PHILIPPINES POLITICAL ECONOMY ASSESSMENT REPORT

An assessment of the political economy factors that shape the prioritisation and allocation of resources for essential health services for women and children

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February 2015
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Acknowledgements

Special thanks go to Drs Willibald Zeck and Raoul Bermejo III in the UNICEF office, Manila for their assistance in the conduct of the field work and preparation of this report.

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**Acronyms**

- AHA: Aquino Health Agenda
- AIP: Annual Investment Plans
- AOP: Annual Operational Plans
- barangays: village
- CiPH: City-wide Investment Plan for Health
- CPR: Contraceptive Prevalence Rate
- Dependency ratio: The ratio of people below 15 and above 65 years of age to the total population
- DBM: Department of Budget and Management
- DILG: Department of Interior and Local Government
- DOH: Department of Health
- EBaP: Evidence-based planning
- Gini coefficient: A statistical estimate of inequality ranging from zero (no inequality) to 1 (all wealth captured by one person)
- LGUs: Local Government Units
- LPRAP: Local Poverty Reduction Action Plans
- MDGs: Millennium Development Goals
- NEDA: National Economic Development Authority
- NHA: National Health Accounts
- NHIP: National Health Insurance Program
- PPP: Public Private Partnership
- PPP: Purchasing Power Parity
- PhilHealth: Philippines Health Insurance Corporation
- RMNCH: Reproductive, Maternal, Newborn and Child Health
- SAM: Severe Acute Malnutrition (weight for height below –3 z scores of the median WHO growth standard for age)
- SBA: Skilled Birth Attendant
- TFR: Total Fertility Rate
- UHC: Universal Health Coverage

**Currencies and exchange rates**

- 100 Philippine Pesos (PHP) = $US 2.27
- 1 $US = 44.1 Philippine Pesos (PHP)

All $ are current United States dollars unless otherwise shown

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**1 Executive summary**

**Background and methodology**

Decisions on the allocation of scarce resources are rarely made purely on the basis of technical criteria: political and other factors also shape decision-makers’ choices. It is therefore important to understand how and why governments in developing countries – as well as development partners – prioritise and allocate their resources. Decisions that are broadly compatible between technical criteria and political economy needs are then more likely to achieve outcomes that are financially, politically and institutionally sustainable, as well as equitable and of broad public benefit.

Since 2011, the Australian Government has been providing development assistance to improve reproductive, maternal, newborn and child health (RMNCH) outcomes in Bangladesh, Indonesia, the Philippines and Nepal. The approach focuses on improved use of local data in the prioritisation, planning and allocation of resources at district level. The main objective has been to develop, through district-level pilots, an ‘investment case’ to encourage sub-national governments to fund RMNCH as a key area of human development. Australian aid funding was channelled through UNICEF and other partners working with governments at national and district level in each country.

To deepen its understanding of the political economy of health and RMNCH in those four countries, UNICEF undertook an analysis during July-September 2014. Field visits were conducted in the Philippines over 14-26 July 2014. A mixed methodology was used, drawing on recommendations from academia and development experts. A questionnaire was developed based on a review of the relevant peer-reviewed and grey literature. Local data was gathered and interviews conducted in-country. This report provides the findings for the Philippines.

**Situation analysis**

Much of the Philippines’s historically disappointing record of development can be explained by five “Ps” of political economy: politics; political patronage; policies; population and problems specific to the country. More specifically, a political system of “checks and balances”, means that politically difficult but substantial reforms that affect poverty and inequity levels can easily be blocked. Political patronage, occurring at national, regional and local levels, intertwined with ‘money politics’ contributes to poor outcomes. Policy distortions are a third factor explaining the poor record to date. Population growth – itself a reflection of political economy needs are then more likely to achieve outcomes that are financially, politically and institutionally sustainable, as well as equitable and of broad public benefit.

Population growth – itself a reflection of political economy needs are then more likely to achieve outcomes that are financially, politically and institutionally sustainable, as well as equitable and of broad public benefit. The Philippines has a mixed record in terms of the health sector, and RMNCH. On the one hand the 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’ political economy is therefore likely to meet the fourth Millennium Development Goal (MDG) target on young child mortality. 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 additional funds to expand UHC. On the other hand, it appears that the maternal mortality ratio (MMR) has worsened from 209 per 100,000 live births in the early 1990s to around 221. 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 MDG5 target on reducing maternal mortality. In a related point, the contraceptive prevalence rate is still only around 50%, with little sign of improvement. Neonatal mortality is 14 per 1000 live births with little progress. Inequity in access to and outcomes of essential health services also remains a major challenge. For example, around 94% of women with a secondary education or higher use a skilled birth attendant (SBA) compared to only 26% of those with no education.

**The political economy of the health sector and RMNCH**

Recent announcements have given very clear and explicit political commitment to the social sector in the Philippines, and are reflected in the 2013 national budget. The health sector has attracted a particularly rapid and sustained increase in budgetary resources, albeit off a small base. Importantly, the Department (or Ministry) of Health (DOH) also attracts an important share of total Government expenditure. The Administration is also achieving initial successes with a pro-poor conditional cash transfer scheme. However, despite budget increases, increased public expenditure is still needed, especially to address the needs of the poor and vulnerable.

Devolution of planning, resourcing, and service delivery has been a major consequence, and driver, of the political economy of RMNCH in the Philippines. The 1991 Philippines Local Government Code involved sudden, major, devolution of functions to subnational institutions, especially small local government units (LGUs). It was an urgent exercise to redistribute political and economic power in the final months of the Cory Aquino administration which feared a return to dictatorship in the coming elections. Devolution involved major structural changes to personnel and budgets, especially at the DOH. However, in the years since 1991, subnational priority setting (deciding what is important), planning (how implementation will take place, when and by whom), budgeting (determining the costs and sources of financial and other resources) and implementation, all key...
In the Philippines health insurance institutions are arguably committed to the health sector is its scaling up of UHC. Planning and resource allocation and usage. A systematic and easily used driver and monitor of health scorecard system has also introduced an evidence-based, into planning and resource allocation at the national level. A “Bottom-up budgeting” is an effort to systematically facilitate and institutionalise the local needs of poorer communities. Curative treatment or end of life care in tertiary facilities, or diagnostic tests by private doctors have a very high cost and is not covered by UHC. In both cases, least at national level, major challenges raised by religious or moral considerations.

The Philippines government has issued regulations that prohibit the use of contraceptives for women and their children. There is an opportunity for engaging in more evidence-based policy dialogue. Well-done accounts can provide a clear and easily accessible overview of the entire health system including sources and uses of funds by public and private sectors. Interviews confirmed that the evidence contained in the NHA is rarely used by public health advocates in the Philippines or other development partners. This is a lost opportunity for engaging in more evidence-based policy dialogue.

Analysis and recommendations

Several practical lessons were identified about current and future approaches for UNICEF and other development partners in the political economy context of the Philippines, as follow:

- Development partners must understand the political economy incentives and can also skew planning and funding priorities and outcomes, including during natural disasters. More generally, he likelihood that “evidence” will influence local authorities’ priorities, plans and budgets depends on what evidence, whose evidence, when does it arrive and how it is presented. Evidence-based planning (EBP) and allocation of funds, a focus of UNICEF since 2012, are irrelevant if implementation and procurement are ill-suited to increased resources. As with much of South East Asia, the for-profit private sector – whether qualified or not – is a major source of health service delivery, especially for the poor. Yet the coverage and quality of the private sector is often overlooked in planning and prioritising new investments in the health sector.

• Mayors are particularly powerful in the Philippines, but medium and longer term health issues may not align with their short terms of office. UNICEF support for capacity building for Mayors on the benefits of local investment in pro-poor health outcomes, particularly RMNCH, is important. Related workshops for the media, politicians and civil society can also be effective in raising the priority of health issues. Well-informed media coverage is a key factor in shaping public opinion.

• The National Health Accounts (NHAs) of a country are a strategic but often underutilised source of evidence for policy dialogue. Well-done accounts can provide a clear and easily accessible overview of the entire health system including sources and uses of funds by public and private sectors. Interviews confirmed that the evidence contained in the NHAs is rarely used by public health advocates in the Philippines or other development partners. This is a lost opportunity for engaging in more evidence-based policy dialogue.

• Conditionality alone rarely works in social sector financing. This partly because external concessional financing is now a relatively small part of the total public health budget. What does make a difference is the provision of accurate, timely, useful, usable insights into the “how” of reform. The unplanned and unexpected can completely overwhelm all planning; development partners need to be realistic about how effective and durable planning processes are, and retain flexibility.

In summary the Philippines is at an important stage in terms of its political economy. It has a reforming President, a growing economy and an Administration committed to UHC. There are opportunities for development partners to assist the health system so that it increasingly benefits the poor, including women and their children, using data, advocacy and existing lines of influence.
2. Background

2.1 Background and purpose of this report

Social and economic development processes involve much more than technocratic approaches: ‘political economy’ factors usually determine the fate of reforms. This finding is clear from the international literature (1-12). More specifically, how – and why – governments make and implement decisions; prioritise the allocation of scarce financial and human resources; resolve trade-offs; regulate the private sector; achieve accountability; and interact with civil society and development partners is an essential key to understanding the process of international development. Understanding how governments use – or don’t use – evidence to shape policies and prioritise the use of their own scarce resources is also increasingly important. That is particularly true as more and more countries achieve middle income status, albeit with large burdens of poverty (13) and aid programs become progressively smaller.

Development partners need to increasingly understand the political economy of decision making and resource allocation if they are to have impact. Traditional forms of Overseas Development Assistance (ODA) have become relatively less important in much of Asia as those economies expand and some development partners withdraw. For example, total ODA in all sectors now constitutes less than one per cent of government expenditure in Indonesia. While ODA can be helpful and catalytic in supporting reforms, the key to improved outcomes will be how countries prioritise and use their own resources. The ‘country-driven development’ vision of the Paris Declaration and Accra Agenda for Action further point unmistakably to the importance of national planning and budgeting, however uncomfortable that may be for development partners increasingly seeking visibility, ‘quick wins’ and avoidance of corruption from their own aid dollar. Development partners have their own political economy incentives and drivers. Those partners wishing to support more evidence-based priorities and resource allocation decisions by developing country governments must identify more sophisticated – but legitimate – entry points of influence.

Understanding the political economy of Reproductive, Maternal, Newborn and Child Health (RMNCH) is a particularly important issue. That is partly because there remains a large but preventable RMNCH burden globally, including in Asia and the Pacific. 2.5 million children under five died in this region in 2013, 41% of the global burden (14). Understanding the political economy of RMNCH is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes have been successfully implemented at scale in some low income Asian countries decades ago (15). Yet if the scientific evidence base, cost-effectiveness and affordability for improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite the political commitments and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure going to health, and especially RMNCH? How can RMNCH be prioritised and resourced in countries which are rapidly decentralising political and economic decision making to sub-national districts and even to villages? Political economy analysis can help provide insights into these issues for the benefit of governments and their development partners.

This report builds on recent collaborative work between Australia and UNICEF aimed at improving the evidence base for investment decisions for RMNCH in Asia. More specifically, the Australian Government’s aid program funded an initiative –the Investment Case Approach – in Bangladesh, Indonesia, Philippines and Nepal since June 2011. Led by UNICEF and its partners, the goal was to demonstrate a new and systematic way of producing evidence that enables policymakers and planners to: 1) assess the extent to which RMNCH services are equitably distributed, using locally gathered data; 2) identify the constraints hampering the scale-up of cost-effective interventions that affect RMNCH; 3) design realistic strategies to address those constraints and 4) estimate the expected mortality and morbidity impact and costs associated with implementing the strategies proposed. The approach sought to influence national policymakers and other stakeholders, including development partners, by highlighting financing gaps within national health systems and in specific geographic areas, as well as gaps in governance of the health sector. But the approach also focuses on improving the evidence base for sub-national planning and budgeting. That is because some of the greatest RMNCH needs occur in geographically and economically disadvantaged areas, where the evidence and capacity for good decision making is weakest.

UNICEF commissioned this report to better understand the political economy of decision making in the Philippines, with particular reference to RMNCH. This report responds to UNICEF’s and DFAT’s wish to better understand the overarching strategic factors that drive priority setting and resource allocations for RMNCH and the health sector more broadly at both the national and sub-national levels in the Philippines. This can, in turn, then inform UNICEF and other stakeholders how they might need to recalibrate their approaches so as to increase their impact on RMNCH and the health sector more broadly. Similar reports are being prepared for three other countries – Bangladesh, Indonesia, and Nepal – where UNICEF and DFAT have been supporting evidence-based planning in support of women and their children. The original Terms of Reference for this report are available on request. The political economy reports are in addition to a quite separate exercise that evaluates the outputs and outcomes of the Investment Case approach.
2.2 Methodology, frameworks used, and report structure

There are numerous analytical tools and approaches that could be drawn on to examine the political economy of health and RMNCH in developing countries, as they are reflected in priority setting, planning and budgeting by Governments. These include a “how to note” on political economy analysis by the UK Department for International Development (DFID) (16) and the World Bank (17); the approach by the Overseas Development Institute (18); and the World Bank’s “problem driven governance” framework presented by Fritz et al. (19). There are also numerous tools and approaches that can be applied to political economy analysis including “Theory of Change”; “Drivers of Change”; “Most Significant Change”. All of these tools and approaches have something to offer, but because there is great variety between, and within, the four countries captured in this study, we have not adhered to one in particular. Indeed, it would be remarkable if any one analytical approach could be applied coherently and comprehensively to all four countries, especially given the focus of the work on sub-national level, which has not been analysed very widely, especially in Asia (20).

However, this analysis of the political economy of RMNCH in the Philippines and the other three countries drew on the methodological framework employed by DFID’s “How to note”, and Fritz’s “problem driven governance”, as they were most applicable to the social sectors. A definition of political economy is at Annex 1. Further details, including a schematic overview of the approaches used by DFID, as well as Fritz et al, are in Annex 2.

