Public Disclosure Authorized

Public Disclosure Authorized

THE WORLD BANK

75010

Philippines' Government Sponsored Health Coverage Program for Poor Households

Sarbani Chakraborty

Universal Health Coverage Studies Series (UNICO)
UNICO Studies Series No. 22

Human Development Network

UNICO Studies Series 22
Philippines' Government Sponsored Health Coverage Program for Poor Households[1]

Sarbani Chakraborty

The World Bank, Washington DC, January 2013

[1] This case study was peer reviewed by Maria-Eugenia Bonilla Chain, Senior Economist, LCSHH; Kai-Alexander Kaiser, Senior Economist, World Bank Philippines Country Office; and Carlo Panelo, University of the Philippines. In addition, comments were received from Dr. Madeline Rosas-Valera, Assistant Secretary, Department of Health, the Philippines.

The World Bank's Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to "develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them." In December 2012, the movement prompted the United Nations General Assembly to call on governments to "urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income "comparator," the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear
UNICO Studies Series Task Team Leader
The World Bank
Washington, DC

TABLE OF CONTENTS

Abbreviations iv
Executive Summary v
1. Country and Health Sector Context 1
2. Targeting, Identification, and Enrolment of Beneficiaries 4
3. Special Topics Related to the Management of Public Funds in HCP 6
4. Management of the HCP Benefits Package 7
5. Discussion of One Theme Specific to the Philippines 10
6. Current Developments and Pending Agenda 14
Annex 1 Description of the Philippines Health Sector 18
Annex 2 Public Health Services and HCP Information Environment 26
Annex 3 Spider Web 29

FIGURES

Figure 1 Percent of Total Philippine Population Enrolled in SP 6
Figure 2 Proportion of Households Exceeding 40 Percent of their Capacity to Pay 12
Figure 3 Proportion of the population who had any admission in the last one year 12

TABLES

Table 1 Benefits Package under NHIP and Special Benefits for SP 7

Abbreviations

DBM	Department of Budget and Management
DHS	Demographic and Health Surveys
DOH	Department of Health
GDP	Gross Domestic Product
GOP	Government of Philippines
HCP	Health Coverage Program
LGU	local government unit
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System-Poverty Reduction
₱	Philippine pesos
PHIC/PhilHealth	Philippine Health Insurance Corporation
RHUs	rural health units
TB DOTS	Tuberculosis Directly Observed Therapy, Short-course
UHC	universal health coverage

Executive Summary

This is a nuts and bolts case study of the implementation of the government-financed health coverage program (HCP) for poor households in the Philippines. The data and information in this case study largely draws upon the 2011 World Bank Report "Transforming the Philippine Health Sector: Challenges and Future Directions" (Chakraborty et al. 2011), and technical work undertaken for World Bank support to the Government of the Philippines (GOP) for universal health coverage (UHC) in the Philippines.[2] The aim of the case study is to understand how the HCP was implemented, what worked and did not work, and how it impacted expected results under the HCP. In 1996, similarly to many low- and middle-income countries, the Philippines introduced a demand-side program for poor households (the Sponsored Program). The objective was to improve access of poor households to needed health services without experiencing a financial burden. Unlike many countries, where such programs are stand alone, in the case of the Philippines it was integrated into the National Health Insurance Program (NHIP). This is a sound design feature from the perspective of providing optimal risk pooling and redistribution, and the Philippines is a model for other countries implementing similar schemes for poor households.

However, in other aspects of program implementation, the HCP faced many problems that had to be addressed. For example, the expectation was that the local government units (LGUs) would identify, enroll, and pay for the poor. All three aspects of design suffered from myriad problems. At the LGU level, there were various loopholes and inconsistencies in the use of defined targeting instruments. While the Philippine Health Insurance Corporation (PhilHealth) was supposed to validate the list, the final decision-making powers on the list of poor households lay with the governor or mayor of the LGU. Moreover, LGU uptake of the HCP was slow, partly due to fiscal constraints and the coexistence of a demand- and supply-side system. Even if LGUs paid premiums to PhilHealth for poor households, they were still expected to finance their own health facilities. At some point, the national government realized this and enrolled poor households using national government subsidies. This worked well and enrolment increased, except financing was from uncertain sources (the Philippines Charity Sweepstakes) and could not be sustained. The national government continued to cofinance 90 percent of the premiums in the poorest LGUs, albeit with no control over the targeting and enrolment mechanism. Generally, targeting suffered from inclusion and exclusion errors, and the real poor were not enrolled in the program.

Another set of problems related to service and financial coverage under the PhilHealth benefits package. The benefits package was too shallow to adequately financially empower households to use services. Moreover, PhilHealth capacity to act as a strategic purchaser holding providers accountable for delivering services under the HCP was weak.

Yet another problem related to public sector health facility management and accountability for funds. In the absence of systems where health facilities could retain earnings from PhilHealth,

[2] The World Bank has been providing technical support to the Government of the Philippines since 2010 in the design of UHC policies, with a focus on the sponsored program. Under this support, various technical studies have been undertaken including a UHC costing study, the development of monitoring and evaluation frameworks, and specific evaluation studies and rapid assessments.

hospitals were inadequately financed and did not improve service quality. There were no explicit systems for monitoring the performance of health facilities.

Fifteen years after the HCP was introduced in the Philippines, little had changed for poor households regarding access and financial protection. Poor households were the lowest users of health services. Moreover, as the 2008 Demographic and Health Survey and the 2011 Family Health Survey show, coverage of key interventions such as facility-based deliveries and prenatal care continue to significantly lag among poor regions and among the poorest income quintiles. While the poor do not face catastrophic health care costs, this is likely due to the fact that health care services are simply unaffordable for poor households, so they do not use the services. Large disparities in health outcomes between the rich and poor persist.

Going forward, there have been several positive developments in the HCP. The HCP has a strong political commitment at the presidential level, but largely with a focus on showing results as part of the social contract with the Filipino people. It is still part of the National Health Insurance Program, thereby supporting risk pooling and redistribution. A revamped targeting mechanism at the national level has been adopted and the national government is providing full national government subsidies for the poorest households. As a result, almost 4.664 million households (20 percent of the entire population of the country) that were previously left out of health insurance are now enrolled. The benefits packages for poor households has been expanded (service and financial coverage), and the premium has been increased to cover these new services. Community health teams that aim to empower poor households access PhilHealth services are being incrementally rolled out throughout the country.

The national government has included financing for poor households in the medium-term national expenditure program, so there is no danger of uncertainty in financing. PhilHealth is incrementally strengthening its contract implementation and monitoring mechanisms. The main challenge now facing the HCP is whether these revamped efforts will be able to quickly address the problem of lack of access to quality and affordable services for poor households. There are supply side constraints – facilities will need to be upgraded to obtain Philhealth accreditation. Accredited health facilities will have to be held accountable for delivering services and where public services are not available, mechanisms for incentivizing the private sector for outreach to poor households will have to be deployed. Much depends on PhilHealth's capacity as an effective purchaser of health services. Local government unit (LGU) facility capacity to respond to revamped PhilHealth incentives is another bottleneck. The other challenge is whether the Department of Health and PhilHealth will be able to quickly build the monitoring and evaluation systems needed to track HCP implementation and make the necessary in-flight adjustments in implementation in a timely manner.

1. Country and Health Sector Context

The Republic of the Philippines is a lower-middle-income country[3] with a population of 94.9 million.[4] It is an archipelago of 7,107 islands located in Southeast Asia and consists of three island groups, Luzon, the Visayas, and Mindanao. Overall, the economic prospects for the country are good. The country has a relatively young population, a talented English-speaking workforce, a dynamic private sector, and an active civil society. While economic performance in the country has improved significantly since 2001, growth has not been inclusive, and poverty has continued to persist and even increase slightly over the years.[5] The poverty index is currently 20.9 percent. There are large inequalities in the nonincome dimensions of poverty (health and education), and poor households are significantly disadvantaged in terms of access to quality health and educational services (World Bank 2009). The large informal sector comprises 50 percent of the population.

While, at the aggregate level, health outcomes have improved significantly in the Philippines, inequalities in health outcomes are persistent and even worsening. Approximately 54 percent of total health expenditures are out-of-pocket, and are a source of impoverishment for many households, especially poor ones. Historically, the Philippines health system was organized similarly to the National Health Service, where the Ministry of Health (the Department of Health, in the Philippines) had responsibility for delivering free health care to the population. Financing was from general budget revenues through line-item budgets to health facilities. A tiered health system existed consisting of primary health care centers; district, provincial, and regional hospitals; and tertiary health care institutions and teaching hospitals in the capital, Metro Manila.

In 1969, the Philippines introduced a social security scheme for formal sector workers (Medicare). It was envisaged that the Medicare program would eventually cover other groups (informal sector workers), as well. However, the Medicare program was not successful at enrolling other groups, and in 1996, the Medicare scheme was expanded to other groups and a single payer—the Philippines Health Insurance Corporation (PHIC, or PhilHealth)—was given the responsibility of implementing Medicare. Programs for the self-employed and organized groups, and a noncontributory program for poor households (the Sponsored Program), were introduced. Sponsored Program beneficiaries enjoyed the same benefits package as other groups and were allowed access to public and private facilities.

On the supply side, a major historical development was the decentralization of health to local government units (LGUs). LGUs were given the responsibility for the financing and provision of health services. The Department of Health retained 72 health facilities—mostly tertiary level hospitals. More than 50 percent of hospital beds in the Philippines are in the private sector, and the private sector is mostly concentrated in large cities and urban areas.

[3] With a Gross National Income per capita (Altas method) of US$2,210.
[4] Based on midyear United Nations population estimates.
[5] Official poverty estimates indicate that the overall incidence of poverty increased from 30 percent in 2003 to 32.9 percent in 2006. The poverty gap and poverty severity also increased during this period.

Objectives of the Case Study and Relevance for the Philippines

Many countries have introduced health insurance schemes for poor households with the objective of improving access to quality health services and financial protection. In some countries, these are stand-alone schemes while in others these are integrated into a unified national health insurance program. Typically, such schemes are financed from general budget revenues and the budget outlays are large. Understanding how such schemes function within the broader health system and whether such schemes are able to deliver on their promise of access and financial risk protection is important. It is also important to understand why such schemes may not have worked, what may have been the particular factors and how these can be addressed going forward. This case study discusses the Philippines Sponsored Program for poor households.

The relevance of this case study on health insurance for poor households is enhanced in a context where the current Government of the Philippines, under the leadership of President Benigno Aquino III, has clearly articulated the scale-up of human development programs in social protection, universal health coverage, and education as a part of the government's social contract with the Filipino people to provide a better life to those groups that are left behind in the development process. The case study—which was carried out under the "Nuts and Bolts of UHC Work Program"—uses the standardized format of the "Nuts and Bolts" questionnaire to highlight the key design features of the sponsored program and how these have changed over time. Then it discusses the impact of the program to date, and the latest policy and program developments to address program challenges. Finally it outlines challenges for the future. The information for the case study was mainly drawn from the 2011 World Bank Review of the Philippines Health Sector, as well as other analytical work conducted by the World Bank jointly with the Government of the Philippines between 2009 and 2012 (Chakraborty et al. 2011).

Sponsored Program Institutional Architecture and Interaction of HCP with the Rest of the Health System

Motivation for Establishing the HCP

At the time the Sponsored Program was introduced, in 1996, health care, at least on paper, was free for poor households provided they used public sector health facilities. However, access to care was not guaranteed, and public sector provision suffered from problems familiar to other countries, as well (informal payments, implicit rationing, turning patients away, and lack of drugs). One of the impacts of decentralization was that provision of health services (primary and secondary) was left to the discretion of local government units (LGUs). Allocations for health varied widely across LGUs and reflected both political commitment and fiscal space.[6] This impacted how much financing was allocated for health in each LGU, and in fact, there was substantial inequity in financing across LGUs. Utilization of certain public health services such as sputum examinations (for TB) and pneumonia case detection declined after devolution. Services requiring consumables such as TB drugs and antibiotics were specifically affected (Solon, Alabastro-Quimbo, and Tan 2003).

