Executive summary

Background
The Philippines is an archipelago in the South-East Asia Region, with a population of 104.9 million as of 2017. It is the thirteenth most populous country in the world. The majority of Filipinos are Christian Malays (92.2%), with Roman Catholics constituting 87.4% of the Christian population. Muslim minority groups, comprising 5.6%, are concentrated in Mindanao. The country has an adult literacy rate of 96.5%. The Philippines is currently one of Asia’s fastest growing economies with a gross domestic product growth of 6.7% at the end of 2017. Categorized as a newly industrialized country, it is transitioning from one based on agriculture to one based more on services and manufacturing.

Filipinos tend to live longer now than in previous decades, with life expectancy at birth increasing from 62.2 years in 1980 to 69.1 years in 2016. This is attributed mainly to improvements in living conditions, better access to health services, and improved management and treatment of infectious diseases like pneumonia and tuberculosis (TB). However, Filipinos now bear a triple burden of disease. First, there is the increasing health impact of globalization and escalating climate change, with the Philippines ranking third in the world in terms of exposure to disaster risks due to strong typhoons occurring with high regularity. Second, changes in lifestyle and the increasing prevalence of risk factors related to diet, tobacco smoke and high systolic blood pressure contribute to a rising incidence of diseases of the cardiovascular system, malignant neoplasms, diabetes and road traffic accidents, which are cases of noncommunicable diseases (NCDs) in the country. Third, despite advances in the management and treatment of infectious diseases, many Filipinos continue to suffer from diseases for which effective interventions are available. These include human immunodeficiency virus (HIV) infection, TB and vaccine-preventable diseases (VPDs) such as measles and diphtheria.
Health service delivery

Health is a basic human right guaranteed by the Philippine Constitution of 1987. This is provided in the Philippines through a dual health delivery system composed of the public sector and the private sector. The public sector is largely financed through a tax-based budgeting system, where health services are delivered by government facilities under the national and local governments. The Department of Health (DOH) supervises the government corporate hospitals, specialty and regional hospitals, while the Department of National Defense runs the military hospitals. At the local level, the provincial governments manage and operate district and provincial hospitals, while municipal governments provide primary care, including preventive and promotive health services and other public health programmes through the rural health units, health centres and barangay health stations. Highly urbanized and independent cities provide both hospital services and primary care services. The private sector, consisting of for-profit and non-profit health-care providers, is largely market oriented, where health care is generally paid for through user fees at the point of service. The introduction of social health insurance administered by the Philippine Health Insurance Corporation (PhilHealth) since 1995 aimed to provide financial risk protection for the Filipino people. The rapid expansion of its membership in the past 5 years is considered a positive development as the Government pursues universal health coverage.

In terms of physical infrastructure, the Philippine health sector has 1224 hospitals, 2587 city/rural health centres and 20 216 village health stations (2016 figures). Sixty-four per cent of hospitals are Level 1 non-departmental hospitals with an average capacity of 41 beds, and 10% are Level 3 medical centres and teaching hospitals, with an average capacity of 318 beds. The private sector’s share of total hospital beds increased from 46% in 2003 to 53% in 2016. The geographical distribution of these resources varies within the country. Almost two thirds of hospital beds are in the island of Luzon, which includes the National Capital Region (NCR). There are 23 hospital beds for 10 000 people in the NCR while the rest of Luzon, Visayas and Mindanao have only 8.2, 7.8 and 8.3 beds, respectively. Operating indicators vary between public and private hospitals. The average bed occupancy rate of public medical centres is significantly higher than for private hospitals. On average, patients stay about two days longer in public than in private medical centres.
In terms of human resources for health, the top four cadres of institution-based health workers are nurses (90,308), doctors (40,775), midwives (43,044) and medical technologists (13,413) [2017 figures]. The public sector engages a higher proportion of nurses (61%), midwives (91%) and medical technologists (53%). There are also marked differences in the number of institution-employed health workers available to serve area populations. The density of nurses per 10,000 population is highest in the NCR at 12.6 and lowest in the ARMM at 4.2. The first point of contact for government-provided health services is the health centre and its satellite village health station(s), which typically employs an average of one doctor, two nurses and five midwives. Data constraints limit country comparisons and historical trend analysis. However, recent reforms in the use of routine surveys and online data entry of physical and human resources are expected to provide regular quality data.

