Explaining the large disparities in health in the Philippines

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This is the second in a series of three policy notes on health prepared for the 11th Development Policy Research Month in September 2013 themed “Making Health More Inclusive in a Growing Economy”. The first policy note provides an overview of the puzzle of economic growth and stalled health improvement while the third identifies opportunities for making health financing and services more inclusive. Due to space limitations, the extensive tables generated for these notes were not included, but will be available in a forthcoming PIDS discussion paper.

Causes of large disparities in health
Despite the complexity and challenges in attribution of what causes good or ill health, there are obvious key factors that can explain health disparities in the Philippines.

First, the underlying social inequity in the country has remained persistently large, in much the same way that poverty has remained chronic. The Gini coefficient—the accepted measure of inequality—is one of the highest in the region, and dropped only marginally from 43.8 in 1991 to 43.0 in 2009 (which means inequality fell only slightly in about two decades). Income inequality is highly associated with inequality in access to health services (World Bank 2013b).

Second, in sharp contrast to its neighbors, the Philippines continued to experience rapid population growth mainly because of the politicization of family planning and reproductive health activities. The 1.9
percent annual rate of population increase in the Philippines far exceeds the rate for the world as a whole (1.2%), Asia as a whole (1.1%), and Southeast Asia (1.2%). The Philippine population grows by a net addition of about 1.6 million a year. Excluding the city-states of Singapore and Hong Kong, the Philippines is now the densest country in Southeast Asia, and the third densest in East Asia. The Philippine has the highest total fertility rate among middle-income Asian countries (3.3 children born per woman of reproductive age), engendering high unmet need for maternal and child health services especially among disadvantaged households (NSO 2010; World Bank 2013a).

Among the poorest households, the average actual number of children is 5.2 while the desired number is only 3.5. Even more disturbing is the increasing rate of adolescent pregnancy, which is a major cause of the worsening maternal mortality ratio. By age 19, one out of five Filipino females have begun childbearing. The effect of family size on poverty has been well researched: those with more children are invariably poorer than those with fewer, and this pattern has been consistent for decades. In 1985, almost 60 percent of families with nine children are poor while only 20 percent of those with two children are poor. Almost a generation later in 2009, 46 percent of families with nine children or more are poor while only 7 percent of those with two children are poor.

Despite this ballooning population, the Philippines has severely underinvested in health facilities, services, and manpower since the 1970s. The number of rural health units stagnated at around 2,300 from the early 1990s until the mid-2000s, while the number of barangay health stations modestly increased from 12,000 in the 1990s to 16,000 in the mid-2000s. The total number of hospitals (public and private) has also stagnated at around 1,400 since the 1980s. As a result, the ratio of hospital beds per 10,000 population has declined from around 32 in the late 1970s to 17 by the late 2000s. The number of government health staff has remained stagnant at around 26,000 since 2000. As a result, the number of government staff per 10,000 population went down from 3.38 in 2000 to 2.95 in 2008 (NSCB). As the Philippine population grew, and as poverty remained persistent, the stagnating rates of health investments can only mean that inequity in access to health services has been worsening through the decades.

Third, political instability due to Leftist and Muslim insurgency has also reduced access to health care among households in areas of civil unrest. A stable health system has been almost impossible to establish in areas wracked by armed conflict, and health workers cannot be expected to locate in such areas. Hence, it is no surprise that the very restive Autonomous Region in Muslim Mindanao (ARMM) also happens to register the worst health indicators in the country.
Antenatal care by a skilled provider is 91.1 percent nationwide but only 46.7 percent in ARMM; skilled birth attendance is 62.2 percent nationwide but only 19.2 percent in ARMM; and facility-based delivery is 44.2 percent nationwide but only 14.7 percent in ARMM. In many of the ARMM and other areas of insurgency, health care is available only in military barracks, or relocation centers, or in spotty areas serviced by courageous nongovernment organizations (NSO 2008).

_Fourth_, the nature of Philippine economic development itself has also contributed to persistent health inequity. Philippine agriculture has not generated enough farm and off-farm employment while Philippine manufacturing has not evolved into a strong sector capable enough to fully absorb the millions of new graduates each year, as well as migrants from rural areas. One Filipino economist (Fabella 2012) has characterized the country’s growth experience as one of “development progeria” (premature aging), as the country relied less on its moribund agriculture and manufacturing, and increasingly relied more on the remittances of its overseas Filipino workers and the revenues of its lucrative business process outsourcing industry, a service-oriented sector that employs children of generally better-off households with appropriate education and language credentials. Between 1998 and 2012, the shares of agriculture and manufacturing to the gross domestic product (GDP) declined from 13.3 percent and 35.3 percent to, respectively, 11.6 percent and 32.1 percent, while the services sector expanded from 51.4 percent to 56.8 percent.

