Health Policy Notes

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"Health Sector Performance on Service Delivery: Have we Achieved Availability and Accessibility of Essential Health Care for all?"

Introduction:

Effective health service delivery rely on the availability of key resources - well equipped health facility, motivated staff, and adequate drugs - but it is also affected by the way the health services are organized and managed, and on the incentives that influence providers and users' behavior (WHO).

The devolution resulted to fragmented and highly politically-driven health service delivery, which widened inequity in health performance between the rich and poor local government units[1,2]. Health Sector Reform Agenda (HSRA) was introduced in 1999 to implement reforms in public health and hospital system. The objective of hospital reforms was to improve management of the Philippine hospital system. Public health reforms aimed to improve the organization and financing of priority public health programs. Considerable gains were achieved following the implementation of these reform initiatives: upgrading of LGU health facilities, income retention in all DOH hospitals, and corporatization of four specialty hospitals. Still these are just a fraction of interventions needed to achieve goodness and fairness in the health sector.

Grounded on the ideals of HSRA, the *Four*mula One for Health was launched as the implementation framework for health sector reform in 2005. Hospital and public health reforms were incorporated into service delivery pillar which objective is to ensure **availability** and **accessibility** of essential health for all. The following strategies were identified to achieve that objective: 1) Ensuring availability of basic and essential health service packages; 2) Assuring the quality of both basic and specialized health services; and 3) Intensifying current efforts to reduce public health threats by undertaking disease free zone initiatives, implementing intensified disease prevention and control, and enhancing health promotion and disease surveillance (DOH, 2007).

Implementation of Reforms on Service Delivery

Substantial investments were allocated to public health and hospitals to ensure implementation of reforms. The budget allocation for service delivery more than doubled from 2005 to 2009 (Figure 1). Thirty-eight percent of this is allocated for MDG programs.

The DOH organized the Policy and Standards Development Team for Service Delivery to ensure effective and efficient implementation of reforms on service delivery through the development of policies, standards and guidelines for health programs, and provision of technical assistance to health service providers. It consists of the National Center for Disease Prevention and Control, National Center for Health Facility Development, National Center for Health Promotion, National Epidemiology Center, Health Emergency Management Staff, Philippine National AIDS Council Secretariat, National Nutrition Council, Commission on Population, and Local Water Utilities Administration. The Field Implementation and Coordination Team consisting of Field Implementation Management Office, Centers for Health Development and the regional offices of DOH attached agencies is tasked to oversee and coordinate implementation of the reforms[3].

The main instrument to implement F1 reforms at the local level is the province-wide investment plan for health, initially implemented in the 16 F1 provinces since 2006 and rolled out to the 21 provinces in 2007. The rest of the provinces are currently developing their plans.

Assesing the Impact of Reforms

The aim of service delivery reform is to ensure availability and accessibility to essential health care by all Filipinos. Has the health sector achieved its objective? What are the impact on final health outcomes?

The status of reform implementation were taken from the accomplishment reports submitted by the different DOH offices and attached agencies. The National Objectives for Health indicators were also used to assess the progress made following the implementation of service delivery reforms. However it is limited by the non-availability of updated data. Additional information from literature and researches are therefore provided to supplement the analysis.

Part 1. Accomplishments in Health Service Delivery

Health Facility Reforms

1. **Rationalization of service delivery** – the uncoordinated efforts between public and private health providers, inefficiencies in the delivery of care, high cost of health care, weak primary curative care, and unregulated supply of health

[1] (Grundy, Healy, Gorgolon, & Sandig, 2005)
[2] (Lieberman, Capuno, & Van Minh, 2005)
[3] (AO 2005-0023)

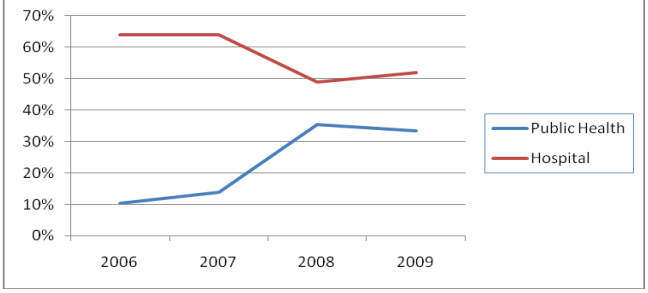
services triggered the rationalization of service delivery. Its primary principle is to provide access to the right facilities in the right places and with the right professionals based on health needs of the population. To rationalize health systems, it urges the provinces to analyze their health needs, health resources and deliver ouputs that are benchmarked against DOH standards reflecting all these in the rationalization plan. At present, sixteen F1 priority provinces, one roll-out province, (Albay) and one volunteer province (Occidental Mindoro) completed their rationalization plans.

2. **Upgrading the service capabilities of health facilities.** Upgrading of health facilities and capability of human resources are crucial to ensure quality of both basic and specialized health services. Since 2007 up to present, about P6.18B have been invested in upgrading national and local government hospitals and in upgrading Barangay Health Stations (BHS) and Rural Health Units (RHUs) nationwide.

3. **Augmenting management capacities of public hospitals** - Hospital governing boards are created as a mechanism to increase autonomy and managerial capacity of hospitals and to strengthen accountability over hospital performance. The governing boards were given power to manage, direct and supervise the properties, business, affairs and transactions of the hospital with corresponding liability in case of gross negligence or violation that could lead to loss or injury to the hospital. Four (4) hospitals have established their Governing Boards. These hospitals are Quirino Memorial Medical Center, Amang Rodriguez Medical Center, Ilocos Training and Regional Medical Center and Mariano Marcos Memorial Hospital and Medical Center.

