The Impact of Structural Adjustment Programs (SAPs) on Health in the Philippines

NYMIA PIMENTEL SIMBULAN

For almost four decades now, the Philippine government has relied primarily on foreign loans from two major multilateral lending institutions, the International Monetary Fund (IMF) and the World Bank (WB) for its economic growth and development and to settle its ballooning foreign debt and balance of payment (BOP) deficits. Since the 1950s, loans to the Philippines have included stabilization loans, standby arrangements, extended fund facilities, sectoral and project loans, and beginning in the 1980s, structural adjustment programs (SAPs). These loans were given in tranches with policy conditionalities and performance targets tied to their release.

Since the Philippines received its first SAP loan (SAL I) in the 1980s amounting to US$200 million, the state of its economy has deteriorated further, forcing the country to borrow more as it sought to address its economic and financial problems. But the principal objectives of SAPs are the promotion of free trade, economic growth and efficiency so that development issues such as equity, poverty alleviation, income-distribution and respect for human rights have usually figured

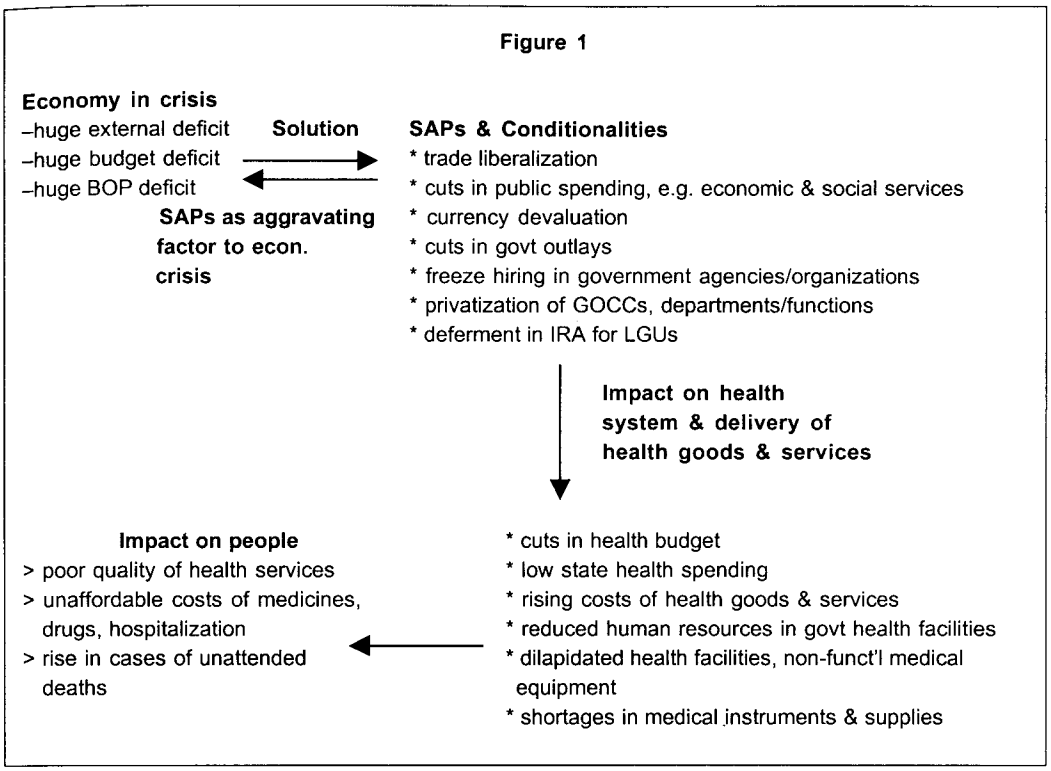
only as secondary concerns (Broad, 1988; Brohman, 1997). Indeed, studies have shown that SAPs work against the interests of debtor countries like the Philippines, resulting in the worsening of living conditions and in gross violations of human rights (Orbeta, 1996; Brohman, 1997; Ofreneo, 1991; Bruin, 1999). Loan conditionalities and neo-liberal policies integral in SAPs such as cuts in real wages, food subsidies, health care and education expenditures continue to generate high social costs, especially for the poor and other disadvantaged groups (Brohman, 1997). Indeed, Brohman (1997) and Bruin (1999) have pointed out that the brunt of the adverse effects of neo-liberal policies such as liberalization and privatization, under SAPs, have consistently fallen on the poor. This is particularly evident in widespread job losses in many labor-intensive and domestically-oriented economic sectors; a decrease in the level of real and minimum wages and in the rise of unemployment; an increase in the prices of food and other basic goods because of cuts in state subsidies; reduction of many basic social services specifically in health and education and the disappearance of many programs and special forms of assistance for the poor.

Below is a diagram illustrating the impact of SAPs on the health care system, particularly on its budget and the delivery of health services, and its effects on people's health. (See Figure 1)

This paper seeks to illustrate the major effects of SAPs on the health budget and on the state's obligation to provide quality, affordable and accessible health care goods and services to the Filipino people from the period 1986 - 1999. It describes the major features and contents of SAPs and how its conditionalities were translated into laws, policies and programs to ensure compliance by the national government.

Brief backgrounder on the SAPs

Structural adjustment program loans (SAPs) refer to macroeconomic policy reforms which seek to improve economic efficiency, increase growth and correct fundamental imbalances in the external and public sector payment accounts of a country such that these are supportive of medium-term development efforts (Clarete,



1996; Montes, 1988; Bello, et al., 1982). Ordinarily, these are loans extended by the IMF-WB to low-income governments experiencing huge external debts, chronic budgetary, trade and BOP deficits, and which require major structural and/or sectoral changes in their financial and economic systems. For many developing countries such as the Philippines, changes would involve the re-shaping of a whole economic sector(s) such as agriculture, industry, banking and/or energy.

Basically, SAPs are based on the neo-liberal philosophy which emphasizes the role of the free market at the same time that it de-emphasizes government intervention in the economy. These are guided by economic doctrines and strategies such as *trade liberalization*, i.e. the removal of trade controls or barriers like tariffs and quotas to allow the free flow of finished products between local markets; *privatization* which involves the turn-over of government enterprises, corporations and business concerns to the private sector for greater efficiency and increased income; and *deregulation* or the reduction, if not ultimate withdrawal, of government involvement

and/or intervention in business with private enterprises as the driving force behind economic development (Ibon Databank, 1997).

These doctrines are usually translated into policies, laws and strategies emphasizing macroeconomic balance, international competitiveness and improved public sector management, in addition to specific sector policies by national governments (Jayarajah, nd). In turn, such policy applications impact on taxes, wages and prices, government revenues and expenditures, local currency, trade, debts, provision of public goods and services, etc.