Thus, recent Philippine economic performance has been characterized as one of jobless growth: GDP expansion with chronically high unemployment and high poverty. From a social development lens, development progeria and jobless growth—combined with historical public underinvestment in health—can only imply greater marginalization of the poor. The government health budget has grown since the late 1990s and significantly so since the late 2000s, but the adverse underlying economic and social environment faced by poor households (unemployment, poverty, poor housing) means that it would take a little longer to realize the gains from such public health investments.

_Fifth_, the archipelagic nature of the country also impinges adversely on health, and yet little analysis has been done on how this physical configuration plays a part in health planning, service expansion, and household access to health care. Small poorly connected islands pose a serious challenge...
to logistics and supply chain management (pharmaceuticals, contraceptives, hospital supplies); mountainous terrains seclude indigenous people from the reach of health programs and workers; and intermittent telecommunication and radio signals constrain wider-scale health communications.

Given the revolutions (“disruptive innovations”) in information technology (IT) such as telehealth, telemedicine, and teleradiology, the country ought to leapfrog from these constraints, but the health sector has been slow in their large-scale adoption. Indeed, technology itself may be contributing to health inequity as larger, more affluent areas and facilities have been much quicker to adopt these efficiency-saving approaches, leaving less affluent and IT-deprived areas and facilities further behind.

Sixth, frequent disasters (natural and human-induced) and environmental risks, especially heightened by climate change, also contribute to health inequity. The Philippines lies in the Pacific Ring of Fire, where volcanic activity is most active in the world. It is also in the path of tropical storms, where an average of 20 typhoons hit each year. Given these hydrologic and geophysical occurrences, the Philippines usually tops (as number 2 or 3) annual global rankings of countries with most disasters, which, in turn, quickly translate into frequent health emergencies (dengue, leptospirosis, cholera, dysentery), often affecting poor people living in environmentally risky and fragile areas. The occurrence of natural and human-induced disasters more than doubled from 228 in 2008 to 556 in 2010; within the same period, affected persons nearly tripled from 2.128 million to 6.387 million.

The heightened challenge of inequity in the ongoing demographic and epidemiologic transitions and population mobility

The challenge of inequity is heightened by long-term perceptible changes in the country’s demography and epidemiology, which often escape officials’ focus on the short-term, immediate, and emergency concerns of governing and management. The first is the demographic transition, and the second is what it feeds: the epidemiologic transition.

The demographic transition refers to the phasing-out process of population growth rates from a virtually stagnant growth stage characterized by both high birth and death rates, through a rapid growth stage with high birth rates and low death rates, to a stable low-growth stage in which both birth and death rates are low. Although population growth rate in the Philippines remains high relative to its Asian neighbors, it is entering a slower growth path, and demographic forecasts indicate the country will likely experience significant changes in the age structure of its population over the
next four decades. For instance, the median-age population has increased from 16 in 1970 to 21.3 in 2003. In contrast, the country’s dependency ratio—the proportion of the young and elderly population that is dependent on the working-age population—has declined from 94.6 in 1970 to 73.0 in 2003. There has been a notable increase in the proportion of the elderly.

The epidemiologic transition refers to the increasing proportion of noncommunicable diseases (NCDs) in the country’s burden of disease. Whereas the country had to deal mainly with communicable diseases and public health problems in the 1960s, 1970s, and early 1980s, problems of NCDs associated with an aging and urbanizing population have gradually emerged. The top four to six causes of mortality and morbidity are already NCDs. From 1980 to 2005, the death rate per 100,000 population for heart disease increased from 60.8 to 84.8 while that for cancer rose from 33.2 to 48.9. In contrast, the death rate for communicable diseases fell from 217.9 to 87.1 (Ulep et al. 2012).

NCDs are daunting. They are more complex as they arise from multiple risk factors, e.g., genetic, biological, environmental, and social. Their prevalence is not easy to establish, i.e., the number of affected people (and their social status) still have to be established, for the most part. They are far more expensive to treat or avert, and the cost-effective interventions are not commonly agreed upon. The known and agreed-upon cost-effective interventions involve a combination of prevention, disease maintenance, or treatment, and often over the lifetime of affected patients, hence involving high costs. The health technologies used for these diseases are far more complex, requiring stronger knowledge management, more coordinated investment, and better technology regulation.

While reports of NCDs still largely involve richer households, this may be due to reporting bias; indeed, some NCDs (hypertension, diabetes, chronic obstructive pulmonary diseases) affect both rich and poor households, and many of them are increasingly viewed as having strong genetic origin, leading some observers to insist that NCDs should not be labeled “lifestyle diseases” (i.e., they do not choose one’s genes or are related to poverty). Smoking, a risk factor for lung cancer, is most prevalent among the poorest households (39.9% among the first quintile and 36.4% among the second quintile). Moreover, the appropriate health financing system to deal with NCDs is more complex (health insurance), in contrast with the financing of traditional communicable diseases (public health financing). The real risk is for the financing of NCDs to crowd out the financing of public health, especially because the latter has become largely a disease of the poor who are often voiceless (Ulep et al. 2012).

