



2008 BUDGET BRIEFER

CONGRESSIONAL PLANNING AND BUDGET DEPARTMENT

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CLOSING THE HEALTH INEQUALITIES GAP*¹

“Because ill-health traps people in poverty, sustained investment in the health of the poor could provide a policy lever for alleviating persistent poverty,”

- World Health Report, 1993

HEALTH INEQUALITIES AND POVERTY

Focus on the health of the poor has become a global priority concern because of the widening health inequalities [across and] within developing countries. This shift of policy attention was drawn from the knowledge that health patterns are always to the disadvantage of the poor—they die earlier and have higher levels of mortality (WHO, 2002; Wagstaff, 2002).

The increasing gaps in health outcomes have raised doubts about the capacity of developing countries to meet their commitments in the Millennium Development Goals (MDGs) in 2015². In fact, recent MDG progress reports indicate large portions of the Asian region are already behind on their social indicators (e.g. health and education) with some of the biggest deficiencies occurring among the poorer segments of the population.

Despite improvement in national averages of life expectancy and mortality rates in many developing countries, it is important to stress that health disparities between different population groups within countries remain large. For example, in most Southeast Asian countries, the probability of under-five mortality rate in the lowest wealth quintile is three times more than that of the richest wealth quintile (WHO, 2007). Likewise, evidence of health service consisting basically of primary health care interventions, indicates that the lower the group’s economic status, the less it uses health services.

¹ This paper was prepared by Director Novel Bangsal. The report benefited from the inputs provided by Executive Director Emmanuel Miral, and from valuable comments of Director-General Rodolfo V. Viceria.

² Three out of seven MDG goals are directly related to health. These are reducing infant and child mortality, reducing maternal mortality, and providing access to reproductive health services.

Apparently the burden of ill-health does not only affect the poor disproportionately, it also causes poverty³. Without adequate social protection, out-of-pocket outlays for serious illness can push poor households into a poverty trap by forcing them into debt or into the sale or mortgaging of productive assets such as land.

Because disease weighs so heavily on poverty reduction, investing in health is therefore an important component of an overall development strategy. Clearly the impact of scaling-up public health expenditures would lead to better health outcomes and more protection for the poor from fiscal shocks associated with illness. According to the World Bank estimates, for developing countries, a 10% increase in public health expenditures as a proportion of GDP would be associated with a 7% decrease in maternal mortality rate, 0.69% decrease in child mortality, and 4.14% decrease in low weight for children under five years of age.

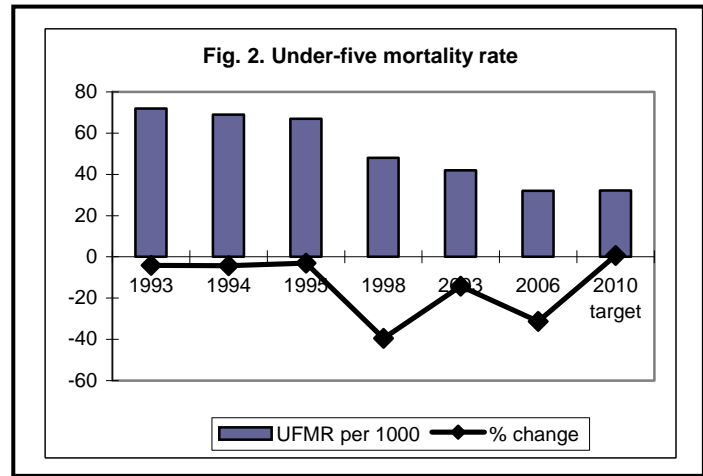
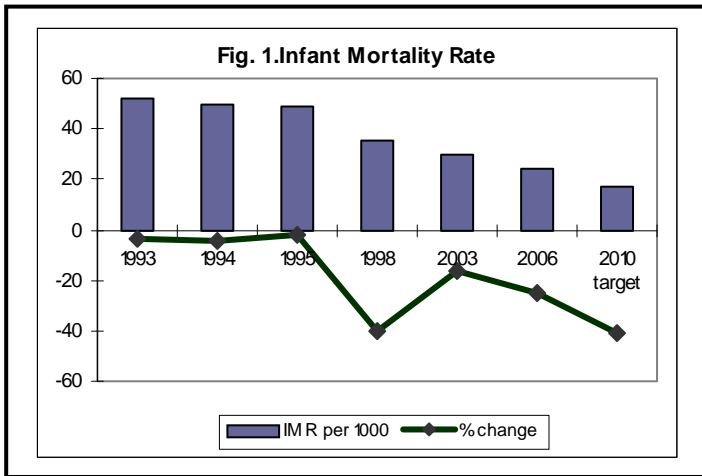
No amount of public health expenditure, however, will improve sector outcomes if the money is spent ineffectively to begin with. More than anything else, it is the composition and the ways in which the expenditure is allocated and targeted that matter for health outcomes. Cost-effective health activities, e.g. immunization programs that yield high marginal improvements for child mortality, should be given more government attention. Thus, it is imperative that any scaling up of public health interventions should be crafted in such a manner that the government is able to get the biggest marginal gains, especially from the poor, in order to improve its prospects of meeting the MDG health targets by 2015.