[6] The local government political cycle in the Philippines is three years. However, it is common for local politics to be captured by families, which means that there is continuity across political cycles.

Moreover, while under the social security system (Medicare), beneficiaries had access to private health facilities, those outside the Medicare system only had access to public providers. By creating a health insurance program for poor households, many of these problems of inequitable access were meant to be tackled. It was expected that under a universal health coverage program with an explicit benefits package and with PhilHealth—as the single payer—driving health facilities to perform better, many of the problems in the supply-side system would be resolved. This, in turn, would also encourage providers to become more accountable to patients. The Sponsored Program was also looked upon as a way to allocate additional resources for the health sector within a wider framework of risk pooling and redistribution. Initially, it was expected that the Sponsored Program (demand side) would continue alongside the supply-side program where government facilities would receive budget financing. However, over time, it was expected that all financing for poor households would be channeled through the Sponsored Program, and supply-side subsidies eliminated.

Program Goals and Objectives

Sponsored Program (SP) goals and objectives are embedded in the National Health Insurance Law of 1995, which states that (a) the NHIP (also referring to the Sponsored Program) shall provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs; (b) the NHIP shall give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits; and (c) the program shall be equitable (have uniform basic benefits, ensure equal access to care based on social solidarity principles, balance the economical use of resources with quality of care, and be implemented in consultation with local government units). The main elements of the SP are as follows:

- Poor households must be identified using appropriate poverty targeting mechanisms.
- Enrolment does not entail costs for the household and eligibility is for one year.
- Sponsored Program members can use public and private hospitals and health facilities.
- Sponsored Program members are covered for hospitalization and outpatient benefits.
- Outpatient benefits are entirely free, while hospitalization may require a contribution.

The benefits package is currently evolving, and there is a focus on providing more depth (more services) and height (greater financial coverage) of coverage.

The Sponsored Program is under PhilHealth, and PhilHealth is governed by a board of directors. The Secretary of Health (Minister of Health) is the chairman of the PhilHealth board, and representatives from the Secretary of Interior and Local Government and the Secretary of Social Welfare and Development also participate. These institutions implement the majority of poverty alleviation programs for LGUs and poor populations in the country.

The National Health Insurance Law states that the Sponsored Program premiums will be cofinanced with LGUs. The premium until 2012 was ₱1,200 (US$25 per targeted family). For poor LGUs (4th, 5th, and 6th class), national government financing was provided (up to 90 percent, or ₱1,080, US$24) for a period of five years. At the end of the five years, LGUs were expected to finance the premiums for the Sponsored Program.

The mechanism for financing is evolving. Under the new policies of the government for universal health coverage, the national government shall pay the full premium subsidy for poor households identified through a national targeting mechanism.[7] Policies on LGU enrolment of the poor are not clear, and for the moment nationally targeted and LGU targeted poor households—for those poor households enrolled by LGUs before 2010—exist in the system. While the premium for all sponsored program enrollees has increased – for LGU identified sponsored program member, PhilHealth has provided a two-year lock-in period during which LGUs have a chance to adjust to the new premium. It is not sure how many LGUs will be able to comply as the lock-in period ends next year, and what implications this will have for LGU targeted poor households. The plan is to transition LGU-targeted poor households into other categories (near-poor, informal sector, organized groups). However, uptake of the nationally determined targeting mechanism (NHTS-PR) among LGUs is slow and therefore if the NHTS will be used to target near poor, then the national government will have to pay for this group as well. (Manasan 2011). The national government already plans to enroll near poor with its own funds since sin tax reform has recently come through.

The Sponsored Program benefits package is as follows: (a) limited coverage (first-peso principle) for hospitalizations based on fee-for-service, (b) outpatient benefits that include free consultations and limited diagnostic testing in rural health units, and (c) benefits for specific conditions such as maternal and neonatal health and tuberculosis (described in greater detail later).

2. Targeting, Identification, and Enrolment of Beneficiaries

Targeting

The Philippines Sponsored Program has undergone major changes in mechanisms for targeting poor households, and there are key lessons learned. Original (1996) PhilHealth implementing rules and regulations specify the process for identifying beneficiaries under the Sponsored Program. The original rules stated that Sponsored Program beneficiaries will be identified through a means test using data from a survey conducted by the Social Welfare and Development Department of the LGU. The means test is administered by the Social Welfare Development officer at the LGU level. The target beneficiaries are the lowest 25 percent of the local population. The beneficiaries are identified through the Community Based Information System-Minimum Basic Needs Indicators and a uniform family threshold, which is then verified by the PhilHealth family data survey. The list is submitted to the LGU for verification and decision making. Given various loopholes in the means test (based on visible assets) and capacity to verify, enrolment of poor households has suffered from inclusion and exclusion errors.

In 2009, the national government announced that it would pay for the Sponsored Program only if households were on the National Household Targeting System-Poverty Reduction (NHTS-PR) list of households. The NHTS-PR is managed by the National Government Department of Social

[7] The national targeting mechanism refers to the National Household Targeting System – Poverty Reduction (NHTS-PR). The NHTS-PR is also used for targeting families eligible for the national government financed Conditional Cash Transfer (CCT) Program.

Welfare and Development and is centrally managed to control for any manipulation of the list. The NHTS-PR uses a multidimensional approach to identify the poor, including a proxy means test. The first list was developed in 2010 and identified 5.2 million households as poor and eligible for the Sponsored Program. When PhilHealth did a cross-match of the 5.2 million list of poor households with the list of already enrolled members on the Sponsored Program list of PhilHealth, only 800,000 members cross-matched (15 percent). This meant that PhilHealth had to enroll 4.4 million new households into the Sponsored Program. There was an intense discussion regarding what should happen to the currently enrolled 3.2 million of LGU-identified poor. As a transition measure, it was agreed that PhilHealth would subsidize the premium for the 3.2 million, and LGUs would continue to pay their share. LGUs did not agree to pay for the NHTS-PR households. As a result, currently there are around 8.4 million households/families classified as Sponsored Program.

Enrolment

Enrolment in the Sponsored Program depends on being identified as a poor household. Once identified, families are enrolled into the NHIP. There are no costs for enrolment. Eligibility is for a one year and re-enrolment is necessary. LGUs are responsible for enrolment. Until 2011, when the national government started fully subsidizing the poorest households identified through the NHTS-PR, LGUs were responsible for enrolment. Normally, the governor of a province or mayor distributed the PhilHealth cards using the final list.

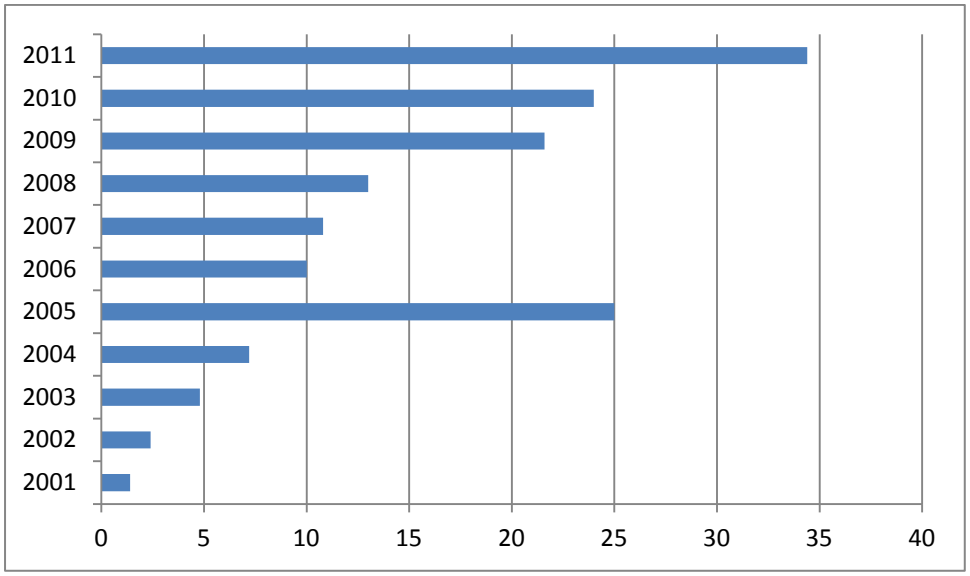
When the national government full subsidy for NHTS-PR targeted households came into effect, questions were asked regarding who should enroll this group. PhilHealth does not have the infrastructure to enroll members, especially poor members. Therefore, it continued to depend on LGUs to distribute the cards for them.

In 2012, PhilHealth introduced a new mechanism. Under the Primary Care Benefits Package, rural health units (RHUs) will receive their capitation payment of ₱500 (around US$15 per household) only when they are able to enroll the households on the NHTS-PR list and give them their first health screening. With this measure, RHUs and the LGUs under which they operate, have an incentive to find and enroll the right households. RHUs are now working with Community Health Teams at the barangay/village level to find and enroll households. Annual verification will be done through a DOH spot-check survey. In the case of the Philippines, with the shift in targeting of poor households, lack of a clear enrolment plan for poor and hard-to-reach households can mean that enrolment does not happen as expected, or happens with substantial delays mitigating the good effects of a universal coverage program.

Figure 1 shows how enrolment of the Sponsored Program has evolved since it was introduced. Immediately after the SP was introduced, PhilHealth upon the recommendation of the National Anti-Poverty Commission focused the SP on the 28 poorest provinces. However, the poorest provinces had neither the resources nor the infrastructure to enroll the poor. In 1998, the SP was expanded to include more affluent provinces and cities. In 2005, enrolment increased significantly when the national government agreed to pay the full premium subsidy for poor households (Solon, Albastro-Quimbo, and Panelo 2003). Enrolment subsequently dropped when this arrangement could not be sustained. Since 2009–10, enrolment has been steadily increasing.

More LGUs have participated in the Sponsored Program since 2009 and 2011, albeit using their own targeting mechanisms. In addition, 5.2 million households identified under the NHTS-PR were enrolled. This significantly increased enrolment to 34 percent of the population. According to the National Statistical Coordination Board, around 25 percent of the Filipino population is classified as poor.

Figure 1 Percent of Total Philippine Population Enrolled in SP



3. Special Topics Related to the Management of Public Funds in HCP

The management of public funds in the HCP has several dimensions: (a) flow of funds for national government counterpart financing—which flows from the Department of Budget and Management (DBM) to PhilHealth, and (b) PhilHealth flow of funds to public providers. Key objectives for the introduction of the Sponsored Program were raising more funds for the health sector and improving access of the population to public and private providers and to generate competition between the sectors. Regarding the allocation of national government funds to PhilHealth, there have been long backlogs and delays in payments to PhilHealth. Due to national government budget deficits and the fact that PhilHealth built substantial reserves over the years, funds flow for the SP to PhilHealth are delayed or sometimes not made at all.[8] This means that PhilHealth has had to finance the SP from contributions by other members.

Regarding provider payments, PhilHealth adopted the same payment mechanisms for public and private providers (fee-for-service where money follows the patient). The PhilHealth outpatient benefits package program only worked with public providers using a capitation. In reality, since health facilities are owned and managed by the DOH and LGUs, these facilities were not able to fully capitalize on the PhilHealth payment system. In 2003, as mentioned, the DOH introduced

[8] This has been a recurrent problem. For example, in September 2012, PhilHealth still had not been paid the national government premium contribution for the SP.

income retention for its hospitals. However, as noted in a study by Lavado et al. (2010), the guidelines for using funds from income retention are not clear, and so far, other than for accrediting hospitals, PhilHealth has not held hospitals accountable for performance, including the quality of care. Although DOH hospitals are expected to submit hospital reports to the DOH, the information is sometimes incomplete and missing key information. The DOH National Center for Health Facility Development does not impose sanctions on hospitals that do not submit reports or that submit incomplete reports. The last consolidated hospital report for DOH hospitals was produced in 2004.

