Social Protection in Action: Building social protection floors for all

Country Brief: The Philippines

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Extending Social Health Protection in the Philippines: Accelerating progress towards Universal Health Coverage

1. Introduction

Health is recognized as a human right by the 1987 Philippine Constitution, which declares that "the State shall protect and promote the right to health of the people." To this end, remarkable progress has been made towards the achievement of universal health coverage (UHC) in the Philippines over the last decade. Currently, the national health insurance programme (NHIP), administered by the Philippine Health Insurance Corporation (PhilHealth), covers 85 per cent of the population, including more than 18 million workers in the informal economy and their dependents. Rapid expansion of population coverage was supported by sin tax revenues, demonstrating the important role of collectively financed mechanisms to cover the costs of accessing health care.

Despite impressive progress in terms of population coverage, obstacles related to low quality of care, high out-of-pocket (OOP) spending, limited accessibility of services and low utilization rates among the poor are currently stalling progress towards UHC. To lay the foundations for the comprehensive reforms necessary to expand financial protection and access to health services for all, the government passed the Universal Health Care law in 2019, [1] the implementation of which is expected to respond to the main challenges of the social health protection system.

2. Context

The Government of the Philippines introduced Medicare, the country's first mandatory health insurance scheme for public and private sector employees, in 1969, through the Social Security System (SSS) and Government Service Insurance System (GSIS). Just over three decades later, the National Health Insurance Act of 1995 established PhilHealth —the national health insurance organization responsible for the implementation of the single-payer fund, NHIP. [2] This move

[1] Implemented through the Congress of the Philippines, Republic Act No. 11223 Instituting Universal Health Care for All Filipinos, available at: https://lawphil.net/statutes/repacts/ra2019/ra_11223_2019.html.

[2] While the Government Service Insurance System (GSIS) and the Social Security System (SSS) are responsible for the pension plans of public and private sector employees, PhilHealth provides health insurance.

towards a single pool, with PhilHealth as the main purchaser, has been utilised by the Filipino Government to work towards the expansion of coverage to all segments of the population, including those in the informal economy and other hard-to-reach groups.

Significant milestones include, among others, the introduction of a Sponsored Programme for poor households and a no-balance-billing policy for these households. To facilitate the enrolment of informal economy workers, partnership programmes were launched with Organized Groups and microfinance institutions in 2003 and 2006, respectively. Funded by an increase in taxes on tobacco and alcohol, full subsidies were also extended to the poor and the near-poor in 2012 through the amendment of the National Health Insurance Law. Efforts towards expanding coverage have been furthered through the 2019 Universal Health Care Act, which aims to facilitate automatic enrolment of all citizens onto PhilHealth, enhance financial protection, improve the quality of health facilities (especially in underserved areas), respond to health gaps, and improve health service delivery.

3. Design of the social health protection system

- Financing

In 2019, total health expenditure stood at 906 billion Philippine Peso (PHP), equivalent to 4.6 per cent of the national GDP (Philippine Statistics Authority 2020). The main financing sources of the health system include the following: public health expenditure, comprising general government revenues and mandatory social health insurance contributions, accounting for 42 per cent of total health expenditure (THE); voluntary social health insurance contributions, comprising 10.1 per cent of THE; and OOP payments, which account for 47.9 per cent of THE (WHO n.d.).

