SP4PHC
Strategic Purchasing for Primary Health Care

ENSURING EQUITABLE POPULATION COVERAGE: IMMEDIATE ELIGIBILITY TO PHILHEALTH BENEFITS

THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care services, with a focus on family planning and maternal, newborn, and child health. The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell in collaboration with country governments and local research partners. The SP4PHC project is focused on purchasing reforms in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda.

In the Philippines, the project provides technical assistance to national and local governments to strengthen health purchasing policies and practices in support of the implementation of the Universal Health Care (UHC) law enacted in 2019. To demonstrate applicability, incubate innovative ideas, and generate evidence, ThinkWell supports UHC Integration Sites in the provinces of Antique and Guimaras.

People should be at the center of UHC, and so population coverage should be prioritized, especially for the most disadvantaged groups. The Philippines' UHC law mandates that all Filipinos be given immediate access to the benefits of the country's national health insurance through the Philippine Health Insurance Corporation (PhilHealth), irrespective of pre-existing membership. This brief outlines how the population coverage of PhilHealth has improved through the years and how the UHC law aims to sustain and extend these gains.

INTRODUCTION

Population coverage is one of the three dimensions of UHC. Countries build towards UHC by increasing the proportion of services paid from pooled funding, as well as the proportion of costs covered, and the share of the population that benefits from these arrangements. Putting people at the center of UHC means prioritizing the universal enrollment of a country's population into publicly funded social protection mechanisms. To achieve this, special attention must be given to ensure that disadvantaged population groups, such as the poor and vulnerable, are not systemically excluded (WHO 2010; WHO and World Bank 2014).

Health outcomes have improved in the Philippines over the past decade, but there continue to be significant inequities. The latest National Demographic and Health Survey (NDHS) has shown improvements in health indicators for the country in 2017. However, inequities across place of residence, region, and wealth quintile are noticeable. For example, while the average infant mortality rate has been decreasing through the years, the rates for those in the three poorest wealth quintiles are more than double than those in richer quintiles (Figure 1). A similar pattern can be observed in facility-based deliveries, where only 58.4% of women in the poorest quintile deliver in a facility compared to 96.9% of women in the richest quintile (Figure 2) (PSA and ICF International 2018).

The inability of households to pay is one of the primary factors that limit access to health services. In 2017, the NDHS identified money as the biggest hindrance to accessing healthcare when sick, especially for those in the poorest wealth quintile (Figure 3). Similarly, lack of money and transportation were the top two reasons for which respondents chose not to deliver in a health facility (PSA and ICF International 2018).

Equitable population coverage needs to be ensured by public financing of health services. Figure 4 shows that while overall PhilHealth coverage has been increasing since 2008, it has actually decreased since 2013 for those in the poorest wealth quintile (NSO and ICF Macro 2009; PSA and ICF International 2014, 2018).

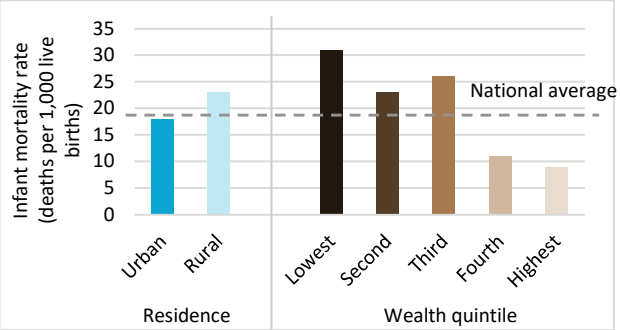

Figure 1. *Infant mortality rate per 1,000 live births across place of residence and wealth quintiles in the Philippines, 2017 (PSA and ICF International 2018).*

