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Graduate School of Development Studies

**SAVING MOMMY FROM THE GRAVE:**

**The Impact of Health Financing Scheme on the Promotion of Facility-Based Deliveries in the Philippines**

A Research Paper presented by:

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## LIST OF ACRONYMS

BHI	Basic Health Insurance
CBIS-MBN	Community-Based Information System – Minimum Basic Needs
CHO	City Health Office
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EmOC	Emergency Obstetric Care
GSIS	Government Service Insurance System
ICD	International Classification of Diseases
IRA	Internal Revenue Allotment
HSRA	Health Sector Reform Agenda
LGU	Local Government Unit
MD	Medical Doctor
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NDHS PUF	National Demographic and Health Survey Public Use File
NHIP	National Health Insurance Program
PhilHealth	Philippine Health Insurance Corporation
RA	Republic Act
RHU	Rural Health Unit
SNMN	Seguro Nacional de Maternidad y Nifiez
SSS	Social Security System
TBA	Traditional Birth Attendants
TB-DOTS	Tuberculosis - Directly Observed Treatment Short course
UN	United Nations
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organization



## 1 INTRODUCTION

This research explores the issue on how social health insurance (SHI) as a health financing scheme had impacted on the promotion of facility-based deliveries. It touches on the dynamics of being pregnant and giving birth and variations in maternal spending as well as the processes involved in accessing the SHI which tend to exclude most poor mothers. It also analyzes women's experiences and opinions on giving birth as it influences their decision on whether to use SHI in giving birth in a facility or not. By discussing these insights, this paper is contributing on understanding how to reduce maternal mortality.

The social exclusion and rights-based approach are used to examine whether women's rights are translated into government's provision of SHI to enable them to access health services and from there know the impact of government's SHI program in averting maternal deaths.

This research intends to provide a theoretical and empirical contribution to the ongoing debate on whether health financing schemes such as SHI can contribute to the prevention of maternal deaths by broadening access to facility-based deliveries. Another important contribution is the first hand information from beneficiaries themselves which gives a clear picture on how the dynamics of health service utilization works. It will also illustrate the inclusion and exclusion of certain groups of people that comes with the introduction of SHI.

There are four existing conditions that served as a stimulus for this research on maternal mortality and health financing:

First, maternal mortality is still highly prevalent in most developing countries despite the initiatives carried out by both the government and donor agencies. It was estimated that annually more than half a million women die during childbirth. This tragedy does not only affect the women's family but also the society as a whole. "Each of these women dies in the prime of life, when she is most socially and economically active" (Panos 2001: 4).

Second, as opposed to the widely perceived notion, maternal mortality is not as easily preventable as donor agencies thought it would be. Maternal mortality reduction is already included in the international global agenda and reducing maternal mortality ratio (MMR) is a major goal of the Millennium Development Goals (MDGs), International Conference on Population and Development and the Fourth World Conference on Women in Beijing. Various programs and policies such as the Safe Motherhood Initiative, training of traditional birth attendants, and information and education campaign were put in place. In some countries these did work, but to most it did not make much difference. At the moment, most of the developing countries are still struggling in finding ways to prevent maternal deaths. Hence, the need to

evaluate the policies and strategies adopted by the developing countries became of utmost importance.

Third, the Philippines is a signatory to these international commitments and has been implementing different programs. Despite this, the country hasn't experienced a significant improvement in terms of maternal mortality incidence. Just recently, a UN official commented that the country needs to take urgent action or it might not reach a universal goal to reduce its maternity death rate by 75 percent by 2015 (Associated 2007). Based on the 2006 Family Planning Survey, for every 100, 000 live births in the Philippines, 162 women die during pregnancy and childbirth or shortly after childbirth (National Statistics Office 2006). This is just a little improvement from the 1998 level of 172 per 100, 000 live births (National Statistics Office et al. 1999).

Lastly, one of the "major interventions made by the government to reduce maternal mortality is to improve the accessibility of maternal health services thru the inclusion of a maternity care package among the service packages of the National Health Insurance Program" (NEDA 2005: 75). To accelerate the enrolment of poor people in the NHIP, a sponsored or indigent program was even created. It is assumed that an increased utilization of maternal services through the introduction of the social health insurance could lead to the prevention of maternal deaths.

Given this scenario, this research intends to address these questions:

To what extent has the introduction of social health insurance led to increased facility-based deliveries?

*Sub-questions:*

1. What is the existing situation (maternal mortality, maternal health and health financing policy) before the introduction of the new health financing scheme?
2. How are variations in maternal services spending and utilization of maternal services manifested within class (income groups) and geography (urban-rural)?
3. How did the financing schemes impact on the accessibility of maternal health services? Will there be a difference on its impact when it is implemented on a different geographical setting (urban and rural)?
4. What are the deciding factors behind the beneficiaries' utilization of maternal services after the introduction of SHI as a financing scheme? How has the utilization of services prevented maternal deaths?
5. Does the introduction of such a scheme result in the inclusion or exclusion of poor people in the maternal services provided by the government?

The paper has three major chapters. First is the chapter that will situate the study into the literature. Debates such as those dealing with the strategies to reduce maternal mortality are explored and challenged by presenting studies from various contexts. The evidences from the Philippine setting are also presented to give an overview of the existing maternal health situation in the country.

The second chapter is a discussion of the evolution of the health financing schemes in the Philippines. The underlying assumption in the creation and implementation of the current health financing scheme, which is the SHI is also dealt with.

The third chapter presents the impact of the SHI on women's utilization of health facilities and relating it to its possible effect on the prevention of maternal mortality. This chapter highlights the differences on the SHI's impact between urban and rural areas and also analyzes the dynamics behind the health-seeking behaviour of mothers.

The paper ends with the conclusion and policy implications.

## **1.1 Analytical Framework**

### *Women's right to live*

Maternal mortality should not only be seen as a mere health problem. It is important to recognize that maternal deaths result from the violation of women's right which is rooted in the underlying structures in the society. Cook *et.al.* (2003) further argues that a neglect of medical procedures that only women need, such as those services necessary to ensure safe pregnancy and childbirth, constitutes a form of discrimination against women thus offending the right to sexual non-discrimination found in most national constitutions and in regional and international human rights conventions.

The State and the health care system are the most important entities in realizing this right. As Article 12 of the Convention of the Elimination of All Forms of Discrimination against Women states:

*Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation (Committee on the Elimination of Discrimination against Women 18 December 1979).*

The State therefore, should ensure that the 3As (accessibility, availability and affordability) to right to health as well as high quality of services are met. In terms of availability, functioning

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public health and health care facilities, goods and services as well as programmes have to be available in sufficient quantities (Centre for Development and Human Rights 2003: 91).

However, it is of utmost importance that these goods and services are not just available but also accessible to all. Four dimensions should be satisfied to guarantee this: a) non-discrimination in the provision; b) physical accessibility which means that the facilities and services must be within safe physical reach for all sections of the population especially the vulnerable; c) economic accessibility wherein payment for health care services have to be based on the principle of equity ensuring that these services whether privately or publicly provided are affordable to all including socially disadvantaged groups; and d) information accessibility in which everyone should have the right to seek, receive and impart information and knowledge concerning health issues (ibid).

Lastly, all health facilities, goods and services should be “culturally acceptable, scientifically and medically appropriate and must be of good quality” (ibid: 92). It is important to note however, that quality is important in rendering maternal care services because it is one of the major factors that determine the level of women’s utilization of these services.

Yet, there are various instances when the State is unable to fulfil its duties. Gruskin and Tarantola argue that “a government violates its responsibility to respect the right to health when it is responsible for providing medical care to certain populations and it arbitrarily decides to withhold that care” (ibid: 97). Very often, resource constraint is the government’s *raison d’être* in overlooking the importance of providing health services. But the Limburg Principles clearly states that “State parties must move as expeditiously as possible towards realisation of rights and that resource constraints cannot be used as an excuse to defer the realisation of these rights” (ibid: 56).

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Furthermore, for the State to meet its obligations and avoid these violations, a working health care system is needed. The WHO defines health care system as “a system that includes all actors, institutions and resources that undertake health actions – where a health action is one where the primary intent is to improve health” (2001). “Beyond improving health, it is also the goal of the health system to be responsive to the population that they serve which is determined by both the way and environment in which people are treated and at the same time to ensure that the financial burden of paying for health is fairly distributed across households” (ibid). This is to say that both the State and the health systems have to fulfill women’s right to live.

### *Politics of inclusion*

Anchored on women's right to health, it can be said that many women die, especially the poor because they tend to be excluded from health care by barriers that are difficult to overcome (Schneider and Dmytraczenko 2003: 2). It should be recognized that for the most part, women's lack of financial capacity to pay for basic maternal services and the poor quality of care have played a big role why women postpone or do not seek health care at all.

This is where the health financing schemes could make a difference because its aim is to "maintain and increase access by all to basic health services; generally improve quality of services so that utilization of health services and facilities and the efficiency of resource utilization will increase; and to create incentives for providers and consumers to use more services efficiently through various payment methods" (World Health Organization 2006: 23).

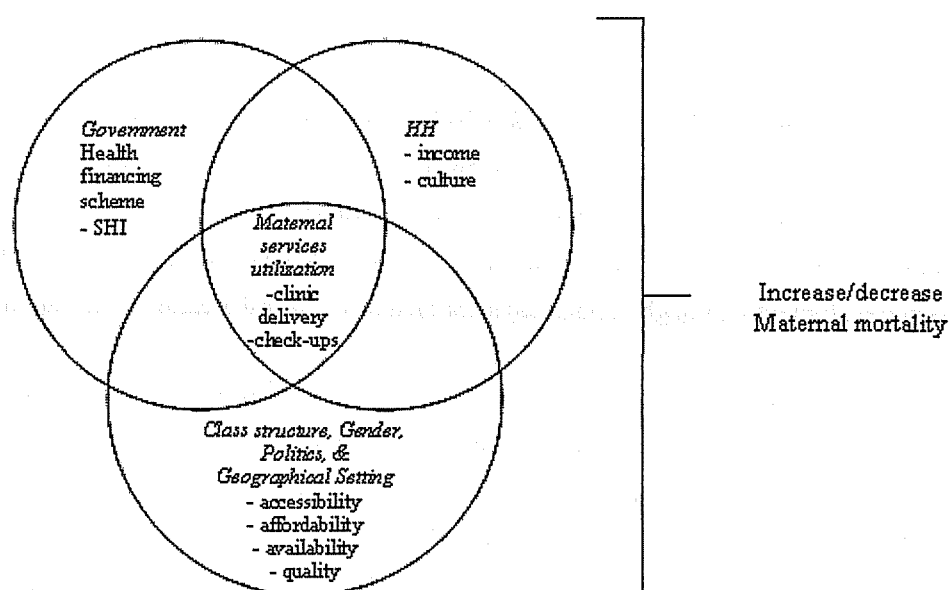
Figure 1 below provides the overall framework in looking at how health financing schemes such as SHI could have an impact on maternal mortality reduction. In principle, insurance reduces individuals' exposure to risk, and this reduction in uncertainty is a value in itself, particularly for poor people (Bennett and Gilson 2001: 8). It is one of the alternatives that could address women's financial barriers – if it would result into the beneficiaries' utilization of maternal care services, specifically clinic delivery then a reduction in maternal mortality is possible.

But there are cases when SHI does not necessarily lead to positive maternal outcome. This happens when poor women are excluded from the scheme and maternal services became inaccessible, unavailable and unaffordable due to political, gender, class structure and geographical reasons.

It is important to take into account the political aspect in the process of inclusion/exclusion because the design of redistribution is basically based on politics. Houtzager argues that "the territorially defined nation-state today remains the only actor able to attract the vast resources from society that make possible significant distributive and redistributive policies and the only actor capable of providing public goods on a significant scale"(2003: 4). He further points out that the "State is an organizational authority with which most people have contact in their daily lives and that provides the most readily available route for poor social groups to influence the conditions of their own lives" (ibid). Therefore, the inclusiveness of a policy such as the provision of SHI lies in the hand of the State and when it does not give that care as discussed

above, the consequence is that women especially those who are poor would be excluded from maternal care services.

**Figure 1. Overall framework**



Source: Own construction

According to the social exclusion approach, the processes of deprivation in the society also serve as a barrier in the accessibility of interventions like the insurance. “Socially determined structures and processes impede access for some members of society to economic resources, social goods and institution” (Wuyts 2004: 9). In this case, class structure and gender plays a big role<sup>1</sup>. Within the class structure, health interventions usually reach the rich more rapidly and intensely than poor (World Health Organization 2006: 10). Further, due to gender inequalities in the society women are often the least priority even within the family when it comes to health provision.

Also, geographical setting plays a role in the accessibility and quality of services provided. Rural areas are more underserved in terms of maternal health services (personnel and infrastructure) than the urban areas. Among the reasons for this are inadequate resources and commercial health providers find rural areas less profitable.

<sup>1</sup> The role of class structure and gender in maternal services deprivation will be discussed in detail on the next chapter.



Beyond these, at the household and individual level other factors such as income and culture could somehow influence the uptake of health services. Women have a tendency of not utilizing maternal services even if it is available if their family have low or no income at all because they either cannot pay for it or they could not afford the transportation cost despite having insurance. In some instances, the same tendency can be attributed to the culture<sup>2</sup> of a society where a woman belongs. Sue even stressed the importance of understanding the role of 'shame' and of protecting (saving) 'face' in the underutilisation of health services among Asian groups (MacLachlan 2006: 171).

## **1.2 Importance of the research**

At the moment, the studies made on SHI in the Philippines focuses on how it eases government's burden in financing health care. There has been no research done that focuses on the impact of SHI as a health financing scheme on the improvement of maternal mortality in the Philippines. Thus, at the policy-making field, the empirical evidence that will be presented in this research could contribute significantly in providing insights on the effectiveness of this health financing policy in reducing maternal deaths.

## **1.3 The methodology**

Considering the variations in maternal mortality among geographical areas in the Philippines, the research made use of a comparative case study between urban and rural areas in answering the questions presented. The following are the reasons for this comparison:

- a) Rural areas have high MMR compared to urban areas;
- b) Rural areas face more barriers in accessing maternal services than urban areas. Among these barriers are fewer health facilities and personnel; and less public transportation that could be use in travelling to health care providers. Hence, given this scenario, it would be interesting to know if the implementation of health financing schemes would result to different maternal health outcomes;
- c) In the Philippines, poverty is more severe in rural areas than urban areas. Thus, poor people who usually have greater maternal health care needs can be found in rural areas.

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<sup>2</sup> Culture is a system of interrelated values active enough to influence and condition perception, judgment, communication and behavior in a given society and is rooted in institutions such as families and schools (Airhihenbuwa 1995: 3)

Being at the heart of the National Capital Region (NCR), Pasay City was taken as the urban case because its characteristics are representative of other urban areas in the country; while the island province of Palawan was chosen because it resembles other rural areas in the country due to the remoteness of its municipalities and the nature of its inhabitants' livelihood activities. It should also be noted that both cases are implementing the PhilHealth Indigent/Sponsored Program.

