PHILIPPINES

1. CONTEXT

1.1 Demographics

The population of the Philippines, as of the last census in 2007, numbered 88,574,614, with a population density of 295 per square kilometre. This translates to an average annual population growth rate of 2.0% for the period from 2000 to 2007, which was the lowest annual population growth rate recorded for the Philippines since the 1960s.

The country’s projected population for 2010 was 94,013,200. It is predominantly young, with the 0-14 years age group representing 33.8% and those aged 65 years and above comprising only 4.4%. There are almost equal numbers of males and females. The crude birth rate is 19.7 per 1000 midyear population and the crude death rate is 5.0 per 1000 midyear population. Life expectancy for both sexes was 70 years in 2009: 67 for males and 73 for females.

1.2 Political situation

The Philippines is a democratic and republican state subscribing to the presidential form of government. There are three branches of government—the executive, legislative and judicial. The country has a unitary form of government and a multiparty political system. Executive power is vested in the President, who is the head of state and commander-in-chief of the armed forces. The Cabinet members are the heads of agencies and assist the President in drafting executive laws, policies and government programmes. The Constitution ensures direct election by the people for all elective positions from the President down to members of the barangay (village) councils.

In 1991, the Local Government Code transferred some of the powers of the national government to local government officials. The Code devolved basic services, including health, giving responsibility to local government units (LGUs). The country is made up of political local government units of provinces, cities, municipalities and barangays. A local chief executive heads each LGU. Administrative autonomy enables the LGUs to raise local revenues, to borrow and to determine types of local expenditure, including expenditure on health care.

Since May 2010, the country has been under a new administration led by President Benigno "Noynoy" Aquino III, the 15th President of the Republic.

1.3 Socioeconomic situation

Over the last decade, the Philippine economy has posted significant economic growth. Gross national product (GNP) grew by an average of 5% per year during the period from 2000 to 2009, with growth peaking in 2007, when the economy grew by 7.5%. It even posted a growth rate of 6.2% in 2008, the year when there were food and fuel price shocks globally. In 2009, a slowdown in economic growth started. The 5% growth in remittances recorded in 2009 was significantly lower than the 13% growth registered in 2007 and 2008. This led to GNP growing by 3% while gross domestic product (GDP) grew by only 0.9%. Data for 2010 suggest that the economy is on its way to recovery. GDP and GNP grew by 7.3% and 9.5% during the first quarter of 2010, with all sectors, except agriculture, posting significant growth. The rebound was spurred on by the global economic recovery, election-related stimuli and the continuous growth of remittances from Filipino workers overseas. With the population still increasing at more than 2% per year, however, per-capita incomes rose by only 20% in real terms from 1981 to 2009.

Despite economic gains, a significant proportion of the population has remained poor over the past two decades. In 2006, poverty incidence went up slightly, primarily due to inflationary pressures. In the aftermath of the global financial and economic crisis (which reached the country in the latter part of 2008) and with natural calamities like the destructive typhoons Ondoy and Pepeng (in October 2009), followed by the El Niño phenomenon (that emerged in the latter part of 2009), further worsening of poverty was expected in 2009.
President Benigno S. Aquino III, on assuming leadership of the country, embarked on a programme based on a so-called “Social Contract with the Filipino People”, wherein he articulated a commitment to transformational leadership, institutional reform, economic stability and inclusive growth. The Philippine Development Plan for 2011-2016 centres on five key strategies: boosting competitiveness in the productive sectors to generate massive employment; improving access to financing to address the evolving needs of a diverse public; investing massively in infrastructure; promoting transparent and responsive governance; and lastly, developing human resources through improved social services and protection.

Previous governments have devoted considerable resources to delivery of social services to those lacking access to health care and education. However, poor households in isolated areas face difficulties in going to health centres and schools, even when services are offered free or at highly subsidized rates. Clearly, poor infrastructure provision, aside from being a hindrance to investment and business activity, also prevents physical access to basic services.

In terms of gender and development, women are becoming more empowered through political and economic participation, and are becoming more visible as leaders and thus more involved in policy decision-making at both the national and local levels. There are also more female workers deployed abroad to work for the welfare of their families. More often than not, however, they tend to accept jobs that are usually not commensurate with their educational attainment, such as domestic workers, caregivers, entertainers, clerical staff or factory workers.

1.4 Risks, vulnerabilities and hazards

Due to its geographical location along the so-called Pacific Ring of Fire and the typhoon belt, the country faces various natural disasters such as typhoons, landslides, volcanic eruptions and earthquakes. Since 2006, the Philippines has consistently been among those countries around the world most often hit by natural disasters and, in 2009, it topped the list, ranking third in terms of mortality (1334 deaths) and second in terms of number of victims (13.4 millions). At the same time, the chronic emergency due to armed conflict in Mindanao has been ongoing for more than four decades. Intensification of fighting alternating with periods of relative calm has led to displacement of those in affected communities, and currently there are around 24 000 individuals seeking refuge in evacuation centres and host communities. Recent flooding in several provinces in Mindanao affected more that 600 000 people and displaced more than 10 000 families.

Environment-related health risks have also been cited as a significant problem, with air pollution, water pollution, poor sanitation and unhygienic practices, and mismanagement of solid wastes, among others, contributing to an estimated 22% of reported cases of disease and nearly 6% of reported deaths, and costing around Php 14.3 billion (US$ 287 million) per year in lost income and medical expenses.

Most regions in the country point to the transport sector as the major source of air pollution. It has been estimated that 21% of the pollutants come from stationary sources, 65% from mobile sources, and the remaining 14% from area sources. Carbon monoxide (CO) contributes the biggest pollution load (50%), mainly due to the increasing numbers of gasoline-fed vehicles, including cars (13.6%) and motorcycles/tricycles (47.9%).

