The Philippine Universal Health Care Law: A Differing View

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Abstract

The World Health Organization espouses Universal Health Care (UHC) as a means to address health inequity and allow the poorest sections of the population to access health care. In the Philippines, government efforts to implement this have evolved over the last ten years, resulting in the passage of the Universal Health Care Act in 2019. The law relies heavily on health financing as the central driver of the healthcare system reforms. This article describes and analyzes key actors on the implementation of the UHC Act, particularly the insurance program it is anchored on, the agency that will be primarily tasked to implement it, and the overarching principle behind the law. These are burdened with problems that are anathema to the outcomes sought. Rather than a market based neoliberal capitalist direction in health development, a rights-based approach is posited to be a better framework and roadmap to achieve health for all. **Key words**: health financing; health insurance; equity, access to healthcare

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Introduction

The Philippine healthcare system is burdened by issues and challenges that have accumulated over several decades. Inequities in health remain widespread and the lack of access to basic services is still the major concern in the country. Children born in the poorest households are four times more likely not to reach their fifth birthday compared to those born in the richest households (1). Regional and socio-economic discrepancies in availability and accessibility of healthcare resources are substantive. The country's two-tiered health system has resulted into parallel systems operating side by side: there is the underfunded, understaffed, and resource-poor public healthcare system that caters to the vast majority of the population on one hand, and the expensive and well-equipped private healthcare system on the other (2).

The cost of healthcare is so prohibitive that hospitalization or a chronic illness can easily be catastrophic financially. Illness and the corresponding treatment had pushed 1.5 million Filipinos into poverty (3). This is aggravated by the high prices of medicine (4). These, together with the limited number of government-run healthcare facilities especially in areas away from city centers, result in the lack of access to healthcare by the poor (2,5,6).

Several key government health programs have been made in an attempt to improve access to healthcare. In 1999, the Estrada administration formulated the Health Sector Reform Agenda, which sought to focus government intervention in health in five key areas (7). The Macapagal-Arroyo administration that followed further took february the Philippine Health Insurance Corporation (PhilHealth) as a central player in healthcare (8).

The Universal Health Care (UHC) model espoused by the World Health Organization (WHO) was adopted by the Aquino administration in 2010, which named its entire health program as Kalusugang Pangkalahatan, the Filipino translation of UHC (9). The main thrust was to further expand PhilHealth coverage and increase its benefits. The Duterte administration took this a step further and promulgated RA No. 11223 or the UHC Law in 2019.

The WHO dubbed the passage of UHC law as the "new dawn of healthcare" and is expected to address the most fundamental issues in the Philippine healthcare, particularly in terms of access to health care and services (11). Yet the UHC Law is framed around PhilHealth. This paper therefore seeks to determine if reforms through a health insurance-based system is the way to achieve health for all. The paper also analyzes the law through the global experience of how the WHO moved from Primary Health Care to Universal Health Coverage.

PhilHealth as the major component of the Universal Health Care Law

The National Health Insurance Corporation was established in 1995 through RA 7875 to implement the National Health Insurance Program (NHIP) (12). As a social health insurance program, it was meant to allow the rich to share in the burden of healthcare for the poor. Much of the trajectory of health development in the Philippines followed the prescriptions contained in the 1993 World Bank Report entitled "Investing in Health", including the establishment of a social health insurance program (13).

However, the NHIP did not become a core reform area in the Philippine healthcare system until 2004, when PhilHealth figured prominently in the presidential elections (14,15). Since then, PhilHealth has taken a more prominent role the provision of health care.

The UHC Law was enacted in 2019 as Republic Act No. 11223 (10). It is anchored on PhilHealth and based on its language, reads like a health financing document. Out of the 46 sections of the Law, 27 contain the terms "PhilHealth", "NHIP" and related terms while 24 sections include financing terms like "private risk protection", and health maintenance organizations (HMOs). Overall, 25 out of 46 sections (76%) are about PhilHealth and health financing.

The UHC Law can be broken down to two major parts: (1) provisions that strengthen PhilHealth and (2) provisions on Department of Health (DOH) mandates.

Provisions that Strengthen PhilHealth

The UHC Law provides PhilHealth with greater scope. Population coverage is expanded as all Filipino citizens are automatically enrolled in the program. Service coverage is also increased to include goods and services deemed appropriate by the Health and Technology Assessment Council (HTAC). Outpatient benefits like outpatient medication for chronic illnesses and medical services are also included, as recommended by HTAC (Chapter 2).

