Towards Expanding Access to Health Care Services: A Policy Simulation of the Aquino Health Agenda in the Philippines

フィリピン大統領に就任したアキノ３世は医療サービスを充実させるという「アキノ・ヘルス・アジェンダ」を公表した。その効果を検証する。

Rachel Lynn Y. Belandres[1]

[1] Instructor, School of Economics, University of Asia and the Pacific, Philippines

Abstract

The Aquino Health Agenda was developed to address the problem of accessing health care services in the Philippines. To determine if these policies are really pro-poor and cost effective, the study simulated the effects of the Aquino Health Agenda policies in expanding access to health care services, specifically in increasing the number of live births attended by skilled health personnel in the Philippines in terms of equity and efficiency. The two Aquino Health Agenda policies that were simulated using Benefit Incidence Analysis (BIA) and Cost Effectiveness Analysis (CEA) are (1) upgrading health facilities under the Health Facilities Enhancement Program (HFEP) and (2) expanding health insurance coverage under the National Health Insurance Program (NHIP).

The results reveal that when it comes to equity, expanding health insurance coverage is more pro-poor than upgrading of health facilities in ARMM, Eastern Visayas, and Bicol Region. On the other hand, when it comes to efficiency or cost-effectiveness, expanding health insurance coverage is more cost effective in Eastern Visayas, while upgrading of health facilities is more cost effective in ARMM and Bicol Region. However, it is still highly recommended that both policy options be implemented by the Aquino administration in the said regions, since they complement each other.

Keywords Policy Simulation, Aquino Health Agenda

Introduction

Human development is essential to every individual. It is the “process of enlarging people’s choices and building human capabilities, enabling them to live a long and healthy life, have access to knowledge, have a decent standard of living and participate in the life of their community and the decisions that affects their lives[1)]” as defined by the United Nations and Development Programme (UNDP). Based on the given definition of UNDP, one component of human development is health, which involves the longevity and nutrition needs of persons. This is the reason health organizations advocate for improvements on health services and for the achievement of health-related Millenium Development Goals (MDGs) all over the world. Access to health care services is one method that can lead to positive health outcomes and, eventually, to human development.

For some developing countries, however, access to health care services continues to be a problem, particularly among the poor and marginalized. In the Philippines, families from the poor income class, who are estimated to be 10.8 million[2], are the ones who mostly experience difficulty in gaining access to health care services. Based on the 2008 National Demographic and Health Survey (NDHS) of the National Statistics Office (NSO), the top five problems that Filipinos in the lowest quintile face in relation to accessing health care services are: (1) getting money for treatment (74.0% of respondents), (2) concern that no drugs are available (71.0%), (3) distance to health facility (57.8%), (4) having to take transport (56.1%) and (5) concern that no provider is available (54.0%). The majority of the problems mentioned indicate financial concerns of the poor, low accessibility of the poor to health care services, and infrastructure and equipment problems of health facilities. This signifies that problems in accessing health care services are multidimensional.

One reason the poor face these problems in accessing health care is the insufficiency of their average monthly income amounting to 3,460 pesos[3] to cover for their basic needs. As this is the case, those of the lowest quintiles are often left to decide whether to seek medical treatment at the expense of missing meals, foregoing the education of their children, or facing financial ruin and destitution. Another reason is that the average travel time of the poorest quintile to the nearest health facility or provider is about 46.8 minutes, while that of the highest quintile is about 34.6 minutes.[4] This difference of 12.2 minutes, or almost quarter of an hour, can mean a matter of life and death. This may result from geographical barriers causing long distances between the home of the poor and the health facility. Or there may be problems on transportation going to the health facility.