Very few LGU hospitals have income retention, so even if a hospital has many PhilHealth patients and submits claims to PhilHealth, the money does not go back to the hospital but rather to the LGU. The LGU distributes funds back to the hospitals based on a historical line-item budget. This means that Level 1 or 2 hospitals with low occupancy rates (30 to 40 percent) receive a budget irrespective of level of effort, and a Level 3 hospital with a 120 percent occupancy rate receives the same historical budget. The less efficient hospital has no incentive to improve performance, while the busy hospital is overstretched but does not have additional funds to improve services. While PhilHealth payment mechanisms follow the principle that money follows the patient, in the absence of autonomy, hospitals are not able to use the funds to improve performance. The full impact of the lack of income retention at the LGU facility level is not known, but there is anecdotal information that PhilHealth payments may be financing other priority sectors—not necessarily health—at the LGU level.

4. Management of the HCP Benefits Package

The HCP benefits package has evolved over the years, and an interesting feature is that since implementation began in 2000, PhilHealth has added specific benefits for the Sponsored Program that are not available to other NHIP beneficiaries (table 1).

Table 1 Benefits Package under NHIP and Special Benefits for SP

Type of Benefit	Details of Coverage	Only for Poor or All NHIP
Inpatient Acute Care	First-dollar (peso) coverage for hospitalization. Payment is on a fee-for-service basis, up to a limit identified by PhilHealth. PhilHealth pays for (a) room and board; (b) services of health care professionals; (c) diagnostic, laboratory, and other medical examination services; (d) use of surgical or medical equipment and facilities; (e) prescription drugs, subject to limitations; and (f) inpatient education packages. Hospitals are allowed to balance bill over and above the PhilHealth payments. Prices are not regulated by PhilHealth and are not transparent.	For all members
Inpatient Acute Care	No Balance Billing package where public hospitals are paid a fixed rate per case. Initially, 23 cases are included PhilHealth hopes to cover all cases in 2012.	Only for Sponsored Program using services in public hospitals. For private hospitals, case rates apply but private

		hospitals allowed to balance bill.
Special packages TB DOTS (Tuberculosis Directly Observed Therapy, Short-course), Maternal and Neonatal Care	Provides fixed rates with no balance billing. Now, largely integrated into No Balance Billing scheme.	All members
Outpatient benefits	The outpatient benefits cover primary consultation with general physicians, as well as lab tests such as complete X-rays, fecal and urine analysis, complete blood count, and sputum microscopy.	Only Sponsored Program

Inpatient Care

Balance billing[9] has traditionally been a big barrier to the use of health services by poor households. Moreover, the latest Family Income and Expenditure Survey shows that out-of-pocket payments, including among poor households, has been increasing. Paying for medicines and hospitalization costs are key expenditures. Therefore, in 2011, PhilHealth expanded the benefits package for Sponsored Program members. It introduced No Balance Billing for 23 medical and surgical cases (identified on the basis of those that affect poor households the most). Under this arrangement, for those 23 cases, Sponsored Program members using public hospitals would not have to pay anything out-of-pocket. Hospitalization would be cashless for poor households. In reality, the system of balance billing implementation is not foolproof.

A 2012 rapid assessment of the implementation of no-balance billing (World Bank 2012) found that patients (Sponsored Program members) were being charged, so the policy objective of cashless hospitalization is not being achieved. The main reasons for this are (a) distrust of hospitals that PhilHealth will pay them on time; (b) a cash flow problem the result of which hospitals are unable to advance medicine and other initial diagnostics to patients. Another critical factor is limited PhilHealth capacity in monitoring compliance with policies.

In response to the data generated from the study, PhilHealth has adopted a "global budget" policy, which means that hospitals will get advance payments that will then be adjusted against actual claims data.[10] Even with the implementation of global budgets (advance payments), it is unclear how this policy will work out for public hospitals that have Government Owned and Controlled Corporation and income retention status, versus hospitals that have no autonomy. In hospitals that have no autonomy, some of the problems related to stock-out of drugs, lack of

[9] Balance billing is a system in which hospitals and health facilities are allowed to charge over and above what PhilHealth pays through the benefits package. This policy was initiated mainly to address the fact that overall financing in the system is low, and therefore PhilHealth could not cover the full price of service provision, especially in private hospitals. Public facilities are also allowed to balance bill. If they have income retention, then they are allowed to retain the funds. If they do not have income retention, then the earnings are reverted to the Treasury.

[10] The global budget policy is being implemented on a pilot basis.

diagnostic equipment, and others could continue. Moreover, the hospitals with no autonomy may face a problem if the funds (global budgets) are transferred to the LGU treasury rather than to hospital trust funds and can be accessed by the hospitals.

This indicates how plans to serve poor households with an enhanced benefits package, and to reduce out-of-pocket payments may not work if hospital governance and accountability arrangements are not adequately addressed. This can be a key barrier to the goals of achieving universal health coverage through pro-poor insurance schemes. The government recognizes that hospital autonomy is key and has included this as one of the elements of the supply-side reforms under universal health coverage. DOH hospitals are expected to become autonomous. LGU hospitals are more problematic, but in some LGUs where the governors are willing, autonomy is possible.

Special Packages for Poor Households

In addition to the outpatient package, PhilHealth implemented special packages such as the maternal and neonatal health package and the TB DOTS (Tuberculosis Directly Observed Therapy, Short-course) package. These packages can be implemented only in PhilHealth-accredited maternity clinics and PhilHealth-accredited hospitals and TB DOTS centers. Private facilities that are accredited as these centers are also eligible. When combined with appropriate supply-side reforms, such as through DOH support to LGUs to upgrade facilities, these interventions have had impacts on the ground (see box 1).

Box 1 Integrating Purchasing and Service Delivery Interventions to Improve Access to Maternal Care Services

The Philippines has a well-developed program to incentivize institutional deliveries in rural and poor areas. There is a DOH policy on institutional deliveries which is included in the National Safe Motherhood Program and which supports an integrated/health systems approach to addressing maternal mortality including (a) sector governance (improving accountability and regulatory oversight); (b) human resources development, that is, formation of women's health teams; (c) results-based financing and social health insurance; and (d) service delivery improvements to ensure quality assurance/accreditation by PhilHealth.

The Maternal Health Care Package of PhilHealth, introduced in 2003, was an attempt to selectively enhance the breadth and depth of coverage for institutional deliveries and to jump-start the achievement of universal coverage for selected high-priority health interventions. The maternal and neonatal package of PhilHealth is paid on a per-case basis (a bundled payment of up to ₱8,000 or US$181 per institutional delivery in a primary care hospital or Level 1 facility, or ₱6,500 or US$147 in a Level 2 and Level 4 facility). Providers are not allowed to balance bill under the PhilHealth package for institutional deliveries.

To help facilities gain PhilHealth accreditation, the DOH has helped facilities upgrade to Basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care. A retrospective longitudinal study (Huntington et al. 2011), in different provinces of the Philippines, shows that the number of facility-based deliveries increased rapidly in provinces that fast-tracked the implementation of the integrated approach.

In 2009, the Government of the Philippines introduced a conditional cash transfer program for pregnant women. This program provides households additional cash, based on the completion of four prenatal visits and completing an institutional delivery. The conditional cash transfer funds can be used for transportation, family travel, and other purposes. A 2011 (early) evaluation shows that utilization of prenatal care in conditional cash transfer treatment provinces was higher than in the controls (World Bank 2011).

Outpatient Services

With the objective of enhancing the benefits package for poor households, Philhealth introduced an outpatient benefits package in 2000. This was meant for only poor households and included ₱300 (approximately US$7) for each family enrolled under the Sponsored Program. It was expected that each Sponsored Program member would be assigned to an RHU and that the RHU would act as the gatekeeper. PhilHealth's responsibilities under the outpatient benefits policy were to pay municipalities the ₱300 per enrolled member, monitor compliance, and provide technical assistance and other support services during implementation. The municipality was required to establish a trust fund so that the money for the capitation payments would not comingle with other municipality revenues. In addition, the municipality was required to oversee and supervise the implementation of the package by RHUs, make sure that facilities are upgraded to provide the services, and monitor that services are being delivered to beneficiaries.

In reality, there was a gap between policy and implementation. Many LGUs did not comply with PhilHealth requirements to establish the capitation trust fund. As a result, while LGUs received the funding from PhilHealth, there was no mechanism to track whether the funds were allocated to rural health units. In some municipalities, the trust funds were established and the capitation funds were used to improve services. But largely the implementation of the outpatient benefits package did not result in improved access to primary care facilities for poor households. Philhealth monitoring systems were weak and there was no compliance monitoring by PhilHealth.

In April 2012, PhilHealth repackaged this outpatient benefits package and renamed it Primary Care Benefits, focusing on incentivizing the delivery of the package at the RHU level. There is now a performance-based element of the management of Primary Care Benefits and simple verification mechanisms before the municipality receives the financing for each household. Moreover, PhilHealth is enforcing the establishment of trust funds. However, many RHUs are not autonomous entities, and introducing pay-for-performance in a context where RHUs do not have autonomy to use funds to obtain results is problematic. This aspect of the reform is yet to be addressed.

5. Discussion of One Theme Specific to the Philippines

While in the previous sections we described the nuts and bolts of the Sponsored Program, in this section we will briefly highlight the impacts of the program and what could be some of the reasons for these outcomes.

One of the key objectives of the Sponsored Program was to ensure that poor households in the Philippines had access to needed health services without experiencing financial hardship. Has this goal been achieved? It is difficult to get information only on the Sponsored Program, and outcomes are not tracked specifically for this group. Therefore, we broadly look at these indicators from the perspective of income quintiles as reported in various household surveys, regional differences, and urban and rural difference, although indicators for rural areas are no longer a good proxy for poor households since urban poverty is increasing in the Philippines. We draw upon data from two Demographic and Health Surveys (DHS 2003, 2008), the 2011 Family

Health Survey, the Family Income and Expenditure Surveys, and the Annual Poverty and Institutional Survey.

Health Outcomes

According to the 2011 Family Health Survey, the number of maternal deaths per 100,000 live births during 1993–2011 has increased in the Philippines. While, in 2006, the number of maternal deaths decreased to 162 per 100,000 live births, in 2011, it increased to 221. While it is not possible to break down the number of maternal deaths by income quintile, it is well known that poor households are at high risk for maternal deaths and that these deaths tend to be highly clustered among poor households. Infant and under-five mortality rates have been improving and, at an aggregate level, the Philippines is on track to achieving Millennium Development Goal 4, to reduce by two-thirds the under-five mortality rate by 2015. Nevertheless, there are significant regional differences. For example, while the national average of the infant mortality rate per 1,000 live births is 24.6 (Family Health Survey 2011), the National Capital Region has a rate of 14 per 1,000 live births, while Region 4B (Mimaropa) and Eastern Visayas have rates of 39 and 40 per 1,000 live births, respectively. These are some of the poorest regions in the country. Comparison of the 2003 and 2008 Demographic and Health Surveys (DHS) indicate that the infant mortality rate (IMR) among the poorest quintiles improved marginally (from 42 per 100,000 live births in 2003 to 40 per 100,000 live births in 2008). The greatest improvements in IMR were recorded in the richest quintile (from 19 in 2003 to 15 in 2008).

Financial Protection

At the aggregate level, out-of-pocket payments in the health system remain high (54 percent of total health expenditures). Analysis of data from the Family Income and Expenditure Survey indicates that catastrophic payments among poor households is low (figure 2). However, this could be an indication of low use of health services because of the costs involved. Data from the 2007 Annual Poverty and Income Survey show that the number of hospital admissions among poor households is significantly lower than the levels for the overall population (less than half), and three times less than the richest 10 percent (figure 3). Since one of the main objectives of expansion of the Sponsored Program was to ensure better access to health services for poor households, it appears that this objective has not been achieved. The 2003 and 2008 DHS obtained information on problems in accessing health care. The percentage of households reporting “getting money for treatment” to be a problem decreased from 87 to 74 percent from 2003 to 2008 (National Statistical Office 2004, 2009). Nevertheless the percentages reporting this to be problem remain high. Other key problems noted in the DHS are distance to health facility. The percentage reporting this to be factor changed from only 57 percent to 56 percent, indicating that in addition to financial protection, access to health services is a significant concern.