The first structural adjustment program loan (SAL I) amounting to $200 million and intended to solve the $570 million BOP deficits incurred by the Marcos government was extended by the WB to the Philippine government in 1980. It was given in two tranches, with the release of the first tranche contingent on the government's compliance with the condition that tariff rates be reduced by 20 percent and import controls deregulated.

It was followed by SAL II amounting to $302.3 million in 1983 which was granted on condition that industrial incentives and trade policy be reformed. This meant pursuing a national development program based on a foreign investment-led strategy, i.e. giving priority to foreign investors in terms of government infrastructure support and tax incentives. By the end of 1997, the Philippines had a total of nine structural adjustment programs with the WB (CASA Concept Paper, 1999; FDC, 1999).

Features of SAPs affecting health

From 1986 to December 2000 – a period that covered the administrations of former Presidents Corazon C. Aquino (1986 to 1992), Fidel V. Ramos (1992 to 1998) and Joseph Ejercito Estrada (1998 to January 2001) – the Philippine government received several structural adjustment and stabilization program loans from the IMF-WB. Among these were the 1985-1988 SAP, 1989-1991 Extended Arrangement, 1991-1993 Economic Stabilization Program, 1992 Economic Integration of the WB, 1994-1997 IMF Exit Program and the 1998-2000 Precautionary Standby-Arrangement.

The structural reforms to which each of the three administrations committed themselves were woven into the core objectives, policies and development strate-

gies stipulated in the Medium-Term Philippine Development Plans (MTPDPs). Essentially, the development programs of the past three administrations did not differ from one another in terms of vision, goals and strategies. The three administrations consistently adhered to neo-liberal policies and the principles of liberalization, privatization, deregulation and decentralization to attain economic growth and development, and to become globally competitive.

Policy objectives and conditionalities stipulated in the various SAPs from the early 1980s to 1999 had serious implications and effects on social services, specifically health, among these the following:

1. *Limiting/reducing public sector and national government deficits every year.* Fulfilling this policy objective meant rational spending and the efficient use of government resources including expenditure reduction and/or tightening of expenditure control. These led to wage freezes, cuts in yearly government budgets and subsidies, the maintenance of operational and maintenance expenditures, and a freeze in the hiring of government employees.
2. *Assumption by the national government of the external debt liabilities of government and private entities/corporations and the Central Bank (CB).* Because of the 1989-1991 Extended Arrangement, the national government had to absorb the P5 billion Central Bank deficit in clear disregard of the earlier objective of limiting national government deficits. Consequently, the country's debt and BOP deficit increased. The national government and its various agencies had to raise revenues to meet their financial obligations to private banks and multilateral financial institutions. A wage freeze, a freeze in filling vacant positions in the bureaucracy, reduction of subsidies to public corporations and reduction in government spending, etc., were among the austerity or belt-tightening measures taken.
3. *Reducing and/or maintaining general expenditures of sectors such as economic and social services to their previous levels.* The years 1998-1999 saw a 25 percent cut in discretionary expenditures. While the government said it would protect poverty alleviation programs or, in the inevitability of cuts, that social programs would be the first to be restored once conditions improved, these programs suffered anyway because of the financial crisis.

4. *Reduction of national government outlays*. This meant suspending or stopping the construction, expansion and/or improvement of government facilities and infrastructures including hospitals, sanitaria, medical and health centers, as well as the acquisition and repair of hospital equipment.
5. *Freeze in the hiring of new workers to replace those who left, or were laid off from, government service*. The implementation of this policy as a fulfillment of the conditionalities in the 1994-1997 IMF Exit Program left some 15,000 government posts vacant by the end of 1995. It also led to a decline in the total number of civil servants.
6. *Re-engineering of the bureaucracy to involve the merging, abolition, transfer, devolution to local government units and/or privatization of government departments or functions*. This key policy strategy led to the retrenchment and displacement of thousands of government employees including health and education workers in light of the government's objective to significantly reduce its work force (1994-1997 IMF Exit Program). In the name of streamlining and rationalizating the government bureaucracy, the following measures were instituted: (a) moratorium on the creation of new positions in the central offices of departments, (b) deployment of central office personnel in the regions, and (c) establishment of ratios for career and non-career positions, and central and field office personnel (NEDA, 1987, 1993 & 1999).
7. *Privatization of government-owned and -controlled corporations, departments and/or functions*. This is in line with the government policy of turning over to the private sector state enterprises and functions the sector is presumed to manage best with a view toward improving revenue-generating capacity and financial efficiency. The private sector is considered to be the true engine of economic growth and development. Privatization has consistently been incorporated in the Medium-Term Development Plans of the past three administrations (NEDA, 1987, 1993 & 1999). Privatization in the health sector is carried out by converting regional and tertiary hospitals into government corporations which function as autonomous financial bodies.
8. *Deferment of the internal revenue allocation (IRA) for local government units (LGUs)*. The policy of the Estrada government to defer 10 percent in

the IRA of LGUs adversely affected the delivery of health care services, especially since most of the functions of the Department of Health (DOH) were already devolved to the LGUs. This led to a reduction in the supply of medicines and medical supplies provided to various health facilities as well as in budget cuts for the operations of devolved health facilities such as municipal and district hospitals, clinics, health centers, etc.

SAPs and health policies, laws and programs

The programs, policies and laws in the health sector which have been formulated to fulfill the conditionalities of SAPs under the past three administrations were primarily reflected in sectoral medium-term development plans including the Department of Health's *Plan for People's Health (1987-1992)*, the *National Health Plan (1995-2020)* and the *Health Sector Reform Agenda (1999-2004)*.

On paper, the *Plan for People's Health (1987-1992)* of the Aquino administration underscored the "development of a healthy and productive citizenry and maximization of people's contribution to socio-economic development as well as increasing their share in the fruits of economic progress." The plan called for making basic health, nutrition and family planning services accessible to the poor and high-risk groups using the primary health care approach; collaboration with the private sector for health, nutrition and family planning as well as an increase in, and efficient use of, government resource allocations to the health, nutrition and family planning sectors.

These policies were reiterated in the *National Health Plan (1995-2020)* of the Ramos government. This time, however, the plan expanded the role of the private sector in health care delivery, financing and human resource development and called for streamlining the health bureaucracy. Privatization was seen as a key development strategy to "allow the government to redirect its resources to the underserved and unserved areas and sectors of society" (DOH, 1995).

