The Philippine Health Agenda for 2016 to 2022

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Introduction

Health has been a priority in the Philippine development agenda since the adoption of the Millennium Declaration. Among the eight Millennium Development Goals (MDGs), there are three health-specific goals—for child health (MDG4), maternal health (MDG5), and combating HIV/AIDS, malaria, and other diseases (MDG6). In addition, the goal for reducing poverty (MDG1) includes nutrition targets, which directly impact health; and three other goals address social dimensions critical for improving health—education (MDG2), gender equality (MDG3), and environmental sustainability (MDG7).

Given poor progress in achieving some of the above goals, they remain relevant beyond 2016 in the Philippines. Articulation of health goals for 2016 and beyond must also take into consideration the emerging as well as pervasive health challenges of the country. These include the increasing prevalence of non-communicable diseases (NCDs) and injuries, and rising inequities in health care and outcomes.

Recognizing the fact that many nations did not achieve the MDGs and that other important health issues have emerged, last September, 2015, the member states of the United Nations adapted the Sustainable Development Goals (SDGs) to replace the MDGs. Between 2016 and 2030, the same 195 countries that weighed in on the MDGs committed to achieving the SDGs. The principal health-specific SDG is SDG No. 3: Ensure Healthy Lives and Promote Well-Being for All at All Ages. Within SDG 3 are nine major targets namely:

1. Reduce the global Maternal Mortality Rate (MMR) to less than 70 per 100,000 live births
2. End preventable deaths of newborns and under-five children
3. End the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases
4. Reduce by 1/3 pre-mature mortality from NCDs through prevention & treatment, & promote mental health & wellbeing
5. Strengthen prevention & treatment of substance abuse, including narcotic abuse & harmful use of alcohol
6. Halve global deaths & injuries from traffic accidents
7. Ensure universal access to Sexual & Reproductive Health (SRH) care services, including family planning, information & education, & integration of Reproductive Health into national strategies & programs
8. Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, & access to safe, effective, quality, & affordable essential medicines & vaccines for all
9. Substantially reduce the number of deaths & illnesses from hazardous chemicals & air, water, and soil pollution & contamination

Health Agenda for 2016 to 2022

Within the framework of the MDGs and the SDGs, the Philippine Health Agenda can be summed as follows:

Unfinished Agenda:

High rates of avertable child, maternal and infectious disease illness and deaths – the unachieved Health-Related Millennium Development Goals

a. As of 2015, the MMR was at 204 mothers dying per 100,000 live births – a far cry from the MDG-MMR target of 52 per 100,000 by 2015 and even more than the MMR of 192/100,000 live births recorded at baseline in 1990.

b. As of 2015, the Infant Mortality Rate (IMR) was 20 infants dying per 1,000 live births – just shy of the MDG-IMR target of 19. We could have done better but neonatal mortality rate, a component of IMR did not go down, the reason being that maternal mortality has not been reduced.

c. As of 2015, as many as 25 new cases of HIV/AIDS

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were being reported to be diagnosed on a daily basis. In 2000, less than one new case of HIV/AIDS was being diagnosed every day.

d. The prevalence of smear-positive Tuberculosis has increased from 246/100,000 population in 1990 to 273/100,000 population in 2008. The target for 2015 is 0.0.

Despite increased funding for health-related MDGs over the last several years, the achievements are inadequate and uneven. MDG 5 (Improve Maternal Health) is the goal we were farthest from meeting and subsequently, the goal we did not meet. The current annual population growth rate of 1.9% means that nearly two million Filipinos are added to the population every year. It is claimed that the country is making good progress on provision of antenatal care, facility-based delivery and delivery by skilled birth attendants, so one needs to ask, why then did we not meet our goal of reducing maternal mortality.

Delivery in well-equipped birthing facilities by skilled birth attendants, as well as rapid access to lifesaving hospital services are essential to reducing maternal mortality. These require well-trained and responsive health professionals, well-equipped facilities and the availability of needed medications, in addition to physical and financial access at the time of need. While hospital care is expensive, the social and economic costs of preventable maternal death can be far higher.

As important, and even more cost-effective than the provision of antenatal care, facility based delivery and delivery by skilled birth attendants, is the provision of family planning goods and services to those who require them but cannot afford to pay for them. There has been no progress in providing for the unmet needs for family planning of poor women until lately.

Now that the Supreme Court has upheld the constitutionality of the Reproductive Health and Responsible Parenthood Law, government must exert mightily to provide the mandated reproductive health services to all who need them but cannot provide for themselves.

