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Health and Access in Metro Manila

Challenges and Possible Ways Forward[1]

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Introduction

The health sector is the largest service devolved to local governments units (LGUs) by Republic Act No. 7160 or the Local Government Code (LGC) of 1991. However, devolution has not automatically improved health service delivery and made accessible services across LGUs. Health human resources, budget, and facilities are spread unevenly across the country, with Metro Manila or the National Capital Region (NCR) and other centers having more of these. Because NCR has many advanced health facilities, most case studies on health services and devolution focus on rural areas where services are very basic and limited. However, NCR also experiences uneven access to health services.

Thus, it is important to look at NCR's health situation and access to services and discuss possible institutional and other reforms, especially with the current national administration's proposals to initially revise and now amend the 1987 Philippine Constitution. It is also important in the context of NCR's LGUs currently dealing with COVID-19 and its consequences, especially for vulnerable sectors. This policy brief utilizes the human security approach and relies on available assessments of the situation and access to health services in NCR.

Human Security, the Human Security Approach, and Health Security

Human security shifts security's definition from a traditional military-oriented, state-centric view to a more people-focused one. It has three dimensions, namely: freedom from fear, freedom from want, and freedom to live in dignity. It addresses the protection of people from "critical (severe) and pervasive (widespread) threats and situations … using processes that build on people's strengths and aspirations" (CHS 2003, 4). Thus, the human security approach targets the vulnerable and directly addresses factors that increase vulnerability to poverty, disease, conflict, and disempowerment (Mani 2005). It has both top-down (protection) and bottom-up (empowerment) approaches and requires mechanisms to be established at different levels of government and multilevel governance to address threats.

The United Nations Development Programme (UNDP) (1994) includes *health security*, which is concerned with "the protection of individuals from sudden or chronic health threats and efforts to empower individuals to lead healthy lives" (Andersen-Rodgers and Crawford 2018, 180), under human security. Health concerns become security concerns "when they arise from systemic inequality or deprivation created by societal norms surrounding individuals' health needs, the weakness or inefficiency

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of health care institutions, or…the structural instability imposed by active armed conflict or state collapse[;]" they arise from the state's failure to protect the population or some segments of it from harm (ibid., 180–81).

Devolved Structure of Health Services

The LGC brought about significant changes in the public health system. The decentralization of health services is described as the most radical in the developing world in terms of scope of devolved personnel, finances, facilities, and responsibilities (Atienza 2004, 32; World Bank 1994, 49). A large part of the services devolved to LGUs is borne by provinces and municipalities; large cities, or the highly urbanized ones, are chartered and have administered and financed their own health systems years before 1991.

Problems and Issues of the Public Health System

Due to devolution, LGUs gained significant powers and responsibilities in health service delivery. However, various issues immediately surfaced: (1) financial constraints like inadequacy of the Internal Revenue Allotment (IRA) share and its skewed distribution, benefitting cities while provinces and municipalities' shares are not commensurate with devolved responsibilities; (2) health personnel issues like low pay, low promotion prospects, and possible conflicts with local elites; and (3) LGUs' possible lack of prioritization or competence in health.

Almost thirty years since the Code's enactment, despite some trailblazing local governments with successful health programs, reforms made by the Department of Health (DOH), and some national laws addressing health devolution-related issues, problems remain, particularly in health financing; health personnel; and organization/structural issues, like some non-functioning Local Health Boards (LHBs), NGOs' non-representation in some LHBs, and the fragmented health care delivery system (Cuenca 2018).

Adjustments in the Public Health System

After the 1992 elections, health workers clamored to recentralize health services. Congress passed a bill postponing health devolution, which President Fidel Ramos vetoed in 1995, further institutionalizing devolution.

Despite experiencing the most difficult transition among the devolved agencies, the DOH has worked hard in making the necessary adjustments. It restructured itself, implemented the Health Sector Reform Agenda, and created programs to assist LGUs to fulfill health responsibilities and achieve national health goals. It has encouraged more participatory mechanisms in service delivery (GOLD Project 1999, 4–6).

Two recent developments may have long lasting impacts on the delivery of health services and access to these. The Supreme Court decided in 2018 and reaffirmed in 2019 to define the LGC's provision of the 40 percent share of LGUs from national taxes to be based not just on national internal revenue taxes but all "national taxes" as stated in the 1987 Constitution. Then, the 2019 Universal Health Care Law grants all Filipinos basic health coverage in order to lower out-of-pocket expenses, particularly for the poor, and tries to solve the fragmentation of the public health system and increase people's access to health services. Its success, however, depends on funding, availability of skilled personnel, LGUs' readiness or receptivity, etc.

