Improving Health Outcomes Especially for the Poor

Background

A healthier nation, but some serious gaps remain.

The Philippines generally has enjoyed better health over the past 15 years. The infant mortality rate declined from 57 per 1,000 live births in 1990 to an estimated 29 in 2003. The under-five mortality rate also improved from 80 per 1,000 children under five in 1990 to an estimated 40 in 2003. For child health, at least, the country is on track to meet its Millennium Development Goals (MDGs) for 2015. However, the country is falling behind on other health-related goals. Malnutrition among 0–5-year-old children has declined at a disappointing rate, from 34.5% of children underweight in 1990 to 32% in 1998. Malnutrition levels remain far above the MDG target of 17.25% for 2015. Maternal mortality has, though, declined substantially, from 209 maternal deaths per 100,000 live births in 1990 to 172 in 1998, but this is still not rapid enough to instill confidence that it would reach the target of 52.2 for 2015. While the improvements made in child health are significant, weaknesses in nutrition and in maternal mortality indicate the underlying difficulties that make future improvements uncertain.

Issues in Health

Health improvements among poor Filipinos lag behind the rest of the nation.

Despite population-wide improvements in infant and child survival, poor Filipinos lag behind in benefiting from these improvements. The infant mortality rate among households in the poorest quintile is 2.3 times higher compared to those from the richest quintile. Likewise, the under-five mortality rate is 2.7 times higher among the poorest quintile than the richest. The inequality is also evident in differences in the health-seeking behavior of different income groups. The 1998 Department of Health data reveal that over 90% of women in the poorest quintile were exposed to the higher risks of their babies being delivered by traditional birth attendants at home, while women in the richest quintile secured lower risks from having deliveries attended by doctors and in hospitals or private facilities. Lagging health improvements in some regions provide another indicator of inequities in health outcomes. For example, life expectancy of adults in the Autonomous Region in Muslim Mindanao (ARMM) in 2000 is just at the comparable national level reached in 1970, indicating that in this important measure of health outcomes, the ARMM is at least 30 years behind the rest of the country.

These striking gaps in health outcomes of the poor and the non-poor result from continuing differences in living standards and in access to health care. Because costs of health care are still mainly financed through out-of-pocket payments, the financial burden of paying for services is a major obstacle to the poor's access to care and can make them even poorer. While wealthier families enjoy high quality, up-to-date health facilities comparable to those in many industrial countries, poor families must frequently forgo health care or go into debt, sell their assets, or pull children out of school to pay for health care during catastrophic illnesses. In addition to the high cost of health care, illness or long-term disability is a major cause of temporary absence from or permanent dropping out of work or school, perpetuating poverty over the longer run and even into the next generation.

Structural inefficiencies have limited the capacity of the country's health system to deliver better health outcomes for all, particularly for the poor.

For its level of health spending, the country could achieve more in terms of health outcomes if its resources were used more

efficiently. The following structural inefficiencies have the most potential for improvement.

Excessively high prices of medicines leading to inadequate and irrational use. Drug prices in the Philippines are generally higher than in many other developing countries, and even in some industrial countries. The high price of drugs leads to incomplete or inadequate treatment, more self-care, and inadequate consultations with health professionals.

There are many reasons why drug prices are so high in the Philippines. These include the existence of near-monopoly players in the drug distribution and retail industries and the dominance of expensive, heavily promoted, brand-name products in the drug market. These latter capitalize on the low credibility of the quality assurance operations of the Bureau of Food and Drugs (BFAD) to challenge the quality of generic drug products. Lack of alternative sources of information on drugs—for patients and physicians alike—to counterbalance marketing claims of drug companies is also a factor. In public facilities and community-based outlets where generic drugs are more widely available, and could be accessed free or at lower-prices by the poor, inadequate and irregular supplies limit access. Among these sources, poor procurement practices, inefficient logistics, and poor financial management also result in higher purchase prices, wrong inventories, and unnecessary waste.

