Health Poverty and Equity Mechanisms in the Philippines

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Abstract

The Philippines is one of the few countries where decentralization in the delivery of local anti-poverty programs can result in the reduction of targeting failures that characterize traditional delivery mechanisms of centralized bureaucracies. Here, the primary challenge for the health sector is in identifying ways to improve the efficiency and effectiveness of health-service delivery for illness, particularly those related to catastrophic disease management.

On the one hand, devolution highlights both the limited resources and weak capacity of local government. A rationalized health service delivery system is expected to lead to efficiency gains. Improved coverage under health equity mechanisms (through social health insurance) would reduce household health care cost, particularly against illness and disaster, which further aggravate poverty.

Against the background of persistent poverty and unacceptable mortality levels, the present study evaluates the health equity mechanism and its innovativeness, as well as other home-grown programs. The study explores how such programs can contribute to achieving the Millennium Development Goals (MDG) in addressing ill health and catastrophic health-related expenditures in the Philippines. The study also presents an extensive review, impact evaluation, and cost-effective analyses of on-going programs on "catastrophic health expenditures and poverty" and "reducing poverty resulting from ill-health" that are supported by health-equity mechanisms in the region.

Introduction

The Philippines is one of the few countries where (whose) experiences suggest that decentralization of anti-poverty programs at the local level can result in reduction of failures that have plagued traditional centralized bureaucracies delivery mechanisms entrusted to centralized bureaucracies. Despite the substantial progress made during the past 15 years, poverty reduction is still a major challenge for policy makers in Philippines. Poor health and expenditure on health care are important causes of poverty in the country. Nonetheless, the challenges faced by the health sector—that are affected by diseases of poverty and diseases of affluence, on the one side, and frequent post-disaster health care management, on the other side are expected to result in a slower pace of improvement in health and poverty, thereby threatening the country's chances of meeting health-related Millennium Development Goals. The primary challenge facing the health sector is identifying ways to improve the efficiency and effectiveness of health service delivery for illness particularly catastrophic health care management. Improved coverage under social health insurance (through Philhealth) would reduce household health care cost, particularly for the poor against catastrophic diseases health spending which further leads to poverty. On the other hand, devolution has highlighted limited resources and weak capacity at the local government units level. A rationalized health service delivery system is expected to lead efficiency gains. Against the background of persistent poverty and unacceptable levels of morbidity, the present research initiative attempted to examine and evaluate the existing health financing mechanisms and its home-grown innovativeness from around the developing and transition that can contribute to achieving the MDGs addressing ill-health and catastrophic health related expenditures in the specific context of Philippines. Nonetheless, the present

study focused to extract equity and equality approaches in relation to catastrophic diseases-related expenditures in reducing health poverty in the Philippines.

The Health Care Framework

The study adopted Health Care Benefits Methodology (HCBM) based on the health status of population in terms of the disease continuum as well as its care continuum. HCBM provides a structure that allows for identification and consideration of issues across the care continuum. The methodology provides a strong foundation for exploring and modelling the impact of approaches, financing mechanisms and strategies that are exists. In other words, this methodology deals with components (needs of the population, responses of services, financial expenditure on services, resource distribution and its outcomes) of the health system in which services are conceived for, and delivered to, whole population. It is an analytical tool, rather than prescriptive, which can assist decision-makers understand the care continuum and, in so doing, inform the establishment of an appropriate mix of services to meet the health care needs of the population served. The HCBM follows a two dimensional matrix, i.e., mapping or linking information on the numbers of people in need of a particular intervention and related resources needs. It is a decision-support tool that in its basic form provides a mechanism for looking at the health sector as a whole. It offers health sector a wide structured way of conceptualizing the need for health care and associated responses.

With these methodological advantages, the present study chose to conduct the study in two provinces namely *Capiz* and *Pangasinan* from Formula-1 sites (formerly known as Health Sector Reform Agenda) and from non-Formula-I & non-Rollout provinces, *Cavite* was chosen. All these provinces were selected based on the statistical data that were provided by Department of Health, Local Health Units and PhilHealth. The endorsement of Secretary of Health, Department of Health, Director, Bureau of International Health, Centre for Health Development, and Governors and Provincial Health Officers of the respective Provinces were received for implementing the research work (Fig-A). The selection of health facilities were done at area level by using sample proportional to population and number of registered catastrophic cases (Fig-B).

Fig-A Approval and Data Gathering Process

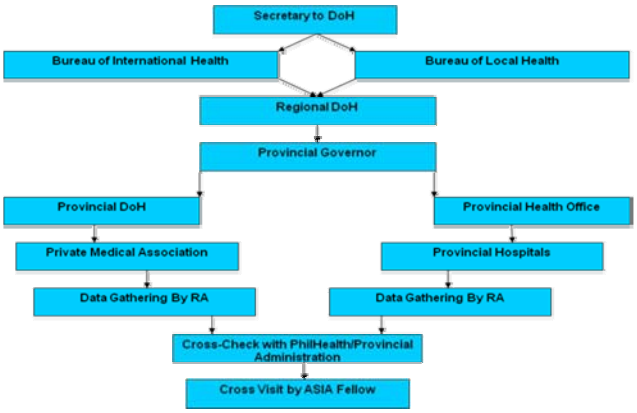
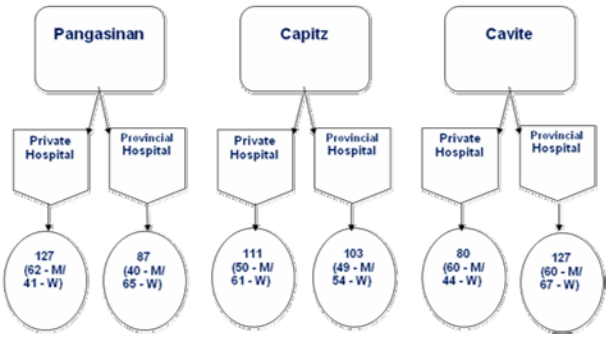


Fig-B Sampling Process



The clinical and financial data collected from each health facility- treatment facilities, drug supply and management, quality of services and drugs, record keeping and compliance of social health financing mechanism - were assessed and evaluated using a grouping process for health care benefits and costs modelling. At each health facility, the patients' records were reviewed and treatment performance and health insurance compliance were assessed in detail with randomly selected patients. In each selected areas, at least, 2 NGOs/CBOs (subject to availability) were contacted and their involvement and

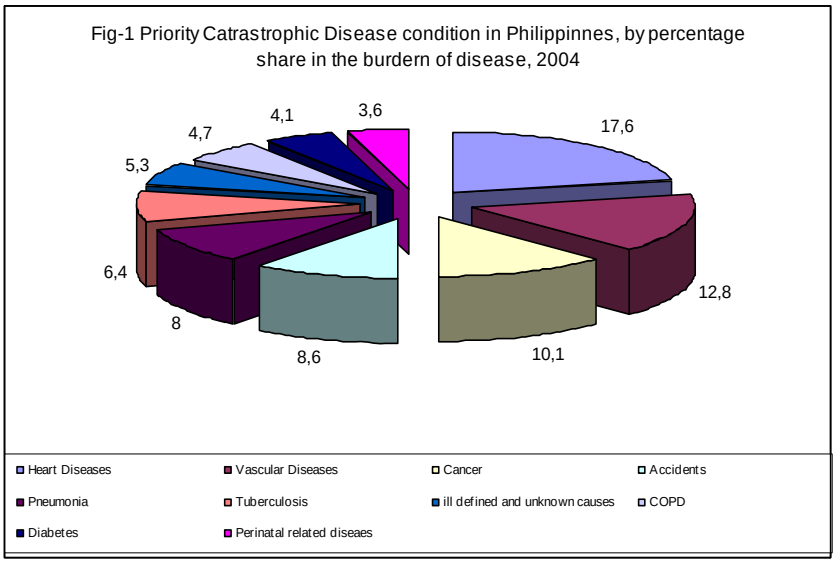
participation in mitigating high cost health expenditure assessed. A comprehensive tool and template were prepared to analyse the performance statistics of health system and facilities. A draft evaluation framework (on the basis of these tools) was prepared in the qualitative phase of the study for developing health care benefits methodological framework. For qualitative data, observation and case study method were being used especially in the context of patients' and community survey. The field questionnaire (especially the quantitative data) was translated from English to local languages as per the nature of the regions/province. The secondary and quantitative data collected were analyzed and compiled as per the methodological framework developed.

Conversely the study has limited catastrophic diseases to only those of top six catastrophic diseases such as cancer, diabetes, renal diseases, COPD, CVD and hypertension. This limitation itself became a strength to itself [1] as no studies focused on non-communicable diseases in this country so far; [2] millennium development goals of the country do not address these non-communicable diseases; [3] the country experiences high morbidity and mortality due to the catastrophic diseases, i.e., every 6 cases out of top 10 morbidity cases are of these catastrophic diseases; [4] catastrophic diseases are related to life style basis; and [5] since there is no curative health care system, unlike communicable diseases, it is a lifelong health care affair. These factors lead to define "health poverty" which is missing in the health policy, welfare programs and millennium development goals.

Diseases Burden in Philippines: Estimations and Causal Analysis

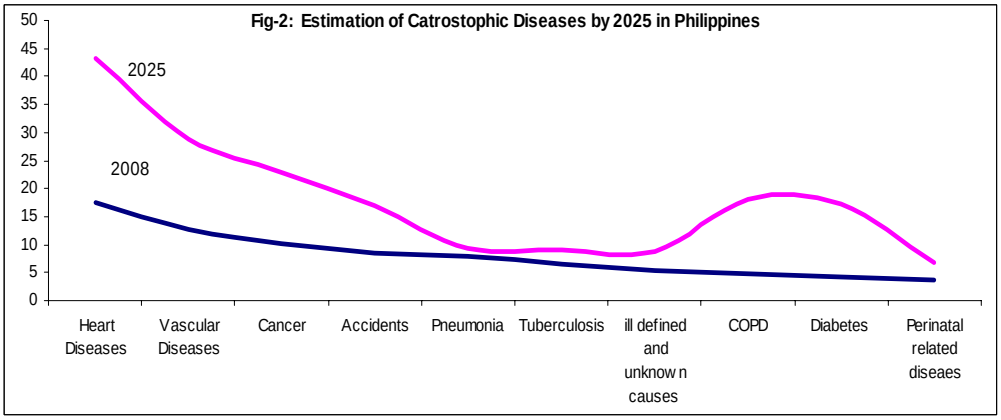
Disease burden estimations based on sound epidemiological research provide the foundation for public policy. Which diseases and what interventions does public policy needs to focus upon are normally derived from such evidence. Well researched, longitudinal data can enable judicious targeting and help decide what needs to be done where, for whom, and when. Conversely, the absence of such good quality empirical data can affect program designing and consequently outcomes. Philippines has ample evidence of such impacts, often due to the mismatch between diseases burden and its causal factors, and the intervention adopted and priorities in resource allocation. Besides the need to avert disease for enhancing the quality of life, neglect can have adverse consequences on the well being of affected families – social, psychological as well as economic. Identification of the diseases were based on four criteria: first, Philippines is one of the 23 selected countries contributing to around 80% of the total mortality burden attributable to catastrophic diseases in developing countries, and 50% of the total disease burden caused by non-communicable diseases worldwide (Fig-1). That is, seven out of ten leading causes are catastrophic diseases accounting for 57.8% of all causes of mortality. Second, the likelihood of the burden of specific health conditions

Fig-1 Priority Catrastrophic Disease condition in Philippinnes, by percentage share in the burdern of disease, 2004

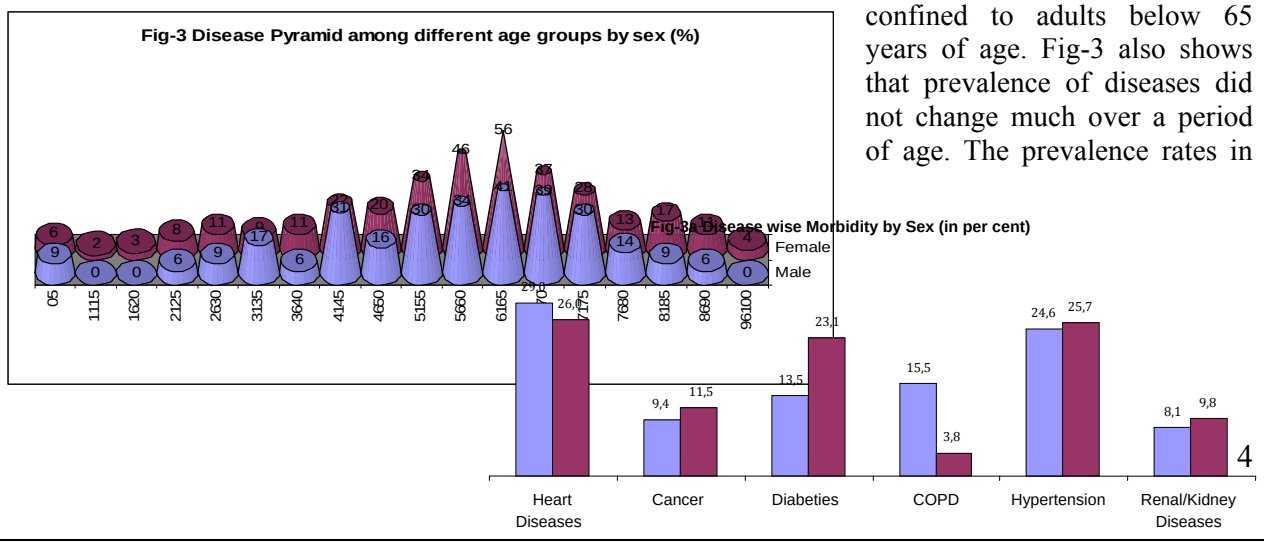


falling on the poor; third, diseases (such as) that are heavily concentrated among young and working adults or the poor as in the case of cardiovascular disease, cancer, renal diseases, hypertension, diabetes and chronic obstructive pulmonary disease which have a ruinous impact as, such diseases are extremely expensive to treat, especially due to lack of health financing mechanisms; and four, the possibility of a health condition driving a sufficiently large number of people into financial hardship, including their falling below the poverty line.

