

June 2020

POLICY PAPER

The Philippines' COVID-19 Response: Symptoms of Deeper Malaise in the Philippine Health System*

Paul L. Quintos
Senior Lecturer
National College of Public Administration and Governance
University of the Philippines

NOTICE: The views articulated in this document do not represent the official position of the author's institutional affiliation(s). For questions or clarifications, please send an email to: plquintos@up.edu.ph

*This paper benefited from the inputs of Dr. Josh San Pedro of the Coalition for People's Right to Health and Sanny Afable of the UP Population Institute.

Executive Summary

The Philippine government's COVID-19 response has been reactive, *ad hoc* and inadequate. While quarantine and social distancing measures may have slowed down the spread of new cases of SARS-CoV2 infections, the government has been slow to scale up the capacity of the healthcare system to test, trace and treat COVID-19 patients as well as attend to the non-COVID related health needs of the population. The gaps and failings in the government's COVID-19 response can not merely be attributed to poor leadership or the lack of experience in dealing with a pandemic of this scale. From the onset, the Philippine's pandemic response has been fundamentally constrained by the sorry state of the public health system in the country. This weak public health system is the result of deliberate policy choices, fiscal priorities and institutional design made over many years up to the present. As the country and the rest of the world move slowly and cautiously towards a "new normal," it is essential to remedy the fundamental ills of the Philippine health system beyond the requisites of dealing with emergency situations such as the COVID-19 pandemic. We need an inclusive, just and equitable health system that will help us look forward to a "new and better normal" for all.





A white swan event

According to the World Health Organization (WHO), the first cluster of pneumonia cases of unknown etiology were first reported by officials in China in December 2019. Some of the earliest known patients were discovered to have bought food at a wholesale food market in Wuhan City in the Hubei Province of China. Environmental samples taken from this market tested positive for a novel coronavirus strain subsequently named SARS-CoV 2. This has been taken as evidence that the market in Wuhan City played a role in the initial amplification of the outbreak of COVID-19, the name of the disease caused by this novel coronavirus (World Health Organization [WHO], 2020a).

The first lab-confirmed case outside China was reported in Thailand on 13 January 2020 (WHO, 2020b). By 1 February, there were 11,953 reported cases in 24 countries worldwide (WHO, 2020c). Three months later, the World Health Organization (WHO) recorded over 3.1 million confirmed cases and 224,172 deaths worldwide, with only 13 countries and territories reporting zero cases of COVID-19 (WHO, 2020d).

Table 1. Global tally of COVID-19 cases and deaths

Date	Total confirmed cases	Total confirmed deaths	No. of countries/ territories
Jan. 1	27	0	1
Feb. 1	11,953	259	24
Mar. 1	87,137	2,979	59
Apr. 1	823,626	42,540	205
May 1	3,175,207	224,172	214

Over the past four months, over 3.2 billion people have been placed under some form of lockdown or government-imposed restrictions on

movement to slowdown the transmission of the virus (Buccholz, 2020 April 23). More than 70% of the world's school population are affected by school closures due to the pandemic (United Nations Educational, Scientific and Cultural Organization, n.d.). With workplaces forced to shutdown across the globe, total working hours declined in the first quarter of 2020 by an estimated 4.5% globally—equivalent to approximately 130 million full-time jobs lost or suspended—compared to the previous quarter. The world's 1.6 billion informal economy workers are among the worst affected by lockdown measures (International Labour Organisation, 2020 April 29). Early estimates by the World Trade Organization (WTO) indicate that global gross domestic product (GDP) and merchandise trade will decline by around 2.5% and 13%, respectively, in 2020 (WTO, 2020 April 8). And even if a vaccine is successfully developed and deployed by next year (according to the most optimistic scenario), no one expects the world to return to the “old normal”.

The speed and scale of the COVID-19 pandemic and its social and economic ramifications throughout the world have few if any historical precedent.¹ As such many people are calling it a “black swan event”—a term popularized by Nassim Nicholas Taleb, a finance professor in New York University and former Wall Street trader who used it to refer to extremely rare and unexpected events with catastrophic consequences such as the 2008 global financial crisis or the 911 attacks in the US. Taleb himself, however, insists that the COVID-19 pandemic is in fact a “white swan event”—a predictable and preventable occurrence (Schatzker, 2020 March 31).

¹ Perhaps only the 1918-1919 “Spanish Flu” pandemic is comparable. This pandemic killed an estimated 20 to 50 million people and infected 500 million or one-third of the world's population in two years.



Indeed, no less than 11 major infectious-disease outbreaks, epidemics, and pandemics occurred somewhere on the planet between 2002 through 2015, providing the world a preview of 2020.

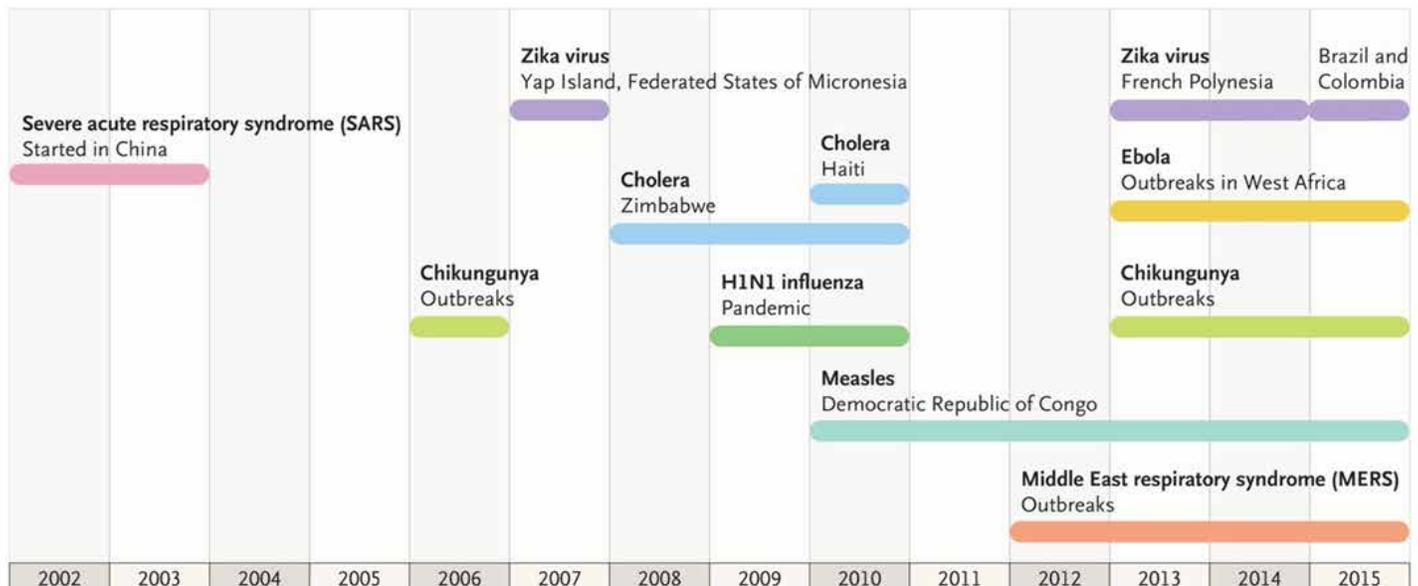
For many years now, epidemiologists have been on the lookout for when, not if, a global pandemic will next occur. Even experts from beyond the medical fields such as Taleb and Bill Gates have raised the alarm about the threat of another global pandemic. Four years before COVID-19, the Commission on a Global Health Risk Framework for the Future warned (Sands, Mundaca-Shah, & Dzau, 2016):

Although we cannot know with any certainty the probability of future epidemics, let alone pandemics, nor estimate with precision their likely impact, the case for greater investment is compelling. The rate of emergence of new infectious diseases appears to be increasing. As a result of increased population, and consequently greater human-wildlife interaction and increased livestock production, there is greater probability of zoonotic transmission. In addition, ever increasing global trade and travel increase the potential for outbreaks

of new or resurgent pathogens to turn into epidemics or pandemics. Globalization drives economic growth but also facilitates the spread of contagion. (p. 1284)

Formed in 2015, the Commission is composed of 17 members—clinicians, scientists, social researchers, policy experts, industry leaders, financiers, and community leaders—from 12 countries. They produced a set of 26 recommendations designed to work together as a comprehensive framework “to counter the threat of infectious-disease crises” (Sands, Mundaca-Shah, & Dzau, 2016, p. 1282). These recommendations included “measures directed at reinforcing national public health capabilities and infrastructure, such as disease-surveillance systems and laboratory networks;” “strengthening the WHO’s leadership role in coordinating global preparedness and response;” “[mobilizing] international financial resources;” and engaging communities in pandemic preparedness and response (Sands, Mundaca-Shah, & Dzau, 2016, p. 1282).

Figure 1. Major Emerging and Reemerging Infectious-Disease Outbreaks, Epidemics, and Pandemics, 2002-2015.



Source: Sands, Mundaca-Shah, & Dzau, 2016, p. 1281



Public health measures such as safety standards and regulations, information/education campaigns, vector control activities and immunization programs are examples of public goods.² Because once provided their benefits extend to everyone or beyond their direct recipients (consumers), profit-maximizing economic agents cannot be expected to supply them at socially efficient levels, if at all. Unfortunately, public health is also a prime example of a public good that is largely invisible. Most people enjoy it unknowingly when there is a low incidence of disease and epidemics do not occur. But people realize its absence or inadequacy, often belatedly, when morbidity and mortality surge. For this reason, even though public healthcare is primarily the responsibility of government, self-interested vote-maximizing politicians also tend to underrate their importance.

It is this kind of mindset that filters out the urgency of pandemic preparedness. As the Commission puts it,

If outbreaks are framed as a health issue, spending on preventing and preparing for them pales against more pressing and visible health priorities. Governments find it difficult to justify spending money on avoiding relatively low-probability crises, and the private sector foresees relatively little return on such investments.

