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SCOPING REPORT

Financing Primary Health Care in the Philippines

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Acronyms

BLHSD	Bureau of Local Health Systems Development
CHD	Center for Health Development
CHE	Current Health Expenditure
DBM	Department of Budget and Management
DOF	Department of Finance
DOH	Department of Health
EPCB	Expanded Primary Health Care
FDA	Food Drug Administration
GDP	Gross Domestic Product
HCPNs	Health Care Provider Networks
HFS	Healthcare Financing Strategy
HFSRB	Health Facilities and Services Regulatory Bureau
LIPH	Local Investment Plan for Health
LGC	Local Government Code
LGUs	Local Government Units
MDG	Millennium Development Goals
MNCH-FP	Maternal, New-Born, Child and Family Planning
MFO	Major Final Outputs
NHIP	National Health Insurance Program
PAP	Programs/Activities/Projects
P/CIPH	Province-Wide and City-Wide Investment Plans for Health
PCB	Primary Care Benefit
PHC	Primary Health Care
PHIC/ PhilHealth	Philippine Health Insurance Corporation
PNHA	Philippines National Health Accounts
OPB	Out-Patient Benefit
OPIF	Organizational Performance Indicator Framework
OOP	out-of-pocket payment
SDN	Service Delivery Network
SHF	Special Health Fund
STL	Sin Tax Law
THE	Total Health Expenditure
TRAIN	Tax Reform for Acceleration and Inclusion
UHC	Universal Health Care

Executive summary

This report provides an assessment of the role of financing to realise the Philippines' Primary Health Care (PHC) ambitions. It was undertaken for the Lancet Commission on Financing Primary Health Care, which aims to generate evidence-based, actionable policy recommendations on how countries can use health financing tools to improve efficiency and equity of PHC. The report is part of a set of country case studies that present empirical evidence on arrangements for financing PHC, drawing on published and unpublished literature, policy documents, surveys and census data. The other study countries are Brazil, Chile, China, Ethiopia and India.

Primary Health Care (PHC) was adopted by the government in 1979 as an approach to bring health services closer to the people. This is institutionalized through the Local Government Code passed in 1991, decentralizing the administration of PHC to the local government units, particularly the cities and municipalities.

The devolution, however, resulted to fragmented financing and provision of PHC. The funding for decentralized functions that was transferred to LGUs through the Internal Revenue Allotment (IRA) proved to be inadequate, with the provincial and municipal governments bearing a higher cost. The referral system, which was organized previously as District Health System, became broken when local hospitals were transferred to provincial governments, while the primary care facilities and barangay (village) health stations were transferred to municipal governments.

Over the years, the government has shown political will to mobilize resources for health, from establishing PhilHealth, envisioned to become the main purchaser of health care, to passing of various tax measures that increased the budget of DOH six-fold between 2009 and 2020. The LGUs have also learned how to manage their local health systems with whatever resources available to them. Despite these efforts, households remain the largest purchaser of health care, constituting 48 percent of health spending in 2019. These various resources for PHC reflect a very fragmented financing of PHC in the country. Marshalling these resources effectively befall on the capacity of the municipal health office to do so.

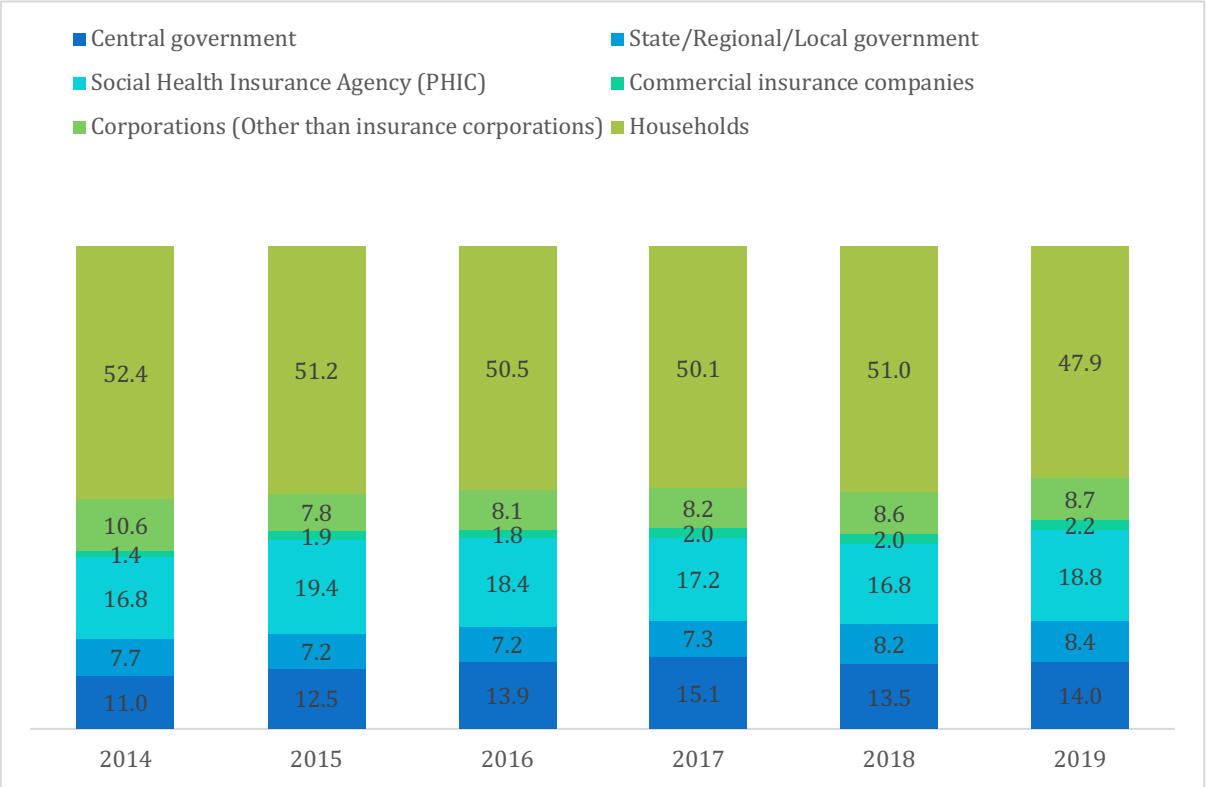
Recognizing the broken financing and delivery of health services, the Universal Health Care Act is envisaged to integrate the local health system by establishing the province-wide and city-wide health system. The law also directs the financing integration through the creation of the Special Health Fund that will be managed by the Provincial Health Board. The implementation of these strategies remains to be seen.

1. Organisation of PHC system in the Philippines

The Philippines has a mixed health system organized in a devolved setting. Composed of the public and the private sectors, the health system is underscored by the way it is financed, with about 60 percent of health spending coming from private sources (**Figure 1**). The public sector is generally funded through taxes while the market-oriented private sector is largely paid for through user fees.

The Local Government Code of 1991 devolved the provision of primary health care[1] (PHC) to the Local Government Units (LGUs) particularly to cities and municipalities. The Department of Health (DOH) provides the national policy direction, leads the development of national strategic plans, standards, and guidelines for health services and provides technical guidance to LGUs. Philhealth, the national health insurer, traverses the dual health system by paying the services rendered by both public and private providers (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018).

Figure 1. Current Health Expenditure by Financing Agent, in Percent, 2014-*2019*



Source: Philippine Statistics Authority

The key players in the public PHC system include the DOH and its attached agencies as developers and enforcers of policies and standards, PhilHealth as payer of PHC services, the LGU as provider as well as purchaser of PHC and private primary care facilities as service providers (**Figure 2**).

[1] In this scoping study, PHC and primary care are used interchangeably.

At the national level, the DOH has several offices that provide technical guidance and regulate the primary care providers. The Bureau of Local Health Systems Development (BLHSD) is the primary policy and standard setting agency for PHC, including guidance in developing local health plans called Province-Wide and City-Wide Investment Plans for Health (P/CIPH). A Province-Wide Investment Plan for Health (PIPH) incorporates the health plans of municipalities under the jurisdiction of the province. These Local Investment Plans for Health (LIPH) are used by DOH to provide PHC support to LGUs. Other DOH offices and attached agencies provide specific guidance on public health programs. For instance, policies on family planning services do not only emanate from the Family Planning Program of DOH but also from the Population Commission.

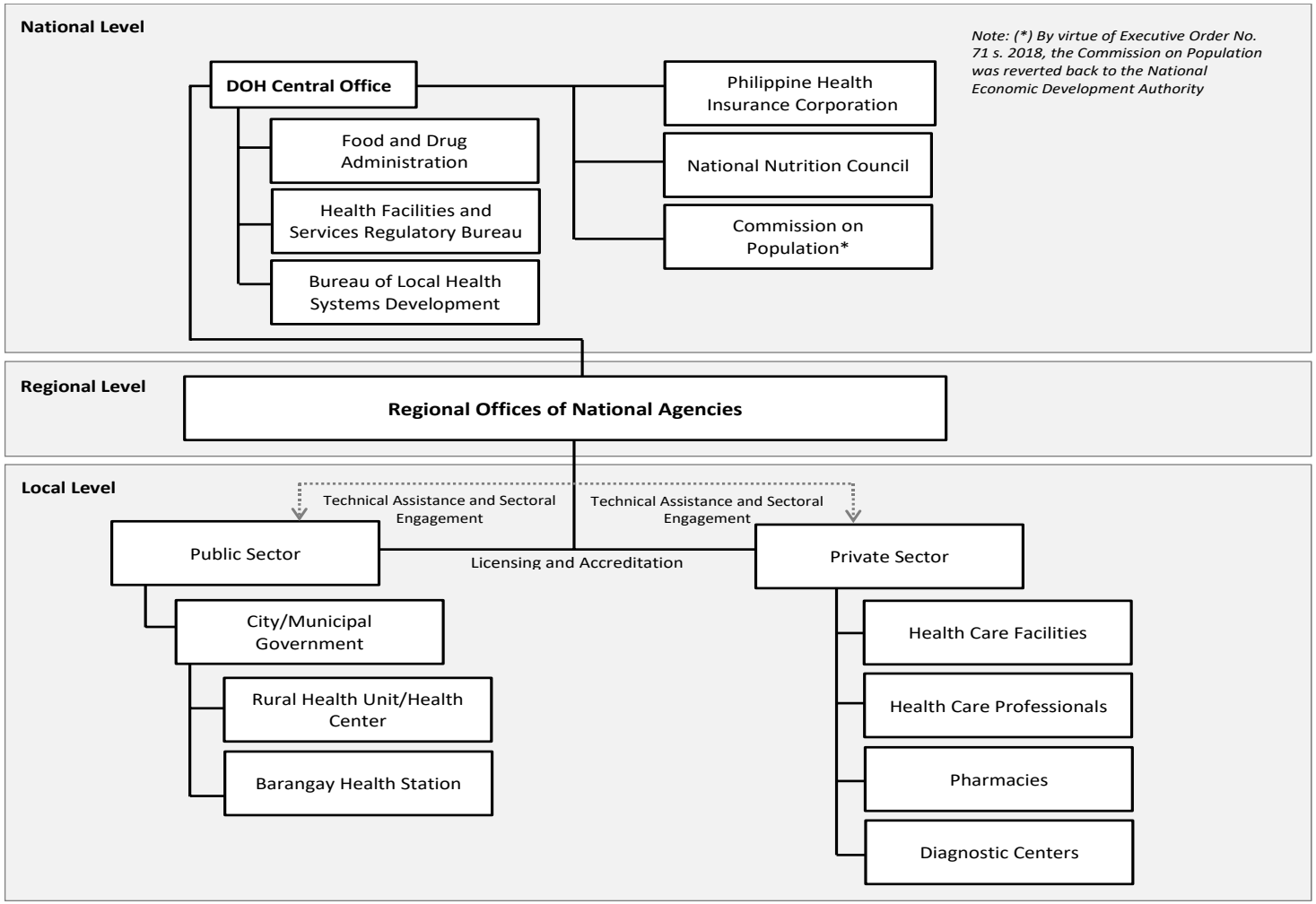
Implemented by several bureaus and offices, the regulatory function covers both public and private providers. The DOH Health Facilities and Services Regulatory Bureau (HFSRB) provides the licensing of health facilities (hospitals and primary care clinics), diagnostic facilities and ambulance services, while the DOH-attached Food Drug Administration (FDA) regulates pharmacies and health products (i.e., pharmaceuticals and medical devices, among others). The practice of health professionals is regulated by the Philippine Regulatory Commission, a government agency not attached to DOH.

The Philippine Health Insurance Corporation (PHIC, or PhilHealth), another attached agency of DOH, accredits health professionals and facilities for primary care benefit as well as specific health services[2] and pays them accordingly. Being attached to DOH, the PhilHealth Board of Directors is chaired by the Secretary of Health.

The DOH Regional Offices, called Center for Health Development, provide technical assistance to the LGUs, renew the licenses of health facilities, and monitor their continued compliance to DOH standards. On the other hand, PhilHealth Regional Offices accredit health providers, process the benefit claims, and pay the providers. They are also responsible in informing PhiHealth beneficiaries of their benefits. Aside from at the national level, the DOH regional director and PhilHealth regional vice presidents are expected to coordinate their activities to achieve the health system goals.

[2] In addition to the Primary Care Benefit, PhilHealth pays maternal and newborn care, FP services, TB-DOTS, ambulatory surgical services, animal bite treatment, etc., as separate benefit packages in PHC facilities.

