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FINANCING HEALTH CARE FOR POOR FILIPINOS

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US\$1	=	56.08 PHP

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ABBREVIATIONS AND ACRONYMS

BHIP	Bukidnon Health Insurance Project
DBM	Department of Budget and Management
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FAP	Financial Augmentation Program
GNP	Gross National Product
GMA	Greater Medicare Access
GZT	German Technical Cooperation
HAMIS	Health Administration Management Information System
HPDP	Health Policy Development Project
HPDPB	Health Policy Development Project Bureau
HSRA	Health Sector Reform Agenda
HSRTAP	Health Sector Reform Technical Assistance Project
IRA	Internal Revenue Allotment
LGUs	Local Government Units
MBN	Minimum Basic Needs
MOOE	Maintenance and other Operating Expenses
MSH	Management Sciences for Health
NDPS	National Drug Policy Staff
NGOs	Non-Government Organizations
NHIP	National Health Insurance Program
NSCB	National Statistical Coordination Board
PAGCOR	Philippine Amusements and Gaming Corporation
PCSO	Philippine Charity Sweepstakes Office
PHIC	Philippine Health Insurance Corporation
PIDS	Philippine Institute for Development Studies
PMS	Presidential Management Staff
RHUs	Rural Health Units
SHINE	Social Health Insurance Network and Empowerment
SONA	State of the Nation Address
UHNP	Urban Health and Nutrition Project
UNICEF	United Nations International Children's Fund

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Overview

This paper aims to assess the various channels critical in financing the health care needs of poor Filipinos. Next the paper discusses how public policies can and can not help in facilitating financing of health services for poor Filipinos.

The paper is divided into three parts. The first tackles issues related to the definition and identification of the poor and their health concerns.

The second part examines a range of issues from family out-of-pocket spending to social health insurance programs. The strengths and weaknesses of each are described using recent data.

The third part of the paper considers proposals to introduce health policy reforms and how these might affect access to health care by poor Filipinos. Implementing health policy reforms in localities designated as convergence zones is examined from a political economic perspective. What makes this proposed strategy compelling is the potential for local politics to drive and sustain health policy reforms.

The Poor and their Health

The government defines poor Filipinos as those with incomes that are inadequate to meet the cost of basic food, clothing, housing, medical care, education, transportation, communications and personal care. This translates to an annual threshold income of about US\$271.95 per capita (66 percent of that is spent on food alone). By this definition, the National Statistical Coordination Board (NSCB) of the Philippines classified 33.7 percent of Filipinos as poor (NSCB, 2002).

With an estimated population of 81.36 million, that means there are 27.42 million poor Filipinos in the country today. More than one-half of this number are in rural areas. The 2002 GNP per capita income is US\$217.33, well below that of the poverty threshold income.

At the same time, the poor are difficult to identify for targeting purposes; income and food expenditures are difficult to observe. Government agencies, non-government organizations (NGOs), political interest groups and the media have used various targeting methods to guide their operations and activities. Identifiers range from a Minimum Basic Needs (MBN) check list employed by the Department of Social Welfare and Development (DSWD), to residential neighborhoods and housing conditions used by NGOs in working with the urban poor as well as self-assessments of poverty used in commercial surveys.

Curiously, health status and access to health care are not used to identify poverty. Reliable clinical assessments of health status are expensive and rarely used in large surveys. While self-assessment of health status is easier to collect, it is difficult to know what is being measured and difficult to compare across groups.

For example, in a recent household survey of the 21 largest cities in the Philippines by the Department of Health (DOH), 87 percent of respondents from poor urban residential areas assessed themselves as being in good health. For those living in non-poor residential areas, about 90 percent gave a similar response. When asked about the number of illnesses experienced by the household during the past month, the poor and non-poor gave similar answers.

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There are marked differences between the poor and the non-poor when health care utilization patterns are examined. For example, in response to a health complaint, only 31 percent of those belonging to the poorest income quartile were able to consult a physician. Those in the richest quartile sought doctor services 50 percent more often than those in the

poorest quartile. Poor families, especially in rural areas, rely heavily on publicly provided services, while non-poor families tend to use private facilities (**Table 1**). It is well known that the quality of care in such facilities tends to be lacking because of inadequate public subsidies. Both poor and non-poor Filipinos compete for health services rendered by public hospitals.

Table 1. Utilization Rates of Health Facilities, by Type of Facility and Income Group

Health Facility Type	Poor	Non-poor
Government hospital	8.1	9.8
Private Hospital	2.9	10.1
Private Clinic	6.4	16.6
Rural Health Center	14.1	9.4
Barangay Health Station	7.4	4.3
Others	0.9	0.5

Note: Multiple responses were allowed so column totals do not sum to 100. Utilization rates are conditional on reporting *any* illness during the reference period.

Source: N. Kakwani, 2000. Poverty, Inequality, and Well-Being in the Philippines, with Focus on Mindanao. Asian Development Bank (Unpublished).

Since the Philippines does not collect data on health status, morbidity and mortality rates, by income or poverty indicator, the health concerns of poor Filipinos may be characterized only in terms of their access to and use of quality health care.

The danger of focusing on obstacles to health care utilization is that we may miss out on such basic influences on health as the mothers' education, water and sanitation. A child whose mother has an elementary education is 2.1 percent more

likely to have been ill during a six-month period. Similarly, a child belonging to a household with its own piped water source is 2 percent less likely to be ill (S. Alabastro-Quimbo, 2001).

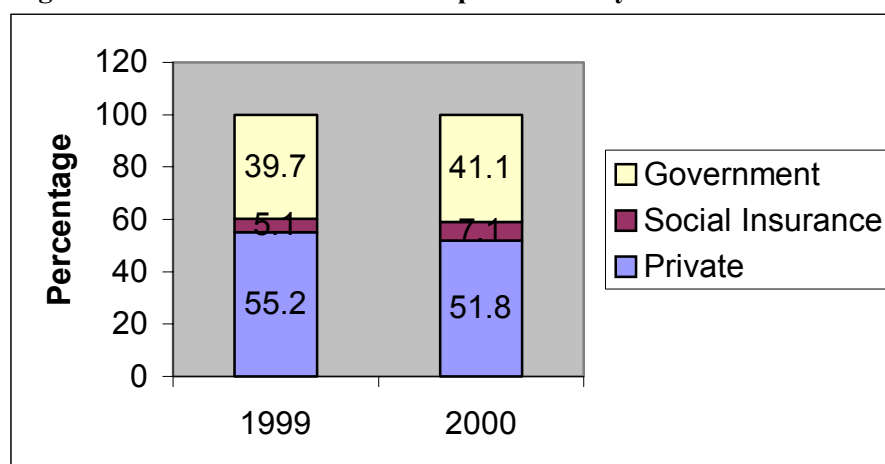
Because access to health services is a key concern of poor Filipinos, we argue for scrutinizing health care financing, especially expenditures, and their impact on access to health care services. A pattern emerges from the Philippine National Health Accounts (**Table 2** and **Figure 1**).

Table 2. Health Expenditures by Source of Fund (1999-2000 in Millions of Dollars)

Sources of Funds	1999	2000
Government	1049.95	1054.52
National	555.04	552.13
Local	494.91	502.40
Social Insurance	134.60	182.33
Medicare	127.77	176.47
Employees' Compensation	6.83	5.84
Private Sources	1459.97	1329.98
Out-of-Pocket	1161.35	1052.85
Private Insurance	59.23	52.15
HMOs	105.93	99.12
Employer-based Plans	107.01	96.63
Private Schemes	26.47	29.23
All Sources	2644.53	2566.83

Source: NSO, 2000. National Health Accounts. National Statistics Office, Republic of the Philippines.

