NSCB, 2010.

Figure 1-3 Infant mortality rate per 1000 live births, by region, 1998 & 2006



Notes: S. – Southern; C. – Central; W. – Western; N. – Northern; E. – Eastern; Regions are sequenced according to average annual family income as of 2003, with NCR having the highest and ARMM, the lowest. Southern Luzon (IV) was divided into Region IV-A and IV-B in 2002.
Sources: NDHS 1998, FPS 2006.

Figure 1-4 Total desired fertility rate vs. total fertility rate, by wealth index quintile, 2003 & 2008



Note: DFR – Desired Fertility Rate; TFR – Total Fertility Rate.
Source: NDHS 2003 & 2008, NSO.

Social, economic, and geographic barriers result in inequity in access to services and explain the inequity in health outcomes. Poor people in greatest need for health care, namely, pregnant women, newborns, infants, and children, are underserved. Based on the 2008 NDHS, 66.0% of women in the lowest quintile in the country received iron tablets or syrup, whereas 91.5% of women from the top quintile obtained this vital supplement. While 83.0% of children age 12-23 months from top quintile homes received the EPI vaccines (BCG, measles and three doses each of DPT and polio vaccine) in 2003, only 55.5% of those from low quintile families did so. For maternal health, the most striking comparison is regarding place of delivery, with 83.9% of highest quintile women delivering in health facilities compared to just 13.0% of those in the lowest wealth index quintile. During deliveries, 94.4% of highest quintile women were attended by a doctor, nurse or midwife, compared to only 25.7% of lowest quintile women.

To summarize, inequity in health status and access to services is the single most important health problem in the Philippines. As the succeeding sections will show, this inequity arises from structural defects in the basic building blocks of the Philippine health system, including the low level of financial protection offered – problems which until recently have been inadequately addressed by reform efforts.

2. Organization and Governance

2.1 Section Summary

In its current decentralized setting, the Philippine health system has the Department of Health (DOH) serving as the governing agency, and both local government units (LGUs) and the private sector providing services to communities and individuals. The DOH is mandated to provide national policy direction and develop national plans, technical standards and guidelines on health. Under the Local Government Code of 1991, LGUs were granted autonomy and responsibility for their own health services, but were to receive guidance from the DOH through the Centres for Health Development (CHDs). Provincial governments are mandated to provide secondary hospital care, while city and municipal administrations are charged with providing primary care, including maternal and child care, nutrition services, and direct service functions. Rural health units (RHUs) were created for every municipality in the country in the 1950s to improve access to health care.

The private sector, which is much larger than the public sector in terms of human, financial and technological resources, is composed of for-profit and non-profit providers that cater to 30% of the population. Although the private health sector is regulated by the DOH and the Philippine Health Insurance Corporation, health information generated by private providers is generally absent in the information system of the DOH. Regulation of health science schools and universities is under the Commission on Higher Education, while the regulation of health professionals is carried out by the Professional Regulation Commission.

PhilHealth introduced health technology assessment (HTA) in the early 2000s to examine current health interventions and find evidence to guide policy, utilization and reimbursement. As a third party payer, PhilHealth regulates through the accreditation of health providers that are in compliance with its quality guidelines, standards and procedures. The Food and Drug Administration (FDA) regulates pharmaceuticals along with food, vaccines, cosmetics and health devices and equipment.

At present, patients´ rights and safety are expressed under the purview of the Penal Code and Medical Act of 1959 and health professional practice acts. The lack of a gatekeeping mechanism in the health system allows patients to choose their physicians. Patient empowerment, on the other hand, has remained more a concept than a practice. The relationship of the health system with individuals, families and communities is still largely one of giver to recipient.

Table 2-1 Principal Legislation in the Health Sector

Year	Act
1954	Republic Act No. 1082 "Rural Health Act".
1957	Republic Act No. 1939 "Contributions for the Maintenance of Hospital Beds".
1959	Republic Act No. 2382 "Medical Act".
1979	Adoption of primary health care (PHC)
1982	Executive Order 851 "Reorganizing the Ministry of Health, Integrating the Components of Health Care Delivery into its Field Operations, and for Other Purposes".
1987	Constitution of the Republic of the Philippines.
1988	Republic Act No. 6675 "Generics Act".
1991	Republic Act No. 7160 "Local Government Code".
1994	Republic Act No. 7722 "Higher Education Act".
1995	Republic Act No. 7875 "National Health Insurance Act".
1997	Republic Act No. 8344 "An Act Prohibiting the Demand of Deposits or Advance Payments for the Confinement or Treatment of Patients in Hospitals and Medical Clinics in Certain Cases".
1999	Republic Act No. 7305 "Magna Carta for Public Health Workers".
2003	Republic Act No. 9184 "Government Procurement reform Act".
2004	National Health Insurance Act of 1995 amended to Republic Act No. 9241.
2008	1988 Generics Act– amended to Republic Act No. 9502 "Cheaper and Quality Medicines Act".
2010	Republic Act No. 7432 'Senior Citizens Act" – amended to Republic Act No. 9994 "Expanded Senior Citizens Act".

2.2 Historical Background

Table 2-1 provides a list of principal legislation in the health sector. In 1941, the Department of Health was carved out of the Department of Health and Public Welfare and established as a separate entity. From the 1950s onwards, there was a steady improvement in patient care, medical education, and public health comparable to other developing countries. The national public network of health centres had its roots in the 1954

Rural Health Act, which transformed the puericulture centres to rural health units (RHUs) in municipalities and to city health centres in cities all over the country (DOH, 1995). In 1983, EO 851 integrated public health and hospital services under the integrated public health office (IPHO) and placed the municipal health office under the supervision of the chief of hospital of the district hospital.

Private sector health services, organized around free-standing hospitals, physician-run individual clinics, and midwifery clinics, have largely followed the North American models of independent institutions economically dependent on fee-for-service payments. They range in size from small basic service units operated by individuals to sophisticated tertiary care centres.

To improve the poor's access to health care, various reforms have been instituted over the past 30 years (DOH, 2005). Among these were: the adoption of primary health care (PHC) in 1979; the integration of public health and hospital services in 1983 (EO 851); the enactment of the Generics Act of 1988 (RA 6675); the devolution of health services to LGUs as mandated by the Local Government Code of 1991 (RA 7160); and the enactment of the National Health Insurance Act of 1995 (RA 7875). In 1999, the DOH launched the health sector reform agenda (HSRA) as a major policy framework and strategy to improve the way health care is delivered, regulated and financed.

Among these reform efforts, the Local Government Code (RA 7160 of 1991) changed the delivery of health services as it gave local government units (LGUs) responsibility for and financial management of their own health activities, with the DOH providing guidance and advice. After many protests and much criticism, this devolution was finally implemented in 1993.

Another key reform effort was the enactment of the National Health Insurance Act of 1995 (RA 7875), which replaced the Medicare Act of 1969 and established PhilHealth as the national health insurance corporation. It aimed to ensure universal coverage with financial access to quality and affordable medical care for all Filipinos by 2010.

2.3 Organization and Governance at Local Level

2.3.1 Local Government Level

The LGUs make up the political subdivisions of the Philippines. LGUs are guaranteed local autonomy under the 1987 Constitution and the LGC of 1991. The Philippines is divided into 78 provinces headed by governors, 138 cities and 1496 municipalities headed by mayors, and 42 025 barangays or villages headed by barangay chairpersons (NSCB, 2010). Legislative power at local levels is vested in their respective sanggunian or local legislative councils. Administratively, these LGUs are grouped into 17 regions.

Wlithin this decentralized setting, the LGUs continue to receive guidance on health matters from the DOH through its network of DOH representatives under the supervision of the regional centres for health and development (CHDs). Provincial governments are primarily mandated to provide hospital care through provincial and district hospitals and to coordinate health service delivery provided by cities and municipalities of the provinces. City and municipal governments are charged with providing primary care including maternal and child care, nutrition services and direct service functions through public health and primary health care centres linked to peripheral barangay health centres (BHCs) or health outposts.

2.3.2 Private Sector

A major share of the national expenditures on health (about 60%) goes to a large private sector that also employs over 70% of all health professionals in the country. The private sector consists of for-profit and non-profit providers which are largely market-oriented. Health care is paid through user fees at the point of service, or subsidized by official aid agencies or philanthropy. This sector provides services to an estimated 30% of the population who can mostly afford to pay these user fees.

The PhilHealth benefits scheme pays for a defined set of services at predetermined rates. However, claims payments are uncertain because both the whole claim and the items in each claim may be disregarded or reduced. Private hospitals derive a significant proportion of their incomes from PhilHealth payments as the largest number of PhilHealth members are employed in the private sectors and usually go to private hospitals for health care. HMOs and other private prepayment schemes

that supplement PhilHealth coverage of private sector employees further facilitate their accessing of private hospital care services.

The private health sector is regulated by the DOH through a system of standards implemented by licensure procedures of the department and accreditation procedures of the PhilHealth. Professional organizations, particularly medical specialty groups, also participate in certification systems and programmes.

2.4 Decentralization and Centralization

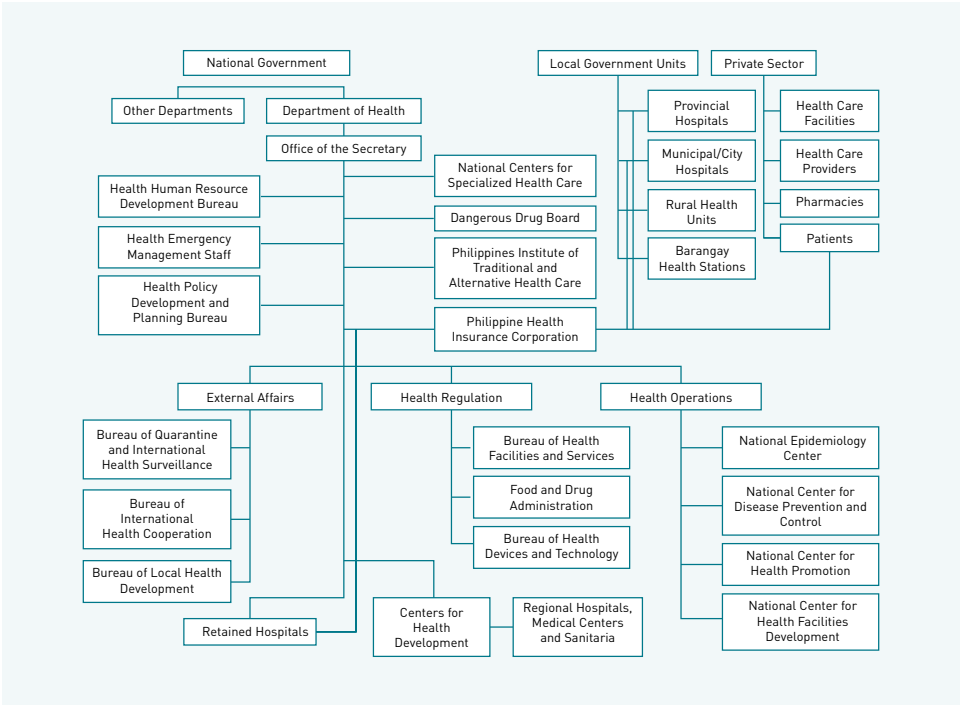
Under the decentralized or devolved structure, the state is represented by national offices and the LGUs, with provincial, city, municipal, and barangay or village offices. Figure 2-1 shows the structure of the Department of Health (DOH) alongside the levels of health facilities found in the LGU and the private sectors. The DOH, LGUs and the private sector participate, and to some extent, cooperate and collaborate in the care of the population.

Before devolution, the national health system consisted of a three-tiered system under the direct control of the DOH: tertiary hospitals at the national and regional levels; provincial and district hospitals and city and municipal health centres; and barangay (village) health centres. Since enactment of the 1991 LGC, the government health system now consists of basic health services–including health promotion and preventive units–provided by cities and municipalities, province-run provinicial and district hospitals of varying capacities, and mostly tertiary medical centres, specialty hospitals, and a number of re-nationalized provincial hospitals managed by the DOH.

The DOH was made the "servicer of servicers" by:

1) Developing health policies and programmes;
2) Enhancing partners' capacity through technical assistance;
3) Leveraging performance for priority health programmes among these partners;
4) Developing and enforcing regulatory policies and standards;
5) Providing specific programmes that affect large segments of the population; &
6) Providing specialized and tertiary level care.

Figure 2-1 Organizational structure & accountability in the health care system



The LGUs serve as stewards of the local health system and therefore they are required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. They are also in charge of creating an environment conducive for establishing partnerships with all sectors at the local level.

Among the LGUs, the Autonomous Region of Muslim Mindanao (ARMM) has a unique organizational and governance structure. It has retained the centralized character of its health system under the ARMM DOH, which directly runs the provincial hospitals and the municipal health centres under its jurisdiction instead of the component provinces and towns of ARMM.

2.5 Planning

2.5.1 Planning of human resources

The initial HRH plans developed by the DOH focused exclusively on health workers employed directly by DOH. The first truly national HRH

plan, covering all government employees (DOH and also health workers employed by the Department of Education, the armed forces etc) as well as those in private facilities, was crafted in the 1990s, but its implementation was hampered by changes such as migration of health workers, the increase in the number of nursing schools and globalization. In 2005, the DOH, in collaboration with WHO-WPRO, prepared a long-term strategic plan for HRH development. The 25-year human resource master plan from 2005 to 2030, was to guide the production, deployment and development of HRH systems in all health facilities in the Philippines. The plan includes a short-term plan (2005- 2010) that focuses on the redistribution of health workers as well as the management of HRH local deployment and international migration. A medium-term plan (2011-2020) provides for the increase in investments for health. A long-term plan (2021-2030) aims to put management systems in place to ensure a productive and satisfied workforce. The DOH also created an HRH network composed of different government agencies with HRH functions to support implementation of the master plan.

2.5.2 Health Facility Planning

In 1995, the National Centre for Health Facilities Development (NCHFD) of the DOH crafted the Philippine Hospital Development Plan to create a more responsive hospital system by delivering equitable quality health care across the country. The Plan underscored the importance of leadership; strategic planning based on population needs; accessibility of services especially those in hard-to-reach areas; technical and human resource development; operational standards and technology; and networking in the development of hospitals. As part of HSRA, the Plan was revised in 2000. The new Plan included an investment of Php 46.8 billion to develop 256 LGU district hospitals, 70 provincial hospitals, 10 city hospitals and 70 DOH retained hospitals. In 2008, the plan was expanded and renamed the Philippine Health Facility Enhancement Programme (HFEP). The expansion included the inclusion of rural health centres and village health stations. From 2007 to 2010, a further Php 8.43 billion was invested in infrastructure and equipment upgrade projects to support health sector reforms and the MDGs (Abesamis, 2010).

The building of hospitals and other health facilities is planned and designed according to appropriate architectural practices, functional programmes and codes of the DOH. Relevant guidelines include AO 29 series of 2006 (Guidelines for Rationalizing the Health Care Delivery

System based on Health Needs) and AO 4-A and 4-B of 2006 (Guidelines for the Issuance of Certificate of Need to Establish a New Hospital). The Rationalization Plan serves as a requirement for the crafting of the Province-wide Investment Plan for Health (PIPH) by provinces, cities or ILHZs.

The AO on the Certificate of Need (CON), also created in 2006, stipulates the requirements for establishing new hospitals, upgrading or converting them, and increasing the bed capacity of existing hospitals. This policy applies to both government and private hospitals. The proposed health facility's catchment population, location and the LGUs' commitment to fund and maintain the health facility are all taken into account. For secondary and tertiary hospitals, utilization rate, number of staff and bed-to-population ratio are also considered. Each CON is evaluated in the context of the Province/City/ILHZ Strategic Plan for Rationalization of Health Care Delivery System.

The regulation of hospitals, on the other hand, is mandated by R.A. 4266 or the Hospital Licensure Act. To support the implementation of the law, Administrative Order 147 series of 2004 was crafted to govern the registration, licensing and operation of hospitals and other health facilities.

2.6 Health Information Management

2.6.1 Information Systems

The current state of health information systems closely reflects the larger health system. The national and local health information systems are poorly integrated and are weakly governed (Marcelo, 2005). These negative conditions create information gaps at the national and local levels. The lack of health informatics standards -- which prevents any system from scaling at a faster rate or inter-operating with another system – is a key issue. Vertical disease surveillance systems also have produced redundancies and duplications. Some of these systems include the (a) NDRS, FHSIS or Notifiable Disease Reporting System of the Field Health Service Information System; (b) NESSS or National Epidemic Sentinel Surveillance System; (c) EPISurv or Expanded Programme on Immunization diseases targeted for eradication or, Elimination Surveillance System; and (d) IHBSS or Integrated HIV/AIDS Behavioural and Serologic Surveillance System.

The DOH has attempted to address this fragmentation by developing the Philippine Integrated Disease Surveillance and Response Project or PIDSR (Tan, 2007). The PIDSR aims to establish a surveillance system that enables early detection, reporting, investigation, assessment, and prompt response to emerging diseases, epidemics and other public health threats (Figure 2-2). This was followed by a DOH-led Philippine Health Information Network (PHIN) in 2008 which designed and now implements the Philippine Health Information System (PHIS). The PIDSR, PHIN and PHIS clearly document the health information strategy at the national and regional levels but the specifics and operational aspects at the field level (barangay) and among individual patients are vague at best.

At the local level, the information gap in rural health information systems is to some degree being addressed by the University of the Philippines Manila's Community Health Information Tracking System or CHITS (Tolentino, 2004), which provides as an electronic medical records system for rural health units. CHITS is now operating in several health centres. As it is free and is an open source software, it allows partnerships with other universities who then embed CHITS into their undergraduate health and IT professions education. Lessons from the implementation of CHITS show the importance of preparing trainee health workers on how to use electronic medical records as documentation and quality assurance tools for health care.

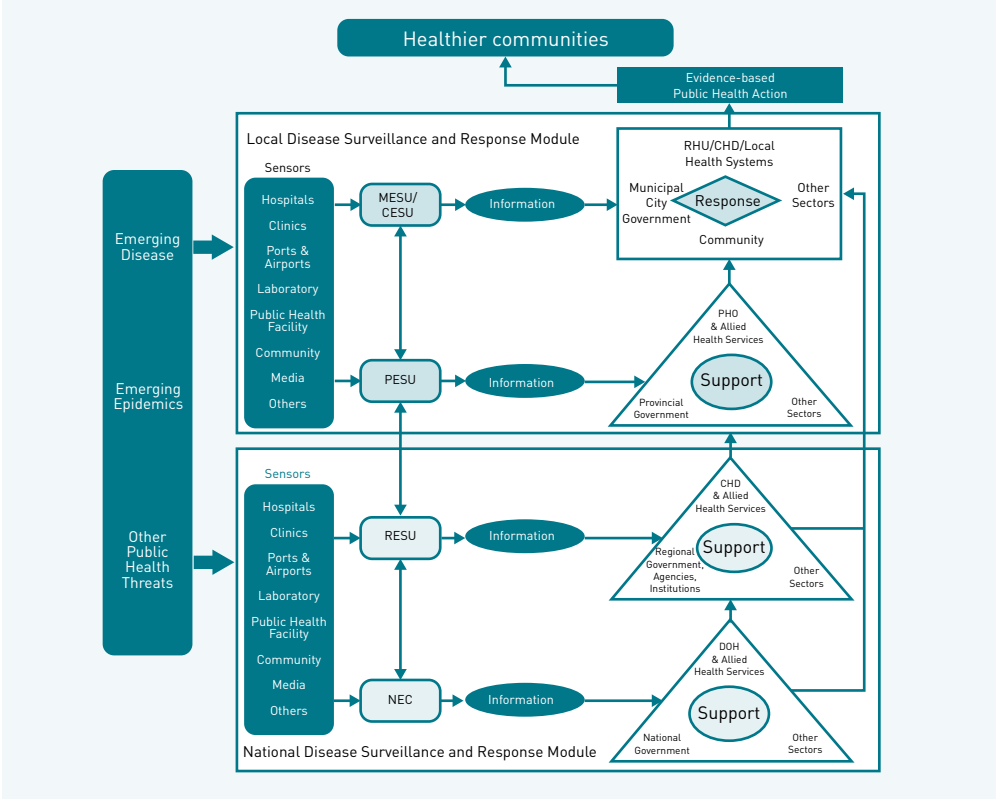
The experience of vertical information systems at the DOH provides a concrete example of the problems associated with the lack of health informatics standards, mentioned above. The Electronic TB (Tuberculosis) Registry and the Philippine Malaria Information System or PhilMIS are DOH-implemented projects supported by the Global Fund and the World Health Organization. Both systems are now being maintained by the DOH's National Epidemiology Centre (NEC). Unfortunately, private sector information, which forms a large bulk of actual transactions with family physicians and general practitioners, is essentially absent in these DOH systems. This is partly due to weak enforcement of information-sharing regulations but also reflects a preference for proprietary software in private facilities, which limits the ability of the DOH to obtain assistance from other IT specialists in other sectors.

The Philippine Health Insurance Corporation has the largest clinical database in the country and has one of the most sophisticated information technology infrastructures. Yet it still manages claims manually, using

paper. This adds undue burden on both providers and payers and increases the cost of processing claims on hospitals and on Philhealth. Out of the nine steps required to process claims electronically, Philhealth is now at step 2 (eligibility checking) and is progressing slowly. The incomplete implementation also prevents the corporation from realizing the economic benefits from computerization. In terms of information use, the lack of timely, accurate data from claims limits PhilHealth's ability to detect fraud and monitor disease patterns.

In summary, the lack of IT governance structures such as explicit standards and blueprints for health information, in addition to unclear considerations for the role of IT in primary health care, hinder the wide-scale deployment of reliable and operable information systems in the country.

Figure 2-2 Philippine Integrated Disease Surveillance and Response Framework



Note: CESU – City Epidemiology and Surveillance Unit; CHD – Centre for Health Development; CHO – City Health Office; DOH – Department of Health; MESU – Municipal Epidemiology and Surveillance Unit; NEC – National Epidemiology Centre; PESU – Provincial Epidemiology and Surveillance Unit; PHO – Provincial Health Centre; RESU – Regional Epidemiology and Surveillance Unit; RHU – Rural Health Unit.
Source: PIDSR Manual, DOH

2.7 Regulation

2.7.1 Overview and history of health regulation in the country

The main government health care regulators are the DOH for goods, services and facilities and the Professional Regulations Commission (PRC) for professional health workers. The DOH's regulatory agencies consist of the Food and Drug Administration or FDA (formerly Bureau of Food and Drugs), the Bureau of Health Facilities and Services (BHFS), the Bureau of Health Devices and Technology (BHDT) and the Bureau of Quarantine (BOQ). The FDA is responsible for the regulation of products that affect health while BHFS covers the regulation of health facilities and services. BHDT regulates radiation devices, and BOQ covers international health surveillance and security against the introduction of infectious diseases into the country. In addition, as an agency linked to the DOH, Philhealth through its accreditation process also has a regulatory function, which overlaps with that of DOH.

The LGC has no direct provision for health regulation by local government units. The general powers and authorities granted to the LGUs, however, do carry several regulatory functions that can directly or indirectly influence health. These include the issuances of sanitary permits and clearances, protection of the environment, inspection of markets and food establishments, banning of smoking in public places, and setting taxes and fees for local health services. However, the regulation and issuance of licenses and other regulatory standards pertaining to the operation of hospitals and health services remain with the DOH.

There are many challenges to improving the current health regulatory system. Scarce resources are invested in the implementation of rules and mandates. There are few technical experts in the DOH bureaucracy that can handle the areas of quality assurance of health care and certification, conformity testing and the monitoring of health products, or products that can affect health.

2.7.2 Regulation and governance of third party payers

PhilHealth, the country's national health insurance programme, is governed by the National Health Insurance Act of 1995 or the Republic Act 7875, which replaced the Medicare Act of 1969. It is mandated to provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines (RA 7875).

The president of the Philippines appoints the members of the board of directors, comprised by the secretary of health (ex officio chair), the president of the corporation (vice–chair), a representative from: labor and employment; interior and local government; and social welfare and development; a representative from the labor sector and on behalf of employers; the SSS administrator or a representative, the GSIS general manager or a representative, the vice chairperson for the basic sector of the National Anti-Poverty Commission or a representative, a representative of the Filipino overseas workers, a representative of the self-employed sector, and a representative of health care providers to be endorsed by the national associations of health care institutions and medical health professionals (RA 9241, section 3).

The board serves as the policy-making and quasi-judicial body of the corporation. Among other areas, it sets and implements the policies, standards, rules and regulations of contributions and benefits (the portability of benefits, cost containment and quality assurance); and health care provider arrangements, payment methods, and referral systems (IRR of RA 9241). Under the law, congress retains oversight functions. Private health insurance and HMOs, which comprise 6.88% of total health expenditures, are regulated jointly by the Philippine Insurance Commission and DOH (NHA, 2007).

2.7.3 Regulation and governance of providers

The DOH Bureau of Health Facilities and Services (BHFS) with the regulatory teams in Centres for Health Development (CHDs) is in charge of licensing hospitals, clinics, laboratories and other health facilities. It sets the regulatory policies and standards of licensing, accreditation and monitoring of health facilities and services to ensure quality health care. Yearly, the DOH requires all health facilities to renew their license to operate. However, there are challenges in the implementation of adequate quality assurance measures. These include inadequate capacity building for regulatory officers and fast turnover and lack of availability of permanent positions for regulatory officers in CHDs. In the private sector, international quality certification efforts are driven by the government's policy of promoting medical tourism.

