

TECHNICAL REPORT
IN COLLABORATION WITH:



BREAKING NEW GROUND

Extending Universal Health coverage for the informal sector in Philippines

Analysis and Recommendations

October 27th – November 3rd 2014

TECHNICAL

Acknowledgements:

We would like to express our sincere gratitude to all individuals and organizations who contributed to the ideas presented in this report. We are especially grateful to all PhilHealth staff for their engagement throughout the mission process of developing this report, and to the ILO's Impact Insurance Facility for making this work possible.

Authors:

This report was prepared by Caroline Phily, Yogesh Rajkotia and Michal Matul for the ILO's Impact Insurance Facility and PhilHealth Corporation.

Recommended Citation:

Phily, Caroline; Rajkotia, Yogesh; Matul, Michal. Extending Universal Health coverage for the informal sector in Philippines. November 2014. ThinkWell.

This report was produced by ThinkWell, with funding from the ILO's Impact Insurance Facility under contract number PO 40132864/0.

ACRONYMS

DOH	Department of Health
DSWD	Department of Social Welfare and Development
GHE	Government Health Expenditure
ILO	International Labour Organization
IPP	Individual Paying Program
LGU	Local Government Unit
NBB	No Balance Billing
NHA	National Health Account
NHTS	National Household Targeting System
NSO	National Statistics Office
PHPA	Philippine Healthcare Professionals Association
PIDS	Philippine Institute for Development Studies
PSA	Philippines Statistics Authority
RHU	Regional Health Unit
SSS	Social Security System
SWS	Social Weather Station
THE	Total Health Expenditure

UHC Universal Health Care

TABLE OF CONTENTS

Acronyms	3
Table of Contents	4
Executive summary	5
I. Introduction	7
II. Objective of the Assessment	7
III. Methodology	7
IV. Context	8
V. Findings	9
1. A pivotal moment: PhilHealth is emerging as a defining player for healthcare in the Philippines.....	9
2. The missing middle is within reach: Many opportunities emerging.....	10
3. Expansion of coverage and benefits is eminent: Absorptive capacity development is essential	16
4. PhilHealth has the potential to influence the performance of the health sector	17
VI. Recommendations	18
1. Rationalize iGroup program to maximize enrollment	18
2. Develop comprehensive plan to improve premium continuity.....	19
3. Improve outcomes through efficient partnerships	21
4. Action & Advocacy to improve the ‘product’	22
VII. Conclusion	23
Annex 1	24
Annex 2	26
Annex 3	28

EXECUTIVE SUMMARY

Philippines is one of the most advanced middle-income countries with regard to its achievement in universal health coverage (UHC). Today, 82% of its population benefits from PhilHealth coverage and have access to public and private hospital services. But still around 18 million Filipinos, mainly informal workers, are excluded from the system.

In the interest of improving its performance, PhilHealth requested ILO's Impact Insurance Facility and ThinkWell to conduct a scoping study and explore potential strategies to further expand coverage of the Filipino population, as well as to improve PhilHealth's role in setting health quality standards.

The team found that PhilHealth is emerging as a defining actor for healthcare in the country. Its legitimacy among the population has grown over the years, it benefits from strong political support and its purchasing power has grown to one-third of public health expenditures.

The team also confirmed that, with several strategy adjustments, PhilHealth has the potential to cover the 'missing middle': 14 million uncovered informal workers and their dependents. Strategies to reach this population include improvement of enrollment systems for microfinance partners, the extension of the current iGroup program to microinsurance providers, enforcement of the mandatory registration to open businesses, and requiring students to register with PhilHealth as a mandatory prerequisite for college enrollment. Altogether, these strategies have the potential to reach 60% of the uncovered population. Improving continuity of payment is fundamental.

As coverage continues to expand, PhilHealth will need to develop absorptive capacity. It is urgently necessary to improve the current IT system for distributors, a main barrier for group distribution scale up. Second, improved communication with partners and better partnership management is necessary to improve confidence in the system.

The team also highlighted the potential for PhilHealth to influence the performance of the health sector. As PhilHealth continues to increase its purchasing power and mature as an organization, it can eventually hold providers accountable for quality of services, improve the functioning of the primary care system through gatekeeping, and improve drug availability and pricing.

Based on our findings, the team recommended the following strategic directions:

1. Rationalize iGroup program to maximize enrollment

- Harmonize all benefits and policies across iGroup & IPP
- Selectively work with large distributors, instead of smaller groups
- Simplify financial incentives structure for groups
- Research non-financial incentives to motivate group registration

2. Develop comprehensive plan to improve premium continuity

- Assess impact of PhilHealth policies on renewals
- Develop coordinated communication plan with distributors for members transitioning out of their group
- Assess possible incentives for renewal at all levels and develop a comprehensive premium continuity plan
- Underpin the renewal strategy with ongoing education about PhilHealth benefits

3. Improve outcomes through efficient partnerships

- Conduct a review of current enrollment and billing system and develop a plan for quick improvement
- Assess optimal repartition of roles and responsibilities of all actors
- Develop partnership management processes
- Build dedicated vendor support capabilities within PhilHealth to provide adequate support to distributors
- Consider partnering with private health insurance providers to improve benefit package, increase renewals and stimulate innovations

4. Act and advocate to improve the 'product'

- Establish 'managed-care' unit to enforce the delivery of high-quality health services
- Restructure reimbursement rates for public providers such that they are reflective of public-health need, not cost
- Enforcement of gate-keeping at primary care level through patient financial incentives
- Consider phased-in prescription benefit for generic pharmaceuticals through accredited private pharmacies

I. INTRODUCTION

Philippines is one the most advanced middle-income countries with regard to its achievement in universal health care (UHC). With 82% of the population covered, it places just after Thailand in the ASEAN region. President Aquino put achievement of universal health coverage as a major objective for his presidency¹, thus creating momentum for improving coverage and benefits of PhilHealth. Economical context is also favorable for social protection expansion, with an average 5.5% GDP growth per year the last 7 years.

While developing countries are making progress towards UHC, almost all are facing the challenge of covering the missing middle, those near poor who are covered by neither social assistance nor formal social protection mechanisms. Near poor are often referred to as the informal sector. This is also the case for Philippines, where informality is slowly decreasing but remains high, estimated at 67% of the population².

Many countries are looking at UHC progression with the coverage lens but the financial protection and scope of services dimensions should also be considered. In Philippines, population coverage is high but out of pocket expenditures are still higher than targeted, providing limited financial protection to the population. Though expanding progressively, PhilHealth's benefit package mainly covers hospitalization.

In this context, the International Labour Organization's (ILO) Impact Insurance Facility tasked ThinkWell to conduct a scoping study, within PhilHealth, to explore potential strategies for expanding coverage to the remaining 18% of the population, as well as looking at potential strategies to improve PhilHealth's role in setting health quality standards.

II. OBJECTIVE OF THE ASSESSMENT

A rapid assessment was conducted to examine potential strategies to expand coverage to and enrollment of informal sector, with a particular focus on current group distribution strategy (known as iGroup). Concurrently, the assessment aimed to provide observations regarding PhilHealth's role in the health sector. The team was tasked to provide broad, strategic-level recommendations to guide future directions.