The local health system is re-organized to further widen the scope of PhilHealth (Chapter 5). Local health units are categorized and organized into a province- and city-wide health system. These are further organized into service delivery networks (SDNs) that includes private primary care providers (Chapter 4).

Resources are to be managed and pooled through the Special Health Fund (SHF), which comes from both non-governmental organizations and government agencies. In this scheme, PhilHealth is the main financial provider of the organized local health system (Chapter 5).

PhilHealth will have access to greater funds under the UHC Law (Chapter 3). With expanded population coverage, the number of people paying premiums will likewise increase. Moreover, monthly premium rates will increase in a stepladder manner, from 2.75% in the first year of implementation to 5% in the fifth year. The income ceiling, for which the maximum amount of contribution is based, will also increase from P50,000 in 2019 to P100,000 in 2024. Such collections are supposed to help PhilHealth attain its P257B and P280B budgets for its first two years of implementation.

At the same time, PhilHealth is given stronger regulatory functions (Chapter 7). It decides on incentives to be given to hospitals that provide quality health service based on their rating system. PhilHealth, together with the DOH, will oversee the prices of health services and health products (including drugs and heath devices).

PhilHealth will also be involved in the preferential licensing of health facilities in geographically isolated and disadvantaged areas (GIDA), which are the underserved and unserved areas in the country.

DOH Mandates

The UHC Law includes provisions on DOH mandates. While the department is already performing some of these provisions, other provisions still need to be implemented.

For instance, the law mandates the DOH to coordinate population-based health services and interventions (Chapter 4). Population-based health services, including epidemiological survey and proactive and effective health promotions program, are meant as public health programs. Yet all of these are currently being performed by the DOH already. Furthermore, provisions on human resources (Chapter 6) that include a health workforce support system and scholarships with return service agreement are already in place and have been implemented by the DOH under the Pinoy MD program prior to this law.

Some provisions of the UHC law also focus on matters that should have been performed by the DOH but have not done so. For instance, the DOH has yet to establish a proper registry of medical and allied health professionals (Chapter 6) before enactment of the law. Additional mandates of the DOH in the UHC law are safety and quality assessment of drugs (Chapter 7) and health technology assessment (Chapter 8).

PhilHealth Performance

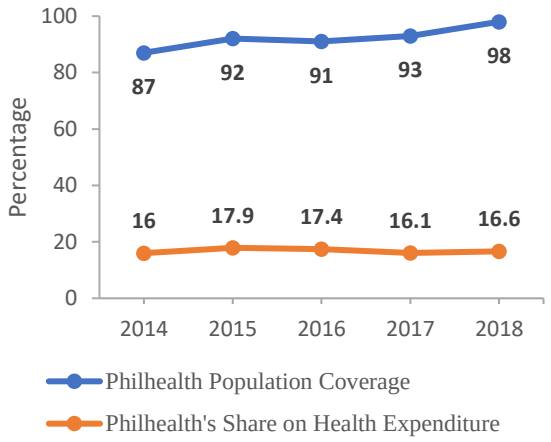
Over the last two decades, PhilHealth has taken a more central role in the provision of healthcare. The UHC law essentially expands PhilHealth. However, PhilHealth itself is afflicted with problems that complicate its expanded role.

Insufficient Financial Risk Protection

PhilHealth has reported an increase in its year-to-year population coverage from, from 87% in 2014 to 98% in 2018 (Figure 1) (16). But this increase in coverage does not translate to an increase in the share of health expenditure. In fact, even though there is a continued increase in population coverage from 2016-2018 (91-98%), there is a slight decrease in PhilHealth's share of health expenditure in the same period (17.4-16.6%) (16,17).

Out of pocket (OOP) expenditure remains the highest source of health financing in the Philippines, accounting for more than half the total health expenditure (Figure 2) (17). Despite substantial increases in budgetary allocation of PhilHealth from P2 B in 2010 to P57.13B in 2018 (Figure 3), there is no substantial decrease in OOP during the same period (18).

Figure 1.



Percent Population Coverage and Percent of PhilHealth's share on Health Expenditure. Increases in population coverage do not mirror any increase in PhilHealth's share on health expenditure. Source: Philhealth, 2018 (16); PSA, 2019 (17)

Support value is a key financial indicator used by PhilHealth to measure financial risk protection of its members. This is defined as the percentage of total costs that is covered by PhilHealth during hospital stay. Support value has been reported to be approximately 40-60% in the period of 2012-2018, with an average of 33.8% (16,19). An independent study showed that individual support value might vary, from a meager 10% to almost 100%, depending on hospital ownership, severity of the case, and type of membership (19,20).