To improve access to health care services, the government should intervene to achieve efficiency and equity in the provision of health care services. They can tackle either the financial problems of the poor, the infrastructure and equipment problems of health facilities, or the low accessibility of the poor to health facilities. With this, they can adopt multidimensional policies, which are complementary, in addressing problems related to access to health care. Some solutions for the problems the poor face in accessing health care services are expanding health insurance coverage and upgrading health facilities. Expanding health insurance coverage can protect the poor from financial risks. On the other hand, upgrading health facilities can lead to the expansion of health facilities to rural areas, where the majority of the poor are, and improvements in infrastructure and equipment, which are essential to the provision of quality health care.

In the Philippines, the Department of Health (DOH) has drafted different reforms throughout the years to achieve three primary health goals: (1) better health outcomes, (2) more responsive health system and (3) more equitable health financing. Among these reforms are the Primary Health Care approach in the late 1970s, the Generics Act in the late 1980s, the devolution of health services in the early 1990s, the National Health Insurance Act in 1995, and the Health Sector Reform Agenda (HSRA) in the late 1990s.[5]

In 1999, the DOH drafted general policies for health through the Health Sector Reform Agenda (HSRA). It was only in 2005, however, when then-Secretary of the DOH Francisco T. Duque III, together with other members of the DOH, formulated the Formula One for Health (F1), a new implementation framework based on the HSRA. "F1 focuses on cost-effective interventions which can create the most impact, while maximizing limited health resources and generating buy-in from all potential partners." Its objective is to concentrate on health care financing, health regulation, health service delivery and good governance.[6]

This commitment of the Philippine government to health reform was solidified through a declaration of the newly elected President Benigno S. Aquino III during his inaugural address on June 30, 2010, to improve public health services within the next three years[7] By December 16, 2010, the DOH released Administrative Order No. 2010-0036 (AO2010-0036), entitled "The

Aquino Health Agenda: Achieving Universal Health Care for All Filipinos," which provided the initial steps to achieve universal health coverage.

The Aquino Health Agenda is considered to be a more focused implementation framework, based from the HSRA and F1. This first administrative order highlighted three main "strategic thrusts." First, there is to be the rapid expansion in enrollment and benefit delivery of the National Health Insurance Program (NHIP) for the poorest families, who are part of the National Household Targeting System for Poverty Reduction (NHTS-PR) of the Department of Social Welfare and Development (DSWD). Second, there is to be accelerated upgrades for public health facilities in order to improve access to quality hospitals and health care facilities under the Health Facilities Enhancement Program (HFEP). Finally, in order to attain health-related MDGs, additional effort and resources are to be applied in localities with high concentrations of families who are unable to receive critical public health services.

The mentioned policies under the Aquino Health Agenda are crucial in the expansion of access to health care services in the Philippines, especially to those regions that have high percentage shares both in the total number of NHTS-PR families and in the total number of health facilities to be upgraded, such as Autonomous Region in Muslim Mindanao (ARMM), Eastern Visayas, and Bicol Region. The reality is that government resources for health are limited, yet the health care needs of people should be prioritized as a requirement. Thus, this study simulated whether government spending on the policies under the Aquino Health Agenda has positive effects in expanding access to health care services in terms of distribution of benefits or equity, and in terms of cost effectiveness or efficiency. This study simulated only the first two strategic thrusts of the Aquino Health Agenda, which are the upgrading of health facilities under the HFEP, and the expansion of health insurance coverage under the NHIP. Moreover, analysis was done for the following Philippine regions only: ARMM, Eastern Visayas, and Bicol Region.

Methodology

Two empirical frameworks were used in this study to determine if government spending on the policies under the Aquino Health Agenda has positive effects in expanding access to health care services in ARMM, Eastern Visayas, and Bicol Region in terms of equity and in terms of efficiency. These frameworks were the Benefit Incidence Analysis (BIA) and the Cost Effectiveness Analysis (CEA). The BIA was used to measure the impact of the Aquino Health Agenda policies in expanding access to health care services in the said regions in terms of equity. On the other hand, the CEA was implemented to determine the impact of the said policies in expanding access to health care services in the mentioned regions in terms of efficiency.

