How Do We Finance Universal Health Care in the Philippines?*

RAMON PEDRO P. PATERNO

The Policy Questions

This paper addresses the following health policy questions:

- How much will universal health care (UHC) cost?
- Can we generate the needed revenues?
- What would be the optimal combination of tax generated revenues and social health insurance (SHI) premium generated revenues to meet the financial cost of UHC?
- Should the SHI premiums for the informal sector be contributory or non-contributory (subsidized through taxes)?

The original question, "How do we finance UHC in the Philippines?" has refined in the course of recent global developments regarding how developing countries can best achieve universal coverage rapidly. The original question had an underlying issue of whether UHC should be financed primarily through a tax-funded national health service or through SHI. There is, however, a fine line distinguishing a tax-funded national health service and a social health insurance-financed system.

* The author would like to acknowledge the research assistance furnished by Julian Canero, MD; Paul Gideon Lasco, MD; and Marlene Rillera Bermejo, MD.

The World Health Organization (WHO) has in fact suggested that the path towards universal coverage would either be tax-financed or social health insurance-based, or a combination of both (Carrin 2004); the Department of Health's Health Care Financing Strategy 2010–2020 echoes this (DOH 2010a). The Philippines' path would most likely be a combination of both given its historical development of a tax-funded Department of Health (DOH) and a premium-based Philippine Health Insurance Corporation (PhilHealth).

Recognizing that health is both a human and constitutional right and that there is a need to address increasing health inequities and disparities among regions and income groups, the present administration under President Benigno S. Aquino III has committed to achieve universal health care in the Philippines by the end of his term in 2016 (DOH 2010b). The Aquino Health Agenda (AHA) and the DOH's *Kalusugan Pangkalahatan* (KP) both recognize three basic health system problems that have to be addressed: low financial protection for the poor, low access by the poor to quality health services (access to quality health facilities), and difficulties in achieving the Millennium Development Goals by 2015 (DOH 2011).

To address the low financial protection afforded the poor, the AHA called for a revitalized and refocused national health insurance program that would lead to an expansion of coverage by the enrollment of the poorest of the poor with premiums subsidized by the national government, and mandatory enrolment of the informal sector with sharing of premium payments between the informal worker and the local government unit (LGU). The AHA specifically calls for the informal sector to pay PHP100 per month, which PhilHealth plans to raise to PHP200 per month (PhilHealth 2011).

Recent developments in the global experience in SHI have raised the issue of the impact of a contributory SHI for the informal sector on the ability of a developing country to achieve universal coverage rapidly. Contributory means that the informal sector is expected to pay the premium for SHI coverage.

Presuming that the administration will commit the necessary funding for UHC, the question and its derivatives therefore arise: how should the Philippines finance a health care system that can ensure access to quality health care for *all* Filipinos?

The Context

The Philippine Health Financing Situation

The Philippines faces major health financing issues similar to other countries of the WHO Western Pacific Region. They are: chronic underfunding, inequitable sourcing of funding (low public spending leading to high out-of-pocket spending), efficiency issues in terms of allocation of limited financial resources, and payment mechanisms leading to higher health care costs. In addition, there is fragmentation and overlap of the various health financing institutions—DOH, PhilHealth, and LGUs.

Underfunding of the Health System

From 1995 to 2007 the Philippines' total health expenditure (THE) as a nation had ranged from 3.4 to 3.7 percent of gross domestic product (GDP). In 2007, the Philippines spent PHP235 billion or 3.5 percent of GDP on health (figure 1). The black line tracks the Philippines' health expenditure. The grey line tracks what it should have been at 5 percent of GDP.

WHO recommends 5 percent of GDP as public or government health expenditure. Evidence within the Asia Pacific Region, which covers the 37 countries of the WHO Western Pacific Region and the 11 countries of the WHO South-East Asia region, suggests that the percentage of households experiencing catastrophic health expenditures tend to decrease significantly when public health expenditure is greater than 5 percent of GDP (WHO 2009, appendix 1).

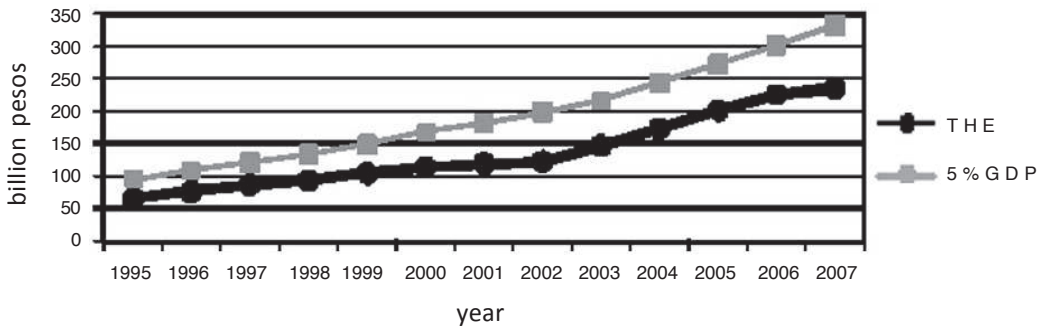

Figure 1. The Philippines' total health expenditure (THE), 1995-2007

Source: National Statistical Coordination Board 2007

Government share (both national and local) of THE had steadily decreased from the year 2000 and was only PHP61 billion, or 26.6 percent, of THE in 2007; Philhealth's share had risen, but at a very slow rate, and had even decreased from 2005 to only PHP20 billion, or 8.5 percent, of THE. As a result, out-of-pocket share had risen to 54.3 percent (PHP127 billion) of THE in 2007 (figure 2).

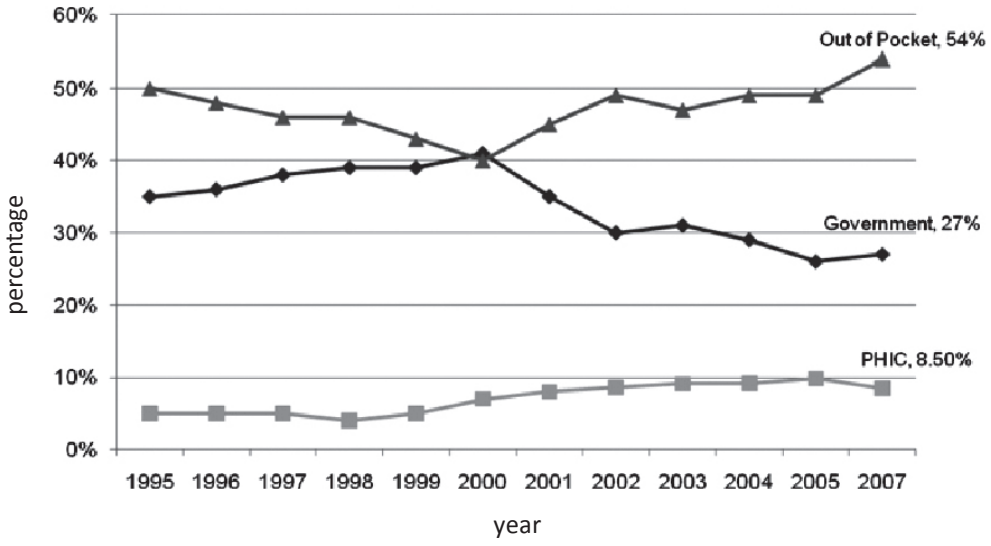

Figure 2. Trends in out of pocket spending versus Philhealth and government share in Total Health Expenditure

Source: National Statistical Coordination Board 2007

Almost half of THE in 2007, or around PHP110 billion out of PHP235 billion, was spent on pharmaceuticals.

The National Statistical Coordination Board (NSCB) has updated the national health accounts for the years 2004-2008 and presented these at the 12th National Forum on Health Research for Action on November 14, 2011 (figure 3). This latest update, however, only covers the years 2004-2008, and hence 2007 figures were used above to show trends from 1995.

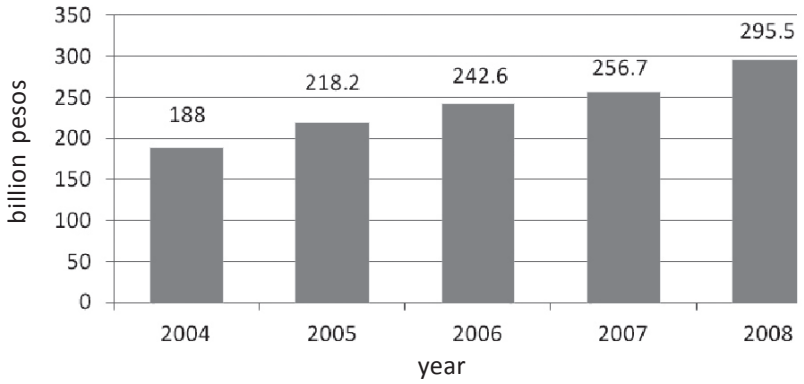

Figure 3. Total Health Expenditure in billion pesos, 2004-2008

Source: Clariño 2011

With the readjusted figures, THE in 2007 was PHP256.7 billion, up from the previous figure of PHP235 billion; THE in 2008 reached PHP295.5 billion. Government share had decreased to 23.7 percent (national government, 13.4 percent and local government, 10.4 perent), and PhilHealth's share decreased to 7.2 percent from 8.2 percent in 2004. Out-of-pocket share had worsened to 57.9 percent in 2008 (table 1).