Progress in reducing HIV/AIDS, malaria, and other diseases (MDG6) is varied. While the Philippines attained some of the MDG targets for tuberculosis and malaria, we hold the dubious distinction of being one of only nine countries in the world where the incidence of HIV/AIDS is on the rise. Most HIV/AIDS financing comes from external sources, which is declining and will likely drop significantly in the next two years. Not only do we need to pick up the slack, we have to devote more resources to combatting HIV/AIDS.

Overall, the incidence and prevalence of tuberculosis has not declined, even though the death rate associated with tuberculosis is going down. In addition, multi-drug-resistant tuberculosis (MDR TB) is becoming a major challenge. Malaria prevalence and deaths have dropped significantly but programs for diagnostic testing, medicated bed nets and drug therapy need to be sustained.

Other Infectious Diseases

Communicable diseases remain a serious concern in the Philippines. While the country's disease burden shifts away from communicable to non-communicable diseases (NCDs), it is important to improve upon the gains made in controlling infectious diseases such as measles and not to ignore the threat of emerging communicable diseases such as Ebola, MERS-COV, bird flu and Zika infection. NCDs mainly affect the elderly and adults. However, people of all ages will continue to suffer and die from communicable diseases. These are contained at considerable cost, and continuing investment is needed to control them.

Resurging vector borne diseases, including dengue and leptospirosis, and most recently, Zika virus infection, are also substantial public health problems. These diseases are spreading, driven partly by urbanization, land-use changes, and climate change. Natural disasters in the country also impact these resurging diseases. Flooding often contaminates drinking-water, increasing the transmission of waterborne diseases such as cholera, and hepatitis A.

Antimicrobial resistance (AMR) is a growing challenge, largely due to inappropriate and irrational use of anti-infective drugs in humans and animals. This impacts our ability to treat many illnesses and results in new, powerful, and ever more dangerous infectious agents. MDR TB and growing artemisinin-resistant malaria in the Philippines bear witness to this problem.

Under-nutrition

An important contributor to both NCDs and communicable diseases is under-nutrition and early stunting, which occur when children are deprived of the proper nutrients from the time of conception through the first two years of life (the "first 1,000 days").

Up to now, one in four children under five years is underweight and undernourished. Undernourished and stunted children are less likely to complete schooling, join the workforce, or have future incomes equivalent to children who are not stunted. They are more likely to suffer later in life from NCDs, such as heart and kidney disease, and diabetes. Stunted girls are themselves likely to be mothers to underweight babies, potentially transmitting ill health and poverty across generations.

New Agenda – Non-communicable Diseases (NCDs) and

Injuries

NCDs, including cancer, cardiovascular diseases, chronic respiratory diseases, diabetes, and accidental injuries are now the most frequent causes of death in the Philippines.

We face the double burden of communicable and non-communicable diseases (NCDs). NCDs are the predominant cause of mortality and communicable diseases are the predominant cause of morbidity in the country. Risk factors—such as tobacco smoking, high blood pressure, high lipid levels and diabetes—contributing to NCDs, are increasing substantially, calling for more attention to preventive health care and health promotion.

While part of the increase in proportion of deaths is due to aging of the population and having more people at risk, it is also a result of rising rates of NCDs at younger ages. NCDs thus impact the working-age population and increase the economic burdens of the country.

When it comes to injuries, rapid motorization and expansion of road infrastructure has led to an increase in traffic fatalities. Traffic-related deaths and injuries most often affect the poor as they are the ones who utilize the most dangerous type of motorized vehicles - motorcycles.

Pervasive Agenda - Health Inequity

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.

Every year 75,000 children die before their fifth birthday. Children from rural and poorer households are disproportionately affected. Children from the poorest 20% of households are almost three times as likely to die before their fifth birthday as children in the richest 20%.

Maternal health is an indicator that thoroughly demonstrates the wide gaps in health care and outcomes between rich and poor in the country. The inequality among women of differing socio-economic states is remarkable. Poor mothers in poor rural communities are more than five times more likely to die from complications of pregnancy and childbirth than affluent mothers. Among the rich, the average desired fertility rate and the average actual fertility rate are the same (~two children) whereas among the poor, the average actual fertility rate (~six children) is double the average desired fertility rate (~three children). This reflects the inability of poor women to access family planning goods and services – something that rich women take as a given.

For every other indicator of health, the same wide disparity between the rich and poor is noted. Perhaps the greatest challenge facing health care in the Philippines is the reduction of health inequity.

The Aquino Health Agenda

In the words of President Benigno S. Aquino III, his social contract with the people will bring his administration "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." After six years, the Aquino administration has a mixed bag of results to show for its efforts.