III. METHODOLOGY

The methodology used to conduct the study consisted of two components. First, a literature review was conducted to analyze existing data and assessments about the health financing system in the Philippines. In particular, we focused on gathering

¹ In December 2010, the Department of Health Administrative Order No. 2010- 0036, entitled "The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos", was signed

² In the past 15 years, the share of own-account and unpaid family workers have decreased, from 51% in 1997 to 45% in 2012 (Philippines Development Report: Creating more and better jobs, September 2013, World Bank)

information about the informal sector in Philippines, the strengths and weaknesses of the health system, and the functioning of PhilHealth.

Second, a one week field visit was undertaken to interview existing and potential partners of PhilHealth, including one public and one private hospital, one RHU, one LGU, three member groups, two non-member organizations, a commissioner of SSS, a representative of DSWD, and a representative of informal workers. (*See List of Interviews in annex 1*). Intensive meetings with a range of departments within PhilHealth were also undertaken.

Finally, a validation meeting was held with PhilHealth senior management and Informal Member Management Group to review findings and recommendations.

IV. CONTEXT

The Philippines Health Insurance Corporation (PhilHealth) was created in 1995 via the National Health Insurance Act³ (RA 7875), with the objective of providing equitable access to health care for all Filipinos. Since 1995, PhilHealth has been expanding its coverage to all the segments of the population and now reaches 82% of Filipino population (*see annex 2*). All poor households are provided with subsidized insurance (paid by the central & local government), formal workers have a mandatory coverage, and informal workers contribute voluntarily in the Individual Paying Program or the iGroup program. Each segment of the population is contributing to a different program, with six different programs running in parallel⁴. Despite this very successful level of coverage, 18 million Filipinos are still out of coverage.

PhilHealth benefit packages vary based on the population segment. All packages include inpatient care at accredited public and private hospitals. Since 2013, hospitals are paid based on case based tariffs, where fixed prices per medical or surgical cases cover professional fees, supplies and rooms. Outpatient coverage is accessible for members of the Indigent & Sponsored program at public RHUs, as well as for members from the iGroup program. A recent board meeting confirmed the extension of outpatient coverage for all members for selected diseases (hypertension, diabetes...).

Out of pocket spending, which is still very high, is the main contributor to total health expenditure (THE) (54%⁵) and is driven by cost of drugs. Case based payments do not account for the whole value of claim, and support value⁶ can be very low, especially at private providers. The drug supply is dominated by private drugstores (80.1% of the market⁷). Drugs sold at hospitals are reported to be double the price of those sold in drugstores (DOH 2008) and form part of the hospital revenue.

³The National Health Insurance Act was amended in 2013 and new Rules & Guidelines are enforced.

⁴Formal sector, Individual Paying Program (IPP) & iGroup for the informal economy, Lifetime for retirees, Indigent & Sponsored for the poor

⁵ NHA 2001

⁶ Support Value is the percentage of PhilHealth share among the total cost of claim

⁷ PHAP 2008

Payments to providers are made on a case-payment basis. However, the large portion of private health care providers⁸ and the high level of decentralization⁹ complicates its control over providers' behavior. Nevertheless, PhilHealth is making impressive progress in this area, as shown by the enforcement of the No Balance Billing (NBB) Policy for the Indigent and Sponsored members, who can access care without any co-payment.

PhilHealth relies on various strategies to enroll the informal households. Since 2003, it has partnered with organized groups, often Microfinance Institutions, to distribute PhilHealth to their members. The program, first known as POGI, then Kasapi, and now iGroup, has gone through various iterations and adopted new policies to improve enrollment¹⁰. Total coverage through the program is still limited today, with 70,000 individuals covered¹¹. As per the law, PhilHealth is also progressively enforcing mandatory PhilHealth coverage for entrepreneurs, who are required to enroll themselves when registering a new business. PhilHealth is also looking at partnering with schools to cover student above 21 years.

V. FINDINGS

1. A PIVOTAL MOMENT: PHILHEALTH IS EMERGING AS A DEFINING PLAYER FOR HEALTHCARE IN THE PHILIPPINES

Legitimacy of PhilHealth within the population has grown. The latest nationwide satisfaction survey conducted by the Social Weather Stations (SWS) institute, showed an impressive satisfaction scoring (+82, ranked as excellent) for PhilHealth, increasing from 60 in 2009 and 67 in 2011. Eighty seven percent of interviewed persons were satisfied with the service provided by PhilHealth. Awareness about the scheme is very high (90% of the interviewees knew of at least one PhilHealth service). The perceived value and demand for the product seems to be high.

“PhilHealth is a good product” *ALLWIES*

“All our clients want PhilHealth” *CARD*

“Thanks to case base payment, PhilHealth benefit package has improved a lot” *KMBA*

PhilHealth benefits from strong political support. President Aquino has made achievement of UHC one of his key priorities for the country. With the Universal Health Care Plan (Kalusugang Pangkalahatan), the president committed to sponsor membership of 1st and 2nd income level quintiles with the national budget. The proceeds from the

⁸ 60% Of hospitals are private

⁹ Since 1991, LGUs have the autonomy to manage their own health services, while provincial governments have the responsibility of the secondary hospitals. DOH serves as the regulator, defines the country health priority and national plans and develops standards and guidelines.

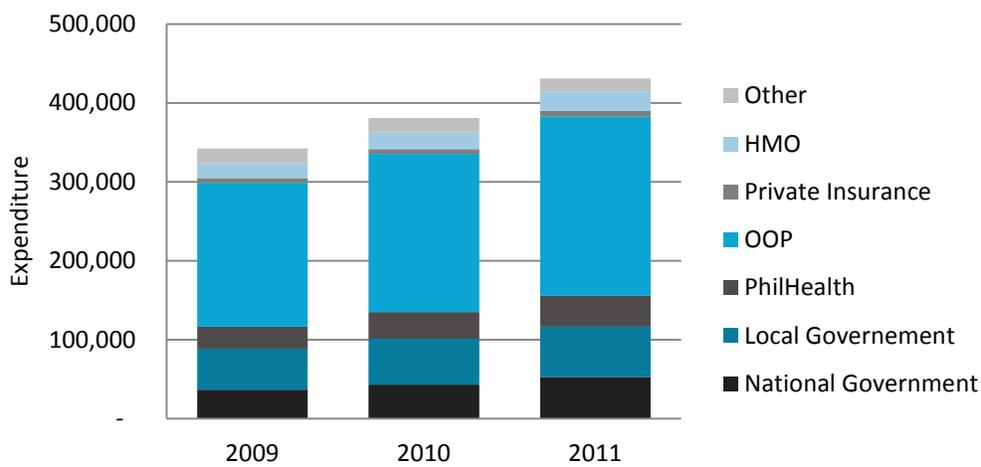
¹⁰ If the change from POGI to KasaPi mainly resulted in a need to change the name (POGI meaning handsome), the transformation from KasaPi to iGroup was an intent to remove enrollment barriers: The minimum size for member group was reduced from 1000 to 30, and the requirement to enroll at least 70% of group members was removed. The benefit package was expanded to offer outpatient coverage. Under iGroup, groups are classified by size and a progressive incentive structure and preferred conditions for higher group size, such as access to NBB policy.

¹¹ PhilHealth data as of August 2014.

newly adopted 'sin' tax on alcohol and tobacco will be used to expand the number of subsidized households.

PhilHealth purchasing power is increasing. PhilHealth expenditures on health are slowly increasing, from 8.1% of THE in 2009 to 9.1% in 2011. This represented one third of all government expenditures in the latest National Health Account of 2011. This trend should accelerate in the future, as PhilHealth will continue to expand its coverage and widen its benefit package. The planned inclusion of primary care for all PhilHealth programs should significantly change the picture. With growing purchasing power, PhilHealth will be able to grow its influence in setting quality standards for providers.

