

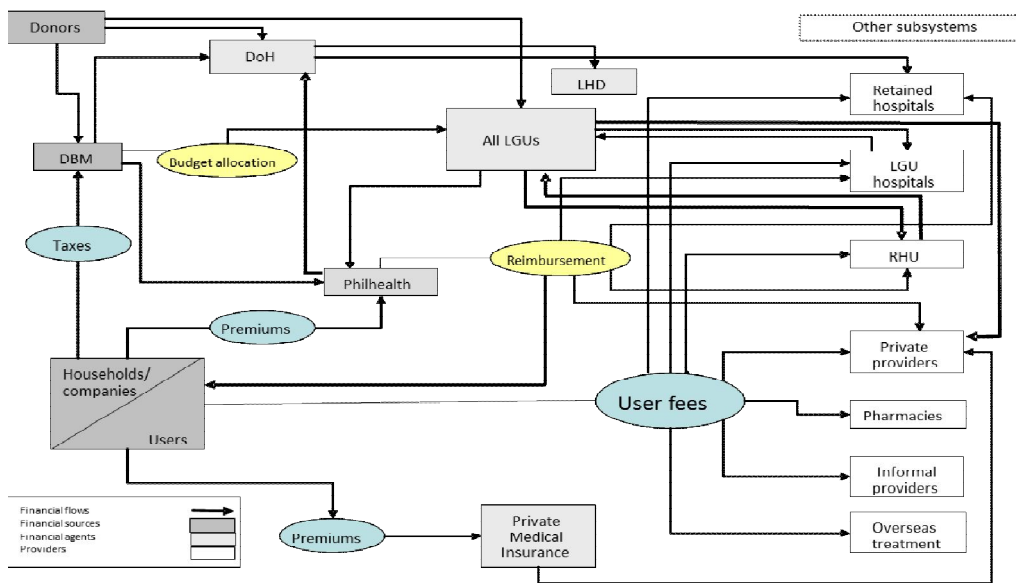
CHAPTER 1

THE PHILIPPINE HEALTH SYSTEM AT A GLANCE

1.1. HEALTH FINANCING

The health financing system in the country is complex as it involves different layers of financial sources, regulatory bodies and health service providers. **Figure 1** shows the financing flows for health as to sources and uses. In general, there are four main sources of financing: (1) national and local government, (2) insurance (government and private), (3) user fees/out of pocket and (4) donors.

FIGURE 1. HEALTH FINANCING FLOW, PHILIPPINES



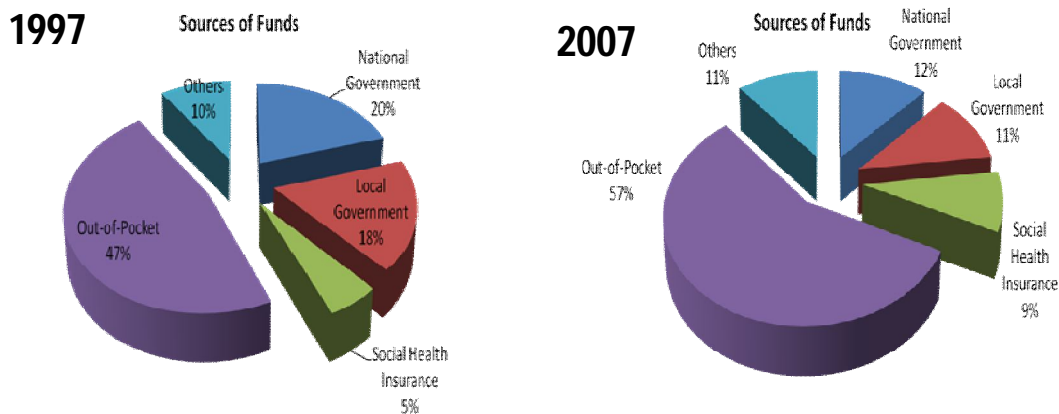
Source: HSRA Monograph on Health Care Financing, Department of Health

In 1995, the National Health Insurance Program (NHIP) managed by Philippine Health Insurance Corporation (PHIC or PhilHealth) was institutionalized and signaled the movement towards a single-payer premium-based financing or insurance system. However, the current system continues to maintain a dual financing system existing parallel to each other.

The total health expenditure increased from Php 87 Billion in 1995 to almost Php 225 Billion in 2007 (National Statistical Coordination Board, 2007). Although there is an increase in the total health expenditure in nominal terms, its share on the GDP is still at 3.5 to 3.6 percent (National Statistical Coordination Board, 2007). **Figure 2** shows the share of different health financial sources. Out of pocket has the largest share of

the total health expenditure. Despite the safety nets like NHIP, the share of out of pocket expenditure increased from 47 percent in 1997 to 57 percent in 2007 (National Statistical Coordination Board, 2007). The share of local and national government subsidy also decreased on the same period.

FIGURE 2. TOTAL HEALTH EXPENDITURE BY SOURCE, PHILIPPINES, 1997 AND 2007



Source: Philippine National Health Accounts, NSCB

The high level of out of pocket may lead to financial catastrophe and impoverishment. **Table 2** validates the large contribution of out of pocket during healthcare seeking episodes. Majority of patients from both public and private utilize out of pocket during confinement but it is significantly higher among patients confined in public facilities. Despite the presence of safety nets, donations (from philanthropists and charity organizations) would still count as one of the major sources of financing (Lavado and Ulep, 2011).

