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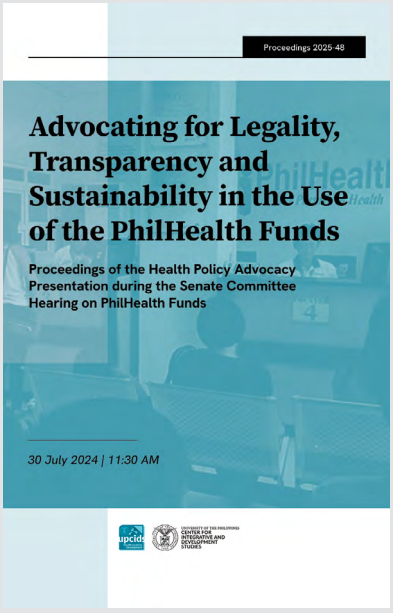

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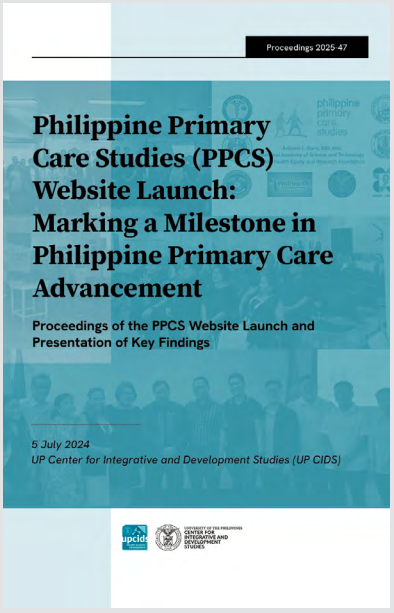

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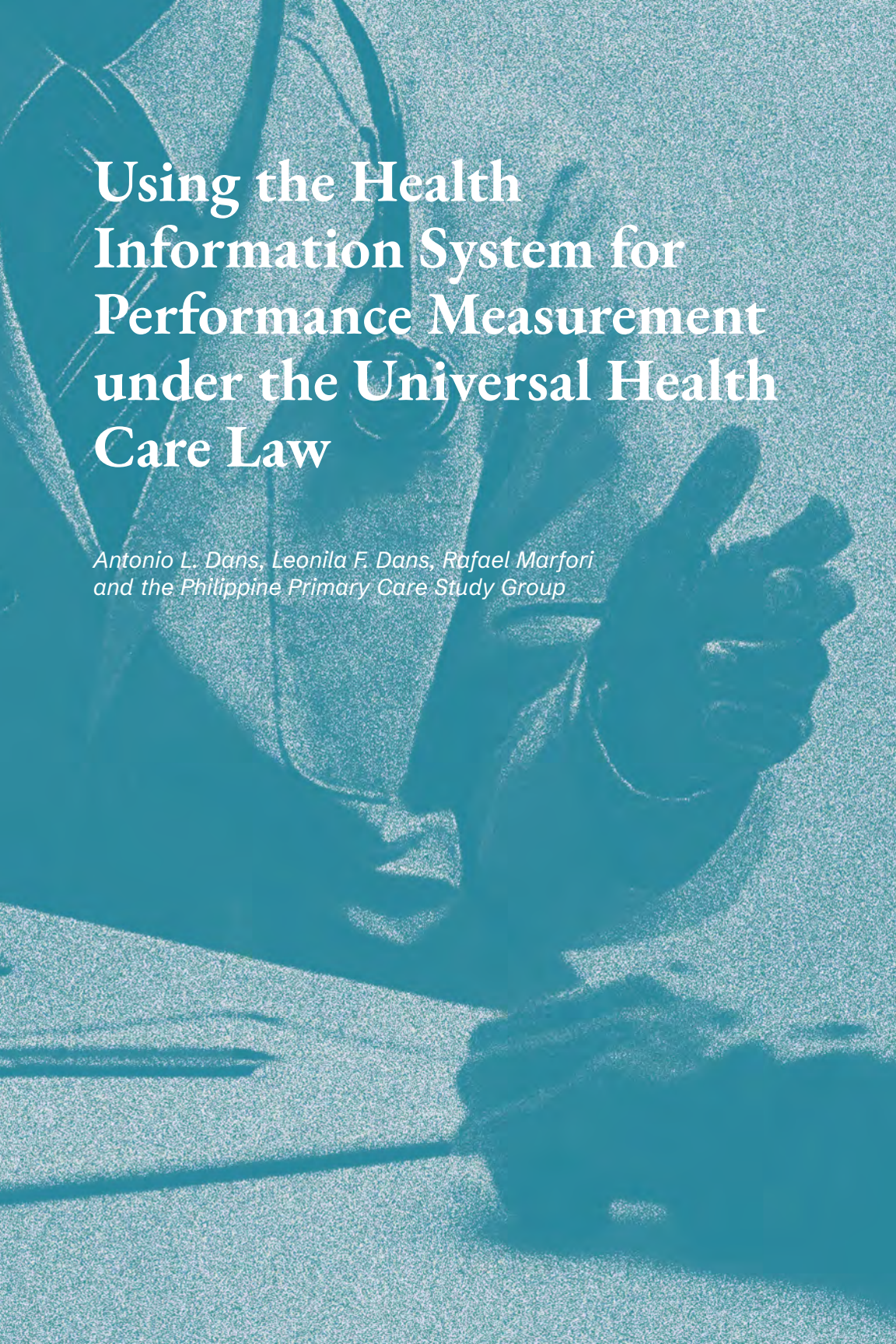