PhilHealth also exercises regulatory functions through accreditation and other quality control mechanisms. RA 7875 explicitly mandates PhilHealth to "promote the improvement in the quality of health services

through the institutionalization of programmes of quality assurance". In 2001, PhilHealth developed the Benchbook on Quality Assurance which introduces process and outcome-focused standards of accreditation. This focuses on safety, effectiveness and appropriateness of health care, consumer participation, access to services, and efficiency of service provision. Since 2010, the Benchbook has been applied to all hospitals applying for PhilHealth accreditation, though it is still too early to assess its impact. Related to this, a unified and streamlined DOH licensure and PhilHealth accreditation for hospitals and health facilities is currently being discussed.

2.7.4 Regulation of health professional schools

The Commission on Higher Education (CHED) is the governing body that regulates both public and private higher education institutions as well as degree-granting programmes in all tertiary educational institutions, including health science schools in the Philippines (CHED, 2009). The CHED is responsible for ensuring access to quality education; however, political will to guarantee this seems to be insufficient. Nursing schools have mushroomed over the years (Table 2-2) due to the demand for Filipino nurses in other countries, making it difficult to standardize and assess the quality of education.

Table 2-2 Trend in the Number of Nursing Schools, Philippines, AY 1998-99 to 2007-08

Academic Year	# of Nursing Schools	% Change
1998-99	189	
1999-00	185	(2.12)
2000-01	182	(1.62)
2001-02	201	10.44
2002-03	230	14.43
2003-04	301	30.87
2004-05	328	8.97
2005-06	437	33.23
2006-07	439	0.46
2007-08	466	6.15

Note: AY – Academic Year
Source: CHED-MIS, 2009

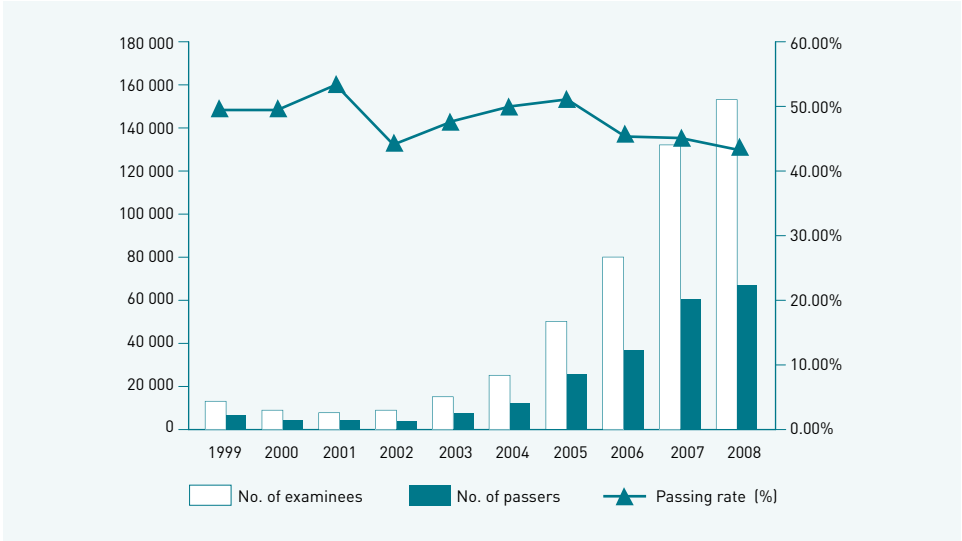
In 2005, the CHED Technical Panel for Nursing Education issued the Nursing School Report Card that classified nursing schools based on performance. This is measured by the schools' average licensure rating within a five-year period. In 2005, it was found that only 13% of the total number of schools produced quality graduates, as shown by their consistently high licensure passing rate of 75% and above. In spite of the evaluation, the increase in nursing schools persisted. To date, no schools have yet been closed by the CHED due to poor quality education or licensure exam performance, demonstrating a lack of political will to improve the system.

2.7.5 Registration/licensing of health workers

The Professional Regulations Commission (PRC) administers, implements and enforces the regulatory policies of the national government with respect to the regulation and licensing of the various professions and occupations under its jurisdiction, including the enhancement and maintenance of professional and occupational standards and ethics and the enforcement of the rules and regulations. It administers and conducts the licensure examinations of the various regulatory boards twice a year. It is made up of professional regulatory boards that monitor the conditions affecting the practice of professions and, whenever necessary, can adopt measures as may be deemed proper for the maintenance of high professional, ethical and technical standards.

Among the professionals regulated by the PRC are nurses, doctors, dentists, pharmacists, midwives and physical and occupational therapists. The regulatory boards are responsible for preparing the licensure examination of health professionals. This examination is commonly taken a few months after graduation. A professional license to practice is awarded by the PRC as the graduate passes the examination; not all who take the examination pass and obtain their license. As far as the nursing licensure from 1999-2008 is concerned, only about half pass the exam (Figure 2-3). This figure shows that while there is a rapid increase in the number of nursing graduates, advancement towards the professional level seems to be difficult. As shown by the figure, the national average passing rate is only 49.19% for the 10-year period.

Figure 2-3 Nursing Licensure Examination Trends, 1999-2008



Specialty societies in medicine, surgery, obstetrics and gynaecology and paediatrics practice self-regulation in their field of expertise. These organizations set standards and recognize or provide accreditation to hospitals that offer residency training in their specialties. Candidates have to pass examinations given by these organizations to merit the title of "Diplomates of the society." These societies monitor the practice and hold continuing education programmes for their members, encouraging members to participate in conferences and other society activities. The accreditation function of the specialty societies is sanctioned by the Professional Regulating Committee and accepted by the Philippine Medical Association (PMA).

2.7.6 Health technology assessment

In the early 2000s, health technology assessment (HTA) was introduced by PhilHealth and a committee was established to examine current health interventions and find evidence to guide policy, utilization and reimbursement. The HTA committee works to identify priority problems on the use of medical technologies needing systematic assessment. It also conducts assessments on the use of medical devices, procedures, benefit packages and other health-related products in order to recommend to Philhealth the crafting of benefit packages. In addition, HTA capabilities are due to be strengthened through the new health technology unit of the FDA recently reinforced by legislation.

2.7.7 Regulation and governance of pharmaceutical care

Pharmaceuticals are regulated by the FDA which was recently strengthened by a new law—RA 9711. This established four specialty areas: (1) Centre for Drug Regulation and Research (to include veterinary medicine and vaccines); (2) Centre for Food Regulation and Research; (3) Centre for Cosmetics Regulation and Research (to include household hazardous/urban substances); (4) Centre for Device Regulation, Radiation Health, and Research, formerly the Bureau of Health Devices and Technology. A director-general with quasi-judicial powers heads the FDA.

Some of the challenges that the FDA faces include the following: (1) real and perceived quality concerns that have affected generic drug products for two decades because not all drug companies comply with bioequivalence requirements; (2) the fact that compliance to current good manufacturing practice (cGMP) certification is not applied to the sources of finished medicine products imported by local importers; and (3) the lack of an effective post-marketing surveillance that covers functional adverse drug reactions (ADR) monitoring within the context of an integrated pharmaco-vigilance system (among regulators, industry and health care providers).

The Philippine National Drug Formulary (PNDF) is a regulatory tool of the DOH. This formulary is a list of essential medicines reviewed and recommended by the National Formulary Committee, which serves as a basis for all government drug procurement and for PhilHealth reimbursements. Related to this is the revised Generics Act of 2008 (RA 9502), which strengthened the provision of and access to quality and cheap medicines through mechanisms such as compulsory licensing, parallel importation, price controls and generic substitution at the point of sales.

2.7.8 Regulation of capital investment

The DOH exercises regulatory control over the establishment of new DOH health facilities. The planning of hospital physical facilities should be in accordance with needs and plans approved by the National Economic Development Authority (NEDA). The review of plans is within purview of the DOH´s National Centre for Health Facility Development (NCHFD). DOH AO 2006-0023 provides a mechanism to avoid costly competition by regulating the establishment of service facilities in a given geographic setting. For both government and private health facilities, LGUs

represent another level of regulation, such as the issuing of licenses for environmental clearances.

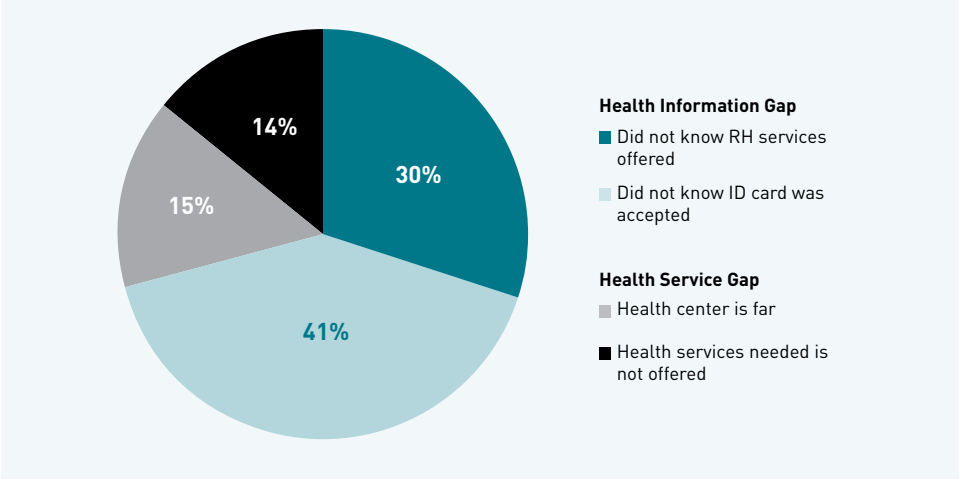
2.8 Patient Empowerment

2.8.1 PhilHealth and Patient Information

PhilHealth is mandated to provide health education to address the health care information gap. As determined by the Corporation and from Republic Act 7875, section 10 – the following will be provided: inpatient care with inpatient education packages and outpatient care with personal preventive services. Furthermore, the Implementing Rules and Regulations calls for health education packages. These may be provided by community-based health care organizations, physicians and midwives, etc.

A study carried out by PhilHealth in 2006 among its sponsored members (Figure 2-4) found that the major reasons for non-use of health centres were lack of health care information and inadequate service provision. Approximately 30% did not know what health care services were available; another 41% did not know that PhilHealth membership was accepted in health centres, and 29% of respondents were unable to access the services they needed.

Figure 2-4 Sick Members not using PhilHealth ID card for Health Centre Services



Source: PHIC, 2006.

The status of information received by sponsored members is a reflection of the information gap in the outpatient benefit (OPB) package. Just over half or 54% of survey respondents were given information on the availability of the OPB in the health centre, while 46% were provided information on what benefits are included by PhilHealth. Only 57% of sponsored members were informed about their reproductive health benefits, 44% were told what services are included in the package, and 39% what laboratory services they could receive from the health centre. In contrast, more than 90% of respondents knew that they could use their PhilHealth membership for hospitalization.

2.8.2 Patient Rights

The Philippine government through its 1987 Constitution and several international instruments explicitly recognizes health as a human right. Specifically, the Constitution establishes the rights of patients with the following provisions:

- The State shall protect and promote the right to health of the people and instill health consciousness among them. (Sec 15, Art II, 1987 Constitution); and
- No person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the laws. (Sec 1, Art III, 1987 Constitution)

In addition, patients´ rights are protected under the purview of the Revised Penal Code and the Medical Act of 1959.

2.8.3 Patient Choice

There is no effective gatekeeping mechanism. Patients are free to choose their physicians, including specialists. However, poor patients have extremely limited choice of service provider due to financial constraints. Patients' choice may also be affected by the providers' or health facilities' accreditation by PhilHealth. As of 2008, not all health facilities are accredited with PhilHealth. Only 1531 hospitals, 843 Rural Health Units, 19 dialysis clinics, 406 TB- DOTS clinics, 288 maternity clinics and 20 576 physicians are accredited by PhilHealth (PHIC, 2009).

2.8.4 Patient Safety

The Code of Ethics of the Medical Profession in the Philippines promulgated as Republic Act No. 4224 establishes the right of the patient to proper treatment by physicians.

The law stresses the need for a high standard of care in the medical profession and the protection of every Filipino's right to life. Proposed legislative proposals for formal laws on "Patients´ Rights" and "Medical Malpractice", have been recently rejected.

2.8.5 Patient Participation/Involvement

Although the DOH adopted PHC in 1979, patient empowerment has remained more a concept than a practice. The relationship of the health system to individuals, families, and communities is still largely one of giver to recipient. On the whole, the patient and community remain recipients of health care. While there has been increasing awareness of the need for community and patient participation in health decision-making, structures for ensuring this are still weak or non-existent (DOH, 2005). Organized communities have been encouraged to take the initiative and provide the human resources needed for health care, such as community health workers to address basic health care gaps (Espino et.al., 2004), but they have not been given the guidance and the needed capacity building support.

3. Financing

3.1 Section Summary

Over the years, nominal health care spending has been steadily increasing. Low efficiency in spending by the government and low utilization rates of PhilHealth indicate that the problem is not only the overall amounts spent but also optimizing the use of available resources.

Clearly, the most important concern is that the burden of health care spending falls mostly on private households as out-of-pocket (OOP) payments, with a share of over 48% of total health expenditure. This overreliance on OOP spending is the most worrisome, especially in the context of a political commitment to a social health insurance programme with a mandate to provide universal coverage. Moreover, poor households are more vulnerable than the rich—they are more prone to illness, their OOP payments are relatively larger, and they are unable, for structural reasons (such as a lack of awareness and difficulty in identifying the truly poor), to maximize the use of social protection provided by the government.

Philippine health care financing is a complex system involving various players, at times operating in unsynchronized ways. The public and private sectors, while to some extent providing similar basic services, are organized very differently. Public and private health care professionals face very different types of financial incentives. Public facilities, whether devolved or retained, are generally autonomous and thus, their performance depends to a large extent on resources at their disposal and the ability of their managers. On the other hand, private health providers respond primarily to market forces. As such, outcomes (e.g. quality) across public and private sectors are uneven. The PhilHealth programme in itself is quite complex. The benefits package is long and continues to have additions. The system of charging and collecting premiums varies by and within programmes. Members' perceptions are that they have insufficient information and that the transactional requirements to make claims are too large. Moreover, although estimates of PhilHealth

coverage of the population vary, there are legitimate concerns that the amount of financial protection provided by the country's largest insurance programme is actually small, at least relative to its infrastructure and available resources.

In 2010 the newly-elected government launched a major reform effort aimed at achieving 'universal coverage' which focused on increasing the number of poor families enrolled in PhilHealth, providing a more comprehensive benefits package and reducing or eliminating co-payments. So far the results are promising. As of April 2011, almost 4.4 million new poor families had been enrolled in PhilHealth, equivalent to a 100 percent increase in enrollment for the real poor. In 2011, PhilHealth introduced a no-balanced-billing policy for these sponsored households.

Devolution has its advantages, but one disadvantage is that it reduces the potential benefits from pooling resources in the public sector. PhilHealth is unable to compensate for this loss in purchasing power as long as balanced billing is allowed and prices charged by health care providers are not negotiated (i.e. PhilHealth's purchasing power is not exercised). Government budgets are historically determined and rather sensitive to political pressures. Thus, the introduction of health care financing reforms intended to provide stronger incentives for the rational allocation of resources (e.g. performance-based budgets) is likely to be operationally challenging.

3.2 Health Expenditure

Total health care expenditure per capita, in nominal terms, has increased steadily from 1995 to 2005 at an average annual rate of 8.2% (Table 3-1). In real terms, however, health expenditure per capita has grown by only 2.1% per year, suggesting that increases in nominal spending have been mostly due to inflation rather than service expansion. The Philippines allotted 3.0-3.6% of its gross domestic product (GDP) to health between 1995 and 2005 (Table 3-1). This share rose slightly to 3.9% in 2007 (Figure 3-1), but remains relatively low, compared with the WHO Western Pacific Region 2006 average of 6.1%.

In the Philippines, there are three major groups of payers of health care: (1) national and local governments, (2) social health insurance, and (3) private sources. Government accounted for 29-41% of total health expenditures in the period 1995-2005. Health as a share of total

government spending in the same period was about 5.9%, lower than in Thailand (10%), only slightly higher than Indonesia (4.1%) and comparable to Viet Nam (6.3%).

The social health insurance programme, known as PhilHealth, increased its share of total health spending at an average annual rate of 9.7% from 1995 to 2005. "Public funding" through PhilHealth has been expected to set the incentive environment in order to have a greater leverage and drive forward health system performance. However, the 2007 share of less than 9% remains low, at least relative to the 30% target set by the DOH in the 1999 health reform agenda to reduce out-of-pocket share of total health expenditure.

The private sector continues to be the dominant source of health care financing, with households' out-of-pocket (OOP) payments accounting for 40-50% of all health spending in the same period. In recent years, the trend for OOP payments has been upward despite the expansion of social insurance.

The government, as a whole, spent more on personal health care than public health care each year from 1995 to 2005 (Table 3-2). More detailed expenditure accounts indicate that spending on hospitals dominated the government's personal health care expenditures. The government also allots a much larger share of its resources to salaries of employees compared to maintenance and operations and capital outlay (Table 3-3). The share of capital outlay both by national and local governments to total health expenditures is negligible.

Table 3-1 Trends in health care expenditure, 1995-2005

Selected indicators	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Mean annual growth rate
THE per capita (in Php at current prices)	961	1099	1226	1288	1397	1493	1484	1461	1804	1978	2120	8.2
THE per capita (in Php at 1985 prices)	411	431	454	435	442	453	425	405	472	494	507	2.1
THE per capita (in PPP int. $ at 1995 prices)	68	68	68	60	57	56	51	47	54	55	54	-2.2
THE (as % of GDP)	3.4	3.5	3.6	3.5	3.5	3.4	3.2	3.0	3.4	3.4	3.3	
Health expenditure by source of funds (as % of THE)												
Government	35.0	36.0	38.0	39.1	39.2	40.6	36.2	31.0	31.1	30.7	28.7	
National	19.2	19.7	20.3	20.8	20.7	21.2	17.1	15.8	15.2	15.7	15.8	
Local	15.9	16.2	17.6	18.4	18.5	19.3	19.1	15.2	15.9	15.0	12.9	
Social insurance	4.5	5.0	5.1	3.8	5.0	7.0	7.9	9.0	9.1	9.6	11.0	
PhilHealth (Medicare)	4.2	4.7	4.8	3.5	4.8	6.8	7.7	8.8	8.6	9.4	10.7	
Employee's compensation (SSS & GSIS)	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.5	0.3	0.4	
Private sources	59.6	58.1	56.1	56.1	54.5	51.2	54.5	58.6	58.6	58.5	59.1	
Out-of-pocket (OOP)	50.0	48.3	46.5	46.3	43.3	40.5	43.9	46.8	46.9	46.9	48.4	
Private insurance	1.8	1.7	1.9	2.0	2.2	2.0	2.5	2.9	2.3	2.5	2.4	
HMOs	2.0	2.3	2.5	2.9	4.0	3.8	3.1	3.6	4.7	4.3	3.9	
Employer-based plans	4.9	5.0	4.4	4.0	4.0	3.7	3.9	4.1	3.4	3.6	3.2	
Private schools	1.0	0.9	0.8	0.9	1.0	1.1	1.2	1.3	1.3	1.2	1.2	
Others	0.8	0.9	0.9	1.0	1.3	1.3	1.3	1.4	1.2	1.2	1.2	
THE (in billion Php at 1995 prices)	65.7	70.5	76.0	74.6	77.6	81.5	78.0	76.0	90.3	96.5	101.0	4.4
GDP (in billion Php at 1995 prices)	1906	2017	2122	2110	2181	2312	2352	2457	2578	2742	2878	4.2
Total government spending (as % of GDP)	19.9	22.1	23.2	23.8	23.2	19.8	19.8	17.8	18.0	17.1	16.7	
Government health spending (as % of total government spending)	6.1	5.8	5.9	5.8	5.9	7.0	5.9	5.1	5.9	6.1	5.7	
Government health spending (as % of GDP)	1.2	1.3	1.4	1.4	1.4	1.4	1.2	0.9	1.1	1.0	1.0	

Note: THE – Total Health Expenditure
Source: Philippine National Health Accounts 2005, NSCB.

Figure 3-1 Health expenditure as a share (%) of GDP, Philippines & other countries, 2007

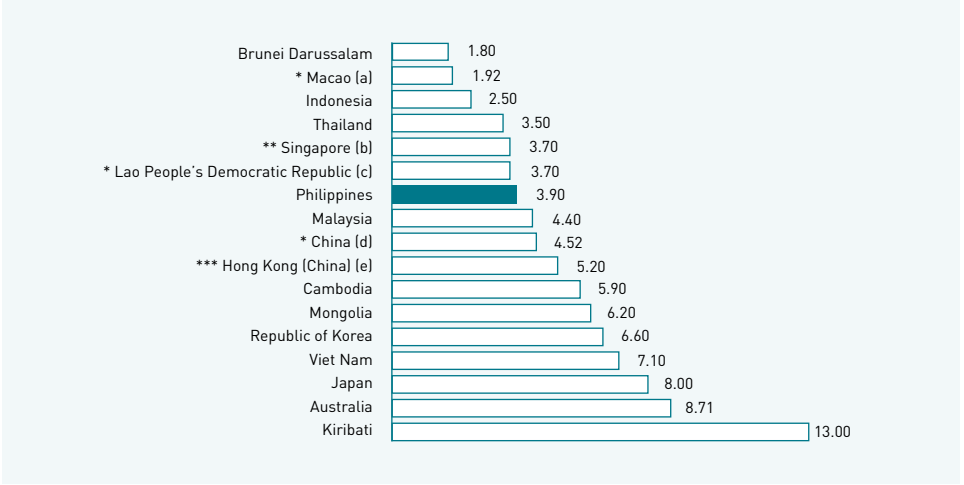


Table 3-2 Government health expenditure, by use of funds (% of THE), 1995-2005

Year	National			Local			Total		
	Personal	Public Health	Others	Personal	Public	Others	Personal	Public Health	Others
1995	10.7	3.7	4.8	4.3	7.9	3.7	15.0	11.7	8.4
1996	11.7	4.4	3.6	4.4	7.9	3.9	16.1	12.3	7.5
1997	11.0	4.4	4.9	4.5	9.0	4.2	15.5	13.4	9.1
1998	12.8	4.3	3.7	5.0	8.9	4.4	17.8	13.3	8.1
1999	13.3	4.0	3.5	4.9	8.7	4.8	18.1	12.7	8.4
2000	13.5	4.5	3.3	4.7	9.3	5.3	18.2	13.8	8.6
2001	10.1	4.4	2.6	5.0	9.2	4.9	15.1	13.6	7.4
2002	9.8	3.4	2.6	3.7	6.9	4.6	13.5	10.3	7.2
2003	9.7	2.7	2.8	4.3	7.6	4.1	13.9	10.3	6.9
2004	9.5	3.3	2.9	3.8	6.8	4.4	13.3	10.1	7.3
2005	8.5	5.1	2.2	3.3	6.0	3.6	11.8	11.1	5.8

Source: Philippine National Health Accounts 2005, NSCB.

Table 3-3 Government health expenditure, by type of expenditure (% of THE), 2005

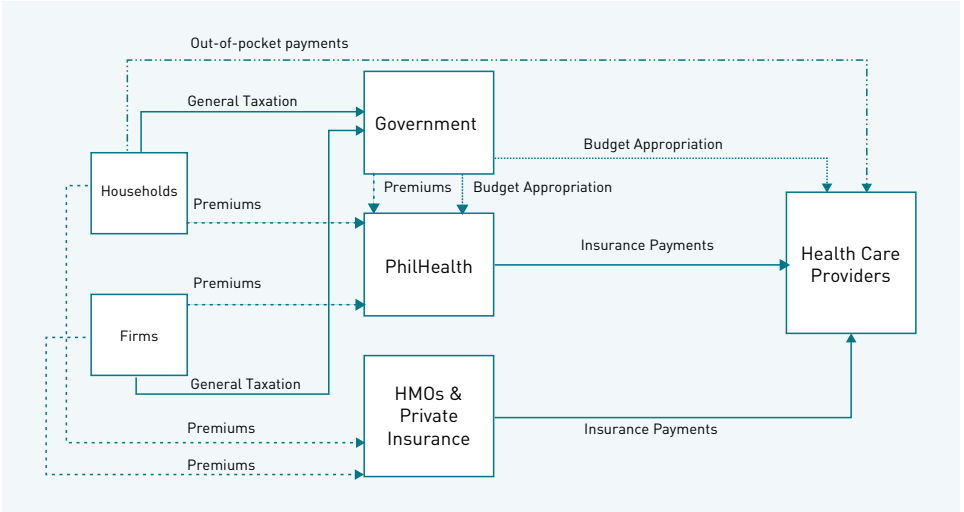
Expenditure item	National		Local	Total by type
	DOH & attached agencies	Other NG agencies		
Salaries	3.87	1.90	8.87	14.63
Maintenance & other operating expenses	3.71	1.45	3.73	8.89
Capital outlay	0.04	0.01	0.27	0.33
Total by source	7.61	3.37	12.87	23.85

Note: Excludes expenditure on foreign assisted projects (FAPS), which could not be disaggregated by expenditure type. FAPs were 4.87% of THE in 2005. Total by type in 2005 including FAPs is 28.7.
Source: Philippine National Health Accounts 2005, NSCB.

