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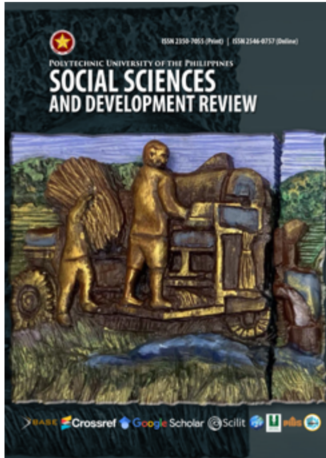

Healthcare Advocacy & Legislation in the Philippines: Social Movement/Civil Society Alternatives to Privatization and Commodification

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Healthcare Advocacy & Legislation in the Philippines: Social Movement/Civil Society Alternatives to Privatization and Commodification

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ABSTRACT

The Philippine Health Insurance Corporation's (PhilHealth) financial situation is in dire straits, with an official claiming that its actuarial life would last until 2027 only. To achieve free universal healthcare, alternative financing options for the Philippines' national healthcare system would have to be considered. This paper aims to analyze historical government healthcare reform policies vis-à-vis social movement/civil society alternatives – and the corresponding paradigm shifts that they present – which culminate in the recently filed House Bill 9515 ("An Act Providing for a Free, Comprehensive, and Progressive, National Public Healthcare System") authored by the Makabayan Coalition – a bloc of grassroots party-lists with strong links with social movements. House Bill 9515's provisions would bring the Philippine system closer to Cuba's and the United Kingdom's systems which both offer useful springboards in making public healthcare free for all. Thus, the bill can potentially help the Philippines transition from privatization and commodification which have characterized the prevailing framework in the country's healthcare system for decades now.

Keywords: *healthcare reform, healthcare advocacy, free healthcare, social movements, anti-neoliberalism*

INTRODUCTION

The policy to further increase and deepen privatization of health services provisioning is detrimental to PhilHealth's financial sustainability, as recent trends on its finances show. As the Philippine government is unable to spend more for public healthcare institutions, trends point to continuing and even expanding private sector dominance in healthcare, observed in the increasing number of private hospital beds vis-à-vis public hospital beds, ever-increasing PhilHealth payments to private healthcare providers, and the bigger current percentage of private healthcare institutions in the total number of PhilHealth-accredited healthcare institutions (HCIs). Such de-facto privatization of healthcare – within the framework of Public-

Private Partnership (PPP) schemes where delivery of services is partially privatized, with some citizens required to pay out-of-pocket expenses – negatively affects PhilHealth's financial situation as this means perpetuating a system where overpayments, fraud, upcasing, and lack of ample documentary support for payments, enable private firms to reap profits at the expense of the national health insurance's bleeding coffers. Seeking an alternative financing scheme is, thus, necessary.

At least two feasible alternatives to the Philippines' public-funding-for-privatized-health-care scheme can be considered: UK's and Cuba's public sector-dominated healthcare, which, while coming from two separate ideological traditions, are both characterized by heavy government spending for public health and generally free health services with relatively minimal out of pocket payments (OOPPs) compared with Philippine statistics for OOPPs. Such alternatives are closer to Philippine social movements' past and present healthcare advocacies for accessible or free public healthcare services.

This research aims to answer the following questions: 1) How did healthcare reform paradigms change (or remain constant) in the Philippines?; 2) How does House Bill 9515 intends to reform healthcare financing in the Philippines?; 3) How does the bill embraces (or sets the limits of) de-commodification and de-privatization of the Philippine healthcare system?; 4) How does it mirror the Cuban and/or the UK healthcare systems on healthcare financing?

METHODOLOGY

This study primarily used comparative documentary analysis mainly spanning the period from the first Marcos administration to the Duterte administration. Documents related to past and present healthcare reform – both from the State and social movements – were analyzed to gain insights on the prevailing healthcare reform paradigms and how such paradigms change (or remain constant). Documents on the current healthcare financing system (such as the Universal Healthcare Act/UHCA and related PhilHealth policy issuances) were compared with the full text of House Bill 9515 to analyze how the bill intends to reform healthcare financing in the Philippines. The same documents were used in answering the other research questions. In discussing and summarizing such analyses, indicators used for applying the framework of McIntyre and Kutzin (2016), adopted from (Myint et al., 2019), with the current researcher's modifications, would be utilized. Thus, differences between the status quo and how the bill intends to reform the system on matters of revenue raising, resource pooling, service purchasing, extent of benefits, and provision for financial protection (against OOPPs) were highlighted. Insights on the bill's embrace of or limitations on de-commodification and de-privatization were emphasized within the discussions on resource

pooling, service purchasing, and provision for financial protection. Various national health systems reviews and related scholarly works and documents were analyzed vis-a-vis the provisions of the aforementioned bill. Finally, recent legislation on free healthcare – which generally mirrors many aspects of UK's and Cuba's healthcare systems – were analyzed to reveal how the status quo differs from the said models and social movement/civil society alternatives to healthcare privatization and commodification.

RESULTS AND DISCUSSION

The country's long march to fulfilling universal healthcare provision started through the enactment in 1969 of Republic Act No. (R.A.) 6111, which established the Philippine Medical Care Plan (Medicare) and created the Philippine Medical Care Commission — precursors of what would become the Philippines' public healthcare insurance system. This law declared that the government intends to "gradually provide total medical service for our people by adopting and implementing a comprehensive and coordinated medical care program based on accepted concepts of healthcare, namely: (a) There shall be total coverage of medical services according to the needs of patients; (b) There shall be coordination and cooperation in the use of all medical facilities of both the government and the private sector; and (c) The freedom of choice of physicians and hospitals and the family doctor-patient relationship shall be preserved" (Republic Act No. 6111, 1969, emphasis supplied). The said law also included the following in its "main purposes and objectives": "(a) Extension of medical care to all residents in an evolutionary way within our economic means and capability as a nation..." (Republic Act No. 6111, 1969, emphasis supplied). It listed two plans, one for those formally employed and one for those who are not, for which regular contributions are required to avail of fixed-rate benefits for hospitalization, surgery, and "necessary professional medical treatment," and that do not cover any expense for:

