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The Financial Health of Select Philippine Hospitals and the Role of the Philippine Health Insurance Corporation as the National Strategic Purchaser of Health Services

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Abstract

Health care providers such as hospitals and primary health care facilities form an integral part of any health system. Providers must have both financial sustainability, such that they are able to continuously deliver health care services without bankruptcy, and sufficient profits to maintain and improve the quality of their services. In this context, the Philippine Health Insurance Corporation (PhilHealth) is envisioned to be the national purchaser of health services that can support both inpatient and primary health care providers in the country while providing financial risk protection for Filipinos. In this paper, we (1) described the financial health of select public and private hospitals in the Philippines, and (2) examined PhilHealth's current position in relation to its envisioned role as national strategic purchaser for Universal Health Care (UHC).

On the financial health of select Philippine hospitals, we found that the size of public and private hospitals in our sample has been growing steadily from 2015 to 2020, with public hospitals turning to government capital investment programs and private hospitals using debt and profits from patients to expand assets. Private hospitals showed decent profitability margins, but they may easily fall into financial distress if their cash flows are disrupted such as from inability to collect on receivables from health insurance payments. Meanwhile, prior to any government subsidies, public hospitals faced continuous negative profitability margins, signaling that they continuously operate on financial deficits. Ultimately, their heavy reliance on subsidies indicates that public facilities are not self-sufficient and may be chronically underfunded. Limited budgets seem to be channeled towards essential expenses, like personnel services, to keep operations going.

Compared with the expectations of UHC for the institution, PhilHealth is still far from functioning effectively as the country's envisioned national purchaser. In gathering monopsonistic power, PhilHealth has unimpressive purchasing and leveraging power to shape health care provider network (HCPN) behavior and drive UHC goals. PhilHealth contribution to the country's total health expenditure continues to be stunted, and reliance on household out-of-pocket (OOP) spending is still prominent. Moreover, PhilHealth's contribution in financing LGU health services, for both hospital and primary health care, was weak compared to consolidated expenditures from LGU themselves. PhilHealth benefit payouts on inpatient claims also significantly overwhelm payments for PHC and outpatient care. The poor coverage of PhilHealth for PHC and outpatient care manifests in its paltry support to HCPN public financing for PHC. PhilHealth has not been able to facilitate equity in financing and access to care: Hospital-leaning payment patterns of PhilHealth is that claim payments are siphoned towards geographic locations and the private sector which have a larger share of total hospitals.

Keywords: Health financing, hospitals, financial health, PhilHealth, universal health care, primary health care, equity

Disclaimer: *This article/report reflects the points of view and thoughts of the authors', and the information, conclusions, and recommendations presented are not to be misconstrued as those of the Department of Health. Furthermore, this article/report has not yet been reviewed by our collaborators at the DOH at the time of writing. The material presented here, however, is done in the spirit of promoting open access and meaningful dialogue for policy/plan/program improvement, and the responsibility for its interpretation and use lies with the reader.*

Executive Summary and Recommendations

Hospitalizations continue to persist as the biggest contributor to health expenditures in the country, consistently overtaking expenditures for primary health care (PHC). Hospitals have consistently constituted 40% of total health expenditures in the Philippines. In absolute amounts, this is equivalent to ₱200.7 billion in 2014 and ₱345.5 billion in 2019. With the locus of service delivery concentrated largely on hospitals, understanding their financial health is integral in ensuring they continue to operate. In any health system, health care providers must have both financial sustainability, such that they are able to continuously deliver health care services without bankruptcy, and sufficient profits to maintain and improve the quality of their services

In this context and with the enactment of the Universal Health Care (UHC) Act, the Philippine Health Insurance Corporation (PhilHealth) is envisioned to be the national purchaser of individual-based health services for both inpatient and primary health care in the country. Under UHC, PhilHealth is pictured to have strong monopsonistic leverage in hospitals, health care provider networks, and PHC facilities. Such purchasing power should be able to drive the health system towards equitable service delivery, strong primary health care, and consolidation of province- and city-wide health systems and health care provider networks. Given the tall order put on PhilHealth by the UHC reforms, we must understand how the institution is currently positioned.
In this paper, we assess the state of financing of select hospitals in the Philippines and PhilHealth's current positioning, particularly as it relates with key reforms in the UHC Act.

The Financial Health of Select Philippine Hospitals

- **The size of public and private hospitals in our sample has been growing steadily from 2015 to 2020, with public hospitals turning to government investment programs and private hospitals using debt and profits from patients to expand assets.**
    - Median assets of sampled public and private hospitals grew from ₱662 million in 2015 to ₱1,476 million in 2020, and ₱70 million in 2015 to ₱158 million in 2020, respectively.
    - On the median, private hospitals had a debt equivalent of around 50% of their total assets and sourced 98% of their revenues from hospital fees (i.e., inpatient and outpatient care).
    - Public hospitals have enjoyed assistance from the Health Facility Enhancement Program (HFEP) which has replenished their capital assets. The average age of fixed assets of public hospitals in our sample decreased from 7.46 years in 2015 to 5.64 years in 2020. Median spending of public hospitals for routine repair and maintenance, however, was only 1.5% of their maintenance and operating expenses (MOOE).
    - Meanwhile, fixed assets of the private hospital subsample has been steadily aging, recording a median average age of plant in 2015 of 7.53 years and 8.97 years in 2020.
- **Private hospitals showed decent profitability margins, but they may easily fall into financial distress if their cash flows are disrupted.**
    - Sampled private hospitals were efficient in creating revenues from assets**,** generating a median of ₱0.74 to ₱0.82 cents per ₱1 of assets and keeping salary expenses below 30% of their revenues for the period 2015-2020. This resulted in consistently generating a median of ₱8-9 in net income per ₱100 of operating revenues for 2015-2020.

- However, our sample of private hospitals would only be able to operate at a median of around 32 days without additional revenues, leaving them vulnerable to persistent declines in patient volume or inability to collect payments and receivables.
- Median time to collect on patient receivables has grown undesirably from 37 days to 54 days for this sample of private hospitals. Delays in insurance payments can cause a significant strain on a hospital's available cash needed to run operations. For example, a delay in reimbursements of even ₱10 million is equivalent to 26 days of operating expenses, assuming the median annual operating expenses of ₱391 thousand per day for 2020.

- **Prior to any government subsidies, public hospitals faced continuous negative profitability margins, signaling that they continuously operate on financial deficits.**
  - Public hospitals have relatively inefficient asset turnover ratios, generating only ₱0.20-₱0.30 in revenues per peso of assets for the period 2015-2020.
  - A sharp decline in public hospital profitability occurred in 2020, and for every ₱100 in revenues sampled public hospitals generated, they lost ₱265 on the median (without subsidies). This was likely caused by the COVID-19 pandemic which stifled patient revenue and increased costs from infection control.
  - Every year, however, government subsidies have proven useful in, if not essentially, bailing out public hospitals from negative profit margins, resulting in practically no likelihood of closure. After subsidy, profitability turns positive with margins stable at around ₱15-18 in income for every ₱100 in revenues. Public hospitals only source 16% of their revenues from hospital fees, and most of the revenues from subsidies.
  - Liquidity measures show that, on paper, public hospitals can operate at a median of 110 days in 2020 even without additional cash. This is largely caused by subsidies they receive.
- **Despite looking healthy on year-end financial statements, ultimately, the reliance on subsidies indicates that public facilities are not self-sufficient and may be chronically underfunded. Limited budgets seem to be channeled towards essential expenses, like personnel services, to keep operations going.**
  - Prior to subsidies, salary expenses in public hospitals, on the median, amounted to 104% of generated revenue in 2015 and 192% in 2020. Personnel services constituted 62% (median, IQR: 55%-67%) of total operating expenses of the public hospitals. In contrast, private hospitals in the sample spent 40% (median, IQR: 30%-51%) of total operating expenses on PS, 66% of which was spent on salaries, 10% on benefits, and 23% on outsourced services.
  - Expenses for medical supplies and drugs comprise, on median, 9% (IQR: 3%-15%) and 29% (17%-34%) of sampled public hospitals MOOE expenses for 2020.

PhilHealth as the National Strategic Purchaser

Compared with the tall order and expectations of UHC for the institution, PhilHealth is still far from functioning effectively as the country's envisioned national purchaser. This is highlighted through several weaknesses in leveraging purchasing power, steering cost-effective service delivery towards primary health care (PHC), and distributing resources equitably.

- **In gathering monopsonistic power, PhilHealth has unimpressive purchasing and leveraging power to shape health care provider network (HCPN) behavior and drive UHC goals.**

- **PhilHealth contribution to the country's total health expenditure continues to be stunted, and reliance on household out-of-pocket (OOP) spending is still prominent.** PhilHealth share in THE remained between 16% to 19% for 2014-2019. OOP's contribution to THE was 44.7% in 2020, only 1% lower than the sum of all three government schemes (i.e. PhilHealth, LGUs, central government).
- **At the facility level, the median share of PhilHealth reimbursements declined for both public and private hospitals.** Share of PhilHealth payments in total hospital revenues steadily decreased from 52% to 28% and 33% to 11% for sampled private and public hospitals. Similarly, proportions of expenses that PhilHealth can cover also decreased from 59% to 32% and 43% to 15% in sampled private and public facilities.
- **Overall, PhilHealth's contribution in financing LGU health services, for both hospital and primary health care, was weak compared to consolidated expenditures from LGU themselves.** On a per-capita basis, median LGU health spending steadily increased from ₱425 in 2010 to ₱754 in 2020. And while median PhilHealth per-capita contribution to LGU facilities in the 115 HCPNs increased from ₱42 in 2010 to ₱249 in 2017, it has been constantly eclipsed by LGU budget allocation. In 2020, PhilHealth contribution now amounts only to a median of ₱154 per-capita in 2020.
- **On a positive note, looking only at LGU hospitals, PhilHealth seems to have a degree of leverage, although variation is observed in the ability of LGUs to harness PhilHealth financing.** For HCPNs with LGU-owned hospitals, the share of PhilHealth in public hospital financing increased steadily from a median of 30% in 2010 to a peak of 55% in 2016.

- **Health system and PhilHealth financing for cost-effective primary health care services has been grossly inconsequential in noncompetitive compared to that of LGUs.** Moreover, it fails to support the move towards contracting and paying HCPNs, because the PHC base is not well-supported and vulnerable to being overpowered by focus on inpatient services.
  - **At the macro-level, resources spent for PHC has been consistently significantly less than that of hospital-based care.** PNHA from 2014 to 2019 shows that almost half (41%-43%) of THE in the country are spent on hospitals. Spending for primary preventive care failed to reach even at least 10% share in the THE.
  - **PhilHealth benefit payouts on inpatient claims also significantly overwhelm payments for PHC and outpatient care.** Payouts for inpatient services form the majority of PhilHealth claims, averaging at a share of 90.2% from 2015 to 2020. In the case of primary health care outpatient services, the very small benefit payout peaked at 10% in 2020. The share of PhilHealth's primary health care benefit package (i.e., "Tsekap") in overall PhilHealth payments was practically non-existent (<0.01%).
  - **The poor coverage of PhilHealth for PHC and outpatient care manifests in its paltry support to HCPN public financing for PHC**. Median LGU per-capita spending for primary health care climbed from ₱324 in 2010 to ₱444 in 2020, while **median PhilHealth per-capita contribution to public PHC and outpatient care has never breached ₱15** — and it never gone beyond a maximum of ₱100 for any one LGU

- **PhilHealth has also not been able to facilitate equity in financing and access to care in three areas: geography, facility ownership, clientele type.**
  - **Hospital-leaning payment patterns of PhilHealth is that claim payments are siphoned towards geographic locations with higher concentrations of hospitals.** Claims data show that around 60% of PhilHealth payments are concentrated in the

richer NCR and Luzon areas which are home to 63% of all the licensed hospitals in the country**.**

- **The biggest share of PhilHealth payments also go to private facilities, particularly large corporate hospitals.** PhilHealth and DOH 2020 data shows that 60% of accredited hospitals and 67% of licensed hospitals are privately owned. Consequently, the greatest share in PhilHealth claims payment also goes to private hospitals who have taken 59%-63% of reimbursements from 2015-2020, with corporate hospitals averaging 43% for the period.
- **Indigent patients receive less share in PhilHealth payments following their service delivery access points.** In general, public facilities served more indigent patients (68% in 2019, 59% in 2020) than private facilities (38% in 2019, 37% in 2020) as measured by PhilHealth claims counts in facilities. Specific within private facilities, private single proprietorship and partnership hospitals, which are mostly composed of level 1 hospitals, have a fairly equal distribution of indigents and non-indigent patients. However, these subtypes of private facilities get a very small share (10.4%) of total claims payment.

Recommendations

We provide recommendations to advance Universal Health Care from a health system perspective, going beyond a focus on hospitals. Specifically, our recommendations have in mind this goal of UHC:

> *"Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship."*

- **Primary health care, which is more cost-effective and equitable than hospital care, should be strengthened and prioritized in terms of service delivery enhancement, financing, and incentives.** Establishing this primary health care base will need coordinated supply- and demand- side initiatives spearheaded by DOH and PhilHealth.
  - **From the supply-side, infrastructure expansion and investments should pour towards PHC first.** Plans for hospital expansion should be calibrated with consideration of PHC's potential impact. Strengthening PHC can prevent diseases and complications that require hospitalization, which would subsequently decrease the need for hospital beds.
  - **Public PHC facilities must be better equipped to pass standards and requirements for PhilHealth's enhanced benefit packages for PHC.** The upcoming Comprehensive Outpatient Benefit Package (COPB) aims to ensure that all Filipinos have entitlements to a wide range of preventive, promotive, PHC services in accessible PHC facilities.
  - **From the demand-side, PhilHealth PHC payments should increase to rates comparable to LGU investments to become a reliable source of financing for PHC services.** The COPB should move towards at least matching existing expenditures of LGUs on PHC, to capture and impose leverage.

- **PhilHealth should expand its fiscal space through premium increases, as stipulated by the UHC act, side-by-side with commensurate, definite, clear benefit expansions.** PhilHealth must generate more resources to attain monopsony. It must absorb a greater share of OOP for health and eventually cover the MOOE of health facilities. Premium

increases commensurate with expansions in benefit entitlements can motivate support from people, and likewise drive providers to expand to cover growing service inclusions.

- **PhilHealth's <u>prospective, closed-end, performance-based payment mechanisms should be expedited</u> to better support private and public facilities.** Prospective payment is a provider payment mechanism where providers are paid a lump-sum amount prior to service delivery to finance of services for a specific period of time. Payments are calibrated to tranches linked with achievement of performance indicators. Paying providers in advance will allow them to strategize to efficiently use resources. This also allows PhilHealth to put itself in a position of greater leverage by guaranteeing financing for its contracted facilities. Such monopsony will give PhilHealth advantages such as cost containment, better control on user charges, and enforcement of performance-based mechanisms for healthcare output and quality.
    - **At the inpatient level, this refers to a global budget payment system with proper costing** for health services that can adequately cover hospital MOOE. Prospective payments can greatly unburden fiscal stress of hospitals. For private hospitals, prospective payments essentially eliminates PhilHealth receivables, ensuring a more predictable flow of finances. For public hospitals, subsidies from national and local governments can be concentrated towards capital outlay, personnel services, or growth. Overall, there will be greater confidence to put up more hospitals and expand bed capacity in the country.
    - **At the primary health care level, this points towards capitation payment.** Though current PhilHealth PHC benefits are cited as capitated, it still practically follows a reimbursement scheme as payments are only made after certain services are provided. Historically, delays in PhilHealth reimbursements for PHC have caused a huge disincentive for rural health units (RHUs) to seek accreditation, much less expand.
- **<u>Capital investments and the expansion of public hospitals</u> should be done with proper pace, strategy, and complementary capacity building in effective financial management to ensure their long-term financial sustainability.** Forming the PHC base will require some time, and thus hospital capacity will still need to expand and be a major financial commitment of the government. Furthermore, changes in PhilHealth payments will not be implemented immediately, and the responsibility of financing public hospitals will still largely fall on the government.
    - **National and local governments must prepare to cover the significant operating costs of new public hospitals.** Otherwise, new facilities may suffer from chronic financial distress, that may lead to deterioration in initial capital investment and subpar healthcare quality.
    - **Resources for LGU hospitals should be protected, particularly PhilHealth payments, to ensure adequate financing of public facilities**. **The Special Health Fund (SHF) indicated in the UHC Act should be prioritized for establishment across all LGUs.** Increasing PhilHealth payments and improving payment arrangements will not translate to any positive yield if money is still not protected for health. Through the SHF, resources for health and revenues from health-related activities shall be earmarked within this exclusive fund pool, ensuring that they are reinvested for improvements in health services.
- **More implementation research is necessary to know <u>how public hospital fiscal space and financial management may be improved</u>**.
    - Part of this is understanding **how public hospitals can be made sustainable** through means like reimbursements from PhilHealth or conversion to government-owned and controlled corporations or local economic enterprises.