3.3 Sources of Revenue and Financial Flows

Figure 3-2 shows a simplified representation of the flow of health care resources from health care payers to the health care providers. "Government" can still be further divided into local and national and "health care providers" can be further segmented into public and private. The ultimate sources of health care funds are households and firms, while the pooling agencies include the government and PhilHealth, as well as HMOs and private insurance companies. In general, there are four types of financial flows in the sector: (1) OOP payments from households to health care providers, (2) premium contributions or prepayment from households and firms either to PhilHealth, HMOs or private insurance carriers, (3) budget appropriations from government for public health care facilities as well as for PhilHealth, and (4) taxes paid by households and firms to fund budget appropriations.

Figure 3-2 Financial Flows



3.4 Overview of the Statutory Financing System

3.4.1 Coverage

In the Philippines, the National Health Insurance Programme (NHIP) is the largest insurance programme in terms of coverage and benefit payments. The private insurance and HMO sector has grown considerably in recent years, but continues to account for a small share of total health spending (less than 7%).

NHIP Coverage Breadth

In 1995, the Philippines passed the National Health Insurance Act (RA 7875), which instituted the NHIP. The law also created the Philippine Health Insurance Corporation (PHIC), more commonly known as PhilHealth, to administer the NHIP and to replace the then existing Philippine Medical Care Commission that operated the Medicare Programme.

Prior to the institution of the NHIP, the government had administered a compulsory health insurance programme for the formally employed known as the Medicare Programme. In 1997, PhilHealth assumed the responsibility of administering the Medicare Programme for government employees from the Government Service Insurance System (GSIS) and in 1998, for private sector employees from the Social Security System (SSS). These formally employed individuals constitute the PhilHealth's "regular

programme". In 1996, the sponsored programme (SP) was launched to accelerate coverage of poor households. Three other programmes were initiated primarily to expand PhilHealth enrolment of specific population groups. In 1999, PhilHealth launched the individually-paying programme (IPP) that primarily targeted the informal sector and other sectors of society that are difficult to reach. The IPP covers the self-employed, those who were separated from formal employment, employees of international organizations, and other individuals who cannot be classified in the other programmes (e.g. unemployed individuals who are not classified as poor). In 2002, the non-paying programme was introduced to target pensioners and retirees. Finally, in 2005, PhilHealth assumed the administration of the Medicare Programme for overseas Filipino workers (OFWs) from the Overseas Workers Welfare Administration.

According to the 2007 annual poverty indicators survey (APIS), only about 37% of households have at least one household member who is covered by PhilHealth (Capuno and Kraft, 2009). The 2008 NDHS similarly indicates a 38% PhilHealth coverage rate among the population. However, from 2000 to 2008, PhilHealth's official coverage rate almost doubled (Table 3-4). Private sector employees account for the largest share of PhilHealth membership. A huge increase in the coverage rate was recorded in 2004 when SP enrolment grew by over 350%, largely owing to subsidies from national government for contributions. However, sharp declines in coverage rates from 2004 to 2005, and again from 2006 to 2007, were due to non-enrolment or non-renewal of many indigents under the SP.

Under the SP, LGUs voluntarily enrol indigent households and subsidize their premiums. One feature of the SP is that LGUs have discretion in identifying "poor" households. As a result, a number of indigent households under the SP are said to be "political", that is, with actual incomes exceeding the poverty line but classified as "poor" by LGUs for political reasons. Based on the 2004 APIS, 72% of those identified as "true poor" do not have PhilHealth coverage (Edillon, 2007).

In 2010 the government identified achieving universal health care as the main goal of its new health sector plan. The plan aims to increase the number of poor people enrolled in Phil Health and improve the outpatient and inpatient benefits package. A full government subsidy is offered for the poorest 20% of the population, and premiums for the second poorest 20% will be paid in partnership with the local government units. So far

the results are promising. As of April 2011 almost 4.4 million new poor families had been enrolled in PhilHealth, equivalent to a 100 percent increase.

Table 3-4 Number of active PhilHealth beneficiaries (members & dependents), 2000-2008 (in thousands)

No. of members & dependents	2000	2001	2002	2003	2004	2005	2006	2007	2008
Government	6967	8948	10 199	7632	7866	7493	5385	7420	7739
Private	19 126	20 767	19 576	23 155	23 556	23 188	23 403	24 858	23 185
IPP	1908	4182	6755	2744	6563	8471	9148	11 069	12 509
SP	1596	2847	6304	8741	31 291	12 440	24 847	13 635	16 491
Non-paying programme	--	--	730	130	230	334	448	572	885
OFW programme	--	--	--	--	--	2673	5172	6912	8059
Total NHIP beneficiaries	29 597	36 744	43 565	42 401	69 506	54 599	68 403	64 467	68 869
Philippine population (projected)	76 946	78 537	80 161	81 818	83 510	85 237	86 910	88 617	90 356
NHIP coverage rate (in %)	38.5	46.8	54.3	51.8	83.2	64.1	78.7	72.7	76.2

Note: IPP – Individually-paying Programme; SP – Sponsored Programme; NHIP Coverage Rates are authors' estimates based on the projected Philippine population.
Source: Philippine National Health Accounts 2005, NSCB.

Coverage Scope and Depth: What and how much is covered under the NHIP

PhilHealth provides insurance coverage, which covers expenditures as per the benefits schedule up to a ceiling, but over this ceiling, patients have to cover the costs. The basic type of coverage is reimbursement for inpatient services. Ceilings are specified for each type of service, including: (1) room and board; (2) drugs and medicines; (3) supplies; (4) radiology, laboratory and ancillary procedures; (5) use of the operating room; (6) professional fees; and (7) surgical procedures. They vary by hospital level (whether 1, 2, 3 – see page 65), public and private, and by type of case, i.e. whether ordinary (type A), intensive (B), catastrophic (C), or super catastrophic (D). PhilHealth also covers specific outpatient services such as day surgeries, chemotherapy, radiotherapy and dialysis.

This structure of basic benefits has provided a substantial amount of financial protection but only for limited types of care. Table 3-5 shows PhilHealth's estimated support values for ward charges, using data on actual charges as reported on the members' claim forms. PhilHealth

members can potentially obtain a 90% support rate (defined as PhilHealth reimbursements as a percentage of total charges) for ordinary cases, provided that they obtain inpatient care in government hospitals and are confined in wards. PhilHealth support can drop to less than 50% as shown in private hospitals for all types of cases, even if a member opts for ward accommodations.

Table 3-5 Estimated PhilHealth support values for ward hospitalizations, in percent, by type of hospital & case, 2005-2006

Case	2005		2006	
	Private hospitals	Government hospitals	Private hospitals	Government hospitals
Ordinary	49	92	43	90
Intensive	43	73	37	91
Catastrophic	41	87	19	82
All cases	44	84	33	88

Source: PHIC, 2009.

In addition to basic inpatient benefits, PhilHealth offers special benefit packages for specific services or illnesses. In 2000, PhilHealth introduced the outpatient consultation and diagnostic package which is currently available only to members of the sponsored programme. LGUs that opt to be included in this programme, which is a very pro-poor element of the health insurance system, receive a capitation payment of Php 300 (US$ 6.28[1]) from PhilHealth for every indigent household enrolled. This capitation payment is intended primarily to finance the provision of this outpatient benefit package (OPB) through accredited rural health units (RHUs) and city health centres (CHCs). In 2003, PhilHealth introduced an outpatient package for tuberculosis-direct observed therapy (TB-DOTS) under which a payment of Php 4000 (US$ 83.77) is paid to an accredited DOTS facility to cover diagnostic procedures, consultation services, and drugs. Special benefit packages were also introduced around this time (Table 3-6).

The universal coverage reforms aim to increase the level of support provided by Phil Health, particularly to the poorest families. For inpatient benefits, fixed payments will be introduced, per patient seen and episode of care; and, copayments will be eliminated. On outpatient services, the package of benefits is being upgraded to cover non-communicable diseases and a drug package.

1 Exchange rate as of August 2009 was Php 47.75 per 1 USD.

Table 3-6 PhilHealth Special Benefit Packages

Package	Payment in Php (US $)
Normal spontaneous deliveries (NSD)	4500 (94.24)
Maternity Care Package (MCP)	4500 (94.24)
Overseas Workers Programme (OWP) members	6 000 000 (125 657) global budget
Newborn care (including newborn screening)	1000 (20.94) per case
Family planning (tubal ligation or vasectomy)	4000 (83.77)
Cataract	16 000 (335.09) per case
Malaria	600 (12.57) per case
Severe acute respiratory syndrome (SARS) and pandemic influenza/avian influenza	50 000 (1047.14) for members
Influenza A(H1N1)	75 000 (1570.71) for members and dependents
	150 000 (3141.43) for health care workers

Source: PHIC, 2009b.

Philhealth's Office of the Actuary estimates utilization rates for all programmes at 3.9% on average for 2006 (Table 3-7). SP utilization rates are particularly low, ranging only from 1.7-2.3% in the period 2002-2006. On the other hand, utilization rates of the non-paying members (retirees) have ranged from 41-81% in the same five-year period. While the elderly are indeed expected to have a higher than average hospitalization or illness rates, the poor are likewise expected to be sicker, yet this is not reflected by the very low SP utilization rates. One possible explanation could be that PhilHealth provides limited financial protection for many services. Another reason could be that the poor are also less aware of the benefits from the SP programme, as suggested by the 2003 National Demographic and Health Survey (NDHS).

Table 3-7 PhilHealth utilization rates (percentage) by sector, 2002–2006

Year	All sectors	SP	Government-employed	Private-employed	IPP	OFW programme	Non-paying programme
2002	5.21	1.69	8.80	6.82	2.02	--	--
2003	4.80	2.30	8.29	5.43	2.52	--	61.67
2004	3.86	2.08	7.51	4.80	2.75	--	81.23
2005	4.92	2.10	7.11	4.41	5.14	--	52.19
2006	3.88	1.83	6.29	3.76	7.27	2.04	40.97

Note: SP – Sponsored Programme; IPP – Individually-Paying Programme; OFW – Overseas Filipino Workers.
Source: PHIC Office of the Actuary, 2009.

Drugs accounted for the largest share of NHIP benefit payments in 2008 with slightly over 30% of benefit payments allotted to drugs and 24% and 21% spent on room charges and diagnostic procedures, respectively. Professional fees had a 17% share of total PhilHealth benefit payments.

3.4.2 Collection

General government budget

Government health expenditures are funded out of general tax revenues collected by the Department of Finance (DOF). National government agencies such as the DOH and Philhealth are then allotted annual budgets by the Department of Budget and Management (DBM). Local governments also receive a share of taxes from the national government. This allotment is known as internal revenue allotment or IRA and is based on a formula that consists of the following variables: land area, population, and revenues generated by LGUs, such as local taxes.

Since 2000, national tax revenues have grown by an average of 9.9% per annum. Taxes collected in 2008 amount to 14% of GDP. Over 75% of all national taxes are collected by the Bureau of Internal Revenue (BIR) and mostly in the form of direct taxes. Over 40% of total national tax revenues are generated from net income and profits. Excise taxes have been on the decline at least from 2005 to 2007. This trend may have some implications on health care financing as a law on sin taxes (RA 9334) provides for the earmarking of 2.5% of the incremental revenue from the excise tax on alcohol and tobacco products for the DOH's disease prevention programmes and 2.5% of the incremental revenue for the PhilHealth's coverage of indigent households, which was not actually implemented. For local governments, the shares from national tax revenues are more than double the amount of tax collected from local sources.

Data from the 2006 Family Income and Expenditure Survey (FIES) suggest that taxes paid by households are progressive, e.g., the poorest 60% pay less than 6% of total taxes. There is a similar progressive pattern for tax shares to total household income and expenditure. A substantial portion (82%) of reported tax expenditures by households are income or direct taxes. The rest of the taxes paid by households are in the form of consumption taxes or indirect taxes, which have been found to be regressive.

Taxes or contributions pooled by a separate entity

For formally employed PhilHealth members, premium contributions are collected as payroll taxes (automatic deductions from monthly salaries) and are shared equally by the employer and employee. Premiums amount to 2.5% of the salary base. Monthly premiums range from a minimum of Php 100 (US$ 2.09) to a maximum of Php 750 (US$ 15.71), which is equivalent to 2.5% of a monthly salary cap of Php 30 000 (US$ 628.29). Thus, premium contributions become regressive for those with salaries exceeding the cap, although the cap has been pushed upwards over the years to make the situation less regressive.

Under the SP, annual premium contributions amounting to Php 1200 (US$ 25.13) per family are fully subsidized by the national government and LGUs following a premium-sharing scheme that depends on the LGU's income classification. Monthly premium contributions for individually-paying programme (IPP) members are pegged at Php 100 (US$ 2.09) which can be paid quarterly, semi-annually, or annually. For overseas Filipino workers (OFWs), the payment of PhilHealth premium contributions is mandatory whether they are leaving the country for jobs overseas for the first time or returning to their employment sites overseas under new work contracts. Annual premiums are pegged at Php 900 (US$ 18.85), which is 25% lower than the minimum premium contributions for those locally and formally employed. Finally, individuals who have reached the age of retirement and have made 120 monthly contributions become lifetime PhilHealth members. They are exempted from premium payments and, along with their qualified dependents, are entitled to full benefits.

Premium collections consistently exceeded benefit payments, with an average benefit payments-to-premium collections ratio of 76% per year. Annual growth rates in both premium collections and benefit payments have been erratic, although the average annual growth in premiums outpaced that of benefits between 2003-2008.

Premiums for the NHIP as a whole and for the SP in particular are subsidized by the following national taxes and other sources of funding:

- The Reformed Value-Added Tax Law of 2005 (RA 9337) which provides that 10% of the LGU share from the incremental revenue from the value-added tax shall be allocated for health insurance premiums of enrolled indigents as a counterpart contribution of the local government to sustain universal support.

- Sin Tax Law of 2004 (RA 9334) which provides that 2.5% of the incremental revenue from excise taxes on alcohol and tobacco products starting January 2005 shall be remitted directly to PhilHealth for the purpose of meeting the goal of universal coverage of the NHIP.
- Bases Conversion and Development Act of 1995 (RA 7917) which provides that 3% of the proceeds of the sale of metropolitan Manila Military camps shall be given to the NHIP.
- Documentary Stamp Tax Law of 1993 (RA 7660) which states that starting in 1996, 25% of the incremental revenue from the increase in documentary stamp taxes shall be appropriated for the NHIP.
- Excise Tax Law (RA 7654) of 1993 which states that 25% of the increment in the total revenue from excise taxes shall be appropriated solely for the NHIP.

3.4.3 Pooling of funds

In the Philippines, the two main agencies that pool health care resources are the government and PhilHealth (Figure 3-2).

National Government

The annual process of developing a DOH budget starts with the issuance of the budget call by the Department of Budget Management (DBM) around late February to the middle of March. The budget call is a DBM advisory informing national government agencies to start formulating their budgets for the year. The budget ceilings issued by DBM are based on available funds in treasury and projected government income for the year. Line agencies like the DOH then prepare annual budget proposals based on these set ceilings. The line agency proposals are consolidated into a national expenditure programme (NEP) that is submitted to congress. Congress then converts the NEP into a general appropriations bill which will be deliberated on and passed jointly by both houses.

Table 3-8 shows that annual budget allotments of the DOH have been steadily increasing in recent years (''allotments'' constitute only a part of the total allocation to the DOH, so their available budget may in fact be higher). In 2008, there was a huge increase in allotments, due mainly to an increase in revenue collection by the government and the prioritization of social services, particularly those related to achieving MDGs. A comparison of allotments and actual spending ("obligated funds"), however, points to underutilized resources. On average, only 77% of total appropriations were obligated.

Table 3-8 Allotments, obligations & unobligated balances of DOH, 2006-2008

Year	Allotment	Obligations	Unobligated balances	Obligation rate (%)
2006	2 181 022 004	1 747 785 641	433 236 363	80.1
2007	2 595 909 766	2 225 812 588	370 097 178	85.7
2008	5 620 891 377	3 602 821 029	2 018 070 348	64.1

Source: DOH Finance Service, 2009.

There are two possible explanations for the inability of the DOH to maximize spending of available resources. The first relates to weaknesses in the capacity of the central DOH, CHDs and LGUs to spend resources effectively. Another reason for low fund utilization relates to weak incentives among managers to push spending.

While the DOH accounts for a substantial portion of national government health expenditures, there has been increased health spending in recent years by other national government agencies such as the office of the president and the Philippine Charity Sweepstakes Office (PCSO). The PCSO, as the lead agency for charity work, provides financial assistance for hospitalization and medical support to those in need. In 2005, while spending by the DOH and its attached agencies accounted for about half of national government health expenditures, the share of other national government agencies (e.g. individual congressional activities as well as health programmes/services and facilities in schools, military installations and prisons) was 21%. These health expenditures by other national government agencies are sometimes implemented by the DOH but not usually covered by the medium-term planning carried out for the sector by the DOH as this funding source is usually erratic, is subject to fund availability and could be motivated by reasons other than national health goals. As this non-DOH national government spending becomes relatively larger, there is a greater need to coordinate these two expenditure streams so that overlaps and crowding out are minimized and gaps are properly identified and addressed.

Local Governments

LGU health budgets are developed in a similar way to the DOH budget. This begins with the issuance of the budget call by DBM, which stipulates the internal revenue allotment (IRA) allocation for the year. In addition to the IRA, the LGUs aggregate funds from all sources, such as income

from user fees, PhilHealth capitation and reimbursements and grants from external sources. In areas where there is an existing province-wide or city investment plan for health (PIPH/CIPH), the annual budget is synchronized with its annual investment plan. The annual budgets are passed by respective LGU legislative councils.

Box 2 The Autonomous Region in Muslim Mindanao (ARMM)

A unique feature of the Philippine health care system is the existence of a non-devolved autonomous health care system in the ARMM consisting of the provinces of Basilan, Lanao del Sur, Maguindanao, Sulu, Tawi-tawi and Marawi City. A regional government authority manages the region, and constituent provincial and city governments report to as well as receive budgets from this authority. Health services in ARMM are provided mainly through a public sector health system managed by a regional authority—the DOH ARMM. The ARMM has among the lowest health worker-to-population ratios and consequently, also has the worst health indicators.

A regional health accounts study done by Racelis, et al (2009) showed that in 2006, ARMM spent an estimated Php 3.4 billion on health. In terms of sources, the national government (DOH and DOH ARMM) accounts for 14%, households for 29%; local governments for 2%; and PhilHealth for 4%. The remaining 51% came from foreign assisted projects (FAPs) (at national level, FAPs account for just 3.6% of total health spending). Local government spending is low since health is a non-devolved function and hence is paid for largely by the national and regional governments. PhilHealth shares are also low owing to limited enrolment and the small number of accredited providers.

In terms of the distribution of funds to health providers (excluding FAPs): 49% was for services in hospitals, rural health units and other ambulatory care providers; 12% for public health programmes; 35% to pharmacies and 4% for administration. Lastly, in terms of uses of funds by type of health care service, 31% was for curative care, 15% for public health, 15% for mixed curative and public health services, 35% for drugs and medicines, and 4% for administration and capacity building (both human and physical capital).

The budget process in ARMM begins with a budget call issued by DBM stipulating the IRA allotment for ARMM. The regional government then comes up with a consolidated regional budget similar to other local governments. In 2009, ARMM completed its ARMM investment plan for health (AIPH) and its corresponding annual operating plan (AOP) to guide health investments in the region and provide the framework for national government support to ARMM.

LGUs procure all commodities through their own LGU bids and awards committees (BAC). These committees abide by the provisions of the Procurement Law (RA 9184). DOH is attempting to restore some of the purchasing power lost during devolution through the establishment of pooled procurement mechanisms run by inter-local government unit cooperation.

PhilHealth

PhilHealth pools funds from all sectors of Philippine society. For the formally employed, premiums are collected through payroll taxes. For the indigent households, LGUs make direct payments to PhilHealth for their share of premium contributions, while the national government (particularly the Department of Budget and Management) is billed for their corresponding share. For the individually paying members, premiums are paid voluntarily through a network of collecting agents, including PhilHealth regional and service offices and selected private banks. Similarly, overseas workers may remit premium payments through selected financial institutions overseas. Premiums, once collected, are managed as a single fund, with the various membership groups enjoying uniform benefits. The exception to this uniformity rule is the sponsored programme (SP), whose members are entitled to basic outpatient services in RHUs.

Table 3-9 shows the extent of cross-subsidization across the various membership groups. Overall, benefit payments represent less than 80% of total premium collections. This means, allowing for admissible administrative expenses (2.5% of premium collections), PhilHealth has been financially stable. But low benefits-to-premiums ratio represents limited the financial protection provided by PhilHealth.

In 2007, SP members' benefit payments have exceeded premium collections by 4%. Retirees, who are not charged premium payments, have increased benefit payments by over 230% from 2006 to 2007. Benefit payment to retirees is likely to be a serious financial burden on PhilHealth. On the other hand, the formally employed (particularly private sector employees) have benefits-to-premiums ratios sufficiently lower than one. IPP members have shown relatively high programme utilization rates that could be indicative of adverse selection. OFWs, whose premium contributions rates are relatively low, and who do not yet have benefits that are globally portable, have also shown relatively high benefit

payments to premium contribution ratios. The pooling of premiums from the different sectors contributed to increased fund viability given these different utilization patterns across membership groups.

Table 3-9 Premium collections & benefit payments, by type of membership, 2006-2007

Member Type	2006			2007		
	Premium collection (millions)	Benefit payment (millions)	Benefits-to-premiums ratio	Premium collection (millions)	Benefit payment (millions)	Benefits-to-premiums ratio
Government employees	4434	3861	0.87	4509	3824	0.85
Private employees	12 918	8333	0.65	14 575	7740	0.53
Individually paying members	892	1409	1.58	1024	2149	2.10
Sponsored members	3735	2779	0.74	2987	3116	1.04
Retirees		398	-		936	-
Overseas workers	601	421	0.70	632	687	1.09
Total	22 580	17 201	0.76	23 727	18 451	0.78

Source: PHIC Corporate Planning Department, 2009b.

3.4.4 Purchasing and Purchaser-Provider Relations

National government and its retained hospitals

In 1991, the management of provincial, district, and municipal hospitals as well as primary care facilities was transferred to LGUs, i.e. the provincial and municipal governments, under the leadership of governors and mayors, respectively. However, specialty hospitals, regional and training hospitals, and sanitaria (health facilities for the recuperation and treatment of individuals with leprosy) were retained under the management of the central DOH. Over the years, some hospitals that were originally devolved were eventually re-nationalized. To date, there are about 70 retained hospitals throughout the country.

Since 2001, retained hospitals enjoyed a significant degree of management and fiscal autonomy in accordance with a special provision in the General Appropriations Act (GAA), which was implemented through various guidelines. These issuances allowed DOH-retained hospitals to retain their income which can be used for Maintenance and Other Operating Expenses (MOOE) and capital outlay (CO) but not for the

payment of salaries and other allowances. Retained hospitals were also given authority (even encouraged) to set and collect user charges. A DOH directive has set a ceiling for mark ups to a maximum of 30% of actual cost, so user charges cannot be readily used to compensate for other cost centres in hospital operations. Overseeing the implementation of these policies is the National Centre for Health Facility Development (NCHFD).

Table 3-10 Funds of selected DOH-retained hospitals (in million Php), by major source, fiscal year 2004

Hospital	Bed Capacity	Sources of funds				
		MOOE	Continuing appropriations & sub-allotments	Priority Development Assistance Fund	PCSO & others	PHIC reimbursement
Amang Rodriguez Medical Centre	150	22.1		6.8	2.2	**
Dr. Jose Fabella Memorial Hospital	700	56.3	1.2	0.6	0.8	38.2
Jose R. Reyes Memorial Medical Centre	450	78.5	n.a.	n.a.	n.a.	23.4
National Centre for Mental Health	4200	119.6	n.a.		0.2	not ent.
National Children's Hospital	250	37.4	2.2	1.0	9.0	2.8
Philippine Orthopedic Centre	700	94.0	7.2	6.8	*	21.6
Quirino Memorial Medical Centre	350	50.6		2.7	5.1	34.1
Research Institute for Tropical Medicine	50	35.4	37.4	0.4	20.0	2.2
Rizal Medical Centre	300	41.0		4.0	2.4	25.5
Tondo Medical Centre	200	25.4		1.6	n.a.	**

Notes: PCSO – Philippine Charity Sweepstakes Office; n.a.- data not available; * - no data; ** - included in hospital income; not ent.- not entitled.
Source: DOH–NCHFD, 2004.

In addition, retained hospitals continue to receive budget appropriations from the national government. The size of the appropriations is historically determined, i.e., dependent primarily on past appropriations. A retained hospital's budget appropriation is also heavily dependent on the amount of "insertions" made by congressmen during the budget deliberations. These "insertions" typically come from congressmen's pork barrel funds or their Priority Development Assistant Fund (PDAF) (allocations given to legislators by national government to fund local

projects for their constituents) and are earmarked for expenditure items such as direct patient subsidies for their constituents in specific retained hospitals. Given the historical approach to budget setting, these insertions get carried over in future budgetary appropriations, such that hospital budgets have no semblance to their original per bed per day allocation (see Table 3-10 for maintenance and operating expenses (MOOE) allocation vs. bed capacity). These insertions also tend to distort rationality in the establishment and development of hospitals in the public sector.

LGUs and Local Hospitals

The relationship between LGUs and local hospitals is very similar to that between the DOH and its retained hospitals. Provincial and district hospitals are funded out of the provincial government's budget while municipal/city hospitals are financed by the municipal/city budgets. Many government hospitals that are under the management of LGUs also charge user fees, generally below cost. Management and financial parameters are determined primarily by the local chief executive and, in varying level of influence and technical leadership, the local hospital chief.