Figure 2. Primary Health Care Service Organogram



Source: Authors' own work

1.2 Role of the private sector in delivering PHC services

Both public and private sectors provide primary care services. In the public sector, the city and municipality governments oversee and fund the operations of their PHC facilities.[3] However, aside from administering the devolved health services (see **Annex A**), the LGUs also have regulatory oversight over the private primary care providers in their jurisdictions. They ensure that private health facilities in their jurisdiction are licensed by DOH by making this a requirement before issuance of Mayor's (business) permit. In addition, LGUs may also require health facilities to have PhilHealth accreditation.[4]

The private sector consists of thousands of for-profit and non-profit[5] health providers, which are largely market-oriented and health care is generally paid for through user fees at the point of service. PHC private providers consist of clinics, infirmaries, laboratories, and drugstores. For-profit PHC providers are largely run by self-employed health professionals, family-owned businesses, and corporate entities, while non-profit health enterprises are commonly run by charitable institutions, faith-based organizations, civil society organizations (CSOs) and community-based volunteer groups (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018).

Both public and private PHC providers are regulated by the government through licensing and certification (DOH) and accreditation (PhilHealth). Prior to operating their primary care facility, the private sector must also get a business permit (Mayor's Permit) from their LGU.

1.3 Planning PHC services

Planning and budgeting for the national government involves four distinct processes or phases: plan and budget preparation, budget authorization, budget execution and accountability. DOH is guided by a 3-level hierarchy of outcomes (societal, sectoral and organizational), known as the agency's Organizational Performance Indicator Framework (OPIF). This serves as the logical framework for results-oriented budgeting and performance management (DBM, 2012). The organizational outcomes are linked to Major Final Outputs (MFO) – mandated deliverables of agencies/departments though programs/activities/ projects (PAPs). Budget allocation for each MFO is a product of planning, negotiation and consolidation within various DOH units/bureaus. The proposed budget of the DOH for the succeeding fiscal year cover the existing PAPs (Tier 1) and the new and expansion of current PAPs (Tier 2) (Monsod, 2019). In the formulation of budget proposal, the DOH considers the targets in the following plans: the Philippine Development Plan; the National Objectives for Health; Local Investment Plan for Health (LIPH); Annual Operational Plans of Local

[3] These are called health centers or rural health units (RHUs) located at the city/town proper and barangay health stations in the barangays/village under their jurisdiction.
[4] An example is Quezon City Ordinance SP-2100 s. 2011 entitled "An Ordinance Regulating the Operations of Birthing Homes in Quezon City"
[5] To date, the total number of private primary care facilities in the country is not known since these are not licensed by DOH until 2020. The National Health Facility Registry only reports 2,592 rural health units owned by LGUs.

Government Units (LGUs), and other components of the National Budget Priorities Framework. The Office of the Secretary executes the majority of the DOH budget through its central bureaus and units, regional DOH offices known as Centers for Health Development (CHDs) and DOH hospitals. CHDs are responsible for the field operations of DOH in the regions, coordinate with other agencies for health-related concerns and support the health programs of LGUs (Monsod, 2019).

A medium-term plan, LIPH[6] is an instrument of partnership between DOH and LGUs to achieve health sector goals (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018). This is translated into concrete actions at the local levels and becomes the basis for DOH in prioritizing investments in local health facilities, deployment of health personnel, medicines and other medical supplies and technical assistance. LIPH is also a mechanism to integrate investments in local health system through inter-LGU planning, particularly in organizing the province-wide health system.[7] However, only 62% of provinces and cities have approved LIPH in 2016 (DOH, 2018). It can be surmised that even without an approved LIPH, DOH still provides support to LGUs in terms of grants for public health programs, health personnel, drugs and other medical logistics and funding for local health facilities. This may also be interpreted as LGUs not relying on the resources mobilized through LIPH.

1.4 Integration of PHC services

Through various policies, the DOH has tried to mitigate the fragmentation in service delivery caused by the devolution by promoting inter-LGU arrangements. These range from forming Inter-Local Health Zones (ILHZ), to establishing a Service Delivery Network (SDN) (DOH, 2018) and to organizing local health systems into Health Care Provider Networks (HCPNs) as provided in the Universal Health Care Act (Republic Act 11223, 2019) (

[6] LIPH refers to both Province-wide investment plan for health (PIPH) City-wide investment plan for health (CIPH). Although the provincial and municipal governments are two independent units, the PIPH incorporates the needs of its component municipalities.

[7] DOH AO No. 2020-0022 - Guidelines on the Development of Local Investment Plans for Health

Annex B). DOH released various guidelines on how to establish an integrated local health system[8] and the context of service delivery integration, with horizontal integration being the partnership between PHC facilities and organizations while vertical integration as the continuity of care from primary care system to higher level of care.[9]

After almost twenty years of efforts in organizing the local health system, a recent study of service delivery network experience in the Philippines showed that the SDNs are still at an early stage of development. Most SDNs have improved referral systems, with a focus on maternal, newborn, child and family planning services (MNCH-FP). However, fundamental challenges need to be addressed, particularly the fragmentation of financing, organization, and provision of healthcare across different government entities at central, provincial and local levels. This is compounded by lack of capacity of current SDNs to operate across LGU geographic or political boundaries (La Forgia, Yujuico, Yogyog, & Estrada, 2020). Moreover, assessment of two provincial level SDNs showed no clear picture on how these networks are financed, with most managers either unaware of financing mechanism or acknowledge the lack of one (La Forgia G. M., 2020).

1.5 Health care reforms

The Philippine government adopted the PHC approach in 1979. This policy was further reinforced by the passage of the Local Government Code (LGC) in 1991, which aimed to bring the health services closer to the people and communities. Under the LGC, LGUs have full autonomy to finance[10] and operate the local health systems. Provincial governments are tasked with providing primary and secondary hospital care, while city and municipal governments are tasked with providing primary health care, promotive and preventive health programs, and basic ambulatory clinical care (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018). However, the transfer of responsibility for delivering primary health services to LGUs resulted in fragmentation of health services (World Bank, 2011). While the LGC was designed to provide the legal framework for an efficient and effective health service delivery, its implementation created unintended consequences of fragmented health system. These include weakened implementation of national health programs due to high transactions costs of engaging individual and autonomous LGUs; reduced effectiveness of public health delivery system; and increased variation in access and quality of health services across the country (Panelo, Solon, Ramos, & Herrin, 2017).

Consistent with the government's commitment to achieve universal health coverage (UHC) articulated in 2010,[11] efforts have been made to ensure that resources are available for the health system and the legal framework to re-establish an integrated health delivery system is

[8] DOH AO No. 2020-2021 - Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)
[9] DOH AO No. 2020-0024 - Primary Care Policy Framework and Sectoral Strategies
[10] While PhilHealth is mandated to purchase health services, LGUs can finance their PHC facilities using their income from national and local sources. Thus, there are LGUs whose health facilities are not accredited and therefore not earning from PhilHealth.
[11] DOH AO No. 2010-0036. The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos

in place. The Health Care Financing Strategy of the Philippines 2010-2020 underscored fundamental problems: underspending in health, fragmented health financing system, weak social protection, equity, and solidarity, inappropriate incentive structures and marginal impact of past reforms (DOH, 2010). Several changes in laws and policies soon followed. These include: transferring the responsibility of identifying the poor to be enrolled in PhilHealth from the LGUs to the national government thereby using the same database of the Department of Social Welfare and Development (DSWD) in identifying the beneficiaries of the government's conditional cash transfer program;[12] removing the sharing of premium payment for the poor between the LGUs and the national government and making DOH responsible for ensuring that the poor have PhilHealth coverage; and, increasing available resources for health through new legislation. For instance, the Sin Tax Law (STL) was not only passed to reduce alcohol consumption and tobacco smoking but also to generate additional revenue for health programmes as well as PhilHealth premium subsidies for the poor.

As a result of these reforms, DOH budget increased from PHP 53.2 billion (US$ 1.06 billion) in 2013 (pre-STL) to PHP 165 billion (US$ 3.3 billion) in 2019. The STL and its implementing rules require that 80 percent of the Sin Tax incremental revenue for health[13] is allocated to enrolment and coverage of indigent families to PhilHealth, strengthening of preventive health programs towards the attainment of MDGs, health awareness programs and implementation research to support UHC. While the remaining 20 percent of revenue is allocated for Medical Assistance, investment in health facilities through the Health Facilities Enhancement Program (HFEP) and support to the establishments of SDNs (DOH, 2020). LGU beneficiaries for HFEP are identified through LHIP. Assessment of HFEP utilization showed that of the 4,167 health facilities that received HFEP funding between 2010 and 2014, 71 percent (2,968) were primary care facilities (Picazo, et al., 2016).

Understanding that UHC would require a comprehensive law, the Universal Health Care (UHC) Law (Republic Act 11223, 2019) was passed to "*progressively realize UHC in the country through a systematic approach and clear delineation of roles of key agencies and stakeholders towards better performance in the health system; And ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risk*."

The law also provides for structural and functional changes in health financing, service delivery, and governance of the health system. Particularly, the law mandates establishment of a province- or city-wide health system where every Filipino will have a primary care provider (private or public) that will serve as initial point of contact, navigator and coordinator in healthcare delivery system. To operationalize these aspirations, DOH issued the policy framework to strengthen primary care and to delineate the roles and responsibilities of different stakeholders to ensure efficient and quality primary care.[14]

Annex C lists the key laws and policies related to PHC from 1979 to 2020.

[12] Pantawid Pamilyang Pilipino Program or 4Ps
[13] 85% of the total revenue from STL is earmarked for health.
[14] DOH AO No. 2020-0024 - Primary Care Policy Framework and Sectoral Strategies

2. Overview of health expenditure

2.1 Trends over time

The Total Health Expenditure (THE) in the Philippines remains at below 5% of its Gross Domestic Product (GDP), with marginal increases noted from 3.17% in 2000 to 4.59% in 2018 (**Error! Reference source not found.**). Likewise, the Philippines National Health Accounts (PNHA) reported that THE at current prices grew by 8.3 percent in 2018 amounting to PHP 799.1 billion (USD16B) from PHP 737.8 billion (USD15.3B) in 2017, contributing 4.6 percent to GDP. The 2018 THE comprised of 96.0 percent Current Health Expenditures (CHE) and 4.0 percent Health Capital Formation Expenditures (HK) in government sector (PSA, 2020).

The private sector accounts for more than half of health spending and its contribution has increased from 51.84 percent of THE in 2000 to 63.90 percent in 2018 (**Table 1**). This is largely driven by out-of-pocket expenditures, which rose from 41.02 percent to 51.68 percent of THE in the same period. In 2018, household-out-of-pocket payment (OOP) is pegged at PHP 413.0 billion (USD8.5 billion), which contributed more than half (53.9 percent) of current health spending. Of this amount, 50.1 percent (PHP 206.7 billion or USD4.2billion) was spent on pharmacies (PSA, 2020). The OOP is largely driven by spending on out-patient medicines, which, on average, 62 percent of the total household spending on health (Bredenkamp & Buisman, Universal Health Coverage in the Philippines: Progress on Financial Protection Goals, 2015). This is also due to the failure of PhilHealth's provider payment mechanism to effectively constrain what the patients pay out-of-pocket, its limited benefit coverage and general inability to influence patients not to self-refer to higher level and more costly hospitals (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018; Bredenkamp, Gomez, & Bales, 2017).

Growth in the use of private prepaid plans is also observed, almost doubling from 5.92 percent of THE in 2000 to 10.79 percent in 2018. This may be attributed to the usual inclusion of health maintenance organization (HMO) plans as part of employment benefits in the private sector. The portion of public health expenditure, on the other hand, have been decreasing over time, accounting for 44.21 percent of THE in 2000 and dropping to 31.34 percent in 2018. However, the per capita government expenditure on health has tripled from $47.08 in 2000 to $128.62 in 2018. The membership expansion of the Philippine Health Insurance Corporation (PhilHealth), the state health insurer established in 1995, may have contributed to this increase in per capita public health spending as well as increase in the DOH budget particularly in health facility enhancement program.

Table 1. Trends in health expenditure in the Philippines, 2000-2018

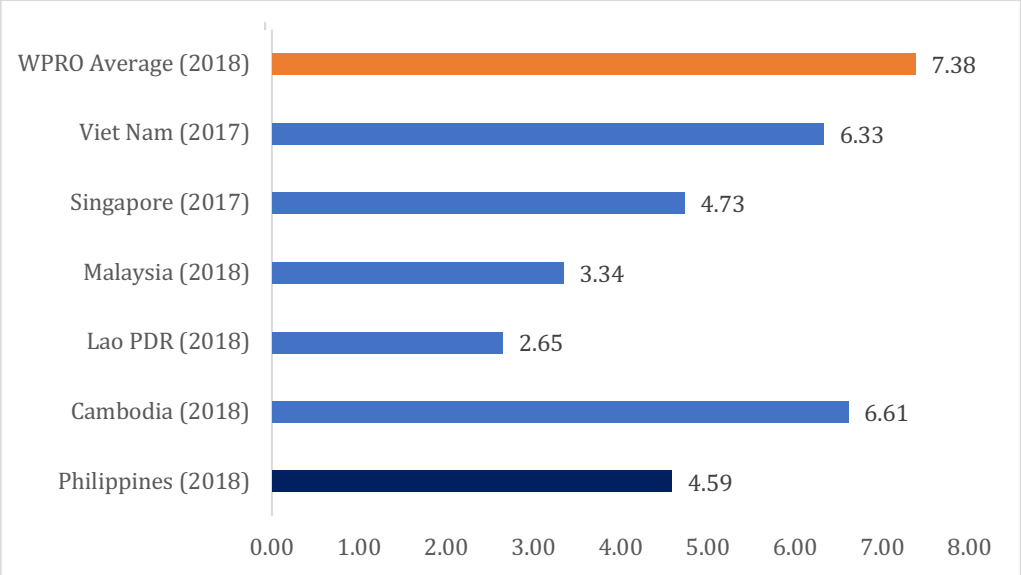
Expenditure	Philippines				
	2000	2005	2010	2015	2018
1. Total expenditure on health as % of GDP (THE%GDP)	3.17	3.91	4.37	4.45	4.59
2. General government expenditure on health as % of GDP(GGHE%GDP)	1.40	1.29	1.38	1.36	1.44
3. Per capita government expenditure on health, US$ adjusted for purchasing power ("purchasing power parity" (PPP) or $ International)	47.08	54.94	75.24	99.51	128.62
4. General government expenditure on health as % of total general government expenditure (GGHE%GGE)	6.52	6.61	7.18	7.25	6.60
5. General government expenditure on health as % of total health expenditure (GGHE%THE)	44.21	32.99	31.46	30.58	31.34
6. Private expenditure on health as % of total health expenditure (PHE%THE)	51.84	62.47	65.38	65.19	63.90
7. External resources for health as % of total health expenditure (EXT%THE)	3.52	4.20	1.77	1.35	0.73
8. Out-of-pocket expenditure as % of total expenditure on health (OOPS%THE)	41.02	51.93	54.08	53.21	51.68
9. Private prepaid plans as % of total expenditure on health (VHI%THE)	5.92	7.15	8.36	10.29	10.79

Source: World Health Organization – Global Health Expenditure Database

Philippine health expenditure compared with selected Asian countries

The total expenditure on health as a portion GDP in the Philippines and selected neighboring countries in Asia is lower than the Western Pacific Region average for 2017/2018 (Figure 3). Cambodia and Viet Nam are faring relatively better at 6.61 percent and 6.33 percent, respectively, being close to the regional average of 7.38 percent. The total expenditure on health as a portion GDP in Singapore, a high-income country, is only slightly higher than the Philippines while middle-income country Malaysia has 3.34 percent of its GDP attributed to health expenditures.

