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**Philippine Institute for Development Studies**  
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## Health Financing for the Poor in the Philippines: Final Report

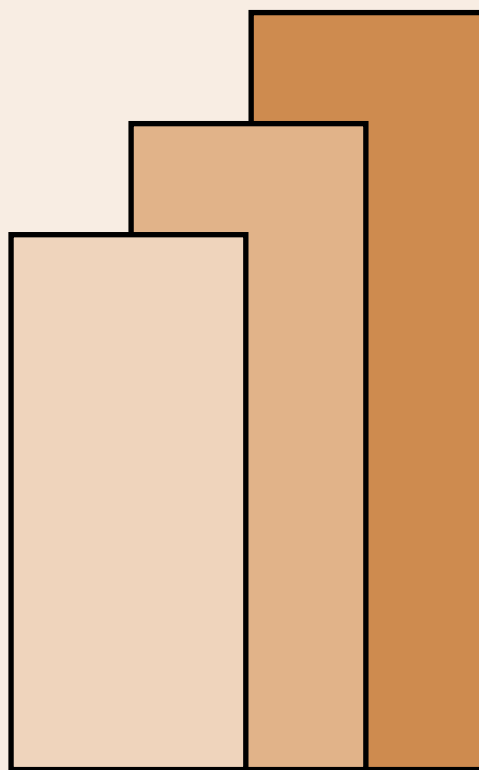
*Michael R. Cabalfin*

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# **Health Financing for the Poor in the Philippines:**

## **Final Report\***

Michael R. Cabalfin<sup>†</sup>

### **Abstract**

Indigent membership in PhilHealth has surged in recent years, driven by the nation-wide identification of the poor. However, the massive identification has led to the enrolment of more members than official poverty estimates, resulting in leakages in the government's social health insurance subsidy. The massive enrolment has been facilitated by the incremental revenues from the revised sin tax law. Subsidy for the poor now comprises over a third of the national health insurance fund, effectively subsidizing health care service for other members especially the informal sector. Hospitals also enroll the poor as well as the near poor in PhilHealth at point-of-care and may over-subscribe the poor given the higher reimbursement relative to the premium subsidy. The poor are covered by a No Balance Billing policy in which they are not liable to pay hospital fees over the case rate. Despite this, close to half of the poor still incur out-of-pocket expenses especially for medication. Close to three-fourths of the poor are also covered by the Primary Care Benefit 2 Package which pays for out-patient medicines for certain illnesses to prevent catastrophic conditions. Finally, close to 1 percent of the benefits for the poor is estimated to fall under the Z Benefit Package which subsidizes catastrophic illnesses.

Keywords: health insurance, poverty, social protection

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\* This is an output for the PIDS research project "Rapid Review of PhilHealth's Initiatives and Programs for the Indigents". This report was approved by Dr. Aniceto C. Orbeta, Project Director of said research project.

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# **I. Research Design**

This paper has ten parts including this section. This section discusses the research objectives and methodology. The next three sections provide a general context for the PhilHealth programs for indigents. Section II analyzes the institutions (i.e. laws, policies and programs) governing the provision of social health insurance for the poor. Section III looks at PhilHealth coverage and the indigent and sponsored members program. Section IV looks at the fiscal context, sources and distribution of public spending on health.

## **A. Research Objectives**

The Terms of Reference for the study has the following objectives pertaining to specific PhilHealth initiatives for indigents. The relevant sections addressing the objectives are identified in parentheses.

1. Review and provide updates on the available literature on and progress of the various initiatives for the Indigent and Sponsored Programs of PhilHealth in terms of operations and finances.
  - a) Point-of-Care (POC) Enrollment (Section VI)
  - b) No Balance Billing (NBB) (Section VII)
  - c) Senior Citizens (also covered in Section VII)
  - d) Z Benefit Package (Section VIII)
  - e) Primary Care Benefit (PCB) 2 Package (Section IX)
  - f) Others
2. Identify gaps in the implementation and program design of the above initiatives. The study looks into the gaps in indigent automatic enrolment (Section VI.D) - whether they are aware of their entitlements or not and their health-seeking behaviour (section VI.B)
3. Compare PhilHealth benefit utilization between paying and sponsored/indigent members using PhilHealth claims data (section V.B).
4. Provide recommendations for the improvement of the initiatives and for the advancement of the health service delivery (section X). This is done by looking at how PhilHealth work can be improved in the following areas: enrolment (section X.A), accreditation of facilities and personnel, claims processing (section X.B), support value (benefit structure) (section X.C) and provider payment systems (section X.D).

Section X also provides a summary and conclusion.

## **B. Scope of Work**

The scope of work for the research is as follows (with the relevant sections identified):

1. A desk research and literature review of the available literature on recent PhilHealth initiatives particularly for the poor.
2. A comprehensive review of the various PhilHealth initiatives for the poor based on the initiatives identified in the literature review. The review includes the following (with corresponding section numbers):
3. Consult with PhilHealth officers, hospital directors and municipal/city health officers as well as experts in the field.

### **C. Methodology**

The study is essentially an operational evaluation which determines whether the programs are being implemented as planned by comparing program status with objectives and targets. The operational evaluation will be helpful for prospective impact evaluation of PhilHealth initiatives and programs on access to health services, financial protection, and health status of the poor. The operational evaluation was conducted using institutional analysis, public expenditure analysis, benefit incidence analysis and beneficiary assessment.

Institutional analysis was conducted by reviewing the policies, programs, objectives and strategies governing the implementation of social health insurance in the country including the National Health Insurance Act, the Universal Health Care program, the National Objectives for Health, and the National Health Financing Strategy. It also includes an analysis of the PhilHealth policies on Point-of-Care enrolment, No Balance Billing, Z Benefit Package, and Primary Care Benefit package. Implementation of the programs is then assessed against these policies through case studies involving in-depth interviews of key informants from PhilHealth-CAR, the Baguio City social welfare office and the Baguio General Hospital and Medical Center (BGHMC) to determine implementation processes, status and constraints.

1. Public expenditure analysis was conducted by analyzing the fiscal context in terms of general government spending and revenues, national health spending, government health spending, the sources of national health insurance financing and the distribution of benefits.
2. Benefit incidence analysis was conducted to estimate the size of benefits received by different groups especially the poor. This was undertaken using administrative data on the number of beneficiaries by type and actual spending for different types of beneficiaries.
3. Beneficiary assessment was undertaken by interviewing PhilHealth beneficiary patients of BGHMC regarding their knowledge about their entitlements, their

health condition, the health benefits they received, their health spending and their health- seeking behavior.

## **II. Introduction**

The World Health Organization (2014a) defines universal health coverage as the goal of “ensur(ing) that all people obtain the health services they need without suffering financial hardship when paying for them.” It requires a well-managed health system that responds to people’s priority health needs, a financial system that prevents financial hardship of people availing health services, access to essential diagnostic and treatment medicines and facilities, and skilled health workers.

Universal health coverage pertains to two aspects of health system performance: health service and financial protection (World Health Organization, 2014b). Health service includes health promotion and prevention; and treatment, rehabilitation and palliation. Financial protection includes assistance in times of catastrophic health spending and prevention of impoverishment due to health spending. Health spending is catastrophic when household out-of-pocket health spending is greater than or equal to capacity to pay (Xu, 2005).

Universal health coverage entails three specific policy goals: equitable health care utilization, quality health care, and financial protection (McIntyre and Kuzin, 2016). Equity pertains to the consistency between health care need and actual utilization. Quality refers to the improvement of health status or the achievement of desired health outcomes. Financial protection refers to health service financing to prevent impoverishment as a result of health service payments.

Towards achieving these goals are three intermediate objectives: efficiency, transparency and accountability. Efficiency refers to the production of as much quality health services as possible given the resources available. Transparency refers to people’s awareness of their rights and benefits and their ability to exercise and avail of these. Accountability refers to the health system’s openness to public examination of its performance against the goals and objectives set.

In view of these intermediate objectives, the health system undertakes the following functions: revenue raising, pooling and purchasing. Revenue raising pertains to the sources of funds, the organization of payments or modes of contributions for financing health services and system of collection. Pooling refers to combining revenues for the health purposes intended. Purchasing refers to the allocation of the resources to the provision of health services. This is closely related to the design and rationing of benefits. Rationing entails private or out-of-pocket payments for benefits not fully supported by pooled resources or waiting time to avail of health services.

## **A. National Health Insurance Program**

In 1995, the Philippine government instituted the National Health Insurance Program aimed at providing compulsory universal health coverage to Filipinos, that is, to provide all citizens access to financial resources for health care services. Guided by principles of equity and solidarity, it aims to give priority and facilitate the delivery of health care to the economically disadvantaged segment of society. Notwithstanding the compulsory coverage, benefit entitlement is limited to enrolled members with contributions for at least three months in the last six months.

Members are classified into five main categories: formal economy, informal economy, indigents, sponsored members, and lifetime members (RA 10606). Formal economy members include government and private employees, enterprise owners, household help and family drivers; informal economy members include migrant workers, informal sector workers, self-earning individuals, Filipinos with dual citizenship, naturalized Filipinos, and foreign citizens (IRR RA 10606). Indigents are defined as those with no or inadequate income for subsistence as identified by the Department of Social Welfare and Development. Sponsored members are those whose contributions are paid by another individual, government agency or private entity. Lifetime members are retirees with at least 120 monthly premium contributions.

The implementing rules and regulations of the National Health Insurance Act, as amended (National Health Insurance Corporation, 2013), identify enrolled indigents among the members of the National Health Insurance Program. The NHIC coordinates and enters into agreements with LGUs for the implementation program for indigents in their areas. Indigent members are identified through social survey together with the Community Based Information System, and evaluated annually. In 2010, the government adopted a National Household Targeting System to identify poor households which will be the beneficiaries of social protection programs (Office of the President of the Philippines, 2010). PhilHealth adopted the NHTS-PR Indigents for enrollment to the Sponsored Program (Philippine Health Insurance Corporation, 2012e).

The National Household Targeting System for Poverty Reduction (NHTS-PR) has three main phases: preparatory phase, data collection and analysis, and validation and finalization (Department of Social Welfare and Development, n.d.). The preparatory phase involves the identification of areas: all provinces, municipalities, and cities are covered; and the identification of strategy: complete enumeration (saturation) is done for all rural barangays and in pockets of poverty in urban barangays. The data collection and analysis phase involves a family assessment (based on FIES, LFS, and Census indicators). A Proxy Means Test (PMT) statistical modeling is done to estimate family

income based on housing, access to basic services and facilities, ownership of assets, etc.. A household is considered poor if estimated income is below the provincial poverty threshold. Validation is done by posting the list of poor families at the barangay to gather community feedback. A municipal level validation committee acts on any complaints before the list is finalized.

Apart from indigents, there are sponsored members. These include members of the informal economy not qualified for full subsidy sponsored by the LGUs and/or Congress and other sponsors including the National Government. It also includes DSWD-sponsored orphans, abandoned and abused minors, out-of-school youths, street children, persons with disability (PWD), senior citizens and battered women. The local government units may also sponsor barangay health workers, nutrition scholars, barangay tanods, and other barangay workers and volunteers. Un-enrolled indigent women who are about to give birth are also sponsored by the national government and/or LGUs, legislative sponsors, and the DSWD. Non-members who are assessed and classified as poor or near poor and members not covered due to lack of qualifying contributions assessed and classified as poor or near poor are also sponsored by hospitals at point-of-care.

## **B. Universal Health Care Program**

In 2010, the Department of Health embarked on the Aquino Health Agenda for Achieving Universal Health Care for All Filipinos (Department of Health, 2010a). It aims to improve financial risk protection through the expansion of NHIP enrolment and benefit delivery, improve access to quality hospitals and health care facilities, and attain the health-related Millennium Development Goals. To achieve these objectives, the agenda employs six instruments: health financing, service delivery, policy standards and regulation, governance, human resources, and health information.

The overall goal of the Universal Health Care program of the government is better health outcomes through equitable access to affordable health care. The universal health care program has three final outcome indicators.

- 1.** Financial risk protection - the poor are to be protected from the financial impacts of health care use as measured in terms of the benefit delivery ratio.
- 2.** Improved access to quality hospitals and health care facilities
- 3.** Attainment of the health-related Millennium Development Goals the government aims to reduce maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of non-communicable diseases.



## C. Financial Risk Protection

In view of the foregoing overall outcomes, the government endeavors to provide sustained health financing and responsive health system. Specific indicators and targets are identified in the National Objectives for Health 2011-2016 (Department of Health, 2011):

4. Toward financial risk protection, the government aims to
  - a) expand enrollment to the National Health Insurance Program from 62 percent in 2010 to more than 90 percent by 2016;
  - b) augment and effectively use resources to protect the poor and vulnerable. The government aims to reduce out-of-pocket health expenditures from 54.3 in 2007 to less than 50 percent by 2016;
  - c) increase PhilHealth spending from 9 percent in 2007 to 19 percent of Total Health Expenditure by 2016;
  - d) promote quality health services at accredited facilities through no balance billing arrangements for sponsored members. It hopes to make all government hospitals have no balance billing for poor households by 2016.
5. PhilHealth is also implementing various initiatives in view of the overall goals including:
  - e) Point of Care Enrolment Program: the Point of Care Enrolment Program provides coverage and considers as sponsored members at the time of admission to a government health facility patients and their families whose incomes are less than or are not over 40 percent higher than the regional poverty threshold, or those with special circumstances or members of particular sectors as defined by law (Philippine Health Insurance Corporation, 2013).
  - f) No Balance Billing Policy: Under the no balance billing policy, members shall not pay for fees in excess of the prescribed case rates for common medical and surgical services (Philippine Health Insurance Corporation, 2011a).
  - g) Z Benefit Package: the Z Benefit Package “aims to increase financial risk protection for PhilHealth members” by reimbursing payments for “catastrophic” illnesses at prescribed rates (Philippine Health Insurance Corporation, 2012b).
  - h) Primary Care Benefit 2 package: the Primary Care Benefit 2 Package pays for “out-patient medicines for PhilHealth qualified members or dependents with hypertension, diabetes and dyslipidemia, long before their conditions become catastrophic” (Philippine Health Insurance Corporation, 2014b)
  - i) Senior Citizen coverage: in 2014, Republic Act 10645 established “mandatory PhilHealth coverage for all senior citizens” (Republic of the Philippines, 2014).

### III. Enrolment and coverage

PhilHealth initially catered to formal economy members, particularly government and private employees covered by the erstwhile Medicare program. In 1995, their enrolment rate was estimated at less than half (roughly 47%). Various programs were launched over time to cover other sectors including the sponsored program in 1996, the individually-paying program (IPP) in 1999, the non-paying program in 2002, and the program for overseas workers in 2005 (Romualdez, et al., 2011). In 1997, 14,520 indigents were enrolled under the sponsored program and in 1999, 32,944 informal economy members including overseas workers were enrolled under the IPP (PhilHealth, 2003).

Figure 1 shows PhilHealth enrolment<sup>1</sup> and coverage<sup>2</sup> for 2006-2015. The growth of PhilHealth enrolment has been slow in 2006-2010, averaging only 3.5 percent per annum. 2011 saw a breakthrough in PhilHealth enrolment, growing by 54 percent. This is due to the massive enrolment of indigents. 2014 again saw a huge jump in enrolment, by 36 percent, due to the surge in indigent enrolment. With the progress in enrolment, the target of >90% enrolment has been achieved (even surpassed) in 2014. Moreover, the estimated beneficiaries based on enrolment in 2015 are 5 percent higher than the projected population! This is because dependents are estimated by sector using multipliers (Department of Health, 2010) rather than counted from member records. In 2013, PhilHealth started monitoring coverage rate, instead of enrolment rate. Coverage rate increased from 67 percent in 2013 to 92 percent in 2015.

PhilHealth membership increased from 16.4 million in 2007 to 22.4 million members in 2010 (Manasan, 2011). Membership increased in all categories with sponsored indigents showing the most substantial increase, from 2.7 million in 2007 to 6 million in 2010. Consequently, the share of indigents to total membership increased from 17 percent to 27 percent. On the other hand, the share of private employees dropped from 43 percent to 35 percent while that for government employees decreased from 11 to 9 percent. The shares of non-paying members, individually paying members and overseas workers are not much changed. In 2010, their shares were as follows: individually paying members (16.7%), overseas workers (10.4%), and non-paying members (2.2%). Coverage rate for all members increased from 40 percent in 2007 to 43 percent in 2010. Coverage rates have increased especially for indigents

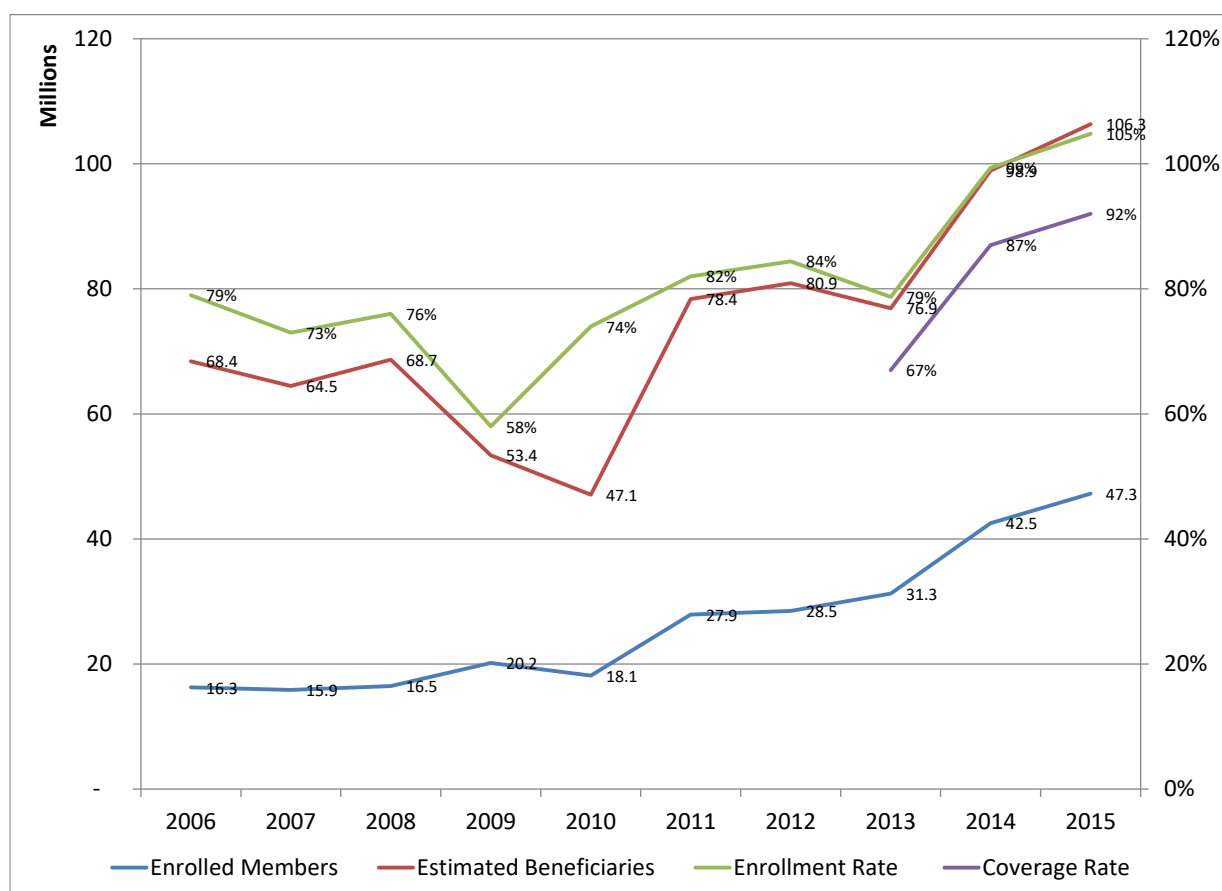
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<sup>1</sup> The National Health Insurance Act of 1995 defines enrollment as “the process... (of) enlist(ing) individuals as members or dependents covered by the Program.”

<sup>2</sup> Coverage is defined as “the entitlement of an individual, as a member or as a dependent, to the benefits of the Program.”

(73%-154%) and individually-paying members (25%-33%). Coverage rates decreased for government employees (68%-65%) and private employees (55%-54%).

Figure 1: PhilHealth Enrolment and Coverage, 2006-2015



Source: PhilHealth Corporate Planning Department

The excessive enrolment of indigents in 2009-2010 is attributed to poor targeting (Manasan, 2011). In fact, only 21 percent of those identified as poor by NHTS were sponsored and only 15 percent of those sponsored were considered poor. With the targeting undertaken by barangay officials, it was prone to political patronage. On the other hand, the significant under-enrolment in the employed program is attributed to the difference in definition of formal employment between PhilHealth and NSO's Labor Force Survey and non-compliance of employers in enrolling their employees to PhilHealth.