PhilHealth introduced the No Balance Billing (NBB) policy in 2011 for equitable financial protection of indigents, sponsored members, lifetime members, senior citizens, and "kasambahay" (household help) (21,22). However,

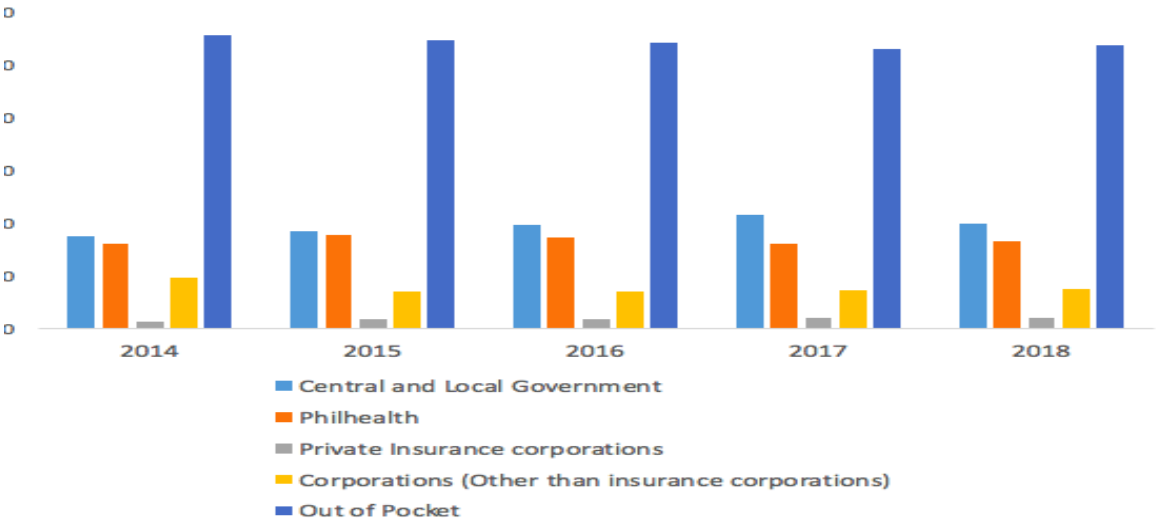
implementation of the program proved to be difficult. Lam and Rivera (2017) documented several hospitals committing NBB policy violations (23). By 2018, only 84% of sponsored and indigent members had NBB (16). Gaps still remained in its full implementation.

Poor Utilization

PhilHealth suffers from a low utilization rate. By their own statistics, only 14% of eligible members were able to utilize PhilHealth benefits in 2017 (16).

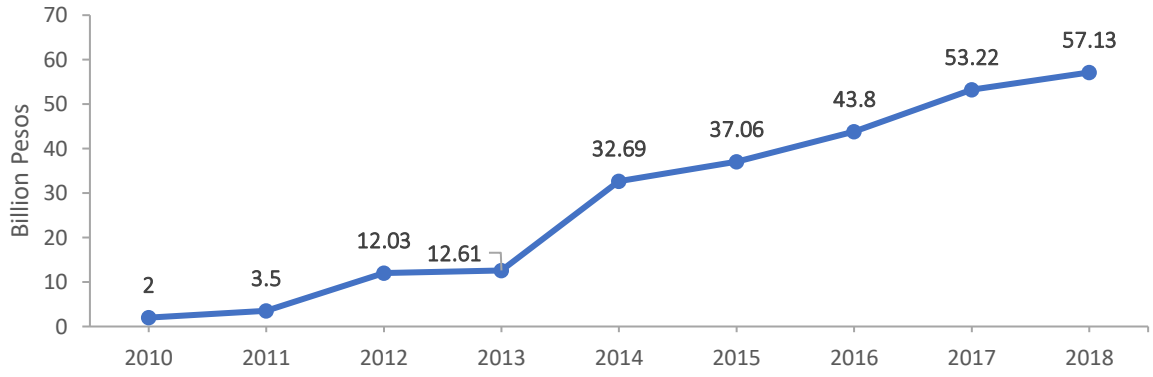
In the study by Faraon et al. among PhilHealth members in selected communities in Manila, underutilization of benefits is highest among the sponsored members (24). Sponsored members belong to the poorest quintile of the

Figure 2.



Sources of health financing in the Philippines. OOP expenditures were still the highest source of financing health expenditures. Source: PSA, 2019 (17)

Figure 3.



