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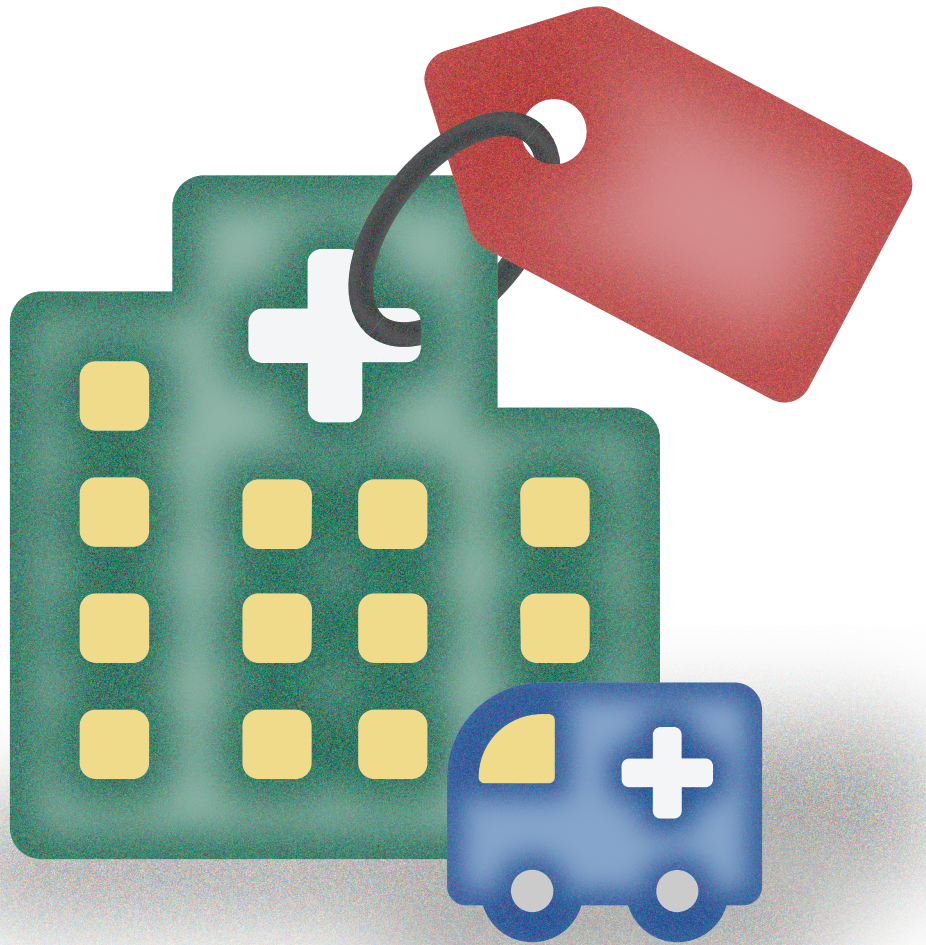

The Price of Privatized Healthcare

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Content

Acronyms and abbreviations

ADB	Asian Development Bank
AHA	Aquino Health Agenda
ALRTI	Acute Lower Respiratory Tract Infection
ARTI	Acute Respiratory Tract Infection
BARMM	Bangsamoro Administrative Region in Muslim Mindanao
BGHMC	Baguio General Hospital and Medical Center
BHS	Barangay Health Station
BOT	Build-Operate-Transfer
BUHC	Build Universal Health Care
CALABARZON	Cavite, Laguna, Batangas, Rizal, Quezon (Region IV-A)
CAR	Cordillera Administrative Region
CBHP	Community-Based Health Program
CC	Component City
CHED	Commission on Higher Education
CHO	City Health Office
CHU	City Health Unit
COA	Commission on Audit
CVMC	Cagayan Valley Medical Center
DepEd	Department of Education
DOH	Department of Health
DOLE	Department of Labor and Employment
FIES	Family Income and Expenditure Survey
FLW	family living wage
GAA	General Appropriations Act
GDP	gross domestic product
GIDA	Geographically Isolated and Disadvantaged Area
GOCC	government-owned and controlled corporation
GSIS	Government Service and Insurance System
HB	House Bill
HC	Health Center
HCI	health care institution
HCPN	Health Care Provider Network
HEA	Health Emergency Allowance
HFEP	Health Facilities Enhancement Program
HFSRB	Health Facilities and Services Regulatory Bureau
HMO	Health Maintenance Organization
HRH	human resource for health
HSDP	Health Sector Development Program
HSRA	Health Sector Reform Agenda
HUC	Highly Urbanized Center
ICC	Independent Component City
ICD	Ischaemic heart disease
ICU	internal care unit
IFI	international financial institution
ILHZ	inter-local health zone
ILS	Institute of Labor Studies
JRMMCEU-AHW	Jose Reyes Memorial Medical Center Employees Union-Alliance of Health Workers
KP	Kalusugang Pangkalahatan
kWh	kilowatt per hour
LCP	Lung Center of the Philippines

LGC	Local Government Code of 1991
LGU	local government unit
LMC	Labor Management Council
LUC	Local Universities and College
MDGs	Millennium Development Goals
MHC	Municipal Health Center
MHU	Municipal Health Unit
MOH	Minister of Health
NA	nursing attendant
NCD	noncommunicable disease
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NGO	non-government organization
NHIP	National Health Insurance Program
NICU	neonatal intensive care unit
NKTI	National Kidney and Transplant Institute
NNC	National Nutrition Council
OOP	out-of-pocket
OWS	Occupational Wages Survey
PCF	Primary Care Facility
PCMC	Philippine Children's and Medical Center
PGH	Philippine General Hospital
PhilHealth	Philippine Health Insurance Corporation
PHC	Philippine Heart Center
PHC	primary health care
PHS	Philippine Health Statistics
PITAHC	Philippine Institute of Traditional and Alternative Health Care
PPP	public-private partnerships
PSA	Philippine Statistics Authority
RA	Republic Act
RHC	Rural Health Center
RHU	Rural Health Unit
RMP	Rural Missionaries of the Philippines
SDG	Sustainable Development Goal
SSS	Social Security System
SUC	State Universities and College
SY	school year
TB-DOTS	Tuberculosis-Directly Observed Therapy
THE	total health expenditure
TNC	transnational corporation
UHC	Universal Health Care
UHC	universal health coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UP	University of the Philippines
UW	utility worker
UTI	Urinary Tract Infection
WHO	World Health Organization

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Introduction

It is enshrined in the constitution of the World Health Organization (WHO) that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] This definition acknowledges the completeness of health and that it is not only affected by the presence of diseases but also by other factors like socioeconomic conditions.

The WHO constitution also accredits States as primarily responsible for the attainment of people's health through the formulation and implementation of adequate health and social measures. The attainment of the highest state of health is a fundamental right that every human, regardless of race, religious and political belief, and socioeconomic conditions, should enjoy. Thus States have the responsibility to uphold this basic human right.

The Alma-Ata Declaration of 1978 further identified primary healthcare as the key to the attainment of a level of health that will allow all peoples to lead a socially and economically productive life.

But 70 years of the WHO and 45 years after the Alma-Ata Declaration, these basic principles are veering towards other directions that are not necessarily favorable to the goal of health for all. The Declaration of Astana in 2018 has opened health provision to private partners and to the intensive commercialization and privatization of health systems through the neoliberal framework of "universal health coverage" or UHC. The new declaration on primary healthcare has practically weakened the role of States.

Primary healthcare is an all-encompassing level of healthcare. It does not only focus on the curative aspect of health attainment but also on providing promotive, preventive and rehabilitation services. It also gives emphasis on socioeconomic and political conditions affecting the people's attainment of the highest level of health.[2] Primary healthcare focuses on ensuring people's health and well-being and that they will be veered away from illnesses and diseases to avoid needing hospitalization.

It includes educating the people on different health issues and the methods of preventing these. It also deals with promotion of accessible and nutritious food supply, safe water supply and basic hygiene and sanitation.

It also includes maternal and child healthcare, including family planning. Immunization against major infectious diseases and prevention and control of locally endemic diseases are also under primary healthcare. Ensuring appropriate treatment of common diseases and injuries and the provision of essential drugs are also under primary healthcare.

To begin with, 45 years since the Alma-Ata Declaration, the Philippines is still far from achieving the highest level of health. Instead of strengthening primary healthcare, the government has reformed the health system into a commercialized and privatized one. Reforms have made health services farther from the reach of ordinary Filipinos.

The WHO and the United Nations (UN) have been instrumental in legitimizing the privatization of global health systems through the UHC framework, and this neoliberal framework has guided the Philippine government for decades in turning primary healthcare into a profitable venture for the private sector.

An economy weakened by neoliberalism

The bigger blunder is how the Philippine government has allowed neoliberalism to be its guiding force in running the economy. Neoliberal policies have weakened the social determinants of health to a tragic state, resulting in persistent poverty, a massive jobs crisis, low incomes, and diminishing social services and protection.

The Philippines is an archipelagic country that is rich in natural resources – rivers and lakes, rich forests and mountains and vast arable lands. The population is more than 109 million (2020) with more than 26 million households. The most populated regions in the country are Region IV-A (CALABARZON), National Capital Region (NCR), and Region III (Central Luzon), also with the most number of households of 4.06 million, 3.50 million, and 3.04 million, respectively.[3] **(See Table 1)**

The average family size in the country is 4.1 family members. On a regional level, the Bangsamoro Administrative Region in Muslim Mindanao (BARMM) has the highest with 5.9 members, while NCR has the lowest with 3.8 members.

TABLE 1. Household population by region, 2020

REGION	POPULATION	NO. OF HOUSEHOLDS	AVERAGE
Philippines	**108,667,043**	**26,393,906**	**4.1**
National Capital Region	13,403,551	3,499,652	3.8
Cordillera Administrative Region (CAR)	1,791,121	439,166	4.1
Region I (Ilocos Region)	5,292,297	1,306,256	4.1
Region II (Cagayan Valley)	3,679,748	907,472	4.1
Region III (Central Luzon)	12,387,811	3,040,488	4.1
Region IV-A (CALABARZON)	16,139,770	4,062,720	4.0
Region IV-B (MIMAROPA)	3,212,287	792,875	4.1
Region V (Bicol Region)	6,067,290	1,365,044	4.4
Region VI (Western Visayas)	7,935,531	1,939,989	4.1
Region VII (Central Visayas)	8,046,285	1,966,588	4.1
Region VIII (Eastern Visayas)	4,531,512	1,082,106	4.2
Region IX (Zamboanga Peninsula)	3,862,588	895,899	4.3
Region X (Northern Mindanao)	5,007,798	1,197,736	4.2
Region XI (Davao Region)	5,223,802	1,337,781	3.9
Region XII (Soccsksargen)	4,351,773	1,065,453	4.1
Region XIII (Caraga)	2,795,340	661,773	4.2
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	4,938,539	832,908	5.9

NOTE: The Philippine total population as of 2020 is 109,035,343 persons. Data in the table does not include the 2,098 Filipinos in Philippine embassies, consulates and missions abroad.
SOURCE: *Philippine Statistics Authority 2020 Census of Population and Housing*

Unrelenting poverty

The economy is rich in both natural and human capital. The potential labor force is 76.6 million, 64.7% of which or 49.6 million is the current labor force as of 2022. The Filipino working force is distributed across three sectors, the services sector (59%), agriculture (23%), and industry (18%).

However, despite growth in employment, jobs created have become increasingly informal particularly after the pandemic with many Filipinos forced to make do with whatever work they can find. The number of part-time workers soared by 3.4 million from 12.6 million in pre-pandemic 2019 to almost 16 million in 2022 while full-time workers only grew by 1.4 million from 29.1 million to 30.5 million and those with a job but not at work by 94,000.

Meanwhile, the number of openly informal workers grew by a huge 3.1 million to 19.9 million or 42.4% of total employed (46.9 million) in 2022. Informal workers are comprised of the self-employed (13 million), domestic workers (2 million), and those working in own family-operated farms or businesses (4.9 million; of which, 3.7 million are unpaid family workers).[4] This lack of decent and quality employment shows that there is a worsening jobs crisis – one that stems from an economy (weakened by decades of neoliberal policies) that has lost its capacity to create meaningful employment.

The country has no mandated national minimum wage. Wage rates differ across regions.[5] NCR has the highest minimum wage at Php570 for non-agricultural work and Php533 for agricultural work. **(See Table 2)**

TABLE 2. Summary of regional daily minimum wage rates, as of December 2022 (in Php)

REGION	EFFECTIVITY	NON-AGRICULTURE	AGRICULTURE	
			PLANTATION	NON-PLANTATION
National Capital Region	June 04, 2022	533 - 570	533	533
Cordillera Administrative Region (CAR)	June 14, 2022	380	380	380
Region I (Ilocos Region)	June 06, 2022	342 - 400	342 - 372	342 - 372
Region II (Cagayan Valley)	June 08, 2022	400	375	375
Region III (Central Luzon)	June 20, 2022	399 - 450	384 - 420	372 - 404
Region IV-A (CALABARZON)	June 30, 2022	350 - 470	350 - 429	350 - 429
Region IV-B (MIMAROPA)	June 10, 2022	329 - 355	329 - 355	329 - 355
Region V (Bicol Region)	June 18, 2022	365	365	365
Region VI (Western Visayas)	June 05, 2022	420 - 450	410	410
Region VII (Central Visayas)	June 14, 2022	387 - 435	382 - 425	382 - 425
Region VIII (Eastern Visayas)	June 27, 2022	350	320	320
Region IX (Zamboanga Peninsula)	June 25, 2022	351	338	338
Region X (Northern Mindanao)	June 18, 2022	390 - 405	378 - 393	378 - 393
Region XI (Davao Region)	June 19, 2022	427	422	422
Region XII (Soccsksargen)	June 09, 2022	368	347	347
Region XIII (Caraga)	June 06, 2022	350	350	350
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	July 21, 2022	316 - 341	306 - 316	306 - 316

SOURCE: *National Wages and Productivity Commission*

The mandated minimum wages in the Philippines are far from the family living wage (FLW) estimated by IBON, the amount a family of five members would need to live decently. According to IBON, the latest FLW in NCR should be Php1,140. The minimum wage thus is 50% short of decent living.[6]

Due to low wages and incomes, millions of Filipino families are experiencing involuntary hunger and are pushed into deep poverty. In 2021, the Philippine Statistics Authority (PSA) reported that poverty incidence increased to 18.1% of the population from 16.7% figure in 2018. This means that there are about 20 million Filipinos living below the poverty threshold of Php12,030 per month.[7] But even this poverty statistics is conservative as the threshold is set too low and does not reflect the true condition and needs of the Filipino families. **(See Table 3)**

The regions with the highest poverty incidence also have relatively lower minimum wage rates. Also, in these regions the common nature of work is agricultural. Farmers, fisherfolk and farmworkers are the country's poorest sectors.

TABLE 3. Poverty incidence among families by region (in %)

REGION	2015	2018	2021
Philippines	**18.0**	**12.1**	**13.2**
National Capital Region	2.8	1.4	2.2
Cordillera Administrative Region (CAR)	17.1	8.6	6.9
Region I (Ilocos Region)	14.0	7.0	11.0
Region II (Cagayan Valley)	13.1	12.5	11.7
Region III (Central Luzon)	8.3	5.2	8.3
Region IV-A (CALABARZON)	9.2	5.1	7.2
Region IV-B (MIMAROPA)	18.0	10.5	15.0
Region V (Bicol Region)	31.0	20.0	21.9
Region VI (Western Visayas)	18.5	11.9	13.8
Region VII (Central Visayas)	24.9	13.4	22.1
Region VIII (Eastern Visayas)	33.0	23.9	22.2
Region IX (Zamboanga Peninsula)	29.7	25.4	23.4
Region X (Northern Mindanao)	32.3	17.3	19.2
Region XI (Davao Region)	18.0	13.9	11.9
Region XII (Soccsksargen)	31.2	22.4	21.4
Region XIII (Caraga)	31.1	24.1	25.9
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	53.8	54.2	29.8

SOURCE: *Philippine Statistics Authority Official Poverty Statistics*

Poor social services

The Philippines has a chronic problem of population density caused by regional migration since jobs and opportunities are clustered in the NCR, Central Luzon, and Southern Luzon. The urban-centric employment opportunities have created informal settlements and slums in the cities, bringing along other social issues.

In terms of housing, only 3 out of 5 Filipino families own the house and lot they are living in as of 2022. **(See Table 4)** Majority of the families, about 58.5%, are residing in a housing unit with a floor area of less than 50 square meters. **(See Table 5)**

The poor condition of housing leads to diseases and the poor prevention of diseases. During the COVID-19 pandemic, for instance, when granular or localized lockdowns were implemented, it was difficult for the people from poor communities to observe social distancing, which made the virus more transmissible especially among poor households. Also, epidemics like dengue and malaria are more prominent in overcrowded and informal housing settlements.