4. **Income retention in public hospitals** - Income retention is implemented in all DOH hospitals through a special provision in the annual General Appropriations Act. The use of hospital income had contributed significantly to a more responsive delivery of quality health services since funds are readily available for day-to-day operations and for the purchase of hospital equipment. In 2008, cumulative hospital income reached Php 2.4B or an increase by 6% compared to previous year's income. As a result, budget for public health was increased from 2006 to 2008 since availability of other sources for hospital budget shifted portion of the hospital budget to public health services. There is however a slight decline in 2009 budget allocation for public health (Figure 2). This reform is still for implementation in devolved hospitals.

Figure 2. Trend of DOH Budget Allocation by Service Delivery Function



Public Health Reforms

1. **Reforms to rapidly reduce maternal and neonatal deaths -** The slow progress in achieving improved maternal health outcomes has caused the DOH to shift from risk approach which identifies high-risk pregnancies for referral during the prenatal period, to the Emergency Obstetric and Newborn Care (EmONC) approach which considers all pregnant women to be at risk of complications at childbirth. This new policy direction directs all births to be health facility-based and delivered by skilled birth attendants. A taskforce was created to oversee the implementation of the Maternal, Newborn and Child Health and Nutrition (MNCHN) Policy. To date more than 300 barangay health stations and rural health units are upgraded to provide Basic Emergency Obstetric and Newborn Care (BEmONC), selected hospitals are upgraded to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC), capacity of the professional providers of care were enhanced while traditional birth attendants (TBAs) are given a new role: from birth attendants to a member of the women's health team who will be in charge of tracking pregnant women to help them plan for their delivery.

2. **Public-private collaboration in service delivery** – this reform initiative aims to increase access to health services by engaging the private sector to deliver essential public health services. Some of the programs with the active public-private partnership include the National Tuberculosis Program which has the most advance public-private partnership with over a hundred Public-Private Mix for DOTS (PPMDs) for TB established all over the country. The DOLE-DOH-PRISM Partnership for Strengthening Support for Workplace Health Programs, which initiated family health programs in the workplace, is another showcase of public-private partnership. Others include: Coalition to Eliminate Lymphatic Filariasis Philippines (CELF), Zamboanga City Multi-Sectoral AIDS Council (ZCMSAC), La Union Medical Center Economic Enterprise for Sustainability and Development, and the most recent is the DOH partnership with private hospitals to treat leptospirosis cases after the massive flooding caused by Typhoon Ondoy and Pepeng.

3. **Performance-based budgeting for public health** – this reform aims to maximize government's limited resources by linking budget to specific output or outcomes. It sets the guidelines for prioritizing public health programs, adoption of performance-based budget allocation and execution for priority public health programs including the performance-based awards to LGUs. The Maternal, Newborn, and Child Health and Nutrition (MNCHN), and Reproductive Health

Programs implemented the performance-based grant facility. The reproductive health performance-based grant facility have already provided Php150 million grant to LGUs through the CHDs in 2008. To continuously reward LGUs for good performance, the DOH is implementing the MNCHN Grants Facility with a total of Php150 million for 2009.

4. **Improvement in the organization of public health program packages –** there are efforts to integrate interventions or strategies into a single package to improve efficiency in the delivery of health services. The vertical child health programs of skilled birth attendance, neonatal care, breastfeeding, expanded program for immunization (EPI), Integrated Management of Childhood Illnesses (IMCI), Infant and Young Child Feeding (IYCF), malaria prevention, and hygiene and sanitation were integrated into one child survival strategy which highlights the importance of providing a package of services for children to further decrease the under-five mortality rate (UFMR). The Philippine Integrated Disease Surveillance and Response (PIDSR) was introduced as strategy to harmonize all existing disease surveillance systems in the country for the purpose of strengthening the capacity of local government units in performing disease surveillance and response.

Ensuring availability of health services

1. **There is improvement in the availability of essential health services**

Based on the standards, hospital bed and BnB outlets seems to be adequate. The number of RHUs have also increased. The number of nurses corresponds to the standard (Table 1).

The DOH has shown its leadership in ensuring availability of the BnB outlets to ensure access of the Filipinos to affordable quality medicines. The number of BnB outlets have shown great progress as it increased three-fold since 2005. Majority of the regions have accomplished the 2010 target of 1 BnB for every 3 barangays (Table 2).

Traditional and alternative medicine are integrated and established in DOH-retained and other government hospitals like Philippine Orthopedic Center, Amang Rodriguez Memorial and Medical Center, Mariano Marcos Memorial Medical Center and Veterans Regional Hospital

The DOH have also provided technical experts, cash, assorted medicines and supplies in response to disasters and emergencies caused by Typhoon Frank in Region VI, Typhoid Outbreak in Calamba, Laguna, M/V Princess of the Stars sea tragedy, armed conflict in Mindanao, Typhoon Ondoy in NCR and Region 4A, and Typhoon Pepeng in Northern Luzon. The Philippines have also provided humanitarian assistance to other disaster-stricken countries.

2. **Availability of quality health services was ensured**

Patient safety is institutionalized as a fundamental principle of the health care delivery system in improving health outcomes. Continuing Quality Improvement (CQI) Program Committee was established in DOH Hospitals to continuously improve the quality of health care services in all of the DOH hospitals. To date, all DOH retained hospitals have functional CQI Program and Committee.

The National Voluntary Blood Services Program (NVBSP) rationalized more than 200 blood service facilities and centralized the testing in selected blood centers. The program also conducted facility mapping of blood service facilities vis-à-vis Basic/Comprehensive Emergency Obstetric Centers.

To ensure the availability of quality health facilities, about P6.18B were invested in upgrading national and local government hospitals and in upgrading Barangay Health Stations (BHS) and Rural Health Units (RHUs) nationwide since 2007 to 2009. This also includes the infrastructure and equipment of subspecialty capabilities in Heart, Lung and Kidney Disease in five (5) DOH-Regional Hospitals/Medical Centers in Luzon, Visayas and Mindanao.

To capacitate health providers, health service packages were developed and updated for evidence-based interventions for health programs and capacity building activities were conducted.