Figure 3. Health expenditure as a share (%) of GDP, latest available year



Source: World Health Organization – Global Health Expenditure Database

Annex D shows other health spending indicators of the Philippines vis-à-vis elected countries in Asia.

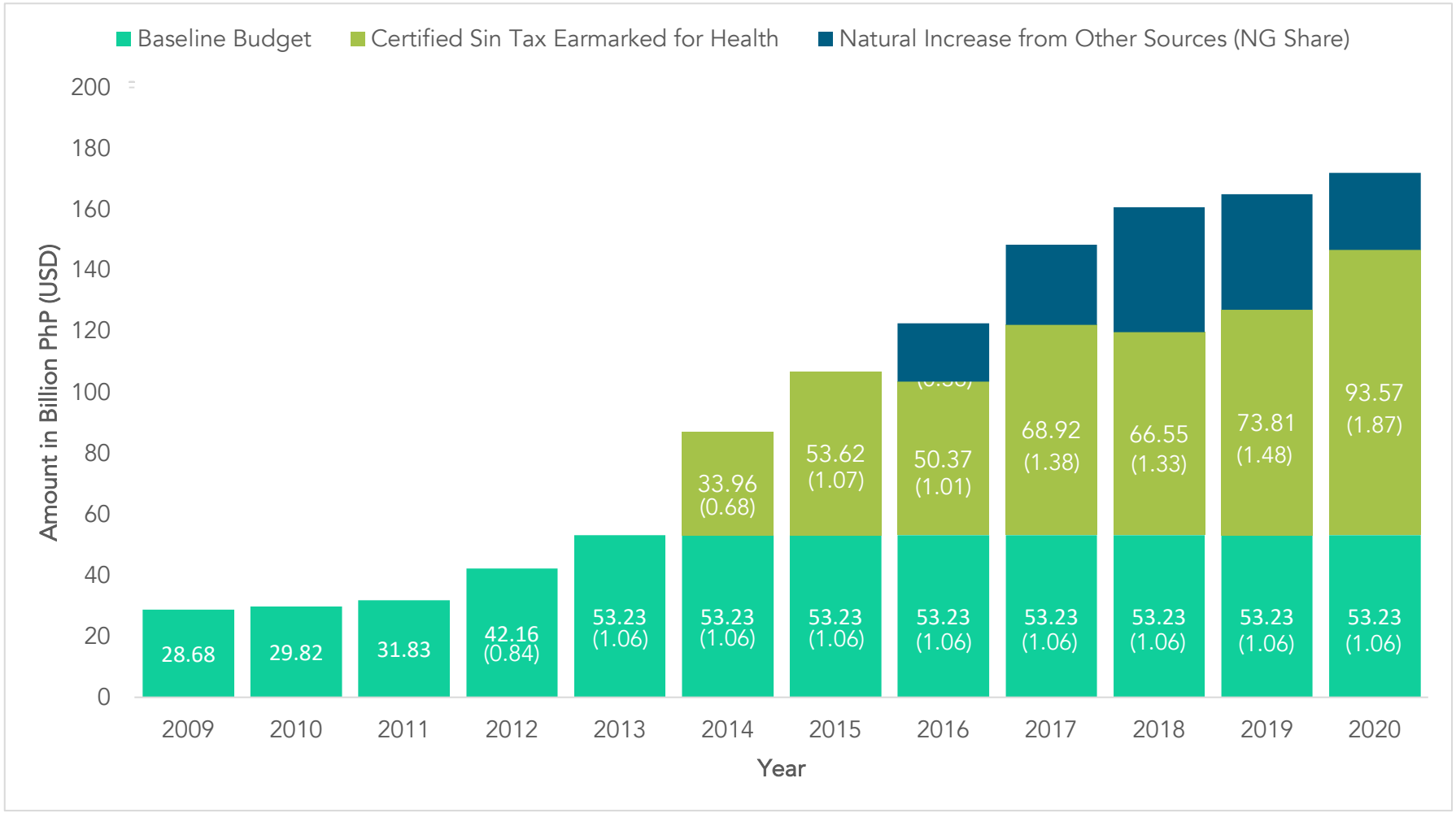
2.2 Sources of government revenue for health

Error! Reference source not found. shows the incremental revenues appropriated to DOH budget, which includes the health insurance premium of the poor families and senior citizens who are not lifetime members of PhilHealth. Year 2013 is the baseline year, prior to the passage of the Sin Tax Law (STL).

The DOH budget, net of allocation for PhilHealth premium of the poor and the elderly, has increased three times in the last decade from PHP 53 billion in 2013 to PHP 98 billion (USD 1.96 billion) for 2019.

The largest increase was on Personnel Services (PS) that grew from PHP 6 billion to PHP 43 billion. Maintenance and Other Operating Expenses (MOOE) has increased from PHP 10 billion to PHP 38 billion, and Capital Outlay (CO) from PHP 6 billion to 17 billion. The DOH budget allocation, net of PhilHealth premiums, peaked in 2018 with an appropriation of Php 106 billion (ProtectHealth, 2020).

Figure 4: STL Incremental Revenue for Health in the DOH Budget 2014-2019 in PHP billions (USD)



Mobilising tax and other revenues for health

Any revenue mobilization measure would require navigating though both houses of Congress (and their respective committees) before getting finalized in bicameral reconciliation. Considering the institutionally weak political parties, personalistic and local dynastic interests, prevalent money politics and ubiquitous party switching, various actors outside the legislative process help push through the tax reforms.

In the past decade, two key tax measures were passed to finance access to health services. First is the STL passed in 2012, which earmarked 85 percent of incremental revenues on health to ensure PhilHealth coverage of the poor as identified by the country's targeting system, investing in public health facilities and supporting public health programs. Prior to the passage of STL, the combination of limited fiscal space vis-à-vis patronage politics both at the national and local levels, undermined the state's ability to deliver effective poverty reduction, social protection, and health programs. By earmarking for health, the government provided the means to ensure the scaling-up of social and health programs. Factors that facilitated the passage of STL include strong executive leadership under Aquino Administration along with leadership from various government agencies and civil society groups; creation of reform coalitions consisting of seasoned and committed reformists; fusion of political economy, institutional dynamics and technical analysis; framing the message of health reform over a tax measure; and, vigilant and sustained attention from legislation to implementation (Sidel, 2014; Kaiser, Bredenkamp, & Iglesia, 2016).

Another tax reform, the Tax reform for Acceleration and Inclusion (TRAIN) was passed to finance the ten-point socioeconomic agenda of the Duterte Administration. Essentially, these tax reforms are expected to raise PHP 786 B (US$15.72 B) over 5 years to fund the President's priority social and infrastructure programs (DOF, 2018). These include construction and upgrading of local hospitals and primary care facilities, deployment of health professionals and funding to provide 100 percent Philhealth coverage under the UHC Act.

2.3 Allocation of government health expenditure

Current health spending is mostly channeled to provision of medical services, with curative services accounting for 46.43 percent of total expenditure on health (PSA, 2020). Government health expenditure represents 41.25 percent of current health expenditure in 2019, and if this proportion will be applied on expenditure by health service program, it is estimated that 53.15 percent of government health spending was used to finance the provision of medical services – the curative and rehabilitative services in particular (**Error! Reference source not found.**). Spending data from 2014 also show that investment on education and training and health research and development is very low, representing only less than one percent of public health spending and total expenditure on health. Government spending on preventive services is estimated to be around 2.63 percent of total expenditure on health.

Table 2. Public health expenditure on health by service program, 2019

Expenditure	Philippines (2019)	
	% of public expenditure on health	% of total expenditure on health
1. Health administration and insurance	7.47[15]	2.69[16]
2. Education and training	0.00[17]	0.00[18]
3. Health research and development	0.33[19]	0.06[20]
4. Public health and prevention[21]	7.28[22]	2.63[23]
5. Medical services	53.25[24]	19.22[25]
a) inpatient care		
b) outpatient/ambulatory physician services (primary care)		
c) outpatient/ambulatory physician services (specialist care)		
d) outpatient/ambulatory dental services		
e) home or domiciliary health services		
f) mental health		
g) ancillary services	1.74[26]	0.63[27]

Source: Philippine National Health Accounts 2014 and 2019

[15] Estimated by multiplying the current heath expenditure on governance, and health system and financing administration to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of general government health expenditure. Data from 2019 Philippine National Health Accounts.

[16] Estimated by multiplying the current heath expenditure on governance, and health system and financing administration to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of total expenditure on health. Data from 2019 Philippine National Health Accounts.

[17] Calculated using 2014 data from Philippine National Health Accounts.

[18] Calculated using 2014 data from Philippine National Health Accounts.

[19] Calculated using 2014 data from Philippine National Health Accounts.

[20] Calculated using 2014 data from Philippine National Health Accounts.

[21] The figures only reflect expenditure on preventive care.

[22] Estimated by multiplying the current heath expenditure on preventive care to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of general government health expenditure. Data from 2019 Philippine National Health Accounts.

[23] Estimated by multiplying the current heath expenditure on preventive care to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of total expenditure on health. Data from 2019 Philippine National Health Accounts.

[24] Disaggregated data on inpatient and outpatient care are not available. This figure represents the current health expenditure on curative and rehabilitative care (excluding ancillary services), multiplied by general government health expenditure as percentage of current health expenditure. This is then presented as percentage of general government health expenditure. Data from 2019 Philippine National Health Accounts.

[25] Disaggregated data on inpatient and outpatient care are not available. This figure represents the current health expenditure on curative and rehabilitative care (excluding ancillary services), multiplied by general government health expenditure as percentage of current health expenditure. This is then presented as percentage of total expenditure on health. Data from 2019 Philippine National Health Accounts.

[26] Estimated by multiplying the current heath expenditure on ancillary services to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of general government health expenditure. Data from 2019 Philippine National Health Accounts.

[27] Estimated by multiplying the current heath expenditure on ancillary services to general government health expenditure as percentage of current health expenditure. This is then presented as percentage of total expenditure on health. Data from 2019 Philippine National Health Accounts.

3. Resource mobilisation and allocation

3.1 Sources of revenue and financial flows in PHC system

Table 3 shows five major revenue sources for health in the country:

1. Transfers from government domestic revenues allocated for health purposes, i.e., health-related activities funded by appropriations, with health activities identified based on agency mandate or activity descriptions.
2. Transfers distributed by the government from foreign-assisted projects.
3. Social health insurance contributions, which is largely contributions to PhilHealth.
4. Voluntary pre-payment.
5. Other domestic resources coming from households and corporations. Public corporations that provide additional financial resources for health include the Philippine Amusement and Gaming Corporation (PAGCOR) and the Philippine Charity Sweepstakes Office (PCSO), but their contributions to health are highly unpredictable (PSA, 2020).

