

The Impact of Budget-Related Structural Adjustment on Education and Health-Care Services in the Philippines: A summary report

Sacrificing People's Health and Future at the Altar of Maximum Efficiency and Profits

By Nymia Simbulan

For almost four decades now, the Philippine government has greatly depended on foreign loans from the IMF-WB and has consistently implemented their neo-liberal prescriptions in the attainment of economic growth and development. It has historically followed an economic development model that primarily relied on export-oriented but import-dependent and foreign investments-led strategies. Such development model has resulted in a cycle of serious economic and financial crisis and short-lived growth.

While the growth has been commonly measured in terms of increases in the growth rate of the gross national product (GNP) and the gross domestic product (GDP), the crisis has manifested itself primarily in the ballooning of the country's foreign debts and balance of payments (BOP) deficits. It has likewise led the Philippine government to operate beyond its means with its expenditures going way above its revenues or income. Thus, for several decades now, the economy has been running based on deficit spending. (See Table 1)

To address the country's economic and financial crisis, the Philippine government has consistently viewed foreign loans as a reliable and effective solution. It has historically approached and relied on the two most powerful multilateral lending institutions, the International Monetary Fund (IMF) and the World Bank, to bail the economy out of the crisis and put it back on its path toward development through the availment of various types of loans.

Given in tranches or segments and replete with policy conditionalities and performance targets for the borrowing government, IMF and World Bank loans extended to the Philippines since the 1950s have included stabilization loans, standby arrangements, extended fund facility, sectoral and project loans, and structural adjustment program loans (SAPs).

Conceived by the World Bank in 1979, SAPs have heightened the combined power of the Bank and the Fund over debtor countries like the Philippines because of the tremendous control exerted by these institutions on major economic policies. Since 1980 when the country received the first structural adjustment loan (SAL I) amounting to \$200 million, the state of the economy has worsened, leading to more heavy borrowings to solve its economic and financial problems.

Studies have revealed that SAPs have worked against the interests of the people of debtor countries, in general, and the Filipino people, in particular, resulting to a worsening of living conditions and gross violations of human rights. (Orbeta, 1996; Brohman, 1997; Ofreneo, 1991) Since the principal concerns/objectives of SAPs have been efficiency and growth, poverty alleviation and income-distribution have usually figured out as secondary concerns. (Broad, 1988) Moreover, analysts contend that SAPs and other neoliberal programs have not only neglected many of the broader structural concerns of Third World development, but have also produced widening polarization and rising social costs in many countries. While the exigencies of the free market have been given priority and the focus has been on improving market

efficiency and macro-economic conditions, development issues like equity, income distribution, poverty alleviation and respect for human rights have been subordinated, if not ignored, in SAPs. Neoliberal policies contained in SAPs like cuts in real wages, food subsidies, and health care and education expenditures, continue to generate high social costs, especially for the poor and other disadvantaged groups. (Brohman, 1997) As pointed out by Brohman (1997), the brunt of SAPs have consistently fallen on the basic sectors for the following reasons:

- Liberalization measures have caused widespread job losses, especially in many labor-intensive, domestically oriented economic sectors;
- Neoliberal policies have removed labor regulations, causing levels of both real wages and minimum wages to decline and unemployment levels to rise;
- Prices of food and other basic goods have risen dramatically as liberalization measures have cut state subsidies designed to hold down prices for the urban poor and other popular sectors;
- Access by the popular sectors to many basic social services has been reduced following cutbacks and/or privatization; and
- Government cutbacks have eliminated many programs targeting particular groups for special forms of assistance.

Thus, it is not surprising to note the detrimental impact of SAPs on basic social services like health and education and its concomitant effects on the people's lives and well-being. (See Table 2)

In the light of the need to illustrate the effects of SAPs on the Filipino people's lives, this study was undertaken to investigate the concrete impact of budget-related SAPs on the delivery of basic services focusing on health and education. The results are expected to support and strengthen the position of civil society of the urgency to break-away from IMF and World Bank-sponsored programs and to identify alternative measures or actions aimed at managing the country's huge external debts, solving the economic crisis, and pursuing genuine development efforts.

Study Objectives

The study had the following objectives:

1. To identify the major features/contents of SAPs that affect health and education from 1986-1999;
2. To identify the concrete translations of the SAPs in terms of policies, programs in the health and education sectors from 1986-1999;
3. To determine the major effects/consequences of SAPs on the health and education budgets and on the delivery of services with focus on the following areas:

Education:

- ◆ Emerging patterns and trends in budget allocation and expenditure of the education sector as a whole and state colleges and universities (SCUs) in particular;

- ◆ Comparisons with respect to the percentage share to total national budget of the education sector, zeroing in mainly on SCUs with those of other services, defense and debt service; and
- ◆ People's perceptions and analysis of such effects/consequences using the standpoint and experiences of organized groups.

Health:

- ◆ Emerging patterns and trends in budget allocation and expenditure of the health sector as a whole and tertiary and special hospitals in particular;
- ◆ Comparisons with respect to the percentage share to total national budget of the health sector zeroing in mainly on tertiary and special hospitals with those of defense and debt service; and
- ◆ People's perceptions and analysis of such effects/consequences using the standpoint and experiences of organized groups.

Study Design

The study is a multi-stage impact evaluation using generic and shadow control designs. It zeroed in on analyzing the budget-related effects of SAPs in the following areas:

- 1) The effects of the conditionalities contained in SAPs from 1986-1999 on budget policies on health and education; and,
- 2) The status of particular tertiary and special hospitals, and SCUs in the NCR.

The generic and shadow control designs are used in a condition where the population cannot be categorized into experimental and control groups since everyone is covered and affected by SAPs. Generic and shadow controls are primarily judgmental: comparing outcomes with existing standards or norms, and using judgments of experts, administrators, or participants, as ways of assessing the impact of a program like SAPs. (Rossi & Freeman, 1982) Moreover, since SAPs have definite target objectives that can be considered as absolute standards, these then can be used as measures in assessing the impact of a program like SAPs on such areas as health and education.

Study Methodology

The study used a combination of data collection techniques namely:

- Review and content analysis of private and public records, documents/materials; and
- Qualitative/participatory method in the form of key informant interviews (KIIs) with officers, staffs, union leaders of government tertiary hospitals, teachers and student leaders of SCUs in the National Capital Region (NCR).

A total of six (6) individuals from four (4) NCR-based government tertiary and special hospitals, three (3) student leaders from two NCR-based SUCs and a faculty member who is also a member of the faculty union of one of the biggest SCU in the NCR, were interviewed for the study.

A former top official of the Ramos government was also interviewed particularly on matters pertaining to government budget.

Limitations of the Study

As stipulated in the objectives, the study focused on the impact of SAPs on health and education, namely: the sectoral budget and the overall status of the delivery of these social services from 1986-1999. The six-month period allotted for the study made it difficult for the research team to cover more areas of the two sectors. Moreover, the health and education institutions investigated were those based in the NCR although these are considered major ones in terms of the magnitude of services delivered and wide coverage.