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Key Highlights

- PhilHealth's Konsulta/YAKAP programs were introduced to strengthen primary care, but their current design has produced inefficiencies, irrational use of resources, and heavy documentation burdens that pull healthcare workers away from patients. As a result, enrolment of LGUs has been low and utilization by the public minimal.

- The root causes include the mandatory First Patient Encounter (FPE), extensive reporting, non-integrated systems such as GAMOT and the FHSIS, and quota-based performance targets that reward volume over appropriateness.

- We recommend shifting from quota-driven compliance to three reforms: simplification of the health information system, building LGU transparency via data integration, and rationalizing performance measures.

- The expected outcomes are: a) Reduced HCW burden, b) More accurate and reliable data for policymaking, c) Prevention of irrational testing and prescribing, d) Improved LGU transparency, e) Reduced fraud, f) Increased trust among HCWs, LGUs, and the public, g) Higher utilization of Konsulta/YAKAP, and h) Delivery of higher-quality primary care.

Introduction

Background, Policy Landscape, and Rationale

Universal health care (UHC) has long been recognized as both a moral imperative and a strategic investment for national development. Globally, UHC is framed by the World Health Organization as ensuring that all people have access to needed health services of sufficient quality without suffering financial hardship. In the Philippine context, this global commitment was institutionalized through Republic Act No. 11223, or the Universal Health Care Act (UHC Act), enacted in 2019. The law represents a watershed moment in Philippine social policy, explicitly recognizing health as a right and mandating the State to progressively realize universal access to comprehensive health services.

The UHC Act introduced major structural reforms to the health system. Chief among these was the designation of the Philippine Health Insurance Corporation (PhilHealth) as the primary and dominant purchaser of individual-based health services, financed through a combination of member premiums and substantial national government subsidies. These subsidies were, in turn, anchored on earmarked revenues from the Sin Tax Reform Law, which increased excise taxes on tobacco, alcohol, and later vapor products, explicitly linking public health objectives with sustainable health financing.

Parallel to financing reforms, the UHC Act emphasized the need for evidence-based governance. It mandated the development of an integrated Health Information System (HIS) that would support planning, regulation, performance monitoring, and accountability across the health sector. The rationale was clear: a complex, devolved health system cannot be effectively governed without reliable, timely, and transparent information. Performance measurement, tracking whether health services are accessible, equitable, efficient, and of acceptable quality,was envisioned as a core function of HIS under UHC.