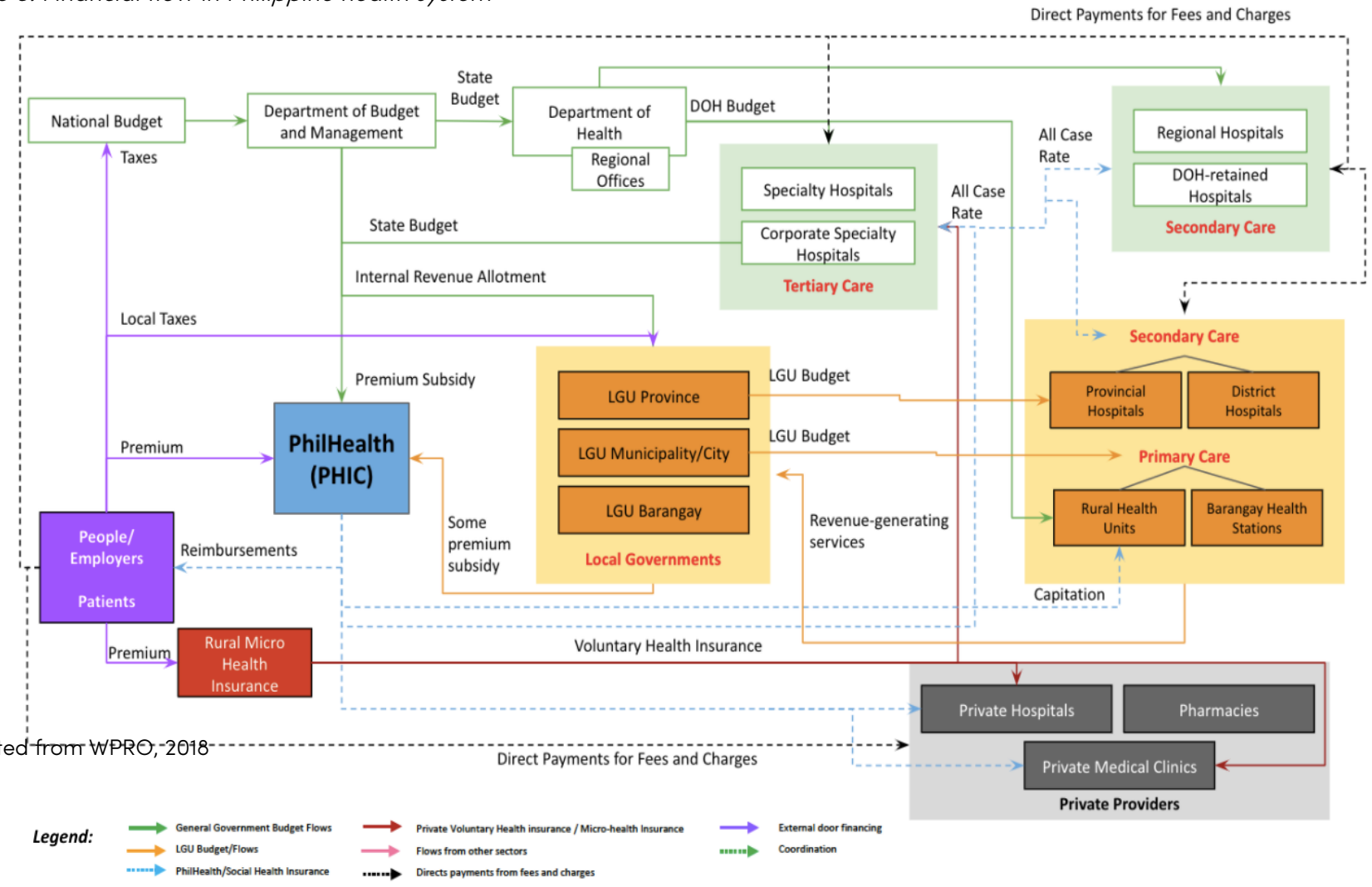
In 2019, the households remain the largest revenue source at about 48 percent paying out of pocket for health services, followed by government domestic revenues at 34 percent while contributions to social health insurance is a far third at 6.7 percent. It must be noted that the government subsidy for the social health insurance of the poor and the elderly are included in transfers from government domestic revenues under DOH appropriations funded by the STL revenues (**Table 3**).

Table 3. Current health expenditure by source of revenue, in million PHP (US$)

Revenues of Health Financing Scheme	2014	2015	2016	2017	2018	2019
	PHP (USD)	PHP (USD)	PHP (USD)	PHP (USD)	PHP (USD)	PHP (USD)
Transfers from government domestic revenue (allocated to health purposes)	118,984 (2,380)	153,725 (3,074)	169,840 (3,397)	197,517 (3,950)	227,691 (4,554)	271,613 (5,432)
Internal transfers and grants	118,984 (2,380)	153,725 (3,074)	169,840 (3,397)	197,517 (3,950)	227,691 (4,554)	271,613 (5,432)
Transfers distributed by government from foreign origin	7,278 (146)	7,832 (157)	13,560 (271)	14,386 (288)	1,227 (25)	3,338 (67)
Social insurance contributions	47,855 (957)	51,060 (1,021)	53,171 (1,063)	47,972 (959)	46543 (931)	53428 (1,069)
Social insurance contributions from employees	14,608 (292)	14,142 (283)	13756 (275)	16700 (334)	15270 (305)	17683 (354)
Social insurance contributions from employers	13,335 (267)	12,476 (250)	12452 (249)	12175 (244)	12230 (245)	14513 (290)
Social insurance contributions from Self-employed	19,275 (385)	19,413 (388)	19460 (389)	17019 (340)	18679 (374)	21210 (424)
Other social insurance contributions	637(13)	5,030 (101)	7503 (150)	2078 (42)	365 (7)	22 (0.44)
Voluntary prepayment	49,418 (988)	42,407 (848)	48190 (964)	56426 (1,129)	62902 (1,258)	71618 (1,432)
Other domestic revenues	265,532 (5,311)	288,557 (5,771)	313701 (6,274)	339414 (6,788)	376408 (7,528)	392557 (7,851)
Revenues from households	256,157 (5,123)	278,197 (5,564)	302176 (6,044)	328828 (6,577)	364241 (7,285)	379731 (7,595)
Revenues from corporations	9,375 (188)	10,360 (207)	11526 (231)	10586 (212)	12167 (243)	12826 (257)
TOTAL CURRENT HEALTH EXPENDITURE	**489,067 (9,781)**	**543,582 (10,872)**	**598,462 (11,969)**	**655,714 (13,114)**	**714,770 (14,295)**	**792,554 (15,851)**

Source: Philippine Statistics Authority, 2020

Figure 5. Financial flow in Philippine health system



Source: Adapted from WPRO, 2018

3.2 Collection, pooling and use of revenue

Department of Health

The flow of funds in the Philippine health system is shown in Figure 5. Government health expenditures are funded out of general tax revenues[28] that are collected by the Department of Finance (DOF). Out of the total government revenues of PHP 2,850 billion in 2018, 90% (or PHP 2,566 billion) came from taxes and 10% from non-tax revenues (PHP 269 billion).[29] National Government agencies such as the DOH and PhilHealth are then allotted annual budgets by the Department of Budget and Management (DBM). Similarly, each LGU receives a share of the national revenue called IRA. In terms of health services, the DOH appropriations are not only spent on secondary and tertiary level of care but also on PHC infrastructure and equipment under the HFEP, medicines and other medical supplies and human resource requirements to provide primary care services. DOH also pays the premium contributions of the poor and elderly.

PhilHealth

PhilHealth collects premium contributions from its members[30] **(Table 4)** and the subsidized premium for indirect contributors. These contributions, as well as the donations and grants and other appropriations earmarked by the national government are purposely for the implementation of the National Health Insurance Program (NHIP) managed by Philhealth. In addition, revenues from the following sources subsidize the premium for indirect contributors of PhilHealth (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018):

- The Reformed Value Added Tax Law of 2005 (Republic Act No. 9337), which provides that 10 percent of the LGU share from the incremental revenue from the VAT shall be allocated for health insurance premiums of enrolled indigents as counterpart contribution.
- Bases Conversion Development Act of 1995 (Republic Act No. 7917), which provides that percent of the sale of the proceeds of Metropolitan Manila camps shall be given to the NHIP.
- Documentary Stamp Tax Law of 1993 (Republic Act No. 7660), which states that starting in 1996, 25 percent of the incremental revenue from the increase in documentary stamp taxes shall be appropriated for the NHIP.
- Excise Tax Law (Republic Act No. 7654) of 1993, which states that 25 percent of the increment in the total revenue from excise taxes shall be appropriated solely for the NHIP.

Moreover, the UHC Act also identified the following funding sources to ensure the implementation of the law and the expansion of Philhealth benefits to address the health care needs of Filipino people:

- Total incremental collection from Sin Tax Law
- Fifty percent (50%) of the national government share from the income of the Philippine Amusement Gaming Corporation (PAGCOR), which will be transferred to

[28] Including STL and TRAIN taxes that have earmarked provisions for health
[29] Downloaded from C1.pdf (dbm.gov.ph)
[30] Republic Act No. 11223 (the Universal Health Care Act) passed in 2019 provides that all Filipinos are automatically included in the National Health Insurance Program managed by PhilHealth

PhilHealth every quarter and to be used by PhilHealth to improve its benefit packages.

- Forty percent (40%) of the Charity Fund from the Philippine Charity Sweepstakes Office (PCSO), which will be transferred to PhilHealth every quarter and to be used by PhilHealth to improve its benefit packages.

Table 4: PhilHealth Membership types based on UHC Act

Direct Contributors	Indirect Contributors
Employees in government and private sector, regardless of status of employment/appointment	Indigents identified by DSWD
Kasambahay (househelp, family driver, etc)	Beneficiaries of the government's CCT program
Self-earning individuals	Senior citizens not covered by PhilHealth
Professional practitioners	Person with disability
Overseas Filipino Workers,	*Sanggunian Kabataan* officials (elected youth leaders)
Filipinos Living abroad	Individuals previously registered in PhilHealth under the Point-of Service[31]
Filipinos with dual citizenship	All Filipinos aged 21 and above who do not have the capacity to pay the premium
Lifetime members of PhilHealth	
All Filipinos aged 21 and above who have the capacity to pay the premium	

Source: RA 11223 Implementing Rules and Regulations

As of 2019, PhilHealth reported that 90 percent of the estimated 108 million Filipinos have been registered in the database (
). Prior to UHC Act, PhilHealth reported its eligible members and their dependents in terms of "coverage rate" or percentage of population with updated PhilHealth premium contribution for the year. With the passage of UHC Act, all Filipinos are covered, i.e., 100 percent coverage rate. But to realize this, PhilHealth must ensure that every Filipino is registered in its database and informed of his/her PhilHealth benefits. Bredenkamp and colleagues reported that the awareness of Philhealth coverage by the poor for various types of hospital care is high, with 75 percent of respondents knowing the no-balance billing policy. However, only a minority of poor people know of their primary care benefit (Bredenkamp, et al., 2017). This may be because these Sponsored Philhealth members are identified through the country's targeting system and other registries (e.g., registry for senior citizen), and may not know of their PhilHealth coverage or the benefits that go with it.

[31]These are patients on government hospitals who do not have PhilHealth coverage for the year. They are initially enrolled by the hospital so that their current admission will be covered by PhilHealth, and upon assessment they are identified as an indigent by the hospital social worker.

Table 5. Registered Filipinos under PhilHealth

Membership Category	Members	Dependents	Beneficiaries
Direct Contributors*	**30,282,610**	**28,380,254**	**58,662,864**
Employed: Private	14,342,431	11,366,233	25,708,664
Employed: Government	2,333,730	3,726,641	6,060,371
Informal/Self Earning	8,442,963	8,962,161	17,405,124
OFWs/Migrant Workers	3,628,196	3,163,923	6,792,119
Lifetime Members	1,319,377	978,819	2,298,196
Organized Group/Group Enrolment	138,932	127,844	266,776
Kasambahay, Family Drivers, Enterprise Owner	72,830	52,434	125,264
Others**	4,151	2,199	6,350
Indirect Contributors*	**23,059,023**	**16,028,686**	**39,087,709**
Indigents	12,834,955	11,348,233	24,183,188
Senior Citizens	8,070,076	2,159,799	10,229,875
Sponsored Program****	2,153,992	2,520,654	4,674,646
Total	**53,341,633**	**44,408,940**	**97,750,573**

Source: Stats and Charts, PhilHealth, 2020

Notes:

*Modified categories based on Republic Act No.11223 (UHC Act)

**Filipinos w/ Dual Citizenship, Naturalized Filipino Citizens, PRA Foreign Retirees, Citizens of Other Countries working / residing / studying in the Philippines

***PhilHealth Circular No.2019-0010 (Re: Guidelines on the Granting of Immediate Eligibility to Members): https://www.philhealth.gov.ph/circulars/2019/circ2019-0010.pdf

****Special Government Programs (PAMANA and Bangsamoro), NGAs, LGUs, POS, Private, etc.

- Indigent count of members and dependents were based on DSWD LisTahanan database and are subject for further validation.
- 2019 Projected Population is 108,099,455 estimated from the August 2015 Pop Cen by PSA with a 1.72 Growth Rate.

Local Government Units

LGUs mobilize funds from two sources: external sources and internal sources (Cruz-Sta. Rita, Magno, Galvez, & Reyes-Cantos, n.d.). External fund sources include (i) internal Revenue Allotment (IRA), which is about 40% of the income tax, VAT, and excise taxes imposed by the national government, (ii) share from the use of national wealth in their jurisdiction, including mining taxes, royalties, forestry and fishery charges, among others; (iii) financial grants or donations from local and foreign assistance agencies, including funds coming from their House Representatives/ Senators; and, (iv) considered as an innovative provision of the Local Government Code, LGUs may use credit financing, build-operate-transfer (BOT) schemes, bond flotations, and other investment strategies to finance their local development programs and projects. Moreover, the Mandanas Doctrine[32] will increase the IRA of LGUs by 55.7 percent in 2022, from PHP 695.49 billion

[32] The Supreme Court ruling in 2018 on the petitions of Batangas Gov. Hermilando Mandanas and former Bataan Gov. Enrique Garcia Jr.

(US$14.49 billion) to PHP1,082.73 billion (USD22.56 billion).[33] Each LGU is expected to receive an estimated increase of 27.61 percent increase of IRA shares.

LGUs can also mobilize funds internally. These include (i) local taxes, fees, and charges; and (ii) income from investments, privatized and development enterprises, and inter-local government undertaking. Local taxes can also be imposed in the exercise of local regulatory powers, while charges can be imposed on the services delivered or for use of LGU facilities. For example, an LGU may charge fees for services rendered by its health facilities, including the issuance of sanitary permit (a requirement for business permit), pre-marriage counselling, including family planning services (requirement for getting married), pre-employment medical clearance and other health care services (e.g., charge for laboratory tests). They also earn income from PhilHealth through their accredited health facilities, which can be ring-fenced if Philhealth payments are placed in a trust fund as required by PhilHealth. The revenues raised by LGUs are allocated to its various programs, plans and activities, including the devolved health functions like PHC.

3.3 Resource allocation in the PHC system

The Philippines has no centralized resource allocation authority. Aside from the country having a mixed system of public and private providers and financing agents, the public system itself is also fragmented between supply-side financing by DOH and LGUs[34] and demand-side financing paid by PhilHealth.[35] This precludes rational resource allocation, which results to gaming for resources by facility managers and programme implementors. There is unclear accountability on who pays for what service and who is accountable to whom problems. Decisions about the health-care budget are made at different levels, often resulting in overlaps (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018). For instance, LGU budgets for its primary care facilities, including the services being paid by PhilHealth and for which DOH also provides logistics for. As an example, the management of tuberculosis under directly observed therapy, short course (DOTS) is an essential service provided by LGU health centers. Health personnel are salaried, and laboratory supplies for microscopy are budgeted for. If the health center is accredited by Philhealth for this service, the health center is paid for each TB patient. DOH also procures anti-TB medicines that are distributed to LGUs.