(a) Cosmetic surgery or treatment;
(b) Dental Service, except major dental surgery or operation which needs hospitalization;
(c) Optometric service or surgery;
(d) Services related to the case of psychiatric illness or of diseases traceable to such illness; and
(e) Services which are purely diagnostic.
(Republic Act No. 6111, 1969)

Section 18 of R.A. 6111 also allows co-payments:

> Provided, that when the charges and fees agreed upon between the employee and the hospital and/or medical practitioner are in excess of the amount of the benefits provided for under this Act, such employee shall be liable only for the payment of that portion of such fees and charges as are in excess of the benefits payable under this Act. (Republic Act No. 6111, 1969, emphasis supplied)

Nevertheless, as this is the first Philippine law that aspired for a semblance of universal healthcare, the government's own euphemistic declaration (Department of Health [DOH], 2014) that "it was a major step in the journey towards achieving healthcare for all Filipinos" is truthful, especially considering that the 1943 Constitution (in effect during that decade) did not even contain a provision on healthcare.

Meanwhile, Section 7 of the amended 1973 Constitution includes such essential provision, albeit healthcare is lumped with other public services:

> The State shall establish, maintain, and ensure adequate social services in the field of education, health, housing, employment, welfare, and social security to guarantee the enjoyment of the people of a decent standard of living. (Philippine Constitution, 1973, amended)

Such laudable provision was indeed even a few years ahead of the 1978 Alma Ata Declaration (to which the Philippines is a signatory), which, among other things:

> Strongly reaffirms that health... is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector... Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment, by all peoples of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life. Primary healthcare is the key to attaining this target as part of development in the spirit of social justice. (World Health Organization [WHO], 1978)

Simply put, this international declaration pushed for "Health for All" as a primary social goal.

The government's own reckoning of healthcare history in the Philippines (DOH, 2014) points out that the health minister then initiated the implementation of the country's "Primary Healthcare" plan and adds that the Marcos regime built specialized healthcare facilities such as the Philippine Children's Medical Center (PCMC), the Philippine Heart Center, the Lung

Center of the Philippines, and the National Kidney Institute. The Martial Law Museum (n.d.) emphasizes that such supposed "achievements in public infrastructure did not come without a price. Many of Marcos' projects were funded by foreign loans that left the Philippines with an outstanding debt of about $28.3 billion by 1986. These projects were also often the site for gross overspending, garishness, and corruption". Fineman's investigative report (1987) cited "statistics gathered from the World Health Organization, the United Nations, Philippine government physicians and health officials, and several international relief agencies working in the Philippines," and revealed that:

> tens of thousands of Filipinos die each year simply because there are too few hospitals, too few doctors, too little medical equipment and medicine, and too little money to help the government cure its national disaster. For years under Marcos, the nation's health was gradually deteriorating into what has now become a seemingly insoluble crisis; yet the danger signs were not only ignored but deliberately hidden by a government determined to show the world that the nation was healthy and strong... many of the national and local officials in the Marcos administration routinely diverted huge sums of government health-care funds to favorite or political projects (p. 35).

A published scholarly assessment of healthcare under the Marcos regime and the first Aquino administration supplied essentially the same findings (Pagaduan-Lopez, 1991):

> Chronic underdevelopment in the Philippines explains much of this country's poor health record. Almost 75 per cent of Filipinos live below the poverty threshold... In 1985 alone, over three million people, or 15 per cent of the total labour force of 20.6 million, were out of work. Six years later, under the Aquino government, the figure has increased to 20.2 percent... This grim picture is compounded by inadequate transportation and communications systems, which hamper the ability of rural residents to reach health facilities in central towns and cities. Even in urban centres, the high cost of prolonged institutional medical care is far beyond the means of the average wage earner.

Pagaduan-Lopez (1991) added that:

> (h)ospitals often have to get by with inadequate supplies of x-ray film, bed linens, and antibiotics. In 1983, for instance, doctors at the Philippine General Hospital, the country's biggest tertiary state hospital, reported that a shortage of x-ray film had forced them to forego taking essential radiographs of many patients. Over 50 per cent of the country's doctors and more than 60 per cent of its nurses work outside the country. Of those doctors who remain in the country, most have private practices in

> urban areas. Manila, the country's capital, has 15 times as many doctors as outlying rural areas.

Furthermore, Pagaduan-Lopez (1991) revealed that:

> ...in the two years before the fall of the Marcos regime between 30 and 40 per cent of the national health budget for supplies and materials had been diverted into 'kickbacks, corruption, and graft'.

He concludes by remarking that the country's healthcare woes remain unsolved:

> ...the Aquino government seems nowhere close to solving the myriad problems it inherited from the Marcos regime. Saddled with a deteriorating economy, destabilisation efforts from both right and left wing factions, graft and corruption, and poor central planning, it has often been accused of resorting to increased militarisation to contain political violence against its continued existence.

Such stark reality contrasted with a 1988 speech celebrating the 40th anniversary of the World Health Organization (WHO), in which then President Corazon C. Aquino reiterated her government's firm commitment to "the objective of health for all by the year 2000 through the primary healthcare approach..." (Aquino, 1988, p. XX).

The first Aquino presidency did pass vital laws on healthcare, "although the sweeping reforms signaled by both laws were not immediately felt" (DOH, 2014). The administration passed the Generics Act, described as "a landmark legislation which guaranteed generic prescription and dispensing, and the right of informed choice for consumers" (Presidential Management Staff, 1992), consequently allowing cheaper medicines to become available. Furthermore, "RA 7160 or the Local Government Code of 1991 ushered in the devolution of services not only for the DOH but also for other government agencies. Devolution effectively transferred the management and implementation of public services to local government units..." and in 1992, "the Magna Carta for Public Health Workers (RA 7305) was passed, providing for the benefits of health workers. Insufficient funds, however, kept it from being fully implemented" (DOH, 2014). Despite the documented continuing expansion and increase of healthcare facilities from basic clinics to specialized hospitals during the first Aquino administration (Presidential Management Staff, 1992), the country's healthcare system remained largely unreformed, especially in terms of healthcare financing, until the Ramos administration was elected. Nevertheless, it must be emphasized that the 1987 Constitution's more progressive provisions on healthcare such as Article II, Section 15—"The State shall protect and promote the right to health of the people and instill health consciousness among them"—and Article XIII, Section 11—"The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health, and

other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers."—gave impetus to the preceding post-Marcos Sr. era healthcare reforms.