TABLE 2. SOURCE OF FINANCING DURING INPATIENT VISITS, PHILIPPINES, 2008

Sources of Payment	Confined in Private Hospitals (%)	Confined in Public Facilities (%)
Salary/Income	48	51
Loan	17	23
Savings	37	32
Donation	17	23
PhilHealth	51	24
SSS/GSIS	4	2
HMO	6	1
Others	0.82	0.32

Source: Raw data from National Demographic and Health Survey, NSO 2008

Looking at the components of out-of-pocket by quintile, more than half of the medical expenditure was spent on medicine. However, share of medicine on the total medical expenditure was consistently higher among the poor compared to their richer counterparts. Expenditure on contraceptives was also higher among the poor household (Lavado and Ulep, 2011).

TABLE 3. DISTRIBUTION OF OUT-OF-POCKET EXPENDITURE BY COMPONENTS AND BY SOCIO-ECONOMIC STATUS, IN PERCENT, PHILIPPINES. 2000-2009

Components	Poorest				Richest				Philippines			
	2000	2003	2006	2009	2000	2003	2006	2009	2000	2003	2006	2009
Medicines	74.2	75.0	73.5	74.7	59.5	59.7	59.1	57.2	67.6	66.6	66.6	65.7
Hospital Charges	1.8	2.1	2.2	2.1	7.2	6.7	6.9	7.0	4.4	4.4	4.6	4.7
Medical and Dental	6.0	5.3	5.6	6.2	19.8	18.6	18.0	16.7	12.5	12.6	11.6	11.5
Other Medical Goods	9.0	8.4	8.7	8.9	11.7	13.7	10.3	10.9	10.8	11.6	10.1	10.6
Other Medical Services	8.8	1.1	1.7	2.0	1.3	0.4	0.8	0.9	4.4	1.0	1.6	1.7
Contraceptive	0.3	8.0	7.4	5.0	0.5	0.8	1.4	2.0	0.5	3.9	3.6	3.1
Food Supplement			0.9	1.1			3.6	5.4			1.9	2.7

Source: Raw data Family Income and Expenditure Surveys, 2000-2009

1.2. HEALTH CARE DELIVERY SYSTEM

The Philippine health care system has rapidly evolved with many challenges through time. Health service delivery was devolved to the Local Government Units (LGUs) in 1991, and for many reasons, it has not completely surmounted the fragmentation issue. Health human resource struggles with the problems of underemployment, scarcity and skewed distribution. There is a strong involvement of the private sector comprising 50% of the health system but regulatory functions of the government have yet to be fully maximized.

1.2.1. Health Facilities

Health facilities in the Philippines include government hospitals, private hospitals and primary health care facilities. Hospitals are classified based on ownership as public or private hospitals. In the Philippines, around 40 percent of hospitals are public (Department of Health, 2009). Out of 721 public hospitals, 70 are managed by the DOH while the remaining hospitals are managed by LGUs and other national government agencies (Department of Health, 2009). Both public and private hospitals can also be classified by the service capability (see DOH AO 2005-0029). A new classification and licensing system will soon be adopted to respond to the capacity gaps of existing health facilities in all levels. At present, Level-1 hospitals account for almost 56 percent of the total number of hospitals (Department of Health, 2009; Lavado, 2010) which have very limited capacity, comparable only to infirmaries.