Majority of Filipino households already have electricity. But rotational brownouts are still common in the regions. The country is also under threat of looming energy crisis due to the unstable energy supply–the Malampaya gas plant which supplies 30% of Luzon's energy needs is estimated to be depleted by 2024. Electricity rates in the Philippines are among the highest in the Southeast Asia regions also because of the nature of the power industry being privatized. In December 2021, the Philippines has the second highest residential electricity rate at $0.16/kWh, much higher than Thailand's and Indonesia's $0.10/kWh, and triple of Malaysia's rate of $0.05/kWh.[8]

Access to clean water supply is still wanting for most Filipino households. Only 54.1% of households have piped water supply into their dwellings, while 21.5% still rely on protected wells and 7.4% have water supply piped into yards or plots. About 1% of Filipino families rely on natural sources such as rivers, streams, ponds, lakes, or dams, and rain. **(See Table 6)**

Regional data show the disparity in access to piped water into dwellings. In NCR, 92.6% of households have water piped into dwellings, while BARMM and Cagayan Valley have has 8.7% and 22.7%, respectively. There is also huge disparity among regions with regard to access to drinking water, 99.3% of NCR families have basic service level of drinking water, while only 87.8% of BARMM's population has this same level of access. **(See Table 7)**

Inequitable access to safe and potable water has an impact on community health. Outbreaks of diarrhea and other water-borne diseases such as amoebiasis are common occurrences, especially in the overcrowded urban settlements.

TABLE 4. Percentage distribution of families by tenure status of the housing unit and lot they occupied by region and area of residence, 2022

REGION/RESIDENCE	TOTAL NO. OF FAMILIES (in thousands)	TENURE STATUS OF THE HOUSING UNIT AND LOT (in percent)							
		TOTAL	Own house & lot or owner-like possession of house & lot	Rent house or room, including lot	Own house, rent lot	Own house, rent-free lot w/ consent of owner	Own house, rent-free lot no consent of owner	Rent-free house & lot w/ consent of owner	Rent-free house & lot no consent of owner
Philippines	**26,942**	**100.0**	**62.1**	**9.5**	**1.9**	**15.3**	**2.5**	**8.3**	**0.3**
National Capital Region	3,574	100.0	51.6	28.6	1.1	3.3	3.9	10.7	0.7
Cordillera Administrative Region (CAR)	456	100.0	79.8	7.4	*	3.0	*	8.4	*
Region I (Ilocos Region)	1,289	100.0	75.0	4.9	*	9.6	*	8.6	*
Region II (Cagayan Valley)	912	100.0	86.5	1.4	*	5.2	*	5.8	*
Region III (Central Luzon)	3,058	100.0	76.6	8.7	*	4.3	2.0	6.4	*
Region IV-A (CALABARZON)	4,194	100.0	58.1	15.7	1.9	12.2	1.3	10.6	*
Region IV-B (MIMAROPA)	803	100.0	63.6	3.5	*	18.7	3.4	10.2	*
Region V (Bicol Region)	1,356	100.0	57.8	1.9	1.0	23.2	6.3	9.5	*
Region VI (Western Visayas)	1,982	100.0	45.6	2.3	2.1	42.0	2.6	5.1	*
Region VII (Central Visayas)	2,012	100.0	68.5	7.7	3.2	12.7	2.4	5.4	*
Region VIII (Eastern Visayas)	1,159	100.0	54.3	0.9	4.7	30.1	4.1	5.4	*
Region IX (Zamboanga Peninsula)	886	100.0	63.4	2.4	3.9	20.0	4.7	5.2	*
Region X (Northern Mindanao)	1,213	100.0	66.1	4.4	2.7	16.9	3.1	6.6	*
Region XI (Davao Region)	1,431	100.0	65.5	6.1	2.2	13.6	1.1	11.4	*
Region XII (Soccsksargen)	1,230	100.0	59.8	5.1	2.2	22.4	1.6	8.4	*
Region XIII (Caraga)	679	100.0	55.2	2.3	4.7	26.2	3.0	8.2	*
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	709	100.0	52.6	*	*	33.1	1.7	11.8	*
Residence									
Urban	13,987	100.0	58.7	16.0	2.2	10.5	2.7	9.5	0.5
Rural	12,955	100.0	65.8	2.5	1.6	20.4	2.4	7.1	0.2

Details may not add up due to rounding.

* - An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

SOURCE: *Philippine Statistics Authority 2022 Annual Poverty Indicators Survey*

TABLE 5. Percentage distribution of families by floor area of the housing unit they occupied by region and area of residence, 2022

REGION/RESIDENCE	TOTAL NO. OF FAMILIES (in thousands)	TOTAL	FLOOR AREA IN SQUARE METER (in percent)							
			Less than 10	10-29	30-49	50-79	80-119	120-149	150-199	200 and above
Philippines	**26,942**	**100.0**	**0.1**	**30.4**	**28.0**	**19.9**	**12.6**	**3.1**	**2.7**	**3.2**
National Capital Region	3,574	100.0	*	39.8	29.2	16.6	7.0	1.9	2.0	3.1
Cordillera Administrative Region (CAR)	456	100.0	*	24.4	21.7	24.4	20.1	3.3	2.8	3.4
Region I (Ilocos Region)	1,289	100.0	*	9.4	24.5	29.0	23.3	6.1	3.9	3.6
Region II (Cagayan Valley)	912	100.0	*	27.1	37.5	16.5	11.9	3.8	2.0	1.3
Region III (Central Luzon)	3,058	100.0	*	15.9	31.1	26.5	15.7	3.5	3.7	3.6
Region IV-A (CALABARZON)	4,194	100.0	*	18.5	29.8	26.4	15.4	4.0	3.2	2.7
Region IV-B (MIMAROPA)	803	100.0	*	43.4	29.4	15.2	7.4	1.0	1.3	1.8
Region V (Bicol Region)	1,356	100.0	*	29.8	27.8	16.1	14.3	3.5	3.4	5.3
Region VI (Western Visayas)	1,982	100.0	*	37.0	23.1	17.9	11.0	2.4	3.3	5.1
Region VII (Central Visayas)	2,012	100.0	*	44.5	27.0	12.0	9.6	2.2	1.9	2.8
Region VIII (Eastern Visayas)	1,159	100.0	*	29.8	27.8	22.2	11.2	2.8	1.9	4.4
Region IX (Zamboanga Peninsula)	886	100.0	*	48.8	23.5	14.8	9.2	1.3	*	*
Region X (Northern Mindanao)	1,213	100.0	*	18.9	28.0	22.9	18.2	4.6	3.4	3.9
Region XI (Davao Region)	1,431	100.0	*	43.3	22.0	15.3	11.7	3.0	2.9	1.8
Region XII (Soccsksargen)	1,230	100.0	*	47.8	27.3	11.7	6.6	1.9	2.3	2.4
Region XIII (Caraga)	679	100.0	*	34.9	26.8	19.6	12.5	2.4	2.2	1.7
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	709	100.0	*	28.5	30.8	16.4	13.3	4.5	1.9	4.5
Residence										
Urban	13,987	100.0	*	29.0	27.8	21.2	12.7	3.1	2.9	3.1
Rural	12,955	100.0	*	32.0	28.2	18.5	12.5	3.1	2.5	3.2

Details may not add up due to rounding.

* - An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

SOURCE: *Philippine Statistics Authority 2022 Annual Poverty Indicators Survey*

TABLE 6. Percentage distribution of families with electricity in house/building they reside in, main source of water supply by region and area of residence, 2020

REGION/RESIDENCE	TOTAL NO. OF FAMILIES (in thousands)	WITH ELECTRICITY (in percent)	MAIN SOURCE OF WATER SUPPLY (in percent)											
			TOTAL	Dwelling	Yard/ Plot	Public trap	Protected well	Unprotected well	Developed spring	Undeveloped spring	Rivers/ Stream/ Pond/ Lake/Dam	Rain water	Tanker truck/ Peddler/ Neighbor
Philippines	**25,848**	**94.5**	**100.0**	**54.1**	**7.4**	**4.6**	**21.5**	**3.9**	**4.0**	**1.3**	**0.7**	**0.2**	**2.3**
National Capital Region	3,449	98.1	100.0	92.6	3.5	1.2	1.3	*	*	*	*	*	1.5
Cordillera Administrative Region (CAR)	439	97.2	100.0	52.1	11.1	2.6	8.9	*	16.9	4.1	*	*	3.1
Region I (Ilocos Region)	1,252	98.1	100.0	31.7	5.8	*	55.3	3.0	3.1	*	*	*	*
Region II (Cagayan Valley)	883	94.9	100.0	22.7	1.5	*	59.0	2.5	5.0	2.5	*	*	6.3
Region III (Central Luzon)	2,923	96.9	100.0	66.4	2.7	1.4	24.6	1.0	2.3	*	*	*	*
Region IV-A (CALABARZON)	3,970	98.4	100.0	77.2	4.5	1.9	10.3	2.4	*	*	*	*	2.9
Region IV-B (MIMAROPA)	770	91.4	100.0	39.7	11.6	5.2	32.2	5.2	4.1	*	*	*	*
Region V (Bicol Region)	1,319	92.1	100.0	33.9	9.3	9.7	28.2	11.3	3.9	1.4	*	*	1.4
Region VI (Western Visayas)	1,907	93.3	100.0	31.6	7.1	2.3	40.6	5.8	5.7	*	*	*	5.0
Region VII (Central Visayas)	1,927	91.4	100.0	48.1	10.0	6.0	14.3	7.0	6.7	3.6	*	*	4.0
Region VIII (Eastern Visayas)	1,108	93.9	100.0	35.9	9.6	17.8	26.2	5.5	1.8	1.6	*	*	0.8
Region IX (Zamboanga Peninsula)	863	86.3	100.0	36.1	13.3	11.1	16.3	6.6	6.6	5.4	*	*	3.6
Region X (Northern Mindanao)	1,168	90.5	100.0	48.2	16.0	8.9	11.0	1.9	10.3	*	*	*	2.4
Region XI (Davao Region)	1,356	90.7	100.0	46.4	14.9	6.5	15.7	3.6	9.3	1.5	*	*	*
Region XII (Soccsksargen)	1,181	92.6	100.0	33.7	14.5	6.3	33.5	4.3	4.5	2.0	*	*	0.8
Region XIII (Caraga)	649	94.7	100.0	48.2	9.8	13.2	13.2	5.5	5.7	*	1.5	*	*
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	683	84.1	100.0	8.7	3.9	7.1	30.2	15.6	8.2	3.5	13.1	3.5	6.2
Residence													
Urban	13,332	96.6	100.0	73.8	6.3	2.0	11.2	1.9	1.8	0.5	0.2	*	2.3
Rural	12,516	92.3	100.0	33.0	8.6	7.4	32.5	6.0	6.4	2.1	1.2	0.3	2.4

Details may not add up due to rounding.

* - An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

SOURCE: *Philippine Statistics Authority 2020 Annual Poverty Indicators Survey*

TABLE 7. Percentage distribution of families by service level of drinking water by region and area of residence, 2022

REGION/RESIDENCE	TOTAL NO. OF FAMILIES (in thousands)	SERVICE LEVEL OF DRINKING WATER (in percent)				
		TOTAL	Basic	Limited	Unimproved	Surface water
Philippines	**26,942**	**100.0**	**96.3**	**1.3**	**2.3**	**0.1**
National Capital Region	3,574	100.0	99.3	0.6	*	*
Cordillera Administrative Region (CAR)	456	100.0	94.0	1.3	4.5	*
Region I (Ilocos Region)	1,289	100.0	99.1	*	*	*
Region II (Cagayan Valley)	912	100.0	99.1	*	*	*
Region III (Central Luzon)	3,058	100.0	99.3	*	*	*
Region IV-A (CALABARZON)	4,194	100.0	98.7	*	*	*
Region IV-B (MIMAROPA)	803	100.0	92.1	2.3	5.2	*
Region V (Bicol Region)	1,356	100.0	90.1	4.6	4.9	*
Region VI (Western Visayas)	1,982	100.0	94.7	1.6	3.4	*
Region VII (Central Visayas)	2,012	100.0	94.7	1.7	3.6	*
Region VIII (Eastern Visayas)	1,159	100.0	93.6	2.0	4.3	*
Region IX (Zamboanga Peninsula)	886	100.0	90.2	1.9	7.9	*
Region X (Northern Mindanao)	1,213	100.0	95.5	*	3.8	*
Region XI (Davao Region)	1,431	100.0	97.3	*	1.9	*
Region XII (Soccsksargen)	1,230	100.0	95.9	1.1	2.9	*
Region XIII (Caraga)	679	100.0	94.0	*	4.9	*
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	709	100.0	87.8	6.3	5.5	*
Residence						
Urban	13,987	100.0	98.4	0.7	0.8	*
Rural	12,955	100.0	94.1	1.9	3.9	0.2

NOTES:

1. Families that use bottled water or refilling stations for drinking are classified as using an improved source only if the water they use for cooking and handwashing comes from an improved source. Otherwise, they are classified as unimproved source of drinking water.
2. Limited services includes those familes with improved source of drinking water however the collection time cannot be determined.
3. Service level classifications of water source based on WHO/UNICEF JMP Report 2017:
   Improved sources are those that have the potential to deliver safe water by nature of their design and construction. These include piped supplies (such as households with tap water in their dwelling, yard or plot; or public standposts) and non-piped supplies (such as boreholes, protected wells and springs, rainwater and packaged or delivered water)
   ***Basic** - Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing.*
   ***Limited** - Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing.*
   ***Unimproved** - Drinking water from an unprotected dug well or unprotected spring.*
   ***Surface Water** - Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal.*
4. * - An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

SOURCE: *Philippine Statistics Authority 2022 Annual Poverty Indicators Survey*

Families also suffer from lack of sanitation facilities within their homes. It has been reported that 84.0% of households have improved sanitation facilities. But looking at the report closely, only 5.3% have flush to piped sewer systems. Meanwhile, 2.6% still have no facility or resort to open defecation. **(See Table 8)**

When it comes to education, the net enrolment rate for elementary school was just 89.1%; for Junior High School 81.5%; and for Senior High School 49.5% as of latest available data (SY 2020-2021). The cohort survival rates for these levels were only 83.0%, 82.8% and 71.3%, respectively.[9] Meanwhile, those that had reached or completed college level were just 11.5% of the population aged 15 to 19 years old; 47.3% of 20 to 24 year olds; and 30.9% of 25 year olds and above.[10]

TABLE 8. Percentage distribution of families by sanitation facility by area of residence, 2022

TYPE OF SANITATION FACILITIES	URBAN	RURAL	TOTAL
TOTAL NO. OF FAMILIES (in '000)	**13,987**	**12,955**	**26,942**
TOTAL	**100.0**	**100.0**	**100.0**
Improved, not shared facility	**84.6**	**83.3**	**84.0**
Flush to piped sewer system	7.5	2.8	5.3
Flush to septic tank	72.4	64.0	68.4
Flush to pit latrine	3.9	14.4	8.9
Ventilated improved pit latrine	0.6	1.1	0.9
Pit latrine with slab	0.1	1.0	0.5
Composting toilet	*	*	*
Shared facility[1]	**11.9**	**9.5**	**10.8**
Flush to piped sewer system	0.5	0.1	0.3
Flush to septic tank	10.2	6.8	8.6
Flush to pit latrine	1.1	2.2	1.6
Ventilated improved pit latrine	*	*	*
Pit latrine with slab	*	0.4	0.2
Composting toilet	*	*	*
Unimproved facility	**2.3**	**3.2**	**2.7**
Flush to open drain	0.9	1.0	0.9
Flush to don't know where	0.3	*	0.2
Pit latrine without slab/open pit	*	0.3	0.2
Bucket	*	*	0.1
Hanging toilet/hanging latrine	0.4	0.7	0.5
Public Toilet	0.4	0.6	0.5
Other	0.2	0.4	0.3
No facility/bush/field	**1.2**	**4.0**	**2.6**

NOTES:
1. Shared with two or more households.
2. * - An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

SOURCE: *Philippine Statistics Authority 2022 Annual Poverty Indicators Survey*

Also in 2020, only 5.8% of the population aged 15 to 24 years old availed of the government's Senior High School Voucher Program. The voucher program is supposed to provide financial assistance to qualified senior high students opting to attend private schools amid concerns of public SHS facilities' ability to accommodate a large number of learners and provide quality education. But one of the criticisms of the program is how the voucher amount is not enough to cover all private school costs, thus many students particularly those that are poor or low-income, are unable to avail of this. Additionally, only about 2.7% of the same population group had received or availed of free tuition from State Universities and Colleges (SUCs) or Local Universities and Colleges (LUCs).[11]

The poor quality of social services only reflects the State's abandonment of its responsibility in ensuring social services especially to the disadvantaged. In recent years, there has been a striking contrast between the budgets allocated to the government's infrastructure program and to social services. For 2022, the government allocated 15.4% of the national budget to communications, roads and other transportation programs, while allotting only 5% to health services. Housing and community development got 0.1%; social security, welfare and employment got 9.5%; and other social services got 0.1 percent. The national government's allotment of subsidy to local government units for social services is only at 7.6 percent. **(See Table 9)**

The government also did not put importance on the productive sectors. In 2022, agriculture and agrarian reform received an allotment of 3.0% of the total budget, which was lower compared to 2021's 3.2% and 2020's 4.2% shares.