Establishing causality, i.e. the cause-effect relationship between the variables under study, is a common concern raised when conducting evaluation studies. This becomes more an issue when the study designs used are not experimental in nature because other types of study designs are considered to be less rigorous. However, with the use of the generic and shadow control designs, the study was cognizant that the major variable under study, i.e. SAPs, may not be the only factor having an impact, though a critical and major one, on the health and education sectors.

Study Findings

As a strategy for economic growth and for managing particularly problematic sections of the national economy, SAPs contain provisions for the reduction and/or tightening of government expenditures through decreases in government subsidies to public corporations, tax reform measures including the imposition of new taxes, privatization of government-owned and controlled corporations, streamlining and re-engineering of the bureaucracy, freeze in the hiring of new workers in government offices/agencies, tight money supply, currency devaluation, increased in interest rates, etc.

According to Herrin, changes in the above-mentioned variables affect macroeconomic processes, namely, the supply and demand in labor and other factor markets, goods and services markets, on one hand, and the public provision and financing of goods and services particularly in health, nutrition and education, on the other. (Herrin, 1992) Ordinarily, these provisions result into budgetary cuts in social services, specifically health and education, which translate into serious human capital outcomes as in the state of morbidity and mortality patterns, magnitude and nature of malnutrition particularly among the young population, decline in literacy and functional literacy rates and worsening of school attainment and achievement. (See Table 3)

A. Features of SAPs affecting health

As pointed out earlier, SAPs contain certain provisions or conditionalities that debtor countries are required to implement and realize in order for loans to be released. The number of conditionalities varies, depending on the nature and length of time of the loan extended. For instance, the Agricultural Sectoral Adjustment Loan (SECAL) extended to Morocco contained 142 conditionalities while the SAL I and SAL III for Senegal had 42 and 82 conditionalities,

respectively. Meanwhile, the six trade and agricultural SECALs for Brazil, Colombia and Mexico had provisions ranging from 31 to 51 conditionalities. (Jayarajah)

Conditionalities, especially the critical ones, are significant in relation to tranche release conditions, i.e. second and later tranches. Non-implementation or fulfillment of the conditionalities may result to delay or postponement of tranche release.

From 1986 to December 2000 covering the administrations of former Pres. Corazon C. Aquino (1986 - 1992), Fidel V. Ramos (1992 - 1998) and Joseph Ejercito Estrada (1999 - 2000), the Philippine government received several structural adjustment and stabilization loans/programs from the IMF-WB. (See Tables 4 & 5) The structural reforms to which each of the three administrations have committed themselves were primarily translated into the goals/objectives, policy pronouncements and development strategies stipulated in the Medium-Term Philippine Development Plans (MTPDPs).

Among the goals/objectives and policy directions stipulated in the various SAPs from the early 1980s to 1999 with serious implications and effects on social services, specifically health and education, were the following: (See Tables 4 & 5)

1. Limiting/reducing public sector and national government deficits every year.

This was a fiscal objective stipulated in the 1985-1988 SAP given to the Aquino government, the 1991-1993 Economic Stabilization Program and 1994-1997 IMF Exit Program. To attain this objective/target meant rational spending and efficient utilization of government resources, including expenditure reduction and/or tightening of expenditure control. These objectives were commonly translated into fiscal policies/measures such as wage freezes, cuts in the annual government budget, cuts in government subsidies and hiring freeze on government vacancies. Particularly for economic and social services, limiting or reducing government deficits meant budget cuts and/or maintaining the operating and maintenance expenditures at the minimum or based on previous years' level. An example is the provision contained in the 1985-1988 SAP.

2. Assumption by the national government of the external debt liabilities of government and private entities/corporations and the Central Bank (CB).

This was a fiscal policy of the Aquino government to comply with the conditionalities set by the IMF in the 1985-1988 SAP and the 1989-1991 Extended Arrangement. In the 1989-1991 Extended Arrangement, the national government was required to absorb the Central Bank's P5 billion deficit. Clearly, such measure directly contradicted earlier objectives of limiting national government deficits such as that stipulated in the 1985-1988 Adjustment Program. Consequently, the country's debts and BOP deficits further increased. Moreover, the national government and its various agencies had to work harder in order to generate and raise the much-needed revenues to be able to meet its financial obligations to private banks and MFIs. Instituting austerity and belt-tightening measures like wage freeze, freeze in the filling-up of vacant positions in the bureaucracy, cutting down of subsidies to public corporations, reduction in government spending, etc., were among the measures taken to realize these objectives. (1985-1988 IMF Adjustment Program; 1989-1991 IMF Extended Arrangement; 1998-2000 Standby Arrangement)

3. *Reduction and/or maintaining general expenditures of sectors such as economic and social services as in previous years.*

For instance, a fiscal measure to satisfy the conditionalities of the 1998-1999 Standby Arrangement was the implementation of a 25% cut in discretionary expenditures. Although, it was stated that best efforts will be undertaken to protect poverty alleviation programs or if cuts are inevitable, social programs will be the first to be restored once conditions improve, said programs were affected anyway because of the crisis. (1985-88 IMF Adjustment Program; 1989-91 IMF Extended Arrangement; 1991-93 IMF Economic Stabilization Program; 1998-1999 Precautionary Standby Arrangement)

4. *Reduction of national government outlays.*

This meant either suspending or stopping the construction, expansion, improvement of government facilities and infrastructures, including hospitals, sanitariums, medical centers and health centers. The acquisition and repair of hospital equipment are likewise affected.

5. *Freeze in the hiring of new workers to replace those who have left government service.*

This is another measure adopted by the national government to reduce its expenditures and subsequently, its budgetary deficits. For instance, the implementation of this policy as a fulfillment of the conditionalities contained in the 1994-1997 IMF Exit Program had resulted to an estimated 15,000 unfulfilled government posts by the end of 1995, as well as a decline in the number of general civil servants.

6. *Re-engineering of the bureaucracy resulting to the merging, abolition, transfer, devolution to local government units and/or privatization of government departments or functions.*

This key policy strategy has led to the retrenchment and displacement of government employees, including health and education workers, in the light of the government's objective to significantly reduce its workforce. (1994-1997 IMF "Exit Program") The streamlining of the bureaucracy, including the rationalization of existing inter-agency committees/councils and the maintenance of a leaner and more cost-effective bureaucracy continues and is being implemented through:

- A moratorium on the creation of new positions in the central offices of departments;
- Proper deployment of central office personnel in the regions; and
- Establishment of appropriate ratios for career and non-career positions, and central and field office personnel.

Successive administrations have adopted all these are major policies and strategies in compliance with the provisions of SAPs. (See MTPDP, 1987-1992; 1993-1998; 1999-2000)

7. *Privatization of government-owned and controlled corporations, departments and/or functions.*

This is in line with the government policy of putting into the hands of private sector state enterprises functions that such enterprises can better manage particularly in terms of improving revenue-generating capacity and financial efficiency. The state recognizes the private sector as the true engine of economic growth and development. (1998-1999 Precautionary Standby Arrangement, 1987 Economic Recovery Program & 1992 Economic Integration, of the WB) For this reason, privatization has consistently been made a part of the Medium-Term Development Plans of the past three governments. (MTPDP, 1988-1992; 1992-1998; 1998-2000) In Philippines 2000, privatization was one of the principles that guided the development planning and formulation of the medium-term Philippine vision. In in the MTPDP of former Pres. Estrada, privatization was a major policy commitment intended to improve efficiency in the use of resources and to strengthen domestic and international competitiveness. In the health sector, privatization has taken the guise of converting regional and tertiary hospitals into government corporations enjoying the capacity to function as autonomous financial entities.