TABLE 1. Distribution of health expenditure by source of funds

Source of funds	Percent Share				
	2004	2005	2006	2007	2008
Government	**27.1**	**27.8**	**26.1**	**24.8**	**23.7**
National Government	13.0	15.0	13.6	12.7	13.4
Local Government	14.1	12.9	12.6	12.1	10.0
Social Health Insurance (NHIP)	**8.2**	**8.8**	**7.8**	**7.7**	**7.2**
Private Sources	62.2	62.3	64.2	67.0	67.8
Out Of Pocket	**51.9**	**52.9**	**55.1**	**57.6**	**57.9**
HMO	4.5	4.1	4.2	4.6	4.8
Foreign Grants	**2.4**	**1.0**	**1.8**	**0.4**	**1.2**
All sources	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Clariño 2011

WHO regional data suggest that countries with less than 20 percent out-of-pocket health expenditures exhibited a low percentage of households with catastrophic health expenditures. Above 20 percent, the percentage of households experiencing catastrophic health expenditures begins to rise, with the increase becoming significant when the share is greater than 30 percent (WHO 2009, appendix 2).

Allocative Efficiency

As a country, we are not spending enough on public health and primary care. We spend from 73 to 78 percent of our national health expenditure on personal care versus 11 to 14 percent for public health. The Philippine Health Sector Reform Agenda had envisioned that, as government hospitals exercised fiscal autonomy and were allowed to charge user fees and retain income (in large part from Philhealth reimbursements), they would need less and less government subsidies; this in turn would lead to a shift of the DOH budget from hospital subsidy to more funding for public health programs. As can be seen in figure 3, this shift did not happen as the public health expenditure has remained fairly constant at about 11-14 percent of THE. One explanation for this is that both personal care and public health are underfunded given that our THE is significantly below the WHO recommended 5 percent of GDP, so that any increase in one will be absorbed without any resultant shifting of funds.

This pattern of inefficient allocation of limited financial resources is problematic and reflective of Western Pacific regional trends, as the WHO has noted.

> [Eighty percent] of essential care and 70% of desirable health interventions can be delivered at the primary level but an average of only 10% of health resources are used for primary care in Asia… six countries in the Asia Pacific region spent less than 20% on primary health care. The Philippines spent about 11% on public health care. By comparison, in 11 OECD countries, outpatient care costs averaged 28% (WHO, 2009).

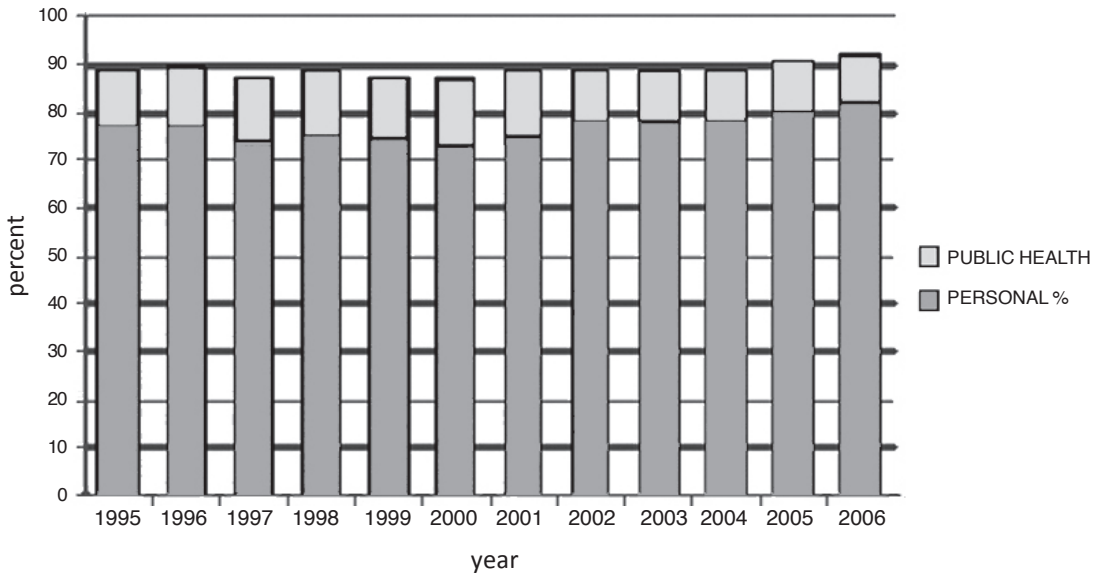

Figure 4. Total health expenditure by use of funds 1995–2006

Source: National Statistical Coordination Board 2007

Payment Mechanisms

A fee-for-service payment mechanism remains the dominant form of reimbursement mechanism of Philhealth, constituting 90 percent of reimbursement for hospital claims (Paterno 2007). In fee-for-service schemes, the more services the provider gives, the more the provider is paid. This has led to overprovision of services and higher cost of health care.

PhilHealth is now in the process of implementing case payments schemes where a fixed negotiated amount will be paid for 23 clinical cases. This will initially cover sponsored beneficiaries in PhilHealth's no balance billing (NBB) program in all government hospitals. The list of cases covered by case payments will gradually be expanded.

Fragmented Health Financing System

Government health spending is fragmented among hundreds of stakeholders: DOH, LGUs (provincial governors and municipal and city mayors), and PhilHealth with different health financing philosophies, mandates, and responsibilities. The

LGUs comprise 81 provinces, 136 cities, and 1,495 municipalities. DOH finances retained hospitals and national health programs. LGUs use their internal revenue allotments to finance their health facilities and services. The provinces finance the provincial and district hospitals. Municipalities are in charge mainly of public health and primary care. PhilHealth pays for services of DOH, LGUs, and private health facilities. There is often an overlap with what PhilHealth reimburses and what the DOH and LGUs provide. The private sector, comprising more than half of service providers and hospitals, have their own largely unregulated fee schedules (Department of Health 2010a).

The Path to Universal Health Care

Carrin et al. (2008) described the path to universal coverage from an initial stage of a health system characterized by the absence of financial protection with a dominance of out-of-pocket expenditures to an intermediate stage of coverage characterized by a mixture of predominantly out-of-pocket payments, community-based health insurance initiatives, and limited social health insurance and tax-based spending to the stage of universal coverage characterized by a predominance of a tax- or social-health-insurance-funded health system, or a combination of both.

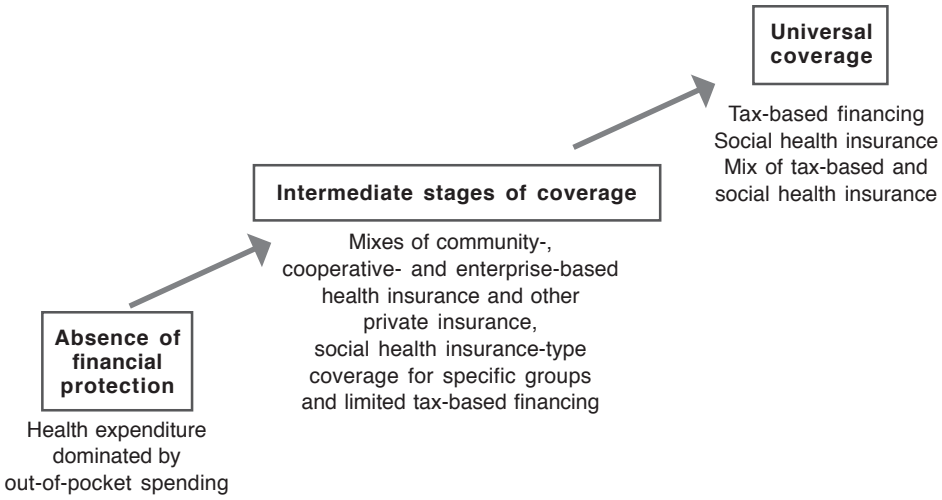

Figure 5. Key health financing options on the path to universal coverage

Source: Carrin and James 2004

Tax-based versus Social Health Insurance Revenue Generation for Financing Universal Health Care

The main advantages of generating revenues for health through taxes, if properly designed and collected, are that the burden of contribution is more progressive and it usually incurs less administrative costs. Coverage is by virtue of citizenship or residence. A tax funded national health service has more direct ways of containing costs. Its major disadvantage is that tax revenues generally go to general appropriations, and the government health agency has to compete with the other government agencies for the appropriate budgetary allocation for health (Normand 2009). This may however be offset by an automatic appropriation for health. If there is an automatic appropriation for debt servicing, then there is a moral and ethical basis for automatic appropriation for health, given that health as a human right is universally accepted.

The major advantages of financing UHC through social health insurance are that SHI can generate additional funds for the health sector and that the funds raised through SHI premiums are earmarked for health. On the other hand, the disadvantage of SHI is higher administrative costs, especially in countries where the employed formal sector is not fully developed and where there is a large informal sector and many indigents. Coverage is dependent on identification, enrollment, and collection of premiums. Historically SHI started in Germany. It took Germany 47 years to achieve 50 percent coverage and another 58 years to achieve 88 percent coverage. This was because of the difficulty of covering the informal sector (Carrin and James 2004).

SHI, because of its nature as an insurance system, pays for personal care. Public health services, which should cover the whole population, are expected to be paid from general taxation revenues. Therefore there would still be a need to generate revenues from taxes to pay for population-based health interventions, such as health promotions, safe water and sanitation, or services that require high or almost universal population coverage, such as immunization.

The major disadvantage of SHI is that premium contributions are less progressive than income tax payments. Formally employed workers bear the burden of financing universal coverage as they are triple taxed in the form of automatically deducted

income tax, automatically deducted SHI premiums as payroll tax, and indirect taxes, such as value added tax.

