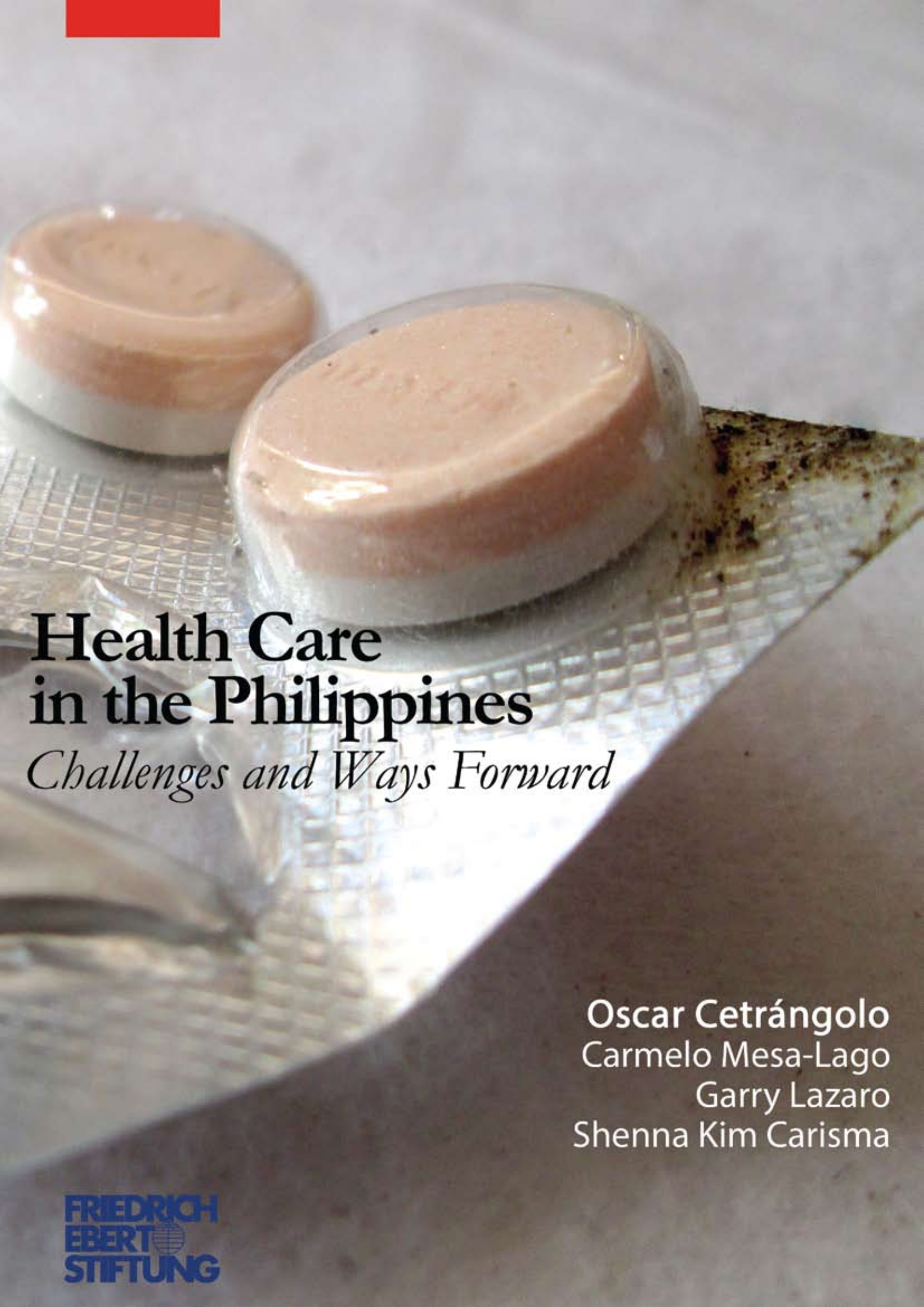


Health Care in the Philippines

Challenges and Ways Forward

Oscar Cetrángolo
Carmelo Mesa-Lago
Garry Lazaro
Shenna Kim Carisma

FRIEDRICH EBERT STIFTUNG

THIS PAGE INTENTIONALLY LEFT BLANK

HEALTH CARE IN THE PHILIPPINES: CHALLENGES AND WAYS FORWARD

THIS PAGE INTENTIONALLY LEFT BLANK

HEALTH CARE IN THE PHILIPPINES: CHALLENGES AND WAYS FORWARD

Oscar Cetrángolo
Professor of Economics, University of Buenos Aires
Principle Investigator, Friedrich-Ebert-Stiftung

Carmelo Mesa-Lago
Distinguished Service Professor Emeritus of Economics, University of Pittsburgh
Consultant, Friedrich-Ebert-Stiftung

Garry Lazaro
Senior Researcher and Executive Director, Institute of Politics and Governance

Shenna Kim B. Carisma
Research Assistant and Program Officer, Institute of Politics and Governance

FRIEDRICH EBERT STIFTUNG

Health Care in the Philippines: Challenges and Ways Forward

Copyright © 2013

By Friedrich-Ebert-Stiftung – Philippine Office, Oscar Cetrángolo, Carmelo Mesa-Lago, Garry Lazaro, and Shenna Kim Carisma

Published by Friedrich-Ebert-Stiftung – Philippine Office.
2601 Discovery Centre, #25 ADB Avenue
Ortigas Center, Pasig City 1600 Philippines
Tel. Nos.: +63 2 6346919, 6377186 to 87
Fax. No.: + +63 2 6320697
Email: info@fes.org.ph
Website: www.fes.org.ph

The views and opinions expressed in this publication are those by the authors and do not necessarily reflect that of the Friedrich-Ebert-Stiftung. The authors are responsible for the accuracy of facts and figures presented in this publication, which is supported in good faith by the Friedrich-Ebert-Stiftung.

All rights reserved.
Not for commercial use. No part of this book may be reproduced in any form or by any means without the permission from the Friedrich-Ebert-Stiftung – Philippine Office.

Photo and cover design by Aildrene Tan
Layout by Nikki Al Ben Delfin

ISBN 978-971-535-037-2

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

FIGURES

TABLES

APPENDIX TABLES

SYMBOLS

PhP	Philippine Pesos
US$	United States Dollars
1 PhP Billion	PhP 1,000 Million

Blank (in Boxes or Tables) means No Available Data

FOREWORD

Gains in the health care system in the country cannot be understated. The past year alone we have seen the passage of two hallmark legislation – the Reproductive Health Law and the Sin Tax Law – both of which will guarantee higher resources for the public health care system and increase access of marginalized sectors to health services. Within Asian countries, the Philippines also appear to be halfway in achieving the Millennium Development Goals indicators on health.

Moreover, improvements in the Philippine Health Insurance Corporation (PhilHealth) have been observed, more notably the increase in coverage of members and beneficiaries from 38% of the total population in 2000 to 82% in 2011. Benefits provided as well as collections from members have likewise increased. Social Weather Station's survey late last year further shows PhilHealth's public satisfaction rating increase from plus 67 percent to plus 82 percent. There is thus much to be hoped for in achieving universal healthcare in the Philippines.

Taking these improvements into account however, considerably more than what was achieved still needs to be done. For example, the quality of healthcare services remains inconsistent across the country with the inefficient decentralization of healthcare functions and resources. Coverage thus is highly unequal among the different regions and provinces of the country, with coverage reaching up to 67.5% in Northern Mindanao but remaining as low as 17.5% in ARMM. There is also substantial difference in access to health services between urban and rural areas, as well as, across quintiles of the population, given that only 21% in the poorest quintile have access to health insurance while access of the richest quintile is at 65%. Moreover, out-of-pocket spending on health remains high at 53% of total health spending showing the high financial burden on each individual that government fails to attend to, exacerbated further by the highly unequal wealth distribution in the country. The Philippines consequently lags behind her Southeast Asian neighbors in healthcare reform.

The Friedrich-Ebert-Stiftung is committed to the values of social democracy and social justice, and hence has been working on the promotion of accessible health care and social security services as an integral part of policy decisions and processes in the Philippines. With the current situation of the health care system in the country, there is indeed fertile ground for progressive reforms and much room for innovations.

The Friedrich-Ebert-Stiftung thus presents this study to provide a comprehensive and objective diagnosis of the state of the Philippine health care system and its ongoing reforms, and forward policy recommendations to lawmakers and government officials, as well as to the academe and civil society organizations. Hopefully the study will be able to provide further input into the reform process and expansion of the health care system as well as in shaping the ongoing public debate.

The study looks at the following key aspects of the health care system: (1) the epidemiological profile of the Philippines, (2) the current organization of the health care system, (3) the health care coverage provided under the National Health Insurance Program of the government, (4) health expenditure and financing, (5) the supply of services and sufficiency of benefits, (6) the social solidarity, regional and gender equity, and (7) the financial/actuarial sustainability of the health system. The study then summarizes the challenges that the health care system is facing and provides specific recommendations and policy proposals on critical reforms that need to be addressed by stakeholders and decision-makers.

We thank Dr. Oscar Cetrángolo from the University of Buenos Aires, the principal investigator for this study, for sharing his expertise in the health sector and providing leadership in the critical analysis of the health care system in the Philippines. We also thank Dr. Carmelo Mesa-Lago from the University of Pittsburgh for his invaluable inputs to the study, as well as Mr. Gari Lazaro and Ms. Shenna Kim Carisma of the Institute for Politics and Governance (IPG) – Philippines who provided technical assistance in the data-gathering and writing of this study. Finally, we would like to thank representatives from the PhilHealth, the Department of Health (DOH), the Department of Budget and Management (DBM), the World Health Organization (WHO), the private sector, the academe and the various civil society organizations who have provided time and resources in identifying leads, pooling in data and refining the study into its final form.

We lastly invite all the stakeholders, especially policy and decision-makers to take a close look at the challenges presented herein, and seriously weigh the recommendations in their efforts to attain universal healthcare for Filipinos.

Berthold Leimbach
Resident Representative
Friedrich-Ebert-Stiftung– Philippine Office

ACKNOWLEDGMENTS

This report was commissioned by the Friedrich Ebert Stiftung. It was written by Oscar Cetrángolo based on the guidelines from Professor Carmelo Mesa-Lago, Senior Consultant and Advisor, in collaboration with Gari Lazaro and Shenna Kim Carisma, and with the assistance of Osvaldo Ulises Garay and Ariela Goldschmit.

The development of this study was made possible through the generosity of numerous public officials, academics, experts from international organizations, and representatives from civil society organizations who were interviewed during a visit by Cetrángolo to Manila on August 5 to 17, 2012 through the invaluable help of Ms. Anne-Helene Vasudevan. The Appendix gives a list of interviewees, whom the authors wish to thank for the information and comments they provided. Also, they wish to thank the response, comments and recommendations from Junice Melgar, Nerissa Santiago and the assistance to the seminar organized to discuss the main findings of the study, in Manila on February 7, 2013.

ABBREVIATIONS

ACS	Auto-Credit System
ADB	Asian Development Bank
AFP	Armed Forces of the Philippines
AHMOPI	Association of Health Maintenance Organizations of the Philippines
ARMM	Autonomous Region in Muslim Mindanao
ASSA	ASEAN Social Security Association
BDR	Benefit Delivery Ratio
BFP	Bureau of Fire Protection
BHSs	Barangay Health Stations
BJMP	Bureau of Jail Management and Penology
CDA	Cooperative Development Authority
CDD	Complete Disability Discharge
CHDs	Centers for Health Development
DBM	Department of Budget and Management
DHS	Demographic and Health Survey
DOF	Department of Finance
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EAP	Economically Active Population
FFS	Fee-for-service
GDP	Gross Domestic Product
GSIS	Government Service Insurance System
HIF	Medicare Health Insurance Fund
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HMO	Health Maintenance Organizations
HSRA	Health Sector Reform Agenda
IMF	International Monetary Fund
IMR	Infant mortality rate
IPD	Institute for Popular Democracy
IPP	Individually-Paying Program
IRA	Internal Revenue Allotment
IRR	Implementing Rules and Regulations
LGU	Local Government Unit
MCP	Maternity Care Package
MDG	Millennium Development Goals
MIMAROPA	Mindoro, Marinduque, Romblon, Palawan (Region IV-B)
MPI	Medicare Program I
MPII	Medicare Program II
NBB	No Balance Billing
NCR	National Capital Region
NDHS	National Demographic and Health Survey

NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
NPP	Non-paying retirees and pensioners
NSO	National Statistical Office
OFWs	Overseas Filipino Workers
OWP	Overseas Workers Program
OWWA	Overseas Workers Welfare Administration
PhilHealth	Philippine Health Insurance Corporation
PhP	Philippine Peso
PMCC	Philippine Medical Care Commission
PMRF	PhilHealth Member Registration Form
PNP	Philippine National Police
POEA	Philippine Overseas Employment Administration
PPP	Purchasing Power Parity
PROs	PhilHealth Regional Offices
RA	Republic Act
RHB	Reproductive Health Bill
RHUs	Rural Health Units
SARS	Severe Acute Respiratory Syndrome
SEC	Securities and Exchange Commission
SEPO	Senate Economic Planning Office
SOs	Service Offices
SP	Sponsored Program
SSS	Social Security System
TB-DOTS	Tuberculosis – Directly Observed Treatment Shortcourse
UNDP	United Nations Development Programme
VAT	Value-Added Tax
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The Philippines is at a crucial moment in its brief history as an independent nation. It is a middle-income country and is facing a process of consolidating a more equitable economic and social development pattern that might sustain its young institutional and democratic organization. In this context, discussions and decisions on social protection are central. The government has put into motion major initiatives to increase the coverage of health insurance and modernize public sector institutions.

A. Health Status in the Philippines

The health status in the Philippines has improved but not as much as in other Southeast-Asian countries. The analysis of the country's demographic and health aspects show that it is going through a demographic and epidemiological transition, characterized by a decrease in fertility, increase in life expectancy and a substantial change in risk factors. Rapid urbanization, high population density, and climate change have begun to influence the emergence and re-emergence of new infectious diseases.

As in other countries, the increase in life expectancy of the Filipinos may be attributed to the improving health status of the people and other socio-economic factors. In the future, more people will reach old age, thus changing the current population pyramid where, currently, those over seventy years old represent a low proportion of the population. With this trend comes an increase in the occurrence of degenerative diseases and disabilities associated with an aging population, and a subsequent rise in health care costs. The health focus therefore should be able to design public policies that cope with future changes in demand.

In the past few decades, the Philippines achieved notable gains in reducing both the infant and child (age under five) mortality rate, but the performance in reducing maternal and fetal death rates is not as commendable. Nowadays, the three most common causes of infant deaths are pneumonia, bacterial sepsis, and disorders related to short gestation and low birth weight, while the most common causes of child mortality are pneumonia, accidents, and diarrhea. The Philippines' rate of prevalence of malnutrition in children under five is similar to the median in the group of middle-income countries but the improvement over time is less than that for this group as a whole.

The analyses of the causes of morbidity in the Philippines indicate that they result from development issues. As in the past, most of the ten leading causes of morbidity are communicable diseases-related. Dengue fever has had sudden increases in outbreaks within a year. The prevalence of HIV/AIDS is estimated to be low, but high-risk behaviors appear to be increasing and could lead to high incidence over time. Unlike the indicators of morbidity, non-communicable diseases are responsible for

the majority of deaths in the country, thus heart diseases and malignant neoplasm cancer comprise more than a third of the total causes of death.

Due to its geographical location, the Philippines has always been subject to natural disasters such as typhoons, earthquakes, tsunamis, volcanic eruptions, among others. All of these factors make the Philippines one of the most exposed countries to natural disasters in the world, leaving it vulnerable to the emergence and re-emergence of diseases related to climate change and other geophysical hazards.

The country still lacks a comprehensive program to assist victims of such disasters, who, more often than not, tend to be poor people living in dangerous areas and in makeshift lodgings. Agriculture, where two thirds of the income of the poor depends, is the most vulnerable to the effects of climate change and the impact of plagues and diseases. In conclusion, a comprehensive assistance program is an important concern since disasters cause serious damage and loss of property especially to the poor, and destroy their only means of living. If they do not receive assistance, the risk of falling in a perpetual poverty trap is high.

B. Organization of the Health System

Since 1995, the National Health Insurance Program (NHIP), provided by Philippine Health Insurance Corporation (PhilHealth), is a government mandatory health insurance program that seeks to provide universal health insurance coverage and ensure affordable, acceptable, available, accessible, and quality health care services for all Filipinos. This program includes reforms to widen coverage in a gradual manner through various PhilHealth components. The most important among them is the introduction of the Sponsored Program (SP), which aims at covering the poorest households (PhilHealth, 2012).

The goal of the NHIP is to provide compulsory health insurance coverage for all as a mechanism to allow all Filipinos to gain financial access to health services. The provision for universality and equity applies to the various classifications of members in the resident population and those working overseas on a contractual or long-term basis. Although the system is still far from achieving its long-term goals, that is the outlook of the current reform process.

There are five types of NHIP members, tied to five different PhilHealth programs, each with diverse conditions of access, benefits and financing:

i. ***Employed Sector Program:*** compulsory coverage of all employees in government and the private sector.
ii. ***Individually Paying Program:*** voluntary coverage of the self-employed and others not covered by the rest of the programs.
iii. ***Sponsored Program:*** covers the extremely poor (quintiles 1 and 2).
iv. ***Overseas Filipino Workers***
v. ***Lifetime Member Program:*** free for members that have already completed their 120 monthly contributions.

In addition, PhilHealth covers, without additional premium, the member's dependents: the legitimate spouse who is not a member in her/his own right, children and step-children below 21 years of age, and parents or step-parents aged 60 and older who are not members. There is no limit to the number of member's dependents.

The private subsector captures the greatest proportion of health care resources. A small group of Health Maintenance Organizations (HMOs) is devoted to providing or arranging for the provision of pre-agreed or designated health care services to its enrolled members for a fixed prepaid fee in a specific period of time.

The Philippine health system is ruled by the national government through the Department of Health (DOH), the lead agency in the sector, which is responsible for the general regulation and supervision of the country's health system. Its most important task is to manage the sector's national policies and develop national plans, as well as establish health technical standards and guidelines. DOH is headed by a cabinet-rank secretary, who is appointed by the President of the Republic.

Since the devolution of health services in 1991 by the Local Government Code, the provision of such services, particularly at the primary and secondary levels, is through the local government units (LGUs). Hence, health service is managed through provincial, municipal and barangay local government offices. Provincial and district hospitals are the responsibility of provincial governments while the Rural Health Units (RHUs) and Barangay Health Stations (BHS) are managed by municipal government units. To prevent the likely negative effects of institutional fragmentation, special importance should be given to the relationships among programs, the different levels of government and its institutions.

C. Coverage

Despite the long-term objectives and measures implemented in the past few decades, the Philippines' health care coverage is still insufficient in terms of the number of people covered, benefits assured to each group, and the quality of such services. NHIP is the largest insurance program in terms of coverage and benefit payments. While private insurance and HMOs have grown considerably in recent years, their share of the total health spending remains small relative to the NHIP.

PhilHealth coverage has increased significantly, from 38% of the total population in 2000 to 82% in 2011. However, 18% of the population is not covered and has no access to quality health care. The composition of the coverage in PhilHealth components shows that the Sponsored Program covered 49.1% of all beneficiaries in 2011, thus reflecting the equity objectives sought by the program since they are low-income beneficiaries. Health care coverage from other components are as follows: the private employed component at 23.1%, Individually Paying Program (IPP) at 12.6%, government employed at 7.5%, overseas workers at 6.5% and lifetime members at 1.2%. In an aggregate way, the contributory components' share in the NHIP is growing and covered 37.6% of the employed population in 2010.

PhilHealth membership in 2010 was considered significant because of the following points: a) the government sector had the highest share in the reference population covering 64.4% of all civil servants; b) the private-sector employees component covered 54.0% relative to formal private sector employees; c) the IPP component accounted for 20.3% of informal employees, a significant increase in the incorporation of members although such share is still considerably low and reveals the limited coverage of the informal sector (above 50% of the labor force) hence the need to develop a strategy to effectively reach the members of this sector; d) the Non-Paying Lifetime Members, account for less than 10% of the population older than 60, a confirmation of the weak contributory history of Filipino workers.

Beneficiaries of the Overseas Workers Program (OWP) are particularly relevant as usually members are abroad, but their dependents reside in the Philippines. This component constitutes an innovative and unique health policy.

PhilHealth is carrying out various measures to fight fraud and abuse, particularly declaring non-dependents as dependents, through the Fact Finding Investigation and Enforcement Department. It aims to control and supervise the system and prevent the proliferation of adversarial selection practices of the beneficiaries, fraudulent practices by providers, and the "cleansing" of the list of beneficiaries in the system.

In 2010, the government's main goal in its new health sector plan was to achieve universal health care. The plan was to increase the number of poor people enrolled in PhilHealth and to improve the outpatient and inpatient benefits package. A full government subsidy is offered to the poorest 20% of the population, and premiums for the second poorest 20% will be paid in partnership with the LGUs. This measure has led to an explosion of members and beneficiaries of this component that compensates for the adverse effects of the current global financial crisis.

Likewise, the private sector offers coverage through voluntary pre-paid medical insurance. In some cases, additional coverage is given on top of that granted by social security, thus resulting in a double coverage of the higher-income strata. Despite the growth of this subsector, it accounts for barely 10% of the covered population.

The expected evolution of health coverage for the population in the next few years is based on five groups of effects that reflect the situation of the PhilHealth components:

i. The contributory component of coverage is closely related to labor market dynamics.
ii. OWP coverage will depend on the demand for Filipino workers abroad and, consequently, on the economic evolution of the countries importing Filipino labor.
iii. Voluntary contributions of IPP and OWP, as well as private coverage like HMO are closely linked to individual decisions, but are also associated with economic

activity and formal employment. In the case of private coverage, its expansion might also have been the result of dissatisfaction of scope and quality of services provided by the different PhilHealth components.

iv. Non-contributory state-financed coverage is strongly linked to the evolution of general and extreme poverty incidence (SP beneficiaries); demographic dynamics (i.e., as the population ages, there would be more non-paying retirees and pensioners (NPPs)); and the fiscal space wherein the government has to increase financing for programs aimed at the needy.

v. Projections of coverage of the population older than 60 (NPP beneficiaries), do not show a significant expansion, even when this group faces more and costlier health services due to its characteristics.

The current scope for the SP should provide coverage to the poorest 40% of the population so that in a scenario perfectly focused and completely covered as stated in the program, the worsening socio-economic conditions of the population resulting from an unfavorable economic cycle might not result in a greater coverage, but in a change of coverage towards more vulnerable sectors. In this context, the ability of this component to have a countercyclical response is strongly limited, therefore reducing the possibilities of gaining access to health coverage for a wide range of population sectors.

To better cope with crisis effects, the NHIP should assign more resources to the SP in order to finance non-contributory health services for the needy. Under a crisis, a higher number of beneficiaries are incorporated into this component, thus partly making up for the decrease in beneficiaries in the contributory part. Therefore, the non-contributory component might act in a countercyclical way. However, it is difficult to rapidly incorporate new SP beneficiaries because of red tape and timing, as well as unsustainable funding, and significant challenges to cover the poor in the long run.

D. Expenditures and Financing

The resources earmarked for health financing in the Philippines are little (3.6% of GDP in 2011), a result of different factors combined: a low tax burden (12.3% of GDP) and a low public budget share of health spending (only 7.6% of the total). A system that rests on the financing of the private sector, where there is a high proportion of out-of-pocket spending to gain access to health services or medicine, is a significant source of inequality.

LGUs are responsible for the provision of direct health services, particularly at the primary and secondary levels. Provincial and district hospitals are under the provincial government while the municipal government manages the RHUs and BHSs.

The health care's financing system is fragmented and inequitable. It is fragmented into different NHIP components and between public and private spending. It is inequitable due to the high burden on individuals such as private and out-of-pocket spending. Additionally, the differences in coverage, typical of a decentralized scheme,

must be taken into account. For this reason, the financial transfer system between government levels plays a key role. Lastly, inequality is rather evident in the level of out-of-pocket expenses for medicines and other medical services. Private sub-sector share was 2.3% of GDP and 64.8% of total spending, out of which 83.8% went to out-of-pocket expenses, thus leaving vulnerable the financial and health status of the poor and low-income group.

Summing up, the financing and resources of the Philippines' health system are inadequate to reach the goal of access to universal coverage.

E. Supply of Services

The access to health services for the population depends on their supply, the access conditions, and the degree to which the benefits provided by public programs are adequate to meet people's needs. The distribution and coverage of health services' supply largely determines the real possibilities the citizens have to gain timely access to health facilities and human resources. As in most developing countries, the general pattern in the Philippines is the concentration of health services in relatively affluent urban areas (Mariano, 2012-I).

As a result of the process of decentralization, public health services are mainly delivered by LGUs with the technical aid of the national government through the DOH. In addition, there are specific campaigns and other national programs coordinated by the DOH and the LGUs. Provincial governments manage secondary and tertiary level facilities, and the national government manages a number of tertiary level facilities. In a decentralized system as that of the Philippines, the nearest services to households are the BHS.

The private sector delivers services at all three system levels. Private primary services are provided through freestanding clinics, private clinics in hospitals and group practice or polyclinics. Private health clinics, diagnostic/imaging centers, and laboratories operate in larger towns. The distribution of hospitals by region also shows disparities that characterize the country's level of access to health services, where there is an uneven pattern of distribution of facilities from both the public and private sector.

On average, there are 54 beds per hospital, with higher bed availability in the public sector (68) relative to the private sector (45), and a distribution of such beds in a somewhat even fashion between government and private hospitals.

Medicine production and distribution must be better regulated due to its impact on out-of-pocket spending. Retail pharmacies and drug stores are the main sources of prescription and over-the-counter drugs; they used to be single proprietorship businesses but have been dominated by national retail pharmacy chains and franchises (60% of the market). In recent years, village and town pharmacies sponsored by DOH (e.g. Botikang Barangay, Botikang Bayan) have been revived and multiplied in poorer

Barangays lacking a private retail pharmacy, but most have low turnover and face difficulties with replenishing their supply.

The Philippines has ratios of nursing and midwifery, dentistry, and pharmaceutical personnel of one to every 10,000, in line with upper middle-income countries or even going beyond their values. But when focusing on the available human resources in the LGUs, there has been some stagnation in the last few years. An important issue affecting the health sector's human resources is the growing migration of trained resources to other countries. The Philippines has become a major source of health professionals to many countries because of their fluent English, skills and training, compassion and patience in caring. This leads to a costly brain drain, hence hurting the health sector. Measures should be taken so that the human resources required for the functioning of the sector remain in the country.

F. Sufficiency of Benefits

PhilHealth combines different methodologies and mechanisms to provide benefits.

- With the exception of SP, inpatient care benefits provide "first-peso" coverage up to a maximum amount which is payable to providers on a fee-for-service basis. The coverage cap varies with case type (surgical, general medicine, maternity, pediatrics, etc.) and level of the facility (primary, secondary, tertiary).
- Fixed case payments are made for the TB-DOTS, the Maternity package and the SARS and Avian Influenza package.
- In the case of the outpatient package provided to indigent members, PhilHealth uses capitation payments.
- For Sponsored Members and their dependents, the case rates and No Balance Billing (NBB) combination of policies guarantees access to a complete set of services without the need to shell out additional payment over and above the case rates. However, in support of the country's commitment to reducing maternal and infant mortality rates, NBB is also applied to other beneficiaries of components of NHIP (different from SP) for the maternity care and newborn care packages in all accredited Maternity Care Package (MCP) non-hospital providers (e.g. maternity clinics, birthing homes).
- There also exists the possibility of reimbursement upon submission of an official invoice, which is deducted from the case payment.
- When a sponsored member is admitted in a private hospital, the NBB policy will not apply, unless the private hospital voluntarily implements it.
- Additionally, since September 2011, PhilHealth has begun to use the case rate scheme for medical and surgical procedures. This was implemented in order to limit discretionary measures in the collection process for such services and in order to make information transparent to the patients. This scheme has a fixed rate for each treated case, in all hospitals, regardless of types and levels.
- "PhilHealth plus" is a plan aimed at providing, besides the basic minimum package, supplemental health benefit coverage to beneficiaries of contributory funds. The goal of this scheme is to bring down out-of-pocket expenses to the lowest possible level, which will help mitigate the financial risk of the patient in the face of illnesses. This includes what basic insurance would not cover fully, or it will cover the cost of receiving care in a private room or having a choice of physician/s and minimizing waiting time. All this complements the benefits

provided by PhilHealth; it should be noted however that this may widen inequity as the highest-income sectors will undoubtedly be those that will be able to gain access to differentiated health services.

- Additionally, PhilHealth implemented an initial package of Z Benefits. These are the cases that are at the end of the spectrum if we rank all illnesses and interventions from A to Z based on their increasing complexity and cost. Thus, PhilHealth started to have a special coverage for the treatment of catastrophic illnesses, whose bearing on the spending of households is a determining factor and, in many situations, worsens the income level of affected households and ends up pushing them into poverty.

Sufficiency is the degree to which the benefits provided by the program are adequate to meet the needs of different beneficiaries; it requires economic resources to provide timely access to proper health care regardless of the economic situation of individuals. There are no appropriate indicators to accurately measure sufficiency of benefits. However, these benefits encompass different health services usually not used simultaneously by the same person; hence, it is possible to have an approximate assessment based on the "financial protection" provided by the program for specific services.

The average financial protection, the share covered by PhilHealth out of the total health care cost, shows that 88% of the hospital bill is covered by the program in public facilities, while 53% of the bill is covered in private hospitals. And yet, such figures do not include payments made outside of the hospital. Estimating such spending in a study which sampled 937 hospitalized children under the age of six, their average financial protection was limited to 53% (Bodart and Jowett, 2005).

In fact, the structure of the benefits covered by NHIP in a minimum or basic package imposes limits to the sufficiency of such benefits. This means it is only sufficient for restricted types of care and treatments and, in many cases, limited to services in government hospitals, which can be a basis for rethinking the real financial protection that is being provided to its members and their respective dependents.

The limited coverage of the benefits explains the growing share of out-of-pocket expenses in total health spending, which makes the health system regressive. In addition, the high out-of-pocket spending also explains why the use of NHIP services is low for SP members - an important barrier to accessing health care, especially for the very poor that require hospital services.

G. Social and Regional Solidarity

The combination of low public spending on health and the high share of private spending is most indicative of a system that is far from meeting its objective of developing a universal insurance coverage for all Filipinos. The high private spending means that the poorest households will depend on the expansion and effective range

of subsidized coverage programs and, in turn, the lower middle-income households will have serious difficulties in achieving universal coverage.

The health coverage is inadequate and uneven, worsening inequalities that characterize developing countries. Here, universal coverage means something much more ambitious than the title of universal access or achieving "some" coverage for every citizen. It means ensuring uniform and sufficient levels of coverage for all citizens, funded with tax revenue.

It is possible to distinguish three types of fragmentation in the financing of health systems that affect equity in access to services. First, the problems associated with high levels of out-of-pocket spending on health should be considered. Second, the fragmentation that comes from the differences that separate those with formal social security coverage from those who work in informal sectors of the economy should also be reflected upon. Finally, the territorial fragmentation that derives from the existence of health systems at the subnational level with different levels of coverage on the basis of the socio-economic conditions of each locality is also a factor. Thus, the inhabitants of the same country have different levels of coverage of the public sector due to its geographical location.

The poor are the most vulnerable as they are less able to recover from the financial consequences of out-of-pocket payments and loss of incomes associated with ill health. In order to cope with illness-related expenditures, they often have to cut down expenditures on necessities like food and clothing or take their children out of school as they cannot afford to pay the school fees anymore. In other words, overall financing for health is regressive in the Philippines. A major portion of the limited benefits offered by the public sector is received by the less needy. Meanwhile, direct payments are high and worsen the inequity of the system.
Additionally, it is inevitable to refer to territorial disparities within the Philippines when evaluating equity in access to health services. As a first approach to the problem, it is enough to say that this is a country where regions with poverty incidence at barely 4% of the population (NCR) live together with others like ARMM, Caraga and Region V where the indicator is located above the 45%. Despite the overall significant unequal distribution, health spending is not distributed in a compensatory fashion.

In the Philippines there has been, over the last two decades, a deep and unfinished discussion on the benefits and difficulties of health decentralization. The challenge is to achieve a weighted position that takes into account the particular conditions of each case and search for solutions to improve the provision of goods and services by the State so that the most significant changes for the citizens' well-being are achieved. To this end, it is essential to consider the degree of regional productive disparity within the country as this imposes serious limits to the working and financing of decentralized services, particularly when its provision affects equity as in the case of health.

In countries with internal development differences of the magnitude that occur in the Philippines, the most complex problems facing decentralized systems of public provision of social expenditure are related to the lack of resources, poor management, and inefficient allocation of expenditure in the less developed regions. In such cases, it is necessary to reinforce the role of the Central Government and search for new ways of transferring resources to compensate for the differences between regions. In this sense, it is important to incorporate incentives for expenditure allocation in the direction required to improve the provision of services to the needy. An alternative in this sense refers to the incorporation of performance-based grants as positive incentive to local effort to improve governance and local revenue mobilization, as well as matching grants to equalize fiscal capacities of local governments. While these are mechanisms gradually incorporated in order to improve resource allocation and equity in decentralized systems, it should not be ignored that problems may develop with the eventual loss of resources in jurisdictions that are less efficient in their use.

A classification of restrictions to the use of health services are as follows:

Supply-side barriers:

1. Limited and uneven number of accredited facilities
2. Unaffordable health facilities; constraints on distance and related transportation costs
3. Inadequate supply of medicines in RHUs
4. Lack or ineffective social marketing strategy

Demand-side barriers

1. Lack of financial resources (i.e., to purchase medicines, pay for additional provider fees)
2. Lack of information on benefits, availment process
3. Lack of resources to visit health facilities (i.e., transportation costs due to distance)
4. Perception of poor quality of healthcare services

As a result of these barriers, the gap between the high percentage of the population covered by PhilHealth and low percentage of its spending in the total is extremely high. This signifies the necessary reforms to reach effective universal health coverage for the whole population. Indeed, the fact of having a credential does not necessarily mean access to services. As a result of these problems, a research team from the University of the Philippines – School of Economics, led by Orville Solon, developed the concept of Benefit Delivery Ratio (BDR). It aims to reflect the weaknesses of the health delivery chain in each of the regions of Philippines. The estimations of this rate for a group of regions highlight the low effective coverage and confirm the significant inequality among regions in the Philippines.

H. Financial/Actuarial Sustainability

The Philippines' health system is funded from a mix of sources including: a) payroll contributions from both employees and employers in the formal sector of the economy; b) payment of premiums from the self-employed, informal workers and OFWs; c) general fiscal revenues that finance health insurance for the poor (sponsored program); and d) public programs. At the LGU level, financing is fragmented across provinces, municipalities and cities, with each LGU financing its own facilities. LGUs receive: a) part of the taxes from the national government; b) the internal revenue allotment (IRA); and c) other revenues of the LGUs allocated to the sector such as PhilHealth capitation and reimbursements and grants from external sources.

The confluence of various sources reveals a significant fragmentation in the financing of the health system. In addition, beneficiaries confront out-of-pocket payments for fees, copayments and drugs, whereas highest-income households pay voluntary premiums to access private health coverage from HMOs.

Payment mechanisms differ on the basis of the services provided. The outpatient package services provided by RHUs are usually free of charge. In the case of the special benefits packages, health care providers are paid per case, set by PhilHealth. In turn, inpatient care incorporates a fee-for-service (FFS) regime, in which public and private hospitals have the possibility to charge over the fees (balanced billing).

In the case of human resources, payments are associated with the facilities in which they work. Doctors from the private sector receive fee-for-service or payments pursuant to contracts with HMOs. In the public sector, the staff receives monthly salaries according to the Salary Standardization Law and additional reimbursements from PhilHealth.

Since 2011, PhilHealth established fixed rates to a number of special packages of benefits for medical and surgical procedures, eliminating the discretionary collections and making information transparent to patients. There have been case rates of No Balance Billing (NBB) for sponsored members since 2010, which permit them to gain access to health treatments and services in public hospitals with no additional cost.

PhilHealth pools funds from all sectors of society: formally employed, direct payments from LGUs, national government budget, and voluntary premiums. All collected resources are managed as a single fund, with uniform benefits for the members and dependents of the various components of the program. This results in a series of cross-subsidies. While on the aggregate, in 2011, benefit payments represented a ratio of 1.05 of total premium collections, the public and private employed programs show a benefits-to-premium ratio below 1 (0.75 and 0.61, respectively). Meanwhile, in the SP and IPP programs, the benefits paid far exceed the premium (3.11 and 2.83 respectively). Obviously, the same occurs in lifetime members, who are not charged with premiums.

As opposed to the PhilHealth risk pool, private health insurance only has limited risk-pooling capacities because of smaller groups. Additionally, HMOs have incentives to adversely select its members, giving priority to healthier people into the pool, therefore leading to the cream skimming effect.

The National Health Insurance Program (NHIP) is entirely administered by PhilHealth, which collects premiums, accredits providers, determines benefits packages and provider payment mechanisms, processes claims, and reimburses providers and beneficiaries. Thus, PhilHealth takes over responsibilities of supervision, follow-up and monitoring of the NHIP.

Salaries and other operating expenses are financed from premium collection and revenues from the fund's investment returns. As set forth by law, PhilHealth can use up to 12% of the previous year's premium and 3% of the fund revenue for operating expenses. The share of administrative expenditures in PhilHealth's total expenditures averaged around 11.89% in 2000-2010.

Membership's projections show progress in coverage, considering a growth of 1.18% per year from 2012 until 2021, in comparison with the total population growth at a rate higher than 1.7%. With a size of 3.19 members per household, the total coverage of the program would be around 88.11% in 2021.

In this context, in alternative scenarios, the actuarial report notes continuous financial unsustainability of the fund (NHIP, 2012). Changing the structure of taxes and increasing wages subject to contribution ceilings, among other assumptions, the projected scenarios show insufficient revenues to meet the expenses of the program. In all cases, the fund is projected to survive until 2016, at the latest.

The various actuarial scenarios projected for the NHIP demonstrate that the program is not financially sustainable in the long run unless reforms are rapidly implemented. Among the problems to be faced are the following:

- The increasing trend in payments to non-paying members and the resulting increase in the benefit/payments ratio (Jowett and Hsia, 2005);
- The irregularity of premium payments by the IPP (Jowett and Hsia, 2005);
- The incorporation of additional benefits (such as case rates) and new SP beneficiaries without any corresponding additional revenues;
- No change in the contribution rate, which is around 3%;
- The growth of fraudulent payments (between 10-20% of benefit claims); and
- The deterioration of the financial statement and fund reserves in recent years.

Based on the NHIP actuarial study, there are serious concerns on the long-term financial sustainability of PhilHealth under scenarios that do not involve drastic reforms in the scope of programs and funding. Therefore, it is imperative to boost collection efficiency, compliance rate, and the number of months paid in order to

boost revenues and impose mandatory coverage in the informal sector, overseeing the persistence and continuity of premiums payment by its members.

INTRODUCTION

The Philippines is a lower-middle income country consisting of an archipelago of 7,107 islands that occupy a territory of 343,282 square kilometers located in the Southeast Asian Region. Luzon, in the north, is the largest island, 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 center (see Figure 1).

Figure 1: Map of the Philippines

The country's total population is estimated at 96 million, distributed in a territory composed of autonomous regions, provinces and independent cities, municipalities and component cities and barangays[1]. For administrative purposes, the provinces and cities are grouped into 17 administrative regions, with uneven economic development and the population's life conditions. As can be seen in Appendix Table 1, average income in the National Capital Region (NCR), the region with the highest Human Development Index, is three times more than that of the Autonomous Region in Muslim Mindanao (ARMM), which has the lowest Human Development Index. Each territorial level is governed by corresponding Local Government Units (LGUs).

It is important to remark two special traits that define an important part of everyday life in this archipelago which, as will be explained further on, influence, directly or indirectly, the health system.

Firstly, the Philippines has a tropical climate. 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.