Meanwhile, the *Technical Report on the 1996 Accomplishments of the Ramos Administration* prepared by the Presidential Management Staff (PMS) described the rationalization of the size of government, its structures and operations to facilitate the faster delivery of public services. Redundant or irrelevant functions at the

DOH, for instance, were either scaled down or phased out while several positions were re-assigned to so-called priority programs. The "right-sizing" of the bureaucracy resulted in the abolition of 5,110 positions, generating savings of at least P227.30 million (PMS, 1996).

During the short-lived Estrada administration, other SAP conditionalities, particularly the policy to convert "government hospitals into fiscally autonomous entities" were incorporated into key government documents such as the *Health Sector Reform Agenda 1999-2004*, the *Hospital System Reform Act of 2000* and the DOH Philippine Hospital Development Plan. The privatization scheme specifically called for transforming national and regional hospitals into government-owned corporations to achieve fiscal and management autonomy and stability. This allows health institutions to collect and allocate revenues from "socialized user fees."As a result it is expected that state subsidies for hospitals will be reduced, consequently freeing more money for other priority concerns like public health programs.

The plan to corporatize government hospitals under the Estrada government's *Health Sector Reform Agenda 1999-2004* sought to: 1) upgrade physical infrastructures, diagnostic equipment, laboratory facilities and human resource development; 2) enhance revenue-generation by increasing the number of pay wards, private rooms and doctors' Out-Patient Department clinics, and expanded hospital services for ambulatory surgical care and domiciliary care; 3) impose hospital fees and charges; 4) efficiently use hospital income from income-generating areas (laboratory, x-ray, delivery room, operating room, etc.) by decreasing turn-around time for the return of hospital income; 5) set up or upgrade hospital pharmacies to make them a viable source of revenues; and 6) expand health insurance coverage and the package of hospital services to be reimbursed by the health insurance system.

Furthermore, the streamlining of the bureaucracy under the Estrada government was done through the government's *Rationalization and Streamlining Plan* (RSP). The *Rationalization and Streamlining Plan* (RSP) or "right-sizing" involves organizational change, streamlining of operations and rationalization of human resources. It introduced new systems, procedures and protocols within the DOH supposedly to reduce bureaucratic red tape, graft and corruption and poor management of government health programs (DOH Year-End Report 2000; DOH Press

Release, 5 Jan. 2001). Similarly, Executive Order 102 ("Redirecting the Functions and Operations of the DOH, " May 1999) redefined the post-devolution role of the DOH to that of policy formulation, standard-setting, regulation and provision of technical assistance (DOH Press Release 5, January 2001).

Effects of SAPs on the health budget and the delivery of health services

1. Cuts in a low health budget

Contrary to policy pronouncements contained in its medium-term development plans which recognize the key role of health in social and human development, health has not been a priority concern of the Philippine government at all. Proof of the low priority given to health is the sector's yearly low appropriations and expenditures. With the imposition of SAPs and conditionalities such as reduction in national expenditures through budget cuts, the resultant health budget has been insufficient to meet even the most basic health needs of the people, particularly the poor – the population most vulnerable to diseases. As a result, the people's health has deteriorated as maybe seen in the persistence of infectious but preventable and curable diseases like bronchitis, pneumonia and tuberculosis, widespread malnutrition among infants and children, high infant and maternal mortality rates, etc.

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Between 1986 and 2000 and particularly in 1993, 1995, 1998, 1999 and 2000, the health sector suffered several cuts in its programmed expenditures. The biggest cut was in 1993 when the health expenditure plummeted to P6.2 billion from P11.3 billion in 1992. (See Table 1) During that year, the combined appropriations for "hospital and regional operations and services" decreased from P6.3 billion in 1992 to P2.0 billion in 1993. (See Table 2) Affected in the budget cuts were the operations, management and maintenance of special, regional, provincial, district, municipal hospitals/offices and other facilities; medical centers and sanitaria; construc-

tion and renovation of hospitals and related offices and the purchase of medical equipment and drugs.

As shown in the annual National Expenditure Program (NEP) for the period covered by this paper, i.e., 1986–1999, the share of health in the total budget never went higher than four percent. The highest share ever allocated the health sector in the yearly budget was 3.8 percent in 1991 – the year the Local Government Code (LGC) was enacted into law. The lowest was 1.8 percent in 2000 under the Estrada government. (See Tables 1, 3a & 3b) Moreover, the average increase of the health budget was 3 percent.

The low priority given by the government to health becomes more marked when comparing its expenditure and budget to that of other departments and sectors, particularly those of national defense and debt service. Between 1986 and 2000, the defense expenditure was, in the main, more than twice the health budget. In 1991, while the share of health in the National Expenditure Program (NEP) was 3.8 percent, that of national defense was 10.8 percent. Meanwhile, the allocation for debt service in 1989 was 42.7 percent. Throughout the period, the average share of health expenditure to the NEP was 3 percent; that of defense and debt service were 8 and 29 percent, respectively. (See Table 1)

The health budget was at its lowest in 1997 as a result of the Asian financial crisis. That year, it underwent huge cuts with the imposition of the 25 percent forced savings policy, a fiscal austerity measure adopted in order to satisfy the conditionalities of the 1998-1999 Precautionary Standby Arrangement extended by the IMF. Seriously harmed by the budget cuts were key public health programs including the schistosomiasis, TB control and expanded immunization programs which suffered a 31 to 45 percent budget cut.

The schistosomiasis control program reduced its target by one-fourth or from 400,000 to 296,000 patients. About 90,000 TB patients could not be treated (DOH, 1999). This also meant that the large number of beneficiaries either had to personally shoulder the cost of medicines or, in the case of poor patients, were forced to forego treatment or medication.