In 2011, most provinces had moderate to excessive leakage rates for indigents but some also experience moderate to severe under-enrolment (Silfverberg R. R., 2014). The growth in enrolment is attributed to the introduction of the outpatient benefit package and capitation program in 2000, new benefit packages (e.g. TB-DOTS, MCP) in 2003, increasing engagement of local government units, and the Plan 5M/Plan 2.5M. Leakages were more likely in provinces with medium human development, in

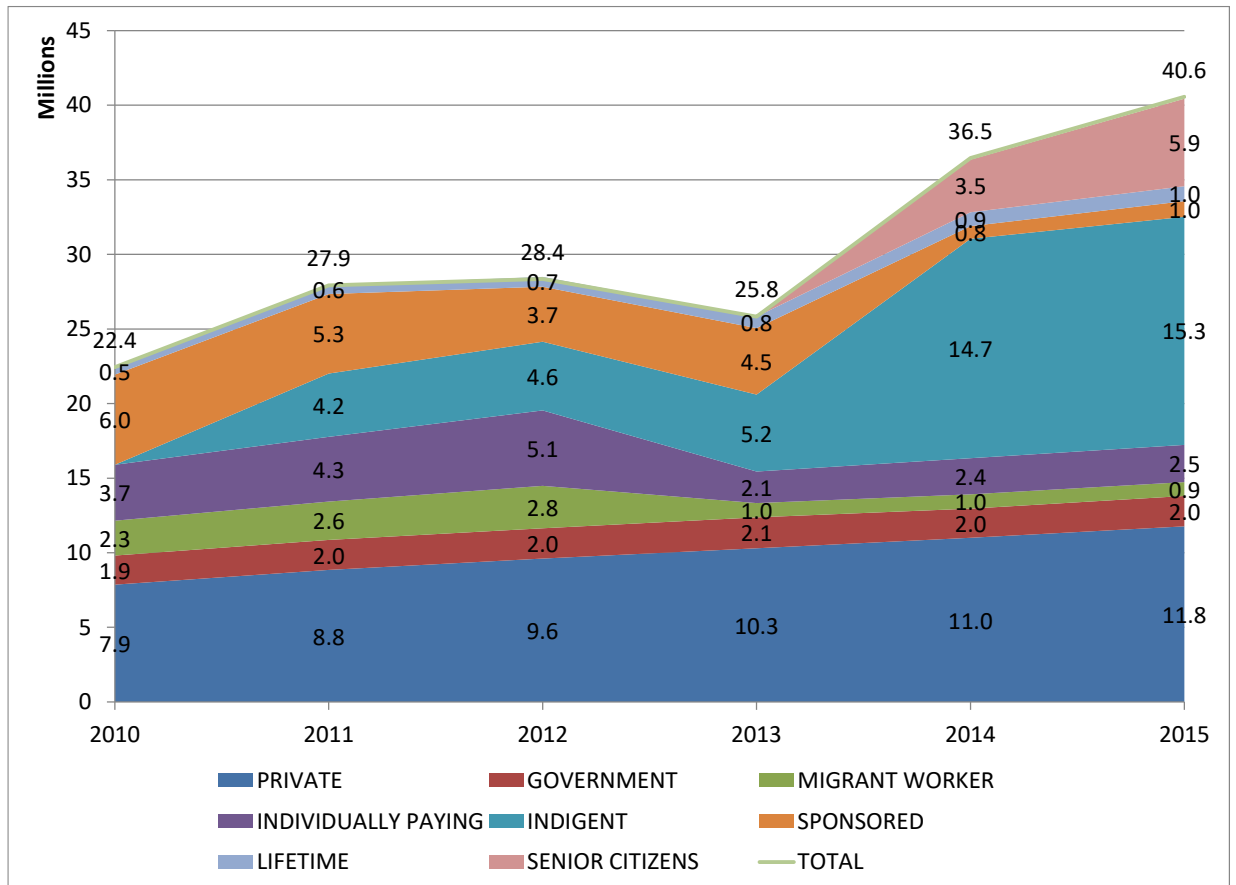
first-class provinces, and less likely in provinces with high severity of poverty and in provinces with high administrative governance ranking. Under-enrolment is less likely but leakages more likely among local governments with greater resource generation capability. Under-enrolment and leakages are both more likely among more participatory local governments. The presence of accredited health facilities also tends to increase leakages.

As of 2012, the employed program had enrolment rates of 76 percent (moderate enrollment) for the government sector and 104% (full enrolment) for the private sector (Silfverberg, 2013). Enrolment rate in the private sector was found to be higher for larger enterprises. For the government sector, enrolment rate was found to be positively related to local GDP per capita. Enrolment rate for individually paying members was 80 percent. Enrolment rate was found to be positively related to the number of private hospitals, the availability of health services proxied by the ratios of hospital beds and health professionals to the population, and membership in certain sectors like mining considered hazardous.

## **A. Membership, 2010-2015**

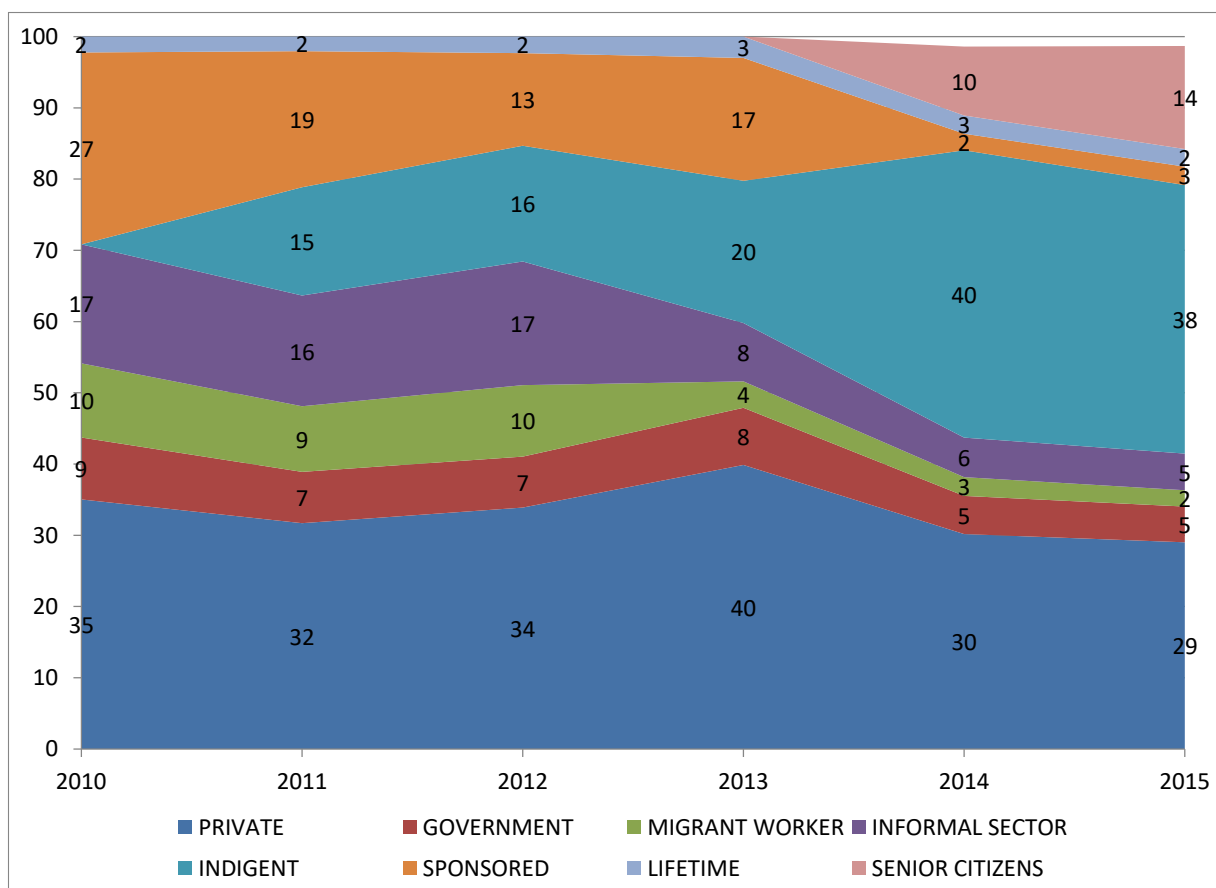
PhilHealth membership increased from over 22.4 million in 2010 to almost 40.6 million in 2015. Figure 2 shows the composition of membership over time. Membership increased by 5.5 million in 2011 due mainly to the massive enrolment of indigents numbering 4.2 million. There was minimal growth in 2012, with the growth in private, migrant worker, individually paying and indigent membership mostly offset by the decrease in sponsored members. Enrolment decreased in 2013 due to reductions in individually paying and migrant worker membership. There was a resurgence in membership in 2014 with indigent enrolment almost tripling and the mandatory enrolment of senior citizens, although the latter is largely offset by the decrease in sponsored members. The number of indigent members surged as more families within the same household have been identified as poor. The rise in membership in 2015 is due mainly to increases in private employee, indigent and senior citizen memberships. The further rise in the number of indigents is due to the inclusion of members of the 4Ps and Modified Cash Transfer Program of DSWD.

Figure 2: PhilHealth Membership by Category, 2010-2015



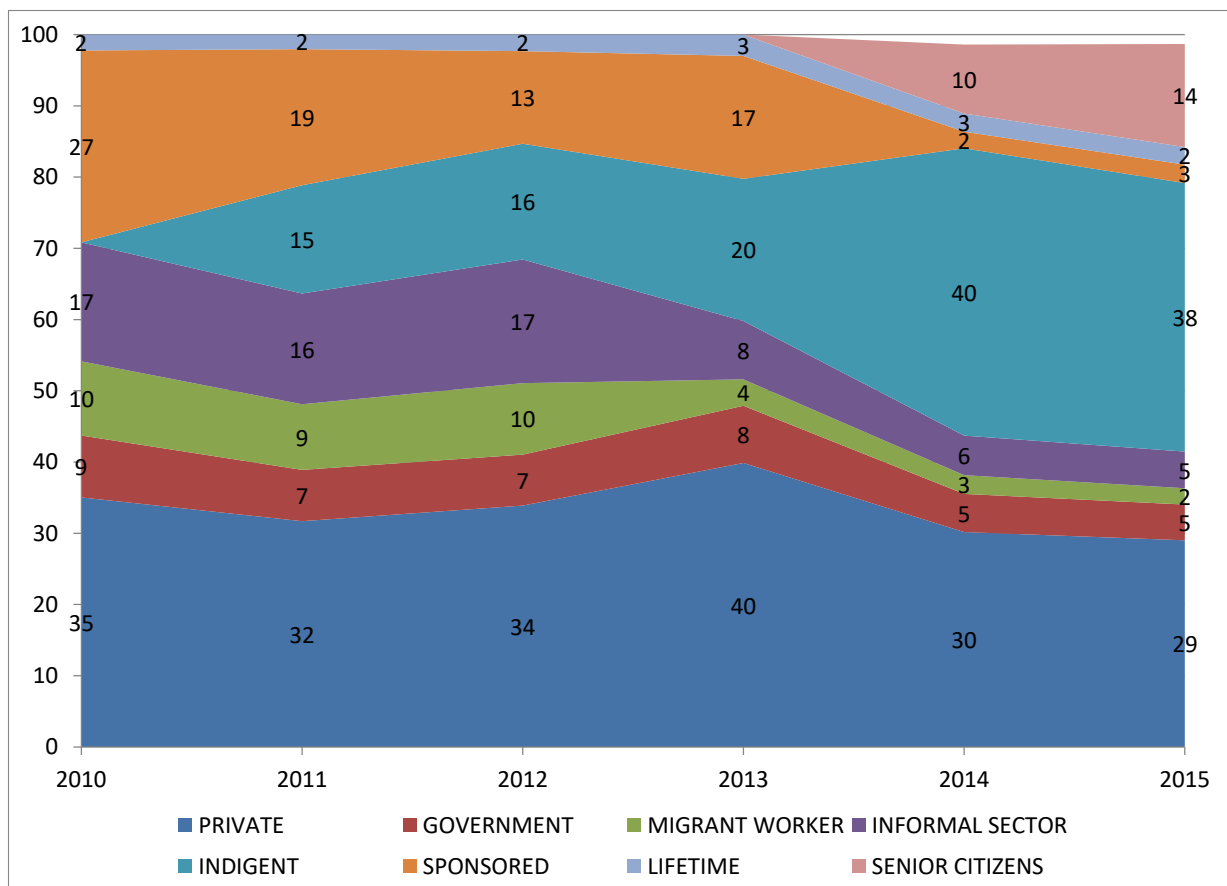
Source: PhilHealth Corporate Planning Department

Figure 3: Distribution of PhilHealth Members, 2015



Source: PhilHealth Corporate Planning Department shows the trend in the distribution of members by category. With their enrolment starting in 2011, the share of indigents was 15 percent. With the continued increase in their membership in 2012-2013 and the surge in enrolment in 2014, the share of indigents grew to 40 percent in 2014. This share slightly decreased in 2015 with the relative increase in the share of senior citizens. While the share of lifetime members increased only slightly particularly in 2013, the mandatory coverage of non-paying senior citizens starting in 2014 yielded a share of 10 percent, increasing to 14 percent in 2015. While the share of indigents generally increased, the share of sponsored members decreased from 27 percent in 2010 to 3 percent in 2015. The shares of informal sector members and migrant workers also generally decreased, from 17 percent to 5 percent for the former and from 10 percent to 2 percent for the latter. Although the shares of sponsored, informal sector and migrant worker members decreased, former members, especially of the two former categories, would have been absorbed into the indigent program. While the number of private employee members increased at a relatively constant rate, their share to total membership fluctuated but generally decreased from 35 percent in 2010 to 29 percent in 2015. Finally, although the number of government employee members was relatively unchanged, their share decreased from 9 percent to 5 percent.

Figure 3: Distribution of PhilHealth Members, 2015



Source: PhilHealth Corporate Planning Department

In 2011, there were 5.26 million identified poor families out of 10.9 million assessed. This translates to 48.2 percent of households assessed considered poor. In contrast, there are 4.7 million poor households based on the 2012 Family Income and Expenditures Survey, or 22.3 percent poverty incidence among families. This translates to 12 percent more NHTS-poor families than FIES-poor families. This confirms leakages in the indigent program. The indigent PhilHealth members numbering 4.2 million comprise 80 percent of the NHTS-poor households and 89 percent of the FIES poor households. The indigent PhilHealth members are 3.7 times the poor labor force in 2011 (labor force multiplied by the poverty incidence among the population. In the 2015 round, out of 15.1 million households assessed, 5.1 million (34%) were considered poor.

## B. Coverage

Table 1 shows the enrolment rates by membership category for 2015. The enrolment rates are analyzed with reference to the 2010 figures (Manasan, 2011). Coverage rate for indigents over the poor labor force (138%) continues to be the highest and in excess of complete coverage. However, it is less than in 2010 calculated over

poor households. With indigent enrolment (sponsored program in 2010) quadrupling between 2010 and 2015, coverage rate over poor households would rise to 338 percent. A separate coverage rate is computed for sponsored members (36%) over the near poor population.<sup>3</sup> Coverage rate for the informal sector<sup>4</sup> over the self-employed workers is at 22 percent. This is lower than the combined coverage rate for individually paying members and overseas workers of 33 percent in 2010 over the members of the informal sector. The current estimates include a separate coverage rate for overseas workers of 39 percent.

Table 1: PhilHealth Enrolment Rates by Membership Category, 2015

Category	Population (thousands)	Members (thousands)	Enrolment Rate
Private	18,185 <sup>a</sup>	11,770	65%
Government	3,308 <sup>b</sup>	2,035	62%
Informal Sector	11,087 <sup>c</sup>	2,481	22%
Migrant Worker	2,377 <sup>d</sup>	930	39%
Indigents	11,101 <sup>e</sup>	15,289	138%
Sponsored Members	2,911 <sup>f</sup>	1,050	36%
Senior Citizens	7,844 <sup>g</sup>	5,868	75%
Lifetime Members		1,002	
Total	56,812	40,425	71%

Labor Force Survey, October 2015: Employed who

a/ Worked for Private Establishment,

b/ Worked for Government/Government Corporation

c/ Self-employed without any paid employee

d/ Number of Overseas Contract Workers, 2015 Survey on Overseas Filipinos

e/ Labor Force \* Poverty Incidence among Population (%)

f/ Near Poor Households as of 2012 (Paqueo, Orbeta, Cortes, & Cruz, n.d.) \* Poverty Incidence among Population / Poverty Incidence among Families

g/ Population aged 60 and above, 2015 Projection, 2000 Census

Lifetime members and senior citizens combined have the second highest coverage rate at 75 percent. This is mainly due to the mandatory coverage of senior citizens starting in 2014. Under-coverage continues for private employees (although coverage rate rose to 65 percent) as well as for government employees (with coverage rate further decreasing to 62 percent). This may be due to persistent contractualization of

<sup>3</sup> The hospital-sponsored program covers the poor (not captured in the indigent program) and the near poor whose income is no more than 40 percent greater than the poverty threshold. Paqueo, Orbeta, Cortes, & Cruz (n.d.) estimate a near poor household population of 2.99 million in 2012. This is adjusted by the ratio of poverty incidence among the population to the poverty incidence among families.

<sup>4</sup> This excludes workers in private households, paid workers in family-owned enterprises as formal workers, and enterprise owners as PhilHealth considers these as part of the formal economy.

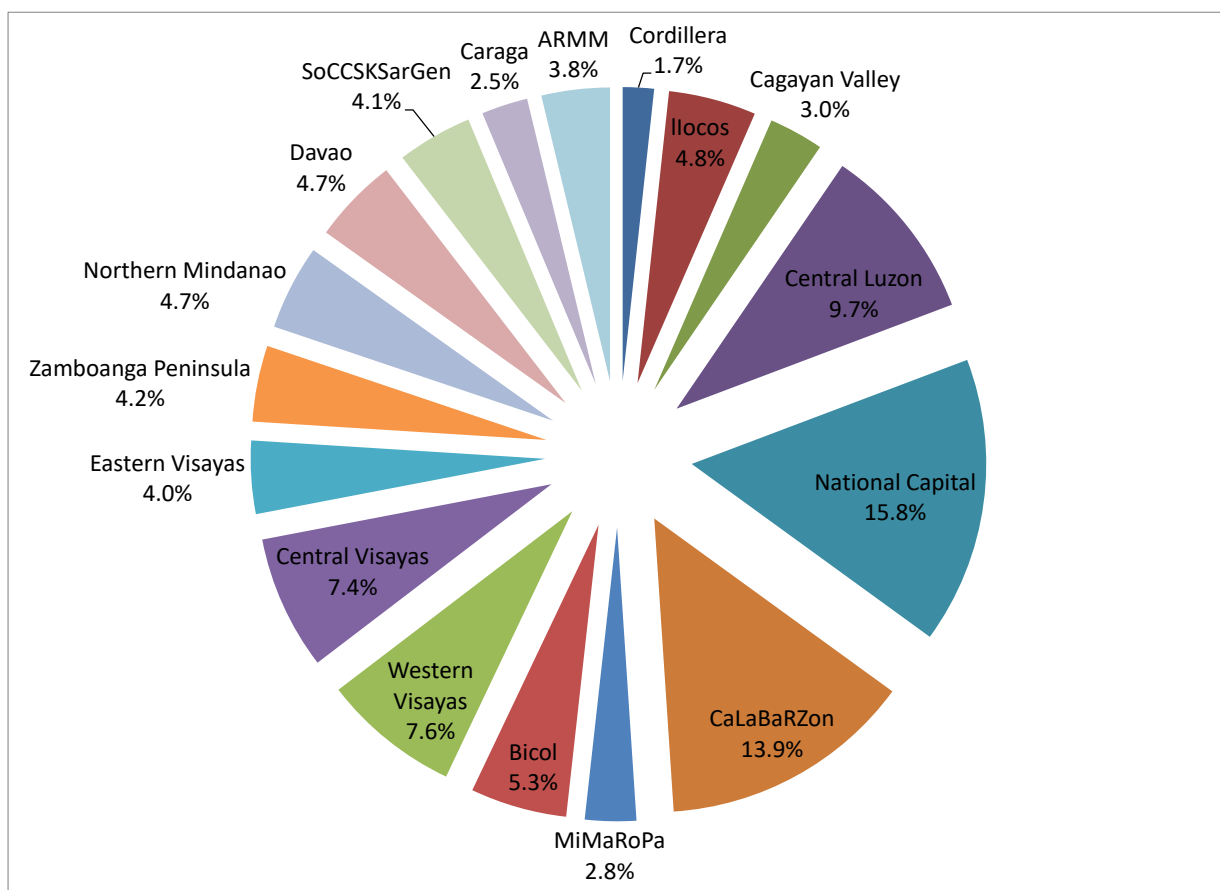


employees in private businesses and even in government, a practice which the new administration seeks to stop.

### C. Regional coverage

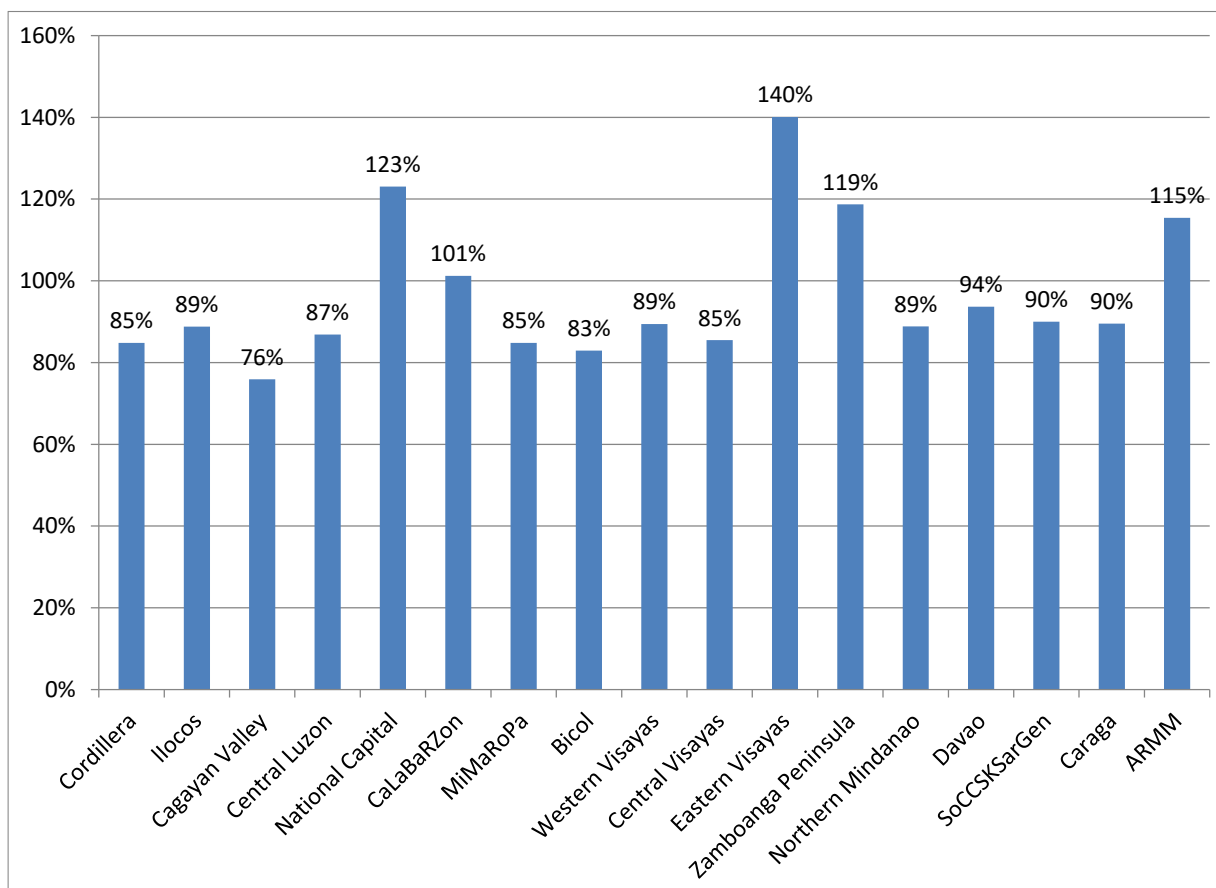
Figure 4 shows the distribution of members by region in 2015. The regions of Luzon account for almost six out of ten members. Visayas regions account for less than one fifth of the members while the regions of Mindanao constitute less than one fourth. The national capital has the largest share at 16 percent followed by CaLaBaRZon (14%) and Central Luzon (10%). Cordillera has the lowest share at 1.7 percent, followed by Caraga (2.5%) and MiMaRoPa (2.8%). Coverage rates across regions relative to the labor force are given in Figure 5. Under-coverage ranges from 6 percent in Davao to 24 percent in Cagayan Valley. Over-coverage ranges from 15 percent in ARMM, 19 percent in Zamboanga, and 23 percent in NCR to 40 percent in Eastern Visayas. Calabarzon has complete coverage.