Secondly, the Philippine social life is strongly influenced by religions (Claudio, 2012-I). Indeed, the Philippines is one of only two countries (along with Vatican City) where divorce is not incorporated in state legislation¸ just as in decisions related to health practices of its population. Additionally, Islam, although professed by only 5% of the population, has enormous influence on the southern islands and had been a major reason in the creation of the ARMM in 1989.

The Philippines' health system presents an organization in constant movement, which cannot be considered in any other way but in transition (WHO, 2011). Its present organization should be explained and evaluated on the basis of the expectations and possibilities of its future evolution. In this sense, the main characteristic that defines the reforms of the last years is the decision of focusing it on universal health coverage.

In this context, this paper aims to study, present a situational analysis and make recommendations on reform of the health system in the Philippines, with attention paid to the different programs that cover different population groups. After a presentation of the necessary epidemiological characteristics and the history of the health system, the study will describe the institutional characteristics, population coverage, expenditures, health services and benefits, social and territorial solidarity and gender equity, and financial sustainability of the Philippine health care system. In relation to each of these aspects, the study will present in the final chapter, a set of public policy recommendations that should constitute a path of reforms in the sector aimed at improving the health coverage of the Filipinos, the system's equity and the adequacy of benefits provided.

1 The Barangay is the basic unit of government in the Philippines. As the lowest level of political and governmental subdivision in the Philippines, every Barangay is under the administrative supervision of cities and municipalities. Every Barangay manages its own budget and collects its own taxes.

The study took place in 2012 in six stages. First, there is a thorough analysis of the existing information and studies. Second, there is an elaboration of an initial draft that allowed organizing, at the following stage, of the numerous interviews done during October with officials, experts and other personalities that provided essential information for the study to be done. Having these new input, in the course of the fourth stage, a preliminary version was written, which was discussed in the fifth stage of the job and resulted, at the sixth stage, in the writing of this version of the study. Consequently, this study has been benefitted from the excellent quality of the studies reviewed and the people interviewed.

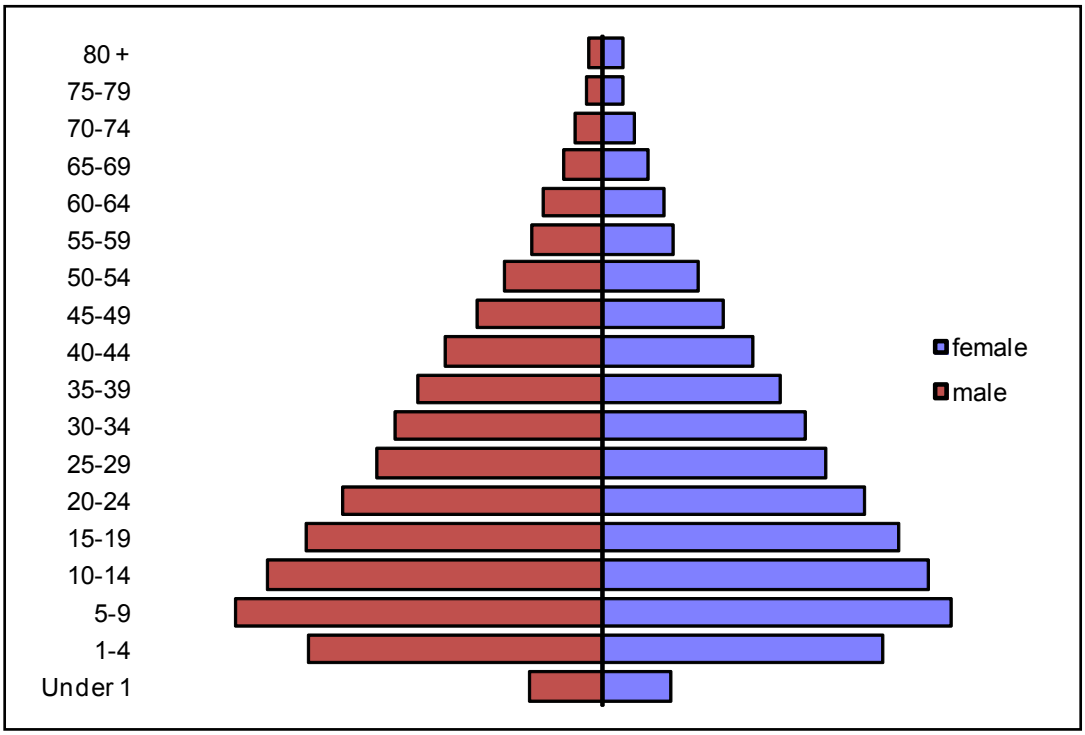
CHAPTER 1: EPIDEMIOLOGICAL PROFILE OF THE PHILIPPINES

There have been improvements in the health sector of the Philippines in recent years but these improvements still pale in comparison to other countries in the Southeast Asian region. The analysis of its demographic and health aspects shows that the country is going through a demographic and an epidemiological transition, characterized by a decrease in fertility, higher life expectancy and a substantial change in the risk factors. Nowadays, the rapid urbanization, high population density, and factors related to climate change have begun to influence the emergence and reemergence of new infectious diseases.

1a. Population Structure and Demographic Trends

The total population of the Philippines in 1980 was near 48 million, which increased to 76 million in 2000 and is approximately 92 million in 2010 and 96 million in 2011. The age structure is a classical broad base indicating a high proportion of children, a rapid rate of population growth, and a low proportion of older people (DOH, 2005) (see Figure 2).

Figure 2: Population Pyramid by Sex and Age in the Philippines, 2000

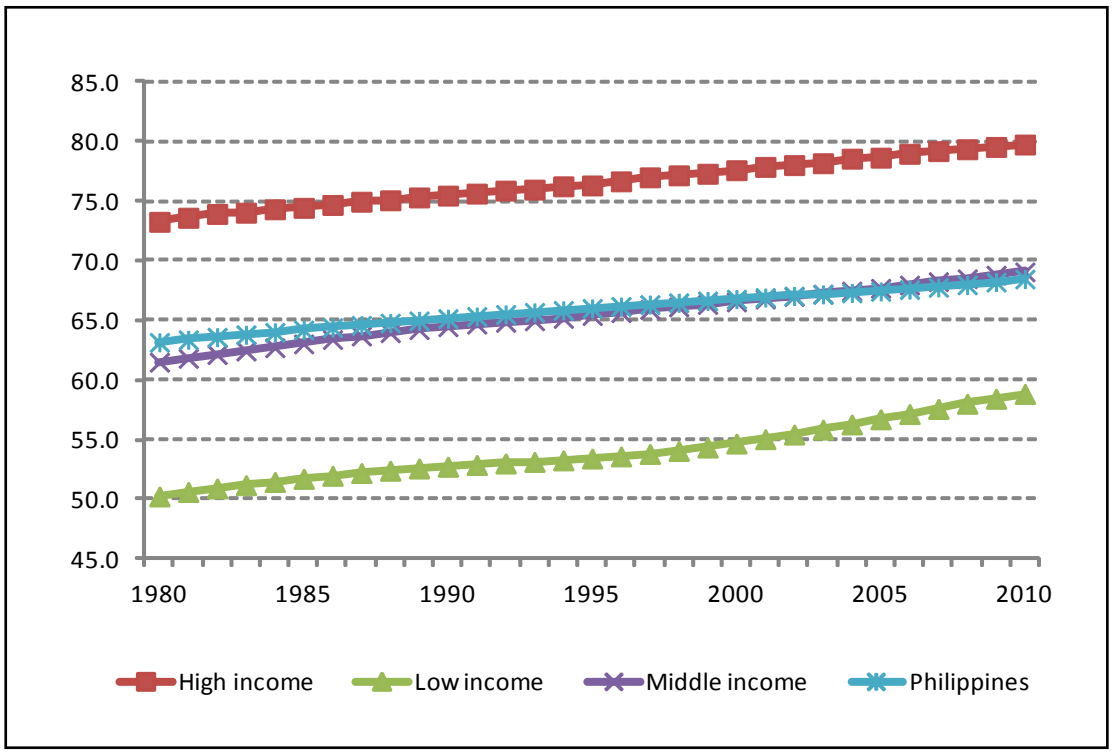


Source: National Statistics Office (2011)

According to the Demographic and Health Survey (DHS) data (Gwatkin et al., 2000), the population growth is higher among the poor, which seems to be linked to low-income groups with a limited access to modern contraceptives. The Philippines' fertility rates and contraceptive use appear to be strongly dependent on women's socio-economic background, which raises concerns about equity in utilization and financing of services and products (Schneider and Racelis, 2004)[2].

Nevertheless, the population is still far from being regarded as aging. On the contrary, since 1980, annual population growth has remained at around 2.35 %, much higher than the average growth rate in Southeast Asia (1.5 %). Similarly, the Philippines' crude birth rate of 27 per 1,000 in 2001 is one of the highest, next only to Cambodia's and Laos's. The Philippine population is still predominantly young, with the age group 14 years old or younger constituting 40 % of the total population. In fact, women's fertility rate, the average number of births that a woman has at the end of her reproductive life, is among one of the highest in the region at 3.03 children per woman, only behind Laos (3.42). However, it should be noted that this has considerably decreased already in the past 40 years from a level of 6 in 1973 (Gwatkin et al., 2000; Schneider and Racelis, 2004).

Figure 3: Projected Life Expectancy at Birth, Philippines and Selected Group of Countries, 1980-2010



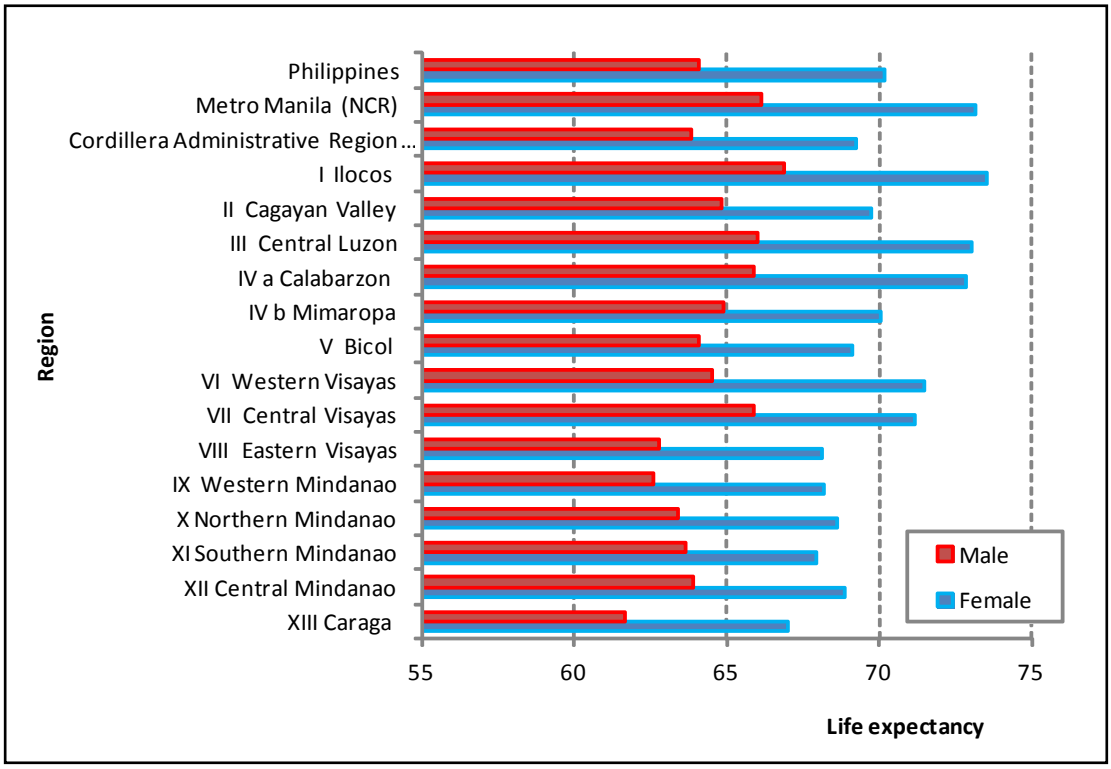
Source: World Bank (2012)

2 At the writing of this report, a controversial Reproductive Health Law is being debated. Under the law, free contraceptives and information on family planning will be available through government health centers, and comprehensive reproductive health classes will be given in schools.

The average life expectancy at birth in the Philippines rose from 61 years in 1980 to 65 in 1990, 69 in 2000, 70 in 2005 and 71 in 2010. Life expectancy of females has always been higher than in males (72.8 and 67.5 years, respectively, in 2010). Such ranges are similar to those of some countries with the United Nations Development Programme's (UNDP) average Human Development Index (HDI), and also similar to other countries in the region such as Malaysia (72), Thailand (70) and Vietnam (72). Some neighboring countries are below these levels: Laos (61), Cambodia (61) and Myanmar (56), whereas others are above: Brunei (76) and Singapore (81) (UNDP, 2012; WHO, 2012).

The analyses of the evolution of life expectancy over the past 30 years show that the Philippines remained at a level close to that of middle-income countries. Looking at the evolution of the trend, it is important to note that the growth of life expectancy in the Philippines was lower than that in middle-income countries as a whole. Thus, while in 1980 it was above the average for this group of countries, today life expectancy is below the average for middle-income group (see Figure 3).

Figure 4: Life Expectancy at Birth by Sex and Region, 2005

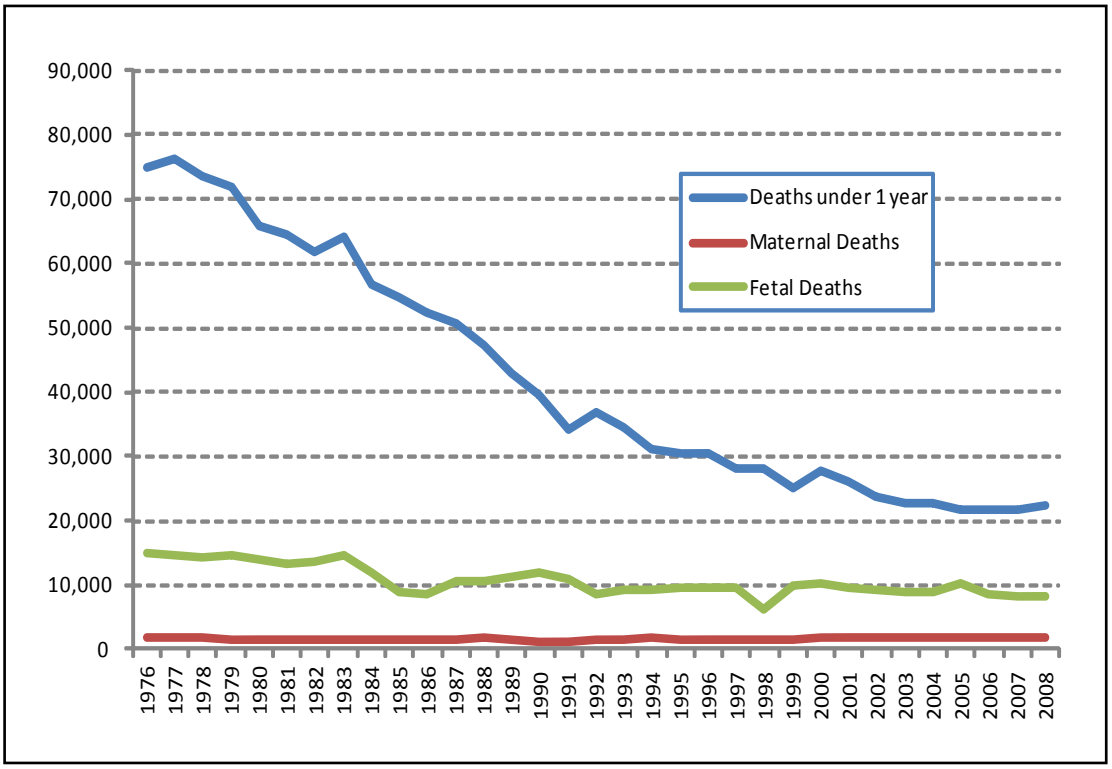


Source: National Statistics Office (2011), 2000 Census-based Population Projection

Looking at the distribution of life expectancy at birth by region and sex, it is possible to see a significant spread between them (see Figure 4). Comparing percentages by gender, women have a higher life expectancy than men in all regions. If one considers the difference in the absolute values between regions of highest and lowest life expectancy, the gap reaches five and seven years for men and women, respectively. These significant differences show the disparity that currently exists within the geographic regions of the Philippines and the need to prioritize some districts in particular when planning interventions and delivering services.

Finally, the evolution of demographic indicators should be focused on the need to design public policies that forecast future changes in the demands for intervention. As in other countries, the increase in years in the lives of the Filipinos may be attributed to their improving health status and other socioeconomic factors (DOH, 2005). In the future, more people will reach old age, thus, changing the current population pyramid where those over seventy years old represent a low proportion of the population. With this trend comes an increase in the occurrence of degenerative diseases and disabilities associated with an aging population, therefore causing an increase in health care costs.

Figure 5: Deaths under One Year, Maternal Deaths and Fetal Deaths, 1976 to 2008



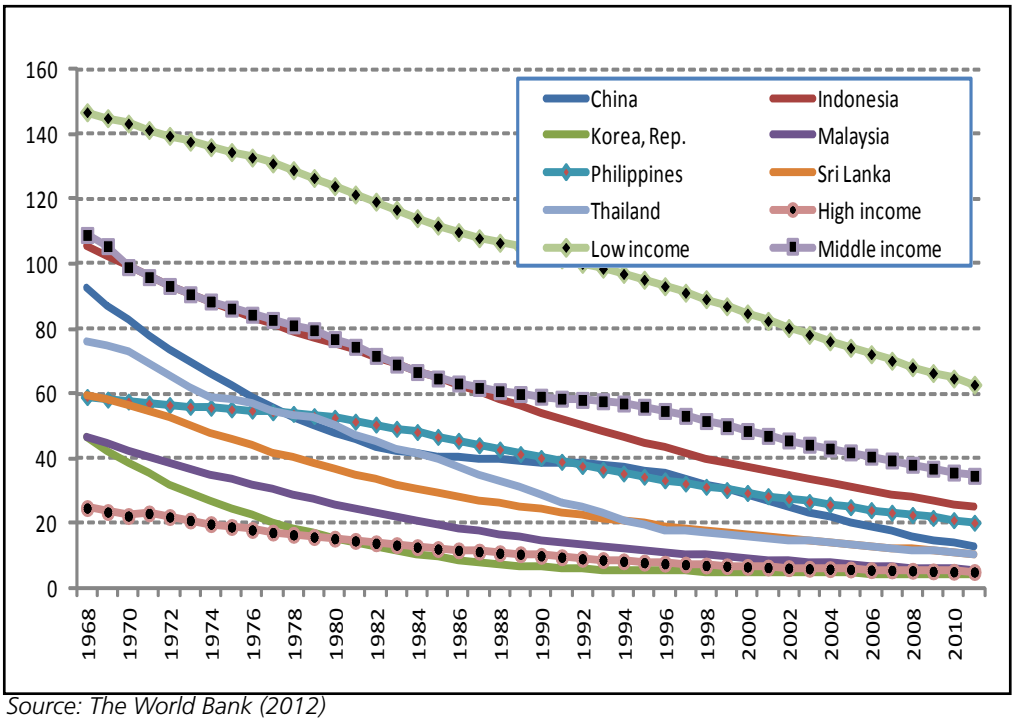
Source: National Statistics Office (2011)

1b. Basic Indicators: Infant and Maternal Mortality and Malnutrition Prevalence

The Philippines recorded notable gains in 1990-2006 in reducing both the infant mortality rate (IMR) and child (age under five) mortality rate; nevertheless, the performance in reducing the maternal and fetal deaths is not as commendable. During this period the infant mortality was reduced to half: from 57 infant deaths per 1,000 live births in 1990 to 25 in 2008, while the child mortality rate went down from 80 to 34 per 1,000 children. In both cases, the rate of progress needed to reach the Millennium Development Goals (MDG) 2015 target is less than the actual rate of progress to date, hence, it is likely that the MDG targets for child health will be achieved (United Nations, 2012). Nowadays, the three most common causes of infant deaths are pneumonia, bacterial sepsis, and disorders related to short gestation and

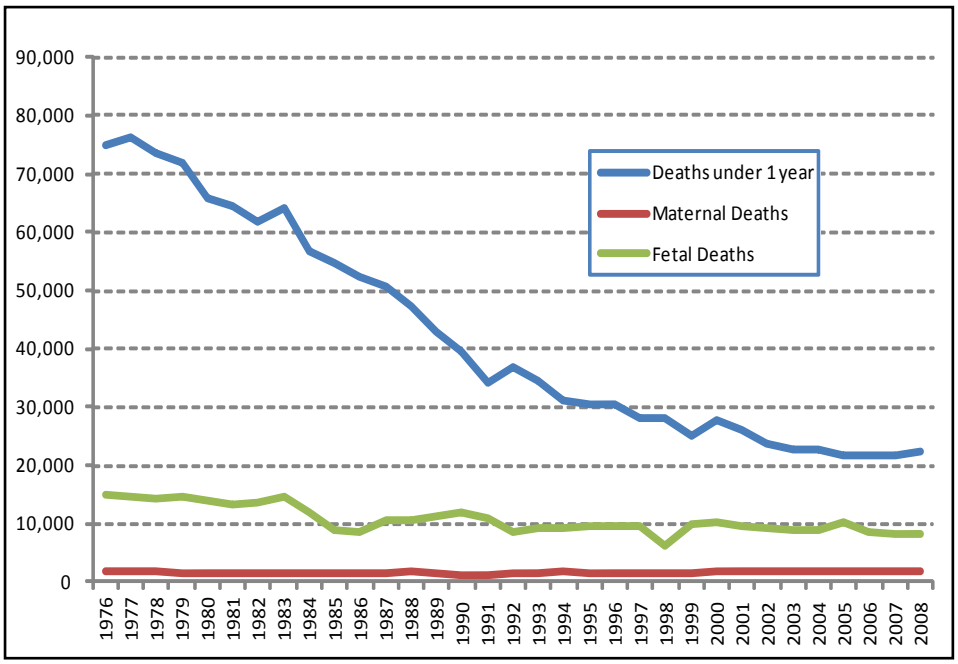
low birth weight, while the most common causes of child mortality are pneumonia, accidents, and diarrhea (DOH, 2008).

Figure 6: Infant Mortality Rate (per 1,000 live births), by Country and Group of Countries, 1968-2011



Source: The World Bank (2012)

Figure 7: Malnutrition Prevalence, Weight for Age (% of children under 5) in the Philippines and Selected Group of Countries, 1975-20112008



Source: The World Bank (2012)

Within Asian countries, the Philippines appears to be halfway in achieving the MDG target. It has higher IMR than Malaysia and Thailand, but lower than Indonesia's rate (DOH, 2005) (see Figure 6). The importance and complexity of these problems is uneven among countries based on the indicators shown and by taking into account the different health conditions among countries. In 2003, there are Philippine regions with IMR above 45 (e.g. MIMAROPA, ARMM) while others rank well below the national average of 30 (e.g. CAR with 20). The same regional disparity can be observed regarding maternal death (see Appendix Table 1).

Table 1: Ten Leading Causes of Morbidity, Number and Rates, 2008 (rate per 100,000 inhabitants)

Disease	Morbidity	
	Number	Rate
1. Acute respiratory infection	1,647,178	1,840.6
2. ALTRI and pneumonia	78,199	871.8
3. Bronchitis/Bronchiolitis	519,821	580.8
4. Hypertension	499,184	557.8
5. Acute watery diarrhea	434,445	485.4
6. Influenza	362,304	404.8
7. TB respiratory	96,497	107.8
8. Acute Febrile Illness	35,381	39.5
9. Disease of the Heart	32,541	36.4
10. Chickenpox	25,677	28.7

Source: National Statistics Office (2011) based on Field Health Service Information System, Department of Health

By analyzing the evolution of the prevalence of malnutrition in children under 5 years in the Philippines compared to groups of high, middle and low-income countries, it is possible to observe a similar trend to that of life expectancy. The Philippines' rates are similar to the mean of middle-income countries but the improvement over time is less for the Philippines than for this group as a whole (see Figure 7). The World Bank defines a "Prevalence of child malnutrition as the percentage of children under age 5 whose weight for age is more than two standard deviations below the median for the international reference population ages 0-59 months" (The World Bank, 2012).

1c. Causes of Morbidity and Mortality

The analysis of the causes of morbidity in the Philippines is related to development problems. As in the past, most among the ten leading causes of morbidity are communicable diseases. The leading causes of morbidity from infectious diseases in 1996-2006 were: acute lower respiratory tract infection and pneumonia, bronchitis/bronchiolitis, acute watery diarrhea, influenza, pulmonary tuberculosis, acute febrile illness, malaria, chicken pox, measles, and dengue fever. Such rates have declined over the last couple of years. Malaria is still the most common and persistent mosquito-borne infection in the country and drug resistant cases are on the rise. Two of the top ten leading causes of morbidity are non-communicable diseases: hypertension and cardiovascular diseases (DOH, 2008) (see Table 1).

Other infectious diseases such as rabies, filariasis, schistosomiasis, leprosy, and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) remain important public health problems even though they are not leading causes of illness and death. Nevertheless, it is important to point out that rabies incidence in the Philippines is the sixth highest in the world; filariasis is the second leading cause of permanent disability among infectious diseases; schistosomiasis remains endemic in the country although it has been eliminated in most Southeast Asian countries; and, while leprosy seems to be eliminated at the national prevalence level, certain areas still have it. Dengue fever has sudden increase in outbreaks. HIV/AIDS prevalence is estimated to be low in the Philippines but high-risk behaviors appear to be increasing and could lead to high incidence over time (DOH, 2008).

Table 2: Ten Leading Causes of Mortality, Number and Rates, by Sex, 2006

Diseases	Total	Number		Total Rate
		Male	Female	
1. Diseases of the heart	83,081	47,259	35,822	95.5
2. Diseases of the vascular system	55,466	30,869	24,597	63.8
3. Malignant neoplasm	43,043	22,472	20,571	49.5
4. Pneumonia	34,958	17,166	17,792	40.2
5. Accidents	36,162	29,160	7,002	41.6
6. Tuberculosis, all forms	25,860	17,862	7,998	29.7
7. Chronic lower respiratory diseases	21,216	14,715	6,501	24.4
8. Diabetes mellitus	20,239	9,818	10,421	23.3
9. Certain conditions originating in the perinatal period	12,334	7,425	4,909	14.2
10. Nephritis, nephrotic syndrome and nephrosis	11,981	7,107	4,874	13.8

Source: Philippine Health Statistics (2011)

Unlike the leading causes of morbidity as seen above, non-communicable diseases are responsible for the current rate of mortality or for the majority of deaths in the country; thus, heart diseases and malignant neoplasm comprise more than a third of the total causes of death (see Table 2). Deaths due to accidents doubled from 21.5 per 100,000 of the population in 1994 to 41.3 in 2004 (NSO, 2011). Deaths caused by communicable diseases have been reduced by more than half in the last twenty years. This is quite evident in the decrease in number of deaths caused by pneumonia from 86.4 per 100,000 of the population in 1984 to 38.4 in 2004. Deaths from all types of tuberculosis have also decreased by 40 percent in the last two decades. This is the result of more aggressive disease prevention and control efforts by the government and improvements in curative care (DOH, 2008).

To sum up, although progress has been made in the past decades to control communicable diseases as leading causes of deaths, their burden as a cause of morbidity is still high. On the other hand, non-communicable and chronic diseases have emerged as major causes of death.

1d. Natural and Man-made Disasters

Due to its geographical location, the Philippines has always been subjected to natural hazards such us typhoons, tornadoes, earthquakes, tsunamis, and volcanic eruptions, among others. These factors, when put together, turn the country into one of the most exposed to natural disasters in the world. This leaves the country vulnerable to the emergence and the reemergence of diseases related to natural disasters and climate change, which should be addressed by the country's health care system (Nyunt-U, 2012-I).

Natural disasters and human induced incidents contribute significantly to the disease and injury burden of Philippines. In 2010, 556 occurrences of natural and man-made disasters were reported, which affected 6,386,781 persons. Near 109,133 houses were fully damaged and 186,313 were partially damaged (see Table 3). It is extremely interesting to note that while the economic damage was caused, almost entirely, by destructive typhoons and the effects of "El Niño", the highest number of deaths was due to vehicular accidents. The appendix shows a breakdown of each of the categories included in this table.

Table 3: Damages Caused by Major Natural Disasters and by Man-made Disasters, 2010

Disasters	Occurrence	Casualties			Affected		Houses Damaged		Cost of Damages
		Dead	Injured	Missing	Families	Persons	Total	Partial	(in Million Pesos)
Total	**556**	**766**	**2**	**148**	**1,315,069**	**6,386,781**	**109**	**186**	**25**
A. Natural Incidents	234	59	57	5	737	3,600,799	484	2	13
B. Typhoons	11	136	133	85	543	2,596,587	103	184	12
C. Human-induced Incidents	311	571	1	58	35	189	5	465	205

Source: National Statistics Office (2011) based on the National Disaster Risk Reduction and Management Council

According to a study by the Asian Development Bank (ADB), the country is still lacking in a comprehensive program to assist people affected by disasters. The scope of humanitarian aid is insufficient and disaster response efforts are often uncoordinated. Only half of the Filipinos affected by typhoons and other hydrometerological phenomena in rural areas are assisted by the government and private institutions providing humanitarian aid. In the urban setting, there are significant restrictions in providing health services during flood and other disasters (Claudio, 2012-I). The victims of these disasters tend to be the poor who live in environmentally hazardous areas and often in makeshift housing. Agriculture, the sector on which two-thirds of the income of the poor depends, is the most vulnerable to the vagaries of the weather and the incidence of pests and diseases. In conclusion, this is an important concern as disasters cause serious damages and losses to property, especially of the poor, and destroy their only means of living. If they do not receive assistance, the risk of falling in a perpetual poverty trap is high (ADB, 2007).

CHAPTER 2: CURRENT ORGANIZATION OF THE HEALTH CARE SYSTEM

2a. Brief Description of the Historical Evolution of the Health Care System

As in many other countries, the history of the Philippines' health care system dates back to the turn of the twentieth century. During the American colonization, the health industry began taking shape after the establishment of the University of the Philippines - College of Medicine and Surgery and the subsequent flourishing of medical associations. Before then, health service providers consisted mostly of traditional healers or hospitals run by religious orders. With American-induced bureaucratization of the state, regulations on health service provision were put in place, with the establishments of some public agencies and the passage of the first health-related laws and policies. In 1907, the Philippine General Hospital was opened.

However, during the Japanese occupation, developments in the health sector were disrupted and thus the health sector deteriorated. Professional training was interrupted and the various health services were discontinued. Only with the arrival of the Independent Third Republic did public policies and regulations of the sector went back to their original path. In 1947, the Department of Health was created. By 1954, there was a partial decentralization of the sector based on the creation of the Rural Health Units. Table 4 summarizes the main features of the health system during the different stages of its development.

As the sector's historical summary shows, the health system's evolution has been determined by a sequence of rules governing the performance and programs provided by the state. In many cases, such rules preceded the guarantee of the right to health care as stated in the 1987 Constitution. Section 15 of Article II states that: "The state shall protect and promote the right to health of the people and instill health consciousness among them".

In 1969, the Republic Act (RA) 6111, otherwise known as the Philippine Medical Care Act, was passed. It established the Philippine Medical Care Plan and the Philippine Medical Care Commission (PMCC). However, it was only in 1971 when the latter was organized with the appointment of a nine-member Board of Commissioners (ASEAN Social Security Association, 2012).

The PMCC was given the task of administering the Philippine Medical Care Plan, commonly known as Medicare. This program implemented a policy to provide "total medical services" to the people based on the following concepts of health care: comprehensive, in accordance with the patient's individual needs, coordinated through the use of government and private medical facilities, and common pooling of contributions into the Medicare Health Insurance Fund (HIF).

Table 4: Brief Historical Overview of the Philippine Health Care System

	Pre-colonial	Spanish	American	Japanese	Early Republic	Martial Law	Decentralization
Health financing	Fee-for service	Religious hospitals financed by donations	Largely fee-for service	Services given for free	Health services in government facilities provided free for all	Medical Care Act of 1969 implemented	Philhealth created (1995)
Health human resources	Each village had its own healer	Native healers, para-professionals and religious order	UP College of Medicine and Surgeryestablished; medical associations began to flourish; several medical doctors got trainings abroad	Health professional training disrupted	Different laws regulated the practice; medical doctors continued to train in the US with some choosing to migrate	Migration of medical doctors to US increased	Continued migration of health workers, now including nurses and other professionals
Information systems	Oral traditions committed to memory and passed on through apprenticeship	Pen and paper; data not standardized and unreliable	Data kept per hospital/ facility; centraliza-tion still a problem	Many health records and facilities destroyed	Established as the Disease Intelligence Center in 1960	Integrated health information system attempted but not continued	FHSIS developed in 1990; National Telehealth Center of UP-NIH established
Governance and Regulation	Healers had concurrent functions as village elders or priests	Largely by religious orders	Military Board of Health to care for the injured American soldiers (1898); establishment of the Civilian Bureau of Health and Bureau of Govern-mental Laboratories (1902); health system centralized; policies such as Food & Drugs Act enacted (1914)	National Government dissolved; health service was relegated to the Department of Education, Health and Public Welfare	DOH, Bureau of Hspitals, and Bureau of Quarantine created (1947); Institute of Nutrition established (1948); Food & Drug Administra-tion established (1953); Partial decentralization of DOH (1958)	Focus on Health Maintenance; Specialty Hospitals built	Generics Act passed (1988); health care devolved through the LBU Code (1992).; Health Sector Reform started (1999)
Service delivery	Done by healers; very local in scope	Hospital ran by religious orders catered to the elite, soldiers and the indios; private practice began in the late 19th century	Philippine General Hospital established (1907);Community Health and Social Centers established (1933)	Many services not continued	RHU Act institutiona-lized the Rural Health Units (1954)	Nutrition and child health emphasized with the establishment of NNC (1974) and EPI (1976); primary health care started (1979); integrated health care delivery system mandated (1982)	Inter-local health zones started (1999); TB DOTS implemented (2002).

Source: Own elaboration based on Acuin et. al. (2010)

Medicare aimed to provide health care to Filipino citizens in an evolutionary way within the economic capacity of the country, and as a viable means of helping the people pay for their own adequate care. It consisted of two programs or phases, namely:

1. The Medicare Program I (MPI) is designed for the formal sector of the labor force (regularly employed and salaried), basically private sector employees who are members of the Social Security System (SSS), and civil servant-members of the Government Service Insurance System (GSIS).
2. The Medicare Program II (MPII) is designed for the informal sector of the labor force, mainly the self-employed who are not members of either SSS or GSIS.

Program I was implemented ahead of Program II. It officially started in January 1972 when members of GSIS and SSS began to make contributions to the health insurance funds of their respective systems through mandatory salary deductions. These two agencies date back to the 1950s and provide different social security services, including health services, to their members (Mesa-Lago et al, 2012). These agencies collected the contributions, administered and collected funds including their investment, and took charge of processing, adjudicating and paying the hospitals, physicians, and the payment claims for medical care services that are rendered to the members.

Program II started as a pilot test in 1983 in Bauan, Batangas, Unisan and Quezon. Later, membership was expanded to include retirees and pensioners and overseas contract workers as well as their legal dependents. It was operated and managed by the LGUs and the benefits varied from one community to another.

In the course of time, and with the purpose of providing better service quality, the MPI coverage began to expand through several decrees and executive orders.

Other important regulations that should be noted for a comprehensive analysis of the health sector and its performance include the integration of public health and hospital services in 1983 (EO 851) and, subsequently, the devolution of health services from central government to LGU as mandated by the Local Government Code of 1991 (RA 7160). The latter constitutes a key factor in understanding the performance of health service provision in a country with great population dispersion (i.e., while NCR has more than 11 million inhabitants, the Cordillera Administrative Region (CAR) only has 1.5 million) and little interconnection among local governments due to geographical barriers. In 1999, the Department of Health (DOH)[3] launched the Health Sector Reform Agenda (HSRA) as the major policy framework and strategy to improve the way health care is delivered, regulated and financed (DOH, 2005).

Although Medicare ran for almost a quarter of a century, the need for improvements was recognized mostly due to the need to widen the population's health coverage, ensure the quality of the services, improve the processing system, redefine the content of the benefit packages, and rationalize payment schemes, among other issues.

3 DOH is the leading agency in Philippine's health policy, as will be explained in section 2.c.

In 1995, with the passage of the National Health Insurance Act (RA 7875) the National Health Insurance Program (NHIP) was established. The same law created the Philippine Health Insurance Corporation (PhilHealth or PHIC) as the agency responsible for the administration of the NHIP. Unlike the centralized structure of the Philippine Medical Care Commission, the PhilHealth adopted a decentralized organization and a community-based setup. Additionally, the new program targeted universal coverage compared with the select groups of the population that benefitted from the Philippine Medical Care Commission. The widening of the coverage implied a gradual process in which different components currently making up the PhilHealth were applied.

In 1996, the sponsored program (SP) was launched, which aimed at covering the poorest households. In 1997 PhilHealth assumed the administration and coverage of civil servants that were previously under the GSIS then, while in 1998, it absorbed the coverage of the private sector previously under the SSS. Other components of the program focused on capturing specific sectors or groups of the population which were not as easy to classify. Particularly, PhilHealth implemented the Individually-Paying Program (IPP) in 1999, which focused on the informal sectors of the population. This program provides coverage to the self-employed, informal workers, employees of international organizations, and other individuals who cannot be classified in the other programs (e.g., unemployed individuals who are not classified as poor).

In 2002, the government introduced the Non-Paying Program in order to provide free health care to retirees and pensioners. By 2005, PhilHealth also took over the responsibility of administering the program for Overseas Filipino Workers (OFWs) from the Overseas Workers Welfare Administration (OWWA) (WHO, 2011).

Finally, in 2010, "The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos" was launched through Administrative Order No. 36. This agenda, also named "Kalusugang Pangkalahatan," provided for three strategic thrusts to achieve universal health care:

1. Rapid expansion in NHIP enrollment and benefit delivery targeting national subsidies on the poorest families;
2. Improved access to quality hospitals and health care facilities through accelerated upgrading of public health facilities; and,
3. Attainment of the health-related MDG through additional effort and resources in localities with high concentration of families who are unable to receive critical public health services.

Table 5 summarizes the main historical events since the creation of the PhilHealth and identifies the different groups of the population that have been covered throughout time and the widening of the benefits provided by the program.

2b. Brief Description of Current Social Security Contributory and Non-Contributory Health Care Schemes

Like any other health care system that intends to improve the population's health conditions and respond to various changes (demographic, technological, social, economic, political, etc.) affecting the sector, the Philippines' system presents an organization in constant movement, which cannot be considered in any other way but in transition (WHO, 2011). Thus, its present organization should be explained and evaluated on the basis of the expectations and possibilities of its future evolution. In this sense, the main characteristic that defines the reforms of recent years is its focus on universal coverage.

Table 5: Main Historical Facts about PhilHealth, 1995-2010

1995	The National Health Insurance Act of 1995 (Republic Act 7875) creates PhilHealth which is tasked to administer the NHIP.
1996	The Board approves the first Implementing Rules and Regulations (IRR) of RA 7875.
	PhilHealth begins its LGU networking and formally launches the Indigent Program in Abra and Camiguin.
1997	PhilHealth assumes Medicare claims processing functions for government sector workers from the GSIS.
	Administrative Order 277 mandates PhilHealth to cover the poorest 25 percent of the population in a period of five years.
1998	PhilHealth assumes the Medicare claims processing functions for privately-employed sector from the SSS.
	By late 1998, the Indigent Program expands to include the poor in more affluent provinces and cities. As a result, enrolment increases to 45,000 families.
1999	PhilHealth increases benefits by an average of 50% for all members.
	The DOH launches the HSRA as the major policy framework and strategy to improve the way health care is delivered, regulated and financed.
2000	Start of Auto-Credit System (ACS) in reimbursing health care professionals.
2001	156,039 urban poor households enrol for Plan 500; 613,576 households enrol in the Indigent Program (inclusive of Plan 500); 929,589 enrol in the Individually Paying Program.
2002	Inpatient hospital ceilings for certain benefit items increased by as much as 43%.
	Launching of registration of Retirees and Pensioners to the Non-Paying Program
2003	Introduction of the Dialysis Package and Outpatient Anti-tuberculosis/DOTS Benefits Package.
	PhilHealth Board approved the PhilHealth Medium-Term Plan (2004-2012).
2004	The Plan 5/25 Program is launched which, along with the Plan 500, brings in more than six million families or over 30 million individuals under the Sponsored Program and enables PhilHealth to now boast coverage of three-fourths of the population.
2005	PhilHealth assumes the administration of the OFW health coverage.
2010	The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos (Administrative Order 0036/2010) was enacted.