Health financing

Total health expenditure (THE) has consistently increased since 2005 and compares well with neighbours like Indonesia. Government health expenditure has increased significantly in nominal terms, but it has been eclipsed by private sector funding sources, which have grown rapidly with the economy. Much of THE is for personal care, although the Government has raised spending on public health since 2007. The three major flows of public health financing have overlapping coverage. The DOH funds regional and apex hospitals, while local government units (LGUs) fund primary- and secondary-level care. PhilHealth reimburses government as well as private health facilities. It reportedly covers 92% of the population, 40% of which is the poor population and subsidized by the Government for premium payments. Covered services are focused on inpatient care and inadequate outpatient care that only covers the poor members of PhilHealth. Financial protection is limited, resulting in a high level of household out-of-pocket (OOP) payment. Despite efforts to reform the provider payment system to increase financial protection, the share of facilities’ bill covered by PhilHealth is on average 30% and has not gone beyond 52%.

PhilHealth cannot yet be considered a strategic purchaser of services, mainly because it accounts for a small share of THE while OOP spending continues to be the dominant source of financing for health care. While PhilHealth has shifted its payment system from fee-for-service to case rates, first testing the system with high-volume claims in 2011 and fully implementing the payment system in 2013, this reform has not resulted
in technical efficiency, much less financial protection. These case rates are supposed to impose a hard budget constraint to the health provider for a given case type, incentivizing the health provider to ensure that average costs per case fall below the case rate. However, this does not happen because health facilities can set their own service charges and then bill the patient whatever share of the service charge is not covered by the PhilHealth case rate. Thus, providers face almost zero financial risk and have very little motivation to provide care more efficiently. The implementation of case rate payment is different for poor patients as they are covered by the policy of no-balance billing, i.e. zero co-payment and 100% of facility bill covered by PhilHealth when they are admitted in government health facilities. The plan to further reform provider payment by adopting the diagnosis-related group system is again expected to achieve efficiency. Voluntary private health insurance is a minor source of funding, but provides supplemental insurance to non-poor households.

**Health governance and regulation**

As the national technical authority on health, the DOH provides national policy direction and strategic plans, regulatory services, standards and guidelines for health, and highly specialized and specific tertiary-level hospital services. It provides leadership, technical assistance, capacity-building, linkages and coordination with other national government agencies, LGUs and private entities in implementing health policies. The LGUs, i.e. provincial, city and municipal governments, on the other hand, are responsible for managing and implementing local health programmes and services. A local health board chaired by the local chief executive (governor or mayor) serves as an advisory body to the local chief executives and the local legislative council members (sanggunian) on the local health system, while the DOH Regional Health Office is represented by either a DOH representative or Development Management Officer under the DOH Provincial Health Team. In Mindanao, a distinct subnational entity called the Autonomous Region in Muslim Mindanao (ARMM) was created by Republic Act No. 6734, as amended by Republic Act No. 9054. ARMM consists of five provinces and has its own regional Department of Health that is directly responsible to the ARMM Regional Governor. It directly administers the provincial, city and municipal health offices, and the provincial and district hospitals within the autonomous region.
Key health reforms are articulated (or sometimes renamed) in every administration. The most recent one is Kalusugan Pangkalahatan (KP), the country’s Universal Health Care (UHC) policy initiated in 2010. Through KP, the Government continued the health reform efforts through three key strategies: achieving universal and sustainable PhilHealth membership, upgrading and modernizing government health facilities through the Health Facilities Enhancement Program and fortifying efforts to achieve the Millinnium Development Goal (MDG) targets. The implementation of KP became a Presidential priority, aided by the Sin Tax Law in 2012, the Reproductive Health Law in 2012 and the amendment of the National Health Insurance Law in 2013. The Sin Tax Law raised and simplified tobacco and alcohol excises, increased government revenues and provided the impetus to reduce smoking among Filipinos.