Figure 4: Distribution of Members by Region, 2015



Source: PhilHealth Corporate Planning Department

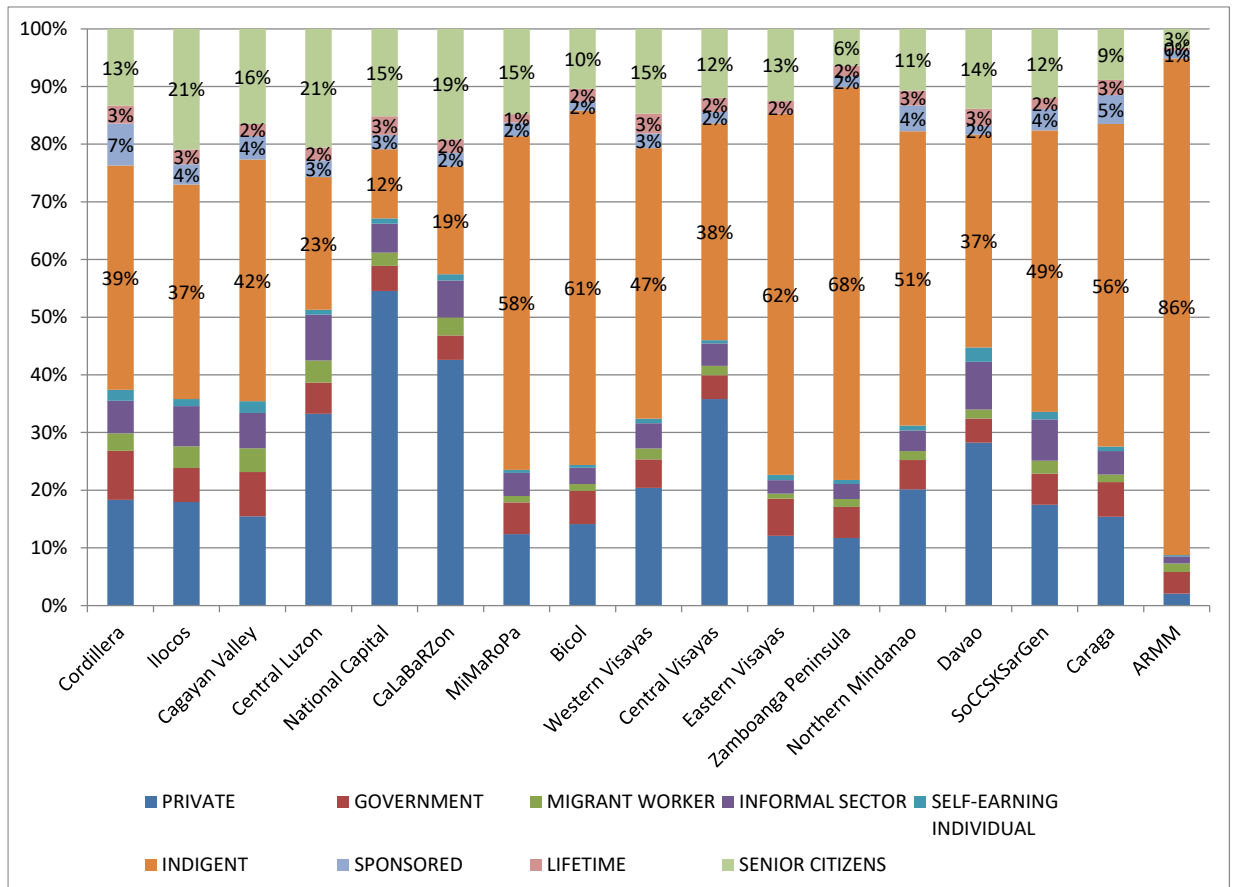
Figure 5: PhilHealth coverage rate by region, 2015



Source of basic data: PhilHealth, Labor Force Survey 2015

Figure 6 shows the distribution of members for each region in 2015. In most regions, indigent members have the largest share. This is true for the entire Visayas and Mindanao where indigent members' share ranges from 37 percent in Davao to 86 percent in ARMM. For most regions in Luzon, indigents also have the largest share, ranging from 37 percent in Ilocos to 61 percent in Bicol. On the other hand, the share of indigents is second only to those of private employees in the national capital and adjoining regions Central Luzon and CaLaBaRZon, and in Central Visayas. There are generally less indigents in the regions of Luzon but there are more sponsored beneficiaries. On the other hand, there are more indigents in Visayas and Mindanao and less sponsored beneficiaries. This is said to be because local governments in Luzon have more income.

Figure 6: Distribution of Membership by Region, 2015



Source of basic data: PhilHealth Corporate Planning Department

Table 2 shows the comparative poverty incidences by region. In Metro Manila, the NHTS poverty incidence is almost 12 times the FIES poverty incidence. Across other regions, NHTS poverty incidence ranges from 1.3 to 3.8 times more than the FIES poverty incidence. However, the shares of poor show a different picture. Luzon has a bigger share of NHTS poor (41%) compared to its share of the FIES poor (37%). This is true for most regions, especially the National Capital Region whose share of NHTS poor is (6%) is almost three times its FIES share of poor (2.2%), except Cordillera and Cagayan Valley. On the other hand, Visayas has a smaller share of NHTS poor (20%) compared to its share of FIES poor (25%) and this is true across its three regions. Mindanao has a slightly higher share of NHTS poor (39%) compared to its share of FIES poor (37%). This is mainly due to the much larger share of NHTS poor in ARMM (10.1%) compared to the FIES poor (5.6%). While the shares of NHTS poor are also larger than the shares of FIES poor in Zamboanga Peninsula and Caraga, these are offset by the lower NHTS shares of poor in Northern Mindanao, Davao and Soccsksargen.

Table 2: NHTS Poverty 2011 and FIES Poverty 2012

Region	NHTS 2011				FIES 2012				NHTS Poor / FIES Poor	NHTS Poverty / FIES Poverty
	Households Assessed	Poor Households	Poor / Assessed (%)	Share of Poor	Families (thousands)	Poor Families (thousands)	Poverty Incidence	Share of Poor		
National Capital	697,443	316,823	45.4	6.0	2917	111	3.8	2.4	2.9	11.9
Cordillera	234,233	79,816	34.1	1.5	375	85	22.6	1.8	0.9	1.5
I Ilocos	543,948	247,882	45.6	4.7	1105	184	16.7	3.9	1.3	2.7
II Cagayan Valley	408,233	118,118	28.9	2.2	771	153	19.8	3.3	0.8	1.5
III Central Luzon	712,255	322,622	45.3	6.1	2386	292	12.2	6.2	1.1	3.7
IV-A CALABARZON	912,988	389,811	42.7	7.4	3082	345	11.2	7.4	1.1	3.8
IV-B MIMAROPA	513,759	242,633	47.2	4.6	638	181	28.4	3.9	1.3	1.7
V Bicol	775,014	461,242	59.5	8.8	1165	398	34.1	8.5	1.2	1.7
VI Western Visayas	957,128	385,518	40.3	7.3	1604	396	24.7	8.5	1.0	1.6
VII Central Visayas	781,572	314,654	40.3	6.0	1577	454	28.8	9.7	0.7	1.4
VIII Eastern Visayas	719,273	335,208	46.6	6.4	902	335	37.2	7.1	1.0	1.3
IX Zamboanga Peninsula	599,951	369,239	61.5	7.0	772	285	36.9	6.1	1.3	1.7
X Northern Mindanao	691,689	338,749	49.0	6.4	976	348	35.6	7.4	1.0	1.4
XI Davao	547,775	272,933	49.8	5.2	1078	308	28.6	6.6	0.9	1.7
XII Soccsksargen	581,853	296,043	50.9	5.6	988	371	37.5	7.9	0.8	1.4
XIII Caraga	405,310	232,301	57.3	4.4	532	182	34.1	3.9	1.3	1.7
ARMM	827,032	531,526	64.3	10.1	557	261	46.9	5.6	2.0	1.4
TOTAL	10,909,456	5,255,118	48.2	100.0	21425	4688	21.9	100.0	1.12	2.2

Source of data: data.gov.ph; Philippine Statistical Association

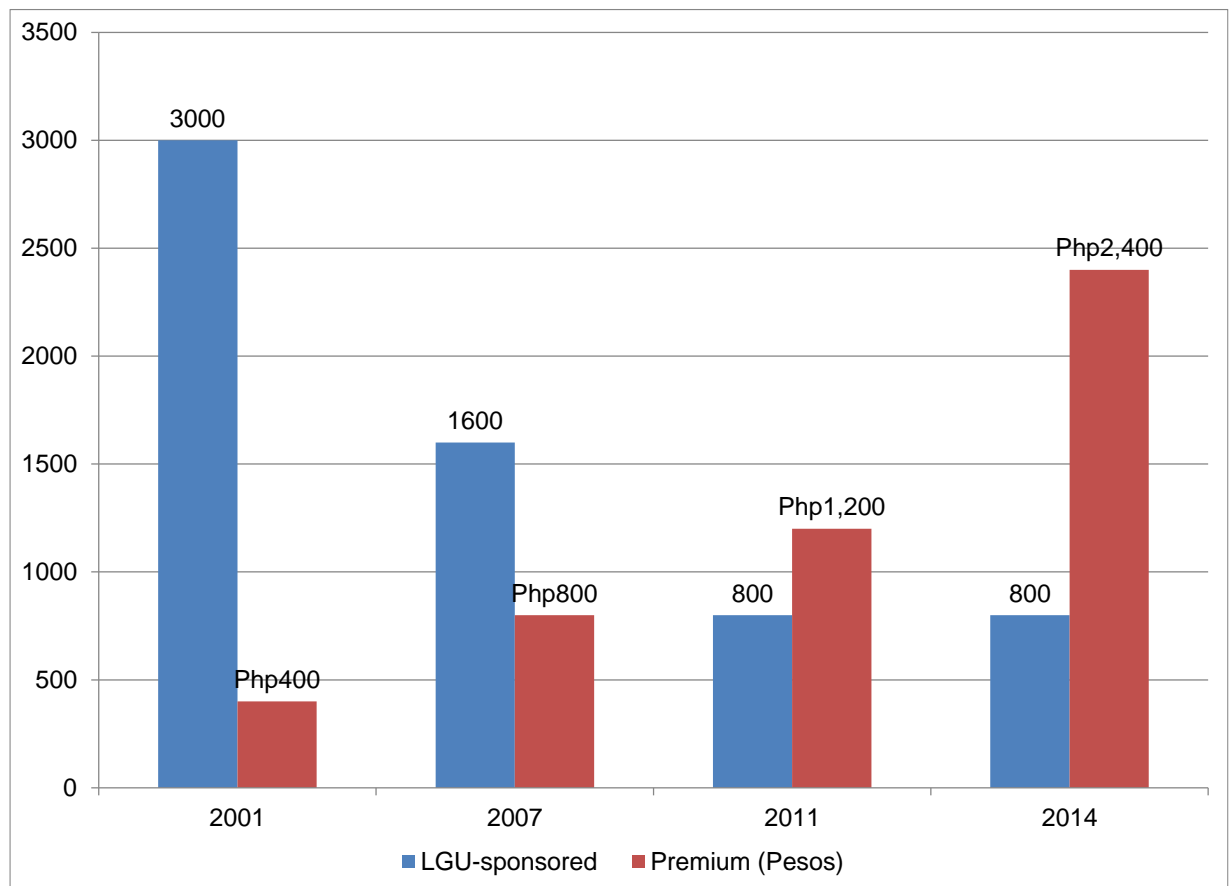
## **D. LGU-Sponsored Members: Baguio City**

In the Cordillera, out of 232,228 households assessed, 77,811 (33.5%) were indigents. In Benguet, 17,947 poor households were identified which is 31.4% of 57,118 assessed. In Baguio City, 15,083 households were assessed, of which 3,595 (23.8%) were indigents, 77.5% of whom are covered by 4Ps. Out of 128 barangays, 15 were considered pockets of poverty. Together with the NHTS Indigents, there were 833 LGU-sponsored members, for a total of 4,428 poor households. Most of the poor are said to be transients / immigrants. Out of 4,223 poor families identified in the CBMIS, 3,806 were confirmed poor by the NHTS. Of these, the health insurance of 2,920 was covered by the 4Ps. The rest was sponsored by the local government.

To obtain a picture of local government sponsorship of PhilHealth members, a case study of Baguio City was conducted. As with other LGUs, the indigent program started in 2001 as “Medicare para sa Masa” (Medicare for the masses). The poor were identified using the Community-Based Management Information System (CBMIS) under the government’s Minimum Basic Needs (MBN) approach. In 2009, the poor were identified using the Local Poverty Indicators Monitoring System (LPIMS) with the assistance of the National Statistical Coordination Board (NSCB). In 2011 and 2014, the poor were identified using the NHTS under the government’s Bottom-up Budgeting.

Figure 7 shows the number of LGU-sponsored members from 2001 to 2014 against the premium contribution. From 2001 to 2013, the local government budget for PhilHealth sponsorship of the poor was P1Million per year. The number of sponsored families decreased from 3,000 in 2001 to 1,600 in 2007 as the premium increased from P400 to P800. The sponsorship decreased further to 800 in 2011-12 as the premium increased further to P1,200. In 2014, while the local government budget increased to P2 Million with additional funding from the congressman's PDAF, the premium also increased to P2,400 restricting the number of beneficiaries. Out of 2,900 poor (based on the poverty threshold), only 833 were sponsored (based on the food threshold) due to the limited budget. These include community volunteers, street sweepers, barangay health workers, barangay nutrition scholars, and barangay tanods. The rest were referred to the hospital point-of-care program. Based on this experience the CSWO believes that the local government needs more funds to sponsor the poor. Also, premium payments should be lower for self-employed, youth, women, and those with irregular employment.

Figure 7: LGU-sponsored members and premium contributions, Baguio City



Source of data: City Social Welfare Office

Of the identified poor, 60 percent are estimated to have availed of their PhilHealth benefits. Prior to the PhilHealth program, the poor would line up for financial assistance at the CSWO for medication, laboratory tests to operation. Each of the city's 15 social workers would have 25 clients with health related concerns. With the PhilHealth program, the cases decreased to 10-12 clients per social worker per day and these relate more to chronic cases where their PhilHealth benefits have been used up.

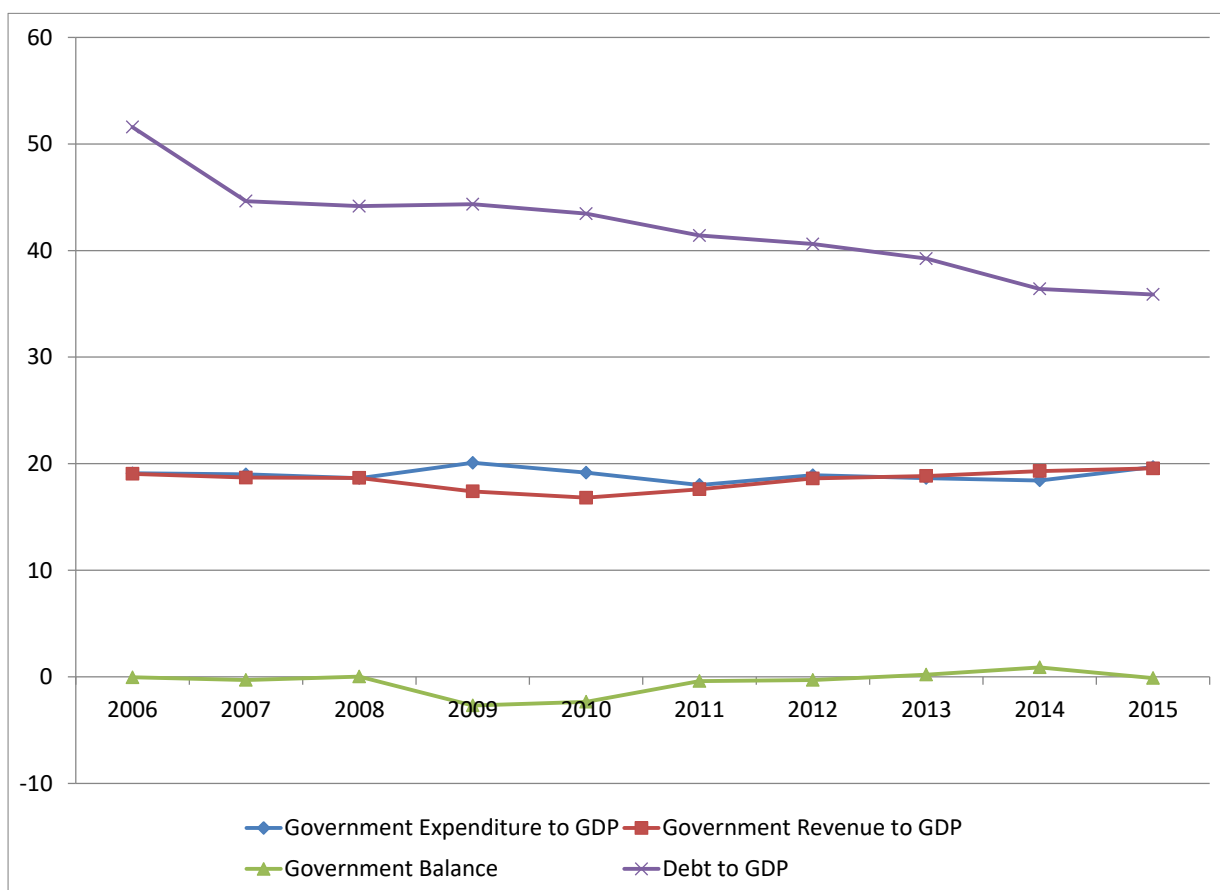
## IV. Fiscal Context

The fiscal environment is important to the performance of the health system, particularly to the health financing activities it can undertake and the universal health coverage goals it can achieve (McIntyre and Kuzin, 2016). Fiscal capacity or the ability and willingness of the government to marshal public resources is important as it enables the government to allocate resources for health programs and services. The greater the public resources for health, the less dependent the system is on out-of-pocket health spending and the lower the risk of catastrophic health condition.

Important fiscal indicators include government spending to GDP ratio, government revenue to GDP ratio, budget surplus or deficit and government debt to GDP ratio.

Figure 8 shows the fiscal position of the Philippines. The fiscal capacity of the Philippines is low. While government spending rose from 18 percent of GDP in 2011 to 19.7 percent in 2015, it remains low. The “rule of thumb” for medium government spending to GDP is at least 25 percent. Government revenue is similarly low. While it has been increasing from 16.5 percent in 2010, it remains below 20 percent as of 2015. The government budget is generally on balance, although it turned negative in 2009-2010 and somewhat positive in 2014. This means that there is no scope for increasing government spending on health. The Philippines has achieved a “prudent” government debt-to-GDP ratio of 35.9 percent in 2015, down from 51.6 percent in 2006. For developing countries, a government debt-to- GDP ratio of no more than 40 percent is considered “prudent”. Debt-servicing is therefore sustainable and does not threaten government spending on health.

Figure 8: Fiscal Position



Source of data: IMF Fiscal Monitor

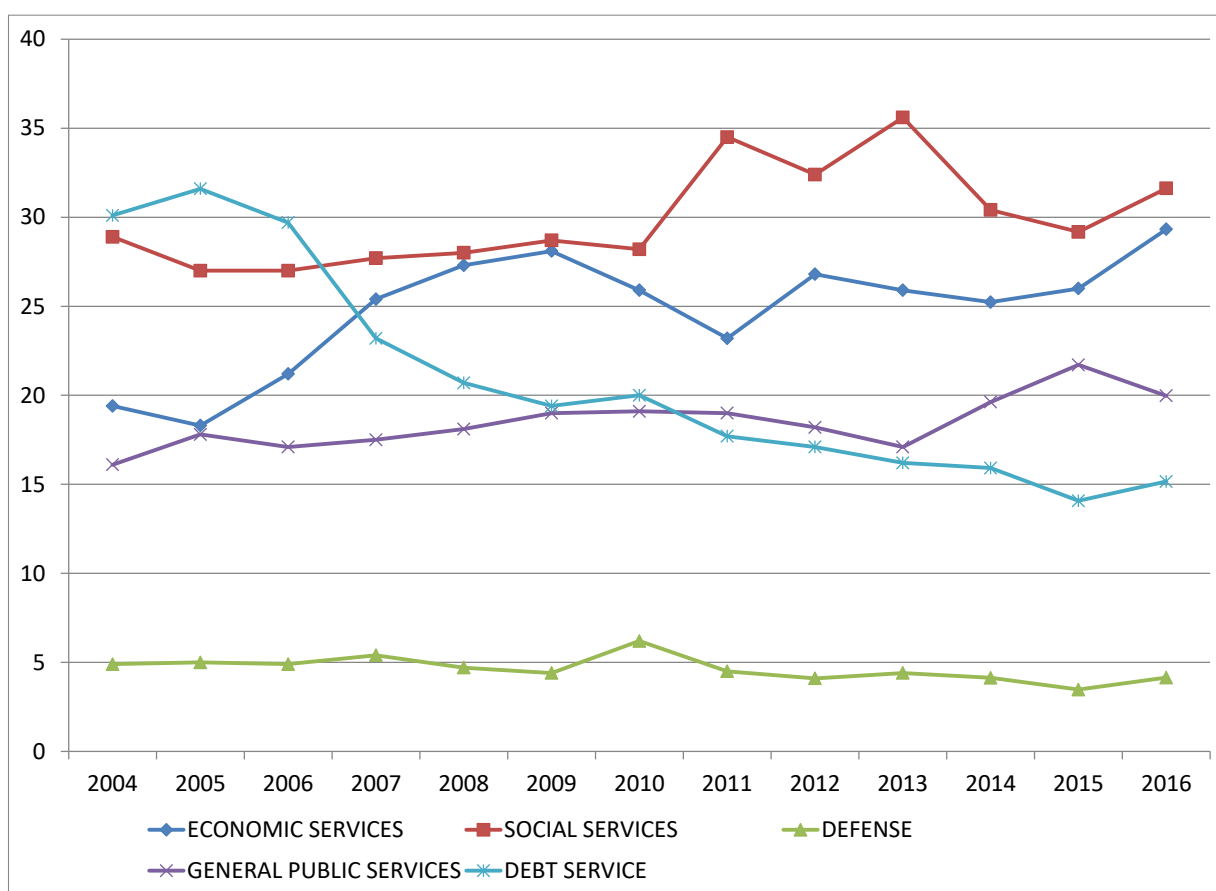
Figure 9 shows the sectoral distribution of public spending for 2004-2016. Social spending only changed slightly between 2004 and 2010, averaging about 28 percent of

total government spending. Social spending jumped in 2011-2013, averaging around 34 percent. However, it declined in recent years, averaging around 30 percent in 2014-2016.