Source: Own elaboration based on Solon (2003); The PhilHealth Chronicles (2005); DOH (2005); and Manasan (2009, 2011)

While there are important private sector schemes which has filled the spaces traditionally reserved for prepaid medicines as well as other public sector schemes which have proved to be inefficient, we will focus on the description of the public and social security subsector components, which should be considered as a whole due to the recent reforms of the sector (HMOs will be discussed at the end of the chapter).

Considering that there is a strong process of decentralization in the sector, most of the health public programs are managed by the LGUs; however, there are some important initiatives managed by the central government level such as social assistance and other poverty-targeted programs (Banzon, 2008; Orbeta, 2011)[4]. In addition, there are program packages for the prevention, management and control of diseases, as well as health promotion and protection. These packages cater 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 the elderly), and to specific diseases (tuberculosis, malaria, cardiovascular, cancer) (DOH, 2005). All programs are financed by general taxes, hence, these are non-contributory.

As previously mentioned, the public and social security subsectors should be approached as a whole, taking into account the reforms initially introduced in the mid-1990s. Since 1995, the NHIP through PhilHealth is a government mandatory health insurance program that "seeks to provide universal health insurance coverage and ensure affordable, acceptable, available, accessible, and quality health care services for all citizens in Philippines" (PhilHealth, 2012).

Box 1: PhilHealth's Purpose of Being

PhilHealth's primary purpose of being is to ensure that all Filipinos, especially those who cannot afford the cost of health care, are given real financial risk protection. PhilHealth's real financial risk protection means that:

1. All Filipinos are enrolled into the NHIP (i.e., 100% coverage).
2. Members are empowered to enjoy their enhanced benefits.
3. Each member will be assigned to a primary care provider who shall address his/her health needs.
4. Members have access to accredited facilities that are of superior quality.
5. Every Filipino who desires to avail of the No Balance Billing (zero co-payment) policy will always have an opportunity to do so anywhere in the county. This reduces, if not totally eliminates, debilitating out-of-pocket health expenses that drive families deeper into poverty.

Source: PhilHealth (2012)

The NHIP should provide compulsory universal health insurance coverage as a mechanism to allow all Filipinos to gain financial access to health services (United Nations, 2012). The NHIP's provision for universality and equity applies to the various classifications of members of the resident population and those working overseas either on a contractual or long-term basis. Given that the system is far from achieving its long-term goals, these will remain to be the target of the present reform process. This is the reason why it is convenient to highlight the existence of this outlook in Box 1.

As explained, different programs have been successively incorporated in the NHIP since 1995 to provide health care

4 Chapter 6 evaluates the alternatives and challenges of the health services decentralization process.

coverage to different population groups. Currently, there are five membership types under the NHIP that lead to five different PhilHealth programs. Each has different conditions of access, benefits and financing. The five[5] programs are:

1. ***Employed Sector Program:*** compulsory coverage of all employees in government and from the private sector
2. ***Individually Paying Program:*** voluntary coverage of the self-employed and others in the informal sector, as well as those previously formally employed and any other not covered by the rest of the programs
3. ***Sponsored Program:*** covers the extremely poor whose income is insufficient for the subsistence of their families; provides access to health care to those in the lowest 40% income bracket of the population (quintiles 1 and 2)
4. ***Overseas Filipino Workers:*** registered with the Overseas Workers Welfare Administration (OWWA)
5. ***Lifetime Member Program:*** free for members who already completed their 120 monthly contributions

In addition to the principal members, PhilHealth covers, without additional premium, the member's dependents: the legitimate spouse who is not a member in her/his own right, children and stepchildren below 21 years of age, and parents or step-parents aged 60 and older who are not themselves members of PhilHealth. There is no limit to the number of dependents of each member (United Nations, 2012). As will be explained in Chapter 3, the beneficiaries of the program include the main members and their dependents.

Lastly, as analyzed in Chapter 4, the private subsector captures the greatest proportion of resources destined to the Philippine health care, although this does not necessarily imply that the magnitude of health resources is high. The private subsector includes: for-profit and non-profit health providers offering health services in clinics and hospitals that are paid by users; health insurance financed by voluntary premiums; manufacture and distribution of medicines, vaccines, medical supplies, equipment and health and nutrition products; research and development; human resource development; and other health-related services (DOH, 2005). Furthermore, out-of-pocket expenses from households for many contingencies are not covered by the subsectors of the health system. According to Orbeta, nascent community-based health care systems are voluntary complementary schemes paid to private non-profitable organizations (Orbeta, 2011).

2c. Role of the State in Regulation and Supervision of the Entire Health Care System

The Philippine Health system is ruled by the national government through the DOH and the public sector includes, additionally, LGUs and other national government agencies providing health services. The DOH is the leading agency in health. It is responsible for the general regulation and supervision of the Philippines' health care system, with its most important tasks to manage the sector's national policy and

5 Characteristics and coverage of each of these programs will be described in Chapter 3.

develop national plans, as well as establish the technical standards and guidelines on health. The DOH is headed by a cabinet-rank Secretary of Health appointed by the President of the Republic.

According to the DOH, "In the Philippines, the major objective of health regulation reforms is to assure access to quality and affordable health goods and services, especially those commonly used by the poor. On the supply side, the strategic approach is the harmonization of systems and processes for licensing, accreditation or certification of health products, devices, facilities and services to make health regulation rational, simple and client-responsive" (DOH, 2005).

The DOH consists of 17 central offices, 16 centers for health development (CHDs) located in various regions, 70 retained hospitals, and four affiliated agencies. The general coordination and monitoring of the National Health Objectives and Local Government Code with the various CHDs is under the Office of the Secretary of Health. It includes the Health Emergency Management Staff, the Internal Audit Staff, the Media Relations Group, the Public Assistance Group, and three Zonal Offices of the DOH, each located in Luzon, Visayas and Mindanao (World Bank, 2011).

Among the various clusters assigned to the management and regulation of different aspects of the health system, the following offices must be highlighted: the Sectorial Management Support Cluster which is responsible for functions such as policy-making and priority setting, including the generation of the evidence base for health reforms, the Internal Management Support Cluster, the Health Regulation Cluster which is composed of the Bureau of Health Facilities and Services, the Food and Drug Administration and the Bureau of Health Devices and Technology and the Bureau of Local Health Program Development Cluster.

Additionally, there is a series of attached agencies, among which are the Dangerous Drugs Board, the Philippine Institute of Traditional and Alternative Health Care, and the Philippine National AIDS Council. For the purposes of this study, the most relevant is PhilHealth, which is the agency responsible for implementing the national health insurance law and administering the NHIP.

On matters of governance, the PhilHealth administers the program at the central level with a consolidated policy-making and managerial function (Domingo, 2012-I). Its roles include: policy formulation, program development and administration, overall financial management, research development, determination of standard settings, development of guidelines on premiums, benefits and referral systems, and the establishment of PhilHealth Regional Offices (PROs) and Service Offices (SOs). The PROs and SOs coordinate closely with the LGUs on the implementation of the program at the local level, which provides a greater degree of decentralization to the management of the program (ASSA, 2012).

PhilHealth has the status of a tax-exempt government corporation attached to the DOH. The Secretary of Health heads the PhilHealth Board of Directors. This Board is composed of 11 members wherein seven are from government agencies and the remaining four are representatives from civil society (labor, employers, self-employed

sector and providers). The President of the Philippines appoints the Members of the Board upon the recommendation of the Chairperson of the Board (Secretary of Health). The President of PhilHealth is appointed for a non-renewable term of six years upon the recommendation of the Board. PhilHealth has management autonomy since the president can set, within certain limits, his/her own salary scales. PhilHealth is required by its law to establish local health insurance offices in each province or chartered city (World Bank, 2011).

Since the devolution of health services in 1991, the provision of health services, particularly primary and secondary levels of health care, became the mandate of the LGUs. In this sense, health is managed by provincial, municipal and barangay local government offices. Provincial and district hospitals are the responsibility of provincial governments while municipal governments are responsible for the rural health units (RHUs) and Barangay Health Stations (BHSs).

In general, LGUs have minimal institutional infrastructure to manage health. In addition to the DOH, PhilHealth, and LGU structures, there are existing professional and civil society groups in the Philippines, i.e. the strong presence of the Philippine Hospital Association and the Philippine Medical Association to which the Philippine Family Medicine Association is linked (World Bank, 2011; Patino, 2012-I).

2d. Regulation of Health Maintenance Organizations (HMOs)

Lastly, regarding the private sector, in the Philippines there is a small group of Health Maintenance Organizations (HMOs) devoted to providing or arranging for the provision of pre-agreed or designated health care services to its enrolled members for a fixed prepaid fee for a specific period of time (Da Silva, 2012-I). There are three different types of HMOs:

1. The ***investor-based HMO*** which is organized to operate at a profit. In 2011 there were 20 issued clearances to operate in Philippines.
2. The ***community-based HMO***, a non-profit organization designed for the benefit of a particular community. In 2011, there were no such community-based HMOs recorded to have been operating in the Philippines.
3. The ***cooperative HMO*** which fills the requirements of a cooperative (as prescribed in the Cooperative Code of the Philippines). In 2011, there was only one Cooperative HMO.

According to A.O. 34 of 1994 (Rules and Regulations on the Supervision of HMO), the minimum facilities required to any applicant investor-based HMO shall be:

1. Management of one tertiary hospital or affiliation with five tertiary hospitals
2. An outpatient clinic with basic diagnostic facilities for ECG, chest and extremity X-rays, CBC, urinalysis and fecalysis
3. Forms of all standard contracts to be entered into with prospective members

4. A copy of the brochures on the standard procedures for availability of benefits and fees of PhilHealth/Medicare
5. A statement describing the differences, if any, in the standard benefits and fees of PhilHealth against non-members
6. A copy of the agreement between the applicant HMO and the providers who shall furnish the pre-agreed or designated health care services to the HMO's prospective member
7. A statement of the HMO capitalization duly certified and attested by the Securities and Exchange Commission (SEC) or Cooperative Development Agency (CDA), as the case may be
8. A listing of the names and locations of the providers and other persons or facilities either owned or controlled by the applicant HMO or with whom it has contracted to furnish designated health care services to its prospective members

Additionally, for community-based or cooperative HMO, the minimum facilities required are:

1. One affiliated general hospital
2. One affiliated outpatient clinic
3. A copy of the standard benefit packages to be offered to prospective members
4. Schedule of fees to be charged for the standard packages

According to information given by the Association of Health Maintenance Organizations of the Philippines (AHMOPI), HMOs covers mostly those in the employed sector. Payment of premium depends on the agreement among the employee and the employers. In 2011, there were around 3.3 million of HMO plan holders, mainly located in Metro Manila. Usually, the payment mechanism is per service, but there are some cases of capitation (Da Silva, 2012-I)[6].

6 Unlike PhilHealth, payments made by HMOs are subject to Value-Added Tax (VAT).

CHAPTER 3: HEALTH CARE COVERAGE

Over and above the long-term objectives and the measures implemented in the past few decades, the Philippines' health care coverage is still insufficient in terms of the quantity of people it has covered, benefits assured to each group, and the quality of such services. However, the NHIP is the largest insurance program 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, as will be presented in Chapter 4. In the present chapter, the different aspects of the health coverage shall be evaluated, particularly those which are provided by PhilHealth.

3a. PhilHealth Coverage

PhilHealth is mandated to provide universal coverage of health services. As shown in the previous chapter, the Philippines's health care system is made up of different subsectors and components that provide coverage to various segments of the population. Details of the target population of those subsectors and components have been briefly described already and are further elaborated below. Total beneficiaries are members or dependents in the various programs making up PhilHealth (PhilHealth, 2012).

A. MEMBERS

1. ***Employed Sector Program:*** compulsory coverage of all employees in government and in the private sector. These groups were covered by the GSIS and the SSS, respectively, but PhilHealth took over the roles that these institutions used to play. They are incorporated into these categories:

   i. ***Government Sector:*** Employees of the government, whether regular, casual or contractual, who render service in any government branch, military or police force, political subdivisions, agencies, or instrumentalities, including government-owned and controlled corporations, financial institutions with original charters, constitutional commissions, and fill either elective or appointive positions, regardless of status of appointment.

   ii. ***Private Sector:*** Those who are employed by the following:

   - Corporations, partnerships, or single proprietorships, non-government organizations, cooperatives, non-profit organizations, social, civic, professional or charitable institutions, organized and based in the Philippines
   - Foreign corporations, business organizations, or non-government organizations based in the Philippines
   - Foreign governments or international organizations with quasi-state status based in the Philippines which entered into an agreement with PhilHealth to cover their Filipino employees

- Foreign business organizations based abroad with agreement with PhilHealth to cover their Filipino employees
- Sea-based OFWs
- Household employees

2. Individually Paying Program: Voluntary coverage of:

i. Self-employed individuals: Those who work for themselves and are therefore both the employer and employee, including but not limited to the following:
   - Self-earning professionals like doctors and lawyers
   - Business partners and single proprietors/proprietresses
   - Actors, actresses, directors, scriptwriters and news reporters who are not under an employer-employee relationship
   - Professional athletes, coaches, trainers and jockeys
   - Farmers and fisher folk

ii. Workers in the informal sector such as ambulant vendors, watch-your-car boys, hospitality girls, tricycle drivers, etc.

iii. Separated from employment: Those who were previously formally employed (with employer-employee relationship) and are separated from employment.

iv. Employees of international organizations and foreign governments based in the Philippines without agreement with PhilHealth for the coverage of their Filipino employees in the program.

v. All other individuals not covered under the previous categories mentioned, including but are not limited to the following:
   - Parents who are not qualified as legal dependents, indigents or retirees/ pensioners
   - Retirees who did not meet the minimum of 120 monthly premium contributions to qualify as non-paying members
   - Children who are not qualified as legal dependents
   - Unemployed individuals who are not qualified as indigents
   - Retired AFP personnel who are not yet 56 years old
   - Optional retirees who have rendered 20 years in military service
   - Complete Disability Discharge (CDD) retirees separated from military service due to physical disability incurred in the line of duty
   - Qualified beneficiaries of deceased AFP uniformed personnel

3. Sponsored Program: Covers the extremely poor:

- Qualified indigents belonging to the lowest 40% of the Philippine population
- Families listed in the National Household Targeting System for

Poverty Reduction (NHTS-PR) of the Department of Social Welfare and Development

- Families identified as poor by the sponsoring LGUs

4. Overseas Filipino Workers

i. Active land-based Overseas Filipino Workers (OFWs) who underwent the normal process of registration as an OFW at Philippine Overseas Employment Administration (POEA) Offices

ii. OFWs who are currently abroad but are not yet registered with PhilHealth may also register under this category

5. Lifetime Member Program: This program is free for members that have already completed their 120 monthly contributions including:

- Old-age retirees and pensioners of the GSIS, including uniformed and non-uniformed personnel of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408
- GSIS disability pensioners prior to March 4, 1995
- SSS pensioners prior to March 4, 1995
- SSS permanent total disability pensioners
- SSS death/survivorship pensioners
- SSS old-age retirees/pensioners
- Uniformed members of the AFP, PNP, BFP and BJMP who have reached the compulsory age of retirement on or after June 24, 1997, being the enforcement date of R.A. 8291 which excluded them in the compulsory membership to the GSIS
- Retirees and pensioners who are members of the judiciary
- Retirees who are members of Constitutional Commissions and other constitutional offices
- Former employees of the government and/or private sectors who have accumulated/paid at least 120 monthly premium contributions as provided for by law but separated from employment before reaching the age of 60 years old and thereafter have turned 60 years old
- Former employees of the government and/or private sectors who were separated from employment without completing 120 monthly premium contributions but continued to pay their premiums as Individually Paying Members until completion of the required 120 monthly premium contributions and have reached 60 years old as provided for by law
- Individually Paying Members, including SSS self-employed and voluntary members, who continued paying premiums to PhilHealth, have reached 60 years old and have met the required 120 monthly premiums as provided for by law
- Retired underground mine workers who have reached the age of retirement as provided for by law and have met the required premium contributions

B. DEPENDENTS

- Legal spouse (non-member or with inactive membership)
- Children: legitimate, legitimated, acknowledged and illegitimate (as appearing in birth certificate), adopted or step below 21 years of age, unmarried and unemployed
- Children 21 years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support
- Parents (non-members or membership is inactive) who are 60 years old, including step-parents (biological parents already deceased) and adoptive parents (with adoption papers)

Table 6: Number of Members and Beneficiaries Covered by PhilHealth, 2000-2012

Year	Government Employed		Privately Employed		Individually-Paying		Overseas Workers		Non-Paying/ Lifetime Members		Sponsored Members		Total	
	Members	Beneficiaries	Members	Beneficiaries	Members	Beneficiaries	Members	Beneficiaries	Members	Beneficiaries	Members	Beneficiaries	Members	Beneficiaries
2000	1,868	6,967	5,293	19,126	43	1,908			-	-	347	1,596	7,551	29,597
2001	2,011	8,948	5,291	20,767	930	4,182			477	716	619	2,847	9,328	37,460
2002	2,137	10,199	4,905	19,576	1,364	6,755			487	730	1,261	6,304	10,154	43,565
2003	1,645	7,632	5,938	23,155	555	2,744			76	130	1,762	8,741	9,976	42,401
2004	1,689	7,866	5,947	23,556	1,329	6,563			1	23	6,258	31,291	15,224	69,299
2005	1,846	7,493	6,450	23,188	1,889	8,471	545	2,673	20	334	2,492	12,440	13,242	54,599
2006	1,288	5,385	6,558	23,403	2,013	9,148	1,187	5,172	263	448	4,946	24,847	16,256	68,403
2007	1,781	7,420	6,998	24,858	2,427	11,069	1,586	6,912	337	572	2,721	13,635	15,850	64,467
2008	1,856	7,740	6,379	23,185	2,723	12,509	1,837	8,059	403	685	3,264	16,491	16,461	68,669
2009	1,902	8,935	7,007	28,608	3,326	14,973	2,105	8,614	462	846	5,382	19,202	20,182	81,178
2010	1,949	6,581	7,863	22,633	3,748	10,920	2,337	6,900	500	846	6,045	22,104	22,441	69,985
2011	2,010	5,904	8,850	18,097	4,339	9,905	2,571	5,086	572	945	9,574	38,449	27,916	78,386
First quarter of 2012	2,017	5,955	9,095	18,586	4,578	10,467	2,618	5,168	593	989	9,031	36,504	27,933	77,669

Source: 1997 to 1998: Comptrollership Dept.; 1999 to 2011: Human Resource Dept. Philhealth
Note: Blank spaces mean No Available Data

Tables 6 show the number of beneficiaries (members and dependents) enrolled in each of the five PhilHealth Programs since 2000, while Table 7 estimates the population covered by PhilHealth. Both tables exhibit the steady, impressive growth of total coverage of PhilHealth from 2000 to 2011. Specifically, members increased by almost 20 million people and beneficiaries rose by 49 million people in this timeframe.

Coverage grew from 38% of the total population in 2000 to 82% in 2011. In this period, the growth of members (216%) was greater than that of dependents (144%) except perhaps in 2011, which, as will be mentioned later, is linked to PhilHealth's effort to clear their list of beneficiaries to prevent fraudulent practices in the incorporation of dependents. Unfortunately, being enrolled or registered in PhilHealth is quite different from being eligible to use the benefits. This issue will be analyzed in Chapter 6.

While the coverage has grown significantly in the last decade, almost 20% of the population is still not covered and has no access to quality health care, which makes the system far from being universal. However, it should be recognized that compared to other countries in the region, according to data presented by Tangcharoensathien et. al. (2011), the Philippines is located in a good position: below countries like Malaysia and Thailand which have coverage bordering 100% of total population, but the country has a better result than Indonesia (48%), Vietnam (54.8%) and Cambodia (24%).

Table 7: Percentage of the Total Population Covered by PhilHealth, 2000-2012

Year	Population (projected)	Estimated Beneficiaries*	%
2000	77,000,000	29,596,703	38
2001	79,000,000	36,744,229	47
2002	80,000,000	43,564,610	54
2003	82,000,000	42,401,432	52
2004	84,000,000	69,506,343	83
2005	85,000,000	54,598,650	64
2006	87,000,000	68,402,639	79
2007	89,000,000	64,467,384	72
2008	91,000,000	68,669,304	75
2009	92,000,000	81,178,456	88
2010	92,000,000	69,984,584	76
2011	96,000,000	78,386,398	82
First quarter of 2012	96,000,000	77,669,321	81

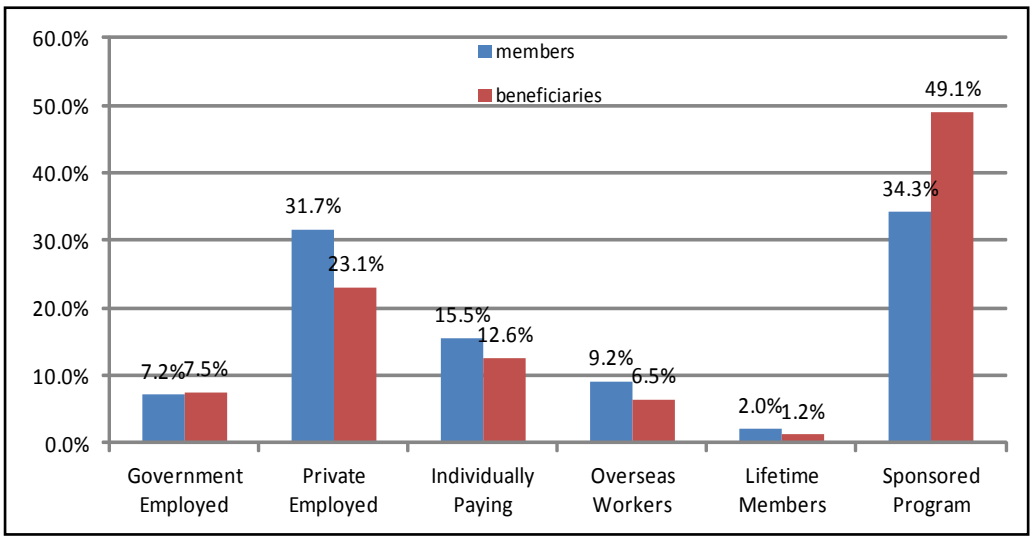
Source: PhilHealth, Comptrollership Department (1997 to 1998); Human Resource Department (1999 to 2011)
**Total from Table 6*

Upon analyzing the composition of coverage according to the different components of the program, it is noticeable that the majority of beneficiaries fall under the Sponsored Program, which in 2011 covered 38.4 million beneficiaries, representing 49.1% of all the beneficiaries of the system. This undoubtedly reflects the equity objectives sought by the program since these are low-income beneficiaries (see Chapter 6). The privately-employed component comes in second place, covering 18 million beneficiaries in 2011 (23.1%). These are followed, in order of magnitude, by: the Individually Paying Program (12.6%), Government employed (7.5%), Overseas workers (6.5%), and Lifetime members (1.2%).

If the number of members, instead of that of beneficiaries, is considered, the above-mentioned percentages are considerably altered and will change even the order of the components. This is strongly linked to the number of dependents incorporated, on average, into the different programs. Figure 8 compares the total percentage of members and beneficiaries of the different components, where the Sponsored Program has, on average, the greatest number of dependents and beneficiaries (49.1% of the total) vis-à-vis 34.3% of the total members. As should be expected, since it is an older adult population, the share of Lifetime Members is 2% of the total members and 1.2% of beneficiaries.

Different measures are being carried out by PhilHealth to fight fraud and abuse problems, specifically pertaining to members declaring non-dependents as dependents. To this end, PhilHealth has set up a Fraud Prevention and Detection Unit, now called the Fact Finding Investigation and Enforcement Department, which aims to control and supervise the system and prevent the proliferation of adverse selection practices of beneficiaries as well as fraudulent practices by providers, and the cleansing of the list of beneficiaries in the system.

Figure 8: Members and Beneficiaries of NHIP components, 2011 (% of total)



Source: PhilHealth, Comptrollership Department 1997 to 1998); Human Resource Department (1999 to 2011)

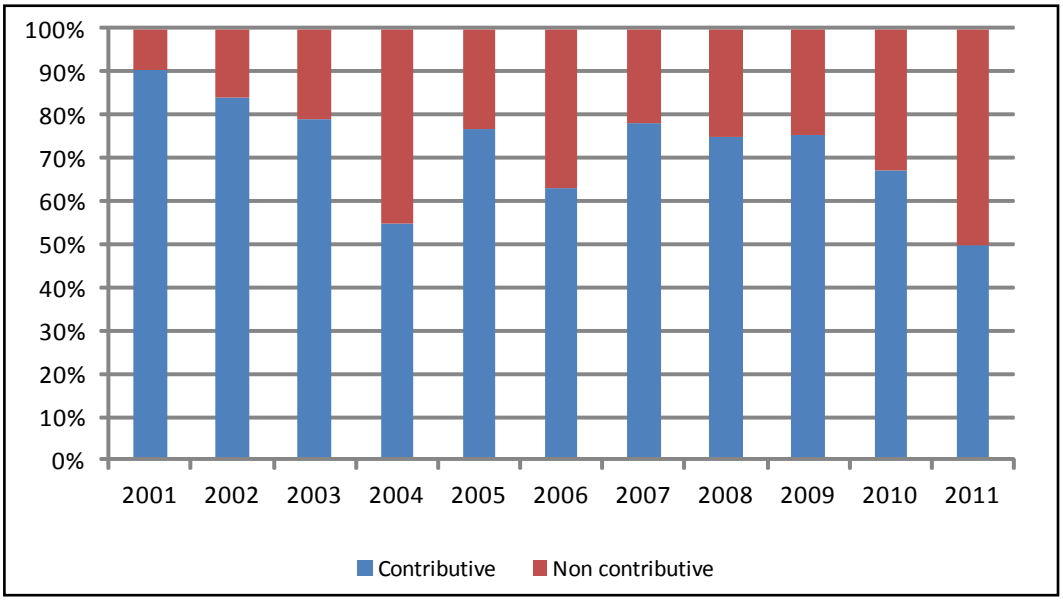
The improved method for counting beneficiaries has had a bearing on the statistics herein presented. In the earlier years, only the principal members were enrolled in the program; PhilHealth failed to get the data on their dependents and just accepted who the dependents were as identified by members. Recently, there was a change in how beneficiaries were counted, in which data from administrative records of dependents were based on actual count. While the number of dependents was more speculative and based on an adopted multiplier linked to a standard family, PhilHealth now relies on an actual count basis. Consequently, the number of beneficiaries in the system continues to show a different pattern than that of the direct members, basically due to administrative reasons. Therefore, for a better assessment of the evolution of coverage, it is advisable to analyze the data corresponding to direct members.

The evolution of the Sponsored Program (SP) coverage has been erratic. As mentioned, SP members included families who are listed in the targeting system (NHTS-PR) and those identified as poor by the sponsoring LGUs. The number of beneficiaries went up from 1.6 million in 2000 to 31.3 million in 2004. Thereafter, it decreased to as low as 13.6 million in 2007. This is due to the "5 Million Program" that was put into practice in 2004 with the goal of enrolling as many households as possible, but was later downsized to 2.5 million and ultimately expired by the end of 2007. Thus, the

SP showed an explosive growth in 2004 and an equally dramatic decrease until its disappearance in 2007.The funds for this initiative came from the Philippine Charity Sweepstakes Office (PCSO) without any LGU contribution. When funding from the PCSO stopped, the number of sponsored members sharply declined.

After 2007, SP resumed its upward trend and reached 38.4 million beneficiaries in 2011. This can partly be explained by the new health sector plan put in place in 2010 by the new administration which seeks to strengthen PhilHealth programs and ensure universal health care (Bala, 2012-I). The new health sector plan aimed to increase the number of poor people enrolled in PhilHealth and improve the outpatient and inpatient benefits package. A full government subsidy is offered for the poorest 20% of the population, and premium for the second poorest 20% will be paid in partnership with the LGUs (WHO, 2011). The explosion of members and beneficiaries under this component is thus understandable and the new policy appears to have made up for the adverse effects of the global financial crisis.

Figure 9: Beneficiaries of Contributory and Non-contributory Components of NHIP, 2001-2011 (in percentages)



Source: PhilHealth, Comptrollership Department 1997 to 1998); Human Resource Department (1999 to 2011)

The evolution of the PhilHealth coverage differentiating between the contributory and non-contributory components shows the growing importance of the non-contributory component based on a steady growth of the number of its beneficiaries (save in 2005 and 2007). On the other hand, there is a decrease in the contributory component share, largely since 2009, in line with the international financial crisis and, more importantly, with the above-mentioned cleansing of the members list. Thus, while in 2008, 77% of the population covered by the NHIP was made up of the contributory part, in 2011, such proportion decreased to 50% (see Figure 9). The inclusion of a significant number of the population without health coverage is positive, but its effects in terms of financial sustainability should not be overlooked. To cite, 93% of total premium contributions in 2011 came from contributory components (see Chapter 7).

Table 8: Economically Active Population (EAP), Employed and Members of Employed Sector and Individually Paying Programs as Percentage of their Reference Population, 2001-2010

Year	EAP (in thousands)	Formal and informal employees (in thousands)	Government members/ formal public sector employees (%)	Private sector members/ formal private sector employees (%)	IPP members/ informal sector employees (%)	Total contributory members/ Total employees (%)
2001	32,809	29,156	86.10	43.70	6.30	28.20
2002	33,936	30,062	89.90	39.90	8.90	28.00
2003	34,571	30,628	69.50	52.60	3.30	26.60
2004	35,862	31,613	69.80	47.40	8.00	28.40
2005	35,381	32,312	75.30	52.60	10.70	31.50
2006	35,464	32,962	50.80	52.50	11.20	29.90
2007	36,213	33,560	67.90	54.00	13.50	33.40
2008	36,805	34,089	68.10	48.00	15.10	32.10
2009	37,892	35,061	66.40	50.70	18.10	34.90
2010	38,894	36,035	64.40	54.00	20.30	37.60

Source: PhilHealth, Comptrollership Department and Human Resource Department; Based on BLES (2005, 2010 and 2011)

Relating the members of each program with their reference population group, which is the population group each program targets to serve, allows some preliminary findings about the level of non-compliance in those programs. For example, based on the number of members in the Employed Sector and Individually Paying Programs in 2010, the following were identified[8]:

a. As expected, the component with the highest share in the reference population is that of the government sector, which covers as many as 64.4% of all civil servants.
b. Second is the private-sector employee component, with 54% coverage relative to the corresponding population group.
c. In the IPP component, there is a significant trend of incorporating members into the program leading to a steady increase in the proportion of coverage relative to informal employees which was 20.3% in 2010. However, despite the progress made, such share is still low and shows the limited coverage of this sector, in view that the informal sector is above 50% of the labor force. Hence, there is still a need to develop a strategy to effectively reach members of this sector.

8 The data on employed, unemployed population and rate of activity are available in Appendix Table 6.

d. In an aggregate way, the contributory components' share in the NHIP is growing relative to the number of employees in the Philippines, covering 37.6% of the employed population in 2010, while the share of these components in the total of the NHIP has declined.
e. Lastly, the total number of the Non-Paying Lifetime Members account for less than 10% of the population older than 60, thus confirming the history of weak contributory practices of Filipino workers.

The Overseas Workers Program (OWP) is one of the most characteristic features of the Philippine Health System. Due to surplus labor, the Philippine Overseas Employment Administration (POEA) promotes labor emigration, thus making the Philippines rank third among top labor-exporting countries. The Commission on Filipinos Overseas (CFO) estimates a total of 8.5 million Filipinos abroad. Out of this total, 92% are regular migrants where 47% are permanent and 45% temporary (FES, 2011)[9].

In light of the above-mentioned data, the Philippines have significant remittances (about US$23 billion annually), which considerably improve the life conditions of the migrants' families left behind. According to World Bank estimates, Philippines is the third country with the largest remittances, after China and India (World Bank, 2012).

OWP beneficiaries have particular relevance because, in most cases, the members are abroad but their dependents reside in the Philippines. Therefore, the existence of a component providing coverage to this segment of the population constitutes an innovative and virtually unique health policy.

The private sector also provides health care services to Filipinos through voluntary prepaid medical insurance. In some cases, such insurance is additional to that granted by the social security services, thus resulting in double coverage of the higher-income strata. Nonetheless, despite the growth of this subsector, it accounts for barely 10% of the insured population (WHO, 2011).

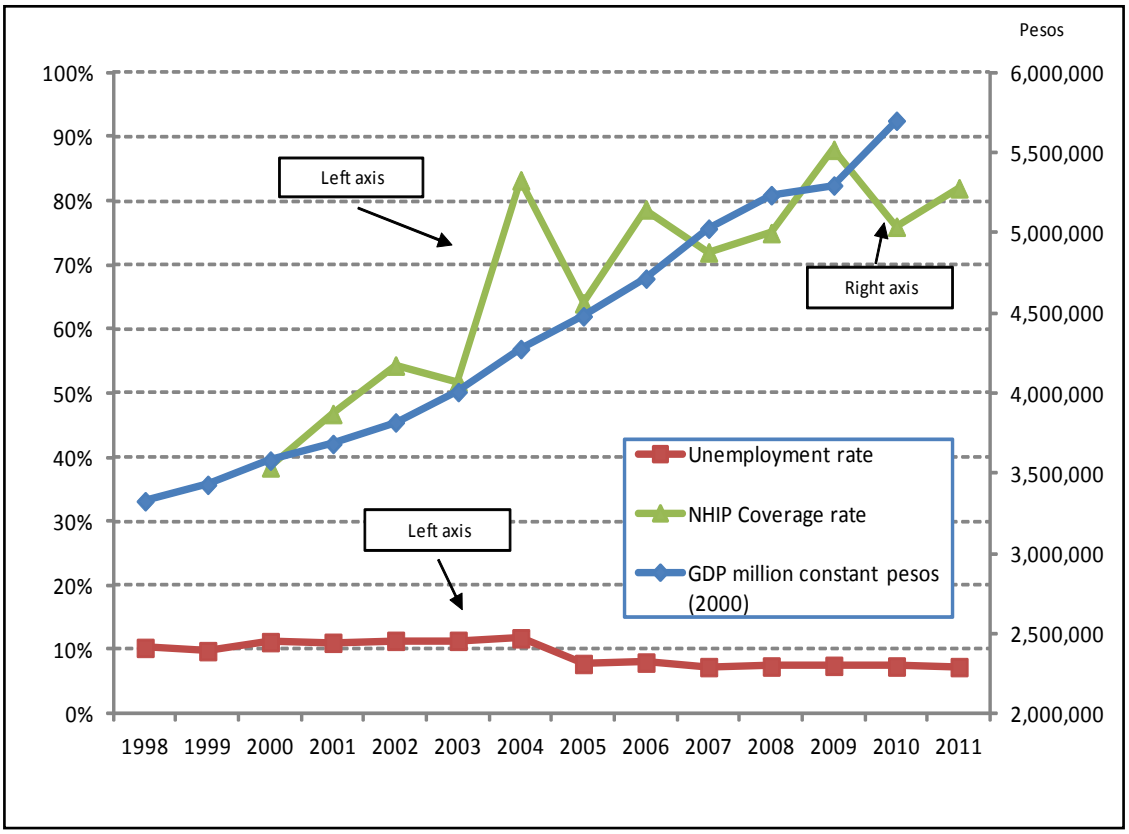
3b. Reasons for Potential Decline in Coverage and Impact of the Financial Crisis

It has been demonstrated that the percentage of the total population of PhilHealth beneficiaries generally shows a growing trend throughout time, albeit still insufficient to reach the aspired universal coverage. The expected evolution of health coverage for the population in the next few years is based on five sets of effects that reflect the situation of the components of PhilHealth.

First, the contributory component of coverage is closely related to labor market dynamics: the number of public and private employees, the level of informality and salaries, etc. In a moderate economic growth scenario, the expected behavior of this component would be stabilized as it is improbable under the existing conditions that there will be a significant change in the size of public or private sector formal employees.

9 The Philippines signed bilateral social security agreements with Austria, United Kingdom, Ireland, Spain, France, Canada, Switzerland, Belgium, Korea, Israel, and the Netherland (FES, 2011).

Figure 10: Unemployment Rate, NHIP Coverage Rate and GDP of Philippines, 1998 - 2011



Source: National Statistical Coordination Board, National Statistics Office, Labor Force Survey, Public Use Files and Philippines National Health Accounts (2010)

Second, OWP coverage will depend on the demand for Filipino workers abroad and, consequently, on the economic development of the countries importing Filipino labor.

Third, voluntary contribution to the IPP and OWP components of the NHIP as well as private coverage (e.g. HMO) is closely linked to individual decisions, but also associated to the economic activity and formal employment. In the case of private coverage, it is inversely related to the scope and quality of services provided by the different PhilHealth components.

Fourth, the non-contributory state-financed coverage is strongly linked to the increase of general poverty and extreme poverty incidence (SP beneficiaries) and demographic dynamics, (e.g., as the population ages there would be more non-paying retirees and pensioners) therefore, the government has to increase financing to programs aimed at the needy. According to Mesa-Lago, et al. (2011), the poverty incidence among the population (individuals) decreased from 33.1% to 24.9% in 1991-2006 but rose and stagnated at 26.5% in 2006-2009; individual poverty increased by 3.3 million in 2003-2009 or 17%. There are also signs of a resurgence of poverty aggravated by global crisis, typhoons, and the El Niño phenomenon that hurt the local economy

in 2009. Population poverty incidence was estimated at 33% in 2010 (NAPC, 2011). If poverty rates increase, a higher demand for SP services might be expected, hence putting pressure on this program's financing which will further be exacerbated by other problems such as decreased contributory coverage.

The SP should provide coverage to the lowest income quintiles (the poorest 40% of the population) so that in a scenario perfectly focused and completely covered, the worsening socio-economic conditions resulting from a crisis will not result in a greater total coverage although it might reflect a higher number of people that might not pay for coverage voluntarily. In this context, the ability of this component to have a countercyclical response is strongly limited, reducing the possibilities of gaining access to health coverage for a wide range of population sectors.

Fifth, with regards to the coverage of the population older than 60 (NPP beneficiaries), population projections do not show a significant expansion of coverage demand in this segment even when it requires more and costlier health services due to its characteristics.

In 2009, the global financial crisis hit the Philippines relatively harder than in some countries in the region such as China, Vietnam, and Indonesia, but less so than others such as Thailand, Malaysia, and Korea. Along with other countries in the region, the severe world crisis affected Philippine trade and financing (IMF, 2012a).