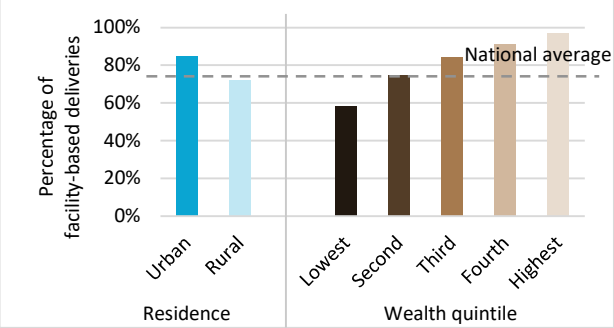

Figure 2. *Percentage of facility-based deliveries across place of residence and wealth quintiles in the Philippines, 2017 (PSA and ICF International 2018).*

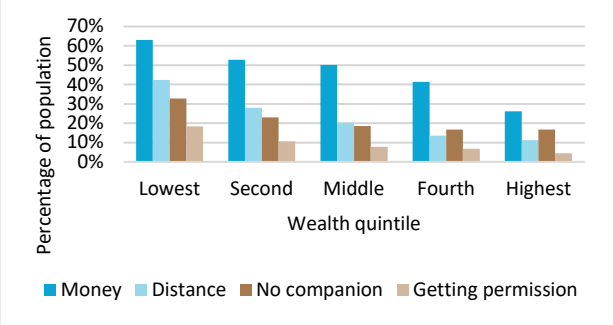

Figure 3. *Problems in accessing healthcare when sick in the Philippines, 2017 (PSA and ICF International 2018).*

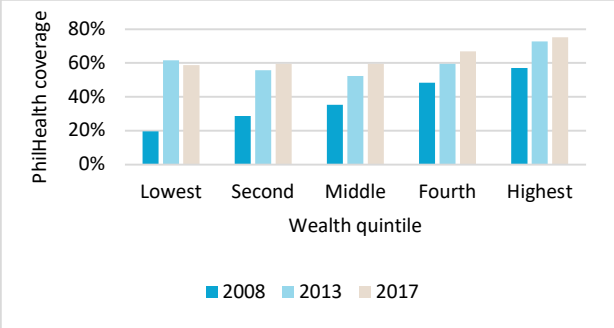

Figure 4. *PhilHealth coverage across wealth quintiles (NSO and ICF Macro 2009; PSA and ICF International 2014, 2018).*

The purpose of this brief is to outline how PhilHealth population coverage has improved over time and how the UHC law aims to sustain and extend these gains. This brief has drawn on secondary sources of information. The team conducted a quantitative analysis of PhilHealth data on membership and claims, and a desk review of the existing literature and PhilHealth policies, particularly those related to its membership.

INTERVENTIONS TO SCALE UP PHILHEALTH POPULATION COVERAGE

The enactment of the National Health Insurance Act of 1995 (Republic Act [RA] No. 7875) paved the way for the creation of PhilHealth, which was mandated to provide health insurance coverage to all Filipinos. The Act signaled the country's shift from a system where the government focused on a budget-financed, public-delivery system to one where money follows the patients, with private providers complementing public providers. Formal sector employees were previously covered by the Medical Care Program (Medicare),[1] managed by the Government Service Insurance System and Social Security System. With the enactments of RA No. 7875, PhilHealth became responsible for covering formal sector employees. The January 2020 Labor Survey estimates that 65.2% of the 42.5 million employed population are formal wage and salary workers (PSA 2020).

Over time, PhilHealth started to introduce new programs that aimed to expand population

[1] Established by the Philippine Medical Care Act of 1969, Medicare aimed to provide full coverage of medical services according to the needs of Filipinos. The program was overseen by the Philippine Medical Care Commission, which began operations in 1971. It had two basic programs – Program I for the members of national social insurance programs (Social Security System and Government Service Insurance System); and Program II for the rest of Filipinos. However, although operations for Program I started in 1972, implementation of Program II never took off.

