The Impact

of the

Asian Financial Crisis

on the

Health Sector in the Philippines

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency virus
ASEAN	Association of South East Asian Nations
BCG	Bacille Calmette-Guerin vaccine
CHD	Council for Health and Development
CIDSS	Comprehensive Integrated Delivery of Social Services Program
DOH	Department of Health
DOTS	directly observed treatment short course
DPT	Diphtheria Polio Tetanus (vaccine – also known as triple antigen)
EPI	Expanded Program on Immunisation
FP	Family Planning
GDP	gross domestic product
GNP	gross national product
HIV	Human immunodeficiency virus
IDUs	intravenous drug users
IMR	infant mortality rate
IUD	intrauterine device
LGU	local government units
MBN	minimum basic needs
MIMAP	Micro Impacts of Macroeconomic Adjustment Policies
NEDA	National Economic Development Authority
NFA	National Food Authority
NGO	Non-government organisation
OCP	oral contraceptive pill
PHC	primary health care

SCNEP	Street Children Nutrition and Education Project
SSN	Social Safety Net
STD	sexually transmitted disease
SWS	Social Weather Station
TB	tuberculosis
USD	United States dollars
UN	United Nations
UNICEF	United Nations Children's Fund
VGF	Vulnerable Groups Facility
WB	World Bank
WHO	World Health Organization

Summary and Recommendations

Effects of the Crisis

The Philippines was less affected by the crisis in comparison with several of its regional neighbours. Nevertheless just like other countries in the region it has become increasingly vulnerable as result of the effects of the crisis. The economy suffered a range of negative consequences due to the crisis and these were compounded by two other factors: firstly Government Departments are at various stages in the **process of decentralisation**, and secondly **unfavourable environmental conditions** for agriculture occurred as a result of a lengthy drought associated with the El Nino phenomenon and subsequent typhoons.

Analysis of the impacts of the crisis has been made extremely difficult as there is no single monitoring system at a National level that would allow monitoring of health and other consequences of the crisis and little data have been collected by other agencies.

Prior to the crisis the Philippines had experienced significant economic and human development improvements from various policy reforms instituted from 1991 to 1996. Since the crisis, much of these gains have been eroded. Economic impacts included devaluation of the peso by up to 62.4% against the US dollar, a slowing in the rate of growth of GNP (negative growth of 0.3% in one quarter of 1998), and disinvestment (the average growth in investment of 10.5% recorded in the first three quarters of 1997 became a contraction of 13.8% in the same period in 1998). Inflation rose from 6.0% in 1997 to 10.4% in 1998 and had reached 11.6% by January 1999, while the rate of unemployment increased from 8.7% in 1997 to 10.1% in 1998.

National government revenues were reduced by about 11% between 1997 and 1998. Reduced employment increased the demands for benefits of the SSN. Government expenditure on social support was largely maintained through foreign bonds and financing. However declines were concentrated on local government expenditures which has implications for the government's ability to maintain health, nutrition and family support services.

In 1997-98, government health spending contracted by 6.03% compared with a rate of growth of 26.17% the previous financial year. There was also evidence of significant shortfalls between the budget appropriation and the apportionment of funding or delays in allocating funding for a number of important health programs including the procurement of drugs and medicines, STD/AIDS control, physicians for "doctorless" communities, maternal and child health services, nutrition services, family health programs and immunisation .

According to the World Bank, budgetary cuts in government health expenditure meant that the extended program of immunisation would reach only 58% of DPT and polio targets and 70% of those for BCG vaccine. **There were also reports of a decline in the percentage of fully immunised children (9-11 months old) from 89.8% in 1996 to 74.9% in 1998.**

Economic modelling has suggested that the prevalence of malnutrition will rise and this will increase the vulnerability of the poor to disease.

The depreciation of the peso led to increases in the cost of pharmaceuticals by up to 40%. Data from household surveys suggested that the average allocation of income for medical and health costs had risen from 7.9% in 1997 to 8.1% in 1998. Focus group responses from the

same study suggested that **households tended to place health expenditure in a lower priority** and also were relying more upon free or cheaper sources of health care such as government services, traditional healers, and self-medication.

There is also likely to be a decline in household incomes which will lead to increased demand for home-based health care and care in public and charitable facilities as well as a lowering demand for private treatment in clinics and hospitals.

Responses to the Crisis

Macroeconomic responses to the crisis were quick and apparently stabilising. A World Bank review assisted in prioritising expenditure to protect vulnerable groups. Emergency rice imports were permitted without tariffs which protected the staple diet of low-income earners. Excessive interest rates were prevented and promotion of wage restraints moderated increases in inflation and unemployment.

Despite the resilience of the Philippines to the crisis so far it remains vulnerable to a continuation in the situation. Structural weaknesses have resulted in problems responding to the crisis. There has not been a discernible deterioration in nutrition or health that can be directly attributed to the crisis. However, given the preexisting high levels of poverty (a third living below the poverty line) and the meagre SSN in place this may not be the case in the foreseeable future. The World Bank has indicated that it intends to work with the Government of the Philippines to improve the health, nutrition and population outcomes of the poor; enhance the performance of the health care system by supporting the integration of local primary health care delivery systems; and improve the targeting of public health investments to public health priorities.

In addition, the World Bank has indicated that together with partners including UNICEF and the ADB, it will conduct a detailed review of the Philippines health care sector with a view to developing a policy framework to deal with such issues as the mismatch between central funding and local delivery of health services, devolution, and regulatory and technical capacities at the central level.