The government points out that budget allotment for social services has already increased through the years. But it is still not enough to fund the severe lack and weakness of the social services sector. Instead, the government is prioritizing infrastructure flagship projects that are focused on mobility and ease of business, not on social services for the underserved majority of population. Infrastructure development, including provision of public utilities, is privatized, thereby removing the responsibility from the State of ensuring adequate and quality access to these utilities by the poor.

These dire socioeconomic conditions disproportionately impact the poor's full attainment of health. States have had a fragmented and disjointed view on health, as they only focus on health policies and services and not on the wider

scope of improving the social determinants of health. Still, in the case of the Philippine government, despite having the myopic view, it is still failing in giving the needed and appropriate health services to the people. Instead of ensuring to establish a comprehensive and people-centered public health system, the Philippine government has become the main driver of the privatization and commercialization of health.

TABLE 9. Expenditure program by sector, FY 2020-2022 (percentage distribution)

PARTICULARS	FY 2020	FY 2021	FY 2022
Economic services	**26.2**	**29.4**	**29.3**
Agriculture and agrarian reform	4.2	3.2	3.0
Natural resources and environment	0.5	0.6	0.5
Trade and industry	0.4	0.2	0.2
Tourism	0.1	0.1	0.1
Power and energy	0.4	0.3	0.3
Water resources development and flood control	1.4	2.0	1.8
Communications, roads and other transport	12.5	16.0	15.4
Other economic services	1.0	0.9	0.8
Subsidy to local government units	5.8	6.0	7.2
Social services	**40.7**	**37.0**	**38.3**
Education, culture and manpower development	15.8	17.3	16.0
Health	5.9	4.9	5.0
Social security, welfare and employment	12.6	8.3	9.5
Housing and community development	0.3	0.1	0.1
Land distribution	-	-	-
Other social services	0.1	0.1	0.1
Subsidy to local government units	6.1	6.3	7.6
Defense	**4.2**	**4.6**	**4.5**
Domestic security	4.2	4.6	4.5
General public services	**19.6**	**16.6**	**17.2**
General administration	6.6	3.7	3.8
Public order and safety	6.6	7.1	6.4
Other general public services	1.8	1.1	1.3
Subsidy to local government units	4.6	4.8	5.7
Net lending	**0.5**	**0.6**	**0.6**
Debt-service - Interest payments	**8.8**	**11.8**	**10.2**
TOTAL	**100.0**	**100.0**	**100.0**

FY - fiscal year
SOURCE: *Department of Budget and Management Budget of Expenditures and Sources of Financing 2022*

Liberalization of public healthcare

Philippine public healthcare has undergone several reforms starting in the 1990s, mainly directed by global institutions such as the UN, WHO, as well as the World Bank. In particular, the World Bank started becoming influential in the health policy reforms across the globe when it released in 1993 the report titled "Investing in Health". This has set the thrust of health policies and goals that should be followed by countries, especially low-income and low-middle income countries

(including the Philippines) which are recipients of World Bank's program loans. The Philippine government has since then obediently followed and implemented these neoliberal health policies.

Devolution

The direction towards privatization and commercialization of the health system started with the decentralization and devolution of health services from the central government to the local government units (LGUs) through the Local Government Code of 1991 (LGC). The LGC was enacted when the Mandanas-Garcia ruling won in the Supreme Court, which meant that there would be a revision in how the national government would allocate the national revenue among the LGUs.

The term "devolution" pertains to the act in which the national government confers power and authority upon the LGUs to perform specific functions and responsibilities. Section 17 of the LGC states that basic services and facilities are devolved to the LGUs. Additionally, the national government or the next higher level from an LGU may provide or augment the basic services and facilities assigned to the lower level LGU when such services or facilities are not made available or, if made available, are inadequate to meet the requirements of its inhabitants.[12]

The LGC enumerates the types of health facilities and services that are discharged to various levels of local government. This decentralization of health services and facilities has been reaffirmed in the recently issued Department of Health (DOH) Devolution Transition Plan for 2022-2024, which also aligns the devolved services to the implementation of the Universal Health Care (UHC) Law in the country.[13]

The following are the respective LGUs assigned on specific health expenditures, according to the plan:

PROVINCE	Health services which include hospitals and other tertiary health services
MUNICIPALITY	➔ Health services which include the implementation of programs and projects on: • Primary Health Care, • Maternal and Child Care, and • Communicable and Non-communicable Disease Control Services ➔ Access to secondary and tertiary health services ➔ Purchase of medicines, medical supplies and equipment ➔ Rehabilitation programs for victims of drug abuse ➔ Nutrition services and family planning services ➔ Clinics, health centers, and other health facilities necessary to carry out health services
CITY	All the services and facilities of the municipality and province in addition thereto, adequate communication and transportation facilities
BARANGAY	Health services which include the maintenance of barangay health facilities

Under the LGC, financing and delivery of the specified health services and programs will be under the responsibility of the assigned LGU. Meanwhile, the DOH retains its inherent functions according to its mandate on policy and standards development, regulations, performance management, and other governance functions. On the other hand, the management of human resources, infrastructure, equipping, and information technology management are the DOH's support for equity or augmentation to the LGUs.[14]

Different types of social services that were previously provided by the different national government agencies were devolved to the LGUs, with the premise that LGUs would have the capacity to fund these services with their increased allotment from the national revenue. One of the services devolved was the provision of health services that were previously managed by the national government through the DOH.

With the LGC in place, the provincial governments are tasked to facilitate and provide primary and secondary hospital services through the operations of district and provincial hospitals. The city and municipal governments are appointed to provide promotive and preventive health programs among their constituents, and to deliver basic clinical care through managing Rural Health Units (RHUs), Health Centers (HCs), and Barangay Health Stations (BHS). The DOH retains its function of formulating and laying down national policies and plans, developing technical standards, and enforcing health regulations. The DOH also maintains its operation in some tertiary and specialized hospitals.

The main problem with devolution is that LGUs have different financial capacities and priorities in legislation, which causes wide gaps in health care provisions among LGUs. Also, most tertiary and specialized hospitals are operating in the NCR, while others are in the so-called Highly Urbanized Centers (HUCs) and other bigger cities. With this uneven distribution of health facilities, people living in so-called Geographically Isolated and Disadvantaged Areas (GIDA) and other poorer LGUs have limited or no access to health services. The differences in the amount of available resources and budget have affected the quality and quantity of health services provided regionally, perpetuating health inequalities in the country.

Health Sector Reform Agenda (HSRA) of 1999

The DOH considers the HSRA as one of its major accomplishments, setting it as the blueprint for improving the health sector. In the beginning, the department identified five main reforms that would cover the different aspects of the health system, namely:

1. Fiscal autonomy for hospitals
2. Development of local health systems
3. Strengthening regulatory systems
4. Expanding coverage of the national insurance program
5. Secure funding for public health programs

These points were then further developed to cover five major areas of the health system. The reform strategies have been geared towards the corporatization of the public health system, to wit:

1. **Hospital Systems**
    - Parallel and rational revitalization of provincial and district hospitals together with the regional and national hospitals
    - Expansion of hospital financing systems of the regional and national hospitals
    - Guided and phased-in conversion of regional and national hospitals into government corporations or other appropriate government institutions
    - Expansion of the existing government hospital networking and patient referral system to include private hospitals and form the Philippine Hospital System
    - Integration of appropriate and priority public health programs into hospital areas
2. **Public Health Programs**
    - Increase of investments in public health programs
    - Upgrading of the physical and management infrastructure at all levels of the health care delivery system
    - Development and strengthening of technical expertise in public health practice
3. **Local Health Systems**
    - Development and advocacy for local health systems
    - Capacity building of health human resources in synchronization with the development of hospital systems and public health programs
    - Strengthening of inter-LGU linkages, cost sharing schemes, and local financing for health in a devolved set-up
    - Expansion of opportunities for participation of the private sector, non-government organizations (NGOs), and communities in local health systems
    - Development of mechanisms to sustain local health systems

4. **Health Financing**
    - Improvement of benefits to make the National Health Insurance Program (NHIP) more attractive
    - Aggressive enrolment of members
    - Introduction of measures to improve program performance
    - Development of administrative infrastructure that can handle the increased workload
5. **Health Regulation**
    - Identify and address the gaps in health regulation, particularly, strengthen the legal mandates for regulation and enforcement
    - Strengthen the capabilities of central office and regional health offices in standards development, licensing and enforcement
    - Develop new regulatory instruments to promote competition, cost containment, better accessibility and quality assurance in health care markets

The HSRA of 1999 further decentralized and devolved public hospital management and services. Public hospitals were then given the task to be fiscally autonomous by charging user-fees to gain profits to be used in their operations and enhancement of facilities.

This replaced national government responsibility through the DOH and LGUs of ensuring that public hospitals have enough budget for them to continue giving affordable hospital services. With HSRA, public hospitals have been expected to be cost-efficient and independent, which allowed the national government and LGUs to cut their budget allocations for said hospitals.

Another aspect of the HSRA that has lessened the responsibility of the national government is the formation of inter-local health zones (ILHZs) and private sector partnerships. An ILHZ is defined by the DOH as a formation of different health providers and facilities that have coordinated operations within a local geographic area under the management of more than one LGU. An ILHZ can be composed of primary health care providers, such as BHS, RHU, HC, community hospitals, private practitioners, traditional/alternative providers, caregivers, and households; core referral hospital(s) such as district hospital or provincial hospital; and end referral hospital(s) such as higher level hospitals. This has resulted in less incentive for the government to strengthen and expand public hospitals' capacity, since services not available in the government health facilities can be easily passed on to the more advanced private facilities.

Build-Operate-Transfer Law

The Republic Act (RA) No. 6957, or the Build-Operate-Transfer (BOT) Law, is instrumental in opening up construction, rehabilitation and enhancement of infrastructure and facilities to the private sector. Private corporations are also allowed to manage and operate publicly owned infrastructure through shared responsibilities with the national government or LGU. This law has likewise facilitated public-private partnerships (PPP) in the health sector.

One of the most hyped PPP projects in the country is the expansion of the National Kidney and Transplant Institute (NKTI). The NKTI is a government-owned and controlled corporation (GOCC) hospital specializing in treatment of kidney and related diseases through dialysis and transplantation. NKTI also serves as a health research institute focused on developing materials on prevention, diagnosis, and rehabilitation, of kidney and related diseases. Under the Aquino administration, the NKTI has entered into a long-term PPP plan with foreign health corporations such as Fresenius Medical Center and Baxter International.

The NKTI was able to expand and increase its hospital services capacity, but this resulted in lower ratio of served indigent patients. In its annual reports, the agency showed that most of the patients they have served in the recent years are mostly paying patients and low number of hospital beds are provided to indigent patients. **(See Table 10)**

Currently there are a total of nine PPP projects for health on the list from the PPP Center. Four are being implemented, while five are still in the pipeline. **(See Table 11)**

TABLE 10. National Kidney Transplant Institute patient mix

OPERATIONAL DATA	2015	2016	2017	2018	2019	2020
Actual bed capacity	**309**	**329**	**355**	**371**	**371**	**293**
Pay	238 (77%)	243 (74%)	252 (31%)	262 (31%)	254 (68%)	181 (62%)
Service	71 (23%)	86 (26%)	103 (29%)	109 (29%)	117 (32%)	112 (38%)
Occupancy rate	**79.0%**	**82.0%**	**85.0%**	**85.0%**	**84.9%**	**68.0%**
Patient mix ratio	**81% : 19%**	**77% : 23%**	**74% : 26%**	**74% : 26%**	**73% : 27%**	**61% : 39%**
Inpatients admission	**16,571**	**16,934**	**17,119**	**16,950**	**16,097**	**7,760**
Philhealth support value	**12%**	**14%**	**22%**	**23%**	**nda**	**nda**

nda - no data available
SOURCE: *National Kidney Transplant Institute Annual Reports 2015-2020*

TABLE 11. Public-Private Partnership Projects for Health

PROJECT TITLE	IMPLEMENTING AGENCIES	ESTIMATED TOTAL PROJECT COST	PRIVATE PROPONENT	STATUS
University of the Philippines (UP) Philippine General Hospital (PGH) Manila Cancer Center	UP	Php4.6 billion	International Finance Corporation-World Bank Group	Ongoing implementation
UP PGH Diliman	UP	Php21.3 billion	PwC Philippines	Ongoing implementation
Baguio General Hospital & Medical Center (BGHMC) Renal Center Facility	DOH, BGHMC	Php470 million		Ongoing implementation
Cagayan Valley Medical Center (CVMC) Hemodialysis Center	DOH, CVMC	Php140 million		Under development
Mariveles Mental Wellness Center	DOH, Mariveles Mental Wellness and General Hospital	TBD		
Bicol Medical Center's (BMC) Medical Arts Building and Upgrading of Health Services	DOH, BMC	TBD		
New Ospital ng Makati	Makati City Government	TBD		Project info for verification
Pasig City Mega Dialysis Center	Pasic City Government	Php100 million	Premier 101 Healthcare Management, Inc.	Ongoing implementation
Valenzuela City Multispecialty Healthcare and Wellness Center	Valenzuela City Government	Php220 million	Premier 101 Healthcare Management, Inc.	Awarded

SOURCE: *Public-Private Partnership Center, Department of Health*

The biggest project in the pipeline is the University of the Philippines (UP) Philippine General Hospital (PGH) Diliman project, with a total worth of Php21.3 billion. It involves the construction of PGH Diliman with 700-bed capacity. It will be a multi-tertiary specialty hospital that will include different types of services such as outpatient, medical research, medical school, hospice, and ancillary facilities.

There are also PPP projects for local specialty hospitals like the Cagayan Valley Medical Center (CVMC) Hemodialysis Center Project worth Php140 million and the Baguio General Hospital and Medical Center (BGHMC) Renal Center Facility Project worth Php470 million. These two projects are still in the development stage, but once finished they will impact the quality and price of hospital services provided.

National Health Insurance Act of 1995

The introduction of social health insurance in health financing came after devolution. RA No. 7875, or the National Health Insurance Act in 1995, enacted the formation of the Philippine Health Insurance Corporation or PhilHealth, which would be the implementing body for the National Health Insurance Program (NHIP).

The avowed objective is to make health affordable to the majority. The NHIP mentions giving priority to the needs of vulnerable sectors such as the underprivileged, sick, disabled, elderly, women, and children. It also states that it is a State policy to make healthcare free for the poor.

After its introduction in 1995, the social health insurance program has undergone many changes as there has been little effect on making health services affordable and accessible to the population. It has implemented different systems in purchasing and financing health services such as the case-rate packages and interim reimbursement mechanism.

Decades of social health insurance has shown insignificant results in improving the health outcomes. PhilHealth reports wider population coverage, yet the number of claims covered per year has not consistently increased. Compared to the claimed covered percentage of the population, a small portion has benefited from its case rate packages as reported in their final number of claims paid.

The private health sector has benefited the most in PhilHealth. Most of the claims were paid to private health facilities. The insurance system has only ensured profitability of health services to the private corporations which has allowed them to proliferate and take over the health system in regions with higher economic activities.

The NHIP was revised in 2013 to give PhilHealth more roles and to expand its mandates from a mere purchaser of health services. Yet, despite its low utilization in almost two decades, it was still chosen as the main implementer and focus of the UHC Law.

The UHC Law

According to the WHO, universal health coverage (UHC) is the financial risk protection of all individuals and communities when they receive health services. The WHO proposed the UHC to prevent people from catastrophic spending on health due to expensive costs of healthcare services across the globe. The UHC will be a framework of health services provision through purchasing and financialization instead of pushing for health systems strengthening by capacitating the public health system. This mechanism is instrumental in giving bigger roles to the private health sectors as they will serve as providers of the health services that the public health system cannot give.

In the Philippines, the adoption of UHC started in 2010 with the promotion of the Aquino Health Agenda (AHA) by then President Benigno Aquino III. The AHA was later renamed the Universal Health Care (a new meaning to UHC) or Kalusugang Pangkalahatan (KP) with the main goal of achieving universal health coverage for all Filipinos.

But UHC was only made into law in 2019, or nine years later, through the certification of RA 11223 or UHC Act by former President Rodrigo Duterte. The Duterte administration declared the UHC as the State's policy to protect and promote the Filipinos' right to health and health consciousness. UHC became the framework for the Philippine health system to provide access to comprehensive health services. UHC is to be the model in designing promotive, preventive, curative, rehabilitative, and palliative health services and in ensuring that the people will be protected from financial risks.

But in order for UHC to work, the PhilHealth needs to be strengthened. So, the government has pushed for the expansion of the social health insurance as it will be the main tool in the implementation of UHC. The Aquino administration started

the strengthening of PhilHealth in 2013 and it carried on until Duterte's term until the passage of UHC in 2019.