There is a 38% increase in the number of accredited health facilities from 2005 to the 1st quarter of 2009 while accredited health professionals increased by 7%. In 2008, 94% of DOH hospitals are Philhealth accredited.

Encouraging successes were observed at the first 16 F1 provinces with high levels of PHIC accreditation which suggest adequacy in infrastructure and competency of health human resources. Many health centers and RHUs are OPB and TB-DOTS accredited. Many are also preparing to have MCP and newborn package accreditation[4].

Ensuring accessibility to health services

1. **Efforts were undertaken to improve accessibility to health services**

Accessibility is the ability of a population to reach appropriate health services. Major factors that

[4] (EC Technical Assistance, 2009)

affect access include geographical location, financial capability and cultural factors.

On the average, a patient will take a little more than 30 mins to reach a health facility. Government health facilities are accessible (less than 30 mins) than private health facilities (more than 35 minutes)[5].

Philhealth benefit packages are expanded and now covers out-patient benefit package for malaria, TB DOTS, confirmed cases of novel Influenza A (H1N1) in humans, cost effective public health interventions for HIV, maternal care and newborn which includes immunization. Aside from Philhealth, the Person with Disabilities (PWD) are also entitled to 20% discount on medical and related products and services by virtue of the RA 9442 "An Act Amending the Magna Carta for Disabled Persons".

Latest data showed fewer patients have consulted traditional healers for birth deliveries compared to the preceding survey (FPS 2006). The availability and physical accessibility of health facilities have contributed perhaps to this behavioral change.

Impact of Reforms on Access and Final Health Outcomes

1. **Disease-Free Zones**
Areas that are disease-free for filariasis, schistosomiasis, leprosy and rabies have increased. Malaria is no longer on the top 10 causes of morbidity in 2008 and has even surpassed its 2010 target (Table 4). The availability of guidelines on diagnosis and treatment, cost-effective preventive strategies with wide coverage (Table 3), access to laboratory networks, and availability of malaria benefit package are the factors that contributed to the program's success.

2. **Intensified-Disease Prevention and Control**
The health sector demonstrated good performance on the Intensified Disease Prevention and Control Initiatives, since majority of the 2010 targets were achieved or even surpassed earlier than the deadline. The health sector performed well in terms of TB case detection rate since the 2010 target is achieved even before the expected time (Table 3). Access to PPMD facilities contributed in the success of the program. The Philippines maintained to be one of the few remaining low HIV prevalence country in Asia. The hospitals have the capability to provide supportive treatment to dengue cases hence; there is low dengue mortality rate. The Philippines remained bird-flu free and has effectively controlled and managed the Influenza A H1N1 cases with low case fatality (Table 4). DOH got high satisfaction rating (78%) for effective response against Influenza A H1N1 in June 2009 SWS Survey and got commendation from WHO for its 'swift and tireless' efforts in responding to the emerging threat.

3. **Healthy Lifestyle and Management Of Health Risks**
Morbidity rate from heart and vascular diseases is decreasing since 2005 (FHSIS, 2005-2008). The proportion of population with sustainable access to improved water source, and proportion of urban population with access to improved sanitation has **high** probability of achieving its MDG target levels by 2015 and is consistently on track in almost all of the regions[6].

4. **Reproductive Health Outcomes**
Child and maternal health indicators such as fully immunized children, exclusive breastfeeding, Contraceptive Prevalence Rate (CPR), and skilled birth attendance in a health facility have improved (Table 3). There are improvements in the maternal, neonatal, infant and child mortality rates as well as in the % of under-weight children, number of deaths of under-five children due to pneumonia and total fertility rate (Table 4). The Under 5 Mortality Rate (U5MR), Infant Mortality Rate (IMR) and prevalence of underweight children under 5 years of age have **high** probability of achieving its MDG target levels by 2015[7]: On a regional level, consistently on track in all seventeen regions is the target on U5MR and on track in almost all regions are targets on nutrition and IMR.

One of the strategies undertaken is the *Pantawid Pamilyang Pilipino Program (P4)*. The DOH collaborated with the DSWD's conditional cash transfer program that provides grants to extremely poor households to improve health, nutrition and education of children 0-14 years old by requiring the households to comply with conditions such as availment of pre and postnatal care, immunization and regular health check-ups of children 0-5 years old. The approval of the revised IRR for milk code provided "broader" powers to DOH to intensify its promotion of breastfeeding. The Mother-Baby Friendly Hospital Initiative is now part of Philhealth accreditation requirements for all hospitals to promote and support breastfeeding in all hospitals. The *Save the Children Report 2007* recognized the Philippines as number 1 among the 55 developing countries with best child health care program.

Table 1. RATIO OF HEALTH RESOURCES TO POPULATION

Indicators	Standard	Baseline	Latest data
Health facilities			
RHU: population ratio	1:20,000	1: 41,813 (2001)	1: 37,176 (2005)
Hospital bed: population ratio	1:1,000	1: 941 (2002)	1:943 (2007)
Health human resource			
Government physicians per 10,000 population at the LGU	0.5	0.4 (2005)	0.3 (2008)
Government nurses per 10,000 popn at the LGU	0.5	0.5 (2005)	0.5 (2008)
Government midwives per 10,000 popn at the LGU	2	2.05 (2005)	1.9 (2008)
Pharmaceuticals			
Botika ng Barangay: barangay ratio	1:3	1:9 (2005)	1:3 (2009)

Data Sources: FHSIS, BLHD, BHFS and NDP-PMU 50 reports
Note: 2005 population: 84,241,341; 2007 population:88,574,614; 2008 population: 90,457,200; 2009 population: 92,226,600

[5] (WHO, 2003)