8. *Deferment in the internal revenue allocation (IRA) for local government units (LGUs).*

This was one of the policies formulated by the former Estrada government to comply with the provisions of the 1998-1999 Precautionary Standby Arrangement extended by the IMF. Such a policy has had negative consequences particularly in the delivery of health care services since most of the DOH functions have already been devolved to the LGUs. Thus, the implementation of a 10% deferment in the IRA of LGUs has meant a reduction in the supply of medicines and medical supplies provided to various health facilities, budget for the operations of devolved health facilities like municipal and district hospitals, clinics, health centers, etc.

Essentially, the development programs of the past three administrations have not differed from one another in terms of their vision, goals and objectives, and strategies. As a means of attaining economic growth and development, and becoming globally competitive, they have consistently adhered to neoliberal policies/principles of liberalization, privatization, deregulation and decentralization. In other words, these programs are all SAP-driven and inspired.

B. SAPs and health policies, laws and programs

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

The *Health Plan for People's Health (1987-1992)* of the Aquino government had recognized the following policies and strategies in 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":

- ◆ Improved provision and utilization of accessible, appropriate and adequate basic health, nutrition and family planning services especially to the poor, unserved, underserved and high-risk groups using the primary health care approach.
- ◆ Strengthened and sustained effective collaboration with the private sector in health, nutrition and family planning by developing wider opportunities for coordination at various levels and

by providing incentives to encourage private initiative in the delivery of health, nutrition and family planning services.

- ◆ Increased government resource allocation to health, nutrition and family planning sector and ensuring the proper and efficient resource utilization. This meant working for more state support in terms of budget allocation for health compared to other sectors to be able to provide adequate services to the growing population. This also entailed more efficient utilization of available resources through administrative and management reforms such as the minimization of “red tape” and eradication of graft and corruption. Moreover, better coordination between the national and local governments was recognized as a means to minimize funding overlaps and duplication of programs and projects.

The above policies were reiterated in the *National Health Plan (1995-2020)* of the Ramos government. The country plan had upheld and emphasized such guiding principles as expanding the role/involvement of the private sector and non-government organizations (NGOs) in health care delivery, health financing and health human resource development and the streamlining of organizations and using only the resources that are really needed. Privatization, i.e. minimizing government involvement in areas or endeavors “where private participation is considered adequate, efficient and effective, and acceptable”, had been recognized as a key development strategy that will “allow the government to redirect its resources to the underserved and unserved areas and sectors of society”. (National Health Plan, 1995-2020)

Furthermore, in the *Technical Report on the 1996 Accomplishments of the Ramos Administration* prepared by the Presidential Management Staff (PMS), the move to rationalize the size of the government and its existing structures and operations to facilitate faster delivery of public services was highlighted. Among the measures taken to streamline operations of government agencies such as the DOH were scaling down or phasing out of redundant or irrelevant functions, redeployment of positions to priority programs and the consequent modification of the composition and structure of positions in each organizational unit. The “right-sizing” of the bureaucracy as contained in the report had resulted in the abolition of 5,110 positions, generating at least P227.30 million savings from personal services and maintenance and other operating expenses. (PMS, 1996)

In the *Health Sector Reform Agenda (1999-2004)* of the Estrada administration, the Hospital System Reform Act of 2000 and the DOH Philippine Hospital Development Plan, a health goal satisfying the SAP conditionalities had been the policy to convert “government hospitals into fiscally autonomous entities”. The plan to transform regional and national hospitals like the Jose R. Reyes Memorial Hospital, National Orthopedic Hospital, into government-owned corporations, the equivalent of privatization in the health sector, is intended to make hospitals achieve fiscal and management autonomy, and become more financially stable and viable. These health institutions will be allowed to collect, retain and allocate revenues from socialized user fees. Consequently, direct subsidies from both the national and local governments for hospitals will be reduced, freeing more money supposedly for other priority concerns like public health programs. The corporatization of government hospitals will be achieved through the following mechanisms: (Health Sector Reform Agenda, 1999-2004)

- ◆ Upgraded critical capacities like physical infrastructures, diagnostic equipment, laboratory facilities, and human resource development to enable hospitals to provide better quality of health services, be more competitive and be more responsive to the needs of the population;

- ◆ Revenue enhancement through increases in the number of pay wards, private rooms and doctors' OPD clinics, and expanded hospital services for ambulatory surgical care and domiciliary care;
- ◆ Review and implementation of appropriate hospital fees and charges;
- ◆ Better utilization of hospital income from the income-generating areas (laboratory, x-ray, delivery room, operating room, etc.) by decreasing the turn-around time for the return of hospital income from the Bureau of Treasury to the Department of Budget and Management and back to the DOH. This also looks into the possibility of transforming hospital income into revolving funds.
- ◆ Expanded sources of hospital revolving funds to include proceeds from the sale of drugs and medicines. In line with this strategy is the plan to establish and/or upgrade hospital pharmacies to enable them to compete with retail outlets, and therefore be another source of revenue for the hospital.
- ◆ Expanded health insurance coverage (potential hospital patients) and package of hospital services to be reimbursed by the health insurance system.

Still part of the strategy to privatize public tertiary health facilities by converting them into public corporations is the plan to upgrade regional and national hospitals into state-of-the-art level hospitals with the capability to perform highly specialized curative and rehabilitative services. Stipulated in the Philippine Hospital Development Program, this measure is envisioned to increase the income-generating capacity and financial viability of these health facilities. In addition, there is also the plan to put up regional specialty centers such as heart-lung-kidney centers, pediatric centers, oncology centers, toxicology centers in Mindanao, Visayas and Luzon. All these will require a tremendous amount of money for the construction of physical infrastructure, purchase of high-level hospital technology and equipment, human resource training and development, etc., which will come from government funds and external sources specifically foreign loans and investments, project proposals, grants-in-aid. (Health Sector Reform Agenda, 1999-2004)

In addition, the government's commitment to privatization particularly in the health sector has been reiterated in the December 1996 Presidential Management Staff (PMS) technical report entitled: *The Philippine Turn-Around Story: Peace and Development in a Democracy*. According to the report, the privatization program of the government continues and that it is "working on studies to implement the third wave of privatization involving public-private partnerships in social services, especially in the health and education sectors and pension funds". (PMS, 1996)

The streamlining of the bureaucracy, another budgetary policy which forms part of the national government's revenue-generating strategy, has been operationalized by the DOH with the implementation of its Rationalization and Streamlining Plan (RSP). This called for organizational change, streamlining of operations and rationalizing of the human resource complement. The RSP introduced new systems, procedures and protocols within the DOH to reduce bureaucratic red-tape, graft and corruption and poor management of government health programs. (DOH Year-End Report 2000; DOH Press Release, 5 January 2001) Then, there is Executive Order 102 titled "Redirecting the Functions and Operations of the DOH" and issued in May 1999, which redefined and emphasized 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)

