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Overview of Health Sector Reform in the Philippines and Possible Opportunities For Public-Private Partnerships

MARIA ELENA B. HERRERA, FASP, PHD
FRANCISCO L. ROMAN, DBA
FACULTY, ASIAN INSTITUTE OF MANAGEMENT

MARIA CRISTINA I. ALARILLA
RESEARCHER, ASIAN INSTITUTE OF MANAGEMENT

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THE AUTHORS

MARIA ELENA B. HERRERA, FASP, PHD
AIM Executive Education and Lifelong Learning Center

FRANCISCO L. ROMAN, DBA
AIM W. SyCip Graduate School of Business

MARIA CRISTINA I. ALARILLA
AIM Ramon V. del Rosario Sr. Center for Corporate Social Responsibility

Overview of Health Sector Reform in the Philippines and Possible Opportunities for Public-Private Partnerships[1]

Maria Elena B. Herrera, FASP, PhD and **Francisco L. Roman, DBA,** Authors
Maria Cristina I. Alarilla, Researcher

Analysis of the sector's key participants—the hospitals, health workers, clinics, and the insurance system—suggests a system failure. Inadequate budgets, insufficient equipment, declining involvement of the government at the national level, unclear systems of accountability and lack of hospital facilities in rural areas are just some of the problems plaguing the Philippine health care system.

The potential public-private partnerships (PPP) in the Philippine health sector include (1) creating a regulatory framework for licensing and accrediting facilities and professionals; (2) pooling resources in private and public sectors through social health insurance where government provides tax-generated funding with private premiums and provides subsidies for indigents; and (3) subcontracting the provision of medical services or operation of healthcare facilities to the private sector.

Despite formidable operating constraints, the paper concludes that PPP in the health sector may alleviate the issue of inequitable access to health care, particularly for the inadequately serviced rural poor. Furthermore, the structure of policies and laws, the existence of many sometimes overlapping organizations involved in healthcare reform, and the slow expansion of enhanced health education and training for healthcare providers offer reason for optimism.

[1] This paper was presented at the World-Bank Institute's Hospital and Health Reform Conference/Training and Development held in Thailand in February 2010.

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1 EXECUTIVE SUMMARY: CONTEXT

The Philippine[2] health sector exists in a context of persistent poverty and financial challenges. As of 2009, the Philippines had a national poverty index of 20.9%, with many of the poorest spending for medical care out-of-pocket. The government has instituted a National Health Insurance Program (NHIP) to help make health care more accessible to Filipinos, but contentious coverage issues as well as lack of facilities and trained medical personnel are continuing obstacles for the program. Health sector and hospital reform programs instituted by the government have yielded some positive results, but the Philippines is still far from achieving its goal of a sustainable, high quality, and cost-efficient healthcare system that can be accessed by all Filipinos.

1.1 Poverty and Hunger

About 24 out of 100 Filipino families (equivalent to about 30 out of 100 Filipinos) did not earn enough in 2003 to satisfy their basic food and non-food requirements. The poorest Filipino families live in Zamboanga del Norte (64.6% poverty incidence), followed by the province of Maguindanao (60.4% incidence). The 10 poorest provinces consist of seven provinces in Mindanao, two in Luzon, and one in Visayas (NSCB 2007). An average Filipino family (with five family members) living in the National Capital Region (NCR) must earn a monthly income of about PhP10,000 to stay out of poverty.[3] This figure is based on an estimate of basic needs such as food, clothing, shelter, and transportation, and excludes recreation and emergency expenses (Remo 2008). The minimum wage per person in NCR is pegged at PhP404[4] per day or PhP9,696 per month based on 24 working days (DOLE, 2010), which is below the minimum estimate for staying out of poverty. To compound this issue, a fairly large percentage of the population is either unemployed or underemployed. In the June 2009 SWS survey, adult unemployment levels were at 25.9%, slightly lower than the February 2009 estimate of 34.2%. The labor force is comprised of 63.3% of the population, with 29% of the labor force (18.2% of the total population) underemployed as of January 2009 (NSCB 2009).

[2] Located in Southeast Asia, the Philippines is an archipelago with over 7, 108 islands, divided into 17 regions, 81 provinces, 136 cities, 1,494 municipalities, and 41,995 *barangays* or villages.

[3] Poverty statistics in the Philippines are conducted every three years. The latest results published were the 2006 figures. The official figures were determined in 2009 and will be released in 2011. (Remo, 2008)

[4] In the NCR, the minimum wage for non-agriculture workers is PhP404. This is the highest rate compared to other regions in the country, where the rate ranges from PhP196 to PhP320. (DOLE, 2010)

According to the Social Weather Stations (SWS) Fourth Quarter Report of 2009, "the proportion of families experiencing involuntary hunger at least once in the past three months reached a new record-high of 24.0%, or an estimated 4.4 million households." The same report also stated that 46% or an estimated 8.5 million Filipino families consider themselves Poor, and 39% or an estimated 7.1 million families consider themselves Food-Poor (SWS 2010).

1.2 The Philippine Health Sector

The Philippine healthcare sector is generally divided along the following axes—public/private, formal/informal, and modern/traditional.

Public/Private

Public health providers offer free medical services and are usually governed or regulated by the government through the Department of Health (DOH) or local government units (LGUs). Private providers, on the other hand, generally charge fees for services. The latter include both for-profit and non-profit organizations. However, there is a generally observed disparity in quality between the medical services from private and public providers. According to a report published by the Asian Development Bank (ADB) (2007),

> … private health facilities, which were considered by clients as providing better quality of services, were more heavily used by patients from the higher income groups (about 15%) than from the lower ones (about 5%). People at the lower end of the income distribution used public health facilities such as rural health units and village health stations more than those at the upper end. Such facilities are generally perceived to provide low-quality health services: diagnosis is poor, resulting in repeat visits; medicines and supplies are inferior and rarely available; staff members are often absent, especially in rural areas, and are perceived to lack medical and people skills; and waiting time is long, schedules are inconvenient, and facilities are rundown.

This situation was echoed by current DOH Secretary Dr. Enrique Ona (2010) in his speech at the 2010 World Population Day Celebration:

> … (There is) unfair and inequitable access to healthcare that leaves the poor behind; low overall government spending on health; high out-of-pocket spending that impoverishes thousands of Filipino families; persisting high maternal and newborn deaths that are among the highest in the Southeast Asian region; high fertility rates among our poorest women; the continuing challenge

> of infectious diseases like TB, dengue and malaria; emerging diseases like HIV/AIDS and the interlocking crisis of non-communicable diseases… The shortage in human resources for health, particularly doctors, is a well-known fact. 70% of all health professionals are working in the private sector addressing the needs of about 30% of our population while 30% of health workers employed by government are addressing the health needs of the majority of Filipinos.

Formal/Informal

The formal sectors consist of registered medical and non-medical facilities and registered medical personnel. The informal sector is largely unregistered by government regulation agencies, and consists mainly of traditional healers and unlicensed midwives. Sources suggest that the formal sector is predominant in the urban areas, while the informal sector thrives in the provinces where the regulation is minimal and there is a lack of access to medical facilities and personnel.

Modern/Traditional

Services can be classified into either modern medical services or traditional medical practices (such as massage, faith-healers, acupuncture, herbal clinics). Due to poverty, most Filipinos in the provinces tend to subscribe to traditional medical practices such as *hilot* (traditional Filipino massage), *albularyo* (Filipino folk healers), and faith-healers. Traditional medical practices are also gaining popularity among the higher income segment of the population. However, these practices consist of herbal supplements, acupuncture, various Asian massages, and well-being exercises.

1.3 National Health Insurance Program

To assist Filipinos in gaining access to quality healthcare, the Philippine government instituted the NHIP to provide universal health coverage for the Philippine population. The Philippine Health Insurance Corporation (PhilHealth), a government-owned and -controlled corporation, is mandated to administer the NHIP and to ensure that Filipinos have financial access to health services.

The law provides for the funding of contributions for indigents partially from LGUs. In practice, however, funding for indigent contributions has come either fully or partially from the national government, with the balance being shouldered by the local government. Historically,

the challenge in the implementation of the program has been the identification of the indigent, with some studies showing that there have been periods of significant leakage. According to former DOH Secretary Alberto Romualdez, only about 20% of the poor are considered indigent. The government has been promoting the use of a "means test"[5], but only recently has this generally acceptable tool become available for use.

In terms of enrolment, PhilHealth may be regarded as a success. (Obermann et.al. 2006) As of March 2010, about 20 million Filipinos are registered members of PhilHealth, with most of its members located in NCR and North Luzon (43%), while the rest is spread in South Luzon and Visayas (35%) and Mindanao (22%). In terms of membership by sector, 36% are from the private sector and 25% are sponsored by the local and national government. The rest is composed of the following sectors: Individually Paying (17%); Overseas Workers Program (11%); Government Employees (9%) and Lifetime Members (2%).

In early 2010, PhilHealth announced achievement of universal coverage, or that 85% of Filipinos are covered by the National Health Insurance Program. However, questions have been raised on the validity of the statistics. Studies of an academic group and the 2008 National Demographic and Health Survey (results released in January 2010) argue that PhilHealth coverage has only reached 54% and 38% of the total population, respectively.

In terms of facilities accreditation, about 8 of 10 DOH-licensed hospitals are accredited by PhilHealth. Of the 1,404 hospitals accredited, 60% are private hospitals and 37% are government hospitals. As of 2010, PhilHealth has also accredited 22,444 medical personnel to service over 90 million Filipinos. The licensed personnel are composed of General Practitioners (10,617), Medical Specialists (11,286), Dentists (184) and Midwives (357). The ratio of PHIC Beneficiaries to PHIC Accredited Professionals varies depending on the region. In NCR, the ratio is one accredited professional for every 1,379 PHIC beneficiaries. This increases for the Autonomous Region of Muslim Mindanao, where the ratio is 1:8,504. (Solutions Incorporated 2009)

[5] This is a protocol administered at the *barangay* level to determine the ability of individuals or households to pay varying levels of contributions to the Program, ranging from the indigent in the community whose contributions should be totally subsidized by the government, to those who can afford to subsidize part but not all the required contributions for the Program. (RA 7875)

1.4 Healthcare Financing

From 2005 to 2007, healthcare expenditure in the Philippines experienced decelerating growth rates. At current prices, "total outlay for health went up from PhP198.4 billion in 2005 to PhP234.3 billion in 2007, registering a growth rate of 9.1 percent in 2006 and 8.3 percent in 2007." Looking at per capita spending this translates to "an increase in per capita health spending of PhP14 in 2006 and PhP11 in 2007." (Virola 2010) The latest statistics from the Philippine National Health Accounts 2007 on healthcare financing are as follows:

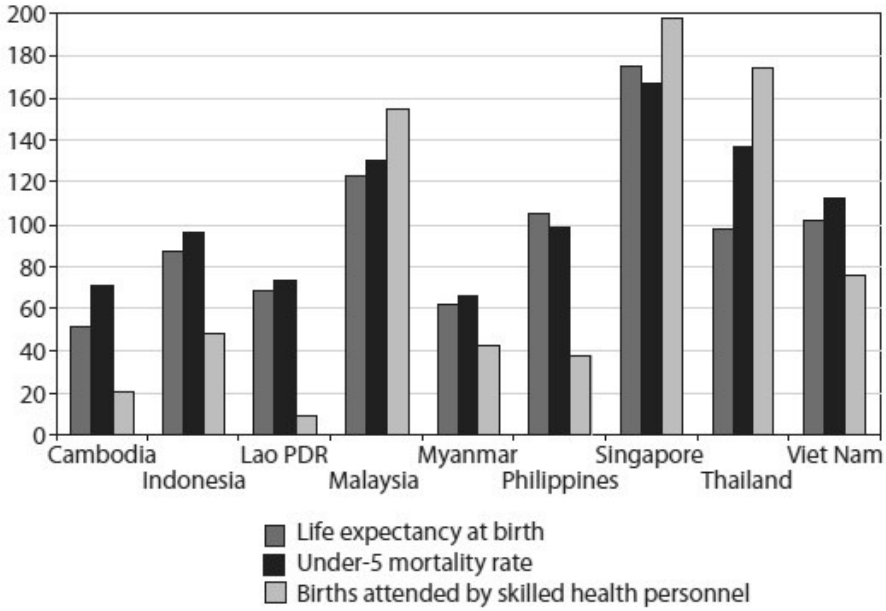
- The level of health expenditure in 2005 to 2007 was within the target of 3 to 4 percent of GNP set as part of the National Objectives for Health 2005-2010.
- Filipino households continued to bear the heaviest burden in terms of spending for their health needs as private out-of-pocket surpassed the 50 percent mark in health expenditure share in 2006, reaching 54.3 percent in 2007.
- Government came in a far second in health spending contribution, with the national government and the local government units (LGUs) footing almost equal shares of 13.0 percent and 13.3 percent in 2007, respectively. It is worth noting that the LGUs spent more than the national government in 2006 and 2007.
- Health expenditure from social insurance barely grew from PhP19.4 billion in 2005 to nearly PhP20.0 billion in 2007, indicating an average annual growth of only 1.6 percent. Thus, instead of picking up as targeted, the social insurance share in health spending went down from 9.8 percent in 2005 to 8.5 percent two years later.