Allocation of PHC resources to purchasers

With the devolution of PHC services, city and municipal governments allocate funds to operate Rural Health Units (RHUs), City Health Offices (CHOs) and Barangay Health Stations (BHS) in their respective jurisdictions. These services are funded through the city/municipal budgets – which are mobilized from their IRA, local and non-tax revenues, loans and grants, PhilHealth payments[36] and resources from the DOH that are allocated to LGUs either in cash or in kind through personnel deployment program, medicines procured under public health programs, and capital investments under the HFEP.

[33] DBM, (2020), Dir. Macaspac's presentation on DILG webinar series
[34] All LGUs allocate budget for devolved health services. Specifically, city and municipal governments allocate funding for PHC
[35] See section on how PHC services are provided
[36] Unless the LGU creates a trust fund for PhilHealth payments, these payments revert to Municipal treasury and treated as local income. The release of the professional fee component of PhilHealth payments to health workers could be influenced by the local chief executive.

Various revenues that the LGU receives are pooled into the LGU budget and then allocated and budgeted by the local council, with strong influence from the governor or mayor or their designated provincial, city or municipal development officer. In a baseline study for service readiness to provide PHC, 194 LGUs out of the 240 reported maintaining Trust Fund account, 80% of them dedicated for capitation or PFP (World Bank Group., 2019).

Autonomy of purchasers

While the IRA of LGUs is calculated based on population and geographical area of LGU, there is no prescribed percentage of IRA that should be allocated to health to ensure effective management of the local health system. Some LGUs are too small, or too isolated that economies of scale can be a major obstacle for cost-effective service provision. On the other hand, some LGUs have too small population size which renders it unfeasible to establish the full range of health services needed by their constituents. PhilHealth, envisioned to be the single payer of health care, has not evolved its payment mechanism to adopt a risk-adjusted rates (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018).

In 2000, PhilHealth first offered the Out-Patient Benefit (OPB) package to Sponsored Program members by accrediting the RHUs and health centers.[37] In 2012, the OPB package was updated and renamed Primary Care Benefit (PCB) to ensure that the health services are delivered to Sponsored Program members. With the national government taking responsibility in paying the insurance premium of the poor, PhilHealth designed the benefit package to ensure that every poor family is assigned[38] to a PCB provider and health services are provided. PCB providers were paid 'capitation' (per family payment or PFP), with releases conditional to the number of the SP members (and their dependents) enlisted (registered) and profiled in their respective rural health units. The policy on PCB also made explicit instruction on how to disburse the payment (80 percent for medicines and medical supplies and 20 percent for professional fee of health care team). It also provided monetary incentive for providers who would use electronic patient records.

In 2019, an upgraded version of the PCB, called Expanded PCB (EPCB) was rolled out. More Philhealth members type become eligible for this benefit package (including the formal sector, lifetime members and senior citizens) and more services are provided, with more diagnostic tests and medicines. Recognizing that the number of public PHC providers are not enough, private clinics as well as the out-patient department of accredited hospitals can provide EPCB. Also, building upon the PCB Package, the EPCB is a blended payment system that combines (1) 'risk-based capitation' (per family) payment with (2) performance incentives (e.g., maintenance medicines for hypertensive and diabetic patients as well as limit to the proportion of patients admitted for conditions that should have been managed through EPCB) and (3) fixed co-payment. These revised incentives aimed to ensure that the PCB providers locate beneficiaries assigned to them,

[37] PhilHealth limited the members who are eligible to avail Outpatient Benefit Package, initially only for the Sponsored Program members, i.e., members whose premium contributions are paid for by national government and LGUs, being responsible for identifying the poor in their locality. This system of enrolling the poor has been amended since 2012.

[38] The initial design pf PCB was to assign or lock in the PhilHealth member's family to their RHU but as PhilHealth rolls out the benefit to other member types and accreditation primary care provider is extended to private sector, the assignment of PhilHealth members have been discontinued.

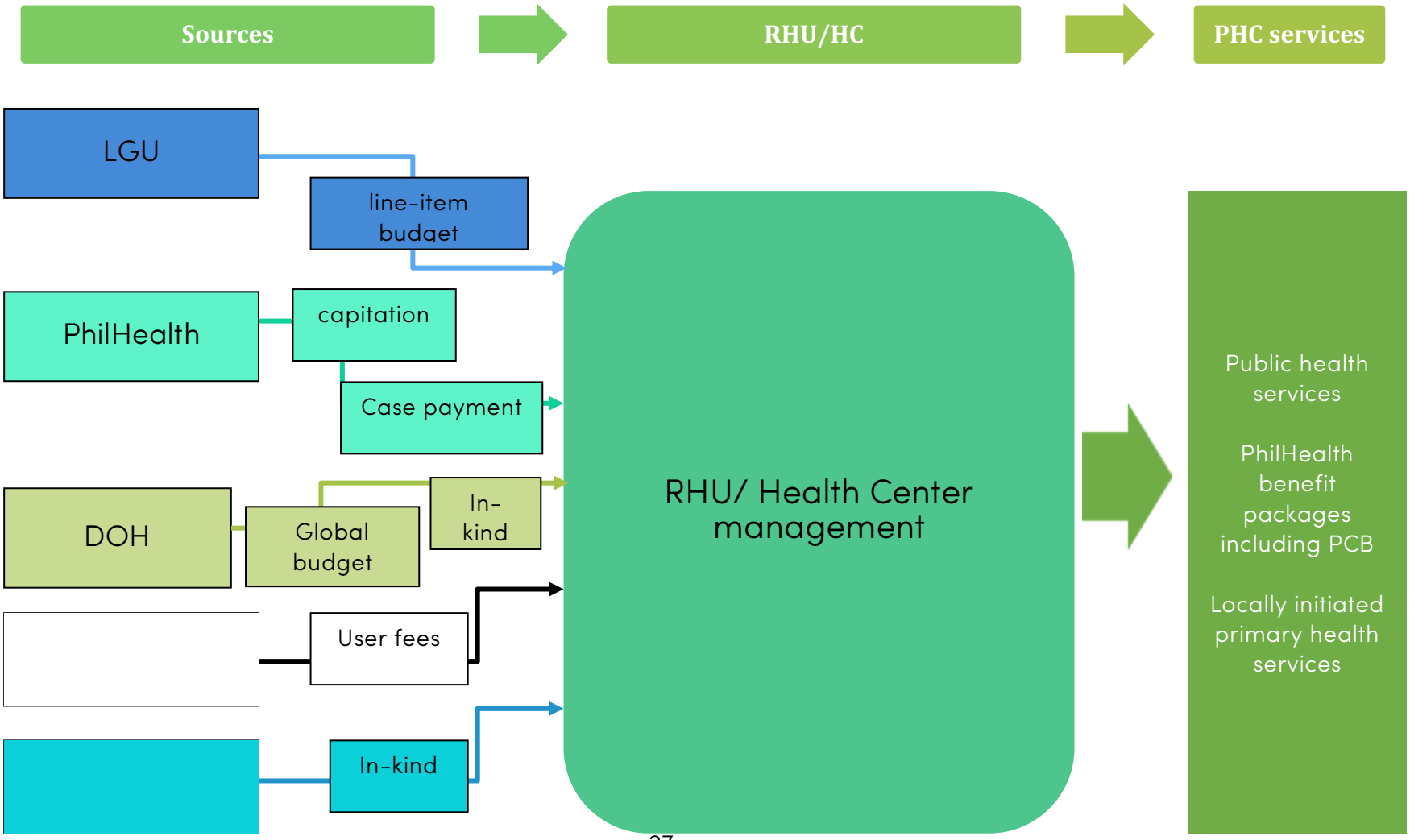
assess their health conditions, and follow up patients with chronic conditions.[39] Sixty percent of the PFP is computed based on the newly assigned members per month while the remaining 40% is based on performance targets (PhilHealth, 2019).

In addition, PhilHealth also covers disease/condition specific benefits like maternal and newborn care, family planning services, TB DOTs, animal bite, out-patient HIV, and in endemic areas, malaria treatment.

In 2019, of the PHP97.39 billion (US$ 1.95 billion) benefit payments of PhilHealth in 2019, 5 percent or PHP4.96 billion (US$ 99million) was payment for PCB. The corporation also paid an additional PHP 8.87 billion (US$ 177.4million) for maternal and new-born care, TB DOTS, outpatient HIV treatment and FP services ((PhilHealth, 2020). Annex E lists other related primary care benefits covered by PhilHealth.

[39] PCB providers have access to electronic database of PhilHealth members and they can identify who are eligible for EPCB. They need to submit the list of names that are registered in their facility for them to get paid for PCB.

Figure 6. *Fragmented financing of PHC in a devolved PHC provider*



3.4 Efficiency Reforms

Figure 5 and **Figure 6** show the fragmented financing of the entire health system, as well as the financing of one public primary care center. Fragmentation creates huge transactions costs as DOH has to negotiate with individual and autonomous LGUs to rationalize investments and service delivery, whose local chief executives may have contrary perspectives or priorities. Moreover, disconnected responsibilities along the three administrative layers (national, provincial and municipal/city governments) leads to poor accountability and considerable administrative workload. Meanwhile, incentives have not been used to rationalize the allocation of resources. LGUs have prerogative and power to make decisions about their health service delivery network even without coordinating with their neighboring LGUs or considering the overall national referral system; while the private sector is driven by market-based motives, setting up practice where people can pay for their services, mainly in urban areas. Moreover, supply-side allocations, largely through DOH and LGU budgets, do not provide the right incentives for performance, both in terms of quantity and quality. From the demand side, PhilHealth has not ensured adequate health care provision. Primary care facilities may not have the ability to retain income since they do not have their own accounting unit within the facility and the lack of fiscal autonomy may serve as disincentives since these facilities will not benefit from possible PhilHealth income (Panelo, Solon, Ramos, & Herrin, 2017; Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018).

Given these problems, the Healthcare Financing Strategy (HFS) for the Philippines 2010-2020 has identified efficiency as one of critical goals to pursue (DOH, 2010). On one hand, improving allocative efficiency was expected to be realized by delineating essential health services to be funded through budgetary commitment between DOH and LGUs and defining the PhilHealth benefit package that complements the public health package, thereby clearly identifying who pays for what expenditure. Based on the Philippines three expenditure categories, i.e., personnel services (PS), maintenance and operating expenses (MOOE), and capital outlays (CO), the vision set by HFS was that PhilHealth would fully cover all PS and MOOE for curative care and personal preventive services, LGUs would fully cover these costs for public health services (community-level preventive care), and the DOH and LGUs would continue to share responsibility for CO for DOH-retained and LGU-owned facilities, respectively. On the other hand, technical efficiency was envisioned to happen by reforming the provider payment system, providing or increasing the autonomy of retained hospitals, managing LGU health facilities as economic enterprises with the authority to retain income, and strengthening the functional local health system through accreditation.

Review of the HFS in 2018 showed that the expected improvement in allocative efficiency, by reducing duplication and overlap in "who pays for what", has not been achieved. The MOOE and PS budget responsibility has not shifted from the DOH and LGUs to PhilHealth. With substantial increase in its budget as brought about by STL implementation, DOH has continued to spend on devolved functions, particularly capital investment on primary care facilities through HFEP, deployment of primary care personnel to LGUs and procurement of medicines for LGUs. While the strategy to choose the appropriate purchaser would lead to allocative efficiency, there is an urgent need to define more clearly the package of services to be paid by the government (DOH and LGUs) and by PhilHealth (Bales, Bredenkamp, & Gomez, 2018). While the passage of UHC Act and the subsequent issuance

of DOH policy to delineate individual-based and population-based primary care service packages[40] to identify the appropriate purchaser for these services are in the right direction, these policies have yet to be implemented.

The HSF review on technical efficiency focused only on provider payment mechanisms used by PhilHealth and how these payment mechanisms are envisioned to incentivise better provider performance. HFS emphasized the shift from fee for service (FFS) to case mix system for inpatient and specialist care and capitation payments for primary outpatient care that would include outpatient medicines. For primary care benefit, the blended capitation payment, consisting of a fixed payment per family enrolled and additional payments for performance, is theoretically well grounded. It provides an important complement to the LGU health budgets, ensuring a basic income to RHUs based on PhilHealth members assigned to the health facility while also incentivizing the provision of critical elements of the of primary care services. However, the well-designed provider incentives in the capitation payment are diluted by the cumbersome arrangement whereby, instead of paying facilities directly, PhilHealth transfers the capitation payment into an LGU trust fund which then only disburses funds to facilities based on purchase orders for consumables while the professional fee portion of the capitation payment is almost directly to health workers, thus maintaining a good share of the intended incentive effect. Moreover, effective Inclusion of outpatient drugs into the primary care has PCB package has yet to be established. The current PCB has limited outpatient drug package while LGU procurement and continuing supply from DOH through vertical programs remains as default system.

How integration of PHC services may change the sources of revenue

The fragmentation of health service delivery and financing due to devolution has plagued the Philippine health system for almost three decades. Through several efforts, the DOH tried testing various service delivery arrangements to address the disintegration of the local health system, from the Interlocal Health Zone during the Health Sector Reform Agenda in early 2000s to Service Delivery Network (SDN) in 2016 to Health Care Provider Network as provided by the UHC Act. However, the review of SDN experience in the Philippines showed no clear picture on how SDNs are financed, with most managers either unaware of financing mechanism or acknowledge the lack of one ((La Forgia G. M., 2020). While the UHC Act establishes the legal basis for pooling of funds into Special Health Funds at the provincial and city levels, financial capacity to develop an SDN wide business plan is still lacking. Moreover, strict rules on auditing and accounting of public funds may deter the participation of the private sector.