FIGURE 3. NUMBER OF HOSPITALS BY CLASSIFICATION AND OWNERSHIP, PHILIPPINES, 2009

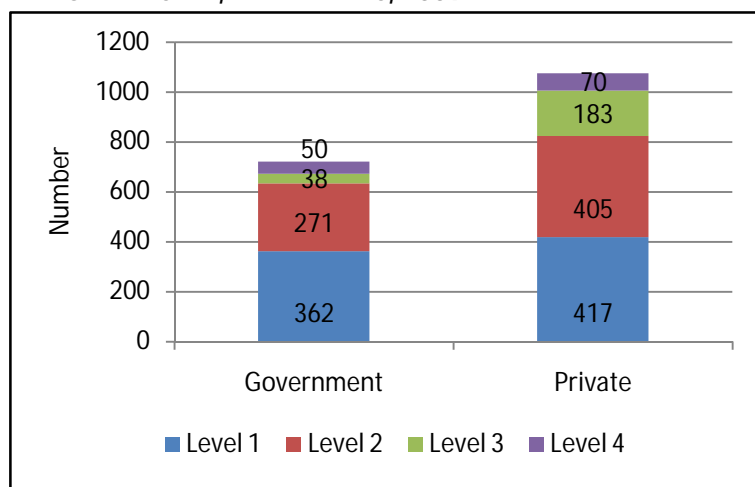
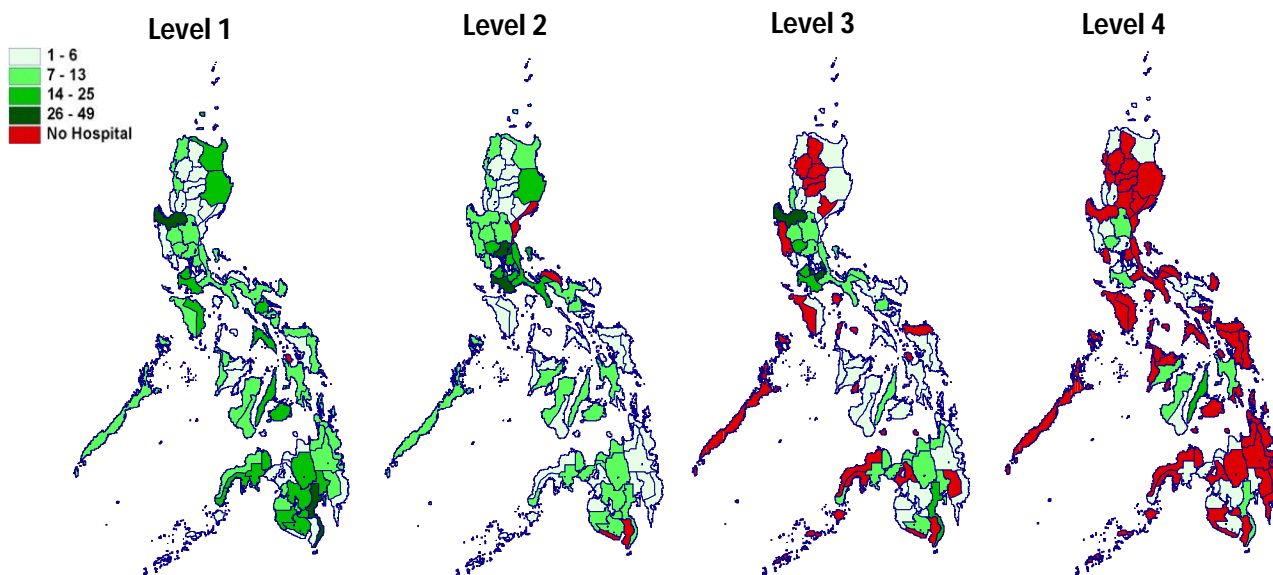


Figure 3 shows that the private hospitals outnumbered the government hospitals in all categories. The disparity is more noticeable in tertiary hospitals where the number of private hospitals is four times that of the government hospitals.

Source of Raw Data: List of Hospitals and Other Facilities, BHFS-DOH

Figure 4 shows the distribution of hospitals by level. Levels 1 and 2 hospitals are relatively well-distributed across the country (though there are few provinces with limited level 2). However, hospitals with higher service capabilities are highly concentrated in Region 3 and National Capital Region (NCR) (Lavado, 2010)

FIGURE 4. DISTRIBUTION OF HOSPITALS BY LEVEL AND GEOGRAPHICAL DISTRIBUTION, PHILIPPINES, 2009



Source of Raw Data: List of Hospitals and Other Facilities, BHFS-DOH

The number of hospital beds is also a good indicator of health service availability. Per WHO recommendation, there should be 20 hospital beds per 10,000 population. **Table 4** describes the

distribution of private and public hospital beds by region. Almost all regions have insufficient beds relative to the population except for NCR, Northern Mindanao, Southern Mindanao and CAR. Among the seventeen regions, Autonomous Region for Muslim Mindanao (ARMM) has the lowest bed to population ratio (0.17 beds per 1000 population), far lower than the national average.

TABLE 4. NUMBER OF BEDS AND RATE PER 1000 POPULATION BY REGION, PHILIPPINES, 2008

Region	Number of beds	Rate per 1000 population
Ilocos Region	4163	0.84
Cagayan Valley	2779	0.86
Central Luzon	8218	0.84
Region IV-A (CALABARZON)	9459	0.83
Region IV-B (MIMAROPA)	2093	0.73
Bicol Region	4156	0.76
Western Visayas	5714	0.78
Central Visayas	6190	0.92
Eastern Visayas	2845	0.67
Zamboanga Peninsula	2909	0.87
Northern Mindanao	4858	1.16
Southern Mindanao	4580	1.08
Central Mindanao	3680	0.94
NCR	27779	2.47
CAR	2472	1.52
ARMM	586	0.17
CARAGA	1718	0.70
Philippines	94199	1.04

Source: Department of Health

1.2.2. Health Human Resource

The health human resources are the main drivers of the health care system and are essential for the efficient management and operation of the public health system. They are the health educators and providers of health services. The Philippines has a huge human reservoir for health (see **Table 5**). However, they are unevenly distributed in the country. Most are concentrated in urban areas such as Metro Manila and other cities.