coverage, especially for the vulnerable groups. In 1997, it introduced the indigent or sponsored program, where premiums of these select beneficiaries – usually those belonging to the poorest quintile – were paid for by the national government, local government units (LGUs), or the private sector. When the program started, there was no formal identification method of the poor and PhilHealth left it to the payer to identify who to enroll. The effect was sporadic and uneven in terms of membership due to difficulty in sustaining funds from these different sources (Lavado 2010). In 2004, for example, funding from the Philippine Charity Sweepstake Office Greater Medicaid Access Program covered 6.3 million families for a year, but this fell back the following year to 2.5 million families when it cut back its support (PhilHealth 2005). It was also difficult to convince LGUs to continuously pay the premiums of their poor constituents while balancing financial constraints and low perceived benefit. LGUs did not have effective mechanisms to identify the true poor among their constituents.

The reforms over the past decade have aimed to correct implementation challenges in the indigent or sponsored program of PhilHealth. In 2008, the country implemented a conditional cash transfer program called the *Pantawid Pamilyang Pilipino* Program. The beneficiaries of this program were identified through the National Household Targeting System for Poverty Reduction (NHTS-PR) using a proxy means test (DSWD 2008). In 2011, the Department of Health (DOH) issued Department Order 2011-0188, which led to PhilHealth covering the bottom 40% of the population, as identified through the NHTS-PR. In addition to this, RA No. 9994 or the Expanded Senior Citizen's Act of 2010, paved the way for mandatory PhilHealth coverage for all indigent senior citizens. Subsequently, sustainability of these subsidies was assured through the passage of RA No. 10351 or the Sin Tax Law of 2012. The national government increased its subsidy for those included in the NHTS-PR from 3 billion Philippine Pesos (PHP) (US$ 60 million) in 2011 to PHP 12 billion (US$ 240 million) in 2012, covering around 5 million indigents (PhilHealth 2012; Pantig 2012). An amendment of the National Health Insurance Act in 2013 legislated this premium subsidy for indigent members as identified by the NHTS-PR. This subsidy increased again in 2014 to more than PHP 35 billion (US$ 300 million), covering around 15 million indigents out of a national population of 100.5 million in the same year (DBM 2014; Cabalfin 2017).

For the vulnerable population who had not been identified by the NHTS-PR mechanism, PhilHealth also started to implement mechanisms to ensure their registration and eligibility at the point of health service. In 2013, PhilHealth started to implement a Point of Care (POC) Enrollment Program in select government health facilities. This program used social workers to identify non-PhilHealth members who were indigent (according to criterion set by the DOH) and enroll them into PhilHealth as sponsored members (PhilHealth 2013b). The facility was responsible for paying the premiums of those enrolled through this program. Those who were not eligible for the POC Enrollment Program could choose to enroll and personally pay their annual premium contributions. In 2018, the POC Enrollment Program was transitioned into the Point of Service (POS) Program where premiums of those unable to pay and unregistered Filipinos accessing services in government health facilities were paid for by the national government, as opposed to by the facility (PhilHealth 2018).

In addition to efforts to ensure coverage of the poor, PhilHealth also created programs to encourage the enrollment of the informal sector. Enrollment of informal sector members, or those without formal employment, was voluntary. The Individually Paying Program was created in 1999 to extend coverage of the informal sector. In 2003, PhilHealth started to partner with a variety of organizations to enroll informal sector households and those not covered by PhilHealth through formal employment mechanisms. However, even with these strategies, coverage remained limited (Phily, Rajkotia, and Matul 2014). In 2017, just over 6.3 million of the 16 million informal sector population of the Philippines was registered to PhilHealth, and only 2.4 million were actively paying members (PhilHealth 2017a). A study identified that the following factors affected the enrollment and retention of the informal sector to PhilHealth: 1) overlaps in categorization of membership types, 2) insufficient or inappropriate initiatives of PhilHealth for the informal sector, 3) lack of awareness and

understanding of the purpose of PhilHealth as a national health insurer, 4) supply side factors, and 5) inconvenience and cost of premium payment (Sales, Reyes, and Ting et al. 2020).