National Health Insurance

PhilHealth claims having reached 92% enrolment in the national health insurance program this year, and the support value of the insurance on the actual medical expense has improved to 56%. The government allots billions of pesos (36.7 billion pesos in 2015) to pay the insurance premiums of 15.3 million families but has problems identifying who exactly are these 15.3 million poor families deserving of government funded health insurance. The utilization rate of national health insurance by the poor, though rising, is nowhere what it should be to make the expenditure worth it.

It can even be said that the greater national health insurance coverage of the population has increased health inequity in the country. The well to do are the greatest users of the national health insurance program and the greatest claimants are the modern and expensive hospitals that they patronize. In effect, the government is paying for the health care of the rich by subsidizing the health insurance premiums of the poor.

The health care program must ensure that people who are poor gain at least as much as those who are better off at every step of the way. Progressive universal health care might include both a publicly financed, well disseminated health insurance package which covers essential health-care interventions for all, and a second benefit package, funded through a range of financing mechanisms (e.g., private insurance, copayments), with only poor people exempted from all payments. The former package directly benefits the poor, since they are disproportionately affected by health problems. The latter has the potential for reducing unproductive cost increases.

Health Facilities Enhancement

There is no disputing the fact that most of our government health facilities, are in a state of disrepair, inadequately equipped, scantily supplied and poorly manned. Years and years of neglect of the government's health infrastructure

have resulted in this. It is really time to expand and upgrade public health facilities to levels appropriate for the provision of necessary quality health services nationwide. Over the past 10 or so years, more than 75 billion pesos have been allocated to health facilities enhancement – for building, upgrading, equipping and supplying barangay health stations, rural health units, birthing clinics, district hospitals, provincial hospitals, regional medical centers, special hospitals, etc. This year, another 26 billion pesos has been budgeted for the program.

Keen inspection of the accomplishments of the health facilities enhancement program reveal many inefficiencies, such as: 1) Construction and upgrading of many health facilities are not completed on time; 2) new facilities are being built very near areas that have functioning facilities of the same nature; 3) new health facilities are being located in areas that are not accessible to the population; 4) equipment are bought for facilities where they cannot be utilized, because for example, the power supply is inadequate, 5) personnel trained in the operation of the equipment bought are not available. In addition, there is usually no budget provision for maintenance and repair of equipment so that the first time a machine breaks down becomes the end of the useful life of that machine.

Many other issues associated with planning, allocation, operation etc. will need to be resolved before more good money is thrown after bad.

On the other hand, there is certainly acute need for more high level health care facilities that can provide quality health care at sustainable costs to the poor, not just in Metro Manila but in all regions of the country. The rich, except in the most catastrophic instances, can take care of their health care costs but the poor cannot and we must focus on providing appropriate health care to the latter group first and foremost.

The government has capitalized and continues to subsidize specialty hospitals such as the National Kidney and Transplant Institute, the Lung Center of the Philippines and the Philippine Heart Center, but the prime beneficiaries of these hospitals are the affluent and the politically well-connected. In fact, the ratio of rich vs. poor patients served in these hospitals approach the ratio in private tertiary hospitals that receive neither subsidy nor tax incentives from the government. We need to link public funding (whether from the budget or from public insurance) to quality services for the poor. Governments should stop demanding that public specialized hospitals fund themselves from private sources as this is the very reason why we now have these government facilities operating like private establishments and serving more paying patients than the poor. A better option is to fully fund these specialty hospitals to serve poor patients exclusively or almost exclusively.

Health Human Resources

Interventions don't deliver themselves. Thus an adequate number of health care workers (HCW) at every level of health care, from primary to tertiary, must be available through a service delivery network of both public and private sources to provide the appropriate service to those who need them.

At the moment there is a severe mal-distribution of health care providers in the Philippines. Consider that less than 20% of the active medical practitioners in the country are employed in public facilities that take care of nearly 70% of the health care needs of the population. The problem is compounded by the fact that a majority of HCWs are stationed in urban areas and very few serve in rural and depressed communities.

The DOH reports that in 2015, 398 physicians (Doctors to the Barrios), 13,500 NDP nurses, 2,700 Midwives, 480 Dentists, and 1,120 Medical Technologists were deployed to various public health facilities and offices. It is not clear what orientation and training these health professionals underwent, what capabilities they possess and what their functions are in their areas of deployment.

It is also reported that 40,851 Community Health Teams (CHT) have been trained and deployed in the barangays. A hundred households are assigned per team to whom they are supposed to deliver basic preventive health care. It is not clear what capabilities these CHTs have in terms of delivering key health messages and basic preventive health care, not to mention what value they add to the delivery of health care in the country. For various reasons, the CHT program was defunded by national government last year. Their functions have reverted to the original duty holders, the Barangay Health Workers.