[6] NSCB, 2008

[7] NSCB, 2008

Table 2. DISTRIBUTION OF HEALTH RESOURCES PER REGION

Region	Bed to population ratio (2005)	Physicians per 10,000 population (2008)	BnB to barangay ratio (2009)
NCR	1:766	0.5	1: 3
CAR	1:941	0.5	1: 3
I	1:2069	0.3	1: 3
II	1:1706	0.3	1: 5
III	1:2262	0.3	1: 2
IV-A	1:3336	0.2	1: 3
IV-B	1:1481	0.3	1: 2
V	1:1939	0.3	1: 10
VI	1:2013	0.3	1: 3
VII	1:1756	0.3	1: 6
VIII	1:1779	0.4	1: 7
IX	1:2222	0.3	1: 4
X	1:1975	0.3	1: 2
XI	1:3491	0.2	1: 2
XII	1:2766	0.3	1: 3
ARMM	1:5005	0.2	1: 9
Caraga	1:766	0.3	1: 4

Sources: FHSIS 2008, BHFS Report 2005 and NDP-PMU 50 Report 2009

Table 3. PERFORMANCE ON ACCESS, COVERAGE AND UTILIZATION INDICATORS

Indicators	2010 Targets	Baseline Data and Source of Data	Latest Status and Source of Data
DISEASE-FREE ZONE INITIATIVES			
Annual mass treatment coverage for filarial endemic provinces	85%	82% NCDPC, 2003	71.2% NCDPC, 2006
Insecticide treated net utilization	95%	81.8% NCDPC, 2005	95% NCDPC, 2009
INTENSIFIED DISEASE PREVENTION AND CONTROL			
Case detection rate of sputum positive cases*	70%	61% Source: NTP Accomplishment Report, DOH, 2002	76% Source: NTP Accomplishment Report, DOH, 2008
Cure rateof sputum positive cases*	85%	85% Source: NTP Accomplishment Report, DOH, 2002	83% Source: NTP Accomplishment Report, DOH, 2008
HEALTHY LIFESTYLE AND MANAGEMENT OF HEALTH RISKS			
Percentage of households with access to safe water supply *	94%	89.3% Source: National Demographic and Health survey 2003	82% Source: FHSIS 2008
Percentage of households with sanitary toilet facility*	91%	85% Source: National Demographic and Health survey 2003	77 % Source: FHSIS 2008
IMPROVING REPRODUCTIVE HEALTH OUTCOMES			
Proportion of children under 6 months that are exclusively breastfed	50%	33.5 percent Source: National Demographic and Health survey 2003	34 percent Source: National Demographic and Health survey 2008
Coverage of fully immunized children (FIC)	95% in every baran-gay	69.8% Source: National Demographic and Health Survey 2003	79.5% Source: National Demographic and Health Survey 2008
Contraceptive Prevalence Rate*	80%	48.9 Source: National Demographic and Health survey 2003	51% Source: National Demographic and Health survey 2008
Percentage of deliveries assisted by skilled birth attendants and in a health facility*	70%	37.8% delivered in health facilities 59.8% assisted by skilled birth attendants Source: National Demographic and Health Survey 2003	43.8% delivered in health facilities 61.8% assisted by skilled birth attendants (doctors, nurse and midwife) Source: National Demographic and Health Survey 2008

Note: * MDG indicators

Table 4. IMPACT ON FINAL HEALTH OUTCOMES

Indicators	2010 Targets	Baseline Data and Source of Data	Latest Status and Source of Data
DISEASE FREE ZONES			
Number of provinces declared as malaria-free	**13 Malaria-free provinces 5 more declared as malaria-free**	**13 malaria-free provinces Source: DOH Administrative Reports, 2004**	**Total of 22 malaria-free provinces Source: DOH Administrative Reports, 2007**
Number of provinces and cities with less than one case of leprosy per 10,000 population	Prevalence rate of less than one case per 10,000 population in 5 provinces and 8 cities	Five provinces and eight cities with prevalence of more than one case of leprosy per 10,000 population Source: NCDPC 2004	3 Provinces and 6 cities with less than one case of leprosy per 10,000 population. Source: FHSIS 2008
Number of provinces with schistosomiasis prevalence rate of less than one percent for five consecutive years	9 provinces	0 province Source: NCDPC, 2004	5 provinces Source: NCDPC, 2008
Number of provinces with prevalence rate of less than one case of filariasis per 1,000 population	6 provinces	0 province Source: NCDPC, 2004	2 provinces Source: NCDPC, 2008
Number of provinces with less than 0.5 cases of rabies per million population	7 provinces	0 province Source: DOH 2006	1 province Source: NCDPC 2008
INTENSIFIED DISEASE PREVENTION AND CONTROL			
Morbidity rate of Tuberculosis per 100,000 population*	137.3/100,000 population	174.6 Source: Field Health Service Information System 2000	273.0 Source: Field Health Service Information System 2008
Mortality rate of Tuberculosis per 100,000 population*	19.6/100,000 population	36.1 Source: Philippine Health Statistics, DOH, 2000	29.8 Source: NSO, 2005
Prevalence of HIV per 100,000 population	**Less than one case per 100,000 population**	**0.03 Source: Field Health Service Information System 2003**	**0.0168% Source: DOH-NEC estimates, 2008**
Incidence rate of dengue hemorrhagic fever (DHF) cases per 100,000 population	Less than 10 DHF cases per 100,000 annually	13 DHF cases per 100,000 Source: Field Health Service Information System 2004	14.5 DHF cases per 100,000 Source: Field Health Service Information System 2008
Percentage of deaths from dengue hemorrhagic fever (DHF) over the number of cases (as percent) of dengue	**Less than 1%**	**1.7% Source: National Epidemiologic Sentinel Surveillance System, 2004**	**0.9% Source: Philippine Integrated Disease Surveillance and Response, 2008**
Avian Flu Case fatality rate	**Less than 10%**	-	**0 cases Source: DOH**
Influenza A H1N1 case fatality rate	**Less than 10%**	-	**0.6% Source: Influenza A (H1N1) Surveillance Progress Report**