Table 1. *Summary of policies and programs that have affected PhilHealth's population coverage over the years*

Year	Policies and programs	Effects on PhilHealth population coverage
1995	**RA No. 7875: National Health Insurance Act of 1995**	Mandated to provide social health insurance coverage to all Filipinos
1997	**Indigent Program**	Covered indigents[2] whose premiums were funded by national and local governments
1999	**Individually Paying Program**	Covered the informal sector[3]
2003	**Partnerships with organized groups**	Aimed to encourage enrollment of informal households
2010	**RA No. 9994: Expanded Senior Citizen's Act**	Covered all indigent senior citizens
2012	**RA No. 10351: Sin Tax Law of 2012**	Covered the subsidies of the bottom 40% of the population identified by the NHTS-PR, as well as indigent senior citizens
2012	**RA No. 10606: Amendment of the National Health Insurance Act of 1995**	Covered those identified as poor by the NHTS-PR
2013	**POC Enrollment Program**	Mandated government health facilities to identify those who can be enrolled into PhilHealth sponsored by the facility; transitioned into the POS Program in 2018
2018	**POS Program**	Mandated the national government to subsidize premiums of financially incapable and unregistered Filipinos who access services through government health facilities

Source: Compiled by authors

POPULATION COVERAGE AND ACCESS TO HEALTH SERVICES

The policies and programs described above and summarized in Table 1 have contributed to the increase of PhilHealth's population coverage since establishment in 1995. PhilHealth estimates that its population coverage – which is based on primary members and dependents in its database – has increased from around 38% of the population in 2010 to as much as 98% of the population in 2018 (Soria 2019) (Figure 5). Figure 6 shows the numbers of primary members only and illustrates that this increase in membership was mainly due to the increase of those indigents from the NHTS-PR list, as well as senior citizens. Household survey data from the NDHS, however, shows that only 66% of the population reported PhilHealth coverage in 2017 (PSA and ICF International 2018). The gap between self-reported coverage and PhilHealth coverage data is a concern. One contributing factor is lack of awareness of benefits, which is discussed further below. Figure 7 illustrates membership type by wealth quintile from NDHS data and shows that the

[2] Indigents are defined as "those who have no visible means of income or whose income is insufficient for the family subsistence".

[3] The informal sector is comprised of people hired without contracts or fixed term of employment and without employee-employer relationship, including job order contract workers and seasonal employees.

two poorest quintiles are mainly covered through the premium subsidy by the national government based on the NHTS-PR list.

Increase in population coverage, especially of the poor, may have contributed towards increasing the poor's utilization of PhilHealth benefits in the past decade. Through these various policies and programs, there is a notable increase in benefit payout for indigents and senior citizens. This is especially observed from 2012 when the national government stared to provide premium coverage for the poor (Figure 8). Analysis of maternity claims gives a more nuanced understanding of the evolution of PhilHealth coverage. Sponsored and indigent members have increasing shares of delivery benefit utilization over the years, but most notably following the introduction of premium subsidy in 2012 (Figure 9). A study in 2016 found that there is a higher likelihood of facility-based delivery for women who are insured by PhilHealth than for those without insurance, especially among rural and poor women (Gouda, Hodge, and Bermejo et al. 2016).

