THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) 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.

ThinkWell's Philippine UHC Law Series presents an overview of the country's health system and the ongoing implementation of the UHC Law. This third brief in the series focuses on health financing in the Philippines, summarizes the current situation, identifies challenges, and describes how some major provisions of the UHC Law are intended to respond to these challenges.

INTRODUCTION

Health financing is a key health system component that drives its performance. All health systems perform four generic functions namely (1) stewardship, (2) generation of human and physical resources, (3) service delivery, and (4) financing. While they do not act alone, health financing systems can directly or indirectly influence overall attainment of health system and UHC goals in any country (Kutzin 2013) (Figure 1).

This brief describes current health financing arrangements in the Philippines, highlights challenges, and then explains how the UHC Law is designed to respond to these challenges. The recently passed UHC Law introduces reforms to the three main health financing functions namely (1) revenue collection and resource generation, (2) pooling, and (3) purchasing. We follow this structure, reviewing existing literature, evidence, and reports to briefly describe the current health financing arrangements in the Philippines. We identify key challenges in the current set-up, and finally we describe how solutions put forward in the UHC Law seek to address these issues.

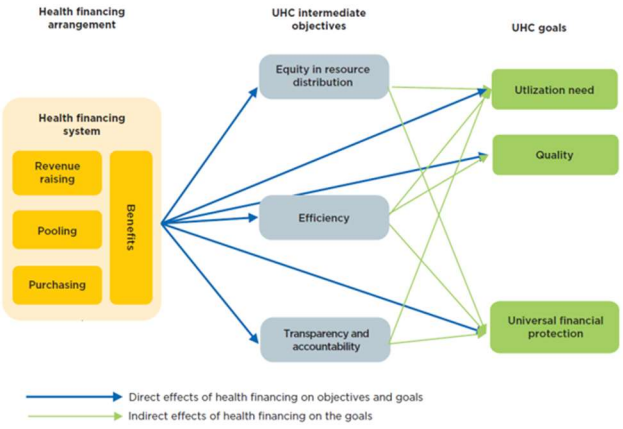


Figure 1. *Influence of health financing in achieving UHC (adapted from WHO 2019).*

CURRENT HEALTH FINANCING ARRANGEMENTS

Revenue generation

The total health expenditure (THE) in the Philippines has continued to grow over the years,

but most of the burden is still placed on out-of-pocket (OOP) spending. Revenue for health is generated through four main sources, namely (1) national and local governments, (2) social health insurance through the Philippine Health Insurance Corporation (PhilHealth), (3) OOP spending, and (4) other private spending, which may include private health insurance and donor funding, among others (DOH 2011; Solon, Herrin, and Florentino et al. 2017; Romualdez, Rosa, and Flavier et al. 2011; Dayrit, Lagarda, and Picazo et al. 2018). Over the past years, government resources spent for health have been growing, evidenced by larger national and local allocations for health, benefit payouts of the National Health Insurance Program (NHIP), and the THE in the country. However, OOP spending continues to be the biggest source of funds in the country (Figure 2), representing 54% of the THE in 2018. Data from the Philippine Statistics Authority (PSA) also show that around 1.5 million Filipinos are impoverished due to catastrophic health spending (PSA 2019).

In the past years, increases in government resources for health have been driven by "sin tax" collections. A step change in government funding for health can be observed in 2014 with the passage of the Republic Act No. 10351 or The Sin Tax Law of 2012. The sin tax raised an additional PHP 30.5 billion for health in 2014, 80% of which was earmarked for premium subsidies, and 20% for the Department of Health (DOH) medical assistance and health facilities enhancement programs (DOH 2015) (Figure 3).

Finances for health at the local level are sourced from the central government through internal revenue allocation (IRA) mechanisms, and revenues generated from locally implemented taxes. Budgets for health activities and health facilities at different levels of government are appropriated through local legislation. Devolution mandates local governments to deliver health services for their own constituents (Capuno 2009). Devolution also gives local governments the responsibility to generate resources to finance their own local health systems, which they achieve by raising local taxes. In 2019, locally generated revenues amounted to around PHP 207 billion. Figure 4 shows that local government units (LGUs) do not rely solely on their locally generated revenues. In fact, most local resources still come from fiscal transfers from the national government. On the average, around 69% of resources used by the local governments are coming from the national government, most of which are funneled through the IRA mechanism.

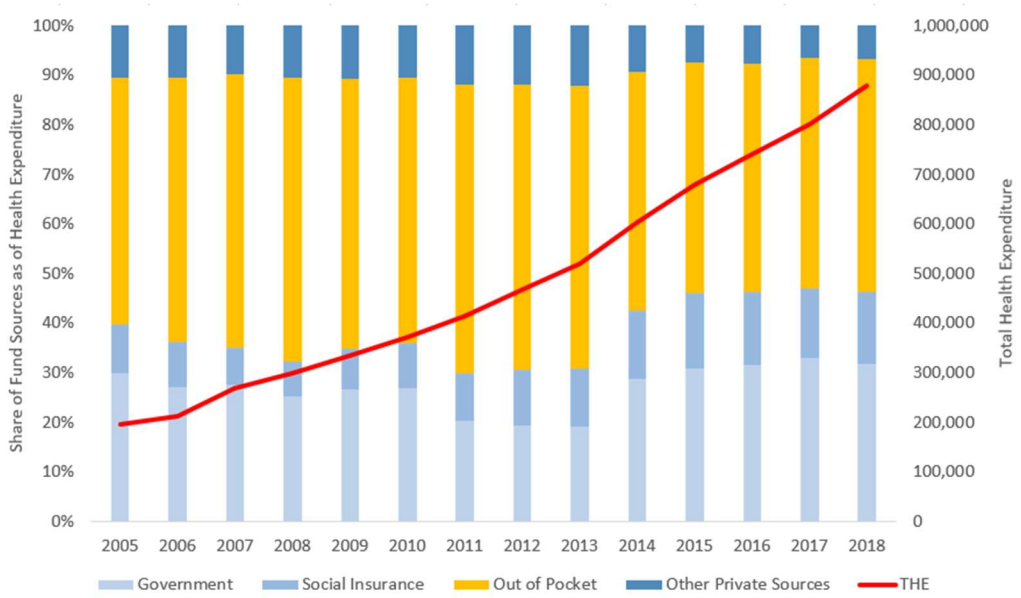


Figure 2. *Health expenditure and shares of sources of funds in the Philippines, 2005-2018, in million PHP (PSA 2019).*