However, the promise of UHC is unfolding within a challenging political and fiscal landscape. Over the past several years, health care professionals and civil society organizations have raised alarm over a series of legislative and budgetary actions that appear to undermine both the letter and spirit of the UHC Act. These include the diversion of PhilHealth funds to non-health purposes, the withholding of legally mandated national government subsidies, the expansion of discretionary medical assistance funds controlled by politicians, and proposed rollbacks of sin tax policies that threaten long-term health revenues.

These developments raise fundamental questions about the viability of performance measurement under UHC. Health Information Systems do not operate in a political vacuum. The indicators they generate, the targets they inform, and the decisions they support are all shaped by underlying governance structures and financing arrangements. When these foundations are destabilized, HIS risks becoming an instrument that obscures rather than illuminates system performance.

This discussion paper is grounded in the collective statement of health care professionals on the systematic hijacking of UHC funds. It takes this statement not merely as an advocacy document, but as an entry point for a deeper policy analysis of how political capture of health financing undermines the use of HIS for performance measurement and accountability.

Statement of the Argument and Research Questions

The central argument of this paper is that distortions in health financing do not merely weaken service delivery but systematically alter the meaning and interpretation of performance data. When UHC funds are diverted, withheld, or politicized, Health Information Systems (HIS) no longer function as instruments of accountability. Instead, they generate misleading signals that can be used to justify further policy decisions detached from population health needs. In this context, HIS becomes an instrument not of governance, but of policy misdiagnosis.

Specifically, this paper argues that:

1. The systematic diversion and withholding of PhilHealth funds undermine the institutional capacity of PhilHealth to act on performance data, rendering HIS-driven measurement largely symbolic.

2. The expansion of discretionary medical assistance funds fragments health financing and information systems, obscuring true patterns of access, equity, and need.

3. Legislative actions that erode sin tax revenues compromise the long-term sustainability of UHC and weaken the feedback loop between health outcomes and financing decisions.

4. A robust HIS, if protected by transparency and legal accountability, can serve as a powerful tool to expose governance failures and reclaim UHC from political capture.

Guided by this argument, the paper addresses the following research questions:

1. How does the UHC Act envision the role of Health Information Systems in performance measurement and accountability?
2. In what ways do recent budgetary and legislative actions affecting PhilHealth distort HIS-based performance indicators?
3. How does the proliferation of discretionary health funds affect data integrity, equity analysis, and system-wide performance assessment?
4. What theoretical and policy frameworks can explain the relationship between political capture, health financing, and information systems?
5. What policy reforms are necessary to restore the integrity of HIS-driven performance measurement under UHC?

Literature Review

Universal Health Care as a Governance and Financing Reform

UHC is not merely a health sector reform but a comprehensive governance project. The literature emphasizes that UHC fundamentally restructures how states raise, pool, allocate, and account for public resources for health. Kutzin and colleagues describe UHC financing as requiring coherence across revenue generation, pooling, and purchasing, with accountability mechanisms embedded at every stage. In this sense, UHC laws function as fiscal constitutions for the health sector, setting binding rules that constrain political discretion in favor of equity and efficiency.

In low- and middle-income countries, UHC reforms often emerge in contexts of weak institutions and entrenched patronage politics. Scholars note that while legal frameworks may formally enshrine rights and entitlements, their realization depends on whether political actors respect the constraints imposed by law. Comparative studies of UHC implementation in Asia, Latin America, and Africa demonstrate that deviations from rule-based financing such as off-budget spending, discretionary subsidies, and earmark violations consistently undermine coverage expansion and financial protection.