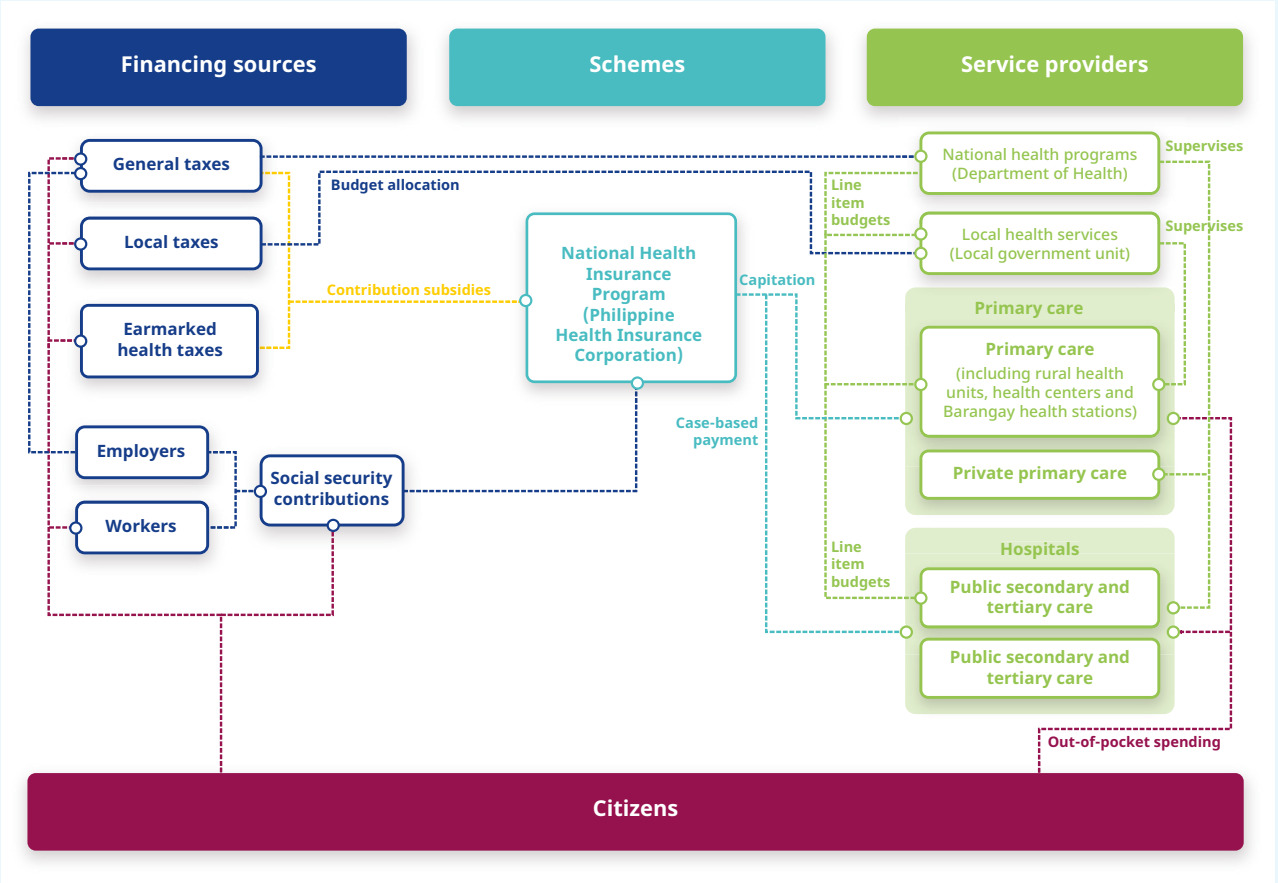
In December 2019, the Philippines Congress ratified a bill to increase taxes on alcohol, vapes and e-cigarettes (Department of Finance 2019), which has allowed for the creation of additional fiscal space to extend coverage of PhilHealth.[3] In addition, package 2 of the Comprehensive Tax Reform Programme (CTRP) aims to fill the current funding gap of PHP75 billion (US$1.47 billion) within the budget for 2020, to facilitate the successful implementation of the UHC Law. This measure is expected to create additional revenues of PHP47.9 billion (US$939 million) in 2020, which will ensure coverage for over 120 primary care drugs, and the treatment of all conditions at the primary care level.

The NHIP is financed by central and local government revenues and social health insurance contributions. Previously, seven categories of members were defined, but this has been simplified by the new UHC Law into two main categories: ”direct contributors” (contributors from payroll) and “indirect contributors” (fully subsidized from tax revenues). For direct contributors, 2.75 per cent of a member’s monthly salary is paid by the insured and their employer (where there is one). The salary floor of the contribution is PHP10,000 (US$195), and the ceiling is PHP50,000 (US$975). Through the implementation of the UHC Act, it is expected that contribution rates will increase to 5 per cent in 2025. For indirect contributors, contributions are fully subsidized by the government.

Online payment of contributions is possible through PhilHealth online payment options for employers. The Moneygment, an independent mobile application, serves as a contribution payment tool for self-employed individuals, small-to medium-enterprises, overseas Filipino workers and those without bank accounts (Moneygment 2020). It also allows better tracking of total expenses against one’s income through ‘’zero-based budgeting.” Through the application, users can not only pay their PhilHealth contributions but also compute and file their taxes, utility bills, loans and other insurance payments.

[3] Another benefit of imposing higher excise taxes on sin products and thus increasing their prices is discouraging their consumption. Available information on sin taxes indicates that, at the macro level, public health gains for the poorest population groups resulting from reduced consumption, combined with free health insurance for the poorest, could offset the regressive effect of indirect taxes on households (Kaiser et al. 2016).

▶ **Figure 1. Overview of main financial flows of the social health protection system in the Philippines**



Source: Authors.