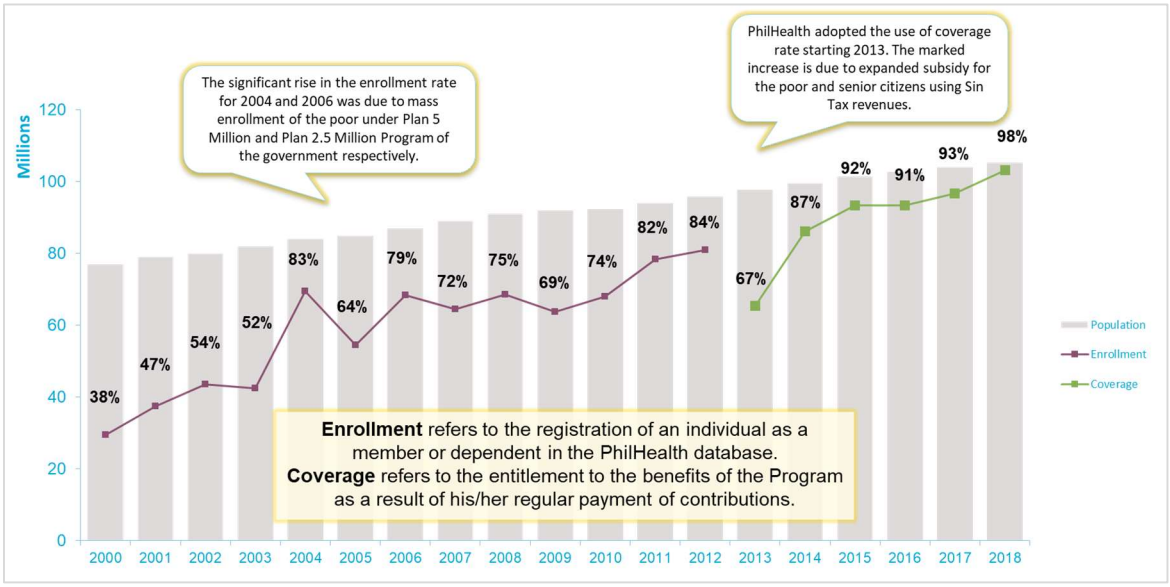

Figure 5. *Estimated population coverage of PhilHealth, 2000-2018 (Soria 2019).*

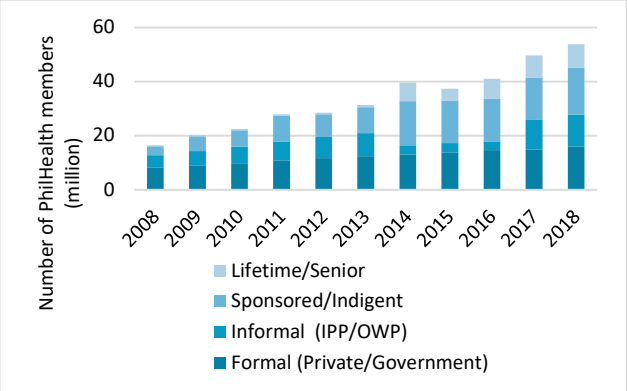

Figure 6. *Type of membership of primary member, 2008-2018 (PhilHealth 2020).*[4]

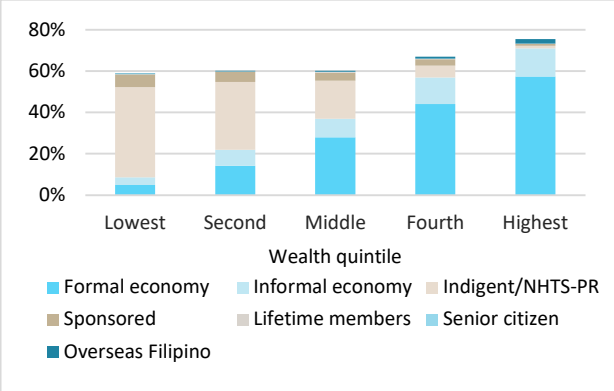

Figure 7. *Household survey data on type of PhilHealth membership according to wealth quintile, 2017 (PSA and ICF International 2018).*

[4] Numbers were collated from the **PhilHealth Stats and Charts** and aggregated into four major groups: 1) Formal or Government; 2) Informal, including Individual Paying and Overseas Worker Program; 3) Sponsored, including NHTS-PR, Indigent, and LGU-Sponsored; and 4) Lifetime and Senior Citizen members. To note, there were changes in policies regarding membership categories over the years, which may also affect the data presented.

