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**HEALTH
FINANCE
DEVELOPMENT**
PROJECT

HFDP Monograph No. 1
March 1992

Department of Health
Republic of the Philippines

United States Agency for
International Development
(USAID)

**Towards
Health Policy
Development
in the
Philippines**

Alejandro N. Herrin

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University of the Philippines
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List of Abbreviations

ADB	Asian Development Bank
BHS	Barangay Health Station
CHRD	Commission on Health Research for Development
DECS	Department of Education, Culture and Sports
DOH	Department of Health
ECC	Employee Compensation Commission
FIES	Family Income and Expenditure Survey
FNRI	Food and Nutrition Research Institute
GDP	Gross Domestic Product
GNP	Gross National Product
GSIS	Government Service Insurance System
GTZ	German Agency for Technical Assistance (Deutsche Gesellschaft Für Technische Zusammenarbeit)
HAMIS	Health and Management Information System
HEWSPECS	Health, Education and Welfare Specialists, Inc.
HFD	Health Finance Development Project
HIS	Health Intelligence Service
HMO	Health Maintenance Organization
IHPP	International Health Policy Program
INCLEN	International Clinical Epidemiology Network
INTERCARE	Integrated Health Care Services, Inc.
NEDA	National Economic Development Authority
NGO	Non-government Organization
NHA	National Health Accounts
NSCB	National Statistical Coordination Board
NSO	National Statistics Office
PIDS	Philippine Institute for Development Studies
RHU	Rural Health Unit
RTI	Research Triangle Institute
SEAMEO-TROPMED	Southeast Asian Ministers of Education Organization Tropical Medicine and Public Health Project
SSS	Social Security System
SGV	Sycip, Gorres, Velayo & Co.
UPSE	University of the Philippines School of Economics
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Introduction

In September 1990, the Department of Health (DOH) launched a program called the "Health Policy Reform Initiative" which seeks to improve the processes and institutions for formulating, implementing and evaluating policy reforms in the health sector. In support of this Program, the DOH and the United States Agency for International Development (USAID) formulated a bilateral project called Health Finance Development Project (HFD), the purpose of which is to develop the capacity for research-based policy formulation and to establish mechanisms for interactive and participative health policy process. Considerable work has been done in formulating the objectives and major activities of the project through a series of discussions and consultations between the DOH, USAID, and representatives of various sectors, both public and private. The purpose of this study is to review what has been done and to provide further background information on various aspects of health policy formulation, implementation and evaluation as inputs into the final design of the HFD.

Specifically, this study attempted to: (1) determine the DOH's vision of its role in health policy development; and (2) elaborate on the concept of health policy development and the major sets of activities involved, in particular by: (a) describing a conceptual framework for identifying policy issues and a common criteria for assessing health sector performance and impacts of health policy reforms; (b) identifying the major research areas to be investigated to support health policy formulation; (c) assessing the current statistical sys-

tem for health and formulating a strategy for strengthening the system; and (d) identifying the components of a strategy for building national capacity for research, training and technical assistance in support of the health policy process.

The DOH Vision of Its Role in Health Policy Development

The DOH sees its role in health policy development from two perspectives: as one of the stakeholders in the health sector, and as the agency mandated by the government to act as the policy and regulatory body for health. As one among many stakeholders in the health sector, the DOH sees the following possible roles: (1) as a technical resource agency providing data and information to interest groups and concerned parties; (2) as a catalyzer in public discussions on health policy; (3) as an advocate for policy positions relative to other parties in the health sector; (4) as an administrative and political sponsor in government processes in behalf of the whole health sector; and (5) as the implementing arm of government in so far as policies require an organizational executor.

On the other hand, from the perspective of being the lead agency in health policy development, the major task that the DOH sees for itself is to establish the processes and institutions which would enable the various actors in the health sector to perform their respective roles in health policy change. The DOH envisions a fully participative

process of health policy development involving all the various groups in the health sector.

Health Policy Development

Health policy development is defined in this study as the process of strengthening and sustaining the capacity of the DOH, in collaboration with the various groups in the health sector, to formulate, implement and evaluate health policies to achieve greater efficiency and equity in the provision and financing of health services. Health policy development involves three major sets of activities: (1) establishment of an interactive health policy process; (2) setting up of organizational structures within the DOH to initiate, guide and sustain the health policy process; and (3) strengthening of institutional support systems for sustaining the health policy process.

The interactive health policy process consists of the following specific activities: (1) formulation of a health policy framework; (2) development of a health policy research agenda; (3) implementation of health research studies; (4) development of a health policy agenda; (5) promulgation of health policy actions; and (6) monitoring and evaluation of policy actions.

To initiate, oversee and sustain this process, the following organizational or institutional structures within the DOH are to be created: (1) Health Policy Advisory Council; (2) Health Policy Technical Group; and (3) Health Policy Reform Secretariat.

Finally, to support to the entire

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process of health policy development, the following mechanisms are to be instituted: (1) the establishment of a Multisectoral Health Policy Forum; (2) the development and maintenance of a national statistical database and a health policy database for health policy research and analysis; and (3) the development of a health policy research, training and technical assistance program.

Building on the work that has been done, this study elaborated on several key activities, in particular: (1) with respect to the health policy process, the development of conceptual frameworks to guide the formulation of a health policy framework, and the identification of major research areas to be investigated in support of research-based policy formulation; and (2) with respect to support systems, the formulation of a strategy for developing a national statistical data base for health policy research and analysis, and the formulation of a strategy for building national capacity for research, training and technical assistance in support of health policy development.

Conceptual Frameworks

A major activity in the health policy process is the formulation of the Health Policy Framework. This Framework describes the policy areas, policy issues, and policy questions that must be addressed in order to move the health sector towards greater efficiency and equity. To facilitate the formulation of this framework, there is a need for a common understanding of how the health sector operates to influence health and a common set of criteria for assessing the performance of the health sector in terms of efficiency and equity in the provision and financing of health services.

A conceptual framework is described which highlights the major issues confronting decision-makers and health administrators in the health sector. These issues are classified into the

following broad categories: (1) intersectoral resource allocation; (2) health service structure; (3) health service focus; (4) health service utilization; (5) health service production; (6) management and operations; (7) health care financing mechanisms; and (8) public-private sector roles in health service provision and financing.

A set of efficiency and equity criteria to assess the performance of the health sector as well as the impact of any policy reform in each of these areas of decision-making is likewise described.

Research Activities

A consolidated research agenda for health policy development is described according to three categories of research, namely: baseline research, policy research and policy analysis.

Baseline Research. Baseline research refers to research that will provide a wide range of information on the operation of the health sector including assessments of its performance. The agenda for baseline research include:

(1) research areas identified and to be undertaken by the DOH-PIDS-World Bank Health Policy Development Project. These include a wide range of topics, broadly classified into: (a) beneficiary profile and behavior; (b) provider profile and behavior; (c) evaluation of Medicare I; (d) financial resource base and financial institutions; (e) health financing environment; and (f) planning models for health care financing. The research will have as inputs the findings of the following studies: (a) completed studies under HPP sponsorship; (b) on-going studies under the Child Survival Project and the HAMIS project; (c) studies undertaken to provide more background information for the design of the Health Finance Development Project; and (d) studies being undertaken on health care utilization and the role of the private sector supported by the Asian Development Bank.

(2) research leading to the development of a statistical system for health

policy development to be undertaken by the DOH-USAID Health Finance Development Project under the Policy Formulation Component. The scope of this research will cover the entire information system for the health sector. It will involve (a) assessment of current data sources; (b) identification of alternative ways of obtaining relevant data on a regular basis and publishing them for ready access to both researchers and policy analysts; and (c) testing new concepts and methodology for generating new data, particularly on health needs, target populations, utilization of health care services, service capacities, costs of health care, health care expenditures, and on sources of financing.

(3) research leading to the development of a health policy database to be undertaken by the DOH-USAID Health Finance Development Project under the Policy Formulation Component. The research will involve archiving and cataloguing existing health policies and regulations together with data and analyses used as bases for their formulation and adoption.

(4) research involving synthesis of policy relevant research on a wide range of concerns, in particular: (a) determinants of health transition; (b) demand and utilization of health services; (c) cost-effectiveness of various health interventions; and (d) assessment of health care financing modes in other countries.

Policy Research. This research focuses directly on identified priority policy issues with the aim of producing specific policy recommendations and producing specific designs of the proposed interventions, including, when necessary, the demonstration of the feasibility and effectiveness of such interventions in actual field settings. The policy issues that have been identified by the DOH for immediate consideration are those related to health financing and hospital reforms. Hence, much of initial health policy research will be focused on areas directly addressing these issues. These research areas include:

(1) research leading to reforms in the existing Medicare Program and to the development of alternative health care financing systems to be undertaken by

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the DOH-USAID Health Finance Development Project under the Health Finance Component. The research will have as inputs the findings of the baseline studies under the DOH-PIDS-World Bank Project and the benchmark studies under the DOH-USAID Child Survival Project.

(2) research leading to hospital sector restructuring and institutional strengthening of public and private hospitals to be undertaken by the DOH-USAID Health Finance Development Project under the Hospital Financing Reforms Component. The research will have as inputs the findings of the baseline studies under the DOH-PIDS-World Bank Health Policy Development Project, the DOH-USAID Child Survival Project, and a forthcoming Asian Development Bank-supported studies on hospitals.

(3) evaluation of public health programs to determine whether the theoretical cost-effectiveness of these programs are in fact being closely approximated in large-scale field situations. These public health programs include the DOH's impact programs on diarrheal diseases, acute respiratory infection, malaria control, schistosomiasis control, and TB control.

Policy Analysis. This is research that is directly linked to the political and bureaucratic processes of decision-making. It responds to specific questions regarding policies that are either being decided upon in the Cabinet, Congress or within the DOH, or to specific questions regarding policy decisions that have been made, but for which there is a demand from various sectors including the DOH for a reconsideration. The task of research is to provide information to show why certain proposed policy actions should be adopted or not, or should be postponed until more information and analysis are made; and if a decision has already been made, to estimate the costs in terms of efficiency and equity loss, if not loss in health improvements, so that the decision can be reconsidered in the light of this new information.

In addition, policy analysis involves anticipating where reactions to new policy initiatives are likely to occur - in

a public or political arena, or in a bureaucratic arena - and who are the principal stakeholders involved. This analysis will essentially determine the gainers and losers of a new policy initiative, the likely reactions of these gainers and losers that might influence both the promulgation of the policy action and the implementation of the policy action.

At present, there are key policy decisions or proposals affecting the health sector which directly affects DOH's short-run and long-run performance. These require immediate attention with respect to policy analysis. These policies or proposals include the budget cuts for health and the legislative proposals to expand health service capacity, particularly public hospitals. Thus, the agenda for policy analysis will initially focus on:

(1) analysis of the implications of (actual or proposed) budget cuts for health (now or in the near future) particularly in times of economic crisis and in a policy environment of fiscal restraint. Answers to the following questions are needed:

(a) How much of the gains from past investments in health will be eroded as a result of budget cuts for health. These include gains in health status improvements and gains in efficiency and equity in health care provision?

(b) How much additional gains in health status and in efficiency and equity of health service provision will be foregone and will be difficult to recapture even when fiscal resources become less constrained?

(c) How much (or how little) can the reduction in public spending be made up by private activities and spending?

(2) analysis of the merits and implications of proposals from Congress to expand service capacity, particularly hospital services, to deal with the perceived large "unmet needs" for services. The DOH has a responsibility to inform the political decision makers of what the true situation is, and what the real health needs are. For this it needs to have the necessary information on the following specific questions:

(a) What is the true, as opposed to commonly perceived "unmet health needs" and the reasons for the con-

tinued existence of real unmet needs, of which lack of access to services is only one of many reasons and which in some cases may not be the most important one.

(b) Given the nature of unmet health needs, what should be the corresponding structure of services to provide?

(c) What are the current service capacities of both public and private sectors?

(d) What type of service capacity (hospital services, primary care services, etc.) should be expanded or modified, and by whom (public or private sector)?

Other research areas in each of these categories will be identified as various related activities are undertaken: on the first category when the on-going baseline studies shall have identified the major gaps in information that require additional research; on the second category when the Health Policy Framework shall have been formulated with inputs from the on-going baseline studies; and on the third category, whenever new issues arise and DOH is called upon to inform the political decision-making processes.

Statistical System for Health Policy

A review of the current statistical system and of the institutions involved in maintaining the system points to the need for considering the following:

1. The National Statistical Coordination Board is the government body which oversees the development and assessment of statistics for policy formulation and planning. There is a need to impress upon this body the need to consider the development of statistics for health policy and planning as part of their agenda.

2. The National Statistics Office is the government body which is mainly responsible for collecting, tabulating and publishing national socioeconomic and population data through censuses and surveys. While the NSO has strong capability of performing its routine

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tasks, there is a need to provide support to this institution for additional activities such as the preparation and making available major data sets for public use, i.e. available for use by researchers and analysts. Such support should enable the NSO to have additional staff or time to help researchers and analysts prepare the data files needed for specific analyses. Moreover, additional NSO staff time is needed to assist researchers and analysts in the proper handling of the data sets, i.e. merging data files from different surveys when necessary, or in the assessment of the quality of data, or in facilitating data retrieval for analysis.

The same type of support is needed, perhaps even more so for other government agencies responsible for collecting and analyzing data such as the Food and Nutrition Research Institute.

3. There is a need to review and strengthen the legal basis for collecting certain information and strengthen the primary agency capacity to record, retrieve, compile, tabulate and submit reports to appropriate coordinating agencies, such as the DOH, for final tabulation and publication. The information referred to include information on health establishments and information on the characteristics of health personnel, while the primary agencies involved include the Bureau of Licensing and Regulation of the DOH, Professional Regulatory Commission, and the National Statistics Office.

4. There is a need to support exploratory analysis of available national survey data sets from the standpoint of data quality, developing new methodologies for analysis, determining additional data to be collected, and refining the data coding and file system creation in order to make current surveys more useful for health policy research and analysis.

5. There is a need to support activities leading to the design and conduct of new censuses and surveys, in particular, the census of health establishments, the survey of employer-based health benefits, and NGO health-related activities and expenditures in order to supplement data on private sector provision and financing of health care.

6. There is a need to develop concepts and methodology for estimating national health expenditures and sources of financing, and to apply these to existing and prospective data.

7. Finally, there is a need to review the health information activities of the DOH with the view of expanding its role as the central coordinating body for the collection, compilation, tabulation and publication of health-related statistics in collaboration with the National Statistics Office and the National Statistical Coordination Board. This is to ensure that its information system is sector-wide rather than just confined to the activities of the DOH.

Building National Capacity for Research, Training and Technical Assistance

Although the final set of activities to be undertaken in support of capacity building can be determined only after a thorough assessment of individual institutions and consultations with various groups including the client groups, in particular the DOH, it is possible to identify a generic set of capacity-building activities that will have to be undertaken under the Health Finance Development Project under the direction and coordination of a lead institution. These activities include training, research, technical assistance, and networking and collaborative arrangements with national and international institutions. The specific activities are described below:

Training. Training activities would include:

1. Orientation visits for policy makers and policy analysts involved in the health policy process to selected countries to study the process of health policy development in these countries;

2. Orientation seminars/workshops

for policy makers, members of the Health Policy Development Advisory Council, Health Policy Development Technical Committee, Health Policy Development Staff, policy researchers and policy analysts on the process of health policy development;

3. Short-term training (two weeks to three months) in health economics and health care financing, health service administration, and hospital management and information system for policy implementors through programs designed and offered by national institutions or through existing programs offered by international institutions. This would include internship in health service administration and hospital management and information system in national or international institutions.

4. Short-term training (six months to one year) in health economics and health care financing, health service administration, and hospital management and information system for policy researchers, trainers and analysts through training programs, postdoctoral programs or internships offered by national or international institutions.

5. Long-term training (two to four years) in the field of health economics and health care financing, health service administration, and hospital management and information system for policy researchers, trainers and analysts through graduate programs offered by national and international institutions.

Research. Each of the different categories of research identified in the research agenda require different research skills. Baseline research would require skills in disciplinary research, both theoretical and empirical but with a conscious view of the relevance of the research to potential policy issues. Policy research would require, in addition to skills in disciplinary research, an orientation towards what can be done and what works. Policy analysis would require, in addition to the preceding two types of skills, an appreciation of the political and bureaucratic processes of decision-making and a keen understanding of the goals and behavior of various

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stakeholders in the health sector. The various types of training described above serve to build these different skills. However, building capacity for research would obviously involve, in the end, providing opportunities for undertaking actual research. Thus in addition to basic training and orientations, there is a need to institute on-the-job training activities for young and promising researchers and policy analysts by making them participate in a broad range of research activities which include:

1. Inter-disciplinary research in the behavioral and management sciences to better understand the behavior of beneficiaries and providers, and to develop new methodologies and data bases for health policy research and analysis;
2. Policy research on a number of topics designed to clarify policy issues, identify policy options and assess the potential impacts of alternative policies;
3. Evaluation of demonstration projects for feasibility and impact;
4. Synthesis of policy-relevant research;
5. Policy analysis of recommended policy actions for political acceptability

and administrative feasibility;

6. Monitoring and evaluation of policy actions for progress of implementation and impacts, both intended and unintended.

Technical Assistance. Various types of technical assistance from both local and foreign experts are needed to assist in the design and implementation of various activities related to the health policy process and to capacity building. In particular, technical assistance will be needed in the following areas:

1. Health Policy Process: formulation of health policy framework, research agenda and policy agenda;
2. Training: needs assessment and design of training programs;
3. Research: design of analytical framework, data collection methodologies, and analysis;
4. Demonstration Projects: design and evaluation;
5. Policy Actions: design of interventions, design of monitoring and evaluation plan, and analysis of impacts.

Networking and Collaborative Arrangements. A number of existing national institutions with potential capability for research, training, and technical as-

sistance are institutions which have had collaborative arrangements on project to project basis with international institutions while some have ongoing informal links with various international institutions through the long-standing association in professional organizations or through collaborative work of their individual members. Such arrangements have in fact been one of the strategies which these institutions have used to build their capacities in their respective disciplines or lines of activities. However, to build and sustain their capabilities to support health policy development, there is a need to forge new collaborative arrangements with international institutions specifically engaged in health policy research, training and analysis.

In addition to collaboration and networking with international institutions, there is a need to strengthen existing collaborative arrangements and networking activities among national institutions and to establish new ones in support of health policy development.

Main Report

Introduction

Background

The decade prior to 1986 was characterized by slow improvements in the health status of the population as indicated by the trends in life expectancy at birth and infant mortality rates, the persistence of infectious and parasitic diseases as major causes of mortality and morbidity, and the continued high rates of malnutrition. Both proximate factors (in particular the slow decline in fertility and the low level of health service utilization) and underlying socioeconomic factors (in particular the increasing poverty rate and the slow progress in education) are known to have largely contributed to this lack of progress in health status improvements.

The recognition of this situation by the new leadership in the DOH is clearly revealed in the following observations which the new leadership described as the "DOH's Cross to Bear":

"As 1986 began: increases in life expectancy have slowed down; morbidity and mortality rates from preventable causes have stabilized at high rates; declines in infant and child mor-

"... as the economic status of the nation worsened, advances in health status slowed down."

tality have decelerated; malnutrition incidence has increased; practice of family planning has decline; health status of large pockets of disadvantaged sectors has further deteriorated. In short, as the economic status of the nation worsened, advances in health status slowed down." (DOH Briefing Documents, 1987).

Recognizing the deficiencies of past health sector performance, the new leadership in the DOH embarked upon a set of new initiatives designed to strengthen the health sector and to make it more responsive to the health needs of the growing population. For the medium term, the DOH set the following objectives for itself: "(1) to sustain and gradually accelerate health program activities addressed to the main health problems of the nation; (2) to direct priority improvements in health programs towards the worst-off sectors of the population; (3) to institutionally strengthen the planning, implementing and service delivery capabilities of the national health network; and (4) to improve the financial and managerial base of the network in order to preserve and expand program and institutional gains." The DOH succinctly summarized its tasks in the following terms: "to do more, to do even more for priority groups, to do better, and to secure the improvements." (DOH Briefing Documents, 1987).

The objectives that DOH set for itself in the early years of the administration became the basis for the major policy thrusts and strategies of the entire health sector. These policy thrusts and strategies are contained in the Medium-Term Philippine Development Plan 1987-1992 and in the subsequent updates of the Plan. Among the major policies and strategies were: (1) increased resource allocation to the health sector and its proper and efficient allocation; (2) improved provision

and utilization of basic health services especially for the poor, unserved and high risk groups; (3) greater emphasis on, and more vigorous implementation of, preventive and promotive health measures; and (4) strengthened information and research-based decision-making and implementation.

While this is not the place to assess health sector performance against the stated policy thrusts and strategies, it is useful to highlight some of the policy initiatives and major accomplishments of the health sector in order to better

"DOH's Cross to Bear"

As 1986 began:

- ◆ *increases in life expectancy have slowed down;*
- ◆ *morbidity and mortality rates from preventable causes have stabilized at high rates;*
- ◆ *declines in infant and child mortality have decelerated;*
- ◆ *malnutrition incidence has increased;*
- ◆ *practice of family planning has decline;*
- ◆ *health status of large pockets of disadvantaged sectors has further deteriorated.*

understand the motivation behind the DOH's desire to preserve and sustain the gains thus far achieved through more effective health policy formulation, implementation and evaluation.

