Legislative Budget Research and Monitoring Office (LBRMO)

Budget Facts & Figures

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Health Expenditure

(In Million Pesos)

Source of Funds	2011
Government	**116,433**
National Government	53,069
Local Government	63,364
Social Insurance	**39,126**
Nat'l Health Insurance Prog.	39,022
Employees' Compensation	104
Private Sources	**272,009**
Private Out-of-Pocket	227,215
Private Insurance	7,222
Health Maintenance Org.	24,570
Private Establishments	9,297
Private Schools	3,706
Rest of the World	**3,478**
Grants	3,478
ALL SOURCES	431,047

Source: NSCB

Health Expenditure as % of GDP

Country	2000	2010
Brunei	3.0%	2.9%
Cambodia	6.3%	6.0%
Indonesia	2.0%	2.8%
Lao PDR	3.3%	2.6%
Malaysia	3.1%	4.4%
Myanmar	2.1%	2.0%
Philippines	3.2%	4.1%
Singapore	2.8%	4.5%
Thailand	3.4%	3.9%
Viet Nam	5.3%	6.8%

Source: WHO

HEALTH SECTOR BUDGET: AN ANALYSIS

I once was tasked by my father to personally transport blood needed by his brother who was confined at their provincial hospital, and there I first heard the locals called the said hospital as "Mona Lisa Hospital" because, according to them, the lyrics of the famous song "Mona Lisa" describes the patients admitted in that hospital, i.e., "*they just lie there and they die there*".

It is very unfortunate that public hospitals and other health facilities, in general, are seen as inadequate in terms of providing their most basic function, but it is more unfortunate that these are the only available facilities for those who cannot afford to pay for the cost of private health service. This realization leads me to wonder: How much money goes to health expense annually? What are the initiatives of government to address the inadequacy in health facilities, human resources, medicines and supplies? How does health service reach those most in need of it?

Total Health Expenditure

Health authorities note that the health expenditure of a country should be at least 5% of its Gross Domestic Product (GDP). Based on the 2013 statistics of the World Health Organization (WHO), the total health expenditure ratio of the Philippines improved from 3.2% in 2000 to 4.1% in 2010, gaining 0.9 percentage point over a decade, albeit still below the benchmark. Among the ten selected countries in Southeast Asia, the Philippines ranked 5th both in 2000 and in 2010, as shown in Table 1. Cambodia took the lead with 6.3% in 2000 followed by Viet Nam with 5.3%, but it was reversed in 2010 when Viet Nam recorded a ratio of 6.8% while Cambodia fell to 6.0%. Only these two countries exceeded the 5% total health expenditure-to-GDP ratio.

Table 1.

Health Expenditure as % of GDP, 2000 and 2010

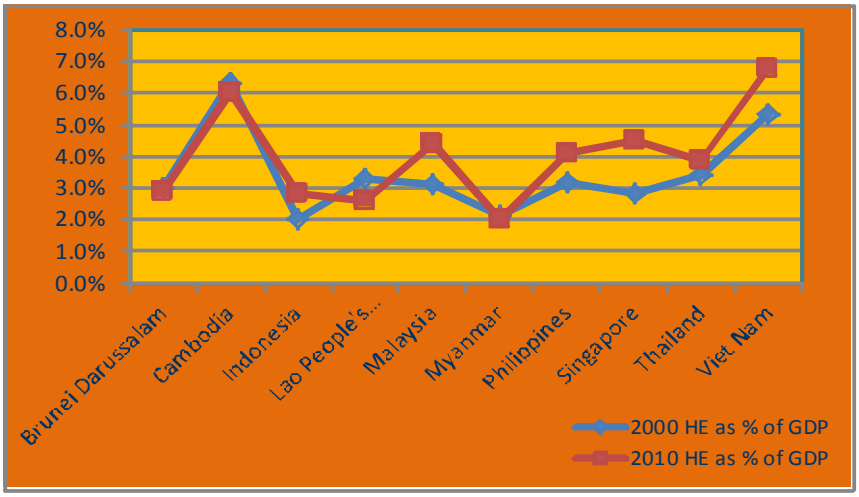
Southeast Asia	2000	2010
Brunei Darussalam	3.0%	2.9%
Cambodia	6.3%	6.0%
Indonesia	2.0%	2.8%
Lao People's Democratic Republic	3.3%	2.6%
Malaysia	3.1%	4.4%
Myanmar	2.1%	2.0%
Philippines	**3.2%**	**4.1%**
Singapore	2.8%	4.5%
Thailand	3.4%	3.9%
Viet Nam	5.3%	6.8%

(Source: WHO World Health Statistics 2013)

Except for Lao People's Democratic Republic, Cambodia, Brunei Darussalam and Myanmar, the selected countries registered growths in ratio with Singapore, Viet Nam and Malaysia occupying the top three positions having 1.7, 1.5, and 1.3 percentage points, respectively. The Philippines was next in line, ahead of Indonesia and Thailand. The Chart below graphically shows the comparative changes in the health expenditure ratio of the countries in Southeast Asia for the years 2000 and 2010.