As PhilHealth's website explained (2014):

> (i)n the 1990s, a vision for a better, more responsive government healthcare program was prompted by the passage of several bills that had significant implications on health financing. The public's clamor for a health insurance that is more comprehensive in terms of covered population and benefits led to the development of House Bill 14225 and Senate Bill 01738, which became the National Health Insurance Act of 1995 or Republic Act 7875, signed by President Fidel V. Ramos on February 14, 1995.

The said law

> paved the way for the creation of the Philippine Health Insurance Corporation (PhilHealth), mandated to provide social health insurance coverage to all Filipinos in 15 years' time. PhilHealth assumed the responsibility of administering the former Medicare program for government and private sector employees from the Government Service Insurance System in October 1997, from the Social Security System in April 1998, and from the Overseas Workers Welfare Administration in March 2005 (PhilHealth, 2014).

Its full text included a provision establishing the

> "National Health Insurance Program, the compulsory health insurance program of the government as established in this Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available, and accessible healthcare services for all citizens of the Philippines."

Despite such rhetoric for "universal health," the country's citizens remain overburdened with out-of-pocket payments then (and now), and millions were not enrolled in the so-called national insurance scheme. The Estrada administration attempted to remedy the situation by adopting the Health Sector Reform Agenda (HSRA), which, at the very least, expanded the coverage of the National Health Insurance Program (DOH, 2014; Priela, 2001). Yet by 2005, the second year of Macapagal-Arroyo's second term, the Philippines' estimated formal national health insurance coverage as a percentage of the total population stood at only 55% (International Labor Organization, 2007), falling further to 53% in 2010 (DOH, 2010).

Moreover, high out-of-pocket payments (OOPPs) persisted and even worsened from 2000 to 2018 (see Figure 1), starting at 41.2% in 2000—an all-time low for the period—breaching more than 50% in 2005 and never returning below that level, peaking at 58.9% in 2011. Two years after the establishment of PhilHealth, in 1997, 51.5% of total health expenditure was categorized as private health expenditure, 4.6% of which was labeled as "private insurance," and 95.4% as OOPPs (Musgrove et al., 2002). Private insurance is, in fact, OOPPs too, as premiums for private health insurance are technically out-of-pocket payments. In the same year, Cuba's private health expenditure was pegged at 12.5%, while the UK's was at 16.3%. If rounded off, the latest available data for OOPPs as a percentage of current health expenditure in the Philippines would still be around 50%, or 47.9% to be exact (PSA, 2020).

Figure 1

Philippines' Out-of-pocket Expenditure (% of current health expenditure)

Note. Figure from the World Bank (2021).

Under the Macapagal-Arroyo administration, no major healthcare reform was enacted, though two health-related developments are notable: healthcare discounts for

senior citizens through the Expanded Senior Citizens' Act and the regulation of medicine prices through the Cheaper Medicines Act. The country's healthcare system – especially healthcare financing – remained almost untouched until the UHCA was signed into law in 2019, under the Duterte administration. However, it must be emphasized that the groundwork for UHCA was first laid down through the second Aquino administration's DOH Administrative Order No. 2010-0036 with the "Subject: The Aquino Health Agenda: Achieving Universal Healthcare for All Filipinos." Short of automatic public insurance enrollment, the said administrative order compelled PhilHealth to "(e)xpand NHIP coverage by ensuring the annual registration and enrolment of poor families while leveraging for local counterparts and providing member and provider services to promote utilization of NHIP benefits" and to "(s)ecure financial risk protection for inpatient services by implementing a no-balance-billing policy (NBB policy) in government hospitals for our poorest population." The second Aquino presidency bolstered the achievement of these goals by passing RA 10606, which amends the National Insurance Act of 1995 to institutionalize the NBB policy – albeit, for poor citizens only – by explicitly stating that "no other fee or expense shall be charged to the indigent patient, subject to the guidelines issued by the Corporation..." The said law, now known as the National Health Insurance Act of 2013, rhetorically supported "mandatory coverage" for all citizens but does not include a mandate for automatic enrollment. The UHCA built on these policies by legislating universal healthcare as a national policy through automatically enrolling every citizen into the national insurance program, with the government shouldering the premium contributions for indigent citizens, thereby drastically increasing PhilHealth's funding sources, in contrast with the old scheme where despite universal health declarations, healthcare services for all poor citizens were not automatically subsidized. Under the UHCA, the NBB policy has also been expanded to cover all citizens regardless of socio-economic status, subject to a condition: "...no co-payment shall be charged for services rendered in basic or ward accommodation".

In view of the above, there are at least three paradigm shifts in the government's official healthcare financing policy: 1) gradual transition to a system of public healthcare provisioning, subject to the country's financial capacity, albeit, with continuous private sector existence (Marcos Sr. regime to the first Aquino administration); 2) nominal subscription to the universal healthcare paradigm, with a clear schedule (Ramos administration), and still retaining private sector involvement; 3) a two-tier universal healthcare paradigm, with free services for the poorest citizens (or at least those listed in the government database), and with (theoretically) affordable healthcare for currently employed citizens (second Aquino administration to Duterte regime), which still allows co-payments to be collected and profit-oriented healthcare facilities to operate. While the current system is definitely better than the one in place in the late 1960s – with ever-broadening healthcare coverage for citizens, though

still at a cost for many citizens – things could still get better, as the second half of this paper would argue.

At this point, it must be highlighted that the government's forward-looking policy shifts (however limited) are partly the result of social movement-driven or -influenced campaigns and/or advocacies for health policy reforms. At times, social movements are powerful enough to compel governments to craft meaningful policy shifts. Sometimes, the governments are only compelled to make relatively minor concessions which don't alter the status quo of a commodified, private sector-dominated healthcare system.