First, the DOH has succeeded in increasing government resources for health. Early in 1986, the DOH convinced the national government to make available more than 500 million pesos of its required reserves for additional financing of essential drugs and operating costs. Subsequently, the DOH has succeeded in increasing government health expenditures both as a proportion of GNP and on a real per capita basis. Government health expenditures as a proportion of GNP rose from 0.58 percent in 1986 to 0.73 in 1990. Moreover, real government expenditures per capita, in 1972 prices, rose from 9.82 pesos in 1986 to 13.13 pesos in 1990. More noteworthy is the fact that real per capita government health expenditures have more than fully recovered from the very sharp fall in 1984 in spite of the continued rapid growth of the population while real GNP per capita has yet to fully recover from its 1982 level.

Secondly, recognizing the persisting imbalance between the existing health care service structure and the health care needs of the large majority of the population, and recognizing that public sector health expenditure patterns in the recent past have aggravated this imbalance, the new leadership in the DOH adopted a more vigorous implementation of preventive and promotive health measures, particularly in the area of maternal and child health, even as efforts were made to upgrade government hospitals in terms of financial, equipment and manpower complements. The maternal and child health program involves a set of inter-related activities which include immunization, nutrition, maternal care, family planning, and the control of diarrheal diseases and respiratory infections.

The most visible component of the program is the expanded program of immunization. From an estimated coverage of 25 percent in 1985, the percentage of fully immunized children is estimated to have risen to 80 percent in 1989 (Updates of the Medium-Term Philippine Development Plan, 1990-1992, *et al.*). Efforts to reduce the high rates of malnutrition among preschoolers, which included health-related interventions, also appeared to have contributed to the decline in the percentage of underweight preschoolers from 17.7 percent in 1987 to 13.9 percent in 1989. The implementa-

tion and coordination of the national family planning program, which suffered setbacks in the early years of the new government because of its linkage with the controversy about fertility reduction as a national policy, (a controversy which to date has remained unresolved), was effectively taken over by the DOH in 1989. A Five-Year Directional Plan was developed and new resources were generated to implement the program as an integral part of the total health program. The control of diarrheal diseases has gained impetus with intensified efforts to shift case management from the use of intravenous therapy, anti-diarrheals and antibiotics to the use of oral rehydration therapy, supported by the production of ORISOL packets. Finally, in the control of acute respiratory infections among infants and young children, the DOH has formulated a national program that emphasizes the use of modern and more cost-effective method of diagnosis and case management involving the use of midwives in lower level facilities in place of traditional and more expensive case management methods based in hospitals.

Thirdly, efforts to achieve greater efficiency in resource use were undertaken. In addition to the shift towards more cost-effective methods of controlling two of the most important health problems, i.e. diarrheas and acute respiratory infections already noted above, perhaps the most prominent policy change affecting efficiency in resource use is the passage of the Generics Act of 1988 as part of the overall National Drugs Policy. The Act provided for the use of generic terminology in the importation, manufacture, distribution, marketing, advertising and promotion, prescription and dispensing of essential drugs. The objective of this policy is to help control the cost of essential drugs, which is a major component of the total cost of

Government health expenditures increased from 0.58% of GNP in 1986 to 0.73% in 1990.

Immunization coverage rose from 25% in 1985 to 80% in 1989.

Support value of Medicare which has declined to only 33% was restored to 70-80% in 1989.

Underweight children among pre-schoolers declined from 17.7% in 1987 to 13.9% in 1989.

health care by giving consumers greater choice in the purchase of drugs.

Fourthly, in an effort to improve access to health care, the benefits of the Medicare Plan were raised in 1989 through Executive Order No. 365. The support value of Medicare, which was originally designed at 70 percent in 1972, had eroded considerably over the years so that by 1989, its support value was estimated at only 33 percent. This support value was raised to 90 percent in 1989 based on 1987 costs, which roughly translates to an effective support value of 70 to 80 percent in 1989.

In addition, the allocation of the increased budgetary resources for health took greater account of the need to shift health services towards the poor and underserved areas. Thus, budget increases were allocated: (1) at the regional level, on the basis of regional poverty rates; (2) at the provincial level, on the basis of population size, with 65 percent going to public health and 35 percent to hospitals; and (3) at the hospital level, by occupancy rates.

Finally, in the area of strengthening information and in the promotion of research-based policy decision-making and implementation, various activities were undertaken including the review and development of field health information systems and more generally of health and management information systems; a study of health care financing; the fielding of a national health

survey in 1987; the development of a program budgeting system and the training of DOH personnel in the implementation of such a system; and the development of a research program for health sector assessment and health care financing.

This brief and highly selective review of health sector policy thrusts and accomplishments highlights the fact that carefully thought out policy initiatives can in fact be made even in an environment of severe resource constraints and highly competitive sectoral claims against such resources, and in an environment of contentious debates regarding certain aspects of policy (as in the Generics Act and the family planning program). While it is too early to fully assess the health impacts of all these initiatives, it is expected that the impacts would be positive and would cumulate over time. The task that lies ahead then, as the DOH leadership sees it, is how to preserve the gains that have been made and how and build on them to achieve even greater accomplishments.

Encouraged by its past accomplishments and cognizant of the larger task ahead, the DOH seeks to pursue its health policy initiatives by institutionalizing the process of policy reform itself. Thus on September 1990, the DOH's Executive Committee launched a program called the Health Policy Reform Initiative. This program seeks "to establish a process for considering, studying, testing, promoting, adopting, implementing, monitoring, and evaluating policy reforms in the health sector."

Scope and Objectives of the Study

In support of its Health Policy Reform Initiative, the DOH and USAID have formulated a bilateral project on Health Finance and Development. The purpose of the Project is "to increase resource mobilization, efficiency, and quality of health services in the Philippines by improving the processes and institutions for generating and implementing policy initiatives and reforms in the health sector." The Project will consist of three major components: (1) Policy Formulation, (2) Health Financing, and (3) Hospital Reforms. The task of this study is to assist DOH and USAID in designing the

DOH Health Policy Reform Initiative :

establish a process for considering, studying, testing, promoting, adopting, implementing, monitoring, and evaluating policy reforms in the health sector.

Policy Formulation Component of the Project.

Specifically, this study will:

1. Determine the DOH's vision of its role in the development, formulation, evaluation, and advocacy of health policy;
2. Determine institutional organizations and/or arrangements required to achieve DOH's mandate as a policy and regulatory body;
3. Identify the required processes to formulate a policy framework and a policy agenda in the health sector and the respective roles of the public and private sectors in these endeavors;
4. Identify major research areas that need to be investigated to support policy formulation, and to develop a schedule for carrying them out;
5. Assess local research and consulting capacity to carry out research supportive of policy formulation;
6. Determine manpower development requirements to support health policy formulation; and

USAID Health Finance Development Project : 3 components :

- ◆ *Policy Formulation*
- ◆ *Health Financing*
- ◆ *Hospital Reforms*

7. Conceptualize an activity for institutionalizing a replicable health sector database, identify the most appropriate government or private sector entity (entities) in which this activity could be housed, and discuss human resource requirements and sustainability of this activity.

Organization of the Report

The remainder of this paper is organized as follows. Section 2 discusses the vision of the DOH as to its role in the development and advocacy of health policy. This vision is distinguished from the vision of its role in health development, which is a broader vision and guides all of its activities.

Section 3 elaborates on the concept of health policy development and the major sets of activities involved. It builds on the considerable amount of thinking that has already been made by both DOH and USAID.

Sections 4 and 5 discuss aspects of the policy process. Section 4 discusses basic concepts that are useful in the formulation of a health policy framework and a research agenda as well as in the evaluation of policies in terms of efficiency and equity of health sector performance. Section 5, on the other hand, describes early and recent efforts at developing an agenda for research, and considers additional areas for research that could be undertaken under the Health Finance Development Project.

Sections 6 and 7 discuss aspects of the health policy support systems. Section 6 assesses current statistics for health and considers ways of strengthening the current statistical system. In particular, it considers the possible institutional arrangements for data collection, tabulation and publication of key statistical indicators, and considers the need to develop a national accounts system for health along the lines of the national income accounting system. Section 7, on the other hand, reviews recent international and national thinking on the subject of capacity building for health policy research, training and consultancy; assesses current national capacity; and considers ways of upgrading such capacity in the short- and long-run.

The DOH's Vision of its Role in Health Policy Development

It is necessary to distinguish between DOH's vision of its role in health policy development which is a more focused one, and its vision of its role in the promotion of better health, which is the broader one and which guides all of its activities. We first describe this broader vision.

The DOH's Vision of its Role in Health Development

The DOH's vision of its role in the promotion of health as stated in its early briefing documents is as follows:

"Health is a basic human right. A continuum of services must be provided to assure the enjoyment of this right, especially by the poor."

Explicit in this vision is the recognition of health as a basic human right. This aspect of the vision is drawn directly from the Constitution which provides that:

"The State shall protect and promote the right to health of the people and instill health consciousness among them" (Article II, Section 15).

Also explicit in this vision is the promotion of greater equity. This aspect of the vision, which has been emphasized in many public statements by the Secretary of Health and by the other top leaders of the DOH, is also drawn from the Constitution which provides that:

"The State shall adopt an integrated and comprehensive approach to health and development which shall endeavor to make essential goods, health and other social services available to all the people at affordable costs. There shall be priority for the needs of the under-

privileged sick, elderly, disabled, women and children. The State shall endeavor to provide free medical care to paupers." (Article XIII, Section 11)

What is not readily apparent in the statement of the vision is the achievement of greater efficiency in health sector performance. In public statements made by the top leadership in DOH, however, efficiency is indeed an important element of this vision. The top leadership in DOH has stated on many occasions that in carrying out policies and strategies, the DOH has been guided by certain values, foremost among them is equity in the provision and financing of basic health services, and within equity considerations, maximum efficiency and quality." (Statement of Undersecretary Mario Taguiwalo, HAMIS Workshop, Puerto Azul, 1990). In the particular case of health care financing, achieving greater efficiency in health sector performance means "building discipline into the supply side and demand side of the system" (Statement of Secretary Bengzon, Seminar/Workshop on the Development of the National Health Insurance Program for the Philippines, Tagaytay, November 30- December 2, 1988).

To understand this vision of its role both as earlier stated in briefing documents and as later elaborated in public statements, it is necessary to examine the provisions of the Constitution and Executive Order No. 119 from where this vision finds legal basis. One also needs to examine the manner in which this vision has been translated into objectives of the DOH for the medium-term, and how these objectives in turn were later translated into specific policies and strategies for the entire health sector (i.e. health, nutrition, and family planning) in the Medium-Term Philippine Development Plan, 1987-1992. Finally, one needs to examine the

Health Development Values

- ◆ health as a basic human right;
- ◆ equity in the provision and financing of health services;
- ◆ greater efficiency in health sector performance.

performance of the health sector and the role that the DOH played in it to see how the vision is being translated into reality. In Section I, we have briefly described the performance of the health sector under the DOH leadership. In Annex A we present the relevant provisions of the Constitution and the Executive Order No. 119, as well as the objectives, policies and strategies of the health sector for the reader's examination.

The DOH's Vision of its Role in Health Policy Development

As articulated by its leaders, the DOH's role in health policy development can be viewed from two perspectives: as one of the stakeholders in the health sector, and as the agency mandated by the government to act as the policy and regulatory body for health. As a stakeholder in the health sector, the DOH can perform

any of the following possible roles: (Based on Undersecretary Taguiwalo's statements in Health Finance Development Project Design Workshop, Punta Baluarte, May 1991, and Private Sector Health Finance Consultative Workshop, Makati, July 1991):

- (1) as a technical resource agency providing data and information to interest groups and concerned parties;
- (2) as a catalyzer for public discussions on health policy;
- (3) as an advocate for policy positions relative to other parties in the health sector;
- (4) as an administrative and political sponsor in government processes in behalf of the whole health sector; and
- (5) as the implementing arm of government in so far as policies require an organizational executor.

However, the other stakeholders in the health sector can also play any of these possible roles in various forms. What distinguishes the DOH from the other stakeholders is that the DOH is the agency mandated by the government to act as the policy and regulatory body for health. This mandate comes from Executive Order No. 119 issued in January 1987, entitled "Reorganizing the Ministry of Health, its Attached Agencies and for other Purposes which provided that:

"The Ministry (Department of Health) shall be primarily responsible for the formulation, planning, implementation, and coordination of policies and programs in the field of health. The primary function of the Ministry (Department of Health) is the promotion, protection, preservation or restoration of the health of the people through the provision and delivery of health services and through the regulation and encouragement of providers of health goods and services." (Section 3).

Thus from this perspective the DOH

DOH Roles

- ◆ as one of the stakeholders in the health sector;
- ◆ as the agency mandated by the state to act as policy and regulatory body for health.

sees a larger task for itself which is to establish the necessary processes and institutions that would enable the various stakeholders in the health sector to perform their respective roles in health policy change. The DOH envisions a fully participative process of health policy development involving all the various actors in the health sector. This vision is articulated in an earlier statement by Secretary Bengzon in the following terms: "the DOH is not only a direct provider of health services, but also a policy contributor and formulator, and on these latter roles, the DOH's task is to set up the environment for various actors in the health sector to perform their functions" (Paraphrase of a statement of Secretary Bengzon in Seminar/Workshop on the Development of the National Health Insurance Program for the Philippines, Tagaytay, 1988).

Besides its mandate as the policy and regulatory body for health, the factors that shaped its vision of its larger role in health policy development include: (1) the DOH's own assessment of the challenges that the health sector currently faces and will likely face in the future; (2) the lessons it learned from the health policy debates and reforms in other countries; (3) its understanding of the goals, the behavior, and the power and influence of various stakeholders or interest groups in the health sector; and (4) its appreciation of the political processes of decision-making and the role of government bureaucracies in policy implementation.

First, the DOH recognizes that the nature and character of current economic, demographic and epidemiological changes will inevitably translate themselves into new and different patterns of health needs and demand. Hence, there is a need now to lay the groundwork for the health sector's response to this inevitable health transition even as current policy reforms in the health sector will themselves help influence the pattern and speed of this health transition. On the other hand, the DOH also recognizes that the health sector has the potential capability and flexibility to provide the changing mix of services that will be demanded during this health transition. However, that potential may not unfold automatically or rapidly as evidenced by the inadequate health sector performance in the recent past and by the still continuing struggle to increase the flow of resources for health, to improve service effectiveness and efficiency, and to sustain improve-

ments in health status through health care. Hence, there is a need to ensure that this potential unfolds quickly into reality. And here the DOH sees an important task that it must perform, that of helping to develop within the health sector, the ability to initiate and sustain change so that potential becomes reality quickly to respond to new health needs. It is useful at this point to recall one of Secretary Bengzon's statements to get a sense of the nature of change that is being contemplated. The kind of change being envisioned is one of "accelerated evolution rather than revolution, that is, participative and peaceful change with revolutionary fervor" (Seminar/Workshop on the Development of a National Health Insurance Program for the Philippines, Tagaytay, 1988).

Secondly, the DOH has been an active participant in international discussions on health and health policy reforms in such fora as the World Health Assembly and the WHO Regional Committee Meeting. It has been alert to international debates on the underlying problems of particular health systems and the appropriate choices to be made to address those problems (such as debates on the sources of health care cost escalation and the impact of health care financing schemes on cost and access to health services). Finally, it has also been a keen observer of health policy changes in other countries especially in the areas of health care financing and the role of the private sector in the provision and financing of health care. The DOH also perceives that interna-

Possible Tasks in the DOH

- ◆ technical resource agency for health concerns;
- ◆ catalyzer of public discussions on health issues;
- ◆ advocate of positions in health policy;
- ◆ administrative and political sponsors of policy adoption;
- ◆ implementor of health policy adopted.

Institutional and Operational Aspects of Health Policy Development

Introduction

The Health Policy Reform Initiative of the DOH is a program that seeks to operationalize and institutionalize health policy development. An input into this Initiative is the Policy Formulation Component of the Health Finance Development Project. An early description of this component is contained in a draft Project Identification Document of December 1990. This description has been subsequently refined on the basis of further discussions and consultations, the latest in a Project Design Workshop held in May 1991 participated in by individuals representing various sectors. The basic features of health policy development contained in the early description, however, are retained in subsequent versions. These are:

(1) The policy, regulatory, and legislative recommendations must be based on broad-based consultation, solid research, and proper demonstration of recommended changes.

(2) The policy process must be iterative, consisting of various activities that finally lead to the design and implementation of appropriate policies, regulations and legislation. It is to be iterative in order to allow for modification of policies, regulations, and legislation after thorough evaluation of their potential impact as determined by careful analyses and demonstration.

(3) Certain organizational structures need to be established to take lead responsibility for the entire as well as for specific aspects of the policy process.

The refinements made as of May 1991 included the following:

(1) A clearer (more concrete) articulation of the intermediate outputs or objectives of the policy formulation

component, which are: (a) to build capacity in government and in DOH in particular for research-based policy formulation; (b) to establish a mechanism for a continuous health policy dialogue on a wider range of issues among a larger group of participants; and (c) to develop a national health accounts and health policy data base.

(2) A more logical flow of the different activities as well as a clearer description of each activity to achieve each of the intermediate objectives; and

(3) The addition of two important activities in the policy formulation process, namely, the monitoring and evaluation of policy actions as distinguished from the monitoring and evaluation of demonstration projects.

Health Policy Development

Building on the work that has been done, this section elaborates on the concept of health policy development and its component activities. Health policy development is defined in this study as the process of strengthening and sustaining the capacity of the DOH, in collaboration with the various groups in the health sector, to formulate, implement and evaluate health policies to achieve greater efficiency and equity in the provision and financing of health services. Health policy development involves three major sets of activities: (1) the establishment of an interactive health policy process; (2) the setting up of organizational structures within the DOH to initiate, guide and sustain the health policy process; and (3) the strengthening of institutional support systems for sustaining the health policy

process. Below we elaborate on each of these major activities.

Health Policy Process

This involves an iterative and an interactive process consisting of the following specific activities: (1) development of a health policy framework; (2) development of a health policy research agenda; (3) implementation of health research studies; (4) development of a health policy agenda; (5) promulgation of health policy actions; and (6) monitoring and evaluation of policy actions.

Development of a Health Policy Framework.

This framework describes the policy areas, policy issues and policy questions that must be considered in order to effect efficiency and equity improvements in the health sector.

The basic inputs into the identification of policy areas and issues and the formulation of specific policy questions would include the following:

(1) A common conceptual framework for analyzing health sector performance and for identifying policy issues to guide the initial thinking process. (A conceptual framework useful for this purpose is described in Section 4).

(2) The results of past research and independent assessments of health sector performance.

(3) The DOH's own assessment of health sector performance and its experience in health service provision and financing.

(4) Policy issues and questions that other government agencies and various sectors of society, particularly the

various stakeholders in the health sector, perceive to be important and need to be addressed. These include issues and questions regarding recent policy actions and the manner of their implementation.

(5) A comprehensive baseline information obtained from on-going research which may uncover many areas and issues for policy consideration.

At any given time, it is possible to identify a limited set of policy areas, issues and questions to be addressed, even as the results of on-going and future research and deliberations will later help define other areas to be considered.

Based on its own assessment of health sector performance and its reading of the demands for reforms from various sectors, a preliminary framework was developed by the DOH which consists of five broad policy areas: (1) public sector health financing; (2) private sector provisions for public goals; (3) efficiency and equity enhancement in public and private health sectors; (4) national health care financing system; and (5) new perspectives in the Philippine health sector. Of these five policy areas, two were selected to be addressed under the Health Financing Development Project, namely: efficiency and equity enhancement in public and private health sectors with attention to hospitals, and national health care financing systems with attention to Medicare and other systems to reach the population currently not covered by Medicare.

The Health Policy Development Process

- ◆ *establish, strengthen, and sustain capacity in the DOH for developing health policy;*
- ◆ *link this DOH capacity with other groups and interests in the health sector;*
- ◆ *interact among parties to formulate, implement, and evaluate health policies;*
- ◆ *test policies against efficiency and equity goals of the health sector.*

Considerable effort has been exerted in formulating specific policy questions in these two areas, and a number of researches were commissioned by USAID to help provide additional background information.

Development of a Health Policy Research Agenda. Viewed from a linear standpoint, there will be research that will be needed to help formulate the Health Policy Framework. Once the policy areas, issues and questions have been identified, research will be needed to generate findings that could lead to recommendations for reforms. Then research will be needed to generate data and analysis to help design and test the recommended reforms. Finally, research will be needed to monitor and evaluate the coverage and impact of the policy actions that have been taken. Thus one could conceive of research as moving from one stage to another in tandem with the stages of the policy process.

However, what we will likely find is that the Health Policy Framework, once formulated, will contain policy areas, issues and questions with different levels of specificity and urgency. Thus, on some critical policy areas, there will be a need for more baseline information to understand the issues involved and to specify the questions more concretely. In others, the issues and questions are clear, and so research can proceed towards generating data and analysis that could help formulate the recommendations. In others, the questions relate to ongoing programs, and so research can start with evaluation of program coverage with the view of recommending operational changes at the margin. In others, the question might be on whether there is a need to reconsider a major policy decision that has recently been made, and so research might focus on monitoring and evaluating the actual and potential impacts of such a policy with a view to its possible modification or abandonment.

