

# Analysis of the Philippine Health Insurance Corporation's Individually Paying Program and Employed Program

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## ABSTRACT

The provision of social health insurance has been an increasingly popular mechanism for addressing financial barriers to health care in developing countries. In the Philippines, the social health insurance program known as PhilHealth has been expanding its breadth of coverage since its promulgation in 1995. This study looks at the regional- and provincial-level coverage of two different PhilHealth programs: the Individually Paying Program (voluntary) and the Employed Program (government and private), and identifies the possible reasons for the variation between provinces. Coverage levels for the Individually Paying Program were found to be considerably below the government's full coverage target. The regional average was found to be at 57 percent while provincial average was at 53 percent. Variation was massive, ranging from 2.4 percent to 166 percent. For the voluntary program, provinces with higher bed-population and health professionals-population ratios were more likely to have higher coverage rates. The number of private hospitals in the province was also found to be a positive indicator for coverage levels. That is, the more the number of private hospitals, the higher the PhilHealth coverage level in a province. Curiously, incomes did not appear to be a factor in the level of insurance coverage in the province. For the Employed Program, both the private and government sectors have not achieved full coverage but the figures observed are promising. The private sector Employed Program's regional average is at 71 percent

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while the provincial average is at 75 percent. For the government Employed Program, the regional average lies at 74 percent while the provincial average is at 80 percent. For the private sector, the size of the establishment (in terms of number of employees) proves to be a significant factor. That is, as more employees are hired by medium-sized establishments, the higher the province is likely to experience PhilHealth undercoverage. Certain sectors are also found to be more prone to undercoverage. These findings are possible propositions on how targeting should be implemented. For the government sector, no clear pattern was found based on the model presented.

## INTRODUCTION

As Philippine medical care remains expensive, the government has aimed to achieve universal health coverage so that the poorer segments of the population can utilize health care without becoming further impoverished. Health insurance allows people access to care that they would otherwise not be able to afford. It also ameliorates the risk of financial loss.

Universal coverage has three components: breadth, depth, and height. Breadth refers to population coverage; depth refers to service coverage, including inpatient and outpatient services; and height refers to the level of financial protection (Tangcharoensathien et al. 2011).

In past decades, an increasing number of governments in developing and underdeveloped countries are providing social health insurance as a mechanism to address financial barriers to accessible health care, especially for the marginalized sectors of the population. Countries that have achieved universal health coverage such as South Korea, Germany, and Thailand have all started with mandatory health insurance before expanding into the informal sector. Theoretically speaking, compulsory health insurance is preferred over voluntary health insurance since it circumvents the problem of adverse selection (Kwon 2009). However, health insurance enrollment can only be enforced if there exists a legal mechanism or structure that allows for compulsory enrollment. Such a mechanism exists in the formal sector in the form of established employer-employee relationships or formal agreements in the form of an employment contract.

In the Philippines, the Medicare Program that existed prior to 1995 was a form of mandatory health insurance that covered employees in both the government and private sectors. The Philippine Health Insurance Corporation (PhilHealth) took over the responsibilities of Medicare and expanded to the informal sector as well.

Covered under the Employed Program (EP) are individuals in the government and private sectors with a formal employer-employee relationship.

The monthly premium contribution is up to 3 percent of the monthly basic salary with a PHP 50,000 cap. This premium is jointly shouldered by the employer and employee and remitted by the former on a monthly basis. The contribution table can be found in Appendix A.

Quimbo et al. (2011) found that, for the Philippines, “increased insurance or better financial protection confers better health and non-health (e.g., food) consumption of the patient in the future.” Although the study was not able to disaggregate whether the benefit was driven by breadth or depth, it nonetheless indicates a good starting point for the promotion of universal health coverage.

A joint study conducted by the Department of Health (DOH) and PhilHealth in 2008 “highlighted the need to increase enrollment coverage, improve availment of benefits and increase support value for claims in order for the National Health Insurance Program to provide Filipinos substantial risk protection” (DOH Administrative Order 2010-0036). The Benefit Delivery Review found that the benefit delivery rate nationwide is only around 8 percent (DOH 2010).

This study will only focus on the breadth aspect of the coverage. Looking at coverage levels will help determine the reasons for undercoverage and leakage in different regions and provinces. Next, establishing the issues pertaining to coverage will help formulate the steps necessary toward universal health coverage.

## **THE NATIONAL HEALTH INSURANCE PROGRAM**

Promulgated in 1995, the National Health Insurance Act (Republic Act 7875) “seeks to provide universal health insurance coverage and ensure affordable, acceptable, available, accessible, and quality healthcare services for all citizens of the Philippines” (PHIC 2012). As earlier mentioned, when PhilHealth replaced the Medicare Program, it expanded its coverage to not just the government and private sector employees but individuals in the informal sector as well.

PhilHealth is divided into the following schemes:

- 1) *Employed Program (EP)*. This covers individuals in the government and private sectors with a formal employer-employee relationship.
- 2) *Individually Paying Program (IPP)*. This refers to people who opt to pay for their own membership. This generally includes the self-employed, self-earning, and those in occupations without a formal employer-employee relationship.
- 3) *Sponsored Program*. This covers the “lowest 25 percent of the Philippine population” and families targeted by the Department of Social Welfare and Development (DSWD) under the National Household Targeting System for Poverty Reduction (PHIC 2013).

- 4) *Lifetime*. This encompasses individuals 60 years and over who were previously covered by any of the four schemes and had accumulated 120 premium monthly contributions.
- 5) *Overseas workers*. This refers to active land-based overseas Filipino workers. This study focuses on the IPP and the EP programs, the latter of which covers both the government and private sectors.

The national health insurance scheme allows members to enlist any number of dependents. Qualified dependents include the legal spouse, parents over 60 years of age who are nonmembers or have inactive memberships, and children below 21 years of age who are unmarried and unemployed. Children over the age of 21 suffering from disabilities that render them completely reliant on the member are also included in the scheme. Dependents are collectively allowed 45 days of coverage per calendar year.

#### **DETERMINANTS OF HEALTH INSURANCE ENROLLMENT**

Several theories on decisionmaking exist when it comes to enrolling in a health insurance scheme. Consumer theory is often used to explain the decisions that individuals take on health insurance. These decisions are made under uncertainty, but Cameron et al. (1988) argue that individuals do not base their decision solely on their utility but also on their expectations about certain factors. A number of theories on decisionmaking under uncertainty have sprung up over the years, including “expected utility theory”, “state-dependent utility theory”, “endowment effect theory”, “status quo bias theory”, “regret and disappointment paradigms”, and “prospect theory” (Schneider 2004). Factors affecting choice may be context-specific as those experienced in some developing countries (Box 1).

Studies on enrollment determinants have seen an array of approaches. Nyman (1999) looks into the “access motive” of acquiring health insurance. He argues that the long-standing explanation for health insurance status is something that should be incorporated into the theory on health insurance: That is, the value of health insurance is that it makes otherwise unobtainable health care obtainable.

There are demand-side and supply-side aspects to the decisionmaking process of availing health insurance. Ultimately, the decision lies with the individual. The state-dependent theory, for instance, suggests that “consumers’ utility levels and tastes are influenced by their state, such as their health or socio-economic status” (Schneider 2004). The supply-side aspects of the decision can be attributed to the concept of “trust” as put forward by Mechanic (1998). Trust is defined as “the expectation that individuals and institutions will meet their responsibilities to us” (Mechanic 1998). Both availability and accessibility of health-care services form part of the trust equation. Consumers need to know that the services will be there when needed; otherwise, getting health insurance would be for naught.

**Box 1. Factors affecting choice: Cases of other developing countries**

1. **Viet Nam.** Willingness to participate in health insurance determined by affordability, quality of existing schemes, supply of health-care services, and a lack of understanding about health risks and pooling (Castel et al. 2011).
2. **Thailand.** Identified determinants include educational level, average number of employed members in the household, average annual income, and the presence of illness (Supakankunti 2000).
3. **Ghana.** Significant determinants include income, educational level, technical quality of care, service delivery adequacy, and “health beliefs and attitudes” (Jehu-Appiah 2011).