Figure 1. Distribution of Health Expenditures by Source of Fund



Source: NSCB, 2000. National Health Accounts 2000. National Statistical Coordination Board, Republic of the Philippines.

The data show a heavy reliance on private spending for health care. Out-of-pocket expenditures account for 80 percent of private spending on health. While social health insurance may have increased its share to 7.1 percent, that is small in terms of overall contribution. National government spending accounts for the

largest percentage; however, health spending by local governments is on the rise.

The rest of this paper examines the various sources of financing that directly affect health care access by the poor.

Financing from Family Out-of-Pocket Spending

In 1999, family out-of-pocket spending paid for 46 percent of total health expenditures in the Philippines (DOH, 2000). In the Filipino health care delivery and financing system, only those with the ability to pay are able to access health care. Clearly, the poor are at a distinct disadvantage.

For example, based on an estimate by the DOH, the average cost of anti-tuberculosis (TB) drugs for a complete course of treatment is roughly US\$70 per patient. That figure easily adds up to US\$100 when professional services and laboratory examinations are included. This sum is nearly 30 percent of the annual income of 34 percent of Filipinos who live below the poverty line.

The average cost of an appendectomy in a charity ward of a mid-sized private

hospital is around US\$400 (Caballes, 2001). This amount represents 1.5 times the annual income of a person at the poverty level.

Based on demand-price elasticity estimates, if the total hospital bill in a private hospital increases by one percent, the likelihood that a person from the poorest income quartile will seek services drops by eight percent. Among public hospitals, a one percent increase in charges reduces utilization by the poor by as much as 26 percent (C. Tan, 2001).

The estimates in **Table 3** show that health care utilization is sensitive to price changes. The implication is that poor families are likely to avoid facility-based care because of price barriers. It also means price subsidies can be a powerful instrument in increasing health care utilization.

Table 3. Price Elasticity for Health Care by Income Quartile and Type of Care

Type of Care	Poorest Quartile	Second Quartile	Third Quartile	Richest Quartile
Private outpatient care	-0.22788	-0.58814	-1.27341	-1.66996
Private inpatient care	-8.0031	-8.22322	-8.34959	-7.98586
Public inpatient care	-26.8891	-30.3869	-31.8073	-30.4357

Source: C. Tan, 2001. "An Econometric Analysis of Demand for Inpatient Care: Alternative Approaches in the Estimation of Price and Insurance Effects". Ph.D. Thesis, School of Economics, University of the Philippines Diliman, Quezon City (Unpublished).

Table 4. How Families Pays their Hospital Bills

Source of Family Out of Pocket Payments	Percent
Family savings	59
Loans, sale of property	33
Gifts and transfers	16
Employment benefits	4
Private insurance	2
Medicare	21
Others	1

Source: Department of Health – Philippine Institute for Development Studies Survey, 1994.

Before acknowledging the implications of price barriers to health care, it should be noted that non-financial barriers also prevent poor Filipinos from utilizing health care. These obstacles include knowledge and information, attitudes and values, distance, and time (O. Solon, et. al., 2000).

If and when Filipinos access hospital services, they pay for them in the following ways: (1) reducing current and future consumption; (2) reducing future income; and (3) tapping into existing social networks (**Table 4**). As families dip into whatever savings they have accumulated to pay for medical expenses, they reduce consumption and forego investments (e.g., their children’s college education). Similarly, if they borrow money or sell existing properties, the family mortgages its future income. They reduce consumption and forego investments (e.g., their children’s college education). Similarly, if they borrow money or sell existing properties, the family mortgages its future income.

The burden of paying for health care services is even heavier on the poor since their consumption of services is negligible. They have no future income to leverage and they have weak social institutions to depend on. Perhaps this explains an oft-quoted statistic from the Department of Health, which says 6 out of 10 people who died from non-violent causes did not receive any medical attention during the episode of illness prior to their death.

Financing through Community-Based Schemes

In the 1990’s community-based health cooperatives or community-based health financing schemes operated all over the Philippines. Government and non-governmental organization (NGO) registries show that over 200 schemes assisted in delivering or financing the health needs of community members. The actual number of schemes may have been even greater than that. Some schemes may have been too small or informal to be captured by registries; health care may have been an incidental benefit with other schemes (M. Lorenzo, et. al., 1997).

Although community-based health schemes cover small population groups and have limited resources, size may be a comparative advantage in member participation and management accountability. Efficiencies abound when the cost of operating is low and the payment cycle is short due to proximity of the program and its members (M.C. Bautista, et. al., 2001). The community members’ sense of ownership and empowerment is believed to be the source of its success. These features are essential to the ability of community-based schemes to reach poor Filipinos.

A number of recent surveys describe community health financing schemes and assess their impact (SHINE, 2001). These surveys are concerned with how social health insurance programs interface with community-based schemes.

Recent case studies, however, suffer from a limited sampling from an unknown universe of community-based health care organizations. Hence, these studies generate their samples from existing networks (e.g., SHINE, HAMIS) and allow for the possibility of selection bias in their observations.

Notwithstanding sampling limitations, recent studies challenge popular expectations of community-based health care organizations. Community-based health care organizations do not exclusively cover the poor. Most of the schemes depend on external support. Moreover, their operations may have hidden costs and subsidies. While benefits are limited, their actuarial value tends to be lower than member contributions because risks and resource pools are also limited. Based on a sample of community health insurance schemes, the average premium is US\$7, which is less than 40 percent of the basic premium under the Philippine Health Insurance Corporation (PhilHealth). In turn, the average ceiling for inpatient benefits for this coverage is US\$230, which is also less than 40 percent of the PhilHealth ceiling.

Earlier studies did not measure the incomes of beneficiaries covered by these community-based schemes. However,

many point out that most of these schemes were for people with lower incomes (M.C. Bautista, et. al., 2001). They operated in 4th to 6th class localities; Class 1 drew from the most affluent localities (M. Lorenzo, et. al., 1997).

However, a recent study of community-based schemes affiliated with SHINE, indicated that the average annual incomes of families covered by such schemes was around US\$900, slightly more than three times the poverty income threshold per capita (J. Flavier, 2000).

Many and all of the oldest community-based health care organizations tend to be located in areas where public and private health facilities are insufficient to local needs. A subset of community-based schemes that feature health insurance to deliver benefits tend to be in places where social health insurance programs are lacking. As expected, the average community-based scheme services around 4,000 beneficiaries (J. Flavier, 2000).

The range of health benefits offered by community-based health care organizations varies widely (Table 5). Some schemes cover benefits that are highly susceptible to moral hazard, but it is not clear if the way community schemes are organized address such adverse behavioral responses.

Table 5. Benefits Offered by Community-Based Health Care Organizations

Benefits	Percent CBHCO Offering As Main Benefit
Access to medicines	13
Dental services	3
Diagnostic services	15
Outpatient consultation	22
Ambulance services	10
Hospitalization	37

Source: J. Flavier, 2000.

The health care utilization patterns among beneficiaries of community-based schemes are disturbing. The use of home remedies and visits to traditional healers still prevail for acute respiratory infections like bronchopneumonia. It begs us to question the appropriateness and

effectiveness of such community-based health care organizations.

