

### Quick Health Financing Stats for the Philippines

Basic statistics (2013, WHO Global Health Observatory)	Philippines
Population	93 million
GDP per capita (USD) [data.worldbank.org]	\$2,787
Total health expenditure per capita (USD)	\$122
Total health expenditure as % of GDP	4.4%
Government health expenditure as % of total government expenditure	8.5%
Government health expenditure as % of total health expenditure	31.6%
OOP spending as % of total health expenditure	56.7%

### DEMAND-SIDE PROGRAMS<sup>i</sup>

In this framework we define demand-side UHC programs as programs that aim to reduce economic barriers and expand access to more and better services.

Many major national, demand-side health system programs either target a specific population (*poor and vulnerable people*, the *non-poor informal sector*, or the *formal sector*) or have distinct design features depending on the beneficiary's economic and work status. Therefore, this matrix includes questions specific to the program's design features for each specific population.

		The Sponsored Program as part of PhilHealth (aka Health Coverage Program)	PhilHealth
Identify each major, nationwide program/system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		<ul style="list-style-type: none"> <li>Non-contributory program under Medicare for poor households</li> <li>Introduced 1996</li> </ul>	<ul style="list-style-type: none"> <li>Introduced as Medicare (social security system) for formal sector workers in 1969</li> </ul>
Population Covered: <ul style="list-style-type: none"> <li>How are beneficiaries identified and targeted?</li> <li>What are the eligibility rules?</li> </ul>	Poor/vulnerable	<ul style="list-style-type: none"> <li>Local government units (LGUs) previously enrolled poor households; policies not clear.</li> <li>Nationally determined targeting mechanism – poverty reduction (NHTS-PR) introduced in 2010. All households on the list are eligible for Sponsored Program.</li> <li>NHTS centrally managed by the National Government Department of Social Welfare and Development</li> <li>Uses a multidimensional approach to identify the poor, including a proxy means test.</li> <li>In 2012, PhilHealth introduced Primary Care Benefits Package. Rural health units (RHUs) receive capitation payment of ₱500 (around US\$15 per household) when they are able to enroll the households on the NHTS-PR list and give them their first health screening. RHUs and the LGUs under which they operate have an incentive to find and enroll households. RHUs work with Community Health Teams at the barangay/village level.</li> <li>Plan to transition LGU-targeted poor households into other categories (near-poor, informal sector, organized groups).</li> <li>National government plans to sponsor near-poor enrollment soon.</li> </ul>	See Sponsored Program
	Non-poor informal sector	<ul style="list-style-type: none"> <li>See near-poor information above.</li> <li>Around 3.4 million families had been enrolled by LGUs into the Sponsored Program prior to 2010, but did not qualify as an NHTS-PR household in the</li> </ul>	<ul style="list-style-type: none"> <li>Voluntary enrollment</li> <li>Member categories:                             <ul style="list-style-type: none"> <li>Migrant workers</li> </ul> </li> </ul>