There is limited information on the financing status of local government hospitals. Early studies under the health sector reform agenda (HSRA) reported that most LGUs spend close to 70% of their health budgets on personal care, mainly hospitals (Solon, et al. 2004). Hospital budgets, in turn, are used mainly for staff salaries (around 80%). One proposal to free up LGUs from the burden of financing and managing hospitals was to corporatize these facilities. Corporatization was one of the alternatives in hospital reform espoused by the HSRA in 2000. This approach aimed to provide fiscal and management autonomy to public hospitals. To date, all DOH-retained hospitals have fiscal autonomy.

PhilHealth and its accredited health care providers

For health care providers to be eligible for insurance reimbursements, they need to be accredited by PhilHealth. Accreditation is primarily for purposes of quality assurance –"the verification of the qualification and capabilities of health care providers prior to granting the privilege of participation in the NHIP, to ensure that health care services that they are to render have the desired and expected quality" (PHIC, 2004). Both health care professionals (doctors, dentists, midwives) and facilities (hospitals, RHUs, TB-DOTS facilities, free-standing dialysis centres, maternity care clinics) undergo independent PhilHealth accreditation processes.

Accreditation contracts are renewed yearly for facilities and every three years for professionals, but can be suspended or revoked during the period of validity if acts are committed resulting in adverse patient outcomes.

Table 3-11 Number of PhilHealth-accredited facilities & physicians, 2008

PhilHealth regional offices	Hospitals	RHUs	Dialysis clinics	TB-DOTS clinics	Maternity clinics	Physicians
NCR/Rizal	190	183	14	58	79	7241
NCR-Las Piñas	54	69	2	22	25	--
NCR-Manila	51	84	8	28	34	--
NCR-QC	85	30	4	8	20	--
Luzon	685	186	2	76	14	6909
CAR	52	71	0	30	6	557
Ilocos (I)	107	90	2	40	5	904
Cagayan Valley (II)	66	25	0	6	3	553
C. Luzon (III)	135	107	4	3	41	1814
CALABARZON (IV-A)	112	40	1	26	25	2512
MIMAROPA (IV-B)	112	68	2	7	6	
Bicol (V)	101	80	2	27	12	569
Visayas	232	323	1	182	106	3181
W. Visayas (VI)	80	114	0	102	47	1280
C. Visayas (VII)	92	96	1	47	31	1350
E. Visayas (VIII)	60	113	0	33	28	551
Mindanao	424	151	2	90	89	3245
Zamboanga (IX)	60	44	0	29	15	416
N. Mindanao (X)	106	73	0	43	33	974
Davao (XI)	100	34	2	18	41	899
SOCCKSKARGEN (XII)	91	27	0	23	13	488
CARAGA	47	45	0	13	11	312
ARMM	20	7	0	2	0	156
Total	1531	843	19	406	288	20 576

Note: Generated totals, with the exception of that of hospitals, do not tally with reported totals.
Source: PHIC Corporate Planning Department, 2009b.

One important concern is the uneven distribution of accredited providers throughout the nation as shown by 2008 accreditation figures (Table 3-11). In particular, 35% of PhilHealth accredited doctors are based in the National Capital Region (NCR) alone. Moreover, the number of NCR-based doctors is about eight times more than the average number of PhilHealth accredited doctors in regions outside NCR. Close to 60% of all accredited hospitals are located in Luzon and over 70% of free-standing dialysis clinics are found in NCR alone. PhilHealth accepts any facility which meets standards; there is little overall planning / management on the supply side.

3.5 Out-of-pocket Payments

According to the 2006 FIES, the average Filipino household spends about Php 4000 (US$ 84) per year on medical care. This represents about 2% of total household expenditures. Drugs account for almost 70% of total household OOP payments while less than 10% of total OOP is spent on professional fees. When OOP payments on health care are broken down by income quintile, it becomes evident that the poorest households allot about 73% of their OOP payments to drugs and medicines, about 13 percentage points higher than the share among the richest households.

Data from the 2004 Annual Poverty Indicator Survey show that on the average, OOP payments of households without PhilHealth coverage are about 38% lower than those with coverage (Table 3-12). While health insurance is expected to reduce OOP payments, this table indicates that in the Philippines, the opposite may be true. There are many possible explanations for this, including that those with PhilHealth coverage are more frequently sick. With PhilHealth coverage, they may also be more likely to seek care in a facility and to increase utilization of services. While the poorest households have substantially lower OOP payments when covered with PhilHealth, richer households with PhilHealth coverage on the average spend more than their uninsured counterparts. We estimate that, on average, direct payments of medical goods and services, which are not covered by PhilHealth, account for 82% of the total charges paid by patients. For the poorest households, this share can be as high as 94%.

Table 3-12 Average OOP payments of households with & without PhilHealth coverage, 2006

Income decile group	Average medical OOP payments of households with at least one member who visited a health facility (Php)		
	With PhilHealth coverage	Without PhilHealth coverage	Share of PhilHealth- unsupported OOP to total bill
1 (poorest)	484	1865	94%
2	961	859	85%
3	1081	914	85%
4	1539	1106	83%
5	1605	1469	85%
6	2259	1769	84%
7	2435	2821	87%
8	3569	4882	88%
9	5368	6871	88%
10 (richest)	11 210	12 002	86%
ALL	4465	2763	82%

Notes: Household PhilHealth coverage denotes having at least one household member with PhilHealth membership. Share of PhilHealth-unsupported OOP is calculated by assuming a PhilHealth coverage rate of 37%, a PhilHealth support value of 35%, and a PhilHealth claims rate of 88%.
Source of basic data: APIS 2004, NSO.

3.6 Voluntary Health Insurance

Based on the 2005 Philippine National Health Accounts, 6.3% of all health care spending was financed by private health insurance and HMOs. This combined spending is about 40% lower than PhilHealth's share of total health spending. In terms of coverage, however, the 2003 NDHS indicated that private insurance and HMOs together account for less than 10% of all insured households, while PhilHealth had a dominant 86% share. The disproportionately large spending of private insurance and HMOs is likely to be financing the more expensive services purchased by the richer households, who are more likely than the poor to have membership in private insurance and HMOs.

3.7 Other Sources of Financing

Donors account for a relatively small share of total health care expenditures. From 1998 to 2004, foreign-assisted projects (FAPs) had an average share of 3.4% of total health expenditures (Table 3-13). FAPs include all those projects undertaken by the DOH, including other national government agencies with health-related mandates. Compared to other developing countries, this share is relatively low, although higher than Asian neighbors Viet Nam, Indonesia and Thailand.

Table 3-13 Health expenditures by FAPs, in million US$, 1998-2005

Year	FAPS Loans (million US$)	FAPS Grants (million US$)	Total FAPS (million US$)	THE (million US$)	FAPS Loans (% of Total FAPS)	FAPS Grants (% of Total FAPS)	Total FAPS (% of THE)
1998	29.4	34.5	63.9	2309.8	46.1	53.9	2.8
1999	59.7	38.2	97.9	2681.8	61.0	39.0	3.7
2000	42.3	48.0	90.3	2600.2	46.9	53.1	3.5
2001	26.3	58.9	85.2	2286.6	30.8	69.2	3.7
2002	43.9	19.1	63.0	2270.8	69.7	30.3	2.8
2003	43.4	46.9	90.2	2724.6	48.1	51.9	3.3
2004	39.0	74.1	113.1	2949.6	34.5	65.5	3.8
2005	118.5	41.2	159.8	3281.7	74.2	25.8	4.9

Note: THE – Total Health Expenditure; each value in US$ was computed by dividing the peso value by the average annual Php/US$ exchange rate.
Source: Philippine National Health Accounts 2005, NSCB.

3.8 Payment Mechanisms

3.8.1 Paying for Health Services

Public health services and outpatient care

In general, services provided by RHUs are free of charge. The main constraint in these public facilities is availability of both goods and services. RHUs belonging to LGUs that are enrolled in PhilHealth's outpatient benefit package (OPB), in principle, are partly funded by capitation fees collected from PhilHealth. As mentioned earlier, LGUs are reimbursed Php 300 (US$ 6.28) for every indigent household enrolled under the SP, with the understanding that this capitation is used to fund the provision of free outpatient care at the RHUs. In practice, however, capitation fees from the OPB are not always spent for the intended purpose. Under the programme, LGUs are not actually prohibited from pooling these capitation fees into their general funds, which means such fees can be (and frequently are) spent on items other than outpatient care (Kraft, 2008). Observers cite the failure of PhilHealth to properly communicate to the LGUs the intent of the fund as well as to closely monitor the utilization of the capitation fund as the main reason for the underperformance of the OPB.

Under PhilHealth's special outpatient benefit packages, namely the outpatient TB-DOTS benefit package and the outpatient malaria package, health care providers are paid per case. Under the case payment scheme, providers are paid a set fee per treated case handled. The amounts of the case payment as well as the recipient of the payment (whether facility or professional) vary for each package. Accredited providers are given Php 600 per malaria case eligible for the outpatient malaria package. Accredited DOTS facilities are paid a flat rate of Php 4000 per case in two installments: Php 2500 after completion of the intensive phase of treatment and Php 1500 after the maintenance phase.

Inpatient care

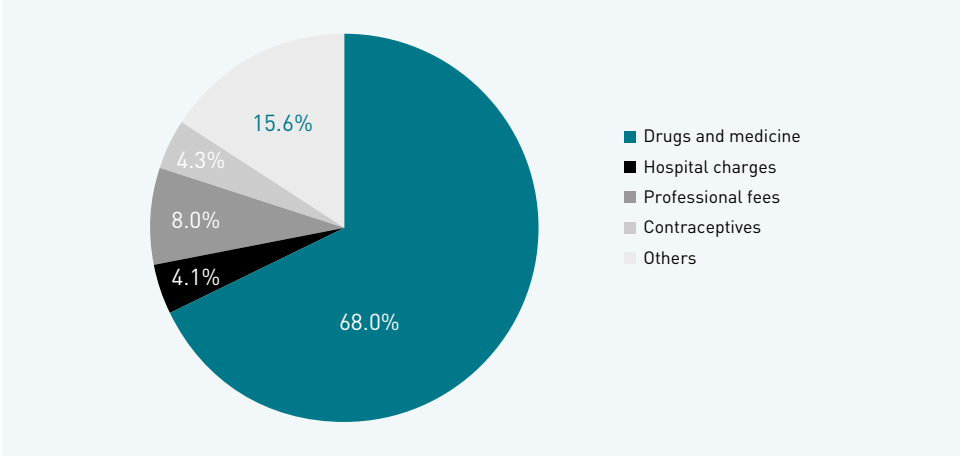
Both public and private hospitals charge user fees for inpatient services. User fees are not subject to any form of regulation, as such facilities with fiscal autonomy are free to charge rates which they deem appropriate. In public facilities, while charges may vary according to a patient's willingness-to-pay, charges may still fall below cost. A 2003 survey of 30 district hospitals in the Visayas shows that zero fees were charged in three out of ten provinces. While there has not been any recent study on

pricing in local hospitals, observers believe that under the devolved set-up, some public hospitals may either not have strong incentives to charge prices that reflect the true cost of resources or may lack the technical skills to charge the appropriate prices.

Pharmaceutical goods

PhilHealth's inpatient benefit package provides for reimbursement of expenses on drugs and medicines listed in the Philippine National Drug Formulary (PNDF) up to specified ceilings. However, household data have shown that, to a very large extent, OOP payments are used for drugs and medicines (Figure 3-3). Until recently, drug prices were largely unregulated and were determined by market forces. In August 2009, however, after much public debate, maximum retail drug prices (MRDPs) were imposed by the DOH on selected drugs, resulting in a 50% reduction in current prices.

Figure 3-3 Households' out-of-pocket payments, by expenditure item, 2006



Note: Hospital charges refer to charges for room and board.
Source: Family Income and Expenditure Survey 2006, NSO.

3.8.2 Paying Health Care Professionals

Health care providers in the Philippines are paid in a combination of ways. Doctors in private practice charge fees-for-service, with the exception of those under retrospective payment arrangements with health maintenance organizations. On the other hand, doctors and other health care professionals working in the public sector are paid salaries. In addition to salaries, the staff in public health facilities may

receive PhilHealth reimbursements provided that they are employed in PhilHealth-accredited facilities.

The basis for payments also varies across sectors. Private health care professional typically charge market-determined rates. In the public sector, salaries follow the rates stipulated in the Salary Standardization Law. To illustrate, a doctor employed as medical officer III in a district hospital receives a minimum monthly basic salary of Php 19 168 (US$ 401.43) whereas a hospital chief (chief of hospital I) receives at least Php 25 196 (US$ 527.68) per month. The Magna Carta for Public Health Workers provides for additional benefits but the amount depends on factors such as the basic pay and nature of assignment of workers, and the employer's capacity to pay.

PhilHealth reimburses its accredited physicians based on the number of days a patient is confined. General practitioners are allowed to charge Php 100 (US$ 2.09) per day of confinement, while specialists are paid an additional Php 50 (US$ 1.05) per day. For performing a surgical or medical procedure, however, physicians are paid an amount related to the procedure's complexity as reflected by the assigned relative value unit (RVU). The more difficult a procedure is compared to other procedures, the higher its RVU. The relative value scale (RVS), which is the listing of reimbursable procedures with their corresponding RVUs and codes, is subject to periodic revision by PhilHealth. A physician's compensation is computed by multiplying the RVU by the peso conversion factor (PCF), which varies by physician type. For instance, the PCF for general practitioners is lower than that for specialists.

Regulation of physician fees is absent, and physicians are allowed to balance bill the patients. Balance billing is a method of billing the patient and refers to the difference – the balance – between provider's actual charge and the amount reimbursed under the patient's benefit plan. Balance billing has been one of main barriers to enhance financial protection of the PhilHealth programme.

4. Physical and Human Resources

4.1 Section Summary

There has been a general upward trend in the number of both private and government hospitals over the last 30 years, with the biggest growth noted in the 1970s, and a flattening off of growth in the last ten years. Most hospitals in the country are privately-owned. The average bed-to-population ratio from 1997 to 2007 matches the DOH standard, i.e., 1:1000 population. The DOH is directly responsible for planning of government health facilities; all proposed new health facilities, including those in the private sector, must obtain a certificate of need from the DOH. Funding of hospitals is through the General Appropriations Act, local government budgets, PhilHealth and user fees.

In terms of absolute numbers, there are more nurses and midwives than any other category of health worker in the Philippines. The supply of nurses has increased rapidly in response to international market demands. In contrast, there is an underproduction in other categories such as doctors, dentists and occupational therapists compared to the needs of the population. In response to these challenges, an HRH master plan was prepared in 2005 in order to address the long-standing inequities in HRH distribution and to better manage the supply of health workers and the cycles of health worker migration.

4.2 Physical Resources

4.2.1 Infrastructure

In the Philippines, hospitals and other health facilities are classified according to whether they are general or special facilities and their service capability. General health facilities provide services for all types of ailment, disease, illness or injury. Special health facilities, on the other hand, render specific clinical care and management, ancillary and support services.

All hospitals have basic clinical, administrative, ancillary and nursing services. Variations in these services depend on the level of the hospital. Level 1 hospitals provide emergency care and treatment, general administrative and ancillary services, primary care for prevalent diseases in the area, and clinical services such as general medicine, paediatrics, obstetrics and non-surgical gynaecology and minor surgery. Level 2 hospitals are non-departmentalized and cater to patients who require intermediate, moderate and partial supervised care by nurses for 24 hours or longer. These hospitals provide the same services as Level 1 hospitals, but with the addition of surgery and anesthesia, pharmacy, first level radiology and secondary clinical laboratory. Level 3 hospitals are organized into clinical departments and offer intensive care, clinical services in primary care and specialty clinical care. As teaching and training hospitals, Level 4 hospitals render clinical care and management as well as specialized and sub-specialized forms of treatment, surgical procedures and intensive care, and are required to have at least one accredited residency training programme for physicians. Apart from hospitals, other health facilities exist, such as birthing homes and psychiatric care facilities.

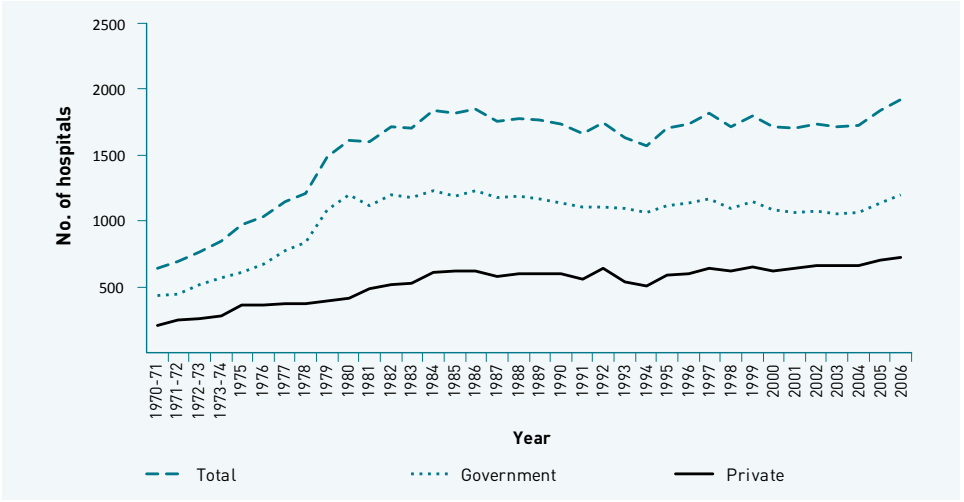
The number of both private and government hospitals generally increased in the last 30 years (Figure 4-1). About 60% of all hospitals in the country are privately-owned (Table 4-1). Government hospitals, however, are more strategically located as they serve as core or terminal referral hospitals in regions and provinces. While some serve as referral facilities, private hospitals are more often based in cities or more urban municipalities.

Table 4-1 Hospitals by ownership and service capability, 2005-2007

Hospitals/ Year	Level 1/ Primary		Level 2/ Secondary		Level 3/ Tertiary		Level 4/ Teaching/ Training		Total	
	No.	%	No.	%	No.	%	No.	%		
Year 2005										
Government	336	48.3	271	38.9	26	3.7	62	8.92	695	1755
Private	465	43.8	397	37.4	113	10.6	85	8.01	1060	
Year 2006										
Government	331	47.0	282	40.1	36	5.12	54	7.68	703	1771
Private	437	40.9	411	38.4	151	14.1	69	6.46	1068	
Year 2007										
Government	333	47.5	282	40.2	32	4.56	54	7.70	701	1781
Private	439	45.6	405	37.5	169	15.6	67	6.20	1080	

Source: Bureau of Health Facilities and Services, DOH, 2009.

Figure 4-1 Number of government and private hospitals, 1970-2006



Source: Department of Health.

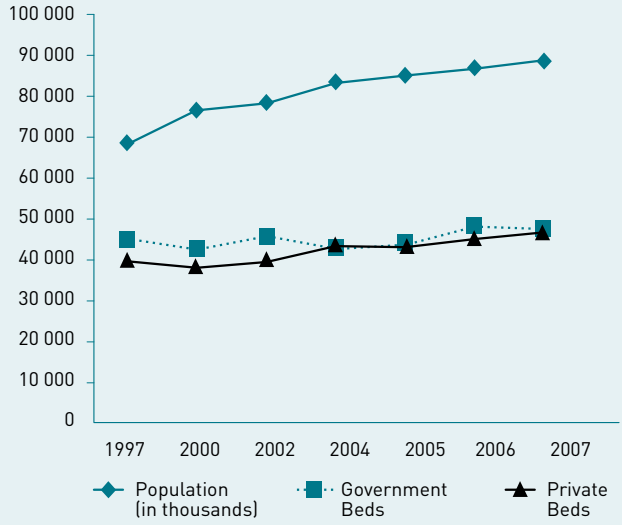
Hospital Beds

Traditionally, government hospitals in the country are larger and have more beds compared to private hospitals; however, there are more private hospitals. Over the years, the difference between government and private hospital beds has decreased as shown in Figure 4-2. From 1997 to 2007, the average number of beds totaled to 43 846 in government hospitals and 41 206 in private hospitals. The average bed-to-population ratio for the country for the 10-year period was 107 per 100 000 population. Although this ratio meets the standard set by DOH for the country (1 bed per 1000 population), ratios across regions, provinces and municipalities vary. Figure 4-2 also shows the increasing gap between population size and the supply of hospital beds.

Hospital beds are not classified according to the patients' level of care, whether acute or chronic, but rather according to the hospitals' service capability. In terms of the mix of beds, there are more Level 2 and Level 4 hospital beds in the government sector. Level 1 (or primary) government and private hospital beds are almost equal in number. About 40% of beds in all hospitals are found in teaching/training hospitals. In relation to Table 4-2, it is worth noting that DOH classifies government acute-chronic and custodial psychiatric care beds and facilities as Level 4 facilities, leaving only private psychiatric care beds and facilities in these categories.

Based on Republic Act 1939 (1957), government hospitals are mandated to operate with not less than 90% of their bed capacity provided free or as 'charity'. For private hospitals, the DOH through AO 41 (2007) required all private hospitals to identify not less than 10% of the authorized bed capacity as charity beds. This was issued as a requirement for hospital licensure.

Figure 4-2 Number of beds in government and private hospitals and total population, 1997-2007



Distribution

Inequities are evident in the distribution of health facilities and beds across the country. In terms of the regional distribution of hospitals, urban based hospitals — such as those found in the NCR and Region IV-A — comprise about 17% of all hospitals from all regions in 2005. The hospital beds in these two regions account for 36% of the total for the country (Table 4-3). Of the regions, Region XIII and ARMM have the least number of health facilities and beds.

ARMM, in 2005, was most deprived of hospital beds given its population size. The ARMM population is comparable to that of Regions IX, IV-B and XIII but with only 20 hospitals to serve the population (Table 4-3). Although the number of beds in ARMM increased from 560 to 640 in 2008, the ratio is still 0.19 per 1000 population (AIPH, 2008), far below the DOH standard.

Table 4-2 Beds in government and private hospitals and other health facilities, 2003-2007

Facility	2003			2004			2005			2006			2007		
	Gov't Beds	Private Beds	Total No. of Beds	Gov't Beds	Private Beds	Total No. of Beds	Gov't Beds	Private Beds	Total No. of Beds	Gov't Beds	Private Beds	Total No. of Beds	Gov't Beds	Private Beds	Total No. of Beds
Level 1 / Infirmary	6496	6102	12 598	6094	6341	12 435	6094	6341	12 435	6440	5872	12 312	6516	5889	12 405
Level 2 / Primary	14 976	11 772	26 748	16 257	11 663	27 920	16 237	11 663	27 900	15 583	11 497	27 080	15 175	11 374	26 549
Level 3 / Secondary	3014	7598	10 612	2982	8784	11 766	2982	8784	11 766	4282	11 938	16 220	3881	13 498	17 379
Level 4 / Tertiary	17 425	15 053	32 478	17 157	16 072	33 229	18 357	16 072	34 429	21 469	14 989	36 458	21 569	14 659	36 228
Birthing Home	22	196	218	69	374	443	69	374	443	123	496	619	100	710	810
Acute-Chronic Psychiatric Care	0	195	195	0	99	99	0	99	99	0	214	214	0	279	279
Custodial Psychiatric Care	0	31	31	0	64	64	0	64	64	0	280	280	0	335	335
TOTAL	41 933	40 947	82 880	42 559	43 397	85 956	43 739	43 397	87 136	47 897	45 286	93 183	47 241	46 744	93 985

Source: Bureau of Health Facilities and Services, DOH, 2009.

Table 4-3 Distribution of licensed government and private hospitals and beds by region, 2005

Region	Population (in millions) (NSCB, 2007)	Primary care hospitals		Secondary care hospitals		Tertiary care hospitals		Total hospitals	Total beds
		Gov't	Pvt	Gov't	Pvt	Gov't	Pvt		
PHILIPPINES	88.6[a]	272	395	26	111	61	85	695	43 670
NCR	11.6	18	58	8	14	24	32	55	12 972
CAR	1.5	11	9	0	0	1	0	37	1451
Ilocos (I)	4.5	15	28	1	6	6	5	39	2030
Cagayan Valley (II)	3.1	17	10	0	3	2	0	35	1649
C. Luzon (III)	9.7	38	77	1	16	6	6	58	3628
CALABARZON (IV-A)	11.7	31	83	3	23	2	9	66	2794
MIMAROPA (IV-B)	2.6	13	6	0	0	0	0	34	1553
Bicol (V)	5.1	16	18	2	10	4	2	50	2411
W. Visayas (VI)	6.8	29	7	2	3	3	8	59	3085
C. Visayas (VII)	6.4	24	14	0	8	4	9	60	3250
E. Visayas (VIII)	3.9	15	10	1	1	1	1	47	2030
Zamboanga Peninsula (IX)	3.2	7	13	0	4	1	1	28	1274
N. Mindanao (X)	4.0	12	21	3	9	2	5	34	1775
Davao Region (XI)	4.2	5	17	2	6	2	4	16	1053
SOCCKSARGEN (XII)	3.8	7	20	0	5	3	3	25	1165
CARAGA (XIII)	2.3	8	3	3	3	0	0	32	990
ARMM	2.8	6	1	0	0	0	0	20	560

[a] Population counts for the regions do not add up to national total. Includes 24 789 persons residing in the areas disputed by City of Pasig (NCR) and the province of Rizal (Region IVA); and 4555 persons in the areas disputed by the province of Davao Oriental (Region XI) and Surigao del Sur (Caraga) as well as 2279 Filipinos in Philippine embassies, consulates, and missions abroad.
ARMM population based on 2000 census
Source: Population source: http://www.nscb.gov.ph/secstat/d_popn. accessed on February 16, 2011; hospital data: Bureau of Health facilities, DOH 2009.