The specific methodology used for each of the four countries was as follows. The lead author first reviewed different approaches to political economy analysis, especially as it applies to the health and social sectors, in peer-reviewed and/or grey literature. He then searched the peer-reviewed and grey literature and open access data bases to identify the main political economy characteristics of each country’s health and development sectors. The literature review and data base analyses were then used to develop an inception report summarising the key political economy characteristics and RMNCH status of each country. The Inception Report also set out the proposed methodology and analytical approach, including ethical issues; a proposed standard questionnaire for interviews, and a recommended program of field level interviews, decided in collaboration with the UNICEF Country Office. The Inception Report for the Philippines is available at Annex 3.

Once UNICEF had reviewed and approved the Inception Reports and methodology, field level interviews were conducted involving one or two week visits to each of the four countries over 7 weeks during July – September 2014. Interviews in the Philippines occurred over the period 14-26 July in Manila as well as a field visit to Davao to interview stakeholders in the UNICEF-supported evidence-based planning program. In total 28 stakeholders from government, civil society (research and academic institutions) and development partners were interviewed (Annex 4). It is worth mentioning that more than two thirds of those senior interviewees were female: a welcome reflection of the women’s status in positions of authority in the Philippines. Unfortunately, requests for interviews with the national Department of Health, Department of Budget and Management, and the Australian Department of Foreign Affairs and Trade in Manila could not be accommodated in the time available. The lead analyst (Ian Anderson) was accompanied and actively supported in all interviews by Dr Raoul Bermejo III, Health Specialist, UNICEF Philippines. The questionnaire used as the basis for interviews is available on request. Conceptualisation, oversight of the design and implementation of the work was provided by the second author of this report (David Hipgrave).

The country level visits and interviews involved a mixed method approach. This involved:

a. Discussions with local staff on the findings of the desk review and exploring its implications for their local activities in health and other sectors.

b. Interviewing wherever possible experts from government in the finance, planning, health and other social sectors.

c. Discussions with the major development partners and academics who have previously assessed the political economy of social sector issues

d. Gathering and analysing quantitative data on social sector spending, disbursement and sub-sectoral allocations (infrastructure, human resources, advocacy /communications), as well as local analysis on related policy direction

This report is structured as follows. Section 3 provides a summary and analysis of the RMNCH situation and development context of the Philippines. Section 4 summarises the structure and function of the health sector and RMNCH at the national and sub-national level, and provides an appraisal of its performance. Section 5 provides recommendations based on the foregoing.

3. The RMNCH situation of the Philippines

3.1 RMNCH achievements and ongoing challenges

The Philippines has made strong and steady progress – at least at a national level – in reducing child and infant mortality. As seen in Chart 1 below, the latest Government report (21) states that under-five mortality rate at the national level fell from 80/1000 live births in 1990 to 30/1000 live births in 2011 (the latest year available in this series). The infant mortality rate has fallen from 57/1000 to 22/1000 over the same period. The neonatal mortality rate was 14/1000 in 2012. That Government report further states that the Philippines has a “high” probability to achieve the MDG 4 target on reducing child and infant mortality by two thirds between 1990 and 2015 (22). That report further states that the Philippines also has a “high” probability to provide universal access to primary education; provide educational opportunities for girls; reverse the incidence of malaria; increase tuberculosis detection and cure rates; and increase the proportion of households with access to safe water supply. The MDG target of halving the proportion of people with no access to basic sanitation has already been achieved. Each of these developments is valuable and worthwhile in their own right. Each will also contribute directly or indirectly to improved health for women and children.

![Chart 1. Progress on under-five, infant, and neonatal mortality in the Philippines](image)

Source: Government of the Philippines / UNDP (2014)
However there has been little progress – and even reversal – in terms of maternal health and modern family planning. The Philippines has a Total Fertility Rate (TFR) of 3.1 per woman (23). The latest Government report (21) confirms that the maternal mortality ratio (MMR) was an estimated 209/100,000 live births in 1990, falling to 162/100,000 by 2006. However the 2014 Family Health Survey report estimated the MMR at 221/100,000 – higher even than the starting point in 1990. Measuring MMR is difficult, so such variations are not particularly surprising. Indeed, the apparent increase may reflect better statistical reporting rather than an actual increase. Whatever the explanation, it is clear that the Philippines will not be able to reduce maternal deaths by three quarters and so reach the Philippines’ MDG 5 MMR target of 52/100,000. Similarly, the Philippines has a poor record in terms of increasing coverage of modern family planning (MDG target 5b). Government reports state that the Contraceptive Prevalence Rate (CPR) was essentially “stagnant” at around 50% of currently married women4 between 1998 and 2006, and may have slipped further to just less than half (48.9%) by 2011 (21). Uptake of safe and effective modern family planning is disproportionately low among the poor. A 2014 UNFPA report (23) cites evidence from 2007 that unplanned and unwanted births are higher among the poor in the Philippines than in the average in 41 comparable countries, and significantly higher than in neighbouring Indonesia (Chart 2).

3.2 Political, economic and development context

Despite its potential, the Philippines has had a disappointing record of economic growth and social development since Independence in 1946. The Philippines has had, on average, lower economic growth, lower poverty reduction, and higher inequality than comparable countries in the region or at its level of income over the decades (26). While other countries in the region have had higher initial rates of poverty, they have been able to reduce poverty rates faster than the Philippines. This is apparent from Chart 3 below.

The latest Government report states that the incidence of poverty has reduced from over one third (34.4%) in 1991 to just over one quarter (25.2%) in 2012 (21). While welcome, this reduction is still well above the 17.2% poverty rate that would have enabled the Philippines to reach the MDG 1 target on reducing poverty by half between 1990 and 2015.

Chart 3. Slower rate of reducing poverty in the Philippines than comparable countries.

Poverty headcount ratio at USD 1.25 a day

Source: WDI

Note: EAP stands for East Asia and Pacific countries. Some countries have missing values during certain years.

Politics is one factor explaining the poor record to date. The Philippines is a democratic republic with a particularly vibrant and free press. However it also has several political characteristics that have impeded broad based socio-economic growth. As a former colony of the USA, the Philippines inherited the US system of checks and balances between legislature (Congress), executive (the President and the administration) and an independent judiciary. In principle, this should have prevented concentration of power in the hands of one arm of Government. However, the longstanding Marcos dictatorship, a period of martial law, corruption and

Notes:

4 It could be assumed that the CPR among women who are not married, including adolescents, is higher.

5 The Gini coefficient estimates the extent of inequality of income and wealth in a country. More formally, the World Bank states that the “Gini index measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution.” A score of one means one individual hypothetically owns all the wealth in the country. A score of zero means there is no inequality in the dispersal of income and wealth in the country.

Source: World Bank (26)

Inequity remains a major challenge in the Philippines. The World Bank estimates that the Gini Index of inequality for the Philippines is 43.0 (24). While not as high as Colombia (Gini coefficient of 53.5) and several other Latin American countries, the Philippines has a higher inequality score than Indonesia (Gini coefficient 38.1) and many other countries in Asia. Even more worrying is the fact that income inequality has remained virtually the same for more than 20 of the last years in the Philippines. Using slightly different data sets and approaches the latest Government of Philippines reports (21) state that the Gini index of inequality in the Philippines was 0.47 in 2012, barely different from the estimate of 0.48 of 1991. There are significant inequalities in the use of important health services. For example significant inequalities occur in terms of access to and use of skilled birth attendants (SBA) in the Philippines across a range of socio-economic criteria: education, income, or geography. More specifically, latest WHO statistics (25) show that 73% of women with a secondary education or higher, 94% of the women in the highest wealth quintile and 78% of women in urban areas use a SBA, compared to only 11% of those with no education; 26% of those in the lowest quintile and 48% of those in rural areas. Interestingly, there are significant inequalities in the contraceptive prevalence rate based on education – women with secondary or higher levels of education are four times more likely to use modern contraception than those with no education – but there is virtually no rural/urban difference (25).

Source: UNFPA (2014)

Chart 2. Unplanned / unwanted pregnancies in the Philippines, Indonesia and 39 other countries

Source: UNFPA

Note:

EAP stands for East Asia and Pacific countries. Some countries have missing values during certain years.

Poverty headcount ratio at USD 1.25 a day

Source: WDI
Large numbers of unplanned children add to household costs among the poor, exacerbating household poverty. Under-nutrition in mothers, and children, and quite strikingly, as a summary measure of weak service delivery performance, a higher per centage of children are reportedly underweight. Political patronage is also intertwined with ‘money politics’. Another recent analysis concluded that:

The patronage nature of Philippine politics makes politicians’ reliance on money crucial to their political survival. An entirely new way to increase a politician’s chances of re-election is to influence public spending via a politically targeted provision of public goods and services through the pork barrel (which includes the Priority Development Assistance Fund … various congressional allocations and congressional insertions). Hence, this is often not enough, given the perennially tight fiscal situation of the Philippines. As a result, politicians aspiring to remain in power must increase their chances of re-election by other means, such as raising money from outside the purview of the government. This very high reliance on money for political survival has often resulted in the entrenchment of money politics and hence corruption in various government agencies. In some agencies, rent-seeking, patronage, and politicization of various functions of the government have become standard ways to raise money and to ensure the political survival or advancement of many politicians. For the same reason, politicians are also very susceptible to vested interests when deciding on new laws. Even the most reform-minded politician requires money, as his capacity to govern and enact reforms crucially depends on how well he garners political support, which is often gained through money.

Policy distortions are a third factor explaining the poor record to date. In any country, policies are essentially a reflection of the interests/visions of the political elite, and political economy factors. In some cases, it is the absence of good policies – including family planning and nutrition – in mothers and children – that helps to explain persistently high levels of poverty in the Philippines. In other cases it is the policies chosen. The World Bank latest Development Report for the Philippines summarises the historical situation as follows:

The country’s long history of policy distortions slowed the growth of agriculture and manufacturing in the last six decades. Instead of rising agricultural productivity, plying the way for the development of a vibrant labour-intensive manufacturing sector and subsequently of a high-skill services sector, the converse has taken place in the Philippines. Agricultural productivity has remained depressed, manufacturing has failed to grow sustainably, and a low-productivity, low-skill services sector has emerged as the dominant sector of the economy. Lack of competition in key sectors, insecurity of property rights, complex regulations, and severe underinvestment by the government and the private sector has led to this growth pattern, which is not the norm in the East Asia region. This anomalous growth pattern has failed to provide good jobs to the majority of Filipinos and has led to a substantial outmigration of many of the country’s best and brightest people.

Population growth – itself a reflection of political economy factors – has made the task of socio-economic growth harder and more expensive. The Philippines Commission on Population estimated that the Philippines population reached 100 million on 26 July 2004, almost 4 times larger than the population in 1960 (33). An estimated babies are born every day in the Philippines, whose crude birth rate (25/1000 people) is 1.66 times that of other developing countries in east Asia and the Pacific. This reflects the influence of the Roman Catholic church’s opposition to modern family planning, as well as national poverty levels. A rapidly increasing population puts additional demands on RMNCH services in the short term, education facilities in the medium term, and job creation in the longer term. Moreover, the latest World Bank analysis suggests that structural factors in the Philippines have traditionally resulted in high levels of unemployment, under-employment, and low productivity informal employment (26). This means the Philippines could miss the opportunity of a “demographic dividend” and instead face a “demographic burden”. High total fertility means that the Philippines still has a high (albeit declining) dependency ratio of around 63% of the population: one of the highest in the region (Chart 4).

**Chart 4: Philippines population growth and dependancy ratios**

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Dependency Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>31.6 million</td>
<td>0.52</td>
</tr>
<tr>
<td>1980</td>
<td>41.7 million</td>
<td>0.63</td>
</tr>
<tr>
<td>1995</td>
<td>47.4 million</td>
<td>0.67</td>
</tr>
<tr>
<td>2004</td>
<td>80 million</td>
<td>0.63</td>
</tr>
</tbody>
</table>

6 Large numbers of unplanned children add to household costs among the poor, exacerbating household poverty. Under-nutrition in mothers, infants, and children directly increases the susceptibility to disease and indirectly reduces income earning potential, thereby exacerbating poverty.

7 In essence, a “demographic dividend” occurs when a large youth bulge finds good well-paying jobs in the formal sector that then generates income, taxes and wealth that can be invested by the country for longer term social benefit. A “demographic burden” occurs when youth bulge is not able to be fully employed and so creates an additional burden on welfare and other services.

8 Those aged less than 15 years, and those aged older than 64 years i.e. “dependents”) as a ratio of the total population. A higher per centage means more people are ‘dependent’ on the working age population to support them.
Problems particular to the Philippines also explain the disappointing record on socio-economic growth. The Philippines has had decades-long insurgenies and conflicts with the communist New Peoples’ Army in several provinces, and Islamist separatists in parts of Mindanao. Poverty incidence is higher in conflict provinces (42%) than in non-conflict provinces (22%). Around 36% of poor Filipinos, or 8.4 million, reside in conflict provinces (26). As noted earlier, the Philippines is particularly prone to natural disasters including typhoons, earthquakes and volcanoes. The widely dispersed, multiple island nature of the Philippines creates challenges and additional costs in delivering basic social services.

These “five Ps” are particularly relevant to explaining relatively poor and inequitable RMNCH outcomes. Low economic growth and tax collection has meant limited fiscal space for investing in health and RMNCH, particularly in the face of a growing population. Political factors and policies have outlawed and/or financially starved family planning programs. Political patronage and lack of “voice” of the poor means what little has been invested in health and RMNCH is often skewed in favour of the rich. Latest research from the World Bank (34) finds that the Philippines is one of only 20 countries in the world (among 69 assessed) where government expenditure on health is “significantly pro-rich.” Problems specific to the Philippines often disproportionately affect women and children: UNICEF reports that super typhoon Haiyan/ Yolanda hit Tacloban and surrounding areas where 40% of children were already living in poverty.