The catastrophic effects of health conditions accounts for the large share, followed by communicable diseases, of the disease burden in Philippines - vascular system diseases, cancer, diabetes and respiratory diseases. In Philippines, the increase in life expectancy, rapid urbanization and life style trends have resulted in a considerable change in the health profile. Recent statistics attest to this. The life expectancy of Filipinos in 2005 had gone up to 70.5 years. The process of aging brings out myriad degenerative diseases. The study data suggest that these conditions will account for fairly sharp increase in Philippines's disease burden in the future (Fig-2). As the country's per capita income raises, the social and economic challenges similarly increase and so do the health hazards and risk behaviors of big segment of the population. Increase in catastrophic disease effect could be accounted through three factors: first, a large number of diseases which were considered to be lifestyle related and affecting the rich were seen to be affecting the poor as well, and increasingly so. In a study conducted by FNRI(expand) (2003), it was found that 90 per cent of Filipinos have one or more of these high risk factors: hypertension, high blood sugar, obesity, cancer etc. Second, in the absence of operational research there was also weak evidence regarding the type of interventions that would be most cost-effective in the different provincial settings in the country. Third, the non-availability of good quality data has been a major hardship in arriving at reliable estimations of the diseases burden, halting the process of formulating equity and equality measures and creating adequate health financing mechanisms (Fig-2).



The spectrum of clinical manifestations of catastrophic disease effect is wide. The prevalence of catastrophic disease was much higher in female than the male. The prevalence of catastrophic diseases is confined to adults below 65 years of age. Fig-3 also shows that prevalence of diseases did not change much over a period of age. The prevalence rates in



males varied from 6-41% and for females varied from 2- 56%. The median values of these prevalence rates are 1.75% for males and 2.55% for females. However, that in productive age group 30-65 years, the prevalence rates is 22.1% for males and 29.7% for females. There are great variations in the reported morbidity (Fig-3a), among males and females, which could partly be due to the differences in the accessibility and financing services. Similar observations were also made in varied age group in Philippines. A majority of cases with chronic COPD were found to be among males while in the case of diabetes, it was females. Similar differences among heart diseases and cancer have been reported.

Contextualization of Poverty

Sustainable poverty reduction is the overarching mission of every government in the world. It is known that, "Guaranteeing basic social services and strengthening social protection" (BMG, 2005) can contribute sustainably to poverty reduction and prevent conflicts within society. Poverty and disease are indivisible and there are a variety of linkages between them (Schwefel et al, 2004). Worldwide, 1.6 billion people live in transition countries are without adequate and affordable access to health services. These populations go without preventative or primary care, lifesaving medicines or advanced medical care (Prekar et al, 2002). The problems are not confined only to the poor health care provision often found in rural areas, or the inadequate quality of services in developing countries. A key issue is the 'catastrophic health expenditure' or high cost of obtaining medical services. Therefore, ensuring an adequate health care and setting up appropriate financial mechanisms to provide coverage against the social, economic and health risks of illness are core elements of social protection (Wagstaff and Eddy, 2003). Thus, health is an essential human right, a societal asset and a necessity in order to live, work and earn income (Wagstaff and Mariam, 2004).

In transition economies like Philippines, ill health is one of the risks most likely to result in poverty due to high catastrophic health expenditure. The health status of poor people is fundamentally worse than that of people belonging to higher social classes when a disaster or major ailment strikes. This is a consequence not only of inadequate nutrition and a lack of information about disease prevention and treatment but also of the heightened health risks to which the poorer population is generally exposed. The most major health problems are closely related to global inequalities, and poor people in developing countries are disproportionately affected (Sachs, 2001). Predictably, infectious diseases are commonplace but chronic ones are also a mounting concern since they are increasingly occurring in younger people. All over the world, such disparities can be traced back largely to differences in income (World Bank, 1994). Although it is the poorest 84% of the world's people who bear 93% of the global burden of diseases, this vast group benefits from only 11% of worldwide health expenditure (Preker et al. 2002). Health in its own right and as the basis of the ability to work productively has clear implications for individual and family income, but is also of wider importance. It is an essential prerequisite for a country's economic development and for the reduction of poverty. In other words, 'poverty' means the denial and deprivation of basic health care needs. These may be non-quantifiable needs like being able to live healthy and creative lives, enjoyment of decent standards of living, freedom, dignity, self-respect and respect to others (UN, 2000).

Localization of Poverty

Nonetheless, as many definitions as there are, wide and varied issues have also arisen as to the causes and effects of poverty, and its implications on public policy. Philippines Constitution refers to "paupers" and "the poor" are referred to as "indigent" in RA 7875. An indigent is defined as "a person who has no visible means of income or whose income is insufficient for the subsistence of his family, as identified by the Local Health Insurance Office and based on specific criteria set by the Corporation in accordance with the guiding principles set forth in Article I of this Act" (Article II, q). This definition is supported in the IRR in its definition of universal coverage. This is supposed to be comprised of the coverage of the

employed in the government and private sectors, enrollment of indigent households and individually paying groups, and linkages with community based health care organizations (CBHOs) and other similar institutions (Rule I, Section 4). Among these groups, the poor is often considered synonymous with indigent household; in reality the poor may include individually paying groups and members of CBHOs as well. In fact, Rule V on the Specific Provisions concerning Individually Paying Members of the IRR does recognize that charitable organizations, duly registered associations, CBHOs, cooperatives, private non-profit health insurance organizations, or an individual may pay the premium contribution of individuals identified through defined criteria set by the Corporation. It is the only apparent recognition by the IRR of the need by other members, aside from those defined as indigent, to have their premiums subsidized by others.

According to PhilHealth Insurance Corporation's definition, there are two types of poor: those who live below the subsistence level and those with income between the subsistence level and the poverty line. Both definitions take income as a means to measure poverty. On the average, the poverty line in Philippines is set at a per capita annual income of P14,000 while the subsistence level is set at a per capital annual income of P9000. The average annual per capita income of all Filipinos is at P25,000 or P123,000 per family.

Who is poor?

According to the poverty incidence statistics, there are about 31m poor in the Philippines, which correspond to about 40 percent of the population. Out of them, nearly 17m are hard-core poor, which means that they have barely enough for subsistence. The current PhilHealth program for the poor *(Medicare Para sa Masa)* covers 2.8 m individuals, which corresponds to less than 10 percent of the total poor population.

A review of poverty assessment in the Philippines conducted in 1994 recommends that poverty in the Philippines, which is measured in the absolute sense, be approached instead in the relative sense, wherein the extent of deprivation of an individual or family is measured relative to the rest of society using some social standards of living. A common indicator of poverty used in the country is the head count index and is based on income rather than expenditure (Marquez and Virola, 1994). In line with this, one of the key programs that have been developed in the Social Reform Agenda was the Comprehensive and Integrated Delivery of Social Service (CIDSS). One of the key strategies in the CIDSS is focused targeting, or the identification of target beneficiaries using the 33 Minimum Basic Needs (MBN) indicators[1] as basis for prioritization (Bautista, 1999). The 33 indicators are subsumed under ten general areas, namely: a) Food and Nutrition; b) Health; c) Water and Sanitation; d) Clothing; e) Shelter; f) Peace and Order; g) Income and Employment; h) Basic Education and Literacy; i) People's Participation; and j) Family Care and Psychological Needs. In addition, the National Anti-Poverty Commission defines poverty not only as the lack of income or material resources, but also the absence of capabilities, power, and opportunities to allow an individual to assume his role in the community. It classifies the poor in the Philippines in three ways: by sector, by capacity to meet basic needs, and by income (NAPC, unpublished).

The sectoral classification of the poor is as follows: landless rural workers, artisan fishers, upland dwellers, urban poor, workers in the informal sector, indigenous peoples, and lastly, the disadvantaged sectors (e.g. the disabled, women). The second classification is based on their capacity to meet minimum

[1] The 33 indicators used in the MBN was formulated through consultations with various institutions such as the Presidential Commission to Fight Poverty (PCFP), Philippine Institute for Development Studies (PIDS), Department of Social Welfare and Development (DSWD), Department of Interior and Local Government – Local Government Academy (DILG-LGA), University of the Philippines- National College of Public Administration and Governance (UP-NCPAG), the United Nations Development Program (UNDP) and the United Nations Children's Fund (UNFPA).

basic needs (MBN). The poor are classified into: 1) those in the survival stage (i.e., who have difficulty meeting their survival needs), and 2) those in the security stage.

While there are those who say that *"poverty', is always defined according to the conventions of the society in which it occurs,"* (Hobsbawm,1968), there are still those who argue that for persons wanting to study the conceptions and measurement of poverty, the conventions of society are a matter of fact and are not issues of morality or subjective search (Sen, 1984:17). If this is the case, what then are the conventions of Philippine society—more specifically, the sectors which deal closely with providing social insurance to the poorest of the poor. The Means Test instrument used by the PhilHealh and developed along with HAMIS and FAMUS, could be considered the convention of what poverty means for the health financing sector. It has also been said that poverty standards are best adopted *"by those who conceive, prepare and undertake action to eliminate poverty"* (Drewnowski, 1997). Thus, searching for reliable and valid poverty indicators is in the instruments that have been developed by those who are directly involved in social health insurance, i.e., the Means Test. As far as the Indigent Program of the PhilHelath is concerned, the definition of subsistence poor seems more applicable and corresponds to the "poorest of the poor" and which is followed by the present study.

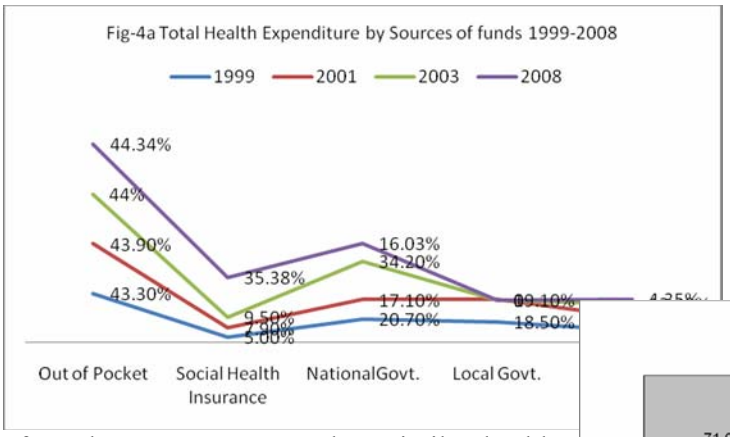
Health financing: Coverage and Trends of Health Expenditure

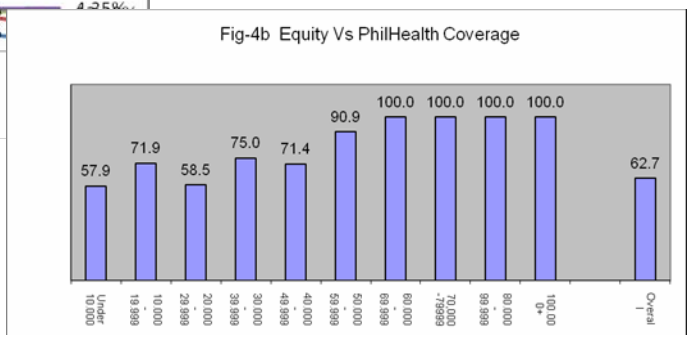
The increase in health spending from 1991 to 2000, averaging 13.8 per cent a year to 22.75 in 2001-2008, compared to the average annual population growth rate of 2.3 per cent at current prices showing that the population is growing much faster rate than the rate of increase in total health expenditure at current prices. In 2005, social insurance and private sources' share to the country's total health expenditure increased to 11.0 and 59.1 percent, respectively. On the other hand, the share of government in health expenditure declined to 28.7 percent (Table-1). The share of other sources of health expenditure remained at 1.2 percent.

Table-1 SOURCE OF FUNDS	AMOUNT (in million pesos)		Growth Rate (in percent)
	2004 [1/]	2005	
GOVERNMENT	**50,792**	**51,922**	**2.2**
National	26,019	28,651	10.1
Local	24,772	23,271	(6.1)
SOCIAL INSURANCE	**15,935**	**19,899**	**24.9**
PhilHealth (Medicare)	15,481	19,253	24.4
Employees' Compensation	454	646	42.4
PRIVATE SOURCES	**96,616**	**106,848**	**10.6**
Out-of-Pocket	77,524	87,508	12.9

Private Insurance	4,084	4,344	6.4
HMOs	7,079	7,082	*
Employer-Based Plans	5,903	5,755	(2.5)
Private Schools	2,026	2,158	6.5
OTHERS	**1,953**	**2,102**	**7.7**
ALL SOURCES	**165,295**	**180,772**	**9.4**

In 2009, about 45 per cent in total health expenditure came from out-of pocket expenditure of individual families. The burden of financing health care is heaviest on individual families. That is, high spending on hospital or personal health care and not enough for preventive and promotive health services. Government's share is only 16% in 2005 compared to 34.2% in 2003 (Fig-4a). This shows that Philippines is neither spending enough nor effectively for health. Social health insurance accounted from 9.5% in 2003 to 35.4% in 2009 while other sources like private health insurance, community based financing and employer's benefits accounted for 4.4% in 2009 from 12.3% in 2003. This reflects the family, through direct out-of pocket expenditure, is the least effective and most inefficient health insurance institution. Family income and size limit the resources that can be pooled. Moreover, members often share or are exposed to similar health risks, the family has limited risk-pooling capacity. In other words, the increases in the personal health care expenditure reflect the influence of private and political interests. Interestingly, the tax-financed open-access health delivery system under the national and local government offers a larger resource pool. Since people are taxed before they realized the need for health services, government health budgets are insurance funds. But it is an inefficient form of insurance since individual contributions are often based on consumption or income rather than on health risk. There has been limited progress made in expanding social risk pools (government budgets and social insurance funds for health). With the devolution of health services and PhilHealth financing mechanisms, the share of risk pools increased from 9.5% in 2003 to 35.4% in 2009. Six interrelated reasons explain the relatively slow and cautious increase in the share of social insurance to total health expenditure. first, though PhilHealth is trying to improve their services, their benefits are still low. In other words, subsidies are poorly targeted. Second, partly because benefits are low, the coverage of the informally employed sector has not expanded. Third, the benefit from PhilHealth services to the indigents is to be renewed every year and many of the indigents who may have been enrolled without their knowledge end up paying for the services (Fig-4b). Fourth, the study found that about 11.7 per cent of the people who may be above poverty level reaped the benefits that's given to poor/ indigent or take away the benefits through their political mileage or using political clout. There is no cross check mechanisms exist for "political indigent" in preventing such misuse of the power and/or benefits. Fifth, Social risk pooling mechanism is unlikely to be effective in areas where local financing is severely limited and where administrative or political infrastructures are weak. Sixth, social health financing mechanisms introduced capitation scheme for ambulatory care delivered in health centres/hospitals where providers are remunerated based on the size of the population enrolled in the program. However, starting 2001 PhilHealth has made inroads in its indigent program, with coverage





increasing to 31 million beneficiaries or 90 per cent of targeted indigents by 2004 (NOH, 2005-10). Sadly, this has fallen to 62.7 in 2009 due to the above interrelated reasons (Fig-4b).