In the Philippine context, the UHC Act was explicitly designed to address long-standing fragmentation in health financing. Prior to its enactment, PhilHealth operated alongside numerous national and local funding streams, many of which were discretionary and politically mediated. The consolidation of individual-based services under PhilHealth was intended to reduce these inefficiencies and align financing with national health priorities. The literature, therefore, positions PhilHealth not simply as an insurer but as a governance institution tasked with disciplining both providers and policymakers through standardized rules and performance metrics.

Strategic Purchasing, Performance Measurement, and Data Use

Strategic purchasing literature emphasizes that the ability of a purchaser to improve system performance hinges on three interrelated capacities: financial autonomy, regulatory authority, and information. Performance measurement is the connective tissue linking these capacities. Indicators on service utilization, cost-effectiveness, quality, and equity inform benefit design, provider payment reforms, and contracting decisions.

However, multiple studies caution that performance measurement systems are highly sensitive to incentive structures. Where performance data influence budgetary allocations or provider revenues, actors have incentives to invest in accurate reporting and quality improvement. Conversely, when financing decisions are decoupled from performance evidence and driven instead by political negotiation, data systems tend to atrophy or become symbolic.

Thailand's Universal Coverage Scheme illustrates the importance of aligning financing integrity with information systems. Its protected financing structure allows performance data to directly inform benefit design and provider payments. In contrast, when financing is subject to diversion or discretionary allocation, as observed in the Philippine context, the feedback loop between data and decision-making is weakened, limiting the utility of HIS for strategic purchasing.

Health Information Systems as Political Institutions

While HIS is often discussed as a technical infrastructure, critical scholars argue that information systems are inherently political institutions. They define what is visible, measurable, and contestable within policy debates. Decisions

about what data to collect, how to aggregate it, and who has access to it reflect underlying power relations.

The WHO health systems framework positions HIS as a core building block, but subsequent analyses highlight that its effectiveness depends on governance arrangements. HIS can reinforce accountability when data are transparent and used to sanction nonperformance. Conversely, in politicized environments, HIS may be manipulated, underfunded, or selectively ignored.

Studies on public financial management underscore that reliable performance measurement requires alignment between financial flows and information flows. When funds are channeled through parallel or discretionary mechanisms, data fragmentation becomes inevitable. This weakens system-wide analysis and obscures inequities.

Political Economy, Patronage, and Health Financing

Political economy analyses of the Philippine state consistently identify patronage as a dominant organizing principle of public finance. Discretionary funds, whether labeled as development assistance, social amelioration, or medical aid, have historically served as tools for political consolidation. Even after judicial rulings curbed explicit pork-barrel mechanisms, scholars observe their re-emergence under new institutional forms.

In the health sector, discretionary medical assistance programs are particularly potent because they allow politicians to claim credit for lifesaving interventions. However, the literature warns that such programs undermine universalism by replacing rights-based entitlements with favor-based access. They also weaken institutions like PhilHealth by siphoning resources and political attention away from systemic solutions.

Synthesis and Research Gap

The reviewed literature converges on a critical insight: UHC success depends on the integrity of financing and information systems, both of which are vulnerable to political capture. However, there remains a gap in explicitly linking fund diversion and discretionary budgeting to the erosion of HIS-based performance measurement. This paper contributes to filling this gap by analyzing contemporary Philippine developments through an integrated governance, financing, and information lens.

Methodology and Theoretical Framework

Research Design and Approach

This study employs a qualitative, interpretive policy analysis. Rather than testing hypotheses through statistical methods, it seeks to explain institutional dynamics by examining laws, budgetary decisions, and policy practices in light of established theoretical frameworks. This approach is appropriate for analyzing governance failures where causal mechanisms are embedded in political processes rather than observable through quantitative indicators alone.

Primary sources include the UHC Act, the Sin Tax Reform Law, annual General Appropriations Acts, congressional records, and public policy statements by health professional organizations. Secondary sources include peer-reviewed literature, policy reports, and comparative UHC studies. The analysis also draws on publicly available PhilHealth and Department of Health (DOH) reports to illustrate how financing decisions intersect with information systems.