The BIA is a tool used to measure the distributional incidence of benefits of public spending on a certain service for different groups of households (usually income and expenditure groups) in a certain nation or area.[8)] In this study, the BIA was implemented to determine if government spending on upgrading health facilities (HFEP) and on expanding health insurance coverage (NHIP) in ARMM, Eastern Visayas and Bicol Region are pro-poor, which signifies that the actual share of the poor in total government spending on the mentioned policies are higher than the ideal share. Ideal share refers to equal sharing of benefits among income groups. In addition, the BIA was implemented in this study to find out if poor households in the mentioned regions have higher shares in total government spending on the two health policies as compared to their total income.

Total government spending on the two Aquino Health Agenda policies, shares of the poorest income group in total subsidy, the suits index and the Gini coefficient, and subsidy rates[9)] were used to analyze the results of the BIA.

The suits index is the most common summary measure of the distribution of benefits (government spending) across income groups. On the other hand, the Gini coefficient is the most common summary measure of the distribution of income across income groups.

If the suits index is negative, this signifies that government spending on each of the Aquino Health Agenda policies is pro-poor or progressive in absolute terms. On the other hand, if the suits index is positive, this implies that government spending on each of the Aquino Health Agenda policies is not pro-poor or regressive in absolute terms. Moreover, if the suits index is algebraically less than the Gini coefficient, this means that the poorest group gets a larger share of benefits from government spending on the two Aquino Health Agenda policies than from their total income. This also signifies that government spending is progressive in relative terms. On the other hand, if the suits index is algebraically more than the Gini coefficient, this signifies that the poorest groups gets a smaller share of benefits from government spending on the two policies than from their income. This also implies that government spending is regressive in relative terms.

The CEA, on the other hand, is an empirical framework used to evaluate social intervention programs according to both their costs and their effects with regard to producing an expected outcome.[10] It is essential in this study, since it can be a guide to government officials in determining which programs can be implemented with higher effectiveness at the same time, with the least cost.[11]

In computing the cost-effectiveness ratio of HFEP and NHIP in this study, the costs of each program were divided by the effectiveness data, which is the measure for the outcome or effectiveness of a program. Number of live births attended by skilled health personnel was used as effectiveness data in this study, since the Philippines has a low probability of achieving the fifth millennium development goal of improving maternal health in 2015, and at the same time, most of the equipment under the HFEP are related to improving maternal health.

After computing for the cost effectiveness ratios of both HFEP and NHIP, the estimated ratios of both programs were compared with each other. For a program to be cost effective, it needs to have the least cost in its implementation, and at the same time, greater effects in influencing expected outcomes. This implies that the program that will have a lower cost-effectiveness ratio will be the most cost effective or the most efficient program in expanding health care services, specifically in increasing the number of live births attended by skilled health personnel in ARMM, Eastern Visayas, and Bicol Region.

Results and Discussion

Based on the benefit incidence results, expanding health insurance coverage is more pro-poor compared to upgrading health facilities in ARMM, Eastern Visayas, and Bicol Region. In terms of budget, the NHIP has a higher amount compared to the HFEP in all mentioned regions. In real terms, the NHIP has budgets equivalent to 663.280 million pesos, 598.573 million pesos and 626.515 million pesos for ARMM, Eastern Visayas and Bicol Region respectively. On the other hand, the HFEP has respective budgets equal to 23.070 million pesos, 75.037 million pesos and 57.811 million pesos only for ARMM, Eastern Visayas and Bicol Region.

On the other hand, in terms of percentage distribution of health subsidy, the shares of the first and the second income deciles have increased when the NHIP budget is added to the government spending on health in ARMM (from 23.46% to 47.55%), Eastern Visayas (from 21.48% to 40.08%), and Bicol Region (from 19.89% to 34.51%) in 2012, while they have remained the same when the HFEP budget is added. However, it is expected in the future that the shares of the poor income deciles in the total health subsidy will increase with the inclusion of the HFEP budget, since more health facilities, especially rural health units and barangay health stations, signify a greater probability that the poor will have greater access to health care services.