In-depth semi-structured interviews<sup>3</sup> were done on both Phil Health beneficiaries and non-beneficiaries to know whether having SHI had led to facility-based deliveries and to understand the dynamics behind the maternal care services utilization and spending. The following is the number of respondents:

Insurance status	Criteria	No. of respondents
Indigent/Sponsored program beneficiaries	Women living in rural area	4
	Women living in urban area	2
PhilHealth Employed program beneficiaries	Women living in rural area	2
	Women living in urban area	2
Poor Women without insurance	Living in rural area	2
	Living in urban area	2
Non-Poor Women with insurance	Living in rural area	2
Non-Poor Women without insurance	Living in urban area	2

The input of midwives and nurses are also captured through in-depth semi-structured interviews<sup>4</sup>. Getting their experiences on deliveries is deemed important because it provided first hand information on the differences of facing a complication at home and in a health facility. Their analysis of reasons for exclusion of women from the insurance and maternal services is also taken into account.

To identify the process behind the targeting of the insurance's beneficiaries and the conditions that brought about the introduction of the existing health financing scheme, interviews<sup>5</sup> were conducted on the following:

- a) Supervising officer of the Health Policy and Planning Bureau (Department of Health);
- b) Senior officer of PhilHealth;
- c) Head of City Health Office (urban);

<sup>3</sup> Interview schedule in the annex

<sup>4</sup> Interview Schedule in the Annex

<sup>5</sup> Interview Schedule in the Annex

- d) Head of Maternal Health and Family Planning Division (rural); and
- e) Head of Municipal Social Welfare and Development (rural).

Participatory observation was also done in a barangay<sup>6</sup> health centre and lying-in clinic to get additional insights.

Secondary data includes NDHS PUF dataset, official statistics and reports, and literature on maternal mortality, maternal health and health financing.

## 1.4 The Limitation

Insurance under the PhilHealth Indigent/Sponsored Program are usually granted and named after the head of the households who are often the males. Women and children in the family are the beneficiaries of the husband. Thus, locating women who had used the insurance's maternity care package was very difficult. For this reason, a survey could not be conducted. Nevertheless, the in-depth interviews on a number of beneficiaries are substantive and insightful enough to answer the questions posted on this research.

## 1.5 Background on case studies

### *Pasay City*

Pasay City is located in the western coast of NCR (Prime Asia Consult Corporation and Company 2001). It has 201 barangays, 18 of which are squatter colonies. According to the 2000 Census, the city's population is around 363, 000 with most of its labour force gainfully employed.

The city has adequate public and private health facilities. It has two big private hospitals, San Juan de Dios and Manila Sanitarium. It's biggest government hospitals were Pasay City General Hospital and the Villamor Air Base Hospital (ibid). The bed capacity for these public hospitals stood at 1:648. As of 2006, all of these hospitals were already PhilHealth accredited together with 13 barangay health units, 1 TB DOTS clinic and 1 maternity clinic.

In terms of health personnel, the city is a lot better than NCR (ibid). Below is the number and ratio of the city health workforce.

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<sup>6</sup> Smallest political unit; equivalent to a village

Table 1. City health office workforce (2000)		
Type	Number	Ratio to Population
Physicians	24	17,473
Dentist	17	24,668
Nurses	23	18,233
Midwives	57	7,357
Nutritionist	3	139,783
Med-tech	8	52,419
Sanitary Inspectors	10	41,935
Laboratory Aides	10	41,935
Pharmacist	1	419,349

Source: City Health Office and DOH and from Computations by Consultants (ibid).

### *Palawan*

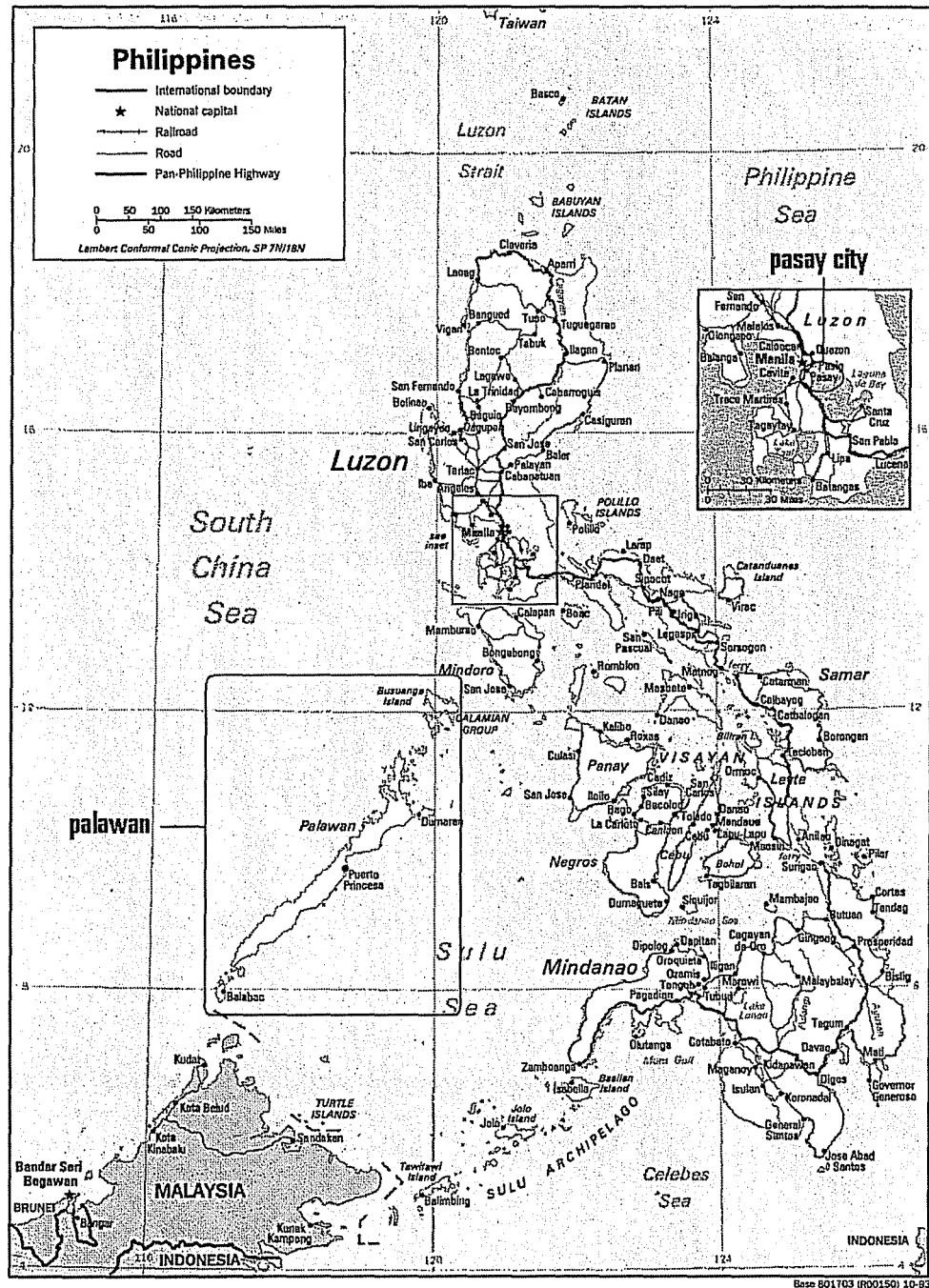
Palawan is an island province in Luzon. Based on the 2000 Census, Palawan has a population of 755,412 with most of the employment in agriculture and fisheries sector. The province consists of 23 municipalities and a component city (Provincial Government of Palawan 2001: 9). Of this, 13 are mainland and 11 are island municipalities.

As of 2003, there are 11 government hospitals and 6 private hospitals in the province. The health centre ratio to population is 1:31249 while the barangay health station ratio to population stands is 1:31680.

According to PhilHealth, there are 14 accredited hospitals in the province, 8 accredited RHUs and 1 TB DOTS accredited clinic.

The ratio of government health manpower to population is very low. The ratio of physicians to population in municipalities ranges from 1:30000 to 1:390000. While midwives to population ranges from 1:17000 to 1:500000 depending on the municipality.

# Location of the cases



1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the statistical analysis performed.

3. The third part of the document presents the results of the study, showing the trends and patterns observed in the data. It includes several tables and figures to illustrate the findings.

4. The fourth part of the document discusses the implications of the results and the potential applications of the findings. It also addresses the limitations of the study and suggests areas for future research.

5. The fifth part of the document provides a conclusion and summarizes the key points of the study. It also includes a list of references and a bibliography.

6. The sixth part of the document contains a list of appendices, including a detailed description of the experimental setup and the data collection process. It also includes a list of abbreviations and a glossary of terms.

7. The seventh part of the document contains a list of references and a bibliography, providing a comprehensive overview of the literature related to the study.

8. The eighth part of the document contains a list of figures and tables, providing a visual representation of the data and the results of the study.

9. The ninth part of the document contains a list of footnotes and a list of references, providing additional information and sources for the study.

10. The tenth part of the document contains a list of references and a bibliography, providing a comprehensive overview of the literature related to the study.

## 2 EXPLORING DEBATES, LOOKING AT REALITY

This chapter situates the study into the literature by presenting four major debates on the strategies on reducing maternal mortality. Each debate was challenged by drawing on the experiences of different countries with a particular focus on the Philippine context.

### 2.1 Antenatal care = Reduction in maternal mortality?

Maternal health is a state of complete physical, mental and social well-being of women not only during pregnancy, but from the preconception period right through the spectrum of their reproductive experiences, and not merely the absence of disease or infirmity<sup>7</sup>. Improving maternal health entails that a woman should have proper nutrition, regular antenatal and post-natal check-ups, and complete with vaccinations.

While maternal death was defined in the Tenth Revision of the International Classification of Diseases (ICD-10) as *the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes* (U. WHO, UNFPA 2004: 3).

Despite the United Nation's explicit inclusion of maternal mortality ratio as an indicator for monitoring the progress of the MDG Goal in improving maternal health, the belief that an improvement in maternal health is directly translated in the reduction in maternal mortality has been challenged. It has been argued that maternal health and maternal mortality are two different things. As Dr. Danguilan pointed out:

*There is a need to distinguish between maternal mortality and maternal health as a woman's health status is not a guarantee of a safe delivery. Improvements in maternal health, though important in and of themselves, will not necessarily be accompanied by reductions in maternal mortality. Conversely, the strategies needed to reduce maternal mortality – increased access to emergency obstetric care (EmOC) during pregnancy and childbirth – will not improve maternal health and need to be complemented by efforts to address women's well-being (August 2007).*

Antenatal care has long been regarded as a core component of routine maternal and child health services and receives the largest allocation of budgetary resource in many developing countries (Campbell and Graham 2006: 1294). This notion of taking care of pregnant women's health through antenatal care to avoid maternal deaths is a misconception. For example, the graph

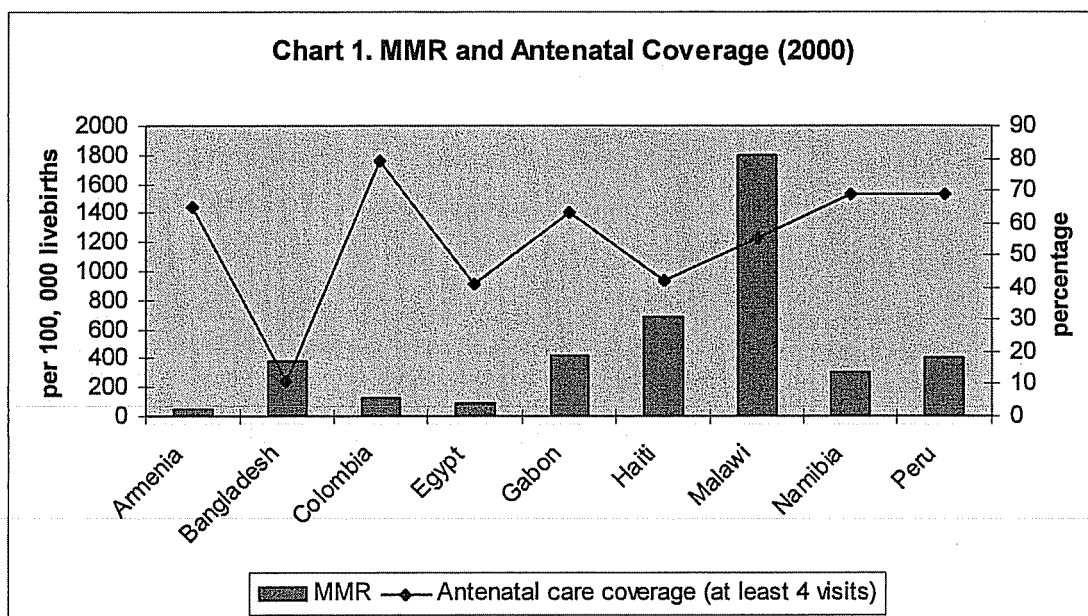
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<sup>7</sup> This definition was taken from Loes Keyser's presentation entitled "Maternal Health and Mortality in Development Context" for the Politics of Reproduction: Health, Rights and Empowerment class in ISS, The Netherlands, 12 March 2007.

below shows that maternal mortality is still high for most countries<sup>8</sup> with high coverage of antenatal care. Colombia for instance, had an MMR of 130 per 100, 000 live births in 2000 despite the fact that 79 percent of women have at least 4 antenatal visits. The same is true with Namibia and Peru which both have 69 percent coverage but have more than 300 maternal deaths.

In the Philippines, both 1998 and 2003 NDHS reveal that nine in ten mothers have received antenatal care (National Statistics Office and ORC 2004). In spite of this, no significant decline in the number of maternal deaths was seen in the past years. Therefore, it is safe to say that there is really no direct correlation between high antenatal coverage and improvement in maternal death.

Antenatal care is not a guarantee that women will not die during delivery because even among well-nourished and well-educated women who receive pre-natal care, a sizable proportion develop serious complications during delivery (Thaddeus and Maine 1994: 1092). Attempts to identify those women who are at risk and refer them to hospital for delivery cannot eliminate maternal deaths because apparently 'high risk' women will have no problems, whilst women who are not seen as being at risk can still rapidly develop unforeseen complications (Oxaal and Baden 1996: 3).



Source: Statistical Information System (WHO)

<sup>8</sup> Countries are selected based on the availability of data. A limitation to this kind of comparison is that MMR for different countries might have been derived using different methods.



Nevertheless, this is not to say that providing antenatal care is a futile exercise because it is also important in itself. It could serve as a locus for the delivery of other services such as tetanus toxoid immunizations, information on the danger signs of pregnancy and labour, information on birth spacing, and a route for ensuring that pregnant women do in practice deliver with the assistance of a skilled health care provider (AbouZahr and Wardlaw 2003: 2).