Each Filipino generates between 0.3 kg and 0.7 kg of solid waste daily, with the National Capital Region (NCR) posting the highest rate per capita per day, and the Autonomous Region of Muslim Mindanao the lowest. Total waste generation amounts to 35 154 tons per day, or 12.8 million tons every year. Compliance with the Ecological Solid Waste Management Act, however, has been weak, and its targets have yet to be attained: (1) Only 338 LGUs (20.9% of the 1610 cities and municipalities) have completed their solid waste management plans. In Metro Manila, only eight out of 17 cities and municipalities (47%) have complete plans; (2) Nationwide, only 7680 out of 42 000 barangays are covered by materials recovery facilities (MRFs), giving a compliance rate of 18.3%. In Metro Manila, 685 out of 897 barangays are covered by MRFs, giving a compliance rate of 76%; and (3) Of the 1205 disposal facilities in the country, 1172 are open and controlled dumpsites, and only 33 are sanitary landfills serving 75 LGUs nationwide, giving a compliance rate of only 2.7%. In Metro Manila, there are two disposal facilities. There is a controlled dumpsite in Payatas, which was scheduled for closure by the end of 2010; the other is a sanitary landfill in Navotas. Most Metro Manila LGUs dispose of their residual wastes in sanitary landfills outside the metropolitan area.

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1 Annual disaster statistical review 2009. Centre for Research on the Epidemiology of Disasters
In addition, the around 1461 public and private hospitals nationwide (approximate capacity of 44,296 beds), generate 28,000 kg of health care waste (HCW) per day at an average of 0.3 kg per bed capacity per day. There are also around 393 public hospitals, with an approximate capacity of 44,000 beds, generating 13,200 kg of HCW per day. The NCR has the largest bed capacity (approximately 30,000 beds), which can generate 9,000 kg of HCW per day. The volume does not include the waste from small clinics, stand-alone laboratories, research laboratories, municipal health centres and barangay health stations, which generate mostly general or domestic health care waste. The general distribution of health care waste is as follows: general or domestic waste (80%); pathological and infectious waste (15%); chemical and pharmaceutical waste (3%); sharps (1%); radioactive waste, cystostatic waste, pressurized containers, broken thermometers and used batteries (less than 1%).

Of the 72 hospitals managed by the Department of Health, 30% are located in Metro Manila and contract out their waste treatment and disposal requirements. Most use chemical disinfection for waste treatment and have limited or no access to a sanitary landfill for the final disposal of treated waste. Of these same 72 hospitals, 90% have existing sewage treatment plants or are currently in the process of installing such facilities.

The degradation of the environment aggravates the impacts of disasters and climate change. Deforestation increases the chance of landslides. The risk of drought and poor availability of water are aggravated by the loss of forest cover1. Depleted mangrove reserves deprive coastal communities of natural protection from storm surges. Uncontrolled urban growth, coupled with poor land-use planning, results in encroachment on protected forests or danger zones like riverbanks. Together with shortfalls in basic services, such as proper waste disposal and decent housing, these result in clogged waterways and increased flood risk.

In its scenarios for 2020 to 2050, the Department of Science and Technology-Philippine Atmospheric, Geophysical and Astronomical Services Administration (DOST-PAGASA) projects widespread warming in most parts of the country. The number of days with maximum temperature in excess of 35°C is expected to increase in all parts of the country within that period. Projected seasonal mean temperatures are expected to rise by about 0.5°C - 0.9°C for 2020 and by 1.2°C - 2.0°C by 2050. Extreme rainfall is also projected to increase in Luzon and Visayas, while a decreasing trend is projected in Mindanao.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, health risk factors and transition

National HIV prevalence remains under 0.1% on average, but is rapidly expanding among key populations, such as men who have sex with men, with a prevalence rate of 6% in the 2011 Integrated HIV Behavioral and Serologic Surveillance (IHBS), and injecting drug users, with a rate of 53% in the 2011 Respondent Driven Sampling in Cebu City.

The number of cases reported in the AIDS Registry has been increasing gradually and has shown a steep increase in the last four years, from an average of less than one case a day in 2006 to five cases a day in 2010, and six cases per day in the first two quarters of 2011.

Among the reported cases, sex is still main the mode of transmission, but it has shifted from heterosexual to homosexual and bisexual transmissions, accounting for up to 80% in 2010.

Tuberculosis continues to plague a sizeable segment of the population although, in recent years, effective case-finding, disease management using the directly observed treatment, short-course (DOTS) strategy, and partnership with the private sector have made inroads in the prevention and control of the disease.

1 Philippine Development Plan 2011-2016.
Vectorborne diseases, such as malaria, dengue and filariasis, are an ever-present danger. Although malaria is no longer a leading cause of death, it continues to threaten the lives of about 12 million Filipinos in the 58 endemic provinces. In 2010, there were 17,008 cases and 19 deaths reported. Commonly affected population groups are farmers relying on forest products, migrant workers, indigenous cultural groups, settlers in frontier areas, soldiers, communities affected by armed conflicts and pregnant women and children. Early diagnosis and prompt treatment, as well as and the use of insecticide-treated nets, are the interventions being used for control and elimination of malaria, while indoor residual spraying is adopted in areas where the use of nets is not culturally acceptable, for displaced populations and in epidemic situations.

Dengue fever also remains a threat, with cyclical outbreaks every three to five years. In 2010, a total of 135,355 cases of dengue and 793 related deaths were reported, with a case fatality rate of 0.6%. The age group with the highest (78%) number of cases was 1-20 year-olds and a case fatality ratio greater than 1 was noted in those less than one year of age.

Soil-transmitted helminths are endemic nationwide, with a prevalence rate of 6%-97% among children aged six to 14 years and 66% among those aged one to five years. Schistosomiasis is endemic in 28 provinces, with a prevalence rate of 0.04 to 3.95 per 100,000. The population at risk is estimated to be 12 million, with 2.5 million people directly exposed to schistosomiasis infection.