Yet when the issue is framed as one of security or threat to human lives, it seems remarkable how little we spend. Pandemics arguably pose more of a threat to human lives than war, terrorism, or natural disasters. Framed as a risk to economic growth and stability, the danger is equally stark. (Sands, Mundaca-Shah, & Dzau, 2016, p. 1284)

² In this paper, public health refers to health-related goods and services that are pure public goods (non-excludable and non-rivalrous) as well as merit goods (goods and services with positive externalities).

Unfortunately, the way that nearly all governments—in developed as well as developing countries—have been caught unprepared by the COVID-19 pandemic shows the prescience of the Commission's work.

This paper reviews the Philippine government's response to the COVID-19 pandemic from the start of 2020 up to the third week of May, focusing on the role of the Department of Health (DOH) and the public health system.

Waging a war with the wrong ammunition

The Philippines is no stranger to infectious diseases such as dengue, chikungunya, leptospirosis, measles, pertussis, and meningococemia, among others. It has also had its share of responding to biological hazards that have posed serious health threats, such as the severe acute respiratory syndrome (SARS) in 2003, the avian influenza in 2004, the Ebola Reston virus and H1N1 in 2009, the Middle East respiratory syndrome-corona virus in 2012, the West Africa Ebola virus in 2014, and the Zika virus in 2016. The DOH responded to at least 70 major emergencies and disaster events from 2006 to 2016, including biological hazards (Law, 2016). Moreover, millions of Filipinos work in other countries where they are potentially exposed to numerous vectors of endemic or emerging infectious diseases.

Given these conditions, the DOH has produced guidelines to deal with avian influenza, MERS-CoV, Zika virus, Ebola virus and influenza A H1N1 developed by the Emerging and Re-emerging Infectious Diseases Program (DOH, n.d.-a).

As news of a novel coronavirus started trickling out of China, the Philippine government took early notice. As early as 5 January 2020, the DOH "ordered tighter screening of incoming travelers



from abroad following reports of a 'mysterious disease' from China" (ABS-CBN News, 2020 January 5, "DOH orders tighter screening..."). On 21 January 2020, the DOH released its "Interim Guidelines on the Preparedness and Response to Novel Coronavirus (2019-nCoV) from Wuhan" (DOH, 2020 January 21). The DOH established surveillance systems to actively look for cases of COVID-19. The Epidemiology Bureau (EB) and the Bureau of Quarantine of the DOH were directed to work "in close collaboration with LGUs to trace possible contacts of confirmed cases, using passenger manifests of public transport means including flights, ferries and buses" (WHO Philippines, 2020 March 9, p. 4). Epidemiological Surveillance Units (ESU) at municipal, city, provincial and regional level were directed "to continuously conduct event-based (or rumor-based) investigations, searching for clusters of diseases of unknown origin and/or pneumonia-like illness" (WHO Philippines, 2020 March 9, p. 4).

Within the DOH, an Emergency Operation Center for COVID-19 was established to serve as the command center in-charge of consolidating updates and information as the COVID-19 health event evolves (DOH, 2020 March 2). The Inter-Agency Task Force on Emerging Infectious Diseases (IATF-EID) led by the DOH was first convened on 28 January to serve as the lead advisory body to the President on the management and implementation of necessary actions related to COVID-19 (DOH, 2020 January 29).

Despite these early efforts to prepare for the possibility of a COVID-19 outbreak in the country, the government's subsequent response revealed the inadequacies of the national disaster response framework and exposed the sorry state of the country's health system. The attempts to contain the pandemic also shone a harsh light on long-standing deficiencies in the country's social,

economic and political institutions that have exacerbated the vulnerability of vast swathes of the population.

The first confirmed case of COVID-19 in the Philippines was reported on 30 January 2020 in the person of a woman who entered the country from Wuhan, China. This finally prompted the government to prohibit the entry of travelers from the Chinese province of Hubei after weeks of rejecting calls for a travel ban for travelers coming from China (CNN Philippines Staff, 2020 January 31).

Even then, President Rodrigo Duterte continued to downplay the threat of the new virus. Five days after the WHO declared the novel coronavirus outbreak (2019-nCoV) a public health emergency of international concern (PHEIC), on 3 February, President Duterte told media, "There is nothing really to be extra scared of that coronavirus thing although it has affected a lot of countries but in... You know one or two in any country is not really that fearsome" (Presidential Communications Operations Office [PCOO], 2020 February 3, "Media Interview of President Rodrigo Roa Duterte..."). It took another month before President Duterte declared a state of public health emergency in the Philippines on 9 March—two days after the DOH had recorded the first case of local transmission in the Philippines.

Prior to this declaration, the DOH and the National Disaster Risk Reduction and Management Council (NDRRMC) led a national contingency planning exercise for COVID-19 on 27–28 February 2020. This was attended by representatives from various government agencies, the United Nations (UN), Red Cross, and non-governmental organizations who discussed the roles and responsibilities of different government and non-government actors for a whole-of-government response to a COVID-19 outbreak in the country (WHO



Philippines, 2020 March 9, p. 3). But in the WHO Philippines situation report dated 9 March, it was reported that the national government was still finalizing the draft contingency plan for COVID-19 (WHO Philippines, 2020 March 9). It was not until 24 March that the IATF-EID unveiled this National Action Plan to the public (Lopez, 2020 March 25)—more than two months after the WHO issued a comprehensive package of technical guidance online with advice to all countries on how to detect, test and manage potential COVID-19 cases (WHO, 2020 April 27).

On 14 March, the government placed the National Capital Region (NCR) under community quarantine for 30 days. Two days later, the President announced a month-long lockdown of the entire island of Luzon from 16 March until 12 April to arrest the spread of COVID-19. At the same time, the country was placed under a state of calamity to allow the government to tap into emergency funds to respond to the crisis (Presidential Communications Operations Office [PCOO], n.d.).

On 16 March, the government also announced its initial emergency response package to combat the coronavirus, totaling PhP27.1 billion (USD535 million). Of this amount, only PhP3.1 billion (11.4%) was set aside to acquire testing kits while PhP14 billion (51.7%) was set aside to boost the sagging tourism industry. The remaining 36.9% was earmarked for socioeconomic assistance for displaced workers and farmers as well as small and medium enterprises affected by COVID-19 (CNN Philippines Staff, 2020 March 16). A week later, on 23 March, the Philippine Congress passed the “Bayanihan to Heal as One Act” which grants President Duterte even more powers to respond to the pandemic and the authority to realign the national budget (CNN Philippines Staff, 2020 March 24).

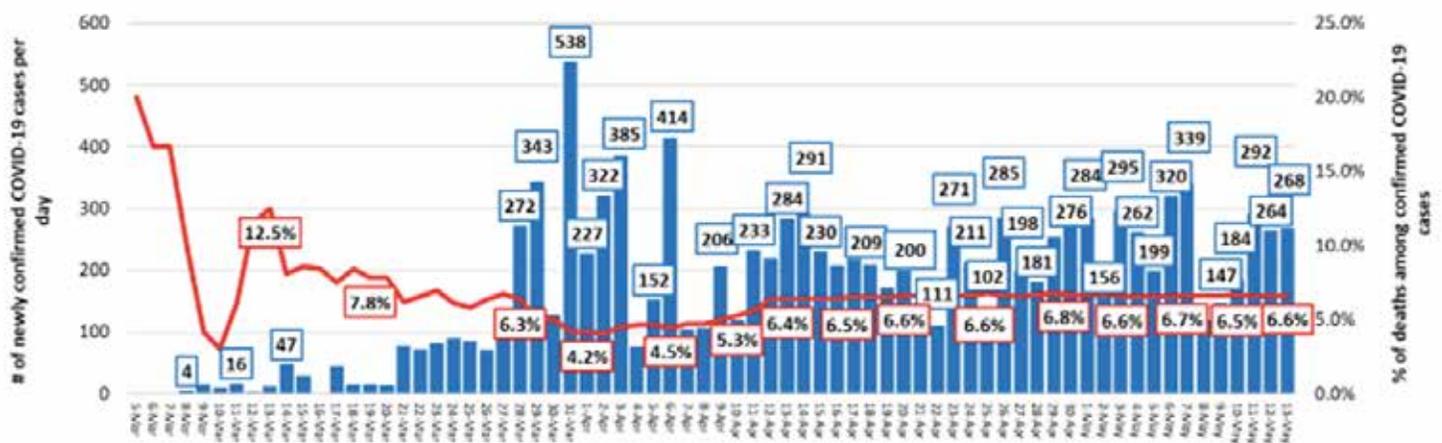
Since then, the movement of people in many parts of the country including the capital has been limited to accessing basic necessities and work. Land, domestic air, and sea travel in and out of the capital region have been restricted. Mass gatherings have been prohibited and classes have been suspended. The lockdowns have engendered their own array of problems including the massive loss of livelihoods, the collapse of businesses especially micro, small and medium enterprises (MSMEs), the universal disruption in learning, a drastic reduction in government revenues, numerous cases of police abuse, domestic violence, a rise in hunger and the worsening plight of the poor. These deserve another set of papers to analyze.

Nevertheless, a number of independent groups of experts, such as the University of the Philippines’ COVID-19 Pandemic Response Team, credits the government’s quarantine measures along with other interventions for slowing down the rate of infections from around three days doubling time at the start of the quarantine period to around six days doubling time by 10 April (Lontoc, 2020 April 20).

Numerous critics, however, emphasize that the actual number of cases in the Philippines may be significantly higher and more spread out than what is reported because many infections remain undetected due to the country’s low testing capacity for COVID-19. Testing is crucial as it is the basis for identifying infected persons, tracing potential cases, and identifying who needs to be isolated and treated. As explained by Tedros Adhanom Ghebreyesus, director-general of the WHO, individual precautionary behavior such as social distancing, regular handwashing and coughing into your elbow is not enough to contain the spread of the disease. “We simply cannot stop this pandemic if we don’t know who is infected”, according to Tedros (UN News, 2020 March 16).



