Shaping the Agenda for the 2022 Elections: Building a National Health Services (NHS) for the Philippines Towards Achieving 100% Free Health Care for Everyone

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Abstract:

This short paper is primarily aimed at stimulating public discussions on setting the electoral agenda for the 2022 Philippine elections. Specifically, this paper intends to 1) discuss why the current Universal Health Care (UHC) system in the Philippines is not good enough; 2) explain how de-facto privatization masquerading as a "public-private partnership" scheme contributes to the depletion of PhilHealth funds; 3) outline a practical plan to build a National Health Services (NHS) for the Philippines that will provide 100% free health care to all citizens, with no co-payments or huge out-of-pocket payments (OOPPs), thereby ending the tyranny of financial crowdsourcing, online begging, and medical-related bankruptcies which should have no place in a genuinely caring & sharing community that we all aspire to achieve in the near future.

Keywords: free health care, National Health Services (NHS), 2022 Philippine elections, health sector reform, health care financing mechanisms

Evidence of the Failure of the Universal Health Care (UHC) System in the Philippines: Continuing Huge OOPPs, Financial Crowdsourcing, Online Begging, and Medical-Related Bankruptcies

Our own experiences – especially as we all suffer under the now two-year old pandemic – can be summed up as a long, endless litany of financial crowdsourcing, online begging, and medical-related bankruptcies which, unfortunately are not being discussed (or even considered as a problem) by mainstream political groups – even among the broadest

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group in the opposition at this point – 1Sambayan[2]. Nevertheless, it is heartening to note that Makabayan Bloc has filed House Bill 9515 ("AN ACT PROVIDING FOR A FREE, COMPREHENSIVE, AND PROGRESSIVE, NATIONAL PUBLIC HEALTH CARE SYSTEM") just last May 29, 2021.

Our people yearn for a better system where health care will be a human right, and where no one will be forced to beg just to pay for essential health services, but at this point, most mainstream politicians mouth only useless soundbites or motherhood statements with no concrete offerings – if they talk policy at all. In many instances, they don't even bother discussing issues or people's concerns; they would rather brag about their equally useless dynastic patriarchs. Of course, why would they care about local health services when they can always go abroad for expensive treatment anytime – paid for by the people's money that they squander legally (through huge salaries and allowances which they don't deserve as they are mostly useless) and illegally (through plundering the national treasury through all means possible).

Hence, we academics are compelled by the circumstances to write about policies which should be the centerpiece of every electoral campaign now, if we are to survive as a country. In this paper, I intend to discuss how the Philippines can build an NHS that will cover every citizen's medical expenses and even eliminate all out-of-pocket payments (OOPPs) – genuine Universal Health Care in a nutshell.

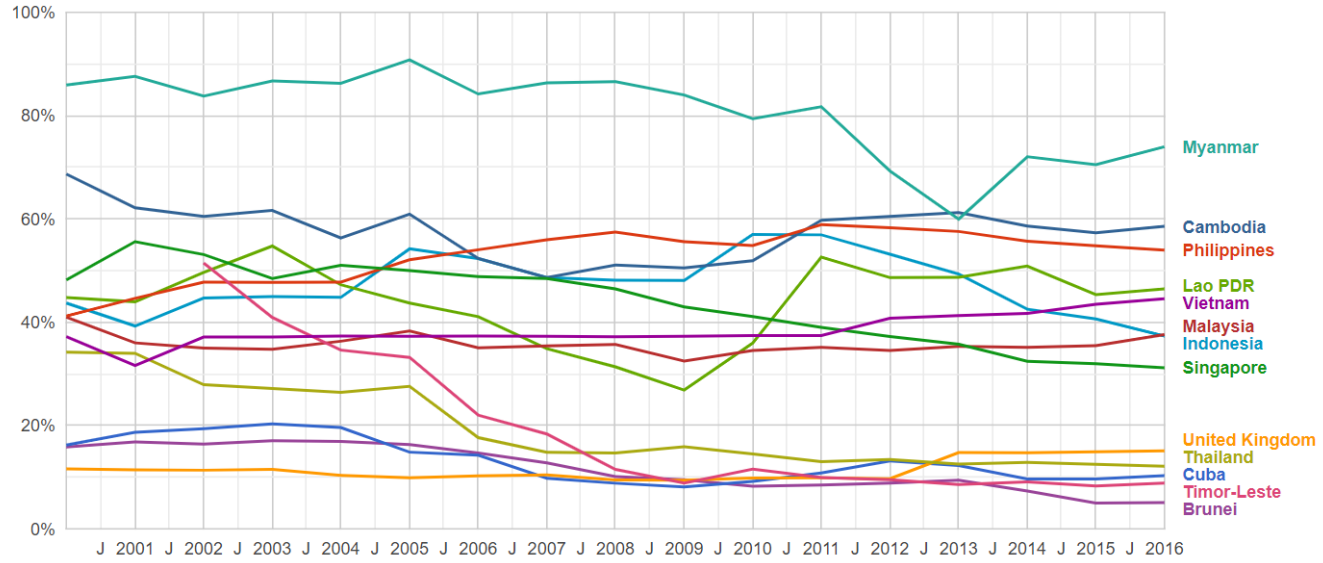
Universal Health Care in the Philippines was nominally adopted in 2019 through Republic Act No. 11223 or the Universal Health Care Act. While such policy shift enabled the Philippine government to provide free health services to the poorest segments of society, its neoliberal framework still allows the collection of co-payments beyond the maximum amount per illness and per type of service covered by the national public health insurance system, run by the Philippine Health Insurance Corporation or PhilHealth. Hence, our country's citizens remain burdened with huge OOPPs from medical consultations to

[2]Free health care is not in the "vision of a better nation" featured in the current homepage of 1Sambayan (www.1sambayan.org) as of 08 June 2021. Only the following catchphrases were mentioned in the said homepage: "leadership by heart"; "economic stability"; "drug-free nation"; "inclusive governing"; "low crime rate"; & "corruption-free."

prescription medicines, and from major surgical operations to rehabilitation procedures. Out-of-pocket expenditure as % of current health expenditure amounts to almost 54% of the country's total health spending in 2018, lower than the all-time high of 58.9% in 2011 but way above the all-time low of 41.2% in 2000, in contrast with the global average pegged at just slightly more than 18% in 2018 and peaking at 19.3% in 2000 (World Bank, 2021). Among Southeast Asian countries, the Philippines is the third worst country when it comes to OOPPs (see **Figure 1**).

Figure 1

Out-of-pocket payments (OOPPs) as % of Current Health Expenditure in Southeast Asian Countries, Cuba, & the United Kingdom (2000-2016)



Note. World Bank data (2020) from Google Public Data Explorer.

Figure 1 also shows that the Philippines' OOPPs is also way above the percentages of out-of-pocket expenditures of Cuba & the United Kingdom (UK), two ideologically different countries (with contrasting GDP sizes too as seen in **Figure 9**) which are nevertheless similar in successfully maintaining their predominantly public health care systems with good health outcomes too (**Figures 2 to 8**). Whatever limitations their systems contend with, we have to admit that theirs is working way better than ours – offering world-class,

top-caliber, 100% free health services with zero or minimal OOPPs (on the Cuba health care system, see Keck, 2021 and Pineo, 2020; on UK's NHS, see Gulland, 2017 and Cylus et al., 2015; see **Table 1**) – and they can become prospective models for our country too.

Table 1

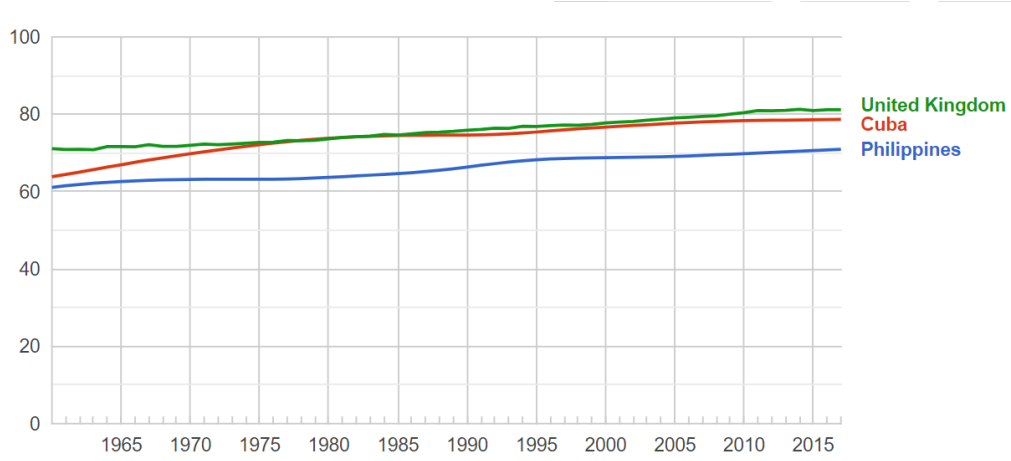
Illustrative Comparison of the Health Care Systems of the Philippines, UK, & Cuba

Country	**Government Expenditure on Health**	**Out-of-pocket payments (OOPPs)**	**Medicines (Prescription Drugs)**	**Total Hip Replacement**
Philippines	Low	Big	Not free; Free essential medicines available thru some LGUs; Subsidized medicines (30 drugs) also available to certain sectors 48.5% of OOPPs spent for "drugs, neutraceuticals and medical products" Drug prices historically high (especially when compared with India & Pakistan)	Free for "indigent, sponsored, and kasambahay members"; With "negotiated fixed co-pay" (OOPPs) "for all other eligible members and their qualified dependents," for expenses beyond 103,400.00 pesos (for members who are 66 years old & above); and beyond 160,400 pesos (for members who are 65 years and 364 days old and below)
UK	High	Small	Free/no charge in Scotland, Wales, & Northern Ireland; Minimal charge in England (£9.35 or 632 pesos per item) but 90% of items are still free of charge	Free
Cuba	High	Small	Focus is on preventive health care; Prescription drugs for hospitalized patients, free; Shortage of medicines documented in recent years List of subsidized drugs (162 items) retained	Free

Note. Data from: DOH (n.d.); Picazo, 2012; Dayrit et al., 2018; BBC, 2011; teleSUR, 2020; Ulep & De La Cruz, 2013; PhilHealth, 2014; Cylus et al., 2015; Spiegel & Yassi (2004); Riera (2006); NHS Business Services Authority (n.d.).

