COUNTRY FACTSHEET: THE PHILIPPINES 2020

Strategic Purchasing for Primary Health Care (SP4PHC) is a multi-country project implemented by ThinkWell with support from the Bill & Melinda Gates Foundation. Its purpose is to improve how governments pay providers for primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project is implementing programs of work in Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda. We developed factsheets for each of the five countries that serve as a data reference for the strategies we chose within each.

Demographic & Socioeconomic Characteristics

<table>
<thead>
<tr>
<th>Indicator (2019)</th>
<th>Philippines</th>
<th>Indonesia</th>
<th>East Asia &amp; Pacific*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (millions)</td>
<td>108.1</td>
<td>270.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>1.4</td>
<td>1.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Urban population (% of total population)</td>
<td>47.1</td>
<td>56.0</td>
<td>56.6</td>
</tr>
<tr>
<td>Total fertility rate (births per woman)</td>
<td>2.6 (2018)</td>
<td>2.3 (2018)</td>
<td>1.9 (2018)</td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.90 a day (% of population)</td>
<td>6.1 (2015)</td>
<td>4.6 (2018)</td>
<td>N/A</td>
</tr>
<tr>
<td>Human Development Index Rank (out of 189)</td>
<td>106</td>
<td>111</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Excluding high-income countries
Source: World Development Indicators Databank 2019, UNDP Human Development Reports 2019
The modern contraceptive prevalence rate (mCPR) for all women in the Philippines is much lower than regional peers. The pill is the most used method of contraception among married women, followed by (female) sterilization, injection, and intrauterine devices (IUD). Barangay health stations are the most common public sector source for contraception, and pharmacies are the main private provider of contraception. Total fertility rate is highest amongst the poorest women.

**Key Family Planning Indicators**

The modern contraceptive prevalence rate (mCPR) for all women in the Philippines is much lower than regional peers. The pill is the most used method of contraception among married women, followed by (female) sterilization, injection, and intrauterine devices (IUD). Barangay health stations are the most common public sector source for contraception, and pharmacies are the main private provider of contraception. Total fertility rate is highest amongst the poorest women.

**mCPR among all women (2019)**

- Philippines: 25.6%
- Cambodia: 30.4%
- Myanmar: 32.8%
- Lao PDR: 41.1%
- Indonesia: 43.5%
- Viet Nam: 47.6%

*Source: FP2020 Estimate Tables*
Current use of modern contraception among all women (2017)

*LAM = Lactational Amenorrhea Method
Source: Philippines DHS 2017

Provider source for women accessing family planning by method type (2017)

Source: Philippines DHS 2017
Total fertility rate by wealth quintile (2017)

Source: Philippines DHS 2017
Maternal and neonatal mortality rates have not improved as much as expected in the last few decades, despite steady increases in the percentage of women who had four or more antenatal care (ANC) visits and women who delivered in a health facility. There is considerable variation across wealth quintiles for almost all MNCH coverage indicators – with the exception of ANC from a skilled provider for which the coverage rates are uniformly high. There is a large urban-rural gap in facility births and by wealth quintile.


Source: Philippines DHS 2017

Trends in maternal mortality rate, compared with region and SDG target (1990-2015)

Note: East Asia & Pacific - no available 1990 and 1995 data; this is the modelled estimate
Source: WHO and Population Division 2015; World Development Indicators Databank 2019
Key MNCH trends (1993-2017)

Note: 1993 data on postnatal check during first 2 days after birth (mother) not available; 1998 data refers to postnatal check during first 6 days after birth (mother)

Proportion of women receiving MNCH services across the continuum of care by wealth quintile (2017)

Source: Philippines DHS 2017
Percentage of deliveries by place of birth and wealth quintile (2017)

Source: Philippines DHS 2017
Current health expenditure (CHE) per capita is higher in the Philippines than the average for lower-middle income countries. Although the Philippine Health Insurance Corporation (PhilHealth) coverage increased over the last two decades, household out-of-pocket (OOP) expenditure as a share of CHE is still high at 53%.

Source: Global Health Expenditure Database 2019

### Table

<table>
<thead>
<tr>
<th>Indicator (2017)</th>
<th>Philippines</th>
<th>Lower-Middle Income Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHE per capita (US$)</td>
<td>132.9</td>
<td>129.9</td>
</tr>
<tr>
<td>Domestic general government health expenditure as % of CHE</td>
<td>31.9</td>
<td>44.3</td>
</tr>
<tr>
<td>Current PHC expenditure as % of CHE</td>
<td>51.9 (2016)</td>
<td>58.1 (2016)</td>
</tr>
</tbody>
</table>

Source: Global Health Expenditure Database 2019

### Trends in CHE by financing source (2000-2017)

Source: Global Health Expenditure Database 2019
OOP expenditure and PhilHealth coverage, compared to other LMICs (2000-2017)

Source: Global Health Expenditure Database 2019
The table below provides key details about the main purchasers of health services in the Philippines.