The UHC has four guiding principles[15]:

1. Adopt an integrated and comprehensive approach to ensuring health literacy, healthy living, and protection from hazards and risks
2. Develop a healthcare model that provides comprehensive health services without causing financial hardship to citizens, specifically the poor and marginalized members of society
3. Pursue a whole-of-system, whole-of-government, and whole-of-society approach in developing health policies
4. Adhere to a people-oriented approach centered on people's health needs and well-being

The UHC adopts the WHO framework on universal health coverage which has three major dimensions as illustrated in the UHC cube.

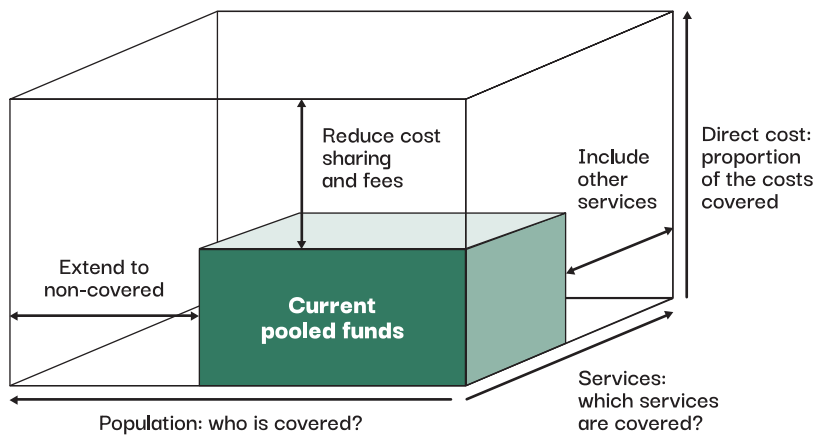


FIGURE 1. *Three dimensions of Universal Health Coverage, WHO World Health Report 2010*

The three coverage of UHC are the following:

1. **Population coverage** - this answers the question "Who is covered?". In the context of PhilHealth, basically all Filipinos are covered through membership with PhilHealth.
2. **Service coverage** - this answers the question "Which services are covered?". There is an existing system with PhilHealth in identifying the health services that can be covered by the agency. There are the Case Rate system, the Primary Care Benefit program through KONSULTA, Z Benefit, Pregnancy packages, among others.
3. **Financial coverage** - this answers the question "Which proportion of the cost or health expenditure will be covered?". This is the government's way of reducing people's out-of-pocket expenditure for health.

Under the UHC, the Health Care Provider Network (HCPN) was institutionalized. HCPN refers to the group of primary, secondary, and tertiary care providers that offer comprehensive health care in an integrated and coordinated manner to their catchment population.[16] An HCPN can be composed of purely public or private health facilities or a mix of both. HCPN can be considered as the UHC version of HSRA's ILHZ.

Meanwhile, UHC classified health services into two categories: the individual-based and population-based. Individual-based are health interventions that can be accessed within a health facility or remotely; can be definitely traced back to one recipient; have limited effect at a population level; and do not alter the underlying cause of illness.[17] These are the basic hospital services like medical check-up, laboratory procedures (x-rays, ultrasound, etc.), operations and surgeries. Population-based are health interventions that have targeted population groups as receivers, such that services cannot be specifically traced back to a single person or beneficiary. These are government-led programs such as immunization, feeding programs for malnourished and undernourished children, education campaign for diseases prevention, among others.

Still, despite bigger allocation, PhilHealth has still performed poorly. In its yearly report, it can be seen that a small portion of the Filipino population has benefited from it. There is low utilization for health insurance because of the complicated process and several requirements needed before the patient is qualified for the case benefit package.

From 2017 to 2022, the number of claims paid were much smaller compared to the size of population covered. During this period, the number of claims paid were only 11.1% of the total population covered. And since the reported claims paid were not unique claims, it can be assumed that the share of population who benefited in PhilHealth's case-rate packages were much smaller.

PhilHealth also perpetrated the growth of private health insurance through Health Maintenance Organizations (HMOs) by encouraging them to create complementary health packages, making them more marketable to private corporations and employees.

Despite the framing of the UHC as a comprehensive health framework, the real story is that UHC perpetuates disease-based and specialist-centric health care services in the country. Under PhilHealth, both the healthcare institution and professionals are required to undergo the agency's accreditation process. The accreditation is needed for them to be able to accept the "reimbursement" or payment of case-rate packages.

The role of the Declaration of Astana 2018

The UHC is far from the comprehensive primary healthcare being promoted as a step towards Health for All in the Alma-Ata Declaration. It veered away from the rights-based approach on health, and instead commodified and commercialized health services. Under the UHC, the State is now only a purchaser of health services, may they be from public or private facilities, purportedly to efficiently manage the country's health financing. The UHC framework has not focused on strengthening the public health system, instead it has become a perpetrator of the commercialization and privatization of health systems across the globe.

To further justify the use of UHC as a global health policy, the WHO called for another conference allegedly to affirm its strong commitment to the attainment of the highest standard of health by apparently sticking to the core principles and values mentioned in the Alma-Ata Declaration of 1978. In 2018, the WHO, UN Children's Fund (UNICEF), and WHO member states have convened in Astana, Kazakhstan to reaffirm their commitments. The event was called the Conference of Global Primary Health Care and its goal was to strengthen primary healthcare as an essential step towards global universal health coverage.

This declaration has fast-tracked the implementation of universal health coverage as health system framework around the globe. The Astana declaration has resulted in the integration of the commercialized and privatized health insurance system and financing. And WHO member countries are now compelled to follow and fulfill the UHC indicators which are set accordingly by the liberalized health insurance system. The Astana declaration also watered down the impact of social determinants to the health outcomes of the people, which was already highlighted by the Alma-Ata declaration.

Push by International Financial Institutions (IFI)

Neoliberal policies in health are conditionalities to IFI lending. The World Bank as well as the Asian Development Bank (ADB), through their different health program supports, have been pushing these policies not just in the Philippines but also in other poor countries to realize the accessibility and equity of health services through privatization and other neoliberal health reforms. In the Philippines, these policies were modeled with technical guidance and intervention by these institutions.

In 1992, the ADB has granted a technical assistance under the health and social protection sector for the implementation of the devolution of health services through the LGC. This project was the Devolution of Health Services to Local Government Units which was worth US$100 million. An additional technical assistance for the devolution implementation was given in 1993 through the Implementation of the Local Government Code in the Health Sector project worth US$300 million.

The implementation of HSRA of 1999 had a loan program under the ADB worth US$200 million under the project name of Health Sector Development Program (HSDP), which aimed to support the DOH in realizing the HSRA and in achieving the United Nations Millennium Development Goals (MDGs) for Health by 2015. The HSDP was both a project loan by the ADB and co-financed by the Philippine government. In the ADB's Validation Report made by the Independent Evaluation Department, the overall assessment of the program was "Less Than Successful" despite the initial rating of "Successful" in the Program Completion Report.[18]

In 2011, the World Bank granted a specific investment loan to help increase the utilization of health services among the poor populations of Eastern Visayas region through subsidized vouchers under the PhilHealth. This was the Philippines Public Health project worth US$6.63 million, approved in 2011 and closed in 2015.

And then in 2019, the World Bank has approved an investment project financing worth US$1.35 million to support the enhancement of PhilHealth payment and performance mechanisms. This project was called the Philippines Health Financing Strengthening and was implemented by the DOH. Aside from this, the Philippine government also received another loan program from the ADB to support the implementation of the UHC. This was called the Build Universal Health Care (BUHC) program, and this is worth US$600 million.

The mentioned loan and technical assistance programs from the ADB and World Bank have shown the push and influence of these IFIs in the implementation of neoliberal health policies in the country. These IFIs are also on hand in the conduct of these projects as most of the terms and targets for each project are dictated by these institutions. For example, the ADB has a guidebook for the PPP projects of hospitals in the Philippines–as the ADB has been very supportive of the PPP in the health sector.

Benefits to corporations

Despite the many declarations on the capacitance of the health system around the world, the implementation of neoliberal policies and programs in the health sector has been hindering countries from achieving health for all. Powerful institutions such as the WHO and the UN have pushed for these neoliberal policies to change the health system under the guise of efficiency of services. Changes in the health system has made achievement of efficiency and equitability of health services as the end-goal instead of promoting the free health services for all.

It is notable that among the huge funders of the WHO are transnational corporations (TNCs) that have investments in private healthcare, medical facilities, pharmaceuticals, among others. The promotion of health insurance has also financialized health and made accessibility farther from the grasp of poor people.

The WHO pushes for health reforms to lean on privatization and liberalization of health services and does this with the support of TNCs focused on making profit from health. It is ironic how the WHO has kept on receiving funds from TNCs investing in the unhealthy food and beverages industry, and other harmful substances like alcohol, etc.

Neoliberal policies have shaped the country's health system into a privatized, commercialized, commodified, and disease-centric one that is more and more out of reach by ordinary Filipinos.

Systemic ills

Healthcare is composed of facilities, institutions, organizations, and people whose primary function is to deliver health services to the population. These health services should promote, restore, or maintain the well-being of the people. This entire system also includes ensuring the social determinants of health and direct health-improving services.[19]

The present structure and condition of the Philippine health system is a conjunction of the neoliberal policies that have been implemented for several decades. These policies have introduced corporatization and privatization of the health sector, and in the process have weakened the role of the State.

Weakened health governance

The health system in the country is spearheaded by the DOH, which is responsible for the formulation and regulation of health policies and programs. The DOH is headed by a secretary appointed by the Philippine president. It is funded annually through the General Appropriations Act (GAA) or the national budget.

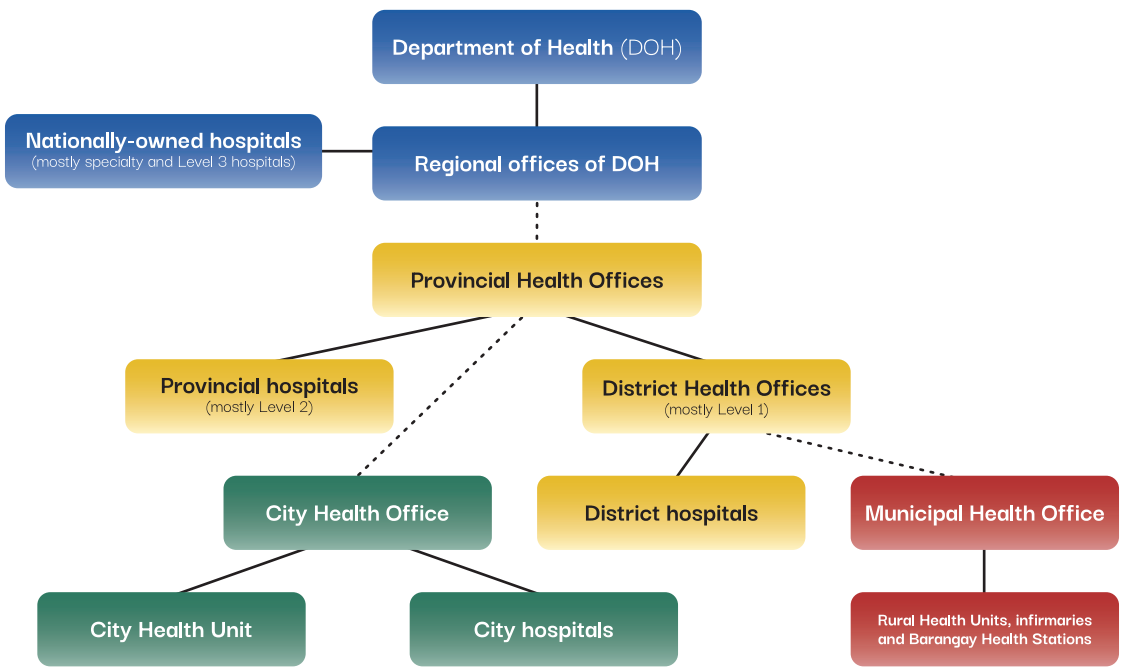


FIGURE 2. *Governance structure of Philippine healthcare system, DOH Health Facility Development Plan 2020-2040*

The DOH has two attached agencies also involved in health system governance–the Philippine National AIDS Council and the National Nutrition Council (NNC). These two bodies are also funded through GAA.

There are also existing GOCCs dedicated to the health sector. These are partially funded by the national government. These GOCCs are: the Lung Center of the Philippines (LCP), NKTI, Philippine Children's and Medical Center (PCMC), Philippine Heart Center (PHC), Philippine Institute of Traditional and Alternative Health Care (PITAHC), and the PhilHealth.

Among these GOCCs are four specialty hospitals (LCP, NKTI, PCMC, and PHC) that are involved in delivering direct health services. These are also hospitals that are recognized as experts in treating targeted diseases. Meanwhile the other two, the PITAHC and PhilHealth, are corporations with governing and managing responsibilities.

The four GOCC hospitals were initially built as public specialty hospitals under the management of the DOH. But, years after these hospitals started operations, government has declared that these hospitals are operating below its capacity. And it was raised that corporatizing these hospitals will help boost the capacities of these centers as it will make private investments easier to enter in these facilities.

These GOCCs are led by mixed sets of officials and are designed to work like private corporations. They have a Board of Trustees or Directors, which is composed of public officials and prominent businessmen and technocrats. GOCC presidents or directors are also appointed by the Philippine president who can also assign individuals to take other positions in the GOCCs, such as directors, senior vice presidents, or members of the Board of Directors.

Since the privatization and corporatization of health services, private corporations and entities have become major players in the health system. A huge number of private health care institutions (HCIs) are offering health services, from primary to tertiary hospital care, and specialty health interventions like maternal care, hemodialysis, and laboratory services, among others. This is while health governance has been restructured, reducing DOH's role to monitoring and accreditation of private HCIs. The DOH has no control over the prices of different services offered by these facilities.

In 2022, the DOH has licensed a total of 4,264 health facilities offering primary health care services, 3,507 or 82% of these facilities are privately owned. These facilities are classified into three types, the Primary Care Facilities (PCF), Infirmaries, and Clinical Laboratories. PCFs pertain to the Municipal Health Units (MHUs) or the Rural Health Units/Centers (RHU/Cs). These are LGU-operated basic health facilities, with different level of capacities. PCFs are also unevenly distributed among regions, Region 2 has the most number of PCFs with 101, and meanwhile there are 4 regions (Regions VI, IX, XII, and BARMM) with no government-owned PCFs. **(See Table 12)**

TABLE 12. List of DOH-licensed Primary Care Facilities, Infirmaries and Clinical Laboratories

REGION/CHD	PRIMARY CARE FACILITIES			INFIRMARIES			CLINICAL LABORATORIES		
	Gov't	Private	TOTAL	Gov't	Private	TOTAL	Gov't	Private	TOTAL
National Capital Region	18	-	18	-	17	17	23	640	663
Cordillera Administrative Region (CAR)	56	-	56	-	7	7	26	61	87
Region I (Ilocos Region)	2	-	2	-	27	27	50	131	181
Region II (Cagayan Valley)	101	-	101	-	9	9	28	87	115
Region III (Central Luzon)	11	1	12	5	24	29	18	581	599
Region IV-A (CALABARZON)	5	-	5	-	20	20	11	585	596
Region IV-B (MIMAROPA)	3	-	3	-	10	10	45	74	119
Region V (Bicol Region)	67	-	67	-	27	27	11	97	108
Region VI (Western Visayas)	-	-	-	-	3	3	28	254	282
Region VII (Central Visayas)	1	-	1	3	10	13	53	164	217
Region VIII (Eastern Visayas)	3	-	3	1	7	8	4	71	75
Region IX (Zamboanga Peninsula)	-	-	-	1	16	17	24	61	85
Region X (Northern Mindanao)	1	1	2	3	17	20	46	104	150
Region XI (Davao Region)	2	3	5	11	36	47	53	167	220
Region XII (Soccsksargen)	-	-	-	-	30	30	21	80	101
Region XIII (Caraga)	-	1	1	1	8	9	14	52	66
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	-	-	-	1	15	16	6	9	15
TOTAL	**270**	**6**	**276**	**26**	**283**	**309**	**461**	**3,218**	**3,679**

SOURCE: *Department of Health - Health Facilities and Services Regulatory Bureau*

The infirmaries and clinical laboratories are supplementary provider of primary health services. There is a total of 309 licensed infirmaries in the country of which 92% are privately owned. On the other hand, the clinical laboratories which make up the 86% of the primary health services provider are also dominated by the private health sector. Eighty-seven percent of the licensed clinical laboratories are privately owned.

