

1 DEFINING THE PHILIPPINE HEALTH SECTOR

Description of the Country

Geographic Characteristics

The Philippines is an archipelago of 7,107 islands located in the western part of the Pacific Ocean off the coast of Southeast Asia. Only 4,000 islands are named and only 1,200 are inhabited. The country has a total land area of 300,000 square kilometers and is one of the largest island groups in the world. The two largest islands are Luzon in the north and Mindanao in the south. Between these islands lies a group of small to medium-sized islands collectively called the Visayas. Manila, located in the central part of Luzon, is the capital city. Metropolitan Manila, also known as the National Capital Region (NCR), is the biggest urban center in the country. It is made up of 14 highly urbanized cities and three municipalities.

The Philippines is mountainous with narrow strips of lowland along the coast and some broad inland plains, particularly in the bigger islands. Tropical forests used to cover most of the Philippines, but very large areas are devoid of forests, causing soil erosion and flash floods. The country has an extensive coastline and many fine bays and harbors. A wide variety of tropical plants and animals can be found in its mountains, rivers and lakes and along its coastal areas. Except for a few plants, the medicinal values of these floras remain to be fully tapped. The seas surrounding the islands are considered one of the richest marine habitats in the world in terms of biodiversity and also one of the most delicate in terms of environmental protection.

The country's climate is generally hot and humid with an average temperature of 32°C. The hottest months are from March to June



when temperatures may reach 38°C. The weather from November to February is pleasantly cool and dry with temperatures around 23°C. Rains and typhoons prevail from July to October. The Philippines is prone to natural disasters brought about by volcanic eruptions, earthquakes, floods and typhoons. The tropical temperature favors the existence of disease vectors and parasites.

Demographic Characteristics

Based on the National Statistics Office (NSO), the total population of the Philippines in 1980 was 48,316,503. This figure has increased to 76,485,088 in 2000, a 58 percent increase between 1980 and 2000. The population is projected to increase to 84,241,341 in 2005 and 91,868,309 in 2010 (PSY 2004). Manila and the other cities and municipalities comprising NCR have a total projected population of 11,240,743 in 2005, around 13.3 percent of the total population of the Philippines.

The population grew at the rate of 2.36 percent annually between 1995 and 2000. Projected annual population growth rate between 2000 and 2005 is 2.1 percent. Five out of the 17 administrative regions have growth rates higher than the national average: Central Luzon, Southern Tagalog, Central Visayas, Southern Mindanao and the Autonomous Region in Muslim Mindanao (ARMM). NCR has the lowest population growth rate of 1.06 percent and ARMM has the highest at 3.86 percent.

Table 1.1 Population, Population Growth Rate and Population Density by Region Philippines, 2000

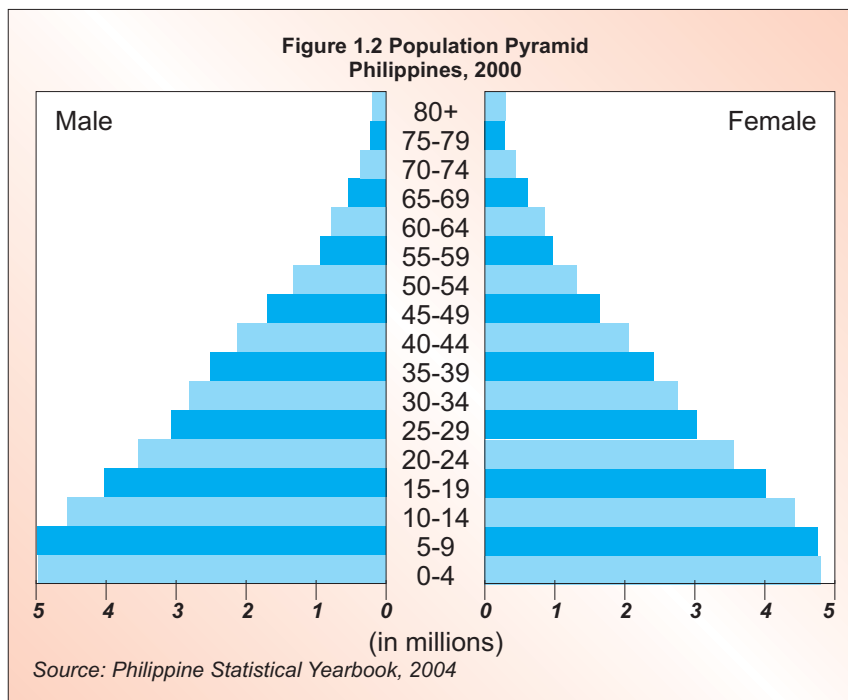
Region	Population	Population Growth Rate (Percent)	Population Density (Person/sqkm)
NCR	9,932,560	1.06	16,091
CAR	1,365,412	1.82	70
Ilocos	4,200,478	2.15	318
Cagayan Valley	2,813,159	2.25	90
Central Luzon	8,030,945	3.20	437
Southern Tagalog	11,793,655	3.72	239
Bicol	4,686,669	1.68	258
Western Visayas	6,211,038	1.56	301
Central Visayas	5,706,953	2.79	359
Eastern Visayas	3,610,355	1.51	155
Western Mindanao	3,091,208	2.18	161
Northern Mindanao	2,747,585	2.19	170
Southern Mindanao	5,189,335	2.60	183
Central Mindanao	2,598,210	2.08	144
Caraga	2,095,367	1.63	98
ARMM	2,412,159	3.86	95
Philippines	76,485,088	2.36	255

Source: Philippine Statistical Yearbook, 2004

In 2000, the population density is 255 people per square kilometer, but this is unevenly distributed throughout the islands with 56 percent of the population living on the island of Luzon. The greatest population concentration is in NCR, with a population density of 16,091 people per square kilometer, a ratio that is 63 times the national average. The least populated areas are the Cordillera Administrative Region (CAR) and Cagayan Valley with a population density of 70 and 90 people per square kilometer, respectively.

The median age of the Philippine population is 21 years old, which means, half of the population is below 21 years old. This makes the Philippines a country of mostly young people. Males outnumber females with a sex ratio of 101.43 males for every 100 females. There are more males than females in the age groups 0-19 and 25-54 years.

The age structure of the Philippine population is a typical broad base at the bottom consisting of large numbers of children and a narrow top made up of fairly small numbers of older persons. The dependency ratio is 69, which means that every 100 persons in the working age group (15-64 years old) have to support about 63 young dependents and about six old dependents. Young dependents belonging to 0-14 age group comprise 37 percent of the



population. The old dependents (65 years old and over) account for 3.8 percent, while 59.2 percent comprise the economically active population (15-64 years old). Women of reproductive age comprise around 51 percent of the total number of females in the country (NSO 2004).

Approximately 52 percent of the Philippine population lives in rural areas (NSO 2004). Urbanized areas are rapidly expanding and offer a wide range of economic, educational, recreational and other facilities. These attract migrants from rural communities. Settlements in remote frontier areas are also increasing. Rural-to-urban and rural-to-rural migration put so much pressure on providing basic social services like health care, shelter, water, sanitation and education. The congestion and pollution in urban areas are harmful to health. In frontier areas, the people's health is affected by difficult access to health services and the presence of locally endemic diseases like malaria, filariasis and schistosomiasis.

In comparison with other countries, the Philippines ranked twelfth among the countries of the world in terms of total population. The Philippines is also among the countries of

Table 1.2 Average Annual Population Growth Rates ASEAN Countries, 1962-2000

Country	Period	Growth Rate
Malaysia	1991-2000	2.6
Brunei	1991-2001	2.5
Cambodia	1962-1998	2.5
Laos	1985-1995	2.5
Philippines	1990-2000	2.3
Singapore	1990-2000	1.8
Myanmar	1973-1983	1.7
Vietnam	1989-1999	1.7
Indonesia	1990-2000	1.5
Thailand	1990-2000	1.1

Source: ASEAN in Figures, 2003

the world with a high annual population growth rate and is ranked fifth among Southeast Asian countries.

Socio-cultural Characteristics

The Negritos, the first known settlers in the Philippines, arrived in the islands about 50,000 years ago. Modern Filipinos are generally descended from Indonesians and Malays who settled in the Philippines about 3,000 BC. They intermixed with more recent immigrants who include the Chinese, Indians, Spaniards and Americans. The

complex mix of peoples has created a blend of eastern and western influences that is uniquely Filipino.

The Philippines is the only predominantly Christian country in Asia. Eighty-two percent of Filipinos are Roman Catholics, 5.4 percent are Protestants, 4.6 percent are Muslims, and the rest belong to other Christian and non-Christian religions. There are two official languages: Filipino and English. Filipino, which is based on Tagalog, is the national language. English is widely used and is the medium of instruction in higher education and the language of government. There are at least 110 ethno linguistic groups, but eight major languages are spoken by majority of the Filipinos: Tagalog, Cebuano, Ilocano, Ilonggo, Bicol, Waray, Pampango, and Pangasinense. Indigenous peoples account for approximately 18 percent (15.2 million) of the population.

The presence of a well-established educational system accounts for the high literacy rate of 92.3 percent. The literacy rate among females is 92.5 percent while it is slightly lower among males at 92.1 percent (PSY 2004). In urban areas, where the people have easier access to educational facilities, including mass media and electronic communications, the literacy rate is higher compared to rural areas. Although the literacy rate is high, folk beliefs, misconceptions and practices detrimental to health are still common. Socio-cultural barriers to health are prevalent and more apparent in indigenous communities.

The family is the basic unit of Filipino society. It is usual to find extended families where the members include not just the husband, wife and their children but also grandparents, parents, siblings and other relatives. Families are close knit, strongly influenced by

tradition and have a sense of loyalty to family and the community. Special events like births and deaths and religious affairs like fiestas bring families together. The family support system is very strong, especially in times of need.

Government and Political System

The Philippines is a democratic and republican state with three branches of government (executive, legislative and judicial). The Philippines has a unitary form of government and a multi-party political system. The Constitution guarantees direct election by the people for all elective positions from the President down to the members of the barangay or village councils.

The executive power is vested in the President, who is the head of state and the commander-in-chief of the Armed Forces. The President appoints the Cabinet members who assist the President in executing laws, policies and programs of the government. The lawmaking power is vested in a bicameral Congress composed of the Senate and the House of Representatives. The Senate has 24 senators directly elected nationwide by the people. The House of Representatives has 250 members elected by congressional districts and by party list system. Judicial power is vested in the Supreme Court and a system of several lower courts. The Supreme Court is composed of the Chief Justice and 14 associate justices.

The local government units (LGUs) make up the political subdivisions of the Philippines. LGUs are guaranteed local autonomy under the 1987 Constitution and the Local Government Code of 1991. As of 2004, the Philippines is divided into 79 provinces headed by governors, 117 cities and 1,500 municipalities headed by mayors, and 41,975 barangays or villages headed by barangay chairpersons (NSCB 2004). Legislative power at local levels is vested in their respective sanggunian or local legislative councils. Administratively, these LGUs are grouped into 17 regions.

Economic Characteristics

The Philippines is a developing country. In 1997, the per capita gross national product (GNP) was P34,365 while the per capita gross domestic product (GDP) was P32,961. By 2003, the per capita GNP has increased to P56,109 and the per capita GDP to P52,241. The economy grew at a faster rate in the 1990s than in the 1980s. From 1988 to 1997, the country's GNP grew at an annual average of 4.1 percent while the GDP went up by an

average of 3.4 percent. It improved in 2002-2003 as GNP growth rate increased to 5.6 percent and GDP to 4.7 percent (NSCB 2005).

In 2000, the annual per capita poverty threshold was estimated at P11, 605, an 18 percent increase over the 1997 threshold of P9, 843. With this threshold, a family of five members should have a monthly income of P4, 835 to meet its food and non-food basic needs. Average annual family income reached P148, 757 in 2003, increasing by 2.5 percent over the P145,121 average in 2000. As earnings rose across all income levels, poverty among Filipino families dropped by almost three percentage points from the 27.5 percent revised estimate for 2000 down to 24.7 percent in 2003 (NSCB 2005).

