3

GOVERNANCE IN HEALTH

PEDRITA B. DELA CRUZ

I. INTRODUCTION

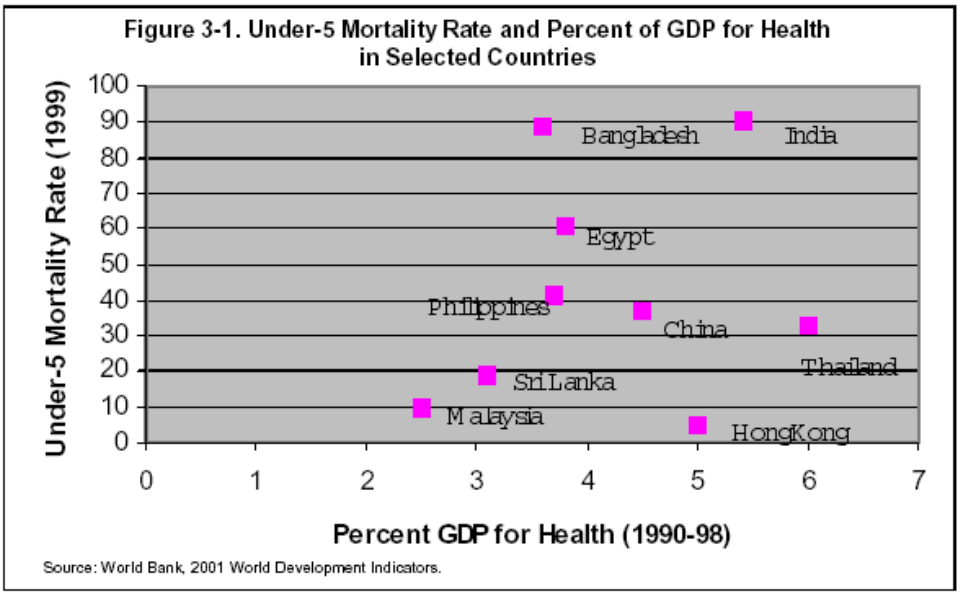
A nation's health does not exist in a vacuum. Today, health is no longer seen from a narrow disease-oriented perspective but recognized as both a means and an end of development.

This chapter defines health governance as the ability to harness and mobilize resources to fulfill three fundamental goals: (1) improve the health of the population to help achieve productivity or societal goals; (2) respond to people's expectations; and, (3) provide financial protection against the cost of ill-health. The World Health Organization (WHO) identified these goals as concerns that should drive health systems (World Health Report 2000: 8).

The term "resources" covers both material and non-material resources. Material resources include financial, human, facilities, equipment and others. These constitute the "oil" that determines the depth and reach of public health programs or campaigns. Non-material resources, on the other hand, include leadership and management, morale and teamwork, confidence, vision and discipline, creativity and openness, values and culture. They are the "glue" that holds the material resources together, and the "energy" that gives governance ethical direction and momentum. They produce or multiply the material resources. They determine whether these resources are harnessed and maximized or go to waste. Material resources alone are not enough to ensure good health outcomes.

Sri Lanka, for example, has a relatively low percentage of GDP devoted to health expenditures but has good health status indicators. India, which has a relatively high percentage of GDP for health expenditures, performs poorly, as measured by health indicators (Figure 1). The efficiency of the use of health sector resources is more likely to influence health outcomes than the share of national resources allocated to health. Compared with many countries, the Philippines has a lower proportion of GDP devoted to health care, but relatively good health indicators. For example, the under-five mortality rate (U5MR) in the Philippines is relatively low compared with that of other developing countries that spend a higher percentage of GDP on their health (Figure 1). Efficiency requires that stewards of resources possess leadership, management and vision. These attributes are necessary if morale, teamwork, creativity and discipline for better performance in health are to be fostered.

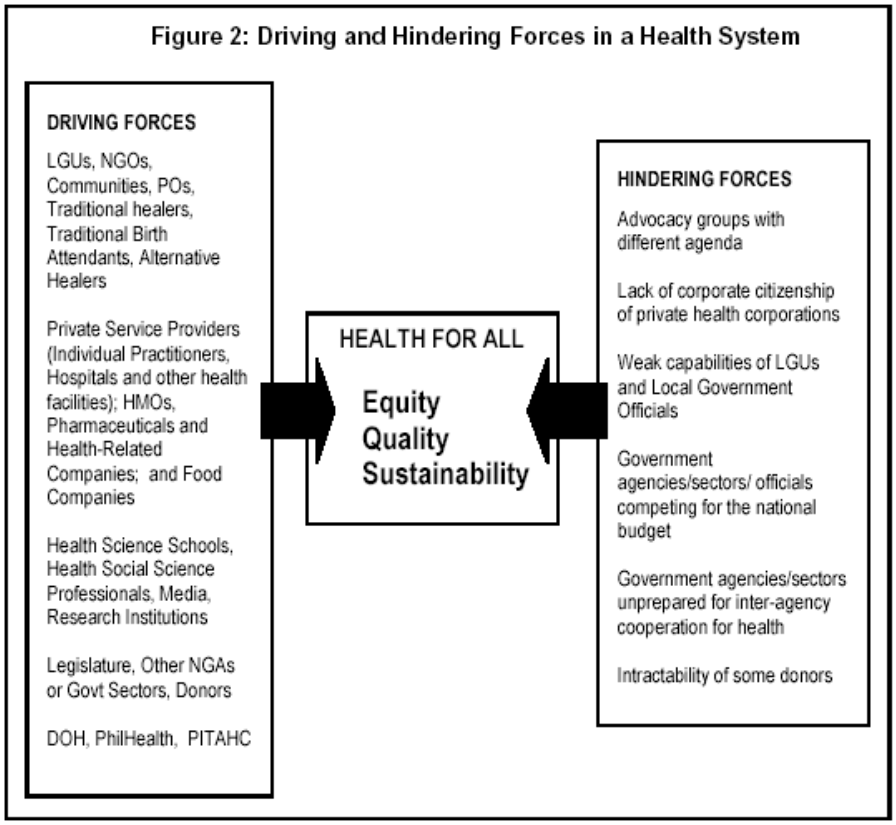
Figure 1.



The use of the term "resources" recognizes the inclusiveness of the health system. As the WHO defines it, a health system includes – …all the activities whose primary purpose is to promote, restore or maintain health. Formal health services, including the professional delivery of personal medical attention, are clearly within these boundaries. So are actions by traditional healers, and all use of medication, whether prescribed by a provider or not. So is home care of the sick. Such traditional public health activities as health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement, are also parts of the system. Beyond the boundaries of this definition are those whose primary purpose is something other than health – education, for example – even if these activities have a secondary, health-enhancing benefit. Hence, the general education system is outside the boundaries, but specifically health-related education is within. (World Health Report 2000: 3).

From this description of the health system, we can surmise the enormity of the task and the cutting-edge nature of health governance. Going back to the proposition that health does not exist in a vacuum, the health sector must reach out to each and every element, current and emergent, of the health system to produce good health. With the political democratization in the post-Marcos years that saw an increasing number of stakeholders participating for better health, followed by the decentralization of health services delivery, which made the clarion call for self-reliance and building up of capacities among local government units, the boundaries of the health system expanded. This expanded environment requires a new way of looking at things and new approaches at problem solving. At the core of the challenge is the provision of an enabling environment for the old and the newly recognized players in the system to do their part for better health.

The expanded environment is composed of the stakeholders listed below (Figure 2) that are considered as driving forces of the health system.



The cluster consisting of LGUs, NGOs, POs, communities, and the indigenous or alternative health human resources is first in the list. This emphasizes the spirit of decentralization, which treats LGUs as the main provider of health services. They are also co-guardians of people's health at the local level.

Except for this emphasis, there can be no cut-and-dried sequencing of the players, for the dynamics within and outside the health system's boundaries at any given epoch determine the degree of significance or sphere of influence of all the other players.

LGUs, NGOs, Indigenous Health Human Resources

In terms of health services delivery before decentralization in 1993, local authorities had some impact in terms of influencing appointments and contributing to local resources. In the case of cities, they already had full control of local health services except for appointing personnel to key positions, which were made by the DOH. With the decentralization, however, the role of LGUs became more pronounced.

The Philippines has 79 provinces, 1,496 municipalities, 114 cities and 41,945 barangays (DILG, 2002). As to NGOs, a 1998 inventory produced a list of 500 organizations engaged in community-based activities, with health programs as

either the main work focus or one of the components of integrated development initiatives. Although the lists included religious and socio-civic group, cooperatives, and offices of educational institutions, the great majority of these organizations claimed legal personalities as NGOs (Veneracion, 1999). As to traditional healers, a study done in 1984-1985 by the Health Action Information Network (HAIN) in 108 barangays in 15 provinces and Metro Manila indicated that there were 5.65 traditional medicine practitioners per barangay. In 1989, the total number of traditional medicine practitioners was estimated at 200,000, of which about 40,000 were traditional birth attendants or *hilots* (UNDP, 1994). The high incidence of maternal mortality rate in the country, which is largely attributed to deliveries with untrained hands, is telling of how the country is harnessing its traditional healers, particularly the traditional birth attendants.

The Private Sector

The private sector can be categorized under three types: the private health care providers, both individual and institutional; business establishments engaged in health-related activities (HMOs, pharmaceuticals and other health-related products); and, those involved in the food industry who, in recent years, have shown increasing responsibility for health and nutrition.

A 1998 WHO study revealed that between 1990 and 1995, the country had about 82,494 doctors, 256,629 nurses, and 102,878 midwives (WHO, 1998, as cited in the DOH National Objectives for Health, 1999). Although there is no data available on the number belonging to the private sector, including those engaged in individual practice, we could surmise, based on government figures that an overwhelming majority belongs to the private sector. As to private health facilities, there were 1,068 private hospitals registered with the Bureau of Licensing and Regulation of the DOH in 2001. This number represents a decrease from the 1996 figure of 1,138 (BLRDOH, 1996 and 2001). As to private outpatient clinics and polyclinics in the Philippines, they are usually owned and run by physicians themselves. Except those that are accredited for conducting medical examination of overseas workers and seafarers, these clinics are beyond the regulatory powers of the DOH at this time. They are registered with the local government units for business licensing purposes and not for health regulation.

As to Health Maintenance Organizations (HMOs), there are reportedly 36 to 38 of them operating in the country, of which the top 25 have an aggregate membership of 1.1 million individuals and 4,200 corporate clients (AHMOPI, 2001). HMOs are the fastest growing source of spending for health, posting an average annual growth of 32.1 percent. In 1999, the share of HMOs in overall health spending (P108.299 billion) was at P4.154 billion, with benefits paid to members amounting to P2.8 billion (NSCB, 2002).

Aside from HMOs, there are also private insurance firms dispensing health benefits through reimbursements for hospitalization, which is the oldest form of health insurance in the country. The 1999 National Health Accounts reflected a private insurance share of P2.312 billion in 1999 compared to P1.986 billion in 1997. It is noteworthy that, in 1999, private insurance firms spent more for administrative and operating costs (P1.495 billion) than for the benefits of its members (P816 million). For an industry as big as that of HMOs and private insurance firms, government has not stepped in to exercise even minimal regulation. Currently, three agencies are among these suggested to regulate HMOs: the DOH, the Insurance Commission (IC), and the Security and Exchange Commission (SEC). PhilHealth's opinion is that the regulatory

responsibility should be lodged jointly with the DOH and the IC, with the health aspects regulated by DOH and the financial aspect by the IC (Bernardo, 2001).

There are 2,310 pharmaceutical and medical device firms operating in the Philippines (see Table 3-1). The top 20 drug manufacturers control 75 percent of the market, and the top five distributors control 80 percent of the distribution market. Together, they fill the demands of the Philippine pharmaceutical market which – at US$1.29 billion as per a 1996 study – is considered the third largest in Southeast Asia. The largest drugstore chain, Mercury drug, serves 40 to 50 percent of the drug retail market (Management Sciences for Health, 1999).

Table 3-1: Number of Pharmaceutical Establishments, 1996

Drug Manufacturers	244
Drug Traders	388
Drugstores	11,617
Drug and Medical Device Distributors	1,633
Medical Device Manufacturers	36
Medical Device Traders	11

The health-related private sector consists of firms who, over the years, have given support to vital public health programs and projects (e.g., cervical cancer control, national immunization days). This includes those engaged in the manufacture and/or distribution of cosmetic products and toiletries.

As to food companies, there were 40,893 and 508 food manufacturing and beverage manufacturing establishments, respectively, operating in the country in 1995 (NSO, Philippine Yearbook 2001). Food manufacturers can play a significant role in promoting better nutrition. For example, the prevalence of Iodine Deficiency Disorder (IDD), which is the largest cause of mental retardation among children under five can be reduced significantly if programs like salt iodization and distribution (especially to those in marginalized communities) are given enough push. Toward the later part of the previous decade, only 24.8 percent of Filipino households were using iodized salt (FNRI, 1998).

Medical Schools, Health Professionals. Media and Research Institutions

The country has now 31 medical schools producing an annual average of 2,000 newly licensed doctors. Based on data from the Commission on Higher Education (CHED), there are also 280 nursing schools and 218 schools offering midwifery.

From 1991 to 1996, the country produced the following number of graduates of various health courses:
Medicine - 10,956
Nursing - 146,020
Dentistry - 15,208
Midwifery - 76,578
Medical Technology - 18,742
Radiologic Technology - 3,126

Aside from the conventional health science courses, there are also institutions providing formal training (degree and non-degree) in the fields of health economics, public health, and health social science.

As to mass media, its role in fostering health awareness and participation in public health initiatives cannot be emphasized enough, as experienced in the National Immunization Days and family planning campaigns.

Research institutions like the FNRI, PCHRD, as well as their counterparts in the academe, the non-government sector and the private sector are also considered as stakeholders inasmuch as the information they generate guides governance.

Other Government Sectors and Donors

As implied in our definition of the health system and as we will see later on in this chapter, other government sectors or agencies, aside from the DOH, have important roles to play in fostering better health. The Department of Interior and Local Government (DILG) is mandated to ensure that local government units responsibly take on the devolved functions, aside from monitoring peace and order. Together with the Department of Public Works and Highways (DPWH), the DILG is also responsible for the provision of safe water supply at the community level. The Department of Environment and Natural Resources (DENR) is responsible for monitoring and enforcing environmental health standards. The Commission for Higher Education (CHED) can, if it so chooses, influence the supply, distribution and, more importantly, the formation of health providers. The Department of Labor and Employment (DOLE) has the responsibility for enforcing occupational health and safety standards, while the task of ensuring travel safety falls on Department of Transportation and Communication (DOTC). Our experience in food and agriculture issues that have grave impacts on health (e.g., hoof-and-mouth disease, red tide, dumping of contaminated poultry products, dumping of pesticides banned in the First World) also warrants the inclusion of the Department of Agriculture (DA) and the Department of Trade and Industry (DTI) as major stakeholders in health. The DTI also takes a lead role in drug pricing and supply of pharmaceuticals and medical equipment.

The country's public health system is still heavily dependent on donor support. Like in other sectors, capability-building projects in the health sector are funded from foreign sources. Examples of these are the Integrated Community Health Services Project (ICHSP), Urban Health and Nutrition Project (UHNP), and Women's Health and Safe Motherhood Project (WHSMP). Also included are health projects initiated at the local level by the LGU, POs and NGOs, and major initiatives promoting the role of the private sector in service provision (e.g., FriendlyCare Foundation; Well-Family Midwife Clinic). Aside from multi-lateral agencies (WHO, UNICEF, UNDP, World Bank, Asian Development Bank) big unilateral agencies (e.g., USAID, AusAID, JICA, KfW, CIDA), international civic organization like Rotary International, there are also foreign NGOs serving as conduit of funds to their local NGO and PO partners. The share of grants from donors in health spending has been decreasing since 1997. The share of loans in health spending, on the other hand, increased significantly in 1999 (NSCB, 2002). There is an observation that coordination between donors and implementers of foreign-funded projects in health is somewhat lacking, leading to overlaps in the areas and activities funded.