Analytical Framework

The analysis integrates three theoretical lenses:

1. Strategic Purchasing Theory, which emphasizes the alignment of pooled funds, provider incentives, and performance data.

2. Principal–Agent Theory, which highlights the role of monitoring and information in ensuring that agents (implementing institutions) act in the interest of principals (the public).

3. Political Economy of Institutional Capture, which explains how powerful actors reshape rules and resource flows to serve narrow interests.

Together, these frameworks allow for an examination of how deviations from rule-based financing undermine both the demand for and supply of reliable performance information.

Causal Pathway Linking Financing to HIS Distortion

This paper conceptualizes a four-step causal pathway:

1. Financing distortion (diversion, withholding, discretionary funds)
2. Provider and system response (reduced participation, delayed reimbursements, altered incentives)
3. Data distortion (changes in utilization, reporting behavior, and apparent performance indicators)
4. Policy misinterpretation (incorrect attribution of underperformance to providers or systems rather than financing constraints)

This pathway highlights that observed performance gaps may reflect politically induced constraints rather than true system inefficiencies.

Definitions and Criteria for Evaluation

For analytical clarity, key terms are defined as follows:

1. Health Information System (HIS): the integrated set of institutional arrangements, technologies, and processes for collecting, managing, analyzing, and disseminating health-related data.
2. Performance Measurement: the systematic use of indicators to assess progress toward UHC goals, including equity, efficiency, quality, and financial risk protection.
3. Political Capture: sustained patterns of decision-making that privilege political or commercial interests over legally mandated public objectives.

The evaluation of UHC implementation is guided by criteria of legality, transparency, equity, efficiency, and accountability.

Discussion and Argumentation

1. The Centrality of PhilHealth to UHC Performance

The UHC Act's designation of PhilHealth as the dominant purchaser was intended to resolve chronic fragmentation in health financing. As a single

payer for individual-based services, PhilHealth is uniquely positioned to generate comprehensive utilization and cost data. These data form the empirical foundation for performance measurement and strategic purchasing.

However, this role presupposes fiscal integrity. When PhilHealth's legally earmarked funds are diverted or withheld, its capacity to function as a strategic purchaser is compromised. Performance indicators derived from claims data may reflect constrained benefits or delayed reimbursements rather than true population health needs.

2. Fund Diversion as Institutional Sabotage

The 2024 diversion of ₱60 billion from PhilHealth constitutes more than a budgetary adjustment; it represents institutional sabotage. By reallocating funds earmarked for health insurance benefits to non-health purposes, policymakers effectively nullified performance targets embedded in the UHC framework.

From an information systems perspective, such diversion introduces structural noise into performance data. Declines in utilization, provider participation, or patient satisfaction may be misinterpreted as operational failures. Without transparent attribution of causality, HIS loses its diagnostic function.

3. Withholding of Mandated Subsidies and Manufactured Underperformance

The cumulative withholding of ₱270.3 billion in national government subsidies from 2023 to 2025 has profound implications for equity. Indirect contributors rely entirely on state subsidies for coverage. When these subsidies are withheld, coverage gaps emerge that are politically induced rather than system-generated.

HIS-based equity indicators become misleading under these conditions. Apparent failures to achieve universal coverage may be cited to justify further retrenchment, creating a self-reinforcing cycle of underperformance.

4. Zero Budgeting and the Breakdown of Accountability

The approval of a zero-subsidy budget for PhilHealth in 2025 through a closed-door bicameral process represents a breakdown of democratic

accountability. Transparency is a prerequisite for both fiscal governance and information integrity. When budgetary decisions are insulated from public scrutiny, HIS cannot fulfill its accountability function.

For example, declines in utilization rates under Konsulta or reduced provider participation may be interpreted as program inefficiency. However, these indicators may instead reflect delayed reimbursements, funding uncertainty, or administrative burdens arising from financing constraints. Without explicit linkage between financing flows and performance indicators, HIS risks attributing causality incorrectly.