In terms of the suits index, government spending on total health in ARMM, Eastern Visayas, and Bicol Region in 2012 is progressive both in absolute and relative terms when both the HFEP and the NHIP budgets are added (as shown in Table 1). In addition, the

suits indices of total health spending when the NHIP budget is included are more negative compared to the suits indices of total health when the HFEP budget is added. This implies that the poor have higher shares in government spending on all health facilities including the NHIP budget in all selected regions in the Philippines in 2012 than in government spending on all health facilities including the HFEP budget.

In terms of subsidy rates, the inclusion of both HFEP and NHIP on the government spending on health in ARMM, Eastern Visayas, and Bicol Region in 2012 has contributed to the increase of the percentage share of health subsidy in covering the expenses of the poor, who are persons from the first and second income deciles (as shown in Tables 2, 3, and 4). However, NHIP has a higher contribution in the increase of the percentage share of health subsidy in covering the expenses of the poor than HFEP.

This is expected, given that NHIP is meant to benefit only the poor-income deciles, while HFEP benefits all income deciles. The reason for this is HFEP is aimed to improve the supply side of the health sector, while NHIP is implemented to develop the demand side. It is easier for the government to target the poor in the demand side compared to the supply side, since it is clear that the poor are the ones who are in need of health insurance, while there are a lot of leakages or inefficiencies in upgrading of health facilities. Leakages in the supply side imply that there is no assurance that the investments on the upgrading of health facilities will target the real needs of the poor, since the rich also have access to public health facilities.

Because of this, the effect of NHIP on benefitting the poor is greater compared to that of HFEP. Thus, government spending on expanding health insurance coverage is more beneficial to the poor than government spending on upgrading health facilities in expanding access to health care services, specifically in increasing the number of live births attended by skilled health personnel.

On the other hand, based on the results of the cost effectiveness analysis, ARMM has HFEP or upgrad-

Table 1 Suits Indices of Government Spending on Health

Region	Suits Index (Without Policy Intervention)	Suits Index (HFEP)	Suits Index (NHIP)	Gini Coefficient
ARMM	-0.445013	-0.445013	-0.740006	0.294824
Eastern Visayas	-0.335455	-0.335455	-0.592664	0.484084
Bicol Region	-0.285559	-0.285559	-0.511455	0.416391

Source: National Statistics Office (NSO) and Author's computations

Table 2 Subsidy Rates of Government Hospitals on the First Income Decile

Regions	Without Policy Intervention	With HFEP Policy	With NHIP Policy
ARMM	0.3001%	0.3334%	3.3342%
Eastern Visayas	1.2082%	1.3559%	4.9004%
Bicol Region	1.4267%	1.5378%	4.3656%

Source: NSO and author's computations

Table 3 Subsidy Rates of Rural Health Units on the First Income Decile

Regions	Without Policy Intervention	With HFEP Policy	With NHIP Policy
ARMM	0.5772%	0.6379%	6.4122%
Eastern Visayas	1.7001%	1.9736%	6.8956%
Bicol Region	1.2718%	1.3724%	3.8914%

Source: NSO and author's computations

Table 4 Subsidy Rates of Barangay Health Stations on the First Income Decile

Regions	Without Policy Intervention	With HFEP Policy	With NHIP Policy
ARMM	0.3528%	0.4585%	3.9195%
Eastern Visayas	0.7776%	0.9170%	3.1538%
Bicol Region	0.9581%	0.9993%	2.9315%

Source: NSO and author's computations

ing health facilities more cost effective than NHIP, since HFEP in ARMM has a cost effectiveness ratio of 340,638.570 pesos per live birth attended by skilled health personnel, while NHIP in the said region has a cost effectiveness ratio of 452,281.812 pesos per live birth attended by skilled health personnel. This is due to the fact that the number of live births attended by skilled health personnel as a result of HFEP is higher than that of NHIP. This implies that less cost is incurred in HFEP in increasing the number of live births attended by skilled health personnel in ARMM as compared to NHIP.