Total Health Expenditure



Progress in improving access to No Balance Billing policy (NBB) demonstrates PhilHealth’s growing power. PhilHealth committed to provide NBB to members of the indigent and sponsored program, as well as to members of the iGroup programs with more than 2450 members¹². The NBB provides “that no other fees or expenses shall be charged or be paid for by eligible patients above and beyond the packaged rates”¹³. However, because of vested interests and supply constraints within the health sector, only 7% of those eligible were receiving the NBB benefits in 2013. In a sign of increasing political and financial clout, PhilHealth was able to dramatically increase the access to NBB last year by demanding compliance, reaching 42% of eligible members.

2. THE MISSING MIDDLE IS WITHIN REACH: MANY OPPORTUNITIES EMERGING

Informal workers are the bulk of the 18 million uncovered Filipinos

More than 14 million informal workers and their dependents still remain uncovered.

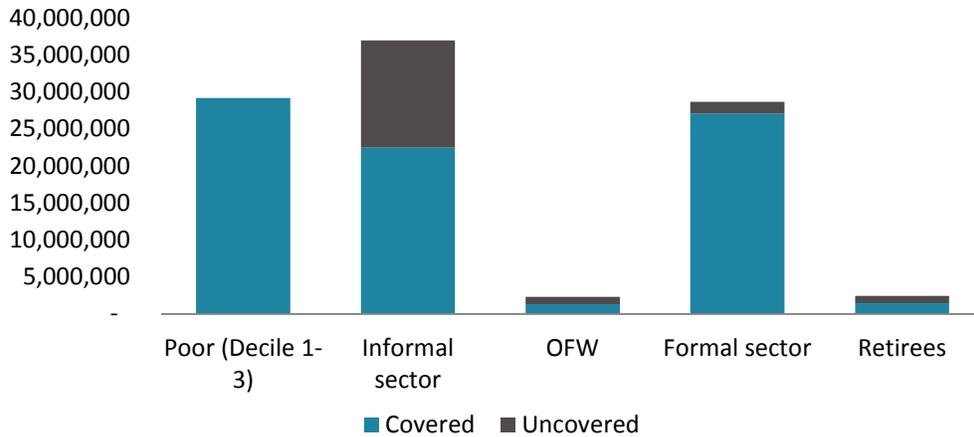
Under the current act, enrollment in PhilHealth is compulsory for all citizens, but coverage gaps remain. Indeed, the informal workers can access PhilHealth on a voluntary basis, but face enrollment constraints such as lack of knowledge on how to enroll, inconvenient access to payment infrastructure, and conflicting spending priorities. Estimated coverage

¹² Access to NBB for iGroup members will be stopped by end of 2014 for budget constraints reasons, PhilHealth, Cir.03.2014

¹³ PhilHealth, Cir.03.2014

gap include 14 million from the informal sector, 1 million from the overseas Filipino workers (OFW) and retirees, and 1.5 million from the formal sector^{14, 15}. Non-regularized workers, such as contractual, project based workers, and domestic workers are counted as part of the formal sector and represent the formal sector coverage gap.

PhilHealth Coverage by Segment



Uncovered informal workers are rural and urban entrepreneurs¹⁶. As per Llanto classification, the informal economy is composed of two segments: the wage earners, being landless rural workers, fish workers, or urban workers working on temporary jobs, and the rural and urban self-employed. Both rural and urban wage earners are the poorest of the informal economy and should be covered by the Indigent and Sponsored Program, while the self-employed and small farmers are the main targeted population of PhilHealth’s informal economy program¹⁷.

Estimated coverage rate of the informal economy is 61%¹⁸. Actual coverage of the informal economy still mainly comes from enrollment of the non-poor households into the sponsored program. If the policy of the sponsored program changes, it may impact the current coverage of the sector. The IPP program covers a significant part of the informal economy, including the higher end part of the population such as doctors and lawyers. The iGroup program so far contributes to a negligible percentage of the coverage.¹⁹

¹⁴ Estimation are based on the following: Poor benefiting from Indigent & Sponsored program (income decile 1-3), Total informal sector (including the poor) representing 67% of the total population (OFW data, extracted PSA statistics), retirees estimated as 7.9% of the formal sector, as per DHS repartition of the population by age. PhilHealth’s Coverage rates as of June 2014.

¹⁵ Those estimation are based on the assumption that there is no coverage gap among the poorest part of the population (income decile 1 to 3).

¹⁶ Llanto.1998. Handbook of the informal sector.

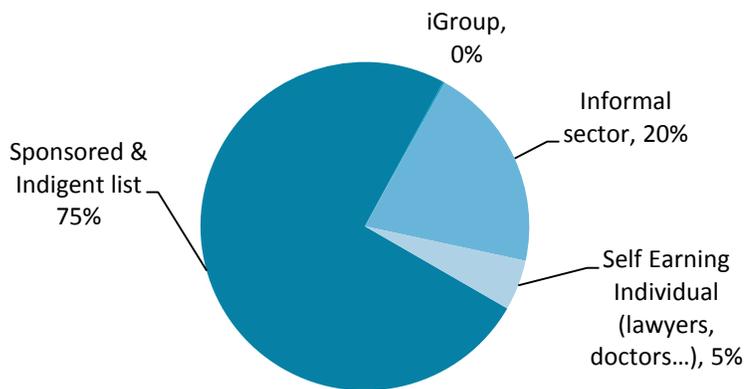
¹⁷ As per PhilHealth new Rules and regulation, the informal sector is composed of “among others, street hawkers, market vendors, pedicab and tricycle drivers, small construction workers, and home-based industries and services.”

¹⁸ Authors own estimation, based on PhilHealth coverage figures and estimation of the informal economy size (excluding the poor eligible to Indigent and Sponsored program).

¹⁹This result is in line with results of PIDS study, estimating coverage rate among IPP program to 55%.

“Analysis of the Individually Paying Program of the Philippine Health Insurance Corporation” Denise Valerie Silfverberg, PIDS, March 2014

Current Coverage of Informal Economy



There is scope to dramatically expand the reach of the iGroup program

Microfinance institutions (MFIs)²⁰ are reaching 4.3 million clients all across Philippines. Total borrowers and savers of MFIs represent approximately 4.3 million households or 10 million of potential insured²¹. MFI's clients are rural and urban entrepreneurs who should benefit from PhilHealth informal sector program. The 10 biggest MFIs (CARD, ASA, Green Bank, FICCO, KMBI, NWTF, Pagasa, TSPI, TSKI, ASKI) count 3 million low-income clients²² (7.8 million individual) and represent 2.8 million potential additional individuals covered (see table 1).

MFIs can unlock demand for PhilHealth. A recent Randomized Control Trial study conducted among potential clients of the IPP program showed that complexity of enrollment processes were the main constraint for informal workers enrollment into PhilHealth. Potential members of the IPP program were randomly proposed either a premium subsidy or support in completing paper work for enrollment. Penetration rate increased by 5% for the group that received premium subsidies, and by 36% for the group receiving support for enrollment, reaching a total penetration rate of 40%²³. MFIs can ease PhilHealth enrollment and therefore unlock demand for PhilHealth.