Unemployment and underemployment rates have increased in the past three years. Unemployment rate stood at 10.2 percent in October 2002, it has gone up to 10.9 percent as of October 2004. Underemployment has also gone up from 15.3 percent in October 2002 to 16.9 percent in October 2004. Average inflation rate has also gone up from 3.5 percent in 2003 to six percent in 2004 (NSO 2004).

In 2003, the GDP was mainly from the service sector (43 percent), followed by the industry sector (31 percent) and the agriculture, fishery and forestry sector (18 percent). Traditionally, the economy depends on agriculture, fishing, forestry and mining. In recent years the service sector and the manufacturing sector have grown rapidly. The service sector, which include education, transportation and communication, property, health, housing and government services, account for the biggest sector of the economy. They employ the bulk of the workforce. The manufacturing sector has also grown rapidly, with the food and beverage, electrical and electronic components and production of garments, wood products and furniture as major industries. Our overseas Filipino workers (OFWs) have also contributed their share to the country's economy. From 1987 to 2002, compensation income (inflows) from overseas workers totaled P406.2 billion or 3 percent of the total GNP for the period covered.

Major imports include machinery and equipment, oil and petroleum products, chemicals and semi-processed materials. The major trading partners of the Philippines have remained to be the United States, Japan, the European community and the Association of Southeast Asian Nations (ASEAN). China is emerging as a major trading partner in recent years.

Health Status of the Filipinos

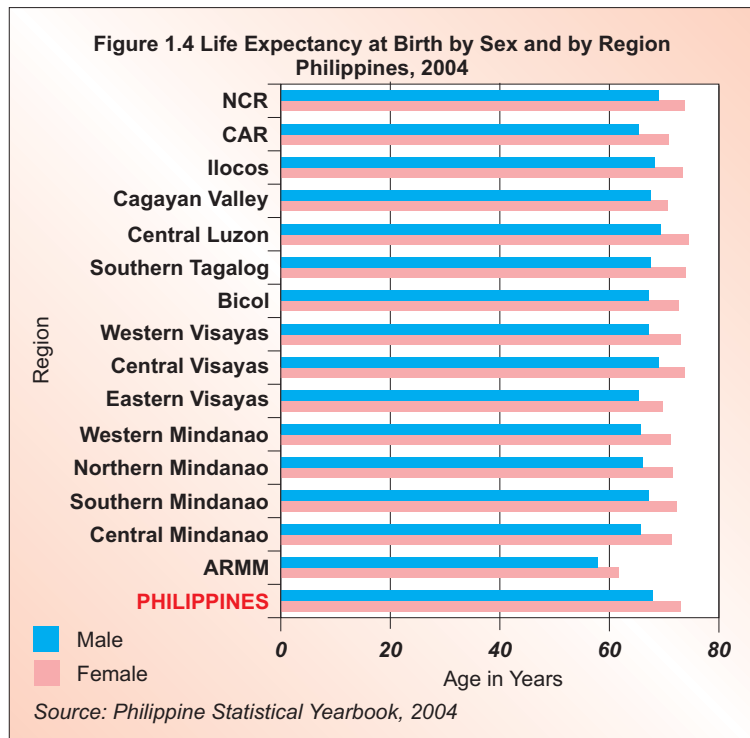
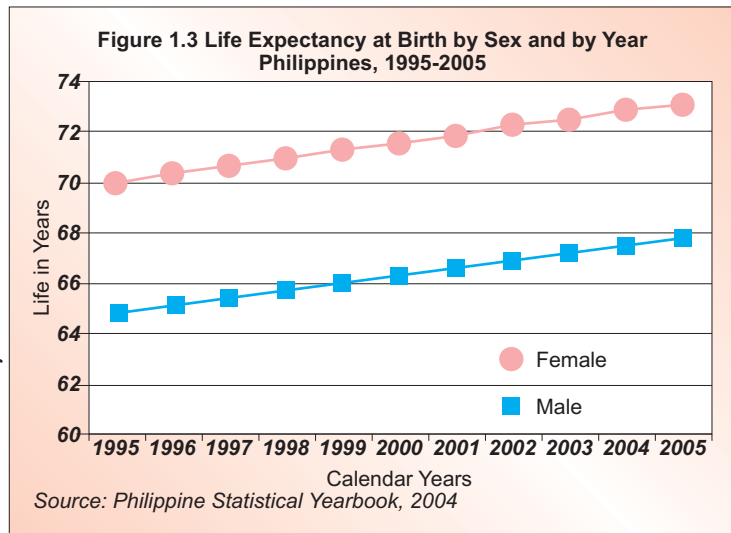
Life Expectancy at Birth

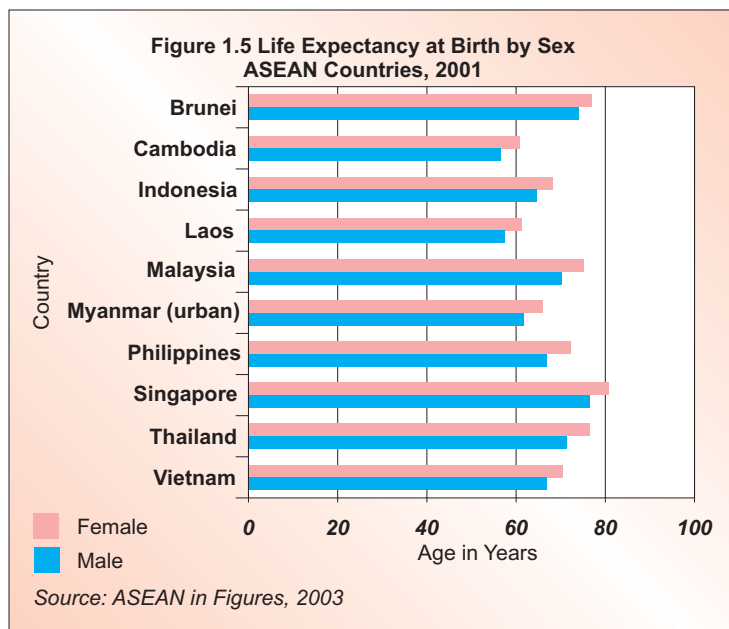
The Filipino's average life expectancy at birth rose from 61.6 years in 1980 to 64.6 years in 1990. Further increase was noted during recent years to an average life expectancy of 69 years in 2000 and projected at 70.5 years in 2005. Life expectancy of females has always been higher than males in the Philippines (72.8 years for females compared to 67.5 years for males in 2004).

The increase in years in the lives of the Filipinos may be attributed to the improving health status of the people and other socioeconomic factors.

Large variations in the average life expectancy at birth occur among the different regions of the country. Central Luzon has the highest life expectancy at 71.7 years followed by the NCR at 71.6 years, Central Visayas at 71.2 years, and Ilocos at 70.6 years in 2004. ARMM has the lowest life expectancy at 59.3 years, followed by Eastern Visayas at 67.3 years and CAR at 67.8 years in 2004.

The rising life expectancy implies that more people will reach old age. This means a higher proportion of older persons in the general population is expected in the future. With this trend comes the increase in the occurrence of degenerative diseases and disabilities associated with an aging population. The large differences in life expectancy among the different regions mean that there is a need to prioritize health and other socioeconomic inputs in some regions, particularly those below the national average.





Average life expectancy at birth in the Philippines is comparable with Vietnam. Although it has lagged behind Brunei, Malaysia, Singapore and Thailand, life expectancy in the Philippines is better than Indonesia, Myanmar, Laos and Cambodia.

Crude Birth Rate and Crude Death Rate

In 1950, the crude birth rate (CBR) was a high 31.7 births per 1,000 population. It became constant at approximately the same

level until the end of the decade. The trend decreased in the 1960s and early 1970s, reaching a low rate of 24.8 per 1,000 population in 1972. Rates from 1973 showed an upward trend, soaring to 30.7 per 1,000 population in 1979. From the 1980s to the 1990s there was again a decline in the CBR, eventually decreasing to 23.1 per 1,000 population in 2000 (PHS 2000).

The total live births in 2000 was 1,766,440 of which 918,243 or 52 percent were males and 848,197 or 48 percent were females. As in previous years, there was a higher proportion of males born in 2000 compared to females, resulting in a birth sex ratio of 108 baby boys born for every 100 baby girls born. The daily average of birth occurrence was 4,826, an addition of three babies to the population every minute (NSO 2003).

The Philippines has reduced mortality from 1950 to the present. A sharp decline of the crude death rate (CDR) was noted from the 11.2 deaths per 1,000 population recorded in 1950 to the rate of 7.3 per 1,000 population recorded in 1959. From 1960s until 2000, a slow but steady decline in the CDR was noted, from the rate of 7.8 per 1,000 population in 1960 to 4.8 per 1,000 population in 2000 (PHS 2000).

There were 366,931 deaths reported in 2000. Daily death occurrences were two deaths every three minutes. The mortality rate for males was 5.7 deaths per 1,000 male population while that for females was 3.9 per 1,000 female population. Of the number of deaths, 217,404 or 59.2 percent were males and 149,527 or 40.8 percent were females, a death sex ratio of 145 males per 100 females dying in 2000 (NSO 2004).

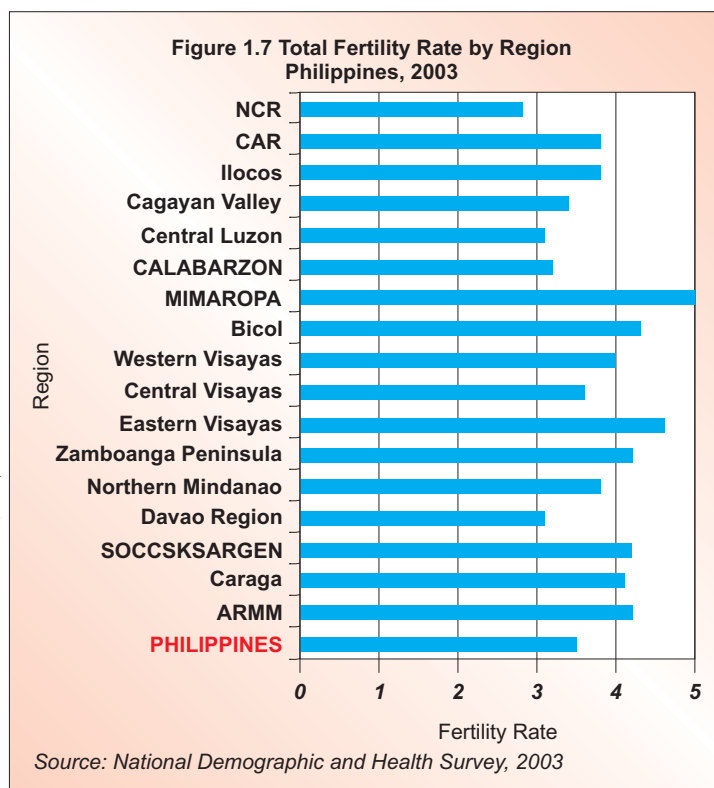
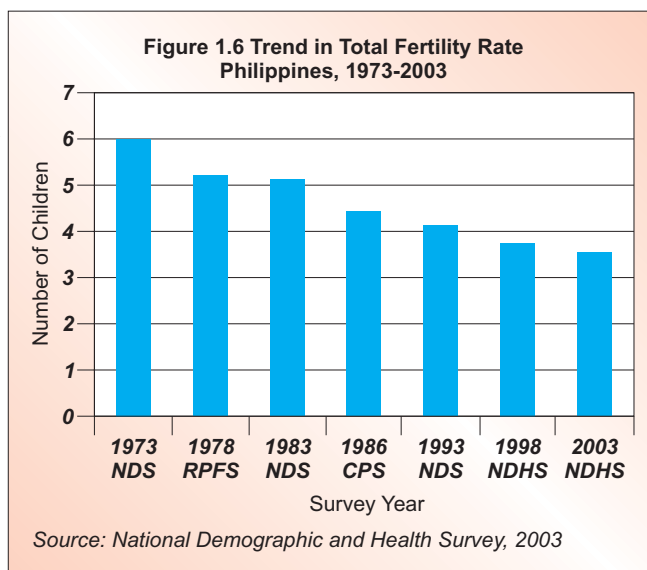
Death rates by age tend to be very high at infancy and early childhood, declining sharply by the age of 10. The rates remain low from this age. They begin to climb at around 40 years and accelerate beyond 50 years and above.