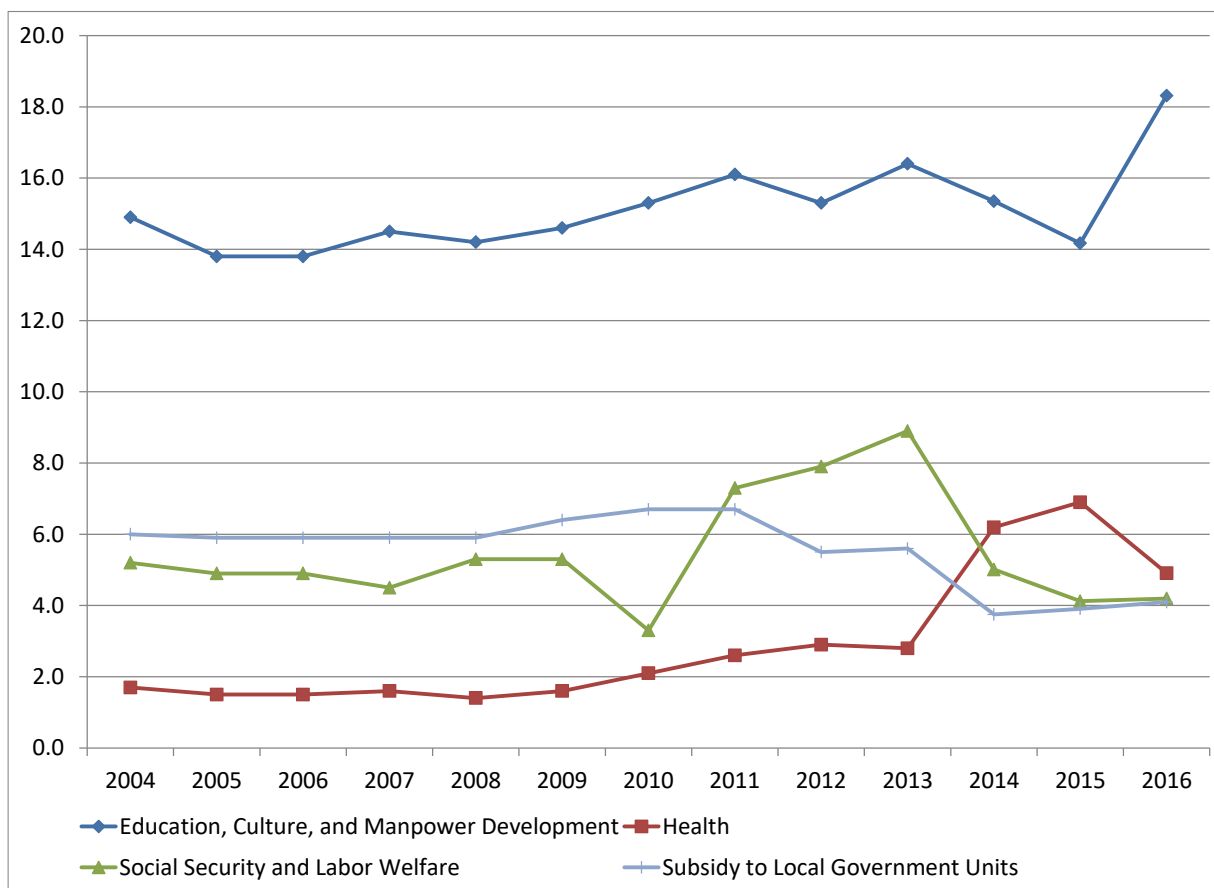
Figure 10 shows the distribution of public spending on social services. The jump in social spending in 2011-2013 is mainly due to the increase in the share of social security and labor welfare to 8 percent from an average of 4.8 percent in 2004-2010. The jump in social spending also reflects the movements in education and health spending, each contributing around 1 percentage point in the increase in 2011-2013. However, while the share of health spending jumped from 2.8 percent 2013 to 6.9 percent 2015, the share of total social spending actually decreased following the decrease in the shares of education spending and social security and labor welfare.

Figure 9: Sectoral Distribution of Public Expenditures, 2004-2016



Source: DBM Fiscal Statistics Handbook (2004-2013), BESF (2016)

Figure 10: Distribution of Public Expenditures on Social Services



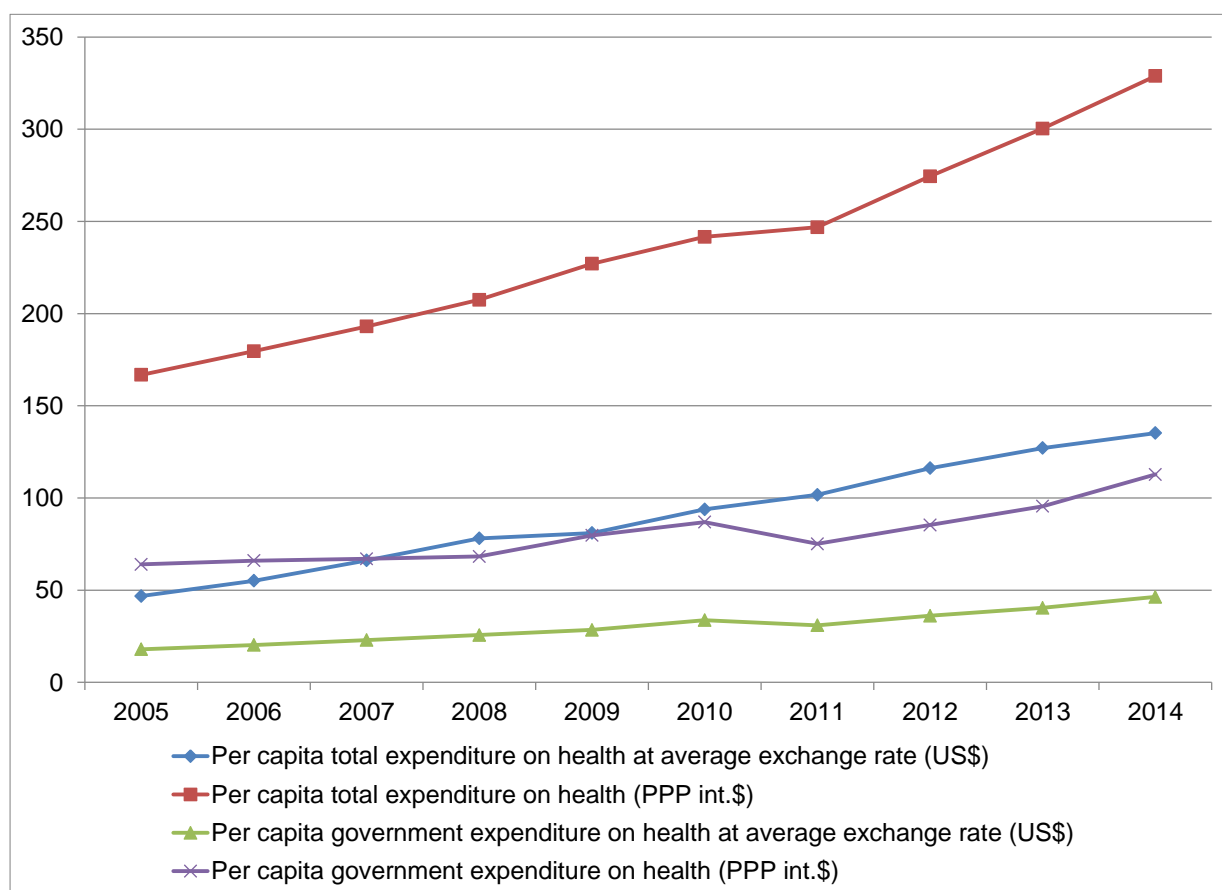
Source: DBM Fiscal Statistics Handbook (2004-2013), BESF (2016)

In examining the health financial system, it is important to look at the level, trend and composition of health spending (McIntyre and Kuzin, 2016). Important indicators include the total health expenditure as a proportion of GDP (THE/GDP), the general government health expenditure as a proportion of GDP (GGHE/GDP), per capita government health expenditure, general government health expenditure as a proportion of total health expenditure (GGHE/THE), private health expenditure as a proportion of total health expenditure (PHE/THE), out-of-pocket spending as a proportion of total health expenditure (OOPS/THE), and voluntary health insurance as a proportion of total expenditure on health (VHI/THE).

Figure 11 shows the total and government health expenditures in US and PPP Dollars. Total health spending per capita (PPP) rose from \$167 in 2005 to \$329 in 2014. In 2013, per capita health spending in the Philippines was \$300, lower than the averages for South Asia (\$321), East Asia and the Pacific (\$589), and even for low middle income countries (\$310). Nevertheless, health spending per capita increased as a percentage of GDP per capita from 3.9% in 2005 to 4.7% in 2014 (Figure 12), achieving the target of 4-4.5% before 2016. The share of government in health expenditure generally decreased between 2005 and 2014. From 38.4% in 2005, the share of government spending decreased to 34.3% in 2014. Corollary to this, the share

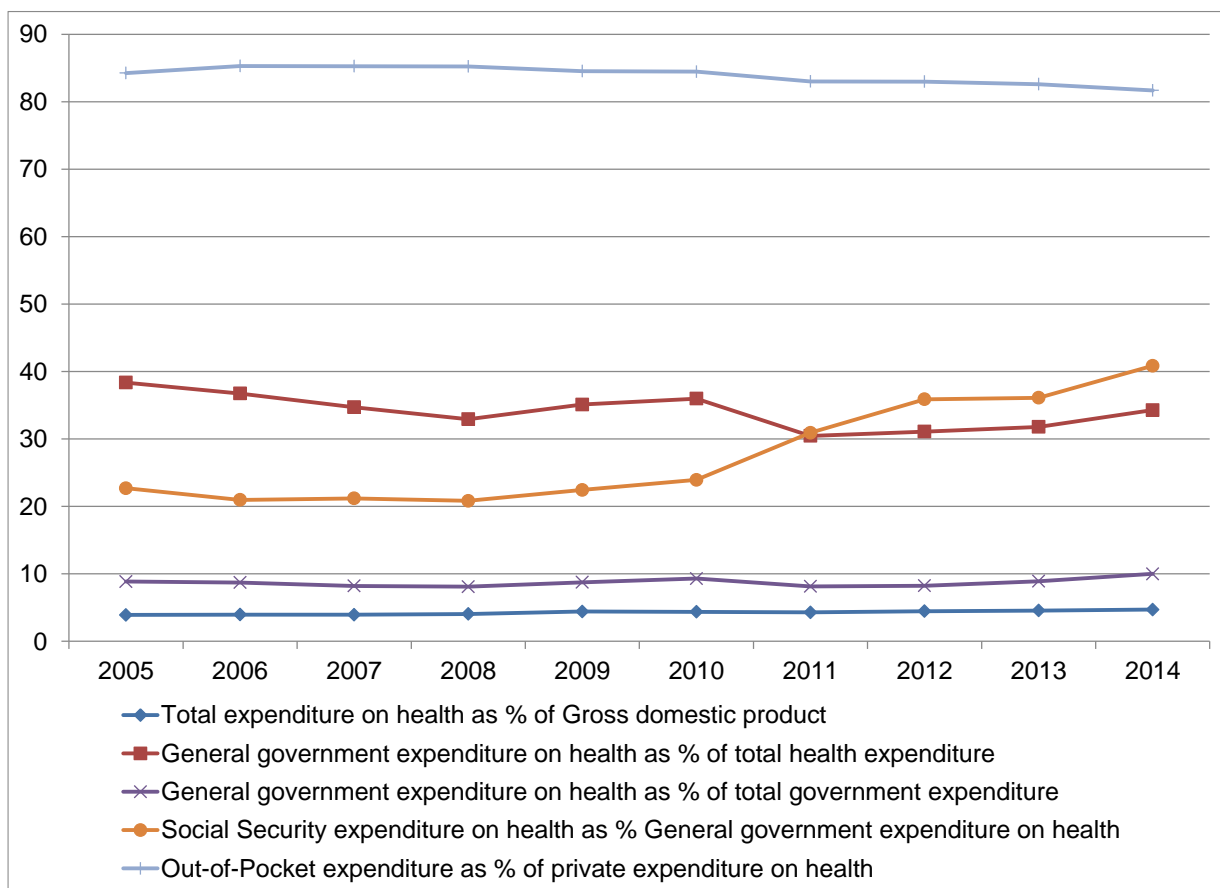
of private health spending increased from 61.6% to 65.7%. Government spending on health as a percentage of total government spending fluctuated between 2005 and 2014 but rose from 8.1% in 2011 to 10% in 2014, achieving the target of 6%. In 2013, this share was 8.9 percent, higher than the average for South Asia (8.3%) but lower than the average for East Asia and the Pacific (11.5%) and even for low income countries (10.8%). Of the total government spending on health, the share of social security increased from 21% in 2006 to 41% in 2014. Of the total private expenditure on health, the share of out-of-pocket expenses decreased from 85.3% in 2006 to 81.7% in 2014 while that of voluntary health insurance increased from 9.6% to 13.1%. In 2013, out-of-pocket spending as a share of total health spending was 56.3%. This is still far from the target of 45% and higher than the averages for South Asia (50.3%), East Asia and the Pacific (27.5%) and low income countries (42.3%). In 2014, the proportion of social insurance to total health spending (share of social insurance to government health spending times share of government health spending to total health spending) was 14 percent.

Figure 11: Health Expenditures in US\$ and PPP Int'l \$



Source: WHO Global Health Expenditure Database

Figure 12: Relative Health Expenditures



Source: WHO Global Health Expenditure Database

The sources of revenue can be classified into mandatory prepayment, voluntary prepayment, out-of-pocket spending and foreign sources (McIntyre and Kuzin, 2016). In 2013, the Philippines' total health expenditure was over 526 Billion Pesos. Figure 13 shows the distribution of national health spending in 2013.

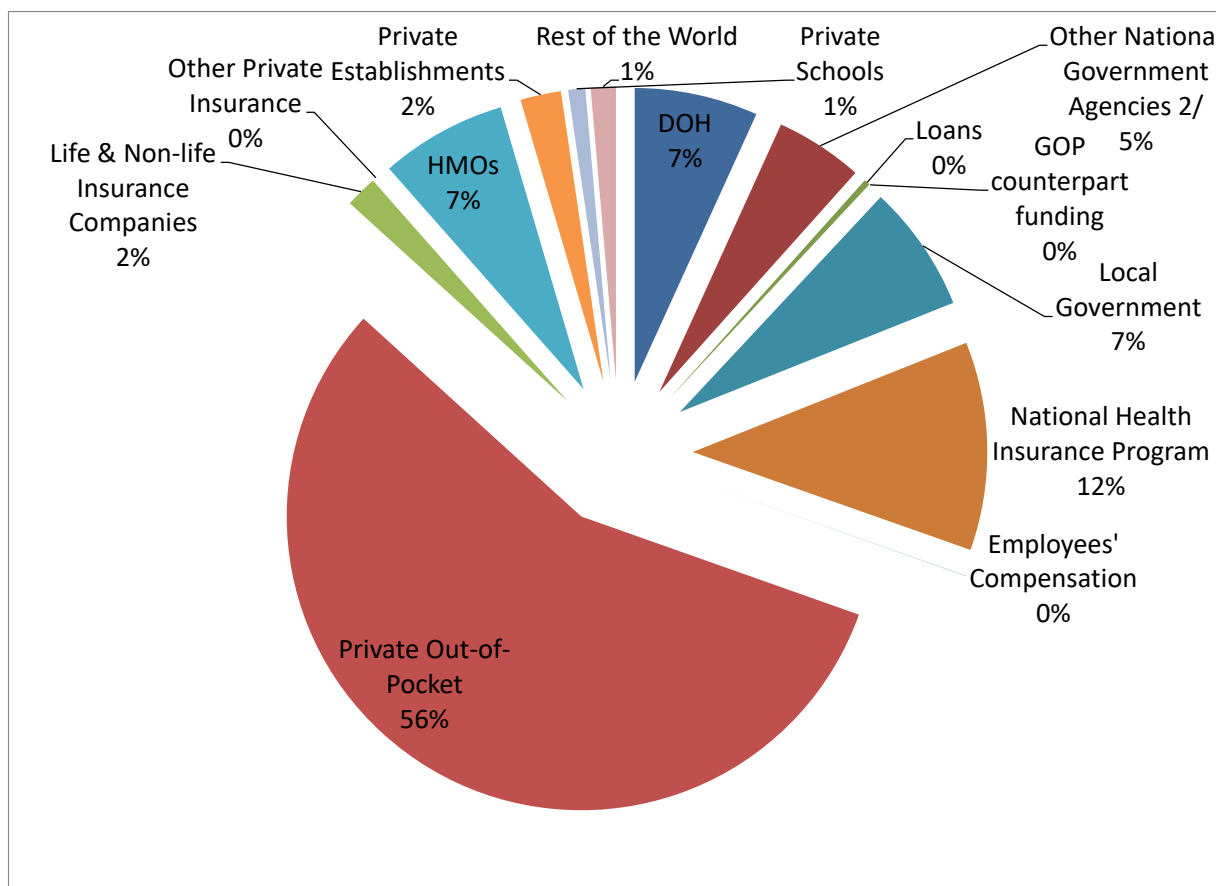
Mandatory pre-payment constitutes 30.4 percent of total health spending. This includes general spending by the national government (11.9%) and local governments (7%), social health insurance (11.5%) from earmarked revenues (3.5%) and member contributions (8%). National government spending includes spending by the Department of Health (6.8%), other national agencies with health-related activities (4.8%) and loans and government counterpart for foreign-assisted projects (0.3%). Social insurance is financed almost entirely by the National Health Insurance Program, partly by a subsidy for indigents (3.5%) from earmarked revenues.

Voluntary prepayment schemes constitute 8.7% of total health spending while private sources constitute 4 percent, and foreign sources constitute 1.4 percent. The existence of prepayment schemes apart from the national health insurance program indicates fragmentation in pooling arrangements. Independent health spending by

local governments, given the devolution of health services, also contributes to the fragmentation (Department of Health, 2010). The higher share of compulsory prepayment over voluntary prepayment is good progress toward universal health care.

Private out-of-pocket expenditure constitutes the bulk (56.3%) of health spending and remains a financial barrier to access to health services. Ulep & Dela Cruz (2013) studied the distribution of out-of-pocket expenditures. They found that in 2012, half of out-of-pocket spending went to medical products, of which almost two-thirds went to pharmaceutical products and almost three-tenths went to supplements. The share of medical products to out-of-pocket spending was higher among the poor (59% for the 1<sup>st</sup> quintile) than among the rich (46% for the 5<sup>th</sup> quintile). On the other hand, the shares of inpatient and outpatient services were higher among the rich (37% and 17%) than among the poor (28% and 13%). For inpatient services, the share of spending for public hospitals decreased with income while the share of spending for private hospitals increased with income. The burden of health payments, which is share of out-of-pocket spending to income over subsistence level, increased from 2.8 percent in 2000 to 4.8 percent in 2012 and increased with income. The share of households incurring catastrophic health payments (out-of-pocket health spending over 40% of their income) has increased from 0.5% in 2000 to 1.5% in 2012. The proportion would be higher if the 10% threshold of the World Bank is used instead of the 40% threshold of WHO. In 2012, the average out-of-pocket spending of the poorest quintile was 11.5% of its disposable income.

Figure 13: Distribution of National Health Spending, 2013



Source of data: NSCB National Health Accounts

In 2014, the national government earned almost Pesos 1.95 Trillion in revenues 89 percent of which are from tax revenues (Commission on Audit, 2014). Almost four-fifths of tax revenues come from business taxes (almost 45%) and income taxes (33%). The rest of the tax revenues come from excise tax (12.3%), documentary stamp tax (4.2%), import duties (3.3%), motor vehicle user charge (1.4%), estate taxes (0.7%) and other taxes (0.4%).

Business income is taxed at 30 percent since 2009; before that, the tax rate was 35 percent. Individual income tax is progressive. Individual income tax is composed of a fixed tax and a percentage tax that both increase across seven income ranges. The percentage tax starts at 5% for annual incomes not exceeding 10,000 pesos up to 32 percent for incomes exceeding 500 thousand pesos. The fixed tax ranges from 500 pesos for incomes more than 10 thousand pesos but not more than 30 thousand pesos to 125 thousand pesos for annual incomes greater than 500 thousand pesos. The combined fixed and percentage taxes yield an effective tax rate of at least 5 percent to over 25 percent.

Total revenues account for 38 percent of cash inflows of Pesos 4.9 Trillion. The national government had a total appropriation of almost Pesos 3.1 Trillion, 93 percent of which are current appropriations and 7 percent are continuing appropriations from previous years. General appropriations make up 56 percent of current appropriations, while automatic appropriations constitute 43 percent; supplemental appropriations make 1 percent. Appropriations for health amounted to Pesos 56.8 Billion, accounting for 1.8 percent of the total appropriations.

In 2016, the Department of Health has a general appropriation of Pesos 122.6 Billion of which 99 percent goes to programs and 1 percent goes to projects. Almost 93 percent of the budget for programs goes to operations. The bulk (82%) of operations budget goes to technical support services, of which 47 percent goes to the health insurance subsidy of indigents. The subsidy for the premium contributions of indigents constitutes 36 percent of the entire appropriation for the health department.

With almost half (45%) of government revenues financed by corporate tax and almost two-thirds (64%) of the health department's spending financed from the general fund, roughly one-third of health spending would be financed by corporate taxes. If we assume business taxes are predominantly incurred by the rich, the burden of health spending financed by corporate taxes would be considered progressive. With a third of government revenues financed by individual income tax, roughly two-ninths of health spending would be progressive, that is, borne more by higher income groups. So, health spending in general is a form of cross-subsidy from the rich to the poor. On the other hand, with the subsidy for premium contributions of the poor financed by excise taxes, the burden of over a third of national health spending would be regressive, borne more by lower income groups.

The national health insurance subsidy for the premium contributions of indigents is financed by excise taxes. The ad valorem tax on alcohol (15% in 2013, 20% since 2015) is theoretically neutral (the same proportion is paid as income increases) but the specific tax (P15 per liter in 2013, P20 since 2015) is theoretically regressive (the tax decreases in proportion as income increases). The fixed tax on wines (apart from the excise and value added taxes) is two-tiered, amounting to P250 for wines costing no more than 500 pesos and P700 for wines costing more than P700. In each tier, the tax is theoretically regressive (the tax decreases in proportion as income increases). Cigars have 20% ad valorem tax and a P5 specific tax per cigar. Hand-packed cigarettes have a fixed tax of P12 in 2013 rising to P30 in 2017 and by 4% each year thereafter. Machine-packed cigarettes costing P11.50 or less are taxed P12 while those costing more are taxed P25 per pack. The fixed tax in each tier is regressive. The predominance of fixed taxes indicates that the "sin" tax system is theoretically generally regressive, assuming

that consumption of “sin” products are similar across income groups. In effect, the poor are financing their own health insurance through “sin” taxes.