AusAID's Philippines Country Strategy Program (1998/99-2002/03) recognised the adverse effects of structural readjustment, the Asian financial crisis and the El Nino/La Nina weather patterns on the poor. The strategy identified the need for a Vulnerable Groups Facility (VGF) as a short-term mechanism to support SSN programs. The objective of the VGF is to increase basic social services to vulnerable groups by funding selected successful and well targeted Philippine Government activities which provide such services and which face current budgetary restrictions. AusAID have committed A$19 over three years.

Recommendations

Recommendation 1: Provide support for elements of programs that are currently inadequately covered by the government budget.

- Supplementary budget support should be considered for existing special programs such as TB, immunisation, HIV/AIDS, and family planning. A focus of support for HIV/AIDS could be the provision of antiretroviral drugs and other effective interventions to HIV-positive pregnant women to reduce the risk of perinatal transmission of the virus. Purchase of

contraceptives and promotion of FP services at the PHC level should also be supported. Consideration should be given to Hepatitis B immunisation programs for infants and children – this vaccine ceased to be provided nationally from 1998 due to the impact of the crisis.

Recommendation 2: Provide policy and financial support to assist with the procurement of essential drugs.

- Review should be undertaken of current policy and practice and promotion of rational use of drugs, increased use of generic drugs and standardised prescribing practices instigated. Logistics systems also need improving.

Recommendation 3: Provide support for NGO-based crisis supplementary feeding projects for vulnerable groups.

- While there is little hard evidence of a nutritional impact of the crisis, a third of the Philippine population exist below the poverty threshold and are vulnerable to the impacts of reduced incomes and rising food prices. The effects on nutrition may not be immediately apparent, but children and pregnant and lactating women are at greatest risk.

Recommendation 4: Provide support for promotive and preventative health services in particular, to rural and poor and urban areas.

- Commitment to essential primary health care projects at the community level is essential. There has been an emphasis on curative services rather than preventative services with an over-concentration of resources on hospitals. NGO-based health projects targeted at vulnerable groups should also be supported.

Recommendation 5: Promote support for a strengthened and expanded health monitoring system that would increase the capacity to assess the impact of the crisis in rural and urban poor.

- This system should also include surveillance of child and maternal nutritional status and complement initiatives in this area being undertaken by the ADB and AusAID. Studies should focus on particular disadvantaged groups, such as the urban and rural poor, unemployed, female-headed households, and homeless children.

Longer Term Assistance

Recommendation 6: Provide support for the development of health care financing initiatives.

- This should include cost recovery, more effective targeting of government subsidies, the development of a stronger planning and policy capability in the field of national health insurance to improve long term sustainability of the health system.

Recommendation 7: Provide support to strengthen health information systems and provide assistance in the training of health information managers.

- Monitoring systems and health service studies on utilisation rates, service costs, etc. should include assessments of the quality of health services being provided.

Recommendation 8: Provide assistance for the training of financial planning officers at both the national and local levels to address some of the complications brought about by devolution and intensified by the economic crisis.

- The devolution of responsibility for health services to LGUs has resulted in a need to strengthen planning and management skills in LGUs to ensure that appropriate and high quality health services are provided. At the national level the DOH requires support to provide technical leadership for national health programs.

Recommendation 9: Provide support to expanding health promotion programs, especially those aimed at preventing non-communicable diseases and injuries.

- The leading causes of death in the Philippines have shifted from those relating to communicable diseases to those related to non-communicable and work and environmental factors.

- This support should initially be in the form of applied health research, especially interventional research studies that develop appropriate strategies in the context of the Philippine health profile, culture, risk behaviours, and available resources. Support to health promotion programs will eventually lead to increased cost-efficiency in the health sector as healthier communities require less expensive clinical services to manage chronic diseases.

Section 1: Background

1.1 Economic Indicators

According to the Asian Development Bank (ADB), the economy of the Philippines was relatively strong prior to the economic crisis (Reyes, de Guzman, Manasan, and Orbeta 1999). In the three years prior to 1997, the economy recorded growth, stable prices, and favorable balance of payments and fiscal position.

The Philippines has been less affected by the crisis in comparison to several of its regional neighbors, although the economy suffered a range of negative consequences in the wake of currency devaluation in Thailand, Korea, and Malaysia. In January 1998 the Peso reached its lowest value against the US Dollar with an exchange rate of P42.70, representing a devaluation of approximately 62.4% compared with prior to the crisis (Reyes et al. 1999)

The effects of the currency crisis were compounded by unfavourable environmental conditions as a result of a lengthy drought associated with the El Niño phenomenon and subsequent typhoons in October 1998 (Reyes et al. 1999; Council for Health and Development 1998; Health Action Information Network 1998; Pernia and Knowles 1998).

Although the Philippines economy suffered a significant reversal in the wake of the Asian financial crisis, technically it escaped recession since negative growth (0.3%) of Gross National Product (GNP) was recorded in only one quarter of 1998. According to the National Economic Development Authority (NEDA), GNP was maintained due to continuing strong remittances from abroad - primarily from overseas contract workers - despite an actual decline in the amount of such remittances in 1998 (National Economic Development Authority 1999; Reyes et al. 1999).

Gross Domestic Product (GDP) growth declined from 5.2 per cent in 1997 to an estimated 0.2% in 1998, but is projected to reach a growth rate of 2.5 per cent in 1999 (International Monetary Fund 1999). The industry most affected appears to be the construction industry which has suffered a major contraction; in the first quarter of 1997 it grew at 21.3 per cent but by the third quarter of 1998 it had recorded negative growth of 15 per cent (National Economic Development Authority 1999).

