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PERSPECTIVES ON IMPLEMENTING OBJECTIVE-ORIENTED HEALTH REFORMS

Staying the Course: Reflections on the Progress and Challenges of the UHC Law in the Philippines

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ABSTRACT

The Philippine Universal Health Care (UHC) law enacted in 2019 aimed to address entrenched health system challenges to achieving equitable access to quality health care. This commentary discusses the progress in its implementation to meet its objectives. Some of these health system challenges include overlapping financing roles; weak incentives for integrating health services across local government units (LGUs), the inclusion of the private sector in networks of care, and fragmented primary health care services. The UHC law introduced reforms to transform the Philippine Health Insurance Corporation (PhilHealth) into a strategic purchaser of health services, expand population coverage, and prioritize comprehensive outpatient and primary care services. Furthermore, the law mandated bolstering subnational health financing through a Special Health Fund (SHF) intended to encourage LGUs to integrate into provincial or city health systems. Pilots of the SHF highlighted opportunities and challenges in pooling, prioritizing, and redistributing resources if local health systems are capacitated. Despite facing implementation challenges, including changing priorities, politics, and lack of resources, the Philippines' experience emphasizes the importance of adaptive leadership, sustained commitment, and effective stakeholder engagement to ensure that these health financing reforms remain objective-oriented. Maximizing the UHC law's potential going forward requires addressing ongoing challenges: sustained resource generation, ensuring effective coverage of the poor, and capacitating local health systems. The journey of the Philippines toward UHC offers valuable insights for global health reformers, underscoring the need for adaptive approaches and active political engagement to sustain and achieve progress toward universal and equitable health care access.

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Introduction

The Philippines enacted the Universal Health Care (UHC) law in 2019 to mandate radical structural reforms of the health system. The law's explicit objective is to progressively realize equitable access for all Filipinos to quality and affordable health care goods and services, while ensuring financial risk protection through a systemic approach and clear delineation of roles.[1] This focus on equity stems from the fact that, even with increased public funding for health and improvements in health outcomes and coverage indicators in the past decade, inequities across wealth quintiles and between urban versus rural areas persist.

Health expenditure in the Philippines more than doubled between 2015 and 2022. Over the same period, out-of-pocket expenditure as a share of current health expenditure decreased from 51% to 45%, while the government's share of health spending increased from 39% to 45%.[2,3] Although overall rates are improving, the average infant mortality rate for the three poorest wealth quintiles is more than double that of those in wealthier quintiles. Institutional deliveries have increased to 88% in 2022, but the percentage of births in a health facility is higher in urban versus rural areas and increases with wealth.[4]

Despite facing many challenges over the past four years, the country has made progress in implementing the UHC law.[5,6] In this commentary, we discuss the country's progress in utilizing the law to address the systemic barriers to UHC and reflect on how the reform process has ensured it remains focused on the overarching objectives.

Discussion

The Challenges of a Fragmented Health Financing System

Despite (or perhaps due to) past reforms, the Philippines' health financing system faces four main issues. The first issue is a lack of delineation among the roles of subnational or local government units (LGUs), the Department of Health (DOH), and the