A healthcare workforce crisis is at hand and the shortage and mal-distribution of the country's health care workforce is a prime contributor to the poor state of health care in the Philippines.

Consider that a majority of Filipinos and most of the poor seek medical care in public health facilities, but of the 66 thousand physicians, 500 thousand nurses and 74 thousand midwives who are actively practicing their profession, only three thousand, five thousand and 17 thousand respectively, work in a public national facility as of 2013.This translates to less than one physician, less than one nurse and less than two midwives per 10,000 population doing public health work in the DOH. This number is only 1/10th of the 24/10,000 recommended by the WHO, as the minimum number needed to address just the Millennium Development Goals(MDG's) of maternal and child health. Until now, more than 50% of our people die without the benefit of medical attention.

There are no signs that the imbalance between supply and demand in health care will improve anytime soon. In fact, all signs point to a worsening disparity. Demand is increasing because of 1) a growing population, as well as 2) increasing population health insurance coverage and 3) an increased range of services offered by PhilHealth. Supply, on the other hand, is further threatened by mal-distribution and continued migration of HCW's. The exodus is fueled by low salaries, lack of benefits, poor work environment as well as perceived deterioration of the socio-political environment.

The DOH is attempting to augment this meager health care workforce through its doctor, nurse and midwife deployment programs. The DOH must look for a more permanent solution to this health care workforce problem. Aware that low salaries is one of the most important reasons why health professionals, particularly doctors, are not attracted to public service, government has tried to augment their compensation by allowing them to share in PhilHealth reimbursements. All sorts of problems have arisen from this practice, from actual or perceived inequitable distribution of professional fees, to outright refusal of local chief executives to give health workers a share of the PhilHealth reimbursement, to inappropriate use of the PhilHealth reimbursement. The better option is for government to disallow health professionals a direct share in PhilHealth reimbursements and pay them just wages and a performance incentive.

Our capacity to pay for health care has vastly increased with a better economy and access to Sin Tax revenues but this has not translated into just compensation for our health care workers, particularly those working under hardship conditions. Thus, our capacity to deliver health care has not kept in stride. Ironically, expansion of the national health insurance program threatens to worsen existing inequities in health care as services become less accessible to the disadvantaged.

An important corollary issue is the capacity of health care workers to respond fully to the services required of them. Health service providers must be provided new skills and knowledge in order to do their job well, thus, considerable amounts of "training time" are spent by health workers but without adequate provision for the service requirements they leave behind. A system for mitigating this must be put in place. Surge capacity must also be created, for the times when catastrophes occur. In times of disaster, the current practice is for everybody to drop everything else to respond to the emergency. It is not difficult to imagine what happens to "normal" service during these times. The DOH seems to be on the right track in its plan to establish a "DOH Academy." The next DOH leaders must take a serious look at this infantile program and plan and implement it well to make sure health professionals are brought up to speed with skills and knowledge without sacrificing service.

Priority should thus be given to augmenting and strengthening health human resources, specifically the health workers who are at the frontline of our health care delivery networks.

Legislation

Credit must be given to President Aquino and his congressional allies as well as civil society for the passage of four landmark laws that have the potential of improving the state of health care in the Philippines. These are:

1) The Reproductive Health and Responsible Parenthood Law (RA 10354) of 2012,

2) The Sin Tax Reform Law (RA 10351) of 2012,

3) The National Health Insurance Act of 2013

4) The Graphic Health Warnings Law of 2014

The Reproductive Health Law and the Sin Tax Reform Law met and are still meeting stiff opposition from vested interests but the will of the people and the Aquino administration prevailed. The next administration must see to the speedy and proper implementation of all these laws and do everything in its power to make sure that the will of the people is not thwarted.

Some Social Determinants of Health

Social determinants of health refer to the conditions in which people are born, grow, live, work and age that affect their health.

Structural determinants generate stratification and divisions in society and define individual positions within hierarchies of power, prestige and access to resources. Examples include income, education, occupation, social class, gender and ethnicity.

Intermediary determinants are factors that directly shape individual health choices and outcomes and through which structural determinants operate. They span financial circumstances, psychosocial circumstances, behavioral factors and the health system. For decades, public health interventions have dealt with intermediary determinants such as lifestyle. However, global evidence shows that structural determinants such as macroeconomic policies and cultural belief systems exert a huge influence on intermediary determinants and eventually widen inequalities. It is important that they be addressed.