Government Expenditure on Health

The absolute amount of the share of foreign assistance has generally declined since the past years although between 2002 and 2003 foreign grants increased by 153.4 per cent and foreign loans increased by 18.2 per cent (Table-2). However, total national government health expenditure registered a 10.1 percent growth, from P26.0 billion in 2004 to P28.6 billion in 2005. This was largely due to the 43.0 percent increases in loans and health expenditure of other national agencies, respectively. Declines were, however, noted in expenditure of DOH agencies and grants at 10.8 percent and 45.3 percent, respectively (Table-2). Though, it is believed that the financing sources allows prioritize the public health programmes to pursue long-term goals, it is vulnerable to the politics of the annual budget cycle, with political decisions leading to more pronounced bias for personal health care services.

Table-2 Details of National Government Health Expenditure 2004-2005

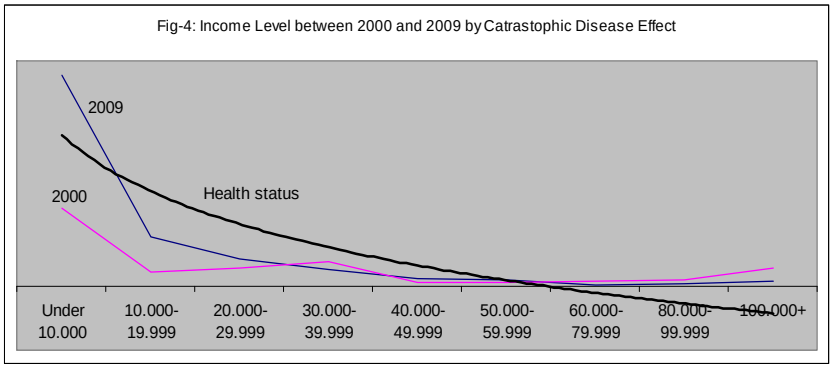
YEAR	AMOUNT (in million pesos)					PERCENT SHARE			
	DOH and its Attached Agencies	Other National Agencies	Loans	Grants	Total	DOH and its Attached Agencies	Other National Agencies	Loans	Grants
2004 1/	15,425.2	4,256.1	2,183.7	4,154.3	26,019.3	59.3	16.4	8.4	16.0
2005	13,764.5	6,086.4	6,529.8	2,270.8	28,651.4	48.0	21.2	22.8	7.9
2004-2005 Growth Rate	(10.8)	43.0	199.0	(45.3)	10.1				

Spending of DOH and its attached agencies decreased by 10.8 percent, from P15.4 billion in 2004 to P13.8 billion in 2005. Spending on public health care increased during 2003 by 16.7 percent while spending on personal health care and other services exhibited declines by 13.4 percent and 19.8 percent, respectively. Still the DOH spends about 64 per cent of its resources to support meager (72) national and regional hospitals. This is not an effective way of targeting subsidies to poor.

Local health expenditures have increased beyond what would have been required to support the cost of devolved health functions. Local government facilities, especially Rural Health Units (RHUs) run by municipalities, are the main channel for delivering public health programs and services. However, the impact of local health spending may have been weakened by administrative and technical fragmentation arising from the devolution. District hospitals designed to be the base for technical supervision are cut off from RHUs. Moreover, the concerns that district hospitals are unable to compete with provincial hospitals for funding from provincial governments. Perhaps, more people are falling into catastrophic diseases spectrum and there is a lack of prevention and early intervention services, resulting in high-tertiary care costs. Also, the range of funding reflected service availability or access rather than prevalence of the disease and related complications. As varying levels of rehabilitation services are provided in the studied provinces, expenditures for such services varies considerably. For example, there is no funding for renal dialysis services either by government, health insurance services or social health financing mechanisms. However, Table-2 illustrates that a disproportionate share of resources is going to care of persons with communicable diseases and its related complications. This also reveals that national health promotion was not involved in any key activities for diabetes prevention. However, the number of other programs promoting health life styles choices are limited to 5 per cent of activities.

Correlation between health and poverty

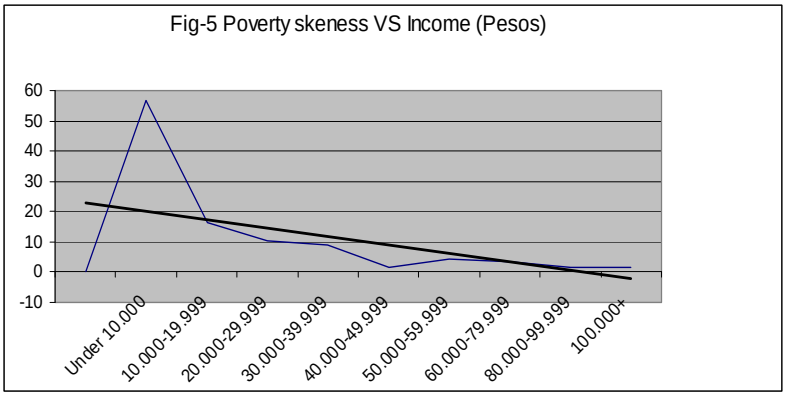
From a purely economic perspective, the nexus between health-poverty-income illustrates that per capita income and health status are strongly associated, while there appears to be an inverse relationship between poverty and health status, as shown in the Fig-4. Analysis shows that life expectancy is likely to rise by 1.3% with a thousand pesos increase in per capita health expenditure. In other words, increase in income positively related to high health expenditure among the population living below and above the poverty line.

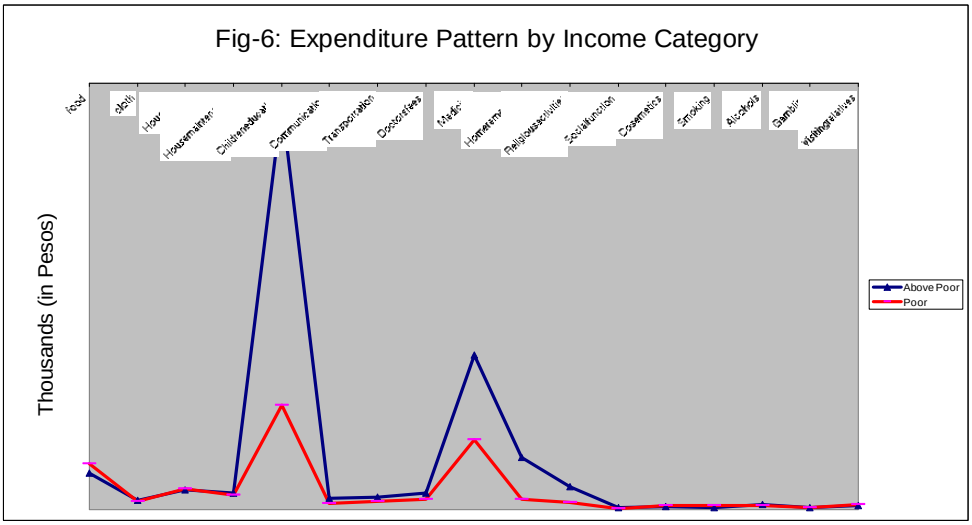


Nonetheless, the study noted that there is a sharp increase among the population above poverty line in falling to poverty-trap is noted, especially at the highest levels of income. Apart from the effects observed at the income level, there are adverse implications at the individual and household levels that can be ameliorated by investments in health. Catastrophic health effects can lead to lost earnings on account of days missed for work which together with substantial expenditures incurred on account of medical treatment, can impoverish families, particularly those living on the margins of survival. For a country with minimal resources for health care, the cost of treating these diseases would be enormous and could drain vital resources. The Fig-4 illustrates that income losses from severe illness amounted to nearly 23% of the total annual consumption expenditures per capita of the poorest of one-quarter of the population, compared to 11.8% richest one-fifth; and medical expenses for hospitalization typically ranged from 35% to 66% of annual per capita consumption expenditures. The financial impacts of ill-health are severe indeed – and can serve both to deepen poverty and increase the number of people living below the poverty line. In other words, increases in the average income are also associated with increased health expenditure which increases in the poverty ratio, especially when the overall distribution of income does not simultaneously improve too much. To the extent that commonly used measures of absolute poverty incorporate expenditure required to achieve minimal level of purchasing power, it is reasonable to argue that increases in the average income, taking account of disparities, would tend to be associated with improvements in the health of the poorest.

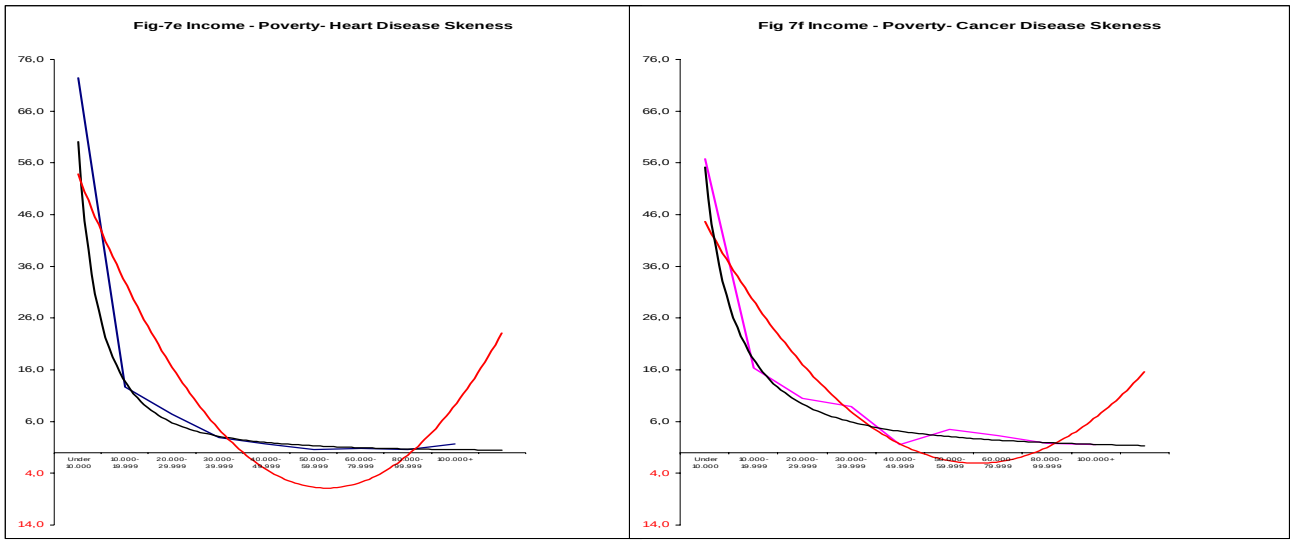
Since the 1990s, there has been a consistent decline in Philippines's poverty rate, together with a significant growth in the real income per capita. During 1990-2008, Philippines real per capita income has nearly doubled, having grown at an annual average rate of 3.5%. Philippines poverty ratio declined to 34.7% by the year 2008. This has been used to bolster the claim that Philippines's rapid economic growth can be effective in substantially reducing poverty. However, the above regression analysis and its projects implicates that this will not be so. The study estimates based on its household consumer expenditure survey that the financial burden imposed by health related spending could raise the proportion of people living below the poverty line in Philippines as much as 2.6 percentage points. That is, the people living at or around the poverty line have imperfect access to credit market or health financing mechanism; in the absence of strong social health insurance mechanism and in its absence health spending could result in increasing the severity of poverty among the already poor. In other words, households at levels of income at or around the poverty line cannot lend and borrow freely. Thus when they need to spend on health, all they have is their own resources. In the absence of health spending, poor would have consumed all they earned in any given year.