HEALTHY LIFESTYLE AND MANAGEMENT OF HEALTH RISKS			
Mortality rate from vascular diseases per 100,000 population	Less than 63.2 deaths per 100,000 population	63.2 Source: Philippine Health Statistics 2004	63.8 Source: NSO 2005
Mortality rate from COPD per 100,000 population	Less than 20.8 deaths per 100,000 population	20.8 Source: Philippine Health Statistics 2004	24.58 Source: NSO 2005
Mortality rate from diabetes mellitus per 100,000 population	Less than 14.1 deaths per 100,000 population	14.1 Source: Philippine Health Statistics 2004	21.63 Source: NSO 2005
Mortality rate from all forms of malignant neoplasm per 100,000 population	Less than 47.7 deaths per 100,000 population	47.7 Source: Philippine Health Statistics 2004	48.92 Source: NSO 2005
Morbidity rate from heart and vascular diseases per 100,000 population	Less than 65.7 cases per 100,000 population	65.7 Source: Field Health Service Information System 2006	36.4 Source: Field Health Service Information System 2008
Prevalence rate of hypertension	13.9%	22.5% Source: National Nutrition Survey 2003	25.3% Source: National Nutrition Survey 2008
Prevalence rate of adults with high fasting blood sugar	2.1 %	3.4% Source: National Nutrition Survey 2003	4.8% Source: National Nutrition Survey 2008
Prevalence rate of tobacco smoking among: Adolescents aged 13-15 years	Less than:15.0%	15.0% Source: GYTS 2003	22.0% Source: GYTS 2007
IMPROVING REPRODUCTIVE HEALTH OUTCOMES			
Neonatal mortality per 1,000 live births	10	17 Source: National Demographic and Health survey 2003	13 Source: Family Planning Survey 2006
Infant mortality per 1,000 live births*	17	29 Source: National Demographic and Health survey 2003	25 Source: National Demographic and Health survey 2008
Under five mortality per 1,000 live births*	32	40 Source: National Demographic and Health survey 2003	34 Source: National Demographic and Health survey 2008
Percent of underweight children under 5 years old*	21 percent or less	27.6 percent Source: National Nutrition Survey 2003	26.2 percent Source: National Nutrition Survey 2008
Mortality rate of pneumonia among under 5 year-old children	33 deaths per 100,000 under 5 year old children	66.11 deaths per 100,000 under 5 year Source: Philippine Health Statistics 2000	37.99 per 100,000 under 5 year Source: NSO 2005
Maternal Mortality Ratio per 100,000 live births*	90	172 Source: National Demographic and Health survey 1998	162 Source: Family Planning Survey 2006
Total Fertility Rate	2.1	3.5 Source: National Demographic and Health survey 2003	3.3 Source: National Demographic and Health survey 2008


means the target or standard has been achieved or even surpassed


means there is progress but the 2010 target or standard is not yet achieved


indicates no improvement or even deterioration from the baseline.

Part 2. The Challenges, Issues, and Gaps

Issues in the implementation of Service Delivery Reforms

1. Implementation of the national health programs at the local level has become complex due to devolution. There is varying LGU support in localizing health policies and programs as well as variation in the LGUs' capacity to implement these policies and programs. Although some LGU have accepted the challenge of local health governance, there are still some misperceptions on what health services the LGU should deliver. For instance, primary health and maternity health care are effectively implemented in most of the RHUs in Ilocos Sur but communicable and non-communicable control services are not since most of the health workers thought that the Department of Health has the responsibility to implement such programs[8].

2. "Public-private partnership is confined to few programs and components in the health system. Systematic utilization of the advantages in the private sector, the management of performance and of risk among private providers is still deficient. The conspicuous lack of targeted subsidies reflects how unmindful DOH is of the private sector. Consequently, there is no systematic collection and analysis of data on performance of private providers. There are no deliberate studies of the advantage and risks of the sector for each program, and there are no plans laid out for managing them to improve health system outcomes. The private sector thus, in most cases, operates independent of the public sector, after licensing, accreditation and certifications are dispensed."[9]

3. Some of the strategies implemented have minimal effect on health outcomes. Focusing on a particular strategy without addressing issues in the health system is not enough to improve health. The readiness of the health facilities, drug supply, and health providers in a broader context were considered rarely in the development of protocols or guidelines, or seldomly assessed in connection with the achievement of specific health outcomes.

4. There are many strategies that are done independently and without complementarity with other health programs. Planning, costing, data collection, training and monitoring are done

[8] (Bueno, 2008)
[9] (David and Geronimo, 2007)

programmatically at the national level even there are areas for collaboration and integration.

5. Efficient mechanisms were not successfully implemented to ensure effective utilization of service delivery funds. Bottlenecks in the procurement and in fund releases were observed. Only few programs implement performance-based budgeting for public health. Performance-based budgeting for hospitals, which aims to link hospital performance with budget allocations, is not fully implemented since the lack of concrete mechanism elicit reactions from the DOH retained hospitals.
6. Adjustment to new opportunities and challenges is sluggish. Service packages for special groups such as isolated and displaced population, indigenous population, call center agents and returning OFWs are few, if not yet in place. Another example is the proliferation of food supplements in the market where the DOH has not taken a clear action.

7. Information essential for decision-making and policy-making are insufficient because it is either not collected, or data received were not being processed or analyzed. The knowledge-based decision-making at the sub-national level is even weaker. While there is a huge amount of data being generated at all levels, few of them are accessible to the DOH[10]. On the other hand, data can be confusing since one indicator can have several sources. This only reflects how fragmented the health information is.