In Section 5 we review recent efforts towards developing a research agenda that will provide a wide range of baseline information about the health system, and a research agenda that addresses specific policy issues and questions. We also explore other policy issues and questions that might be considered of high priority and the corresponding research agenda to address them.

Implementation of Health Research Studies.

The research studies will likely be implemented by group researchers coming from different disciplines. Apart

Activities to Create the Policy Development Process

- ◆ *generating and assembling the knowledge base for policy discussions and decisions;*
- ◆ *establishing and activating within the DOH the organizational structures, mechanisms and procedures for policy deliberation;*
- ◆ *orchestrating participation of institutions and organizations in the health sector to sustain the knowledge base and support the sectoral consensus on policy.*

from the question of management, i.e. identification of researchers, arranging meetings, preparing contracts, enforcing timeframes, etc., there is something about policy research involving many disciplines that needs to be considered. Each discipline has its own concepts and theories and specific research approach to a given problem situation. As such the work of individual researchers will have strong but perhaps narrow disciplinary orientation. What is needed, however, is a complete view of reality. Hence, a major consideration in the implementation of health research studies is how to combine the different disciplinary perspectives into a single coherent view of reality. The following activities might be considered as part of the overall research implementation:

(1) Formation of an ad hoc multi-disciplinary group to assist a principal study director (who will come from a particular discipline) in research design, data collection, analysis and interpretation of results. This study director himself/herself could be a member of another multi-disciplinary group assisting another principal investigator.

(2) Establishment of a regular research forum whereby the research framework, methods of data collection and analysis, and the principal findings are discussed by a larger group of researchers from different disciplines.

(c) Formation of special research teams to evaluate and synthesize research findings as they come out, to relate these findings to the larger body of knowledge that already exist, and to draw out policy implications, formulate specific policy recommendations, design the specific forms of interventions and assess their potential impacts. Selected personnel from the DOH should join such teams so that over time a core of DOH personnel could gain enough experience in research synthesis and utilization for policy purposes.

Development of Health Policy Agenda. The findings from the research studies as evaluated and synthesized for policy purposes will be reviewed and further evaluated by a high level committee (to be discussed later) and from which a set of policy recommendations, together with the corresponding instruments for intervention, will be made. The policy recommendations resulting from this review process will constitute the official Health Policy Agenda of the DOH. In an interactive policy process, this Agenda will include not only new initiatives but also recommendations for modification, refinement or abandonment of recently promulgated policy actions based on new information and careful policy analysis.

Among the new policy recommendations, some can be proposed for immediate adoption while others may require further demonstration. The former will be immediately proposed for policy action, while the latter will be tested and validated in demonstration projects.

Knowledge and Ideas for Policy Development

- ◆ *developing a health policy framework;*
- ◆ *crafting a health policy research agenda;*
- ◆ *undertaking policy-relevant research;*
- ◆ *formulating a health policy agenda;*
- ◆ *testing policy via demonstration projects;*
- ◆ *monitoring and evaluating policy actions.*

Conduct of Demonstration Projects. Certain policy recommendations will involve new approaches that they will need to be tested, validated, and thoroughly assessed for their feasibility and actual impact. For these recommended approaches, demonstration projects will be conducted where the policies and their impact will be evaluated in a real life situations. In these demonstration projects, the evaluation will consider not only what would work under pilot test conditions but more importantly, to consider what the results would be like when the policy or program is implemented on a larger scale. Since the conditions underlying pilot tests are not likely to be fully replicated on a national scale, it is important to take note of the favorable situations in the pilot test situation, e.g. well trained and dedicated personnel, well informed beneficiaries, efficient logistics, etc., and to conduct sensitivity tests where these favorable situations are "diluted" in a national coverage.

Promulgation of Health Policy Actions. This involves the promulgation of recommended policy actions on any of four levels of policy actions: Constitutional amendments, Republic Acts, Executive Orders, and Administrative Orders.

Monitoring and Evaluation of Policy Actions. Once policy actions are implemented, these will monitored for their progress (i.e. compliance, coverage of intended beneficiaries, quality and quantity of resources or services reaching the target beneficiaries, etc.) to determine whether further refinements are needed in their implementation or management. Finally, the policy actions will be evaluated for their impacts on efficiency and equity of health sector performance, both intended and unintended, to determine whether to continue the policies, to strengthen them, to modify them so as to achieve greater intended impacts or minimize unintended adverse impacts, or to abandon them if found ineffective under changed or unforeseen conditions.

In evaluating the impact of policy actions, it is essential to have a common criteria by which to judge "success" or "failure". This is so because the success of any policy action is relative. In any policy change, there will be losers and gainers. The losers would obviously consider the policy action a failure from their own perspective. The gainers would obviously have quite a different conclusion. But in the end, the policy actions must be evaluated on the basis of a commonly agreed criteria of

efficiency and equity of health sector performance and other objectives of the health sector. It is also to be expected that adverse reactions to a policy action from some stakeholders would arise only during implementation. These reactions may be due to the way the policy actions are being implemented, or more substantively, due to the fact that only then would these groups realize the magnitude of the potential loss to them of the policy change. Such reactions could lead to unproductive and contentious debates on the merits and demerits of the policy action if a common and a solid information base derived from scientific monitoring and evaluation is not readily available to resolve claims and counterclaims. Thus monitoring and evaluation data, in addition to serving the purpose of determining how to make the policy actions more effective, could also serve as an input into the continuing policy analysis to inform various stakeholders and the general public of what the true situation really is.

Organizational Structure Within DOH

Preliminary discussions and subsequent deliberations on the organizational or institutional structures for health policy development have identified the need to create the following bodies within DOH to oversee the entire process: (1) Health Policy Advisory Council; (2) Health Policy Technical Group; and (3) Health Policy Reform Secretariat. Below we elaborate on the functions of these bodies.

A Health Policy Advisory Council. It is a multisectoral body to be established by Executive Order with representation from the DOH, related government agencies, and various interest groups such as universities and research institutions, private sector health care providers and financiers, and professional associations. Its main function is to provide advice and to assist the DOH in performing its leadership role in health policy development. (Note: The use of the terminology "Advisory Council" instead of "Steering Committee" used in preliminary documents is probably more accurate since the function of the body is meant to be essentially advisory in nature. The DOH still retains the mandate and the respon-

sibility of formulating and coordinating policies related to health).

Specifically, the Advisory Council will advise and assist the DOH in performing the following tasks:

(1) Formulation of the Health Policy Framework.

(2) Review and approval of the Health Policy Research Agenda.

(3) Formulation of the Health Policy Agenda.

(4) Initiation of the administrative and organizational actions necessary for the promulgation of appropriate policy actions.

(5) Overseeing the monitoring and evaluation of policy actions.

(6) Sponsoring and advocating health sector reforms.

(7) Broadening the participation of various stakeholders in the health policy process.

(8) Developing technical capability for initiating and sustaining health policy reforms in the health sector, both within and outside of the DOH.

Health Policy Technical Group. This is composed of key public and private sector policy analysts headed by the Undersecretary of Health and designated by the Secretary of Health.

The Technical Group will provide technical oversight for the entire policy process. Specifically its functions will be:

(1) To provide technical oversight for policy framework, research agenda and policy agenda preparation.

(2) To provide technical oversight for the conduct of research studies, pilot tests and demonstrations of specific policy recommendations, and monitoring and evaluation of policy actions.

(3) To provide technical oversight for the development of a statistical system for health, including the development of a National Health Accounts System.

(4) To oversee the development of technical skills in health policy research and analysis, particularly in the synthesis and utilization of the findings of health policy research, among the staff in the DOH and in other government agencies involved in health-related activities.

(5) To promote the development of national institutions for health policy research, training and technical assistance.

(6) To encourage the technical discussions of policy and research issues in health sector development among the various stakeholders in the health sector.

To perform these tasks, the Technical Group will draw on individuals from universities, research institutions, con-

sulting firms, trade associations, professional societies, pharmaceutical industry, medical equipment industry, and health financing industry for assistance and advice.

In addition, the Technical Group will form special teams to undertake synthesis and utilization of research findings and demonstration results for policy analysis. These teams will consist of experts from the above institutions and selected personnel from the DOH.

Health Policy Reform Secretariat. This will be composed of DOH personnel to be headed by an Assistant Secretary and designated by the Secretary of Health. The Secretariat will provide administrative support to the work of the Advisory Council and the Technical Group, and will serve as liaison with the non-DOH agencies and bodies involved in health policy development.

Support Systems for Health Policy Development

Multisectoral Health Policy Forum. In order to foster a continuous health policy dialogue, an independent Forum for Health Policy will be created. The Forum will be a loose association of various professional associations, private sector providers and financiers of health care, universities and research institutions, academic disciplines, the DOH and other related government agencies. The Forum will consider, discuss, and debate policy issues. Many of the ideas generated through the Forum will become inputs into the health policy process itself. The Forum could also serve as a mechanism by which the DOH can raise awareness and forge consensus among the various stakeholders in the health sector about aspects of the policy process, i.e. the policy framework, the research agenda, and the policy agenda itself. The Forum will not take the place of the usual public hearings required in policy decision-making, but rather it will expand the participation of various groups and expand the range of issues to be publicly discussed.

The DOH, in its role as catalyzer, will convene representatives of institutions to present this idea of an independent Forum, and to encourage them to form a loose association. Once formed, the Forum will create its own

Systems in Support of Policy Development

- ◆ *Multisectoral health policy forum for consensus building;*
- ◆ *National statistics for health;*
- ◆ *Health policy research, and training programs.*

small secretariat which will manage and coordinate day-to-day activities. The HFD Project may initially provide a grant to fund the secretariat. Later the secretariat will be funded entirely by the members of the Forum through contributions. In addition, the HFD Project may provide small grants to help institutions represented in the Forum to prepare analysis and reports for discussion.

National Statistics for Health. Reliable data to assess the performance of the health sector are currently not available or readily accessible, particularly in the area of health care expenditures and financing, economic costs of various health programs and services in both private and public facilities, health manpower, and demand and utilization patterns. There is a need to develop and maintain national statistics for health that will support health research and analysis. We describe the development of this statistical system in Section 6.

Health Policy Research, Training and Consultancy Program. Since the health policy development is premised on research- and information-based policy formulation, implementation and evaluation, it is necessary to build and strengthen the national capacity for health policy research, training and technical assistance. Initial thinking about the processes involved has been made at the national and international levels. We draw on the results of this initial thinking in our assessment of the current national capacity and in our identification of capacity-building activities to be undertaken under the Project. We describe these in Section 7.

Conceptual Framework for Health Policy Formulation and Assessment

Introduction

A major activity in the health policy process is the formulation of the Health Policy Framework. This Framework describes the policy areas, policy issues, and policy questions that must be addressed in order to move the health sector towards greater efficiency and equity. To facilitate the formulation of a Health Policy Framework, there is a need to consider a common set of conceptual frameworks about the determinants of health and how the health sector operates to influence health. There is also a need to consider a common set of criteria for assessing the performance of the health sector in terms of efficiency and equity of health care provision and financing. We describe below some basic concepts derived from social science disciplines, in particular economics, which can serve as inputs into the formulation of a Health Policy Framework.

Determinants of Health

A simple framework for analyzing the determinants of health outcomes can be briefly described as follows. (See Figure 1). Health outcomes, which are measured either in terms of mortality, morbidity, nutritional status or disability, are determined directly by a set of "proximate" determinants. These are (1) health service utilization, (2) environmental contamination, (3) nutrient/dietary intake, (4) fertility, and (5) injury. These proximate determinants in turn are

determined by a host of socioeconomic, demographic and cultural factors. These factors include (1) individual characteristics such as age, sex, education, occupation, and health beliefs and attitudes; (2) household characteristics such as household income/wealth, the age-sex composition of the household, and social networks; and (3) community level factors which include ecology; structure of markets and prices for goods and services; transportation networks, population size, structure and distribution; and social structure and organization.

It should be evident from this simple framework that health care service utilization (preventive or curative) which has been the traditional concern of health care providers is only one of many factors influencing the health status of the population.

This broad framework facilitates the identification of major areas for health interventions. Thus, direct interventions might include the provision of health care services, reduction in environmental contamination, provision of adequate nutrition, provision of safe means of fertility control, and provision of safety measures at home and at the working place. Beyond these traditional areas of biomedical intervention are interventions in the socioeconomic field which indirectly affect health outcomes through their impact on one or more of the proximate factors. These include the provision of better education and health information, increased employment and incomes, improved transportation and communication, and various policies affecting prices of goods and services.

The various interventions influencing health outcomes are carried out by different sectors, each involving several government agencies and various private institutions. The health sector is

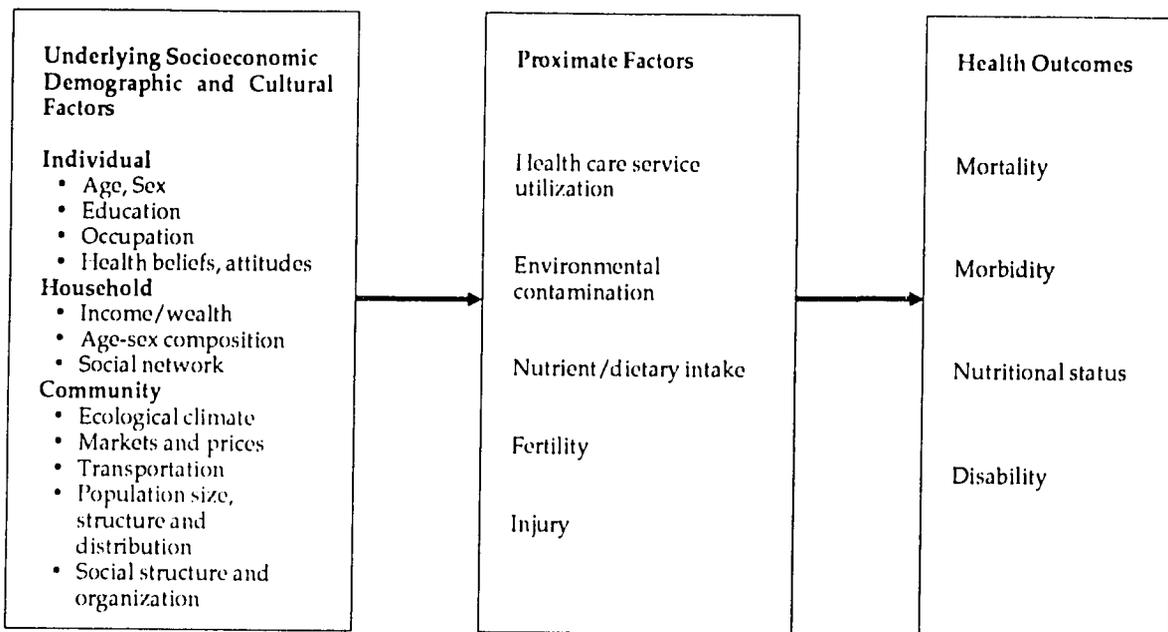
only one of these sectors and the impact of its activities could either be facilitated or constrained by the success or failure of the other sectors in their respective areas of responsibility. For example, the lack of transport facilities in certain areas could limit access to health care services. There is a growing recognition that greater intersectoral coordination is essential so that sectoral activities, while implemented independently by each sector and by different agencies or bodies in each sector, can be designed so that their direct and indirect impacts cumulatively contribute to greater health improvements. The conceptual framework of the determinants of health just described helps us to visualize the various activities that need to be coordinated in order to achieve greater health impacts.

Operation of the Health Sector

There are several ways of describing the health sector depending upon the purpose of the analysis. Given our purposes of identifying key policy areas, issues and questions, and of evaluating the economic performance of the sector in terms of efficiency and equity, the operation of health sector may be described in terms of a set of input-output relationships. (See Figure 2). (This framework as well as the criteria for assessing health sector performance is based on the work of Andreano and Helminiak, 1987; 1988).

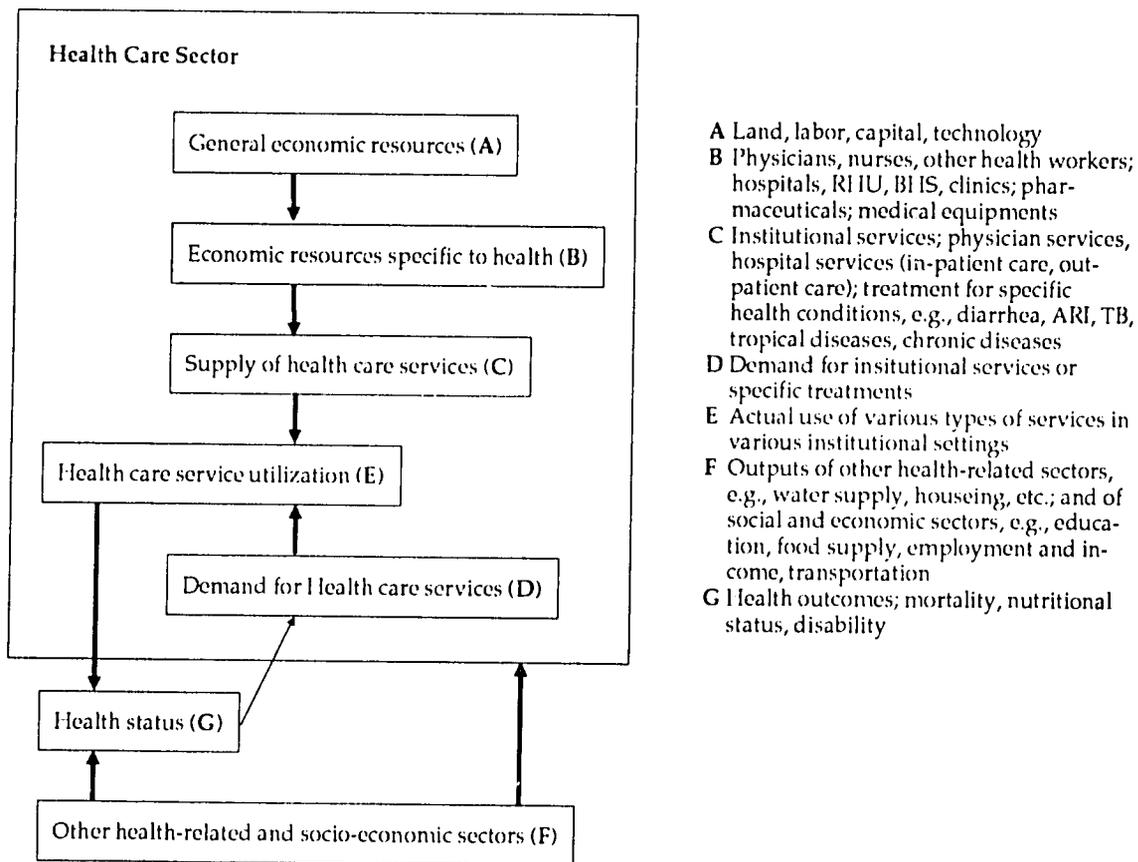
We start with the mobilization of general economic resources i.e. land, labor, capital and technology which are then transformed into resources specific to health, i.e. various types of health care facilities and manpower,

Figure 1. Determinants of Health: Major Factors and Intervention Points



Framework adapted from Mosley and Chen (1984).

Figure 2. A Conceptual Framework of the Health System with Attention to the Health Care Sector



Adapted from Andreano and Helminiak (1988).

drugs, medical equipments, etc. In turn these resources are the inputs used to produce specific types of health care services, i.e. community health services and personal health services, which, given the demand for such services, lead to the utilization of such services. The utilization of health care services in turn is an input which, together with the impact of the activities of other health-related sectors and the social and economic sectors, determines health status.

Based on this highly simplified view of the operation of the health sector in the context of the larger socioeconomic environment, we can readily identify the general policy areas, issues and questions that could initially form the conceptual basis for the formulation of a health policy framework.

Policy Areas, Issues and Questions: General Framework

There is a need to develop an overall conceptual framework because the consideration of any specific issue or area of reform would inevitably involve consideration of its impact on the overall health system. Piecemeal and isolated initiatives are likely to fail, or worse, could produce unintended adverse effects that are larger than the effects of the specific policy problem that is being addressed. Hence, we outline below the elements of such an overall framework. The framework not only shows the policy areas, policy issues and policy questions that need to be addressed, but also it indicates what should be considered in assessing the equity and efficiency impacts of a

Intersectoral resource allocation efficiency :

How much of the total economy's resources should be allocated to the health sector relative to the other sectors of the economy in order to maximize social welfare?

policy action. Hence, we also discuss various concepts of efficiency and equity that are relevant to a specific policy concern.

The major issues confronting decision-makers and health administrators to improve health status as efficiently and equitably as possible may be classified into the following broad categories: (1) intersectoral resource allocation; (2) health service structure; (3) health service focus; (4) health service utilization; (5) health service production; (6) management and operations; (7) health care financing mechanisms; and (8) public-private sector roles in health service provision and financing. (See Figure 3).

Intersectoral Resource Allocation. How much of the total economy's resources should be allocated to the health sector relative to the other sectors of the economy? The resources referred to here include private expenditures on health services by individuals and households, and publicly budgeted expenditures for health services. This is the question which policy makers inevitably ask and in which they show great impatience when a single quantitative answer can not be readily provided.