Insufficient effort expended on prevention of new diseases, particularly noncommunicable diseases. Of the 10 leading causes of death in the country, at least half of them—including heart and vascular diseases, cancer, accidents, and chronic lung diseases—could be reduced significantly, and at lower cost, if more aggressive preventive measures were taken. For a few of these, changes in people's lifestyles to reduce smoking, improve diets, and increase physical exercise would save lives at little or no additional cost to the health system, and at significantly lower cost per life saved than the expensive drugs and medical procedures in use today. Environmental protection measures could likewise reduce deaths and illness on a large scale. While the Government has taken steps to promote these preventive measures, a more aggressive approach is required to achieve greater savings in lives and in health expenditures.

Excessive reliance on use of high-end hospital services rather than primary care and outpatient specialist care. There is widespread belief among the population and among health care professionals that high-quality care can be found only in hospitals. Thus many patients go to hospitals for conditions that could be satisfactorily managed on an outpatient basis. In many ways, this bias is understandable. Many of the best doctors are found in hospitals, especially the larger specialist hospitals, and these hospitals tend to be better stocked with medicines, have better trained nonmedical staff, such as nurses and midwives, and have better facilities. And yet, the most cost-effective health interventions are often those that could be provided in primary care facilities or in first-level referral hospitals by general practitioners or by nonmedical staff.

Inefficient organization of the country's hospital system. The wide network of hospitals in the country includes a large number of very small hospitals, mostly of 30 beds or less, that are too small to sustain even the most basic hospital operations efficiently; they tend to be understaffed, underresourced, poorly maintained, and underutilized. Advances in modern medicine and health care organization have rendered these smallest hospitals largely anachronistic. On the other hand, large numbers of patients are managed expensively in specialized hospitals when they could be managed adequately in general hospitals, clinics, or in the community. health centers In terms of hospital care, what the country needs, and can afford at this time, is wider coverage by a somewhat larger number of higher-quality, strategically located medium-sized general

hospitals and a limited number of specialized hospitals distributed proportionately across the population and handling only cases that cannot be treated at lower levels of the system.

Insufficient quality assurance mechanisms to eliminate poor and wasteful medical practices. Very little is currently being done to monitor and regulate the ongoing processes of health care, apart from the regulation of entry of providers into the service market, through such actions as licensing and accreditation. Even with the best qualified and most professional care, patient outcomes can still fall short of reasonable expectations. And with patients having little understanding of medical science, it is rare that patients know the difference between good and bad medical practice. Nevertheless, there is growing belief among health professionals and their **patients** that low-quality and wasteful clinical practices abound, leading to a waste of time and money and, too often, unnecessary deaths. The high level of public concern surrounding the recently revived (though failed) attempt to pass a medical malpractice law is one indication of the widespread anxiety about the quality of care that patients in the Philippines routinely obtain.

The health system has undergone major changes in the last 15 years but the agenda is largely unfinished.

Following earlier successes in reducing communicable diseases, governments in the Philippines have shifted their attention in the last two decades to system-wide efficiency improvements to accelerate health gains. By and large, significant portions of the reform agenda remain undone. Major inefficiencies persist, and the large gap between rich and poor remains.

The generic drugs law, parallel drug importation and community initiatives. The generic drugs law, passed in 1988, aimed to promote the use of generic (nonproprietary) drugs in lieu of higher-cost branded equivalents. Among other things, the law mandated the use of generic names in drug prescriptions and enjoined pharmacists to inform customers of generic alternatives and their prices. Despite some serious effort, generic drugs have made little headway in the country since the law was passed. The structural inefficiencies in the drug market, described above, continue to sustain dominance by branded products.

In 2001, the Government launched a new program called Pharma 50 to introduce lower-priced drugs in the market through parallel importation of widely-used branded drugs. On the justification that international drug suppliers were selling their (patent-protected) products at higher prices in the Philippines than in other counties, the Government negotiated to import a small number of products directly from wholesalers in other countries, bypassing the locally established importation channels and underpricing them in the process. Though limited in the range of products involved, and restricted to branded drugs, the program succeeded in making the point that local drug prices could be reduced by as much as 50% and in pressuring some local distributors to lower their own prices. To further capitalize on this success, funds earmarked for parallel imports of branded drugs could alternatively be used in competitive bidding of generics—whether locally produced or imported—targeted for public health facilities.