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		<p>cross-match. This group has, for the moment, been retained under the Sponsored Program and enjoys the same benefits.</p> <ul style="list-style-type: none"> <li>National government not paying for this group; PhilHealth reserves getting depleted.</li> <li>National government may be able to finance near-poor group with sin taxes.</li> </ul>	<ul style="list-style-type: none"> <li>Informal sector</li> <li>Self-earning individuals</li> <li>Dual citizens</li> <li>Naturalized citizens</li> <li>Foreign citizen residents<sup>ii</sup></li> </ul>
	Formal sector employees	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>All employers in the country are required to provide this benefit to their employees<sup>iii</sup></li> </ul>
<p>Services and Benefit entitlements</p> <ul style="list-style-type: none"> <li>Summarize the services or benefit entitlements for each population group</li> <li>Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined.</li> <li>How are benefit packages selected?</li> <li>How are they updated over time? For example; health technology assessment</li> </ul>	Poor/vulnerable	<ul style="list-style-type: none"> <li>Inpatient acute care: First-dollar (peso) coverage for hospitalization. Payment is on a fee-for-service basis, up to a limit identified by PhilHealth. PhilHealth pays for (a) room and board; (b) services of health care professionals; (c) diagnostic, laboratory, and other medical examination services; (d) use of surgical or medical equipment and facilities; (e) prescription drugs, subject to limitations; and (f) inpatient education packages.</li> <li>Special packages (Tuberculosis Directly Observed Therapy (TB-DOTS), Short-course), Maternal and Neonatal Care (only in PhilHealth- accredited maternity clinics and PhilHealth-accredited hospitals and TB DOTS centers).</li> <li>Outpatient benefits (introduced 2000): primary consultation with general physicians, as well as lab tests such as complete X- rays, fecal and urine analysis, complete blood count, and sputum microscopy.</li> <li>Case Type Z benefit include early stage breast cancer and prostate cancer with low to intermediate risk, both with a package rate of P100,000; childhood acute lymphoblastic leukemia (standard risk) which will be paid at P210,000 and low risk end-stage renal disease requiring renal transplantation with P600,000 benefit package.</li> </ul>	See Sponsored Program
	Non-poor informal sector	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>Same as sponsored program, except outpatient benefits (except for migrant workers)<sup>iv</sup></li> </ul>
	Formal sector employees	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>Same as sponsored program, except outpatient benefits<sup>v</sup></li> </ul>
<b>MANAGING MONEY/ FINANCING UHC</b>			
Financing sources	<ul style="list-style-type: none"> <li>Government source of revenue (e.g., taxes) for this program? Earmarked taxes, sin taxes, general taxes?</li> <li>Mandatory contributions by formal sector workers (payroll taxes)?</li> <li>Beneficiary premiums?</li> <li>Beneficiary cost sharing at the point of service?</li> <li>Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable).</li> <li>Summarize how each source of financing is collected.</li> </ul>	<ul style="list-style-type: none"> <li>The national government and local government contributions of the premium subsidy for Sponsored Program enrollees are directly paid to PhilHealth.</li> <li>In addition, the DOH directly finances 72 DOH hospitals largely for payments to health personnel (around 75% of the total budget in 2008).</li> <li>LGUs (provincial and municipal level) finance hospitals, rural health units, and barangay (village) health centers.</li> <li>The National Health Insurance Law states that the Sponsored Program premiums will be co-financed with LGUs. The premium until 2012 was ₱1,200 (US\$25 per targeted family). For poor LGUs (4th, 5th, and 6th class), national government financing was provided (up to 90%, or ₱1,080, US\$24) for a period of five years.</li> <li>At the end of the five years, LGUs were expected to finance the premiums for the Sponsored Program.</li> <li>Under the government's new policies for universal health coverage, the national government shall pay the full premium subsidy for poor households identified through a national targeting mechanism.</li> <li>National government plans to enroll near-poor with sin tax reform.</li> </ul>	<ul style="list-style-type: none"> <li>Formal sector premiums shared equally between employee and employer is dependent on employee salary range<sup>vi</sup></li> <li>Informal sector and self-employed pay full premiums with a three month waiting period before benefits are available (or immediately if the enrollee pays 12 months' premiums up front)</li> <li>Informal sector premiums: Individually Paying Members earning an average monthly income of P25,000 and below pay P600 quarterly or P2,400 per year, while those earning above P25,000 pay P900 quarterly or P3,600 per year. Premium contributions may be paid quarterly, semi-annually or annually.<sup>vii</sup></li> <li>Some subsidization by LGUs and national government, mainly to facilities.</li> <li>Balance-billing by facilities allowed for most services for non- Sponsored Program enrollees.</li> </ul>
Risk pooling	<ul style="list-style-type: none"> <li>Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools?</li> <li>Are the poor cross-subsidized by</li> </ul>	<ul style="list-style-type: none"> <li>One national risk pool.</li> <li>Contributions from the formal sector, informal sector, self-employed, and organized groups are combined with public subsidies for poor households within a single payer system .</li> </ul>	