- We must also **know the degree to which public hospitals are underfunded and how their large operating deficits affect their monthly cash flow**. Public hospitals must be given sufficient resources to not only cover immediate personnel costs, but also long-term MOOE investments like repairs and staff training that may have been deprioritized in favor of more urgent expenses necessary to keep operating (e.g., PS, utilities, drugs and supplies).
- There also may be **room for efficiency gains in the procurement** of medicines and supplies that account for a high percentage of public hospital MOOE. This can be facilitated by **technical assistance from the national government and platforms for pooled procurement and price negotiation**, amongst others.
- **Private sector participation should be enjoined in the primary health care agenda and the development of HCPNs.** Although the gaps in hospital bed capacity right now is considerable, the short fall in PHC facilities is greater. Steering the private sector to invest more in PHC capacity will be integral in meeting needs on this service level, and further expand access points for communities and households.
- **Mechanisms to efficiently and healthily mix private with public facilities in HCPNs must be established**, as this can break down existing tendencies towards service delivery dichotomy and facilitate further mixing of case profiles. For example, global budgeting or **adequate and responsive PhilHealth payments should allow lower income households financial access to even private facilities**.

- **A systematic and routine monitoring and collection of hospital financial health data and PhilHealth contributions to facilities, LGUs, and eventually HCPNs should be established.** It is not enough to monitor the quantity and presence of functional capital structures. Continuously investing in new infrastructure without having an eye on operations of current facilities and their sustainability sets the stage for a host of future fiscal problems. Proper understanding of how resources flow from national and local pools to service delivery conduits such as hospitals should be prioritized and linked with the development of investment plans such as the PHFDP. **Clear metric and performance indicators on financial health should be set to guide performance-based payments** of PhilHealth, as well as future capital infusions or interventions (e.g., public-private partnerships) from the government.

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The Financial Health of Select Philippine Hospitals and the Role of the Philippine Health Insurance Corporation as the National Strategic Purchaser of Health Services

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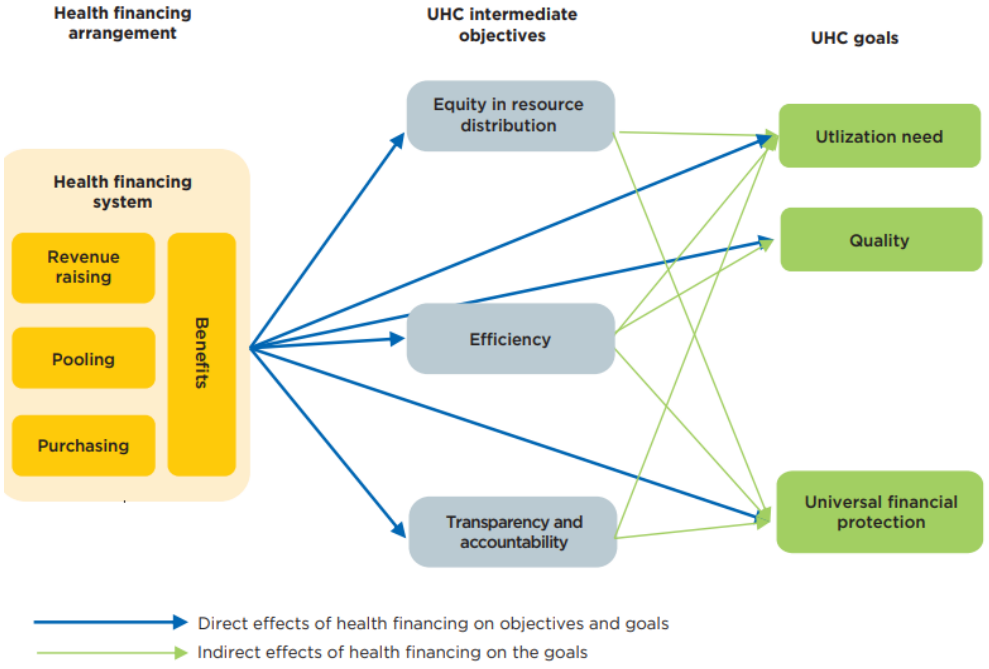
1. Introduction

Health financing is one of the main functions of the health system, and it is crucial in the achievement of the health system's intermediate and universal health care goals (Figure 1). Health financing is composed of three main functions: revenue generation, pooling (consolidating resources), and strategic purchasing (Dela Cruz et al., n.d.; Gottret & Schieber, 2006; World Health Organization, 2019). Achieving proper balance in policy and implementation across these three functions is necessary to (a) ensure sufficient funds to pay for population health needs and (b) align health provider behavior to health system goals through financial incentives. Overall, a country's health financing system - or how it purchases health services is a conduit for how resources generated by the health sector will be allocated and spent, particularly as it facilitates efficient and equitable delivery of quality health care to the people (Kutzin, 2013). **For health care providers, such as hospitals, country health financing arrangements form the financial landscape that influence their financial health. Moreover, health financing systems must help keep providers of health care financially sustainable.**

Figure 1. Health Financing and Goals of Universal Health Coverage



1 Supervising Research Specialist, Consultant, Research Analyst, and Senior Research Fellow, respectively. This study was done in collaboration with the Department of Health - Health Facility and Development Bureau (DOH-HFDB). The authors would like to thank Dr. Gabrielle Ann T. Dela Paz and Dr. Terence John M. Antonio for their valuable support and insights for the study.

In the Philippines, hospitals draw the lion share of the health care market, with hospitalizations persisting as the biggest contributor to total health expenditures in the country. Hospitals have consistently constituted 40% of total health expenditures (Philippine Statistics Authority, 2020). In absolute amounts, this is equivalent to ₱200.7 billion in 2014 and ₱345.5 billion in 2019 (Philippine Statistics Authority, 2020). Meanwhile **expenditures for more cost-efficient preventive and ambulatory have only averaged 8% and 4%** within the same period (Philippine Statistics Authority, 2020).

With the enactment of the Universal Health Care (UHC) Act, the Philippine Health Insurance Corporation (PhilHealth) is envisioned to be the national purchaser of individual-based health services for both inpatient and primary health care in the country. PhilHealth is a government-owned and controlled corporation (GOCC) that implements the National Health Insurance Program (NHIP) which aims to ensure financial risk protection for all Filipinos. Historically, however, PhilHealth's performance as a national purchaser has not been at par with expectations, and Filipinos continue to be burdened with high out-of-pocket spending and susceptibility to catastrophic health expenditures (Obermann et al., 2018). Its weak performance in the past, leaves PhilHealth unable to strategically purchase health services, and leverage better prices for quality health services. As such, PhilHealth fulfilling its role as the envisioned national purchaser is a tall order from its existing positioning in the sector.

In this study, we **assess the state of financing of hospitals in the Philippines**, particularly as it relates with key reforms in the UHC Act. Specifically, the **objectives of this study are as follows:**

- To describe the financial health of select hospitals in the Philippines,
- To evaluate PhilHealth's leveraging capacity to drive the health system toward equitable service delivery, strong primary health care, and consolidation of province- and city-wide health systems and health care provider networks.

2. Methods

This study was a merging and analysis of multiple secondary data sets on the financing of hospitals and primary health care facilities in the Philippines. **Table 1** summarizes the datasets used and their sources.

Table 1. Summary of secondary datasets and sources

Dataset	Data Owner	Coverage	Variables Covered
1. National Health Facility Registry (NHFR)	Department of Health (DOH)	2021, all licensed Philippine hospitals	Facility counts and characteristics (e.g. ownership type, service capability, location)
2. PhilHealth claims	PhilHealth	2010-2020, all claims from accredited hospitals and outpatient providers	PhilHealth reimbursement to hospitals

3. Hospital annual financial statements (FS)	Securities and Exchange Commission Hospital administrators	2015-2020, select hospitals	Assets, liabilities, income, expenses
4. Local government Statement of Receipts and Expenditures	Department of Finance - Bureau of Local Government Finance	2010-2020, all local government units (LGU)	LGU expenses for public health, primary health care, and owned hospitals

Collection and Analysis of Hospital Financial Statements

With regards to the hospital annual financial statements, the target population was all 1,302 licensed hospitals across the country. We attempted to collect the annual FS of as many hospitals as possible, covering the financial years 2015-2020. **As of 1 December 2021, our analysis includes the FS of 195 hospitals (15% of 1,302).** FS are received as digital copies and require encoding into a standard data structure for analysis. Collection, encoding, and quality checks for encoded FS data are ongoing. Thus, we present only partial data for our analysis of hospital financial health. Difficulties and causes of delay encountered in the collection and encoding of hospital FS data were:

- FS showed varying accounting practices using different terminologies, formats, structures, and charts of accounts that make standardized encoding difficult.
- Requests for LGU hospitals require approval of not only hospital administrators, but also accounting offices or chief executives of the LGU.
- Often, the FS of LGU-hospitals were incomplete and with limited content (e.g., no statement of financial position, no cash flow statement) and breakdowns (e.g. expenses).
- Many LGU-owned hospitals did not have FS, because their finances are integrated with their mother LGU who finance them under the LGU's general fund.
- However, some LGU hospitals are registered with the Securities Exchange Commission and operate like corporations, able to provide FS at par with auditing standards with desirable format and content.

For this data, we did a **ratio analysis of hospital financial statements to gauge the financial health and performance of hospitals** in our sample. **Table 2** provides a description of the **4 types of 10 financial ratios analyzed here**.

Table 2. Indicators of hospital financial health and their definitions

Indicator	Formula	Description
A. Size and Capital Structure		
1. Total Assets	Cash + Cash Equivalents + Inventories + Property and equipment + Investments + Receivables	Measure of hospital size and includes everything that the hospital owns (e.g. cash, receivables, equipment) Desired Trend: Upward over time
2. Financial Leverage	Total Liabilities / Total Assets	Hospital's use of debt to finance its operations and capital investments

Indicator	Formula	Description
		Desired Trend: Downward over time
B. Profitability		
3. Total Margin	Net Income / Total Revenues	Measure of how much out of every peso of revenue the hospital keeps as earnings or profit Desired Trend: Upward over time
4. Operating Margin	Income from operations / Total Revenues	Measure of financial performance in providing patient care (hospital's core business) and control of operating expenses Desired Trend: Upward over time
C. Assets Liquidity		
5. Current ratio	Current Assets / Current Liabilities	Measures the hospital's ability to pay for short-term obligations due in one-year using its available assets Desired Trend: Upward over time
6. Days Cash on Hand	(Cash + Cash equivalents) * 365 / Operating expenses	Number of days the hospital can operate and pay for its operating expenses if they earned no additional cash Desired Trend: Upward over time
D. Operating Efficiency		
7. Average Age of Plant	Accumulated depreciation / annual depreciation expense	Average age in years of the hospital's fixed or long-term assets used to provide health care services (e.g.., buildings, equipment, vehicles) Desired Trend: Downward over time
8. Assets Turnover	Revenue / Total Assets	Measure of efficiency in how a hospital generates revenues per peso of assets Desired Trend: Upward over time
9. Days Patients Accounts Receivables	[(Accounts receivables - allowances for uncollectible) * 365] / Total Revenue	Measure of how efficient a hospital is in collecting debts for its health care services: Number of days it the hospital to collect outstanding payments to itself Desired Trend: Downward over time
10. Salary to Revenue	Salary Expense / Total Revenues	Measure of staffing efficiency: proportion of revenues consumed by salary expenses

Indicator	Formula	Description
		Desired Trend: Downward over time

Source: Author's compilation of literature (Burkhardt & Wheeler, 2013; Curtis & Roupas, 2009; Dong, 2015; Levitt, 2018)

3. Financial Health of Select Philippine Hospitals

Hospitals are core health providers in any health care system. It is important to monitor their **financial health, as financing is an upstream factor that influences a hospital's ability to operate and deliver quality health care services.** Hospitals must be financially sustainable such that they are able to generate sufficient income to continuously deliver health care services without closure.

Moreover, financial sustainability allows hospitals to grow and improve their services. Continuous quality improvement is an expensive endeavor. Poor financial health may lead hospitals to cut costs and focus on operational efficiency to stay sustainable. This may ultimately affect quality if cost containment entails reducing expenses for inputs, which then decreases the likelihood of good health care processes (Bazzoli et al., 2007; Duffy & Friedman, 1993; Kim et al., 2006; Lindrooth et al., 2007). Examples include decreased funding for skilled human resources (e.g., quantity, opportunities for continuous education, wages) or essential technology and infrastructure (e.g. maintenance of equipment, upkeep of sanitation facilities, limited stocks of supplies and medicines).

A total of **195 hospitals** were included in our financial statement analysis, covering financial years 2015 to 2020. Of these **79 (41%) are public hospitals and 116 (59%) are private** (**Table 3**). Sampled hospitals are concentrated in Luzon (45%) which, according to the DOH-National Health Facility Registry (NHFR) (Department of Health, 2021), contains 51% of the licensed hospitals in the country.

Table 3. Hospital sample characteristics

Variable	All Hospitals n=195	Public n=79	Private n=116
Bed capacity, median (IQR)	94 (42-200)	200 (68-400)	70 (30-100)
Ownership			
Government - National	62 (32)	62 (78)	-
Government - LGU	17 (9)	17 (22)	-
Private	116 (59)	-	-
Functional Capacity, n (%)			
Level 1	83 (43)	33 (42)	50 (43)
Level 2	64 (33)	11 (14)	53 (46)
Level 3	48 (25)	35 (44)	13 (11)
Location, n (%)			
National Capital Region	46 (24)	18 (23)	28 (24)
Luzon	87 (45)	31 (39)	79 (48)
Visayas	18 (9)	11 (14)	7 (6)
Mindanao	44 (23)	19 (24)	25 (22)

Looking at the public hospitals in our sample, 62 (78%) are DOH-retained hospitals. Among the sampled public hospitals, 44% are level 3, 14% are level 2, and 42% are level 1. In contrast, the **subsample of private hospitals were composed of lower level hospitals**: 43% being level 1, 46% level 2, and 11% level 3 hospitals. Lower-level hospitals are smaller, as evidenced by the smaller median bed capacity of the sampled private hospitals (70, IQR: 30-100) compared to sampled public hospitals (200, IQR: 68-400).

Based on this descriptive comparison of our limited sample of public and private hospital, we give the **following limitations for the interpretation of the results** in this section:

- Our sample of hospitals is non-random and not representative of hospitals in the Philippines.
- However, our sample of public hospitals provides a relatively good representation of DOH-retained hospitals as we capture the majority (84%) of the 74 DOH-hospitals.
- Though we stratify our results by public versus private hospitals, the subsample of hospitals under each ownership type are not comparable. Differences in the financial health of public hospitals and private hospitals should not be interpreted as a cause-and-effect relationship.

Overall, this financial statement analysis **aimed to provide descriptive insight into the financial health of sampled public and private hospitals**. In doing so, we demonstrate how systematic and continuous monitoring of hospital financial data at the health-system level can provide health sector administrators (e.g., DOH, PhilHealth, LGUs) with valuable information that can aid in strategies for UHC, particularly the achievement of the Philippine Health Facility Development Plan (PHFDP) 2020-2040 (Department of Health, 2020b). We improve upon past studies on the financial performance of hospitals in the Philippines which were either conducted prior to the 2000 (Avestruz, 1995; Bengzon, 1972; Crisostomo, 1976) or had limited sample sizes (Banzon et al., 2014; dela Pena et al., 2005).

3.1. Size and Capital Structure

The size of public and private hospitals grew steadily from 2015 to 2020, registering 5-year compound annual growth rates (CAGR) of 17.4% and 17.7% on median total assets (Figure 2). In absolute terms, this translates to median assets of ₱662 million in 2015 to ₱1,476 million in 2020 for public hospitals and ₱70 million in 2015 to ₱158 million in 2020 for private hospitals. Looking at the breakdown of hospital assets (Table 5), the fact that hospitals are a capital intensive industry is evident in that, on median, 64% of public hospital assets (IQR: 55%-72%) and 60% (IQR: 43%-76%) of private hospital assets are composed of property, plant, and equipment.