KP resulted in providing PhilHealth coverage of 92%, upgrading and construction of 4920 local health facilities and improving an additional 4000 LGU facilities, which is under way. These capital investments are complemented with deployment of 23 800 health professionals and mobilization of 51 594 community health teams. Moreover, National Government hospitals were upgraded, and critical equipment and health commodities were distributed to LGUs. Preliminary assessment of these investments showed increased health service coverage, including facility-based deliveries and utilization of outpatient and inpatient care. However, these gains were not produced early enough to contribute to attaining several MDG targets in 2015. The DOH has also undertaken strategies to continue its support to LGUs through subsidizing PhilHealth premiums for poor families, constructing and upgrading new health facilities, deploying doctors, nurses and midwives to poor and underserved communities, and procuring and distributing commodities including vaccines, TB medicines, insecticide-impregnated bednets and other medicines.

The Insurance Commission (IC) under the Department of Finance regulates and supervises the operations of private insurance companies, including health insurance and pre-need companies as well as mutual benefit associations. Since 2015, health maintenance organizations (HMOs) are also regulated by the IC. PhilHealth is exempted and is regulated through a Board of Directors, chaired by the Secretary of Health. The DOH is in charge of licensing hospitals, laboratories and other health facilities through the Health Facilities and Service Regulatory Bureau (HFSRB) and health products through the Food and Drug Administration (FDA). Any health facility that is accredited by DOH Regional Offices is automatically accredited by PhilHealth.
Health system performance

The national objectives for health (NOH) have well-specified targets, but progress of local governments towards these targets remains highly uneven due to devolved health financing and service delivery. While PhilHealth membership coverage has expanded, its benefit coverage remains mainly for inpatient care and it provides only limited financial support. Access remains highly inequitable due to the maldistribution of facilities, health staff and specialists. While deployment programmes are easing these problems somewhat, these strategies result in monitoring and sustainability problems. Patient satisfaction and user experience of health services may show improvements, but balance billing, i.e. service charges set by the hospital, which are not covered by PhilHealth case rate payment, are billed to the patient and outside-hospital purchases continue to impoverish patients. The limited number of health facilities relative to the growing population, overprovision of physicians, underprovision of care and poor physician adherence to clinical practice guidelines contribute to a low quality of care.

Lessons learnt from health system reforms

The Government’s aspirations to improve health outcomes, provide protection from the impoverishing effects of increasing cost of care and ensure responsiveness of the health system to the population’s health needs were embodied in several iterations of its health reform policies. The DOH was successful in generating political and financial support to pursue KP and in legislating various policy proposals, most notably the Sin Tax Law and the Reproductive Health Law.

However, strong political support and wider fiscal space do not automatically impact on health system performance, as there is lack of institutional capacity to translate policy into effective programme implementation, monitoring and evaluation. For instance, while PhilHealth’s membership coverage has expanded and its payment mechanism has improved, PhilHealth’s strategic purchasing has yet to assure its members of affordable, comprehensive and quality health care. Meanwhile, despite the DOH’s investments to construct and upgrade local health facilities and deploy critical health staff, access remains highly inequitable due to the maldistribution of health facilities, health personnel and specialists. With increased financial resources for health, overlapping areas in financing and delivering health services occur, as in the case of maternal and child health care and TB management.
Meanwhile, addressing critical health needs such as the rise in NCDs, including mental and oral health, remain inadequately funded.

Governance reforms compelled by key legislations have visibly improved specific facilities and programmes. These legislations include the Sin Tax Law and the National Health Insurance Act of 2013 that raised and allocated more resources for health, the Reproductive Health Law of 2012 that guarantees universal and free access to the most modern contraceptives for all Filipinos, and the Philippine Disaster Risk Reduction and Management Act of 2012 that ensures engagement of all stakeholders in pursuing a holistic, comprehensive and integrated approach to reducing the socioeconomic and environmental impacts of disasters.