A basic principle based on economic theory can be given, namely, that greater efficiency in resource allocation can be achieved by allocating relatively more of the additional resources available to those sectors that offer larger contributions to social welfare and relatively less of the additional resources to those sectors that offer lesser contributions to social welfare. We shall call this type of efficiency as intersectoral resource allocation efficiency. This is perhaps the most abstract, and most difficult to measure, performance indicator. The problem lies in the difficulty of measuring "social welfare" or the "well-being of a society", of which health is but one of its components. The other components of social welfare would invariably include increased income, more productive employment, better knowledge, freedom of choice, and an acceptable distribution of income. Measuring the net benefit to society of allocating additional resources to the health sector means measuring both the impact of such resource allocation on health status improvements and on the other dimensions of social welfare, and then measuring the value to society of both the resulting health status improvements and the changes in the other components of social welfare. This benefit would then have to be compared with the benefit to society

Service structure efficiency :

Given the resources available for the health sector, how should these be allocated among various combinations of services in order to maximize impact on health status?

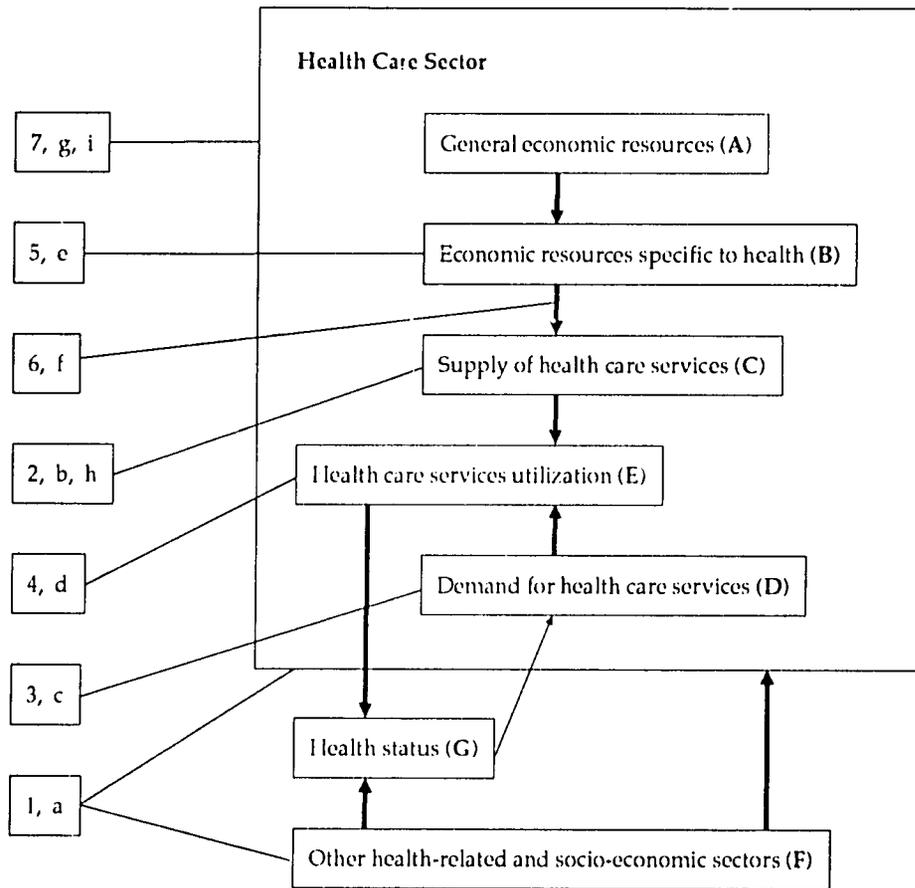
that could be obtained by allocating the same additional resources to the other sectors of the economy. While the measurement of the relative impacts of sectoral investments on health status improvements and other components of social welfare can, in principle, be measured scientifically (although there exist as yet no practical procedure that can be routinely applied), the determination of the contributions to social welfare of changes in health and other components of social welfare involves value judgements regarding the importance of each component to the overall welfare of society.

Health Service Structure. The health sector can produce various kinds of services that will improve health status. Broadly, these services would include community health services and personal health services. Community health services in turn include such services as public information and education, health surveillance, environmental health services, and research and training; while personal health services include both outpatient and inpatient care. Given the resources available for the health sector, how much should be allocated to each of these different services, or stated differently, what combination of health services should be

Service focus efficiency :

Given the combination of services being produced, to whom should such services be focused to maximize impact on health status?

Figure 3. Policy Areas, Issues, Questions and Criteria for Assessing the Economic Performance of the Health Care Sector



Policy Areas, Issues and Questions

- 1 Intersectoral resource allocation
- 2 Health care service structure
- 3 Health care service focus
- 4 Health care service utilization
- 5 Health care service resource mix
- 6 Management and operational procedures
- 7 Organization of the health care sector (i.e., private-public sector mix in service delivery and finance)

Criteria for Assessing the Economic Performance of the Health Care Sector

- a Intersectoral allocative efficiency
- b Service structure efficiency
- c Service focus efficiency
- d Service utilization efficiency
- e Production efficiency
- f Operational efficiency
- g Financial efficiency
- h Distribution (access) equity
- i Financial equity

Adapted from Adriano and Helminiak (1988).

produced and be made available to the population?

Given the level of resources available, greater efficiency in resource allocation can be achieved by producing that combination of services that is the most effective in improving health status. We shall call this type of efficiency as the service structure efficiency. This implies, in part, choosing the combination of health services of given quantity and quality that adequately addresses the most important health problems/diseases. Because choices once made are difficult to reverse once the health service infrastructure is set in place, it is, therefore, important to inform such choices with the findings of scientific research on the persisting and evolving patterns of disease as well as on the demonstrated relative cost-effectiveness of alternative health services.

Health Service Focus. The health needs of different population groups vary, often widely, due to a number of factors, some related to personal and demographic characteristics, others to their own patterns of behavior, and still others to their exposure to environments on which they have little individual control. Different population groups also, due to the same set of factors, vary with respect to their access to health services. Given the combination of health services that are produced, what population groups should get priority in the provision of such health services, or stated differently, to whom should such services be focused or targeted?

Greater efficiency in the provision of health services can be achieved if the services that are produced are focused or targeted to the population most in need of such services, i.e. those who could benefit the most in terms of health impacts. We shall call this type of efficiency as service focus efficiency.

Service utilization efficiency :

Given the services being produced and the beneficiaries being targeted, how should services be utilized in order to maximize impact on health status?

Moreover, greater equity can be achieved if services are made available to those in need irrespective of their income and geographic location. We shall call this type of equity as access equity.

To operationalize these guiding principles, it is necessary to be able to clearly define and identify the population groups that are most in need of health services either because they are at higher risk of poor health or because they are least able to obtain the needed services using only their own limited resources. This ability to define and identify target populations can be increased by research and data collection activities that can quickly inform decision-makers of the changing patterns of health needs and the population groups involved.

Health Service Utilization. A common approach adopted by many governments to respond to the perceived unmet health needs of their population is to provide more facilities and services closer to where people live. This approach, however, has not been found to be entirely successful. Instead, one finds the seemingly incongruous coexistence of unmet needs and inappropriate or excessive use of services on the one hand, and of underutilized service capacity in certain health facilities and overcrowding in others, especially at the higher levels of the delivery structure, on the other.

Greater efficiency can be achieved if (1) those with real health needs as medically defined do seek and get care; (2) those that do get care do not demand or are not provided excessive or unnecessary services as medically defined; and (3) those that do seek care for real health needs seek and are provided with necessary services at the most appropriate health facility in the delivery structure. We shall call this type of efficiency as service utilization efficiency.

To achieve greater service utilization efficiency through the design of mechanisms or incentive structures that will modify the behavior of consumers and providers with respect to service utilization, and through the design a delivery structure that will maximize utilization of services and facilities, it is necessary to understand, through careful research and analysis, both the demand and supply factors influencing health service utilization.

Health Service Production. A particular health service, whether community or personal service, can be produced using different kinds of inputs, e.g. dif-

Service production efficiency :

What combination of resource inputs would yield the best quality and most quantity of appropriate services utilized by the targeted beneficiaries at least cost?

ferent types of human resources, medical equipment and facilities, and drugs. What resource inputs, and in what combination, should be employed in the production of health services of given quality?

Greater efficiency can be achieved by choosing that combination of health inputs that is the least costly among alternative combinations given the relative prices of various inputs and given the prevailing medical technology. Alternatively, greater efficiency can be achieved by choosing the combination of health inputs that produces the greatest quantity and quality of health services given the amount of resources that is available. We shall call this type of efficiency as service production efficiency.

The effective application of this principle requires not only the consideration of substitution possibilities among different types of inputs that already exist, but also the expansion of the range of substitution possibilities through research and careful experimentation. Moreover, there is a need to review certain established practices in health care provision that, while designed with lofty objectives such as ensuring high quality of service, unintendedly tend to restrict input substitution, and hence, the achievement of greater efficiency.

Management and Operations. It is generally accepted that in spite of limited budgets, governments can still generate additional resources for expanding and improving the quality of health services by simply managing the resources that they now have more efficiently. Greater efficiency can be achieved by adopting management and operational procedures that ensure that the potential quantity and quality of health services that were expected from the chosen combination of resource inputs (refer to the concept of service

Operational efficiency :

How can chosen inputs be managed to produce the best quality and quantity of services possible under a given budget?

production efficiency) are actually realized. We shall call this type of efficiency as operational efficiency.

There are many areas where operational efficiency can be improved. These include the areas of personnel motivation and supervision, procedures for drugs and supplies procurement, and logistics. Other areas include operational procedures for identifying target populations for service provision, and budgeting procedures. Still others include the locus of decision-making and communication channels, i.e. what decisions are best devolved to various units of decision-making, e.g. BHS, RHU, hospitals, and what decisions are best left to central management; and how are the health needs and demands perceived at lower administrative levels communicated to upper decision making units so that resource allocation decisions are made that reflect these needs and demands?

Health Care Financing Mechanisms. How should health care services be financed? A variety of health care financing schemes can be used. Some would be more efficient from a financing standpoint than others. Among health care financing schemes that can generate the same level of financial resources, the more efficient scheme is the one that require lower cost of generating such financial resources. We shall call this type of efficiency as financial efficiency.

Moreover, among alternative schemes, the scheme where beneficiaries with higher incomes make progressively higher contributions relative to those with lower incomes would be more financially equitable than those where the beneficiaries are required either to contribute amounts proportional to their incomes, or worse to contribute equal absolute amounts towards the financing of health services. We shall call this type of equity as financial equity.

Finally, the choice of which scheme or combination of schemes to adopt must be based on careful assessment of its overall impact on efficiency and equity of health sector performance, i.e. on the various types of efficiency and equity described above. Among health care financing schemes, the scheme or combination of schemes that promotes greater efficiency and equity in the overall health system is to be preferred to those that does not.

Public-Private Sector Roles in Health Service Delivery and Financing. What should be the respective roles of the private sector and the public sector in health service delivery and financing? In particular, which services should best be provided or financed by the public sector and which services should be left to the private sector to provide or finance? Economic theory provides some guiding principles. We discuss these principles in a later part of this section. To inform actions in this area of policy, it is necessary to have good information on what services these two sectors are currently providing or financing and how each of these sectors are performing in terms of the efficiency and equity criteria we have described above.

The conceptual framework just described provides a useful guide to the analysis of various policy concerns. This is so because any policy area, issue or question must ultimately be addressed from the standpoint of its impact on the overall health sector. Below we consider three major policy areas in more detail and then consider their relation to other policy areas using the general framework just described.

Quality of financing mechanisms :

How should services be financed in order to achieve maximum resource mobilization at minimum cost, equity in contributions relative to capacity to pay, and greater overall efficiency and equity in the health system?

Basic Issues and Questions in Health Service Utilization

Earlier, we noted that one major factor determining health outcomes is the utilization of health services. We now focus our attention more narrowly on issues related to efficient and equitable utilization. What is the best use of health services by the population?

Efficiency in health service utilization is achieved when individuals with real health needs, i.e. those recognized by medical science including both curative and preventive care, do seek care and are able to obtain the needed care from the appropriate health care facilities. Inefficient utilization of health care services can, therefore, take on several forms, namely:

(1) Unmet needs: individuals with real health needs either do not seek care or are unable to obtain the appropriate care.

(2) Inappropriate use of existing health care facilities: individuals seeking care bypass lower level facilities in favor of higher level facilities even if they could be appropriately attended to at the lower level facility, resulting in underutilized facilities at the lower level and overcrowding at the higher level facilities.

(3) Inappropriate use of health services: individuals either fail to come for necessary follow-up consultations and treatment or claim more service or drugs than they need. Likewise, practitioners either require unnecessary follow-up consultations or require more services and drugs than their patients require, or require patients to stay longer in the hospital more than is necessary.

Conceptually, utilization, that is the actual use of preventive and curative health services, is determined jointly by the demand for services by the consumer (beneficiary) and by the supply of services by the provider. Thus, it is necessary to understand the basic factors affecting demand and supply, and how the problems of inefficient utilization arises. For example, the problem of unmet needs may not be due to lack of service capacity but rather to lack of demand arising from an incorrect perception by the people about their true health needs as medically defined. Thus expanding health facilities to meet this "unmet need" may only lead to underutilization of health facilities.

On the other hand, the overcrowding in certain facilities such as tertiary hospitals does not necessarily mean that there is a lack of such facilities. Such overcrowding could in fact be the result of the appropriate lower level facilities being bypassed because of poor service arising from lack of personnel or drugs, inconvenient scheduling of services, etc. Expanding tertiary hospitals to address this "overcrowding" problem may only shift resources away from improving services in lower level facilities, thus possibly aggravating the overcrowding problem in higher level facilities and the underutilization problem in lower level facilities all at once.

First, there is a need to understand the proximate factors that directly determine demand and supply, and secondly, how these proximate factors are in turn influenced by other factors in the economy and in the health sector itself. The factors that directly affect demand include health knowledge and beliefs, education, prices (money and time cost) of services, income, insurance coverage, and demographic factors. On the other hand, the supply of health services, which refers to the number and location of health facilities of various types and the scope and quality of service (e.g. the adequacy of personnel and drugs), are directly affected by such factors as the cost of inputs and the management of these various inputs (e.g. personnel management, logistics, information system for planning required tasks and monitoring performance) to produce the desired quantity and quality of services.

Focus on Best Use of Services

- ◆ *how do providers deliver (or not deliver) the services made available?*
- ◆ *how do beneficiaries utilize (or not utilize) the services made available?*
- ◆ *what can be done to improve the health impact through more appropriate utilization of services?*

In turn, these direct or proximate factors affecting demand and supply, and utilization depend on underlying factors which include:

(1) Macroeconomic trends that affect incomes and prices.

(2) Past health sector policies that affect the service structure (i.e. the mix of health care services and the various levels of facilities); development of human resources for health and the choice of health technology (input mix), and the public-private sector mix in health care provision and financing.

The basic policy issues and questions related to more efficient health service utilization, in addition to the question of how to stimulate or modify demand towards those that are based on medically justified health needs, are the same set of issues and questions that have been identified earlier, i.e. those related to service structure, service focus, input mix, and the larger questions of public and private sector roles in the provision and financing of health services, and the total amount of resources that should be allocated to the health sector relative to the other sectors of the economy.

Health Care Financing: Basic Issues and Questions

It is important at the outset to determine what health care financing is not, and what it actually involves. First, health care financing is not just a question of raising funds to finance the expansion of health services or of recovering the cost of existing services, nor just a question of containing or reducing costs. What health care financing involves from a larger perspective is the concern of how to make the health system more efficient and equitable. The inefficiencies and inequities of the current health system may in fact arise from the way the system is financed. Thus, health care financing involves basic choices that affect the efficiency and equity of the health system of which the choice of appropriate financing mechanisms is but one. These basic choices include:

(1) How much financial resources should be allocated to the health sector?

(2) What health services should be financed? This actually involves three interrelated questions: (a) what health care services are to be produced (ser-

vice structure or output mix); (b) how should such services be produced (input mix); (c) who should use the services that are produced (focus); and (d) how should such services be used (utilization)?

(3) Who should finance what health services (public-private sector mix)?

(4) How should health services be financed, given the large variety of health care financing schemes that are available?

In each of these areas of choice, there is a need to assess efficiency and equity impacts. Since these are the same areas that are addressed in the general framework, then the concepts of efficiency and equity that we have described under the general framework can be used to make such assessments.

In addition to the above general issues are specific issues that merit careful attention. These issues which are currently being addressed in part by the DOI-USAID Child Survival Program, include:

(1) Cost containment issues. There are various categories of costs that need to be taken into account and accurately measured to make cost containment activities meaningful. The concepts include: (a) the cost with respect to choice of services to be produced; (b) the cost with respect to choice of inputs in the production of specific services; (c) the cost of providing services to targeted beneficiaries; and (d) the cost of providing services in various health facilities.

(2) Cost recovery issues. Not only do we need to have an accurate measure of costs, but it is also important to determine the impact of any cost recovery measures on: (a) financial efficiency and financial equity; (b) access to basic services (access equity); (c) composition of services (service structure efficiency) and on input mix (production efficiency); and (d) the utilization of services (utilization efficiency).

(3) Public-private sector collaboration issues. It is necessary likewise to determine the impact of any measure or policy on (a) total resources generated (displacement effect); (b) health service structure and input mix; and (c) financial equity and access equity.

(4) National and local government shares issues. There is a need to assess any given sharing scheme for (a) sustainability and adequacy of financing given the highly uneven financial bases of local governments; and (b) level of health activities given the possible variance of local priorities with that of national priorities for health.

The Role of Public and Private Sectors in Health: Basic Issues and Questions

In order to properly address the question of what is the appropriate role of the public and private sectors in the delivery and financing of health care services, it is necessary to understand the underlying conditions under which each sector is more likely or less likely to achieve greater efficiency and equity. Basic economic concepts provide useful analytical tools.

Efficiency and Equity in the Private Sector.

The notion that the private sector may be more efficient, although it may not be more equitable, than the public sector rest on the assumption that the private sector operates under the conditions of "perfectly competitive markets." These conditions include: (1) there is perfect information among consumers and producers; (2) consumer satisfaction depends only on the quantities of commodities that they individually consume (i.e. commodities do not provide benefits to more than one individual at the same time; these commodities are often referred to as "public goods") and as such it is possible to collect payment from individual consumers or to exclude from consumption those who are not willing to pay; (3) the benefits and costs of an activity to an individual are enjoyed and borne, respectively by such an individual and do not spill over to other individuals (the benefits and costs of an individual activity that spill over to other individuals are often referred to as externalities); (4) the cost per unit of output does not become cheaper as the firm produces very large quantities of output making the firm virtually the only seller in the market or a "natural monopoly" (if this were so, then it would mean no competition, contrary to the essence of competitive markets); (5) self-interest is the dominant motive, that is, consumers maximizes utility while producers maximizes profits; (6) there is freedom of entry or exit in the market.

Under these conditions, the actions of numerous consumers and producers each acting independently according to their own self-interests as reflected in the demand and supply of commodities and factor inputs in their respective markets will inevitably lead

to an efficient allocation of resources as if guided by an "invisible hand". Simply put, efficiency in the allocation of resources results when the benefits consumers get from an additional unit of a commodity equals the cost of producing that extra unit.

Market Failure and the Role of Government.

In real life, the conditions under which most markets operate, particularly health care markets, are not those that characterize perfectly competitive markets. Thus the operation of these markets will not lead to an efficient allocation of resources, that is, there is "market failure."

In the health care market, the sources of market failure include the following:

(1) Imperfect information. Consumers often have imperfect knowledge and information regarding the causes, transmission and effects of diseases and the types of treatment that are effective and available, hence their demand for health care services may be less than optimal;

(2) Public goods. There are certain types of health services or activities that benefit everybody in the community simultaneously, i.e. vector control. These are called "public goods". Consumers are not likely to voluntarily pay for these services nor to reveal how much they are willing to pay for them, hence, private producers are not likely to produce these goods;

(3) Externalities. There are many types of health services, such as immunizations and the control of communicable diseases where the benefits of the use of the service are enjoyed not only by the consumer of the service but also spill over to other individuals in the community by reducing the trans-

mission of diseases. The demand for these goods by individuals who consider only the direct costs and benefits to them is not likely to be optimal from society's standpoint since other costs and benefits accruing to society at large are not reflected in individual demand.

(4) Conflict between economic and non-economic goals. There may be providers of health services who are not solely motivated by profit maximization but by other goals, e.g. prestige maximization by having the largest facility with the most modern and expensive equipment. As such, certain investment decisions may be made with less regard to the criteria of economic efficiency but more with regard to the achievement of these other goals.

(5) Barriers to entry. There are certain practices and legislation that pose entry barriers to certain health professions such as limits to the number of medical schools through strict accreditation process, lengthening of training and residency requirements for physicians, and legal restrictions on tasks performed by certain health professionals. While these practices are ostensibly designed to assure high quality of health service, they also limit input substitution which is a factor that could limit the achievement of greater efficiency in production. Moreover, entry barriers to health care markets may arise from market failure in the other parts of the economic system as when capital markets fail to provide access to credit to individuals or institutions wishing to engage in the provision of health care services.

Thus there are many situations where private markets are not likely to produce efficient resource allocation. Moreover, the market system is an impersonal system. It takes the current distribution of income as given and distributes the goods produced by the economy to those who have the money incomes to purchase them. The distribution of income, in turn, depends on the distribution of resources that households/individuals own, i.e. land, labor, physical and human capital. If the distribution of income is inequitable to start with, the market system will simply reflect this in terms of an inequitable distribution of the goods and services that are produced. Thus beyond market failure, the market system by itself may not promote greater equity if the initial income distribution is inequitable.