Chart 1.

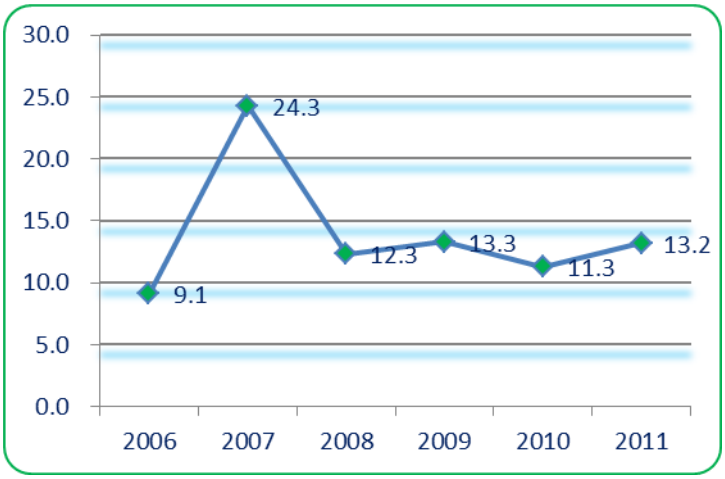
Health Expenditure as % of GDP, 2000 and 2010



In the Philippines, the total health expenditure has four major sources, namely: 1. government; 2. social insurance; 3. private sources; and 4. rest of the world, and for the period covering the years 2005 to 2011 it continued to escalate and more than doubled from P198.4 Billion to P431.0 Billion, as shown in Table 2.

Using simple average, health spending grew by P38.8 Billion or 13.9% annually, although the growth had been erratic. The highest nominal increase of P52.5 Billion was recorded in 2007, followed by P50.2 Billion in 2011 and P40.1 Billion in 2009; while, the highest percentage increases were posted in 2007 (24.3%), 2009 (13.3%) and 2011 (13.2%), as plotted in Chart 2.

Chart 2.
Total Health Expenditure Growth Rate, 2005-2011



The growth in 2007 resulted mainly from the P34.8 Billion or 30.8% increase in out-of-pocket expenditure, coupled with the P5.7 Billion or 21.3% and the P3.0 Billion or 30.0% from national government and health maintenance organizations (HMOs), respectively. The local government actually augmented its health expenses by P10.8 Billion, marking the highest growth rate of 35% by source of expenditure, but such level of health spending was not maintained in the immediately succeeding year. In 2009, the local government once again hit the 35% growth rate compounded with the largest nominal increment of P13.5 Billion, but it was not repeated in 2010, not even in 2011.

The National Health Insurance Program (NHIP) contributed about P19 Billion to P21 Billion annually for the period 2005 to 2008 and such contribution started to go up to P28 Billion in 2009, P34 Billion in 2010 and P39 Billion in 2011; however, the magnitude of additional expenditure was declining both nominally and in ratios. In 2009, NHIP contribution grew by P6.4 Billion or 30.2%; but, in 2010, it was only P6.0 Billion or 21.6%; and, in 2011, it further fell to P5.2 Billion or 15.5%.

Except in 2007, the percentage increase in out-of-pocket expenses was decreasing from 15.9% in 2006 to 15.7% in 2008, to as low as 6.6% in 2009; however, it began to rise to 9.7% in 2010 and to 13.6% in 2011.

The growth pattern of the national government in the total health expenditure was quite similar to out-of-pocket expenses. The increases in the national government health expenditure were shrinking from P5.7 Billion or 21.3% in 2007 to P3.8 Billion or 11.6% in 2008, to only P0.4 Billion or 1.1% in 2009; but, it moved up to P6.4 Billion or 17.4% in 2010 and to P9.7 Billion or 22.3% in 2011.

Table 2.
Health Expenditure by Source of Funds, 2005-2011
(In Million Pesos)

Source of Funds	2005	2006	2007	2008	2009	2010	2011
Government	**58,474**	**57,475**	**74,036**	**74,875**	**88,722**	**101,378**	**116,433**
National Government	30,416	27,001	32,749	36,554	36,949	43,375	53,069
Local Government	28,058	30,475	41,288	38,320	51,773	58,003	63,364
Social Insurance	**19,360**	**19,098**	**19,972**	**21,434**	**27,897**	**33,925**	**39,126**
National Health Insurance Program	19,270	19,005	19,838	21,345	27,791	33,799	39,022
Employees' Compensation	90	93	134	88	107	126	104
Private Sources	**118,293**	**135,376**	**173,987**	**202,054**	**217,865**	**239,139**	**272,009**
Private Out-of-Pocket	97,562	113,087	147,873	171,116	182,370	199,983	227,215
Private Insurance	4,112	3,924	4,175	5,108	6,083	6,401	7,222
Health Maintenance Organizations	8,853	10,097	13,123	15,638	18,199	21,170	24,570
Employer-Based Plans/Private Establishments	5,699	5,813	5,996	7,043	7,809	7,937	9,297
Private Schools	2,068	2,455	2,820	3,148	3,404	3,649	3,706
Rest of the World	**2,271**	**4,463**	**933**	**3,682**	**7,681**	**6,384**	**3,478**
Grants	2,271	4,463	933	3,682	7,681	6,384	3,478
ALL SOURCES	**198,398**	**216,413**	**268,928**	**302,043**	**342,164**	**380,826**	**431,047**

(Source: National Statistical Coordination Board)

The bulk of the total health expenditure consistently came from private sources, specifically from private out-of-pocket which comprised more than half, except in 2005 when it was only 49.2%, of the total health expenditure.