## **2.2 Facility-based deliveries: “the driving force”**

Addressing maternal deaths entails a two stage process: first, strengthening women’s choice over reproductive decision-making and secondly, ensuring that once a woman is pregnant, she has access to appropriate care including emergency interventions if necessary (Oxaal and Baden 1996: 2).

The first stage involves family planning services. This lessens the numbers of pregnancies and thereby, possibly reduces the occurrence of maternal mortality and abortion. However, Oxaal and Baden pointed out that “family planning should not be seen as the sole answer to the problem of maternal mortality because it cannot help reduce the risk of death once a woman has become pregnant” (ibid). Hence, it is also worthwhile to consider maternal deaths in the context of the second stage (ibid: 3), with a specific focus on facility-based deliveries which is the main concern of this paper.

Homebirth remains a strong preference, and often the only option, for many women in the developing world, most of which take place without a skilled attendant (Walraven and Weeks 1999: 527). For this reason, the WHO advocated for the training of traditional birth attendants (TBAs) during the 1970s and 1980s with the goal of decreasing maternal mortality. But in the 1990s there was still no significant maternal death reduction in countries where training was invested hence, the international community found it necessary to jump from one strategy to another – from training TBAs to training only professional midwives (ibid: 528).

There are two opposing sides on this view as to whether home-based deliveries done by a skilled attendant could make a difference. For instance, Campbell stated that in Malaysia (mid-1970s and mid-1980s) and the Netherlands (1955 to 1980), deliveries at home by professionally trained staff marked degree of success in achieving low maternal mortalities (M.A. Koblinsky et al. 1999: 402). Nonetheless, deliveries by TBAs did not last for long in Malaysia’s case. A move from TBAs to professional midwives supported by health units was made and complicated births took place in a maternity home or hospital (ibid).

This notion of home-based delivery was also refuted by a study made by Ronsmans et. al in Matlab, Bangladesh. After doing an in-depth interview with skilled attendants, they claimed that

a) basic conditions in homes in rural areas may prevent midwives from delivering skilled care; b) that home delivery care is inefficient in terms of midwives' time and ability to cope with emergencies and; c) home-based provision is less likely to be sustained in the long-term (2006: 58). Given this, it is useful to look at the review done by Koblinsky which used a variety of settings to explore the possible influence of different organizational delivery characteristics (e.g. place of attendance and person assisting in delivery) on maternal mortality.

As can be seen in the table below, Model 1 involves giving birth at home and being attended by non-professionals who may or may not have training in delivery (e.g. mother herself, a family member or relative TBAs). In this model, the role of these non-professionals in triage and referral of complicated births is probably pivotal (M.A. Koblinsky et al. 1999: 402). Yet, evidence shows that this usually does not happen. For example, in Forteleza Brazil the TBAs like China's barefoot doctors are unlikely to be able to manage obstetric complications (ibid). Likewise, there is no evidence that this model can produce a MMR under 100 per 100, 000 live births (ibid: 405).

Table 2. Models of safe motherhood care: features of successful service organization			
Who delivers	Where birth takes place		
	Home	Basic essential obstetric care facility	Comprehensive essential obstetric care facility
Non-professional	Model 1: lay provider recognizes complications; family or provider organizes access to EmOC; functioning EmOC available		
Professional	Model 2: professional recognizes complications; professional provides basic EmOC; family or provider organizes access to EmOC; functioning EmOC available	Model 3: professional recognizes complications; professional provides basic EmOC; facility organizes access to EmOC; functioning EmOC available	Model 4: professional recognizes complications; professional provides basic and comprehensive EmOC

Source: (M.A. Koblinsky et al. 1999)

Model 2 is still home-based but with deliveries assisted by professionals like midwives and doctors. Malaysia had been successful in using this model especially in the rural areas mainly because it implemented a strong referral system wherein any serious complications that could not be handled by the professionals because of lack of equipment at home are transported to health facilities capable of providing comprehensive EmOC.

The countries that successfully implemented the Model 2 approach usually made the transition to Model 3, in which all essential obstetric functions are available except for surgery, anaesthesia and blood transfusion (ibid: 403). As discussed, this is where Malaysia eventually moved and what Sri Lanka had implemented. Sri Lanka had constructed maternity homes, central dispensaries, rural and cottage hospitals and trained medical, nursing and midwifery staff (ibid).

Model 4 is the typical model of most developed countries. Australia, Japan and New Zealand and most countries in Northern and Western Europe and North America provided deliveries in this category and their MMR are usually under 10 per 100, 000 (ibid: 404). On introducing a professional attendant, in Models 2-4 and establishing strong referral mechanisms, the MMR can be reduced to 50 or lower (ibid: 405).

Having said these, it is interesting to look at the Philippine context and understand what is recognised as the role of facility-based delivery in the overall goal of reducing maternal mortality.

The Philippine government initiated the training of TBAs in 1954. The programme was based on the principle that the TBA – called the *hilot* – could be safely entrusted with the care of expectant mothers and newly born infants in communities where professional midwifery personnel were not available if they were given training and practical guidance (Mangay-Angara 1981: 38). However, there has been a major paradigm shift from the “risk approach” (which identifies high-risk pregnancies for referral during the prenatal period) to the “EmOC approach” which considers all women to be at risk of complications at childbirth (Canlas 2007: 41). This shift is reflected in the maternal care policy that strengthens the capacity for facility-based delivery attended by health professionals and discouraging home deliveries attended by *hilots* (ADB 2007: 43).

The DOH had even issued an administrative order to stop the training of *hilots* based on the notion that the training had not led to necessary behavioural changes among *hilots* and the use of their services was actually one of the main causes of maternal deaths (ibid: 19). This notion is based on a well-known fact that *hilots* give advice on how to prevent pregnancy and how to induce abortion. As a midwife in Palawan pointed out:

*...one of the reasons why the DOH stopped in training hilots is that there are lots of hilots after undergoing the training who practice abortion and use it as a source of income. That's why*

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*young girls who get pregnant seek their services. Then these hilots do the abortion to end the pregnancy (Rural health unit midwife).*

Evidently, this practice contributes to “unsafe abortion that has a clear and well-established link to maternal mortality: its consequences such as infection and haemorrhage can lead to maternal deaths” (Gill et al. 2007: 28).

Based on the empirical data presented, it can be argued that facility-based deliveries is the driving force in reducing maternal mortality as effective treatment of emergency obstetric complications can only be provided by an EmOC health facility. The evidence in a variety of settings is less convincing for overall increases in the detection of complications, in referral to the formal health care system and in the utilization of essential obstetric services among women attended by (trained) TBAs (Bailey et al. 2002: 15). Moreso, in the case of the Philippines, it was seen that there is a strong basis for promoting facility-based deliveries and discouraging the training of TBAs because instead of averting maternal deaths trained and untrained *hilots* contribute to maternal mortality through unsafe abortions.

### **2.3 SHI and maternal mortality: the “linkage”**

As we have seen, increasing the proportion of women who deliver in a health facility can be a key in reducing maternal deaths especially in low-income setting (Parkhurst et al. 2006: 438). Nonetheless, the goal of having all births attended by a professional - who provides a paid service – or shifting to facility-based deliveries (for EmOC) has in most instances required women to pay for maternal care services (WHO 2006). This financial barrier is what women continuously confront.<sup>9</sup>

Health insurance addresses this financial barrier and usually increases utilization of services while contributing to increasing efficiency and quality of care over time (Schneider and Dmytraczenko 2003: 3). SHI is an example of this. It can be called National Health Insurance and is generally compulsory for certain groups in the population (Conn and Walford 1998). “The premiums are determined by income rather than health risk” (ibid). Though, according to the WHO “in the context of universal coverage, the government makes a contribution to the scheme on behalf of those who are unable to pay” (2006). This redistributive mechanism is done specifically to cover the poor population.

The linkage between the SHI and the reduction in maternal mortality comes in the benefit packages included in the insurance. It is argued that offering a maternal care package in an SHI

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<sup>9</sup> Discussed in detail in the previous chapter

scheme is a good effort in encouraging deliveries in health facilities and hence, in averting maternal mortality.

A notable example is the *Seguro Nacional de Maternidad y Niñez*<sup>10</sup> (SNMN), an SHI in Bolivia. SNMN's goal is to reduce maternal and child mortality by increasing the utilization of formal health services (Dmytraczenko et al. 1999: 3). Its services were increased when it was changed into the Basic Health Insurance (BHI). BHI explicitly covered complications of pregnancy, delivery and postpartum including post abortion care, coverage for complications of the newborn, sexually transmitted infections, malaria, tuberculosis and cholera (Marjorie A. Koblinsky et al. 2003: 83). These services are provided free-of-charge to the beneficiaries which eliminated the economic barrier to access (Dmytraczenko et al. 1999: 3). In addition, Camacho et al pointed out that "through the use of explicit performance agreements with set output and process targets, the reforms have sought to improve accountability and responsiveness to clients, which entail improving accessibility and quality of services (2003: 13)".

The studies on SNMN revealed that this SHI had indeed improved the utilization of services that can reasonably be expected to lower maternal and childhood mortality rates (ibid:12). Among the positive outcomes are the increase coverage of institutional deliveries (ibid: 11); the strong utilization among the poorest segment of the society and adolescents (a group not formally using formal health services) (Dmytraczenko et al. 1999: 5); and the success of the government's promotional efforts in informing the public about the insurance program and therefore, about health services in general (ibid).

Hence, these findings suggest that a maternity care package integrated into the SHI could result to positive maternal outcomes. Further on, this paper would analyze the impact of the SHI's implementation in the urban-rural Philippines.

## **2.4 Inequalities in maternal services accessibility: the barriers**

Debate on inequality in accessing maternal services has three faces: urban-rural disparity, class disparity and gender inequality.

There can be little doubt that the huge rural-urban differences in maternal mortality are due, at least in part, to differential access to high quality maternity care (C. Ronsmans et al. 2003: 940). A study carried out in eight countries in West Africa concluded that in urban areas, the vast majority of births took place in a health facility (83%) or with a skilled provider (69%), while 80 percent of the rural women gave birth at home without any skilled care (ibid). This discrepancy is attributed largely to the fact that EmOc, health facilities and skilled attendants are more

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<sup>10</sup> National Insurance for Mothers and Children

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accessible in the urban than rural areas. Elo also argues that “much greater effort to redistribute health-care resources on the part of the government are required if modern maternal-health care services are to reach women in rural areas” (1992: 16).

Existing literature on health service utilization are divided into two opposing sides. Becker, Develay, Magadi and others point out that increasing the availability and accessibility of health services is sufficient to increase utilization (Matsumura and Gubhaju 2001: 24). On the contrary, there are those who claim that the availability of health services does not guarantee utilization. Caldwell argues that in general, “women with low status are less likely to use modern facilities, whereas women with higher status take the initiative in seeking care for themselves and their children (ibid)”. This status pertains to either women’s economic status, intra-household decision making power or educational level (ibid). Based on developing countries’ experience, Caldwell’s argument seems right. For instance, in the Philippines women’s economic status has a bearing on maternal services utilization. Table 3 reveals that women who belong to the highest income group tend to give birth in a health facility, assisted by a professional during delivery and access EmOC more than those who belong to the lower income groups. These results, therefore challenges the first assumption that availability of health services is enough to increase utilization because in reality, social structure and other factors influence people’s health-seeking behaviour.

Gender inequality in maternal care services has two sides: demand and supply. The demand side deals with the utilization of services. Oxaal and Baden claims that analysing gender relations in a given context is crucial in understanding the processes by which women decide to seek health care services for pregnancy and childbirth (1996: 19). Several factors that come into play are that a) decisions to seek medical care are not done by the woman herself but by her mother or husband; b) pregnancy may not be a condition perceived by the community as requiring care hence, it causes delays in seeking health services; and c) women’s autonomy in deciding to seek care is hampered by her economic dependence, as well as the unaffordable costs of emergency interventions (ibid: 19).

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**Table 3. Maternal services delivery per quintile (2003)**

<b>Maternal Services</b>	<b>Quintiles</b>				
<b>Place of delivery</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>
Government hospital	8.7	19.6	30.4	34.6	29.9
Government health center	0.5	0.8	1.8	3.0	1.4
Private sector	1.2	4.4	11.1	22.2	45.5
Home	88.7	74.3	56.2	39.0	22.6
Other	0.1	0.3	0.2	0.3	0.1
<b>Assistance during delivery</b>					
Doctor	8.6	21.0	37.4	52.6	73.2
Nurse	0.5	1.7	1.8	0.6	1.2
Midwife	16.0	28.7	33.2	31.2	18.0
Midwife	68.9	45.4	26.3	13.3	7.0
Midwife	4.9	2.4	1.1	1.4	0.6
Relative/friend/other	0.4	0.2	0.1	0.0	0.0
No one					
<b>Delivery by C-section</b>	1.7	3.4	6.8	10.8	20.3

Source: (National Statistics Office and ORC 2004)

The supply side is linked to the accessibility of maternal services. The UN Conference on Women highlighted the fact that women's health is also affected by gender bias in the health system which causes inadequate and inappropriate medical services to women (ibid: vi). In short, it is necessary for the government to take into account the women's specific needs in terms of maternal services.

Moreover, gender inequality is also reflected in SHI policies. This happens when the entitlement to the insurance is linked to a family member's employment and spousal coverage (WHO 2006) as in the Philippines, where the indigent or sponsored program<sup>11</sup> grants the insurance on the typical male household head. The woman and children are usually the dependents of the husband hence; in cases when the man dies there is a big chance of the discontinuation of the insurance.

It is important to point out that as discussed in the analytical framework, all the issues presented should be viewed in terms of the women's right to access and utilize quality maternal care services.

<sup>11</sup> A type of SHI that covers the poor population. Its components will be discussed in the next chapter.





### **3 HEALTH FINANCING SCHEMES: PRESENTING THE BASIS, REVEALING THE INTENTIONS**

This chapter illustrates how the health care system in the Philippines works. It recounts the evolution of the health financing schemes in the country. Towards the end of this chapter the components of the SHI<sup>12</sup> is presented as well as the intentions behind the implementation of such scheme.

#### **3.1 The Philippine health care system: extensive but weak**

The Philippines operates on a two-tier health care system: the public sector which is financed through a tax-based budgeting system at the national and local level and where services are generally free at the point of service (although socialized user charges have been introduced in recent years for certain type of services); and the private sector which is largely market-oriented where health care is paid through fees at the point of service (Department of Health October 2005: 15).

Under this health system, the public sector is composed of the DOH, local government units (LGUs) and other national government agencies providing health services (ibid). DOH is the central authority for coordinating the health sector and is responsible for making policies and plans, setting standards, defining national priority public health programs, and licensing and regulation of health facilities (ADB 2007: 45). Due to decentralisation in 1991, the LGUs are mandated to maintain health care facilities at the local level (provincial and city hospitals, barangay health centres and RHUs).