MFIs are ready and interested to distribute insurance products. All the biggest MFIs of the country are already selling life microinsurance products to their clients²⁴. They therefore have developed internal systems to support promotion, enrollment, premium collection, and claim support of insurance products (see box 1). Moreover, MFIs have a strong interest to sell health insurance to their clients as health shocks are main drivers of defaulting on loans and clients are very worried about managing health risks. Solving this problem has a huge potential to reduce default rates and increase customer loyalty for

²⁰ For the purpose of this report MFIs include banks, rural banks and other financial service providers that reach to low-income segment of the population.

²¹ We are using the approximation of 2.26 individual insured per household, as per PhilHealth data

²² Mix Market information: www.mixmarket.org

²³ "Effects of Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme", WP 6893, Capuno & Al, World Bank, May 2014

²⁴ Insurance is the most attractive non-financial product for MFI, way before money transfer or remittances (The 2012 Microfinance mapping, National Microfinance)

MFI. For example, Fonkoze, leading Haitian MFI, doubled customer loyalty rates after bundling catastrophic insurance solution with loans²⁵.

Box 1: Notes from interviews with MFIs

CARD has been distributing PhilHealth products since 2003, when the POGI program started. Cross selling of PhilHealth is considered part of their social mission and is also seen as a tool to improve the quality of their loan portfolio. To support its agents in distributing PhilHealth, CARD developed a training curriculum and loan officers are conducting weekly training short sessions during ten subsequent solidarity group meetings on PhilHealth benefits and processes to their members. PhilHealth member often take a health loan to pay PhilHealth insurance premium, at a subsidized interest rate (24% per year).

TSPI also partnered with PhilHealth since introduction of the POGI program. TSPI's interest in the partnership is not driven by the financial incentive, but by a will to better service their clients. TSPI developed its own IEC material to communicate about the product and health loan interests are also subsidized.

Insurance Providers are successful in reaching the informal sector

Cross selling PhilHealth through microinsurance providers has potential to reach a significant part of the uncovered. Microinsurance providers are successful in reaching the informal sector. Microinsurance is very popular in the Philippines, with almost 20 million active policies and the highest penetration rate of the region²⁶. While the majority of microinsurance is distributed through MFIs, innovative distribution models are emerging. Distribution through retailers is becoming successful, as shown by the example of CLIS (see box 2) and international literature²⁷. Many microinsurance providers are starting to develop their own mobile agent networks and could be a possible channel for distribution in the future. The microinsurance providers contacted during the study all expressed interest in a potential partnership with PhilHealth.

Box 2: Distributing Microinsurance through pawn shops, the example of Cebuana Lhuillier Insurance Solutions (CLIS).

CLIS is an insurance agency, part of the J.P Cebuana Lhuillier group. Since 2008, the Cebu pawnshops have been offering clients Personal Accident policies, with some added property coverage. CLIS has been very successful in distributing the product, with more than 4 million insured clients at any time of the year. When clients pawn a product, they are automatically enrolled for the insurance unless they opt out. CLIS is currently looking for solution to offer health solutions to their clients and is willing to partner with PhilHealth.

Partnering with Philippines Crop Insurance Corporation may support coverage of rural entrepreneurs and farmers. Currently, PCIC provides insurance protection to farmers and other agricultural stakeholders against losses of their crops, farm machinery and

²⁵ Solana and Merry (2014).

²⁶ The landscape of microinsurance in Asia - <http://www.munichre-foundation.org/home/Microinsurance/MicroinsuranceLandscape/2013AsiaOceania.html>

²⁷ Leach et al. 2014. **Achieving scale and efficiency in microinsurance through retail and banking correspondents.** Microinsurance Paper, Impact Insurance Facility.

equipment, transport facilities, and other related infrastructures due to natural calamities, pest and diseases, and other perils beyond their effective control. The corporation covers less than 300,000 farmers but coverage is growing fast (+82% in 2013)²⁸.

Health microinsurance products could cover supplementary needs of the informal sector. Some HMOs are currently considering developing health microinsurance products to reach the informal population. Some health microinsurance policies are already available in the market, either providing a comprehensive package (and competing with PhilHealth) or providing supplementary products such as coverage for loss of income or transportation costs. A health microinsurance regulation is currently under development, led by the Filipino insurance commission, in consultation with the DOH, PhilHealth, and representatives of the HMOs. The objective of the new policy framework is to encourage public private partnership and to ensure that the private sector can complement the current PhilHealth benefit package²⁹.

Additional strategies to squeeze the middle are necessary to continue expand coverage Enforcement of mandatory coverage can cover an additional 4 million individuals. As per PhilHealth Rules & Regulation, it is required to show proof of PhilHealth enrollment in order to obtain a business license or permit. The enforcement of the law is happening progressively, with some LGUs having implemented it already³⁰. Thirty percent of self-employed workers³¹ are registered by the government; this represents around 9 million members and could significantly improve PhilHealth coverage rates. Nevertheless, the impact of such policy on economic development should be assessed, as well as the performance of such mechanism on premium continuity monitored.

The extension of the lifetime program and introduction of student plan should continue to reduce the coverage gap. The extension of lifetime coverage to all citizens above 60 should reduce the coverage gap by 1.5 million individuals. Moreover, targeting the uncovered students, who are not dependent of their parents, could bring an additional half million members. Other strategies, such as the one stop shop approach to provide social protection services to the informal economy, may provide additional members to PhilHealth.

Collaboration with other social protection initiatives through a one stop shop approach will also contribute to expansion of coverage. Under the umbrella of the ILO office, all social protection partners are discussing the implementation of a single window approach for social protection³², to improve the coordination, monitoring, and delivery of integrated social protection and labour market interventions. Single Social Protection offices would be based at the local level. Families will access harmonized information on social protection benefits (PhilHealth, SSS, Conditional Cash Transfer Programs, etc.) and be able to enroll in the different programs. If successful, this initiative can complement PhilHealth's enrollment strategies and continue to help reduce the current coverage gap.

²⁸ PCIC website www.pcic.gov.ph

²⁹ <http://inclusiveinsuranceasia.com/>

³⁰ San Pablo and Makati LGU reported implementing mandatory coverage already.

³¹ Philippines Development Report: Creating more and better jobs, September 2013, World Bank

³² Schmitt et al. The Single Window Service in Asia and the Pacific. ILO Regional Office for Asia and the Pacific.

The implementation of above-mentioned strategies should enable coverage of 60% of the current uninsured members.

Table 1: Potential coverage by strategy

	Total population	Est. Pop already covered	Est. total new population eligible	Estimated penetration rate	Total potential new members	Total potential new individuals ³³
Partnering with 10 biggest MFI	3,000,000	30%	2,100,000	60%	1,260,000	2,847,600
Partnering with major MI provider ³⁴	5,000,000	50%	2,500,000	30%	750,000	1,695,000
Lifetime expansion ³⁵	7,865,088	80%	1,461,500	100%	1,461,500	1,461,500
Mandatory coverage ³⁶	3,300,000	50%	1,650,000	100%	1,650,000	3,729,000
Students ³⁷	3,000,000	30%	2,100,000	30%	630,000	630,000
Additional PhilHealth insured						10,363,100

Access to payment infrastructure is essential to improve continuity of payment

There is a difference between effective coverage and enrollment, due to difficulty of enforcing continuity of payment. As per PhilHealth definition, a person is covered if he/she has paid at least 3 month premium within the 6 month previous to claim³⁸. Ninety five percent of the population has a PIN number, meaning they have once been enrolled within PhilHealth, but only 82% have active coverage. Drop-out rates are especially high for the Individual Paying Program (IPP), estimated at between 40% to 60% a year³⁹. Improving continuity of payment is essential to ensure that the increase of coverage rate is sustained. It is also key to improving PhilHealth’s financial sustainability by reducing

³³ We are assuming an average size of family of 2.26 as per current PhilHealth data from the IPP program.