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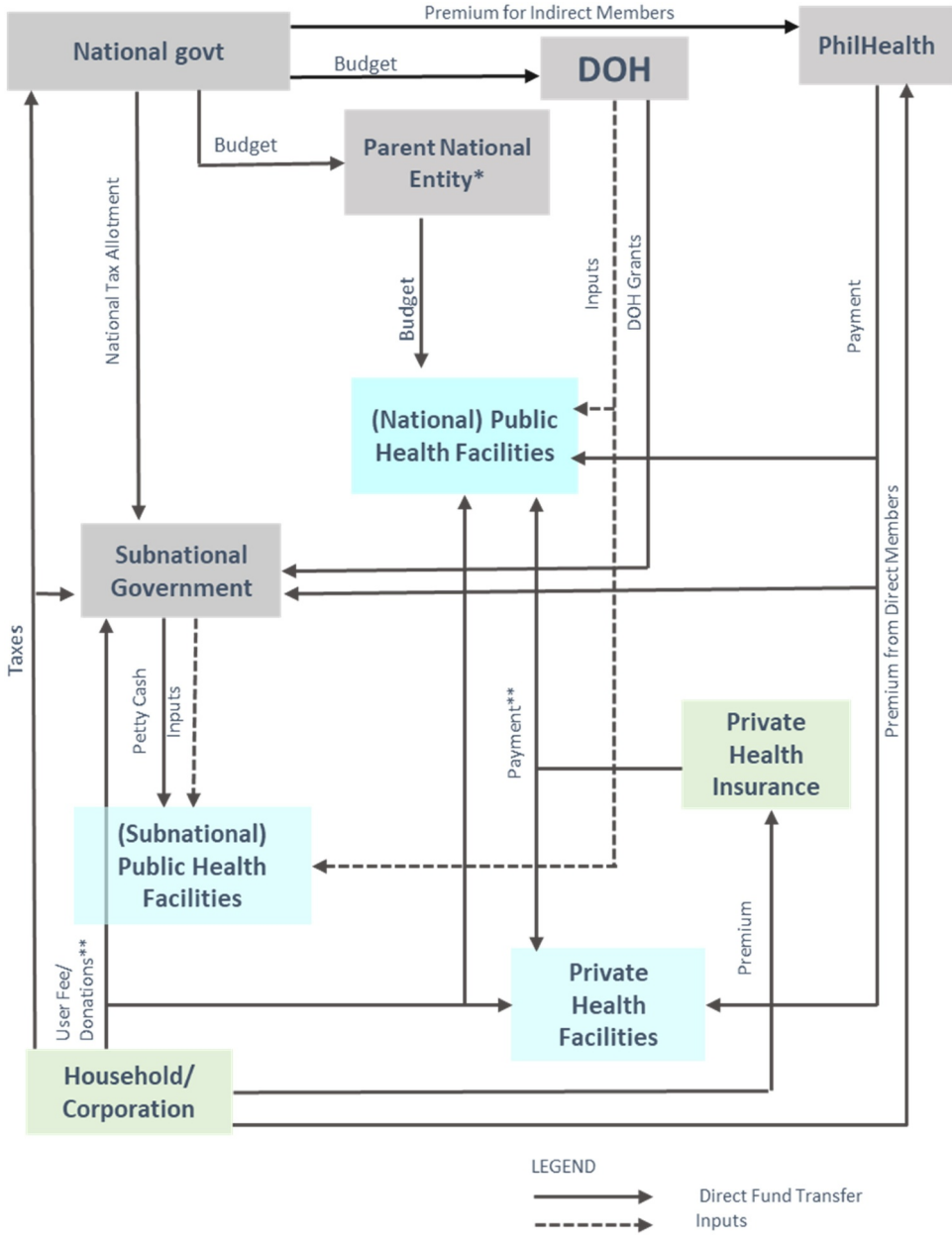

Figure 1. Simplified diagram of Philippine health system funding flows. Source: Authors *National entities include DOH, other national ministries, and state universities **Some subnational hospitals receive user fees—these collections are transferred to the LGU. Rural Health Units generally do not collect user fees.

Philippine Health Insurance Corporation (PhilHealth). This situation resulted from disjointed reform efforts following the devolution of the Philippines's health system in 1991 (Figure 1).[7] Devolution granted LGUs both responsibility and administrative and fiscal autonomy for health services. However, the LGUs were ill-prepared for such responsibilities, so the DOH continued providing inputs, including staff, commodities, and equipment. The creation of PhilHealth in 1995 changed payment for health services from a budget-line finance model to one that was demand-side driven through private and public providers. However, overlaps remained among the premium-funded benefits by PhilHealth and the tax-funded services by LGUs and DOH, leading to confusion in accountability, duplication of payments, and a lack of coherence in financial coverage.[4] Additionally, there is a lack of complementarity of financing between PhilHealth, which should cover all Filipinos, and other private health insurance (PHI), which mostly covers the formally employed segment of the population.