Table 4-4 Patient care utilization & activities in selected government hospitals, 2001- 2006

	2001	2002	2004	2006
Total patient days				
Specialty hospitals	206 330	167 447	200 573	201 573
Medical centers	2 465 759	2 096 394	2 458 300	2 558 300
National Center for Mental Health	1 404 949	990 738	1 325 512	1 326 515
District Hospital	42 536	68 781	84 717	84 717
Sanitaria	688 678	318 352	553 210	553 210
Total In-Patient Days				
Specialty hospitals	566	152	672	638
Medical centers	6754	5744	6680	6680
National Center for Mental Health	3850	1357	3571	3573
District hospitals		188	250	250
Sanitaria	1887	872	1474	1474
Average Length of Stay (Days)				
Specialty hospitals	6.70	7.26	7.26	7.26
Medical centers	5.80	5.54	5.54	5.54
National Center for Mental Health	91.45	91.45	91.45	91.45
District hospitals	3.40	3.64	3.64	3.64
Sanitaria	-	53.1	53.1	53.1
Authorized Bed Capacity and Occupancy Rate (%)				
Specialty hospitals	773 (87)	590(77)	824 (91)	824 (92)
Medical centers	7800 (87)	6550 (101)	7300(92)	7300 (92)
National Center for Mental Health	4700 (81)	4700 (74)	4700 (86)	4700(87)
District hospitals	400 (67)	350 (86)	385 (75)	385 (75)
Sanitaria	4680(33)	4220(43)	4320(48)	4320(48)
Implementing Bed Capacity and Occupancy Rate (%)				
Specialty hospitals	758 (77)	582 (79)	917 (79)	917 (79)
Medical centers	7416 (94)	5692 (101)	7524(93)	7524 (93)
National Center for Mental Health	4234 (92)	4291 (82)	3654 (97)	3654 (99)
District hospitals	198 (70)	204 (109)	270 (80)	270 (80)
Sanitaria	1706(75)	702(76)	2072(82)	2072(82)

Source: DOH-retained hospitals profile only, Bureau of Health Facilities and Services, DOH, 2009.

Hospital Performance

The average length of stay (ALOS) reflects the relative case mix among different hospitals. As shown in Table 4-4, this varied from 2001 to 2006. ALOS in Level 3 and 4 hospitals such as specialty hospitals, research hospitals, medical hospitals and regional centres ranged from 5.8 days in 2001 to 7.26 days 2006. Patients in sanitaria (treatment and rehabilitation facilities for individuals with leprosy) (53.1 days) and psychiatric facilities (91.45 days) have the longest ALOS. District hospitals, which are Level

1 or 2 facilities, have shorter average length of stay. This ranged from 3.4 days in 2000 to 3.64 days in 2006. Generally, the approved number of beds as per issued license to operate (authorized) is higher than the actual beds used (implementing beds). However, in 2004 and 2006, it was noted that implementing bed capacity and occupancy rates are higher than those authorized for medical centres, suggesting more congestion in these government facilities compared to others.

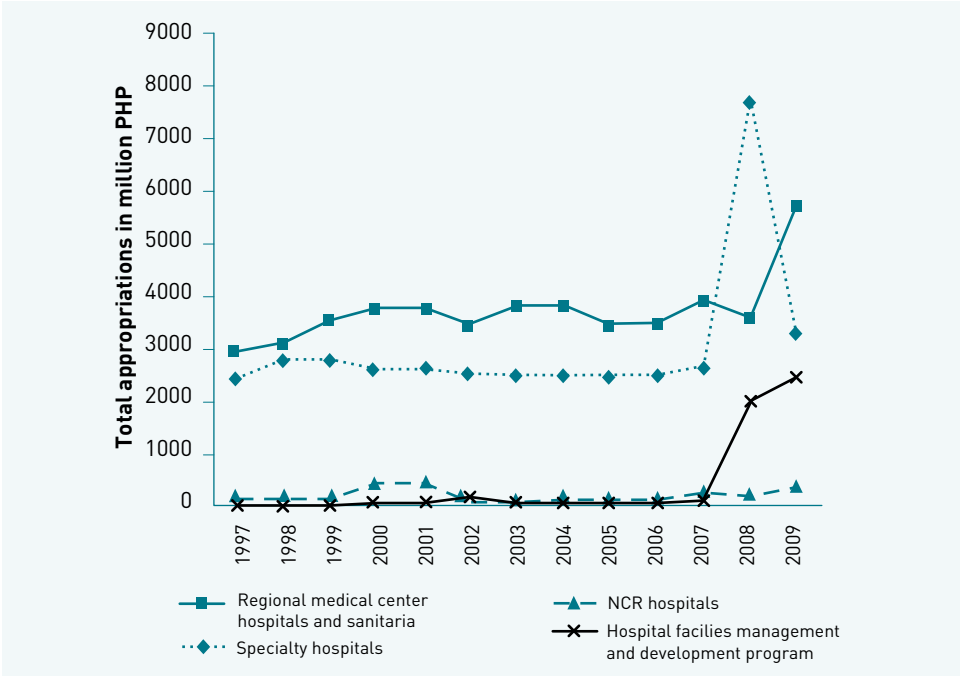
Consumers perceive government hospitals to be of lower quality than their private counterparts. Addressing this perception is a challenge, especially in underserved areas, where quality is affected by limited financial resources and a lack of trained health workers.

4.2.2 Capital Stock and Investments

Funding of government hospitals is largely done through the General Appropriations Act (GAA). Based on the distribution of budget by class in CY 1998-2007, half of the budget went to salaries and other personnel costs (Php 5.79 billion), Php 4.64 billon (41%) to maintenance and other operating expenses (MOOE) and Php 0.97 billion (9%) for capital outlay. Of the MOOE budget for CY 1998-2007, provision of hospital services had the largest share amounting to Php 2.22 billion or 48%. This was spent on the management and maintenance of the 67 retained and renationalized hospitals nationwide (DOH, 2007). As shown in Figure 4-3 there was a 22.7% increase in the overall DOH budget in 2008 (reflected in the budget spike for specialty hospitals). An additional Php 1.110 billion was allocated for the health facilities enhancement programme; Php 390 million for specialty hospitals like the National Kidney and Transplant Institute, Philippine Heart Centre, Lung Centre of the Philippines and Philippine Children's Medical Centre; and Php 122.4 million as assistance to national hospitals (Araneta, 2008). The fluctuating appropriations reflect the shifting priorities of the DOH during those periods.

Currently all DOH-retained hospitals are supported by the income retention policy of the DOH which allows them to use and allocate income from OOPs where needed. This was made possible through a special provision made in the annual General Appropriations Act. Other funding sources include loans, donations and allocation from politicians. Private hospitals, on the other hand, receive no direct subsidies for capital investment from government.

Figure 4-3 DOH total appropriations for government hospitals by year in Php, 1997-2009



Source: General Appropriations Act for Health, 1997-2009.

Table 4-5 Number of functioning diagnostic imaging technologies per region, 2007-2009

Region	General radiography						PET/CT						MRI	
	2007		2008		2009		2007		2008		2009		2009	
	No.	per 100 000	No.	per 100 000	No.	per 100 000	No.	per 100 000	No.	per 100 000	No.	per 100 000	No.	per 100 000
NCR	1072	9.28	1125	10.00	1207	10.58	108	0.93	105	0.93	106	0.93	22	0.19
CAR	66	4.34	66	4.06	67	4.04	3	0.20	3	0.18	3	0.18	0	0.00
Ilocos (I)	90	1.98	91	1.83	93	1.83	6	0.13	16	0.32	16	0.32	1	0.02
Cagayan Valley (II)	95	3.11	99	3.05	100	3.02	4	0.13	4	0.12	4	0.12	0	0.00
C. Luzon (III)	432	4.44	433	4.43	433	4.35	24	0.25	31	0.32	31	0.31	4	0.04
CALABARZON (IV-A)	819	5.73	864	6.06	886	6.07	28	0.20	24	0.17	25	0.17	4	0.03
MIMAROPA (IV-B)													0	0.00
Bicol (V)	144	2.82	145	2.64	151	2.69	7	0.14	6	0.11	6	0.11	0	0.00
W. Visayas (VI)	155	2.26	153	2.10	160	2.15	7	0.10	13	0.18	13	0.17	2	0.03
C. Visayas (VII)	187	2.92	196	2.90	200	2.90	10	0.16	9	0.13	9	0.13	4	0.06
E. Visayas (VIII)	94	2.40	100	2.34	100	2.29	1	0.03	1	0.02	1	0.02	0	0.00
Zamboanga (IX)	70	2.17	72	2.15	72	2.11	5	0.15	5	0.15	5	0.15	0	0.00
N. Mindanao (X)	84	2.13	87	2.08	91	2.14	4	0.10	4	0.10	4	0.09	3	0.07
Davao (XI)	132	3.18	135	3.20	136	3.17	2	0.05	2	0.05	2	0.05	2	0.05
SOCCSKSARGEN (XII)	91	2.38	93	2.38	95	2.38	3	0.08	3	0.08	3	0.08	0	0.00
CARAGA (XIII)	40	1.74	1,125	45.85	46	1.84	3	0.13	2	0.08	2	0.08	0	0.00
ARMM	23	0.56	23	0.68	23	0.66	0	0.00	0	0.00	0	0.00	0	0.00
Philippines	3594	4.06	4807	5.31	3860	4.19	215	0.24	228	0.25	230	0.25	42	0.05

Notes: * Voluntary reporting only; ** Proportions for 2007 were computed based on population data from the NSCB PSY 2008, while those for 2008-2009 were from census-based population projections in 2000.
Source: BHDT, 2009

4.2.3 Medical Equipment, Devices and Aids

The Bureau of Health Devices and Technology, Radiation Regulation Division of the DOH formulates and enforces policies, standards, regulations and guidelines on the production, import, export, sale, labeling, distribution, and use of ionizing and non-ionizing devices in medicine and other activities. General radiography represents the most basic equipment available across the country. As of 2009, these devices totaled to 3860 with 31% found in the NCR. NCR has a ratio of 11 general radiography devices per 100 000 population. In 2009, a total of 4123 general radiography devices, CT/PET and MRI were documented across the regions. Though most regions are recorded as having at least one X-ray and CT scan or MRI (Table 4-5), the real numbers are likely to be higher as data regarding these equipment and facilities is only voluntarily submitted to the DOH.

4.2.4 Information Technology

Due to its prohibitive cost, the DOH has hesitated to invest in building national health information systems, although it has had a policy for automating information systems since 1974. A quick assessment, however, shows that most health facilities do recognize the value of information technology. Computers are procured regularly and increasingly and internet connectivity is finding its way into annual operating and investment plans. This reflects the growing awareness among stakeholders of the value of information and communications technology in health. A rapid survey among DOH doctors-to-the-barrios (DTTB) revealed that a majority of them have computers inside their rural health units and at least half have access to some form of internet. Almost half of those with internet, however, pay for it from the personal account of the doctor rather than from the local government budget (See Table 4-6).

The same study found that only a few rural health units have invested in the procurement and installation of electronic medical records (e.g. community health information tracking system or CHITS). Private hospitals with more resources have adopted some degree of automation especially in areas related to billing and reimbursements. The Philippine General Hospital, for example, has a patient tracking system operated centrally, while other private tertiary hospitals like St. Luke's Medical Centre and The Medical City have invested in proprietary software systems to manage their information. This range of approaches results

from the lack of IT governance structures, such as standards and blueprints, as described in chapter 2.

Table 4-6 Rural Health Units (RHUs) with computers and internet access, 2010

Area	RHUs with computers		RHUs with internet (payer)			Total no. of respondent RHUs
	No.	%	No. (LGU)	No. (Personal)	Total No.	
Luzon	9	82.0	2	3	5	11
Visayas	7	87.5	0	4	4	8
Mindanao	8	88.8	4	1	5	9

Source: Rapid Survey among Doctors to the Barrios 2010, UP National Telehealth Centre.

The DOH information management service (IMS) has developed and maintained the hospital operations and management information system or HOMIS. HOMIS is a computer-based system of software developed by the DOH, through the National Centre for Health Facility Development (NCHFD) and the Information Management Services (IMS). It is developed to systematically collect, process, and share information in support of hospital functions for effective and quality health care. At present, there are no formal evaluations of the number of hospitals using HOMIS, nor of its impact

Decision-making for information systems infrastructure in the Philippines is devolved to the local health facilities. Because of the lack of a national e-health master plan or roadmap, there is no clear directive to the public and private sector on how they should invest in information and communications technology in health.

4.3 Human Resources

There are 22 categories of health workers trained in the Philippines. Some health worker categories do not correspond to international classifications as they have emerged because of demands within the Philippine health care system. Here, the focus is on the major internationally-recognized professional categories, namely doctors, nurses, midwives, dentists and physical therapists.

At present, there is no actual count of active health workers, and these data are not regularly collected. Some studies, such as that in 2008 by the Pharmaceutical and Health Care Association of the Phillipines (PHAP)

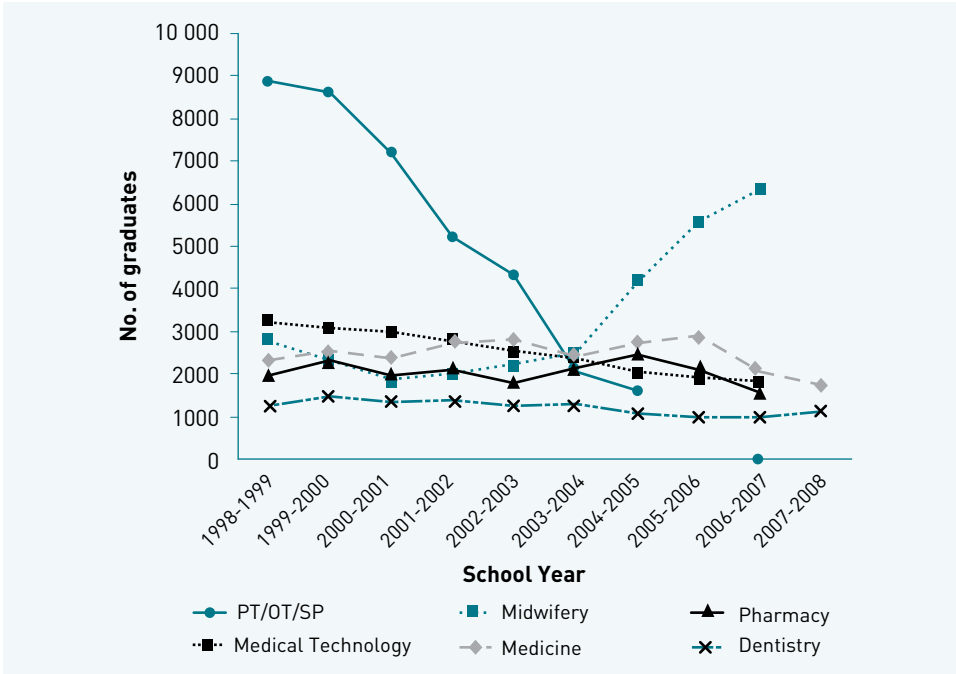
attempted to document the number of active doctors by specialization, but these were estimates.

Health professional training programmes, which are dominated by private colleges and universities, abound in the Philippines. In response to strong overseas demand there has been an increase in the number of health professional programmes especially in nursing and in the rehabilitation sciences, namely physical, occupational and speech therapy (PT/OT/ST). In particular, there was a surge in nursing enrolment from the mid 1990s to mid 2000s (leading to a steep rise in the number of graduates from 2003 on, see Figure 16). As there is still no system to track health professionals who leave the Philippines, statistics on health care human resources based on graduates or licenses need to be interpreted with caution.

4.3.1 Trends in Health Care Personnel

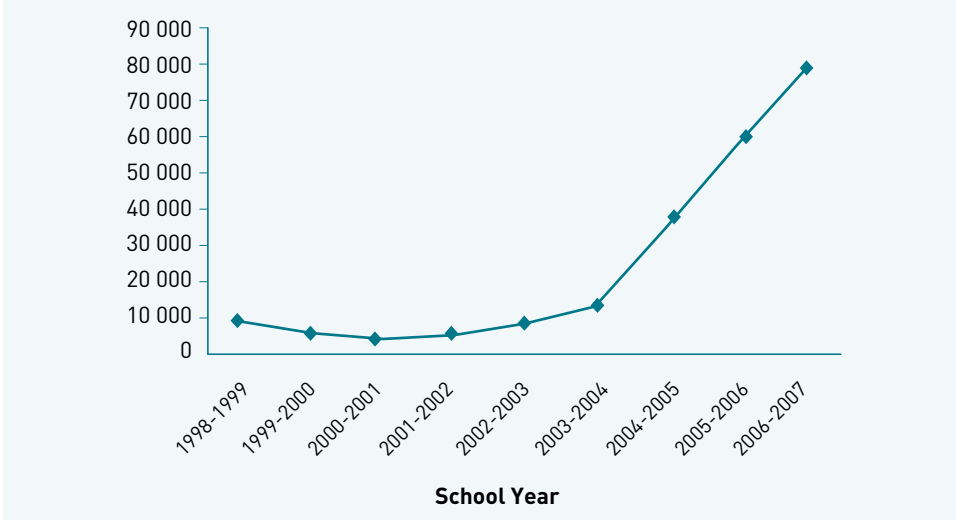
The largest category of health workers in the Philippines are nurses and midwives due to overseas demand for Filipino nurses. With the oversupply of nurses in the country, many newly graduated or licensed nurses are unable to find employment. Conversely, there is an underproduction in other categories such as doctors and dentists (Figure 4-4). In terms of health worker to the population ratios, doctor, nurse, medical technologist and occupational therapist ratios have constantly increased over the years, while ratios for the other health professionals to the population have fluctuated, again reflecting changes in local supply of particular health worker categories.

Figure 4-4 Trend in the number of graduates of different health professions in the Philippines, 1998-2008



PT- Physical Therapist; OT- Occupational Therapist; SP – Speech Pathologist
Source: CHED, 2009.

Figure 4-5 Trend in the number of BS Nursing graduates in the Philippines, 1998-2007



Source: CHED, 2009.

Health Worker Distribution

Since data on the actual number of health professionals in the private sector is not readily available, the minimum number of health workers required by the DOH for hospitals to be licensed is used to describe distribution (assuming that hospitals should have the minimum human resources for health (HRH) requirements before they can be licensed). As shown in Table 4-7 there are clear differences in government and private sector distribution. More hospital-based doctors, nurses, PTs and OTs are in the private sector than in government. The table also shows that the positions in government and private hospitals for PTs/OTs and dentists are only in Levels 3 and 4 facilities. The inadequate number of government positions are largely due to the inability of government to create enough positions in the bigger hospitals.

Table 4-7 Minimum number of health workers required in government & private hospitals based on DOH- BHFS licensing requirements, Philippines, 2007

Health Worker Type/ Level of Health Facility	Government		Private	
	No.	%	No.	%
A. Physicians	4818	100	5676	100
Level 1	666	14	878	15
Level 2	1798	37	1541	27
Level 3	526	11	1952	34
Level 4	1828	38	1305	23
B. Nurses	19 349	100	19 584	100
Level 1	2172	11	1960	10
Level 2	5338	28	4193	21
Level 3	1816	9	6405	33
Level 4	10 023	52	7026	36
C. PTs/OTs	54	100	67	100
Level 1	0	0	0	0
Level 2	0	0	0	0
Level 3	0	0	0	0
Level 4	54	100	67	100
D. Dentists	86	100	236	100
Level 1	0	0	0	0
Level 2	0	0	0	0
Level 3	32	37	169	72
Level 4	54	63	67	28

Note: The computation here is based on the authorized bed capacity indicated in the following: DOH AO No.70-A Series of 2002; DOH AO No. 147 Series of 2004; and DOH AO No. 29 Series of 2005. Computation here also takes into consideration the number of shifts as well as the number of relievers.
Source: DOH-BHFS, 2009;

The inequitable distribution of government health workers is also reflected in DOH and NSCB statistics. These show that three regions, namely the NCR, Regions III and IV-A (which are relatively near to metropolitan Manila) have a higher proportion of government health workers than other more remote regions like those in Mindanao (Table 4-8). This regional distribution data is not available for health workers working in the private sector.

Table 4-8 Government health workers per region, 2006

Region	Doctors		Nurses		Dentists[a]		Midwives	
	No.	%	No.	%	No.	%	No.	%
NCR	650	22.0	683	15.6	561	28.8	1065	6.3
CAR	83	2.8	151	3.5	32	1.6	599	3.6
Ilocos (I)	154	5.2	232	5.3	110	5.7	1019	6.0
Cagayan Valley (II)	95	3.2	176	4.0	69	3.5	816	4.8
C. Luzon (III)	284	9.6	384	8.8	171	8.8	1630	9.7
CALABARZON (IV-A)	247	8.4	459	10.5	259	13.3	1802	10.7
MIMAROPA (IV-B)	83	2.8	124	2.8			527	3.1
Bicol (V)	179	6.1	271	6.2	89	4.6	1072	6.4
W. Visayas (VI)	263	8.9	485	11.1	111	5.7	1689	10.0
C. Visayas (VII)	215	7.3	305	7.0	139	7.1	1495	8.9
E. Visayas (VIII)	152	5.1	208	4.8	90	4.6	880	5.2
Zamboanga (IX)	94	3.2	167	3.8	42	2.2	541	3.2
N. Mindanao (X)	116	3.9	203	4.6	73	3.8	956	5.7
Davao (XI)	69	2.3	110	2.5	62	3.2	859	5.1
SOCCSKSARGEN (XII)	108	3.7	186	4.3	55	2.8	817	4.8
CARAGA (XIII)	85	2.9	116	2.7	57	2.9	631	3.7
ARMM	78	2.6	114	2.6	26	1.3	459	2.7
Philippines	2955	100.0	4374	100.0	1946	100.0	16 857	100.0

[a]2005
Source: DOH, 2009; PSY 2008, NSCB.

Health Worker Density

Figure 4-6 to Figure 4-9 show the density of health workers in the country compared to other countries within the Asian region. Although Philippine density is comparable to selected countries, it should be noted that the Philippine ratios are computed based on "ever-registered" health professionals. Ever registered data does not take into account those who have died, retired or those who are not practicing their professions. This data limitation creates a likely overestimation of the supply of health professionals in the Philippines.

In the last two decades, the density of doctors in the Philippines rose sharply, and then slightly decreased to 1.14 per 1000 population in 2004

(Figure 4-6). As for the nurse-to-population ratio in the Philippines, it was 0.31 per 1000 people in 1993, but since then, this number grew dramatically to 4.43 per 1000 in 2000 and stabilized until 2005 (Figure 4-7). This large increase was mainly due to the high demand for nurses in other countries.

Of all the selected countries, the Philippines had the highest dentist density, having 0.54 to 0.56 dentists for every 1000 Filipinos in the period 1997 to 2004 (Figure 4-8). The pharmacist-to-population ratio grew in the last 20 years for all selected countries except China (Figure 4-9). Average midwife-to-the population ratio is 1.70 per 1000 people, the highest of all the selected countries. This is followed by Malaysia and Indonesia.

The World Bank's 1993 Development Report suggested that, as a rule of thumb, the ratio of nurses to doctors should be 2:1 as a minimum, with 4:1 or higher considered more satisfactory for cost-effective and quality care. In the Philippines, for government and private health workers in hospitals in 2006, the nurse-to-physician ratio was 3:1, while the midwife-to-physician ratio was 2:1.