³⁴ This exclude current insured from MBA, as it is assumed they are already all covered by MFIs.

³⁵ Based on DHS 2013 data, 7.9% of the population is above 60. This percentage is applied to all informal and poor population

³⁶ Corresponding to 30% of total Self Employed workers. Number of self-employed workers taken from the Labor Force Survey 2011

³⁷ Higher Commission on Education, Year 2011, 2012

³⁸ Sect 12, Rules & Regulations 2013

³⁹ As per feedback from the informal members department

adverse selection (In 2013, PhilHealth collected Premium 3 B and Paid 10 B Claims for the IPP program⁴⁰).

Growing coverage through MFIs will improve continuity of payment. Linking PhilHealth premium collection to loan reimbursement, either via health loan or cash payment, should improve client retention. The majority of MFIs are providing health loans to their client to cover for annual premium payment. Potential for automatic deduction from savings account also exists and could be considered for improved renewal rates.

Access to payment infrastructure is increasing, which should facilitate continuity of payment in the future. With a high penetration of mobile phone (107%) and enabling regulation, mobile money should soon take up and ease continuity of payment. Today, there are 24 million active e-money accounts and the sector is growing at a 34% a year. Retail banking is also on the rise, with supermarkets and pawn shops offering a broad range of financial services. Today, the country counts more than 10,000 mobile money agents who could potentially collect premiums in the future.

3. EXPANSION OF COVERAGE AND BENEFITS IS EMINENT: ABSORPTIVE CAPACITY DEVELOPMENT IS ESSENTIAL

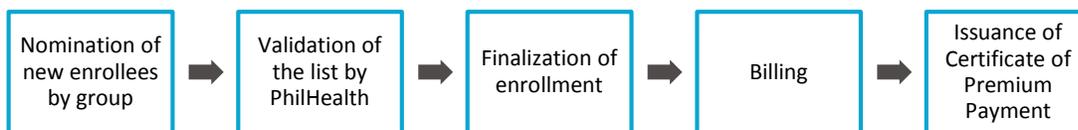
Improvement of IT systems for distributors can boost informal sector coverage

The egroup web based enrollment system is the key barrier for iGroup expansion. All groups we interviewed reported that the system is the only reason why they are not promoting PhilHealth products among their clients. Time to register a member has been reported as taking between 10 to 30 minutes, making it impossible for groups to support the human cost related to data entry. It seems to be a software issue rather than a connectivity problem.

“After 11 years as an iGroup partner, our board meeting decided to stop the iGroup program because of the system issue. CARD will still continue to sell PhilHealth product using the IPP program.” *CARD*

“If systems issues are not solved by the end of the year, TSPI will stop its partnership with PhilHealth. We have partnered with an HMO to continue provide health insurance to our members.” *TSPI*

Non integration of the enrollment and billing system leads to substantial delays in member coverage. In the iGroup program, enrollment follows the following steps:



Billing can only happen the last day of the quarter, forcing group to remit premium in a very short time. It then takes a lot of time for PhilHealth headquarter to issue the Certificate of Payment or Member Data Record (MDR), due to non-integration of the enrollment system and the billing system. As reported by the groups we interviewed, the

⁴⁰ PhilHealth Annual Report 2013

whole process can take up to 6 months. Members who need care in this period require an ad hoc process and follow up by the organized group staff to avail PhilHealth benefits.

Consistent communication is needed to continue building confidence in system

Communication to members about their policy and benefits is limited. New members do not receive any informational documents, such as brochures or even a policyholder document once they register, making it difficult for clients to understand their benefits. PhilHealth benefit package is not accessible through PhilHealth website. PhilHealth communication strategy is constrained by the complexity of procurement processes and budget constraints, which limits the opportunity to leverage powerful communication channels, such as television and mobile messaging.

There is no customized communication strategy to reach the informal sector. PhilHealth communication department is in charge of covering all PhilHealth programs and has traditionally focused most on reaching members of the formal sector. Some initiatives were conducted to promote PhilHealth among the informal sector, such as putting ads in buses and other transport vehicles, but the scope of the initiative is still limited.

Groups are developing their own tools to conduct promotion among their members. Many groups have developed their own promotion tools using their own resources. TSPI developed its own promotion brochure but the constant changes in program rules and names require constant refinements and printing of the new materials. CARD relies on its loan officers to conduct learning sessions with their clients. A training curriculum has been designed by the CARD's communication team, divided in eight sessions of 15 minutes.

Lack of partnership management undermines relationship with organized groups

With only four staff in the informal sector department, it is challenging for PhilHealth to effectively service the 50 groups of the iGroup program. Groups need support in many of the activities they are conducting, including:

- Easy access to IT support when they experience problems with the system;
- Rapid solutions when their members are denied access to care due to unrecognized documentation or in case of registration delays;
- Support from the claim department when providers do not apply the correct reimbursement rate or when the NBB policy has been denied to their member;
- Support from the PhilHealth team to conduct promotion campaigns and get information on PhilHealth rules and policies.

The current PhilHealth structure is not conducive to efficient problem solving, leading to frustration among Group partners. Groups with higher membership, such as CARD find their way to get their message across, but smaller ones are having difficulties raising their voice.

4. PHILHEALTH HAS THE POTENTIAL TO INFLUENCE THE PERFORMANCE OF THE HEALTH SECTOR

As described in section 1 of this report, PhilHealth's prominence in the health sector has grown over the last decade. This enables PhilHealth to exert strong influence on the performance of the health sector.

PhilHealth is improving its ability to hold providers accountable for quality services. In 2010, PhilHealth developed a self-assessment tool to be filled by providers as part of the

accreditation process, focusing on key dimensions of quality. To enforce participation of providers in quality standards setting, the accreditation function will soon be outsourced to an independent entity, governed by representative of providers and purchasers. The claim department also made impressive progress in monitoring the quality of care, client satisfaction, and financial protection. They have developed processes for facility audits, claim profiling, and patient exit interviews. Quality assurance is nevertheless primarily done ex post, by analyzing processed claims trends. Retrospective reviews of practice guidelines are conducted after claims have been submitted. Nearly no due diligence is conducted during the claims process thus the appropriateness of care is not scrutinized. While the random ex-post audits are a strong step forward, the system still contains vulnerabilities to inappropriate or unnecessary service delivery.

Extension of outpatient benefits is an opportunity to improve the functioning of the primary care system. It is well documented that the primary care system in the Philippines is in need of reform. The large majority of people bypass primary care centers and seek primary care in hospitals. This increases overall system costs, and will present a greater challenge as coverage continues to expand and sustainability becomes more of an issue.

Construction of case-based payments do not correspond to the cost of services. Most inputs related to the cost of a 'case' (drugs, consultation, tests, materials) are covered through public budgets. Therefore, the PhilHealth reimbursement serves as a 'top-up' for health providers. The reimbursement rate of this 'top-up' could be **structured to incentivize pre-determined services** based on disease burden or public health need.