Budgetary allocation of PhilHealth (in Billion Pesos). There is a considerable increase of PhilHealth Budget from 2010 to 2018. Source: DOH, 2018 (18)

population and are supposed to be the main beneficiaries of the NHIP. In addition, the study revealed that those who had the lowest income had the highest underutilization rate (64%). These results point to a disconnect between the stated PhilHealth goal and actual service utilization. While the objective of PhilHealth is to provide access to quality health care for the poor, the poor are the very ones who are unable to fully utilize its benefits.

Several factors affect poor service utilization despite PhilHealth membership. These include lack of awareness of PhilHealth programs and benefits, lack of awareness of its processes, including perceived obstacles due to the numerous requirements, and lack of appropriate documentation for claiming benefits (25, 26, 27).

Another major reason why poor families forgo their PhilHealth benefits is the indirect costs of healthcare, which are substantial. This includes perceived and actual OOP expenses, transportation costs, and lost wages. Mothers who choose to utilize their PhilHealth card for a healthcare facility still have to spend PHP 2275 for their care, PHP 69 for transportation, and if employed, will lose potential wage for that day of around PHP 481. This will result in at least PHP 2825 OOP expenses, a considerably large amount for poor families who can only spend approximately 2% of their income for health (27).

Corruption Issues

Issues of anomalies, fraud, and corruption have consistently plagued PhilHealth. According to the Commission on Audit (COA) report, PhilHealth has lost around 154 billion pesos in 2013-2018 due to overpayments and fraudulent schemes (28). The COA also flagged unauthorized perks given by PhilHealth to its officials and personnel in 2009, 2010, and 2014, amounting to P164 million. In 2012, several PhilHealth officials were suspended for alleged fund diversion amounting to P114 million (29).

Loopholes in the PhilHealth system are exploited for fraudulent schemes, which include ophthalmologists performing unindicated cataract surgeries to claim benefits; hospitals issuing fake medical receipts to pad charges and fees and thus increase claims; and dialysis centers filing for claims of deceased patients (28,30,31). In 2020, around 20,000 possible fraud cases in the agency have been investigated (32).

The latest of PhilHealth anomalies is the P15 billion "lost funds" due to the Interim Reimbursement Mechanism in 2020 (33). This was heavily investigated by the Philippines Senate, eventually leading to the resignation of the PhilHealth president and the filing of cases against top officials of the agency (34,35).

The failure of PhilHealth to substantially decrease OOP expenses, mitigate health inequities, improve healthcare utilization, and address issues of corruption has undermined its credibility. Obermann and colleagues have suggested reforms in the organization to improve its capacity to lead the way towards improving healthcare services (8). However, these reforms are not enough to help achieve the national goals. There are innate problems in the framework on which PhilHealth and the UHC Law is based on: the Universal Health Coverage framework pushed by the WHO.

Moving Away From Primary Health Care

The focus of the WHO has considerably changed from the 1978 Alma Ata Declaration on Primary Health Care (PHC) to the 2018 Astana Declaration on Universal Health Coverage.

Putting forward PHC as a new international health policy, the WHO cemented the rights-based approach to health in clear, unequivocal terms in the 1978 Alma Ata Declaration (36). The holistic and community-oriented approach called attention to "existing gross inequalities among and within nations" as unacceptable and called on governments to work towards attaining the "highest level of health as a worldwide social goal". The definition of health emphasized the "complete physical, mental, and ***social*** well-being" rather than just "the absence of disease or infirmity" (underscoring ours). Thus, achieving health was not just through improvements in the healthcare delivery system but more on social and economic development.

However, the rise of neoliberalism, or the market-based capitalist approach to health, has become anathema to PHC. This encroachment is clearly articulated in the World Bank Report "Investing in Health", which basically turned healthcare into a commodity and patients into

consumers (13). The report also pushed for austerity measures and encouraged shifting of healthcare financing from governments to individuals, while at the same time promoting healthcare privatization through market competition, especially among private healthcare "providers" and even insurers. Left to neoliberal market forces, healthcare became even more inaccessible to patients.

The WHO adapted this neoliberal approach in its push for Universal Health Coverage, which, despite the rhetoric, focused more on coverage (i.e. private or public insurance systems) than on the actual provision of care (37). The policy is plagued with neoliberal elements like the proliferation of user fees, the privatization and outsourcing of health care, and the entry of market forces for profiteering corporate interests (i.e., insurance companies, and pharmaceuticals) (38).