Health Status, Access, and Equity in Metro Manila

The National Capital Region

NCR is composed of 16 highly urbanized cities and one municipality. It is the country's political, economic, and social center though "the smallest and most densely populated region in the country" (UN OCHA 2017). It contributes about 36 percent to the country's gross domestic product (GDP) (World Bank Group 2017). In 2015, NCR's population was 12,877,253, representing 12.8 percent of the country's population. Quezon City and Manila have the biggest populations (PSA 2016).

Despite its economic growth, NCR in 2012 had an estimated 1.3 million or 11 percent of its population living in informal settlements (World Bank Group 2017). This represents nine percent of the country's urban poor, which may be relatively low compared to national statistics, but "disparities in living conditions are most evident in urban areas"

(ibid., 3–4). The urban poor face multiple forms of exclusion (from basic infrastructures, services, and economic opportunities) and are most vulnerable to environmental hazards.

Health Facilities, Personnel, and Services

NCR's health facilities and personnel are significantly higher than in other regions. In 2013, it has the most endowed hospitals in terms of machines and equipment (Dayrit et al. 2018, 223); however, most are private hospitals which are very expensive.

Public hospitals, where the poor normally go, have deficiencies. DOH data show a 1:800 ratio of hospital beds to people in government hospitals with poor support facilities in 2017 (de la Cruz 2017). Three in 10 health facilities in the Philippines lack clean toilets, with NCR's facilities heavily affected by the 2019 water shortage (Cabico 2019). COVID-19 further exposed the lack of basic and specialized supplies like masks, alcohol, ventilators, and personal protective equipment.

The number of health professionals, especially in public hospitals, is insufficient. While the lack of personnel is higher in other regions, NCR's numbers are still insufficient compared with its population. It lacks 594 doctors based on the accepted standard of 1.1 doctors per 1,000 population (David et al. 2019). In community or primary health care, there are only 3.3 midwives per 10,000 population in 2017, much lower than 12 other regions (Dayrit et al. 2018, 144).

Patients have to be admitted despite lack of personnel, but the quality of services suffers due to the constraints; health workers also suffer from overwork, burnout, and diseases. Personnel are also not immune to attractions of higher pay and perceived better working conditions abroad.

The public health system's limitations lead to its inability to control diseases prone to spread in congested urban areas. Since last year, DOH's and NCR's health officials have been challenged by dengue, leptospirosis, and measles. Now, COVID-19 adds to the challenges.

Because NCR's public health facilities are a combination of both local and national facilities, the inadequacies can be attributed to both the LGUs' and the DOH's limitations and inefficiencies. Each LGU has a different appreciation and prioritization of health. It is also difficult to attract health professionals to work in public hospitals and facilities given the low salaries and difficult conditions. In addition, the national government has been perennially giving the health sector less than the proposed budget annually. The DOH itself has inefficiencies in management.

Access to Public Health Services

Health outcomes of "Filipinos living in urban slums are worse than those living in non-slums, and sometimes worse than those living in rural areas" (Carpio 2018). NCR's informal settlers face many difficulties, like accessing clean water, medical services, and other health services (World Bank Group 2017), leading to health, nutrition, and environmental problems. Overcrowding also means overcrowded health facilities. Unless they are organized and/or have ties with LGUs, especially with *barangay* governments, they are excluded from decision-making processes that affect them (ibid., 89). Madcasim's study (2018) of Quezon City and Manila found that discrimination based on income, religion, and ethnicity occurs in service delivery and access to facilities; local government officials can exploit health services for patronage and corruption; and not all LGUs partner with the private sector and civil society in service delivery.

Ways Forward

Federalism or Metropolitanization

Since coming to power in 2016, the Duterte administration has pushed shifting to a federal form of government. The NCR was designated by the draft Bayanihan Constitution of the Consultative Committee as a special metropolitan region. Unfortunately, the draft federal constitution did not get the support of both Houses of Congress in 2018.

The administration's cuurent strategy, through the Inter-Agency Task Force headed by the Department of the Interior and Local Government (DILG), is to focus on "surgical amendments" to the 1987 Constitution, particularly in including the recent Supreme Court decision that all LGUs are entitled to a 40 percent share of all national collections and transforming the Regional Development Councils

(RDCs) into Regional Development Authorities with their own budget and power to implement development plans (Atienza 2019).

What could be the implications of federalism for health service delivery in the Philippines, particularly for NCR?