Health benefits offered by community-based schemes are supposedly based on the health needs of beneficiaries. Other schemes consider the capacity to pay by

members and the organization. A few mimic existing schemes. There is no indication that actuarial studies were undertaken to check the balance between contributions and benefits. For example, Flavier reports an average annual contribution of US\$7 with an average value per claim of US\$34. A US\$7 premium is reasonable if utilization rates are around 20 percent. From an actuarial point of view, in a much larger risk pool, utilization drops to around eight percent; in effect, a premium contribution of US\$7 buys up to US\$87 worth of benefits.

The typical community-based health care organization can not survive on member contributions alone. On average, 37 percent of operating expenses depend on government contributions, mostly from local government and donors. Moreover, the day-to-day operations of community-based schemes depend on voluntary labor.

Clearly, there are outstanding cases where community-based health schemes have been effective in reaching the poor. But the problems mentioned earlier suggest that these schemes can not be relied upon as a major vehicle for ensuring poor Filipinos have the financing to access to health care. Perhaps the comparative advantage of organizing and eliciting active participation among community members can be even more effective if small communities can tap into larger risk and resource pools offered by larger social health insurance programs because of reinsurance.

Financing Health Care through Charity

Medical providers, religious organizations, civic organizations, big business as well as governments engage in charities that respond to the health care needs of the poor. Such charities come in the form of fee discounts, services in charity wards, medical missions, charity funds, and from specific donations. Health-related charities represent up to 2 percent of total health care spending (A. Herrin, et. al., 1996). However, charities may not be a vehicle that the poor can rely on as a social class, but only as individuals.

The most frequent and possibly the greatest number of charities are those performed by medical practitioners themselves. The most common form of charity offers discounts to patients in charity wards or to those perceived to be indigent. However, discounts may be regarded as a form of price discrimination. For example, a price discriminating provider may charge different fees to different consumers, but no one fee will be lower than his or her costs. On the other hand, a charitable provider may charge some patients below his or her margin. Based on an exit poll of hospital patients in a sample of hospitals in the Philippines in 1994, price discrimination may be a more common practice than charity (Table 6).

Table 6. Price, Cost, and Subsidy Rate for Charity Patients

	Private Hospital	Public Hospital
Price	4,590	838
Cost	4,307	5,881
Subsidy Rate	-6.06	601.8

Source: P. Gertler and O. Solon, 1998.

Religious organizations have institutionalized charity by running their own hospitals. Most religious hospitals operate with support from abroad or by generating income from their own schools. Religious hospitals with affiliated schools tend to be more resilient to changing market conditions.

Other sources of financing for religious hospitals include donations, tax exemptions, and socialized pricing. Generally, service fees are lower in religious hospitals. A common trait among these institutions is the presence of charity wards; “charitable” billing and collection departments are questionable. While many of these facilities, as well as those run by NGOs and charity foundations, are non-profit, that does not mean user charges do not reflect a profit margin. The law only requires that net income be plowed back to improve the facility and not be divided among its trustees or owners. Professional fees by physicians are independent of this arrangement.

The DOH has a designated assistance fund for indigents confined to private hospitals. In 2002, the National Expenditure Program listed it as a special provision in the amount of US\$259,687.50; of that, US\$117,187.50 is earmarked as a support mechanism for social health insurance (DBM, 2001). Prior to 2000, this fund was solely for individual charity patients in DOH facilities. This fund also assisted indigent patients in private hospitals when patients needed services the government could not provide.

Civic organizations and big business often channel health-related charity work through medical missions. What happens is a team of doctors conducts diagnostic, treatment and even minor surgical services in a given location for one or two days. Between 1999 and 2000, the average number of medical missions per population was estimated at one per 186,000 (J.R. Nanagas, et. al., 2001).

While the perception is medical missions are undertaken by private entities, approximately 58 percent of these

missions were supported by the DOH and local government units (LGUs). National and local politicians often organize medical missions using public health resources for political and charitable motives.

The criteria used to choose the location for medical missions suggest poor targeting. A study by the Center for Economic Policy Research, commissioned by the DOH, reports that 42 percent of mission locations were chosen based on perceived health needs and 25 percent were chosen because of requests from LGUs. The rest chose locations based on accessibility. Based on a small sample survey of beneficiaries, medical missions do not work exclusively with the poor. Around 20 percent of beneficiaries had annual household incomes of US\$600 (almost three times the poverty threshold). Moreover, 80 percent of beneficiary households had a piped water supply and electricity.

It is estimated that the cost of a single patient served by a medical mission is US\$6; this is one-third of the premium required for a year of insurance coverage for the basic package of benefits under PhilHealth.

Aside from sponsoring missions, private companies also provide goods in kind, such as medicines. Examples include companies like GlaxoSmithKline Philippines, the second largest pharmaceutical company in the country, which has paid the premiums for indigents to enroll in PhilHealth. The company is joined by 24 other socio-civic and religious groups and 42 congressmen (DOH, 2002).

The national government, under the Office of the President, also delivers substantial charity-like health services, using funds from the Philippine Charity Sweepstakes Office (PCSO) and the Philippine Amusements and Gaming Corporation (PAGCOR). Financial support for such charities comes from revenues generated by government-operated lotteries and casinos.

Established as early as 1954, the PCSO Charity Fund consists of 30 percent of net lottery revenues. In 1998, for example, the Charity Fund received US\$41.6 million, an amount representing close to 60 percent of premium subsidies needed to cover the poorest 25 percent of Filipinos.

Instead the Charity Fund pays for the cost of hospitalizing individual patients for up to US\$400 per case. PCSO guidelines restrict eligibility to families with incomes below US\$2,600 per year. Note that this ceiling is 10 times the poverty income threshold. That means the Charity Fund does not exclusively benefit the poorest Filipinos.

In addition, PCSO operates a Financial Augmentation Program (FAP) that provides grants to hospitals and other organizations implementing health-related programs. Grants of up to US\$1,000 are provided to NGOs and US\$4000 to national and local government agencies for the purchase of medicines and other equipment for indigent patients. Grants are awarded to existing facilities on the basis of their track record for helping the poor and the presence of an effective fund management infrastructure. PCSO also provides endowment funds of up to US\$200,000 for selected government hospitals to invest in increasing capacities for the emergency treatment of indigents. PCSO likewise supports specific health projects, such as the provision of ambulance units to LGUs, charity clinics, and support to pharmacies (PMS, 2001). Of late, it has also given US\$1.18 million to PhilHealth as premium payments to enroll indigents (DOH, 2002).

Fund application guidelines drawn up by the PCSO and PAGCOR leave out details to fund administrators, which makes fund utilization subject to patronage politics. Like private charities, these funds benefit specific poor individuals and middle

income families rather than the poor as a social class. The selection of beneficiaries tends to be arbitrary.

Financing Health Care through Local Budgets

Since the implementation of the Local Government Code in 1992, LGUs (provinces, cities and municipalities) are mainly responsible for financing and operating a network of public health facilities in the country. Provinces operate provincial and district hospitals while cities and municipalities operate health centers and rural health units (RHUs). Note that the network of health centers, district hospitals and provincial hospitals are considered to be the most accessible to the poor (in terms of location and price), especially in rural areas. Hence, how the public health system has performed under LGU management and financing is really a concern about access to health care by the poor.

Based on National Health Accounts, in general, LGU spending for health has been increasing (**Table 7**).

A small survey of municipalities and barangays commissioned by the DOH shows that the devolution of the open access public health system had mixed results on service delivery. The survey collected information on service utilization based on records at the RHUs and the barangay health stations (UPEcon 1998).