Thus, despite attempts to reiterate its stance on PHC and the Social Determinants of Health ("Primary Health Care: Now More Than Ever" in 2008 (39); Social Determinants of Health Commision in 2005 (40)), the WHO largely moved to favor Universal Health Coverage as its principal policy ("Health System Financing: The Path to Universal Coverage" in 2010 (41); "Arguing for Universal health Coverage" in 2013 (42)). Widely adapted by policymakers worldwide, Universal Health Coverage was even heralded as one of the 2015 Sustainable Development Goals: "Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (43). By this defintion, two fundamental elements of Universal Health Coverage are evident: essential services and financial risk protection. "Essential services" is the term used for the limited (rather than comprehensive), packaged, and commodified healthcare services while "financial risk protection" only means the prevention of medical bankruptcy and protection of insurance capital (44).

By 2018, the WHO Astana Declaration proclaimed that Universal Health Coverage can be attained through PHC but essentially cemented its neoliberal approach as "all people have equitable access to quality and effective health care they need', safe from "financial hardships" (45). Thus, the WHO, while paying lip service to the PHC principles, had actually adopted a framework dominated by neoliberalism.

Criticisms of UHC

Changes in the WHO outlook and emphasis from Alma Ata to Astana did not escape scrutiny. Sanders and colleagues described the move to Universal Health Coverage as "one step forward and two steps backward" in attaining health for all (46). In the same year, the Peoples' Health Movement, a global network of PHC advocates, released a statement on behalf of civil society and called the dominant discourse on Universal Health Coverage as "favoring market-based neoliberal reforms" (47). Bern and Nervi noted that Universal Health Coverage "stems from, and is consistent with, the neoliberal turn in global capitalism" (44). Recent analysis of Cabello 2021 echoed the same sentiments that Universal Health Coverage is "new facet of neoliberalism in health policies arena" (48).

UHC Failures

To be clear, Universal Health Coverage does not at all ensure health for all. On the contrary, health insurance schemes that are promoted by governments in pursuit of Universal Health Coverage are excluding majority of the people, "leaving the poor behind" (49).

A study in sub-Saharan Africa has shown that access to primary obstetric care is hindered by factors beyond health coverage. This includes transportation costs, cultural beliefs, stigmas, and physical distance to facilities (50). Similarly, non-financial factors like physical accessibility of facilities and biomedical barriers deter access to primary care in Vietnam and in Bangladesh (51).

The poor quality of services due to insufficient health workers, medicines, and equipment continues to afflict countries implementing Universal Health Coverage (52), resulting in further disparities in health services across socio-economic groups. The privileged tend to prefer and receive higher quality healthcare from private and higher institutions, while the poor and underprivileged have much less options and are left with low quality care (52,53).

Philhealth and Universal Health Coverage

The failure of WHO's Universal Health Coverage is mirrored by the failures of the Philippine government-run health isurance program. Increased budgetary allocation did not translate to higher utilization of PhilHealth or better access by the poor to health services. Worse, the mixed financing, both from government funding and from private payments of premium, has severely aggravated health inequities. Such disparities were documented by Caballes and colleagues in their study on the utilization of PhilHealth by the poor in hospitals. The study revealed that the poorest 20% of Filipinos were not the ones who utilized PhilHealth the most even though they were supposed to be its principal beneficiary. Instead, it was the near-poor and middle 20% of the population who benefitted from PhilHealth (54).

Moreover, PhilHealth has failed to substantially reduced OOP as it failed to socialize health costs among its members. It failed to protect the Filipinos poor from catastrophic health expenditure and did little to reduce the exorbitant costs of healthcare in the country for the rest of the population. Instead, PhilHealth functioned more as a corporate entity, a conduit for health services as market goods that enriched private hospitals, laboratories, and drug companies.

The two most recent Philippine governments - the Aquino and Duterte administrations - have their respective versions of Universal Health Coverage. Both versions, however, are predicated in packaging and commodifying healthcare (Aquino's Essential Health Package and Duterte's Minimum Health Package) rather than providing comprehensive and holistic services (10,55,56). Both have put health financing as the main driver of health policy and "reforms", thereby subscribing to the WHO's Universal Health Coverage framework and the neoliberalism it embodies. The yawning gap between healthcare available to the poor and the rich remains.

