

THE NATIONAL HEALTH ACCOUNTS (NHA) PROJECTIONS: 1999-2004
An Exploratory Study for Estimating the National Health Expenditures for CY 2004
based on the Health Sector Reform Agenda (HSRA) Target

Mario C. Villaverde, MD,MPH and Thiel B. Manaog, MA*

I. Background

The percentage of the Gross National Product (GNP) in the Philippines devoted to health is still low. Based on the 1991-1999 National Health Account (NHA) data, GNP share to health remained almost unchanged ranging from 3.0 to 3.4 percent. Although the country's total health spending has improved, it has remained inadequate. The current problems of the health care financing system brought the government to introduce the Health Sector Reform Agenda (HSRA) in 1999. Notably, HSRA brings to the fore an overriding health care financing target to achieve the five percent GNP share for health expenditure by 2004 (from the 1999 level of 3.4 percent). The reform targets are expected to effect changes in the country's health care provision and health financing patterns. Table 1 below provides the targets or benchmarks for reapportioning the sources and uses of health care financing in the country as stipulated in the HSRA policy document.

Table 1: HSRA Health Financing Targets for 2004 compared to Actual Expenditures for 1999 (in percent)

USE OF FUNDS	SOURCE OF FUNDS								TOTAL BY USE	
	Government		Social Health Insurance (SHI)		Out-of-pocket		Others		Actual	Target
	Actual	Target	Actual	Target	Actual	Target	Actual	Target		
Personal Health Care	18	10	4	25	46	20	8	7	76	62
Public Health Care	12	20	0		0		0		12	20
Others	8	10	1	5	0		3	3	11	18
TOTAL BY SOURCE	38	40	5	30	46	20	11	10	100	100

Source: NSCB, 1991-1999 Philippine National Health Accounts, May 2001

Based on these benchmarks for restructuring the patterns of health care financing, the Health Sector Reform Agenda aims to: 1) raise overall and aggregate health care spending, 2) change the structure of health care spending by source and for specific uses, 3) expand the role and share of social health insurance (SHI) in personal health care spending, 4) shift the burden of financing personal health care from out-of-pocket (user fees) and government expenditures to SHI, 5) prioritize government health spending toward primary health care and preventive public health services, and 6) democratize access to health care and improve quality of care for all.

*Dr. Mario C. Villaverde, is the Director of the Health Policy Development and Planning Bureau (HPDPB) and Thiel B. Manaog, is Supervising Health Program Officer from the same Bureau.

This paper attempts to come up with an estimation of the five percent target GNP share to health expenditures by CY 2004. The estimation is crucial to identify additional resources needed to allow the implementation of health reforms, as well as to identify mechanisms to fill resource gaps. This paper serves as an initial exploratory study to determine the size of the health expenditures given the benchmark of five percent share of GNP that was set in the HSRA.

II. Objectives of the Study

The general objective of this study is to estimate the absolute amount of the national health expenditures based on the five percent GNP target share to health by CY 2004.

Specifically, the study will come up with estimate of projected growth in national health expenditures by source and use of funds; assess feasibility of achieving HSRA financing targets; determine suitable policy directions and strategic options for restructuring of health care financing (HCF).

III. Methodology

This paper reviews the sources and uses of health sector funds in the Philippines from 1991 to 1999. The health expenditure data are derived from the NHA released by the National Statistical Coordination Board (NSCB). The NHA historical estimates from 1991 to 1999 serve as the costs base for imputing for these health expenditures projections. Likewise, a technical and general assumption has been applied for coming up with the NHA projections.

Other data sources include NEDA Medium Term GNP/GDP Projections and the Demographic Variables Population Projections derived from the National Statistics Office (NSO). Secondary data on health care financing were also reviewed and used as reference for the analysis of the study results.