The second issue is the structural and political nature of subnational health financing, which has led to

challenges in care coordination across jurisdictions. Each LGU has its own geographic and technical scope, with municipalities and provinces tasked with providing primary and tertiary care, respectively, to their constituents. There is no clear mandate for secondary care, so some municipalities and provinces also provide this service. Each LGU manages multiple pools of funds from various sources whose divergent natures pose challenges to effective and efficient utilization. Elected local chief executives, supported by variably-skilled finance and health bureaucrats, are the primary decision-makers for these resources.[4]

Third, a limited number of financial mechanisms exist to integrate private health providers into local networks of care. The private sector accounts for most of the health services delivered in the country, operating in parallel with government-owned healthcare facilities. DOH and LGUs must undertake a lengthy process to purchase services from private providers. PhilHealth can purchase more services from private providers, who constitute 42% of their accredited facilities (2022).[8] However, PhilHealth needs to improve its incentive structure to ensure services are integrated across types and levels of providers and include the private sector.

Fourth, how primary health care (PHC) services are financed and organized is profoundly fragmented. Budgets for the DOH's various health programs (such as for family planning, tuberculosis, and malaria) are planned and implemented separately to provide additional personnel, capital expenditures, supplies, and commodities to subnational systems. Municipal LGUs maintain primary care teams (under the direct supervision of a physician) but structure their budgets and service delivery as vertical health programs. The vertical model for delivery of health services is a reflection of how the country struggles to implement comprehensive and life-stage appropriate primary care.

Combined, these four issues result in a fragmented health financing system, which continues to hinder the country's progress toward ensuring better and more equitable health outcomes. Out-of-pocket expenditure remains high, and money is the biggest hindrance to access to private health care among poor people.[9] At the same time, access to quality and comprehensive health services in the public sector may be affected by each LGU's individual socio-economic profile and health investments. Additionally, the geographic scope of each LGU can limit constituents' access to public health services beyond their residential areas, and no mechanisms exist for redistribution or resource-sharing between LGUs. Thus, financing mechanisms are severely limited in how they contribute to ensuring that resources generate equitable health outcomes through PHC.

Progress of Financing Reforms Under the UHC Law

After lengthy deliberation, the UHC law introduced interventions (Table 1) to address the country's fragmented health financing system. Broadly, the law aims to strengthen national capacity for strategic purchasing of comprehensive health services for all Filipinos. Additionally, it seeks to improve subnational financing mechanisms through implementation of a Special Health

Table 1. Financing reforms in the UHC law to address fragmentation.

Financial fragmentation challenge	Mandate(s) in the UHC law	Progress (as of publication)
Lack of delineation among purchasers (DOH, PhilHealth, LGUs, and PHI)	• PhilHealth becomes the strategic purchaser of individual-based health services for all Filipinos through ○ Simplified PhilHealth membership ○ Increased resources from direct members' premium increases and additional national funds transfers ○ Prospective provider payment methods to HCPNs • DOH and LGUs will pay for population-based services • Ensure complementary coverage of PhilHealth and PHIs	• Official policy has been released delineating individual- and population-based services • PhilHealth is implementing simplified membership, has increased premium rates (but delays persist in shifting provider payment methods) • Ongoing deliberations on ensuring benefit complementarity between PhilHealth and PHIs
Fragmented funding pools for LGUs	• Integrated PCWHS are mandated to create a common SHF	• Ongoing pilots of SHF contracting mechanisms
Misaligned incentives for public- and private-sector providers	• Delineates purely public, purely private, or mixed (with public and private providers) HCPNs • PhilHealth contracts HCPNs for delivery of individual-based services	• DOH policy guidance for PCWHS released on engaging the private sector
Fragmented financing for primary health care services	• PhilHealth is mandated to create a comprehensive outpatient benefits package purchased through HCPNs	• Improved selective PhilHealth benefits for primary care approved as an interim measure • Lack of complementarity among DOH funding for vertical PHC programs, PhilHealth, and LGU financing continues