Conclusion

The Universal Health Care Law in its present form is essentially an expanded PhilHealth, an insurance program that embodies a neoliberal approach to health. The UHC law reinforces, expands, and strengthens the National Health Insurance Program and makes it the central driver of the country's healthcare system. However, both the program and institution implementing it are replete with problems that the law does not address or mitigate. If the WHO's Universal Health Coverage is meant to reduce health inequities and improve healthcare utilization by marginalized populations, implementing it through a law anchored on a market-driven health insurance program will be problematic. A better framework is warranted. As articulated in the Alma Ata Declaration, a holistic and rights-based approach is still the best way towards achieving health for all. Even under a capitalist society, a rights-based healthcare system can be achieved if the prevailing government policy puts premium on human life and health, thereby ensuring that all government agencies function towards this end. As such, a system that regards health as a basic human right is more capable of providing comprehensive healthcare services than one driven by health financing and market forces.

References

1. Philippine Statistics Authority (PSA) and ICF. Philippines National Demographic and Health Survey 2017. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF; 2018.

2. Dayrit MM, Lagrada LP, Picazo OF, Pons MC, Villaverde MC. The Philippines Health System Review. New Delhi, India: World Health Organization, Regional Office for SouthEast Asia; 2018.

3. Bredenkamp C, Buisman LR. Financial protection from health spending in the Philippines: policies and progress. Health Policy Plan. 2016 Sep;31(7):919-27. doi:10.1093/heapol/czw011. Epub 2016 Apr 11. PMID: 27072948.

4. Lambojon K, Chang J, Saeed A, Hayat K, Li P, Jiang M, Atif N, Desalegn GK, Khan FU, Fang Y. Prices, Availability and Affordability of Medicines with Value-Added Tax Exemption: A Cross-Sectional Survey in the Philippines. Int J Environ Res Public Health. 2020 Jul 21;17(14):5242. doi: 10.3390/ijerph17145242. PMID: 32708060; PMCID: PMC7400398.

5. Collado ZC. Challenges in public health facilities and services: evidence from a geographically isolated and disadvantaged area in the Philippines. Journal of Global Health Reports. 2019 Nov 21;3. doi: 10.29392/joghr.3.e2019059

6. Ulep VGT, Casas LDD. Regional health integration and cooperation in the Philippines. Quezon City, Philippines: Philippine Institute of Developmental Studies; 2021. Report No.: 2021–16.

7. Department of Health of the Philippines. Annual Report 1999: Setting the Agenda for Reform. Manila, Philippines; 1999.

8. Obermann K, Jowett M, Kwon S. The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis. Glob Health Action. 2018;11(1):1483638. doi: 10.1080/16549716.2018.1483638. PMID: 29914319; PMCID: PMC6008596.

9. Department of Health of the Philippines. Kalusugang Pangkalahatan 2010-2016: An Assessment Report. Manila, Philippines; 2016

10. Universal Health Care Act, Republic Act No. 11223, 17th Cong., 3rd Sess. (2019)

11. UHC Act in the Philippines: A new dawn for health care [Internet]. World Health Organization. 2019 Mar 14. [cited 2019 Dec 12]. Available from: https://www.who.int/philippines/news/feature-stories/detail/uhc-act-in-the-philippines-a-new-dawn-for-health-care

12. National Health Insurance Act of 1995, Republic Act No. 7875, (1995).

13. World Bank. World Development Report 1993: Investing in Health. Vol. 1. The World Bank; 1993.

14. Gotinga, JG. Duque's Arroyo-era health cards bled PhilHealth billions of pesos, says official [Internet]. Rappler. 2020 Aug 14. [cited 2020 Jan 10]. Available from: https://www.rappler.com/nation/official-says-duque-arroyo-era-health-cards-bled-philhealth-billions-pesos

15. Villanueva M, Crisostomo S. Arroyo launches P3-B health care program [Internet]. Philstar Global. 2004 Feb 3. [cited 2020 Jan 10]. Available from: https://www.philstar.com/headlines/2004/02/03/237479/arroyo-launches-p3-b-health-care-program

16. PhilHealth 2003-2018 Annual Report [Internet]. Philippine Health Insurance Corporation (PhilHealth). 2018. [cited 2020 Jan 10]. Available from: [https://www.philhealth.gov.ph/about_us/annual_report/#gsc.tab=0]

17. Philippine National Health Accounts 2016-2018 [Internet]. Philippine Statistics Authority (PSA). 2019. [cited 2020 Jan 10]. Available from: [https://psa.gov.ph/pnha-press-release/node/144466]

18. Department of Health Philippines: Budget Portfolio FY 2018. Department of Health. 2018 [Internet]. [cited 2020 Jan 10]. Available from [https://www.aidsdatahub.org/sites/default/files/resource/doh-phl-budget-folio-2018.pdf]

19. de Claro V. Rapid Assessment of Strategic Purchasing in the Philippines: A Country Case Study. Kiel, Hamburg: ZBW - Leibniz Information Centre for Economics; 2018.