Figure 2 Proportion of Households Exceeding 40 Percent of their Capacity to Pay

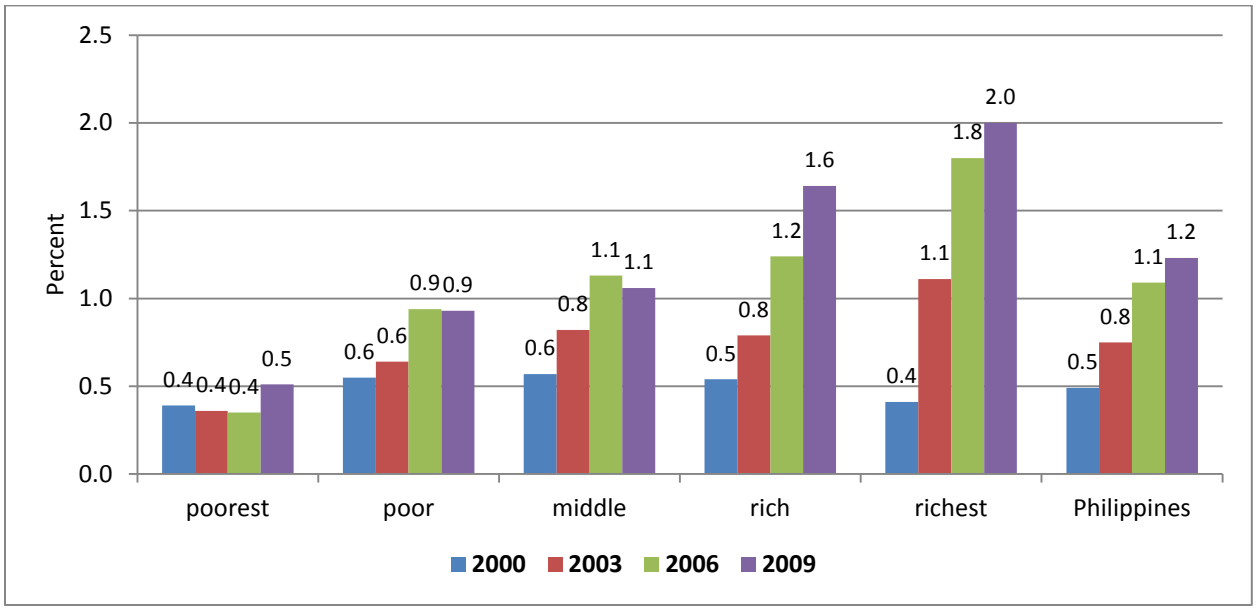
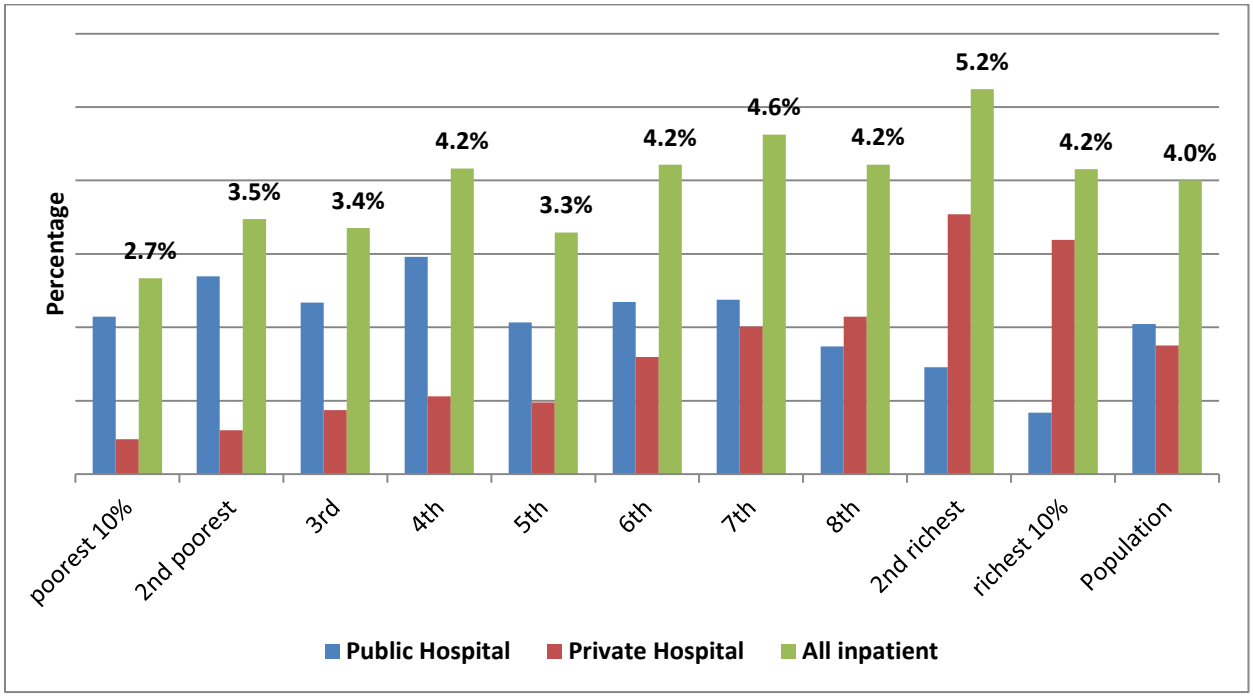


Figure 3 Proportion of the population who had any admission in the last one year



Utilization of Health Services including Priority Services

Prenatal care coverage among women in 2010 (Family Health Survey) was 78 percent. Between 2003 and 2010 (a seven-year period), this indicator has improved by only 8 percent. Between 2008 and 2011, the change was only .2 percent (77.8 percent in 2008 and 78 percent in 2011).

The percentage of births attended by a professional increased from 63 percent in 2003 to 72.2 percent in 2011. Of note, between 2003 and 2008, there was a decline in this indicator (from 63 percent to 62 percent). The percentage of births taking place in a facility increased from 42 percent in 2003 to 55 percent in 2011. Despite this, maternal mortality rates are higher now in the Philippines than before, probably indicating gaps in quality. Moreover, regional gaps are significant for these coverage indicators. While in the National Capital Region 91 percent of births are delivered by a professional, only 31 percent are in the Autonomous Region of Muslim Mindanao, and 48 percent are in Region 9. Basic vaccination coverage for under-five children continues to increase, from 70 percent in 2003 to 79 percent in 2008 and to 85 percent 2011.

This indicates that in terms of outcomes, financial protection and coverage, the situation for poor households has not improved significantly since the Sponsored Program was introduced. Why hasn't it and how is this linked to the HCP?

Institutional Arrangements and Capacity of the Health Insurance Fund (PhilHealth)

PhilHealth—which was originally established to manage a social security scheme for the formal sector—has faced a challenging situation vis-à-vis adapting its business practices for outreach to other population groups, including poor households. The staff, who were largely recruited from the Medicare program (the precursor of PhilHealth), did not have a mindset toward the implementation of social health insurance but rather toward the management of private health insurance and Medical Savings Accounts. Historically, the PhilHealth Board has not been able to hold PhilHealth accountable for the implementation of the NHIP, especially on key aspects of program implementation such as reaching poor households.[11] The governance structure—where the PhilHealth president reports to the president of the country—has made accountability arrangements unclear vis-à-vis the board, which is headed by the Secretary of Health. In 2010, under the leadership of a new Secretary of Health, the Board was strengthened and became to engage actively on PhilHealth matters. This is an important positive development.

The fact that PhilHealth had to depend on LGUs to enroll poor households complicated their relationship vis-à-vis LGUs. On the one hand, PhilHealth has to depend on LGUs to expand sponsored program coverage. On the other hand, it was expected to treat LGUs as providers—holding LGUs accountable for the delivery of quality health services, including for poor households.

Capacity of Public Providers

Another lesson from the Philippines is that pro-poor insurance schemes, such as the Sponsored Program, can only work if providers are responsive to the incentives set by the purchasing agent. In the case of the Philippines, provider accountability is a concern. As was explained earlier, in each and every case of specific provider payment implementation, providers have faced constraints in responding to the incentives and/or the accountability framework set by PhilHealth. In the absence of compliance monitoring, the incentives were not strong enough for providers to comply with the rules and regulations. Even if compliance monitoring had been

[11] World Bank. 2012. Governance of the Philippines Health Insurance Corporation (PhilHealth): A risk analysis at the institutional, organizational and technical levels.

strong, for some providers it would have been impossible to comply since they are dependent on the general, rigid public management framework and have to depend on LGUs to allocate funds and procure goods. They do not have flexibility to fire staff or even increase the number of staff positions to respond to benefits package expansions. Private facilities can do any of these, provided the financial incentives are strong. But the lack of adequate pricing of services and market control by PhilHealth has meant that private providers have not been able to meet the needs of the Sponsored Program.

Stewardship Role of the DOH and other National Agencies

While public purchasing and public provider capacity were key to many of the implementation problems under the HCP, the role of DOH in stewardship needs to be highlighted. Since decentralization, the DOH has had a difficult time obtaining timely access to data from providers, both LGU and private. This has made it difficult for DOH to regularly track program implementation. Moreover, the DOH has an arm's length relationship with LGUs, which means it cannot really influence service delivery. While PhilHealth, as the public purchaser, could have had a more direct impact on service delivery, as mentioned earlier, PhilHealth did not fully take advantage of this power. However, PhilHealth accountability to the DOH, as an affiliated agency of the DOH, has been weak for many years. This has begun to change under the leadership of the new Secretary of Health appointed in 2010, and the DOH has been focusing on identifying appropriate indicators to track the progress of the Sponsored Program. Under an overall GOP program, both DOH and PhilHealth are developing balanced scorecards against which the institutions will be held accountable. A budget line item has been introduced in the DOH which allows the channeling of funds from DBM through DOH to PhilHealth, and allows DOH to hold PhilHealth directly accountable for the performance of the sponsored program. This change in approach to public fund management which focuses on results and enhanced accountability rather than micromanagement of the fund transfer process is a much needed development and is consistent with the GOP's plans for a results based approach to managing the SP.

In conclusion, implementation of a health insurance program for poor households in a highly decentralized health sector context—where local government units have a prominent role to play in the health sector—has proved challenging. Implementation has been constrained by a complex myriad of DOH-PhilHealth–LGU accountability arrangements or the lack thereof.

6. Current Developments and Pending Agenda

Despite the many problems experienced in the implementation of the Sponsored Program, the Philippines is at a turning point in the management of the program within the NHIP. Some of these positive developments were noted in the previous paragraphs. In 2010, recognizing the importance of improving access to needed services for poor households while protecting households from the financial costs, the President of the Philippines declared an accelerated agenda for universal health coverage. Global experience demonstrates that successful UHC implementation – especially HCP for poor households – is likely to have high success when it is targeted as a policy issue at the highest political levels (President, Prime Minister) and overall economic conditions are favorable. The economic and political context in the Philippines is currently favorable for HCP implementation – the President has declared UHC, especially

financial protection and access to quality health services as priorities. The GOP has already committed more resources to UHC (DOH budget was increased by 45 percent in 2012 and by almost 50 percent in 2013). Moreover recently adopted sin tax reforms (tobacco and alcohol)[12] are expected to raise additional revenues for UHC – main targeted areas for sin tax allocation include: (a) health insurance coverage for near poor/quintile 2 and (b) supply side expansions, (c) strengthening public health interventions that benefit all Filipinos. Key developments in HCP since July 2010 include:

- Enrolment of the poorest Filipino households targeted through the NHTS-PR (4.66 million).
- Formalization of national government financing for the 5.2 million households. This has centralized health financing for poor households and eliminated the role of LGUs in enrolling poor households. With this shift in responsibilities, PhilHealth is able to hold LGUs accountable for the delivery of quality health services to the poor. In turn, DOH is able to hold PhilHealth – which is an affiliated agency under the DOH – accountable.
- LGU health facilities can financially gain from providing services to the 5.2 million poor households, especially in a context of enhanced PhilHealth inpatient and outpatient benefits (see next bullet points).
- Increase of the annual premium subsidy payment for poor households (and all NHIP members) from ₱1,200 to ₱2,400 (US$27 to US$52) and inclusion of full financing for the increased premium in the 2012 budget. As a result, national government financing for health is steadily increasing (from ₱31 billion in 2011 to ₱43.6 billion in 2012). This allocation is well targeted to poor households for an enhanced benefits package.
- PhilHealth expansion of its benefits packages during 2011–12, including free hospitalization for priority illnesses for poor families, provided care is sought in a public hospital. Stronger primary care benefits package, which means all poor households have to formally enroll with an RHU and be subjected to a health screening to better manage risks. In addition, PhilHealth is planning the rollout of a primary care benefits package for outpatient drugs targeted initially to poor families, but eventually to all members.
- National government financing for one-time supply-side upgrades for DOH and LGU facilities to address underinvestment in capital outlays. This is being done with the objective of helping these facilities achieve PhilHealth accreditation. Once health facilities are PhilHealth accredited, they can be used by members. Without addressing supply-side problems, expansion in the Sponsored Program will not automatically translate into access to needed services.
- Enhanced national government financing of the Doctors to the Barrios and the Rural Health Practice Program (nurses and midwives) to address critical health personnel shortages in rural areas.