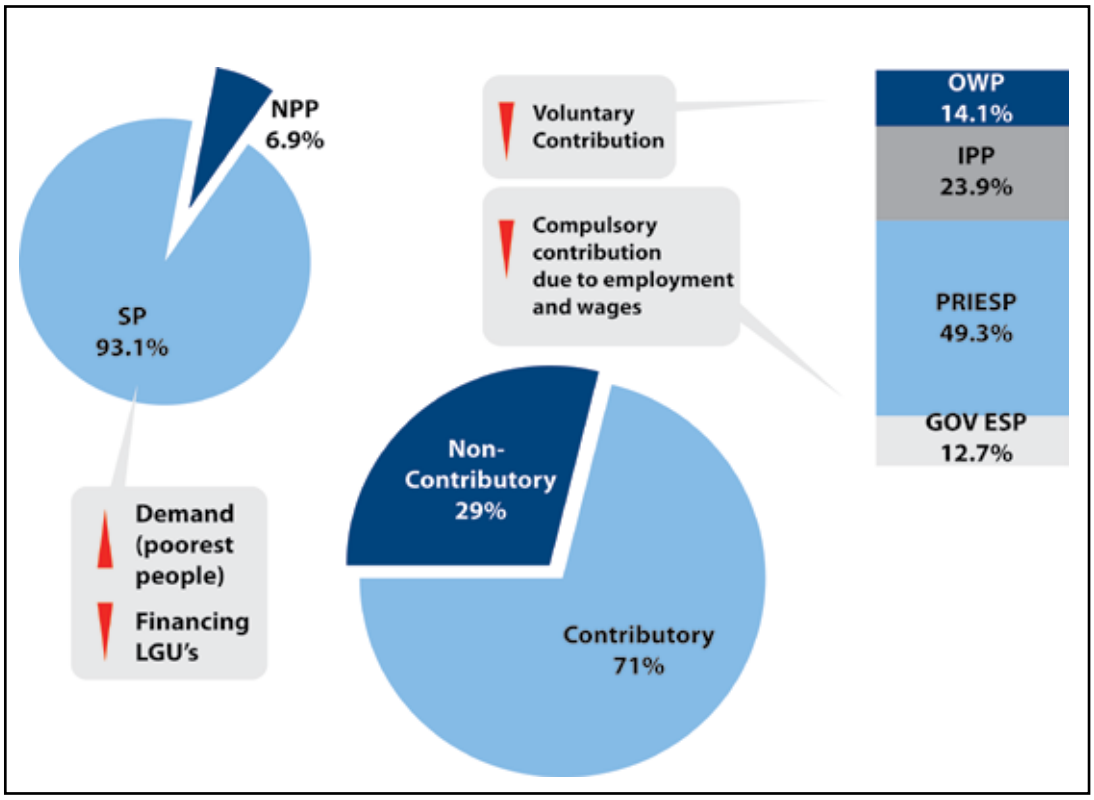
According to the data from the Department of Finance (DOF), Gross Domestic Product (GDP) growth in the country was about 1.1 % in 2009 (roughly -1 % in per capita terms), down from over 7.1% in 2007 and 4.2% in 2008. In 2010, the growth rate reached 7.6%, but reverted to 3.9% in 2011. Demand for exports declined, which also pushed down consumption and investment. The financial system had limited exposure to Europe and little reliance on foreign wholesale funding, but the Philippines was still affected because of pullbacks of credit by European banks to the domestic corporate sector and a retreat by foreign investors from local equity and bond markets. Furthermore, remittances, which comprised 10% of GDP, also declined. Therefore, all economic activities have been affected, and both employment and formality levels decreased and negatively affected health coverage.

Unlike in the case of pensions, the effects on the health care system were immediate as the lack of payment eventually led to the interruption of service provision. Most of those who became unemployed lost their PhilHealth entitlement, unless they became IPP members and paid the contribution voluntarily. Alternatively, according to the conditions of access to the different PhilHealth programs, if an unemployed person falls among the households in the first quintile, he might gain access to the SP coverage.

Data in Table 8 showed that since 2009, despite the crisis, general contributory coverage rose based on the number of members (only decreased in the government

sector)[10]. The same behavior is observed in the case of the programs for those employed, IPP and OFP, whose payments are voluntary. In the latter's case, this can be associated with a prevention strategy by such households within the framework of the crisis. The lack of unemployment insurance or assistance benefits, which usually act as automatic stabilizers during recessions, is an important limitation to counteract the crisis effects. Thus, large groups of the population use their own resources to be covered during the unfavorable circumstances of the economic cycle, paying voluntarily contributions to the NHIP to sustain their health coverage and avoid higher expenditures on health that could worsen their socio-economic situation in the long run.

Figure 11: Crisis Impact on PhilHealth Coverage by Group, 2010 (% structure)



Source: Own elaboration based on PhilHealth Annual Report (2010)

In recent years, there has been a steady deterioration in the international macroeconomic environment. The lower expansion rates of the Asian economies would most likely negatively affect the Philippine economy. In an eventual critical scenario, unemployment could raise the number of informal workers who have low health coverage (Weber and Piechulek, 2009) (see Figure 10). Also, the salary base will stagnate and contributions will subsequently decrease. Moreover, if business opportunities shrink due to an economic downturn, voluntary members may cancel their membership, which may lead to a lower coverage degree of the NHIP contributory

10 As shown in section 3.a, coverage fell due to the cleansing of the list of beneficiaries.

part. Nevertheless, this scenario does not seem to be the most likely in the next few months; the latest estimates are more optimistic as shown in Chapter 4.

To better cope with the crisis, the NHIP should assign more resources to the SP in order to finance non-contributory health services for the poor. In fact, within the framework of a crisis, a higher number of beneficiaries is incorporated into this component, thus making up, albeit partially, for the decrease in beneficiaries in the contributory part (showing that the incorporation of new SP members is more dynamic than in the other components). In this context, the non-contributory component might act in a countercyclical way, showing a gradual increase based on the incorporation of the new SP beneficiaries during a crisis. However, it is difficult to rapidly incorporate new SP beneficiaries because of red tape, timing and unsustainable funding, all of which are significant challenges that should be addressed to effectively provide health care services to the poor in the long run.

Furthermore, the crisis has reduced resources from national and local governments, both of which are responsible for financing the SP services. Presently, it remains unclear if additional allocations will become available in such circumstances. Figure 11 sums up the impact on the above-mentioned effects from the international crisis on the NHIP coverage.

CHAPTER 4: HEALTH EXPENDITURE AND FINANCING

Having introduced the situation and coverage of health, the first half of this chapter analyzes the system's financial aspects starting with two introductory sections: (1) a comparison of the country's spending level with that in other regions and countries, and (2) basic data of the Philippines' public accounts to grasp the fiscal leeway for reforms in the sector. The second half of the chapter looks at the evolution and structure of health accounts, as well as the financing of each of the public programs.

4a. Health Expenditures in a Comparative Perspective

The resources earmarked for health financing in the Philippines remain inadequate. According to estimates by the World Health Organization (WHO), resources spent for health in 2010 reached 3.6% of GDP. In comparison with other countries in the region, the Philippines' percentage is low (i.e., Vietnam, 6.8%; Cambodia, 5.7%; China, 5.1%; Laos, 4.5%, and Thailand, 3.9%). Table 9 presents the estimates for the different regions in the world according to the WHO classification.

Table 9: International Comparison of Health Care Expenditures, 2010

Countries		Total as % of GDP	% of Total exp. in Health		Health as % Total Public Exp.	Private prepaid plans as % of total private	Per capita expenditure on health (PPP int.$)	
			Public	Private			Total	Public
Philippines		**3.6**	**35.3**	**64.7**	**7.6**	**10.6**	**142**	**50**
Regions								
	African	6.3	50.3	49.1	10.3	8.1	220.6	132.1
	Americas	7.5	57.6	42.4	13.2	19.9	1056.9	616.9
	Eastern Mediterranean	5.1	54.5	45.5	8.0	11.8	599.7	387.0
	European	8.2	66.5	33.4	12.9	12.1	2242.3	1656.8
	South-East Asia	4.5	48.2	51.8	7.1	5.1	170.1	101.9
	Western Pacific	8.0	70.8	29.2	13.2	10.0	952.2	715.4

Source: WHO (2012)

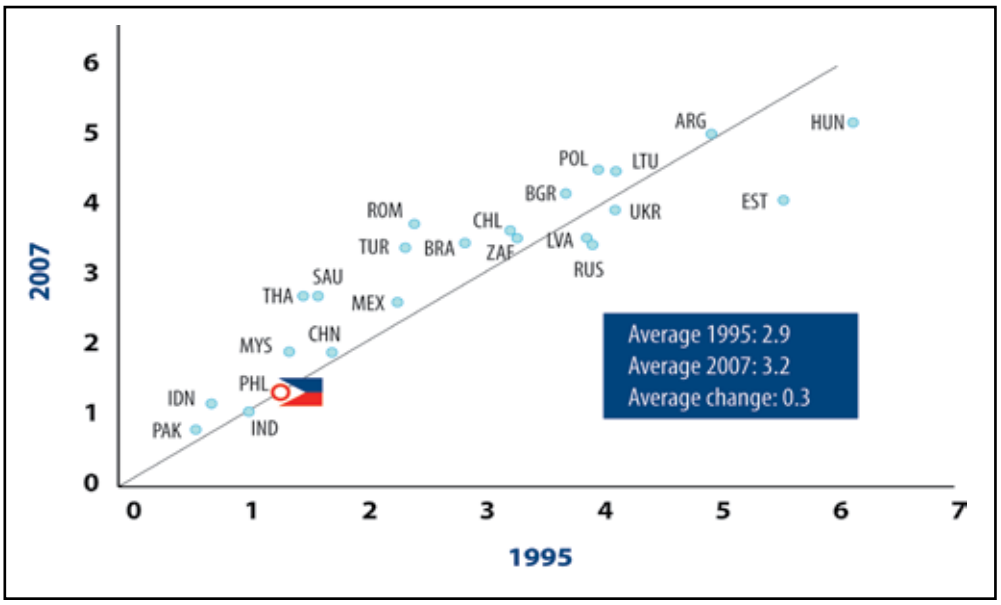
Table 9 also shows that the state participation in total health expenditures is very low as a result of different factors combined. On the one hand, it has a low tax burden (12.3% of GDP in 2011) along with a low share of health spending in the total state budget (7.6%) (WHO, 2012). This share is similar to the average assigned to the sector in Southeast Asian countries. A system that rests on the financing of the private sector, which means there is a high proportion of out-of-pocket spending necessary to gain access to health services or medicine, has been widely recognized as a significant source of inequality (PAHO, 2002).

Additionally, total health spending per capita in US$ of Purchasing Power Parity (PPP) is also low at US$ 142, an indication of poor coverage in health provision (see Chapter 5). Public sector spending per capita is even lower US$ 50. Both indicators are extremely low according to international standards.

A recent World Bank report highlights that the Philippines' spending on public health has not shown significant growth, even in periods of economic growth, opposite to the international experience in this field (see Figure 12). In fact, it points out that "the elasticity of public spending on health to GDP from 1995-2008 was about 0.9, implying that if this trend (of economic growth) continues, the share of public expenditure on health to GDP will continue to decline" (World Bank, 2011). This is partly due to a low dynamism of LGU spending.

In addition, the last Country Report on the Philippines by the International Monetary Fund (IMF) states that "in order to be more inclusive, higher growth will need to be accompanied by a set of mutual reinforcing policies" and "cross-country experience suggests that higher health and education spending helps to increase the inclusiveness of growth" (IMF, 2012a: 19).

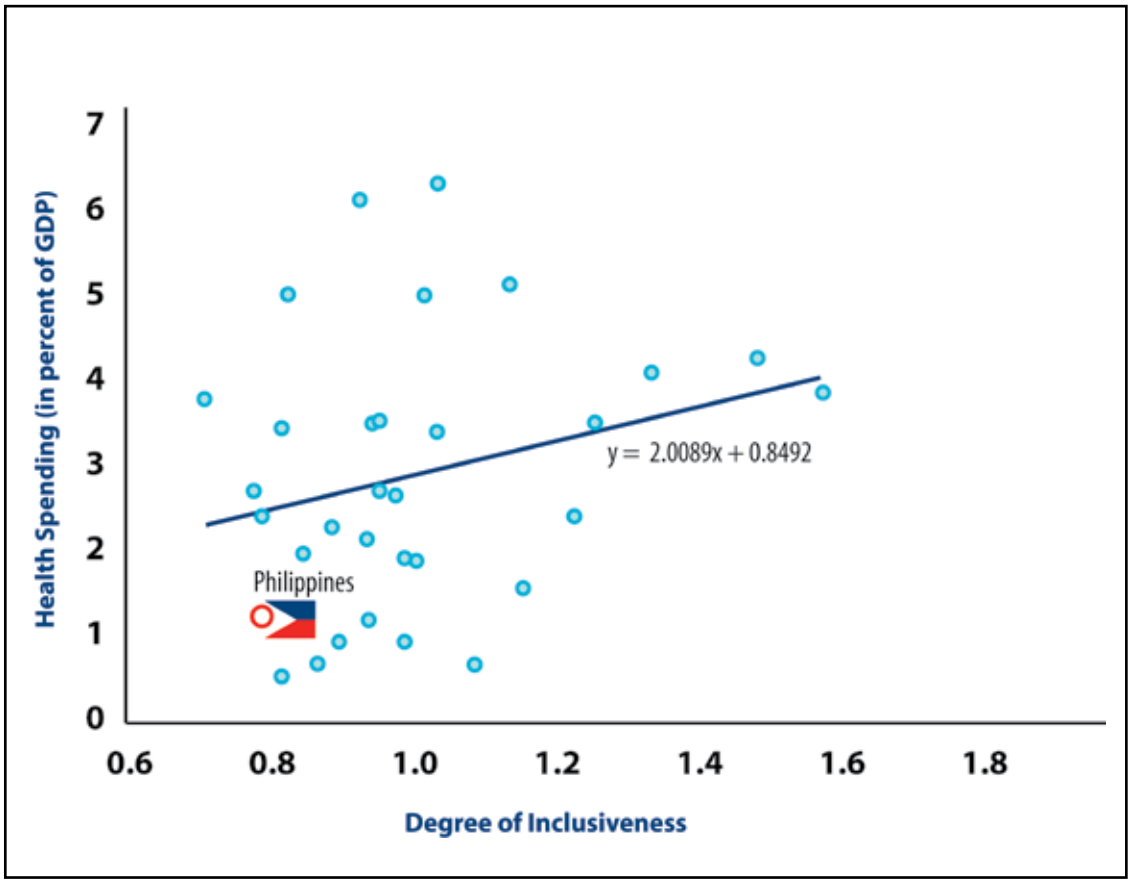
Figure 12: Public Health Spending in Emerging Economies, 1995-2007 (percentage of GDP)



Source: IMF (2012a)

Summing up, the Philippines' spending on health is low, both in terms of GDP and the public budget, as well as in per capita terms. Additionally, the public sector share is limited compared to the private sector share. In contrast with the weak trend in public spending, the importance of private health spending (albeit not its level of coverage) is remarkable with a very high participation in international terms (64.7%), but has very negative effects on the possibility of reaching the objectives of universal and fair health coverage.

Figure 13: Degree of Inclusiveness versus Health Spending



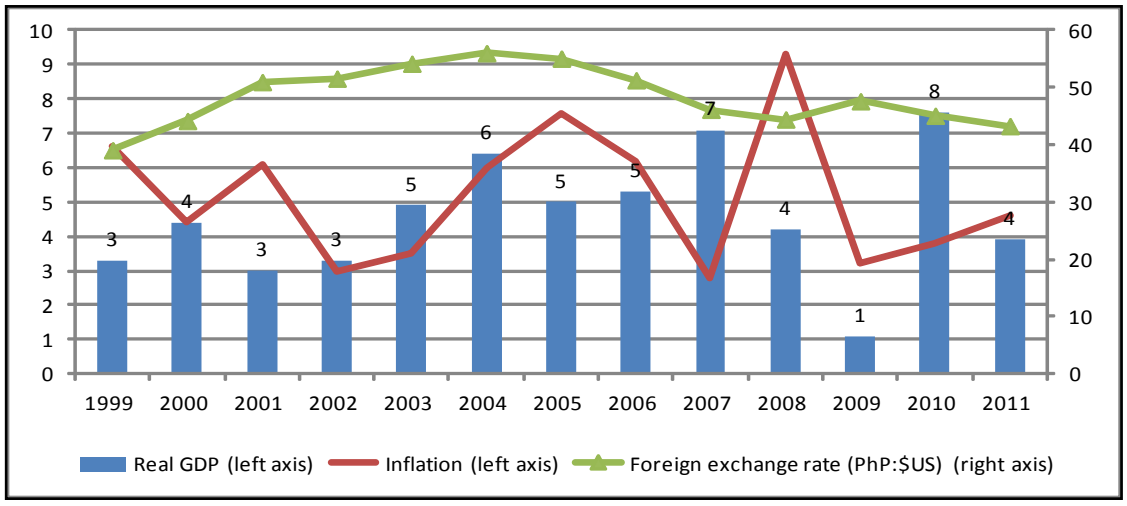
Source: IMF (2012a)

The degree of inclusiveness can be measured by the ratio of the income of the bottom quintile and the mean per capita income. Figure 13 shows that such inclusiveness is very closely associated with the low public health spending and that the Philippines is one of the countries with the lowest degree of inclusiveness and health spending.

4b. Fiscal Accounts and Health Expenditures

This section analyzes the Philippines' macro-fiscal conditions, which are important because of their direct implication on the fiscal leeway available to carry out public policies in the health sector. Macro-fiscal consistency, sustainable fiscal deficit and inter-temporal indebtedness levels are key variables to assess the fiscal space of any sector, including health.

Figure 14: Macroeconomic Variables, 1999-2011



Source: Own elaboration based on Department of Finance data (2012)

Figure 14 presents the evolution of the Philippine GDP, the inflation rate and the exchange rate in 1999-2011. An acceleration of economic growth occurred in 2003-2007 peaking at 7.1%. In 2008, growth slowed down and in 2009, coincidentally with the outburst of the international financial crisis, GDP grew only by 1.1%. In 2010, the economy regained its dynamism, with a rise of 7.6%. The correlation of the economic activity and the inflation rate is high, although the levels of price expansion do not present alarming values, with a peak of 9.3% in 2008.

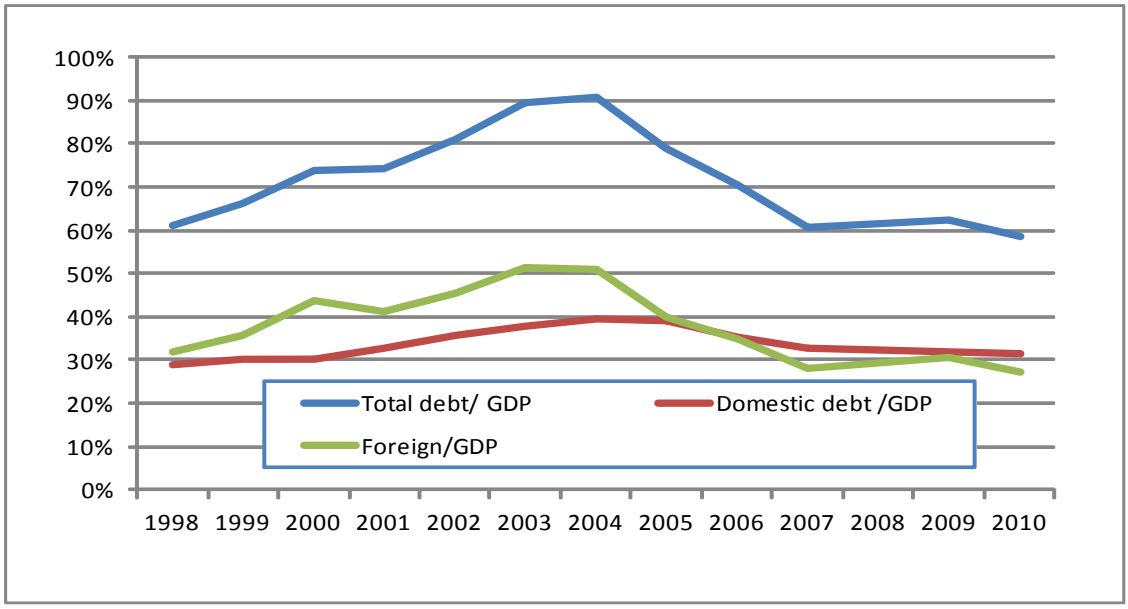
The Philippines had a steady level of fiscal imbalances throughout the period although there was a gradual decrease in GDP terms from a maximum of -5% in 2002 to -0.2% in 2007. It regained momentum in 2009 and 2010, and was around -2.0% in 2011 (see Table 14). Consequently, while the country's total debt has been reduced since the peak in 2003, it still absorbs a high proportion of resources for the payment of services and interests, accounting for almost 60% of GDP (see Figure 15).

According to the Senate Economic Planning Office (SEPO): "The national government deficit for 2012 is targeted to reach PhP 279.1 billion (2.6% of GDP), higher than last year's deficit. For 2013, the deficit is set at PhP 241.0 billion or 2.0 % of the GDP", which explains the commitment of the authorities to pursuing fiscal consolidation in 2013, which means bringing down the deficit and debt to manageable levels. The breakdown of the consolidated fiscal results shows that most of the deficit corresponds to the national government's borrowings. On the other hand, the good fiscal performance of the social security, the financial institutions, and LGUs contribute positively to the public sector consolidated results, albeit still insufficient to compensate for the deficit.

In the past ten years, the revenue effort as a percentage of GDP has not changed significantly. In 2011, the revenue effort stood at 15.1% of GDP, which were results from state tax revenue (13.3% of GDP), most of which was collected through the Bureau of Internal Revenue (10.3%). The rest (2.8%) corresponds to the collections by the Bureau of Customs (Department of Finance, 2012).

The national government's revenue structure for 2010, on the other hand, consisted of the taxes on net income and profits (40.5%), followed by taxes on goods and services (23.6%) and taxes on international trade and transactions (21.5%), while non-tax revenues accounted for only 9.5% of total revenues. The level of tax burden was very low compared to its neighboring countries. In 2010, the Philippines only outperformed Cambodia (10.8%) and Indonesia (11.6%) in tax effort, with Vietnam (24.3%) topping the list (SEPO, 2012).

Figure 15: Evolution of the Philippines' Debt, 1998-2010



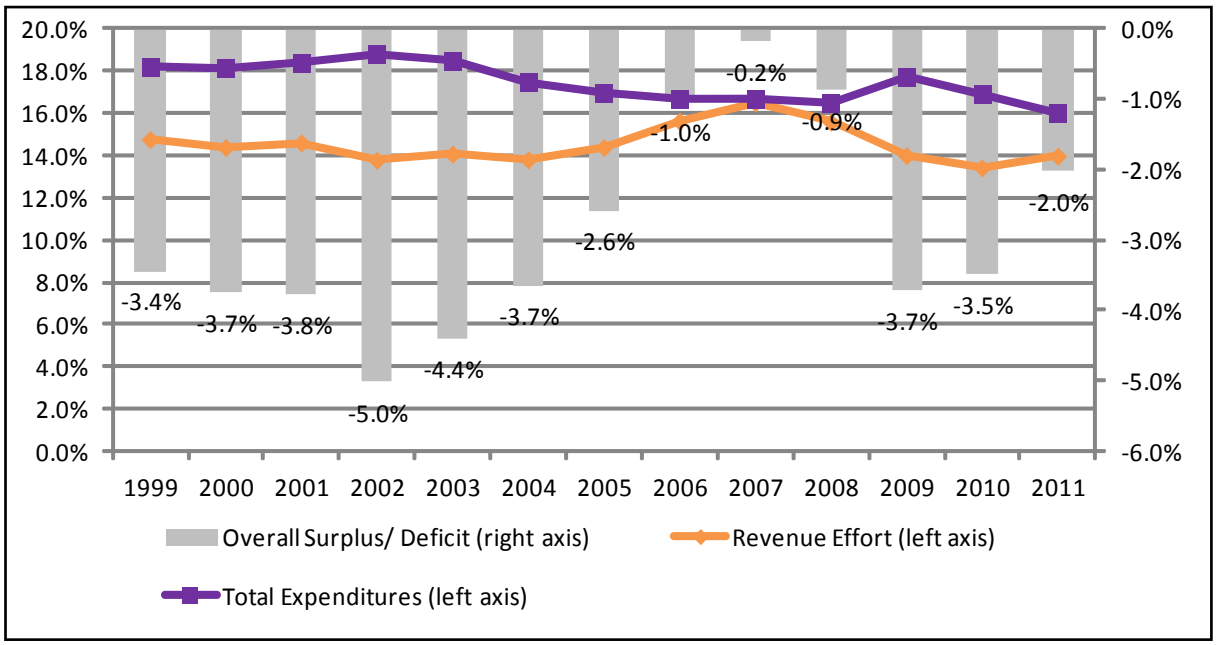
Source: Own elaboration based on Department of Finance data (2012)

Table 10: Consolidated Public Sector Financial Position, 2010-2013 (Billon PhP)

	2010	2011	2012	2013
Total Surplus+/Deficit-	**(403.24)**	**(178.75)**	**(213.92)**	**(158.34)**
as percent of GDP	(0.04)	(0.02)	(0.02)	(0.01)
Total Public Sector Borrowing Requirement	**(389.08)**	**(224.96)**	**(314.52)**	**(287.29)**
as percent of GDP	(0.04)	(0.02)	(0.03)	(0.02)
National Government	(314.47)	(197.75)	(279.11)	(241.00)
CB restructuring	(7.69)	(3.54)	(3.40)	(5.28)
Monitored GOCCs	(66.93)	(23.67)	(32.01)	(41.01)
SSS/GSIS	40.12	47.97	66.76	63.70
BSP	(63.72)	(47.43)	1.00	1.00
GFIs	9.45	9.94	9.34	12.28
LGUs	34.10	34.72	23.51	25.47
Other adjustments	13.32	1.02	0.00	26.50

Source: SEPO (2012)

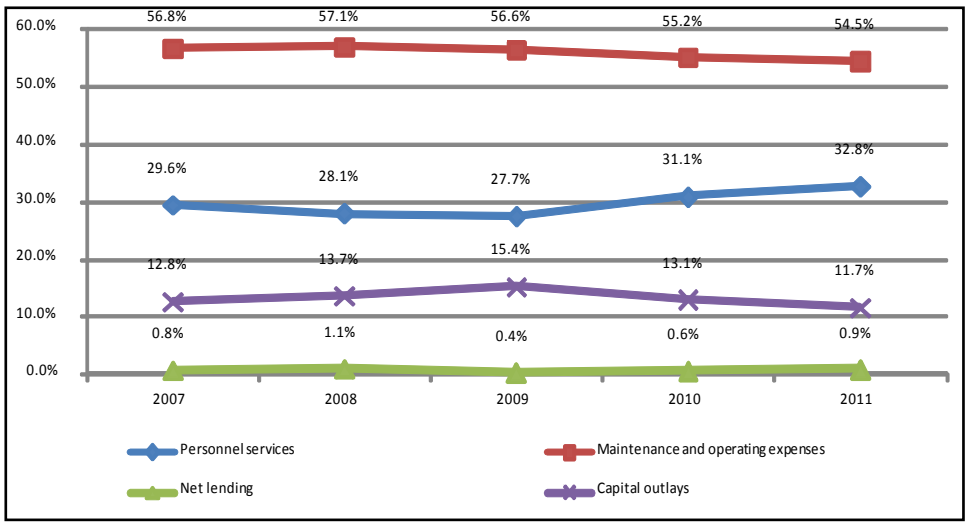
Figure 16: Revenue, Expenditure and Balances, 1999-2011



Source: Own elaboration based on (DOF 2012)

According to the IMF, the tax burden has remained constant over the last decade due to generous and expanding tax incentives, reducing tariff rate, deteriorating tax compliance caused by ineffective and inefficient revenue administration, and a gradual erosion of excise revenue due to non-indexation (IMF, 2012b).

Figure 17: Composition of National Government Spending, 2007-2011



Source: Own elaboration based on Department of Budget and Management (2012)

Regarding spending, minimal change has been observed in the total spending/ GDP ratio: from 18.2% of GDP in 1999 to 16.0% in 2011. In the composition of the national public spending, the maintenance and operating expenses item stands out, with 54.5% of the total spending in 2011. Interest expenses (which in 2011 account for 20.0% of total spending) and subsidies and donations (25.6% of total spending) are included in this line item. Spending on personnel shows an upward trend, that which accounted for 32.8% of total spending in 2011. In contrast, there is a decrease in the capital spending share, which barely reaches 11.7% of the total spending in the last year. It is possible that this structure provides some rigidity to the public budget, reducing the leeway for authorities to adjust spending practices to changes in the economic cycles (Department of Finances, 2012).

Far more interesting for the purposes of this survey is to evaluate the spending on the basis of its objectives. The national government's spending is focused on social services (31.7% of the total and accounted for more than half of the social spending in 2011). Education gets the highest allocation at 17.0% of the total spending. The economic services represent 24.2% of the total spending while spending on public services such as debt interests accounted for 18.3% of the total spending in each case. Health spending, having been decentralized, accounts for less than 3% of the total national public spending (see Table 11).

Table 11: National Public Expenditures, 2009-2011

Public Expenditures	Percent Distribution		
	2009	2010	2011 Proposed
TOTAL	**100.0**	**100.0**	**100.0**
Social Services	28.2	31.7	31.7
Education, Culture, and Manpower Development	15.3	16.5	17.0
Health	2.1	2.3	2.8
Social Security, Welfare and Employment	3.3	5.7	5.8
Housing and Community Development	0.5	0.4	0.4
Land Distribution	0.3	0.2	0.1
Other Social Services	0.1	0.1	0.1
Subsidy to Local Government Units	6.7	6.5	5.6
Economic Services	25.9	22.0	24.2
Defense	6.2	6.2	6.2
General Public Services	19.1	17.5	18.3
NET LENDING	0.6	0.9	1.3
DEBT SERVICE - INTEREST PAYMENT	20.0	21.7	18.3

Source: Department of Budget and Management (2012)

4c. National Health Accounts

Table 12 presents the latest available official data on health spending. In addition to the above-mentioned data about the scarce magnitude of total national revenue allocated to the sector, the set-up of the sector shows the process of decentralization (devolution) of public spending from the national to the local governments. As DOH (2005) states, with the devolution of health services since 1991, the LGUs have been mandated to provide direct health services, particularly at the primary and secondary levels of health care (Rosadia, 2012-I). Under this set-up, provincial and district hospitals are under the provincial government while the municipal government manages the RHUs and BHS.

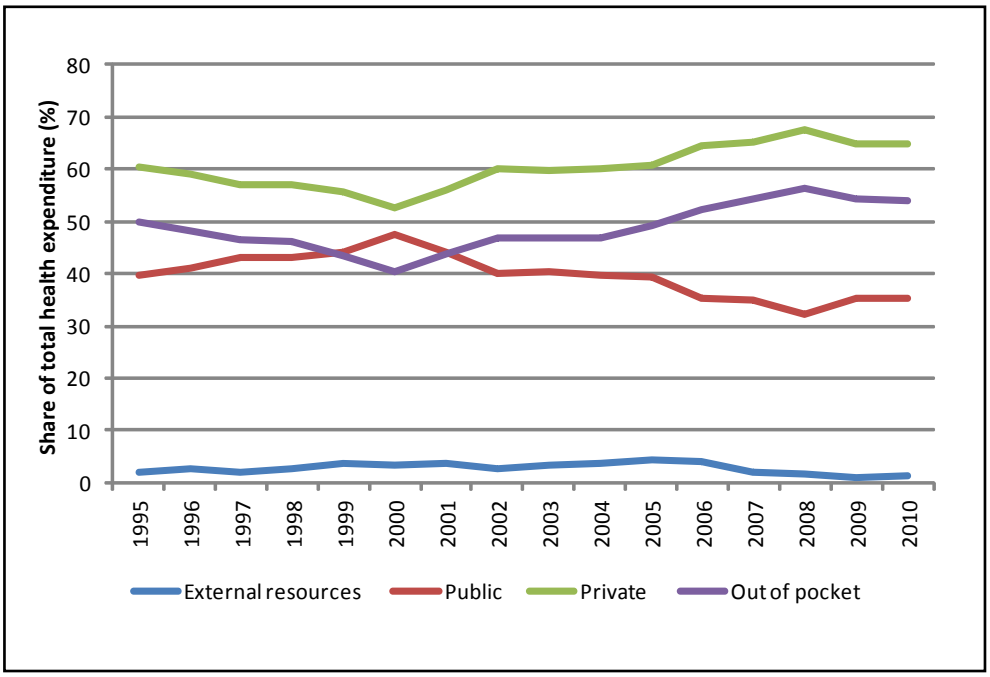
In 2007, the share of public spending on health reached 0.9% of GDP (26.25% of total spending). There is an even share of both levels of government in public health spending, although it is expected that the national government will have lower shares as the local governments begin taking on higher shares in the financing health services of the NHIP Sponsored Program component. Nevertheless, both levels turn out to be minimal relative to the total social service spending. This highlights the importance of strengthening the health budget and spending in both levels of government. Additionally, the spending on social security remains highly inadequate accounting at only 0.3% of GDP (8.52% of total spending), especially in contrast with the objective of reaching universal coverage (see Table 12).

Table 12: Health Expenditure in the Philippines, 2007

Source of funds	Million PhP	% of total	% of GDP
Public sector	**61,507**	**26.25**	**0.90**
National Government	30,441	12.99	0.50
Local Government	31,066	13.26	0.50
Social Security	**19,972**	**8.52**	**0.30**
NHIP	19,838	8.47	0.30
Employees' Compensation	134	0.06	0.00
Private Sources	**151,909**	**64.83**	**2.30**
Private Out-of-pocket	127,346	54.35	1.90
Private Insurance	4,175	1.78	0.10
Health Maintenance Organizations	11,941	5.10	0.20
Employer-Based Plans	5,821	2.48	0.10
Private Schools	2,627	1.12	0.00
Rest of the World	**0.933**	**0.40**	**0.00**
Grants	0,933	0.40	0.00
Total	234,321	100.0	3.50

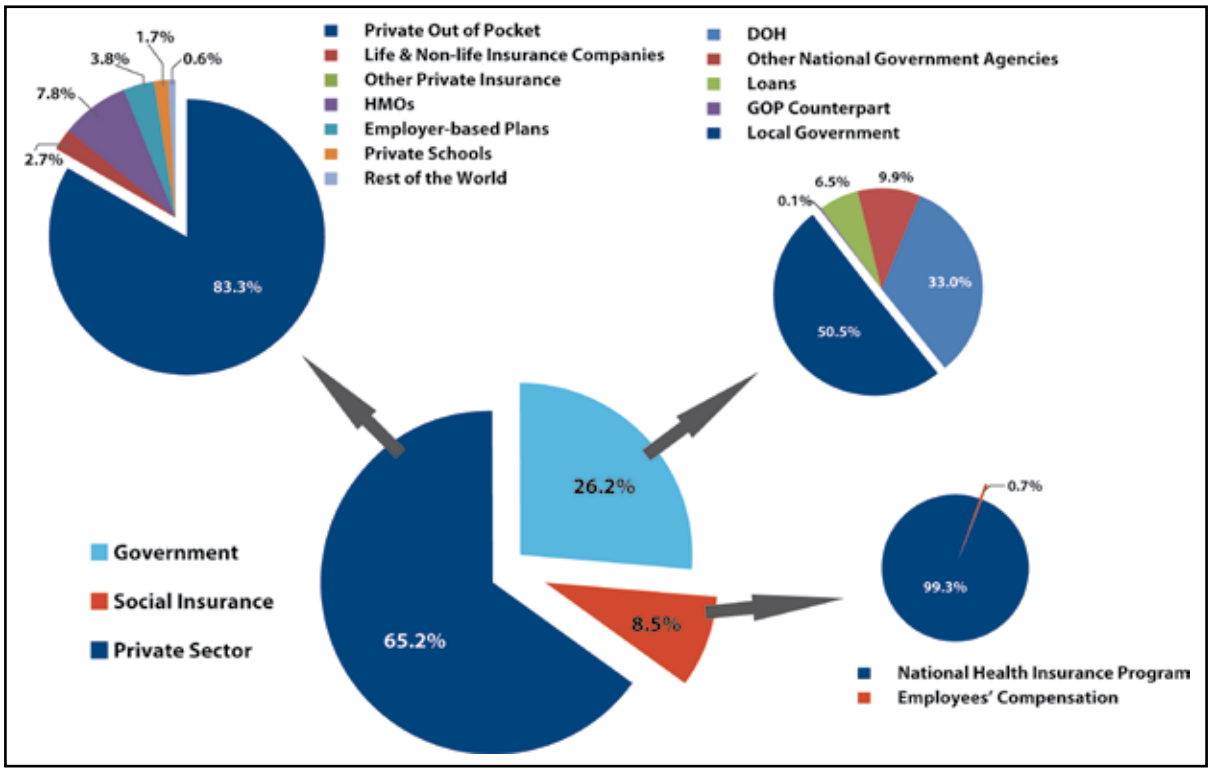
Source: Own elaboration based on National Health Accounts (2010)

Figure 18: Public and Private Health Spending in the Philippines, 1995-2010



Source: WHO (2012)

Figure 19: Philippine National Health Accounts Structure, 2007



Source: Own elaboration based on National Health Accounts (2010)

Three interrelated reasons explain the relatively slow and cautious increase in the share of social security to total health expenditure. First, although PhilHealth is trying to improve its services, its benefits are still low (see Chapter 5). Second, partly because benefits are low, coverage of the informal sector has not expanded at the necessary rate to provide the reference population with complete coverage (see Chapter 3). Third, as a consequence of the decentralization process, insurance is unlikely to be effective in areas where local financing is severely limited and where administrative infrastructures are weak (DOH, 2005).

On the other hand, the private subsector share was 2.3% of GDP and 64.8% of total spending, out of which 83.8% were out-of-pocket expenses, thus leaving the financial and health status of the poor and low-income group vulnerable.

Trends in the various components of health spending in 1995-2010 show the slow dynamism of public spending, and a downward trend since 2000, while private spending and out-of pocket expenses have shown steady increases since 2000 (see Figure 18). Finally, Figure 19 summarizes the Health Spending Structure in the Philippines.

4d. Health Financing

The fragmentation of the health system into different subsectors and covered populations is also reflected in the various sources of financing. Public health, both at the central and the local government level, is financed with resources from their respective funds (i.e., coming from taxation, other resources or external grants).

The NHIP is financed with the payroll tax or voluntary annual contributions, except for the programs targeted on the extreme poor and the NPP. In the Employed Sector Program (for public and private sectors), the monthly premiums (3% of the member's monthly salary base) are shared equally by employees and their employers and remitted to PhilHealth by the latter. This level of contributions over salaries is similar to those of countries in Asia and the Pacific, but insufficient to finance universal health coverage, which might be a factor to the workers' significant private spending[11].

Each of the PhilHealth programs has different requisites regarding the premium its members should pay, as shown below:

1. ***Employed Sector Program:*** The premium contribution of each employed member is up to 3% of his/her basic monthly salary (with PhP 50,000 cap in 2012). The employer and the employee split the premium, and it is directly deducted from the member's salary.
2. ***Individually Paying Program:*** Members in the IPP are obliged to pay the total contribution, on a quarterly, semi-annual or annual basis. Premiums for members with monthly salary over PhP 25,000 are PhP 3,600 per year; others have to pay PhP 2,400.

11 In the region of Asia and the Pacific, the average rate of contribution for social security is around 19%, 16.2% of which goes to pensions and leaves 2.8% to finance health and other social security programs. The Philippines, therefore, is not far from these parameters. In contrast, the average data in Europe are 23% to finance pensions and 8% for the rest (US-SSA, 2012).

3. ***Sponsored Program:*** The total contribution (PhP 2,400 per year) is paid by both the central government and LGUs.
4. ***Overseas Filipino Workers:*** The worker has to make an annual payment of PhP 1,200 during 2012 and PhP 2,400 since 2012.
5. ***Lifetime Member Program:*** This program is free for members that have already completed their 120 monthly contributions.

In 2007, PhP 234.3 billion was spent on health-related expenditures or 3.5% of the GDP. Out of this total, around 65% involved private sources that included out-of-pocket, private insurance, HMO, employee-based plans and private schools. Furthermore, 53% of the total spending is out-of pocket, which means that the burden of paying for health care is still predominantly shouldered by individual families instead of by the government or other insurance (Nyunt-U, 2012-I). The highest proportion of out-of-pocket spending is on drug expenditures at about 70% (see Table 12).