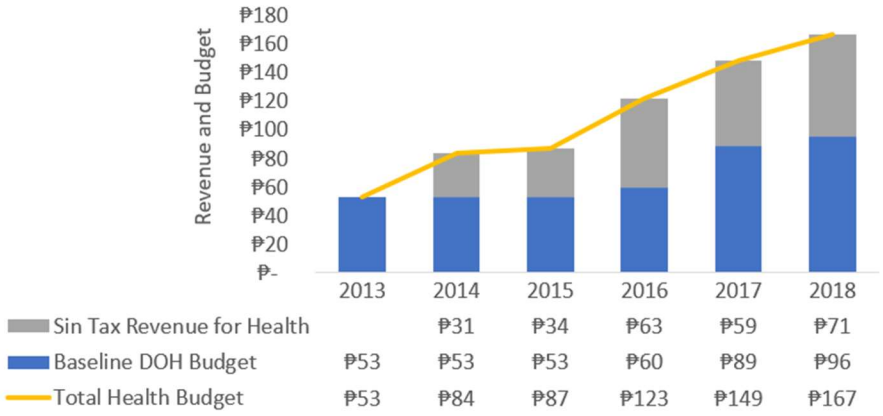
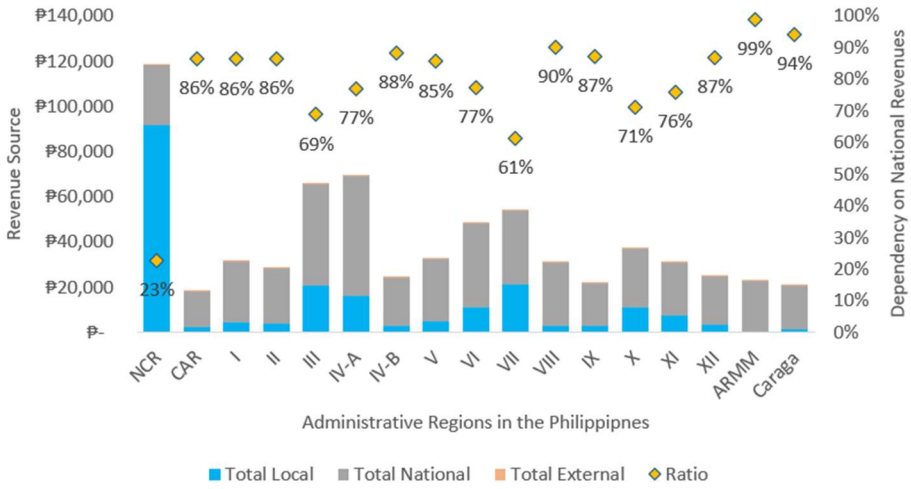


Figure 3. *DOH budget, 2013-2018, in million PHP (DOH 2019a).*



**NCR – National Capital Region; CAR – Cordillera Administrative Region; ARMM – Autonomous Region of Muslim Mindanao*

Figure 4. *Combined local resources from locally generated revenues, national transfers, and other external sources, 2019, in million PHP (DOF 2020).*

Note: Ratio computed as total national and external sources as a proportion of total funds. Higher percentages mean greater dependency on funds that are not locally generated.

Resources for PhilHealth are generated through premium collections and infusions of earmarked taxes from the national government. In 1995, Republic Act No. 7875 mandated PhilHealth to implement the NHIP, with the goal of affording Filipinos financial risk protection when they access health care services. While some of its money comes in through the government budget, the corporate identity and autonomous standing of PhilHealth[1] allows it great flexibility to utilize its resources. Formal and informal economy members directly pay their premiums to PhilHealth. Premiums for indigents or vulnerable families are subsidized by the national government and are included within the budget proposal of the DOH. A large proportion of this premium subsidy is sourced from revenues generated by sin taxes on cigarettes, of which 80% is automatically allotted for premium subsidies. Poor families are identified and counted through the National Household Targeting System (NHTS) of the Department of Social Welfare and Development (DSWD). Once these families are registered to the

[1] While PhilHealth is an attached agency of the DOH, it functions autonomously with its own Board of Directors and Executive and Management Committees. To ensure sectoral alignment, the Secretary of Health sits as the Chairman of the Board.

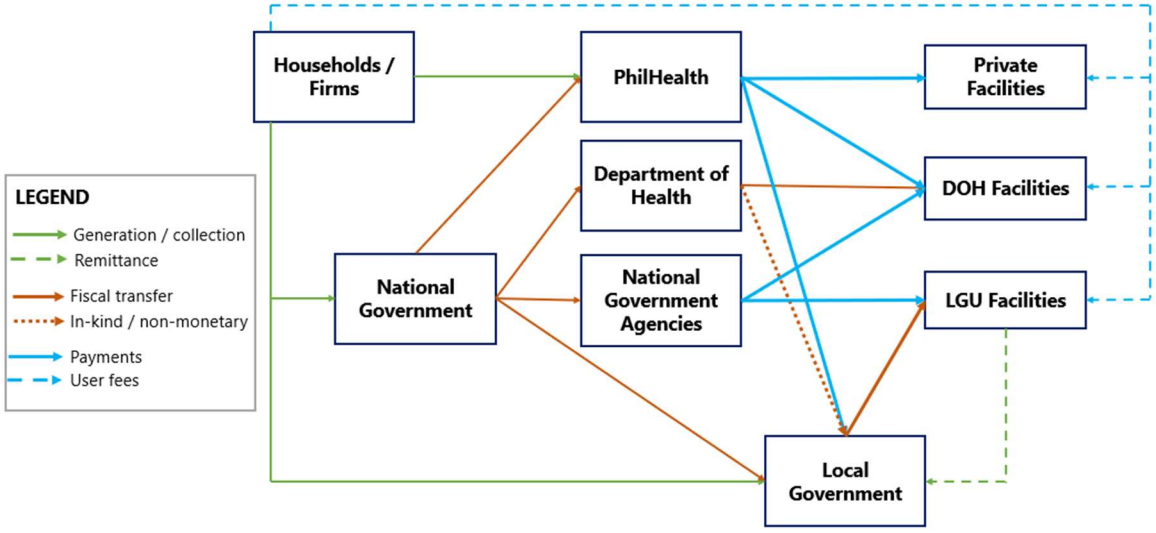


Figure 5. *Financing flows and fund pools in the Philippines, adapted by authors based on Dayrit, Lagarda, and Picazo et al. 2018.*

NHIP, their annual premiums are billed to and paid by the Department of Budget and Management (DBM) to PhilHealth (PhilHealth 2013a).