The definition of health governance in this chapter not only recognizes the inclusiveness of the health system, but also captures much of the dilemmas that

the Philippine health sector is currently faced with. Thus, in addition to improved health, we include *responsiveness* to people's expectations as a goal of health governance. In a country where more than forty percent of the population lives below the poverty threshold, we might be inclined to think that improving health or controlling diseases is all that matters and that quality is a privilege for the few. This view is mistaken, for the poor are just as entitled to quality and humane treatment as the rich, even if they have lesser or no access to greater material resources for health. (In fact, in a resource-poor health situation, improving quality of care may be the factor that leads to improved health outcomes, and it may be all that the system can afford.) Studies have shown that Filipinos, especially women, have mixed feelings toward the health system, having heard rumors or personally experienced any of the following weaknesses:

- A health system that is complex and alien to the ordinary person, who is not readily given the information that would assuage his or her fears or lighten up his or her load;
- Arrogant and overbearing doctors who are intolerant or uncomfortable when patients doubt or question their opinions, findings or prescriptions;
- Crowded and dirty health centers staffed by personnel indifferent to patients' needs;
- Government health services that are free or cheap but of low quality, unreliable and brusquely delivered;
- Private medical care that is reliable and more inspiring of confidence but expensive.

The negative perceptions created by these weaknesses in the health care system discourage voluntary health-seeking behaviors. For instance, women who are aware of the need for vigilance concerning their health may hesitate to go to the clinic because of the intimidating treatment, if not the costs entailed. Adolescents who fear the lapses of confidentiality and privacy will never brave entry to those clinics. If they do, they may never go back to the facility, thus foregoing complete treatment and care. Ultimately, an individual's reticence becomes a public health problem. High incidence of breast and ovarian cancers detected only at the later stages, poor birth spacing and high-risk pregnancies due to unwillingness to accept or listen to family planning counseling, complications in delivery due to non-utilization of ideal pre-natal services are among the consequences of this reticence to avail of health services.

We also include the provision of *financial protection* against the cost of ill health as one of the three goals of health governance inasmuch as this addresses the concern for equity. Poor people are the most in need of financial protection, for even a single episode of illness may have catastrophic impact on their lives. More often than not, the need for health care is unpredictable. It is then important for people to be spared from making a decision between financial hardship and loss of health. Mechanisms for sharing risk and providing financial protection are, thus, important issues in health governance (WHO, 2000: 24).

This discussion of the goals of *responsiveness* and *financial protection*, should not be taken to mean that this paper has a bias for personal health services (clinic- or hospital-based) and relegates public health services, including prevention and promotion, to a secondary place. This paper recognizes that quality care and fair financing are partly instrumental goals, in that they promote the final goal of improvement in the health status of the population – the *raison d'etre* of the field of public health. Moreover, it should be emphasized that pursuing the goals of responsiveness and financial protection does not necessarily take substantial resources away from activities to improve health. (WHO, 2000: 8)

In determining how we are faring in pursuit of these three final goals, it is necessary to have an overview of the country's health sector performance and how the key players are performing their respective roles. Afterwards, we will attempt to arrive at a framework for identifying the key areas in Philippine health sector governance that need to be strengthened.

3

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II. ASSESSING THE HEALTH SECTOR'S PERFORMANCE

It is not possible to describe health care in the Philippines without a tinge of irony. On one extreme, the country possesses what are touted to be among the most advanced medical facilities in the region, along with many internationally renowned public health and clinical experts. At the other extreme is a large impoverished population – mainly dependent on dole-outs – reeling from the effects of a tremendous shortfall in health services delivery.

While it is true that there have been considerable gains in the health status of Filipinos over the last decade, these improvements have been modest and may not be sustainable. Also, the gains have not been distributed equitably and large differentials in health outcomes exist among regions and provinces, as well as between urban and rural residents.

The following sections will discuss these improvements as well as the gaps that have yet to be bridged. The improvements are the results not just of interventions initiated by the government and donor agencies, but also by the LGUs, NGOs, communities and the private sector.

What Ails the Nation?

***Maternal and Child Health*.** Maternal mortality ratio (MMR) is gradually decreasing, from 209 per 100,000 live births in 1990, 179.9 in 1995, and 172 in 1998 (1998 National Demographic and Health Survey). Compared with neighboring countries, however, our MMR is still one of the highest (Figure 3).

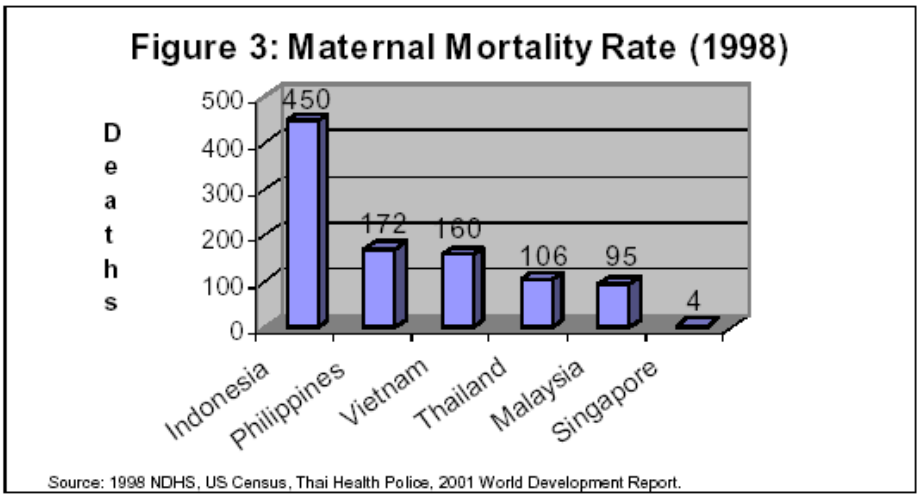
Looking at pertinent performance data, a desirable continuing decrease in maternal mortality faces uncertainty. In 2000, the proportion of children with mothers who received two or more doses of tetanus toxoid during pregnancy dropped by 3 percentage points from its 1998 level (Figure 4). The 1998 National Demographic and Health Survey (NDHS) found that the percentage of live births by mothers who received at least two doses of tetanus toxoid during pregnancy decreased from 42 percent in 1993 to 37 percent in 1998. One reason for this decline was the campaign of the Catholic Church in 1995 against Tetanus Toxoid based on fears that it contained an abortifacient. On the other hand, the number of pregnant women who sought pre-natal care in 2000 increased by 4 percentage points from the 1998 level. Iodine supplementation consistently increased, while iron supplementation remained at 78 percent (Figure 5).

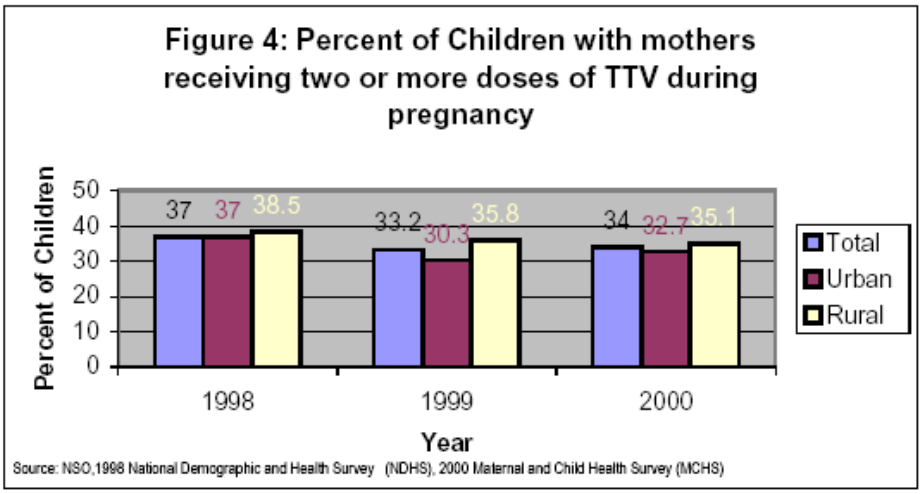
Urban women are more likely to receive prenatal care from doctors than are rural women, while rural women receive prenatal care more from a nurse or midwife. (Maternal and Child Health Survey, NSO 2000).

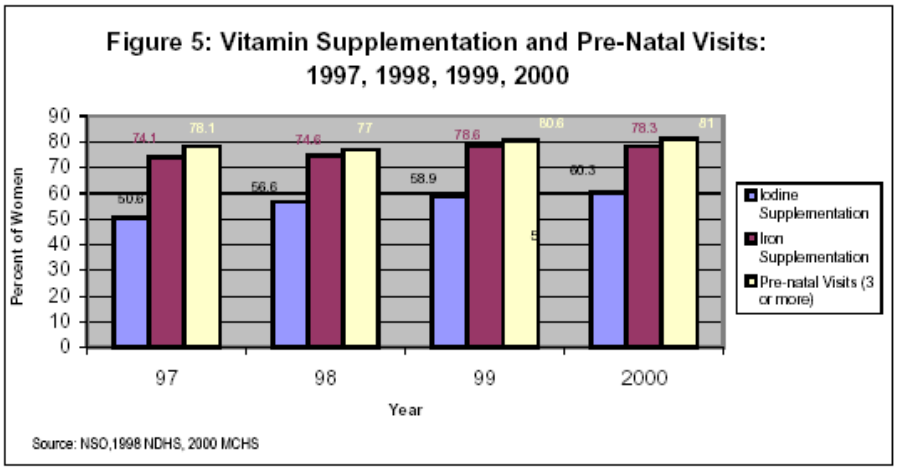
In 1995, the five provinces with the highest maternal mortality had rates twice as high as those of the five lowest maternal mortality provinces (DOH-UNICEF, 1998). Maternal access to primary care seems to be limited by geography or political conflict, as the chart below would show (Figure 6).

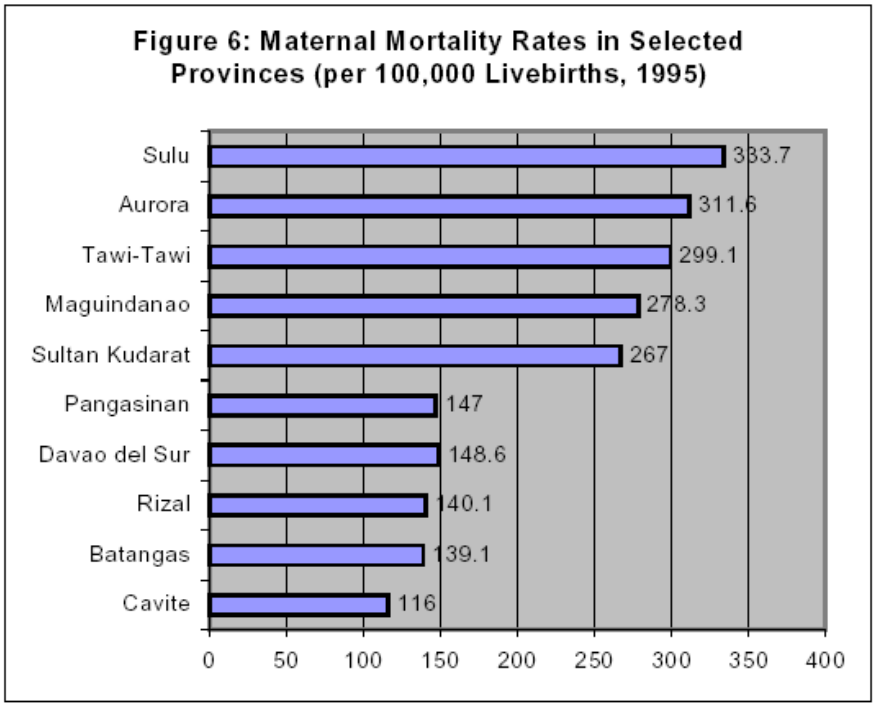
Estimates of Infant Mortality Rate as well as under-five mortality rate from 1990 to 1998 reflect a slow, yet steady progress (Figure 7). IMR dropped significantly between 1970 and 1980 but slowed down because of the economic and political

crisis of the 1980s. By 1995, IMR was about 49 per 1000 live births. IMR declined further in 1998 to 35 per 1,000 live births. U5MR, which includes the IMR, also declined from 80 in 1990 to 48 in 1998. Acute respiratory infections, diarrheal diseases, malnutrition, micronutrient deficiencies, coupled with low education of mothers and poor access to antenatal and delivery care, continue to be the major threats to infants and children under five years of age.

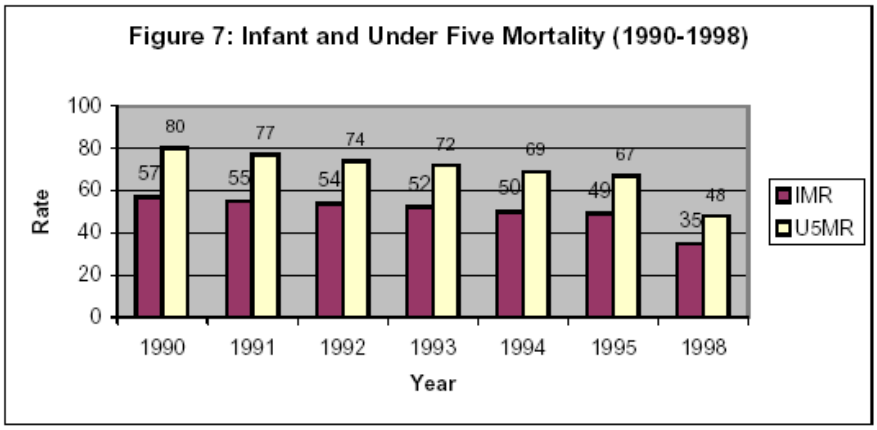








Source: Philippine National Strategic Framework for Plan Development for Children, 2000- 2005, Council for the Welfare of Children, 2000



Source: UNICEF, Report on the Phil. Plan of Action for Children 1997 and State of the World's Children, 1997; NSO, 1998 NDHS

Based on performance data, the Expanded Program on Immunization (EPI) has not recovered momentum after it slackened in 1994. From 91 percent in 1993, the coverage declined to 86 percent in 1995 (UNICEF, 1997). If we are to refer to NSO figures from 1997 to 2000 (Figure 8), we will see that the percentage of fully immunized children has again leveled off since 1999. Based on the 2001 MCHS, it was reported that fewer children were immunized in 2001, from 65.2 percent in 2000 to 61.3 percent in 2001 (NSO, MCHS 2001).

Urban children are somewhat more likely than rural children to receive basic immunizations. Children in ARMM region are much less likely than those in other regions to have received immunization (NSO, NDS 1998, MCHS 2000 & 2001). The setbacks in EPI performance and tetanus toxoid coverage could be attributed to a number of reasons, such as the disturbance in health services delivery resulting from the devolution (and this includes monitoring and supervision), the controversy in 1995 regarding the safety of tetanus toxoid injections for pregnant women, an aging cold chain, and bottlenecks in the procurement and distribution of vaccines by the central DOH.

Notifiable Diseases. The burden of infectious and communicable diseases, including tuberculosis, malaria, acute respiratory infections and diarrheas,

persists while the weight of diseases associated with the epidemiological transition (cardiovascular diseases and cancers) increases significantly.

Like in the past, most of the leading causes of illness are communicable in nature. From 1989 to 1998, these include diarrhea, pneumonia, bronchitis, influenza, tuberculosis, malaria, dengue and varicella (DOH, Philippine Health Statistics 1995 and 1998).