HEALTH STATUS AND TRENDS: LOOKING AT SPATIAL INEQUALITIES

Although modest overall gains were achieved in life expectancy and child survival during the last five years (2000-2005), inequities in health status and in health systems between poor and non-poor groups in the country have persisted, and regional disparities have been widening. This could be related to the dim prospects of the country in achieving crucial human development targets, particularly those relating to maternal health status.

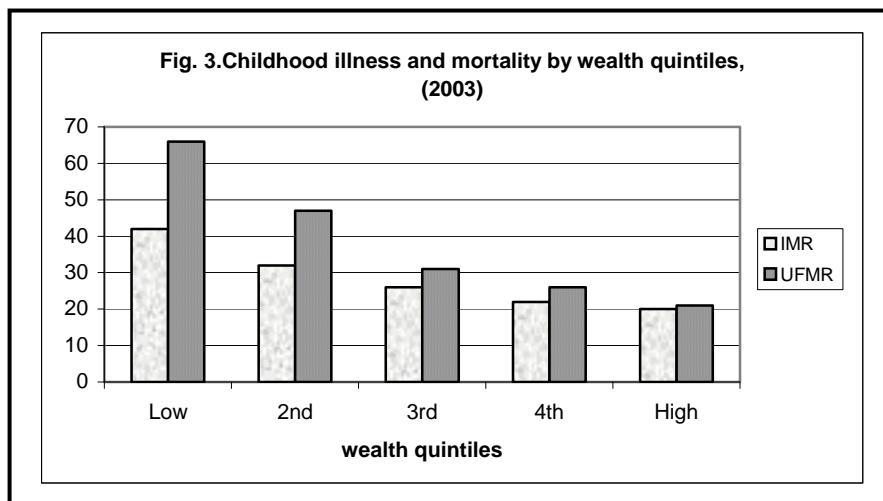
There is some good news of course. Results of the 2006 Family Planning Survey (FPS) show an improvement in the infant mortality rate (IMR) and the under-five mortality rate (UFMR) from 1993 to 2006. Infant mortality fell to 24 deaths per 1000 live births in 2006 from 52 deaths in 1993 or a 54% reduction from that period. Similarly, child mortality decreased to 32 deaths per 1,000 live births in 2006 from 72 in 1993 or 55% reduction.

³ *In Bangladesh, it is reported that sickness is the single most important cause of default among Grameen Bank loan recipients. In China, the country that has lifted more hundreds of millions out of poverty in a shorter time than any time in human history, inadequate access to health care is the single most important cause of households returning back into poverty (Eliya, World Bank, 2007)*



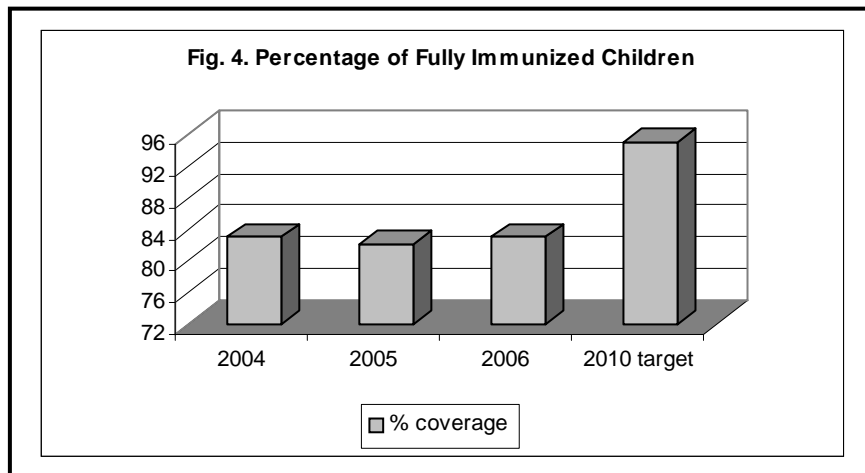
Sources: National Demographic and Health Surveys 1993, 1998 and 2003 and Family Planning Survey 2006

As with all indicators, national averages mask differences among socio-economic and regional groups. The disparity of health status among income groups is evident: the IMR among the poorest quintile of the population is more than twice the level of the richest quintile, and more than thrice for under-five mortality rate. (*Gwatkin et al, World Bank, 2007*). Inequities in health status also result from location differences. For example, the richest quintile in rural areas has an IMR that is twice that in urban areas. Geographic-wise, there were regions that in 2006 had infant mortality rates exceeding the national average of 24 deaths. These were Cordillera (29), MIMAROPA (32), Bicol (26), Eastern Visayas (29), Zamboanga (38), Davao (28), CARAGA (28), and the ARMM (31).