Figure 2

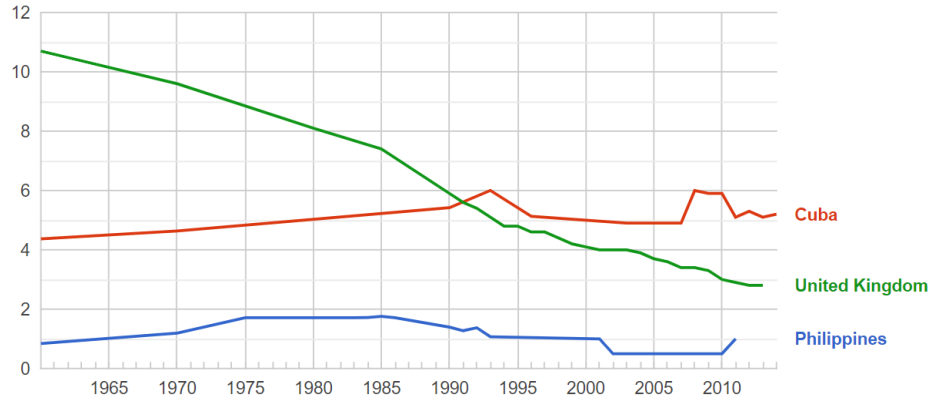
Average Life Expectancy in Cuba, the Philippines, & the United Kingdom (1960-2017)



Note. World Bank data from Google Public Data Explorer (2020).

Figure 3

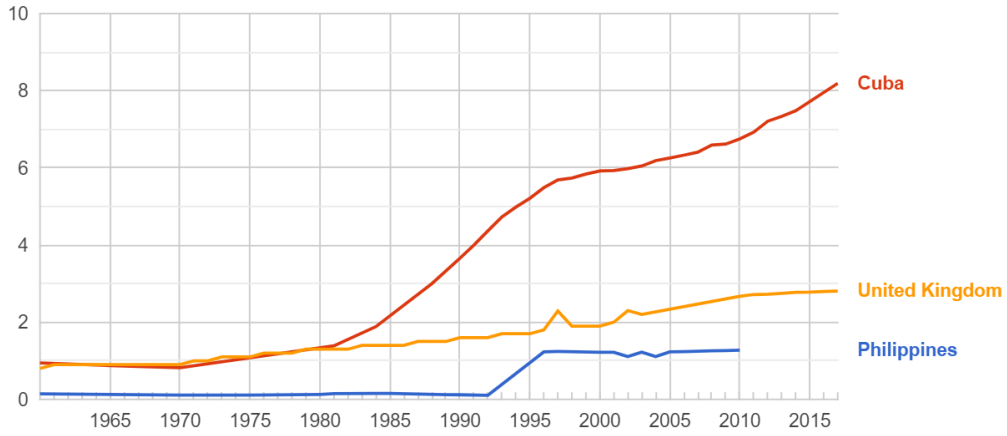
Number of Hospital Beds (Per 1,000 People) in Cuba, the Philippines, & the United Kingdom (1960-2014)



Note. World Bank data from Google Public Data Explorer (2020). Available data for the Philippines is up to 2011 only; for the United Kingdom, up to 2013; and for Cuba, up to 2014.

Figure 4

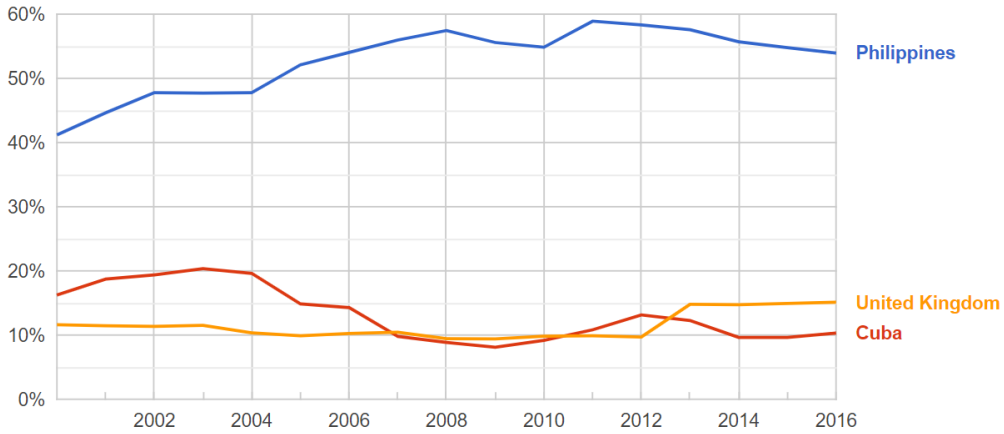
Number of Doctors (Per 1,000 People) in Cuba, the Philippines, & the United Kingdom (1960-2017)



Note. World Bank data from Google Public Data Explorer (2020). Available data for the Philippines is up to 2010 only.

Figure 5

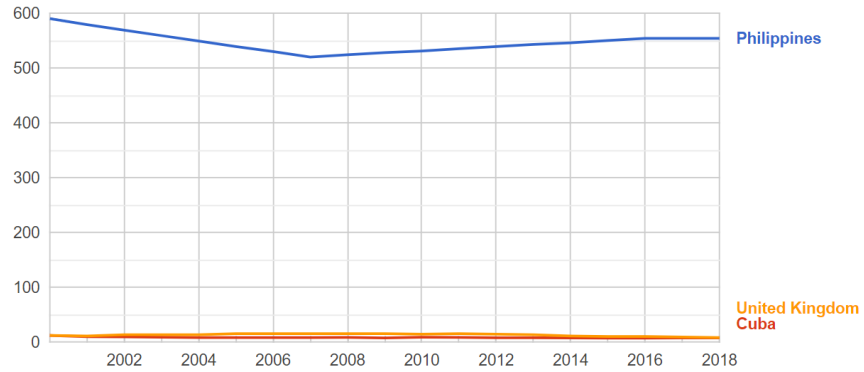
Out-of-pocket Health Expenditure (% of Total Health Expenditure) in Cuba, the Philippines, & the United Kingdom (2000-2016)



Note. World Bank data from Google Public Data Explorer (2020).

Figure 6

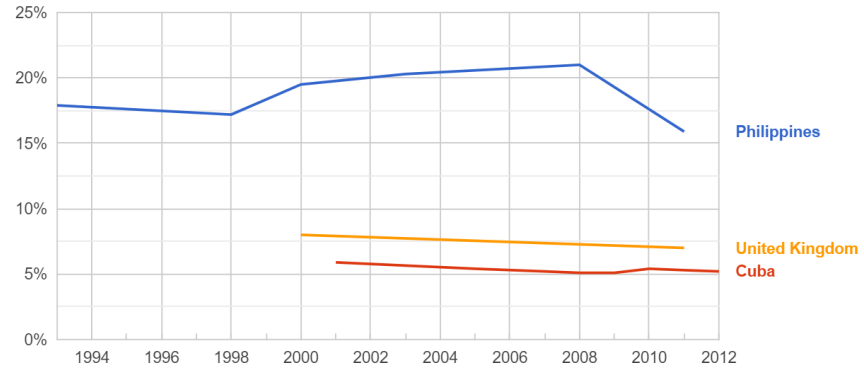
Number of New Cases of Tuberculosis (Every 100,000 People) Every Year, in Cuba, the Philippines, & United Kingdom (2000-2018)



Note. World Bank data from Google Public Data Explorer (2020).

Figure 7

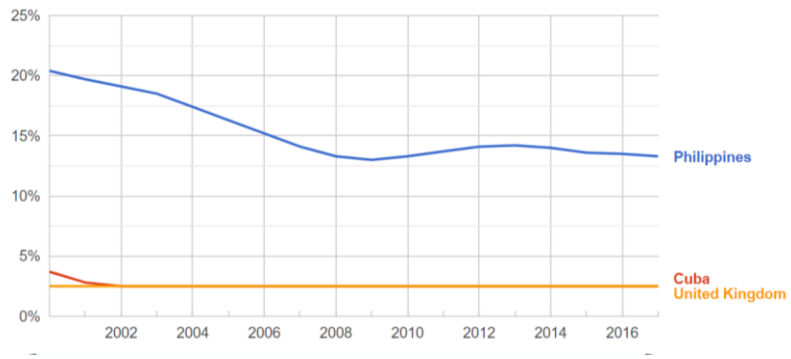
% of Low-birthweight babies in Cuba, the Philippines, & the United Kingdom (1993-2012)



Note. World Bank data from Google Public Data Explorer (2020).