8. It was perceived that the current health promotion efforts seem to be less effective. The current health promotion program of the DOH is more focused on providing health information and promoting awareness through health campaigns. Despite that, desired behavioral change is not apparent. Example is the exclusive breastfeeding which is very low despite of the existence of the milk code and the cost-effectiveness of the intervention. Furthermore, health messages are developed and disseminated by a multitude of stakeholders that are sometimes inconsistent with DOH policies, guidelines and health promotion messages. Advocacy efforts to interest groups, health providers, local chief executives and policy makers are very minimal if at all present.

Gaps in the availability of health resources

1. **On the distribution of health resources:**
   - On the average, the hospital bed to population ratio meet the standard. However, when you look closely at the regional data, only NCR, CAR and Caraga Regions meet the standard which comprise the 35% of the total hospital beds (Table 2).

   - There is glaring shortage in the number of health professionals at the local government units (Table 1). The phenomenon of outmigration of health professionals yielded increase in the production of nurses but not in the number of plantilla positions at the LGUs. For instance, ARMM has only 76 plantilla personnel, as compared to CHD Zamboanga with 321 regular personnel although it has a smaller geographical area and population than ARMM[11]. Another problem is the high number of unfilled positions. The lack of doctors is evident across the different regions in the country except for the NCR and CAR (Table 2). But there is more serious shortage on specialists like anesthesiologist in many LGU hospitals[12].

Note, however, that the latest available data could not directly reflect the impact of the implementation of certificate of need and rationalization of health facilities which were implemented beginning in 2006. An evaluation using 2010 data once available is recommended to assess the impact of reforms to the availability of health resources.

2. **On ensuring availability of quality health services:**

   - Monitoring the performance and ensuring the compliance to standards by the gamut of laboratory and health provider networks are weak. Variation in quality of diagnosis and treatment is still observed in all levels of care.

   - Most public health programs have program manuals and program guidelines which may prescribe service packages and protocols for service delivery of public health services in government primary health care facilities (BHS, RHUs or Health Centers). However, few would have such standards for 1st to 3rd level hospital, when required, and even fewer for private providers[13]. In addition, available policies/protocols are disseminated but are not available at health service level.

   - There are many capacity building activities for implementing policy, but are less organized and systematic[14]. Health workers were taken away repeatedly from their workstations to attend different kinds of trainings. Health providers in government health facilities for the most part were engaged in trainings and administrative work[15].

   - Top three regions with few Philhealth accredited hospitals in relation to their population size is ARMM, VI, and VII while Regions IVA, NCR and III got the highest number of Philhealth accredited hospitals.

[10] (David and Geronimo, 2007)

[11] (MHSPSP, 2008)
[12] (EC Technical Assistance, 2009)
[13] (David & Geronimo, 2007)
[14] (David & Geronimo, 2007)
[15] (Tolabing, 2008)

- Hospitals are still admitting high proportion and getting referrals on primary cases despite of having accredited as tertiary level hospitals. It is reflected on the top 100 Philhealth reimbursements on hospital admisions where persistently high levels of ordinary cases were reimbursed even by highly specialized health facilities[16].

- The upsurge of Influenza A H1N1 and leptospirosis cases showed that the Philippine hospitals' capacity to

  respond to health emergencies and outbreaks are not enough. The capacity to handle such cases are limited leading to congestion of these few hospitals.

Challenges in achieving universal access to health care

Geographical, financial and cultural barriers continue to impede equitable access to essential health services.

- Several areas have limited access to health services. While primary health care facilities are almost distributed in all regions, tertiary level facilities are limited, 1/3 of which are located in the NCR. The notion that the government hospital used to promote social equity does not hold true as government hospitals are significantly less in impoverished regions in the country[17].

- Capacity to pay is the single most important barrier to health care. Almost half of Filipino's total health expenditure comes from out-of-pocket. Philhealth only covers 11% of the total health expenditure (PNHA, 2005). This is a serious concern especially for the 30% of Filipinos living beyond the poverty line (Poverty Survey, 2006).

- Although there are different Philhealth benefit packages, members have low awareness on Philhealth benefits. The lack of awareness on Philhealth benefits is one of the main factors that resulted to low utilization of the OPB package[18], [19]. Furthermore, less than 50% of hospital admissions are covered by Philhealth even at provinces where Philhealth coverage is high (>80%). This is maybe an indication of discrepancy in the counting of the insured households[20].

- Cultural barriers to health care are still present. A segment of population even now relies on untrained birth attendants or *hilots* and herbal doctors or *albularyo* for their health. More than 1/3 of the birth deliveries were assisted by *hilots*. This is more evident in rural areas than in urban areas (FPS 2006). ARMM for instance trust *hilots* more than the professionals[21].

[16] (Caballes, 2009)
[17] (Caballes, 2009)
[18] (Alcantara, Duyongco, Feir, Ferraris, & Yap, 2009)
[19] (Valera, 2008)
[20] (EC Technical Assistance, 2009)
[21] (Oliveros, 2007)

Access and Final Health Outcome Indicators with Poor Performance:

1. **Disease-Free Zones.** Mass treatment coverage for filariasis has declined (Table 3) since there is difficulty in persuading people not ill to take the drugs[22]. Although malaria is no longer on the Philippines' top 10 leading causes of morbidity in 2008, some regions still have malaria on the list specifically Region II, IV-B, and 12. Rabies is still prevalent in Regions 1 and 7. Schistosomiasis is still high in Regions 8, 9, and Caraga (FHSIS 2008).

