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This is a paper in 3 parts: a description of current problems, followed by a fearless forecast of what is to become of our health care in about 10 years time and what can be our collective measures to arrest a projected adverse outcome.

A. Current situation:

Health is a fundamental right guaranteed by our constitution to all citizens. Health care, on the other hand, depends on what each citizen can pay. Health inequity is very evident in our society. The standard in health care for the rich in our country is far different from that for the poor, and this disparity is growing. But for whatever situations, health care is never free. Someone has to pay for it.

The introduction of the Local Government Code of 1991, though well-meaning, has resulted in the unexpected fragmentation of health care. Local governments take care of primary health at the municipal level, while provincial governments are responsible for district and provincial hospitals. The central government health office has exercised little influence over the autonomous local government units in this area.

Further fragmentation exists between public health programs (population health) and clinical care (patients), between general practitioners/community health care providers and clinical super-specialists, between government services and private health care, between central health office and decentralized local health care units. Ironically, international donor agencies and NGOs perpetuate the fragmentation by taking over services piecemeal which government should provide in an integrated more comprehensive manner.

The Health Sector Reform Agenda (HSRA), though started earlier, was structurally launched in 1999 by Health Secretary Alberto Romualdez, in part to address issues brought about by decentralization. But HSRA suffers from a number of flaws:

1. It assumed that technically competent people in the government health offices can manage or even manage well.

2. It assumed that reforming the public health sector (government) will automatically trigger or translate to private health sector reforms, even without actively engaging the private sector and manage their economic agenda.

3. It does not guarantee legal protection for civil servants in the performance of their regulatory duties; i.e., a regulator can be criminally sued in his/her individual capacity, and he/she can expect no legal support from the government. Because the government does not assert its sovereignty, many ombudsman cases are filed simply to harass DOH officers and discourage them from pursuing the public interest. In fact, recently, there has been irrational argument that government agencies cannot be held accountable responsible for the failure of their staff to perform their jobs or mistakes.

4. No provision has been made to train the next generation of health reformists. School curricula do not cover health sector reform, equity, solidarity and financing. Philippine medical schools produce clinically excellent doctors for global export while villages are left without competent health professionals to tend to the needy. Nursing schools overproduce nurses and are challenged by competency concerns. Schools, CHED, PRC and professional organizations have yet to address this dissonance between supply (schools) and demand (needs of Philippine, not global, society).

No one is held accountable for such failures in health, perhaps due to the devolution and diffusion of responsibilities. Instead, a convenient excuse to poor performance has been lack of resources – human resources, equipment, medicines, time. If nothing is done to improve this system of accountability, the steady increase in population will only stretch resources further in the future, not only in health but also in food security, sanitation, housing, education, jobs.

How can health sector reforms be implemented using the six building blocks for strengthening health systems identified by WHO in 2007? And how will these reforms address health inequities and structure universal health care (not just simply coverage)?

- *Governance*

  Wanted: A creative, visionary leader/manager who understands the complex issues which affect the delivery of health services, thinks progressively and systemically, has the courage to implement unpopular yet rational solutions and the moral fiber to withstand parochial and senseless lobbying from all sides. This leader, not necessarily a medical doctor, will be expected to rally the bureaucracy, as well as outside partners, to work together to improve health services for all citizens.

- *Regulation*

  The weakened regulatory system must be strengthened with improved science and better-equipped laboratories in order to register better products and medicines. This sector has to be educated and armed with the right tools to perform difficult task of protecting the health of society at large. It needs to be protected from both political interference and industrial

capture. Quality of services and goods cannot be sacrificed for political and economic expediency.

- *Financing*

  The current government is concentrating on achieving universal health insurance coverage. Those who are already members should be educated on what their coverage entitles them to. In the meantime, the health insurance system should be reviewed and reformed to be better able to respond to the needs of members, both in-patient and outpatient, both clinical needs balanced with public health preventive programs and to be able to spend available resources most efficiently and to benefit the most number of people, fairly and equitably, not to be transactionally abused. Solidarity is not a strong point of our society and government has an opportunity to influence the public at large on this concept through education and action.

- *Human Resources in Health*

  An integrated approach is needed to strengthen basic science education and research capacity at all levels. The internal urban maldistribution and the external out-migration of health professionals need to be systematically addressed through legal, economic, socio-civic and developmental solutions. But no one seems to be in-charge.

- *ICT in Health*

  The use of information technology in health can translate to improved cost-efficiency and transparency. Ideally, ICT in health would be managed by IT experts knowledgeable in health concerns. However, due to the lack of such hybrid professionals, the cost-efficient use of IT in health is still a futuristic vision blocked by some reluctant stakeholders. This is an area where the government provides a good policy for standardization and utilization while allowing the private sector to drive technology and innovations.