Figure 8

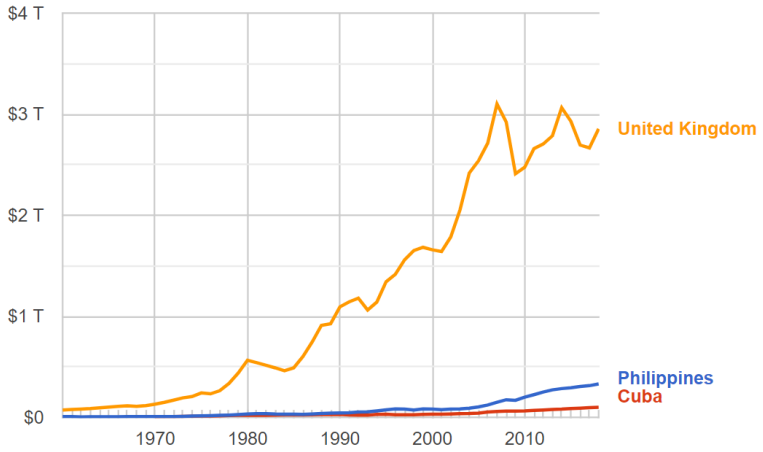
Undernourished Population, % of Total, in Cuba, the Philippines, & the United Kingdom (2000-2017)



Note. World Bank data from Google Public Data Explorer (2020).

Figure 9

Gross Domestic Product (GDP) of Cuba, the Philippines, & the United Kingdom, in Trillion Dollars (1960-2018)



Note. World Bank data from Google Public Data Explorer (2020).

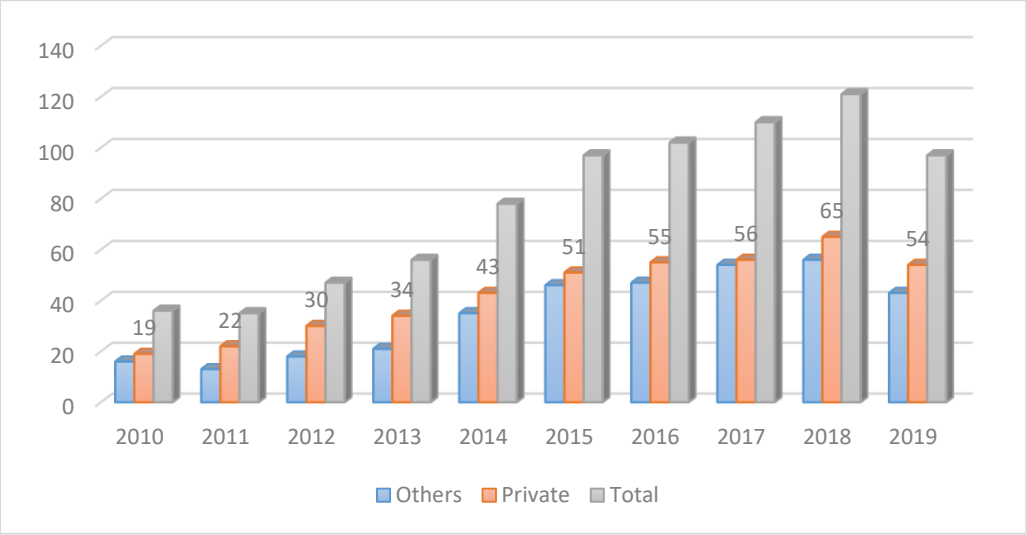
De-facto Privatization's Impact on PhilHealth's Financial Situation

Expanding PhilHealth's maximum coverage per illness and per type of service could theoretically solve the problem – but, **it is not feasible without reforms,** as PhilHealth's financial situation is in already in dire straits partly because of huge annual payments to private health care providers (see **Figure 10 & 11**), on top of still-ballooning pandemic-related claims. Most hospitals accredited by PhilHealth are private (60% in 2019) – including overtly profit-oriented or corporate-linked ones. Hence, a lion's share – 58% or

55,157,742,619 pesos – of the 97,390,600,293 pesos worth of "claims paid" by PhilHealth went to private hospitals (PhilHealth, 2019a).

Figure 10

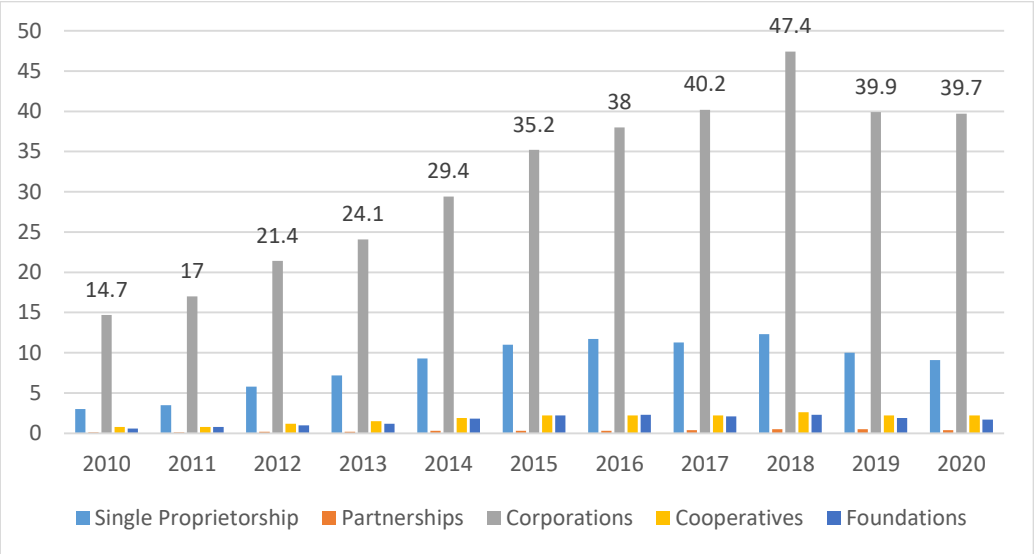
PhilHealth Claims Payment by Sector by Type of Ownership 2010 to 2019 (in billion pesos)



Source: PhilHealth Annual Reports (2010-2018), PhilHealth Stats and Charts (2019), and FOI Request #PH-777581533378.

Figure 11

PhilHealth Claims Payment by Sector by Specific Type of Non-Government/Private Ownership (2010 to 2020) in billion pesos



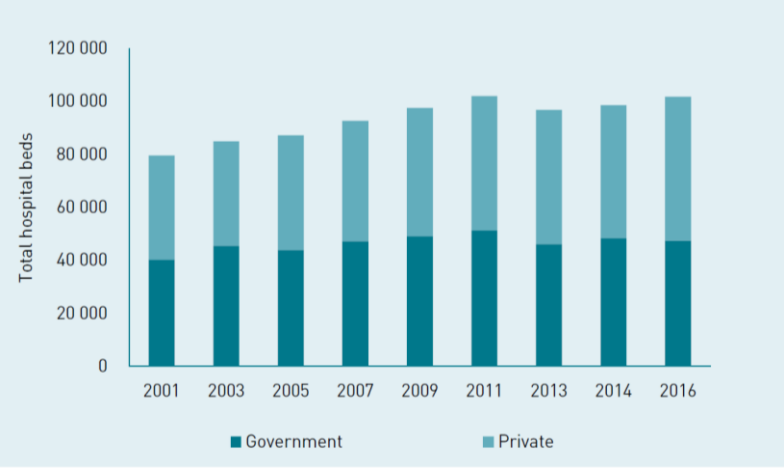
Source: FOI Request #PH-777581533378.

Those listed in the **Appendix (p.30-32)** provide a preview on typical profit-oriented, corporate links in the Philippine health sector. Further researches could be done on this matter, especially on HMO-owned clinics and hospitals, and on hospital chains with authorized billion-peso initial public (stock) offerings/IPOs, such as Allied Care Experts/ACE (Cabuag, 2019), and other stock-offering hospitals (Biolena, 2015). In the past, the Philippines' Securities and Exchange Commission went "after hospitals and medical centers that are offering unregistered securities to the public" (ABS-CBN News, 2013), warned "the public against 'preselling' of stocks" by hospitals (Dumlao, 2013), and intervened in stock-related disputes involving a hospital (Cabuag, 2020). PhilHealth payments to such corporate hospitals are poised to continue as trends on government and private hospital beds and registered hospitals show (**Figure 12**).

A 2018 DOH publication summarized the country's gaps in hospitals beds thus: "The total hospital bed capacity of the country is 101,688 beds, with government hospital beds accounting for 47 percent (47,371) and private hospitals beds for 53 percent (54,317). On the average, one hospital bed served 1,010 people in 2016" indicating "a gap of 1,022 hospital beds…ARMM, CARAGA and MIMAROPA had the least coverage at 0.2-0.5 hospital bed per 1,000 population, which translated to one hospital bed covering as much as 2,000 to over 4,200 population."