- Governance

The health system in the Philippines is highly decentralized and fragmented with significant responsibility for health financing and service provision allocated to local government units (LGU). However, it functions under the overall leadership of the Department of Health (DOH) of the Ministry of Health, which is the regulatory authority responsible for developing policies and ensuring access to health care services, as mandated by the National Health Insurance Act of 2013. In addition, the Ministry implements public health programmes to tackle diseases such as HIV/AIDS, tuberculosis (TB) and Malaria, and provides many tertiary health services.

The national health insurance organization, PhilHealth, is a government entity attached to the DOH, which is responsible for administering the NHIP and providing policy coordination and guidance. PhilHealth functions include collecting contributions, processing claims, defining provider payment mechanisms, accrediting providers, creating benefits packages and reimbursing health providers. PhilHealth is governed by its Board of directors, comprising 13 members appointed by the President. Members include representatives from various government departments and agencies (including DOH, Department of Labour and Employment, Department of Finance and Department of budget and management), and representatives

of employers and workers in the private sector (PhilHealth 2017). [4]

- Legal coverage and eligibility

In the past, enrolment was mandatory for all formal sector members, sponsored members and the poor. Workers in the informal economy, including migrant workers, lifetime members,[5] senior citizens, overseas workers programme (OWP) members and their spouses could enrol on a voluntary basis. Through the new UHC Law, enrolment is mandated for all Filipinos, increasing legal coverage from 98 per cent in 2018 to 100 per cent of the total population, with a goal to progressively realize UHC. [6] Efforts are ongoing to translate this extended legal coverage into effective coverage in practice.

As noted above, members are divided into direct contributors and indirect contributors. Direct contributors are those who have the capacity to pay contributions and are gainfully employed, whether bound by an employer-employee relationship or self-employed. This includes migrant workers and their dependents and lifetime members (individuals aged 60 years and above who have paid at least 120 monthly contributions to PhilHealth and the former Medicare Programmes). Indirect contributors, who are eligible to receive full subsidies, include poor and sponsored members, senior citizens and persons with disabilities.

- Benefits

Defined through a positive list, the benefit package of the NHIP includes the following services: (i) inpatient benefits; (ii) "Z-benefits package" (which expands the scope of the inpatient benefit package to additional conditions that are especially likely to lead to catastrophic expenditure, such as cancer); (iii) outpatient benefits, including day surgery, radiotherapy, haemodialysis, outpatient blood transfusion, and primary care benefits; (iv) other outpatient treatment packages for HIV/AIDS, malaria, TB, surgical contraception and animal bites, reimbursed through case-based payments; and; (v) the TB Directly Observed Therapy Short Course (DOTS) package. Under the National Safe Motherhood Programme, Filipino women have full access to health services during their pregnancy and delivery. For all members, the benefits are the same, with the exception of outpatient primary care benefits, which are only available for poor and sponsored beneficiaries.

- Provision of benefits and services

PhilHealth membership registration is required to access benefits, following which each member is provided with a Member Data Record (MDR) and a PhilHealth ID Card, which is also recognized as a means of identification in the Philippines (PhilHealth 2016). In 2014, in response to challenges related to the registration process, the enrolment process was simplified by reducing the requirements for supporting documentation (PhilHealth 2014).

The service delivery system in the Philippines includes hospitals, primary care facilities and other facilities such as maternity care providers, outpatient HIV/Aids Treatment Centres, DOTS package providers and ambulatory surgical clinics. Out of 8,416 health care providers, there are 4,258 government and 4,158 private providers (PhilHealth 2020). Among all accredited hospitals, 60 per cent are private. The delivery of services at various levels of care is highly fragmented, and a referral system is not in place (Dayrit et al. 2018).

In 2019, PhilHealth reimbursed almost PHP97.34 billion to health facilities for their services to patients (PhilHealth 2018). Over the years, several payment mechanisms have been implemented, with fee-for-service used to pay for certain services, and capitation used to pay LGUs for primary care services. Since 2011, PhilHealth has shifted the provider payment mechanism away from a fee-for-service system with benefit ceilings, to case-based rates first for the 23 selected services. This was subsequently expanded in 2014 to cover all inpatient medical and surgical cases. However, in 2019, PhilHealth revealed that 100 per cent of hospital costs covered by its case rate system have either been underpaid or overpaid (Peralta 2020).