Figure 2. Daily reported confirmed COVID-19 cases in Philippines (5 March – 13 May 2020)



Source: WHO Philippines, 2020 May 13, p. 2

As of 10 May, the Philippines has only tested a total of 1.44 persons per 1000 people compared to 31.82 for Singapore, 12.98 for South Korea, 7.94 for Malaysia, 4.1 for Thailand and 2.68 for Vietnam (as of 29 April). Among its large neighbors, the Philippines' cumulative testing only compares favorably with Indonesia's 0.41 per thousand population (see Figure 3) (Roser, Ritchie, Ortiz-Ospina, & Hasell, 2020).

The relatively low cumulative testing figures in the Philippines is not just the result of limited resources and capacity. As late as 20 March, the DOH insisted that mass testing was not yet needed in the Philippines. It was not until 14 April that the government officially adopted a policy of "mass testing" for "persons under investigation and monitoring, and high-risk patients such as health workers, pregnant women and those with other medical conditions, such as cancer and diabetes" (Peralta, 2020 April 4, para. 2).

Since then, the IATF-EID has aimed to increase the number of accredited testing laboratories to 66 and raise daily testing capacity to 30,000 per day by end of May. The ultimate aim is to test around two million Filipinos or 1.5–2% of

the entire population (Parrocha, 2020 May 19). Starting with only one laboratory accredited to conduct polymerase chain reaction (PCR) tests for COVID-19 at the beginning of the year, there are now 34 accredited testing labs throughout the country as of 25 May, but three-fourths of these are based in Metro Manila (Montemayor, 2020 May 25). This pales in comparison to Vietnam which managed to increase the number of COVID-19 testing laboratories from three in January to 112 by April (Vu, Nguyen, & Pearson, 2020 April 30).

The President's spokesperson claimed on 25 May that the government has already achieved the 30,000 per day testing capacity. But this is just the hypothetical capacity of all accredited labs combined when in fact most recent data show that actual testing stands at a little over 8,000 per day and the total number of persons tested has only reached 272,255 individuals as of 23 May (Merez, 2020 May 25). This is because even with more labs accredited, their actual daily testing is constrained by other factors such as lack of trained personnel and inadequate supply of reagents and other materials. Moreover, the government's test reporting is increasingly



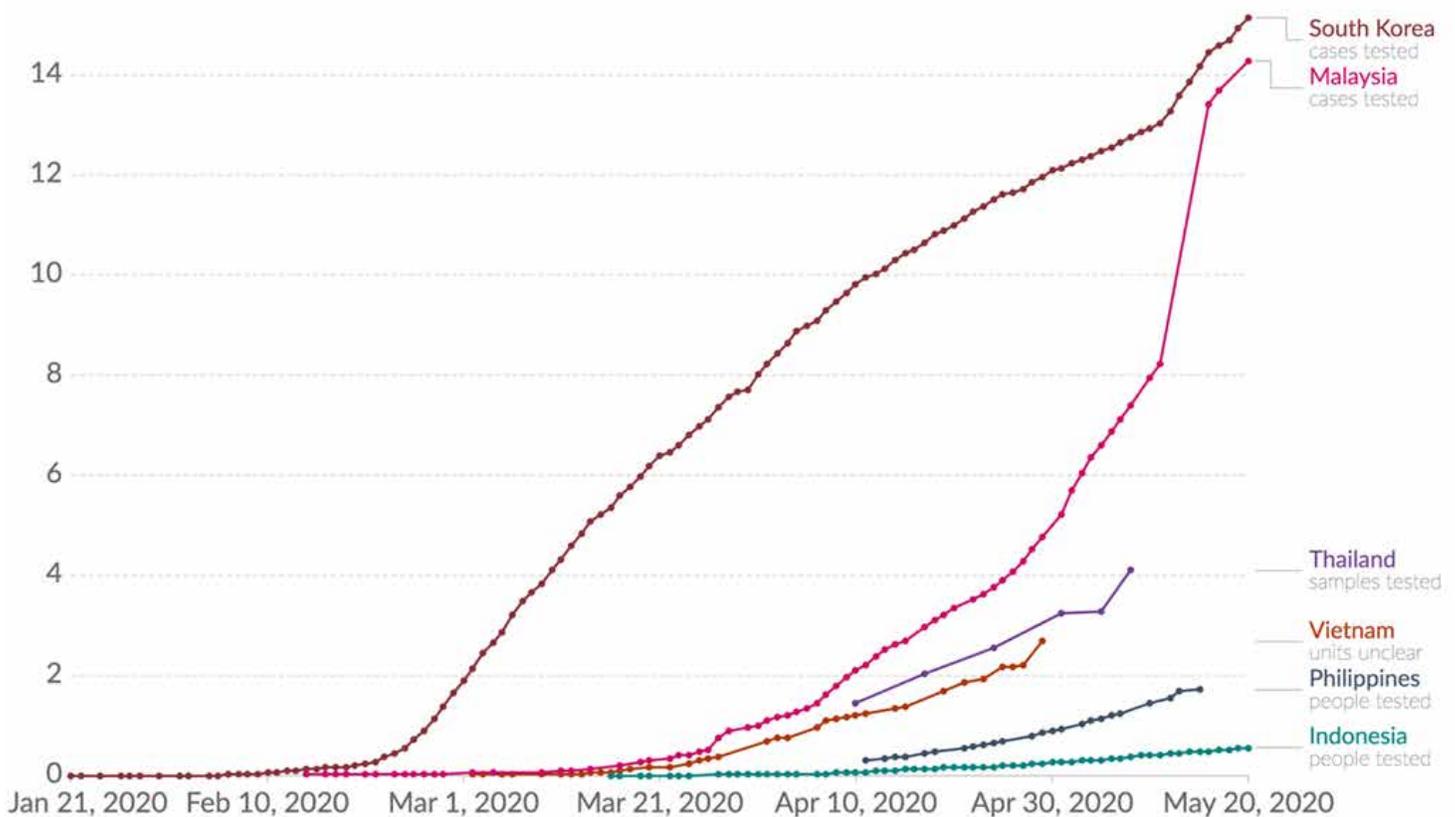
hobbled by backlogs in data processing by as much as 6,000 cases as of 25 May (Merez, 2020 May 25).

Contact tracing capacity is likewise severely limited. The country has a total of 38,315 contact tracers or 35 per 100,000 population whereas the WHO recommends a ratio of one contact tracer for every 800 people (De Vera & Yee, 2020 May 21). According to the President's latest report to Congress, a total of 63,306 close contacts of COVID patients have been traced as of 18 May (Official Gazette, 2020 May 25). This implies that an average of 3.4 contacts have been traced per confirmed case of COVID-19 in the country—possibly just the household members of each case. This is less than one-fifth of what some experts estimate as the average number

of contacts per infected person that should be traced immediately in order to contain the spread of the virus (Kucharski et al., 2020).

Meanwhile, the case fatality rate (CFR) in the Philippines is double the average rate for middle income countries and Asia as a whole. It has not gone down from around 6.5% since mid-April (see Figure 4). Many countries in Europe and the global north more generally have relatively higher case fatality rates because they have a higher proportion of elderly people who are more vulnerable to the SARS-CoV-2 virus (Sung & Kaplan, 2020 May 15). But the Philippines has a much younger demographic profile so there must be other reasons for the higher CFR in the country.

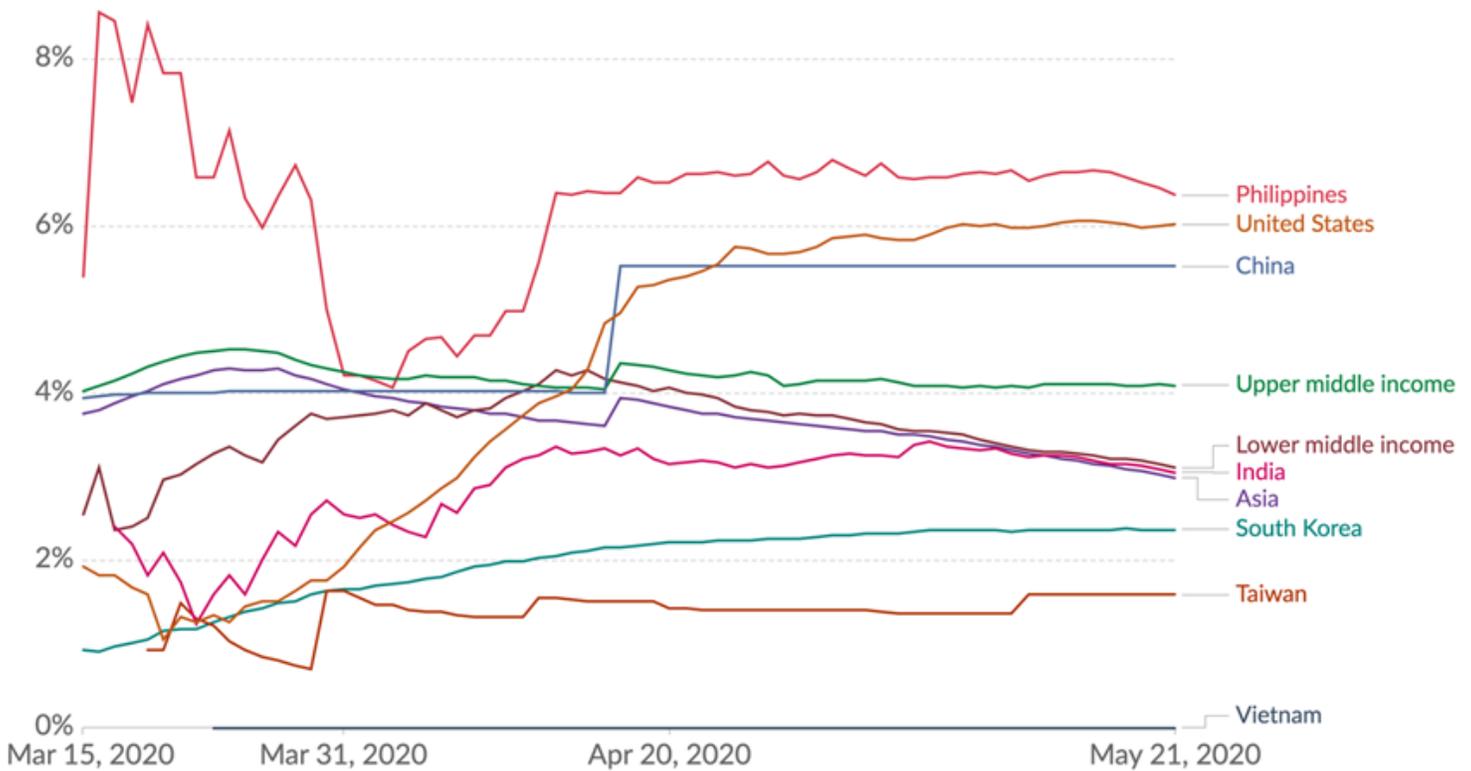
Figure 3. Total confirmed COVID-19 tests per thousand people (Philippines, Malaysia, Thailand, Vietnam and Indonesia)