Figure 12

Government and private hospital beds, 2001–2016

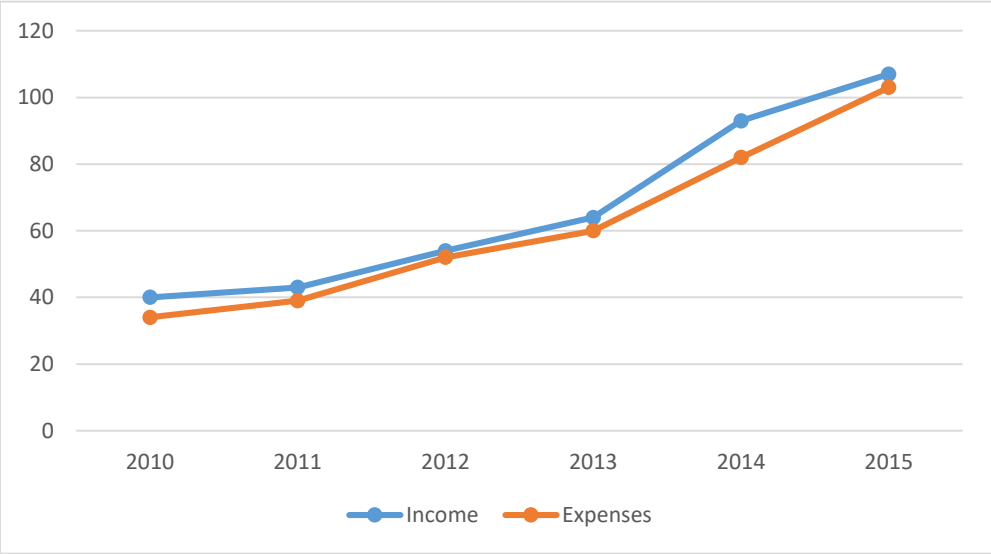


Source: Department of Health-HFSRB, 2016 (cited by Dayrit et al., 2018)

Reviewing PhilHealth's income and expenses could reveal details on its financial sustainability. **Figure 13** shows that from 2010-2015, PhilHealth income consistently went above expenses, with 2014 as the best year for surplus money. Meanwhile, as per **Figure 14**, income was only slightly more than expenses in 2016 (109.7 billion pesos and 109.9 billion pesos, respectively) and in 2017 (113.2 billion pesos and 113.1 billion pesos), while in 2018, income went way above expenses again. Preliminary data for 2019 shows a decrease in expenses, while preliminary data for 2020 projects a more robust increase in expenses (mostly driven by costs related to COVID-19 treatment and/or hospitalization) and a decrease in income (possibly because of lower premium collections due to worsening unemployment especially in the early months of the pandemic). Such reality of falling income and rising expenses compelled some PhilHealth officials to claim that PhilHealth's actuarial life could just be a year (Torregoza, 2020).

Figure 13

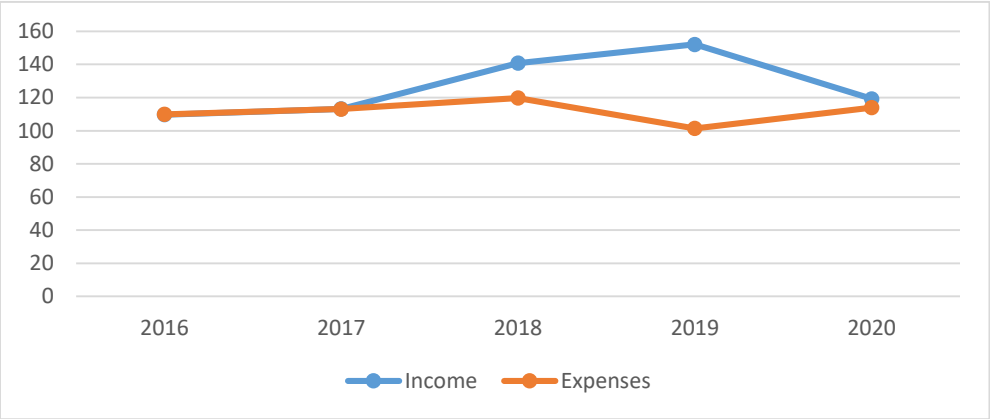
PhilHealth Total Income vis-à-vis Total Expenses (2010-2015), in billion pesos



Source: PhilHealth Annual Reports (2010-2015).

Figure 14

PhilHealth Income from Premium and Interest and Other Income vis-à-vis Expenses for Benefits and Total Operating Expenses (2016-2019), in billion pesos



Source: PhilHealth Annual Reports (2016-2018) and Financial Statements (2019-2020; and PhilHealth Stats and Charts (2019).

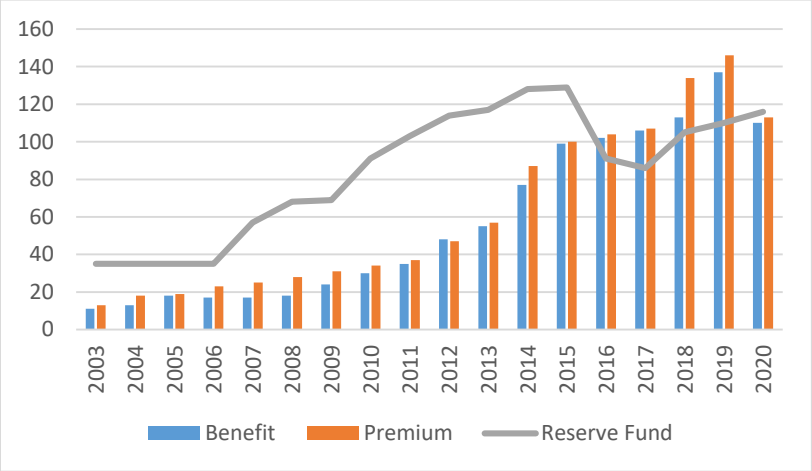
Figure 15 shows a nearly stagnant reserve fund at 35 billion pesos from 2003-2006, and a steady rise in the reserve fund from 2006 to 2015, while two successive drops in the reserve fund are observable in 2016 and 2017, and from then on, the reserve fund seems to be increasing again (albeit, based on preliminary data). The most drastic drop in the reserve fund – observed from 2016 to 2015 (from 129 billion pesos to 91 billion pesos) – is primarily caused by the setting up of a "separate fund for the benefit claims reserve of the existing lifetime members" (so-called "insurance liability for lifetime members") amounting to 22.1 billion pesos. It was the first year ever that such a fund was set up, and it will be retained annually hence, relative to the number of lifetime members. Reserve fund depletion in 2016 and 2017 corresponds to PhilHealth's worst net margins/losses statistics (**Figure 16**), throughout the period 2007-2019. It must be also noted that COA's 2018 report casts doubt on the purported net income in 2017 which was based on restated figures for 2017 "that resulted to a Net Income of P237.167 million from [a previously declared] Net Loss of P4.751 billion."

Benefit payments and premium contributions were generally rising from 2003 to 2017. Premium contributions drastically increased in 2018 (because of scheduled contribution rate hikes that started in 2018-2019, and will continue until 2024-2025; see **Figure 17**).

Preliminary data for 2020 show a decrease in both premium contributions and benefit payments. It is logical to expect that final figures for 2020 will be closer to a decrease in premium contributions (because of pandemic-era unemployment) and definitely soaring benefit payments (due to the pandemic's impact on the health care system).

Figure 15

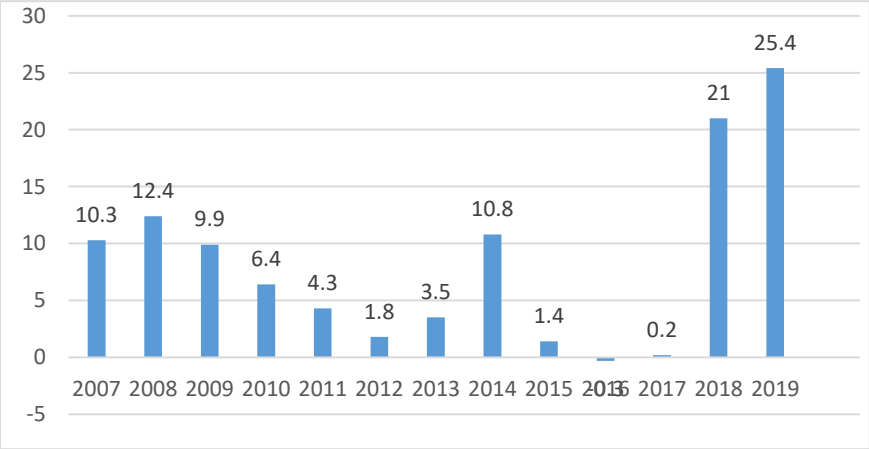
Benefit Claims, Premium Contributions, and PhilHealth Reserve Fund (2003-2020)



Source: PhilHealth Annual Reports (2003-2018); PhilHealth Annual Financial Statements (2010-2020).