The PMS report also cited the continued streamlining of operations and “right-sizing” of the bureaucracy through effective manpower reduction in the national government, including health, as another achievement of the Ramos administration. This, the report claimed, enabled the government to achieve greater cost-effectiveness and rechannel resources to priority projects. (PMS, 1996) For instance, in 1996 as a result of streamlining of the bureaucracy, 5,110 positions were abolished, generating at least P227.30 million savings in personal services and maintenance and other operating expenses (MOOE). On the other hand, since 1992, the rationalization of the size of the bureaucracy has resulted to the reduction of government human resources by 132,360 or 12 percent of permanent positions. (PMS, 1996)

C. Effects of SAPs on the Health Budget and the Delivery of Health Services

1. Cuts in Low Health Budget

Health has not been a priority concern of the Philippine government despite policy pronouncements contained in its medium-term development plans recognizing the key role of health in social and human development. A concrete indicator of the low priority given to health is the sector’s annual appropriations and expenditures. With the imposition of SAPs and concomitantly, its conditionalities such as reduction in national expenditures through budget cuts, the health budget has not achieved an acceptable level necessary to meet even the most basic health needs of the people, particularly the poor and marginalized. The low health budget has contributed to the further deterioration of the people’s state of health manifested in the persistence of infectious but preventable and curable diseases like bronchitis, pneumonia and tuberculosis, widespread malnutrition among infants and children, etc.

Between 1986 and 2000, the health sector experienced several cuts in its programmed expenditure. This was true particularly in the years 1993, 1995, 1998, 1999 and 2000. The biggest cut was made in 1993 when the health expenditure went down from P11.3 billion in 1992 to P6.2 billion the following year. (See Table 6) During this year, the combined appropriations for “hospital and regional operations and services” had also gone down from P6.3 billion in 1992 to P2.0 billion in 1993. (See Table 7b) Included in the budget for “hospital and regional operations and services” are such items as the operations, management and maintenance of health facilities like special, regional, provincial, district, municipal hospitals/offices, medical centers and sanitarium; construction, improvement and renovation of health infrastructures of hospitals/offices; and acquisition/purchase of equipment, drugs and medicines.

With the cut in the total health expenditure from 1998 to 2000, cuts in the budget share of the 13 NCR-based DOH special hospitals were likewise experienced. (See Table 14) As reflected in the annual national expenditure program (NEP) for the period covered by this study, i.e. 1986-1999, the programmed share of health in the total budget has not gone beyond four percent. The highest percentage share ever reached by the health sector in the annual budget was 3.76% in 1991 under the Aquino government and the year the Local Government Code was made into a law. On the other hand, the lowest percentage share of health in the government’s annual appropriations was 1.78% in 2000 under the Estrada government. (See Tables 6, 8a & 8b) Moreover, between 1986 and 2000, the average increase of the health budget was a measly 3.0%.

The low priority on health by the national government becomes more pronounced when its budget is compared to the budgets of other departments and sectors particularly national defense and debt service. Between 1986 and 2000, the defense expenditure had consistently been more than twice the health budget in most of the years. The picture becomes worse when compared with the budget for debt service. While the highest percentage share of health to the NEP was 3.76% in 1991, national defense was 10.81% also in 1991 while that for debt service was 42.68% in 1989. Through the 15-year period, while the average percentage share of health expenditure to the NEP was three percent, it was eight and 29 percent for defense and debt service, respectively. (See Table 6)

Furthermore, between 1986 and 1998, the actual health expenditure for the most part had declined, both in nominal and real terms. From 1991 to 1993, and the year 1995, real growth of actual health expenditure even registered negative figures. (See Table 9) In fact, in 1993, the appropriations for health was cut by almost 100% from previous levels, i.e. from P11.3 billion in 1992 to P6.2 billion in 1993. The state of the health budget had even gone worst as a result of the 1997 Asian financial crisis. This has led to cuts in the health budget with the imposition of the 25 percent forced savings policy, a fiscal austerity measure implemented to satisfy the conditionalities of the 1998-1999 Precautionary Standby Arrangement extended by the IMF. Key public health programs experienced significant cuts in their budgets. Seriously affected were the schistosomiasis program, which experienced a 45% cut in its budget, the TB control program, which suffered a 38% cut and the Expanded Program of Immunization (EPI), which sustained a 31% cut. Consequently, the service targets set by these public health programs had to be scaled down. For instance, the schistosomiasis control program reduced its target from 400,000 patients to 296,000 patients, while the TB control program had estimated around 90,000 patients could not be treated. (DOH, 1999) Thus, these reductions in basic public health programs meant a big percentage of their beneficiaries had to either personally shoulder their medicines/drugs in the case of TB and schistosomiasis patients or just forego treatment/medication, which is usually the case for poor patients.

Actually, the health budget has been consistently experiencing cuts and a generally downward trend in real terms since 1998. In 2000, the percentage share of health to the NEP reached its lowest level at less than two percent. (See Table 6) The observed declines in the health budget were not isolated and are generally part of the overall streamlining of the government's expenditure program for the period. (NEDA, MTPDP 1999-2004)

2. Low Expenditures for Health

Aside from the decreasing trend in real terms of the health budget due to cuts in government spending, peso devaluation, inflation and deregulation of prices of goods and services, the low priority given to health is also manifest in the low percentage share of total health expenditures to GNP. From 1985 to 1991, total health expenditures were estimated to be only about two percent of GNP. (DOH, 1994) This figure did not significantly improve after 1991. The highest percentage share of health expenditures to GNP was 3.50% in 1997. (See Table 10)

The relatively low level of health expenditures in the Philippines compared to other middle-income countries had been affirmed in a 1993 study by no less than the World Bank. Comparing the health care spending of 10 countries in the Asia-Pacific, the study revealed that

the Philippines had the second lowest per capita health expenditure and was also ranked as the second lowest in terms of health expenditure as a percentage of gross domestic product (GDP). (PIDS, 1998) Although the share of health spending to GNP increased from 3.0 percent in 1991 to 3.5 percent in 1997, the figure still does not come close to the World Health Organization (WHO) benchmark of at least five percent of GNP. (DOH, 1999; PIDS, 1998) (See Table 10)

Table 11 shows that for the period 1994-1997, the Philippines lagged behind China, Cook Islands, Mongolia and South Korea with respect to percent share of health expenditures to GNP although it fared comparatively well with Fiji, Lao, Macao, Papua New Guinea, Singapore and Vietnam. Developing countries generally spend four percent of their GNP on health while Europe and Japan set aside seven to eight percent. The United States has the highest share of health expenditure to GNP set at 12.4 percent while the rest of the world puts in an average of 7.5 percent on health care. (PIDS, 1998)

In terms of per capita health expenditure and using 1988 prices, the figures in Table 9 present an increasing trend from 1986 to 1990 but have started to decline in the succeeding years. The highest per capita health spending during the period, which was P119.41 in 1990, is not even enough to cover the price of a minimum package of basic health interventions as estimated by the World Bank. What is even frustrating as far as the study was concerned is that the figure registered in 1996, which was P68.75 based on 1988 prices, did not even reach the 1986 level. (See Table 9) In 1998, the DOH appropriations, on the average, could provide only around P179.00 for each Filipino. Considering the combined effects of inflation and peso devaluation during the same year, the real per person appropriation would amount to only around P60.00. (DOH Annual Report 1998) Although this figure is higher than the previous year (1997), which was P54.00, the overall conclusion is still that the Philippine government is underspending on health.