The Asia-Pacific Region has been the epicentre of some recent emerging infectious diseases like SARS and highly pathogenic influenza A (H5N1), and the threat of emerging diseases continues. Pandemic influenza A (H1N1) 2009 virus is still circulating, while highly pathogenic influenza A (H5N1) is still a threat to the Philippines since almost all neighbouring countries are affected and are continuously harbouring the disease. In 2010, a total of 82,621 influenza-like illness were reported to Department of Health, 16% (132) of which were laboratory-confirmed as influenza A(H1N1). There was no fatality reported among the positive A(H1N1) cases. The Philippines recently reported Ebola Reston in both pigs and humans. Ebola Reston in pigs is new and therefore the risk to humans is uncertain. Further research is needed.

Mortality and morbidity rates for noncommunicable diseases have been increasing steadily since the 1970s. In 1990, diseases of the heart dislodged infectious diseases as the leading cause of mortality. Latest statistics (2005) show that cardiovascular diseases, cancers, chronic respiratory diseases and diabetes continue to be among the country's top 10 killers. Hypertension ranked fourth among the ten leading causes of illness in 2009.

Noncommunicable diseases are often linked by common preventable risk factors related to lifestyle, including tobacco use, unhealthy diet, physical inactivity and alcohol use. In a study conducted by the Food and Nutrition Research Institute (FNRI) in 2003, it was found that 90% of Filipinos had one or more of the following risk factors: physical inactivity, smoking, obesity, hypertension, diabetes and abnormal cholesterol. Alarming, more and more children and adolescents are becoming exposed to NCD risks. The latest FNRI study, carried out in 2008, shows the prevalence of NCD risk factors among adults as follows: hypertension (25%), overweight (27%), high blood sugar (5%) and abnormal cholesterol levels (10%). It is also estimated that about two-thirds (60%) of adults are physically inactive. The obesity trend is also catching up with the young. Prevalence of overweight among adolescents aged 9-11 years doubled from 2.4% in 1993 to 4.8% in 2005. Similarly, the prevalence rate of overweight for children aged 6-10 years doubled from 0.8% in 2001 to 1.6% in 2005. Numerous studies have shown a tendency for obese children to remain obese in adulthood. It is also estimated that about 2% of teenage students are overweight and 30% are physically inactive, spending three or more hours each day in sedentary activities.

The 2009 Global Adult Survey revealed that 28.3% of adults currently smoked (47.7% males and 9% females), 36.9% were exposed to tobacco smoke in enclosed areas at their workplace, and 54.4% were exposed to smoke at home. Of the smokers, 22.5% smoked daily (38.2% men and 6.9% women), 27% smoked manufactured cigarettes (46.6% men and 7.5% women) and 21.5% of ever-daily smokers had quit during the previous year. The average number of cigarettes consumed per day by daily cigarette smokers was 10.6 (11.3 for males and 7 for females). Smokeless tobacco users accounted for 2% (2.8% men and 1.2% women). The average age of initiation of daily smoking was 17.6 (17.4 for men and 19.1 for women). Among adults, 20% were overweight and 5% were

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obese, 22.5% were hypertensive, 60.5% were physically inactive, and a significant number had high blood cholesterol and sugar.

At the same time, the 2007 Global Youth Tobacco Survey showed that 21.7% of students in second to fourth year of high school (29.3% male, 13.8% females) smoked cigarettes; 57.8% were living in homes where others smoked in their presence; 67.9% were around others who smoked in places outside their homes; and 64% of those who bought cigarettes in a store were not refused because of their age.

### 2.2 Outbreaks of communicable diseases

A total of 135,355 dengue cases were reported from different disease-reporting units nationwide between 1 January and 31 December 2010, 234.1% higher than during the same period in 2009 (57,819). The age group with the highest (44.6%) number of cases was 5-14 year-olds. Most (15.8%) of the cases were from region VI. Of the total number of cases, there were 793 fatalities (CFR 0.59%).

Outbreaks of diarrhoeal diseases are common in several areas of the country and are almost always related to a contaminated water supply. Most outbreaks are caused by cholera and salmonella. There were 33 confirmed cholera cases reported in 2010 nationwide, 15-24 year-olds being the age group with the highest number of reported cases (24.2%). Most of the cases were from the National Capital Region.

Pandemic influenza reached the Philippines in 21 May 2009 when the first case was reported and confirmed as the 2009 pandemic H1N1 strain. A total of 5469 confirmed cases and 32 deaths were recorded up to the end of 2009. For 2010, 132 cases were laboratory-confirmed, accounting for 16% of the 82,621 influenza-like illness reported to Department of Health. There was no fatality reported among the positive cases.

Also in 2009, an outbreak of leptospirosis, post-typhoon, affected the National Capital Region, the Southern Tagalog Region and the Ilocos Region. The extensive flooding of many areas of the above-mentioned regions caused the outbreak, which resulted in higher-than-expected numbers of cases and deaths compared with previous rainy seasons. There were 5384 suspected leptospirosis cases reported nationwide, of which 323 died (CFR 6%). The majority of the cases were male (86%). The age group with the highest number of cases was the 25-39 years age group. Most of the cases were from National Capital Region (41.3%). For 2010, there were only 1281 suspected leptospirosis cases reported, with 85 fatalities (CFR 6.6%). Most of the cases were from Region 3.

Since January 2010, large measles outbreaks have been reported nationwide. A total of 10,051 suspected measles cases have been reported, of which 3254 have been clinically confirmed, 140 epidemiologically confirmed, and 2655 laboratory-confirmed. The number of reported cases started to decline after March 2010. Monthly cases vary among regions, with NCR and Regions IVA, V and III having the highest numbers of cases. Of the confirmed cases, 30 have died (CFR 0.50%), the highest fatality rate belonging to children less than nine months of age (CFR 1.33%).

### 2.3 Leading causes of mortality and morbidity

Noncommunicable diseases (NCD) are considered a major public health concern in the Philippines, accounting for six of the top 10 causes of death. Diseases of the heart and vascular system are the leading causes of mortality, comprising nearly one-third (31%) of all deaths. Other NCD topping the list include malignant neoplasms, chronic obstructive pulmonary disease (COPD), diabetes mellitus, and kidney disease.