Another unintended negative effect of SHI is that it might relieve the pressure on the Department of Finance to allot the necessary budget for health, lulled into the belief that SHI (PhilHealth) will be able to generate the necessary revenues for the health sector. It is a given that PhilHealth has always been viewed as having the key role in health financing reforms, notwithstanding its less than 10 percent share in total health expenditure. To quote Wagstaff (2007),

> Embarking down the SHI road is likely to take the pressure off the finance ministry to raise revenues for health. There is a risk that the difficulties of achieving UHI (Universal Health Insurance) through SHI become apparent only after years of trying, by which time the finance ministry will have come to think of the health system as contributory, one not needing tax-financed subsidies (underscoring supplied). By contrast, if the health ministry is engaged with the ministry of finance…it is not inconceivable that a case for extra resources could successfully be made.

Whatever financial route a country takes to achieve universal coverage (through taxes or SHI or a combination of both), the World Health Report 2010 summarizes what countries must do: raise sufficient funds, reduce the reliance on direct payments to finance health services, and improve efficiency and equity.

The Key Role of PhilHealth in Health Financing

Since 2001, the Health Sector Reform Agenda, the National Objectives for Health (NOH) 2005-2010 and Fourmula One, the DOH Health Care Financing Strategy 2010-2020, and now the Aquino Health Agenda have all looked to PhilHealth as having the key role in health financing reform:

- Health care reforms will focus on making the National Health Insurance Program (NHIP) the major payer of health services (HSRA)
- The flagship program of health financing (NOH)
- The lead implementer of health financing reform (Fourmula One)

"Expand coverage, increase benefit payments, include outpatient benefits, use alternative forms of payment mechanisms, improve marketing to increase beneficiary knowledge about PhilHealth benefits, and improve information system"—these are not new but have been the mantra since 2001 and are now being repeated by the Aquino Health Agenda. *Kalusugan Pangkalahatan*, the DOH's program to achieve universal health care, echoes the Aquino Health Agenda.

Inability of PHIC to Achieve its Mandate

There is a consensus among the major stakeholders in health that PhilHealth has acted more as a commercial health insurance rather than a social health insurance, and has failed in its primary mandate to ensure *all* Filipinos of financial access to at least basic health services (Lim 2011).

President Aquino, in his State of the Nation Address last year, already pointed out the major shortcomings of PhilHealth: controversial population coverage, mainly inpatient benefits, low financial risk protection, and low utilization by the poor who need it most. However, he also called for universal PhilHealth coverage in three years.

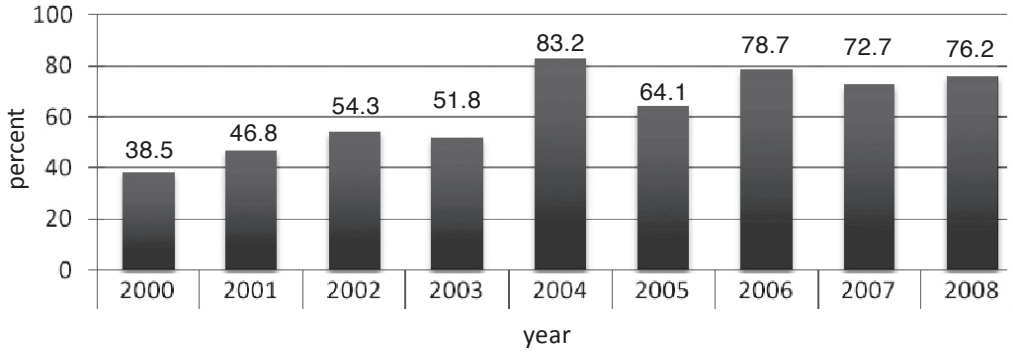

Figure 6. PhilHealth population coverage

Source: Romualdez et al. 2011, 36–43

PhilHealth's coverage has hovered around 50 percent for many years, then dramatically shot up to 83.2 percent of the population in 2004, almost universal by the PhilHealth self-defined universal coverage of 85 percent. The year 2004 was an election year when the administration distributed PhilHealth cards during the

campaign. As most LGUs had not budgeted the premiums associated with these PhilHeath cards, coverage suddenly dropped to 64.1 percent in 2005 (figure 6). For the most part, increases in population coverage depended on national government subsidy for the sponsored program, rising and falling depending on the budget outlay for the sponsored member premiums.

The Need for Universal Health Care Beyond Universal PhilHealth Coverage

Henk Bekedam (2011), in his presentation on behalf of the WHO-Western Pacific Regional Office (WPRO) during the Presidential Forum on Health Financing and Universal Coverage on May 3, 2011, summarized the limitations of PhilHealth coverage. He showed the wide gaps in the three dimensions of coverage: breadth, depth, and height (figure 7).

The breadth of coverage refers to the percent of the population covered. WHO-WPRO is still generous, granting PhilHealth 53 percent population coverage. The National Demographic and Health Survey 2008 gave only a 38 percent population coverage, corroborated by a Social Weather Stations survey done in January 2010.

The depth of coverage is shallow: PhilHealth benefits are mainly inpatient benefits with minimal outpatient benefits. The major stakeholders in health and the Aquino Health Agenda itself urgently call for PhilHealth to roll out comprehensive benefits to include outpatient benefits, including medicines.

The height of coverage or financial protection remains low, with PhilHealth reimbursement levels at 40-50 percent of hospitalization costs. This low level is also being eroded by out of hospital purchases which are not reimbursed by PhilHealth (Quality Improvement Demonstration Studies 2006).

We would like to add a fourth dimension: utilization by the poor. As can be seen from figure 6, utilization by the poor is low.

PhilHealth coverage must be viewed in these four dimensions. When PhilHealth coverage covers *all* Filipinos, provides comprehensive inpatient and outpatient benefits, including outpatient medicines, gives financial protection up to 70 percent of hospitalization costs, applies no balance billing, and is utilized by the poor, only then will PhilHealth universal coverage be equivalent to universal health care.

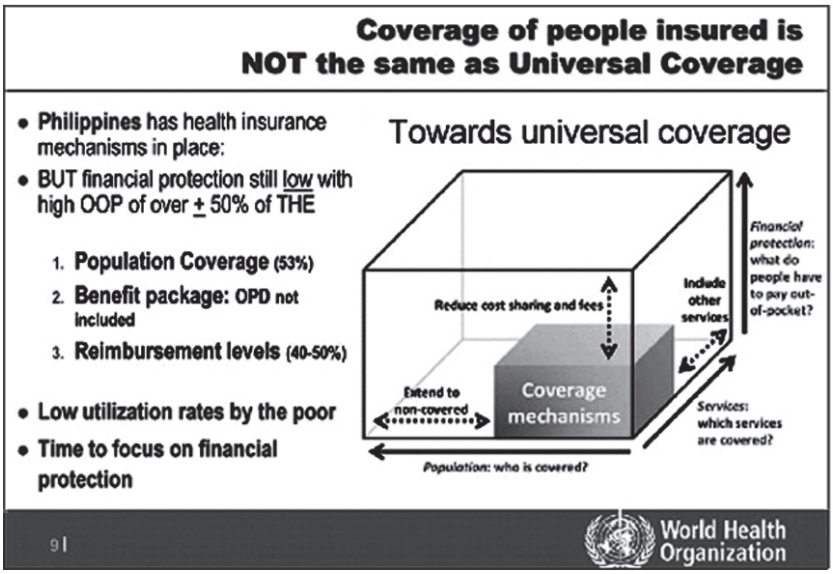

Figure 7. The three dimensions of coverage

Source: Bekedam 2011

The Social Determinants of Health and the Health Systems Approach to UHC

Increasing financial resources for health is necessary but not sufficient to achieve universal health care. Reforms must address the whole health system, including the other five building blocks of the health system: health governance with an overarching philosophy of addressing health inequities, health information to provide evidence for health governance, health regulation, organization of health services, and the production of competent and motivated health human resources to provide the needed quality health services.

The social determinants approach to health, on the other hand, stipulates that health systems improvement only accounts for some 30 percent of improvement in health status, while socio-economic development would account for the 70 percent of the improvement in health status (McKinlay and McKinlay 1987; McKeown 1975). Universal health care will not succeed if the country does not implement a national development plan that leads to inclusive growth.

Financing UHC

How Much Will UHC Cost?

Three methodologies are used to calculate the cost of universal health care, based on: a) WHO's recommended 5 percent of GDP, b) capitation calculations using the cost per capita of the essential health package, and c) projection using the revised 2008 National Health Accounts THE figures.

Based on Percentage of GDP

One way of estimating the cost of UHC would be to calculate it based on the WHO recommendation of 5 percent of GDP. Table 2 shows how much UHC would cost if total health expenditure would reach 5 percent of GDP by 2015.

TABLE 2. Target Scenarios for increasing Total Health Expenditure to 5% GDP by 2015

	Year			
	2007	**2011**	**2013**	**2015**
GDP* in current price (billions of pesos)	6,647	9,018	10,549	12,341
THE as percent of GDP	3.5%	4%	4.5%	5%
THE in billions of pesos	235	361	475	617

* Projected GDP taken from IMF World Economic Outlook Database April 2010

Another way would be to estimate how much outpatient and inpatient services would cost per capita and come out with an amount that must be raised either by PhilHealth premiums or general taxes.

Based on the Essential Health Package Proposal

There is a proposal for an essential health package (EHP) for the Philippines drafted by a multidisciplinary group headed by Dr. Jaime Z. Galvez-Tan (2010) and supported by the WHO country office. It has been submitted to the DOH.

