

The Future of Universal Health Coverage: A Philippine Perspective

Ramon Pedro P. Paterno

The present Philippine administration has committed to achieve Universal Coverage by 2016. Yet the Philippines has relied on Social Health Insurance or PhilHealth as the key to its health financing reform. PhilHealth has been attempting to achieve UHC along the classical “contributory” model in the face of an increasing informal sector, and is experiencing great difficulties in achieving universal population, benefit, cost and utilization coverage. This paper examines governance, both global and national, within and outside the health system, which has hindered the achievement of universal coverage. The Philippines’ continued adherence to a neo-liberal economic development model, its reliance on PhilHealth, and PhilHealth’s insistence on a “contributory scheme” have all contributed to the protracted journey towards universal coverage. Developing countries should reassert the original principles of Alma-Ata Primary Health Care Declaration which called for socio-economic development within a new International Economic Order to achieve health equity and health for all.

INTRODUCTION

“Health is a fundamental human right; that the existing gross inequality in health status of the people, between developed and developing countries and within them, is unacceptable; that economic and social development, based on a New International Economic Order, is of basic importance to the attainment of health for all (or universal coverage), and to the reduction of the health disparities among and within nations.” The world has the necessary resources needed to achieve health for all but “a considerable part... is now spent on armaments and military conflicts.” Thus, with those few phrases, the 1978 Alma Ata Primary Health Care Declaration had capsulized, in broad strokes, the root causes of health inequities, poverty, and underdevelopment; and the needed solution to achieve health for all.

Presently, the World Health Organization (WHO) asserts that the path to universal coverage can be financed either through taxes or Social Health Insurance premiums, or a combination of both.¹ The recent contrasting experience of two ASEAN countries, the Philippines (negative) and Thailand (positive), may hold lessons for the path to Universal Health Coverage (UHC). Although rapid achievement of universal population coverage is very enticing, it represents only the first step and will not be enough to achieve Universal Coverage and the ultimate goal of lessening health inequities. Deeper issues must be examined, particularly those pertaining to governance issues, both at the global and national level, within and outside the health system, and within the health system, design and implementation issues of the Universal Coverage program, be it tax or premium based, or a combination of both. Globally, we need to examine not only WHO health policies but also that of the World Bank and other financial institutions which have gained prominence in terms of Global Health Policy. Again it will be necessary not to confine ourselves to health policy but also to include economic and

political policies, which may have a much larger effect on the improvement of health and the attainment of health equity.

METHODOLOGY

A systematic search of PubMed, ProQuest Central, Science Direct and Wiley Online databases was done. Search items included “PhilHealth” “Social Health Insurance Philippines”, “Universal Coverage,” “PhilHealth enrollment,” “PhilHealth Support Value,” and “PhilHealth utilization.” Searches had no date restrictions. As part of the tri-agency PhilHealth Validation team, from 2006-2008, the author compiled literature on PhilHealth from PhilHealth’s file of commissioned studies including their Annual Reports, Stats, and Charts, as well as presentations to Local Chief Executives, and the DOH’s file on PhilHealth researches, including unpublished studies. The author also conducted key informant interviews of PhilHealth officials at the senior level and conducted field visits of three PhilHealth regional offices, one each in Luzon, Visayas and Mindanao, including the Autonomous Region of Muslim Mindanao (ARMM).

CONTEXT:

The Philippines is considered a lower middle-income country. In 2010, GDP was \$199.5B with a population of 93.2 million, and a per capita GDP of US\$2,140.² In 2009, service industry share was 55.1% of GDP, with industry share at 29.9% and agriculture share at 14.9%. Agriculture remains a major economic activity with manufacturing on the decline over the last two decades. Remittances from overseas Filipino workers are a major source of national income, comprising about 13.4% of GDP in 2009.³

The Philippines was a former colony of the United States and its economic, political, and health systems were closely patterned and linked with the United States. In the economic field, from 1909 to 1946, when the Philippines was still a colony of the United States of America, a series of laws established “free trade” between the United States and the Philippines: the Payne-Aldrich Act during the colonial period, the Bell Trade Act of 1946, extending free trade until 1954, thereafter, tariffs would be increased until its full amount in 1974. In exchange for the release of war damage payments from the United States, the Philippines had to amend its constitution with the Parity Amendment, giving US citizens equal rights with Filipino citizens in land ownership, exploitation of natural resources and operation of public utilities. In 1955, the Laurel-Langley Agreement extended the provisions of free trade to 1974, thus perpetuating the neocolonial nature of the Philippine economy.

In health, the Department of Health (DOH) was carved out of the colonial Health and Public Welfare Bureau. The 1954 Rural Health Act established a nationwide network of Rural Health Units based in the municipalities (towns) and city health centers in the cities.

Direct health provision and governance was centralized in the Department of Health, with its Regional, Provincial, and Municipal Health Offices. In 1978, the Philippines was one of the signatories of the Alma Ata Primary Health Care Declaration, and Primary Health Care and Health for All by 2000 became national health policy. This policy was gradually replaced by various versions of “selective Primary Health Care” following global health trends, such as the implementation of “GOBI” or growth

monitoring, oral rehydration, breast feeding and immunization” as health interventions meant to decrease child mortality without needing to address social inequities. In 1991, with the passage of the Local Government Code, health service provision was devolved to the local government units: provincial, city and municipal government units (local government units or LGUs)

In a decentralized setup, the DOH serves as the lead governing agency, with both local government units (LGUs) and the private sector providing services to the population. The DOH provides national policy direction and develops national health plans, technical standards, and guidelines. The DOH has also retained management of tertiary hospitals such as national specialty hospitals and regional hospitals, and Metropolitan Manila district hospitals. It provides guidance to the regions through its regional offices called Centers for Health and Development, providing technical assistance, medicines, and supplies for LGUs to implement in their areas, national health programs such as the Expanded Program of Immunization, control of leprosy, schistosomiasis, filariasis, rabies, malaria, tuberculosis, HIV/AIDS, dengue, and emerging and re-emerging diseases such as SARS, and avian influenza.⁴ Under the Local Government Code of 1991, provision of health services was devolved to the local government units: the hospitals, (provincial and district), to the provincial government, and the public health and primary care services to the municipal government. The City Health Offices manage both hospital and public health services within the city.⁵ Implementation of the national public health programs became the responsibility of the LGUs.