3.2.1 Where the Philippines is now: recent changes in the strategic landscape

Recent policy pronouncements and allocation of resources to the social sectors imply a very explicit political commitment to the social sectors. The Constitution of the Philippines has enshrined funding for education as the first priority on budget resources since 1986. However recent policy announcements have also given a stronger commitment to health as well. Public statements from President Aquino have been very strong – and refreshingly direct and candid – suggesting a change in substance and style in favour of the majority of Filipinos. As just one example amongst many, President Aquino’s “Social Contract with the Filipino people” prominently pledges a change “from treating health as just another area for political patronage to recognizing the advancement and protection of public health, which includes responsible parenthood, as key measures of good governance.” (35) The Aquino Health Agenda (AHA) also seeks to put substance into the rhetoric by achieving UHC for all Filipinos. The three strategic thrusts of the Aquino Health Agenda and UHC involve:

- “Financial risk protection through expansion in National Health Insurance Program (NHIP) enrolment and benefit delivery – the poor are to be protected from the financial impacts of health care use by improving the benefit: delivery ratio of the NHIP;
- Improved access to quality hospitals and health care facilities – government owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications; and
- Attainment of the health-related MDGs – public health programs shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of non-communicable diseases.” (36)

The Administration is achieving some important successes, including keeping poor children healthy, through a large scale conditional cash transfer program. The program, known as 4P (Pantawid Pamilyang Pilipino Program or Improving the Human Capital of the Poor) combines social welfare objectives in the form of cash grants to poor households with social development objectives (payment is conditional upon investing in the health of infants, children and adolescents). To be eligible, households must meet the following conditions:

- Pregnant women must participate in pre- and post-natal care and be attended during childbirth by a trained health professional;
- Parents must attend Family Development Sessions;
- 0-5 year old children must receive regular preventive health check-ups and vaccines;
- 6-14 years old children must receive deworming pills twice a year.
- All children beneficiaries 0-18 years old must enrol in school and maintain a class attendance of at least 85% per month

The program had 4,090,667 registered households as of 25 June 2014 and operates in 79 provinces covering 1484 municipalities and 143 cities in all 17 regions nationwide (37). An independent evaluation, partly funded by AusAID, concluded that the program appears to be effective on a range of criteria, in terms of directing scarce resources to the poor and vulnerable, helping to keep poor children healthy, well nourished (a 10 per centage point reduction in severe stunting compared to barangays that did not receive the program, where 24% of children aged 6-36 months were severely stunted); enabling poor households to increase their investments in meeting the health and education needs of their children; PhilHealth coverage without impacting decisions to seek work or fertility rates.
4 Structure and function of the health sector and RMNCH at national and sub-national levels and related analysis

4.1 Health system structure, governance and stewardship

The Philippines exhibits many characteristics common to other South East Asian health systems. While there are some first class facilities and personnel in the major cities, the overall density of trained health workers is low, especially in rural areas. Latest available figures from WHO, which unfortunately relate to 2004, suggest only 1.153 doctors, per 1000 population (38). Simultaneously however, many Filipino doctors and nurses successfully migrate to the United States and other OECD countries. As with many countries in Asia, there is also a vibrant – if often poorly regulated – private sector, including pharmacies. In 2011 (latest year available) private expenditure on health represented nearly two thirds (63%) of total health expenditure; 83% of private expenditure was directly out of pocket; and only 11.7% of that was through private prepaid plans (25). External resources for health, including ODA, account for just 1% of total health expenditure. As with many countries in Asia, the Philippines is also investing political capital and financing into expanding UHC.

A key feature of the Philippines health system is devolution: the 1991 Local Government Code involved sudden, major, devolution of functions to subnational units, especially small local government units. Devolution was an urgent and rapid political exercise to distribute political and economic power in the Philippines. The Cory Aquino administration which feared a possible return to Marcos rule, desired decentralisation of its responsibilities to the incoming elections. Most agency functions were devolved, although the Department of Education successfully resisted this. Devolution was intended to create three broad administrative levels for health services: a central DOH in charge of regulation and tertiary care through hospitals that it kept control over; provincial governments would be responsible for provincial and district hospitals and secondary care; and LGUs would be in charge of primary care. Prior to decentralisation, LGUs were responsible for minor activities such as administration of garbage collection. Decentralisation gave them significantly expanded functions including principal responsibility "for the delivery of basic health services" (39). These included responsibilities in: (i) agricultural extension and research, (ii) social forestry, (iii) environmental management and pollution control, (iv) primary health and hospital care, (v) social welfare services, (vi) repair and maintenance of infrastructure, (vii) water supply and communal irrigation, and (viii) land use planning." (39)

Devolution also involved major structural changes to personnel and budgets, especially at the DOH. National level agencies lost staff and budgets to LGUs. More than 60% of DOH’s 74,896 staff, and more than 60% of its nearly 80 billion budget, was devolved to LGUs (39). This clearly created sudden, major, disruption to the planning and operation of health services at both the national and decentralised levels. The situation was further complicated by the fact that responsibility for several health services (immunization, communicable disease control, health planning and resource allocation, and a potentially corrosive effect on accountability. Wealthier provinces and cities (many of which have large slums) with their own sources of tax revenue can fund activities that are only weakly aligned to national priorities and DOH. They can ignore development partners. The financial incentives offered by development partners – and even the DOH - are now so small compared to the budget of the big cities that it is hard to engage them. A World Bank study on service delivery found that “the most common approach to mitigate the limitations in local resource bases was to lobby the national government – either directly through agencies, or indirectly through the local congressmen – to allocate discretionary national funds to finance devolved infrastructure and services” (40).

Clearly, such ‘lobbying’ for resources occurs in all societies, but it is not as national, systematic, efficient or equitable as evidence-based priority setting and planning. Moreover, an environment that requires/facilitates extensive lobbying can have a corrosive effect on local accountability. The same World Bank study also noted that LGUs with limited capacity to raise local revenues lobbied central government for additional national resources. This is understandable. But additional national resources allocated to poorer sub national units often come with political strings attached. Local politicians who focus too much on pleasing political patrons in Manila can also become less attuned to the needs of local communities. As the World Bank study said:

“Reliance on national resources is a pragmatic solution to resource constraints, but it also raises questions of accountability and efficiency. The availability of discretionary funding has commonly been politically conditioned, potentially weakening LGUs’ accountability to their local constituencies. This also damps LGUs’ incentives to raise their own revenues, which again requires a deeper accountability on the use of the revenues raised locally. Finally, opportunistic accessing of national resources in the context of weak local planning can create problems of poor expenditure coordination and reduced efficiency in resource allocation” (40).

A recent Public Expenditure Review in the Philippines concluded that the distribution of revenues, expenditures and some key development outcomes across regions is becoming more unequal. More specifically, it concluded that:

“Since 2000, per capita incomes, wage levels and poverty rates in the different regions have become more diverging paths. Only household expenditures exhibit some modest convergence. Basic education and access to basic infrastructure indicators are also diverging across regions. Health indicators that can be directly attributed to the health sector, such as immunization rates, have not been converging. The only case of clear and strong convergence can be found in infant and child mortality rates (41).

The political economy implications of this are clear. Once again, a strong, centralised, authoritarian state would have more capacity to reallocate resources to poorly performing subnational provinces and districts than a highly devolved state. But devolution, different resource endowments/economic opportunities between different provinces, seems to contribute to unequal access and outcomes, at least in the short to medium term.

The ability of national level agencies to achieve national outcomes is mixed. On the one hand, national level agencies, like the DOH, can be quite powerful. Interviews in Davao revealed that national agencies financed only 40% of all programs approved by the regional NEDA office as meeting local priorities. When over half (80%) of approved projects are unfunded, there would seem to be systematic inefficiency. Despite focusing, the criteria upon which projects are eventually funded is not clear. On the other hand, the DOH has ongoing challenges with respect to national leadership of health. A recent World Bank review of the health sector in the Philippines concluded that:

“While the DOH has been given the mandate for stewardship and oversight of the health sector, it has not been adequately empowered to enforce this mandate. For example, the stewardship of the DOH over LGUs is loosely defined and the DOH cannot require LGUs and the private sector to submit health sector data. This creates a huge challenge for the DOH to exercise its stewardship function. Despite these limitations, the DOH has done a remarkable job in taking forward stewardship of the sector especially vis-à-vis LGUs. The DOH has adopted innovative institutional mechanisms such as LGU scorecards, Centres for Health Development, and the Province Wide Investment Plans to enhance LGU accountability for health sector goals” (42).

4.2 Health financing

The 2013 national budget reconfirms the government’s commitment to the social sector. Social services – especially education but also health – were easily the largest component of the 2013 national budget in absolute and relative terms, being allocated 696 billion or 34.8% of the total budget. Economic services (physical infrastructure etc.) were next at P10 billion (25.5%). Debt servicing was allocated P33 billion (16%). Defence was allocated just P89 billion (4.5%).

The health sector has attracted a particularly rapid and sustained increase in budgetary resources. This is clear from Chart 5 below. In essence, total DOH expenditure was just P71 billion in 1991, and rarely exceeded P10 billion for almost two decades, despite rapid population growth in the Philippines. DOH expenditure increased to P18.9 billion in 2008 (under the Arroyo Administration) but increased even more from 2010 under the Aquino Administration, reaching P86.7 billion in 2014; it is projected to increase to P86.5 billion in 2015. What is particularly noticeable is that the prime – almost sole – driver of the increase is increased expenditure on maintenance and other operating expenses shown in the red line. This includes the very large amount the Government is paying in health premiums for the poor under its scaling up of UHC. Also noticeable is the fact that the allocation to social protection (green line) has remained relatively flat over the last quarter of a century, raising concerns about out of pocket payments or reliance of providers on other sources of income.

6 It is unclear why the Arroyo administration increased health expenditure. All key stakeholders were asked during the field visits. Most were unaware/surprised that budget expenditure rose so quickly under that administration. The UNICEF office in Manila is continuing research on this question.
This chart needs to be interpreted with caution, as the budget allocation going to health is a nationally retained program with little LGU counterpart financing, whereas national DOH expenditure on health is also supplemented by counterpart financing by LGUs (although the total quantum is difficult to estimate).

Despite budget increases, increased public expenditure is needed, especially to address the needs of the poor and vulnerable. The welcome increase in the DOH budget allocation to P83.7 billion in 2014 needs to be put in perspective, especially in a country like the Philippines with its 100 million population. It averages only P830, or around $18.75 per person per year, much lower than the (now dated) $34 suggested by the 2001 Commission on Macroeconomics and Health as the minimum per capita public expenditure on health. 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 (43), and less than a quarter of the $88 per capita that the recently released Chatham House report on health financing recommended all governments in developing countries should be spending on health (44).

Improving the quality of expenditure is as important as the quantity of expenditure. A recent World Bank Public Expenditure Review examined both the quantum and efficiency of public expenditure in the Philippines, and concluded that:

‘...shortfalls in the size of public spending generally appear to be more important than shortfalls in the quality or efficiency of public spending in explaining ... performance gaps. In certain critical sectors, however, the Philippines also exhibits shortfalls in the efficiency of public spending, defined broadly as the performance outcomes achieved per unit of public spending per annum. An important factor contributing to a lower efficiency in public spending are the disparities in the distribution of public expenditures, observed both across income groups and across geographic regions. That is, public expenditures that are concentrated on fewer needy beneficiaries tend to generate weaker development impacts. These findings suggest that the Philippines cannot hope to achieve the same development outcomes as the better-performing countries in the region through efficiency improvements alone, but will have to make a greater effort in stepping up the quantity of public spending in priority areas. Improvements in the efficiency of public spending can, of course, help in reducing the performance gaps, and this can be achieved by ensuring that the benefits of public spending are distributed more equitably across regions and income group. (43)

It is clear that the Philippines administration is determined to scale up UHC quickly, but the challenges should not be underestimated. Out of pocket expenditure is still the largest source of health expenditure in the Philippines, and rising rapidly (Chart 7). Furthermore, in Indonesia a form of UHC induced an increase in out of pocket expenditures amongst the second and third lowest quintiles because increased financial means to access health care resulted in patients being prescribed drugs not covered by the UHC and for which they must then pay out of pocket (45).
A relevant issue from a political economy perspective is also to understand both the sources, and the uses, of increased government expenditure on health. The sources of increased expenditure are important because the raising of additional revenues can be progressive (that is, additional revenue is raised disproportionately from the poorer quintiles). It is not exactly clear what the situation is in the Philippines. However the fact that Value Added Tax, which is applied on most goods and services, is the major source of national government revenue means that it is likely to be regressive\(^\text{12}\) to the extent that the poor do purchase items subject to VAT (46). The recently released Chatham House Report on health financing identifies other pro-poor, pro-health options for government revenue: “Every government should consider improved and innovative taxation as a means to raise funds for health. Promising policies include the introduction or strengthening of excise taxes related to tobacco, alcohol, sugar and carbon emissions, and these should be combined with measures to increase tax compliance, reduce illicit flows and curb tax competition among countries. Other sources of government revenue, particularly in countries rich in natural resources, should also be explored” (44).

Furthermore, the uses of government expenditure – where, on what, why and how that expenditure will occur – are relevant to assessing priority settings and impacts. Government expenditure on curative treatment or end of life care in tertiary hospitals, or on fee for service diagnostic tests by private doctors, are likely to have a very different socio-economic impact than expenditure on promotive and preventive health in primary and secondary care settings.

An example of good use of government revenue is the stronger use of political capital by President Aquino to use increased taxation on tobacco and alcohol as a means of simultaneously increasing revenue for the expansion of UHC, while reducing the burden of non-communicable diseases. This was particularly noteworthy from a political economy perspective (Box 1).”