Figure 2. Hospital total assets and financial leverage (median), 2015-2020

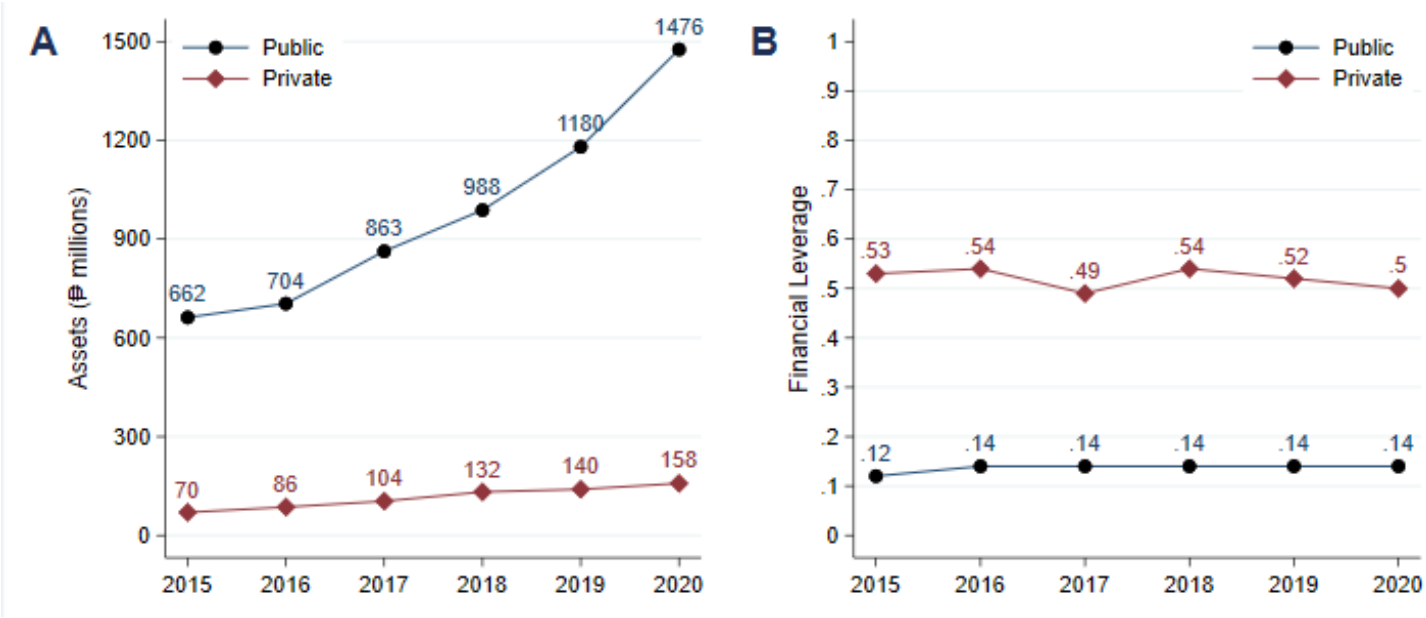


Figure 2B shows that private hospitals likely funded their asset expansion through debt: **their median financial leverage ratio, calculated as total liabilities over total assets, has been relatively stable at a median of 0.49-0.54 from 2015 to 2020 (CAGR: -1.2%)**. This means that the sampled private hospitals, on median, have debt equivalent to around 50% of their total assets. The financial leverage ratios measure the degree to which hospitals take on financial risk in the form of loans to finance the expansion of their assets.

Median financial leverage of sampled public hospitals has stayed at 14% of its total assets between 2016 to 2020, meaning that these hospitals were not reliant on loans to have financed their growth. Rather, the growth in assets of public hospitals who usually have limited funds to expand likely came from the DOH's Health Facility Expansion Program (HFEP). HFEP is a supply-side capital investment program for the expansion and upgrading of public hospitals in the country. It aids both national and LGU-owned hospitals in capital expenses for infrastructure and equipment. HFEP started in 2007 with a budget of ₱500 million (Department of Health, 2012); This increased to ₱13.6 billion in 2013, ₱21 billion in 2016 with sin taxes (Department of Health, 2016), and in 2020 still commands a budget of ₱8.35 billion (Department of Health, 2020a; Guidelines for the Implementation of Projects Funded Under the Health Facilities Enhancement Program (HFEP) Fiscal Year 2020, n.d.).

Table 4. Compound annual growth rate of financial ratio medians, 2015-2020

Variable	Public n=79	Private n=116
Size and Capital Structure		
1 Total Assets	17.4	17.7
2 Financial Leverage	3.1	-1.2
Profitability		
3 Total Margin (prior to subsidy)	0 (-22.3)	-12.9
4 Operating Margin (prior to subsidy)	1.3 (-17.6)	0
Asset Liquidity		
5 Current Ratio	-4.4	-1.7
6 Days Cash on Hand	-4.2	-0.2
Operating Efficiency		
7 Average age of Plant	-5.4	3.56
8 Assets Turnover (prior to subsidy)	-0.6 (-13.5)	-4.5
9 Days Patients Accounts Receivable	6.1	8.1
10 Salary to Revenue (prior to subsidy)	0.5 (13.1)	5.2

Table 5. Breakdown of hospital assets, revenues, and expenses, 2020

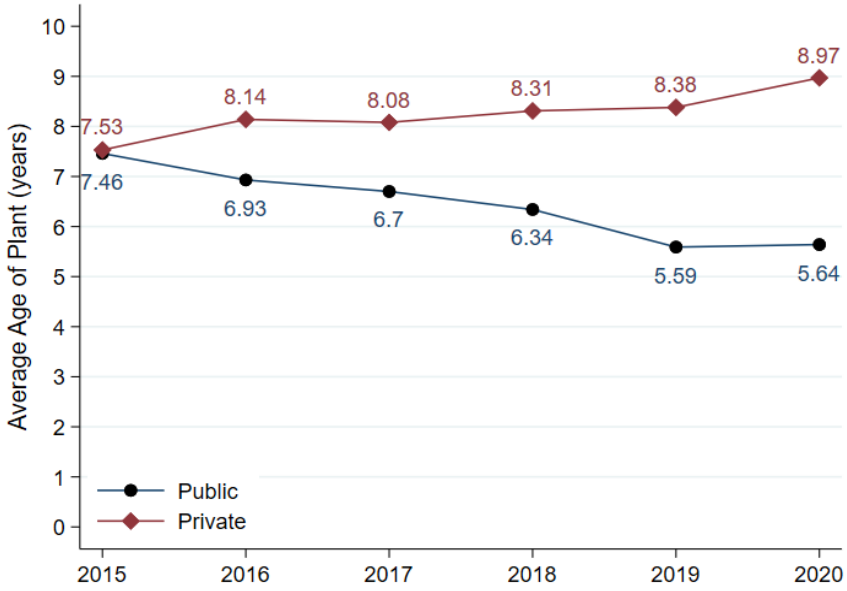
Variable, median	Public n=79	Private n=116
Breakdown of Total Assets		
% Cash or Equivalents	15 (8-25)	7 (3-18)
% Receivables	8 (4-15)	10 (4-18)
% Inventories	7 (3-10)	4 (2-7)
% Property and equipment	64 (55-72)	60 (43-76)
% Investments	7 (4-10)	5 (2-9)
Revenues		
% Hospital Fees (inpatient + outpatient)	16 (9-23)	98 (58-100)
% Government subsidies	78 (60-84)	-
% Other revenues	5 (1-9)	2 (0-42)
Expenses		
1 **% Personnel Costs**	**62 (55-67)**	**40 (30-51)**
Breakdown of Personnel Costs		
Salaries and Wages	51 (46-54)	66 (51-82)
Benefits and other allowances	38 (36-41)	10 (6-23)
Outsourced (e.g., general, professional)	10 (7-17)	23 (10-44)
2 **% Maintenance and Operating (MOOE)**	**38 (33-45)**	**60 (49-70)**
Breakdown of MOOE Costs		
Utilities (electricity, water, gas)	6 (4-7)	4 (7-7)
Supplies - Drug and Medicines	9 (3-15)	3 (15-31)
Supplies - Medical, lab dental	29 (17-34)	17 (34-21)
Repairs and Maintenance	1 (1-3)	1 (0.2-2)
as % of Property, Plant, Equipment	0.5 (0.24-0.96)	1.5 (0.56-3.17)

Assets*		
Training and scholarships	0.17 (0.02-0.94)	0.02 (0.94-0.68)
Rent and rentals	0.2 (0.08-0.5)	0.08 (0.5-0.14)

* This indicator is also called the "Repairs and Maintenance Expense to Fixed Assets Ratio."

The increased capital investments in the sampled public hospitals was evident in the decreasing average age of their fixed assets. **The median age of their fixed assets declined by a CAGR of -5.4%, from 7.46 years in 2015 to 5.64 years in 2020** (Table 4, Figure 2). Meanwhile, the fixed assets of the private hospital subsample has been steadily aging, recording a median average age of plant in 2015 of 7.53 years to 8.97 years in 2020 (CAGR: 3.6%). Fixed assets are property, land, or equipment that the hospitals use for the long-term to generate revenues. A low average of plant ratio means that the hospital has been able to replenish their capital assets; A high average of plant ratio means that either the value of a hospital's fixed assets are depreciating at a fast pace or that the hospital requires new capital investments. While there are no benchmarks in the Philippines, the median average of plant in USA hospitals was 8.8 years to 11.5 years between 1995-2015 (American Hospital Association, 2018).

Figure 3. Hospital average age of plant (median), 2015-2020



Capital investments require routine maintenance and repair to keep them functioning and generating revenue for as long as possible. **In 2020, sampled public hospitals spent a median of 0.5% (IQR: 0.24%-0.96%) in repair and maintenance expenses as a proportion of their total fixed assets** (also called "Repairs and Maintenance Expense to Fixed Assets Ratio")**, while the sampled private hospitals spent 1.5% (0.56%-3.17%)** [Table 5]. As a portion of maintenance and other operating expenses (MOOE), this is equivalent to a median of 1% (private IQR:1%-3%; public IQR: 0.2-2%) in repairs and maintenance expenses.

In a 2014 study by Banzon et al. on the maintenance and depreciation costs of six (6) public hospitals, he reported that hospitals in his sample spent a range of 1.7%-2.58% of their MOOE in maintenance and repairs (Banzon et al., 2014). He further suggests that hospitals must ideally allocate *5% of the original value of the fixed assets* as repairs and maintenance expenses (Banzon et al., 2014; Flessa, 2009). **Based on the proposed benchmark, it seems that median**

spending in our sampled hospitals, particularly public hospitals, for routine maintenance is low. This may mean that the public hospitals may be unable to adequately maintain the capital investments supported by HFEP, and capital assets deterioration will be an issue over time.

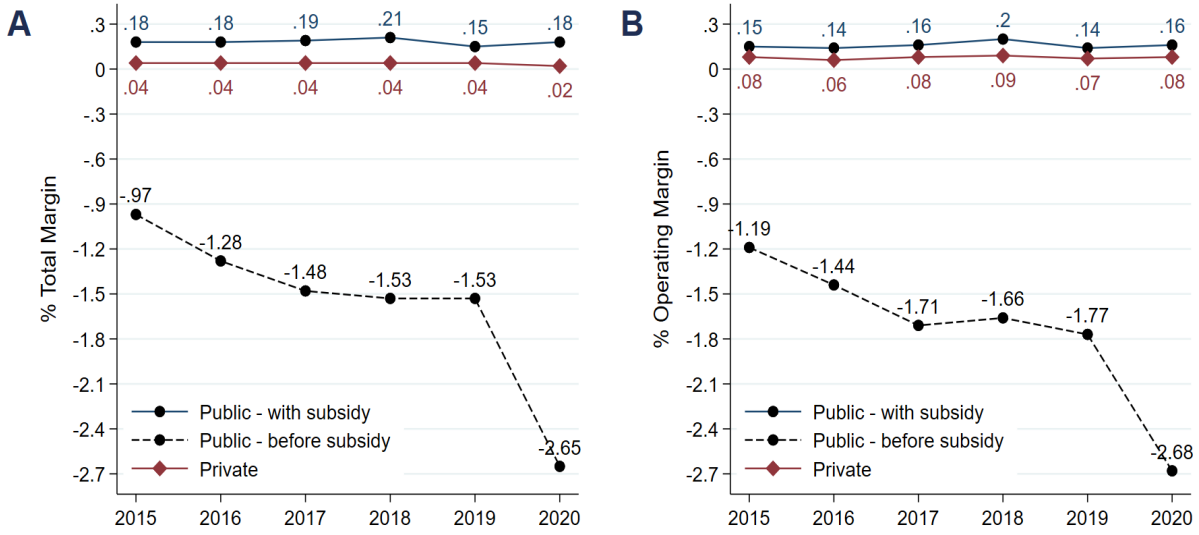
Banzon et al. further posited that repairs and maintenance expenses were "crowded out" of the budget by personnel expenses, which accounted for around 60% of total expenses in the public hospitals he examined (Banzon et al., 2014). Looking at our data in 2020 (Table 5), median PS costs do still make up 62% (IQR: 55%-67%) of operating expenses for public hospitals. However, among the MOOE categories, medical supplies (median: 9% of MOOE, IQR: 3%-15%) and medicines (median: 29%, IQR: 17%-34%), could also be significant expenses that limit repairs and maintenance costs. PS, medicines, medical supplies, along with utilities (which also take a good share of MOOE) seem to be the necessary expenditures to keep operations going.

3.2. Profitability

Profitability directly pertains to the financial viability of hospitals. The two profitability measures presented here measure the ability of hospitals to generate sufficient revenue to survive (i.e., cover operational expenses) and thrive with the remaining profits. First, total margin is the proportion of total revenues kept as profit. Total margin counts revenues from both operating (i.e., patient care) and non-operating (e.g., investments, rentals) activities. Operating margin is a proportion that is similar to total margin, but it only looks at revenues from patient care. Hence, operating margin measures how well hospitals generate income from their core mission of health care delivery. A negative number for either metric means that the hospital is operating at a loss; a zero (0) means a breakeven of revenues and expenses; and a positive number is desirable, because this means that the hospital is generating profits that it can use to pay shareholder dividends or purchase revenue-generating assets.

Sampled private hospitals kept around ₱4 and ₱2 in median net income out of every ₱100 in total revenues for the period of 2015-2019 and 2020, respectively (Figure 4A). **Their median operating margins from core patient care activities was higher, and they kept ₱8-9 per ₱100 in operating revenues for 2015-2020** (Figure 4B). The higher margin from core business operations is because operating margin calculations also account for non-cash revenues, such as decreases in depreciation, additions to their inventories (e.g., medicines, supplies) and collection on patient receivables. Notably for the sampled private hospitals, **98% (median, IQR: 58-100%) of their revenues come from hospital fees (i.e., inpatient and outpatient care)** [Table 5]. Profit margins in capital- and labor-intensive industries like hospitals are not usually high. The profit margins seen here are comparable to those in the USA where median hospital total and operating margins were 7.8% and 6.8% in 2016 (American Hospital Association, 2018).

Figure 4. Hospital total and operating margins (median), 2015-2020



Prior to any government subsidies, sampled public hospitals faced continuous negative profitability margins, signaling that they operated on deficits. Their median total and operating margins before subsidy registered a **CAGR of -22.3% and -17.6% from 2015 to 2020, which means steadily worsening deficits over time** (Figure 4). A sharp decline in profitability occurred in 2020, and for every ₱100 in revenues sampled public hospitals generated, they lost ₱265 on the median. This was likely caused by the COVID-19 pandemic which turned many public hospitals into COVID-19 referral facilities; In effect, they could not receive revenues from regular patients, and, at the same time, had increased expenses (e.g., personal protective equipment, hazard pay benefits) (Interim Guidelines on Health Care Provider Networks during the COVID-19 Pandemic, 2020; Minimum Health System Capacity Standards for COVID-19 Preparedness and Response Strategies, 2020).

To survive, public hospitals are heavily reliant on subsidies. In fact, **public hospitals in this sample only sourced 16% (median, IQR: 9%-23%) of their revenues from hospital fees, and most of their revenues were from subsidies (median: 78%, IQR: 60%-84%)** [Table 5]**.** The DOH funds its hospitals through a line-item in its general appropriations, and it can further augment its hospitals via sub-allotments from the central office (Lavado et al., 2010). Similarly, LGU-managed hospitals are funded and managed by provinces or cities/municipalities, which source financing from their internal revenue allotments (IRA) and local revenues. **With subsidies, the profitability margins of sampled public hospitals were stable, keeping ₱15-18 in income for every ₱100 in revenues** (Figure 4A). While this shows that the government has been able to support its public hospitals and more than cover their expenses at year-end, **highly negative profitability margins prior to subsidies indicate that public hospitals cannot sustain themselves and that they are unable to raise other sources of revenues.**

These results for public hospitals raise three additional concerns. First, financial statements are a snapshot in time, at the end of the financial year when hospitals have received their subsidies. Thus, **even if the public hospitals look healthy on paper, it is not clear how their large operating deficits before receiving subsidies cause them financial distress and affect their monthly cash flows.** For example, deficits towards the middle or end year when the subsidies have been consumed, might inhibit them from paying their staff and suppliers on time (Saludes, 2020; Vera, 2020), prevent them from spending on maintenance, or investing in activities that improve quality of care (e.g., staff training).