Table 4 shows the classification of public health facilities, who administers it, what services are provided and what kind of health personnel, are stationed. It reflects how fragmented the public health system delivery in the country after the decentralization, with the district and provincial hospitals being administered by 79 different provincial governments and the barangay health stations and RHUs by over 1, 000 different city and municipal governments (ibid). This table also suggests that a functioning referral system is vital to effectively provide health services as the barangay health stations and RHUs can only provide primary health care and public health services thus, complicated cases needs to be referred to a district or provincial hospital (ibid).

Moreover, this type of structure provides no incentive for LGUs to provide additional health services like quality EmOC. Since referrals between health facilities exist because of the inter-local cooperation, there is a tendency for an LGU not to upgrade its facilities and just rely on this system.

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<sup>12</sup> SHI and NHIP will be used interchangeably.

**Table 4. Classification of public sector health facilities**

Administration	Category of Health Care Facilities	General Services Provided	Health Professionals
National and regional	Hospitals and medical centers	Tertiary care; teaching, training, research	Chief of Hospitals, Chief of Clinics, medical specialists in a broad range of specialties and subspecialties
Provincial	Hospitals	Secondary care, limited tertiary care	Chief of Hospital, Chief of Clinics, medical specialists in obstetrics, gynaecology, surgery, medicine, pediatrics
District	Hospitals	Primary clinical care, limited secondary care	Medical specialists in surgery (also Chief of Hospital), general practitioner with some training in obstetrics, gynaecology, pediatrics, family medicine, anaesthesia
Municipal	Rural health units	Primary health care services, public health services (including disease control, health promotion, health education)	Municipal health officer or rural health physician, public health nurse, rural health midwife, sanitary inspector, medical technician, dentist
Barangay	Barangay health stations	Same as rural health units	Midwife, barangay health workers

Source: (ADB 2007: 46)

The private sector are also involved in maintaining people's health by providing services in clinics and hospitals, health insurance and other health-related services (Department of Health October 2005: 16). Private tertiary-level hospitals are found in major cities and are perceived to provide higher quality services than public tertiary hospitals (ADB 2007: 45). But since the private sector's services entail a much higher cost, only the upper and middle-income households usually avail of its services.

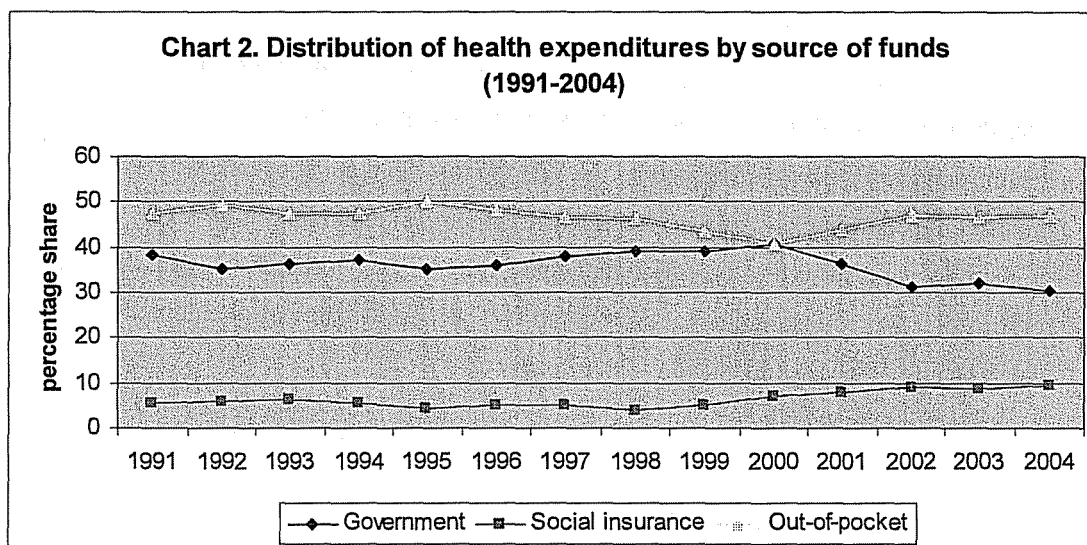
This structure gave rise to an extensive but weak health care delivery system. The system is weak on two counts: a) the free health service delivery provided by the public sector had resulted in poor quality services and the inadequate resources has hampered the establishment of hospitals in the rural areas; and b) although quality services are provided by the private sector, it remains inaccessible to the poor segment of the population.

### 3.2 The health financing system: the basis and evolution

#### *The source of health funds*

Resources for health in the country are obtained from three sources – out-of-pocket, government and SHI. Out-of-pocket is paid by families for health care goods and services that they consumed. Government funds come from taxes at the national and local level. SHI covers health benefit payments provided by the Philippine Health Insurance Corporation<sup>13</sup> (PhilHealth), Social Security System<sup>14</sup> (SSS), and the Government Service Insurance System<sup>15</sup> (GSIS) (NSCB 2006: 37).

Chart 2 presents the percentage share of each source of fund on the total health expenditure and shows that out-of-pocket consistently had the highest share and the SHI remains low at less than 10 percent. Intuitively, it can be argued that the burden of financing health care still lies in the individual families.



Source: Based on NSCB (2004; 2005; 2006)

#### *The evolution of health financing schemes*

The public sector health financing in the country started out as a tax-based system providing free health care services at the point of delivery. In 1995, by virtue of RA 7875, the National Health Insurance Program (NHIP) was created to provide health insurance coverage and ensure

<sup>13</sup> Health insurance provision was transferred to PhilHealth in 1997-1998 from GSIS and SSS.

<sup>14</sup> SSS is mandated to provide social security insurance for the private sector.

<sup>15</sup> GSIS is mandated to provide social security benefits for government employees like life and death benefits.

affordable, acceptable, available and accessible health care services for all citizens of the Philippines (GOP 14 February 1995). However, NHIP proved to be an ineffective mechanism in responding to the health needs of the population. As can be seen in Chart 2, since its inception, the financial burden of paying for health services remains with the families. This is due to the program's limited membership, unattractive benefits and weak administrative infrastructure (DOH December 1999: 17).

Faced with this problem and a deteriorating quality of services in public health facilities due to poor health care financing (ibid: 15), the government undertook the Health Sector Reform Agenda (HSRA) in 1999. The major reforms in HSRA included providing fiscal autonomy to government hospitals, expanding the coverage of the NHIP, securing funding for priority health programs and promoting the development of local health systems (ibid: iii). A strategy adopted to attain these was the collection of socialized user fees. It is a scheme wherein fees are charged at the point of health service delivery based on the patient's ability to pay. Each income bracket had a corresponding fee or benefits.

However, this reform reflects the socio-political context of the 1990s. It can be recalled that after the structural adjustment program in the 1970s and 80s, 1990s was the decade wherein health sector reform was prescribed by the WB to most developing countries. The package imposed the commercialisation of hospitals and the implementation of user charges with the goal of making health services more efficient. Hence, the Philippines did not only implement the reforms due to the reasons cited above but moreso because it was a regular debtor to the WB which had no choice but to take on such reforms.

Like many developing countries, the reforms did not make much improvement, the progress of infant and maternal mortality rates remained slow and health services were still inaccessible to the majority of poor population. For this reason, a new roadmap for health reforms was launched – the *FOURmula One for Health*.

This new program had four pillars namely, health financing, health service delivery, health regulatory and good governance. The examination of documents and issuances related to this program suggests that the main objective was to include certain groups of people (mostly the poor) who were often excluded in the health service delivery, while at the same time improving the quality of services.

Essentially, this program was only different from HSRA because it – made the NHIP the flagship program for health financing. NHIP would serve as the main lever to effect desired outcomes in each of the program's components (DOH 2005). Moreover, this move was geared

towards minimizing out-of-pocket expenditures and using SHI as the major source of health spending (Department of Health October 2005: 56).

In summary, the health financing schemes that the Philippine government has been implementing through the years affirms that in principle, while the State is trying to ensure that the right to health is met, its health policies is still highly influenced by politics of the world economy. In the next chapter, we will see whether this kind of policy makes sense in practice, especially at the local level.

### **3.3 Financing at the LGU level**

Similarly, the 1992 devolution of health services to the LGUs<sup>16</sup> can also be rooted in the overall package prescribed by the WB. The Bank saw local financing as a way “to reduce the demand on state-provided, tax-financed services” (Messkoub 1992: 195) and decentralization as a “necessary condition for greater responsiveness of public services” (Mackintosh 1992: 87). Consequently, the functions previously vested upon the DOH is now being undertaken by each LGU: the operation and maintenance of local health facilities; service delivery (LGSP 2003).

But what is the implication of this kind of financing on the overall goal of making the SHI as a major source of health spending? This kind of system entails that the achievement of this goal lies mainly in the hands of the LGUs because they have the responsibility to fund the SHI hence, a shift from an SHI funded by a national pool to an SHI funded by local funds had ensued.

Now, where will the LGUs obtain the funds needed to provide SHI? Health financing at the LGU level basically comes from two sources: taxes at the local level and the internal revenue allotment (IRA) from the national government. The IRA is the share of the LGU from the national tax revenues. However, the share of each LGU is determined by its population, land area and equal sharing (Nolledo 1995: 122). Inadequate funding becomes an issue as most LGUs do not have enough funds to finance health services and provide SHI to their constituents due to low IRA. This reasoning, however, can be contested. According to the Limburg principles, resource constraint is not an excuse in providing the right to health care because many of the activities in fulfilling this right do not need huge financial resources (Centre for Development and Human Rights 2003: 56).

### **3.4 NHIP and its components**

As depicted in the diagram below the social health insurance in the country has five programs that cater to the variety of needs of the Philippine society: the employed sector (covering both the

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<sup>16</sup> An LGU is a political subdivision that could either be a province, city or municipality.

public and private sector), informal sector (Individually Paying Program), overseas Filipino workers, retirees (Non-Paying Program), and for the poor segment of the society (Sponsored Program). The beneficiaries and dependents of each program are entitled to in-patient, out-patient care and special packages that include a Maternity Care Package.

#### *The maternity care package*

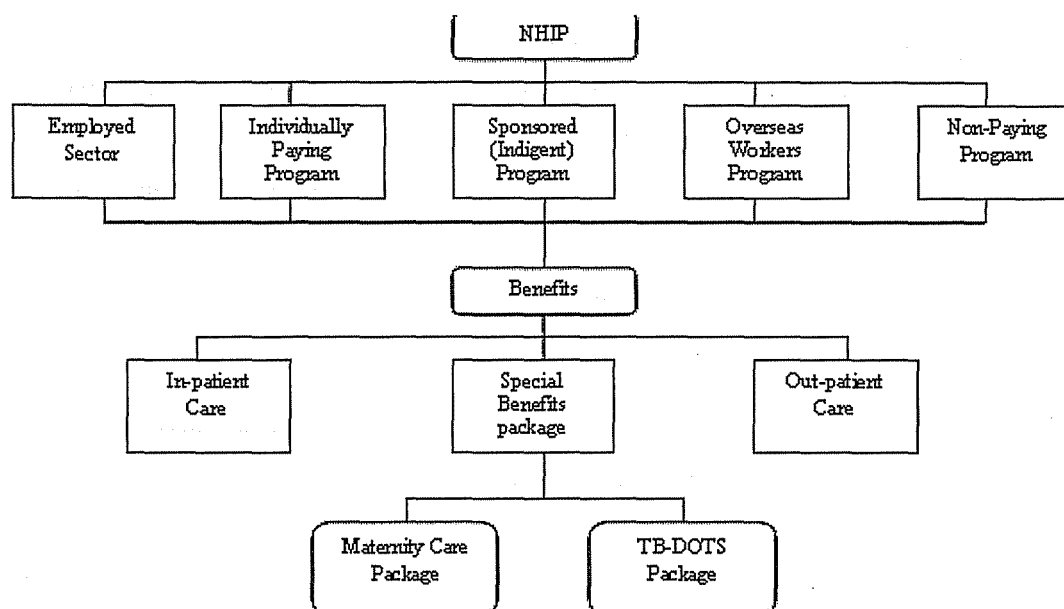
The maternity care package was introduced in 2001 through Resolution No. 388 in an effort to improve the reproductive health in the country. The package covers two normal deliveries<sup>17</sup>, pre-natal and post-partum care, newborn care and family planning counselling (PhilHealth). The government provided the continuum of services for maternity care at the most peripheral, feasible and safe level to ensure accessibility of the maternal care to women in greatest need (ibid). Thus, aside from physicians, trained midwives were viewed as appropriate health care providers during pregnancy and normal birth (ibid). Pregnant women, could therefore, avail of services included in the maternity package in both the hospital and non-hospital facilities such as lying-in clinics, midwife-managed clinic and birthing homes (PhilHealth 2003) that are accredited by PhilHealth.

Nonetheless, the maternity care package is not applicable in non-hospital facilities in the following cases: maternal age under 19 yrs old; women with maternal age of 35 yrs old; multiple pregnancy; ovarian, uterine, placental and fetal abnormalities; history of miscarriage, previous major obstetric/gynaecologic intervention, medical conditions; and other risk factors that warrant a referral for further management (ibid). This was developed to ensure that women who developed serious complications are referred to hospitals that are capable of handling such situations. Based on these provisions, it can be argued that the Philippine government is pushing for facility-based deliveries and recognizes the importance of both role of the professionals and the referral system for safe deliveries.

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<sup>17</sup> The coverage was expanded to three normal deliveries in 2006 due to the noted improved access of quality maternity care in both hospital and non-hospital facilities after the coverage of normal deliveries and in support of the MDG goal in reducing maternal mortality (Philhealth, 'In Support of Millennium Development Goals: Philhealth Introduces New Benefit Packages', <[http://www.philhealth.gov.ph/newsroom/2006\\_news/071906b\\_news.htm](http://www.philhealth.gov.ph/newsroom/2006_news/071906b_news.htm)>, accessed 26/10/2007

**Figure 2. NHIP Structure**



Source: Own elaboration

#### *The Sponsored (Indigent) Program*

The Sponsored (Indigent) Program was institutionalized to provide health insurance to the marginalized sector of the country specifically to those belonging to the lowest 25 percent of the population (PhilHealth). The LGU and the national government give an equal share to enrol each indigent at P1, 200 (€ 20) annually. The premium sharing is based on the income classification of the LGU where those who are having difficulties in providing this type of insurance for its constituents usually tap the help of other government agencies, legislative body officials and the private sector (ibid).

The determination of indigent beneficiaries lies in the hands of the LGUs. Ideally, the LGU conducts a social research survey of the current socio-economic and health profile of the indigent sector through the Community-Based Information System – Minimum Basic Needs (CBIS-MBN) (GOP 14 February 1995). Identified beneficiaries are approved by the City/Municipal Development and Social Welfare Office. The list of eligible NHIP beneficiaries are then submitted to PhilHealth for verification with the Department of Social Welfare and Development (DSWD) (ibid).