During the Martial Law years, social movement-led and/or -influenced organizations engaged in direct action to supply health services that the government is unable too. Thus, rather than formulate a policy-laden counter-proposal to the healthcare status quo, most health service advocacy groups directly offered healthcare services while also providing a comprehensive critique of the social order which fails to mobilize State resources for healthcare and other services. The "nationwide movement" of community-based health programs (CBHPs), which missionaries initiated in 1975 (Khor & Lin, 2002), pre-dated the Alma Ata declaration by a few years. The CBHP scheme "does not provide the solution to health problems but assists and facilitates in laying the foundation of a health system that is governed by the people at the community level…through education, training and services. It is a method or process of giving or transferring knowledge, skills, and power to the people so that they become more responsible for their health. It strengthened the people's resolve to demand their basic right to good health. Therefore, the CBHP is a method of health-care development with and for the people at the community level**"** (Khor & Lin, 2002). CBHP proponents encouraged medical students and new medical program graduates to "immerse themselves in rural communities where the lack of medical services is most visible…" offering CBHP's non-traditional approach to healthcare which encompasses "organizing and enlightening communities to enable them to establish and run their own autonomous healthcare systems" rather than "simply providing medical services" (Quijano, 2002).

Tan (1993) identified "three parallel tracks" that "had emerged within the Philippine healthcare system by the end of the 1970s," including CBHPs, and described their main differences:

> On one hand, there were more health activist NGOs involved, mainly in establishing CBPHs, with emphasis on preventive health and a highly politicized health education program. This ran parallel to the government's public healthcare system, very much hospital-based and curative in orientation. The martial law period also saw the formation of large semi-government health foundations… In a sense, these

> foundations were the earliest of what was later to be called GONGOs (government organized NGOs).

He added that:

> The mainstream private sector, GONGOs and conservative NGOs formed a third track, cooperating to some extent with government and often hostile to the more radical NGOs. For example, many conservative Catholic bishops refused to allow CBPHs in their dioceses and joined the government in labeling these programs as subversive.

The difference in approach was further highlighted by the fact that:

> The CBHP also received lukewarm responses from the mainstream NGOs, particularly professional organizations. Besides the radical politics of the community programs, the concept of having peasants initiating medical treatment was unacceptable to many of these traditional groups. (Tan, 1993)

Influenced by CBHPs or directly engaged in CBHP programs, many doctors, medical students, and the like went to the countryside – including Dr. Bobby De La Paz (Quijano, 2002), who was assassinated under the Marcos regime – to help provide healthcare services within CBHPs' holistic approach to health and development which some elements in the said regime consider as subversive. De La Paz utilized the Primary Healthcare approach (which is in accordance with the Alma Ata Declaration), and "went to remote villages to attend to the sick, teach first aid, basic hygiene and nutrition to community health workers…used appropriate technology with herbal medicine and acupuncture, and even assembled an acupuncture oscillator made from local materials at minimal cost. The martial law regime took note of the couple's activities, and they were labelled as subversives…" (Bantayog Foundation, 2015). As "doctors of the people" true to the spirit of the CBHP, they "took the road less travelled and chose to help those severely neglected and largely ignored by the government" (Umil, 2020). Through this approach, De La Paz "…went to the people and lived with them, in the process witnessing the effects of an unjust system upon the health and lives of poor communities, especially the children…" (Bantayog Foundation, 2015). His social engagement as one "who chose to work in a remote militarised area of Samar Island with the rural poor, thereby sacrificing his life in the course of his clinical work to an unidentified military assailant" is internationally renowned (Claude, 1989). De La Paz's killing moved many doctors and faculty members of UP-College of Medicine – including Dr. Mita Pardo de Tavera who later became Department of Social Welfare and Development (DSWD) Secretary under the first Aquino presidency – to establish the Medical Action Group (MAG), which coordinated with the Free

Legal Assistance Group (FLAG) to provide legal and medical aid to victims of human rights violations, and eventually, in 1984, healthcare activists from UP help established Health Alliance for Democracy (HEAD), which built on MAG's objectives to also include raising the consciousness of those in the health community on realities of Philippine society and help organize them in support of "the national-democratic struggle" (Quijano, 2012). Such dynamism also partly explains the popularity of the communist insurgency during Martial Law and beyond, which, in contrast with the government's inability to provide social services, especially to rural areas, "helps the masses organise their co-operatives, provides them with political education and attends to their health problems" (Davis, 1989).

The CBHP movement's comprehensive approach to healthcare eventually found broader, multi-sectoral support through the left-wing umbrella group Bagong Alyansang Makabayan's (BAYAN/New Patriotic Alliance) founding declaration (1985), which subscribed to the idea that "it is the people's right to avail of social services that take care of their health, ensures employment, housing, social security, and education, simply put, services that respond to the people's basic needs." HEAD was in fact among BAYAN's founding organizations. At least one approved resolution in BAYAN's founding assembly – "Resolution on Genuine Agrarian Reform and Rural Development" – includes the advocacy to "ensure the timely provision, in a coordinated manner, of the full range of services, including…health and nutrition…at the local level," echoing CBHP's approach. In a separate General Program of Action (GPOA), BAYAN pledged to advocate for "…adequate social and public services of the same quality and quantity to rural and urban areas throughout the nation. Such services should include primary healthcare, water, education, housing, light and power, public transport and communications, social security, and recreational and leisure facilities." Such a comprehensive view of healthcare as a basic human right of every citizen, which must be upheld along with other essential socio-economic rights, is typical in many social movements' advocacies throughout history.

After the 1986 EDSA People Power I Uprising, inspired by the opening-up of the so-called "'new democratic space,' the health NGOs moved into advocacy and lobbying work. BUKAS (Bukluran para sa Kalusugan ng Sambayanan) was formally established in May 1986 following a series of 'snap symposia'…BUKAS framed an extensive 'Manifesto for People's Health' that called for reforms in the health sector, from a National Drug Policy to health financing schemes" (Tan, 1993). The campaign for a national drug policy helped gain momentum for the Generic Act, which helped lower the price of medicines in the country. The "Manifesto for People's Health" was considered a local contextualization of the Alma Ata Declaration's health as a human right, especially that it emphasized the need for state funding for primary care and the regulation of the pharmaceutical market (Hermansson, 1989).