The share of the government, national and local combined, in the total health expenditure was about 25% to 30%. Social insurance, the National Health Insurance Program (NHIP) in particular, did not reach 10% in terms of contribution to the total health expenditure. Rest of the world, referring to grants, was at a maximum of 2.2%.

In terms of per capita expenditure and GDP, the National Statistical Coordination Board (NSCB) noted that its 2011 Philippine National Health Accounts Report revealed the following:

- Per capital health expenditure, at current prices, was registered at P4,577 in 2011, a 10.3% increase from P4,112 in 2010.

- As a percentage of GDP, health spending was at 4.4% in 2011, a very slight increase from the previous year's 4.2%.

On the same report, the NSCB also mentioned that based on the goals set by the DOH in its National Objectives for Health 2005-2010, only two out of seven health care financing indicators were within the target, namely:

- Total health spending as a percentage of gross national product; and
- Per capita health expenditure.

Government Health Expenditure

Health service as a function of government has been devolved to the Local Government Units (LGUs) pursuant to the enactment of Republic Act (R.A.) No. 7160, otherwise known as the "Local Government Code of 1991". The devolved basic health services and facilities include the maintenance of barangay health centers; construction of clinics and other health facilities necessary to carry out health services; implementation of programs and projects on primary health care, maternal and child care, communicable and non-communicable disease control; access to secondary and tertiary health care; purchase of medicines, medical supplies, and equipment needed to carry out health services.

The sources of funds of LGUs include, but are not limited to, the internal revenue allotment, share in the national wealth, real property taxes, regulatory fees, donations and local taxes; however, **the local health budget would depend on the priorities given by each LGU to health services and facilities**.

The national health expenditure, on the other hand, refers to the Department of Health (DOH) and other national government agencies with health-related activities. The DOH includes the Office of the Secretary (OSEC), the Commission on Population and the National Nutrition Council, as well as some government corporations such as the Lung Center of the Philippines, the National Kidney and Transplant Institute, the Heart Center of the Philippines and the Philippine Children's Medical Center. The national government agencies with health-related activities include, among others, the Dangerous Drugs Board, the Armed Forces of the Philippines Medical Center, Veterans Memorial Medical Center, the Food and Nutrition Research Institute and the Philippine Council for Health Research and Development.

Based on the Budget of Expenditure and Sources of Financing (BESF), which the Department of Budget and Management (DBM) annually submits to Congress, the health sector allocation of the national expenditure for the period 2005 to 2013 is as follows:

PARTICULARS	2005	2006	2007	2008	2009	2010	2011	2012	2013
Department/Agencies	**12,080,177**	**12,175,623**	**15,085,999**	**15,653,482**	**22,203,383**	**26,348,159**	**31,924,642**	**44,901,259**	**42,473,715**
Department of Health	10,431,864	10,557,562	13,424,090	14,551,499	21,153,725	25,170,053	30,618,385	43,471,914	40,969,880
Office of the Secretary	*10,320,960*	*10,397,759*	*13,062,005*	*13,962,645*	*20,345,660*	*24,359,796*	*30,041,718*	*42,847,536*	*40,324,535*
Commission on Population	*110,904*	*113,118*	*184,835*	*282,507*	*438,008*	*327,462*	*303,522*	*299,455*	*313,867*
National Nutrition Council		*46,685*	*177,250*	*306,347*	*370,057*	*482,795*	*273,145*	*324,923*	*331,478*
Other Executive Offices	172,846	122,517	160,154	185,340	138,500	145,727	172,034	170,842	181,946
Dangerous Drugs Board	*172,846*	*122,517*	*160,154*	*185,340*	*138,500*	*145,727*	*172,034*	*170,842*	*181,946*
Department of Agriculture	45,928								
National Nutrition Council	*45,928*								
Department of National Defense	1,327,347	1,394,351	1,367,358	686,606	746,631	792,156	863,981	836,767	861,827
Armed Forces of the Philippines Medical Center	*753,170*	*816,547*	*710,747*						
Veterans Memorial Medical Center	*574,177*	*577,804*	*656,611*	*686,606*	*746,631*	*792,156*	*863,981*	*836,767*	*861,827*
Department of Science and Technology	102,192	101,193	134,397	230,037	164,527	240,223	270,242	421,736	460,062
Food and Nutrition Research Institute	*62,774*	*63,900*	*81,445*	*165,227*	*98,992*	*117,200*	*169,132*	*159,448*	*221,260*
Phil. Council for Health Research and Devt	*39,418*	*37,293*	*52,952*	*64,810*	*65,535*	*123,023*	*101,110*	*262,288*	*238,802*
Budgetary Support to Government Corporations	**1,772,891**	**3,893,007**	**3,128,342**	**2,912,019**	**1,189,078**	**4,649,796**	**8,584,270**	**1,294,360**	**948,265**
Local Water Utilities Administration							52,800		
Lung Center of the Philippines	*211,510*	*210,810*	*222,440*	*191,230*	*169,583*	*184,205*	*288,083*	*257,560*	*173,400*
National Kidney and Transplant Institute	*268,371*	*244,591*	*232,045*	*498,996*	*305,164*	*305,341*	*337,282*	*264,800*	*202,865*
Philippine Children's Medical Center	*238,025*	*236,825*	*242,120*	*272,600*	*251,650*	*269,920*	*640,858*	*445,000*	*345,000*
Philippine Heart Center	*210,423*	*200,438*	*325,709*	*464,314*	*291,915*	*303,557*	*631,511*	*287,000*	*187,000*
Phil. Inst. for Traditional and Alternative Health Care	*40,000*	*40,000*	*40,000*	*30,000*	*40,000*	*40,000*	*37,000*	*40,000*	*40,000*
Philippine Health Insurance Corporation	*804,562*	*2,960,343*	*2,066,028*	*1,454,879*	*130,766*	*3,546,773*	*6,596,736*		
Other Special Purpose Funds	**10,451**	**5,143**	**23,904**	**75,743**	**22,305**			**4,363,205**	**16,958,062**
Allocation to Local Government Units	10,451	5,143	23,904	75,743	22,305				
Municipal Development Fund	*10,451*	*5,143*	*23,904*	*75,743*	*22,305*				
Premium Subsidy for Indigents under the NHIP									
Miscellaneous Personnel Benefits Fund								2,513,825	1,612,047
Calamity Fund								150,000	150,000
Tax Expenditure Fund								330,430	269,000
Priority Development Assistance Fund								1,368,950	1,368,950
Health Facilities Enhancement Program*									13,558,065
TOTAL HEALTH SECTOR ALLOCATION	**13,863,519**	**16,073,773**	**18,238,245**	**18,641,244**	**23,414,766**	**30,997,955**	**40,508,912**	**50,558,824**	**60,380,042**

**Originally reported in the BESF under Priority Social and Economic Projects Fund but was transferred back to the DOH.*

The amounts reflected in the years 2005 to 2011 are actual health sector expenditures while the remaining two years are still subject to certain budget adjustments; nevertheless, these actual figures reported by the DBM are lower than those reported by the NSCB for the same periods. In the year 2007, for example, the national government health expenditure was P32.7 Billion in NSCB while only P18.2 Billion in DBM, disclosing a variance of P14.5 Billion. The difference is accounted for mainly by the inconsistency in the composition of the amount. NSCB factored in, as much as possible, all activities which are health-related, such as the allocation for the Philippine General Hospital (which the DBM reported as part

of the State Universities and Colleges allocation) and the health expenses shouldered by the Philippine Charity Sweepstakes Office (which the DBM did not include).

Using the BESF, there is an increasing trend in the total health sector spending of the national government, from P13.9 Billion in 2005 to P50.6 Billion in 2012, growing by P36.7 Billion or 264.0% in a span of eight years. The largest nominal increase was posted in 2012 with P10.0 Billion, followed by P9.5 Billion in 2011. The highest percentage growths were recorded in 2010 and in 2011 with 32.4% and 30.7%, respectively.

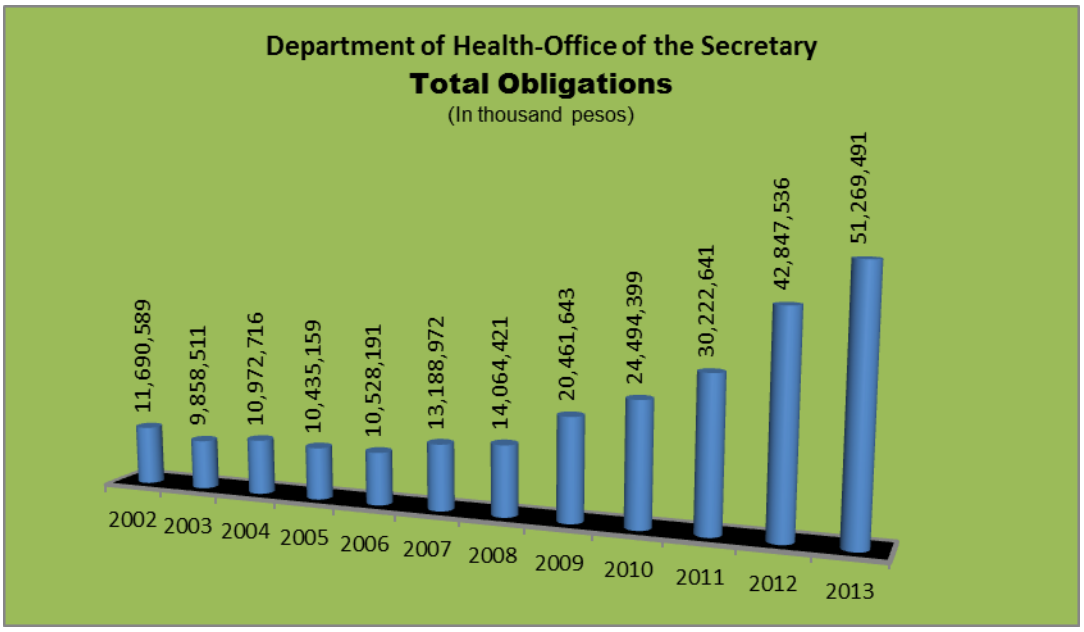
The health sector expenditure in 2013 grew by P9.8 Billion or 19.4%, from P50.6 Billion to P60.4 Billion, which is accounted for mainly by the P8.5 Billion additional funding for Health Facilities Enhancement Program (HFEP). Moreover, the health sector expenditure of the national government for 2013 is expected to still go up due to the approval of R.A. No. 10351, also known as the "Sin Tax Reform Act of 2012", because a portion of the incremental revenues from the excise tax on alcohol and tobacco products will be allocated for health.