TABLE 5. NUMBER OF GOVERNMENT HEALTH WORKERS, PHILIPPINES, 2008

Area	Number of Government Health Workers			
	Doctors	Dentists	Nurses	Midwives
Philippines	2838	1891	4576	17437
NCR	590	498	723	1135
CAR	89	40	131	637
I	159	105	259	1014
II	97	65	196	839
III	278	176	441	1662
IVA	238	189	472	1818
IVB	83	68	142	555
V	157	85	273	1072
VI	234	123	401	1775
VII	177	117	328	1534
VIII	155	94	201	904
IX	100	44	203	697
X	138	74	241	1052
XI	75	69	127	743
XII	113	56	194	878
ARMM	76	30	130	507
CARAGA	79	58	114	615

Source: Department of Health

1.2.3. Utilization of Health Facilities

In the 2008 National Demographic and Health Survey (NDHS), 50 percent of the clients who sought medical advice or treatment consulted public health facilities, 42 percent went to private health facilities, and almost 7 percent sought alternative or traditional health care. Rural Health Units (RHUs) and *Barangay* Health Centers (33 percent) were the most visited health facilities in almost all the regions except for NCR and CAR, where most of the clients visited private hospital/clinic for medical advice or treatment. The most common reasons for seeking health care were illness or injury (68 percent), medical checkup (28 percent), dental care (2 percent), and medical requirement (1 percent) (NSO, 2008). With regard to child delivery, more than thirty-six percent of infants are still delivered by *hilots* despite aggressive efforts of the Department of Health to promote facility-based delivery (National Statistics Office, 2008).

The hospital sector in the Philippines is highly segmented in nature. Utilization of hospitals may be driven by PhilHealth insurance coverage and socio-economic determinants as shown in **Table 6**. People with PhilHealth insurance are more likely to be confined in a private hospital (56 percent), than those without Philhealth insurance (28 percent). Similarly, patients living in urban area (52 percent) and belonging to the richest quintile (74 percent) are also more likely to be confined in private hospitals (Lavado et al., 2010).

TABLE 6. PROPORTION OF POPULATION WHO SOUGHT INPATIENT CARE BY FACILITY AND SELECTED VARIABLES, PHILIPPINES, 2008

Characteristics	Category	Type of facility confined		
		Private hospitals (%)	Public Hospitals (%)	Clinics (%)
PhilHealth coverage	Covered	56.0	39.6	4.4
	Not covered	28.2	66.0	5.8
Type of residence	Urban	52.2	42.9	4.8
	Rural	35.7	59.1	5.2
Wealth Quintile	Poorest	18.9	77.3	3.7
	Poorer	26.3	68.6	5.0
	Middle	36.8	57.3	5.8
	Richer	51.5	41.2	7.2
	Richest	74.1	22.9	2.8

Source: Calculated based on the National Demographic and Health Survey, 2008

Available data shows that on the average, travel time to a health facility is 39 minutes; where travel time is longest in ARMM (83 minutes) and shortest in NCR and Northern Mindanao, (28 minutes). Travel time is relatively longer in rural areas (45 minutes) than in urban areas (32 minutes); and longest for persons in the lowest wealth quintile (47 minutes) and shortest for those in the highest wealth quintile (35 minutes). Older persons seeking care (60+ years old) have longer average travel times than younger persons (National Statistics Office, 2008)

1.2.4. Satisfaction with Health Facilities

Based on a survey by the Social Weather Station in 2006, majority of Filipinos specifically the low income households prefer to seek treatment in a government hospital if a family member needs confinement. Affordability is the main reason for going to a government medical facility, while excellent service is the main reason for going to a private medical facility (Department of Health, 2010).

The net satisfaction with services given by government hospitals has slightly improved from +30 in 2005 to +37 in 2006. Excellent service and affordability are the main reasons for being satisfied whereas poor service is the main reason for being dissatisfied with the services given by government hospitals (Social Weather Stations, 2006).

1.3. HEALTH OUTCOMES

1.3.1. Life Expectancy

The projected average life expectancy of Filipinos in 2005 to 2010 is 68.8 years, with males having an average life expectancy of 66.11 years and females with 71.64 years (National Statistics Office, 2010). It is projected that the average life expectancy of Filipinos will increase to 70.38 years from 2010 to 2015 and 71.59 years from 2015 to 2020 (National Statistics Office). **Table 7** provides the data on projected life expectancy at birth.

TABLE 7. PROJECTED LIFE EXPECTANCY AT BIRTH BY SEX AT FIVE CALENDAR-YEAR INTERVALS, PHILIPPINES, 2000 TO 2040 (MEDIUM ASSUMPTION)

Year	Male	Female	Mean life expectancy*
2000-2005	64.11	70.14	67.62
2005-2010	66.11	71.64	68.88
2010-2015	67.61	73.14	70.38
2015-2020	68.81	74.34	71.59
2020-2025	70.01	75.54	72.77
2025-2030	71.01	76.54	73.77
2030-2035	72.01	77.54	74.77
2035-2040	73.01	78.34	75.68