Pooling

Resources generated by the government for health go into several fund pools. Big fund pools at the national level are those of PhilHealth, the DOH, and other national government agencies that have programs related to health. At the local level, each local government has its own pool of funds for health (Figure 5). Depending on where the fund pool is, resources can be primarily intended for specific groups, or for everyone.

The DOH fund pool comes from an appropriated budget used for centrally driven programs aimed to serve the country's population at large, to provide technical assistance and support for LGUs, and to pay PhilHealth premium subsidies for those who cannot pay. Around 60% of nationally generated taxes are allocated by the DBM to national government agencies, including the DOH, following proposal deliberation.

The DOH budget is annually legislated by the Congress as the General Appropriations Act. In 2019, the DOH received a total budget of PHP 168.5 billion. The agency ranks sixth in terms of budget received across government institutions. This budget is intended to fund operations of central office units, as well as programs that provide support to local governments, such as procurement of select commodities, hiring and deployment of personnel, and even capital expenditures. The DOH budget also supports 70 centrally owned and managed public inpatient facilities, and four specialty centers (Dayrit, Lagarda, and Picazo et al. 2018; ADB and World Bank 2005; DOH 2011; Solon, Herrin, and Florentino et al. 2017; Romualdez, Rosa, and Flavier et al. 2011).

Other national government agencies also hold funds for health, administered through their own individual mechanisms. DSWD[2] receives funds as a budget from the national government, while Philippine Charity Sweepstakes Office[3] (PCSO) and Philippine Amusement and Gaming Corporation[4]

[2] The DSWD is the primary government agency mandated to develop, implement, and coordinate social protection and poverty-reduction solutions for and with the poor, vulnerable and disadvantaged.

[3] The PSCO is the principal government agency for raising and providing funds for health programs, medical assistance and services, and charities of national character. The PCSO holds and conducts charity sweepstakes, races, and lotteries and engages in health and welfare-related investments, projects, and activities to provide for permanent and continuing sources of funds for its programs.

[4] The PAGCOR is a government-owned and controlled corporation that regulates, operates, authorizes, and licenses games of chance, games of cards and games of numbers, particularly casino gaming in the Philippines. It generates revenues for the Philippine government's socio-civic and national development programs.

(PAGCOR) are government-owned and controlled corporations that can generate their own funds through their activities (Philippine Charity Sweepstakes Office 2020, Philippine Amusement and Gaming Corporation 2020).

Each level of the local government also has its own fund pool sourced from a combination of locally generated revenues and fiscal transfers from the national government, and intended primarily for constituents within its jurisdiction. Local governments exist at the provincial and city/municipality levels, which govern all public facilities not owned by the DOH. Around 95% of public facilities are locally owned. Provincial governments are typically in charge of public inpatient facilities. City and municipal governments are in charge of public PHC facilities, such as rural health units (RHUs) and barangay health stations (DOH 2011; Solon, Herrin, and Florentino et al. 2017; Romualdez, Rosa, and Flavier et al. 2011; Dayrit, Lagarda, and Picazo et al. 2018; ADB and World Bank 2005). The fund pools at each level of the local government are intended to finance the public facilities that they own.

Fiscal transfers through the IRA form part of a common fund pool which the local government uses for all its programs and activities, including health. Based on the Local Government Code of 1991, LGUs are entitled to a 40% share of the national internal revenue, automatically earmarked as IRA for distribution to local governments by the DBM at the start of every fiscal year. Of this, 23% are allocated for provinces, 23% for cities, 34% for municipalities, and 20% for barangays. The IRA is regarded as an unconditional block grant that aims to ensure equal distribution of resources across local governments to help finance their operations (Capuno 2009).

Premium collections and infusions are pooled together into one fund pool for PhilHealth where payments of PhilHealth benefits for all members are sourced from. Premium subsidies for indigents form part of the DOH budget, but are automatically downloaded to PhilHealth. In 2019, premium collections from paying members accounted for around 47% of PhilHealth's total fund base, with the remaining 53% coming from subsidies for indigents and vulnerable sectors (Figure 6). This forms the entire fund pool of PhilHealth for payment of benefits of its members. Internally, some of these funds are separated specifically for benefits of Lifetime Members[5], as well as for investment purposes[6] (PhilHealth 2013a; Bredenkamp, Gomez, and Bales 2017).

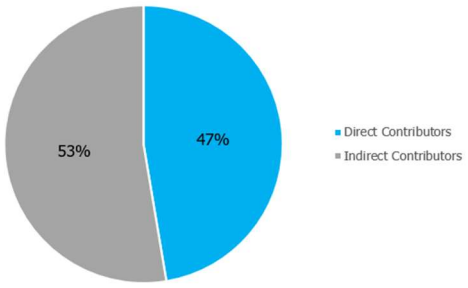


Figure 6. *Breakdown of PhilHealth premium contributions, 2019 (PhilHealth 2019).*

Purchasing

The DOH purchases health services through budgets for nationally owned health facilities, funding for technical assistance to public facilities in underserved areas, and special financial assistance programs that target the poor. Other national level agencies also finance services at the individual level through special financial assistance programs. These purchases from national government agencies are usually towards commodities, supplies, health facility investments, or human resource deployment (Table 1).

[5] Lifetime members are senior citizen members that have paid 120 months / 10 years' worth or premiums to the Corporation. They are no longer required to pay premiums but continue to be eligible for benefits of the NHIP.
[6] PhilHealth is allowed to invest a proportion of its reserve funds to certain investment portfolios for additional revenue generation.