The Philippine health system has a very large, highly unregulated private sector; 70% of physicians are in private practice, private clinics or hospitals, serving the population that can afford to pay from out of pocket or from private health insurance with the remaining 30% as government physicians employed by the DOH in its retained hospitals or by the local government units, serving the rest of the population with low incomes who go to government health facilities.⁶ ((The latest Family Income and Expenditure Survey (FIES 2009)⁷ had the lowest 30% of households with negative savings at the end of the year, with the 5th decile having only P10,479 (\$240 at P43.50:\$1) savings at the end of the year, not even enough for an appendectomy.))

The minimal regulatory function is exercised by the governmental Professional Regulatory Commission, which licenses the physicians, by the DOH, which licenses the health facilities, and by PhilHealth which accredits both the physicians and the health facilities. Only PhilHealth accredited physicians and health facilities can avail of reimbursements from PhilHealth for services rendered.

The attainment of Universal Health Care or Universal Coverage is therefore dependent on the availability and accessibility of health facilities and services provided by the primarily tax financed DOH, and the LGUs, which are financed by a combination of taxes, PhilHealth reimbursements and out-of-pocket payments; and the private sector, financed by out of pocket payments and PhilHealth reimbursements. PhilHealth, as a government owned and controlled corporation manages the National Health Insurance Program, the social health insurance program of the Philippines.

Access has always been problematic in spite of the physical presence of a nationwide network of health facilities from the village “barangay health stations” to municipal (town) and city health centers, and the network of public hospitals from the district, provincial, regional, and national levels, and the network of private clinics and

hospitals. According to the DOH National Objectives for Health 2005-2010, only 35% of deaths were attended by health professionals in the year 2000.⁸ What is perhaps more important is to disaggregate access according to income groups. The National Demographic and Health Survey (NDHS) 2008 found that: 83.9% of mothers from the richest quintile delivered in a health facility, and 77% were delivered by a doctor; in contrast 86.8% of mothers from the lowest quintile delivered at home, and 71% were delivered by a *hilot* or traditional birth attendant. The NDHS 2008 asked women respondents to rank their problems in accessing health care. The women in the poorest quintile ranked their problems thus, in order of priority: getting money for treatment, no drugs available, distance to health facility, having to take transport, no provider available, not wanting to go alone (the need for a watcher means another person taken away from economic production), no female provider available, and getting permission to go for treatment. For all income groups, the three top ranked problems were: getting money for treatment, concerned that no drugs were available, and concerned that no provider was available.⁹

In 1969, the Philippine Medical Care Act was passed and Medicare, as it was eventually called, was implemented in August 1971. The health insurance program provided hospital benefits for the formally employed government sector. The private formally employed sector had health benefits from the Social Security System.

In 1995, Republic Act 7875 established the National Health Insurance Program (NHIP), the country's social health insurance program, and PhilHealth, as the corporation which managed the Social Health Insurance program. PhilHealth is a government owned and controlled corporation, and is an attached agency of the Department of Health. Its mandate was to "provide all citizens of the Philippines with the mechanism to gain financial access to health services." It was supposed to achieve universal coverage in 15 years or by 2010.¹⁰

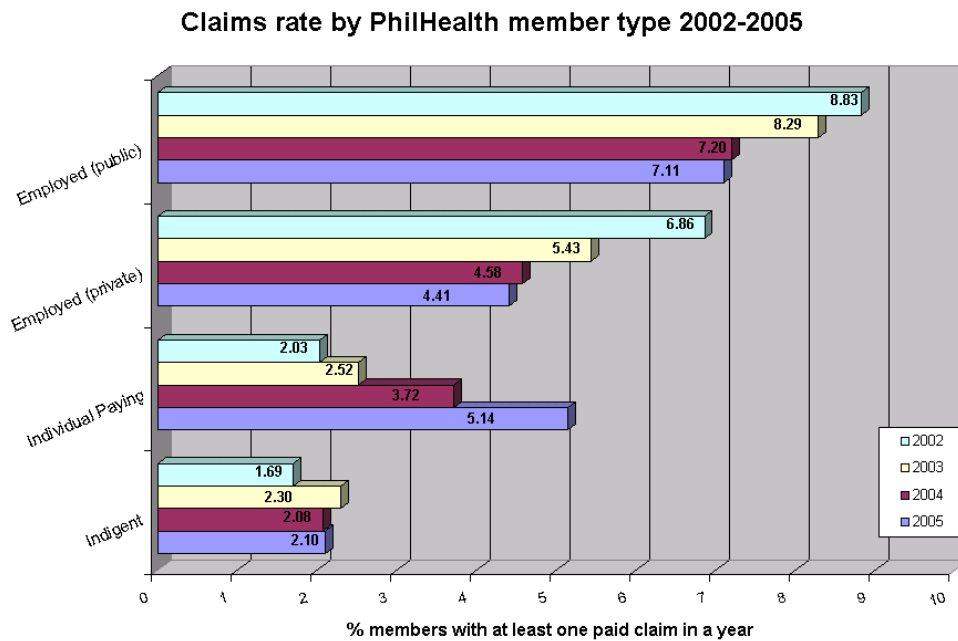
PhilHealth assumed the administration of the former Medicare program from the Government Service Insurance System in 1997, and the health benefits fund for the private formal sector from the Social Security System in 1998, and thus became the single payer for Social Health Insurance.¹¹ (It assumed the administration of the health funds of the Overseas Workers Welfare Administration in 2005).