Source: Roser, Ritchie, Ortiz-Ospina, & Hasell, 2020, "Total confirmed COVID-19 tests per thousand people (Philippines, Malaysia, Thailand, Vietnam and Indonesia)"



Figure 4. COVID-19 Case Fatality Rate (Philippines, US, China, South Korea, Taiwan, India, Asia, Upper Middle Income, Lower Middle Income)



Source: Roser, Ritchie, Ortiz-Ospina, & Hasell, 2020, "COVID-19 Case Fatality Rate (Philippines, US, China, South Korea, Taiwan, India, Asia, Upper Middle Income, Lower Middle Income)"

One likely reason is inadequate testing. When testing is limited to the symptomatic and high-risk cases, those with asymptomatic, mild or less risky cases are unlikely to be counted. This means there is a higher proportion of those more likely to succumb to COVID-19 among those tested and confirmed. Another possible reason is that, among those tested and confirmed, many do not receive timely, adequate or appropriate treatment. High out of pocket costs discourage many Filipinos from seeking timely medical care, even those covered by social insurance (Dayrit, Lagrada, Picazo, Pons, & Villaverde, 2018). Still another reason may be that there is a bigger proportion of the population with co-morbidities (e.g. hypertension, diabetes, asthma, etc.) that make them more vulnerable to COVID-19.

Flattening the COVID-19 epidemic curve means slowing down and reducing the transmission rate of the virus so that the existing capacity of the health system is not overwhelmed. So the lockdown period should be used to raise the capacity of the healthcare system to test, trace and treat COVID-19 patients as well as attend to the non-COVID related health needs of the population. On this point, the government's response appears inadequate because while the lockdown and social distancing measures may have slowed down the spread of new cases, the country's health system is bursting at the seams.



A view from the frontlines

Together with other volunteers and Sonny Afable of the UP Population Institute, the author conducted an online survey of health workers from 24 April to 3 May in behalf of the Alliance of Health Workers (AHW) and the Alliance of Concerned Teachers (ACT) in order to better understand the conditions of health workers who are at the frontlines of fighting this pandemic.

Out of 457 respondents, more than half reported that their health facilities do not meet even 50% of what they perceive as the adequate number of health personnel and the sufficient number of infection, prevention and control (IPC) supplies and personal protective equipment (PPE).

Around two-thirds of respondents believe there is severe lack of doctors, nurses and nurse assistants as well as administration and utility personnel in their health facilities. An even bigger proportion of respondents indicate that there is severe lack of counsellors/therapists as well as midwives. Across all types of medical frontliners, less than 10% of respondents believe there is adequate or near adequate number of personnel.

Despite the release of PhP2.25 billion by the government for the purchase of PPEs, respondents reported severe or moderate shortage of supplies in their facilities, especially for N95 masks, COVID-19 testing kits, mechanical ventilators and isolation quarters. In general, the shortage is felt more acutely by workers in

Figure 5. Reported adequacy of health personnel, by % of respondents rating

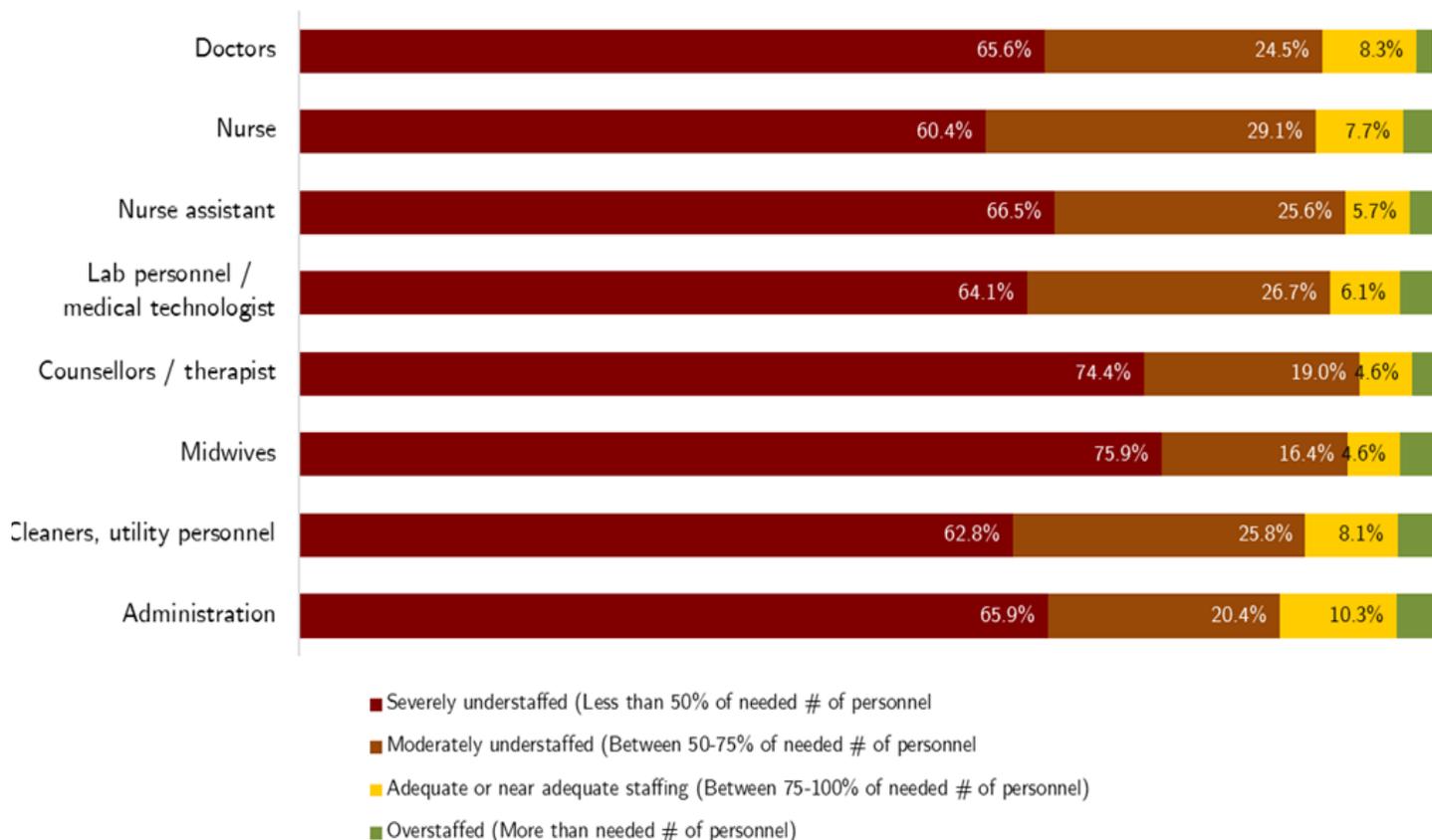
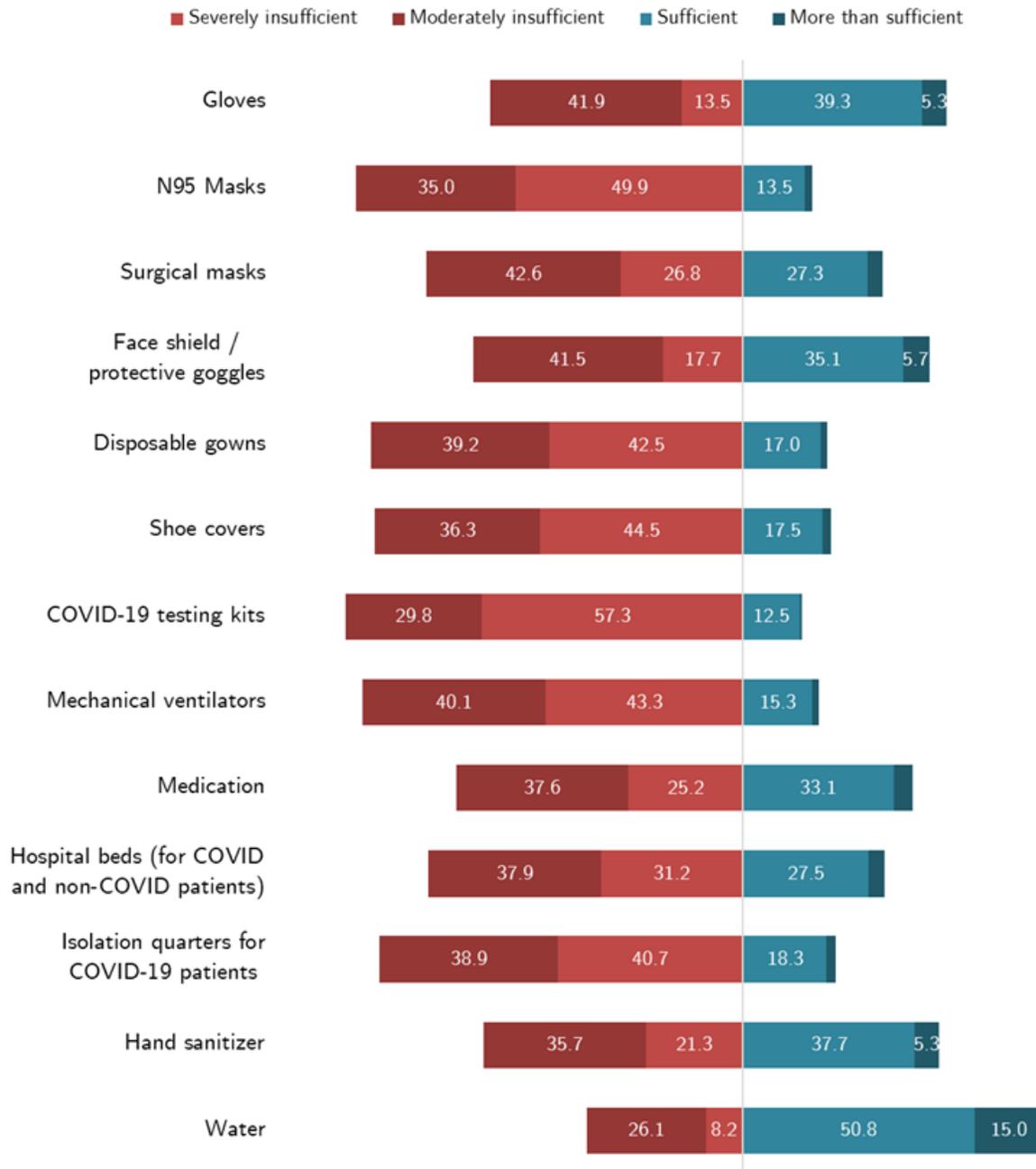