The poor and all other members subsidized by the government are exempt from co-payments. For other member categories, a fixed co-payment is set for the outpatient benefits package

[4] In line with the Congress of the Philippines 2019 Republic Act No. 10932 on strengthen the Anti-Hospital Deposit Law, available at: https://www.officialgazette.gov.ph/2017/08/03/republic-act-no-10932/
[5] This category is comprised of members who have reached the legal age of retirement and have paid at least 120 monthly contributions.
[6] Republic Act No. 11223.

and for the Z-benefits package (Villaverde et al. 2018). The UHC Law states that no co-payment will be charged for services rendered in basic accommodation. A fixed co-payment can be expected for non-basic or non-ward accommodation, regulated by the DOH and PhilHealth. This means patients will know what to expect in terms of their OOP expenditures. [7]

▶ 4. Results

- Coverage

Through the implementation of a rights-based approach, with support from sin tax revenues, social health insurance coverage has gradually expanded over the years, leading to high population coverage in the Philippines. Specifically, PhilHealth increased its effective population coverage from 73 per cent in 2007 (64.6 million members, including dependents) to 85 per cent of the total population in 2020 (93.3 million beneficiaries), and acts as a single payer at national level. Direct contributors comprise 59 million beneficiaries, and indirect contributors account for 34 million beneficiaries (PhilHealth 2020). Notably, PhilHealth successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted mechanisms. However, further efforts are needed to achieve UHC. To do so, it is necessary to eliminate barriers to effective coverage, particularly among workers in the informal economy and migrant workers, who do not seem to be covered in the new UHC law. Many of these workers may not be poor enough to qualify for government subsidies, but they may also not be able to pay regular PhilHealth contributions independently.

- Adequacy of benefits/ financial protection

In 2019, 47.9 per cent of THE was comprised of OOP payments, and the incidence of catastrophic spending stood at 6.3 per cent (Philippine Statistics Authority 2020; WHO and World Bank 2019), which more than doubled from 2.8 per cent in 2000 (WHO and World Bank 2019). The lack of PhilHealth coverage of medicines, and the high cost of drugs, medicines, laboratory and diagnostics have been identified as the main drivers behind the high OOP rate (PhilHealth, 2018). Limited financial protection for members related to limitations in the benefit package and co-payment levels may affect utilization, though there is some evidence that utilization is higher for members than for non-members (Gouda et al. 2016).

In 2018, the benefit payments- to-contribution collection ratio was low for all member groups, except for poor and sponsored members. This is most likely due to the no-balance-billing (NBB) policy, which stipulates that no other fees or expenses shall be charged to or paid for above PhilHealth's package rate, which is applicable only to poor and sponsored members. Evidence suggests that even with this measure, the enforcement of the NBB policy may need to be more stringent to ensure financial protection of the most vulnerable. It would also need to be expanded, since the NBB Programme only covers confinements in basic or ward accommodation (Dayrit et al. 2018).

- Responsiveness to population needs
    - o Availability and accessibility

Inpatient care, deliveries, catastrophic coverage and ambulatory surgeries are available for NHIP members, but the scope of PhilHealth benefits is largely focused on inpatient care, with outpatient benefits still not provided as a universal entitlement. Moreover, there are a limited number of health facilities and staff shortages persist, especially in geographically disadvantaged areas. To compound this, a large share of the population is unaware of their entitlements or unable to access their benefits. In particular, certain challenges have been observed regarding the PhilHealth registration process, including the time and money needed to submit required documentation, which has prevented many families from accessing PhilHealth benefits.

These challenges translate into relatively low utilization rates in the Philippines, particularly among the poor (Dayrit et al. 2018). However, evidence reveals the positive impact of health insurance coverage in increasing utilization. A recent study demonstrated that PhilHealth membership increases the likelihood of outpatient services utilization by 6–6.5 percentage points for adults, and 4.7–8.1 percentage points

[7] Republic Act No. 11223.

for children below 15 years of age (Balamiento 2018). According to the same study, the probability of accessing inpatient care among adults increased by 4.1—8.2 percentage points among poor PhilHealth members compared to non-members. Overall, the study found that the impact of PhilHealth affiliation is greater for children below 15 years of age than for adults. With regard to delivery services, a 2016 study revealed moderate wealth-based disparities in access to institutional delivery (Hodge et al. 2016). However, the likelihood of facility-based delivery for women who are insured through the PhilHealth subsidized coverage programme is 5–10 per cent higher than for those without insurance. This impact is more pronounced among poor women in rural areas, where insurance increases the likelihood of facility based delivery by 9—11 per cent (Gouda et al. 2016).

- Quality and acceptability

Inadequate quality of health services is a significant challenge facing the health system in the Philippines. A survey among women aged 15—49 revealed that 12.6 per cent of women in urban areas and 8.4 per cent of women in rural areas decided not to deliver a baby in a health facility because of poor quality service and lack of trust in the system (Philippine Statistics Authority and ICF 2017). In addition to a shortage of facilities and qualified staff, one of the key constraints to quality improvement is the absence of an efficient referral system. This prevents patients from navigating the health system effectively and can increase waiting times for patients, preventing them from benefiting from timely care.