5. Discretionary Medical Assistance and the Return of Patronage

The expansion of MAIFIP exemplifies the reconstitution of pork-barrel politics within the health sector. While framed as compassionate assistance, discretionary funds undermine universalism by substituting entitlement-based access with political discretion.

Information-wise, discretionary programs operate outside standardized reporting frameworks. This fragments HIS, obscures total health spending, and weakens performance analysis.

6. Erosion of Sin Taxes and the Fiscal Future of UHC

Sin taxes serve a dual function: reducing harmful consumption and financing health services. Proposed rollbacks weaken both objectives. HIS may document rising disease burdens associated with tobacco and vaping, but without fiscal capacity, such evidence cannot translate into an effective response.

7. HIS as an Instrument of Democratic Accountability

Despite systemic challenges, HIS retains transformative potential. When performance data are publicly disclosed and linked to legal standards, they can empower courts, legislators, and citizens to hold decision-makers accountable. In this sense, HIS is not merely a management tool but a democratic institution.

Importantly, the relationship between financing and HIS is bidirectional. While distorted financing undermines the integrity of HIS, weak or fragmented information systems also enable political capture by obscuring the true effects of policy decisions. In the absence of transparent, integrated

data, it becomes difficult for oversight institutions and the public to detect whether underperformance arises from system inefficiencies or deliberate fiscal deprivation.

Conclusion

This paper has argued that the effectiveness of Health Information Systems for performance measure under the Universal Health Care Law is inseparable from the integrity of health financing governance. The systematic diversion, withholding, and politicization of UHC funds undermine not only service delivery but the informational foundations of accountability.

UHC cannot be sustained through discretionary benevolence or technocratic fixes alone. It requires fidelity to law, protection of institutions, and respect for evidence. HIS, when grounded in transparent and rule-based financing, can protect equity and efficiency. When undermined by political capture, it risks becoming a hollow instrument of implementation of UHC.

By simplifying reporting, ensuring transparency, and aligning performance measures with rational care, PhilHealth can reduce HCW burden, improve data quality, and strengthen trust in Konsulta and YAKAP. These reforms will prevent irrational care, improve utilization, and deliver higher quality primary care services.

Policy Recommendations

1. Legally Protect Earmarked Health Funds: Strengthen statutory safeguards to prevent diversion of PhilHealth and sin tax revenues.

2. Mandate Automatic Appropriation of UHC Subsidies: Remove discretionary congressional control over legally mandated subsidies.

3. Abolish or Integrate Discretionary Medical Funds: Transfer programs like MAIFIP into PhilHealth with standardized benefits and reporting.

4. Institutionalize Transparency in Budget Processes: Require public disclosure of bicameral budget decisions affecting UHC.

5. Strengthen HIS Governance: Ensure independence, adequate funding, and public access to health performance data.

6. Link financing to data submission ("no data, no payment"): Require standardized HIS reporting as a condition for reimbursement to ensure completeness and integration of data.

7. Create a publicly accessible HIS performance dashboard: Mandate monthly publication of key indicators (utilization, expenditures, coverage) at the LGU level to strengthen accountability.

Universal Health Care is ultimately a social contract between the State and its people, grounded in the recognition that health is not a privilege to be earned nor a favor to be dispensed, but a fundamental right to be guaranteed. The Universal Health Care Law sought to give concrete institutional form to this contract by establishing rule-based financing, consolidating purchasing authority in PhilHealth, and mandating the use of evidence and performance measurement through an integrated Health Information System (HIS). Together, these elements were designed to replace fragmented, discretionary, and inequitable health financing with a system anchored on transparency, accountability, and equity.

