

Four stylized facts on health in the Philippines

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Filipinos dream of a long and healthy life (NEDA 2016). This allows them to work productively, enjoy the fruits of their labor, and continue doing so into the future. To fulfill this dream, an effective healthcare system is a must.

This *Policy Note* summarizes key trends and challenges in the Philippine health sector into four stylized facts: one on the country's population health situation, and the rest on the primary causes of the current health state of affairs. This Note concludes with an outline of its policy implications and some proposed strategies. These lessons are drawn mainly from recent research done by the author and other researchers at the Philippine Institute for Development Studies.

Health outcomes may be improving, but...

Stylized Fact #1: The Philippines has made important progress in improving health outcomes but has lagged behind its regional and aspirational peers.

A Filipino born in the 1960s was expected to live for about 61 years. That is only a little over the statutory age for optional retirement at age 60, and below the mandatory retirement at age 65 to qualify for the country's old-age pension. Since then, life expectancy at birth among Filipinos has increased by around 10 years

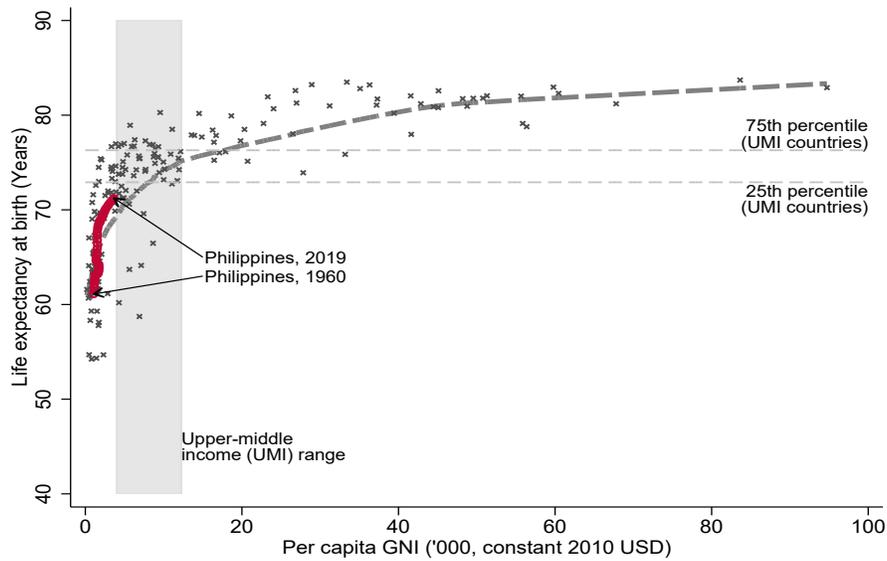
Salient Points:

- *The Philippines has made a lot of progress in improving health outcomes but remains lagging behind other countries in the region and those with similar income levels.*
- *Health outcomes are influenced not only by healthcare interventions but also by many nonmedical determinants.*
- *Government efforts must address the social and economic determinants of health while ensuring that healthcare services are not only available and affordable but also accessible and acceptable to households.*

over six decades (Figure 1). More and more elderly are enjoying longer retirement years.

In the 1960s, only 9 of every 10 born were expected to reach the age of five. Among those who survived up to age 5, only 1 in 5 were expected to reach age 80. Prospects for survival have improved substantially over the past six decades. The country's under-5 mortality rate has declined by about fourfold, while the probability of survival up to age 80 almost doubled during this period (United Nations 2019).

Figure 1. Per capita GDP and life expectancy at birth, 2019



Source of basic data: World Bank (2021)

These remarkable achievements are the results of the confluence of several factors that have evolved over the years. First, critical public health interventions have been introduced, including routine maternal and child immunization, and local water and sanitation systems. Second, the country’s health system has expanded considerably. Finally, greater household incomes afforded families to access better nutrition, information, and health services. Together, these have contributed to the decline in preventable deaths among children and saved lives among adults and the elderly (World Bank 2011; Deaton 2013; Dayrit et al. 2018).