Other efforts to improve procurement and distribution of drugs at the community level, such as the Botika sa Barangay (*barangay* drugstores) program, or at the level of the health facility, such as revolving funds operations, have also been attempted, but these are largely small-scale and difficult to sustain in the long run.

Devolution under the Local Government Code. By far the most far-reaching change in the last 15 years has been the devolution of public sector health services to provincial, city, and municipal governments under the

Local Government Code of 1991. Local hospitals became the responsibility of provincial and city governments; health centers and *barangay* health stations were transferred to municipal and city governments. The Department of Health (DOH) retained only the large regional or national medical centers. It also retained its mandate as the prime national agency responsible for the health of the nation, including the management of national priority public health programs. Attainment of the nation's health objectives, however, became largely dependent on the successful mobilization of the autonomous local government and private sectors.

The performance of the health system is generally considered to have deteriorated markedly under the devolved setup. Several reasons are cited: the unwillingness and inability of local government units (LGUs) to maintain pre-devolution expenditure levels; lack of preparation of DOH and the LGUs for the sudden and radical changes in responsibilities; and the "chopping up" or fragmenting of the health care system among so many levels of the system.

Universal health insurance. In 1995, the National Health Insurance Program (NHIP) was launched under management of the Philippine Health Insurance Corporation (PhilHealth). The NHIP expanded coverage of the old Medicare program for formal wage-earners by adding two programs—the Indigent Program, now called the Sponsored Program (SP) and the Individually Paying Program (IPP). Premiums for members under the first group were to be fully covered under a sharing arrangement between the national Government and LGUs. The latter group included informal sector workers. The law guaranteed all NHIP members a common benefit package.

During its first 5 years of existence, the SP covered only a small portion of the estimated poor population in the country (less than 10%), and the IPP remained almost nonexistent. SP coverage has expanded significantly over the past 3 years, with the Government putting increased SP membership at the top of its national health agenda and with PhilHealth offering incentives to LGUs to increase sponsorship, such as a capitation benefit of P300 for each SP member. The IPP has only recently started to pick up, with PhilHealth offering special incentives to induce existing organizations of self-employed individuals to facilitate enrollment of their members.

While membership among the poor has expanded, low benefit utilization among SP members remains problematic. One consequence has been the large amount of unused program funds and continuing increases in PhilHealth's reserves. More importantly, low utilization rates bring into question the true benefit of the program for the poor families it is meant to help. In fact, despite clear signs recently of increased efforts to deliver on its mandate to ensure universal access, PhilHealth has yet to tap its tremendous potential to contribute to greater equity in health care.

Health Sector Reform Agenda. The Government's newest and most comprehensive response to health sector challenges is embodied in its Health Sector Reform Agenda (HSRA), a strategy adopted by DOH in 1999. Five major areas of reform are proposed: (i) *grant fiscal autonomy to government hospitals*, to reduce their dependence on direct subsidies from government; (ii) *secure funding for priority public health programs*, using multi-year budgeting to guarantee the needed continuity in resource availability; (iii) *promote the development of local health systems* by engaging LGUs in cooperative cost-sharing arrangements, organizing them into Inter-Local Health Zones and providing them with the necessary technical assistance to enhance capacity for governance of health systems; (iv) *strengthen the capacities of health regulatory agencies* with special emphasis on the BFAD; and (v) *expand the coverage of social health insurance* especially for the poor.

Building on the directions of the three earlier major reform measures—the Generic Drugs Program, devolution, and the NHIP—the strength of the HSRA is the extent to which it learns from these earlier reforms. In addition to the potential strengths of the program's individual components, the HSRA as a whole has also served as an organizing framework for the establishment of dialogue and partnerships—between DOH and LGUs as well as among LGUs themselves—so essential for reestablishing stability and coherence in the sector. The new directions are appropriate, overall, and the HSRA represents a major step toward maturity of the system. However, the HSRA remains basically a concept just starting to become reality.