Table 1:
National Expenditure Program by Key Sectors (Million Pesos) & Percent Share, 1986 - 2000

Year	Nat'l Budget	Health [1]	Education	Defense [2]	Debt Service [3]
1986	114,504,792	3,569,741 **(3.12%)**	14,838,073 (12.96%)	7,611,045 (6.65%)	28,061,000 (24.51%)
1987	160,415,788	4,951,519 **(3.09%)**	18,430,862 (11.49%)	8,222,223 (5.13%)	65,895,000 (41.08%)
1988	169,728,000	5,754,050 **(3.39%)**	21,991,942 (12.96%)	9,704,588 (5.72%)	61,450,832 (36.20%)
1989	228,940,000	7,352,532 **(3.21%)**		20,769,777 (9.07%)	97,712,492 (42.68%)
1990	233,507,847	8,204,692 **(3.51%)**	33,814,000 (14.48%)	22,580,090 (9.67%)	86,819,236 (37.18%)
1991	259,283,983	9,743,385 **(3.76%)**	39,417,000 (15.20%)	28,030,091 (10.81%)	74,763,000 (28.83%)
1992	308,368,476	11,284,053 **(3.66%)**	40,255,000 (13.05%)	26,311,004 (8.53%)	113,033,000 (36.66%)
1993	330,237,082	6,237,559* **(1.89%)**	41,799,000 (12.66%)	28,691,135 (8.69%)	126,485,765 (38.30%)
1994	362,038,357	13,050,443 **(3.60%)**	46,392,000 (12.81%)	33,117,168 (9.15%)	117,812,000 (32.54%)
1995	384,713,251	10,122,423* **(2.63%)**	55,294,000 (14.37%)	24,334,484 (6.33%)	109,361,000 (28.43%)
1996	415,557,000	11,470,000 **(2.76%)**	75,994,000 (18.29%)	36,701,000 (8.83%)	69,236,000 (16.66%)
1997	476,170,000	15,919,429 **(3.34%)**	93,512,000 (19.64%)	37,092,196 (7.79%)	74,201,000 (15.58%)
1998	540,788,000	15,281,093* **(2.83%)**	109,490,000 (20.25%)	47,188,113 (8.73%)	75,545,000 (13.97%)
1999	579,481,000	14,107,728* **(2.43%)**	112,356,000 (19.39%)	30,190,411 (5.21%)	120,719,000 (20.83%)
2000	651,000,000	11,562,694* **(1.78%)**		55,209,074 (8.48%)	109,314,000 (16.79%)

Source: National Expenditure Program, *1986-2000. Department of Budget & Management*

** Health budget decreased.*

[1] *Mean increase of Health budget = 3.0%*

[2] *Mean increase of Defense budget = 8.0%*

[3] *Mean increase of Debt servicing budget = 29.0%*

Table 2:
National Health Expenditure (Million Pesos), Distribution of Health Expenditure per Program & Percentage Distribution, 1986-2000

Year	Public Health Services [1]	Primary Health Care Program	Hospital Operations & Facilities Services [2]	Regional Operations Services [3]	Total Health Expenditure Program
1986					3,569,741
1987				3,468,249,000 (70%)	4,951,519
1988	122,818,000 (2.13%)		14,924,000 (.26%)	4,201,930,000 (72.4%)	5,754,050
1989	137,704,000 (1.87%)		21,560,000 (.29%)	4,847,730,000 (66.0%)	7,352,532
1990	131,579,000 (1.6%)		18,043,000 (.22%)	5,651,443,000 (68.9%)	8,204,692
1991	140,924,000 (1.45%)		16,406,000 (.17%)	6,915,428,000 (71.0%)	9,743,385
1992	142,084,000 (1.26%)		16,669,000 (.15%)	6,347,058,000 (56.2%)	11,284,053
1993	301,045,000 (4.83%)		16,818,000 (.27%)	1,912,577,000 (30.7%)	6,237,559
			Hlth. Facilities & Operations		
1994	962,005,000 (7.37%)	214,578,000 (1.64%)	2,583,540,000 (19.8%)		13,050,443
1995	1,500,290,000 (14.82%)	211,359,000 (2.09%)	3,931,712,000 (38.8%)		10,122,423
1996	1,263,354,000 (11.0%)	101,700,000 (.89%)	4,167,711,000 (36.3%)		11,470,000

			Hlth. Facilities Maintenance & Operations		
1997	1,364,882,000 (8.57%)	54,450,000 (.34%)	5,702,751,000 (35.8%)		15,919,429
1998	1,423,976,000 (9.32%)	26,826,000 (.18%)	6,415,137,000 (42.0%)		15,281,093
1999	1,293,513,000 (9.17%)	24,313,000 (.17%)	6,700,438,000 (47.5%)		14,107,728
	Disease Prevention & Control Prog.		**Hospital & Facilities Mgmt. & Devt Prog.**	**Regional Operations**	
2000	3,475,924,000 (30.1%)	26,437,000 (.23%)	146,869,000 (1.3%)	4,553,913,000 (39.38%)	11,562,694

Source: National Expenditure Program, *1986-2000. Department of Budget & Management.*

[1] *Include Public Health Programs like Family Health Nutrition & Welfare; Communicable Disease Control Services like TB, malaria, schistosomiasis, dengue, leprosy, etc.; Non-Communicable Disease Control like cardiovascular disease, cancer, etc., Environmental Health Program. These are classified as preventive programs.*

[2] *Include Hospital Operations & Management Services of special, regional hospitals, medical centers; Radiation Health Services; Hospital Maintenance Services; Health Infrastructure Services; Construction/renovation of office buildings; acquisition of equipment. These are classified as curative programs.*

[3] *Include National Field Operations; Extension of medical & health services for special & regional hospitals, medical centers, sanitaria, provincial health offices, district, municipal & medicare community hospitals; Acquisition of equipment of special hospitals; Construction, improvement & renovation of special hospitals; Purchase of drugs & medicines. These are classified as curative programs.*

Table 3a:
National Government Expenditures by Sector, 1986-1992 (Million Pesos)

Particulars	1986	1987	1988	1989	1990	1991	1992
Total National Government Expenditures	121,339	154,542	167,409	173,340	255,776	293,161	286,604
HEALTH Actual Expenditure	3,531	4,245	5,564	6,488	7,962	9,178	9,908
% Share to NEP	3.12	3.09	3.39	3.21	3.51	3.76	3.66
Actual share to total expenditure (%)	2.91	2.75	3.32	3.74	3.11	3.13	3.46
Actual share to total Social Services (%)	15.73	15.65	17.91	16.85	16.21	17.73	16.83
EDUCATION Actual Expenditure	14,128	16,988	22,022	27,378	33,528	33,510	37,696
% Share to NEP	12.96	11.49	12.96		14.48	15.50	13.05
Actual share to total expenditure (%)	11.64	10.99	13.15	15.79	13.11	11.43	13.15
Actual share to total Social Services (%)	62.93	62.62	70.90	71.09	68.25	64.72	64.04
Defense Actual Expenditure	7,611	8,437	18,297	19,766	22,688	24,944	26,727
% Share to NEP	6.65	5.13	5.72	9.07	9.67	10.22	8.53
Actual share to total expenditure (%)	6.27	5.46	10.93	11.40	8.87	8.51	9.33
DEBT SERVICE Actual Expenditure	34,813	69,825	71,321	56,498	106,346	120,426	109,222
% Share to NEP	24.51	41.08	36.20	42.68	37.18	29.39	36.66
Actual share to total expenditure (%)	6.27	5.46	10.93	11.40	8.87	8.51	9.33

Source: Department of Budget & Management, Budget Planning Bureau.