Total Fertility Rate

The total fertility rate (TFR) refers to the average number of births that a woman would have at the end of her reproductive life. The change of the pattern of total fertility rate has important consequences for the health sector. In the short run, greater spacing between births improves the health of mother and child. A reduction in the actual number of births reduces the need for obstetrical care, immunization and other maternal and child health interventions. In the long run, declining fertility redistributes the age distribution of the population away from younger ones and toward middle and older ages.

The TFR is declining in the Philippines, estimated at six births per woman in 1973 to 3.7 in 1998 and 3.5 in 2003. Although TFR is declining in the country, the Philippines still has the highest TFR in Southeast Asia. In 2003, the TFR in Malaysia was 2.9 children per woman, with Indonesia at 2.3, Thailand at 1.9 and Singapore at 1.3 children per woman.

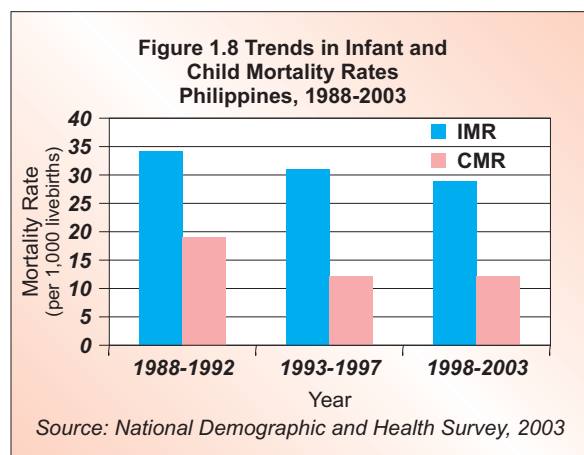
There are regional differences within the country with NCR having the lowest TFR at 2.8 children per woman while MIMAROPA having the highest TFR at five children per woman in 2003. The TFR varies with location and education. The estimated TFR in urban areas is three children per woman. In rural areas it is 4.3 children per woman. Women without education have a TFR of 5.3, almost



similar to the TFR of women with elementary education only (5 children per woman). Among those with high school and college education, the TFR is 3.5 and 2.7 children per woman, respectively (NDHS 2003).

Infant and Child Mortality Rates

The infant mortality rate (IMR) and child mortality rate (CMR) per 1,000 live births in the Philippines have been declining through the years, but the rate of decline has slowed down during the 1980s. After a decade of poor performance, recent estimates suggest



improvements although the decline has not been at par with neighboring countries. The IMR was estimated at 34 infant deaths per 1,000 live births between 1988 and 1992, at 31 per 1,000 live births between 1993 and 1997 and at 29 per 1,000 live births between 1998 and 2003.

Infant mortality varies with socioeconomic and demographic factors. High IMR is noted among infants of mothers with no education, no antenatal and delivery care, and mothers aged below 20 and above 40 years.

IMR is also high among male infants, small or very small infants, birth order number seven and above and past birth interval below two years. The IMR is also lower in urban areas at 24 infant deaths per 1,000 live births compared to 36 per 1,000 live births in rural areas in 2003 (NDHS 2003). The infant death sex ratio is 142.5 male infant deaths for every 100 female infant deaths, indicating a higher risk of dying among male infants (NSO 2004).

Data from the NDHS 2003 show wide regional differences in IMR. IMR is lowest in CAR at 14 infant deaths per 1,000 live births, followed by NCR at 24 per 1,000 live births and Central Luzon and CALABARZON at 25 per 1,000 live births. The three regions with the highest IMR are MIMAROPA at 44 per 1,000 live births followed by ARMM at 41 per 1,000 live births and Western Visayas at 39 per 1,000 live births.

The three most common causes of infant deaths are: pneumonia at 2.0 infant deaths per 1,000 live births, bacterial sepsis at 1.8 per 1,000 live births and disorders related to short gestation and low birth weight at 1.5 per 1,000 live births. Other leading causes of infant deaths are: respiratory distress, congenital malformations of the heart and other perinatal conditions (PHS 2000).

The IMR in the Philippines is high compared with other neighboring Asian countries such as Singapore, Malaysia, Brunei, and Thailand, but it is better

**Table 1.3 Leading Causes of Infant Mortality
Philippines, 2000**

Cause	Number	Rate per 1,000 livebirths	Percent Share from Total Number of Infant Deaths
1. Pneumonia	3,463	2.0	13.8
2. Bacterial sepsis of the newborn	3,174	1.8	12.6
3. Disorders related to short gestation and low birth weight	2,569	1.5	10.2
4. Respiratory distress of the newborn	2,446	1.4	9.7
5. Other perinatal conditions	2,347	1.3	9.3
6. Congenital malformations of the heart	1,596	0.9	6.3
7. Congenital pneumonia	1,359	0.8	5.4
8. Diarrhea and gastroenteritis of presumed infectious origin	1,207	0.7	4.8
9. Other congenital malformations	1,156	0.7	4.6
10. Neonatal aspiration syndrome	1,063	0.6	4.2

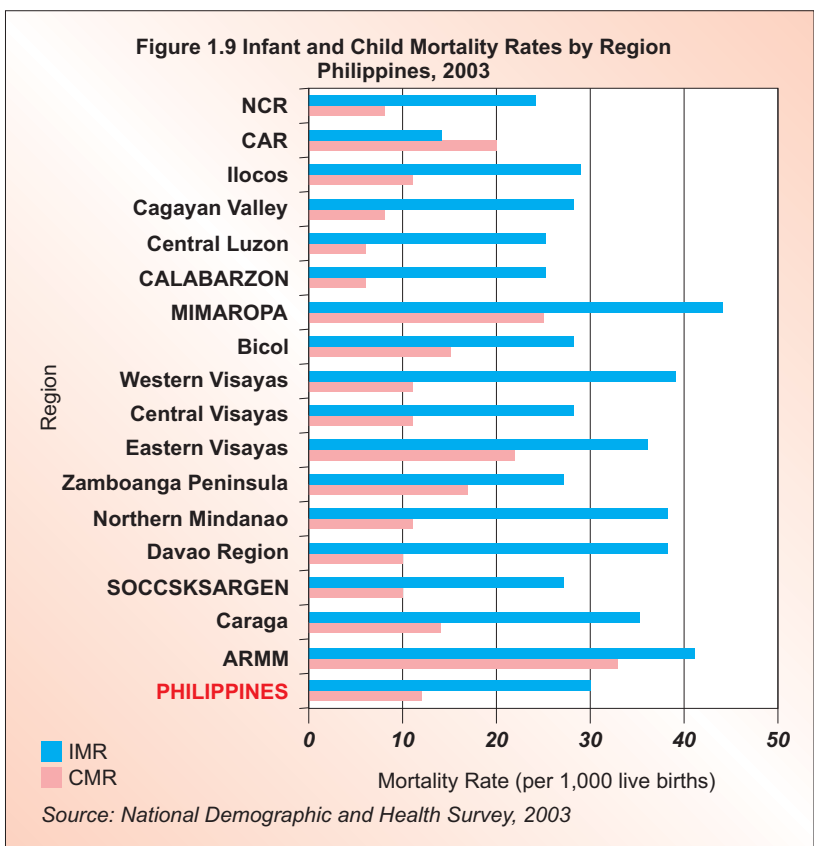
Source: Philippine Health Statistics, 2000

compared to Indonesia, Myanmar, Laos and Cambodia.

The child mortality rate (CMR) per 1,000 live births is also declining in the country. CMR was estimated at 19 deaths per 1,000 live births between 1988 and 1992 and went down to 12 per 1,000 live births between 1993 and 1997 and remained at that level between 1999 and 2003.

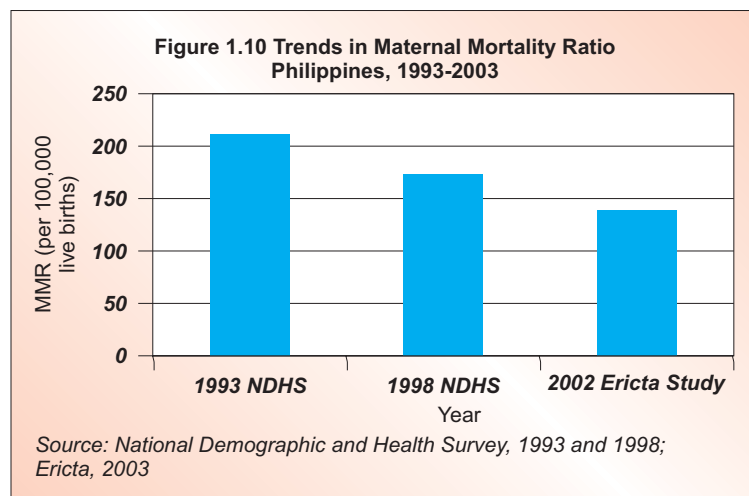
Regional data also show a wide variation among the different regions in the country. Child mortality rate is lowest in Central Luzon and CALABARZON at six per 1,000 live births, followed by Cagayan Valley and NCR at eight per 1,000 live births. It is highest in ARMM at 33 per 1,000 live births, followed by MIMAROPA at 25 per 1,000 live births (NDHS 2003).

The most common causes of child deaths are pneumonia at 37.8 deaths per 100,000 population, accidents at 17.6 per 100,000 population, and diarrheas at 16.1 per 100,000 population (PHS 2000).



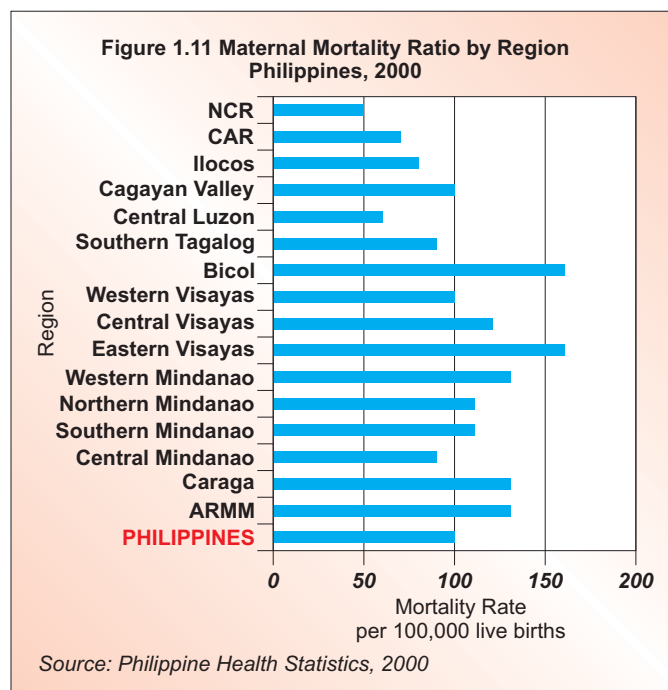
The factors associated with high infant and child mortality point to several areas that need to be addressed. These include not just improving the maternal and child health care programs but uplifting socioeconomic conditions as well.