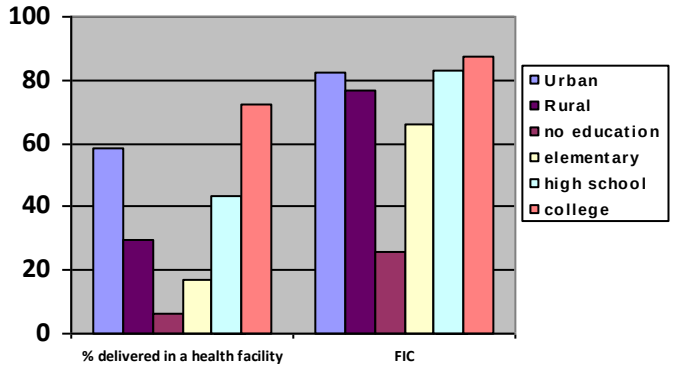
2. **Intensified-Disease Prevention and Control.** Although TB case detection rate has improved, TB cure rate declined from its baseline (Table 3). Majority of TB symptomatics prefer to self-medicate rather than consult health professionals. Private pharmacies remained to be the source of anti-TB drugs for approximately 40% which is dependent on the patient's financial capacity, potentially jeopardizing uninterrupted supply required by DOTS (NTPS, 2007). The availability of PPMD accredited facilities were translated to high TB case detection rate but not to high cure rate thus leading to high TB morbidity rate (Table 4) and MDR-TB cases. The issue of ensuring the supply of free anti-TB drugs at the point of service is a vital element of success to lower the mortality incidence due to TB. Dengue cases have also increased and become an all year-round threat due to climate change, poor water disposal system and urbanization. HIV is described as "hidden and growing" but there is a possibility that this will "expose and explode" since it is increasing among most-at-risk groups.

3. **Healthy Lifestyle And Management Of Health Risks.** The health sector also failed to improve access to safe water supply and sanitary toilet facility (Table 3). Access is hampered by high cost of capital investment with government's inability to finance water and sanitation services[23]. Sanitation does not get enough and appropriate attention to PIPH as the LGUs address this by simply programming the distribution of bowls without systematic problem analysis and site-specific investigation, which may be indicative of lack of national program guidance or lack of creative approaches to deal with the problem[24]. The human resources that implement and monitor implementation of sanitation code at the local level are also deficient.

   The final health outcomes on lifestyle related diseases demonstrated the inadequacy of efforts to reduce lifestyle related diseases. All of the indicators deteriorated from its baseline data

[22] (PIR, 2007)
[23] (Health Policy Notes Volume, Issue 5, 2008)
[24] (EC Technical Assistance, 2009)

Figure 3. Distribution of births delivered in a health facility and FIC by residence and educational level (NDHS, 2008)



except for the heart and vascular disease rate (Table 4). There is failure to change the behaviors of Filipinos to adopt healthy lifestyle. Majority of the Filipinos are practicing unhealthy habits, and behaviors such as smoking have increased. Most non-communicable diseases are catastrophic diseases which will greatly impact on the patient's economic condition while Philhealth's contribution is minimal to protect the patient from impoverishment. The health sector commitment to reduce the mortalities due to non-communicable diseases is expressed in the MDGmax initiative (NHSM Resolution No. 2008-03-01) which strategies need to be defined and operationalized at all levels of care.

4. **Improving Reproductive Health Outcomes.** Recent data reveals that both residence area and educational level are still critical determinants of access to health services. People living in rural areas have lower % of births delivered in a health facility than in the urban areas. Women of higher educational attainment tend to deliver in a health facility than those with lower educational background. The same observations are true for the FIC (Figure 3). The contraceptive prevalence rate of non-poor married women was higher by 5% than the poor married women (FPS, 2006).

While recent data on child health indicators are nearer the 2010 targets, MMR only improved slightly (Table 4), so without effective intervention given its current trend, MDG target for MMR, which is 52 per 100,000 live birth, is a distant possibility. The implementation of the policy on Maternal, Newborn, and Child Health and Nutrition (MNCHN) issued in 2008 is therefore of utmost importance. Available data reveal significant regional differentials in neonatal, infant and underfive mortality rates. Neonatal mortality rate is highest in MIMAROPA, followed by CAR and Davao. Infant and under-five mortality rates are highest in MIMAROPA, ARMM and Zamboanga (Table 5).

Table 5. Neonatal, Infant, and Under-Five Mortality Rates for the 10-Year Period and Total Fertility Rates for 3 Years Preceding the Survey, by Region, Philippines, 2006

Source: National Statistics Office, 2006 Family Planning Survey

REGION	Rate Per 1000 Livebirths			TFR (%)
	NMR	IMR	UFMR	
2010 NOH TARGET	10	17	32	2.1
Philippine average	13	23	31	3.2
NCR	12	19	24	2.6
CAR	16	26	31	3.2
I – ILOCOS	15	26	30	3.0
II – CAGAYAN VALLEY	14	25	30	2.8
III – CENTRAL LUZON	13	19	22	2.7
IVA – CALABARZON	13	19	24	2.9
IVB – MIMAROPA	19	34	45	4.1
V – BICOL REGION	14	25	38	4.1
VI – WESTERN VISAYAS	11	18	25	3.3
VII – CENTRAL VISAYAS	11	20	30	3.3
VIII – EASTERN VISAYAS	14	31	43	3.9
IX – ZAMBOANGA PENINSULA	13	32	44	3.7
X – NORTHERN MINDANAO	10	22	29	3.4
XI – DAVAO	16	26	33	3.4
XII - CENTRAL MINDANAO	12	21	33	3.4
XIII – CARAGA	10	25	35	3.7
ARMM	10	33	45	3.1

Note: Table lifted from SPR, 2007; analysis used the following legend:

Attained 2010 Target	*Reached Nat. Ave. or better*	*Attained lower than Nat. Ave.*

5. **MDGs.** Based on current performance, there is uncertainty that the Philippines will be able to accomplish 50% of the MDG targets by 2015.
   - Indicators with **low** probability of achieving its goals include: Proportion of 1-year old children immunized against measles; Maternal Mortality Ratio; Contraceptive prevalence rate; and Death rate associated with tuberculosis.
   - Those with **medium** probability of achieving its goal are: Percent of household with per capita energy less than 100% adequacy; Proportion of births attended by skilled health personnel; and Prevalence associated with tuberculosis.
   - On a regional level, consistently off-track were the following: dietary energy intake, maternal mortality ratio, and contraceptive prevalence rate.