Rates of investment in the Philippines declined sharply in the wake of the economic crisis. The average growth in investment of 10.5 per cent recorded in the first three quarters of 1997 became a contraction of 13.8 per cent in the same period in 1998 (Pernia and Knowles 1998).

Inflation rose from 6.0 per cent in 1997 to 10.4 per cent in 1998 and had reached 11.6 per cent by January 1999 (International Monetary Fund 1999; Reyes et al. 1999). In the view of the ADB, stable food prices allowed the Philippines to avoid extreme inflation, despite the currency devaluation and adverse agricultural conditions due to drought (Reyes et al. 1999). Inflation of food prices stayed at 11 per cent in November 1998 and commodities that became much more expensive included rice, chicken, pork, sugar, powdered milk, and eggs (Table 1).

Table 1. Price Increase of Selected Basic Commodities (in peso)

Commodities	19 Jul 97	21 Dec 97	8 Feb 98	15 Feb 99
Rice/kg	15.00	15.00	16.00	20.00
Refined sugar/kg	20.50	22.00	22.50	30.00
Powdered milk	22.00	23.50	27.00	27.00
Canned sardines	6.80	7.00	7.25	8.00
Pork/kg	108.00	105.00	104.00	110.00
Chicken/kg	75.00	78.00	78.00	100.00
Egg/piece	2.50	2.50	2.50	3.50
Galunggong fish /kg	50.00	45.00	55.00	40.00
Milkfish/kg	88.00	70.00	80.00	80.00

Source: Guan, 1999 IBON Facts and Figures 15-31 March 1999: 5

Unemployment rates varies between information sources. According to the Asian Development Bank, it increased from 7.4 per cent to 10.4 per cent between 1996 and 1997 (Pernia and Knowles 1998). However, the National Statistics Office reported the following rates (Table 2):

Table 2. Unemployed Rate for the Philippines, 1996-1998

1996	1997	1998
8.5 %	8.7 %	10.1%

Source: Pernia and Knowles 1998

It also appears that the deployment of Filipino migrant workers declined by 23.4 per cent between the first quarters of 1997 and 1998. Wages were low due to retrenchments, the use of contract labor and an agreement between employers and trades unions to maintain jobs in exchange for a freeze on wages (Pernia and Knowles 1998).

The devaluation of the Peso helped to make Philippines exports more competitive and exports continued to grow, despite a slowing of the growth from 22.8 per cent in 1997 to 16.9 per cent in 1998. By contrast the total value of imports was reduced by 18.8 per cent in 1998 compared with the previous year (Reyes et al. 1999).

Several surveys on self-rated poverty index have been conducted by the Social Weather Station (SWS) and Asian Development (ADB). Their different methods of estimating poverty invariably lead to differing rates being reported.

Social Weather Station's survey is replicated quarterly with a sample size of 1,200 capable of extensive analysis over time. SWS's latest self-rated poverty survey revealed 60 per cent of households perceived themselves to be poor in June 1999 compared to 58 per cent in June 1997 (Mangahas 1999).

ADB's household survey, focus group discussions and key informant survey collected in January 1999 revealed that as a result of increased inflation, decline in real income, peso devaluation, and weak purchasing power, the proportion of families who rated themselves as poor rose from 40 per cent in 1997 to 43 per cent in 1999 (Reyes et al. 1999)

1.2 Health Financing Indicators

Health Budget

The effects of the economic crises occurred at a time when the public health care system of the Philippines has been undergoing a series of structural reforms. Since 1991, responsibility for health care has been devolved by the national government to regional, provincial and local government levels of management and there have been moves to introduce privatisation of certain categories of public hospitals (Del Rosario 1997, Council for Health and Development 1998, Health Action Information Network 1998). The budget and human resources to fully support this initiative are only now being seriously committed (even though the process began in 1991). As a result organisational structures in the delivery of health care services are not yet fully developed. (Centre for International Economics, 1999).

Department of Budget and Management figures show a contraction in health sector expenditure on the part of the national government in the wake of the economic crisis (Tables 3-5).

Table 3. Growth Rate of National Government Expenditures on Health 1995/96 to 1998/99

1995-96	1996-97	1997-98	1998-99
34.56 %	26.17 %	- 6.03 %	2.11%

Source: Department of Budget and Management cited in ADB June 1998, Table IV.4

Table 4. National Government Expenditure on Health as a Proportion of GNP, 1996-99

1996	1997	1998	1999 (estimate)
0.46%	0.52%	0.44%	0.4%

Source: Department of Budget and Management cited in ADB, June 1999, Table IV.5

Table 5. Per Capita National Government Expenditure on Health (Peso in 1985 prices) 1996 - 1999

1996	1997	1998	1999 (estimate)
56.98	66.17	55.30	50.92

Source: Department of Budget and Management cited in ADB, June 1999 Table IV.7

The ADB has concluded that "actual delivery of services appears to be adversely affected as the obligation-to-allotment ration reached an average of only 53.1 per cent for public health services as a whole as of the end of December 1998" (Reyes et al. 1999).

Expenditure on health programs and services

Data gathered pre crisis indicate that government health expenditure in the Philippines was only 2-3 per cent of GNP, substantially below the World Health Organization's recommended 5 per cent of GNP level (Del Rosario 1997). The crisis has impacted on the priority of health funding with ranking of the Department of Health in the share of the national budget slipping from fifth place in 1996 to tenth in 1999.