- *Service Delivery*

  Notwithstanding devolution, newer models for health intervention have slowly been developing. The key is in the leadership, whether municipal and provincial leaders will adopt health as a major agenda and spend the necessary funding to improve services. Nevertheless, the private sector will continue to fill in the gap to provide for the health needs of society at large. But, this comes at a steep price to the patients.

While it is true that health is only one concern that any government must face, it is a major issue which will affect other issues. A Whole-of-Government approach must be sought and sustained. We continue to muddle along long past the point when we can afford to. It is time for us to prioritize and exert consistent, unrelenting effort and political will to safeguard our nation's health.

B. Fearless Forecast

What are the major issues in healthcare sector in the Philippines by 2020?

Governance and regulatory inconsistency will dominate the situation on health in the Country. There are just too many stakeholders who only focus on symptomatic solutions and not systemic solutions. Those that attempt to do systemic solutions unfortunately still puts emphasis on policy as the gamechanger. But over the years, we have observed that policies are often guided by personal politics and not by evidence of real need of Publics' health, and implementation of policies have been tactically poor. Four reasons account for such:

1. Lack of leadership and governance training in management implementation
2. The overwhelming desire to change policy overnight without science and consultations
3. The weakness of those in position to challenge the status quo politics.
4. Apathy to sustainability by next generation of professionals and reformists.

The population will still be high and growing, there will be food, sanitation and housing problems and health care will still have the usual inefficiencies (see WHO table on this. WHR 2010). The Philippines will not achieve promised MDG targets and no one will be held accountable. Politics, population (size and level of education), poverty and prices will relentlessly be used as excuses for more legislation, regulations, ordinances, taxes; & violation of the right of law will continue without the fundamental and system solutions addressed. This means that there will still exist a dichotomy of health systems, one for the rich and one for the poor.

Western or first world countries donor and aid agencies will still dominate the agenda on health as health will still be perceived as a gap which a pre-occupied government (due to other concerns – poverty, job creation, education and security) will not address comprehensively. Donor driven vertical programs will further fragment health care unless the DOH, NEDA, DFA, DSWD, DTI fully embrace "whole of government" approach (e.g. Singaporean model). Health NGOs activism and local donors supporting health will experience fatigue. A few big corporations will fund vertical programs as like Gates foundation work, but will need someone or some groups to handle the horizontal integration. A part of this dilemma stems from the fact that traditionally the head of health (secretary of health) is a medical doctor. In theory and practice, the nation's health does not always require a medical doctor to be at the helm as department secretary.

ASEAN policies will continue to be irrelevant notwithstanding the fact that it has put in place challenging issues like mutual recognition agreement for health professionals movement as well as product harmonization. The current problem is in the implementation details.

The issues are better understood by dividing the issues into the 6 building blocks of health care:

- *Governance:* Despite loss of credible progressive thinking leaders, politics will dominate the environment. Political leaders will still be making empty health promises, offering piecemeal solutions and presenting a bad variable precedent factor that will destroy a bottom up approach (demand) for better health services. The rich and the poor gap will widen. OFWs remittances will not create the educated, well informed, economically dependent middle class. The model of provincial government (not municipal) taking responsibility for devolved health will be the partial option of choice for integrating a fragmented health care of over 30 years.

  The problem with Philippines health leadership is that it is not inclusive. Those that are appointed feel that the political anointment and their previous work experience will be the only credible parameters to perform a good job, whose definition is not clearly articulated. These leaders refuse to study or find ways to work together and are saddled by lack of resources to experiment new ways to do reforms. Hence this will lead to a generational gap in leadership. Training institutions are motivated by profit and the lack of socially responsive training courses further this gap, and there is a common reluctance to try to work together and find synergies. The root cause is an issue of the institutional governance.

  Likewise, regulatory capture and poor implementation of global health standards will dominate the scene. A weakened regulatory system due to political and industry influence will further add to the inefficiencies of health care.

  The Philippine societal and statistical norm for respecting culture despite known contribution to corruption and inefficiencies will be the downfall of health governance. At the end of the day, no one is being held accountable. Corruption and fraud will persist in various permutations, and will further add to health inequity.

- *Medicines, supplies, technology:* There will be a critical lack of a breed of assessors/regulatory evaluators who will develop regulatory standards that balance 4 disciplines of epidemiology, economics, public health policy and clinical work. Substandard products and technology will continually dominate the market and will prevail (as long a poverty is used as an excuse for having weak uncompetitive products). Innovations will be largely dependent on the basic researches from neighbouring nations at a large cost to Philippines. The impending patent cliff where no new drugs are developed means the need to find drug security in the Philippines. One such ways is to have scientific development in pharmaceuticals from our biodiversed resources in land and marine life. But we do not have

enough basic scientists and labs, nor do we have venture capitalists investing or inclined in translational research work.