It was the flagship program of the past administration, and in 2005, PhilHealth's president claimed "unprecedented achievements that most sectors brand as 'too good to be true'..." PhilHealth's news release then claimed that due to "the wide extent of information and education campaigns targeting various sectors of the populace, PhilHealth posted an increase in total membership ... from 37.4 M in 2001 to 69.5 M in 2004 or an increase of about 89%."¹² PhilHealth claimed to have achieved 83% coverage by end of 2004, very close to its self-defined universal population coverage of 85%. PhilHealth's success story was being echoed in the international arena, with studies, such as that by Obermann and Jowett which concluded in a 2006 article that: "social health insurance in the Philippines has been a success story so far and provides lessons for countries in similar situation."¹³

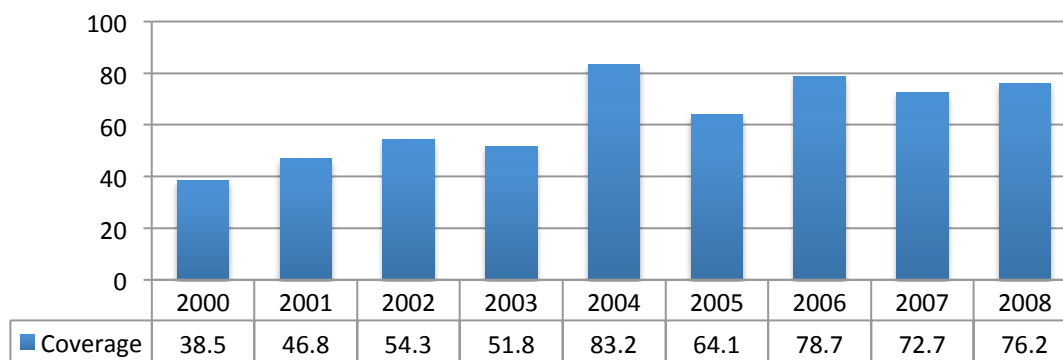
In 2005, Republic Act 9241 amended the PhilHealth Law and in its oversight provision, mandated the National Economic and Development Authority (NEDA) together with the National Statistics Office and the National Institutes of Health of the University of the Philippines Manila (UPM-NIH) to conduct validation studies of PhilHealth performance. The validation studies found that PhilHealth's claimed

population coverage was bloated with double countings, (double counting referred to both working spouses being counted as distinct PhilHealth members and therefore counted as two separate households covered rather than one single household). PhilHealth would not be able to achieve its 85% coverage by 2007, much less sustain it after that; that its benefits were not comprehensive and were mainly inpatient benefits; that its financial protection was only from 30-50% of total hospitalization costs and significantly, the Sponsored beneficiaries were utilizing their PhilHealth benefits less compared to the other PhilHealth member groups, or social solidarity in reverse.¹⁴ PhilHealth reported claims rates or percent of members with at least one paid claim in a year among its different member groups. For the years 2002-2005, the sponsored members consistently had a much lower claims rate (average of 2.04%), while the formally employed government sector had the highest rate, though it decreased through the years (average 7.86%). It is followed by the formally employed private sector, which also shows decreasing trend (average 5.32%). The claims rate of the Individually Paying members steadily increased reaching a high of 5.14% of members with at least one paid claim during the year (average 3.35%), thus, reflecting the trend towards adverse selection. (See Figure 1)¹⁵

Figure 1: Claims Rate by PhilHealth member type 2002-2005



Source: Adapted from a presentation by Matthew Jowett, Eduardo Banzon, Reuben John Basa, “The Impact of Social Health Insurance in the Philippines 1972 – 2007” as cited in *Validation of PhilHealth Performance using 10 Key Performance Areas for the years 2004-2006*.

Figure 2: PhilHealth's population coverage 2000 - 2008

Source: Data from Romualdez et al., 2011 p. 44

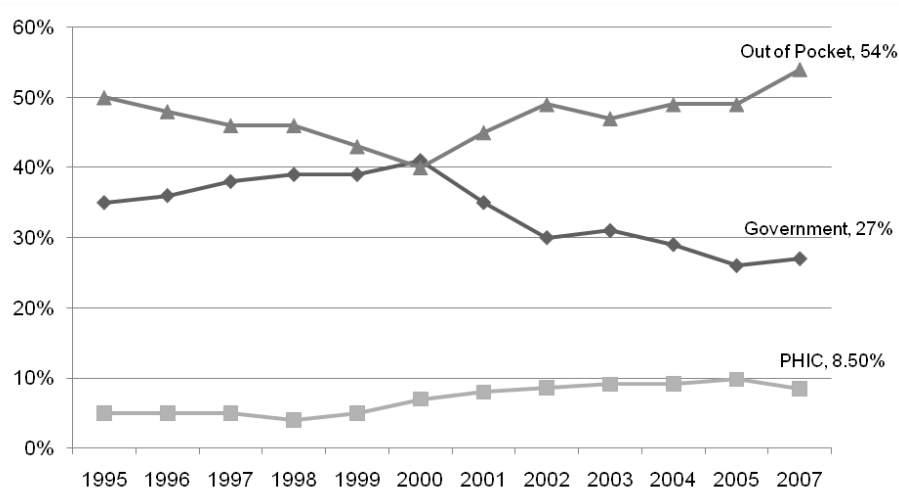
Figure 2 shows the population coverage of PhilHealth which for many years hovered around 50% population coverage, then shot up to 83% in 2004 (an election year and PhilHealth membership cards were given out during the election campaign), then dramatically dropped in 2005.¹⁶ (The local government units had not budgeted their premium counterpart so that the PhilHealth cards given out in 2004 expired after one year).

In 2008, the National Demographic Health Survey (NDHS) covering almost 14,000 households, came out with the result that only 38% of Filipino households had at least one PhilHealth member. (PhilHealth coverage is by household). The wide discrepancy in population coverage as claimed by PhilHealth can be explained by the fact that PhilHealth's claim is an estimate and not based on actual count of its members. PhilHealth's information system has been described by a vice president of PhilHealth as "being islands of good databases that do not talk to each other." Hence, PhilHealth is forced to estimate the number of its members based on its collection database. Each estimated member is considered a head of the household, and a multiplier is applied to come up with the population covered. (Each member group, the formal sector, the informal sector, and the sponsored members have their own multipliers representing the group's average household size). What happens is that a household may have two members, e.g., if both husband and wife are working, and by this method, they are each counted as a separate household. PhilHealth's method of estimating its population coverage therefore has a lot of double counting errors, as explained previously. PhilHealth is now in the process of improving its information system and promises to do an actual count based on its membership database.