All of these are positive developments that will strengthen the Sponsored Program. Some pending issues that could impact program implementation include the following.

Targeting, Identification, and Enrolment of the "Near-Poor." Currently, enrolment of the poorest households (also referred to as Quintile 1) is clear and transparent. Targeting the "near

[12] Republic Act Number 10351 was signed in December 2012.

poor" is not clear. Around 3.4 million families enrolled by LGUs into the Sponsored Program but did not qualify as an NHTS-PR household in the cross-match. This group has, for the moment, been retained under the Sponsored Program and enjoys the same benefits. LGUs are paying a premium of ₱1,200 for this group and PhilHealth is subsidizing the rest under an enhanced premium program (₱2,400). The national government has made the case that as long as they are not paying the subsidies, they are agnostic regarding the group. However, PhilHealth reserves are being used to pay the partial subsidy for this group. The national government has also announced that if it is able to raise additional resources from sin taxes, it will finance quintile 2. Since the sin tax bill was adopted, this is a clear possibility. Under the NHTS-PR list, 10.8 million households are identified of which only 5.2 million are currently classified as poor. A large and pending agenda for the Philippines under the Sponsored Program is targeting the "near poor." It seems this will be resolved as soon as the Department of Social Welfare and Development is able to identify the cut-off for near poor. The question remains what will happen to the funds that LGUs would have spent on enrolling the poor. Rather than focusing on this point, perhaps the emphasis needs to be on how to make LGU facilities accountable for delivering health services under the NHIP.

Monitoring and Evaluation of UHC. As the country embraces a strengthened program to reach poor households through the NHIP, the need for program implementation data to track whether inputs, outputs, and intermediate outcomes are being achieved becomes key. While both DOH and PhilHealth have made good progress through the development of the UHC Dashboard and the PhilHealth Balanced scorecard, ensuring that high-quality data are available in a timely manner is a major challenge. As Annex 1 of this paper indicates, the Philippines is a positive outlier in terms of Internet and mobile phone access. This could be effectively leveraged for timely, quality data reporting. There are ongoing pilots using mobile phones for reporting primary care data to PhilHealth. If shown to be a success, these could be considered for scaling up.

Addressing Public Sector Capacity to Deliver a Strengthened Sponsored Program. Many of the issues on the provider side, including level of autonomy, capacity, and accountability, are unaddressed. As the country seriously contemplates national government financing of quintile 2, it also needs to think about how this will change PhilHealth/LGU relations to PhilHealth's advantage. So far, PhilHealth and LGUs have had a multilayered relationship. On the one hand, PhilHealth has depended on LGUs to enroll members, and on the other, it was expected to hold them accountable for service delivery. This has not worked. Moving ahead, it is important that PhilHealth, as the purchaser of health services, hold all facilities accountable for service delivery and quality of care. At the same time, facilities need to be empowered to respond to this revitalized PhilHealth agenda of a strong purchaser. The role of the DOH in a highly decentralized system is key since LGUs will not have the capacity and will need technical support from the DOH to reform. As PhilHealth expands and strengths its purchasing capacity, LGUs may be genuinely interested in fulfilling their role as provider, but they will not have the capacity to do so. Addressing gaps in the Internal Revenue Allotment (IRA) rules and regulations where IRA allocations are tied to LGU declared income is needed. Keeping LGUs under LGU ownership while allowing autonomy at the facility level may be one answer.

Keeping the Integrity of the NHIP to Support Optimal Risk Pooling and Redistribution. One of the key strengths of the Sponsored Program is that it is integrated into the NHIP. This supports maximum risk pooling and redistribution. While the country's UHC agenda is laudable for its focus on the poor, other NHIP members must be retained and feel the benefits of the NHIP. This means that PhilHealth faces the challenge of reaching the poor, but also of strengthening services for all its members. The impact of these multiple objectives on capacity and how to calibrate capacity to address these dual objectives will have to be addressed.

Keeping an Eye on Fiscal Sustainability through Efficiency Improvements. Right now, the Government of the Philippines is to be commended for tackling increased revenues for UHC through alcohol and tobacco tax reform. However, even as more resources are raised for UHC, it is important that the efficiency dimension of fiscal sustainability and space be kept in mind. This means that through the expanded UHC programs, allocative and technical efficiency is improved and primary care is strengthened.

Annex 1 Description of the Philippines Health Sector

The Philippines is an archipelago of 7,107 islands located in Southeast Asia which is divided into three island groups (Luzon, the Visayas, and Mindanao). In 2011, it had an estimated population of 94.9 million[13] and a per-capita Gross National Income (Atlas method) of US$2,210, making it a lower-middle-income country. The Philippines has strong potential for development in terms of abundant natural resources; a talented, English-speaking workforce; a dynamic private sector; and an active civil society. However, overall development outcomes have fallen short of potential because economic growth and job generation have tended to be more modest than in neighboring countries. Many Filipinos have sought better opportunities outside the country; an estimated 10 percent of the population reside abroad and generate annual remittances equivalent to over 10 percent of the country's gross domestic product (GDP). Since 2001, economic growth has picked up, but this has not translated into poverty reduction. Instead, official poverty estimates indicate that the overall incidence of poverty increased between 2003 and 2006, and then remained unchanged through 2009, while unemployment and underemployment have also remained stubbornly high.[14] The growth that has occurred has not been inclusive.

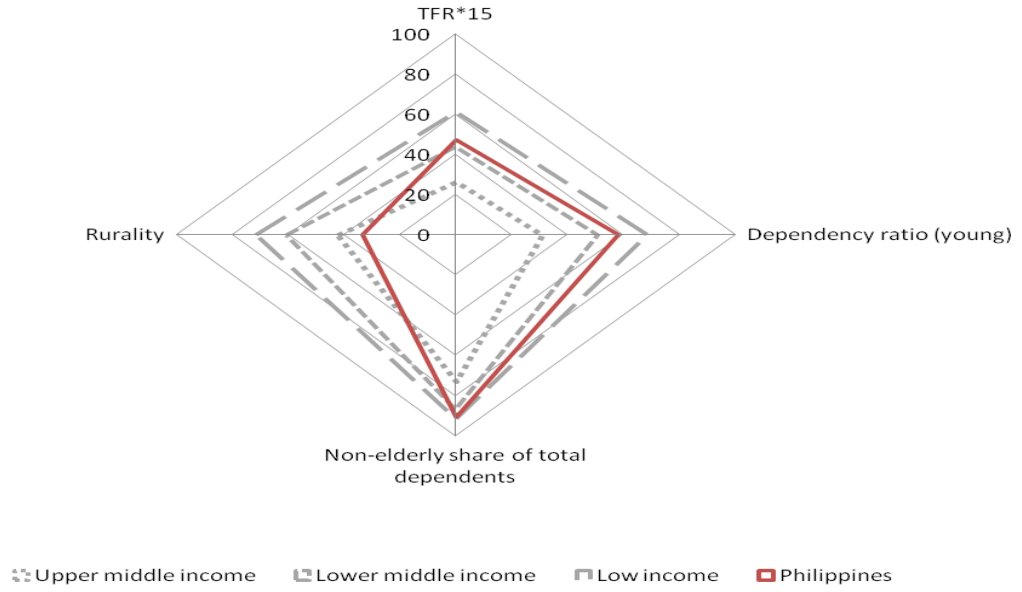
Overview of the Philippines Health Sector

Demography

Demography plays a key role in UHC since it can affect the fiscal situation of social health insurance schemes, as well as determine purchasing decisions and consumer choice of providers. In rural areas where there are not enough providers and consumer choice is limited, payment mechanism may have to de designed differently. Figure A1.1 shows that, in terms of total fertility rates, the Philippines is slightly above the pattern for middle-income countries. Moreover, total fertility rates are much higher among poor populations and rural households. The dependency ratio and nonelderly share of dependents is also higher than in other middle-income countries. This is positive in terms of UHC, since the population is young. Interestingly, rurality rates in the Philippines are low, which indicates that the population is rapidly urbanizing.

[13] Based on midyear United Nations population estimates.
[14] Evidence suggests that growth in the Philippines over the last decade was jobless.

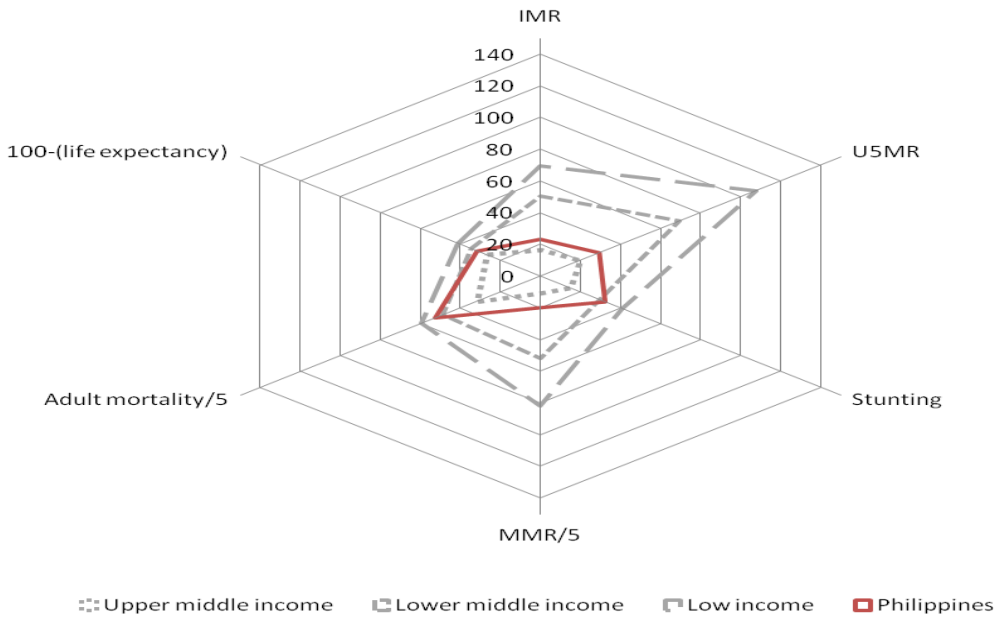
Figure A1.1 Demographics



Health Outcomes

As figure A1.2 shows, regarding key health outcomes, the Philippines performs well for life expectancy, infant mortality rates, under-five mortality rates, and maternal mortality rates compared to other middle-income countries. However, performance on adult mortality and stunting among children is less optimal. More important, one key feature of the Philippines is the large inequality in health outcomes across regions, provinces, urban and rural areas, and income quintiles (see figures A1.2 and A1.3).