Also, shortly after EDSA I, the first Aquino administration assembled the Constitutional Commission (ConCom), which became an arena for progressive ideas, including healthcare reform. Citizen-advocates of healthcare wrote letters to the ConCom to push for big ideas that aligned with social movement-led efforts for holistic social transformation and social services for all. The ConCom Proceedings cited Romulo P. Sandejas III's letter to the Committee on Human Resources "proposing free education and health service, among others"; a "(r)esolution of the Philippine Medical Women's Association, Inc., proposing the principle that it shall be the duty of the state to give free primary healthcare to its underprivileged citizens" (emphasis supplied); and Fidel R. Milan et al.'s letter to the Committee on General Provisions "requesting provisions on urban land reform, free hospitalization…" etc..

Meanwhile, the ConCom's Proposed Resolution No. 277 was entitled "Resolution to Incorporate in the New Constitution a Provision on a National Health Policy for a Comprehensive Healthcare Delivery System for the Entire country," and thus went beyond the Alma Ata Declaration's focus on primary healthcare. The said resolution was introduced by Delegate Minda Luz Quesada and two others. Quesada was a trained nurse by profession and way back in 1984 established the Alliance of Health Workers (AHW), in the same year HEAD was formed. In the ConCom deliberations, Quesada fought hard to enshrine healthcare in the Bill of Rights as a fundamental human right, explaining that "(o)ur personal experience shows that because of inadequacy or lack of social services, like health service, many people have been denied this right to life." Quesada failed in this particular fight, but her social movement-backed insights on a "comprehensive healthcare delivery system for the entire country" were nevertheless adopted and integrated into a particular segment for health in the 1987 Philippine Constitution (Sections 11-13 of Article XIII). Rather than a free healthcare system, the delegates settled for an "affordable" one, with the additional aspiration that "(t)he State shall endeavor to provide free medical care to paupers."

An advocacy pamphlet entitled "Policy Proposals on Agriculture and Countryside Development," impliedly written to influence the policy trajectories of the ConCom, (Kilusang Magbubukid ng Pilipinas/KMP/Peasant Movement of the Philippines, 1986) emphasized ensuring "the effective delivery to the rural population of appropriate health and nutrition services that are anchored on direct participation of the people in the planning, implementation, monitoring and evaluation of these programs," by strengthening "the primary healthcare concept as a basic thrust of the country's rural healthcare program," setting up and sustaining "community-based healthcare programs in the countryside that will integrate and further develop the indigenous yet scientific health practices and health resources of the rural communities" etc.

The push for healthcare for all citizens persisted (and somehow, also had a paradigm shift) even after the 1987 Philippine Constitution was ratified in a national plebiscite. BAYAN's "Deklarasyon ng Mga Prinsipyo at Ang Pangarap ng Isang Pambansang Demokratikong Lipunan"/"Declaration of Principles and Our Aspiration for a National Democratic Society" (c.1987) contains the following healthcare advocacy: "The State must ensure effective and sufficient delivery of basic social services. Be it free or affordable, the provision of ample and suitable health and medical services must be ensured." Partido ng Bayan/PnB (literally, People's Party), a left-wing party established in 1987 by BAYAN-affiliated forces, released an updated "Vision and Program of Government" in 1991, expressing its plan to "provide free primary healthcare and socialized forms of medical services and hospitalization."

Meanwhile, HEAD and other organizations formed the Network Opposed to Privatization (NOP) and "led the protests against government's (hospital privatization) plans" (Nandi et al., 2020) in 1998. In the said launch, the Council for Health and Development (CHD) presented a statement which became the de facto founding manifesto of the NOP, asserting that health is "a basic human right. It is primarily the responsibility of the government to ensure accessible and affordable healthcare for all, especially for the majority of Filipinos who are living in extreme poverty," emphasizing that "(p)rivatization is government's way of shirking its responsibility to the people; and it has the gall to pass on to others (like NGOs, churches and private groups) what it does not have the political will to do..." and calling upon the Filipino people to "reject all moves of the government to privatize healthcare" and "fight for our right to affordable and accessible health services," among other things (NOP, n.d.). In 2007, the NOP along with health sector associations and unions filed a Supreme Court petition to stop "the collection of socialized user fees and the corporate restructuring of government hospitals" under the Philippine government's HSRA. The NOP was relaunched as the Network Opposed to Privatization of Public Hospitals and Health Services in 2012 (All UP Workers' Union, 2012).

In 2000, the People's Health Movement Philippines was launched, with organizational members that include HEAD and AHW, "pursuing the vision of the People's Charter for Health" through initiating and supporting "various campaigns such as the revitalization of primary healthcare; increased access to essential and low cost quality medicines" and opposing the "privatization of health services." The said charter emphasized that the Alma Ata Declaration's "Health for All by 2000" remains unrealized in many countries and thus opposed "international and national policies that privatise healthcare and turn it into a commodity," demanded "that governments promote, finance, and provide comprehensive Primary Healthcare as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access," called upon "governments to adopt, implement and enforce national health and drugs policies," and demanded "that governments oppose the privatisation of public health services and ensure effective regulation of the private medical

sector, including charitable and NGO medical services" (People's Health Movement, 2000) among other things.

Meanwhile, a founding document of the Makabayang Koalisyon ng mga Mamamayan (Nationalist Coalition of Citizens) or Makabayan Coalition/Bloc (2009) — the ideological inheritor of PnB — emphasized affordability of social services as a means of lifting "the majority from poverty," and asserts that the demands of the people should be fulfilled, including "...a more advanced and affordable services in public education, health, housing, water, and electricity..." In 2014, Makabayan Bloc legislators joined the NOP and dozens of similar organizations in filing a Supreme Court petition to stop the privatization or commercialization of the Philippine Orthopedic Center. The petition's "prefatory" asserts that it is the State's responsibility

> to provide and ensure a basic social service such as health based on the people's constitutional right to health and to free medical care and access to affordable health services. Such duty should not be relinquished to a private entity through privatization or commercialization of a government hospital to the prejudice of the poor and underprivileged.