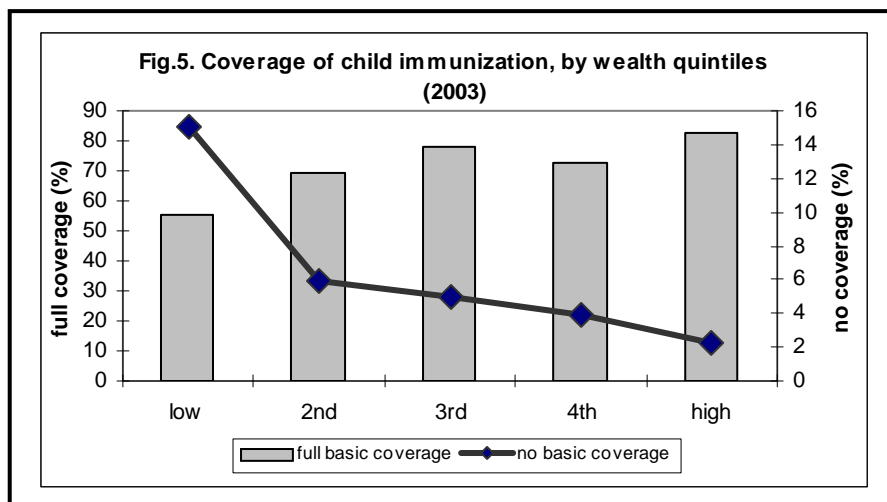
Source: Gwatkin et al, World Bank, 2007

Improvement in the national averages of child health outcomes—in terms of lower infant and child mortality rates—have been attributed to the immunization program of the government since the 1990s which at that time was able to achieved a 90% coverage of fully immunized children (FIC).



Source: 2006 Family Planning Survey

However, recent data indicate the proportion of FIC has drastically declined to 69.8% in 2003 but slightly recovered to 82% from 2004-2006. When cross-national data is applied, findings show that immunization programs disproportionately benefits the richest quintile than the poorest quintile; and that about 15% of the children in the poorest quintile has no basic coverage compared to only 2% in the richest quintile (*Gwatkin et al, WB 2007*). The decline in immunization coverage can be dangerous, considering that the gains in morbidity and mortality reduction especially in infants, recorded for the different vaccine-preventable diseases need to be sustained to pursue disease elimination goals in the medium-term.



Source: Gwatkin et al, World Bank, 2007

The disproportionate number of infant mortality among poor households is borne by the environmental risk and hazards that the poor mostly endure in their living areas. The major causes of child deaths in developing countries, in particular in South Asia and Southeast Asia, reveal the link between child mortality and poverty. About 41% of children's deaths in the region are found to have been caused by only four diseases, namely: acute respiratory infections (19%), diarrhea (18%), measles (3%), and HIV/AIDS (1%). A large proportion of these are largely contracted and transmitted in conditions of poverty such as crowded living quarters, malnutrition, vitamin A deficiency, indoor and outdoor air pollution, unsafe drinking water, and improper sanitation (*WHO, 2006*).

The maternal mortality rate (MMR) is high in the Philippines, despite having dropped from 209 deaths per 100,000 live births in 1993 to 162 in 2006. Though the decline continued, it was at sharply diminishing rate. Of the MDG health targets, the goal in maternal health has been identified as the least likely to be achieved in 2015.

On maternal care, the results of the 2003 National Demographic and Health Survey (NDHS) indicate that 87.6% of women received antenatal care; 70.7% had at least one tetanus injection; and about 76.8% of women were given iron supplements. While this represent adequate coverage, there is marked difference in access across region and income groups. Note that the burden of maternal mortality is weigh more against the poor because of higher adolescent fertility. The adolescent fertility rate in the poor is over ten times that in the richest quintile, exposing poor women by tenfold the lifetime risk of maternal death (*World Bank, 2004*). Despite this imbalance, over 90% of women from the poorest quintile gave birth at home while a mere 20% of the richest quintile had home births (*WHO Fact Sheet, 2007*). More so, less than 20% of poor mothers were assisted during delivery by trained health professionals, e.g., a doctor, nurse or midwife, while more than 80% of mothers from richest quintile received assistance.

Across region, the MMR for the ARMM was 320 in 1998 nearly three times the rate in Metro Manila (*ADB, 2005*). Regional variations indicate that the ARMM again had the lowest proportion of women receiving these reproductive services. Only 40% of all births were delivered in a health facility, though 60% were attended by a skilled health care professional.

Some advances have been made in curbing infectious disease in the Philippines, but tuberculosis remains a major problem. The World Health Organization (WHO) classifies the Philippines as one of 22 high-burden countries, and ranks it 8th in the world in terms of estimated incidence with 320 cases per 100,000 persons. Tuberculosis mortality in the Philippines is 54 per 100,000 persons (*WHO, 2004*).