Figure 16

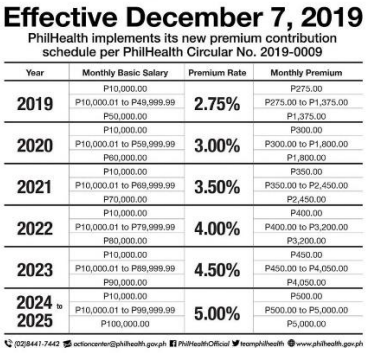
PhilHealth's Annual Net Margins/Losses (2007-2019), In Billion Pesos



Source: PhilHealth Annual Reports 2007-2019.

Figure 17

PhilHealth's Scheduled Premium Rate Hikes (2019-2025)



Effective December 7, 2019

PhilHealth implements its new premium contribution schedule per PhilHealth Circular No. 2019-0009

Year	Monthly Basic Salary	Premium Rate	Monthly Premium
2019	P10,000.00	2.75%	P275.00
	P10,000.01 to P49,999.99		P275.00 to P1,375.00
	P50,000.00		P1,375.00
2020	P10,000.00	3.00%	P300.00
	P10,000.01 to P59,999.99		P300.00 to P1,800.00
	P60,000.00		P1,800.00
2021	P10,000.00	3.50%	P350.00
	P10,000.01 to P69,999.99		P350.00 to P2,450.00
	P70,000.00		P2,450.00
2022	P10,000.00	4.00%	P400.00
	P10,000.01 to P79,999.99		P400.00 to P3,200.00
	P80,000.00		P3,200.00
2023	P10,000.00	4.50%	P450.00
	P10,000.01 to P89,999.99		P450.00 to P4,050.00
	P90,000.00		P4,050.00
2024 to 2025	P10,000.00	5.00%	P500.00
	P10,000.01 to P99,999.99		P500.00 to P5,000.00
	P100,000.00		P5,000.00

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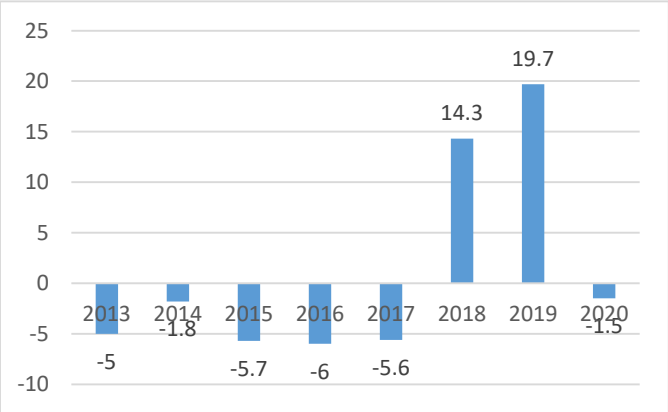
Source: PhilHealth, 2017.

Related to PhilHealth's net margins/losses, a government-initiated performance audit report (COA, 2017) notes that "(f)or the past four years PhilHealth's **net operating income continue to be at the negative level had it not generated the income from the Interest from investment,** accreditation fees and fines and penalties derived from other sources of income." The rebound/recovery for 2018 and 2019 can be attributed only to the hike in premium rates, thus preliminary data for 2020 – which shows regression to negative territory (a net operating loss of 1.5 billion pesos) – shows that PhilHealth's financial status is really unstable (**Figure 18**).

Figure 18

PhilHealth's Annual Net Operating Income/Loss (2013-2017), In Billion Pesos

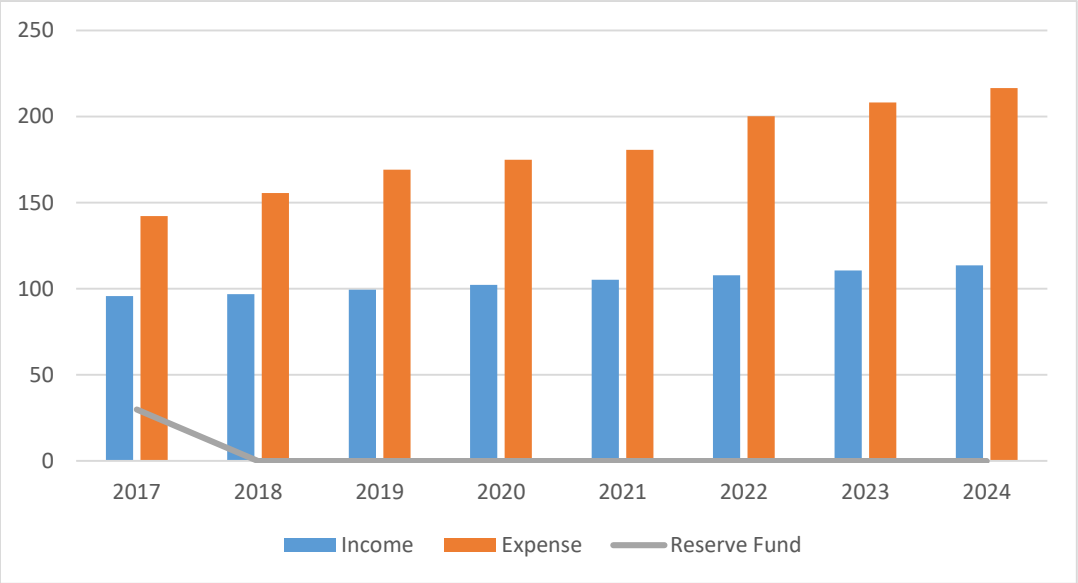


Sources: COA Report, 2017; PhilHealth Financial Statements 2015-2020.

As the pandemic lingers, more Filipinos will be compelled to avail of their PhilHealth benefits, and unemployment rates may also rise again, and despite the current PhilHealth chief's boast of a 132-billion pesos reserve fund (Jalea, 2021), projections (**Figure 19**) made by the "PhilHealth Actuarial Valuation Report" in 2014 (Benipayo & Estrada, 2016), could come to pass from 2020 onwards – especially for PhilHealth's expenses and reserve fund (though these are based on a now-partly-dated status-quo scenario, e.g. no increase in premium rates, rising benefit payments, and no improvement in collection efficiency), once final figures for 2020 claims and premiums have been tallied and publicly released. The researcher filed an FOI request (#PH-291434782117) on PhilHealth's Actuarial Valuation reports, and PhilHealth's reply points out that the "Valuation Report for CY 2020" is still being processed. Only the increase in premium rates have saved PhilHealth from seemingly imminent bankruptcy – at least in the short term, and rising benefit payments coupled with still unimpressive collection efficiency, work against the national insurance corporation's financial health, especially that the national government was also compelled by public clamor to postpone 2021's scheduled premium rate hikes in consideration of the pandemic's negative impact on working people's financial situation.

Figure 19

PhilHealth's Projected Income, Expense, and Reserve Fund (2017-2024) in billion pesos



Source: Raw data from "PhilHealth Actuarial Valuation Report" (2014) in Benipayo & Estrada, 2016.

Except for its “Actuarial Valuation Report” in 2014 – where PhilHealth’s collection efficiency is at 64% for the private sector and 81% for the government – no other publicly available financial statements and reports have collection efficiency statistics. Nevertheless, in a 2018 press release, PhilHealth claimed that “(a)t the close of 2017, PhilHealth’s collection efficiency for the private sector was at 68 percent.” A 2019 privilege speech delivered by Senator Panfilo Lacson revealed that “PhilHealth's collection efficiency rate…is quite impressive at 79%.” In the same year, Senator Franklin Drilon cited concerns that PhilHealth’s actual collection efficiency is just at a very low 50%, and renewed his call for a special COA audit on PhilHealth’s finances. Citing PhilHealth’s projected collection rates for 2021, Marikina Rep. Stella Luz Quimbo says the firm expects “only 10 percent of Individually Paying Program members to pay their premiums this year. The projected collection rate for overseas Filipino workers is lower at 4 percent” (Medenilla et al., 2021). The researcher filed an FOI request on the matter and some of the data are presented in **Table 2**, which shows that collection efficiency rates are still far from ideal (except for the government sector).

Table 2

PhilHealth’s Collection Efficiency (As of December 2020); Efficiency Baseline: 85%

	Formal Economy			Informal Economy		
	Private	Government	Sub-Total	Informal Sector	Migrant Workers	Sub-Total
S-Total NCR	88%	91%	89%	79%	10%	66%
TOTAL (National)	86%	91%	88%	82%	10%	65%

Source: FOI request #PH-443101075857

Endless Greed of Private Health Care Providers: Evidence of Overpayment and Upcasing from Commission on Audit/COA Reports and Senate Investigations

Absent any regulation to limit, minimize or even abolish profit-seeking in the health care sector, PhilHealth funds will continue to bleed as private Health Care Institutions/HCIs gain more profits. Without new regulations, PhilHealth’s support value will also remain lower in private HCIs than in public ones, and hence, patients in private HCIs will still continue to pay big out-of-pocket expenses. A World Health Organization-commissioned health system review (Dayrit et al., 2018) admits that “(t)here is no effective mechanism

to regulate private for-profit health-care providers…There is no effective mechanism in place to monitor the accreditation of facilities, and regulate the cost and quality of services." The same report adds: "Until such time that PhilHealth reimbursement rates approach the true cost of providing care efficiently in the private sector, private hospitals will continue to ask patients to pay balance bills. Under this set-up, the impact of any reforms in provider payment on efficiency and equity will continue to be diluted."