**Box 1:** The “sin tax” on tobacco and alcohol to fund UHC

A win-win for public health and public finance for the poor where the evidence base shifted from public health to public economics. The Philippines has traditionally had one of the lowest rates of tobacco taxation – and consequently one of the highest rates of tobacco use – in the region. This is the result of strong lobbying by international tobacco companies and member of Congress representing tobacco growing districts. The scientific evidence that tobacco is a major cause of premature death and disability is well beyond dispute. The tobacco industry therefore shifted ground away from the public health arguments across to public economic arguments. They argued smuggling would increase; jobs and revenue would be lost; and the poor would suffer the most from increased taxes on tobacco and alcohol. All such claims by the tobacco industry have been shown to be myths (47, 48). President Aquino astutely steered a “Sin Tax Law” through Congress that shrewdly allocated additional revenues from tobacco and alcohol to financing the Universal Health Care scale up. In a politically astute move, President Aquino also ensured that the increased public revenue from the sin tax was also used to compensate tobacco farmers who may have lost production. The law eventually passed Congress by only one vote and the original proposal to raise PHP 60 billion was halved to reduce political resistance.

The Philippines Administration’s plans for UHC also provides important context for health financing in the country. The Philippines is rapidly scaling up UHC, particularly through PhilHealth. Development partners familiar with the DOH as their main counterpart must now engage strategically with social health insurance institutions as UHC expands. PhilHealth is clearly a key and strategic stakeholder in the overall health system of the Philippines, particularly with respect to the poor. As of June 2014 PhilHealth (49) reported that:

- It now provides health insurance for 82% of the Philippines population: around 81.5 million

- Almost half (46%) of PhilHealth beneficiaries are the very poor (‘indigent’ in PhilHealth terminology) and a further 10% are from the informal sector.\(^\text{13}\)
- 90% of DOH-licensed hospitals are accredited with PhilHealth, as are 1060 private institutional health providers and 705 government-owned institutional providers.
- Several benefit packages are of direct relevance to RNMCH including the primary care package and the maternal care package. Revision of these packages is in progress.
- Benefit payments from PhilHealth totalled P94 billion ($755 million) as of June 2014. Benefit payments are increasing over the previous year and are paid reasonably equally between contributing groups (Chart 8).

A person from the lowest quintile paying P50 VAT on any item will lose significantly more relative disposable income than a person from the highest quintile paying the same P50 VAT on the same item.\(^\text{12}\)

The private sector is a dominant part of the Philippines health financing system, but is often overlooked in priority setting, planning and budgeting. As seen in Chart 9 the private sector, including private out of pocket payments for health care, is the dominant part of the health care financing system in the Philippines. Private sources account for 69% of all health financing in the Philippines, growing at 12.4% a year. The private sector, including the for-profit and the not-for-profit sectors as well as private providers, are also important providers of services. Interviews during the field visits confirmed that quality of private sector services varies greatly in the Philippines from world class private hospitals in Makati and Manila, to unregistered and unqualified providers. Importantly, the normally well-respected NGO sector in the Philippines has experienced corruption scandals with “front” NGOs that have led to the arrest of Senators.

### Chart 8: Benefit Payments by PhilHealth (in billion pesos), June 2014

Source: PhilHealth (49)

<table>
<thead>
<tr>
<th>Year</th>
<th>Lifetime Member</th>
<th>Indigent</th>
<th>Informal</th>
<th>Formal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>26.19</td>
<td>3.33</td>
<td>23.35</td>
<td>45.35</td>
<td>97.19</td>
</tr>
<tr>
<td>2014</td>
<td>26.19</td>
<td>3.33</td>
<td>23.35</td>
<td>45.35</td>
<td>97.19</td>
</tr>
</tbody>
</table>

Scaling up health insurance has major implications for government and household budgets. A recent UHC costing exercise estimated that “the total costs of expanding effective universal coverage (adequate financial protection) will be approximately P 408.6 billion ($308 million) over the medium-term (2012-16). This could result in a doubling of public spending on health as a share of GDP by 2016 (Baseline: 1.3% of GDP in 2009). This would not only expand coverage among the poorest households in the Philippines ($2.2 million households targeted under the National Household Targeting System), but expand the depth and height of PhilHealth coverage to provide better financial protection (42). However, expanding coverage may not improve health access and outcomes. Much depends upon the depth, and breadth, of coverage and what services are included. A bias towards curative, hospital based treatment rather than primary and preventive care would not help the poor. Under UHC, private providers have an incentive fee for service payment. But supplier induced demand for unnecessary Caesarean Sections and the like would likely create budget blowouts for government and households, often for little increase in health outcomes (50)
4.3 Health and RMNCH priority-setting at national and sub-national levels

National planning and budgeting in the Philippines health sector is relatively strong. It is guided by planning documents and guidelines that have been strengthened recently and are still in the process of redevelopment and improvement, including with UNICEF support. This has been reported on extensively in Professor Don Matheson’s Inception Report for the Philippines Investment Case, which concluded that:

“The government has well developed planning and investment processes at the national and subnational levels. Provincial and city investment plans for health and other sectors include a prioritisation process for allocating resources, based on issues such as health impact, equity, political commitments, and correcting variation in health performance levels.”

Subnational planning, budgeting and program implementation have, however, been weak. A comprehensive Asian Development and World Bank Study found several weaknesses 10 years after the Local Government Code was implemented: only 30-50% of LGUs had local development councils in place; the Development Plan formulated by the Regional Development Council was seldom followed; and, even when they existed, LGUs tended to focus on inter-provincial projects rather than on local development plans; there was a disconnect between national and regional/provincial planning; LGU budget formulation and execution was weak due to poor income estimates used by LGUs for budget formulation; overexpenditure on salaries; little community participation in prioritising and monitoring projects; mis-procurement and poor financial controls. (39)

Political economy challenges explain much of the acknowledged weaknesses in planning, budgeting and implementation. The same joint study (39) identified several political economy challenges that had weakened planning and priority setting. More specifically, the report found:

• Formidable political economy challenges to efforts for more transparent and accountable local government functioning, such as a recommendation to not underestimate such obstacles, and to keep expectations realistic. While the Local Government Code established secondary regulations, institutions and linkages between them, and coherent rules of procedure, enforcement has been weak due to capture by dominant groups.
• Either because of weak evolution over the last decade or persistent capacity challenges, some aspects of LGU operations remain underdeveloped and exhibit vulnerabilities in transparency, accountability, efficiency and effectiveness.
• The workings of intergovernmental (fiscal, administrative, and political) relations are particularly vulnerable to the instability induced by an excessively politicized system of rewards and allocations, and by uneven institutional strength and resourcefulness among national executive, congressional, provincial, and city or municipal actors. Cumulatively, however, there is evidence that some executives have tried to break from the dominant pattern of politics and taken risks outside the certainty of machine politics. More importantly, these executives have been rewarded by clear support from communities and interest groups, and especially by re-election. (39)

A summary of these strengths and weaknesses is included as Annex 6.

The Philippines National Economic and Development Agency (NEDA) also provided a detailed, written, response to UNICEF’s Questionnaire developed for this analysis. NEDA’s response is at Annex 6. It is clear that NEDA has, at least on paper, a systematic and well organised approach to priority setting and planning, with clear links between medium term strategic goals (including MDG goals) and individual projects and activities on an annual basis. NEDA also uses a transparent, systematic, approach (40) to screening investment projects using five rational criteria: relevance and alignment to national priorities; severity of need; efficiency; effectiveness and impact; and sustainability. There is also evidence that the Philippines wants to make planning and budgeting more transparent, and participatory. For example, the Department of Budget and Management (DBM) introduced “Performance Informed Budgets” during 2014. The aim is to more clearly present and show the links between the purpose, outputs, outcomes and costs of different activities. Part of the aim is to increase the effectiveness and efficiency of resource allocation. DBM states that “performance information can be used as a signalling device. Low performance or a decline in performance can serve as an alarm bell that ought to trigger a closer look into the reasons behind low performance.” (40) But it is also clear that Government, through DBM, intended to send a strong political economy message through these reforms: that old style patronage and back room deals were being replaced with new, publicly stated standards of transparency and accountability in priority setting, planning and budgeting.

The public signalling of a more reformist approach is clear in DBM’s refreshingly candid claim that:

“The new face of the Budget therefore represents the continuing shift away from the dominance of patronage politics and clientelistic relationships towards a more responsive, transparent and accountable public expenditure management system. … With the adoption of performance informed budgets …, the government is changing the face of the budget. Previously a mass of numbers and line items without a clear story on where funds are going, the National Expenditure Plan and the General Appropriations Act beginning in FY2014 will show the link between the funds allocated for government programs and the projected results and outcomes of these.” (41)

“Bottom-up budgeting” (BuB) – also known as “Grassroots Participatory Budgeting Process” – is also an effort to systematically facilitate and institutionalise local needs of poorer communities into planning and resource allocation. In essence, the Bottom up Budgeting (BuB) approach requires all National Government Agencies – not just the Department of Health – to formally allocate from 2013 onwards a percentage of their budget to meet the priorities of local, poorer, communities, and respond positively to local community needs. (38)

Importantly, the political objective of BuB is to encourage / empower local communities to influence national level programs, including health, rather than focusing on planning and budgeting at the subnational and local level alone. Civil society organisations (especially NGOs) assist local government units and municipalities in poorer areas to develop Local Poverty Reduction Action Plans in any sector that are then presented to national agencies in time for those plans to be integrated into the regular budget preparation cycle. The BuB approach was developed following consultations with 609 of the poorest municipalities of the country. A trial involving P8.4 billion ($220 million) was conducted during the process of sub national planning and budgeting. The DOH also has a prioritisation process for allocating resources, based on issues such as health impact, equity, political commitments, and correcting variation in health performance levels.

The government has well developed planning and investment processes at the national and subnational levels. Provincial and city investment plans for health translate national health goals into specific concrete actions at the local level. They become the basis for actions at the local level. They become the basis for provincial and city investment plans for health and other sectors. Provincial and city investment plans for health and other sectors include a prioritisation process for allocating resources, based on issues such as health impact, equity, political commitments, and correcting variation in health performance levels.
in 2013, of which health related activities amounted to P706 million ($175 million). Other community-determined projects included agriculture and fisheries support, potable water supply, and basic education ($53). The BuB approach does not just give poorer communities a more formal say in planning priorities, it is also an opportunity for them to generate additional revenue. That is because BuB resources are additional to the normal allocation they would receive from the Internal Revenue Allotment. For example, Quezon City (where UNICEF is working with informal settlers) had an approved Local Poverty Reduction Action Plan allocation worth around P50 million.

The LGU health scorecard system is also evidence based, systematic, and easily used as a driver of improved priority setting, planning and resource allocation. DOH has developed a scorecard system for LGUs that enables national and local planners to track progress on a range of strategically important outcomes, output and input health needs for women, children and the main features of the scorecard approach, and the evidence base used. It could be argued that 37 separate indicators are too much for LGUs to track, and that there are often severe problems in the accuracy of the data collected.

Nevertheless the approach is clearly systematic and ‘asks the right questions’ at the outcome, output and process levels, and integrates indicators of inequity into the system. An important feature of the LGU Health Scorecard system is also its user-friendly and intuitive approach. The use of traffic light colours alerts Mayors and policy makers to priority issues. For example a change from green to red or orange colouring for childhood immunisation coverage in a particular district or municipality alerts decision makers to a priority need.

Table 1: Key features of the LGU Health Scorecard system

<table>
<thead>
<tr>
<th>Strategic planning issue</th>
<th>Number of indicators</th>
<th>Typical example of indicator used as part of the evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial risk protection</td>
<td>6</td>
<td>Increased numbers of enrolment in PHilHealth and the uptake rate amongst the poorest 20% and 40% of the population.</td>
</tr>
<tr>
<td>Efficiency of health sector spending</td>
<td>6</td>
<td>LGU budget allocated to health (%) and maintenance and operating expenses (MOOE) (%) allocated to health.</td>
</tr>
<tr>
<td>Health facility enhancement program</td>
<td>7</td>
<td>Bed numbers per population; Client satisfaction survey results.</td>
</tr>
<tr>
<td>Internal management and support</td>
<td>3</td>
<td>Nurse to population ratio; Midwife to population ratio.</td>
</tr>
<tr>
<td>Policy standards development and regulations. Scale up of public health interventions for the MDGs</td>
<td>15</td>
<td>Contraceptive Prevalence Rate; full immunisation rate; skilled birth attendance (%); TB case detection rate; health workers receiving the full amount of allowances they are entitled to receive (%).</td>
</tr>
</tbody>
</table>

Source: author’s summary from official documents

However there are clearly still ongoing challenges in terms of health equity setting, planning and budgeting, including issues of inequity. The Philippines has wealthier provinces, districts and cities and poorer ones. Devolution has tended to highlight the difference in economic, fiscal, and managerial resources between the richer and poorer areas. A World Bank study found significant ‘horizontal inequity’ (inequity between different regions) as well as ‘vertical inequity’ (inequity within the same region). More specifically, 16 the “richest” LGU in its sample (a city in Visayas) collected P442 revenue per capita (in constant 1985 Pesos) over 2003-07 whereas the “poorest” LGU (a province in Visayas) collected only P81 revenue per capita. The data also highlighted horizontal inequity across the same level of LGUs. Among the three municipalities in the sample, one municipality collected P427 revenue per capita (a constant 1985 Pesos) over 2003-07 whereas the “poorest” LGU (a province in Visayas) collected only P81 revenue per capita. The data also highlighted horizontal inequity across the same level of LGUs. Among the three municipalities in the sample, one municipality collected P427 revenue per capita (a constant 1985 Pesos) over 2003-07 whereas the “poorest” LGU (a province in Visayas) collected only P81 revenue per capita.