Quality health care services, both preventive and curative, are the cornerstone for building human capital in the area of health. The 2002 Annual Poverty Indicator Survey (APIS) showed that the health facilities most utilized by the bottom 40% income bracket were the public rural health units in both rural and urban areas. The poor tend to go to government-run primary facilities rather than private clinics or hospitals for their health needs. Private health facilities are often prohibitively expensive, and access is a major problem: quality private health care is centered in urban areas.

TABLE I
FAMILIES IN THE LOWEST 40% INCOME BRACKET WITH AT LEAST ONE MEMBER WHO VISITED ANY HEALTH FACILITY IN THE LAST 6 MONTHS, BY TYPE OF HEALTH FACILITY VISITED, 2002 (%)

	<i>Philippines</i>	<i>Urban</i>	<i>Rural</i>
Government Hospital	8.1	9.6	7.6
Private Hospital	3.2	3.7	3.0
Private Clinic	5.9	6.7	5.6
Rural Health Unit	9.2	10.9	8.7
Barangay Health Station	8.0	7.4	8.2

Source: Asian Development Bank, 2005

Overall access to health facilities whether private or public appears reasonably good, but that there are still hard-to-reach pockets (*Filipino Report Card on Pro-Poor Services, World Bank, 2001c*). Among poor households, 20% of those who used private health facilities indicated non-availability of an alternative. Access to health facilities is a constraint facing poor Filipinos. Two main factors play a role in access: availability of facility/personnel, and affordability. There is a severely unequal distribution of medical personnel in rural and urban areas in the Philippines. Though the population is spread relatively evenly between the two, medical personnel are biased heavily in favor of urban areas. According to the World Bank, only 10% of doctors, dentists and pharmacists, 20% of medical technicians, and 30% of nurses practice in rural areas (*World Bank, 2001c*).

The quality and access of government health services are the most pressing issues from the point of view of the consumers. Since the poor primarily frequent government primary facilities, improving the quality and access of their services, with an emphasis on those services mainly demanded by the poor (particularly maternal and child health services and treatment of communicable diseases) would strongly enhance the pro-poor nature of health services (*World Bank, 2001c*).

PUBLIC HEALTH SPENDING: CONSIDERATIONS FOR EQUITY AND COST-EFFECTIVENESS

As pointed out earlier, appropriate investment in health, if used effectively, improves health standard of the population. In turn, a healthier population generates incremental gains in economic growth, which increases the resources that institutions and households can use for health. However, those additional resources need to be distributed and used equitably to secure higher marginal gains from the poorer segment of the population.

Governments' ability to finance the entire spectrum of health services for all their citizens is limited, and economic difficulties in recent years have magnified these constraints. The spending gap between rich and poor countries has continued to grow, with lower-income countries spending a smaller percentage of their much smaller national resources on health.

Within countries, there is a more pressing need to scale up investments in public health services to address the widening health inequalities. In light of the high burden of disease and malnutrition among the poor, many policymakers have assumed that investing in health is investing in poor people. This should serve as a caveat to this mindset: increasing empirical evidence shows that publicly financed health services are likely to benefit the better off (*Gwatkin, World Bank, 2005; WHO, 2006*). Simply increasing health investments for the entire population may not be an effective means of reducing the gap. Public health services should be targeted to the poor and underprivileged.

Given this context, there is much concern about the country's fiscal capacity as reflected in the national health budget to sustain its initial gains in the MDG health-related targets⁴, much more to achieve universal coverage of its critical health services. As it stands, the country still faces many challenges that range from inadequacy of the current level of resources, inefficiency and ineffectiveness in the use of available resources and the inequitable distribution of health goods and services (*NSCB, 2003; NOH, DOH, 2005*).

Note that total health spending in the Philippines may have slightly improved since 2006 but it is still inadequate in so far as international benchmarks for health spending is concerned. First, overall level remains below the 5% standard recommended by the WHO for developing countries. And second, recent levels of government health expenditures are below the recommended level of government spending by the Commission on Macroeconomics for

⁴ Based on draft Mid-Term MDG Progress Report, clear gains have been made in reducing infant deaths per 1,000 live births. Also, the prevalence of human immunodeficiency virus and acquired immune deficiency syndrome (HIV and AIDS) has been kept below the national target of one percent (1%) of the population.

Health⁵ (CMH) for low and medium-income countries which is as follows: mobilizing additional 1% of the GNP for health by 2007 and additional 2% by 2015. These estimates refer to financing minimal health system—one that can attend to the major communicable diseases and maternal and child conditions that account for a significant proportion of the avoidable or preventable deaths in the low-income countries.

Total health care expenditure in the Philippines was 3.4% of GDP in 2005, down from 3.5% in 2000. Of the ASEAN countries, Vietnam spent the highest on health care as a percent of GDP but about two-thirds of that came from private expenditure. The WHO database showed total per capita expenditure on health in the Philippines was at \$177 from 2000–2004. This is relatively low by comparison to neighboring countries like Malaysia (\$355) and Thailand (\$257).