Maternal Mortality Ratio



Maternal mortality or deaths of women during pregnancy, at childbirth or in the period after childbirth is another important indicator of the nation's health. Based on reports from NDHS, the country's maternal mortality ratio (MMR) improved. The MMR between 1987 and 1993 was estimated at 209 per 100,000 live births. This improved to 172 per 100,000 live births based on estimates between 1991 and

1997. A recent study based on the maternal causes of deaths in the civil registry estimated the MMR at 138 per 100,000 live births in 2002 (Ericta 2003).



Among Filipino women, the lifetime risk of dying from maternal causes is one in 100. Maternal deaths made up less than one percent of the total deaths in the country, but they contribute 14 percent of all deaths in women aged 15-49 years (NSO 1998).

PHS also showed wide regional variations in MMR. In 2000, the MMR is lowest in NCR at around 50 maternal deaths per 100,000 live births followed by Central Luzon at 60 per 100,000 live births and CAR at 70 per 100,000 live births. It is highest in Bicol and Eastern Visayas at around 160 maternal deaths per 100,000 live births.

Maternal deaths are mainly due to hypertension at around 20 maternal deaths per 100,000 live births, postpartum hemorrhage also at around 20 per 100,000 live births and

complications from abortions at 10 per 100,000 live births (PHS 2000). Most of these can be prevented through quality maternal care.

The MMR in the Philippines is high compared with Brunei, Malaysia, Thailand and Singapore but better than Indonesia, Cambodia, Laos and Myanmar.

Leading Causes of Morbidity and Mortality

As in the past, most of the 10 leading causes of morbidity are communicable diseases.

From 1995 to 2000, these included diarrhea, bronchitis, pneumonia, influenza, tuberculosis, malaria, chickenpox and measles. Leading non-communicable causes of morbidity are hypertension and diseases of the heart.

Unlike the 10 leading causes of morbidity, deaths are mainly due to non-communicable diseases. Diseases of the heart and the vascular system are the two most common causes of deaths. These made up 29.7 percent of the deaths attributed to the 10 leading causes (PHS 2000). Deaths due to communicable diseases, however, have lessened from 645 deaths per 100,000 population in 1950 to 217.9 per 100,000 in 1980 to 102.6 per 100,000 in 2000. Deaths due to accidents and injuries increased from 6.4 per 100,000 population in 1990 to 42.4 per 100,000 in 2000. In the past decade, diabetes mellitus has emerged as one of the leading causes of death. Meanwhile, deaths due to diarrhea, septicemia, measles, avitaminosis and other nutritional disorders are no longer in the top ten leading causes of deaths although these are still of serious concern.

Although progress has been made in the past decades to control communicable diseases as leading causes of deaths in the country, their burden as a cause of morbidity is still high. On the other hand, non-communicable and chronic diseases

have emerged as the major causes of death. The disease burden is gradually shifting to non-communicable diseases as the Philippines industrializes and becomes more

Table 1.4 Ten Leading Causes of Morbidity Philippines, 2000

Cause	Number	Rate per 100,000 population
1. Diarrhea	866,411	1,134.8
2. Bronchitis	700,105	917
3. Pneumonia	632,930	829
4. Influenza	502,718	658.5
5. Hypertension	279,992	366.7
6. TB Respiratory	126,489	165.7
7. Diseases of the Heart	52,957	69.4
8. Malaria	50,869	66.6
9. Chickenpox	35,306	46.2
10. Measles	23,287	30.5

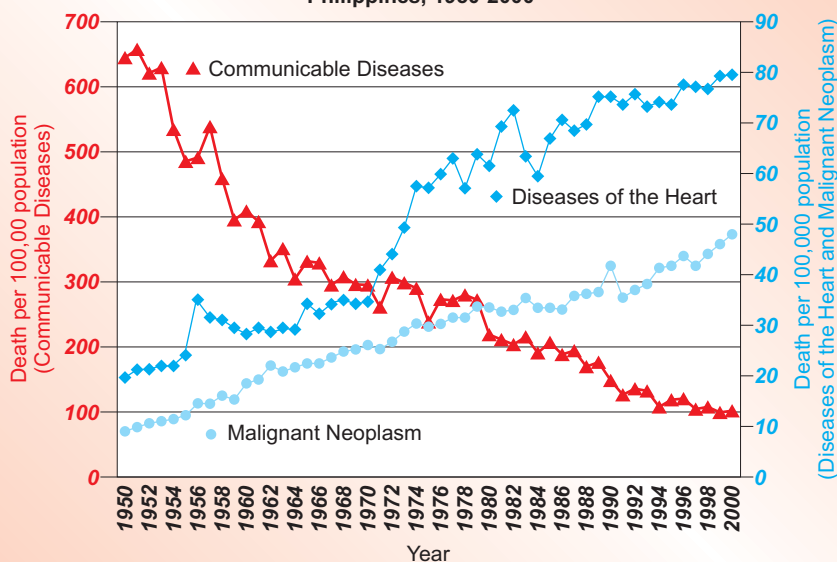
Source: Philippine Health Statistics, 2000

Table 1.5 Ten Leading Causes of Mortality Philippines, 2000

Cause	Number	Rate per 100,000 population
1. Diseases of the Heart	60,417	79.1
2. Diseases of the Vascular System	48,271	63.2
3. Malignant Neoplasm	36,414	47.7
4. Pneumonia	32,637	42.7
5. Accidents	32,355	42.4
6. Tuberculosis, all forms	27,557	36.1
7. Chronic Obstructive Pulmonary Disease and Allied Conditions	15,904	20.8
8. Certain conditions originating in the Perinatal period	15,098	19.8
9. Diabetes Mellitus	10,747	14.1
10. Nephritis, Nephrotic Syndrome and Nephrosis	7,963	10.4

Source: Philippine Health Statistics, 2000

Figure 1.12 Mortality Trends: Communicable Diseases, Diseases of the Heart and Malignant Neoplasm Philippines, 1950-2000



Source: Philippine Health Statistics, 2000

urbanized, as life expectancy increases and as the control of communicable diseases improves. This double burden of disease places a great toll on the health and economy of the people and the nation as a whole. Strategies must be in place to address current and future situations on disease burden.

Table 1.6 Trend of Leading Causes of Mortality Philippines, 1975-2000

Rank	1975	1980	1985	1990	1995	2000
1	Pneumonias	Pneumonias	Pneumonias	Heart Diseases	Heart Diseases	Heart Diseases
2	TB,all forms	Heart Diseases	Heart Diseases	Pneumonias	Diseases of the Vascular System	Diseases of the Vascular System
3	Heart Diseases	TB,all forms	TB,all forms	Diseases of the Vascular System	Pneumonias	Malignant Neoplasm
4	Diseases of the Vascular System	Diseases of the Vascular System	Diseases of the Vascular System	TB,all forms	Malignant Neoplasm	Pneumonias
5	Malignant Neoplasm	Malignant Neoplasm	Malignant Neoplasm	Malignant Neoplasm	TB,all forms	Accidents
6	Gastroenteritis and Colitis	Diarrheas	Diarrheas	Diarrheas	Accidents	TB,all forms
7	Avitaminosis and other Nutritional Deficiencies	Accidents	Accidents	Septicemia	Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease
8	Accidents	Avitaminosis and other Nutritional Deficiencies	Measles	Nephritis, Nephrotic Syndrome and Nephrosis	Other Diseases of the Respiratory System	Certain Conditions Originating in the Perinatal Period
9	Bronchitis	Measles	Avitaminosis and other Nutritional Deficiencies	Accidents	Diabetes Mellitus	Diabetes Mellitus
10	Tetanus	Nephritis, Nephrotic Syndrome and Nephrosis	Nephritis, Nephrotic Syndrome and Nephrosis	Measles	Diarrheas	Nephritis, Nephrotic Syndrome and Nephrosis

Source: Philippine Health Statistics, 2000

Health Care Delivery System

Organization of the Health Care System

The state recognizes health as a basic human right. It protects and promotes the right to health of the people and instills health consciousness among them. Although this provision is guaranteed by the 1987 Constitution (Article II, Section 15) and the health care system in the Philippines is generally extensive, access to health services, especially by the poor, is still hampered by high cost, physical and socio-cultural barriers.

To address these concerns, reforms in the country's health care system have been instituted in the past 30 years: the adoption of Primary Health Care in 1979; the integration of public health and hospital services in 1983 (EO 851); the enactment of the Generics Act of 1988 (RA 6675); the devolution of health services to LGUs as mandated by the Local Government Code of 1991 (RA 7160); and the enactment of the National Health Insurance Act of 1995 (RA 7875). In 1999, the DOH launched the Health Sector Reform Agenda (HSRA) as a major policy framework and strategy to improve the way health care is delivered, regulated and financed.

The Philippines has a dual health system consisting of: the public sector, which is largely financed through a tax-based budgeting system at national and local levels and where health care is generally given free at the point of service (although socialized user charges have been introduced in recent years for certain types of services), and the private sector (consisting of for-profit and non-profit providers), which is largely market-oriented and where health care is paid through user fees at the point of service. The expansion of social health insurance in recent years and its emergence as a potential major source of health financing will have a positive impact on the health care system in terms of health provider practices by both the public and private sectors and in terms of the people's health-seeking behavior.

Under this health system, the public sector consists of the DOH, LGUs and other national government agencies providing health services. The DOH is the lead agency in health. Its major mandate is to provide national policy direction and develop national plans, technical standards and guidelines on health. It has a regional field office in every region and maintains specialty hospitals, regional hospitals and medical centers. It also maintains provincial health teams made up of DOH representatives to the local health boards and personnel involved in communicable disease control.

With the devolution of health services under the 1991 Local Government Code, provision of direct health services, particularly at the primary and secondary levels of health care, is the mandate of LGUs. Under this set-up, provincial and district hospitals are under the provincial government while the municipal government manages the rural health units (RHUs) and barangay health stations (BHSs). In every province, city or municipality, there is a local health board chaired by the local chief executive. Its function is to serve as advisory body to the local executive and the sanggunian or local legislative council on health-related matters.

The passage of the 1995 National Health Insurance Act expanded the coverage of the national health insurance program to include not only the formal sector but also the informal and indigent sectors of the population. The program is founded under the principle of social solidarity where the healthy subsidizes the sick and those who can afford to pay subsidize those who cannot. The Philippine Insurance Health Corporation (PhilHealth), a government-owned and controlled corporation attached to the DOH, is the agency mandated to administer the national health insurance program and ensure that Filipinos will have financial access to health services.

The private sector includes for-profit and non-profit health providers. Their involvement in maintaining the people's health is enormous. This includes providing health services in clinics and hospitals, health insurance, manufacture and distribution of medicines, vaccines, medical supplies, equipment, other health and nutrition products, research and development, human resource development and other health-related services.

Table 1.7 Number and Bed Capacity of Government and Private Hospitals Philippines, 1980-2002

Year	Number of Hospitals			Bed Capacity			Bed per 10,000 pop
	Total	Govt	Private	Total	Govt	Private	
1980	1,607	413	1,194	81,796	39,445	42,351	18.2
1985	1,814	624	1,190	89,508	48,395	41,113	15.5
1990	1,733	598	1,135	87,133	49,273	37,860	14.0
1995	1,700	589	1,111	80,800	43,229	37,571	11.8
2000	1,712	623	1,089	81,016	42,385	38,632	10.6
2002	1,738	661	1,077	85,166	45,395	39,771	10.7

Source: Philippine Statistical Yearbook, 2004

Health Care Facilities

Various health facilities serve the health needs of the Filipinos. The total number of hospitals, both government and private, increased from 1,607 in 1980 to 1,738 in 2002. Though the number of hospitals increased nationwide, the

number of beds per 10,000 population decreased from 18.2 in 1980 to 10.7 in 2002 (PSY 2004). The number of government hospitals nationwide increased from 623 in 2000 to 661 in 2002, while private hospitals slightly decreased from 1,089 in 2000 to 1,077 in 2002. Although only 661 or 38 percent of hospitals are government hospitals, these

contribute 45,395 beds or 53.3 percent of bed capacity nationwide. ARMM has the least number of hospitals, consisting of three private hospitals and 11 government hospitals in 2002. Southern Tagalog has the most number of hospitals with 176 private hospitals and 95 government hospitals (PSY 2004).