Source: Author's compilation

Carrin et al. (2001) identify four main reasons social health insurance in developing countries is difficult to implement. One reason is the lack of a strong and steady political support. Kwon (2009) makes a similar observation for South Korea, stating, “Political will and commitment are crucial for universal coverage of the population in these countries.”

In Castel et al.’s (2011) recommendations for Viet Nam, the authors emphasize the efficiency of making health insurance mandatory. In their recommendations, they propose the possibility of increasing the number of small business registrations with tax authorities. Such a policy would be cumbersome and will most likely prove to be unpopular, especially among small business owners. Adapting such a policy would then require strong political support and thorough follow-through from the administration.

McIntyre et al. (2003) also reiterates the importance of key stakeholders in the implementation and actual design of the social health insurance. In South Africa, the decisions taken by the Department of Health “were heavily influenced by attempts to accommodate the concerns of the National Treasury” (McIntyre et al. 2003). The importance of political feasibility is highlighted in examples given, which include the experiences of Egypt and Israel. It is therefore important to remember the political aspect of the whole process, as it will, in part, determine the failure or success of the social health insurance.

**ISSUES WITH EMPLOYER-SPONSORED INSURANCE**

Sullivan et al. (1992) conducted a study on employer-sponsored health insurance in the United States. Although the health insurance system in the United States is different from that in the Philippines, a couple of parallelisms can be drawn.

One of the issues noted by Sullivan et al. (1992) was the decline in enrollment for employer-sponsored insurance due to fiscal constraints on firms by a recent recession. Fiscal constraints can be a reason some firms in the Philippines choose to hire their employees as “contractuals”. By doing so, they avoid having to enroll

their employees in the health insurance program as well as other social security benefits that are otherwise required by law.

The same study revealed that employees who were not offered health insurance by their employers accessed health coverage through different sources such as trade associations and union health plans. Meanwhile, in the Philippines, the national health insurance is the most widely used insurance. However, the distinction between the PhilHealth programs could allow for brokering. One of two things could happen. First, if the employee is already enrolled in the voluntary program even before being hired by the company and does not demand coverage from the new employer, the latter could choose to not transfer the employee's membership to the EP program. Second, if the employee has no health insurance yet, the employer could negotiate that the employee enroll under the voluntary program if the latter's salary bracket under the EP program requires a higher premium than under the voluntary program.

## METHODOLOGY

This study's main objective is to assess the coverage levels of the two programs and determine the causes of variation among provinces. The level of coverage was computed using the following formulas:

- 1) IPP Coverage = Number of IPP members/Number of informal workers
- 2) EP Coverage = Number of EP members/ Number of formal workers

EP coverage was computed separately for the private sector and for those employed in the government sector.

Three steps were undertaken in order to assess the level of coverage per province. First, the number of people employed in the informal sector was estimated from the merged 2010 Labor Force Survey (LFS) and 2009 Family Income and Expenditure Survey (FIES). Estimates were done on national, regional, and provincial levels. Second, the number of potential dependents was estimated from the same dataset so as to exclude them from the denominator in Equation (1). Third, the coverage rates were computed by employing Equation (1) using data provided by PhilHealth as a numerator.

### Estimation of the informal and formal sectors

Using the merged LFS-FIES dataset, the steps to arrive at the given estimates are as follows:

- 1) The total population of the country was taken from the 2010 Census released by the National Statistics Office;
- 2) Given that only individuals 15 years and older are legally allowed to work, those aged 14 years and below were removed from the sample;

- 3) The proportions of employed, unemployed, and individuals who are not part of the labor force<sup>2</sup> were estimated. The total number of employed people was estimated using the population derived in step 2;
- 4) The proportion of individuals classified as nonpoor was estimated by clustering the third to fifth income quintiles. This proportion was subsequently used to estimate the total number of employed nonpoor population;
- 5) The class of workers listed in the dataset consists of:
  - (0) Private household
  - (1) Private establishment
  - (2) Government/Government corporation
  - (3) Self-employed
  - (4) Employer
  - (5) Family-owned business (with pay)
  - (6) Family-owned business (without pay)

Individuals counted in the informal sector are those belonging to groups (0), (3), (4), (5), and (6). Using the proportions generated, the total number of employed nonpoor was estimated for the informal sector. For the estimation of the formal sector, the same method is employed. Individuals in the formal government sector are derived from those belonging to group (2) while those in the formal private sector are from group (1). Using the proportions generated, the total number of employed nonpoor was estimated for the formal sector.

### **Estimation of potential dependents in the informal sector**

Potential dependents were removed from the informal population before calculating the coverage rates. Conservative and liberal estimates of the potential dependents were provided.

However, there are some individuals working in the informal sector that are potential dependents of workers belonging in the formal sector. Assuming that these potential dependents will not enroll in the IPP program, their proportion is then estimated. This assumption is grounded on the notion that employers automatically enroll those in the formal sector.

The following people are included as potential dependents:

- 1) If the household head is employed in the formal sector (private or government):
  - Child of household head aged between 15 and 20 years in the informal sector
  - Household head's spouse in the informal sector
  - Parent of household head aged over 60 years in the informal sector

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<sup>2</sup> Individuals who are not willing or able to work are not counted as part of the labor force.

- 2) If the spouse of the household head is employed in the formal sector:
  - Household head in the informal sector
  - Child of spouse and household head who is between 15 and 20 years old and works in the informal sector
- 3) If the household head is employed in the informal sector:
  - Child of household head aged between 15 and 20 years in the informal sector
  - Household head's spouse in the informal sector

A conservative estimate of the number of potential dependents was then subtracted from the estimated number of employed people in the informal sector. On the other hand, the liberal estimates consist of the conservative estimate and the number of the rest of the informally employed individuals under the age of 21 years. This paper will utilize the conservative estimates unless otherwise specified.<sup>3</sup>

The aforementioned steps for both the informal sector population and the potential dependents were used to estimate the figures at the national, regional, and provincial levels.

For the provincial level, two estimates were provided. The first was a direct estimate of the data while the second estimate used the jackknife method to get the proportions. The LFS-FIES dataset had been stratified by region, which indicates that the provincial level numbers might not be representative of the true population. Although the estimates are expected to be unbiased, the variance would be higher than desired given the small sample sizes of some provinces. The jackknife method addresses this issue by replicating the sample for each province. This method is used as a form of robustness check.

After deriving the population for the informal sector, the coverage rate per province was estimated. Equations (1) and (2) provide a ratio between 0 and infinity. The ratio is interpreted as follows:

- 1) If  $0 < \text{Ratio} < 1$ , there is undercoverage.
  - If  $\text{Ratio} \leq 0.5$ , the province is classified as having severe undercoverage.
  - If  $0.5 < \text{Ratio} \leq 0.75$ , the province is classified as having moderate undercoverage.
  - If  $0.75 < \text{Ratio} \leq 0.9$ , the province is classified as having mild undercoverage.
- 2) If  $\text{Ratio} = 1$ , full coverage has been achieved.
  - If  $0.9 < \text{Ratio} < 1.1$ , the province is classified as having full coverage.

<sup>3</sup> Figures using liberal estimates can be made available by author upon request.



A 10-percent margin on both sides has been set to allow for error in estimates.

- 3) If  $\text{Ratio} > 1.1$ , overcoverage exists.
- If  $1.1 < \text{Ratio} \leq 1.25$ , the province is classified as having mild overcoverage.
  - If  $1.25 < \text{Ratio} \leq 1.5$ , the province is classified as having moderate overcoverage.
  - If  $\text{Ratio} > 1.5$ , the province is classified as having severe overcoverage.

### Determination of factors leading to undercoverage and overcoverage

To assess the difference in levels of coverage between provinces, an ordered logistic regression (OLR) was employed. OLR is similar to a logistic regression model except that it considers the event and all other events that are ordered before it.

The OLR is modeled as follows:  $C_{ij} = \Pr(y_i \leq j) = \sum_{k=1}^j \Pr(y_i = k)$  where  $C_{ij}$  is the cumulative probability that the province is in the  $j_{th}$  category or higher. The cumulative probability can be converted into a cumulative logit,  $\text{logit}(C_{ij}) = \log(C_{ij}/1-C_{ij})$ . The OLR model then becomes  $\text{logit}(C_{ij}) = \alpha_i - \beta X_i$ , which models the cumulative logit as a linear function of the independent variables.

