

Nov 23 2009 edition from Dr. Alberto G. Romualdez, Jr., M.D.
No further edition anticipated.

Delivered by Dr. Alberto G. Romualdez, Jr., M.D. on November 25, 2009 on the occasion of The Eighth Jaime V. Ongpin Annual Memorial Lecture on Public Service in Business and Government, Veritas, Ateneo de Manila University Professional Schools, 20 Rockwell Drive, Rockwell Center, Makati City

Health Inequities: The Urgent Need for Health System Reforms in the Philippines

1. Introduction:

Last year, as part of the centennial celebrations of the University of the Philippines, Dr. Ernesto O. Domingo (a former Chancellor of UP Manila) and I delivered back to back lectures on the health status of Filipinos and the role of the State University in the country's health system. In the opening statement of my lecture on the state of the nation's health, I said: "One central feature disfigures the state of our nation's health, namely, great disparities in access to and use of health care, resulting in significant differences in health status, between the rich minority and the poor majority of Filipinos."

Two months after these lectures, in last year's Jaime V. Ongpin Memorial Lecture, Professor Arsenio Balisacan stated: "Studies indicate that the response of poverty to economic growth in the Philippines, especially in recent years, is greatly muted compared with that of Indonesia, Thailand, and Vietnam (Balisacan 2007). This observation is partly explained by the comparatively high inequality in incomes and productive assets (including agricultural lands) as well as the inferior social protection infrastructure in the Philippines."

This morning I would like to propose that we analyze the nexus between the UP Centennial Lectures and the Ongpin Memorial Lecture of last year. I will begin by examining standard health status indicators showing differentials among income groups. We will then look at some health outcome inequities that result from inadequacies of the existing Philippine health system.

Finally, I hope to justify some proposed remedies, highlighted by government-led reforms to begin to address this grave health problem. I will not presume to prescribe any roles for the private sector in such a reform program but I am sure that in the course of this lecture you will discern some of these roles and perhaps our reactors can point them out to us later.

2. Inequity of Health Status Indicators

Slide # 1: Table 1

As seen in Table 1, in terms of conventional health status indicators, we lag behind most of our neighbors. As a matter of fact, the health status of most Filipinos is worse than many of us think. Today, I will present evidence that this is due at least in part to the fact that the Philippine health system comprises a part of the “inferior social protection infrastructure” to which Professor Balisacan referred in last year’s lecture.

Slide # 2: Map with Health Status Indicators

When health status indicators such as life expectancy at birth (LEB), infant and child mortality (IMR), and maternal mortality ratio (MMR) are disaggregated according income groups and geographic location, we find that urban communities like those in Metro Manila, Cebu, and Davao, with access to modern facilities, have outcomes comparable to those of developed countries – i.e., LEB over 80 years, IMR less than 10, MM less than 15. In contrast, poor rural communities, such as those in Bicol, the Samar provinces and ARMM, have results that approach those of least developed countries – i.e., LEB under 60 years, IMR over 90, MM over 150. While not quite as bad as least developed countries, urban poor communities have indicators that are from two to five times worse than their neighbors in gated villages.

Recognizing the fact that the majority of Filipino voters are poor, all past administrations (including the current one) claim to be pro-poor. But as a matter of fact, policies and programs tend to have disproportionately adverse impacts on the poor while, in the words of Professor Balisacan, “in practice (national policies) have benefited.... the non-poor, including politicians, bureaucrats, and the elites in society.”

Slide # 3: Table 2 Differential Fertility Rates

This is clearly the case with respect to the impact of the lack of a clearly pro-poor reproductive health policy. Women in the highest income quintiles, having full access to reproductive health information and services, on average achieve their desired fertility rate of two children. In

contrast, the poorest women with little or no access to information and services have twice the number of children that they desire.

Slide # 4: Table 3

The World Health Organization uses an analytical framework that breaks down the health systems into six building blocks, namely: health service delivery, human resources for health, regulatory mechanisms, information systems, governance structures and health financing systems. In the context of the Philippine health system, we can show how inadequacies in each of these contribute to the inequities in access to and use of health care services that result in grossly unequal health outcomes. In the interest of saving time, for today, I would like to focus on just three of these – health services, human resources, and health care financing.

Slide # 5: Organization of Health Services

First, let us take a look at way health services are organized and delivered:

Filipinos who can afford it receive basic health services at private clinics and hospitals that are staffed by specialists and equipped with sophisticated medical equipment. One private hospital in Manila, right next to the Philippine General Hospital, lists 900 medical specialists to service 250 beds. Another private facility near the DOH's Heart, Lung, Kidney, and Children's Centers, has 2,500 specialists for its 500 beds.

The less affluent majority go to government health centers or hospitals. Except for a few localities, these facilities are poorly equipped and often lack supplies. Quality of care is dependent on the degree of commitment of local governments or institutional health staff.