20. Tobe M, Stickley A, del Rosario RB Jr, Shibuya K. Out-of-pocket medical expenses for inpatient care among beneficiaries of the National Health Insurance Program in the Philippines. Health Policy Plan. 2013 Aug;28(5):536-48. doi: 10.1093/heapol/czs092. Epub 2012 Oct 9. PMID: 23048125.

21. Crisostomo S. PhilHealth implements 'no balance billing' scheme [Internet]. Philstar Global. 2012 Jan 19. [cited 2020 Jan 14]. Available from: https://www.philstar.com/business/science-and-environment/2012/01/19/768702/philhealth-implements-no-balance-billing-scheme

22. New Phil Health Case Rates for Selected Medical Cases and Surgical Procedures and the No Balance Billing Policy, Circular No. 011-2011 [Internet]. Philippine Health Insurance Corporation. 2011. [cited 2020 Jan 14] Accessed from [https://www.philhealth.gov.ph/circulars/2011/circ11_2011.pdf]

23. Lam HY, Adovich SR. Independent Assessments towards Validating the 2013-2014 Performance of PhilHealth for the NHTS population. Manila and Quezon City Philippines: National Institute of Health, Institute of Health Policy and Development Studies; 2017.

24. Faraon EJA, Estrada JAG, Farillas ELF, Mabera FRD, Paras AMP, Pastrana MKR, Yap AML.

Significant Predictors of Underutilization of Inpatient Benefits among PhilHealth Members in Selected Barangays in Manila. Acta Medica Philippina. 2013;47(3):69-73. doi: 10.47895/amp.v47i3.1324

25. Alipio M. A Path Analysis Examining the Relationship Between Access Barriers to Health Services and Healthcare Utilization Among the Publicly Insured: Insights from a Multiprovince Survey in the Philippines. Public Health. 2020; d6vbm. doi: 10.31219/osf.io/d6vbm

26. Quimbo S, Florentino J, Peabody JW, Shimkhada R, Panelo C, Solon O. Underutilization of social insurance among the poor: evidence from the Philippines. PLoS One. 2008;3(10):e3379. doi: 10.1371/journal.pone.0003379. Epub 2008 Oct 13. PMID: 18852881; PMCID: PMC2557126.

27. Rivera LJD. Why poor mothers fail to enjoy Philhealth benefits? Barriers to Philhealth Benefit Utilization and Full Financial Support. Quezon City, Philippines: National Anti-Poverty Comission; 2016.

28. Ellao JAK. Philhealth militarization, 'ghost' claims reflect problems in health services [Internet]. Bulatlat Journalism for the People. 2019 Jun 27. [cited 2020 Feb 24] Available from: https://www.bulatlat.com/2019/06/27/philhealth-militarization-ghost-claims-reflect-problems-in-health-services/

29. COA to PhilHealth: Return P164-M illegal perks [Internet]. Rappler. 2018 Aug 3. [cited 2020 Mar 27] Available from: https://www.rappler.com/nation/208734-coa-decision-philhealth-officials-allowances-bonuses

30. Gamboa R.. Corruption and inefficiency in PhilHealth [Internet]. PhilStar Global. 2019 June 20. [cited 2020 Mar 27] Available from: https://www.philstar.com/business/2019/06/20/1927841/corruption-and-inefficiency-philhealth.

31. Nazario D, Damicog JG, Panaligan RG. 'Ghost dialysis' blamed on corruption at Philhealth [Internet]. Manila Bulletin. 2019 June 6. [cited 2020 Mar 27]. Available from: https://mb.com.ph/2019/06/06/ghost-dialysis-blamed-on-corruption-at-philhealth/

32. Ramos CM. Morales: PhilHealth investigating 20,000 fraud cases [Internet]. Inquirer. 2020 Aug 4. [cited 2021 Oct 14]. Available from: https://newsinfo.inquirer.net/1316738/philhealth-investigating-20k-fraud-cases-chief-tells-senate

33. Magsambol B. PhilHealth execs misspent, stole P15 billion, says resigned anti-fraud official [Internet]. Rappler. 2020 Aug 4. [cited 2021 Oct 14]. Available from: https://www.rappler.com/nation/ex-official-says-billions-stolen-by-philhealth-fraud-schemes

34. Kabiling G, Damicog JG. Top PhilHealth officials face charges [Internet]. Manila Bulletin. 2020 Sept 15. [cited Oct 14]. Available from https://mb.com.ph/2020/09/15/top-philhealth-officials-face-charges/]