Figure 6. Adequacy of PPEs, by % of respondents rating



national government hospitals. On the other hand, there is evidence that LGU hospitals disproportionately face shortage of water, medication, and mechanical ventilators.

Compounding these issues which magnify the risks faced by medical frontliners, many of them also work excessively long hours while earning very little pay. The high-risk and high stress

conditions faced by frontline health workers in the Philippines combined with inadequate personnel and protective equipment are surely contributing factors to the high rate of COVID-infection among them.

At least 2,366 health workers in the Philippines have already been infected by the SARS-CoV-2 virus or close to one out of every five confirmed



cases of COVID-19 in the country (Rey, 2020 May 22). Indeed, the WHO expressed its alarm over the high number of healthcare workers infected with SARS-CoV-2 in the Philippines. At 17.4% of total cases (as of 22 May 2020), the rate of infection among frontline health workers in the Philippines is by far the highest among 37 member states in the WHO-Western Pacific Region including China—the ground zero of the COVID-19 pandemic. The average for the region is just two to three percent (CNN Philippines Staff, 2020 April 22).

The Philippine Health System: Chronically Ill

The reactive, ad hoc and deficient COVID-19 response of the Philippine government, particularly the DOH, should not be attributed merely to the incompetence of the current DOH secretary or the poor leadership of the IATF-EID. In fact, the country's health system has been weakened by decades of neglect and the systematic reorientation towards privatized health care at the expense of public health.

In 1999, the DOH embarked on a series of reforms under the Health Sector Reform Agenda (HSRA) that hollowed out the public foundation of the country's health system. The HSRA was premised on the neoliberal principles of New Public Management (NPM), the still influential trend in Public Administration that promotes the adoption of market principles in the public sector. Although the term NPM was coined in the early 1990s, the trend was already practiced in the UK in the late 1970s followed by other Organisation for Economic Cooperation and Development (OECD) countries in the 1980s. It gained popularity amidst the widespread perception of government bloat and inefficiency. Osborne and Gaebler (1992) popularized the ten principles for an "entrepreneurial government" that prescribed a "steering not rowing" and "enterprising not spending" role for government, among others.

NPM principles were often translated into policy in developing countries through conditionalities attached to loans or grants provided by multilateral and bilateral development agencies. For instance, in its loan for the Health Sector Development Program of the Philippines, the Asian Development Bank (2004) framed its recommendations according to its reading of general lessons on health sector reform that hew closely to NPM principles. While it acknowledged that developing countries should initially focus efforts on the poor and basic health services, it states:

the structure of health-care systems must be changed so that competitive pressures push them in a more useful direction, enhancing the power of purchasers and increasing competition in the supply of medical care. Another lesson is that just because governments finance so much of health care, they do not necessarily have to deliver it themselves. Governments also review their role as regulators. A better role for regulators would be to sponsor competition. (p. 8)

This articulated a market-oriented model of healthcare that was also promoted by the World Bank through, for instance, the "World Development Report 1993: Investing in Health" (World Bank, 1993). This neoliberal model of health care ensconced the role of the private (for-profit) sector in health provision while maintaining selective cost-effective public health interventions (e.g., vaccinations, family planning, TB-DOTS, etc.) and safety nets for the poor (e.g., tax-subsidized social health insurance).

In the Philippines, this framework was subsequently implemented through the privatization of government-owned health facilities and the corporatization (or fiscal autonomy) of those that remained under



government-ownership to keep public subsidies at a minimum. It also promoted the shift to insurance-based personal care while minimizing spending on public health, including comprehensive primary and preventive care.

As a result, public expenditure on health has never exceeded 1.6% of GDP in the Philippines since at least the mid-90s (Dayrit et al., 2018). The “fiscal crisis” of the 1980s up to the early 2000s was invariably cited as the constraint to public spending yet over seven percent of GDP on average was allocated for debt service payments from 1986–2003 (Bangko Sentral ng Pilipinas, n.d.). This is indicative of the government’s order of priorities rather than its absolute limitations.

In terms of government spending on health per person, the Philippines’ record is even more opprobrious compared to other countries in the region and beyond. At USD42.4 per person in 2017 (see Table 2), the Philippine government spends less than one-fifth of the ASEAN average and a mere 7.3% of the global average.

Figure 7 shows how the distribution of total health expenditure (THE) in the Philippines has evolved from 2000 to 2014.³ It shows the steep decline in the shares of both the national and local government in THE, from a combined share of 40% in 2000 to less than 18% by 2014. On the other hand, the share of private out-of-pocket expenses of households increased from an already burdensome 41% to more than 55% even though both voluntary and social insurance have covered an increasing share of THE over the same period. Out-of-pocket health expenditure is the most impoverishing form of health financing (Ulep & Dela Cruz, 2016).

It is also important to underscore that out-of-pocket expenses and insurance spending,

whether voluntary or government-mandated social insurance, are spent almost entirely on personal health expenditures and not on public health.⁴ At the same time, a significant portion of government expenditure on health is also spent on personal healthcare and other expenditures (i.e., maintenance and operations). This means only a small fraction of total health expenditure—a little over seven percent in 2014—is spent on public health compared to over 85% on personal healthcare. It would even be lower if not for official development assistance from other countries.

The shift towards insurance-backed personal health care began in the mid-1990s with the National Health Insurance Act of 1995 (Republic Act [RA] 7875). This was given further impetus by the Universal Health Care (UHC) Agenda of the Aquino administration launched in 2010 which sought to cover 100% of the population under the National Health Insurance Program (NHIP) run by PhilHealth. This was eventually translated into law (RA 11223) in 2019 under the present administration. According to the UHC Law, all Filipino citizens will be automatically enrolled into the NHIP which is expected to cover “individual-based health services.” On the other

⁴ The Philippine Statistical Authority (PSA) refers to three types of uses of health expenditures depending on who receives the benefits of the health care goods and services provided. “Personal healthcare” refers to health goods and services for which all benefits are captured by the person who receives them. “Public healthcare” includes both pure public health goods and services and goods/services with externalities (e.g., information/ education campaigns or IEC, safety and standards regulation, spraying for malaria control and other vector control activities, immunization, programs providing personal care services combined with information and education services like primary health care, maternal and child health care, control of diarrheal diseases and control of acute respiratory infections). “Others” cover the indirect costs of providing health goods and services including (1) central administration by government of health activities, by PhilHealth, ECC, SSS and GSIS of social insurance operations and by private insurance companies for private health insurance operations; and (2) health-related research and training.

³ More recent data from the PSA is available up to 2018 but the data categories are not comparable to this longer but older time series.