Furthermore, a distinctive feature of the Sponsored Program is the capitation fund. The aim of the fund is to improve the quality of medical care delivered even at the lowest rung of the health delivery system and make it at par with the standards being set for other health care providers (ibid). For every indigent family enrolled by the LGU into the Sponsored Program, PhilHealth pays back P300 (€5) to the RHU through the sponsoring LGU representing capitation amount per year of enrolment; this amount is taken from the annual premium remittance of the LGU to PhilHealth (ibid). It is used for the procurement of medicines, improvement of the quality of primary services, and payment for referral fees (ibid).

### 3.5 The intentions

In principle, the introduction of the SHI as a new health financing scheme aimed to cover the poor population in health service delivery while preserving the quality of services. Nevertheless, it is also interesting to know the other intentions behind the NHIP specifically, those of the maternity care package being offered by PhilHealth.

#### *Promoting facility-based deliveries but decongesting hospitals*

The discussion with the Supervising Officer of DOH confirmed that the inclusion of a maternity care package in SHI was done to encourage facility-based deliveries. According to her:

*"There is a possibility that we can reduce maternal mortality through the SHI because the deliveries will be facility-based. We are also discouraging the training of 'hilots' so that deliveries will be in the health facilities and not at home." (DOH Officer)*

This is the intention for the long-run. But in the short-run the real objective is to decongest the patient load in government health centres and hospitals (PhilHealth). A PhilHealth Senior Officer pointed out that:

*"Part of the package was to increase accreditation of professionals. We're accrediting not just doctors but also midwives. So, the package was really to declog the hospitals of normal deliveries. The intention was to decongest the secondary and tertiary hospitals because deliveries can be done in birthing homes or lying-in clinics through the assistance of midwives." (PhilHealth Officer)*

#### *Controlling the information to discourage increase in population*

The Philippine constitution protects the rights of people to health especially the marginalized sectors. Section 11 Article 13 of the Constitution stipulates that:

*The State shall adopt an integrated and comprehensive approach to health development which shall endeavour to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the under-privileged, sick,*



*elderly, disabled, women, and children. The State shall endeavour to provide free medical care to the poor (Members of the Constitutional Commission 1987).*

This clause was used as a basis of RA No. 7875, an act that institutionalizes NHIP for all Filipinos. Aside from stating that the insurance program should be universal, equitable and responsive, the RA highlights the need for an informed choice. It mentions that members should be apprised with the full range of providers and services and privileges included in the program (Government of the 14 February 1995).

However, the government has not been providing the complete information to insurance beneficiaries on the privileges of having insurance. The reason is that the government fears that announcing that the insurance covers three normal deliveries for free might back fire on the population control program. This was disclosed by a DOH Senior Officer in an interview:

*... they will not really announce that deliveries are free because it is in a way in conflict with controlling the population. We are discouraging them to continuously give birth. (DOH planning officer)*

The assumption here is that if the beneficiaries knew that deliveries are free, it would serve as an incentive for them to have more children. It is definitely worthwhile to challenge this notion and dig deeper on the consequence of such assumption hence; further discussion on this will be done on the next chapter.

#### *“Tolerating” inclusion of political indigents to encourage LGU’s participation*

Despite having a selection process for beneficiaries, a number of insurance were given to the politicians’ patrons rather than to those who are in need. The inclusion of *political indigents*<sup>18</sup> in the indigent pool has been a long-standing issue since the inception of the sponsored. Apparently, this loophole in the program is known even among the officers of the PhilHealth head office. They knew that supporters and relatives of the LGU officials usually are favoured more than the poor families. But instead of doing something to prevent this, it seems that to a certain extent this behaviour has been justified. A Senior Officer in PhilHealth expressed:

*In the first place, the indigent program was made political from the start because you’re enticing LGUs to provide the money for the insurance premium... so, we know for a fact that when you are a local chief executive, of course you want to give benefits to those who supported you.. Those with the same political colour as you. Those who are loyal to you. We call them not political but patronage. Although we don’t know how many they are and perhaps it’s not done vulgarly (PhilHealth officer).*

This suggests that having political indigents is implicitly being tolerated to avoid discouraging local officials withdrawing from the sponsored program. The dilemma though is

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<sup>18</sup> Beneficiaries who got their insurance because they are the politician’s patrons

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that most of the political indigents don't come from the poor segment of the society and are in fact well-off. Consequently, poor people who are supposed to receive some form of protection through the insurance are being excluded because of political interests.

## 4 IMPACT OF SHI ON THE PROMOTION OF FACILITY-BASED DELIVERIES

This chapter discusses the SHI's impact on the promotion of facility-based deliveries and possibly link it to the prevention of maternal deaths using two cases – urban and rural. The factors that contribute to the (un)successful intervention will be discussed in detail.

### 4.1 Urban Case: the epitome of success

#### *How did they do it?*

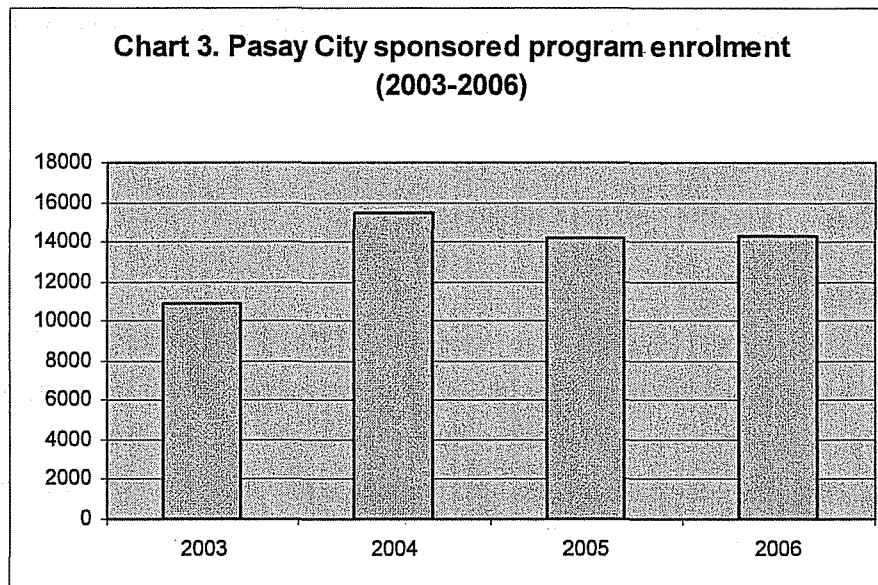
Pasay City started their SHI long before the introduction of the sponsored program. Two years after the ratification of RA 7875, the City Council had approved the resolution making the provision of NHIP to its poor constituent a regular program of the city. It is the political will of the city officials that kept the program going. As the head of the City Health Office (CHO) pointed out:

*... our Mayor committed for the program, every year there is an increase in the budget for the insurance and then in 2004, he pledge 8 million pesos (133,333 euros)... up to now the same amount is allotted annually (CHO head).*

After the introduction of the sponsored program in 2003, there was a substantial increase in the number of beneficiaries in 2004 (see Chart 3). The presidential, legislative and local elections were held in 2004 and during such time the incumbent officials including the President gave out SHI to entice political patronage. After which, the number of beneficiaries remained constant which was also due to the fact that the city made the provision of insurance one of its core programs and allocated a standard annual budget for it.

As the allocation was still not sufficient to cover all the city's poor and the city wanted to ensure that the limited resources was used efficiently, it adopted a mechanism that deviated from the usual process discussed in Chapter 3 to prevent the inclusion of "political indigents" in the program. With the 'go' signal of the city officials and DSWD, the CHO implemented the self-targeting approach in identifying the beneficiaries. The chief nurse in a barangay health centre explains:

*We let people know about the program through information dissemination in each barangay and community assemblies. Then we let people come to the health centres and fill out the form, some were recommended. Then we conduct the interviews... you know what's good is that our barangay health workers knew almost everyone in the community so, it's easy to find out if the household is really poor or not (Chief Nurse).*



Source: PhilHealth main office data

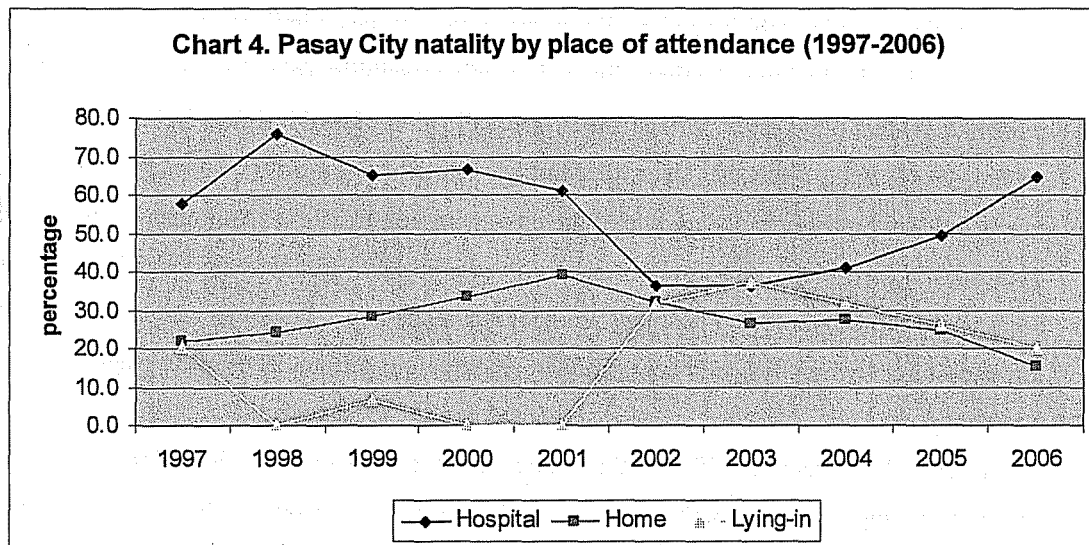
Unlike the usual process, barangay officials were not allowed to screen the applicants. Screening remains at the barangay health centre level and city health office hence, weeding out the political indigents became easier.

Another strength of the program is that they do not change the beneficiaries unless necessary. Unlike other LGUs, the city renews the SHI of the sponsored program beneficiaries. Cross-checking is done every two years, to see if the household is still entitled to receive the insurance. If after the evaluation, it is found out that the family had already improved their economic situation (using income as a criterion) then a new household will be granted the insurance.

#### *Why did they utilize it?*

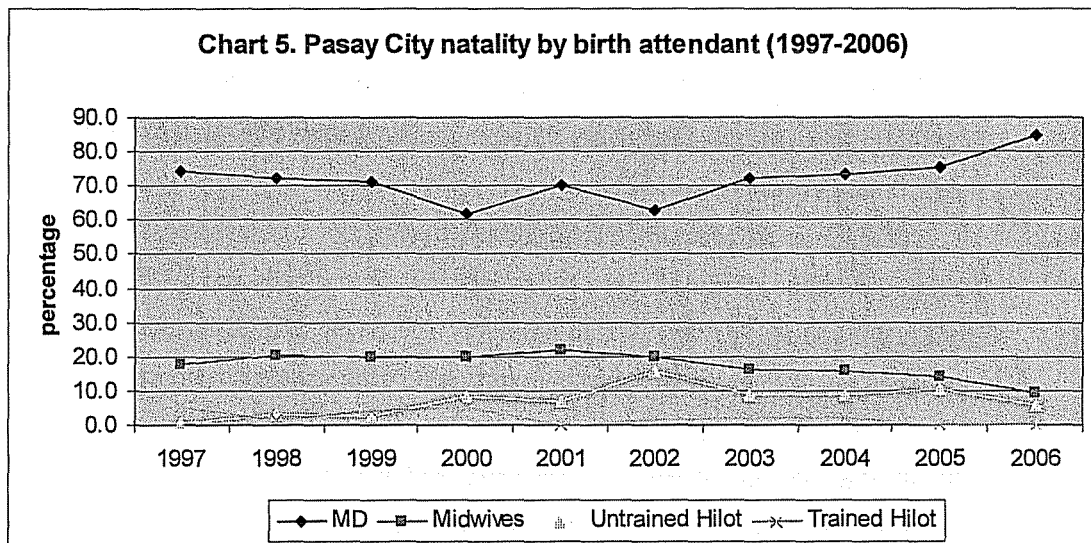
Ever since the introduction of the SHI in 1997, women increasingly went to the health facilities to give birth. The chart below reveals that there is a high disparity between giving birth at home and in a hospital. After the renovation of the lying-in clinic in the city in 2000 to 2001, it is noticeable that the rate of hospital births decreased while the rate of births in lying-in clinics increased. Intuitively, it can be said that there was a movement of preference from delivering in hospitals to lying-in clinics. This can be considered as a positive development because as discussed in

Chapter 3, one of the intentions in introducing the maternal care package is to decongest hospitals of deliveries and encourage birth procedures in lying-in clinics and birthing homes.



Source: Pasay City Annual Health Reports

Not only did women give birth in a health facility but a majority of them were assisted by professionals. For example, for the last ten years the percentage of those attended by medical doctors (MD) never went down to 60 percent and in 2006 alone, more than 80 percent of all births were done by MD. Though there are still deliveries by untrained *hilots*, the percentage was already insignificant.



Source: Pasay City Annual Health Reports

All of the interviewed women (even the non-beneficiaries) gave birth in a health facility i.e. hospital and lying-in clinics. A crucial factor that motivates beneficiaries to use their insurance is the accessibility, affordability and quality of maternal services. Similar to what was discussed in Chapter 1, the city had met the three dimensions of accessibility (physical, economic and information) that plays an important role in the realization of health rights. In Pasay City, health facilities such as hospitals, health centres and lying-in clinic that offer maternal services are easy to reach. They are right in the middle of the city and going from one to another is never a problem because of the efficient transportation system. Accredited PhilHealth facilities (where insurance cards are accepted) include 4 hospitals, 13 health centres, and 1 Maternity Clinic. Thus, the health infrastructures being physically accessible are enough to cater the needs of its pregnant women population.

Even if the interviews affirmed that money is just a secondary consideration in women's decision-making on where to give birth, it is still important to recognize the fact that health services should be economically accessible especially for the marginalized group. Both antenatal and postpartum check-ups are free in the barangay health centres and hospitals. Although these facilities do ask for a small donation, women don't mind giving a small amount. As one of the respondents expressed:

*It's ok to give donations because they accept any amount. Sometimes you can even give 20 pesos (0.33 euros) during check-ups (Sponsored Program beneficiary).*

In principle, deliveries are free for insurance beneficiaries. However, in most cases donations are asked in the health facilities. For example, in the lying-in clinic, P550 (9 euros) was asked as a donation to cover the newborn screening for the baby. But this is a case to case basis, if the beneficiary really doesn't have any money to give for donations; they are not forced to give anything. Hence, the donation doesn't discourage pregnant women to seek the health services of the facilities because it is affordable.

