JAFES
Journal of the ASEAN Federation of Endocrine Societies

FEATURE ARTICLE

Universal Health Care in the Philippines

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Abstract

The Philippines is one of the countries that aim to develop a health care system that provides access to health for all its citizens. This paper presents the status of health reforms in the Philippines, particularly those relating to the attainment of Universal Health Care (UHC). In describing and analyzing the present state of health care in the Philippines, the paper refers to key documents such as the Philippine Health System Review of the World Health Organization and the special issue on Universal Health Care published in the Philippine medical journal, *Acta Medica Philippina*, in 2010.

A huge disparity of health outcomes persists between a rich minority and a poor majority in the Philippines. The current government is committed to reducing these inequities through a universal healthcare scheme called *Kalusugan Pangkalahatan*, which involves addressing problems in the "six building blocks" of UHC: information systems, regulation, services delivery, human resources, financing, and governance, though many challenges remain. Universal Health Care addresses the problem of health inequity by improving access to services and financial protection. However, gaps in the six building blocks of health care must be addressed if the Philippines is to truly achieve "universal healthcare."

Keywords: universal health care, health reform, health policy in the Philippines

INTRODUCTION

In September 2008, the centennial celebration of the University of the Philippines (U.P.) featured two presentations on the assessment of the health sector and the role of the University in health. The analyses established that science-based health services had been put in place throughout the country partly due to the University's significant participation in health development.

Nevertheless, the authors noted that one central feature disfigures the state of the Philippines' health: great disparities in access to health care, resulting in significant differences in health status, between the rich minority and the poor majority of Filipinos.

These centennial lectures, delivered at the Science Hall of the Philippine General Hospital in U.P. Manila, concluded that a century after adopting a modern Western health system, the Philippine health situation was unsatisfactory and that the Philippines' most important health problem was health inequity.

The health community both in and out of the University responded by holding a series of symposia, round table discussions, and other fora to develop approaches to resolving the issue of inequity in the country. The results of these discussions were incorporated into recommendations for government to lead the health sector in implementing reforms to achieve universal health care in the Philippines.

During the presidential elections of 2010, proponents of the reforms exerted efforts to introduce universal health care into the platforms of the different candidates. These efforts were rewarded when the eventual winner adopted universal health care (*Kalusugan Pangkalahatan* in Filipino) as the main objective of the new administration's health program.

This paper analyzes the various issues confronting the Philippine health system and proposes corresponding solutions for carrying out the mandate to establish universal health care for all Filipinos.

MATERIALS AND METHODS

For purposes of this discussion and analysis, the authors used data, information and concepts found in the references listed at the end of the paper.

The *Acta Medica Philippina* is a peer-reviewed publication of the University of the Philippines Manila. The special issue on universal health care, published in the fourth quarter of 2010, is an in depth presentation of the issues

ISSN 0857-1074
Printed in the Philippines
Copyright © 2012 by the JAFES
Received October 15, 2012. Accepted October 29, 2012.

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and proposals of the original Universal Health Care Study Group that collaborated in producing the original centennial presentations and most of the materials for further promoting the idea of advocating for Universal Health Care as the main Philippine health system policy direction.

The World Health Organization's (WHO) Asia Pacific Health Observatory in the Western Pacific produces the Health in Transition Series documenting health development efforts of member countries. The Philippine Health System Review was a collaborative effort of WHO consultants and participants of the various national fora that led to the Universal Health Care movement in the country.

Original information and data used in this paper were sourced from official statistical reports produced by the country's main agencies for the collection of social and economic data, the National Statistics Office and the National Census and Statistics Board. In some instances, data presentation involved simple extrapolation from these two sources.

The paper begins by describing elements of the evidence supporting the assertion that inequity is the country's main health problem. This is followed by an analysis of the defects in the different components of the health system and some suggested general measures to address such defects. For this purpose, the paper uses the health systems analytical framework of six building blocks as proposed by the WHO.

ANALYSIS AND DISCUSSION

Table 1 is entitled "Indicators of Inequitable Outcomes." It is a comparison of three key indicators of maternal and child health of the highest income quintiles with those of the lowest income group showing the disparity of health status between the richest and poorest population groups of the Philippines.