Many of the environmental, demographic, cultural, political and economic determinants of health in the Philippines are fairly obvious. Below are discussed a few of the emerging non-medical issues that impact on health. The most important thing to remember as we try to deal

with these social determinants of health is that the solution is not in the hands of the Department of Health, but in the cooperation of all to improve the environment and make them more conducive to health.

A Graying Population

The impacts of increasing longevity and a high population growth rate on poverty incidence and health expenditures are substantial. Life expectancy at birth continues to rise for both sexes. As a result, the proportion of the elderly (aged 65 and above) in the total population has been steadily increasing. While the magnitude of change is not as significant as that in other countries, it is an issue that we will have to confront sooner rather than later. Population aging is also highly associated with the rise of NCDs. Many of these diseases are chronic and expensive to treat, placing heavy burdens on households and health systems. It is critical that we take aging into account in our national fiscal and social protection planning and develop capacities to address the needs of older persons.

Urbanization

The number of people living in urban areas is now equal to that of people living in rural areas. Rapid and unplanned urbanization causes problems of urban crowding, slum development, and inadequate access to basic services. Hygiene, access to safe drinking water, and sanitation are major issues for urban dwellers. Most slum dwellers in our major population centers lack access to modern sanitation. Diet and lifestyle changes associated with urban living, as well as increased exposure to air pollution from vehicle traffic, also increase the risks for NCDs.

Crowded, impoverished living conditions in urban areas also provide opportunities for diseases such as tuberculosis, diarrhea-causing viruses and bacteria, and fungal and bacterial skin infections. Unsafe and destitute urban conditions result in vulnerability to violence, crime, and abuse, particularly for women and children. Urbanization poses challenges to local and national governments to provide a health enabling environment and appropriate health care services for large, poor and mobile populations.

Climate Change and Degraded Environments

The Philippines is highly vulnerable to climate change and natural disasters. Climate change challenges the public health community at the national and local levels with emerging diseases and spread or reintroduction of existing diseases such as dengue. Climate change–related health impacts include increased health risks from extreme weather, such as floods, and storms, to less dramatic but potentially more serious effects of changing climate on infectious disease dynamics. The health impacts of climate change are potentially huge. Many of the most important diseases, such as malaria, dengue, and waterborne diseases, are highly sensitive to climatic conditions. Much work is needed to mitigate the negative health impacts of climate change.

Internal and External Migration

A healthy migrant workforce benefits the social and economic development of its communities of origin and destination. Yet, internal and overseas migrant workers often work and live in hazardous conditions and tend to be marginalized by society. While the health risks they face are relatively high, they are often excluded from local public health systems. Limited access to public health services and health care increases the risk of the spread of communicable diseases and aggravates many other health problems. There are many barriers to health care that face migrant workers and their families that need to be brought down.

The Health Agenda for 2016 and Beyond:

We need to address the unfinished business of the MDGs while simultaneously finding solutions for emerging health issues that are interlinked with poverty, lifestyle, climate, and demographic changes and ensuring that all have access to quality health care regardless of ability to pay. In addition, the 2016 health agenda has to address not just the universal and equitable provision of health care but also the social, economic, and environmental dimensions of health concerns.

Key Actions to Address the 2016 Health Agenda

The key actions to address the 2016 Health Agenda can be discussed within the framework of the WHO building blocks of health: Governance, Information, Financing, Providers, Products and a Delivery System.

Leadership and Governance

The health of a community relies on many things. One of the most important is a leader who accepts that the health of his constituents is ultimately his responsibility and who will thus be ready to exert his power and influence to assure the provision of health care to all under his stewardship. Chief executives, particularly local chief executives, do not consider health as a priority and the responsibility for the health in the community is frequently left to the health officers of the local government units who often don't have much influence over their budget and personnel.

Recognizing that leadership is the key to improving health systems and programs, the Zuellig Family Foundation

embarked on an health leadership and governance program for mayors to help them understand their critical role in improving the health of their constituents. The program has helped many local chief executives connect their role to their constituents' health and well-being. Programs such as these should be assumed and sustained by government as a means to promote good and equitable health services and outcomes.

Public Policy and Actions Promote Good and Equitable Health Outcomes

The Philippines has enjoyed more than ten years of uninterrupted economic growth but health for all is not improving at the same speed.

Many factors affect good health. Notable are the social determinants, such as education, gender, income level, access to water and sanitation, and living condition, to name a few. These social determinants contribute significantly to a person's health status. They are, however, often underpinned by inequality that aggravates health outcomes. For example, in the Philippines, the under-5 mortality rate among the poorest quintile of the population is three times higher compared to that of the richest quintile. It is also proven that the health outcomes of children are affected by the mother's educational attainment.