Recommendations

Better health outcomes for the poor would contribute to wider poverty reduction, would enable more of the poor to participate in and benefit from economic growth, and would address a major source of disaffection among these groups, thereby contributing to greater social stability in the country. For these reasons, *the new Government may well consider as its overriding objective in the health sector, adopting measures to accelerate improvement of health outcomes among the poor and reduce the gap between the rich and poor.*

Many of the measures needed to achieve these goals are known, but are often technically complex and politically difficult to implement. *It is therefore important to remain selective and focused*. The recommendations listed below are among the most promising of the many possible directions for the immediate future. A number of these are already incorporated in *the current policies of DOH under HSRA, which should continue to serve as the underlying framework for health sector development in the country*.

1. *Use the National Health Insurance Program to exact greater efficiency gains and produce more equitable results from the health system.*

The NHIP is potentially the country's single most powerful tool for ensuring equitable access to health care and obtaining maximum health improvement from such access. PhilHealth has done much to expand enrollment, raise payment levels for existing benefits, introduce new benefits and accelerate accreditation of providers reaching poor communities. Yet it could do considerably more. As an increasingly important "purchaser" of health services, PhilHealth should use its benefit and payment policies and apply its regulatory muscle to induce greater efficiency among providers and increase utilization of services by the poor. By expanding its revenue base among paying members, increasing premium levels of the better-off and reducing its reserves, it would mobilize more resources into the health system and augment the scope for sharing health risks across the entire population. Ultimately its aim should be to achieve the most socially desirable balance among providers' pursuit of their profit-maximizing interests, members' concern about the cost of premiums, and the Government's desire to attain social solidarity in health.

The Philhealth organization is aware of the wide arsenal of program options available to meet this challenge. And yet, reforms continue to proceed in tiny, incremental stages. The issues are largely institutional. The corporation has yet to completely shed its past self-concept inherited from the old Medicare system—as a traditional insurer that passively pays health providers for health bills incurred by enrolled wage-earning members. It needs to make the transition toward the concept of a social reform institution that serves the whole community. Only by fully recognizing its social mission, and more boldly asserting the authorities granted to it under the National

Health Insurance Law, can PhilHealth finally become truly pro-poor.

2. *Enhance competitive pressures in the pharmaceutical market to lower drug prices through stronger regulation and strategic public sector drug procurement.*

Filipinos should not be paying more for drugs than people in other countries. Fifteen years after the generic drugs law, several key actions required to fully achieve the law's objectives have still to be carried out. First, the credibility of BFAD as a regulatory agency should be securely established. Although BFAD suffers from budget shortages like the rest of government, there are well-known ways to make it more operationally effective (by streamlining procedures, outsourcing services, etc.) and to improve its resource base (by increasing user fees and collecting fines more conscientiously). In introducing these changes, BFAD can expect, as it had in the past, to encounter stiff resistance from powerful interests in the pharmaceutical market. But with the full and bold support of the Secretary of Health, and the backing of political leaders at higher levels of government, these changes can nonetheless be made toward achieving large-scale reductions in drug prices without compromising quality and safety.

DOH will also need to work together with LGUs to improve the quality and lower the prices of drugs in their health facilities. LGU procedures for drug procurement should be made completely transparent and competitive—as required under the new National Procurement Law –by reducing the widespread practice of negotiating directly with individual suppliers. Pooled procurement of drugs (e.g., for all hospitals in a province) could also yield better prices. Better management of drug logistics would reduce stock-outs and eliminate the need for emergency purchases at higher retail prices. To help keep prices low, PhilHealth should also apply reference pricing policies and expand coverage of outpatient drugs.

3. *DOH and PhilHealth should work together to ensure the quality and cost-effectiveness of health care practiced by government hospitals, LGU facilities and private providers.*

Small changes in the quality of prevailing provider practices can yield tremendous benefits in improved health outcomes. An example of a simple yet highly successful change in clinical practice was the diffusion starting some two decades ago of oral rehydration therapy. The spread of this lower-cost yet effective treatment is probably a major reason for the elimination of diarrhea from the top 10 causes of death in the country and for marked improvements in child health in the past 15 years. Numerous other improved intervention packages and clinical practice guidelines are already being explored for most areas of care. These improved practices should be adopted as quickly, and applied as widely, as possible.