Accidents of all types, including road traffic crashes, rank 10th among the causes of mortality for all age groups. Road traffic accidents constitute the fifth leading cause of injury death, with a mortality rate of 39.1/100 000. Among children aged 0-17 years, it is the second leading cause of injury death (mortality rate of 5.85/100 000), next to drowning.

Seven of the 10 leading causes of morbidity in 2009 are caused by infections. They are: acute respiratory infection; pneumonia; bronchitis/bronchiolitis; acute water diarrhea; influenza; urinary tract infection and tuberculosis. Among these communicable diseases, pneumonia and tuberculosis continue to be the among the 10 leading causes of mortality, causing a significant number of deaths across the country.

At the same time as deaths due to preventable diseases have been in a decline, lifestyle-related diseases have begun to dominate in the leading causes of death, particularly heart diseases, diseases of the vascular system, malignant
neoplasms, diabetes mellitus, and chronic lower respiratory diseases. However, certain conditions originating in the perinatal period are also among the 10 leading causes of mortality, illustrating the vulnerability of the newborn child.

Accidents and injuries, other leading causes of death, are among the neglected conditions of public health importance. Between 1980 and 1996, the mortality rate for accidents increased gradually from 18.7 deaths per 100,000 population to 23 per 100,000. An abrupt increase has been observed since then, reaching a level of 39.1 per 100,000 in 2005, almost double the 1996 rate.

### 2.4 Maternal, child and infant diseases

The Philippines is one of 55 countries accounting for 94% of all maternal deaths in the world and is statistically off-track for achievement of MDG 5 by 2015, with a maternal mortality ratio (MMR) of 162 per 100,000 live births. Maternal deaths are closely linked with neonatal deaths.

Thirty-seven per cent of all pregnancies every year are unintended, resulting in women having one-third more children than they desire and one-third being born less than two years apart. The updated abortion rate is 27 per 1000 women aged 15–44 per year. Among completed pregnancies, the majority (56%) of deliveries are still home-based, 38% of them attended by an unskilled attendant. Facility-based deliveries and skilled birth attendance are disproportionately in favour of those in the higher wealth quintiles.

The vast majority of maternal deaths are due to haemorrhage, hypertensive diseases, sepsis, obstructed labour and problems related to abortion, all conditions that are treatable if deliveries are attended by skilled health workers. They would also be less prevalent if mothers had only their desired number of children, spaced by at least two years.

The Philippines is also one of 42 countries accounting for 90% of global under-five deaths. The under-five mortality rate (U5MR) is currently 34 per 1000 live births. While the probability of reducing the U5MR by two-thirds by 2015 is considered highly probable, it may not be realized unless deaths during the first 28 days (neonatal period) are dealt with, as they account for 47% of deaths among the under-fives (16 per 1000 live births). Approximately, 75% of neonatal deaths occur during the first seven days of life. Progress to curtail neonatal deaths is dismal, with death rates among this age group remaining statistically unchanged over the past 20 years. The leading causes of under-five mortality are neonatal problems, pneumonia and diarrhoea. The causes of neonatal death are mostly preventable: complications of prematurity, sepsis or pneumonia and asphyxia.

Undernutrition remains a challenge. In 2008, the prevalence of underweight preschool children (0–5 years) was 26.2%, while 27.9% were stunted, 6.1% were considered thin and 2.0% were overweight. According to the 2008 National Demographic and Health Survey (NDHS), 19.6% of babies have a low birth weight.

Exclusive breastfeeding continues to decline, with only 34.0% of children exclusively breastfed up to less than six months of age.

Other nutritional challenges faced by the Filipino child include:

- **Anaemia**: Prevalence rates among children aged 6–12 months remains high at 55.7%. Anaemia in children aged 6–12 years declined from 37.4% in 2003 to 19.8% in 2008.
- **Vitamin A deficiency**: The level among children aged six months to five years increased from 35% in 1993 to 40% in 2003.
- **Iodine deficiency**: According to the 2008 National Nutrition Survey, the iodine status of children aged 6–12 years and 13–19 years is optimal, as indicated by median UIEs. However, localized areas of iodine deficiency still exist. In the following regions, median UIEs are indicative of iodine deficiency: Mimaropa, Soccsksargen, Central Visayas and Western Visayas Regions (6–12 year-olds); and Caraga and Eastern Visayas Region (13–19 year-olds).

The 2008 NDHS showed an historic 10% rise in the number of fully immunized children and a 13% rise in the number of children protected at birth against neonatal tetanus. Local surveys have revealed that children born in

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1. 2008 National Nutrition Survey. Food and Nutrition Research Institute, Department of Science and Technology, Manila.
hospital and receiving a birth dose of hepatitis B vaccine within 24 hours of life rose from 0% in 2007 to 70% in 2008 and 2009.

2.5 Burden of disease

The Philippines is still facing a double burden of disease. Outbreaks of communicable diseases remain a public health problem, while noncommunicable diseases are on the rise, contributing to almost all the top 10 causes of mortality in the country. This double burden has been affecting the country for more than two decades.

Tuberculosis is still among the leading causes of morbidity and mortality. The country has the ninth highest TB incidence in the world and the second highest in the Western Pacific Region. The WHO-estimated prevalence for all forms of TB in the country was 520 per 100,000 population in 2009. In the same year, the estimated mortality caused by TB was 35 per 100,000 population. The Drug Resistance Survey (DRS) conducted in 2004 revealed a primary multidrug-resistant tuberculosis (MDR-TB) rate of 3.8% and an acquired MDR-TB rate of 20.9%. As a result, there are expected to be approximately 6,300 smear-positive MDR-TB cases annually. The TB burden is disproportionately high among the poor, the elderly and the male population, although the death rate is highest among older persons. Since TB principally affects the productive age group, it is estimated that the country loses some Php 26 billion (US$ 540 million) annually due to TB-related premature deaths.