The above sources of funds reflect different insurance mechanisms with varying degrees of ability to pool resources and spread health risk. The individual family, through direct out-of-pocket expenditure, is the least effective and most inefficient health insurance institution. A family's income and size limit the resources that can be pooled for health expenses, and since members are often exposed to similar health risks, the family has limited risk-pooling capacity (DOH, 2008).

Summing up, the Philippines' health care financing system is strongly fragmented and inequitable. It is fragmented among the different components of the NHIP within the social security and between the latter and public and private spending (Solon, 2012-I). It is inequitable due to the strong burden over individuals such as private and out-of-pocket expenditures, further exacerbated by the inefficient revenue distribution in the country.

The fragmentation and inequitable distribution may further be affected by a number of factors which include the widely dispersed LGUs given that the Philippines is an archipelago (see Chapter 5) as well as the unequal financial capabilities of LGUs. Under these circumstances, the decentralization process (or devolution of spending to the LGUs) must be evaluated very carefully. International experience shows that such process takes place in each region and territories with its own peculiarities, each being different with its own health needs, budgetary restrictions, local and regional health policies, and demand profiles. Thus, the development gaps in the countryside have resulted in worsening internal differences as financial possibilities vary widely from region to region, and the financial transfer system between government levels plays a key role (see Chapter 6). Summing up, the Philippines' health financing and resources are inadequate to reach the objective of access to universal coverage.

CHAPTER 5: SUPPLY OF SERVICES AND SUFFICIENCY OF BENEFITS

The access to health services by the population depends on the existence of their supply, the access conditions, and the degree to which the benefits provided by public programs are adequate to meet the people's needs.

5a. Health Services Supply

The distribution and coverage of health services supply largely determines the real possibilities the country's citizens have in gaining access to timely and quality health services. This includes both the supply of health facilities and human health resources. The general pattern in the Philippines–as in most developing countries–is the concentration of health services in relatively affluent urban areas (Mariano, 2012-I).

Table 13: Barangay Health Stations (BHS) in 2008 and Rural Health Units (RHU) in 2005 (Number and Rate per 100,000 Inhabitants, Rate of BHS per Barangay)

Region	Number of BHS (2008) (a)	Number of RHUs (2005) (b)	Number of Barangays (c)	(a) / (c) (%)	BHS per 100.000 inhabitants	RHUs per 100.000 inhabitants
Philippines	**17**	**2**	**42**	**40.5**	**19.2**	**2.6**
NCR	12	431	2	0.7	0.1	3.7
CAR	599	96	1	50.9	39.4	6.3
I-Ilocos	992	150	3	30.4	21.8	3.3
II-Cagayan Valley	1	97	2	43.3	32.8	3.2
III-Central Luzon	2	265	3	57.9	18.5	2.7
IV-a	2	204	4	54.8	18.7	1.7
IV-b	689	77	1	47.3	26.9	3.0
V-Bicol	1	124	3	32.4	22.0	2.4
VI-Western Visayas	2	146	4	41.6	24.6	2.1
VII-Central Visayas	2	136	3	54.0	25.3	2.1
VIII-Eastern Visayas	883	157	4	20.1	22.6	4.0
IX-Western Mindanao	698	94	2	36.7	21.6	2.9
X-Northern Mindanao	1	94	2	50.8	26.0	2.4
XI-Southern Mindanao	703	65	1	60.5	16.9	1.6
XII-Central Mindanao	957	50	1	80.2	25.0	1.3
XIII-Caraga	432	80	1	33.0	18.8	3.5
ARMM	600		2	24.1	14.6	

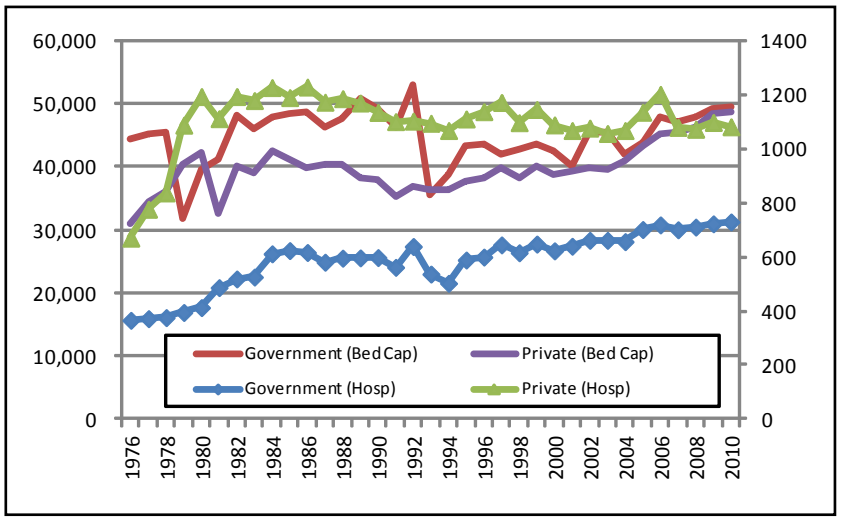
Source: Philippine Health Statistics (2011) based on Department of Health

Despite the devolution of health service responsibility to local governments, the supply of such services did not improve. The reason is largely because the decentralization design failed to develop the needed capabilities and resources–both financial and human–in the LGUs, thus widening the gap in health resource allocation between poor provinces, mostly rural, and higher-income provinces that are more urbanized.

As a result of the process of decentralization, public health services are now mainly delivered by LGUs with the technical aid of the national government through the DOH, albeit there are specific campaigns and other national programs coordinated by the DOH and the LGUs. Provincial governments manage secondary and tertiary level facilities, and the national government retains management of a number of tertiary level facilities. In a decentralized system as that of the Philippines, the nearest services to households are the Barangay Health Stations (BHS).

According to the latest DOH available data in 2007, there were a total of 17,018 BHS, with a spatial distribution shown in Table 13 that explains the disparity of resources in the country. The number of BHS relative to the number of barangays per region is higher in Regions XII (80.2%) and XI (60.5%), while in NCR, such proportion barely reached 0.7% (see Table 13). These data should be supplemented with information (not available) on the number of RHUs and city health centers located in each town/city, with the larger towns/cities having more than one RHU or health center. In 2005, there were 2,266 RHUs or about 1.4 RHUs per town. The private sector delivers services at all three system levels. Private primary services are provided through free-standing clinics, private clinics in hospitals and group practice or polyclinics (WHO, 2011). Private health clinics, diagnostic/imaging centers, and laboratories operate in larger towns.

Figure 20: Number and Bed Capacity in Government and Private Hospitals, 1976-2010



Source: Philippine Health Statistics (2011) based on the Department of Health

The DOH data available up to 2010 show that the number of public and private hospitals rose from 1,607 in 1980 to 1,812 in 2010 (12.8%); the number of government hospitals increased from 413 to 930 (76.8%), while private hospitals decreased from 1,194 to 1,082 (-9.4%). The public sector increased its share in total hospitals from 26% to 40% in 1980-2010, but it is still below that of the private sector which declined from 74% to 60% (see Figure 20).

Table 14: Public and Private Hospitals by Region, 2010

Region	Government		Private		Total	
	No.	%	No.	%	No.	%
Philippines	**730**	**40.3**	**1,082**	**59.7**	**1,812**	**100**
NCR	51	27.9	132	72.1	183	100
CAR	38	66.7	19	33.3	57	100
I-Ilocos	41	33.3	82	66.7	123	100
II-Cagayan Valley	45	49.5	46	50.5	91	100
III-Central Luzon	60	30.3	138	69.7	198	100
IVA	67	28.6	167	71.4	234	100
IVB	37	57.8	27	42.2	64	100
V-Bicol	48	44.0	61	56.0	109	100
VI-Western Visayas	62	72.1	24	27.9	86	100
VII-Central Visayas	59	56.2	46	43.8	105	100
VIII-Eastern Visayas	51	67.1	25	32.9	76	100
IX-Western Mindanao	29	42.0	40	58.0	69	100
X-Northern Mindanao	37	33.9	72	66.1	109	100
XI-Southern Mindanao	20	18.2	90	81.8	110	100
XII-Central Mindanao	28	26.4	78	73.6	106	100
XIII-Caraga	35	59.3	24	40.7	59	100
ARMM	22	66.7	11	33.3	33	100

Source: Philippine Health Statistics (2011) based on the Department of Health

The distribution of hospitals also shows regional disparities in terms of facilities of the public and private sectors. Region XI has the highest percentage of private hospitals (82%) due to a lower allocation of public hospitals. Region IV-A has the highest number of public hospitals and also the highest number of private hospitals in the country (see Table 14 and Appendix Table 9).

On average, hospitals have 54.2 beds per hospital, with higher availability of beds in the public sector (68) relative to the private sector (45) and a distribution of such beds in a somewhat even fashion between government and private hospitals. However,

while the total number of hospitals and available beds has increased since 1980, the number of beds per 10,000 inhabitants decreased from 18.2 in 1980 to 12.3 in 2010, thus providing lower health resources for an expanding population.

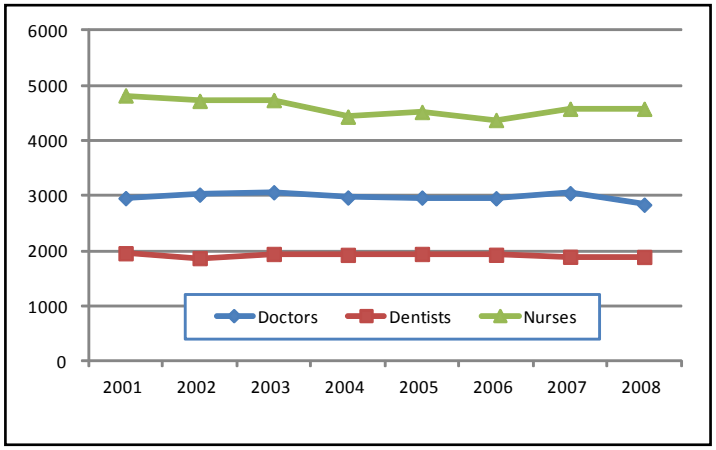
Table 15: Health Care Workforce, 2000-2010

Member State	Physicians		Nursing and midwifery personnel		Dentistry personnel		Pharmaceutical personnel	
	Number	per 10,000 population	Number	per 10,000 population	Number	per 10,000 population	Number	per 10,000 population
PHILIPPINES	**93,862**	**11.5**	**488434**	**60.0**	**45,903**	**5.6**	**49667**	**6.1**
Low income	215761	2.8	522425	6.7	20954	0.3	37826	0.5
Lower middle income	3742065	10.1	6208439	16.8	323311	0.9	1284050	3.5
Upper middle income	2189890	22.4	4333111	44.5	634084	6.5	333219	3.7
High income	3024161	28.6	8315796	78.6	954301	9.1	931948	8.9
South-East Asia Region	903408	5.4	2224133	13.3	111756	0.7	641499	3.8

Source: World Health Statistics (2012)

According to data from the World Bank (2011), retail pharmacies and drug stores are the main sources of prescription and over-the-counter drugs. They used to be simple single-proprietorship businesses, but more recently, they have been dominated by national retail pharmacy chains and franchises which now account for about 60% of the market measured by value. In recent years, village and town pharmacies sponsored by the government through the DOH (e.g. Botikang Barangay, Botikang Bayan) have been revived and multiplied all over the country's poorer barangays or in those lacking a private retail pharmacy. However, most of these government-sponsored pharmacies have low turnover and face difficulties with re-supply.

Figure 21: Number of Government Doctors, Nurses and Dentists, 2001 to 2008of Health



Source: Philippine Health Statistics (2011) based on the Department of Health

The availability of human resources in the health sector shows a different story as there is a high ratio of health workers in the Philippines compared to other countries. Despite a high

and growing population, the Philippines still has a high ratio of nursing and midwifery, dentistry, and pharmaceutical personnel, at one for every 10,000 Filipinos, similar to other upper-middle income countries and higher-income countries (see Table 15).

Table 16: Government Doctors, Nurses, Dentists and Midwives, Number and Rate per 10,000 Population by Region, 2008

Region	Population	Doctors	Dentists	Nurses	Midwives	Doctors per 10.000 population	Nurses per 10.000 population	Dentists per 10.000 population	Midwives per 10.000 population
PHILS.	**88,566,732**	**2,838**	**1,891**	**4,576**	**17,437**	**0.3**	**0.2**	**0.5**	**2.0**
NCR	11,566,325	590	498	723	1,135	0.5	0.4	0.6	1.0
CAR	1,520,847	89	40	131	637	0.6	0.3	0.9	4.2
I-Ilocos	4,546,789	159	105	259	1,014	0.3	0.2	0.6	2.2
II-Cagayan Valley	3,051,487	97	65	196	839	0.3	0.2	0.6	2.7
III-Central Luzon	9,709,177	278	176	441	1,662	0.3	0.2	0.5	1.7
IVA	11,757,755	238	189	472	1,818	0.2	0.2	0.4	1.5
IVB	2,559,791	83	68	142	555	0.3	0.3	0.6	2.2
V-Bicol	5,106,160	157	85	273	1,072	0.3	0.2	0.5	2.1
VI-Western Visayas	6,843,643	234	123	401	1,775	0.3	0.2	0.6	2.6
VII-Central Visayas	6,400,698	177	117	328	1,534	0.3	0.2	0.5	2.4
VIII-Eastern Visayas	3,915,140	155	94	201	904	0.4	0.2	0.5	2.3
IX-Western Mindanao	3,230,094	100	44	203	697	0.3	0.1	0.6	2.2
X-Northern Mindanao	3,952,437	138	74	241	1,052	0.3	0.2	0.6	2.7
XI-Southern Mindanao	4,159,469	75	69	127	743	0.2	0.2	0.3	1.8
XII-Central Mindanao	3,830,500	113	56	194	878	0.3	0.1	0.5	2.3
XIII-Caraga	2,293,346	79	58	114	615	0.3	0.3	0.5	2.7
ARMM	4,120,795	76	30	130	507	0.2	0.1	0.3	1.2

Source: Philippine Health Statistics (2011) based on Department of Health

Note: This includes retained health personnel at the RHOs and devolved health personnel by LGUs.

Available human resources for health services in public sector show some stagnation in recent years; partly due to the growing migration of trained personnel to other countries with better labor conditions (see Figure 21). The Philippines has become a major source of health professionals for many countries because Filipinos are generally fluent in English and adequately skilled and trained in their field, as well as compassionate in nature and patient in providing health care services. The high foreign demand for Filipino health professionals, however, led to a costly brain drain in the country's health sector.

Data on the government sector's work force show clear regional disparities. The national ratios for every 10,000 inhabitants are 0.3 doctors, 0.2 nurses, 0.5 dentists and 2.0 midwives. ARMM region shows the worst at 0.2, 0.07, 0.3 and 1.2, respectively while CAR shows the best ratios, save for nurses, at 0.4, 0.2, 0.5 and 2.9, respectively (see Table 16).

5b. Eligibility Conditions to Access Benefits of the National Health Insurance Program

As shown in the previous section, the health system, through the NHIP, incorporates different components aimed at covering various population segments. Eligibility conditions to access PhilHealth benefits are summarized below (PhilHealth, 2012):

i. Employed Sector Program

- Payment of at least three monthly premiums within six months prior to the month of confinement
- Confinement in an accredited hospital for at least 24 hours (except when availing outpatient care and special packages) due to illness or injury requiring hospitalization
- Attending physicians must also be PhilHealth-accredited
- The 45 days allowance for hospital room and board is not consumed yet

ii. Individually Paying Program

- In certain confinement cases, payment of at least three monthly premiums within the immediate six months prior to the month of confinement
- For pregnancy-related cases and availability of the newborn care package, dialysis (except those undergoing emergency dialysis service during confinement), chemotherapy, radiotherapy and selected surgical procedures, payment of nine monthly premium contributions within the last 12 months is required except for those enrolled under the KASAPI program
- Confinement in an accredited hospital for at least 24 hours (except when availing outpatient care and special packages) due to an illness or injury requiring hospitalization
- Attending physicians must also be PhilHealth-accredited
- Availment is within the 45-day allowance for room and board

iii. Sponsored Program

- The validity period of each beneficiary is stated in his/her PhilHealth card
- The 45 days allowance for room and board of the member or the separate 45 days allowance shared among dependents are not consumed yet
- Admitted in an accredited hospital and attended to by accredited physicians
- Confinement of at least 24 hours (except when availing outpatient care and special packages) due to an illness or injury requiring hospitalization

iv. Overseas Filipino Workers

- Availment must be within the validity period as stated in the OFW's PhilHealth Member Registration Form (PMRF) or in the payment receipt
- The OFW-member's 45 days allowance per year for hospital room and board and the separate 45 days allowance shared among the dependents have not been consumed yet

v. Lifetime Member Program

- Must be admitted in an accredited hospital and attended to by accredited physicians
- Confinement of at least 24 hours (except when availing outpatient care and special packages) due to an illness or disease requiring hospitalization
- Availment is within the 45 days allowance for room and board

All the NHIP components cover dependent family members without any additional cost and with no limit to their number, including spouses, children and parents older than 60 who are not members of PhilHealth. In turn, every member of PhilHealth has access to the same services, with the exception of some special benefit packages only available to beneficiaries of SP and OWP. In turn, the services included in the plans are as follows:

i. In-patient coverage: Subsidies for hospital room and board fees, drugs and medicines, X-ray and other laboratory exams, operating room and professional fees for confinements of not less than 24 hours

ii. Outpatient coverage:

- ***Every program:*** Day surgeries, dialysis and cancer treatment procedures such as chemotherapy and radiotherapy
- ***Sponsored program:***
  - Special Outpatient Benefit
  - Package from accredited rural health units:
    - Preventive Care: primary consultation, blood pressure monitoring, breast examination, rectal exam, body measurement, counseling for the cessation of smoking, and counseling for lifestyle change
    - Diagnostic Services: chest X-ray, sputum microscopy, and visual acetic acid screening for cervical cancer
    - Laboratory Services: fecalysis, and complete blood count

- ***Overseas Workers Program:*** Enhanced Outpatient Benefit Package (available in the Philippines only)
  - Consultation
  - Diagnostic services: Complete blood count, routine urinalysis, fecalysis, fasting blood sugar, blood typing, hemoglobin/hematocrit, electrocardiogram, anti-streptolysin O (ASO-Titer), hepatitis B screening test, treponemapallidum hemaglutination assay, potassium hydroxide, erythrocyte sedimentation rate, pregnancy test, X-ray (skull, chest, lower and upper extremities), sputum microscopy pap smear
  - Visual acuity examination
  - Psychological evaluation and debriefing
  - Promotion/preventive health services: Visual acetic acid screening for cervical cancer, periodic digital rectal examination, Periodic clinical breast examination, counseling for cessation on smoking, Lifestyle modification (regular blood pressure measurement and nutritional or dietary counseling), counseling for reproductive health particularly breastfeeding, nutritional or dietary counseling
  - Auditory evaluation
  - Treatment of the following diseases based on PhilHealth-adopted clinical practice guidelines: Urinary tract infection, upper respiratory tract infection, acute gastroenteritis

Since September 2011, the beneficiaries of the program were also given access to a set of special packages for medical and surgical procedures that have additional cost. PhilHealth, for instance, has started to use case rate schemes with the purpose of making information transparent, thereby limiting the discretionary levels in the collection from patients requiring certain services. A case rate scheme refers to the fixed rate assigned by PhilHealth for each treated case, in all hospitals, regardless of type and level. For health care providers, this scheme would improve efficiency and quality care, and increase accountability as case payments shall be made directly to the hospital/health facility. The payment to the hospital/health facility already includes the professional fees of all accredited doctors and other health professionals. Below is a list of case rates as established by PhilHealth:

Medical Cases

1. Dengue I (Dengue fever, DHF grades I&II): PhP 8,000
2. Dengue II (DHF grades III & IV): PhP 16,000
3. Pneumonia I (moderate risk): PhP 15,000
4. Pneumonia II (high risk): PhP 32,000
5. Essential Hypertension: PhP 9,000
6. Cerebral Infarction (CVA-I): PhP 28,000
7. Cerebral Hemorrhage (CVA-II): PhP 38,000
8. Acute Gastroenteritis (AGE): PhP 6,000
9. Asthma: PhP 9,000
10. Typhoid Fever: PhP 14,000
11. Newborn Care Package in Hospitals and Lying in Clinics: PhP 1,750

Surgical Cases

1. Radiotherapy: PhP 3,000
2. Hemodialysis: PhP 4,000
3. Maternity Care Package (MCP): PhP 8,000
4. Normal Spontaneous Delivery (NSD) Package in Level I Hospitals: PhP 8,000
5. NSD Package in Levels 2 to 4 Hospitals: PhP 6,500
6. Caesarean Section: PhP 19,000
7. Appendectomy: PhP 24,000
8. Cholecystectomy: PhP 31,000
9. Dilatation and Curettage: PhP 11,000
10. Thyroidectomy: PhP 31,000
11. Herniorrhaphy: PhP 21, 000
12. Mastectomy: PhP 22,000
13. Hysterectomy: PhP 30,000
14. Cataract Surgery: PhP 16,000
15. TB Treatment Through DOTS Package for new cases only: PhP4,000
16. Malaria Treatment in accredited Rural Health Units: PhP 600
17. Outpatient HIV/AIDS treatment: PhP 30,000
18. Voluntary Surgical Contraception Procedures (Vasectomy and Tubal Ligation): PhP 4,000

The services not covered by the program are:

1. Fifth and subsequent normal obstetrical deliveries
2. Non-prescription drugs and devices
3. Alcohol abuse or dependency treatment
4. Cosmetic surgery
5. Optometric services
6. Other cost-ineffective procedures as defined by PhilHealth

PhilHealth combines different methodologies and mechanisms to provide benefits to its members. Inpatient care benefits provide “first-peso” coverage up to a maximum amount which is payable to providers on a fee-for-service basis. As such, PhilHealth pays the provider from the first peso of the bill up to the maximum benefit allowable while members are responsible for paying the remaining balance (United Nations, 2012). The coverage cap varies with the case type (surgical, general medicine, maternity, pediatrics, etc.) and level of the facility (primary, secondary, tertiary). On the other hand, fixed case payments are made for the TB-DOTS, the Maternity package, and the SARS and Avian Influenza package (United Nations, 2012). In the case of the outpatient package provided to indigent members, PhilHealth uses capitation payments (Domingo, 2012-I).

Table 17: Beneficiaries and Payment Benefits of NHIP, 2011

	Beneficiaries		Payment Benefits	
	in million PhP	%	in million PhP	%
GOVERNMENT EMPLOYED	5,903	7.5	5,964	17.1
PRIVATE EMPLOYED	18,097	23.1	12,222	35.0
IPP	9,905	12.6	5,826	16.7
OWP	5,085	6.5	1,222	3.5
NPP	945	1.2	2,311	6.6
SP	38,449	49.1	7,338	21.0
Total	78,386	100.0	34,884	100.0

Source: Own elaboration based on PhilHealth (2010)

For Sponsored Members and their dependents, since 2010 (through PhilHealth Board Resolution 1441), the case rates and No Balance Billing (NBB) combination guarantees access to a complete set of services without the need to shell out additional payment over and above the case rates. Supporting the government's commitment to reduce maternal and infant mortality rates, NBB is also applied to other beneficiaries of components of NHIP (different from SP) for the maternity care and newborn care packages in all accredited (MCP) non-hospital providers (e.g., maternity clinics, birthing homes). The member may also apply for reimbursements upon submission of an official invoice, which is deducted from the case payment. When a sponsored member is admitted in a private hospital, the NBB policy will not apply, unless the private hospital voluntarily implements it.

In addition to these benefits in PhilHealth, a "PhilHealth plus" is currently being planned to provide, besides the basic minimum and supplemental packages, benefit coverage to beneficiaries of contributory funds.

The goal of these schemes is to bring down out-of-pocket expenses to the lowest possible level, which mitigates the financial risk of patients facing an illness not fully covered by basic insurance. These also cover the cost of receiving care in a private room or choice of physicians and minimize waiting time for more members. All these supplement the benefits provided by PhilHealth. However, these schemes may also widen inequity in the distribution of services as the highest-income sectors will undoubtedly be those that will be able to gain access to differentiated health services.

Additionally, on June 21, 2012, PhilHealth implemented an initial package of Z Benefits (through PhilHealth Board Resolution 1629). These are the cases that are at the end of the spectrum of all illnesses and interventions which are ranked from

A to Z based on their increasing complexity and cost. This first group of Z Benefits covers four conditions:

1. For children, a package for standard risk acute lymphoblastic leukemia: PhP 210,000 for three years
2. For women, a package for early stage breast cancer: PhP 100,000
3. For men, a package for low to intermediate prostate cancer: PhP 100,000
4. Treatment of low-risk end-stage renal disease requiring kidney transplant: PhP 600,000

Thus, PhilHealth has started a special coverage for the treatment of catastrophic illnesses, which will have direct bearing on the spending of households (Padilla, 2012-I). This includes any illness that may be life or limb-threatening and will require prolonged hospitalization, extremely expensive therapies or any other care that would deplete financial resources, unless covered by special health insurance policies. PhilHealth thus aims to provide greater coverage in the face of financial risk, above all for the poorest sectors of the population. For its initial implementation, the Z Benefit package would be provided by selected PhilHealth accredited Level 3 or Level 4 government hospitals.

To gain access to these benefits, contributory members should pay additional fees on top of their regular fees. PhilHealth covers 100% of the case rate for sponsored program members and, at most, 50% for non-sponsored program members. In the latter, premium contributions must be made for the next three years, requiring from all members a 3-year lock-in membership prior to availment of the benefit, as follows:

1. Individually Paying Program or Overseas Filipino Workers members shall pay a total amount of PhP 7,200.00 (PhP 2,400 x 3 years).
2. For employed members, a certification of approval/agreement from employer to the lock-in membership for the next three years must be submitted.
3. The lock-in membership does not apply to lifetime members and sponsored program members.

5c. Benefit Sufficiency and Program Impact

Sufficiency refers to the degree at which the benefits provided by the program are adequate to meet the needs of different beneficiaries regardless of their economic situation. There are no appropriate indicators to measure sufficiency of benefits accurately. However, these benefits encompass various health services not usually used simultaneously by the same person hence it is possible to have an approximate assessment based on the “financial protection” provided by the program for specific services.

The average financial protection, the share of the total cost covered by PhilHealth, shows that 88% of the hospital bill is covered by the program in public facilities, while 53% of the bill is covered in private hospitals. However, such figures do not include payments made outside of the hospital. In a study which sampled 937 hospitalized children under the age of six, it was estimated that their average financial protection was limited to 53% (Bodart and Jowett, 2005).

Manasan offers some pertinent data on the subject. In 2004, PhilHealth's estimated share of benefits for hospitalization averaged 62%, but according to the same author, the actual share might be lower (Manasan, 2009). A patient exit survey taken at public hospitals in the Visayas in 2005 reported that PhilHealth's share for the hospitalization of children under six was 71%, lower than the 88% based on PhilHealth's own estimate. Furthermore, the hospital bill accounted for 72% of total medical expenses, with the remaining 28% going to purchases of drugs and medicines outside of the hospital. This implies that PhilHealth's share based on the total medical expenses was only around 51% (71% of 72%).

The same author explores three potential explanatory causes of the insufficiency of NHIP benefits: a) the "first peso coverage up to a cap" approach in the provision of benefits, b) paying providers on the basis of fee-for-service, and c) the absence of regulations on the fees that providers charge. These causes were somewhat mollified due to the incorporation of PhilHealth's various strategies, among which are the NBB (described in the previous section) and the enforcement of the case rates that regulated and made transparent the costs of the different benefits (including professional fees). Indeed, it is possible to think that the financial protection provided by PhilHealth to its members has increased in the past few years, limiting in many situations the risk to which individuals are exposed. However, the effect derived from a limited Benefit Delivery Ratio (BDR) should not be overlooked and should take into consideration: a) the formal coverage of the program; b) the real possibility of gaining access to health services from accredited providers; and c) the support value or proportion of the health care bill covered by PhilHealth (see Chapter 6).

In fact, the structure of the benefits covered by NHIP in a minimum or basic package imposes limits to the sufficiency of such benefits to the types of care and treatments and, in many cases, on condition that they obtain the services in government hospitals; these limit the real financial protection that may be provided to its members and their dependents.

The limited coverage of benefits explains the growing share of out-of-pocket expenses in total health spending (see Chapter 4), which makes the health system regressive. In addition, the high out-of-pocket spending also explains why the use of NHIP services is low for SP members - an important barrier to accessing health care - especially for the very poor that require hospital services.

CHAPTER 6: SOCIAL SOLIDARITY, REGIONAL AND GENDER EQUITY

The Philippine health system is highly unfair, in terms of its fragmentation, population coverage, health spending, peoples' access to services, regional disparities and gender equity.

Public health spending is very low. The total consolidated public spending of the various levels of government barely reached 0.9% of GDP in 2007, which, as explained before, is very little by international standards including those of neighboring countries with the same degree of development. The level of public spending is remarkable when compared with private spending, which accounts for 2.3% of the GDP.

The combination of low public health spending and high private spending is the most worrisome inequality aspect of a system rather far from complying with the objective of developing an insurance of universal coverage. High private spending means that the poorest households will depend on the expansion and real scope of the subsidized coverage programs and these, being limited create serious difficulties to reach universal coverage and include the poorest households.

As stated in a recent report of the World Health Organization, its member countries have committed to develop their health financing systems so that everyone has access to services without facing financial difficulties to pay for them. This objective was defined as "universal coverage" (WHO, 2010). In order to reach universal coverage, countries face three interrelated fundamental problems: a) the availability of resources, b) the excessive dependence on direct payments when people need assistance, and c) the inefficient and non-equitable use of the resources.

Many countries, like the Philippines, have decided to provide their populations with universal access to health services but few have made clear and explicit how to reach that goal and what specific level of coverage should be reached. Universal coverage implies something much more ambitious than "some" coverage for each citizen. It means ensuring homogeneous and sufficient coverage levels for every citizen, financed by fiscal resources.

We have already demonstrated three important issues: a) at least one-fourth of the population in the Philippines is not covered by PhilHealth; b) this is largely due to insufficient fiscal resources that impede reaching the target coverage; c) the fragmentation of the health system results in lack of equity; and d) all of the above are closely linked to the financing methodology.

Three types of fragmentation in the financing of health systems affect the equity in access to services. First, the problems resulting from the high levels of out-of-pocket

health spending limit the access to health services of those people who require them the most. Second, fragmentation also results from differences between those who have formal social security coverage and those in the informal sector of the economy who have lesser protection through social assistance or subsidized coverage. Third, there is also territorial fragmentation induced from the existence of health systems at a subnational level with differing coverage depending on the socio-economic conditions of each place; hence, inhabitants of the same country endure diverse levels of public sector coverage due to their residence or location.

In this chapter, four aspects of the fragmented health system of the Philippines regarding equity will be approached: a) coverage problems in an unequal society; b) additional imbalances that demand a decentralization process in an unevenly developed territory; c) access barriers to the different PhiHealth programs, and finally, d) gender-related equity problems.

Table 18: Basic Indicators of Philippines' Neighbor Countries, 2007

Country	Population	Population density	Urban population	Adult literacy	Life expectancy	Infant mortality
	(millions)	(people per km²)	(% of total population)	rate (%)	both sexes (years)	rate (deaths per 1,000 livebirths)
Brunei	0.4	66	72	95	76	6
Singapore	5.0	7	100	94	81	2
Malaysia	28.3	86	68	92	72	5
Thailand	67.8	132	36	94	70	9
Philippines	92.2	307	63	93	71	21
Indonesia	243.3	128	43	92	68	30
Vietnam	87.3	263	28	90	72	11
Laos	6.3	27	27	73	61	49
Cambodia	14.8	82	15	76	61	50
Myanmar	50.0	74	31	90	56	42

Source: Chongsuvivatwong, et al. (2011)

6a. Health Coverage in an Unequal Society

It is impossible to evaluate health equity independently from the general inequality in distribution. Relative to neighboring countries, the Philippines has a high concentration of population in a limited land space (i.e., the population density is second after the state-city of Singapore), has a high proportion of urban population,

and has intermediate social indicators (see Table 18). In particular, the Philippines has high and steady inequality in income distribution: the Gini coefficient index improved very little in the past decade (from 0.49 in the mid-1990s to 0.44 in recent years) and is substantially higher than that in other neighboring countries with the same level of development like Vietnam (0.38), Laos (0.37) and Indonesia (0.37) (UNDP webpage, October 2012; Racelis and Cabegin, 2001).

Table 19: Health Insurance by Income Quintile, 2008 (%)

Quintile	Number of insurance	Any insurance	PhilHealth	Private insurance
1. Lowest	79.1	20.9	19.6	0.2
2. Second	68.9	31.1	28.6	0.3
3. Middle	60.2	39.8	35.3	1.1
4. Fourth	46.0	54.0	48.2	2.0
5. Highest	34.7	65.3	57.0	7.0
TOTAL	57.8	42.0	37.7	2.1

Source: NSO (2009)

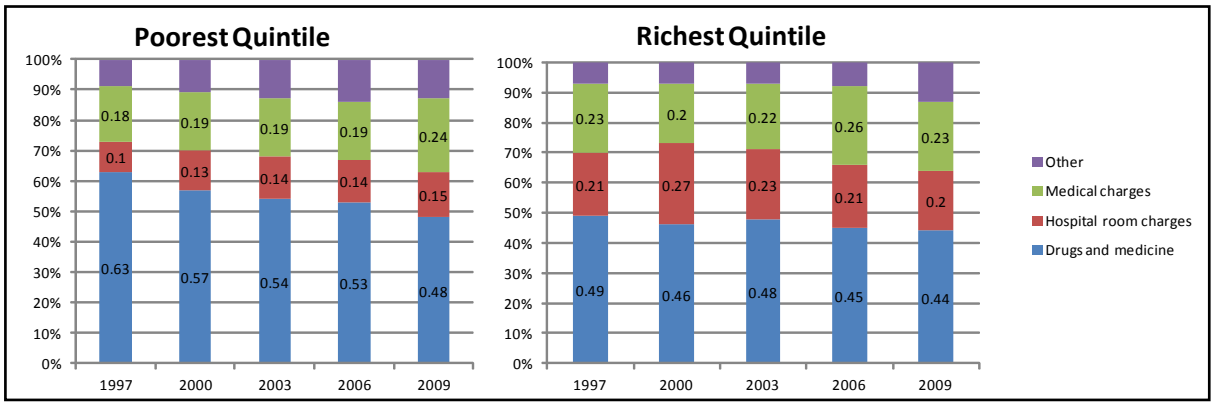
Table 20: Distribution of Health Spending by Quintile and Payer (% of total spending), 2003

Expenditure	Poorest	2	3	4	Richest
Out of pocket	2.67	6.34	10.68	20.37	59.93
PhilHealth	11.29	7.26	13.71	25.81	41.94
Local Government	19.25	21.34	21.76	20.50	17.15
National Government	16.45	19.91	22.08	21.65	19.91

Source: NSO (2009)

The enrolment to PhilHealth evolution was presented in Chapter 2. In 2011, the coverage (enrolment) reached 82% of total population. Unfortunately, effective coverage, meaning to be eligible for the benefits, according to data from the 2008 National Demographic and Health Survey (NDHS) is quite lower than that. Table 19 presents this information, based on a survey of health insurance coverage at the individual level, which shows the inequality in coverage. The percentage of the population with any health insurance (42%) includes people with coverage ranging from 21% in the poorest quintile to over 65% in the richest. This is largely explained by PhilHealth coverage, amounting to 37% of the total population. This coverage is not compensatory, as it

Figure 22: Distribution of Out-of-Pocket Health Expenditure by Components, 1997-2009



Source: Herrin and Lavado (2011)

Table 21: Poverty Incidence in Total Population by Region, 1991, 2003, 2006 and 2009 (%)

	1991	2003	2006	2009
NCR	**7.6**	**3.2**	**5.4**	**4.0**
ARMM	21.5	31.4	42.8	45.9
CAR	37.3	21.7	23.0	22.9
CARAGA	45.0	44.7	44.0	47.8
Region I	34.6	22.8	26.6	23.3
Region II	30.6	19.6	20.0	18.8
Region III	21.8	12.4	15.2	15.3
Region IV-A	24.8	12.1	12.3	13.9
Region IV-B	43.8	37.5	42.2	35.0
Region V	54.6	45.8	45.2	45.1
Region VI	42.1	30.6	28.6	31.2
Region VII	42.4	37.2	38.8	35.5
Region VIII	45.1	37.6	39.0	41.4
Region IX	35.8	45.7	39.8	43.1
Region X	45.3	38.8	39.7	39.6
Region XI	39.3	31.0	31.7	31.3
Region XII	50.4	33.1	33.1	35.7
Average	33.1	24.9	26.4	26.5

Source: Mesa-Lago, et al. (2011)

goes from 20% in the poorest quintile to 57% in the richest (Orbeta, 2008). The share of private insurance is very low with an even higher pattern of inequality. The population without insurance is highly concentrated in the lowest three quintiles (79% in the poorest) whereas it decreases to less than 35% in the richest quintile.

However, despite the better PhilHealth coverage in all the population quintiles, PhilHealth spending was, in 2007, similar to that of private insurance companies and HMOs (0.3% of GDP), as shown in Table 12.

Data on the quintile distribution of each type of health spending confirms the usual assumption about the concentration of the out-of-pocket spending in the richest strata of the society. This trend is replicated, albeit to a lower degree, by PhilHealth spending. However, the weight of out-of-pocket health spending in the total spending of the poorest households is usually higher showing the regression of this type of spending in health financing. Instead, national and local public spending has an almost proportional distribution, with higher relative concentration in middle-income quintiles.

Table 22: Health Insurance Coverage by Region and Provider, 2008

Region	No Insurance	Any Insurance	Phil Health	Private Insurance, HMO, etc.	Other	Don't know/ missing
NCR	48.4	51.3	43.0	5.4	0.5	0.3
CAR	54.3	45.3	42.3	1.1	0.4	0.5
–Region I	54.7	45.2	40.8	1.1	0.1	0.2
Region II	62.2	37.7	35.4	1.1	0.6	0.1
Region III	63.3	36.5	32.3	1.5	0.2	0.3
Region IVA	52.3	47.6	43.4	2.2	0.5	0.1
Region IVB	73.3	26.1	20.8	1.1	0.9	0.5
Region V	61.0	38.7	34.5	0.6	1.8	0.2
Region VI	58.1	41.3	36.3	2.2	0.3	0.6
Region VII	55.8	43.6	39.2	2.2	0.5	0.6
Region VIII	72.2	27.6	26.1	0.6	0.5	0.2
Region IX	70.7	29.2	25.8	1.6	0.3	0.1
Region X	32.2	67.5	66.0	1.6	0.1	0.3
Region XI	60.8	38.8	36.1	2.4	0.5	0.4
Region XII	59.0	40.6	38.4	1.2	0.3	0.4
Region XIII	51.8	48.1	46.4	0.8	0.3	0.0
ARMM	82.3	17.5	17.1	0.4	0.1	0.2

Source: NDHS (2008) and NSO (2009)

The high share of private and out-of-pocket expenses in total health spending clearly plays a strong role in inequality as it leaves a wide range of population groups financially unprotected (Universal Health Care Group, 2012-I). This is the reason why the comparison between the evolution of the out-of-pocket structure for the poorest and richest quintiles is revealing. Figure 22 shows significant differences in the structures of both quintiles: in both, the higher share of out-of-pocket spending is on drugs and medicine, although its importance decreased after 1997. Also, in both quintiles, spending on hospital room and medical charges are second in importance. Both for the poorest and for the richest quintiles, these three types of spending account for 87% of the total.

Regarding the access to health services, there are marked differences between the poor and the affluent when health care utilization patterns are examined. Poor families, especially in rural areas, rely heavily on public services, while non-poor families tend to use private facilities (Solon et al., 2003). In terms of coverage, on the other hand, there is a 14% coverage difference between urban and rural areas. According to NDHS, 50.7% of the urban population lacks health insurance while such percentage goes up to 64.9% in rural areas (NSO, 2009). Overall, financing for health is regressive in the Philippines. A significant part of the scarce benefits offered by the public sector is received by the sectors least in need. On the other hand, direct payments are high and deepen the inequality of the system.