Fund (SHF) for re-integrated provincial- or city-wide health systems (PCWHS). The SHF will pool PhilHealth, DOH, and other monies that flow to PCWHS and their healthcare provider networks (HCPNs).[1]

Transforming PhilHealth to Become the National Health Strategic Purchaser

The UHC law put the onus on PhilHealth to become the strategic purchaser of comprehensive health services for all Filipinos. Making purchasing "strategic" means that purchasing decisions use information (on provider behavior and population needs) to attain efficiency, equity, and financial protection.[10] In the years since the law was passed, PhilHealth has progressively introduced new programs to expand population, service, and financial coverage. These changes may have increased the utilization of PhilHealth benefits and access to health services by poor people in the past decade.[11] However, these policies have had a limited impact on ensuring health outcomes and financial protection.[12] The UHC law clarified purchasing roles and responsibilities among financing agents by tasking PhilHealth with purchasing individual-based health services. Additionally, in order to address the fragmented purchasing of PHC services, the law required PhilHealth to provide comprehensive outpatient and primary care services for all Filipinos. To facilitate this, the law granted all Filipinos immediate eligibility for PhilHealth coverage, simplifying membership based on the source of the premium. Direct members source premiums from wages, while indirect members' premiums are paid from national taxes. Much of the increase in PhilHealth's resources that was needed for UHC law implementation was generated by these gradual increases in direct contribution rates.

However, implementing the reforms has been complicated by several challenges, including strains created by the COVID-19 pandemic, several public scandals,[13–16] and various changes in leadership at PhilHealth[17–21] and DOH.[22] For example, the premium increase for direct contributors was deferred in 2021 to accommodate for the economic burden of the COVID-19 pandemic.[23,24] Meanwhile, gaps remain in expanding effective coverage for the poor. The number of indirect members has not in fact increased beyond the 39 million who were already covered before implementation of the UHC law[8] (following identified through earlier mechanisms, such as the National Health Targeting System or Point-of-Service enrollment). Their premiums continue to be paid mainly from earmarked tobacco and alcohol tax revenues, as legislated in the Sin Tax Reform Act of 2012.[25]

Improvements in expanding inpatient and outpatient benefits have also been slower than originally projected. While case rates were updated in 2024, the proposed transition to diagnosis-related groups is slow, hampered in part due to insufficient investment in the necessary information systems. Further, uncertainty about the strategy for improving benefit design has impeded the transition to a comprehensive outpatient benefit package.[26] PhilHealth has also struggled to engage enough health facilities and networks providing care with sufficient quality to deliver the benefit packages. Some facilities have been reluctant to join, especially given frequent payment delays.[5] Thus far, total benefit payments have stagnated, while premium collections have increased.[27] This leads to a vicious cycle of ineffective purchasing, limiting PhilHealth's ability to gain public trust and leverage additional government resources to meet the mandates of the UHC law.[28,29]

Bolstering Subnational Health Financing Through the Special Health Fund

The mandates of the UHC law affect the LGUs' key health financing processes. The UHC law seeks to address the fiscal fragmentation of subnational systems, encouraging LGUs to voluntarily integrate into PCWHS to coordinate all aspects of health care. To support this approach, LGUs that opt to integrate are slated to get incentives to restructure local health boards and secretariats to strengthen their supervision of pooled resources from the SHF. Subnational public financial management processes regulate the execution of these funds.[30]

The country only recently started piloting the SHF. PhilHealth initiated pilot programs for contracting public and private networks to deliver the primary care benefit package.[31] The pilots aim to create opportunities to use the SHF to pool, prioritize, redistribute, earmark, and spend available resources. However, whether the public and private sectors can work cohesively within one network remains to be seen. Results from early tests stressed the need to capacitate LGUs in public financial management for health. Before fully rolling out these reforms, much more needs to be tested, modeled, and evaluated. Indeed, the law mandates that local health system reforms should be assessed in 2025 (a subnational election year).