Turning now to information accessibility, the high level of awareness in the urban Philippines can be attributed to the wide advocacy approach adopted by the city. The CHO instituted the *Araw ng Buntis*<sup>19</sup> Program. Every Tuesday and Thursday mornings in all barangay health centres, women are given an hour lecture on different aspects of pregnancy and childbearing before the antenatal check-ups. A theme is created in every session as one session will talk about the complications of pregnancy and another session will be about eating the right food. Based on the observation done in one of these sessions, it can be said that the gathering is

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<sup>19</sup> English translation: Day of Pregnant Women

also a good venue for pregnant women to ask questions, clarify their misconceptions and share their experiences. A rapport is also established between the barangay health personnel (doctors, nurses and midwives) and the pregnant women. Indeed, it is easier for the health personnel to encourage these soon-to-be mothers to avail of the maternal services offered by health facilities. For instance, at the end of the session the doctors will always reiterate the importance of giving birth in a health facility and that they can easily avail of this service using their SHI card even in the city's lying-in clinic. Referrals to the lying-in clinic were also automatically done by the barangay health centres.

Undoubtedly, this strategy had led to the utilization of maternal services by the beneficiaries. Another factor that contributed to this is the special treatment given to the sponsored program beneficiaries during deliveries. Like in the city's lying-in clinic, a special room is allotted for PhilHealth beneficiaries. It is some sort of a private room with only two beds in it. This was created to encourage women to make use of their insurance thus, resulting to facility-based deliveries. As the midwife in the clinic explained:

*We have a special place for the SHI beneficiaries... we call it the PhilHealth room. We want the women to feel that they're important and this is how we give them a special treatment. This is to encourage the use of insurance. (Lying-in centre midwife)*

But the special treatment does not only involve the allotment of private rooms. The "special treatment" is also reflected in the provision of medicines. A PhilHealth beneficiary recounted her experience:

*They (health personnel) didn't give me anaesthesia that's why I felt the pain while they're sewing me. It's my fault because I did not say that I have a SHI. I did not tell them right away during the interview. When they asked me if I had a SHI, I told them that my husband has. The health personnel in pink clothes told me you should have told us earlier because we should have given you anaesthesia and dextrose while you are still in labour...I realized that no SHI, no dextrose..(Employed sector insurance beneficiary)*

This strategy has two effects. It can have a positive effect; women can realize the importance of having insurance and actually end up using it. Like the woman above who really appreciated the benefits of the SHI card after her experience. However, it can also have negative effects. The illustration given can mean that certain groups of people can be excluded from such important maternal services because of the discrimination in the provision of these services. For instance, what if a really poor woman uncovered by the sponsored program goes to a health facility? It might mean that she may be treated differently. As can be recalled in Chapter 1, according to the Centre for Development and Human Rights (2003: 91) non-discrimination in the provision of health services should be guaranteed in order to ensure that the right to health is met. This condition is therefore, a violation of women's right to health care.

The good quality of care has also encouraged pregnant women to deliver in the health facilities particularly in the lying-in clinics. Based on the observation done in the clinic, it can be concluded that the health facility had complete delivery facilities and equipments. Further, interviewed women who had given birth in the city's lying-in clinic all expressed their appreciation of the cleanliness, completeness of facilities and friendliness of the health staff. The clinic's midwife pointed out that they ensure the cleanliness of the facilities:

*.. we always make sure that everything is clean and in order. We always sterilized our instruments and make sure that delivery room is disinfected because we don't want the mothers to develop any infections. We even do not let the cleaners do it... we ourselves (doctors, midwives and nurses) who do the cleaning to be sure... (Lying-in centre midwife)*

Another motivation is their safety. Like what was pointed above, money is only a secondary consideration. From the conversations, these women said that they do save little by little in preparation for their delivery. One of the social insurance beneficiaries said:

*Yes, we save...we start during my first month. We save first for the baby's things then for the birth expenses... we need to prepare for it because it's not that easy. (Sponsored program beneficiary)*

Interestingly, even less educated poor women are aware of the importance of getting maternal services from a health facility. From the comments in Box 1 below, it can be concluded that there is a high consciousness of the advantages and disadvantages of delivering in a health facility.



**Box 1. Urban women's view on whether it is much safer to give birth in a health facility than at home**

**Poor**

- *It's better to give birth in a health facility because you're safe if something happens to you. Like what happened to me, I had a bleeding. If that happened at home, they still need to rush me to the hospital. I already felt so sleepy and the doctor said that's not normal and I would have died because my brain is already losing oxygen. That's why it's best to stay here (lying-in clinic) because in case of emergency the doctors are here. — Leah, 30 yrs old*
- *Yes, that's right. Because if you give birth at home and there's something wrong with the baby, you still have to run to the hospital unlike in the hospital everything is already there. I'm scared to give birth at home because you're not sure what kind of instruments the hilots use. In hospitals, there are medical instruments. — Rosalina, 27 yrs old*
- *It's really much safer to give birth in a hospital because you can get a lot of help and there are medicines and equipments. Unlike at home, you're unsure of the instruments that the "hilots" use. Some just use blades soak in hot water and alcohol. There are quite a number of them here, like my husband's auntie who only has the experience but don't have a license. She uses blades because some of our neighbors force her to do so because some women do not have the money. Because some hospitals do not accept patients that easily if they don't have money and doctors are quite expensive. — Simplicia, 34 yrs old*

**Non-Poor**

- *Here (lying-in clinic) because if ever something happens, you will be taken cared off. — Emerie, 20 yrs old*
- *It depends. But I will give birth in a hospital in the future. — Ervelyn, 26 yrs old*

**Women's support: What the city has that the province doesn't have?**

At its present form, Pasay City is already implementing Model 3 of the Safe Motherhood Care model. Births are already facility-based and majority is assisted by professionals. But aside from the utilization of SHI, what does the city have that the province of Palawan doesn't have in terms of its health systems?

Besides those discussed above like accessibility, availability, affordability and quality of services; another distinct feature of the city is its strong referral system. Birth plans is a mandatory practice in the lying-in clinic. It is used in referring women to secondary or tertiary hospitals in cases when complications arise. According to the clinic's head midwife:

*We let mothers fill up the birth plan form (where they plan to give birth, second choice if this lying-in clinic cannot accommodate them, who will be their companion, etc.). So, that if anything happens during the birth procedure or if the doctor decides to transfer them to a hospital, we know where we can refer them. Then we'll call that hospital, tell them that our patient needs to be transferred, explain the condition and give a referral slip. If it's a worst case, a midwife would accompany them using the clinic's ambulance. (Lying-in centre midwife)*

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This system is very important in the whole strategy of averting maternal mortality. Taking the case of Malaysia for instance, its success in reducing maternal death depend mainly on its ability to provide the critical elements of maternal care free of charge to its client and at the same time practicing a strong referral system.

## **4.2 Rural Case: the source of disappointment**

### *Variation in maternal services spending: how is it manifested within class?*

Oftentimes the answer to this question seems obvious: the rich spends more than the poor. But it is also important to understand how the difference in spending affects the utilization of maternal services.

Box 2 illustrates a midwife's perception of how the difference in maternal services spending is reflected within income groups. Surprisingly, the cases reveal that in some instances, even for those who are well-off, money can be a deciding factor in their availment of maternal services. This is against the notion that rich women will automatically go to a high-end facility because they can always pay for the cost. Nonetheless, it is easier for the well-off woman to decide to give birth in a health centre because the risk for her is lower. For example, if a complication arises, she can easily be transported to a hospital because she has the resources and transportation to take her there.

On the contrary, a poor woman doesn't have as much choices. She goes to the health centre for antenatal check-ups because it's free. While this is true, financial constraints do not at all times hinder poor women to access maternal services offered in a health facility. The poor woman below for instance, still opted to give birth in a health centre despite the fact that she could not even afford to buy the basic birth supplies. Although she ended up running away, it is still safe to say that she is aware of the benefits of availing health services. In fact, when she was assured that she need not worry of her debt; she willingly brought her baby back to the centre for free vaccination.

## **Box 2. Differences in maternal health spending: An illustration**

The cases below happened in the same barangay health center in Palawan as told by the midwife who assisted these women.

### *Rich woman*

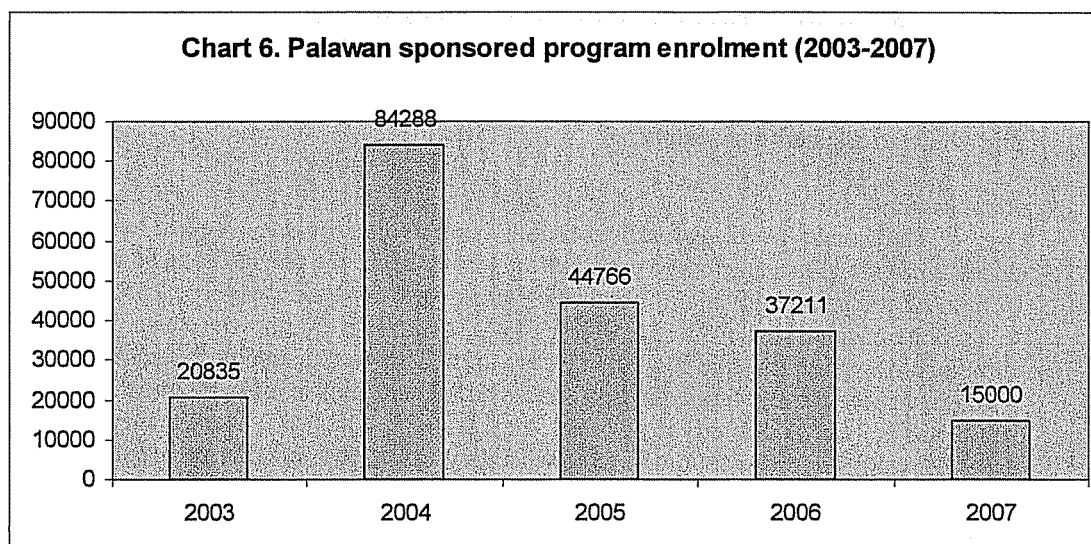
The woman lived in an affluent subdivision in the province. She had her antenatal check-ups in a private clinic. She could easily afford giving birth in a private hospital but insisted to give birth in a barangay health center because it's cheaper. It would only cost P1,500 (€ 25) compared to a private hospital that costs P30,000 (€ 500). The midwife is known to be a good one and if complications arose she said it would be easy to rush her to the hospital because they had a car. After the procedure, the family bought snacks and dinner for the midwife and the barangay health workers. They even doubled the payment, they gave P3,000 (€ 50) because they said that these expenses were still cheaper compared to what they would pay in a private hospital.

### *Poor woman*

The woman was really poor but always went to the barangay health center for the free antenatal check-ups. At the time of delivery, she was asked to buy something to tie the umbilical cord. But she asked the midwife if they can first use her emergency supplies and would just replace it. Six hours after the procedure, the midwife went home to change clothes. When she got back, the poor woman already left without paying the procedure nor replacing the supplies. After that, every time the poor woman and her husband saw the midwife they runaway out of shame. The midwife had to tell them to just forget their debt to convince them to bring their baby to the center for free vaccinations.

## *SHI Provision: Reaching the neediest?*

Ideally, with the mandate of the national government to universalize SHI, poor families should have been covered thru the PhilHealth Sponsored Program. Since its implementation in Palawan in 2003 the coverage has been very erratic (refer to Chart 6). At the onset, out of the 73,049 estimated poor families in 2003, only 20,835 (28.52 percent) were granted the insurance. For the same reason as those mentioned in Pasay City, this has boomed as much as four times in 2004 and was continuously declining since then. As a result, this trend had excluded most poor families, which can be attributed to three factors: not all municipalities sponsor poor families; non-poor families get in to the indigent pool and the insurance is oftentimes granted to different set of beneficiaries yearly.



Source: PhilHealth and conversation with PhilHealth Membership Head, Palawan

Aside from the capital city, only 16 out of 23 municipalities had linked up with PhilHealth for the sponsored program. For some of the LGUs, financial constraint was a barrier for participation hence, the declining number of beneficiaries. As the head of the Municipal Social Welfare and Development Division of Brookespoint conveyed:

*There's one year that we didn't give SHI because we don't have funds but I can't remember what year is that. Usually 20 percent is taken from the development fund and aside from that the Mayor has his own allocation. It is solely funded by the LGUs. (MSWDD head)*

While this maybe true, the fact that giving insurance is a political process should not be overlooked. In the end, the decision to participate in the program still depends on the mayor of the LGU. If (s)he does not include the SHI in the list of priority programs, there is little chance that poor families could avail of it.

In targeting the probable beneficiaries, the following parameters were used: a) the family should be earning annually an income below the poverty threshold which is Php12, 000 (€ 197); b) the family has six members or more; and c) children in the family should be below 21 yrs old. The identification of beneficiaries is done either with the help of midwives and *barangay health workers* or through the *barangay captains*. Midwives and *barangay health workers* are tapped because they know almost everyone in the community which makes the identification of poor families easier and with less administrative costs. After which, identified beneficiaries are subjected to an interview.

Nevertheless, non-poor families still get in to the indigent pool<sup>20</sup>. Unexpectedly, two of the interviewees are political indigents. Each of these women's family is earning more than Php 132,000 (€ 2164) annually, which is above the poverty threshold. The other woman's husband was referred by his cousin who works for the mayor and another one is a municipal employee. Evidently, patronage system is at work in the granting of the insurance thru the sponsored program.

Unlike Pasay City, the sponsored program in Palawan grants the SHI to a different set of beneficiaries annually. Very often, the insurance granted to a beneficiary for this year will most likely not be renewed next year. In an informal talk with the head of the Social Welfare Division in one of the municipalities, she said that they usually do it to give other poor people a chance to have the insurance because due to the limited budget they could not cover everyone all at the same time.

To reiterate, concurring to the politicians' behaviour of using the limited resources to favour a certain segment of the population is defeating the whole purpose of the PhilHealth sponsored program. If the targeting of beneficiaries would continuously be done improperly, then reaching those who are in need would be impossibility.

#### *Right to clinic delivery: Did women make use of it?*

The State is seen as the duty-bearer in terms of providing the necessary services for women to realize their right to health care. The analytical discussion on women's right in Chapter 1 made clear that the State should ensure that mechanisms should be in place for women to access health services in sufficient quantities. In the Philippines, a maternity care package was included in the SHI to ensure that women have the means to exercise their right to deliver safely by giving birth in health facilities. Moreover, in order to ensure that even poor women can exercise this right, a sponsored program was implemented in the LGUs. But this doesn't automatically end here. The bigger question is: does giving women the right to clinic delivery necessarily mean that they would exercise this right?