Table 1. *DOH budget breakdown, 2019, in million PHP.*

ITEMS	DOH allotted budget for 2019, in million PHP			
	Personnel	Maintenance, Operating, and Other Expenses	Capital Outlay	Total
General Administration and Support	7,971	303	24	**8,297**
Support to Operations	990	471	579	**2,040**
Operations	33,875	37,223	16,218	**87,316**
Health Policy and Standards Development Program	100	125		**225**
Health Systems Strengthening Program	5,242	4,788	15,869	**25,899**
Public Health Program	610	16,854		**17,464**
Epidemiology and Surveillance Program	16	247		**263**
Health Emergency Management Program	8	463	300	**771**
Health Facilities Operation Program	27,198	5,249	49	**32,496**
Health Regulatory Program	702	115		**817**
Social Health Protection Program		9,382		**9,382**
Philippine Health Insurance Corporation		67,353		**67,353**
Lung Center of the Philippines		233		**233**
National Kidney and Transplant Institute		885		**885**
Philippine Children's Medical Center		1,083		**1,083**
Philippine Health Center		1,184		**1,184**
Philippine Institute of Traditional and Alternative Medicine		143		**143**
TOTAL	**42,836**	**108,878**	**16,821**	**168,534**

Source: DBM 2019a

Note: *Numbers are based on final budget reflected in the Government Appropriations Act. Blank cells indicate that the budget for these expenditure classes is not part of the allotment, and are usually sourced elsewhere (i.e. income of government owned and controlled operations). In the case of PhilHealth, the Maintenance, Operating, and Other Expenses budget reflects the premium subsidy for indigents and vulnerable groups. The Corporation has its own internal allocation mechanism to fund its other expenditure classes.*

Other national government agencies such as the DSWD, PCSO, and PAGCOR also provide financial support on a per patient basis, following their own screening and application protocols (DOH 2011) (Table 2).

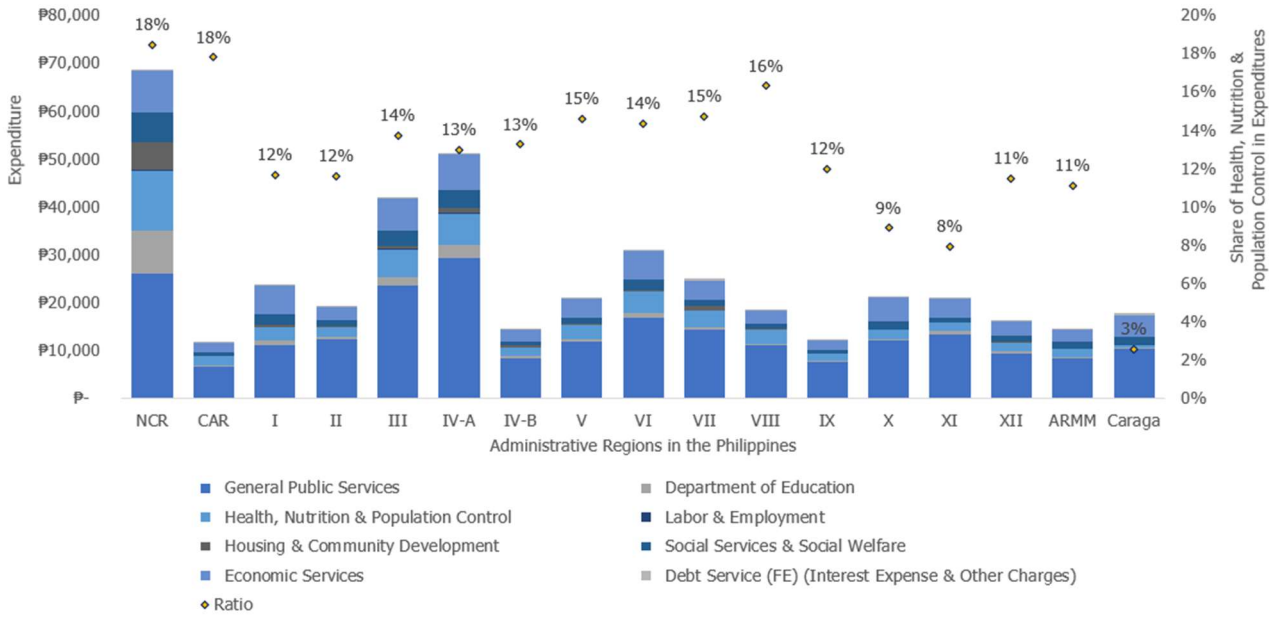
Table 2. *Financial assistance from national government agencies, 2017, in million PHP.*

National Agency	Financial Assistance for 2017, in million PHP
Department of Social Welfare and Development (DSWD)	2,000
Philippine Charity Sweepstakes Office (PCSO)	8,000
Philippine Amusement and Gaming Corporation (PAGCOR)	27,000
TOTAL	**37,000**

Source: DOH 2018

LGUs purchase health services from locally owned health facilities within their jurisdictions. Locally owned public facilities are appropriated budgets by their respective local governments to finance personnel salaries, operating expenses, as well as capital expenditures. Public inpatient facilities can procure their own supplies and commodities, while public PHC facilities procure through their local governments. Public inpatient facilities are also allowed to charge fees from patients in private rooms. LGUs are expected to allot around 15% to 22% of their budget for health as part of the LGU health scorecard of the DOH (DOH 2019b). However, this allocation is not mandatory since LGUs have full financial autonomy. Following regional aggregates for 2019, only NCR, CAR, Region VII, and Region VIII are within this range (Figure 7).

PhilHealth benefits range from outpatient to inpatient services, including catastrophic conditions. Public and private providers are accredited by PhilHealth for these benefits based on service capacity standards. Primary care benefit is paid through capitation, while inpatient services are paid through a case rates system (PhilHealth 2013b, 2013c). There are also bundled packages for outpatient specialist conditions responding to the Millennium Development Goals, and select catastrophic conditions called Z Benefit Packages (PhilHealth 2012, 2015). These different benefits cover costs for personnel, medicines, procedures, and diagnostics as applicable to the condition.