The bulk of the total health sector expenditure of the national government is allocated for the operational requirements of DOH-OSEC. For the period 2005 to 2012, the share of DOH-OSEC ranges from 65% to 87%, and it could be higher in 2013 when the necessary adjustments are made.

The budget of DOH-OSEC is composed of five major parts, namely: 1) general administration and support; 2) support to operations; 3) operations; 4) locally funded projects; and 5) foreign assisted projects. *General administration and support* deals with the overall administrative management and operational support to the entire agency operations. *Support to operations* includes activities such as formulation and development of national health policies and plans, health information systems and technology development, health human resource development, development of policies, support mechanism and collaboration for international health cooperation, health systems development and health care assistance. *Operations* refer to regulation programs, service delivery programs and to the operation of centers for health development. *Locally funded projects* are projects financed out of revenue collections and domestic borrowings; while, *foreign assisted projects* are projects which are wholly or partly financed by foreign loans and/or grants.

The graph below shows that the DOH-OSEC budget was more or less stable at P10.0 Billion for the years 2003 to 2006. It jumped to P13.2 Billion in 2007, registering an improvement of P2.7 Billion or 25%, but the growth immediately slowed down in the succeeding year, recording only an increment of P875 Million or 7%.

Chart 2.



(Source: Budget of Expenditure and Sources of Financing)

The year 2009 signalled a new trend where the augmentation in the annual budget became significant, starting with an additional budget of P6.4 Billion or 45%. The next two years were not as high, with P4.0 Billion or 20% and P5.7 Billion or 23% growth, respectively, but it once again peaked at P12.6 Billion or 42% in 2012. As earlier mentioned, the year 2013 is quite different because the growth projection is seen to still go up with the recent enactment of a new source of fund for health.

The increase in the 2007 budget primarily went to immunization and to *Botika ng Barangay* (BnB). The additional budget aimed to achieve an immunization rate of 84% in 2007, targeting that by 2010, 95% of children with age 0 to 11 months have already been immunized; and, to bring the total number of BnBs to almost 9,400 in order to widen the poor's access to half-priced medicines most commonly used by them.

In 2008, the health-related Millennium Development Goals (MDGs) were prioritized and the budget was focused on tuberculosis (TB) control, creation of additional treatment centers for human immunodeficiency virus-acquired immune deficiency syndrome (HIV-AIDS), expanded program on immunization (EPI), prevention of epidemics like the avian flu and establishment of new BnBs. The allocation for family health was provided for basic obstetric care at the rural health level while the appropriation for health facilities enhancement program was for the upgrade of primary level to secondary care and secondary level to full tertiary care.

The huge leap in total obligation in 2009 was brought about mainly by the accelera-

tion in achieving the MDG targets, the upgrading of selected DOH-managed and LGU-managed hospitals, the speeding up of the implementation of R.A. No. 9502 or the "Universally Accessible Cheaper and Quality Medicines Act of 2008", and the strengthening of regulatory services. The increase in total obligation also included the transfer of the P1.5 Billion fund for the provision of potable water supply from the DPWH to the DOH.

In 2010, the funding for HFEP was augmented from P2.1 Billion to P3.2 Billion for the upgrading of health facilities; and, it accelerated in terms of budget allocation in 2011. From P3.2 Billion, it was further increased to P7.1 Billion in order to reduce the infant and child mortality rates and the maternal mortality ratio.

The EPI in 2011 almost tripled, from P990.8 Million to P2.5 Billion, to cover 2.6 million children and about 865,950 senior citizens. The elimination of TB and other diseases was continued and the implementation of the "Universally Accessible Cheaper and Quality Medicines Act" was supported. The increase in the 2011 DOH-OSEC budget also included the transfer of P3.5 Billion from the Philippine Health Insurance Corporation (Philhealth) under the Budgetary Support to Government Corporations.