The ADB has highlighted a number of programs in which there is currently a significant shortfall between the budget appropriation and the apportionment of funding or delays in allocating funding (Reyes et al. 1999). These indicate that such programs are vulnerable and may be unable to sustain current levels of activity. Programs affected included:

- the procurement of drugs and medicines
- STD/AIDS control
- physicians for communities without doctors
- maternal and child health services
- nutrition services
- expanded program of immunisation
- family health program

International Aid Contributions

International aid from foreign governments, international and non-government organisations (eg., WHO, UNICEF) and major banks (eg., WB, ADB) has historically played a major role in augmenting the government health budget. Data on the current ratio of foreign aid funding to total government health expenditure are currently unavailable (Personal communication, Department of Health Foreign Assistance Coordination Service August 1999). In 1997, the

WHO - Western Pacific Regional Office country budget was predominantly allocated to the Philippines tuberculosis control program (World Health Organization 1999).

1.3 Impact of Economic Crisis on Coverage and Utilisation of Health Services

Expanded Program on Immunisation

According to the World Bank (Pernia and Knowles 1998), budgetary cuts in government health expenditure have meant that the expanded program of immunisation would cover only 58 per cent of DPT and polio targets and 70 per cent of those for BCG vaccine in 1999. Evidence of declining immunisation coverage for children suggests that the percentage of 9-11 months old who are fully immunised has declined from 89.8 per cent in 1996 to 74.9 per cent in 1998 (Department of Health Field Health Services and Information Systems 1998). This is probably due to declines in government spending. The greatest impact is the exclusion of the hepatitis B vaccine from the infant and child vaccine program. This vaccine was withdrawn in 1998 due to increasing costs to the health budget (Centre for International Economics, 1999).

In 1998, average EPI coverage declined by 29 per cent in the country's 12 regions (Table 6), although regional variations were evident. Fifty-nine per cent of regions were below the 58.71 per cent average national immunisation coverage, with the lowest 31.3 per cent seen in Region XI (Southern Mindanao). It is unclear whether this is due to the effects of the crisis, but some impact due to reduced funding is likely.

Table 6. Immunisation Coverage (Fully Immunised) by Region, Department of Health, 1996-1998

	1996	**1997**	**1998**
Average	89.19	87.62	58.71
NCR	94.2	94.8	94.0
CAR	90.2	86.9	86.7
Region I	89.7	84.8	38.7
Region III	90.7	83.4	44.0
Region IV	85.8	90.8	77.9
Region V	90.4	83.8	48.3
Region VI	96.0	95.5	39.1
Region VII	83.4	86.2	85.1
Region VIII	91.7	84.5	33.4

Region X	92.2	88.5	83.9
Region XI	84.7	87.3	31.3
Region XII	81.3	84.9	42.1

Source: 1999 Reyes et al., Table V.25. Note: Four regional data were missing, namely Regions II, IX, ARRM, CARAGA

Family Planning Program

A slight decline in contraceptive usage among currently married women occurred from 48.1 per cent in 1996, 47 per cent in 1997 to the present level of 46.5 per cent in 1998 (Reyes et al. 1999). Reasons for this decline among 15-49 year old women were attributed to fear of side effects, couples wanting to have another child, or no longer requiring contraception (National Statistics Office 1998) rather than any impact of the economic crisis on costs or service coverage.

Seventy-three per cent of women who use contraceptives obtained their supplies from public health facilities (National Statistics Office 1998). The most important public sector suppliers of these contraceptives (ie., oral pills and injectable Depo-Provera) are government hospitals and rural/urban health centres. It is not possible to determine a causal link between the economic crisis and continuing decrease in the use of contraception by Filipino women.

Department of Health data on new acceptors of contraception and continuing users is given in Table 7 and does not appear to indicate a drop in the use of contraceptive services – this is typical of the contradictory picture emerging from different information sources in the Philippines. In addition, the 1998 data are provisional and should not be regarded as entirely accurate.

Table 7: Use of Contraceptives 1996 to 1998

	1996	**1997**	**1998**
New Acceptors			
• Condom	13%	11%	10%
• Injectable	18%	18%	17%
• IUD	6%	5%	6%
• OCP	36%	33%	30%
• Male sterilisation	0.1%	0.1%	0.1%
• Female sterilisation	1.2%	1.1%	1.1%

Continuing Users			
• Condom	14%	13%	12%
• Injectable	9%	13%	14%
• IUD	15%	12%	13%
• OCP	51%	49%	47%

Source: Field Health Service Information System, Department of Health. Note 1998 is preliminary data

Utilisation of Health Facilities

Government Department of Health data appear to indicate that antenatal care – at least in terms of numbers of visits - has not been affected by the crisis, with approximately three fifths of women attending at least 3 antenatal visits (*Table 8*)

The proportion of deliveries attended by either a doctor or midwife comprise over two thirds of all deliveries. Untrained staff attend fewer than 5% of deliveries. The proportions did not change between 1996 and 1998.

Table 8: Antenatal attendances and supervision of deliveries 1996 to 1998

	1996	1997	1998
Pregnant women attending at least 3 prenatal visits	56%	62%	59%
Deliveries attended by:			
• Doctor	25%	25%	26%
• Nurse	1%	2%	1%
• Midwife	43%	42%	42%
• Trained Hilot	24%	23%	25%
• Untrained Hilot	4%	5%	5%
• Others	2%	1%	1%
• Unknown	0.5%	0.5%	0.5%

Source: Field Health Service Information System, Department of Health. Note 1998 is preliminary data.