There is another form of cross-subsidy though, “from the healthy to the sick”, assuming that consumers of “sin” products are still healthy or at least healthier than social insurance beneficiaries. Out-of-pocket payments are independent of income and are theoretically regressive as any amount decreases in proportion as income increases. However, the No Balance Billing policy exempts the poor from out-of-pocket payments.

## **V. PhilHealth Financing**

### **A. Revenue Raising**

The National Health Insurance Fund consists of member contributions, the social security health insurance funds under the Philippine Medical Care Act, earmarked appropriations, subsequent appropriations, and donations and grants-in-aid. Member contributions initially included “payroll taxes” from formal sector employees and voluntary contributions from self-employed members of up to 3 percent of their incomes, and government subsidy for premium contributions of indigents (RA 7875). In 2013, the cap on formal sector member contributions has been increased to 5 percent. Premium contributions of low-income informal sector members not considered as indigents shall now be partly or fully subsidized by local governments, legislators and / or other sponsors.

The subsidy for indigents was initially supposed to be equally shared between PhilHealth and local governments. However PhilHealth shall subsidize up to 90 percent for 4th-6th class municipalities initially for up to five years (RA 7875), then until they become 1<sup>st</sup>-3<sup>rd</sup> class municipalities (RA 9241) with the share of the local government increasing until it equals that of PhilHealth. Now, the national government fully subsidizes the premium contributions for indigents (RA 10606).

In lieu of the local government subsidy for indigents, local governments now sponsor low income individuals not qualified for full subsidy by the national government including barangay workers and volunteers. The DSWD also sponsors members of special sectors including “orphans, abandoned and abused minors, out-of-school youths, street children, PWDs, senior citizens and battered women”. House helpers are sponsored by their employers. Women about to give birth are also sponsored by the national government, local governments and/or legislators.

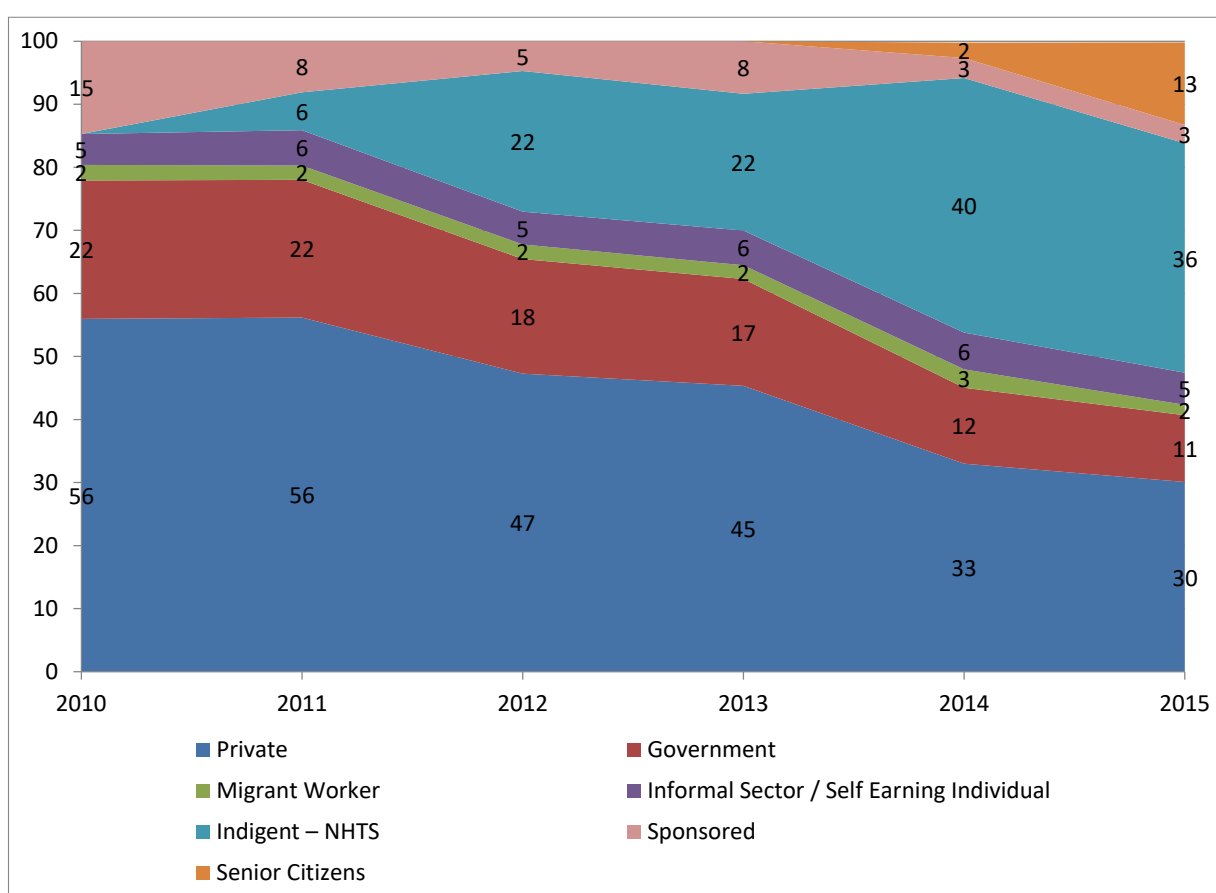
Subsequent appropriations come from twenty five percent of the increase in revenue from the revised excise tax on cigarettes (Republic of the Philippines, 1993b) and twenty five percent of the increase in revenue from the revised tax on documentary



stamp (Republic of the Philippines, 1993a). With the revision of the excise tax on alcohol and tobacco in 2012 (Republic of the Philippines, 2012), eighty percent of the increase in revenue is allotted to the National Health Insurance Program. Additional appropriations may also be requested from Congress.

In 2015, premium contributions amounted to over Pesos 99.6 Billion. Figure 14 shows the distribution of premium contributions. Earmarked revenues constitute over 52 percent of contributions, comprised mainly of premium subsidies for indigents (36%), senior citizens (13%) and sponsored members (3%). Payroll taxes constitute 41 percent of contributions including 11 percent mandatory contributions for government employees, 30 percent for private employees. Voluntary contributions constitute 7 percent including those from the informal economy (5%) and overseas workers (2%).

Figure 14: PhilHealth Premium Contributions, 2010-2015

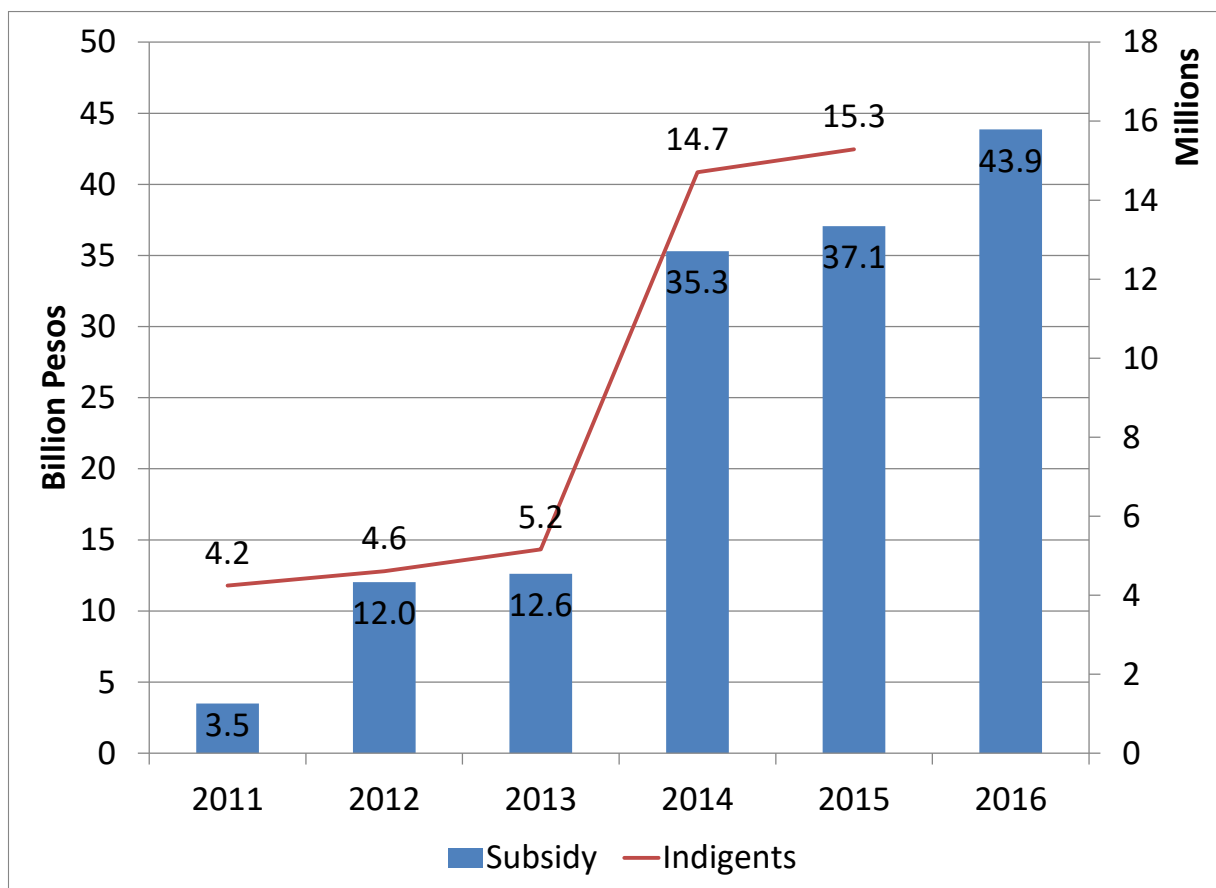


Source: PhilHealth Financial Statements, 2010-2015

Figure 15 shows the PhilHealth subsidy for indigents from 2011 to 2016. In 2011, the subsidy for health insurance premium of indigent families was Pesos 3.5 Billion (including P500 Million for informal sector workers). At the premium of P1,200, this would have covered over 2.9 Million households. With the increase in the premium

contribution to P2,400 in 2012 (Philippine Health Insurance Corporation, 2011b), the budget was increased to P12 Billion in 2012 to cover the NHTS poor including the beneficiaries of the 4Ps program (Philippine Health Insurance Corporation, 2012a). The budget was supposed to be released subject to LGUs' payment of their share but was released on condition that LGU payments will be paid to the national treasury's general fund. This budget represents the national government's full subsidy of the premium contribution of indigents, contrary to the provision in the National Health Insurance Act for sharing of payment with LGUs. The budget rose to over P12.6 Billion in 2013 covering the over 5.25 Million NHTS poor. This again rose substantially in 2014, by 1.8 times to P35.3 Billion covering over 14.7 Million members. This is 9.4 Million more than the NHTS-identified poor. PhilHealth attributes this increase to the enrollment of several families within the same household. The subsidy rose by 5 percent to P37 Billion in 2015. The subsidy covers the poor identified by DSWD, local social workers and medical social workers, non-salaried barangay officials, and unregistered senior citizens. It further rose by 18 percent to P43.9 Billion in 2016, P37 Billion for the poor and P6.8 Billion for unregistered senior citizens. No more than 7 percent of the budget can be used for program administration. The Department of Health has a separate appropriation for hospitalization assistance of indigents amounting to P3.2 Billion in 2014, P1.8 Billion in 2015, and P2.8 Billion in 2016.

Figure 15: PhilHealth Subsidy for Indigents, 2011-2016



Sources of data: General Appropriations Act, various years; PhilHealth

## B. Fund Pooling Arrangements

The national health insurance program is based on the principles of equity and solidarity. Health care access is supposed to be based on need rather than capacity to pay. Risk is shared among members of different incomes, ages and health conditions as well as geographical location. In view of this, the DOH financing strategy aims to enhance cross-subsidy from the rich to the poor.

A comparison of the share of premium contribution (Figure 14) and the share of membership (Figure 3) shows the degree of subsidization. An index of cross-subsidization may be constructed as the ratio of the share to premium contribution to the share to total membership (contribution-membership ratio, CMR). Members with a higher share of contribution relative to their share of membership ( $CMR > 1$ ) are subsidizing other members while the opposite is true ( $CMR < 1$ ) for those being subsidized. Table 3 shows the contribution-membership ratio by member category for 2010-2015. With the huge share to contributions of private employees especially in earlier years, it seems that this group subsidizes the poorer sectors. This is true in 2010-2012. For instance, in 2011, private employees' share to contributions stood at 56 while their share to membership was only 32 percent. This means that private employees were contributing 77 percent more than the average member to the social insurance fund. While their shares to contributions and membership decreased over time, their contributions declined faster than their membership, the former to 30 percent, the latter to 29%, so that in 2015, they were practically paying nothing more than (4 percent that of) the average member. While cross-subsidy from government employees also decreased, they continue to subsidize the poorer segment of society. Government employees paid a little over 3 times more than the average member in 2011 and a little over 2 times more in 2015. So why is there a decline in the cross-subsidies, especially from the private sector. It may be that employers are under-reporting their employees' salaries so they can decrease their share / counterpart to the contribution. This may also be related to the contractualization of employees which is undertaken to avoid health insurance contributions altogether.

Table 3: Contribution-Membership Ratio, 2010-2015

Member Category	2010	2011	2012	2013	2014	2015
Private	1.60	1.77	1.39	1.14	1.09	1.04
Government	2.53	3.03	2.54	2.11	2.25	2.11
Migrant Worker	0.24	0.25	0.23	0.59	1.11	0.72
Informal Sector / Self Earning Individual	0.29	0.36	0.30	0.67	1.05	0.99
Indigent – NHTS		0.40	1.37	1.09	1.00	0.97
Sponsored	0.55	0.42	0.36	0.48	1.37	1.12
Senior Citizens					0.25	0.91

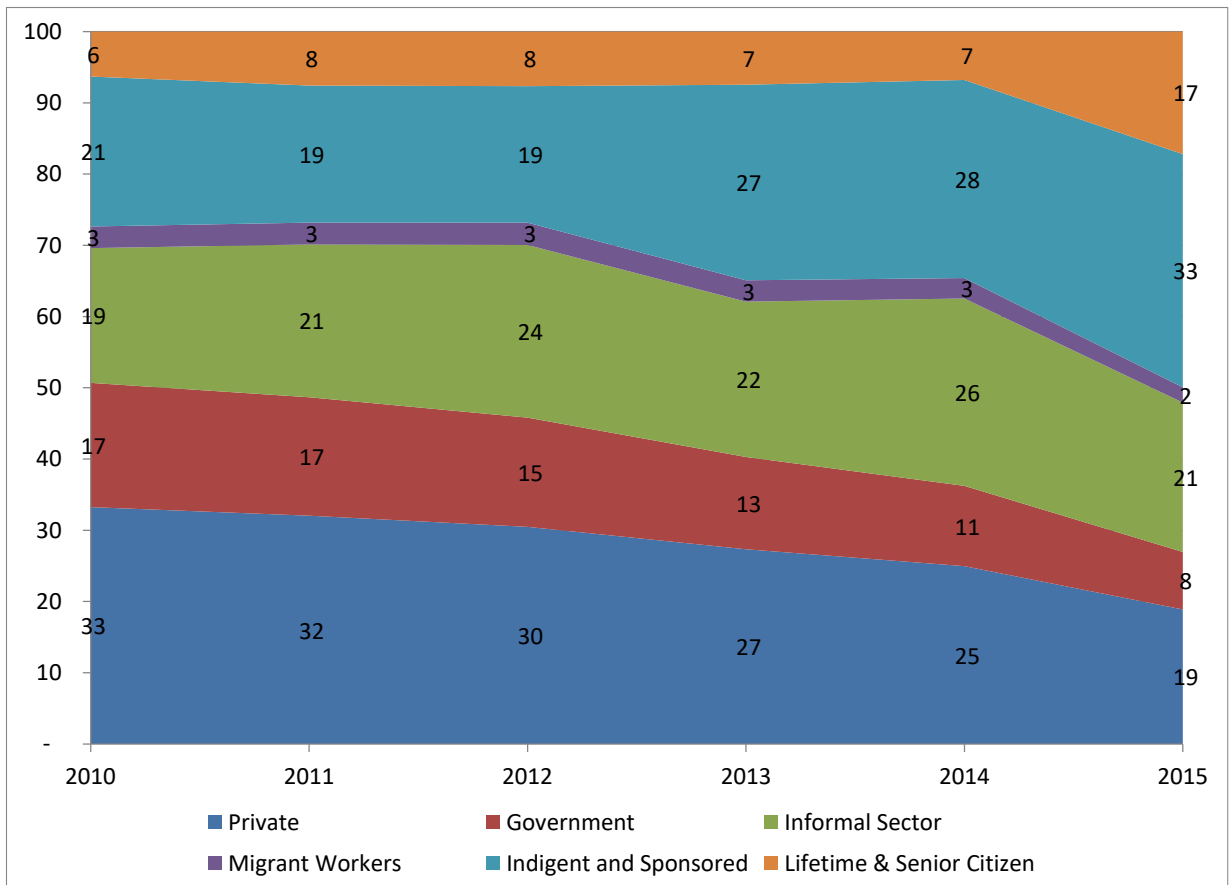
Source: Author's estimates based on PhilHealth data on membership and contributions

If the formal sector is now paying less for health insurance, the informal sector and the poor must now be paying more. While sponsored members paid only 55 percent of what the average member paid in 2010, in 2014 they were paying 37 percent more than the average member. Similarly, indigent members paid only 40 percent of

what the average member paid in 2011 but paid 37 percent more than the average member in 2013, although this has since decreased. In 2014-2015, there is practically no cross-subsidy to the indigents from the richer members apart from the premium subsidy from the government. The same is true for the informal sector and migrant workers. Informal sector members who only paid 29 percent of what the average member paid in 2010, now pay practically the same as the average member. Migrant workers paid only 24 percent that paid by the average member in 2010 but paid 11 percent more than the average member in 2014.

Figure 16 shows the trend in the distribution of benefit claims in 2010-2015. In 2010, private employees had the largest share of claims, accounting for one third of all claims. However, this share decreased over time to less than one fifth in 2015. The combined share of indigents and sponsored members was the second largest in 2010 and although it decreased in 2011, it grew in recent years to reach one third, the largest share in 2015. The share of the informal sector grew from less than one fifth in 2010 to over one fourth in 2014 but decreased to over one fifth in 2015. The government share decreased from one sixth in 2010 to 8 percent in 2015. From 6 percent in 2010, the share of lifetime members only slightly changed for the most part but jumped to one sixth in 2015. The share of migrant workers remained at 3 percent for most years but decreased to 2 percent in 2015.

Figure 16: Distribution of Benefit Claims, 2010-2015



Source: PhilHealth Stats and Charts, 2010-2015

Table 4 shows the proportion of benefit claims to membership by sector for 2010-2015. In 2010, lifetime members had the highest number of claims at 44 percent of membership. This means that on average, 44 percent of lifetime members benefitted from the social insurance. This proportion rose to 57 percent in 2012, but decreased to 10 percent in 2014 due to the huge additional membership particularly of the non-paying senior citizens. Government employees had the largest number of claims in 2010 at 31 percent, increasing to 38 percent in 2014 but decreasing to 33 percent in 2015. Informal sector member claims rose from 18 percent to a staggering 85 percent average in 2014-2015. Claims of private employees were relatively constant at 15 percent but decreased slightly in 2015. Indigent and sponsored member claims fluctuated from 12 percent of sector membership in 2010 to 17 percent in 2015. Claims of migrant workers were the lowest in 2010 at 5 percent of membership but increased to one fifth in 2014-2015.

Table 4: Claims-Membership Ratio, 2010-2015

<b>Membership Category</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
Government	31	33	37	36	38	33
Private	15	14	15	15	15	13
Informal Sector	18	19	24	60	86	84
Migrant Workers	5	5	5	18	20	19
Indigent and Sponsored	12	8	11	17	12	17
Lifetime & Senior Citizen	44	52	57	56	10	21

In 2012, there were 931,794 indigent and sponsored member claims. 55 percent of these were case-based payments while 45 percent were fee-for-service payments. Of the case-based payments, 62 percent were no balance billing. This translates to 34 percent of indigent and sponsored member claims being no balance billing. With this, PhilHealth provides a support value of 55 percent to the poor, with 45 percent incurred by the poor as out-of-pocket spending. In comparison, the non-poor have a support value of 32 percent. In 2013, there were almost 1.6 million indigent and sponsored member claims. The proportion of case-based payments increased to 62 percent with the share of fee-for-service payments decreasing to 38 percent. However, only 30 percent of the case-based payments were no balance billing.



Figure 17 shows the distribution of benefit payments across sectors in 2010-2015. In 2010, private employees enjoyed the largest share of benefits at 36 percent. However, this share decreased over time (with their decreasing share of claims) to half the original share by 2015. Indigents and sponsored members had the second largest share of benefit payments in 2010, and even increased reaching over a third in 2015. The share of government employees and their dependents to benefits was 18 percent in 2010 but decreased over time to 8 percent in 2015. One-seventh of the benefits in 2010 accrued to the informal sector and self-earning individuals and their share rose to one-fourth in 2014 but declined to less than one-fifth in 2015. The share of lifetime members was relatively stable at around 7 percent in 2010-2014, then jumped to one-fifth in 2015 following the mandatory coverage of non-paying senior citizens.