Note: Starting 1987, figures are in billion pesos.

Table 3b:
National Government Expenditures by Sector, 1993-1999 (Million Pesos)

Particulars	1993	1994	1995	1996	1997	1998	1999
Total National Government Expenditures	313,750	327,764	372,081	416,141	491,783		
HEALTH							
Actual Expenditure	6,969	7,902	8,384	11,255	14,154	13,743	
% Share to NEP	1.89	3.60	2.63	2.76	3.34	2.83	2.43
Actual share to total expenditure (%)	2.22	2.41	2.25	2.70	2.88	2.60	
Actual share to total Social Services (%)	10.80	10.27	8.39	9.16	8.91	7.73	
EDUCATION							
Actual Expenditure	38,986	45,131	61,658	74,682	94,954	106,245	
% Share to NEP	12.66	12.81	14.37	18.29	19.64	20.25	19.39
Actual share to total expenditure (%)	12.43	13.77	16.57	17.99	19.31	20.11	
Actual share to total Social Services (%)	60.43	58.67	61.67	60.78	59.77	59.72	
DEFENSE							
Actual Expenditure	19,912	23,125	27,493	30,978	29,212	29,308	
% Share to NEP	8.69	9.15	6.33	8.83	7.79	8.73	5.21
Actual share to total expenditure (%)	6.35	7.06	7.39	7.44	5.94		
DEBT SERVICE							
Actual Expenditure	114,135	79,123	72,851	76,522	77,971	107,687	
% Share to NEP	38.30	32.54	28.43	16.66	15.58	13.97	20.83
Actual share to total expenditure (%)	36.38	24.14	19.58	18.39	15.85		

Source: Department of Budget & Management, Budget Planning Bureau.

2. Low expenditures for health

Aside from the drop in real terms of the health budget due to cuts in public spending as well as the peso devaluation and the inflation and deregulation of prices of goods and services, the low priority given to health by the government can be gleaned from the low percentage share of total health expenditures to GNP. From 1985 to 1991, total health expenditures were only about 2 percent of the GNP (DOH, 1994), a figure which did not significantly improve after 1991. The highest percentage share of health expenditures to GNP was 3.5 percent in 1997. (See Table 4)

Table 4:
Health Expenditure, GNP and Population, 1991- 1997

Statistics	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**
Total Health Expenditure (billion pesos)	37.4	41.7	47.2	55.4	66.6	77.7	88.4
Population (million) 62.4	63.8	65.3	66.8	68.3	69.9	71.5	
Share of Health Expenditure to GNP (%)	**2.98**	**3.04**	**3.15**	**3.19**	**3.40**	**3.44**	**3.50**
Health Expenditure Growth Rate	11.7	13.2	17.2	20.3	16.7	13.7	
Population Growth Rate	2.2	2.4	2.3	2.2	2.3	2.3	
GNP Growth Rate	9.6	9.1	15.7	12.8	15.5	11.7	
Health Expenditure Per Capita (based on current prices)	598.7	654.1	723.2	828.9	975.3	1,112.3	1,236.6
Health Expenditure Per Capita (based on 1988 prices)	94.81	91.57	58.39	59.27	56.81	68.75	

Source: The Philippine National Health Accounts 1991-1997, *National Statistical Coordination Board (NSCB)*

In a 1993 study, the World Bank (WB) cited the relatively low level of health expenditures in the Philippines as compared to other middle-income countries. Of 10 countries in Asia-Pacific, the Philippines had the second lowest per capita health expenditure and was ranked as the second lowest in health expenditure as a percentage of gross domestic product (GDP) (PIDS, 1998). Although the share of health spending to GNP increased from 3 percent in 1991 to 3.5 percent in 1997, this figure does not come close to the World Health Organization (WHO) benchmark of at least 5 percent of GNP for middle-income countries (DOH, 1999; PIDS, 1998). (See Table 4) Developing countries generally spend about 4 percent of their GNP on health while European countries and Japan set aside 7 to 8 percent. The United States has, at 12.4 percent, the highest share of health expenditure to GNP while the rest of the world averages about 7.5 percent on health care (PIDS, 1998).

Based on 1988 prices, per capita health expenditure in the Philippines showed an increasing trend between 1986 to 1990, followed by a decline in the succeeding years. But even the highest per capita health spending during the period – P119.41 (US$4) in 1990 – is not enough to cover the price of a minimum package of basic health interventions as estimated by the WB. Even more frustrating is that the figure registered in 1996 – P68.75 (US$2.15) based on 1988 prices – was lower than in 1986. In 1998, DOH appropriations by average could provide only P179 (US$3.50) for the health needs of every Filipino. Given the combined effects of inflation and peso devaluation during the same year, the real per person appropriation would amount to only about P60 (US$1.17) (DOH Annual Report 1998). Although this figure is higher than that of the previous year's (1997) at P54 (US$1.05), the general trend appears to be that of an underspending on health by the Philippine government.

But the bulk of health spending comes from individual households or families, not from government. From 1991 to 1997, more than half of health spending came from private sources – primarily from out-of-pocket payments by individual families for drugs, hospital charges and doctors' fees (DOH, 1994). Meanwhile, a little over one-third of total health expenditure came from the government with the rest from social insurance.

3. Irrational use of health budget

Contributing to the dismal state of the people's health resulting from budget cuts to an already low allocation is the irrational use of health funds. Historically, the bias of government health expenditures has been towards personal or curative health care. From 1991 to 1997, the bulk of health spending from 72 to 78 percent went to personal or curative health services. (See Table 5)

Table 5:
Health Expenditures by Use of Funds

YEAR	AMOUNT (in billion pesos)				PERCENT SHARE (%)		
	Personal	Public	Others	Total	Personal	Public	Others
1991	28.49	2.84	6.02	37.36	76.26%	7.61%	16.13%
1992	32.63	2.91	6.19	41.73	78.19	6.97	14.84
1993	34.40	5.64	7.18	47.22	72.84	11.95	15.20
1994	39.92	6.97	8.48	55.37	72.09	12.59	15.32
1995	49.08	7.15	10.38	66.62	73.68	10.74	15.58
1996	57.65	9.31	10.79	77.75	74.14	11.97	13.88
1997	63.51	11.95	12.96	88.42	71.82	13.51	14.66

Source: UP Economics (1991-1994); National Statistical Coordination Board (1995-1997)

The irrational use of the limited health budget can be seen in the distribution of the health budget per functions/programs – or between "hospital and regional operations and services or hospital facilities maintenance and operations," on one hand, and "public health services and primary health care programs," on the other. From 1986 to 2000, at least 20 to 73 percent of the total health budget was spent for hospital and regional operations and services.