The ordered categories are:

- Severe undercoverage
- Moderate undercoverage
- Mild undercoverage
- Full coverage
- Overcoverage

The OLR is run on identified demand-side and supply-side, provincial-level characteristics. The vectors of variables identified for IPP estimation are found in Box 2.

A linear regression was also estimated using the same vector of variables but restricted to provinces with undercoverage. For this particular regression, the actual ratios were used as a dependent variable. This second regression was employed due to the highly skewed nature of the coverage rates generated, with approximately 85 percent of the provinces being categorized as undercovered.

A similar methodology was employed for the EP. However, it must be noted that for mandatory health insurance, the decision to enroll lies with the employer and not with the individual/employee. Provincial-level characteristics used for the EP in the private sector differ from that for the EP in the government sector.

The vector of provincial-level characteristics for the private sector consists of:

**Box 2. Vector of variables for IPP estimation**

**X** = vector of sociodemographic characteristics of the provinces

1. Education Index taken from the 2009 Human Development Index
2. Health Index taken from the Good Governance Index
3. Male-female ratio
4. Average household income of nonpoor population
5. Age brackets: Percent of the population aged 0 to 14 years; aged 15 to 64 years; aged 65 years and over
6. Sectoral employment: Percent of employed population in agriculture, sales, services, manual work, processing/manufacturing, mining, skilled work, and education/academe
7. Nature of employment: Percent of employed population with permanent job, short-term job

**S** = vector of supply-side variables (provincial level)

1. Real GDP/capita of province (deflated by the 2006 Consumer Price Index)
2. Health expenditures/capita of province
3. Population ratios: Beds and health professionals
4. Number of private hospitals
5. Number of government hospitals

Source: Author

- 1) Sectoral employment: Percent of employed population in agriculture, sales, services, manual work, processing/manufacturing, mining, skilled work, and education/academe
- 2) Nature of employment: Percent of employed population with permanent job, short-term job
- 3) Union coverage
- 4) Union-employees ratio
- 5) Enterprise size: Number of employees in micro, small, medium, and large enterprises

The vector of provincial-level characteristics for the government sector consists of:

- 1) Good Governance Index
- 2) Real local gross domestic product (GDP) per capita
- 3) Income class

A linear regression was also estimated using the same vector of variables but restricted to the provinces with undercoverage. For this particular regression, the actual ratios were used as a dependent variable. Similar to the IPP, the coverage rates generated were highly skewed, with approximately 77 percent of the provinces being categorized under Undercoverage.

**DESCRIPTION OF VARIABLES**

The vector of variables chosen addresses both the demand-side and supply-side aspects of the decisionmaking process. All the determinants are provincial-level variables.

## Individually Paying Program

### *Vector of demand-side variables*

Education Index. This serves as a proxy for the level of education in the province. The level of education could affect the choices taken. Individuals with higher levels of education are expected to make more informed decisions. They are more likely to have better access to different sources of information and may have the capability to process this information better.

Health Index. This was taken from the Administrative Governance Index of the Good Governance Index.<sup>4</sup> This serves as the provincial-level proxy of the health status of the population.

Male-female ratio. Some studies have shown that female-headed households—or at least households whose health decisions are made by the woman—are more likely to enroll in a health insurance plan as well as avail of health services.

Average income of nonpoor population. This refers to the mean income of the population belonging to quintiles 3, 4, and 5. Income is considered an important predictor of both utilization and health insurance availment. It is expected to have a positive impact on enrollment.

Age brackets. Age is a factor in health insurance enrollment for a number of reasons. Certain age groups might have a higher possibility of achieving well-established employment and thus, higher income. A study found that young adults were the least likely group to have any health insurance. Likewise, it can also be argued that more education and experience are attained with age, which would allow for more informed decisionmaking.

Sectoral employment. Certain types of occupation in each sector are likely to lead individuals to enroll in a health insurance scheme. This could be due to the nature of the occupation in terms of health risks and awareness of the existence as well as the need to avail of certain social security measures.

Nature of employment. The nature of employment (i.e., permanency) is a possible predictor of enrollment. Those with short-term jobs are more likely to enroll in the voluntary program if employers do not provide coverage. On the other hand, the lack of employment would discourage them from enrolling or maintaining their health insurance status.

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<sup>4</sup> Computation of health index: Ave (Health Personnel Per 10,000 Population Index + Percent of Households with Access to Safe Water Index + Live Births Less Than 250 Grams Per 1,000 Births Index + Number of Barangay Health Stations per 100,000 Population Index). Source: NSCB Technical Notes on Good Governance Index. <http://www.nscb.gov.ph/ggi/techNotes.asp>.

*Vector of supply-side variables*

Real GDP per capita of the province. The GDP per capita signals the province's overall level of wealth. This is also an indication of the capacity of the provincial government to provide services to its population.

Health expenditures per capita of the province. Government health expenditure per capita is a proxy for availability as well as accessibility. It is plausible that the more the government spends on health care, the more the quantity of public services is made available, at the very least, and the better the quality, at best.

Beds and health professionals ratios per 10,000 people. Both these variables serve as proxies for availability of services. Availability of services where health insurance can be used is important in individuals' decision to enroll.

Number of hospitals, both government and private. Because PhilHealth's coverage is inclined toward inpatient services, the existence of hospital can be considered an indicator for enrollment. This study looks at private and government hospitals as two distinct categories to determine whether the service provider plays a role in the decision to avail of a health insurance plan.

Vectors of variables chosen for the private EP are different from government EP. All variables are at the provincial level.

**Private Employed Program**

Sectoral employment. Certain sectors may be composed of firms that are easily monitored by government agencies. Said sectors would therefore be more likely to enroll their employees in all social security benefit programs required by law.

Nature of employment. This variable refers to the permanency of employment. Firms that offer short-term employment may be less likely to enroll their employees in the national health insurance scheme.

Union coverage and union-employee ratio. These union-related factors serve as a proxy for the strength of employees' positions in the sector. It can be argued that the stronger the position of the employees—at least collectively—the more likely they are to insist on the provision of social security benefits, among other things.

Enterprise size. Refers to the number of employees employed in micro, small, medium, and large enterprises. Certain enterprise sizes may be more likely to enroll their employees in social security benefit schemes. Large enterprises, for instance, already have employee benefits, particularly social security benefits, factored into their administrative costs as these are included in the packages they offer to new hires.

**Government Employed Program**

Good Governance Index. This variable serves as a proxy for the level of

governance in the province. Governance in this index is defined by the National Statistical Coordination Board as “the manner in which power is exercised in the management of the country’s economic and social resources for development” (NSCB 2013).

Real local GDP per capita and income class. Local GDP pertains to the income of the province generated locally (i.e., the Internal Revenue Allotment from the national government is excluded). The province’s local income per capita will serve as a proxy on the local government’s ability to generate income and thus, to cover expenses.

The income class of the province will serve as a similar proxy as the local GDP per capita.

## RESULTS AND DISCUSSION

### **The Individually Paying Program: Coverage levels**

The national coverage for the IPP is computed at 55.93 percent, indicating moderate undercoverage. The regional coverage rates are found in Table 1.

The provincial coverage rates are illustrated in Figure 1.

Most provinces suffer from undercoverage, with a regional average of 57 percent and a provincial average of 53 percent. The variation among provinces is sizable, ranging from a coverage rate of 2.4 percent to 166 percent. Provinces with the lowest coverage rates are concentrated in the Autonomous Region in Muslim Mindanao (ARMM). All provinces in this region are classified under severe undercoverage, with Sulu and Tawi-Tawi trailing behind the most at 2.39 percent and 2.57 percent, respectively. Bicol and Eastern Visayas regions also have among the lowest coverage rates at 23.58 percent and 28.95 percent, respectively. Most of the provinces with coverage rates below 20 percent are stand-alone islands (Figure 2). This might be an indication of an access issue. Leakages are observed in the Davao region (Region XI), which has a regional coverage of 124.8 percent while SOCCSKSARGEN nears full coverage at 94.8 percent.<sup>5</sup>

Data from LFS-FIES and PhilHealth, as well as new PhilHealth coverage rates for 2012 have been released since the conduct of this study. A considerable increase in the national coverage rate was noted for IPP: It now shows a coverage rate of 80.35 percent for principal members of the program. However, regional and provincial disparities are still observed. Figure 3 shows the change in coverage rates over a span of two years across the different regions.