From 2001, various health sector reform efforts, the DOH's Health Sector Reform Agenda (2001), the National Objectives for Health (NOH) 2005-2010, Formula One and now the DOH Health Care Financing Strategy 2010-2020, have looked at PhilHealth as having the key role in health financing reform: "health care reforms will focus on making the National Health Insurance Program (PhilHealth) the major payer of health services (HSRA), the flagship program of health financing (NOH) and "the lead implementer of health financing reform." (Formula One) Figure 3, however, clearly shows government share (40%) of THE decreasing steadily from the year 2000 to only 27% in 2007, with PhilHealth share slowly increasing only to 8.5%, with a resultant out-

of-pocket share of 54%. Dr Alberto Romualdez, DOH secretary during this time, said in an interview, that PhilHealth would indeed have been the key to health financing, if government share had been maintained at 40% and PhilHealth share had risen to 30%, thus decreasing OOP share to less than 30%.

Figure 3. Government, PhilHealth and Out of Pocket %share in Total Health Expenditure



Source: National Health Accounts, 2007

The DOH Health Care Financing Strategy 2010-2020 recognizes that UHC will be financed by both taxes and PhilHealth premiums but it asserts that “the small share of government spending relative to GDP, approximately 19.0% in 2009, shows the limitation of mobilizing additional resources out of tax-based money.” The policy is further elaborated thus: “The most important goal is to reduce OOP expenditure ... to 35% (of THE) in 2020. Considering the limitations of the government budget, extra-budgetary resources from PhilHealth have the greatest potential to supplant OOP with prepaid funds (underscore ours).” The author disagrees with this analysis, and in another study showed that with political will, the Philippine government can create fiscal space to finance UHC, and even bring down OOP to 20% share of THE. The Philippine government can achieve this by increasing its tax collection rate to 17% of GDP from its present rate of 14% of GDP. Historically, the Philippine government was able to achieve a tax collection rate of 17% GDP in 1997 under then President Fidel V. Ramos.¹⁷ The 3% of GDP additional tax revenue would amount to about P300-400B, (\$6-\$9B), enough to finance UHC by 2015.

“Expand coverage, increase benefit payments, include outpatient benefits, use alternative forms of payment mechanisms, improve marketing to increase beneficiary knowledge about PHIC benefits, and improve information system” has been the mantra since 2001 and is now being echoed by the present political administration as the Aquino Health Agenda. Yet coverage, in all its dimensions, remains problematic: 38% population coverage,¹⁸ mainly in-patient benefit package, and low financial protection. In its 2011 Annual Report, the DOH claimed PhilHealth population coverage had increased to 82% again¹⁹ but the significance of this 82% population coverage is belied

by PhilHealth's persistent, very low share in Total Health Expenditure (THE). (See Figure 3 for National Health Accounts up to 2007²⁰). The latest National Health Accounts data showed PhilHealth's share at 9.1% in 2011 with out-of-pocket share at 52.7%.²¹

WHY WAS PHILHEALTH NOT ACHIEVING ITS MANDATE?

To attempt to answer the above question, the author used the principles contained in the 1978 Alma Ata Primary Health Care Declaration, which also contained the social determinants to health approach. The Alma Ata Declaration reaffirmed that health is a fundamental human right; that the existing gross inequality in health status of the people, between developed and developing countries and within them, is unacceptable; that economic and social development, based on a New International Economic Order, is of basic importance to the attainment of health for all (or universal coverage), and to the reduction of the health disparities among and within nations. Social determinants to health approach is about improving health and decreasing health inequities by tackling the root causes of disease and health inequalities. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH).²² Wilkinson and Marmot assert that "while medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place. Nevertheless, universal access to medical care is clearly one of the social determinants of health."²³

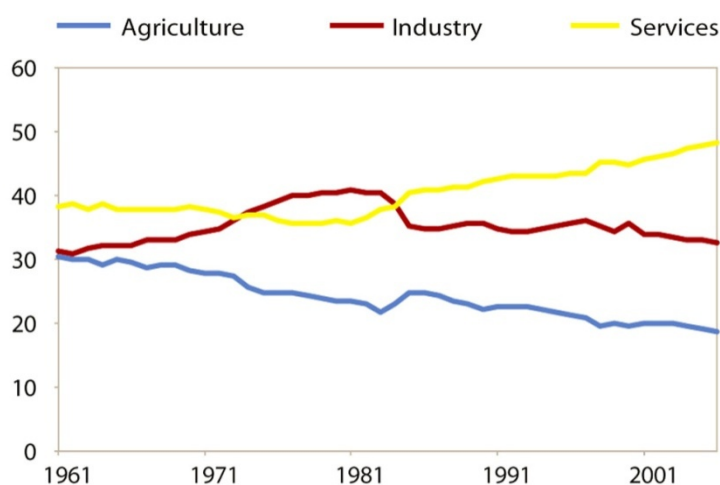
GOVERNANCE ISSUES THAT HAVE DIRECTLY OR INDIRECTLY AFFECTED HEALTH IN THE PHILIPPINES:

Economic Development Policy

As mentioned above, in the 1950's, a World Bank report described, that within Asia, the Philippine economy was second only to that of Japan. Two Philippine presidents, Elpidio Quirino (1948-1953), and Carlos P. Garcia (1957-1961) pursued nationalist economic policies such as the import substitution strategy of development and the Filipino First policy or Buy Filipino, both meant to spur the development of the manufacturing sector. From 1962 onwards, the next Philippine President, Diosdado Macapagal, upon advice of the World Bank and the International Monetary Fund, instituted decontrol of the flow of foreign capital and the devaluation of the Philippine peso. In September 1972, President Ferdinand Marcos declared Martial Law. There was a convergence of interest between Marcos and the US government: Marcos was prevented from running for a third term, and the Laurel Langley agreement, which established "Parity Rights" for American citizens, was about to lapse in 1974. Thus the United States provided tacit approval for the declaration of Martial Law. Vice President George Bush even toasted Marcos for his "adherence to democratic principles." Martial Law saw the development of "Crony Capitalism" or Marcos cronies controlling big business. Foreign debt ballooned, and provided another instrument by which the Philippines had to follow WB-IMF Structural Adjustment Programs.