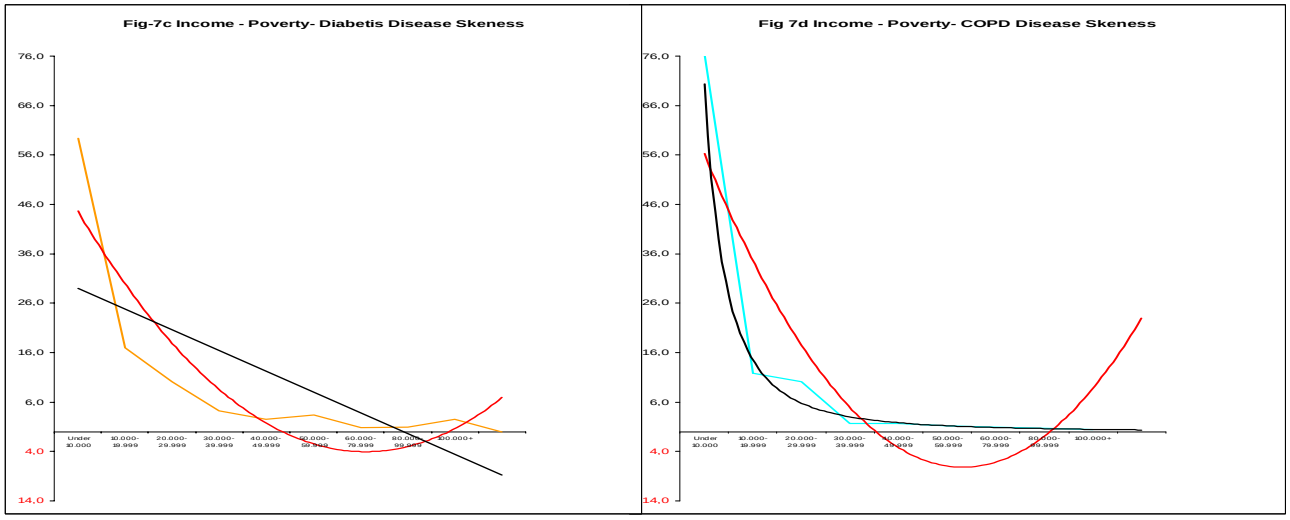
On the other hand, the enormity of household spending due to catastrophic illness is indeed grave among the people living above the poverty line. This depicts the gravity of how catastrophic ill-health affects the standard of living (Fig-5). The richest quintile (P 80000 and above) 6.6% of the population tend to disproportionately rely on sales of their assets while 12.5% above middle income category (P50000-79000), depends on borrowing to finance inpatient care, having little access to savings or social health insurance reimbursement. Moreover, the greater reliance by the middle income category (P 30000-50000) on the social health insurance which are likely to be among their minimal base of non-labor income, and on borrowing, suggests that not only is their purchasing power eroded in the short-term but also makes them vulnerable to slide into long-term poverty (Fig-5). This reflects the health systems continue to rely on the most inequitable method for financing health care services by the patients at the point of services. This deprives many families of needed care because they cannot afford it.

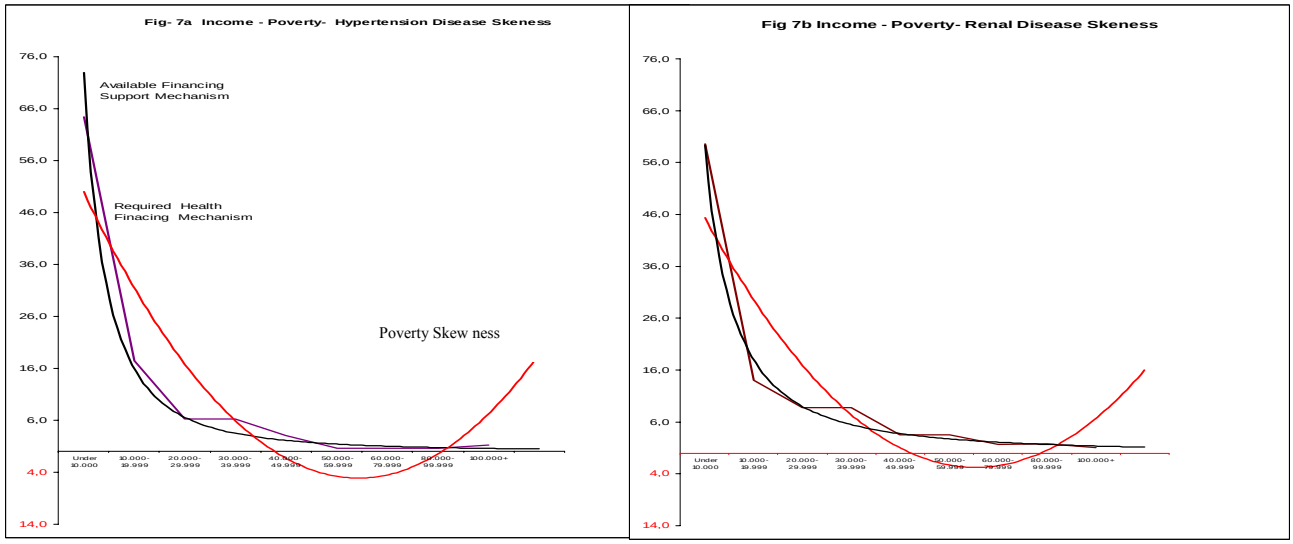




Expenditures are only a part of the overall picture. Given the financial consequences of catastrophic ill-health, the poor opt care only if absolutely necessary. Evidence (Fig-6) from the study data suggest that when sick, poorer groups are less likely to seek care than rich groups, and nearly one-quarter of the poorest in Philippines while one-eighth of poorest quintile forgo treatment when reporting long-term catastrophic ill-health effects and







when sick needing hospitalization go to the public hospitals. Perhaps the most important characteristics of catastrophic ill-health is that its impacts are likely to persist across generations. Not only is the next generation at risk from effects such as poor nutrition, inadequate housing, etc. Often children are pulled

out of school to take care of the sick person at home or often forced to give up their dream of achieving something in their life and take-up work to support the family income; thereby affecting their long-term economic prospectus which are permanent in nature.

There is a need for promoting sustainable financing schemes to allow people who are affected by catastrophic diseases to have access to health services and essential drugs, particularly for long-term care, should be put in place. This reflected in country's out-pocket expenditure statistics.

Causal analysis of catastrophic disease occurrence and progression can be avoided or significantly reduced / contained if access to right information and / or early treatment is assured. In countries such as Philippines where there are limited resources and competing demands, not all conditions can be treated and not every intervention provided at public expenses. At some point prioritization of interventions or population groups that need to be supported with public finding becomes inevitable. The issues then arise as to the criteria that ought to be used for identifying such publicly supported interventions.

Table-3 Treatment and Follow-up care cost of patient with Catastrophic Diseases per year – current level (in pesos)**

Year	Chronic / Follow-up	Hospitalization	Total cost	Disease
2003	8.092	13.757	21.849	CVD / Heart Diseases
2004	8.436	17.715	26.150	
2005	8.564	25.691	34.255	
2006	8.279	24.836	33.115	
2007	7.528	22.583	30.111	
2008	7.885	31.538	39.423	
2003	2,390	10,331	12,730	COPD
2004	4,167	18,436	22,603	
2005	6,144	26,473	32,617	
2006	8,018	32,884	40,902	
2007	9,864	42,780	52,644	
2008	11,774	51228	51.240	
2003	4.425	13.276	17.701	Renal/Kidney
2004	3.813	19.067	22.880	
2005	3.578	21.466	25.044	
2006	3.482	24.374	27.857	
2007	3.327	23.289	26.616	
2008	3.637	25.457	29.094	
2003	4.699	5.639	10.338	Cancer
2004	3.078	5.848	8.925	
2005	3.101	5.891	8.992	
2006	4.425	29.207	33.632	
2007	7.894	23.683	31.577	
2008	8.436	25.307	33.742	
2003	2.631	7.894	10.526	Diabetes
2004	2.593	7.780	10.373	
2005	2.486	9.942	12.428	
2006	2.337	9.350	11.687	
2007	2.271	9.083	11.354	
2008	2.441	12.206	14.647	
2003	850	2.550	3.400	Hypertension
2004	3.650	7.300	10.950	
2005	4.500	4.500	9.000	
2006	3.650	7.300	10.950	
2007	2.739	10.958	13.697	
2008	2.733	13.665	16.398	

Source: Phil-Health Insurance Corporation, Philippines ** (EXCLUDING SURGERICAL COST)

A significant proportion, (46.4%) of the cases were found to suffer from a mild form and only 23.2% had severe catastrophic diseases. The remaining 39.4% formed the moderate category. In fact 28.5 of the total number of cases were not aware that they had the disease and hence did not seek any medical advice. The remaining 17.9% of these mild cases sought treatment as outpatients. Medical and nursing staff interviewed during the review indicated that there appeared to be an increasing number of persons presenting with uncontrolled catastrophic disease and advanced stage complications. For example, the study found, in the case of cardiovascular disease, the out-of-pocket expenditure on treatment and services was reportedly P 8860 per person over a six-month reference period, while for respondents on hospitalized treatment, the expenditures were markedly higher, nearly P 39423 per person over a year period. Roughly 50-75% of these expenditure are financed by family assets, support of other family members, borrowing. The devastating impact of COPD, heart diseases, cancer, renal diseases etc on individual household is similar, with children having to discontinue schooling and/or take up employment to provide additional source of income.

Analysis of the study data suggest that the out-of-pocket expenditure by individuals hospitalized on account of renal diseases was roughly P29094 per person, i.e., 124% of the average annual per capita expenditure of the households they belonged to. Likewise, roughly P 51240 is the annual cost of treatment for acute cases of COPD that involve hospitalization. It is also noted that, on an

average, a person with CVD spent P 21,849 per year in 2003 and the same treatment cost P 39,423; P12,730 in 2003 to 51,240 in 2008 for COPD; P 17,701 in 2003 to 29,094 in 2008 for renal/kidney diseases; P10338 in 2003 to P33772 in 2008 for cancer; P10526 in 2003 to P 14697 in 2008 for diabetes and P3400 in 2003 to P16398 in 2008 for hypertension (Table-3). This increment in the cost of treatment varies from 4.83 times for hypertension to 4.03 times for COPD; while 3.3 times increase in cancer treatment followed by CVD recorded nearly 2 times, 1,6 for cancer and 1,4 times for diabetes patient per year treatment cost. The study considered the average cost of the medicines (guidelines) that are mostly prescribed. Only a common pro rata change was applied to all costs in the present study. However, the cost of treatment would increase as age increases as these catastrophic diseases are degenerating in nature. For example, a change in the life style has strong association between cigarette smoking and pulmonary diseases point out that the need to bring drastic changes in the habits of the population through legislation and increase in the cost of cigarettes. However, the prevalence of pulmonary diseases was found to be 21.3% in heavy smokers, 19.4% in light smokers and 8.6% among ex-smokers. The effect of cigarette smoking may begin at an early age, as indicated by increased illness and diminished pulmonary function in children passively exposed to cigarette smoke at home. After adjusting for age and frequency of smoking, it was found that women who smoke heavily were more susceptible than men to acquire COPD (odds ratio is .47).

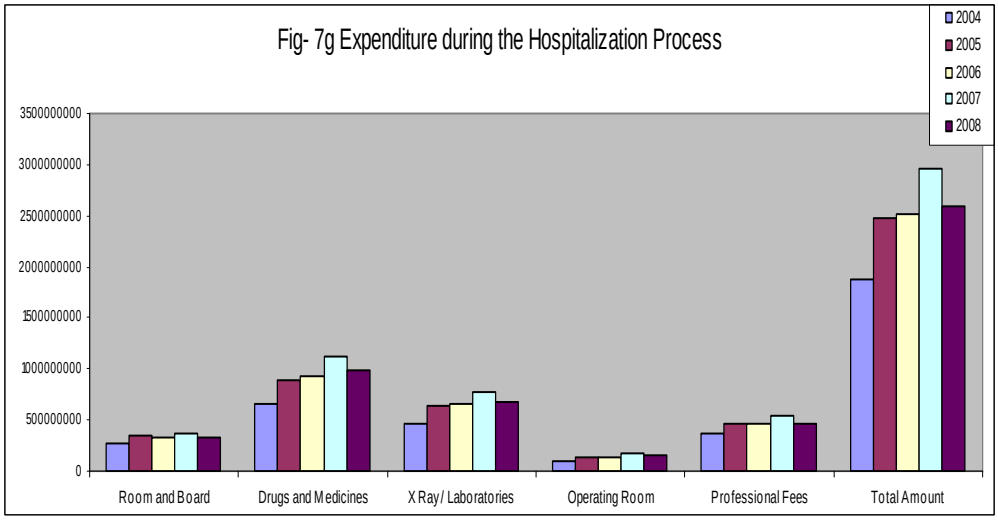


Fig-7g illustrates of the total health care expenditures, drugs and medicines accounted for 46.4 per cent, hospital room charges at 14.1 per cent, professional fees at 17.3 per cent, other services such as X-ray Labservices at 12.4 per cent and the combined expenditures on room and board and operating rooms 9.8 per cent. On the other hand, care for cancer patients typically starts with recognition or suspicion of the disease by the patient and primary health care worker. Specialized services for diagnosis and treatment, and referral, if appropriate to a centre for cancer treatment comprise the next element of the system, however favors an expensive and narrow approach to the problem. For example, high technology for cancer treatment imposes a heavy financial investment, tends to select patients inequitably, and detracts from appropriate emphasis on prevention.

Fig-7g further explains that out-of-pocket payments for catastrophic health care are but one of the sources of health inequity. Deeply unequal opportunities for health combined with endemic inequalities in health care provision lead to pervasive inequities in health outcomes. Growing burden of disease of these regressive patterns of health expenditure is causing increasing intolerance of the whole spectrum of unnecessary, avoidable and unfair differences in health.
Therefore, it is clear that the onset of disease needs to be averted and when it occurs it should be treated quickly. For health policies to ensure this, it is necessary that we have an evidence-based understanding of the extent of diseases burden, the population groups that are the most vulnerable, and what interventions

are needed to avert premature death of needless suffering. However, the rates of health care and follow-up care expenditure in sustaining the healthy life (after hospitalization) showed an age differential across the catastrophic diseases.

The cost of treatment of a patient with acute catastrophic disease per year has two components – cost of regular medication and cost of hospitalization (excluding surgical costs). The cost of regular medication was taken as that for a mild case and was applied to all acute cases, while the cost of hospitalization (excluding surgical cost) was the same as that of the current levels (Table-3). However, the total amount spend by the patient can be drastically reduced by adopting number of strategies such as controlling various contributory factors, e.g. room and board, drugs and medicines, lab costs, professional fees and operating room at lower costs. These strategies are considered to be difficult to implement. Nonetheless, if the patient was treated according to the suggested guidelines, the estimated cost of treating can be reduced considerably.