Disparities in access to basic care have persisted and worsened because of the fragmentation of the country's health system. First, too much of our basic health services are privately provided, privately funded and privately used mainly for the benefit of those who can afford to pay for these. Second, our public sector in health, which is the segment most amenable to equitable re-distribution on basis of the democratic principle of the greatest good for the greatest number, has been kept too small to make a real difference. And third, this already small public sector in health has been further cut up into smaller pieces by the faulty design of our

public sector devolution of health services. In short, our basic health services remain inequitable because too much of it is in private hands, too little is in the public sector, and the little public sector, through the Local Government Code of 1992, we had we divided into small inefficient pieces working independently.

Slide # 6: Inequitable Access

The consequence of all this is that among the poorest Filipinos, less than 50% of pregnant women are given vitamin supplements while 80% of their high income counterparts receive these important nutrients. This translates into a greater number of high risk pregnancies due to under nutrition among poor women who have higher fertility rates and are already at greater risk for unintended pregnancies.

In the lowest income quintile less than 2% of births are by caesarean sections while among the highest income groups the caesarean section rate is greater than 20%. Given the accepted public health gold standard caesarean section rate of 15 %, these figures are bad for both groups – among the poor, this means that women who should have surgery are not operated on, while among the rich, even those who do not need surgery get it.

Only 50% of children from low income groups receive at least partial immunization while over 80% of rich children are fully immunized. Because there are more of them than there are rich children, lower coverage of the poor in part explains why the reduction of infant and childhood deaths called for under the Millennium Development Goals has slowed down.

Finally, while the rich few can afford the most modern technologies to extend their lives or prevent premature deaths, the poor majority have little hope of similarly availing of state-of-the-art interventions in the face of imminent death. This terrible inequity is the result of our non-existent arrangements for delivering tertiary care services to the poorest 60% of our population.

For example, more than half of the patients of the approximately 700 end-stage renal disease patients who received kidney transplants in the year 2007 were foreigners. The rest were the few Filipinos who are lucky enough to afford the exorbitant cost of the procedure.

Slide # 7: Maldistribution of Human Resources for Health

Let us now look at the situation of our human resources for health:

Today, it is estimated that 70% of all health workers are employed in a private health sector that serves only the 30% of the population that can afford to pay for their health care. The other 30% of the workforce are in government services that cater to the needs of the majority of Filipinos who are too poor to afford the cost of private services. It should be noted that even this small number of health professionals engage in private for-pay practice - either licitly or illicitly.

Slide # 8: Maldistribution of HRH

This maldistribution results from the fact that government positions providing basic public health services, are low paying and often considered less prestigious. Private clinical practice in lucrative urban areas is preferred by most doctors and even midwives. For nurses, teaching in nursing schools is significantly more rewarding than providing nursing care. The fact that the market for expensive services is limited to the rich few partly explains the on-going exodus of health professionals at all levels.

For all these reasons, in this country that produces some of the world's best doctors, nurses and other health workers, 60% of Filipinos die without the benefit of health professional attention. Hospitals and other health institutions, both government and private are severely undermanned and entire communities – especially in far-flung areas - are too poor to afford the services of a complete health team.

Slide # 9: Dysfunctional Health Workforce Structure

The Philippines' health human resource problems are the result of its dysfunctional health workforce structure. The problems are introduced at the very onset of the health professional production process. To begin with, the families of those who enrol in health academic

institutions perceive health professional careers as a means of economic advancement and consider training costs as investments from which returns are expected in the future.

The output of a workforce production system that is de-linked from the actual needs of the Philippine system are health providers for whom service is a lower priority than personal professional advancement. They are ill-prepared for dealing with health problems in the Philippine setting. The overwhelming majority of nursing graduates look to overseas employment as their ultimate professional goal. And because they are dissatisfied with the work conditions they encounter after medical schools, a significant number of physicians abandon their profession for overseas possibilities as nurses.

Inadequacies in all of the building blocks of the Philippine health system are in some way ultimately traceable to the system for health care financing. For this reason, it may be useful for us to spend a little bit of time on this component.

Slide # 10: Total Health Expenditure in 2005

The first indication of an inequitable health care financing regime is the fact that so many Filipinos are unable to access and use health care because the costs of their care are missing in the totals. If we accept the World Health Organization's recommendation that countries at our level of development should be spending at least 5% of GNP on health, our health sector is grossly under funded by at least 40%, representing the costs of unmet needs of many of our people.

Slide # 11: Health Expenditure by Source

With half of the total expenditures on health each year sourced from out of pocket payments by individuals and families, our health system is largely financed by user fees and the non-payers are unlikely to be using services. Tax-based government spending (both local and national sources) accounts for less than 40% while the national health insurance program (Phil Health) and private shared-risk schemes (insurance and HMOs) contribute about 11%. Even users of tax-

funded services provided by government and users with some type of health insurance still pay out-of-pocket as part of their co-payments for care. This means that people in need of care without the means to pay out-of-pocket are effectively shut out of a system where out-of-pocket payment becomes one's entry fee.

Slide # 12: Impact of High Out of Pocket Payments

This mode of health care financing so heavily reliant on out of pocket payments has dire implications for individuals, families and communities which do not belong to income groups with large disposable incomes. Only those with money can fully afford out of pocket payments – and often they are also covered by generous insurance benefits. The poor, most of whom do not even have pockets, are totally dependent on government services or private charity. The middle classes and near-poor are always at risk of impoverishment when they need health services particularly those requiring expensive interventions.