In terms of government hospital beds, NCR has the most number at 9,965 beds followed by Southern Tagalog at 6,295 beds and Central Luzon at 3,385 beds. The regions with the least number are ARMM at 870 beds, Northern Mindanao at 1,150 beds and Central Mindanao at 1,195 beds. The government hospital bed to population ratio is worst in Southern Mindanao with one bed for every 3,575 people while it is best in NCR with one bed for every 807 people (NSO 2004).

There is an increasing trend in the number of BHSs from 9,184 in 1988 to 15,343 in 2002 while there is a decreasing trend in the number of RHUs in the country from 1,962 in 1986 to 1,879 in 2001. NCR has the most number of RHUs (Health Centers) while Central Mindanao has the least number of RHUs. On the other hand, Southern Tagalog has the most number of BHSs while NCR has the least (PSY 2004). On the average, each RHU serves around 41,000 people while each BHS serves around 5,100 people.

Table 1.8 Number and Bed Capacity of Government Hospitals by Region Philippines, 2004

Region	Government Hospital		Bed to Population Ratio
	Number	Bed Capacity	
NCR	24	9,965	1:807
CAR	36	1,670	1:916
Ilocos	37	2,100	1:2,109
Cagayan Valley	34	1,720	1:1,754
Central Luzon	45	3,385	1:2,452
Southern Tagalog	93	6,295	1:2,206
Bicol	50	2,250	1:2,260
Western Visayas	53	2,750	1:2,466
Central Visayas	45	2,910	1:2,054
Eastern Visayas	53	2,195	1:1,851
Western Mindanao	29	1,975	1:1,749
Northern Mindanao	24	1,150	1:2,624
Southern Mindanao	32	1,615	1:3,575
Central Mindanao	21	1,195	1:2,176
Caraga	34	1,255	1:1,910
ARMM	24	870	1:2,836
PHILIPPINES	634	43,300	1:1,860

Source: National Statistics Office, 2004

Table 1.9 Number of Rural Health Units and Barangay Health Stations by Region Philippines, 2001-2002

Region	Rural Health Units (2001)	Barangay Health Stations (2002)
NCR	407	17
CAR	88	559
Ilocos	105	911
Cagayan Valley	93	827
Central Luzon	176	1,786
Southern Tagalog	168	2,545
Bicol	67	1,026
Western Visayas	69	1,536
Central Visayas	121	1,717
Eastern Visayas	147	800
Western Mindanao	100	650
Northern Mindanao	67	795
Southern Mindanao	64	655
Central Mindanao	51	654
Caraga	79	506
ARMM	77	359
PHILIPPINES	1,879	15,343

Source: Philippine Statistical Yearbook, 2004

Human Resources for Health

Human resources for health are central to managing and delivering health services. They are crucial in improving health systems and health services and in meeting the desired health outcome targets. Human resources for health are enormous but unevenly distributed in the country. Most health practitioners are in Metro Manila and other urban

centers. Compared to most Asian countries, the Philippines is producing more and better human resources for health.

The number of physicians per 100,000 population slightly increased from 123.8 in 1998 to 124.5 in 2000, a ratio of one physician for every 803 people. The number of dentists per 100,000 population almost remained unchanged at 54.2 in 1998 and 54.4 in 2000 or one dentist per 1,840 people. The number of pharmacists per 100,000 population improved slightly from 55.8 in 1998 to 58.1 in 2000, or one pharmacist for every 1,722

Table 1.10 Number of Local Government Health Practitioners by Region Philippines, 2002

Region	Doctors	Dentists	Nurses	Midwives
NCR	658	540	745	1,165
CAR	85	33	159	579
Ilocos	158	96	203	1,033
Cagayan Valley	175	58	267	801
Central Luzon	297	161	382	1,573
Southern Tagalog	350	256	648	2,282
Bicol	190	85	338	1,026
Western Visayas	226	112	433	1,791
Central Visayas	229	115	379	1,473
Eastern Visayas	153	109	233	887
Western Mindanao	90	55	196	675
Northern Mindanao	99	71	189	803
Southern Mindanao	79	71	161	791
Central Mindanao	84	32	158	671
Caraga	79	54	130	613
ARMM	69	23	99	371
PHILIPPINES	3,021	1,871	4,720	16,534

Source: Philippine Statistical Yearbook, 2004

people. The number of nurses per 100,000 population almost remained constant from 442.7 in 1998 to 442.8 in 2000, a ratio of one nurse per 226 people (SEAMIC 2002).

In 2002, there are 3,021 doctors, 1,871 dentists, 4,720 nurses and 16,534 midwives employed by LGUs. Other health personnel employed by LGUs consist of 3,271 engineers/sanitary inspectors, 303 nutritionists, 1,505 medical technologists, 977 dental aides and 2,808 non-technical staff. Assisting these health personnel at the grassroots are 195,928 volunteer barangay health workers and 54,557 birth attendants (FHSIS 2002).

The Philippines has become a major source of health professionals to many countries because of their fluent English, skills and training, compassion and patience in caring. The country is purportedly the leading exporter of nurses to the world (Aiken 2004) and the second major exporter of physicians (Bach 2003). Although the country is producing a surplus of health workers for overseas market since the 1960s, the large exodus of nurses in the last four years has been unparalleled in the migration history of the country. While Filipino physicians have been migrating to the United States since the 1960s and to the Middle East since the 1970s in steady outflows, the recent outflows are disturbing because they are no longer migrating as medical doctors but as nurses.

Based on the baseline survey of nursing-medics in the Philippines, more than 3,500 Filipino doctors have left as nurses since 2000 and an estimated 4,000 doctors are enrolled in nursing schools all over the country (Galvez-Tan 2004). A little more than 1,500 doctors have passed the national nurse licensure examinations in 2003 and 2004.

The Philippine socioeconomic and political situations have not helped much in retaining licensed and skilled nurses and other health professionals in the country.

Pharmaceuticals

In 1999, the pharmaceutical market in the Philippines was estimated to be around P45 to 47 billion. By 2003 it has grown to approximately P65 to 70 billion and is growing at a faster rate than the domestic economy. Filipinos have one of the highest per capita consumption of pharmaceuticals in Southeast Asia, spending around P750 to 800 per person annually on drugs and medicines (Philippine Pharmaceutical Industry Fact Book 2003). This is around 40 to 50 percent of per capita health spending.

The pharmaceutical market in the Philippines is a segmented market because of asymmetric information, income disparities and inadequacy of the regulatory system. This stems from various factors, including the massive campaign by the bigger manufacturing firms for their products, better incentives given by

**Table 1.11 Comparative Trade Prices of Branded Medicines (in peso)
Philippines, India, Pakistan 2004**

Medicine	Manufacturer	Philippines	India	Pakistan
Ponstan 500 mg tab	Pfizer	20.98	2.80	1.46
Buscopan 10 mg tab	Boehringer	9.26	2.45	0.60
Bactrim 400/80 mg tab	Roche	14.80	0.75	1.09
Adalat Retard 20 mg tab	Bayer	37.56	1.50	3.85
Lopid 300 mg cap	Pfizer	34.66	13.17	2.89
Lasix 40 mg tab	Aventis	8.56	0.53	1.28
Plendil ER 5 mg tab	AstraZeneca	35.94	5.95	8.25
Diamicron 80 mg tab	Servier	11.00	7.57	5.00
Ventolin 50 mcg inh	Glaxo	315.00	132.38	65.88
Voltaren 50 mg tab	Novartis	17.98	0.92	3.92
Isordil 5 mg SL tab	Wyeth	10.29	0.26	0.23
Imodium 2 mg cap	Janssen	10.70	3.27	1.94
Fortum 1 g inj	Glaxo	980.00	418.72	322.75

Source: MIMS 2004, Philippines; IDR 2004, India; Red Book 2004, Pakistan

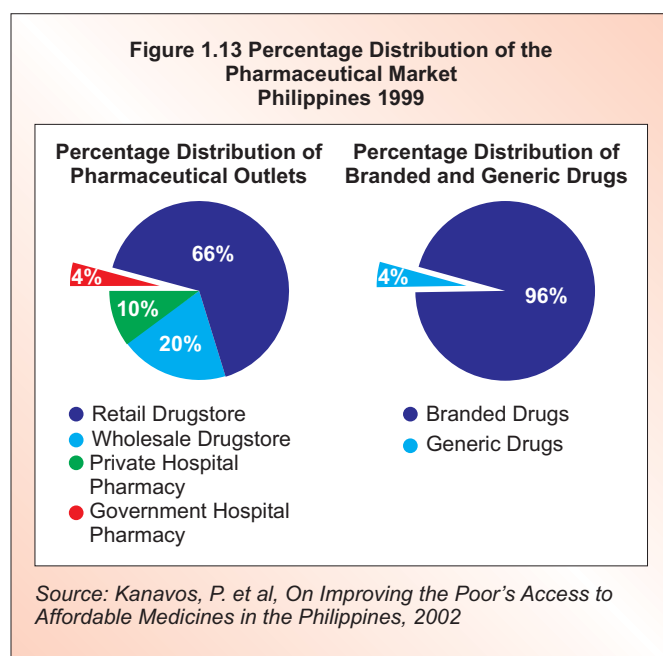
specific firms for prescribers and dispensers of a particular product, the effects of prolonged patent rights, the lack of appropriate public understanding on generics and patent issues, the shortcomings of information and education on pharmaceutical issues and a myriad of political reasons among others.

Multinational drug firms control around 70 percent of market sales. Only 30 percent are accounted for by domestic Filipino companies, with Unilab as the largest Filipino pharmaceutical company. It has the largest individual share (at around 22 percent) among both multinational and local firms. Domestic companies, with the exception of

Unilab and Chemfields, generally do not produce active substances but are limited to activities such as compounding active substances, packing and processing bulk drugs into dosage forms. Recent reports have estimated that 10,000 drugs are off-patent but only around 500 of these drugs are being manufactured by the local industry. The pharmaceutical market is dominated by expensive branded medicines, making drug prices in the Philippines among the highest in Asia (Kanavos et al 2002). The cheaper generic products account for just four percent of the total market. This shows that there are significant problems in the access to medicines by the poor.

Most drug companies use distributors such as Zuellig Pharma, Marsman and Metro Drug to deliver their products in the market. Although distribution fees vary, the cost generally ranges from 12 to 15 percent of product sales. The pharmaceutical retail market in the Philippines is made up of outlets composed of commercial drugstores, government and

private hospital pharmacies. Drugstores account for 85 percent of all drugs sold in the Philippines with the rest of the market served by private and government hospital pharmacies. A single retail chain, Mercury Drugstore, owns most of the big commercial outlets in large urban centers while single proprietors and community-based, non-government organizations own most of the small outlets in rural and small urban communities. Medicines in public facilities are accessed through government hospital pharmacies controlled by the DOH and through provincial and district hospital pharmacies and health centers controlled by local governments.



There is inadequate capacity in ascertaining the quality of medicines so the bigger distributors are able to promote their expensive branded products successfully to health professionals and the general public, and to claim better quality in comparison to more affordable and what are perceived to be inferior products. This tendency is aggravated by the high promotion and gift-giving schemes done by drug companies of expensive brands to health professionals.

Responsiveness of the Health System

Medical Attendance at Births and Deaths

The number of birth deliveries attended by trained health professionals (doctors, nurses and licensed midwives) was 1,153,836 or 65.3 percent of total births in 2000. On the other hand, 610,925 or 34.6 percent were delivered by hilots or unlicensed midwives and other untrained attendants. The regions with the highest total births delivered by trained health professionals were NCR at 89.4 percent followed by Central Luzon at 84.6 percent and Ilocos at 76.4 percent. The regions with very low medical attendance during birth delivery were Caraga at 36.1 percent, ARMM at 38.6 percent and Bicol at 39 percent (NSO 2004).