6b. Decentralization and Territorial Equity

Differences between rural and urban poverty incidence and inequality among regions are significant. The individual poverty incidence among fishermen and farmers is well above the national average (50% and 44%, respectively, in 2009) and also higher in rural over urban areas (74.8% and 25.2%). It is hypothesized that the regions with the lowest poverty incidence have the highest social security coverage because they also have the smallest proportions of informal and rural labor; the opposite is true of regions with the highest poverty (Mesa-Lago et al., 2011).

In addition, there are territorial inequalities on access to health services within the Philippines (Universal Health Care Group, 2012-I), where poverty incidence ranges from 4% of the population in NCR to above 45% in ARMM, CARAGA, and Bicol. Although national poverty incidence declined in 1991 to 2009, it increased in ARMM and CARAGA (see Table 11 and Appendix Table 1). Under these circumstances, the decentralization process can be an obstacle to equity improvement policies.

Besides the significant unequal income distribution, there is also an unfair distribution of health spending across quintiles of the population that fails to exert a compensatory function. Additionally, health insurance coverage is also uneven among regions, reaching 67.5% in Northern Mindanao and 17.5% in ARMM (see Table 22). This region, as noted, before has the worst social indicators among the different regions in the country. Also, coverage is lower in rural areas (35%) than in urban ones (50%) (National Statistics Office, 2009). The worst coverage indicators are in regions with the worst economic-social development as will be shown later (Domingo, 2012-I).

There is also an unfair distribution of public spending among regions (although there is no comparative data on spending in the LGUs in the regions), as well as of different facilities and skilled labor (see Chapter 5). Thus, health coverage, access to services and spending reproduce or even worsen the inequality of the productive system, veering away from a universal, fair and equal coverage. This is undoubtedly related to the health system's structure, the level of decentralization, the availability of resources and the mechanisms of distribution of such resources.

With the devolution of health services from the central government to local governments since 1991, the provision of direct health services, particularly at the primary and secondary levels, is the mandate of LGUs. Provincial and district hospitals are under the provincial government while the municipal government manages the RHUs and BHS. In every province, city or municipality, there is a local health board chaired by the local chief executive that serves as an advisory body on health-related matters to the local executive and the sanggunian or local legislative council (DOH, 2005).The DOH has a field office in every region of the country and operates specialty hospitals, regional hospitals and medical centers, as well as provincial health teams made up of DOH representatives from the local health boards and personnel involved in communicable disease control.

The transfer of health service management and several other functions was accompanied by national government financial transfers to LGUs: the Internal Revenue Allotment (IRA). However, the IRA was allocated independently of need and capacity to raise local revenues and no portion of the IRA was earmarked for health service provision. With lacking commitment and a limited budget to draw from, many LGUs underfund health care. This threatens the supply of drugs, services, and FP products in RHUs and BHS, and leads to the under-provision of care and to the increase of informal fees charged by providers (Mason, Racelis, and Russo, 2002).

Throughout the past two decades, there has been a deep and unfinished debate on the benefits and difficulties of decentralization. Solon, et al. (2003) evaluated the financing and development of provincial hospitals after the decentralization process, and pointed out that in general, the LGUs are unable to maintain pre-devolution expenditure levels. Reduced spending has had an impact on hospital maintenance and other operating expenses. The lack of supplies, drugs and allowances for repair and maintenance of medical equipment had severely impaired service delivery even if the necessary medical personnel were available. On the other hand, Guevara (2012) claims that decentralization has produced very outstanding local executives and local government officials.

BOX 2: The decentralization in the fiscal federalism theory

There is consensus among the leading specialists in fiscal federalism about the overriding importance of political factors in decentralization matters (Musgrave and Musgrave 1993; Ahmad, et al., 1997; Bird, 2000). The advantages and disadvantages of greater decentralization both in the provision and financing of public spending on social goods have been analyzed by the literature in the field of the theory of fiscal federalism. According to this theory, the provision of local public services allows subnational governments or administrations to better capture the preferences and needs of the residents of each area, while, on the other hand, the centralized provision implies a more uniform service (Oates, 1977).

The literature also recognizes the need for a certain degree of centralization in the provision, given the externalities, benefits of scale and imperfect mobility of people. These factors prevent many times matching the supply of the service with local preferences. That is why it is accepted that there are certain functions better managed by the central government, and among them are redistributive policies. The ability to improve the distribution of income at local level is severely limited by the mobility of economic units. In this case, greater decentralization involves a restriction in the policies to assist the poor (Brown and Oates, 1987).

The decentralization of expenditure may not match the resources. In general, what usually prevails is the greater concentration of tax revenues in the hands of the central level and, therefore, subnational governments depend financially on the central government, giving rise to different systems of intergovernmental transfers.

Source: PhilHealth (2012)

Diokno (2012: 9) states that "the share of local budgets devoted to devolved functions has declined, due to creeping re-centralization of health and social welfare functions, increasing substitution of centrally controlled funds for local funds, and misplaced priorities on the part of local authorities. The missing link in ensuring better delivery of devolved services is the weak process of accountability. The electoral process failed to hold local authorities accountable for their fiscal behavior."

Table 23: Amendments of IRA Criteria and Allocation by LGU with Decentralization Process, 1991

	Before 1991	After 1991
IRA Criteria		
1. Size	20% of all internal taxes	40% of all internal taxes
2. Predictability	Discretionary	Mandatory
3. Determinants	Population, land area, equal sharing	
IRA Allocation by LGU		
1. By type of LGU	Provinces: 27% Cities: 22% Municipalities:41% Barangays:10%	Provinces: 23% Cities: 23% Municipalities:34% Barangays:20%
2. By economic attributes	Population:70% Land area: 20% Equal sharing: 10%	Population:50% Land area: 25% Equal sharing: 25%

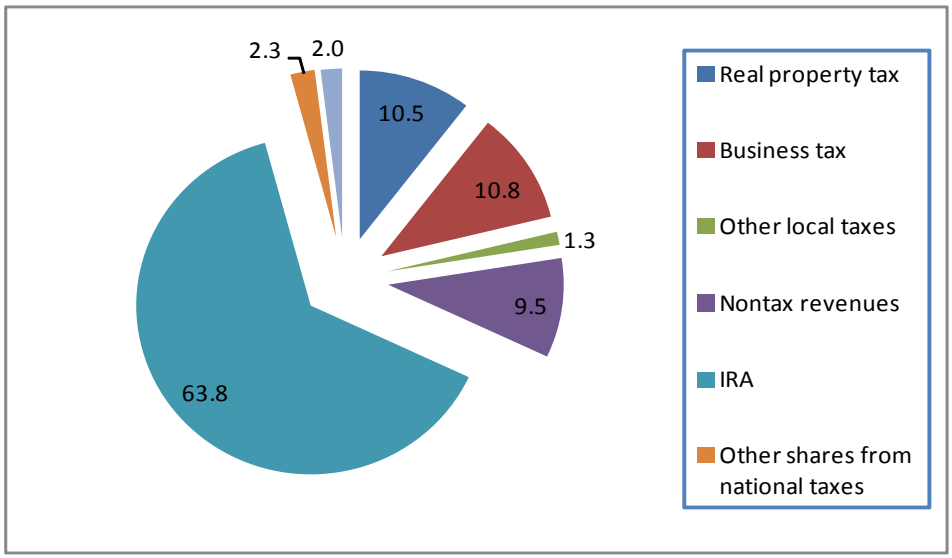
Source: Diokno (2012)

Thus, from diverse viewpoints, great expectations were placed on decentralization to strengthen development, make democratic processes more dynamic, improve equity and efficiency of public spending, and limit the unchecked growth of public spending. Yet, significant part of the debates lacked a clear and feasible recipe for achieving goals under different situations. Unfortunately, such expectations have been much higher than the possibilities of the decentralization processes, as shown in the specialized literature. Box 2 summarizes the main contributions of the fiscal federalism theory regarding the advantages and disadvantages of decentralization.

The challenge is to achieve a weighted position that takes into account the particular conditions of each case trying to find pragmatic responses to encourage the search for solutions to improve the state provision of goods and services in order to maximize the welfare of citizens. For that purpose, it is essential to consider the degree of regional productive disparities within the country since they impose serious limits to the operation and financing of decentralized services and especially when their provision affects equity, as in the case of health. If it is assumed that the merits of decentralization depend on the commitment of the inhabitants of each territory

in the financing of decentralized public services to the payment of taxes (fiscal correspondence), the existence of strong regional productive disparities implies the infeasibility of decentralization. For others, however, it implies that the results of these reforms will depend on the accompanying system of financial transfers and the strong role to be played by central governments. Nevertheless, disparities do not affect exclusively financial resources. It has to be taken into account the problems derived from the different availability of human resources and, in general, the management capabilities across jurisdictions.

Figure 23: Distribution of Total Tax Revenue in all LGUs, 2009



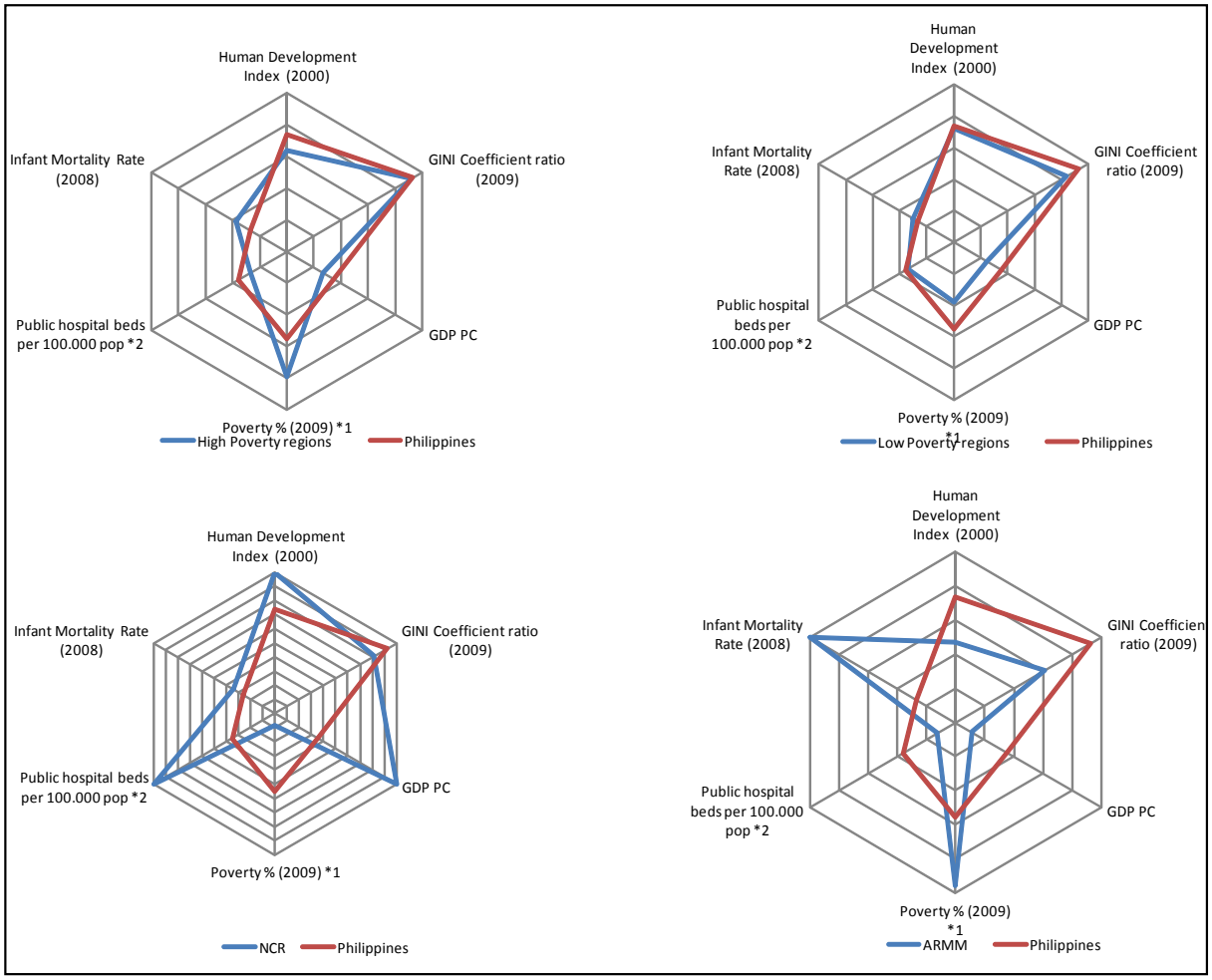
Source: Own elaboration based on Llanto (2012)

In particular, it is crucial to recognize that when these problems exist, the basic dilemma of decentralization of social policies is to find a formula of compatibility between the specific aims of the policy of decentralization and income redistribution. This requires mechanisms for coordination and cooperation between the various levels of government, as well as their funding (Esguerra, 2012-I; Patino, 2012-I). In a country like the Philippines, which is composed of very unequal territories, the search for universal and equitable coverage demands a reinforcement of the role of the central government to compensate for differences and coordinate sector policies that have a common axis, although it may have different degrees of decentralization.

The evaluation of the decentralization process in cases like the Philippines' must consider systems of funds transfers between levels of government. Diokno (2012) explains the main changes in the funds transfer schemes (see Table 23).

In situations where local fiscal capacity is deficient or tax externalities exist, the Intergovernmental Fiscal transfers are broadly responsive to fix these problems (Capuno, 2012). As a result of changes in the IRA, the proceeds of the shares from national taxes make up two thirds of the total resources of the LGUs. The limited resources of the LGUs come mainly from the Real Property Tax and Business Tax, both directly proportional to wealth and economic activity in each territory (see Figure 23). Thus, the less developed areas will have greater difficulty getting resources to improve health care and other decentralized services.

Figure 24: Region Groups



Source: Own elaboration based on National Statistics Office, (2011)

*Notes: The maximum value of the each variable equals 100. Human development index: The regions' values are simple averages of the provinces. As Regions IVA and IVB are not discriminated by this index, they have the same value. *1 refers to the incidence among population. *2 corresponds to all the licensed government hospitals in 2010.*

There is the perception that after two decades of decentralization of health services, the LGUs have not demonstrated the needed ability to improve their management (Picazo, 2012-I), which poses the challenge of improving the policies of the central government to compensate for differences (Esguerra, 2012-I; Universal Health Care Group, 2012-I). Several authors note that well-managed LGUs are the exception rather than the rule (Capuno, 2012; Diokno, 2012).

In countries with important internal development differences, as in the Philippines, the most complex problems facing decentralized systems of public provision of social expenditure are the outcome of lack of resources, poor management, and inefficient allocation of expenditure, especially in the less developed regions. In such cases, it is necessary to search for new ways of transferring resources to compensate for the differences between regions, as well as of incorporating incentives for expenditure allocation in the direction required to improve service provision to the poor. An

alternative in this sense is the introduction of performance-based grants as positive incentives to local effort to improve governance and local revenue mobilization, as well as matching grants to equalize fiscal capacities of local governments (Llanto, 2012). While there are mechanisms being gradually incorporated in order to improve resource allocation and equity in decentralized systems, problems that may arise with the eventual loss of resources in jurisdictions that are less efficient cannot be ignored, as they will induce further loss of equity to the detriment of those jurisdictions, presumably less able.

6c. The Actual Coverage Problems in the Different Programs

Whatever the approach adopted in the reforms to improve the situation of the population in the regions, the strategy must take into account the characteristics and scope of each PhilHealth program, as well as the special circumstances prevailing in each region. In order to illustrate the problem, a first classification of regions has been attempted, combining development indicators (both economic and social), poverty, inequality, hospital facilities, and infant mortality rate. Two extreme situations must be distinguished: NCR and ARMM have, respectively, the best and the worst indicators of each dimension analyzed and are far removed from the rest of the country. Additionally, regions that have above-average poverty indicators were differentiated from the others. Figure 24 shows these dimensions for these four groups of regions, illustrating the great diversity of cases in the Philippines. These groups are: NCR, ARMM, other regions with low poverty indicators than the average and other regions with higher poverty indicators than the average.

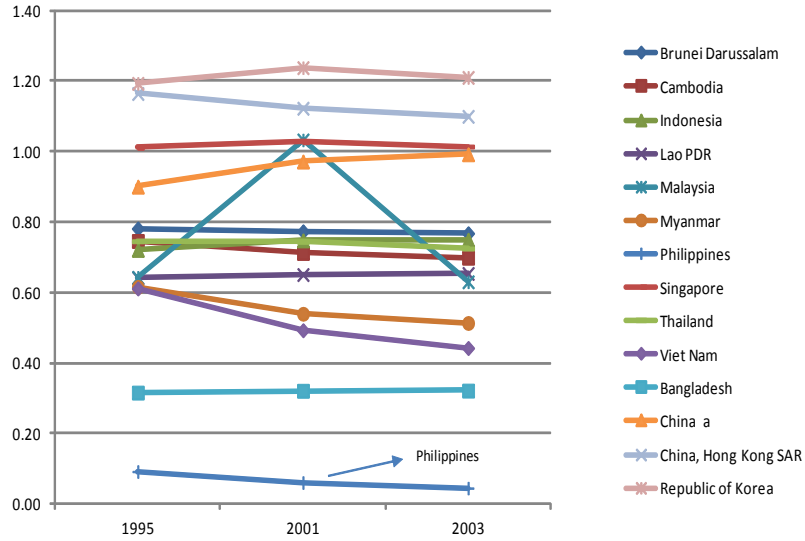
Table 24: Benefit Delivery Ratio by Selected Regions, (%)

Region	Coverage Rate	Availment Rate	Support Value	BDR
Cagayan Valley	48.0	10.4	77.6	1.9
Central Luzon	54.0	24.0	28.5	3.7
MIMAROPA	36.0	25.5	31.9	2.9
Eastern Visayas	37.6	71.8	31.6	8.5
Zamboanga	36.3	91.1	40.2	13.3
Northern Mindanao	73.9	51.3	41.8	15.8
SOCSARGEN	35.2	91.5	37.1	11.9
NCR	77.0	32.9	21.2	5.4
ARMM	13.6	87.0	37.2	4.4

Source: IPD (2011)

Extending effective coverage of population sectors most in need will not be solved by giving them a card and recording them as population covered (Banzon, 2012-I). It is also necessary to facilitate effective access to health services. (Chapter 5 analyzed the benefits accessible to beneficiaries in each PhilHealth program) (Esguerra, 2012-I).

Figure 25: Literacy Rate Gender Gap in Asian Countries, 1995, 2001 and 2003



Source: United Nations (2008)

Note: China does not include those in the Hong Kong Special Administrative Region (SAR), Macao Special Administrative Region (Macao SAR) and Taiwan Province of China.

However, the introduction in 2011 of No Balance Billing policy for sponsored households is expected to have a strong redistributive impact, because the poorest population suffered restrictions in the access to hospitals through co-payments and first-peso coverage. Additionally, government hospitals geared to serve the poor have a large non-poor clientele who resort to those hospitals because of the high cost of private facilities and the low social health insurance reimbursement compared to actual costs. In general, lack of information combined with concerns about costs deters the poor from using health services (WHO, 2011; Capuno, 2012-I; Nemenzo, 2012-I; Nyunt-U, 2012-I; Rosadia, 2012-I; Solon, 2012-I;) (see Chapter 5).

In fact, the NDHS 2008 shows that there is a significant disparity in the use of health services. The skilled birth attendance in the highest income quintile is 94% as compared with the 25% lowest quintile. Only 13% of all births in the lowest quintile occur at the facility level compared with the 84% in the highest quintile. The immunization coverage is only 70% in the lowest quintile vis-a-vis 84% in the highest quintile (World Bank, 2011).

The Institute for Popular Democracy (IPD, 2011) classifies the different restrictions in the use of health services. These are as follows:

Supply-side barriers:

1. Limited and uneven number of accredited facilities
2. Inaccessible health facilities and constraints on distance and related transportation costs
3. Inadequate supply of medicines in RHUs
4. Lack or ineffective social marketing strategy

Demand-side barriers:

1. Lack of financial resources to purchase medicines, pay for additional provider fees
2. Lack of information on benefits, availment process
3. Lack of resources to visit health facilities (transportation costs due to distance)
4. Perception of poor quality of healthcare services.

As a result of these barriers, there is a wide gap between the high percentage of the population covered by PhilHealth and the low share of its expenditures in total spending. This signifies a sign of the necessary reforms to achieve actual universal health coverage. As a result of this problem, the UP Team, led by Orville Solon, developed the concept of Benefit Delivery Ratio (BDR) that aims to reflect the weaknesses of the health delivery chain in each of the regions of Philippines (IPD, 2011).

Table 25: Percentage of Household Population with Specific Health Insurance Coverage and PhilHealth Insurance Coverage, by sex, 2008

Health insurance coverage									
	No insurance	Any insurance	Phil Health	GSIS	SSS	Private insurance/ HMO, etc.	Other	Don't know/ missing	Number
Male	57.7	42.0	37.4	1.6	13.0	2.2	0.5	0.3	30.335
Female	57.8	41.9	38.1	1.9	9.6	2.0	0.4	0.3	29.282
PhilHealth insurance coverage									
	Paying			Indigent					Number
	Total	Member	Dependent	Total	Member	Dependent			
Male	77.4	34.4	43.0	22.7	8.5	14.3			11.345
Female	78.8	24.4	54.4	21.4	3.6	17.8			11.157

Source: NDHS of 2008 from NSO (2009)

The BDR is the percentage of the real spending faced by PhilHealth over the total spending required to provide universal health coverage. In practice, it is the result of multiplying the coverage rate (number of households enrolled in PhilHealth divided by the total number of households), the availment rate (number of households that avail themselves of health services divided by total number of households enrolled in PhilHealth) and the support value (the share of the total cost faced by PhilHealth).

The estimates of these rates calculated by the IPD (2011) for a set of regions highlight the low effective coverage and confirm the significant regional disparities that exist in the country (see Table 24). PhilHealth authorities are using these estimates as an indicator to monitor the difficulties and improvements in coverage.

6d. Gender Equality in the Philippines

Gender equality in the Philippines is fairly good relative to other countries in the region. According to NDHS (2008), "Filipino women have an equivalent and sometimes even better level or status than men. The key explanatory factors are free primary and secondary education in public schools; and a culture that propels women towards education, therefore resulting in women having a better education and being more literate than men" (NSO, 2009).

Figure 25 shows the evolution of the difference in the literacy rate between men and women from 1995 to 2003. The position of the curve shows that the lower the difference, the lower is the gap between men and women; hence, it shows higher gender equity in literacy. In the three years shown in the Figure, the Philippines had the lowest difference among the dozen included countries and had a declining gap.

Another international indicator that compares gender equality shows that Philippines is among the most egalitarian countries in the world. The Global Gender Gap Index of 2008, developed by the World Economic Forum in 130 countries, ranks the Philippines in 6th place after Norway, Finland, Sweden, Iceland and New Zealand, among a total of 130 sampled countries (World Economic Forum, 2008).

Furthermore, the Philippine government is committed to improve the socio-economic conditions of women. One of the important steps is the Magna Carta of Women, signed into law by the President in 2009. The Magna Carta is a Republic Act that prohibits discrimination against women by recognizing, promoting, and protecting their rights. The RA includes Filipino women working abroad through the designation of a gender focal point in the different Philippine embassies or consulates (NDHS 2008 from NSO, 2009).

Concerning gender equality in health coverage of the population, Table 25 shows the percentage of household population with specific health insurance coverage and of all persons covered by PhilHealth insurance, as well as the percentages of those paying for coverage and those that are indigent. These are all classified by members and dependents, and then further by sex. The table shows that there are no significant differences between men and women. The only rate that is higher among women is the dependent status of the PhilHealth coverage. This is due to the higher proportion of men who are employed and calls the attention on labor market discrimination.

Despite these important and positive advances, there are still some worrisome gender inequalities that need to be addressed. According to the Civil Society Resource Institute (CSRI) these are persistent feminization of poverty, exploitation of women as cheap labor and victims of international trafficking, marginalization of Filipino indigenous women, discrimination of Moro women in a male-dominated culture and discrimination of Muslim women in a largely Christian population (Civil Society Resource Institute, 2011).

The cited document also highlights that the maternal mortality rate is alarmingly high, with more than four thousand mothers dying from pregnancy and childbirth every year; that reproductive health services are still unreliable and sometimes not even available; that there is no comprehensive policy or program addressing women's reproductive health rights, and that there is also a need for widely available care (Claudio, 2012-I), including reproductive health (see footnote 2 in Chapter 1 of this document). Emergency obstetric and newborn care facilities are not enough and not utilized by the poorest women. The Philippines has made significant advances on violence against women, addressing such problem and giving justice to their victims. The government agencies have turned into task forces for their implementation, but they claim that enforcement remains a problem. This situation may be causing difficulties on focusing policies on groups at risk.

A UNICEF document highlights the good gender situation of the Philippines relative to its neighboring countries, but stresses the importance of various reforms to address gender issues on health. The proposed reforms include legal and political changes, such as the decentralization of specific international policies like the adoption of the International Labour Organization Convention 183 on maternity protection. It proposes a progressive increase in the national health and nutrition budget to achieve the WHO recommended level of at least 5% of GDP. Concerning health services, the document asks for the supply of sexual and reproductive health services, the expansion of coverage in supplemental feeding to high risk pregnant and lactating mothers, the provision of universal maternal-child health packages to poor and marginalized women and children, the scaling up interventions for HIV and AIDS, and the giving of antiretroviral drugs for prevention of mother to child transmission of HIV (cited by ADB, 2008).

CHAPTER 7: FINANCIAL/ACTUARIAL SUSTAINABILITY

7a. The Financial Flow of the Health System

As already mentioned, the organization and financing of the Philippine's health system is the result of different types of changes implemented over the years. Figure 26 (taken from DOH) shows the complexity of the sector's financing. With this, it shows the effect of the decentralization process through the sharing of resources from the national government to the local governments and the share of the latter in the provision of services.

The Philippines' health system is funded from a mix of sources including payroll contributions from both employees and employers in the formal sector of the economy; payment of premiums from the self-employed, informal workers and OFWs; general fiscal revenues that finance health insurance for the poor (sponsored program) public facilities and public programs, as presented in Chapter 4 of this document.

Both the NHIP in general terms and the SP component in particular are financed with the following resources:

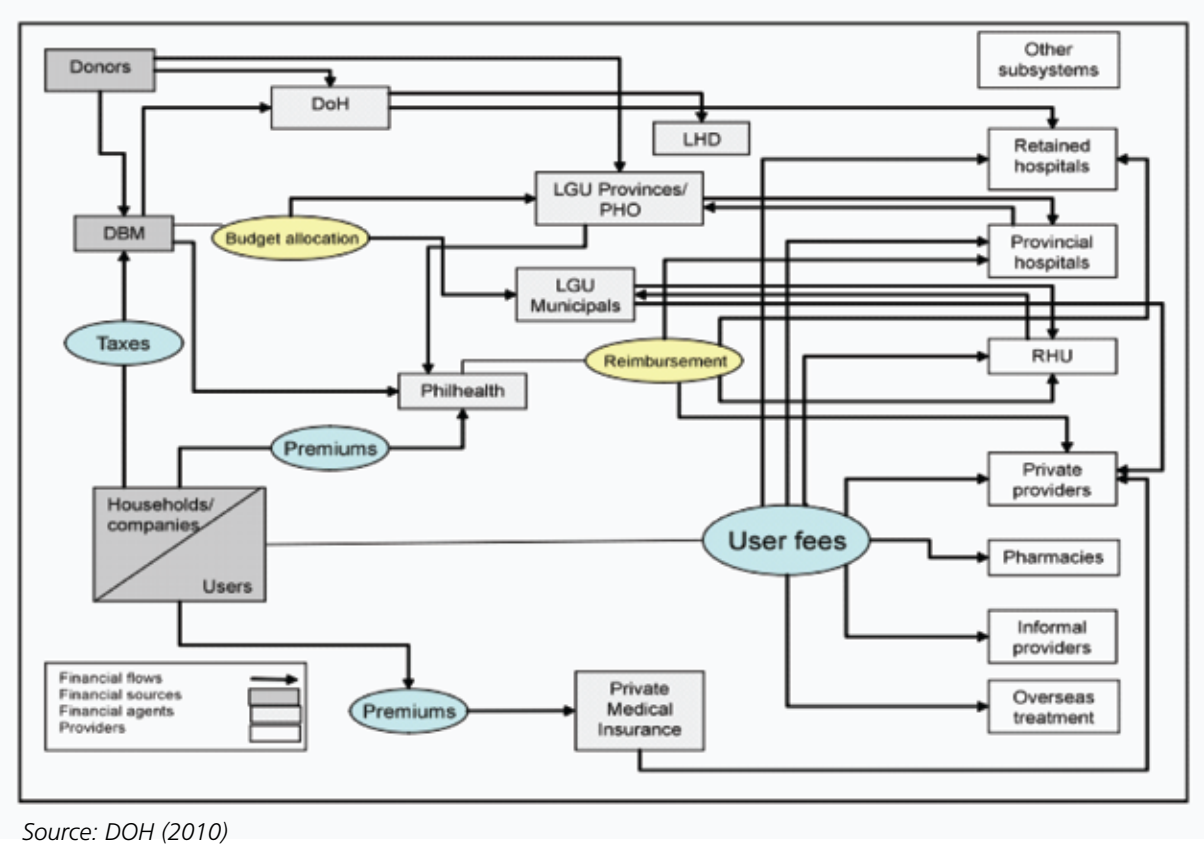
- The Excise Tax Law (RA 7654 of 1993) assigns 25% of the increase in the total revenue from the excise taxes to the NHIP.
- The Documentary Stamp Tax Law (RA 7660 of 1993) allocates 25% of the incremental revenue from the increase in documentary stamp taxes to the NHIP since 1996.
- The Bases Conversion and Development Act (RA 7917 of 1995) allocates 3% of the proceeds of the sale of Metropolitan Manila Military camps to the NHIP.
- The Sin Tax Law revenues.
- The Reformed Value-Added Tax Law (RA 9337 of 2005) allocates 10% of the LGU share from the incremental revenue of the value-added tax to the health insurance premiums of enrolled indigents.

Until 2012, the Sin Tax Law (RA 9334 of 2004) allocated 2.5% of the incremental revenue from the excise tax on alcohol and tobacco to the programs of prevention of diseases of DOH; 2.5% of such incremental revenue covered the indigent households of the NHIP. Since 2013, the new Sin Tax Law (R.A. No. 10351 "An Act Restructuring the Excise Tax on Alcohol and Tobacco Products") has determined a gradual increase in tax rates until 2017. Eighty five percent (85%) of the incremental revenues will be allocated to health care spending in the following way: eighty percent (80%) will be allocated to the universal health care under the National Health Insurance Program and twenty percent (20%) nationwide for medical assistance and health enhancement facilities program. According to official estimates, during 2013 the additional revenues to be allocated to the health sector could reach 0.24% of GDP, equivalent to 20% of public and social security expenditures on health.

At the LGU level, financing is fragmented across provinces, municipalities and cities, with each LGU financing its own facilities (Padilla, 2012-I). The LGUs receive: a) part of the taxes from the national government; b) the internal revenue allotment (IRA) based on a formula (consisting of three variables: land area, population, and revenues generated such as, local taxes); and c) other revenues of the LGUs allocated to the sector such as PhilHealth capitation and reimbursements and grants from external sources.

The confluence of various sources reveals a significant fragmentation in the financing of the health system. Beneficiaries confront out-of-pocket payments for fees, copayments and drugs, whereas the highest-income households pay voluntary premiums to access private health coverage from HMOs.

Figure 26: Flowchart of Health Financing in the Philippines



Source: DOH (2010)

The PhilHealth benefits covered the provision of inpatient and outpatient care, emergency and transfer services, special packages targeted to specific groups such as mothers and children, and patients suffering from TB (maternity and newborn care package and TB package) (see Chapter 5 of this document). In the private sector, there are different defined-benefit packages varying according to the premium paid.

Finally, out-of-pocket spending covers a variety of expenses, characterized by being un-pooled. As discussed in Chapter 4 of this document, out-of-pocket represents the largest share of health spending in the country, although in principle it should be a "residual" expense covering only what the government, PhilHealth and HMOs do

not cover. The magnitude of this expense is tantamount to the rate of households un-insurance or under-insurance or their poor utilization of the available insurance benefits (World Bank, 2011).

7b. Payment Mechanisms

Payment mechanisms differ on the basis of the services provided. In the case of the outpatient package services provided, the RHUs are usually free of charge; however, the problem here is the availability of resources since shortages have been reported and are funded through fees collected from PhilHealth capitation[13] (PhP 300 or US$ 6.28). Capitation funds are not always used to provide health services and in some cases, the LGU allocates those resources for other purposes, incorporating them as general funds.

In the case of the special benefits packages (TB-DOTS, malaria and others), health care providers are paid per case. The amount of the case payment varies for each package and is set by PhilHealth. In turn, inpatient care incorporates a fee-for-service (FFS) regime, in which public and private hospitals have the possibility to charge the fees (balanced billing).

Regarding drug costs, the inpatient package includes the reimbursement of expenditure on a list of drugs and medicines, up to a maximum amount established. However, there are high out-of-pocket expenses in which 45% of them are concentrated on drugs (see Chapters 4 and 6 of this document) (Capuno, 2012-I; Rosadia, 2012-I). This is so, even after maximum drug retail prices were imposed by the DOH on selected drugs in August 2009, it still resulted in a 50% reduction in prices.

In the case of human resources, payments are associated with the facilities in which they work. Private-sector doctors receive a fee-for-service or payments pursuant to contracts with HMOs. In the public sector, the staff receives monthly salaries according to the Salary Standardization Law and additional reimbursements from PhilHealth (based on the number of days a patient is hospitalized),[14] with the final amount depending on factors such as basic pay and nature of assignment of workers, among others. This payment scheme drew serious criticism because it allowed doctors to collect discretionary fees. Thus, the effective financial protection of the program was substantially reduced, affecting mostly the poorest. In order to regulate these problems, PhilHealth sets case rates to a number of special packages of benefits for medical and surgical procedures since 2011, establishing fixed rates for each case, eliminating the discretionary collections and making information transparent to patients (Padilla, 2012-I).

Additionally, as pointed out in the case of sponsored members, since 2010 there has been No Balance Billing (NBB) which permits these beneficiaries to gain access to

13 PhilHealth has started to introduce payments per family instead of per capita.

14 General practitioners charge PhP 100.00 (US$ 2.09) per day of confinement, while specialists charge an additional PhP 50.00 (US$ 1.05) per day. In the case of surgical or medical procedures, an amount related to the procedure's complexity is paid as reflected by the assigned relative value unit (RVU) regularly set forth by PhilHealth.

health treatments and services with no additional cost to public hospitals. In addition, beneficiaries can obtain the benefits and the reimbursements already mentioned, wherein provided by any PhilHealth accredited provider.

Table 26: Premium Collection versus Benefits Payments by Insured Groups of NHIP, 2011

	Premium collection	Benefits payments	Benefits To premium ratio
Government employees	8	6	0.75
Private employees	20	12	0.61
IPP	2	6	2.83
SP	2	7	3.11
OFW	831	1	1.47
Lifetime members	0	2	
Total NHIP	33	35	1.05

Source: Own elaboration based on PhilHealth Annual Report (2010)

7c. Pooling of Funds

The possibility of carrying out strategies of risk pooling depends on the management of financial resources so as to diminish unpredictable health risks among the members of a given group. The pooling mechanisms enable transfers of resources from healthy people to sick people, from the rich to the poor or even along the life cycle of individuals (between active and passive ones). Thus, introducing risk-pooling in the health financing system is justified in terms of its impact on the equity and solidarity of the system. In the Philippines different levels of risk pooling are combined with various sources of financing of the health system.

NHIP financing comes from different sources (see Chapter 4 of this document). PhilHealth pools fund from all sectors of society namely: formally employed, direct payments from LGUs, national government budget, and voluntary premiums. All collected resources are managed as a single fund, with uniform benefits for the members and dependents of the various components of the program. Table 26 shows the existence of cross-subsidies between beneficiaries of NHIP components. On the aggregate, in 2011, benefit payments represented a ratio of 1.05 of total premium collections, meaning that payments were higher than premium hence having implications in terms of sustainability of the system (see next section of this document).

An analysis of the breakdown of the PhilHealth components shows various patterns of use of benefits between them. The public and private employed programs show a benefits-to-premium ratio below 1 (0.75 and 0.61 respectively) whereas in the SP and IPP programs, the benefits paid far exceed the premium (3.11 and 2.83 respectively). Obviously, the same occurs in lifetime members, who are not charged premium.

As opposed to the PhilHealth risk pool, private health insurance has only limited risk-pooling capacities because of smaller groups. Additionally, HMOs have incentives to adversely select its members, giving priority to healthier people in the pool, which leads to the cream-skimming effect.[15]

15 The "cream" – savings from beneficiaries that have lowest risks and cost- is captured by some providers that exclude those with the highest risk and cost.

7d. Operating Expenses

The NHIP is entirely administered by PhilHealth, which collects premiums, accredits providers, determines benefits packages and provider payment mechanisms, processes claims, and reimburses providers and beneficiaries. Thus, PhilHealth takes over responsibilities of supervision, follow-up and monitoring of the NHIP. To this end, it has an Administration Board presided over by the Health Secretary and backed by the President of PhilHealth with representation from other government departments and agencies, and the private sector (see Chapter 2 of this document).

Salaries and other operating expenses are financed from premium collection and revenues from the fund's investment returns. Until 2012, PhilHealth can use up to 12% of the previous year's premium and 3% of the fund revenue for operating expenses. On the basis of recent reforms to the Law, within a transition period of five years, there will be a formula for administrative costs (5% come from benefit payments of last year; 5% from collection, and 5% from income/investment). After that, these percentages will be reduced to 4%.

Table 27: Operating Expenses of NHIP, 2000-2010

Year	Total Expenditures	Benefit payments	Administrative expenditures	Administrative expenses to total expenditures
2000	7,622	6,764	858	11.26%
2001	8,755	7,740	1,015	11.59%
2002	10,002	8,839	1,162	11.62%
2003	12,412	10,957	1,455	11.72%
2004	15,104	12,925	2,179	14.43%
2005	19,270	17,511	1,758	9.12%
2006	19,005	17,105	1,900	10.00%
2007	19,838	17,448	2,390	12.05%
2008	21,345	18,136	3,209	15.03%
2009	27,791	24,211	3,579	12.88%
2010	34,322	30,513	3,809	11.10%

Source: Philhealth Annual report (2000-2010)

Table 27 estimates that the share of administrative expenditures in PhilHealth's total expenditures averaged around 11.89% in 2000-2010. In 2004 administrative expenditures jumped into 49.7% over 2003 while benefit payments rose 18.0%, which resulted in an increase in the administrative share to 14.43%. On the other hand, in 2005 there was an inverse behavior with benefit payments growing 35.5% and administrative expenditures decreased by 19.3%, dropping the share to 9.12%. Such share peaked at 15.03% in 2008 and thereafter decreased to 11.1% in 2010.

7e. Financial/Actuarial Sustainability

Table 28 summarizes the results of the 2011 Actuarial Valuation Report performed by the National Health Insurance Program's Office of the Actuary, which identifies different scenarios projected for 2010-2021 (NHIP, 2012).