Recommendations:

The top priority of the health system must be to improve performance distribution.

- Variations in the availability of health resources, reaching the poor and the vulnerable, and health outcomes must be addressed. Approaches to reach the unreached (i.e. GIDA, IPs, other special population groups) must be developed and operationalized.

- Prioritize resources to areas that are hard to reach and isolated, poorly performing and unable to meet targets.

- The social health insurance as an instrument to reduce financial barriers must make more dent in reducing the out-of-pocket share in total health expenditures.

Public Health Development

- Sustain funding for the MDG commitments. Ensure the continuity of implementation of the MNCHN strategy, and intensify implementation of the strategies for nutrition, child health, TB, HIV, malaria, sanitation, and access to low cost quality drugs.

- Intensify efforts to promote behavioral change to reduce the mortality related to lifestyle-related diseases.

- Health promotion efforts must advance beyond health communication. Lobbying and negotiation skills must be strengthened to effectively influence health service providers, local chief executives and legislators to support the implementation of health programs and reforms.

- Adequate assistance must be provided to the local government units in the form of comprehensive and enforceable service packages, training packages, establishment and upgrading of national reference centers for quality assurance, and expert groups. Incentive schemes for good performance must be sustained.

- Ensure efficient and effective utilization of public health resources by addressing the bottlenecks in utilization such as procurement and fund releases, and through the implementation of performance-based budgeting on public health. Link and leverage performance-based grants and fund transfers on public health to final and intermediate outcomes through the Province-wide Investment Plan for Health and LGU Scorecard.

- Areas for integration must be identified and clear mechanism must be established for its operationalization. Cross-cutting areas must be mainstreamed.

- Public-private partnership must be highlighted as a strategy in expanding the coverage of health programs. The DOH must provide guidance through comprehensive service packages which incorporates private sector participation.

- Develop an integrated system for the collection and publication of hospital and public health statistics from public and private health facilities. Collaboration with research and resource centers must be enhanced for evidence-based policymaking on service delivery. Epidemiology and surveillance units must be established in all provinces and municipalities/cities.

Health Facilities Development

- Variation in the quality of health services must be addressed. Efforts on health facility and human resource upgrading must be continued. Capacity of hospitals during disasters and emergencies must be enhanced.

- Gatekeeping function of primary health care facilities must be improved to free-up higher level hospitals of primary cases that can be managed at the lower level of care.

- Hospitals must intensify the provision of promotive and preventive care to patients on top of the curative care for a holistic health care provision. Incentive mechanisms must be established for health facilities with strong public health programs such as MBFHI.

- Build on the gains of reform and pursue the full implementation of the existing reform policies: performance based grant for hospitals, rationalization of health facilities, income retention in public hospitals including devolved hospitals, and upgrading of capacities of health facilities. A strategy that would bring about rational allocation and efficiency in the use of the 100% income retention among retained hospitals must be established. Adherence of retained hospitals to the Policy on Performance-based Budgeting for DOH Retained Hospitals must be pursued.

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References

1. Alcantara, M., Duyongco, K., Feir, M., Ferraris, K., & Yap, M. (2009). *A Case-Control Study of the Factors Influencing Utilization of the Outpatient Benefit Package and a Descriptive Study of Drug Utilization by Philhealth Sponsored Program Beneficiaries in Moncada, Tarlac.* Quezon City: Ateneo de Manila University.

2. Bueno, C. (2008). *The General Assessment of Local Governance on Basic Services and Facilities in the Implementation of RA 7160 in Ilocos Sur.* Retrieved October 2009, from The Free Library: http://www.thefreelibrary.com/The+General+Assessment+of+Local+Governance+on+Basic+Services+and...-a01073900062

3. Caballes, A. (2009). *An Appraisal of the Policy Environment for the Philippine Hospital Sector Development.* (unpublished).

4. David, L., & Geronimo, M. A. (2007). *Sectoral Performance Review. Performance Assessment of Fourmula One for Health.* Department of Health: (unpublished document).

5. EC Technical Assistance. (2009). *Midterm Review on the Health Sector Policy Support Programme.* Manila: Department of Health.

6. Grundy, J., Healy, V., Gorgolon, L., & Sandig, E. (2005). *Overview of the Devolution of Health Services in the Philippines. Rural and Remote Health.* Retrieved October 2009, from Philippine Center for Investigative Journalism: http://www.pcij.org/stories/2005/devolution.pdf

7. Health Systems 2020. (n.d.). *Chapter 8 Health Service Delivery Module. Health Systems Assessment Approach: A How-to Manual.* Retrieved October 2, 2009, from Health Systems 2020: http://www.healthsystems2020.org/userfiles/file/Chapter_8.pdf

8. Lieberman, S., Capuno, J., & Van Minh, H. (2005). Decentralizing Health: Lessons from Indonesia, the Philippines, and Vietnam. In *East Asia Decentralizes.* World Bank.

9. Mindanao Health Sector Policy Support Programme. *Human Resources Situational Analysis.* Manila. GRM International BV.

10. Oliveros, Y. (2007). Reactions on Parallel Session 6: Service Delivery 2. *Proceedings of the 8th National Forum on Health Research for Action.* Manila: HPDPB-Department of Health.

11. Tolabing, M. C. (2008). Field Health Facilities: Time Utilization Pattern of Health Providers and Activity Standards. *Proceedings of the 9th National Forum on Health Research for Action.* Manila: HPDPB-Department of Health.

12. Valera, M. (2008). Enhancing Philhealth Packages: OPD Evaluation. *Proceedings of the 9th National Forum on Health Research for Action.* Manila: HPDPB-Department of Health.

13. WHO. (2003). *World Health Survey: Report of Philippines.* Geneva: WHO.