Since the 1980s, after Martial law, the Philippines had followed what is called a neo liberal development paradigm with succeeding administrations carrying out more or less similar economic policies within that Neo-liberal framework: liberalized trade and investments, lowered tariffs on imports, wage suppression for global competitiveness, privatization, reduced government intervention, and business deregulation. Liberalized global trade was supposed to lead to national growth and development. Neo Liberal economic technocrats gained ascendancy in reaction to the “state cronyism” of the Martial Law regime from 1970 – 1986. The objective was for Philippine industries to become more competitive and eventually for the Philippines to join the newly industrializing countries: Singapore, Malaysia, Thailand, and Indonesia.²⁴ The government’s role was limited to ensuring the unfettered play of market forces, establishing the infrastructure, and maintaining an equal playing field for both local and foreign investors. The Philippines because of its massive debt, largely incurred again during the Martial law years had to agree to a series of conditionalities, called Structural Adjustment Program, to be able to continue to avail of loans from the World Bank and IMF. Essentially this consisted of addressing the country’s fiscal deficit, managing balance of payments, reducing government spending, mostly for social services and currency devaluation, with the end goal of paying for the national debts incurred. In health, this meant lowered government health expenditure, introduction of user fees, fiscal autonomy for government hospitals for income retention, and safety nets in the form of social health insurance. (See Figure 3, with continued marked decrease of government share in THE from the year 2000.)

Figure 4: Decreasing industry sector share in GDP



GDP = gross domestic product.

Sources: Data from National Income Accounts, NSCB (various years).

Source: ADB, 2007

Each succeeding administration did indeed achieve growth, President Corazon Aquino with an average of 3.9%, President Fidel Ramos with 3.8%, President Joseph Estrada with 2.4%, and President Gloria Macapagal Arroyo, the highest with an average of 4.5%, but all were “non-inclusive” growth. The impact on the economy can be seen from a

2007 Asian Development Bank study which showed both industrial and agricultural share in the GDP steadily decreasing, with the service sector share steadily increasing (see Figure 4).²⁵ The industrial casualties included manufacturers of textiles, paper products, ceramics, rubber products, furniture, petrochemicals, beverages, shoes, and leather goods. While the goal was to make the Philippines a “newly industrializing country” by the year 2000, the opposite had happened. The country was “de-industrializing.” The WHO Commission on Social Determinants to Health explains the mechanism for the de-industrializing effect:

...World Trade Organization (WTO) agreements already in place or under negotiations will restrict the ability of developing countries to pursue policies that favour domestic producers and industries with the potential for rapid growth. Such development policies were routinely used by today’s high-income countries during the process of industrialization and successful late-industrializers adopted economic policies that involved a high level of state planning, including policy instruments at least some of which would not be allowed under current WTO rules...”²⁶

Erik Reinert, a historical economist, asserts in his book, *How Rich Countries Got Rich and Why Poor Countries Stay Poor*, that countries able to industrialize, become rich, and that countries that remain agricultural, remain poor. Countries that were able to industrialize did so with government intervention, providing protection of their fledgling industries.²⁷ Developing countries were not allowed to use these instruments to develop their industries under the neo-liberal economic paradigm. In addition to “de-industrialization”, the Philippines, originally a food exporting country, became a food importing country from the mid-1990s onwards.

The impact of “de-industrialization” is a decrease of the formal sector and an increase of the informal sector, making PhilHealth coverage of the informal sector increasingly difficult if it is through the classic enrollment mechanism.

SAPs affect health in two ways: by cutting down on availability of health services (through health budget cuts), and the demand for health services (by reducing household income), thus families have less money for health. This happens because growth that results is not inclusive growth.²⁸

Global Health Governance

In 1978, the Philippines was one of the signatories of the Alma Ata Declaration of Primary Health Care which asserted that to address health inequities, “economic and social development based on a New International Economic Order is of basic importance to the fullest attainment of health for all”. Yet, after merely a few years, UNICEF came out with what has been called Selective Primary Health Care in the form of specific health interventions (the so-called GOBI or Growth monitoring, Oral rehydration, Breast feeding, and Immunizations) which can be cost effectively implemented and would have dramatic impact on lowering infant and child mortality. Selective Primary Health Care was supposed to be a temporary solution to the more comprehensive and radical Alma Ata Primary Health Care.²⁹

The background paper for the WHO Commission On Social Determinants of Health described the role of WHO during this period:

The late 1980s and early 1990s witnessed a waning of WHO's authority, with de facto leadership in global health seen to shift from WHO to the World Bank. In part this was a result of the Bank's vastly greater financial resources; by 1990, Bank lending in the population and health sector had surpassed WHO's total budget. In part the shift also reflected the Bank's elaboration of a comprehensive health policy framework that increasingly set the terms of international debate, even for its opponents. While open to criticism in many respects, the Bank's health policy model as presented in the 1993 World Development Report *Investing in Health* showed intellectual strength and was coherent with regnant economic and political orthodoxy.³⁰

The World Development Report 1993 *Investing in Health*³¹ came out with a clear acknowledgement of WHO as a “full partner ...at every step of the preparation of the Report.” The three key messages of the WB's *Investing in Health* were: 1). Foster an environment that enables households to improve health, 2). Improve government spending on health, and 3). Promote diversity and competition (WB).

Recommendations for fostering an environment that enables households to improve health included pursuing economic growth policies that benefit the poor, expanding investment in schooling, particularly for girls, and promoting rights of women through political and economic empowerment. Ironically, while calling for the implementation of economic growth policies that benefit the poor, the WB's Structural Adjustment Policy was leading to economic growth in the Philippines that did not benefit the poor. This failure is succinctly capsulized by the presentation of the Philippine's NEDA Director General of the newest Philippine Development Plan 2011-2016, which included the question: “Why is inclusive growth so elusive?” The World Bank country representative, in his closing statement in the Philippine Development Forum last February 2011, also recognized this continuing non-inclusive growth of the Philippines, saying: “They (development partners) also expressed concerns about the fact that the poverty situation has not improved despite the growth acceleration over the last decade....”³²

Recommendations for improving government spending on health include reducing spending on tertiary facilities, specialist training and interventions that are not cost effective; financing a package of public health interventions surrounding infectious disease control, prevention of AIDS, environmental pollution, and risky behaviors; financing and ensuring delivery of a package of essential clinical services; and improving management of government health services through decentralization of administrative and budgetary authority and contracting out of services. Targeting is mentioned with regards to the provision of essential clinical services with the phrase “at least to the poor”.