TABLE 2.
NATIONAL HEALTH ACCOUNTS OF
SELECTED ASIAN COUNTRIES, 2000-2004 (AVERAGE)

	INDONESIA	MALAYSIA	PHILIPPINES	THAILAND	VIETNAM
Total health expenditure as % of GDP	2.7	3.74	3.3	3.48	5.32
General government expenditure on health as % total health expenditure	31.78	56.8	42.46	60.88	28.3
Private expenditure on health as % of total health expenditure	68.22	43.2	57.54	39.12	71.7
Social security expenditure on health as % of total government expenditure	9.82	0.71	20.1	9.96	14.7
Health Expenditure Per Capita (in international dollar rate)	102.22	355.6	177.54	256.96	152.2

Source: WHO, 2007

ECONOMIC SERVICES

Total allocation for economic services amounts to P287.4 billion—the bulk of which amounting to P112.8 billion (39.2%) will go to Communications, Roads and Other Transportation. Of the P112.8 billion, about 92.4% accounts for the combined allocation of the Department of Public Works and Highways (P81.9 billion) and the Department of Transportation and Communications (P22.3 billion). The increase of P13 billion for DPWH

⁵ The Commission on Macroeconomics and Health (CMH) was established by World Health Organization under the leadership of Director-General Gro Harlem Brundtland in January 2000 to assess the place of health in global economic development.

under this sub-sector apparently makes up for the budgetary cut in 2007 when its budget dropped from P73.9 billion (2006) to P68.9 billion (2007). Meanwhile, another P12.3 billion will go to DPWH for water resources development and flood control projects.

Meanwhile, subsidy to local government units (*which is part of the IRA*) accounts for P73.8 billion or roughly 25.7% of the total budget for economic services. About P51.2 billion will go to the Agriculture, Agrarian and Natural Resources sub-sector—of which P23.6 billion will be used for the Agriculture and Fisheries Modernization Program. Although the 2008 allocation for agriculture, agrarian and natural resources is higher by P6.9 billion than in 2007 (P44.4 billion), the increment may not be that much if reckoned with the 2006 spending level of P47.7 billion.

TABLE 4
ECONOMIC SERVICES EXPENDITURE PROGRAM, 2006-2008

PARTICULARS	Levels (Billion Pesos)			% Share to Total NG Budget		
	2006	2007	2008	2006	2007	2008
Agriculture, Agrarian Reform and Natural Resources	47.66	44.38	51.24	4.56	3.94	4.18
Trade and Industry	4.05	3.32	4.25	0.39	0.29	0.35
Tourism	1.72	1.88	1.91	0.16	0.17	0.16
Power and Energy	2.64	2.75	4.34	0.25	0.24	0.35
Water Resources Development and Flood Control	11.11	10.48	12.44	1.06	0.93	1.01
Communications, Roads and Other Transportation	93.88	100.72	112.82	8.98	8.94	9.19
Other Economic Services	2.54	14.32	26.70	0.24	1.27	2.18
Subsidy to Local Government Units	58.26	64.38	73.76	5.58	5.72	6.01
Total	221.85	242.23	287.45	21.23	21.51	23.43

Source of basic data: 2008 BESF (DBM)

Also, NG allocates P4.3 billion for the Power and Energy Sector. The Department of Energy which accounts for 83.9% of this sub-sector's budget will almost double its 2007 spending program to P3.6 billion the next year. Sadly, however, the Tourism sector has always been sidelined with a miniscule budget of P1.9 billion. The budget for the Department of Tourism stays at P1.6 billion. The increase of P29 million for the tourism sector can be attributed basically to a higher allocation for Miscellaneous Personnel Benefits Fund.

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National government spending as a percent of GDP grew from 0.27% in 2006 to 0.31% in 2008. Note that the level of national government spending is below the recommended level of the CMH. In general, modest growth in government expenditures at an average of 18% since 2006 has improved health spending in the country as a percentage of GDP and as per capita spending.

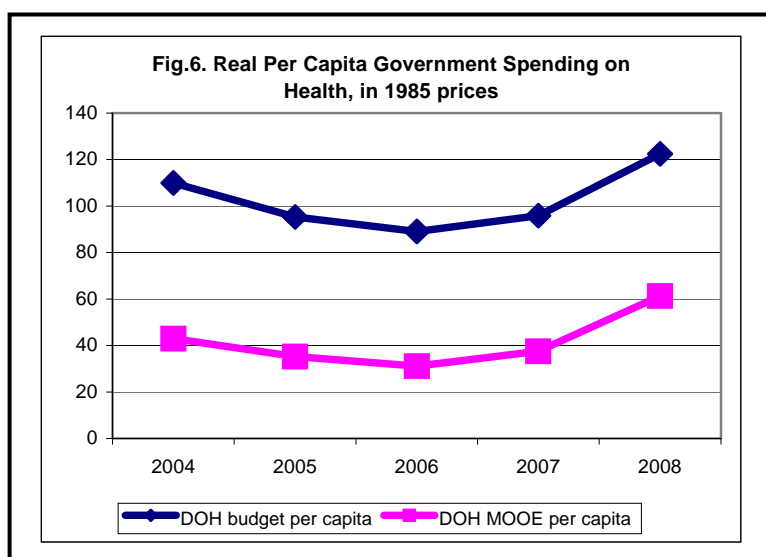
	2004	2005	2006	2007	2008
Total Health Expenditure of National Government (in billion at current prices)	14.478	13.864	16.074	18.356	22.896
NG Health Expenditure Growth Rate (%) at current	16.76	-4.24	15.94	14.20	24.73
NG Health Expenditure as Percent of GDP (%)	0.30	0.25	0.27	0.28	0.31