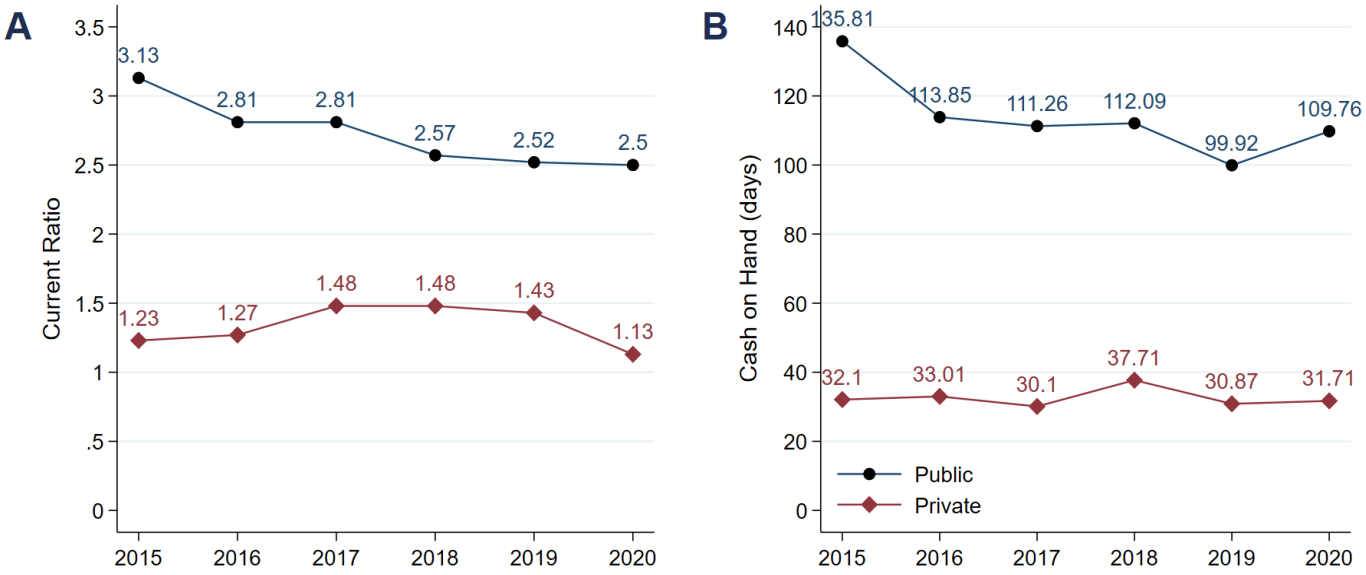
Second, the PHFDP 2020-2040 crafted to support UHC calls for an additional 400 thousand hospital beds by 2040. HFEP is still funding the building of new hospitals and primary health care facilities across the country, but expenses do not stop there. As shown by the negative profit margins**, after the initial capital outlay has been laid out, public hospitals will require significant resources to maintain and operate.** National government and LGUs must anticipate and be prepared to subsidize these expenditures, and not build health facilities they cannot reasonably support.

Third, the PHFDP indicates that both private and public sectors must play a part in meeting this gap in hospital beds. **While positive profit margins for private hospitals may entice the private sector, negative profit margins for public hospitals may make it difficult to encourage LGU officials to open their own hospitals.** This may be especially true in poorer LGUs where operating their own hospitals may cause significant financial burden. More implementation research is necessary to know how public hospitals can be made sustainable and income generating through means like reimbursements from PhilHealth or converting them into government-owned and controlled corporations,[2] while not comprising service delivery to the poorest and underserved. Likewise, the government must study how the increases in LGU IRA from the Mandanas ruling can be used to fund operations of local hospitals (World Bank, 2021a, 2021b).

3.3. Liquidity

Hospital liquidity or the availability of cash (or assets that can be quickly turned into cash) measures a hospital's ability to pay for its immediate obligations like operating expenses. **From 2015 to 2020, the liquidity of sampled public hospitals, as measured by the median current ratio and days cash on hand** (Figure 5), **has been declining with a CAGR -4.4%. and -4.2%** (Table 4).

Figure 5. Hospital current ratio and days cash on hand (median), 2015-2020



[2] Currently, four DOH hospitals are operated as GOCCs: (1) National Kidney and Transplant Institute, (2) Philippine Health Center, (3) Lung Center of the Philippines, and (4) Philippine Children's Medical Center.

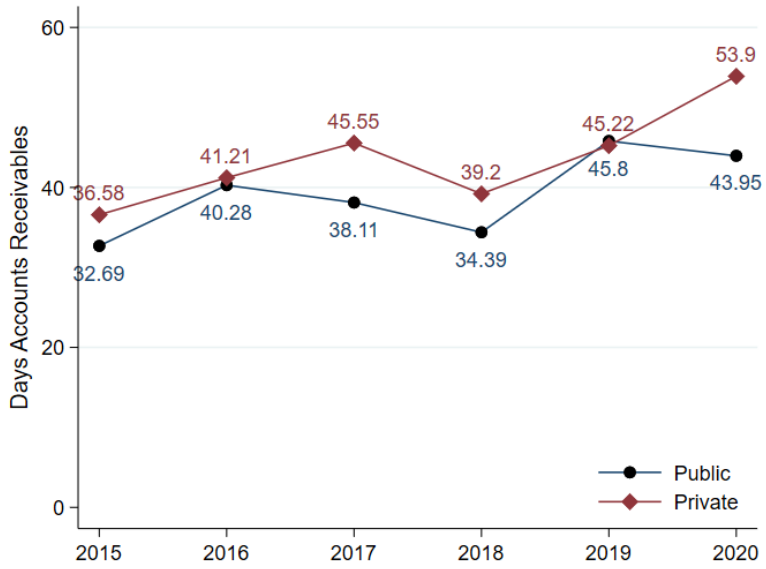
In 2020, however, their assets were, **on median, still 2.5 times greater than their debts** (Figure 5A), which means that they are still fairly liquid, though this downward trend must be carefully monitored for any rapid deterioration. This liquidity translates to the **ability to operate a median of 110 days in 2020 even without earning any additional cash (**Figure 5B). This high liquidity is likely because public hospitals, particularly DOH hospitals, are largely provided for by subsidies such that, at median, 15% (IQR: 8%-25%) of their assets are in the form of cash and cash equivalents (Table 5). Again, the same caveat as that given in the previous section on profitability applies: while sampled public hospitals look liquid on paper in their financial statements, they may not be liquid month-to-month after exhausting the subsidies received at the start of the year.

For sampled private facilities, median current ratio was increasing from 2015-2019, then declined in 2020 (Figure 5A). That is, at median, for every ₱1 in current debt, they had ₱1.13 in current assets to cover this debt - compared to ₱1.43 in 2019. **This is equivalent to being able to operate at a median of around 32 days with no additional revenues by exhausting all cash and cash equivalents.** Coupled with the fact that 98% (median, IQR: 58%-100%) [Table 5] of their revenues came from patients in 2020, **means that these private hospitals are susceptible to closure should there be abrupt and persistent interruptions to cash flow,** such as declines in patient volume or inability to collect on payments and receivables.

3.4. Operating Efficiency

Related to a hospital's liquidity is a hospital's efficiency in collecting money it is owed for services it has rendered. This is captured by the Days Accounts Receivables (DPAR) metric where high values mean that there is a long collection period between patient discharge and receipt of payment. In industries where profitability margins are tight like health care, delays in payments may cause a significant decrease in cash on hand to pay for operating expenses. **For both public and private hospitals, median DPAR has grown undesirably from 33 days and 37 days (around a month) to 44 and 54 days (1.5 to 2 months), respectively** (Figure 6).

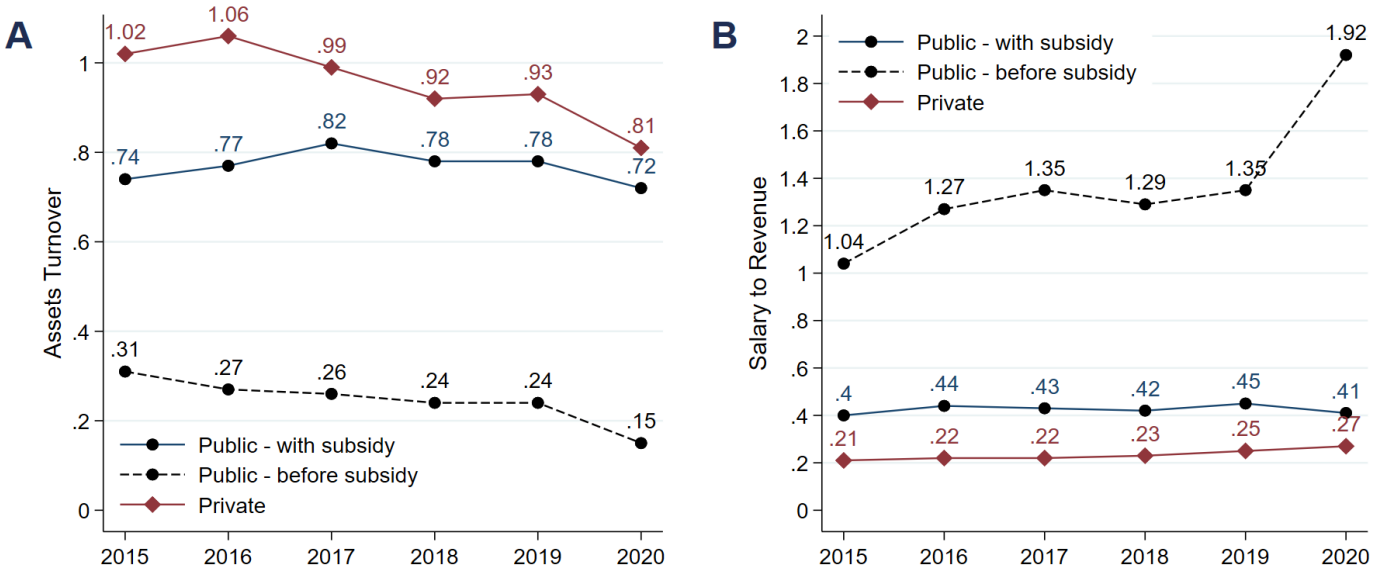
Figure 6. Hospital days accounts receivables (median), 2015-2020



The primary source of receivables in hospitals are insurance companies, and **delays in payments from insurance companies can cause a significant strain on a hospital's available cash and its ability to keep operating** (Graham, 2001; McCue & Thompson, 2011; Ullman, 2015)**.** This was seen in the previous section on liquidity where sampled private hospitals could only survive a median of 32 days without additional revenues. In the Philippines, private health maintenance organizations (HMOs) and PhilHealth are the major players in the insurance market. Unfortunately, because of nonstandard financial statement structures, we were unable to disaggregate receivables from PhilHealth, patients themselves, or private HMO. Anecdotally, however, hospitals have reported significant delays in PhilHealth reimbursement in interviews and are considering opting out of PhilHealth accreditation (Cepada, 2021; Perez-Rubio, 2021; Rendon, 2021). Such concerns are valid, as PhilHealth reimbursements can mean millions in cash that can pay for several days of manpower and supplies. **For example, the median annual operating expenses for private hospitals in our sample for 2020 was ₱143 million (or ₱391 thousand per day), so a delay in reimbursements of even ₱10 million is equivalent to 26 days of operating expenses.**

Looking at asset turnover ratios or how efficient a hospital is at generating revenues per peso of assets, **sampled private hospitals were able to generate a median of ₱0.74 to ₱0.82 cents per ₱1 of assets for 2015-2020 (CAGR: -4.5%)** [Figure 7A, Table 4]. In connection to their low profitability, **sampled public hospitals had declining asset turnover ratios for 2015-2020, earning ₱0.31 to ₱0.15 cents per ₱1 of assets prior to any subsidies (CAGR: -13.5%).** This is likely because public hospitals increased in assets (denominator of the ratio) over the years (review Figure 2A) while revenues (numerator) from operations and subsidies have increased commensurately. Moreover, the low pricing of services in public hospitals usually do not reflect their real costs, much less keep up with rising expenses caused by medical inflation. Careful study is needed to see how public hospital services can be remunerated through entities like PhilHealth, without putting undue financial burden on patients.

Figure 7. Hospital assets turnover and salary to revenue ratio (median), 2015-2020



For the last financial health indicator, we look at the ratio of salary expenses to generated revenue. Since hospitals are also personnel-intensive industries, staff salaries are a major part of expenses that must be well managed. For sampled **private hospitals, the median proportion of revenues consumed by salaries grew from 21% in 2015 to 27% in 2020 (CAGR 5.2%)** [Figure 7B, Table 4]. **For sampled public hospitals prior to subsidies, personnel costs dwarf their entire revenue, with salary expenses amounting to 104% of generated revenue in 2015 and 192% in 2020 (CAGR 13.1%).** Scrutinizing the breakdown of expenses for these public hospitals in 2020 (Table 5), personnel services (PS) constituted 62% (median, IQR: 55%-67%) of total operating expenses of the public hospitals, with 51% of PS expenses spent on salaries, 38% on benefits, 10% on outsourced services (e.g. security, janitorial, legal). In contrast, private hospitals in the sample spent 40% (median, IQR: 30%-51%) of total operating expenses on PS, 66% of which was spent on salaries, 10% on benefits, and 23% on outsourced services.

4. PhilHealth as the National Purchaser of Health Care Services

The Philippine Health Insurance Corporation (PhilHealth) was established through Republic Act (RA) No. 7875 in 1995 (PhilHealth, 2013; An Act Instituting A National Health Insurance Program For All Filipinos And Establishing The Philippine Health Insurance Corporation For The Purpose, 2004)**.** This act effectively transformed the 1969 Philippine Medical Care Commission into PhilHealth, a government-owned and controlled corporation. The Corporation is tasked to implement the National Health Insurance Program (NHIP), with a goal of providing Filipinos financial risk protection when accessing health services. This landmark piece of legislation widened the coverage for health to key vulnerable populations and groups such as the poor or indigents, the self-employed, and the informal sector.

The mandate and role of PhilHealth is ultimately to ensure that Filipinos do not face financial risk from impoverishing expenditures when seeking health care, because they are financially protected by virtue of coverage by the NHIP. As an institution of its scale, PhilHealth can maximize its impact **across the three functions of health financing** (Kutzin, 2013; World Health Organization, 2019)**:**

- **Revenue generation**: PhilHealth collects premiums, much like a special earmarked taxes, from segments of the population with capacity to pay (e.g., formally employed, professionals, etc.). For those without capacity to pay, their premiums are subsidized by the national government. Combined, these two revenue streams form the funds of the NHIP, which can only be used for purposes of paying for health services rendered to PhilHealth members.
- **Pooling**: PhilHealth strives to capture membership of all Filipinos, such that both the healthy and the sick, and poor and rich, are within the same pool and their health costs and needs can offset each other (i.e., principle of risk pooling and cross-subsidization). Funds generated are similarly pooled such that the institution achieves the strongest possible purchasing power.
- **Strategic purchasing**: PhilHealth uses the consolidated fund pool to purchase health services on behalf of its members. In particular, financial resources are used as a means (1) to drive the availability of desired services for members, (2) to bring in providers as access points for members through accreditation or contracting, and (3) to pay these providers strategically to deliver the identified services with efficiency, quality, and financial risk protection.

The overarching banner of the reform in financing in the recently passed Republic Act 11223 or the Universal Health Care (UHC) Act is ensuring clear delineation in financing roles of key players in the sector, with PhilHealth identified to be the national purchaser of individual health service (i.e., primary to inpatient personal care services) (An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor, 2019)**.** The reforms in the UHC Act are a product of years of experience and learnings in the sector, as well as multiple iterations of policies. Key points in health financing reforms stipulated in the UHC Law are:

1. For PhilHealth to be the national purchaser means that it has to be in a **strategic position of dominance** in the financing of health care in the health system. Much like a **monopsony**, or the major buyer in a given market, a national purchaser has capacity to leverage its huge pool of resources to enforce rules on what services are given, how they are given, and how much they are paid for.
2. A primary health care-oriented system is also one of the main elements of the reform. **PhilHealth as an institution can theoretically help steer service delivery towards a primary health care (PHC) orientation** by shifting a greater share of its payments and incentives to cover these services. Preventive and primary health care services are recognized to be much more cost-effective, as it avoids progression to more expensive and debilitating complications that cost more resources for both the individuals and the sector in general (Starfield et al., 2005).
3. The leveraging capacity of an institution like PhilHealth can also help facilitate **equitable delivery of health services** by virtue of cross-subsidization of the healthy and rich to the sickly and poor. This re-distributive function further materializes as poor and vulnerable populations are afforded financial access to health services by way of accredited or contracted health providers and benefits that pay for health services on their behalf. This mechanism ideally facilitates the matching of health services with needs of subpopulations while providing sufficient financial coverage that balances both patient and provider requirements (Kutzin, 2013).

Given the tall order put on PhilHealth by the UHC reforms, we must understand how the institution is currently positioned, vis-a-vis these three main anticipated key points of focus.

4.1. PhilHealth Monopsony in National Health Expenditures and Hospitals

Monopsonistic power is the leverage of an institution to act as a national strategic purchaser of health services. Monopsony is a market condition where there is only one buyer of a particular good or service in the market. In such instances, the monopsonist acts as the dominant player in the market and has the controlling advantage to drive prices of said goods or services down.