On the other hand, in Eastern Visayas, NHIP or expanding health insurance coverage is the most cost effective, since NHIP in Eastern Visayas has a cost effectiveness ratio of 32,903.82 pesos per live birth attended by skilled health personnel, while HFEP in the said region has a cost effectiveness ratio of 67,923.95 pesos per live birth attended by skilled health personnel. This is due to the fact that Eastern Visayas has the highest share in the total number of health facilities under HFEP in the Philippines, and thus, the said region has a high cost of upgrading health facilities. Because of this, HFEP costs in Eastern Visayas will be higher compared to the NHIP costs. This also implies that higher cost is incurred in HFEP in increasing the number of live births attended by skilled health personnel in Eastern Visayas as compared to NHIP.

In Bicol Region, HFEP or upgrading health facilities is the most cost effective, since HFEP in Bicol Region has a cost effectiveness ratio of 20,056.66 pesos per live birth attended by skilled health personnel, while NHIP in the said region has a cost effectiveness ratio of 24,979.86 pesos per live birth attended by skilled health personnel. This is due to the fact that NHIP costs are higher in Bicol Region as compared to HFEP costs. This implies that lower cost is incurred in HFEP in increasing the number of live births attended by skilled health personnel in Bicol Region as compared to NHIP.

Conclusion

Not everyone, especially the poor, has easy access to health care products and services. Thus, government intervenes in health care spending in different ways to achieve human development for all persons, and equity and efficiency in the health sector. At present, the Philippine government intervenes in the health care sector through the implementation of the Aquino Health Agenda with its three strategic thrusts of upgrading health facilities, expanding health insurance coverage and attaining health-related Millenium Development Goals (MDGs) in 2015.

At the national level, it is expected that expanding health insurance coverage is more pro-poor and more cost effective than upgrading of health facilities. Expanding health insurance coverage is more pro-poor, since targeting the poor on the demand side is easier as compared to doing so on the supply side. It is also more cost-effective, since upgrading of health facilities is more costly when it comes to implementation as compared to expanding health insurance coverage. This is also triggered by a lot of investments on infrastructure, equipment, and sustained provision of quality health care services in the upgrading of health facilities. When it comes to pro-poorness, results of the regional simulations reflect that of the national level. This signifies that in all selected regions in the Philippines, expanding health insurance coverage is more pro-poor compared to upgrading of health facilities. However, when it comes to cost effectiveness or efficiency, results vary across regions, and results in some regions do not reflect what is expected at the national level. This is mainly caused by the following factors: (1) number of health facilities under HFEP per region, (2) number of NHTS-PR families per region, and (3) health outcomes per region, specifically the number of live births attended by skilled health personnel per region. However, other factors which are beyond the scope of this study might affect the differences in the cost effectiveness results of the regions, like institutional and political factors, socio-economic factors, etc. When it comes to pro-poorness, expanding health insurance coverage is more pro-poor than the upgrad-

ing of health facilities in ARMM, Eastern Visayas, and Bicol Region. This implies that if the government aims to achieve equity in expanding access to health care services, specifically in increasing the number of live births attended by skilled health personnel in all selected regions in the Philippines, then they should concentrate on expanding health insurance coverage under NHIP. However, the effort to be placed in the implementation of NHIP might differ among the selected regions in the Philippines, since NHIP might be more pro-poor in some regions compared than in other regions. It depends on the circumstances of each region and on the total poor and vulnerable covered by health insurance. For example, based on the results of benefit incidence analysis, the poor in ARMM and Eastern Visayas are the ones who greatly benefitted from NHIP as compared to Bicol Region. This means that more effort in implementing NHIP should be done in Bicol Region.