Ironically, aside from the low percentage share of health expenditure to GNP, the bulk of health spending comes from individual households or families. From 1991 to 1997, more than half of health spending came from private sources primarily from out-of-pocket payments made by individual families for drugs, hospital charges and doctors' fees. (DOH, 1994) Meanwhile, more than one-third of total health expenditure came from the government and the rest from social insurance. The decreasing trend in the proportion of health spending coming from the national government, on one hand, and the steady increase coming from local governments from 1992 onwards can be explained by the devolution of health services to the LGUs. However, as will be pointed out in the next section of this paper, the manner by which LGUs spend their health funds is another problematic matter. (See Table 12)

3. Irrational Use of Health Budget

Contributing to the dismal state of the people's health as a consequence of 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, especially hospitals. Between 1991 and 1997, the bulk of health spending, though slightly decreasing, went to personal or curative health services. The share of personal health expenditures ranged from 72 to 78 percent. (See Table 13)

The irrational use of the limited health budget is further manifested when comparing the distribution of the health budget per functions/programs, specifically that for “hospital and regional operations and services or hospital facilities maintenance and operations”, on one hand, and “public health services and primary health care program”, on the other. From 1986 to 2000, at least 20 percent of the total health budget was spent for hospital and regional operations and services. The share of these programs in the total health expenditure ranged from 20 to as high as 73 percent. (See Table 7a) On the contrary, public health and primary health care programs/services received a measly 1.26 to the highest level reached at 30 percent of the total health expenditure. (See Tables 7b & 7c) The lopsided distribution/use of the health budget not only grossly contradicts and violates the national government’s health policy of giving priority to basic health services like public health programs but is also 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 be directed principally to preventive and promotive health services like essential public health programs on immunization, nutrition, family health and TB, among others. This would be an efficient and equitable manner of utilizing the limited health budget.

It is important to note that although the budget for hospital and regional operations and services had gone down in 1992 with the start of the devolution of health services and the transfer of formerly-managed DOH hospitals to LGUs, the appropriation for these health programs went up again starting 1995. The increase can be explained by the re-nationalization of several devolved hospitals.

The bias toward tertiary/curative services particularly hospitals had persisted even during the 1997 Asian financial crisis. At the national health services level, the allocation for tertiary services has declined the least in real terms compared to other DOH programs like public health services. Moreover, between 1997 and 1999, curative health care got the biggest share of the budget as well as the largest budget increase. (NEDA, MTPDP 1999-2004)

The questionable priority given to hospitals in the health budget is further heightened 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 NCR-based health facilities particularly the 13 special hospitals of the DOH. As shown in Table 14, regions like the NCR, Central Luzon (Region 3) and Southern Tagalog (Region 4) with lower infant mortality rates (IMR) tend to receive higher hospital subsidies while those with higher IMR like ARMM, Region 9 and CAR received lower subsidies. The hospital subsidy of the NCR increased from 24% in 1991 to 53% in 1998. On the other hand, Western Mindanao (Region 9), which had the third highest IMR in 1995, received only 2% of the total hospital subsidy in 1998.

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 were among the regions with the highest MMR in 1995 but ironically were among those with the lowest hospital subsidy. The worst case is that of ARMM, which did not receive any hospital subsidy at all despite its having the highest MMR and second highest IMR in 1995. (See Table 14) As pointed out in the Health Reform Agenda 1999-2004, the same budget for hospitals could have been maintained but a bigger percentage directed to the devolved health facilities in the regions where the funds are most needed on the bases of health indicators like the infant and maternal mortality rates.

From 1989 to 2000, the budget for the special hospitals generally experienced an increase. Out of the total programmed expenditure for health for the period, the budget for special hospitals ranged from 8 to almost 23 percent. (See Table 15)

4. *Rising Costs of Health Goods and Services*

The rising cost of health goods and services is another effect of SAPs on the people's health brought about by conditions like deregulation of prices of goods, peso devaluation, inflation and privatization imposed by the IMF and the World Bank.

The rising cost of medical care services and medicines is a major factor why a large percentage of the population belonging to poor households engage in ill-health behaviors like harmful self-medication measures and delays in seeking appropriate medical help. As revealed in a study of Simbulan on the health-seeking behaviors of TB symptomatic urban poor residents in Metro Manila, poverty aggravated by the rising costs of doctors' consultation fees and medicines have forced urban poor residents to postpone visits to health professionals, including even the barangay health center, to avoid entailing expenses on their part. Despite the various TB symptoms experienced like prolonged cough and/or back/chest pains, majority of the TB symptomatics interviewed engaged in self-medication practices. These include taking a rest or lying in bed, slowing down on vices like smoking and alcohol drinking, taking herbal medicines or western drugs bought over the counter or sari-sari stores like paracetamol, cough syrups, pain relievers, rubbing the head, chest and/or back with Vicks Vaporub, ice or diluted gas, and inhaling steam with salt. (Simbulan, 2001) Going to a health professional, whether at the health center or private clinic, is usually a last resort because of the expenses involved. (*'Pag hirap na hirap na, pupunta sa doktor; Kapag hindi ko na kayang gumawa, nagpupunta ako sa doktor pero hangga't may nagagawa ako, gagamutin ko muna ang sarili ko; Nagpapahinga, umiinom ng gamot na walang reseta. 'Pag di pa rin gumaling, nagpupunta na sa doktor.'*) (Simbulan, 2001)

The above health-seeking behaviors of TB symptomatics has been confirmed by health professionals stationed at two barangay health centers in Navotas, Metro Manila, as pointed out in the Simbulan study. The results of key informant interviews with the health center staff revealed poverty as the underlying reason for such behaviors. According to barangay health center workers, many patients go to them when their illness has already worsened. (*"'Pag malala na saka sila kukunsulta dito sa health center; Malala na ang sakit kapag dinadala nila dito; 60% ng mga tao matindi na ang sakit kapag nagpa-check-up. 'Yung 40% hatiin pa natin ng 20-20. 'Yung 20% ay wala naman talagang sakit, they are just after the medicines.'*") For instance, TB symptomatics seen by the health center staff have been suffering from severe and prolonged cough for several weeks to about a month or have started coughing out blood-streaked sputum. (Simbulan, 2001)

The poor also tend to avoid going to hospitals because the average hospital bill is three times their average monthly income. For instance, the cost of a normal delivery usually ranges from P10,000 in the pay section of a public hospital to P20,000 – 25,000 in a private hospital. (DOH, 1999)

Aside from hospital costs, the exorbitant price of drugs and medicines further aggravates the growing inability of the people to tend to their health needs. Despite the passage of the Generics Act of 1988, the intention of which was to provide safe and effective but affordable drugs particularly to low-income households, the prices of drugs and pharmaceutical products have remained high. (Simbulan, 2000) In fact, the prices of drugs and medicines in the Philippines are one of the highest in Asia. According to former Sec. Alberto Romualdez, the prices of drugs/medicines in the country are 250 to 1,600 percent higher than in neighboring Asian countries like Indonesia, Malaysia, India, Bangladesh and Sri Lanka. (Feria, 1999) (See Tables 16 & 17)

The financial crisis that the country has been experiencing since 1997, which has further depreciated the peso, has also placed drugs and medicines out of the reach of ordinary consumers. According to the Pharmaceuticals and Health Care Association of the Philippines, the peso devaluation has resulted in the following:

- Increases of 25-30 percent in drug prices;
- Increases of 40-60 percent in the price of small medical equipment;
- Decreases of five to six percent in volume;
- Shift of the middle class clients from branded products to generic products; and
- Shift of the poor from generic products to herbal drugs and alternative medicine.