Other measures can be adopted to enhance and ensure the quality of care. At the national level, stronger licensing and accreditation processes for health facilities, the reintroduction of continuous medical education as a requirement for renewal of professional licenses, accreditation of general practitioners, and public information and consumer protection programs would be powerful tools. At the level of the health facilities, therapeutic committees, information systems to set benchmarks for good practice and identify outliers, and other similar objective tools could counteract the unspoken "rules of fraternity" among doctors that keeps them silent in the face of bad practice and could provide more realistic alternatives to a malpractice law. In all these measures, it will be important that DOH collaborate with PhilHealth so that these two agencies do not operate at cross-purposes in the promotion of quality and cost-effective care.

4. *Enhance capacities at selected publicly owned hospitals under the guidance of rational planning rules to enhance operational efficiency.*

There are strong and, in some respects, justified demands for raising the technical and operational capacity of government health facilities. Yet investments in public facilities cannot be undertaken indiscriminately. At the national level, DOH must put an end to the ever-growing budget share of the system of retained (or renationalized) hospitals. Transformation of these hospitals into autonomous government corporations ("corporatization") as well as devolution of some retained hospitals to LGUs may be part of the solution, but in fact, little progress will occur unless truly firm measures are taken to cap DOH's hospital budget. It will take an executive decision by the Secretary of Health backed by combined efforts of national budget authorities and the national executive leadership, working with Congressional leadership, to set up this cap and enforce it during the annual budgeting cycle.

At the local level, provincial and city chief executives will need to work together with municipal authorities to decide on how to streamline local hospital networks, using objective criteria such as utilization rates, patient flows, performance indicators, and geographic access. Attention must be given to assuring that basic service capacities are available in the poorest areas. In all this, DOH will need to conduct dialogue with local leaders and interest groups to convey the message that people will obtain better health care from a well-functioning hospital located farther away than from a hospital that is easier to reach but is without the doctors, nurses, drugs, etc. needed to provide good care.

Budget allocation formulas and PhilHealth payment mechanisms linked to performance or to the number of indigents served—such as those already adopted by Marikina City and Capiz Province—could also be applied. Stronger hospital earnings from PhilHealth to reduce the strain on government budgets is another promising alterative, and this could happen readily if PhilHealth expanded its collections and reduced its reserves.

5. *Introduce stronger measures to prevent the onset of noncommunicable disease among the population*

A more assertive nationwide program in prevention—to reduce tobacco smoking, improve diets, increase physical exertion, reduce air pollution and improve road safety—would go a long way in reducing the cost of saving lives from the major killers in the country. These measures require actions by a broad range of government agencies, from the Department of Finance (to increase taxes on tobacco) to local police (for road safety), and would ultimately only work if people and their communities start to take responsibility for their own health. Stronger and more persistent leadership and advocacy from DOH than has been seen to date will be needed to get these programs to a level where they can make a real dent on health outcome and health costs in the country.

6. *Raise the profile of health equity objectives in the national political agenda and harness all concerned parties to the reform effort.*

As has already been seen in many other countries—industrial and developing—political leaders in the Philippines are becoming increasingly aware of the high priority that their constituents attach to achieving their health objectives. By bringing responsibility for health down to the level of local government, devolution can be credited for this change, which is evidenced by the growing number of provincial and city governments that are taking new and creative initiatives in the health sector. What is needed now is for the top levels of government—the national leadership (the President, Cabinet, and Congress) and those responsible for the sector nationwide (the Secretary of Health, the President of PhilHealth) to demonstrate the

boldness needed to overcome challenges posed by entrenched and powerful interests in the sector and to engage and empower local chief executives to participate in the effort. As discussions above repeatedly imply, technical solutions in health, though complex, are known or knowable. It is decisiveness and direction in leadership that are now needed.