Private corporations engaged in delivering health services are under the regulation and monitoring of the DOH through the Health Facilities and Services Regulatory Bureau (HFSRB).[20]

The HFSRB has eight (8) general functions:

1. Set minimum standards for regulation of health facilities and services
2. Disseminate regulatory policies and standards for information and compliance
3. Issue permits to construct, License to Operate, and Certificate of Accreditation
4. Monitoring of health facilities and services to ensure continuous compliance of health facilities and regulatory standards
5. Provide technical assistance, consultation and advisory services to stakeholders regarding health facilities regulation
6. Conduct research relative to regulation of health facilities and services
7. Conduct fact-finding on complaints against health facilities and services
8. Act on complaints against hospitals and other health facilities

The HFSRB is responsible for the licensing and accreditation of the following health facilities and services:

1. Ambulance Service and Ambulance Service Provider
2. Ambulatory Surgical Clinics
3. Birthing Homes
4. Blood Service Facility
5. Cancer Treatment Facility
6. Clinical Laboratory
7. COVID-19 Testing Laboratory
8. Dental Laboratory
9. Dialysis Clinic
10. Drug Testing Laboratory
11. Drug Abuse Treatment and Rehabilitation Center
12. Hospital
13. Human Stem Cell and Cell-Based or Cellular Therapy
14. Infirmary
15. Kidney Transplant Facility
16. Laboratory for Drinking Water Analysis
17. Medical Facility for Overseas Workers and Seafarers
18. Newborn Screening Center
19. Occupational Establishment Dental Clinics
20. Psychiatric Care Facility
21. Primary Care Facility

The accreditation is also not standardized as the DOH and PhilHealth have different accreditation processes. There are cases where the same facility has different levels of classification due to the differences in requirements set by the two agencies.

This discrepancy has an impact on the delivery of service. For instance, in PhilHealth only higher level facilities can deliver certain types of health services thus they are the only ones eligible for higher case packages. This premise in accreditation can lead to untruthful reporting by the private HCIs on the services they offer so they can avail of the higher

case packages. And since the two agencies have no strong mechanism in monitoring and feedbacking, there are no substantial reports supporting the truthfulness of the accreditation accomplishment of several health facilities.

Defaulting on service delivery

Delivery of primary health services should be in the hands of the government. But since the UHC Law, private primary health care (PHC) providers have been accredited.

In the country, primary health services are offered through different types of public and private health facilities. PCFs are the first-line of contact to patients. These are mostly the Rural Health Centers (RHCs) or Municipal Health Centers (MHCs). But since these PCFs have limited health service capacities, the next supporting facilities are the Clinics and Clinical Laboratory.

In the DOH data, huge number of licensed clinics and laboratories are privately owned.

On the part of the government, there is a mix of LGU- and DOH-controlled health facilities that manage health services. The most basic of these facilities is the Barangay Health Station (BHS). A typical BHS can offer medical check-ups for sick patients or routine check-ups for pregnant women. Some BHS also offer animal bite treatment and some also give free basic medicines. Services offered by BHS vary depending on the financial capacity of the LGU where they belong.

It is ideal for the Philippines to have one BHS per barangay as it serves as the first line of health intervention and should be accessible. But until now, only half (21,730) of the total number of barangays in the country have BHCs.

The next unit for health service delivery is the Rural Health Unit (RHU) or City Health Unit (CHU). The RHU/CHU is under the management of the municipality or city Government. This particular public facility is expected to serve primary care prevention to patients through screening and diagnosis of different diseases. The government's goal is for all Filipinos to have access to RHU/CHU within 30 minutes.[21] But according to the DOH Philippine Health Facility Development Plan 2020-2040, only half of the population have access to RHU/CHU within 30 minutes. And among the regions, BARMM, Regions V and IV-B, are the ones with the highest share of population with no access to nearby RHU/HC.[22] Coincidentally, these regions are also among the most poorest in the Philippines.

The government has a target of a 1:20,000 RHU/HC to population ratio in the country. But before the COVID-19 pandemic in 2019, the government was still far from achieving this target – the national average RHU/HC to population ratio was 1:31,385, which only got worse at 1:32,530 during the pandemic in 2020. This went down further in 2021 with 1:39,541 RHU/HC to population ratio.[23] **(See Table 13)**

TABLE 13. RHU/HC per Population ratio, 2020-2021

REGION	2020	2021
NATIONAL AVERAGE	**1 : 32,530**	**1 : 39,541**
National Capital Region	1 : 29,450	1 : 29,465
Cordillera Administrative Region (CAR)	1 : 18,775	1 : 18,605
Region I (Ilocos Region)	1 : 33,937	1 : 33,208
Region II (Cagayan Valley)	1 : 26,546	1 : 37,518
Region III (Central Luzon)	1 : 36,069	1 : 42,307
Region IV-A (CALABARZON)	1 : 74,678	1 : 71,521
Region IV-B (MIMAROPA)	1 : 37,137	1 : 37,782
Region V (Bicol Region)	1 : 45,089	1 : 45,200
Region VI (Western Visayas)	1 : 54,621	1 : 54,322
Region VII (Central Visayas)	1 : 20,294	1 : 26,609
Region VIII (Eastern Visayas)	1 : 25,911	1 : 27,937
Region IX (Zamboanga Peninsula)	1 : 39,989	1 : 40,568
Region X (Northern Mindanao)	1 : 18,666	1 : 34,791
Region XI (Davao Region)	1 : 69,743	1 : 70,823
Region XII (Soccsksargen)	1 : 30,493	1 : 78,129
Region XIII (Caraga)	1 : 11,066	1 : 30,945
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	1 : 29,055	1 : 36,955

SOURCE: *Department of Health 2021 LGU Health Scorecard Annual Report*

Hospitals are classified into three levels – Level 1, 2, and 3 – with different service capabilities, as follows[24]:

SERVICES	LEVEL 1	LEVEL 2	LEVEL 3
Clinical Services for In-patients	Consulting specialists in, but not limited to: Medicine Pediatrics OB-Gyne Surgery	All of Level 1 plus: Departmentalized Clinical Services	All of Level 2 plus: Teaching/training services with at least any two (2) accredited residency program for physicians in any medical/surgical specialty and/or subspecialty
	Emergency, Out-patient Services	Respiratory Unit	Physical Medicine and Rehabilitation Unit
	Isolation Facilities	General ICU	
	Surgical/Maternitiy Facilities	High-risk Pregnancy Unit	Ambulatory Surgical Clinic
	Dental Clinic	NICU	Dialysis Clinic
Ancillary Services	Secondary Clinical Laboratory	Tertiary Clinical Laboratory	Tertiary Clinical Laboratory with Hispathology
	Blood Station	Blood Station	Blood Bank
	1st Level X-ray	2nd Level X-ray	3rd Level X-ray
	Pharmacy	Pharmacy	Pharmacy

There are 1,289 licensed hospitals in the country in 2021, of which 849 or 66% are privately owned. **(See Table 14)** Total bed capacity is 109,893, of which 54% is in private hospitals. The remaining 50,966 beds are accounted for by government hospitals, either retained by the DOH or managed by the LGUs. Because of the devolution of health services, most of the government-owned hospitals are under the ownership of LGUs. Currently, there are 65 DOH-retained hospitals while 330 are owned by LGUs, 16 hospitals are under the ownership of Minister of Health (MOH) BARMM, while the few remaining others are owned by some other government institutions. On average, a private hospital has a bed capacity of 69, while a public hospital has 116.[25]

Disparity between the highly urbanized and poorer regions is also evident. The regions with the highest number of hospitals are Region IV-A, Region III, and NCR, which have 225, 175, and 159 hospitals, respectively. These numbers are far greater compared to the other regions, such as Region XIII, BARMM, Cordillera Administrative Region (CAR), and Region IV-B, which have 23, 24, 28, and 30 hospitals, respectively.

The private sector has proliferated in the regions with higher population and economic activities as they see more chances of gaining bigger profits in these regions. And because public hospitals in these regions have very limited capacities, many people living in these regions have been pushed to avail health services in the private facilities even though it is much more costly to them.

Government's under-spending

Spending on health should come from the national government through the DOH. But since privatization, the single biggest bulk of total health expenditure (THE) has come from household out-of-pocket (OOP) payments, or the patients' own income, savings or loans, and through HMOs that some Filipinos opt to avail due to the limited coverage of PhilHealth. There is actually a provision under the UHC Law that HMOs and other private insurance corporations are encouraged to have "complementary health packages" to match or supplement the case-benefit packages offered by PhilHealth.

OOP accounted for 41.5% of THE in 2021. **(See Table 15)** It comprised 3.1% of the total household financial consumption expenditure in the economy or the gross domestic product (GDP), which was the highest share in the past seven years.[26]

TABLE 14. Number of Hospitals and Bed Capacity per Region, 2021

REGION	NO. OF HOSPITALS			BED CAPACITY		
	Gov't	Private	TOTAL	Gov't	Private	TOTAL
Philippines	**440**	**849**	**1,289**	**50,966**	**58,927**	**109,893**
National Capital Region	48	111	159	17,275	11,789	29,064
Cordillera Administrative Region (CAR)	14	14	28	1,410	694	2,104
Region I (Ilocos Region)	34	46	80	2,380	2,209	4,589
Region II (Cagayan Valley)	25	41	66	2,274	1,964	4,238
Region III (Central Luzon)	53	122	175	4,850	6,719	11,569
Region IV-A (CALABARZON)	57	168	225	3,545	9,783	13,328
Region IV-B (MIMAROPA)	16	14	30	972	723	1,695
Region V (Bicol Region)	22	32	54	1,725	1,880	3,605
Region VI (Western Visayas)	35	30	65	3,302	3,302	6,604
Region VII (Central Visayas)	22	39	61	2,351	5,112	7,463
Region VIII (Eastern Visayas)	23	27	50	1,805	1,435	3,240
Region IX (Zamboanga Peninsula)	12	30	42	1,267	1,439	2,706
Region X (Northern Mindanao)	22	52	74	2,464	3,318	5,782
Region XI (Davao Region)	12	47	59	2,195	3,848	6,043
Region XII (Soccsksargen)	15	59	74	1,352	3,950	5,302
Region XIII (Caraga)	12	11	23	955	539	1,494
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)	18	6	24	844	223	1,067

SOURCE: *Department of Health - Health Facilities and Services Regulatory Bureau*

Meanwhile the shares of the central government and DOH in THE increased to 26.7% and 23.6%, respectively in 2021, from the 2020 figures of 20.3% and 16.7%, respectively. However these increases were caused by the bulk of spending on COVID-19 response but did not translate to an increase in health investment that would be beneficial to the people in the long run. In fact, their shares remained smaller than the share of OOP.

The government's target for OOP share is below 50%, which it has achieved apparently but not because social health insurance is effective. In fact, as OOP grows, spending of PhilHealth decreases. PhilHealth's share in THE for 2021 was only 13.6%, which was even lower than the 14.7% share in 2020.

In Southeast Asia, the Philippines has one of the highest OOPs in THE. In the latest comparable year (2020), the Philippines ranked 4th in the highest share of OOP. Brunei, Timor-Leste, and Thailand all have OOP expenditure share of less than 11 percent. Meanwhile, the countries preceding the Philippines in OOP expenditure ranking were Myanmar with 78.2% OOP share, Cambodia with 60.6% share, and Lao PDR with 41.8% share. The Philippines also has the 3rd highest per capita OOP expenses, next to Singapore and Malaysia. It was estimated that in 2021, the per capita OOP expense in the Philippines was US$80.4. And among the Southeast Asian nations, Timor-Leste has the lowest OOP per capita expense estimated at US$8.08. **(See Table 16)**

Compared to other Southeast Asian countries, the Philippines has one of the lowest percentage of primary health care spending on its current health spending. As of the latest available data, the Philippines ranked 6 out of 8 countries with recorded 44.5% primary health care spending share, meanwhile Timor Leste has the highest share with 76.24%. **(See Table 17)**

The annual national health budget has been chronically insufficient. For 2021, a year into the COVID-19 pandemic, the government allotted only 4.9% of its yearly budget for health services. This was smaller than the 5.9% share in 2020. **(See Table 9)**

TABLE 15. Percentage distirbution of Current Health Expenditure by Financing Agent

FINANCING AGENT	2014	2015	2016	2017	2018	2019	2020	2021
General government	**35.6**	**39.1**	**39.5**	**39.6**	**39.1**	**40.8**	**45.1**	**49.7**
Central government	11.0	12.5	13.9	15.1	14.2	14.8	20.3	26.7
Department of Health	8.3	9.5	11.2	12.2	10.7	11.2	16.7	23.6
Other ministries, public units (belonging to central gov't)	2.8	3.1	2.7	2.9	3.5	3.6	3.6	3.1
State/Regional/Local government	7.7	7.2	7.2	7.3	8.3	8.6	10.1	9.3
Social security agency	16.8	19.4	18.4	17.2	16.6	17.4	14.7	13.6
Social health insurance agency (PHIC)	16.8	19.4	18.4	17.2	16.6	17.4	14.7	13.6
Other social security agency (GSIS, SSS)[1]	-	-	-	-	-	-	-	-
Insurance corporations	**1.4**	**1.9**	**1.8**	**2.0**	**2.0**	**2.2**	**2.7**	**2.6**
Comercial insurance companies	1.4	1.9	1.8	2.0	2.0	2.2	2.7	2.6
Corporations (other than insurance corporations)	**10.6**	**7.8**	**8.1**	**8.2**	**8.5**	**8.1**	**7.1**	**6.2**
Health management and provider corporations	8.7	5.9	6.2	6.6	6.8	6.4	5.5	4.8
Corporations (other than health service providers)	1.9	1.9	1.9	1.6	1.8	1.8	1.6	1.4
Households	**52.4**	**51.2**	**50.5**	**50.1**	**50.4**	**48.8**	**45.0**	**41.5**
Rest of the world	-	-	-	-	-	-	-	[1]
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

1 - Percent share is less than 0.05 percent.
SOURCE: *Philippine Statistics Authority*

TABLE 16. Out-of-pocket expenditure, 2020

	As % of current health expenditure	Per capita, in US$*
Brunei	6.0	38.75
Cambodia	61.6	70.16
Indonesia	31.8	42.27
Lao PDR	41.8	28.52
Malaysia	35.9	150.26
Myanmar	78.2	56.39
Philippines	41.5	80.40
Singapore	19.0	670.87
Thailand	10.5	32.16
Timor-Leste	6.7	8.08
Vietnam	39.6	65.83

* - data for the Philippines is as of 2021
SOURCE: *World Bank*

TABLE 17. Primary healthcare allocation

	Year	As % of current health expenditure	Per capita, in US$*
Brunei	nda	nda	nda
Cambodia	2019	62.3	71.82
Indonesia	2020	33.3	44.33
Lao PDR	2019	68.6	46.52
Malaysia	2020	43.9	183.74
Myanmar	2019	67.3	41.13
Philippines	2021	44.5	86.05
Singapore	nda	nda	nda
Thailand	2020	59.8	182.32
Timor-Leste	2020	76.2	92.16
Vietnam	2019	16.4	28.44

nda - no data available
SOURCE: *World Health Organization Global Health Expenditure Database*

DOH

For the past years, there has been a decrease in the budget allocated for the 65 government hospitals supported by the DOH and the already minimal budget support to the four GOCC hospitals. **(See Annex 1)** In 2020 the budget for infrastructure development in the LGU-managed hospitals was even decreased despite the urgent need to improve these facilities and build new ones. **(See Table 18)**

TABLE 18. DOH Health Facilities Operations and Health Facilities Enhancement Program budgets (in million Php)

	2015	2016	2017	2018	2019	2020	2021	2022
Health Facilities Operations	**18,969**	**18,960**	**26,068**	**26,193**	**39,904**	**39,904**	**47,197**	**53,612**
Personnel Services	8,052	10,979	18,526	22,359	26,618	29,172	34,229	38,402
Maintenance, Other Operating Expenses	3,949	4,908	5,190	3,834	3,765	8,837	10,129	13,742
Capital Outlays	6,968	3,073	2,352	-	40	1,894	2,838	1,468
Health Facilities Enhancement Program	**5,591**	**26,872**	**24,194**	**30,267**	**8,384**	**8,384**	**7,839**	**23,067**

SOURCE: *Department of Budget and Management*

The DOH manages the funding for national health programs and the DOH-retained health facilities which are mostly specialty hospitals and regional hospitals. It is also the department that manages the national funds for construction, rehabilitation, and maintenance of health facilities in the country. A decrease in the budget for such function thus is lamentable.

In 2022, the national government decreased budgetary support to the capital outlay of DOH-retained hospitals. Instead of allocating a separate capital outlay budget for these hospitals, the government increased the allocation for the Health Facilities Enhancement Program (HFEP) which serves as the central fund for infrastructure projects of the DOH.

HFEP serves as the funding source of government-owned hospitals and health facilities such as BHS, RHUs, and City Health Offices (CHOs) for their infrastructure and equipment needs. Before HFEP, Capital Outlays budget went directly to the hospitals and facilities but the Aquino administration has started the centralization of this fund under the rationale of making capital investments in health more efficient.

But there are contentions on the effectiveness and efficiency of HFEP as a central program for health infrastructure. An initial assessment on the HFEP has shown problems in the implementation of the said program. HFEP was inadequate in funding the local governments' facilities making them shell out their own shares in capacitating their health facilities. Also, the slow disbursement and inefficient budgeting has resulted in delayed completion of projects.[27]

A recent example of inefficiency of the HFEP was flagged by the Commission on Audit (COA) in 2021. According to the audit report, only 36.42% of the program funds was disbursed despite the urgent need to improve and capacitate the health system infrastructure in the midst of COVID-19 surge in the country.