Inequalities in social determinants of health are evitable through adequate policy and actions that promote improved daily living conditions, tackle the inequitable distribution of power, money, and resources, and address bottlenecks outside the health sector, that influence health outcomes. A good example is the water/sanitation–food–health–education nexus, which reflects the linkages between four sectors and how achievements in one sector affect development outcomes in the others.

The 2016 health agenda should provide opportunities to work on health outcomes across sectors. This would need to include strengthening cooperation among different government departments and between national and local leaders. In many instances, they contradict rather than complement each other in relation to health programs. For example, trade policies that actively encourage the production, trade, and consumption of processed foods high in fat and sugar or soft drinks to the detriment of fruit and vegetable production are contradictory to health policy; the same is true for milk formula products, which belong to the most bought consumer products. In the Philippines, the rate of exclusively breast-feeding for the first 6 months of life was below 40% in 2013. The United Nations Children's Fund (UNICEF) estimated in 2008 that 16,000 deaths of children under five in the Philippines are caused by inappropriate feeding practices, including the use of infant formula. Labor laws, including provision of adequate maternity leave, and adhering to core labor standards are important policy actions to not only promote breast-feeding and promote child health but also improve the health status of the population in general.

Local chief executives, from governors to city and municipal mayors must be convinced to put health as among their top concerns and must be capacitated to provide the necessary leadership to their health officers.

National and local chief executives must listen to the governed. Time and time again, they have chosen to ignore clear signals of the people about what they want. The issue of Reproductive Health is a prime example. For decades, survey after survey have revealed that majority of the people support reproductive health rights and want the government to provide reproductive health services for free or at an affordable cost to poor Filipinos. It took a President with political will to successfully overcome the various barriers to the passage of a Reproductive Health Law. Now that there is one, legislators must not obstruct its implementation by withholding the budget for it and national and local executives must make sure that the law is implemented in accordance with its intent. All must refrain from imposing their own beliefs on a populace that is clearly in favor of the free exercise of their reproductive health rights.

Very little of this enterprise sits within the capabilities or responsibilities of the health sector. The challenge is to engage the judiciary, legislators, local chief executives and executives in sectors outside health to support a comprehensive approach to good health for all.

Health Systems and Service Delivery

Addressing NCDs and at the same time maternal and child health and infectious diseases requires moving away from disease-driven initiatives to an approach that focuses on strengthening health systems. Dealing, for example, with the burden of NCDs requires a two-pronged, system-wide approach that involves proactive public health interventions to address the risk factors (e.g., tobacco and alcohol use, unhealthy diets and physical inactivity) on the one hand, and continual, well-coordinated medical services for those with chronic conditions or at high risk of developing such conditions, on the other. "Vertical" initiatives play an important role in tackling the health challenges of maternal and child health and infectious diseases. On top of that, the existing general health care system is characterized by fragmentation, duplication, competition, and disorder. This approach cannot provide a sustainable solution to the new challenges, nor to the unfinished business of the MDGs.

Weak and fragmented health systems in our resource-poor setting are not fully able to provide well-designed, cost-

effective, and mutually reinforcing prevention and treatment interventions. Indeed, health targets of current MDGs have floundered because our health systems are inadequate to simultaneously meet the needs of public health campaigns and everyday health care. Different from the disease-driven programming, which examines a particular issue through a linear, one-directional framework, health system strengthening tackles health issues by emphasizing the underlying infrastructure to effect change that may transcend a particular issue area, as well as social norms, politics, or other intermediary factors that may support or distract from the intended outcomes.

Certain principles may be followed in order to achieve successful health system strengthening. These principles include, but are not limited to the following:

(i) build multidisciplinary and multi-stakeholder involvement to ensure adequate representation of all parts of the system;

(ii) focus on local infrastructure that supports system-wide capacity for health workforce development;

(iii) engage in whole of government approaches to leverage resources and reduce duplication in health system financing;

(iv) ensure local government ownership (i.e., political leadership and stewardship, institutional and community ownership, capabilities, and mutual accountability, including financing) while building partnerships with development partners, civil society, and the private sector even as national government provides policy directions, resource augmentation and overall leadership; and

(v) build evidence-based monitoring and evaluation systems and link subsequent provision of resources to results.

Multi-stakeholder engagement is essential to improve the performance of the health system. Government alone does not and cannot provide the resources or the capacity to provide quality and affordable health care to all. Many people, even those who cannot really afford it, seek diagnosis and treatment from private sector providers (PSPs) because they are perceived to be more accessible and efficient than their public sector counterparts. Working with PSPs is a critical part of health system strengthening. Enacting and enforcing laws and regulations that work to control escalation in treatment costs, limit malpractice, and improve technical quality of care are needed in both public and private sector health care. It is equally important to lower the barriers to entry of the private sector into the health care system and to encourage competition. PSPs for instance, can be contracted for packages of all levels of health care that can be financed fairly through the national health insurance program.