		The Sponsored Program as part of PhilHealth (aka Health Coverage Program)	PhilHealth
	higher income people? Discuss for each program.		
Financial management	<ul style="list-style-type: none"> <li>What institution manages the program?</li> <li>How does the program remain solvent?</li> <li>Are there mechanisms in place, such as caps or utilization review, that maintain the financial viability of the system?</li> </ul>	<ul style="list-style-type: none"> <li>LGUs and Philippines Health Insurance Corporation (PHIC, or PhilHealth).</li> <li>Balance-billing allowed, subject to exclusions.</li> </ul>	<ul style="list-style-type: none"> <li>(PHIC, or PhilHealth)</li> <li>Balance-billing allowed</li> </ul>
Financial protection	<ul style="list-style-type: none"> <li>Financial protection for households: are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?</li> </ul>	<ul style="list-style-type: none"> <li>In 2011, PhilHealth introduced No Balance Billing for 23 medical and surgical cases (identified on the basis of those that affect poor households the most). For those 23 cases, Sponsored Program members using public hospitals would not have to pay anything out-of-pocket.</li> <li>2012 rapid assessment of the implementation of no-balance billing (World Bank 2012) found that Sponsored Program members were still being charged. Facilities concerned about cash flow. <ul style="list-style-type: none"> <li>As of 2013, pilot: PhilHealth will pay hospitals advance payments that will then be adjusted against actual claims data.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>[JW: Limits on annual or lifetime out of spending do not appear to be part of the benefit package, based on reviewed information from PhilHealth website, UNICO study and results of web-based searches.]</li> </ul>
Provider payment	<ul style="list-style-type: none"> <li>Describe the payment mechanisms used to pay primary health care (including preventive and promotive care).</li> <li>Describe the payment mechanisms used to pay for hospital level care.</li> <li>Are payments tied to quality of care, and if so, how does this work?</li> <li>Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.</li> </ul>	<ul style="list-style-type: none"> <li>Same payment mechanisms for public and private providers (fee-for-service where money follows the patient). The PhilHealth outpatient benefits package program only worked with public providers using a capitation. In reality, since DOH and LGUs own and manage health facilities, these facilities were not able to fully capitalize on the PhilHealth payment system.</li> <li>Inpatient acute care: payment is on a fee-for-service basis, up to a limit identified by PhilHealth. Hospitals are allowed to balance bill over and above the PhilHealth payments. No Balance Billing package where public hospitals are paid a fixed rate per case, but private hospitals can still balance-bill Sponsored Program enrollees.</li> <li>Outpatient services: expected that each Sponsored Program member would be assigned to an RHU and that the RHU would act as the gatekeeper. PhilHealth's responsibilities under the outpatient benefits policy were to pay municipalities the ₱300 per enrolled member. In reality there was a gap between policy and implementation.</li> </ul>	<ul style="list-style-type: none"> <li>Inpatient acute care: payment is on a fee-for-service basis, up to a limit identified by PhilHealth. Hospitals are allowed to balance bill over and above the PhilHealth payments. Prices are not regulated by PhilHealth and are not transparent.</li> </ul>

## SUPPLY-SIDE PROGRAMS

In this framework we define supply-side UHC programs as nationwide programs that aim to reform and upgrade the production of health services.

		Facility accreditation for maternal care services	Public hospital income retention	Performance based financing for RHUs	Doctors to the Barrios and Rural Health Practice Program	Hospital global payment
Identify each major, nationwide program / system that aims to reform and upgrade the production of health services. List one program per column.		<ul style="list-style-type: none"> <li>Maternal Health Care Package of PhilHealth, introduced in 2003</li> </ul>		<ul style="list-style-type: none"> <li>Introduced 2012</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced national government financing identified as of 2013</li> </ul>	
Human Resources	<ul style="list-style-type: none"> <li>Summarize design features of programs aiming to improve distribution of health workers, retention of health workers, or outreach by health workers.</li> </ul>				<ul style="list-style-type: none"> <li>Doctors to the Barrios program.</li> <li>Provide Medical Officer III replacements for provincial and district hospitals which are sending their service residents for training.</li> </ul>	

		Facility accreditation for maternal care services	Public hospital income retention	Performance based financing for RHUs	Doctors to the Barrios and Rural Health Practice Program	Hospital global payment
					<ul style="list-style-type: none"> <li>• Augment the Medical Specialist human resource needed in government/public hospitals.</li> <li>• Provide items for residency training to identified physicians who have rendered government service VIII.</li> <li>• Rural Health Practice Program</li> <li>• Brings nurses and midwives to rural underserved areas.</li> </ul>	
Managerial Flexibility	<ul style="list-style-type: none"> <li>• Do managers of facilities or at subnational level have the flexibility to hire and fire, manage money, procure commodities? Summarize design features of programs aiming to improve managerial flexibility in public facilities.</li> </ul>		<ul style="list-style-type: none"> <li>• Public facilities are allowed to balance bill. If they have income retention status, then they are allowed to retain the funds instead of reverting earnings to the Treasury.</li> <li>• Very few LGU hospitals have income retention.</li> <li>• The LGU distributes funds back to the hospitals based on a historical line-item budget. This means that Level 1 or 2 hospitals with low occupancy rates (30% to 40%) receive a budget irrespective of level of effort, and a Level 3 hospital with a 120 percent occupancy rate receives the same historical budget.</li> </ul>	<ul style="list-style-type: none"> <li>• PhilHealth repackaged outpatient benefits package for Sponsored Program members as Primary Care Benefits.</li> <li>• LGUs required to establish trust funds to pay capitation payments to facilities</li> <li>• Focus on incentivizing the delivery of the package at the RHU level.</li> <li>• Performance-based financing element of the management of Primary Care Benefits and simple verification mechanisms before the municipality receives the financing for each household.</li> <li>• However, many RHUs are not autonomous entities, and introducing pay-for-performance in a context where RHUs do not have autonomy to use funds to obtain results is problematic.</li> </ul>	<ul style="list-style-type: none"> <li>• As of 2013, pilot: PhilHealth pays hospitals advance payments that will then be adjusted against actual claims data.</li> <li>• Unclear how this policy will operate for public hospitals that have Government Owned and Controlled Corporation and income retention status, versus hospitals that have no autonomy.</li> <li>• Hospitals with no autonomy may face a problem if the global budgets are transferred to the LGU treasury rather than to hospital trust funds.</li> </ul>	
Private Providers	<ul style="list-style-type: none"> <li>• Summarize design features of programs aiming to increase participation of or oversee quality of private providers.</li> </ul>					
Health Care Provision / Accreditation and Other	<ul style="list-style-type: none"> <li>• Summarize design features of programs aiming to accredit health facilities or regulate quality of service</li> </ul>	<ul style="list-style-type: none"> <li>• To help facilities gain PhilHealth accreditation, the DOH has helped facilities upgrade to Basic</li> </ul>				

