Decisions on the allocation of scarce resources for health are rarely made by governments - or their development partners - purely on the basis of technical criteria. Political and other factors also shape decision-makers’ choices. This is particularly apparent in the Philippines, which has demonstrated that strong and shrewd political leadership can legislate to provide essential reproductive health and family planning, and raise taxation on tobacco to fund health care, despite decades of opposition from vested interests. These and other reforms will help improve reproductive, maternal, newborn and child health (RMNCH). But other political economy challenges remain.

Strategic context

The Philippines has recorded many RMNCH achievements. Under-five, and infant, mortality rates have fallen from 80 and 57 per 1000 live births respectively in 1990 to 30 and 22 per 1000 live births in 2011. The Philippines is therefore likely to meet the MDG 4 target. Universal Health Coverage (UHC) is being scaled up rapidly, partly funded by a politically astute move by the nation’s President to increase taxes on tobacco and alcohol and use the funds on UHC. The health sector has attracted a particularly rapid and sustained increase in budgetary resources, albeit from a small base. Importantly, the Department of Health (DoH) also attracts an important share of total Government expenditure; proxy evidence of increased political priority and commitment from Government.

On the other hand, it appears that the maternal mortality ratio has worsened from 209/100,000 live births in the early 1990s to around 221/100,000. Whether this is due to better recording, or deterioration in the situation, is unclear. What is clear is that the Philippines is a long way from achieving the Millennium Development Goal target of reducing maternal mortality by three quarters between 1990 and 2015. In a related point, the contraceptive prevalence rate is still only around 50%, with little sign of improvement. Recently passed legislation may help address this problem. Neonatal mortality is 14/1000 live births, also with little progress. Inequity in access and outcomes of essential health services also remains a major challenge.
Key messages

Directly affecting the health sector and RMNCH is the level of government expenditure on health. The significant increase in budget allocation to the DoH in 2014 needs to be put in perspective, especially in a country like the Philippines whose population is now 100 million. The national budget allocation of P83.7 billion ($1.8 billion) is still an average of only P830 (around $18.75), government expenditure per person per year. This is still much lower than the (now dated) $34 figure set by the WHO Macroeconomics and Health report as an estimated minimum public expenditure on health even for low income countries. It is also lower than the updated estimate of $54 per person per year estimated by the high profile Taskforce on Innovative Financing in Health (1). And it is less than a quarter of the $86 per person per year that the recently released Chatham House report on health financing recommended all governments in developing countries should be spending on health.(2)

From a political economy perspective, health insurance institutions are now as important as Ministries of Health in determining health access and outcomes in Asia. Development partners who consider the Ministry of Health as their main counterpart need to now engage strategically with social health insurance institutions as Universal Health Coverage (UHC) expands. But the challenges should not be underestimated. Governments will need to raise, pool, and spend funds in ways that are efficient, equitable, and financially sustainable: all aspects that involve political economy challenges. Expenditure levels – and incentives for what that money will be spent on – will change under UHC. Payments for curative treatment or end of life care in tertiary hospitals, or for fee for service diagnostic tests by private doctors will have a different socio-economic impact than expenditure on promotive and preventive health in primary and secondary care settings. Unless carefully designed and monitored, this could see diversion of funds away from RMNCH and public health.

This is important in the Philippines which is quite well advanced in providing a level of UHC financing to its population through an insurance fund. PhilHealth, which now covers around 82% of the population, is therefore a major strategic opportunity to influence nation-wide access to health care that can benefit the poor, including women and their children. UNICEF has already been influential in making the benefits package for newborn care more focused on primary and preventive health care, thereby making the program more evidence based, affordable and cost-effective for society and individual households. This is an important example of a development partner adapting to the needs of a country as the political economy of an issue evolves.

Field visits to Davao city and in Manila confirm that planning and ‘evidence’ does not exist in a vacuum. The capacity of evidence to influence priorities, plans and budgets is context specific. Key factors to assess whether ‘evidence’ will influence decision makers is to assess ‘what evidence’, ‘whose evidence’, ‘when does the evidence arrive’ and ‘how is it presented’. The “new and innovative” can often displace the “proven and essential”. The private sector is often overlooked in planning and priority setting. The unplanned and unexpected can completely overwhelm all planning: Super Typhoon Haiyan/Yolanda is one example that completely – and appropriately given the scale of the problem – overturned plans and priorities of Government and development partners. Good downstream implementation can be more important than upstream planning. Good plans, involving extensive analysis and consultations, have been abandoned part way through the year as a result of mis-procurement or slow release of funds.

Field visits also confirmed that the UNICEF-supported evidence based planning and budgeting approach has been instrumental in mobilising additional and better targeted resources to address severe acute malnutrition at city-wide level in Davao. But there are challenges in planning under a decentralised system. Upstream evidence based planning that advocates for increased expenditure becomes irrelevant if downstream capacity to manage implementation and procurement are weak in local government units.

Decentralisation and increased autonomy for Local Government Units can benefit public health. But autonomy and devolved resources can also facilitate patronage. “Champions” can be important advocates. But that cuts both ways as well: autonomy has meant that local mayors can block family planning.

Finally, the Philippines provides two rich political economy case studies that demonstrate how, where, when and why reforms that benefit the health of the poor can occur: the Reproductive Health Bill and the “Sin Tax” on tobacco and alcohol that is being used to fund UHC.

References

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1 The Philippines is a lower-middle income country, so could be expected to fund a higher level.