On the other hand, when it comes to efficiency or cost-effectiveness, expanding health insurance coverage is more cost effective than upgrading of health facilities in Eastern Visayas, while upgrading of health facilities is more cost effective than expanding health insurance coverage in ARMM and Bicol Region. This implies that if the government aims to achieve efficiency in increasing the number of live births attended by skilled health personnel in Eastern Visayas, then they should focus on expanding health insurance coverage under NHIP. On the other hand, if the government aims to attain efficiency in achieving the policy goal in ARMM and Bicol Region, then they should focus on upgrading health facilities.

Conflicts in implementation, however, might occur when the government wants to achieve both equity and efficiency in expanding access to health care services in some regions. For example, in ARMM and Bicol Region, expanding health insurance coverage is more pro-poor or equitable than upgrading of health facilities in expanding access to health care services, while upgrading of health facilities is more cost-effective or efficient than expanding health insurance coverage. It might be difficult to implement both policies at the same time, since this may lead to inefficiencies. Implementing both policies simultaneously in a specific region might lead to inefficiencies, since the government might not be concentrating on the essential need of the region, which might be more on upgrading of health facilities than on expanding health insurance coverage and vice versa. In this case, the government still needs to determine the specific circumstances of each region, especially in terms of health conditions, so as to determine which of the two policies should be prioritized by the government in the regions that have conflicting results like ARMM and Bicol Region.

Despite the possible occurrence of inefficiencies, it is still highly recommended that both policy options be implemented by the Aquino administration in the said regions, since they are complementary with each other. Also, they address different problems in accessing health care services or in increasing the number of live births attended by skilled health personnel. Upgrading health facilities is beneficial in addressing the problem of low accessibility to health facilities of the people, especially of the poor and the physical problems of health facilities. On the other hand, expanding health insurance coverage is essential in addressing the financial problems of the poor in accessing health care services. In addition, the two mentioned policies are complementary, since upgrading health facilities addresses the supply side of the health sector, while expanding health insurance coverage addresses the demand side. Thus, there is not much impact on the achievement of the policy goal, if only one of the two policy options will be implemented. If upgrading health facilities is the only policy option to be implemented, the poor still face monetary issues, such as paying for the fare going to the health facility and paying for the expenses on health consultations, medicines and other medical expenses. Conversely, if expansion of health insurance coverage is the only policy option to be implemented, the poor can receive treatment, since health insurance can cover for the medical expense, but if there is lack of infrastructure, equip-

ment, medicine stocks and staff within health facilities, then they still cannot have access to health care services. Thus, if both policy options are implemented, then great expansion of access to health care services, specifically, a high number of live births attended by skilled health personnel can be achieved in ARMM, Eastern Visayas and Bicol Region. However, in implementing both policies, the government should take note the specific circumstances of each region, so that they can truly determine what policy they should give more bearing in each of the regions.

Recommendations

Based on the findings and conclusions, the following recommendations are hereby presented:

The government can focus on upgrading health facilities in ARMM and Bicol Region, if their aim is to achieve cost efficiency only in obtaining the policy goal, while they can concentrate on expanding health insurance coverage, if their objective is to attain equity only. On the other hand, they can fully focus on expanding health insurance coverage in Eastern Visayas to achieve both cost efficiency and equity in increasing the number of live births attended by skilled health personnel. The difference in the results of Benefit Incidence Analysis and Cost Effectiveness Analysis among the three regions may be attributed to factors like poverty conditions, geographic location of health facilities, social status of the users of health facilities, number of health facilities, allotted regional government spending, allotted regional HFEP and NHIP budget, total income and expenditure, health conditions, etc. This signifies that the national government should take into consideration the circumstances of the different regions in the Philippines in implementing health policies, so that they can determine what policy they should focus on within a certain region. One way they can do this is through consultations with the members of the health care sector, such as doctors, nurses, midwives, medical technologists, etc. The reason for this is that members of the health care sector are the front liners in providing health care products and services, and thus, they are familiar with the existing problems in accessing health care products and services in different areas.