Several non-government organisations (NGOs) have reported that the Department of Health's plans for privatisation of health care services (Health Action Information Network 1997, del Rosario 1997, Council for Health and Development 1998) will make health care among vulnerable groups likely to become increasingly inaccessible. This is principally because of rising costs of drugs in the wake of the 1997 economic crisis,

The Micro Impacts of Macroeconomic Adjustment Policies (MIMAP) project extrapolated impacts on nutrition and access to health care based on MIMAP quantitative models (Mandap and Reyes 1999). They reported that an expected decline in household incomes and an increase in prices would negatively impact on the demand for different health care facilities. For home care and public facilities, demand is projected to increase while use of private clinics and hospitals visits is expected to decline. A shift from private to public utilisation of health care facilities and services is also likely due to escalating costs of health care.

Tuberculosis Program Coverage

Tuberculosis was the leading cause of mortality and morbidity pre-crisis in the Philippines. The WHO 1997 Annual Tuberculosis Report estimated that 22 million Filipinos are infected with TB and that 270,000 are reported to develop active tuberculosis each year (World Health Organization 1998). The country has the lowest coverage in the Western Pacific Region of multi-drug therapy for tuberculosis, otherwise known as Directly Observed Treatment Short-Course (DOTS), making improved TB control a priority (1997 Health Action International Network). The effectiveness of the tuberculosis control program is threatened by the negative effects of decentralisation and rising cost of drugs as a consequence of the economic crisis (World Health Organization 1999, Tropical Disease Research 1999, Council for Health and Development 1999). It is likely that increased prevalence and incidence of tuberculosis will result if funding and management issues are not addressed.

1.4 Health Outcomes in Vulnerable Groups

Mortality

The Infant Mortality Rate (IMR) decreased from 48 per 1,000 live births in 1993 to 36 in 1998 according to the National Demographic and Health Survey (National Statistics Office 1998). However, the picture was heterogeneous with 63% of the country's 16 regions having an IMR higher than the national level - the worst IMR of 60.8 per 1,000 live births being in Region VII (Eastern Visayas). This picture is contradicted by data from the United Nations which reports that the IMR in 1996 was lower than that quoted by the National Statistics Office at 32 per 1000 (UNAIDS/WHO Epidemiologic Fact Sheet 1998). Data inconsistencies make it difficult to asses the impact of the crisis on IMR and in addition, it is early in the course of the crisis and little if any impact would be expected on mortality rates at this stage.

Morbidity

Table 9 documents the leading cause of morbidity (per/100,000) in vulnerable groups between 1996 and 1998. Overall changes are mostly insignificant.

Table 9: Leading cases of morbidity (per 100,000) 1996 to 1998

Group	1996		1997		1998	
	Cause	Rate/ 100,000	Cause	Rate/ 100,000	Cause	Rate/ 100,000
Children aged < 5yrs	1. Diarrhoea	5 464	1. Diarrhoea	5 319	1. Diarrhoea	5 542
	2. Pneumonia	4 107	2. Pneumonia	4 521	2. Pneumonia	4 400
	3. Bronchitis	2 555	3. Bronchitis	3 004	3. Bronchitis	2 851
	4. Influenza	1 380	4. Influenza	1 383	4. Influenza	330
	5. Measles	140	5. Chickenpox	393	5. Measles	127
Women (aged 15-49 yrs)	1. Influenza	412	1. Influenza	420	1. Influenza	461
	2. Diarrhoea	296	2. Diarrhoea	296	2. Diarrhoea	323
	3. Bronchitis	248	3. Bronchitis	283	3. Bronchitis	296
	4. TB	120	4. TB	135	4. Hypertens'n	152
	5. CVS	56	5. Pneumonia	114	5. TB	128
Elderly (>65 yrs)	1. Influenza	904	1. Pneumonia	1 060	1. Diarrhoea	2 283
	2. Bronchitis	821	2. Influenza	971	2. Hypertens'n	1 000
	3. Diarrhoea	638	3. Bronchitis	608	3. Influenza	846
	4. TB	576	4. Hypertension	644	4. Bronchitis	733
	5. CVS	459	5. Diarrhoea	629	5. Pneumonia	572

Source: Field Health Service Information System, Department of Health. Note 1998 is preliminary data

In the elderly the rate of diarrhoea appear to have doubled from 1997 to 1998, but rates of influenza, pneumonia and bronchitis have dropped. The increase in rates of diarrhoea were not seen in other vulnerable groups. In children, morbidity rates for the major diseases remained reasonably stable although the rate for influenza dropped from 1997 to 1998. It should be noted that measles features in the top five cause of morbidity in young children for both 1996 and 1998, reflecting low EPI coverage.

Nutrition

An important nutritional part of the SSN program is to supplement micronutrients in children's and mother's diets. The 1993-98 Philippine Plan of Action for Nutrition targeted vitamin A, iodine and iron as the three important micro-nutrients for supplementation. By and large the micro-nutrient programs have been maintained. Vitamin A supplementation in targeted children's diets fell in 1997, but increased to 1996 levels again in 1998. Supplementation of iodized salt capsules, targeting married women of child bearing age, was discontinued in 1995

and reinstated in 1998. The use of iodized salt increased from 9% of the population in 1995 to 23% in 1998 through the national salt iodination program. Iron supplementation for infants, school children, pregnant and lactating women was not as successful as the Vitamin A supplementation campaign. (Centre for International Economics, 1999)

In 1998, the Asian Development Bank reported that post crisis teachers had observed that children appeared to be eating less before coming to school which adversely affected their ability to concentrate (Pernia and Knowles 1998). However, a later ADB household survey conducted in 1999 confirmed that meal skipping is not prevalent and does not appear to have resulted in higher incidence of malnutrition though eating patterns being modified (Reyes et al 1999).