In addition, there is a dearth of data on frequency of medical consultation, travel costs, hospitalization, direct and indirect cost to the attendant, and opportunity loses to the patient and attendant. The costs (difference) between these to estimates provide on the notional savings that accrue to patients and their families; a large number of them come from distance province.

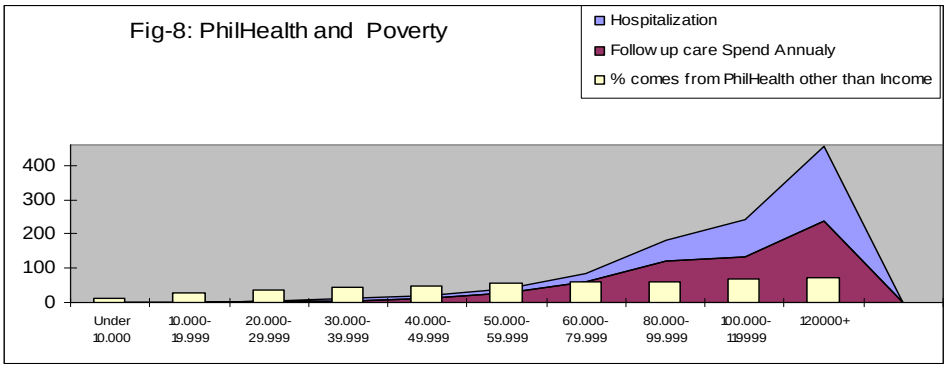
Equity and poverty in health financing

The role of health in influencing economic outcomes has been well understood at the micro level. Healthier workers are likely to be able to work longer, be generally more productive than their relatively less healthy counterparts, and consequently able to secure higher earnings than the latter, all else being the same; illness and disease shorten the working lives of people, thereby reducing their lifetime earnings. This has negative effect on work performance and reduces the efficiency of human capital formation by individuals and households. The causal relationship does not run in only one direction- from health to aggregate economic performance- and there is strong case for considering a reverse link, running from wealth to health. Higher incomes potentially permit individuals and the families to afford better nutrition, better health care and presumably achieve better health. The present study establishes the evidences that such a relationship holds at the national level. The role of health financing influences key policy objective – poverty reduction. The evidences of Philippines health financing mechanism suggest that improvement in health result in improvements in national income, poverty could decline on account of both the standard trickle down effects and an increased financial capacity of nations to set up safety nets. For instance, infant mortality rate[2] declined from 57 per 1,000 live births in 1990 to 50 by 1998[3], and is comparable with that of other countries in East and Southeast Asia. Maternal mortality ratio was 180 deaths per 100,000 live births in 1998, down from 209 in 1990, but still much above the regional average[4]. This resulted in increased GDP from 3.5% in 1997[5], to 5.1% in 2005. Moreover, the health financing mechanisms when directed at the poor could contribute more directly to poverty reduction and serve as an element of a pro-poor growth strategy. A decline in the incidence of poverty in Philippines during 1990s from a half to more-than one-third of its population which still remains below the poverty line.[6]

[2] Intra-country variations are evident: IMR is higher in Eastern Visayas (60), and IMR in rural areas is at least one third higher than in urban areas.
[3] National Statistics Office. 1998. *National Demographic Health Survey*. Manila.
[4] ADB. 2004. The Philippines: Country Strategy Program Update. Manila.
[5] The Health Sector Reform Agenda (HSRA) does not include two priority areas of human resource development, or improving the health information systems. HSRA-plus will include these two cross-cutting areas.
[6] UNESCO Institute for Statistics website.

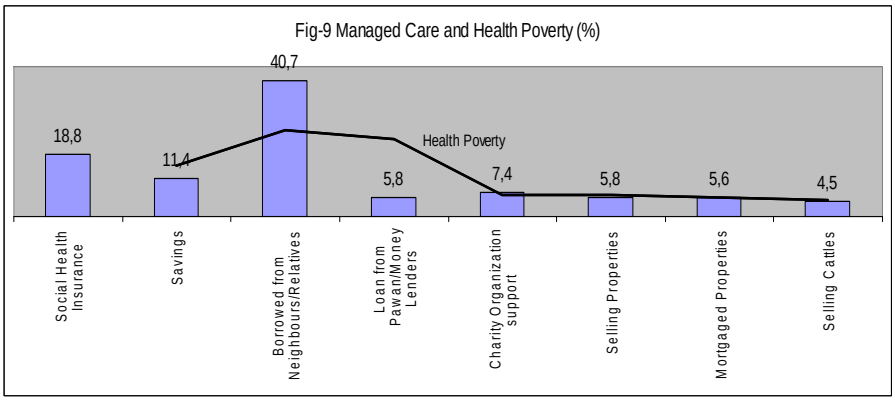
The Figure 7a-7f reveal that the poor bear a disproportionately higher burden of illness and disease which reduces the ability to work and weakens their resistance to diseases. With their body often being their main income earning asset, sickness and disease have significant adverse implication in terms of loss of income, compounded by their inability to obtain adequate health care. Frequently, treatment expenditure and loss of earnings force middle and above income category families (particularly P 40000- 80000 groups) to exhaust their savings and assets, and resort to borrowing, leading to poverty and poor health status. When health improvements are concentrated among people living close to, or below the poverty line, both a trickle-down mechanism and redistributive method to reduce poverty work temporarily. The study data suggest that ill-health and associated economic losses cause as much as 2 million Filipinos, most living marginally above poverty line each year, owing to a combination of income losses on account of being unable to work and declines in non-medical care consumption (Fig-7a-7f).

Poverty is a measure of income that indicates inadequate command over material resources. The level of poverty in a household as well as country depends upon the level of income as well as its distribution.



The catastrophic disease which alters household income would affect poverty (Fig-8). In a household or country with a large income inequality there would be a relatively large number of poor people with a low income. Philippines is the country that pursues a growth-oriented strategy firmly believes that growth will have its trickle-down effects that will help reduce the poverty.

Contrarily, Philippines's poverty reduction depends on health financing mechanism which is determined by the rate of growth of mean income and changes in income distribution in the population. Much of the disease burden in the country is due to hospitalization and follow-up care. This adds to the existing poverty factors which can have an adverse impact on health because of cost of treatment and medicine. Since expenditure on care giving and care giver's opportunity loss and other expenditure on care giver such as income loss, travel cost, food items, etc form a major portion of the budget of the household, eradicating poverty through existing health equity mechanism could be remain a dream. These points to the 'health poverty' reduction nexus and therefore better health can be seen as a factor that contributes to poverty reduction via health financing mechanism. Fig-9 linear regression analysis depicts that when the poor fall sick, they are often unable to afford treatment, and even when they do decide to get treated, tend to sell off productive assets and rely on borrowing, all of which have the potential of decreasing their long run earning capacity- and

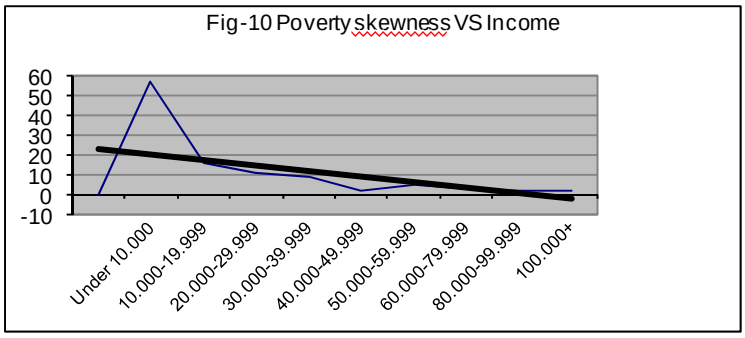


the capacity to take advantage of any trickle down financing mechanism offered by a growing economy. As one may expect, increase in health expenditure and the percentage of population living below the poverty line are positively related and the increase in poverty is sharp, especially at next to poverty line. Possibly the growth in income in this decade has not had any desirable trickle-down effect. The percentage of population living below the poverty line has considerably increased over period and there is a positive relationship between health and poverty, which shows a marginal increase during the last five years (Fig-9).

While social health financing scheme share has significantly increased (Fig-4a), it is still insufficient in terms of providing adequate cover for the health conditions that the population is constantly exposed like catastrophic diseases. That is, burden of paying for health care services is dominated by out-pocket expenditures. This means that household rely mainly on their own resources to finance health services (Fig-9). As we have seen above, the hospitalization costs comprise the largest health expenditures. Nonetheless, there is no denying the policy significance of understanding the determinants of economic growth and its relationship with poverty and improvements in health. If health turns out to have significantly influenced Philippines economic performance, this may call for investing more public funds in health, given that health budgets have been severely resource – constrained in recent years.

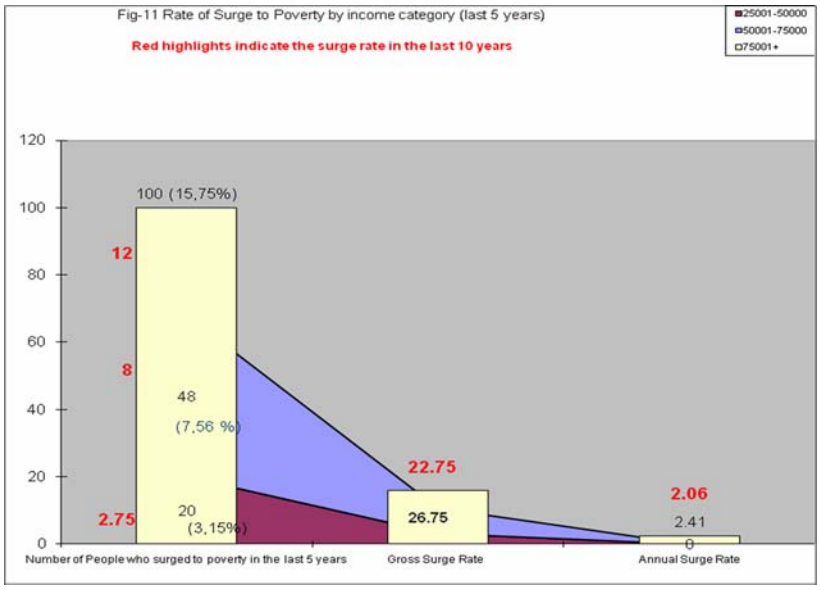
Health Poverty and Health Care

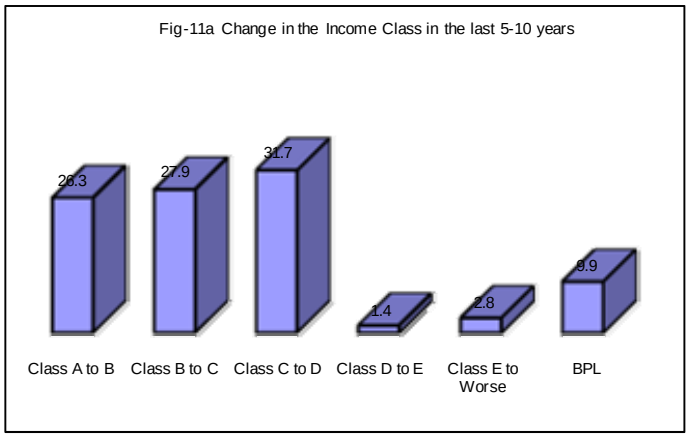
Health poverty is defined in the study as the lack of minimum amount of expenditure to get a certain minimum level of health care services. That is, an absolute minimum level of care and treatment that is necessary for health and acceptable to a society. This approach allows for variation in the proportion of health care services received and the level of service combination chosen is the one that minimizes the cost of reducing the health care expenditure. In other words, the expenditures used to receive needed care level requires predetermining the combination of care, treatment, medicines, food, travel, family care-giver costs, opportunity costs of both patient and the family care giver to access the requisite health services.



The association between long-run per capita income and level of poverty is shown in Fig-10. Increase in income and the percentage of people with catastrophic diseases are positively related and the increase in poverty is sharp, especially middle levels of per capita income. Possibly, the growth in income in the past decade has not had the desirable trickle-down effect. The health-poverty link seems to suggest that rapid growth of per capita income required for accessing and availing health services. Such growth would be able to promote health financing mechanism and thus improve health status.

As illustrated in the Fig-11, population living below poverty line has considerably increased over the period and there is a positive relationship between health-poverty and associated health care, which shows a significant increase during the last decade. The association between health-poverty and per capita income, and catastrophic diseases during the last ten years have been explored using the two stage least squares econometric framework analysis for the two periods, 1999-2008 and 2004-2008. The procedure adopted in the framework is to predict the health poverty using lagged values and the expenditure are used to compute the surge rate as well as for the initial rate. The computed health-poverty surge rate is the decadal rate for the periods and the initial income corresponds to the beginning year of the respective decade. Fig-11 is amply evident that there is a positive association between health, poverty and income. At first glance, this variance with income category results reported high among the richest income level (P 75000 and above) is 15.75 per cent followed by middle income category (P 50001-75000) is 7.56 per cent and the lower income (P 25001-50000), 3.15 per cent. However, gross surge rate stands out with 22.75 for the decade compared to 26.75 in five year period. Interestingly, the middle income category surges faster (8%), nearly three times higher than the lower income category. While richest income group surges to 12 per cent, nearly 1.5 and 4 times higher than the middle and income category respectively. This clearly shows that even with better / higher income category have a fall below poverty line due to catastrophic health effects (Fig-11a). The surge in health-poverty is not uniform across all income levels. The decline is higher at the middle income levels and richer income levels. That is, increased income leads to more investment in health care and thus there is strong case for reverse causality due to catastrophic diseases.