1.5 Health Sector Outcomes

The mission of the Philippine healthcare sector is to create a sustainable, high quality, and cost-efficient healthcare system that can be accessed by all Filipinos. To this end, there are numerous health sector and hospital reform programs that have been implemented—the development of information and communication technology (ICT) software to facilitate health insurance access, devolution of medical services from the central to the local government, corporatization of public health providers, and the promotion of a national health insurance program. To a certain extent, these initiatives, together with the past programs of the Philippine

government, have improved several key healthcare indicators in the country. However, the country still lags behind many of its Asian neighbors as indicated by the numbers below.

Figure 1. Relative Achievements in Health Outcomes for Selected Asian Countries, 2000-2007



Note: The graph presents the relative achievement index, that is, the normalized index of achievement relative to the average achievement of the world; the world index is set to 100. The achievement index considers a further increase in the standard of living of a country that is already at a higher level an achievement greater than that of another country with an equal increase in standard of living but from a lower base.
Source: Son 2009.

In addition, there are critical health and medical issues that need to be addressed. Tuberculosis (TB) remains a widely spread disease, especially with the increased incidence of multiple drug resistant TB viruses, and dengue fever still claims the lives of many, particularly indigents, during rainy seasons (Romualdez, 2010). New challenges are also facing the system, such as the increase of AIDS and HIV incidence in the country, with reported HIV cases increasing by 36% in 2010 (DOH 2010).

According to Dr. Ramon Paterno of the UP National Health Institute, the country needs a universal healthcare system where "every Filipino has access to needed healthcare, with minimal or no co-payment." Current Health Secretary Enrique Ona also raised as an area for improvement the need to "fulfill the mandate of Universal Health Care for all Filipinos"

focusing on a "single national healthcare strategy, protection for the Filipino families against the rising cost of healthcare, and improving outcomes and delivering quality care."

2 A BRIEF HISTORY OF HEALTHCARE REFORM

The earliest attempt towards healthcare reform was the promulgation of Primary Health Care in the country in the 1970s. This was followed by a series of health policies that focused on the use and prescription of medicines (RA 6675: Generics Act of 1988 and RA 9052: Universally Accessible Cheaper and Quality Medicine Act), the devolution of health services to local government units (RA 7160: Local Government Code of the Philippines), and the expansion of the social health insurance program to include indigents (RA 7875: National Health Insurance Act of 1995).

To create a comprehensive and coherent approach to managing the sector, the DOH in 1999 adopted the Health Sector Reform Agenda (HSRA). The objectives were (1) expansion of social health insurance, (2) corporatization of government hospitals, (3) strengthened local health systems, (4) improved health regulation and drug management, and (5) improved public health services. From 1999 to 2006, the DOH adopted various reform implementation strategies to ensure the effective and efficient completion of its target objectives.

To address the population problem of the country and achieve the United Nations Development Programme's (UNDP) Millennium Development Goals (MDGs), the Reproductive Health Initiatives House Bill No. 5043, also known as Reproductive Health and Population Development Act of 2008, was introduced. Its aim is to "uphold and promote respect for life, informed choice, birth spacing and responsible parenthood in conformity with internationally recognized human rights standards." It also aims to guarantee universal access to medically safe, legal and quality reproductive healthcare services and relevant information that prioritizes the needs of women and children.

To address the lack of access to medicine and medical services, Republic Act 8423, also known as the Traditional and Alternative Medicine Act of 1997, promotes the development of traditional and alternative medical system, and supports the development additional research and standards for the practice of alternative medicine. The DOH has already approved the use of 10 medicinal plants—the *bayabas-bayabasan* or ringworm bush,

bitter gourd, garlic, guava, five-leaved chaste tree, Chinese honeysuckle, Blumea camphora, *tsaang gubat, ulasimang bato, pansit-pansitan*, and peppermint.

RA 9052 or the Cheaper Medicine Law (1998) allowed parallel importation of medicines that are produced at lower costs in countries like Pakistan and India. The selection, procurement and management of the identified medicines are handled by the Philippine International Trading Corporation (PITC). The objective of this provision is to promote competitive pricing among large pharmaceutical companies in the Philippines.

Other healthcare reform programs have been instituted to address the current concerns in terms of information technology requirements, lack of emergency care facilities, decentralization of health services and coordination among LGUs, as well as quality and effectiveness mechanisms. The following are examples:

- **Use of information technology in public hospital system.** While the Philippines has a mature communication network, the use of information technology in the public hospital system is still limited. The prevailing challenges in the Philippine health information system are (1) integration of present information systems with the proposed systems; (2) integration at functional, technical, resource, and implementation levels; (3) funding; and (4) providing and sustaining ICT infrastructure. (Valdez 2007)
- **Provision of emergency care**. The private sector mostly provides emergency care in the Philippines, as they have the appropriate equipment for dealing with emergency medical situations. Many public healthcare facilities, particularly in the provinces, lack ambulances and basic emergency devices such as defibrillators and respiratory equipment. The Senate recently submitted Bill 3458 or the Emergency Medical Services Systems Act of 2009. The objective of the bill is to provide for "the creation of the National Pre-Hospital Care Council, the establishment of national standards for the provision of pre-hospital emergency medical service by pre-hospital care professionals, the supervision, control and regulation of the practice of pre-hospital professionals, the program standardization for the training of pre-hospital professionals and the certification and re-certification requirements of pre-hospital care professionals."
- **Decentralization and the challenge of coordination**. The decentralization and the devolution of the primary health service to the local government posed challenges in

terms of capacity as well as coordination. FOURmula One for Health, the current health reform agenda, seeks to

- Introduce reforms in the procurement and logistics process
- Introduce Finance Management Systems
- Increase the coordination of the private sector (donors), the LGUs, and the national government
- Develop a local human resource strategy, and
- Develop the Philippine Health Information System.

- **Economic Enterprise Reforms for public hospitals (income-retention programs).** FOURmula One for Health seeks to
  - Rationalize the source of financing
  - Create an effective financial management system
  - Increase the DOH's budget
  - Upgrade and fully rationalize the entire organization of the DOH
  - Institutionalize revenue enhancement measures and performance-based budgeting systems, and
  - Increase the coverage of the National Health Insurance Program.
- **Facility Management Autonomy, including local governing boards for public hospitals**. To lessen dependency and increase autonomy among public hospitals, the Hospital Reform Agenda is leaning towards the establishment of local governing boards to provide management and operations advice. The ultimate aim is to allow public hospitals to become fiscally autonomous. In order to achieve this, the reforms also seek to improve the networking capability of public hospitals through public-private partnerships.
- **Inter-LGU cooperation (ILHZ).** Due to limited health facilities, professionals, and resources, the health department, with the cooperation of the local and national government, aims to establish health convergence sites for efficient allocation, distribution, and resource-gathering at the local level (provincial and municipal level). DOH seeks to create a network of health providers and stakeholders that can improve the health delivery system within the areas of procurement and logistical needs.

- **Quality and Effectiveness Monitoring initiatives**. To ensure that the objectives are met, the DOH, with PhilHealth and LGUs, has instituted objective and practical mechanisms, such as the LGU scorecards and NHIP "benchbook." In 2001, PhilHealth developed the Benchbook on Quality Assurance, which contains the new accreditation standards for healthcare organizations. The benchbook focuses on the "principles of continuous quality improvement and the use of clinical pathways in all health care organizations." The seven critical areas are (1) Patients' Rights and Organizational Ethics; (2) Patient Care; (3) Leadership and Management; (4) Human Resource Management; (5) Information Management; (6) Safe Practice and Environment; and (7) Improving Performance.

3 CHALLENGES FACING THE PHILIPPINE HEALTH SECTOR

This section is divided into three sub-sections: (1) the context of the Philippine healthcare system and the relationships of key health stakeholders; (2) the state and profile of hospitals and health workers (medical and non-medical); and (3) a history of health and hospital reform in the country. The final section briefly focuses on key concerns, initiatives, and opportunities.

3.1 The Context of the Philippine Health System

In 2006, the Philippines' adult mortality rate—the probability of dying between 15 to 60 years per 1,000 population—was 219. The life expectancy of Filipinos born in 2006 is estimated at 71.5 years (Son, 2009). The top three causes of death in the country are pneumonia, diarrhea, and bronchitis/bronchiolitis. (See Annex Table 1, Top 10 Causes of Morbidity)

The Philippines adopted the MDGs as its basis for measuring success in health care reform. Targets that the Philippines is set to meet by the end of 2010 include under-5 mortality rate, infant mortality rate, proportion of births attended by skilled health personnel, death rate associated with malaria, proportion of tuberculosis cases detected under directly observed treatment short course (DOTS), and proportion of tuberculosis cases cured under DOTS. However, some lagging indicators are the proportion of one-year-old children immunized against measles, maternal mortality rate, and deaths associated with tuberculosis.

Table 1. Critical Healthcare Indicators

Series	1990	1995	2000	2005	2007	2010 Target
Children under 5 mortality rate per 1,000 live births	62	44	37	30	28	32.2
Infant mortality rate (0-1 year) per 1,000 live births	43	33	29	24	23	17.0
Maternal mortality ratio per 100,000 live births		172 (in 1998)			162 (in 2006)	90.0

Sources: Millennium Development Goals and National Statistics Coordination Board.

Another important measure is expenditure by the entire industry. According to the National Health Accounts (NHA) (2007), the Philippines' total health expenditure was PhP234.3 billion, and grew annually by 8.7% from 2005 to 2007. However, health expenditure as a percentage of GDP decreased from 3.6 in 2005 and 2006 to 3.5 in 2007. (See Annex Table 2, Total Health Expenditure, 2005-2007)

In 2005-2007, the highest growth in the sources of funding for health care was employees' compensation at 21.9 percent, followed by private out-of-pocket expenses at 14.2 percent. Lagging behind were public expenditure growth from the national government and NHIP, at 0.0 and +1.5 respectively. The increase in national government spending was largely attributed to loans and health expenditures of other national agencies. (See Annex Table 3, Per Capita Health Spending, 2005-2007; Table 4, Source of Funds, 2005-2007; and Table 5, 2005 Government Health Expenditures by Use of Fund and by Type of Expenditure)

Although there was an increase in social insurance spending as a percentage of total, private sources still account for the majority (almost 60%) of healthcare expenditure in the country; 78% of total health care spending in 2005 was for personal health and 41% of government spending was for personal health.

3.2 Structure of the Healthcare Sector

The Philippine Government plays a significant role in establishing the political and regulatory framework for the healthcare sector. Article 13 Section 11of the 1987 Philippine Constitution states:

> The State shall adopt an integrated and comprehensive approach to health development that shall endeavor to make essential goods, health and other social services available to all the

people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers.

The main institutions in the local health sector are the Philippine Government (as represented by DOH and LGUs); PhilHealth, private insurers and health maintenance organizations (HMOs) as financial intermediaries; institutional medical services providers (public and private hospitals); health professionals (doctors, dentists, and nurses); non-government organizations (NGOs) and health industry associations; patients; and suppliers (pharmaceutical and medical equipment companies).

In the indigent program of PhilHealth, the government (as payor) transfers funds to PhilHealth as contributions for health coverage of indigents under the NHIP-sponsored program. As a financial intermediary, PhilHealth guarantees payment for medical services. Covered individuals are able to avail of services for free up to the NHIP benefit limits; and hospitals and healthcare professionals in turn file claims for payment with PhilHealth. The NHIP is currently primarily focused on inpatient coverage, and very few outpatient benefits are available. As a consequence, drugs are typically only covered if they are administered via a facility, and the transfer of funds is primarily between the facility (primarily hospitals, TB clinics and maternity facilities) and the supplier.

The Philippine healthcare sector is an agglomeration of stakeholders covering government units (national and local level), private enterprises, non-profit organizations, and industry associations, as described below.