Health Department data (Table 10) appear to indicate a fall in malnutrition among children aged 6-59 months from 1996 to 1998 – both in the proportion of moderately and severely underweight children. There has been minimal change in the proportion of pregnant women given or iodized oil. Vitamin A distribution to women and children is also stable.

Table 10: Nutritional indicators 1996 to 1998

	1996	**1997**	**1998**
Moderately underweight children 6-59 mths (%)	13.5%	9.9%	7.8%
Severely underweight children aged 6-59mths (%)	4%	2%	1%
Pregnant women given complete iron course (%)	40%	42%	38%
Women given Iodized oil (%)	21%	17%	4%
Vitamin A given (%)			
• Lactating women	52%	50%	49%
• Children (9-11 mths)	67%	72%	73%
• Children (12-59mths)	94%	93%	90%

Source: Department of Health. Field Service Information Annual Report

The MIMAP simulation suggested that the principal impact of the crisis – in combination with the El Niño drought – was that the lower income deciles were experiencing larger percentage declines in income (*Table 11*) and that poverty incidence will increase from the 32.1 per cent registered in 1997 (Mandap and Reyes 1999).

Table 11. Impact of the Financial Crisis on Income of Households by Decile, 1998

Decile	Percent Change in Income
1*	-7.28
2	-7.08
3	-6.82
4	-6.65
5	-6.30
6	-5.87
7	-5.50
8	-5.06
9	-4.86
10**	-4.64

*(poorest: below P2,000 per month) **(richest: more than P10,000 per month) Source: Mandap and Reyes 1999

The same model suggests that the decline in food intake will be greatest for the poorest quintile (*Table 12*). The main source of calories in the Philippines is cereal which accounts for 78 per cent of the poorest quintile's food intake. As cereal prices increased by 3.9 per cent in 1998 it is likely that the poorest quintile will suffer the largest decline in calorie availability. Given these quantitative projections, it is likely that the prevalence of malnutrition will increase over the next 12 months.

Table 12. Impact of the Financial Crisis on the Demand for Food (per cent change)

Commodity	Quintile				
	1*	2	3	4	5**
Cereal	-12.7	-10.5	-8.4	-8.4	-9.1
Fruit	-20.5	-25.2	-27.7	-25.2	-25.0
Meat	-20.9	-17.8	-16.9	-16.3	-14.0
Dairy & Eggs	-14.5	-19.9	-19.0	-17.5	-15.4
Fish	-18.7	-17.3	-19.3	-17.2	-16.6
Beverage	-11.9	-10.9	-10.2	-7.4	-8.2
Others	-13.4	-14.3	-14.2	-13.2	-13.0

*poorest **richest. *Source:* Mandap and Reyes 1999

Women's Health

Maternal mortality rates remain high – at approximately 180/100,000 births. The crisis may impede reduction of this figure and it may remain high until devolution of budget and capacity to Local Government Units is completed for maternal and child health services (Centre for International Economics, 1999).

Anecdotal information collected from focus group discussions suggests that women and children in some poor communities are being forced into prostitution (Reyes et al. 1999). There have also been reports of increased drug peddling, crime, domestic violence and growing numbers of street children (Pernia and Knowles 1998).

Other health outcomes

One positive impact that can be attributed to the economic crisis was the sharp drop of firecracker injuries by 58 per cent in 1999. This was attributed to the reduced ability of people to purchase firecrackers coupled with aggressive television advertisements in previous New Year celebrations (Health Action International Network 1999).

1.5 Impact of the Crisis on Availability and Costs of Health Care, Drugs and Consumables

Cost of Drugs

The depreciation of the peso had a significant effect on the cost of pharmaceuticals, which increased in price by 5 per cent to 40 per cent in the last six months of 1997 (Health Action International Network 1998, Council for Health and Development 1998). An ADB focus group study estimated that drug costs rose by 20% and that both hospital and private costs had risen (Centre for International Economics, 1999). The prohibitive costs of pharmaceuticals are illustrated by the example of Inderal, a commonly prescribed drug for hypertension, which in 1998 cost P894 for a month's supply. This compares with the minimum monthly wage for a worker in Manila in the same year of P175.05 (IBON Facts and Figures Vital Statistics 1999).

The Council for Health and Development (CHD), a non-government organisation with a conglomeration of community-based health program networks, reported that 90 per cent of tuberculosis patients could not afford to buy anti-tuberculosis drugs in 1999. A six-month regimen of the standard tuberculosis treatment in 1998 cost P7, 023 compared to P5,533 in 1994 (The Council for Health and Development 1998; Health Action International Network 1994). A 40 per cent mark up in the cost of imported consumables like medicines and vaccines added to the cost of essential drugs (Health Action Information Network 1998).

A household survey in 1999 suggested that the average allocation of income for medical and health costs had risen from 7.9 per cent in 1997 to 8.1 per cent in 1998 (Reyes et al. 1999). Focus group responses from the same study suggested that households tended to place health expenditure in a lower priority and also to rely more upon free or cheaper sources of health care such as government services, traditional healers, and self-medication. According to the findings of this focus group, "health care from private practitioners or hospitalisation had become a luxury" (Reyes et al. 1999).