[40] DOH AO No. 2020-0040. Guidelines on the Classification of Individual-based and Population-based Primary Care Service Packages

4. Purchasing PHC services

4.1 How PHC services are funded

While the PNHA does not directly report spending on primary health care, it may be estimated from the currently health spending by providers of ambulatory health care and preventive care. Taken together, these constitute PHP 92.8 billion or 11.7% of CHE in 2019. Table 6 shows the corresponding proportion of PHC spending by financing agent. Households are the largest purchaser of PHC, spending PHP 44.4 billion (USD 889 million) in 2019. Of the pooled purchasers, PhilHealth and other social security agencies spends the highest at PHP 17.5 billion (US$ 350 million). This is followed by the national government (PHP 13 billion), about 80 percent of which is DOH, and corporations (PHP 8 billion). Despite the devolution and putting LGUs at the forefront to health service delivery, the estimated LGU spending for PHC is only about PHP 7.7 billion (US$155 million).

Table 6. Current Health Expenditure by Financing Agent in million PHP (million US$), 2019

Financing Agent	CHE[41]	% of CHE	Est PHC expenditure
Central government[1]	**111,247 (2,225)**	**14.04**	**13,021 (260)**
Department of Health	87,465 (1,749)		
Other ministries and public units	23,783(470)		
Local government[2]	**66,342 (1,327)**	**8.37**	**7,765 (155)**
Social security agency	**149,362 (2,987)**	**18.85**	**17,482 (350)**
Social Health Insurance Agency (PhilHealth)	149,330 (2,987)		
Other social security agency (GSIS, SSS)	33 (1)		
Insurance corporations	**17,219 (344)**	**2.17**	**2,015 (40)**
Commercial insurance companies	17,219 (344)		
Corporations (Other than insurance corporations)	**68,653 (1,373)**	**8.66**	**8,036 (161)**
Health management and provider corporations	54,400 (1.088)		
Corporations (Other than providers of health serv)	14,254 (285)		
Households	**379,731 (7,595)**	**47.91**	**44,446 (889)**
Total	**792,554 (15,851)**		

Source, PNHA, 2014-2019,

Notes:

[1]Central government refers to national agencies like DOH and other agencies with own health services like the Department of National Defence

[2] The international label of state/regional/local government is simplified as local government.

[41] PNHA. 2019. Table 7 Current Health Expenditure by Financing Agent 2014-2019

4.2 Provider payment mechanisms

PHC is paid through various mechanisms (**Figure 6**). DOH and LGU pays through line-item budget. Philhealth pays capitation (or Per Family Payment) for primary care benefit and case rates for other related services like Maternity Care Package (MCP), which includes prenatal, delivery and post-partum care, new-born care and new-born screening for metabolic disorders, Directly Observed TB treatment (TB DOTS), family planning services, and immunization for the elderly, among others. Households pay through fee for service.

Generally, the households are the most important purchasers of health services by spending out-of-pocket (**Table 6**) when they avail of primary care services provided by both public and private providers. In 2019, OOP spending accounted for 47.9 percent of current health expenditure. While OOP has declined from 52.4 percent in 2014 to 47.0 percent in 2019, it still undermines the financial risk protection goal of the health sector. When at catastrophic levels, OOP also pushes 1.5 million Filipino families into poverty every year (Bredenkamp & Buisman, 2015). The main driver for OOP spending is outpatient medicines, which may be due to several factors: health facilities, especially public ones, are not providing complete care and patients are asked to buy medicines outside the hospital/clinic; weak regulation on prices of medicines; PhilHealth does not cover out-patient medicines; and patients self-medicate and forego seeing a doctor.

Also, most of these benefit packages are under the No Balance Billing (NBB) policy, i.e., no other fees or expenses should be charged to or paid for by the patient-member above and beyond package rate, whether provided by public or private health facility. However, uneven application of NBB policy vis-à-vis unregulated charges, fees and prices of medicine in health facilities contribute to higher OOP for health.

Annex F shows the benefits that must be provided under No Balance Billing.

Regulation of PHC providers

It is also worth mentioning that public and private primary care providers must get a license from DOH, secure accreditation from PhilHealth and obtain business permit from their LGU before they start operating their facility. These processes could limit or delay the entry of new PHC providers in the local health system. For instance, one LGU only requires both DOH license and PhilHealth accreditation as requirements before the issuance of business permit.

Degree of autonomy of LGUs that would impact on purchasing PHC

As mandated by LGC, city and municipal governments have autonomous powers to raise, pool and allocate resources. As described previously, LGUs have internal and external means to raise revenues for health; even more so with the implementation of Mandanas Doctrine (Manasan, Fiscal sustainability, equity, and allocative efficiency in the light of the 2019 Supreme Court ruling on the LGUs' share in national taxes, 2020). While DOH and DILG recommends 25-30 percent of LGU budget to be allocated for health (Dayrit, Lagrada, Picazo , Pons , & Villaverde, 2018), the LGUs make the ultimate decision on allocating its resources.

Moreover, the limited operational and financial autonomy of public PHC providers could prevent them from fully responding to the incentives inherent in the different payment modalities of PhilHealth since health centres and RHU do not have their own accounting unit to manage income. But the LGU has the power to establish the financial autonomy of public health facilities either by creating a trust fund to ring-fence PhilHealth payments or establishing an economic enterprise for health. The LGC and the UHC Act also allow LGUs to enter into agreement with other LGUs to establish SDNs with its own management and financial system.

4.3 Incentives targeted at PHC providers

Financial incentives in PHC provision for both public and private is mainly through PhilHealth payments. In some instances, LGUs receive performance grants from DOH for achieving a national target. For example, DOH awards PHP 1M (US$20,000) for eliminating a neglected disease in the whole province (e.g., Filariasis-free province).

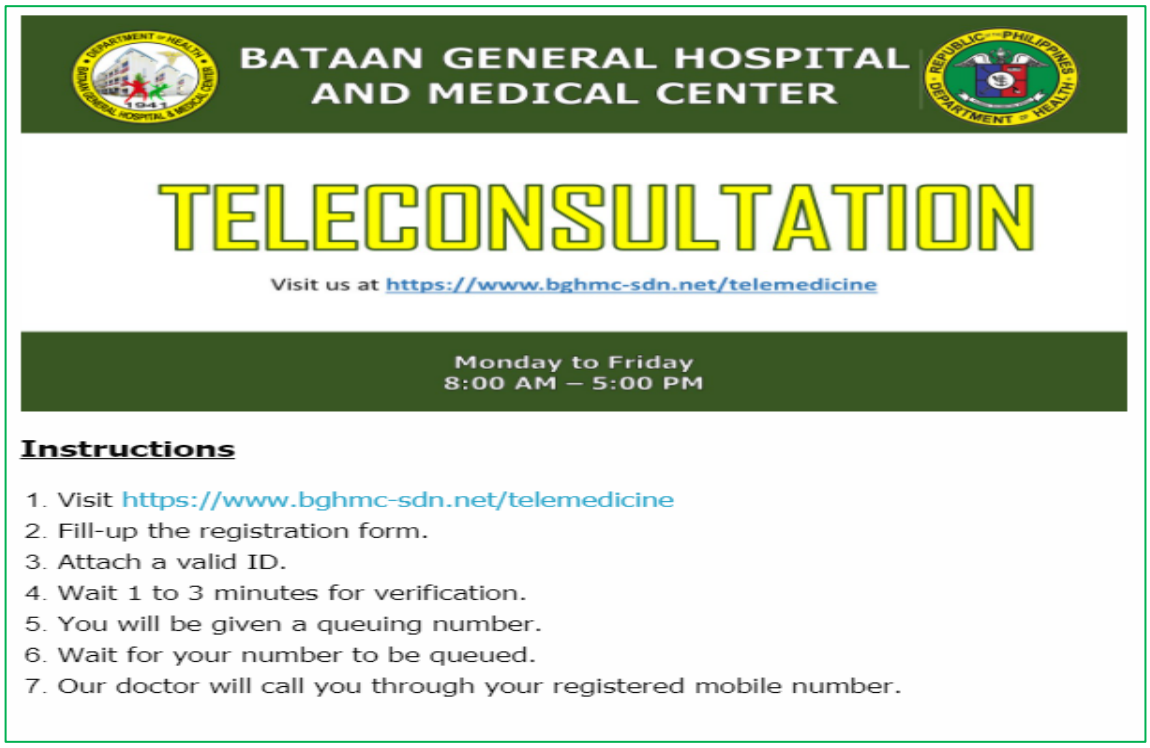
DOH also measures LGU performance using the LGU Scorecard, for which DOH gives the LGU award for exemplary performance. PhilHealth, on the other hand, adopts the Benchbook for Non-hospitals, to recognize primary care facilities as Centres of Excellence (PhilHealth Circular 2017-0002).

5. Digital technologies and health financing

While PhilHealth requires digital technology for receiving and processing claims and EMR in ensuring PCB benefits are rendered, the implementation of these applications is still in its infancy. The country's digital implementation is lagging behind its neighboring countries due to internet connectivity issues, especially in geographically isolated LGUs, electricity interruptions in remote areas, fragmented IT system of PhilHealth having different IT systems for membership, providers, claims processing, etc.

However, these barriers have not prevented a government hospital in transforming its delivering health services to its catchment population. Bataan General Hospital and Medical Center (BGHMC) introduced an innovative online referral system that electronically links RHUs and health centers to BGHMC (**Figure 7**), offering a fast lane to health facilities. The average total response time to patients is 4 minutes and 20 seconds. It has a triaging ability built at the primary care level. BGHMC has started developing its patient database, which allows it to designate families to specific health facilities and set up an electronic referral system. All transactions – from primary care facilities to BGHMC and back are reflected online in real time, facilitating swift treatment and management of cases. BGHMC provided computers to certain municipalities with internet access to encourage their participation in the electronic referral system. An offline version of the referral system is also available for facilities without internet connection.

Figure 7. Instructions on how to avail teleconsultation at BGHMC



The UHC Act mandates that all health service providers must maintain a health information system on enterprise resource planning, human resources, electronic health records, and electronic prescription log, including electronic health commodities and logistics management information. One of the criteria of PhilHealth in contracting the HCPN is its capacity to manage patient records digitally.

6. Conclusion

The Philippines has several enabling laws and policies that should promote patient-centred and affordable primary health care, from the LGC that brings health services closer to the people, to having PhilHealth that could make PHC affordable, whether provided by private or public health facilities, and the UHC Act to ensure that every Filipino has a primary care provider. Several laws also increased resources for health, not only at the national level but also at the level of LGUs through the implementation of Mandanas Doctrine.

The devolution fragmented the financing and delivery of primary care services. While the LGUs are primarily responsible for primary care services, DOH and Philhealth must ensure that services are provided according to guidelines and quality standards. Without a national resource allocation authority, DOH, LGUs, PhilHealth and the households are paying for PHC inefficiently. Unclear responsibility over PHC financing among the pooled purchasers (DOH, LGU and PhilHealth) results to inefficiencies. This is exacerbated by a lack of financial autonomy of government health facilities, which render the provider payment mechanism ineffective as an incentive in providing quality care. Finally, while there are efforts to use digital technology in providing care remotely, PhilHealth has not used it to ensure PhilHealth members enjoy financial protection when using primary health care.

The Universal Health Care Act aims to address the fragmented financing for PHC by consolidating the different funding sources through a Social Health Fund (SHF) that will be managed by the Provincial Health Board; but the prototyping of this new financing arrangement among LGUs is expected to last a decade.

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Annexes

Annex A. Health Mandates of LGUs according to Local Government Code of 1991

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Annex A. Health Mandates of LGUs according to Local Government Code of 1991

SECTION	RESPONSIBILITY	PROVISION
Section 17.a	Provision of basic services and facilities	Local government units shall endeavor to be self-reliant and shall continue exercising the powers and discharging the duties and functions currently vested upon them. They shall also discharge the functions and responsibilities of national agencies and offices devolved to them pursuant to this Code. Local government units shall likewise exercise such other powers and discharge such other functions and responsibilities as are necessary, appropriate, or incidental to **efficient and effective provisions of the basic services and facilities** enumerated herein.
Section 17.b.1.ii	Provision of health services and facilities, barangay	Health and social welfare services which include maintenance of barangay health center and day-care center.
Section 17.b.2.iii	Provision of health services and facilities, municipality	Health services which include the implementation of programs and projects on primary health care, maternal and childcare, and communicable and non-communicable disease control services, access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the enumerated
Section 17.b.2.viii	Establishment of health infrastructure	Infrastructure facilities intended primarily to service the needs of the residents of the municipality and which are funded out of municipal funds including but not limited to… clinics, health centers and other health facilities necessary to carry out health services.
Section 17.b.3.iv	Provision of health services and facilities, province	Health services which include hospitals and other tertiary health services
Section 102.a &b	Establishment of a local health board	There shall be established a local health board in every province, city, or municipality. The following are the functions of the **Local Health Board** shall be: (1) To propose to the Sanggunian concerned, in accordance with standards and criteria set by the Department of Health, annual budgetary allocations for the operation and maintenance of health facilities and services within the municipality, city or province, as the case may be; (2) To serve as an advisory committee to the Sanggunian concerned on health matters such as, but not limited to, the necessity for, and application of local appropriations

		for public health purposes; and (3) Consistent with the technical and administrative standards of the Department of Health, create committees which shall advise local health agencies on matters such as, but not limited to, personnel selection and promotion, bids and awards, grievance and complaints, personnel discipline, budget review, operations review and similar functions.