- **Department of Health.** Its mission is to guarantee equitable, sustainable and quality health for all Filipinos, especially the poor, and to lead the quest for excellence in health. The DOH has 17 central offices, 16 Centers for Health Development located in various regions, 70 hospitals and four attached agencies such as the Philippine Health Insurance Corporation, the Dangerous Drugs Board, Philippine Institute of Traditional and Alternative Health Care, and the Philippine National AIDS Council.
- **Bureau of Food and Drugs (BFAD).** Its main responsibility is to license and regulate the delivery of pharmaceuticals in the Philippines. It is also tasked to test the safety of food and cosmetics. Despite the broad scope and multiple tasks, BFAD has limited

financial resources and lacks the manpower and resources to study all the products submitted for testing (Hamilton 2009).

- **Philippine Health Insurance Corporation.** RA 7875 instituted the NHIP, which promoted the membership of every Filipino in the healthcare program, particularly the indigent sectors of the population. Consequently, it established PhilHealth. PhilHealth has the status of a tax-exempt government corporation attached to the DOH for policy coordination and guidance. Its vision is to "ensure sustainable, affordable and progressive social health insurance which endeavors to influence the delivery of accessible quality healthcare for all Filipinos." Its mission is to "continuously evolve a sustainable National Health Insurance Program that shall: (1) lead towards universal coverage; (2) ensure better benefits for its members at affordable premiums; (3) establish close coordination with its clients through a strong partnership with all stakeholders; and (4) provide effective internal information and management systems to influence the delivery of quality health care services"
- **Public Hospitals.** With the devolution of health services to LGUs, public hospitals in the country are classified into two based on their source of funds and management structure—DOH hospitals and LGU hospitals. DOH hospitals are solely funded and managed by the health department, with their funding included in the annual budget as part of the department's Maintenance and Other Operating Expenses (MOOE). At the moment, 70 DOH hospitals are spread around the country. With the enactment of the 1991 Local Government Code, LGUs were given responsibilities to form and head local health boards at the provincial (led by the governor), city (led by the city mayor) and municipal (led by the municipal mayor) levels. Aside from being an advisory council, the LGUs are tasked to provide healthcare services to its constituents. The health and social welfare services provided by LGUs include (1) maintenance of health centers and day-care centers at the barangay level; (2) implementation of projects on primary health care, maternal and child care, and communicable and non-communicable disease control services, access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out services at the city and municipal level; and (3) provision of health services which include

hospitals and other tertiary health services at the provincial level (1991 Local Government Code).

- **Private Healthcare Providers.** A private hospital is defined as a privately-owned health facility, established and operated with funds raised or contributed through donations, or by private capital or other means, by private individuals, associations, corporations, religious organizations, firms, company or joint stock associations. Similar to its neighbors (Cambodia, Indonesia, Malaysia, Thailand, and Vietnam), private sector participation in the Philippines is strong. The private sector provides more than half of all health services, which is important for primary care services and provides majority of secondary and tertiary services. (Montagu and Bloom, n.d.).
- **Industry Associations.** Industry associations also play an important role in the healthcare sector since they provide an avenue where healthcare stakeholders—especially the providers and health workers—network and discuss the key challenges and reforms in the sector. The major industry associations include the Pharmaceutical and Healthcare Association of the Philippines (PHAP), Philippine Hospital Association (PHA), and Philippine Medical Association (PMA).

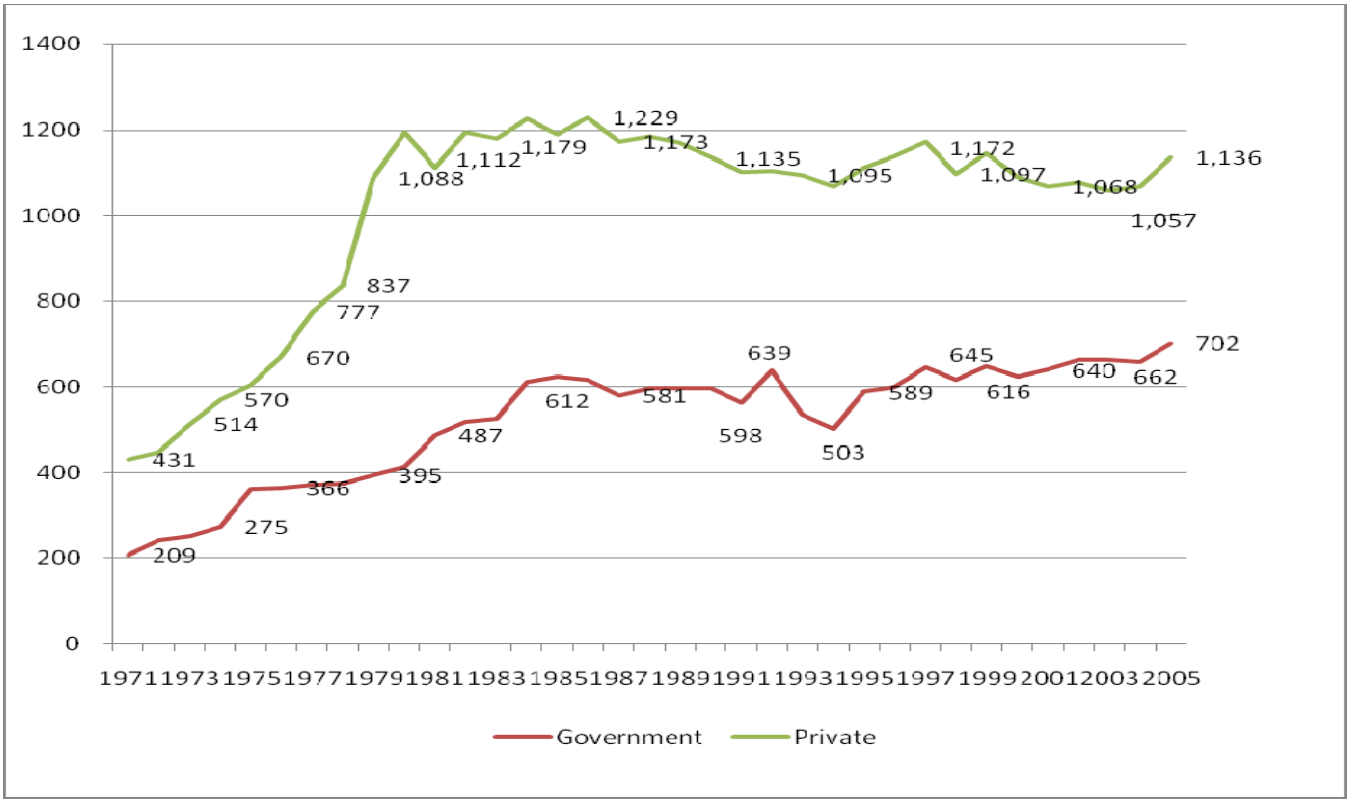
3.3 Profile of Hospitals and Nature of Services Provided

In the Philippines, the State classifies healthcare services into three levels:

- **Level 1 (Primary healthcare)** is provided by *barangay* health stations, rural health units (RHUs), clinics, and other small facilities. These facilities provide the first-level contact to improve health, and are key areas for disseminating information about health on a community level, and also play a key role in immunization programs and the like.
- **Level 2 (Secondary healthcare)** is given by physicians in infirmaries and municipal and provincial hospitals. These facilities offer specialized ambulatory medical services and common hospital care.
- **Level 3 (Tertiary healthcare)** is provided by specialists in medical centers, provincial and regional hospitals, and specialty hospitals such as the Philippine Heart Center, Lung Center of the Philippines, National Kidney Transplant Institute, and Philippine Children's Medical Center. These facilities provide highly specialized, technical, in-patient medical services and complex medical procedures.

Of the 1,781 hospitals in the Philippines, about 60% (or 1,080) are privately owned and operated; the rest (40% or 701) are government (national and local level)-owned and -operated (DOH Bureau of Health Facilities and Services 2009). Most of the hospital beds in public and private hospitals are found in Level 2 and Level 3 hospitals. However, beds are limited in hospitals specializing in birthing, acute-chronic psychiatric care, and custodial psychiatric care. Aside from this, the number of hospital beds available fails to keep up with increases in population.

Figure 2. Growth of Government and Private Hospitals, 1971-2005



Source: NSCB Philippine National Health Accounts, as quoted by Lavado, et al. 2010.

Table 2. Hospitals by Ownership and Service Capability, 2005-2007

Hospitals/ Year	Level 1/ Primary		Level 2/ Secondary		Level 3/ Tertiary		Level 4/ Teaching/Training		Total	
	No.	%	No.	%	No.	%	No.	%		
Year 2005										
Government	336	48.3	271	38.9	26	3.7	62	8.92	695	1,755
Private	465	43.8	397	37.4	113	10.6	85	8.01	1,060	

Year 2006										
Government	331	47.0	282	40.1	36	5.12	54	7.68	703	1,771
Private	437	40.9	411	38.4	151	14.1	69	6.46	1,068	
Year 2007										
Government	333	47.5	282	40.2	32	4.56	54	7.70	701	1,781
Private	439	45.6	405	37.5	169	15.6	67	6.20	1,080	

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

Based on the National Objectives for Health 2005, DOH released reports indicating that almost half (48%) of health expenditures are "out-of-pocket" expenses of individual families. This figure is followed by national government expenditure (16%), local government expenditure (13%), social health insurance (11%), and other sources (11%), which include private health insurance, community based financing, and employer's benefits. (Reyes, 2009)

Table 3. Trends in Healthcare Expenditures

Selected Indicators	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Government	**35.0**	**36.0**	**38.0**	**39.1**	**39.2**	**40.6**	**36.2**	**31.0**	**31.1**	**30.7**	**28.7**
National	19.2	19.7	20.3	20.8	20.7	21.2	17.1	15.8	15.2	15.7	15.8
Local	15.9	16.2	17.6	18.4	18.5	19.3	19.1	15.2	15.9	15.0	12.9
Social Insurance	**4.5**	**5.0**	**5.1**	**3.8**	**5.0**	**7.0**	**7.9**	**9.0**	**9.1**	**9.6**	**11.0**
PhilHealth (Medicare)	4.2	4.7	4.8	3.5	4.8	6.8	7.7	8.8	8.6	9.4	10.7
Employee's Compensation (SSS and GSIS)	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.5	0.3	0.4
Private sources	**59.6**	**58.1**	**56.1**	**56.1**	**54.5**	**51.2**	**54.5**	**58.6**	**58.6**	**58.5**	**59.1**
Out-of-Pocket	50.0	48.3	46.5	46.3	43.3	40.5	43.9	46.8	46.9	46.9	48.4
Private Insurance	1.8	1.7	1.9	2.0	2.2	2.0	2.5	2.9	2.3	2.5	2.4
HMOs	2.0	2.3	2.5	2.9	4.0	3.8	3.1	3.6	4.7	4.3	3.9
Employer-Based Plans	4.9	5.0	4.4	4.0	4.0	3.7	3.9	4.1	3.4	3.6	3.2
Private Schools	1.0	0.9	0.8	0.9	1.0	1.1	1.2	1.3	1.3	1.2	1.2
Others	**0.8**	**0.9**	**0.9**	**1.0**	**1.3**	**1.3**	**1.3**	**1.4**	**1.2**	**1.2**	**1.2**

Source: NSCB Philippine National Health Accounts 2005.