Section 2: Response to the Crisis

2.1 Philippine Government Response

The Philippine Government is presently undertaking a comprehensive health sector review. Key medium term health policies are to improve the health, nutrition and population outcomes for the poor. A World Bank loan is supporting this initiative which includes;

- guaranteeing the provision of minimum basic health care to the underprivileged and vulnerable groups under a devolved public health system
- strengthening the capacity of local primacy health care services
- reforming hospital management and financing structures
- restructuring the Department of Health
- establishing a sustainable system for health financing (World Bank 1999, Centre for International Economics, 1999)

Principal components of Philippine Health Department initiatives include immunisation programs for children (encompassing EPI vaccines) and also tetanus toxoid for women. The program has continued through the crisis and coverage levels appear to have been sustained. The 1999 budget proposes to accelerate the implementation of various foreign assisted health projects and also proposes to create a poverty alleviation fund to back up social services and supplement departmental resources in an effort to reach the most vulnerable (Centre for International Economics, 1999).

The number of children reached by supplementary feeding fell in the mid 90s to 0.7 million, but increased to almost one million in 1998 as a result of the government response to the crisis through a variety of educational, health and social welfare sponsored programs for child nutrition (Centre for International Economics, 1999)

The National Food Authority (NFA) has implemented rice subsidies in four provinces in April 1998 (Reyes et al. 1999). Pre-crisis programs were continued such as the Enhanced Retail Access for the Poor *sari-sari* stores, which sell basic commodities like sugar, coffee, cooking oil, milk, sardines and noodles at lower prices to the poor. They also offered discounts worth P2.50 per kilo of NFA rice. In the second phase of the rice subsidy program, iron fortification (Enriched Rice for Anaemia Protection) was provided in two provinces. Iron fortified NFA rice was subsidised at P1.04 per kilo.

In his 1999 Budget Message, President Joseph Estrada pledged to enhance the delivery of basic health services, particularly in the rural areas and set a government target of increasing life expectancy from 68.6 years to 69.5 years by the year 2002. A special program to assist rural communities with no doctors was implemented by providing a pool of rural health physicians. Approximately P93 million is to be set aside to subsidise the premiums of indigent households for the National Health Insurance Program. This sum is in addition to subsidies for indigent patients treated in private hospitals (Department of Budget and Management 1999).

An important nutritional part of the SSN program is to supplement micro-nutrients in children's and mother's diets. The 1993-98 Philippine Plan of Action for Nutrition targeted vitamin A, iodine and iron as the three important micro-nutrients for supplementation.

2.2 External Crisis Related Assistance to the Health Sector in the Philippines

The World Bank has seven ongoing projects in health, education and social services worth nearly USD400 million as well as programs aimed at public sector management. The Bank has indicated that it intends to work with the Government of the Philippines to:

- improve the health, nutrition and population outcomes of the poor
- enhance the performance of the health care system by supporting the integration of local primary health care delivery systems
- improve the targeting of public health investments to public health priorities

The World Bank has also indicated - together with partners including UNICEF and the ADB – that it will conduct a detailed review of the Philippines health care sector with a view to developing a policy framework to deal with such issues as the mismatch between central funding and local delivery of health services, devolution, and regulatory and technical capacities at the central level (World Bank Social Crisis in East Asia Health and Nutrition in the Philippines 1999). In association with ASEM the Bank has provided USD1 million for Enhanced Poverty monitoring in response to the Asian Financial Crisis to assist the National Statistics Office to design and conduct an Annual Poverty Incidence Survey.

In March 1999, the Philippine government sought USD5.5 billion in official development assistance (ODA) pledges from the international donor community during its Consultative Group Meeting in Japan. The funds are to assist with implementing "pro-poor" programs, especially those that focus on education, housing, and basic health care (World Bank Development News 1999).

The ADB has over USD500 million committed to social infrastructure development that covers Health and Education. An Early Childhood Development Loan (USD25 million) was approved in 1998 to support health, nutritional and educational development of children under 6 years. UNICEF has a 19 project program aimed at child survival, protection and development.

USAID has several programs in the country, including the Improved Maternal and Child Health Project (USD22 million) which is increasing public sector provision of maternal and child health services at local government level from 1995-2001. A Health and Nutrition initiative (USD2.2 million) in 1999-2000 aims to provide assistance to selected local government projects, ie, raising Vitamin A coverage, management of childhood illness, and training health workers.

AusAID's Philippines Country Strategy Program (1998/99-2002/03) recognised the adverse effects of structural readjustment, the Asian financial crisis and the El Nino/La Nina weather patterns on the poor. The strategy identified the need for a Vulnerable Groups Facility (VGF) as a short term mechanism to support SSN programs. The objective of the VGF is to increase basic social services to vulnerable groups by funding successful and well targeted Philippine Government activities which provide such services and which face current budgetary

restrictions. Activities have to be currently operational and have demonstrated effectiveness in meeting their objectives. Two programs have been accepted for funding:

- The Comprehensive Integrated Delivery of Social Services Program (CIDSS) – funding of A$15 million over 3 years.

- The Street Children Nutrition and Education Project (SCNEP) – funding of A$9 million over three years.

Other AusAID projects include the Mindanao Maternal and Child Health Project (funded jointly with UNICEF A$2.8 million; 1997 to 1999). AusAID is also involved in another UNICEF project to protect exploited child laborers which has provided A$1.2 million over 1997 to 1999 to protect children involved in exploitative or hazardous work situations.