During the period of 1991 to 1996, statistical analyses were undertaken to explain variations in delivery of services by local health facilities from 36 municipalities. The study included services such as prenatal and postnatal services, deliveries, family planning, sputum examinations, oral re-hydration therapy, immunizations, and pneumonia (**Table 8**).

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Table 7. Local Government Expenditures by Use of Funds (1991-2000)

Year	Amount (In Millions of Dollars)				Percent Share		
	Personal Health Care ¹	Public Health Care ²	Others	Total	Personal Health Care	Public Health Care	Others
1991	11.04	29.08	15.12	55.20	19.97	52.66	27.37
1992	13.06	34.31	20.47	67.80	19.24	50.60	30.17
1993	61.22	105.35	52.44	219.00	27.95	48.10	23.95
1994	85.83	165.61	79.09	330.53	25.97	50.10	23.93
1995	109.26	203.04	93.54	405.84	26.92	50.03	23.05
1996	130.42	232.82	113.05	476.29	27.38	48.89	23.74
1997	132.95	266.98	124.88	524.81	25.33	50.87	23.79
1998	116.08	206.54	102.35	424.98	27.31	48.60	24.08
1999	130.38	234.55	129.97	494.91	26.35	47.39	26.26
2000	122.87	242.83	136.70	502.40	24.46	48.33	27.21
1999-2000 growth rate(%)	6.54	17.02	18.91	14.76	—	—	—
1995-2000 growth rate (%)	14.11	15.51	20.24	16.31	—	—	—
1991-1994 growth rate (%)	101.83	81.89	76.84	84.93	—	—	—

Source: UPSE (1991-1994); NSCB (1995-2000) from NSCB, 2000. National Health Accounts 2000. National Statistical Coordination Board, Republic of the Philippines.

¹ Personal health care includes pure private health goods and services (e.g., hospital care).

² Public health care includes pure public health goods and services and goods and services with externalities (e.g., information campaign).

Table 8. Average Health Service Utilization in RHUs by Type of Service (1992-1996)

Year	PPNATAL	DELV	FP	SPUEX	CDDORT	IMMUNE	CARI	NUTRI
1991	3400	1479	3869	1435	733	4822	3374	1694
1992	3816	1604	7683	973	768	4838	2909	2102
1993	4314	1572	8216	746	644	4923	2552	2556
1994	4108	1534	6177	815	712	4496	1518	3387
1995	5241	1429	6693	757	599	5113	1242	3055
1996	5040	1647	6451	613	485	4036	1465	3686

Note: PPNATAL = prenatal and postnatal services, DELV = deliveries, FP = family planning services, SPUEX = sputum examinations, CDDORT = oral rehydration therapy, IMMUNE = immunizations, CARI = pneumonia cases, NUTRI = nutrition supplementation.

Source: Study 1, PHDP Evaluation Report (1998).

Pooled time-series regression analyses were conducted to determine what factors influenced service utilization among the devolved primary health facilities. Socio-economic characteristics of the municipalities were controlled to determine the specific influence of devolution.

The analysis showed that devolution had mixed influence on service delivery. Sputum examinations and pneumonia cases declined after devolution compared to nutrition supplementation which increased. For the rest of the service types, devolution had no significant influence on service performance. This pattern suggests that services requiring consumables were adversely affected by the devolution. Anti-tuberculosis (TB) drugs and antibiotics are probably too expensive for a municipality to provide.

Other factors adversely affecting the performance of RHUs include a lack of effective technical assistance; in the past, this assistance came from the provincial

and district levels. While links between these units have broken down, technical supervision from centrally-run programs has been ineffective. For example, there is confusion about the role of central programs in immunization. Local health workers could not determine whether the central program staff should be responsible for direct service delivery or for technical supervision.

In general, the performance of provincial and district hospitals under devolution is considered poor. Critics say that the LGUs are unable and unwilling to maintain pre-devolution expenditure levels. Reduced spending has had an impact on hospital maintenance and other operating expenses (MOOE) (see for example the case of hospitals from the province of Western Samar in **Table 9**). The lack of supplies, drugs and allowances for repair and maintenance of medical equipment has severely impaired service delivery even if the necessary medical personnel were on hand.

**Table 9. Comparative Hospital Budgets, Province of Western Samar
(1992-1993 in Thousands of Dollars)**

Hospital	1992 (under DOH)			1993 (under LGU)		
	P.S.	MOOE	Total	P.S.	MOOE	Total
Samar Provincial	602.94	414.11	1017.06	490.52	157.75	648.27
Basey District	127.96	46.67	174.63	96.16	32.36	128.52
Gandara District	117.49	53.33	170.82	94.91	30.41	125.31
Calbayog District	237.10	146.67	383.65	200.44	108.04	308.49
Tarangnan Municipal	50.43	13.33	63.76	44.91	12.43	57.34
Almagro community	25.25	20	45.25	34.13	18.41	52.55
Total	1161.06	694.12	1855.18	961.07	359.41	1320.48
	100%	100%	100%	88%	55%	76%

Source: Hospital Devolution Study, HPDP (1994).

Table 10. Distribution of Discharges by Type of Facility and Ward by Percent

Type of Ward	Private		DOH		LGU	
	1991	1997	1991	1997	1991	1997
Primary facilities						
Charity ward	8	6	45	34	41	63
Medicare ward	64	56	39	9	30	9
Pay ward	28	38	17	56	30	29
All Wards	100	100	100	100	100	100
Secondary Facilities						
Charity ward	10	11	77	59	70	55
Medicare ward	43	44	6	37	14	29
Pay ward	47	45	17	4	16	16
All Wards	100	100	100	100	100	100
Tertiary Facilities						
Charity ward	26	12	86	80	75	—
Medicare ward	23	29	6	8	15	—
Pay ward	51	59	8	13	9	—
All Wards	100	100	100	100	100	—

Source: HPDP, 1998. HPDP Evaluation Report. Health Policy Development Project. University of the Philippines School of Economics, Diliman, Quezon City.

Note: Figures do not add up due to rounding. 1997 data for tertiary facilities are not available.

Several explanations have been advanced on why provinces were unable to spend the same amount on hospitals after the devolution as before. The most common explanation is the mismatch between the Internal Revenue Allotment (IRA) by the provinces and the operating cost of devolved hospitals.

Another hypothesis is that the number and size of devolved hospitals exceeded what the localities needed because of the incentive structure, which prevailed before the devolution. Localities did not resist legislation to construct provincial and district health facilities because the facilities were to be funded nationally. Thus, a post-devolution reduction in spending may have been considered an appropriate adjustment.

The poor performance of devolved hospitals has also been attributed to rigid operations and logistics. Local executives have to contend with bureaucratic red tape for fund requests to cover salaries and MOOE items. Before devolution, two to three signatures were necessary for purchases; after devolution, 17 signatures were needed for authorization. Since devolution, there is also a delay of two months before medicines and other supplies are delivered. As a result, hospitals are clamoring for a return to the sub-allotment system when they managed their own budgets.

The problem of lack of funds for hospital operations is aggravated by the pre-devolution backlog of requests for the repair and maintenance of hospital facilities and equipment. Prior to devolution, there were no capital outlays budgeted for renovation or repair of hospital facilities.

In addition to funding problems, poor morale and lack of opportunities for continuing education have affected the capacity of devolved hospitals to effectively provide services. Many resident doctors are reported to have left district hospitals and sought employment with municipal hospitals because the

compensation at municipal hospitals was higher.