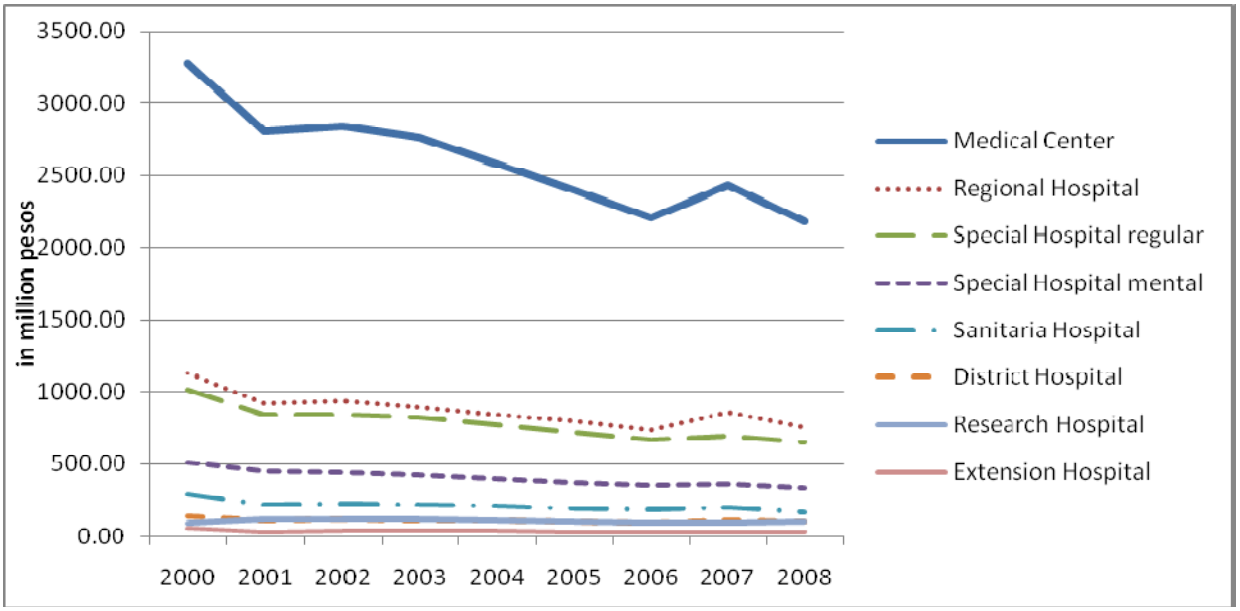
According to Montagu and Bloom (n.d.):

Private expenditure on health is greater than public expenditure and the overall level of government expenditure, (6.1% of total government spending) is among the lowest in East Asia and Pacific Region. The majority (83%) of private expenditure is out-of-pocket payments. Much of this is spent on pharmaceuticals, and medicines make up 46.6% of total health

expenditure – among the highest in the region. Generics represent only 15 to 20% of the market, and distribution is limited to a small number of large private chains.

In terms of total appropriations for 2008, the DOH's allocation for government hospitals was concentrated heavily in medical centers and regional hospitals. This was followed by special hospitals, sanitaria hospitals, and district hospitals.

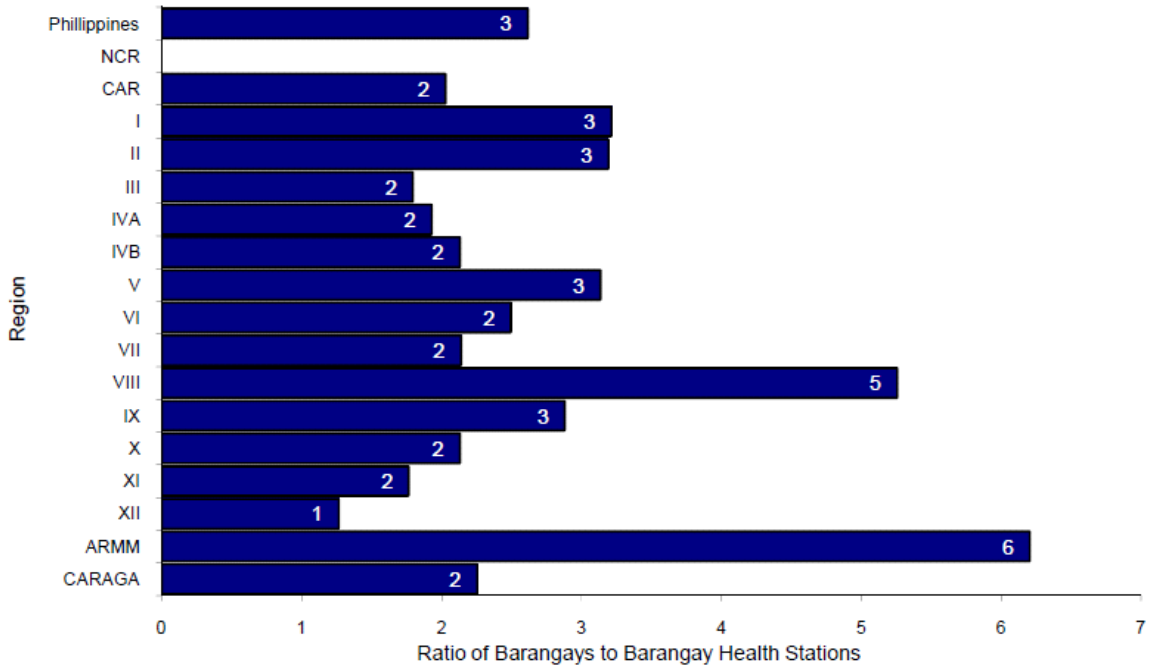
Figure 3. Budget Allocation of DOH-Retained Hospitals By Type of Hospitals, in constant 2000 prices



* Statistics are based on the General Appropriations Act, Department of Budget and Management, and DOH reports.
Source: Lavado 2010.

In terms of geographical presence, most hospitals and healthcare professionals are based in urban areas, specifically NCR. In rural areas (mostly in Visayas and Mindanao), healthcare facilities are limited to lay-in and *barangay* clinics, and healthcare professionals are typically social workers and midwives.

Figure 4. Ratio of Barangays to Barangay Health Stations (Philippines and Regions, 2007)



Source: Field Health Service Information System Annual Report 2007.

Aside from the lack of access to healthcare facilities in the Philippines, there is also a shortage in the availability of functioning diagnostic imaging technologies, such as computed tomography (CT) and magnetic resonance imaging (MRI) scans. These technologies are generally concentrated in highly urban areas. About 50% of the country's CT (106 out of 230 in 2009) and MRI machines (22 out of 42 in 2009) are located in NCR. No CT or MRI is available in the ARMM. There are only 0.25 CT units for every 100,000 Filipinos, and only 0.05 MRI units for every 100,000 (DOH Bureau of Health Devices and Technology 2009).

Table 4. Number of Functioning Diagnostic Imaging Technologies per Region, 2007-2009

REGION	CT						MRI	
	2007		2008		2009		2009	
	No.	Per 100,000	No.	Per 100,000	No.	Per 100,000	No.	Per 100,000
National Capital Region	108	0.93	105	0.93	106	0.93	22	0.19
Cordillera Administrative Region (CAR)	3	0.20	3	0.18	3	0.18	0	0.00
Ilocos Region (I)	6	0.13	16	0.32	16	0.32	1	0.02

REGION	CT						MRI	
	2007		2008		2009		2009	
	No.	Per 100,000	No.	Per 100,000	No.	Per 100,000	No.	Per 100,000
Cagayan Valley (II)	4	0.13	4	0.12	4	0.12	0	0.00
Central Luzon (III)	24	0.25	31	0.32	31	0.31	4	0.04
CALABARZON (IV-A)	28	0.20	24	0.17	25	0.17	4	0.03
MIMAROPA (IV-B)							0	0.00
Bicol Region (V)	7	0.14	6	0.11	6	0.11	0	0.00
Western Visayas (VI)	7	0.10	13	0.18	13	0.17	2	0.03
Central Visayas (VII)	10	0.16	9	0.13	9	0.13	4	0.06
Eastern Visayas (VIII)	1	0.03	1	0.02	1	0.02	0	0.00
Zamboanga Peninsula (IX)	5	0.15	5	0.15	5	0.15	0	0.00
Northern Mindanao (X)	4	0.10	4	0.10	4	0.09	3	0.07
Davao Region (XI)	2	0.05	2	0.05	2	0.05	2	0.05
SOCCSKSARGEN (XII)	3	0.08	3	0.08	3	0.08	0	0.00
CARAGA (XIII)	3	0.13	2	0.08	2	0.08	0	0.00
Autonomous Region in Muslim Mindanao (ARMM)	0	0.00	0	0.00	0	0.00	0	0.00
PHILIPPINES	**215**	**0.24**	**228**	**0.25**	**230**	**0.25**	**42**	**0.05**

Note: Proportions for 2007 were computed based on population data from the NSCB PSY 2008, while those for 2008 and 2009 were from census-based population projections in 2000.
Source: BHDT 2009.

Because of the lack of access to healthcare and perceived high cost of medical service, a significant number of the population prefer not to go to hospitals or clinics for treatment.

Table 5. Health-Seeking Patterns by Income Group, 1993

Response to Health Complaint	Poorest Quartile	Quartile 2	Quartile 3	Richest Quartile
Consulted doctor	25%	36%	37%	48%
Consulted other health professional	5%	3%	1%	1%
Consulted traditional healer	6%	2%	2%	1%
Self-care	64%	59%	60%	50%
Total number of respondents	100%	100%	100%	100%

Source: DOH-PIDS Household Survey (1993) Presentation made by DOH Sec. Dayrit.

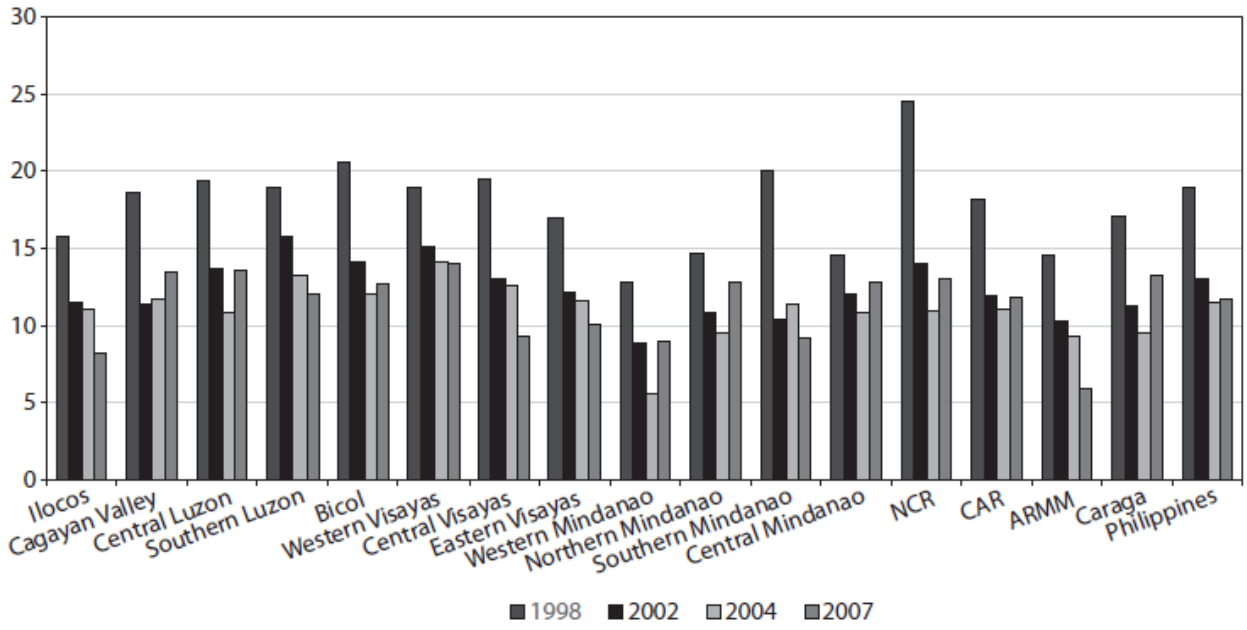
Based on an ADB report (2009), utilization of health facilities declined from 1998 to 2007. There is also a pronounced shift in utilization from private to public hospitals. At the regional level, Filipinos living in NCR are more prone to using health services compared to their rural counterparts (Son 2009).

Table 6. Utilization of Health Services

	1998	2002	2004	2007	Growth Rate
Government hospitals	3.70	2.46	2.80	3.40	-4.0
Private hospitals	3.06	1.93	1.72	2.25	-6.8
Private clinics	5.13	3.33	2.98	2.55	-8.4
Rural health units	4.79	2.74	2.88	2.36	-8.9
Barangay health station	2.45	2.34	2.31	1.82	-2.1
Other services	0.27	0.26	0.28	0.21	-1.2
Any health facility	18.91	13.06	11.48	11.71	-6.9

* Hyun H. Son's estimates based on APIS.
Source: Son 2009.