Despite these many successes, the country lags behind its regional and aspirational peers on different health measures. As shown in Figure 1, the Philippines’ life expectancy at birth (le0) trails behind other countries with similar per capita incomes in 2019. A closer inspection among countries in the ASEAN+3 region, presented in Table 1, shows that the country’s le0 was only ahead of Cambodia, Lao PDR, and Myanmar in 2017. In 1960, only Japan and Singapore’s le0 were ahead of the Philippines’ in the region.

While deaths from infectious diseases, particularly respiratory infections and tuberculosis, have gone down over the years, it has been replaced by complications from all forms of malnutrition, i.e., both under- and overnutrition. Among children, maternal and child undernutrition continues to be a prime risk factor for deaths, claiming about 1 infant for every 100 born in 2019. Among adults aged 55 years and over, dietary and metabolic risks have pushed deaths due to noncommunicable diseases, particularly cardiovascular diseases, neoplasms, and diabetes and kidney diseases, to more than 1,067 per 100,000 population in 2019 from only 726 per 100,000 population in 1990 (Global Burden of Disease Collaborative Network 2020).

There may be large health dividends from managing, if not totally eliminating, maternal and child malnutrition and dietary and metabolic risks. Even halving deaths due to these risk factors for populations aged less than 65 years may contribute about three additional years in the country’s le0, putting the Philippines closer to the average for upper-middle-income countries (Abrigo 2021).

Table 1. Selected health indicators: Philippines and selected peers, 2017

	Per Capita GNI (PPP\$)	Life Expectancy at Birth (Years)	Mortality Rate			
			Neonatal (per 1,000 Live Births)	Infant (per 1,000 Live Births)	Under-5 (per 1,000 Live Births)	Maternal (per 100,000 Live Births)
A. ASEAN+3 countries						
Singapore	88,090	83	1	2	3	8
Brunei Darussalam	64,620	76	6	9	11	31
Japan	42,430	84	1	2	3	5
South Korea	41,120	83	2	3	3	11
Malaysia	25,910	76	4	7	8	29
Thailand	16,640	77	6	8	10	37
China	14,330	76	5	8	9	29
Indonesia	10,590	71	13	22	26	177
Philippines	9,020	71	14	23	29	121
Lao PDR	6,870	67	23	39	49	185
Vietnam	6,650	75	11	17	21	43
Myanmar	4,600	67	24	38	48	250
Cambodia	3,680	69	16	25	29	160
B. Country income groups						
High income	49,204	81	3	4	5	11
Upper middle income	16,105	75	8	12	15	42
Lower middle income	6,650	69	25	39	52	253
Low income	2,291	63	28	51	72	460

Source: World Bank (2021)

Health spending may be increasing, but...

Stylized fact #2: Domestic resources allocated to health care have been increasing but remain unevenly distributed across population groups and lag behind other countries.

Aggregate healthcare spending has been increasing over the years. Between 1994 and 2019, aggregate health expenditures more than quadrupled in real terms, reaching more than PHP 790 billion in 2019 (PSA 2008, 2020). Although population growth and population aging have contributed to this expansion, much of the recent

increase in healthcare spending is brought about by greater expenditure per person (Abrigo 2019).

The share of household out-of-pocket (OOP) expenses continues to represent a substantial portion of health spending but has been increasingly replaced by pooled and prepaid funds. Over the last decade, new medical care entitlements guaranteed by the government, in addition to innovations in the design of the country's social health insurance (SHI) program, have expanded healthcare coverage and access, especially among the poor and the elderly (Abrigo and Paqueo 2017; Abrigo et al. forthcoming). By 2019, government-provided

and -mediated spending accounted for about 42 percent of total health expenditures from only 34 percent in 2009. The share paid through private health insurance, on the other hand, also increased from 7 percent in 2009 to 9 percent in 2019. By 2019, household OOP expense accounted for 48 percent of total current health spending from 53 percent a decade prior.¹

The aggregate picture, however, masks important differences in health spending across locations. Average household per capita health spending in the Bangsamoro Region in 2015, for example, was only about half of those in the National Capital Region when the age-sex distribution of household members, proxying for sex-specific health care needs across the life course, is considered (Abrigo 2021). Other health resources are also unevenly distributed. In 2015, only one in every four cities and municipalities had HHR-to-population ratios above the 45 physicians, nurses, and midwives per 10,000 population recommended by the World Health Organization (WHO) (Abrigo and Ortiz 2019). The supply of HHRs is highly concentrated in economic centers, similar to health facilities and drugstores, which affects the delivery of health services. Indeed, there are documented differences in the quality of health services provided in public health facilities, at least concerning maternal and child health services (Abrigo et al. 2021).