Current system of providing pharmaceutical benefit is not meeting the needs of patients. The pharmaceutical benefit is critical for patients, as drugs can often represent a large share of total cost. However, the system is not structured to incentivize public facilities to deliver on this benefit. Often patients are told to obtain drugs from private pharmacies, which are located adjacent to the hospitals. Ownership of these private pharmacies often presents a conflict of interest with the public sector. While patients can always claim back their expenses ex-post, this is a long process that many patients do not understand. Thus, the vested incentive structure of the pharmaceutical system is damaging the perceived value of PhilHealth.

PhilHealth's implementation of ICD-10 presents a rich compliment to the national HMIS system. Data collected through the coding and claims process is granular and can serve to triangulate information from the national HMIS system.

VI. RECOMMENDATIONS

1. RATIONALIZE IGROUP PROGRAM TO MAXIMIZE ENROLLMENT

Harmonize all benefits and policies across iGroup & IPP. In order to boost enrollment in iGroup, many advantages were added to the iGroup benefit package. All iGroup members have access to outpatient coverage, waiting periods were removed, and members of groups with higher membership were offered NBB policy. This strategy has not proved very useful as coverage rates remained low. With the ending of the NBB for iGroup (to be effective in 2015) and the extension of outpatient coverage to all categories, differences

between the two programs have reduced. For better transparency and ease of transition from one program to another, we suggest only referring to one program, with the same name and same benefit package for the informal economy.

Selectively work with large distributors, instead of smaller groups. The 10 biggest MFIs represent more than 70% of the total microfinance client base. Being more selective in the number of partners should enable improved partnership management and client support. We also recommend opening partnership to non-member based organizations, such as microinsurance providers, once all systems issues have been solved. As in all partnership management, clear selection criteria should be developed, including the following dimensions: potential client base, partners mission and value, partners capacity, including system compatibility, trust between partners and from the population, management structure, and financial viability⁴¹.

Simplify financial incentives structure for groups. Today, there are 3 different incentives structures based on group size. This is complex to administer and does not seem to attract more groups, as financial incentive is not their main priority. We suggest reviewing the incentive structure, applying a single rate for all and defining the level of incentive based on the agreed tasks the group will conduct (training, promotion, enrollment, payment...). We also recommend providing incentives for collecting agents, so as to improve continuity of payment.

Research non-financial incentives to motivate group registration. We recommend conducting a qualitative study to determine what incentive, beyond financial, would enable better group performance in promoting, enrolling and serving PhilHealth clients. During our interaction with current and potential partners, several of them expressed their interest to co-branding the PhilHealth product, or bundling it with their current financial services. Getting a better understanding of the partners' role and interest in selling PhilHealth should help review the current incentive plan.

2. DEVELOP COMPREHENSIVE PLAN TO IMPROVE PREMIUM CONTINUITY

As described earlier in this report, it is key for PhilHealth to keep enrolled members active after the first sale, to sustain coverage and to ensure financial sustainability. Ensuring client retention requires that:

- Members are sufficiently satisfied to want to renew the policy;
- Members understand the product so as to be able to use it;
- Members are aware of the expiry date of the policy and the need to renew;
- Members are able and willing to pay for the renewal in a particular time window;
- Members know how to renew the policy.

A comprehensive plan for improving premium continuity should include measures that improve tangibility of product, communication to client, and relevant incentive for all actors⁴². Therefore, PhilHealth should consider the following:

⁴¹ For more on partner selection criteria refer to Rendek. 2011. Managing insurance partnership. Impact Insurance Facility.

⁴² For more on renewal strategies, see Cimon et al. 2013. Removing obstacles to access microinsurance. Impact Insurance Facility.

Assess impact of PhilHealth policies on renewals. The 3/6 rules to avail benefits may be a barrier for improved premium continuity, as this is a disincentive for people to regularly pay their premium. Once registered, members can access benefits by paying only 3 months premium before getting hospitalized. We recommend assessing the impact of this policy on premium continuity and, if the impact proves to be negative, looking for ways to amend the current law.

Develop coordinated communication plan with distributors for members transitioning out of their group. Members leaving their groups often do not know how to continue accessing PhilHealth benefit. As infrastructure for payment will improve, it will be easier for clients to pursue their PhilHealth membership, provided they are aware of the processes to follow. A communication strategy should be developed to inform clients about continuing their payment. The harmonization of the IPP and iGroup program should facilitate this process.

Assess possible incentives for renewal at all levels and develop a comprehensive premium continuity plan. To ensure effective coverage all stakeholders should be incentivized for premium continuity. Groups could be incentivized to push for continuity of payment and renewal. This could, for example, take the form of subsidized interest rate for premium financing loan. Incremental incentive levels could be developed (the longer the client stay, the higher the commission) for groups and other distributors. PhilHealth offices should be monitored and remunerated based on client retention rate. Incentivizing clients should be also considered, whether by sending reminders via SMS (see Box 3), or by providing discount for longer term payments. The addition of the outpatient benefit should also positively impact the continuity of payment, as research shows that the more tangible the product, the higher the renewal rate.

Underpin the renewal strategy with ongoing education about PhilHealth benefits. The microinsurance research shows that clients' understanding of policies significantly determines renewal behaviors.⁴³ It is difficult to teach all the aspects of the program to members. PhilHealth should explore how to sequence content and what delivery channels would be the most effective to deliver education throughout the member life cycle.

Box 3: On the impact of SMS reminders

CIC, a Kenya cooperative insurance company, tested the impact of SMS reminder to trigger improved contribution for its saving products. The research showed that 10% of those who got a weekly SMS reminder paid their arrears within the next couple of days.

A recent study conducted among banks in Bolivia, Peru and Philippines looked at the impact of SMS reminders on savings behavior. The study found that "text message were increasing savings balances by six percent, and messages that focused on a specific future goal were particularly effective. When the reminders to save were coupled with reminders about savings incentives offered by the bank, savings balances increased by nearly 16 percent."

*Source: CIC M-Bima Project Lessons, Impact Insurance, 2014
Getting to the Top of Mind: How Reminders Increase Saving, Karlan and al, 2010*

⁴³ Matul et al 2013, Why people don't buy microinsurance and what can we do about it? Impact Insurance Facility.

3. IMPROVE OUTCOMES THROUGH EFFICIENT PARTNERSHIPS

In the findings section, we mentioned the need for PhilHealth to develop capacities to handle forthcoming growth. To do so, PhilHealth should analyze its internal capacities and consider outsourcing its weaknesses to relevant partners for improved efficiency. The following actions could be taken to strengthen current processes:

Conduct a review of current enrollment and billing system for external distributors and develop a plan for quick improvement. Solving the system issues is key to maintaining group interest in PhilHealth partnership. If enrollment through other distributors, such as retailer is envisioned, quick enrollment and timely coverage will be a must-have for distributors to engage. If no internal solutions exist, PhilHealth may consider outsourcing its data management system, provided that strong data security processes are developed.

Assess optimal repartition of roles and responsibilities of all actors. Today, iGroup partners are taking on many of PhilHealth functions in servicing their client, but with no clear framework. PhilHealth should assess which of its function (promotion, communication, enrollment, issuance of certificates, customer service, claim support, grievance) it wants to keep internal and which could be more efficiently performed if outsourced. PhilHealth should consider leveraging partners' understanding of client needs to support development of client centric processes. Many MFIs and other distribution channels have access to relevant information and data about clients that could be useful to further adjust PhilHealth processes and benefit package.