The current level of health status depends upon the continuum care. The determinants of health functions can be specified as

$$\ln H = B_{it} + B_2 \ln Y_{it} + B_3 \ln H \, Exp_{it} + B_4 S_{it} + B_5 P_{it} + e_{it}$$

i = 1, 2, ..N Services; t = 1,2, ..T periods where H Exp is the per capita PhilHealth Expenditure on health P is a measure of political power; B are the parameters to be estimated and is the random error term assumed to be distributed with zero mean and constant variance. S is the dimension of human capital, InY is the natural logarithm of initial real per capita income, InH is the logarithm of health financing sources. Increases in per capita income of the people and public health financing mechanisms are expected to improve the health status of population with catastrophic diseases. In addition, the political powers are expected to exert a positive effect on health status. The effect of catastrophic diseases is positive and the coefficient is significant at the 99 per cent level (Table-4). The estimates show that both log per capita income and per capita health expenditure by individuals have a positive, as expected. A 1.75 per cent increase in per capita income would increase health care expenditure by 1.3 per cent while a 500 pesos increase in per capita health expenditure would lead to 2 per cent increase in life expectancy. That is, increase in the shifting cost would reduce the health-poverty (Fig-12). Contrarily, the effect of political factor is positive but not significant. However, the existing health financing mechanism is positive and significant only at the initial expenditure level. The effects of shifting cost towards health expenditure before and after are positive and statistically significant at the 99 per cent level (Table-4).

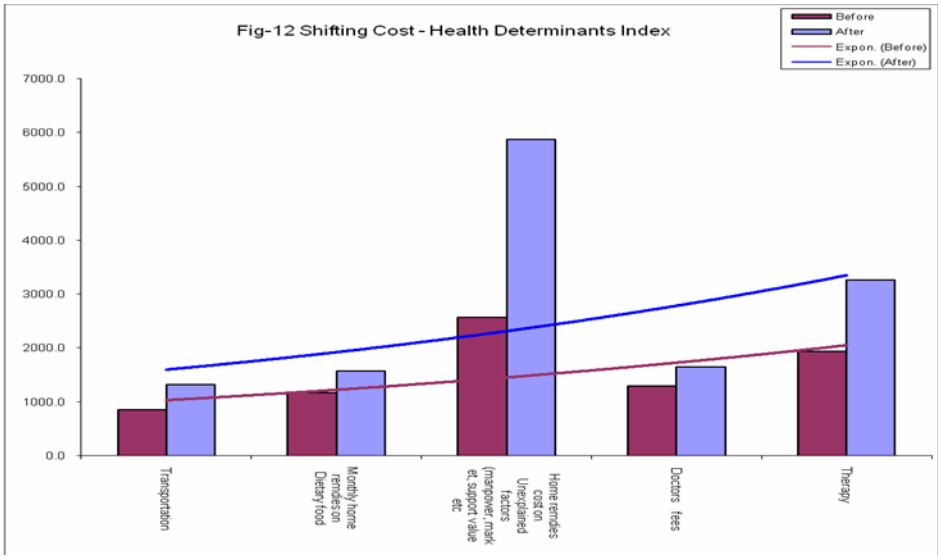


Table-4 Estimates of the effect of health expenditure and income on health-poverty			
Explanatory variables	OLS-1	2SLS-2	2SLS-3
Health care	0.178**	0.078**	0.820**
Health expenditure	0.329*	0.202*	0.405*
Shifting cost	0.056~	0.013~	0.086~
Family Care giver cost	0.910#	0.787#	0.863#
Political power	0.008	0.069	0.005
Health financing mechanism	1.534	1.029	0.710
Constant	-7.639	-3.905	-9.237
R^2	0.883	0.775	0.770

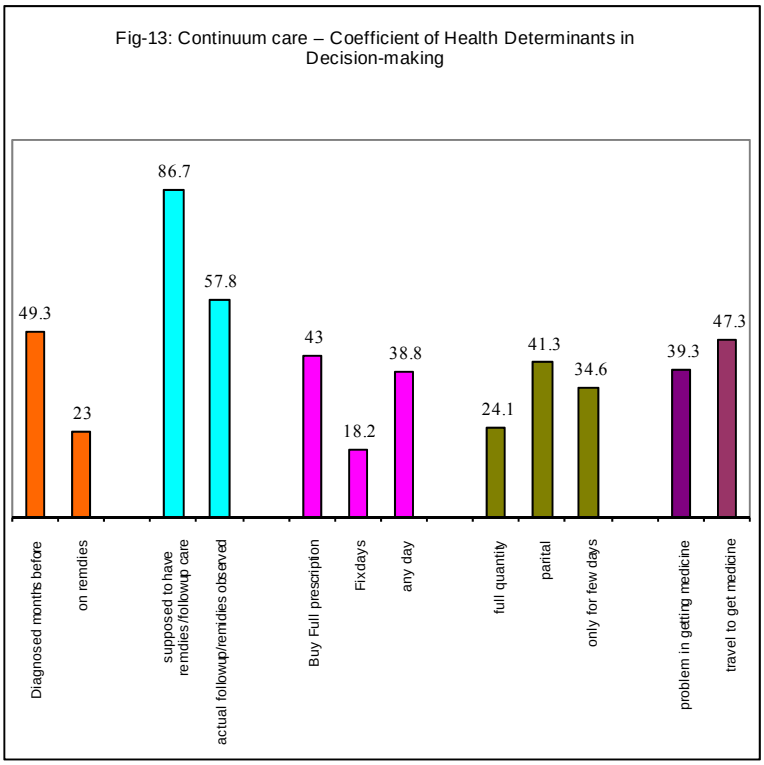
** Significant at 80% level ~ Significant at 90% level * Significant at 99% level # Significant at 95% level OLS: Ordinary least square 2SLS: two-stage least squares

However, the effect of care-giver on expenditure and their contribution towards surging poverty is highly significant, which is due to the high correlation between health of a family member and expenditure. There is a two-way causation between health care and health expenditure. Thus, increasing investment in health is a required policy intervention for accelerating the economy's growth rate. Therefore, growth oriented health financing policies would result in bringing about improvements in the catastrophic health status of the population. Health policies promoting non-health care expenditure such as shifting cost, family caregiver cost and social costs, would have the desirable effect of reducing poverty.

Health Determinants

Continuum Care

Every individual is bound to experience any of catastrophic diseases to a certain degree after reaching a certain age. The age of onset and rate of progression of these catastrophic diseases depend on factors that can be influenced by the socio-economic and physical environment, by the health care system and by the person's behaviors and practices. As it is difficult reverse the state of health of an individual diagnosed with any of these diseases. Unlike communicable disease, which has specific causative biologic agents and which are mitigated or cured through the application of a specific or a combination of treatment regime like vaccines and antibiotics, catastrophic diseases are usually caused by a combination of factors that has yet rendered cure impossible. Once acquired, these become lifetime chronic diseases that can be stabilized only through a combination of behavioral, medical or surgical interventions which would cost very high level at economically, socially, psychologically etc. In addition, there is a compelling reason for stepping up both public and private investment in health which would pay off in the long run.

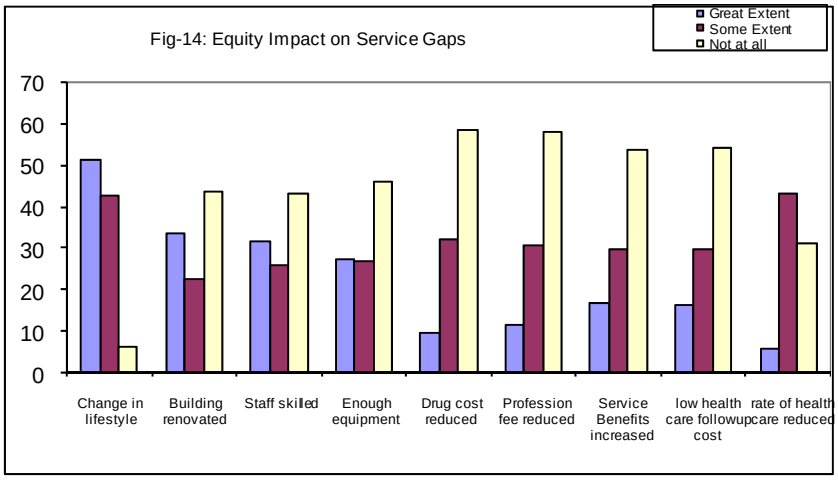


The review of health financing situation is not lack of knowledge as to what to do to turn the rising tide of catastrophic diseases and related complications – they all have a good idea of that. It is having the capacity to respond in terms of physical and human resources. As noted from the study data, there are many conflicts often impedes decision-making and, even when decision are made, often makes it difficult to implement them. Decision-makers are all accountable to the community in general for providing effective health care. If decision-makers fail to act to make the decisions and implement the changes required, it is the population that suffers. When it comes to life threatening and debilitating diseases such as catastrophic disease, there is a high cost for the society to pay. Fig-13 illustrates the continuum care level of health determinants on decision making. The study population data reveal that they often present with catastrophic diseases and related complication and also delay the treatment once they have been diagnosed with catastrophic diseases. Out of 50 per cent study population who are affected with catastrophic diseases, only 23 per cent started the treatment. That is people are presenting with more advanced stage complication than previously. It has been reported that limited access to relevant services is an issue. For many in outlying areas, the cost of travel prohibits their attending clinics (47.3%) and hospitals for assessment (39.3%) and to obtain medication (Fig-13). This reflects the lack of understanding by patients and the community in general of the risks associated with catastrophic disease and they do not view it as serious.

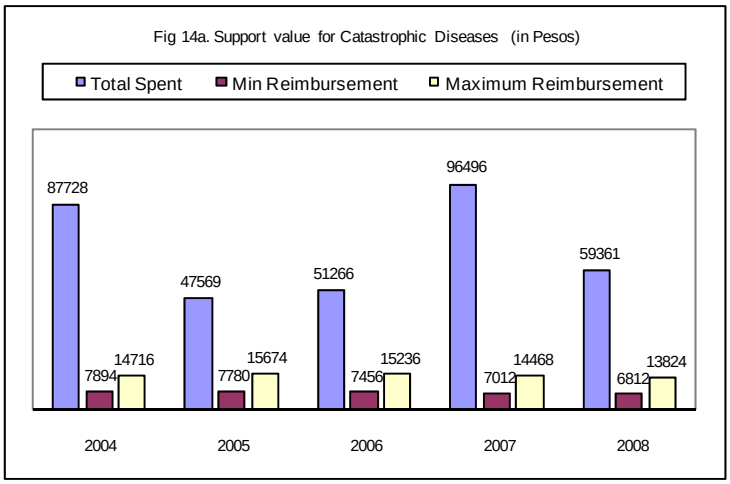
In addition to this, persons with catastrophic diseases do not readily comply with recommended drugs (43%), quantity (24.1%) and exercise regimes (57.8%), and many (86.7%). do not attend clinics on a regular basis for monitoring and general follow-up care. Due to costs of treatment and cost of travel, their poor compliance resulting in increased severity of complications and thus increased treatment costs. Moreover, for traditional and cost reasons many use herbal treatments. From the study data, there is no evidence to suggest such treatments help. Indeed most health care professionals believe that the herbal medicines used may aggravate the disease and related complications. It was also voiced by medical fraternity on herbal medicines is that their use may prolong the time before individuals present for treatment.

Equity Impact on Services

The study identified the equity impact on services involved in catastrophic diseases and its management. Prevention is better than cure. However, it is curative services in Philippines that consume by far the large portion of health care resources. The increased relationship between life style choices and catastrophic diseases is well understood. Over the last few years, the Philippines has attempted to bring about change. With the financial safety net provided to the poor by the expansion of social health insurance coverage, public hospitals at the national, provincial and local levels are eventually restructured into fiscally and managerially autonomous government facilities. As illustrated in Fig-14, the increased social health insurance coverage and its capitation fees reduced the dependence on direct public subsidies to the public hospitals. This eventually freed-up government resources for the delivery of most effective services. There have been a little concerted efforts on: community education programmes, advertisements for diet counseling services and attempts to limit the importation of high fat foods, daily activities focusing on physical exercise and healthy eating etc. This approach is limited in scale and reflects among only few community members (6.25%). However, health officials expressed concern that these education campaigns have not had enough impact and the question of how to influence people to change the way they live still remains. Of more concern was the lack of resources allocated to focused prevention programmes for targeted at risk groups. In previous years such programmes were in place and it was suggested that the recent lack of programmes was a result of the political instability in the country, which has led to fewer resources, in terms of staff expertise, to address key issues. That is, the hospital- and community based staff role in education their patients on how to prevent and care for related complications developing is yet to be seen. However, differing approaches to services provision are noticed among the study provinces. Very few people receive services to catastrophic disease reflect poor health financing mechanisms. This shows that the existing health financing mechanisms do not support the long term care or no treatment is provided unless they pay for their own treatment. Consequently there are increasing demands for treatment to be made available. It is likely that this will put further pressure on household's limited resources for high cost tertiary care at the expense of lower cost-prevention and early intervention services. Fig-14a shows the trends and levels of existing health financing mechanisms reimbursement. The reimbursement value from the existing health financing mechanisms had reduced its maximum value from P 14716 in 2004 to



P 13824 in 2008 and minimum reimbursement was P 7894 in 2004 to P 6812 in 2008. That is reduction at maximum reimbursement level is 6% from the current prices while minimum reimbursement level is 13% from the current prices (Fig-14a). In addition, a review of pharmaceutical expenditures in the Philippines showed that 20% of the total medication budget was spent on anti-hypertensive medication. The first response is to suggest that there is a higher than average prevalence of hypertension in the Islands Country. However, it may be that people with hypertension are diagnosed early and hypertension treated aggressively the high-cost complications arising from it could be averted. Otherwise, in other words, if the individuals concerned are to maintain a reasonable quality of life after diagnosing with catastrophic diseases, they would require both physical and financial supports.