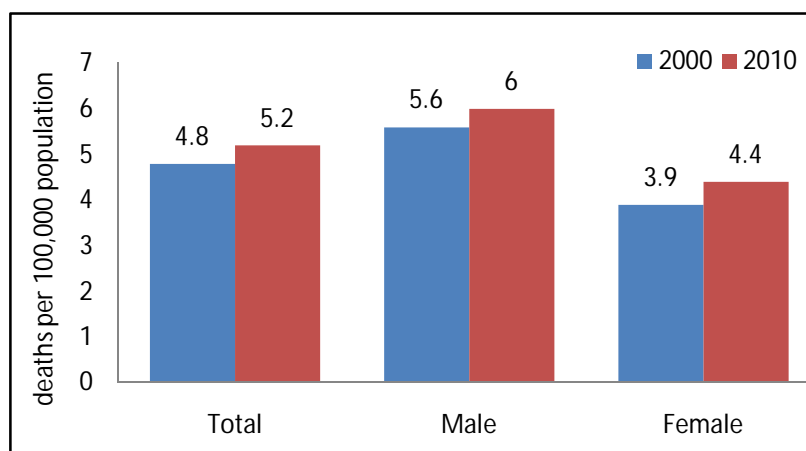
Source: 2000 Census-based Population Projection

*Calculated using National Statistics Office data

1.3.2. Deaths and Births

Deaths and births are commonly measured to determine the status of health and fertility dynamics of an area. The crude death rate (CDR) has been declining since the 1960s. However, no significant change has been noted since 2000-2009. The number of deaths in a particular population is influenced by various

FIGURE 5. CRUDE DEATH RATE, PHILIPPINES, 2000 AND 2010



Source: National Statistics Office, 2010

environmental factors. Global experience suggests that decreasing

CDR is a result of decreasing cases of infectious diseases, improvement of perinatal practices and innovative health interventions (National Statistics Office, 2009).

Seven of the ten leading causes of death are non-communicable in etiology as shown in **Table 8**. Cardiovascular diseases (i.e. diseases of the heart, and cerebrovascular diseases), cancers, chronic obstructive pulmonary disease and diabetes are the leading non-communicable diseases. The lingering problems on infectious diseases like pneumonia and tuberculosis are still evident as they ranked 4th and 5th leading causes of death (National Statistics Office, 2009).

TABLE 8. TOP TEN CAUSES OF DEATHS, PHILIPPINES, 2009

Diseases	Number of deaths	Percentage share
Diseases of the heart	100,908	21.0
Cerebro-vascular diseases	56,670	11.8
Malignant neoplasm	47,732	9.9
Pneumonia	42,642	8.9
Tuberculosis	25,470	5.3
COPD	22,755	4.7
Diabetes	22,345	4.6
Nephritis, Nephrotic syndrome	13,799	2.9
Assault	12,227	2.5
Certain conditions arising from perinatal period	11,514	2.4

Source: National Statistics Office, 2009

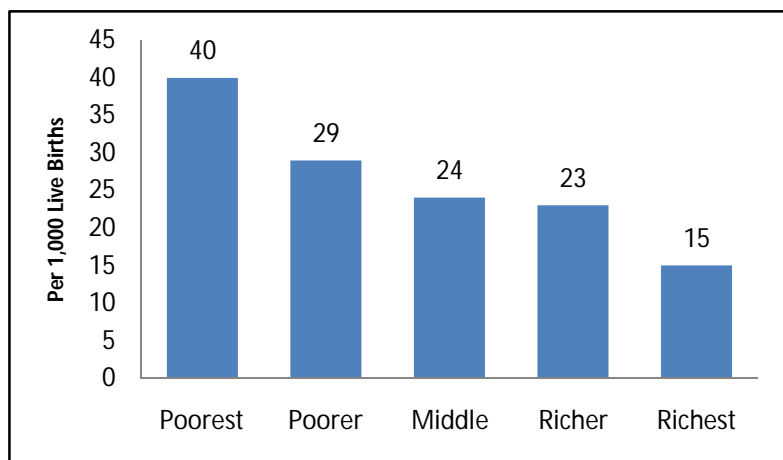
Infant and maternal mortality are the most useful indicators since they reflect the general condition of the health system. **Table 9** shows the decreasing trend in Infant Mortality Rate (IMR) over the last decade. It dropped from 57 infant deaths per 1000 live births in 1990 to 25 infant deaths per 1000 live births in 2008 (National Statistics Office, 2008). However, disaggregating IMR by socio-economic quintiles and regions reveals performance disparities. **Figure 6** shows that the IMR of the poorest quintile in 2008 is similar to the national IMR two decades ago. Regional comparison also depicts wide variations which can be consistently observed since early 1990s.

TABLE 9. CHILD MORTALITY RATE, PHILIPPINES, 1990-2008

Year	Neonatal Mortality	Infant Mortality	Under-Five Mortality
1990		57.0	80.0
1993	17.7	33.6	54.2
1998	17.8	35.1	48.4
2003	17.0	29.0	40.0
2008	16.0	25.0	34.0