Build dedicated vendor support capabilities within PhilHealth to provide adequate support to distributors. A clear communication strategy between partners needs to be in place to ensure partnership success. Each iGroup partner should have a clear point of contact within PhilHealth to support information flow and troubleshooting. A formal communication protocol might be included in the partnership agreement to clarify communication rules⁴⁴. The limitation of the number of iGroup partners should help provide better support to groups. Nonetheless, a review of the current organizational structure may be needed to ensure proper institutional support to partners.

Consider partnering with private health insurance providers to improve benefit package, increase renewals and stimulate innovations. The discussion for the new health microinsurance regulation championed by the Insurance Commission is an opportunity to engage with private insurers and HMOs in a collaborative way. We encourage PhilHealth to engage with the private sector and push for the development of supplementary products that could complement current PhilHealth benefit package. This not only can extend the coverage for some health risks but can also help to improve renewals as private providers will be incentivized to promote PhilHealth while collecting their premiums, especially when their offer would be bundled with PhilHealth's. Lastly, it could also be an opportunity for testing innovative product features (see box 5).

⁴⁴ Look for communication protocol template in Rendek. 2012. Managing Microinsurance Partnership. Microinsurance Paper, Impact Insurance Facility.

Box 5: The demonstration role of microinsurance

Health microinsurance (HMI) schemes can be “learning incubators” and create a demonstration effect for social insurance schemes by providing valuable lessons from their experience of reaching the low income market. HMI experience can also inform operational set up, by creating and testing new technologies (e.g. building management information systems or front-end technologies), building health-care provider payment mechanisms, and developing skills needed to deliver insurance.

In India, the RSBY scheme is outsourcing research and development to an external partner. ICICI Lombard – one of RSBY’s private insurance partners – piloted extension of outpatient coverage to the standard benefit package in two districts in the states of Orissa and Gujarat. During the pilot schemes, information on the impact of outpatient coverage on health seeking behavior, enrollment, and renewals in the program are evaluated, as well as the impact on utilization of hospitals. Based on early but encouraging lessons from the pilots, outpatient benefits will be extended to other districts in the future, with funding from the government. Additional pilots are planned to test further variations of outpatient benefits, including coverage of diagnostic services. These will also test different provider payment mechanisms.

Source: Kimball et al. 2013. Leveraging Health Microinsurance to Promote Universal Health Coverage. Microinsurance paper, Impact Insurance Facility.

4. ACTION & ADVOCACY TO IMPROVE THE ‘PRODUCT’

Establish ‘managed-care’ unit to enforce the delivery of high-quality health services. As PhilHealth’s capacity and purchasing power increases, there is a strong opportunity to deepen PhilHealth’s involvement in the enforcement of practice guidelines and quality of care measures through real-time quality checks prior to claims submissions. This recommendation involves the establishment of a managed care unit staffed with medically-trained personnel. It also involves strong coordination with Department of Health to define the extent to which PhilHealth can play a role in the oversight of health service delivery. Thus, we recommend a feasibility analysis in the short-term, and possible implementation in the medium to long term.

Restructure reimbursement rates for public providers such that they are reflective of public-health need, not cost. Since case-reimbursement payments largely serve as top-ups to health provider salaries, PhilHealth has enormous potential to structure payments such that they incentivize services that are of high national priority, akin to results-based financing. This would involve closely collaborating with Department of Health to rank cases by public health need.

Enforcement of gate-keeping at primary care level through patient financial incentives. Using its increased influence and purchasing power, PhilHealth is in a strong position to enforce a gatekeeping role at the primary care level. This can be accomplished through a range of measures, from differential copays to mandatory referrals for hospitals. Given the addition of outpatient coverage to the population, this is an opportune moment to introduce gatekeeping.

Consider phased-in prescription benefit for generic pharmaceuticals through accredited private pharmacies. The challenges with improving the current pharmaceutical benefit program as currently structured are many, since strong vested interests are involved. One

option to bypass these interests could be to accredit private pharmacies. Drugs are already cheaper at private pharmacies and supplies are more consistent. This could be accomplished using a two-phased approach, in which half of the generics contained in the WHO essential medicines model formulary (WHO, n.d.) are initially covered and the other half after one year of experience.

VII. CONCLUSION

Expanding coverage of PhilHealth to move beyond the 82% is feasible. The current expansion strategies have the potential to increase coverage to 92%. But this is under the condition that current systems and processes are strengthened, either internally or by outsourcing functions. The current strategy for outsourcing distribution to trusted institutions within the informal sector has high potential and should get more internal support within the corporation to ensure its success. But increasing coverage also means improving retention within the scheme, and PhilHealth should focus on developing informed policies to improve its current performance.

Coverage extension is just one piece of the UHC puzzle. Access and quality of care are fundamental, and PhilHealth can have a major role to play in that space. By pushing for needed health reform and leveraging its growing purchasing power, PhilHealth can be a major counterpart of the DOH in impacting Philippines journey toward improved Filipino health.

ANNEX 1

LIST OF INTERVIEWS

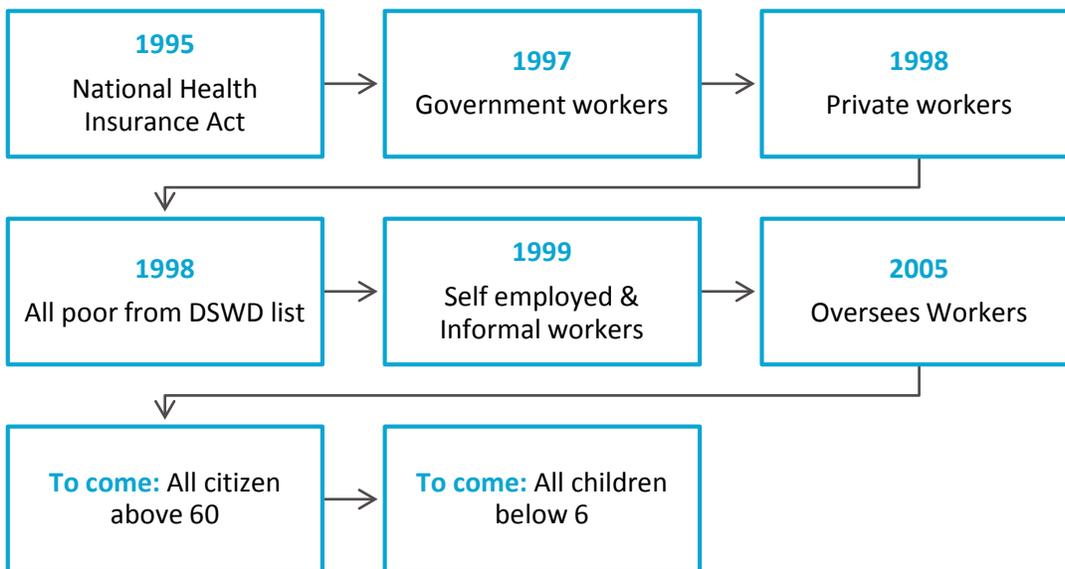
Name	Designation	Organization
Mr. Rulloda Gregorio	OIC, Fund Management	PhilHealth
Ms. Narisa Sugay	Head of Non Formal Sector, Member Management Group	PhilHealth
Mr. Rito Joven	Head of iGroup	PhilHealth
Mr. Rodney Cacatian	Head of Research	PhilHealth
	San Pablo Regional Office	PhilHealth
	Claim Department	PhilHealth
	Actuarial Dept	PhilHealth
	Communications Dept	PhilHealth
	PCare, San Pablo Hospital	PhilHealth
	Various managers	San Pablo LGU
	Director	Public Hospital of
	Back-Office Staff	Private Hospital of Saint Luke
	Medical Staff	RHU San Pablo
Ms. Silvida Reyes-Antiquera	General Manager	KASAGANA-KA
Ms. Jerlene B. Perez	Program Officer	KASAGANA-KA
Mr. Ibarra A. Malonzo	Commissioner	Social Security
Mr. Jonathan D. Batangan	General Manager	Cebuana Lhuillier Insurance Solutions