Figure 17: Distribution of Benefit Payments, 2010-2015

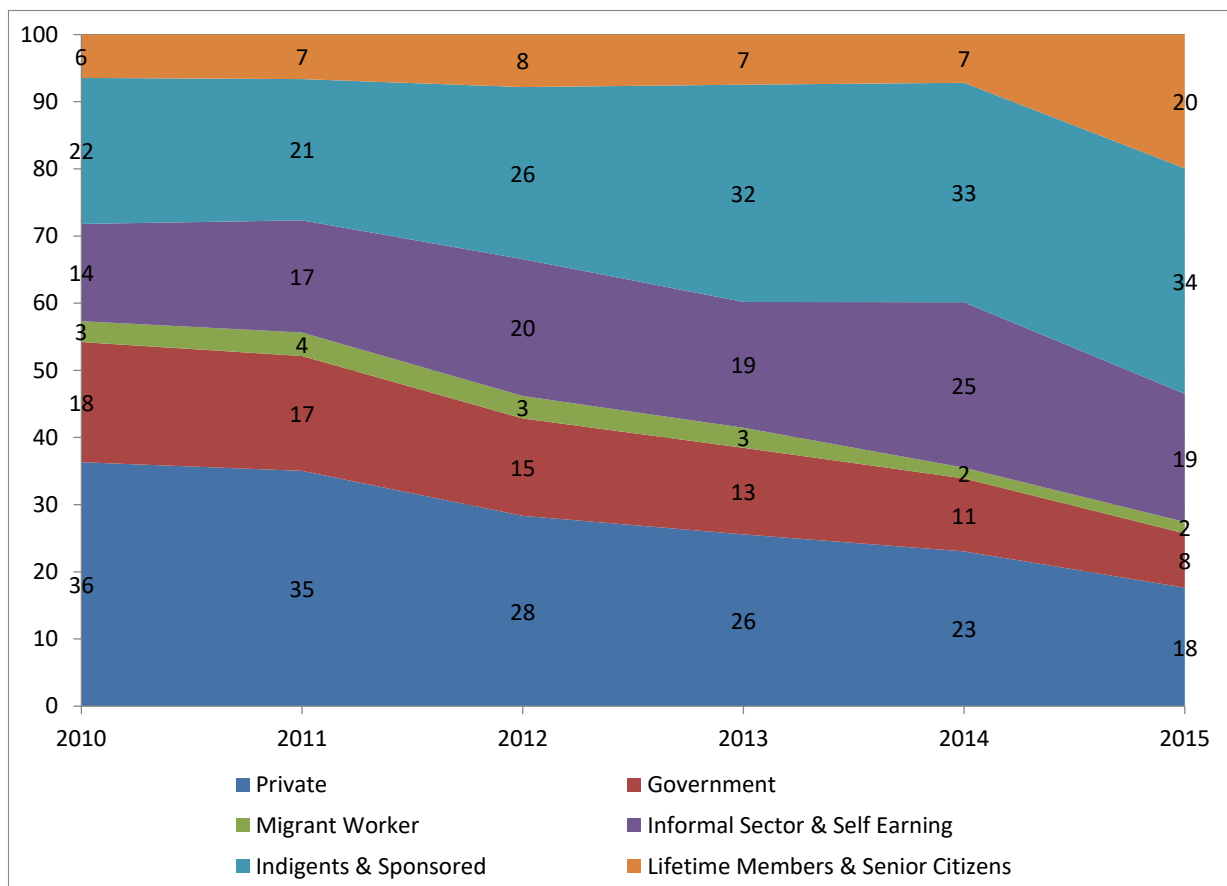


Table 5: Benefit-Contribution Ratio by Member, 2010-2015

Membership Category	2010	2011	2012	2013	2014	2015
Government	0.73	0.74	0.79	0.74	0.81	0.74
Private	0.58	0.59	0.60	0.55	0.63	0.57
Informal Sector	2.66	2.83	3.90	3.32	3.81	3.64
Migrant Workers	1.13	1.47	1.44	1.33	0.49	1.02
Indigent and Sponsored	1.33	1.41	0.94	1.05	0.68	0.83
Lifetime & Senior Citizen					2.65	1.48

Table 5 shows the ratios of benefits to contributions by membership category in 2010-2015. The table shows that there is considerable cross-subsidization “from the healthy to the sick”, particularly from the formal to the informal sector and elderly. Informal sector members had the largest benefits relative to contributions in 2010, receiving benefits 2.7 times their contributions. Their benefits increased further reaching almost 4 times their contribution in 2012 remaining close to this level in 2015. The larger benefits of the informal sector relative to its contributions considering the voluntary nature of its participation indicates adverse selection, the sick tend to join

more than the healthy. Lifetime members and senior citizens had the second largest benefits in 2014 at 2.7 times their contributions. Although this decreased in 2015, they still benefit almost 50 percent more than they contributed. Indigent and sponsored members had the second largest benefit to contribution ratio in 2010, receiving one third more than their contribution, increasing further in 2011. However, benefit payments to indigent and sponsored members decreased to 68 percent of their contributions in 2014 and 83 percent in 2015. Migrant workers had 13 more benefits than they paid in contribution in 2010 increasing further in succeeding years. However, their benefits decreased to less than half their contribution in 2014, and enjoyed benefits no more than 2 percent of their contributions in 2015. Government employees enjoyed relatively stable benefits of between three-fourths and four-fifths of their contribution. Private employees have the smallest benefit-contribution ratios of between 55 and 60 percent.

It must be noted that benefit-utilization does not only depend on the availability of social insurance. It depends on the frequency and types of illnesses suffered by different categories of members. It also depends on the availability of health facilities and the particular services covered by the insurance. For instance, point-of-care enrolment is only available in DOH-retained hospitals and PhilHealth-approved local and other government hospitals. Similarly, No Balance Billing is only done in public health facilities. Z Benefit Package is only provided by PhilHealth-contracted level 3 and 4 hospitals. Primary Care Benefit 1 was provided only by government health facilities and PCB2 was initially implemented in a few “innovation sites”.

## **C. Purchasing**

### **1. Benefit Entitlement**

Philhealth benefit package includes inpatient hospital care, outpatient care, emergency and transfer services, and other appropriate cost-effective services. Excluded health services “a) non-prescription drugs and devices; b) out-patient psychotherapy and counselling for mental disorders; c) drug and alcohol abuse or dependency treatment; d) cosmetic surgery; e) home and rehabilitation services; f) optometric services; g) normal obstetrical delivery; and h) cost-ineffective procedures which shall be defined by the Corporation.”

Members with contributions for at least 3 months in the past 6 months are entitled to the program benefits. However, GSIS and SSS retirees prior to the act, lifetime members (retirees with at least 120 monthly contributions), and enrolled indigents are exempted from this requirement. Benefits are portable across PhilHealth offices.

## 2. Provider payment mechanisms

The National Health Insurance Act (1995) allows fee-for-service and capitation as provider payment mechanisms, subject to the global budget. Fee-for-service is a “payment system under which physicians and other health care providers receive a payment that does not exceed their billed charge for each unit of service provided” (RA9241). Capitation is “a payment mechanism where a fixed rate, whether per person, family, household or group, is negotiated with a health care provider who shall be responsible in delivering or arranging for the delivery of health services required by the covered person under the conditions of a health care provider contract.”

The Implementing Rules and Regulations of the amended National Health Insurance Act (2004) allow PhilHealth to develop new provider payment systems considering the corresponding roles and comparative advantages of the public and the private sectors. The amended National Health Insurance Act (2013) allows case-based payment defined as “Hospital payment method that reimburses to hospitals a predetermined fixed rate for each treated case or disease”.

DOH (2010b) identifies the existing and prospective provider payment mechanisms in the Philippines. As of 2010, capitation was used for outpatient benefits for sponsored members. DOH aims to use capitation as a main payment scheme for primary health care services for the entire population. As of 2010, inpatient services were paid through fee-for-service. The objective is to shift to diagnosis-related group (DRG) payment for inpatient services by 2016. As of 2010, case-based payment was used for maternity care and select medical and surgical procedures. The objective is to use case-based payment for case-mix system by 2016 but initially for preferred providers. This should be adopted for all providers by 2020. Outpatient drugs are also hoped to be included in the benefits.

In 2000, PhilHealth established the Outpatient Consultation and Diagnostic Package for indigents. The package was administered through the capitation of government health centers and rural health units (RHUs). These health facilities are paid for services provided for a particular period. If the payment exceeds the actual cost of services, savings accrue to the health facility, but costs in excess of the payment are shouldered by the facility. The benefit package includes primary consultations with general physicians and laboratory fees for chest X-ray, complete blood count, fecalysis, urinalysis, and sputum microscopy. The capitation amount is P300 per indigent member in the local government unit.

Fee-for-service payment creates an incentive for providers to increase the number of services beyond what is necessary while reducing the service input to improve

efficiency, which may reduce the quality (Cashin, et al., 2015). These could include “prolonged hospital stays, overutilization of diagnostic procedures, and provision of unnecessary and inefficient health care services that insurances paid for without offering any additional value to members” (PhilHealth c31,s2013). In the Philippines, fee-for-service created inequity as PhilHealth beneficiaries who avail of health services in private hospitals receive higher reimbursements than those in public hospitals. On the other hand, case-based payments and diagnosis-related group payments are said to be beneficial to both members and hospitals, and promotes equity in access to basic standard benefit. It also improves efficiency in the processing of hospital claims.

In 2012, PhilHealth shifted from fee-for-service to case-based payment. It also allows the implementation of the No Balance Billing policy for indigents and sponsored members. Case-based payment is defined as a “payment method that reimburses to health care providers a predetermined fixed rate for each treated case or disease” covering professional fees and hospital charges for room and board; diagnostic and laboratory procedures; drugs, medicines and supplies; and operating room and other fees. Case-based payment was piloted on 11 medical and 12 surgical cases in 2011 (c11,2011). In 2012, PhilHealth adopted the “All Case Rate Policy” in which case-based payment has been applied to all medical conditions and procedures, all surgical conditions for select procedures for all members in accredited health care institutions, except for Z type cases (see section VIII). Medical cases are identified based on the International Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision (ICD 10). A list of medical cases covered by PhilHealth is given in the policy circular’s Annex 1. Surgical procedures are identified based on the Relative Value Scale (RVS). A list of procedures covered by PhilHealth is given in the policy’s Annex 2. Based on the case rate policy, the program covers the prescribed rate for a particular case. For medical cases, 70 percent of the case rate is for hospital charges and 30 percent is for professional fees. The health facility deducts the case rate from the member patient’s hospital. No balance billing applies to indigents and sponsored members, meaning they are not liable to pay any amount in excess of those covered by the program. PhilHealth also pays for multiple medical conditions with multiple procedures. In this case, the case payment for the mostly costly condition is referred to as the First Case Rate. However, only certain medical cases and procedures are allowed as a second case (Annex 3). Moreover, only half of the second case rate is paid by PhilHealth except for a few cases. For medical cases, 30 percent goes to professional fee and 20 percent goes to hospital charges. For surgical procedures, 40 percent goes to professional fee and 10 percent goes to hospital charges. The policy provides for a single period of confinement (SPC) rule wherein a patient cannot avail of benefits for the same illness or procedure within 90 days from the first availment, with a few exemptions. The policy also provides for a 45-day benefit limit which covers for up to 45 days of hospital confinement per

year for a member and another 45 days for all his/her beneficiaries, except for a few cases.

Case-based payment is useful when the management capability of the purchaser and the provider are moderate to advanced, when hospital capacity is large and when efficiency improvement is the primary objective (Cashin, et al., 2015). However, case-based payment creates certain incentives for providers, to raise admissions, decrease inputs, unbundle services, and reduce confinement period.

So far, the implementation of case-based payment is said to have shortened the turn-around time for reimbursements with no need to review claims for individual medicines, supplies and tests (Dalmacion, Juban, & Zordilla, 2014). However, the administrative burden is said to have been shifted to hospitals. Also, there is said to be lack of transparency in the determination of case rates. Perhaps as a result, some doctors practice upcoding, recording tests under cases which pay higher rates.

In 2015, BGHMC had 33,167 PhilHealth claims. 1% of all these claims were denied due to the several reasons. The number one reason for denial is violation of single period confinement, accounting for 46 percent of all denied claims. This seems to confirm the incentive of increasing admission and reducing the confinement period as patients are discharged and readmitted within 90 days when they should be undergoing uninterrupted medical care and confinement. The second most common reason for denial of claims is exhaustion of the 45 compensable days (17%), followed by un-accredited doctor (11%), and case not compensable (10%). Other reasons include inconsistent data (8%), non-compliance (7%), lack of qualifying contribution (1%), and filed beyond 60 days (0.6%).

The local health insurance office conducts post-audit of claims and also identified several reasons for denial of claims including violation of single period of confinement, incomplete claim documentation, un-accredited doctors, and filing beyond 60 days. Hospitals have 60 days to appeal denied claims to the local health insurance office and another 15 days to appeal to the central office. Other claims are returned to hospital for correction or referred to PhilHealth's legal section. Hospitals have another 60 days to correct or complete returned claims.

While case-based payments allow for efficiency gains for hospitals, it is being questioned by the Commission on Audit. One suggestion to address the issue is payment of the case rate or the actual charge, whichever is smaller.

Apart from the study of case-based payment system conducted by Dalmacion, Juban, & Zordilla (2014), there are no known comprehensive analyses of the PhilHealth programs particularly the Point-of-Care Enrolment program, the No

Balance Billing policy, and Z Benefit Package. This paper provides a first attempt at documenting what is happening to these programs.

## **VI. Point-of-Care enrolment**

### **A. Background and Rationale**

The National Health Insurance Act of 1995 mandates the universal and compulsory coverage of health insurance coverage of Filipinos. It also aims to “prioritize and accelerate the provision of health services to all Filipinos, especially the segment of the population who cannot afford such services”. Moreover, “all indigents not enrolled in the Program shall have priority in the use and availment of the services and facilities of government hospitals, health care personnel, and other health organizations: Provided, however, That such government health care providers shall ensure that said indigents shall subsequently be enrolled in the Program.” As amended in 2013, the Act mandates compulsory coverage across provinces, cities and municipalities. Under the Universal Health Care program, PhilHealth aims to provide health insurance coverage to all Filipinos, especially those at risk. However, many of the poor were not yet covered by PhilHealth. It is in this light that PhilHealth established the Point-of-Care Enrolment Program in 2013 as a means of enrolling the poor in need of health services.

The Point-of-Care Enrolment Program provides health insurance coverage to poor non-member / uncovered patients or those with special circumstances or members of particular sectors upon admission to a government health facility. Patients availing of outpatient health care are not covered but hospital-sponsored members are entitled to subsequent outpatient care. The providers of point-of-care enrollment include all DOH-retained hospitals and PhilHealth-approved local and other government hospitals. Non-member and uncovered patients are assessed by the hospital medical social worker using an intake questionnaire upon admission. Table 6 shows the classification of patients based on ability to pay or income and the corresponding hospital subsidy. Classes A and B fully pay the hospital charges and professional fees. Classes C and D do not pay for hospital room and board and professional services and get corresponding subsidies for medicines and ancillary services. Class C3 patients are those whose household monthly income per capita (MIPC) is not more than 40 percent higher than the regional per capita poverty threshold (PCPT). Strictly speaking, C3 patients are not poor but near-poor as their incomes are higher than the poverty threshold. However, for the purpose of the Point-of-Care program, they are considered “poor”. Class D patients are those with incomes less than the poverty threshold. Patients classified as C3 and D are eligible for hospital sponsorship. The hospital pays the full PhilHealth premium contribution of the patient, with the patient not required to share any amount. On top of the hospital subsidy for medicines and ancillary services in Table 6, the Point-of-Care program provides no balance billing for hospital-sponsored patients.



Table 6: Classification of Patients in Government Hospitals

<b>Class</b>	<b>Ward / Income</b>	<b>Subsidy</b>
A	Pay	
B	Pay Ward	
C	Ward or Phil health Service Bed	
C1	180%, MIPC $\leq$ 220% PCPT	25%
C2	140% < MIPC $\leq$ 180% PCPT	50%
C3	MPIC $\leq$ 140% PCPT	>50%
D	MPIC < PCPT	100%

Source: Department of Health (2000)

Patients identified as poor (classes C3 and D) are then enrolled and sponsored by the hospital; the hospital pays for membership premium of the poor patients, originally set at P2,400 per year. The hospital-sponsored members are eligible to PhilHealth benefits from the date of admission up to the end of the year including inpatient and outpatient benefits, except Primary Care Benefit 1, and No Balance Billing. PhilHealth shall process the reimbursement of the hospital within a month from the submission of claims and has the right to return or deny questionable claims.

## **B. Implementation and Operationalization: BGHMC**

To gain insight into the implementation of the Point-of-Care program, a case study of Baguio General Hospital and Medical Center (BGHMC) was conducted. BGHMC is a government-owned (DOH-retained) hospital. As a general hospital, it “provides services for all kinds of illnesses, diseases, injuries or deformities” including clinical (family medicine, pediatrics, internal medicine, obstetrics and gynecology, and surgery), emergency, outpatient, ancillary and support services. BGHMC has all the capacities of level 1 hospitals including isolation, surgical, maternal and dental facilities; and level 2 hospitals including departmentalized clinical services, respiratory unit, general ICU and high risk pregnancy unit. Moreover, as a level 3 hospital, it has a residency training program in medicine, pediatrics, obstetrics and gynecology, and surgery; a physical medical and rehabilitation unit; ambulatory surgical clinic; dialysis clinic; tertiary laboratory with histopathology; blood bank and third level X-ray.

Consistent with the Point-of-Care enrolment program and in view of delivering quality healthcare to its clients, the Baguio General Hospital and Medical Center aims to enroll 75% of its patients classified as C3 and D to PhilHealth at Point-of-Care with the hospital sponsoring their membership. To achieve this, the admitting clerk or PCARES<sup>5</sup>

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<sup>5</sup> In 2012, PhilHealth established the Customer Assistance, Relations and Empowerment Staff (CARES) projects which aims to deploy nurses in all accredited level 3 and 4 hospitals and level 1 and 2 government hospitals to provide PhilHealth members with information on membership and benefits, among others (PhilHealth, 2012).

personnel verify the patient's PhilHealth membership; then the Medical Social Worker on duty identifies eligible patients through an assessment interview. She then facilitates the accomplishment of the PhilHealth Membership Registration Form. The Point-of-Care Medical Social Worker in charge then enrolls the patient to PhilHealth online. She also follows up on patients not enrolled upon admission. In the first four months of 2016, the hospital has achieved its objective with an average of 82.5 percent of patients classified as C3 and D being enrolled to PhilHealth at Point-of-Care.

For the assessment, the hospital uses an interview tool to assess the eligibility of the point-of-care patients to hospital sponsorship. The tool collects information on the patient's demographic characteristics; household size and composition; household expenditures on housing, food, medical, lighting, clothing, education, water, transportation, fuel, and others; health insurance; sector; medical data; social functioning; and environmental problems including basic needs and emotional support system. The tool also includes patient modifier which pertain to beneficial or adverse findings towards the eligibility of patients. Table 7 shows the income classification of patients and the corresponding discount on hospital services. The regional monthly per capita poverty threshold is P1,624.

Table 7: Point-of-Care Classification System, BGHMC

<b>Class</b>	<b>Income Bracket</b>	<b>Discount</b>
C1	≥P3,507	25%
C2	P2,728 - 3,507	50%
C3	P1,624 - P2,727	75%
D	≤P1,624	100%

Two cases of hospital-sponsored members were interviewed, one psychiatric case and one ENT case. The first has a case rate of P5,460 for hospital charges and P2,340 for professional fees. The ENT case has a case rate of P2,800 for hospital charges and P1,200 for professional fees. In both cases, the actual hospital charges are higher than the case rate, 50 percent higher for the first and 2.7 times more in the ENT case. In this case, the hospital is said to cover the excess as the patients are covered by no balance billing policy. The actual professional fees are exactly equal to the case rates.

## C. Latest Statistics

The number of hospitals participating in the Point of Care Enrolment Program has increased from 88 in 2013 to 264 in 2014. This is 11.4 percent of the total of 2,323 hospitals in the country. The number of beneficiaries increased from 73,107 to 157,022 for the same period. Figure 18 shows the number (in bar) and percentage distribution (Y axis) of BGHMC patients by income class. The figure shows that most point-of-care patients are indigents. 63 percent of all patients are poor (classes C3 and D), with 64

percent of In Patients considered poor. It is particularly striking that 84 percent of emergency patients are poor. This could mean that the poor are more prone to hazardous living and working conditions.

Figure 18: Point-of-Care Patients by Income Class, BGHMC

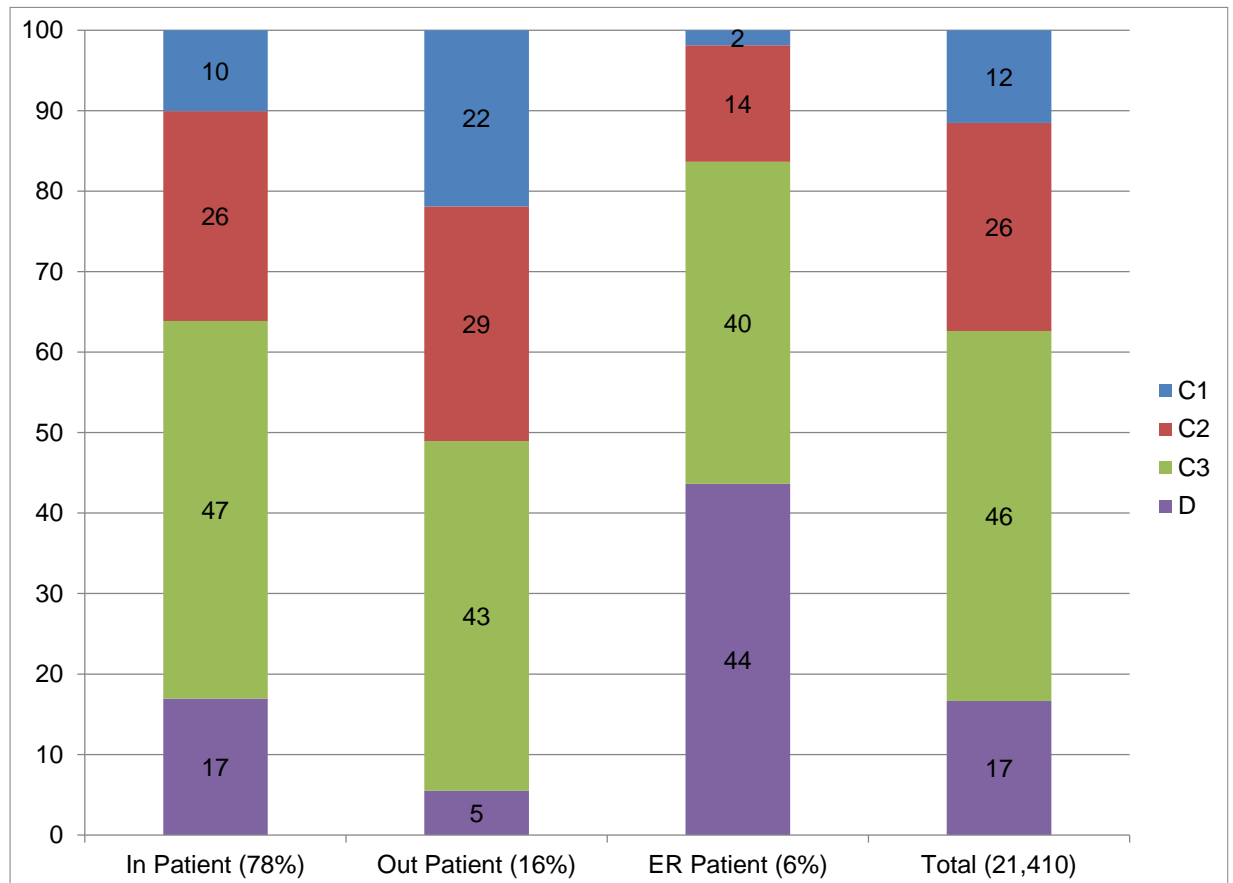
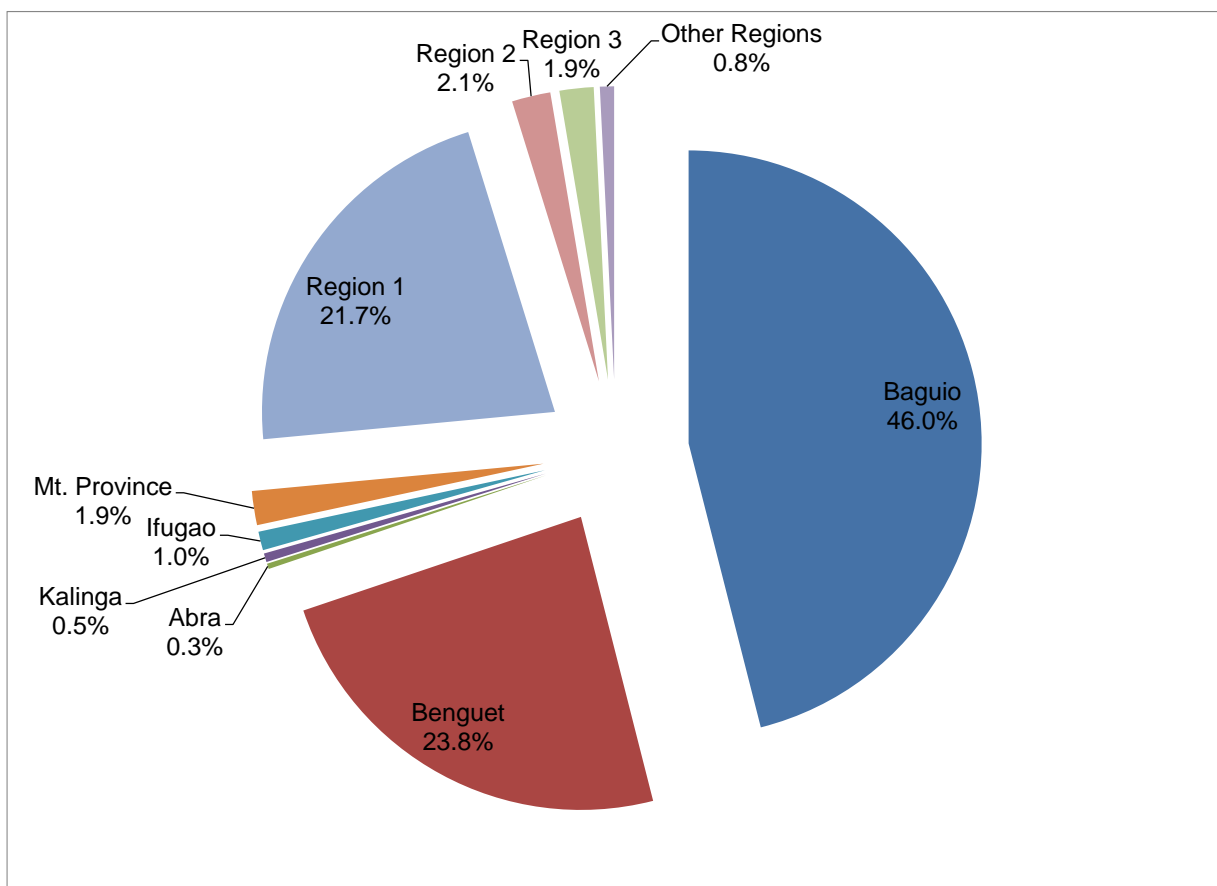