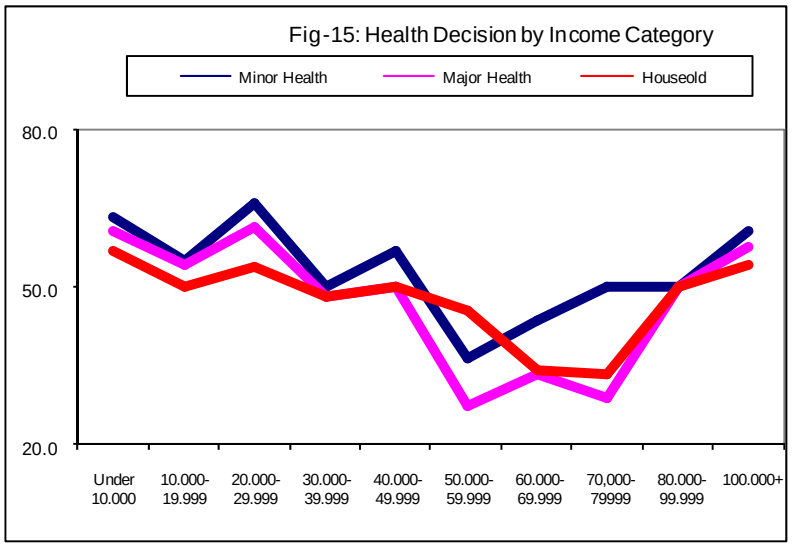


It is not possible or desirable for the counrty's PhilHealth social health insurance system to provide a full range of clinical and follow-up care services to those who are affected with catastrophic diseases, given its limited resources and competing demands. Resource constraints limit the number and type of services that can be provided. The high cost of offshore drugs, referrals for medical treatment and follow-up care (Fig-14) results in the ethical dilemma of just how to determine who will and who will not be provided with services or referred. At the same time, the total cost of treatment at the hospital services is increased at an unsustainable rate by 196 per cent from 2004 to 2008. The total reimbursement costs for catastrophic diseases by social health insurance mechanism was estimated to be 11.3% in 2004 to 16.9% in 2008 while no resources or reimbursement made for non-treatment costs such as travel and accommodation, wage and opportunity loss, family care giver's travel, accommodation and his/her wage and opportunity loss, etc. In other words, the people who are affected with catastrophic diseases need to spend 83.3 to 76.9 per cent of their resources during hospitalization to get about 16.7 to 23.1 per cent, from 2004 to 2008 respectively. These questions the equity mechanism which exists in the Philippines, as does whether resources are targeted at a disadvantage. Technical efficiency is just as important as achieving an allocative effieicincy. Health financing mechanisms need to ensure they are providing least and cost- alternative support value for those affected with catastrophic diseases which drive them in to below or absolute poverty line.

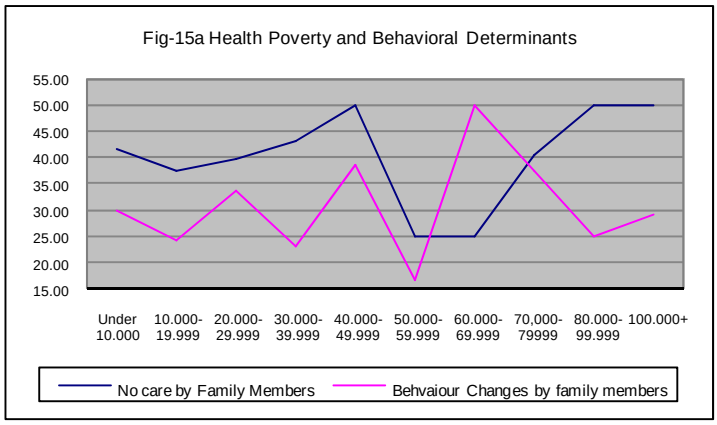
Health Care Decision Making

Health care is the provision of services that promote good health, prevent ill health and provide treatment and follow-up care. Health care needs, therefore, are those needs that can benefit from health care. This involves how to allocate household's resources to provide services across the care continuum (to the members of the family) that maintain or improve health status. The health care sector is a system of interrelated parts. It comprises institutions like family, household and various organizational and funding arrangements to provide a wide range of health care services. Candidly, often the component parts work as separate entities with little interaction. To further complicate this, health care sector in the Philippines is currently undergoing some degree of reform or reorganization. Thus, the multiple determinants of health often make it difficult for the family and households particularly to know just where and how to use the available resources and to get the services of need to their family member with a catastrophic

disease(s). Consequently, the decision making power to understand the current and potential future demands, in terms of health care needs and the rest of the family expectations, and the study evidence suggest that catastrophic diseases reduces the power of provision of decision making (Fig-15). As we live in a world of limited resources and competing demands, there is obviously prioritization of resources addressed. This is very obvious with middle income quintile population compared to rich quintile (P 80000 and above) slightly recovered whereas lowest and lower income quintile seems to enjoy the power of decision making when it comes to major health issues as well minor health issues. This further fueled the burden of the diseases. In other words, any individual faced with a major health problem, the complexity of multiple options, the uncertainty about likely outcomes and the need to weigh all conflicting scenarios, may find the process difficult and stressful to take the course of action in their way. Such decision-making impacts on many family members, such as those in need of care, their families, and range of other issues. In addition, the higher the number of decision-makers involved (at the family level) and the more uncertain the impact, the higher the level of conflict and stress.



Not only is the decision-making process for care and treatment complex, but there is also behavioral factors involved. Often, through no fault of the person who is affected with catastrophic disease, major decisions and behavior changes noted among the family members due to conflict with resources. In this complex environment, the process of decision making ranges from 'no support or no care' to the members affected with catastrophic disease to behavior changes by family members ranges from abuse (11.1%), physical abuse (1.1%), no money provided (10%), no care (4%), no medicines (3.1%) to no sharing with members (14.2%), depending on the situation. The more complex situation is noted with lower, lowest quintile and richest quintile compared to middle income quintile (Fig-15a). Complex health care systems are intrinsically difficult to understand and manage, which makes further decision-making difficult. Health care system covers a very broad range of conditions, which may be life-threatening at one end of spectrum, to minor and self-limiting at the other. The more complex the decision-making problem, the less rational and transparent the decision-making process is likely to be, given information and time constraints. Health financing mechanism or resource providers balance conflicting priorities and objectives, including the needs of individuals, the needs of the society as a whole as well funding demands.



Discussion

Unequal growth, unequal outcomes

In the Philippines, the increase in life expectancy, rapid urbanization and life style trends have resulted in a considerable change in the health profile. Despite improvement in the vital indicators of health, the health system and services are plagued by crucial problems related to equity and efficiency. The life expectancy of Filipinos in 2005 has gone up to 70.5 years. These results were associated with improved access to expanded health care networks, made possible by sustained political commitment and by economic growth that allowed them to backup their commitment by maintaining investment in the health sector. Contrarily, the process of increased life expectancy at birth brings out myriad of degenerative catastrophic diseases. As the country's per capita income increases, the social and economic challenges similarly increase and so do the health hazards and risk behavior of a big segment of the population. These catastrophic diseases are linked by common preventable risk factors related to life style. The risk factors involved are tobacco use, unhealthy diet and physical inactivity among others. Ninety per cent of Filipinos are more exposed and more vulnerable to environmental and health threats that include life style threats, such as smoking, obesity, hypertension, high blood sugar and abnormal blood cholesterol levels – increasingly important causes of morbidity and mortality.

As noted in the study, there is a striking shift in distribution of death and diseases from older to younger ages due to change in the life styles and related causes. This is worrying because the rate of change is accelerating. Unhealthy life-styles, combined with the disintegration of public health programmes, and the unregulated commercialization of clinical services combined with the elimination of safety nets has offset any gains from the increase in average GDP. Poor governance fractured societal relations, increase corruption, and lack of mechanisms in generating legitimate power and authority create backlog of investment needs and limit government resources to meet them. Moreover, more than a half of the rise in catastrophic diseases among females can be ascribed to demographic changes but the contribution of increased prevalence of risk factors is also substantial. In essence, regarding age-sex distribution, it could be persuasively said that females are more at risk for catastrophic diseases. This reflects in widening income inequality and gender bias. Public expenditure on health declined while access to care and social protection deteriorated, particularly for vulnerable population – women. Any strategy to close the health gaps and risks and to correct inequalities within the region has to give consideration to the creation of an environment and commitment to public investment in the health sector. This is not possible without much attention being paid to establishing continuum of comprehensive care than is the case today. It is equally impossible without attention being paid to addressing the pervasive health inequalities within the country.

Trends that undermining the health Systems' Response

Against the background, relying entirely on treatment as a means to conquer catastrophic disease is expensive and ineffective. Unfortunately, there is evidence that current public health system and services are not able to cope with these catastrophic diseases' new challenges. Public health interventions to remove the major risk factors of catastrophic diseases are often neglected, even when they are particularly cost-effective: they have the potential to reduce premature deaths by 47 per cent and increase healthy life expectancy by 9.3 years, as evidences shown globally. This shows the Philippines health sector has been slow in dealing with these catastrophic diseases and/or underestimated health challenges. ASIA Fellow's interaction with policy makers and members of Department of Health revealed that authorities and researchers in the country have also failed to assess, in a timely way, the significance of changes in the health scenario as well as failed to advocate for required changes in their political environment that affect the response capacity. In other words, health authorities and researchers have a poor track record in

influencing such policy changes and developments, and have been ineffective in leveraging the economic weight of health and health care. Many of the critical systemic issues affecting health require skills and competencies that are not found within the public health department. There is a failure to recognize the need for health financing mechanism and an attitude that prevails is one of condemning the strengthening of the comprehensive care due to high public expenditure on health as 'health' is conceived to be individual needs and non-gain able /returnable investment.

The hospital system, as an integral part of health delivery is composed of the public and private sectors, classified into primary, secondary and tertiary levels according to their service capabilities. Regrettably, the health sector reforms are directed towards the public hospitals. The study respondents ranked private facilities as superior on quality aspects, at par with government facilities on convenience of location, and not as good on cost aspects like cost of medicines and supplies, cost of treatment and flexibility of payment. In addition, the private sector has minimal involvement in the delivery of public health program. The role of and contribution of the private sector in the health promotion and diseases prevention is not yet fully harnessed. Candidly, this implies the cost is the only categorical advantage of government facilities over private facilities. Lack of interface between public and private hospital system, including social health insurance mechanism made people who are affected with catastrophic diseases, particularly poor and near poor population, to travel a long distance to access services or ignore the services due to distance and cost on travel. This escalated further the costs on treatment and follow-up. Poorly equipped and poorly staffed local government hospitals (provincial and district hospitals), congested regional and national hospitals; in adequate hospital networking and patient referral system; heavy reliance on direct subsidies from national and local governments; and uncoordinated implementation of public health programs in hospitals. There is a *need for inducing reform on addressing the disparity between public and private health facility performance and enhancing the expansion of public and private networking as well as making them to accountable* is the need of the hour. Moreover, *upgrading the capability of health facilities at all levels for early detection, diagnosis and management* of these diseases is imperative. Depletion of government expenditure on health left Department of Health not to address the needed upgrading in infrastructure, equipment and manpower. Reducing the expenditure burden requires step-up efforts *in establishing public-private partnership mechanism,* which is not present now.

Moreover, a disproportionate focus on specialist, tertiary care, services being focused – often referred to as "hospital centrism" and the pervasive commercialization of health care in unregulated health system. This made under-resourcing and fragmentation of health services towards unregulated fee-for-service sale of health care, regardless of whether or not it is supplied by public, private or NGO providers. This further divided further public and private resources and lost the opportunity of risk pooling. This in turn shifted the cost of services to users in an attempt to compensate for the chronic under funding of the public health sector. In addition to, the pressure from consumer demand, the medical profession and hospital industry is such that public and private health resources flow disproportionately towards specialized hospital care at the expense of investment in primary health care. This itself become a major source of inefficiencies and inequality. National health authorities have often lacked the political clout to curb this trend and achieve a better balance. Donors have also used their influence more towards setting up disease control programs than towards primary health care. Eventually service delivery ends up dealing with the diseases for which social health financing mechanism exists.

It has also been noted that the public health reforms focused mostly on municipal facilities. As a result, there is a need to secure the link between centrally and locally provided public health programs. Changes in a community's health status invariably lead to changes in health care practice, which may also *require changes in health financing mechanism and their organization*s. *Sustainable financing schemes* to allow patients to have access to health services and essential drugs, particularly *for long-term care* should be put in place, particularly for indigent population and near poor population quintiles.

Therefore, action to prevent these diseases should *focus on controlling risk factors in an integrated service delivery* as the most appropriate way to provide services in a cost-effect manner to address the health care needs across the care continuum. The country with minimal resources for health care, the cost of treating these catastrophic diseases felt to be enormous and could drain vital resources as well their controls entails a different public health approach. *Intervention at family and community levels is essential for prevention* because the causal risk factors are deeply entrenched in the social and cultural framework of the society. A *supportive environment for behavior change* that can provide material, human and political resource to promote, adopt and maintain towards healthy lifestyle should be created.

Changing values and rising expectations

The present study noted that poor integration of health sector reform activities and programs in the convergence sites – BFAD and BHDT, especially at local government unit level and provincial level. Activities to ensure presence of accredited drug retailers and medical equipment through the so-called BFAD and BHDT quality seals have been notable absent or non-functional at the convergence sites. This escalated the drug and medicines costs and constitutes 46.4 per cent of total household expenditure for medical care. This has resulted in highly inequitable situation where more than a half of the Filipinos lack access to essential drugs for catastrophic disease. Furthermore, 42.4 per cent of the respondents stated that they given up the care and follow-up care due to the high cost for treatment. This shows that people are unaware of the full scope of health system that creates inequalities. What is more alarming in the Philippines is the fact that local drug prices are in the range of two times to as much as thirty times higher than in India or other neighboring Asian countries. However, while people's knowledge on the drug and medical related topics may be partial, the present study showed that respondent regard social gradient in health as profoundly unjust, on the one hand. This shows the level of regulatory exists, on the other hand, and forces the system to *focus on strengthening the regulatory mechanisms*.