Marked improvements are noted in Regions III, IV-A, National Capital Region (NCR), and Cordillera Administrative Region (CAR) while ARMM

<sup>5</sup> Provincial-level coverage rates can be made available by the author upon request.

**Table 1. Regional coverage for the Individually Paying Program**

Region	Coverage Rate (%)	Remarks
I - Ilocos Region	56.78	Moderate undercoverage
II - Cagayan Valley	42.80	Severe undercoverage
III - Central Luzon	79.95	Mild undercoverage
IVA - CALABARZON	79.24	Mild undercoverage
IVB - MIMAROPA	45.25	Severe undercoverage
V - Bicol Region	23.58	Severe undercoverage
VI - Western Visayas	39.60	Severe undercoverage
VII - Central Visayas	41.85	Severe undercoverage
VIII - Eastern Visayas	28.95	Severe undercoverage
IX - Zamboanga Peninsula	41.49	Severe undercoverage
X - Northern Mindanao	63.53	Moderate undercoverage
XI - Davao	124.80	Moderate overcoverage
XII-SOCCSKSARGEN	94.80	Full coverage
NCR	71.51	Moderate undercoverage
CAR	69.95	Moderate undercoverage
ARMM	5.66	Severe undercoverage
Caraga	65.60	Moderate undercoverage

Source of basic data: Labor Force Survey (LFS)-Family Income Expenditure Survey (FIES) 2009. Figures are calculated/generated by the author unless specified otherwise.

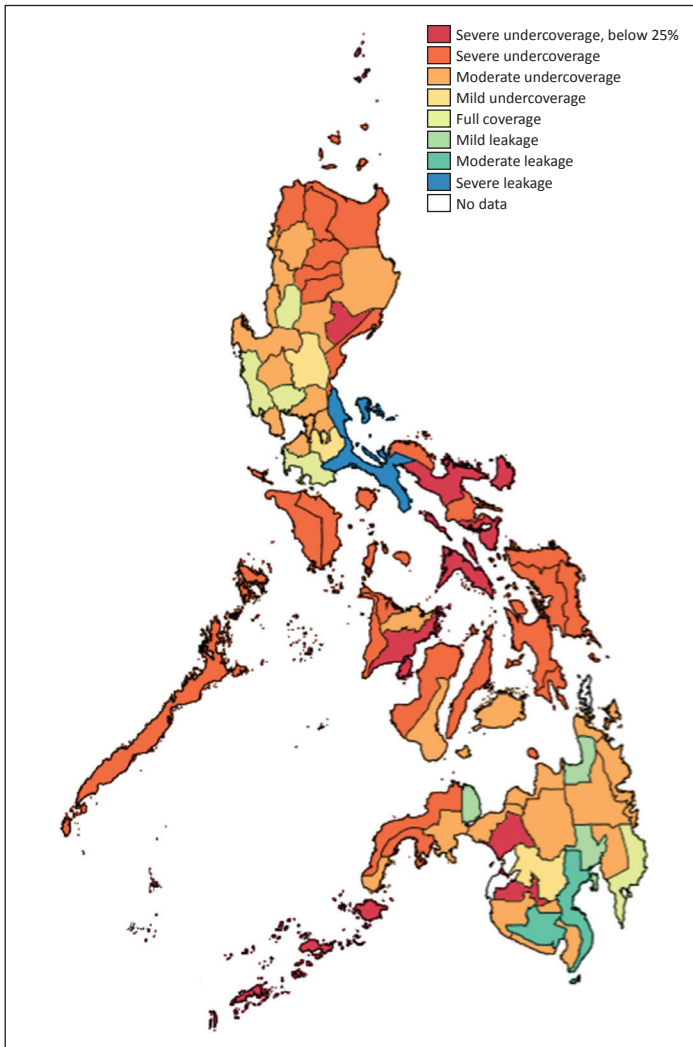
remains the poorest performing region in terms of coverage. Provincial variation is still observed in the 2012 figures. For Region IV-A, for instance, all its provinces are at full coverage except for Rizal, which trails at 57 percent.

### **Employed programs: Coverage levels**

The national coverage rates for the private EP is computed at 97.8 percent (classified as full coverage) and that of the government EP is at 75.7 percent (mild undercoverage). Table 2 shows the coverage rates for private and government EPs by region.

Figures 4 and 5 further present the provincial coverage rates. For the private EP, up to 63 percent of provinces have severe to moderate undercoverage. Two provinces, Quirino and Basilan, have coverage rates below 20 percent. These rates are far from satisfactory given the mandatory nature of the program. Two provinces, Sulu and Tawi-Tawi, have notable overcoverage of over 200 percent. Both provinces have high numbers of microenterprises. These coverage rates can be explained by the possibility that respondents to LFS incorrectly classified

Figure 1. 2010 provincial coverage rates of Individually Paying Program

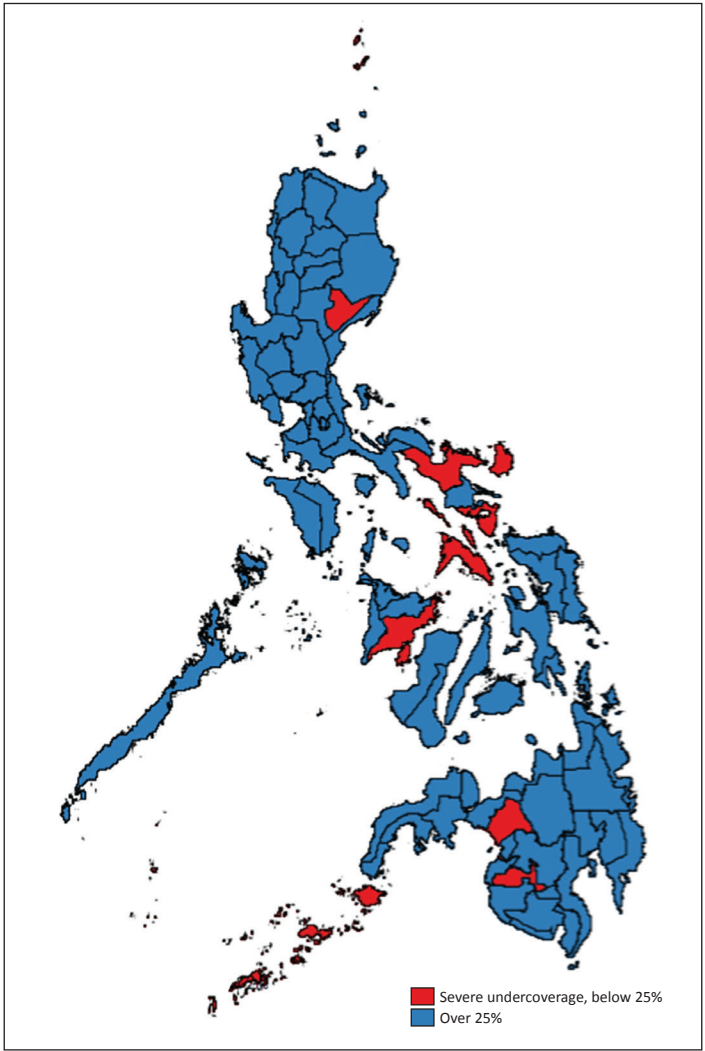


Source of basic data: LFS-FIES 2009

themselves under the informal sector categories instead of as formal private establishments. If this is indeed the case, the coverage rates for these provinces' informal sector are then expected to improve.

More recent 2012 figures are also available for both the private EP and government EP. Figures 6 and 7 show the regional coverage rates of principal members for both programs for the years 2010 and 2012.