At the LGU and health facility level, progressive local government leaders and hospital managers direct governance reforms to expand services and improve the sustainability of operating Government health facilities, regardless of the public hospital’s governance structure, i.e. autonomous or otherwise. Reforms were achieved by expanding internally generated (non-budgetary) funds, initially through patient fees and increasingly through PhilHealth payments. Thus, basic institutional and legislative frameworks to implement governance reforms are not enough. Inertia, lack of scale in implementing reforms, and cautious or tentative leadership can hamper efforts to improve and sustain the improvements in governance, financing and delivery of care.

In mitigating the impact of disasters, using appropriate messages best understood by the population in a timely manner can save lives. During Typhoon Yolanda (Haiyan), if the disaster warning had been translated to a local language to convey the gravity of the impending disaster, it could have saved more lives. Thus, the Government’s investments and initiatives to generate timely information must also incorporate effective messaging directed to the affected population.

**Remaining challenges**

Health outcomes are generally improving, but the stagnant maternal mortality ratio and neonatal mortality rate, and the sluggish rate of improvement in health outcomes compared to neighbouring countries, are worrisome. Many Filipinos suffer from diseases that are preventable and treatable with cost-effective interventions. These include HIV, TB, dengue and VPDs such as measles and diphtheria.
Addressing health system inefficiencies and health inequities due to disorganized governance, fragmented health financing, and devolved and pluralistic service delivery remain critical challenges to the Philippine health system. For instance, PhilHealth, DOH and LGU health facilities are spending on the same maternal and child health services while the growing cases of NCDs, including the emergency care these conditions often require, are inadequately funded and poorly prioritized. Parallel funding by three sources (DOH, PhilHealth and LGU) and lack of demarcation and harmonization in premium-funded benefits versus tax-funded services are the primary reasons for confusion and inefficiencies in Philippine health-care financing. Additionally, engaging the private sector in delivering health care in the UHC context requires strong regulatory capacity, not only by using command and control mechanisms but also by leveraging financing incentives. The impact of these strategies has, however, yet to be developed and harnessed.

Meanwhile, the absence of a facilitated referral system robs the patient of the opportunity to navigate the health system effectively – from identifying the appropriate health-care provider, to getting advice on needed medical tests or procedures and referral back from hospitals to primary care for continued health care. Such a referral system can cut short waiting times, lead to timely care, prevent duplication of diagnostic tests and procedures, and even improve the course of treatment. Patients often bypass the first (primary care) level to seek care in hospitals, as there is no effective referral system or gatekeeping at the primary care level, which also contributes to inefficiencies and increasing cost of care. For instance, patients with easily treatable conditions like simple pneumonia bypass the primary care level and are admitted to hospitals by being up-coded. Investments in health infrastructure and human resources must also be continued and sustained to narrow the gap in utilization of health services between urban and rural areas. As the DOH has intended, the upgraded local health facilities should get PhilHealth accreditation, and income from PhilHealth should be retained to sustain the operations of health facilities, especially in isolated and hard-to-reach areas.

Another set of challenges lies in implementing the National Health Insurance Program to provide financial risk protection and leverage its payments to ensure quality and responsive health care. The different membership contribution rates of PhilHealth engender inequities. While the PhilHealth premium for formal sector employees is set to not exceed 3% of the salary, the low ceiling on contributions (PHP 50 000
since 2013) means that those in the upper salary bracket contribute proportionately less than what they can afford. Moreover, the contribution ceiling is not adjusted for inflation, implying that progressivity diminished when inflation was taken into account. Meanwhile, the benefit package covered by PhilHealth remains inadequate and does not respond to the changing health needs of the population. The provision of primary and palliative care, including dental health and mental health among others, has lagged, particularly in remote areas. This leaves room for private practitioners to fill the gap in access, but at prices beyond the reach of the masses, resulting in catastrophic spending when care is sought.

Engaging the public in improving transparency and accountability in the budgeting, planning, implementation, monitoring and evaluation of Government programmes remains more a rhetoric than a reality. While there have been efforts to encourage the public and civil society in governing health programmes, the participation of civil society organizations in provincial, city and municipal councils is highly uneven, as it depends on the openness of the local government executive. In PhilHealth, representation on its Board of Directors is lopsided in favour of government ex-officio representation, with only one slot devoted to consumer/patient representation. Lack of organized citizens’ efforts (such as a watchdog) to oversee social health insurance issues and proposals for reforms is also a major shortcoming.