Strengthening health systems does not exclude the existing disease-driven programs. Rather, the idea is to promote a synergy between the two while avoiding duplication of efforts. Health systems should be strengthened at the primary health care (PHC) level to handle both MDG/SDG-related challenges, communicable diseases and NCD prevention and detection. The public sector needs to retain responsibility for ensuring access to quality services for priority health goals. At the same time, one might best expect innovation, cutting edge practices and focus on cost-effective interventions on NCDs to be a strength of the private sector, among other things.

Existing "vertical" models and programs can be integrated into NCD control programs or "scaled up" for handling NCDs as well. Staff at clinics or hospitals focusing on treating tuberculosis, for example, can be trained to also address challenges of NCDs, including diabetes, hypertension, and other metabolic disorders. Programs devoted to reproductive and maternal and child health can play a more active role in detecting cervical cancer and breast cancer while helping to prevent the spread of MDG-related communicable diseases, such as HIV/AIDS.

Sufficient and Sustainable Financing for Essential Health Services

Successful implementation of health-related development goals cannot be achieved without sufficient and sustainable financing. The goal of health system financing is not only to mobilize adequate funds for the delivery of public health and medical services, but also to protect against financial risk through reduced reliance on out-of-pocket payments.

Political commitment from the top leadership is essential to earmark sufficient resources for health care. Increased efficiency in "sin tax" revenue collection and distribution will also generate funds to support the health agenda. It also means that national and local governments need to put more efforts in reducing corruption in the health sector.

There is debate whether expansion on both the supply and demand sides of health care is sustainable, how to prioritize investments between primary and inpatient care, and between the extension of population coverage versus expansion of the benefits package, given that our resources are limited.

Taking only a public sector approach to provision of services and health services coverage means relying on a system that is currently weak, underfinanced, and inaccessible to much of the population.

Strong growth in private health services, as well as increased access to information and communication technologies, will provide opportunities for innovations in coverage through demand-based programs, including

conditional cash transfers (CCTs), and expansion of the national health insurance program (PhilHealth). These demand-based programs are now being used to change the allocation of funding from public facilities to clients, particularly for directly subsidizing health insurance coverage for the poor. Demand-side programs open opportunities for new strategies. Service providers do not have to be from the public sector,

indeed the private sector should be encouraged to play a larger role in health service delivery.

Competition among providers should be allowed and the delivery of services should be linked to targeted performance-related subsidies, to help ensure quality services and improve performance from the supply side. Service users can be more involved in providing feedback on service quality and thus can be empowered as "clients" of services rather than only beneficiaries. Measures such as the CCT program and PhilHealth place purchasing power and the choice of provider directly in the hands of the recipients, which encourages the utilization of underused services (e.g., immunization, reproductive health) among the needy and underserved populations.

The National Health Insurance Program precisely aims to shift from supply driven to demand driven health care. But even the best run demand based health system needs to provide space for constituents who are witting or unwitting nonparticipants in the health insurance program.

Universal HealthCare bears numerous challenges. The issue is not just about scalability, but also sustainability. Reaching large numbers of informal sector and poor clients and sustaining demand-based programs pose difficulties. Increased resources are needed to cover service expansion. Allocating more general tax revenues to pay for CCTs and to subsidize national health insurance membership covering the poor and raising new finances such as through further special taxes on alcohol and tobacco may need to be done. Programs must be carefully designed to ensure incentives for better service quality, good health results, and cost containment.

The government's continued ability to provide free health services, as NCDs and chronic illnesses become a larger portion of needed care, is a valid concern. No substantial and sustainable improvement in health can be achieved without addressing coverage, care, and quality of personnel and/or supplies. A system must be put in place for ensuring the sustainability and affordability of services.

Given limited public resources, it is necessary to set up public–private partnerships that can be sustained under local conditions or to find ways to engage private sector resources to fill critical resource and capacity gaps in the public sector. The private sector therefore should be allowed to play a much bigger role in comprehensive health financing. Public–private partnership in health requires governments to design and implement fairly, policy and regulatory frameworks to ensure affordable high-quality service delivery.

Information and Communication Technology for Health

Proper steps should be taken quickly to improve the quality and scope of data collection, recording, analysis and application. At present, there is not a lot of confidence on the data that we collect and use. The timeliness of the data also leaves much to be desired.