Source: BESP and Philippine National Health Accounts

Looking at the distribution of total health spending in the country, there are problems in the way resources for the health system is collected. The burden of paying for health care services is dominated by out-of pocket payments that accounted for 44% of total health expenditures in 2003. This means that households rely mainly on their own resources to finance medical services. Based on the FIES 2003, family expenditures for medical care amounted to P45.1 billion, which translates to P2,752 medical care expenditures for each family in 2003. The expenditures for drugs and medicines accounted for the highest percentage with 45.6%, hospital room charges with 22.8%, medical charges (including doctor's fee) with 23.3%, and the rest for other medical goods. In all, the biggest source of the total resources available in the health system is the household. This leaves the financial and health status of the low-income group of the population vulnerable.

Allocation to DOH. The Department of Health (DOH) which usually gets the largest chunk of health sector budget, will receive only 1% or 16.3 billion of the proposed 2008 national budget. In nominal terms, the DOH budget increased by 11% yearly on the average from P11.1 billion in 2004 to P16.3 in 2008. But just to emphasize, the growth rate of the Department's budget of 34.8% is the highest ever since 1996-1997 when it recorded a 30% increase. This also shows that, with the inclusion of the education and agriculture budgets, the 2008 budget is showing more attention to human development-promoting expenditure items as in the previous years.

Despite this good news, population growth continues to exert pressure on the budget. Thus, real per capita DOH spending only increased by 1% yearly on the average from P109 in 2004 to P122 in 2006. When MOOE budget is considered, the increase in per capita spending is much higher at 5% yearly on the average from P42.9 in 2004 to P61.3 in 2008. Improvement in MOOE level is significant as this addresses budget gap in the provision of immunization programs and low-cost quality drugs.



Source: BESF, DOH Budget Proposals in 2007 and 2008

Scaling up investment in public health. **Health spending of the national government can be categorized according to major budget items, namely: governance, regulation, public health, hospitals and social insurance (NG share in premiums of indigent program of PhilHealth). Of these items, expenditures on public health interventions and social insurance are deemed critical in ensuring the MDG health targets are met, as well as the equity considerations in health care delivery are fulfilled.**

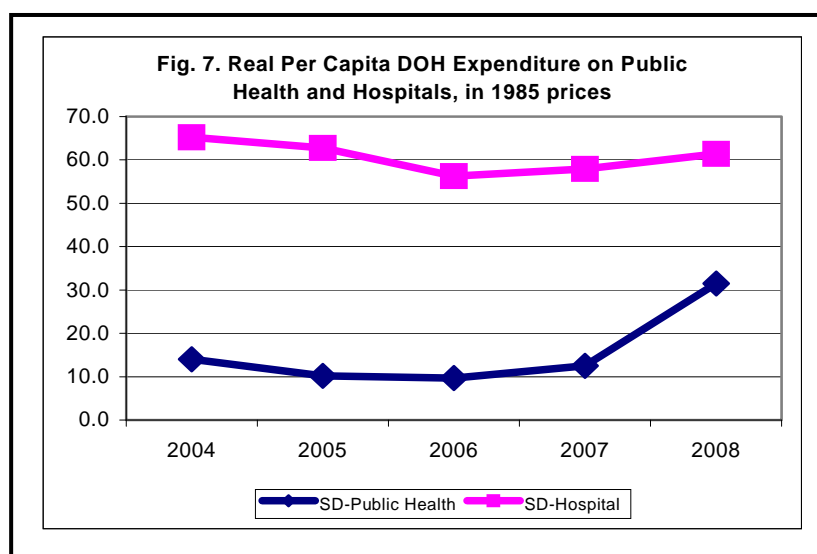
Priority spending on public health service is justified because of its nature as public goods, and that it is more cost-effective and directly affects the health of the poor. Focusing resources on a minimum package of public health/clinical interventions would address very large disease burdens. These clinical interventions are all highly cost-effective—often costing substantially less than \$50 per DALY⁶ gained. Widespread

⁶ DALYs for a disease are the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the poor health condition. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health.

adoption of this health package alone would have a tremendous positive impact on the health of people in developing countries. If 80% of the population were reached, 24% of the current burden of disease in low-income countries will be eliminated (*WDR, 1993*). And essentially, the poor would benefit more because the diseases that these interventions aim to prevent and control are particularly prevalent among the disadvantaged groups.