Conversely, public health and primary health care programs/services received a disappointing 1.3 percent and at the most, 30 percent of total health expenditure. (See Tables 2 & 6) The lopsided apportioning of the health budget not only grossly contradicts the national government's policy of giving priority to basic health services but is inconsistent with the general disease pattern in the country. Since the

leading causes of morbidity and mortality are infectious but preventable diseases, the bulk of the health budget should logically be earmarked for preventive and promotive health services such as public health programs on immunization, nutrition, family health and tuberculosis, among others. Such would be an efficient and equitable use of the limited health budget.

Table 6:
Uses of DOH Expenditures (Million pesos, 1985 prices)

YEAR	PREVENTIVE CARE		CURATIVE CARE		TRAINING		ADMINISTRATIVE		TOTAL	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
1986	798	25.8	2,087	67.5	37	1.2	170	5.5	3,092	100.0
1987	971	28.7	2,289	67.7	27	0.8	96	2.8	3,383	100.0
1988	859	20.0	3,170	73.5	39	0.5	297	6.9	4,302	100.0
1989	858	18.9	3,220	74.6	36	0.3	422	9.3	4,536	100.0
1990	762	15.5	3,792	77.4	49	0.2	388	7.9	4,904	100.0
1991	734	18.4	3,885	75.1	10	0.2	228	4.7	4,857	100.0
1992	867	24.7	3,499	58.0	7	0.1	447	9.3	4,829	100.0
1993	1,252	44.5	1,660	42.1	4	0.1	624	17.6	3,540	100.0
Ave. 1986-1993	888	21.2	2,939	70.3	26	0.6	334	8.0	4,179	100.0

Source: Manasan, et. al, 1996. "Financing social programs in the Philippines: Public policy and budget restructuring." Philippine Institute for Development Studies *(PIDS), p. 115.*

The questionable priority given to hospitals in the health budget becomes more apparent when we look at the DOH spending on hospitals by region and vis-à-vis infant and maternal mortality rates. Before and after devolution, the concentration of health spending for hospitals went to Metro Manila which hosts the 13 special hospitals of the DOH. The metropolis and neighboring regions such as Central Luzon (Region 3) and Southern Tagalog (Region 4) with generally lower infant mortality rates (IMR) tended to receive higher hospital subsidies while those with

higher IMR such as the Autonomous Region in Muslim Mindanao (ARMM) and Western Mindanao (Region 9) in southern Philippines and the Cordillera Administrative Region (CAR) in the north, consistently received lower subsidies. The hospital subsidy for Metro Manila rose from 24 percent in 1991 to 53 percent in 1998. On the other hand, Western Mindanao which had the third highest IMR in 1995 received only 2 percent of the total hospital subsidy in 1998. (See Table 7)

Table 7:
DOH Spending on Hospitals by Region, 1991 and 1998 vis-à-vis IMR & MMR, 1995

	1991 (in billion pesos)	Percent Share (%)	1998 (in billion pesos)	Percent Share (%)	*1995 Infant Mortality Rate	*1995 Maternal Mortality Rate
Phils.	4.79	100	6.69	100	49	180
NCR	1.13	24	3.52	53	32	119
Region 1	0.26	5	0.26	4	46	161
CAR	0.18	4	0.19	3	**55**	**193**
Region 2	0.12	4	0.19	3	54	**191**
Region 3	0.37	8	0.29	4	40	171
Region 4	0.53	11	0.25	4	45	139
Region 5	0.31	6	0.40	6	**58**	166
Region 6	0.35	7	0.32	5	**55**	184
Region 7	0.29	6	0.34	5	47	158
Region 8	0.26	5	0.12	2	**64**	190
Region 9	0.21	4	0.13	2	**59**	**200**
Region 10	0.26	6	0.21	3	54	**225**
Region 11	0.25	5	0.29	4	52	160
Region 12	0.17	4	0.09	1	54	187
CARAGA	0.00	0	0.06	1		
ARMM	0.00	0	0.00	0	**63**	**320**

Source: Solon, Orville. 1998 as quoted in the DOH Health Sector Reform Agenda Philippines 1999-2004; NSCB Technical Working Group on Maternal & Child Mortality as presented in NSCB 2000 Philippine Statistical Yearbook.

***IMR Ranking**: 1 – Region 8, 2 – ARMM, 3 – Region 9, 4 – Region 5, 5 – CAR*

***MMR Ranking**: 1 – ARMM, 2 – Region 10, 3 – Region 9, 4 – CAR, 5 – Region 2*

The same trend is observed in the distribution of hospital subsidies to regions vis-à-vis maternal mortality rates (MMR). ARMM, Regions 9, 10 and CAR — four of the regions with the highest MMR in 1995 — consistently received the lowest hospital subsidies in 1991 and 1998. Based on the Health Reform Agenda of 1999-2004, the same budget for hospitals could have been maintained with a bigger percentage given to devolved health facilities in regions where the funds are most needed because of high IMR and MMR. But this was never the case.

Yet from 1989 to 2000, the budget for special hospitals generally experienced an increase. Of the total programmed expenditure for health during the period, the budget for special hospitals ranged from 8 to almost 23 percent.

4. Rising costs of health goods and services

Another effect of SAPs on people's health is seen in the rising costs of health goods and services brought about by inflation, deregulation in the prices of goods, the peso devaluation, privatization and other conditionalities prescribed by the IMF-WB. The rising costs of medical care and medicines is a major reason why a large percentage of poor families engage in harmful self-medication practices and, in most cases, seek medical help only as a last recourse. A study of Simbulan (2001) on the health-seeking behaviors of TB symptomatic urban poor residents in Metro Manila revealed that poverty, aggravated by the rising costs of doctors' consultation fees and medicines, has forced people to delay visits to health professionals including the *barangay* health centers where they have to spend some money. Even when already experiencing prolonged cough or back and chest pains, a majority of the TB symptomatics interviewed admitted resorting to self-medication practices such as taking herbal medicines or pain relievers bought over the counter, rubbing the head, chest and/or back with menthol eucalyptus oil, ice or diluted gas, and inhaling steam with salt. These health-seeking behaviors of TB symptomatics were confirmed by health professionals stationed at the *barangay* health centers (Simbulan, 2001).

In truth, many Filipinos, especially the poor, have many reasons to avoid going to the hospital or seeing a doctor for illnesses or for other medical reasons. The

average hospital bill is three times the average monthly income which is currently pegged at P250 in Metro Manila.