The rationale for government intervention in private markets then is the existence of market failure and the promotion of greater equity. The economic justification for government

Focus on Financing Quality

- ◆ *how much financial resources should be allocated to health?*
- ◆ *for what should this financing go in terms of service outputs, resource inputs, target users, and desired use?*
- ◆ *who should finance which services?*
- ◆ *how should the system be financed?*

intervention has been succinctly stated as follows:

"Public interventions, either in the delivery or financing of health services should be undertaken only (a) where situations in private markets when they operate freely yield inefficient outcomes (because of market failure), and where the cost of public intervention is less than the benefit of correcting the market imperfection; and (b) where the outcomes of private markets operating freely results in unacceptable inequities that can be corrected by public intervention at socially acceptable costs." (Andreano and Helminiak, 1988).

It should be clear from the above principles that while a case for public intervention can be made on efficiency and equity grounds, it does not mean that governments must necessarily intervene. It only means, at the first instance, that intervention should be considered. The actual decision to intervene must be based on careful consideration of the benefits of reducing inefficiency and inequity against the direct and indirect costs of government intervention.

The direct costs are the costs of designing, implementing or enforcing, and evaluating interventions, while the indirect cost include the unintended adverse effects of the intervention throughout the health system. These

indirect effects could arise as a result of changes in the behavior of consumers and providers which in turn affect the service structure, the input structure, utilization patterns, management and operations.

Market Failure versus Public Sector Failure. Just as there are certain situations which give rise to market failure, there are also conditions that give rise to public sector failure. As described in the literature, there are conditions under which the political processes of decision-making and the operations of bureaucratic agencies which comprise the public sector could fail to achieve greater economic efficiency and promote greater equity.

These conditions include the following: (1) when political decision-makers seek not to maximize economic efficiency but to maximize their own chances of staying in power; (2) when bureaucrats seek not to maximize economic efficiency but to maximize their own budgets; and (3) when individuals or special interest groups use the government to increase their real incomes by demanding the creation of protected market positions for themselves or by demanding the provision of services and transfers from which they can obtain proportionally greater benefits than the rest of the population.

In certain situations the vote-seeking politician may tend to favor programs which entail immediate and visible benefits but deferred and often large intangible costs and, to disfavor programs which entail immediate and visible costs but with large but deferred and intangible benefits. Such biases in the area of public choice can lead politicians to reject economically justifiable programs and to accept programs which are not economically justifiable in the long run but are politically attractive in the short run.

Moreover, in certain situations government bureaucracies may have less incentives to operate efficiently than do private agencies. The market system creates incentives and pressures for internal efficiency (profits and losses) which are often said to be absent in the public sector. Government agencies may not always abandon activities that fail, but may in fact enlarge them. Public programs create constituencies (special interest groups) of bureaucrats and beneficiaries whose political clout may cause programs to be sustained or expanded even after these programs have achieved their objectives or worse even if their programs have failed. Public agencies may seek to have their

budgets enlarged in order to maintain prestige and influence rather than to achieve greater efficiency.

Finally, certain special interest groups may demand, and politicians may quickly vote for, policies that while beneficial to the interests of these special groups may not always confer large benefits to the rest of the population.

In each of these situations, scarce resources are likely to be misallocated and the impacts of such allocations are likely to heighten rather than reduce existing inequities.

Thus in defining the role of the public and the private sectors in health care provision and financing, it is important to keep in mind the realities in private markets and in public decision-making. The task of both public and private sectors as partners in health care provision and financing is to find ways to minimize the effects of both market failure and public sector failure that are inherent in each sector, and at the same time to strengthen the positive features inherent in each system. The general policy questions, therefore, include:

(1) How can the effects of market failure be minimized through public intervention at acceptable social cost? This requires the identification of the various sources of market failure that currently exist in health care markets, and the relative importance of these sources in affecting efficiency and equity. It also requires the identification and measurement of the probable impacts and potential costs of the range of public interventions that are feasible.

(b) How can the effects of public sector failure be minimized and still keep intact the inherent benefits of political decision-making based on representation and the inherent benefits of organized and collective action through government bureaucracies. This requires the identification of the sources of public sector failure and the relative importance of each in affecting efficiency and equity. It also requires the identification and measurement of the probable impacts and costs of alternative reforms in the public sector, including the use of market discipline in its decision-making and operations.

Note that in making these assessments, we again refer to the general conceptual framework and apply the same set of criteria of equity and economic efficiency. It should also be noted that the same conceptual framework can also be used to guide the formulation of a research agenda which we discuss in the next section.

Focus on Public-Private Sector Roles

- ◆ *which service production and utilization segments in the health market can achieve efficiency and equity via the private sector?*
- ◆ *which segments indicate market failure requiring a public sector role?*
- ◆ *which segments indicate public sector failure requiring change in performing such role?*
- ◆ *how should public interventions in delivery or financing be undertaken to maximize overall equity and efficiency in the health system?*

Research Agenda for Policy Formulation and Assessment

Research Agenda Formulation: Recent Efforts

Considerable work has been done in developing a research agenda in support of the health policy process, and some research has recently been completed. This work differs from earlier health research in the sense that this work was specifically designed with health policy formulation and assessment in mind. Representatives from the DOH and other government agencies as well as representatives from the private sector sat in with researchers to discuss research needs and the potential implications of the research results for policy. (For a brief review of earlier research on health issues prior to the recent initiatives in health policy research, see Solon and Herrin, 1990).

The IHPP Connection. The first activity was initiated in 1986 by the Philippine Institute for Development Studies (PIDS) in collaboration with the University of the Philippines School of Economics (UPSE), and was a response to an opportunity to undertake policy-oriented research with support from the International Health Policy Program (IHPP). As an input into the process of identifying key policy research areas, PIDS commissioned review papers dealing with the current health situation and selected aspects of health sector performance in the Philippines. These included reviews on: (1) determinants and consequences of health; (2) demand for health care services; (3) health care financing; (4) health manpower development; (5) health service structure and health interventions; (6) health institutions; and

(7) statistics for health planning. These review papers were discussed in a workshop participated in by researchers from the medical and social sciences and by policy makers and planners at both the NEDA and the DOH. These review papers were subsequently published by PIDS (see PIDS, 1989).

A summary of the principal findings and conclusions of these review papers and an agenda for research based on the major information gaps identified both in the papers and in the workshop was prepared (see Herrin, 1987). The major research areas identified are shown in Table 1.

From these major research areas specific proposals were prepared for funding by the International Health Policy Program. The researches were implemented and completed by a study team composed of researchers from the economics, public administration, and public health units of public and private universities and by researchers from PIDS. In implementing the research, the investigators were guided by senior research advisors from academic institutions and by policy advisors from DOH and NEDA.

The research studies completed were the following:

(1) an analysis of the determinants of health care demand and utilization based on data from the 1981 National Health Survey;

(2) a study of the determinants of hospital cost based on a survey of selected hospitals in Metro Manila;

(3) an exploratory study of Health Maintenance Organizations in the Philippines;

(4) a study of the determinants of household drug consumption based on a small household survey;

(5) a study of health manpower in the Philippines, including estimates of

health manpower levels from various sources and a projection of demand and supply;

(6) a study of the health impact of housing among the urban poor based on a survey of urban poor communities in Cebu and Manila.

TABLE 1
**RESEARCH AREAS IN SUPPORT OF
HEALTH POLICY DEVELOPMENT**

1. Analysis of demand and utilization of health care services.
2. Supply and productivity of health care services: a comparative analysis of the public and private sector.
3. Analysis of alternative health care financing schemes with attention to HMOs.
4. A review of private practices and public policies affecting the pharmaceutical market in the Philippines.
5. Analysis of the economic aspects of health manpower employment and productivity.
6. An assessment of public policies and private practices affecting health professional education.
7. An assessment of the health impacts of development policies.
8. Strengthening basic data sources through analysis.

The World Bank Connection. A second effort in developing a research agenda for health policy development was made by DOH in collaboration with UPSE as an input to the DOH's Health Policy Development Program supported by the World Bank. A comprehensive research agenda was prepared based on a conceptual framework described in the previous section. Table 2 provides a listing of the research areas proposed.

Further deliberations at the DOH on its five major reform areas under its Health Policy Reform Initiative indicated that initial research efforts should be focused on health care financing issues. Thus a research agenda was prepared which aims to provide a wide range of baseline information that will be needed in formulating a health care financing policy framework. Since any discussion of health care financing will inevitably touch on all the major areas of the health sector, the areas for re-

Recent Health Policy Research Initiatives

- *the Philippine effort under the International Health Policy Program;*
- *the policy research component of the Philippine Health Development Project funded by the World Bank;*
- *the health financing benchmarks studies under the Child Survival Program assisted by USAID;*
- *the community health financing contest and district health information system work under the HAMIS Project assisted by GTZ;*
- *studies on health care utilization and the role of the private sector in health care and family planning provision supported by the Asian Development Bank.*

search should likewise be comprehensive in its coverage, as was indeed the case.

The resulting preliminary agenda was discussed in a workshop held in Laguna on November 1990 by experts from public and private sectors. Based on the deliberations of this workshop, the agenda was later refined and the implementation plans made firm. The research is being implemented by researchers from various disciplines and from various institutions, both public and private, and is being managed by PIDS with technical support from UPSE and other key institutions. A listing of the major areas to be covered by the proposed research is shown in Table 3 (see Solon, et. al., 1990 for details).

Other Connections. Related to the above efforts at developing a research agenda and implementing research studies relevant to policy development are (1) benchmark studies on a number of health care financing concerns under the DOH's Child Survival Program supported by USAID; (2) improvement of the health information system for program and policy decision-making purposes under the DOH's Health and Management Information System Project with support from both USAID and the GTZ; and (3) Asian Development Bank-supported studies on health care utilization and the role of the private sector in health care and family planning provision.

Several studies that are in progress under the Child Survival Program include: studies on cost containment and cost recovery; privatization of public hospitals and public-private sector collaboration; and on the role of national and local governments in the financing of child survival activities.

Activities being undertaken under the HAMIS project include a component that aims to streamline field health reporting system and a larger component that aims to develop indicators of health sector performance at the district level. The latter requires data gathering and testing of the validity and usefulness of performance indicators for program and policy decision-making.

Studies being undertaken under the Asian Development Bank sponsorship includes analysis of national survey data on health care utilization and household health expenditure patterns including an analysis of the role of the private sector in the provision of health and family planning services.

In addition to the above efforts, work has also been done in specifying

the research that needs to be undertaken under the three components of the DOH-USAID Health Finance Development Project, namely the Policy Formulation Component, the Health Finance Component and the Hospital Reforms Component. The research under the Policy Formulation Component will deal specifically with developing national statistical database and health policy database; the research under the Health Finance Component will address issues and questions related to the improvement and expansion of Medicare I and to the development of alternative financing schemes; and the research under the Hospital Reforms Component will address issues and questions related to the improvement of hospital efficiency and the privatization of public hospitals. The details of these are described in the draft document of the Health Finance Development Project discussed in a Project Design Workshop held in May 1991.

These research studies, particularly those on Health Finance and Hospital Reforms, are specifically designed to arrive at recommendations for policy and for the design of interventions to be demonstrated for their feasibility and effectiveness. These studies will take as inputs the findings of the baseline studies undertaken under the DOH-PIDS-World Bank research program as well as the findings of a number of studies commissioned by USAID to provide background information in the formulation of the Health Finance Development Project. The latter studies include: a study updating health sector financing database and analysis of health sector performance; a study on the roles, constraints, and prospects of the public and private sectors in the delivery and financing of health services including special attention to an assessment of the current state of hospital management in both public and private sectors; and an analysis of the health insurance industry.

A Consolidated Research Agenda for Health Policy Development

The task of this paper is to "identify major research areas that need to be investigated in support of policy formulation." This task has been

greatly facilitated by recent efforts in formulating a research agenda and in undertaking baseline research. In fact, practically all of the major areas of research have been identified in one form or another. Thus the task that is left to be done is to formulate a consolidated research agenda for health policy

development by building on the research areas that have already been identified.

A consolidated research agenda for health policy development is described below according to three categories of research, namely: baseline research, policy research and policy analysis.

Baseline Research. Baseline research refers to research that will provide a wide range of information on the operation of the health sector including assessments of its performance. The agenda for baseline research include:

(1) research areas contained in Table 3. The research will be undertaken by

TABLE 2

MAJOR RESEARCH AREAS FOR CONSIDERATION IN SUPPORT OF DOH'S HEALTH POLICY DEVELOPMENT PROGRAM

Update of Basic Information

- Health Outcomes: Levels, Trends and Differentials
 1. Update of Mortality Information
 2. Changing Disease Patterns: A Critical Analysis of Mortality Data By Cause of Death and Morbidity Data by Major Disease Classification
- Health Care Expenditures and Sources of Finance
- Health Care Service Delivery System: Facilities and Manpower
- Demand and Health Care Service Utilization
- Synthesis of Studies on Determinants of Health and Cost-Effectiveness of Various Programs
- Cost of Specific Programs and Activities

Policy Research

- Health Care Financing
 1. Evaluation of Medicare I With Attention to Needed Reforms
 2. Financing Public Health Activities: Alternative Cost Recovery Schemes
 3. Feasibility of a National Health Insurance Program
- Hospital Sector
 1. Evaluation of Hospital Performance
 2. Evaluation of Hospital Sector Performance Health Manpower Development
 1. Determination of Shortages and Surpluses in Health Manpower
 2. Labor Market Analysis of Selected Health Manpower
- Pharmaceuticals, Medical Supplies and Support Sectors
 1. Feasibility of Local Production of Essential Drugs
 2. An Evaluation of the Generics Act: Effect on Prices and on the Behavior of Consumers, Prescribers and Manufacturers
 3. Potentials for Reducing Costs and Enhancing Better Use of Medical Supplies and Equipment Through Local Production
- Management Structure
- Special Studies
 1. Health, Health Care Sector and the Macroeconomy
 2. Health Transition and Health Sector Planning
 3. Review of Public Sector Regulations and Private Sector Self-Imposed Regulations and their Impact on the Efficiency of the Health Care Sector
 4. An Evaluation of Inter-Sectoral Organization for Health

Source: Herrin and Solon, 1990.

TABLE 3

BASILINE STUDIES IN SUPPORT OF THE DOH'S HEALTH CARE FINANCING REFORM INITIATIVE

Beneficiary Profile and Behavior

1. Demographic and socioeconomic profile
2. Epidemiological profile and trends
3. Health service utilization and expenditure patterns for curative and preventive services.
4. Health seeking behavior patterns of special beneficiary groups.

Provider Profile and Behavior

1. Health manpower profile
2. Health manpower supply and demand
3. Manpower behavior
4. Health facilities profile
5. Health facilities supply and demand
6. Health facilities: studies on cost and pricing policies
7. Hospital management and administrative systems
8. Pharmaceuticals and other medical supplies

Evaluation of Medicare I

1. Performance evaluation
2. Administrative issues
3. Evaluation of alternatives

Financial Resource Base for the Health Care Financing System

1. Sources and uses of health care expenditures
2. Alternative (non-insurance) sources of financing
3. Private health insurance schemes

Evaluation of the Health Financing Environment

1. Complete description of the health financing environment
2. Impact of the health financing environment on health sector performance
3. Public and private sector roles and mix, and government's role in enhancing the performance of the health care financing system
4. International experiences: lessons and insights

Planning Models for Health Care Financing

1. Planning model for health care financial resources and expenditures
2. Planning model for the health care services sector
3. Planning model for the evaluation of the impact of the macroeconomic environment on health and the health sector
4. Planning model on the long-term interaction between health and socioeconomic development

Source: Solon, et. al., 1990.

the DOH-PIDS-World Bank Health Policy Development Project and will have as inputs the findings of the following studies: (a) completed studies under IHPP sponsorship; (b) on-going studies under the Child Survival Project and the HAMIS project; (c) studies undertaken to provide more background information for the design of the Health Finance Development Project; and (d) studies being undertaken on health care utilization and the role of the private sector supported by the Asian Development Bank.

(2) research leading to the development of a statistical system for health policy development to be undertaken by the DOH-USAID Health Finance Development Project under the Policy Formulation Component. The scope of this research will cover the entire information system for the health sector. It will involve (a) assessment of current data sources; (b) identification of alternative ways of obtaining relevant data on a regular basis and publishing them for ready access to both researchers and policy analysts; and (c) testing new concepts and methodology for generating new data, particularly on health needs, target populations, utilization of health care services, service capacities, costs of health care, health care expenditures, and on sources of financing.

(3) research leading to the development of a health policy database to be undertaken by the DOH-USAID Health

Scope of Baseline Research

- profiles of beneficiaries, providers and financing environment;
- development of statistical system for health policy;
- development of a health policy database;
- synthesis of policy relevant research.

Finance Development Project under the Policy Formulation Component. The research will involve archiving and cataloguing existing health policies and regulations together with data and analyses used as bases for their formulation and adoption.

(4) research involving synthesis of policy relevant research on a wide range of concerns, in particular: (a) determinants of health transition; (b) methodologies for analyzing demand and utilization of health services; (c) cost-effectiveness of various health interventions; and (d) assessment of health care financing systems in other countries.

Policy Research. This research focuses directly on identified priority policy issues with the aim of producing specific policy recommendations and producing specific designs of the proposed interventions, including, when necessary, the demonstration of the feasibility and effectiveness of such interventions in actual field settings. The policy issues that have been identified by the DOH for immediate consideration are those related to health financing and hospital reforms. Hence, much of initial health policy research will be focused on areas directly addressing these issues. These research areas include:

(1) research leading to reforms in the existing Medicare Program and to the development of alternative health care financing systems to be undertaken by the DOH-USAID Health Finance Development Project under the Health Finance Component. The research will have as inputs the findings of the baseline studies under the DOH-PIDS-World Bank Project and the benchmark

studies under the DOH-USAID Child Survival Project.

(2) research leading to hospital sector restructuring and institutional strengthening of public and private hospitals to be undertaken by the DOH-USAID Health Finance Development Project under the Hospital Financing Reforms Component. The research will have as inputs the findings of the baseline studies under the DOH-PIDS-World Bank Health Policy Development Project, the DOH-USAID Child Survival Project, and a forthcoming Asian Development Bank-supported studies on hospitals.

(3) evaluation public health programs to determine whether the theoretical cost-effectiveness of these programs are in fact being closely approximated in large-scale field situations. These public health programs include the DOH's impact programs on diarrheal diseases, acute respiratory infection, malaria control, schistosomiasis control, and TB control.

Policy Analysis. This is research that is directly linked to the political and bureaucratic processes of decision-making. It responds to specific questions regarding policies that are either being decided upon in the Cabinet, Congress or within the DOH, or to specific questions regarding policy decisions that have been made, but for which there is a demand from various sectors including the DOH for a reconsideration. The task of research is to provide information to show why certain proposed policy actions should be adopted or not, or should be postponed until more information and analysis are made; and if a decision has already been made, to estimate the costs in terms of efficiency and equity loss, if not loss in health improvements, so that the decision can be reconsidered in the light of this new information.

In addition, policy analysis involves anticipating where reactions to new policy initiatives is likely to occur - in a public or political arena, or in a bureaucratic arena - and who are the principal stakeholders involved. This analysis will essentially determine the gainers and losers of a new policy initiative, the likely reactions of these gainers and losers that might influence both the promulgation of the policy action and the implementation of such policy action.

At present, there are the key policy decisions or proposals affecting the health sector which directly affects DOH's short-run and long-run performance. These require immediate atten-

Scope of Research Agenda

- **Baseline Research :** information and assessment of current status of health sector.
- **Policy Research :** studies aimed at providing policy recommendations and designs for policy interventions.
- **Policy Analysis :** research directly linked to active policy issues in the political-administrative process of government.

tion with respect to policy analysis. These policies or proposals include the budget cuts for health and the legislative proposal (or action?) to expand health service capacity, particularly public hospitals. Thus, the agenda for policy analysis will initially focus on:

(1) analysis of the implications of (actual or proposed) budget cuts for health (now or in the near future) particularly in times of economic crisis and in a policy environment of fiscal restraint. The question of intersectoral allocation of government resources is decided at the higher levels of decision-making, i.e. the Cabinet and Congress. The DOH will need strong and scientifically-based evidence with which to argue its case for a reasonable share of the national budget. This information would include fast and specific answers to the following questions:

(a) How much of the gains from past investments in health will be eroded as a result of budget cuts for health. These includes gains in health status improvements and gains in efficiency and equity in health care provision?

(b) How much additional gains in health status and in efficiency and equity of health service provision will be foregone and will be difficult to recapture even when fiscal resources become less constrained?

(c) How much (or how little) can the reduction in public spending be made up by private activities and spending?

The findings from the above assessment are likely to strengthen the arguments against budget cuts or arguments for larger claims on public budgets for the health sector. (It is assumed that cabinet secretaries are equally politically adept at defending their budgets, thus, the one armed with

Scope of Policy Research

- reforms in the Medicare Program;
- hospital sector restructuring;
- evaluation of public health programs.

convincing scientific evidence is likely to have a slight edge over others who do not have such kind of evidence). However, in as vicious circle as there is, the current budget cuts for health would themselves prevent the DOH from having the resources to make such an assessment which it needs to strengthen its case against budget cuts now and in the future. This was clearly pointed out by Undersecretary Taguivala in a recent forum sponsored by the Philippine Economic Society in the following terms:

"One of the greatest difficulties in advising Congress and the President about the probable consequences and outcomes of decisions is the lack of information on health assessment. If we cut out travel funds by 50%, what happens to immunization coverage or diarrheal case management? If we suspend all training, what happens to case management skills in diarrhea, TB, malaria and other endemic diseases? To obtain answers to these questions require resources. And these resources have themselves been cut out. The danger is that as we cut out resources for health assessment, we do not even know what happens to the problems we do not attend".