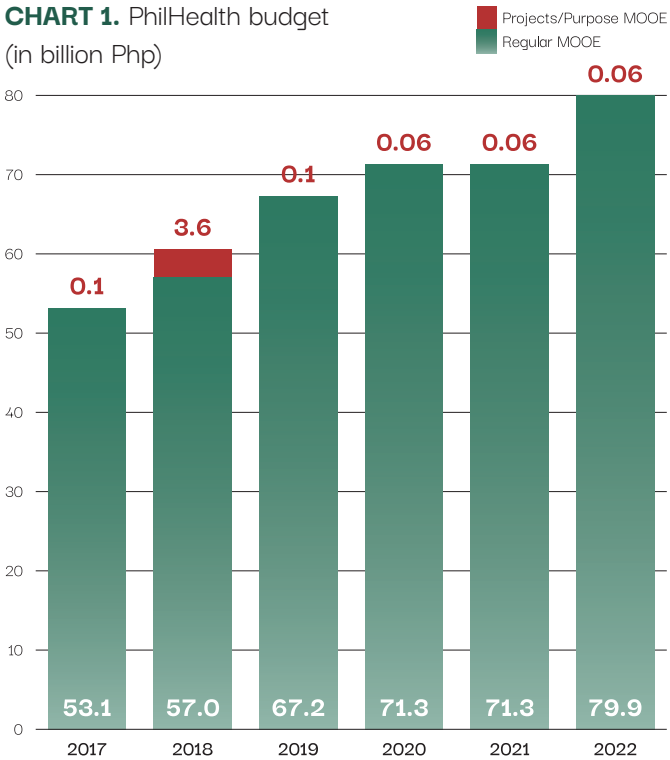
For public hospitals, the DOH is now only funding the DOH-retained hospitals. Meanwhile, the financing of the operations of most public hospitals across the country is now under the responsibility of their respective LGUs–as enacted in the LGC of 1991. BARMM, an autonomous region, has its own DOH-BARMM which funds and manages the public hospitals and health facilities operating in the region.

PhilHealth

The national government allocation for PhilHealth has constantly increased – by 12.1%, from Php71.4 billion in 2021 to Php80 billion in 2022. **(See Chart 1)**

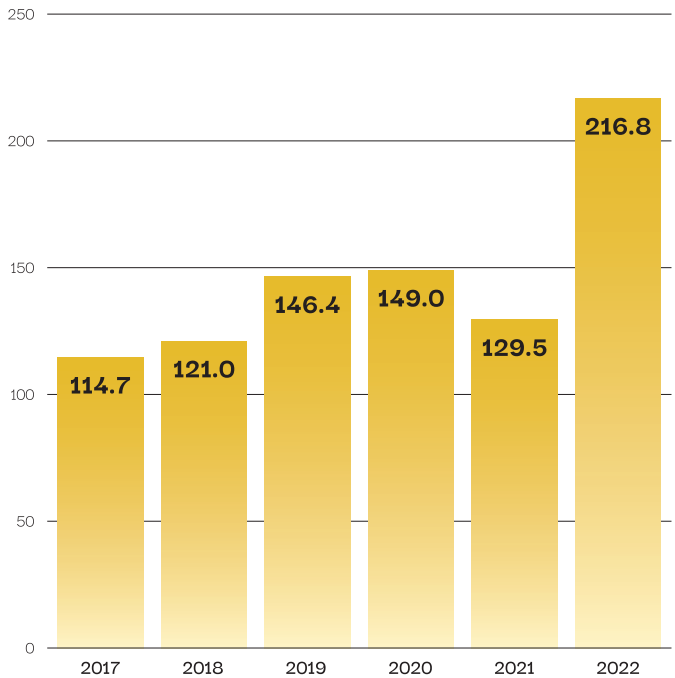
PhilHealth's collected premiums also continuously increased in the past years and only experienced a decline in 2021 since the global pandemic left millions of Filipinos unemployed. The significant increase in PhilHealth contribution happened in 2019, when the 2018 collection of Php121.04 billion increased by 21% to Php146.44 billion in 2019 due to the passage of the UHC Law that year. **(See Chart 2)**

CHART 1. PhilHealth budget (in billion Php)



SOURCE: *Department of Budget and Management*

CHART 2. PhilHealth premium collection (in billion Php)



SOURCE: *PhilHealth Stats and Charts 2017-2022*

Despite the increase in allotted budget and premium collections, the national social health insurance has not significantly contributed to THE. In fact, in the most urgent need, in 2020 and 2021, PhilHealth's share in THE even decreased, from 14.7% share in 2020 down to 13.6% share in 2021. **(See Table 15)** This was despite the additional COVID-19 packages claims that were a major source of financing during this period.

LGU

In 2021, LGUs spent an average of Php1,377.64 per capita on health. This was lower compared to the 2020 average health spending of Php1,441.85 per person, despite the surge of COVID-19. Almost all regions decreased their health spending. Region XI had the highest decrease, 26%, compared to 2020. NCR also had one of the highest cuts, by 14 percent. **(See Table 19)**

Regional data also show differences in regional spending. In 2021, NCR spent the largest per capita with Php2,655.54, almost three times of Region XI's per capita spending of Php904.16. Meanwhile, Region IV-A was among the lowest spenders despite hosting more industries and having higher regional income than the other regions. There is no data for BARMM's per capita health spending in 2021, but the region only spent Php382.87 per person, which was only 27% of the national average spending for that year.

LGUs reported in 2021 a declining share in THE. According to the PNHA, the national government share was 49.7%, of which 9.3% came from LGUs, even smaller than the 2020 share of 10.1 percent. The average annual share of LGUs in THE is only 8.2% for the past eight years.

Despite the gravity of COVID-19 in 2021, many LGUs did not prioritize spending on health services. The national average of total LGU budget allocated for health was 28.8% in provinces, 26.2% in Highly Urbanized Cities (HUCs) and Independent Component Cities (ICCs), and 17.3% in Component Cities (CCs) and Municipalities. **(See Table 20)**

Aside from the unavailability of health facilities, several regions also do not have enough monetary capacity in delivering devolved health services. Low budget prioritization for health programs among LGUs results in inaccessible and

inadequate health services to the people especially to those living in the rural and remote areas and poor communities. Despite the increase in the LGU allocation for health programs from the national government, the investment and operation for health services has not improved. Ironically at times, health services are even used in politicking, where for instance health cards are issued for supposed health benefits but with the name of the local politician on the cards.

Out of the poor's reach

Neoliberal policies have taken their toll on the health system and worsened accessibility especially to the poor majority. The low quantity of health facilities and health workers has had direct impact on accessibility. Until now, majority of Filipinos still do not have access to the most basic health facilities and services, and this results in poor health outcomes especially among the poor who have been effectively marginalized.

TABLE 19. LGU health expenditure per capita (in Php*)

REGION	2019	2020	2021
NATIONAL AVERAGE	**1,079.28**	**1,441.85**	**1,377.64**
National Capital Region	1,914.49	3,097.46	2,655.54
Cordillera Administrative Region (CAR)	1,706.13	1,868.75	1,849.70
Region I (Ilocos Region)	1,199.88	1,407.28	1,267.70
Region II (Cagayan Valley)	1,148.02	1,460.53	1,590.54
Region III (Central Luzon)	916.91	1,103.91	1,165.68
Region IV-A (CALABARZON)	865.66	1,119.62	1,147.36
Region IV-B (MIMAROPA)	1,142.71	1,568.37	1,826.34
Region V (Bicol Region)	768.24	1,076.44	1,055.14
Region VI (Western Visayas)	1,199.02	1,356.96	1,375.47
Region VII (Central Visayas)	1,074.11	1,036.84	1,336.22
Region VIII (Eastern Visayas)	1,068.17	1,423.86	1,193.85
Region IX (Zamboanga Peninsula)	659.44	883.86	950.66
Region X (Northern Mindanao)	1,205.18	1,551.34	1,280.79
Region XI (Davao Region)	964.12	1,224.39	904.16
Region XII (Soccsksargen)	687.01	1,174.37	1,091.54
Region XIII (Caraga)	1,189.98	1,964.53	1,745.05
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)**	217.14	382.87	nda

NOTES:
* Computed by dividing the total obligated health budget of all the LGUs in the region by the 2020 regional projected population based on DOH DM No. 2020-0282
** The 2019 and 2020 data of BARMM are not comparable. 43 of 115 LGUs (36%) in ARMM have submitted their 2019 report as of July 31, 2020 while only 7 of 115 (6%) LGUs have submitted their 2020 report as of October 26, 2021
SOURCE: *Department of Health 2021 LGU Health Scorecard Annual Report*

Distribution of facilities and health services is also lopsided across regions, wherein these are concentrated in the urban centers. Patients from far-flung communities who need specialist care will have to be transported to Metro Manila. Poor patients who cannot pay for transport and lodging in Metro Manila will opt to not seek treatment at all, and this leads to the worsening of health condition or even premature death.

Modern technology and equipment are also scarce in public facilities. Majority of COVID-19 testing centers for instance are in the privately owned facilities because public health facilities do not have the means to invest and fund the technologies needed. Laboratory services, such as ultrasound, X-ray and blood tests, are also offered by private diagnostic centers. These are expensive and inaccessible to most Filipinos.

There has been an increase in PhilHealth's population coverage, but it does not mean that patients have spent less on hospital services. PhilHealth has limited coverage of diseases and mainly supports hospital and surgical procedures. It doesn't have large programs for medical check-ups and consultations and for maintenance medicines, which actually account for the bulk of people's expenses on health.

As shown in the 2022 National Demographic and Health Survey (NDHS), the costs of care has increased dramatically compared to 2017. In 2022, the average amount paid for treatment was Php2,540, an 84% increase compared to 2017 figure of Php1,380. Meanwhile, treatment in public health facility was only Php668 in 2017, this increased by 90% in 2022

TABLE 20. LGU budget allocated for health per region, 2021 (% of total)

REGION	Provinces	HUCs, ICCs	CCs, Municipalities
NATIONAL AVERAGE	**28.82**	**26.15**	**17.27**
National Capital Region	nda	26.57	14.03
Cordillera Administrative Region (CAR)	20.99	9.76	10.47
Region I (Ilocos Region)	32.09	18.45	17.99
Region II (Cagayan Valley)	25.71	28.74	17.16
Region III (Central Luzon)	31.39	43.26	17.51
Region IV-A (CALABARZON)	29.90	16.49	20.25
Region IV-B (MIMAROPA)	32.03	32.79	12.27
Region V (Bicol Region)	29.32	11.92	16.07
Region VI (Western Visayas)	41.44	19.08	32.47
Region VII (Central Visayas)	25.95	20.53	13.98
Region VIII (Eastern Visayas)	29.87	22.22	13.46
Region IX (Zamboanga Peninsula)	10.99	39.26	11.75
Region X (Northern Mindanao)	27.30	23.10	13.15
Region XI (Davao Region)	28.92	27.78	12.24
Region XII (Soccsksargen)	29.69	28.9	13.07
Region XIII (Caraga)	28.60	26.89	14.84
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)*	4.81	20.81	6.16

NOTES:
nda - no data available
* includes only LGUs (Basilan province & its component LGUs, Lamitan and Cotabato Cities) with 2021 data submission of Oct 21, 2022
SOURCE: *Department of Health 2021 LGU Health Scorecard Annual Report*

reaching the amount of Php1,269. For private health facilities, average treatment cost increased by 43%, the previous average amount of Php2,491 reached Php3,563 in 2022. **(See Table 21)**

On confinement, the average cost of treatment was Php46,640, almost four months' worth of salary for a minimum wage worker. And only Php17,507 or 38%, was covered through PhilHealth. For a private facility, the average cost of treatment was Php70,568, and only Php18,062 or 26% was covered by PhilHealth. For a public facility, it was Php27,136, with Php16,939 covered by PhilHealth. Additionally, the average spending on medicines or services from pharmacies or laboratories was Php14,516.[28]

In the 2015 Family Income and Expenditure Survey (FIES), half of family expenditures on health was on medical products, appliances and equipment which includes pharmaceutical products (e.g. medicinal drugs and patent medicines, pharmaceutical products for nutrition and/or to prevent disease), and other medical products.[29]

Low wages and high prices of health services and goods have impacted the treatment seeking behavior of the people. Filipinos, especially the working class, have the tendency to endure their illness until it gets worse. By the time they seek treatment, the disease has already reached a level where it will be hard and costly to treat.

Dire health outcomes

Health outcomes have worsened, even despite the country's adherence to the sustainable development goals (SDGs) and its precursor, the MDGs ending in 2015. Neoliberal policies in fact have been a direct assault on the people's basic right to health.

Incapacity, #1 killer

Life expectancy was estimated at 72 years old in 2020, much higher compared to the 56 years old life expectancy during the 1960s. Compared to decades ago, more and more Filipinos are now reaching the age of 65. There is also a decrease in the mortality rate in the country.

TABLE 21. Average cost of care (in Php)

TYPE OF CARE	2013			2017			2022		
	Any facility*	Public facility	Private facility	Any facility*	Public facility	Private facility	Any facility*	Public facility	Private facility
For those who visited a health facility in the past 30 days									
Cost of transport	69	44	122	89	62	132	174	114	222
Cost of consultation, advice, and/or treatment	1,044	455	2,268	1,380	668	2,491	2,540	1,269	3,563
For those confined to a hospital or clinic in the last 12 months									
Cost of transport	nda	nda	nda	nda	nda	nda	1,347	607	2,259
Total cost of medicines/services from outside pharmacy/lab	4,663	3,924	6,184	5,237	3,856	7,399	14,516	11,180	18,876
Paid from salary/loan/sale of property	4,377	3,622	5,908	6,924	4,209	11,167	12,597	9,094	17,178
Paid by PhilHealth	253	192	380	4,669	3,824	5,997	4,106	4,402	3,720
Total hospital bill	16,052	8,640	25,471	21,400	11,627	33,191	46,640	27,136	70,568
Paid from salary/loan/sale of property	11,233	5,597	18,100	12,530	5,004	20,476	22,600	8,266	36,592
Paid by PhilHealth	5,049	3,221	7,278	9,658	8,270	11,132	17,507	16,939	18,062

* - average for both public and private facilities nda - no data available
SOURCE: *Philippine Statistics Authority National Demographic and Health Survey*

But this improvement does not necessarily indicate improvement in the overall health system and in its delivery of people's health needs. In fact, many of the health issues prevail. Noncommunicable diseases (NCD) remain the top causes of mortality or death. Leading causes of morbidity are the same and have not drastically changed in the past decades.

The 10 leading causes of mortality are:

1. Ischaemic heart diseases (ICD)
2. Malignant neoplasms
3. Cerebrovascular diseases
4. Pneumonia
5. Diabetes Mellitus
6. Hypertensive diseases
7. Chronic lower respiratory infections
8. Respiratory tuberculosis
9. Other heart diseases
10. 1Remainder of disease of the genitourinary system

According to the Philippine Health Statistics (PHS) of 2019, the 10 leading causes of morbidity are:

1. Acute Respiratory Tract Infection (ARTI)
2. Hypertension
3. Urinary Tract Infection (UTI)
4. Acute Lower Respiratory Tract Infection (ALRTI)
5. Acute Watery Diarrhea
6. Pneumonia
7. Skin Disease
8. Animal Bites
9. Bronchitis
10. Influenza

These leading causes of morbidity and mortality are almost the same by region and by sex, with different levels of occurrences. Despite the many years of supposed health reforms, these leading causes remain the same. Yet, these diseases are preventable and could not have led to deaths if the country had strong primary healthcare.

Among the total deaths in the country, 30.5% were unattended, or 3 out of 10 Filipinos have died without seeing a doctor or health professional/s. Several regions have higher unattended death rates.

The burden of NCDs is rising in the poorer communities. Treatment for NCDs is expensive and life- threatening especially on the late stage. There is a need to focus more on prevention, but the government is incapacitated to do that.

Before the COVID-19 pandemic, NCDs were among the top killers in the world, especially in the low- and middle-income countries, like the Philippines. According to WHO, more than 75%, or 31.4 million, of global NCD deaths occurred in these countries.[30] Deaths caused by NCDs are closely linked with poverty, because treatment for NCDs is expensive and often lengthy.

The COVID-19 pandemic worsened this burden for the Philippines, as many NCDs were left untreated due to the full capacity of hospitals during the coronavirus surges. There were several cases of NCD patients being denied admission to hospitals because these were full of COVID-19 cases which were prioritized that time.

Aside from NCDs, communicable diseases like pneumonia and tuberculosis still remain as top causes of mortality in the country. Despite dedicated programs like the Tuberculosis-Directly Observed Therapy (TB-DOTS) and despite having inexpensive cure, the government still has not fully eliminated TB.