Maternal deaths attended by physicians, public health officers and hospital staff were 1,052 or 62 percent of total maternal deaths. On the other hand, 646 cases or 38 percent received no medical attention. The regions with the highest maternal deaths attended by health professionals were NCR at 81.7 percent, followed by Ilocos at 73.3 percent and CAR at 69.6 percent. The regions with the lowest maternal deaths attended by health professionals were ARMM at 41.7 percent, Bicol at 48.4 percent and Central Mindanao at 50 percent (NSO 2004).

The number of deaths from all causes attended by medical or health professionals was 130,501 or 35.6 percent of 366,931 total deaths in 2000. Among the regions in the country, NCR has the highest percentage of deaths from all causes attended by medical

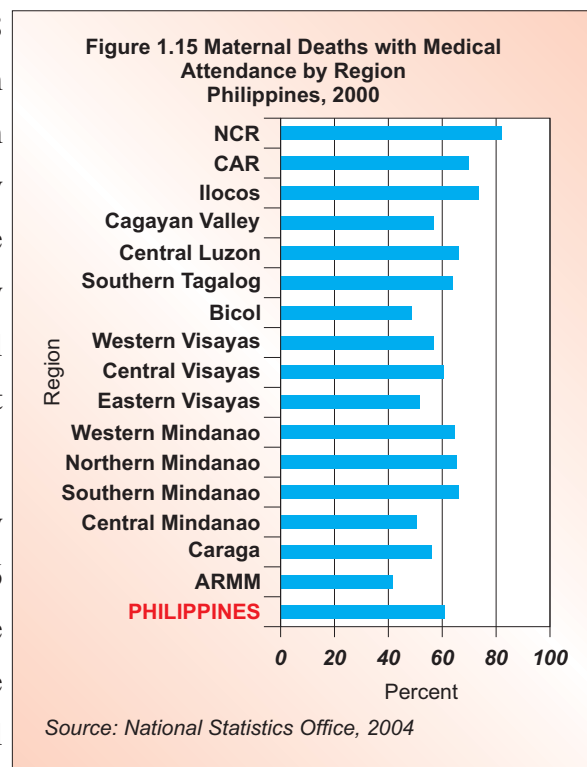
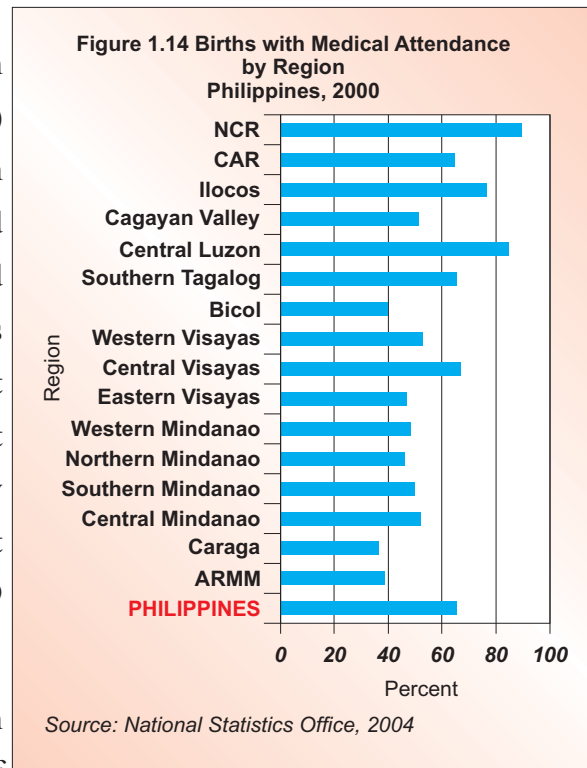
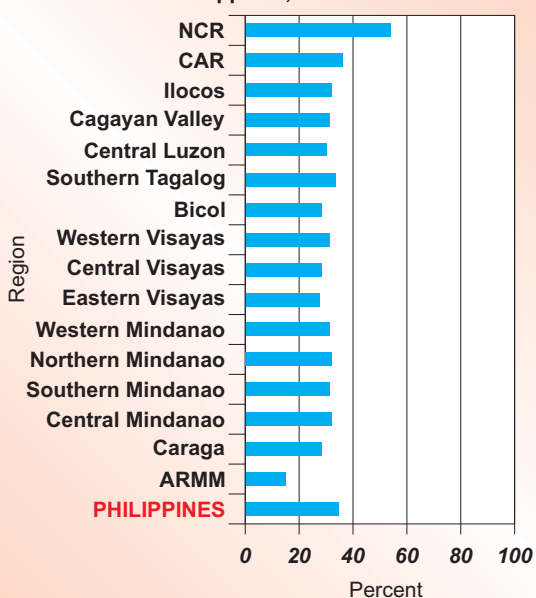


Figure 1.16 Deaths from All Causes with Medical Attendance by Region Philippines, 2000



Source: National Statistics Office, 2004

practitioners at 54.7 percent. ARMM has the least percentage with only 14.4 percent of deaths attended by medical practitioners.

Utilization of Health Facilities

In 2000, the World Bank in collaboration with the Social Weather Station conducted the Filipino Report Card on Pro-Poor Services, a national client satisfaction survey about the performance of government agencies in terms of the people’s access, utilization and satisfaction with public services. The report showed a fairly widespread use of health facilities in the country with 77 percent of the 1,200 households surveyed having used health facilities of one type or another.

The remainder of those who did not visit a health facility (23 percent) gave absence of illness as one of the reasons. A possible implication of this is that the health facilities and services are seen to be essentially “curative,” with lower emphasis on the preventive aspects. Other reasons for not visiting a health facility included self-medication and high cost of medical care.

The proportion of households that visited a health facility is higher for urban (80 percent) compared to rural (72 percent) households. The largest number of visits was made in the

Table 1.12 Utilization of Health Facilities by Area Philippines, 2000

	Philippines (%)	M. Manila (%)	Luzon (%)	Visayas (%)	Mindanao (%)
Visited a health facility	77	82	68	84	82
Mainly used govt. facility	39	35	36	44	42
Government Hospital	20	20	24	16	16
BHS	10	6	4	21	14
RHU	9	9	8	7	12
No private facility	(4)	(2)	(3)	(5)	(9)
Mainly used private facility	30	46	28	27	24
For profit	28	44	27	25	22
Non-profit	2	2	1	2	2
No govt. facility	(2)	(2)	(4)	(0.4)	(3)
Traditional healers	8	2	3	12	17

Source: Filipino Report Card on Pro-Poor Services, World Bank, 2000

Visayas followed by Mindanao. Possible explanations include poorer health status in the Visayas and Mindanao than in Luzon or less effective care necessitating many repeat visits.

Government facilities were the most frequented overall (39 percent) compared to

the private facilities (30 percent). When disaggregated by area, private facilities (46 percent) were visited often in Metro Manila compared to government facilities, despite the large number of government hospitals located there.

Traditional healers were visited by eight percent of the population with a larger proportion of the people from Mindanao and the Visayas accessing their services compared to Metro Manila and Luzon. In the Visayas and Mindanao, there was more frequent reliance on government facilities compared to Metro Manila and Luzon.

Use of private facilities varied significantly by expenditure group and urban-rural residence. Private facilities are predominantly used by rich households and urban respondents, although they account for a significant portion of the health care facilities used by poor respondents as well. In many countries, poor people prefer to spend money on health services from the private sector if they perceive the quality to be higher than that of public services (World Development Report 2000).

Services Provided by Health Facilities

Preventive health services, including immunization, health and nutrition education, family planning and routine check-up, are the mainstay of government facilities accounting for 63 percent of all services provided by government primary facilities.

Treatment of minor accidents and illnesses accounts for another 30 percent of services provided by government primary facilities. These are appropriate functions for the primary health facilities. Traditional healers are most often consulted for minor accidents and illnesses.

Sixty-six percent of all services provided by government hospitals and 69 percent of services by private clinics and hospitals are classified as routine check-ups or minor

**Table 1.13 Type of Services Provided by Health Facility
Philippines, 2000**

	Govt Primary (%)	Govt Hospital (%)	Private Hospital (%)	Traditional Healer (%)
Preventive health care	63	35	37	5
Routine check-ups	34	30	31	5
Immunization	14	1	3	0
Health education	9	3	2	0
Family planning	6	1	1	0
Minor illnesses and accidents	30	31	32	87
Minor illnesses	29	28	31	19
Minor accidents	1	3	1	68
Other services	8	34	31	7
Major accidents	3	20	17	5
Pre/post natal care and deliveries	3	4	4	2
Laboratory services	2	10	10	0

Source: *Filipino Report Card on Pro-Poor Services*, World Bank, 2000

accidents and illnesses, confirming that clients are bypassing lower level facilities that should offer these services. This is despite government primary health facilities being most conveniently located with 94 percent of households having access to a RHU or BHS within a 15-minute walk. However, these facilities are frequently bypassed.

Public primary facilities are perceived for low quality. Those who bypass the primary health facilities are not satisfied with their services. Diagnosis is poor, resulting in repeat visits. Medicines and supplies are inferior and rarely available. The personnel are often not available, especially in rural areas, and are perceived to lack both medical and people skills. Waiting time is long, facility schedule is very inconvenient, and facilities are rundown.

At least two issues must be addressed in this context of bypassing the government primary facilities: how to improve the quality of government primary facilities to enable clients with easy access to use them and how to encourage secondary and tertiary facilities to provide specialized services for which they were created. In addition, referral mechanisms among different health facilities and across LGUs need to be strengthened.

The situation in government hospitals is worsened by the fact that many provincial and district hospitals have inadequate budgetary support after devolution and have lost managerial autonomy. More patients are forced to bypass local government hospitals and seek out better equipped and better staffed national government hospitals. Most of the national government hospitals are in urban and better off areas, worsening the inequity in access to these facilities by residents of poorer and rural areas.

Since public primary facilities are mostly frequented by the poor, improving their quality, with emphasis on services demanded by the poor, would improve their health. This would also reduce inefficient use of public hospitals which should provide higher level of health services rather than primary health care.

Satisfaction with Health Facilities

Overall satisfaction with or appreciation of health facilities is quite high and significantly higher for private facilities than government facilities though government hospitals get higher ratings from rural areas and from among the lower socioeconomic class.

Private facilities are ranked superior on quality aspects of health care, on par with government facilities on convenience of location and not as good on cost aspects. In other words, cost is the only categorical advantage of government facilities over private facilities. Health services provided by public facilities are used mainly by those who could not afford the widely preferred private services.