Table 1. Indicators of inequitable outcomes (Maternal and child H indicators)

	High Income/ Urban	Low Income/ Rural
Infant death per 1000 live births	<10	>90
Maternal death per 100,000 live births	<15	>130
Number of pregnancies during child-bearing Age/ Number of children desired	2/2	6/3

It is noted that the infant mortality rate, at less than 10 per thousand live births, and the maternal mortality ratio, at less than 15 per 100,000 live births, of the high-income quintiles are comparable to those of industrialized countries of the world. On the other hand, the same indicators (IMR greater than 90 and MMR around 200) for the poorest quintile are equivalent to those prevalent in some of the least developed countries of Africa and Asia.

Even more noteworthy is the comparison of fertility rates between the two groups. The wealthiest women have a desired fertility of two and report an average total fertility rate of two children per woman of childbearing age indicating that this group of women achieves their reproductive goals for childbearing. The poorest women however desire to have only three children during their reproductive lifetime but actually bear an average of 5 to 6 children each – being unable to achieve their reproductive goals.

Looking at simple measures of access to health service delivery reveals that these differences are linked to similar disparities. Such measures can be used to gauge access to primary, secondary, and tertiary care interventions.

For example, as an indicator of access to primary care, immunization rates in richer provinces of the country are 30% to 50% higher than those in poorer provinces. Less than half of children from poor families get one vaccination during childhood while over 80% of those from rich families are fully immunized with the seven antigens of the government's expanded program on immunization.

Caesarian section rates are sometimes used as a gauge of quality of secondary care. The internationally accepted gold standard for this measure is 15% of all deliveries in a given population. However, among poor Filipino women, this rate is estimated at 2% - implying that even if they needed it, these group of pregnant women would not be operated on. On the other hand, over 30% of wealthy Filipino women end their pregnancies with a Caesarian section – meaning that, in this population, some women are exposed to the risks of a surgical procedure unnecessarily.

Renal transplantation, a technology intensive intervention, may be used as an indicator of access to tertiary care. In the Philippines, it is estimated that each year approximately 8000 Filipinos develop end-stage renal disease requiring hemodialysis and kidney transplantation. Because of the huge costs involved, almost all of the 500 or so transplants done in the country each year are from high income groups or foreigners.

In 2010, The Lancet Commission asserted that the goal of global health systems is to "assure universal coverage of high-quality comprehensive services that are essential to advancing opportunities for health equity within and between countries."[4]

For the Philippines, advocates have adopted the following definition of universal health care: "the provision to every Filipino of the highest quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public."[2]

Launched in 2010, *Kalusugan Pangkalahan* or the universal health care program of the present government is an ambitious effort to achieve this by instituting reforms in the six basic "building blocks" of the Philippine health system. Three major strategic thrusts are likewise enunciated: (1) Health facilities enhancement; (2) Financial risk protection; and (3) Attainment of the health-related Millennium Development Goals

What follows is a brief overview of major defects in each of six building blocks and possible interventions to remedy these in the next few years.

1. Health information system

The first among these is the health information system, which despite attempts at modernization dating back to the last 30 years, continues to depend on antiquated paper and pencil data collection at the periphery. The data, highly susceptible to human error and manipulation, feeds into a system characterized by the uncoordinated and non-standardized use of modern information and communication technology.

Recognizing the importance of an efficient and accurate information system, the current universal health care program includes the introduction of modern data collection and the adoption of common technology standards to improve coordination among the various parts of the health system. This includes the adoption of tele-medicine, which is already being piloted in some areas.

2. Health Regulation

The next building block consists of the systems for the regulation of quality and availability of health goods and services including pharmaceuticals. The regulatory infrastructure for health in the country is seen as supply-side dominated with conditions mainly dictated by the regulated groups (pharmaceutical companies, doctors and other professionals, and other suppliers of goods and services). This has resulted in an imbalance of market forces that jeopardizes the health of the poor and the weak.

New laws are now in place designed to improve the technical competence of regulatory agencies. The implementation of these laws requires political will to defend these technical units against the strong lobby groups that benefit from a weak regulatory environment in health.