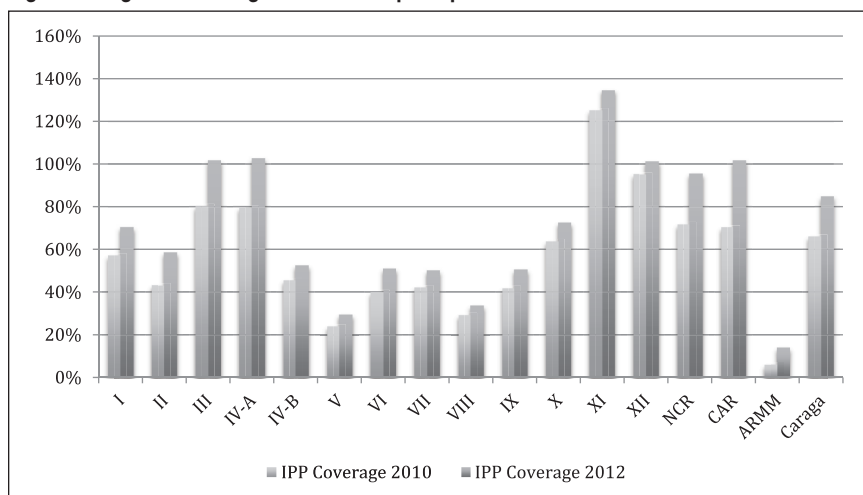
**Figure 2. Provinces with below 25-percent coverage**



Source of basic data: LFS-FIES 2009

From 2010 to 2012, the private EP maintained full coverage at 104 percent at the national level while the government EP only saw a 1-percent increase to 76 percent at the national level. Just as in the IPP, both EP types exhibit variations across regions and provinces. For ARMM, the regional coverage rate has improved significantly for the government EP. However, when assessed by



**Figure 3. Regional coverage rates for IPP principal members**

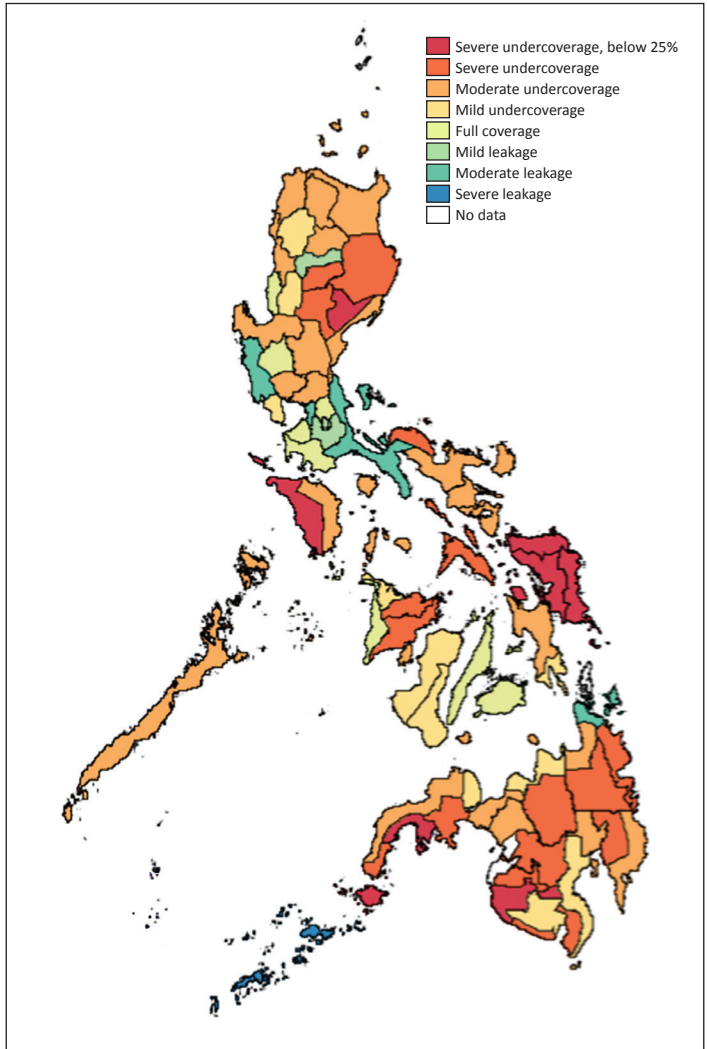
Source of basic data: LFS-FIES 2009, 2012

**Table 2. Regional coverage rates for the employed program (private and government)**

Region	Private Employed Program		Government Employed Program	
	Coverage Rate (%)	Remarks	Coverage Rate (%)	Remarks
I - Ilocos Region	66.75	Moderate undercoverage	87.06	Mild undercoverage
II - Cagayan Valley	48.48	Severe undercoverage	79.76	Mild undercoverage
III - Central Luzon	77.06	Mild undercoverage	83.51	Mild undercoverage
IVA - CALABARZON	111.90	Mild overcoverage	81.70	Mild undercoverage
IVB - MIMAROPA	49	Severe undercoverage	59.68	Moderate undercoverage
V - Bicol Region	51.64	Moderate undercoverage	70.38	Moderate undercoverage
VI - Western Visayas	69.31	Moderate undercoverage	74.96	Moderate undercoverage
VII - Central Visayas	105	Full coverage	60.78	Moderate undercoverage
VIII - Eastern Visayas	59.70	Moderate undercoverage	76.59	Mild undercoverage
IX - Zamboanga Peninsula	57.40	Moderate undercoverage	67.54	Moderate undercoverage
X - Northern Mindanao	68	Moderate undercoverage	61.90	Moderate undercoverage
XI - Davao	76.20	Mild undercoverage	66.16	Moderate undercoverage
XII - SOCCSKSARGEN	54.47	Moderate undercoverage	74.25	Moderate undercoverage
NCR	143.90	Moderate leakage	97.10	Full coverage
CAR	81.90	Mild undercoverage	90.78	Full coverage
ARMM	31.40	Severe undercoverage	54.28	Moderate undercoverage
Caraga	61.90	Moderate undercoverage	71.85	Moderate undercoverage

Source of basic data: LFS-FIES 2009

Figure 4. 2010 Provincial coverage rates for private Employed Program



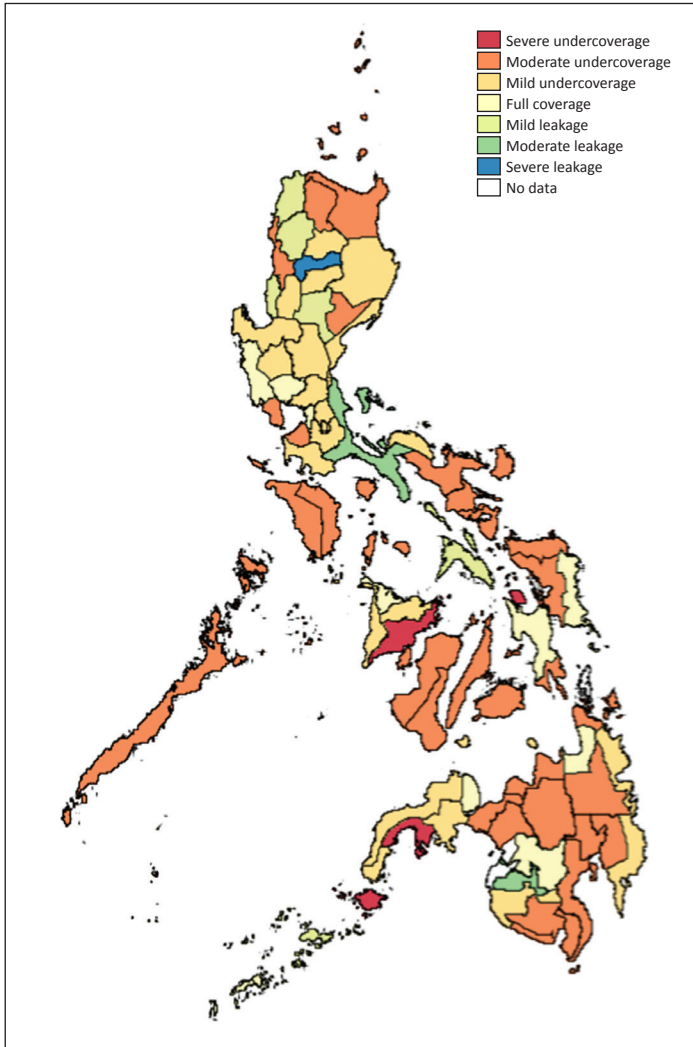
Source of basic data: LFS-FIES 2009

provinces, Basilan is seen to trail behind with a coverage rate of 45 percent while Sulu exhibits overcoverage at 343 percent.<sup>6</sup>

It is worth noting that under the government EP, no region has been classified as having severe undercoverage. Meanwhile, among the provinces, only four have been classified as having severe undercoverage but all hovered around the

<sup>6</sup> Provincial coverage rates are available from the author upon request.