**NCR – National Capital Region; CAR – Cordillera Administrative Region; ARMM – Autonomous Region of Muslim Mindanao*

Figure 7. *Share of health in expenditures, 2019, in million PHP (DOF 2020).*

Public facilities owned and controlled by the DOH receive PhilHealth payments directly and have capacity to retain their income from these payments. However, payments for all other public facilities are made through a trust fund attached to their managing local government due to full financial control of LGUs over facilities they own following devolution (PhilHealth 2013a, 2020). These facilities also do not have their own legal identity and are represented in agreements with PhilHealth by their local governments. LGUs do not necessarily pass PhilHealth payments on to the facilities that claim them.

Private facilities account for around 65% of the health facility mix in the country. However, they do not receive any budget from the national or local government. These facilities charge user fees to patients within a highly unregulated market, and may also claim payments from PhilHealth and/or private health insurance companies if they are an accredited facility (PhilHealth 2018; DOH 2011; Solon, Herrin, and Florentino 2017; Romualdez, Rosa, and Flavier et al. 2011; Dayrit, Lagarda, and Picazo et al. 2018).

CHALLENGES IN THE HEALTH FINANCING SYSTEM

The health financing system in the Philippines involves complex layers of funding agents and governance mechanisms (Table 3). With financial resources coming from and flowing through different channels, inefficiencies are bound to surface. Studies have identified issues such as (1) low absorptive capacity of the DOH, (2) lack of clarity in purchasing roles leading to double payment, (3) inflationary effects of PhilHealth private sector payments, and (4) deficiencies in fund flows that undermine PhilHealth's strategic purchasing role

The DOH has continuously been challenged by low absorptive capacity leading to poor utilization of available funds. DBM has recognized the DOH as one of the three major government executive departments with low utilization of funds (DBM 2019b). In 2017, the DOH reported that 95% of its appropriated budget was obligated. However, only 62% of this total allotment was utilized at the end of the year. With the DBM shifting to cash-based budgeting where absorptive capacity is considered, the DOH experienced a 28% decrease in its appropriation from 2018 to 2019 (DOH 2019a).

Much of the low absorption in the past years was caused by low disbursements of maintenance and operating expenditures (medicines, supplies, and commodities) and capital outlay (equipment and infrastructure) (Monsod 2019; DOH 2019). Particularly for medicines and commodities, some of the biggest roadblocks are stringent rules on procurement, including price caps, as well as complex and time-consuming processes that have resulted in bid failures in the past, leaving obligated money unutilized (Cuenca 2019; Monsod 2016, 2019).

Table 3. *Summary of health financing functions in the Philippine public system.*

	Revenue Generation	Pooling	Purchasing
National (DOH)	Taxes	Fund pools across different agencies, facilitated by national legislation for budget appropriation	Health services and operations of centrally owned hospitals Technical assistance (drugs, commodities, human resources) for select LGUs
Sub-national (LGUs)	Local taxes and fiscal transfers from national government, and PhilHealth payments	Fund pool for each LGU level, facilitated by local legislation for budget appropriation	Health services and operations of locally owned hospitals
PhilHealth	Premium collections and premium subsidies	Single pool	Health services administered in accredited facilities for eligible members
Other national government agencies	Income generation and national budget	Individual pools	Health services for select individuals (application-based)

Source: Authors

Lack of clarity in the respective roles of DOH and PhilHealth leads to purchasing overlap and sometimes double payment, driving further inefficiency. Vertical programs of the DOH centrally procure commodities for certain primary care and outpatient specialist conditions such as tuberculosis, animal bite, maternal and child health, diabetes, and hypertension, which are then downloaded to RHUs. However, these RHUs may also apply for PhilHealth accreditation and claim payments intended to cover commodities for the same set of services. Similarly, public hospitals that receive budgets from the national or local government also file claims from PhilHealth to finance the same costs for the same services. PhilHealth rates are calculated based on the full cost of services in both public and private facilities, and so this "double dipping" for the same bundles of services provided by public facilities fails to optimize the resources available to the government.

PhilHealth payments to private providers drive inflation in the health sector. For services covered by PhilHealth case-based payments, the cost of PhilHealth benefits is first deducted from a patient's bill, with the remaining covered either by OOP or any other private insurance. However, there is no existing cost containment or provider negotiation mechanism, and providers are free to charge on top of the PhilHealth reimbursement for most members, with the exception of indigents in select facilities and accommodation types. A study of the National Demographic Health Surveys in the Philippines shows that the use of PhilHealth benefits to pay for healthcare is associated with higher average costs. Depending on the facility type, average cost can be higher by 244-865% for outpatient care and 135-206% for inpatient care (Haw, Uy, and Ho 2018; Obermann, Jowett, and Kwon 2018; Thatte, Hussain, and de Rosas-Valera et al. 2009; Obermann, Jowett, and Alcantara et al. 2006; Picazo, Ulep, and Pantig et al. 2015). PhilHealth benefits end up having inflationary effects on prices, particularly in private facilities, that are regrettably carried by patients.

Flow of payments to LGU-owned public facilities also undermines PhilHealth's intended strategic purchasing role. Since LGUs have full control and autonomy over their facilities, PhilHealth payments are not directed to the facilities but flow into a trust fund lodged at the local government. Trust funds are not exclusively for health, and benefit payments tend to get mixed with other funding, making them susceptible to re-allocation, repurposing, and even corruption (Banzon, Alcantara, and Diez et al. 2014, 2016; Azfar and Gurgur 2005; Olarte and Chua 2005). This intercession effectively cuts off PhilHealth's capacity to influence behavior at these facilities. In fact, some RHUs even choose not to file claims anymore because PhilHealth payments do not reach them.

THE UNIVERSAL HEALTH CARE LAW

The UHC Law is a landmark legislation that introduces wholesale reforms to the country's healthcare system. It was passed in February 2019, and its Implementing Rules and Regulations were completed and signed in October 2019. The UHC Law touches on several components of the health system, such governance and leadership, service delivery, health information systems, and regulation. These are discussed in the first brief of this series of UHC Law briefs[7]. Specifically, for health financing, reforms seek to embolden PhilHealth's role as the major and most strategic purchaser of health services.