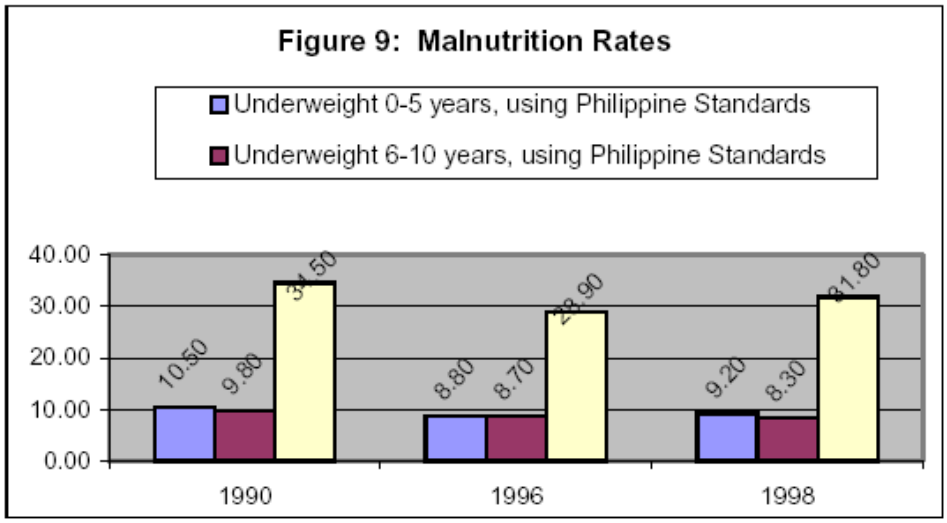
The leading causes of deaths (Table 3-2), on the other hand, are non-communicable diseases, with cardio-vascular diseases as the most common culprits. Tuberculosis, Chronic Obstructive Pulmonary Diseases (COPD), major kidney ailments and diabetes – illnesses that requires prolonged medication – remained to be in the list of the top 10 causes of mortality.

There was also an upsurge of accidents in recent years, which can be attributed to intensified property development and absence or non-enforcement of safety regulations. In 1997 alone more than 3,000 building accidents, resulting to death and total or partial disability of workers, were reported (DOH-UNICEF 1998).

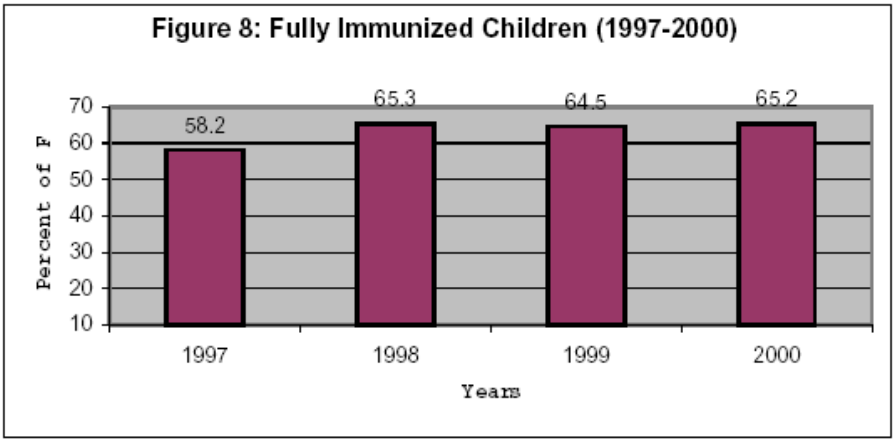
Table 3-2: Ten Leading Causes of Mortality (1975 to 1997)

	1975	1980	1985
1	Pneumonias	Pneumonias	Pneumonias
2	TB, all forms	Heart diseases	Heart diseases
3	Heart diseases	TB, all forms	TB, all forms
4	Disease of the vascular system	Disease of the vascular system	Disease of the vascular system
5	Malignant neoplasm	Malignant neoplasm	Malignant neoplasm
6	Gastroenteritis	Diarrheas	Diarrheas
7	Avitaminosis	Accidents	Accidents
8	Accidents	Avitaminosis and other nutritional deficiencies	Measles
9	Bronchitis	Measles	Avitaminosis and other nutritional deficiencies
10	Tetanus	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis
	1990	1995	1997
1	Heart diseases	Heart diseases	Heart diseases
2	Pneumonias	Disease of the vascular system	Disease of the vascular system
3	Disease of the vascular system	Pneumonias	Pneumonias
4	TB, all forms	Malignant neoplasm	Malignant neoplasm
5	Malignant neoplasm	TB, all forms	Accidents
6	Diarrheas	Accidents	TB, all forms
7	Septicemia	Chronic Obstructive Pulmonary	Chronic Obstructive Pulmonary
8	Nephritis, nephrotic syndrome	Diseases	Diseases
9	and nephrosis	Other diseases of the respiratory	Diabetes Milletus
10	Accidents	system	Nephritis, nephrotic syndrome

Source: Philippine Health Statistics 1995, FHSIS Annual Report 1999



Source: FNRI, DOST as cited in CWC (Child 21) 2001



Source: NSO, MCHS 2000, NDS 1988.

Though deaths, for all ages, from acute respiratory infections and diarrhea declined from 1980 to 1990, the rate of these diseases among children increased sharply. Findings from the Urban Health and Nutrition Project Baseline Studies as well as the Philippine Environmental Health Assessment (DOH-UP CPH-AusAID, 1995) indicate that a large proportion of infectious diseases, such as acute respiratory infections and diarrhea, can be traced to poverty and deteriorating housing and environmental conditions, especially in urban areas. These findings can be alarming when seen in the context of a rapidly urbanizing population and unplanned urban growth. The Philippines is also highly vulnerable to emerging health problems like HIV/AIDS, substance abuse and, as mentioned earlier, occupational accidents. The spread of HIV/AIDS may be attributed to a number of factors, such as poverty that forces men and women to prostitution, a highly mobile workforce, low level of knowledge on prevention and religious prejudices. Since the first reported HIV infection in the Philippines in 1984, there had been 1,076 reported infections, 546 of whom had AIDS (HIV/AIDS Registry, DOH, January 2002). The predominant mode of transmission remains to be sexual. As to substance abuse, a Social Weather Station national survey for the National Youth Commission conducted in April 1996 showed that 7 percent or 1.5 million youths (ages 15-30 years) claimed they had used illegal drugs and 6 percent or 1.3 million claimed to have sold illegal drugs (UNICEF, 1997: 23). Drug abuse, however, is not limited to the young, but is also rampant among those in the older age groups.

Nutrition. Slow progress was achieved in reducing malnutrition among children between 1989 and 1996. Based on the Food and Nutrition Research Institute (FNRI) surveys, the proportion of underweight children dropped from 39 percent in the mid-1970s. It remained stable at 33 percent (using international standards) throughout the 1980s and 1990s. Figure 9 shows the slow decline in malnutrition for both 0-5 and 6-10 age groups. In 1998, the malnutrition rate in the 0-5 age group even increased. Using international standards, our malnutrition rate is higher.

The results of the 1998 National Nutrition Survey, which used international standards for measuring under-nutrition among children, showed that:

- For every 100 preschool-age children (0-5 years old), 32 are underweight, 34 are stunted, and 6 are wasted.
- 39 in every 100 children, 1 year old, are underweight
- 34 in every 100 children, 6 years old, are underweight

Among pregnant women, the 1998 survey revealed that 15 in every 100 women are nutritionally-at-risk, with the teenage pregnant women (younger than 20 years old) more at-risk than their older counterparts.

Regional trends show that Western Visayas (Region VI) had the highest prevalence of underweight children, with nearly 40 in every 100 children underweight for their age, followed by Eastern Visayas (38), Bicol (37), Ilocos (36), Western Mindanao, CARAGA, and Central Visayas, with 34 each.

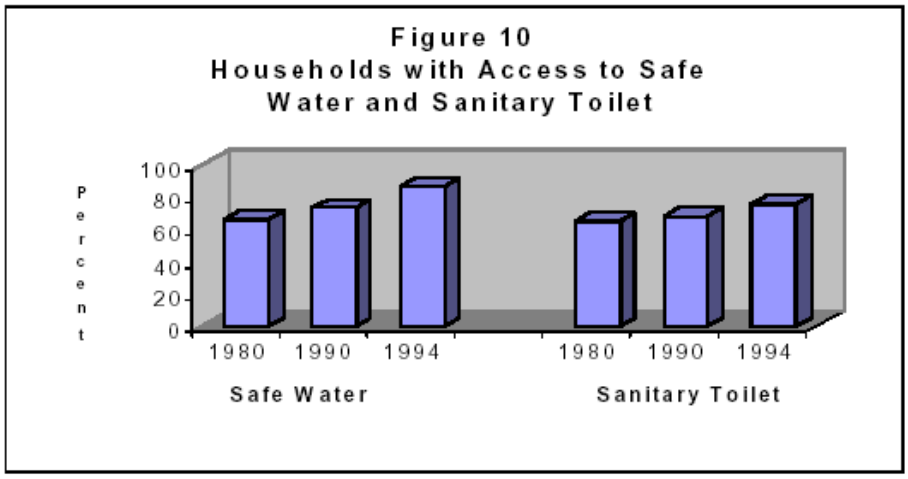
The patterns of incidence of malnutrition (early onset of stunting and underweight before six months of age) suggest that inadequate caring practices and breastfeeding behaviors may be the major causes of malnutrition in the Philippines. The practice of breastfeeding has been declining since the 1970s. In the sixties, breastfeeding nationwide was around 90%, declining to 83.5 percent in 1983, and further down to 79.9 percent in 1986. In 1993, the percentage of children under six months of age who were regularly breastfed was estimated at 72.1 percent. It decreased again to 70.9 percent in 1998. Insufficient milk was the primary reason given for never initiating or stopping breastfeeding (MCHS 1999 and 2000, NSO).

Iron deficiency continues to afflict a considerable proportion of the population, evident in the high prevalence of anemia. Vitamin A deficiency (VAD) among children still remains a problem, with the rate of prevalence increasing from 30.8

percent in 1993 to 35.3 in 1998. Among pregnant women, the prevalence of VAD also increased. From 16.4 percent in 1993 to 22.2 percent in 1998 (FNRI-DOST, 2001).

Water and Sanitation. The heightened, multi-sectoral and inter-agency drive in the prevention of diarrheal diseases in the last decade has resulted in improved access to safe water supply and sanitary toilets. In 1994, 84 percent of households had access to safe water supply while 71 percent had access to a sanitary toilet. However, significant regional disparities remain.

Ten of the 15 regions in 1994 had safe water coverage below the national average of 84 percent (Table 3-3). As to sanitary toilets, eleven of the fifteen regions had a coverage below the national average of 71.1 percent in 1994. Regions II, V, VII, XII and ARMM had the lowest safe water coverage, while CAR, Region II and Region XI had the lowest sanitary toilet coverage.



Source: DOH, Philippine Health Statistics, various years.

Table 3-3: Safe Water and Sanitary Toilet Coverages by Region, 1990 and 1994
(Percent of Households)

REGION	Safe Water Supply		Sanitary Toilet	
	1990	1994	1990	1994
Philippines	80.1	84.0	69.5	71.1
NCR	97.5	94.5	86.9	80.9
CAR	80.0	85.0	62.6	58.2
I	91.9	91.7	78.5	84.3
II	66.0	72.8	78.7	62.92*
III	71.7	96.2	67.8	79.2
IV	80.3	83.3	66.3	66.67*
V	82.2	74.2	60.5	58.1
VI	77.4	83.9	73.7	81.9
VII	75.6	74.3	96.2	64.6
VIII	81.3	78.7	64.8	68.3
IX	62.9	76.5	52.2	66.1
X	879.6	88.1	67.7	67.4
XI	80.4	80.8	68.8	63.5
XII	62.7	73.8	49.1	56.7

ARMM	-	74.0	-	63.8

* 1993 date. Source: DOH, EHS

The performance of NCR, an in-migration area, and that of Regions V and VIII, which are considered out-migration areas, is worth noting. Safe water and sanitary toilet coverage in these regions fell significantly in 1994. In NCR, the decline can be attributed to diminishing water carrying capacity (due to heightening population pressure) and the increasing number of informal settlements. What is striking is the decrease in coverage in Regions V and VIII, which are out-migration areas. This brings to the fore equity considerations, as well as, perhaps, the deleterious social impact of major infrastructure or development projects (e.g., establishment of regional growth centers) without thorough environmental impact assessment and vital infrastructure support (UNICEF-DOH, 1998).

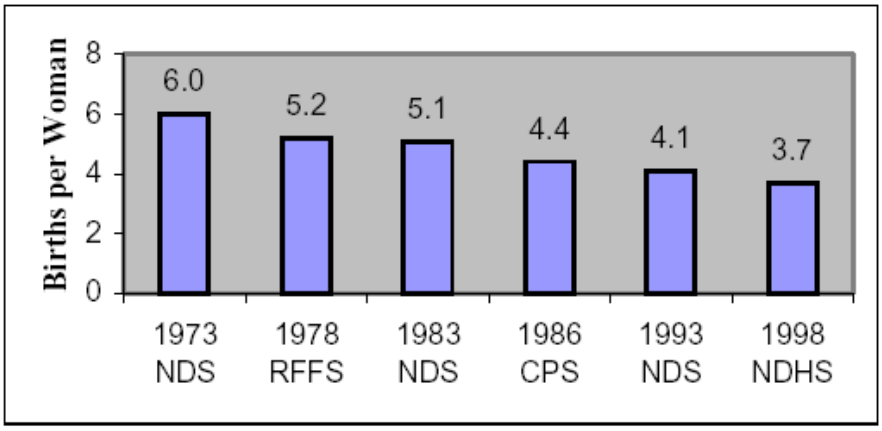
Access to safe water and observance of proper hygiene is a growing concern given the increasing number of informal settlers and the corollary problem in housing and security of land tenure. Aside from the problem of lack of resources and poor access to safe water source in urban poor settlements, studies have shown that urban poor families who do not own their homelots are less likely to invest in improvements in their shelter, including putting up of sanitary toilets.

To bridge the gaps, the capabilities of LGUs and POs to manage, implement, maintain and monitor water and sanitation projects need to be strengthened. Integrating health and hygiene education activities with water and sanitation projects should also be pursued.

Family Planning. The value of government's seriousness in this area cannot be emphasized enough. Success or failure in this specific program area will determine, to a great extent, whether government will be able to close the gap between demand and supply in the social development sectors, including health, housing, education and livelihood.

(1) Fertility. Data from the various rounds of the National Demographic Survey (NDS) conducted in the Philippines indicate that fertility continues to decline gradually but steadily (Figure 11). Based on the 1998 NDHS, the total fertility rate for the period between 1995 and 1998 was 3.7 children per woman, a decline from the level of 4.1 for the 1990-1993 period recorded in the 1993 NDS. A total fertility rate of 3.7, however, is still considerably higher than the rates prevailing in 1998 in neighboring Southeast Asian countries: Malaysia (3.2 children per woman), Indonesia (2.3), Thailand (2.0), and Singapore (1.7).

Figure 11. Trend in Total Fertility Rates, Philippines 1973-1998



Large differential between urban and rural fertility levels persists. The 1998 NDHS shows that the total fertility rate in urban areas in 1996 was 3.0, the rate among rural women was 4.7, or about 5 children per woman. Rural women give birth to almost two children more than urban women.

Significant differences in fertility levels by region still exist. The 1998 NDHS reports that fertility is more than twice as high in Eastern Visayas and Bicol Regions (with total fertility rate well over 5 births per woman) than in Metro Manila (with a rate of 2.5 births per woman). This finding underscores the need to prioritize the least developed regions in the DOH comprehensive program on reproductive health.

As to age-specific fertility rates, a comparison of the figures in Table 3-4 for the years 1984, 1991 and 1996 reveals that the fertility rate of women aged 15-19 years has barely changed from 1984 to 1996. That of women aged 45-49 years declined by almost 50 percent from 1984 to 1991, but remained constant thereafter. Since births to women aged 15-19 and aged 45-49 years have much higher risk of dying compared to women of other ages, this finding suggests that the Philippine Family Planning Program (PFPP) has not done much in reducing the incidence of high-risk pregnancies. It has also not made a significant progress in reducing the unmet need for family planning services as indicated by the data in Table 3-5, which partly explains why fertility in the country has slightly declined in the last 10 years or so.

Table 3-4: Total Fertility Rate and Age-Specific Fertility Rates, Philippines, 1984, 1991, 1996

Age	1984 (1986 CPS)	1991 (1993 NDS)	1996 (1998 NDHS)
15 - 19	48	50	46
20 - 24	192	190	177
25 - 29	229	217	210
30 - 34	198	181	155
35 - 39	140	120	111
40 - 44	62	51	40
45 - 49	15	8	7
TFR	4.4	4.1	3.7

Note: Rates are three-year averages centering on the specified years.