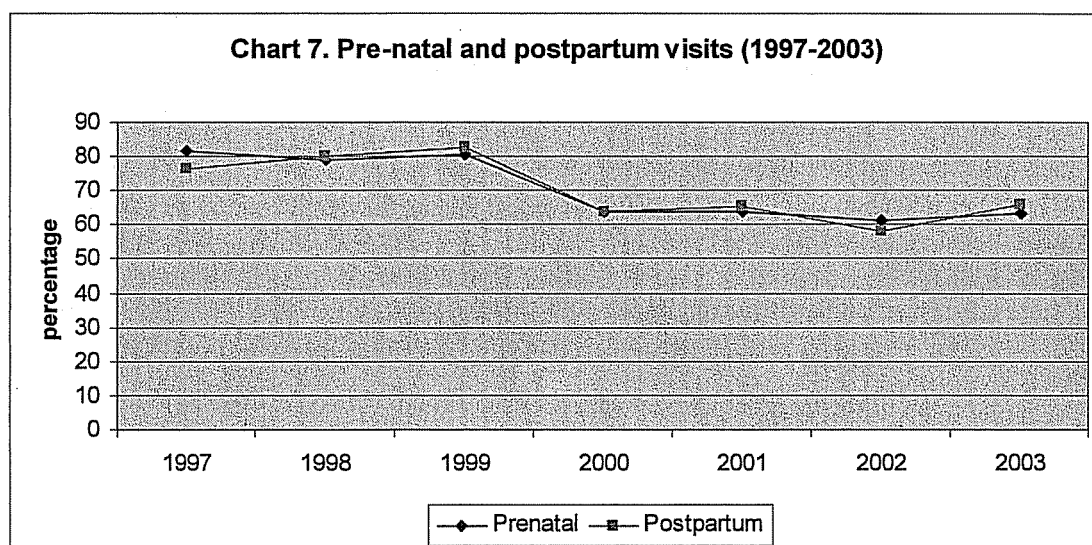
Interestingly, in the rural Philippines the answer is NO. Rural women may use the SHI for some of the maternal services but not at all times.

As explained in Chapter 3, the maternity care package includes free antenatal and postpartum check-ups. The coverage is supposed to encourage women to go to health facilities for their antenatal and postpartum check-ups. An examination of the trends in antenatal and postpartum checkups (see Chart 7) in a rural area in the country suggests that although the

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<sup>20</sup> As discussed in the previous chapter.

number of visits did decline after 1999, when the sponsored program was introduced in 2003, there was an increase in both check-ups. This implies that the program has in a way encouraged women to go for check-ups. This can further be proven by the interviews done with the insurance beneficiaries. All of which conveyed that they did go to health centres and hospitals for complete prenatal and postpartum check-ups.

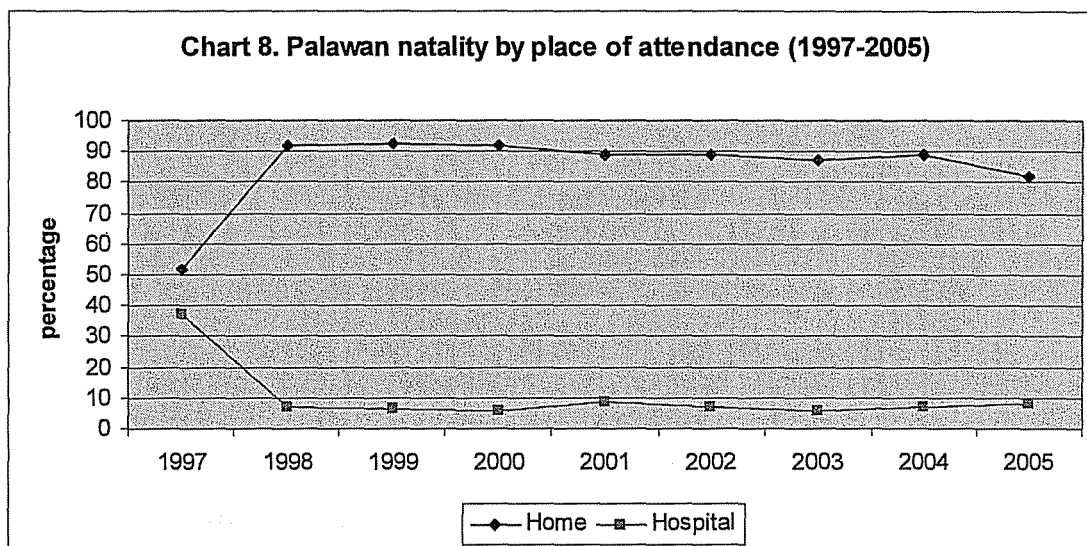


Source: Provincial Annual Health Reports

The most striking feature is that while the availment of prenatal and postpartum services is high in the rural areas, women were still not having deliveries in a health facility with a professional. Evidently, Palawan has a high prevalence in antenatal check-ups (more than 60%) whilst its facility-based deliveries remains to be very low. Based on this, it can be said that Palawan as a rural area is still in Model 1 of the safe motherhood models wherein births take place at home and assisted by non-professional who either have or not have trainings in delivery.

Chart 8<sup>21</sup> shows that almost all rural women still gives birth at home. For instance, after the introduction of the SHI in 2003, more than 80 percent of women still deliver at home. Hence, having a health insurance does not necessarily encourage women to give birth in a health facility.

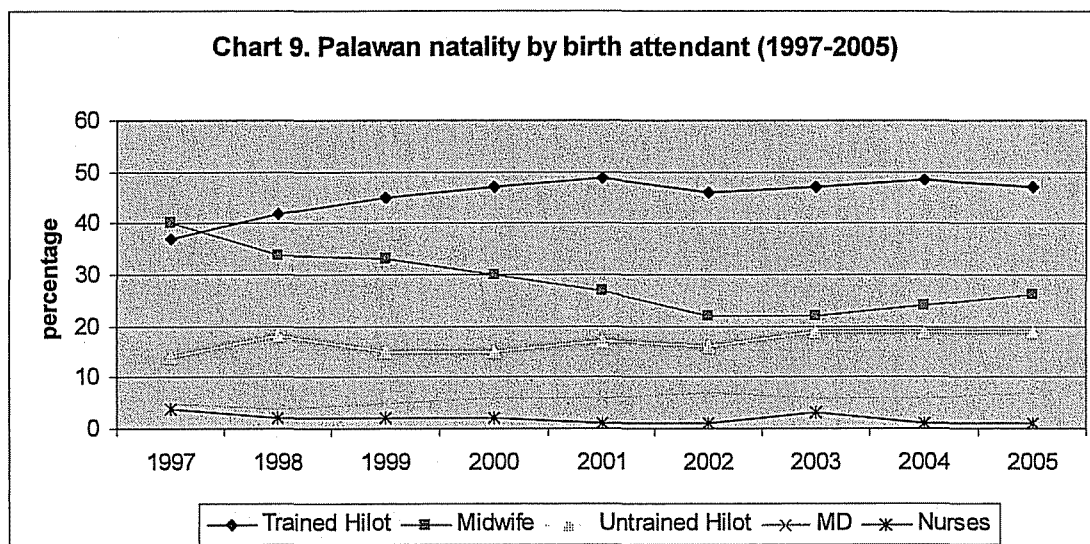
<sup>21</sup> The researcher had inquired at the Provincial Health Office (PHO) in Palawan for the possible reasons on the sudden rise in natality at home from 1997 to 1998. However, the PHO could not provide any reasons for it nor can provide data on the previous years (1990-1996).



Source: Provincial Annual Health Reports

Upon closer examination, women do not only give birth at home but prefer to give birth with the assistance of trained "*hilots*"<sup>22</sup>. This is a consistent trend for the last nine years as depicted by Chart 9. Moreover, births attended by midwives show a fluctuating trend. For example, since 2002, natality by midwives remains to be below 20 percent. The graph also suggests that a majority of rural women were assisted by a non-professional. Deliveries by untrained *hilots* are much higher compared to those by medical doctors. In an informal talk with one of the heads of the health division in the provincial capitol of Palawan, it was recounted that a woman who just lives beside the provincial hospital opted to be assisted by a *hilot* instead of just going to the hospital.

<sup>22</sup> Local name for traditional birth attendants



Source: Provincial Annual Health Reports

#### *Shedding light on the issue why women prefer giving birth at home*

The interviews done on rural women shed light on the issue why they prefer giving birth at home with the assistance of *hilots* rather than in a health facility, even if they have the health insurance that can cover all the maternal services costs. Six factors come into play. The first is the discomfort with the routines of delivery. Most women (both poor and non-poor) emphasized that they do not like the hospital procedures in deliveries. At the top of the most detested procedure is the episiotomy<sup>23</sup>. They don't want to be cut and be sewed back. Another is the cervical exam being done on women who are in labour. As one woman pointed out:

*I find it strange in hospitals. The doctors put their fingers inside your vagina to test if the baby's coming out. I don't like it... its uncomfortable and very painful (Sponsored program beneficiary).*

Also, instructions for them to walk around the labour room while they are still not due dishearten most of them. In short, any procedure that makes women feel uncomfortable and anything that they feel prolongs their agony in giving birth discourages women to avail of hospital services. This is where we can see the difference between the urban and rural Philippines. As was presented in the previous section, the antenatal classes done in Pasay City

<sup>23</sup> An episiotomy is an incision or cut into the perineum (area of skin between the vagina and the anus) to enlarge the space for the baby to pass thru (Oxorn 2007)



had made a difference in women's perception of clinic delivery. Consequently, this is what was lacking in Palawan.

Secondly, women value privacy. They don't want anyone seeing their "private parts" except for the birth attendant. A midwife narrates:

*Oftentimes, women would say: Ma'am, we're really shy to give birth at the centre because a lot of people can see you while your legs were apart and your private parts are exposed. Student practicumers are everywhere. Some would even say: Ma'am, I'll give birth here but in one condition, I don't want students around (RHU midwife).*

Unlike giving birth at home, only the *hilots* could see (which women really like) because even there families are not allowed to watch the delivery. This can be explained partly by the notion of *hiya* or shame embedded in the Philippine culture. Filipino women especially are raised with the belief that their private parts shouldn't be seen by other people except for their husbands. Sue highlighted that shame and protecting 'face' had played a role in the underutilisation of health services in Asian groups (MacLachlan 2006: 171).

Third, a number of respondents disclosed that they acquired their hospital trauma because of someone else experience. At least once in their life they saw someone close to them i.e. a sister, friend or relative who suffer while giving birth in a hospital because of either maltreatment or painful birth procedure. The anecdotal experience indicates that most health facilities in the rural areas have poor quality of maternal care services. Studies have shown that the poor quality of services serves as a major deterrent in the utilization of maternal services.

Fourth, women who did not experience any difficulties in having a baby at home and had never experienced any complications usually opted to continue delivering at home.

Fifth, *hilots* are caring. The concern and encouragement that *hilots* usually show is of utmost importance to women. They said that this act make them feel more relax and more comfortable thus, making the delivery much easier.

Lastly, *hilots* are accessible and easy to call. These TBAs are usually the old woman in the community, women who wish to give birth would not have a hard time looking for them. Rural areas like Palawan often suffer from having too few health facilities such as hospitals and RHUs. It would take at least an hour to get to the nearest RHU unlike in the urban area where facilities are easily accessible. Also, more often than not, these *hilots* are in one way or another related by blood to most people in the community. Thus, trust also plays a big role in women's choice.

Evidently, this result reaffirms that the right to clinic delivery is not a right that rural women necessarily want. Culture might play a role in women's decision to utilize the services but in the

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end it is still the accessibility, availability and quality of maternal services that are seen as the key factors why women withhold their decisions to utilize health services.

*Money and safety: Does it count?*

The discussion above leads one to think where money and safety comes in. Both are issues in the realm of maternal services provision. SHI in the first place was provided for two main reasons: to enable women especially the poor to access maternal services and to ensure the safe delivery of mothers by providing them the ability to avail of this services. Given the factors above, how do the issue of money and safety fit into the picture of the SHI beneficiaries' choices?

As explained in Chapter 3, the maternity care package of the SHI covers three normal deliveries. So, these deliveries are free for insurance beneficiaries as long as they gave birth in an accredited health facility. On the contrary, *hilots'* services were never free. The fee ranges from P500 to P1, 500<sup>24</sup> (€8 to €25) which is equivalent to 2-7 days minimum wage salary in the province. With this cost, it is surprising that even poor women would pay the amount rather than use their insurance. The reasons would still be those discussed above. Worst, some of them would even take debts just to pay for the *hilot's* services.

As pointed out in Chapter 2, facility-based deliveries are the driving force of averting maternal mortality. The argument is that the chances of a mother's survival are higher if she delivers in a health facility than at home.

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<sup>24</sup> Based on the interviews

**Box 3. Rural women's view on whether it is much safer to  
give birth in a health facility than at home**

**Poor**

- *It's almost the same. It really depends on you on how you'll endure it, if you can't bear the pain then you can easily tell your husband to bring you to the hospital. – Maricel, 26 yrs old*
- *It's the same. It depends on what works for the woman but for us who usually has normal delivery, we'll go for what is already "tested" and that is the services of the hilots. The only good thing in giving birth in hospitals is that you're cleaned right away; all the bloods are taken-out and if it doesn't come out, medicines will be prescribed. – Merlyn, 51 yrs old*

**Non-Poor**

- *Maybe for the first timers because there's really no difference. The midwives can do it and they're good at it and can do the deliveries at home. Like my older sister who was traumatized when she gave birth on her first baby in the hospital. So, the second time she gave birth at home with the assistance of a midwife. The good thing at home is that you're well taken cared off and the midwife is very sensitive to your needs unlike in the hospital it's just you and your prayers that you can hold on to. – Lorelie, 29 yrs old*
- *Of course. For example, you if you complications like eclampsia and blood loss. There is a possibility that the mother will die or even the child and it is dangerous. The hilots can't handle such situations and save their lives. If a complication happens while giving birth at home, it might be too late when the woman reaches the hospital. Unlike in the hospital, if this happens then it is easier to find solutions, the doctors can do what needs to be done. – Irna, 29 yrs old*

Box 3 presents the comments made by the respondents about their views on whether it is much safer to give birth in a health facility. Almost all of the interviewees said that there's not much difference in the place of attendance because according to them *hilots* and midwives can do the job and it would depend not on the kind of facility but on woman's capacity to endure the whole experience. However, it is interesting to point out that these perceptions changes whenever a woman experiences a complication herself. Most of the insurance beneficiaries preferred to deliver at home but ended up giving birth in a hospital because they experienced complications. To illustrate, below is one of these cases:

#### Box 4. Insurance holder's utilization of maternal health services

Rutcher, 39 yrs old and a contractual employee in a municipality. She has 3 children from her deceased husband and 1 from her current live-in partner. She has complete antenatal check-ups from the health centers every time she'll get pregnant. She gave birth at home with the assistance of *hilots* for her first three children. When asked why she opted to give birth at home, Rutcher would say with a smile:

*"I never had a hard time in giving birth. I always find it easy, 8 hours is my maximum labor time. I didn't experience any complications. The hilots won't cut you and they usually use herbal medicines like guava leaves for cleaning. Also, giving birth at home is much more comfortable, you have privacy and the hilots are just really good birth attendants."*

Before her husband died, Rutcher was supposed to have another child but died in her womb on her 5<sup>th</sup> month of pregnancy. She went to the district hospital and the child was taken out from her womb. She paid around 1, 000 pesos (€17) for the medicines and other fees because she had no insurance. It was only in 2005 when a private foundation sponsored her children's schooling and grants her SHI. After a year, she became pregnant. Colleagues and the foundation's staff were convincing her to give birth in a hospital because a normal delivery is covered by the SHI and she's already old and might be at risk. Until the end, she still wants to give birth at home on a normal delivery but circumstances did not permit her:

*"I underwent a caesarian operation because my blood pressure was consistently high for three days and the doctor told me that we shouldn't wait for my veins to burst which could lead to my death. So, I asked my husband if he can raise some money because apparently, the insurance only covers a portion of the caesarian operation. But if you'll ask me, if my blood pressure normalized that time, I would still opt to give birth at home."*

These findings imply that in rural areas, complications are the only motivation for most women to give birth in a health facility and actually use their SHI. This is further proven by the result of the interview with the head nurse of one of the provincial hospitals. She disclosed that women especially the poorest of the poor only go to the hospital if they experienced complications. Thus, there can be no doubt that women are forced to ignore their preferences whenever their life is at risk.