Revenue generation

Contributions to PhilHealth shall consistently increase towards the maximum allowable rate, and may potentially double the current revenues collected from premium payments. Premium rates for paying members are currently set at 2.75% of monthly salary, split equally between the employer and employee. The UHC Law schedules increases in premium rates to the maximum allowable 5% based on the PhilHealth law, essentially doubling potential collections. Applied to total collections in 2019, this premium increase could have raised up to an additional PHP 69 billion. This does not account for potential increases in premium rates for indirect contributory members, whose contributions are shouldered by the government (Table 4).

[7] The SP4PHC UHC Law Series briefs can be accessed at: **https://thinkwell.global/projects/sp4phc/philippines/**

Table 4. *Revenues from PhilHealth premium payments, 2019, in million PHP.*

Membership type	Premium collections, in million PHP
Direct Contributory	69,365
Indirect Contributory	77,069
Grand Total	**146,435**

Source: PhilHealth 2019

Members naturally expect increases in premium rates to translate to a more comprehensive benefit package and/or greater financial protection within existing benefits. However, developing additional benefits, or enhancing current benefits, will also naturally take more incubation time than increasing premiums. PhilHealth will need to clearly communicate its benefit plans to manage expectations of its members, and to better position itself as the national purchaser.

Pooling

Risk pooling is maximized by automatic and default eligibility of all Filipinos to PhilHealth benefits, facilitated by a simpler, two-category membership scheme. While PhilHealth declares coverage above 90%, data from other household surveys only show coverage levels at around 60%, largely because many Filipinos are not aware that they are entitled to PhilHealth benefits (Bredenkamp, Gomez, and Bales 2017). The overly segmented membership types and the heavy emphasis on premium payments prior to benefit eligibility contributes to this.

The UHC Law assumes that all Filipinos are automatically members of PhiHealth, and as such are entitled to its full range of benefits. By making membership the default assumption, everyone then comes from an empowered position of knowing they are entitled to benefits. The two-category membership scheme - direct (paying) and indirect (subsidized) contributory (Table 5) also makes for simpler membership administration for PhilHealth. Moral hazards of this immediate eligibility may be expected since benefits will be accessible without premium payments. The UHC Law mandates PhilHealth to directly engage with non-paying members to complete their premium payments with interest. Currently, PhilHealth is working to set limits on the number of times an individual who has not paid premiums may claim benefits, but with difficulties in the management of membership databases, operationalization may still prove to be a challenge.

Current government financing of individual-based health services shall be pooled to PhilHealth. The UHC Law mandates PhilHealth to pool funds from other national agencies that finance healthcare such as PCSO, PAGCOR, and even the DOH budget for individual-based services. This will ensure that PhilHealth can take on its role as national purchaser, giving it the loudest financing voice.

Table 5. *Translation from current to new PhilHealth membership scheme.*

New categorization	Old categorization
Direct Contributors	Government Private Enterprise owner Household help or *kasambahay* Family driver Migrant workers Informal sector Self-earning individuals Organized groups Women about to give birth Filipinos with dual citizenship Naturalized Filipino citizens Citizens of other countries working or residing in the Philippines Foreign retirees
Indirect Contributors	Indigents - NHTS Senior citizens Bangsamoro Autonomous Region in Muslim Mindanao *Payapa at Masaganang Pamayanan* Program National government sponsored individuals Local government sponsored individuals Point-of-Service (vulnerable not initially targeted) Others

Source: adapted from DOH 2019c

Health funds, including PhilHealth prospective payments, shall be pooled at the province level through a Special Health Fund (SHF). The UHC Law

aims to consolidate an overly devolved system at the province-level, in terms of technical, managerial, and financial responsibilities. This will ensure that care can be better coordinated from primary to tertiary levels, and resources can be more strategically distributed across expenditure needs. PhilHealth payments for public facilities will be transferred to a SHF at the provincial level. The UHC Law ensures that resources transferred to the SHF are ring-fenced specifically for health and cannot be repurposed for any other expenditure. PhilHealth will be able to clearly monitor fund utilization and match this with provider performance. However, the LGU Code of 1991 means that the UHC Law does not and cannot mandate local governments to integrate at the province-level. DOH and PhilHealth shall work together to encourage and incentivize provinces to integrate and establish consolidated SHFs.

Purchasing

Under the UHC Law, financing of health services is clearly delineated between the DOH and PhilHealth to avoid duplication and strengthen purchasing roles. The DOH, together with LGUs, shall finance population-based health services[8]. DOH and LGUs will continue to be responsible for paying salaries of public sector staff in the facilities they manage. The role of PhilHealth in financing these salaries through the SHF is still under discussion. PhilHealth on the other hand, shall finance individual-based health services[9], which currently accounts for around 85% of THE (Figure 9) (DOH 2018). This direction of shifting a lion's share of the expenditures aims to position PhilHealth as the national purchaser of health services in the country.

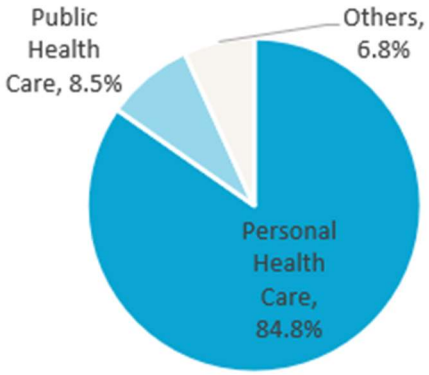


Figure 9. *Breakdown of type of health services and contribution to THE (adapted from DOH 2018).*

Prevailing government rules mean that the DOH can only engage private entities through competitive bidding and procurement. Private facilities often find this inefficient and tedious. Since private providers typically provide individual-based health services, shifting purchasing of these to PhilHealth presents an opportunity to better leverage the capacity of the private sector. PhilHealth can offer incentive systems and front-loaded payments administered through contracts, giving government stronger and more effective stewardship over private facilities.

With the current overlaps in purchasing roles, several elements in the financing landscape will need to undergo adjustments. The current budget of DOH for individual-based health services will have to be transferred to PhilHealth either as direct budget transfers, or as increases in premium subsidies. Similarly, PhilHealth will also have to prepare to demonstrate the additional value it is offering because of this extra funding, for example by increasing benefits or financial cover.