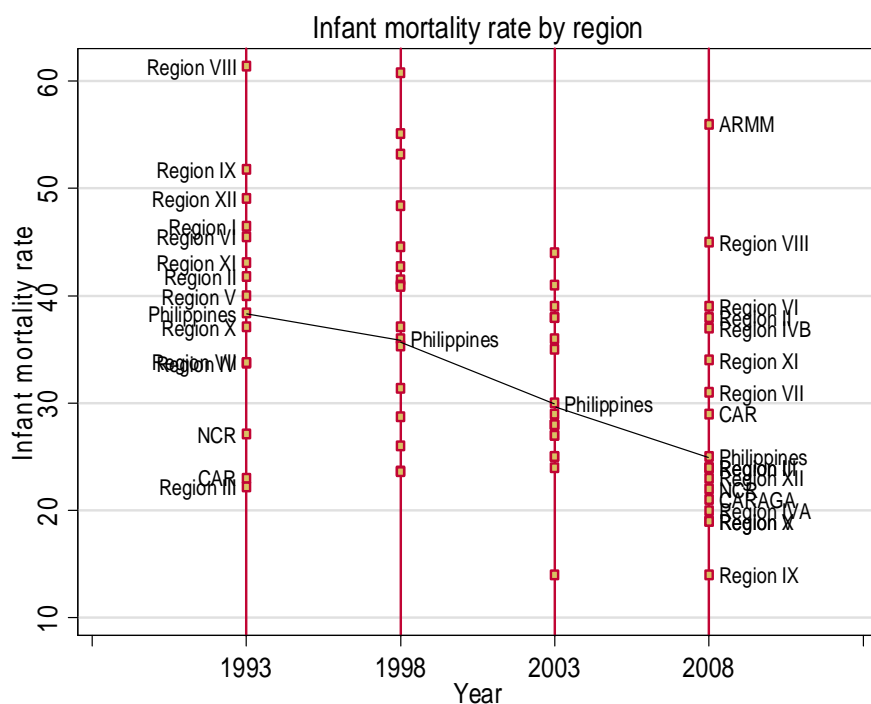
Source: National Demographic and Health Surveys, NSO

FIGURE 6. INFANT MORTALITY RATE BY SOCIO-ECONOMIC STATUS AND REGION, PHILIPPINES, 2008



WHO defines maternal mortality as death of a mother while pregnant or within 42 days after delivery. Risks attributable to pregnancy and childbirth as well as from poor quality health care services make this a strong indicator for health care status. In developing countries, hemorrhage and hypertensive disorder are the major

causes of maternal death. Over the past decade, the decline in the number of maternal deaths per 100,000 live births has slowed down. Stretching as far back as 1993, the National Demographic Survey (NDHS) estimated 209 maternal deaths per 100,000 live births which significantly decreased to 162 in 2006 in the Family Planning Survey (FPS). In 2010, the MMR is estimated to be at 163 per 100,000 live births and the estimate from the Family Health Survey is still to be determined.

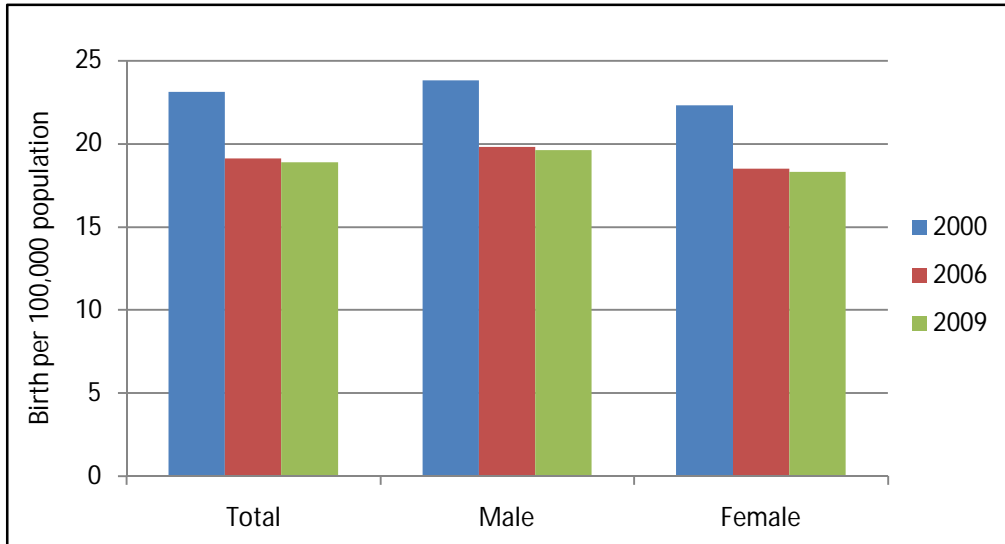


Source: National Demographic and Health Surveys, NSO

Birth rate is a common measure of fertility for a given population. Crude birth rate (CBR) indicates the number of live births occurring during the year, per 1,000 population. Over the last decade, there is a noticeable decline in crude birth rate for both genders (**Figure 7**). Crude birth rate should be analyzed in parallel with more pertinent indicators like total fertility rate. Total fertility rate (TFR) is interpreted as the number of births a woman would have, on average, at the end of her reproductive years (National Statistics Office, 2008). In the Philippines, a woman is expected to have 3 births (National Statistics Office, 2008). However, when disaggregated by socio-economic status, negative correlation is observed such that as socio-