Table 28: NHIP Projections, 2011-2021 (in million PhP)

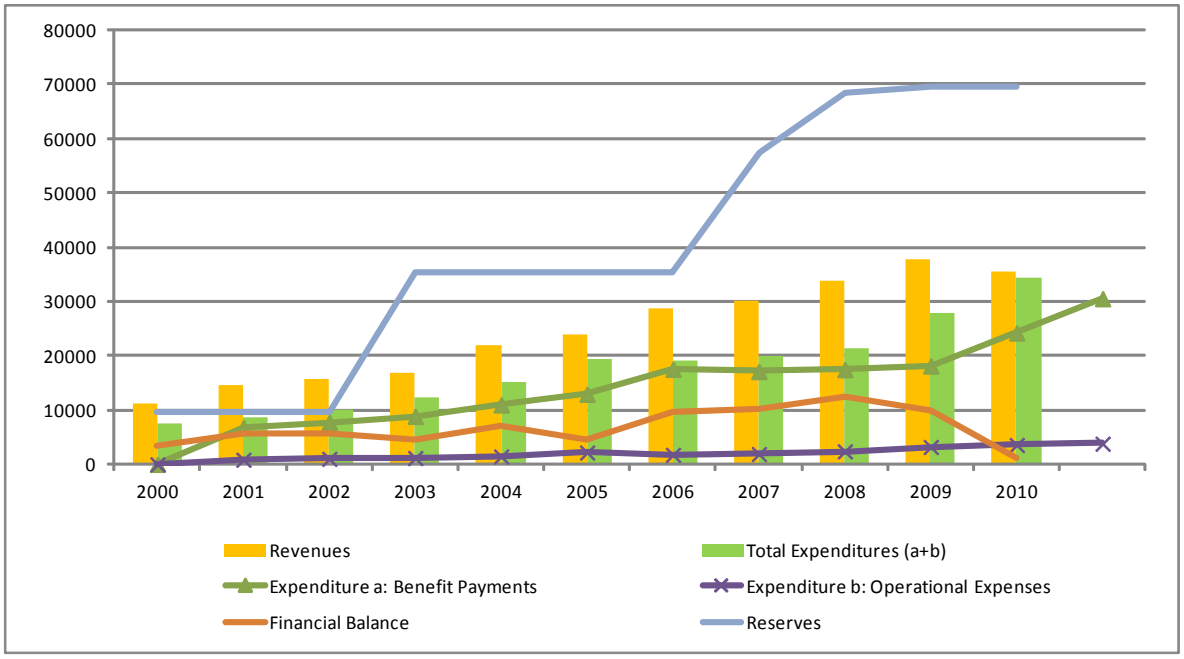
Year	Membership		Collection	Interest Income	Other Income (Accre Fees)	Total Income	Benefit Payment	Operating Expenses	Total Expenses	Annual balance
	Active paying principal members	Total registered beneficiaries								
2010	17,225,623	70,184,683	29,088	6,251	23	35,362	30,629	3,809	34,438	924
2011	22,208,883	88,661,068	33,294	6,644	23	39,961	40,341	4,138	44,479	-4,518
2012	23,092,607	90,822,317	46,680	6,071	26	52,777	48,298	4,195	52,493	284
2013	23,660,350	91,813,569	48,300	5,893	17	54,210	54,048	5,784	59,832	-5,622
2014	24,244,303	92,822,762	49,632	5,441	14	55,087	59,834	5,973	65,807	-10,720
2015	24,854,886	93,888,803	51,034	4,702	26	55,762	65,335	6,119	71,454	-15,692
2016	25,445,236	94,831,461	52,560	3,777	17	56,354	70,062	6,265	76,327	-19,973
2017	26,050,842	95,789,484	54,418	2,414	14	56,846	75,111	6,420	81,531	-24,685
2018	26,672,044	96,763,123	56,302	910	26	57,238	80,504	6,603	87,107	-29,869
2019	27,309,288	97,752,633	59,208	0	17	59,225	86,266	6,784	93,050	-33,825
2020	27,974,058	98,797,798	62,398	0	14	62,412	92,457	7,105	99,562	-37,150
2021	28,563,734	99,701,265	65,890	0	26	65,916	98,817	7,488	106,305	-40,389

Source: NHIP (2012)

A scenario of "stability," maintains most system variables unchanged, albeit assuming significant increase in new SP members and moderate wage rises. After the first year with a small surplus, NHIP total revenues are insufficient to meet with the growing expenditure; and the steady deficit appear to be accelerating from 2013 onwards. The financial balance deteriorates from a surplus of PhP 923 million in 2010 to a deficit of Php 40, 389 million in 2021, reflecting an increase of 44.8 times in the period. The cumulative increase in revenues for the period is 86.4% (an average of 5.42% per year) whereas the cumulative total expenses increase by 208.7% (9.44% annually). The projected deficit assumes that beneficiaries will expand by 42.1% and the members by 65.8% in the period. At a lower rate of expansion, the deficit would be higher, as it would be the case if wages rise at a lower rate. The actuarial report states "this was the expected effect of implementing the 23 case rates in 2011 without any corresponding change in premium structure" (NHIP, 2012)[16]. Should these projections materialize, the fund could only survive until 2018.

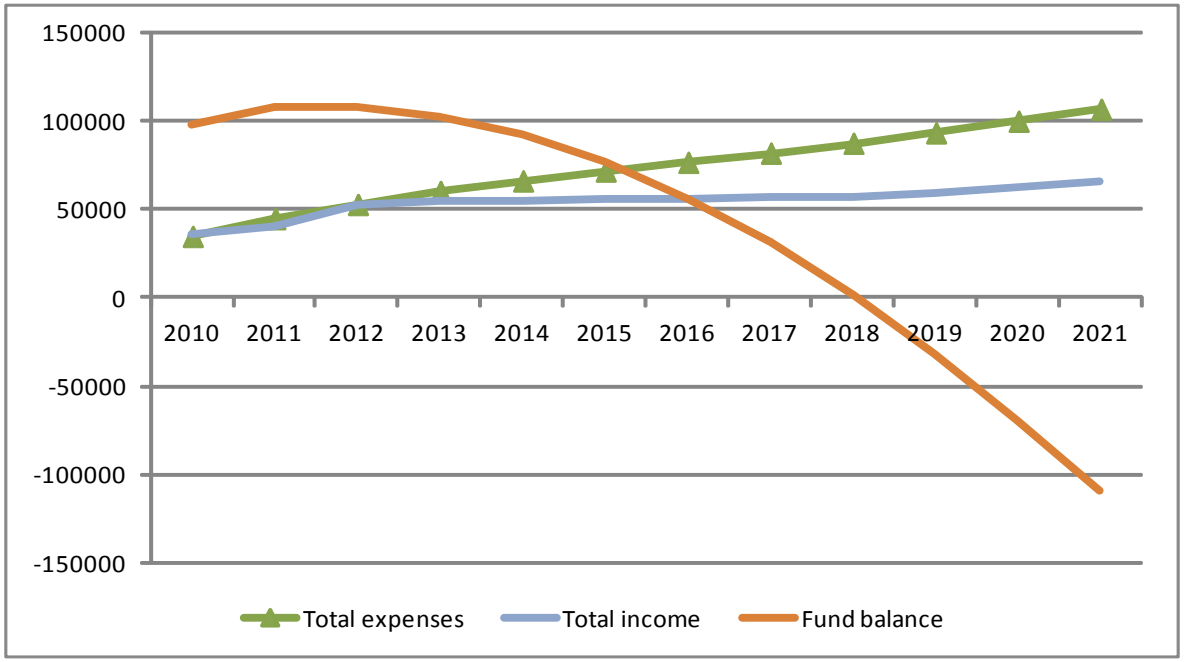
16 The 23 case rates refer to the rates specified by NHIP for medical and surgical cases that guarantees access to a set of services without additional payments. For more information, see Chapter 5.

Figure 27: Financial Balance and Reserves of NHIP, 2000-2010 (in million PhP)



Source: PhilHealth Annual Report (2000-2010)

Figure 28: NHIP Fund Projections, 2011-2021



Source: NHIP (2012)

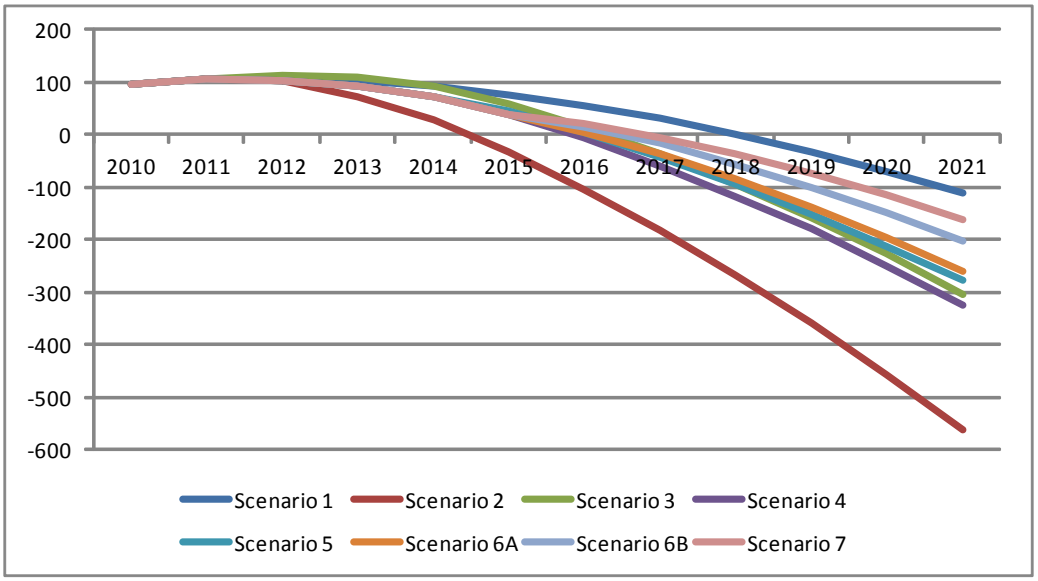
The membership's projections show progress in coverage, considering a growth of 1.18% per year. On the other hand, the total population would grow at a rate higher than 1.7%. With a size of 3.19 members per household, the total coverage of the program would be around 88.11% in 2021.

Table 29: Fund Status and Actuarial Reserve Projections, 2010-2021 under Scenario 1

Year	Fund Balance	Reserves Limit	Reserve Fund
		Next 2 Years Total Expense	(as defined by RA 7875)
2010	98,035	96,971	53,556
2011	108,099	112,325	55,606
2012	108,383	125,639	48,551
2013	102,760	137,261	36,953
2014	92,041	147,781	20,587
2015	76,349	157,859	22
2016	56,376	168,639	0
2017	31,691	180,157	0
2018	1,822	192,611	0
2019	(32,003)	205,867	0
2020	(69,152)		
2021	(109,542)		

Source: NHIP (2012)

Figure 29: Fund Status and Actuarial Reserve Projections, 2010-2021



Source: NHIP (2012)

With regard to the financial position and sustainability of NHIP, it is important to add the reserves accumulated in the fund. The reserve funds are established according to the provisions of RA 7875. In 2000-2008, there was a constant growth of the fund's reserves, although the financial balance gradually declined and became virtually negative in 2010, hence the fund balance stagnated (see Figure 27). Conversely, according to the projections, the financial balance turns into deficit and the fund balance steadily declines since 2011. By 2018, it will be depleted (see Figure 28).

In alternative scenarios[17], the actuarial report notes continuous financial unsustainability of the fund. Changing the structure of taxes and increasing wages subject to contribution ceilings, among other assumptions, the projected scenarios show insufficient revenues to meet the expenses of the program. In all cases, the fund survives up to 2016 at most (see Table 29 and Figure 29).

In sum, the various actuarial scenarios, projected by NHIP, demonstrate that PhilHealth NHIP is not financially sustainable in the long term unless reforms are rapidly implemented. Among the problems faced are the following:

1. The increasing trend in payments to non-paying members and the resulting increase in the benefit to payments ratio (Jowett and Hsia, 2005);
2. The irregularity of premiums payments by the IPP (about two thirds of the members of this component do not pay their premiums regularly (Jowett and Hsia, 2005) ;
3. The incorporation of additional benefits (such as case rates) and of new SP beneficiaries without any corresponding additional revenues;
4. No change in the contribution rate, which is around 3%, a low percentage in comparison with other international social security health schemes;
5. The growth of fraudulent payments (between 10-20% of benefit claims); and
6. The deterioration of the financial statement and fund reserves in recent years.

There are serious concerns on the long-term financial sustainability of PhilHealth based on the NHIP actuarial study. There are scenarios that do not involve drastic reforms in the scope of programs and those that they are funding. Therefore, it is imperative to boost the collection efficiency, the compliance rate and the number of months paid in order to boost revenues and to impose mandatory coverage in the informal sector, overseeing the persistence and continuity of premiums payment by its members.

The next chapter will show that the challenges faced by the Philippines's health system in the medium term are even more important than those raised here.

17 The assumptions used in different scenarios are summarized in Appendix Table 13.

CHAPTER 8: CONCLUSIONS AND POLICY RECOMMENDATIONS

This section summarizes the major findings and challenges in the Philippines' health system in relation to each of the main aspect included in the diagnosis performed, namely, organization, coverage, benefits, social solidarity and gender equity, efficiency, and financial sustainability. The main challenges spotted may be grouped in seven dimensions:

- Coverage expansion
- Improvements in effective availability and use of health services
- Equity improvement in the coverage and use of services, particularly centered on target mechanisms
- Widening and distributive impact of health services financing, whether contributory or non-contributory and the need to reduce out-of-pocket expenses
- Redefinition of system organization, decentralization of services, territorial equity and the LGUs' role
- Improvements in the efficiency of the use of resources and management of the system
- Achieving adequate and sustainable financing in the health system

These dimensions are not independent from each other and should be treated as a whole. The coverage expansion and higher availability of services in the different regions of the country depend on the organization of the system and, more importantly, on the level and type of financing, which ultimately leads to its distributive impact. Additionally, the solution of many of the health-system problems result from general development issues rather than those pertaining to the health sector.

The government has put into motion major initiatives to increase the coverage of health insurance and to modernize public sector institutions. In turn, academia and international organizations have published important studies with diagnoses and reform proposals, which as a result, have enriched the debate. Some civil society organizations seek to improve specific aspects of the sector in behalf of the citizens. Therefore, in addition to their own suggestions, the authors have incorporated recommendations from other sources. They include opinions collected from the valuable interviews done and the conclusions of reviewed documents. Particularly: Solon et al (2003), Bodart (2007), GTZ Study (2007), ADB (2007), Manasan, (2009 and 2011), Acuin et al (2010), WHO (2010), DOH (2010), World Bank (2011), Orbeta (2011), Capuno (2012), Llanto (2012), Diokno (2012) UNDP (2012), Banzon (2012-I), Capuno (2012-I), Claudio (2012-I), Esguerra (2012-I), Ngunt-U (2012-I), Padilla (2012-I), Patiño (2012-I), Picazo (2012-I), Rosadia (2012-I), Solon (2012-I), Universal Health Care Group (2012-I) and Untalan (2012-I).

Coverage Expansion

Access to health services is undoubtedly an essential human right, an indispensable prerequisite for poverty reduction, and for economic growth and development. Taking into account the current health system situation and the government's goals, this dimension should be considered the main challenge encompassing the others (which should be considered, consequently, complementary).

Resources are scarce for the sector to ensure universal and equitable coverage for the country's population. It is true that the public sector policy has been aimed at improving the health coverage of Filipinos by expanding PhilHealth. The progress has been remarkable, but there is still a long road of reforms to meet the targets set.

As shown in actuarial studies, membership's projections show progress in coverage, considering a growth of 1.18% per year from 2012 until 2021 (while the total population would grow at a rate higher than 1.7%). With a size of 3.19 members per household, the total coverage of the program would be around 88.11% in 2021. The universal coverage is far more complex than ensuring membership (Untalan, 2012-I). However, it is necessary to develop a strategy to effectively broaden coverage that includes the different dimensions of the problem, presented as follows.

Improvements in Effective Availability and Use of Health Services

Sufficiency is the degree by which the benefits provided by the program are adequate to meet the needs of different beneficiaries. It requires economic resources to provide timely access to proper health care regardless of the economic situation of individuals. There are no appropriate indicators to accurately measure sufficiency of benefits. However, these benefits encompass different health services usually not used simultaneously by the same person; hence it is possible to have an approximate assessment based on the "financial protection" provided by the program for specific services.

In fact, the structure of the benefits covered by NHIP in a minimum (or basic) package imposes limits to the sufficiency of such benefits. This means that it is only sufficient for restricted types of care and treatments; however, in many cases, limited to services in government hospitals. This makes us think about the real financial protection that is being provided to its members and their dependents.

The classification of restrictions to the use of health services are as follows:

Supply-side barriers:

1. Limited and uneven number of accredited facilities
2. Unaffordable health facilities-constraints on distance and related transportation costs
3. Inadequate supply of medicines in RHUs
4. Lack or ineffective social marketing strategy

Demand-side barriers:

1. Lack of financial resources (purchase medicines, pay for additional provider fees)
2. Lack of information on benefits, availment process
3. Lack of resource to visit health facilities (transportation costs due to distance)
4. Perception of poor quality of healthcare services.

As a result of these barriers, the gap between the high percentage of the population covered by PhilHealth and low percentage of its spending in the total is extremely high and a sign of challenges to reach an effective universal health coverage. As shown. There is an important gap between registered population and those who are eligible to use the benefits. The population of the Philippines has grown considerably in the last two decades. However, the health sector infrastructure has not kept up with these changes.

The Philippines has ratios of nursing and midwifery, of dentistry and pharmaceutical personnel of 1 to every 10, 000. This is in line with the upper middle income countries or even going beyond their values. On the contrary, when focusing on the available human resources in the LGUs, there has been some stagnation in the last few years. An important issue affecting the health sector's human resources is the growing migration of trained resources to other countries. The Philippines has become a major source of health professionals to many countries because of their fluent English, skills and training, compassion and patience in caring, which leads to a costly brain drain, hurting the health sector. Additionally, improving compliance of the Employed Sector Programs and expanding coverage of the informal sector under the IPP will not be possible if the availment rate and the support ratio are not increased.

Recommendations:

- To cover the existing gaps in service delivery capacity, particularly in some regions, often the poorest and most underserved in the country.
- To improve the availment rate, there is a need to upgrade the facilities of public hospitals, RHUs and BHSs so as to increase the number of accredited public health facilities.
- To introduce material or career incentives in order to make the required medical human resources remain in the Philippines.

Equity Improvements in the Coverage and Use of Services, Particularly Centered on Target Mechanisms

With the present scope of SP, it should provide coverage to the last quintiles of income distribution (the poorest 40% of the population of the country) so that it would be in a scenario perfectly focused and completely covered as stated in the program. The worsening socio-economic conditions of the population resulted from an unfavorable economic cycle which might not result in a greater coverage although it might reflect a higher number of people that might not pay for coverage voluntarily.

In this context, the ability of this component to have a countercyclical response is strongly limited, reducing the possibilities of gaining access to health coverage for a wide range of population sectors.

Additionally, coverage problems due to low voluntary adhesion to de IPP have to be faced despite the significant weight of informal employment. This is not an exclusive problem of the health system. Instead, it is related to employment, social protection and taxation policies. Some Latin American countries have implemented simplified tax regimes for individual workers and small businesses that, under special conditions, can include an additional contribution to access health insurance programs (as in the case of Argentina, where there is a system known as "monotributo") (Cetrángolo, Gomez Sabaini and Velasco, 2012).

Recommendations:

- It is critical to expand the coverage of the Sponsored Program of PhilHealth and to improve the selection of beneficiaries.
- The NHIP should assign more resources to the SP in order to finance health services for the needy in a non-contributory fashion.
- Implement a good centrally designed and managed targeting system
- Expand coverage of informal workers to the IPP.
- Encourage the participation of the civil society groups (e.g. religious bodies, non-governmental organizations, cooperatives) that play a key role in promoting the principles of equity and solidarity in society. They should participate in national dialogues to further the extension of coverage to excluded groups and to explain the functioning of the system and the use of health services.

Widening and Distributing Impact of Health Services Financing, Whether Contributory or Non-contributory and Reduce the Out-of-pocket Expenses

This dimension is closely related to the previous one. The limited coverage of the benefits explains the growing share of out-of-pocket expenses in total health spending, making the health system regressive. In addition, the high out-of-pocket spending also explains why the use of NHIP services is low for SP members. It is an important barrier to accessing health care, especially for the very poor that requires hospital services.

The effective health coverage is inadequate and uneven. It worsens the inequalities that characterize the Philippines. The poor are the most vulnerable because they are less able to recover from the financial consequences of the out-of-pocket payments and the loss of incomes is associated with ill health. Overall financing for health is regressive in the Philippines. A major portion of the limited benefits offered by the public sector is received by the less needy. Meanwhile, direct payments are high and worsen the inequity of the system.

Also, maternal care seems to be inadequate. Emergency Obstetric and Newborn Care facilities are not enough and are not utilized by the poorest women who are actually the ones with the highest mortality rate.

Meanwhile, payment mechanisms differ on the basis of the services provided. The case of the outpatient package services provided by RHUs is usually free of charge. On the other hand, the case of the special benefits packages provided by the health care providers and set by PhilHealth are paid per case. In turn, inpatient care incorporates a fee-for-service (FFS) regime, in which public and private hospitals have the possibility to charge over the fees (balanced billing).

There have been important improvements in recent years. Since 2011, PhilHealth has established fixed rates to a number of special packages of benefits for medical and surgical procedures, eliminating the discretionary collections and making information transparent to patients. Since 2010, the sponsored members have case rates of No Balance Billing (NBB), permitting these beneficiaries to gain access to health treatments and services with no additional cost to public hospitals. Finally, since 2012 some medicines have been included in the out-patient benefit package through the initiative called Primary Care Benefit. It has three components. The first is for diagnostics and outpatient services in the clinic. The second covers maintenance drugs for hypertensions and diabetes. Finally, the third one addresses catastrophic illnesses.

Recommendations:

- Improve service coverage. The outpatient consultation and routine diagnostic services should be made available to all members in order to achieve equity across programs. Given that drugs and medicines account for roughly 50% of total out-of-pocket health expenditures of households, the inclusion of drugs and medicines in the outpatient benefit package needs to be reinforced.
- Allow LGUs to play an important role in the enrollment of informal sector workers under the IPP. LGUs should collect the premium contributions of the non-poor informal sector workers and should remit them to PhilHealth. Incorporate incentives for LGUs to play this role.
- Shift the payment system from fee-for-service to a mix of capitation and case-payments, and ban balance billing to increase the PhilHealth support ratio. These changes should be made available not just for the Sponsored Program but for the other programs as well.
- Consider the inclusion of family planning programs in PhilHealth benefits.

Organization, Decentralization of Services, Territorial Equity and the LGUs' Role

The Philippines' health system is funded from a mix of sources including payroll contributions from both employees and employers in the formal sector of the economy; payment of premiums from the self-employed, informal workers and OFWs; general fiscal revenues that finance health insurance for the poor (sponsored program) and public programs. At the LGU level, financing is fragmented across provinces, municipalities and cities, with each LGU financing its own facilities. LGUs receive: a) part of the taxes from the national government; b) the internal revenue allotment (IRA); and c) other revenues of the LGUs allocated to the sector such as PhilHealth capitation and reimbursements and grants from external sources. The

confluence of various sources reveals a significant fragmentation in the financing of the health system. In addition, beneficiaries confront out-of-pocket payments for fees, copayments and drugs, whereas the highest-income households pay voluntary premiums to access private health coverage from HMOs.

Since the devolution of health services by the Local Government Code in 1991, the provision of such services, particularly at primary and secondary levels, is in charge of LGUs hence, health is managed through provincial, municipal and Barangay local government offices. The provincial governments are responsible for the provincial and district hospitals while the municipal governments are responsible for the RHUs and BHSs. To prevent the likely negative effects of institutional fragmentation, special importance should be attached to the relationships among programs, among different levels of government and among its institutions.

In the Philippines, over the last two decades, there has been a deep and unfinished discussion on the benefits and difficulties of heath decentralization. The challenge is to achieve a weighted position that takes into account the particular conditions of each case. In order to achieve the most significant changes to the citizen's well-being, the said challenge will find pragmatic answers, encouraging the search for solutions to improve the provision of goods and services by the State. To this end, it is essential to consider the degree of regional productive disparity within the country because it imposes serious limits to the working and financing of decentralized services, particularly to the provision that affects equity in the health's case.

Finally, taking into account the characteristics of the Philippines, it has to be noted that the country still lacks a comprehensive program that assists victims of natural disasters. This pushes poor people to live in dangerous areas, more often in the makeshift lodgings. Agriculture, wherein two thirds of the income of the poor depends, is the most vulnerable to climate changes and to the impact of plagues and diseases. In conclusion, this is an important concern to address because disasters cause serious damage and loss of property, especially to the poor, and destroy their only means of living. If they do not receive assistance, the risk of falling in a perpetual poverty trap is high.

Recommendations:

- Prevent the possible negative effects of the institutional fragmentation by coordinating with different programs and with the different levels of the government and their entities.
- Strengthen the DOH's coordinator role, accompanied by the administration of financial resources for they are the ones that take up the guiding role of the system.
- Search new methodologies of transferring of resources, which makes up for the differences among the different regions. Also, incorporate incentives that allocate spending in order to improve service provision for the needy.
- In the scheme of transfers to LGUs, evaluate the possibility of incorporating the performance-based grants, as positive incentives, to local efforts in order to improve governance, local revenue mobilization, and matching grants that equalize fiscal capacities of local governments.

- At the same time, accountability of LGUs has to be improved.
- Strengthen plans to foresee natural disasters and to mitigate their effects. Implement a program that envisions to assists victims of natural disasters, extending assistance particularly to those poorest households.

Improvements in the Efficiency of the Use of Resources and Management of the System

PhilHealth collects premiums, accredits providers, determines benefits packages and provider payment mechanisms, processes claims, and reimburses providers and beneficiaries. Thus, PhilHealth is responsible of supervision, follow-up and monitoring of the NHIP. The salaries and other operating expenses are financed from premium collection and revenues from the fund's investment returns.
PhilHealth pools fund from all sectors of society: formally employed, direct payments from LGUs, national government budget, and voluntary premiums. All collected resources are managed in a single fund, wherein its performance has resulted in a series of cross-subsidies. As opposed to the PhilHealth risk pool, private health insurance has only limited risk-pooling capacities because of smaller groups. Additionally, HMOs have incentives to adversely select its members, prioritizing the healthier people in the pool. As a result, it leads to the cream-skimming effect.

Recommendations:

- Reinforce the Fact Finding Investigation and Enforcement Department to control and supervise the system and to prevent the proliferation of adverse selection practices of beneficiaries, fraudulent practices by providers and the cleansing of the list of beneficiaries in the system.
- Strengthen initiatives that fight against fraud and abuse of problems. Enhance PhilHealth enforcement activities by accessing third party information from other government agencies.
- Improve the regulation in the medicines-producing-and-distributing sector by taking into account its particular impact on out-of-pocket expenses.
- Improve both the health regulation and the system of information of the private sector regarding their existing coverage plans and their provision of benefits.

Achieving Adequate and Sustainable Financing in the Health System

The arguments developed in this study have aimed to show that the financing and resources of the Philippines' health system are inadequate to reach the goal of accessing the universal coverage. This is the most important challenge that exceeds the health policies' scope. Even if the major improvements are not considered in the coverage, it is expected that the resources demands are rising.

The combination of low public spending on health and high share of private spending is the most critical aspect of the system that scarcely meet its objective of developing a universal insurance coverage for all Filipinos. The high private spending means that the poorest households will depend on the expansion and effective range of subsidized coverage programs. In turn, the lower middle-income households will have serious difficulties in achieving the universal coverage.

The new Sin Tax Law will lead to a significant increase in the health budget. It is essential to keep this trend of increasing funding, especially considering that the success of the policy against the tobacco and alcohol consumption will reduce the funding of the sector. Additionally, the new resources should be prevented from replacing (total or partially) the existing ones. However, the challenges posed by the health system to achieve universal coverage will require increased funding.

Additionally, based on the NHIP actuarial study, there are serious concerns on the long-term financial sustainability of PhilHealth. These are under scenarios that do not involve drastic reforms in the scope of programs that they are funding.

Recommendations:

- Increase public spending on health.
- Examine the possibility of increasing payment fees on salaries allotted to the financing of the employed program.
- Increase the collection efficiency, the compliance rate and the number of months paid in order to boost revenues and to impose mandatory coverage in the informal sector, overseeing the persistence and continuity of premiums payment by its members.
- Design public policies that predict future changes in the demand of intervention. It has to be motivated by the demographic changes. Moreover, the epidemiological profile of the population needs to be done as well.

Final Thoughts

Despite the effort and progress and the significant reforms made towards the improvement of the Filipinos' health coverage, there is still a long way to solve equity problems. According to the principle of solidarity, everyone should have access to an adequate package of health care and no family should be catastrophically burdened by the cost of illness. The principle of solidarity is directly related to the equity in financing and financial risk-protection. The former means that people should contribute on the basis of their ability to pay rather than to whether they fall ill. On the contrary, if the latter is achieved, it ensures that the cost of care does not put people at risk to financial catastrophe.

The Philippines's health system is highly fragmented. There are three types of fragmentation that can be distinguished in the financing of health systems that affect equity in access to services. First, the problems associated with the high levels of out-of-pocket spending on health should be considered. Second, the fragmentation that comes from the differences of those within formal social security coverage from those with work in the informal sectors of the economy should also be reflected upon. Finally, the territorial fragmentation that derives from the existence of health systems at the sub-national level, with different levels of coverage reflecting the socioeconomic conditions of each place, should also be considered a factor. Thus, the inhabitants of the same country have different levels of coverage in the public sector due to its geographical location.

In order to reach the ambitious universal and target equitable health coverage, many complex tasks are required. This needs to be considered as a long-term vision to be fulfilled after lengthy and difficult path of reforms. Given the social consensus on this vision, the path should consider the financial management required in order to move in a certain direction. Furthermore, there should also be policy space to address these reforms. On the other hand, in the particular case of the Philippines, it must be considered that many of the problems of the system are part of the more general problem of development.

It is also necessary to make two additional clarifications. First, the shortage of resources is not a problem unique to health but it is the result of a more general concern about the difficulties that the Philippines is facing with the increasing tax burden. Second, it clearly reflects that this is not only a matter of increasing the available resources to the sector but a matter of efficiently using them.

In order to acquire reforms, there have been steps justified by the difficulties encountered in the course of this research. For instance, the contributory funding is a factor of tax systems that leads to fragmentation. However, even if it is desirable to exclusively address the funding with general taxation, there are difficulties that the Philippines faces in raising taxes. It forces to keep tax burdens on wages during a transition (of unpredictable duration) so that the cost of maintaining the segmentation of the sector is longer than the desired ones. There is no doubt that the different aspects of health sector reform should be analyzed as a whole. And this reform has to be put in the broader context of the economic growth and social development of the Philippines.

Appendix Table 1: Selected Statistics by Region

Region	Population	Human Development Index (2000)	GINI Coefficient ratio (2009)	Poverty % (2009) *1	Infant Mortality Rate (2008)	Average income (2009 in billion U$S)	Revenue collections per capita (U$S 2010)	Public hospital beds per 100.000 pop *2
Philippines	48,098,460	0.66	0.45	26.48	22.00	4.28	410	103
NCR	5,925,884	0.89	0.40	3.96	29	7.40	2819	286
CAR	914,432	0.57	0.42	22.94	24	4.55	83	184
I Ilocos	2,922,892	0.65	0.41	23.31	38	3.87	48	68
II Cagayan Valley	1,919,091	0.63	0.44	18.81	24	3.76	42	103
III Central Luzon	4,909,938	0.67	0.37	15.27	20	4.59	90	75
IV a	4,603,435	0.65	0.41	13.89	37	5.18	192	64
IV b	1,408,040	0.65	0.40	34.96	19	2.93	37	117
V Bicol	3,476,982	0.58	0.42	45.09	39	3.16	33	73
VI Western Visayas	4,525,615	0.59	0.42	31.18	31	3.31	52	72
VII Central Visayas	3,787,374	0.57	0.46	35.51	45	3.83	87	74
VIII Eastern Visayas	2,799,534	0.55	0.48	41.43	14	3.33	34	78
IX Western Mind-anao	1,771,860	0.50	0.47	43.06	19	2.99	37	93
X Northern Mind-anao	2,226,169	0.56	0.47	39.59	34	3.43	56	96
XI Southern Mind-anao	2,198,683	0.56	0.43	31.33	23	3.45	95	51
XII Central Mind-anao	1,722,727	0.54	0.44	35.69	21	3.20	41	67
XIII Caraga	1,371,512	0.54	0.46	47.80	56	3.10	46	82
ARMM	1,560,480	0.42	0.29	45.87	83	2.35	19	36

Source: National Statistics Office (2011)

Notes:
Human development index: The regions' values are simple averages of the provinces. As IV-a and IV-b regions are not discriminated by this index, they have the same value.
**1 Poverty % Incidence among population*
**2 Correspond to all the licensed government hospitals in 2010. Source: Bureau of Health Facilities and Services, DOH.*

Appendix Table 2: Population, Land Area and Density by Region, 1980, 1990, 2000 and 2007

Region and province	Population					Density (persons/sq km)			
	2007	2000	1990	1980	Land area (sq km)	2007	2000	1990	1980
Philippines	**88,566,732**	**76,506,928**	**60,703,206**	**48,098,460**	**343,448.3**	**258**	**223**	**177**	**140**
National Capital Region	11,566,325	9,932,560	7,948,392	5,925,884	619.5	2,681	16,032	12,830	9,565
Cordillera Administrative Region	1,520,847	1,365,220	1,146,191	914,432	19,422.0	78	70	59	47
I Ilocos	4,546,789	4,200,478	3,550,642	2,922,892	13,012.6	349	323	273	225
II Cagayan Valley	3,051,487	2,813,159	2,340,545	1,919,091	28,228.8	108	100	83	68
III Central Luzon	9,709,177	8,204,742	6,338,590	4,909,938	22,014.6	441	373	288	223
IV-A CALABARZON	11,757,755	9,320,629	6,349,452	4,603,435	16,873.3	697	552	376	273
IV-B MIMAROPA	2,559,791	2,299,229	1,774,074	1,408,040	29,620.9	86	78	60	48
V Bicol	5,106,160	4,674,855	3,910,001	3,476,982	18,155.8	281	257	215	192
VI Western Visayas	6,843,643	6,211,038	5,393,333	4,525,615	20,794.2	329	299	259	218
VII Central Visayas	6,400,698	5,706,953	4,594,124	3,787,374	15,886.0	403	359	289	238
VIII Eastern Visayas	3,915,140	3,610,355	3,054,490	2,799,534	23,193.7	169	156	132	121
IX Zamboanga Peninzula	3,230,094	2,831,412	2,221,382	1,771,860	17,270.3	187	164	129	103
X Northern Mindanao	3,952,437	3,505,708	2,811,646	2,226,169	20,496.0	193	171	137	109
XI Davao Region	4,159,469	3,676,163	2,933,743	2,198,683	20,357.4	204	181	144	108
XII SOCCSKSARGEN d	3,830,500	3,222,169	2,399,953	1,722,727	22,513.3	170	143	107	77
XIII Caraga	2,293,346	2,095,367	1,764,297	1,371,512	21,478.4	107	98	82	64
Muslim Mindanao	4,120,795	2,803,045	2,075,238	1,560,480	33,511.4	123	84	62	47
Filipinos in Philippine Embassies/ Consulates and missions abroad	2,279	2,851	2,336	-	…	…	…	…	…
Homeless population	-	-	2,876	-	…	…	…	…	…

Source: National Statistics Office (2011)

Appendix Table 3: Basic Social Indicators in Asian Countries

Country	Population (millions)	Population density (people per km²)	Urban population (% of total population)	Adult literacy rate (%)	Life expectancy, both sexes (years)	Life expectancy, women (years)	Life expectancy, men (years)	Population aged 65 years or older (%)	Total fertility rate (children per woman)	Infant mortality rate (deaths per 1000 livebirths) in 2010	Under-5 mortality rate (deaths per 1000 livebirths) in 2010	Maternal mortality rate (deaths per 100000 livebirths) in 2008	Mortality of people aged 15–60 years (deaths per 1000 population) in 2010
Brunei	0.4	66	72%	95%	76	80	75	4%	2.05	6	8	37	104
Singapore	5	7022	100%	94%	81	83	78	9%	1.26	2	3	16	67
Malaysia	28.3	86	68%	92%	72	77	72	4%	2.51	5	5	42	118
Thailand	67.8	132	36%	94%	70	72	66	7%	1.82	9	9	47	150
Philippines	92.2	307	63%	93%	71	74	70	4%	3.03	21	29	84	170
Indonesia	243.3	128	43%	92%	68	73	69	6%	2.13	30	37	229	173
Vietnam	87.3	263	28%	90%	72	76	72	7%	2.03	11	13	64	141
Laos	6.3	27	27%	73%	61	66	63	4%	3.42	49	68	339	216
Cambodia	14.8	82	15%	76%	61	63	59	3%	2.86	50	60	266	243
Myanmar	50	74	31%	90%	56	63	59	5%	2.28	42	55	219	219

Source: Chongsuvivatwong et al (2011)

Appendix Table 4: Household Population by Religious Affiliation and by Sex, 2000

Religion	Both Sexes	Male	Female
Total	76,332,470	38,416,929	37,915,541
Roman Catholic	61,862,898	31,197,055	30,665,843
Islam	3,862,409	1,907,721	1,954,688
Evangelical	2,152,786	1,067,708	1,085,078
Iglesia ni Cristo	1,762,845	889,774	873,071
Aglipayan	1,508,662	765,799	742,863
Seventh Day Adventist	609,570	301,699	307,871
United Church of Christ in the Philippines	416,681	209,647	207,034
Jehovah's Witnesses	380,059	184,489	195,570
Other Protestants	340,765	169,053	171,712
United Methodist Church	305,690	152,516	153,174
Convention of the Philippine Baptist Churches	217,806	106,462	111,344
Church of Jesus Christ of the Latter Day Saints	181,485	89,789	91,696
Bible Baptist	176,112	86,462	89,650
Tribal religion	164,080	84,399	79,681
Philippine Episcopal Church	161,444	82,869	78,575
Association of Fundamental Baptist Churches			
in the Philippines	148,776	72,796	75,980
Southern Baptist	116,546	58,585	57,961
Philippine Benevolent Missionaries Association	107,890	54,200	53,690
Other Baptist	69,158	33,883	35,275
Buddhist	64,969	32,257	32,712
Iglesia Evangelista Methodista en las Islas Filipinas	54,709	27,240	27,469
Lutheran Church - Philippines	46,918	23,846	23,072
Missionary Baptist Churches of the Philippines	25,547	12,807	12,740
Other Methodist	24,520	11,861	12,659
Salvation Army, Philippines	12,596	6,239	6,357
Association of Baptist Churches in Luzon,			
Visayas and Mindanao	11,476	5,668	5,808
International Baptist Missionary Fellowship	7,452	3,670	3,782
None	73,799	38,985	34,814
Unknown	351,632	182,210	169,422

Source: National Statistics Office (2011)

Appendix Table 5: Number of Registered Filipino Emigrants by Major Occupational Group, 1991 to 2010

OCCUPATIONAL GROUPING	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
TOTAL	**62,464**	**64,154**	**66,390**	**64,531**	**56,242**	**60,913**	**54,059**	**39,009**	**40,507**	**51,031**	**52,054**	**57,720**	**55,137**	**64,924**	**69,028**	**82,967**	**80,599**	**70,800**	**79,718**	**86,075**
A. Employed																				
Professional, Technical and Related Workers	7,635	7,299	7,225	6,369	5,416	6,315	5,522	3,425	2,521	6,154	6,932	8,294	7,574	9,540	9,095	12,526	7,816	7,072	6,849	7,932
Managerial, Executive, and Administrative Workers	461	548	823	800	613	635	687	621	740	791	932	890	928	770	1,025	1,449	1,708	1,553	2,001	2,603
Clerical Workers	1,928	1,789	2,079	2,153	2,270	1,600	1,646	1,357	1,339	1,625	1,480	1,377	1,333	1,450	1,454	1,945	2,153	1,979	2,451	2,596
Sales Workers	2,878	3,031	2,116	2,681	2,524	2,704	2,695	1,862	1,793	2,324	2,291	2,830	2,886	3,426	3,358	3,564	3,576	3,037	3,227	2,950
Service Workers	1,965	1,755	1,724	2,436	1,230	1,026	1,103	752	1,129	964	992	1,046	1,139	1,338	1,850	1,192	1,035	1,188	1,600	1,688
Agri, Animal Husbandry, Forestry Workers & Fisherman	1,412	1,177	1,409	1,294	1,020	1,189	1,003	739	693	899	965	979	920	1,098	888	1,086	1,201	948	1,217	1,311
Production Process, Transport Equipment Operators & Laborers	3,113	2,507	2,906	2,616	2,407	2,721	2,204	1,487	1,545	2,025	1,695	1,762	1,759	2,198	1,821	2,260	2,374	2,188	2,801	2,889
Members of the Armed Forces	285	159	84	67	48	41	32	18	357	73	139	358	217	57	116	310	289	226	247	389
B. Unemployed																				
Housewives	12,248	15,076	15,850	14,800	12,863	14,549	13,377	9,545	10,146	11,000	11,561	12,138	11,418	12,014	13,477	17,701	17,677	14,396	15,283	14,036
Retirees	2,107	1,948	2,236	2,241	1,670	2,069	1,897	1,326	1,706	1,898	2,288	2,207	1,936	2,378	2,325	3,152	4,310	3,322	3,821	3,315
Students	13,722	15,324	17,725	16,954	14,760	17,019	14,572	10,552	10,903	12,908	12,731	13,656	13,098	14,990	16,931	20,465	21,151	18,885	20,897	23,145
Minors (Below 7 years old)	4,783	4,913	4,642	4,315	4,216	4,342	3,523	2,497	2,594	3,286	4,060	4,796	4,688	5,880	5,672	6,692	5,820	4,954	5,831	7,162
Out of School Youth	270	325	201	3	6	2	-	-	-	163	371	655	376	677	550	178	307	299	380	457
Refugees	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
No Occupation Reported	9,656	8,303	7,370	7,802	7,199	6,701	5,798	4,828	5,041	6,921	5,617	6,732	6,865	9,108	10,466	10,447	11,182	10,753	13,113	15,602

Source: National Statistics Office (2011)

Appendix Table 6: Labor Force Participation Rate and Employment Status: Total, Urban and Rural, 2001 to 2010 (in thousands and %)

Year/ Area	Labor Force Participation Rate (Percent)	Total Labor Force	Labor Force by Employment Status			
			Employed		Unemployed	
			Number	Percent	Number	Percent
Philippines						
2001	67.1	32,809	29,156	88.9	3,653	11.1
2002	67.4	33,936	30,062	88.6	3,874	11.4
2003	66.7	34,571	30,628	88.6	3,936	11.4
2004	67.5	35,862	31,613	88.2	4,249	11.8
2005	64.7	35,287	32,312	92.2	2,748	7.8
2006	64.2	35,465	32,962	92.0	2,829	8.0
2007	64.0	36,213	33,560	92.7	2,653	7.3
2008	63.6	36,805	34,089	92.6	2,716	6.8
2009	64.0	37,892	35,061	92.5	2,831	7.5
2010	64.1	38,894	36,035	92.6	2,859	7.4
Urban						
2000	63.0	15,147	13,022	86.0	2,125	14.0
2001	64.7	16,013	13,762	85.9	2,251	14.1
2002	65.2	16,581	14,210	85.7	2,371	14.3
Rural						
2000	66.8	15,764	14,430	91.5	1,334	8.5
2001	69.4	16,796	15,394	91.7	1,402	8.3
2002	69.7	17,354	15,851	91.3	1,503	8.7

Source: National Statistics Office (2011)

Notes:

1. Data were revised based on NSCB Resolution 9, Series of 2009 which prescribes the use of the average estimates of the four LFS rounds for the annual figures.