This paper has shown, however, that the realization of this vision is being systematically undermined. The diversion of PhilHealth funds, the withholding of legally mandated government subsidies, the approval of zero-budget appropriations through opaque legislative processes, the expansion of discretionary medical assistance programs, and the erosion of sin tax revenues are not isolated policy failures. Taken together, they reveal a coherent pattern of political capture that weakens both the financial and information foundations of Universal Health Care. These actions impair PhilHealth's ability to function as a strategic purchaser and distort the performance data generated by the HIS, obscuring whether observed gaps in coverage and service delivery reflect system inefficiencies or deliberate fiscal deprivation.

The analysis further demonstrates that Health Information Systems cannot be treated as neutral or purely technical tools. Their effectiveness depends on the integrity of the governance and financing environments in which they operate. Where funding is predictable, legally protected, and transparently allocated, HIS enables meaningful performance measurement, supports continuous improvement, and exposes inequities that demand policy correction. Where funding is politicized and discretionary, HIS risks being reduced to a hollow compliance exercise—producing data that are ignored, manipulated, or selectively deployed to justify decisions driven by political interests rather than public need.

Importantly, the erosion of HIS-based performance measurement is not merely a managerial concern but a democratic one. Performance data constitute a critical mechanism through which citizens, health professionals, oversight institutions, and courts can hold the State accountable for its legal obligations under the UHC Law. When information systems are compromised through fiscal manipulation and institutional weakening, the public's capacity to scrutinize government action and demand accountability is correspondingly diminished. In this sense, the hijacking of UHC funds is also a hijacking of the public's right to know, to question, and to seek redress.

Reclaiming UHC, therefore, requires more than technical fixes or administrative reforms. It requires a reaffirmation of the rule of law in health financing and a deliberate effort to insulate PhilHealth and the Health Information System from political interference. Only when funds are allocated in accordance with legal mandates, and only when performance information is allowed to guide decision-making, can UHC fulfill its promise of equitable, accessible, and financially protective health care.

UHC must remain a people's right, not a political instrument. A robust Health Information System—protected from capture, grounded in transparency, and embedded within rule-based financing—is indispensable to safeguarding this right. Without it, UHC risks being reduced to rhetoric and patronage. With it, the promise of UHC can be measured, defended, and ultimately realized for all Filipinos.

Proposal

Performance measures should evolve from year 1 to year 2.

<table>
<tr><th></th><th>Year 1</th><th>Year 2</th></tr>
<tr><td rowspan="2">Goals</td><td>Establish HPCN transparency</td><td rowspan="2">Implement performance measures that drive higher quality of care</td></tr>
<tr><td>Benchmark performance measures</td></tr>
<tr><td rowspan="2">First tranche</td><td>Fulfill accreditation requirements (HIS, HRH, connectivity, facilities, etc.)</td><td>same</td></tr>
<tr><td>Registration process using biometrics</td><td>same</td></tr>
</table>

	Year 1	Year 2
	Registrants limited based on primary care physician density □ Urban (5,000 per MD)* □ Rural (10,000 per MD) □ Remote (20,000 per MD)	For adjustment after benchmarking from year 1
Second tranche	Transparency target - automated patient level data regularly transmitted to PHIC repository, including expenses	same
	Transparency target - bi-annual health financial report (tests, medicine, HHR, MOOE)	same
	Volume target - utilization □ Urban (75% of registrants) □ Rural (60% of registrants) □ Remote (40% of registrants)	For adjustment after benchmarking from year 1
	Volume target - services 75% of tests, and treatments prescribed must be rendered by the HPCN	For adjustment after benchmarking from year 1
	Quality of care target - none yet	Implement some quality of care targets: e.g., BP targets, A1C targets, consult duration, antibiotic choice for LRTI

*assumptions: 1) 261 working days, 2) 15 minutes per consult, 3) 50% of work hours spent seeing patients, 4) 50% on studies, reading, teaching, administrative and public health functions, and 5) rural and remote physicians will have more nurses, midwives, and BHWs working with them.

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