In 2012, a new locally-funded project, "Equity for the Modernization of Twenty-Five Regional Hospitals under the Public-Private Partnership Framework", with a funding of P3.0 Billion, was introduced in the budget of the DOH-OSEC and complemented the HFEP, which was also given P5.1 Billion, in order to upgrade healthcare facilities. Support for family health and responsible parenting, as well as for doctors to the barrios and rural health practice program, was emphasized; while, programs for the prevention and elimination of diseases, including the provision of medicines and other medical supplies, were continued. It was likewise in this budget year when the premium subsidy for indigents under the National Health Insurance Program (NHIP) ballooned from P3.5 Billion to P12.0 Billion.

For this year, the Universal Health Care Program (UHC) is highlighted with an allocation of P33.8 Billion, supplemented by another P4.6 Billion that is lodged under the budgets of the Department of the Interior and Local Government Units and the DPWH. The program includes the HFEP, NHIP, EPI, family health and responsible parenting, implementation of doctors to the barrios and rural health practice program, national pharmaceutical policy development, elimination of diseases as public health threat, tuberculosis control, rabies control program, other infectious diseases and emerging and re-emerging diseases, and the social protection package for former rebels. On top of this, a standby authority is provided under the unprogrammed fund to be sourced from the sin taxes.

Given the increasing budget for DOH-OSEC in these recent years, is it enough to conclude that health service delivery has significantly improved the lives of Filipinos, especially those mired in poverty?

Millennium Development Goals

One set of measure which could evaluate the effectiveness and progress of health programs is the Millennium Development Goals or MDGs, especially the health-related targets and indicators. The periodic report as to the status of attainment of each indicator gives us a hint whether the programs of government properly address the specific health situation that such programs seek to deal with. The likelihood of achieving the target translates to improvement in a certain indicator, which in real life situation means, among others, adequate health care facilities, sufficient and skilled human health resources, affordable medicines and supplies, as well as access to quality health services.

The status report on MDGs is contained in the Socioeconomic Report 2010-2012 of the National Economic and Development Authority. The health-related indicators with the corresponding targets and accomplishment rates are reproduced and presented in the table on page 11.

Among the indicators shown above, the maternal mortality ratio of 50 is the least likely to be met by the end of 2016. From the baseline value of 95-163 maternal deaths for every 100,000 live births in 2010, the ratio worsened to 221 at the end of 2011, contrary to the objective of decreasing it to only 97 for the same year. The increasing maternal deaths could be attributed to inadequacy in delivery facility or lack of skilled health professional that assists the pregnant mother, or to the inability to pay for the needed health service. The report of the World Bank (WB) in June of 2011, entitled "Philippines: Public Expenditure Review-Strengthening Public Finance for More Inclusive Growth", revealed that the share of women who did not get prenatal care from medical professionals declined from 7% in 2003 to 5% in 2008, and that the proportion of pregnant women who did not receive any antenatal care also went down from 6% in 2003 to 4% in 2008. If more women got prenatal care from medical professionals and more women received antenatal care in 2008 than in 2003, it would, normally, have favorably affected the maternal mortality ratio. On the other hand, if such behaviors were not repeated in the succeeding years, it would also have contributed to the deterioration of the ratio from the range of 95 to 163 in 2010 to 221 in 2011.

The WB report likewise noted that the proportion of those who did not get antenatal care from medical professionals plus the proportion of those who did not get any antenatal care at all is higher for women from less wealthy households than for women from the higher wealth quintiles, and that the proportion of live births delivered in a health facility is lower for women from poorer households than for those from better-off quintiles. These findings mirror the accessibility and affordability of health services wherein those belonging to the higher wealth brackets had more capacity to go to a health care facility

Indicators	Baseline		2011			2012			2016 End-of-Plan
	Year	Value	Target	Actual	Acc. (%)	Target	Actual	Acc (%)	Target
Maternal mortality ratio (per 100,000 livebirths) decreased	2010	95-163	97	221	-27.8	84	NA		50
Infant mortality rate (per 100,000 livebirths) decreased	2008	25	23	22	104.3	22	NA		17
Underfive mortality rate (per 1,000 livebirths) decreased	2008	34	31.6	30	105.1	30.4	NA		25.5
Prevalence of underweight children under five years of age decreased (in %)	2008	20.6	17.6	20.2	85.5	16.6	NA		12.7
Proportion of households with per capita intake below 100% dietary energy requirement decreased (in %)	2008	66.9	54.1	NA		49.9	NA		32.8
Contraceptive prevalence rate (all methods) increased (in %)*	2006	51	56.2	48.9	87.0	57.9	NA		63 (2015)
HIV prevalence maintained (in %)	2009	<1%	<1%	<1%		<1%	NA		<1%
Malaria morbidity rate (deaths per 100,000 population) decreased	2009	22	16.9	9.5	143.8	14.3	NA		4
Malaria mortality rate (deaths per 100,000 population) decreased	2009	0.03	<0.03	0.03		<0.03	NA		<0.03
TB (all forms) prevalence rate (per 100,000 population) decreased**	2008	548	446	NA		434	NA		398
TB (all forms) mortality rate (per 100,000 population) decreased	2007	41	36	33	108.3	35	NA		33
TB case detection rate (all forms) increased (in %)	2008	73.0	79.0	75.0	94.9	81.0	NA		85.0
TB cure rate (New Sm+) increased (in %)	2008	79.0	82.0	85.0	103.7	83.0	NA		85.0
Proportion of HH with access to safe water increased (in %)	2008	82.3	83.0	NA		84.0	NA		88.0
Proportion of HH with access to sanitary toilet facilities increased (in %)	2008	76.8	79.0	NA		81.0	NA		88.0
Population with access to affordable essential drugs increased (in %)	2009	73.0	NA	NA		NA	NA		95.0
Mean percentage essential drugs availability in rural health units/city health centers and level I to IV public hospitals***	2009	25.3	31.6	45.15	142.9	39.5	NA		NA
National Health Insurance Program coverage increased (in %)	2008	53.0	70.0	NA		85	NA		100.0
National Health Insurance Program enrolment rate increased (in %)	2010	74.0	85.0	82.0	96.5	90	85.0 as of May	94.4	100.0