The field visits confirmed that decentralisation and increased ‘vertical inequity’ for LGUs can benefit public health. The Mayor of Davao City had decided on his own accord to make Davao City virtually tobacco free. Davao’s mayor allocates around P100 million (40% of the total budget) to the “Linggap” emergency health care fund and then personally dispatches funding to individuals who attend the Mayor’s office every Monday morning. The policy problem here is that such financing is entirely reactive to individual claims (not strategic, forward looking or evidence based); it essentially focused on curative measures (not preventive or public health) and, by design or by implication, clearly involves patronage and clientism. Mayors in general may have a political incentive to retain such a “hand out” facility to the detriment of more institutional approaches. The World Bank study on local service delivery made the interesting finding that:

1. The six disorders tested for newborn screening are: congenital hypothyroidism; Congenital Adrenal Hyperplasia; Galactosemia; Phenylketonuria; Glucose-6-phosphate-dehydrogenase deficiency; Maple Syrup Urine Disease. The Philippines has long had one of the highest total fertility rates in the region, and highest levels of unmet contraceptive need. The powerful Roman Catholic church consistently and vigorously opposed modern family planning. Their power to affect politics was clear given that the Church had demonstrably been a critical player in the successful overthrow of President Marcos in 1986. It could – and would – also specifically mobilise voters to vote against candidates standing for Congress. Various Reproductive Health Bills have been languishing in Congress for over 30 years. Although the scientific evidence about the health benefits of family planning never changed, the political environment did. President Aquino used his political capital to strongly and astutely advocate passage of Reproductive Health Bill (S68). This was widely supported by the general public, and academics, including from the Roman Catholic Ateneo University. The Philippines now has a law funding the distribution of free contraceptives, requiring government hospitals to provide reproductive health services, and mandating public schools to teach sex education. It’s not a perfect law. The delivery of RH services remains the primary responsibility of the national government - not local government units - and optional for most private hospitals. Even so the political capital he used to push the policy (including mandatory public school sex education classes) to win the public’s support has been very successful. RH services are also optional for private schools” (58).

"Champions" can be important advocates, or not. Much of the literature on reforms in health refers to the need for ‘leadership’ and ‘champions’ (15, 54-56). Local political analysis in the Philippines points to the critical role that President Aquino played in steering through the “sin tax” on tobacco and alcohol to fund UHC, and to allow modern family planning to occur in the Philippines (Box2) (57). On the other hand, well-intentioned “champions” can also generate priorities and resource allocation decisions that are not evidence-based and are not in the best interests of public health or the poor. For example, a “Champion” in the Philippines Senate advocated for nationwide screening of all newborns within three days of birth to screen for certain inherited diseases.16 The policy problem that arises is that each of the six diseases are rare; it is not-cost effective to screen all newborns, and there is a high opportunity cost in terms of how resources used for screening could have achieved higher, pro-poor, impacts if using evidence-based criteria for resource use.
Development partners can skew planning and funding priorities. In 2011 development partners contributed around 13% of total health expenditure in the Philippines (25). Despite this low share of expenditure, and despite the rhetoric and commitment to the Paris Declaration and its successor agreements, it is clear that development partners can skew priorities. There was strong criticism from NEDA during interviews in Manila that development partners particularly ignored national and regional priorities in disaster emergencies including the recent Typhoon Haiyan. There is also a risk that the focus on "renewal" by development partners will lead to short termism and funding activities that the Philippines can do well already, including vaccinations, rather than focus on the more difficult, essential, but less appealing issues of procurement, training and per diems and fuel budget to allow nurses to vaccinate children in remote areas. There was also little bureaucratic incentive to fund ongoing training of past – yet strongly evidence based – programs. For example, retirements and a low level of ongoing training meant that there was a low level of workers in Davao now trained in the Integrated Management of Childhood Illnesses (IMCI). UNICEF bottleneck analysis found that only 26.3% public nurses and midwives in Davao, and only 9.1% in Quezon City, were currently trained in IMCI: a strongly evidence-based and cost-effective approach for reducing child death and disease.

UNICEF’s investment case work has focused on the use of evidence in planning, prioritisation and budgeting. Interviews in Manila, and field visits to Davao and Quezon City, confirmed that ‘evidence’ does not exist in a vacuum: what evidence; whose evidence; when is it presented? Yet they also noticed that “the new” could displace the funding of basic services over time. While it would be possible to analyse the political economy of projects, interviews confirmed that those programs that are most transformational are the least measurable’ (68) Having said this, expenditure on development programs is a major arena for corruption and politicking, and it is imperative for partner funds to be overseen carefully. For example, there are allegations that Mayors aligned to national party leaders get preferential access to development resources. Political controversy can escalate quickly and from unanticipated quarters. Opponents of President Aquino are now seeking his formal impeachment over the reallocation of undisbursed funds from the well-intentioned and developmentally oriented Disbursement Acceleration Program.

Upstream EBaP becomes irrelevant if downstream implementation and procurement are ill-suited to increased resources. Several senior and well-educated officials from a wide spectrum said during the field visits that the biggest challenge they faced was no longer a shortage of funding and a lack of capacity for “planning” for them was that financing was now increasing rapidly, yet the systems they had for procurement and financial management were still tailored to a period of austerity and small scale purchases. Several officials said independently that they needed training in consultancy management for outsourcing and procurement management, rather than training on planning itself.

Implementation is arguably more important than planning. The increasing availability of financial resources flowing through to LGUs in the Philippines has put increased – and changing – demands on capacity and skills. Historically, LGUs were used to small grants and so had little experience or incentive to improve their capacity for implementation or finance, procurement or contract management. Yet in such situations, officials must spend undisbursed funds on big ticket items (vehicles or overseas training courses) in order to fully disburse time-restricted funds and not jeopardise future funding. Filipino authorities, particularly those in poorer LGUs at sub-national level, will benefit as much from support to improve administrative and financial accountability as they will from having more resources allocated.

The “new and innovative” can often displace the “proven and essential”. Interviews confirmed that LGUs were under pressure to adopt new and innovative initiatives from DOH and/or local Mayors. Experienced officials noted that internal bureaucratic incentives meant it was difficult to resist pressures to adopt “the new”. Yet they also noticed that “the new” could displace the funding of basic services such as the registration of newborns, delivery of routine vaccines, etc. Yet they also noticed that “the new” could displace the funding of basic services over time. It was difficult to resist pressures to adopt “the new”.

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The analysis also found that civil society activists were also important in building coalitions and coordinating political inputs. The Asia Foundation and Overseas Development Institute recently used two case studies in the Philippines to explore the political economy of institutional reform. Both case studies – one dealing with land registration reform and the other with tobacco control – involved active and astute advocacy by local Filipino NGOs. In the case of the successful tobacco control reform, the study concludes:

There was a multimedia information campaign and some civil society mobilisation of a classic sort, especially around the public health dimensions. But what tipped the balance in the end was the work of a dedicated core of individuals in a couple of organisations. This core group was able to address the severe coordination problems that normally afflict broad-based campaigns. It was also in a position to make tactical decisions about how to divide the opposition and make alliances, without the need for consensus other than on the reform objective itself (7).

Annex 7 provides further details about sub-national EBaP arising from the site visits to Davao.

Finally, despite being the major focus for health expenditure, the private sector is not systematically taken into account in priority setting, planning and budgeting. Interviewees confirmed that there is some formal engagement with the private sector medical associations at the national level, but little engagement at local levels. Interviewees in both the public and private sector said that part of the difficulty in engaging with the private sector was the absence of formal structure of the private sector. Individual specialties had associations that pursued their own agendas, but there was not an overarching, cohesive, framework for engaging with the private sector on policy matters. Some interviewees noted that many NGOs, and some in the media, tended to have an ideological bias against the private sector, especially what was seen as “big pharma”. This, in turn, may have coloured politicians’ and officials’ appetite for engaging publicly with the private sector.
4.4 Procurement and logistics

Procurement and logistics have been challenging under decentralisation, raising issues of priority setting, quality of services, and corruption. International research finds that government and development partners tend to focus on upstream planning, but fail to follow-up on downstream implementation (10). An evaluation conducted in 2011 found that very strong, evidence-based, subnational plans for RMNCH in the Philippines were abandoned part way through the financial year because procurement delays and sluggish financial flows overtook events. As mentioned already, mis-procurement or delayed procurement often has a dramatic effect on downstream implementation (10). An evaluation finds that government and development partners alike.

In the Philippines, each local government similarly manages its own system of drug procurement, inventory, dispensing, and financing. The quality of locally procured drugs is generally poor, the purchase price is often higher than in private pharmacies, stock shortages are frequent, and irrational drug use occurs. A principal reason is that local therapeutic committees are not constituted, not functioning, or not well trained in modern drug management. Local drug procurement is also corrupt in many places: bids are rigged, qualified bidders are “pre-identified,” and bidders connive. Moreover, the supply chain extends only to urban centers; poor outlying municipalities rely on itinerant drug peddlers who arrive infrequently (62).

China’s national government has also moved to regulate pharmaceutical procurement in its decentralised health sector, for similar reasons (61). Efficiency and accountability in the areas of procurement and logistics are important priorities for improvement in the Philippines. A study of the decentralisation experience in Indonesia, Philippines and Vietnam found that:

Development partners should understand the politics of the Philippines but stay distant from it. Expenditure on development programs can be a major arena for corruption and politicking. The worst case outcome for UNICEF or another development partner would be to cross the line and have its evidence or approach captured by a political process or be seen to be partisan, especially by beneficiaries or other partners attempting to rise above partisanship.

Like most LMICs, the Philippines needs better quality data to inform planning, monitoring and regulation of programs. Data is more important than ‘tools’, but the data needs to be appropriate. Virtually all officials interviewed during the field visits said that the system for prioritising and planning were satisfactory or at least ‘good enough’. However many officials said that a key problem was lack of reliable and regular data. Several stressed that household expenditure data would be a particularly valuable source of evidence to help shape priorities, planning and resource allocation. On the other hand, some officials during field visits suggested they needed better estimates of the maternal mortality ratio in their LGU, which is unlikely to be feasible or accurate enough to guide related programs. Many nations are starting to pay attention to the value of data, especially those whose decentralisation demands local information. This is a highly appropriate area of focus for the government and development partners alike.

Effective implementation of well-designed regulation can generate social benefits and fiscal resources far in excess of the associated costs. A recent study in India found that almost one quarter of school teachers are absent without approval at an estimated cost to government of around $1.5 billion/year. However it also found that “investing in better governance by hiring more inspectors to increase the frequency of monitoring could be over ten times more cost effective at increasing teacher-student contact time (net of teacher absence) than hiring more teachers.” (62). Interestingly, “top down” i.e. government monitoring was found to be more effective than grass roots community-based monitoring of attendance in reducing absenteeism and corruption, a finding shared by Oklen’s research in Indonesia (63). Political economy issues will still arise of course: inspectors may seek bribes and public sector unions may resist inspection. But an estimated cost: benefit ratio of 10$ is a strong incentive for government to resolve the political economy challenges.

PhilHealth is a major strategic opportunity to influence nation-wide access to health care that can benefit the poor, including women and their children. As noted, PhilHealth covers 82% of the population of the Philippines, or 81.5 million people. While the benefits package is currently limited in size and scope, it is developing and growing over time. The future design of the premiums, benefits package and the payments schedule will change the incentives for poor people to access essential health care. 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 for individual households. There are ongoing opportunities for development partners including UNICEF, the World Bank, ADB, WHO and others to assist PhilHealth to scale up and redesign its health insurance program in ways that are evidence-based and serve the interests of the poor.

Mayors are particularly powerful in the Philippines, and should be engaged for local support of development initiatives. However, medium and longer term health issues may not align with their short terms of office. On the other hand, many will rotate within the civil service, taking their knowledge and experience with them as they move on. UNICEF support for capacity building for Mayors on the benefits of EBaP and local investment in pro-poor health outcomes, particularly RMNCH, is important.

Well informed media coverage, including radio and social media, is often a key factor in shaping public opinion. In an increasingly connected world, even in nations whose governments attempt to control social and mass media, it is increasingly important to acknowledge access to and the content of information that is disseminated. Journalists may not have the technical expertise/time to analyse plans and budgets. Journalist training is an effective means of reducing the risk of misinforming the public, or of influencing the media in

5. Recommendations

The preceding section analysed the current situation. This Section makes observations and recommendations about how the Philippines and its development partners can build on the preceding analysis to further improve development effectiveness. The aim of this Section is to offer practical, “actionable” recommendations.

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desired directions. Moreover, UNICEF’s Child Friendly Budgeting approach provides a useful perspective on what to look for in a national and sub-national budget. UNICEF and other development partners could analyse budgets and provide briefing notes/points to look for in a budget. The current initiative of training Mayors about the importance of including health priorities in the local budgets could also be augmented by workshops for politicians, media, and NGOs on key things to look for in a budget that affects RMNCH.

The NHAs of a country are a strategic but often under-utilised source of evidence for policy dialogue. They set out the sources of health financing: government, private, social insurance, development partner etc. NHAs also set out the uses to which those funds are then put: tertiary level hospitals, secondary level hospitals, private practitioners etc. Done well, NHAs therefore provide a clear and easily accessible overview of the whole health system. Despite NHAs being a particularly powerful and strategic evidence base for policy, interviews confirmed that they are rarely used by public health advocates. This is a lost opportunity for engaging in more evidence-based policy dialogue. Philippines development partners and government should both attempt to improve the content of the NHAs and more use of them in health program planning and monitoring.

The unplanned and unexpected can completely overwhelm all planning: development partners need to be realistic about how effective and durable planning processes are, and retain flexibility. Super Typhoon Haiyan /Yolanda devastated lives and infrastructure in the central Philippines in November 2013. Although typhoons and other natural disasters (including volcanoes) are common in the Philippines, the scale and destructive force of Haiyan /Yolanda was unprecedented. UNICEF Manila dramatically scaled up expenditure from $6 million to $36 million within two years. That then completely – and quite appropriately given the scale of the problem – overturned the then current country assistance strategy, priorities, planning and budgets. The same principle applies to other development partners. The main factors that drove Australian expenditure over the last few years were all exogenous, completely unexpected, and overwhelmed past plans and priorities. These included the Indonesia tsunami; the emergence of Timor Leste as a nation; 9/11; programs in the Solomon Islands and even the integration of AusAID into DFAT.