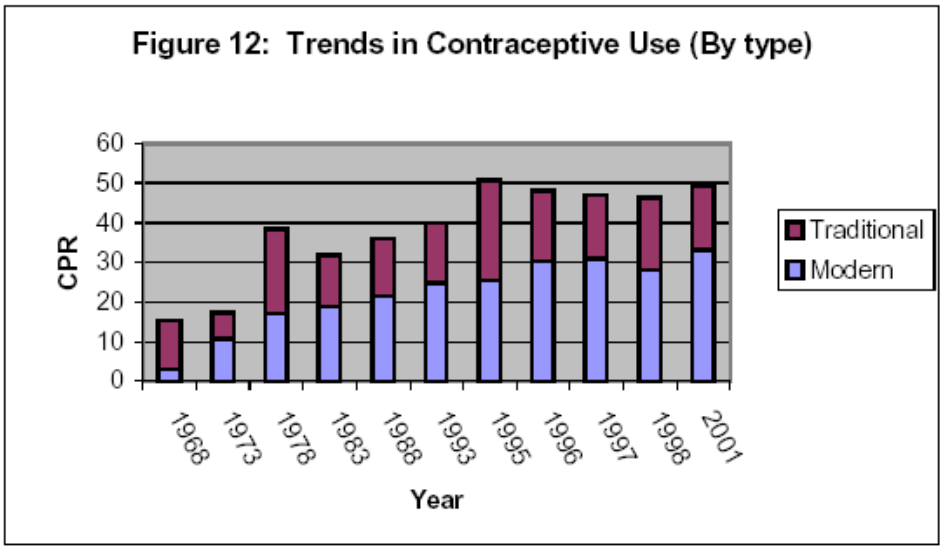
One reason that fertility has not fallen more rapidly is that women in the Philippines still want moderately large families. The 1998 NDHS reports that only one third of women said they would like to have one or two children. In 1998, the mean ideal number of children among women was 3.2 children, which is the same as that reported in the 1993 NDS. Another reason for the relatively high fertility level is that unplanned pregnancies are common in the Philippines. Overall, 45 percent of births in the five years prior to the 1998 NDS were reported to be unplanned: 27 percent were mistimed (wanted later) and 18 percent were unwanted.

Fertility is inversely related to women's education. Women with no formal education give birth to an average of 5.0 children in their lifetime compared with

2.9 among women with at least some college education. Women with either elementary or high school education have intermediate levels of fertility.

(2) Contraceptive Prevalence Rate. A review of the results of the National Demographic Surveys and those of Family Planning Surveys (FPS) conducted annually since 1995 indicates that there may have been a leveling-off in contraceptive prevalence rate (CPR) in recent years. The CPR was 48.1 percent in the 1996, it dropped to 46.5 percent in 1998 and was up again at 49.5 percent in 2001.

The percentage using modern contraception increased steadily, from 3 percent in 1968 to 22 percent in 1988, 25 percent in 1993, 28 percent in 1998, and to 33.1 percent in 2001. By comparison, the percentage using traditional methods exhibited an erratic trend. In 1998, the traditional family planning methods were being used by 18 percent of currently married women, in 2001, by 16.4 percent. Use of traditional methods of family planning has always accounted for the relatively high percentage of the overall CPR in the Philippines, holding steady at around 40 percent from 1983 to 1998, and one-third in 2001 (Figure 12).



Source: National Statistics Office, 2001 Family Planning Survey; NSO, DOH and Macro International, 1998 NDHS

A challenge for the PFPP is to promote a shift from traditional to more effective modern methods. Another challenge is to reduce the high level of contraceptive discontinuation. The 1998 NDHS results show that about 40 percent of contraceptive users in the Philippines stop using a method within 12 months after starting the method; the most commonly cited reason for stopping is unwanted pregnancy.

(3) Unmet Need for Family Planning Services. In 1998, one-fifth (20 percent) of currently married women did not want any more children or wanted to space their next birth yet they were not using any method of family planning. This represents the unmet need for family planning services for the year, and constitutes 28 percent of the total demand. By comparison, the unmet need in 1993 was 26 percent, constituting 38 percent of the total demand for the year. The total demand, which is the sum of the contraceptive prevalence rate and unmet need for family planning services, hardly changed from 1993 to 1998: 69 percent in 1993 and 70 percent in 1998. Only about three-fourths of the total demand in 1998 was satisfied or met, up from 62 percent in 1993.

Table 3-5: Need For Family Planning Services, 1993, 1998

Background characteristic	Unmet need for family planning		Total demand for family planning	
	1993 NDS	1998 NDHS	1993 NDS	1998 NDHS
TOTAL	26.2	19.8	68.5	69.5
Urban	23.5	16.3	68.7	69.9
Rural	29.1	23.3	68.3	69.1
Region				
NCR	24.3	15.0	68.7	67.6
CAR	27.2	26.9	67.2	72.0
Region I	28.5	23.5	71.5	68.5
Region II	24.3	18.7	66.6	69.0
Region III	23.4	14.6	69.2	73.1
Region IV	25.3	20.9	62.7	69.0
Region V	32.1	25.1	71.5	65.8
Region VI	27.1	22.7	68.6	70.9
Region VII	21.8	15.1	70.9	70.7
Region VIII	36.5	28.0	75.2	69.8
Region IX	31.5	23.7	60.9	69.7
Region X	23.8	18.4	76.2	76.2
Region XI	24.3	15.8	72.2	73.9
Region XII	27.2	23.1	61.3	72.4
ARMM		29.4		46.8
Caraga		21.2		72.2

Source: NSO, 1993 NDS, 1998 NDHS

Unmet need is higher among rural women than among urban women. Also, at least two out of ten women in CAR, Ilocos Region, Southern Tagalog, Bicol, Western Visayas, Eastern Visayas, Western Mindanao, Central Mindanao, ARMM and Caraga have an unmet need for family planning services.

Despite the decline in the unmet need for family planning, the figures in Table 5 show the need for the Family Planning Program to intensify efforts to address the unmet need especially in regions where it is high.

Low Access to Health Care. As reflected in the foregoing sections, even in basic health services or disease control programs (which are shared domains of the DOH and the LGUs), access varies widely. Much more in terms of personal health care which counts largely on the income standing of the populace and the LGUs.

Even with the big number of medical professionals produced by the country, access to health care remains to be low. The proportion of medically attended deaths was at 55 percent in 1998 (NSO Vital Statistics 1998). The incidence of maternal mortality remains to be high, which may be attributed to the lack of trained health workers attending to birth deliveries.

While the overall physician-to-population ratio in the Philippines is comparable to that in Taiwan, and exceeds the ratios in Thailand and Indonesia, these physicians are not distributed evenly across the country: only 10 percent of the doctors, dentists and pharmacists, 20 percent of medical technicians, and 35 percent of nurses practice in the rural areas. (WB-EAPR, 2001: 45). Yet even in the urban areas, there are growing pockets of urban poor communities whose access to health care remains low. Except for small primary health care projects initiated by NGOs and some donor agencies, the country is sorely lacking of an urban primarily health care strategy that would enhance access as well as utilization of primary health care services by the marginalized urban populace.

In cases when the poor in both urban and rural areas can visit a doctor or nurse, the cost of medicines is often prohibitive. Various studies point to high drug prices in the Philippines, compared to some developing countries and even compared to some developed countries. A 1995 study of retail drug prices of 100 units (tablets/capsules) of 16 commonly used drugs in 13 countries showed that the Philippines has higher drug prices than Indonesia, Malaysia, India, Nepal, Sri Lanka, Bangladesh, Germany and Canada. The US, as the study showed, has higher drug prices, but it must be noted that most drug purchases in the US are covered by health insurance. The Philippines does not enjoy high insurance coverage (Balasubramanian 1995, as cited in Lim and Pascual, 2002).

As studies have pointed out, the high costs of drugs result to their inadequate and ineffective use by the poor. Owing to financial constraints, many of the poor who purchase medicines do not get the proper dosage and do not take the medicines based on the prescribed frequency and length of time, thus retarding the potential health benefits and medical cure derived from the drugs and medicines (Lim and Pascual, 2002). The effects of improper drug use can be disastrous. In the case for example of anti-TB drugs, inadequate use may result to the development of resistance against medication.

High drug prices in the Philippines may be attributed to three factors. First is the existence of segmented markets due to income disparities, asymmetric information and lack of quality control due to the limited resources and capacity of the Bureau of Food and Drugs (BFAD). This leads to under-utilization of cheaper generic medicines in favor of more expensive brands. Branded products dominate the pharmaceuticals market, accounting to more than 95 percent of the total market sales.

This attests to the failure of the Generics Drugs Act of 1988 to provide cheaper generic medicines for the poor. A second factor is the monopoly in the wholesale and retail distribution of pharmaceutical products. This includes the large costs of marketing and promotions to encourage sales of higher priced branded medicines. The third factors is the monopoly enjoyed by large pharmaceutical firms in the production of drugs and medicines. This includes the practice of transfer pricing of imported raw materials and inputs, and high patent and license fees (Lim and Pascual, 2002).

While high drug prices partly explain the lack of utilization of drugs and medicines by the poorer segment of the population, the low access of the poor to physicians and medical facilities or lack of utilization of their services are also considered as factors.

Table 3-6 below depicts the usual response to health complaints by the different income groups by quartile. This shows that the poorest group consults the doctor much less compared to the richer quartiles. Only 25 percent of the poorest quartile consult the doctor when a complaint arises, compared to 48 percent for the richest quartile. This accounts partly why the poor do not get medical prescriptions and proper medical advice (Lim and Pascual, 2002).

Table 3-6: Health-Seeking Patterns by Income Group, 1993

Response to health complaint	Poorest quartile	Quartile 2	Quartile 3	Richest quartile
Consulted doctor	25%	36%	37%	48%
Consulted other health professional	50%	30%	10%	10%
Consulted traditional healer	60%	20%	20%	10%
Self-care	64%	59%	60%	50%

Total number of respondents	100%	100%	100%	100%

Source: DOH-PIDS Household Survey (1993) as cited in the Health Sector Reform Agenda Philippines 1999-2004, DOH 1999 and in Lim and Pascual 2002.

Low access to physicians and medical facilities could be a function of financial and physical barriers (e.g., distance), while low utilization may be attributed, among others, to the perceived weaknesses in the quality or responsiveness of care which will be tackled at length later.

Diagnosing the Key Players in the Health Sector

***Local Government Units*.** In specific terms, the devolution resulted to the transfer of the following responsibilities to the LGUs:

Barangay Health and social services which include maintenance of the barangay health center and day care center

Municipality Health services which include:
(a) implementation of programs and projects on primary health care, maternal and childcare, and communicable and non-communicable disease control services;
(b) access to secondary and tertiary health service;
(c) purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated; and,
(d) nutrition services and family planning services.
Province Health services which include hospitals and other tertiary health services.

City Health services which include implementation of programs and projects on primary health care,
maternal and childcare, communicable and non-communicable disease control services, and
provision of hospital care and other tertiary health services.

The DOH retained the following functions, services, facilities, programs, and personnel:

- Components of national programs which are funded from foreign sources;
- Nationally-funded programs which are in the process of being pilot-tested/experimented or developed;
- Health services and disease control programs which are covered by international agreements such as quarantineable diseases and disease eradication programs;
- Regulatory, licensing, and accreditation functions which are currently exercised by the DOH pursuant to the existing laws; and,
- Regional hospitals, medical centers and specialized health facilities.

While more and more LGUs are taking on or beginning to recognize the functions that were devolved to them, some weaknesses remain in developing the necessary management support systems in order for local health delivery systems to thrive. Among these are:

Health Information Systems. The health information system at the local level remains incapable of generating sound information to guide decision-making and planning from a program perspective, as well as from a management perspective as in the case of a clinic head, a municipal or city health officer, or the local chief executive.

Information systems planning below the level of the national agency is still weak. Perhaps, an exception would be the pilot provinces of the Integrated Community Health Services Project (ICHSP), the project areas for the Health and

Management Information System (HAMIS). It is observed, though that even in ICHSP provinces, there is under-utilization of the information system that was installed. An innovation at the grassroots level, namely, the community-based health information and monitoring system or the Community Health Data Board, has been proven to be useful in giving an overall health picture of communities, and effective in instilling a sense of responsibility for health among members of the community. However, this has not been widely promoted and have had mixed acceptance by political
leaders.

Hospital Management and Operations. Budgetary requirements for devolved health services, particularly hospitals, are just daunting for many provinces to reckon with. Provinces on the average, needed 30 percent of their total expected releases in the IRA to cover hospital funding requirements for Personal Services and Maintenance and Other Operating Expenses (DOH-LGAMS Bulletin on Devolution, No. 14, March 1995). Surveys conducted by the Local Government Assistance and Monitoring Service (LGAMS) of the DOH, show that the distribution of hospital budgets is heavily lopsided with Personal Services (PS) accounting for nearly 70 percent of total requirements (DOH-LGAMS,1996 Survey on Status of Devolved Health Services). This percentage may be higher if the Salary Standardization Law and Magna Carta for Public Health Workers are fully implemented. Budgets for MOOE of hospitals are below the recommended 60 percent ratio while PS budgets are above the 40 percent ceiling.

DOH funding for hospital operations prior to the devolution, were at the ratio of 60 percent for PS and 40 percent for MOOE, also not within the recommended levels. This suggests that the inefficiencies that characterized the pre-devolution budgetary support for health under DOH were passed on to LGUs with the devolution.

Unfortunately, health facilities were devolved at the same time that government was implementing Salary Standardization and the Magna Carta salary benefits for health workers, which made devolved health workers potentially the highest-paid government workers in 1993. Meanwhile, resources for hospital operations such as allocations for drugs and medicines, maintenance of facilities and equipment, and training have not increased correspondingly. The DOH did not have time to implement or did not foresee the need to improve the ratios with the administrative adjustments.

The under-investment in hospitals has led to an increase in number of downgraded hospitals, especially district hospitals that cannot comply with licensing requirements for a secondary hospital classification. This situation, coupled with the inability of lower level hospitals to accommodate patients that should first be attended at their levels, explains the marked increase in the occupancy rates of Regional and Provincial hospitals.

While not commonly practiced due to restrictive COA-prescribed regulations, the successful implementation by a number of LGUs of such schemes as retention of hospital revenues and setting up of a revolving fund for hospitals, like Quezon and Negros Oriental provinces, have proven to improve systems and delivery of hospital services.

Leadership and creativity make all the difference in devising means for generating resources. In the case of Negros Oriental, resource generation for hospital operations experienced a historic breakthrough when its former governor, Emilio Macias, made a simple decision of expanding the membership of the boards of its provincial and district hospitals. Aside from representatives of NGOs, the private sector, religious organizations and socio-civic groups, Governor Macias also included the mayors of cities and municipalities, within the hospital's catchment area, in the respective hospital boards. With greater awareness and accountability, catchment LGUs, through their representatives in

the hospital boards, started giving to the hospitals substantively. In 1994, while most provinces were seeking augmentation funds for hospitals from the national government, the provincial hospital of Negros Oriental was in the black, generating a revenue of P6 million at year's end (LGAMS-DOH, 1996).

Health Planning. While majority of RHUs undertake annual health planning activities (USAID-GOLD Project, Field Appraisal, various years), the preparation of plans however do not ensure provision of budgets or resource support for health activities, thus leading to widespread skepticism on the value of planning (ADB-DOH 1998). DOH seems to be reinforcing this attitude. For example, there are logistics support coming from DOH that are not based on LGU determined needs, but on DOH determined targets and allocations. Devolved health programs like TB control, Nutrition, and Maternal and Child Health services, which remain heavily reliant on resource support from DOH, has harnessed the planning capacity of LGUs, but only in limited areas. Generally speaking, vertical programs duplicate planning processes to their own ends and leave LGUs confused.