**new baseline year*
***updated baseline data*
****proposed new indicator*
NA – not available

There are specific activities in the DOH-OSEC budget with direct impact on the reduction of maternal mortality ratio, like the women's health and safe motherhood project and the HFEP, but the worsening maternal mortality ratio indicates that the government's effort is still not enough. Let us take the case of HFEP, the infrastructure program of the DOH-OSEC. In 2010, P3.3 Billion was appropriated for the program, which was increased to P7.1 Billion in 2011. Another P5.1 Billion was provided in 2012, and still another P13.6 Billion for 2013, although some P2.8 Billion of the 2013 budget was transferred to the DPWH for implementation. One of the purposes of the HFEP is to significantly reduce the infant mortality rate and the maternal mortality ratio; thus, in 2011 alone, out of the 7.1 Billion HFEP fund, P5.7 Billion or 80% was allocated, pursuant to the presidential veto statement on the 2011 budget of the DOH-OSEC, for the establishment of basic emergency obstetrics and neonatal care facilities. However, the implementation of the program had been slow. During the hearing of the Joint Congressional Oversight Committee on Public Expenditures on the DOH-OSEC budget, the status of HFEP was presented and it was revealed that the 2011 infrastructure completion rate for rural health units with birthing facility was only at 6% as of June 2012, and still zero for 2012. The DOH noted that in 2011, the Special Allotment Release Orders (SAROs) were released only October 2011; while, in 2012, the SARO was released in May 2012.

With regard to the infant mortality rate and under-five mortality rate as MDG indicators, the country is on track. In 2011, the target was to reduce infant deaths to 23 for every 100,000 live births and to bring down child deaths to 31.6 per 100,000 live births. At the end of 2011, the infant mortality rate and under-five mortality rates were decreased to 22 and 30, respectively, surpassing the goal. This kind of performance implies that there is high probability that the end-of-plan target of reducing the infant deaths and child deaths to 17 and 25.5, respectively, for every 100,000 live births in 2016 can be achieved. It likewise signifies that health programs, such as EPI and new-born screening, actually hit the health condition they seek to address. On the other hand, the likelihood of attaining the 2016 target is lesser as to the prevalence of underweight children under five years of age because in 2011, there was already an underperformance. The goal was to cut the prevalence of underweight children to 17.6 but it was diminished only to 20.2, although the 12.7 goal at year-end of 2016 is still feasible with the 85.5% accomplishment rate in 2011.

The HIV prevalence rate was maintained at less than 1% of the population, which is also the target at the end of 2016; however, there has been a notable increase in HIV positive cases in the country. The National Epidemiology Center of the DOH monitored that for the period 1984 to April of 2013, there were 13,179 HIV positive reported cases, out of which 1,253 were AIDS cases resulting to 353 deaths. In 2011, there were 2,349 reported cases and it rose by 989 cases or 42% in 2012. For the first four months of the current year, reported cases already reached 1,477, exceeding the 1,032 cases, by 445 cases or 43%, for the same period last year. By gender, majority of the accumulated cases, comprising

11,480 or 87%, were males; while, by age group, 25-29 had the most number of cases with 30%, followed by 20-24 with 22% and 30-34 with 19%. There were also 62 cases involving children, those below 15 years old, and 3,228 cases affecting the youth, those aging 15 to 24 years old. In terms of geographical location, more than half (51%) of the cases came from the National Capital Region; and, 17% of the total reported cases were HIV positive OFWs. Based on the data of DOH, the most common mode of HIV transmission is sexual contact, which could be homosexual, heterosexual or bisexual; but, transmission is likewise possible by other modes like needle-sharing among injecting drug users, mother-to-child transmission and transmission through blood/blood products.