The proposed EHP is based on a working inter-local health zone (ILHZ) consisting of a district hospital with four to five cooperating municipal health centers. Under a devolved set up, the municipal health centers are independent of the district hospital, which is organizationally under the authority of the province. The ILHZ was proposed by the DOH as a voluntary coming and working together of the district hospital and four to five cooperating municipal health centers.

The EHP builds on what is currently being provided by our municipal and city health centers, namely: maternal health and reproductive health services, Integrated Management of Childhood Illnesses (IMCI) including immunization and nutrition programs, prevention and treatment of common infectious disease, and prevention and treatment of non-communicable diseases (with very limited medicines). In addition, the EHP proposed to include the following: oral health, community mental health, emergency care, necessary diagnostic laboratory exams up to the district hospital level, and the provision of essential drugs for both communicable and non-communicable diseases. What is different with this EHP proposal is that the cost was estimated based on an ILHZ model serving a catchment population of 200,000.

Starting with an actual ILHZ, the cost was computed for the existing personnel and infrastructure, then adjusted for the projected number of contacts based on the proposed EHP using international utilization rates and time needed per contact. Providing EHP was then estimated to cost PHP1,382 per person, and this included personnel, drugs, maintenance and other operating expenses (MOOE), and capital investment for facility enhancement. This per capita cost covered the above costs for the five participating municipalities and the district hospital.

For 2012, the total cost for the country would be population multiplied by the capitation figure, that is, 97.6 million Filipinos times PHP1,382 equals PHP135 billion for outpatient services from the barangay health stations to the level of a district hospital (population figure from the Commission on Population as cited in Crisostomo 2012). For 2015, with a projected population of 103 million, EHP would cost at least PHP142 billion.

TABLE 3. Total and per capita costs of the Essential Health Package

Cost component	Municipality	All Munic.	District Hosp.	Total ILHZ	%
Personnel	7,596,155	37,980,777	15,444,043	53,424,820	19
Drugs	31,514,123	157,570,613	27,806,579	183,377,192	67
Other MOOE 10%	3,911,028	19,555,139	4,325,062	23,880,201	9
Investment	1,790,480	8,952,400	4,789,576	13,741,976	5
Total	44,811,786	224,058,929	52,365,260	276,424,188	100
Per head	1,120	1,120	262	**1,382**	

Source: Modol 2010

Interestingly, drugs make up 67 percent of the cost, and 56 percent of the cost of drugs were for treating non-communicable diseases, mainly hypertension and diabetes. Providing vaccines would only make up 1 percent of the drug component costs; treating infectious diseases would make up 1 percent, and treating mental patients another 1 percent, as shown in table 4.

TABLE 4. Cost of drugs of the essential health package

Drug Component	Cost	%
Basic meds	40,109,000	25%
Complementary meds	24,984,400	15%
Non-communicable disease meds	90,181,511	56%
Psychiatric meds	2,370,000	1%
Infectious disease meds	1,519,215	1%
Vaccines	2,033,432	1%
Sub-total	**161,197,558**	**100%**
15% for others and lab supplies	24,179,634	
TOTAL	**185,377,192**	

Source: Modol 2010

The National Health Accounts do not disaggregate the health expenditure for hospitals from the provincial level up to the regional and national hospitals. However, Dr. Alvin Caballes (2009), who was involved with the DOH monograph, "An Appraisal of the Policy Environment for Philippine Hospital Sector Development," estimates hospital expenditure to be about 34 percent of THE. If we take the projected GDP for 2012 at PHP9.75 trillion, THE would amount to PHP390 billion and 34 percent of this equals PHP132 billion for hospital expenditures. We would therefore need at least PHP135 billion to cover basic health services at the ILHZ and PHP132 billion for hospital services from the provincial level up, or a total of PHP267 billion as THE for 2012.

The minimum amount of PHP267 billion is needed for 2012 for universal health care financed and delivered through the public health care delivery system. For 2015 it would be at least PHP282 billion. Costs would be higher because services are also delivered through the large private health sector.

The revised National Health Accounts of 2008 gave a THE of PHP295 billion. From 2004 to 2008, the annual growth rate of THE was 12 percent. Given this growth rate, THE in 2012 may go as high as PHP465 billion and PHP653 billion by 2015. Five percent of the 2015 projected GDP equals PHP617 billion.

Options for UHC Financing Schemes in the Philippines

Option A: UHC with Contributory Premiums for the Informal Sector or the Near Poor

This is the option taken by the DOH as expressed through its main health agenda, *Kalusugan Pangkalahatan* (KP). The KP road map sets the launch phase to reach the end of 2011, the scale-up phase to be from 2012 to 2013, and the sustainability phase to go from 2014 to 2016.

Financial protection will be increased through a refocused and revitalized PhilHealth. PhilHealth's strategic directions for 2011–2016 describes how financial protection will be increased through reforms in provider payment mechanisms, benefit design, and provider accreditation.

Expanded Population Coverage

The KP targets the sustained enrolment of 15 million families. The national household targeting system would identify 5.3 million families belonging to the lowest quintile income group, and their premiums would be subsidized by the national government, with improved benefits for the PhilHealth sponsored program. A total of 2,552 government health facilities in areas where most of the poor are found would be upgraded. Implementation of focused public health services would be scaled up starting in identified 12 priority areas (Bayugo 2012).

Enrolment of the informal sector will be compulsory. A mechanism for this is to require proof of PhilHealth membership for any government transaction, including business permits, licenses, etc. The informal sector will be segmented into informal sector professionals and informal sector non-professionals. Informal sector professionals will have to pay premiums based on their income, which can be based on their income tax returns (ITRs). The premium of the non-professional segment will be jointly paid by both the informal workers and by their respective local government units.

Comprehensiveness of Benefits

PhilHealth will roll out its outpatient benefits to cover medicines, including those for hypertension, diabetes, and asthma. The DOH has a similar program with treatment packs for hypertension and diabetes using PHP500 million from the National Planning and Policy Division (NPPD) budget (Ona 2011).

Increase in Philhealth Premium Rates

PhilHealth will increase its premiums, and therefore its premium collections. It will triple its benefit payments by 2015.

In the recently concluded National Academy of Science and Technology roundtable discussion (RTD) on updates on universal health care held last February 21, 2012, Dr. Robert So presented the projections for PhilHealth benefit payments (table 4). Premium collection by PhilHealth is projected to increase to PHP50

billion in 2012, steadily rising to PHP79 billion by 2015, with total revenues generated for the health sector at PHP110 billion (total revenues equals premium collections plus PHP3 billion from investment income and another PHP28 billion from its PHP107 billion reserve fund). Benefit payments were only PHP34 billion in 2011, and this sum is projected to increase to PHP103 billion by 2015.

TABLE 5. Projection of PhilHealth benefit payments, in billions of pesos

	2012	2013	2014	2015	Total
Benefit Payments	**58**	**77**	**92**	**103**	**330**
Inpatient + Ambulatory + MDG	51	65	74	81	271
Paid by Case Rates and Fee-for-service	*46*	*55*	*64*	*71*	*236*
Paid by Global Budget (Access benefits > Support to health facility enhancement)	*5*	*10*	*10*	*10*	*35*
Case type Y/Z (Catastrophic)	3	3	4	4	14
Primary Care	4	9	14	18	45
Benefit Implementation Expenses	*4*	*5*	*7*	*7*	*23*
Financing Sources					
Premium Collections	50	67	76	79	272
Investment Income	6	5	5	3	19
Charge from Reserve Fund	6	10	18	28	62
Reserve fund	*101*	*91*	*73*	*45*	

Source: So 2012

Premise: There is Limited Fiscal Space

The DOH health care financing strategy 2010–2020 monograph (2010a) asserts that "the small share of total government spending relative to GDP, approximately 19.0 % in 2009, shows the limitation of mobilizing additional resources out of tax-based money." However, the present government allocation for health (estimated

at 5.5 percent) is far from its potential. Without Pakistan, India, and Myanmar, the regional average would be 8.5 percent.

Granting PhilHealth's success in raising the necessary revenues (PHP110 billion) and its paying out PHP103 billion by 2015, this would represent only 20.9 percent of THE of PHP493 billion computed at 4 percent of the projected GDP of PHP12.3 trillion (Note: we are not even using the WHO recommended 5 percent of GDP). PhilHealth's 20.9 percent of THE plus the target 20 percent out-of-pocket share would mean government must make up the shortfall of 59 percent of THE. This in effect means that we would still have a predominantly tax-funded universal health care system, given a contributory option.

Possible Outcomes

Adam Wagstaff (2007), in a World Bank Policy Research Working Paper, asserted that it is an opportune time to "reexamine the merits of SHI as a health financing mechanism," in the light of the fact that many developing countries are attempting to achieve universal coverage through SHI "when three of the oldest SHI countries—France, Germany and the Netherlands—are in the process of reducing their reliance on payroll contributions."

Carrin and James (2004) point out the experience of Germany, which took 47 years to cover 50 percent of the population and another 58 years to raise coverage from 50 to 88 percent of the population.

For developing countries like the Philippines, Wagstaff points out two major problems: exclusion of the true poor and inclusion of the non-poor for SHI coverage of the poor; and the high administrative costs of collecting revenues from the informal sector. To quote Wagstaff (2007): "Suffice to say for now that the task is a huge one, that the revenues raised are rarely those that would be expected on the basis of contribution rules, and the collection costs are formidable." In the 2006 International Conference on the Informal Sector organized by PhilHealth, Wagstaff stated that traditionally, the health system spends US$1 to collect US$1.50 from the informal sector and suggested it might be more cost efficient just to subsidize the premiums of the informal sector.