		Facility accreditation for maternal care services	Public hospital income retention	Performance based financing for RHUs	Doctors to the Barrios and Rural Health Practice Program	Hospital global payment
Regulation of Quality	provision in another way.	Emergency Obstetric Care and Comprehensive Emergency Obstetric Care				
Health Care Provision / Integrating the Health System	<ul style="list-style-type: none"> <li>How is beneficiary care coordinated across levels of care? Is there a system of referrals and counter-referrals and the information system to manage this? Please describe.</li> </ul>	<ul style="list-style-type: none"> <li>The maternal and neonatal package of PhilHealth is paid on a per- case basis (a bundled payment of up to ₱8,000 or US\$181 per institutional delivery in a primary care hospital or Level 1 facility, or ₱6,500 or US\$147 in a Level 2 and Level 4 facility).</li> <li>Providers are not allowed to balance bill under the PhilHealth package for institutional deliveries.</li> </ul>				
<b>ACCOUNTABILITY IN THE HEALTH SECTOR</b>						
Accountability	To what extent is health sector governance characterized by decentralization and regulation, or what <i>Going Universal</i> refers to as “arm’s length” relationships-an actor who delegates the task (e.g., MoH; purchaser of health services) and a separate actor who is responsible for carrying it out (e.g., local government; service providers)? Summarize the governance structure of the health sector and features of the purchaser-provider split, where one exists.	<ul style="list-style-type: none"> <li>Historically, the PhilHealth Board of Directors has not been able to hold PhilHealth accountable for the implementation of the NHIP, especially on key aspects of program implementation such as reaching poor households.ix PhilHealth president reports to the president of the country; this structure has made accountability arrangements unclear vis-à-vis the board, which is headed by the Secretary of Health.</li> <li>In 2010, under the leadership of a new Secretary of Health, the Board was strengthened and began to engage actively on PhilHealth matters.</li> <li>The Sponsored Program is under PhilHealth. The Secretary of Health (Minister of Health) is the chairman of the PhilHealth Board, and representatives from the Secretary of Interior and Local Government and the Secretary of Social Welfare and Development also participate.</li> <li>DOH has an arm’s length relationship with LGUs, which means it cannot really influence service delivery.</li> <li>PhilHealth, as the public purchaser, could have had a more direct impact on service delivery but historically did not fully take advantage of this power.</li> <li>Providers have faced constraints in responding to the incentives and/or the accountability framework set by PhilHealth. In the absence of compliance monitoring, the incentives were not strong enough for providers to comply with the rules and regulations.</li> <li>Even if monitoring were stronger, for some providers it would have been impossible to comply since they are dependent on the general, rigid public management framework and have to depend on LGUs to allocate funds and procure goods. <ul style="list-style-type: none"> <li>Public facilities do not have flexibility to fire staff or increase the number of staff positions to respond to benefits package expansions.</li> <li>Private facilities can do these (above), provided the financial incentives are strong. But the lack of adequate pricing of services and market control by PhilHealth has meant that private providers have not been able to meet the needs of the Sponsored Program.</li> </ul> </li> </ul>				

<sup>i</sup> Source for all information in the matrix is UNICO study with the exception of footnoted bullets

<sup>ii</sup> <http://www.philhealth.gov.ph/members/informal/member.html>

<sup>iii</sup> <http://faq.ph/how-to-apply-for-a-voluntary-member-with-philhealth/>

<sup>iv</sup> <http://www.philhealth.gov.ph/benefits/>

<sup>v</sup> <http://www.philhealth.gov.ph/benefits/>

<sup>vi</sup> <http://www.philhealth.gov.ph/members/formal/>

<sup>vii</sup> <http://www.philhealth.gov.ph/members/informal/registration.html>

<sup>viii</sup> <http://www.doh.gov.ph/node/1101>

<sup>ix</sup> World Bank. 2012. Governance of the Philippines Health Insurance Corporation (PhilHealth): A risk analysis at the institutional, organizational and technical levels.