3. Health System

3.1 Ministry of Health’s mission, vision and objectives

Under the new administration, the Department of Health is focusing its “Aquino Health Agenda” (AHA) on the achievement of “universal health care.” Under administrative order 0036, the AHA was launched to “improve, streamline and scale up reform interventions espoused in the HSRA [Health Sector Reform Agenda] and implemented under FI [FOURmula One].” Accordingly, there will be a deliberate focus on the poor, such that implementation of health reforms moves forward with nobody left behind, and that inequities in health outcomes are addressed by ensuring that all Filipinos, especially those belonging to the lowest two income quintiles, have equitable access to quality health care.

Consistent with the World Health Report 2010, the Philippines has identified health care financing as its path and driver to the attainment of universal health coverage. Under the AHA, the National Health Insurance Program (NHIP) is the prime mover in improving financial risk protection, generating resources to modernize and sustain health facilities, and improving the provision of public health services to achieve the Millennium Development Goals (MDGs).

To achieve universal health coverage, the Department of Health has identified the following three strategic thrusts:

1. Financial risk protection through expansion of NHIP enrollment and benefit delivery, whereby the poor are to be protected from the financial impacts of health care use by improving the benefit delivery ratio of the NHIP.
2. Improved access to quality hospitals and health care facilities. Government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain the MDGs, attend to traumatic injuries and other types of emergencies, and manage noncommunicable diseases and their complications.
3. Attainment of the health-related MDGs. Public health programmes will be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of noncommunicable diseases.

The national policy on universal health coverage also stipulates that the following six strategic instruments will be optimized to achieve the above-mentioned thrusts:

1. Health financing, as the instrument to increase resources for health that will be allocated and utilized effectively to improve the financial protection of the poor and the vulnerable.
2. Service delivery, as the instrument to transform the health service delivery structure to address variations in health service utilization and health outcomes across socioeconomic variables.
(3) Policy, standards and regulation, as the instrument to ensure equitable access to health services, essential medicines and technologies of assured quality, availability and safety.

(4) Governance for health, as the instrument to establish the mechanisms for efficiency, transparency and accountability, and to prevent opportunities for fraud.

(5) Human resources for health, as the instrument to ensure that all Filipinos have access to professional health care providers capable of meeting their health needs at the appropriate level of care.

(6) Health information, as the instrument to establish a modern information system that will provide evidence for policy and programme development in a timely manner, as well as facilitate support for immediate and efficient provision of health care and management of province-wide health systems.

Efficiency in implementation, through integration of health service delivery and harmonization of systems and processes, is being promoted. Implementation of reforms also follows a sector-wide approach, covering the entire health sector, and an investment portfolio that encompasses all sources. The capacities of LGUs are being enhanced to improve public health conditions in their respective jurisdictions. The National Government, on the other hand, maintains institutional influence over the LGUs by leveraging with incentives and regulatory functions.

3.2 Organization of health services and delivery systems

The power of the Department of Health diminished significantly with the transfer of responsibility for health to about 1600 LGUs under the Local Government Code of 1991. With the devolution of health services to LGUs, fragmentation of services became evident. The provincial governments now oversee provincial and district hospitals, while the municipal governments manage rural health units (RHUs) and barangay (village) health stations. The Department of Health, however, maintains specialty hospitals, regional hospitals and medical centres. Sub-national Department of Health offices or "centres for health development" are located in 16 regions.

Service provision is regarded as 'dual', consisting of both the public and private sectors. The public sector has three largely independent segments or sets of providers: (1) national government providers, which include, among others, hospitals run by national government agencies (e.g., hospitals of the Department of Health and the Department of National Defense), and central and regional offices of the Department of Health; (2) provincial government providers, which include provincial hospitals, provincial blood banks and the provincial health offices; and (3) local (municipal or city) government providers, including rural health units or RHUs, city health centers and barangay health stations or BHSs. Each BHS is staffed by a midwife, and each RHU is staffed by a doctor, a nurse and midwives.

The Department of Health has taken steps to address the challenges of devolution. It developed the Health Sector Reform Agenda (HSRA) in 1999, which set the strategic direction to promote and ensure effective and efficient provision of adequate health care to the population, despite devolution. The National Health Insurance Program (NHIP) is envisioned as the main lever to effect desired changes and outcomes. The Department's role now focuses on regulation, technical guidelines/orientation, planning, evaluation, and inspection, while the provincial government is responsible for provincial and municipal hospitals, health centres and health posts, although funding flows do not exactly match responsibility. The role of the municipal-government level is not well defined and capacity is reportedly weak.

With decentralization of service delivery, local chief executives became core players in the health sector. The number of actors involved multiplied and hence the need for coordination and policy monitoring. Under a devolved setting, the LGUs serve as stewards of the local health system and are therefore required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. They are also in charge of creating an environment conducive to establishment of partnerships with all sectors at the local level.

Ongoing reforms in health service delivery are aimed at improving the accessibility and availability of basic and essential health care for all, particularly the poor. Public primary health facilities are perceived as being low quality, and are thus frequently bypassed. Clients are dissatisfied due to long waiting times; perceived inferior medicines and supplies; poor diagnosis, resulting in repeated visits; and the perceived lack of medical and people skills of the personnel available, especially in rural areas. The result is that secondary and tertiary facilities are inundated with patients needing primary health care. Since public primary facilities are more accessible to households and are mostly visited by the poor, improving the quality of those services particularly demanded by
the poor would improve their health. Furthermore, referral mechanisms among different health facilities across local government units need to be strengthened.

Private providers are predominantly located in highly urbanized areas. The private sector consists of a wide range of privately operated facilities, such as pharmacies, physicians in solo or group practices, small hospitals and maternity centres, diagnostic centres, employer-based outpatient facilities, and secondary and tertiary hospitals, as well as traditional birth attendants and indigenous healers.