The policy to provide autonomy to government hospitals by allowing them to collect user fees and reduce their dependence on government subsidies is another factor that has contributed to the difficulties of people to access affordable quality hospital services. This is also in connection with the plan to convert regional and tertiary hospitals into government corporations. Thus, some hospitals have started to implement measures calculated to increase their revenues. These include limiting the number of charity patients through stricter screening procedures, imposing a ceiling amount for those classified as indigent patients, requiring all charity patients to buy most, if not all, medical supplies needed for their treatment/operation like cotton, bandages, sutures, plaster, intravenous fluids, syringes, needles, etc.

Targeted for privatization in the health sector are the four DOH specialty hospitals, namely the Philippine Children's Medical Center (PCMC), Philippine Heart Center, Lung Center of the Philippines and National Kidney and Transplant Institute (NKTII). Steps have also been taken to convert DOH special tertiary hospitals like the Jose R. Reyes Memorial Hospital, National Orthopedic Hospital into government corporations and the Fabella Medical Center, a public maternity and children's hospital, into a private general hospital. (Ibon Special Release, July 1997)

Yet another aggravating factor is the deteriorating conditions in primary health facilities like rural health units and barangay health stations due to lack of funds. These basic non-hospital health care facilities have chronically experienced shortages of medical supplies, medicines and basic medical instruments/equipment like stethoscopes, weighing scales and microscopes, and are commonly housed in dilapidated and leaking structures.

Moreover, many of these public health facilities especially those in the rural areas do not have competent medical staff due to the uneven distribution of health workers and professionals. Most of these personnel 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 physicians. Based on 1990 data, Metro Manila alone account for about 43 percent of all doctors while of the total number of specialists recorded, 64 percent are found in Regions 3, 4 and Metro Manila. (DOH, 1999) (See Table 18)

The maldistribution of health specialists across the country is primarily due to the higher incomes and brighter prospects for professional growth in more developed areas. Consequently, many rural health units and facilities remain “doctorless”. Thus, it is not surprising that the proportion of medically attended deaths is low, at around 40 percent, indicating that as much as 60 percent of the population do not have reliable access to medical care even for life-threatening conditions. (DOH, 1994) Ironically, large numbers of women and children in the rural areas die without being seen by a doctor even if the country may be producing so many doctors, nurses and other health professionals yearly.

5. Displacement of Government Employees Due to the Reengineering/Rightsizing and Devolution of the DOH

Large-scale retrenchment and displacement of government health workers has occurred with the implementation of the re-engineering/streamlining policy contained in Rationalization and Streamlining Plan of DOH and Executive Order 102. This is not to mention the devolution of health services to the LGUs as part of the implementation of the 1991 Local Government Code (LGC).

Under the LGC, central revenues and services are decentralized to local governments expanding further the administrative autonomy of the latter with respect to raising local revenues and conducting operations. Centrally provided services from various executive departments like the DOH have also been devolved to cities, provinces and municipalities. (World Bank, 1994)

Under Executive Order 102, more than 90% of the DOH central office staff have been appointed to their new positions resulting in a significant contraction of the agency’s personnel from 2,950 to 1,299 employees. The rest have been deployed to frontline service areas like hospitals, the Philippine Health Insurance Corporation (PHIC) or the Centers of Health Development. (DOH Year-End Report 2000) Still, other DOH central office employees were deployed to the regions without the necessary support mechanism, while those employed in the DOH central offices, which were abolished or merged, were forced to resign or retire. This has led to DOH employees like the Malaria Employees and Workers Association to file a complaint against DOH officials at the Manila Regional Trial Court Branch #15. (DOH Press Release, 2 October 2000)

With the completion of the first phase of the RSP at the end of 2000, the second phase, which entails the reengineering of field offices, hospitals and attached agencies, (DOH Press Release, 5 January 2001) is now being pursued. The sudden change of administration, from that of Estrada to Gloria Macapagan Arroyo, however, has temporarily suspended RSP implementation. The DOH is yet to come out with an official position regarding the reengineering plan.

Meanwhile, the devolution of hospitals and field health services of the DOH to the LGUs and the transfer of operations of provincial and district hospitals from the provincial governors

and rural health units (RHUs) to city and municipal mayors, have resulted in the devolution of 45,000 health personnel to local governments. This roughly translates to an estimated cost of P4.2 billion of devolved health functions based on the 1992 health budget. (*Health, Nutrition and Population Strategy Note*, June 1998)

Furthermore, though the objectives of the transfer of management and financial responsibilities for the different levels of health services including facilities and personnel to LGUs are noteworthy, i.e., ensuring a more efficient and equitable delivery of health services, devolution has not improved the overall health status of the population. The decentralization plan has been beset with economic and administrative problems like the lack of knowledge and skills of LGUs to assume their additional functions vis-à-vis the delivery of health programs and processes. LGUs lack the necessary resources to effectively deliver basic health services and expand the coverage of these programs/services due to the mismatch between the costs of devolved functions and the corresponding revenues allocated. This is clearly exemplified in the policies and manner the internal revenue allocation (IRA) is allocated to LGUs. Using the formula stipulated in the Local Government Code, provincial and municipal governments with higher fiscal capacity (using per capita income as a measure of financial base) tend to get higher per capita IRA allocations compared to those with lower fiscal capacity. (Manasan and Llanto, 1996) The regressive character of the IRA distribution formula has resulted in enormous problems and difficulties on the part of LGUs since the formula does not take into account the burden imposed on the LGUs to support the devolved functions, particularly hospital operations. Consequently, many municipalities and provinces have experienced financing shortfalls aggravated by the fact that some municipalities have diverted funds from health to other priorities. (*Health, Nutrition and Population Strategy Note*, June 1998)

Provincial and district hospitals, which were performing poorly prior to devolution, have become worst after devolution due to the inability of LGUs to maintain their pre-devolution expenditure levels. (DOH, 1999) Table 19 comparing the budgets of hospitals in Western Samar before and after devolution illustrate not only a decline in the hospital budgets. More importantly, the decline has affected maintenance and other operating expenses (MOOE) of hospitals. In operational terms, the decline has meant lack of supplies, drugs and allowances for repairs and maintenance of medical equipment of these hospitals, which are already in a deplorable state to begin with. Health services thus have become more inadequate and inaccessible to especially to the poor.