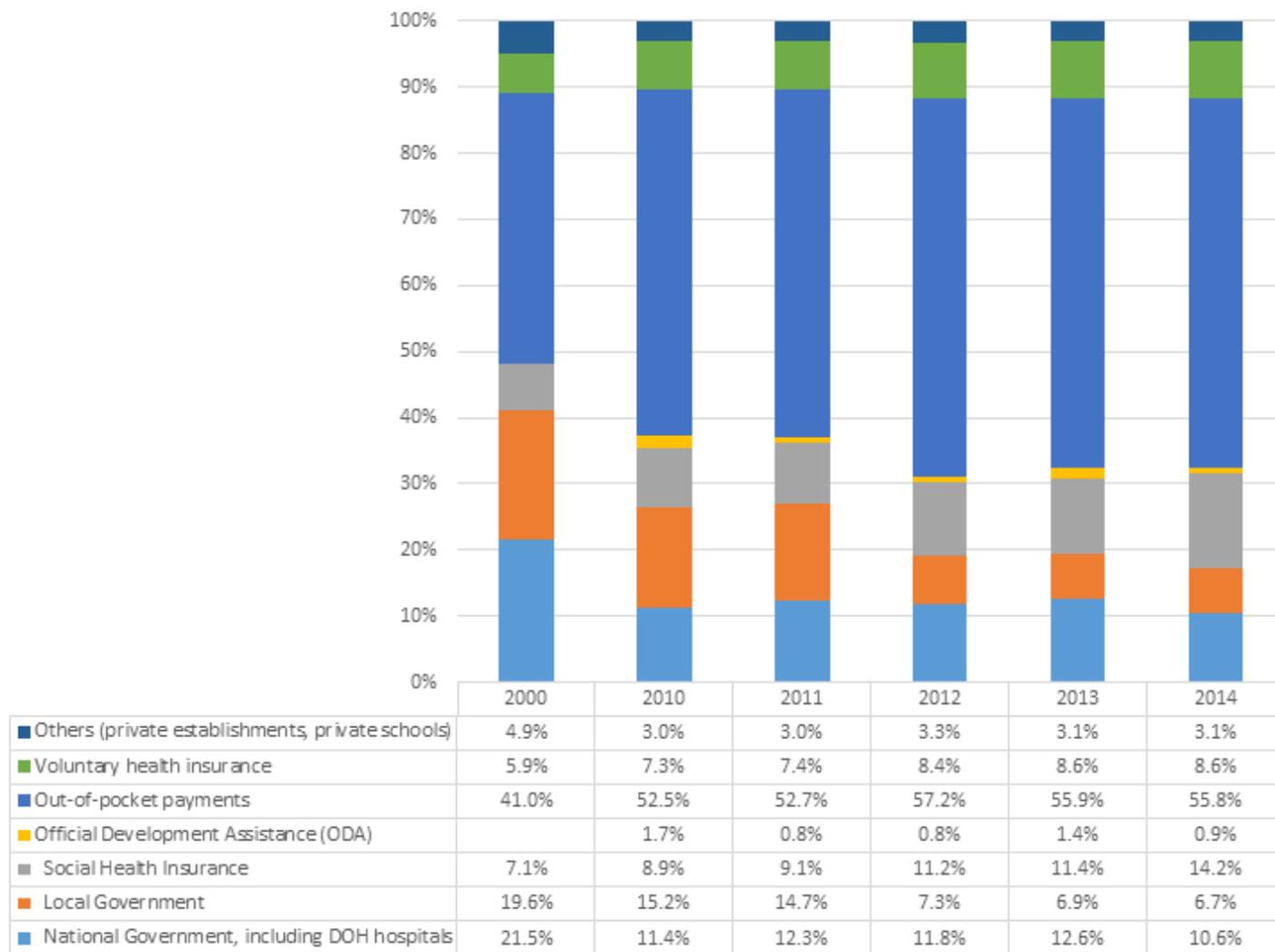
**Table 2. Domestic general government health expenditure**

WHO region	in US\$ per capita		as percentage of GDP	
	2017	2000	2017	2000
Global	578.9	224.2	3.3	2.8
<i>By WB income group</i>				
Low-income	9.9	3.9	1.4	1.4
Lower-middle-income	62.6	19.8	2.4	2.1
Upper-middle-income	300.3	98.3	3.8	3.4
High-income	2,088.5	845.4	5.4	4.3
<i>By WHO Region</i>				
Africa	60.2	22.1	1.9	1.7
Americas	581.5	222.1	4	3
South-East Asia	120.3	18.8	2.1	1.4
Europe	1,648.1	671.8	4.9	4.1
Eastern Mediterranean	374.4	144.9	2.6	2.1
Western Pacific	688.9	265.4	4.2	4.5
ASEAN	231.6	84.7	1.9	1.3
Singapore	1,262.3	298.2	2.1	1.2
Brunei Darussalam	636.7	427.9	2.3	2.1
Malaysia	194.3	52	2	1.2
Thailand	188.1	34.4	2.9	1.7
Viet Nam	63	6.6	2.7	1.7
Indonesia	55.6	4.6	1.4	0.5
Timor-Leste	54.9	n.a.	2.6	n.a.
Philippines	42.4	14.6	1.4	1.4
Lao People's Democratic Republic	21.8	4.1	0.9	1.2
Cambodia	19.5	3.9	1.4	1.3
Myanmar	8.6	0.4	0.7	0.2
<i>Other reference countries</i>				
Republic of Korea	1,310	238.5	4.4	2
Cuba	883.4	151	10.5	5.5
Costa Rica	638.9	163	5.4	4.3
China	249.8	9.3	2.9	1
Sri Lanka	68.5	23.4	1.6	2.3
India	18.8	3.8	1	0.8

Source: WHO, 2020 January 23, "Domestic General Government Health Expenditure"



Figure 7. Distribution of Total Health Expenditure, by source of funds



Source: Dayrit et al., 2018, p. 78

hand, the DOH and local government units (LGUs) are expected to focus on “population-based health services” which refer to interventions that address population-wide concerns such as health promotion, disease surveillance, and vector control (National Economic and Development Authority [NEDA], n.d.).

Yet Figure 7 also shows that the decline in the share of local government in THE is even more precipitous than the decline in that of the DOH, from under 20% in 2000 to under seven percent by 2014. This is a cause for major concern because it implies low spending on primary health care, promotive and preventive health programs

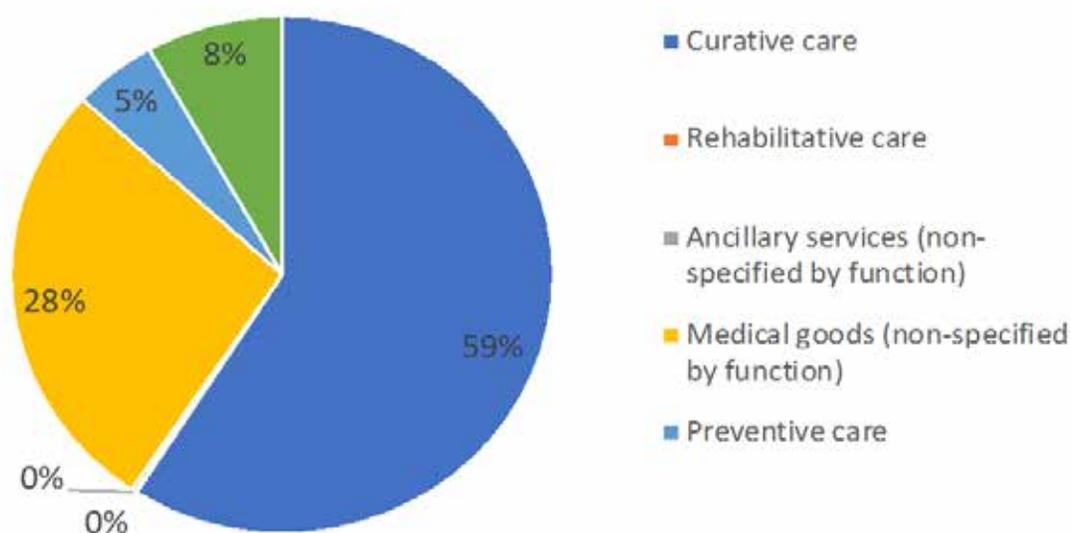
which are mainly the responsibility of municipal governments according to the Local Government Code of 1991 (Republic Act 7160). Indeed, Figure 8 shows that the share of preventive care in total current health expenditure in 2018 is a mere five percent compared to 59% spent on curative care. As of 2019, only 45% of all barangays in the country have barangay health stations. This means one barangay health station must cater to the primary health care needs of 4,638 persons on average (DOH, n.d.-b).

**Table 3. Distribution of Total Health Expenditures in 2014, by use of funds**

Source of Funds	Use of Funds			TOTAL in thousand pesos
	Personal	Public	Others	
National Govt	53.02%	34.88%	12.10%	61,815,688
Local Govt	27.72%	45.04%	27.24%	39,321,470
Social Insurance	93.86%	0.00%	6.14%	83,323,630
Private Sector (incl. OOP)	96.22%	0.00%	3.78%	395,343,226
Rest of the World (ODA)	0.00%	37.95%	62.05%	5,503,244
TOTAL	85.81%	7.07%	7.12%	585,307,258

Source: Philippine Statistics Authority, 2016, "Table 8. Philippine National Health Accounts by Use and Source of Funds, 2014 (in thousand pesos)"

Note: The recent editions of the Philippine National Health Accounts no longer provide a breakdown of total health expenditure according to the use of funds (personal health, public health and others).

Figure 8. Distribution of current health expenditure by healthcare function, 2018

Source: Philippine Statistics Authority, 2019, "Table 8 Current Health Expenditures by Health Care Function"

While RA 7160 was intended to engender greater accountability of LGUs and greater local participation in collective decision-making, Dayrit et al (2018) conclude that

[the devolution] of health services from the national government to LGUs[...] fragmented the system into thousands of local health systems run by provinces, cities and

municipalities, often lacking coordination and having great variation in local resources for health. The devolution and inadequate transfer from the National Government to poorer LGUs contributed to underfunding of local hospitals and health units, resulting in poorly equipped facilities and an inadequate complement of human resources.(p. 263)

**Table 4. Number of Local Health Facilities by Region and Population**

Region Name	Population	No. of Brgys	BHS	RHU	Infirmary	Birthing Homes
NCR	13,633,497	1,710	22	495	30	87
Region I	5,225,800	3,267	1794	152	37	151
Region II	3,619,689	2,311	1470	97	35	130
Region III	12,105,494	3,102	2069	283	43	281
Region IV-A	15,742,673	4,019	2792	226	32	347
Region IV-B	3,135,503	1,460	1158	81	34	0
Region V	6,071,398	4,051	1795	129	64	215
Region VI	7,835,883	3,003	2000	146	33	34
Region VII	7,853,606	4,390	2334	160	49	79
Region VIII	4,680,701	1,904	925	167	38	236
Region IX	3,754,387	3,471	778	97	30	97
Region X	4,956,259	2,022	1252	121	43	77
Region XI	5,210,081	1,162	1192	69	68	113
Region XII	4,850,329	1,195	1152	62	56	141
Region XIII	2,723,012	1,311	847	81	29	47
CAR	1,791,881	1,177	921	98	32	8
ARMM	4,097,957	2,490	630	128	21	147
TOTAL	107,288,150	42,045	23,131	2,592	674	2,190
Excl. NCR	93,654,653	40,335	23,109	2,097	644	2,103

Source: Department of Health, n.d.-b, "DOH National Health Facility Registry"

Starved of funds but not of talent, the Philippines now has the dubious distinction of being one of the leading exporters of medical professionals to the rest of the world even as it suffers from a shortage of health care workers at home (Lopez & Jiao, 2020 April 24). The country has around four doctors, nine nurses, four midwives, one medical technologist and 10 hospital beds for every 10,000 persons (see Table 4) with a disproportionate share concentrated in the national capital and a few other regions. Compare this to the ASEAN average of nine doctors, 26 nurses and midwives, and 21 hospital beds per 10,000 persons (WHO, 2018).