Recommendations for promoting diversity and competition include: government spending for public health and essential health package; other remaining services to be financed privately or by social insurance (underscore ours). Diversity and competition in provision of health services and insurance can be promoted by encouraging social or private insurance for clinical services outside of the essential package, encouraging suppliers to compete to provide inputs, (domestic suppliers should not be protected from international competition), to address information asymmetry, disseminate information on provider performance, on drugs and equipment, and on accreditation of facilities and providers.

Promote diversity and competition was another way of saying privatize health services outside of public health and the essential health package, with insurance, both private and social, as one major component. In fact, Table 7.1 of the WB Report, re-labels “Promote diversity and competition” as “Facilitate involvement by the private sector.”

In contrast to the social determinants approach, the WB document asserts, “increased scientific knowledge has accounted for much of the dramatic improvement in health that has occurred in this century”, citing smallpox eradication and reflecting a biomedical paradigm for addressing health inequities. The tacit premise also of the WB document is that government resources are limited, that is why the private sector must be involved.

The law (RA 7875)³³ that established social health insurance in the Philippines mandated PhilHealth to “provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs.” Highest priority was given to “coverage of ALL with at least a basic minimum package of health insurance benefits.”

The PhilHealth law reflected the guidelines set forth in the WB 1993 document. It makes a distinction between Public Health Services and Personal Health Services and states:

“The Government shall be responsible for providing public health services for all groups such as women, children, indigenous people, displaced communities in environmentally endangered areas, while the Program (PhilHealth) shall focus on the provision of personal health services.”

This echoes the WB recommendation: government to cut down on spending for tertiary, specialist care, and focus on spending for public health services and essential health services, leaving the financing of the other health services to private financing, private insurance and social health insurance. Until recently, this has guided PhilHealth in its benefit package formulation, concentrating on inpatient benefits, with a few outpatient benefit packages, such as TB DOTS. Outpatient benefits included health consultation and limited diagnostic laboratories in accredited government health centers, which were mostly free to begin with.

In its guiding principles, the law reiterates a Philippine constitutional provision which contains the targeting provision for PhilHealth:

“...the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.”

Unfortunately, the Philippines has limited technical capacity in identifying the poor. Identification depends on a means test, which tries to classify families based on proxy indicators for family income. The information system is not developed enough to document family income. PhilHealth attempts at identifying the poor families for their Sponsored programs depended on the LGUs identifying the poor and because local politics were dominated by political patronage, the Sponsored program in the past was plagued with what PhilHealth officers called “the political poor” or those selected for their support for the incumbent local chief executive. The Sponsored program was

plagued with exclusion of the true poor and inclusion of the non-poor.³⁴ This assessment is echoed by the DOH Health Care Financing Strategy monograph, which states: "...deficient targeting tools might have led to non-poor households that are being subsidized, while a big number of poor households have been excluded."³⁵

GOVERNANCE OF THE PHILIPPINE HEALTH SYSTEM

As mentioned above, the Department of Health is the lead agency of the health sector in the Philippines. Before the devolution in 1991, the DOH headed a centralized three-tiered health organization: tertiary hospitals at the national and regional levels; provincial and district hospitals; and city and municipal health centers including village health centers. After devolution, governance became fragmented: cities and municipalities were in charge of providing basic health services including promotion and preventive services; provinces were in charge of provincial and district hospitals and the DOH was in charge of national health governance and the direct supervision of retained tertiary regional hospitals and national specialty hospitals. PhilHealth was in charge of running the National Health Insurance Program.

PhilHealth is a government owned and controlled corporation that is an attached agency of the Department of Health. Although the Secretary of Health sits as the Chairperson of the Board of PhilHealth, PhilHealth, as a government corporation, had substantial autonomy in organizing its offices, in setting premium rates, designing benefits, accreditation of health care providers and determining the mechanisms for paying them.³⁶ Often times, PhilHealth would drag its feet when it came to benefit package formulation, especially if it was perceived to lead to a decrease in PhilHealth's reserve fund. There was also a recognized problem of "who pays for what services" between the DOH and PhilHealth.³⁷

The president of PhilHealth is appointed by the President of the Philippines. PhilHealth has had 6 presidents: the first two were not public health doctors, nor administrators. The first was a legal officer of the Department of Health and the second was an actuary of a commercial insurance company. PhilHealth has a board, which sets the overall policy and strategic directions of the SHI program. On paper, the board represents all the sectors of Philippine society: local government, social welfare and development, the National Anti-Poverty Commission, Civil Service Commission, Government Social Insurance System, the social security system for private employees, the labor sector, employers, overseas Filipinos, self-employed, and health care providers; but the directors are the head officers of these government agencies or their representatives. There are no direct representatives of people's organizations such as trade unions, farmers associations, consumer groups or PhilHealth beneficiaries to provide feedback to the board.

The major achievement of PhilHealth was having established itself as a national organization, with 17 regional offices and 106 local offices, with the national office able to manage billions of pesos as the country's single social health insurance payer. In 2010, it collected P30 billion (\$694 Million) in premiums and reimbursed P30.5B (\$701 million) as benefit payments. This was the first time PhilHealth's reimbursements exceeded its premium collection since 1995.³⁸

Its major weakness had been its commercial insurance orientation in terms of benefit package formulation, and build-up and protection of its reserve funds. Former senior government officials have critiqued the PhilHealth board and its president in an interview in March 2011 as being “afraid to spend the PhilHealth reserves, ‘that’s why it is often called an HMO (health maintenance organization) or commercial health insurance.”³⁹ Its reserve at that time was P110 Billion (\$2 Billion USD) when the Department of Health’s annual budget was less than P30 Billion (\$689 Million USD).

DESIGN AND IMPLEMENTATION ISSUES THAT HINDER UNIVERSAL HEALTH CARE

PhilHealth is a social health insurance, following the principle of social solidarity. As the social health insurance program of the Philippines, it is the sole payer.