Medical care is fraught with serious information asymmetry between providers (hospitals, doctors) and patients, as well as between payers/funders (health insurance, health maintenance organization) and patients. Empowering patients with information is often seen to tilt the balance in their favour, but actual restructuring of the relationship and redistributing the power between providers/payers and patients have yet to happen. Patient empowerment is particularly critical and challenging in the Philippines, especially in view of pervasive income inequality (forcing doctors and hospitals to practise price discrimination among patients categorized according to their capacity to pay), incomplete evolution of social health insurance (with large balance billing),¹ lack of advertising in the medical profession (thus limiting information dissemination) and pervasive lack of people’s knowledge of fees and prices. Legislative attempts to arm patients with information have failed. Similarly,

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¹ Balance billing is the amount that health facilities can bill patients for, and is the balance that is left after payments from PhilHealth are subtracted from their charges.
keeping the poor informed of their rights and entitlements remains an administrative and logistical challenge as PhilHealth fails to issue membership cards to them to facilitate access and navigate utilization of the health services.

**Future prospects**

The Government continues to aspire for an efficient, effective and responsive health system that delivers affordable and quality care. To achieve this end, the DOH is pursuing another wave of health reforms through the Philippine Health Agenda – 2016. This policy addresses the aforementioned challenges through various measures:

- guaranteeing population- and individual-level interventions to promote health, prevent and treat the triple burden of disease, delay their complications, facilitate rehabilitation and provide palliation. Addressing the triple burden of disease means focusing resources and strategies to deal with the backlog of reducing or eliminating communicable diseases and neglected tropical diseases; tackling the challenges of NCDs such as cancer, diabetes and heart disease; their risk factors like obesity, smoking, poor diet, sedentary lifestyles and malnutrition; and cooperating with other sectors to undertake strategies to manage health problems related to globalization, urbanization and industrialization, including injuries, substance use and abuse, mental illness, pandemics, travel medicine and other health consequences of climate change. The strategies will also include strengthening the delivery of maternal, newborn and child health services, especially in geographically isolated and disadvantaged areas, and making vaccines available, including for Japanese encephalitis, neonatal tetanus and other VPDs;
- ensuring that all Filipinos have access to appropriate health services through functional service delivery networks (SDNs). SDNs aim to address fragmentation issues in service delivery by streamlining the management of health facilities, rationalizing multiple payers of care, linking public and private providers, rationalizing vertical public health programmes and establishing continuity of care. The DOH envisions SDNs as being located close to the people, supported by an effective gatekeeping mechanism, consisting of fully functional health facilities that provide services 24/7 and comply with clinical practice guidelines, enhanced by telemedicine. This new wave of reform builds on the assumption
of a strong PhilHealth, strategic purchasing and a fully supportive private sector that actively participates in SDNs;

• assuring that PhilHealth’s support value is 100%, i.e. zero-copayment for the poor and those admitted in basic accommodation; and a predictable (fixed copayment) for those admitted in private accommodation. PhilHealth’s benefit packages will be comprehensive and guided by health technology assessment, covering outpatient diagnostics, medicines, and blood and blood products. PhilHealth will also update the costing of current case rates to ensure that they cover the full cost of care and that the payment is linked to the quality of service provided. Finally, PhilHealth will improve its capacity to enforce its contracting policies and aspire to become a strategic purchaser of health services;

• engagement of the private sector by the DOH and PhilHealth in planning supply-side investments, forming SDNs and expanding PhilHealth accreditation for all benefit packages. They will also engage nongovernmental organizations and other professional organizations to ensure good governance through advocacy, community mobilization and health promotion. The DOH will continue to promote better performance and transparency by publicizing health information like prices of common drugs and services, noncompliant/erring providers, targets of the NOH and various health scorecards;

• coordination of the DOH with other stakeholders to ensure that all Filipinos understand their health entitlements (especially the poor). This will be coupled with mechanisms to promote participation in programme planning and implementation and to address complaints effectively.