Such an important assessment, therefore, should be priority research to be supported with extra budgetary resources.

(2) analysis of the merits and implications of proposals from Congress to expand service capacity, particularly hospital services, to deal with the perceived large "unmet needs" for services. The vision of the DOH as a leader in health policy development is probably partly influenced by the realities that health policy initiatives and health policy actions can occur outside of DOH, that the process can move so fast, and that sometimes they may not always be based on good information and careful analysis. The recent legislative proposal which seeks to expand public hospital capacity is a case in point. The DOH has a responsibility to inform the political decision makers of what the true situation is, and what the real health needs are. For this it needs to have the necessary information on the following specific questions:

(a) What is the true, as opposed to commonly perceived "unmet health needs" and the reasons for the continued existence of real unmet needs, of which lack of access to services is only one?

(b) Given the nature of unmet health needs, what should be the corresponding structure of services to provide?

Scope of Policy Analysis

- analysis of implications of levels in annual budget allocations for the public health sector;
- analysis of legislative proposals for service expansion in health.

(c) What are the current service capacities of both public and private sectors?

(d) What type of service capacity (hospital services, primary care services, etc.) should be expanded or modified, and by whom (public or private sector)?

Other research areas in each of the above categories will be identified as various related activities are undertaken: on the first category when the on-going baseline studies shall have identified the major gaps in information that require additional research; on the second category when the Health Policy Framework shall have been formulated with inputs from the on-going baseline studies; and on the third category, whenever new issues arise and DOH is called upon to inform the political decision-making processes.

Each of these categories of research require different research skills. The first would mainly involve skills in disciplinary research, both theoretical and empirical but with a conscious view of the relevance of the research to potential policy issues. The second would require, in addition to skills in disciplinary research, an orientation towards what can be done and what works. The third would require in addition to the two above, an appreciation of the political and bureaucratic processes of decision-making and a keen understanding of the goals and behavior of various stakeholders in the health sector and how they can potentially contribute to the success or failure of policy actions. In the Section 7, we discuss the issue of capacity-building for research as well as for training and technical assistance in support of health policy development.

Statistical System for Health Policy

Introduction

Valid and reliable sets of statistics on health and health sector performance are obviously important both for research and policy analysis. Such sets of statistics do not exist at the moment. Recent research efforts have been geared towards the painstaking task of compiling a set of data from various secondary sources to answer what to the uninitiated are very simple questions, such as: what is the infant mortality rate this year compared to five or ten years ago; how many physicians and nurses are currently practicing in the country; how many people were hospitalized last year; and how much of total national resources was spent on health care and who paid for it?

The difficulty in quickly arriving at some satisfactory answer to this set of questions is partly due to the nature of

Health policy research is constrained by "the lack of institutional development in the systematic collection, tabulation, and publication of data relevant to health and health sector performance."

the data itself, like mortality, which tends to be underreported in the vital registration systems or even in household surveys in developing countries. The other reason, and perhaps the major one, is the lack of institutional development in the systematic collection, tabulation and publication of data relevant to health and health sector performance. What current data exist are collected by various institutions in frequencies and levels of aggregation that are most suitable for their own purposes but often are not readily useful for purposes of policy research and analysis. Moreover, these data are not normally published and, thus, access to them on a regular basis is limited.

Is there a way to collect, tabulate and publish a set of statistics useful for health policy research and policy analysis? Below we describe what might be considered a preliminary set of statistics useful for health policy development and in each we assess what we have in terms of reliability and usefulness for health policy research. We then identify what other types of statistics are needed, and discuss how the required data might be effectively and efficiently collected. We also identify the institutions who can be responsible for the collection, tabulation and publication of such statistics.

In addition to basic statistics, there is the need to develop a health policy archive where documentation of major policies (laws, executive orders, administrative orders) are compiled for ready reference, together with information on the supporting data and analysis that were considered, the process of policy development, and the results of monitoring and evaluation. The development of a health policy archive was suggested in a recent Project Design Workshop held in May 1991.

Indeed such an archive will be very useful in providing ready access to documents and analyses that will serve as references to current policy discussions and deliberations. This suggestion has been incorporated in the design of the Health Finance Development Project and we have formally added this to our consolidated research agenda under baseline research in Section V. In this section, we focus our attention on the development of basic statistics for health policy development.

Population, Health and Vital Statistics

These include statistics on population, its demographic characteristics and geographical distribution; vital statistics, i.e. births and deaths; morbidity statistics; nutrition statistics; and statistics on contraceptive use.

Population and Its Distribution. Data are obtained from the census of population conducted by the National Statistics Office (NSO) which also has the responsibility for tabulation and publication. The NSO also makes and publishes detailed population projections by national and sub-national areas. This set of statistics is readily available, and the institutional mechanism for collection, tabulation and publication is well developed.

Births and Deaths. One major source of data on births and deaths is the data obtained by the Vital Registration System. By law, (Civil Registry Law) all births and deaths are to be registered with the Office of the Local Civil

Major Categories of Statistics for Health Policy Development

Population, Health and Vital Statistics

1. Population and population distribution
2. Vital statistics: deaths (by cause of death, medical attendance, age and sex, place of residence); and births (by sex, age of the mother, place of birth and delivery attendant).
3. Morbidity: reports of notifiable diseases (by cause, age and sex, and place of residence).
4. Nutrition: anthropometric measures and dietary and nutrient adequacy (by nutrition status, age and sex, place of residence).
5. Family planning: prevalence by methods, age of woman, place of residence).

Resources for Health

1. Health care institutions: type of institution, number of beds, type of ownership, and location.
2. Human resources for health: age and sex, date of registration, specialty, employment status, place of work, location.

Health Care Utilization

1. Inpatient care: hospital admissions, bed occupancy, duration of stay, discharges by specialty, surgical operations.
2. Outpatient care: outpatient attendances at hospitals and primary care facilities and dental clinics.
3. Other services: radiology, laboratory tests.

Health Expenditures, Sources of Financing and National Health Accounts

1. Government expenditures and sources of financing.
2. Private expenditures and sources of financing: insurance, HMOs, private employers, user charges.
3. National health accounts: estimates of health care services produced and consumed.

Registrar. These data are compiled by field health personnel of each City and Provincial Health Office and submitted both to the Regional Health Office and to the Health Intelligence Service (HIS) of the Department of Health on a monthly basis. The HIS consolidates these data and publishes an annual report called Philippine Health Statistics.

For each death report, information is obtained on the age and sex of the deceased, cause of death, medical attendance, and place of occurrence. On the other hand, for each birth report information is obtained on the sex of the child, the place of birth, delivery attendance, and age of mother.

Births and deaths from this source, however, have been known to be underreported. Thus, unless the extent of underregistration is known from independent sources such as from a national demographic survey, it is difficult to rely totally on the birth and death rates directly estimated from this source.

National demographic surveys conducted every five years provide another source of data for estimating fertility and mortality rates. But even here, underreporting is still a problem and so indirect methods of estimation are often used to obtain more accurate estimates. These indirect estimation methods that demographers have developed over the years can also be applied by combining census data on population and age distribution, and vital registration data to obtain mortality rates. From such a procedure, one can obtain estimates of mortality rates (life expectancy, crude death rates, infant mortality probabilities) disaggregated by regions and provinces. Estimates from this procedure, however, are not done on a regular basis as data become available. For example, for quite some time the only estimates obtained from this procedure were those made and published in 1981, but the estimates refer to the year 1970 (See Flieger, et. al., 1981). It is only recently that similar estimates were made for the year 1980 (See Cabigon, 1990). Even then, however, the estimates are ten years outdated. Nevertheless, such estimates would still be useful as benchmark estimates, and for analyzing geographic differentials in mortality. Estimation of mortality rates using the 1990 census and vital registration data should be undertaken as soon as possible.

Estimates of mortality applying indirect methods either on combined census and vital registration data or on data from the national demographic surveys are not published regularly in

Needed in Policy Research

- *basic statistics useful to policy research;*
- *health policy archive.*

official statistical publications. The DOH itself does not seem to make much use of such estimates in its description of mortality trends.

The cause of death statistics are also known to have serious shortcomings because a large number of reported deaths are without medical attendance (about 60 percent in 1988). This introduces an (unknown) bias in the cause structure of deaths which are needed to determine the nature and pace of the health transition. Efforts are needed to assess this potential bias by comparing reported cause of death structure with those of other countries at similar stages of economic and demographic development but with reasonably good data on mortality levels and cause of death.

Morbidity statistics. These are obtained from reports of cases of, and deaths from, "notifiable diseases" as required by law (Law of Reporting of Communicable Diseases). These reports are made weekly by hospitals and primary care facilities, both public and private, using a standard reporting form which are submitted to the City Health Office or Provincial Health Office, and from there to the Regional Health Office and the Health Intelligence Service of DOH. The reports include information on age and sex, cause of morbidity, and the place of occurrence. Reports are consolidated for the whole country and for the regions by HIS. The HIS also publishes these annually with highlights on the ten leading causes of morbidity in the Philippine Health Statistics.

Not all cases of morbidity will have medical attendance, hence a certain (unknown) proportion of cases will go unreported. It is also not always clear how complete and accurate is the reporting of those cases with medical attendance. The completeness and accuracy of reporting by health institu-

tions will depend partly on their commitment, the effectiveness of their own internal information systems, and the strictness with which the reporting of morbid cases is enforced by the DOH. We are not aware of any study that made such assessments. Incomplete and inaccurate reporting of morbidity cases will obviously bias the data needed for the analysis of morbidity structure by cause of morbid condition essential for determining the nature and pace of the health transition. Again, some efforts are needed to assess this potential bias so that the changing health transition can be described with reasonable accuracy.

Another source of morbidity data is the National Health Survey which is conducted every five years by the DOH in collaboration with the NSO. The survey obtains information on individuals who were ill during the past month, and for each individual who was ill, information is obtained on the diagnosis if the person had medical attendance, or symptoms for those without medical attendance. We have not come across analysis that relates this set of information with that obtained from the regular reporting system, and to indicate what new insights can be obtained from the survey data that we cannot get from the regular morbidity reports. Analysis of such survey data on mor-

bidity is needed to see how useful are such information for describing morbidity condition at the national and regional levels.

Nutrition. Reliable data on the nutritional status of the population based on anthropometric measures and measures of dietary and nutrient adequacy can be obtained from the National Nutrition Surveys conducted every five years by the Food and Nutrition Research Institute (FNRI). The FNRI both analyzes and publishes the results. Because the survey involves intensive data collection on food intake per household, the sample size of the survey is relatively small (about 3,000 households) for estimating reliable sub-national rates of malnutrition. In 1989, the FNRI conducted a National Anthropometric Survey. This survey had a larger sample size (about 9,500 households) and should allow estimation of malnutrition rates, particularly among preschoolers, at a more disaggregated level.

Another source of data on the nutritional status of preschoolers based anthropometric measurements is the "Operation Timbang" conducted by the National Nutrition Council and implemented in the field by the DOH and the DECS. While national in scope and estimates can be made at the municipal level, the data are seriously flawed for policy and program purposes. The reason is that the coverage of the eligible children, i.e. the proportion of children actually weighed to total eligible children of specific ages, vary so widely from one municipality to another. This makes comparison of estimated malnutrition rates by municipalities difficult because serious selection biases are introduced in the data, i.e. those not weighed but eligible might have different nutritional characteristics than those who were actually weighed. This would bias the estimated rates based only on those who were actually weighed, and the bias can go in either direction from one municipality to another. Moreover, this bias cannot be known a priori. There is a need to improve data collection methodology in order to make "Operation Timbang" more useful for program purposes. For national policy purposes, the national anthropometric survey conducted by FNRI which is of high quality should suffice, and therefore, should be conducted regularly.

Family Planning. Statistics on contraceptive use is available from the National Demographic Surveys conducted every five years. The data are quite detailed

and one can analyze not only contraceptive prevalence rates by characteristics of the couple but also the determinants of contraceptive choice. One can also estimate different concepts of "unmet needs" for contraception. However, like the estimates of fertility and mortality, the estimates of contraceptive prevalence rates do not always find their way to being published in the Statistical Yearbook or similar such compendium.

Service statistics are also available from family planning outlets. However, in the past it was difficult to avoid double counting when clients go to more than one outlet for supplies or services. Thus the data contained serious flaws. Unfortunately, it is often these data and not the one based on national surveys that get published in government statistical reports. There is obviously a need to improve service statistics for program purposes. However, greater attention should be made in making the data from the national demographic surveys readily available in official publications for policy purposes.

Resources for Health

The resources referred to here are the real resources rather than financial resources. The latter are described under Health Care Financing. Real resources include the health facilities, equipment, and human resources, i.e. physicians, nurses, midwives, dentists, pharmacists, medical technologists, radiologists and others.

Health Care Facilities. Current information of health care facilities or institutions are obtained from various sources. The number of DOH health facilities and their distribution by region are easily available from the DOH. These facilities include hospitals of various types, medical centers, rural health centers, barangay health stations, and puericulture centers.

Data on private health facilities are available only for hospitals. The Bureau of Licensing and Regulation of the DOH compiles the number of hospitals and their bed capacities. Hospitals are classified by type of hospital (primary, secondary or tertiary), by type of ownership (public or private), and by regional distribution. The Philippine Hospital Association, also compiles data on its member hospitals, both government and private.

Under-Reporting

- *Births and deaths data from the Vital Registration System have been known to be under-reported.*
- *Fertility and mortality rates estimated from National Demographic Surveys also have to deal with under-reporting.*
- *Morbidity statistics from field reports of DOH units are also known to be under-reported due to cases not medically attended.*

Note: It is not clear to me whether licenses are renewed every year or at some fixed intervals of time. If renewed every year, then not only could the data on number of facilities be obtained but other information as well, such as human resources of various categories and specialties, and the number and types of equipments installed. A questionnaire can be filled out by a responsible person in each facility and the report submitted to the Bureau of Licensing and Regulation as a condition for renewal of license. Moreover, there might be a need for a specific law that requires health facilities to submit certain information about the characteristics of the facility to the DOH if this is not already subsumed under the powers of the DOH as a regulatory body. These information could then be consolidated, tabulated and published on an annual basis by the DOH.

Alternatively, the DOH can conduct a special census of health establishments which will obtain information about health facilities and their resources. A detailed questionnaire can be filled out by a responsible person in each facility and the report forms submitted to the DOH through its Regional Health Offices. This could be done at appropriate intervals such as every three years or so. The information so obtain will then be consolidated, tabulated and published by the DOH. Another approach, and which is to be preferred, is that once this special census has been conducted and the results assessed for completeness, reliability and usefulness, it could then be undertaken as part of the regular census of establishments conducted by the NSO.

Human Resources for Health. Information on various kinds of human resources for health appears to be a most difficult type of information to obtain as the

"Information on various kinds of human resources for health appears to be a most difficult type of information to obtain."

recent study of Reyes and Picazo, (1989) demonstrates. The number and types of health personnel in the DOH are readily available but not the number and types of health personnel in the private sector. Data from professional organizations are incomplete, and one needs to compile them from various professional organizations. The data on registered health personnel from the Professional Regulatory Commission updated annually refer to cumulative totals, and does not distinguish between those who have retired, or those who have stopped their practice for some reason or other (especially among nurses and midwives), and, therefore, the data do not give an accurate profile of the different kinds of health personnel who are currently employed in the private sector.

Yet it would seem that the Professional Regulatory Commission should be the main source of information if some reforms in reporting can be made. First, there is a need for a law (if there is not yet one) which requires health professionals to register or renew licenses at fixed intervals, and that as a requirement for registration or renewal of license, they should submit information which could be specified by law to include: age, sex, category of personnel and specialty, place of work (e.g. public or private hospital, clinics, etc.), and location. It might also be possible to add information on the details of qualification such as: year of passing board examination, institution which conferred the degree, and specialist qualification. Copies of these registry forms should then be submitted to the DOH for consolidation, tabulation and publication.

Health Care Utilization

Statistics on health care utilization can viewed from the facility standpoint (hospital vs. primary care facilities) or from the practitioner standpoint (physician, midwives, etc.), for both public and private sectors.

Indicators of hospital utilization include use of inpatient facilities, e.g. number of admissions, bed-days, length of stay, bed occupancy, discharges by specialty, surgical operations; outpatient attendances; services rendered in dispensary by specialty; and use of other hospital services e.g. radiology and laboratory examinations. Data on these indicators are collected by the DOH from reports of hospitals under the DOH, and are available on

Utilization data may be obtained from standpoints of facility, practitioner, or household. In none of these cases is the data complete, adequate, or easily available.

an annual basis. The data, therefore, do not include those of private hospitals. Moreover, even the reports from DOH hospitals are grossly incomplete for some years. Making the reporting compulsory for DOH hospitals and stricter enforcement of such requirement could significantly improve the usefulness of the data for analysis.

The reporting requirements should extend also to private hospitals and could be obtained together with the other data to be collected as a requirement for annual registration or renewal of licenses.

Data from field reports of services rendered by DOH primary care facilities, i.e. Rural Health Units and Barangay Health Stations are also available. But the volume of such reports must be staggering. However, serious efforts are currently being made to streamline field health service reports to make them more manageable from a reporting and data utilization standpoints.

Another source of information on health care utilization of both public and private health facilities, and of different types of health practitioners are the National Health Surveys conducted every five years by DOH in collaboration with NSO. The data from these surveys provide a perspective of health utilization that is from the standpoint of the beneficiary, i.e. households, rather than from the standpoint of the health provider as in the case of field health services reports mentioned above. The data could thus allow us to determine from a group of eligible beneficiaries the coverage rates (i.e. the proportion of total eligible population who received a particular service from a particular health facility or health personnel) of various public and private facilities as well as of various practitioners. This is often difficult to make from health facility reports, be-

cause such reports consider only the facility's own coverage of the target population and not also the coverage of the other providers in the same catchment areas.

Health Expenditures, Sources of Financing and National Health Accounts

Total health expenditures and sources of financing are difficult to obtain for the Philippines. Data on government health expenditures, however, are relatively easier to estimate than private expenditures. The first attempt to estimate total expenditures and sources of financing is the INTER-CARE study conducted in 1987 with support from the Asian Development Bank.

An ongoing study is being conducted by the Research Triangle Institute and the University of the Philippines School of Economics for the USAID Mission in Manila to update data on health expenditures. Various data sources were examined, reconciled, and aggregated into appropriate categories. Moreover, considerable effort has been made to document data sources. But even this effort is still ad hoc at best. There is a need to institutionalize data recording, tabulation, and publication as we shall elaborate below.

Government Health Care Expenditures.

Government health care expenditures include those of the DOH and other government agencies engaged in health activities. The main source of data for estimating total government expenditures is the data from the Department of Budget and Management. Data include budget appropriations and expenditures on an obligation basis for each department. These are often available in summary form by sectors including the health sector and are used by the NEDA for planning purposes. Analyses of these data were done by Manasan (1988). The basic data are also published in the Statistical Yearbook.

While aggregate expenditures on an obligation basis can be readily compiled from existing sources, these expenditures cannot be easily disaggregated according to categories that one might use for analysis. Thus it might be useful to decide on specific

and analytically relevant expenditure categories, define them clearly, and then design the recording procedures within each government agency engaged in health activities with these categories in mind for easy data retrieval and reclassification. These analytical categories should include: (a) expenditures by type of service or activity, i.e. hospital services, field health services, administration, etc.; and (b) expenditures by type of input, i.e. recurrent and capital expenditures, and among recurrent expenditures, expenditures for personnel, drugs, supplies, maintenance, etc. In short, there is a need for a common agreement on what categories to use, and an agreement among concerned agencies to organize their accounting systems to reflect these categories, or at least to make the retrieval of these information easy and routine. The DOH can then compile these data, tabulate them and publish them annually.

Because it is important to have consistency in the definition of terms and aggregation of specific budget line items into broad analytical categories of expenditures, it is desirable to conduct a "demonstration study" which consists of a thorough examination of the recording system, definitions used, and aggregation methods employed with the view of designing a more efficient system of data recording and retrieval for research and policy analysis purposes.

As local governments gain more fiscal autonomy and assume greater responsibility for health service provision and financing in their respec-

tive localities, it will become necessary to transfer this information system to local governments.

Private Expenditures and Sources of Financing.

These are the most difficult information to obtain. The major source for estimating household expenditures for is the Family Income and Expenditures Survey which is conducted every three years by the NSO. The data on health expenditures come from responses to questions on the amounts spent for specific categories of health expenditures, i.e. medical services, hospital services, dental services, drugs, and other health care. Respondents are asked to recall these expenditures for each semester (January-June and July to December) of the past year. The responses are then aggregated to estimate the annual expenditures for health. It is not clear how accurate these recall data are since there has been no reliable benchmark from which to make useful comparisons.