Not only are hospital facilities inadequate, most of them are also in the private sector. Two-thirds of all hospitals and 53.4% of all hospital beds

are in the private sector (see Figure 9; Dayrit et al., 2018, p. 133). The larger share of the for-profit private sector in the health infrastructure of the country exacerbates the inequitable access to and fragmentation of the health system, making it even more difficult for the national government to coordinate personnel, equipment and logistics in cases of public health emergencies such as the current pandemic.

The DOH is expected to be the apex agency to lead and coordinate the government's response to public health emergencies. But public health does not seem to be among the top priorities of this administration, the UHC Law notwithstanding. In its proposed National Expenditure Plan (NEP) for 2020, the Duterte administration's proposed budget for DOH was 10% lower than its 2019 level.



Congress increased it by three percent instead in the General Appropriations Act (GAA). But the already miniscule budget for the agency's Epidemiology and Surveillance Program, which

has a central role in pandemic preparedness and response, was reduced by 56% in both the proposed (NEP) and approved (GAA) budget.

Figure 9. Distribution of hospitals and hospital beds in the Philippines, by ownership (2016)



Source: Dayrit et al., 2018, p. 133

Table 5. Health personnel and hospital beds per 10,000 population

Country	Medical doctors (2017)	Nurses & Midwives (2017)	Hospital beds (2015)
ASEAN average	9.1	25.7	20.9
Singapore	22.936 ⁱ	62.432	24
Brunei Darussalam	16.09	60.989	27
Malaysia	15.358 ⁱⁱ	34.676	19
Thailand	8.05	29.573	21 ^{viii}
Viet Nam	8.281 ⁱ	14.463	26 ⁱⁱⁱ
Indonesia	3.767	20.532	12
Timor-Leste	7.504	17.413	59 ^{vii}
Philippines	3.9	12.7	10.1
Lao People's Democratic Republic	3.726	12.643	15 ^{iv}
Cambodia	1.927 ⁱⁱⁱ	7.007	8
Myanmar	8.638	10.054	9 ^{iv}
Other reference countries			
Republic of Korea	23.608	71.203	24
Cuba	82.95	77.286	52 ⁱⁱⁱ
China	19.798	26.621	42 ^{iv}
Sri Lanka	9.277	19.966	35 ^{vi}
India	7.779	21.079	7 ^v

ⁱ 2016 data; ⁱⁱ 2015 data; ⁱⁱⁱ 2014 data; ^{iv} 2012 data; ^v 2011 data; ^{vi} 2010 data; ^{vii} 2009 data; ^{viii} 2005 data

Sources: Data for the Philippines from Dayrit et al, 2018, pp. 134, 143, 146. Data for all other countries from WHO, 2018, "Global Health Workforce Statistics"

**Table 6. DOH Budget, 2019-2020, in thousand pesos**

Programs	2019 GAA	2020 NEP (proposed)	2020 GAA (approved)
DOH Total	97,653,633	88,261,787	100,559,985
Health Facilities Operation Program	32,496,085	41,096,139	42,032,937
Health Systems Strengthening Program	25,899,088	9,642,424	19,332,324
Public Health Program	17,463,544	16,992,002	17,519,002
Social Health Protection Program	9,381,810	9,439,974	10,483,474
General Administration and Support	8,297,410	6,637,881	6,637,881
Support to Operations	2,040,330	2,432,554	2,433,554
Health Regulatory Program	816,584	880,379	880,379
Health Emergency Management Program	770,715	730,069	830,069
Health Policy & Standards Development Program	225,070	294,864	294,864
Epidemiology and Surveillance Program	262,997	115,501	115,501
<i>Nota Bene</i> PhilHealth	67,353,360	67,353,360	71,353,360

Source: Department of Budget and Management, 2019, 2020a, 2020b

The Epidemiology Bureau is not only constrained by a miniscule budget, it is also limited by its mandate. It is tasked with disease surveillance but has to coordinate with other units such as the Bureau of Quarantine when persons under investigation (PUI) need to be quarantined, and the Research Institute for Tropical Medicine (RITM) when PUIs need to be tested (Paris, 2020 February 15). The coordination challenges involved are certainly unhelpful when dealing with public health emergencies such as a pandemic.

To sum up, after years of neglect and diminution of public health, especially in terms of primary health and preventive care at the community level, the country's health system was dreadfully ill-prepared to respond to the COVID-19 pandemic when it hit our population at the start of 2020. With inadequate health personnel, equipment, infrastructure, training and experience to fight a pandemic, the government has relied more on the state's security apparatus to enforce social distancing and community quarantines. This is evident in Table 6 which shows that for the first

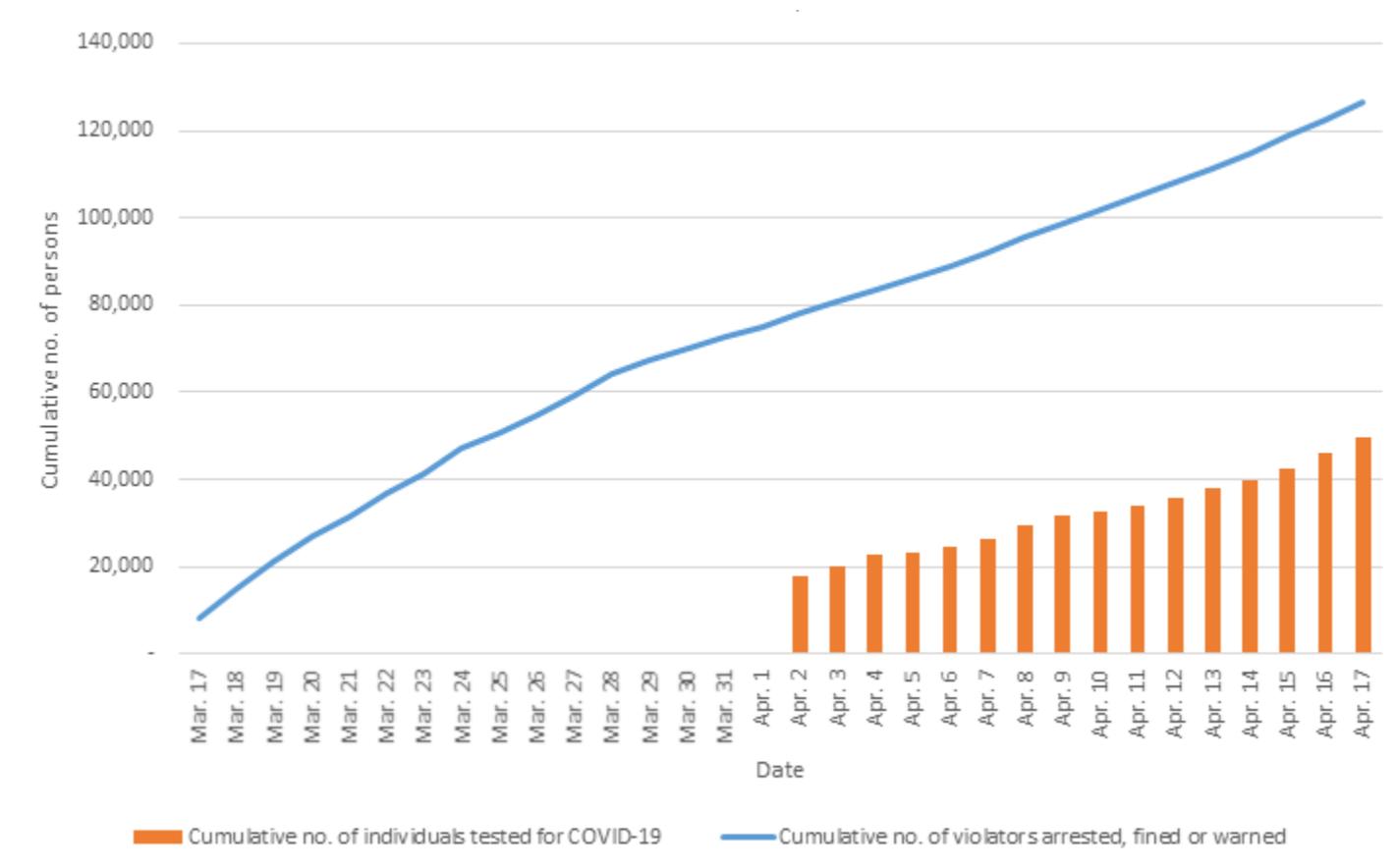
month of the community quarantine (17 March-17 April 2020), a total of 126,382 persons were arrested, fined or warned by the police for violating curfew and other quarantine regulations. This is around 2.5 times the total number of persons (49,534) tested for COVID-19 as of April 17.

This has invited numerous criticisms of the government's lopsided approach that prioritizes "militarist" methods and "self-care" (e.g., regular handwashing, wearing of facemasks, staying at home) over public health measures such as mass testing, more extensive contact tracing, more targeted quarantines and community engagement. As Manila Times columnist Yen Makabenta (2020, May 21) puts it, the Philippines "has attracted attention for assembling the oddest task force to fight the pandemic, a squad full of soldiers but without a single epidemiologist" ("First word").