TABLE 22. Deliveries attended by skilled health professionals, 2020 (as % of total deliveries)

REGION	MDs	Nurses	Midwives	TOTAL
Philippines	**56.25**	**1.44**	**32.46**	**90.15**
National Capital Region	67.77	0.29	25.58	93.65
Cordillera Administrative Region (CAR)	86.17	1.97	9.83	97.97
Region I (Ilocos Region)	79.29	0.25	20.16	99.7
Region II (Cagayan Valley)	72.27	1.04	24.64	97.95
Region III (Central Luzon)	63.43	0.54	34.12	97.09
Region IV-A (CALABARZON)	50.34	1.76	42.69	94.79
Region IV-B (MIMAROPA)	55.46	1.98	23.66	81.11
Region V (Bicol Region)	38.41	8.12	47.07	93.6
Region VI (Western Visayas)	66.15	0.59	28.72	95.45
Region VII (Central Visayas)	43.85	0.27	36.66	80.78
Region VIII (Eastern Visayas)	57.66	1.69	32.6	91.95
Region IX (Zamboanga Peninsula)	50.27	1.78	30.21	82.25
Region X (Northern Mindanao)	63.08	1.51	27.78	92.37
Region XI (Davao Region)	60.98	0.27	30.94	92.19
Region XII (Soccsksargen)	48.69	0.78	41.08	90.55
Region XIII (Caraga)	54.98	0.81	38.19	93.98
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)**	15.92	3.86	30.92	50.69

SOURCE: *Department of Health FHSIS 2022*

Not improving child and maternal health

Child and maternal health are among the most measured indicators in health because the health of mother and child can affect many health outcomes. This is under the UN Sustainable Development Goal (SDG) 3, under which there is also a target to reduce the number of maternal mortality, neonatal and under-5 mortality.

The DOH reports that child and maternal health has significantly improved from decades ago. Yet even though the national average shows the country reaching its SDG target, regional data present a different outcome. Despite the national count of fetal deaths decreasing, regional data show that some regions are still failing in ensuring safe and healthy delivery of babies. Attended births also differ across regions where national data present that the majority of births were attended by

health professionals, yet there are regions where majority of birth counts remained unattended.

One of the steps that the government has done to decrease the number of maternal and neonatal deaths is introducing the "no home birthing" policy. Under this rule, mothers are only allowed to give birth in health facilities and attended by health and allied personnel like doctors, nurses, or licensed midwives. But this policy has put more burden on far-flung communities with no access to these requirements. Before, practiced *manghihilot* or massage therapists and *kumadrona* or midwives could facilitate birthing in the mother's home, but now pregnant women are required to give birth in birthing centers or hospitals. But not all provinces have access to birthing clinics, and mothers from the rural areas are put at risk for travelling to the nearest facility to give birth. Aside from the risk, this policy has also made birthing more expensive. **(See Table 22)**

TABLE 23. Fully immunized children per region (% of population)

REGION	2020	2021	2022*
NATIONAL AVERAGE	**65.18**	**62.86**	**59.92**
National Capital Region	59.31	59.48	72.14
Cordillera Administrative Region (CAR)	67.91	67.62	55.77
Region I (Ilocos Region)	76.63	77.36	65.41
Region II (Cagayan Valley)	73.60	73.44	63.01
Region III (Central Luzon)	78.75	65.86	68.96
Region IV-A (CALABARZON)	55.09	53.88	53.85
Region IV-B (MIMAROPA)	52.19	58.64	51.36
Region V (Bicol Region)	55.89	55.93	47.23
Region VI (Western Visayas)	71.02	65.68	59.52
Region VII (Central Visayas)	63.76	63.77	56.48
Region VIII (Eastern Visayas)	59.39	52.76	46.20
Region IX (Zamboanga Peninsula)	60.69	63.15	55.57
Region X (Northern Mindanao)	74.72	76.51	68.43
Region XI (Davao Region)	73.48	67.89	64.73
Region XII (Soccsksargen)	64.15	61.46	55.37
Region XIII (Caraga)	75.54	73.88	67.65
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)**	62.51	60.71	57.38

Eligible population is 0-12 months old.
* - sourced from Field Health Services Information Survey (FHSIS) 2022
SOURCE: *Department of Health 2021 LGU Health Scorecard Annual Report, FHSIS 2022*

Malnutrition in children has not been eliminated despite dedicated feeding program in public schools. The pandemic also impacted these feeding programs, as the children were not able to go to school. Low and loss of income of millions of Filipino families is a major contributor to the persistent malnutrition among children.

Immunization of children aged 12 months and below is essential in protecting these children from several diseases like polio, hepatitis, among others. Child immunization target is 95% of the total population of children aged 12 months and below. The DOH and LGUs have failed to reach this target. In 2022, national average for child immunization was 60 percent. No region was able to achieve the target, and 15 regions reported lower immunization rate in 2022 compared to 2021. **(See Table 23)**

Health workers: neoliberalism's sacrificial lamb

The Philippines has a large pool of labor, as the current population is mostly of working age. The country is also rich in young health professionals. But despite having a pool of health workers, the country is suffering from health workforce shortage.

Approximately, there was a total of 596,440 human resource for health (HRH) active in the labor force in 2020.[31] But this number was far from the recorded statistics on HRH actively working as health professionals in health facilities. In the latest DOH data, there is a total of 190,367 HRH working in public and private hospitals.[32]

In the public sector, there are 134,437 healthcare workers, of which: 78,468 are hired in public hospitals; 32,125 hired in different LGUs Primary Health Care programs (i.e. MHOs, RHUs, etc.); and 23,844 DOH-deployed workers in primary health care. This total number comprises 64% of the country's total health workforce. Meanwhile the private sector has a total of 75,617 healthcare workers, or 36% of the country's health workforce, despite having more hospitals than the public sector.

Of the total healthcare workers, majority are nurses which is about 95,039 or 45% of total. They are followed by midwives with a total number of 44,102 or 21% of total. Next are the physicians at 16% with a total of 34,477 workforce.

Regional distribution data show that regions with high incidence of poverty have smaller numbers of HRH to population ratio. The national average for HRH to population ratio is at 18.83 HRH per 10,000 population. But on a regional scale, CAR has the highest number of HRH to population with 42.45 HRH per 10,000 population, followed by NCR with 30.88, Region II with 25.21, and Region I with 22.33. Meanwhile, the region with the lowest number of HRH per 10,000 population is BARMM with 9.28, less than a third of NCR's ratio and less than half of the national average. BARMM is followed by Region IV-A with 12.96, Region IV-B with 14.14, and Region III with 14.61. **(See Tables 24 and 24.1)**

HRH pool is too small to serve the entire population of about 110 million. This reflects on the total number of Filipinos who died without being able to see or visit a healthcare professional.

The overall average of 18.83 HRH per 10,000 population is also way below the WHO-recommended ratio of 44.5 HRH per 10,000 population. The DOH already recognized this issue even before the onset of the COVID-19 pandemic, stating in 2019 that the country had a shortage of 290,000 health workers. This was worsened when the pandemic hit. As the first line of defense, the country's healthcare workers were among the first ones to be infected with coronavirus, and many health workers died due to the virus.

Based on the 2020 Occupational Wages Survey (OWS), specialist medical practitioners are the highest paid among health workers with an average wage rate of Php37,347, followed by generalist medical practitioners (medical doctors) with Php32,246.[33] Nursing professionals, which are the majority of the healthcare worker population, have an average pay of Php21,389 per month. Midwifery professionals have a lower pay with Php14,227 per month wage rate. Pharmacists and medical technologists are paid Php17,687 and Php17,451 respectively. Meanwhile, medical technicians are paid Php18,264 per month. **(See Chart 3)** Other than those of specialist and general medical practitioners, most health workers' salaries fall short of the estimated Php24,803 monthly living wage needed by a family of five to meet their basic needs in the NCR.[34]

In a study conducted by the Department of Labor and Employment – Institute of Labor Studies (DOLE-ILS) among health workers hired in three major urban centers (Metro Manila, Metro Cebu, and Metro Davao), the wages received also vary depending on whether they are hired by public or private facilities.

The overall average salary for health workers hired by public facilities are Php30,000 (physician), Php25,000 (nurse), Php20,000 (medical technologist), Php15,000 (laboratory technician), and Php15,000 (administrative and others). This reported average salary is not very far from the reflected average monthly wages in the OWS.

Meanwhile, health workers hired by the private sector have generally lower pay than those hired in public facilities. The average wages for private health workers are Php30,000 (physicians), Php15,000 (nurse, medical technologist, administrative and others), and Php20,000 (laboratory technician). Public and private hired physicians and administrative staff have the same average monthly wages, according to the study.

On the other hand, there is a huge gap between the pay of other health professionals in the public and private facilities. For nurses, those hired in private facilities receive Php10,000 less than those in public facilities. Medical technologists

TABLE 24. Human Resources for Health (HRH)

	2016	2017	2018	2019	2020	2021	2022
TOTAL NO. OF HRH	**197,314**	**204,318**	**187,633**	**189,204**	**190,367**	**188,219**	**210,054**
Primary healthcare	52,874	54,007	53,712	55,301	56,266	53,442	55,969
Public hospitals	74,793	76,314	67,482	67,470	67,558	67,836	78,468
Private hospitals	69,647	73,997	66,439	66,433	66,543	66,941	75,617
HRH BY PROFESSION							
Nurses	87,486	89,848	87,339	89,254	90,205	88,519	95,039
Midwife	42,243	43,183	42,531	42,108	42,094	41,500	44,102
Physician	39,136	40,828	28,378	28,428	28,639	28,817	34,477
Medical Technologist	12,064	13,494	12,811	12,754	12,792	12,904	17,999
Pharmacist	4,943	5,062	5,082	5,115	5,113	5,167	5,731
Dentist	4,754	4,823	4,525	4,470	4,447	4,284	4,445
Radiologic Technologist	2,835	3,063	2,922	2,922	2,933	2,948	3,876
Nutritionist/Dietician	2,032	2,103	2,189	2,231	2,231	2,155	2,257
Physical Therapist	1,028	1,060	1,036	1,102	1,092	1,101	1,213
X-ray Technologist	652	702	672	672	673	676	729
Occupational Therapist	141	152	148	148	148	148	186

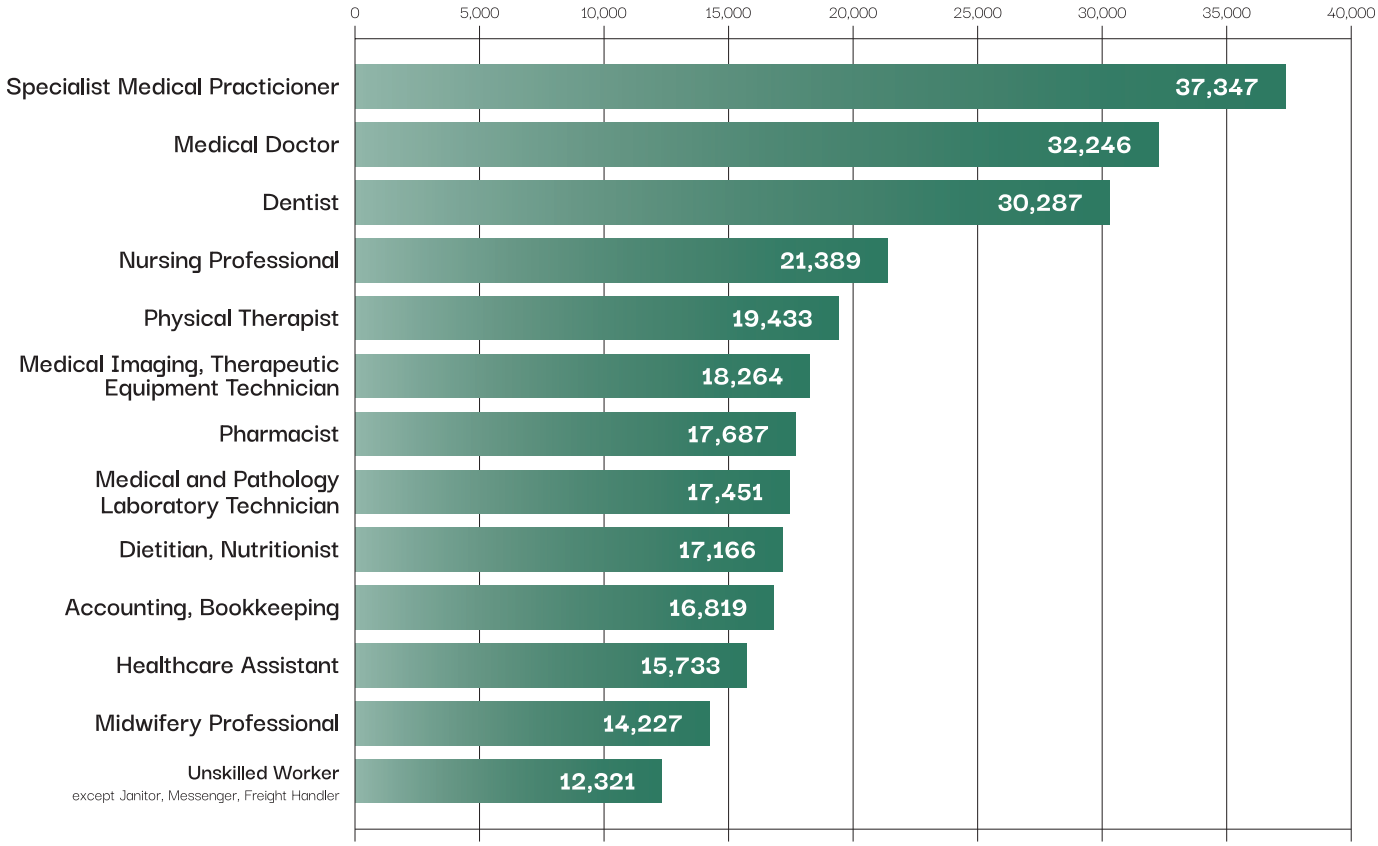
SOURCE: *Department of Health Health Human Resource Development Bureau HRH Statistics*

TABLE 24.1. Regional HRH by location of practice, 2022

REGION	HRH in Public			HRH in Private hospitals	Total HRH	HRH to 10k population
	DOH-deployed in Primary healthcare	Public hospitals	LGU-hired			
National Capital Region	477	18,504	5,048	19,564	43,593	30.88
Cordillera Administrative Region (CAR)	764	3,806	1,044	2,184	7,798	42.45
Region I (Ilocos Region)	910	4,689	1,948	4,407	11,954	22.33
Region II (Cagayan Valley)	726	5,042	1,529	2,101	9,398	25.21
Region III (Central Luzon)	1,776	7,636	2,763	6,383	18,558	14.61
Region IV-A (CALABARZON)	2,372	3,922	3,211	12,083	21,588	12.96
Region IV-B (MIMAROPA)	170	1,955	1,579	887	4,591	14.14
Region V (Bicol Region)	1,794	3,923	1,616	2,610	9,943	15.91
Region VI (Western Visayas)	1,476	5,751	3,052	3,853	14,132	17.59
Region VII (Central Visayas)	1,926	5,094	2,269	6,360	15,649	19.21
Region VIII (Eastern Visayas)	2,483	4,077	1,377	1,762	9,699	19.94
Region IX (Zamboanga Peninsula)	1,403	2,441	954	2,184	6,982	18.21
Region X (Northern Mindanao)	1,754	3,281	1,595	3,452	10,082	19.66
Region XI (Davao Region)	1,254	2,253	1,164	3,959	8,630	15.83
Region XII (Soccsksargen)	1,673	2,969	725	3,040	8,407	16.65
Region XIII (Caraga)	1,312	2,053	922	717	5,004	17.81
Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)**	1,574	1,072	1,329	71	4,046	9.28
TOTAL	**23,844**	**78,468**	**32,125**	**75,617**	**210,054**	**18.83**

SOURCE: *Department of Health Health Human Resource Development Bureau HRH Statistics*

CHART 3. Average monthly wage rates of health workers, August 2020 (in Php)



SOURCE: *Philippine Statistics Authority 2020 Occupational Wages Survey*

receive Php5,000 less than their public facilities counterpart. Laboratory technician is the only health professional paid higher in private facilities with Php5,000 additional pay than the one in public facilities.[35]

In the same study, it was noted that 13 private hospitals reported that around 20-29% of their workforce had chosen to work outside the country in the last five years. Meanwhile, it was reported that government health workers were less likely inclined to move abroad. Only one government hospital reported that 20-29% of their health workforce moved abroad. Among the surveyed health workers, the main factors that pushed their migration are compensation and benefits, career growth and knowledge/skills acquisition, work/employment conditions, and pathway to overseas residency or family migration/reunification.

Low income and poor working conditions among health workers are definitely the push factors in a consistently large number of health professional deployment abroad despite the shortage of health workers in the country. In 2018, a total of 22,067 Filipino health workers were deployed abroad, of which 15,028 or 68% were nursing professionals. It should also be noted that the majority (around 80%) of the overseas Filipino health workers are female. Currently, there is an estimated total of about 500,000 overseas Filipinos working as health professionals.

Aside from low wages, other benefits and compensations given to health workers in the country are sparse compared to other countries. Aside from mandated social protection programs (e.g. SSS, GSIS), few hospitals offer other social services. Among the respondents, only 24% have provided accommodation, subsistence allowance, and legal and outpatient services to their workers.