To come up with the national health expenditure estimates, the following steps were employed:

1. This was drawn by subtracting the 1999 actual 3.4 percent GNP share from the five percent targeted GNP share to health by year 2004 and dividing this by five years (the number of years covered by the projection, 2000-2004). And by using the 1999 actual 3.4 percent GNP share to health as the baseline, GNP share to health was estimated to increase at 0.3 percent annually. Thus, the GNP share to health in 2000 is estimated to be 3.7 percent; in 2001 at four percent; in 2002 at 4.3 percent; in 2003 at 4.6 percent; and in 2004 at 4.9 (rounded off to 5.0) percent.

2. The absolute amount for the annual total health expenditure (THE) was derived by multiplying the NEDA low GNP estimates for 2000-2004 with the corresponding annual GNP percent share to health as estimated above.
3. The absolute amount for the sources and uses of the NHA was obtained by multiplying the projected annual THE with the given HSRA percentage targets for the specific sources of funds (government, social health insurance, out-of-pocket, and others) and uses of funds (personal health care, public health care, and others) as shown in Table 1.

IV. National Health Expenditures Projection: Results

Gross National Product (GNP) Projection

In 1991, the country's Gross National Product (GNP) at current prices was ₱1,255 Billion (B). This has grown in 1999 to ₱3,156B. NEDA projections for 2004 estimate the GNP at ₱5,096B (using low estimate).

Table 2: Gross National Product (GNP) and Selected Macro Indicators Estimates

Selected Indicators	Actual Estimation		Projection
	1991	1999	2004
GNP at current prices (in billion pesos) /a	1,255	3,156	5,096
GNP share to health (in percent)	2.86	3.43	5.0
Total Health Expenditure (THE) (in million pesos)	35,861	108,300	254,845
Population (in million) /b	62	74.7	80.8
Health expenditure per capita at current prices (in pesos)	575	1,449	3,154

Sources: /a NEDA Medium Term Growth GNP/GDP Low Projections, Oct 2001

/b NSO Population Projections Low Estimates, 2000

Total Health Expenditure (THE)

In 1991, the country's total health expenditure was ₱35.9 B, equivalent to 2.86 percent of the Gross National Product (GNP). In 1999, total health expenditure has grown to ₱108.3B, equivalent to 3.43 percent of GNP. Under the HSRA, the proportion of total health expenditures to GNP has been targeted to improve to five percent in 2004, an increase of at least 0.3 percent share of total health expenditures to GNP per annum. At this target, total health expenditure is projected to increase to ₱ 254.8 B in 2004, that is, ₱146.5B more than the 1999 figures. In per capita terms, this represents the equivalent of ₱575 per person in 1991 to ₱1,449 per person in 1999. By 2004, health expenditure is projected to increase to ₱3,154 per person.

Total Health Expenditure by Source of Funds

There are three major sources of financing for health: (1) government, consisting of both national and local governments, (2) social health insurance and (3) private sources, consisting of out-of-pocket expense and other private sources.

Government Sources. Between 1991 and 1999, the relative share of government in the total health expenditure slightly decreased from 38.5 percent to 38.0 percent. The fall in the government's share was associated with the relative decrease in national government spending for health, from 34.7 percent to a low 20.0 percent of total health expenditure. This came mainly from the decrease in the DOH budget, from 71 percent share of national government spending for health in 1991 to 57 percent in 1999, as a result of the implementation of devolution of health services to local government units (LGUs). Compared to the national government, LGU spending grew remarkably from 3.9 percent of total health expenditure (₱1.4B) during the pre-devolution period (1991) to 18.0 percent (₱19.4B) in 1999 (post-devolution period). This indicated that devolution has shifted resources to LGU.

Under the HSRA target, the share of government expenditure to the total health expenditure is projected to increase over a five-year period from 38 percent in 1999 to 40 percent by 2004. Recognizing that responsibility of health service provisions is now transferred to LGUs, the government expenditure target is to shift more resources from national to local government. With this, the relative share of national spending for health is forecast to decrease from 20 percent (₱21.7B) in 1999 to 18 percent (₱45.9B) of total health expenditure in 2004. As a result, the relative share of local government spending for health is targeted to grow more, from 18 percent of total health expenditure (₱19.3B) in 1999 to 22 percent (₱56.0B) by 2004. Total government (national and local) spending for health is forecast to grow to ₱101.9B in 2004 based on the HSRA target.