Name	Designation	Organization
Ms. Susanita G. Tesiorna	President	Alliance of Workers in the Informal Economy Sector
Ms. Venus F. Rebuldela	Deputy Program Manager	DSWD
Dr. Eduardo Banzon	Head of Health Department	Asian Development
Ms. Dinah G. Bohol	Program Supervisor	TSPI
Ms. Marlyn Manila	Manager	CARD
Ms. Lourdes Macapanpan and ILO employees	Programme coordinator	ILO Phillippines
Mr. Geric Laude	Managing director, Microinsurance	Pioneer Life
Mr. Wiliam Martirez	Manager	MicroEnsure
Mr. Jun Jay Perez	Executive director	Rimansi
Ms. Ghay Mapano	Microinsurance project coordinator	Rural Bankers Association
Mr Ferdinand Florendo (and Ms Rosalina Bactol)	Deputy Commissioner	Insurance Commission of the Philippines
Mr. Antonis Malagardis	Programme Director	GIZ Philippines

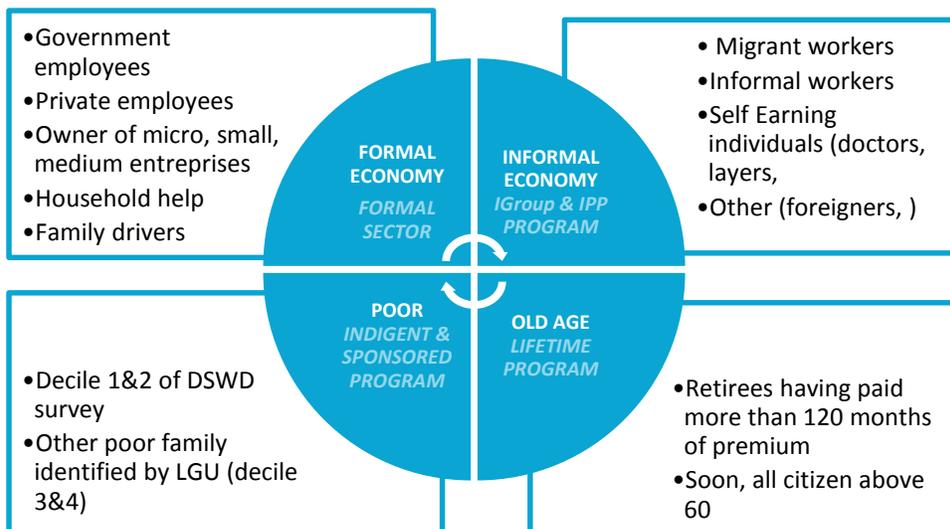
ANNEX 2

PHILHEALTH HISTORY AND PROGRAMS

PhilHealth History



PhilHealth Programs



Source: Rules & Guidelines, 2013

Premium Contribution per Program

Program	Premium rate	% of income
FORMAL ECONOMY	3.5% paid by the employer, 3.5% paid by the employee	
INFORMAL ECONOMY	P 2400/year/capita (income < 25 000/year) P3 600 (income > 25,000). Difficult to enforce.	1.57% *
INDIGENT & SPONSORED	P 2400, fully subsidized by central government, for the indigent and LGUs for sponsored members	Free
LIFETIME	PhilHealth Fund	Free

*Average income per decile, NSO 2011

ANNEX 3

BIBLIOGRAPHY

2011. **KaSAPI Kalusugang Sigurado at Abot Kaya PhilHealth Insurance External Evaluation and Recommendations.** GIZ.
2011. **Philippines Pharmaceutical Country Profile.** DOH
- Asia Pacific Observatory on Health Systems and Policies. 2011. **The Philippines Health System Review.** Health Systems in Transitions, WHO.
- Capuno et al. 2014. **Effects of Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme.** Policy Research Working Paper, World Bank.
- Cimon et al. 2013. **Removing obstacles to access microinsurance.** Microinsurance Paper, Impact Insurance Facility.
- GSMA. **Mobile Money in the Philippines – The Market, the Models and Regulation.** Health Sector Reform Agenda. 2010. **Towards Financial Risk Protection. Health Care Financing Strategy for Philippines 2010-2020.** Monographs, DOH.
- ICF international. 2014. **National Demographic and Health Survey.** PSA.
- Karlan et al. 2010. **Getting to the Top of Mind: How Reminders Increase Saving.**
- Kimball et al. 2013. **Leveraging Health Microinsurance to promote universal health coverage.** Microinsurance Paper, Impact Insurance Facility.
- Leach et al. 2014. **Achieving scale and efficiency in microinsurance through retail and banking correspondents.** Microinsurance Paper, Impact Insurance Facility.
- Mangahas. 2012. **Profiling of Workers Associations in the Informal Economy.** ILS Discussion Paper Series.
- Matul et al. 2014. **CIC M-Bima Project Lessons.** Emerging Insight, Impact Insurance Facility.
- Matul M., A. Dalal, O. de Bock, W. Gelade (2013) **Why people don't buy insurance and what can we do about it?** Impact Insurance Facility, ILO.

Mukherjee et al. 2013. **The Landscape of Microinsurance in Asia and Oceania**. Munich Re Foundation.

National Microfinance. 2012. **The 2012 Microfinance client mapping**.

NSO. 2008. **Informal Sector Survey of the Philippines**.

NSO. 2012. **Family Income and Expenditure Survey**.

PhilHealth. 2013. **Annual Report**.

PhilHealth. 2013. **The revised implementing rules and regulation of the Health Insurance Act 2013**.

Picazo et al. 2013. **Opportunities for making health financing and services more inclusive in the Philippines**. Policy Notes, PIDS.

PSA. 2012. **Statistics on non-regular workers**. Labstat updates, PSA.

Reinschet et al. 2010. **Costs and Benefits of Health Microinsurance Premium Loans and Linkages with Health Providers CARD's Experience in the Philippines**. Freedom from Hunger Research Paper.

Rendek. 2012. **Managing Microinsurance Partnership**. Microinsurance Paper, Impact Insurance Facility.

Reyes et al. 2011. **A Profile of the Philippine Pharmaceutical Sector**. Discussion Paper Series, PIDS.

Schmitt et al. **The Single Window Service in Asia and the Pacific**. ILO Regional Office for Asia and the Pacific.

Silfverberg. 2014. **Analysis of the Individually Paying Program of the Philippine Health Insurance Corporation**. Discussion Paper Series, PIDS.

Silfverberg. 2014. **The Sponsored Program of the Philippine National Health Insurance – Analyses of the Actual Coverage and Variations across Regions and Provinces**. Discussion Paper Series, PIDS.

Solana M., A. Merry (2014) Fonkoze case brief, Impact Insurance Facility, ILO,
<http://www.microinsurancefacility.org/publications/cb5>.

World Bank. 2013. **Philippine Development Report. Creating More and Better Jobs.**