Furthermore, due to intensive lobbying and massive marketing campaigns; promotion, gift-giving schemes and advertising targeting mainly towards physicians and pharmacists on the part of multinationals; and concentrated monopoly in the drug procurement and distribution, the Generics Act (RA 6675, 1988), was enacted to promote, require and ensure the production of an adequate supply and distribution of essential drugs, failed to remove the cloud of doubt over the perceive inferior quality of local generics, thus consumers continued to patronize branded over generic products, despite the price differential. In addition to these efforts, the government created Botika ng Barangay /Botika ng Bayan networks for drug importation and making home remedies available in National Food Authority rolling stores so as to make quality drugs accessible to the country's population, particularly poor, is still a dream.

The health care market in the Philippines are competitive and in the unregulated, fee for service payment system, providers are able to maximize profits by increasing volume, use of high cost technology and intensive resource use, increasing the overall cost of care, necessitating designing of alternative system of financing health care that would have incentives to contain cost. ASIA Fellow observed that about 63 per cent of Botika ng Barangay and 31.5 per cent Botika ng Bayan (out of 660) are non-functional and also noted that 'poor pharmacist' who lacks enterprising skills constitute only four per cent of the market. This fueled in sustained increase in the essential drugs and medicines prices, which are no more affordable to poor or near poor population. This calls for *strong regulatory mechanism in delineating the various roles that different stakeholders play, ranging from the supply side to the demand side, in terms of production, distribution, regulation and financing,* ensure support across the whole spectrum.

Devolved health Service Delivery: Unclear Mission

Field experiences and discussion with both public and private key stakeholders revealed that national and local governments are at times unclear on the operational definition of 'devolved health services'. The perceived exclusivity of devolved health services as a local government unit does not conform to certain service delivery functions of Department of Health. This vague characterization of 'devolved health services' at times becomes the source of misunderstandings and conflicts among national, provincial and municipal health facilities and the private as well affecting the overall effectiveness and efficiency of the health care delivery system. Thus, the *integration of public health and hospital program* has remained weak. The lack of integrated framework and mechanisms has largely contributed to this condition. As a result, the efficient and effective use resources both for clients and providers are not fully maximized. This decreased in spending for public health programs from 14.4 per cent in 2000 to 10.1 per cent in 2005. Conversely, a large share of government budget goes to tertiary hospital care (only to 72 hospitals). The double burden of diseases from infections and degenerative diseases has overloaded the health system, draining resources for health. The lack of fund becomes more evident in the low quality or unavailability of medicines and supplies in the government health facilities, the prevailing deterioration of equipment and facilities, and the migration of trained and capable health workers to other countries. These are factors greatly affecting the delivery of quality services to the people. These in turn have created social inequality and tensions that affected the legitimacy of political leadership. Nevertheless, on the whole, *the system needs to work for the common good, to do this well and with foresight*.

The core values articulated by the primary health care movement three decades ago – the values of equity, integration of the system, community participation and comprehensive care are still considered to be radical by many stakeholders. Today, these values have become widely shared social expectations for health that increasingly pervade many – though language people use to express these expectations may differ from the Alma-Ata. It opens fresh opportunities for generating social and political momentum to move health systems in the direction of people, particularly who are affected with catastrophic diseases, want them to go. This *calls the system from a purely hospitalization treatment perspective focused to financing mechanism to include political consideration on the social goals that define the direction in which to steer health system.*

Health financing as brokers for health reform

Philippines's social health insurance is considered as 'prospective' financing where funds are pooled in advance, mainly in the form of regular contributions from insurance fund members, employers and the government. It addresses inequities in health financing where 'healthy pay for the sick' and 'those who can afford medical care subsidized those who cannot'. The review of health financing mechanism in the Philippines noted that PhilHealth's membership has reached about 62.7 per cent in 2009, a decline from 81 per cent in 2004 achieved due to political vote gains. Despite many achievements, PhilHealth faces few challenges, first, in ensuring its members with highest financial risk protection and the highest standards of quality in health care. Second, none of the designated convergence sites have reached the 60 per cent enrollment target indigent for social health insurance scheme. Focus has been made on the enrollment under the indigent programme but the expansion of enrollment of individually paying members remained to be a gap. Sustaining the indigent programme, with the devolution, PhilHealth finds difficulty in looping local government units which do not see health as a priority plan. Education of local unit in addressing and supporting the catastrophic diseases and building the local units capacity is the need of the hour.

On the other hand, utilization rate of indigent is just six per cent. They cannot be assumed to be healthier but the relatively low support value necessitates out-of-pocket counterpart members. Also, the study

indigent respondents indicated that, first, many indigent members are not fully aware of their rights and responsibilities as PhilHealth members and as to how they can access benefits from the program. Second, only about 20 per cent of the indigent kept renewed every year as per the schemes. Due to renewal condition of the membership, the scheme does not attract sponsor or politician to support the indigent every year. Contrary, as political officials sponsor the indigent to the program, it cannot be avoided that they would enlist their constituents who are not necessarily poor. This has pushed poor and vulnerable population towards commercial care, which they, rightly or wrongly perceived to be effective. Respondents clearly stated that they want effective health care when they are sick or affected by catastrophic diseases in particular. They want it to come from PhilHealth and other social health insurance mechanism with the integrity to act in their best interests, equitably and honestly with knowledge and competence. Moreover, the PhilHealth and the health system underestimated the needy as meager receiver of biological services needy. All studied indigent respondents inimitable voiced that PhilHealth and service providers to be organized around their needs, respectful of their beliefs and sensitive to their particular situation in life. They do not want to be taken advantage of by unscrupulous providers, nor do they want to be considered mere targets for indigent program or for disease control program. They never might have liked that, but they are now certainly becoming more vocal about it. In other words, intolerance to inequality in health and to the exclusion of the needy population and the vulnerable groups from health benefits and social protection mirrors or exceeds intolerance to inequality in income. Thus there is a *need to strike the balance approach in screening and identifying the poor as well as improve efficient and equity*.

An important public health function that governments are expected to perform is expanding access to public goods by focusing on preventive care and promotive health education. In the Philippines, such an interventionist role of local units have been negligible: an omission given the huge treatment costs that will be required to cope with emerging epidemic of non-communicable diseases.

Weak systems give room for discretion and scope for fraud and more importantly for delays largely due to raising meaningless and frivolous queries. This therefore *calls for greater professionalism in the PhilHelath set up and also sharing of responsibility, making the equally accountable for poor expenditure. PhilHealth should change its mindset from account-keeping to being facilitators for achieving certain goals should be the key for future. PhilHealth should take measures for assuring equitable access to secondary care and reducing the financial burden on households, social health insurance is recommended as a way forward. PhilHealth should provide leadership in bringing about behavior change for adoption of healthy lifestyles and practices that promote well-being and good health values.*

There is increasing worldwide recognition that *health systems should be accountable* to the broader community for expenditure of funds, and not just to individual patients for the care they receive. For instance, service delivery is not always managed in an integrated way and patient care could be improved by a more systematic approach to service provision and care planning. The *establishment of effective governance mechanisms could enhance and support desired improvements in service outcomes and improve public accountability.* That is, public finance management systems should be enhanced by developing a comprehensive and integrated financial management information system and by improving accountability and audit systems.

Health Equity: A Job Unfinished?

Apart from the effects observed at the health financing mechanism in the study, there are adverse implications at the individual and household levels that ameliorated by investments in health. As noted in the study, catastrophic disease or ill-health led to lost earning on account of medical treatment,

impoverished families, particularly those is living on the margins of survival. Estimates based on household expenditure survey in the Philippines (2006) suggest that the financial burden imposed by health related rose from nearly 12.1 per cent for COPD to 27.4 per cent for CAD and amounted to 57.5 per cent for CVD of the total annual consumption expenditures (Table-3). The enormity of household spending due to illness is indeed grave. Equally disturbing are the larger rich-poor disparities in household spending. These estimates reflect the people living at or around the poverty line have imperfect access to credit markets; in its absence health spending resulted in increasing the severity of poverty among the middle income quintile and among the already poor. Moreover, the greater reliance by the poor on sale of assets, non-labor income and on borrowing suggests that not only is their purchasing power eroded in the short-term but also makes them vulnerable to slide into long-term poverty. Perhaps, the most important characteristic of catastrophic diseases is that its impacts are likely to persist across generations. Moreover, middle and rich quintiles that slide into poverty due to catastrophic diseases or ill-health are not reported as their self-esteem, self-worth, and sense of self with past status prevent them in recording them for financial benefits from government mechanisms or any services recipient. This continues for generations suggest that financial burden imposed by health related spending could raise the proportion of people living below the poverty line in the Philippines by as much as 2.65 percentage points. However, this indicates neglecting people's needs and expectations is a recipe for disconnecting health services from the communities they serve.

Table-5 Summary of Economic Costs in US$

Smoking-related Diseases	Health Care Costs	Productivity Losses from Death	Productivity Losses from Disease	Total Costs
Cancer	9,188,871	189,709,987	3,407,151	202,306,009
CVD	507,315,052	2,930,533,343	38,910,556	3,476,758,951
CAD	236,888,476	1,312,836,695	88,922,515	1,638,647,686
COPD	104,561,119	569,530,925	54,043,648	728,135,692
All four Diseases	857,953,518	5,002,610,950	185,283,871	6,045,848,339

Source: Tobacco and Poverty Study in the Philippines, 2006

Philippines' performance in reducing health inequalities also stacks up unfavorably. For instance, female-to-male ratios of life expectancy have increased over the past 15 years; so there is some evidence that the status of women's health is improving. However, there is considerable variation in the catastrophic diseases at any given point of time. The Philippines has a long way to go before it can claim to have achieved gender equality in health outcomes. Then there are inequalities across the age categories of economically and socially deprived groups. Not only the poor, but also the near-poor face a disproportionately greater share of the burden of catastrophic diseases. As we have seen in this paper that the response of the health sector and societies to these challenges has been slow and inadequate. This reflects both an inability to mobilize the requisite resources and institutions to transform health around the values of primary health care as well as a failure to either counter or substantially modify forces that pull the health sector in other directions namely: a disproportionate focus on specialist hospital care; and the proliferation of unregulated commercial care. Ironically, these powerful trends lead health systems away from what people expect from health and health care.

Apart from the objective of promoting health, protection from financial risk for the most in need has been a second major objective of the Philippines health system. The main mechanism by which the achievement of this goal was sought to be provided was free or subsidized care at public health facilities. Despite the provision of free or heavily subsidized health care, which the poor tend to use more than other groups, subsidies to the health sector are not particularly well targeted. In a perverse sense, subsidies and social health financing mechanism benefit the rich more than the poor, particularly at higher levels of care, such as during hospitalization. That is, existing financing mechanism help only for hospitalized care while service provision limits only for initial days of admitted care. Looking ahead, if PhilHealth financing provides kind of service or support value limitation continues to stagnate as they have and, as in some cases, decline, it is the poor who are the most affected. The poor therefore access private health care

which may further impoverish them. A major concern is lack of adequate support value. The present study estimated that no more than 15 per cent of health spending on curative care covered by PhilHealth financing mechanism with another about 20 per cent coming from public subsidies in health facilities operated by the public sector. One can imagine what the potential financial consequences could be for households in the absence of such facilities. Stress and psychological costs to the person and his/her family members, or work-day lost to both patient and family care givers, were over and above this subsides.

Experiences from this study noted that people increasingly want to have a say in important decisions that affect their lives which would include issues such as resource allocation and the organization and regulation of care. Only people centered services will minimize social exclusion and avoid leaving people at the mercy of unregulated commercialized health care, where the illusion of a more responsive environment carries a hefty price in terms of financial expenses.

Mitigating Health Poverty through Social Investment

Financing of health care for poor and vulnerable population poses specific challenges, which often require larger investment and per capita expenditure. However, universal coverage reforms required to move towards greater equity demand the enduring commitment of the highest political levels of society. Three levers may be especially important in accelerating action on health equity and maintaining momentum over resources and time. The first is raising the visibility of health inequities in public investment and policy debates. The 'health poverty' is intimately linked to the measurement of health inequalities. Second, demand from the 'health poverty' communities that bear the burden of existing inequities are among the most powerful driver in efforts and coverage reforms to reach the unreached and the excluded. The third is the creation of space for civil society participation in shaping health equity and reducing health poverty through health financing mechanisms. However, there is much the health system itself can do to mitigate the health poverty effects and promote fairer access to health care services at family level. Social participation in health action becomes reality at the local level, at times, it is there that inter-sectoral action most effective engages the public investment, allocation of resources and adequate financing mechanism that shape people's health prospects, widening health equity and reducing health poverty gaps.

Summing up

Investing in health is valuable on economic grounds as well as for improving the well-being of the population. Increased health care benefits or subsides or increased social health financing support values is likely to be even greater for a country lagging in its health achievements. In any case, much remains to be done, particularly addressing catastrophic diseases and its related economic implications in improving health status in MDG is to be noted as well to be achieved. Inability to address these conditions can set back the Philippines meager health achievements to date and its ambitions to achieve higher economic growth rate. Thus, *tackling the catastrophic disease burden in an effective manner should therefore be the most critical* focus for the Philippines for the coming years.

Improvements in population health outcomes are an important goal of health policy, but so is protection from the financial risk associated with catastrophic illness. Thus, compared to degenerative diseases, malaria diseases impose a much greater disease burden in the Philippines at present, but the former obviously imposes a much greater financial risk on affected households. This then justifies the urgency to avoid and prevent the onset of these diseases to the extent possible. It is clear that there is gross inadequacy of public finance in the health sector and an immediate and significant scaling up of resources is an imperative. The undue burden on households spending on health cannot be wished away. Further it is also clear that there is an urgent need to restructure the budgeting system to make it more functional,

amenable to review resource-use for taking corrective measures in time and flexible enough to give the capacity to respond catastrophic diseases need.

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