Social Health Insurance. Social health insurance (SHI) contribution to total health expenditure grew from ₱1.9B in 1991 to ₱5.3B in 1999. The growth however, was almost insignificant, ranging between 3.7 and 6.3 percent of total health expenditure from 1991 to 1999.

Under the HSRA policy document, SHI is the key reform strategy to serve as a feasible mechanism for ensuring equitable distribution of financing and health provision to the Filipino people. From the existing five percent share, SHI expenditure is targeted to increase under HSRA to 30 percent of total health expenditure in 2004, that is equivalent to ₱76.5B or around 15 times more than current expenditure from social health insurance. The assumption is that the financial mechanism for insuring individual families, particularly the indigent sector and the informal sector, needing medical care has been established through the Philippine Health Insurance Corporation (PHIC).

Private Sources. In 1999, expenditure for health from private sources amounted to ₱62B or 57 percent of total health expenditure. Comparing with the 1991 figure of ₱20.1B or 56.0 percent from private sources, this is a big increase in absolute terms

although minimal increase in relative proportion to the total health expenditure. Household out-of-pocket expenditure served as the major private source of funding for health services. From 1991 to 1999, the proportionate share of household out-of-pocket expenditure never went down to 46 percent. This means that individual families carried the financial burden of paying for health services.

Under the HSRA strategy, the burden of financing for health shall be shifted from out-of-pocket sources towards universal social health insurance coverage as mandated by law (National Health Insurance Act of 1995). As a consequence, household out-of-pocket spending is targeted to fall to 20 percent of total health expenditure. By reducing the relative share of household out-of-pocket spending to total health spending, it is estimated to grow only by ₱867M, from ₱50B in 1999 to ₱50.9B in 2004.

Total Health Expenditure by Use of Funds

There are three major uses of funds as classified under the National Health Account system: (1) personal health care, which is largely curative care or hospital-based health care; (2) public health care, which is generally preventive and promotive health services; and (3) other uses, which include administrative and management support for health services.

Personal Health Care. The country spent ₱82.7B for personal health care in 1999, a big increase from the 1991 spending of ₱28.7B. However, the relative share of spending for personal health services declined from 80 percent in 1991 to 76 percent of total health expenditure in 1999. Previous studies showed that most of these expenses went to drugs and medicines by individual families. Household out-of-pocket expenditure was the major source for financing personal health care. Household expenditure for personal health care increased from ₱17.1B in 1991 to ₱50.1B in 1999. Government hospital expenditure was the second major source, where spending increased from 17.5 percent (₱7.6B) in 1991 to 18 percent (₱19.1B) of total health expenditure in 1999. Most of these government resources came from national sources, in particular, hospital spending by DOH. The DOH hospital spending by no means went down to 60 percent over the nine-year period. Personal health care spending by LGU grew from 22 percent (₱0.2B) in 1991 to 26 percent (₱5.1B) of total health expenditure in 1999. Social health insurance spent only ₱4.2B out of ₱82.6B expenditure for personal health care in 1999.

Under HSRA, personal health care expenditure is forecast to grow to ₱158B, although its relative share in the total health expenditure is targeted to decrease to 62 percent in 2004, a difference of 14 percentage points from 76 percent in 1999. The projected rise in absolute amount for personal health care is associated with the projected increase in social health insurance spending assuming that expansion of the National Health Insurance Program (NHIP) has gained headway. For 2004, the target SHI spending for personal health care is at 25 percent. This is equivalent to a health spending of ₱63.7B out of ₱76.5B total expenditures by SHI. The key health care financing strategy of increasing the share of SHI for personal health care to 25 percent is intended to provide an alternative financial mechanism to absorb the large out-of-pocket

expenditures of individual families. The target out-of-pocket share to personal health care is projected to decrease from 46.2 percent to 20 percent of total health expenditure although in absolute amount it will still increase by ₱0.9B, from ₱50.1B in 1999 to ₱51 B in 2004.