The other categories of private expenditures include employer expenditures for health as part of the benefit package given to employees; insurance benefits paid by Medicare through SSS and partly through GSIS; health-related benefits paid by the ECC; benefits paid by private insurance and other types of financiers including HMOs; and benefits paid by voluntary organizations, civic groups and philanthropic societies. Except for data on the insurance benefits paid by Medicare and the health-related benefits paid by ECC which are readily available from the respective agencies, little is known about these other categories of private expenditures. There is, therefore, a need to conduct periodic surveys to get information on these other categories of expenditures at the same time that the FIES are conducted.

National Health Accounts. Useful estimates of total public and private health care expenditures can be made for policy purposes if a commonly accepted methodology is developed and applied consistently to available data, that is, a methodology based on concepts and estimation procedures used by the national income accounting system, hence the term National Health Accounts. Thus the first priority for the HFD Project is to support studies leading to the development of concepts and methodology for estimating the value of the health care services that were produced (production side) and the value of the health care services that were consumed (consumption or expenditure side). Based on the data that

Government health expenditures in aggregates are relatively easy to obtain but disaggregates useful for analysis are not easily available.

Private health expenditures and sources of financing are the most difficult information to obtain.

are available and data that will be obtained through surveys of other private sector expenditures to be conducted at the same time as the next FIES is conducted, benchmark estimates can be made. These could then be updated with the same frequency as the FIES, and the intervening years can be estimated, if desired, using parameters obtained during the survey years.

An illustrative approach is to consider the question from the standpoint of the population receiving health care (consumption side): what is the money value of the health care that they received (consumed)? Health care includes all components: personnel services, drugs, hospital charges, laboratory tests, X-rays, etc. A first approximation to this amount would be the sum up the following components based on the current structure of delivery and financing system:

1. the total amount that households actually spent from their own pockets (user charges or out-of-pocket expenses);
2. the total amount of benefit payments paid by Medicare, ECC, private insurance and other financiers including individual and organizations donating funds to pay for specific health services rendered to individuals; (plus administrative costs);
3. the value of services rendered by HMOs with salaried physicians and have own facilities, estimated by the amount of salaries paid and rental value of facilities; (plus administrative costs);
4. the value of services provided by

**Some Institutions Involved
in the Health Statistical
System :**

- National Statistical Coordination Board
- National Statistics Office
- Department of Health (Central Offices)
- Food and Nutrition Research Institute
- Professional Regulatory Commission

government facilities to the population for "free" (i.e. services paid for by tax revenues), estimated as the "total government expenditures" less the amount of benefit payments paid by Medicare and other financiers to government facilities for services rendered to their clients and the amount of revenues they collect from user charges.

This sum is a first rough approximation to the total health care expenditures viewed from the consumption side. Approaches to estimation of total expenditures are described in more detail in the on-going study on health care expenditures and sources of financing undertaken by RTI and UPSE.

Institutional Strengthening in Support of Statistical System Development for Health Policy

From the above review, the following needs to be considered:

1. The National Statistical Coordination Board is the government body which oversees the development and assessment of statistics for policy formulation and planning. There is a need to impress upon this body the need to consider the development of statistics for health policy and planning as part of their agenda.

2. The National Statistics Office is the government body mainly responsible for collecting, tabulating and publishing national socioeconomic and population data through censuses and surveys. These data include the population census, census of establishments, national demographic surveys, health surveys, family income and expenditure surveys, and labor force surveys. All of these data sets provide information useful for health policy research and analysis. While the NSO has strong capability of performing its routine tasks, there is a need to provide support to this institution for additional activities such as the preparation and making available these data sets for public use, i.e. available for use by researchers and analysts. Such support should enable the NSO to have additional staff or time to help researchers and analysts prepare the data files needed for specific analyses.

Moreover, additional staff time is needed from the NSO to provide assistance to researchers and analysts in the proper handling of the data sets, i.e. merging data files from different surveys when necessary, or in the assessment of the quality of data, or in facilitating data retrieval for analysis.

The same type of support is needed, perhaps even more so for other government agencies responsible for collecting and analyzing data such as the Food and Nutrition Research Institute.

3. There is a need to review and strengthen the legal basis for collecting certain information and strengthen the respective agency capacity to record, retrieve, compile, tabulate and submit reports to appropriate coordinating agencies such as the DOH, for final tabulation and publication. The information referred to here includes information on health establishments and information on the characteristics of health personnel; while the agencies involved include the Bureau of Licensing and Regulation of the DOH, Professional Regulatory Commission, and the National Statistics Office.

4. There is a need to support exploratory analysis of available national survey data sets from the standpoint of data quality assessment, developing new methodologies for analysis, determining additional data to be collected, and refining the data coding and file system creation in order to make current surveys more useful for health policy research and analysis.

5. There is a need to support activities leading to the design and conduct of new censuses and surveys, in particular, the census of health establishments, the survey of employer-based health benefits, and NGO health-related activities and expenditures in order to supplement data on private sector provision and financing of health care.

6. There is a need to develop concepts and methodology for estimating national health expenditures and sources of financing, and to apply these to existing and prospective data along the lines described earlier.

6. Finally, there is a need to review the health information activities of the DOH with the view of expanding its role as the central coordinating body for the collection, compilation, tabulation and publication of health-related statistics in collaboration with the National Statistics Office and the National Statistical Coordination Board. This is to ensure that its information system is sector-wide rather than just confined to the activities of the DOH.

Building National Capacity for Research, Training, and Technical Assistance

Introduction

The Health Policy Reform Initiative of the DOH is a recognition that policy formulation, implementation and evaluation can be significantly improved by scientifically valid, relevant and timely research. The lack of research-based policy making in the past has been attributed to a number of factors.

First on the policy makers side, it has been alleged that policy makers do not appreciate the usefulness of research in policy making, and if they do, they lack the capability to synthesize and translate research findings for policy purposes.

Secondly, on the researchers' side, it has been alleged that the research being produced in academic and research institutions are essentially "discipline research" undertaken to understand and explain a given phenomena, but contains little practical insights on what can actually be done to solve a given problem. In other words, the research being done is not "policy research." There is obviously an important distinction between the two types of research, although both are based on scientific methods. Thirdly, even if there exist a demand for research among policy-makers and a capability to use the findings for policy formulation, and there exist a group of researchers willing and capable to undertake the needed policy research, there is no mechanism that brings these two vital elements together in a sustained manner. The interactions between policy-makers and researchers that existed in the past were often of an informal nature, forged by previous professional and personal links between them, and such interactions ceased with changes in key actors in policy-

making bodies or in academic/ research institutions.

Thus institutionalizing research-based policy making requires strengthening the capability of policy-makers to make policy choices on the basis of sound research and analysis, and of researchers to undertake policy research on a wide range of policy issues. In addition, it also requires a mechanism to formalize the interactions between policy-makers and researchers in identifying policy issues, developing information bases, and evaluating policy choices on the basis of research and analysis.

In this section, we discuss the issue of capacity building in support of health policy development. We start out with a review of current thinking in national and international circles about such issue, then attempt a quick survey of national institutions that could perform key functions in research, training and policy analysis, and finally discuss capacity building needs and strategies for meeting those needs.

Recent International Thinking Relevant to National Institution-Building for Health Policy and Training

Commission on Health Research for Development. The Commission, an independent international initiative formed in 1987, has recently completed a review of health research in both developing and developed countries and has made specific recommendations for building and sustain-

ing research capacity particularly in developing countries.

The Commission's findings and recommendations relevant to our purposes is summarized below. (See Commission on Health Research For Development, 1990 for details).

The Commission observed that the pattern of research investments in developing countries show a heavy dominance of clinical, biomedical and laboratory research in total health research expenditures. On the other hand, research expenditures were particularly small in the areas of health information systems, field epidemiology, demography, behavioral sciences, economics and management. Since the latter types of research would tend to be country-specific in nature, while the former types would tend to be global in nature, the Commission inferred that country-specific research, which is most critical in health policy deliberations, has been relatively neglected in most developing countries.

The Commission identified a number of constraints faced by researchers in developing countries which limit their capacity to respond to the research needs of policy-makers. These constraints include:

(1) Personal Factors: intellectual isolation, low salaries, limited opportunities for promotion, few career paths, restricted research choice, and insufficient training;

(2) Work Environment: lack of access to information and research journals, inadequate support staff, lack of facilities, and lack of budgetary support for sustaining institutional activities; and

(3) Macro-Environment: lack of demand for, or social appreciation of, research in general; and for policy purposes in particular, lack of scientific culture, bureaucratic rigidity that affect the management of high-quality re-

search either in government agencies or in government-supported research institutions, and poor economic situation which leads to budgetary cutbacks for research.

Another factor that affect research in developing countries is the degree of dependence on foreign funding for research. Although foreign funding for research can significantly augment resources for research, there are undesirable consequences, which include: "the short duration of funding, the 'artificial growth and fragmentation' of research programs and institutions, and the imposition of foreign research agenda on national priorities" (Commission, 1990, p.48). To address these particular potential problems, the Commission recommended that (a) a much longer duration of support by foreign funders is necessary to build national research capability; and (b) a much stronger national research plans and domestic priorities need to be established within developing countries so that foreign research investments can be rationalized and made more effective.

In the Commission's view, the overall goal of capacity building is to improve the capabilities of individuals and institutions to address health problems through research. Capacity building for science-based research would involve at least four components:

(1) Individual competence: strengthening of those skills and attributes associated with the direct conduct of research and with successful policy formulation and research-based management of action for health and development;

(2) Institutional infrastructure that supports research in universities and research institutes as well as in ministries and departments of government and nongovernmental organizations oriented toward action-research: upgrading of career structures, salaries, scientific information, facilities, equipment, and supplies; improving research priority setting and the management of research activities; increasing training capacity; and developing operational links with action units in the country;

(3) Research component of policy formulation and field action: placing highest priority for research on country-specific health problems, and towards this end, a major effort is needed to strengthen epidemiology, the social sciences (particularly economics), health management, and applied clinical and biomedical research; moreover, to create a demand

for research among those responsible for policy formulation and field action by fostering good communication between researchers and users of research results; and

(4) Global health research: to contribute as much as possible to research aimed at discovering new knowledge and technologies to solve health problems, there is a need for highly qualified scientists in the relevant disciplines, adequate research support, and good linkages to a network of peers worldwide.

The Commission has identified what might be the most effective strategies for capacity building as follows:

(1) Institutional strengthening: research capacity building requires capable management and stable sup-

port of institutions over an extended period usually 10 to 15 years based on the view that much better results would be obtained from an initial long-term commitment to an institution by a donor agency subject only to achieving reasonable milestones and to the normal legal caveats of the agency;

(2) Professional and career development: appropriate professional training, support and career incentives can be achieved through a number of ways, among them would be: (a) support professional training by channeling funds through selected institutions or via an open process; (b) training can be free-standing or integrated with specific research activities; and (c) to minimize intellectual isolation through conferences, workshops, access to literature, and sabbatical time abroad.

(3) Networking: Networking is a useful mechanism to provide international support and communication for scientists while at the same time strengthening national research capacity. The network can achieve depth and diversity of research capability that would not be possible in individual institutions.

Centres' Working Group. A Working Group composed of 18 African and Asian health policy-makers, educators and researchers was formed in 1989 to advise the International Health Policy Program (IHPP) on capacity-building for health policy. Its report, which was presented to the IHPP in 1990, contained a number of findings and recommendations that are relevant to the current question of how to build national capacity for research, training and technical assistance in support of health policy development.

The Working Group's identification of the main areas for capacity building, although described in the context of establishing a "Center" (i.e. a single institution) for health policy research and training within a country to serve national needs and possibly regional needs as well, is particularly relevant for our purposes. These areas are shown in Table 4.

Parenthetically, it might be noted that the Working Group's original idea was on developing a "Center" or an institution in a country that can undertake policy research and training on a sustained basis. This idea was based on the premise that in some countries, such an institution does not yet exist. In the Philippine context, however, there are already many institutions that can perform such tasks, some more able than others on specific areas, but all would need upgrading and support in

TABLE 4
MAIN AREAS FOR CAPACITY BUILDING

Human Capacity

- strengthening the capacity for research and training in health policy related issues;
- developing the capacity of policy researchers to communicate with, and respond to, policy-makers' needs; and the capacity of policy-makers to appreciate and utilize the tools and findings of policy analysis;
- strengthening the skills of policy-makers in areas relevant to their professions;

Institutional Capacity

- developing institutions which can serve as a resource base [resource bases] at which policy analysis, research and training are conducted;
- creating an institutional mechanism for systematic interaction and exchange among policy makers, implementers and researchers;
- establishing the supporting infrastructure for the activities of institutions;

Financial Capacity

- becoming financially self-sustaining; and
- generating and managing resources towards fulfillment of the individual institution's mission.

Source: Centres Working Group, Health Policy Training and Research Centres: Capacity-Building in Africa and Asia: A Proposal to the International Health Policy Program, 1990.

TABLE 5

LESSONS LEARNED FROM INSTITUTIONAL DEVELOPMENT EXPERIENCE

Institutional Development

Successful institutional development depends, among others, on the ability to be resourceful in:

- development, motivation and retention of staff;
- creation of a workable organizational structure;
- establishment of appropriate domestic relationships and international linkages.

Policy Relevance and Linkage

Successful policy-related institutions were typically linked to the policy process, and regarded by policy-makers as relevant and responsive.

Ways of doing this include:

- making communication and dialogue part of the institution's mission and day-to-day operations;
- tailoring policy analysis, research and training "products" to policy-makers' needs;
- creating mechanisms for reacting to expressed demand on the part of policy-makers;
- working to ensure that research findings are used;
- developing flexibility and the capacity to adapt to a changing environment.

Functional Autonomy

This refers to the ability of an institution to manage itself towards the attainment of its objectives. Some of the characteristics of institutions which have attained a degree of autonomy include:

- diversified sources of support and a range of clients;
- some degree of insulation from political upheavals;
- competent, motivated and confident leadership;
- institutional productivity and high-quality output;
- full utilization of the institutional capacity.

Financial Viability

Successful institutions maintain financial viability by generating resources from a range of channels, including government support, private sources, external agencies, consulting income, research contracts and in-kind assistance.

Source: Centres Working Group, Health Policy Training and Research Centres: Capacity Building in Africa and Asia, 1990.

order for them to be able to adequately respond to the needs of health policy development, a new area for most institutions. Hence, in the Philippine context, the idea of "many centers" is perhaps most appropriate. For a discussion on how this conclusion was arrived at, see Solon and Herrin (1990).

The Working Group also undertook an extensive review of existing models of organizational efforts to build research and training capacities in such diverse fields as management, agriculture, and economic development; and examined over thirty specific cases including university-based programs, independent institutes, international consortia, networks and donor programs in order to determine what characteristics appear to contribute to successful institution building. The lessons learned from this review that are relevant to institution building in the Philippine context are summarized in Table 5. These lessons could serve as objectives that institutions engaged in health policy research, training and technical assistance can pursue, or as criteria for assessing their performance, or as items for consideration in supporting certain institutions.

National Capacity for Research, Training and Consultancy

There exist in the Philippines today untapped capacity for research, training and consultancy in support of health policy development. There are a number of national institutions with demonstrated capacity for research and training in specific disciplines. (Following the Centre's Working Group modest criteria, demonstrated capacity is defined as "standing the test of time (i.e. survival), and establishing a reputation for quality work in a given field"). These institutions are enumerated below. In the health sciences, they include:

(1) Philippine Council for Health Research and Development which supports and coordinates a network of institutions engaged in biomedical research aimed at discovering new knowledge and at developing and transferring new technologies to solve health problems.

(2) Food and Nutrition Research Institute which undertakes national nutrition surveys and analyses of nutrition problems.

(3) Research Institute of Tropical Medicine which engages in biomedical research, epidemiology and the development and testing of cost-effective technologies for the control of public health problems.

(4) University of the Philippines College of Medicine which engages in training and applied clinical and biomedical research. It has recently established a Clinical Economics Unit.

(5) University of the Philippines College of Public Health which engages in training and research in the various fields of public health, i.e. epidemiology, nutrition, occupational health, dental health, and hospital administration.

(6) University of the Philippines College of Home Economics, in particular the Food Science and Nutrition Department, which engages in training and research on nutrition problems and nutrition policy.

In the social sciences and management sciences, they include:

(1) University of the Philippines School of Economics which engages in training and research in the broad field of economic development and policy as well as in the narrower field of human resource economics. In 1986, it established a program of training and research in health economics.

(2) University of the Philippines Population Institute which engages on training and research on population and health-related issues.

(3) University of the Philippines College of Public Administration which engages in health research particularly in assessments of health service delivery systems and health institutions, and in training of government personnel in public administration.

(4) University of San Carlos Office of Population Studies which engages in training and research in population and health-related issues.

(5) Xavier University Research Institute for Mindanao Culture which engages in training and research in population and health-related issues.

(6) Ateneo de Manila Institute of Philippine Culture which engages in training and research in the behavioral sciences such as anthropology, psychology and sociology with particular attention to their application in community health.

(7) De La Salle University Integrated Research Center which engages in training and research in community health and the delivery of basic services.

(8) Asian Institute of Management which has expanded its internationally known training program of business

management into the public management area for government agencies.

(9) Center for Communication and Research which engages in training and research in business and industrial organizations and economic policy with a recent interest in health issues.

(10) Philippine Institute for Development studies which engages in policy research in a number of policy areas including recently in the area of health.

In addition to the above institutions are institutions engaged particularly in undertaking demonstration projects and action research as well as training and consultancy work. They include:

(1) Philippine Center for Population and Development (formerly Population Center Foundation) which engages in action-oriented research and technical assistance on issues of population, family planning and health, and in developing and testing alternative health delivery systems involving community participation in rural and urban poor areas.

(2) Nutrition Center of the Philippines which engages in action-oriented research on nutrition.

(3) SGV Consulting (Sycip, Gorres, Velayo & Co.) which engages in health policy research, demonstration projects and technical assistance with strong links with international consulting firms.

(4) Development Academy of the Philippines which engages in training of senior government personnel and technical assistance.

(5) Intercare Research Foundation which engages in health policy research and demonstration projects in the area of health care financing.

(6) HEWSPECS which engages in consulting activities and demonstration projects in collaboration with national and international institutions.

Finally, there are institutions capable

There are a number of national institutions with demonstrated capacity for research, training, and consultancy. But all would need upgrading and support in order to adequately respond to the needs of health policy development.

of undertaking networking activities such as the Philippine Social Science Council which is a network of social science professional associations. Each member in the Council can also perform networking activities. Currently, the Philippine Population Association is finalizing plans with the DOH with support from the USAID for the establishment of a Health Research Network involving regional institutions to respond to the need for health policy research and training needs of regional and local units of the DOH.

A Strategy for Upgrading Capacity

The existence of a number of national institutions with demonstrated capacity for research, training and consultancy as identified above implies that capacity building in the Philippines in support of health policy development need not start from scratch. It only needs upgrading of existing capacity on a sustained basis by addressing particular needs. These needs, as identified earlier, include the following:

(1) Generating demand for health policy research and analysis.

(2) Generating interest among individuals and institutions to undertake research, training and technical assistance in support of health policy development.

(3) Upgrading individual skills in policy research and analysis through both short-term and long-term training programs.

(4) Upgrading the capacity of institutions to train, recruit and retain individuals with capacity to undertake policy research, training and technical assistance.

(5) Establishing mechanisms for sustaining the above activities.

Generating Demand for, and Interest in Research-based Health Policy Development.

The increased recognition and appreciation of the need for research-based health policy formulation among the top leaders in the DOH has created a demand for health policy research and training in support of health policy development. This demand is articulated in the DOH's Health Policy Reform Initiative. Moreover, the strategy of the DOH to enlist broader participation in the health policy formulation process has generated heightened interest in health policy is-

ues among various institutions and a willingness by these institutions to participate in undertaking major health policy research and analysis. The stage is set, at least in the short-term for health policy development to proceed on a strong partnership between the DOH, the various stakeholders, and the various institutions capable of undertaking health policy research and analysis based on the common understanding and appreciation of the need for research-based policy formulation.

There is, however, a need to expand and sustain the demand for research-based policy formulation beyond the confines of the current leadership in the DOH by orienting a larger group of policy makers in government, particularly the legislators, and policy implementers in various agencies of government, on the one hand, and a larger group of stakeholders, i.e. practitioners and providers, funders and financiers, and the community, on the other, on the merits of research-based health policy formulation.

Moreover, to sustain interest among individuals and institutions to undertake the needed research and policy analysis, there is a need to strengthen current mechanisms for information-sharing, dialogues and consultations between policy makers, policy implementers and the other stakeholders representing the demand side, and the individuals and institutions capable of undertaking training, policy research and policy analysis representing the supply side.

It is expected that the "market" for research-based policy formulation (i.e. the existence of demand and supply) would be firmly established once the benefits of a research-based policy formulation process become evident in terms of achieving the desired policy impacts. Thus it is important that the net benefits of a research-based policy formulation process be demonstrated as early as possible. This could be done by selecting a policy reform area where the issues are clear, research questions could be addressed quickly, recommendations could be formulated clearly, policy actions could be decided upon and implemented quickly, and the impacts become evident quickly. This experience will help provide the confidence necessary to tackle larger and more complex policy issues later.