▶ 5. Way forward

The Philippines has made remarkable progress towards UHC by extending social health insurance coverage to large parts of the population. The allocation of subsidies financed through sin taxes to cover vulnerable groups with low contributory capacities is particularly noteworthy. Similarly, the existence of a central purchaser managing all of the different entry points into the system represents an effort towards increased equity, and provides an opportunity for impactful purchasing strategies. However, the financial burden of OOP expenditures and impoverishing health expenditures remain problematic, comprising almost 50 per cent of THE, despite the achievement of high population coverage. Ensuring adequacy of benefits with a comprehensive benefit package, including primary care, is of essence in this context. In addition, increased investments in health infrastructure and efforts to enhance quality, availability and accessibility of the system are required.

The UHC Law of 2019 sets an ambitious reform agenda towards a system that guarantees equitable access to quality and affordable health care and financial protection for all, and envisages providing all citizens with a benefit package that includes a more comprehensive range of outpatient services (PhilHealth 2019). Specifically, the law stipulates structural changes in health financing, service delivery and governance, and aims to facilitate innovative financing streams for population-based and individual-based interventions. With a view to address fragmentation in the system, the law has mandated the establishment of province- or city-wide health care provider networks (HCPNs), starting with 33 selected pilot provinces. Lessons learnt will be used by DOH and PhilHealth to support the eventual rollout of the law. Moving forward, in line with the new law, the role of DOH will be more focused on regulation, policy development, standard setting and implementation guidance at the local level, while PhilHealth's role as national purchaser of services will be strengthened. DOH and LGUs will be responsible for population-based interventions and health services, such as immunization and health promotion programmes, while PhilHealth will finance individual-based health services.

To prevent duplication of diagnostic procedures and improve overall quality of care, the UHC law mandates the establishment of a primary care network of public and private providers to serve as initial contact points and facilitate two-way referrals (Dayrit et al. 2018). In a move to further promote quality improvements, the UHC Law and Implementing Rules and Regulations instruct PhilHealth to shift to paying providers using performance-based, prospective payments based on disease or diagnosis related groupings and develop different payment mechanisms that give due consideration to service quality, efficiency and equity. [8] Currently, there is a lack of effective

[8] Implementing Rules and Regulations of Republic Act No. 11223.

auditing processes to ensure transparency of reimbursement of providers, which reduces value for money.

6. Main lessons learned

- Gradual expansion of social health insurance coverage, including to workers in the informal economy, through a rights-based approach has led to high health protection coverage in the Philippines. PhilHealth has successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted financing and administrative mechanisms. The expansion of population coverage has been supported by sin tax revenues, demonstrating the important role that such taxes can play in efforts to move towards UHC.
- Despite broad population coverage, the burden of OOP health expenditures remains high for Filipino households, underlying the need to now prioritize benefit adequacy. The fact that impoverishing health expenditures remain high demonstrates that universal legal population coverage alone is not enough to provide financial protection. Effective coverage through a broad benefits package and limited co-payments is essential to move towards adequacy of benefits in line with international social security standards.
- Low PhilHealth share of THE, comprising only 17 per cent, prevents comprehensive coverage. This is mostly due to issues with effective coverage of the benefit package and underutilization of health services among poor members. Expanding the scope of benefits for vulnerable groups would ensure both higher PhilHealth funding of health facilities and broader risk pooling across the nation. Although it has increased greatly over the years, a higher share of THE would enable PhilHealth to provide enhanced financial protection for its members. In addition to providing more financing for health, the recently introduced UHC Law aims to deliver more value for money by reducing inefficiencies through consolidation of the system and strengthened governance.
- PhilHealth introduced the TB DOTS outpatient benefit package to deal with the burden of TB, which has illustrated the importance of comprehensive outpatient care coverage and provides an interesting example of integrating of formerly vertically-funded programmes. Accredited TB-DOTS centres (public and private) were strategically conceptualized by the Philippine Coalition Against Tuberculosis and PhilHealth to help finance detection and treatment of TB cases by PhilHealth. Only accredited facilities providing TB-DOTS treatment are eligible to receive reimbursement from PhilHealth. By 2020, 20 per cent of all PhilHealth accredited facilities provided the TB-DOTS package (PhilHealth 2020). This initiative highlights the importance of integrating the benefit package and building partnerships between the social health protection system and the broader health system.

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