As of writing, the government has started easing quarantine restrictions in different parts of the country in a phased manner, according to the



Figure 10. Cumulative no. of persons arrested, fined or warned vs. no. of persons tested for COVID-1 (17 March 17 - 17 April)



Source: Data on quarantine violators from the Joint Task Force-COVID Shield (2020, May 3) while the data on COVID-19 testing is from the data dump of the Department of Health, accessed on 23 May 2020 from bit.ly/2ZwKJx3.

level of risk of another outbreak. Various sectors of the economy are gradually being allowed to operate subject to social distancing measures. However, because testing, tracing and treatment capacity remain limited, there is real fear of a new upsurge in infections and fatalities occurring in the near future.

Building a new and better normal

While the lockdown and social distancing measures implemented by the Philippine government may have slowed down the spread of new cases of SARS-CoV2 infections, it has been slow to scale up the capacity of the healthcare system to test, trace and treat COVID-19 patients as

well as attend to the non-COVID related health needs of the population. At the same time, the lockdowns have engendered their own set of problems including the massive loss of livelihoods, the collapse of businesses especially SMEs, the universal disruption in learning, a drastic reduction in government revenues, numerous cases of police abuse, domestic violence, a rise in hunger and the worsening plight of the poor.

The gaps and failings in the COVID-19 response of the Philippine government cannot merely be attributed to poor leadership or the lack of experience in dealing with a pandemic of this scale. From the onset, the Philippine government's response to the COVID-19 pandemic has been



fundamentally constrained by the sorry state of the public health system in the country.

This weak public health system, in turn, must not be seen as just another unavoidable or immutable feature of developing countries in general. As repeatedly indicated in the preceding sections, the Philippine government's pandemic preparedness and response has fared poorly on numerous metrics when compared with other developing countries at similar or even lower levels of economic development (in terms of GDP per capita) such as Vietnam.

Rather, the country's weak public health system is the deplorable outcome of market failure as well as government failure. It is the result of deliberate policy choices, fiscal priorities and institutional design made over many years up to the present.

As the country and the rest of the world move slowly and cautiously towards a "new normal," it is essential to remedy the fundamental ills of the Philippine health system beyond the requisites of dealing with emergency situations such as the COVID-19 pandemic. The following are some recommendations for building an inclusive, just and equitable health system that will help us look forward to a "new and better normal" for all.

1. Conduct a participatory human rights audit in relation to the right to health.

The COVID-19 pandemic has put forward the urgency of examining whether the Philippine government is fulfilling its obligations to respect, protect and fulfill the right to health, in accordance with the intent of the 1987 Constitution and the International Covenant on Economic, Social and Cultural Rights (ICESCR) which the Philippines ratified in 1974.

Health as a basic human right is enshrined in the 1987 Philippine Constitution (Article II, Section

15), which declares "the State shall protect and promote the right to health of the people and instill health consciousness among them." Under this mandate, the State, particularly through the DOH as the national authority on health, has the obligation to ensure the highest achievable standards of physical and mental health for all citizens.

According to the Committee on Economic, Social and Cultural Rights, the UN body that monitors compliance with the ICESCR, states have a core minimum obligation to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups (United Nations Economic and Social Council, 2000). This means ensuring functioning public health and healthcare facilities, goods and services must be available in sufficient quantity and quality; they must be accessible physically (in safe reach for all sections of the population); and they must be accessible financially (not subject to one's ability to pay).

It is also important to be reminded that the right to health is not just about ensuring access to health care by building health facilities, distributing medicine and medical supplies, and deploying health workers. According to the UN Office of the High Commissioner for Human Rights (OHCHR, n.d.), the right to health is an inclusive right that includes a wide range of factors necessary to enjoy a healthy life such as:

- safe drinking water and adequate sanitation;
- safe food;
- adequate nutrition and housing;
- healthy working and environmental conditions;
- health-related education and information;
- gender equality. (p. 3)

Moving forward, there should be a human rights audit of government policies, institutions and



budgets with civil society participation to hold the government to account in relation to its obligations towards the right to health. Human rights-based indicators can be developed to support the effective monitoring of health outcomes and processes to achieve them. Human rights impact assessments should be conducted to anticipate the likely impact of a proposed policy and inform the public as well as policymakers. Mechanisms for redress should be established, not just complaints procedures or client feedback mechanisms.

2. Increase public spending on health to at least 5% of GDP financed through progressive taxation

Under the ICESCR which includes the right to health, states must demonstrate that they are making every possible effort, within available resources, to fulfill all rights under the Covenant. Setting a target level of public spending on health is a concrete and useful way of holding governments accountable for the progressive fulfilment of the right to health.

Studies using detailed health service cost data and modelling techniques project that public health expenditure should range from six to seven percent of GDP in order to achieve universal health care systems as well as reduce the share of out-of-pocket payments in total health expenditure (Mcintyre, Meheus & Rottingen, 2017). While this may be deemed aspirational for low- and middle-income countries starting at a low base figure such as the Philippines, the fact that average public spending on health among upper middle income countries is around 3.8% of GDP should be taken as evidence that it is possible to significantly scale up public spending on health in the Philippines (see Table 2 on page 14). As the Philippine government aspires to upper middle income status within the next few years, a 3.8% level of spending should be

an immediate minimum target that would signal its commitment to dedicate maximal available resources towards fulfilling the right to health. Moreover, the principle of progressive realization of rights should prod the government to increase the public budget for health over time.

To be equitable, public health expenditure must be financed through progressive taxation rather than relying mainly on consumption taxes or user fees. A thorough discussion of the necessary reforms in the tax system and broader development policies of the government is beyond the scope of this paper. Nevertheless, there is a clear need and potential for progressive tax reform in the country. For instance, IBON Foundation estimates that a wealth tax of one percent on wealth above Php1 billion, two percent on wealth above Php2 billion, and three percent over Php3 billion can raise Php236.7 billion annually just from the 50 richest Filipinos alone—more than enough to double the level of public health spending in the country (Africa, 2020 May 25).

3. Expand and strengthen primary health care as the foundation of universal healthcare

The 1978 International Conference on Primary Healthcare sponsored by the WHO and UN Children's Fund (UNICEF), and held in Alma-Ata, Kazakhstan, identified primary healthcare as the key to the attainment of the goal of "Health for All."

The landmark Alma-Ata Declaration defined primary healthcare as:

essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and



self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process. (p. 16)

At the minimum, primary healthcare must ensure:

- community education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food security and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health, including family planning
- immunization against the major infectious diseases
- prevention and control of locally endemic diseases
- scientifically and culturally appropriate treatment of common diseases and injuries
- provision of essential drugs. (WHO, 1978, p. 4)

Note that these are mostly public goods or merit goods that for-profit private health providers are demonstrably unable to provide adequately. This implies a dominant role for public-sector providers in primary healthcare. More importantly, primary health care requires a prominent role for community health workers and community involvement in planning, accountability and preventive healthcare as well as addressing the social and environmental determinants of health (Global Health Watch, 2017).

To expand and strengthen primary healthcare throughout country, the national government

must work with local governments to ensure that each barangay has a fully functional barangay health station with a barangay health team composed of at least one doctor, one nurse, one midwife, one dentist and one sanitation expert. At the same time, the barangay health team should train lay health workers from the community and involve them in community health planning, health education, sanitation, first-level care and psychosocial support, among other responsibilities. They can also train health workers or health committees in schools and workplaces.

The barangay health team, together with the community itself, is responsible for addressing the health needs of the community with appropriate referrals to secondary and tertiary health facilities when necessary. Barangay health stations, secondary and tertiary health facilities should be linked through interlocal health systems at the province or city-level overseen by provincial and city health offices.

4. Expand and upgrade the health workforce and protect the rights of health workers

The Department of Budget and Management (DBM) should raise the number of plantilla positions for doctors, nurses and other healthcare workers necessary to ensure health for all. The number of positions needed to lay down primary healthcare in all barangays should be the baseline but many health facilities and health offices at other levels also need more personnel.

The government should provide more scholarships and train more healthcare professionals especially those coming from underserved areas subject to return-of-service agreements.

Salaries and benefits of healthcare professionals should be upgraded to encourage more of them to remain in the country instead of seeking



greener pastures abroad. The government should implement the Magna Carta of Public Health Workers (Republic Act 7305) to promote and improve the social and economic well-being of health workers in the country, develop their skills and capabilities, and encourage them to remain in public service.

Congress should also pass the proposed Magna Carta for Private Health Workers (House Bill 5184) to protect the rights of health workers in the private sector including their right to a living wage, adequate benefits, decent work hours and work conditions; security of tenure and employment; and right to organize and bargain collectively.

5. Adopt a whole-of-society approach to comprehensively address the social, economic and environmental determinants of health.

In the Preamble of the WHO's Constitution (1946), health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 1). Therefore ensuring health for all requires far more than universal access to health goods and services (or insurance coverage). It requires the development of agriculture, animal husbandry, food, water, industry, education, housing, public works, communications, information technology and other determinants of people's well-being. It calls for support for research and development, and domestic manufacturing of medicines, medical supplies and other health-related goods. It demands environmental protection through community sanitation, preventing land degradation and urban decay, pollution and waste management, etc. In short, ensuring the health and well-being of the people requires a whole-of-government and whole-of-society approach.

The post-pandemic period should be an occasion for deeper public reflection and deliberation about our shared vision for a healthy Philippines. This shared vision should be the basis of the government's new framework on health and well-being for all Filipinos. It should also serve as a guide for all branches of government and executive agencies so that they can explicitly take into account the health implications of their policies and programs. Learning from the pandemic, this new framework should shift the focus of healthcare to primary health care, prevention, reducing health inequalities, and empowering people and communities to better look after their own health and well-being. A shared vision for a healthy Philippines will also help foster a culture of civic engagement and government accountability.

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