The impact of devolution on access to hospital services by the poor can be gleaned from discharges based on the type of room accommodation (**Table 10**). Charity ward admissions between 1991 (one year before devolution) and 1997 (5 years after devolution) also appear in **Table 10**.

Between 50 to 80 percent of patients in government facilities are admitted to charity wards, compared to 20 to 30 percent of patients in private facilities who are admitted to charity wards.

Meanwhile, as noted in **Table 10**, charity ward admissions to secondary and tertiary public facilities generally decreased. Between 1991 and 1997, charity ward admissions dropped from 70 percent of all admissions to 55 percent for secondary hospitals operated by LGUs. During the same period, utilization by the poor seemed to have shifted to primary hospital facilities — charity ward admissions increased from 41 percent of all admissions in 1991 to 63 percent in 1997.

Since the devolution, several provincial governments have attempted to shift the application of local subsidies from the supply side (i.e., budgets for local health facilities) to the demand side (i.e., health insurance premium subsidies). The first province to do so was Bukidnon.

In 1994, the provincial government of Bukidnon established the Bukidnon Health Insurance Project (BHIP) that enrolled families under a health insurance scheme that offered both outpatient and inpatient benefits. The project did not exclusively target the poor; premium subsidies went to all enrollees regardless of income.

A major question faced by the BHIP was: Who did it serve? Was it for poor residents of the province?

A survey of households and public and private providers was conducted in 1998

to assess the project (O. Solon and Herrin, 1998). **Table 11** shows estimates of a logit model used to determine who was more likely to be enrolled in the BHIP.

The positive (and significant) estimated coefficient for income suggests that the likelihood that individuals would enroll in the BHIP increased with household income. This means the poor were less likely to benefit from BHIP coverage.

The negative coefficient of income squared suggests that while enrollment increased with income, the increase diminished at higher income levels. Middle-income families were more likely to be enrolled in BHIP compared to the very poor and the very rich.

Based on estimated coefficients for dummy variables for the more affluent municipalities of Bukidnon, Malaybalay and Valencia, residents from poorer municipalities were unlikely to be covered by BHIP. Moreover, in a province where less than one-half of its residents has access to electricity, the estimated coefficient dummy for the presence of electricity at home reinforces the finding that BHIP did not have a distinct pro-poor bias.

However, the benefits of BHIP for the poor may be indirect. With insurance, BHIP members reduced utilization of provincial hospitals in favor of private health facilities; the latter are perceived to offer better amenities.

Based on the same survey, a sub-sample of individuals who sought hospital inpatient and outpatient care were used to estimate a health care provider choice model.

Table 11. Estimates of a Logit Model for Enrollment in the BHIP

Variable	Coef. (z)
Income	0.0000197
	(6.604)
Income squared	-9.04e-11
	(-5.405)
Malaybalay=1	0.1235547
	(1.469)
Valencia=1	0.2150263
	(2.682)
Medicare=1	-0.0735129
	(-0.987)
Age	-0.0026593
	(-1.349)
Male=1	0.0875344
	(1.332)
Electricity at home=1	0.3373777
	(3.739)
College graduate =1	0.2774602
	(3.198)
Years of residence in the barangay	0.0084738
	(3.028)
Constant	-2.584887
	(-20.548)
Number of observations	6026
Log likelihood	-2911.2362

Source: O. Solon, and A. Herrin, 1998. An Evaluation of the Bukidnon Health Insurance Program, Philippine Center for Population and Development.

Table 12. Estimates of a Conditional Logit Model of the Choice of Government Hospital Outpatient Services

Variable	Coef. (z)
Age	0.052046 (1.71)
Age squared	-0.00055 (-1.202)
Years of residence in the barangay	1.51E-05 (0.013)
Net income	-2E-05 (-0.325)
Net income squared	4.96E-10 (0.354)
BHIP member=1	1.458853 (3.729)
Medicare member=1	-0.61081 (-1.268)
Constant	-4.85511 (-4.376)
Number of observations	558
Log likelihood	-110.54488

Source: O. Solon, O. and A. Herrin. 1998. An Evaluation of the Bukidnon Health Insurance Program, Philippine Center for Population and Development.

Note: Although not shown, municipal dummy variables were included as regressors.

In both **Tables 12 and 13**, the coefficients of income and income squared suggest that the likelihood of an individual's choosing a provincial hospital's outpatient and inpatient services over a private hospital decreased with income. More significant, the BHIP membership dummy shows a negative influence in choosing publicly-provided inpatient services.

How did this benefit the poor? Existing direct budget subsidies could be focused on poor patients. Middle income families with insurance do not crowd out the poor; they shift to privately-provided services.

Sustaining this indirect manner of targeting budget subsidies for the poor requires political commitment from local chief executives. Last year, the newly elected governor of Bukidnon closed

Table 13. Estimates of a Conditional Logit Model of the Choice of a Provincial Health Facility for Inpatient Care

Variable	Coef. (z)
Age	0.094286 (2.748)
Age squared	-0.00095 (-1.922)
Years of residence in the barangay	-0.00234 (-1.405)
Income	-4.5E-05 (-0.714)
Income squared	7.15E-10 (0.593)
BHIP member=1	-1.05425 (-1.644)
Medicare member=1	0.277787 (0.578)
Constant	-2.74847 (-3.819)
Number of observations	555
Log likelihood	-96.879171

Source: O. Solon, and A. Herrin, 1998. An Evaluation of the Bukidnon Health Insurance Program, Philippine Center for Population and Development.

Note: Although not shown, municipal dummy variables were included as regressors.

down the BHIP amid criticisms that provincial subsidies were applied inappropriately.

Financing Health Care through the Department of Health (DOH)

The DOH performs three sets of activities that affect access to health services by the poor. One set includes the delivery of tertiary hospital services by facilities financed by DOH. Another set includes priority public health services, such as the control of infectious and communicable diseases. The third set includes regulatory and licensing activities directed at product safety and service quality. The 10-year average budget for these activities is around US\$0.2 billion, an amount representing 15 to 20 percent of total health care spending.

FINANCING HEALTH CARE FOR POOR FILIPINOS

Between 50 to 60 percent of the DOH budget funds the operation of tertiary hospitals retained after the devolution in 1992. After the devolution, 47 hospital facilities remained under the DOH. However, the number has since grown to 72 facilities; some district hospitals were reclassified as regional or national centers. Expenses for these facilities account for nearly 70 percent of the DOH budget.