Annex B. Inter-LGU Arrangements Promoted by DOH to Address the Fragmented Health System

Name	Description	Legal Basis
Inter-Local Health Zone (ILHZ)	The Inter-Local Health Zone (ILHZ) is DOH endorsed unit for local health service management and delivery, based on the concept of the District Health System. An ILHZ is a cluster of municipalities with a defined population within a defined geographical area and comprises a central (or "core") referral hospital (usually district hospital owned by the provincial government) and a number of primary level facilities such as Rural Health Units and Barangay Health Stations. In addition to government health services, ILHZs are inclusive of all other stakeholders and sectors involved in the delivery of health services or the promotion of health, including community-based NGOs and the private sector (local and foreign) Source: Department of Health (2002) A Handbook on Inter-Local Health Zones. District Health System in a Devolved Setting.	Health Sector Reform Agenda 1999
Service Delivery Network (SDN)	Health service delivery structure composed of a network of health service providers at different levels of care. SDN can be as small as an Inter-Local Health Zone (ILHZ) or as large as a regional SDN with the regional hospital serving as the end referral hospital.	DOH Administrative Order 2010-0036. The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos
	SDN refers to the network of health facilities and providers within the province or citywide health systems, offering a core package of health care services in an integrated and coordinated manner similar to the local health referral system.	DOH Administrative Order 2014-0046. Defining the Service Delivery Networks (SDNs) For Universal Health Care or *Kalusugan Pangkahalatan*
Health Care Provider Networks (HCPN)	Refers to a group of primary to tertiary care providers, whether public or private, offering people-centered and comprehensive care in an integrated and coordinated manner with the primary care provider acting as the navigator and coordinator of health care within the network.	Implementing Rules and Regulations of the Universal Health Care Act (Republic Act 11223)

Annex C Major health laws and policies that impact on Primary Health Care, 1979-2019

Year	Legal Basis	Primary Health Care Specific Provisions
1979	AO	Adoption of PHC as an Approach
1991	Local Government Code	PHC services are devolved to city and municipal government units. Please see Annex A for details.
1995	Republic Act No. 7875 National Health Insurance Act	The act aims to create the National Health Insurance Program (HNIP) to provide all Filipinos with the mechanism to gain financial access to health services. Particular provisions include: ● Government health care providers shall ensure that indigents shall subsequently be enrolled in the program (Section 7 (d)) ● Formulation and implementation of financial mechanisms including healthcare provider arrangements, payment methods, and referral systems are within the powers and functions of the Philippine Health Corporation (PHIC) (Section 16 (d)) ● Negotiation and entering into contracts with any accredited government or private health provider organization through authorized Local Health Insurance Offices (Section 16 (k)). ● Requirements and guidelines (Section 16 (l)) and supervision of health benefits provisions to health care providers (Section 16 (m)). ● The PHIC was also granted powers on the suspension, revoke, or restoration of health care provider accreditation (Section 17 (c)). ● The PHIC board of directors includes a representative of health care providers (Section 18 (a)) ● Article VIII of the Act directs its provision to the Health care Providers where sections 30-38 grants the free choice of health facility, eligibility & minimum requirements of accreditation, provider payment mechanisms, capitation, quality assurance, and safeguards for utilization.
1999	Health Sector Reform Agenda	The Health Sector Reform Agenda or HSRA is the blueprint on how health care is to be delivered, regulated, and financed. It has five (5) major areas of reform, such as: public health, hospital system, local health, health regulation, and health financing. Particular to PHC, below are the reform strategy in each area: ***Public Health Programs Reform Strategy*** ● Increase investments in public health programs ● Upgrading of the physical and management infrastructure at all levels of the health care delivery system ● Development and strengthening of technical expertise in public health practice ***Local Health System Reform Strategy*** ● Development and advocacy for local health systems

Year	Legal Basis	Primary Health Care Specific Provisions
		● Capacity building of health human resources in synchronization with the development of hospital systems and public health programs ● Strengthening of inter-LGU linkages, cost sharing schemes, and local financing for health in a devolve set-up ● Expansion of opportunities for participation of the private sector, NGOs, and communities in local health systems ● Development of mechanisms to sustain local health system ***Health Regulation Reform Strategy*** ● Identify and address the gaps in health regulation, particularly, strengthen the legal mandates for regulation and enforcement. ● Strengthen the capabilities of central office and regional health offices in standards development, licensing and enforcement. ● Develop new regulatory instruments to promote competition, cost containment, better accessibility and quality assurance in health care markets.
2005	FOURmula One (F1) for Health	The FOURmula One (F1) for Health was initiated to serve as the implementation framework for the medium term (2005-2010). It is a sector wide approach to address the fragmentation of the health system in the country through securing increased, better, and sustained financing for health; affordability and quality of goods and services; access and availability of essential and basic health packages; and health system performance improvement. The implementation covers four components which are: Financing, Regulation, Service Delivery, and Governance. Particular to PHC, below are the reform strategy of such component: ***Health Regulation*** Objective: to assure access to quality and affordable health products, devices, facilities and services, especially those commonly used by the poor. ● Harmonizing licensing, accreditation, and certification ● Developing quality seals ● Pursuing cost recovery with income retention ● Assuring the availability of low-priced quality essential medicines commonly used by the poor ***Health Service Delivery*** Objective: to improve the accessibility and availability of basic and essential health care for all, particularly the poor, which shall cover all public and private facilities and services. ● Ensuring availability of basic and essential health service packages in all localities ● Making available specific and specialized health services in strategic locations

Year	Legal Basis	Primary Health Care Specific Provisions
		● Intensifying current efforts to reduce public health threats ***Good Governance in Health*** Objective: to improve health systems performance at the national and local levels ● Establishing FOUR-IN-ONE advanced implementation sites ● Developing an LGU FOURmula ONE for Health Scorecard ● Institutionalizing a FOURmula ONE for Health Professional Development and Career Track
2008	Republic Act No. 9502 Universally Accessible Cheaper and Quality Medicines Act	The act allows the government to adopt appropriate measures to promote and ensure access to affordable quality drugs and medicines for all. ● Drugs and medicines price regulation are primarily with authority of the President of the Philippines (Section 17) and the Secretary of the Department of Health (Section 18) ● Conforming to the conditions of the Act, every manufacturer, importer, distributor, wholesaler, trader or retailer of a drug and medicine intended for sale shal display the retail price which shall not exceed the maximum retail price approved by the President of the Philippines (Section 26*)* ● The Local Government Units along with the Department of Trade and Industry shall help in ensuring the price implementation by submitting quarterly price monitoring reports to the Secretary of the Department of Health (Section 27) ● Refusal to carry either by sale or by consignment, or offer for sale drugs and medicines brought into the country are deemed unlawful for any retail drug outlet (Section 33*).* The same is also true for the refusal to sell any drug or medicine without good and sufficient reasons (Section 34*)* to manufacturer, importer, trader, distributor, wholesaler. ● Every drug manufacturing company operating in the Philippines are required to make available an unbranded generic counterpart of their branded product (Section 39)
2010	Health Financing Strategy 2010–2020	Supports the overall sector goals of improving financial protection, achieving efficiency gains and ensuring access to quality care through five pillars: creating more fiscal space for health (pillar 1), sustaining membership in PhilHealth-pooling (pillar 2), who pays for what (pillar 3), provider payments (pillar 4), and fiscal autonomy of health facilities (pillar 5).
2010	DOH Administrative Order No. 2010–0036 Aquino Health Agenda for Universal Health Care	This order provides the guidelines, approaches, and resources needed to affect and influence public-private partnership, and benefit families, civil society, private and public health care providers, and local government units in the local health system. Specifically, this policy reform aims to (i) strengthen the National Health Insurance Program (NHIP) as the prime mover in improving financial risk protection; (ii) generate resources to modernize and sustain public health facilities; and (iii) improve the provision of public health services to achieve the Millennium Development Goals (MDGs).

Year	Legal Basis	Primary Health Care Specific Provisions
		Delineating the roles, at the health service delivery level (LGU), they are encouraged and assisted to: ● Develop policies and plans aligned with the Aquino Health Agenda (AHA) ● Mobilize and utilize resources (i.e., Internal Revenue Allotment, PHIC reimbursements, user-feeds, capitation, and other resources) ● Allow hospitals and public health facilities appropriate incentives ● Organize community health teams and service delivery networks in partnership with the private sector In support of the above, the DOH is mandated to facilitate the implementation of the AHA by influencing the LGUs to govern local health systems.
2011	Republic Act No. 10152 Mandatory Infants and Children's Health Immunization Act of 2011	The act mandates free mandatory basic immunization at any government hospital or health center to infants and children up to five years old. ● Declares that the government shall take a proactive role in the preventive health care of infants and children for the following vaccine-preventable diseases: (i) tuberculosis; (ii) diphtheria, tetanus and pertussis; (iii) poliomyelitis; (iv) measles; (v) mumps; (vi) German measles; (vii) hepatitis-B; (viii) H. influenzae type B (HiB) (Section 3). ● All infants shall be given the birth dose of the hepatitis-B vaccine within 24 hours of birth (Section 3). ● Health education and promotion campaign is emphasized in this act to educate pregnant women (Section 4) and promote an informed obligation to the availability, nature, and benefits of immunization (Section 5) ● Led by the DOH with the assistance of LGUs, academe, societies and organization, continuing education and training of health personnel is also required (Section 6).
2012	Republic Act No. 10351 Sin Tax Reform Act of 2012	The act aims to (i) raise revenues for health and (ii) discourage the consumption of the tobacco products and alcoholic beverages by imposing higher excise taxes on "sin" products.
2012	Republic Act No. 10354 Responsible Parenthood and Reproductive Health Act	The act guarantees universal and free access to nearly all modern contraceptives for all Filipinos, including impoverished communities, at government health centres. The law mandates reproductive health education in government schools and recognizes a woman's right to post-abortion care as part of the right to reproductive health care. ● Provided the provisions of the act, the LGUs will endeavour to hire adequate health professionals for maternal health care and skilled birth attendance (Section 5) ● The LGUs, provided the necessary data and conditions set in this act, shall establish or upgrade hospitals and facilities with adequate and qualified personnel, equipment, and supplies (Section 6) ● The act mandates the DOH to coordinate with all appropriate local government bodies to plan and implement the procurement and distribution of family planning supplies (Section 10) ● The law also highlights innovation through the provision of mobile health care service (Section 13), reproductive

Year	Legal Basis	Primary Health Care Specific Provisions
		health education (section 14) and promotion/public awareness (Section 20), and sexual and reproductive health programs for Person with Disabilities (Section 18) and integration of responsible parenthood and family planning component in anti poverty programs (Section 11). ● The law is also reinforced by Executive Order No. 12 s. 2017, Attaining and Sustaining Zero Unmet Need for Modern Family Planning through the Strict Implementation of the Responsible Parenthood and Reproductive Health Act, Providing Funds Therefore and for Other Purposes.
2013	The National Health Insurance Act of 2013 [Republic Act No. 7875 as Amended by Republic Act No. 9241 and Republic Act No. 10606]	Salient amendments include: (i) provision of full National Government subsidy to enrol poor families identified by the DSWD's National Household Targeting System – Poverty Reduction (NHTS- PR) and coverage for pregnant women; (ii) simplified membership requirements; (iii) simplified availment rules and increased financial protection for the poor through no-balance billing; (iv) streamlined accreditation process, and (v) better administration of the National Health Insurance Program.
2014	Republic Act No. 7432, as Amended by Republic Act No. 9994 and Republic Act No. 10645, an act Providing for The Mandatory PhilHealth Coverage for All Senior Citizens	Seeks to provide all Filipinos with the mechanism to gain financial access to health services, giving priority to those who cannot afford such services.
2016	Administrative Order No. 2016–0038 The Philippine Health Agenda 2016-2022	Building on previous reforms, the Philippine Health Agenda (PHA) aims to (i) ensure the best health outcomes for all, without any form of inequity; (ii) promote health and deliver health care through means that respect, value, and empower clients and patients as they interact with the health system; and (iii) protect all families especially the poor, marginalized, and vulnerable against the high costs of healthcare. ● The PHA guarantees that health services are (i) available for both the well and the sick at all life stages and responsive to the triple burden of disease; (ii) delivered by a functional network of health facilities; and (iii) financed predominantly by PhilHealth. ● To achieve these guarantees, the strategy to be implemented is the "ACHIEVE" meaning, **A**dvance quality, health promotion, and primary care; **C**over all Filipinos against health-related financial risk; **H**arness the power of strategic human resources for health development; **I**nvest in eHealth and data for decision-making; **E**nforce standards, accountability, and transparency; **V**alue all clients and patients, especially the poor, marginalized, and vulnerable; and **E**licit multi sectoral and multi stakeholder support for health.