Figure 5. Utilization of a Facility by Region, 1998-2007 (%)

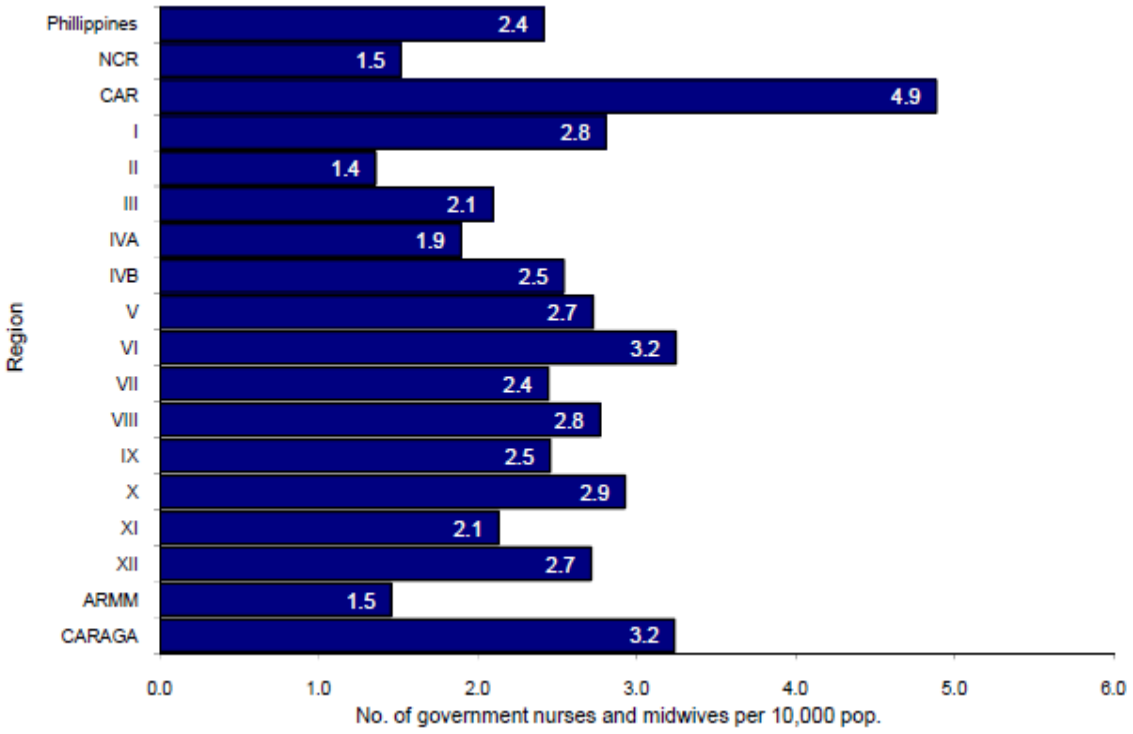


* Estimates of Hyun H. Son based on APIS.
Source: Son 2009.

3.4 Health Workers

The number of government health practitioners has declined over the past 17 years. In 1990, the estimate was 1.22 doctors for every 10,000 Filipinos. By 2007, this figure dropped to 0.33. In addition, while there were 0.17 nurses for every 10,000 Filipinos in 1990, the number was down to 0.05 in 2007.

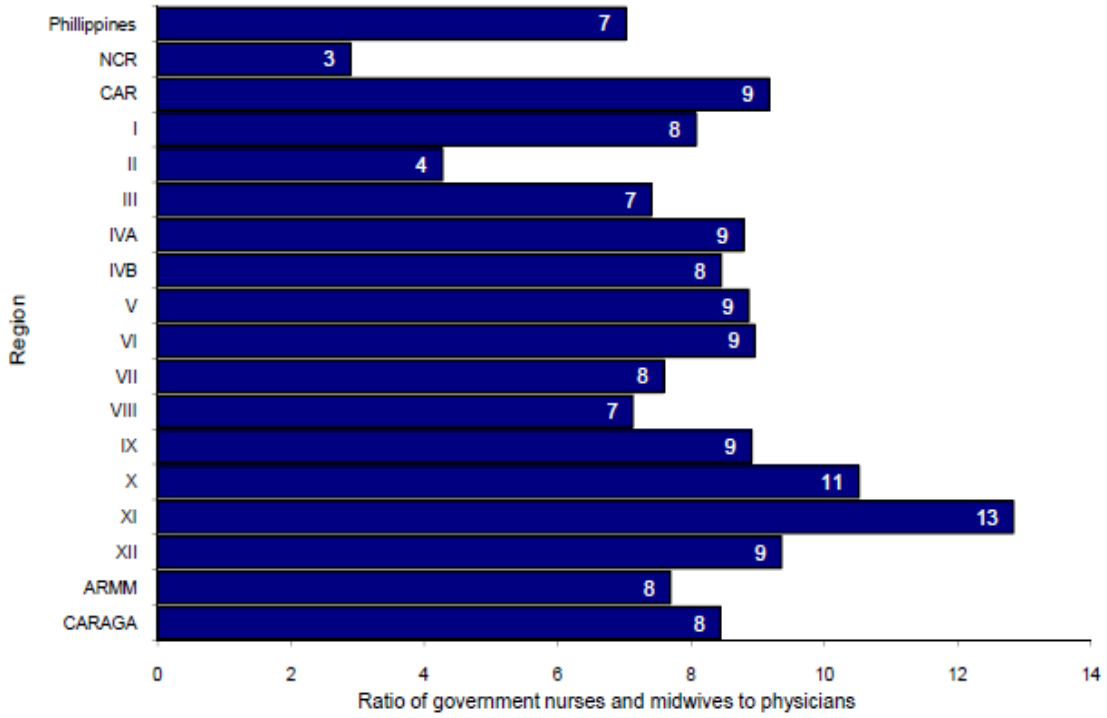
Figure 6. Number of Government Nurses and Midwives per 10,000 Population (Philippines and Regions, 2007)



Source: Field Health Service Information System Annual Report 2007.

The concentration of government health practitioners is also an issue. More than six out of 10 (62%) doctors, nurses, and dentists work in Luzon (particularly NCR), while the rest (38%) are divided between the islands of Visayas and Mindanao (DOH Field Health Information System 2007).

Figure 7. Ratio of Government Nurses and Midwives to Physicians (Philippines and Regions, 2007)



Source: Field Health Service Information System Annual Report 2007.

3.5 Non-Hospital Health Providers (Clinics) and Medicine Access

Barangay health stations and rural health units suffer from similar limitations as hospitals. From 1999 to 2006, nationwide, less than 2,000 *barangay* health stations were set up, and only 50 rural health units and 16 accredited dialysis clinics were added in 2002. Many barangay stations provide some access to free basic medicines and supplements (vitamins, paracetamol, certain antibiotics, painkillers, etc), but supplies tend to be sporadic.

Table 7. Health Facilities and Government Health Manpower, 1995-2005

Item	1999	2000	2001	2002	2003	2004	2005	2006
Hospitals	1,794	1,712	1,708	1,739	1,719	1,725	1,838	1,921
Government	648	623	640	662	662	657	702	719
Private	1,146	1,089	1,068	1,077	1,057	1,068	1,136	1,202
Government Health Manpower								
Doctors	2,948	2,943	2,957	3,021	3,064	2,969	2,967	2,955

Item	1999	2000	2001	2002	2003	2004	2005	2006
Dentists	2,027	1,943	1,958	1,871	1,946	1,929	1,946	1,930
Nurses	4,945	4,724	4,819	4,720	4,735	4,435	4,519	4,374
Midwives	16,173	16,451	16,612	16,534	17,196	16,967	17,300	16,857
Barangay Health Stations	14,416	15,204	15,107	15,283	14,490	15,099	15,436	16,191
Rural Health Units a/	2,212	2,218	1,773	1,974	2,259	2,258	2,266	...

a/ One-time survey under Safe Motherhood Project and the DOH.
Source: Department of Health.

Nonetheless, the government has strongly been promoting access to cheap medicine through the *Botika ng Bayan* program. The markup prices of medicines in the Philippines are usually 100 times more expensive than India and Pakistan (Hamilton 2009), and the government hopes to remedy this situation.

Table 8. Comparison of Selected Drug Prices (2008)

Product	Manufacturer	Price in the Philippines	Price in India	Price in Pakistan
Norvasc	Pfizer	45	5	n/a
Ventolin	GSK	315	123	62
Imodium	Jansen	10	3	1.8

* Prices in peso equivalents.
Source: Business Meridian International, quoted by Hamilton 2009.

Roberto Pagdanganan, CEO of PITC, noted the dominance of large private corporations in the sector:

> Mercury Drug was selling at 60 percent on drug retail and Zuellig Pharma 80 percent of wholesale. Zuellig had a sister company, Interphil, which controlled 80 percent of manufacturing. The multinational companies controlled 70 percent of the drug market. And 23 percent of the remaining 30 percent was controlled by Unilab. The top 20 companies controlled 93 percent of the market.

The *Botika ng Bayan* program allows the government to increase access to quality and affordable medicine through franchises and microfinancing. From 427 outlets in 2003, the outlets increased to 12,341 in January 2009. These outlets offer lower-priced, generic medicine. A generic loperamide tablet will cost only PhP 1.05 in a *Botika ng Bayan*, compared to PhP 4.10 for a generic brand and PhP 14 for a branded tablet. (Ragaza and Morales 2009)

Despite these achievements, operations and geographic presence continue to be challenges. In terms of geographic location, the outlets are located in only half (or 42,000) of the total number of *barangays* in the Philippines. Some of the poorest provinces in the country have no *Botika ng Bayan* outlets. In terms of operations, the outlets do not offer medicines for "malaria, influenza and tuberculosis, the leading causes of mortality and morbidity in the country," or for "filariasis and schistosomiasis, two of the leading diseases in some poor communities." (Ragaza and Morales 2009)

3.6 Social Insurance

The National Health Insurance Program covers six sectors: (1) sponsored program; (2) government-employed, (3) private-employed, (4) individually paying program, (5) overseas Filipino workers, and (6) non-paying program. The highest utilization rates come from members in the non-paying program with 40.97% in 2006.

According to the PHIC Corporate Plan 2006 and 2007, PhilHealth collected the highest amount of premiums in real terms among private employees, while the highest amount of payment benefits were for individually paying members. In 2007, the ratio of benefits to premiums among private employees was 0.53; among individually paying persons, the ratio was 2.10. Most PhilHealth-accredited facilities are in NCR and Luzon, as shown in Table 9.

Table 9. Number of PhilHealth-Accredited Facilities as of December 2008

PhilHealth Regional Offices	Hospitals	RHUs	Dialysis clinics	TB DOTS clinics	Maternity clinics
NCR/Rizal	190	183	14	58	79
Luzon	685	186	2	76	14
Visayas	232	323	1	182	106
Mindanao	424	151	2	90	89
Total	1531	843	19	406	288

Note: Generated totals, with the exception of those of hospitals, do not tally with reported totals.
Source: PHIC CorPlan.

4 HEALTH SECTOR REFORM AGENDA: FOURmula One for Health

FOURmula One for Health is the DOH's Road Map for Health Sector Reforms in the Philippines from 2005 to 2010. It is designed to implement critical health interventions as a single package, backed by effective management infrastructure and financing arrangements.

FOURmula One engages every stakeholder in the health sector—the public and private sectors, national agencies and local government units, external development agencies, and civil society. The over-all goals are to provide (1) better health outcomes, (2) a more responsive health system, and (3) more equitable healthcare financing.

Implementation requires achieving critical reforms with **speed, precision and effective coordination** directed at improving the quality, efficiency, effectiveness and equity of the Philippine health system in a manner that is felt by Filipinos, especially the poor. On a more specific note, in five years, the program aims to (1) secure more, better and sustained financing for health; (2) assure the quality and affordability of health goods and services; (3) ensure access to and availability of essential and basic health packages; and (4) improve performance of the health system.

Another major section of the health sector reform agenda is the reform components, divided into (1) Health Financing, (2) Health Regulation, (3) Health Service Delivery, and (4) Good Governance in Health. The DOH web site describes the components accordingly:

- **Health Financing**. Its objective is to "secure more, better and sustained investments in health to provide equity and improve health outcomes, especially for the poor." This can be carried out through: (1) revenue-generating initiatives; (2) efficiency in mobilizing investments; (3) performance-based financial system; (4) health agencies and facilities with significant revenue-generating capacities should not only support its own requirements but also contribute to meet the needs of non-revenue generating priority programs; and (5) further strengthening of the NHIP by expanding enrollment coverage, improving benefits and leveraging payments on quality of care.
- **Health Regulation**. The main objective is to assure "access to quality and affordable health products, devices, facilities and services, especially those commonly used by the poor." The approach will focus on the supply and demand of health regulation. For the supply side, the reform will harmonize and streamline the "systems and processes for licensing, accreditation and certification in order to make health regulation more rational and client-responsive."
- **Health Service Delivery**. The objective is to improve "the accessibility and availability of basic and essential health care for all, particularly the poor." Both the public and

private providers are covered under this component and are challenged to develop basic and essential health service packages.

- **Good Governance in Health**. The objective is to "improve health systems performance at the national and local levels. FOURmula ONE for Health will introduce interventions to improve governance in local health systems, improve coordination across local health systems, enhance effective private-public partnership, and improve national capacities to manage the health sector."