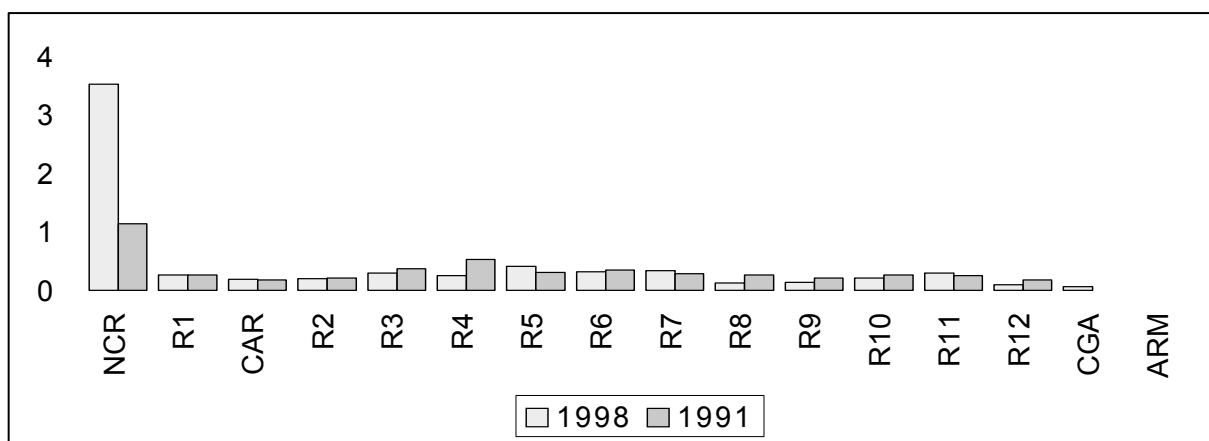
Managers of retained facilities have repeatedly raised concerns about their lack of resources and the need to expand capacity to accommodate patients that bypass poorly-equipped provincial and district facilities. Consequently, the share of the DOH budget spent on retained hospitals has substantially increased. In fact, the DOH spends more money on a smaller number of hospitals than before the devolution (**Table 14**).

Table 14. DOH Expenditures by Use of Fund

Year	Amount (in Millions of Dollars)				Percent Share		
	Personal Health Care	Public Health Care	Others	Total	Personal Health Care	Public Health Care	Others
1991	245.52	53.68	55.64	354.12	69.34	14.95	15.71
1992	245.73	45.18	57.88	348.78	70.45	12.95	16.60
1993	142.95	83.06	50.70	276.72	51.66	30.02	18.32
1994	204.43	51.14	36.21	291.82	70.06	17.53	12.41
1995	189.34	72.33	58.60	320.27	59.12	22.58	18.30
1996	236.53	80.53	51.68	368.74	64.15	21.84	14.01
1997	225.36	102.17	84	411.53	54.76	24.82	20.41
1998	200.59	62.62	42.62	305.83	65.59	20.48	13.93
1999	214.99	53.53	49.80	318.34	67.54	16.82	15.64
2000	234.23	47.24	63.69	345.14	67.86	13.69	18.45
1999-2000 growth rate	23.15	(0.27)	44.57	22.56	—	—	—
Average growth rate	5.98	5.22	3.81	3.86	—	—	—

Source: UPSE (1991-1994); NSCB (1995-2000); from NSCB, 2000. National Health Accounts 2000. National Statistical Coordination Board, Republic of the Philippines.

Figure 2. Distribution of the DOH Budget Across Regions (in Billions of Pesos)



Source: NSO, 2000. National Health Accounts. National Statistics Office, Republic of the Philippines.

However, this approach to dealing with the disruption caused by the devolution is inefficient and inequitable. Regional hospitals have higher operating costs; as a result, some cases are best handled at provincial and district facilities. Regional hospitals are located in urban centers and in the richer provinces of regions; as a result, using them for devolution purposes is inequitable. **Figure 2.**

A related issue concerns the quality of services provided by public facilities. Do poor families who have access to public facilities receive quality care?

Table 15 presents the average total bill, inclusive of subsidies, for various types of hospital facilities based on household survey data. After adjusting for quality (i.e., standardized set of medical and hotel services),¹ tertiary public hospitals are much more expensive than their private counterparts. On the other hand, primary

and secondary hospitals (mostly devolved district and provincial facilities) are much cheaper than their private counterparts. This latter finding puts the deterioration of devolved facilities in a different light; where government services are competitive with the private sector, investments are inadequate.

Direct measures of quality also confirm the pattern revealed in **Table 15**. The DOH has selected 10 hospitals for possible upgrading; they include national medical centers, regional hospitals and provincial hospitals. To determine the quality of services delivered, we developed a way to measure quality on a case by case basis (O. Solon, et. al., 2000). Ten diagnoses were chosen for this exercise, including Caesarian section, cholecystectomy, pneumonia in children, acute gastroenteritis, sepsis in children, schizophrenia, open fractures and joint operations.

¹ Quality-adjusted prices are predicted prices using parameters from an estimated hedonic price equation.

**Table 15. Average Total Hospital Bill of Public and Private Hospitals
(1991 in Dollars)**

Hospital Type	Private		Public	
	Nominal	Quality-adjusted	Nominal	Quality-adjusted
Primary	194.64	182.68	88.12	118.68
Secondary	201.44	209.48	191.72	205.56
Tertiary Teaching	339.88	355.72	591.36	574.52
Tertiary Non-Teaching	304.36	315.20	622.04	592.36

Source: Department of Health – Philippine Institute for Development Studies Survey, 1994.

Table 16. Average Total Quality Scores by Type of Service and Public Hospital

Service	Ideal Score	National Medical Center	Regional Medical Center	Provincial Hospital
Cesarean Section	5.0	21.7	24.4	17.8
Cholecystectomy	5.0	16.9	21.2	29.9
Treatment of Pneumonia in Children	5.0	27.5	22.0	21.2

Source: Caballes, A. 2001. Clinical and Socioeconomic Correlates in the Care of Appendicitis Patients. PDE Thesis, School of Economics, University of the Philippines Diliman, Quezon City, Philippines (Unpublished).

A manual search of patients' charts, based on final diagnoses, was done in all hospitals. A sample of 30 charts from each hospital included randomly-selected charts from each month for the year 1999. In hospitals where the number of cases admitted was less than 30, all of the charts were reviewed.

Experts rated hospital performance based on the data presented and what they considered the best practice. The experts rated each hospital on a score of 1 to 10. A score of 1 was close to ideal of best practice; a score of 10 means the hospital was far from the ideal of best practice. Each hospital received five scores, one for each of the following categories: length of stay, diagnostics, treatment procedures, drugs, and outcomes.

Table 16 reports the average total quality scores for the national medical centers, regional medical centers and provincial hospitals that participated in the assessment. Total scores for the three procedures common to all hospitals appear in **Table 16**. The ideal score of 5.0 is the sum of ideal scores for each category.

Low scores received by public hospitals were largely due to over prescription of antibiotics, routine use of basic laboratory tests, lack of appropriate diagnostic facilities for surgery, and poor case outcomes (e.g., post-operative infections and death in the case of pneumonia).

The second set of activities undertaken by the DOH that is critical to the delivery of health care services to the poor is national

priority disease control programs. While such programs as TB control, maternal and child health services, malaria control and schistosomiasis control do not exclusively target the poor, the burden of infectious and communicable diseases these programs address weighs heavily on poor Filipinos.

Recent assessments by the DOH show that the performance of priority public health programs is lacking (DOH, 2000). The failure of priority public health programs to eliminate infectious diseases is attributable to three factors. One, the capacity of the DOH to provide technical leadership over disease control programs is weak. Two, the capacity of the DOH to coordinate implementation by a highly decentralized primary care system is limited. And three, the way these programs are financed makes long term planning difficult.