Although policymakers are aware that public health services are cost-effective, priority health interventions have been severely underfunded in the past. Historically, the bias of government expenditures has been towards personal or curative care, especially hospitals. While the budget share of tertiary care still dominates the DOH budget, it has been contracting since 2005 from 71% to 55% in 2008. This downward trend can be partially attributed to the adoption of the income retention policy of DOH-retained hospitals in 2003.

In a positive reversal, the allocation for public health has been on the upswing, increasing by 26% in 2007 and 62% this 2008. Moreover, real per capita DOH spending on public health for 2008 will be more than twice the 2004 per capita spending. Specific health interventions that are cost-effective continue to enjoy government priority attention as indicated in the 2008 health budget.



Source: BESF, DOH Budget Proposals in 2007 and 2008

The Expanded Program on Immunization (EPI) will receive an 11.4% increase from P444 million in 2007 to P483 million in 2008. Likewise, other essential items will receive large increases in budgetary outlays, namely: tuberculosis control at 101.4%, family planning at 416.6%, malaria, rabies filariasis treatment and control at 367.6%, and control of other

infectious and emerging diseases at 217.2%. Significant gains in public health interventions spending may augur well for the country to meet its MDG health targets. But this progress need to be sustained and that more public investment is required in other health areas, e.g. maternal health, where prospect of success is dim.

	2007 budget (P)	Proposed 2008 budget	Proposed additional 2008 budget	% increase
EPI	444,857,000	483,857,000	39,000,000	11.4
TB control program	139,007,000	280,007,000	141,000,000	101.4
Family health including Family Planning	232,098,000	1,199,111,000	967,013,000	416.6
Malaria, rabies, leprosy, filariasis, others	29,609,000	138,443,000	108,834,000	367.6
Infectious and emerging disease, HIV, dengue, others	28,939,000	91,797,000	62,858,000	217.2

Source: 2008 DOH Budget Proposal

Manasan (*PIDS, 2007*) presented cost estimates of key health interventions needed to attain MDG targets⁷ in 2015 and compared these with the amount of resources that are projected to be available for the said interventions based on MTPDP growth projections⁸. The amount of resources that will be made available to public health from the national government was estimated by allowing the 2007 baseline to grow in pace with the growth in national government revenue at a yearly average of 10-11%. It is notable that the 2007 baseline already incorporates a shift of budgetary resources from retained hospitals to public health.

Accordingly, the amount of resources needed to support the attainment of the MDG on public health is equal to P8.96 billion (or 0.13% of GDP) in 2007 and equal to a cumulative total of P104.4 billion (0.08% of GDP) in 2007-2015. These amounts can be assumed to cover the minimum package of essential clinical services with associated regulatory and policy functions and social insurance. For specific health

⁷ For health related targets, the MDG aims to achieve the following by 2015: reduce UFMR by 26.7 per 1,000 children and IMR by 19 per 1,000 livebirths; improve MMR by 52; increase access to reproductive health services by 70% and reduce HIV prevalence by less than 1%; and reduce malaria morbidity rate to 24 per 100,000 population.

⁸ Manasan based her cost estimates on the following assumptions of MTPDP growth: 6.5% growth in 2007, 6.8% for 2008 and 7.0% for the next seven years until 2015; and inflation rate constant at 5.0% for the study period (2007-2015).

interventions as indicated below, the budgetary requirements for the next 8 years to achieve MDG health targets by 2015 already constitute 42% of the total resource requirement.

	<i>EPI</i>	<i>Micro-nutrients</i>	<i>TB</i>	<i>Malaria</i>	<i>STD/HIV</i>
2007-2015	6,420	1,154	18,143	15,746	2,133

* *The low-cost estimate of Manasan assumed that health service delivery has attained a certain level of operational efficiency such as lower wastage allowances for vaccines and supplies, and better targeting in the delivery of some of the public health programs (e.g. micronutrient supplementation and malaria control).*
Source: Manasan, PIDS, 2007

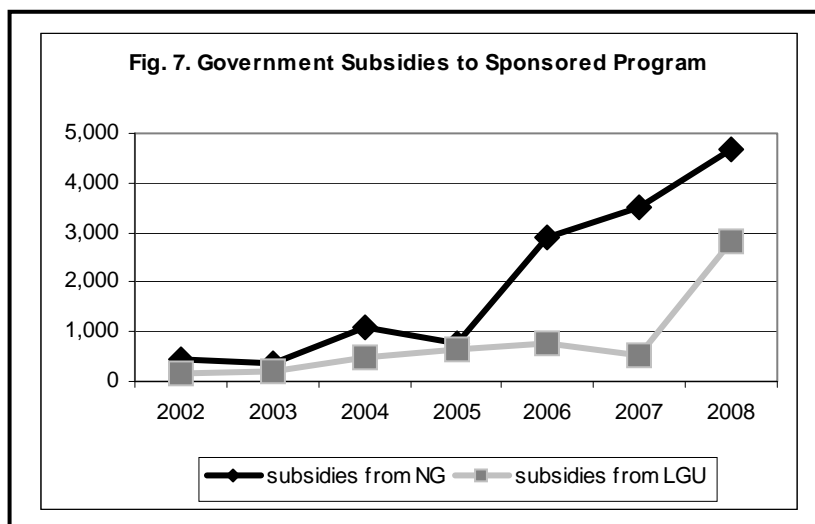
At the rate that the budget allocation to public health has been progressing or decelerating, it is clear that current levels are inadequate to sustain whatever gains that have been achieved so far. More so, more investment should be focused on critical health interventions that will be achieved higher marginal gains in improving the national averages of health-related targets.