In terms of management structure, the DOH and the LGUs will converge their efforts to ensure that the program and policies are implemented and objectives are reached. Certain DOH units will be clustered together and designated to oversee the implementation of the reform agenda. The management structure is expected to account for the monitoring and implementation at the national, regional and local levels. At the national level, there are several teams that are tasked to assume the roles of Governance and Management Support, Policy and Standards Development and Technical Assistance, and Field Implementation and Coordination. At the regional level, there will be Regional Implementation and Coordination Teams that are composed of DOH-CHD, PhilHealth Regional Office, POPCOM Regional Office, all retained health facilities and other related agencies and organizations at the regional level. At the local level, the Local Implementation and Coordination Team are organized composed of Existing Local Health Boards and Inter-Local Health Boards.

5 PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

Public-private partnership (PPP) is a process and a mechanism used by different countries to address the problems and opportunities in providing public goods and services to a diverse group of multiple stakeholders. In the healthcare sector, both developed and developing countries use PPP to assist their governments in improving health services delivery by engaging the private sector to actively participate in providing goods and services of high quality in a timely fashion. The PPP can also assist in regulating or developing appropriate behavior—for example by enhancing transparency and accountability. The critical conditions needed for PPP to work in the healthcare sector include the readiness of the public sector as well as the establishment of an incentive mechanism for the private sector.

For the public sector, readiness includes the presence of complete and accurate information to establish a framework for implementation as well as strengthened capability in assessing and regulating the industry based on the set guidelines (Lagomarsino et al. 2009). The presence of complete and accurate information pertains to the compilation of data and information on the current developments in the health sector. It should include the documentation of the interaction and relationship among the players, as well as the data on the transfer of financial resources and services. As for setting up an established framework and priorities, the government must be able to identify its key objectives and priorities in order to correctly define the relevant outputs and its corresponding activities. Lastly, readiness requires strengthening the capacity of all stakeholders—including the public sector in terms of its planning, enforcement, and monitoring capabilities.

Consequently, the public sector must ensure the presence of incentives that will encourage the private sector to engage in the partnership. Since profitability is still the private sector's primary motivation, the government must be able to develop partnership plans that will contribute to the company's bottom-line while addressing the recurring concerns of distribution, quality and cost of medical services and facilities that prevail in the provision of many public goods.

Based on the experiences of other countries, the available methods for PPP include (1) creating a regulatory framework for licensing and accreditation of facilities and professionals; (2) pooling resources among private and public sector through social health insurance where government provide tax-generated funding with private premiums and subsidies for the poor; and (3) subcontracting the provision of medical services or operation of healthcare facilities to the private sector.

The Philippines has a strong and vibrant private sector participation in the provision of medical services. Both the regulatory framework as well as infrastructure exist in a limited fashion for licensing private providers. The social health insurance program is nationwide in infrastructure and universal in terms of its mandate. It is designed for mandatory participation of formally employed individuals via salary taxes (employer and employee shares) as well as coverage of the indigent sector via government subsidies. The national health insurance program accredits both private and public institutions. It accredits private physicians and midwives and has recently begun to accredit physicians working in the public sector.

However, there are still numerous opportunities for improvement:

First, the government manages and monitors the availability of information. The primary sources of information are the DOH and the National Statistical Coordination Board. In addition, the National Health Insurance Program is a rich source of information. However, not all of the information is electronically encoded. Hence, opportunities for timely and comprehensive analysis to be used for informing policy and operational decisions may be lost.

In addition, there is a lack of transparency in the reporting of actual budgets and expenses for healthcare, which increases the danger of misuse of funds. The devolution of the management and funding of health services to the local government units not only further complicates governance and accountability, it also increases the vulnerability of the sector to financial anomalies.

Second, the DOH has established a clear set of guidelines and activities needed to improve the healthcare sector through the Health Sector Reform Agenda and the FOURmula One Program. The DOH has acknowledged the major challenges in the healthcare sector, and used it in identifying the major objectives and priorities of the programs. Moreover, it also stated the long-term and short-term goals that should be addressed with the specific guidelines to be followed and the activities that must be conducted. However, implementing the framework into practical and doable activities and ensuring a direct link between the activities and the objectives are major challenges

Although there is a national mandate and framework for implementing reform structures in the Philippine health sector, with possible initiatives to work with the private sector, a one-size-fits-all strategy and action plan will not work for all regions and provinces. LGUs' priorities depend on the context of their needs. Specifically, the socio-economic environment of the province affects the decision of the LGU to determine which government services should come first. For example, in Mindanao, where armed conflict is prevalent, it is difficult to ensure the safe deployment of medical doctors and nurses for its constituents. Hence, a different strategy may need to be taken into consideration—such as training traditional medical practitioners in every clan or tribe among indigenous peoples.

Third, in terms of capacity building, the DOH has set the guidelines in regulating and monitoring the performance of the health sector. However, there is a challenge in improving the competency of these regulating officers to enable them to properly regulate the industry.

One inherent challenge is the lack of financial resources available for capacity building because the budget, as indicated in the DOH's Maintenance and Other Operating Expenses, is allocated mostly for the salaries and maintenance of the public hospitals. In terms of governance, there is difficulty in implementing the regulation and monitoring of the industry in the different regions due to the devolution of health activities. Although the DOH central office takes on the policymaking role, there can be problems on implementation at the local level—in some cases, local DOH units do not have the capacity to adhere due to lack of funds, manpower, or knowhow.

At the moment, at least two PPP programs have been implemented in the Philippines to address the need for cheaper medicines and improved maternal services for the poor.

5.1 *Botika ng Bayan* and *Botika ng Barangay*: Cheaper Medicines for All

Compared with other Asian countries, medicines in the Philippines are three to 100 times higher. Aside from the high prices, the country's poorer rural communities also lack pharmacies. In response, the Philippine government, through the PITC, has created mechanisms to promote cheaper medicine through the *Botika ng Bayan*. In this endeavor, the private sector will act as "alternative distribution channels, while applying price regulations" (Montagu and Bloom, n.d.).

The *Botika ng Bayan* was launched in 2004. It is generally composed of a franchise of privately owned drugstores. PITC, a government-owned and -controlled company, handles the management of the program by identifying the drugs to be sold in the pharmacies as well as the suggested retail prices among the *Botika ng Bayan*. Moreover, it is in charge of the centralized procurement of drugs from China and India, as well as from local pharmaceutical companies. As of latest count, there are 1,971 franchisees. To increase its scope and reach, PITC launched a second program called *Botika ng Barangay*, a smaller pharmacy selling essential prescription and over-the-counter medicines. Majority are owned and operated by the local government units, but NGOs (such as community cooperatives) can also be franchisees. As of late, there are 12,814 *Botika ng Barangay* in the country (Ibid.).

The private sector organizations that can avail of the franchise include NGOs and cooperatives; trade and labor unions, employees' associations; corporate foundations and

religious groups; senior citizens' and women's groups; and sole proprietorships, partnerships and corporations (Bizmind 2009).

Aside from the private sector, government agencies, through their employee organizations are participating in the program. In February 2009, the Department of Trade and Industry (DTI) in Taguig—through the Department of Science and Technology (DOST) Management and the DOST-wide Employees' Associations—launched the *Botika ng Bayan sa DOST*. According to then DOST Secretary Estrella Alabastro, "This project will surely help maintain the well-being of the mind and body of the entire DOST S&T manpower – spread throughout twenty-one attached agencies... at affordable prices, maintenance drugs for hypertension, diabetes, and other age-related ailments would be readily available to the officials and rank-and-file of the department" (Carteciano 2009).

Medicines sold in the *Botika ng Bayan* are 40-50% lower, compared to larger pharmaceutical stores around the country. Euglocon, a medicine for diabetes (a common disease among Filipinos), retails for PhP10 to PhP11 a capsule. Its generic counterpart can be bought for only PhP5-6 in the *Botika ng Bayan*. Filipinos with hypertension need to shell out about PhP132 to buy Nifedipine (an antihypertensive drug) that retails for about P44 a tablet, to be taken three times a day. If the generic brand is bought, it will cost only PhP78 because it is sold at the *Botika ng Bayan* at PhP25 to PhP26 (Remo 2007).

In 2000, another initiative was implemented to support the current structure in providing cheaper and quality medicines—the Health Plus program led by the DOH and the National Pharmaceutical Foundation (NPH), with funding from the German Development Bank (KfW) and the German Development Agency (GTZ). The main implementing agency is the NPH, "which operates on two tiers, as a wholesale distributor in 27 provinces to *Botika ng Barangays*, LGUs and hospitals, and as the operator of the 575 HEALTH Plus social franchise outlets (targeting the urban poor)." Their mandate is to "offer quality controlled generic medicines at prices that are fixed and published throughout the country." For strategic positioning, NHP ensures that most of its franchises are located in poorer communities where the commercial pharmacies are not present (Montagu and Bloom, n.d.).

5.2 Maternal Services for the Poor

To address the increasing maternal mortality rates among poorer communities in the Philippines, as well as acknowledging its limited capacity to train sufficient health professionals (midwives) to be deployed in the provinces, the United States Agency for International Development (USAID) implemented the Private Sector Mobilization for Family Health (PRISM) in 2004. PRISM aims to "increase private sector participation in the delivery of family planning and maternal and child health services." USAID tapped public and private organizations, among which are the Philippine Chamber of Commerce and Industry (PCCI), the Employers Confederation of the Philippines (ECOP), business companies and labor groups, as well as the Department of Labor and Employment (DOLE), to facilitate the implementation of the program. Aside from its mission to market cheap contraceptives, PRISM also "trained thousands of private midwives to become entrepreneurs, resulting in hundreds of them setting up their own midwife clinics that provide quality family planning and maternal and child health services" (USAID web site, 2010).

The project has six objectives aimed at increasing (Ibid.)

1. The use of modern methods from private sector sources
2. The proportion of modern method users in participating companies/cooperatives
3. Proportion of continuing family planning users in the private sector
4. The use of unsubsidized contraceptive pills and injectables from the private sector
5. Private sector share of IUDs, and
6. Private sector coverage of selected maternal and child health services: tetanus toxoid vaccination, pre-natal services (including micronutrient supplementation and birth plan formulation) and breastfeeding counseling.

PRISM, on the other hand, has three components (Ibid.):

- Workplace initiative. To seek greater involvement of the formal employment sector in the provision of family planning and maternal and child health services.
- Market development. To support the introduction of new, low-priced but profitable contraceptive brands by manufacturers.
- Private practice service expansion. To expand the role of midwives in the delivery of family planning and maternal and child health services as profitable business ventures.

Besides training and promoting entrepreneurship among midwives, PRISM also assisted them in increasing the possibility to be accredited by PhilHealth. Aside from this, PRISM is also involved in ensuring "the accreditation of private-practice, midwife-owned birthing facilities" (Montagu and Bloom, undated).

In 2009, PhilHealth's maternity care package was amended to include "spontaneous natural deliveries." The current maternity package is PhP4,500, with plans to increase to PhP6,500. In addition, the package can be used in hospitals as well as in accredited lying-in clinics, but not for home deliveries. In terms of application, "in principle, the maternity package can cover pre- and post-natal care as well, but PhilHealth is still fine-tuning how this can happen, and what would be included for pre- and post-natal care" (Tan 2009). PhilHealth has implemented the maternity package nationwide. The package includes not just pre-natal care and attendance during delivery but also the first set of basic immunizations for the infant.

5.3 Blue Star Pilipinas: Social Franchising for Health

In 2008, Population Services Philippines, Incorporated (PSPI) started Blue Star Pilipinas (BSP), a "franchise run by private midwives in order to increase access to family planning services among Filipino women." Aside from addressing the need for healthcare facilities in the country, BSP also encourages entrepreneurship among women and targets the indigent community, who have the least access to medical services in the country.

Franchising. As of April 2010, BSP had about 159 franchisees, who are "female practicing mid-wives located in urban, peri-urban, and rural areas." Franchisees pay an annual fee of PhP1,000 (USD 22). To set up the clinic, BSP provides subsidy to potential franchisees amounting to PhP50,000 (USD 1,095), which include a table, lamp, maternity bed, speculum, and forceps. The total amount can be paid on an instalment basis for only PhP300 (USD 6.60) per week for three years.

Requirements. To meet the franchisee criteria, a midwife must (1) be licensed by the Philippine Regulatory Commission for private practice, (2) posses a business permit from the municipal government, (3) have a waste disposal permit, (4) have a professional tax receipt, (5) be willing to promote and provide modern family planning methods, (6) have no existing agreements/contracts with organizations providing similar assistance as PSPI, (7) not be employed in a government or private health facility, (8) have no plans to work abroad, (9) have

good reputation in the community, (10) be willing to complete all the required trainings, and (11) be registered with the Integrated Midwives Association of the Philippines.