Pharmaceutical challenges remain due to asymmetric information, income distribution and the inadequacy of the regulatory system. This stems from various factors such as massive campaigns by and lucrative incentives from multinational drug firms, prolonged patent rights and a lack of appropriate public understanding regarding generics.

3.3 Health policy, planning and regulatory framework

The Government's policy to achieve improvements in health includes a perspective on the integral value of health for any nation, the coordination of resources from all sectors, the right to access to quality care, and the presence of socioeconomic fundamentals. While the Government provides the leadership and stewardship to ensure that all efforts in the health sector lead to a common goal, greater support to local health system development and emphasis on strong management and administrative support systems at all levels of governance is likewise critical. Better coordination between national policies and external development partner priorities play a major role in fostering harmonization of resources for health. In the context of securing sustained financing for ongoing health sector reforms, budget reforms have been underway such that resources that are within the direct control of the Department of Health are aligned and utilized in support of LGU plans for health.

A six-year strategic plan, the National Objectives for Health, is developed every six years, synchronizing with every change in administration of the Philippine Government. It describes the achievements and problems of the health sector in the previous six years (previous administration), its goals for the next six years, and its strategies for achieving those goals. It is a roadmap of key targets, indicators and strategies to bring the health sector to its desired outcomes.

The fragmentation in management functions brought about by devolution required that planning between the national and local levels be coordinated. Since the previous administration, with FOURmula ONE as its implementation framework, each local government develops a Province-wide Investment Plan for Health (PIPH). This is intended to rationalize the local health systems and harmonize support from the national Government and development partners. PIPH implementation is accompanied by a service-level agreement defining the benchmarks for LGU performance, which triggers the release of corresponding grant/s and variable tranches from the Department of Health. LGU performance is measured using an LGU scorecard that explicitly tracks and holds LGUs accountable for their performance using a set of health outcome, output and governance indicators. The system has guided LGUs to develop PIPHS and City Investment Plans for Health, with the National Objectives for Health serving as a reference and guide in the drafting of PIPHS. At the same time, the Department of Health attempts to work hand-in-hand with LGUs and to ensure commitment of support to health initiatives coming from the LGUs. Such a scheme ensures the synchronicity of local health programmes with national health goals and has reduced fragmentation in the health service delivery system.

Moreover, the Department of Health has adopted a sectoral development approach for health, which is a way of organizing the planning and management of international and national support for health reforms. Corresponding memorandums of agreement are signed between the Department of Health and the provinces to formalize their collaboration in the implementation of their provincial health plans, with defined roles and responsibilities for the stakeholders involved. This arrangement is envisioned to continue with the new Department of Health administration.

With the public health mandate of the Department of Health, health standards, policies and guidelines to support implementation of health services at the local level are provided on a continuous basis. For example, the Philippine National Strategic Plan for Emerging Diseases was developed in response to implementation of the Asia Pacific Strategy for Emerging Diseases (APSED), fulfilling many of the requirements of the revised International Health Regulation (IHR) 2005. One important policy to support the Philippine strategy is the Philippine Integrated Disease Surveillance and Response (PIDSAR) policy. The policy aims to increase the
capability of LGUs to perform disease surveillance and response, and to increase utilization of disease surveillance data for decision-making, policy-making, programme management and evaluation. Thereby, it aims to increase capability at the local level for risk assessment to prevent outbreaks and for early detection of outbreaks, as well as strengthening preparedness and response.

The Department of Health’s regulatory agencies consist of the Food and Drug Administration or FDA (formerly the Bureau of Food and Drugs), the Bureau of Health Facilities and Services (BHFS), the Bureau of Health Devices and Technology (BHDT) and the Bureau of Quarantine (BOQ). The FDA is responsible for the regulation of products that affect health, while the BHFS covers the regulation of health facilities and services. The BHDT regulates radiation devices and the BOQ covers international health surveillance and security against the introduction of infectious diseases into the country. There is no direct provision for health regulation by LGUs. The general powers and authorities granted to the LGUs, however, do carry several regulatory functions that can directly or indirectly influence health. Examples include: issuance of sanitary permits and clearances, protection of the environment, inspection of markets and food establishments, banning of smoking in public places, and setting taxes and fees for local health services. However, the responsibility for regulation of medical practice and issuance of licenses and other regulatory standards pertaining to the operation of hospitals and health services remains with the Department of Health.

### 3.4 Health care financing

While budgeting for health follows a yearly cycle, this is based on a Health Sector Expenditure Framework that is developed through discussion and negotiation with the Department of Budget and Management. This defines the amount of resources that will be available in the medium term and the corresponding allocation to health programmes and institutions. The Department of Health has also established the Organizational Performance Indicator Framework, which is an approach to expenditure management that directs resources towards results, with the agency’s performance measured by the Framework’s key quality and quantity indicators. The Department of Health budget has been restructured to allow performance-based budget allocation and coordinated national and health spending through the PHIPs.

The financial protection of the population against the costs of ill health is deteriorating. In terms of overall trends, out-of-pocket spending has been increasing, while public spending has been declining. This is contrary to the trend in other Asian countries. Out-of-pocket payments account for almost half of all health spending in the Philippines and their share has been increasing (56.2% in 2008). At the same time, health insurance coverage in the country is still low, at around 40%, and the subsidies for health services are poorly targeted, as the true poor and indigent households are not adequately captured in the programme of social health insurance. Moreover, health insurance coverage is no guarantee of financial protection and enhanced access to good quality health services, due to the limited nature of Philippine Health Insurance Corporation (PHIC) benefits and the difficulties in accessing them.