Conditionality rarely works. The World Bank states it has learnt this lesson and has moved “from lender with conditions to facilitator with influence”(11). For example Official Development Assistance can provide the financial ‘breathing space’ to allow governments to implement and sequence reforms; but it rarely, if ever, results in a sustained change in policies or programs if this conflicts with the political economy incentives of the host government. (5, 64, 65).

In summary the Philippines is at a particularly important stage in terms of its political economy. It has a reforming President, the economy is growing, and the government is rapidly scaling up UHC. There are opportunities for UNICEF and development partners to assist the rapid evolution of the health system so that it increasingly benefits the poor, including women and their children.

References
44. WHO. WHO Philippines Country Cooperation Strategy at a glance. 2014.
Annex one: definitions of political economy

There is no single, agreed definition of the term “political economy”. The OECD concisely says that: “Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time.” (16) Bluevan says “In its modern form, political economy studies refer to the study of the relations between political and economic processes which involve several factors such as incentives, relationships, and the distribution of power between various interest groups in society, all of whom have an impact on development outcomes.” (66).

DFID has a more expansive description, which highlights how political economy analysis can improve development effectiveness:

Political economy analysis is a powerful tool for improving the effectiveness of aid. Bridging the traditional concerns of politics and economics, it focuses on how power and resources are distributed and contested in different contexts, and the implications for development outcomes. It gets beneath the formal structures to reveal the legacies, prior experiences with reforms, social trends, interests, incentives, rents/rent distribution, historical legacies, prior experiences with reforms, social trends, and how all of these factors effect or impede change. Such insights are important if we are to advance challenging agendas around governance, economic growth and service delivery, which experience has shown do not lend themselves to technical solutions alone. It can also contribute to better results by identifying where the main opportunities and barriers for policy reform exist and how donors can use their programming and influencing tools to promote positive change. This understanding is particularly relevant in fragile and conflict-affected environments where the challenge of building peaceful states and societies is fundamentally political. (16)

The World Bank (17) says:

What is political economy? Political economy (PE) is the study of both politics and economics, and specifically the interactions between them. It focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes. PE analysis involves more than a review of institutional and governance arrangements: it also considers the underlying interests, incentives, rent/distribution, historical legacies, prior experiences with reforms, social trends, and how all of these factors effect or impede change.

Annex two: approach and methodology

The following is an extract on initial thinking about methodology and approaches written by Dr Midori Sato. The full text is available on request.

There are numerous analytical tools and approaches that could be used to examine governance and political economy of priority setting, planning and budgeting in the social sectors of developing countries. According to DFID’s “how to note” on political economy analysis (15), these tools are broadly divided into three types: 1) Macro-level country analysis (understanding how political and economic systems of a country enable or hold back overall development, and to identify strategic entry points for programming in a country); 2) Analysis focused on particular sectors (understanding the interests, incentives and institutions operating within a particular sector, to inform the design of a sector programme); and 3) Problem-focused analysis (understanding and resolving a specific problem that may be encountered in a particular donor programme). (16)

For example, the analytical process proposed by DFID/ODI (Figure 1) broadly follows these three stages (including the above two levels of analysis at both country-level and sector/intra-sector level) and supports DFID’s “Drivers of Change” (19).

Another option is a problem-driven framework for political economy analysis (Figure 2) which was informed by a review by Wild et al. (2012), (20) on governance and political factors affecting weak service delivery in three social sectors (education, health and water and sanitation) in multiple countries.

McLoughlin (2012) maps technical characteristics of service provision in particular sectors and sub-sectors and identifies the political and governance implications of these characteristics for provision.

These papers facilitate our understanding by providing an analytical toolbox to give shape to the complex web of incentive structures that affect sector performance. The problem-driven analysis framework (Figure 2) presents a way of thinking about governance and political economy and the interaction between the three sets of variables/factors and corresponding steps to analyse those variables:

(i) Identifying the problem, opportunity or vulnerability to be addressed,
(ii) Mapping out the institutional and governance arrangements and weaknesses, and
(iii) Drilling down to the political economy drivers, both to identify obstacles to successful and progressive change and to understand where a ‘drive’ for positive change could emerge from and likelihood of is stakeholder support for various change options.

The second and third layers are differentiated in order to emphasize that institutional and governance dimensions as well as stakeholders and their interests, motivations, power and behavior will be explicitly considered in the second layer. The framework is useful in framing the concrete, problem-focused analysis and for structuring the inquiry process, yet it has limitation, such as difficulty in understanding linkages between wider country-level dynamics and specific problem analyzed within specific sector (Fritz et al., 2009).
Other tools and approaches that can also be applied for political economy analysis include: “Power Analysis”25 by SIDA (Swedish), which focuses on the nature of power relations, distribution of power, and incentives for pro-poor reforms; “Strategic Governance and Corruption Analysis (SGACA)”26 developed by the Netherlands’ Ministry of Foreign Affairs, which is very similar to “Drivers of Change,” but with a more tightly structured process and heavily relying on secondary sources of data conducted within a short timeframe; other tools include, but are not limited to “Politics of Development” by DFID and “Addressing Governance in Sector Operations” by the European Commission (ECI).

All of the tools and approaches described above have strengths and weaknesses. Considering that there is great variety between, and within, the four assessment
Country Political Economy Profile: The Philippines

Key messages
- The Philippines has a large (96.7 million) and fast growing population. Poverty rates are still high: almost three quarters of the population live below $2 a day. There is inequity in access and outcomes.
- The Philippines has had a turbulent political history (including coups, and assassinations) and, until recently, a sluggish economy. Fiscal decentralisation in 1991 reflects political pressures at the time and decentralisation is yet to be fully worked through.
- Expenditure on health is increasing in absolute and relative terms, albeit from a low base.
- There is a history of Government launching of health sector reforms, but arguably less commitment to sustained implementation. Government does appear strongly committed to scaling up UHC.
- Private expenditure and private providers are important components of the health system.

The political environment

The Philippines has had a turbulent political history since gaining independence from the United States (and prior to that Spain) in 1946. The Philippines has experienced martial law during President Marcos’ long reign (1965-86); a ‘people power’ revolution backed by the military and civil society in 1986; a military supported removal of President Estrada; corruption claims against three Presidents (Marcos, Estrada, and Arroyo); the assassination of a potential Presidential candidate (Ninoy Aquino) and of numerous journalists; and a longstanding conflict with Islamic separatists in Mindanao (MILF)(67).

Benigno Aquino (son of previous President Corazon Aquino) became President in June 2010 based partly on his commitment to “inclusive growth” and anti-corruption. President Aquino’s Liberal Party became the largest party in the lower chamber of Congress during the May 2013 mid-term elections. However, lacking an outright majority it was forced to form alliances (and therefore compromises) with other parties. President Aquino’s term finishes in June 2016 and, under the Constitution, he is not eligible for re-election. Main parties and political groupings in the Philippines are the Liberal Party; Lakas-Kabila ng Malayang Pilipino-Christian Muslim Democrat (Lakas-Kampi-CMD); Nacionalista Party; Nationalist People’s Coalition (NPC); Pwersa ng Masang Pilipino (PMP); Partido Demokratiko Pilipino-Lakas ng Bayan (PDP-Laban); Communist Party of the Philippines (CPP); Moro National Liberation Front (MILF); Moro Islamic Liberation Front (MILF)(68).

The socio-economic environment

The Philippines has a Gross National Income27 (GNI per capita of $3270 in 2013(68) making it a lower middle income country. With generally good literacy and has the same weaknesses as seen recently in the USA; the potential for political logjams that prevent reform. The informal political system is strongly influenced by family political dynasties (Marcos family, Aquino family etc); the military; the Roman Catholic church; wealthy landowners and business elites; and strong, articulate, NGOs.

The Philippines is scaling up Universal Health Coverage. (81, 82)

The resource allocation environment: proxy evidence of political priorities and commitment.

Total health expenditure (THE) which includes public as well as private expenditure on health was the equivalent of 4.5% of GDP in 2012, around the average for lower middle income countries (LMICs) globally 4.80. As in much of Asia with poorly developed health insurance or pooling mechanisms, much of the total health expenditure in the Philippines is financed privately (ie not by government).

Furthermore, the vast bulk of private expenditure on health is then financed directly out of pocket (ie without insurance). This is shown in Table 1 below. High levels of direct out of pocket payments for health care are a barrier to seeking essential care amongst the poor and / or a cause of financial distress and poverty: one reason why the Philippines is scaling up Universal Health Coverage.(81, 82)

The latest Gini index28 for the Philippines is 4.4 in 2006, little changed from 4.3 in 1991, and higher than the latest Gini index for Indonesia (38.1), Nepal (32.8) and Bangladesh (32.12). The latest available figures for the under-five mortality rate in the Philippines is 59/1000 live births in the lowest wealth quintile compared to 17/1000 in the highest; 46/1000 in rural areas compared to 28/1000 in urban areas; 41/1000 for boys compared to 34/1000 for girls. (76) There is a large disparity in DPT 3 immunisation among 1 year olds based on the education level of the mother (90 % immunisation coverage if the mother had secondary or higher education compared to 36% coverage if the mother had no education). This disparity is, intriguingly, as it is much larger than wealth differences (94% immunisation amongst the wealthiest, compared to 72% coverage amongst the poorest) or geography (88% coverage in urban areas and 83% coverage in rural areas). Women’s access to essential services is also demonstrably inequitable on several criteria. For example, 94% of women in the highest wealth quintile, 78% of urban women, and 73% of women with a secondary education or more have births attended by skilled health professionals compared to just 26% of the poorest wealth quintile, 48% of rural women, and 11% of women with no education. Inequity of access and outcomes has been a longstanding, stubborn, challenge in the Philippines for decades, with multiple complex causes some of which overlap with the persistently high levels of poverty (76-79) (80)

<table>
<thead>
<tr>
<th>Country or grouping</th>
<th>Private expenditure on health as % Total Health Expenditure in 2011 (per cent)</th>
<th>Out of Pocket Expenditure on Health as % private expenditure on health (per cent)</th>
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</thead>
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<tr>
<td>Bangladesh</td>
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<td>96.6</td>
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<td>Indonesia</td>
<td>62.1</td>
<td>76.3</td>
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<td><strong>Philippines</strong></td>
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<td>Low Income Countries globally</td>
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<tr>
<td>Lower Middle Income Countries globally</td>
<td>63.4</td>
<td>87.1</td>
</tr>
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</table>

Source: World Health Statistics 2014

27 GNI is a better measure of economic wealth as, unlike Gross Domestic Product, GNI captures the effect of overseas remittances: key issues in Asia.

28 A standard measure of inequality where 0 equals total equality and 100 is total inequality, with one person owning all income.
In essence, Purchasing Power Parity (PPP) is an estimate that seeks to avoid market exchange rate movements and takes into account the fact that prices of goods and services may well be lower in developing countries. It expresses figures in notional “International dollars” or $I to distinguish the estimates from $US.

Per capita expenditure on health is rising off a low base in the Philippines. As shown in Chart 1 below, real (adjusted for inflation) per capita expenditure on health in Purchasing Power Parity29 terms in the Philippines was generally low ($ International 70 per person per year) and flat from 1995 to 2003. It then rose steadily (purple line, at the top of Chart 2) since then, reaching $ International 202.50 per capita in 2012, higher than the LMIC global average of $ International 177.68.

Virtually all countries make bold political commitments to improving health outcomes for the poor and vulnerable, including especially women and children. But resources (money, health personnel, political capital) are always scarce, especially in developing countries. Where, why, and how the political / bureaucratic system allocates its scarce resources is therefore the true litmus test of what is actually a priority to the decision makers. As seen in Chart 2, the Government of the Philippines has allocated (purple line) only around 8% of total government expenditure to the health sector for more than a decade prior to 2008. The share of government expenditure allocated to health has risen since then to 10.3% by 2012 (68) partly reflecting the commitment to Universal Health Coverage.

The environment for RMNCH and the health sector more broadly.

Life expectancy at birth (both sexes) had improved from 60.8 in 1990 to 68.5 years in 2012. (63) However, like other countries in the region, the Philippines, is facing a “double burden” of communicable and non-communicable diseases. More specifically, communicable, maternal, perinatal and nutritional conditions still constitute 30% of all deaths for all ages; NCDs (especially cardiovascular disease) constitute 62% of deaths, and injuries constitute 8%. (84) An estimated 44% of male and 35% of female NCD related deaths are premature. (84)

Reproductive, maternal newborn and child health show mixed progress. On the positive side, UNICEF statistics show that the under-five mortality rate, and infant mortality rate, have both steadily fallen by more than half since 1990: the U5MR falling steadily from 60/1000 live births in 1990 to 29/1000 in 2010, and the IMR falling steadily from 42.5/1000 to 23 /1000 over the same period. (85) The Philippines has moved from having the 59th worse rate for U5MR in 1990 to 30th in 2012. As noted above, there are substantial and persistent inequalities of access and outcomes based on wealth, education levels and geography, but these are nevertheless substantial achievements at a national level.

Less promising is the situation for reproductive health, maternal health, and nutrition. The contraceptive prevalence rate is less than half (48.9%) and the Total Fertility Rate is 3.1 (83) : higher amongst poorer communities. Over one fifth (21%) of babies are low birth weight. (83) The prevalence of moderate to severe stunting is 32%. (83) Overweight and obesity rates are increasing. The adjusted maternal mortality ratio is 99 /100,000 live births. (83) As seen in Chart 3, the MMR in the Philippines (bottom line) is lower than other comparable countries, but there has also been much less progress over the years in reducing the ratio of deaths.