Figure A1.2 Health Outcomes



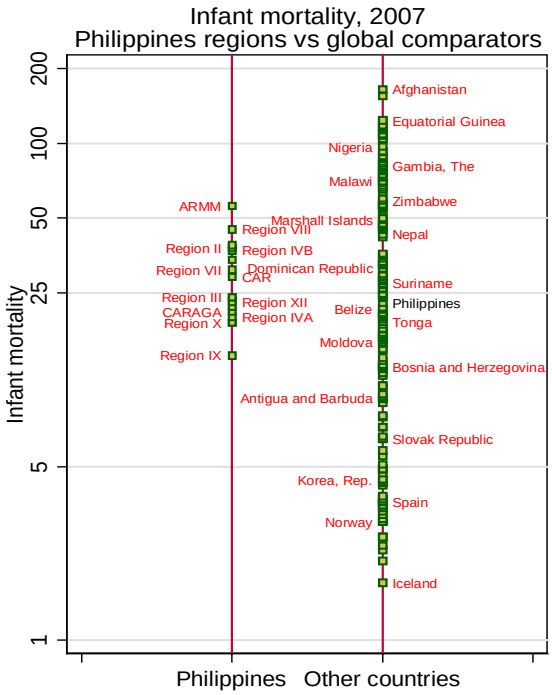
Note: IMR = infant mortality rate, MMR = maternal mortality rate, U5MR = under-five mortality rate.

Figure A1.3 Provincial Disparities in Health Outcomes in the Philippines

Panel A

Source: WDI;UNDP

Panel B

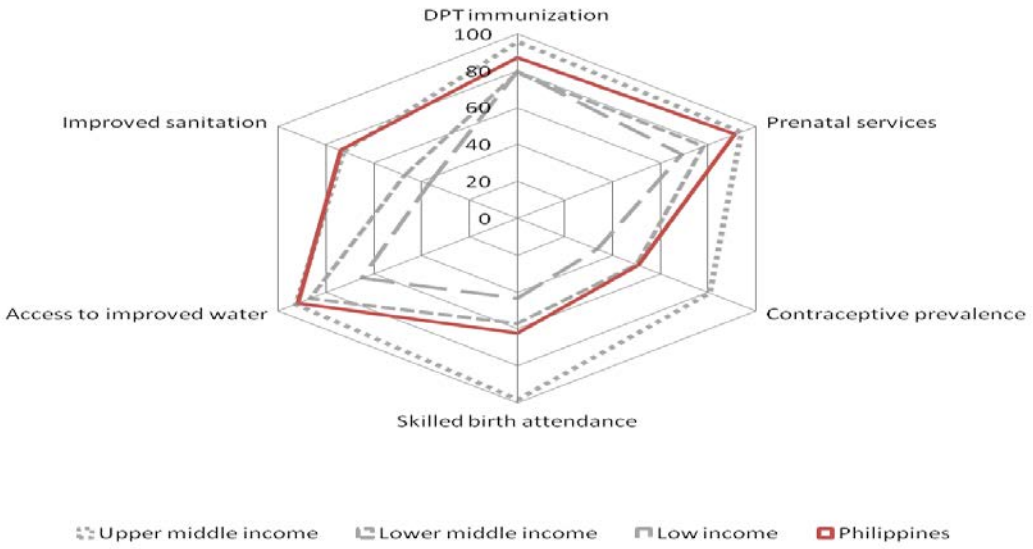


Source: WDI;NDHS

Coverage of Key Health Interventions

In terms of coverage of key interventions, coverage of DPT (diphtheria, pertussis, and tetanus) immunization among children is high, as is access to improved sanitation and safe water. Access to skilled birth attendants is slightly above that of other middle-income countries, but again, there is a wide disparity between rich and poor. According to the 2008 DHS, 94 percent of the richest quintiles used a skilled birth attendant compared to only 13 percent in the lowest income quintiles. For contraceptive prevalence, the Philippines is not an outlier. However a different picture could emerge if this is looked at from a disaggregated perspective in terms of urban/rural and across income quintiles (figure A1.4).

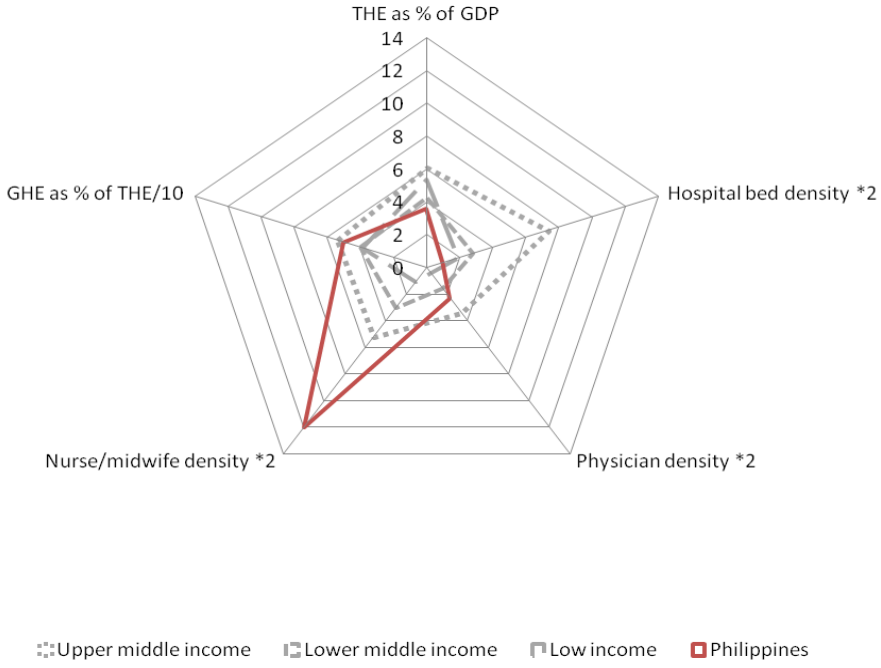
Figure A1.4



Health Inputs

In terms of total health spending, government health expenditures as a percent of total health expenditures in the Philippines is a negative outlier; that is, expenditures are lower than in similar-income countries (figure A1.5). For the number of nurses and midwives, it is a positive outlier, while hospital bed density is lower than in other similar-income countries.

Figure A1.5 Inputs

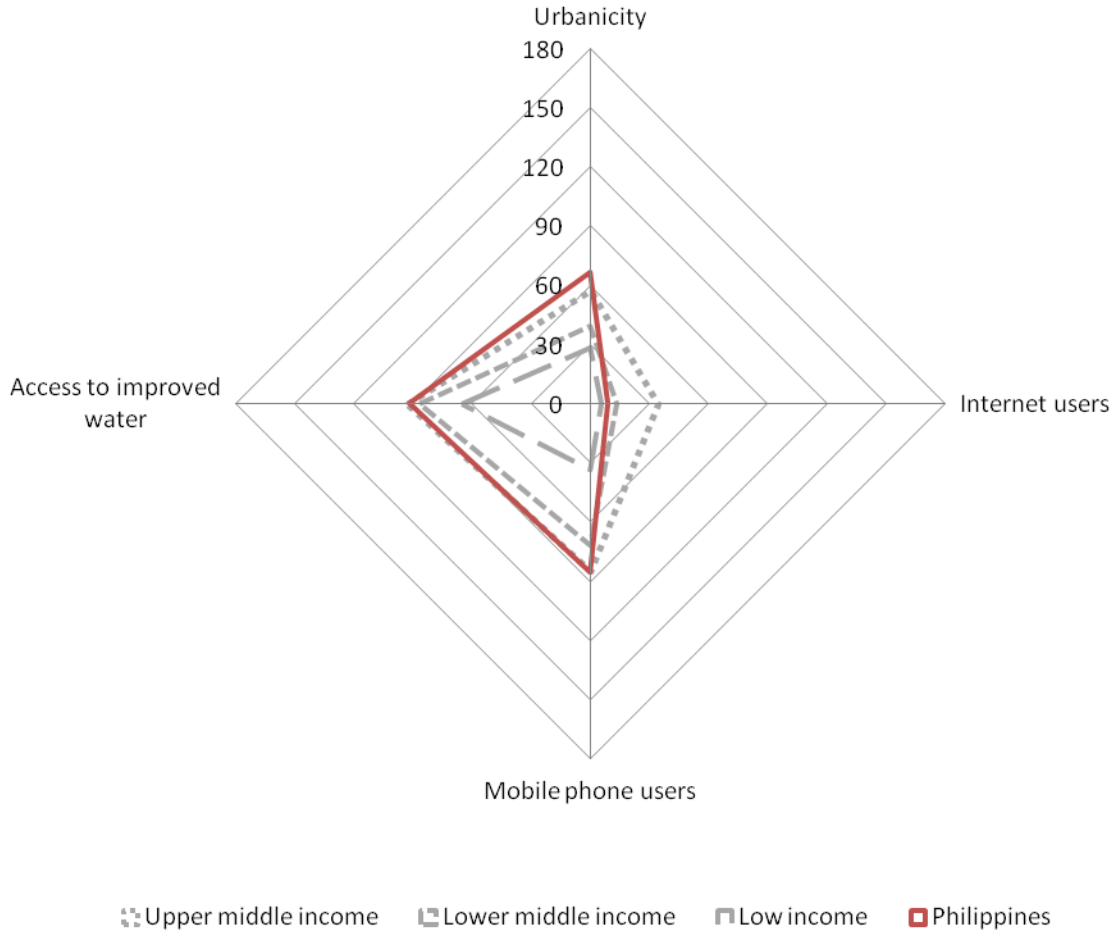


Note: GHE = government health expenditure, THE = total health expenditure.

Infrastructure

Overall, the Philippines does well on infrastructure and is a positive outlier for indicators such as the number of Internet and mobile phone uses (figure A1.6). This also reiterates the potential of using this infrastructure for an improved and timely information environment for UHC. The level of urbanacity is also very high. This reiterates the point made earlier about low levels of rurality.

Figure A1.6 Infrastructure



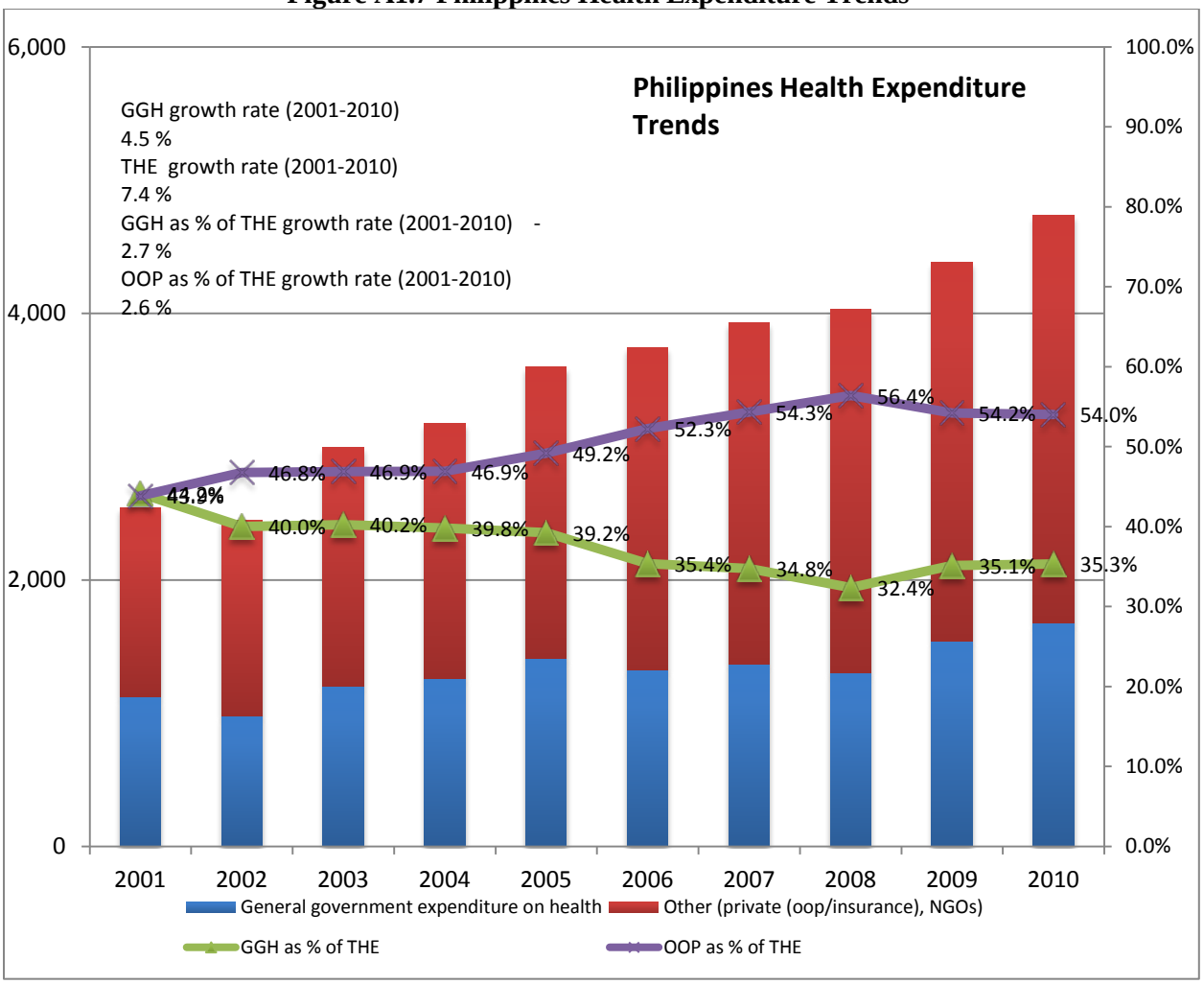
Description of the Health Financing and Service Delivery Systems

To understand the Health Coverage Program (HCP), (henceforth referred to as the Sponsored Program), it is important to know the underlying health system and overall health financing system, in particular. The Philippines health system is financed from multiple sources of financing, both public and private. During 2007–11, the Philippines spent 3.6 percent of GDP on health. This translates into US$77 per capita on health care, of which approximately 35 percent was public spending and the remainder was private spending. Of private spending, 83.6 percent was out-of-pocket at point-of-service (unpooled) and the remainder was from pooled sources (payments for private health insurance) (World Bank 2011). Health spending as a percentage of total government expenditures was around 6.6 percent (Asia Pacific Observatory 2011).