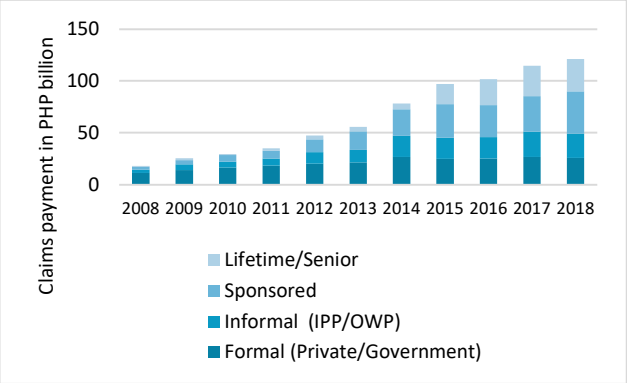

Figure 8. *Benefit payout per PhilHealth member type in PHP, 2008-2018, collated by authors using data from PhilHealth 2020.*

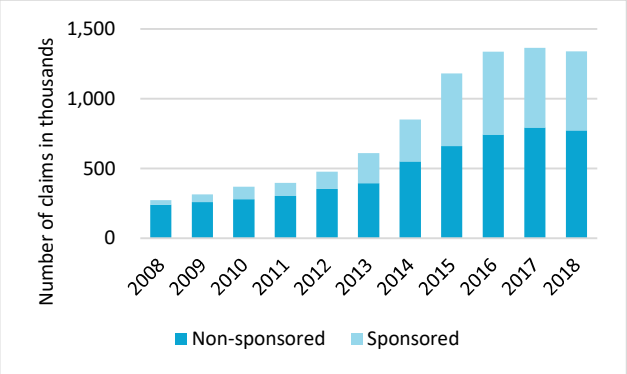

Figure 9. *Number of claims for facility-based deliveries by sponsored and non-sponsored PhilHealth members, 2008-2018, collated by authors using data from PhilHealth 2019.*

However, gaps remain in access to and utilization of health services by the poor. As mentioned above, the poor continue to have lower rates of facility-based delivery compared to wealthier quintiles. Lack of awareness in terms of entitlement is one of the contributory factors. A study done in a tertiary hospital in Southern Luzon shows low levels of benefit awareness of respondents, but also established that pregnant women who knew of their benefits were more likely to avail of them (Bernardino and Burog 2017). Another study found that although Filipinos have high (95.7%) awareness that PhilHealth covers inpatient benefits, only 31.6% of those surveyed were aware of PhilHealth's benefit for primary care (Bredenkamp, Capuno, and Kraft et al. 2017).

Increased utilization will not deliver improved outcomes without high service quality. Even though it is likely that PhilHealth enrollment of the poor can be linked to the increase in access to services, this does not automatically translate into better outcomes. For example, despite increases in facility-based deliveries from 44% in 2008 to 72% in 2017, the maternal mortality ratio in the Philippines has been decreasing only slowly from 144 per 100,000 live births in 2010 to 127 in 2015 and 121 in 2017 (PSA and ICF International 2018; MMEIG 2020). This remains far from the target of 70 per 100,000 live births set by the 2015 Sustainable Development Goals. Global reviews suggest that poor quality of care may mean that increases in access may not be reflected in improved outcomes (Kruk, Gage, and Arsenault et al. 2018).

IMMEDIATE ELIGIBLITY TO PHILHEALTH BENEFITS THROUGH THE UNIVERSAL HEALTH CARE LAW

The Philippines' UHC law attempts to sustain and further scale successes in terms of population coverage. The law aims to progressively realize "universal health care in the country" and "ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risk" (Congress of the Philippines 2019). It contains stipulations to ensure the three pillars of UHC: population coverage, service quality, and financial risk protection (WHO 2010). For population coverage, the law effectively removes contribution-based eligibility rules in availing PhilHealth benefits through two important mandates. First, every Filipino citizen shall be automatically included in the National Health Insurance Program (NHIP). Second, every member will be granted immediate eligibility for health benefit packages in the program. Practically, this means that when a patient without a PhilHealth identification card visits a contracted facility, they must be treated as a PhilHealth member, and will be able to access PhilHealth benefits. They will also be automatically enrolled into the PhilHealth system for future visits.