In terms of health insurance, 100% of the population is targeted to be covered by and enrolled under the NHIP by 2016. In 2011, the goal was set at 85% but only 82% were actually enrolled; while, in 2012, the goal was 90% and as of May 2012, the enrolment rate was at 85%. The current effort of the government is not purely concerned with the number of enrolees in the NHIP, but includes improvement in health benefit-packages and increasing access to such health facilities. For instance, the P8.5 Billion or 243% increase, from P3.5 Billion to P12.0 Billion, in premium subsidy for indigent families enrolled under the NHIP in 2012 was not directly intended for the additional indigent families to be enrolled under the sponsored program.

The augmentation in the budget was for the national government to shoulder in full the premium requirements of those enrolled in the sponsored program, instead of waiting for the LGUs to provide their counterparts before the sponsored program beneficiaries could enrol with Philhealth. In effect, the beneficiaries of the sponsored program could readily enrol with the Philhealth at the beginning of the year. Indirectly, the LGUs were freed of their obligation to provide for counterpart funding for the sponsored program, and such savings should have enabled the LGUs to enrol their constituents who belong to the next poorest quintile of the population, which, if done, will likewise pull the enrolment rate and the coverage rate up.

The increase in subsidy likewise covered the increase in premium from P1,200 to P2,400 per annum for the sponsored program. Such increase in premium allowed the Philhealth to come up with improved health benefit-packages, like the case rates scheme and the no balance billing policy for the sponsored program beneficiaries. However, the improved health benefits cannot be enjoyed in the absence of accredited health care facilities, especially in areas where the sponsored program beneficiaries are located; thus, the Philhealth was also encouraged to fast-track the accreditation of health care providers in order to increase the utilization of available health benefits.

Health is just one facet of the government's social service function, wherein each element is somewhat inter-related with the others. Thus, an effort in one aspect could likewise

affect the others. For instance, the conditional cash transfer (CCT) program of the Department of Social Welfare and Development (DSWD) sets forth health-related conditions, namely, pre-natal and post-natal care for mothers and immunization, deworming, weight monitoring, nutrition counselling and disease management services for children. The DOH, in turn, provides technical support for the program, such as the deployment of health workers and the supply of vaccines, deworming tablets, as well as the distribution of Philhealth cards, in the CCT areas.

Conclusion and Recommendation

Health is everyone's concern, whether you belong to the higher or lower brackets in the hierarchy of wealth. One significant difference between the rich and the poor when it comes to health is that the former can easily afford to pay for their health needs, and this is the reason why the government should intervene and provide health assistance to the less privileged members of the population.

Health service delivery is not merely the responsibility of the national government. It is also an obligation of the local government units, considering that health service is a devolved function and the local officials are supposedly more aware of the health situation of their respective constituents. Let us not ignore the reality that the unavailability of sufficient fund is a perennial obstacle, despite the increasing health expenditure, for both the national and local governments. We cannot likewise blame the people when they perceive that health service has been neglected by the government.

In recent years, the efforts of the national government to improve health service delivery can be seen through the programs of the DOH, like the health facilities enhancement program, the modernization of regional hospitals, the provision of premium subsidy for indigents enrolled in the NHIP, the national pharmaceutical policy development, the expanded program on immunization, the elimination of various diseases and others. Ideally, these efforts, particularly those involving infrastructure, should actually be implemented and should not remain as objectives for purposes of budget deliberations, in as much as for every budget item that is given priority a corresponding sum of money is also set aside. It would be unjustifiable for those depending on the government for health service and for the other programs of the government which are not given the same priority if at the end of the year a considerable portion of the health budget will end up unused or unobligated, or worse, reverted to the national coffers as savings. The execution of infrastructure projects is understandably more difficult but a well thought out plan, more often than not, will lessen such difficulty.

The initiative to improve the health condition, initially, of those belonging to the poorest segment of the population through the CCT program of the DSWD is at least

a step forward. Healthy children could lead to increased attendance in school, which in the long run could produce more qualified human resources for the economy. Besides, a healthy population could mean lesser health expenditure in the sense that the expense to maintain health is normally lower than the expense to treat or cure an illness to regain health.

The undertaking to upgrade health facilities should be underscored if the government aims to enable health care facilities to adequately cater to the needs of the people and to inspire the health workers/professionals working therein to adequately provide the services which they are required to deliver. Of course, these human health resources should likewise be equipped with sufficient skills and training in order to cope with the requirements of their jobs, and they should likewise be properly compensated to prevent them from leaving our health care facilities.

With the foregoing in mind, who knows, the "Mona Lisa" lyrics that was used to refer to a hospital would be replaced with that of "Amie" which says "*tell it like you still believe that the end…brings a change for you and me*" to refer to the hope that one day, we will achieve the kind of health care system that we all dream of.

This article was written by Atty. Noemi S. Sabornido, Supervising Legislative Staff Officer II, with the supervision of Director Mercedita F. Urbano and under the over-all guidance of Director-General Yolanda D. Doblon of the Legislative Budget Research and Monitoring Office . The views and opinions expressed in this article are those of the author and do not necessarily reflect the views or any policy initiatives of the Senate, its leadership, or its individual members.

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