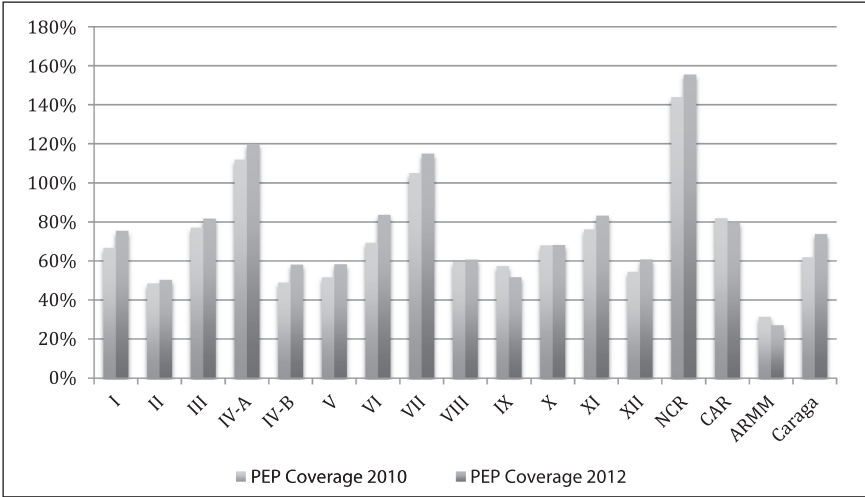
**Figure 5. 2010 Provincial coverage rates for government Employed Program**



Source of basic data: LFS-FIES 2009

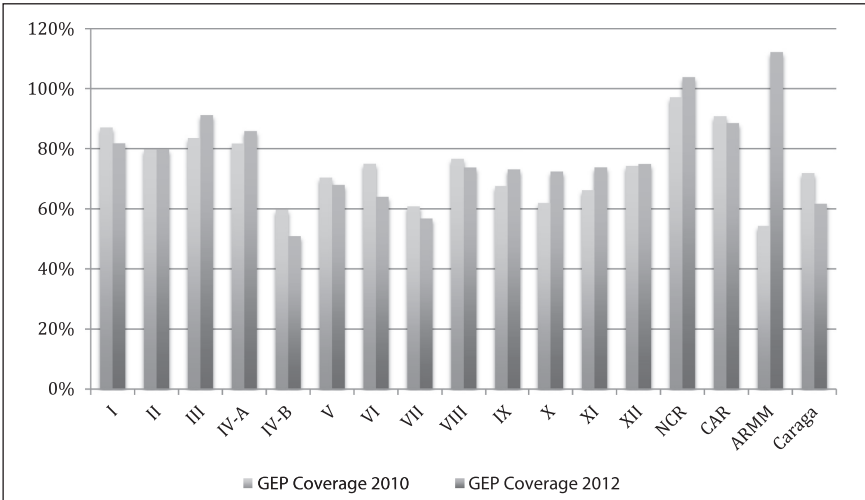
50-percent mark. Observed coverage levels for the program that fall below 100 percent can be partially explained by a difference in definition between the LFS-estimated population and the PhilHealth population. Some respondents for the LFS who classified themselves as government employees might have been casual employees or contractuels. These types of workers are not entitled to the same benefits as those of a regular employee. To get more accurate coverage rates for

**Figure 6. Regional coverage rates for private EP principal members**



Source of basic data: LFS-FIES 2009, 2012

**Figure 7. Regional coverage rates for government EP principal members**



Source of basic data: LFS-FIES 2009, 2012

the government EP, the number of contractuels and casual employees have to be subtracted from the estimated population.

**Regression results**

The OLR and OLS results for the IPP are found in Tables 3 and 4.

From the regression results, four points are worth highlighting. First, availability of health-care resources appears to be an issue. Bed-population and health professional-population ratios come out significantly positive in most of the regression results. This means that the higher the ratios (i.e., the more beds and health professionals for the population), the more likely it is for the province to have higher coverage rates. Bed-population and health professional-

**Table 3. Ordered logit regression on IPP coverage rates**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
Education index	-9.436	7.677	-7.493	8.781
Health index	0.004	0.006	-0.005	0.006
Male-female ratio	0.938	13.340	12.098	14.372
Number of government hospitals	-0.308***	0.091	-0.323***	0.102
Number of private hospitals	0.057*	0.035	0.080**	0.035
Population aged 0–14	-13.669	12.708	-19.728	14.249
Population aged 15–64	-13.388	12.716	-19.385	14.238
Population aged 65 and over	-13.411	12.731	-19.762	14.274
Bed-population ratio (per 10,000)	0.244***	0.095	0.276***	0.103
Health professional-population ratio (per 10,000)	0.403	0.258	0.762**	0.324
Real GDP per capita	-0.317***	0.121	-0.518***	0.182
Health expenditures per capita	-0.001	0.003	0.001	0.004
<b>Sectoral employment</b>				
Agriculture	-0.236	0.249	0.192	0.143
Sales	-0.142	0.251	0.322*	0.190
Services	-0.128	0.273	0.347**	0.167
Manual	-0.387	0.306	-0.032	0.187
Processing/Manufacturing	-0.178	0.273	0.215	0.181
Mining	0.036	0.234	0.401**	0.201
Skilled	0.296	0.487	0.916*	0.484
Education	-0.059	0.321	0.219	0.263
<b>Nature of employment</b>				
Permanent	-0.155	0.151	-0.062	0.151
Short term	-0.091	0.164	-0.029	0.172
Average household income	0.000	0.000	0.000	0.000

Significant at \*\*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

Source: Author's calculations

**Table 4. Ordinary least squares regression on IPP coverage rates**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
Education index	-0.032	0.451	0.092	0.448
Health index	0.000	0.000	0.000	0.000
Male-female ratio	0.729	0.698	0.758	0.690
Number of government hospitals	-0.016***	0.005	-0.014***	0.005
Number of private hospitals	0.004*	0.002	0.004*	0.002
Population aged 0–14	2.546***	0.843	2.500***	0.838
Population aged 15–64	2.579***	0.845	2.532***	0.840
Population aged 65 and over	2.550***	0.844	2.506***	0.840
Bed-population ratio (per 10,000)	0.027***	0.006	0.028***	0.006
Health professional-population ratio (per 10,000)	0.030*	0.016	0.024	0.015
Real GDP per capita	-0.019***	0.004	-0.019***	0.004
Health expenditures per capita	0.000	0.000	0.000	0.000
<b>Sectoral employment</b>				
Agriculture	0.003	0.015	0.004	0.009
Sales	0.008	0.016	0.009	0.011
Services	0.009	0.016	0.007	0.010
Manual	0.001	0.019	0.003	0.011
Processing/Manufacturing	0.009	0.016	0.011	0.011
Mining	0.023	0.015	0.031	0.014
Skilled	0.005	0.030	0.005	0.024
Education	0.017	0.018	0.017	0.012
<b>Nature of employment</b>				
Permanent	-0.004	0.009	-0.008	0.007
Short term	-0.002	0.009	-0.006	0.008
Average household income	0.000	0.000	0.000	0.000
Constant	-257.022***	84.685	-252.200***	83.841

Significant at \*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

Source: Author's calculations

population ratios are proxies for availability of health-care services. This result indicates the importance of having the health-care resources within reasonable proximity. Availability is especially important in health-care utilization as greater availability means less waiting time, which in turn leads to less opportunity costs for individuals seeking care.

Second, the greater the number of private hospitals, the more likely it is for the province to have higher coverage rates. Interestingly, the higher the number of government hospitals, the more likely the province will belong to lower coverage categories. This result is consistent with the substitution effect observed in other studies on voluntary health insurance.

In developing countries, the private sector is often assumed to offer better quality of services than the public sector due to the lack of subsidies or government funding for the latter. Ha et al. (2002) also point out that private facilities are “considered to have more flexible opening hours, more ready access, greater drug supplies and more respectful treatment of clients.” Since PhilHealth can be used for both public and private facilities, private medical services become more affordable to the general populace with the help of insurance coverage. The existence of private hospitals seems to encourage individuals to enroll into the health insurance scheme, presumably with the notion that they can seek private medical care with the help of PhilHealth.