PhilHealth provider payment mechanisms shall be strengthened to enable strategic purchasing. This expansion of resources will go to waste if they are not utilized correctly. Providers shall now be contracted by PhilHealth through prospective, performance-based payments, complemented by strong cost containment mechanisms. In particular, case-based payments shall be upgraded into

[8] Population-based health services are defined as health services or goods that cannot be definitively traced back to a singular beneficiary, i.e., health promotion, disease surveillance, vector control, etc.
[9] Individual-based health services are defined as health services or goods that can be definitively traced back to one beneficiary, i.e., primary care, inpatient, medicines, diagnostics, laboratory tests, etc.

diagnosis-related groups-based global budget payments. However, PhilHealth currently has limited experience in terms of prospective payment mechanisms such as global budget, and its internal mechanisms will need review to manage diagnosis-related groups (DRGs). The capacity of providers to manage pre-payment also merits attention to ensure efficient use of PhilHealth funds.

CONCLUSION

The UHC Law reforms the health financing landscape in the country by reorganizing roles of institutions, shifting towards more prepayment schemes, and improving overall purchasing arrangements. These reforms are summarized in Table 6. The roles of DOH, LGUs, and PhilHealth in financing healthcare are clearly delineated. This defines the purpose and accountability of each fund pool even in a devolved set-up and puts the government in a better position to mobilize and leverage its resources. The goal is to lessen reliance on OOP spending, and shift more heavily towards prepayments in the form of government allocated budget and PhilHealth payments. Reforms to make PhilHealth the major purchaser will also transform purchasing from input-based towards performance-driven payments that reward outputs, efficiency, and results. PhilHealth will also take advantage of its wider redistributive capacity to pool funds and pre-pay services from both public and private facilities. PhilHealth's contracting capacity should enable it to hold LGUs and providers accountable in a way that the DOH cannot, because of devolution. Ultimately, these policy changes will make government purchasing of health care in the Philippines more strategic.

Table 6. *Summary of relevant Philippine UHC Law reforms per health financing function.*

Health financing function	Current	Future
Revenue Generation	Low premium rates	Scheduled increases in premium rates to expand fiscal capacity of PhilHealth
Pooling	Overly segmentized membership scheme that fail to facilitate member awareness and empowerment to benefits	Automatic eligibility facilitated by a simpler, two-category membership scheme
	Fragmented pools of funds across national and local government agencies	Clear delineation in purchasing roles, with consolidation of funds to PhilHealth as national purchaser; local government fund pooling at the province-level through a SHF
Strategic Purchasing	Inadequate PhilHealth benefit for primary care leading to minimal private sector participation	Primary care services regarded as individual-based health service, to be financed by PhilHealth through a comprehensive outpatient benefit package, which include outpatient medicines and emergency
	Retrospective case-based payments through an All Case Rates (ACR) System	Prospective, closed-end, performance-based payments through DRG-GB as the primary payment mechanism for inpatient care
	Individual payments for facilities facilitated mostly by an accreditation scheme	Contracting of healthcare provider networks that provide continuing and coordinated primary to tertiary care

Source: Authors, with inputs based on the UHC Law

The health financing reforms of the UHC Law necessitate major paradigm shifts and capacity building and re-building. The expectation from PhilHealth to be the national strategic purchaser is a massive responsibility and will require institutional changes to adapt. Mechanisms to facilitate front loaded payments and provider contracting will have to be put in place, and in-house capacities need to match the demands of these new processes. Innovative policies will be needed to ensure that gaps related to financing of commodities, management of public sector salaries, and voluntary payments of informal economy members are addressed. Improved engagement with the private sector will be crucial. All these will naturally take time, and the transition will need to be carefully monitored to ensure success of the reforms.

Through its SP4PHC project, ThinkWell Philippines provides technical assistance in evidence-generation, analytics, and policy development for both DOH and PhilHealth to operationalize the vision for PhilHealth and the entire health sector reform at large. Key areas of focus include provider payment reform, private sector engagement, formation of health care provider networks, as well as integration of local health systems. The next part of the series shall look at provider payment reforms of PhilHealth, its current issues and challenges, and how the UHC Law seeks to address them.

Recommended citation:
Nuevo, Christian Edward, Jemar Anne Sigua, and Matt Boxshall. 2020. "Health Financing in the Philippines. The Philippine UHC Law Series: Brief 3." Washington, DC: ThinkWell.

SP4PHC is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation.

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

REFERENCES

Asian Development Bank and World Bank. 2005. Decentralization in the Philippines: Strengthening Local Government Financing and Resource Management in the Short Term.

Azfar O and Gurgur T. 2005. Does Corruption Affect Health and Education Outcomes in the Philippines?

Banzon EP, Alcantara, MGL, Diez MA, Sayson LA. 2014. Analysis of the Maintenance and Depreciation Costs and other Requirements of Selected Government Hospitals. Philippine Institute for Development Studies. Discussion Paper Series No. 2014-50.

Banzon EP, Alcantara MGL, Diez MA, Sayson LA. 2016. How budgeting practices on healthcare equipment may fail government hospitals. Philippine Institute for Development Studies. Discussion Paper No. 2016-27.

Bredenkamp C, Gomez V, and Bales S. 2017. Pooling Health Risks to Protect People: An Assessment of Health Insurance Coverage in the Philippines

Capuno J. 2009. A case study on the decentralization of health and education services in the Philippines. Human Development Network. HDN Discussion Papers Series No. 3.

Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. 2017. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva: World Health Organization; Health Financing Working Paper No. 17.4.

Congress of the Philippines. 1991. Republic Act 7160. An Act Providing for a Local Government Code of 1991.

Congress of the Philippines. 1994. Republic Act 7875. An Act Instituting A National Health Insurance Program For All Filipinos And Establishing the Philippine Health Insurance Corporation for the Purpose.

Congress of the Philippines. 2012. Republic Act No. 10351: An Act Restructuring the Excise Tax on Alcohol and Tobacco Products by Amending Sections 141, 142, 143, 144, 145, 8, 131 and 288 of the Republic Act No. 8424 Otherwise Known as the National Internal Revenue Code of 1997,

as Amended by Republic Act No. 9334, and for Other Purposes.

Congress of the Philippines. 2019. Republic Act No. 11223. An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor.