When benchmarked with other countries in the region, the Philippines continues to lag in health spending per person despite the robust domestic growth (Figure 2). Viet Nam, which used to spend only USD 138 in purchasing power parity² per person in 2000, was spending USD 440 in 2018, compared with the Philippines' USD 150 in 2000 and USD 393 in 2018.

¹ This is based on the Philippine National Health Accounts (PSA 2013, 2020). Alternative estimates provided by WHO (2021) show similar trends in health spending shares across financing schemes, although the magnitudes differ.

² Purchasing power parity exchange rates are used to convert amounts in local currency units into a common currency that eliminates the effects of differences in price levels among countries (World Bank 2017).

Indonesia, which was spending only USD 123 per person in 2000, is also closing the spending gap relative to the Philippines, with the former spending USD 375 in 2018. More developed economies in the region had already breached the USD 3,000 (South Korea) and USD 4,000 (Japan, Singapore) per capita health spending levels.

Interventions may be cheap, but...

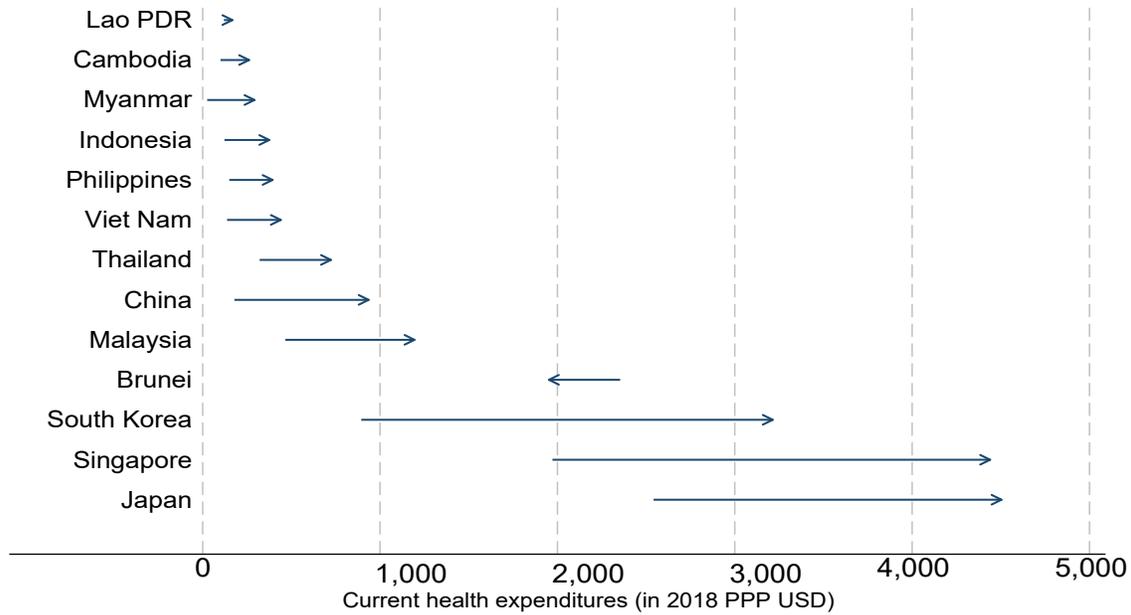
Stylized fact #3: Many necessary health interventions are inexpensive but require substantial time investments that people may not afford or be willing to provide.

