Executive Summary

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTS examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

Section 1 introduces the country, its people and the political context, and briefly describes trends in health status. The Philippines is an archipelago of 7107 islands, subdivided into 17 administrative regions. A low middle-income country, its economy has not kept pace with its ‘Asian Tiger’ neighbours, and the benefits of growth have been inequitably distributed: average annual family income is as high as US$ 6058 in the National Capital Region (where Manila is located), while families in the poorest regions earn less than a third of this amount.

One break on the economy is the high population growth rate of 2% per year; the total population now stands at 94 million. Driving this is a high fertility rate of three children per woman. This average masks considerable inequalities between income groups, with the poorest women having on average almost six children, and the richest less than two.

The Philippines experienced dramatic improvements in levels of child and maternal mortality and communicable disease control during the second half of the twentieth century. However, gains have slowed in recent years, in part due to the poor health status of those on low-income and living in less developed regions of the country. Life expectancy in richer provinces is more than 10 years longer than in poorer ones.
Section 2 summarizes the organization and governance of the health system, including the underpinning governance and regulations. Under the current decentralized structure, the Department of Health (DOH) serves as the principle governing agency of the health system, mandated to provide national policy direction and develop national plans, technical standards and guidelines on health.

Decentralisation was first introduced in 1991, when Local Government Units were granted autonomy and responsibility for their own health services, and provincial governments given responsibility for secondary hospital care. Initially, the quality of services deteriorated due to low management capacity and lack of resources. A health sector reform programme introduced in 2005 helped to address some of these issues and improve overall health sector performance. It focused on expanding public and preventative health programmes and access to basic and essential health services in underserved locations. However, the involvement of three different levels of government in the three different levels of health care has created fragmentation in the overall management of the system. Local and provincial authorities retain considerable autonomy in their interpretation of central policy directions, and provision of the health services is often subject to local political influence. As a result, the quality of health care varies considerably across the country.

Section 3 describes the financing of the health sector in the Philippines; it includes an overview of the system, levels of spending, sources of financing and payment mechanisms. It finds that total health expenditure per capita has grown slowly in real terms: by 2.1% per year between 1995 and 2005. Total health spending now stands at 3.9% of GDP – low compared to the Western Pacific regional average of 6.1%.

The major health financing concern in the Philippines is the high level of out-of-pocket payments, which account for 48% of total health expenditure. The Philippines has a national health insurance agency – PhilHealth – however the level of financial protection it provides is limited as patients are often liable for substantial copayments. In 2010, the newly-elected government launched a major reform effort aimed at achieving ‘universal coverage’ which focused on increasing the number of poor families enrolled in PhilHealth, providing a more comprehensive benefits package and
reducing or eliminating co-payments. So far the results are promising. As of April 2011 almost 4.4 million new poor families had been enrolled in PhilHealth, equivalent to a 100 per cent increase in enrolment for the real poor. In 2011, PhilHealth introduced a no-balanced-billing policy for these sponsored households.

The fee-for-service payment system and the limited regulation of provider behavior have also contributed to financial burden on patients. Financial reform in the Philippines is made more complicated by the presence of a large private sector which has incentives towards over-provision. Thus, the introduction of reforms intended to provide stronger incentives for the rational allocation of resources is operationally challenging.

Physical and human resources available to the health sector are described in Section 4. There has been a general upward trend in the number of both private and government hospitals over the last 30 years, with the biggest growth noted in the 1970s, and a flattening off of growth in the last ten years. Most hospitals are privately-owned, though there are roughly equal numbers of public and private beds. The expansion of private hospitals has been principally centred in urban or near-urban areas leading to an inequitable distribution of health facilities and beds across the country.

The largest categories of health workers are nurses and midwives. Currently, there appears to be an oversupply of nurses relative to national needs – as many are trained with the intention of working overseas – and an underproduction in other professional categories, such as doctors, dentists and occupational therapists. In 2009, over 13 000 Filipino nurses took up positions overseas. Migration is internal as well as external – with a growing private sector absorbing an increasing number of health staff. HRH planning is thus particularly challenging in the Philippines.

Section 5 describes the health services delivery mechanisms, explaining the various facilities available at each level and the referral system. Public health services are delivered by Local Government Units, with the Department of Health providing technical assistance. In addition, specific campaigns and dedicated national programmes (such as TB) are coordinated by the Department of Health and the LGUs. Provincial governments manage secondary and tertiary level facilities, and the
national government retains management of a number of tertiary level facilities. The private sector delivers services at all three levels of the system. Private primary services are provided through freestanding clinics, private clinics in hospitals and group practice or polyclinics.

Though a referral system which aims to rationalize health care use has been in place since 2000, it is common practice for patients to bypass the primary level and go direct to secondary or tertiary level facilities. Hospital admissions data from PhilHealth suggests that specialized facilities are continuously treating primary and ordinary patients. Dissatisfaction with the quality of services, lack of supplies in public facilities, and the absence of a gate-keeping mechanism are among the reasons that patients bypass lower levels of care.

The principle health care reforms are described in Section 6. Over the last 30 years a series of reform efforts have aimed to address poor accessibility, inequities and inefficiencies of the health system, with mixed results. The three major areas of reform are health service delivery, health regulation, and health financing. The service delivery component of the health sector reform agenda included provision of a multi-year budget for priority services, upgrading of the physical and management infrastructure at all levels, and the strengthening of technical expertise in the DOH.

Health financing reforms have focused on expanding health insurance – including a recent push toward universal health coverage as mentioned above. Experience from past reform efforts suggests that higher levels of enrollment of “sponsored” families (premiums paid by the government) has not automatically translated into greater use of services – most likely because of the concerns about service quality and high co-payments. The government is therefore now looking at options to reduce or eliminate co-payments. Attracting the self-employed has also proved a difficult challenge in the past.

Regulatory reforms were implemented in the pharmaceutical sector in the late 1980s. An essential drugs list was established, a Generics Act promoted and required greater use of generic medicines – 55-60% of the public now buy generics – and capacities for standards development,
licensing, regulation and enforcement were strengthened at the Federal Drug Authority. In 2009, the DOH set maximum retail prices for selected drugs and medicines for leading causes of morbidity and mortality.

Section 7 presents an assessment of the Philippines health system against a set of internationally recognized criteria. It suggests that, despite important progress in improving health status, successive waves of reform – from primary health care to decentralization to the more recent health sector reform agenda – have not succeeded in adequately addressing the persistent problem of inequity. An independent and dominant private health sector, the disconnect between national and local authorities in health systems management, and the absence of an integrated curative and preventive network have together had a negative impact on economic and geographic access to health care as well as its quality and efficiency. However, these issues are now attracting attention at the highest levels of government which suggests that the coming years present an important window of opportunity for reform.