Field surveys also show that there is no standard approach to health planning and its use. One major planning challenge that LGUs must address is the integration of public health planning into the hospital planning system. As it is, planning on these two aspects of the local health system remains separate due to the different administrative levels of the health system and the dissolution of the district health system. Also, hospitals are less involved in the planning process with majority of hospital health workers indicating that they had no participation in the development of plans. Budgets are based on previous year levels and are not based on actual requirements determined through needs assessment activities.

Despite operational problems, the presence of Local Health Boards (LHBs) provides opportunities in improving the process of health planning and decision-making in local government units. LHBs may be more useful to provincial and district-wide planning than municipal-level planning alone, which has led to greater disuse at the municipal level. Problem-solving and strategic thinking for health at the local level will be given significant push if only attitudinal constraints are hurdled so that LHBs truly function as a democratic, participative and consultative decision-making mechanism.

Health Human Resource Development. In the 1996 rapid appraisal of decentralization (USAID-GOLD Project), findings from earlier appraisals were confirmed that "where devolved personnel oppose devolution, they do so because of concerns about career security and advancement, not because they believe that LGUs are incapable of delivering services". This finding underscores the importance of setting up a human resource management and development system at the local level. Field surveys conducted in 1998 under the Integrated Community Health Services Project (ICHSP) revealed that no office at the LGU level is involved in the planning of the professional growth of health personnel. There are existing Health Resource Management Officers (HRMOs), but they have very limited training in HRD functions. Fund allocation for training by LGUs is minimal. Most training activities at the local level are conducted by Regional Field Offices (now Centers for Health Development) of DOH, but are mainly on preventive health programs. Training activities planned by DOH for hospital personnel development are also very limited (DOH-ADB, 1998). Likewise, most training (whether DOH- or LGU-initiated) are program-based and not management-oriented. HRD initiatives often gloss over needs for enhancing management/organizational skills.

On the positive side, the impact of the huge training investments in primary health care can be gleaned from the competence of field trainers in the regional, provincial and municipal health offices. Midwives, nurses and other staff involved in training are not only efficient to manage training sessions but also competent to act as resource persons (DOH-ADB, 1998).

As to recruitment, there is inadequate staffing of RHUs, especially of Rural Health Midwives and Dentists. This has been attributed to lack of positions or vacancies. (DOH: Assessment of Decentralized Health System, 1996). For LGUs willing to hire additional health personnel, they are constrained by restrictions on the prescribed proportion of PS to MOOE. As mentioned earlier, most LGUs are currently budgeting beyond the ceilings for PS (as allowed by the LGC) due to the absorption of devolved health personnel.

Financing the Cost of Devolved Functions. As a general trend, local health expenditures have increased after devolution, with a significant portion being spent on public health services. Local government spending is becoming the main source of funding for public health services (Solon, 1997, as cited in DOH-HSRA, 1999)

While the Local Government Code of 1991 mandated the transfer of powers and responsibilities for the delivery of health services to LGUs, and provided substantial increases in their financial resources to support the new functions, there are disparities in the sharing of the burden of devolved costs.

The LGC provides the basis for the sharing of IRA among LGUs through the following formula: 23 percent - Cities, 23 percent - Provinces, 34 percent - Municipalities, and 20 percent - Barangays. This is then distributed among the LGUs through the following:
Population 50 percent
Land area 25 percent
Fixed share 25 percent
Apparently, the allocation of shares in the national wealth has a bias toward highly populated LGUs, which are mostly composed of cities and first class provinces who have higher capacities to generate additional income. Among LGUs at the same level, the IRA formula is applied uniformly. This is regressive and results to inequity in resource allocation.

Of the P4.1 B Health CODEF in the first year (1992) of devolution, roughly 60 percent was shouldered by Provinces, which now assume the responsibility for operating hospitals, 38 percent by Municipalities, and only 3 percent by Cities. Expenses for city-funded hospitals that were originally operated by cities have also been considered part of the CODEF. Cities and Provinces have the same allocations of 23 percent from the IRA, yet the burden of financing devolved services falls heavily on the provinces.

The demand for LGUs to keep pace with the rising demand for health services has resulted to a number of LGUs initiating various resource mobilization schemes (e.g., community health financing, private sector involvement, health insurance projects). Some of these schemes had been proven sustainable and worthy of replication in areas where funding for health is wanting.

DOH has had extensive efforts in developing health financing schemes in support of LGUs, such as the Health Development Fund, Comprehensive Health Care Agreements and PHC funds. Foreign-assisted projects such as those under the Health Finance Development Project (HFDP), the Health and Management Information System (HAMIS) Project and the more recent SHINE project are also noteworthy. During the early years of devolution, a handbook on "Management Options for Devolved Hospitals" was also developed by DOH to show LGUs the various ways and means by which the pressure of hospitals' on limited local government resources can be eased without compromising quality of care. However, the ideas and suggestions conveyed in the handbook failed to elicit the interest of LGUs.

Procurement and Logistics. After the devolution, procurement at the provincial level has become circuitous and highly centralized. Individual hospitals within a province were treated as separate entities and have to compete with other local

offices and other devolved agencies in procurement activities that are centralized under an overloaded General Services Office. All proceeds from payments of services, supplies, drugs and medicine were remitted to the General Fund of the Province and revolving funds were abolished.

The documentation needed for the procurement of drugs, medicines and hospital supplies requires a minimum of 18 signatures, compared to only four before the devolution. Furthermore, items requested through RIV take three or more months to reach the provincial hospitals. Drugs and medicines were most often not delivered on time, and inappropriately to boot. A study conducted under the Health Finance Development Project in the Province of Negros Occidental found that lag time between the preparation and approval of Purchase Requests to final delivery could be lessened by as much as 50 percent if the following procedural reforms are undertaken: a) streamlining of Purchase Request and payment processing procedures; b) adoption of a re-order scheme; and c) consolidation of procurement plans of all hospitals and; d) conduct of bulk procurement.

There are no clear-cut guidelines to allow LGUs to initiate remedies such as the establishment of revolving fund systems and delegation of responsibilities for hospitals to undertake their respective procurements. A Joint DBM-DOH-DILG Circular ("Expanded Fund Allotment System for Devolved Hospitals") issued in 1995, allows devolved hospitals to issue payments, yet only a few LGUs have adopted it because of varying interpretations by provincial COA personnel.

At the district or municipal level, mayors who believe that inter-LGU cooperation can minimize bottlenecks and the risks of getting poor quality products have sought to streamline procurement. In Sorsogon, the municipalities of Irosin, Gubat and another town decided in 1995 that they would jointly undertake the master-listing and accreditation of suppliers and, whenever appropriate, the bidding of required drugs and medicines.

Department of Health (DOH)

Transition and Permanence. From a nondescript institution established by the American Military Government in 1898, the DOH has evolved into a complex organization. The international community has acknowledged public health initiatives by the government, like the National Immunization Days and the Mother-Baby Friendly Hospital Initiative, as models for innovation. Yet, even these achievements are overshadowed by the grim reality of poor access to health services by a greater part of the population. (Medical Observer, October 1999)

The overriding concern to improve health services delivery in the country has led to waves of reforms in the health sector. In 1958, DOH established 8 Regional Health Offices whose major functions were to administer, direct, coordinate and supervise all preventive and curative health services and activities in the region not specifically reserved to line authority from the central office, and supervise, through the Provincial Health Officers, the operation of hospitals in the region (Azurin, 1988 as cited in Alfiler, 1995). Provincial Health Offices (PHOs) were also organized to implement preventive and curative health services. The DOH structure again underwent major changes with the reorganization in 1972. Hospitals, rural health units (RHUs) and sanitariums in the provinces were placed under the administrative direction, supervision and control of the PHO.

In 1982, Executive Order 851 authorized the reorganization of the DOH which led to the integration of public health and hospital subsystems into a unified health service delivery network. Provincial hospitals which were previously operating almost independently were merged with Provincial Health Office to form the Integrated Provincial Health Office. Under the supervision and control of the Regional Director, it became responsible for the complete integration of the promotive, preventive, curative, and rehabilitative components of the health

care delivery system within the province. The PHO exercised supervision and control over district hospitals and other DOH field units in the province. The district hospitals, for their part, had supervision and control over RHUs and specialized field units which served as the out-patient area of the district hospitals in their respective areas. Barangay health stations became extensions of RHUs. District hospital staff, as supervisors of RHUs, were expected to visit their satellite RHUs for supervision and to extend necessary health service and familiarize themselves with the implementation of public health programs.

In the Aquino years, prior to the passage of the Local Government Code in 1991, the Philippines had just started its re-democratization processes. Despite formal policies encouraging decentralization, local governments were weak and largely dependent on the national government for their financial resources as well as for the provision of basic services like health and education. The public health system, which had health facilities at all levels, was directly controlled from Manila by the Department of Health. Within the Department, however, administrative de-concentration had started. The Central Office in Manila had delegated administrative authority to its Regional Offices, with the province serving as the integrated unit for planning and delivering preventive and curative care. While the local government units had no control over the public health system operating in their areas, public health officers were expected to coordinate with officials of these local governments (Alfiler, 1995).

Finally, in 1993, the Local Government Code of 1991 was implemented in the health sector, not without debates and doubts as to its timeliness. For Health Secretary Juan Flavier and his team, the attitude was that the best way to handle the situation was to treat devolution as a given and see how the opportunities it offers could be enhanced and its threats reduced.

Among the national agencies that have devolved, the DOH was observed to have the clearest vision of its role under a decentralized system. During the early stages of devolution in 1993, it came out with a policy framework, defining goals for action, as well as its *modus vivendi* with the LGUs who will now be primarily responsible for the management and operation of devolved health units. The policy framework is contained in the paper, "Managing Health Services: Post Devolution Perspectives and Strategies" and further elaborated in the primer titled "Health in the Hands of the Filipino People." With the transfer of functions from DOH to the LGUs, the next logical step would be to radically transform the department – from a provider of services to a "servicer of servicers". This, however, did not come about easily. Aside from the frequent changes in leadership since 1995, the clamors for re-nationalization coming from local government units and some members of Congress resulted to missed opportunities for a thorough-going reform and re-orientation of the health sector. These factors not only weakened the capacity of DOH to reinvent itself, it also affected its leverage and performance in building the capability of LGUs to manage health services delivery.

As "servicer of servicers", the DOH retains the mandate to promote and safeguard the health of the population. Although the DOH has done a commendable job in resolving some transition issues of the devolution, it has been somewhat remiss in carrying out vital tasks that are necessary in hastening stabilization. Among these are:

- Harnessing inter-agency and inter-sectoral support for health and nutrition;
- Improving government health spending and allocative efficiency; and
- Establishing a coherent framework that harnesses the technological, regulatory and financial resources to improved access, equity and efficiency in a devolved set-up.

Recent Reforms. Responding to the challenges the DOH, during the term of Dr. Alberto Romualdez (September 1999 to January 2001), enunciated the painful and long-overdue transformation of the health department. With *the National Objectives for Health for 1999 to 2004* unveiled earlier by his predecessor,

Romualdez commenced with the exhaustive and consultative process of formulating the Health Sector Reform Agenda (HSRA) to define the major strategies, organizational and policy changes and public investments needed to improve the way health care is delivered, regulated and financed. The HSRA identified five major reform areas, namely: a) health financing; b) local health systems; c) public health programs; d) hospital systems; and e) health regulation. Since these five reform areas are interdependent and complementary, it was envisioned that the implementation of the HSRA would be done as a package.

In May 1999, Malacañang issued Executive Order 102 redirecting the functions and operations of the DOH to suit its new role in a devolved set-up. Braving backlashes from workers and career persons whose jobs and career path will be affected, the Romualdez administration implemented the re-organization of the DOH as embodied in the Executive Order.

Under the Executive Order, the mandate of the DOH is to provide assistance to local government units, communities, people's organizations and other members of civil society in effectively implementing programs, projects and services that are consistent with its goals. These goals are the promotion the health and well-being of the Filipino, prevention and control of diseases among high risk groups, protection of persons exposed to hazards and risks, and treatment and rehabilitation of individuals affected by disease and disability. It also retains its role as the lead agency in the implementation of the National Health Insurance Program; in emergency preparedness; in policy formulation and standard-setting and regulation; and in articulating the national objectives for health to guide the development of local health systems.

Aside from this, the DOH is also expected to serve as a scientific and technical authority as well as an innovator, builder and promoter of new strategies and capabilities. At about the same time it was going through the pains of re-organizing the DOH, the Romualdez administration was also pursuing the benchmarks of the National Objectives for Health and laying the groundwork for implementing the HSRA, including negotiation with donors for them to invest in the reform areas. Realizing the staggering amount of resources required by the reform initiative (estimated at P112 billion pesos over the next five years), the DOH opted to implement the reforms in stages, starting with a set of pilot provinces and cities and later on proceeding to include more and more LGUs. The reform initiative had barely taken off the ground when a new leadership took over, resulting to the loss of momentum in pursuing the reforms. The current Secretary of Health, Dr. Manuel Dayrit (since March 2001), has articulated his administration's plan to pursue the HSRA and has actually adopted the HSRA framework in implementing what his administration deems as priority health programs (e.g., acceleration of enrollment in the Indigent Program of PhilHealth, implementation of "Pharma 50", a program to reduce by 50 percent the prices of drugs and medicine frequently bought by the poor). With this articulation, the doors for a no nonsense health sector reform is now wide open, and to think that the DOH alone can do this would be a fatal mistake.

Philippine Health Insurance Corporation (PhilHealth)

Social Health Insurance under NHIP and Its Cutting-edge Values. The rapid population growth and a shift in prevailing diseases from infectious to degenerative demands expanded health services and, hence, more resources. Inasmuch as it is the less-privileged segment of the population who are the least capable of availing curative or personal health care services, addressing the demand for expanded health services should be driven by equity concerns. Under social health insurance, equity is considered more achievable through social solidarity, that is, the rich contributing for the health of the poor, the young contributing for the elderly, the employed contributing for the unemployed.

It is in this spirit that the National Health Insurance Program (formerly Medicare) or NHIP was instituted in 1995 by virtue of Republic Act 7875 otherwise known as the National Health Insurance Act of 1995. As the country's largest and premiere social health insurance program, "the NHIP aims to provide accessible, affordable, acceptable and adequate health services for all Filipinos from all walks of life." (PhilHealth Primer)

The said law also created the Philippine Health Insurance Corporation (PhilHealth) and mandated it to administer and manage a sustainable program that will ensure better benefits at an affordable cost, as well as extend quality and relevant health care services to a broader membership base, eventually leading to universal coverage. The PhilHealth Board is headed by the Secretary of Health as Chairperson, with the President and CEO of PhilHealth as Vice-Chairperson. Other members of the Board include heads of other national government agencies such as the DSWD, DILG and DOLE, the presidents of the GSIS and SSS and the representatives of employer's sector, health care provider's sector, self-employed sector, and labor sector.

Considered as one of the most important social legislations in Philippine history, the National Health Insurance Act of 1995 has brought with it not only the promise of financial safeguard against the cost of ill-health especially among low income and indigent Filipinos. It also has a streamlining value that could be woven into various priorities (e.g., local health systems development, quality and affordable drugs, enhancement of standards of health facilities) identified by the DOH.

Accomplishments and Bottlenecks. From a strictly fiscal perspective, PhilHealth is a robust organization. With a total current net worth of P34.2 billion (as of March 2002), it has acceptable ratios of fund utilization. In 2001, over-all fund utilization for benefit payment (based on collections) was recorded at 69.9 percent against 79 percent in 2000. On the other hand, fund utilization for operating expenses was computed at 9.2 percent. This means that it paid back to its members around 69.9 centavos of each peso it collected and spent another 9.2 centavos for its operation (PhilHealth, Stats and Charts 2002). However, good fiscal performance at this juncture can only be useful if it enables the breaching of thresholds for better coverage.

As it is, the NHIP is still characterized by limited coverage: limited number of Filipinos covered by the Program and limited coverage in terms of benefits being provided to its members.