The hospital reform goal under HSRA is to improve the quality of government hospital services by making these hospitals financially autonomous. This will allow for improvement in the management and operations of government hospital facilities. By allowing hospital to retain and utilize their income, dependence from direct government subsidy is projected to decrease to 10 percent of total health expenditure by 2004, from 18 percent in 1999. Savings from direct government subsidy for hospitals can be re-allocated for public health care spending.

Public Health Care. Spending for public health care amounted to 8.0 percent (₱ 2.9B) of total health expenditure in 1991. This has grown to 12.3 percent (₱13.3B) of total health expenditure in 1999. Public health care spending is forecast to significantly increase to ₱51.1 B or 20 percent of total health expenditure in 2004. This means the need to target an increase of at least 2.4 percent in public health budget annually between 1999 and 2004. Projected increase in public health expenditure will be attributed largely to the reallocation of direct government subsidy from hospital care to public health care.

The government will be the main source of the projected increase in public health spending. In particular, the local governments will be the biggest spender on public health care as a consequence of the devolution. As such, LGU public health expenditure is projected to rise from ₱9.2B in 1999 to ₱27.5B in 2004. The national government, largely through the DOH, is forecast to increase spending on public health care to ₱ 7.0B in 2004, from ₱2.1B in 1999.

Administrative Services and Other Uses. Expenditures on administrative and other support services grew only from ₱4.3B in 1991 to ₱12.3B in 1999. In percent share to the total health expenditure it decreased slightly from 12 percent in 1991 to 11.4 percent in 1999.

For administrative and other support services, the target is to increase spending from 11.4 percent in 1999 to 18 percent of total health expenditure in 2004. SHI is forecast to be the highest spender for administrative services, that is, from a low 1.0 percent share (₱1.1B) in 1999 to a five percent share (₱12.7B) by 2004. The projected increase will come from PHIC's large spending for infrastructure development and upgrading of administrative capacity in anticipation for intensifying comprehensive coverage and improving benefits that people can avail from social health insurance. The remaining increase of two percent is targeted to come from government spending for administrative and support services, from the eight percent in 1999 to 10 percent of total health expenditure in 2004. The projected increase will be invested for strengthening quality assurance, licensing and regulation, management support services particularly for strengthening the role of DOH, LGU, PHIC and private sectors. Consequently, increased

health spending is expected to come from other private sources contributions, estimated to increase from ₱3.2B in 1999 to ₱8.0B in 2004.

The National Health Account Projection for 2004

Compared to Table 1, which illustrates HSRA targets in percent, the table below completes the NHA matrix with projected health expenditures in absolute amount for 2004, with 1999 as the base year. The computation and projection of the absolute amount was based on the projected GNP of the Philippines for 2004 and the targeted total health expenditure of five percent of GNP that was set under the HSRA.

Table 3: HSRA Health Financing Targets for 2004 compared to Actual Expenditures for 1999 (in billion pesos)

USE OF FUNDS	SOURCE OF FUNDS								TOTAL BY USE	
	Government		Social Health Insurance (SHI)		Out-of-pocket		Others		Actual	Target
	Actual	Target	Actual	Target	Actual	Target	Actual	Target		
Personal Health Care	19.1	25.5	4.2	63.7	50.1	51.0	8.7	17.8	82.7	158.0
Public Health Care	13.3	51.0	-	-	-	-	-	-	13.3	51.0
Others	8.7	25.5	1.1	12.7	-	-	3.2	8.0	12.3	45.8
TOTAL BY SOURCE	41.1	101.9	5.3	76.5	50.1	51.0	11.9	25.8	108.3	254.8

Based on these targets, THE in 2004 will amount to ₱ 254.8B (an increase of more than two times the 1999 level). Of this amount, ₱102B will be sourced from both national and local governments (an increase of almost two and a half times the 1999 level), ₱76.5B from social health insurance (an increase of more than fourteen times the 1999 level), ₱51B from out-of-pocket expense (almost no increase from the 1999 level), and ₱25.8B from other private sources (an increase of two times the 1999 level). From these financing sources, ₱158B will be spent for personal health care (an increase of almost two times the 1999 level), ₱51B for public health care (an increase of almost four times the 1999 level), and ₱45.8B for administration and other health support services (an increase of almost four times the 1999 level).