Year	Legal Basis	Primary Health Care Specific Provisions
		● Following the health system structure of the Philippines, it is still the responsibility of the LGUs to develop policies and plans in support of PHA, mobilize and utilize resources, and partner with the private sektor to ensure adequate health investments and service delivery.
2018	Administrative Order No. 2018-0014 FOURmula One (F1) Plus for Health	With the revitalization of the F1 Plus Strategy, the four components (a.k.a. Pillars) of health reform was expanded and highlights greater focus on performance accountability towards the Filipino people. Particular to PHC, below are key reform strategy of the revitalized components: *Financing* Objective: secure sustainable investments to improve health outcomes and ensure efficient and equitable use of health resources. ● Fiscal autonomy and income retention for government-owned health facilities ● Delineation of health interventions, where population-based interventions is financed through line item budgetary sources (national and local), while personal insurable health interventions will be with NHIP ● Fixed co-payments for selected health packages *Service Delivery* Objective: ensure the accessibility of essential quality health products and services at appropriate levels of care. ● Made available of a comprehensive essential health service package for all life stages ● Revitalized Botika ng Bayan Program ● Upgrading of existing and construction of new health facilities ● Ensure equitable distribution of HRH ● Engage SDNs to deliver comprehensive health service package both private and public *Regulation* Objective: ensure high quality and affordable health products, devices, facilities, and services. ● Harmonization and streamlining of regulatory systems and processes (i.e., One-stop-shop licensing, interagency data sharing, and systems automation among others) ● Innovation in the development of regulator mechanisms for equitable distribution of quality and affordable health goods and services.
2019	National Objectives for Health	The medium-term roadmap that indicates the specific objectives, strategies and targets of the Philippines towards achieving

Year	Legal Basis	Primary Health Care Specific Provisions
	2017-2022	UHC. It was built along the DOH sectoral strategy which is the FOURmula One Plus for Health.
2019	Universal Health Care Act [Republic Act No. 11223] and its Implementing Rules and Regulations	The act serves as the legal backbone to address the country's perennial problems of a disjointed health system, high out-of-pocket expenditures, and mixed health outcomes. Particular to PHC, below are the provisions mandated: ● Automatic coverage of all Filipinos with NHIP (Section 5) ● Every Filipino shall afford (Section 6 (c)) and register (Section 6 (d)) a primary care provider of their choice. ● Population-based health services of province-wide and city-wide health system shall have the following minimum requirements: primary care provider network with patient record accessible through the system; epidemiologic surveillance systems; and health promotion programs or campaigns (Section 17). ● PhilHealth shall endeavour the contracting of public, private, or mixed health care provider networks for the delivery of individual-based services (Section 18), and pay for comprehensive primary care (Section 18 (b)). ● Integration of health systems into province-wide and city-wide health system (Section 19) ● Production of health workers with competencies in the provision of primary care services (Section 25 (d)) ● Institutionalization of licensing and regulatory system for stand-alone health facilities, including those providing ambulatory and primary care services, and other modes of health service provision (Section 27) ● Readily accessible and up-to-date information regarding the prices of health services, and all goods and services being offered is required from Health care providers and facilities (Section 28 (c)) ● All health service providers and insurers shall each maintain a health information system (Section 36)

Annex D. Comparing Philippine Health Spending with other Countries in Asia

The annual growth rates of total health spending as percentage of GDP in the Philippines have been fluctuating since 2000 (**Table 7**). Looking at data from more recent years, however, annual growth rates have been declining since 2014/15, even recording a contraction of 1.75% in 2017/2018. Fluctuations in annual growth rates in total expenditure on health as percentage of GDP are also noted in the whole Western Pacific Region. Since 2006/07, average annual growth rates in the region have not exceeded 5%, even recording some contractions in succeeding years.

Table 7. Annual growth rate of total expenditure on health as % of GDP, 2000 to 2018

Country	2000-2001	2002-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Philippines	-6.59	-7.03	16.56	-0.80	23.01	0.97	-0.29	2.72	8.97	-0.83	-1.92	3.98	2.26	-7.34	5.27	2.85	1.99	-1.75
Cambodia	17.79	-5.56	-4.60	-0.36	-9.97	-11.43	-11.22	23.24	13.36	-9.01	-3.09	-3.98	-2.92	-7.04	-6.09	-2.12	-2.41	9.63
Lao PDR							7.28	-9.68	37.51	-28.94	-34.59	5.81	11.51	-1.84	7.81	-7.44	11.96	-2.82
Malaysia	8.56	-1.64	15.47	-6.49	-9.01	10.54	-1.18	-1.96	12.57	0.08	-1.94	3.33	0.08	4.31	2.89	-3.35	0.30	1.46
Singapore						-2.17	-2.42	14.29	8.85	-8.20	-1.91	6.24	10.92	7.37	8.55	5.66	-0.81	
Viet Nam	21.52	-19.88	1.66	-3.01	7.05	5.01	-0.05	-3.04	8.59	5.73	-2.44	5.62	0.58	-7.19	-2.19	-3.06	6.55	
WPR Average	15.09	-15.26	0.15	4.88	0.93	53.57	-26.40	-2.38	3.74	-5.65	-3.70	-4.01	2.53	-0.05	0.70	4.76	-6.76	0.40

Source: World Health Organization – Global Health Expenditure Databas

In the Western Pacific Region, the average growth rate of total health spending as a portion of GDP from 2015-2018 contracted to 0.54% (**Table 8**). With the exception of Malaysia, most Southeast Asian countries recorded positive average annual growth rate from 2015 to 2018, outperforming the regional average. The Philippines, in particular, performed better than the regional average in this period, but lagged behind some of its neighbors like Cambodia, Viet Nam, and Singapore.

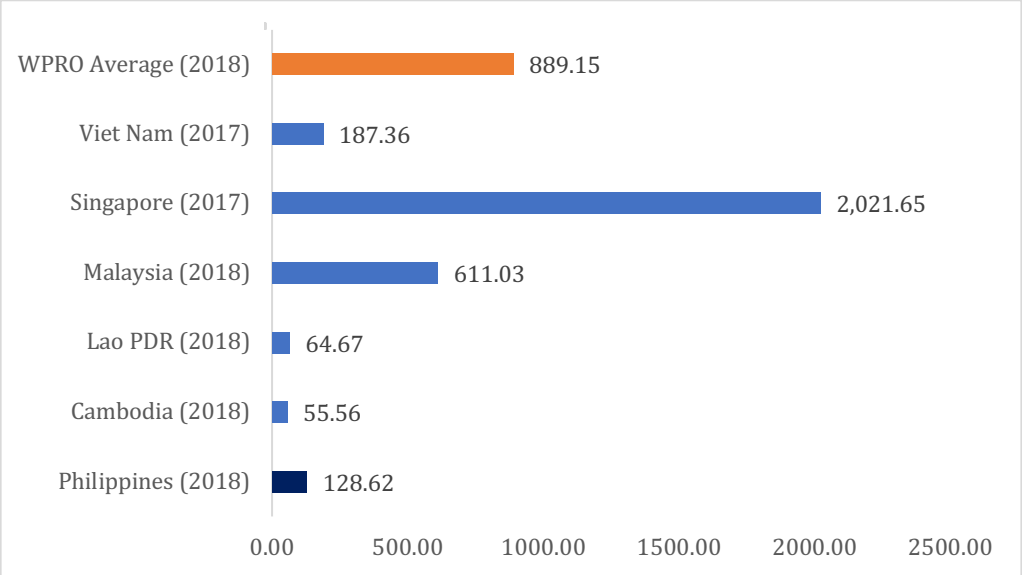
Table 8. Annual growth rate of THE as % of GDP, 2000 to latest year available

Country	Ave. Growth Rate 2000-2005	Ave. Growth Rate 2005-2010	Ave. Growth Rate 2010-2015	Ave. Growth Rate 2015-2018
Philippines	5.03	2.31	0.45	1.03
Cambodia	-0.54	0.99	-4.62	1.70
Lao PDR		1.54	-2.26	0.57
Malaysia	1.38	4.01	1.73	-0.53
Singapore		2.07	6.23	2.43
Viet Nam	1.47	3.25	-1.12	1.74
WPR Average	1.16	4.58	-0.91	-0.54

Source: World Health Organization – Global Health Expenditure Database

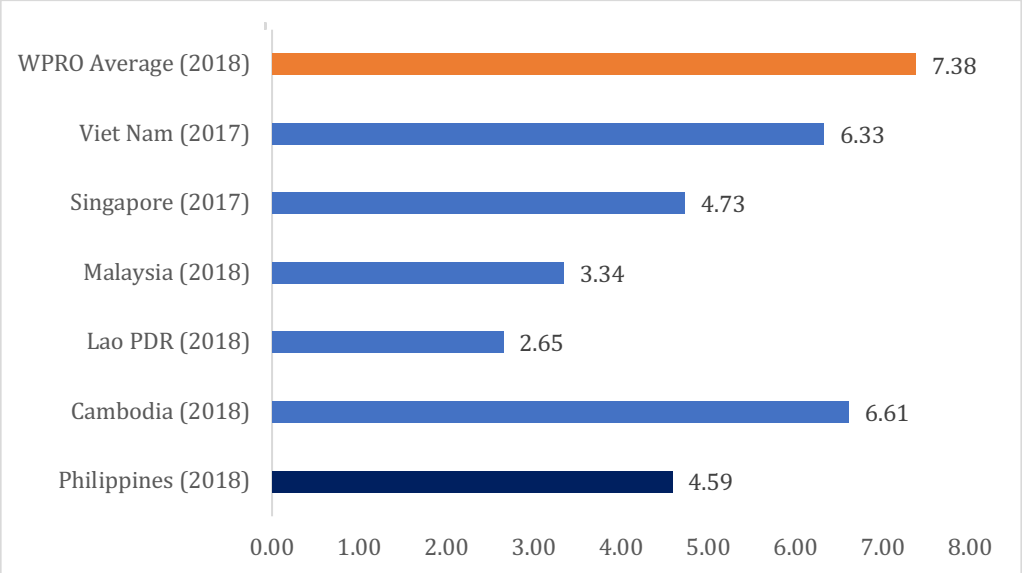
The per capita health expenditure, however, tells a different story. Lower middle-income countries recorded a much lower per capita health expenditure compared to the regional average, with Viet Nam and the Philippines faring slightly higher than Lao PDR and Cambodia (Figure 8). Singapore's per capita health expenditure is more than double of the regional average while Malaysia approaches the regional average with its $611.03 per capita health spending.

Figure 8. Health expenditure in PPP International $ per capita, latest available year



Source: World Health Organization – Global Health Expenditure Database

Figure 9. Health expenditure as a share (%) of GDP, latest available year

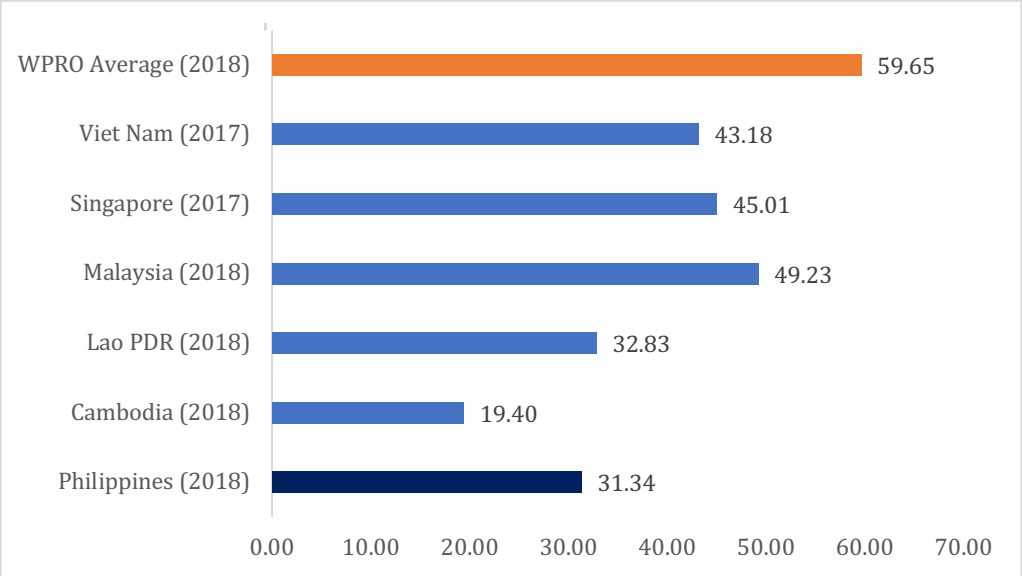


Source: World Health Organization – Global Health Expenditure Database

The Western Pacific Region average shows that government accounts for almost 60% of the total health spending in many economies. Many Southeast Asian countries, however,

fall below this regional average. Public health spending in Malaysia, Singapore, and Viet Nam account for almost half of their government health expenditure. Lao PDR and the Philippines have almost a third of their health spending financed by government (Figure 10).

Figure 10. Public sector health expenditure as a share (%) of THE, latest available year



Source: World Health Organization – Global Health Expenditure Database

Annex E. Primary care and other related benefits covered by Philhealth

Benefit	How much per case
Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease	Php 12,000 ($240) per patient in a given fiscal year.
Expansion of the Primary Care Benefit to Cover Formal Economy, Lifetime Members and Senior Citizens (Revision 1)	An average of Php 800 ($16) per family per year
Enhancement of PhilHealth Newborn Care Package	Php 2,950 ($ 59) per case
Medical Detoxification Package	Php 10,000 ($ 200) per case
"PD First" Z Benefits: The Z Benefits for End-Stage Renal Disease Requiring Peritoneal Dialysis (Revision 1)	Php 270,000 ($ 5,400) per year
PhilHealth Subdermal Contraceptive Implant Package	Php 3,000 ($ 60) per case
New PhilHealth Dialysis Package (Revision 1)	Case Rate: Php 2,600 ($ 52) (inclusive of HCI and Professional Fee)
Outpatient HIV/AIDS Treatment (OHAT) Package *(PhilHealth CIrcular 19, s.2010) Revision 1*	Php 7,500 ($150) per quarterly release payable to the HCI.
Revised Guidelines for the PhilHealth Outpatient Anti-Tuberculosis Directly Observed Treatment Short-Course (DOTS) Benefit Package	Php 4,000 ($ 80) per case

Source: various PhilHealth circulars

Annex F. PHC Benefits covered with No Balance Billing Policy

Type of *HCI*	Gov't	Private	Benefits Covered by NBB
1. Outpatient Malaria Providers	✓	×	Outpatient Malaria Package
2. Animal Bite Treatment Centers	✓	×	Animal Bite Treatment Package
3. Treatment Hubs	✓	×	Outpatient HIV-AIDS Treatment Package
4. Ambulatory Surgical Clinics	✓	×	All benefits covered by NBB
5. Freestanding Dialysis Clinics (hospital and non-hospital based)	✓	×	Dialysis Package
6. Peritoneal Dialysis Center	✓	×	Peritoneal Dialysis
7. TB DOTS Centers	✓	✓	OTS Package
8. Birthing home	✓	✓	Maternal Care Package, Antenatal Care, Normal Spontaneous Delivery, New-born Care Package, family planning procedures
9. Primary Care Benefit (PCB) Providers	✓	✓	PCB, family planning procedures

Source: PhilHealth Circular 2017-0017