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29 In essence, Purchasing Power Parity (PPP) is an estimate that seeks to avoid market exchange rate movements and takes into account the fact that prices of goods and services may well be lower in developing countries. It expresses figures in notional “International dollars” or $I to distinguish the estimates from $US.
• providing fiscal autonomy and retention of hospital
• the Health Sector Reform Agenda (HSRA) in 2000
several major reform programs involving the Department
provinces and districts in the health sector and other
implementation of services between central authorities,
led to fragmentation of policy, planning, budgeting, and

A sudden and rapid process of political and fiscal
decentralisation occurred in 1991 via the Local
Government Code (Republic Act 7160), largely in response
to fears that an authoritarian, centralised political regime
would take power after President Corazon Aquino’s
terms of office ended. The speed of decentralisation
led to fragmentation of policy, planning, budgeting, and
implementation of services between central authorities,
provinces and districts in the health sector and other
sectors. Government of Philippines has since launched
several major reform programs involving the Department
of Health. These have included, for example:

• the Health Sector Reform Agenda (HSRA) in 2000
  • as an overarching framework for health policies and
    investments between government and development
    partners;
  • providing fiscal autonomy and retention of hospital
    income to 68 DOH hospitals in 2003;
  • the launch in 2005 of the FOURmula ONE for Health(F1)
    focusing on a more responsive health system, more
    equitable health financing, and better health outcomes,
    reduced fragmentation of the Philippine health system
    and reduced inequity in health care.

• Launch of the Sector-wide Development Approach
  for Health in 2007 to integrate development partners’
support with the “F1” program.
• Launch in 2008 of the Maternal, Neonatal, and Child
  Health and Nutrition Strategy (MNCHN) nationally. Pilot
implementation of the Investment Case” for maternal
newborn and child health with support from UNICEF and
Australia.
• Launch in 2010 of Universal Health Care (UHC) known as
  “PhilHealth Sabado.”

These developments demonstrate a political appetite
amongst politicians and bureaucrats for reform in the
health sector (or at least an appetite for launching
reform initiatives). Field evaluations in 2012 of the
Investment Case approach suggest, however, that the
initial enthusiasm for reform is not always sustained.
Local political priorities, bureaucratic inertia, and an
understandable focus on crisis management (including
disbursement and procurement delays) can drain political
and bureaucratic commitment and capital.

• Launch in 2010 of Universal Health Care (UHC) known as
  “PhilHealth Sabado.”

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Annex four: List of people interviewed in the Philippines

The following is the list of those people interviewed in the Philippines during the period 14-25 July 2014. Organisations, and names of individuals, are listed in alphabetical order. Interviews were requested with the Department of Health, Manila; Department of Budget and Management; Australian Department of Foreign Affairs and Trade (DFAT) and the World Bank but could not be accommodated in the time available.

<table>
<thead>
<tr>
<th>Organisation/individual’s name (in alphabetical order)</th>
<th>Title of Individual</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Civil Society Organisations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maria Calimag</td>
<td>President, Philippine Medical Association</td>
<td><a href="mailto:erviecalimag@gmail.com">erviecalimag@gmail.com</a></td>
</tr>
<tr>
<td>May-1 Fabros</td>
<td>Executive member, Womanhealth Philippines Inc</td>
<td></td>
</tr>
<tr>
<td>Junice Melgar</td>
<td>Executive Director, Likhan Centre for Women’s Health, Quezon City</td>
<td><a href="mailto:Junice@likhaan.org">Junice@likhaan.org</a></td>
</tr>
<tr>
<td>Ana Maria Nemenzo</td>
<td>National Coordinator, Womanhealth Philippines Inc</td>
<td><a href="mailto:anamenexo@yahoo.com">anamenexo@yahoo.com</a></td>
</tr>
<tr>
<td>Regina Ingeinte</td>
<td>Executive Director, Development of Peoples Foundation, Davao</td>
<td></td>
</tr>
<tr>
<td><strong>Davao City officials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florence Cayon</td>
<td>Project Monitoring and Evaluation Division Chief, City Planning and Development Office, Davao</td>
<td></td>
</tr>
<tr>
<td>Alice Crumb</td>
<td>Planning Officer, Department of Health Regional Office, Region XI</td>
<td><a href="mailto:alicerhodora@yahoo.com">alicerhodora@yahoo.com</a></td>
</tr>
<tr>
<td>Floremae Lofranco</td>
<td>Budget Officer 11</td>
<td></td>
</tr>
<tr>
<td>Melchor V. Quitain</td>
<td>City Administrator, Davao City</td>
<td></td>
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<tr>
<td>Joy Josephine Villafuerte</td>
<td>City Health Officer, Davao City</td>
<td></td>
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<tr>
<td><strong>National Economic and Devt Authority (NEDA) in Davao</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janice Cerezo</td>
<td>Senior Economic Development Specialist, National Economic and Development Agency, Region XI</td>
<td><a href="mailto:Janice_cerezo38@yahoo.com">Janice_cerezo38@yahoo.com</a></td>
</tr>
<tr>
<td>Mae Ester Guarnadel</td>
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</tr>
<tr>
<td>Fely Rabe</td>
<td>Senior Economic Development Specialist, National Economic and Development Agency, Region XI</td>
<td><a href="mailto:felyrabe@yahoo.com">felyrabe@yahoo.com</a></td>
</tr>
<tr>
<td><strong>National Economic and Devt Authority (NEDA) in Manila</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roma Atabug</td>
<td>UNICEF Program Coordinator</td>
<td><a href="mailto:rmatabug@neda.gov.ph">rmatabug@neda.gov.ph</a></td>
</tr>
<tr>
<td>Erlinda Capones</td>
<td>Director IV, Social Development Staff</td>
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</tr>
<tr>
<td>Tom Javate</td>
<td>Social Development Group</td>
<td><a href="mailto:tpjavate@neda.gov.ph">tpjavate@neda.gov.ph</a></td>
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<table>
<thead>
<tr>
<th>Organisation/individual’s name (in alphabetical order)</th>
<th>Title of Individual</th>
<th>Email</th>
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<tbody>
<tr>
<td><strong>PhilHealth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lezel P. Lagada</td>
<td>OIC-Vice President, Quality Assurance Group, Health Insurance Products - PCB and MDG, Philippine Health Insurance Corporation.</td>
<td></td>
</tr>
<tr>
<td><strong>UNICEF</strong></td>
<td></td>
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<tr>
<td>Raoul Bermejo</td>
<td>Health Specialist, Health and Nutrition Section, Manila</td>
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</tr>
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<td>Augusto Rodriguez</td>
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</tr>
<tr>
<td>Pura Angela Wee</td>
<td>Health Specialist, Manila</td>
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</tr>
<tr>
<td>Willibald Zerk</td>
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</tr>
<tr>
<td><strong>University of the Philippines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bernardino Aldaba</td>
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<td>Ernesto Domingo</td>
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</tr>
<tr>
<td>Aleli Kraft</td>
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</tr>
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<td>Marilyn Lorenzo</td>
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</tr>
<tr>
<td>Carlo Panelo</td>
<td>Associate Professor, Social Medicine Unit, Department of Clinical Epidemiology</td>
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</tr>
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<td>Orville Solon</td>
<td>Professor, University of Philippines School of Economics, Chief of Party, Health Policy Development Program</td>
<td><a href="mailto:Orville.solon@gmail.com">Orville.solon@gmail.com</a></td>
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</tbody>
</table>
Annex five: Strengths and weaknesses of the Philippines system of priority setting, planning and budgeting

<table>
<thead>
<tr>
<th>Priority setting, planning and budgeting issue</th>
<th>Strengths of the Philippine system from a political economy perspective</th>
<th>Weaknesses of the Philippine system from a political economy perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence and data base</td>
<td>Increasingly output / outcome oriented.</td>
<td>MDG and other distal outcomes are far removed from the political cycle.</td>
</tr>
<tr>
<td></td>
<td>Philhealth benefit package for NCDs screening is based on WHO evidence based and cost-effective “Package of Essential NCD” (PEN) approach</td>
<td>Lack of data, or capacity to interpret data strategically, at the LGU level.</td>
</tr>
<tr>
<td>Planning process overall</td>
<td>The formal system, and the criteria used, are generally of very high standard, are rational, and strategic. NEDA Investment Coordinating Committee uses cost benefit and cost-effectiveness.</td>
<td>Very hard to get data about, let alone from, the private sector even though they are prominent in health (especially hospitals) and education. The poor and vulnerable not included in vital registration statistics.</td>
</tr>
<tr>
<td>Participation in priority setting and planning</td>
<td>Generally very strong at the national level.</td>
<td>Implementation is weak (see below).</td>
</tr>
<tr>
<td></td>
<td>Bottom up budgeting is a serious effort.</td>
<td>There is a high level of “formal” transparency.</td>
</tr>
<tr>
<td></td>
<td>Very strong and well informed NGO community (&quot;Alternative Budget Initiative&quot;) has been producing its own very credible “Alternative Budget” for many years.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Priority setting, planning and budgeting issue</th>
<th>Strengths of the Philippine system from a political economy perspective</th>
<th>Weaknesses of the Philippine system from a political economy perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget allocation and budget execution</td>
<td>Social sectors attract the majority of public resources at the national level.</td>
<td>Highly politicised. Congressional and local mayors have high degree of discretion that breeds a reactive (not strategic) and patronage based approach to expenditure.</td>
</tr>
<tr>
<td></td>
<td>DBM has a task force that reviews budget releases and reviews projects at that time</td>
<td>Mayors can basically overrule previous evidence based plans.</td>
</tr>
<tr>
<td>Sources and uses of funds in the health sector</td>
<td>Excise duties on tobacco and alcohol then used for expanding UHC is a world class example of a “win-win” for public health and fiscal space, as well as making financial resources more predictable, sustainable, and less amenable to political diverting for pet projects.</td>
<td>Sources of funds tend to be from VAT which is regressive compared to income tax. Uses of funds hard to determine but much appears to be going to tertiary level, private hospitals.</td>
</tr>
</tbody>
</table>

| Efficiency, effectiveness and equity of public expenditure | Public Expenditure Report (PER) finds that efficiency of public expenditure in social sectors is in line with comparator countries. However the quantum of public expenditure is low. | Variable but generally very weak. Provinces and LGUs have planning, budgeting, contracting and procurement processes that are still suited to an era of scarce resources, not large increases. |
|                                                             | Trialling of new program budgeting approach by DBM links budget lines to outputs and outcomes. | DOH rationalisation is seeing a reduction in program managers and focal points at the same time public expenditure is increasing. |
|                                                             | Expenditure is pro poor for primary level education but pro rich for tertiary. | LGUs have planning, budgeting, contracting and procurement processes that are still suited to an era of scarce resources, not large increases. |
|                                                             | National Government spending on public health has been progressive, while spending on hospital services is regressive. | Use of PHILHealth – while not perfect - indicates substantial scale up is possible. |
|                                                             | Between 2003-2007, total spending on the health sector became less regressive because of the increase in the share of public health expenditures in the overall DOH sector budget. | Sources of funds tend to be from VAT which is regressive compared to income tax. Uses of funds hard to determine but much appears to be going to tertiary level, private hospitals. |

| Implementation | Scale up of PHILHealth – while not perfect - indicates substantial scale up is possible | Some indicators are too distal (eg MDG indicators) to be relevant to LGUs. |
| Monitoring and evaluation | LGU Scorecard system is clear and intuitive | Operational monitoring is adequate but there is insufficient impact evaluation; a key gap when funding is increasing rapidly. |

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Annex six: Explanation of priority setting and planning by the National Economic and Development Authority (NEDA) of the Philippines

1. How are national priorities set in your country? What is the process? To what extent does “evidence based planning” play in the setting of priorities? Do you ever use formal criteria for including or excluding a program or project cost effectiveness analysis? Which are the most powerful agencies inside and outside of government that help make those decisions? How do budgets and staffing levels get changed to reflect these priorities? What happens if there is a disagreement between the national level view of priorities and a strong sub-national view of priorities?

The PDP Process

The Philippine Development Plan (PDP), which embodies the country’s national priorities, serves as the government’s guide in formulating policies and implementing development programs. The PDP is produced every six years which coincides with the election of the new president. It translates the new administration’s vision and development agenda into strategies, policies, programs and activities for the plan period.

In the deliberation phase of the PDP, the administration’s development agenda are converted into actual plans. The NEDA issues the planning guidelines and spearheads the convening of working committees and sub-committees composed of various government agencies in charge of the various sectors/chapters that compose the Plan. In the current PDP, a Plan Steering Committee (PSC) and Planning Committees (PCs) were created. The PCs, through NEDA, conducted national and regional consultations among the various stakeholders – legislature, executive agencies, local government units, private sector, and other stakeholders – to generate inputs for the Plan and the Investment Program. The PCs then drafted the Plan chapters based on the inputs during the consultations and submitted it to the PSC. The PSC harmonized the submissions of the PCs into an initial draft Plan and presented it to the NEDA Board and the LEDAC. After incorporating the comments of the NEDA Board and the LEDAC, the PSC submitted the Plan to the President for final approval.

PDP accompanying documents

The PDP formulation is accompanied by the preparation of the Public Investment Program (PIP), the Results Matrices (RMs), and the Regional Development Plans/Investment Program.

The PIP contains the priority programs and projects to be carried out by the national government in support of the Plan. It is an instrument to target and monitor NG commitments and resources over the medium-term in support of the PDP. It is intended to tighten the link among planning, programming, budgeting and monitoring and evaluation. The PIP is prioritized through the Sectoral Efficiency and Effectiveness Review (SEER) criteria. The formulation of the PDP 2015-2016 marks the first time that the government is utilizing the RMs – an indicator framework that identifies the results chain from the subsector/intermediate outcomes to sector outcomes, and finally to the societal goal of “poverty in multiple dimensions reduced and massive quality employment created.” The RMs contain statements of results to be achieved, corresponding links to specific items of the government’s five major Guide Posts (based on the President’s 16-Point Agenda), indicators, baseline information, end-of-Plan targets and responsible agencies. Each chapter of the PDP has a corresponding chapter in the RMs. The RMs replaced Strategy Planning Matrices (SPMs) which was used in the previous national plan (MTPDP 2004-2010).

The NEDA Board

The powers and functions of the NEDA reside in the NEDA Board. It is the country’s premier social and economic development planning and policy coordinating body.