Besides hospital expenses, the high prices of drugs and medicines are an added burden to the growing inability of people to meet their health needs. Despite the passage of the Generics Act of 1988 – a law meant to provide safe and effective but affordable drugs particularly to low-income households – the prices of drugs and pharmaceutical products have remained high. In fact, the prices of drugs and medicines in the Philippines are one of the highest in Asia. According to former Health Secretary Alberto Romualdez, the prices of drugs in the country are 250 to 1,600 percent higher than in Indonesia, Malaysia, India, Bangladesh, Sri Lanka and other neighboring Asian countries (Feria, 1999). However, the Pharmaceuticals and Health Care Association of the Philippines has cited the peso devaluation stemming from the Asian financial crisis of 1997 as the cause of the 25-60 percent increase in the prices of drugs and small medical equipment and for the shift of middle class clients from branded to generic products and of the poor from generic to herbal drugs.

Already beleaguered by increasing hospital expenses, the people are finding it harder to access affordable but quality public hospital services owing to the policy of making state hospitals autonomous, reducing subsidies and allowing these hospitals to collect user fees. Recall that this policy was part of the general plan to convert regional and tertiary hospitals into government corporations as a phase of privatization. To make up for the decrease in state subsidies, some hospitals have resorted to revenue-generating measures such as limiting the number of charity patients and requiring them to buy most medical supplies such as cotton, bandages, sutures, plaster, syringes and needles for their treatment or surgery.

Aggravating the difficulties of people in accessing affordable health services is the deterioration of primary health facilities such as rural health units (RHUs) and *barangay* health stations due to lack of funds. Usually housed in decrepit and leaking structures, these basic non-hospital health care facilities have experienced chronic shortages of medical supplies and basic medical equipment like stethoscopes, weighing scales and microscopes.

Moreover, many of these public health facilities, especially those in the rural villages, do not have competent medical staff due to the uneven distribution of health workers and professionals. Most health professionals and workers are concentrated in the cities and urban centers, particularly Metro Manila, Southern Tagalog (Region 4) and Central Luzon (Region 3), which account for nearly two-thirds of the country's total number of physicians. In 1990, Metro Manila alone accounted for about 43 percent of all doctors; of the total number of specialists recorded, 64 percent were found in Regions 3, 4 and Metro Manila (DOH, 1999).

The uneven distribution of health specialists across the country stems from the not unfounded general perception that it is in urban areas where higher incomes and brighter prospects for professional growth are available. Thus, it is not surprising that the proportion of medically-attended deaths is low at around 40 percent. This further shows that as many as 60 percent of the population do not have access to medical care even during life-threatening conditions (DOH, 1994). It is ironic that a country that produces a large number of doctors, nurses and other health professionals annually has large numbers of women and children in the rural areas die because of a lack of doctors.

5. *Displacement of government employees due to the reengineering/right sizing and devolution of the DOH*

Meanwhile, the DOH's re-engineering and streamlining ("right sizing") policy in line with the department's Rationalization and Streamlining Plan (RSP) and Executive Order 102 complements the 1991 Local Government Code (LGC) which devolved health services to the LGUs. Under the LGC, central functions and services are devolved to local governments with the objective of expanding the latter's administrative autonomy in raising local revenues and in operations. Among the functions and services devolved are those related to health previously centralized in the DOH (World Bank, 1994).

To the DOH's rank-and-file personnel, however, the "right sizing" policy only resulted in the large-scale retrenchment and displacement of health employees. Executive Order 102 reassigned more than 90 percent of the DOH central office staff to new positions, leading to a significant contraction in the number of DOH

personnel from 2,950 to 1,299 employees. Those who were not retained were deployed to frontline services such as hospitals, the Philippine Health Insurance Corporation (PHIC) or to centers of health development (DOH Year-end Report 2000). Other central office employees were deployed to the regions without the necessary support mechanisms. Those whose positions were abolished or merged were forced to resign or retire.

Meanwhile, the devolution of hospitals and field health services of the DOH to the LGUs, along with the transfer of operations of provincial and district hospitals to the provincial governors and of RHUs to the city and municipal mayors, also resulted in some 45,000 health personnel devolved to the local governments. These devolved health functions roughly translated to a cost of P4.2 billion, based on the 1992 health budget (PIDS, 1998).

On the surface, the rationale for the transfer of management and financial responsibilities over the different levels of health services including facilities and personnel to LGUs was noteworthy, i.e., to ensure a more efficient and equitable delivery of health services to grassroots communities. However, devolution did not improve the general health of the people. For one, the decentralization plan did not equip LGUs with the administrative and management skills needed to sustain the delivery of health services. LGUs also lacked the resources for effective health delivery because revenues collected at the local level were less than the actual costs of devolved functions.

However, devolution did not improve the general health of the people.

This dilemma is partly rooted in the manner in which the internal revenue allocation (IRA) is earmarked to LGUs. Under the Local Government Code, provincial and municipal governments with higher fiscal capacity (using per capita income as a measure of financial base) receive higher per capita IRA as compared to those with lower fiscal capacity (Manasan & Llanto, 1996). This has caused financial shortfalls to the LGUs since the formula does not take into account the burden of supporting the devolved functions, especially in maintaining hospital operations. These financial problems are often aggravated by the fact that some municipalities tend to divert funds from health to other priorities (PIDS, 1998).

Equally bothersome, the poor performance of provincial and district hospitals prior to devolution later worsened because of the inability of LGUs to maintain their pre-devolution expenditure levels (DOH, 1999). In Western Samar (Central Philippines), for instance, budgetary cuts for government hospitals affected maintenance and operating expenses (MOOE), leading to critical shortages of supplies, drugs and money for repair and maintenance of medical equipment in hospitals already in a deplorable state (See Table 8). Thus, health services became more inadequate and inaccessible to many of the rural folk, especially the poor.