The impact of de-facto privatization on PhilHealth's finances can be also revealed through a close reading of Commission on Audit/COA's findings on its financial statements. Earlier studies (Paterno & Bermejo, 2013; and Benipayo & Estrada, 2018) have also analyzed COA findings, but did not highlight the connection between such findings and private sector dominance. Over-all, direct links to private health care institutions (HCIs) can be observed in the following COA findings in recent years: overpayments to private HCIs, lack of documentary support for claims, possible fraud and/or upcasing, irregular charging of unpaid hospital bills into amount that will be supposedly refunded to patients, and charging co-payments to patients covered by No Balance Billing/NBB policy. For the purpose of this paper, COA's findings on overpayment and upcasing is enough to prove the point.

In 2019, COA observed that in CARAGA, representing 13,055 claims, "pneumonia was the medical case with the highest overpayment amounting to P105.933 million, this difference of 117.67 per cent from the actual charges," labeling it "highly unusual." Furthermore, COA remarked that "(t)he risk that simple coughs could be turned into a medical case of pneumonia may happen and be possibly abused by unscrupulous individuals/institutions." The same COA report adds that such issue has been "recurring," and thus recommends "including a provision that reimbursements should be based on the member-patient's actual hospitalization charges plus PF or the Case Rate amount, whichever is lower.**"**

In a related PhilHealth media release (2019b), Dr. Roy B. Ferrer, PhilHealth Acting President and CEO pointed out that "the tendency of a few unscrupulous providers to defraud the government, particularly in the case of upcasing, ghost patients and fabrication of claims," should be a concern. He adds that "(i)n the case of pneumonia, a

facility can 'upcase' a simple cough or cold by inventing a false claim for pneumonia. So they collect higher reimbursable amounts from P15,000 to P32,000." In the same year, Senate Blue Ribbon Committee[3] head Sen. Richard Gordon Gordon says "PhilHealth disbursed P68.65 billion for 4.76 million pneumonia patients from 2014 to 2020, but DOH data show there were only 2.44 million cases of pneumonia in the country from 2015 to 2020" (Domingo, 2020). This reign of greed must be ended, once and for all by working towards crafting a public sector-dominated health care system and drastically limiting the operations of, if not totally eradicating all profit-oriented private health care firms.

Public Health Care is Cheaper and More *Sulit*: Data on PhilHealth's Support Value

Another reason to transition towards a deprivatized system is the fact that private hospitals are not even cost-effective, as evident in data on PhilHealth's "support value" ("the proportion of total hospitalization costs that are reimbursed by the NHIP") which was "estimated at 31.5%" – 37.3% for public hospitals and only 28.6% for private hospitals (Dayrit et al., 2018). PhilHealth Circular No. 0031-2013 confirmed that PhilHealth's average support value for private health care institutions is lower than 30%. The researcher also filed an FOI request on the matter (see **Table 3 & 4**). These tables show that in general, PhilHealth's support value is still higher in almost all types of government health care facilities compared with private ones. In fact, it's only in Maternal Care Package (MCP) providers that private facilities have matched PhilHealth's support value in government facilities. Thus, this means that PhilHealth's money – our money – is better spent and more maximized, more *sulit,* in public health care facilities.

Table 3

PhilHealth's National Average Support Value in Various Private Health Care Facilities (2017)

Private Facility Type															
Member Category	Level 1			Level 2			Level 3			MCP (Maternal Care Package) Provider			Infirmary/Dispensary		
	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support
National	**63%**	**52%**	**53%**	**48%**	**41%**	**42%**	**40%**	**35%**	**36%**	**99%**	**72%**	**73%**	**71%**	**57%**	**58%**

Legend: USV – Unadjusted Support Value; ASV – Adjusted Support Value

Note. Data from author's FOI request #PH-435443369785. Figures were rounded off.

[3]Sen. Gordon was supposed to release the Senate Blue Ribbon Committee's report on the matter in September 2020, but he deferred it and as of this writing, based on a search at http://legacy.senate.gov.ph/lis/leg_sys.aspx for all reports released from November 2020 to January 2021, such report is still unreleased.

Table 4

PhilHealth's National Average Support Value in Various Government/Public Health Care Facilities (2017)

Government Facility Type															
Member Category	Level 1			Level 2			Level 3			MCP (Maternal Care Package) Provider			Infirmary/Dispensary		
	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support
National	**84%**	**66%**	**67%**	**74%**	**59%**	**60%**	**71%**	**56%**	**57%**	**99%**	**72%**	**73%**	**85%**	**67%**	**68%**

Legend: USV – Unadjusted Support Value; ASV – Adjusted Support Value

Data from author's FOI request #PH-435443369785. Figures were rounded off.

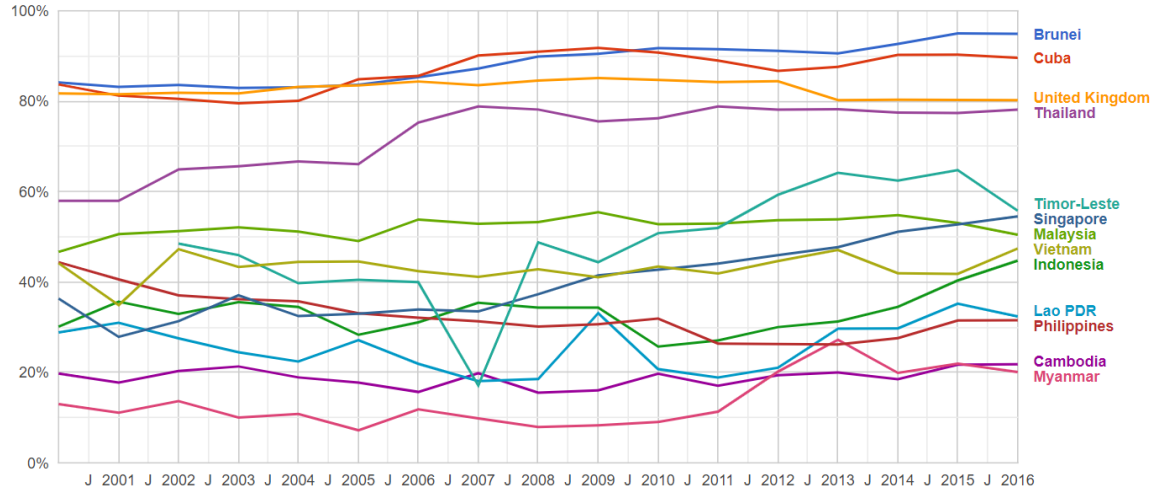
Further hikes in premium rates or mandatory contributions to PhilHealth will be politically unpalatable because taxpayers are still reeling from the pandemic's effects, and rates are already high and scheduled to increase annually until 2025. Thus, adopting a better system away from commodification and privatization seems to be the only cost-effective way to go. International benchmarks can offer insights towards achieving such goal.

Building the National Health Services: (NHS) Increase State Spending for Health Care, Abolish HMOs, & Transition to a Fully-Public Health Care System

In raising revenues for the health care system, the Philippines can learn from Cuba & the United Kingdom's big state expenditures for health care which offer some protection against commodifying or treating health care as a business opportunity for private firms rather than a human right that must be upheld by the state and enjoyed by all. Citizens in Cuba & the United Kingdom, and in most Southeast Asian countries too, are somehow protected from OOPPs because of the huge resources spent by their respective states on health care (**Figure 20**), which are mostly way above state spending in the Philippines.

Figure 20

Domestic general government health expenditure (% of current health expenditure), 2000-2016



Note. World Bank data from Google Public Data Explorer (2021).

In the Philippine situation, the data suggest that OOPPs can be further reduced (or even totally wiped out) if bigger government expenditure on health care will be guaranteed and consistently implemented. **Bigger state spending on health care will automatically help us transition towards a system that covers all expenses – a genuinely 100% free health care!** Indeed, this explains why the Makabayan Bloc's House Bill 9515 stipulates that "the primary mode of financing the health care system shall be government appropriation for public health care as part of the DOH budget and the annual General Appropriations." This is closer to the Cuban model which is 100% tax-funded. Meanwhile, UK's NHS is partly funded "with a small amount from National Insurance Contributions (NICs)" (Cylus et al., 2015) which is mandatory for those "16 or over and are either: an employee earning above £184 a week" – equivalent to 12,415 pesos, or "self-employed and making a profit of £6,515 or more a year" (UK Government, n.d.) – equivalent to 439,569 pesos or more. Considering the Philippines' big population (around 111 million as of 2021, compared with Cuba's 11 million & UK's 68 million), it seems more practical to retain mandatory public insurance payments (e.g. PhilHealth premium contributions), while ensuring that corruption is eradicated and a top-heavy bureaucracy is trimmed down. Meanwhile, House Bill 9515 favors the abolition of PhilHealth and mandatory premium contributions, coupled with the establishment of a purely tax-funded health care