Figure 4-6 Ratio of doctors per 1000 population, 1990-2008

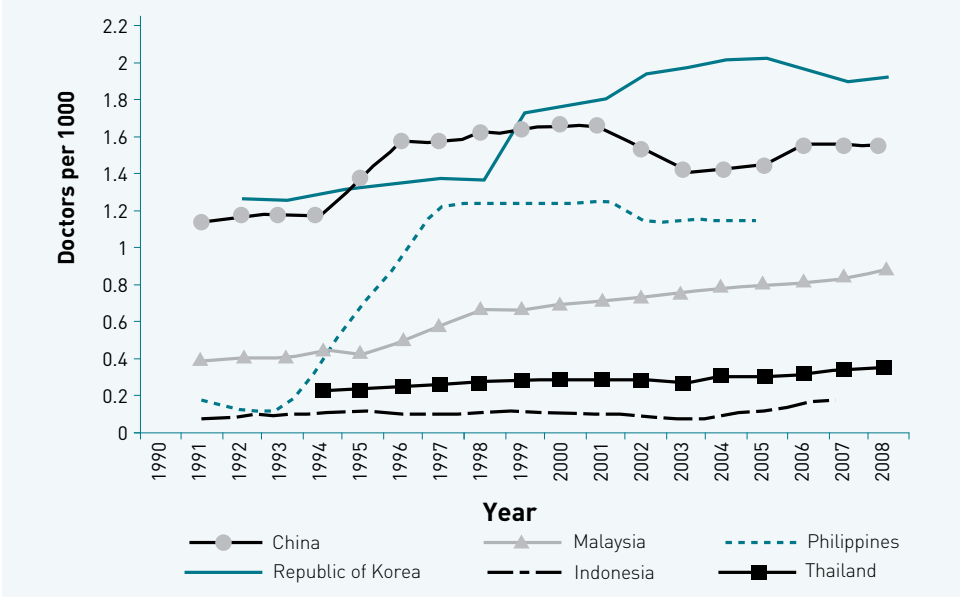


Figure 4-7 Ratio of nurses per 1000 population, 1990-2008

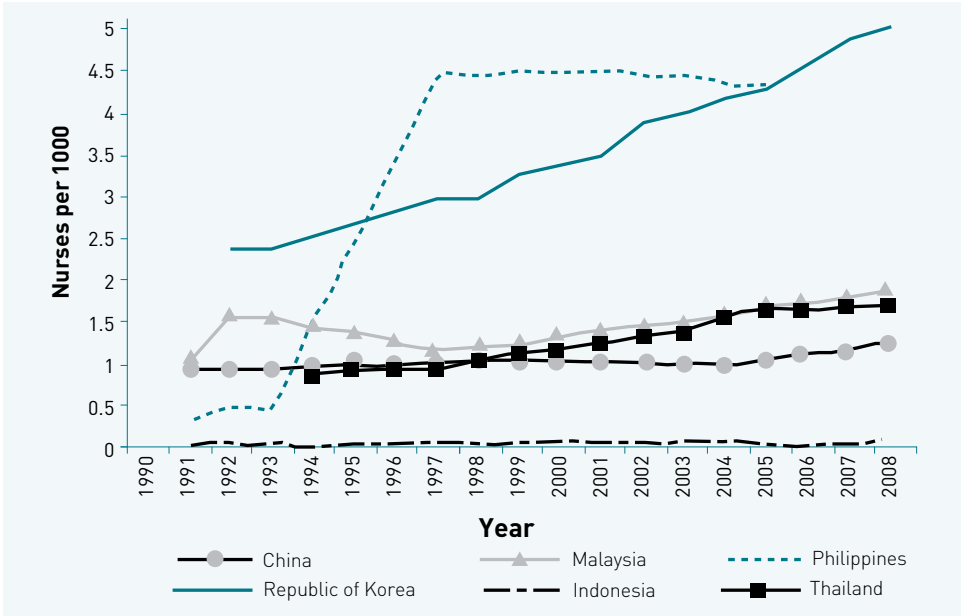


Figure 4-8 Ratio of dentists per 1000 population, 1990-2008

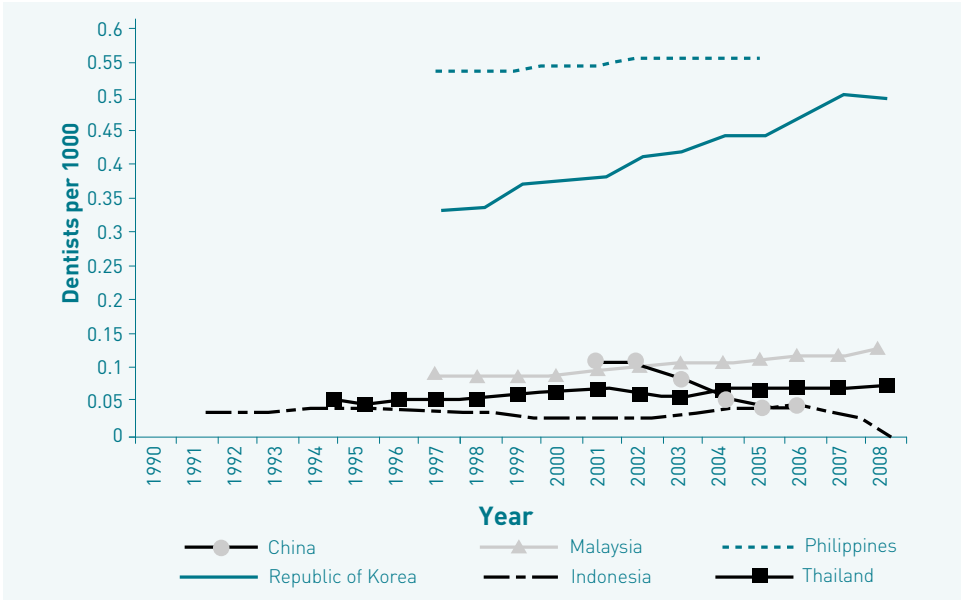
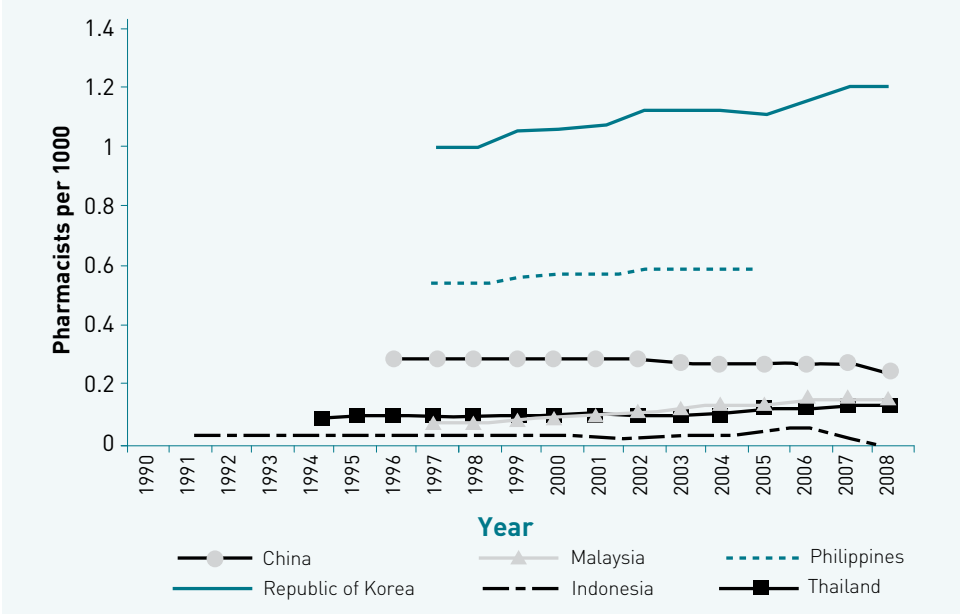


Figure 4-9 Ratio of pharmacists per 1000 population, 1990-2008



4.3.2 Training of Health Care Personnel

Doctors complete a 4-year pre-medical course and a 4-year medical education programme followed by a one-year internship programme that is patterned after the American medical education system. This prepares them for general practice and for beginning specialization in surgery, internal medicine, paediatrics or obstetrics and gynaecology. Nurses go through a 4-year programme consisting of general education and professional courses that mainly trains them in community health and general hospital care.

Pharmacists have a 4-year pharmacy education programme that chiefly prepares them for practice in community pharmacies. A newer direction for pharmacists is towards industrial pharmacy or the practice of pharmacy in pharmaceutical companies. Medical technologists are likewise trained through a 4-year programme. Dentists finish a 6-year programme with the first two years categorized as pre-dental and the last four years as dental curriculum. The pre-dental curriculum is comprised of general education and health-related subjects while the dental curriculum covers basic medical and dental sciences, pre-clinical subjects and clinical training. Physical and occupational therapists (PT/OT) complete 5-year programmes consisting of general education and

professional courses. All programmes include licensure examinations that screen graduates for safe practice.

The regulation of health professional education is carried out by the Commission on Higher Education (CHED, RA 7722). CHED sets minimum standards for programmes and institutions of higher learning recommended by panels of experts in the field and subject to public hearing, and it enforces this. Its coverage includes both public and private institutions of higher education as well as degree-granting programmes in all post-secondary educational institutions, public and private. CHED has the mandate to open institutions and to close those that perform poorly based on the percentage of graduates who successfully pass national board examinations.

4.3.3 Health Professionals' Career Paths

There are many vacant government health sector positions in rural and low-income areas. However, some doctors find these areas unattractive due to long and irregular working hours, isolation from medical colleagues, and the absence of incentives to stay in these areas. Newly-trained doctors face radically different choices of where and how to practice. New doctors are much less likely to enter solo practice and are more likely to take salaried jobs in group medical practices, clinics, and health networks (DOLE, 2008). In terms of the career paths that doctors commonly take, Table 4-9 shows that of 45 555 doctors surveyed in 2006 by PHAP, 68% are practicing as specialists and 32% as general practitioners. Of the specialties, the most common tracks are internal medicine (17.5% of all physicians), paediatrics (15.5%), OB-gynaecology (12.5%) and surgery (10.6%). More than half of the specialists surveyed (52%) are found in metropolitan Manila in contrast to only 9% in Mindanao.

There are several distinct levels of the nursing career structure distinguished by increasing education, responsibility, and skills. Advanced practice nursing (APN) involves the expansion of the nurses' clinical role: Advance practice nurses are clinical nurse specialists and nurse practitioners who have acquired a PhD and have gained specializations in clinical nursing, research, health policy, teaching, and consultations. The concept of APN is being implemented, in part, in the form of the ''clinical nurse specialist (CNS)", supported by Board of Nursing Resolution in 1999 (BON No. 14 s. 99) and the Philippine Act

of 2002. While CNS is essentially a certification process to recognize graduate education, research and experience obtained by the nurse, it is anticipated that this will be expanded to define the scope of CNS practice in health facilities. A revision of the 2002 law, currently underway, will formalize APN as a distinct category of health worker.

Table 4-9 Distribution of doctors per specialty, 2006

Specialty	Metro Manila	Luzon	Visayas	Mindanao	Total	Percentage
Internal medicine	4133	2027	1157	678	7995	17.55
Internal medicine	2940	1637	907	580	6064	
Pulmonology	399	118	79	32	628	
Endocrinology/Diabetology	224	103	43	17	387	
Oncology	128	36	19	11	194	
Gastroenterology	185	55	45	13	298	
Rheumatology	37	7	11	5	60	
Nephrology	220	71	53	20	364	
Cardiology	713	192	117	62	1084	2.38
Dermatology	712	226	64	69	1071	2.35
Paediatrics	3467	1979	985	643	7074	15.53
OB-Gynaecology	2748	1580	797	569	5694	12.50
Surgery	2300	1307	656	550	4813	10.57
General surgery	1608	1011	506	441	3566	
Orthopedic surgery	470	216	123	84	893	
Uro-surgery	222	80	27	25	354	
EENT	1315	522	200	177	2214	4.86
Opthalmology	616	160	78	53	907	
EENT/ENT	699	362	122	124	1307	
Psychia/Neuro	637	162	110	69	978	2.15
Psychiatry	322	82	76	42	522	
Neurology	315	80	34	27	456	
Total no. of specialists	16 025	7995	4086	2817	30 923	67.88
General practice	4653	5205	2644	2130	14 632	32.12
Total no. of doctors	20 678	13 200	6730	4947	45 555	100.00

EENT – Eye, Ear, Nose, Throat; ENT- Ear, Nose, Throat (Otolaryngology)
Source: PHAP Factbook 2008

4.3.4 Migration of Health Professionals

Among Asian countries, the Philippines holds the record for the greatest increase in migration, across all sectors, since the 1970s. In 1975, just 36 035 workers – mostly professionals – migrated. By 1997, 747 696 Filipino workers went overseas, compared to 210 000 from Bangladesh, 162 000 from Sri Lanka and 172 000 from Indonesia. By 2001, the number of overseas Filipino workers had reached 866,590. Overseas workers provide remittances of at least US$ 7 billion annually, with high unofficial

estimates suggesting that the figure may be as high as US$ 12 billion (Tujan, 2002).

The migration of health professionals from the Philippines to industrialized countries is a well-known characteristic of the health workforce – nurses (predominantly female) and physical and occupational therapists account for a large share of total migrants. The health professionals' decision to migrate relates to a number of factors: economic need, professional and career development, and the attraction of higher living standards. A common reason for migration given by health workers is the low and variable wage rates that do not allow them to earn "decent living wages" in the Philippines (Lorenzo et al, 2005). Destination countries such as Saudi Arabia, Singapore, UAE, Kuwait and Canada require migrant health workers to have some years of experience in the hospital setting, creating high-turnover of skilled staff (Lorenzo et al, 2005) (Table 4-10). This, in turn, leads to increased workload in health facilities and the hiring of many new graduates to replace the skilled nurses that left. This situation presents challenges in ensuring quality care for patients.

Table 4-10 Number of deployed Filipino nurses by Top Destination Countries, new hires, 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Total	9270	8879	7768	8528	9004	12 618	13 465
Saudi Arabia	5996	5926	4886	5753	6633	8848	9965
Singapore	326	166	149	86	273	667	745
UAE	267	250	703	796	616	435	572
Kuwait	51	408	193	354	393	458	423
Canada	25	14	21	7	19	527	346
Libya	52	10	23	158	66	104	276
USA	197	373	229	202	186	649	242
UK	1554	800	546	145	38	28	165
Qatar	243	318	133	141	214	245	133

Source: Philippine Overseas Employment Agency (POEA), 2009

The majority of Filipino health professionals migrate on a temporary basis, but there is also some permanent migration (Table 4-11). Between 1997 and 2009, 103 628 nurses left on temporary contracts, mainly for countries in the Middle East, the UK and Singapore (POEA, 2009). In contrast, from 2003 to 2008, 18 289 nurses left on permanent immigration visas to countries including the US, Canada, Australia and New Zealand.

To manage migration flows of health professionals and as part of the HRH master plan, more comprehensive labor agreements are currently being pursued by the Philippine Overseas Employment Administration, the Department of Foreign Affairs, the Department of Labor and Employment and the Department of Health with destination countries. Agreements are in the form of bilateral labor agreements and memorandum of agreements.

Table 4-11 Distribution of health professionals by type of migration, 1997-2008

Health Professional	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Doctors													3678
Temporary	60	55	59	27	61	129	112	91	97	169	164	214	1238
Permanent	--	128	65	158	179	204	237	295	275	358	286	255	2440
Nurses													128 100
Temporary	4242	4591	5413	7683	13 536	11 866	8968	8611	10 718	8076	8429	11 495	103 628
Permanent	438	321	370	1231	1575	2248	2245	3988	3827	5953	1267	1009	24 472
Dentists													2120
Temporary	53	32	56	33	57	62	40	88	70	71	43	--	605
Permanent	--	84	34	125	133	158	112	173	159	183	169	185	1515
Pharmacists													1655
Temporary	57	42	47	55	30	64	57	74	70	99	80	48	723
Permanent	82	41	20	73	87	91	59	76	113	95	108	87	932
Midwives													2737
Temporary	--	113	149	66	55	81	172	275	252	230	367	423	2183
Permanent	--	48	27	58	44	42	58	60	60	53	53	51	554

Source: CFO, 2009; POEA, 2009; processed by NIH-IHPDS, 2009

5. Provision of Services

5.1 Section Summary

The Local Government Code (LGC), enacted in 1991, devolved the health services from the national to the local governments. This law mandates the provincial governments to manage secondary level facilities, such as the district hospitals, while the municipalities take charge of the primary level facilities, such as the RHUs and BHCs. The DOH has retained the management of tertiary level facilities such as the regional hospitals, medical centres, specialty hospitals and metropolitan Manila district hospitals. The involvement of the different government entities in the management of the different levels of health care has created challenges for integration and efficiency.

Public health services in the Philippines are delivered to communities by the LGUs, with the DOH (through the CHDs) providing technical assistance. In addition, campaigns and implementation of specific national programmes/strategies such as TB, family planning, EmONC, are coordinated by the DOH with the LGUs. At present, other types of health care such as long-term care for the elderly and for persons with disabilities, palliative care, mental health care, dental health care and alternative/complementary medicine are still lacking.

Overall, access remains the fundamental objective of the delivery of public health services. However, problems persist with the quality and effectiveness of these services. Solutions to improve health outcomes through various reforms in the public health system are continuously being pursued.

5.2 Public Health

Improving access to public health services is a fundamental goal of the Philippines' health system. Public health in the Philippines consists of programme packages for the prevention, management and control of diseases, as well as the promotion and protection of health. To ensure access, these health programme packages have been adapted to the various levels of health care delivery (from community-based to tertiary-level facilities), to various population groups (mothers and infants, children and adolescents, adults and older persons), and to specific diseases (tuberculosis, malaria, cardiovascular diseases, cancer) (DOH, 2005). The quality of public health services remains a widespread concern.

The system is managed by the DOH and the local government units (LGUs). While direct delivery of public health services is no longer the DOH´s function, it provides the LGUs with technical assistance, capacity building and advisory services for disease prevention and control, and also supplies some medicines and vaccines. More specific national programmes include campaigns and coordination with LGUs on the implementation of specific programmes and strategies to eliminate leprosy, schistosomiasis, filariasis, rabies and malaria; and reduce morbidity and mortality from vaccine-preventable diseases, tuberculosis, HIV/AIDS, dengue and emerging and re-emerging diseases such as SARS and avian influenza.

Tuberculosis (TB) is the 6th leading cause of morbidity in the country since 1998. According to the 2009 Global TB Report of WHO, the Philippines is 9th of the 22 high-burden TB countries in the world (WHO, 2009). Directly observed treatment, short course (DOTS) is a strategy that the National Tuberculosis Programme adopted in mid-1990s, implementation of which has five components: a) political commitment; b) diagnosis by sputum microscopy; c) directly observed treatment or supervised treatment; d) uninterrupted drug supply; and e) standardized recording and reporting (DOH, 2005). While the 2010 targets for TB prevalence and mortality rates have not been achieved, the country has improved its case-finding and case-holding activities, resulting in increased case detection (from 61% in 2002 to 75% in 2007) and cure rates (85% in 2002 to 88% in 2007) (DOH, 2010).

TB services are delivered at the local level through the rural health units (RHUs) and barangay health centres (BHCs). In order to improve the case detection and management of TB cases, partnership with the private sector has been forged through the public-private mix DOTS (PPMD) strategy where private physicians refer patients to a public facility that offers DOTS services. Due to this partnership, privately-owned health facilities offering DOTS services are increasing. To date, there are 220 public-private mix DOTS (PPMDs) in the country. TB DOTS PhilHealth benefit package is being offered since 2003 in accredited TB-DOTS centres/facilities. TB remains a considerable problem because of the difficulty in managing TB in children and the emergence of multiple drug resistant strains of TB.

Strategies to improve reproductive health outcomes include:

- The attendance of skilled health professionals at all deliveries, and all deliveries in health facilities capable of providing basic or comprehensive emergency obstetric and neonatal care (BEmOC or CEmOC). Steps to implement this new approach include the upgrading of facilities to become BEmONC and CEmONC (more than 300 BHCs and RHUs, and selected hospitals are upgraded); and the organization of BEmONC teams (1217 are organized; 381 are functional, as of 2009).
- Expanded Programme on Immunization (EPI) through the administration of BCG, DPT, MMR, OPV and Hepatitis B vaccine; provision of ferrous sulfate and vitamin A supplementation to children and mothers, and tetanus toxoid to pregnant mothers; breastfeeding, integrated management of childhood illnesses (IMCI), and nutrition programmes; prenatal and postnatal check-ups; family planning, contraceptive self-reliance (CSR), and adolescent health programmes.
    - While the DOH 2010 target for Contraceptive Prevalence Rate (CPR) of 80% has not been achieved, CPR slightly increased from 48.9% in 2003 to 51% in 2008 (NDHS, 2003 & 2008). One important factor is the gradual phase-down of foreign donations of contraceptive commodities, which started in 2004 and ended in 2008. The government responded with the formulation and implementation of the contraceptive self-reliance (CSR) strategy, which aims to eventually eliminate the unmet needs for family planning. A CSR Rapid Assessment Survey in 2009 of selected provinces found that: 12 LGUs have procured more than or equal to their full requirement of contraceptives; 4 procured less than the full requirement; 7 did not procure at all. The DOH and POPCOM promote natural family planning under the responsible parenting movement (DOH, 2009).

- The prevention of cardiovascular diseases, diabetes mellitus, chronic obstructive pulmonary disease, breast and cervical cancers is advocated and promoted through the healthy lifestyle and management of health risks programme of the DOH.

Since devolution, the LGUs have provided primary and secondary levels of health care through their local health facilities. The municipal governments, through their municipal health offices, implement public health programmes (e.g. primary health care, maternal and child care, communicable and non-communicable disease control services) and manage the primary health care units as RHUs and the BHCs in their respective localities. Public health workers such as doctors, dentists, nurses, midwives and volunteer BHWs administer the public health services in the communities. Inequities are noted in the distribution of such health facilities and human resources for health, as most facilities are concentrated in the NCR and Luzon areas, while southern Mindanao has the least. Most barangay health centres (BHCs) are in Region IV-A and Region III (NSCB, 2008). The provincial governments, through their provincial health offices, manage the provincial and district hospitals, while city governments, through their city health offices, are in charge of the public health programmes as well as city hospitals. A local health board chaired by the local chief executive is established in every province, city and municipality. It serves as an advisory body to the sanggunian or local legislative council on health-related matters. The DOH is represented in all local health boards by the DOH representatives.

The private sector has been a participant in public health service delivery such as the TB-DOTS, family planning, and maternal and child health programmes have been mainstreamed among private service providers. Further, the private sector is well-represented in various inter-agency technical advisory groups to the secretary of health, such as the national immunization committee and the national infectious disease advisory committee.

5.3 Referral System

The devolution of health services ended the concept of integrated health care at the district level. Public health and hospital services are now administered independently. The provincial governments took over the management of secondary level health care services such as provincial and district hospitals, while the municipal governments were put in

charge of the delivery of primary level health care services and the corresponding facilities, such as the RHUs and the BHCs. The national government, meanwhile, has retained the management of a number of tertiary level facilities. Fragmentation is compounded by the management of the three levels of health care that is vested in three different government levels—an arrangement that has been marred by political differences.

In the early 2000, the DOH embarked on setting the standards of the referral system for all levels of health care. While this system was promoted to link the health facilities and rationalize their use, in practice adequate referral mechanisms were not put in place, and the people's health-seeking behavior remains a concern. In general, the primary health care facilities are bypassed by patients. It is a common practice for patients to go directly to secondary or tertiary health facilities for primary health concerns, causing heavy traffic at the higher level facilities and corresponding over-utilization of resources. Hospital admissions from the data of PhilHealth reimbursements show that highly specialized health facilities continuously treat primary or ordinary cases (DOH, 2010). Dissatisfaction with the quality of the services and the lack of supplies in public health facilities are some of the reasons for bypassing (DOH, 2005). This is aggravated by a lack of gatekeeping mechanisms, enabling easy access to specialists.

5.4 Primary Care Services

Primary care services are provided by both the government and the private sector. The main providers of primary health care services are the LGUs as mandated by the LGC of 1991. Under this set-up, BHCs and RHUs in the municipalities serve as patients´ first place of contact with the health workers. BHCs are staffed by barangay health workers, volunteer community health workers, and midwives, while the RHUs are staffed by doctors, nurses, midwives, medical technologists, sanitary inspectors, nutritionists and volunteer health workers. A World Bank study (2000) on the type of services provided by health facilities in the Philippines found that 63% of services provided by government primary care facilities are preventive in nature (i.e. immunization, health and nutrition education, family planning services); 30% are for the treatment of minor illnesses and accidents and other services, such as pre/post natal care and deliveries, and the remainder are for laboratory services.

Private sector health professionals provide primary care services through free-standing private clinics, private clinics in hospitals, and group practice clinics or polyclinics. They generally cater to the paying population who can afford user fees.

5.5 Specialized Ambulatory Care/Inpatient Care

Inpatient care is provided by both government and private health care facilities categorized as secondary and tertiary level hospitals. This type of care is reimbursed by PhilHealth. Filipinos who can afford it receive inpatient care services in private clinics and hospitals that are staffed by specialists and equipped with sophisticated medical equipment. Those who cannot afford private health care go to government facilities that are perceived to be poorly equipped and often lack supplies.

It is common practice for medical specialists to conduct private practice in their clinics located in either public or private hospitals, where they also refer their patients for short or long-term periods. Generally, the specialists charge more for outpatient consultations in private hospitals. Unlike the poor who mainly go to the outpatient units of the public hospitals and are attended by residents, the paying patients can go to the specialists of their choice. There are also a small number of ambulatory surgical clinics (ASCs) which provide day surgeries and ambulatory procedures. This care is eligible for reimbursement through PhilHealth, although a present there only 42 ASCs and all are located in urban areas.

5.6 Emergency Care

Emergency care is governed by RA 8344 which was passed in 1997, penalizing hospitals and medical clinics for refusing to administer appropriate initial medical treatment and support in emergency or serious cases. With a goal of protecting patients in a medical emergency, it mandates that all emergency patients should be stabilized by giving necessary emergency treatment and support without a demand for deposit or advance payment. However, a key weakness of RA 8433 is that it does not set out how this care will be financed, in effect shifting all the financial risks to the hospitals, which then develop schemes to deter the poor from accessing emergency care.

While it is crucial that emergency cases are promptly identified in the hospital's emergency department/unit, it is more vital that management of emergency cases start at the origen of the emergency situation.

Unfortunately, only a few LGUs across the countries have the capacity to manage emergency situations. Most of the management of emergency cases only starts at the emergency room, and not at the source of emergency situation. Since the devolution of health services, emergency management at the municipal and city levels has depended on the political will of the local chief executive to fund and implement an emergency management system.