The existing health care financing structure also induces health care organizations and institutions to “follow the money”. Almost 70% of the DOH budget is allocated for retained hospitals which, like private hospitals, emphasize high tech expensive interventions. Fiscal autonomy for government hospitals has not significantly reduced their dependence on subsidies mainly because income can be generated only from out of pocket payments. Thus even hospitals that are traditionally service-oriented like PGH require such payments from their patients.

Slide # 13: Phil Health Reimbursements

Ironically, even the national health insurance program which is supposed to be one of the answers to inequity in health care financing, turns out to be itself a factor that enhances inequality. One indication is the fact that the institutions that receive the highest share of Phil Health reimbursements are those that cater mainly to rich or well-to-do clients. The Davao Medical Center is the only government hospital that is among the top ten recipients of Phil Health reimbursements. Another indication is the fact that Phil Health benefits utilization rates are highest among the more highly paid employed members and remain very low among

sponsored indigent members. And even among employed members, those with high incomes have higher utilization rates than those in the lowest income groups.

Slide # 14: Increasing Out of Pocket Payments

Even more disturbing is the fact that, since Phil Health was established by law in 1995 private sources of health financing comprising mainly out of pocket payments have soared. From 39 billion or 40 percent of total, this component of health financing rose to 150 billion or 56 percent of total in 2006. It is clear that the Social Health Insurance scheme as currently implemented by the Philippine Health Insurance Corporation or Phil Health is not working as envisioned.

Slide # 15: Differential Fertility Rates

The differences in fertility rates between rich and poor women mean that the health disparities I just described are being transmitted to the next generations. Unless the health of the poorest Filipinos improves faster than they increase, the weight of their increasing sick numbers will consign the population of this country to remain increasingly poor and unhealthy. The situation is urgent not just for the poor themselves but for all Filipinos whose general welfare depends on the good health of all. Migration offers escape only to those fortunate to get a visa to other countries at whatever cost. Yet the loss of the healthy, able and capable Filipinos to other countries only make our state worse.

Slide # 16: Recommended Reforms Toward Universal Health Care

Following our UP Centennial Lectures, Dr. Domingo and I organized a group of about 25 health experts, academics, and practitioners into a series of workshops and consultations to come up with suggested reforms in the Philippine Health Systems. These recommendations were presented yesterday at a symposium on Universal Health Care at UP Diliman. For the six building blocks of the health system, these are summarized in the next three slides:

Slide # 17: Recommended Reforms Toward Universal Health Care

To develop a more responsive and modern Information System, we proposed the creation of a national council mandated to craft the e-Health master-plan that is anchored on primary health care. The backbone of the system should be a collaborative effort of all concerned agencies led by DOH including the NIH, Phil Health, DOST, and the other statistics offices of government.

For the regulatory system, implementation of health regulations should be based on the principle that health concerns take precedence over business interests. On this basis, regulatory functions of DOH and local governments should be further strengthened to promote the double objectives of health sector reform -- equity and efficacy. This includes the creation of an efficient health, drug and technology regulation that is strongly anchored in science.

Slide # 18: Recommended Reforms Toward Universal Health Care

For Governance, the DOH should be transformed into a national institution that is able to effectively wield its influence on the different health sector actors –government, private and civil society – towards universal access.

In the organization of health services, government facilities should be reorganized and integrated in accordance with the principles of primary health care based on an updated version of the Alma Ata Declaration. They should provide integrated health services either directly or through a unified and formalized referral system.

Slide # 19: Recommended Reforms Toward Universal Health Care

In Human Resources for Health, the health workforce production system should be restructured to emphasize service over self-interest. This can be carried out by integrating all the health professional regulatory entities under one agency attached to the DOH.

Reform of health care financing should feature a quantum increase in tax-based coordinated government spending and reorientation of Philhealth as a true social health insurance program that maximally spends its health fund on benefits to fully support the health requirements of all Filipinos.

Yesterday, our Universal Health Care Group summarized our presentation as follows:

It is time to elevate the level of politicization of health from that of parochial self-interests and petty patronage to a national issue of common concern.

Government spending of 200 billion pesos annually on health is not unrealistic if we consider it in the context of a national budget of 1.5 trillion pesos. But political will is necessary to enable quantum increases in coordinated health spending by national and local governments as well as the social health insurance program within a national health reform framework.

While initially such efforts should focus on strengthening services for the poor, there should be a clear understanding that the system will eventually cover all socioeconomic classes. This is necessary to avoid developing a two-tier health care system that will exacerbate inequity.

To generate such political commitment, health reform advocates must build alliances starting with the national academic institutions but eventually extending to all concerned institutions, groups, and most importantly communities. These alliances must commit to generate support for a thorough restructuring of the entire health sector, public and private, over the next ten or fifteen years.

These three factors: a quantum increase in coordinated government spending, public support for reforms, and an initial focus on the poor, if introduced to the political process in the next three years can make a reality what many countries already have and Filipinos can now only dream about – UNIVERSAL HEALTH CARE.

.....