As of June 2001, PhilHealth has covered about 32.8 million Filipinos or about 44 percent of the population. The private sector comprises two-thirds of this membership base, while the Indigent Program and the Individually Paying Program (for the self-employed and OFWs) are reported to have nearly identical shares at almost 7 percent each. The slow pace may be attributed to a number of reasons. One is the low insurance benefits for members. For every peso contributed, the NHIP spends only 22 centavos on benefits. Partly because of this level of benefit, population covered has not significantly expanded beyond the formal wage sector (DOH HSRA, 1999). The more crucial reason, though, is the inability or unwillingness of the LGUs to participate, or both, due to the perceived double burden of the LGUs who have to pay for the premiums of the poor as well as providing health services with little chance of reimbursement.

Another reason for the weak performance is PhilHealth's initial bias of targeting first the poorer LGUs for expansion of coverage. With its Indigent Program, PhilHealth initially targeted LGUs under the Social Reform Agenda (SRA). However, faced with the inability or unwillingness of many of these low income LGUs to provide counterpart funds, PhilHealth revised the scheme which saw then the inclusion of high-income LGUs like Tagaytay City. This was seen as a good step to make the indigent component of the NHIP more sustainable as richer LGUs support or cross-subsidize the health expenses of the poor ones. In

1999, PhilHealth commenced on a more active pursuit of partnership with LGUs. This resulted to a ten-fold increase of households enrolled in the Indigent Program in the last two and a half years, from 47,304 by the end of 1998 to 540,845 households or 2.35 million beneficiaries in June 2001. However, this is equal only to 4.4 percent of the population, which means actual accomplishment in this regard lags far behind the target of twenty-five percent of the population in the first five years of operation. As of March 2002, 78 cities, and 55 provinces are said to have already signed a MOA with PhilHealth. A total of 307 municipalities signed the MOA independently (PhilHealth Stats and Charts 2001).

A related issue is the utilization rates for the Indigent Program which remains low. Active members of the Indigent Program account for about five percent of the total NHIP membership and yet they account for less than 1 percent of the total benefit payments. Members of the Indigent Program utilize the program benefits four (4) times less than the members from the government sector and seven (7) times less than members from the private sector.

Another bone of contention in the implementation of the NHIP is its contribution structure, which is observed to be inappropriate, if not regressive. One of the stinging criticisms against the contribution structure of the Medicare Program is that it was regressive, with the salary cap minimizing the cross-subsidization of the poor by the rich, the low- to middle-income earners by the higher-income earners. Until December 1999, the salary cap was pegged at P3,000. This means than all those earning P3,000 and above pay the same absolute amount of contributions, even though the percentage of such contribution to the salary decreases as the income increases. To address this regressive feature, the PhilHealth increased the salary cap to P5,000 in January 1, 2000 and then to P7,000 starting January 1, 2001.

The PhilHealth Board has recently approved a further adjustment of said salary cap to P10,000 beginning January 1, 2002. With this proposed increase, the maximum amount of contribution would increase to P250 per month, up from the current figure of P187.50 per month. Given the fact that PhilHealth has only 6.8 million actively paying members, or less than half of the estimated 14.4 million salaried and wage-earning individuals nationwide, one may ask if it is a matter of increasing the salary cap or increasing the collection efficiency. According to a PhilHealth document, the government as the biggest employer has yet to cope with the adjustments made in the salary cap for 2000 and 2001. For 2000, the national government owes the Corporation P350.639 million and P1.058 billion in 2001 for a total of P1.4 billion. The document also says that despite PhilHealth's request, the Department of Budget and Management (DBM) has not included the 2000, 2001 and 2002 round of increases in its Budget Call.

Aside from design problems, another observed weakness of PhilHealth is that it lacks the conceptual framework in identifying outpatient benefits, a weakness that may be traced to unclear health objectives, implying a seemingly weak functional relationship with the DOH in program development. As of this writing, PhilHealth has yet to adopt a conceptual framework for the identification of packages or services that would be included in its benefit package.

The Philippine Institute of Traditional and Alternative Health Care (PITAHC) The Philippines is rich in botanical resources with 12,000 species of plants. Almost 1,500 species are used by traditional healers in providing primary care in the communities. Of these, only 120 have undergone some form of scientific validation under the Philippine Council for Health Research and Development (PCHRD). From these 120 species, 79 are part of a herbal medicine guide book published by the Department of Science and Technology (DOST). Ten (10) are being promoted by the DOH for use at the household level for primary health care needs. To date, only 3 species have been studied enough to be developed into dosage forms (tablets, syrup, lotion) and registered with the BFAD as medicines. Most of the plants have minimal scientific validation and are viewed

by the BFAD as merely nutraceuticals or health food supplements. Aside from this, the Philippines is a country with a rich experience in traditional healing methods. Some of these methods have been proven useful in delivering health care especially to the poor in remote rural areas, while some have found their way or are now being introduced in the urban areas, as in the case of alternative healing methods. In 1997, Fidel Ramos appreciating the potentials of traditional medicine in health and economic progress, included this as one of his administration's pole-vaulting strategies.

While there were efforts even during the pre-EDSA years to harness traditional medicine, particularly herbal medicine, it was during the term of Dr. Juan Flavier that the DOH first came out with the Traditional Medicine Program. This program was tasked to promote and advocate traditional medicine nationwide. In order to institutionalize the program, the drafting of a traditional medicine law soon followed. In 1997, the Traditional and Alternative Medicine Act (TAMA) was passed by Congress, after which came the creation of the Philippine Institute of Traditional and Alternative Health Care (PITAHC). As a corporation attached to the DOH, this agency is vested with the following key functions (Primer on Republic Act 8423):

- To plan and carry out research and development activities in the areas of traditional and alternative health care and its ultimate integration into the national health care delivery system;
- To verify, package and transfer economically viable technologies in the field of traditional and alternative health care, giving emphasis on the social engineering aspects for group endeavor;
- To provide the database for policy formulation that will stimulate and sustain production, marketing and consumption of traditional and alternative health care products;
- To organize and develop continuing training programs for health professionals, health workers, students, scientists and extension workers in the field of traditional and alternative health care;
- To formulate policies that would create public awareness;
- To formulate a code of ethics and standards for the practice of traditional and alternative health care modalities for approval and adoption by the appropriate professional and government agencies;
- To formulate standards and guidelines for the manufacture, marketing and quality control of different traditional and alternative health care materials and products for approval and adoption by the BFAD.

A cursory review of PITAHC's accomplishment since it formally operated in the year 2000 shows that the agency has ably put on track vital activities relative to its promotion, public awareness, technology transfer, and networking functions. It has promoted and raised public awareness for traditional and alternative health care by conducting lectures and other information activities in the communities and schools, and participating in various fora sponsored by NGOs, civic organizations, other government agencies and the private sector. It has developed training modules and regularly conducts training on topics like herbal medicine preparation, massage therapy, acupuncture and stress management. It has strengthened and built new partnership with NGOs and GOs, the academe, the private sector (through the Chamber of Herbal Industry in the Philippines, Inc., which, to date, has 32 members) and international institutions. It has managed to maintain the four existing herbal pharmaceutical and processing plants in Tuguegarao, Davao, Tacloban and Cotabato despite the aging equipment and problems in ownership of plant sites.

However, key result areas like research and development, human resource development and policy development have not proceeded as they should. For an initiative like PITAHC, an unimpeded flow of resources is needed. The P250 million Traditional Medicine Development Fund that is supposed to come from the earnings of Duty Free Philippines in the first three years of PITAHC's operation has not materialized.

For its first year of operation (2000), the PITAHC was allocated P12 million, instead of the P50 million that was stated in Republic Act 8423. In 2001, the budget for PITAHC was P90 million, but only P40 million was released. For 2002, the agency has a budget of P96 million, but with the amount released on a monthly staggered basis (at P9 million a month). With these fiscal constraints and the additional bureaucratic procedures attendant to budget releases, the agency is being deprived of the time and capacity for long-range planning and plan implementation.

In the case of the herbal medicine industry in the Philippines, it is still in its infancy, but with the demands for these products increasing. To date, only one pharmaceutical company has gone into the integrated herbal medicine business. The herbal medicines they are selling are 50 percent to 300 percent cheaper than their synthetic drug counterparts (all of which are imported). The technology was developed by the government since the private sector was not prepared to invest on research and development because of the long gestation period, if not the amount involved. The other Filipino herbal businesses are selling products based on folkloric knowledge and indications.

Aside from funding constraints and weak synergy for R&D and human resource development between the government and the private sector, policy development has not minimized the disincentives for private sector participation in the herbal medicine industry. Foremost of these is the long and tedious regulatory and licensing requirement of BFAD. A proposal made years ago for a separate accreditation and licensing track to be established at BFAD for herbal medicine and related products seems not to have gained ground despite its merits. This is not totally unexpected since BFAD's installed capacity has not increased even when the demands on it has grown tremendously over the years.

NGOs and Other Civil Society Group

The role of NGOs in health in the country has assumed various forms over the last three decades, ranging from being initiators of independent community-based health projects to co-implementers of DOH-initiated projects; from gadflies and advocates for good health governance to builders of capabilities of communities. In fact, these types of involvement represent the spectrum of capabilities of NGOs. Owing to their organizational flexibility and close relationship with communities, NGOs remain to be fountainheads of innovation in health services delivery. Even before the Alma-Ata Conference in 1978, which declared Primary Health Care (PHC) as the main strategy in achieving "Health for All", a number of NGOs, university- and church-based groups as well as private health practitioners were already immersed in the communities, independently initiating community health service schemes in marginalized areas (Galvez Tan, 1987 and Alfiler, 1986 as cited in Veneracion, 1999). With the establishment of a Philippine PHC program in 1979, a national strategy and plan of action for PHC that recognized the importance of collaborating with NGOs were formulated. By the end of 1981, a nationwide implementation of PHC was already being undertaken. Government health offices at the regional and provincial levels were encouraged to work with NGOs operating in their areas (Veneracion, 1999).

DOH-NGO partnership in PHC was further bolstered when Corazon Aquino assumed leadership. She sustained her bond with this segment of the civil society and openly welcomed the participation of NGOs in governance (Veneracion, 1999 and Bautista, 1999). This stance was subsequently embodied in the 1987 Constitution, which says that, "The State shall encourage non-governmental, community-based, or sectoral organizations that promote the welfare of the nation." (Section 23) Under the leadership of Alfredo Bengzon (1986 to 1991), experiments were made to forge partnerships with NGOs. Seeking to distance itself from the "thwarted advocacy" connotation of PHC under the former regime, the new leadership launched the Partnership for

Community Health Development (PCHD) in 1989 (Bautista 1998). This is a component of the World Bank-funded Philippine Health Development Project. Under PCHD, community health development was conceived as a "people-centered development process where people who initially are beneficiaries of health programs become partners in health care until they are finally empowered to become managers of their own health programs and able to attain self reliance and self-determination" (*DOH Primer on PCHD*, as cited in Bautista, 1998). While subscribing to the concepts of PHC for intersectoral collaboration, peripheral focus and participatory decision-making, PCHD differed from government-instigated PHC in that the responsibility for executing the whole development process belongs to the NGOs, instead of the field health personnel of the DOH. Partnership building, capability building, and provision of grants for project communities to pursue health and development projects were the main strategies employed by the program (Bautista, 1998 and 1999).

An evaluation of the impact of PCHD on project areas indicated positive effects, such as forging of unity among community members, improved access to health and other basic community services, increased understanding on the nature and prevention of diseases, improved health condition, and acquisition of skills and knowledge by key leaders, volunteer health workers and residents in organizational and health management. At the organizational level, PCHD was noted to have strengthened the capabilities of provincial and municipal partners in community organizing, resource mobilization and project management (Development Partners Inc., 1994, as cited in Bautista, 1999).

Also during the term of Bengzon, a nationwide search for innovations in health care was launched through the First HAMIS (Health and Management Information System) contest, under the auspices of the DOH and the German Agency for Technical Cooperation (GTZ). Aside from cash prizes and national recognition given to the winners, a documentation of these award-winning innovations capturing the spirit of partnership in community health management was also undertaken. It was during the term of Flavier when this documentation, "Good Health Care Management", came out.

The appointment of Dr. Juan Flavier (1992-1994) at the DOH brought about a renewed focus on PHC and partnership building with civil society groups. The term PHC was once again used and was mandated to permeate all program and projects of the DOH. A framework for PHC was defined with the active participation of NGOs and the private sector in the task forces that were formed. An administrative order was passed in 1993 to install PHC as the core strategy that should permeate all program thrusts of the government at national, local and community levels. The Philippine Policy Paper on PHC elucidated that it is an approach to bring "Health in the Hands of the People" (Bautista, 1998). The formulation and adoption of this policy took place amid organizational changes and uncertainties brought about by the implementation of the Local Government Code of 1991 in the health sector. Although a good number of NGOs with national presence opposed the devolution of health services to LGUs, they accepted it as a *fait accompli* and proceeded to forge partnerships with local government units in pursuing their work. Somehow, these NGOs found the Code as further enabling NGO-LGU collaboration. Also, LGUs could not ignore NGOs not only because of provisions in the Code but because the DOH continued to advocate partnerships with NGOs and other organized groups as an indispensable strategy in health development (Veneracion, 1999).

Aside from direct involvement in PHC, NGOs also participated in important policy-making bodies such as the National Drug Policy Forum, where the private sector and the academe was also represented, and the executive committee of National Aids Prevention and Control Program. During the term of Flavier, NGO representatives were part of the policy advisory groups that the Office of the Secretary consulted on vital concerns.

In 1994, another development that sought to foster DOH-NGO collaboration came with the establishment of the NGO track for the UNFPA-assisted Reproductive Health Project. This track facilitated the provision of assistance to family planning NGOs while also encouraging other NGOs to be a part of the reproductive health initiative. With this project, the Philippine NGO Council for Reproductive Health (PNGOC) evolved. PNGOC has now 75 member organizations and is recognized as a model of inter-NGO coordination for reproductive health.

Addressing the need to determine the breadth and depth of PHC implementation in the country – a need that was aired during the term of Galvez Tan – the DOH during the watch of its first woman secretary, Carmencita Reodica (1996-1998), initiated multisectoral workshops and related activities to assess PHC (Veneracion 1999).

Out of these workshops, the Policy Framework of Primary Health Care for Community Health Development was formulated and saw print in 1996. The policy reiterated the value of community organizing as a critical strategy and underscored the need for a continuing and stronger partnership with NGOs. The Reodica Administration also saw the opportunity in establishing linkage with the Social Reform Agenda (SRA) in spurring further NGO involvement in health. In 1998, it came out with the Health Development Fund for the provision of PHC support for selected SRA provinces. In screening what projects were eligible for support under the Fund, priority was given to those that were supported by POs or NGOs (Bautista, 1998).

The Romualdez administration recognized the role of NGOs and other civil society groups in accomplishing one of its reform agenda, namely the development of local health systems. Although the pursuit of this reform agenda was cut off with the advent of a new administration, it was during the watch of Romualdez that a grand vision for an NGO in health materialized. In late 1999, FriendlyCare Foundation was established, with prominent business and civic leaders constituting its Board. With funding support from the United States Agency for International Development (USAID), FriendlyCare positioned itself as a private sector vehicle for the delivery of quality and affordable reproductive health care services, especially family planning. Aside from its mandate to provide reproductive health services, FriendlyCare was also conceived to segment the market, to attract the low income Filipinos to avail of its out-patient services in order to ease the pressure on public health facilities that should focus on serving the poorest of the poor.

3

GOVERNANCE IN HEALTH

PEDRITA B. DELA CRUZ

III. FULFILLING THE GOALS OF HEALTH GOVERNANCE

At the outset of this chapter, we defined health governance as the ability to mobilize both material and non-material resources to achieve the goals of improved health, security against the cost of ill health, and quality or responsiveness of care. Based on the foregoing sections, we can paint the following impressions on the frame of these three goals:

Goal No. 1: Improved Health Condition

The Philippines has shown that it has the capabilities to bring about substantive improvements in the health condition of Filipinos, yet these capabilities tend to be overshadowed by perennial weaknesses in equity, in which the marginalized segments of the population get even less of essential services. Large differentials in health outcomes exist between regions and provinces as well as between urban and rural residents.