In an administrative order (AO) issued in 2004 declaring a national policy on health emergencies and disaster, all health facilities were enjoined to have an emergency preparedness and response plan and a health emergency management office/unit; establish a crisis and consequence management committee to handle major emergencies and disasters; designate an emergency coordinator in all health facilities; train all health workers on health emergency management; encourage LGUs to establish a health emergency management team and coordination mechanism to link up with DOH-HEMS; and have DOH provide technical assistance on health emergency management to LGUs. The DOH serves as the Operations Centre through health emergency management system monitoring all health emergencies and disasters, informs the public of health emergencies and enforces standards and regulates facilities in the implementation of health emergency procedures (DOH AO 168, s. 2004). Many LGUs have now implemented this AO and have developed disaster management plans. In addition, the National Disaster Risk Reduction and Management Council (NDRRMC), a network of government agencies, monitors, responds, and assists LGUs during health and health related emergency and disaster situations. The DOH is a council member of the NDRRMC.

5.7 Pharmaceutical Care

Pharmaceuticals reach consumers via a supply-driven distribution scheme. Among the wholesalers and retailers, the drugstores have the greatest percentage share in the market at 80.1% (chains have 62.7%, independent stores have 17.4%) while the hospitals have the smallest share at 9.7% (private 7.4%; government 2.3%). Others account for 10.2% market share Clinics, NGOs at 9.9%; government agencies at 0.3%) (PHAP, 2008). Monopolistic pricing exists in hospital drug sales, especially in private hospitals where outside purchases are discouraged. Drug prices in hospitals are reported to be double those of prices in retail outlets (DOH, 2008).

Access to essential drugs is constrained by limited availability, irrational use and high costs (DOH, 2008). Availability of medicines is dependent on the presence of doctors to prescribe drugs and the existence of drugstores or pharmacies in the area. Most government health professionals practice in urban areas, especially in NCR and Region III. As private physicians charge for their services, long queues for government physicians in the public health facilities are often the norm. The situation is worse in southern Mindanao (with only 69 government doctors) and ARMM with 78 government doctors. Half of the 3000 plus drugstores in the country are in NCR while the rest are in urban areas nationwide. As a result, remote areas suffer from a shortage of drug supply. To address this, some health workers dispense drugs though their own clinics, RHUs, government hospitals and "BnB outlets" or pharmacies that operate without pharmacists. While there is a law mandating a separation between the prescribing of physicians and the dispensing of pharmacists, this is difficult to implement in practice: clinics and RHUs essentially dispense without pharmacies, while BnBs operate as pharmacies with no pharmacist.

5.8 Long-Term Care

Older Persons

In the Philippines, RA 9994 defines senior citizens as those aged 60 and above; at this age, medical benefits become available. There are an estimated five million Filipinos aged 60 years old and above. Older persons comprise a little over 6% of the total population, but the proportion is expected to be more than 10% by year 2020 as the number of older people will double by that time (NEDA, 2009). The role of geriatric care is very limited as there are very few homes for the elderly, and geriatric wards are rare in hospitals.

After having reached the age of retirement and have paid at least 120 months premium to the programme (including those made during the former Medicare Programme), PhilHealth members are granted lifetime coverage. As lifetime members, they are entitled to full benefits together with their qualified dependents (PHIC, 2009). Lifetime members comprise 1% of the 68.67 million Filipinos covered by PhilHealth (PHIC, 2008).

RA 9994 or the Expanded Senior Citizens' Act of 2010 granted the senior citizen a direct discount of 20% on all pharmaceutical purchases as well as exemption from 12% VAT on these purchases The benefit covers goods

and services from drugstores; hospital pharmacies, medical and optical clinics and similar establishments dispensing medicines (including influenza and pneumococcal vaccines) and medical rehabilitative/assistive devices; medical and dental services in private facilities, and free medical and dental services in government facilities, including diagnostic and laboratory fees. A limitation of the Senior Citizen's Act is that the burden of financing the discount is mostly shouldered by the provider of services – who are consequently reluctant to provide access to care for the elderly. Up to 6.7% of the 20% discount may be transferred as tax credits, but few providers exercise this option.

Persons with Disability

RA No. 7277, otherwise known as the Act Providing for the Rehabilitation, Self-Development, and Self-Reliance of Disabled Persons and Their Integration into the Mainstream of Society and for Other Purposes, was passed in September 1995. This mandated the DOH to institute a national health programme for the prevention, recognition and early diagnosis of disability and early rehabilitation of the disabled. It also required the DOH to set up rehabilitation centres in provincial hospitals, and render an integrated health service for persons with disability (PWDs) in response to seven different categories of disability such as psychosocial, learning, mental, visual, orthopedic, communication or those disabilities due to chronic illnesses.

Twenty-one hospitals under the DOH or 22% of all DOH hospitals are maintaining rehabilitation centres. Of the 1492 towns, about 112 (7.5%) have had their frontline health workers trained in community-based rehabilitation. The lack and mal-distribution of rehabilitation health professionals and facilities is alleviated by the community-based rehabilitation (CBR) approach which is widely accepted and used in providing services to PWDs. Difficulties with the assessment and diagnosis of disability or impairment by rural or city health personnel is one of the persistent challenges cited by regional coordinators handling the Philippine registry for PWDs. There is no national consensus on standard definitions for disability types or methods for collecting information. There are not enough facilities nationwide that deliver community or institution-based rehabilitation services, and their number is decreasing. There were 19 recorded institutions that provide social services to the disabled, elderly persons and special groups in 1996, but they have gradually decreased to 12 in 2003.

5.9 Palliative Care

In 1991, the Philippine Cancer Society broke new ground when it established the country's first home care programme for indigent, terminally-ill cancer patients led by a multidisciplinary team made up of a doctor, nurse and social worker. From the mid 1990s onwards, palliative care in the country was enlarged by NGOs and the private sector. A number of hospice care facilities opened during this period. Government support for palliative care for the poor is through the Philippine Charity Sweepstakes Office (PCSO), which covers the cost of patient hospitalization and the establishment of free medical and dental missions in depressed areas

5.10 Mental Health Care

In April 2001, the Secretary of Health signed the National Mental Health Policy which contains goals and strategies for the Mental Health Programme (NMHP). Under the DOH, the NMHP aims to integrate mental health within the total health system. It has initiated and sustained the integration process within the hospital and public health systems, both at the central and regional level. Furthermore, it aims to ensure equity in the availability, accessibility, appropriateness and affordability of mental health and psychiatric services in the country. Priority areas are substance abuse, disaster and crisis management, women and children and other vulnerable groups, traditional mental illnesses (schizophrenia, depression and anxiety), epilepsy and other neurological disorders, and overseas Filipino workers.

Challenges in the provision of mental health care are the following: continuous overcrowding of mental hospitals (the large ones with as many as 3500 patients) despite efforts to integrate mental health within the general health services and the development of community-based programmes; the non-availability of psychiatric drugs; the fact that hospital-based psychosocial rehabilitation of chronic patients remains the norm, and the reality that university and private hospitals with psychiatry departments are generally situated in urban areas. Home-care services for chronic patients are increasing (in Manila), but the quality of care provided is largely unmonitored.

To address these problems, the NMHP has articulated its support for a policy shift from mental hospital-based psychiatric treatment to community-based mental health care. As a first step, the integration of

mental health care into general health services proposes the opening of acute psychiatric units and outpatient clinics in 72 government hospitals and the provision of psychiatric drugs. Due to budgetary constraints, only ten hospitals have opened an outpatient clinic. For those hospitals that have opened clinics, the NMHP has provided guidelines and recommendations as to the standards of psychiatric care. The role of the NMHP in the current situation, where land currently occupied by the National Centre for Mental Health is being acquisitioned for city developments, is not clear. This development could be an opportunity for the NMHP to participate in redirecting the budget for the development of community-based mental health programmes and for the reorientation of mental health professionals. In doing this, the NMHP may be able to realize its goal to fully integrate mental health care into general health services in the community (Conde, 2004).

5.11 Dental Care

About 92.4% of Filipinos have dental caries or tooth decay and 78% have periodontal disease according to the National Monitoring and Epidemiological Dental Survey in 1998 (DOH, 2005). In terms of the decayed, missing, filled teeth index (DMFT), the Philippines ranked second worst among 21 WHO Western Pacific countries. Dental caries and periodontal disease are significantly more prevalent in rural than in urban areas as more dentists practice in urban settings.

Only tooth extraction and dental check-ups are free if and when materials and dentists are available in public facilities. PhilHealth does not cover dental health benefits. Oral health is still not a priority of the government, international agencies, lawmakers, communities, families and individuals in terms of financial support, human resources for health, and partnership and collaboration. This has fragmented dental health programmes and has caused poor oral health outcomes over the years. The decision to access oral health care is largely personal and most Filipinos pay for such services out-of-pocket.

In 2003, the National Policy on Oral Health was formulated and disseminated as a guide in the development and implementation of oral health programmes. It is focused on health promotion, preventive, curative and restorative dental health care for the population. Oral health services are being integrated in every life stage health programme of the DOH.

5.12 Alternative/Complementary Medicine

A traditional health system evolved from pre-Spanish Philippines with its own popular knowledge and practices and recognized healers that include the hilots (either birth attendants or bone setters), the albularyos (herbalists), and the faith healers. Traditional birth attendants provide home services that are more personal, culturally acceptable and financially accessible than midwives, and this may make it difficult to fully implement the policy of having all births in birthing facilities attended by health professionals.

In 1993, a division of traditional medicine was established in the DOH to support the integration of traditional medicine into the national health care system as appropriate. In 1997, the Traditional and Alternative Medicine Act was legislated to improve the quality and delivery of health care services to the Filipino people through the development of traditional and complementary/alternative medicine (TCAM) and its integration into the national health care delivery system. The Act created the Philippine Institute of Traditional and Complementary/Alternative Health Care (PITAHC), which was established as an autonomous agency of the DOH. The Institute's mission is to accelerate the development of traditional and complementary/alternative health care in the Philippines, provide for a development fund for traditional and complementary/alternative health care, and support TCAM in other ways. It also gives technical advice to regulators such as the Bureau of Food and Drugs (BFAD) or the Food and Drug Administration (FDA) and DOH – Bureau of health facilities and services. Currently, TCM practitioners are not reimbursed by PhilHealth.

6. Principal Health Reforms

6.1 Section Summary

Health care reforms in the Philippines over the last 30 years have aimed to address poor accessibility, inequities and inefficiencies of the health system. The three major areas of reform are health service delivery, health regulation, and health financing. In line with the Alma Ata Declaration, the primary health care (PHC) approach was adopted in 1979. The DOH implemented PHC through two key policies: the integration of public health and hospital services to create the Integrated Provincial Health Office; and the arrangement of district hospitals, RHUs and BHCs into health districts. The Local Government Code of 1991 transferred the responsibility of implementing the PHC to LGUs, particularly to the mayors of cities and municipalities, resulting in fragmentation of administrative control of health services. The health sector reform agenda (HSRA) was introduced in 1999 to address this fragmentation and other problems brought about by the devolution. The service delivery component of the HSRA included a multi-year budget for priority services, upgrading the physical and management infrastructure in all levels of health care delivery system and developing and strengthening the technical expertise of the DOH both at the central and regional level.

In 1987, the DOH promulgated the Philippine National Drug Policy (PNDP), which had the Generics Act of 1988 and the Philippine National Drug Formulary (PNDF) as its components. The Generics Act promoted and required the use of generic terminology in the importation, manufacturing, distribution, marketing, prescribing and dispensing of drugs. The PNDF or essential drugs list served as the basis for the procurement of drug products in the government sector. The HSRA has also strengthened the mandate of the FDA and increased the capacities for standards development, licensing, regulation and enforcement. The gains of these regulatory reforms include the improved use of PNDF System, which contributed to 55-60% of the general public buying generic medicines, and the strengthening of the Botika ng Barangay (BnB) Programme, which sold drugs that are 62% cheaper than in commercial

drug stores. Later in 2009, the DOH imposed maximum drug retail prices (MDRP).

The major reforms in health financing have been directed at the expansion of the NHIP to achieve universal coverage. The HSRA implementation review revealed that enrolment for the indigent programme has increased to meet the 2004 enrolment target, but utilization rates have been low. The expansion of the programme to cover the self-employed was the most challenging. As a result, Philhealth began developing mechanisms to enrol members, collect contributions and manage the IPP membership base through cooperatives and other occupation-based organizations. The DOH budget is also being restructured in favor of performance-based budget allocation, and coordinated national and health spending through the PIPH.

6.2 Historical Perspective

The following section on health care reforms describes the implementation and impact of policies that have been instituted over the last 30 years, ranging from administrative policies to legislative measures (Table 6-1). This section is divided into three parts. The first part presents the chronological development of policies directing the reforms. The second analyses the health reforms, including defining the trigger of the reform, describing the process and evolution of reform implementation and identifying implementation barriers. Three areas of reform are discussed: (1) service delivery, including PHC; (2) health regulation; and (3) health financing. Finally, the last part proposes further reforms in the health care system.

Table 6-1 Major health reforms in the Philippines, 1979-2009

Year	Reform	Brief description
1979	Primary Health Care	Prioritizes the eight essential elements of health care including education on prevalent health problems and their prevention and control; promotion of adequate food supply and proper nutrition; basic sanitation and adequate supply of water; maternal and child care; immunization; prevention and control of endemic diseases; appropriate treatment and control of common diseases; and, provision of essential drugs. As an approach, PHC encouraged partnership of government with various segments of civil society; incorporated health into socioeconomic development; and, advocated the importance of health promotion and preventive aspects of health care.

Year	Reform	Brief description
1982	Executive Order 851	Directs the regional health offices to be responsible for the field operations of the ministry in the region by utilizing the primary health care approach in delivering health and medical services that are responsive to the prioritized needs of the community as defined by its members, and by ensuring community participation in the determination of health care requirements.
1987	Executive Order 119	Creates the District Health Office (DHO) as one of the component structures of the Ministry of Health. The DHO provides supervision and control over district hospitals, municipal hospitals, rural health units, and barangay health centres. Moreover, this Order creates the Community Health Service under the Office of the Minister to provide services related to the formulation and implementation of health plans and programmes in coordination with local governments and non-government organizations.
1988	RA 6675 The Generics Act of 1988	Aims to promote and assure adequate supply, distribution and use of generics drugs and medicines. This law also emphasizes increased awareness among health professionals of the scientific basis for the therapeutic effectiveness of medicines and promotes drug safety
1991	RA 7160 Local Government Code of 1991	Paves the way for the devolution of health services to local government units. The process of transferring responsibility to the local government units breaks the chain of integration resulting in fragmentation of administrative control of health services between the rural health units and the hospitals
1995	RA 7875 National Health Insurance Act	Seeks to provide all Filipinos with the mechanism to gain financial access to health services, giving particular priority to those who cannot afford such services.
1999	Health Sector Reform Agenda	Aims to improve the way health care is delivered, regulated and financed through systemic reforms in public health, the hospital system, local health, health regulation and health financing.
	Executive Order 102	Redirects the functions and operations of the DOH to be more responsive to its new role as a result of the devolution of basic services to local government.
2004	RA 9271 The Quarantine Act of 2004	Aims to strengthen the regulatory capacity of the DOH in quarantine and international health surveillance by increasing the regulatory powers of its Bureau of Quarantine (BOQ). This includes expanding the Bureau's role in surveillance of international health concerns, allowing it to expand and contract its quarantine stations and authorizing it to utilize its income.

Year	Reform	Brief description
2005	FOURmula ONE (F1) for Health	Implements the reform strategies in service delivery, health regulation, health financing and governance as a single package that is supported by effective management infrastructure and financing arrangements, with particular focus on critical health interventions.
2008	RA 9502 Universally Accessible Cheaper and Quality Medicines Act	Allows the government to adopt appropriate measures to promote and ensure access to affordable quality drugs and medicines for all.
2009	RA 9711 Food and Drug Administration Act	Aims to 1) enhance and strengthen the administrative and technical capacity of the FDA in regulating the establishments and products under its jurisdiction; 2) ensure the monitoring and regulatory coverage of the FDA; and 3) provide coherence in the regulatory system of the FDA.

6.3 Analysis of recent reforms

6.3.1 Health Service Delivery

For more than four decades after World War II, the health care system was administered centrally. Although there was decentralization of powers when 8 regional offices were created in 1958 and later expanded to 12 regional offices in 1972, a national health agency based in Manila continued to provide the resources, develop health plans and policies and supervise the operation of health facilities and the implementation of various health programmes. The delivery of health care services at the community level was hampered by the concentration of health staff in Manila and other urban centres despite the fact that 80% of the population lived in rural areas (Gonzales, 1996).

The Philippine Government's commitment to the primary health care (PHC) approach in 1979 opened the door to participatory management of the local health care system. With the goal of achieving health for all Filipinos by the year 2000, this commitment was translated into action by prioritizing the delivery of eight essential elements of health care, including the prevention and control of prevalent health problems; the promotion of adequate food supply and proper nutrition; basic sanitation and an adequate supply of water; maternal and child care; immunization; prevention and control of endemic diseases; appropriate treatment and control of common diseases; and provision of essential drugs.

Primary health care as an approach was piloted between 1978 and 1981 and then institutionalized from 1981 to 1986. Accordingly, the DOH established organizational structures and programmes to implement PHC through two key administrative policies: EO 851 which directed the regional health offices to utilize the primary health care approach to provide the region with effective health and medical services, responsive to the prioritized needs of the community, and to ensure community participation in the determination of its own health care requirements; and EO 119 that created the Community Health Service that provided services related to the formulation and implementation of health plans and programmes in coordination with local governments and non-government organizations and organized district hospitals, RHUs and BHCs into health districts. Succeeding years have seen the refocusing of PHC as Partnership in Community Health Development (PCHD) (Bautista et. al., 1998). This was reflected in the 1987 Constitution which recognized the importance of "community-based" groups in promoting the welfare of the nation.

Accordingly, the DOH adopted the agenda of "health in the hands of the people" and implemented it through four strategies: (1) partnership building at the provincial, municipal and barangay levels to support the community-based efforts and initiatives of people's organizations (POs) and the community as a whole; (2) building the capacities of LGUs, the DOH, NGOs and POs for their various roles in the partnership; (3) enabling communities to mobilize their resources and produce sustainable and justly distributed improvements in their quality of life; and (4) the provision of grants or additional resources for priority communities to pursue health development projects that are locally identified and tailored to community needs and problems (Development Partners, Inc., 1994). These pre-devolution efforts to engage the LGUs and the community in formulating and implementing health plans, programmes and projects may have contributed to the increase in immunization coverage between 1980 to 1990 (WHO & UNICEF, 2006).

The People Power Revolution in 1987 and the subsequent fall of the Marcos regime strengthened the call for legitimate local representation. The 1987 Constitution provides that the Congress shall enact a local government code to establish a more responsive and accountable local government structure that will be instituted through a system of decentralization. This strong decentralist provision was later articulated in the Local Government Code (LGC) of 1991. Consistent with the primary

health care approach of putting health in the hands of the people, this landmark legislation transferred the responsibility of providing direct health services to LGUs, particularly to the mayors of cities and municipalities.

However, various problems beset the initial years of LGC implementation. The central DOH was slow to transform itself structurally and operationally, while many of its employees resisted decentralization (DOH, 1999). In addition, many local officials were unaware of the precise nature and the extent of their new responsibilities and powers in managing the local health system and delivering health services to their constituents. The disintegration of administrative hierarchy between the provinces and cities and municipalities resulted in fragmentation of services between the district and provincial hospitals and the RHUs and health centres. Moreover, chronic understaffing and lack of adequate funds to operate and maintain the health infrastructure led to a breakdown of the referral system and loss of distinction between different levels of care. Frequently, primary and secondary hospitals were located close to RHUs and performed the same basic outpatient services (Grundy et. al., 2003).

The aim of decentralization was to bring the governance of health services closer to the people, making health programmes, plans and projects more transparent and responsive. However, in practice, the quality of health governance varies across LGUs and the effect on health outcomes is mixed. Decentralization has given local authorities greater leeway to adapt local innovations in health planning, service delivery, and financing (PIDS, 1998) and encourages local participation in health prioritization. For instance, a study that examined the models by which minimum basic needs (MBN) data in social services, including health, are applied in local planning and resource allocation at the municipal and barangay levels, found that new working relationships within the community and among the stakeholders have promoted coordinated services, collaborative planning and development of joint projects (Heinonen et. al. 2000). BHWs as key health providers in health service delivery have been successful implementators of public health programmes, including malaria control (Bell et.al., 2001), but their potential contributions to scale up health services remain to be fully tapped (Lacuesta, 1993, and Gonzaga & Navarra, 2004)

The health care delivery system continued to deteriorate after devolution due to a lack of resources and local capacity to manage devolved health facilities, the unwillingness or inability of local authorities to maintain pre-devolution spending for health, and low morale and lack of opportunities for continuing education among devolved health providers (DOH, 1999). In response to these problems, the health sector reform agenda (HSRA) was introduced. The service delivery component of the HSRA focused on reforming the public health programmes and the hospital system. Reform strategies include increasing investments in public health programmes through a multi-year budget for priority services, upgrading the physical and management infrastructure at all levels of the health care delivery system and developing and strengthening the technical expertise of the DOH both at the central and regional level. The hospital reforms were designed to meet the problems that plagued the public hospital system: (1) revitalize local hospitals and upgrade retained hospitals into state-of-the-art tertiary level health facilities; (2) improve the hospital financing systems of regional and national hospitals; (3) convert the regional and national hospitals into government-owned corporations; and (4) include the private sector in the existing government networking and patient referral system to form an integrated hospital system.

Mid-implementation review of HSRA (Solon, et. al., 2002) reported remarkable progress in the implementation of the national health insurance programme nationally and, good progress in overall sector reform in those provinces where the reform package was tested (known as convergence sites). However, the review also found limited progress in hospital reforms, public health, and health regulation as well as little integration between the different strands of reform. Meanwhile, the HSRA aim of establishing DOH leadership over public health programmes was compromised by loss of skilled staff due to quick turnover and reassignment. According to the regional directors interviewed for this mid-term review, the two main reasons for not achieving HSRA targets were budget cuts and ineffective articulation of the implementation strategy, especially at the regional level and below.

The gains in implementing HSRA provided the impetus to pursue critical reforms for 2005-2010 articulated in FOURmula one for health (F1). While HSRA made the distinction between hospital and public health reforms, F1 incorporated these reforms into one pillar called health service delivery with the aim of ensuring access and availability of essential and

basic health packages. To this end, F1 adopted the following strategies: (1) making available basic and essential health service packages by designated providers in strategic locations; (2) assuring the quality of both basic and specialized health services; and (3) intensifying current efforts to reduce public health threats.

Implementation of these strategies appears to have had some positive impact. In public health, an increasing number of areas have been declared as disease-free for endemic diseases like filariasis, schistosomiasis, leprosy and rabies. As of 2008, malaria is no longer among the top 10 causes of morbidity. Moreover, early attainment of the MDG targets for TB control was partly due to improved access to TB services through public-private mix DOTS (PPMD) facilities. Public hospitals have increased capability to provide health services during dengue epidemics and to address emerging public health threats like bird-flu and Influenza AH1N1. NDHS 2008 likewise reported improvements in maternal and child health services: the proportion of births occurring in the health facility has increased from 38% in 2003 to 44% in 2008. Meanwhile, the full immunization coverage among children ages 12-23 months has improved from 70% in 2003 to 80% in 2008.

One important area of reform is rationalization of health facility investment and upgrading. There is too much infrastructure in some areas and too little in others without any real logical pattern. Sixteen F1 priority provinces, one roll-out province, and one volunteer province have completed their health facility rationalization plans, which are linked to the Province-Wide Investment Plan for Health (PIPH) and the Annual Operations Plan (AOP). Another critical reform strategy for DOH-retained hospitals is income retention, which has been implemented in all DOH hospitals through a special provision of the annual General Appropriations Act. The use of hospital retained-income is expected to contribute significantly to a more responsive delivery of quality health services since funds are readily available for day-to-day operations and for the purchase of hospital equipment. In 2008, cumulative hospital income reached Php 2.4 billion or an increase of 6% compared to previous year's income, resulting in a relatively higher budget for public health between 2006 and 2008 and reflecting the shift in priorities from curative care to public health programmes. However, a study carried out by Lavado et. al. (2010) on resource management in government-retained hospitals showed that there are no guidelines on how to utilize the retained income. Furthermore, submitted reports on utilization of

retained income were not analysed and, despite increased revenues, the planning and budgeting capacities of hospitals remain ad hoc, lacking an overall investment strategy.

Efforts to ensure that quality health services are available are reflected in a 38% increase in the number of Philhealth accredited health facilities and a 7% increase in accredited health professionals from 2005 to the first quarter of 2009. In 2008, 94% of DOH hospitals were PhilHealth-accredited. Encouraging successes were likewise observed at the first 16 F1 provinces with a high number of Philhealth accredited facilities which suggest adequacy in infrastructure and competency of health human resources. Many health centres and RHUs are accredited for outpatient benefits and TB-DOTS. Many are also preparing to have maternity care package and newborn package accreditation (EC Technical Assistance, 2009).

6.3.2 Regulatory Reforms

Through the years, regulatory reforms sought to ensure access to safe and quality medicines, health services and health technologies. Traditionally, the DOH has regulated medicines, health devices and products and hospitals, but to date, there is no coherent framework to regulate the outpatient or free-standing clinics.

Similar to major changes in service delivery in 1987 after the People Power Revolution, the impetus in adopting pharmaceutical reforms was also linked with the rise of a new government. This, combined with strong leadership in the Department of Health, an empowered community of non-governmental organizations that participated in the policy process and a growing body of knowledge about the drug management issues, helped to secure reform (Lee, 1994; Reich, 1995). The Philippine National Drug Policy (PNDP) was created; it served as the overarching framework for ensuring that safe, efficacious, and good quality essential medicines are available to all Filipinos at a reasonable and affordable cost. PNDP is anchored on five interconnected pillars of quality assurance, rational drug use, self-reliance on the local pharmaceutical industry, tailored or targeted procurement, and people empowerment. The two major strategic components of the PNDP are the Philippine National Drug Formulary (PNDF) as mandated by EO 175, signed on May 22, 1987 and the Generics Act of 1988 (RA 6675).