A review of Commission on Audit's (COA) annual audit reports on PhilHealth from 2006 to 2009 gave interesting results. In 2009 PhilHealth's total revenues were PHP34 billion. From 2006 to 2009, premiums made up an average of 81.5 percent of PhilHealth's revenues and interest from investments contributed 18.1 percent. A large share of premiums, 87.3 percent, were paid for by the members, with only 12.7 percent subsidized by government for the sponsored members. The informal sector only contributed an average of 4.5 percent of total premiums. In 2009 the informal sector paid PHP1.4 billion (5.2 percent) out of the total PHP27.5 billion premiums collected.

PhilHealth is allowed by law to spend 12 percent of contributions and 3 percent of investment earnings for administrative expenses. In 2008 PhilHealth spent PHP3.2 billion for administrative expenses, or 12 percent of the PHP26.8 billion premium collection (COA 2010).

John Langenbrunner (2012), in his presentation at the Health Financing Matters Conference at Mahidol, Thailand in January 2012, stated that for developing countries, there is a long road to universal coverage.

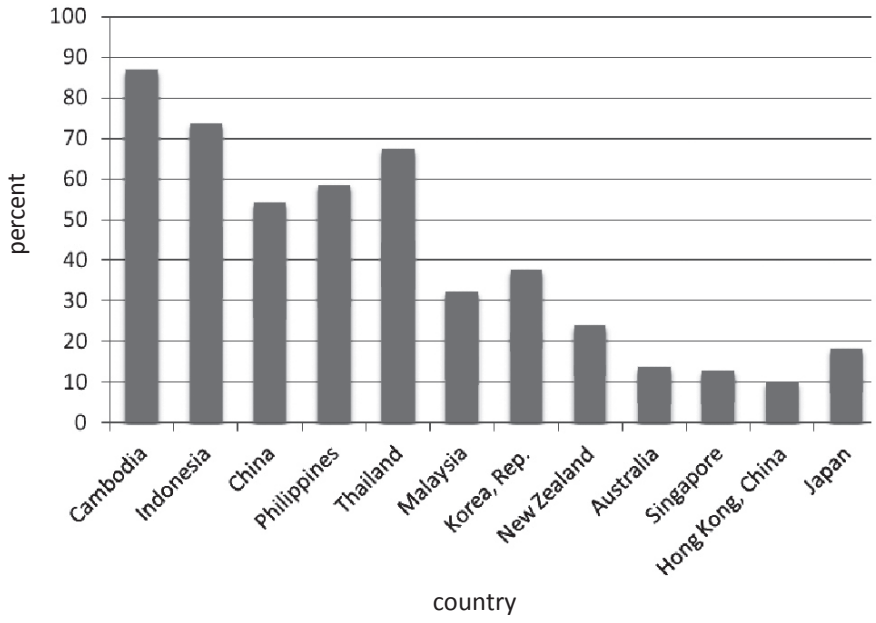

Figure 8. Informal Sector as a percentage of total employment in East Asian and Pacific

Source: Langenbrunner and Somanathan cited in Langenbrunner 2012

Figure 8 shows that 60 percent of the work force in the Philippines is made up of the informal sector, defined as self-employed, in both the agricultural and non-agricultural work force.

Developing countries with a large informal sector and that opt for a contributory model for the informal sector often get stuck in their level of population coverage (figure 9). This has been the experience of the Philippines with PhilHealth population coverage.

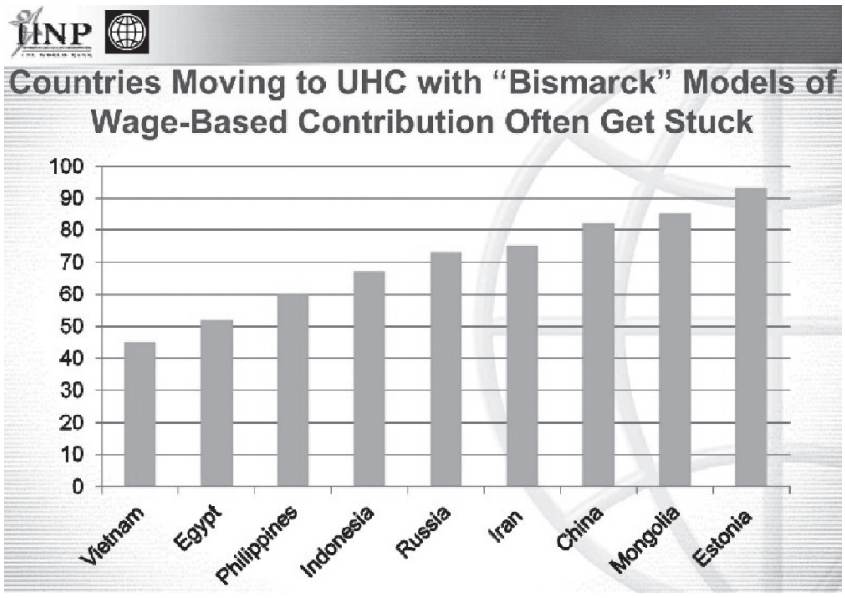

Figure 9. Presentation slide showing percentage of coverage in countries moving to UHC with Bismarck models of wage-based contribution

Source: Langenbrunner 2012

Figure 10 shows the share of GDP from industry steadily decreasing for the Philippines. Therefore, in the foreseeable future, the informal sector will most likely increase rather than decrease, making enrolment of the informal sector and thus universal coverage increasingly difficult.

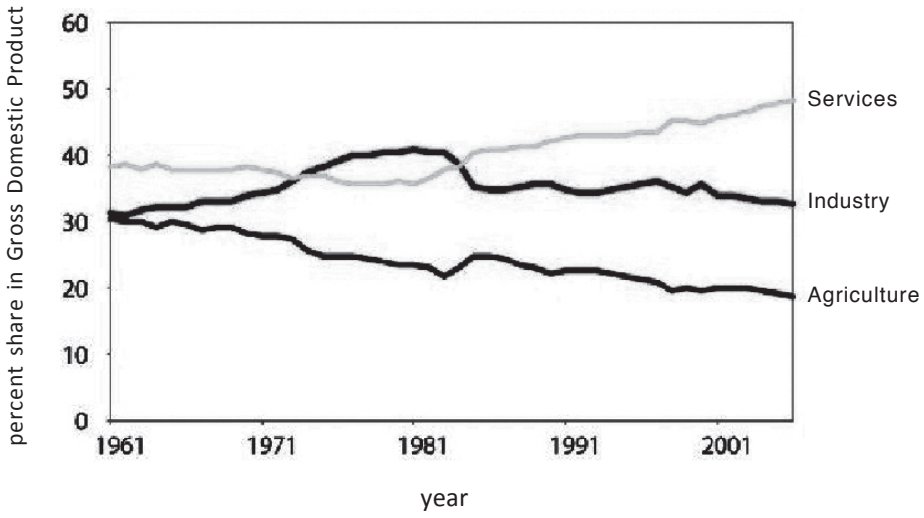

Figure 10: Decreasing industry sector share in GDP

Source: Asian Development Bank 2007

Lessons from Malaysia

In a symposium held in Malaysia in October 2011, the issue of whether to introduce social health insurance in Malaysia was intensely debated. Malaysia is slightly larger in land area compared to the Philippines but has a population of only 27.5 million compared to the Philippines' 97.6 million. The economy of Malaysia, on the other hand, is almost twice that of the Philippines in terms of GDP. Malaysia has achieved a higher level of industrialization than the Philippines, and its informal sector is estimated to be only 14.2 percent of the workforce compared to 50-60 percent for the Philippines (ADB 2011). Malaysia inherited a tax-financed national health service from its British colonizers when it gained independence in 1957. One of the most remarkable features of the Malaysian health care system is its ability to achieve good health indices in spite of a relatively low health budget. Malaysia's under-five mortality of 6.0 per 1000 in 2009 is at par with many high-income countries. Yet, Malaysia has a 40 percent out-of-pocket share. A reason for this might be the growing private sector in health, which Malaysia strengthened in the 1980s as a state policy. Presently Malaysia's health care system is two-tiered,

with a public health care system catering to the needs of those who cannot afford private health care, and private health care catering to those who can afford it (Quek 2009; Barraclough 1997).

In the symposium, the Ministry of Health proposed the introduction of social health insurance to ensure financial sustainability in the face of rising health care costs and an ageing population. Those who were opposed to the proposal argued that with a relatively low health budget, the Malaysian health system has been able to achieve health indices comparable with the more developed countries. If ever there were a Southeast Asian country in which SHI might be an appropriate mechanism for financing universal health care, it should be Malaysia because of its more developed industries and a resultant larger formal sector and a smaller informal sector. Yet, Malaysians are still debating about it.

Option B: UHC Financed with a Greater Share of Rax Revenues versus PhilHealth Premium Revenues, with a Non-contributory Scheme for the Poor (Sponsored Program) and the Informal Sector (Individually Paying Program).

Premise: There is Fiscal Space

According to the WPRO Health Financing Strategy 2010–2015,

> Regional data suggest that with the exception of some Pacific island countries, tax revenues in the Asia Pacific region—13.2% of GDP, with total government revenues at 16.6% of GDP—are the lowest of any region in the world. This suggests that there is room to raise revenues to finance a higher level of [health] spending as percentage of GDP, especially in countries experiencing economic growth (WHO 2009).

The present tax collection rate of the Philippines is 14 percent of GDP. Historically, the Philippines was able to achieve a peak tax collection rate of 17 percent of GDP in 1997 under the administration of President Fidel Ramos (Diokno 2008).