Appropriate information and communication technology is the game changer that will facilitate timely, quality data and the monitoring of health-related outcomes. Suitable technological applications in areas where this is already possible and measures to quickly retrofit those areas (and their personnel) that are not, must be supported and financed.

Stakeholders, including civil society, labor unions, private sector, UN agencies, bilateral donors, multilateral development agencies, global health partners, and academic institutions, need to be involved in investing in data management and monitoring health-related objectives.

Civil society organizations, ranging from health-promoting or health-providing nongovernment organizations to faith-based organizations, can play a constructive role in collecting health data, disseminating health-related information, and reporting and monitoring disease outbreaks. To ensure that the 2016 health agenda is relevant and effective, the voices of patients, elderly people, and marginalized populations, such as migrant workers, should be heard in the monitoring process.

Health System Strengthening Needs Better Monitoring

Given its importance in addressing new health challenges, there is a need to better measure and monitor progress in health system strengthening and the other building blocks of health. These core indicators enable policy makers to track health progress and performance, evaluate impact, and determine accountability. This is important for the design and implementation of future health projects. We should be increasingly interested in the delivery of actual results that have a positive impact on health outcomes rather than just the process.

Determine Quality of Coverage Indicators for Universal Health Coverage

Universal health coverage has two fundamental goals: maximizing health and reducing pauperization due to health care costs. It is essential that there be solid indicators and targets for health outcomes and health system performance in addition to coverage, since coverage alone is not necessarily linked with improved health outcomes. WHO has developed a two-component approach to measuring progress toward Universal Health Care, focusing on health service coverage and financial risk protection, and selected determinants of health service coverage.

Monitor Transnational Health Threats and International Health Regulation Compliance

The International Health Regulations (IHR) are legally-binding international instruments for all member states of WHO. Under IHR, all governments have to develop core capacities to detect, assess, notify, and respond to public health threats. Strong political commitment to tackling public health security threats is required and government needs to adopt a "whole-of-government"–"whole-of-society" approach to protect against health security threats.

At present, the Philippines does not meet the IHR requirements in core capacities. We have some focus on surveillance capacity building, but little on building capacities in human resources, laboratories, and responses. There is inadequate multi-sectoral national and local coordination for response activities. The capacity gap highlights our lack of readiness to respond to public health emergencies. The insignificant stockpile of antivirals is a marker of the same. We are going to be at a loss if a viral pandemic reaches our shores.

Monitor Health-Related Outcomes

It is essential to improve the recording, reporting, quality, and use of the data needed to make health data monitoring effective, and efficient. This would require strong national commitment and capacity to maintain accurate routine administrative records on the health system performance (e.g., through a routine health facility reporting system and disease reporting system). Validation and adjustment against data obtained from census and other population-based surveys and assessments need to be done on a regular basis. This requires investments in civil registration and vital statistics, which are very weak in the country.

There is also the need to continuously invest in the country's disease surveillance system so that it can effectively detect, assess, notify, and respond to public health threats. In case of public health emergencies, the government needs to have the "surge capacity" to effectively utilize personnel, technologies and information systems to prepare reports to local and higher-level health authorities and government agencies in a timely and accurate manner.

Since the impact of an outbreak is felt by almost every sector of society, it is important to increase open and effective communication between multidisciplinary groups and multiple sectors that involve various key operational areas (e.g., hospitals, clinics, airports, ports, ground crossings, laboratories, government agencies).

Health Workforce

The crisis in our health care workforce has been discussed in a previous section. A sufficient number and appropriate mix of staff that are competent, responsive and productive and distributed in accordance with need is the goal. It is clear that private sector providers are needed to augment or complement the healthcare workforce in the public sector. Public and private sector providers must work together to achieve the best health outcomes possible given the circumstances and limited resources.

Health Products

Essential medicines, vaccines and technologies must be available and affordable, of assured quality and properly used both by providers and patients. They should be selected based on real needs, evidence of efficacy and safety and cost effectiveness. Appropriate use of medical products in health facilities and communities must be strongly encouraged so as not to waste limited resources and jeopardize the quality of health care.

Final Words

Health is a striking example where inadequate progress has been made in the Philippines despite sustained economic growth. Health care systems must be directed by leaders who acknowledge that the health of their constituents is their responsibility and who will commit to strengthening health systems with investments in infrastructure and health human resource. At the same time, changing health needs should be tackled to mitigate the economic impact of poor maternal and child health, prevalent infectious diseases, increasing NCDs and of a changing climate. The often cited quote "health is wealth" remains valid and calls for continued investment to achieve health outcomes in the country where focus on economic growth and wealth has often missed the core reason for development—improving the lives of all people.

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