The government has long guaranteed many life-saving health interventions, including routine maternal and child vaccination, micronutrient supplementation, tuberculosis treatment, and primary care consultation, which should be available at zero, or, at worst, minimal cost to patients in public health centers in all cities and municipalities around the country. Further, hospital care for the poor and the elderly may be availed without any hospital OOP expense under the “No Balance Billing” policy of the Philippine Health Insurance Corporation, the country’s SHI agency.

But the availability of health services, even if at no cost to patients, does not necessarily translate to household access to health care. In many settings, accessing healthcare services, especially those given at no cost to patients, requires time—for planning, traveling, waiting in line, receiving care, etc.—that potential patients may not afford or be willing to provide. The opportunity cost of time to avail of health services may be higher than the benefits (net of direct costs) that people may receive, whether these are perceived or real (cf. Posnett and Jan 1996).

Anecdotal evidence from focus group discussions with child caregivers in several parts of the country suggests that work, whether unpaid household work or paid market

Figure 2. Current health expenditures: Philippines and regional peers, 2000–2018



PDR = People's Democratic Republic; PPP = purchasing power parity; USD = United States dollar
 Source of basic data: WHO (2021)

work, may dissuade households, especially in resource-poor settings, from accessing health services, e.g., prenatal care, or providing critical inputs for health, e.g., breastfeeding (Abrigo et al. 2019). This may involve the lack of support systems to care for children or livestock that will otherwise be left unattended. In others, accessing health services may involve foregoing compensation from paid work, which may be crucial for their survival (cf. Capuno et al. 2019).

The decision to breastfeed showcases the importance of the opportunity cost of time in health. Breastfeeding is a time-intensive investment that has many essential benefits for maternal and child health (Rollins et al. 2016; Victora et al. 2016). The WHO recommends that infants be exclusively breastfed until six months and continuously up to age two. Evidence from the Philippines suggests, however, that employed mothers are more likely to introduce breastmilk substitutes earlier, although this may be attenuated by having extended family members in the household (Abrigo 2016, 2021).

Medical care may be central, but...

Stylized fact #4: Health outcomes do not solely rely on medical care but also on a host of other socioeconomic, political, and even cultural considerations.

The previous stylized fact on the saliency of the opportunity costs of time regarding accessing health care underscores a nonmedical factor that has an enormous potential impact on population health. Indeed, while medical care is an essential aspect of health, many other nonmedical factors may either promote or hinder households from attaining optimal health outcomes (Marmot and Wilkinson 2005).

For example, Filipino women of reproductive age from poorer socioeconomic backgrounds have been documented to be less likely to finish high school, be exposed to different media, be employed, or have any health insurance coverage. But they are more likely to report having serious problems in accessing health care.

Children from poorer households, on the other hand, are more likely to be born underweight, not receive all basic or age-appropriate vaccines, and be sick from fever or diarrhea but not seek treatment. They are also more likely to die young (PSA and ICF 2018).

The disparity in health outcomes may be quite stark across the socioeconomic gradient. Children born from the poorest household wealth quintile are about three times more likely to die before reaching their first birthday than children born from the richest household wealth quintile.

These material differences may persist across the life course. Individuals from poorer households are more likely exposed to more unsatisfactory household conditions, including indoor air pollution. They are less likely to have health insurance coverage. They are more likely to report being sick but less likely to say they have visited a health facility when sick. These

observations are summarized in Figure 3 and appear to be common across life stages.

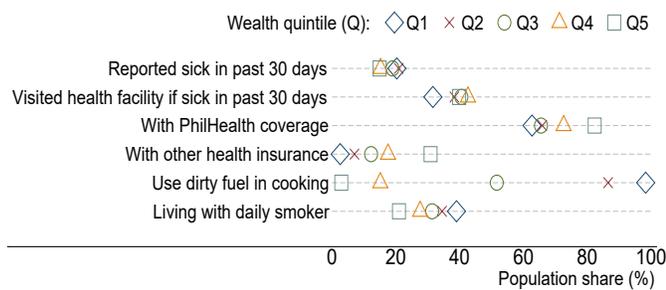
Politics and culture may also play significant roles in households' healthcare experience. Routine anthropometric measurements, for example, allow government field health personnel to gauge the development of children and suggest or provide appropriate care when needed. But in many parts of the country, measuring children supine is taboo, which may hinder parents from participating in the annual program or may lead to inaccurate body measurements. Shifting priorities among local governments have also been documented to affect the delivery of health services, which, in turn, is expected to affect household health outcomes (Abrigo and Ortiz 2018; Abrigo et al. 2019).