Cuenca, JS. 2019. A Note on the 2019 President's Budget. Philippine Institute for Development Studies. Discussion Paper Series No. 2019-04.

Dayrit MM, Lagrada LP, Picazo OF, Pons MC, Villaverde MC. 2018. The Philippines Health System Review. Vol. 8 No. 2. New Delhi: World Health Organization, Regional Office for SouthEast Asia.

Department of Budget and Management. 2019. Government Appropriations Act FY 2019.

Department of Budget and Management. 2019. Reforming the Philippine Budgeting System: A Modern and Open Cash-Based Budget for Disciplined, Accountable, and Faster Service Delivery.

Department of Finance. 2020. Bureau of Local Government Finance. Local government Statements of Receipts and Expenditures.

Department of Health. 2011. 2011-2016 National Objectives for Health, Health Sector Reform Agenda Monographs.

Department of Health. 2015. Sin Tax Law Incremental Revenue for Health Annual Report CY 2015. Details on Expenditure of the Amounts Earmarked for Health.

Department of Health. 2018. National objectives for health Philippines 2017-2022. Manila, Philippines: Department of Health.

Department of Health. 2019a. Department of Health Budget Briefer FY 2019. Health Policy Development and Planning Bureau.

Department of Health. 2019b. Department Memorandum No. 2019 – 0464. Implementation of LGU Health Scorecard Performance Results for 2019.

Department of Health. 2019c. Implementing Rules and Regulations of the UHC Law (RA 11223).

Hanson K, Barasa E, Honda A, Panichkriangkrai W, Patcharanarumol W. 2019. Strategic purchasing: the neglected health financing function for pursuing universal health coverage in low-and middle-income countries comment on "what's needed to develop strategic purchasing in healthcare? policy lessons from a realist review". Int J Health Policy Manag. 2019 08 1;8(8):501–4.

Haw NL, Uy J, and Ho BL. 2019. Association of SHI coverage and level of healthcare utilization and costs in the Philippines: a 10-year pooled analysis, Journal of Public Health, fdz142.

Kutzin J. 2013. Health financing for universal coverage and health system performance: concepts and implications for policy. Bulletin of the World Health Organization 2013;91:602-611.

Monsod, TC. 2016. Government "underspending" in perspective: Incompetence, inertia, or indigestion? UP School of Economics Discussion Paper No. 2016-12.

Monsod TC. 2019. Budget Credibility in the Philippines' Health Sector: Regional Comparisons and Case Studies. International Budget Partnership.

Obermann K, Jowett MR, Alcantara MOO et al. 2006. Social health insurance in a developing country: the case of the Philippines. Soc Sci Med 2006;62(12):3177–85

Obermann K, Jowett M, Kwon S. 2018. The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis. Glob Health Action 2018;11(1).

Olarte AM and Chua YT. 2005. Up to 70% of local funds lost to corruption. Philippine Center for Investigative Journalism.

Philippine Amusement and Gaming Corporation. 2020. PAGOR Charter. https://pagcor.ph/transparency/docs/pagcor-charter.pdf, accessed Sep 2020.

Philippine Charity Sweepstakes Office. 2020. PCSO Charter RA 1169. https://www.pcso.gov.ph/About/Mandate/PCSOCharter.aspx, accessed Sep 2020.

Philippine Health Insurance Corporation. 2012. PhilHealth Circular No. 048, s.2012. Implementing Guidelines on the Z Benefit Package.

Philippine Health Insurance Corporation. 2013a. The Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606).

Philippine Health Insurance Corporation. 2013b. PhilHealth Circular No. 0031, s.2013. All Case Rates (ACR). Policy No. 1 -- Governing Policies in the Shift of Provider Payment Mechanism from Free-For-Service to Case-Based Payment.

Philippine Health Insurance Corporation. 2013c. PhilHealth Circular No. 0035, s.2013. ACR Policy No. 2 -- Implementing Guidelines on Medical and Procedure Case Rates.

Philippine Health Insurance Corporation. 2015. PhilHealth Circular No. 2015-035. The Guiding Principles of the Z Benefits.

Philippine Health Insurance Corporation. 2018. PhilHealth Stats and Charts 2018. Retrieved from https://www.philhealth.gov.ph/about_us/statsncharts/snc2018.pdf, accessed Sep 2020.

Philippine Health Insurance Corporation. 2019. Fiscal Report as of December 31, 2019. https://www.philhealth.gov.ph/about_us/transparency/accomplishment_report/FS_4thQtr2019.pdf

Philippine Health Insurance Corporation. 2020. PhilHealth Accreditation of Institutions and Providers. https://www.philhealth.gov.ph/partners/providers/, accessed Sep 2020.

Philippine Statistics Authority. 2019. Philippine National Health Accounts. https://psa.gov.ph/pnha-press-release/tables-year/2018, accessed Sep 2020.

Picazo OF, Ulep VGT, Pantig IM et al. 2015. A Critical Analysis of Purchasing of Health Services in the Philippines: A Case Study of PhilHealth. Manila: Philippine Institute of Development Studies; 2015 (Discussion Paper). Report No.: 2015-54. http://dirp3.pids.gov.ph/websitecms/CDN/PUBLICATIONS/pidsdps1554.pdf.

Romualdez JR. A, Rosa J, Flavier J, Quimbo S, Hartigan-Go K, Lagrada L, et al. 2011. The Philippines Health System Review. Vol. 1 No. 2. Manila: World Health organization, Regional Office for the Western Pacific.

Solon OJC, Herrin AN, Florentino JL. 2017. Health Care Financing. UPEcon Health Policy Development Program.

Thatte U, Hussain S, de Rosas-Valera M et al. 2009. Evidence-based decision on medical technologies in Asia Pacific: Experiences from India, Malaysia, Philippines, and Pakistan. Value Health J Int Soc Pharmacoeconomics Outcomes Res 2009;12(Suppl 3):S18–25

World Health Organization. 2010. World health report 2010: health systems financing: the path to universal coverage. Geneva: World Health Organization.

World Health Organization. 2017. Strategic purchasing for UHC: Unlocking the potential. Global meeting summary and key messages; 2017 Apr 25–27; Geneva, Switzerland. Geneva: World Health Organization.