For example, many health care workers in both public and private health facilities have yet to receive their Health Emergency Allowance (HEA). Under Republic Act 11712 or the "Public Health Emergency Benefits and Allowances for

Heath Care Workers Act", health care workers are entitled to a monthly HEA amounting to Php3,000 for those working in low-risk areas; Php6,000 for those in moderate-risk areas; and Php9,000 for those in high-risk areas. due them as frontliners amid the COVID pandemic. As of December 2022, all health workers have not been given their HEA covering the period of July-December 2021 and July-December 2022. Meanwhile, health care workers at private hospitals, local government units, and other health facilities have also not yet received their HEA for the period of January-June 2022.[36]

It is also not easy for health workers to bargain and fight their poor working conditions. Sixty percent (60%) or 43 out of 72 hospitals surveyed in Metro Manila, Cebu, and Davao, do not have a labor union. Only 27% or 19 hospitals have a Labor Management Council (LMC).

Despite receiving higher salaries than those working in the private sector, working in the public health sector is still one of the most exploitative and abusive conditions. First, the government has different mechanisms in employing healthcare workers. Because of the devolution of health services, hiring in local government managed facilities is under the authority of the LGU. Since the LGUs have varied capacities when it comes to hiring, some regions and provinces do not have enough number of workforce. As most LGUs do not prioritize hiring of health workers, there is a huge shortage.

Aside from the shortage, the employment terms of LGU-hired health workers are not optimal. Since the LGU will base hiring on its yearly budget allocation, most LGU-hired health workers are under service contract or job order, making their employment subject to yearly change in budget. Most of the LGU-hired employees thus are under one-year contract and are subjected to renewal once the LGU has enough budget to hire them. There is no security of tenure or regularization of jobs for health workers under the LGU.

Another factor adding to this insecurity is when the LGU changes leadership. Since LGU heads–governors, mayors, and others have three-year terms only. There are cases where once a province or city has a new governor or mayor, he/she will hire a new set of people who are connected to him/her or have supported him/her.

Secondly, due to shortage of public health workers, the hired ones are mostly overworked. They have to compensate for the lack of working hands in their respective health facilities. This condition worsened during the COVID-19 pandemic when many health workers also fell ill, so the remaining uninfected health workers had to work overtime just to fill their duties.

For instance, Cristy Dongeuines, president of Jose Reyes Memorial Medical Center Employees Union-Alliance of Health Workers (JRMMCEU-AHW) shared in a Bulatlat.com interview that health personnel at the government-run hospital JRMMC had to extend their duty to 16-hour shifts to make up for the lack of HRH. This has left health workers exhausted, many have become sick, and left them little or no time for their families. Worse, they are not compensated for overtime work.[37]

In a statement, the All UP Workers Union-Manila/PGH, also shared that at the country's largest government tertiary hospital, nursing attendants (NAs) have also had to function as utility workers (UWs) because of severe understaffing. This is due to the lack of hiring for unfilled plantilla positions for both NAs and UWs. Already, the nurse-to-patient ratio at the PGH wards are 1:18-20 including more or less six intubated patients. And, like at JRRMC, PGH nurses must work longer shifts with no overtime pay.[38]

Thirdly, there is government's inefficiency in paying the health workers' wages, benefits and other compensation sufficiently and on time. For regular public health workers, their wages are automatically disbursed to them once or twice a month, depending on the payment term. Their wages and regular benefits are already approved before the start of the year and there is already an allocated budget for them. Meanwhile, for job orders and service contractuals, their salaries have to undergo approval from different offices before they are disbursed. It can take up to two months before they can receive

their monthly wages. Most of the time, their salaries get to them late. Since they are only under job orders, they also do not have the benefits enjoyed by the regular health workers, like GSIS, Pag-IBIG and PhilHealth and they have to avail of these voluntarily if they want to have them, which requires another set of administrative tasks from them.

Prescriptions for meaningful changes

Privatization and commercialization of health services in the country has caused the chronic crisis of weak public healthcare. This has gotten worse with the full implementation of devolution and UHC. The health system needs a major overhaul for it to be a genuine public service and promoter of the basic human right to health.

The need for free, comprehensive and progressive public healthcare

The chronically ill health system can only be cured through major restructuring and repudiation of the health framework that has been anchored on neoliberalism and profit-oriented mechanisms. The country's health system will only truly serve the people's needs if it will be reoriented towards a structure that is people-centered and towards the people's highest attainment of needs in a rights-based approach.

In 2022, the Makabayan bloc in the House of Representatives, composed of progressive party-lists ACT Teachers Party-List, GABRIELA Women's Party and KABATAAN Party-List, filed a bill that addresses the failures of the current Philippine health system. House Bill (HB) 208 or the Free, Comprehensive, and Progressive, National Public Health Care System Act, is a proposed bill that contains the reforms that the health system needs. This bill is a comprehensive plan that shows the doable reforms that the government can implement in the public health system.

The call for the consideration of this bill became more urgent because of the emergence of the COVID-19 pandemic which put the already weak Philippine health system into a more vulnerable position.

The bill is calling for provision of free access to health services in all public hospitals and facilities. Aside from free provision, the public health facilities should also give comprehensive healthcare, starting from consultations, outpatient and in-patient care, up to post confinement, and continuing treatment and management. Other health services such as health promotion, health education, disease prevention, drugs and devices, among others should also be offered free of charge by the public health facilities.

HB 208 also emphasizes the importance of community-based primary care and the DOH and local authorities should ensure its proper implementation. The bill also includes free provision of oral and dental health care and reproductive health care. It also calls for the integration of school-based health services between the DOH, Department of Education (DepEd) and Commission on Higher Education (CHED) in providing adequate school health projects such as mental health psycho-social services, nutrition, immunization, health education, and dental services.

One of the highlighted proposed items in HB 208 is the renationalization of GOCC hospitals and health facilities. This means that these health facilities will be reverted back to the DOH with the goal of integrating these into the public health system and will be instrumental in providing free health services to the Filipino people.

The bill details the health facilities needed in order to improve and strengthen the different levels of healthcare – primary, secondary, and tertiary. It also includes the need for a national pharmaceutical industry in the country. The bill also tackles the need for State regulation in the private health facilities and HMOs.

In the bill's Chapter IX on "Health Financing", it states that the initial implementation of HB 208 will need Php441.2 billion and details where the funds may be sourced.

Looking deeper at the definition of health, ensuring the accessible health services is only one aspect of the attainment of the highest level of health. Social determinants of health play a huge factor in ensuring people's health. If the social determinants of health like poverty, low wages, poor access to sanitation and water supply, and inadequate housing services, are not resolved, poor health outcomes will still persist.

The HB 208 was composed with the recognition of the impact of the social determinants in the status of the people's health. This is the main reason that the core of this proposed law is the provision of free health services to all to ensure the accessibility of health services to the Filipino population.

The Community-Based Health Approach

To augment the severe lack of health facilities and inefficient primary health system in the country, a NGO named Rural Missionaries of the Philippines (RMP) has started building Community-Based Health Programs (CBHPs) across the country in 1973. The CBHPs are community initiated health program that encourages community participation in the facilitation and managing of health system. This approach is a good example of people-oriented program that instills the importance of people's participation in ensuring a well-functioning primary health system. And CBHPs also has recognition of the importance of the social determinants in the achievement of health in the community.

Because of the hospital-centric and disease-based health system that exists, the Philippine government has failed to utilize the use of community-based health approaches to strengthen the current health system. The country's geographical characteristics have made it harder for health services to be delivered in the far-flung communities. Most of the time, people living in rural areas and the mountainous regions need to travel for hours or even days just to reach the nearest health facility.

Commercialization of the healthcare system has made health services a disease-based system and has removed the importance of prevention and primary level intervention. The Philippines has a rich history of community health practices that can be further developed for the benefit of the population.

Protection of health workers' rights

The government has to take serious steps in ensuring the rights and overall condition of its health workers. It has to address several issues within the health system that themselves violate the rights of the health workforce.

Devolution has brought severe gaps. Job insecurity has been normalized in LGUs and should be stopped. The national government and the DOH need to implement a policy that will regularize and provide job security among the public health workforce and will ensure them living wages and socioeconomic welfare. The government should also include in its monitoring the issues of health workers in the private sector, providing mechanisms that will protect them from exploitation and abuse by the private corporations.

Reforming the health system is urgent and should be immediately prioritized by the national government. The COVID-19 pandemic should have served as a wake-up call for the government to strengthen the country's health system. The State should recognize that the highest attainment of health is not through privatization and commodification but a right that the Filipino people should be able to exercise. The State should assume full responsibility in ensuring the accessibility and equitability of health care to the population.

Annex

ANNEX 1. List of DOH-retained hospitals

REGION	PROVINCE	HOSPITAL	LEVEL
NCR	Caloocan City	Dr. Jose N. Rodriguez Memorial Hospital and Sanitarium	3
NCR	Las Pinas City	Las Pinas General Hospital and Satellite Trauma Center	3
NCR	Malabon City	San Lorenzo Ruiz General Hospital	1
NCR	Manila	Dr. Jose Fabella Memorial Hospital	3
NCR	Manila	Jose R. Reyes Memorial Medical Center	3
NCR	Manila	San Lazaro Hospital	3
NCR	Manila	Tondo Medical Center	3
NCR	Mandaluyong City	National Center for Mental Health	3
NCR	Marikina City	Amang Rodriguez Memorial Medical Center	3
NCR	Muntinlupa City	Research Institute for Tropical Medicine	3
NCR	Pasig City	Rizal Medical Center	3
NCR	Quezon City	East Avenue Medical Center	3
NCR	Quezon City	Philippine Orthopedic Center	3
NCR	Quezon City	National Children's Hospital	3
NCR	Quezon City	Quirino Memorial Medical Center	3
NCR	Valenzuela City	Valenzuela Medical Center	3
CAR	Apayao	Conner District Hospital	1
CAR	Apayao	Far North Luzon General Hospital and Training Center	1
CAR	Benguet	Baguio General Hospital and Medical Center	3
CAR	Mountain Province	Luis Hora Memorial Regional Hospital	2
I	Ilocos Norte	Mariano Marcos Memorial Hospital and Medical Center	3
I	La Union	Ilocos Training and Regional Medical Center	3
I	Pangasinan	Region I Medical Center	3
II	Batanes	Batanes General Hospital	1
II	Cagayan	Cagayan Valley Medical Center	3
II	Isabela	Southern Isabela Medical Center	3
II	Nueva Vizcaya	Region II Trauma and Medical Center	3
III	Bataan	Bataan General Hospital and Medical Center	3
III	Nueva Ecija	Talavera General Hospital	2
III	Nueva Ecija	Dr. Paulino J. Garcia Memorial Research and Medical Center	3
III	Pampanga	Jose B. Lingad Memorial General Hospital	3
IV-A	Cavite	Southern Tagalog Regional Hospital	1
IV-A	Batangas	Batangas Medical Center	3
IV-B	Palawan	Culion Sanitarium and General Hospital	1
IV-B	Palawan	Ospital ng Palawan	2
V	Albay	Bicol Regional Hospital and Medical Center	3
V	Camarines Sur	Bicol Region General Hospital and Geriatric Medical Center	2
V	Camarines Sur	Bicol Medical Center	3
VI	Iloilo	Western Visayas Sanitarium	1

REGION	PROVINCE	HOSPITAL	LEVEL
VI	Iloilo	Western Visayas Medical Center	3
VI	Negros Occidental	Corazon Locsin Montelibano Memorial Regional Hospital	3
VII	Cebu	Vicente Sotto Memorial Medical Center	3
VII	Cebu	Saint Anthony Mother and Child Hospital	1
VII	Cebu	Eversley Childs Sanitarium and General Hospital	1
VII	Cebu	Cebu South Medical Center	2
VII	Bohol	Don Emilio Del Valle Memorial Hospital	1
VII	Bohol	Gov. Celestino Gallares Memorial Hospital	3
VIII	Leyte	Schistosomiasis Hospital	1
VIII	Leyte	Eastern Visayas Medical Center	3
IX	Zamboanga Del Norte	Dr. Jose Rizal Memorial Hospital	1
IX	Zamboanga Del Sur	Margosatubig Regional Hospital	1
IX	Zamboanga Del Sur	Labuan General Hospital	1
IX	Zamboanga Del Sur	Mindanao Central Sanitarium	1
IX	Zamboanga Del Sur	Zamboanga City Medical Center	3
IX	Basilan	Basilan General Hospital	1
IX	Sulu	Sulu Sanitarium	1
X	Misamis Oriental	Northern Mindanao Medical Center	3
X	Misamis Occidental	Mayor Hilarion A. Ramiro Sr. Medical Center	2
X	Lanao Del Sur	Amai Pakpak Medical Center	3
XI	Davao Del Norte	Davao Regional Medical Center	3
XI	Davao Del Sur	Southern Philippines Medical Center	3
XII	Cotabato City	Cotabato Regional and Medical Center	3
XII	Maguindanao	Cotabato Sanitarium and General Hospital	1
XIII	Surigao Del Sur	Adela Serra Ty Memorial Medical Center	2
XIII	Surigao Del Norte	CARAGA Regional Hospital	2

SOURCE: *Department of Health Health Facilities and Services Regulatory Bureau*

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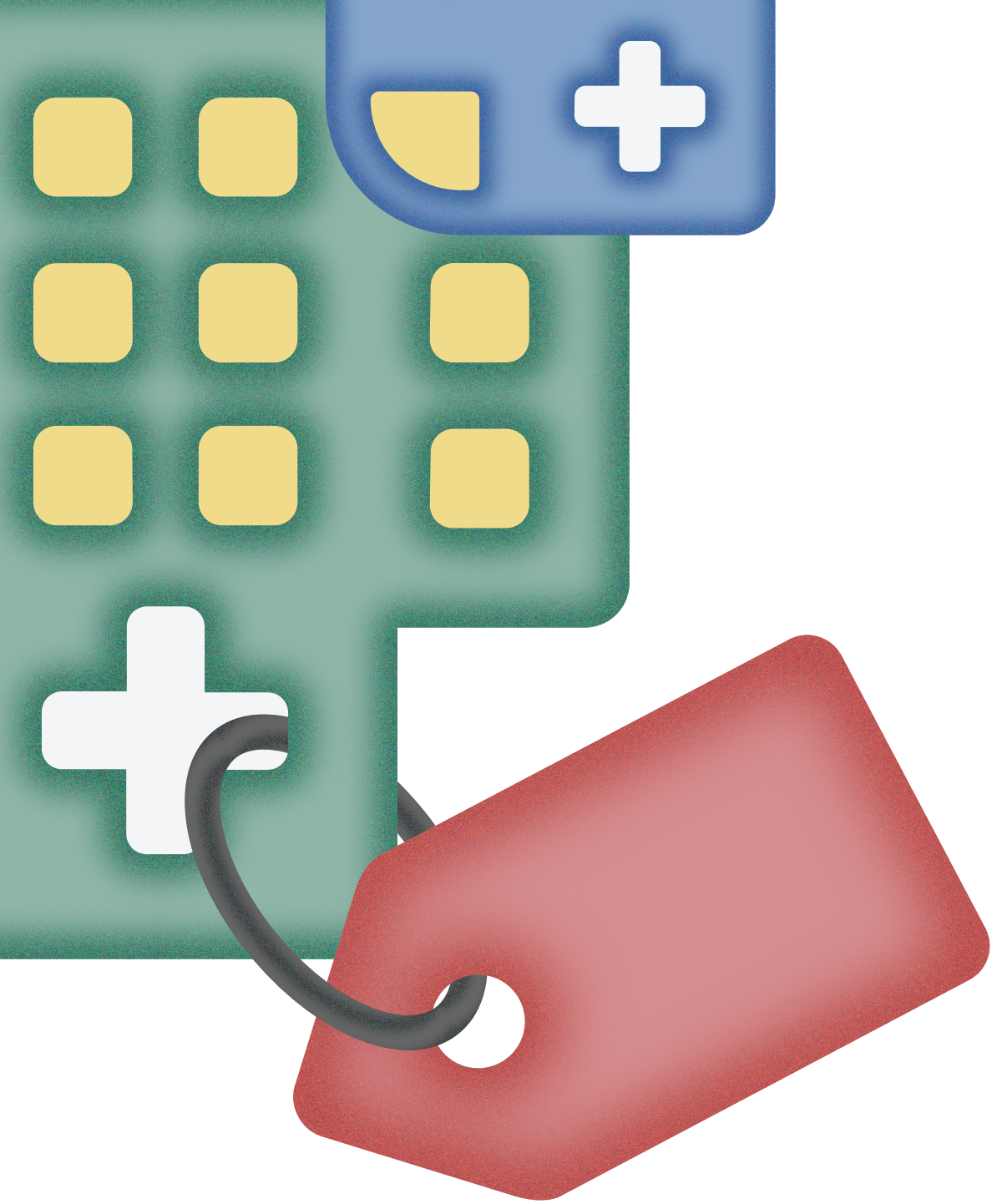

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