Figure 19 shows the BGHMC point-of-care patients by origin. As a DOH-retained hospital, BGHMC caters to patients regardless of residence. The figure shows that 46 percent are from Baguio City. Most (54%) patients are from outside the city: 24 percent of patients come from the rest of the province (Benguet), almost 4 percent come from the rest of the region (Cordillera), almost 22 percent come from the adjacent region (Ilocos) and almost 5 percent come from other regions (esp. Regions II, III).

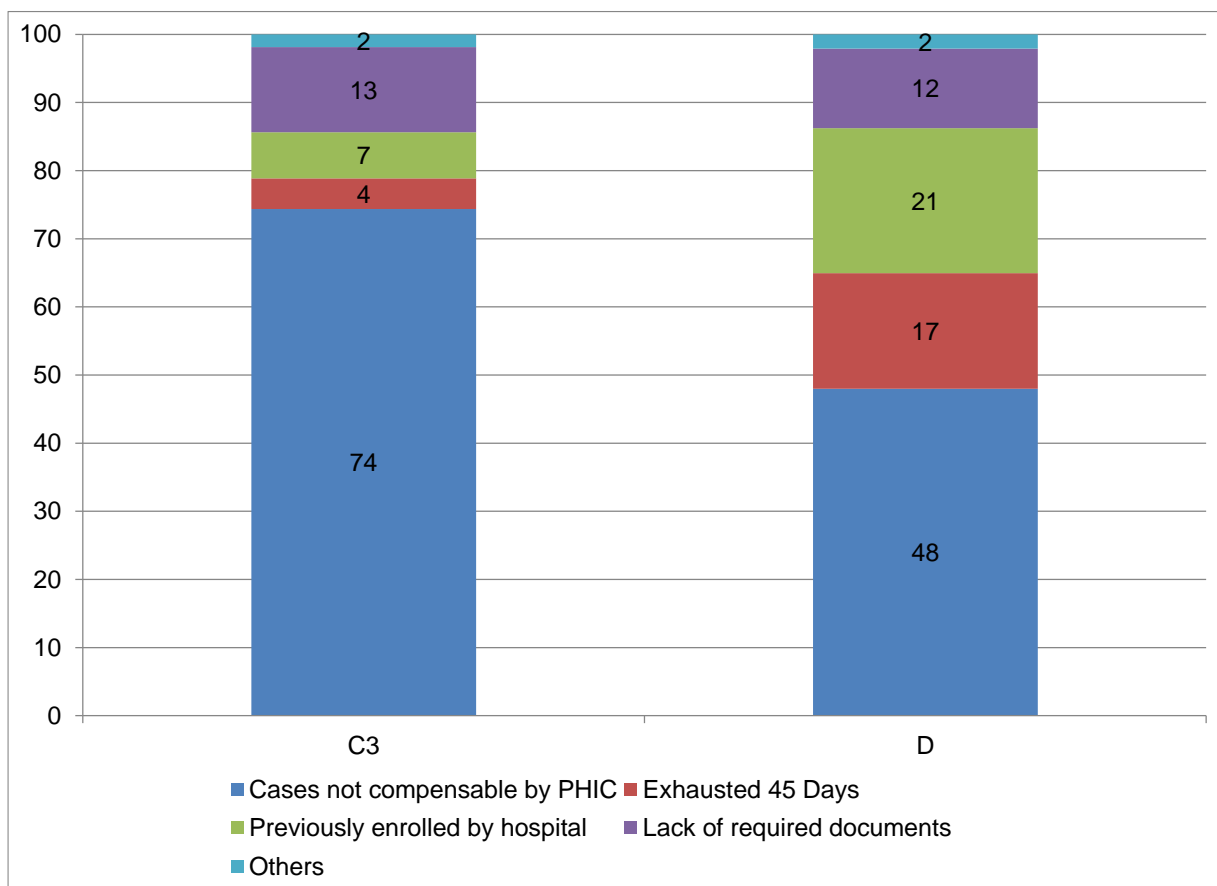
Figure 19: Point of Care Enrolment by Origin



#### D. Operational Issues: BGHMC

Figure 20 shows the reasons for non-enrollment or cancellation of Point-of-Care membership for C3 and D patients in BGHMC. Almost three quarters of C3 patients' membership are cancelled because their cases are not compensable by PhilHealth (i.e. not included in Annexes 1 and 2 of the All Case Rate policy). For class D patients, the corresponding proportion not compensable by PhilHealth is lower but it is also the primary reason accounting for 48 percent. For C3 patients, the second top reason is lack of required documents especially the PhilHealth Member Data Record (MDR). This includes the absence of parents to sign the PMRF for the child patient; discrepancy in the name; emancipated minors with no valid ID provided by the guardian; and no certificate of guardianship of abandoned child. For D patients, the second most common reason is previous enrollment with the hospital. Apparently, many hospital-sponsored members are not subsequently verified as poor by the DSWD. The third reason for cancellation among D patients is the exhaustion of the 45-day benefit. This may suggest that the poorest patients fall ill and get confined in the hospital more frequently.

Figure 20: Reasons for Cancelled POC Enrolment, BGHMC



The implementors also faced a few problems. They failed to meet the target point-of-care enrollment previously for lack of staff for processing documents and ward follow-ups and the absence of full time social worker to follow-up on patients eligible for point-of-care enrollment. The PhilHealth Onsite Rapid Enrollment (ORE) System also experiences technical difficulties with erratic (“99% unreliable”) availability in July-December 2015. Related to this, there are inconsistencies in the system with active PhilHealth members not detected by system or inactive detected.

The point-of-care enrolment program creates certain incentives to health service providers. In particular, it tends to increase admission because while a hospital incurs P2,400 per sponsored member, it would be able to reimburse up to the case rate. As a result, more beneficiaries may be enrolled as poor than the actual number of poor, resulting in leakages.

## **VII. No Balance Billing**

### **A. Background and Rationale**

In view of universal health coverage by 2013 and consistent with its authority to develop and implement policies for the management of the social health insurance program, PhilHealth instituted a case rate system in 2011. The case rate system is an internationally accepted means of packaging health care payments which is said to benefit PhilHealth members, health care providers and PhilHealth itself. It is expected to improve the transparency of health care payments, the predictability of health insurance coverage, and the reimbursement of health provider claims. The case rates were “determined through a process where tariff rates, contracting rates for public and private hospitals, and average value per claim for preceding years were considered and percentage weights were given to each. The highest computed rates were identified and used. The top conditions and procedures that make up 49% of total claims from preceding years were prioritized to be packaged into case rates.” Of the case rates prescribed, professional fees constitute 30 percent for medical cases and 40 percent for surgical cases.

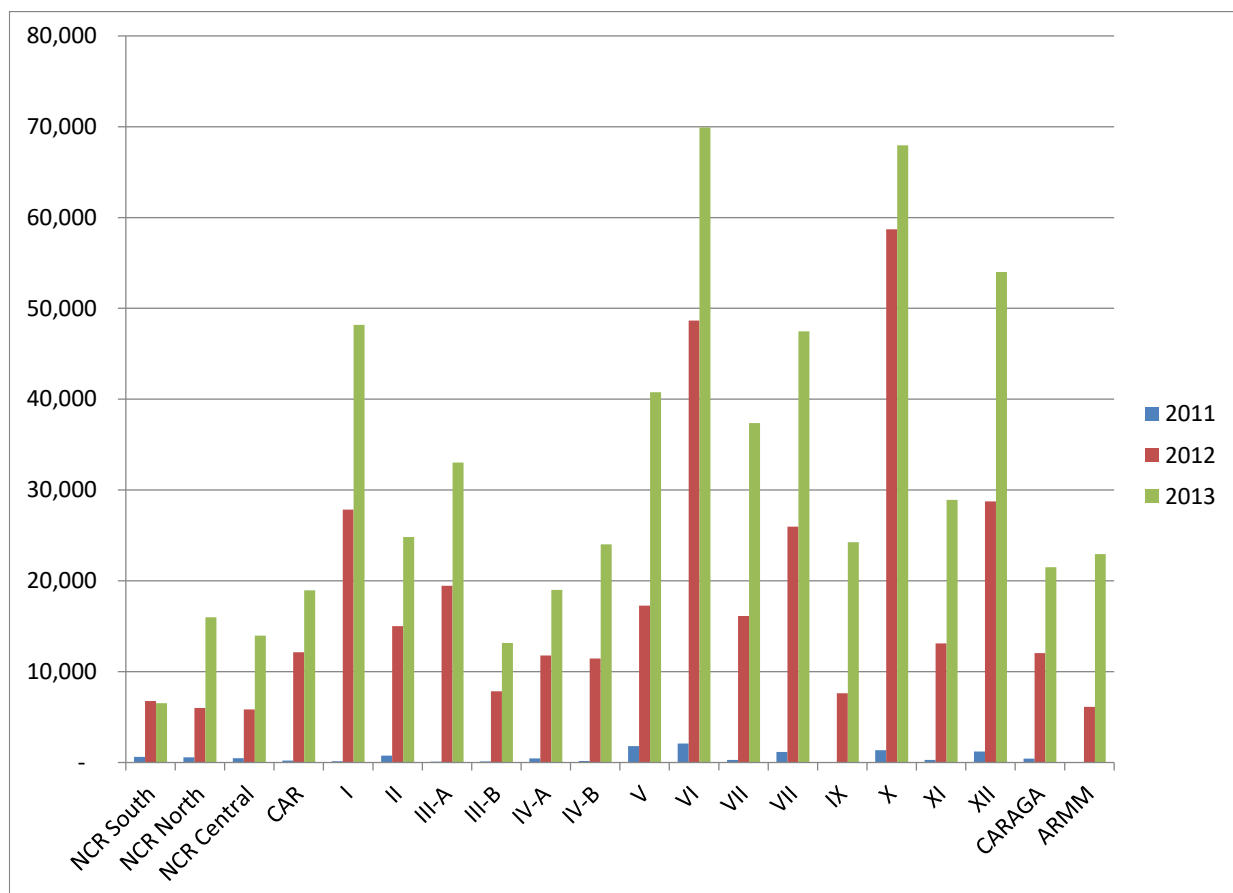
Consistent with the universal health care objective of providing financial risk protection to its members especially the poor, PhilHealth adopted a No Balance Billing policy for the most common medical and surgical cases in the country, effective September 2011. The No Balance Billing policy applies to sponsored members and their dependents for the said cases and when admitted to public health facilities, reimbursing for certain procedures in accredited public facilities, availing of TB-DOTS, Malaria, HIV-AIDS outpatient services; and maternity and newborn care packages. No Balance Billing means that sponsored beneficiaries shall not pay for fees in excess of the prescribed case rates for common medical and surgical services. Supplies and services unavailable in the hospital must be bought by the same in behalf of the patient. Drugs bought and used by the hospitals should be based on the Philippine National Formulary. Out-of-pocket expenses for hospital charges and professional fees shall be reimbursed to the member and deducted from the case payment to the health facility. Reimbursements for hospital services are made directly to the hospital including the professional fees of accredited doctors. “Cases attended by non-accredited professionals shall be denied.” PhilHealth beneficiaries not covered by the No Balance Billing policy are liable to pay hospital charges in excess of the case rate. The days of confinement are deductible from member’s total of 45-days entitlement per year, subject to the “rule on single period of confinement”. Hospital claims should be filed within sixty days from the patient’s discharge. Claims with incomplete requirements are returned and re-filed within another sixty days. Claims should separate case payment and service fee claims.

There are a few targets on no balance billing. One is 100 percent of Hospitals have NBB for Conditional Cash Transfer / NHTS families by 2016. Another is the increase in the proportion of NBB to Sponsored Member Claims in Government Facilities from 7% in 2012 to 40% in 2014 and  $\geq 70\%$  in 2015. The target for 2014 has been accomplished at 40.5%, but the 2015 accomplishment of 51% failed to meet the target.

## B. Latest Statistics

Figure 21 shows the NBB Cases by Region for 2011-2013. There were over 12 thousand NBB cases in 2011. Region VI had the highest number of cases at one-sixth of all the cases followed by Region V (one-seventh), X (one-ninth) and XII (one-tenth). The total number of NBB cases grew by over 29 times in 2012 to over 358 thousand. The largest growth of cases in 2012 was experienced in ARMM, with the cases growing at 437 times, followed by Region IX (254 times), Region III-A (191 times) and Region I (187 times). The total number of cases grew by 80 percent in 2013 to almost 633 thousand, with ARMM again experiencing the highest growth at 3.8 times, followed by Region IX (3.2) and NCR North (2.7 times).

Figure 21: No Balance Billing cases by Region, 2011-2013



Source of Data: PhilHealth Corporate Planning Department



In 2014, No Balance Billing claims constituted 40.5 percent of Sponsored Program claims, over the 15 percent target.

In 2014, there were 6,459 NBB cases in BGHMC; 73 percent were Family Health Card<sup>6</sup> holders comprising NHTS Indigents and LGU-sponsored beneficiaries and 27 percent were hospital-sponsored members. In 2015, the NBB cases grew by almost 2.3 times to 14,685. The largest share (48%) of NBB cases are Family Health Card holders. This is followed by hospital-sponsored members at 37 percent. The remaining 15 percent comprised senior citizens with the implementation of the mandatory PhilHealth coverage for Senior Citizens.

### **C. Implementation and Operationalization: BGHMC**

As implemented by the hospital, no balance billing means no out-of-pocket payment in excess of the case rate. Hospital charges in excess of the case rate were shouldered by the hospital. On the other hand, any excess of the case rate over the actual hospital charges was income for hospital. The NBB implementation covered hospital-sponsored, NHTS-PR Indigent, and LGU-sponsored beneficiaries as well as Senior Citizens and household help (Kasambahay). However, they have to stay at the charity ward and cannot choose the attending physician. If they stay in a pay ward / private room or choose a doctor, they will not be eligible to no balance billing. Paying PhilHealth members pay charges in excess of the case rate. NBB policy covers all services available in hospital as well as procedures not available in the hospital and referred to hospitals where BGHMC has a memorandum of agreement (such as Notre Dame for CT scan, MRI and ultrasound). If drugs, medicines and supplies are not available in the hospital, the hospital undertakes an emergency purchase. PhilHealth claims are usually filed within 30 days from patient discharge, within the prescribed maximum of 60 days.

From the patient perspective, the NBB is a welcome development. For some patients, if they had no PhilHealth benefits, they would only go to the barangay health clinic or borrow from neighbors to be able to go to the hospital. For the brain tumor case, they would only buy medicine to the stop head ache. However, PhilHealth members are not yet fully aware of their entitlements. For instance, some patients expected minimal payment for being a PhilHealth beneficiary, but did not expect no balance billing. Notwithstanding the NBB policy, there remain out-of-pocket spending for patients. For instance, those who come from other provinces pay for the

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<sup>6</sup> This a proof of PhilHealth membership provided to indigent and sponsored members (PhilHealth, 2004). This has been replaced by the PhilHealth Identification Card (ID) (PhilHealth, 2010).

provincial/municipal ambulance fuel and driver in traveling to Baguio and return fare back to their province. Patients also spend for their regular medication.

There are four cases of indigents interviewed: two surgery cases and 2 IDB cases. In three of the four cases, the actual hospital charges are 18 percent to 2.7 times more than the case rate. For the other case, hospital charges are 85 percent of the case rate. In three of the cases, the professional fee is exactly equal to the case rate; the other could not be determined.

#### **D. Operational Issues**

One issue on the NBB is the prescribed purchase and use of drugs based on the Philippine National Drug Formulary (PNDF). Violation of this policy is considered fraud. However, some drugs such as those used in chemotherapy for breast cancer are not in the PNDP or in government hospital pharmacies. So, to avoid denial of claims or even legal sanctions, hospitals have an incentive to let the patient buy non-PNDF drugs out-of-pocket.

## **VIII. Z Benefit Package**

### **A. Background and Rationale**

Certain diseases are considered ‘economically and medically “catastrophic”’ as they can drive those suffering into poverty, notwithstanding existing support for financial risk protection on common health conditions. In this light, PhilHealth aims to enhance and widen the benefits for catastrophic conditions to further protect members from financial risk and improve their health (Philippine Health Insurance Corporation, 2012c). In view of financially catastrophic illnesses, PhilHealth aims to “1) identify and support cost-efficient interventions; 2) employ rational cost-containment measures; 3) ensure quality of care for members; 4) incentivize and enable facility improvement.”

For this purpose, PhilHealth created a case type Z defined as “any illness as a primary condition that is life or limb-threatening and requires prolonged hospitalization, extremely expensive therapies or other care that would deplete one’s financial resources, unless covered by special health insurance policies.” It developed the Z Benefit Package covering all PhilHealth members and dependents with full support value for sponsored members and at least half for non-sponsored members. Only PhilHealth-contracted level 3 and 4 hospitals can provide the package. The services covered include hospitalization, drugs and medicines, and professional fees. The case rates are determined using previous average claims, current rates, stakeholder consultations and input prices. The packages cover complete treatment from the early stages for early detection and treatment. A fixed number of days is deducted from the 45-day annual benefit. For indigent, LGU- and hospital-sponsored beneficiaries, no balance billing is applied. For non-sponsored beneficiaries, a fixed co-payment scheme is applied where the beneficiary pays an amount depending on their ability to pay but no more than the case rate.

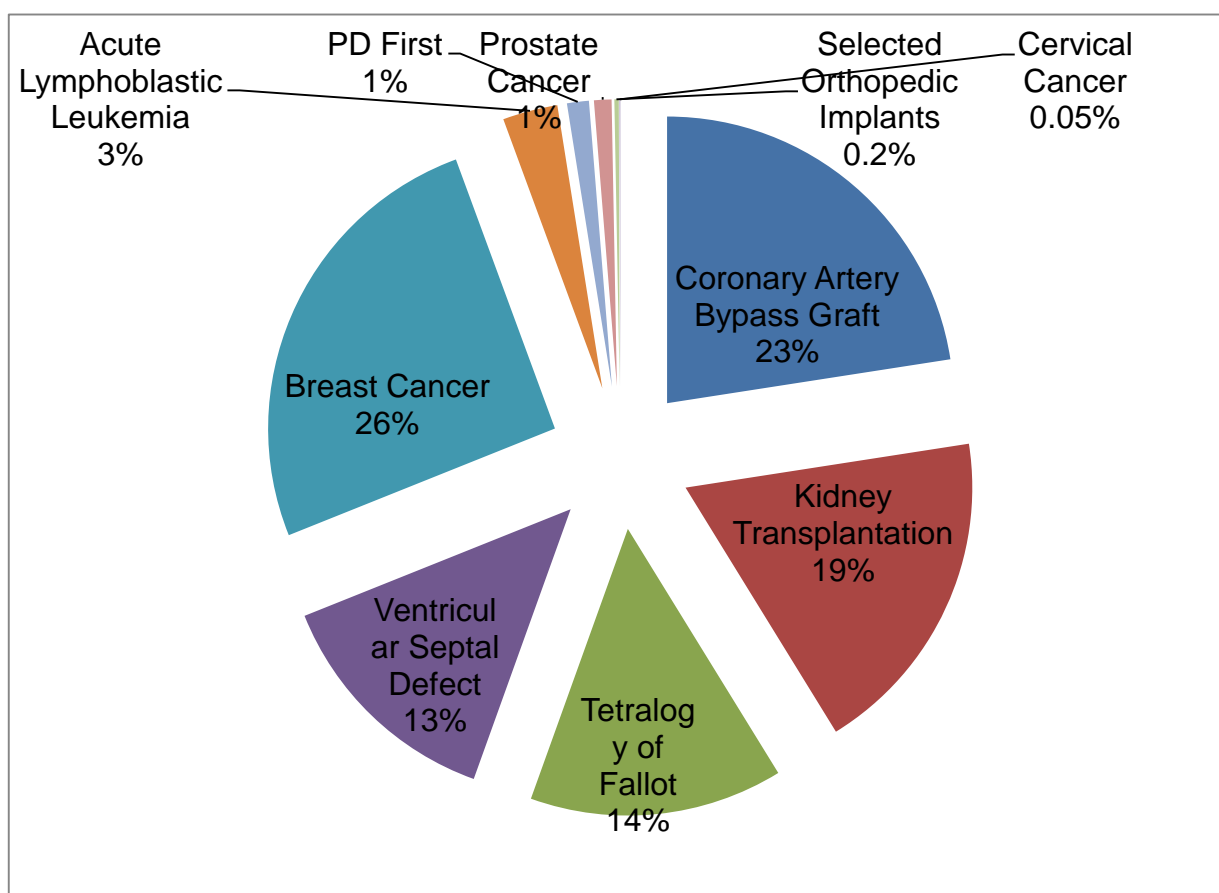
The phase 1 of the Z Benefit Package covers Acute Lymphocytic Leukemia (ALL), Breast Cancer, Prostate Cancer, and Kidney Transplant Philippine Health Insurance Corporation (2012d). These cases are subject to the general policies stated in the foregoing as well as the following. The professional fee should not exceed 15% of package. Patients are deducted 5 days from the 45 days annual benefit irrespective of the actual duration of confinement. The package rate for ALL is P210,000 paid in three tranches, P140,000 after the first cycle, and P35,000 each after the third and eighth maintenance cycles. For Breast Cancer, the package rate is P100,000 payable in two

tranches, P75,000 after the surgery and P25,000 after the last chemotherapy. The package rate for Prostate Cancer is P100,000 paid in full upon discharge. The package rate for Kidney Transplant is P600,000 payable in two tranches, P550,000 within sixty days upon discharge after the transplant, P50,000 90 days after the transplant. New cases are covered by other PhilHealth policies.