According to former Department of Budget and Management Secretary Benjamin Diokno (2008), "While the 1986 tax reform program contributed significantly to fiscal improvements in the late 1980s and early 1990s, the 1997

Comprehensive Tax Reform Program (CTRP) was a major contributor for the progressive decline in tax effort. Tax effort increased from 10.7% in 1986 to 15.4% in 1992, then peaked at 17.0% in 1997." Tax effort is defined as tax collection rate as percent of GDP.

The 1997 CTRP had the effect of reducing corporate income tax to 32 percent from 34 percent, reducing the VAT base, and shifting from ad valorem to specific taxes for downstream oil industry and "sin" products (cigarettes and liquor). Measures to rationalize fiscal incentives were not passed, while nine tax laws granting more incentives and raising exemptions were passed. As a result, tax effort declined from a peak of 17 percent of GDP before the 1997 CTRP to 12.5 percent in recent years.

Professor Leonor Briones, former Philippine Treasurer, asserted that the Philippines can create fiscal space through: more efficient collection of existing taxes, plugging of unnecessary tax holidays, and correcting erroneous prioritizaton of government spending. Other sources of revenues would be sin taxes, documentary tax, tax on the Philippine Charity Sweepstakes Office (PCSO), tax on the Philippine Amusement and Gaming Corporation (PAGCOR), and road users' tax. What is crucial, she said, would be political will (Briones 2011).

Undersecretary for Finance Gil Beltran (2011) echoed the same sentiment: "We have the personnel and the capacity. There is no reason why we cannot achieve a tax collection rate of 17% (of GDP) again."

With political will and the proper tax reforms, we can again achieve the 17 percent of GDP tax collection rate. The 3 percent of GDP additional revenues for the Philippines would mean about PHP300 billion, more than enough to finance universal health care and decrease out-of-pocket spending to 20 percent of THE. PhilHealth's reserve fund of more than PHP100 billion is another source of funding that can be used to prime universal health care without initially increasing PhilHealth premiums or taxes. Fifty billion pesos of this could be used to provide comprehensive benefits for the sponsored members, that they would feel, and which would later justify increasing taxes or PhilHealth premiums (Paterno 2010).

Lessons from Thailand: Achieving Universal Health Care Rapidly

In a Council on Foreign Relations roundtable (de Ferranti, Hsiao, and Huang 2012), William Hsiao said to look at Thailand if we want to see how the new SHI works. Thailand provides us lessons on the path to achieving universal health care. In 2002 Thailand had several schemes to cover different segments of its population. The Civil Servant Medical Benefit Scheme (CSMBS) covered government employees and retirees and their dependents. It was non-contributory (no premiums) but financed from general taxes. The social health insurance covered private sector employees but not their dependents. It was financed from a tripartite payroll tax, with contributions from employees, employers, and the national government.

A Tax-funded, Non-contributory Universal Coverage Scheme

To achieve universal coverage, Thailand implemented a universal coverage scheme, called 30 Baht Scheme at that time. It covered the rest of the population (74 percent), was non-contributory, and was financed from general taxes (table 6).

TABLE 6. Health insurance schemes when universal coverage was achieved, early 2002

Scheme	Target Population	Coverage	Source of fund	Payment method
Civil Servant Medical Benefit Scheme *Since 1963*	Government employee, retiree and dependents	6 million, 10%	General tax, non-contributory	Fee for service reimbursement model
Social Health Insurance *Since 1990*	Private sector employee	8 million, 13%	Payroll tax tripartite contribution	Capitation inclusive OP, IP
UC Scheme *Since 2002*	Rest of population	47 million, 74%	General tax, non-contributory	Capitation OP and P&P, global budget and DRG for IP

Source: Tangcharoensathien et al. 2007

Answering the question, why promote a general-tax-financed universal care scheme?, the authors argued that,

> Financing UC scheme by general tax revenue was a pragmatic decision, as it is technically not feasible to achieve Universal Coverage rapidly with the application of the contributory scheme. Thai Rak Thai (Thailand's political party that implemented the UC scheme) needs (sic) to scale up UC immediately, as part of the social obligations during the election campaigns. The UC members, largely engaged in agricultural informal sector do not have regular cash income, for annual premium payment. Premium collection is difficult, enforcement of contribution by members are not possible (Tangcharoensathien et al. 2007).

Adam Wagstaff (2007) added:

> Collection costs in the SHI systems…are nontrivial; and, of course, given that taxes have to be collected for other purposes anyway, and there are economies of scale in tax collection, the collection costs associated with SHI could probably by and large be avoided together if health care were financed out of general revenues.

Langenbrunner (2012) showed the contrasting experiences of developing countries on the long road to achieving universal coverage. In figure 11, he noted the rapid increase in Thailand's population coverage from 2002 when Thailand implemented its universal coverage scheme for the rest of the population outside of the formal sector. Note in contrast the slow increase of the Philippines in population coverage from 1995 when PhilHealth began.

From table 7, we can see that only Thailand has achieved an out-of-pocket share of less than 20 percent (19.2 percent) as a proportion of total health expenditures. The 20 percent out-of-pocket share is what we should target for universal health care in the Philippines. Evidence from the Asia Pacific region suggests that countries with higher than 30 percent out-of-pocket expenditures had a higher percentage of households experiencing catastrophic health expenditures and consequent impoverishment (WHO 2009). Indonesia is at 30.1 percent, and the rest (Malaysia, Philippines, Vietnam, Laos, and Cambodia) have out-of-pocket shares greater than 40 percent, with the Philippines at 54.7 percent.

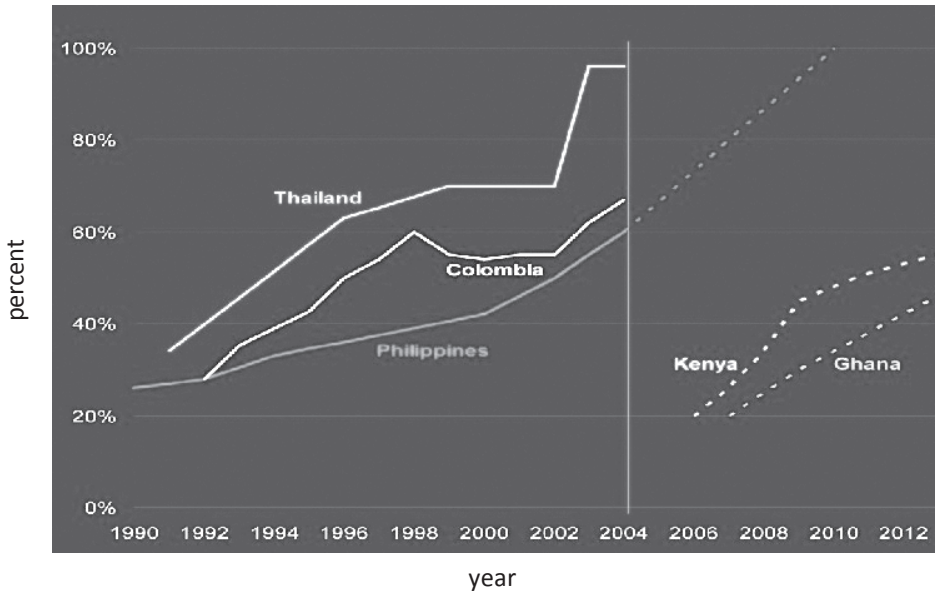

Figure 11. Coverage rate trends in selected countries

Source: Langenbrunner 2012

SHI shares in these countries hover at 7-8 percent, with Vietnam having the highest at 12.7 percent. Even for lower middle income countries, SHI share is only at 15.8 percent of THE. The figures for GGHE (General Government Health Expenditure) as a percentage of THE demonstrate where Thailand is different. GGHE for Thailand is the highest at 73.2 percent, and this comes from taxes. The next highest is Indonesia with 54.5 percent and Malaysia 44.4 percent, with the Philippines at 34.7 percent.

Note also in table 7 that even for upper middle income countries, the average share of SHI is 21.0 percent of total health expenditure, while that for a lower middle income country is 15.8 percent. The projected benefit payments of PhilHealth, 20.1 percent of THE, approximates the average of an upper middle income country. Assuming that PhilHealth will be able to achieve this target, from its 7.2 percent share in 2008, we would still have a shortfall of 60 percent of THE if we want out-of-pocket share to decrease to 20 percent, or a 50 percent shortfall if we accept an out-of-pocket share of 30 percent of THE. This 50-60 percent shortfall must then come from tax revenues if we are really committed to universal health care.

TABLE 7. Key health financing indicators in seven countries in Southeast Asia in 2007

	THE (% GDP)	GGHE (%THE)*	Private health expenditure (% of THE)*	GGHE (% government expenditure	External (% of THE)	SHI (%THE)	Out-of-pocket (%THE)	THE (per capita US$)	THE (per capita PPP int$)
Malaysia	4.4	44.4	55.6	6.9	0.0	0.4	40.7	307.2	604.4
Thailand	**3.7**	**73.2**	26.8	13.1	0.3	**7.1**	**19.2**	136.5	285.7
Philippines	**3.9**	**34.7**	65.3	6.7	1.3	**7.7**	**54.7**	62.6	130.2
Indonesia	2.2	54.5	45.5	6.2	1.7	8.7	30.1	41.8	81.0
Vietnam	7.1	39.3	60.7	8.7	1.6	12.7	54.8	58.3	182.7
Laos	4.0	18.9	81.1	3.7	14.5	2.3	61.7	26.9	83.9
Cambodia	5.9	29.0	71.0	11.2	16.4	0.0	60.1	36.8	108.1
Low income	5.3	41.9	58.1	8.7	17.5	4.6	48.3	26.8	67.0
Lower middle income	4.3	42.4	57.6	7.9	1.0	15.8	52.1	80.2	181.0
Upper middle income	6.4	55.2	44.8	9.4	0.2	**21.0**	30.9	487.9	757.0
High income	11.2	61.3	38.7	17.2	0.0	25.6	14.0	4405.2	4145.0
Global	9.7	59.6	40.4	15.4	0.2	24.6	17.7	802.3	862.5

Source: World Health Statistics 2010 cited in Tangcharoensathien 2011

Option C: Shift to a tax-funded National Health Service System

This option will not be considered at this time as it is not within the present policy choices.