Section 3: Potential Areas for Donor Response

3.1 Study Constraints

The following constraints should be noted:

1. Monitoring systems for assessing the impact of the crisis on the health sector are inadequate. Most available data pre-date the crisis; hence, opportunities for comparative analysis are limited. Contradictions in data between sources have been evident and these have been noted in the text. A Department of Health official revealed that "there is no unit or task force monitoring the impact of the economic crisis on the health sector" (Personal Communication from the Special Assistant for Policy, Planning, and Research Department of Health, 1999).

2. Causal links between the crisis and health outcomes have been difficult to establish. In some cases, trends were already discernible prior to the crisis (eg., decline in contraceptive use by women). Factors such as devolution and the effects of natural disasters might also have affected immunisation, nutrition, family planning and tuberculosis control programs.

3. Potential community-based monitoring systems are related to several specific development projects like MIMAP, Community Integrated Development SS, Minimum Basic Needs (MBN). These monitoring systems do not operate on a regular basis and may not necessarily reflect issues arising from the crisis.

3.2 Summary of Impact of Crisis

The Philippine GDP did not fall as sharply as other ASEAN countries, but the crisis does threaten the sustainability of previous gains in health and nutrition. The impact of the crisis was compounded by two other factors; ongoing decentralization of government and adverse weather patterns (El Nino and La Nino). Macroeconomic responses to the crisis were quick and apparently stabilising. A World Bank review assisted in prioritising expenditure to protect vulnerable groups. Emergency rice imports were permitted without tariffs which protected low income earners diet staple. Excessive interest rates were prevented and promotion of wage restraints moderated increases in inflation and unemployment.

Despite the resilience of the Philippines to the crisis so far it remains vulnerable to a continuation in the situation. Structural weaknesses have resulted in problems responding to the crisis. There has not been a discernible deterioration in nutrition or health that can be directly attributed to the crisis. However, given the preexisting high levels of poverty (a third living below the poverty line) and the meagre SSN in place this may not be the case in the foreseeable future. (Centre for International Economics, 1999).

Areas of potential impact include:

- declining incomes, loss of employment, and rising food prices increase the threat of malnutrition (in particular micro-nutrients) - in the very young, reproductive age women and the elderly

- reductions in government expenditure reducing health care services for the poor

- budget cuts for health programs being introduced "across the board" instead of in a strategically targeted way

- dysfunctional budgetary arrangements between central revenue allocation and local government health care within the decentralized system of the Philippines, resulting in under-funding of key health programs

- disruptions in a range of vital health projects such as TB, HIV/AIDS, vaccination programs and family planning

Recommendations for donor action

Immediate

- Provide support for elements of programs that are currently inadequately covered by the government budget. Supplementary budget support should be considered for existing special programs such as TB, immunisation, HIV/AIDS, and family planning. A focus of support for HIV/AIDS could be the provision of antiretroviral drugs and other effective interventions to HIV-positive pregnant women to reduce the risk of perinatal transmission of the virus. Purchase of contraceptives and promotion of FP services at the PHC level should also be supported. Consideration should be given to Hepatitis B immunisation programs for infants and children – this vaccine ceased to be provided nationally from 1998 due to the impact of the crisis.

- Policy and financial support should be provided to assist with the procurement of essential drugs. Review should be undertaken of current policy and practice and promotion of rational use of drugs, increased use of generic drugs and standardised prescribing practices instigated. Logistics systems also need improving.

- While there is little hard evidence of a nutritional impact of the crisis, a third of the Philippine population exist below the poverty threshold and are vulnerable to the impacts of reduced incomes and rising food prices. The effects on nutrition may not be immediately apparent, but children and pregnant and lactating women are at greatest risk. NGO-based crisis supplementary feeding projects should be supported for such vulnerable groups

- Commitment to essential primary health care projects at the community level is essential. There has been an emphasis on curative services rather than preventative services with an over-concentration of resources on hospitals. Emphasis needs to be on provision of promotive and preventive health services in particular to rural and poor urban areas. NGO-based health projects targeted at vulnerable groups should be supported

- Support should be promoted for a strengthened and expanded health monitoring system that would increase the capacity to assess the impact of the crisis in rural and urban poor. This system should also include surveillance of child and maternal nutritional status and complement initiatives in this area being undertaken by the ADB and AusAID. Studies should focus on particular disadvantaged groups, such as the urban and rural poor, unemployed, female-headed households, and homeless children.

Longer Term Assistance

- Support should be given to development of health care financing initiatives including cost recovery, more effective targeting of government subsidies, the development of a stronger planning and policy capability in the field of national health insurance to improve long term sustainability of the health system.

- Support should be given to strengthen health information systems and provide assistance in the training of health information managers. Monitoring systems and health service studies on utilisation rates, service costs, etc. should include assessments of the quality of health services being provided.

- The devolution of responsibility for health services to LGUs has resulted in a need to strengthen planning and management skills in LGUs to ensure that appropriate and high quality health services are provided. Assistance should be given with the training of financial planning officers at both the national and local levels to address some of the complications brought about by devolution and intensified by the economic crisis. At the national level the DOH requires support to provide technical leadership for national health programs.

- As the leading causes of death in the Philippines has shifted from those relating to communicable diseases to those related to non communicable and work and environmental factors, support should be provided to expanding health promotion programs, especially those aimed at preventing non-communicable diseases and injuries This support should initially be in the form of applied health research, especially interventional research studies that develop appropriate strategies in the context of the Philippine health profile, culture, risk behaviours, and available resources. Support to health promotion programs will eventually lead to increased cost-efficiency in the health sector as healthier communities require less expensive clinical services to manage chronic diseases.

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