3. Health services delivery

Health services are severely hampered by a fragmented delivery system consisting of an under-resourced public component serving the poor majority and an over-resourced private component for the rich minority. A Local Government Code that divides responsibilities between the national, provincial, and municipal government units further fragments government service delivery. Most importantly, a formal referral system to move clients between each of the different levels of service is practically non-existent.

The universal health care program of the government includes provisions to encourage referral mechanisms, and strengthens delivery mechanisms that are seen to facilitate the achievement of the Millennium Development Goals.

Moreover, other programs such as the conditional cash transfer (CCT) of the government, aimed at improving the lives of the poorest of the poor, also have a health component; and essential services such as immunizations for children and regular checkups for pregnant women are included among the conditions for the covered families to receive cash subsidies. These features of the CCT are complemented by the provision of innovative service delivery systems, such as the 'community health teams' (CHTs) that focus on preventive and promotive care.

4. Health Financing

A major feature of the country's mode of health care financing is its reliance on out of pocket payments – estimated in 2007 to have reached 57% of total health expenditures. This situation is totally inappropriate for a country where the majority of the population is too poor to afford to pay even partially for the costs of effective care. It is unfair as economic barriers are the major determinants of access to life-saving interventions.

A newly invigorated National Health Insurance Program is rapidly expanding coverage among the country's poorest groups. The benefits packages of the program are also being broadened to include preventive outpatient procedures. There are plans to urgently address the pressing issues of poor utilization of benefits and public facilities by poor income groups.

5. Health Human Resources

Probably the single most important building block of a health system is its health workforce. High income expectations and inadequate values formation has resulted in a poorly motivated workforce. Rational deployment is prevented by the fact that health workers skills sets do not match the needs of the communities needing service. Perhaps 'irrational deployment' is best demonstrated by the oversupply of nurses in the country following the increased demand in the United States and other countries. With thousands of nurses unemployed, many hospitals have resorted to accepting them as 'volunteers'; and in other cases, they are made to undergo 'on-the-job trainings' that they themselves had to pay. To ameliorate the situation, the government in 2011 launched 'RN Heals,' a program that deploys nurses to underserved communities as part of community health teams.

The Health Human Resource Master Plan needs to be updated to fill the needs of a future universal health care system. Moreover, health professionals need to be

compensated well if the country is to prevent its experienced and skilled people from being 'pirated' by other countries. Finally, all policies related to health workforce production, deployment and management must be reviewed and existing legislation revised where needed.

6. Health Governance

Finally, in the area of health governance, there still remains a lack of consensus among stakeholders about a common definition of equity in health and the parameters that will determine whether universal health care is achieved. In addition, processes for policy and decision-making are still mainly top down. This kind of policy architecture makes health governance dependent on the political landscape, and the six-year cycle of each presidency.

There is a need to develop new mechanisms of stakeholder consultations at different levels. Such mechanisms may be evolved from market-research techniques that are employed by private enterprise to promote their products. Some health agencies, such as PhilHealth and the Department of Health, are beginning to develop these capabilities.

SUMMARY AND CONCLUSION

The Philippines is committed to achieving universal health care for its people in the shortest possible time. To this end, the current government has announced an ambitious program comprising three major thrusts of financial risk protection for the sick, upgrading and improvement of government facilities, and enabling communities to achieve the health targets of the Millennium Development Goal while addressing the emerging threat of non-communicable diseases.

In order to achieve the equity goals of universal health care, the three thrusts of the government program must be aimed at providing remedies for major defects in six building blocks of the health system. True universal health care providing equal access to services for all Filipinos may be achieved if the following conditions are met:

1. The existence of a modern information system optimally;
2. Strengthened mechanisms to regulate quality and availability of health goods and services;
3. Integrated delivery of promotive, preventive, curative, and rehabilitative health services at all levels;
4. A restructured health financing system that emphasizes government and shared risk sourcing of funds and minimizes reliance on out of pocket payments at the point of service;
5. Improving stakeholder inputs in the system for health governance;
6. A well motivated, appropriately trained health workforce deployed to areas of need.

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