Implications for policy

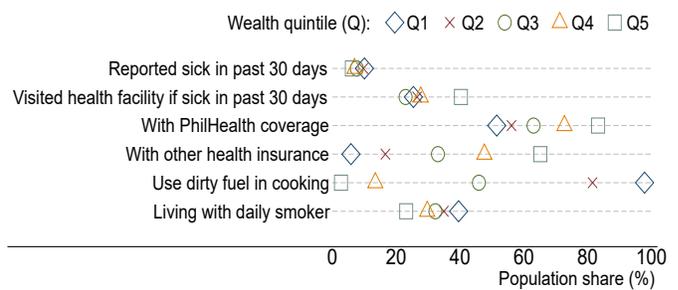
The preceding stylized facts have important implications on health outcomes. The objective of the government should

Figure 3. Proximate health indicators over the lifecycle by wealth quintile

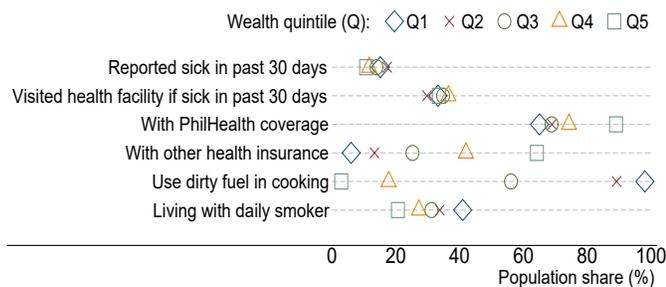
A. Children aged below 20 years



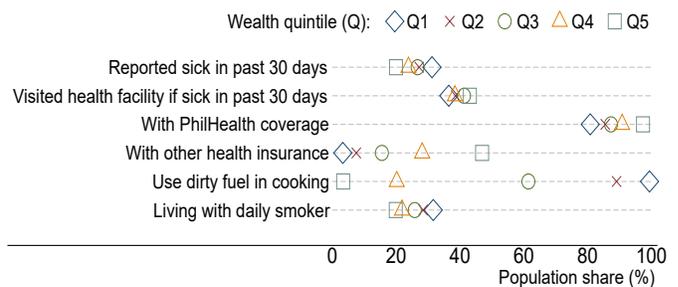
B. Young adults aged 20–39 years



C. Prime-age adults aged 40–59 years



D. Elderly aged 60+ years



Source of basic data: PSA (2018)

therefore be confined to ensuring that health services are not only available and affordable but also accessible and acceptable to households. We propose some strategies to address the identified key challenges in health.

Ensure the complete, consistent, and continuous availability of health services.

Disparities in the quality, timeliness, and extent of healthcare services are a longstanding issue that plagues the country's health sector. Ensuring the unhampered availability of quality healthcare services across the country should be a foremost priority of the government. This necessarily requires greater public investments in the health sector.