Cost. The services offered by BSP franchisees are cheaper compared to private institutions. For example, midwives charge PhP1,500 to 3,500 (USD33-77) for deliveries, whereas private doctor and hospital prices range from PhP 10,000-15,000 (USD 220-330)." BSP franchisees also offer lower family planning services and sell IUD at PhP100 (USD 2), a price three to six times cheaper than private clinics. In addition, all franchisees offer "discounts for services when clients cannot pay—up to 40% of their clients required discounts of some kind" (Roman 2010).

Benefits. For the franchisees, the benefits are increased income, increased client numbers (up to 70%), increased knowledge of family planning, training, clinic refurbishments, and increased skills to treat more clients.

5.4 Enhancing the PPP

Further efforts are needed to enhance the outcomes of the PPP. Three possible areas of action are (1) to increase the quality and quantity of healthcare facilities, (2) to improve the health information system, and (3) to increase public-private insurance coordination.

Availability and Quality of Healthcare. Taking off from the *Botika ng Bayan* concept, the DOH, together with the private sector, could implement a franchise of clinics. As an add-on, the DOH can encourage the private sector to establish clinics in poorer areas—these clinics can provide medical services that are basic and are able to address the primary healthcare needs of the Filipinos surrounding it. The DOH can also subcontract specific services from the private sector, which are costly when funded on a regular basis. Subcontracting of medical services can be limited to a certain period and renewed when the need arises. In addition, the DOH can also subcontract public hospital management, including audit, finance, and human resource departments. These initiatives may provide opportunities to not only cut cost but also provide flexibility in allocating funds to more productive health programs. Moreover, if such outsourcing follows a nationwide structure and policies, this would have the potential for improved data capture and an opportunity to improve performance.

A more ambitious scheme would be for the DOH and local governments to partner with a private service provider (hospital or corporation) willing to invest in a build-operate-and-transfer scheme. This might be one way to address availability problems in certain locations.

Improving the Health Information System. In addressing the need to update the health information system, the DOH instituted the Information, Communication, and Technology (ICT) Program. Despite its modernization endeavors, there is still a lack in the actual management and updating of the information system. As such, the PPP can come into the form of increasing capability and competence among health officials by subcontracting consultants to train and act as advisory panels on how to actually improve the system as well the people handling the information.

Another possible PPP initiative is to privatize the handling of the health information system. The privatization will ensure that the corporation in-charge will need to act in an efficient and professional manner to deliver its mandate. Furthermore, it lessens the burden to the DOH in gathering the data needed, thus it could concentrate on the immediate health needs of the country.

Interface of Social Insurance, Private Insurance, and Free Services. The key initiatives in financing stem from social insurance and free services form government hospitals and clinics. There is clearly still a need to clarify the interface between social insurance and free services. The interface between private insurance and social insurance is better-defined and managed. However, universal coverage remains an elusive goal and the extent of protection provided still leaves much to be desired. The government has begun promoting social insurance through PhilHealth. One PPP initiative might focus on the government's capability to establish a framework for increasing the number of private insurance players. By increasing their numbers, competition may prosper, thus improving the quality and decreasing the cost of membership. Of course, the government must ensure that they have the mechanisms to protect the health insurance members.

Charity Services. Since most provincial hospitals are in need of adequate health professionals and latest medical equipment, the DOH can encourage private hospitals or even pharmaceutical companies to "adopt a hospital." Similar to the Department of Education's Adopt-a-School program, the private sector (corporations or individuals) can contribute to improving the healthcare facility in certain medical facilities. As part of private corporations/

individuals' social programs, they can provide training to the health professionals, donate old medical equipment, professionalize hospital administration, and provide capacity-building measures for health and non-health professionals.

5.5 Opportunities

To conclude, public-private partnerships provide an opportunity to harness the unique strengths of both public and private sectors in order to enhance the sustainability and success of the health sector reform initiatives. One of the key challenges is trust. The pervasive and systemic corruption that occurs in the different government agencies and officials has lowered the trust rating of the private sector concerning a meaningful partnership with government. Trust is a key element in building a successful long-term partnership.

The next challenge is the alignment of goals and objectives. It is essential to identify these because both sectors have different ends and means. The private sector will always focus on efficiency and profitability, while the public sector will focus on effective and high-impact projects. It is difficult to balance both differing means and ends. A framework of partnership will be essential; this can delineate the duties and responsibilities of both parties; from the resources committed, to the type of delivery system to be implemented. With the "buy-in" and "commitment" of both the private and public sector formalized it will serve as the guiding principle during the implementation stage. The main challenge in the implementation stage is to adhere to the commitment that was agreed upon.

Finally, the progress of the partnership needs to be constantly evaluated and monitored. This can be done through the hiring of a third party evaluator. Evaluation of the project can monitor the success and impact of the project.

Partnership entails a level of trust and commitment. Without these two essential pillars, a successful public-private partnership can never occur. It is important to note that both sectors must come to an understanding that they both need each other. Both of them have their strengths and weaknesses, but in creating and forging a partnership, both can combine their strengths and compensate their weaknesses. Overall, if all stakeholders will be willing to work towards common objectives and remove all their preconceived notions and misunderstandings, a successful private-public partnership will be achieved.

Clearly, not all of these things will happen overnight. The key is to choose high-impact projects with a high probability of success.

6 KEY CURRENT CONCERNS, INITIATIVES, AND OPPORTUNITIES

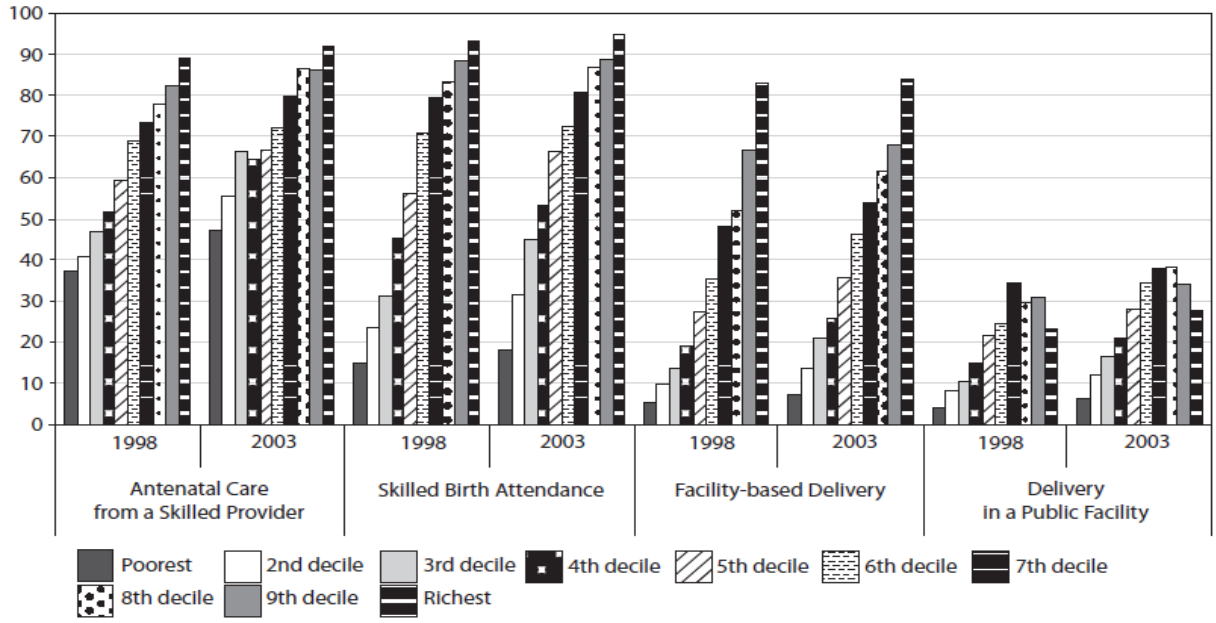
6.1 Issues in the System as a Whole

Romualdez (2010) believes that the most significant health issue faced by the country today is "health inequality"—wherein the poor who are most in need of medical attention fail to avail healthcare services because they lack financial capability. To illustrate this point, he said:

> People who live in rich urban communities with access to modern facilities can expect to live to the age of 80 or more. Less than 10 of every 1,000 babies born to their families each year are likely to die before their first birthday. Only 15 mothers out of every 100,000 who give birth actually die from obstetric or other child-bearing complications each year. These health outcomes are just like those of the most developed countries of the world. On the other hand, life expectancy in poor communities is less than 60 years, infant mortality rate is as high as 90 per thousand, and maternal mortality significantly more than 150 per 100,000 live births – just like the least developed countries of Africa and South Asia. The majority of Filipinos live in such communities (Romualdez 2010).

Furthermore, there is a gap between the births attended by skilled health personnel based on the educational level of the mother and income levels. In the Philippines, skilled health personnel supervise about 92.4% of births in the highest income group, while only 25.1 in the lowest income group receive skilled supervision. Regarding the educational level of the mother, about 71.8% among highest educational levels are well supervised, compared to only 11.0% among the lowest educational levels (World Health Organization 2003). This is also supported by an ADB report saying: "Less than 10% of women in the lowest wealth decile deliver in a health facility, while about 84% of their wealthiest counterparts deliver in a health facility" (Son, 2009).

Figure 8. Selected Maternal Health Service Utilization Indicators, 1998-2003



* Hyun H. Son's estimates based on NDHS.
Source: Son 2009.

Looking at the mortality rate per region, the ADB report (2007) states that "the NCR has an infant mortality rate of around 20, which is very close to the norm of developed countries, whereas some parts of Mindanao have mortality rates of about 100, similar to the least developed countries." According to Romualdez (2010), this is prevalent because of several factors: (1) strong presence of privately provided healthcare, who cater to the upper income groups, which make up 25% of the population; (2) lack of financial resources and capability of the public medical providers to provide for the rest of the population (75%); and (3) the "faulty design" of the devolution of health services to the local government units.

In terms of health-seeking patterns, sources suggest most Filipinos in the lower income levels tend to refuse medical services because they have a perception that they cannot afford it. Due to the lack of financial resources and the geographic orientation of the country, there is difficulty in equitably transporting and providing medical services.

To expand affordability, LGUs depend on the internal revenue allotment (IRA) as the primary source of funds. The lack of resource-generating mechanisms on the part of the LGU results in the dependency on the IRA—for all public goods. Not all provinces and municipalities are rich enough to provide good and quality medical services for everyone. For

example, Makati is the central business area of the country and is able to collect substantial amounts of taxes to provide basic services such as education and medicines. In Mindanao, specifically in the ARMM, armed conflict is a threat, and much of the population live in poverty—the government relies primarily on the appropriations of the national government and to a certain extent on the informal sector to fund the provision of public goods.

6.2 Hospital Reform

As with healthcare reform, the hospital industry also faces problems stemming from the lack of medical facilities in the poorer areas, NHIP accreditation, availability of healthcare professionals, quality of healthcare, financing, governance mechanisms, and timely and accurate reporting. In general:

- Healthcare providers in the Philippines are heavily concentrated in urban and wealthy communities, including cities in the NCR and in its neighboring provinces. Rural communities in greater need of healthcare have limited access to healthcare facilities.
- The nationalization of the social healthcare insurance expanded the membership presence outside the urban areas. However, the challenge begins with promoting physical availability because in many areas no provider even exists to be accredited.
- In order to attract these professionals to stay in the country and to work in the rural areas, these professionals need an increase in income and benefits, especially those in the public sector. In addition, the government needs to assign more healthcare workers in the provinces.
- The prevalence of poor healthcare facilities and services can be associated with (1) the proliferation of medical and nursing schools, which are unable to comply with government regulations and requirements, thus producing students who are unable to pass the medical licensure examinations; (2) the lack of a regulatory framework in assessing which healthcare workers practicing have passed the medical examinations; and (3) the presence of “unlicensed” clinics and hospitals operating in the provinces. There is clearly room for improved regulation.
- Financing and availability of funds are two important concerns for the sector. Due to the limited funds and high investment outlay, private institutional providers are unable to expand their operations to the rural communities. Moreover, public hospitals are

unable to hire health professionals and improve their facilities because they rely on LGU or national government allocation.

- The DOH has been disseminating information about health and risks by running radio and television infomercials. However, in areas with minimal electricity or telecommunications infrastructure, Filipinos are unable to hear or see these education campaigns.
- To improve timely and accurate patient information, the DOH, with the National Center for Health Facilities Development and Information Management, devised software—the Hospital Operations and Management Information System. However, the problem of financing persists, and maintaining the system and updating information carries added costs.