The health sector's capabilities are now also being challenged by urbanization and the epidemiological transition, emerging diseases and a growing concern for hitherto taken for granted segments of the population, namely, the elderly and the adolescents. As such, the considerable gains in the health status of Filipinos over the last decade, which many consider as modest, may not be sustainable. However, given the effort of the DOH to pursue reforms in health financing, together with the growing initiative of LGUs to take on the devolved functions offer hope that the gaps will be further brought to fore and addressed with tested as well as with new and innovative means of resource mobilization and service provision. Likewise, how resolutely will NGOs pursue their role as equalizer, with their preferential option to serve the poor through advocacy or service provision, will also determine how the country will fare in bridging inequities in health. The same is true with the members of the private sector who have realized how slow human development can impair economic growth and social progress. The stakeholders in the expanded environment for health that were enumerated at the outset of this chapter clearly needs harnessing or regulation to bring about the desired improvement. To do these, champions of health governance at the various levels of the politico-administrative set-up and across the various sectors are needed.

Goal No. 2: Financial Security Against Ill Health

Much remains to be done in shifting the burden of health financing to social insurance. The NHIP is characterized by its low impact on the poor. Indigent members comprise only 7 percent or even less of the entire membership base which is constituted mainly by those in the formal sector. As such, the burden of paying for health care services financing is still borne by individual families. The latest National Health Accounts reveal that 46 percent of the total national spending for health in 1999 was out-of-pocket (NSCB, 2002). Utilization rates for the Indigent Program have remained extremely low, accounting for less than 1 percent of the total benefit payments. Members of the Indigent Program utilize

the program benefits much less than the members from the government sector and even lesser than members from the private sector. To address this problem, PhilHealth is implementing programs to recruit more poor households and offer benefits that are more accessible to the poor.

The Philippines was quite ambitious, and rightly so, when it came out with a national health insurance program. Although there are signs that PhilHealth is now positioning itself for better coverage, basic policy tensions (e.g., increase contribution or focus on collection; promote quality of care or prolong the exclusion of private out-patient providers; increase benefits or increase program asset base) remain. As mentioned earlier, a well-directed social insurance program can very well be woven into the strategic concerns of the health sector, namely, quality and affordable drugs and quality of health care.

Meanwhile, as the NHIP contemplates its future direction, there are smaller health financing schemes in limited areas that are responding to the needs of communities for accessible and affordable health care. Even before the implementation of the National Health Insurance Program in 1996, several community health insurance schemes were already providing limited to comprehensive benefits to its members in the event of illness. Depending on the people's capacity to pay dues, a corresponding type of medical benefit is provided. Community health insurance continues to thrive from a variety of entry-point activities: primary health care projects; income-generating activities; and bigger economic activities complementing existing
people's organizations.

In the case, for example, of Bukidnon, Guimaras and Guilhungan in Negros Oriental, the scheme was introduced at the outset as a health insurance scheme. Another model, the cooperative hospital pioneered by the Medical Mission Group in Davao City, has even been replicated in other countries. While there is a strong appreciation of the value of providing the people in the low income groups financial safeguards against the cost of ill health, the reach of innovations has been limited to a number of communities and LGUs. While the interest of NGOs and communities for smaller community health financing schemes has not waned even after the NHIP was launched, there is now palpably lesser support coming from government in support of such schemes.

Goal No. 3: Quality or Responsiveness of Care

Private and public sector provision of health services in the Philippines is clearly wanting in terms of quality or responsiveness. This may be attributed to a number of factors like medical education, facility administration (which is partly shaped by the presence or absence of resources), and the behavior of those who are harnessing, regulating or taking advantage of the market for health professionals (e.g., HMOs).

The DOH is clearly taking on the challenges of improving quality of care, as manifested in programs like the Mother and Baby-Friendly Hospital initiative, Hospitals as Centers for Wellness, Stop Death Program and the Sentrong Sigla. After devolution, the DOH also became stricter in dispensing its hospital licensing and regulatory functions. Be that as it may, there is an observation that quality of care in public health facilities further weakened after the devolution. In fact, much of the disappointment regarding devolution concerns hospitals since, as elaborated earlier, LGUs find it difficult to source out funds to finance hospital operations.

This means that simple enforcement of licensing and regulatory functions alone may not be sufficient. Provision of incentives has been proven to work at the RHU level and this could also be applied to higher level facilities in the public sector. However, to sustain and build up on the improvements in quality, the provision of incentives should be coupled with innovations in management that effectively foster accountability, shared responsibility and responsiveness. The expanded membership in the hospital board as pioneered in Dumaguete and the upland municipalities of Negros Oriental is a classic example of what management innovations can do in mobilizing human and material resources necessary in providing quality and responsive health care.

In the private sector, groups like the Philippine Society for Quality Assurance (PSQua) and the medical societies have started the development and promotion of protocols for quality care. The PHIC and private providers like FriendlyCare has taken advantage of these inroads and has developed packages of services guided by evidence-based protocols developed by experts.

Table 3-7 shows people's overall net satisfaction rating of various health facilities. For all income groups, it is clear that private for profit and non-profit health facilities as well as traditional healers enjoy a higher rating than government health facilities.

Table 3-7: Overall Net Satisfaction Rating of Most Frequently Used Health Facility

Poverty Group	Barangay Health Station	Health Center	Govt. Hospital	Private For Profit Clinic/Hospital	Non-Profit Clinic/Hospital	Traditional Healer
RP	1.14	1.22	1.19	1.55	1.57	1.55
Bottom 30%	1.24	1.16	1.17	1.69	1.60	1.52
Middle 30%	1.02	1.20	1.32	1.44	1.14	1.80
Top 40%	1.17	1.35	1.09	1.57	1.82	1.40

Source: World Bank, " Filipino Report Card on Pro-Poor Services" (May 2001), Environment and Social Development Sector Unit East Asia and Pacific Region as cited in Lim and Pascual 2002

It is worth noting that the non-profit health facilities, including those run by non-government organizations, have the lowest percentage share of utilization (Table 3-8) given their very limited presence but have the highest net satisfaction rating (Table 3-7) among all types of facilities. This suggests that health care provision by the non-profit sector is worthy of emulation and that both government and private for-profit sectors could learn more from the operation of these non-profit facilities. On a different vein, that traditional healers got a high rating and has a relatively higher utilization implies the importance of harnessing traditional healers in strengthening grassroots health care delivery system.

Table 3-8: Utilization of Health Facilities by Location and Expenditure Class (Percentage Usage)

Area/Grp	Barangay Health Station	Health Center	Govt. Hospital	Private Clinic/ Hospital	Non-Profit	Traditional Healer
Urban	24	19	36	56	4	20
Rural	37	28	43	38	3	39
Bottom	37	28	37	28	3	40

30%						
Middle 30%	34	27	48	42	4	31
Top 40%	21`	16	34	68	4	16

Note: The row totals add up to significantly more than 100% due to multiple uses of the facilities by many households.
Source: Philippines Filipino Report Card on Pro-Poor Services; Document of the World Bank; May 30, 2001, Environment and Social Development Sector
Unit East Asia and Pacific Region

In sum, much remains to be done to improve quality or responsiveness of care. Ultimately, the country may have to go back to basics – the technical training as well as value formation of health professionals.

3

GOVERNANCE IN HEALTH

PEDRITA B. DELA CRUZ

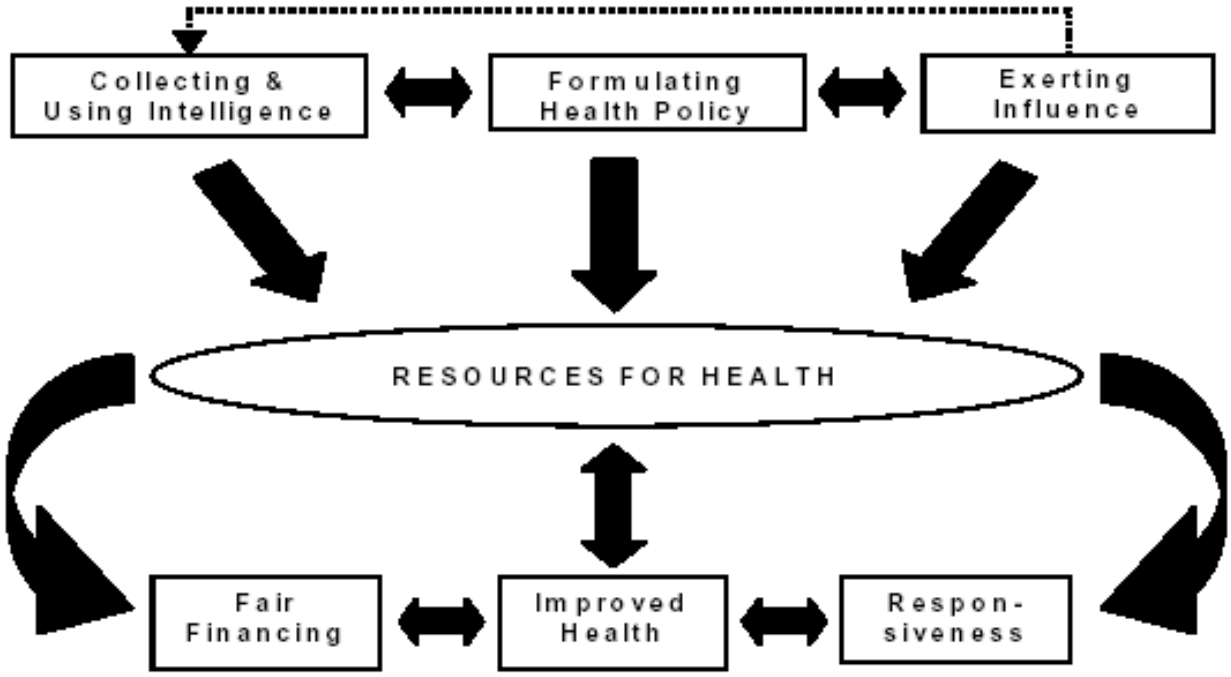
IV. EMERGING FRAMEWORK FOR HEALTH GOVERNANCE

Having taken a look at the performance of the health sector and some of the dynamics in the health system, let us now try to arrive at a framework for health governance that will highlight for us the key areas that need strengthening. In doing this, let us draw from what experts have identified as three components of effective health stewardship, namely: (1) collecting and using information; (2) formulating health policy; and (3) exerting influence (Report on Meeting of Experts on the Stewardship Function in Health Systems, WHO September 2001). Under these three components are the following activities:

Collecting & Using Intelligence		
Intelligence gathering (e.g., conduct of regular national and population based surveys) Monitoring and evaluation of public health Encouraging dialogue between communities and the health system Communication / Social Marketing Use of Information Technology	Policy analysis Policy formulation with involvement from stakeholders and civil society groups Development of an over-arching national health plan Defining a mission/vision for Health High-level investment and resource allocation decisions Establishing shared values and the ethical base for health action Policy evaluation and correction	Consensus building inside and outside the health sector Synchronization of health players Strategic institution building (inc. training) Regulation and enforcement Promulgation of an over-arching national health plan Promoting a mission/vision for health Formulating cost-effective strategies to achieve health Promoting and strengthening shared values and the ethical base for health action Creating incentives; consumer education; establishing and institutionalizing transparency in management; advocating for healthy public policies in other sectors

We can relate these components to the three goals we have discussed earlier to come out with a framework (Figure 13). We see this framework as useful in guiding governance across different levels and various stakeholders in the health system.

Figure 13. A Framework for Health Governance.



Collecting and Using Intelligence

If planning is the science of anticipating future events or developments and making allowances for them, then health planning as a specific governance function should be elevated to its proper place. It should be given proper attention and support in order to guide decision-making and help steer the health system to reach its fullest potentials. We marvel at the usefulness of information when the first National Health Accounts came out in the early 1990s that we followed that up with yearly calculation and estimates of overall health spending by various categories.

Now, we know that with the National Health Accounts we have a sound basis for launching reforms in health financing. The same is true with the National and Demographic and Health Surveys, the Food and Nutrition Surveys, Water and Sanitation Surveys, the TB Prevalence Surveys and other epidemiological and population studies.

In order to be more helpful to resource allocation decisions that promote equity, disaggregation of data to the lowest level of governance possible should be

made. In some of the strategic concerns of the DOH and other key players in the health sector, the useful information have long been there, while in some others only proxy indicators are available. In both cases, we have to rely on one thing – critical thinking for health.

Critical Thinking. Critical thinking dictates that we make use of available information in order to optimize and mobilize resources for health. In more specific terms, critical thinking should enable the key players in the health system to perform the following:

- Define target clients, their location, the types of services they need and the reason(s) for their need of these services, and how these services should be provided.
- Monitor developments within the health system, and make policies and investment decisions accordingly. These include developing a responsive organization, process and controls that would improve health planning, organizing, budgeting, staffing, logistics, directing, coordinating, reporting and evaluation.
- Develop health sector strategies (e.g., an urban primary health care strategy, borne out by the rapid pace of urbanization and the fact that health problems in urban areas differed considerably from those in the rural areas).
- Undertake responsive functions during epidemic outbreaks and natural and man-made disasters, as borne out by findings from pro-active risk assessments.
- Sound-out alert for a potential health problem.
- Force-out the need for inter-sectoral and inter-agency partnership in addressing key health problems.
- Keep track of best practices in health care delivery.

Performance of the aforementioned tasks requires not just management skills but, more importantly, an inspiring leadership.

Also, from the items mentioned above, it could be gleaned that aside from a functional information and communication system, dialogues between 'communities' and the health system are also important in collecting information. Dialogues are particularly useful when it comes to identifying partners and generating consensus. In terms of gauging performance, dialogue has inherent limitations. At the national and local levels of governance, the growing need to satisfy the priority needs and wants of constituents and relating to them better than before has led to the appreciation of a more systematic scientific approach to getting citizens' feedback.

As a way of relating to the constituents, this type of governance, which is called "constituency-responsive governance", is primarily concerned with treating the governed as customers. It is governance that establishes, maintains and deepens the government's way of relating with its constituents. According to Roberto (AIM, 2002), the data gathering methods often used especially by local governments who treat citizens' feedback data as a guide for resource allocation and service delivery decisions are grossly deficient. Instead of the public hearings and error-ridden "man-on-the-street" surveys, he advocates the use of facts and figures from carefully designed and implemented survey monitoring of citizens' feedback. The ability to listen and learn spells a big difference, but governance will not be complete if action is not taken – these are the two sides of constituency-responsive governance.

As this book goes to print, the DOH is still reeling from the heels of the debilitating finding that the country has new polio cases, after having been declared as polio-free just two years ago (Year 2000). The far-reaching implications of such a finding behooves us to ask in what aspect of collecting and using information was the health sector remiss in this particular case.

Communicating. Communicating information is vital in determining whether the information collected gets to be used at all by policy-makers, decision-makers and service providers. Thus, knowing the specific audience for a type of information is important in designing communication and advocacy activities. At the national level, for example, the Arroyo administration has pledged to reduce by 50 percent the prices of drugs commonly used by the poor. Otherwise known as Pharma 50, this pledge is made up of two parts. The first part is the short-term strategy (August 2001–July 2002) which is the continuation of the Parallel Drug Importation (PDI) strategy, with imported but cheaper drugs made available in government hospitals. The second part is the medium and long-term strategies (to commence during the first six months of 2002) which include, among others, social marketing activities that were sorely lacking in the initial implementation of the PDI. Despite the lower costs, utilization of medicines under the PDI strategy was very low, averaging only 12.5 percent utilization rate for all medicines in all 30 participating hospitals (Lim and Pascual, 2002). Partly because of this, the PDI has not been successful in influencing the prices of most commonly used drugs to go down. The information that helped shaped the policy to pursue the PDI was not utilized to generate demands and forge alliances vital in pushing the project. The present administration seems to have learned from this weakness. Under Pharma 50, social marketing activities will be undertaken (alongside with the expansion of sales outlets to local government hospitals, NGOs and rolling stores) to get the support of key stakeholders (including the pharmaceutical sector) and generating demand for PDI drugs and medicines as well as those with generic labels.