Monopsonistic power can be best manifested by different financing arrangements in accordance with prevailing health system realities and the country governance landscape: In (1) single-payer systems, the purest form of monopsony, a single entity, usually the government, commonly owns all health care providers and pays for health care through state funds or taxes. Another form is (2) quasi-government financing where multiple purchasers, such as health insurance entities, may be organized and regulated by the government to fulfill functions of the payer to providers. Countries such as the United States with large private health insurance markets exemplify this scheme. Last are (3) **social health insurance models where special government institutions, like PhilHealth, collect premium payments and pool resources to engage providers.** This usually comes with special capacities to mobilize pooled

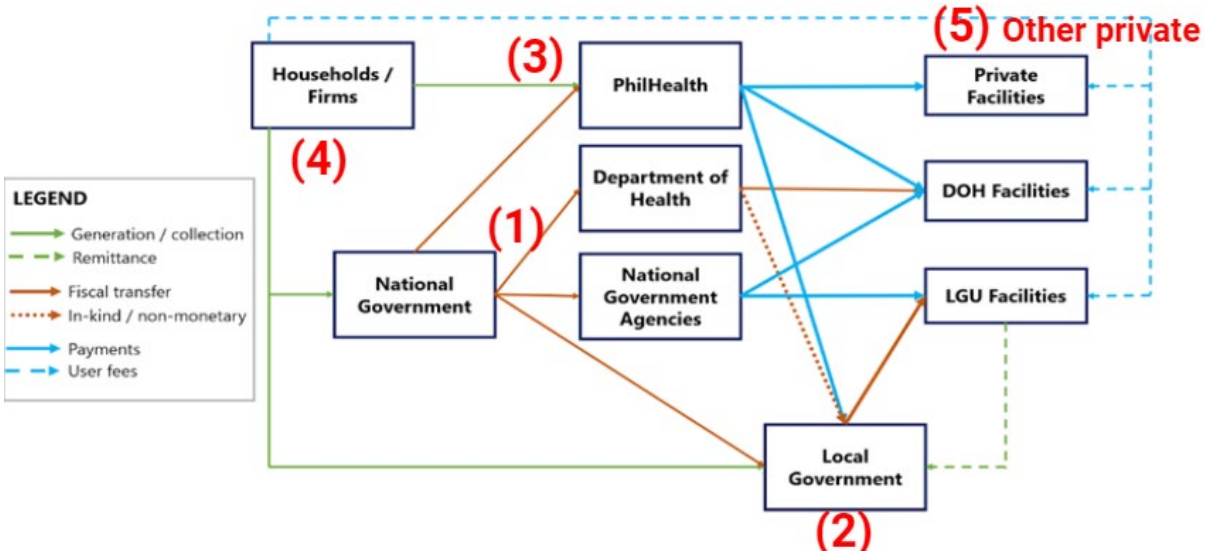
funds and engage both public and private entities, which is best in countries with mixed health service delivery entities.

In all these arrangements, purchasing entities can form a single risk pool, where all individuals afforded coverage are assembled. The pool helps operationalize the principle of social solidarity, and concretely establishes a mechanism for redistribution between the rich and poor, the healthy and the sickly. This intergenerational coverage also greatly incentivizes preventive and primary health care services, because keeping individuals healthier and with less health risks can help make the system more efficient and sustainable overall (Hussey & Anderson, 2003).

Regardless of arrangement, **monopsonistic power is about establishing a dominant financing position appropriate that allows the representing institution enough leverage to strategically purchase health services.** Central to the idea of a strategic purchasing in health through monopsonistic leveraging includes universal coverage, a single comprehensive benefit package, and universal negotiation of provider reimbursement (Cai et al., 2020; Donnelly et al., 2019; Levitt, 2018). **In effect, the financing institution has purchasing power to demand for the health services it wants to pay for, while commanding the price and manner of payment to providers.** Overall, it can facilitate the availability of accessible, affordable, and quality services that improve the health of the population (Dela Cruz et al., n.d.; Development Academy of the Philippines, 2018; Hussey & Anderson, 2003).

Currently, the health financing system in the Philippines involves complex layers of overlapping funding from different institutions, governance mechanisms, and health service providers. This dilutes the strategic purchasing capacity of any one entity, including that of PhilHealth's. The country's health financing system is an intersection of five main sources (Figure 8), namely (1) national government, (2) local governments units [LGU], (3) social health insurance through PhilHealth, (4) household out-of-pocket (OOP) spending, and (5) other private spending which may include private health insurance, donor funding, among others (Dayrit et al., 2018; Department of Health, 2011; Romualdez et al., 2011; Solon et al., 2017).

Figure 8. Financing flows in the Philippines



Source: Author's creation

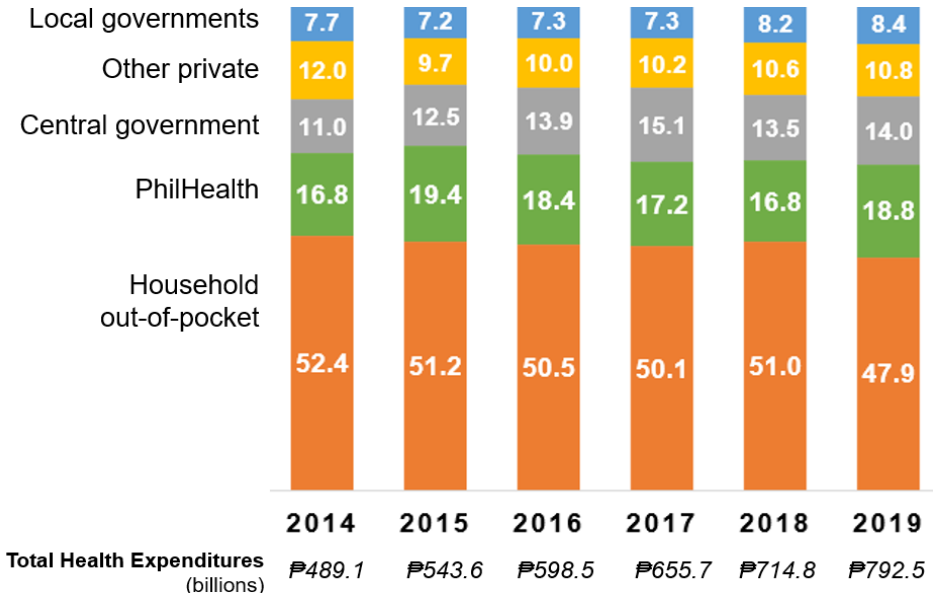
At the macro- or national-level, the contribution of PhilHealth to the country's total health expenditures (THE) continues to be stunted, remaining between 16% to 19% of THE from 2014-2019 (Figure 9). As investments in the health sector and THE have been growing, this steady percentage signals that PhilHealth is having difficulty attaining a monopsony in the Philippine health care market. The growing share of THE covered by LGUs and central government means that government purchasing power is being further fragmented among these two entities and PhilHealth, resulting in the diminishing power of any one government purchaser, much less PhilHealth, to enforce strategic purchasing. In a country with a service delivery mix of public and private facilities that function under a free market or unregulated pricing regime, strategies to enforce financial discipline and incentivize providers to align behavior to the objectives of UHC reforms are crucial. Otherwise, patients ultimately pay the difference between health care charges and PhilHealth's coverage.

Consequently, PhilHealth, as the social health insurance institution of the country, has been unable to fulfill its mandate of financial risk protection. Out-of-pocket (OOP) spending, although declining over the years, continues to prevail as one of the main sources of funds for health (Figure 9). **In 2020, the contribution of OOP to THE was 44.7%, only 1% lower than the sum of all three government schemes (i.e., PhilHealth, LGUs, central government)** (Philippine Statistics Authority, 2021)**.** OOP as a source of financing for health services is regarded as regressive and inefficient. This is largely because it is a major source of risk to the patient: prices are unpredictable or arbitrary (subject to providers; information asymmetry), charges are inefficient and may be excessive, which financially limits access to health services and increases the chance of catastrophic spending. While OOP in itself may not be problematic for richer households, the risk of impoverishing health spending is significant for lower-income households (Bayati et al., 2019; Puteh & Almualm, 2017; Rostampour & Nosratnejad, 2020; Sarker et al., 2021; Ulep & Dela Cruz, 2013).

Facility level analysis reinforces this diminishing financial leverage of PhilHealth in hospitals, both as source of income and source of financing for expenses**.** Analysis of financial statements and PhilHealth claims shows that **from 2015 to 2020, the median share of PhilHealth reimbursements in total hospital revenues steadily decreased from 52% to 28% (CAGR: -12%) and 33% to 11% (CAGR: -20%) for private and public hospitals** in the sample, respectively (Figure 10A). Further look into the data reveals that median PhilHealth reimbursement (numerator) remained relatively stable among our sampled hospitals (except in 2020 where it decreased), but hospitals have had considerable increases in total income (denominator) [Appendix Table 1]. Other income streams such as user charges may be factoring in as a stronger source of revenue for these hospitals. In effect, hospital income is much less dependent on, and leveraged by, PhilHealth payments.

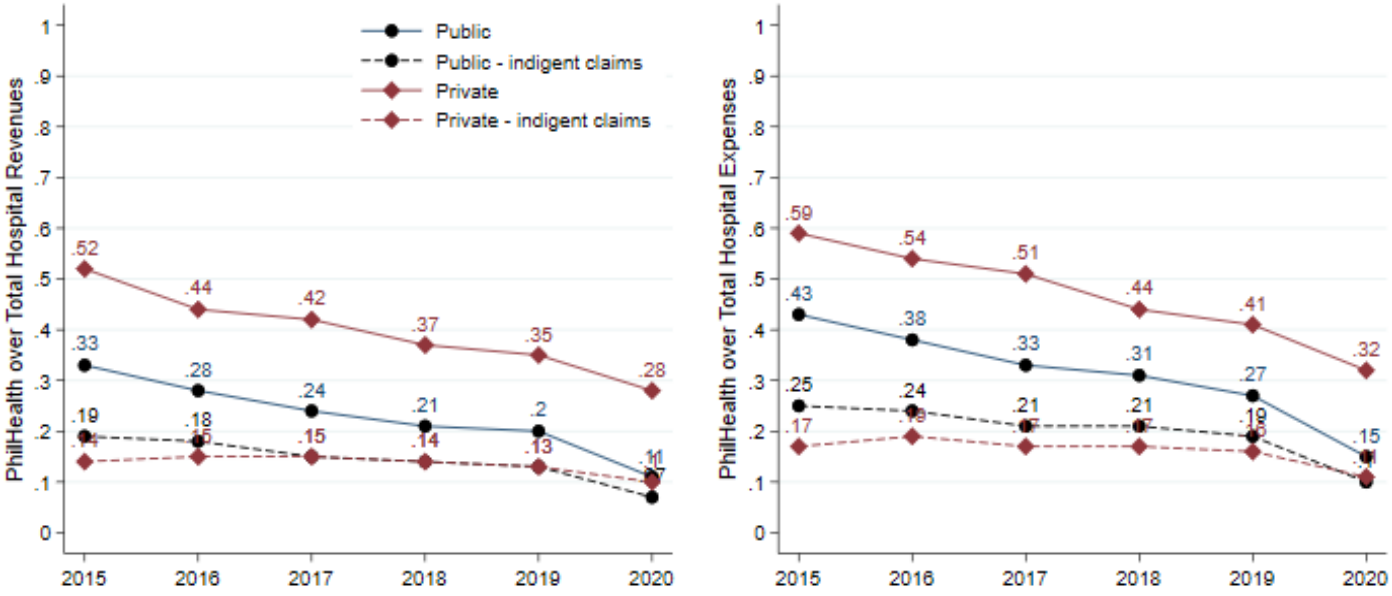
A similar decrease can be observed in the ability of PhilHealth to cover the expenses of hospitals (Figure 10B). **In private hospitals, the proportion of expenses that PhilHealth can cover decreased from 59% in 2020 to 32% (CAGR: -12%); while in public facilities, it declined from 43% to 15% (CAGR: -19%)** Much like the case of total hospital income, the steeper growth in hospital expenses versus the relatively stable amount of PhilHealth reimbursements resulted in diminishing contribution of PhilHealth payments to covering hospital expenses (Appendix Table 1).

Figure 9. Current health expenditure by financing agent (%) share to total, 2014-2019



Source: National Health Accounts 2014-2019 (Philippine Statistics Authority, 2020)

Figure 10. Share of PhilHealth over hospital revenues and expenses (median), 2015-2020



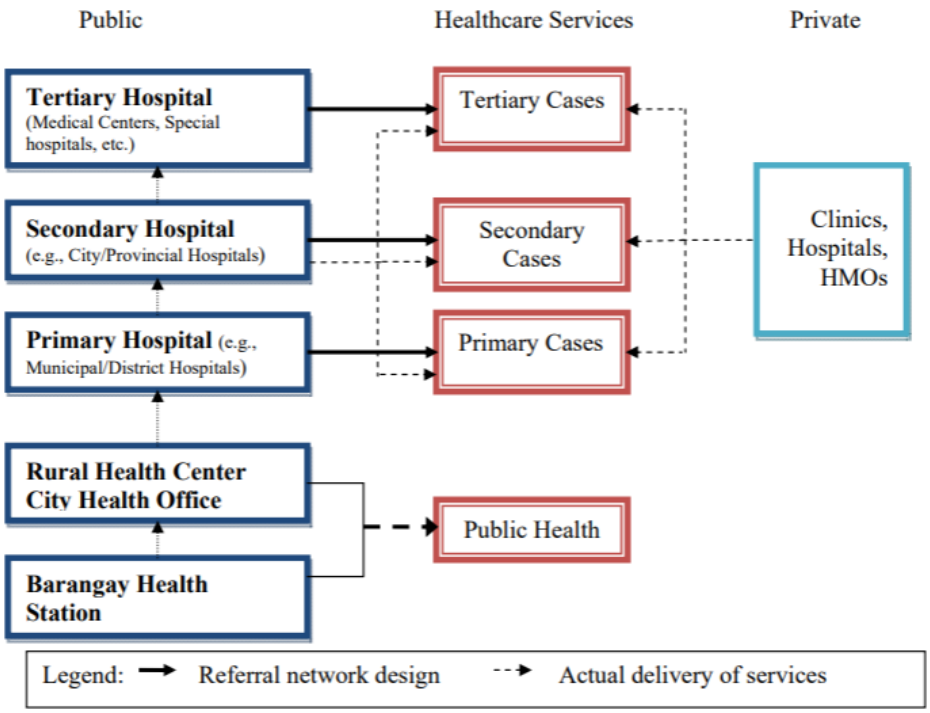
Source: Authors' analysis of a sample of 195 hospitals (79 public, 116 private)

4.2. PhilHealth Monopsony in Financing Public Health care Provider Networks

Another major reform of the UHC Act is the consolidation of public and private health care providers into at least 81 province-wide and 34 city-wide health systems (P/CWHS). **Public facilities within these jurisdictions are to be assembled as health care provider networks (HCPNs) that share responsibility for health care delivery as well as financial resources, including PhilHealth payments (Figure 11).**

The historically devolved nature of the country's health system has been a major hindrance in forming referral networks. This breaks the continuity of service delivery for patients and provider accountability in resources. Governance and management of the facilities are separate, which creates a natural detachment across levels of care that rarely communicate: lowest level PHC facilities and level 1 hospitals are managed by municipalities and cities; secondary hospitals are typically owned by provinces; and tertiary or specialty hospitals may be managed by the DOH or provinces (Lavado et al., 2010). Service delivery is top-heavy where higher-level facilities continue to accommodate cases that may be handled by lower-level facilities. This leads to two interconnected results of inefficiency: (1) Higher-level facilities consume more resources to attend to large patient volumes, which drive up their costs, leading treatment to become more expensive for patients. (2) Higher-level facilities become unnecessarily burdened while primary level facilities are underutilized and underfunded.

Figure 11. Referral Network in Health Service Delivery in Public Facilities



Source: Lavado et. al, 2010

Within this context, **PhilHealth's role under UHC is to contract entire HCPNs through prospective payments in the form of global budgets and capitation.** Such payments must be directed strategically to incentivize public health providers to work together and deliver affordable, quality, and patient-oriented care to populations under their jurisdiction. **Hence, in the same way that PhilHealth needs leverage in hospitals, so too does it need leverage on HCPNs as one unit to align their behavior with UHC goals.**

PhilHealth's contribution in financing LGU health services, for both hospital and primary health care, has been weak compared to consolidated expenditures from LGU themselves (Table 6). Ten-year LGU and PhilHealth financing data showed that, on a per-capita basis, median LGU health spending steadily increased from ₱425 in 2010 to ₱754 in 2020. And while median PhilHealth per-capita contribution to LGU facilities in the 115 HCPNs

increased from ₱42 in 2010 to ₱249 in 2017, it has been constantly eclipsed by LGU budget allocation. Moreover, PhilHealth contribution has been declining since 2018, amounting only to a median of ₱154 per-capita in 2020.

Isolating only financing for LGU hospitals, however, **PhilHealth contributions to hospital health spending was relatively large compared to that of the LGU.** For HCPNs with LGU-owned hospitals, the share of PhilHealth in public hospital financing increased steadily from a median of 30% in 2010 to a peak of 55% in 2016 (**Table 7**). A significant decline in PhilHealth's share was observed in 2020, likely due some LGU hospitals becoming COVID-19 referral facilities and the general decrease in patient volume caused by the pandemic.