To conclude this overview, the Philippine government has been highly supportive of environmental policies and laws affecting the health and welfare of its people. Some regulations include The Philippine Environment Code of 1977, Marine Pollution Decree of 1974 and 1976, The Philippine Water Code of 1976, Sanitation Requirements for Transport Facilities of 1974, Sanitation Code of the Philippines of 1975, Environmental Impact Statement System of 1978, Toxic and Hazardous Waste Act of 1990, Philippine Clean Air Act of 1999, Ecological Solid Waste Management Act of 2002, and Philippine Clean Water Act of 2004. In terms of health education, the DOH has partnered with the Department of Education to pursue child nutrition programs and projects, such as Health and Nutrition Education; National Drug Education Program; Medical, Dental and Nursing Program; TB prevention and control program; School Milk Project; and Breakfast Feeding Program.

7. ANNEX

Table 1. Top 10 Causes of Morbidity in the Philippines

Cause	Number	Rate/100,000 Population
1. Pneumonia	734,581	924.0
2. Diarrhea	726,310	913.6
3. Bronchitis/Bronchiolitis	629,968	792.4
4. Influenza	484,388	609.3
5. Hypertension	304,690	383.2
6. TB Respiratory	114,221	143.7
7. Diseases of the Heart	52,237	65.7
8. Malaria	39,994	50.3
9. Chicken Pox	28,600	36.0
10. Measles	24,639	31.0

Source: Department of Health.

Table 2. Total Health Expenditure, 2005-2007

ITEM	2005 [1]	2006	2007	Average Annual Growth Rate, 2005-07
Total Health Expenditure (in million pesos, at current prices)	198,398	216,413	234,321	
Total Health Expenditure Growth Rate (in percent, at current prices)		9.1	8.3	8.7
Total Health Expenditure (in million pesos, at constant 1985 prices) [2]	47,418	49,586	51,564	
Total Health Expenditure Growth Rate (in percent, at constant 1985 prices)		4.6	4.0	4.3

1/ Revised

2/ Derived using the consumer price index (CPI) for all items

Source: National Statistical Coordination Board

Table 3. Per Capita Health Spending, 2005-2007

ITEM	2005	2006	2007	Average Annual Growth Rate, 2005-07
Per Capita Health Expenditure (in pesos, at current prices)	2,327	2,488	2,642	
Per Capita Health Expenditure (in pesos, at constant 1985 prices)	556	570	581	
Population (million)	85.3	87.0	88.7	2.0
Per Capita Health Expenditure Growth Rate (in percent, at current prices)		6.9	6.2	6.5
Per Capita Health Expenditure Growth Rate (in percent, at constant 1985 prices)		2.5	2.0	2.2

Source: National Statistical Coordination Board.

Table 4. Source of Funds, 2005-2007

Source of funds	Percent Share		
	2005	2006	2007
GOVERNMENT	29.5	26.6	26.2
National Government	15.3	12.5	13.0
Local Government	14.1	14.1	13.3
Social Insurance	9.8	8.8	8.5
National Health Insurance Program	9.7	8.8	8.5
Employees' Compensation	0.0	0.0	0.1
Private Sources	59.6	62.6	64.8
Private Out-of-pocket	49.2	52.3	54.3
Private Insurance	2.1	1.8	1.8
Health Maintenance Organizations	4.5	4.7	5.1
Employer-Based Plans	2.9	2.7	2.5
Private Schools	1.0	1.1	1.1
Rest of the World	1.1	2.1	0.4
Grants	1.1	2.1	0.4
ALL SOURCES	**100.0**	**100.0**	**100.0**

Source: National Statistical Coordination Board.

Table 5. 2005 Government Health Expenditures by Use of Fund and by Type of Expenditure

SOURCE OF FUND	Amount (in million pesos)				Percent 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
Gen. Admin. 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	0.0
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
Gen. Admin. and Operating Cost	612	589	3	1,204	50.8	49.0	0.2
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	1,870	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
Gen. Admin. 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 Statistical Coordination Board.

References

Asian Development Bank. 2007. *Philippines: Critical development constraint (Country diagnostic studies)*. Manila: Asian Development Bank.

Bernabe, Kirsten. 2010. I-TEAM REPORT: THINK ISSUES : Health care beyond reach of poor, say critics (11th of the series). *Philippine Daily Inquirer*, 13 April. http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20100413-263926/Health-care-beyond-reach-of-poor-say-critics.

Bizmind. Botika ng Bayan business program for aspiring health entrepreneur. Entre Pinoy Bank. http://entrebankph.com/botika-ng-bayan-business-program-for-aspiring-health-entrepreneur/.

Carteciano, Jowi A. Botika ng Bayan sa DOST. National Research Council of the Philippines. http://nrcp.dost.gov.ph/index.php?option=com_content&view=article& id=83:botika-ng-bayan-sa-dost&catid=103:previous-news&Itemid=68.

Castro, Lina V. 2009. 2006 poverty statistics for the basic sectors. Presented at the Users' Forum on the 2006 Poverty Statistics for the Basic Sectors and 2006 Child Development Index, June 25, Makati, Philippines.

Dayrit, Manuel M. Presentation on DOH-PIDS household survey. Department of Health FOURmula One. http://www2.doh.gov.ph/f1primer/F1-Page.htm.

Department of Health. 2007. *Field health service information system annual report 2007*. Manila: Department of Health.

———. FOURmula one for health: Implementation framework for health sector reform. http://www2.doh.gov.ph/F1/Presnt.htm.

———. Health sector reform agenda. Department of Health. http://www2.doh.gov.ph/hsra/hsra/hsraA1.htm.

———. List of administrative orders. DOH. http://www.doh.gov.ph/.

Department of Labor and Employment. 2010. Summary of current regional daily minimum wage rates: Non-agriculture and agriculture. http://www.nwpc.dole.gov.ph/pages/statistics/stat_current_regional.html.

Hamilton, Booz Allen. 2009. *HealthCLIR pilot diagnostic: The Philippines—Health business climate legal and institutional reform*. Manila: United States Agency for International Development.

Lagomarsino, Gina, Stefan Nachuk, and Sapna Singh Kundra. 2009. *Public stewardship of private providers in mixed health systems*. Washington, DC: Results for Development Institute and The Rockefeller Foundation.

Lavado, Rouselle F. et al. 2010. How are government hospitals performing? A study of resource management in government-retained hospitals. *PIDS Discussion Paper Series* 2010-02.

Lopez, Tony. 2007. Fighting the drugs cartel. *Manila Times*, May 8.

Mangahas, Mahar. 2009. Five years of high unemployment. Social Climate, *Philippine Daily Inquirer*, September 12. http://opinion.inquirer.net/inquireropinion/columns/view/ 20090912-224788/Five-years-of-high-unemployment.

Montagu, Dominic, and Abby Bloom. Undated. The private sector and health services delivery in the EAP region: Background report to UNICEF on the role and experiences of the private sector in provision of child health services. Draft paper.

National Statistical Coordination Board. 2010. Philippine national health account 2007. http://www.nscb.gov.ph/stats/pnha/2007/shareexpdt.asp.

———. 2005. Philippine national health account 2005. NSCB. http://www.nscb.gov.ph/ stats/pnha/2005/default.asp.

———. FAQs on official poverty statistics of the Philippines. NSCB. http://www.nscb.gov.ph/poverty/2007/ NSCB_FAQsOnPovertyStatistics.pdf.

———. Official poverty statistics for the basic sectors. NSCB. http://www.nscb.gov.ph/ poverty/default.asp.

———. Statistical indicators on Philippine development: Chapter on responding to basic needs of the poor – Health services. NSCB. http://www.nscb.gov.ph/stats/statdev/2009/ Health%20Services/Chapter_Health_Services.asp

Obermann, Konrad, Matthew R. Jowett, Maria Ofelia O. Alcantara, Eduardo P. Banzon, and Claude Bodart. 2006. Social health insurance in a developing country: The case of the Philippines. *Social Science and Medicine* 26, no. 12 (June), linkinghub.elsevier.com/ retrieve/pii/S0277953605006568.

Office of the President of the Philippines. Profile of the Philippines. Office of the President. http://www.gov.ph/index.php?option=com_content&task=view&id=200020&Itemid=26. (Accessed January 2010).

Ona, Enrique T. 2010. Making Filipinos count and counting on Filipinos to address the gaps in health care. Speech during the 2010 World Population Day Celebration, July 12, 2010, Mandaluyong City. http://www.doh.gov.ph/sec_speech.

Ople, Carlo. The Philippines cheaper medicines act petition to Philippine congress. Carlo Ople. http://www.petitiononline.com/cheap862/petition.html.

Pharmaceutical and Healthcare Association of the Philippines. Company profile. PHAP. http://www.phap.org.ph.

Philippine Congress. 1991. *Local Government Code of 1991*. 8th Cong., 6th sess.

———. 1995. *National Health Insurance Act of 1995*. 9th Cong., 3rd sess. www.philhealth.gov.ph/about_us/others/ra7875.pdf.

———. 1998. *Hospital Licensure Act.* 10th Cong.

Philippine Health Insurance Corporation. Corporate Profile. Philippine Health Insurance Corporation. http://www.philhealth.gov.ph/about_us/.

———. Promoting quality healthcare in the Philippines. ASEAN Social Security Association. www.asean-ssa.org/Phic5.PDF.

Philippine Medical Association. Association profile. Philippine Trivia. http://clipmarks.com/clipmark/B6B752E5-A137-4D3E-9E44-6E366DF7C076/.

Ragaza, Jan Marcel and Alliage Morales. 2009. Botika ng barangay not in poorest places despite GMA's claim (first of two parts). *Manila Times,* April 14. http://www.manilatimes.net/national/2009/april/14/yehey/top_stories/20090414top7.html.

Remo, Amy R. 2007. 'Botika ng bayan' makes cheaper medicines available to poor. *Philippine Daily Inquirer,* March 18. http://newsinfo.inquirer.net/breakingnews/metro/view/20070318-55594/%91Botika_ng_bayan%92_makes_cheaper_medicines_available_to_poor.

Remo, Michelle. 2008. New poverty threshold set at P10,000 in NCR. *Philippine Daily Inquirer,* June 1. http://newsinfo.inquirer.net/breakingnews/nation/view/20080601-140029/New-poverty-threshold-set-at-P10000-in-NCR.

Roman, Francisco L. 2010. Assessing and improving social franchising in the Philippines: Blue Star Pilipinas. Asian Institute of Management.

Romualdez, A.G. 2010. PhilHealth proclaims success. *Malaya*, 17 February. http://www.malaya.com.ph/02172010/edromuald.html.

Romualdez, Alberto. 2010. Quasi's Notes. http://www.facebook.com/notes.php?id=100000576154116.

Social Weather Stations. 2010. Fourth quarter 2009 social weather survey: Hunger at new record-high 24.0%. News release, January 12. http://www.sws.org.ph/.

Solutions Incorporated. 2009. Technical assistance on the preparation of PhilHealth chairman of the board strategy frame for improved benefit packages for mothers and children (PhilHealth Benefit Delivery Review): Final report.

Son, Hyun H. 2009. Equity in health and health care in the Philippines. ADB Economics: Working Paper 171, Asian Development Bank. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1616951.

Tan, Michael. 2009. PhilHealth coverage and 'folk illnesses'. Pinoy Kasi, *Philippine Daily Inquirer*, May 22. http://opinion.inquirer.net/inquireropinion/columns/view/20090522-206419/PhilHealth-coverage-and-folk-illnesses.

United Nations Statistics Division. Millennium development goals indicators. United Nations. http://mdgs.un.org/unsd/mdg/Data.aspx?cr=608.

USAID Philippines. Private sector mobilization for family health (PRISM) project. USAID Philippines. http://philippines.usaid.gov/he_mch_prism.html, accessed January 2010.

Valdez, Crispinita A. 2007. Philippine Health Information System. Presentation at the 1st National Staff Meeting CY 2007, January 24-25, 2007, Clark Field, Pampanga. home.doh.gov.ph/nhsm/4thNSM/day%202/3-PHIS-Dir.%20Valdez.ppt.

Virola, Romulo A. 2010. Total health expenditure growing, but is it enough? National Statistical Coordination Board Press Release. August 3. http://www.nscb.gov.ph/pressreleases/2010/PR-201008-SS1-01_healthexp.asp.

World Health Organization. Global observatory for ehealth. WHO. http://www.who.int/goe/en/.

———. Core health indicators. WHO. http://apps.who.int/whosis/database/core/core_select_process.cfm.

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Eugenio López Foundation Bldg.
Joseph R. McMicking Campus
123 Paseo de Roxas, Makati City 1260
Metro Manila, Philippines
Tel. No. +632 8924011 to 25
Fax No. +632 8179240
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