Another point to consider is that although prioritizing investment in health conditions that affects the poor more is justified, it is not always the case that the intended beneficiaries—the poor—are able to secure the most benefits from these interventions. As indicated earlier, even health services, e.g. child immunization, attended delivery, etc. that tend to address “diseases of the poor” has been captured by the well-off than by the poor.

Broadening coverage of social health insurance. **The burden of paying for health care services is typically dominated by family out-of-pocket payments. This highlights the real issue of the high proportion of catastrophic expenses of households, especially among the poor. It is the realization of paying health care that causes family impoverishment that has led government to pursue social health protection for the entire population.**

The National Health Insurance Program (NHIP), being implemented by Philippine Health Insurance Corporation (PhilHealth) was designed to achieve universal coverage by 2010. In 2006, it has already covered about 79% of the total population or about 68 million people. Coverage of the formal seems fairly extensive but coverage of indigents and workers in the informal sector need to be improved.

The high priority accorded to the provision of subsidies for the PhilHealth's sponsored or indigent program in recent years is notable. After allocating a yearly average of P1.1 billion from 2002 to 2006 and P3.5 billion in 2007, the national government will be setting aside P4.6 billion this 2008 which may be sufficient to cover about 80-90% of the total eligible households.



Source: 2008 Budget Proposal of PhilHealth

While efforts are being made to achieve universal coverage of health insurance, there are issues that need to be addressed to ensure that risk protection is adequate without unnecessarily raising the total cost of health care. Chief among them is how to sustain the sponsored or indigent program. Higher allocation for indigent premium subsidies in recent years is not enough to enroll the number of target poor families. In 2005 and 2006, the level of national government subsidies is enough to deliver only 70% of the number of target families.

Year	Subsidies from National Government (in billion)	NG Funding Requirement (in billion)	Target Poor Families	Enrolled Indigent Families (actual)
2005	0.7	4.38	5,877,784	2,492,356
2006	2.9	4.47	5,996,421	4,946,433
2007	3.5	4.56	6,117,524	3,447,143
2008	4.65 (proposed)	4.65	6,241,145	6,241,000*

*target number of enrolled indigent families

Source: PhilHealth Briefer, 2007

Note that the both national government and local government units (LGUs) through PhilHealth share the premium payments for the indigents to be enrolled. Despite competing local expenditures, the LGUs on the whole have been responsive to financing of premium

subsidies for the indigent program of PhilHealth (*Herrin, WHO, 2005*). However, there is still much further to go in view of the slow decline in poverty rates and the fact that LGUs with large numbers of the poor are also the ones with limited financial capacity to subsidize their premium.

Conclusion

If the government is to sustain and accelerate health gains of recent years, especially in the context of achieving the MDG targets in 2015, it is imperative that policy attention and available resources focus on health areas that would yield the optimum health impact. It is important that these new set of policy initiatives adequately address critical issues of health inequalities since most of the deficiencies in the country's health indicators are occurring in the poorest segments of the population.

The evidence presented here clearly points that poor people have worse health outcomes than the better-off, and that publicly financed health care has not been able to reach its intended beneficiaries. Given the relative disempowerment of the poor that limit them to avail of intended benefits, new initiatives for health programs and strategies should take into consideration the following important points:

Prioritize investments in health conditions that disproportionately affect the poor. Focusing on TB, malaria, HIV, infant and child mortality, maternal ill-health, and malnutrition is a strategy to improve the health of the poor and reduce poor-non-poor health differences.

Prioritize investments in types of services that are likely to disproportionately benefit the poor. Primary health care, public health interventions, and preventive or promotive (rather than curative) services can improve the health of the poor.

Prioritizing investments in regions or areas where the poor are concentrated (geographic targeting). Resources should be reallocated in favor of poorer geographic areas, and to the lower tiers of service delivery. Health infrastructure should be expanded to provide more service delivery points where the poor live, especially in remote rural communities. The number and reach of outreach clinics should be increased. Services can be tailored to the needs of vulnerable groups, such as slum dwellers, migrant, etc.

Reducing financial access barriers. When universal provision of subsidized care is considered too costly and/or not effective in reducing poverty, one alternative is targeted subsidies. Targeting is primarily an attempt to increase fairness in financing. From

another perspective, it involves redistributing resources and transferring purchasing power to the poor without increasing public spending.

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