It also asserted that "the right to health, right to access to affordable health services, and right to free medical care are legally demandable rights." In 2015, Makabayan Bloc's official declaration of endorsement for the presidential and vice-presidential ticket of Grace Poe and Chiz Escudero pointed out their pledge to "increase the budget and expand the system of public education, hospitals, health centers, and housing..." Poe and Escudero's signed response to the endorsement (2015) provided details of such healthcare policy:

> The health of everyone is important. A person's family must not become bankrupt because of his/her sickness. They should not be made to choose between eating and buying medicines for a sick loved one. Public hospitals must be increased and strengthened. There should be health centers in all communities, and sufficient medicines, doctors, nurses, and midwives should be ensured. The policy of commercialization and privatization of public hospitals must be reviewed. Healthcare services are not a privilege for those who have money, but a right that must be enjoyed by everyone in society.

Another left-wing party, Akbayan Citizens' Action Party/Akbayan Party-list (n.d.) criticizes "the dominance of a market-oriented framework" in Philippine healthcare and "asserts that public health is not a question of market imperatives or trade, where profit dictates over human development and social equity. Our agenda is to put public health back in the realm of basic rights and human dignity. The right to health...is as inalienable as

the right to life." The said party did not directly call for free healthcare but put "focus on the following areas: overhauling the neoliberal framework in Philippine healthcare system and pushing for greater State responsibility; addressing flaws in the devolution of health service; and attending to a myriad of issues, such as labor migration policies, population growth and the well-being of mothers and children, access to essential medicines, prevention through effective community-based and primary healthcare, reproductive health, corruption and patronage in healthcare, and patient's rights." Makabayan Bloc's advocacy, coupled with Akbayan's eventual role as a junior coalition partner of the second Aquino presidency (Juliano, 2015), arguably partly aided (if not compelled) the latter's pioneering adoption of the "universal healthcare" framework, albeit, in a limited manner constrained by public-private partnership schemes which essentially allow (if not encourage) the continuous involvement of profit-oriented firms in the healthcare sector. The popularity of the universal healthcare framework is proven by Risa Hontiveros' successful senatorial win in 2016, which definitely rode on her clear advocacy for universal healthcare (Geronimo, 2016; Lim, 2016). Before she was elected as senator, Hontiveros was an Akbayan representative in Congress and was also later appointed by the second Aquino administration to PhilHealth.

In 2017, the National Anti-Poverty Commission (NAPC) headed by Liza Maza, a Makabayan Bloc stalwart, released the "Kilos Sambayanan (People Act) Primer," which was drafted through consultative, multi-sectoral assemblies. The said primer pushed for the fulfillment of 10 basic needs (including health services), as a "call for convergence of all sectors in society, inside and outside government, to create the movement against poverty" that would ensure the right to "highest possible standard of health" in a country where 93 million citizens (92%) are covered by the National Health Insurance Program in 2015, "inching towards the desired goal of universal health insurance coverage though out-of-pocket costs still amount to 55.8%." The same primer also called for further state investments in the healthcare system to reverse the prospective privatization of 70 public hospitals, a policy which was initiated under the second Aquino administration. Furthermore, the said primer emphasized that it is the government's obligation "to ensure that everyone enjoys suitable and affordable healthcare, including other essential needs for good health such as sufficient food, safe drinking water, and a clean environment." Maza's Makabayan Bloc colleagues in Congress initially supported an early version of House Bill 5784 (what eventually was passed as the Universal Health Care Act/UHCA) but they withdrew their co-authorship of the final bill because it "is not in consonance with our position that free healthcare and a unified public healthcare should directly be funded by the government through public hospitals… the bill pushes for the privatization and commercialization of the healthcare system," and will "reduce the funding of public hospitals, allowing private facilities to dominate the healthcare system," in which the government will merely become a "collector of contributions" rather than a "primary funder" of public healthcare (Cupin, 2017).

Makabayan Bloc's earliest legislative advocacy for free healthcare based on the House of Representatives' online archives was in 2009 – under the 14th Congress – when Bayan Muna Rep. Satur Ocampo filed House Bill 5831 ("AN ACT AMENDING SECTION 4 (e) OF REPUBLIC ACT 7432, OTHERWISE KNOWN AS THE SENIOR CITIZENS ACT OF 1992, AS AMENDED, GRANTING FREE HOSPITALIZATION TO SENIOR CITIZENS IN ANY GOVERNMENT HOSPITAL"). A substitute bill was eventually passed as R.A. 9994 in 2010, but it included only discounted rates for healthcare treatment of senior citizens, rather than 100% free healthcare. Representatives of the Makabayan Bloc also filed succeeding bills very similar to House Bill 5831, still focusing on directly providing free hospitalization for indigent senior citizens in any public hospital (such as House Bill 4712 in 2011 and House Bill 3461 in 2013), but such bills gained no ground in Congress. In 2016, the Makabayan Bloc also filed House Bill 2475 ("AN ACT PROHIBITING THE PRIVATIZATION AND CORPORATIZATION OF PUBLIC HOSPITALS, PUBLIC HEALTH FACILITIES AND PUBLIC HEALTH SERVICES"), which gained support in Congress through a substitute bill, House Bill 7437, which was filed in 2018 and passed by the House of Representatives on the same year. Health advocacy groups like AHW (2017) also support that initiative asserting "that public hospitals, public health facilities and public health services from the barangay to the national level should not be privatized..." and "that public healthcare system from the barangay level to the public hospitals should be modernized and developed and be given free to the public. This should be tax-based and not open for private partnership."