On top of the demographic and epidemiologic transitions is the high
mobility of Filipinos. Some 10 million Filipinos are outside the country, many working as overseas Filipino workers (OFWs). The Philippine Overseas Employment Agency processes 1.6 million employment contracts, of which 1.5 million are deployed a year (CFO 2013). These mobile Filipinos and their families need to be provided with adequate health insurance and access to services, but in 2011, only 2.57 percent of them have PhilHealth coverage. Together with the high mobility of Filipinos, the burgeoning tourist arrivals into the country increase the cross-border dimension of international health. Regional epidemics (SARS, AH1N1/avian flu, swine flu) have occurred over the past decade. The Philippines has successfully controlled these outbursts, averting what would have been high economic and social costs. But this only means the continuing need to be vigilant about emerging and re-emerging infections, especially in poor rural and congested urban areas where information on epidemics is difficult to relay, and where surveillance is more challenging. Equity is a serious issue in emerging epidemics: while richer households have easier access to information and the wherewithal to buy needed prophylaxis (including Tamiflu vaccines for AH1N1), poorer households do not.

**Contributing challenges to health inequity**

At the health sector level, policymakers and program managers continue to struggle with the devolution of first- and second-level health services that have been turned over to 80 provincial, 138 city, and 1,496 municipal governments since 1992 as a result of the passage of the Local Government Code. Putting local government units (LGUs) at the helm of managing local health services seemed well-advised then, but on hindsight, it has resulted in a highly fragmented system of financing and service delivery, and has contributed to greater variability in performance and therefore disparity in the availability and quality of health services. Some LGUs performed well, garnering awards (such as the annual Galing Pook), but many performed poorly due to many factors (small size, limited internal revenue allotment, remoteness, underlying poverty, skill deficits). Devolution certainly needs to be revisited in light of the overall goal of improving equity in health access and quality of services.

Skill deficits and maldistribution also continued to bedevil health service provision, financing, regulation, and planning. The Professional Regulations Commission certifies tens of thousands of
doctors, nurses, dentists, and other allied health professionals a year. While the Philippines prides itself in being one of the largest health manpower producers and exporters in the world (and in the process, earning hefty remittances that alleviate poverty), the marketability of Filipino health workers has had a deleterious effect on the country’s health services. Students are heavily oriented to going abroad rather than serving locally, in part because of the Western orientation of curricula. Local pay and benefits have not been able to compete with those obtained abroad, and legally mandated benefits (such as those stipulated in the Magna Carta for government health workers) have not been uniformly given by LGU employers. In effect, the incentive structures in which health workers render services vary widely, affecting their service productivity and contributing to inequitable access among households.

But there are other skill deficits in very short supply; their shortage will spell major difficulties in the health sector and will contribute to further inequity and inefficiency in the future. These include graduate-level professionals such as health economists; actuaries and health financing specialists; clinical, field, and managerial epidemiologists; social care specialists; health planners; hospital management specialists; medical informatics and IT specialists; health regulation specialists; health technology assessment specialists; health policy researchers and analysts; and public health program managers. While other countries in the region have invested heavily in these professions in recent years (including graduate education abroad), the Philippines has severely underinvested in them.

Poor management of resources is frequently mentioned, and it could also contribute to inequitable access. The Commission on Audit regularly publishes reports on identified mismanagement in public hospitals and health facilities, but there have been little systematic studies on how these adverse practices lead to inequitable access across health facilities and localities. When the Aquino II administration took over in 2010, it used the anticorruption slogan “Daang Matuwid” (Straight Path) as a political platform, and dramatically increased the annual budgets to health. Today, the health sector is generally deemed less corrupt than other sectors. But it has to face the problem of absorbing available resources. Based on the calculation of appropriations, allotment and obligation data from the Department of Budget and Management (DBM) show improving Overall Absorptive Capacity Index1 (from 0.79 in 2011 to 0.96 in 2012), but the prospect of managing substantial allocation from the sin taxes is immense. At the local level where service delivery occurs,

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1 An OAC > 1 suggests that the agency can still absorb more funds, if funds would have increased. An OAC < 1 indicates that the DBM programmed more funds for the agency than what it can absorb. An OAC = 1 represents the happy middle that is achieved when budget programming matches the agency’s capacity for fund absorption.
health inequity tends to persist because poorer localities also have generally weaker absorptive capacities.

In a way, the problem of resource absorption is also true in PhilHealth, the social health insurance program, as it has historically been unable to spend its collected premiums and direct government subsidies to dramatically improve the health benefits of its members and reduce their out-of-pocket spending. Out-of-pocket spending accounts for a substantial 52.7 percent of total health expenditures, and this percentage has not changed much for many years (NSCB 2011). Meanwhile, PhilHealth reserves are equivalent to three years of annual benefit spending, which means that the money is sitting idle while members have to pay out of pocket, on average, about two-thirds of the cost of care (since the PhilHealth support value is only around one-third of the average cost of care). High out-of-pocket spending is particularly inequitable as it disproportionately affects households in the lower-income quintiles, and high costs especially of catastrophic illness can make middle-class households slide back to poverty.

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