To cite another case, the DOH had invested heavily in establishing the nationwide technical infrastructure for such programs as control of diarrheal diseases (CDD) and control of acute respiratory illnesses (CARI). In a 1994 report, however, the DOH anticipated that the success of the programs depended on the LGUs' ability to sustain the supply of drugs, technical supervision and continued quality of care, among others (DOH, 1994). Considering the fiscal, administrative and technical limitations of LGUs in their post-devolution state, it is highly probable that

Table 8:
Comparative Hospital Budgets (In thousand pesos), Province of Western Samar, 1992

Hospital	1992 (under DOH)			1993 (under LGU)		
	P.S.	MOOE	Total	P.S.	MOOE	Total
Samar Provincial	15,375	10,500	25,935	13,293	4,275	17,568
Basey District	3,263	1,190	4,453	2,606	877	3,483
Gandara District	2,996	1,360	4,356	2,572	824	3,396
Calbayog District	6,046	3,740	9,783	5,432	2,928	8,360
Tarangnan Municipal	1,286	340	1,626	1,217	337	1,554
Almagro Community	644	510	1,154	925	499	1,424
TOTAL	29,607 100%	17,700 100%	47,307 100%	26,045 88%	9,740 55%	35,785 76%

Source: Hospital Devolution Study HPDP (1994) as presented in DOH Health Sector Reform Agenda 1999-2004

the viability of the public health programs will be seriously impaired and their desired benefits rendered unattainable.

Devolution has also made the health delivery system more vulnerable to the whims and caprices of local government executives, many of whom do not consider health to be a priority. Local authorities are free to decide on how services are to be financed and delivered. This prerogative, often dictated by political and other expediencies as well as by corruption, often results in the uneven provision and delivery of health services and, consequently, poor health delivery across communities. This authority has also resulted in public health responsibilities being passed on to the private sector – all in the name of efficiency and equity. If privatized, health services become costlier and inaccessible to the target beneficiaries. Devolution has, after all, made the flow of local health services contingent on the capability of LGUs to mobilize and efficiently use resources and on the prices of health products and services for which these resources are spent (World Bank, 1994). The inability to raise revenues and the low allocation of IRA by the national government give the LGUs all the more reason to pass on responsibility for health to the private sector.

Meanwhile, while there is a growing demand to increase the health budget for LGUs, health expenditures have decreased following devolution, as maybe seen in the Comparative Consolidated Schedule of Actual Expenditure of LGUs. Although the LGUs' health expenditures in 1993 increased by 290 percent from their 1992

Table 9:
Actual Expenditures of LGUs for Health Services, 1992-1996 (in million pesos)

Year	Amount	Growth Rate
	1992	1,137.0
1993	4,437.9	290.3%
1994	6,544.3	47.5%
1995	7,896.9	20.7%
1996	9,378.8	18.8%

Source: Commission on Audit as cited in Ibon, 15 October 1998

level, there was a significant drop in health spending in the succeeding years (Ibon, 1998). (See Table 9) This may indicate that any increase in local revenues, particularly in the health budget, will not necessarily translate into higher health spending and a better delivery of health services since health programs have to compete with the other priorities and concerns of LGUs. This also means that, under the LGUs' discretion, funds that may have been earmarked for health services can be diverted for other purposes.

The devolution of health functions to the LGUs has caused demoralization among health personnel, owing to a breach in the labor contract between the DOH and devolved health workers. Citing financial shortfalls, LGUs have failed to provide or to match the salaries and benefits of devolved health personnel. Based on the Health, Nutrition and Population Survey Note of June 1998, the transfer of devolved health workers to the LGUs resulted in the following: job insecurities; limited prospects for promotion and career advancement; uncertainty about retirement benefits and other allowances; unfavorable changes in job descriptions; reduction in perks and other privileges and tensions with the local bureaucracy and political leaders (PIDS, 1998).

Conclusion and Recommendations

The paper showed the detrimental effects of SAPs on the health budget and on the delivery of health services by indicating how SAPs and their conditionalities have undermined the state's obligation to promote and protect the people's right to health through the provision of accessible, affordable and quality health goods and services. Following the neo-liberal principles of liberalization, deregulation and privatization, SAPs are gradually transforming the health care system of the country into a private or corporate entity; health goods and services are seen as commodities, given the rising costs of medicines and drugs, medical supplies, professional fees and hospitalization. Moreover, cuts in the health budget and the removal of government subsidies for social services have exacerbated the people's inability to meet their health needs and to improve their well-being. Thus, health is fast becoming the privilege of a few, rather than a right of the many.

Thus, health is fast becoming the privilege of a few, rather than a right of the many.

The continued implementation by the Philippine government of the neo-liberal development paradigm of liberalization, privatization and deregulation as the panacea to the country's economic crisis has been shown to be highly ineffective. It has, instead, perpetuated the country's dependence on foreign loans and has contributed to the worsening of the crisis, pushing the economy deeper into debt and instability. It has undoubtedly worked against the interests of the Filipino people as illustrated in its dire consequences on the state of the delivery of health services and on the people's health.

There is an urgent need on the part of the national government to consider viable alternatives to SAPs as a means of solving the country's ballooning external debt, budgetary and balance of trade and payment deficits. Involving civil society groups — NGOs, people's organizations, sectoral and multisectoral groups — may facilitate the search process for workable alternatives to SAPs.

While a lasting solution to the country's economic crisis will certainly require fundamental structural changes, there are important measures which can be undertaken by the national government to help improve the delivery of health services to the Filipino people in light of the problems and issues identified in the paper:

1. Prioritize social services, i.e. health, education and housing, in the annual budget allocation. It is imperative that an assessment and re-alignment of national budget allocations be done so that more resources are committed to social services. The immediate repeal of PD 1177 which calls for the automatic allocation of more than 20% of the approved national budget to debt servicing is a critical step which the national government should take to demonstrate its decisiveness in addressing the problem of lack of funds for social services. Definite measures must also be taken to ensure that the resources for social services, specifically health, are used more efficiently and equitably. Moreover, at least 5 percent of the GNP must be allocated for health expenditures to satisfy the benchmark set by the WHO for medium-income countries such as the Philippines.

2. The "20/20 Initiative" launched in 1994 by UN agencies, specifically the UNDP, UNESCO, UNICEF and WHO, to encourage governments and international aid agencies to allocate 20 percent of their budgets to basic social services to fill the huge gaps in funding and to provide universal access must be supported and possibly, expanded.
3. Based on the country's disease pattern and health needs, an overhaul of the composition of health expenditures needs to be done so that the distribution of health funds between preventive/public health programs such as the National TB Control Program, Nutrition Program, Health Education Program and the National Malaria Control Program and curative/hospital services is more rational. Moreover, the distribution of funds for public health programs and curative services must be equitable, to ensure that the regions or areas of the country most in need are given priority.
4. Strengthen LGU capability for the delivery of affordable and quality social services, particularly health. Instituting capacity-building programs to strengthen the planning and management capability of local governments is a requisite to help LGU officials more effectively assume devolved health functions.

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Notes

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Data analysis focused on determining patterns or trends in the annual budget allocation for health and comparisons between the health budget and the budgets of other national program items, specifically national defense and debt servicing.

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