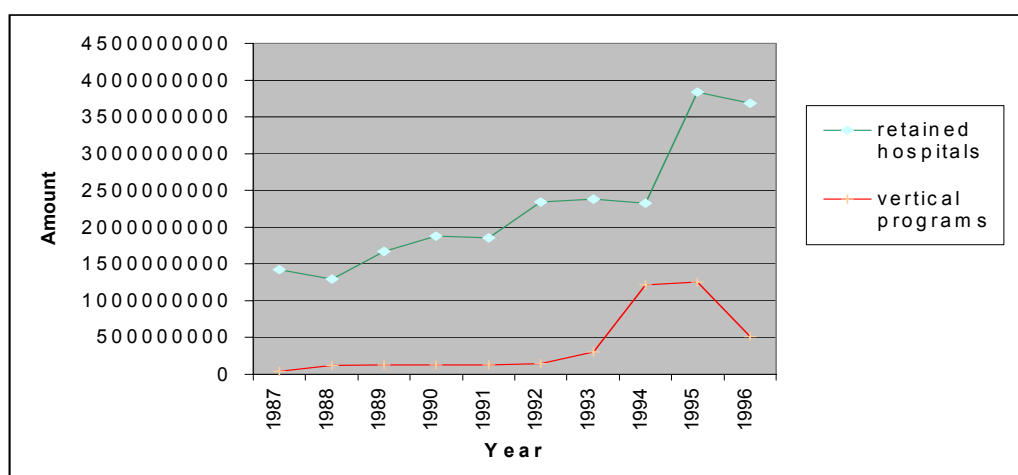
DOH programs overemphasized its service delivery role and relied on building its own parallel delivery system. In doing so,

DOH neglected its technical leadership role for standards setting, program design and evaluation, and disease surveillance based on scientific research.

With devolution, DOH priority programs lost their authority over primary delivery systems. Program managers can not use department orders to set targets and marshal the local health facilities. A new management approach needs to be developed that draws on such tools as better data, technical competence, and financial leverage.

Another weakness of public health programs is their financing. Public health programs rely heavily on foreign assistance. Such sources are multi-year, which offers some security. But they are a distraction from the DOH agenda and its intended beneficiaries. On the other hand, the politics of the annual budget cycle makes it difficult for disease control programs to plan their activities over the long term (**Figure 3**).

Figure 3. DOH Budgetary Trends 1987-1996 (Amount is in Philippine Pesos)



Source: DOH, 2000. The Health Sector Reform Agenda monograph, Department of Health, Republic of the Philippines.

Certain DOH programs like the Urban Health and Nutrition Project (UHNP) have identified poor families as their intended beneficiaries. An important concern is whether they have targeted or reached

their intended beneficiaries and by how much.

Take the case of UHNP, which has targeted poor urban residents in the 21

largest cities in the Philippines. After unsuccessful attempts in identifying the urban poor, using income and other socioeconomic indicators, the project adopted a residential clustering scheme used by the National Housing Authority. Once poor urban residential clusters were identified, the project directed resources to urban health centers serving those clusters. Using baseline data for the project the estimated coverage rate (i.e., percent of target population actually reached by the project) was between 70 to 75 percent depending on the type of service (Ferrer, 2001).

Regression analyses of data from a post-project survey of residents in the 21 cities

covered by the project suggest that targeting may have actually been less effective than expected. Take the case of TB control services directed at the urban poor, financed by UHNP. **Table 17** shows the marginal effect on utilization of various TB control activities of being in a targeted UHNP poor urban residential cluster (O. Solon, et. al., 2001).

Estimated coefficients of service utilization regression models suggest that poor urban residents targeted by UHNP were better off than non-target poor residents – only with respect to the use of sputum exams, drug compliance, and the perceived TB cure rate.

Table 17. Comparative Effects on the Utilization of TB Control Activities in UHNP and Other Residential Clusters

UHNP Targets For TB Control	UHNP Poor Cluster Compared to Non-UHNP Poor Cluster	UHNP Poor Cluster Compared to Non-Poor Cluster
TB Diagnosis by Health Center	No significant difference	No significant difference
Three Sputum Exams in Health Center	UHNP significantly higher	No significant difference
TB Drugs Supplied by Own Health Center	No significant difference	No significant difference
Use of TB Treatment Partner	No significant difference	UHNP significantly lower
TB Drug Compliance among those whose first consultation was in a Health Center	UHNP significantly higher	No significant difference
Perceived TB Cure Rate	UHNP significantly higher	UHNP significantly higher

Source: O. Solon, et. al., 2001. UHNP End of Project Evaluation Study. Department of Health, Republic of the Philippines.

The results also suggest similar crowding-out effects of access by non-poor families in publicly provided health centers. The third column of **Table 17** suggests that access by residents from non-urban poor clusters to TB services from health centers was no different from that of poor urban cluster residents.

Financing Health Care through Social Health Insurance

It was not until the National Health Insurance Act of 1995 that the Philippine Social Health Insurance Program had the objective of providing health insurance coverage to poor Filipinos. PhilHealth has

a mandate to enroll at least 25 percent of the poorest Filipino families under what is called the Indigent Program.

The National Health Insurance Act of 1995 specifies that by the year 2010, the Indigent Program should cover 100 percent of its target population. By 1998, which was three years into implementation, PhilHealth managed to enroll fewer than 3,000 families under the Indigent Program. The main reason for the slow start was that PhilHealth, following guidelines set by a national anti-poverty program, focused the Indigent Program on the 28 poorest provinces in the Philippines. The downside to this approach was that the poorest provinces did not have the resources, the management infrastructure, and the health facilities necessary for the Indigent Program to enroll and deliver services to its target population.

By late 1998, the Indigent Program expanded to include the poor in more affluent provinces and cities. As a result, enrollment increased to 45,000 families. As of October 2001, nearly 80,000 indigent families were enrolled (PHIC, 2001). This number represents about 15 percent of the target population.

Because of the commitment of President Gloria Macapagal-Arroyo, PhilHealth enrolled over 500,000 families by July 2002. This figure represents 25 percent of the target number of indigent families. Furthermore, 402 urban LGUs participate in what is now called the Greater Medicare Access (GMA) 500 program. Likewise, several congressmen, non-governmental organizations and private foundations have invested funds to cover the cost of premium payments for the indigent (DOH, 2002). Whether this number and rate of enrollment can be sustained remains to be seen.

There are three major obstacles that prevent PhilHealth from making the Indigent program effective – benefits, service delivery, and local co-financing. The current basic benefit package of

PhilHealth provides for inpatient services only. Inpatient health care services may not be the most appropriate set of services for the poor. From 1995 to 1997, the benefit utilization rate for the Indigent Program remained at 2 percent; overall, the PhilHealth average is around 6 percent. During the same period, the average value of claims was 25 percent of the national program's average. As a result, PhilHealth designed alternative benefit packages for the poor and implemented them in selected demonstration sites. The pilot program implementing the outpatient benefit package in the demonstration sites is expected to generate greater utilization and enrollment. At present, the outpatient package pays for consultation and basic laboratory diagnostic procedures on a capitation arrangement.

The second obstacle faced by the Indigent program is a lack of accredited service delivery facilities in localities where Indigent Program members reside. RHUs and district hospitals, the frontline facilities most accessible to the poor, rarely meet PhilHealth's accreditation requirements. To date, 139 RHUs have been accredited; the DOH and PhilHealth continue to work out a way to streamline and simplify their licensing and accreditation procedures.

The third obstacle, expected to prevail over the long term, is the inability (and sometimes unwillingness) of LGUs to co-finance the premium subsidy that the Indigent Program needs. By law, depending on their socioeconomic classification, LGUs must pay between 10 and 50 percent of total premium subsidies for indigents.

Since LGUs are already underwriting the budgets of local health facilities, many consider co-financing premium subsidies an additional burden. Unless LGUs can shift existing supply-side subsidies to the demand-side, the fiscal burden of the Indigent Program may be onerous. The cities are an exception; no health facilities devolved to them in 1992.