Table 6. Median Per-capita contribution to total health spending in an HCPN by LGUs and PhilHealth, 2010-2020

Year	Province / City HCPNs	PhilHealth Claims to LGU facilities*
2010	₱425	₱42
2011	₱470	₱52
2012	₱486	₱74
2013	₱528	₱102
2014	₱380	₱160
2015	₱394	₱236
2016	₱443	₱258
2017	₱486	₱249
2018	₱560	₱222
2019	₱629	₱226
2020	₱754	₱154

* Includes inpatient and outpatient claims of all PhilHealth-accredited LGU facilities (hospitals and primary health care) within each of the 115 public HCPNs.

Table 7. Median percent PhilHealth contribution to HCPN LGU hospitals, 2010-2020

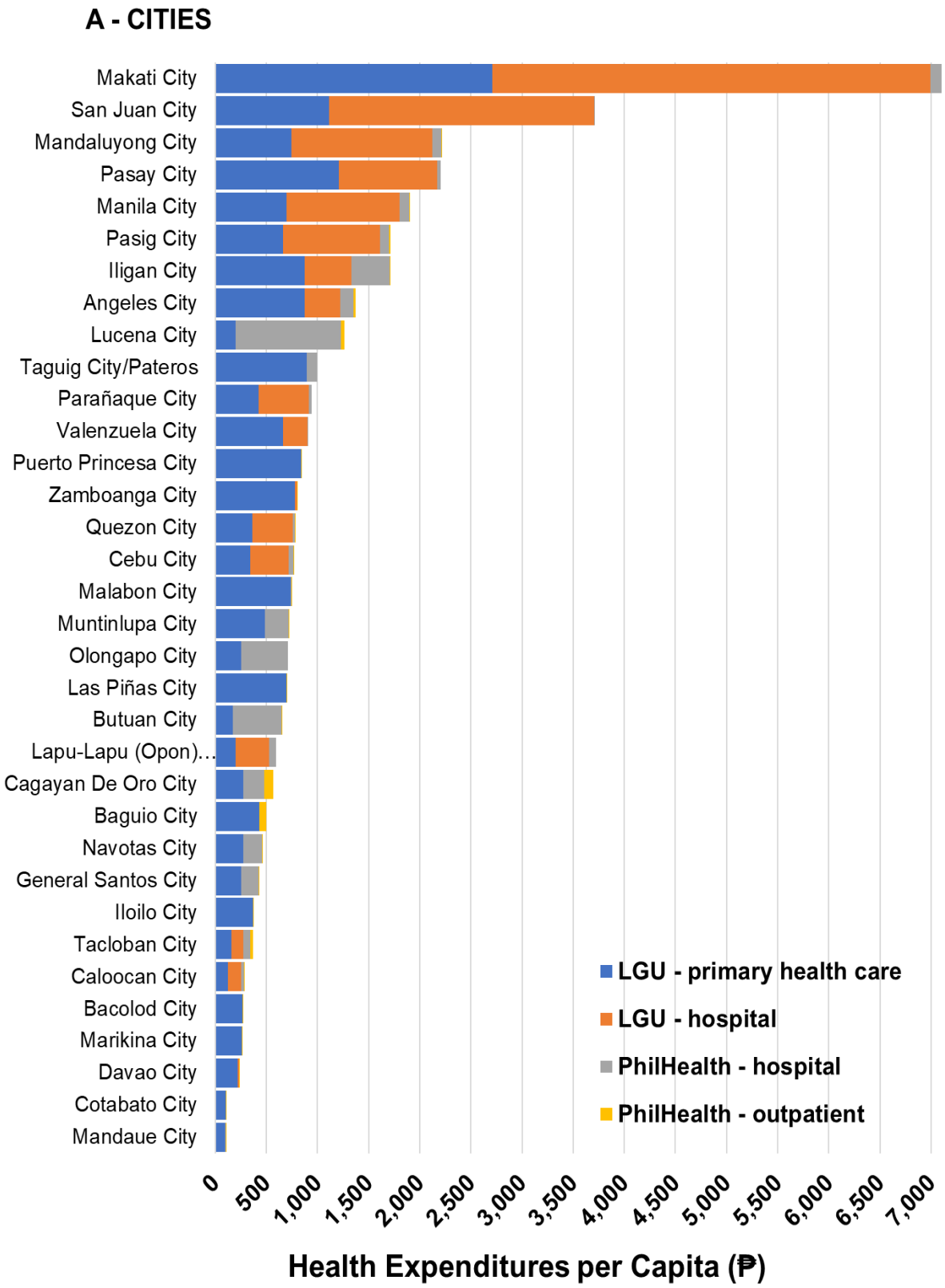
Year	% PhilHealth Contribution to LGU-owned Hospitals
2010	30%
2011	31%
2012	40%
2013	43%
2014	47%
2015	54%
2016	55%
2017	52%
2018	47%
2019	44%
2020	33%

* Formula:

$$\frac{\text{PhilHealth paid claims to LGU hospitals} * 100}{(\text{PhilHealth paid claims to LGU hospitals} + \text{LGU expenses for its hospitals})}$$

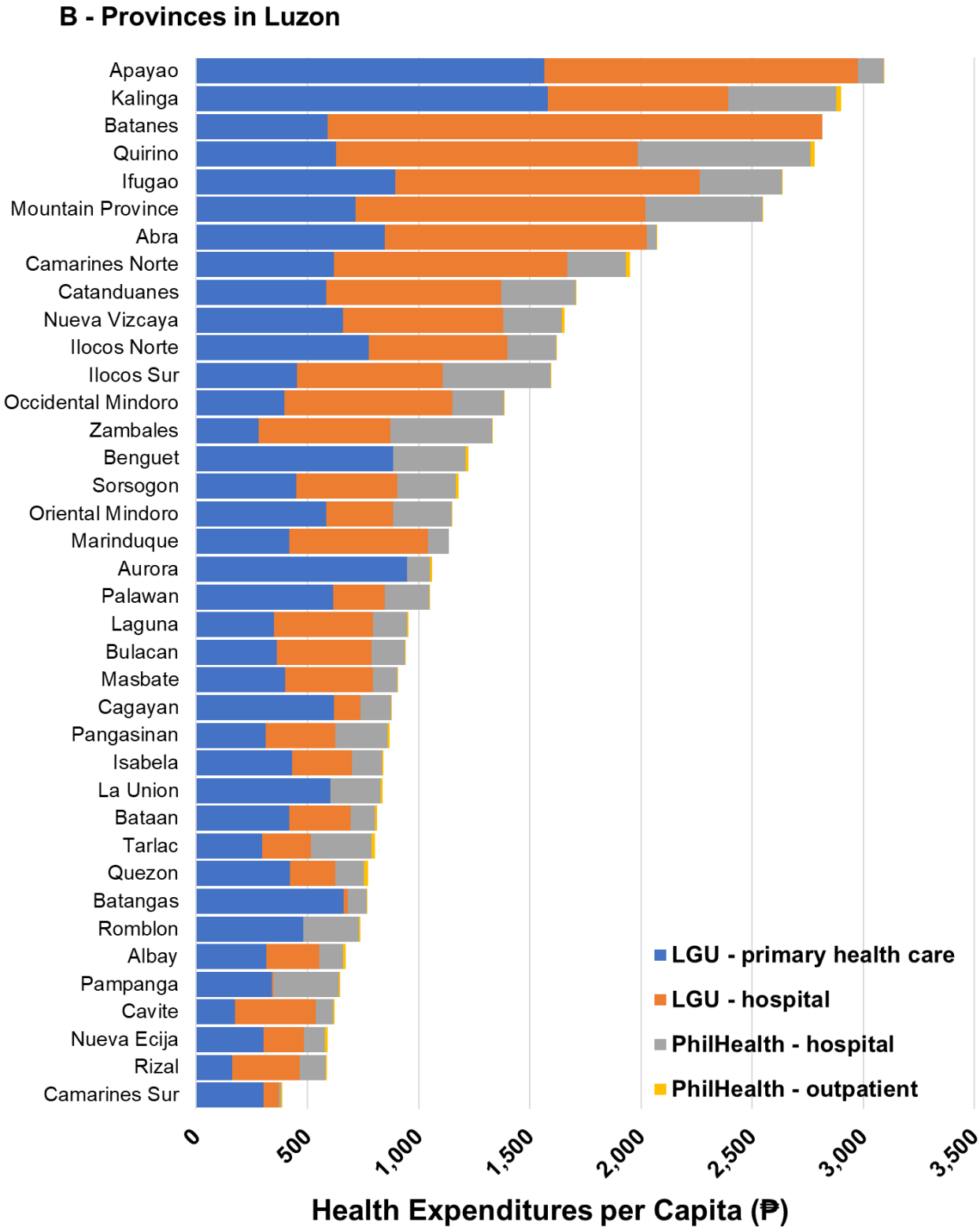
Although on the average (Table 6, Table 7), **PhilHealth seems to have a degree of leverage in the public hospitals, there is large variation in the ability of LGUs to harness PhilHealth financing** (Figure 12 A-C, Appendix Table 2)**.** Several cities and provinces across Luzon, Visayas, and Mindanao showed that PhilHealth contributed significant public financing for their hospitals in 2020. But there were also LGUs where PhilHealth's contribution was entirely negligible. For example, among NCR cities alone: Marikina City does not operate a hospital, hence 100% of public financing is from the LGU, and it is directed wholly to PHC. In contrast, Navotas City operates one public hospital, and 40% of public financing for its hospital is from PhilHealth. In general, LGUs where PhilHealth contribution to public financing is significant were those that owned at least one PhilHealth-accredited hospital.

Figure 12. Per-capita public financing in HCPNs with breakdown of LGU and PhilHealth contribution for hospital or primary health care, 2020



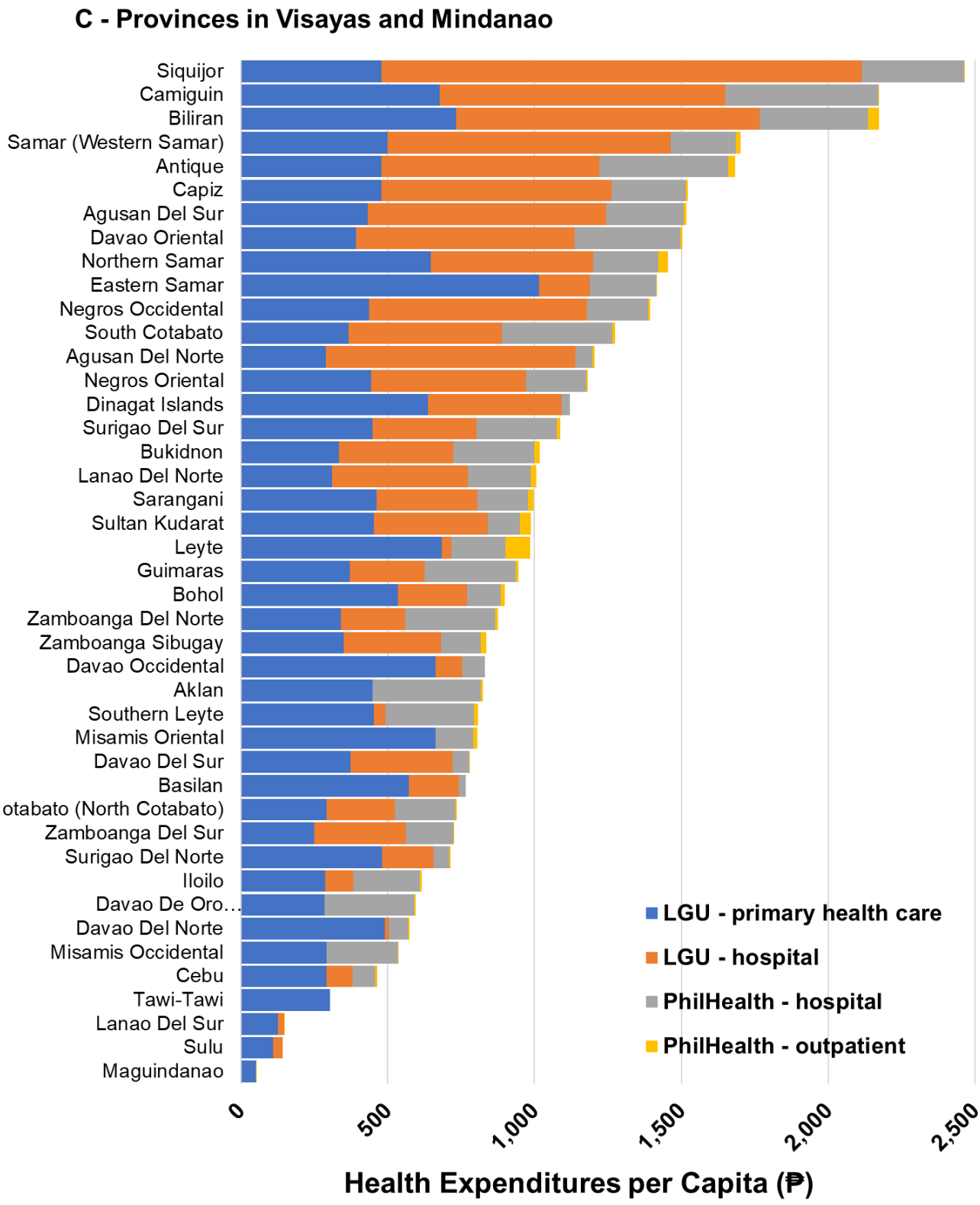
* See Appendix Table 2 for the numbers underlying the graph.

Figure 12. Per-capita public financing in HCPNs with breakdown of LGU and PhilHealth contribution for hospital or primary health care, 2020



* See Appendix Table 2 for the numbers underlying the graph.

Figure 12. Per-capita public financing in HCPNs with breakdown of LGU and PhilHealth contribution for hospital or primary health care, 2020



* See Appendix Table 2 for the numbers underlying the graph.

4.3. PhilHealth Financing of Primary Health Care (PHC)

Countries that have achieved UHC put the greatest value on primary health care, making it the cornerstone of health system strengthening. PHC, as a service delivery concept, is a level of care in the health system that provides entry into the system for all new needs and problems in a person-focused rather than disease-focused manner (Starfield et al., 2005). PHC has been shown to allow equitable access to health care by making essential health services available at the community-level for households and families. It also reduces expensive complications of disease through preventive and promotive services, and effective gatekeeping mechanisms that help patients navigate access to hospital care, specialty care, and other diagnostic needs. This facilitative and integrative component also empowers communities by guiding patients on how to appropriately take care of their health. In global literature, PHC has resulted in better population health (Ang et al., 2014; Atun, 2009; Greenfield et al., 2016; Tangcharoensathien et al., 2015).

At the national-level, resources invested in and spent for primary health care has been consistently significantly less than that of hospital-based care. Data from the PNHA show that from 2014 to 2019, almost half (41%-43%) of THE in the country are spent on hospitals (**Table 8**). This is followed by spending on retailers and other providers of medical goods (around 30%-33% of THE), which include drug stores and other sellers of medical equipment and supplies. **Spending for primary preventive care failed to reach even at least 10% share in the THE**, **with a peak of only 9.2% in 2017.** Even if this is combined with the share of ambulatory health care (which are mostly outpatient in nature), the highest total share would only be 13% — still very far from spending for hospitalization services.

Table 8. Distribution of total health care expenditures by health care provider, 2014-2019

Health care provider	2014	2015	2016	2017	2018	2019
Total (₱ billion)	489.1	543.6	598.5	655.7	714.8	792.6
Hospitals	41.0%	43.0%	41.2%	41.2%	42.1%	43.6%
Public general hospitals	15.9%	17.4%	16.7%	16.7%	18.0%	19.0%
Private general hospitals	16.7%	17.4%	16.6%	16.2%	15.7%	16.1%
Specialized hospitals (other than mental health hospitals)	2.4%	2.7%	2.5%	2.4%	2.6%	2.6%
Other hospitals	6.0%	5.5%	5.5%	5.9%	5.9%	5.8%
Preventive health care	8.0%	8.7%	9.1%	9.2%	7.1%	7.3%
Ambulatory health care	4.2%	4.5%	4.3%	4.2%	4.3%	4.4%
Retailers and other providers of medical goods	33.1%	32.4%	32.1%	31.7%	32.2%	30.3%
Other providers	13.6%	11.5%	13.3%	13.7%	14.2%	14.3%

Source: (Philippine Statistics Authority, 2020)

PhilHealth benefit payouts reflect the same narrative, with inpatient claims significantly overwhelming payments for PHC and outpatient care (Table 9). Payment for inpatient services practically account for the majority of PhilHealth claims, averaging at a **share of 90.2% from 2015 to 2020.** Claims are relatively equally distributed across levels of hospitals, except for infirmaries which receive 3-5% of total claims. The **very small benefit payout for the variety of outpatient benefits (which includes PHC) peaked at 10% in 2020, and remained steady at 8% in other years.**

Focusing only on PhilHealth's **primary health care benefit package (i.e., "Tsekap") revealed even more alarming results: its share in overall PhilHealth payments was practically non-existent (<0.01%).** In 2020, the "Tsekap" benefit package was expanded to the "Konsulta" package. However, PhilHealth was only able to accredit very few facilities, and payments have not actualized; This explains the 0% share for PHC in 2020.