35. Romero A. Morales resigns as PhilHealth CEO after Duterte gives hint to quit [Internet]. Philstar. 2020 Aug 26. [cited 2021 Oct 14]. Available from: https://www.philstar.com/headlines/2020/08/26/2038045/morales-resigns-philhealth-ceo-after-duterte-gives-hint-quit

36. World Health Organization. Declaration of Alma-Ata. World Health Organization; 1978.

37. Giovanella L, Mendoza-Ruiz A, Pilar A de CA, da Rosa MC, Martins GB, Santos IS, et al. Universal health system and universal health coverage: Assumptions and strategies. Ciencia e Saude Coletiva. 2018 Jun 1;23(6):1763–76.Bern 2016

38. Birn AE, Nervi L, Siqueira E. Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond. Development and Change. 2016 Jul 1;47(4):734–59.

39. World Health Organization. The World Health Report 2008: Primary Health Care Now More Than Ever. World Health Organization; 2008.

40. World Health Organization. Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization; 2008.

41. Etienne C, Asamoa-Baah A, Evans DB.. Health systems financing: the path to universal coverage. World Health Organization; 2010.

42. World Heatlh Organization. Arguing for Universal Health Coverage. World Health Organization; 2013.

43. Transforming our world: the 2030 Agenda for Sustainable Development Transforming our

world: the 2030 Agenda for Sustainable Development Preamble. 2015.

44. Birn AE, Nervi L. What matters in health (care) universes: delusions, dilutions, and ways towards universal health justice. Vol. 15, Globalization and Health. BioMed Central Ltd.; 2019.

45. World Health Organization. Declaration of Astana. World Health Organization; 2018.

46. Sanders D, Nandi S, Labonté R, Vance C, Van Damme W. From primary health care to universal health coverage-one step forward and two steps back. Lancet. 2019 Aug 24;394(10199):619-621. doi: 10.1016/S0140-6736(19)31831-8. PMID: 31448726.

47. People's Health Movement. A civil society assessment of the political declaration of the UN High Level Meeting on Universal Health Coverage (Internet). Health for All Now: People's Health Movement. 2019 Sep 23. [cited 2021 Oct 26] [https://phmovement.org/wp-content/uploads/2019/09/Civil-Society-Assessment-of-UHC-HLM-declaration_16-Sept.docx.pdf]

48. López Cabello A. Pandemic momentum for health systems financialisation: Under the cloaks of Universal Health Coverage. Global Public Health. 2021;16(8–9):1334–45.

49. Averill C, Marriott A. Universal health coverage: why health insurance schemes are leaving the poor behind. Oxfam International; 2013.

50. Kyei-Nimakoh M, Carolan-Olah M, McCann TV. Access barriers to obstetric care at health facilities in sub-Saharan Africa-a systematic review. Syst Rev. 2017 Jun 6;6(1):110. doi: 10.1186/s13643-017-0503-x. PMID: 28587676; PMCID: PMC5461715.

51. Bedford J, Singh A, Ponferrada M, Eldred L. Access to Health Services: Analysing Non-Financial Barriers in Ghana, Bangladesh, Vietnam and Rwanda Using Qualitative Methods A Review of the Literature. New York, NY: United Nations Children's Fund; 2013. Available from: https://www.unicef.org/health/files/Access_to_Health_Services-Ghana-Bangladesh-Vietnam-Rwanda__2013.pdf

52. Sanogo NA, Fantaye AW, Yaya S. Universal Health Coverage and Facilitation of Equitable Access to Care in Africa. Front Public Health. 2019 Apr 26;7:102. doi: 10.3389/fpubh.2019.00102. PMID: 31080792; PMCID: PMC6497736.

53. Rodney AM, Hill PS. Achieving equity within universal health coverage: a narrative review of progress and resources for measuring success. Int J Equity Health. 2014 Oct 10;13:72. doi: 10.1186/s12939-014-0072-8. PMID: 25928840; PMCID: PMC4192297.

54. Caballes AB, Söllner W, Nañagas J. Financial protection mechanisms for inpatients at selected Philippine hospitals. Soc Sci Med. 2012 Nov;75(10):1820-7. doi: 10.1016/j.socscimed.2012.07.027. Epub 2012 Aug 6. PMID: 22901795.

55. Acuin CS, Lim BA, Lasco PG. Universal Health Care in the Philippines: An Introduction. Acta Medica Philippina. 2010;44(4):14-21.

56. Romualdez AG.. Universal Health Care in the Philippines: Governance. Acta Medica Philippina. 2010;44(4):22-24.