- *Strengthen the incentive structure to entice health professionals to work in underserved areas.* The government has a long tradition of augmenting the health personnel in underserved areas through a national human resources for health (HRH) deployment program. A recent evaluation, however, shows that physicians are less likely to continue working in their deployment sites after the program even if offered the same compensation package (Abrigo et al. 2021). Providing scholarship grants to locals in exchange for return service in their hometowns as provided in the *Doktor para sa Bayan* Act may be a sustainable option to ensure the supply of physicians in underserved areas. Providing additional incentives on top of existing benefit packages for HRH to work in difficult-to-fill posts may be explored.
- *Unload government health professionals of noncore functions.* Public health personnel are often given administrative and management responsibilities, which may compete with their core function of providing health care (Abrigo et al. 2019). The government may consider hiring professional managers and administrators, and support staff to unburden the limited supply of public HRH from activities that may be beyond their professional training. Adopting technology solutions to ease everyday functions, e.g., health surveillance, medical recording, supply chain management, etc., may also be explored.
- *Leverage on the strong supply of nursing professionals for primary care.* Nursing professionals vastly outnumber physicians (Abrigo and Ortiz 2019). The Professional Regulation Commission, in consultation with professional associations, may consider expanding the roles of nursing professionals, especially in community settings. In other parts of the world, such as in the United States and Canada, nursing professionals may provide primary care, including interpreting diagnostic tests, diagnosing illnesses, and prescribing medicines, given the appropriate training and certification.
- *Tackle bottlenecks in the financing, procurement, and delivery of medical supplies.* Bottlenecks throughout the medical supply chain remain an important challenge in the health sector. These supply chain issues have been documented to delay the delivery of health services, including child immunization and reproductive health services, in recent years (Abrigo et al. 2021; Ulep and Uy 2021). Addressing this issue requires taking a closer look at each stage of the process to provide effective solutions.
- *Ensure the sustainability of government-provided and -mediated health care.* The country's SHI program has expanded considerably over the last decade due to recently introduced health entitlements, particularly for the poor and the elderly, and a stronger mandate of the national government for financing. Population aging, however, threatens the sustainability of the SHI program as the elderly consume more health care per capita. At the same time, their insurance coverage is financed primarily through payroll taxes and incremental revenues from sin taxes. With the current schedule of contributions and benefits, a greater share of the elderly is projected to increase health insurance payments and decrease premium contributions (Abrigo 2019, 2020). Tempering

potential future losses from SHI operations requires early and proactive interventions. Such interventions may include promoting and incentivizing healthy aging to lower the cost of health care; introducing medical savings account on top of basic health insurance coverage to strengthen the incentive-compatibility between health financing and consumption; and relying more on general taxes, including levies on tobacco and alcoholic products, as well as on sweet, salty, and fatty food products, to aging-proof health financing while promoting healthy lifestyles.

Promote timely access to critical health interventions.

This necessarily relies on the complete, consistent, and continuous availability of health services and the ability of households to access these services. Interventions that aim to bridge the gap between the supply of and demand for healthcare services among households should recognize the many different constraints that effectively limit their access to these services.

- *Adopt a lifecycle approach to health care instead of the traditional programmatic and siloed programs.* Adopting a continuum of care based on the life course provides a natural progression to different health services. It signals to households that health care is vital in maintaining optimal health at all life stages rather than only when already sick or in need of health intervention. It also forces public health programs to be aware of their roles in promoting population health in relation to other programs.
- *Empower, professionalize, and integrate barangay health volunteers and traditional health workers in the national and local health systems as health caseworkers.* Barangay health volunteers and traditional health workers have been documented to be well regarded in the community. They are trusted sources of health information (Abrigo et al. 2019;

Rogers and Solomon 1975). The government may consider enlisting their services as health caseworkers who may help households navigate local health systems to ensure critical health interventions are provided and accessed throughout the life course. Training and certification programs may need to be set up to harmonize and standardize the quality of care that health caseworkers will provide. Incentives for health caseworkers may be tied to household health outcomes.

Address gaps in the social and economic determinants of health

As mentioned earlier, there are many factors other than medical care that may determine health outcomes. Solutions to health challenges may be beyond the health sector and may transcend other sectors, including agriculture, education, and labor. Addressing health sector issues should therefore include addressing the social and economic determinants of health.

- *Improve household living conditions while tackling the inequitable distribution of resources.* The government should support policies that raise household incomes to allow families to provide a safe living environment and access better alternatives on food, information, and health services. At the same time, the government should strengthen its redistributive role to ensure a level playing field and universal access to basic social and economic services.
- *Measure both the extent of the problem and the impact of interventions.* Understanding the scope and nature of a problem is critical in devising possible solutions. The impact of interventions, on the other hand, needs to be measured to allow comparison across alternative solutions. Strengthening regular surveillance of key health indicators and their distal and proximal determinants will allow better monitoring and design of interventions.

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