As if the fiscal, organizational and operational problems and issues attendant of devolution were still not enough, LGUs have had bear the tremendous responsibilities in the handling of public health programs. For instance, although the DOH had invested heavily in establishing the technical infrastructure for delivering cost-effective case management interventions across the nation for programs like control of diarrheal diseases (CDD) and control of acute respiratory illnesses (CARI), “the full benefits of these past investments can be realized if LGUs are able to sustain the supply of drugs, technical supervision and quality of care and carry out proper and effective case referral and in-service training under the devolved set-up.” (DOH, 1994) It is highly probable that the fiscal, administrative and technical weaknesses and limitations of LGUs in the post-devolution state have undermined the coverage, utilization and effectiveness of public health programs, thus leading to a worsening of the people’s health status.

Devolution has made the health delivery system more vulnerable to the whims and caprices of local government executives many of whom do not consider health as a priority. These executives have the freedom to decide how services are to be financed and produced. This prerogative may result in marked differences in the provision and delivery of health services and consequently, health outcomes across localities since LGUs can determine who will be responsible in the delivery of health services. Ultimately, executives will pass on these responsibilities to the private sector in the name of efficiency and equity. Moreover, devolution has made the flow of health services within any locality contingent on the capability of LGUs to mobilize resources, utilize the available resources and determine the prices of goods and services on which those resources are spent. (World Bank, 1994) Thus, the state of health programs and services in a community will be significantly affected by the LGUs' capability to raise revenues and the amount of revenues received in the form of IRA from the national government. And since they are already facing enormous fiscal difficulties in the light of their added health-related functions, passing on these responsibilities to the private sector would be an easy, if not, attractive option.

Meanwhile, available data shows that while there is a growing demand to increase the health budget of LGUs, health expenditures have slowly decreased after devolution as reflected in the Comparative Consolidated Schedule of Actual Expenditure of LGUs. As presented in Table 20, although the health expenditures in 1993 of LGUs have increased by 290% from its 1992 level, there has been a gradual decline in health spending in the succeeding years. (Ibon, 15 October 1998) This indicates that increases in local revenues and the health budget do not necessarily translate into higher health spending and better delivery of health services since health programs have to compete with other priorities and concerns of LGUs. Thus, it is highly probable that with devolution, health disparities between communities as a result of differences in income, as well as attitudes toward and treatment of, health programs and services of local executives, have heightened.

The devolution of health functions to the LGUs has also caused demoralization among the ranks of health personnel due to breaches in the labor contract between the DOH and devolved health workers. Due to financial shortfalls, LGUs have failed to provide or match the salaries and benefits of devolved health personnel. Their transfer to the LGUs have given rise to:

- Insecurities regarding tenure;
- Limited prospects for promotion and career advancement;
- Uncertainty about retirement benefits and other allowances;
- Changes in job descriptions;
- Reduction in perks and other privileges; and
- Tensions with local bureaucracy and political leaders. (Health, Nutrition and Population Strategy Note, June 1998)

The MTPDP 1999-2004 has targetted to maintain the proportion of one civil servant to tend to the needs of 51 Filipinos, or a ratio of 19:1000. The streamlining of the national government bureaucracy has resulted in a decline in the growth of government employment from 8.4 percent in 1995 to 1.4 percent in 1997. At the end of 1997, around 323,000 national government employees were terminated, constituting about 19 percent of government employees. (MTPDP, 1999-2004) However, for the health sector, devolution has contributed to a worsening of the inefficient and inequitable state of the country's health delivery system.

D. People's Assessment

Representatives from a corporate hospital and two DOH NCR-based special hospitals were interviewed to validate the above findings of the study on the effects of SAP conditionalities on the delivery of health services. These were the Philippine Children's Medical Center (PCMC), Jose R. Reyes Memorial Hospital and the National Orthopedic Hospital and Rehabilitation Medical Center (NOH).

Key informants raised two major issues or concerns affecting the delivery of health services as well as the plight of government health workers. These were cuts in the health budget and the plan to corporatize regional and tertiary government hospitals.

According to key informants from the PCMC, a premier training center for pediatrics with a 70 percent charity ward and one of the specialty hospitals of the DOH, the hospital had experienced a 30 percent deduction in government subsidy under the Estrada administration. The cut forced hospital administrators to implement cost-cutting measures to be able to minimize expenses and maximize the limited budget. Among the major consequences of the decrease in government subsidy on hospital operations were the following:

1. Reduction of capital outlays for maintenance and moratoria on the purchase of machines and equipment and infrastructure renovation such as the expansion of the hospital's ambulatory (outpatient) division services;
2. Restrictions on the purchase of medical supplies and drugs due to limited budget and high prices;
3. Implementation of measures, e.g., limiting support for indigent patients, to increase hospital revenues. Patients, regardless of classification, are now required to pay for all medical supplies and medicines used. These include cotton balls, needles, syringes, sutures, bandages, etc. In fact, hospital officials and staff are constantly reminded "to earn, otherwise, we sell".

Key informants also revealed that in line with the streamlining policy, a plan to integrate some of the departments and functions like administration, human resource/personnel, dietary, maintenance & engineering, etc., of the four specialty hospitals, namely, the PCMC, Philippine Heart Center, Philippine Kidney Institute (PKI) and the Lung Center of the Philippines, is now in place. Once implemented, this will result in retrenchment and displacement of many hospital workers and employees.

Another case is that of the Jose R. Reyes Memorial Hospital, one of the 13 DOH NCR-based special hospitals, where 90 percent of clients are indigents mostly coming from the Tondo area. According to key informants, this hospital has effected many changes in policies and operations over the past several years. For instance, before 1997, indigent patients received all the necessary assistance that the hospital can provide such as free medicines and medical supplies. However, starting 1997, under the Ramos administration, hospital staffs have begun to implement revenue-generating measures. These include making charity patients pay for most, if not all, expenses including cotton, bandages, needles, syringes and sutures. At the Emergency Room (ER), before the start of any medical/surgical procedure, patients are asked to buy all the medical supplies and medicines, which they will be using/need. Stricter classification of

patients as charity cases has likewise been done by the Social Service Department of the hospital. Moreover, for those classified as indigent patients, a P5,000 ceiling per patient has been set. If the hospital expenses of the indigent patient exceeds this amount and the patient is not capable of assuming the excess, the case is first referred to the chief of clinics for appropriate action before the treatment of the said patient proceeds.

Key informants from JRR Memorial also revealed that the inability of many poor patients to shoulder their hospital expenses or complete the course of antibiotics while in the hospital has encouraged an increasing number of said patients to opt for HAMA or Home Against Medical Advice.

Other changes instituted by the hospital management as part of its revenue-generating thrust include the following:

- 1) Institutionalization of 24-hour work shifts for social workers to ensure round-the-clock screening of patients classified as indigent;
- 2) Strict monitoring and recording by the health staff of all medical supplies used or consumed,
- 3) Costing for every procedure undertaken such as x-ray, laboratory, etc., and
- 4) Increased workload for the health staff because of additional tasks/functions assigned to them.

Due to budget deficits and the lack of available cash, which was seriously felt starting 1999, actual cash releases have been able to cover only about 40 percent of DOH spending authority for non-personnel expenditures. This has also affected DOH hospitals like the JRR Memorial. According to key informants, starting 1999, releases of appropriations, which were formerly done on a quarterly basis, were now on a monthly basis. The Department of Budget and Management (DBM) also imposed a stricter system of reporting and amount of cash releases, making these contingent on the previous month's release/allocation, availability of savings as reflected in institution's bank account, and release of the National Treasury to the DBM.