Meanwhile, overall public spending on health, while increasing very slightly, is still below the level of other similar-income countries (US$ 2145.9 in 2009). The Department of Health budget has doubled as a percentage of government expenditure, resulting in an increase in government expenditure from 6% in 2002 to 7.2% in 2009. In particular, spending on public health interventions, such as vaccines, antituberculosis drugs, and the upgrading of government health facilities to provide emergency obstetric care, has increased in the past two years. However, the increase has largely been limited to central government expenditure, while LGU expenditure on health has declined in real terms. Based on the Local Government Code, LGUs with higher fiscal capacity (using per capita income as a measure of financial base) tend to get higher per capita internal revenue allocations than those with lower fiscal capacity. Many municipalities and provinces have experienced financial shortfalls, causing the diversion of health funds to other priorities. In addition, the PHIC share of health expenditures has hardly grown since it was established in 1995.

While the national health insurance programme, PhilHealth, has made a relatively slow and cautious increase in its share of total health expenditure, utilization of PhilHealth benefits is reduced among the poor due to lack of awareness of benefits and the stringent requirements for availing of them. The limited financial protection provided by PhilHealth is closely related to the current provider-payment system. As physicians provide more services and raise prices under the current fee-for-service system, medical care expenses increase rapidly. PhilHealth pays only up to a rather low benefit ceiling and patients pay the rest of the expense. As a result of the
low benefit ceiling and physicians’ freedom to extra-bill without fee regulation, it is easy to extract profit out of patients’ insurance benefits. Discussions are now ongoing to explore the feasibility of extending benefit coverage by raising the benefit ceiling.

Public health facilities are funded through a mix of public subsidies, such as PhilHealth reimbursements, user fees and, to a lesser degree, private health insurers. At the primary level, public subsidies and PhilHealth capitation allocations are funding services for both insured and non-insured members and for both public health and personal care. At the local level, several schemes are in operation, depending on local priorities and management styles. Drugs are mainly purchased by out-of-pocket payments from private for-profit retailers. The Government recently introduced thousands of non-profit community outlets, but their impact on access and costs supported by patients remains to be seen.

Based on the latest national health accounts, most health care financing resources are spent on hospital-based curative services, with a smaller share going to preventive and health-promotion services, signs that the country is not spending adequately or effectively on health. Meanwhile, the large hospitals in Metropolitan Manila and other urban areas get the biggest share of spending. Non-hospital health services, on the other hand, face difficulties in securing adequate funding.

The Universal Health Care roadmap under the new Department of Health administration hopes to address the above-mentioned challenges by improving health care financing polices to realistically enhance access, equity and effectiveness in resource mobilization and allocation, as well as use of health services.

3.5 Human resources for health

The Philippines is purportedly the leading exporter of nurses to the world and the second major exporter of physicians. Paradoxically, there are shortages of physicians and a fast turnover of nurses in the country, especially in rural areas. The high unemployment rates among health professionals, in spite of the considerable number of vacancies in rural areas, is another irony. Prevailing challenges include unmanaged emigration of Filipino health workers, a weak and inadequate human resources for health (HRH) information system, and the existing distribution imbalance, among others. Responses to HRH issues in the past have more often been stop-gap measures, and the interventions of the agencies concerned have not been coordinated.

In order to address such complex and multifaceted issues, a comprehensive HRH master plan has been developed and implementation of activities is underway. A high-level coordinating body and multisectoral working group was established in 2006 to mobilize the political commitment, donor/partner support and funding needed to accomplish the priority activities of the master plan. Called the Human Resources for Health (HRH) Network, the group was able to successfully convene a policy forum to advocate their policy agenda, which aims to resolve issues related to the production, entry and retention of health professionals, as well as their exit and re-entry.

Strategic thrusts for 2005-2010 included development of HRH policies and strategies to address outmigration; sustaining incentive mechanisms for HRH distribution and complementation in underserved areas; and making education, training and skills development more appropriate to local needs. The strategies undertaken included, among others, the institutionalization of the HRH management and development system; improvement of the technical competence and relevant skills of health professionals through education and training; provision of targeted and performance-linked compensation benefits; strengthening of the coordination mechanism between the education sector, regulatory agencies and HRH users; and installation of an HRH information system.

3.6 Partnerships

The attainment of national health goals has progressed as a result of the reforms in the health sector. The Department of Health has learnt from previous experience that better harmonization of efforts among the various stakeholders at all levels is critical. Currently, assistance for the health sector comes mainly in the form of grants, loans and technical support. A sectorwide development approach for health between the Government and its partners is being initiated to maximize investments, minimize duplication of initiatives and generate the necessary resources for the health sector. The Department of Health is working closely with international organizations and global initiatives to strengthen implementation of priority health programmes. The Department of Health leads a regular meeting of health partners, and has institutionalized mechanisms, such as reviews carried out by the joint
appraisal committee and a joint assessment and planning initiative, where development partners and the Department jointly review progress at both the national and local levels.

### 3.7 Challenges to health system strengthening

The publicly funded health system has been undergoing major reforms since 1999. At the broadest level, this has included a review of the Department of Health’s primary functions, roles and responsibilities, as well as the suitability of the existing organizational structure to support these at both the strategic and service-delivery level. Introduction and pilot-testing of the different concepts and strategies of health sector reform in selected provinces showcased some gains in health systems development.

Data from various sources, however, show that poor Filipino families have yet to experience real access to critical health services. In addition to increasing enrolment in social health insurance, there is a need to improve the use of benefits and to increase the support value for claims in order for PhilHealth to provide Filipinos with substantial financial risk protection. The health care delivery system has yet to address some major issues and challenges, such as the absence of data disaggregated at provincial/municipal levels (for baseline and monitoring); the minimal involvement of the private sector in the delivery of public health programmes; the still excessive reliance on use of high-end hospital services rather than primary care; the slow improvement in maternal mortality; and population growth. Issues such as geographic inequity, where people who live in rural and isolated communities receive less and lower quality health services, and socioeconomic inequity, where the poor do not receive health services due to inaccessibility and/or unaffordability, continue to abound in the country.