<table>
<thead>
<tr>
<th>PURCHASER ATTRIBUTES</th>
<th>Department of Health (DOH)</th>
<th>Local Government Unit (LGU)</th>
<th>Philippine Health Insurance Corporation (PhilHealth)</th>
<th>Private health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of revenue (e.g. taxes, contribution)</td>
<td>Taxes (budget appropriation)</td>
<td>Local taxes and revenue allocation from the national government</td>
<td>Premiums (only select members pay their own premiums; premiums of indigent population are paid from earmarked sin taxes)</td>
<td>Premiums</td>
</tr>
<tr>
<td>Population covered</td>
<td>General public</td>
<td>Constituents of a particular local government unit</td>
<td>Universal coverage as of January 2020</td>
<td>Voluntary - generally employed (3.2%*)</td>
</tr>
<tr>
<td>Basis for enrollment</td>
<td>No enrollment needed to access services in DOH-owned hospitals</td>
<td>No enrollment needed in accessing services in LGU-owned hospitals**</td>
<td>Formal &amp; non-poor informal sector (mandated), poor informal sector (determined poor through the National Household Targeting System)</td>
<td>Members (voluntary or payroll contributions)</td>
</tr>
<tr>
<td>Benefits/services covered (PHC, hospitalization, inpatient, outpatient)</td>
<td>Inpatient and outpatient; private accommodation is associated with a payment; outpatient services are available only in outpatient units of DOH-owned hospitals and there can be a charge; DOH supports local level facilities by deployment of nationally hired personnel to local level facilities and providing selected drugs and commodities procured by vertical programs; for FP and MNCH services, DOH supports through direct supply of commodities and other technical assistance</td>
<td>Inpatient and outpatient; private accommodation is associated with a payment; health centers (all public primary care facilities are LGU-owned) provide services free of charge; Inputs for inpatient and outpatient FP and MNCH services</td>
<td>Inpatient (all members), outpatient (selected services available to all members); all FP methods; MNCH services (all inpatient procedures, only selected outpatient services (e.g. deliveries in lying-ins*, ANC, postnatal care, newborn care); routine vaccinations are generally excluded</td>
<td>Inpatient and outpatient (usually no medicines), dependent on the scheme; FP and MNCH services may be covered as part of inpatient or outpatient benefits depending on the scheme</td>
</tr>
</tbody>
</table>

*ANC: Antenatal Care
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</thead>
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<tr>
<td>Types of facilities included (referral hospitals, health centers, health posts, etc.)</td>
<td>72 DOH retained hospitals (approx. 1.3% of government hospitals)</td>
<td>All LGU hospitals (approx. 98% of government hospitals), health centers</td>
<td>Public and private; accredits hospitals, ambulatory surgical clinics, dialysis centers, lying-in clinics, outpatient clinics, health centers (60-65% of accredited facilities are private)</td>
<td>Public and private; hospitals, outpatient clinics</td>
</tr>
<tr>
<td>Provider payment methods (with FP and MNCH specifics)</td>
<td>Input based financing; DOH-owned hospitals submit budget proposal to DOH and, together with DOH, which has a standard cost per bed per day (differentiated based on facility level), they reconcile the budget based on historical bed counts and occupancy rates</td>
<td>Input based financing; LGU-owned health facilities submit proposals to their respective LGU (province, municipality, or city) who then decide on the final budget allocation; proposals do not necessarily follow the DOH standard cost per bed per day, but are itemized into cost components (personnel services, capital expenditure, operating expenses); The Universal Health Care (UHC) Law moves towards provincial integration and financing of non-DOH facilities should be at the provincial level</td>
<td>Inpatient: fixed case rates, no balance billing for select membership types (poor and vulnerable), in basic accommodation in public and select private facilities; outpatient: capitation, bundled payments; co-payment allowed in the private sector; FP services: case rates for long acting/permanent methods, capitation for all other methods; MNCH services: capitation, case rates</td>
<td>Depends on the scheme; generally, fee-for-service or case rate</td>
</tr>
</tbody>
</table>

*Insurance provided by “any private insurance company, health maintenance organization, and pre-need insurance plan company” (based on Philippines DHS 2017).
**Budgeting and allocation at the local level typically take into account the area’s population.
^A lying-in facility is a primary level health facility for low-risk childbearing women and having normal status during pregnancy, childbirth and postpartum.
The Philippines' R.A. 11223 (UHC Law)* offers an unprecedented opportunity to make purchasing of PHC more strategic. SP4PHC is supporting the DOH and PhilHealth to design and implement provisions of the UHC Law to strengthen purchasing of PHC, especially FP and MNCH services. It is critical to improve not only the volume of services, but also service quality.

Pregnant women in the Philippines can benefit from PhilHealth’s Maternity Care Package (MCP), which includes ANC, delivery, postpartum care for the mother, and newborn care. The number of MCP claims submitted to PhilHealth is low and declining over the last four years – compared to approximately 1.6 million live births per year. This can be explained by policy changes, increased providers’ perception of a high administrative burden engaging with PhilHealth, and changes regarding the place and delivery type.

*For more information on the Philippines UHC Law, please see this brief.

Number of PhilHealth Maternity Care Package claims by status, Philippines (2016-2019)

Note: RTH = return to hospital
Source: PhilHealth 2020
Implants have been a target of negative publicity and a ‘temporary restraining order’ in the Philippines in 2015. This was only lifted in 2017 and explains the increasing number of claims since then. In the following two years, the number of claims submitted to PhilHealth for implants increased.

More private than public facilities are engaged with PhilHealth to provide family planning services, as well as MCP, as seen by the two following graphs.

Note: The total number of health facilities providing family planning services is 1,060.
Source: PhilHealth 2019
PhilHealth empaneled health facilities providing MCP services (2019)

Note: The total number of health facilities providing MNCH services is 2,989.
Source: PhilHealth 2019

Recommended Citation