Third, income levels are not a factor for insurance coverage. Two results from the regression analysis illustrate this point. First, the magnitude and significance of the nonpoor population’s average household income in the province are not relevant. Second, real GDP per capita of the province, albeit significant, has a negative coefficient. This indicates that provinces with a higher real GDP per capita tend to belong to lower coverage categories.

Fourth, the size of certain sectors in the province has a statistically significant effect on the level of coverage in the province. However, this is only true for the regressions using the jackknife estimates. Sectors that were more likely to lead to higher coverage rates for the voluntary program are sales, skilled work, services, and mining. The first three sectors are not surprising results as these sectors tend to employ people with higher socioeconomic profiles that, according to literature, are the more likely individuals to enroll in health insurance programs. The significance of the mining sector was somewhat unexpected but can be explained by its perilous occupation; hence, the high propensity for those within this sector to get a health insurance plan.

Table 5 shows that the nature of employment significantly affects the coverage levels of the province. Both permanent and short-term employments have a positive impact on the coverage levels. However, when looking at the OLS regressions (Table 6), which focuses on the provinces with undercoverage, the effect not only becomes insignificant but also diminishes considerably in terms of magnitude. Sectoral employment was largely insignificant except for the skilled sector. That is, the higher the percentage of people working in the skilled sector, the more likely it is for the province to belong to higher coverage categories.

**Table 5. Ordered logit regression for private EP**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
<b>Sectoral employment</b>				
Agriculture	-0.2077	0.2125	0.0314	0.1184
Banking/Finance	-1.0008*	0.5212	-0.8807*	0.4665
Sales	-0.2139	0.2148	-0.0568	0.1377
Real estate	0.5591	1.0302	1.3381	1.0712
Services	-0.2143	0.2247	0.1555	0.1244
Manual	-0.1985	0.2427	0.0265	0.1386
Mining	-0.3005	0.2066	-0.1983	0.1904
Processing/Manufacturing	-0.1842	0.2227	0.0151	0.1291
Skilled	0.4515	0.3996	0.6455**	0.3142
Education	-0.1412	0.2274	0.1370	0.1538
<b>Nature of employment</b>				
Permanent	0.3336***	0.1288	0.2014**	0.0990
Short term	0.4250***	0.1375	0.3124***	0.1083
Union coverage	-0.0689	0.0635	-0.0026	0.0628
Union-employee ratio (per 10,000 population)	0.1060	0.0905	0.0386	0.0890
<b>Enterprise size (No. of employees)</b>				
Micro	0.0000	0.0001	0.0000	0.0000
Small	0.0001	0.0001	0.0001	0.0001
Medium	-0.0006**	0.0003	-0.0007**	0.0003
Large	0.0000**	0.0000	0.0001***	0.0000

Significant at \*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

Source: Author's calculations

The result is consistent with the OLS regressions. The same result is observed for the services sector although it was only significant in the OLS regression. The banking/finance sector also came out significant but negative, signifying a low enrollment rate. When assessed by enterprise sizes, both the medium and large enterprises came out significant with opposing results: The former showed a negative coefficient, while the latter had a positive coefficient. This indicates that the greater the number of employees in the medium-sized enterprises, the more likely it is for the province to have lower coverage levels. Conversely, the greater the number of employees in large-sized enterprises, the more likely it is for the province to have higher coverage levels. This result suggests that medium-sized enterprises are less likely to enroll their employees



**Table 6. Ordinary least squares regression for private EP (restricted to provinces with undercoverage)**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
<b>Sectoral employment</b>				
Agriculture	0.0199	0.0193	0.0083	0.0091
Banking/Finance	-0.0110**	0.0049	-0.0049	0.0420
Sales	0.0187	0.0192	0.0021	0.0114
Real estate	-0.0752	0.1028	0.0671	0.1058
Services	0.0254	0.0201	0.0198**	0.0091
Manual	0.0349	0.0222	0.0174	0.0105
Mining	0.0133	0.0171	0.0081	0.0141
Processing/Manufacturing	0.0226	0.0213	0.0113	0.0105
Skilled	0.1058**	0.0426	0.0620**	0.0295
Education	0.0263	0.0223	0.0151	0.0115
<b>Nature of employment</b>				
Permanent	0.0109	0.0100	0.0115*	0.0067
Short term	0.0116	0.0110	0.0132	0.0080
Union coverage	0.0029	0.0085	-0.0003	0.0074
Union-employee ratio (per 10,000 population)	-0.0064	0.0152	0.0030	0.0141
<b>Enterprise size (No. of employees)</b>				
Micro	0.0000	0.0000	0.0000	0.0000
Small	0.0000	0.0000	0.0000	0.0000
Medium	0.0000	0.0000	0.0000	0.0000
Large	0.0000	0.0000	0.0000**	0.0000
Constant	-2.8051	1.8587	-1.7075	1.0515

Significant at \*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

Source: Author's calculations

in the EP while large-sized enterprises are more likely to enroll their employees in the same program. However, it must be noted that the magnitude of the coefficients are very small.

For the government EP, only the local GDP per capita came out as significant for the ordered logistic regression (Table 7). This signifies that the higher the local income generated by the province per capita, the more likely it is for the province to have higher coverage rates.

The income class of the province had no significant impact on the level of coverage (Table 8). Cross-tabulation of income class against coverage-level

**Table 7. Ordered logit regression for government EP**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
Good Governance Index	-0.006	0.010	-0.008	0.010
Real local GDP/capita	0.088**	0.041	0.088**	0.041
Income class	0.040	0.212	-0.067	0.216

Significant at \*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

Source: Author's calculations

**Table 8. Ordinary least squares regression for government EP (Restricted to provinces with undercoverage)**

Independent Variables	No Jackknife		Jackknife	
	Coefficient	Standard Error	Coefficient	Standard Error
Good Governance Index	0.001	0.001	0.001	0.001
Real local GDP/capita	0.002	0.011	0.003	0.011
Income class	-0.018	0.015	-0.017	0.015
Constant	0.630***	0.087	0.594***	0.087

Significant at \*\*\*1-percent level, \*\*5-percent level, \*10-percent level.

categories showed no evident pattern. It must be noted that the R-squared for the ordered logistic regressions and the OLS regressions are very low at 0.027 and 0.125, respectively. This implies that the model explains very little on the variation among provinces. To improve the model, the number of casual or contractual employees per province should be included. Second, a better proxy for corruption might be able to better explain the observed variation among provinces.

## LIMITATIONS

- 1) This paper studies the variation of coverage levels between provinces using provincial-level characteristics. Results here should therefore only be considered as an indicator and must be corroborated by an analysis done at the individual level.
- 2) Individual Paying Program's coverage levels are computed based on estimates. A margin of error is expected based on two data shortcomings: (1) estimates from FIES are taken from a sample population and cannot be expected to correspond completely to the true population count; and (2) the "cleanliness" of PhilHealth data registry cannot be guaranteed. PhilHealth uses headcount data, which do not update in real time in terms of which members are eligible to claim and which ones have lapsed memberships.

- 3) The computation of coverage rates for EP is based on estimates from FIES and LFS datasets as well as headcount membership data from PhilHealth. There may exist discrepancies in how these datasets had defined the different classes of workers.
- 4) The models, especially that of the government EP, need further improvement. The incompleteness of the model implies that there are certain factors that would have better explained the variation in coverage levels. This study is constrained by the lack of appropriate proxies for factors such as corruption as well as the number of casual or contractual employees.
- 5) The analysis focuses on the provincial-level characteristics. Ideally, the analysis should be done at the level where the decision is taken. For the private EP, this would be at the firm level while for the government EP, this would be at the local government unit level.

## RECOMMENDATIONS

### Individually Paying Program

#### *Policy recommendations*

- 1) **Channeling public funds into the health insurance system instead of the public providers.**

Results indicate that there is a tendency to avail of services in the private sector. In countries where public health services are not established, there is a culture of mistrust toward public health facilities. In the achievement of universal coverage in South Korea, Kwon (2009) notes that by channeling budget allocation to health insurance “in the form of premium contribution increases the leverage that the health insurance scheme can use on healthcare providers.” This recommendation is not to undermine government health services providers. Rather, by supporting the health insurance system and in effect promoting enrollment, consumers are able to decide which services to avail. This fosters market competition, which could encourage unsustainable public health services providers to innovate so as to compete with the rest of the market.