- *Financing:* unless the PHIC as an organization, its philosophy and management are radically reformed, there will be no health equity for all Filipinos. Corruption and ignorance of available benefit package is the main factor for lack of good health financing implementation. Competing resource needs in a poor country (education, housing, jobs, food) will be used as excuse.

- *Human Health Resources:* there remain no rules on the integration of health professionals. Julio Frenck et al in their paper called the Lancet Commission, 21st century health professional education reforms, refer to the need to address the demand requirements of health care amidst the new landscape. In the Philippines, there is great deficiency in addressing the solutions to the problems of fragmentation. Much of the health professional education system in the country has not embraced the study of health reforms. The supply side still and will heavily be focused on economically driven production of clinical professions despite the political rhetorics for better public health systems strengthening. Two of the many reasons have something to do with lack of sound public health educators who are real public health practitioners, and the orientation of health professional schools towards clinical health service delivery that condescendingly looked down on the preventive and promotion health care. Unless the rules of health financing at the moment are radically changed and implemented to provide the carrot and the stick for education reforms to happen in health professional schools, there will never be real health equity. The last time legislators spoke on HRH was on the issue of nurse migration and a committee report in senate was compiled within the last 5 years. This is only part of the problem and belies the naivety of our country leaders in seeking better systemic solutions in integration. We do not have quality assured interconnected schools. PRC exams are not attuned with the changing needs of our country. Research, science and objectivity is not developed and further contributes to deterioration of HRH in the nation or technology development. Health professional organizations will continue to lobby and dictate on the inefficient ways of business that only allows better economic returns for clinicians. Various health professional organizations are part of the problem.

Ethical issues will continue to hound socially irresponsible health practitioners who collude with BIR in evading paying of correct taxes. Unless this is addressed, a dichotomy of health care – one for rich and one for poor will continue to exist.

The DOH 25 year masterplan (started in the mid-2000's) for health civil servants and private health care workers will have variable results, mostly a failure in addressing the supply side of the health system.

By 2020, we will be able to witness whether two theories of change will work:

1. Ateneo School of Medicine and Public Health would have over 300 graduates either under clinical residency training or in practice (first batch of 70 graduating and taking board exams by 2012, another 3 to 5 years of residency, and 5 years of practice and deployment) and ascertain outcome.

2. By 2014, the first batch of 150 or so UP Med graduates with return service of 3 years will take effect. There is great hope for this first batch. But whether there is a cumulative impact or not in our Philippine society, we can assess by 2020.

- *ICT in Health:* There will be great reluctance in embracing a common IT reform platform. The lack of intergovernmental coordination means that private sector will continue to offer divergent softwares that further widen interoperatibility divide. The reforms in IT mean better cost-efficiency and transparency. However, from a government perspective, many rank and file will oppose the entry of these types of reforms.

  IT can be used in CME reforms. And at this stage, using IT systems for an integrated professional education may offer lowered marketing expenditures from pharma industry which makes the latter happy. While CME reforms are timely, but will take a long duration to adopt. Part of this root cause is the lack of hybrids of health-IT knowledgeable expertise. While PRC wants to have a better system for mapping and professionalizing CPE, this will take a duration of time for implementation.

  IT in health improvements may occur in spurts depending on the championship of select groups. The lack of serious analysts of hard data however will hamper the utility and application of such data.

- *Service Delivery:* Fragmentation due to local government health care (a devolved phenomenon) will persist. However, newer models for health intervention are slowly surfacing. The theory of change might be in the political provincial governor. If and when he adopts health as a major provincial agenda, will to spend the requisite funding, may bridge public health needs with clinical services in the hospitals. RH and MCH will continue to work inefficiently and the result is an unpredictable MMR and IMR and U5MR. There will be heavy reliance on the private sector to pick up the health needs of society at large.

C. Collective Actions

A whole of government and whole of community approach is necessary to create the environment to embrace the much needed reforms.

RE-education is needed for those in governance to appreciate that good health can be good politics. Health also creates wealth, and industry must be reminded of their duty to maintain labourers health.

The demand for equitable and better health care services must come from the society. But society must think solidarity and not personal health. This means society needs to pay upfront money that government can be relied upon to utilize and allocate rationally. More investment in public health and preventive/promotive medicine over paying for last resort measures (as like in hospital admissions) must be the regime. On this note, self-inflicted medical conditions should never be covered by group health finances. It is unfair for those who contribute money and opt to stay healthy but those who are irresponsible receive the benefits they do not actually deserve.

The truth is that with a ballooning population, we do not have enough resources to be shared with the entire sick society when the time comes. It will come to rationing one day, and yet this does not guarantee health equity.

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