Membership and enrolment

Although the Philippine constitution recognizes health as a right, entitlement to PhilHealth benefits is dependent on PhilHealth’s capacity to enroll the potential member. PhilHealth has the following member groups: the formally employed private sector, the formally employed government sector, the informal sector under the Individually Paying Program, the indigents enrolled in the sponsored program, the retirees who have been paid up members for at least 10 years, enrolled in the Non-Paying Program, and as a recent addition, the overseas Filipino workers.

PhilHealth employs a “premium contributory system” as a requirement for membership. The formal sector is automatically enrolled by their employer whether private or government. Premiums at 2.5% of their month salary are automatically deducted, equally shared by employer and employee, and remitted to PhilHealth. PhilHealth applies a salary cap on computing the monthly premium; the latest salary cap as of 2013 is P35,000 (\$805) monthly income. The salary cap means that a person earning more than P35,000 (\$805) per month will be paying the same amount in premiums as someone earning P35,000 (\$805). Above the salary cap, premium contribution becomes regressive. PhilHealth has so far refused to remove the salary cap in premium contribution.

Enrollment for the Sponsored member previously depended on the LGU’s identification of those qualified to be sponsored, i.e., those classified as the poorest of the poor based on a means test. Because Philippine politics is characterized by political patronage, sponsored members included what PhilHealth officers refer to as the “political poor” or those granted PhilHealth membership cards in exchange for their loyalty and support. LGUs’ sponsored members more often than not included non-poor while excluding some true poor. Enrollment is also dependent on the local government’s willingness to budget their counterpart premium share.⁴⁰

The present revitalized PhilHealth program⁴¹ attempts to remedy this by: identifying the sponsored members through the National Household Targeting system implemented by the Department of Social Welfare and Development, for its Conditional Cash Transfer program. Beneficiaries under this Conditional Cash Transfer program are automatically enrolled in the PhilHealth sponsored program and their premiums are fully subsidized by the national government from taxes, to obviate non-enrollment because of lack of LGU premium counterpart. Reports however are already coming in

from interviews of Municipal Health Center physicians of similar deficiencies again in this household targeting system (inclusion of non-poor and exclusion of true poor).

Although by law, PhilHealth membership is compulsory, in implementation, membership of the informal sector is voluntary. The informal sector must contribute P200 a month (about \$4.50) to be a member. Since their income was irregular, it was difficult to enroll and collect their premiums regularly. PhilHealth initially tried to enroll the informal sector through its PhilHealth Organized Groups Interface (POGI) with limited success because of the generally unorganized nature of the informal sector (estimates of the informal sector range from 40 – 70% of the workforce, and they are made up of farmers, street vendors, tricycle drivers, jeepney drivers, and small neighborhood store owners. The informal sector also includes self-employed professionals like doctors and lawyers.) POGI gave way to Kasapi or PhilHealth's attempt at enrolling the informal sector, this time, through microfinance groups with at least 1000 members, again with limited success as seen from their struggle to achieve universal population coverage. The plan now is to make PhilHealth membership compulsory by requiring proof of PhilHealth membership a requirement for all government transactions. So tricycle and jeepney drivers will have to show their PhilHealth membership card when they renew their licenses. The same will be true when small neighborhood stores will renew their business permit. However the problem remains in identifying the non-professional informal sector or the near poor from the professional informal sector. The LGUs will partially subsidize the premiums of the near poor, while the professional informal sector will have to pay premiums based on their income. Segmentation of the informal sector between the professionals and non-professionals for differential premiums will again entail additional administrative expense. Reports are coming in that there is substantial overlap between the sponsored members subsidized by the National Government, and the sponsored members identified and subsidized by the local government units, again compounding estimation of population coverage.

Benefits Package Formulation

Member benefits are mainly in-patient. In-patient benefits are uniform for all member groups and cover room and board charges; professional fees; laboratory charges; charges for use of hospital facilities and equipment, and prescription drugs. Emergency and transfer services are also included but are not well publicized.

The formulation of PhilHealth benefits has not been based on burden of disease studies (for one, Philippine burden of disease studies have so far been limited to a few conditions), but have been: 1). Benefits inherited from the previous Philippine Medicare program and 2). products of lobby efforts of various interest groups. For example, PhilHealth has delayed coming out with an outpatient anti-hypertension benefit package, in spite of hypertension being associated with many of the top ten causes of mortalities in the Philippines. It has instead come out with a newborn package that includes newborn screening for metabolic disorders (the most common disorder G6PD had an incidence rate of 1.9% of those screened while the next one, congenital hypothyroidism had an incidence of 0.03% .)⁴²

Some packages reflect a commercial health insurance orientation. For example, PhilHealth continues to point out that it has an inpatient SARS package of P50,000 (\$1,150) in spite of the many years that have passed since the last case of SARS.

There are limited outpatient benefits, which presently include outpatient consults, limited laboratory exams, and limited prescription drugs in accredited government health centers for Sponsored members. Other outpatient benefits for all members include Directly Observed Treatment Short course for TB, and antenatal and post-natal checkups included in the maternity package. PhilHealth has been studying an out-patient benefit package that would include medicines for hypertension and diabetes, two co-morbidities of leading causes of mortality.

Payment Mechanisms

PhilHealth reimburses providers primarily through a fee-for-service payment mechanism, which incentivizes providers towards overprovision of services. To remedy this, PhilHealth is in the process of moving to case payments, and later on, to case mix DRG based payments. At present, it only has 23 cases under the case payment mechanism but projects to cover all cases by the end of 2013. PhilHealth is slowly expanding its case payment mechanisms to cover more cases and will also be implementing a true capitation payment mechanism for outpatient benefits targeted initially for Sponsored members.

Financial Protection

Estimates of PhilHealth's financial protection range from 30-50% of hospitalization costs, depending on the severity of illness, with lower percentage for the more serious illnesses. One of the major reasons for this is its First Peso design with low ceiling benefits, with balance billing allowed. This means PhilHealth pays for the first peso of hospital confinement up to the set ceiling benefits. The hospital or the provider is allowed to charge the patient for the balance of the bill. If, for example, the patient's hospital bill reached P100,000 (\$2,300) and PhilHealth covers the first P40,000, (\$920) the patient still has to pay the balance of P60,000 (\$1,380) to the provider. In this setup, PhilHealth transfers the financial risk to the patient. Gertler and Solon in 2002⁴³ showed that when PhilHealth raises its ceiling benefits without reforming its first peso coverage and with balance billing allowed, hospitals just raise their fees, with private hospitals capturing 100% of the increase in ceiling benefits and government hospitals capturing 70%. Providers still pass on the same balance to the patient. Increases in PhilHealth ceiling benefits therefore will not provide the member with increased financial protection but will increase the income of the providers and lead to higher health care costs.