In the case of the NOH, where 90 percent of clientele are indigent, problems have arisen similar to those experienced by JRR Memorial. Key informants revealed that the cost-recovery scheme of the hospital was directed to the corporatization of the institution. Like JRR Memorial Hospital, NOH patients now pay for most, if not all, hospital expenses, a trend that began during the Ramos administration.

Rightsizing of labor has also been implemented. Affected are the administrative personnel, institutional, clerical and utility workers, and those assigned in dietary where there is a hiring freeze. Moreover, not all the 1,100 positions of the NOH are currently filled-up. More than 900 items are filled-up but the target of the institution is to reduce this number to 800. To further increase its revenues, there is a plan to hire contractual workers for departments or functions like engineering, dietary and accounting.

The hospital has experienced a gradual decrease in its annual budget because of the corporatization policy. There is no more budget provided by the national government for capital outlays because the hospital is expected to generate the necessary funds for this purpose from its revenue-generating activities.

Still part of the revenue-generating activities are the non-implementation of the economic benefits stipulated in the Magna Carta for Public Health Workers. These include hazard pay for hospital employees. Overtime pay is also no longer paid in monetary terms but transformed into days-off and health staff particularly nurses are overworked due to the non-hiring of additional staff in the light of the increasing volume of patients.

Conclusion and Recommendations

SAPs do impact directly on the delivery of basic services, specifically health and education. SAPs and its conditionalities do affect the state of people's access to affordable and quality education and health services.

However, since the study just covered a few aspects of health and education vis-à-vis SAPs, i.e., state colleges and universities for education and special hospitals for health, and since it is part of what is envisioned to be a multi-stage research project, additional research needs to be done on the other components of basic services affected by SAPs such as the effects of devolution on the delivery of health services and its impact on people and communities, alternative health delivery systems and privatization policy in tertiary education.

This study also recommends civil society groups to investigate the following key issues related to social services on the basis of which campaigns can be made sharper and popular:

- Increased budget for social services particularly health and education;
- More efficient and equitable use of budget for social services, i.e., giving priority to basic and secondary education and public health programs in the allocation of funds;
- Just and equitable implementation of the policy on streamlining/re-engineering of the bureaucracy as it affects the DECS and DOH; and
- Strengthening of LGU capability to deliver affordable and quality health services.

REFERENCES

Bangko Sentral ng Pilipinas (BSP). *The Philippines: Consolidating Economic Growth*. September 2000. 39-40.

Broad, Robin. 1988. *Unequal Alliance, 1979-1986: The World Bank, the International Monetary Fund, and the Philippines*. Quezon City: Ateneo de Manila University Press. 104.

Broad, Robin & Walden, B. 1982. "Structural and Other Adjustments," in Walden Bello et al., *Development Debacle: The World Bank in the Philippines*. San Francisco: Institute for Food and Development Policy. 165 – 181.

Brohman, John. 1997. "The South (1): Neoliberal Policy and Strategy." *Popular Development: Rethinking The Theory & Practice of Development*. Oxford: Blackwell Publishers. 132 – 172.

CASA. 1999. *Background on the World Bank and the International Monetary Fund*. Concept Paper.

Clarete, Ramon L. "Structural Adjustment and Agriculture: Developing A Research Analytical Framework." *Philippine Institute for Development Studies (PIDS)*, Working Paper Series No. 92-21.

Department of Health. *Health Plan for People's Health, 1987-1992*.

Department of Health. 1999. *1999 Updates: Philippine Health Statistics*.

Department of Health. 1999. *Health Sector Reform Agenda: Philippines 1999-2004*.

Department of Health. 1994. *Investing in Equity in Health: The Ten-Year Public Investment Plan for the Health Sector (1994-2004)*.

Department of Health. *National Health Plan (1995-2020)*.

Department of Health. *DOH Annual Report 1998*.

Department of Health Year-End Report 2000.

Department of Health Press Release 2 October 2000 & 5 January 2001.

Feria, Monica, "Fighting the high cost of health." *Philippine Graphic*. September 27, 1999. 10(17): 10-12.

Freedom from Debt Coalition. 1992. *Primer on Structural Adjustment*.

Health, Nutrition and Population Strategy Note. June 1998.

Herrin, Alejandro N. 1992. "Micro Impacts of Macroeconomic Adjustment Policies on Health, Nutrition and Education." *MIMAP on Health, Nutrition and Education*, MIMAP Research Paper No. 7.

Ibon Databank. *Sapped! A Primer on Structural Adjustment and Development*.

Ibon Facts & Figures Special Release. "Privatization: Turning Government Over to the Transnationals." July 1997.

Ibon Facts & Figures Special Release. "The New IMF Program." July 1998.

Ibon Facts & Figures. "The Primary Health Care: A Post-Mortem." 5 October 1998.

Jayarajah, Carl. *Public Welfare – Developing Countries Social Dimension of Adjustments*.

Manasan, R. & Llanto, G. M. 1996. "Financing social programs in the Philippines: Public policy and budget restructuring." *Philippine Institute for Development Studies (PIDS)*. 115.

Montes, Manuel F. 1988. "Review of Structural Adjustment in the Philippines." *Journal of Philippine Development*. XV(2): 139 –165.

National Economic and Development Authority (NEDA). *Medium-Term Philippine Development Plan*, 1987-1992; 1993-1998 (Philippines 2000); 1999-2004 (*Angat Pinoy*)

Ofreneo, Rene P. 1991. "The debt crisis in the Philippines." *The Philippines: Debt and Poverty*. 5 – 16.

Orbeta, Aniceto C., Jr. 1996. "Structural Adjustment and Poverty Alleviation in the Philippines." Paper prepared for the Senior Policy Forum of EDAP Network on Social Reform and Social Development Policies in Asia-Pacific Region. Hainan, P.R.O.C.

Philippine Institute for Development Studies (PIDS). 1998. "Health Care Financing Reform: Issues and Updates." *PIDS Policy Notes*. No. 98-06.

Presidential Management Staff (PMS). 1996. *The Philippine Turn-Around Story: Peace and Development in a Democracy, A Technical Report on the 1996 Accomplishments of the Ramos Administration*.

Rossi, Peter H. & Freeman, Howard E. 1982. *Evaluation: A Systematic Approach*. Beverly Hills: Sage Publications. 2nd edition.

Simbulan, Nymia Pimentel. 2000. "Can We Afford to Get Sick in the Era of Globalization? A Look at the People's Health." *Human Rights Forum*. X(1): 118-142.

Simbulan, Nymia Pimentel. 2001. *The Effects of a Health Education Package on the Health-Seeking Behavior of TB Symptomatic Urban Poor Residents*. Manila: U.P. Manila. (Unpublished Dissertation)

Soriano, Ma. Cecilia G. 1992. "Philippine Structural Adjustment Measures." *Philippine Institute for Development Studies*, Working Paper Series No. 92-10.

World Bank. 1994. *Philippines Devolution and Health Services: Managing Risks and Opportunities*.