Summary

Recognizing that health is a right, and to address increasing health inequities among regions and population groups, the present Aquino administration has committed to achieve universal health care by 2015. This paper examines two policy options for financing the achievement of universal health care by 2015.

The first option is the current policy in which PhilHealth is viewed as the key to health financing reforms because of government's limited fiscal space. Population coverage will be mandatory, with the sponsored members, identified by the National Household Targeting system, and their premiums subsidized by taxes from national government. The informal sector is expected to contribute to the premiums of the

individually paying program, with partial subsidies from the LGUs. The large size of the informal sector, the administrative costs involved in identifying, enrolling, and collecting from them will most likely lead to a stagnant population coverage of 80 percent at most by 2015, with PhilHealth share of total health expenditure at 20 percent at best.

To achieve UHC rapidly, we propose the second option where the premiums of the non-professional segment of the informal sector will be non-contributory or subsidized by taxes. The premiums of the sponsored members will still be subsidized by national government. Coverage for the rest of the population outside of the formal sector will be by virtue of citizenship. In this manner, we can achieve universal population coverage rapidly.

The large number of the unorganized informal sector members and their irregular income make their identification and the collection of premiums difficult. Premiums from the individually paying program presently make up about 5 percent of PhilHealth's premium collections and PhilHealth has high administrative costs. If we want to decrease out-of-pocket expenditures to 20 or 30 percent of THE as protection against impoverishment from catastrophic health expenditures, government's share, both national and local, must increase to 50–60 percent of total health expenditures because PhilHealth's share would reach only 20 percent at best, based on the experience of middle income countries.

1. Costs for universal health care in 2015 would range from PHP615 billion at 5 percent of projected GDP, to a high of PHP653 billion based on the NHA 2008 total health expenditures computed at 12 percent annual growth rate. The minimum amount of PHP282 billion would be needed for 2015 for universal health care financed and delivered through the public health care delivery system. Costs would be higher because services are also delivered through the large private health sector.
2. With political will, we can raise the revenues for UHC. With the appropriate tax reforms and increased collection efficiency, we can increase the tax collection rate from its present 14 percent of GDP to 17 percent. The 3 percent differential would mean an additional PHP300 to PHP400 billion in revenues, more than enough to finance UHC and reduce out-of-pocket share to about 20 percent of total health expenditures.

3. Government, both national and local, must spend for 50-60 percent of THE, while PhilHealth pays for 20 percent of THE so that we can bring down the out-of-pocket share to 30 percent or even to 20 percent.
4. The premiums of the non-professional informal sector should be subsidized by government if we want to achieve universal health care rapidly.
5. Increasing government and PhilHealth spending in health is necessary to finance the achievement of universal health care rapidly. It is however not sufficient to decrease health inequities rooted in social inequities (Alma Ata PHC). It is crucial to have socio-economic development that will lead to inclusive growth for UHC to lessen health inequities and improve health outcomes.

• • • • • • • • • • • •

Postscript

How Do We Finance Universal Health Care in the Philippines? An Update.*

The Philippine Statistical Authority has released the 2012 National Health Accounts (NHA). The major results validate the projections and conclusions of our original paper.

After two and a half years of *Kalusugan Pangkalahatan (KP)* implementation, out-of-pocket share of total health expenditures (THE) has barely decreased from 57.7 percent in 2011 to 57.6 percent in 2012, social health insurance has increased, but barely, from 9.4 percent to 11.1 percent. Most alarming is that government share, both national and local, has decreased.

Total health expenditures showed the same annual increase of 12 percent as noted previously by the National Statistical Coordination Board (NSCB) for the National Health Accounts (NHA) 2008 - 2011. NSCB has adjusted the NHA 2011 values with the release of the NHA 2012. Historical data for THE are shown in figure 1.

* The author would like to acknowledge the research assistance furnished by Marlene Rillera Bermejo, MD and Ria Verdolaga, MD.

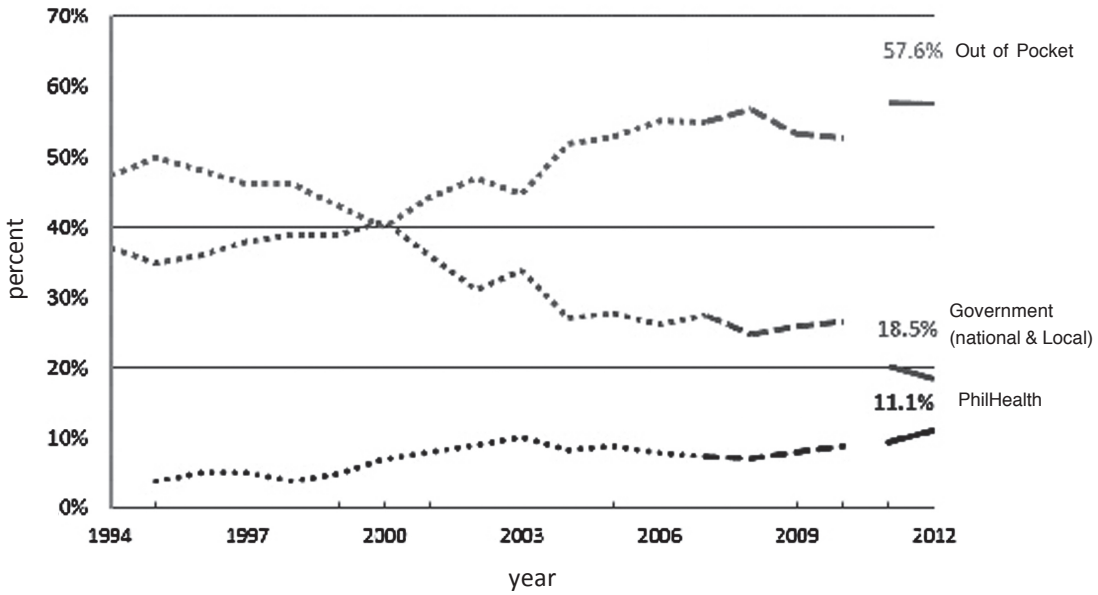

Figure 1. The distribution of the shares of total health expenditures, 1994 – 2012. Data for 1993-2007 (dotted line) are from Herrera, Roman, and Alarilla (2010), and Racelis et al. (2006), for 2007-2011 (dashed line) from the Philippine National Health Accounts (National Statistical Coordination Board 2013), and for 2011-2012 (solid line) from Philippine National Health Accounts 2012 (National Statistical Coordination Board 2014).

In our original paper, we projected that THE would be about PHP464 billion in 2012 and PHP652 billion by 2015, based on an annual growth rate of 12 percent as noted by NSCB for 2004 to 2008. Actual THE for 2012 was PHP467.8 billion (National Statistical Coordination Board 2012).

We also said that PhilHealth's share of THE, projected to increase to PHP105 billion, would most likely increase to only 15 percent (20 percent would be optimistic) by 2015, and that for the Philippines to bring down the out-of-pocket share to 20-30 percent, the government share must increase to 45-55 percent of THE. For 2015 this would mean about PHP293 to PHP359 billion.

PhilHealth will not be able to generate the needed revenues for *Kalusugan Pangkalahatan* if its major source of revenues will be from contributory premiums because of the low paying capacity of the potential members of PhilHealth. If we want to continue with the social health insurance model to finance *KP*, the premiums for the poor (as identified by the Department of Social Welfare and Development's

National Household Targeting System) and the informal sector will have to be more and more subsidized from taxes (national and local government share). PhilHealth should advance from mere population coverage to ensuring a deep comprehensive benefit.

In 2010, we asserted that government can create fiscal space by achieving a tax effort (tax rate as percentage of GDP) of 17 percent instead of its 14 percent tax effort then. An article by Zinnia Dela Peña (*Philippine Star,* September 9, 2013) echoed this assertion:

> The country's tax effort or total tax revenues as a percentage of gross domestic product (GDP) rose to 13.58 percent in the first half of the year… It (the government) aims to increase this further to around 16 to 18 percent by the end of President Aquino's term in 2016… Finance Secretary Cesar Purisima said the BIR's tax take must hit at least PHP2 trillion by 2016 if it wants to achieve its 18 percent tax effort goal.

William Hsiao (2012), professor of Economics, Harvard School of Public Health, points to our future direction:

> I will suggest actually something that's not on the table for a long time but is in the academic world, and that is to say you really develop a new kind of social health insurance; new kind, not the German model. The German model is you develop social insurance for those who are in the formal sector, whom you can collect the premium easily through their employment. I would argue the new model of social insurance is that you do impose the social health insurance, you ask these formally employed people [to] pay, but you use general revenue taxes (to) subsidize the premium for the poor people and near poor. That's also social health insurance.
>
> Now, if you want to see how that works, look at Thailand, look at China…

Insisting on a contributory, premium-based social health insurance model may have unduly delayed our achieving universal health care. It is time to seriously review our health care financing strategy to achieve universal health care.