The Board is composed of the President as chairman, the Secretary of Socio-Economic Planning and NEDA Director-General as vice-chairman, and the following as members: the Executive Secretary and the Secretaries of Finance, Trade and Industry, Agriculture, Environment and Natural Resources, Public Works and Highways, Budget and Management, Labor and Employment, Interior and Local Government, Health, Foreign Affairs, Agrarian Reform, Science and Technology, Transportation and Communications, Energy, and the Deputy Governor of the Central Bank of the Philippines.

Assisting the NEDA Board in the performance of its functions are seven cabinet-level interagency committees, as follows:

1. Development Budget Coordination Committee (DBCC)

The DBCC is composed of the Secretary of Budget and Management, as chairman; the Director-General of the NEDA Secretariat, as co-chairman; and the Executive Secretary, Secretary of Finance and the Governor of the Central Bank of the Philippines, as members. The DBCC recommends to the President the following:

- Level of annual government expenditures and the ceiling of government spending for economic and social development, national defence, and government debt service;
- Proper allocation of expenditures for each development activity between current operating expenditures and capital outlays; and;
- Amount set to be allocated for capital outlays broken down into the various capital or infrastructure projects.

2. Infrastructure Committee (InfraCom)

The InfraCom is composed of the Director-General of the NEDA Secretariat, as chairman; Secretary of Public Works and Highways, as co-chairman; and the Executive Secretary and Secretaries of Transportation and Communications, Finance, and Budget and Management, as members. The InfraCom does the following:

- Advises the President and the NEDA Board on matters concerning infrastructure development, including highways, airports, seaports and shore protection; railways; power generation, transmission and distribution; telecommunications; irrigation, flood control and drainage, water supply and sanitation; national buildings for government offices; hospitals and related buildings; state colleges and universities elementary and secondary school buildings; and other public works;
- Coordinates the activities of agencies, including government-owned or controlled corporations involved in infrastructure development;
- Recommends to the President government policies, programs and projects concerning infrastructure development consistent with national development objectives and priorities.

3. Investment Coordination Committee (ICC)

The ICC consists of the Secretary of Finance, as chairman; the NEDA Director-General, as co-chairman; and the Executive Secretary, the Secretaries of Agriculture, Trade and Industry, Budget and Management and the Governor of the Central Bank of the Philippines, as members. The ICC has the following functions:

- Evaluates the fiscal, monetary and balance of payments implications of major national projects, and recommends to the President the timetable of their implementation on a regular basis;
- Advises the President on matters related to the domestic and foreign borrowings program; and
- Submits a status of the fiscal, monetary and balance of payments implications of major national projects.

4. Social Development Committee (SDC)

The SDC performs the following functions:

- Advises the President and the NEDA Board on matters concerning social development, including education, manpower, health and nutrition, population and family planning, housing, human settlements, and the delivery of other social services.
- Coordinates the activities of government agencies concerned with social development; and
- Recommends appropriate policies, programs and projects consistent with the national development objectives.

5. Committee on Tariff and Related Matters (CTRIM)

The CTRM is composed of the Secretary of Trade and Industry, as chairman, the Director-General of the NEDA Secretariat as co-chairman; and the Executive Secretary, the Secretaries of Foreign Affairs, Agriculture, Transportation and Communications, Environment and Natural Resources, Budget and Management, and Finance, the Governor of the Central Bank, and the Chairman of the Tariff Commission.
The RDCom performs the following functions:

- Advises the President and the NEDA Board on Tariff and related matters and on the effects on the country of various international developments;
- Coordinates agency positions and recommends national positions for international economic negotiations; and
- Recommends to the President a continuous rationalization program for the country's tariff structure.

6. Regional Development Committee (RDCom)

The RDCom was created by virtue of EO 257 issued on 15 December 2002. It is composed of the NEDA Director-General, as Chair. Its member are the Secretaries of the Department of Budget and Management and of the interior and Local Government, RDC Chair or Co-chair each coming from Luzon, Visayas, and Mindanao and four (4) regional development expert from the private sector and academe.

The RDCom performs the following functions:

- Formulates and monitors the implementation of policies that reduce regional growth disparities, and promote rational allocation of resources among regions;
- Serve as clearing house for key regional development policy/programs proposals which impact on two or more regions;
- Formulates and monitor implementation of the framework for regional development of the Medium Term Philippine Development Plan;
- Directs the formulation and review guidelines for the regional allocation of agency budgetary resources;
- Periodically reviews the viability of the regional configuration of the country and recommend to the President the re-delineation of regions, as may be necessary; and
- Periodically reviews the composition, structure and operating mechanism of the Regional Development Councils and recommend to the President changes as may be necessary.

7. National Land Use Committee (NLUC)

The NLUC was created by virtue of Executive Order Nos. 770 and 770-A on 01 December 2008 and 30 September 2009, respectively.

Composed of NEDA (Chair), DENR, DA, DAR, DTI, DPWH, DOTC, DOT, DILG, DOJ, DOST, DOE, HUDCC/HLURB, NCIP, LPP, LCP, LMP and two private sector representatives, the Committee is primary tasked to:

- Advise the President on matters concerning land use and physical planning;
- Formulate a national physical framework plan and other inter-sectoral policies and programs that guide the rational utilization and management of the country's land and other physical resources, and the preparation of sub-national physical framework plans;
- Promote the integration of land use and physical planning policies, plans and programs, including disaster risk management, into national socio-economic plans and programs;
- Decide and resolve land use policy conflicts among agencies of the national government;
- Establish and maintain, in conjunction with various appropriate government agencies, a database system which would identify and classify the present and possible uses of specific land areas, public and private, comprising the total land resource of the nation; and
- Provide policy directions to the Regional Land Use Committee in the performance of their physical planning functions.

Question: What is the fastest growing part of the national budget now and over the coming 3 to 5 years?

In line with the government’s priority agenda of reducing poverty incidence, the social services sector receives the largest budget among the other sector allocations from the period 2010 to 2014 (See Table 1). The budget supports the key result area (KRA) of the Social Contract with the Filipino People on poverty reduction and empowerment of the poor and vulnerable. Some programs supported include provision of basic education (elimination of all resource gaps), Universal Healthcare Program, provision of decent and affordable housing and the Pantawid Pamilyang Filipino Program, among others.

Public spending on social services is programmed to increase at least in the medium-term. The share of social services to total budget increased from 28.2 per cent in 2010 to 34.5 per cent in 2011 in line with the government’s commitment to enhance the capabilities of the poor to participate in the growth process. From 32.4 per cent in 2012, the share of social services expenditures to total budget (net of debt amortization) reached 34.9 per cent in 2013 and is programmed at 37.2 per cent in 2014.

In addition, the government also prioritizes increasing public expenditure on infrastructure to boost economic services in the country through public construction and capital outlay with projects consisting of rehabilitation/construction of roads and bridges, enhancement of tourism access, and irrigation to support the agriculture sector. Expenditure policy seeks to substantially increase public infrastructure spending from 2.5 per cent of GDP in 2010 to at least 5.0 per cent by 2016.

Table 1. Allocation of National Government Expenditures (Obligation Basis), By Sector 2010-2014

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>ECONOMIC SERVICES</td>
<td>25.88</td>
<td>23.17</td>
<td>26.80</td>
<td>25.38</td>
<td>26.02</td>
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<tr>
<td>SOCIAL SERVICES</td>
<td>28.23</td>
<td>34.48</td>
<td>32.38</td>
<td>34.87</td>
<td>37.16</td>
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<tr>
<td>DEFENSE</td>
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<td>4.49</td>
<td>4.07</td>
<td>4.46</td>
<td>4.09</td>
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<tr>
<td>GENERAL PUBLIC SERVICES</td>
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<td>19.05</td>
<td>18.15</td>
<td>17.32</td>
<td>16.07</td>
</tr>
<tr>
<td>NET LENDING</td>
<td>0.63</td>
<td>1.14</td>
<td>1.50</td>
<td>1.32</td>
<td>1.10</td>
</tr>
<tr>
<td>DEBT SERVICE</td>
<td>19.98</td>
<td>1766</td>
<td>1710</td>
<td>16.65</td>
<td>15.55</td>
</tr>
<tr>
<td>TOTAL (Net of Debt</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
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</table>

Amortization)             |             |             |             |               |              |

Source: Budget of Expenditures and Sources of Financing, various years Department of Budget and Management

The PDP and the National Objectives for Health set all the health program goals which operational strategy for improving the country’s health status is called the Kalusugan Pangkalahatan (KP) or Universal Health Care. KP seeks to ensure equitable access to quality health care for all Filipinos beginning with those in the lowest income quintiles. Its strategic thrusts are: (1) achieve health-related Millennium Development Goals (MDGs); (2) improve financial risk protection by expanding national health insurance coverage and benefits; and, (3) ensure access to quality care delivery system and improve health governance.

The planning and prioritization of programs and projects for maternal, newborn and child health is spearheaded by the Department of Health (DOH). Key policies and programs on these concerns requiring inter-agency inputs or action are discussed in the Social Development Committee (SDC).

While family planning is sometimes seen as a sensitive subject, the passage of Republic Act 10364 known as the “Responsible Parenthood and Reproductive Health Act of 2012” laid down the government’s policy to “promote and provide information and access, without bias, to all methods of family planning, including effective natural and modern methods.”
Question: What has been the trend in generating government revenue over the last 5 years? What is the forecast for government revenue generation over the coming years?

To achieve the medium-term targets, revenue-enhancing measures will focus on heightened collection efforts of the BIR in tandem with anti-smuggling strategies of the BOC in coordination with relevant government agencies. In the case of the BIR, enhanced tax collection will be supported by increased collection efficiency from the self-employed business and professionals, better assessment of estate taxes, and strengthened Fiscal Unit/Revenue Intelligence Unit. On the other hand, BOC’s comprehensive anti-smuggling strategies will include port accreditation, import mapping, fuel marking alongside the conduct of audit on oil companies, trade statistics reconciliation, and the requirement to submit a rolling import plan from all importers of sensitive commodities.

Other policy and legislative initiatives that will be pursued to support the expansion of fiscal space and to get on a sustainable revenue-and-spending path for the fiscal sector include (a) Customs Modernization and Tariff Act (CMTA); (b) rationalization of the mining fiscal regime; and (c) transparency and accountability in the administration and rationalization of fiscal incentives.

Non-tax revenue collection was also recorded at 1.8 per cent of gross domestic product (GDP) in 2009 and slowed down to 1.3 per cent in 2010, and reached 1.6 per cent for the years 2011, 2012 and 2013. The overall strategy in the fiscal sector is to increase the revenue effort to 17.1 per cent of GDP by 2016. This is to be achieved through an annual rise in tax revenues to be supported by increased collection efficiency from the self-employed business and professionals, better assessment of estate taxes, and strengthened Fiscal Unit/Revenue Intelligence Unit. On the other hand, BOC’s comprehensive anti-smuggling strategies will include port accreditation, import mapping, fuel marking alongside the conduct of audit on oil companies, trade statistics reconciliation, and the requirement to submit a rolling import plan from all importers of sensitive commodities.

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Annex seven: Evidence based planning and budgeting in Davao City

The problem of malnutrition, as well as practical cost-effective solutions, both rest on a solid evidence base already. UNICEF documents state that the Philippines has one of the highest under-five mortality rates in the East Asia and Pacific region. An estimated 195 children die per day in the Philippines, and 35% of those deaths are malnutrition related. The Philippines ranks 9th in the world for stunting and 10th for wasting. Nearly 5 million children suffer from malnutrition in the Philippines including an estimated 300,000 cases of Severe Acute Malnutrition (SAM), see abbreviations and glossary for definitions. Over 2000 children have SAM in Davao, a city of over 1.5 million with 182 barangays, in Mindanao. Community Management of Acute Malnutrition (CMAM) and ready to use therapeutic foods are also evidence based approaches that, properly implemented, allow SAM children to be treated effectively at home rather than families having to incur the cash and time expense of accessing health centres and/or ultimately requiring intensive care hospitalisation due to delayed treatment (86).

The UNICEF supported Evidence Based Planning and Budgeting (EBaP) approach has been instrumental in mobilising additional -- and better targeted -- resources to address acute malnutrition at a city-wide level in Davao. The Mayor of Davao and his city government already had a commitment to public health (see the case study on banning tobacco). They also state they have a commitment to the “least, last, and lost” and other marginalised groups. The administration recognised that malnutrition was a particular challenge. UNICEF selected Davao as one of its 3 partner cities32 to address SAM in Davao, using EBaP approaches. While too early to see impact and outcomes, the EBaP approach was critical to achieving much better input and process indicators. More specifically the 2013 City budget for health was P 6 million, of which P 5 million was allocated to personnel costs, leaving just P 1 million for programs. However largely as a result of presentations of EBaP findings, the operations budget for addressing malnutrition increased by P 5.5 million, around half of the total increase allocated to the City health budget.

Furthermore, the nutrition interventions are now institutionalised as an ongoing program. Executive Order 26/2014 of the Office of the City Mayor of Davao formally and permanently integrated the Integrated Management of Acute Malnutrition into the local health system. The approach in Davao to identifying children at risk of SAM, and using community based interventions such as supplementary feeding, is now considered by health workers as a more effective approach than the previous DOH nation-wide approach that tended to focus just on weighing infants and children. Identifying children with SAM, and the underlying causes on the demand and supply side of health care, was now starting to open a broader policy discussion about upstream prevention of SAM.

The EBaP principles are starting to be applied in other contexts circumstances. The process of looking systematically at the demand side, as well as the supply side of health care, and using local evidence to identify the most critical gaps, is being applied in other contexts. Early examples include using EBaP principles to disaster preparedness and resilience planning: a contrast to a simplistic “shopping list” approach whereby a Mayor had recently asked UNICEF to fund a fire truck as that LGUs simply “shopping list” approach whereby a Mayor had recently asked UNICEF to fund a fire truck as that LGUs.

32 In Quezon City UNICEF the EBaP approach focuses more on informal settlers, and in Puerto Princesa the EBaP focuses more on reproductive, maternal, newborn and child health services.