Elasticity of public spending on health in the Philippines was below 1 (around .83). This means that even when overall government expenditures have grown in the country, public spending on health has grown at a pace less than 1 (Tandon and Regondi 2010).

On all health expenditure indicators, the Philippines is below the average for East-Asia and Pacific and similar middle-income countries (figure A1.7). This indicates that the Sponsored Program has historically been implemented in a context of low public sector allocations to the health sector. While public spending on health is low in the Philippines, fiscal space to rapidly expand spending is also limited. The Philippines has one of the lowest public revenue collection-to-GDP ratios among Asian countries (Tandon and Regondi 2010). The impact of these overall health expenditure patterns, fiscal space, and the Sponsored Program will be discussed in Annex 2.

Figure A1.7 Philippines Health Expenditure Trends



Note: GGH = General Government Expenditure on Health, OOP = out-of-pocket, THE = Total Health Expenditure.

The main sources of financing in the Philippines health system include (a) the national government, (b) LGUs, (c) firms, (d) households, and (e) external financing. The main financing

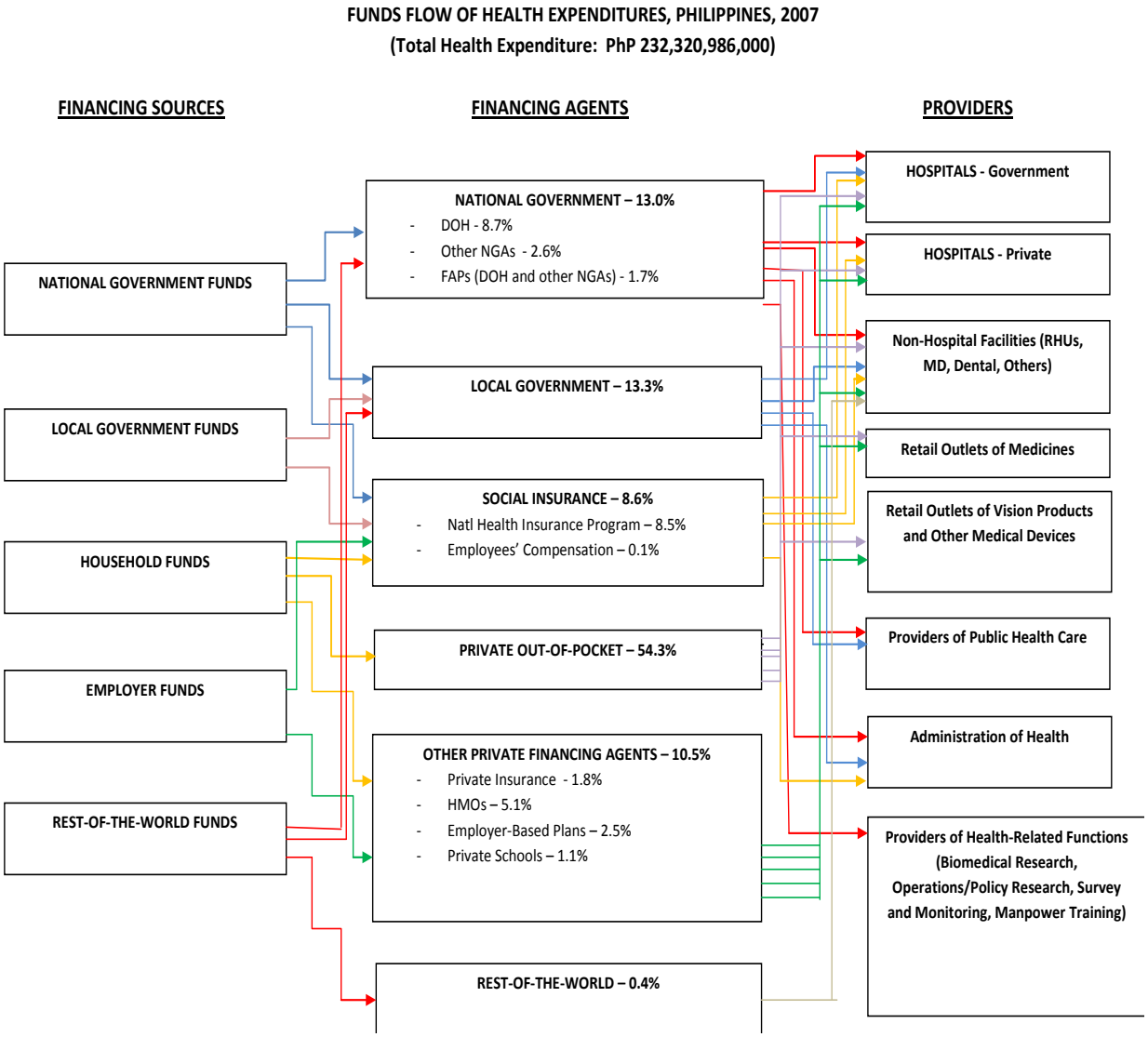
agents are (a) the Department of Health, (b) LGUs, (c) the Philippines Health Insurance Corporation (PhilHealth), and (d) private health insurance companies (see figure A1.8 The 1995 National Health Insurance Law of the Philippines expanded the existing Medicare system for the formal sector to cover the informal sector and poor households. Contributions from the formal sector, informal sector, self-employed, and organized groups are combined with public subsidies for poor households within a single payer system. The national government and local government contributions are directly paid to PhilHealth. In addition, the national government, through the DOH, directly finances 72 DOH hospitals. This financing is largely for payments to health personnel (around 75 percent of the total budget in 2008).

Other expenditures such as maintenance and operations costs and capital outlays are severely underfinanced. Since 2003, DOH hospitals have been allowed to retain income from other sources (out-of-pocket payments, PhilHealth payments, others) and use these funds for improving hospital services (Lavado et al. 2010).

LGUs (provincial and municipal level) finance hospitals, rural health units, and barangay (village) health centers. Allocations made by governors and mayors are based on historical allocations. Only a small minority of LGU health facilities have income retention. All additional earnings, including from PhilHealth payments, are made to the LGU treasury. Annual allocations are made by the LGU to each health facility based on a line-item budget from where annual allocations are made based on the budget (explained in greater detail in Annex 2.

The Philippines has a mixed service delivery system of government health facilities (DOH-owned, LGU-owned, several Government Owned and Controlled Corporations hospitals) and private for-profit facilities (hospitals, physician clinics, and pharmacies), and a small number of nonprofit private facilities managed by nongovernmental organizations and religious groups (figure A.8). According to the latest available data, there are about 1,600 hospitals in the Philippines of which 60 percent are in the private sector. Private sector hospitals are largely clustered in Metro Manila and other large cities such as Cebu, Davao.

Figure A1.8 Flow of Funds in the Philippines Health Sector



Annex 2 Public Health Services and HCP Information Environment

Brief Description of Public Health, Primary Care, and Key Supply-side Efforts

Public health services are provided by local government units (LGUs) with support from the Department of Health (DOH). The DOH, in partnership with Centers of Health Development at the regional level, implements almost 40 public health programs that range from adolescent health to TB control. The objective of these programs is to set national standards and capacitate LGUs in implementing these standards. LGUs have the main responsibility for primary care, which is provided by the Barangay Health Stations (at the barangay/village level) and Rural Health Units (RHUs). Hospitals are managed by the DOH and provincial and municipal LGUs (table A2.1).

Table A2.1 Public Health, Primary Care, and Key Supply-side Efforts, Public Sector

Type of Health Facility	Services Provided	Ownership
Barangay Health Station (BHS)	BHS is technically the first contact point in the health sector for households, and along with RHUs is responsible for delivering primary care to the population. A BHS provides first-aid, maternal and child health services, and community-based interventions including immunizations. A BHS is staffed by doctors, midwives, nurses, and volunteers (Barangay Health Workers). Services provided in the BHS are free of charge, as are medicines. Some expensive medicines may be subsidized. BHS would be responsible for referral to an RHU.	Municipality
Rural Health Units (RHUs)	RHUs, along with BHSs, form the primary care network for the population. An RHU has doctors, nurses, and midwives. The RHU supervises the BHS and provides a full range of primary care curative and preventive health care services. Basic laboratory services are available in an RHU. RHUs also provide Basic Emergency Maternity and Obstetric Care.	Municipality
Municipal or district hospitals (Level 1)	Emergency hospital provides: - Initial treatment for cases that require immediate treatment and that provide primary care for prevalent diseases in the area - General medicine, pediatrics, minor surgeries, and nonsurgical gynecology - Primary clinical laboratory, pharmacy, and first-level radiology - Nursing care for patients needing minimal supervised care - Comprehensive Emergency Maternity and Obstetric Care.	Province
Provincial hospital (Levels 2 and 3)	Level 2: Nondepartmentalized hospitals provide: - General medicine, pediatrics, surgery, anesthesia, obstetrics and gynecology, first-level radiology, secondary clinical laboratory, pharmacy - Nursing care for patients needing intermediate supervised care. Level 3: Departmentalized hospitals provide: - All clinical services provided by Level 2 hospitals - Specialty clinical care - Tertiary clinical laboratory, pharmacy, second-level radiology - Nursing care for patients needing total and intensive care.	
Regional hospitals and medical centers (Level 4)	Teaching and training hospitals provide: - All clinical services provided by Level 3 hospitals - Specialized forms of treatments, intensive care, and surgical procedures - Tertiary clinical laboratory, third-level radiology, pharmacy - Nursing care for patients needing continuous and specialized critical care.	Department of Health

Source: Data for this table were obtained from the Department of Health, Manila.

The 1991 devolution of health services to LGUs has had long-standing implications for the Philippines health sector. It has contributed to fragmentation and duplication in the provision of health services, underinvestment in infrastructure, and inequity in the provision of health services, since the quality and quantity of health services provided in each LGU are dependent on the LGUs' political commitment to financing health services. Moreover, there is no single governance framework for the hospitals. Some LGU hospitals have been implementing elements of hospital autonomy (a drug revolving fund, income retention), while others continue to work under a traditional public sector management framework where hospital earnings from health insurance claims are channeled to the LGU treasury—instead of to the hospital.

As a result, although some hospitals have high volumes of patients (such as provincial hospitals), they still receive funds based on historical allocations. Other hospitals (for example, Level 2), which may see smaller numbers of patients, also receive their historical allocation. In the case of the higher-productivity hospitals, this generates no incentives to see PhilHealth patients, since the funds go the LGU treasury. Moreover, hospitals cannot respond to incentives to improve internal management or performance in a situation where hospitals do not have autonomy.