These design problems have been largely recognized by DOH and the new PhilHealth administration. The large PhilHealth reserve fund will be mobilized to increase PhilHealth reimbursements and therefore increase PhilHealth's share in total health expenditures. DOH is implementing a policy of zero co-payment, no balance billing for all Sponsored members confined in government hospitals admitted for one of the 23 cases defined for case payment. However, even with the projected increase in

PhilHealth reimbursements and the shift to case payments, PhilHealth's share in the Total Health Expenditure will most likely increase to only 20% of THE⁴⁴.

In summary, PhilHealth is having problems achieving Universal coverage in its breadth, depth and height dimensions for the following reasons: 1). Breadth or universal population coverage: the persistent poverty incidence, which necessitates identification of the poor and subsidy of their premiums; and the increasing number of the informal sector within a "de-industrializing" economy; 2). Comprehensiveness of benefits – the orientation set by the World Bank's *Investing in Health* model wherein the DOH spends for public health and essential health package, and PhilHealth concentrates on other health services, and a persistent commercial health insurance mindset, which delayed the development of outpatient benefits including outpatient medicines, and 3). Height of financial protection – the first peso coverage, with low ceiling benefits, with balance billing allowed, the slow shift to case payment mechanisms and resistance by the private sector to this shift. The future of Universal Coverage in the Philippines would require:

In the short term

Integration of national health governance among the different stakeholders in the health sector, primarily between the DOH and PhilHealth in the implementation of Universal Coverage or *Kalusugan Pangkalahatan*. DOH should be the lead agency, together with the other major stakeholders in health, to map out the direction and implementation of Universal Health Care. The distinction between revenues raised for the health sector whether from general taxes or from SHI premiums should blur. Revenues whether from taxes or from SHI premiums should be considered revenues for the whole health sector and should be allocated in the most efficient manner: essentially a primary care based Universal Health Care. (UHC should go beyond insurance coverage.)

A clear articulation of the health policy of addressing health inequities through Universal Health Care, accepted by the major stakeholders.⁴⁵ Health inequities among income groups must be included in the monitoring indicators for Universal Health Care. Addressing health inequities must be considered in the formulation of benefit packages and the priority areas for implementation of UHC.

A quantum increase in government spending for health to bring down the OOP share to 20 - 30% of Total Health Expenditures (THE).⁴⁶ PhilHealth's share in total health expenditure will most likely only reach 20% of THE,⁴⁸ necessitating government share, both national and local, to increase to 50 - 60% of THE. Health financing is a necessary but not sufficient component for Universal Health Care; but we cannot even talk of Universal Health Care if financing is insufficient for both public health and personal care.

Automatic coverage of the rest of the population outside of the formal sector. The Philippines has much to learn from Thailand in its rapid achievement of universal population coverage. In contrast to the Philippines' difficult and complicated path to Universal population coverage, Thailand's experience has been more rapid and straight forward. Thailand retained its insurance schemes for the private employees (SSS), and for government employees and dependents (CSBMS), and decided to cover the rest of the population through a tax financed universal coverage scheme. (UCS).⁴⁷ In less than 10 years, Thailand has been able to reduce Out of Pocket expenditure to less than 20%.⁴⁸

Accelerated development by PhilHealth of comprehensive benefit packages (outpatient and inpatient) that will benefit first, its sponsored beneficiaries and eventually all Filipinos. Global budget for tertiary hospital benefits and contractual capitation for outpatient and secondary hospital benefits should be the way to go in terms of payment mechanisms.

In the long term:

The Social Determinants approach to health: A review of the Philippines' national economic development paradigm to ensure inclusive growth in the light of the country's experience with the Neo-liberal economic development framework which had not led to industrialization and inclusive growth. It must also be recognized that the Structural Adjustment Program had affected the achievement of Universal Health Care by drastically reducing government expenditure on health and depressing household income. Industrialization must be a strategic part of the Philippine Development Plan.

The National Economic and Development Authority (NEDA) in its "The Philippine Midterm Progress Report on the MDGs 2007, prescribed an anti-poverty strategy that "must focus on agriculture and rural development through asset reforms (agrarian reform, urban land reform and ancestral domain reform) accompanied by reforms in the agricultural center, such as investments in productivity improvements and supporting infrastructure." By implementing a genuine land reform, the Philippines will create a domestic market of about a 100 million population, with money to buy products manufactured by local industries. Manufacturing can initially start with producing farm support equipment such as water pumps and handheld tractors and eventually diversify to non-agricultural products. Such a program for national industrialization would be a departure from the neo-liberal economic development paradigm.

It might be well worth the time for a developing country like the Philippines, to examine the Cuban paradox^{49,50} for the paradox consists of two achievements: firstly, that a small, low income country was able to attain a health status comparable to that of richer developed countries and secondly, that Cuba was able to achieve economic development and address social and health inequities outside of the Neo-liberal economic framework.

Finally, in the arena of global health governance, WHO must boldly reassert its moral leadership on global health policy and review all global health policies through the lens of health as a fundamental human right and not health as an investment for Global trade and "trickle down" development.

The future of Universal Health Coverage still has to be: back to the original message of Alma Ata Primary Health Care: that "health is a fundamental human right", that "the existing gross inequality in health status of the people between the developed and developing countries as well as within them – is politically, socially and economically unacceptable ..." that "economic and social development based on a New International Economic Order is of basic importance to the fullest attainment of health for all"; that "governments have a responsibility for the health of their people,..." , that "an acceptable level of health for all the people of the world ... can be attained through a fuller and better use of the world's resources..."⁵¹

Ramon Pedro P. Paterno is the convenor of the Universal Health Care Study Group, under the Institute of Health Policy and Development Studies of the National Institutes of Health at the University of the Philippines, Manila.

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