An even greater question in terms of sustainability is the payment of premiums by the national government. As LGUs pay their share of premium payments, PhilHealth is mandated to do its part through national budgetary allocations. Due to annual budget deficits, the Department of Budget and Management (DBM) has yet to release its national contribution to premium payments. As more individuals enroll in the social health insurance program, PhilHealth will have no recourse but to draw on its present reserves to pay for its operations. As a result, the social health insurance fund may be in jeopardy of bankruptcy, unless appropriate capital investments are made with current assets.

Health Policy Reforms and the Poor

Because their own resources are limited, poor families rely on community resources, charities, and central and local government funds to access health services.

There are two ways out of this situation. One is to introduce reforms that would create more jobs and offer greater economic opportunities to poor Filipinos. The assumption is that with more income, the poor would be in a better position to address their own health care needs and to access health care providers of their choice. This is the approach taken by government policies and programs directed at poverty alleviation.

The second approach recognizes that improved economic conditions of poor Filipinos do not necessarily mean they have greater access to quality health care. Private health care markets are non-competitive. Public health care facilities and programs, while lacking in capacity, have little incentive to perform. Specific programs aimed at the poor are unfocused and subject to changes in political commitment. Addressing these interrelated problems is at the heart of comprehensive health sector reform.

The Philippine Department of Health (DOH) has taken a bold step in that direction with its Health Sector Reform Agenda (HSRA) (DOH, 2000). The agenda promises to introduce reforms directed mainly at:

- ♦ expanding coverage of national and local public health programs;
- ♦ increasing access, especially by the poor, to personal health services delivered by both public and private providers; and
- ♦ reducing the financial burden on individual families through universal coverage of the National Health Insurance Program (NHIP).

The DOH proposes to change health care delivery and financing by undertaking reforms in five interrelated areas:

- ♦ *Hospitals*: provide fiscal and managerial autonomy to government hospitals so that quality of care is improved, hospital operations are cost efficient, and their dependence on direct budget subsidies is reduced.
- ♦ *Local Health Systems*: promote the development of local health systems; municipal and provincial health facilities cooperate with one another and share costs among LGUs in the health zone or catchment area.
- ♦ *Public Health Program*: give the DOH the capacity to exercise technical leadership in disease prevention and control, enhance the effectiveness of local public health delivery systems, and sustain funding for priority public health programs over a sufficient period to eliminate public health threats.

- ♦ *Health Regulations:* affirm the rationale for health regulations and upgrade capacities so that regulatory functions ensure that health products, devices and facilities are safe, of good quality and affordable.
- ♦ *Social Health Insurance:* expand coverage of the NHIP to reduce the financial burden on individual families through effective social risk pooling and offer the NHIP greater leverage to ensure value for the money it spends on benefits.

Having said that, there are serious financial, organizational, informational, technical, legal, and political constraints faced by the DOH in undertaking the proposed reforms.

In recognition of these constraints, the DOH realizes it is unlikely that the HSRA can be implemented on a national scale. Hence, the DOH proposed to undertake its reform package in selected implementation or convergence sites (A.O. No. 37, s. 2001). The idea was to generate sufficient improvements in health delivery and financing so that residents discern tangible benefits from the reforms. The hope is that satisfied residents and their political representatives will create a strong constituency behind the reform package, making HSRA implementation irreversible.

The implementation strategy adopted by the DOH is based on the recognition that health sector reforms do not translate into concrete benefits that people can identify. If reforms are to be effective, they must be tangible.

The DOH proposes to target beneficiaries with a product previously referred to as the Health Passport. For political reasons, the name was later changed to PhilHealth Plus. After enrolling beneficiaries, the DOH, PHIC and the LGU deliver an integrated package of personal and public health benefits. PhilHealth Plus also

identifies accredited health care providers, assuring the beneficiary of affordable and quality care. Finally, PhilHealth Plus also tells the member what his or her responsibilities are as well as those of the DOH, PhilHealth and the LGU.

Ideally, PhilHealth Plus should be implemented nationwide. But resources, time and political constraints suggest that the DOH, even under the best of circumstances, will not be able to offer universal coverage. Issuing the product to 30 percent of the total population will have little impact, compared to attaining universal coverage in a few provinces and cities containing 30 percent of the population. Hence, a key strategic element to HSRA implementation is to focus on selected sites where universal PhilHealth Plus coverage is achieved.

An important consideration of site selection, apart from favorable local conditions and the interest and commitment local executives, is that the sites generate significant impact on the neighborhood. Successful implementation at one site should inspire other LGUs to demand that similar efforts be initiated in their jurisdictions.

Site-based HSRA implementation should also allow reformers to tailor their packages to suit local conditions and priorities. Moreover, experience gained as reforms move from one site to another should allow reformers to perfect models, processes and operations over time.

The DOH has targeted 12 sites (10 provinces and 2 cities) for HSRA convergence implementation from 2001 to 2004 (HPDPB, 2002). This target was then narrowed to eight sites. Likewise, this number may have to remain constant; recent assessments show inadequate capacities by the DOH to sustain its efforts while also starting new sites (NDPS, 2002).

The question is: Will implementation of the HSRA mean anything to poor Filipinos? The HSRA Implementation

Plan, adopted as an administrative order in 2001, specifies that by 2004 at least 500,000 indigent families should be covered by PhilHealth Plus at the selected sites. (M. Villaverde, et. al., 2001). While this target may have been met, enrolled indigents do not necessarily come from convergence sites; mostly they come from poor urban communities. Some of the enrolled may not get the benefits enjoyed by those living in convergence areas.

Nationwide implementation will depend on the level of success and constituency building created in advanced implementation sites. At this point, it is tempting to suggest that political will is necessary to sustain reform. What may be more essential is for reforms to be consistent with political interests. In provinces, cities and municipalities, commitment and support for health reforms should mean more votes. At the local level, politicians identified with PhilHealth Plus are more likely to be elected.

Political will at the national level is more difficult to ensure. Bureaucrats at national health agencies do not face elections. Moreover, health is not as critical as jobs, prices, and peace and order in campaigning for national positions.

Two related solutions to bringing political commitment to reforms are being discussed among health policy circles in the Philippines. The DBM is introducing performance benchmarks into its budget process. This means that the national leadership evaluates access to effective health services or insurance coverage by poor Filipinos and how much should be spent for health. Setting performance benchmarks should improve the politics of the annual budget process.

The other approach being proposed by

some members of the Philippine Senate is to incorporate health sector reforms into law. The proposed Health Sector Development Act (i.e., Senate Bill No. 1, series 2001) specifies a six-year period for reforms to be undertaken. It pre-commits a fixed amount of the DOH budget to implement reforms. Performance is reviewed against predetermined benchmarks.

Conclusion

Health care financing in the Philippines can be described as fragmented, inequitable, inefficiently utilized and inadequate. What few resources the health sector has are not effectively targeted to the poor. This weakness was magnified when health services devolved to local governments in 1992.

While many of the health care financing channels help, most of them reach individual poor people instead of the poor as a social class. As a result, access to these resources is subject to barriers of geography and information.

The Philippine health sector has undergone reforms characterized by a decentralization of functions, a reallocation of resources to identify priorities and targeting clientele for government health services.

While reforms, such as decentralization, may pose a threat, they are also regarded as the most efficient and effective means of ensuring adequate health financing by poor Filipinos.

It is high time that stakeholders examine devolution more closely and design new methods for health care financing that will thrive. One of these efforts is the Health Sector Reform Agenda being spearheaded by DOH.

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