2. Urban and rural classification was no longer applied starting the July 2003 round of the LFS.

3. Details may not add up to totals due to rounding.

Appendix Table 7: Selected Health Output Indicators, 1998-2006

	1998	1999	2000	2001	2002	2003	2004	2005	2006
% of pregnant women with 3 or more pre-natal visits	59.4%	65.6%	64.8%	62.9%	60.5%	64.3%	64.7%	62.3%	61.5%
% of pregnant women given tetanus toxoid vaccination at least twice	68.8%	59.4%	62.5%	54.2%	54.3%	59.6%	60.0%	58.8%	59.1%
% of lactating mothers given Vitamin A	49.1%	54.6%	57.0%	55.3%	52.9%	61.6%	53.2%	54.7%	59.3%
% of livebirths attended by medical professional		69.0%	69.0%	70.0%			68.7%	68.0%	70.0%
% of fully immunized children under 1	84.8%	87.9%	86.5%	81.7%	76.7%	83.7%	84.8%	83.7%	82.9%
% of infants given 3rd dose of Hepa B	37.3%	45.2%	6.2%	41.9%	38.5%	45.2%	45.6%	42.9%	72.9%
% of diarhhea cases amongst children under 5 given ORS	28.4%	25.9%	24.1%	22.4%	17.7%	17.8%	15.5%	14.2%	14.0%
% of pneumonia cases amongst children under 5 given treatment	94.7%	94.5%	93.9%	94.2%	94.7%	97.3%	99.9%	95.3%	96.0%
% of children under 1 given Vitamin A	72.8%	74.0%	76.9%	74.6%	74.7%	89.8%	79.2%	80.0%	81.0%
% of children between 1 and 5 given Vitamin A	89.6%	84.1%	101.3%	95.1%	94.1%	106.1%	111.1%	97.8%	95.7%
TB morbidity rate a/ b/	206.7	203.9	174.1	149.9	154.1	120.3	133.3	137.1	169.9
Malaria morbidity rate a/	96.8	91.8	66.6	39.1	50.3	36.5	24.9	43.3	27.6

Source: Manasan (2011) based on Field Health Service Information System, various years

**Data shown for entire Philippines; data by province and city are also available*

a/ per 100,000 population

b/ respiratory plus other forms of TB

Appendix Table 8: Live Births, Total deaths, Deaths under One Year, Maternal Deaths and Fetal Deaths, 1976 to 2008

Year	Live Births	Total Deaths	Deaths under 1 year	Maternal Deaths	Fetal Deaths
1976	1,314,860	299,861	74,792	1,862	14,865
1977	1,344,836	308,904	76,330	1,909	14,589
1978	1,387,588	297,034	73,640	1,734	14,365
1979	1,429,814	306,427	71,772	1,634	14,586
1980	1,456,860	298,006	65,700	1,609	13,965
1981	1,461,204	301,117	64,415	1,542	13,343
1982	1,474,491	308,758	61,665	1,425	13,465
1983	1,506,356	327,260	64,267	1,502	14,780
1984	1,478,205	313,359	56,897	1,379	11,884
1985	1,437,154	334,663	54,613	1,489	8,948
1986	1,493,995	326,749	52,263	1,573	8,400
1987	1,582,469	335,254	50,803	1,611	10,515
1988	1,565,372	325,098	47,187	1,745	10,641
1989	1,565,254	325,621	43,026	1,579	11,423
1990	1,631,069	313,890	39,633	1,307	11,915
1991	1,643,296	298,063	34,332	1,144	10,776
1992	1,684,395	319,579	36,814	1,394	8,631
1993	1,680,896	318,546	34,673	1,548	9,338
1994	1,645,011	321,440	31,073	1,791	9,291
1995	1,645,043	324,737	30,631	1,488	9,731
1996	1,608,468	344,363	30,550	1,557	9,693
1997	1,653,236	339,400	28,061	1,513	9,706
1998	1,632,859	352,992	28,196	1,579	6,232
1999	1,613,335	347,989	25,168	1,348	9,841
2000	1,766,440	366,931	27,714	1,698	10,360
2001	1,714,093	381,834	26,129	1,768	9,625
2002	1,666,773	396,297	23,778	1,801	9,341
2003	1,669,442	396,331	22,844	1,798	8,986
2004	1,710,994	403,191	22,557	1,833	8,935
2005	1,688,918	426,054	21,674	1,732	10,351
2006	1,663,029	441,036	21,764	1,721	8,458
2007	1,749,878	441,956	21,720	1,672	8,191
2008	1,784,316	461,581	22,351	1,731	8,306

Source: National Statistics Office (2011)

Appendix Table 9: Number of Hospitals by Type and by Region, 2000 to 2010

Year	Philippines	Region															
		NCR	CAR	I	II	III	IV-A	IV-B	V	VI	VII	VIII	IX	X	XI	XII	XIII	ARMM
Government Hospitals																		
2000	623	49	24	36	38	43	98		50	40	56	48	30	17	34	20	33	7
2001	640	50	32	37	39	51	80		50	50	56	48	28	23	32	20	33	11
2002	661	51	27	38	38	56	95		50	53	57	48	24	26	33	20	34	11
2003	662	54	30	37	37	53	97		49	53	60	49	25	30	18	23	35	12
2004	657	51	37	40	36	59	98		49	57	42	40	30	30	21	24	33	10
2005	702	59	37	39	35	58	66	34	50	60	60	48	29	34	16	25	32	20
2006	719	56	38	40	40	61	67	35	51	62	60	49	31	32	19	25	33	20
2007	701	51	37	40	38	60	65	35	50	61	60	48	31	36	19	26	33	11
2008	711	50	36	41	43	59	64	37	50	62	60	46	33	36	19	27	35	13
2009	723	51	34	41	43	60	67	38	48	62	60	50	31	36	20	27	35	20
2010	730	51	38	41	45	60	67	37	48	62	59	51	29	37	20	28	35	22
Private Hospitals																		
2000	1089	130	20	81	45	112	179		84	23	46	30	44	56	134	74	26	5
2001	1068	127	21	82	44	134	166		77	19	46	27	43	64	119	71	25	3
2002	1077	127	18	87	42	136	176		73	19	46	28	41	63	123	69	26	3
2003	1057	129	20	84	45	137	177		72	19	46	27	40	65	93	72	25	6
2004	1068	141	20	85	43	136	179		75	20	47	24	42	70	85	74	21	6
2005	1136	157	20	85	37	144	172	23	74	29	48	27	42	71	95	83	22	7
2006	1202	166	19	83	51	140	192	29	72	24	50	30	44	72	119	79	24	8
2007	1080	132	19	78	46	141	168	25	67	24	47	24	41	72	89	77	22	8
2008	1073	128	19	80	44	138	168	26	66	24	47	24	42	73	88	76	22	8
2009	1098	144	17	80	46	138	169	27	66	24	46	24	41	73	92	79	23	9
2010	1082	132	19	82	46	138	167	27	61	24	46	25	40	72	90	78	24	11

Source: National Statistics Office (2011)

Appendix Table 10: Damages Caused by Major Natural Disasters and by Man-made Disasters, 2010

Disasters	Occurrence	Casualties			Affected		House Damaged		Cost of Damages (million pesos)
		Dead	Injured	Missing	Families	Persons	Total	Partial	
2010	556	766	1,612	148	1,315,069	6,386,781	109,133	186,313	25,281.5
A. Natural Incidents	234	59	57	5	736,838	3,600,799	484	1,766	12,684.2
Earthquakes	127								
Volcanic Activity	9	1			2,834	14,161			12.3
Landslide	28	18	19		756	3,998	51	36	9.3
Flashfloods/Flooding	47	17	10	3	117,972	593,796	115	855	133.0
El Nino	1				477,868	2,389,340			12,107.1
Soil Erosion	1	1	3						
Tornado	8		1		217	1,109	49	204	0.1
Strong Winds	3		2		110	433	29	81	1.4
Whirlwind	1		3		125	625	33	92	1.1
Pest Infestation	1								
Thunderstorm	1				225	997	44	181	
Continuous Rains	2	16	2	2	136,731	596,340	163	317	419.9
Lightning/Thunderstorm	5	6	17						
B. Typhoons	11	136	133	85	543,311	2,596,587	103,334	184,082	12,392.0
Destructive	2	133	133	50	542,867	2,594,367	103,334	184,082	12,392.0
Non-destructive	9	3		35	444	2,220			
C. Human-induced Incidents	311	571	1,422	58	34,920	189,395	5,315	465	205.4
Structural Fires	132	70	79	3	11,822	58,801	5,260	242	205.4
Sea Mishaps	25	16	26	50					
Air Mishaps	5	19	10	3	8	34	8		
Vehicular Accidents	57	211	1,017				7		
Armed Conflict	17	34	39		6,601	34,772	7	220	
Epidemic/Disease Out-break/ Viral Contamination	15	139			14,139	83,910			
Bomb/Grenade Explosions	29	28	187					2	0.1
Mining Incidents	1	1							
Fuel/Chemical Leak/Gas Poisoning	4	8	28		2,000	10,000			
Coal Spill	1								
Oil Spill	1								
FishKill	1								
Electrocution	1	7	1						
Drowning	8	19		2					
Mountain Climbing	1	1	3						
Food Poisoning	3	2				128			
Collapsed Structure	10	16	32		350	1,750	33	1	

Source: National Statistics Office (2011)

Appendix Table 11: Government Health Expenditures by Use of Fund and by Type of Expenditure, 2005

SOURCE OF FUND	AMOUNT (in million PhP)				SHARE (%)		
	PS	MOOE	CO	Total	PS	MOOE	CO
DOH and its Attached Agencies	**6,991**	**6,707**	**67**	**13,764**	**50.8**	**48.7**	**0.5**
Personal Health Care	4,787	4,013	34	8,834	54.2	45.4	0.4
Public Health Care	468	1,886	22	2,376	19.7	79.4	0.9
Others	1,736	808	10	2,555	67.9	31.6	0.4
General Administrative and Operating Cost	1,625	760	10	2,395	67.8	31.7	0.4
Research and Training	111	49	0	160	69.5	30.5	0
Other National Agencies	**3,437**	**2,623**	**26**	**6,086**	**56.5**	**43.1**	**0.4**
Personal Health Care	2,604	1,845	22	4,471	58.2	41.3	0.5
Public Health Care	172	167	0	339	50.6	49.3	0.1
Others	661	612	4	1,276	51.8	47.9	0.3
General Administrative and Operating Cost	612	589	3	1,204	50.8	49.0	0.3
Research and Training	49	22	0	71	68.8	31.0	0.2
Local Government	**16,028**	**6,748**	**495**	**23,271**	**68.9**	**29.0**	**2.1**
Personal Health Care	3,994	1,87	145	6,008	66.5	31.1	2.4
Public Health Care	7,457	3,093	269	10,819	68.9	28.6	2.5
Others	4,577	1,785	81	6,443	71.0	27.7	1.3
General Administrative and Operating Cost	4,577	1,785	81	6,443	71.0	27.7	1.3
Research and Training	0	0	0	0			

Source: National Health Accounts (2005)

Note: DOH: Department of Health; PS: Personal Services; MOOE: Maintenance and Other Operating Expenses; CO: Capital Outlay, no year

Appendix Table 12: Early Childhood Mortality Rates by Region, 2003 and 2008

Region		Infant Mortality Rate		Child Mortality Rate		Under-five Mortality Rate	
		2003	2008	2003	2008	2003	2008
NCR	National Capital Region	24	22	8	3	31	24
CAR	Cordillera Administrative	14	29	20	-2	34	-31
I	Ilocos	29	24	11	2	39	26
II	Cagayan Valley	28	38	8	-8	35	-46
III	Central Luzon	25	24	6	5	31	29
IV-A	CALABARZON	25	20	6	8	31	28
IV-B	MIMAROPA	44	37	25	13	68	49
V	Bicol	28	19	15	16	43	34
VI	Western Visayas	39	39	11	5	50	43
VII	Central Visayas	28	31	11	4	39	35
VIII	Eastern Visayas	36	45	22	19	57	64
IX	Zamboanga Peninsula	27	14	17	17	43	31
X	Northern Mindanao	38	19	11	8	49	27
XI	Davao	38	34	10	10	47	44
XII	SOCCSKSARGEN	27	23	10	11	37	34
XIII	Caraga	35	21	14	10	49	30
ARMM	Muslim Mindanao	41	56	33	40	72	94

Source: National Health Accounts (2010)

Appendix Table 13: Assumptions under Different Projected Scenarios

Scenario	Assumptions
Scenario 1	Status Quo:
	2.5% contribution rate
	PhP 4,000 salary floor
	PhP 30,000 salary cap
Scenario 2	Increase in benefits (expanded case rates and Access benefits)
Scenario 3	New premium structure:
	3% contribution rate
	PhP 7,000 salary floor
	PhP 50,000 salary cap
Scenario 4A	Increase in contribution & benefits with discounts:
	PhP 600 in CY 2012 and PhP 1,200 in CY 2013 for LGU-Poor
	PhP 1,200 in CY 2012 and 2013 for IPP and OWP
	Allowance for administrative expense (12% of collection and 3% of interest income)
Scenario 4B	Allowance for administrative expense (10% of collection and 3% of interest income)
Scenario 4C	Allowance for administrative expense from 4% to 5%
Scenario 5	Decrease in membership for LGU-Poor by 50% in CY 2014
Scenario 6A	Increase in minimum annual contribution to PhP 3,000 in CY 2016
	PhP 9,000 salary floor at 3% contribution rate
	No decrease in LGU-Poor membership
Scenario 6B	Increase in minimum annual contribution to PhP 3,600 in CY 2016
	PhP 10,000 salary floor at 3% contribution rate
	No decrease in LGU-Poor membership
Scenario 7	Increase in minimum annual contribution to PhP 3,600 and contribution rate to 3,5% in CY 2016
	PhP 9,000 salary floor
	No decrease in LGU-Poor membership

Source: NHIP (2012)

LIST OF INTERVIEWEES

(Interviews are cited in the text by the last name of the person interviewed, and 2012-I).

Government Agencies

PHILHEALTH
- Dr. Eduardo Banzon, President and CEO
- Atty. Alexander Padilla, Chief Operating Officer
- Lemuel Untalan, Senior Manager, Corporate Planning Department
- Dr. Shirley Domingo, Vice President, PRO NCR-Rizal

NATIONAL ANTI-POVERTY COMMISSION (NAPC)
- U/Sec. Patrocinio Jude Esguerra, National Anti-Poverty Commission

DEPARTMENT OF HEALTH
- Dr. Lilibeth C. David, Director IV, Health Policy Development and Planning Bureau
- Fely Mariano, Bureau of Health Facilities and Services

DEPARTMENT OF SOCIAL WELFARE AND DEVELOPMENT
- Undersecretary Alicia Bala

DEPARTMENT OF BUDGET AND MANAGEMENT
- Director Cristina Clasara
- Director Dante De Chavez

PHILIPPINE INSTITUTE OF DEVELOPMENT STUDIES
- Dr. Oscar Picazo

International Institutions

WORLD HEALTH ORGANIZATION
- Dr. Soe Nyunt-U, Country Representative

WORLD BANK
- Dr. Bobby Rosadia, Health Specialist

Private Sector/Health Maintenance Organizations

ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATION OF THE PHILIPPINES, INC. (AHMOPI)

- Mr. Carlos Da Silva, President, - FES Office

Non-Governmental Organizations

- Dr. Sylvia Claudio, Executive Director, of LIKHAAN and UP Center for Women and Studies
- Ms. Princess Nemenzo, Executive Director of Women's Health-Philippines
- Mr. Patrick Patino, Executive Director of Institute for Popular Democracy

Academia

UNIVERSITY OF THE PHILIPPINES SCHOOL OF ECONOMICS

- Dr. Joseph J. Capuno
- Dr. Orville Solon

UNIVERSTY OF THE PHILIPPINES-NATIONAL INSTITUTE OF HEALTH/UNIVERSAL HEALTH CARE STUDY GROUP

- Dr. Alberto Romualdez, Jr., MD
- Dr. Ernesto Domingo, MD
- Dr. Ramon Paterno, MD, MPH
- Dr. Cecilia S. Acuin, MD, PhD

LIST OF VALIDATION WORKSHOP PARTICIPANTS

We would like to acknowledge the invaluable help of the attendees of the validation launch of this study on February 07, 2013 at the Hotel InterContinental Manila. Their feed-back and input on the study's findings not only enriched the discussion, but also the final version of the present document.

In attendance were the following:

Government Agencies and International Organizations

PHILHEALTH/ PHIC
Ms. Nerissa Santiago, Vice President, Office of the Actuary
Mr. Lemuel Untalan, OIC, Corporate Planning Office

Department of Health (DOH)
Dr. Lilibeth C. David, Director IV, Health Policy Development and Planning Bureau

National Anti-Poverty Commission (NAPC)
Mr. Elmer Gomez
Ms. Susan Obedoza

Department of Budget and Management (DBM)
Ms. Yolanda Reyes
Ms. Micaela Alvarez

Department of Social Welfare and Development (DSWD)- Pantawid Pamilya
Mr. Jose Castillo
Ms. Jennifer Godio
Mr. Hussein Macarambon
Mr. Arjay M. Rosario

Department of Social Welfare and Development (DSWD)- Poverty Reduction Programs Bureau (PRPB)
Ms. Mely S. Pansiunan

World Health Organization (WHO)
Ms. Lucille Nievera

Academe

University of the Philippines School of Economics
Dr. Albert Domingo

Universal Health Care Study Group / UP-Manila Institute of Health Policy and Development Studies
Dr. Cecilia Acuin
Dr. Yves Aquino
Dr. Emer Faraon
Ms. Caterina Lagdameo
Ms. Stephanie Katalbas
Dr. Albert Romualdez

Civil Society Organizations

Action for Economic Reforms (AER)
Ms. Luz Anigan

Active Citizenship Foundation (ACF)
Mr. Marlon Cornelio

AKBAYAN! Citizens' Action Party- Women's Committee
Ms. Ellen B. Barrel
Ms. Merci E. Gonzales
Ms. Jocelyn V. Padolina
Ms. Chona Prado
Ms. Raquel E. Tolentino

Action and Solidarity for the Empowerment of Teachers (ASSERT)
Mr. Fidel Fababier

Association of Health Management Organization of the Philippines, Inc. (AHMOPI)
Mr. Carlos da Silva

Construction and Building Workers Alliance of Caloocan (CBWAC) – Alliance of Progressive Labor (APL)
Mr. Mario D. Parde II

Center for Agrarian Reform, Empowerment and Transformation (CARET)
Ms. Imelda Limueco-Lucio

Center for Youth Advocacy and Networking (CYAN)
Mr. Alvin Quintans

Health Justice Philippines
Mr. Ralph Degollacion

Institute of Politics and Governance (IPG)
Ms. Lett Tabora

Kampanya Para sa Makataong Pamumuhay (KAMP)
Ms. Mercy L. Fabros

Gamut Sa Abot-Kayang Presyo
Ms. Ludy Casaña

Labor Education and Research Network (LEARN)
Mr. CJ Castillo
Ms. Hazel Dimacale
Mr. Yolanda P. Pinzon

Minimal Government Thinkers
Mr. Nonoy Oplas

Public Services Labor Independent Confederation (PSLINK)
Ms. Jillian Roque

WAGE-APL Women
Ms. Evelyn Ornopia

WomanHealth Philippines
Ms. Ana Maria Nemenzo
Ms. May-I Fabros
Ms. Mercy Fabros

BIBLIOGRAPHY

"A Case Study of the Decentralization of Health and Education Services in the Philippines." (2008). Quezon City: University of the Philippines, HDN Discussion Paper Series, PHDR Issue 2008/2009 No. 3.

Acuin, Cecilia S., Lim, B.A. T., Lasco, P. G. D. (2010, October – December) *Universal Health Care fo Filipinos: A Proposal.* University of the Philippines: Manila National Institutes of Health. In: Acta Medica Philippina. Volume 44, Number 4.

Ahmad, E., D. Hewitt, y E. Ruggiero, (1997), "Assigning Expenditure Responsibilities" in Ter Minassian, T. (ed.) *Fiscal Federalism in Theory and Practice,* IMF, Washington.

Asian Development Bank. (2007) *Country Diagnostics Studies, Philippines: Critical Development Constraints.* Manila: Economics and Research Department. Retrieved from http://www.rvrcvstarr.aim.edu/Library%20CV%20Starr/Other%20Publications%20of%20Note/ADB/Philippines%20Critical%20Development%20Constraints.pdf on June 29, 2012.

ASEAN Social Security Association. (2012). Retrieved from .http://www.asean-ssa.org/ on September 10, 2012.

Banzon, E. (2008). "Successes and failures in expanding and deepening coverage of health protection-the Philippine Experience," Presentation at the WB Managing Vulnerability in East Asia, Bangkok, Thailand, June 25-26.

Bautista, Maria Christina G., Yap, E.C. and Soriano, E.S. (1999). *Local Governments' Health Financing Initiatives: Evaluation, Synthesis and Prospects for the National Health Insurance Program in the Philippines.* Small Applied Research 7. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

Bird, R. (2000). "Intergovernmental Fiscal Relations in Latin America: Policy Design and Policy Outcomes" Technical Paper Series, BID, Washington.

Bodart, C. & Jowett, M.(2007). "Insuring the Very Poor against Health Risks in the Philippines" in *Extending Social Protection in Health. Developing Countries' Experiences, Lessons Learnt and Recommendations.* City of Eschborn: Deutsche Gesellschaftfür Technische Zusammenarbeit (GTZ) GmbH. Retrieved at http://www.socialhealthprotection.org/pdf/SHI-ConfReader_Druckkomprimiert.pdf on November 10, 2012.

Brown, Ch. y W. Oates (1987),"Assistance to the Poor in a Federal System" en Journal of Public Economics 32, North Holland.

Bureau of Labor and Employment Statistics (BLES). Retrived at http://www.bles.dole.gov.ph on September 25, 2012.

Current Labor Statistics. (2011). Retrieved at http://www.bles.dole.gov.ph/PUBLICATIONS/Current%20Labor%20Statistics/index.html onApril 16, 2012.

Capuno, Joseph (2006). "Social Health Insurance for the Poor Programs of the Philippines and Vietnam." Philippine Journal of Development..Vol. xxxiii, No 1 & 2.

Cetrángolo, O. J. C. Gómez Sabaini.y P. Velasco (2012). "Los caminos alternativos elegidos para aumentar el nivel de carga tributaria en los países de la región" (mimeo), Banco Interamericano de Desarrollo, Washington.

Caragay, R.N.& Villegas, KS. (2008). "Validation of Coverage, Accreditation and Benefit Package Formulation of PhilHealth for the Year 2005." Manila: PhilHealth, Corporate Planning Department.

Carmelo, Mesa-Lago, Viajar, V. D and Castillo, R. C. J. (2011). *Pensions in The Philippines: Challenges and Ways Forward.* Pasig City: Friedrich-Ebert-Stiftung Philippine Office.

Chongsuvivatwong, V., et al (2011). "Health and Health-Care Systems in Southeast Asia: Diversity and Transitions." .Lancet, 377 (9763):429-37.

Department of Budget and Management. (2012). Our Budget, (2007-2012). Retrieved at http://www.dbm.gov.ph/ on June 26, 2012.

Department of Finance. (2012). *Formulation, Institutionalization and Administration of Fiscal Policies, Statistics and Economic Data.* Retrieved at http://www.dof.gov.ph/?page_id=4024 on October 20, 2012.

Department of Health.(2005). *National Objectives for Health Philippines*, 2005-2010. Manila. Retrieved at http:// www.doh.gov.ph on July 8, 2012.

Department Order No. 2010-0036. (2010). *The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos* Philippines: Department of Health.

Department Order No. 2011-0188. (2011). *Kalusugan Ppangkalahatan Execution Plan and Implementation Arrangements.* Philippines: Department of Health.

Diokno, Benjamin. (2012). *Fiscal Decentralization After 20 Years: What Have We Learned? Where Do We Go From Here?.*The Philippine Review of Economics, Vol. XLIX, No.1, University of Philippines.

Eaton, Kent. (2002). Politicians and Economic Reform in New Democracies : Argentina and the Philippines in the 1990s . USA: The Pennsylvania State University.

Economic Report 12.01. *Philippine Economy: Sluggish in 2011, Bullish in 2012.* (2012). Retrieved at http://www.senate.gov.ph/publications/ER%202012-01%20-%20March%202012.pdf on August 5, 2012.

FES. (2011). *Migrant Workers' Right to Social Protection in ASEAN.* Case Studies of Indonesia, Philippines, Singapore and Thailand. Singapore.

Gwatkin, D. (2000). "*Health Inequalities and the Health of the Poor: What do We Know? What can we do?"* Bulletin of the World Health Organization, 78, 3-18.

Gertler, P.and Solon, O.(2002). *Who Benefits From Social Health Insurance? Evidence from the Philippines.* California: University of California. Retrieved at http://faculty.haas.berkeley.edu/gertler/working_papers/gertler-solon%20philippines%20hopsital%20paper%203-1-02.pdf on June 30, 2012.

Gloor, Reiner (2012). Health for all. Perspectives from pharmaceutical and health care association of the Philippines on socialized health care. Available at: http://www.bworldonline.com/weekender/content.php?id=50268 (April 15)

Guevara, Mlilwida M. (n/d). The fiscal decentralization process in the philippines: lessons from experience. Available at: http://www.econ.hit-u.ac.jp/~kokyo/APPPsympo04/Philippine-Guevara.pdf (June 5)

Gwatkin, D. (2000) Health inequalities and the health of the poor: What do we know? What can we do? Bulletin of the World Health Organization, 78, 3-18.

Hausmann, Ricardo, Laura D. Tyson, SaadiaZahidi (2008). The Global Gender Gap Report 2008. World Economic Forum. Geneva, Switzerland 2008. Available at: https://members.weforum.org/pdf/gendergap/report2008.pdf (July 1)

Herrin, A. and Lavado, R.(2011). *Equity and Financial Risk Protection in the Philippines.* Senior Policy Seminar. May 3-5, 2012.

International Monetary Fund. (2012). IMF Country Report No. 12/49 . The Philippines, 2011 Article IV Consultation. Washington, D.C.

IMF Country Report No. 12/60. Philippines: Technical Assistance Report on Road Map for a Pro-Growth and Equitable Tax System. (2012). Washington, D.C.

Jowett, Mathew. (2004). "The Philippines: One Health Plan for All." Social Health Insurance Systems of Solidarity Health, Education, Social Protection Sector Project Social Health Insurance. Experiences from German Development Cooperation. Germany: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

Jowett, M. and Hsiao, W.. (2005)."Extending Coverage beyond the Formal Sector."

Llanto, Gilbert. (2012) The Assignment of Functions and Intergovernmental Fiscal Relations in the Philippines: 20 Years after Decentralization. University of the Philippines:The Philippine Review of Economics. Vol. XLIX, No.1.

Manasan, Rosario. (2011). "Expanding Social Health Insurance Coverage: New Issues and Challenges." Discussion Paper Series No. 2011-21. Makati City: Philippine Institute for Development Studies.

Mason, A. W., Racelis, R. H., and Russo, G. (2002). "Policies, Programs and Health Care Expenditures for People Age 65 and Over in the Philippines." *Aging Populations, Health Systems and Policy Reform Study and Aboutt Associates/ Partners for Health Reform Plus.* Honolulu: East-West Center.

Modol, Xavier. (2008). *Technical Assistance to the Health Sector Policy Support Programme: PhilHealth's Outpatient Benefit Package Evaluation.* A European Union Funded Programme managed by the EC Delegation and the DOH.

Musgrave, R. y Musgrave, P. (1993). Hacienda Pública. Teórica y Aplicada. Madrid: Quinta Edición, McGraw-Hill.National Anti-Poverty Commission. 2011. *"Draft Poverty Program of the Aquino Administration (2010-2016), Parts 1 and 2."* Prepared by the Cluster Secretariat, Human Development Cluster, August 11.

National Health Accounts. (2010). National Statistical Coordination Board. Retrieved at http://www.nscb.gov.ph/stats/pnha/ on August 10, 2012.

National Health Accounts. (2012). *Global Health Expenditure Database.* Retrieved at

http://www.who.int/nha/expenditure_database/en/

National Health Insurance Program. (2012), *CY 2011 Actuarial Valuation Report.* PhilHealth: Office of the Actuary.

National Statistics Office (NSO) [Philippines] and ICF Macro. (2009). *National Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

National Statistics Office (NSO) [Philippines]. (2011). *The Philippine Statistical Yearbook.* Makati City: National Statistical Coordination Board.

Oates, W. (1977). Federalismo Fiscal, Instituto de Estudios de Administración local, Madrid. Ahmad, E. y Craig, J. (1997). "Intergovernmental Transfers" en Ter-Minassian, T. (ed.) *Fiscal Federalism in Theory and Practice.* Washington: IMF.

Ofreneo, Rosalinda Pineda, Manasan, R. G. and Orbeta, Jr., A. C. (2012). *Strengthening Social Protection Components and Strategies in the Philippines: A Compilation of Social Protection Think Papers.* Philippines: Department of Social Welfare and Development United Nations Development Programme and National Economic and Development Authority.

Orbeta, Aniceto Jr. (2011). *Social Protection in the Philippines: Current State and Challenges.* Discussion Paper Series No. 2011-02. Makati City: Philippine Institute for Development Studies.

Overview of the Philippine Health System and the implementation Framework for Health Reforms. (2008). Manila. Retrieved at http:// www.doh.gov.ph onJune 29, 2012.

PAHO. (2002). *La Salud en las Américas.* Edición de 2002. Washington D.C. Retrieved at http://www2.paho.org/hq/dmdocuments/salud-americas-2002-vol-1.pdf on September 10, 2012.

Paradox and Promise in the Philippines: A Joint Country Gender Assessment. Manila: Asian Development Bank, Canadian International Development Agency, European Commission, National Commission on the Role of Filipino Women, United Nations Children's Fund, United Nations Development Fund for Women, United Nations Population Fund.

PhilHealth Annual Report. (2010).*Labinlimang Taon ng Segurong Pangkalusugan Para sa Lahat.* Retrieved at: http://www.philhealth.gov.ph/about_us/annual_report/ar2010.pdf on August 10, 2012.

Philippine Constitution. (1987). Retrieved at: http://www.gov.ph/the-philippine-constitutions/ on October 20, 2012.

PhilHealth. (2005). The PhilHealth Chronicles. Corporate Planning Department.

Quality Improvement Demonstration Study (QIDS). (2008). *Underutilization of PhilHealth Benefits for Hospitalization.* A DOH-PhilHealth-UCSF-UPecon Partnership. Research Bulletin No. 9

Racelis, R. H. and Cabegin. E. A. (2001). *Income Inequality, Education, Working Females and the Elderly: A Review of Philippine Research.* Honolulu: East West Center: Population, Development, and Inequality Project.

Racelis, R. H, et al.(2007). "The National Health Accounts of the Philippines: Continuing Development and New Findings."Capuno and Orbeta. (Eds.).*Human Capital and Development in the Philippines*. Manila: PIDS.

Reforming Social Protection Policy: Responding to the Global Financial Crisis and Beyond. (2009). Discussion Paper Series No. 2009-22. Makati City: Philippine Institute for Development Studies.

Republic Act 9710. (2008). *An Act Providing for the Magna Carta of Women. Metro Manila: Second Regular Session*, Congress of the Philippines.

Romeo, Raymond Santos. (2011).*The Internal Revenue Allotment: A Review of Legislative, Executive and Judicial Decisions.* Philippines: L.J. 845.

Schneider, P. and Racelies, R.(2004). *The Impact of PhilHealth Indigent Insurance on Utilization, Cost, and Finances in Health Facilities in the Philippines.* Bethesda, MD: The Partners for Health Reform Plus Project, Abt Associates Inc.

Senate Economic Planning Office. (2012). Budget Report. *The President's 2013 Budget: the Macroeconomic and Fiscal Perspectives.* Retrieved at: http://www.senate.gov.ph/publications/BN%202012-01%20-%20Macroeconomic%20assump.pdf on July 5, 2012.

Solon, Orville, Quimbo, S. A. and Panelo, C. I. A. (2003). *Financing Health Care For Poor Filipinos. Working Paper Series No. 2004-8.*

Stiftung, Friedrich Ebert. (2011). *Keeping People Healthy and Far from Hospitals: Holding Local Governments to Account for Outpatient Cure and Diagnostics, IPD-FES.* Institute for Popular Democracy.

TamangSagot (TS). (2012). *PhilHealth's Frequently Asked Questions.* Retrieved at: http://www.philhealth.gov.ph/about_us/philhealth_faqs.pdf on June 1, 2012.

Tan-Torres, Tessa. (1995). *A Study on Primary Health Care Services in the Philippines.* Discussion Paper Series No. 95-20. Makati City: Philippine Institute for Development Studies.

Tangcharoensathien Viroj, Patcharanarumol Walaiporn, Ir Por, Aljunid Syed Mohamed, Ghufron Mukti Ali, Akkhavong Kongsap, Banzon Eduardo, Huong Dang Boi, Thabrany Hasbullah and Mills Anne. (2011). *Health-Financing Reforms in Southeast Asia: Challenges in Achieving Universal Coverage. Health in Southeast Asia Series.* Retrieved at www.thelancet.com.

"The PIPER Forum on 20 Years of Fiscal Decentralization: A Synthesis." (2012). *The Philippine Review of Economics*, Vol. XLIX, No.1.

The Role of Private and Local Government Health Insurance Schemes in Achieving Universal Coverage: Opportunities and Risks Health Policy Notes. (2009). Volume 5: Issue 2.

The World Bank Database. (2012). Retrieved athttp://data.worldbank.org/indicator/SP.DYN.LE00.IN on September 10, 2012.

Toward Financial Risk Protection: Health Care Financing Strategy of the Philippines 2010-2020. (2010). Health Sector Reform Agenda Monograph No. 10.

United Nations. (2008). Department of Economic and Social Affairs. *Statistical Yearbook. Fifty-Second Issue.* Retrieved at http://unstats.un.org/unsd/syb/syb52.pdf.

UNDP Webpage. (October 2012). Retrieved at http://hdrstats.undp.org/en/indicators/67106.html.

U.S. Agency for International Development. (2005). *Study on PhilHealth Operational Issues Conducted in Six Selected LGUs.* Deliverable No.28. Retrieved athttp://erc.msh.org/LEAD_CD/D_Partnership_Arrangements/PhilHealth_Operational_Issues.pdf on June 5, 2012.

US-SSA, Social Security Programs. (2012). Retrieved at http://www.ssa.gov/policy/docs/progdesc/ssptw/2010-2011/asia/philippines.html on October 20, 2012.

Weber, Axel and Piechulek, Helga. (2009). *The Impact of the Global Recession on the Poor and Vulnerable in the Philippines and on the Social Health Insurance System. Discussion Paper. Retrieved at: http://s3.amazonaws.com/zanran_storage/www.adb.org/Conte*ntPages/82475389.pdf on June 10, 2012.

World Bank. (2011). Philippine Health Sector Review. *Transforming the Philippine Health Sector: Challenges and Future Directions.* Retrieved at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/08/05/000386194_20110805013231/Rendered/PDF/635630WP0Box361516B0P1190 6800PUBLIC00ACS.pdf on July 5, 2012.

World Economic Forum. (2008).*The Global Gender Gap Report.* Geneva, Switzerland. Retrieved at: https://members.weforum.org/pdf/gendergap/report2008.pdf on October 19, 2012.

World Health Organization (WHO). (2010). "Health Systems Financing: The Path to Universal Coverage." *The World Health Report.* Switzerland. Retrieved at: http://www.who.int/whr/2010/cover_en.pdf on August 20, 2012.

World Health Organization. *The Philippines Health System Review: Asia Pacific Observatory on Health Systems and Policies.* Retrieved at: http://www2.wpro.who.int/asia_pacific_observatory/resources/Philippines_Health_System_Review.pdf on August 20, 2012.

Yearbook of Labor Statistics 2004 and 2009. (2005 and 2010). Retrived at http://www.bles.dole.gov.ph/ARCHIVES/YLS/2005YLS/ylspage.html&http://www.bles.dole.gov.ph/ARCHIVES/YLS/2010%20YLS/2010YLS.html on April 16, 2012.

Yu Jose, Lydia N. (Ed.). (2011). *Civil Society Organizations in the Philippines: A Mapping and Strategic Assessment.* Quezon City.

Friedrich Ebert Stiftung
2601 Discovery Centre, #25 ADB Avenue
Ortigas Center, Pasig City 1600 Philippines
Tel. Nos.: +63 2 6346919, 6377186 to 87
Fax No.: +63 2 6320697
Email: info@fes.org.ph
Website:www.fes.org.ph