At the grassroots level, the medium is also the message in the Community Health Data Boards that are built through the shared efforts of the community. The information on the health condition of the community reflected in numbers and signs and the makeshift character of the board catches the attention of the local population and their leaders and enjoins them to do their share for better health.

Formulating Health Policy

A fundamental task in health governance is defining a vision for health that stakeholders can identify with. Needless to say, vision-setting must be a participatory exercise involving all possible stakeholders. The same is true in formulating health plans and policies. The most common pitfall in planning and policy-making is the assumption that those in the health sector alone can make and unmake health policies. This assumption has proven to be fatal to promoting shared values for collective health action. At both the national and local levels, a health plan should be the expression of a comprehensive effort involving the various stakeholders in the health system.

A national health plan for the period 2005 to 2020, with the vision of "Health in the Hands of the People" has been formulated during the term of Carmencita Reodica (1996-1998). This plan should be continually updated to ensure relevance and responsiveness to new developments. There should also be renewed emphasis on the instrumental goal of "Health By All" and not just on the mission of "Health for All". The over-arching framework of the plan, which is

empowering individuals and communities to take responsibility for their health, should consistently be embodied in major policies.

Two Parameters. In formulating plans and policies, it is important to be guided by the parameters of relevance and do-ability.

1) Relevance. Relevance dictates that the health sector remain faithful to its mission of not just "Health for All" but also "Health By All" in policy formulation, which includes resource allocation decisions. This means instituting changes in the allocation and sourcing of funds. In specific terms, this means giving attention to the disadvantaged sectors by liberating some of the resources spent on curative programs and plowing them to preventive and primary health services that have greater reach and impact. The DOH spends more than half of its resources (54 percent in 1997) on around 50 hospitals. Experience shows that this is not an effective way of targeting subsidies to the poor. Budgetary figures show how inequitably distributed DOH hospital subsidies are. In 1998, for example, 53 percent of subsidies are accessible only to residents of Metro Manila (DOH HSRA, 1999).

Relevance in policy formulation, including resource allocation, also tells us that resources should be made available for research and training. Since the devolution of the responsibilities for health services delivery in 1992, the DOH has emphasized its lead role in health policy, program planning and standards-setting. While there is now a strong appreciation of the value of research and training in health policy formulation, systems development and operations, and service provision, this has not led to a corresponding increase in resource support for research and training. The bulk of government spending for "other" services went to general administration and operating costs and only a relatively small amount was spent on research and training.

Of the P8.74 billion total expenditures in 1999 on "other services", only P0.88 billion was devoted to research and training (NSCB, 2002). This low level of spending for research and training might be eating up on the ability of the DOH to establish shared values and strengthen the ethical base (equity, quality, sustainability) for health action.

Relevance also dictates that the health sector take the lead in addressing health concerns that has the most multiplier effect in the fulfillment of its mandates. For example, this means DOH should not backtracked from its pivotal role of promoting family planning since, as pointed out earlier, success in this area is more likely to lead to success in other areas of health services delivery. It could mean less maternal and infant mortality and less economic abortion.

2) Do-ability. In his analysis of the strengths and weaknesses of the DOH organization vis-à-vis its roles in a decentralized set-up, AIM Dean Eduardo Morato elaborated on what "do-ability" means. He explained that do-ability is about the "implementing force of organizational will, facilitative structures, a committed people, effective systems, efficient procedures and inspirational leadership" to come out with viable strategies and to implement and sustain them. His diagnosis of the DOH organization, done in 1992, remains to be valid until today.

"As an organization, the DOH possessed capabilities that allowed certain latitudes in strategy formulation. For one, it has a technically competent staff of doctors, dentists, nurses, midwives, medical technologists, nutritionists, pharmacists, health educators, health inspectors and engineers. Two, the DOH

had access to international funds that stretched its financial resources beyond the limiting confines of the Philippine budget. Three, it had strong health programs in place (e.g., immunization, disease control, etc.). Four, it could tap a vast network of health services that included private voluntary organizations and individual volunteers. Fifth, it has a bureaucracy in place that could deliver services with well-articulated systems and procedures, especially under normal situations. Sixth, it had a nationwide presence in terms of physical facilities.

"Several weaknesses inhibited the DOH from fully optimizing its strategic interventions, however. First, the very same bureaucracy, which enabled standard programs to be accomplished, retarded the use of creative and innovative approaches. This was especially true for emergency and 'non-standardized' health activities (e.g., health financing, massive community mobilization for health care, disaster management). Second, its budget allocation from government was decreasing relative to other sectors. Third, the DOH lacked the personnel to enforce regulations (e.g., on the use of drugs, safety measures, health hazards, etc.). Fourth, it did not have a sophisticated information and communications system to pro-act or react fast and adequately. Fifth, a certain weakness was noted in the managerial aspects of organizing, mobilizing and implementing health services particularly when the participating agencies of groups were not under the direct control of the DOH. Sixth, the well articulated systems and procedures served as bureaucratic bottlenecks during critical situations.

"In summary, the strengths and weaknesses of the DOH were two sides of the same coin. They were strengths when applied to 'standard' programs, activities and tasks but turned to weaknesses when applied to 'non-standard,' innovative and crisis situations." (AIM, 1992 and 2000)

The Arroyo government identified its own priorities for the health sector when it came out with its three pledges in the National Socio-Economic Pact 2001, namely: 1) expand the coverage of services under the National Health Insurance Program (NHIP) and accelerate the roll out of areas of the Indigent Program; 2) reduce by half the prices of medicine commonly used by the poor; and, 3) Restructure the BFAD and adopt other measures to improve the registration process. These pledges specifically address the goal of fair financing and access to quality and affordable drugs.

Also, the strategies that were identified to fulfill two of these pledges provide space for civil society organizations, including the private sector, to play significant roles. In relation to NHIP, these strategies include private sponsorship mobilization for the Indigent Program and link-ups with organized groups as collecting agents for the Individually-Paying Program. In terms of drug price reduction, the strategies include working with pharmaceutical firms and NGOs/POs (through the Botica sa Barangay). There are doubts, however, as to their 'do-ability' within the given time-frame, considering that activities like private sector and community mobilization is not one of the strengths of DOH.

Thus, aside from referring to capacity, resources and resourcefulness to implement and sustain viable strategies, do-ability also dictates that DOH, as well as other key players, build on existing capacities and overcome weaknesses.

Exerting Influence

Since most of the component activities that are necessary for exerting influence for better health - such as strategic institution building (e.g., training), regulation and enforcement, promulgation of an over-arching national health plan, promoting a vision for health, and the provision of incentives – had been tackled in earlier sections, this part will just focus on three key activities: consensus-building inside and outside the health sector; synchronization of health players; and establishing and institutionalizing transparency in management.

Consensus-building. In a free-market environment where the state has not been vigilant in safeguarding the people's health, health policy-making that addresses long-standing causes of ill health and inequity is more likely to go through the crucible of opposition that, in worst cases, may result to paralysis. It is necessary for policy proponents to be mindful of the whole process of policy formulation as an exercise aimed at influencing or convincing the influentials to get into the act. Plans and policies can only be effective if they mirror, even to the subjective eye, the hopes of the stakeholders who are expected to move the policy out of the drawing board and to the battle lines. We saw this clearly during the deliberations on the Generics Law and, more recently, the Clean Air Act. At the program level, we saw how consensus building for preventive health can result to a huge success as the first rounds of the National Immunization Days in 1993.

The technology of social marketing should be utilized to rally and cultivate the support of target partners and clienteles. Team-building and continuing dialogue should be observed in order to share a common goal that transcends sectoral interests. All these are necessary if the health sector wants to expand the base of responsibility for health and see itself effectively exerting influence over other stakeholders in the system.

Synchronization of Health Players. Owing to resource constraints, the DOH, LGUs, NGOs or the private sector could not single-handedly address or provide health care. The most critical variable, therefore, in ensuring a successful health strategy is to elicit the full participation of the stakeholders identified at the outset of this chapter. Health should be adopted as a national program for human development rather than the responsibility of just one department. To achieve this, there should be integrating, networking and linking mechanisms to synchronize the health efforts from the national down to the local levels and vice-versa (pyramidal) and across agencies or sectors (lateral). The integrating, networking and linking mechanisms should address both the technical as well as the managerial aspects of producing and receiving health (Morato, 1992 and 2000).

In the area or community level, the DOH must facilitate the integration, networking and linking of LGUs, NGOs and POs. Local health systems development should, therefore, be driven by these sub-strategies, with LGUs exercising direct command, NGOs giving primary support, and the POs as both self-services and health recipients.

At the sectoral level, the DOH should take the lead and orchestrate the supporting cast of health organizations (NGOs, PhilHealth, PITAHC, private health care institutions, pharmaceutical and health-related companies, others) and government agencies vital to producing health (DepEd, CHED, DENR, DILG, DBM, DPWH, DA, DOLE, DTI, others). Synchronization is expected to result not only to sectors and agencies knowing and doing their roles for better health, it also tells them when to perform specific roles. It tells at what point the DOH comes in during the health impact assessment stage of environmental

impact assessment process led by the DENR, or when the responsibility of the public works and sector for safe water stops and that of the DOH or the local health office begins. In the case, for example, of paralytic shellfish poisoning (red tide), synchronization defines the area of responsibility of the DOH vis-à-vis that of the DA. Synchronization defines the nodes of coordination and leaves no room for buck-passing.

Establishing and Institutionalizing Transparency in Management. Our experiences at the national and local levels are clear that those who wish to exert influence and generate goodwill for health should first embody transparency in management. Whether these two values or traits are inextricably linked in the persona of leaders, or the latter is just consciously performed in cognizance of a means end relationship, various documentation of best practices in health point to one thing – that the flair for establishing and institutionalizing transparency in management goes hand in hand with the ability to mobilize resources for health.

While a number of these documentations illustrate varying shades and hues of "transparency" (e.g., joint master-listing of drug suppliers, pooled procurement of drugs, participatory approach to decision-making, complete and timely delivery of reports on business transactions like bidding results, prohibition of *jueteng* by the governor), the bottom-line was there – the constituents believed that nothing was being done behind their backs by those who were governing them.

3

GOVERNANCE IN HEALTH

PEDRITA B. DELA CRUZ

V. RECOMMENDED PRIORITY ACTIONS

Immediate

Joint Planning and Programming for Equity. Given the glaring disparities in health coverage and outcomes across areas and population groups, the DOH should force out the issue of equity in resource distribution. There is a need for DOH to undertake joint planning and programming exercises with core agencies like the DOF, DBM, NEDA and DILG and line agencies like the DSWD, CHED, DA, DAR, DPWH and others. Joint strategies should be threshed out to remove disparities in health. On the health front, such strategies logically include accelerating the coverage of social health insurance, making drugs accessible to the poor, and selective deployment of health human resources for disease prevention and control (e.g., tuberculosis, malaria, filariasis) and for promotion and health maintenance (e.g., immunization, family planning). Enhancing access to drugs needs the support of the DTI and DOF, while additional health human resources for marginalized areas calls for the concurrence or approval of the DBM.

From an inter-agency standpoint, joint strategizing means convergence of interventions that address not just the problem of poor health but the factors that underpin them. The DOH should draw from the experience in the implementation of the Minimum Basic Needs (MBN) approach under the Social Reform Agenda and use the learning to exert further influence on other agencies. Poor people in areas who are at the receiving end of health disparities should be provided access to productive resources, like credit, capital, land, market, training, technologies and organization.

For example, DSWD or the DA may choose to synergize with the DOH in bringing health and livelihood support interventions to priority areas for TB prevention and control, a type of collaboration that has been proven to bring positive results in other countries implementing the Directly Observed Treatment Short-Course (DOTS).

For its part, CHED should initiate dialogues with health science schools and the DOH in order to determine the key actions that have to be taken to bridge the gap between demand and supply of health human resources in marginalized areas. Beyond that, CHED should embark on a review of the medical curriculum in the country with the end in view of strengthening the community or social medicine aspects of the field. Other agencies whose support are pivotal to achieving equity in health, like DAR, DPWH and DILG, should also be convinced to get into the act. The NEDA must be able to orchestrate responsibility-taking for health by the different agencies. It must also draw from the consensus that would be arrived at to guide its efforts to rationalize the use of donor resources to better serve the goal of equity. With various government agencies doing their part for better health, the participation of civil society would be easier to elicit.

Increased Support for Research and Development. Spending on activities critical to effective governance in the health sector, like bio-medical research, operations and policy research and survey and monitoring did not change in absolute amounts from 1991 to 1997, despite the expansion of the health sector (DOH, HSRA 1999). As an orchestrator, standard-setter and "servicer of servicers", DOH should increase its support for research and development. Among the agencies that are direly in need of increased support are the Philippine Council for Health Research and Development (PCHRD) and the Food and Nutrition Research Institute (FNRI) of the DOST, the Essential National Health Research (ENHR) of the DOH, and the Philippine Institute for Traditional and Alternative Health Care (PITAHC). Increased R&D support to PITAHC, for example, will enable it to develop mechanisms that will strengthen the integration of traditional medicine and primary health care at the grassroots level. Additional resources will also enable PITAHC to support basic researches on additional medicinal plants, complete the initial researches on the previously selected medicinal plants, and develop standards and guidelines for the practice of various modalities of traditional medicine, complementary and alternative medicine.

Medium-term

Push for Universal Social Health Insurance Coverage. If there is a single most important impact that can be felt in terms of health, it is the realization of universal coverage under the National Health Insurance Program. As it is, the NHIP has a long way to go. Nevertheless, there are still opportunities for fast-tracking implementation so that universal coverage becomes achievable by 2010. The push toward universal coverage can be done via a two-pronged strategy that combines an area-based approach through the local government units and a sectoral approach through major occupational groups (e.g., teachers, farmers, military personnel, small transport workers and their families). As a pre-requisite, PhilHealth must first increase its support benefits. Moreover, PhilHealth should encourage the formation of community based health insurance schemes by barangays, POs, sectoral groups and non-government organizations. It must provide technical assistance as well as design a social re-insurance strategy for these community-based efforts to thrive and become sustainable pillars of expanding coverage.

An ideally functioning NHIP will not only enhance access and equity, it will also have a profound impact on improving quality and responsiveness of care, as accredited providers from the private sector, the public sector and the NGOs learn from each others strengths and weaknesses in health care delivery.

Cross-Cutting Concerns

Scale-up Best Practices. While there has been various documentation of innovations in health care delivery, the replication of best practices has been rather slow. Positive experiences have not been given enough attention to inspire stakeholders, thus contributing to an overwhelming sense of malaise and discontent toward the health system.

The scaling up of best practices, that draws from the strengths of LGUs, NGOs, communities and POs, should provide the nuts and bolts of local health systems development.

A Broad Alliance for Health. There are clear signs that the health system needs some shaking. Even with the ground-breaking reforms in the policy arena

in the last two and half decades, which include the passage of the Generics Law, the implementation of the Local Government Code of 1991, and the establishment of the National Health Insurance Program, the country's performance in health has failed to live-up to the ideals of the many high moments of the health sector. We have yet to see the time when the health system shall have breached the thresholds and unswervingly pursuing the vision of "Health by All" in attaining "Health for All".

We admire other countries who have developed their human capital reasonably well, yet we seem to miss the fact that in these countries health, with its vital linkages, has always been a central concern in governance, permeating debates in development planning and resource allocation. A spark that will be strong enough to ignite a wildfire of responsibility-taking for health is needed. The spark could be in the form of an inspiring and animated leadership at the health department that will make "Health by All" a living reality, a way of life. The spark could also be in the form of a strategic or white paper – underscoring health as an engine of growth - written by an inter-disciplinary team of respected experts. Or it could be the site of prominent leaders from the civil society, including icons from the business sector, pounding on the urgency of health action NOW as indispensable in attaining human development, or else the country would sink deep into the mire of hopelessness and ill health.

In 1993, during and after the first rounds of the National Immunization Days (Oplan Alis Disease), we learned how collective action for health could bring about an astounding feat and renew our faith in ourselves as a people. It is now time to muster the same spirit of participation for health and make it govern our everyday lives.