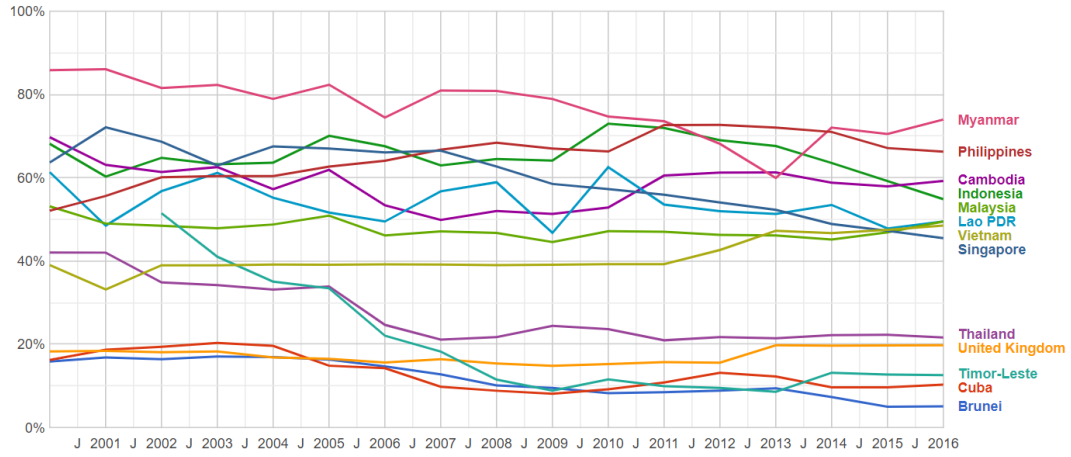
system – providing an impressive, but nevertheless, possibly insufficient list of tax sources.

While we may disagree with the abolition of mandatory public insurance payments, as the surveyed countries' cases show, at the very least, drastically increasing government expenditure for health care is certainly doable even within the confines of current mainstream economic thinking. For better results and broader sources of funding, a two-pronged approach can be tried on this regard: state spending for health care is increased and public health insurance premium for middle-class and rich employees and employers be **painlessly hiked**. Of course, the latter can only be feasible if private health insurance is abolished, and huge premium payments formerly gobbled up by private HMOs would instead be diverted to the public health insurance system. Under such a scheme, increasing the public health insurance premium rates for middle-class and rich employees and employers is **technically painless as they are only re-channeling payments previously made to HMOs to the public health insurance system instead, which, as explained above is better maximized in the public health care system. In exchange for a system that drastically reduces if not totally eliminates OOPPs for all health services, abolishing HMOs and consequently re-aligning resources previously spent by their Filipino clients into the public insurance system, is a necessary and very cost-effective move.** These profit-oriented HMOs have no place in a country where health care is enshrined as a human right in the Constitution, as they don't actually serve the people but exist only to reap profits, accumulating huge premiums which their rich shareholders pocket as dividends, while they refuse to cover/reimburse many health care expenses that their clients need. For example, during this pandemic, as my own experience proves, **HMOs refuse to cover/reimburse COVID-19 swab tests for asymptomatic cases.** Thus, I disagree with House Bill 9515's provision allowing the continued existence of HMOs, albeit "subject to State regulation." I think that HMOs would have to be abolished if we are to swiftly transition to a fully publicly funded & generally public health care system. As the HMOs' sole purpose is to accumulate profits, their continued existence will be a big obstacle to a general paradigm shift towards the decommodification of health care.

Cai et al.'s (2020) study on the projected costs of single-payer healthcare financing in the United States can be replicated for the Philippines. Their study found out that "replacing private insurers with a public system is expected to achieve lower net healthcare costs." Within the context of Cai et al.'s research (2020), the Philippines' huge private spending for health care (**Figure 21**) which is among the worst in Southeast Asia – and a big portion of which is gobbled up by private, profit-oriented HMOs as shown by the Insurance Commission's statistics on HMO revenues in the Philippines, pegged at 24 billion pesos as of June 2019 – can instead be realigned to public health insurance and the public health care system where every cent is more maximized as nothing is spent for profit-taking and everything is only spent for services. The current big role of private insurance in health care spending in the Philippines (80 billion pesos or 10.1% of the total spending) is also summarized and compared with public spending and OOPPs in **Figure 22**.

Figure 21

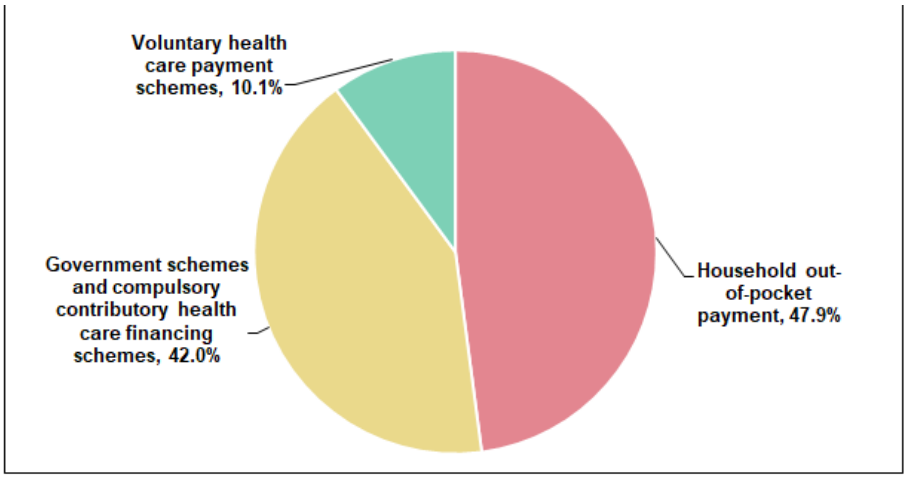
Domestic private health expenditure (% of current health expenditure), 2000-2016



Note. World Bank data from Google Public Data Explorer (2021).

Figure 22

Current Health Expenditure by Health Care Financing Scheme: 2019



Source: Philippine Statistics Authority

Note. Data from the Philippine Statistics Authority, 2020. The same report notes that spending for "providers of health care system administration and financing (7.4%) accounted for PhP 58.9 billion." Technical jargon aside, such expenses are nothing but private bureaucratic waste innate in a fragmented, highly privatized system which could be eliminated if the health care system transitions towards a fully publicly run and financed one.

Cuba & the United Kingdom offer lessons on transitioning towards a public sector-dominated health care system which is capable of minimizing OOPPs. United Kingdom offers middle-of-the-way approach as their country retains private providers but the system is nevertheless dominated by the public sector which ensures that profit-taking in health care, and hence health care commodification is the exception rather than the rule. However, recent complaints on creeping, piecemeal privatization of UK's NHS (see Givan & Bach, 2007; Calovski & Calnan, 2020; Hall et al., 2020; and Davies, 2020) should also caution the Philippines against retaining private providers absent any strong regulation to limit if not totally eliminate profit-taking and "profit-orientedness" of private health care providers. With regard to coverage scope of each health care system's services, Cuba offers the best deal as it technically covers all services.

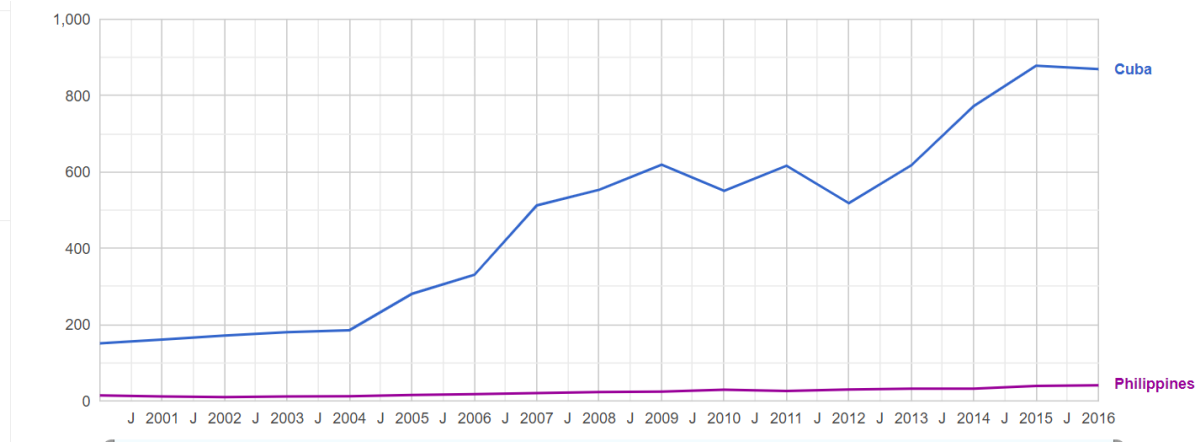
The Philippines can even be in a better situation than Cuba – if reforms are instituted (e.g. at the very least, catching up with Cuba's impressive state spending per capita; see **Figure 23**), as our country has more financial leeway (as we do not face an economic blockade, and our GDP is relatively bigger as seen in **Figure 24**, and current private

spending on health care proves that there is cash elsewhere which can be rechanneled towards the public insurance and public health care system). The Philippines can certainly minimize waiting times too, as the country has the financial and human resources for ideal patient to medical personnel ratios, if the country's decades-long record as a health care personnel-exporting nation will be taken into consideration (International Labour Organization, 2006; **Figure 25**), while at the same time replicating Cuba's impressive maximization of state resources for a public health care system that punches above its weight – taking care of its citizens and at the same time, having personnel and resources for international health solidarity too (see Huish, 2014 & 2020; Birn & Muntaner, 2018; Escobedo et al., 2021) and tops regional benchmarks in life expectancy and other health outcomes too despite relatively meager resources and lack of private insurance.