## B. Latest Statistics

For the Z Benefit Package: there were a total of 2,031 unique claims paid as of 2015. The distribution of claims by package is given in Figure 22. Breast cancer has the highest share at 26 percent, followed by coronary artery bypass graft (23 percent). Kidney transplant has the third highest share at 19 percent, followed by Tetralogy of Fallot (14 percent) and ventricular septal defect (13 percent). Claims for Acute Lymphoblastic Leukemia comprise 3 percent while the rest each have 1 percent share or less.

Figure 22: Distribution of Unique Claims Paid under the Z-Benefit Package

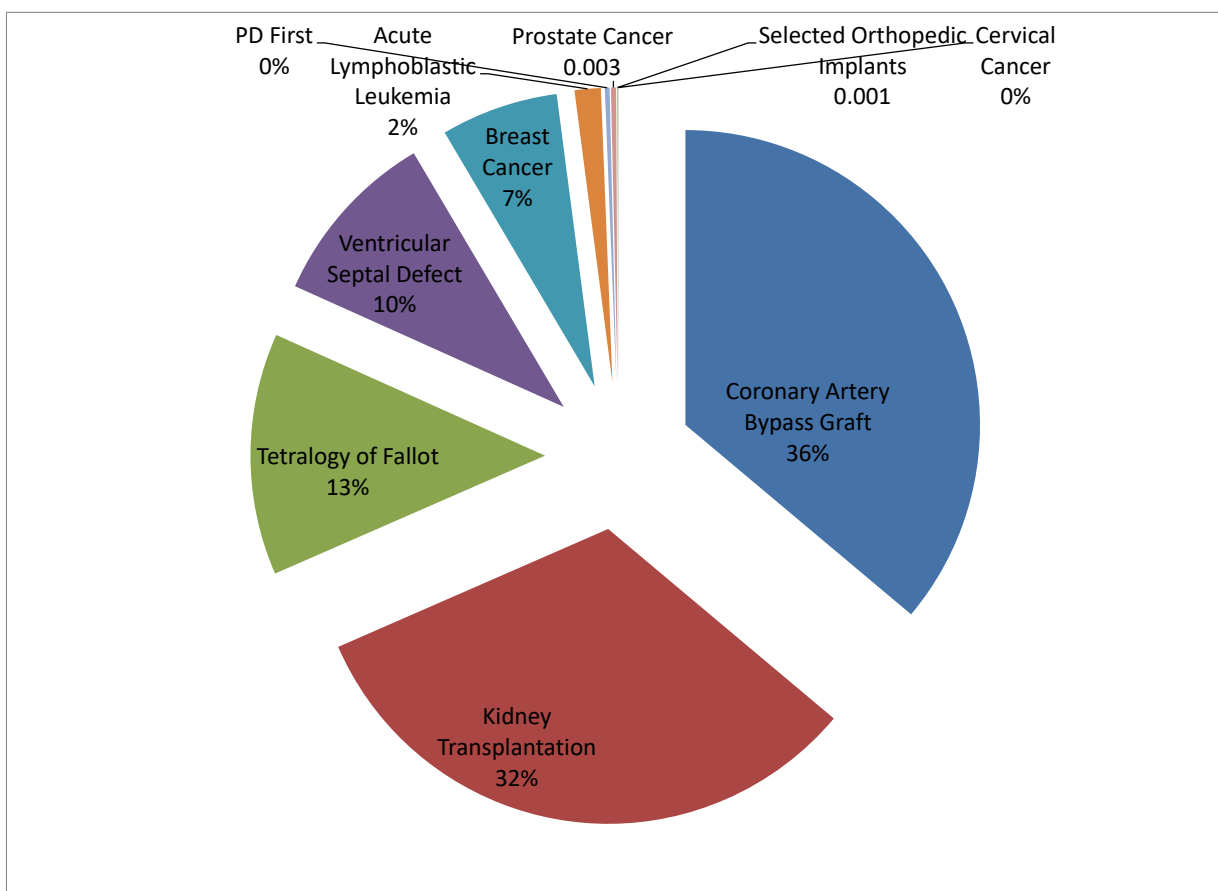


Source: PhilHealth Stats and Charts 2015

## C. Financing

As of 2015, over Pesos 697 Million was paid for the Z-Benefit Package. The distribution of this amount is shown in Figure 23. Coronary Artery Bypass Graft has the highest share (36 percent) followed by Kidney Transplantation (32 percent). Tetralogy of Fallot has the third largest share (13 percent), followed by Ventricular Septal Defect (10 percent), and Breast Cancer (7 percent). Acute Lymphoblastic Leukemia has a 2 percent share while the rest each have negligible shares.

Figure 23: Distribution of Amount of Claims Paid under the Z-Benefit Package



Source: PhilHealth Stats and Charts 2015

### A. Implementation and Operationalization: BGHMC

As implemented by the hospital, the eligible beneficiaries of the Z Benefit Package are all PhilHealth beneficiaries including indigents, LGU- and Hospital-Sponsored beneficiaries. Only Acute Lymphocytic Leukemia and Breast Cancer are covered. No prostate cancer case has been covered as the only prospective case was in its late stage and therefore ineligible. The hospital has no experience in Kidney Transplant so it is ineligible to provide this service. For the Z Benefit cases, only newly diagnosed cases are eligible. While recurring cases are ineligible, they can still be covered under the Case Rate system. Only 5 days deducted from 45 days annual benefit regardless of

length of stay. The hospital has experience with denied claims with a few notable cases. One Z Benefit case wrongly filed under Case Rate was denied. Another was filed on new forms after the prescribed period; the delay is attributed to the delay in the communication of PhilHealth guidelines. However, according to PhilHealth, the guidelines are already available on the PhilHealth website. OOPS / hospital charges up to P60K allowed by PhilHealth (usually goes to PF, > prescribed 15% of package rate).

From the perspective of patients, the Z Benefit package is significant. According to one patient, if they did not have PhilHealth benefits, they would approach DSWD, the Barangay Captain, and their Mayor. A Breast Cancer patient enjoyed the Z Benefit package as a contributing member from the Informal Economy, being a household help (Kasambahay). She and her husband (a driver) complain that had she not paid her premium for the past year, she would not be eligible for the benefit package because although they consider themselves poor, they complain that indigent members are chosen subjectively by their barangay officials, even including the well-off, couples, and OFWs. Also, notwithstanding the benefit package, patients still have out-of-pocket expenses including for transportation to and from Baguio, initial check-up (OPD), and supplies such blood platelet for an ALL case.

Two sample cases of breast cancer are analyzed, one NBB case and one fixed co-pay case. The case rate for breast cancer is P100,000, 75 percent of which is payable in the first tranche and the remaining 25 percent payable in the second tranche. Up to 15 percent of the case rate goes to professional fees. In both cases, the actual charges are higher than the case rate, 36 percent more for the NBB case and 16 percent more for the fixed co-pay case. For the NBB case, the actual payment is 25 percent for the first tranche and 75 percent for the second tranche. For the fixed co-pay case, the actual payment is 77 percent for the first tranche and 23 percent for the second tranche. There are no professional fees for the NBB case. The fixed co-pay case includes a professional fee of P60,000 paid in the first tranche, or 60 percent of the case rate and 52 percent of the actual charges, much higher than the 15 percent prescribed by policy. This is said to be allowed in the contract with PhilHealth. There is a suggestion to change fixed co-payment to maximum co-payment where the patient only pays the excess of the hospital charges over the case-rate.

## **IX. Primary Care Benefit**

### **A. Background and Rationale**

In 2014, the PhilHealth has developed the Primary Care Benefit 2 Package which pays for “out-patient medicines for PhilHealth qualified (indigent and sponsored) members or dependents with hypertension, diabetes and dyslipidemia, long before

their conditions become catastrophic” (Philippine Health Insurance Corporation, 2014b). This is based on the fact that much of Filipino families’ spending on health goes to medicines, reaching more than half among the poorest. Mortality from non-communicable diseases (NCD) is significant with over a third of deaths in 2009 due to cardio-vascular diseases and diabetes, and their prevalence has increased in 2003-2008. PhilHealth pays a substantial amount for non-communicable diseases, mostly for essential hypertension, hypertensive heart disease and chronic renal failure. The benefit package aims to improve access to out-patient medicines for indigent and sponsored beneficiaries, reduce hospitalization due to NCDs, improve the health of NCD patients, and promote rational drug use among NCD patient members. Only one family member with over 30 percent cardio-vascular risk for ten years can avail of the package. In 2014, the package has been piloted in Pateros, Capiz, and in some municipalities in Palawan.

## **B. Latest Statistics**

One indicator being monitored is the proportion of LGUs with PCB providers. The target is to increase this from 83% in 2012 to 85% in 2013 and 90% in 2014. These targets have been accomplished at 93.7% in 2013 and 93% in 2014. Another indicator is the proportion of NHTS-PR members assigned to PCB provider. The targets for this indicator are 50% for 2013 and 65% for 2014. The accomplishment in 2013 is 31%, less the target, but the accomplishment in 2014 is 72%, over the target. Number of hospitals participating in the program has increased from 88 in 2013 to 264 in 2014 while the Beneficiaries increased from 73,107 to 157,022.

## **C. Implementation and Operationalization: BGHMC**

Out-patient services in BGHMC are not covered by PhilHealth as these mainly involve consultation. New patients only pay a minimal registration fee of P20. Minor procedures are covered by PhilHealth. However, procedures relating to hypertension, diabetes and dyslipidemia are not covered by PhilHealth even for indigents. These include basic procedures such as blood pressure taking, ECG, blood chemistry, urinalysis, lipid profiling, fasting blood sugar, and chest X-ray. Other procedures carried out as necessary include liver enzymes, ultrasound of the abdomen, CT scan and electrolyte. All these procedures are paid for by the patient unless he is admitted.

BGHMC implemented PCB1 but is not implementing PCB2, not having expressed interest. Nevertheless, existing cases of hypertension, diabetes and dyslipidemia are covered under the case rate system which serves as the counterfactual for the PCB2. For diabetes, the case rate is P12,600 of which 70 percent is allotted to hospital charges and 30 percent is allotted to professional fees. Four sample cases were analyzed, two

PhilHealth and two Non-PhilHealth members. For the first PhilHealth case, hospital charges are 42 percent higher than the case rate although the professional fee is exactly the case rate. (P3,840 for room and board and P4,980 for X-ray, lab, and others) and 30 goes to professional fees. The second case is a self-employed PhilHealth member; hospital charges are 61 percent higher than the case rate and professional fees are 3 times the case rate. These may be due to other confounding diagnoses. There is one other similar case with Non-PhilHealth membership paying hospital charges equivalent to 44 percent of the case rate; no information on the professional fee was provided. For essential hypertension / malignant hypertension, the case rate is P9,000 of which 6,300 is allotted to hospital charges and P2,700 is allotted to professional fees. There are two sample cases, one non-paying PhilHealth member and the other a non-PhilHealth member. The Phil- health member was charged hospital charges almost twice as much as the case rate and professional fees 2.45 times the case rate but there are other diagnoses. The non-PhilHealth member paid hospital charges equivalent to 68 percent of the case rate, no information on the professional fee was provided.

#### **D. Implementation Issues**

There are several questions relative to the implementation of the case rate system for the NCD cases. What accounts for the difference in hospital charges between Phil- Health and Non-PhilHealth members? Why are hospital charges generally higher for PhilHealth members? Why are hospital charges for PhilHealth members generally higher than the case rate? Some of these questions may be answered by closer analysis of patients' statement of account. However, this researcher was only provided a summary table. There is a need to enhance transparency of information in the interest of accountability in the use of public funds notwithstanding the confidentiality of patient information. There is also a need to make hospital technical and financial statistics more accessible to the public as sample cases do not show the complete picture as to the implementation of the program.



## **X. Summary, conclusion and recommendations**

In its earlier years, social health insurance in the Philippines has catered only to the formal sector composed of government and private employees. With the establishment of the National Health Insurance Program, the social health insurance coverage of indigents has become mandatory. From a membership of less than 15 thousand in 1997, indigents now have a membership of over 15 million and are now the largest group of PhilHealth members comprising close to 4 out of 10 members. This growth in membership has been driven by the nation-wide identification of the poor by the National Household Targeting System - Poverty Reduction (NHTS-PR) program of the DSWD. This massive identification has led to the enrolment of more members / households than the poor population / families estimated by Philippine Statistical Authority. This means that the government's social health insurance subsidy is leaking out to the non-poor. Notwithstanding the guidelines in the identification of the poor, there seems to be subjectivity in the selection of beneficiaries. One patient complains that despite their poverty, they are not selected as beneficiaries and that their barangay officials choose even the well-off, couples, and OFWs. However, the evidence is anecdotal and the size of the problem cannot be determined in this study. Nevertheless, there is a need to ensure integrity of identification of poor.

The fiscal capacity of the Philippines is relatively low with the government budget just on balance. However, the sustainable debt-servicing does not threaten government spending on health. Moreover, there is scope for increasing government spending on health, especially with the incremental revenues from the revised sin tax law earmarked for the subsidy of premium contributions for the poor.

While health spending per capita for the country is lower than the averages for South Asia, East Asia and the Pacific and low-middle income countries, it has reached 4.7 percent in relation to per capita income, higher than the target of 4.5%. The share of government to health spending has decreased to 34 percent while the share of private health spending has increased to 66 percent. Nevertheless, the share of health to government spending has risen to 10 percent, surpassing the target of 6 percent. Moreover, the share of social security to government health spending has increased to 41 percent. The share of social health insurance to total health spending stood at 14 percent. As a share of private health spending, out-of-pocket spending has decreased while voluntary health insurance has increased. However, out-of-pocket spending remains to be the main source of national health spending, is far from target and higher than those of neighboring countries. Half of out-of-pocket spending goes to medical products, mostly to pharmaceutical products and supplements (Ulep & Dela Cruz, 2013).

Government subsidy for the social health insurance of the poor is financed by the incremental revenues from revised sin tax law. This subsidy has increased from 3.5 Billion Pesos in 2011 to 43.9 Billion Pesos in 2016. It now comprises over a third of the national health insurance fund surpassing the share of payroll contributions from private employees. With its huge share, the premium subsidy for indigents is effectively subsidizing health care service for other members as well particularly the informal sector while cross-subsidies from the formal sector has decreased. While benefit claims in proportion to membership have increased for indigents in recent years, these are lower than those for other sectors except private employees. Relative to contributions, benefits for indigents are also lower than those for the informal sector and the elderly.

Until recently, PhilHealth predominantly used fee-for-service for inpatient services and capitation for outpatient benefits for sponsored members. Fee-for-service payments are said to have resulted in inequity with private hospitals receiving higher reimbursements than public hospitals. Aimed at promoting equity as well as efficiency in benefit payments, PhilHealth has recently adopted case-based payments, initially for select medical and surgical cases and now for most cases. PhilHealth reimburses health care providers a fixed rate for a particular case covering both hospital charges and professional fees. This is said to have facilitated hospital reimbursements but shifted administrative burden to hospitals. Given the fixed case rates, the payment scheme is also said to have induced some doctors to upcode tests under cases which pay higher rates. Evidence also suggests the tendency to increase admission and reduce confinement period with the violation of the single period confinement being the number one reason for denial of claims of the studied hospital. Moreover, the provision for multiple medical conditions in the case rate system may induce unnecessary second cases because while second cases are reimbursable at only half the case rate, the share of professional fee remains intact. Finally, while case-based payments allow for efficiency gains for hospitals, it is being questioned by the Commission on Audit. One suggestion to address the issue is payment of the case rate or the actual charge, whichever is smaller.

Apart from the sponsorship of the poor by the national government and disadvantaged sectors by local governments, poor and near poor who have no coverage are also sponsored by hospitals at point-of-care. These are assessed and enrolled by the hospital medical social welfare office. While the purpose of the program is noble, it is said to induce increased enrolment because while hospitals pay for the poor patients' premium contributions, they reimburse much higher case rates. However, point-of-care enrolment can be cancelled for various reasons such as cases excluded from the "All Case Rate" policy, previous hospital sponsorship, insufficient documentary

requirements, and exhaustion of the allowable period of confinement. Moreover, hospital-sponsored members may not be verified as poor by the DSWD in the succeeding year and lose their benefits.

There has been significant progress in the PhilHealth initiatives and programs for indigents. The Point-of-Care enrollment program has seen an increase in the number of participating hospitals. The share of No Balance Billing claims to all sponsored program claims has surpassed the target in 2014. However, NBB patients still incur out-of-pocket spending for transportation and medication. The proportion of LGUs with Primary Care Benefit providers has exceeded the target. PhilHealth has also developed new Z Benefit Packages for catastrophic health conditions, although less than the number targeted.

Benefit claims of indigents, sponsored members (including hospital-sponsored members), and senior citizens have been increasing and constituted half of all claims in 2015. Majority (51%) of these claims were administered under the No Balance Billing policy. However, while the policy has taken strides in just 5 years of implementation, close to half of claims still involve out-of-pocket spending for the poor.

Claims for catastrophic illnesses under the Z Benefit Package constituted 1 in over 4 thousand claims. While the number of claims is small, the value of the payment is bigger at 0.7 percent of all claims. While the average value per claim is only P10,388, the average value of Z Benefit claims is P343,259. If we assume the same proportion of Z Benefit claims for indigents and sponsored members (including hospital-sponsored and senior citizens) as with the total claims, the poor would be enjoying over 348 million pesos in benefits for catastrophic illnesses. This would be 0.7 percent of the total benefits for these beneficiaries.

The following are some recommendations on the point-of-care enrolment program, claims processing under the case-rate system, the benefit structure, and provider payment system.

## **A. Enrollment**

The main reason for the cancellation of PhilHealth membership at point-of-care is that the cases are not compensable by PhilHealth. There is a need to review the cases that are compensable by PhilHealth to include cases that the poor commonly suffer from. Documentary requirements should not hinder the poor from accessing free health care. Hospitals should provide sponsorship and the necessary health care at no cost to the poor pending the verification of their PhilHealth membership. The hospital intake assessment should be able to determine the true eligibility of patients. The

second reason for cancellation of PhilHealth membership among the poor is the exhaustion of the 45 day annual benefit. The review of the cases suffered by the poor should consider the length of hospitalization required. Cases requiring long hospitalization should be included in the Z Benefit package to address this limit. Hospital sponsorship of the poor is also cancelled due to previous sponsorship. There should be a clear guideline allowing hospitals to renew their sponsorship pending verification of the poor by the DSWD. This will prevent the denial of hospital claims by PhilHealth. Hospitals cannot just renew sponsorship as denial of their claims means they shoulder not just the premium contribution but the cost of the services. However, public hospitals should have allowances for such costs considering the subsidy to hospitals and a separate budget for medical assistance for indigents.

## **B. Claims Processing**

The number one reason for the denial of PhilHealth claims is the violation of the single period confinement rule. However, certain illnesses like Pneumonia may recur in less than 90 days prescribed for benefit availment. For this reason, there is a need to review the single period confinement rule or consider the exemption of certain illnesses. The second reason for denial of claims is the exhaustion of 45 days annual benefit. As in the previous section, there is a need to review the 45-day limit or exempt certain cases requiring long periods of hospitalization. The third reason for denial is attendance by non-accredited doctors. There is a need to further analyze attendance by non-accredited doctors. Is there a lack of accredited doctors? If so, is the non-accreditation due to shortcomings of the doctor or hospital or the rigidity in the accreditation procedure. The fourth reason for denial is the case is not compensable by PhilHealth. As in the previous section, there is a need to review compensable cases to include justifiable ones. In this regard, PhilHealth should consult hospitals on the cases that can be considered for inclusion among the compensable cases.

## **C. Benefit Structure**

In almost all of the cases, the actual hospital charges are higher than the case rate. Does this mean that the case rate does not reflect the real market value of the services or are the hospital charges exorbitant? In some cases, the actual charges include diagnostic procedures for confounding illnesses. So while total charges may be higher than the case rates, the specific charges relating to the particular cases may be lower. There may be a need for separate billing / statements for different cases to determine the appropriateness of existing case rates. While the analysis of certain cases provides a glimpse on some of the issues relating to the benefit structure, it does not allow a thorough evaluation of existing case rates. To do this, PhilHealth and hospitals must be open to providing access to financial data not currently accessible.

## **D. Provider Payment Systems**

The allocation for DOH in the General Appropriations Act includes a budget for Assistance to Indigents and Poor Patients for the payment of PhilHealth premium under the Point-of-Care program, hospitalization, and grant assistance. The budget of DOH also includes provisions for hospital services including personnel services, maintenance and other operating expenses, and capital outlay. It also has a budget for the purchase of drugs, medicines and vaccines as well as for vaccines for indigent senior citizens. For the hospital studied, premium payments for hospital-sponsored members are initially funded from “employees’ share of PhilHealth” (presumably from the appropriations for personnel benefit fund). Hospital services are funded by the DOH subsidy and hospital income. The services provided to PhilHealth beneficiaries are then reimbursed from PhilHealth. The issues and recommendations for service payment are the same as those in section 10.2.

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