In ARMM, the poorest of the poor or the first income decile are the ones who mostly access rural health units and barangay health stations, but not government hospitals without NHIP. Because of this, the government should make sure that the poor will receive health insurance, so that they can afford to pay for complex services in government hospitals. With this, the share of the poorest income decile in government spending on government hospitals will increase. Also, HFEP is more cost effective than NHIP in ARMM, based on the results of cost effectiveness analysis. To further strengthen the cost effectiveness of HFEP in increasing the number of live births attended by skilled health personnel or in increasing the number of live births in health facilities, public health facilities should be located in the poor areas like the Conditional Cash Transfer (CCT) sites, which are selected by the Department of Social Welfare and Development (DSWD).

In Eastern Visayas, the poorest of the poor or the first income decile are the ones who mostly access rural health units and barangay health stations, but not government hospitals without NHIP. Also, NHIP is more cost effective than HFEP in Eastern Visayas, based on the results of cost effectiveness analysis. Because of this, the government should make sure that the poor will receive health insurance, so that the poor can afford to pay for complex services in government hospitals. With this, the share of the poorest income decile in government spending on government hospitals will increase. Also, this will improve the cost effectiveness of NHIP in the said region.

In Bicol Region, the first income decile greatly benefits from all public health facilities with or without HFEP and NHIP. However, if the Aquino Health Agenda aims to achieve universal health coverage, then both HFEP and NHIP should still be implemented to catalyze the attainment of the said goal.

However, to really increase the probability of

attaining the policy goal, the government should implement both policy options of upgrading health facilities and of expanding health insurance coverage to all regions in the Philippines. If they really want to increase the number of live births attended by skilled health personnel, they have to address the top three problems of accessing health care: financial problems of the poor, geographical barriers and physical problems of health facilities. Also, there should be an alignment in the implementation of the two mentioned policies by focusing on sites, where majority of the poor are, like the Conditional Cash Transfer (CCT) sites as determined by the Department of Social Welfare and Development (DSWD). However, the government should still consider the circumstances of each region, since there are regions, especially the highly urbanized ones that have enough health facilities, but still cannot access health facilities due to high out-of-pocket spending. Because of this, the government should concentrate more on expanding health insurance coverage in these regions than on upgrading of health facilities. On the other hand, regions that are mostly rural have problems with shortages of health facilities. Thus, the government can focus on upgrading health facilities in the said regions rather than on expanding health insurance coverage.

In addition, to further strengthen the implementation of the two mentioned policy options, the government can implement methods that can improve private sector participation in the health care sector. Private sector participation can improve efficiency and equity in the health care sector by building more health facilities that can cater to those who belong to the middle and rich income deciles, since they can afford to pay for health care products and services. Through this, public health facilities can focus on providing services to the poor deciles. In addition, private sector participation can spur competition among health facilities, and through competition, all health facilities, both public and private, will be pressured to improve the quality of health care services that they provide. Some ways that can strengthen private sector participation are through public-private partnerships in the construction and upgrading of public health facilities, through increased capitation funds provided by the government to private health facilities from health insurance, and through the construction of more public health facilities in rural areas. The increased capitation funds from health insurance will incentivize the private sector to provide quality health care services. On the other hand, the construction of more public health facilities in rural areas can induce investments from the private sector, such as construction of more private health facilities and drug stores.

The government can also review the governance structure of the Department of Health in implementing health policies. The implementation of some health policies, like the upgrading of health facilities, is currently devolved to the local government units (LGUs). This might induce problems in the implementation of health policies, since some LGUs might lack the absorptive capacity to implement health policies.

For the members of the health sector, they should provide inputs to the government as regards problems in the health sector and the possible solutions in addressing these problems, so that health policies can be directed in attaining the real policy goals in the sector.

For the academe and economists, they should employ research to determine the possible outcomes of the government's health policies. The results of their research can also serve as an aid to the government in drafting health policies. This is one reason why the academe and the government should collaborate with each other. The government can provide data and other information regarding their policies to the academe and economists, while the academe and economists do the policy simulations.

Footnotes

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