In 2019, under the 18th Congress, the Makabayan Bloc filed a more encompassing bill – which could have been a good starting point for a broader publicly-funded and public sector-dominated universal healthcare system – House Bill 224 ("AN ACT PROVIDING FOR FREE HEALTH SERVICES TO ALL FILIPINOS IN ALL GOVERNMENT HOSPITALS, TREATMENT REHABILITATION CENTERS AND SANITARIA, RURAL HEALTH UNITS, AND BARANGAY HEALTH CENTERS). The said bill garnered just one co-author outside their bloc, and eventually, the UHCA – which somehow fulfilled Makabayan Bloc's advocacy for free public healthcare services in public hospitals (although limited to basic or ward accommodations), but which they rightfully criticized as a law that still allows (if not expands) private sector dominance in the healthcare system – was passed. Similarly, the People's Health Movement Philippines opposes UHCA as its provisions can set "limits for insurance claims..." which "will mean more out-of-pocket spending, more commercialized and privatized healthcare," thus, in lieu of the UHCA, they instead propose "...a free, comprehensive, progressive and unified public healthcare system that is tax-based and anchored on the principle of health as a fundamental human right" (De La Paz, 2019). Another organization, HEAD (2020), labeled UHCA as a "neoliberal program" which intends to hike PhilHealth premium rates, fails to resolve backlogs in the number of healthcare personnel and public healthcare facilities, and that "worsens the commercialization of the health system...where big capitalists...benefit more" through profit accumulation in exchange for health services. Their description of the

UHCA as a neoliberal scheme suits some scholars' characterization of the Duterte regime as an essentially neoliberal one (Lindio-McGovern, 2020; Ramos, 2021). As an alternative to the UHCA, HEAD (2020) wants expansion of the public healthcare system through directly increasing the government's expenditure for public healthcare facilities rather than for or via subsidizing PhilHealth. Meanwhile, Akbayan legislators supported and lauded the passage of UHCA (Hontiveros, 2019; Reganit, 2019). Describing herself as an Akbayan senator, Hontiveros (2019) – a co-sponsor of UHCA – praised the measure as a "key milestone in efforts to make the country's health services equally accessible, effective, and affordable for all Filipinos." Nevertheless, the principled opposition to UHCA – premised on the assertion that it is not good enough in limiting if not totally wiping out healthcare commodification – persisted and even seems to have been revitalized by the COVID-19 pandemic that has exposed the weaknesses of the public healthcare system and the inequities of UHCA-era healthcare (Martinez, 2020; Bekema, 2021).

In April 2020, a citizen-initiated change.org petition to stop PhilHealth's mandatory collection of premiums from Overseas Filipino Workers (OFWs)—a new policy explicitly contained in Section 4(f) and Section 10 of the UHCA—went viral, reaching around 300,000 signatures in a few days (Rappler, 2020) and close to 465,000 signatures as of this writing. Due to such public pressure, then President Duterte was forced to temporarily stop PhilHealth from collecting these premiums from migrant workers. The suspension of this collection still stands as of this writing.

Upping the ante for broader healthcare reform, in September 2020, HEAD and other allied organizations initiated a petition entitled "Philhealth, not a solution. Demand for Genuine Free Healthcare Services for the People!" (HEAD, 2020). The statement cited DOH's National Objectives for Health 2017–2020 and pointed out that:

> "PhilHealth's services account only for 16.7%, while out-of-pocket spending constitutes the biggest share—52.2%—of the country's total health expenditure from the period 2012–2016. Filipinos from many rural communities have yet to see a health worker, let alone a health center, and seven out of ten Filipinos still die without ever seeing a health professional."

It concluded with calls such as:

> "Abolish PhilHealth, and allocate its funds directly to public health, state-run hospitals, and health facilities. With bigger and better funding, public health facilities can have more complete medical supplies, medicines, and equipment. Barangay and rural health centers can provide free and quality outpatient services, while larger facilities like hospitals will have better and more complete diagnostic and therapeutic

> capabilities; develop and strengthen the public healthcare system that is integrated, tax-funded, and that provides free and comprehensive healthcare; develop a healthcare system that is centrally planned and anchored on a social orientation with its basic principle of health as a right."

In February 2021, various NGOs, including the liberal-leaning think tank Stratbase ADR Institute for Strategic and International Studies (Calayag, 2021), launched the broad group UHC Watch through a Manifesto for Universal Healthcare in the Philippines (UHC Watch, 2021). The said manifesto seemed to echo HEAD's concluding calls, albeit in a milder tone and short of calling for the abolition of PhilHealth:

> As infections continue to spread plus the absence of universal healthcare coverage, access to reliable and affordable medical and health services is a daily challenge faced by a vast majority of Filipinos… We appeal to the Government to prioritize the implementation of the Universal Healthcare Law, together with other health laws, and allocate adequate resources for their operationalization… We call for urgent improvement of the public health system and adopt measures that will ensure inclusive, accessible, adequate, and timely quality health services – especially for the most vulnerable and marginalized sectors of society (women, children, elderly, indigenous peoples, persons with disabilities, and those with chronic illnesses)… We demand for a transparent and accountable public health system. (UHC Watch, 2021)

In 2021, Laban ng Masa (LnM), another left-leaning coalition distinct from both the Makabayan Bloc and Akbayan, released a comprehensive 25-point agenda for the 2022 elections on its website, covering "COVID-19 AND HEALTHCARE," where the following items were tackled:

> Disband the useless Inter-Agency Task Force on COVID-19 (IATF) and form a new cohesive body that is led by proven medical professionals who will actively solicit popular participation in the formulation of pandemic plan to provide free, rapid, and comprehensive testing, vaccination, and medical treatment for all. Create a COVID-19 Economic Fund that aims to provide direct, emergency support to every person in the Philippines. Enact an ambitious universal healthcare program founded on the principles of accessibility, wide coverage, and guaranteeing the right of every Filipino to healthcare, not profit. Significantly raise the salaries of public healthcare providers in recognition of their important role in protecting our society. Dramatically improve the access of Filipinos to dental care, mental health, neglected tropical diseases, and other unaddressed health issues. (emphasis supplied)

A version of the said manifesto published by the Inquirer (2021) was more direct, from a policy perspective:

> From the proceeds of the wealth tax and the debt cancellation, increase funds for vaccine purchases, institute a universal basic income of 1,500 a day for each family, fund a universal healthcare program delivering quality, preventive care for free... (emphasis supplied)

Before this recent intervention, LnM, along with Sanlakas, an LnM-allied left-wing formation that used to have a partylist representative in Congress (1998–2001 & 2001–2004), had no publicly available stance (or statement) on UHCA.