Table 9. Comparison of Amount of PhilHealth Payments for Inpatient versus Outpatient

	2015	2016	2017	2018	2019	2020
All claims (₱ millions)	93,128	102,042	104,194	106,073	110,869	84,210
Inpatient	**91%**	**92%**	**91%**	**91%**	**90%**	**86%**
Infirmaries	5%	5%	4%	4%	4%	3%
Hospitals - Level 1	29%	29%	28%	28%	28%	25%
Hospitals - Level 2	26%	27%	27%	28%	27%	29%
Hospitals - Level 3	31%	31%	32%	32%	31%	29%
Outpatient	**9%**	**8%**	**8%**	**8%**	**8%**	**10%**
Primary Health Care	0.001%	0.001%	0.003%	0.007%	0.001%	0%
MCP and FP	3%	3%	3%	3%	3%	4%
HIV/AIDS, TB, Malaria, Animal Bite, Drug Abuse	0%	0%	0%	0%	0%	0%
Dialysis - free standing	3%	3%	4%	5%	5%	8%
Ambulatory Surgery	2%	1%	1%	1%	2%	1%
Diagnostics	[redacted]					0.3%
COVID-19 Community Isolation						0.3%

MCP and FP - Maternal Care Package and Family Planning; HIV - Human immunodeficiency virus/ Acquired immunodeficiency syndrome; TB - Tuberculosis.

The poor coverage of PhilHealth for PHC and outpatient care manifests in its paltry support to HCPN public financing for PHC. Comparing per-capita contributions from budgets of provinces and cities versus PhilHealth payments show the stark difference (**Table 10**). **While median LGU HCPN per-capita spending for PHC climbed from ₱324 in 2010 to ₱444 in 2020, median PhilHealth per-capita contribution to public PHC and outpatient care has never breached ₱15** — and it has never gone beyond a maximum of ₱100 for any one LGU HCPN (**Table 10**). In the earlier years of 2010-2013, PhilHealth contribution to HCPN public financing for PHC was the weakest (<0.05%). It increased in the succeeding years, peaking at 4.8%, but it again started decreasing from 2017 onwards to eventually land at 1.5% of HCPN public financing for PHC in 2020. Figure 12 further emphasizes the point that PhilHealth contribution to PHC among LGU HCPNs can barely be seen.

This continuing poor performance in financing and incentivizing primary health care services puts PhilHealth in a weak position to steer service delivery in the country towards a PHC-orientation. Moreover, it fails to support the move towards contracting and paying HCPNs, because the PHC base is not well-supported and vulnerable to being overpowered by focus on inpatient services.

Table 10. Median PhilHealth contribution to HCPN primary health care financing, 2010-2020

Year	Province / City HCPNs per-capita spending for Primary Health Care (max) N=115	PhilHealth per-capita spending for PHC and outpatient care (max)	% PhilHealth contribution to HCPN public financing for PHC*
2010	₱324 (2,425)	₱0.2 (11.3)	0.06%
2011	₱365 (1,391)	₱0.4 (13.8)	0.11%
2012	₱367 (1,317)	₱1.4 (25.2)	0.35%
2013	₱402 (1,177)	₱3.4 (36.5)	0.66%
2014	₱226 (987)	₱5.6 (92.3)	2.16%
2015	₱242 (848)	₱10.7 (99.6)	3.76%
2016	₱263 (1,249)	₱13.0 (83.8)	4.81%
2017	₱296 (1,701)	₱11.1 (58.8)	3.61%
2018	₱317 (2,029)	₱5.1 (44.4)	1.54%
2019	₱344 (2,382)	₱4.6 (46.1)	1.33%
2020	₱444 (2,708)	₱6.1 (87.6)	1.51%

* Formula: (PhilHealth paid outpatient claims for LGU facilities) * 100
(PhilHealth paid outpatient claims for LGU facilities + LGU expenses for PHC)

4.4. PhilHealth Distributional Equity

A consequence of the **hospital-leaning payment patterns of PhilHealth is that claim payments are siphoned towards geographic locations with higher concentrations of hospitals.** Claims data show that around **60% of PhilHealth payments are concentrated in the richer NCR and Luzon** areas which are home to 63% of all the licensed hospitals in the country (Table 11). Ideally, instead of hospitals, health financing should follow PHC facilities. Because while not all LGUs have PhilHealth hospitals, all LGUs have at least one PHC facility in the form of a rural health unit (RHU). This is one mechanism of how PHC-orientation promotes equity and facilitates a wider accessibility of preventive services to communities who need them.

Table 11. Distribution of PhilHealth claims by geographic location, 2015-2020

	% of Licensed Hospitals	2015	2016	2017	2018	2019	2020
All claims (₱ millions)		93,128	102,042	104,194	106,073	110,869	84,210
National Capital Region	12%	19%	18%	19%	18%	17%	17%
Luzon	51%	39%	39%	40%	42%	42%	46%
Visayas	14%	16%	17%	16%	16%	17%	17%
Mindanao	23%	26%	26%	25%	24%	24%	21%

Source: Author's analysis of PhilHealth claims data and the DOH National Health Facility Registry

Aside from geographic maldistribution of PhilHealth financing, the biggest share of PhilHealth payments went to private facilities (Table 12). PhilHealth and DOH-NHFR 2020 data shows that 60% of accredited hospitals and 67% of licensed hospitals are privately owned (Dayrit et al., 2018; Department of Health, 2019; PhilHealth, 2020). Consequently, the greatest share in PhilHealth claims payment also goes to **private hospitals who have taken 59%-63% of PhilHealth claims from 2015-2020, with corporate hospitals averaging 43%** for the same period.

Table 12. Share in PhilHealth claims by facility ownership, 2015-2020

	2015	2016	2017	2018	2019	2020
All claims (₱ millions)	93,128	102,042	104,194	106,073	110,869	84,210
Ownership	100%	100%	100%	100%	100%	100%
Government	**41%**	**43%**	**43%**	**43%**	**43%**	**37%**
National	18%	19%	19%	20%	20%	18%
Local Government	23%	24%	23%	22%	23%	20%
Private	**59%**	**57%**	**57%**	**57%**	**57%**	**63%**
Cooperative	3%	2%	2%	2%	2%	2%
Corporation	43%	41%	42%	43%	43%	48%
Foundation	2%	2%	2%	2%	2%	2%
Single Proprietorship	10%	10%	10%	9%	10%	10%
Partnerships	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Unknown	0.4%	0.4%	0.5%	0.5%	0.5%	0.5%

Source: Author's analysis of PhilHealth claims data and the DOH National Health Facility Registry

These private hospitals cater less to poor and vulnerable patients (i.e., indigents). **In general, public facilities served more indigent patients (68% in 2019, 59% in 2020) than private facilities (38% in 2019, 37% in 2020)** as measured by PhilHealth claims counts in facilities (Table 13). Upon closer look into ownership subtypes of private facilities, we saw that only 34%-36% (by claims counts in 2019 and 2020) of those who filed for PhilHealth in corporate hospitals, which have the largest share of PhilHealth claims, were indigents. On a positive note, **private single proprietorship and partnership hospitals,** which are mostly composed of **level 1 hospitals, have a fairly equal distribution of indigents and non-indigent patients** (Table 13). However, these subtypes of private facilities get a very small share (10.4%) of total claims payment (Table 12).

Table 13. Share in PhilHealth claims by facility ownership, disaggregated for indigents 2019-2020

	2019				2020			
Ownership	Counts (thousands)	% Indigent by count	Paid (₱ millions)	% Paid - Indigent	Counts (thousands)	% Indigent by count	Paid (₱ millions)	% Paid - Indigent
All hospitals	**9,314**	**52%**	**100,205**	**54%**	**7,398**	**46%**	**72,236**	**48%**
Government	**4,150**	**68%**	**46,617**	**70%**	**3,093**	**59%**	**30,242**	**64%**
National	1,847	64%	22,360	66%	1,512	51%	14,635	59%
LGU	2,303	71%	24,257	73%	1,582	67%	15,608	68%

Private	**5,164**	**38%**	**53,588**	**40%**	**4,304**	**37%**	**41,994**	**36%**
Cooperative	219	38%	2,444	40%	168	36%	1,811	37%
Corporation	4,108	36%	41,011	36%	3,522	35%	33,297	34%
Foundation	196	39%	1,969	40%	155	38%	1,436	37%
Single Proprietor	566	56%	7,375	59%	396	49%	4,891	52%
Partnership	24	49%	295	53%	19	43%	183	47%
Unknown	52	34%	495	35%	44	34%	375	32%

Source: Author's analysis of PhilHealth claims data and the DOH National Health Facility Registry

5. Conclusions

Health care providers such as hospitals and primary health care facilities form an integral part of any health system; They are the platforms where care can be accessed by individuals to maintain or improve their health. Health financing arrangements and institution financial health greatly influence the ability of these health care providers to operate and deliver quality health care services. Providers must have both financial sustainability, such that they are able to continuously deliver health care services without bankruptcy, and sufficient profits to maintain and improve the quality of their services. In this paper, we (1) described the financial health of select public and private hospitals in the Philippines, and (2) examined PhilHealth's current position in relation to its envisioned role as national strategic purchaser under Universal Health Care. This purchasing role pictures PhilHealth in an emboldened position of monopsonistic power, with financial leverage to incentivize the formation of health care provider networks, drive investments and focus on primary health care, and distribute health sector resources equitably to Filipinos based on their health needs.

5.1. The Financial Health of Select Philippine Hospitals

Private hospitals showed decent profitability margins, but they may easily fall into financial distress if their cash flows are disrupted. The size of private hospitals in our sample was steadily growing as measured by their total assets. Some portion of expansion was likely funded by debt and some by profits from patient fees. Majority of private hospital revenues were from patient fees. The sampled private hospitals were fairly efficient in generating revenues from their assets and keeping salary costs managed at <30% of their revenues, to ultimately result in operating margins of 8-9% (on median) for their core activity of patient care. An area of concern for these private hospitals seemed to be in the increasing time it takes to collect on their receivables (from 1 month to around 2 months on median), particularly from insurance payments, which could challenge their cash flow and liquidity. Since private hospitals do not receive subsidies from the government like public hospitals, liquidity issues such as these could put them in a position susceptible to closure, especially smaller level 1 hospitals, should there be any abrupt, considerable, and persistent interruptions on cash flow, such as those from decreased patient volume and delays in the collections for patient receivables.

Prior to any government subsidies, public hospitals face continuous negative profitability margins, signaling that they continuously operate on financial deficits. They have relatively inefficient asset turnover ratios, generating only ₱0.20-₱0.30 in revenues per peso of assets. Deficits worsened in 2020 because of COVID-19 where public hospitals were likely unable to generate revenue from non-COVID-19 patients while having additional expenses for infection control (e.g., personal protective equipment, sanitation) and increases in personnel hazard pay.

Every year, however, government subsidies have proven useful in, if not essentially, bailing out public hospitals from negative profit margins, resulting in practically no likelihood of closure. This is expected in public facilities since governments, whether the national or local, may continue to infuse funds to help these facilities cover expenses to continue operating. With these end-year subsidies, public hospitals are fairly liquid on paper, able to operate three to four months (on median) even with no additional cash earned. Moreover, government assistance for capital investments via the Health Facility Enhancement Program have helped public hospitals, particularly the DOH hospitals who make up a large part of our public hospital sample, grow and replenish their fixed assets.

Despite being healthy on paper, ultimately, the reliance on subsidies proves that public facilities are not self-sufficient and may be chronically underfunded. Limited budgets seem to be channeled towards essential expenses to keep operations running: personnel costs (median: 60% of total expenses), medicines, medical supplies, and utilities. This lower spending on maintenance and other operating expenses (MOOE) may translate to minimal spending on routine maintenance of fixed assets and growth activities (e.g., training and staff development). The large financial deficits prior to receiving subsidies may also translate to compromised monthly cash flow and inability to pay for monthly expenses, like staff salaries, on time.

5.2. PhilHealth as the National Strategic Purchaser

Compared with the tall order and expectations of UHC for the institution, PhilHealth is still far from functioning effectively as the country's envisioned national purchaser. This is highlighted through several weaknesses in leveraging purchasing power, steering cost-effective service delivery, and distributing resources equitably.

In gathering monopsonistic power, PhilHealth has unimpressive leveraging power to shape health care provider behavior and drive UHC goals. At the macro-sectoral level, share in total country health expenditures still show great dependency on unpredictable and risky OOP at around ~50%, with PhilHealth's share stunted at less than 20%. With health financing burden still reliant on citizen pockets, financial risk protection is far from assured. At the facility-level, PhilHealth's share in hospital income and expenses was following a diminishing trend compared with other sources of income and medical inflation. Furthermore, PhilHealth's contribution to public health care provider networks was weak compared to consolidated provincial- or city-expenditures for health.

PhilHealth financing for cost-effective primary health care services has been grossly inconsequential. With the UHC Act pushing for stronger focus on primary health care, PhilHealth's role in financing health services at this level should be competitive with that of LGUs. However, PhilHealth benefit payment over the years has been overwhelmingly hospital-

centric, and incentivizes expensive inpatient care versus more cost-effective and accessible PHC services. Even within inpatient facilities, tertiary level facilities receive a greater share compared with lower hospitals that are more accessible and affordable to poorer households. This poor performance in financing PHC also puts PhilHealth in a weak position to consolidate HCPNs, as PHC facilities serve as the integral base of any service delivery network.

PhilHealth has also not been able to facilitate equity in financing and access to care in three areas: geography, facility ownership, clientele type. Hospital-leaning payment patterns of PhilHealth translated to siphoning of finances towards geographic locations with higher concentrations of hospitals, which are usually high-income areas as poorer LGUs commonly do not have their own hospitals. Furthermore, since private facilities are greater in number than public facilities, they receive a large proportion of PhilHealth funds, particularly the private corporate hospitals. These private facilities tend to cater more to non-indigents, so resources here tend towards richer clientele; Ideally, with PhilHealth, rich and poor patients should be able to have equal access to these larger private hospitals. On the other hand, private level 1 single proprietorships or partnerships, that have a fairly equal distribution of and access by indigents and non-indigent patients, receive smaller comparative shares of PhilHealth benefit payouts (10.4%).

6. Recommendations

In this last section, we provide recommendations to advance Universal Health Care from a health system perspective, going beyond a focus on the hospital sector. Specifically, our recommendations have in mind this goal of UHC:

> *"Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship."* (*Universal Health Coverage (UHC)*, 2021)

Primary health care should be strengthened and prioritized in terms of service delivery enhancement, financing, and incentives. The benefits of establishing strong primary health care as the core of the health system have been showcased globally by various countries. With the hospital-centric system of the Philippines, establishing this primary health care base will need coordinated enhancements both from supply and demand sides, spearheaded by the DOH and PhilHealth, respectively.

Infrastructure expansion and investments should pour towards primary health care; these plans should also be calibrated with consideration of PHC's potential positive impact on decreasing the need for hospitalization. The Philippine Health Facility Development Plan (PHFDP) 2020 - 2040 of the DOH indicates that an additional 400,000 beds will be needed by 2040, with priority for level 1 hospitals given that it has the largest gap in beds. It is estimated that at least ₱56 billion every year should be spent by the national and local governments for capital investment with the majority expected from the former. The private sector is also seen as a crucial partner. This doubling of bed count from 1.2 beds per 1,000 to 2.7 beds per population was calculated based on global benchmarking, and more importantly a model projection of burden of disease (BOD) in the country (Department of Health, 2020b). However, this BOD projection uses a linear model, with very strong focus on expanding hospitalization capacity and with the assumption that BOD patterns; This means that the projects do not consider the potential gains of a strong PHC base. Strengthening PHC can prevent the development of diseases and complications that require hospitalization, which would subsequently decrease the need for hospital beds. Currently, DOH AO NO. 2020-0024

entitled “Primary Care Policy Framework and Sectoral Strategies” outlines key principles and areas of work to steer the primary health care agenda. The roles and expectations from different bureaus such as the Health Human Resources Development Bureau (HHRDB), Health Facilities and Services Regulatory Bureau (HFSRB), Health Facility Development Bureau (HFDB), Disease Prevention and Control Bureau (DPCB), among others, are also identified here (Primary Care Policy Framework and Sectoral Strategies, n.d.). This plan should be followed and implemented with heavy focus, and should be the priority of capital investment for public facilities such as the HFEP.

By capacitating public PHC facilities, they will be better equipped to pass eligibility and other PhilHealth accreditation requirements for the enhanced benefit packages for primary health care. The UHC Act mandates PhilHealth to guarantee financial coverage on primary health care services through a Comprehensive Outpatient Benefit Package (COPB). This aims to ensure that all Filipinos have entitlement to a wide range of preventive, promotive, primary health care services in accessible primary health care facilities, which will direct them to higher-level services as necessary. The envisioned COPB is a huge jump from the current primary health care benefits of PhilHealth: The current package only covers a slim set of primary health care services; The COPB is envisioned to be disease agnostic, such that any service deemed appropriate at the primary or outpatient level shall be covered. Capital infusions will be important to ensure that public primary health care facilities can grow and expand towards this capacity.