The Philippines can thus be a regional leader in health care equity – the Cuba of health care in Southeast Asia, minus Cuba's current disadvantages (which, to its credit, are somehow beyond its control – especially when USA's trade embargo against them is taken into account – and thus still show how impressive their achievements are, in a relative sense).

Figure 23

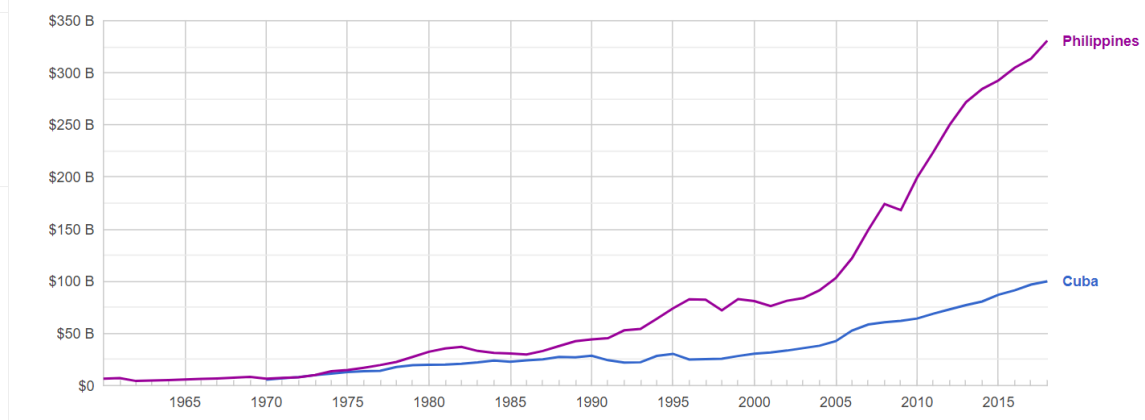
Cuba and the Philippines' domestic general government health expenditure per capita (current US$), 2000-2016



Note. World Bank data from Google Public Data Explorer (2021c). Source adds this note: "Public expenditure on health from domestic sources per capita expressed in current US dollars."

Figure 24

Cuba and the Philippines' GDP, 1960-2016



Note. World Bank data from Google Public Data Explorer (2021b). Source adds this note: "GDP in current U.S. dollars. Not adjusted for inflation."

Figure 25

Deployed Landbased Overseas Filipino Workers by Top 10 Skills-New Hires

Major Occupational Group	2016	2015	% CHANGE
Household Service Workers	275,073	194,835	41.18
Manufacturing Labourers	43,538	41,038	6.09
Nursing Professionals	19,551	22,175	-11.83
Waiters	18,812	18,352	2.51
Cleaners and helpers in offices, hotels and others	17,006	14,116	20.47
Home-based personal care workers	8,095	10,181	-20.49
Civil engineering labourers	7,718	7,286	5.93
Welders and flamecutters	7,437	8,156	-8.82
Plumbers and pipe fitters	6,696	6,629	1.01
Building construction labourers	5,906	5,870	0.61
Other Skills	172,984	186,579	-7.29
Total-New Hires	**582,816**	**515,217**	**13.12**

Note. Data from the Philippine Overseas Employment Administration (POEA), 2016. Nursing professionals are still in the top skills of new hires for Overseas Filipino Workers/OFWs. Such brain and brawn drain in health care proves that the country has the human resources to plug gaps in local needs, if enough financial incentives are offered for health care professionals to stay and serve in the public health care system, rather than go and work overseas.

Conclusion

This paper has established that the current Universal Health Care (UHC) system in the Philippines is not good enough because it allows citizens to suffer from huge yet largely avoidable OOPPs. Furthermore, the current health care system's de-facto privatization

masquerading as a “public-private partnership” scheme has been proven to be among the chief causes of the depletion of PhilHealth funds. Finally, a practical plan to build an NHS for the Philippines that will provide 100% free health care to all citizens, with no co-payments or huge out-of-pocket payments (OOPPs) has been outlined through increasing state spending for health care and re-aligning private insurance payments into public health care premiums. Along with Makabayan Bloc’s House Bill 9515, insights from this paper can help popularize the idea of a 100% free health care for every citizen. Ending the tyranny of financial crowdsourcing, online begging, and medical-related bankruptcies which should have no place in a genuinely caring & sharing community that we all aspire to achieve in the near future, is thus proven possible.

Against the prevailing mood of doom and gloom, of apathy and despair amidst the seemingly insurmountable reign of corrupt-to-the-bones and generally inept political dynasties backed by big businessmen who have no sense of nation-building and who only exist solely to accumulate wealth as the rest suffer in unbearable wretchedness, powered by an army of paid trolls who sow disinformation, and bolstered by state security forces coupled with a top-heavy bureaucracy that seem to have equated “the state”/“the people”/“the Republic” with “the sitting president,” all citizens are thus called upon to set the agenda for 2022 and ensure that all presidential, senatorial, and partylist campaigns will have building an NHS for the Philippines as a priority issue.

Health and power to the people!

07 June 2021

Written while in quarantine and on the way to full recovery from COVID-19.

In memory of all COVID-19 victims in the Philippines – a largely avoidable tragedy if our situation as an archipelago will be taken into account (see Ryall, 2020; Graham-Harrison, 2020).

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Appendix:

Selected Corporate-owned/Corporate-linked, PhilHealth-accredited Private Health Care Institutions

Hospital	PhilHealth Accreditation	Corporate Owner/Co-Owner or Corporate Linkages	Note on Owner or Business Partner
Makati Medical Center	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc. (MPHHI)	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Davao Doctors Hospital	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Cardinal Santos Medical Center	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Dr. Pablo O. Torre Memorial Hospital	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Our Lady of Lourdes Hospital	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Asian Hospital, Inc.	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
De Los Santos Medical Center	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Central Luzon Doctors' Hospital, Inc.	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Manila Doctors Hospital	Level 3 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
St. Elizabeth Hospital, Inc.	Level 3 Hospita	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Sacred Heart Hospital of Malolos, Inc	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
West Metro Medical Center	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Marikina Valley Medical Center	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Dr. Jesus C. Delgado Memorial Hospital	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Manuel J. Santos Hospital	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Los Baños Doctors Hospital And Medical Center, Incorporated	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed

Ramiro Community Hospital	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Calamba Medical Center, Inc.	Level 2 Hospital	Metro Pacific Hospital Holdings, Inc.	MPPHHI shareholder Metro Pacific Investments Corporation (MPIC) is stock-listed
Qualimed Health Network Sta. Rosa	Level 2 Hospital	Part of a network of healthcare facilities "owned and operated by Mercado General Hospital, Inc. (MGHI) in partnership with Ayala Land, Inc. (ALI)"	ALI is stock-listed
Qualimed Health Network SJDM	Level 2 Hospital	Part of a network of healthcare facilities "owned and operated by Mercado General Hospital, Inc. (MGHI) in partnership with Ayala Land, Inc. (ALI)"	ALI is stock-listed
Qualimed Health Network (Iloilo)	Level 2 Hospital	Part of a network of healthcare facilities "owned and operated by Mercado General Hospital, Inc. (MGHI) in partnership with Ayala Land, Inc. (ALI)"	ALI is stock-listed
Daniel O. Mercado Medical Center	Level 2 Hospital	Part of a network of healthcare facilities "owned and operated by Mercado General Hospital, Inc. (MGHI) in partnership with Ayala Land, Inc. (ALI)"	ALI is stock-listed
CAPITOL MEDICAL CENTER, INC.	Level 3 Hospital	Among the partner-hospitals of Mount Grace Hospitals, Inc. (MGHI) – "a member of the United Laboratories Group, the Philippines' largest pharmaceutical company"	Unilab is a privately-held company, "now the biggest pharmaceutical company in Southeast Asia based on revenue of close to $900 million in 2013…" (Dumlao-Abadilla, 2015); Capitol Medical Center, Inc. has stockholders based on a public announcement for a stockholder's meeting (2020)
Medical Center Manila (ManilaMed)	Level 3 Hospital	Among the partner-hospitals of Mount Grace Hospitals, Inc. (MGHI) – "a member of the United Laboratories Group, the Philippines'	Unilab is a privately-held company, "now the biggest pharmaceutical company in Southeast Asia based on revenue of close to $900 million in 2013…" (Dumlao-Abadilla, 2015); ManilaMed's corporate website also notes that "(i)n March 2013, Mount

		largest pharmaceutical company"	Grace Hospitals Inc. bought majority shares of HMSI and now operates and manages Medical Center Manila, rebranding it with its former nickname, ManilaMed."
St. Luke's Medical Center Global City	Level 3 Hospital	Private stockholders	According to a 2018 Securities and Exchange Commission advisory, it is "authorized to issue...shares to the public."
Diliman Doctor's Hospital Inc.	Level 2 Hospital	Private stockholders	According to a 2018 Securities and Exchange Commission advisory, it is "authorized to issue...shares to the public."

Sources: PhilHealth data vis-à-vis corporate websites.

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