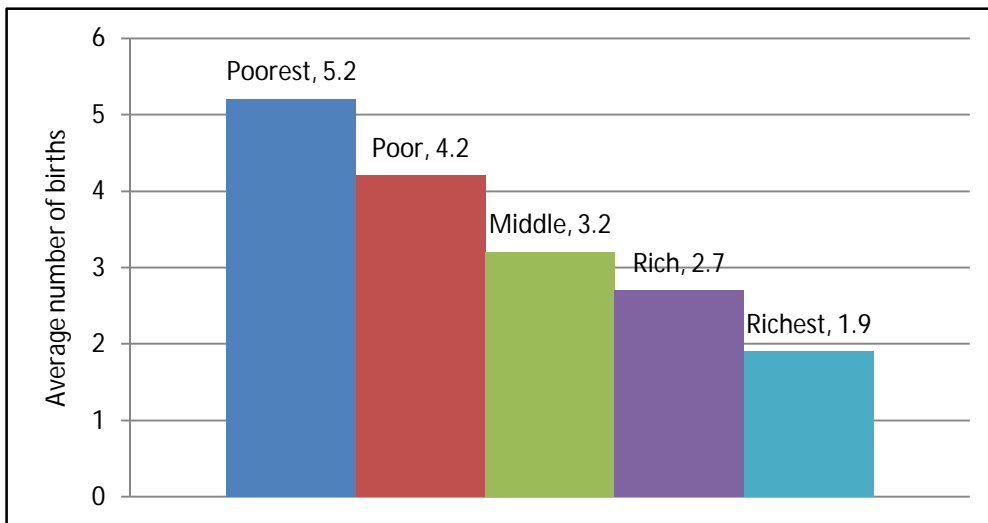
economic status increases, the TFR decreases (**Figure 8**). On average, a woman under the poorest quintile is likely to have 5 births while the richest quintile is only likely to have 2 births (National Statistics Office, 2008).

FIGURE 7. CRUDE BIRTH RATE BY GENDER, PHILIPPINES, 2000, 2006 AND 2009



Source: National Statistics Office

FIGURE 8. TOTAL FERTILITY RATE BY INCOME QUINTILE, PHILIPPINES, 2008



Source: National Demographic and Health Survey 2008

1.3.3. Disease Trends in the Philippines

The country's health profile depicts a distinct epidemiologic and demographic transition characterized by double burden of diseases consisting of communicable diseases (which require major public health intervention) and non-communicable diseases (which need expensive curative and chronic-care intervention). This scenario makes the country's health profile a "hybrid" or combination of health situations found in both developed and developing countries. Similar to Sub-Saharan Africa, many regions in the Philippines are still struggling to eliminate hunger and infectious diseases while continually battling on non-communicable diseases (NCDs) as experienced in developed countries. The health status of the country therefore can be best described to be at the crossroads of infectious and non-communicable diseases.

1.3.3.1. Communicable diseases

In the Philippines, eight out of the ten leading causes of morbidity or illness can be attributed to infectious diseases. Illnesses related to the respiratory system such as acute respiratory infection, pneumonia and bronchitis are the top 3 leading cause of illness as shown in **Table 10**.

TABLE 10. TOP TEN CAUSES OF MORBIDITY, PHILIPPINES, 2010

Rank	Disease	Number	Rate per 100,000 population
1	Acute Respiratory Infection	1,095,328	1203.0
2	ALRTI and Pneumonia	557,786	612.6
3	Bronchitis/Bronchiolitis	346,627	380.7
4	Hypertension	333,497	366.3
5	Acute Watery Diarrhea	322,799	354.5
6	Influenza	271,011	297.7
7	Urinary Tract Infection	82,867	91.0
8	TB Respiratory	73,614	80.9
9	Accidents	50,004	54.9
10	Injuries	35,396	38.9

Source: Field Health Services Information System, DOH

The country commits to control tuberculosis in response to the Millennium Development Goals (MDGs). Despite the aggressive campaigns initiated by the Department of Health (DOH) in collaboration with donor agencies, tuberculosis remains among the leading causes of morbidity and mortality in the country. HIV control is also one of the country's commitments to the MDGs. Though HIV prevalence of the country is less than 1 percent, HIV cases are increasing exponentially. Endemic diseases like malaria, schistosomiasis and filariasis are still prevalent in several regions. The country has also experienced cases of re-emerging infectious diseases, including new and emerging diseases because of various demographic and environmental factors.

1.3.3.2. *Non-communicable diseases*

Non-communicable diseases (NCDs) are increasing rapidly in the Philippines. In 2009, seven of the ten leading causes of death are non-communicable in etiology. Majority of the NCDs mortality cases (i.e. cardio-vascular diseases, cancer, chronic obstructive pulmonary disease and diabetes) as shown in **Table 11** are considered lifestyle-related. Around 75 percent of the total deaths can be attributed to NCDs which is similar to the estimates in most developing countries, and 30-50 percent occurred pre-maturely (below 60 years old) (Ulep, 2012). It is noteworthy that over-nutrition is increasing in the country while under-nutrition remains a problem especially in rural and poor areas. **Table 11** further provides data on deaths attributed to NCDs by gender without much difference except for accidents and injuries.