There is a strong private sector delivery system and the private sector constitutes 60 percent of total hospital beds in the country. The majority of private facilities are in large city centers and urban areas of the country. The majority of private facilities are Level 2 and 3 hospitals. There are also quite a few Level 1 private health facilities.

The Information Environment of the HCP

The information environment for HCP is very weak. The majority of data are still manually reported. PhilHealth claims forms are cumbersome, requiring multiple attachments.

PhilHealth does not use claims data for any evidence-based policy making and in fact is hardly able to generate and track basic information on the Sponsored Program. Improving the information environment for HCP has been discussed, and Health Information System reforms have been proposed for many years. Master plans and roadmaps have been developed but never implemented by PhilHealth because of lack of governance and leadership in PhilHealth. Only recently (January 2012) was the long proposed solution of hiring a strong Chief Information Officer for PhilHealth endorsed, and now overhaul of the information environment is underway.

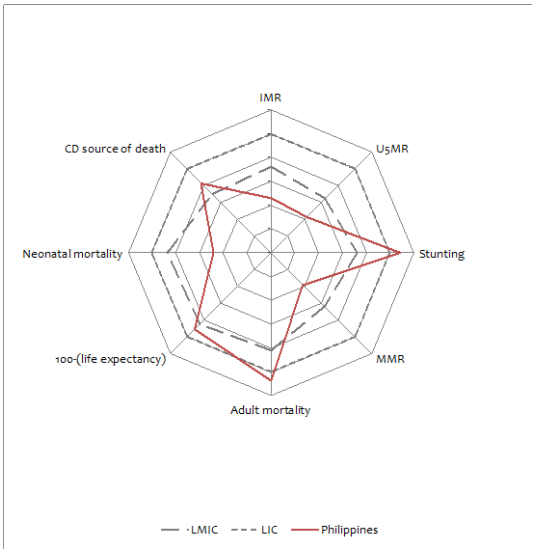
Health outcomes data are reported through the vital registration system and the Field Health information system. However, given the highly decentralized nature of the health system, it has been very difficult for the DOH to get consistent and timely data from all LGUs. Moreover, the private sector has not complied with reporting data regularly to the DOH. As a result, information on health outcomes, such as the infant and child mortality rate, maternal mortality rate, and other health outcomes information is largely obtained from periodic survey data.

Incentives for various agents to accurately report health data are very weak. During 2006–10, under the previous health reforms, the DOH initiated LGU scorecards, eventually linked to performance-based grants for LGUs. The objective of the LGU grants was to incentivize timely submission of data by LGUs. The LGU scorecard includes a mix of coverage indicators such as

immunization rate, TB case detection and treatment rate, number of facility-based deliveries, and enrolment in the National Health Insurance Program. The main source of data for the LGU scorecards is the Field Health Information System.

Annex 3 Spider Web

I. Outcomes comparisons: Phillippines and Lower Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

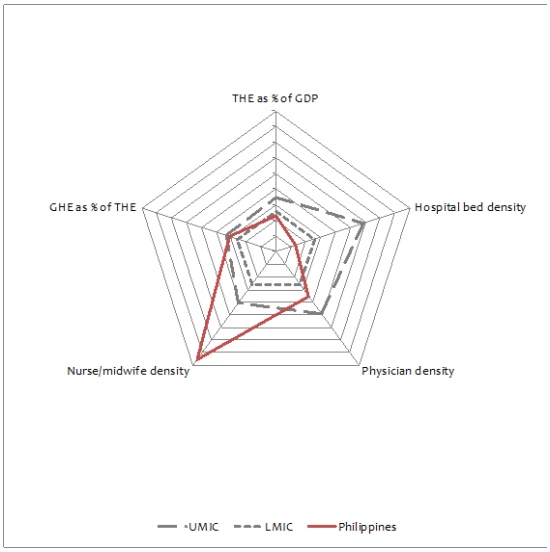
The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

< -50%
[-25% ; -50%]
[-25% ; +25%]
[+25% ; +50%]
> 50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
IMR	23.2	50.3	-53.9%
U5MR	29.4	69.4	-57.7%
Stunting	32.3	29.7	8.8%
MMR	99.0	260.0	-61.9%
Adult Mortality	261.9	244.1	7.3%
100-Life Expectancy	31.5	34.6	-9.0%
Neonatal Mortality	14.0	29.1	-51.9%
CD mortality	39.0	47.0	-17.0%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Phillippines and Lower Middle Income Countries



Note on interpretation:
This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

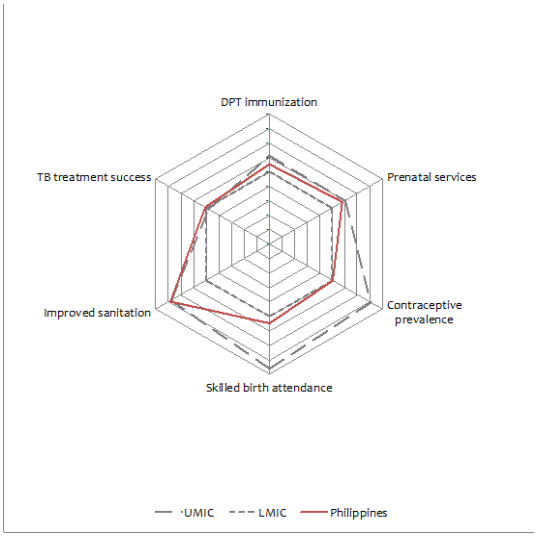
The table below summarizes inputs comparisons with the average lower middle income country (LMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
THE %GDP	3.6	4.2	-14.8%
Hosp. bed density	0.5	1.4	-64.0%
Phys. density	1.2	0.8	48.5%
Nur./midwife dens.	6.0	1.5	296.9%
GHE %THE	50.3	40.2	25.2%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons
Phillippines and Lower Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

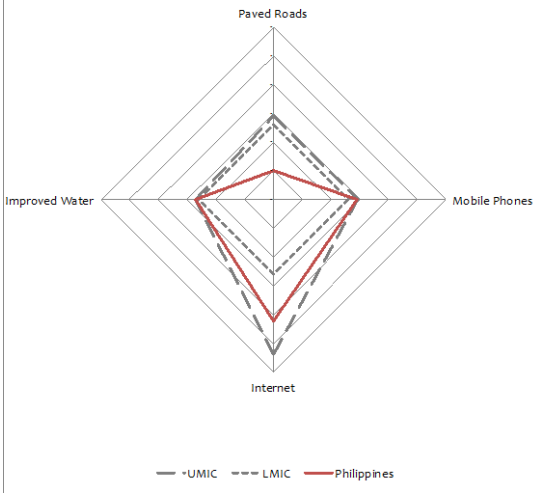
The table below summarizes coverage comparisons with the average lower middle income country (LMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
DPT	87.0	78.7	10.5%
Prenatal	91.1	78.1	16.6%
Contraceptive	50.7	50.1	1.2%
Skilled birth	62.2	56.9	9.3%
Sanitation	74.0	47.0	57.4%
TB success	89.0	88.0	1.1%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons
Phillippines and Lower Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

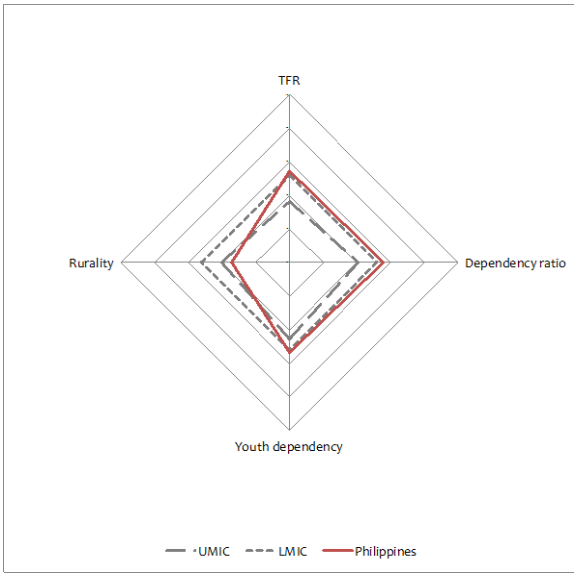
The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
Paved roads	9.9	49.5	-80.0%
Mobile phones	92.0	79.3	16.1%
Internet	29.0	16.0	80.8%
Water	92.0	87.3	5.4%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons
Phillippines and Lower Middle Income Countries



Note on interpretation:
Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

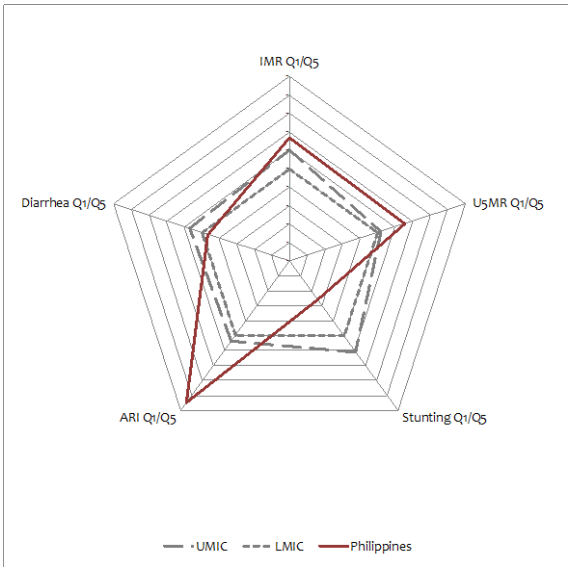
The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
TFR	3.1	2.9	7.2%
Dependency (Total)	64.2	58.8	9.2%
Youth share	90.7	86.7	4.5%
Rural pop.	33.6	60.6	-44.5%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons
Phillippines and Lower Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).

< -50%
[-25% ; -50%]
[-25% ; +25%]
[+25% ; +50%]
> 50%

Country Data	Philippines	LMIC	% Diff.
GNI pc (2000 USD)	1047.7	592.4	76.8%
IMR Q1/Q5	2.7	2.0	33.0%
U5MR Q1/Q5	3.4	2.6	31.6%
Stunting Q1/Q5	1.4	2.7	-48.6%
ARI Q1/Q5	2.5	1.3	89.7%
Diarrhea Q1/Q5	1.4	1.5	-7.2%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (http://data.worldbank.org/data-catalog/HNPquintile).

References

Asia Pacific Observatory on Health Systems and Policies. 2011. The Philippines Health System Review. Health Systems in Transition, Volume 1, Number 2, Manila, The Philippines.

Chakraborty, S., G. Schieber, O. Picazo, and A. Tandon. 2011. "Transforming the Philippine Health Sector: Challenges and Future Directions." he International Bank for Reconstruction and Development, the World Bank, Washington, DC.

Huntington, D., E. Banzon, and Z. Recidoro. 2012. "A Systems Approach to Improving Maternal Health in the Philippines." *Bulletin of the World Health Organization* 90–110, Geneva, Switzerland.

Lavado et al. 2010. "How Are Government Hospitals Performing? A Study of Resource Management in Government Retained Hospitals." Philippines Institute for Development Studies Discussion Paper Series –2010–02, Manila.

Manasan, R. 2011. Philippines Institute for Development Studies (PIDS) Discussion Paper Series, 2010–2011. Manila.

National Statistics Office. 2009. Philippines National Demographic and Health Survey (NDHS). NSO, Manila.

———. 2012. Family Health Survey. National Statistics Office, Manila.

———. 2004. National Demographic and Health Survey. National Statistics Office, Manila.

———. 2009. National Demographic and Health Survey. National Statistics Office, Manila.

Solon, O., S. Alabastro-Quimbo, and Panelo Tan. 2003. "Financing Health Care for Poor Filipinos." International Bank for Reconstruction and Development and the World Bank.

Tandon, Ajay and Regondi Ilara. 2010. "Fiscal Space Analysis in the Philippines Health Sector." Background document prepared for the Philippines Health Sector Review. World Bank, Washington, DC.

World Bank. 2009. "Philippines: Fostering Inclusive Growth." World Bank, Manila.

———. 2011. *World Development Indicators*. Washington, DC: World Bank.

The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.

THE WORLD BANK