V. Challenges for Health Care Financing

This section discusses the challenges and certain policy options facing the health sector, particularly on health care financing, some of which reiterate the policy changes identified in the Health Sector Reform Agenda that are necessary to improve the way health care is delivered, regulated and financed.

1. Increasing total spending for health

Over the past decade, the country's total health spending has improved (more in current terms than in real terms), but remains inadequate. As a consequence, the

country's health status has not significantly improved. Financing health services is stalled by global recession, structural adjustments, organizational inefficiencies, population growth and other sectors competing for funding.

The government initiated a comprehensive Health Sector Reform Agenda (HSRA) in 1999 to address the need to improve the way health care is delivered, regulated and financed. Specifically, the HSRA calls for increasing resources for health to improve access to quality and affordable health services and to improve the health status of the population, especially the poor and other marginalized sectors of society. The HSRA sets a benchmark of five percent GNP share to health by 2004 from the 1999 level of 3.4 percent. This will entail more than doubling the current THE from ₱108.3B in 1999 to ₱254.8B in 2004. With this benchmark, there is a need to increase investment for health by all sectors within the short to medium term period.

With the economic slowdown and the tight fiscal budget that the country is experiencing, this benchmark is a very difficult proposition. The challenge is not only for the government but the entire health sector to explore ways on how to mobilize additional resources. Health care financing options may include: introducing socialized user fees (that is, those who can afford shall pay the full cost of health services while those who cannot shall be subsidized); rationalizing the charging and pricing policies of health facilities; expanding the coverage and increasing the benefit spending of social health insurance; cost-sharing arrangements between national and local governments; public-private sector partnerships; and prioritizing allocation of resources for the health sector versus allocation for the other sectors from both the national and local government budgets.

2. Changing the structure of health expenditure, by source and specific use of funds

a. Shifting the burden of financing personal health care from out-of-pocket and government expenditures to social health insurance (SHI)

Health insurance should be viewed in the larger context of its role in the health care delivery system of the country. At present, financing of personal health care is mainly through out-of-pocket or user fees (46 percent) with social health insurance covering a mere five percent. The poor, not able to afford out-of-pocket expenditure for health, bears the heaviest burden in the current health care financing system. The objective of the HSRA is to expand the coverage of social health insurance by enrolling the poor through national and local government subsidies and to increase PHIC share for personal health care to 25 percent by 2004. This target is estimated to cost ₱63.7B in PHIC benefit spending by 2004. If this target is realized, PHIC will be the major purchaser of health services in the country.

Shifting the burden of health care financing from out-of-pocket and government expenditures to social health insurance will provide more equity in terms of health services. Through social health insurance, it is expected that the rich and the healthy will subsidize the poor and the sick, thereby providing better safety net for the latter. The

growth of social health insurance will ensure greater financial protection among the majority of the population to avail itself of health care services provided in both public and private health facilities.

b. Moving towards financial autonomy of government hospitals

Hospital care is the most expensive component of the health care system. With the high cost of hospital infrastructure and technology development and their enormous operating costs, coupled with the extensive size of its staff, hospitals can easily gobble up a large portion of government budget for health and impoverish the rest of the health care system. In the 1999 Philippine National Health Accounts, the combined expenditures of both local and national governments for hospital care amounted to ₱19B or almost 50 percent of government expenditures for health. The DOH spending alone for its hospital services amounted to ₱8.4B, almost 68 percent of its budgetary allocation for 1999. This leaves the other components of the health care system – like public health, health regulation, and other support services – with meager allocation.