Upgrading Individual Skills. Various types of skills need to be upgraded among various types of individuals who currently have the basic skills for research and training. These skills would include: (a) skills in discipline research

applied to health issues among current researchers in various disciplines, particularly in the social sciences; (b) skills in policy research applied to health issues among current researchers in both health and social sciences; (c) skills in synthesizing research results for policy formulation among current researchers in academic and research institutions and among selected personnel in government, particularly in the DOH; (d) skills in policy analysis among teams of policy analysts from both academic/research institutions and personnel from government agencies particularly from the DOH using as inputs the results of policy research and demonstration projects; and (e) skills in monitoring and evaluation of policy actions.

Various individuals in academic and research institutions have, over the years, developed demonstrated capacity for research and training in their respective disciplines. Few of them, however, have applied their skills in health research. Yet these individuals constitute a potential pool of future policy researchers and policy analysts. As a long-term strategy, there is a need to gradually involve these individuals in health policy research, training and technical assistance in support of health policy development. To ease the transition, there is a need to encourage these individuals, mostly social scientists in economics and the behavioral sciences, to apply their skills in disciplinary research to health issues by helping them acquire basic orientation to major health issues, to the

It is important that the net benefits of a research-based policy formulation process be demonstrated as early as possible. This could be done by selecting a policy reform area where the issues are clear, research questions could be addressed quickly, recommendations could be formulated directly, policy actions could be taken promptly, and the impacts could be evident shortly thereafter.

operation of various health institutions in the entire health delivery structure, and to the concepts and methodologies of the various health sciences, in particular, epidemiology.

Such orientation can be done through (a) postdoctoral studies of six to 12 months; (b) internships in the DOH, health institutions, or research institutes engaged in health science research and action programs; (c) participation in short-term training courses (up to three months) here or abroad dealing with health issues and health science methodologies, and health care financing and health administration; and (d) participation in seminars and workshops here and abroad, either those that are sponsored regularly by institutions or those that can be set up specifically for orientation purposes.

To encourage research on health issues, there is a need to set aside funds to support these individuals to undertake research. It is understood that the research will deal with the application, and if necessary, the extension, of disciplinary methods to health problems and issues.

For individuals who have undertaken research in the field of health in their own disciplines, there is a need to encourage them to undertake health policy research, that is, research with the specific view of arriving at recommendations for policy actions or demonstration projects. This could be done in several complementary ways: (a) orientation seminars and workshops on the nature of policy research as distinguished from conventional discipline research; (b) dialogues with policy makers, policy implementors, and various stakeholders with respect to formulation of policy questions to be addressed, research methodologies to be adopted, and research outputs to be produced; (c) internships in the DOH and health institutions; (d) provision of easy access to policy research conducted in other countries; (e) technical assistance from policy researchers in other countries; and (d) support for actual policy research.

For certain individuals with experience in both discipline research and policy research, there is a need to upgrade skills in synthesizing research coming from both discipline research and policy research for use in formulating and assessing alternative policy recommendations. Moreover, from this group of individuals, there is a further need to develop skills in policy analysis where various recommended policy options are assessed for their political acceptability and administra-

Strategies for Upgrading Individual Skills

- *involve experts from various disciplines in health policy research and training;*
- *encourage experts who have done health research to undertake policy-related work through policy design or demonstration projects;*
- *provide mechanisms for experts to develop skills in synthesizing discipline research with policy requirements.*

tive or bureaucratic feasibility. Both set of skills, but specially the latter can be developed through training programs using the case method that has been successfully applied in management training programs for business managers. The cases could come from successful (and unsuccessful) experiences in policy reforms in other sectors within the country, or from the experiences in other countries. In the end, however, the skills can be developed on the job itself, a case of learning by doing.

Upgrading the Capacities of Institutions.

Since the individuals whom we expect to apply their (upgraded) skills come from institutions, there is a need to upgrade the capability of these institutions to provide support and encouragement to these individuals. The support that individuals need from their institutions would include: (a) career and financial incentive structures that are competitive with similar institutions; (b) opportunities for further training; (c) easy access to scientific information, national data sets, research and training facilities and equipment, and support staff; and (d) opportunities for contact with similar individuals in other institutions both within the country and abroad.

It should be noted that the institutions that were enumerated above got

to where they are now because of their capacities to provide the necessary leadership and support for its members. However, for many of these institutions reorienting some of their activities towards health policy research, analysis and training would require additional resources, which can be initially provided through grants, to finance further training for its members, acquisition of library materials and scientific journals, acquisition of additional facilities and equipment, and technical assistance. In addition, some institutions need information regarding national and international networks, the possibilities for collaborative arrangements with national and international institutions engage in health policy research, analysis and training, and potential donor agencies interested in institutional development. It is expected that in time, these institutions, as in the past, will be able to generate their own resources from a wide range of sources, foremost among them would be from research, training and consulting contracts with client agencies.

Establishing Mechanisms for Sustaining the Above Activities. These mechanisms would include: (a) establishing formal linkages between policy makers and researchers; (b) establishing linkages among researchers, trainers and policy analysts as well as their respective institutions both domestically and internationally. It should be noted that the mechanisms designed to institutionalize health policy development described earlier also serve as the mechanisms to develop individual and institutional capabilities. Thus the organization of various committees to initiate and oversee health policy development as well as the establishment of an independent Multisectoral Health Policy Forum also serve to establish the formal linkages between policy makers, researchers and analysts, and other stakeholders of the health sector. The commitment to a research-based policy process by the DOH and other stakeholders also serve to generate effective demand for research, training and policy analysis from which institutions can derive resources to further upgrade and maintain their capabilities. The provision of technical assistance in a wide range of activities also serve to fortify existing linkages between the national institutions and the international community as well as to develop new linkages, networks and collaborative arrangements among institutions.

Implementing the Strategy: The Need for a Lead Institution

To implement the above strategy, there is a need for a lead institution to assist the DOH organize and coordinate capacity building activities in support of health policy development. Currently, there exists several institutions with capability to play the role of lead institution. For example, there is the Philippine Council for Health Research and Development which currently works with and support a network of institutions in the field of biomedical research. However, it does not have in-house capacity to conduct research and training activities. There is the Philippine Institute for Development Studies which has demonstrated its capacity for organizing a network of institutions and individuals in undertaking policy research and analysis in the broad field of economic policy. However, it also has limited in-house staff for health research and practically none for training. There is the Philippine Population Association which is currently in the process of organizing a network of regional institutions to undertake health and population research responsive to local health issues. However, its commitment to health policy research and training may vary with changes in leadership. Finally, there is the University of the Philippines School of

Possible Lead Institutions

- *Philippine Council for Health Research and Development*
- *Philippine Institute for Development Studies*
- *Philippine Population Association*
- *University of the Philippines School of Economics*

Economics which can play a lead role in organizing and coordinating activities in health policy development with particular attention of health care financing issues and the broad field of resource allocation. It has the advantage of having in-house capacity for research and training, although it would need additional support to reorient part of its activities towards health policy development.

The functions of the lead institution would be as follows: (a) to identify current needs for individual and institutional upgrading of capabilities and support systems, respectively; (b) to establish mechanisms for supporting the health policy development processes including the establishment of new networks, both national and international, and the establishment of a Multisectoral Health Policy Forum; and (c) to undertake specific training, research and technical assistance activities in collaboration with other institutions in the network.

Activities in Support of Capacity Building

Although the final set of activities to be undertaken in support of capacity building can be determined only after a thorough assessment of individual institutions and consultations with various groups including the client groups, in particular the DOH, it is possible to identify a generic set of capacity-building activities that will have to be undertaken under the Health Finance Development Project under the direction and coordination of a lead institution. These activities include:

- (1) Training: short and long-term, national and international.
- (2) Research: discipline, policy research, demonstration projects, monitoring and evaluation.
- (3) Technical Assistance: training, research, and policy analysis.
- (4) Networking: national and international.

Training. Training activities would include:

- (1) Orientation visits for policy makers and policy analysts involved in the health policy process to selected countries to study the process of health policy development in these countries;
- (2) Orientation seminars/workshops for policy makers, members of the Health Policy Development Advisory

Council, Health Policy Development Technical Committee, Health Policy Development Staff, policy researchers and policy analysts on the process of health policy development;

(3) Short-term training (two weeks to three months) in health economics and health care financing, health service administration, and hospital management and information system for policy implementors through programs designed and offered by national institutions or through existing programs offered by international institutions. This would include internship in health service administration and hospital management and information system in national or international institutions.

(4) Short-term training (six months to one year) in health economics and health care financing, health service administration, and hospital management and information system for policy researchers, trainers and analysts through training programs, postdoctoral programs or internships offered by national or international institutions.

(5) Long-term training (two to four years) in the field of health economics and health care financing, health service administration, and hospital management and information system for policy researchers, trainers and analysts through graduate programs offered by national and international institutions.

Research. Building capacity for research to support of health policy development would obviously involve, in the end, providing opportunities for undertaking actual research. Thus in addition to basic training and orientations, there is a need to institute on-the-job training for young and promising researchers and policy analysts through participation, under the guidance and supervision of senior researchers and policy analysts, in a

Training for participants in and contributors to the health policy development process is essential.

Research generates the data and insights for policy decisions. It is also a vehicle for training and consensus building.

broad range of research activities which include:

(1) Inter-disciplinary research in the behavioral and management sciences to better understand the behavior of beneficiaries and providers, and to develop new methodologies and data bases for health policy research and analysis;

(2) Policy research on a number of topics designed to clarify policy issues, identify policy options and assess the potential impacts of alternative policies;

(3) Evaluation of demonstration projects for feasibility and impact;

(4) Synthesis of policy-relevant research;

(5) Policy analysis of recommended policy actions for political acceptability and administrative feasibility;

(6) Monitoring and evaluation of policy actions for progress of implementation and impacts, both intended and unintended.

Technical Assistance for Training, Research and Policy Analysis. Various types of technical assistance from both local and foreign experts are needed to assist in the design and implementation of various activities related to the health policy process and to capacity building. In particular, technical assistance will be needed in the following areas:

(1) Health Policy Process: formulation of health policy framework, research agenda and policy agenda;

(2) Training: needs assessment and design of training programs;

(3) Research: design of analytical framework, data collection methodologies, and analysis;

(4) Demonstration Projects: design and evaluation;

(5) Policy Actions: design of interventions, design of monitoring and evaluation plan, and analysis of impacts;

Networking and Collaborative Arrangements. The various institutions mentioned earlier are institutions which have had collaborative arrangements on project to project basis with international institutions while some have ongoing informal links with various international institutions through the long-standing association in professional organizations or through collaborative work of their individual members. Such arrangements have in fact been one of the strategies which these institutions have used to build their capacities in their respective disciplines or lines of activity. However, to build and sustain their capabilities to support health policy development, a new field for many institutions, new collaborative arrangements with international institutions specifically engaged in health policy research, training and analysis may need to be forged. These international institutions could include those found in the United States such as Harvard Institute for International Development, Research Triangle Institute, Rand Corporation, East-West Center; those found in other developed countries such as the London School of Economics, London School of Tropical Medicine, University of Keele Centre for Health Planning and Management, and McMaster University Centre for Health Economics and Policy Analysis; and those found in the developing countries of Asia such as Korean Development Institute, and Mahidol University Institute of Health Development.

Moreover, there are some national institutions that are currently members of international networks or are participating in the activities of international programs. However, there is a need to explore the possibilities for more national institutions to become active members, or at least to participate in the activities of international networks or international programs engaged health and health policy development. Such networks or programs include the following: International Clinical Epidemiology Network (INCLIN), Southeast Asian Ministers of Education Organization Tropical Medicine and Public Health Project (SEAMEO-TROPMED), International Health Policy Program, and the various programs of the World Bank and World Health Organization.

In addition, there is a need to strengthen existing collaborative arrangements and networking activities among national institutions and to establish new ones.

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Annex A

Constitutional Mandate for Health / DOH's Mandate as a Policy and Regulatory Body / DOH's Vision, Mission and Overall Strategy

Constitutional Mandate for Health

Several provisions of the 1986 Philippine Constitutions provide the mandate for the government to engage in health activities. First, under the article on the Declaration of Principles and State Policies, we have:

Article II, Section 15. The State shall protect and promote the right to health of the people and instill health consciousness among them.

Secondly, under the article of Social Justice and Human Rights, we have a specific section on health with the following provisions:

Article XIII, Section II. The State shall adopt an integrated and comprehensive approach to health and development which shall endeavor to make essential goods, health and other social services available to all the people at affordable costs. There shall be priority for the needs of the underprivileged sick, elderly, disabled, women and children. The State shall endeavor to provide free medical care to paupers.

Article XIII, Section 12. The State shall establish and maintain an effective good and drug regulatory system and undertake appropriate health manpower development and research responsive to the country's health needs and problems.

Article XIII, Section 13. The State shall establish a special agency for disabled persons for their rehabilitation, self-development and self-reliance, and their integration into the mainstream of society.

Thirdly, there are several provisions that refers to specific activities that are related to the provision of health services including environmental health, occupational health, nutrition of children, family planning, and consumer protection. These are: (a) the State's duty to provide adequate social services among others as a means to promote a just and dynamic social order (Article II, Section 9); (b) the State's duty to protect and advance the right of the people to a balanced and healthful ecology (Article II, Section 16); (c) the State's duty to protect working women by providing safe and healthy working conditions (Article XIII, Section 14); (d) the State's duty to defend the right of children to assistance, including proper care and nutrition (Article XV, Section 3(2)); (e) the State's recognition of the sanctity of family life and its duty to protect the life of the mother and the life of the unborn from conception (Article II, Section 12), to strengthen the solidarity of the family and promote its total development (Article XV, Section 1), and to defend the right of spouses to found a family in accordance with their religious convictions and the demands of

responsible parenthood (Article XV, Section 3(1)); and (f) the State's duty to protect consumers from trade malpractices and from substandard or hazardous products (Article XVI, Section 9).

Finally, there are provisions that call for the need for collaboration between public and private sectors. These include: (a) the State's recognition of the indispensable role of the private sector (Article II, Section 20); (b) the State's duty to encourage non-governmental, community-based, or sectoral organizations that promote the welfare of the nation (Article II, Section 23); (c) the State's duty to defend the right of families or family associations to participate in the planning and implementation of policies and programs affecting them (Article XV, Section 3(4)).

These constitutional provisions were taken as guiding principles in the formulation of the policy and strategy framework of the Medium-Term Philippine Development Plan, 1987-1992 and appear explicitly in the Plan Update for the Health, Nutrition and Family Planning Sector, 1988-1992.

DOH's Mandate as a Policy and Regulatory Body

While the several provisions of the Philippine Constitution mandates the government to protect the right to health of the population and to adopt an integrated and comprehensive approach to health development, the specific mandate of the DOH to act as a policy and regulatory body comes from Executive Order No. 119 issued in January 1987, entitled "Reorganizing the Ministry of Health, its Attached Agencies and for other Purposes. The Executive Order defines the mandate of the DOH and spells out its powers and function.

The mandate given to the DOH by the Executive Order is as follows:

"The Ministry (Department of Health) shall be primarily responsible for the formulation, planning, implementation, and coordination of policies and programs in the field of health. The primary function of the Ministry (Department of Health) is the promotion, protection, preservation or restoration of the health of the people through the provision and delivery of health services and through the regulation and encouragement of providers of health goods and services." (Section 3).

The Executive Order also define the powers and functions of the DOH under Section 4 as follows:

(a) Define the national health policy and formulate and implement a national health plan within the framework of the government's general policies and plans, and to present proposals to appropriate authorities on national issues which have health implications;

(b) Provide for health programs, services, facilities and other requirements as may be needed subject to availability of funds and administrative rules and regulations;

(c) Assist, coordinate or collaborate with

local communities, agencies and interested groups including international organizations in activities related to health;

(d) Administer all laws, rules and regulations in the field of health, including quarantine laws and food and drug safety laws;

(e) Collect, analyze and disseminate health statistical and other relevant information on the country's health situation, and require the reporting of such information from appropriate sources;

(f) Propagate health information and educate the population on important health, medical and environmental matters which have health implications;

(g) Undertake health and medical research and conduct training in support of its priorities, programs and activities;

(h) Regulate the operation of, and issue licenses and permits to, government and private hospitals, clinics and dispensaries, laboratories, blood banks, drugstores and such other establishments which by the nature of their functions are required to be regulated by the Ministry;

(i) Issue orders and regulations concerning the implementation of established health policies; and

(j) Perform other functions as established by law or as ordered by higher authorities.

The mandate of the DOH is thus clear which is that of being "primarily responsible for the formulation, planning, implementation, and coordination of policies and programs in the field of health." In addition, one of its major function is to "define the national health policy and formulate and implement a national health plan." It is particularly with respect to this mandate and primary function that the current Health Policy Reform Initiative of the DOH attempts to address.

The DOH's Vision and Mission, and Their Translation Into Objectives, Policies and Strategies

As soon as the new leadership assumed office at the DOH, it began to articulate its vision, mission and overall strategy, consistent with the various constitutional provisions related to health and from the mandate and powers and functions provided in the Executive Order No. 119.

The following are how the DOH has articulated its vision, mission, and overall strategy: (DOH Briefing Documents, 1987).

1. Vision: Health as Right. Health is a basic human right. A continuum of services must be provided to assure the enjoyment of this right, especially by the poor.

2. Mission of the DOH. The DOH should work to make enjoyment of the right to health a reality by making services available: by arousing community awareness; by mobilizing resources; and by promoting the means to better health.

To accomplish the above, DOH must: identify the "health package;" define the obstacles to providing such package; and

provide the solution to these obstacles.

3. Health For All Strategy. A basic package of health and health-related provisions must be delivered to all, utilizing available technologies and available services. This requires intersectoral collaboration, beneficiary participation and technical leadership.

When the new leadership at DOH entered office, they were faced with a number of concerns which they categorized as follows: (a) program concerns – issues of direct service delivery to people; (b) interagency concerns – issues of direct impact requiring DOH collaboration with other agencies such as environmental health, nutrition, family planning, drugs and pharmaceuticals, and manpower development; (c) funding concerns – issues of resource provision which includes the health budget, rationalizing private spending, foreign funding, health insurance and general health care financing; (d) institutional concerns – issues concerning DOH institutional capabilities to achieve programs, collaborate with other agencies and properly utilize resources.

Faced with these concerns, the DOH set its specific objectives for the medium-term as follows:

1. To sustain and gradually accelerate health program activities addressed to the main health problems of the nation;
2. To direct priority improvements in health programs towards the worst off sectors of the population;
3. To institutionally strengthen the planning, implementing and service delivery capabilities of the national health network;
4. To improve the financial and managerial base of the network in order to preserve and expand program and institutional gains.

The DOH succinctly summarized these objectives in terms of the following: "to do more, to do even more for priority groups, to do better, and to secure the improvements". (DOH Briefing Documents, 1987).

These objectives were later translated into specific policies and strategies for the entire health sector (i.e. health, nutrition and

family planning) in the Medium-Term Philippine Development Plan, 1987-1991, and reiterated in the Plan Updates of 1988-1991. The specific policies and strategies for the medium-term were:

1. Improved provision and utilization of accessible, appropriate and adequate basic health, nutrition and family planning services, especially to the poor, unserved, underserved and high-risk groups.
2. Integration of efforts within the health, nutrition, and family planning sectors and ensuring multi-sectoral consistency and support.
3. Promotion of individual and collective responsibility for health, nutrition, and family planning.
4. Greater reliance on indigenous resources and technology.
5. Strengthened and sustained effective collaboration with the private sector.
6. Greater emphasis on, and more vigorous implementation of, preventive and promotive health and nutrition measures.
7. Strengthened promotion of family planning as a component of comprehensive maternal and child health.
8. Enhancement of the status and role of women as program beneficiaries and program implementors.
9. Improved regulation of environmental health, sanitation and occupational safety.
10. Increased government resource allocation in the health, nutrition, and family planning sector and ensuring its proper and efficient utilization.
11. Strengthened information and research-based decision-making and implementation.
12. Strengthened and intensified manpower development.
13. Improved regulation of health, nutrition, and family planning goods and services to protect the beneficiaries consistent with economic efficiency.

In carrying out these policies and strategies, the DOH has been guided by certain values foremost among them is equity in both provision and financing of basic health services, and within equity considerations, maximum efficiency and quality. While

these individual values are reflected in various Constitutional provisions, in the statement of vision and mission of the DOH, and in the statement of objectives and strategies for the health sector, one gets a clear sense of this hierarchy of values from the public statements of the top leadership of DOH.

The DOH's Health Policy Reform Initiative

The DOH's "strategic initiatives" in the health sector generally revolved around five major areas, namely: (1) intensification of implementation of public health impact programs; (2) formulation and implementation of a national clinical care development plan; (3) institutional strengthening of the health sector; (4) formulation and implementation of a National Drug Policy; and (5) formulation and implementation of a health care financing strategy. The DOH recognizes that in some of these major areas, there had already been significant accomplishments made during the past five years; in other areas, there are on-going activities that require strengthening; and still in other areas, there are aspects of specific initiatives that are in their early phases of development.

In reviewing its past performance in policy reform and looking forward into the future, the DOH recognizes the need for strengthening the process by which policy reforms are conceptualized, developed, adopted, implemented, and finally evaluated for their impact. Thus, on September 1990, the DOH Executive Committee approved a program for health policy development called the Health Policy Reform Initiative. As a continuing response to the DOH's mandate to be "primarily responsible for the formulation, planning, implementation, and coordination of policies and programs in the field of health," this initiative seeks "to establish a process for considering, studying, testing, promoting, adopting, implementing, monitoring and evaluating policy reforms in the health sector."