### 4.3 Dispelling national government's misconceptions

#### *Having insurance entails having more children*

As presented in Chapter 3, the national government had an assumption that "broadcasting" the SHI's maternal care package's coverage of three free normal deliveries might encourage women to give birth more, hence, negating the population control policy. But the interviewed women's comments in the urban and rural Philippines challenges this notion. The Box below suggests that having insurance doesn't entail having more children. The reasons cited were raising children

have high economic costs, it's not easy to give birth, and the insurance is just for emergency purposes.

#### **Box 5. Women's view on whether having insurance entails having more children**

##### **Urban women**

- *No. I don't want to give birth anymore. Insurance doesn't entail having a child. I'm already practicing family planning. — Michelle, PhilHealth Employed Sector Program*
- *Life is not easy these days even if you have SHI and you can't avoid some things that might happen to you. Yes, you have SHI but we also pay for it. Two children are enough. — Babylyn, Philhealth Employed Sector Program*
- *Not anymore. Three children are enough. We only tried if we'll have a baby girl. But I still gave birth to a boy but that's enough because the children might suffer. We're getting older. My husband will be in his 50s by the time our children goes to college. If we have lots of money, then we can afford to have more children and all of them will be educated. — Simplicia, Philhealth Sponsored Program*

##### **Rural Women**

- *People were saying "why are you afraid to give birth, you have the SHI". I told them yeah I have the insurance but it's not that easy. You still have to save to pay half of the bill and that's also difficult. My husband is the only one who's earning now unlike before I used to work. — Yolanda, PhilHealth Employed Sector Program*
- *If you have SHI, it doesn't mean that you'll always opt to be pregnant. The insurance is there to be used just in case you'll need it. — Rutter, PhilHealth Sponsored Program*
- *That's not the case. It's difficult if you undergo a caesarian operation. Like if the temperature is low, you'll feel the pain inside. — Ailene, PhilHealth Sponsored Program*

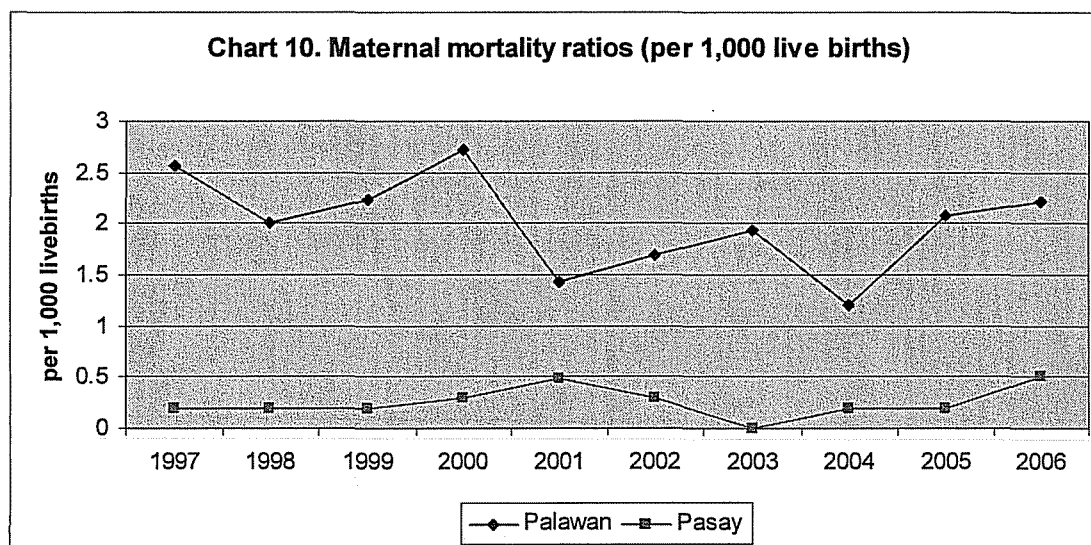
#### ***Tolerating political indigents encourages LGU's participation***

This notion is dismissed by Pasay City's experience. Even without providing an avenue for the local officials to get political indigents, LGUs would still participate in the program as long as they're committed in providing health services to their people especially those who are underprivileged. All it takes is political will to keep the program going.

#### 4.4 Possible impact of SHI on Maternal Mortality

SHI as a health financing scheme could have a positive impact on maternal mortality if women actually make use it. For example (see Chart 10<sup>25</sup>), Pasay City has been successful since 1997 in encouraging women to use health facilities in giving birth by providing them the SHI. These facility-based deliveries had in turn been translated into an aversion of maternal deaths in the city. For the last ten years, the maternal mortality ratio in the city has been very low ranging from 0.02 to 0.05 deaths per 1, 000 live births.

On the contrary, Palawan's MMR remains at high levels ranging from 1.2 to 2.7 deaths per 1, 000 live births which can be attributed to the high deliveries at home. With the rural Philippines' case, the SHI as a health financing scheme had insignificant impact because the beneficiaries did not utilized it. Interestingly though, it appears that MMR is sensitive to the enrolment in SHI. For instance, in 2004 when the enrolment of SHI is high, the maternal mortality in Palawan also dropped to a low level. Intuitively, it can be argued that SHI could in a way have a positive impact on the reduction of maternal deaths.



Source: Palawan and Pasay City Annual Health Reports

<sup>25</sup> Previous years MMR (1990-1996) are unavailable

## 5 CONCLUSIONS AND POLICY IMPLICATIONS

Evidence presented in this research proved that the extent to which the introduction of SHI could lead to increased facility-based deliveries would depend on how the SHI is organized. Three strong points came out that could significantly dilute the impact of SHI as a health financing scheme.

Firstly, decentralized budgeting has impeded both the provision of insurance and quality services. Ideally, the shift from the national pool fund to the local pool was intended to target a wider population and provide more efficient services. However, the end results were reversed. Limited resources became a major constraint for most of the LGUs in the inclusion of their poor constituents in the SHI pool. In instances when the LGU had managed to make the health insurance available, the problem of providing good quality maternal services still remained. This problem oftentimes resulted in the non-utilization of health insurance among the beneficiaries as seen in the rural case. Though there are cultural factors that influenced the women's decision to access the services, it was seen that the inaccessibility, unavailability and poor quality of maternal services was the biggest factor that hindered them to utilize their health insurance.

While this is true in the rural case, there can be exceptions as seen from the Pasay City. Essentially, the availability of SHI and the quality of health services is geographically-based and decentralized budgeting is widening the gap between urban and rural areas – with the rural areas having lower chances in implementing these health interventions. Decentralization has also resulted to a movement from national redistribution to provincial/municipal redistribution of resources – a shift that limits the insurance coverage.

Secondly, the whole process of implementing the SHI, specifically the Sponsored Program, has been very political. The decision on the size of the insurance pool, its membership and the mechanisms that will be used to encourage insurance utilization rests solely in the hands of the LGU officials. This was evident in the fluctuations of the enrolments in both cases, inclusion of “political indigents” in Palawan, and the laudable mechanisms that Pasay City had put in place to encourage both the usage of health insurance and the sustainability of the program.

Lastly, the national government's theory that broadcasting SHI maternity care coverage will increase population is weakening the whole policy exercise. It was confirmed from the interviews, that having SHI is not a deciding factor for women to give birth more. Quite the opposite, as seen in Pasay City's case, giving information seminars had dispelled the cultural hindrances in urban settings.

In sum, these points should take the national government back to rethink the whole process of SHI financing and implementation if it's intention of promoting facility-based deliveries for

maternal mortality reduction is genuine. It should bear in mind that an SHI under the umbrella of decentralization will most likely have limited benefits as opposed to an SHI that is nationally funded. In any case, it would be useful for the national government to revisit what Pasay City had done and learn from its experience.

In Pasay City's experience, it appears that for the SHI to be effective, a number of mechanisms should be put in place. First, in order to address the leakage in the system a move from individual assessment to self-targeting is necessary to weed out the political indigents. Second, high awareness building is key to change the perception of pregnant women on the use of maternal care services. Third, a functioning referral system should be established between different health care facilities. Lastly, quality health care facilities (e.g. lying-in clinics) should be available because the success of SHI in providing access to health care is directly tied to social infrastructure development.

In conclusion, for the government to achieve its goal of increasing facility-based deliveries to address maternal mortality, it should design policies that cater to the specific needs of pregnant women. Also, it should take into account the capacity of the LGUs in implementing maternal care programs and provide the necessary support if needed. Only after this has been satisfied can the government say that it is really *saving mommy from the grave*.



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## ANNEXES

### SEMI-STRUCTURED INTERVIEW SCHEDULE (Beneficiaries and non-beneficiaries)

Name of Interviewee	
Insurance Status	
Age	
Highest Educational Attainment	
No. of children	
Municipality/City/Province	
Date	

1. Are you a member of any health insurance schemes? If no, why not? If not, how do you pay?

*Kayo po ba ay may insurance? Kung hindi bakit? Paano po kayo nagbabayad para sa mga serbisyong maternal?*

2. To what type of health facility do you usually go to have your pre-natal and post-natal check-ups and deliveries? If you have a choice will you prefer to go to another health facility?

*Saan pasilidad po kayo kadalasang pumupunta upang magpatingin at manganak? Kung kayo po ba ay papapipiliin nanaisin nyo po bang pumunta sa ibang pasilidad? Bakit?*

3. What type of health facility you go to? Who decides what type? What health facility was available?

*Anong uri ng pasilidad pangkalusugan kayo pumupunta? Sino ang nagdedesisyon kung saan kayo pupunta? Anong mga pasilidad ang meron?*

4. Did you ever use family planning?

*Gumamit po ba kayo ng family planning?*

5. Did you ever visit a doctor for your antenatal check-ups? If yes, how often? If not, why?

*Bumisita po ba kayo sa doktor para magpakonsulta nung kayo ay buntis? Kung oo, gaano kadalas? Kung hindi, bakit?*

6. Did you ever encounter any difficulties during pregnancy? in giving birth? If yes, how did you dealt with it?

*Nahirapan po ba kayo sa pagbubuntis? Sa panganganak? Kung oo, ano po ang inyong ginawa?*

7. There is an assumption that it is much safer for a woman to give birth in a health facility. Please comment.

*Madalas pong sinasabi na mas ligtas manganak sa pasilidad na pangkalusugan katulad ng hospital. Ano po ang masasabi nyo dito?*

8. How much do you usually pay for maternal health services?

*Magkano po ang kadalasang binabayad ninyo sa maternal health services?*

9. People who have insurances tend to utilize the maternal health services more. Please comment.

*Ang mga mayroong insurance ay mas madalas na tumatangkilik/gumagamit ng maternal health services. Ano po ang opinyon ninyo dito?*

10. What do you think are the advantages of having insurance?

*Ano po sa tingin ninyo ang mga benepisyo ng pagkakaroon ng insurance?*

11. In your opinion, do you think the provision of insurance is enough to meet you maternal health needs? Why?

*Sa inyong opinyon, sa tingin nyo po ba sapat na ang pagakakaroon ng insurance upang matugunan ang inyong mga pangangailangang maternal? Bakit?*

### SEMI-STRUCTURED INTERVIEW SCHEDULE (midwives, nurses, doctors)

Name of Interviewee	
Position	
Type of Facility (rural health station, barangay health station, hospital)	
Municipality/City/Province	
Date	

1. Who usually avails of the maternal health services? Poor or non-poor? Age differences? Religious differences? Neighborhood differences?

*Sino po ang kadalasang tumatangkilik/gumagamit ng maternal health services? Mahirap o may kaya? Edad? Relihiyon? Lugar na pinanggagalingan?*

2. Are some services better attended than other? If so, which and why?

*Merong po bang serbisyong mas pinagtutuunan ng pansin? Alin? Bakit?*

3. What are the reasons of women's difficulties in giving birth? And how do you deal with them?

*Ano po ang mga dahilan ng problema sa panganganak? Pano nyo po ito hinaharap?*

4. Are there women who have died of giving birth? What happened?



*May mga kababaihan po bang namamatay dahil sa panganganak? Ano po ang nangyari?*

5. What is the form of payment for deliveries?

*Ano po ang binabayad sa panganganak?*

6. What happens if someone cannot pay?

*Ano po ang nangyayari kung hindi kayang makapagbayad?*

7. Is there change in the number of pregnant women who avail of the services after the introduction of social health insurance?

*May pagbabago po ba sa bilang ng mga buntis na tumangkilik/gumamit ng serbisyo nang maipatupad ang social health insurance?*

8. Social health insurance could improve both the accessibility and utilization of maternal health services. Please comment.

*Ang social health insurance ay nagreresulta sa dali ng pagkuha ng maternal health services at higit na pagtangkilik/paggamit ng mga serbisyong ito?*

### INTERVIEW (Health Officials)

Name of Interviewee	
Position	
Institution	
Date	

1. What is the health financing policy before the introduction of social health insurance?
2. What brought about the introduction of social health insurance as a health financing scheme?
3. What kind of services is covered by the social health insurance?
4. Has there been a change in the quality of service since the introduction of social insurance? In terms of payment? Reduction in other subsidies?
5. Are there areas that are not covered or with limited reimbursement under social insurance? Has this changed demand for different types of services?
6. How are the beneficiaries for the indigent program selected?
7. Who usually end up in the indigent pool?
8. The indigent program includes a maternity package and there is an assumption that the beneficiaries will utilize more the maternal health services provided if they are covered by the insurance. Please comment.
9. If you are covered by the insurance, maternal health services (pre and post natal check-ups, deliveries) are free. Please comment.
10. An increase in the utilization of maternal health services can prevent maternal deaths. Please comment.