**Table 1.14 Net Satisfaction with Most Used Health Facility by Area
Philippines, 2000**

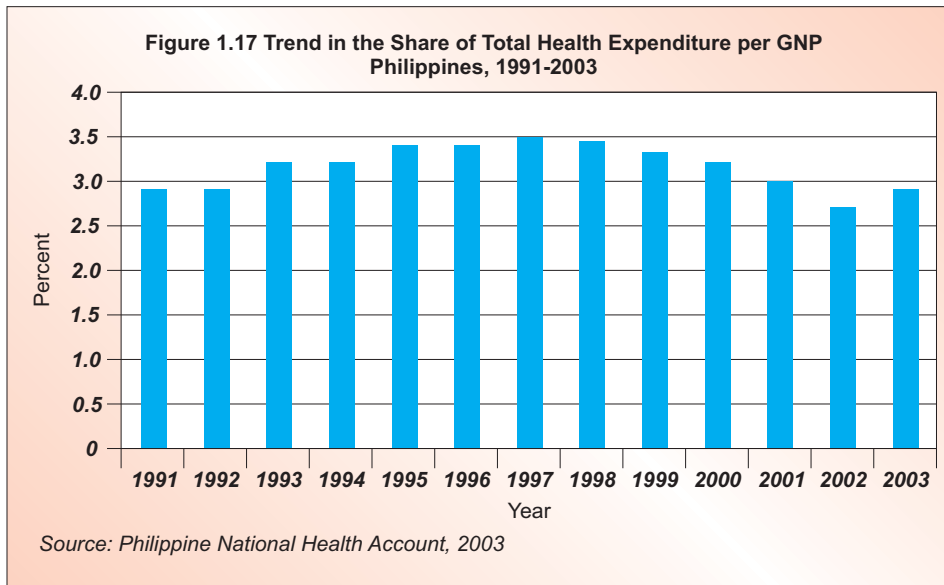
	Philippines	Metro Manila	Luzon	Visayas	Mindanao
Over-all satisfaction	+87	+87	+88	+88	+83
For-profit hospital	+96	+95	+96	+100	+93
Traditional healers	+94	+100	+88	+97	+93
Non-profit hospitals	+91	+100	+71	+100	+100
RHU	+82	+100	+90	+81	+62
Government hospital	+79	+72	+85	+70	+76
BHS	+74	+50	+59	+84	+75

Source: Filipino Report Card on Pro-Poor Services, World Bank, 2000

Health Financing System

Levels and Trends of Health Expenditure

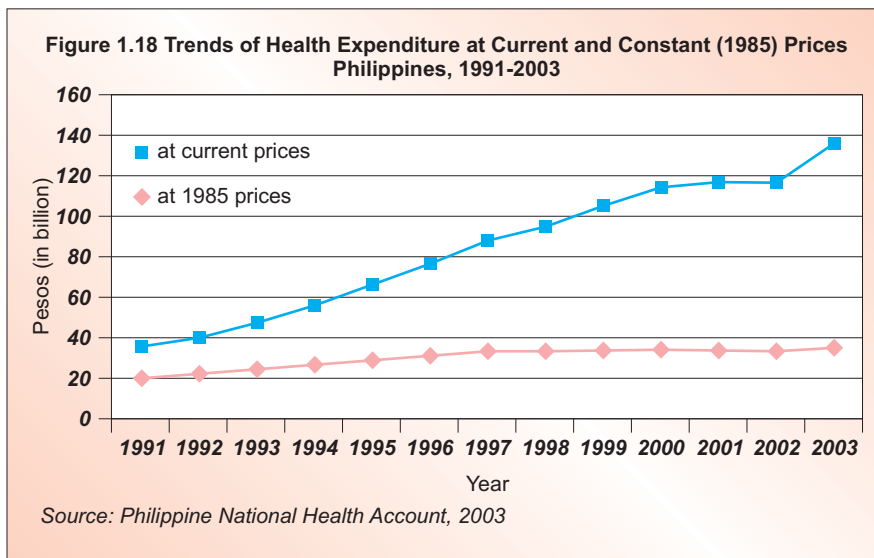
From 1991 to 1997, total health expenditure rose from 2.9 to 3.5 percent of GNP. From 1997, total health expenditure as a percentage of GNP went on a downward trend, reaching its lowest level in 12 years at 2.7 percent in 2002. The Philippine National



Health Account (PNHA) of 2003 showed a total health expenditure of P136 billion or 2.9 percent of GNP which is an improvement compared to the previous year.

Total health expenditure at current prices grew from P36 billion in 1991 to P136 billion in 2003. At constant 1985 prices, total

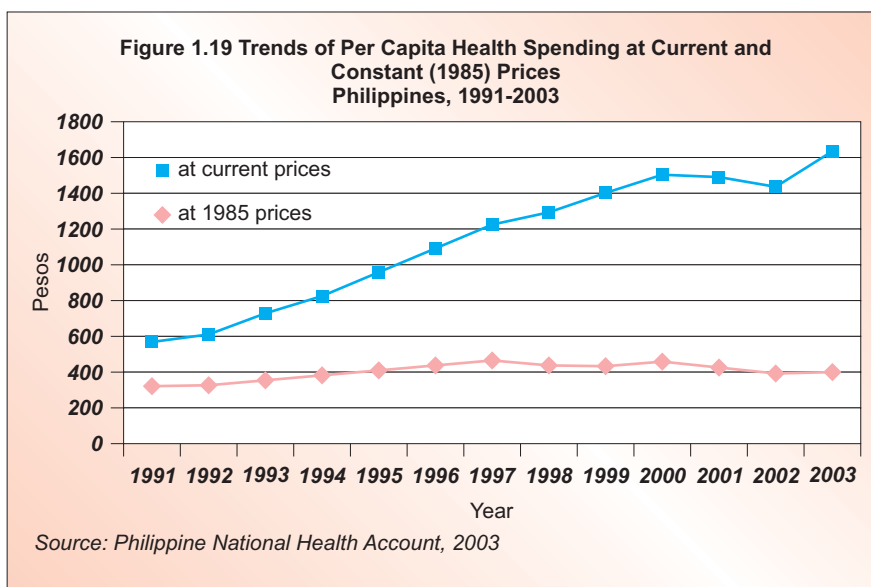
health expenditure increased from P21 billion in 1991 to P35.5 billion in 2003. The growth rate of total health expenditure at constant 1985 prices was negative in 1998 due to the impact of the Asian financial crisis, and in 2001 and 2002 due to the negligible



increase in investment for health.

The increase in health spending from 1991 to 2000, averaging 13.8 percent a year, compared to the average annual population growth rate of 2.3 percent during that time, allowed per capita health expenditures at current prices to increase from P577 in

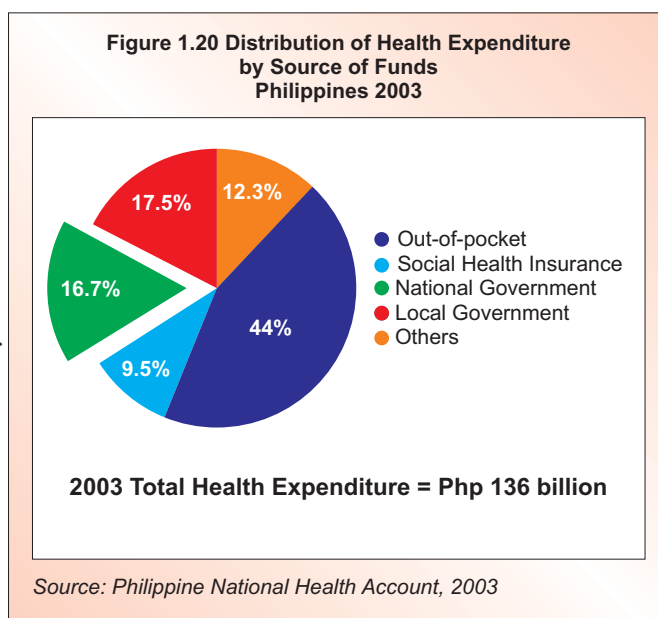
1991 to P1,496 in 2000. In 2001 and 2002, with population showing a faster growth rate than the rate of increase in total health expenditure at current prices, per capita health spending went down by P34, from P1,496 in 2000 to P 1,462 in 2002. It dramatically improved at P1,662 in 2003. At constant 1985 prices, the increase has been from P336 in



1991 to P454 in 1997. With the impact of the Asian financial crisis in 1997, per capita health expenditure at 1985 constant prices decreased to P435 in 1998 but slightly recovered to P454 in 2000. With the population growth rate higher than the total health expenditure growth rate during the period 2001 to 2002, per capita health expenditure at constant 1985 prices shrank to P405 in 2002 but recovered at P434 in 2003 (PNHA 2003).

Sources of Health Financing

In 2003, out of the P136 billion total expenditure for health, P60 billion or 44 percent came from out-of-pocket expenditure of individual families. The burden of financing health care is still heaviest on individual families. Government's share was only P46.5 billion or 34.2 percent of total health expenditure (17.5 percent local government and 16.7 percent national government). Social health insurance accounted for P12.9 billion or 9.5 percent of total health expenditure while other sources (like private

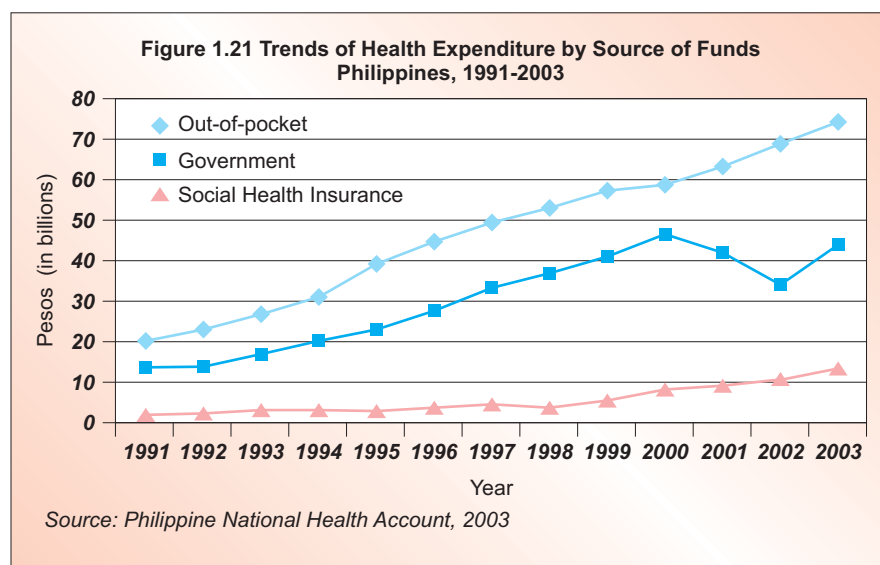


health insurance, community based financing, and employer's benefits) accounted for P14.9 billion or 12.3 percent of total health expenditure (PNHA 2003).

The various sources of funds shown in a typical national health accounts matrix are different insurance mechanisms with varying degrees of ability to pool resources and spread risk. The family, through direct out-of-pocket expenditure, is the least effective and most inefficient health insurance institution. Family income and size limit the resources that can be pooled. Moreover, since members often share or are exposed to similar health risks, the family has limited risk-pooling capacity.

The tax-financed open-access health delivery system under the national and local governments offers a larger resource pool. Since people are taxed before they realize the need for health services, government health budgets are insurance funds. But it is an inefficient form of insurance since individual contributions are often based on consumption or income rather than on health risk. Nonetheless, national and local tax-financed health care delivery systems are more effective forms of insurance than the family.

There has been limited progress made in expanding social risk pools (i.e., government budget and social insurance funds for health). In 1991, social risk pools financed only as



much as 44 percent of total health spending. The burden on individual families from direct out-of-pocket expenditure was around 47 percent of total health expenditures. With the devolution of health services and with the new national health insurance program, the share of social risk pools remained almost the same at 43 percent in

1997, lower than the share of out of pocket family spending of 46 percent. In 2003, social risk pools slightly increased in proportion at 44 percent while out-of-pocket family spending leveled at 44 percent of total health expenditure. Thus, the financial burden on individual families remained high through the years.