Primary health care payments of PhilHealth should increase to competitive rates comparable to LGU investments, and be supported by strategic payment systems, to become a reliable source of financing for primary health care services. Historically, delays in PhilHealth reimbursements for primary health care services have caused a huge disincentive for rural health units (RHUs) to seek accreditation, more so to expand their services. Furthermore, results of this study highlight that the prevailing primary health care rates are negligible to actual LGU spending. The COPB should move towards at least matching existing expenditures of LGUs on primary health care, in order to successfully capture and impose leverage. Payment mechanisms should also move away from reimbursement systems that contribute to failure in purchasing power of PhilHealth

The UHC Act stipulates that PhilHealth shall pay providers through prospective, closed-end, performance-based payment mechanisms. At the primary health care level, this points towards capitation payment. While the current primary health care benefit of PhilHealth is capitated, it still practically follows a reimbursement scheme as payments are only made after certain services are provided - i.e., registration, profiling, etc. True prospective capitation means that payments should be made prior to service delivery, calibrated to tranches linked with achievement of performance indicators. **At the inpatient level, this refers to global budget payment** - a provider payment mechanism where providers are paid a lump-sum amount of money to finance its services. Prospective payments will allow providers to strategize on their resources, and make demands for performance more reasonable. It also allows PhilHealth to put itself in a position of greater monopsony by guaranteeing significant financing for its contracted facilities. The fixed payment amounts enforced by capitation and global budget payment are effectively caps that help contain costs of health care providers. This impacts user charges and OOP spending, as well as inflation in medical prices. The performance-based aspect at the primary and inpatient levels are supported by contracting mechanisms where certain quality, output, and outcome indicators will be indicated. Overall,

the shift in payment scheme will help support PhilHealth in its emboldened role as strategic purchaser.

While the reforms in PhilHealth payment systems help strengthen its leveraging power and monopsonistic positioning, these will only be effective if the institution has sufficient resources. In 2020, Philippine National Health Accounts (PNHA) total health expenditures (THE) of ₱895.88 billion. 44.7% is from OOP, and only 14.9% from PhilHealth. This share of PhilHealth in THE effectively shows the limits of its resources. Theoretically, a majority of the OOP costs should be absorbed by PhilHealth. **MOOE of health facilities currently being shouldered by national and local governments should also be eventually covered by PhilHealth as part of its prospective payments**. This necessitates PhilHealth to generate more resources. Fiscal space should be expanded by enforcing the premium increases stipulated in the UHC Act. However, these premium increases should be presented side-by-side with commensurate, definite, clear benefit expansions. Linking premium increases with expansions in benefit entitlements and guarantees can motivate support from people, and likewise drive providers to expand in accordance with growing service inclusions.

In the case of public hospitals, capacity expansion should be done with the proper pace and strategy to ensure financial responsibility and sustainability. Forming the primary health care base will require some time, and thus hospital capacity will still need to expand and be a major financial commitment of the government. Furthermore, changes in PhilHealth payments will also not kick-in right away, and the responsibility of financing operations of hospitals will still largely fall on the national and local governments. The circumstance of negative profitability of existing public hospitals will most probably hold true for new ones, and reliance on subsidies will carry through. National and local governments must carefully anticipate necessary fiscal capacity to cover operating costs of new public hospitals. Otherwise, any new facility will suffer from chronic financial distress, resulting in deterioration in initial capital investment, as well as quality of service delivery.

Strategies to ensure proper cash flow for public facilities should be developed and implemented, in accordance with envisioned financing roles from the UHC Act of national and local governments, and PhilHealth. Shift in provider payments of PhilHealth is key to rationalizing financing roles, and consequently ease fiscal flows. The relatively good fiscal health presented by public hospitals on paper may not reveal the picture of daily operations, given public hospital dependency on subsidies from national or local governments to cover large operating deficits. Ultimately, public hospitals are still grossly underfunded. Financial deficits greatly affect MOOE as shown by skewed spending towards personnel services (PS), which expectedly cannot be decreased since health workers salaries need to be constantly paid. **PhilHealth should expedite development and roll out of its global budget payment mechanism, complemented by proper costing approaches. This will greatly unburden fiscal stress of hospitals, as resources from national and local governments can be concentrated towards capital outlay and PS.** Furthermore, there will be greater confidence from the national and local governments to put up more hospitals and expand bed capacity in the country, because operating expenses will have a financial source through PhilHealth. In the interim, efficiency gains in procurement of medicines and or medical supplies could help public hospitals since these account for a high percentage of MOOE. This can be facilitated by technical assistance from the national government such as platforms for pooled procurement and price negotiation, among others, all of which are also backed by the UHC Act.

With the expected shifts in financial flows from recent legislations, LGUs and LGU facilities should be properly capacitated on effective financial management. The UHC Act rationalizes financial roles of the national and local governments, and PhilHealth. The recently passed Executive Order 138 s.2021, which emanated from the Mandanas-Garcia Supreme Court Ruling, is set to increase resources of LGUs given the expanded base for the computation of the Internal Revenue Allocation (IRA) which forms the basis for downloaded funds to provinces, municipalities, and cities from the national government. Early estimates show that the IRA will be expanded by around 37.9% across the board (Diaz-Manalo et al., n.d.; Full Devolution of Certain Functions of the Executive Branch to Local Governments, Creation of a Committee on Devolution, and For Other Purposes., 2021). These changes in roles and fiscal shifts will mean greater responsibility for local governments in managing finances for all its operations, including health. Historically, most LGUs have been coming from resource-constrained circumstances, and the huge windfall of finances may come as a shock. Enhancing financial planning and management capacity will be crucial to ensure proper use and allocation of resources.

Resources for LGU hospitals should be protected, particularly PhilHealth payments, to ensure adequate financing of public facilities. Revenues generated by LGU-owned public facilities, including PhilHealth payments, are within management mandate of LGUs following bestowed autonomy from the LGU Code of 1991. Prevailing PhilHealth rules indicate that reimbursements should be put in a trust fund to ensure they are earmarked for health. However, LGU trust funds are not exclusive to health, and are still within discretionary decision-making of local chief executives (Querri et al., 2018). As a result, PhilHealth payments do not necessarily go to the public facility that provided the services. Furthermore, anecdotal evidence from discussion with provincial accountants reveal that budgeting and auditing practices in LGU-operated hospitals are not yet really results-based budgets. This means that current financial practices are not linked to a formalized desired outcome or social objectives, and budget allocations and approval may not align with actual needs, or even reasonable rights to finances following revenues generated by the facility. Increasing PhilHealth payments and improving payment arrangements will not translate to any positive yield if money is still not protected for health. Currently, hospitals that function as local economic enterprises (LEEs) are more self-sufficient and self-reliant, and can keep their own revenues, including PhilHealth generated income. This establishes the case that such an arrangement is possible.

In the long-term, the Special Health Fund (SHF) indicated in the UHC Act should be prioritized for establishment across all LGUs. Through the SHF, resources for health and revenues for health-generated activities shall be earmarked and ring-fenced within this exclusive fund pool, ensuring that they are reinvested for improvements in health services. Given that public hospitals provide health care services as a public good, playing a key role in providing health care access to those without means to pay, protecting funds of these facilities will allow them to perform their sectoral role more effectively.

PhilHealth prospective payments should also be expedited for purposes of supporting private facilities and avoiding problems on receivables that may push them towards financial distress. The study showed that while private hospitals enjoy relatively good margins, the biggest risk they face are challenges in collecting receivables. This constrains their liquidity and puts them at risk of having insufficient resources to fund operations, particularly lower level hospitals. The risk of closing these lower level hospitals fall on indigent households, since these form the majority of their clientele. This shift to prospective payment essentially eliminates all receivables, and private hospitals will have a more stable and

predictable flow of finances. This also helps place PhilHealth in better negotiating and purchasing power with private hospitals, which is crucial given that more than 50% of service delivery mix in the country is from the private sector.

While private contribution is important in expanding inpatient capacity in the country, the sector should also be enjoined in the primary health care agenda. Although the gaps in hospital bed capacity right now is considerable, the short fall in primary health care facilities is even greater. Steering the private sector to invest more in primary health care capacity will be integral in meeting needs on this service level, and further expand access points for communities and households.

Likewise, the private sector should be welcomed in the establishment of health care provider networks (HCPNs), and facilitated to mix with public facilities. Current patterns as shown in the claims reveal a dichotomy in the sector - the rich opting for private facilities, and the poor accessing care through public facilities. This dichotomy can prove problematic because health profiles of the well-off and the vulnerable do not mix, and certain facilities may be burdened disproportionately. In the future, there should be no difference in the capacity and quality of services between the public and private. And more importantly, there should be no difference in the clientele served. Public facilities should be at par that richer households see them as a real alternative when seeking care. Private facilities should have more affordable services through adequate and responsive PhilHealth payments that lower income households see them as viable options. Mixing public with private facilities in HCPNs further this breakdown of dichotomy and facilitates further mixing of case profiles.

A systematic and routine monitoring and collection of hospital financial health data and PhilHealth contributions to facilities, LGUs, and eventually HCPNs should be established. PhilHealth includes submission of financial statements as part of its claims reimbursement requirements, but these are left unanalyzed and unused. Experience in the conduct of the study also shows that no existing monitoring of hospital financial health exists and PhilHealth contributions to facilities exist. Regular mechanisms to generate similar analysis to this study will be productive in policy and program implementation. It is not enough to monitor the quantity and presence of functional capital structures. Continuously investing in new infrastructure without having an eye on operations of current facilities and their sustainability sets the stage for a host of future fiscal problems. Proper understanding of how resources flow from national and local pools to service delivery conduits such as hospitals should be prioritized and linked with the development of investment plans such as the PHFDP.

Clear metric and performance indicators on financial health should be set to guide performance-based payments of PhilHealth, as well as future capital infusions from the government. In countries like the USA, such data are collected routinely and following a standard, allowing governments to assess (1) financial health of critical access hospitals, (2) effects and leverage of insurance payments, (3) identification of model facilities that display efficiency and financial sustainability for benchmarking and replication of best practices, even (4) needs for special interventions such as centralization or privatization of facilities (American Hospital Association, 2020; Cole et al., 2014; Hussey & Anderson, 2003; Levitz & Brooke, 1985; McCue & Thompson, 2011; *Ziegler 2018 Not-For-Profit Healthcare Medians*, 2020). Furthermore, knowing the financial health of facilities, including PHC facilities, will be crucial to implementing HCPNs and supporting their flourishing.

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Appendix

Table 1. Total PhilHealth claims amount compared to Hospital income and expenses of sampled public and private facilities, 2015 - 2020

Year	Total Claims Amount (median)	Total Income (median)	Expenses (median)
Public Facilities			
2015	111,149,585	496,131,031	361,952,768
2016	140,424,817	587,177,503	465,466,464
2017	145,236,994	700,742,733	556,386,880
2018	156,144,674	843,129,255	656,254,144
2019	154,577,252	924,933,100	699,719,648
2020	102,932.468	1,124,011,696	922,982,720
Private Facilities			
2015	51,490,608	93,749,941	9,018,315
2016	54,088,590	109,591,960	12,783,614
2017	53,717,558	123,563,518	17,595,490
2018	54,498,062	135,658,618	17,456,717
2019	54,825,051	148,780,153	19,732,883
2020	42,872,715	144,973,381	20,172,734

Table 2. Per-capita public financing in HCPNs with breakdown of LGU and PhilHealth contribution for hospital or primary health care, 2020 (₱)

A - Cities

	LGU		PhilHealth		Total per capita within LGU HCPN
Local Government Unit	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Mandaue City	99	0	5	2	99
Cotabato City	104	0	0	3	104
Davao City	223	11	0	3	234
Marikina City	263	0	0	0	263
Bacolod City	268	0	0	6	268
Caloocan City	123	134	26	0	257
Tacloban City	156	116	72	27	273
Iloilo City	372	0	0	3	372
General Santos City	253	0	170	11	253
Navotas City	277	0	184	6	277
Baguio City	428	0	0	69	428
Cagayan De Oro City	277	0	205	88	277
Lapu-Lapu (Opon) City	198	329	69	0	527
Butuan City	174	0	477	7	174
Las Piñas City	700	0	0	0	700
Olongapo City	257	0	457	0	257
Muntinlupa City	485	0	233	3	485
Malabon City	740	0	8	0	740
Cebu City	344	374	48	10	718
Quezon City	366	393	23	0	759
Zamboanga City	782	18	0	1	800
Puerto Princesa City	842	0	0	1	842
Valenzuela City	660	239	5	0	899
Parañaque City	425	488	27	0	913
Taguig City/Pateros	894	0	101	0	894

Local Government Unit	LGU		PhilHealth		Total per capita within LGU HCPN
	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Lucena City	200	0	1,027	37	200
Angeles City	872	352	128	22	1224
Iligan City	872	458	377	3	1330
Pasig City	664	950	86	15	1614
Manila City	694	1,111	92	6	1805
Pasay City	1,211	959	37	0	2170
Mandaluyong City	746	1,378	90	1	2124
San Juan City	1,117	2,592	5	0	3708
Makati City	2,708	4,288	108	0	6996

B - Luzon Provinces

Local Government Unit	LGU		PhilHealth		Total per capita within LGU HCPN
	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Camarines Sur	303	68	10	7	371
Rizal	160	306	114	8	466
Nueva Ecija	303	180	96	11	483
Cavite	176	362	77	6	538
Pampanga	339	6	297	5	345
Albay	314	239	108	10	554
Romblon	482	0	248	7	482
Batangas	664	17	86	3	681
Quezon	423	202	129	19	624
Tarlac	298	217	273	16	515
Bataan	419	276	109	10	695
La Union	602	0	226	10	602
Isabela	432	268	135	7	699
Pangasinan	311	314	234	11	625
Cagayan	620	117	138	5	738
Masbate	400	394	112	2	794
Bulacan	362	426	149	5	789
Laguna	351	443	153	7	794
Palawan	617	230	202	3	846
Aurora	948	0	105	9	948
Marinduque	419	623	94	0	1042
Oriental Mindoro	584	301	263	3	885
Sorsogon	451	453	265	12	904
Benguet	887	0	325	13	887
Zambales	281	593	457	0	874
Occidental Mindoro	396	757	229	5	1153
Ilocos Sur	451	656	485	5	1108
Ilocos Norte	777	621	221	0	1398
Nueva Vizcaya	660	720	264	13	1381
Catanduanes	586	785	336	1	1371
Camarines Norte	618	1,049	263	21	1668
Abra	849	1,178	43	0	2027
Mountain Province	717	1,302	528	1	2019
Ifugao	893	1,370	371	1	2263

Local Government Unit	LGU		PhilHealth		Total per capita within LGU HCPN
	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Quirino	627	1,358	776	19	1986
Batanes	590	2,226	0	0	2816
Kalinga	1,581	813	486	20	2394
Apayao	1,564	1,411	115	4	2975

C - Visayas and Mindanao Provinces

Local Government Unit	LGU		PhilHealth		Total per capita within LGU HCPN
	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Maguindanao	52	0	0	1	52
Sulu	110	33	0	0	143
Lanao Del Sur	126	20	0	1	146
Tawi-Tawi	303	0	0	0	303
Cebu	291	89	78	7	380
Misamis Occidental	292	0	242	2	292
Davao Del Norte	490	15	65	5	505
Davao De Oro (Compostela Valley)	285	0	306	4	285
Iloilo	288	96	225	7	384
Surigao Del Norte	481	175	55	3	656
Zamboanga Del Sur	249	313	162	4	562
Cotabato (North Cotabato)	292	234	204	5	526
Basilan	572	169	24	0	741
Davao Del Sur	375	347	56	2	722
Misamis Oriental	664	0	127	14	664
Southern Leyte	453	39	301	14	493
Aklan	449	0	369	6	449
Davao Occidental	664	90	78	0	754
Zamboanga Sibugay	351	330	136	19	681
Zamboanga Del Norte	340	219	306	11	560
Bohol	535	236	114	14	771
Guimaras	372	255	310	8	627
Leyte	684	31	185	85	716
Sultan Kudarat	452	387	111	37	839
Sarangani	462	344	173	17	806
Lanao Del Norte	311	462	214	19	773
Bukidnon	335	388	276	19	723
Surigao Del Sur	450	353	273	13	803
Dinagat Islands	638	454	29	0	1092
Negros Oriental	445	525	205	6	970
Agusan Del Norte	291	848	60	7	1139
South Cotabato	367	522	376	10	889
Negros Occidental	437	742	207	8	1179
Eastern Samar	1,016	173	226	4	1189
Northern Samar	646	554	221	32	1200
Davao Oriental	394	743	360	7	1137
Agusan Del Sur	432	812	265	8	1244
Capiz	478	784	252	8	1262

Local Government Unit	LGU		PhilHealth		Total per capita within LGU HCPN
	Primary health care	Hospital	Hospital	Outpatient (with PHC)	
Antique	478	743	438	25	1221
Samar (Western Samar)	500	963	223	16	1463
Biliran	733	1,035	369	38	1767
Camiguin	676	975	520	3	1651
Siquijor	480	1,634	349	0	2114