The reform initiative to transform government hospitals as financially autonomous entities will allow government hospitals to collect and retain socialized user fees, generate new sources of revenues, set up drug revolving funds, rationalize charging and pricing policies, among others, and eventually raise the amount of revenues that the facilities obtain. These mechanisms will reduce the dependence of government hospitals on direct subsidies from the government. This will free up resources that can be invested in public health programs, local health systems development, health regulation and quality assurance. However, there is a need to push for safety net measures, like social health insurance, as complementary strategy to protect indigents who are mostly dependent on government facilities for their health care. Such measures shall provide financial protection for the poor as we shift government subsidies from hospital services towards the more equitable financing mechanism offered by social health insurance.

c. Allocating more funds for public health programs and local health systems development

The country's total uses of health care financing show definite partiality for hospital care. As stated above, more than half of DOH spending is allocated to tertiary hospitals. Of the total DOH budget in 1999, only 17 percent or around ₱2.1B was allocated to public health programs. In 1999, local government spending for public health amounted to ₱9.1B or 47 percent of LGU spending for health. The target set under the HSRA is for government (combined local and national) to increase its investment for public health to 50 percent of government allocation by 2004 (that is, ₱51B out of the projected ₱101.9B government investment for health in 2004). Currently less than one-third (₱13.3B) of the ₱41.1B government budget for health is being spent on public health.

The primary goal of the HSRA is to shift the burden of financing hospital services to the social health insurance program and use the freed-up resources to expand the coverage for the more cost-effective services, particularly primary health care and

preventive services. For example, maintaining emphasis on public health programs, such as immunization, tuberculosis control, women's health and child health, among others, are sound public investments as these programs reach more people in terms of coverage.

While local government spending for health is increasing (as a consequence of devolution and increased Internal Revenue Allocation) and almost half of this spending goes to public health programs, the cost-effectiveness of this increased expenditure needs sound assessment. The approach is to give emphasis to health services for geographically isolated and disadvantaged populations where interventions produce the greatest improvement in health status. Also, the need to strengthen primary level hospital referral support for public health and preventive services should be emphasized. All of these will entail development of health systems within the context of local autonomy mandated by the Local Government Code of 1991.

d. Increasing investments for quality assurance, enforcement of regulations and standards, and management support systems

The Philippine National Health Accounts shows that the spending trend for health regulatory services and management support systems remains constant at low level (that is, only around 11 percent of total health expenditures in 1999). With the implementation of the HSRA, the target is to increase the critical investment (at least up to 18 percent of total health expenditures by 2004) for strengthening financial and procurement systems at both national and local levels, upgrading capacities of health regulatory agencies to enforce health regulations and standards, improving quality assurance programs, and upgrading support systems to achieved improved efficiency for managing the health systems.

Higher investment for regulatory and management support systems, as in public health, is possible only if investment for hospital services can be freed-up and the burden of personal health care is shifted to social health insurance.

3. Increasing the health care goods and services procured out of existing resources

The difficulty faced by the health sector in increasing total investments for health and in re-allocating these resources from personal health care to public health care can be alleviated by efficiency measures that can increase the health care goods and services procured or produced out of existing resources.

Shifting priorities and resources from health care services that utilize large investment, as typified by highly specialized and more labor-intensive health care services that benefits a few, towards the more efficient and effective health services that reach the greater number of beneficiaries at a lower cost, will expand or increase the population covered by health programs and services without need for increasing budgetary outlays. Specifically in the government sector (both national and local), reforming the financial and procurement systems and strengthening administrative controls will reduce leakage, wastage and fraud in the utilization of resources. This will

mean savings that can be used to procure more health goods and services for a greater number of people.

Improving the balance between allocations for personal services, and operating expenses and capital outlay will avoid problems related to health personnel given salaries and benefits but less work due to reduced budget for operations. Adopting a performance-based budget system rather than an incremental budget system will improve program performance. Networking and sharing of resources between the government and private sectors, between national and local levels, and among local government units, will avoid duplication of efforts and overlaps of services. These measures will result in better efficiency in the health system and savings.