- 2) **Examining the depth of coverage of IPP.**

The benefits of the IPP scheme are one sided because of the great emphasis on inpatient care. One of the lessons learned from South Korea’s case is that by introducing outpatient care coverage, an increased benefit from health insurance becomes tangible to the populace. Also, the dropout rates are minimized (Kwon 2009). Since income does not appear to be a barrier in obtaining health insurance for the nonpoor segment of the population,

it denotes that something else is. Obermann et al. (2006) note that one of the problems in health-care delivery in the Philippines is the high prices of medicines. This type of expenditure is often incurred through outpatient services, which are not covered by the social health insurance scheme. Indeed, if there is an impression that the coverage offered by a health insurance will not account for majority of their health expenditures, the individual will see no need in availing of the health insurance. A study on out-of-pocket expenditures on outpatient services should thus be conducted. If high out-of-pocket expenditures are established, this would be a basis for expanding the current outpatient benefit package of PhilHealth to include even those who are part of the voluntary program.

**3) Service availability and accessibility in targeted provinces.**

For individuals to decide to enroll in a health insurance scheme, they must first see the value of doing so. Availability and accessibility to health-care services is a crucial determinant in the decision to whether or not avail of health insurance, as this is subsequent to the decision to avail of services. As previously noted, provinces with the lowest coverage rates tend to be stand-alone islands. The issue of availability or accessibility might then be particularly true for certain provinces that are more geographically constrained. Government providers can address this problem by providing mobile clinics or augmenting district hospitals—i.e., by ensuring that the facility meets minimum requirements in terms of equipment and staff, and avoiding stock-outs of medicine—especially in geographically isolated areas. Both can be done through public-private partnerships. PhilHealth can help address this issue by assisting in the accreditation process of the closest health-care facilities. Furthermore, PhilHealth can participate in information campaigns in select areas by communicating where the closest PhilHealth-accredited facilities are located and what services their health insurance can avail of from these providers.

**4) Targeting certain employment sectors.**

Albeit insignificant, the agricultural sector and those employed in manual labor were more likely undercovered. Identifying sectors that employ individuals who are less likely to avail of health insurance will allow for a targeted approach to achieving universal coverage. Creation of programs similar to the *Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance (KaSAPI)*, which partners with local nongovernment organizations and rural banks, is a way of expanding into certain employment sectors that tend to have low coverage levels.

*Methodological recommendations***1) Conduct individual-level analysis.**

The National Demographic and Health Survey was scheduled to be conducted in 2013. When the dataset becomes available, a similar study using the individual as a unit of analysis should be conducted to corroborate the findings in this study.

**2) Improve the model.**

- a. The model can be improved by adding a proxy for quality of care. If an appropriate proxy is found, this might verify whether or not the choice of facilities is driven by quality of services. Possible proxies include patient satisfaction, readmission rates, or even malpractice claims.
- b. Another improvement to the model is to look into the level of awareness regarding the entitlements and benefits of PhilHealth. This can be proxied by an index created from the number of information campaigns and randomized interviews or focus group discussions.

**Private Employed Program****1) Monitoring medium-sized establishments.**

Results indicate that the more number of employees hired by medium-sized establishments, the larger the likelihood of the province to have undercoverage. The opposite was found for large establishments. Although the impact was miniscule, the direction of the relationship and the significance are indicators that these establishments are more likely to fall between the cracks.

From PhilHealth's contribution table, the contribution of the EP individual is the same as the IPP member up to a salary range of PHP 24,999. In the absence of any external monitoring, a small-sized establishment will likely encourage employees who earn over PHP 13,000 to enroll in the IPP scheme instead and offer to pay half the premium in order to save on monthly premium costs.

**2) Targeting of certain sectors.**

The banking and finance sector presented a negative impact on provincial-level coverage. The most relevant lesson from this is that certain sectors might be more prone to undercoverage. This highlights the importance of targeting enrollment by sector. A number of countries that have achieved universal coverage started with sectoral coverage. Luxembourg started with the manufacturing and industrial workers while Israel started with the agricultural sector (Carrin et al. 2001). The same principle is applied with the government EP.

**3) Monitoring of casualization.**

Under Article 280 of the Labor Code of the Philippines, it is stated that “any employee who has rendered at least one year of service, whether such service is continuous or broken, shall be considered a regular employee with respect to the activity in which he is employed and his employment shall continue while such activity exists.” However, there are anecdotal evidences of firms that terminate employment every six months before rehiring them so as to maintain the employee’s casual status. The one-year clause of the Labor Code should be properly implemented through monitoring as well as through information campaigns directed at casual employees. Enrollment in social security benefit schemes, which include the national health insurance, will then be improved when casualization is addressed.

**Government Employed Program****1) Enrollment of casual and contractual employees.**

Government should mandate the enrollment of nonregular employees into the health insurance program, if not as formal employees then as members of the voluntary program. Workers belonging to these categories are waiting for regularization. They are then more likely to postpone enrollment until they become regular employees and can avail of the same benefits as their counterparts.

**2) Monitoring of local government units.**

Monitoring of government enrollment must be done at the local level. To attain universal health coverage, the importance of political will cannot be stressed enough. The lack of coverage in the government sector, which is supposed to be mandatory, signals a lack of political will for expansion in other sectors. Under the revised National Health Insurance Act (NHIA) of 2013, Section 28 has been amended to include: “It shall be mandatory for all government agencies to include the payment of premium contribution in their respective annual appropriations.” The Implementing Rules and Regulations of NHIA 2013 should, thus, include provisions on how the proper implementation of this clause can be monitored.

## APPENDIX A

Premium contribution table

Salary Bracket	Salary Range	Salary Base	Total Monthly Premium	Employee Share	Employer Share
1	7,999.99 and below	7,000.00	175	87.5	87.5
2	8,000.00–8,999.99	8,000.00	200	100	100
3	9,000.00–9,999.99	9,000.00	225	112.5	112.5
4	10,000.00–10,999.99	10,000.00	250	125	125
5	11,000.00–11,999.99	11,000.00	275	137.5	137.5
6	12,000.00 - 12,999.99	12,000.00	300	150	150
7	13,000.00 - 13,999.99	13,000.00	325	162.5	162.5
8	14,000.00 - 14,999.99	14,000.00	350	175	175
9	15,000.00 - 15,999.99	15,000.00	375	187.5	187.5
10	16,000.00 - 16,999.99	16,000.00	400	200	200
11	17,000.00 - 17,999.99	17,000.00	425	212.5	212.5
12	18,000.00 - 18,999.99	18,000.00	450	225	225
13	19,000.00 - 19,999.99	19,000.00	475	237.5	237.5
14	20,000.00 - 20,999.99	20,000.00	500	250	250
15	21,000.00 - 21,999.99	21,000.00	525	262.5	262.5
16	22,000.00 - 22,999.99	22,000.00	550	275	275
17	23,000.00 - 23,999.99	23,000.00	575	287.5	287.5
18	24,000.00 - 24,999.99	24,000.00	600	300	300
19	25,000.00 - 25,999.99	25,000.00	625	312.5	312.5
20	26,000.00 - 26,999.99	26,000.00	650	325	325
21	27,000.00 - 27,999.99	27,000.00	675	337.5	337.5
22	28,000.00 - 28,999.99	28,000.00	700	350	350
23	29,000.00 - 29,999.99	29,000.00	725	362.5	362.5
24	30,000.00 - 30,999.99	30,000.00	750	375	375
25	31,000.00 - 31,999.99	31,000.00	775	387.5	387.5
26	32,000.00 - 32,999.99	32,000.00	800	400	400
27	33,000.00 - 33,999.99	33,000.00	825	412.5	412.5
28	34,000.00 - 34,999.99	34,000.00	850	425	425
29	35,000.00 and up	35,000.00	875	437.5	437.5

Note: Employee share represents half of the total monthly premium while the employer shoulders the other half.  
Source: PHIC website (2013)

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