The above-mentioned health development efforts/reforms have been generally aimed at addressing problems of inequitable access to health services. After four decades, however, inequity continues to be the main root of health sector problems. There remain large disparities in health outcomes between the rich and the poor as a result of economic and geographic barriers to health service access. For example, the infant mortality rate (IMR) among the poorest quintiles is four times that for the richest. Another example is that the Autonomous Region of Muslim Mindanao and other poor areas have consistently poorer health status than richer regions. There are also large income-related disparities in the utilization of health services. For instance, there is skilled attendance at 94% of births among the highest income quintile, compared with 25% in the poorest quintile, and only 13% of all births in the lowest quintile occur at a health facility, compared with 84% in the highest quintile. Similarly, immunization coverage is only 70% among the lowest quintile, compared with 94% in the highest (NDHS 2008, 2009). The unfair distribution of coverage rates is paralleled by similar disparities in the distribution of human and physical resources in the health system. While nationwide average supply levels are adequate or nearly adequate, distribution across provinces is not consistent with need or poverty level.

Utilization patterns are affected by financial barriers and negative perceptions or lack of awareness of services. The poor utilize primary health facilities like RHUs and BHCs more than hospitals because of the co-payments and balance-billing in government or private hospitals, which they cannot afford to pay. In addition, government hospitals and lower-level facilities, despite their geographical accessibility are bypassed in favour of private facilities and higher-level facilities, respectively, because of perceived quality issues. Government hospitals intended to serve the poor are utilized by a large non-poor clientele, who patronize those facilities because of the high cost of private facilities and the low level of support from social health insurance. To a large extent, lack of information often combines with cost considerations to cause low utilization of services among the poor.

There are also capacity constraints as health sector inputs have not kept up with population growth. The bed-to-population ratio is roughly 1 per 1000 inhabitants, lower than in other East Asian countries, such as China (2.6 beds per 1000 inhabitants), Viet Nam (1.2 beds) or Thailand (2.2). Moreover, many of these hospital beds are clustered in large city centres and better-off LGUs. This is particularly true for private hospital beds, which account for approximately half of all hospital beds in the country. The availability of skilled health sector staff is also a problem, especially in the public sector. Weaknesses in management and compensation of human resources for health have not been adequately addressed.

Likewise, inadequacies in health information systems to guide planning and implementation of health programmes need to be addressed as a matter of urgency.

Overall, health system strengthening efforts have made important contributions to the health sector but have not effectively addressed significant gaps, namely: (1) the continuing low levels, fragmentation and inequity in public
financing for health; (2) limitations in PHIC performance in the implementation of universal social health insurance and using health financing as a lever to drive health sector development; (3) gaps in service delivery capacities; and (4) weak stewardship at all levels of the health system, particularly with regard to data for decision-making, monitoring and sector performance management, outdated or non-existent strategies in hospitals, pharmaceuticals and supply-chain management, public and private sector regulation, and public health.

4. LISTING OF MAJOR INFORMATION SOURCES AND DATABASES

Title 1: Republic of the Philippines (official website)
Web address: www.gov.ph

Title 2: The Philippines in Figures 2011
Web address: http://www.nso.gov.ph/

Title 3: Philippines National Demographic and Health Survey 2008
Operator: National Statistics Office (NSO) [Philippines], and ICF Macro [Calverton, Maryland]
Web address: http://www.measuredhs.com

Title 4: 2007 Government of the Philippines Year-End Report
Web address: http://www.gov.ph/faqs/yearend_reports.asp

Title 5: Philippine Environment Monitor 2006
Operator: The World Bank Group
Web address: http://www.worldbank.org.ph/perm

Title 6: National Epidemiology Center
Operator: Department of Health, Philippines
Web address: http://www2.doh.gov.ph/nec/

Title 7: 2007 Philippines Development Forum.
8-9 March 2007, Cebu City, Philippines.

Title 8: 2005-2010 National Objectives for Health,
Operator: Department of Health, Philippines.

Title 9: National Nutrition and Health Survey (NNHeS): Atherosclerosis-related Disease and Risk Factors,
Operator: Antonio Dans, Dante Morales, Felicidad Velandria, Teresa Ahola, Artemio Roxas Jr., Felix Eduardo Punzalan, Rosa Allyn Gyi, Elizabeth Paz-Pacheco, Lourdes Amarillo and Maria Vanessa Villaruz


5. ADDRESSES

DEPARTMENT OF HEALTH
Office Address: San Lazaro Compound, Tayuman,
Sta. Cruz, Manila
Official Email Address: info@doh.gov.ph
Telephone: (632) 743-8301
Fax: (632) 743-1829
Website: http://www.doh.gov.ph

WHO REPRESENTATIVE IN THE PHILIPPINES
Office Address: Ground Floor, Building 3,
Department of Health, San Lazaro Compound,
Sta. Cruz, Manila, Philippines
Postal Address: P.O. Box 2932, Manila
Official Email Address: who@phl.wpro.who.int
Telephone: (632) 338-7479/ 338-8605
Fax: (632) 338-8605
6. **ORGANIZATIONAL CHART: Department of Health**

![Organizational Chart](image)

- **Office of the Secretary**
  - Health Emergency Management Staff
  - Health Human Resource Development Bureau
  - Health Policy Development and Planning Bureau

- **Health Regulation Cluster**
  - Bureau of Health Facilities & Services
  - Bureau of Food and Drugs
  - Bureau of Health Devices & Technology

- **External Affairs Cluster**
  - Bureau of Quarantine & Intl. Health
  - Bureau of Intl Health Cooperation
  - Bureau of Local Health Development

- **Health Operations Cluster**
  - Natl Epidemiology Center
  - Natl Center for Disease Control & Prevention
  - Natl Center for Health Promotion
  - Natl Center for Health Facility Devt

- **Support Services**
  - Administrative Service
  - Information Management
  - Finance Service
  - Procurement & Logistics Service

- **Agencies & Boards**
  - Philippine Health Insurance Corp
  - Dangerous Drugs Board
  - Institute of Traditional and Alternative Health Care
  - National AIDS Council
  - National Centers for Specialized Health Care