Premium contributions will depend on members' capacity to pay. The Implementing Rules and Regulations of the UHC law stipulate that those who have financial capacity are still required to pay their contributions as direct contribution, while the government will pay premiums for those without financial means, who will be categorized as indirect contributors. PhilHealth has already issued guidelines for the assessment of the financial capacity of patients upon admission to a PhilHealth-

accredited health facility, utilizing the POS Program (PhilHealth 2019).

The implementation of these membership policies currently faces severe challenges. To ensure the sustainability of the NHIP amidst expansion of population and benefit coverage, the national government needs to find a way to increase the total value of premiums collected by PhilHealth. The UHC law mandates gradual premium increases that will cover both the expansion of benefits and the growth in subsidized membership. These increases have resulted in a backlash from certain sectors, such as physicians and Overseas Filipino Workers, who will face significant increases in premiums. Complaints have been brought to the level of senate and congress where several hearings have already taken place. The COVID-19 pandemic added further strain to the situation because of its negative effect on the economy. Protestors argued for the need to allow optional participation in the NHIP and to delay premium increases because of the growth in unemployment (Cepeda 2020). Nevertheless, ensuring PhilHealth coverage for all Filipinos is an important mechanism to provide continued social support during the economic upset, especially during a pandemic.

Providing effective population coverage takes more than just identifying and paying the premium of the poor. The concept of "effective coverage" conveys the importance of quality to translate access into health gains. Effective coverage was defined in the early 2000s as "the fraction of potential health gain that is actually delivered to the population through the health system, given its capacity" (Jannati, Sadeghi, and Imani et al. 2018). Members will have to be thoroughly informed and educated on their benefits to ensure that they are empowered to fully utilize their entitlements. This is especially important for vulnerable populations and those from geographically isolated and disadvantaged areas, who may have challenges accessing information and facilities. The national and local governments should ensure that members can access the high-quality health services they need without hindrance, both physically and financially (ADB 2016). To be able to develop programs and policies that are appropriate to the needs of all, more research and monitoring should be consistently conducted to identify the factors that affect access, quality, and health outcomes.

CONCLUSION

The Philippines' UHC law creates an opportunity to sustain and ensure increased and equitable population coverage for health services. Over the years, gains have been seen through the various initiatives of PhilHealth to expand its coverage of the Filipino population. The mandates of the UHC law can further improve population coverage, despite the challenges PhilHealth faces in its implementation, especially amid a global pandemic. In order to move forward, PhilHealth must regain public trust so that it can continue to improve premium collection and sustainably ensure coverage of its members. However, ensuring equitable access to health services takes more than enrolling Filipinos to PhilHealth. Population coverage must be accompanied by improved understanding of rights and benefits so that it can be translated into equitable use. Work must also be done in terms of expanding the package and quality of services and improving financial protection – the other two dimensions of UHC aside from population coverage. As the law is implemented, continued research, monitoring, and evaluation need to be done to ensure that the NHIP contributes to equitable access to health services and improved health outcomes for all citizens.

ThinkWell Philippines, through its SP4PHC project, supports the national and local government efforts in the development of rules and regulations for operationalizing the reforms of the UHC law. The team provides technical assistance to DOH, PhilHealth, and other stakeholders in the development of supporting policies for the UHC law. Particularly, the team has been aiding PhilHealth in the development and implementation of the UHC law's benefit packages, as well as policies related to health financing. Lessons from these pieces of work will not only support in the improvement of health outcomes in the Philippines but will also contribute to the global discussion on UHC and health systems development.

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For more information, please visit our website at **https://thinkwell.global/projects/sp4phc/**. For questions, please write to us at **sp4phc@thinkwell.global**.

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