4. Reducing the gaps in terms of access and utilization of health goods and services

One of the most challenging issues for health care financing is the reduction of the gaps in terms of access and utilization of health goods and services. Several measures can be pursued: (1) rationalizing distribution of resources – shifting allocation from national government to local government, and from urban areas to rural areas; shifting from general subsidy to the entire population (which include those that can afford to pay for health goods and services) to a more focused subsidy to the poor and the marginalized (one option is though the indigent component of the National Health Insurance Program); (2) rationalizing pricing policies, specifically in the private sector, through price reduction and cost containment measures or by leveraging the presence of quality low cost government facilities, goods and services to be competitive with the private sector; (3) providing government incentives for stronger private sector participation in health – through tax incentives for private investments in health in the less developed areas; through government subsidies for health services provided by the private sector to the poor; and (4) consolidating public and private sector complementation and partnership in health care.

VI. Conclusions and Recommendations

The Department of Health faces substantial challenges in its pursuit to implement reforms to improve the efficiency, accessibility, equity and financial sustainability of health services to the Filipino people, especially the poor. With the looming economic environment that influence health status through increasing poverty and budgetary cuts on social services and health expenditures, the National Health Accounts estimation is being explored to determine the feasibility of the targets set in the HSRA for resources needed to achieve reforms. In summary, given the above NHA projection results -- is the targeted expenditure for 2004 realistic and attainable?

Overall, this study leads to a major conclusion that the prospects for achieving increases of about ₱254.8B spending for health care by 2004 may not be economically feasible and realistic, that is, given the range of factors: the susceptibility in the over-all economy; budget deficit and cut in health allocation experienced by national and local governments in the previous years up to the present; low income of households; and low

investments by all sub-sectors in health. However, the success factor still rests on the political will of national and local government officials and the cooperation and support provided by the private sector and international donor agencies on how to ensure policy focus and a sense of urgency to implement the HSRA to attain the irreversible momentum by 2004 as envisioned.

The challenges and opportunities facing the DOH in its attempt to introduce a coherent health care reform strategy in the country are complex and hard. The current economic downturn aggravates the situation. Nonetheless, the government must continue to deal with the health care financing issues. The decision not to do anything will however, only result in the further worsening of the health system and most important, of the health status of the population. As such, the government through the DOH needs to explore other options for mitigating these health care financing problems. This paper presents a number of strategic options on how new resources can be mobilized and how available resources can be used more efficiently, distributed more equitably and according to need. In summary, these include:

1. The Department of Health needs to prioritize investments for: strengthening capacities for public health programs and local health systems development; upgrading of hospital facilities and pursuing fiscal autonomy; and strengthening regulatory capacity for quality assurance and cost containment in health goods and services;
2. The local governments need to prioritize investments for: establishing inter-local health systems including resource-sharing, networking and quality improvement mechanisms; premium payment for enrolling indigents in the National Health Insurance Program; and strengthening delivery of primary health care and health promotion programs;
3. The Philippine Health Insurance Corporation needs to prioritize investments for: expanding membership and improving benefits; strengthening administrative support and fraud control measures; ensuring national premium counterpart for indigent members of the NHIP; revising the premium structure to provide more equity in contribution (requiring higher income groups to pay more); and strengthening mechanisms for complementation with community based health care financing and private health insurance organizations;
4. The health sector in general (both government and private) needs to prioritize investments for: establishing a strong mechanism for socialized pricing for out-of-pocket payment for health; developing adequate quality assurance programs and appropriate pricing policies for health care goods and services; and strengthening public-private partnership and networking of resources.

Finally, from this study is the realization for the need to **develop and institutionalize an appropriate Philippine National Health Accounts Projection Model**. This will serve as a useful tool for obtaining information and for identifying

major constraints in the allocation of resources for the health sector, as well as for identifying mechanisms to address these potential constraints. In particular, there is the need to design and develop a useful methodology and specifications for projecting the NHA to guide policy makers on the appropriate level of investment for health and the appropriate distribution of these resources among the different sources and specific uses of health care financing.