References

Asian Development Bank. 2007. *Country diagnostics studies: Philippines: Critical development constraints*. Mandaluyong City: Asian Development Bank. http://www.adb.org/documents/books/philippines-critical-dev- constraints/critical-dev-constraints.pdf.

_____. 2011. Malaysia fact sheet. August. http://www.adb.org/Documents/Fact_Sheets/MAL.pdf.

Barraclough, S. 1997. The growth of corporate private hospitals in Malaysia: Policy contradictions in health system pluralism. *International Journal of Health Services* 27(4): 643-59.

Bayugo, G. 2012. Updates for Kalusugan Pangkalahatan. Presented at the National Academy of Science and Technology Roundtable, Manila, February 21.

Bekedam, Henk. 2011. The world health report: Health systems financing: The path to universal coverage. A presentation at the Presidential Forum on Health Financing and Universal Coverage, May 3. http://www.wpro.who.int/NR/rdonlyres/8AC13E1C-BCBC-41C2-A820-B4CD31848D4/0/PHLUHCPresidentForumMay411.pdf.

Beltran, Gil. 2011. Interview by author. September.

Briones, Leonor. 2011. Interview by author. March.

Caballes, A. 2009. An appraisal of the policy environment for the Philippine hospital sector development. Unpublished manuscript.

Carrin, Guy and Chris James. 2004. Reaching universal coverage vs. social health insurance: Key design features in the transition period. *Health financing policy issue paper*. January. Department of Health Systems Financing and Resource Allocation, WHO/EIP. http://whqlibdoc.who.int/hq/2004/EIP_FER_FOH_ PIP_04.1.pdf.

Carrin, Guy, Inke Mathauer, Ke Xu, and David B Evans. 2008. Universal coverage of health services: Tailoring its implementation. *Bulletin of the World Health Organization* 86(11): 857-63.

Clariño, G. 2011. Updates on the Philippine national health accounts. Presented at the 12th National Forum on Health Research for Action, November 14, Manila.

Commission on Audit. 2010. Philippine Health Insurance Corporation annual audit report 2009. http://www.coa.gov.ph/2009_AAR/GOCCs/Zipfiles/PHIC_aar09.zip.

Crisostomo, Sheila. 2012. Population to hit 97.6 million in 2012. *The Philippine Star,* January 1. http://www.philstar.com/Article.aspx?articleId=763892&publicationSubCatego ryId=63.

De Ferranti, David, William Hsiao, and Yanzhong Huang. 2012. Universal health coverage: How do we get there? Transcript of a roundtable discussion, Council on Foreign Relations, January 9. http://www.cfr.org/global-health/universal-health-coverage-do-we-get-there-transcript/p27092.

Dela Pena, Zinnia. "Tax effort hits 13.58% of GDP." The Philippine Star. September 9, 2013. Retrieved on May 12 2014 at http://www.philstar.com/business/2013/09/09/1187811/tax-effort-hits-13.58-gdp.

Department of Health. 2010a. Toward financial risk protection: Health care financing strategy of the Philippines 2010-2020. *Health sector reform agenda monograph no. 10.* Manila: Department of Health. 28.

_____. 2010b. Administrative order no. 2010-0036. http://www.doh.gov.ph/system/files/ao2010-0036.pdf.

_____. 2011. Department order no. 2011-0188. Manila: Department of Health.

Diokno, Benjamin. 2008. The Philippines: Fiscal behavior in recent history. UP School of Economics Discussion Papers: Discussion Paper No. 0804. University of the Philippines School of Economics.

Herrera, Maria Elena B., Francisco L. Roman, and Maria Cristina I. Alarilla. 2010. Overview of health sector reform in the Philippines and possible opportunities for public-private partnerships. *Asian Institute of Management Working Paper Series* 10-002. http://www.aim.edu/files/download/131.

Hsiao, William. 2012. Universal health coverage: How do we get there? Transcript of a round table discussion, Council of Foreign Relations, January 9. http://www.cfr.org/global-health/universal-health-coverage-do-we-get-there-transcript/p27092.

International Monetary Fund. 2010. *World economic outlook database. April 2010 Edition.* Washington, D.C.: International Monetary Fund. http://www.imf.org/external/pubs/ft/weo/2010/01/weodata/index.aspx.

Langenbrunner, J. 2012. Bismarck vs. Beveridge: Is there still a debate? Presented at the Health Financing Matters Conference, Mahidol, Thailand, January. http://www.pmaconference.mahidol.ac.th/index.php?option=com_docman&task=doc_download&gid=579.

Lim, Niel. 2011. 'Conservative' and 'sluggish' PhilHealth misses health care target. *Vera Files.* http://verafiles.org/2011/03/28/'conservative'-and-'sluggish'-philhealth-misses-health-care-target/.

McKeown T, Record RG, Turner RD. An interpretation of the decline in mortality in England and Wales during the twentieth century. Population Studies. 1975 Nov;29(3):391-422.

McKinlay J & McKinlay SM. Medical measures and the decline of mortality. In H. D. Schwartz (Ed.), Dominant issues in medical sociology (2nd edition). New York: Random House, 1987.

Modol, X. 2010. Costing of the essential health package: Final report. EU Technical Assistance to the Health Sector Policy Programme of the Philippines.

National Statistical Coordination Board. 2007. *Philippine national health accounts.*

National Statistical Coordination Board. 2013. Philippine national health accounts 2005-2011. October. http://www.nscb.gov.ph/stats/pnha/publication/NSCB_PNHA%202005-2011.pdf.

_____. 2013. Philippine national health accounts 2005-2011. October. http://www.nscb.gov.ph/stats/pnha/publication/NSCB_PNHA%202005-2011.pdf.

_____. 2014. Philippine national health accounts 2011-2012. August 11. http://www.nscb.gov.ph/stats/pnha.

Normand, Charles and Axel Weber. 2009. Social Health Insurance, A Guidebook for Planning.2nd edition. World Health Organization/ILO. www.who.int/health_financing/documents/shi-guidebook.pdf last Accessed on October 12, 2014.

Ona, E. (2011) Department Order No. 2011-0188: *Kalusugan Pangkalahatan Execution Plan and Implementation Arrangements.* Manila: Department of Health.

Paterno, Ramon. 2007. Validation of PhilHealth performance areas using 10 key performance areas for the years 2004–2006. A report submitted to PhilHealth Executive Committee and the Senate Committee on Health.

Paterno Ramon, Herrera, C.E.. 2010. Health Financing. *Acta Medica Philippina*, vol. 44, no. 4, 58-70, Oct- Dec 2010.

Philippine Health Insurance Corporation. 2011. Circular no. 022, s-2011. http://www.philhealth.gov.ph/circulars/2011/circ22_2011.pdf.

Philippine National Health Accounts (PNHA 2011) 2005 – 2011 National Statistical Coordination Board. October 2013. Retrieved from http://www.nscb.gov.ph/stats/pnha/publication/NSCB_PNHA%202005-2011.pdf.

Philippine National Health Accounts (PNHA 2012) 2011 – 2012. Philippine Statististical Authority. National Statistical Coordination Board. August 11, 2014. Retrieved from http://www.nscb.gov.ph/stats/pnha/.

Quality Improvement Demonstration Studies. 2006. PhilHealth support in QIDS sites. Research Bulletin No. 3 (March). http://qids.ph/wp-content/uploads/Policy_Brief_3_April_2006_SupportValues.pdf.

Quek, D. 2009. The Malaysian health care system: A review. Presented at the Malaysian Medical Association.

Racelis, Rachel M., Fe V. N. Dy-Liaco, Raquel V. Sabenano, Mylene M. Beltran, and Thiel B. Manaog. 2006. The national health accounts of the Philippines: Continuing development and new findings. http://dirp3.pids.gov.ph/ris/pjd/pidspjd06-healthacct.pdf .

Romualdez, Alberto G. Jr., Jennifer Frances E. de la Rosa, Jonathan David A. Flavier, Stella Luz A. Quimbo, Kenneth Y. Hartigan-Go, Liezel P. Lagrada, Lilibeth C. David. 2011. The Philippines health system review. *Health Systems in Transition 1(2).* Geneva: The World Health Organization.

So, Robert. 2012. PhilHealth Insurance Corporation. Presented at the National Academy of Science and Technology roundtable, Manila, February 21.

Tangcharoensathien, Viroj, Phusit Prakongsai, Supon Limwattanon, Walaiporn Patcharanarumol, Pongpisut Jongudomsuk. 2007 Achieving universal coverage in Thailand: What lessons did we learn? A case study commissioned by the Health Systems Knowledge Network. March. http://www.who.int/social_determinants/resources/csdh_media/universal_cov erage_thailand_ 2007_en.pdf.

Tangcharoensathien, Viroj, Walaiporn Patcharanarumol, Syed Mohamed Aljunid, Ali Ghufron Mukti, Kongsap Akkhavong, Eduardo Banzon, Dang Boi Huong, Hasbullah Thabrany, Anne Mills. 2011. Health-financing reforms in Southeast Asia: Challenges in achieving universal coverage. *The Lancet* 377(9768): 863-73. doi:10.1016/S0140-6736(10)61890-9.

Wagstaff, Adam. 2007. Social health insurance reexamined. World Bank Policy Research Working Paper No. 4111, January 1. http://www- wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2007/01/09/000016406_20070109161148/Rendered/PDF/wps4111.pdf.

World Health Organization. 2009. *Health financing strategy for the Asia Pacific region (2010-2015).* Geneva: World Health Organization. http://www.wpro.who.int/publications/PUB_9789290614586.htm.