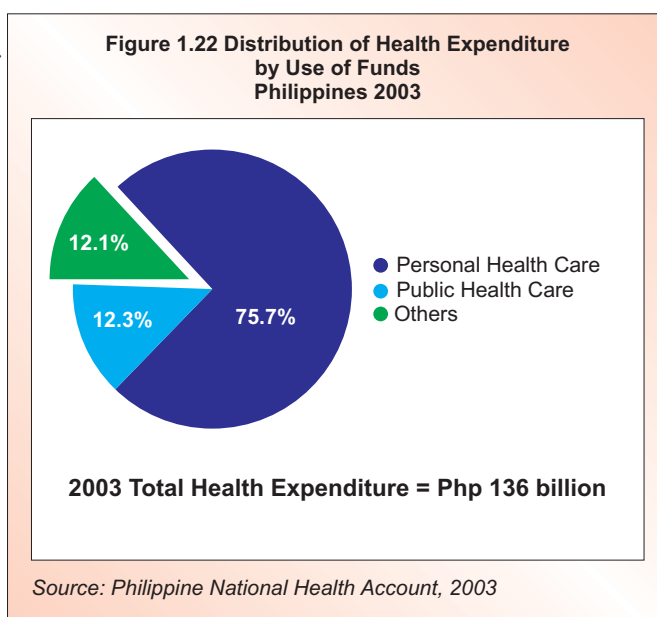
In terms of growth in expenditure, the National Health Insurance Program under PhilHealth is the mechanism with the most potential although it still lags behind other

sources of funds in terms of total expenditure. In 1991 it spent only P1.9 billion or 5 percent of total health expenditure. After the National Health Insurance Act was enacted in 1995, the share of social insurance to total health expenditure remained almost the same at 4.5 percent in 1995 to 5.1 percent in 1997 with the lowest share of 3.8 percent in 1998. The share of social insurance began to take off in 2000 with around P8 billion spent or 7 percent of total health expenditure, eventually reaching P12.9 billion expenditure or 9.5 percent of total health expenditure in 2003 (PNHA 2003).

Two interrelated reasons explain the relatively slow and cautious increase in the share of social insurance to total health expenditure. One, though PhilHealth is trying to improve their services, their benefits are still low. Two, partly because benefits are low, the coverage of the informally employed sector has not expanded. Insurance is unlikely to be effective in areas where local financing is severely limited and where administrative infrastructures are weak. Between 1995 and 1998, the program managed to enroll less than 2 percent of targeted poor members whose premium contributions are fully subsidized from national and local sources. However, starting 2001 PhilHealth has made inroads in its indigency program, with coverage increasing to 31 million beneficiaries or 90 percent of targeted indigents by 2004.

Uses of Health Financing

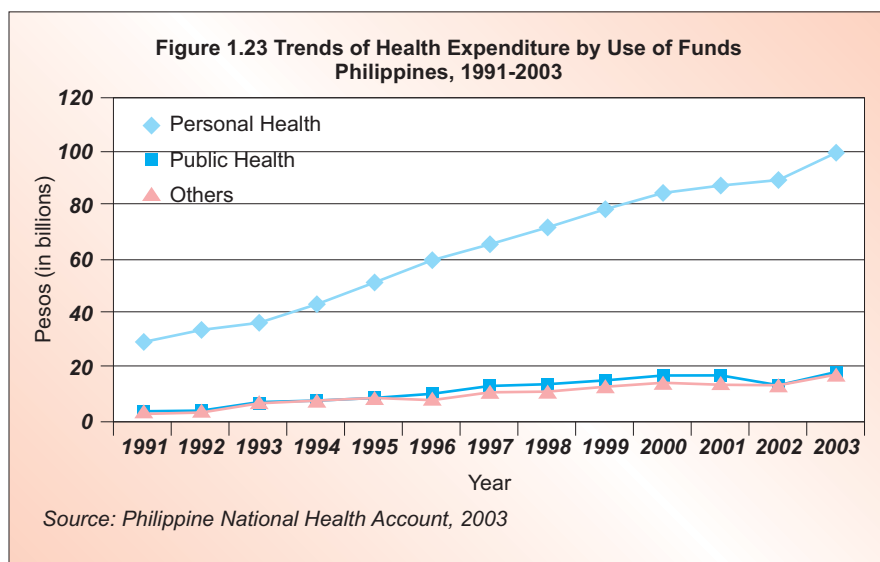
In 2003, P102.9 billion or 75.7 percent of the total health expenditure were spent on personal health care services. In contrast, only P16.7 billion or 12.3 percent were used for public health care services. This amount is almost equal to the P16.4 billion or 12.1 percent of total health expenditure for administrative and other support services needed to run the entire health system (PNHA 2003). There are signs that the Philippines is neither spending enough nor effectively for health. There was heavy spending on hospital or curative care (personal health care) and not enough for preventive and promotive health services (public health care). The subsidies for health services are poorly targeted. The large hospitals in MetroManila and other urban centers



get the biggest share of spending to the detriment of primary care services at the local level.

The increasing levels on the personal health care services reflect the influence of private and political interests over resource allocation decisions. The interest of individual families is to focus spending on health care services with benefits that accrue to the family or its members. Personal health care, being more visible and more effective in promoting patronage is more likely to receive greater attention in political decision-making. The continued dominance of family out-of-pocket spending as a financing source would suggest that a large portion of health expenditures are likely to be spent on personal health care services. Individuals and families are expected to put greater priority on services that directly benefit its members.

Public health programs and primary health care services have been declared the priority of government. But information from studies in public health programs suggest that the fragmentation of local health networks and difficulties in managing centrally-run public health programs might have rendered funds for public health less effective.



Effective program management is more important for public health programs than the resources needed to running health facilities. Spending on administration by national agencies (mainly the DOH) might be inadequate, considering that these agencies not only deliver services but also perform critical regulatory

functions like food and drugs administration. Spending on activities critical to effective leadership by government in the health sector like bio-medical research, operations and policy research and survey and monitoring did not change in absolute amounts despite the expansion of the health sector.

The absolute amount of the share of foreign assistance (i.e., loans and grants) has generally declined since the past years although between 2002 and 2003 foreign grants

increased by 153.4 percent and foreign loans increased by 18.2 percent. For some observers, the lesser the share of foreign loans and grants means less dependence on foreign assistance that can allow the DOH to have an independent agenda. On the other hand, foreign assistance is often spent to support public health services and investments in effective management. This financing source also provides the means to secure funding over periods longer than the usual budget cycle, allowing priority public health programs to pursue long-term goals. Moreover, priority public health programs become more vulnerable to the politics of the annual budget cycle, with political decisions leading to more pronounced bias for personal health care services.

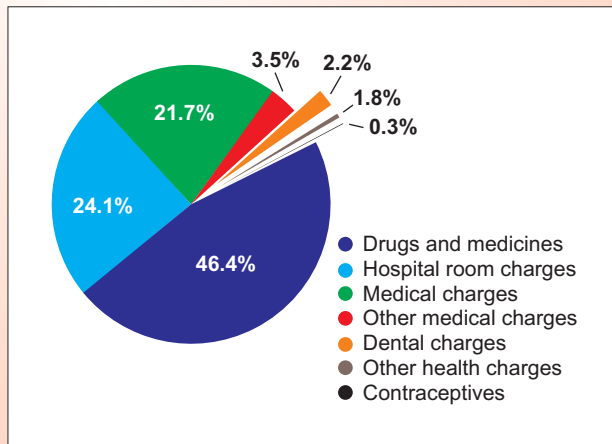
The DOH had an opportunity to focus its resources and efforts on public health concerns when the devolution was implemented. In 1993, spending on personal health (i.e., hospital-based services) dropped to P3 billion. At this point it had less than 50 hospitals to operate, allowing it to focus on national public health programs like TB control, immunization campaign, maternal care, among others. Beginning in 1995, the DOH budget picked up and then by 1997, it surpassed the level it had before the devolution. But the share given to public health declined afterwards. The DOH spends almost 70 percent of its resources to support 72 national and regional hospitals. This is not an effective way of targeting subsidies to the poor.

Local health expenditures have increased beyond what would have been required to support the cost of devolved health functions. Moreover, a significant portion is being spent on public health services. Local government spending is becoming the main source of funding for public health services. Local government facilities, especially RHUs run by municipalities, are the main channel for delivering public health programs and services. However, the overall impact of local health spending may have been weakened by administrative and technical fragmentation arising from the devolution. District hospitals designed to be the base for technical supervision are cut off from RHUs. Moreover, there are concerns that district hospitals are unable to compete with provincial hospitals for funding from provincial governments.

Family Expenditure on Health

The total family income for the year 2000 is estimated at P2.2 trillion while total family expenditures is estimated at P1.8 trillion. Of the total expenditures, around P785 billion or 43.6 percent went to food consumption while P35 billion or 1.9 percent went to

**Figure 1.24 Family Expenditure on Health by Category
Philippines, 2000**



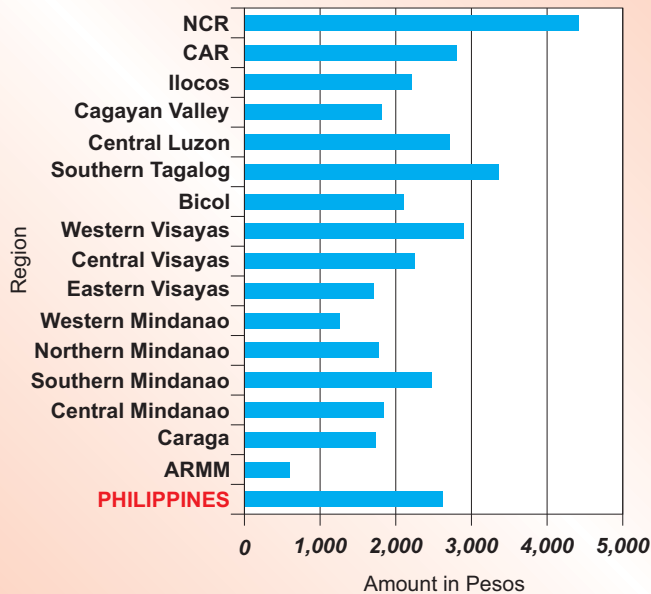
Source: Family Income and Expenditures Survey, 2000

medical care. This translates to an average of P2,660 medical care expenditures per family in 2000 (FIES 2000).

Of the total medical care expenditures, drugs and medicines accounted for 46.4 percent, hospital room charges at 24.1 percent, medical charges including doctor's fee at 21.7 percent, other medical goods at 3.5 percent and the combined expenditures for dental charges, contraceptives and other health services at 4.3 percent.

Across the regions, NCR reported the highest average total family expenditures for medical care at P4,430. Four other regions had average family expenditure for medical care that is more than the national average. These are Southern Tagalog at P3,359, Western Visayas at P2,881, CAR at P2,799 and Central Luzon at P2,701. ARMM reported the least average family expenditures for medical care at P572.

**Figure 1.25 Average Family Expenditure on Health by Region
Philippines, 2000**



Source: Family Income and Expenditures Survey, 2000

Health Provider Payment Schemes

Health professionals and health provider organizations can influence the pattern of health care in the country. They are motivated to do so because they are either profit

maximizers or aiming to reach a target income that assures them of an acceptable standard of living (Witter et al 2006).

In the Philippines, health personnel in the public sector are paid a fixed salary. They get their monthly salary even if the health practitioner has little work load or has thousands of patients to attend to. Compensation is based on a pre-set salary scale. Government health institutions are given a fixed annual budget. The budget is computed according to

the historical budget of previous years, adjusted according to the total government funds available and other factors such as inflation, regardless of the type or complexity of cases they admit. This kind of budgeting is inefficient since the health providers may be discouraged to admit the more complex cases, which are more expensive and more difficult to treat.

The private sector relies on the fee-for-service payment scheme. Services include basic physician consultations, diagnostic tests and drugs prescribed. This kind of payment scheme is direly inefficient since there is a financial incentive to over-provide services for each patient. Health providers tend to recommend too many tests, too many visits or prescribe too many drugs.

The salary payment scheme and the historical fixed budget system in the public sector encourage inefficiency and poor quality of health services. On the other hand, the fee-for-service scheme in the private sector produces a pattern of expensive and excessive use of services that are more lucrative to health providers.

The government-run social health insurance and private health insurance companies rely on retrospective reimbursement based on a fee-for-service scheme for hospital services. Private managed care organizations generally pay through a capitation scheme where the health provider is paid a fixed amount per person, regardless of the number of services provided to the patient. The social health insurance program introduced a capitation scheme for ambulatory care delivered in health centers where providers are remunerated based on the size of the population enrolled in the program.