TABLE 11. DISTRIBUTION OF DEATHS BY CAUSE AND BY GENDER, 2008

Disease classification	Total		Male		Female	
	Number	%	Number	%	Number	%
Infectious diseases	81,821	17.73	46,465	17.29	35,356	18.34
Maternal and child health related	14,296	3.10	7,537	2.80	6,759	3.51
Ill-defined	16,010	3.47	8,048	2.99	7,962	4.13
Non-infectious in nature	349,454	75.70	206,714	76.92	142,740	74.02
CVDs	152,964	43.77	86,042	41.62	66,922	46.88
Cancer	49,047	14.04	25,341	12.26	23,706	16.61
Accidents and injuries	35,522	10.17	28,915	13.99	6,607	4.63
Diabetes	22,778	6.52	11,034	5.34	11,744	8.23
Chronic lower respiratory diseases	21,870	6.26	15,188	7.35	6,682	4.68
Chronic liver diseases and cirrhosis	6,774	1.94	5,293	2.56	1,481	1.04
Malnutrition	2,453	0.70	1,094	0.53	1,359	0.95
Mental disorder	762	0.22	579	0.28	183	0.13
Other diseases that cannot be classified as infectious	57,284	16.39	33,228	16.07	24,056	16.85

Source: PIDS Study on NCDs, 2011, Source of data: NSO 2008

Vulnerability factors associated with lifestyle-related diseases are also now prevalent in the country. Around 5 percent of the population are now considered to be obese, 10 percent are diagnosed with hypercholesterolemia and 24 percent are considered hypertensive. Moreover, most of these lifestyle related diseases share common risk factors (i.e. unhealthy diet, smoking, sedentary lifestyle and alcohol consumption). Over the years, there was an observable increase in the consumption of NCD implicated food items (i.e. saturated oil, sugar and fast food), and decrease in the consumption of complex carbohydrates like root crops and vegetables(Ulep, 2012).

Tobacco use is considered as one of the commonly shared risk factors of major NCDs like cardio-vascular disease, certain cancers and diabetes mellitus. Smoking is also a strong risk factor of chronic obstructive pulmonary disease and asthma. In a recent study using the 2008 NNS data, almost 31 percent

of the adult population are current smokers and 14 percent used tobacco in the past (Ulep, 2012). Comparing with the GATS in 2009, the prevalence rate is almost close at 28.3%. The prevalence of smoking is significantly higher among the poor adults. Alcohol is causally linked in varying degrees to cancers, cardio-vascular diseases, liver disease and pancreatitis. In the country, about a quarter of the adult populations are alcohol drinkers in 2008 (Ulep, 2012). Another study in 2009 indicates that almost half of the alcohol drinkers are adults (Department of Health, 2009).

Health Reform Initiatives in the Philippines

Health reforms in the Philippines build upon the lessons and experiences from the past major health reform initiatives undertaken in the last 30 years. The adoption of primary health care (PHC) approach in 1979 promoted participatory management of the local health care system. The goal was to achieve health for all Filipinos by the year 2000. It emphasized the delivery of eight essential elements of health care, including the prevention and control of prevalent health problems; the promotion of adequate food supply and proper nutrition; basic sanitation and adequate supply of water; maternal and child care; immunization; prevention and control of endemic diseases; appropriate treatment and control of common diseases; and provision of essential drugs. To implement PHC, EO 851 was issued in 1983 integrating public health and hospital services (World Health Organization, 2011).

The People Power Revolution strengthened the call for legitimate local representation. In early 1990s, RA 7160 or the Local Government Code (LGC) transferred the responsibility of health service provision to the local government units. The intention of LGC was to establish a more responsive and accountable local government structure. However, this has resulted to fragmentation of administrative control of health services between the rural health units and hospitals and between the different levels of political structure (World Health Organization, 2011). Prior to that, the Generics Act was adopted in 1988 to ensure adequate supply, distribution and use of generics thereby improving access to affordable drugs and medicines.

During that time, more than half of the population had no coverage, especially the poor, the self-employed and informal sector workers (World Health Organization, 2011). This led to the enactment of the National Health Insurance Act of 1995 or RA 9875 which aims to provide all citizens a mechanism for financial protection with priority given to the poor. It created the National Health Insurance Program “which shall provide health insurance coverage and ensure affordable, acceptable, available and accessible health services for all citizens of the Philippines.”

In 1999, the health sector reform agenda was launched as a major policy framework and strategy to improve the way health care is delivered, regulated and financed. With a battle cry of “*Kalusugan Para sa Masa*”, it was

designed to implement the reform package in the convergence sites. The five reform areas are: 1. public health; 2. hospital; 3. local health systems; 4. health regulations and 5. health financing (Department of Health, 2004). It was during this time that the DOH underwent a major organizational reform to pursue its new role as a result of the devolution. At the local level, the municipalities were joined together to form inter-local health zones (ILHZs) to optimize sharing of resources and maximize joint benefits from local health initiatives.

The operational framework of health sector reforms was adopted in 2005 and was called *FOURmula One for Health (F1)*. The objective was to undertake critical reforms with speed, precision and effective coordination directed at improving the efficiency, effectiveness and equity of the Philippine health system in a manner that is felt by the Filipinos especially the poor. The F1 organized health reform initiatives into four implementation components, namely: financing, regulation, service delivery and governance (DOHAO 2005-0023). This time also marked the enactment of two pieces of legislation: the Universally Accessible Cheaper and Quality Medicines Act of 2008 and the Food and Drug Administration Act of 2009.

However, despite the important progress made, successive reforms have not succeeded in adequately addressing the persistent problem of inequity.