Lessons in Sustaining Reforms Working Toward Objectives

As in other countries dealing with objective-oriented health systems reform, the Philippines has had to resolve various complex, entrenched, and interconnected problems in order to achieve better and more

equitable health outcomes. The country's efforts to strengthen national strategic purchasing mechanisms must be aligned with improving the systems and capacities of LGUs and health facilities to ensure that increasing financing effectively translates to outcomes.[32] Even as PhilHealth transforms into a strategic purchaser, the financial management systems of both LGUs and public-sector healthcare providers also need to be developed to efficiently manage increased resources. Building the capacity of one without reaching the other is likely to dilute the overall impact of the UHC law. However, ensuring sufficient attention to addressing these problems can be challenging in the face of limited resources for reform.

The approval of the UHC law opened a "policy window" that created attention and resources, but this did not happen randomly or in a vacuum. It resulted from an active and adaptive process of understanding problems, generating solutions, and intensive political engagement. Policymakers built on existing mechanisms, such as funding sources and mechanisms to provide coverage for the poor, and defined new solutions, such as the SHF. Implementation of the law has been shaped by the need to scrutinize new opportunities and challenges that emerge in changing contexts, such as the shifts in politics and economic conditions brought about by the shock of the pandemic. Emerging understandings and new framing of concepts in health financing (such as the importance of health public financial management[33,34] or how health facilities should be financed[35]) have also influenced the direction of the reforms. The practitioners managing the reform process have had to be flexible in designing policies within changing understanding and parameters.

Reviewing the events surrounding the adoption and implementation of the UHC law reaffirms that health financing reforms cannot be divorced from politics at any stage of the policy cycle. The design and approval of the law took more than two years of policy engagement by local reformers. PhilHealth and DOH continue to be accountable to the Philippine Congress for the increased revenue they generate and to ensure effective PHC financing. Sustained subnational-level reforms need ongoing commitment from LGUs, who in turn demand proof that the SHF results in efficient financing for outcomes.[36] While navigating political scrutiny and discourse can be difficult, reformers need to keep the conversations technically precise, solutions-focused, and objectives-oriented. Instead of dwelling on blame and failure, consolidating lessons learned from the development and implementation of reforms will enrich this discourse to guide future policies and legal amendments to effectively address the challenges of achieving UHC. Options include using taxes more, to simplify resource generation,[37–39] using technology for effective strategic purchasing,[40] and working toward public providers' financial autonomy.[41]

This brings us to reflect on how the Philippines (and other countries) could be better supported as they strive to reform health financing systems to achieve target outcomes.[42] The Philippine experience highlights the reform process' uncertainties, challenges, and messy realities.

Although there are various tools[43,44] to help manage the messiness, we want to emphasize the important role of health financing reformers—at all system levels—to lead these processes, to achieve the intended results, and to ensure that reforms stay the course despite complex, dynamic, and politicized reform processes. The Philippine experience, much like other countries,[45] highlights that reforms cannot be done in isolation from the many stakeholders that will be part of design, implementation, and institutionalization (and, perhaps, eventual revocation). In addition to technical capacity in systems and strategic thinking, data-driven decision-making, resource management, and finance, reformers also need "softer" skills in, for example, effective communication, change management, community engagement, cross-sectoral partnership, and justice, equity, diversity, and inclusion.[46] For health reforms to remain objective-oriented, reformers must continue to engage with stakeholders to debate, dialogue, promote acceptance, and create consensus on a shared vision of change.

Conclusion

The UHC law has not yet been fully implemented, but it has already introduced key mandates to address the longstanding issues of fragmented health financing and service delivery. Notable progress has been made, but many challenges remain to ensure that reforms to the health system remain objective-oriented. Issues, such as sustaining resource generation, bolstering outreach to indirect members, accelerating development of PHC incentives, and capacitating local health systems, need continual attention. Doing so would maximize the UHC law's potential to achieve universal and equitable health care access for all.

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