The Generics Act of 1988 aims to promote and require the use of generic terminology in the importation, manufacturing, distribution, marketing, advertising, prescribing and dispensing of drugs. Complementing the Act is the PNDF or essential drugs list – the main strategy in promoting rational drug use. Pursuant to EO 49, PNDF is also used as a basis for the procurement of drug products in the government sector. It contains the core list of drugs in their international nonproprietary name/generic names, as well as a complementary list of alternative drugs.

After seven years of implementation, the review of the Generics Law and the programme evaluation of the national drug policy showed mixed results. Gains from these policies include increased general awareness about generics drugs, higher demand for generics as the public sector complied with EO 49, which stimulated local production of generics, compliance with GMP by the local pharmaceutical industry and the progressively increasing capacity of BFAD to ensure quality assurance. However, several barriers reduced the gains from implementing these policies: there was no administrative mechanism to track local implementation of these policies; GATT/WTO agreements worsened the uneven playing field in the pharmaceutical industry; and, the country lacks a pricing mechanism that ensures affordable generic medicines can compete with branded ones.

Regulatory gaps also exist in other areas, such as health technology (e.g., non-radiation devices) and private health insurance. In part, problems are due to inadequate expertise and a shortage of staff working as regulatory officers and to limited understanding of regulatory functions at local health facilities. In response to these problems, the HSRA has proposed two reform strategies: (1) strengthening the mandate in health regulation, particularly in areas of food and drugs; health facilities, establishments and services; health devices and technology; health human resources; and, quarantine and international health surveillance; and, (2) increasing the capacities of health regulatory agencies in standards development, licensing, regulation and enforcement.

Recently, the implementation of various regulatory reform policies is beginning to bear fruit. For instance, the current generic medicines policy is further strengthened by generics prescribing in the public sector and improved use of the PNDF system. These two instruments may have resulted in 55-60% of the general public buying generic medicines (SWS, 2009). Moreover, the PNDF Perceptions Survey

confirmed that prescribing within the PNDF significantly increases the proportion of drugs taken by patients, thereby improving the likelihood of patient adherence. However, despite increased likelihood of Philhealth reimbursement when complying with PNDF, physicians prefer their autonomy in choice of drug for their patients, whether the drugs are included in PNDF or not.

Universally Accessible Cheaper and Quality Medicines Act of 2008 specifically mandated the regulation of the prices of medicines. Consistent with this law, EO 821 was signed in July 2009 prescribing the Maximum Drug Retail Prices (MDRP) for selected drugs and medicines for leading causes of morbidity and mortality. The medicines for which the MDRP will be applied are selected based on the following criteria: (1) conditions that address public health priorities, especially those that account for the leading causes of morbidity and mortality; (2) drugs that have high price differentials compared to international prices; (3) lack of market access, particularly for the poor; and (4) limited competition with their generic counterparts. EO 821 imposed MDRP to five molecules, but the multinational pharmaceuticals have agreed to lower their prices by 50% for selected products for at least another 16 molecules. These medicines are for hypertension, goiter, diabetes, allergies, influenza, infections, hypercholesterolemia, arthritis and cancer. In response to EO 21, other companies have also volunteered to reduce drug prices by 10-50% in an additional 23 molecules under the government mediated access price scheme by the end of 2009. By mid-2010, the prices of 93 more medicines and 5 medical devices were reduced up to 70% off the current retail prices (DOH, 2010).

MDRP monitoring among physicians and patients commissioned jointly by the Department of Trade and Industry (DTI) and the DOH in June 2010 reported that more than half of interviewed physicians prescribe more innovator brands than generic brands, while only 13-18% prescribe more generic brands than innovator brands for chronic diseases. About two thirds of doctors prescribe the original brand while only 8% of them prescribe generics for IV antibiotics. Among the patients interviewed, 90-98% of them claimed that they generally follow the brand prescribed by their doctors, except among patients requiring IV antibiotics, where about 7% of patients would occasionally not comply with what was prescribed. Awareness of the generic counterpart of medication among patients is variable; only 48% of patients are aware of the generic counterpart of their medicines for hypertension and heart disease, while 87% of them

know the generics of oral/suspension antibacterials. Patients receive information on the generic counterpart of their medicines from doctors (41%) and pharmacies (34%). The patients perceive the price of medicines as between somewhat cheap to somewhat expensive, but more patients (60-63%) requiring IV antibiotics and antibacterials think that their medicines are somewhat cheap (DTI & DOH, 2010).

To ensure accessibility of medicines, the DOH expanded the distribution network for medicines and strengthened the Botika ng Barangay (BnB) Programme, which aims to establish one pharmacy in every village. Each BnB can offer up to 40 essential medicines and are allowed to sell 8 prescription preparations. On average, the medicines sold at BnBs are 60% cheaper compared to commercial drug stores. As of July 2010, 16 279 BnBs have been established in the whole country. A GTZ-European Commission study reported that among BnBs that were operating for at least two years, 85% remained functional and served around 500 patients per month per outlet. To complement BnBs, DOH-Philippine International Trade Corporation (PITC) sets up a nationwide network of privately-owned and operated accredited pharmacies called Botika ng Bayan (BNBs), or town pharmacy. As of August 2009, 1971 BNB outlets have been established nationwide.

6.3.3 Health Financing Reforms

Prior to the enactment of the National Health Insurance Act (NHIA) in 1995, the Philippine Medical Care Commission managed the Medicare Programme by directly paying the accredited providers or by reimbursing the patients for actual expenses incurred. More than half of the population had no coverage, especially the poor, the self-employed and informal sector workers (Solon, et. al., 1995). With the National health Insurance Programme (NHIP) established through the National Health Insurance Agency (NHIA), the entire population was organized into a single pool where resources and risks are shared and cross-subsidization is maximized.

As the main purchaser of health services in the country, the role of PhilHealth is critical in achieving universal coverage and reducing the out-of-pocket spending for health. The inadequate benefit package of the NHIP, its bias towards hospital-based care, the limited coverage of the population and inefficient provider payment mechanisms led to its very low contribution to total health expenditure in the 1990s. To

address these issues, the HSRA has defined reform strategies aimed at expanding the NHIP in order to achieve the universal coverage. These strategies include a) improving the benefits of NHIP and increasing its support value; b) aggressively enroling more members by expanding to the indigent population and the individually paying sector; c) improving programme performance through securing required funding and establishing accreditation standards; and, d) establishing the administrative infrastructure to manage the increased load brought about by the expanded NHIP (DOH, 1999).

The review of HSRA implementation (Solon et. al., 2002) found impressive progress in enrolment expansion for the indigent programme. As of mid-2002, over 900 000 families were enrolled into the indigent programme, already reaching 47% of the 2004 target for indigent enrolment. However, the absence of long-term contractual instruments requires PhilHealth to negotiate the counterpart payment provided by LGUs on a yearly basis. Furthermore, LGUs have indicated that they may not have enough resources to raise their counterpart subsidies to 50% after five years of engagement, as required by the NHIP Law. In addition, low utilization rates among indigent members led many LGUs to question the attractiveness of the programme. The expansion of the IPP to cover the self-employed has proven even more challenging. Philhealth has started to develop mechanisms to enrol, collect contributions and manage the IPP membership base through cooperatives (e.g. DAR and PCA) and other occupation-based organizations, but progress has been slow.

The success of health financing reforms under HSRA is heavily dependent on broader improvements in the NHIP. To date, NHIP has failed to achieve the goals of providing financial protection, promoting equitable financing and securing universal access to health services. Section 3 discusses these issues in more detail.

Both HSRA and F1 for Health also promote reform of the DOH budget through: 1) developing and updating the Health Sector Expenditure Framework (HSEF) which demonstrates the link between budget allocation and performance; 2) establishing a system for budget allocation, utilization and performance monitoring in order to shift from historical and incremental budgeting system to a performance-based mechanism; 3) mobilizing extra-budgetary funds through the SDAH; and 4) coordinating the national and local health spending through the province-wide investment plan for health.

As a result of these strategies, there was increase in the DOH budget allocation in CY 2008-2010. The DOH budget has also been aligned with F1 priorities and thrusts. Moreover, a health financing strategy has been developed to articulate the strategies that will improve the health financing reform implementation from 2010 to 2020. The Programme Planning and Budgeting Development Committee (PPBDC) has been created to ensure effective programme planning and development in line with the F1 for health goals and objectives.

6.4 Future Developments

Universal health care means ensuring that every Filipino family is within reach of a professional health provider capable of meeting their primary health needs and with the capacity to refer them to higher level providers for their other health needs. To achieve this, local health facilities must be upgraded, health provider networks must be established and adequate health providers must be deployed. Moreover, every poor Filipino family shall be covered by the National Health Insurance Programme.

To achieve universal health care, the capacity of local government units to manage the local health system must be strengthened, including their ability to engage the private sector in health service delivery. The DOH must be able to effectively use its policies and guidelines to ensure the quality of health services provided at all levels of care and to leverage its resources to achieve better health outcomes. The new Aquino administration has called for universal health coverage (Aquino, 2010) and this is now a major policy priority for the sector.

7. Assessment of the Health System

7.1 Section Summary

Despite some successes and important progress in some areas, the Philippines' health sector remains marred by problems of inequity, even after successive waves of reform, from primary health care decentralization to the more recent health sector reform agenda. An independent and dominant private health sector, the disconnect between national and local authorities in health systems management, and the absence of an integrated curative and preventive network together have had a negative impact on economic and geographic access, quality and efficiency of health services.

Health development efforts in the Philippines have aimed to address the problem of inequity for almost four decades. Selective implementation of primary health care (PHC) in 1979 resulted in some improvements in basic health services for the poor but did not alter the structure of secondary and tertiary care services that continued to benefit only those population segments that could afford to pay for services. Devolution of health services to local governments in 1992 worsened the unequal distribution of health resources between high income provinces and poor localities. Reforms of the health sector beginning in 2000 have continued to have little or no impact on a hospital network dominated by high-end for-profit private institutions. As a consequence, inequity continues to be the main health problem of a health sector where poor health outcomes persist for the poorest income groups and geographic areas.

7.2 The Stated Objectives of the Health System

The Philippine health system has elaborated specific goals and objectives for the medium term period of 2005-2010 in its National Objectives for Health 2010 monograph. It specifies three goals of (1) better health outcomes, (2) more equitable financing, and (3) increased responsiveness and client satisfaction. For the 2011–2016 plan, the government has identified achieving universal health care (*Kalusugan Pangkalahatan*) as the main goal.

Improvements in the delivery of key public health services have, in turn, improved overall health outcomes but progress towards the health MDGs appears to have slowed, especially in economically-depressed communities. Regulation of goods and services has been strengthened by laws, but commercial interests continue to dominate regulatory processes. Despite strong efforts in the implementation of Philippine Health Insurance Law, out-of-pocket costs have continued to increase, eroding progress towards more equitable health financing. Reforms in the governance of the health system continue to be stymied by a flawed Local Government Code (LGC) that has increased fragmentation in the management of health services.

7.3 Equity

Access to services is limited by financial and social barriers. There are widespread disparities of coverage rates for many public health programmes. In a major and basic programme like child immunization, as many as 70% of local government units (LGUs) have coverage rates lower than the national average. This indicates that only 30% of LGUs, usually metropolitan areas, prop up the national performance levels. The lowest coverage rates for major programmes on child health, maternal care and infectious disease are typically in difficult-to-reach island provinces, followed by mountainous areas, and areas of armed conflict. The Region of ARMM, with a number of island provinces and with many conflict areas, consistently registers the lowest coverage rates in the country. Low coverage rates are also found in the poorest quintiles of the population, among rural areas and among families with uneducated mothers. These disparities are consistently found in population surveys, special studies and routine data collection on the health system.

Inequities in the coverage of health services are paralleled by similar disparities in the distribution of human and physical resources. While nationwide average supply levels of health staff are adequate or nearly adequate, distribution across provinces is not consistent with need or poverty levels. Only large public regional hospitals operated by the DOH in 16 regions of the country are distributed in a way that reflects the needs of poorer groups (Caballes, 2009). Local government public hospitals provide physical access to services, but fail to address financial barriers; their distribution based on population size rather than poverty incidence. Infectious diseases, child care and maternal care have basic care packages at all levels of care, while non-communicable disease services

lack systematic programmes, standards, and service packages at first levels of care.

Utilization patterns are affected by financial barriers, negative perceptions about quality of care, and lack of awareness of services. The poor utilize primary health facilities like RHUs and BHCs more than hospitals because of co-payments and balance billing in government and private hospitals. In terms of hospital utilization, government hospitals or lower-level hospitals, despite their geographical accessibility, are bypassed in favor of private facilities and higher level facilities, respectively, because of perceived poor quality. In fact, government hospitals intended to serve the poor have a large non-poor clientele, who patronize government facilities because of the high cost of private facilities, and the low support value of social health insurance (ie, the low levels of reimbursement compared to actual costs). In general, a lack of information combined with concerns about cost deters the poor from using health services. Even the utilization of PhilHealth benefits is low among the poor due to lack of awareness about benefits and the complex administrative requirements for receiving such benefits

Public financing levels have steadily increased, however remain low in regional terms. High and steadily increasing out-of-pocket spending exposes the population, particularly the poor, to large financial risks from illness. Social health insurance (PhilHealth), which was set up 14 years ago to be a major payer of health care, is only financing about a tenth of the country´s total health expenditures. Local government financing for public health services at community levels pays for more of the health sector expenditures than PhilHealth, but still finances less than the targeted share. Although studies suggest that the large out-of-pocket (OOP) spending does not have a major impact on poverty, it is likely that high OOP is a major barrier to accessing services in the country (NSO, 2003).

Overall, financing for health is regressive in the Philippines. Richer populations capture a greater share of the benefits offered by public facilities. In addition, PhilHealth premium collection becomes regressive for salaries exceeding the Php 30 000 monthly salary cap. The amount of direct payments for medical goods and services unsupported by PhilHealth, and paid OOP remains high and is even higher among the poor. The two poorest income quintiles have the least PhilHealth coverage and frequently register the lowest PhilHealth utilization rates.

7.4 Allocative and Technical Efficiency

As measured by the national health accounts (see section 3), more health resources are spent on personal care than public health, although it is difficult to determine their optimal mix. Drug expenditures consume 70% of out-of-pocket health expenditures and are largely spent on heavily marketed non-essential and mostly ineffective medications. Health facilities and human resources for health are concentrated in relatively affluent urban areas. Devolution of health service responsibility to local governments has widened the gap in health resource allocation between poor mostly rural provinces and those with high incomes that are more urbanized.

Health workforce production is geared toward a perceived lucrative international market rather than national health needs. National government facilities providing expensive tertiary level care have budgets that are disproportionately high in relation to local primary care programmes and facilities. The national health insurance programme also follows this trend by favoring hospital-based care even for relatively simple health problems. Fragmentation is evident in the lack of coordination/integration between primary levels of care and specialty intervention within government, within the private sector, and between the private and public sector.

7.5 Quality of Care

Available data point to inadequate levels of quality in the health system. Efforts to improve quality are typically ad hoc and uncoordinated, involving many different authorities. This may be due to the lack of data on quality, and the lack of incentives for quality practice.

On the positive side, most hospitals and professional practitioners meet the quality standards set by licensing requirements and PhilHealth accreditation standards. However, quality processes are substantially lacking in primary health centres, where licensing standards are absent, and accreditation rates are very low. A current measure to further improve quality in hospitals is the PhilHealth benchbook, which contains all standards of quality processes and outcomes for hospitals. These standards are complex and may take some time to produce results on quality care.

Data on quality outcomes are few and unreliable, but surveys show private providers are favored over public providers because they are perceived to offer better quality care. Primary care facilities and lower level hospitals are bypassed because of similar perceptions of low quality. Effective consumer participation strategies to increase accountability of public providers and primary care facilities and to increase client voice are at an early stage, and may need to be coupled with performance incentives in order to have an effect on improving quality in these facilities.

7.6 The Contribution of the Health System to Health Improvement

The health system in the Philippines has made some observable contributions to health improvement in the country. In programmes where there is substantial participation of national government and strong coordination with local governments, improvements in health outcomes are noticeable. This is true for communicable disease control (such as tuberculosis, leprosy, and filariasis) as well as child health programmes (collectively labeled "Garantisadong Pambata" or guaranteed child health). Where the national policy is not directly supportive of local government action, health results are adverse–for example, persistent high fertility rates due to a disjointed family planning policy.

In comparison to lower middle income countries (WB, 2009), the Philippines shows better health indices, despite the relatively lower economic indicators and larger population. Health outcomes are generally good. Life expectancy shows increasing years of life, and major health indicators for child health and infectious disease have improved. However, the rate of improvement in recent years has slowed down, and it appears unlikely that MDG targets set for 2015 will be reached.

The major weakness of the health system, nevertheless, is its failure to address the large disparities in health outcomes between the rich and poor, resulting from economic and geographic barriers to health services. For example, the ARMM and similar geographic areas have consistently poorer health status than the richer regions around metropolitan areas. The prolonged inequity of outcomes can be traced to a historical trend of poor basic health services at primary and secondary level of care.

8. Conclusions

As measured by standard health status indicators, the health of Filipinos improved considerably during the second half of the 20th century. Infant and maternal mortalities, as well as the prevalence of communicable diseases, have been reduced to half or less, while life expectancy has increased to over 70 years. Control programmes for prevalent communicable diseases such as leprosy, malaria, schistosomiasis, and tuberculosis have drastically reduced morbidities and mortalities due to these illnesses.

These improvements, due to improved social conditions, are also the result, at least in part, of a health system with modern technologies. Public health interventions delivered by government health services have penetrated most areas of the country. Sophisticated curative interventions are available in major metropolitan areas, especially in a dominant private health sector.

Nevertheless, for many Filipinos, health services have remained less than adequate. This is evidenced by a slowing in the rate of health improvements like children's morbidity and mortality. Maternal mortality ratios have remained unacceptably high. The prevalence of most communicable diseases continues to be high and requires continuous attention.

In addition, the Philippines' health sector faces increasing challenges from emerging new communicable diseases, such as the changing influenza patterns and the dangerously increasing threat of an HIV/AIDS epidemic. Also, non-communicable diseases associated with lifestyle changes of modern living are steadily growing in importance, as illustrated by diabetes, cardiovascular disorders and cancers, which have continuously increased in incidence and prevalence. This is reflected in the present mortality and morbidity patterns.

The slow improvement in health status indicators and the need for more sophisticated interventions for emerging infections and degenerative

diseases have highlighted the health sector's main problem, namely a significant and growing inequity in access to health services at all levels. In order to face the problem of inequity, reforms in all areas of the Philippine health system are required in order for the country to attain universal health care.

The fragmentation of health service delivery needs to be addressed from a number of angles. Government services, broken up through their devolution to local governments, must be re-integrated either by mandate or by agreement among different levels of government. Referrals will also need to be established not only between primary, secondary, and tertiary levels of care, but also between government and private providers.

A comprehensive national health information system based on automated data collection and dissemination is necessary to resolve the problem of an antiquated and uncoordinated information system. Such a system can only be developed by a coordinated effort of the different government agencies currently involved in collecting, analyzing, and disseminating health information. In addition, involvement and cooperation by private institutions will be required to ensure that information is all inclusive.

Regulatory mechanisms that support the provision of equitable health services are an important component of a programme aimed at universal health care. Regulatory reforms ensure that health concerns are given priority over commercial interests, guaranteeing that health care goods and services contribute to the attainment of equity in health. Particular attention needs to be paid to the reform of regulatory agencies affected by the new food and drug law.

To build participative mechanisms that are currently missing in the health policy process, the national government needs to initiate governance structures that include the interest and voices of all stakeholders in the health system, especially the individuals, families, and communities that are in need of health services. Such mechanisms can include, but are not limited to, local health boards, the governing bodies of hospitals and other health service facilities, and major policy-making bodies. The health governance structures developed for this purpose can be informed by the principles of primary health care as originally contained in the Alma Ata Declaration and updated by recent international initiatives such as the Report of the Commission on the Social Determinants of Health.

Further elaboration of the Human resources for health master plan, coordinated by the DOH, needs to include provisions that address the issue of health inequity. The plan should take into account the current uncoordinated structures that govern human resource planning, recruitment, deployment and management. Particular attention should be given to establishing links between the country's needs for professionals and the production processes that are lodged mainly in academic institutions and professional organizations oriented towards an overseas market. An important first step is the establishment of an up-to-date health workforce information system.

Last but not least, the issue of equity in access to health services requires major changes in the way these services are financed. In particular, a strong effort needs to be initiated to drastically reduce the share of out–of-pocket payments as a source of health financing. This effort should be government led and will require substantial and coordinated increases in tax-based spending at national and local levels, in addition to substantial improvements in the current design of the social health insurance scheme. The latter can be supported by a reform of the premium and benefits structure that will eliminate the ceiling on premium collection and expand the benefits package.

All reforms in the different components of the health system aim at the common objective of universal health care for Filipinos. The efforts have an initial focus on improving coverage of the poor, but need to eventually cover the whole population, regardless of income, in order to avoid or reverse a two-tiered system that tends to worsen inequities.

9. Appendices

9.1 References

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9.2 Useful websites

Available in English as of October 2010:

Government Agencies and Offices

Commission on Higher Education (CHED)
http://www.ched.gov.ph

Department of Budget and Management (DBM)
http://www.dbm.gov.ph/

Department of Finance
http://www.treasury.gov.ph

Department of Health (DOH)
http://www.doh.gov.ph

Health Sector Reform Agenda
http://erc.msh.org/hsr/index.htm

House of Representatives
http://www.congress.gov.ph/index.php

National Economic Development Authority (NEDA)
http://www.neda.gov.ph

National Statistical Coordination Board (NSCB)
http://www.nscb.gov.ph

National Statistics Office (NSO)
http://www.census.gov.ph

Official Gazette of the Government of the Philippines
http://www.gov.ph/

Philippine Council for Health Research and Development (PCHRD)
http://www.pchrd.dost.gov.ph/

Philippine Health Insurance Corporation (PhilHealth)
http://www.philhealth.gov.ph

Philippine Institute for Development Studies (PIDS)
http://www.pids.gov.ph/

Philippine Overseas Employment Administration (POEA)
http://www.poea.gov.ph/

Professional Regulation Commission (PRC)
http://www.prc.gov.ph

Senate of the Philippines
http://www.senate.gov.ph

Society of Philippine Health History
http://www.sphh.org.ph

Local Institutions, Agencies and Organizations

Community Health Information Tracking System (CHITS)
http://www.chits.ph/web/

Galing Pook Foundation
http://www.galingpook.org/main/

National Institutes of Health (NIH)
http://nih.upm.edu.ph/

Social Weather Stations (SWS)
http://www.sws.org.ph/

Society of Philippine Health History
http://www.sphh.org.ph

University of the Philippines – Manila
http://upm.edu.ph/upmsite/

University of the Philippines
http://www.up.edu.ph/

International Agencies

Asian Development Bank – Philippines
http://www.adb.org/philippines/main.asp

The World Bank
http://www.worldbank.org/

UN data
http://data.un.org/

UNICEF Philippines
http://www.unicef.org/philippines/

United Nations – Philippines
http://ph.one.un.org/

United Nations Development Programme – Philippines
http://www.undp.org.ph/

World Development Indicators Database
http://data.worldbank.org/data-catalog/world-development-indicators

World Health Organization – Western Pacific Region
http://www.wpro.who.int/

World Health Organization
http://www.who.int/en/

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with an external editor and the Secretariat of the Asia Pacific Observatory, based in WHO's Western Pacific Regional Office in Manila. HITS are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Data are drawn from information collected

by national statistical bureaux and health ministries. Furthermore, international data sources may be incorporated, such as the World Development Indicators of the World Bank.

In addition to the information and data provided by the country experts, WHO supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the Western Pacific Country Health Information Profiles (CHIPs) and the WHO Statistical Information System (WHOSIS). HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process consisting of at three stages. Initially the text of the HiT is checked, reviewed and approved by the Observatory Secretariat. It is then sent for review to at least two independent experts, and their comments and amendmentss are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are to check for factual errors within the HiT.
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

9.4 About the authors

Alberto G. Romualdez Jr is a retired Professor of Physiology. He was Dean of the University of the Philippines College of Medicine from 1984 to 1988 and Secretary of Health of the Philippines From 1998 to 2001. He served as Regional Adviser for Human Resources for Health and Director for Health Services Planning and Development at the Western Pacific Regional Office of WHO from 1988 to 1996.

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Fely Marilyn E. Lorenzo is a research professor at the University of the Philippines, Manila. She was founding Director of the Institute of Health Policy and Development Studies of the National Institutes of Health and directed the research and policy development work there from 1999 to 2006. She continues to do research at the National Institutes of Health - Institute of Opthalmology and engages in policy-related consultancies and projects.

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The Asia Pacific Observatory on Health Systems and Policies is a collaborative partnership which supports and promotes evidence-based health policy making in the Asia Pacific Region. Based in WHO's Regional Office for the Western Pacific it brings together governments, international agencies, foundations, civil society and the research community with the aim of linking systematic and scientific analysis of health systems in the Asia Pacific Region with the decision-makers who shape policy and practice.

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