Federalism provides both opportunities and issues for health service delivery (Atienza 2017). Bhatia and Haussmann (2014, 1) noted that "[f]ederal systems are prone to dividing health benefits inconsistently across subnational jurisdiction," and there are "significant subnational variations in access to health services and insurance coverage." There are also different models of health administration and delivery across federal countries that vary in income levels and systems of government. While federalism usually provides opportunities for more experimentation at the state/regional levels, meaningful social change itself through non-discriminatory policies supporting various sectors is only possible if it comes from the ground up, coupled with more progressive legislation and innovative practices at all levels, branches, and agencies of government, political parties, and other organizations (Jamieson 2012; UN 2003).

Based on actual cases, federalism in itself will not automatically improve health service delivery and citizens' access (Atienza 2017); it can further entrench existing disparities. A number of issues, some already evident now, must be addressed to improve health in a federal setup. Some recommendations are as follows (ibid.):

(1) Exemplary and inclusive local health innovations can be replicated, scaled up, or adjusted for different settings like NCR's.

(2) The improvement of health services across geographic and political units may be addressed through better intergovernmental coordination mechanisms and working accountability mechanisms.

(3) Local success in quality of services and democracy require active civil society, citizens, and leadership and technical capacities and resources of regional/state and local governments.

(4) Complementary legal reforms are needed in electoral systems, political parties, anti-poverty programs, accountability institutions, and monitoring of central government.

(5) Responsibilities, like health, across all levels of government and other stakeholders should be clearly defined.

While the proposed shift to a federal form may have lost its momentum, it is still possible to discuss the potentials of a metropolitan regional government. A regionally-elected body with an empowered RDC may be able to address some of the common problems faced by NCR, including health service delivery. However, many of the same issues related with a full federal shift and implications on health service delivery must be resolved. Furthermore, the readiness and openness of different stakeholders, including mayors and other local officials, to this possible reform must also be considered.

New mayors in NCR may have opened more doors for the possibility of a metropolitan government (CNN Philippines Staff 2019b; Tuquero 2019), supported by the recent pro-active LGU responses to COVID-19 in NCR and concerted efforts of mayors to address the pandemic as one geographical area through the Metro Manila Council, but plenty of discussions are still needed, particularly in terms of coordination and shared responsibilities and delineating which levels of government have jurisdiction over certain functions, including health facilities, personnel, and services.

Finally, creating a regional metropolitan body for NCR even without fully shifting to a federal form for the country will require amendments in the Constitution's Article X which mandates the creation of only two autonomous regional governments (Muslim Mindanao and the Cordilleras).

Amendments in the 1991 Local Government Code

The Code is ripe for a number of amendments that can be prioritized for improved and inclusive health services, including in NCR. The Inter-Agency Task Force is now pushing for amendments like revising the revenue share distribution formula based on need, responsibilities, and performance and empowering the RDCs to become true planning and implementing authorities. However, other amendments are needed, like making mandatory the inclusion of sectoral representatives in the local legislative councils, clear

budget for devolved services like health, and limits to political dynasties.

Community Participation

Using the human security approach and people empowerment which is one of decentralization's major principles, improving and making accessible health services cannot be addressed solely through top-down/protection-focused reforms. Bottom-up/ empowering reforms are also needed. Institutional reforms and informed and committed local officials may be available, but they need partnership with other stakeholders, like civil society, the private sector including hospitals, and government agencies. As shown by other countries with federal systems and the country's successful LGUs in health service delivery, community empowerment and participation in local decision-making bodies are needed. Community or primary health care systems focusing on health promotion and preventive approaches must also be strengthened to avoid overwhelming hospitals.

The human security approach also calls on LGUs and NCR, together with various stakeholders, to focus not just in making health services inclusive and equitable. They need a more comprehensive long-term approach addressing the major sources of vulnerability, such as poverty, hunger, lack of sustainable livelihood, and poor sanitation and environment, which affect the constituents' health.

Conclusions

Metro Manila LGUs, despite having more health facilities, budget, and personnel compared with other Philippine LGUs, still have problems addressing constituents' needs. Several conclusions can be made. First, health is a security issue in highly urban NCR with poor, marginalized, and informal settlers having difficulties accessing health services. Second, health issues are not just about want; fear of health threats and inability to access health services lead to insecurity. All citizens deserve to live in dignity, including access to quality health services. Finally, protection and empowerment approaches are both needed to enable vulnerable sectors to access services. While institutional reforms are warranted, NCR needs an enabling environment where partnerships with various duty-bearers are developed and sustained, and communities are participants in improving the community's overall health. ■

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