In the same year, under the 18th Congress, the Makabayan Bloc filed House Bill 9515 (“AN ACT PROVIDING FOR A FREE, COMPREHENSIVE, AND PROGRESSIVE, NATIONAL PUBLIC Healthcare SYSTEM”). This is the most comprehensive healthcare reform legislation so far, since the UHCA (and if the UHCA is excluded, this bill is arguably the only comprehensive healthcare legislation from a social movement-backed party-list grouping at this point). The breadth and depth of this bill is a testament to how far the country’s healthcare reform agenda has gone from (see Table 1) the days of merely aspiring for healthcare for all with no clear timetable, to dreaming of a healthcare system that is free for all, with no co-payments whatsoever.

Table 1

Summary of Social Movements' Health Policy Advocacies & Notable Paradigm Shifts in the Philippines

Social Movements with Health Policy Advocacies	Main Advocacies	Administration	State Response/s	Notable Paradigm Shift
NGOs' CBHPs	• Providing basic healthcare services & health literacy • Direct stakeholders' engagement in establishing and running CBHPs • Political Education and Mobilization	Marcos	Medicare Act (contribution-funded public health insurance; compulsory for employed, voluntary for those not employed)	Health for all as an aspiration
BUKAS BAYAN KMP	• Cheaper medicines • Bigger state funding for primary healthcare • Free or affordable comprehensive healthcare for all • Sustaining CBHPs	C. Aquino	Generics Act of 1988 Local Government Code of 1991 (covers healthcare)	Devolution of healthcare to LGUs Regulation of medicine price through cheaper generic medicines
PnB	• Free primary healthcare and socialized forms of medical services and hospitalization	Ramos	PhilHealth Organic Act	Timetable for healthcare for all
People's Health Movement	• Anti-privatization • Free comprehensive primary healthcare	Estrada	Health Sector Reform Agenda	Greater coverage of the National Health Insurance Program

Social Movements with Health Policy Advocacies	Main Advocacies	Administration	State Response/s	Notable Paradigm Shift
Makabayan	• Affordable healthcare • Free public hospitalization for senior citizens	Macapagal-Arroyo	RA 9994 (discount for medical services for senior citizens) Cheaper Medicines Law	Healthcare Discount for Senior Citizens Regulation of medicine price through cheaper generic medicines
Akbayan Makabayan	• Expanded state-funded healthcare • Free public hospitalization for indigent senior citizens • Anti-privatization	B. Aquino	Administrative Order for a Universal Healthcare Plan	Universal health coverage for the poorest
KILOS SAMBAYANAN LnM Makabayan	• Free healthcare • Tax-funded free healthcare • Free public hospitalization for all citizens • Tax-funded free healthcare	Duterte	UHCA	Zero co-payments for the poorest (No Balance Billing); Automatic public insurance coverage for all Snowballing support for free, tax-funded healthcare for all Legislative advocacy for renationalization (reversal of devolution to LGUs) and against privatization

Note. Author's summary of the current review.

In sum, social movements in the Philippines emphasize universal access to healthcare then and now – the concept that healthcare is a right, a state responsibility, rather than a commodity. Hence, social movements advocate making healthcare free, or at least, affordable for all & free for the poorest. In most cases, throughout history, Philippine social movements tackle healthcare as an essential component of sweeping and comprehensive socio-economic reforms for which they mobilize their forces and intend to muster public support. Usually, social movements link healthcare services to other basic social services such as education and housing. Little by little, social movements were able to push for healthcare reforms, which have compelled the Philippine state from merely aspiring for healthcare for all in the 1970s, to making membership in the public insurance system automatic, and even free (state-funded) for the poorest segments of the population, just one step short of making it free for everyone, which is what House Bill 9515 intends to do. As a review of the origins of the concept of UHC emphasizes, UHC is a political struggle that is waged and won by mostly left-wing parties (Greer & Méndez, 2015), backed by and/or having roots in robust social movements.

Breadth and Depth of Healthcare Reform Under House Bill 9515

House Bill 9515 intends to remake the country's healthcare system away from commodification and privatization, closer to a genuinely universal healthcare system where tax-funded free health services – with no OOPPs – are available at least in public healthcare facilities (see Table 2). The most far-reaching reforms that House Bill 9515 intends to achieve include the following: 1) instituting tax revenues as the sole source of funds for the public healthcare system thereby abolishing PhilHealth and doing away with mandatory contributions (Section 6; Section 32-33); 2) free healthcare in public health facilities (including free medicines) with no OOPPs (Section 6); 3) free oral and dental healthcare services in all facilities (Section 13); 4) renationalization of health services or the reversal of healthcare devolution to LGUs (Section 18); 5) setting minimum number of (and standards for) public healthcare facilities from the barangay to the national levels (Section 23); 6) prohibition of privatization (Section 34); and 6) tax holidays and incentives for local private hospitals in areas where there are no public facilities (Section 39).

Table 2

Comparison of Elements and Indicators of Health Financing Mechanisms Under UHCA and House Bill 9515

Elements in the framework	Indicators (UHCA/Status Quo)	Indicators (House Bill 9515)
Revenue raising	• Government revenues (taxes, mandatory contributions, & other revenues) • Out-of-pocket	• Government revenues (taxes) • Out-of-pocket
Pooling	• Single pool (PhilHealth) • Continuing presence of private health insurance	• Single pool (directly tax-funded; PhilHealth is abolished) • Continuing presence of private health insurance, albeit, subject to regulation
Purchasing	• Public, private, and mixed providers (private sector is dominant, in general) • Payments/reimbursements capped at case rates, beyond which OOPPs are collectible	Transition to a public sector-dominant system • Full cost of treatment in public facilities is shouldered by the state; OOPPs are technically still collectible in private ones
Benefits	• Capped at case rates	• No cap for public facilities
Financial protection	• Continuing out of pocket payments (OOPPs)	• Theoretically minimal out of pocket payments (OOPPs)

Note. Indicators used for applying the framework of McIntyre & Kutzin (2016), adopted from (Myint et al., 2019), with the current researcher's modifications.

At the outset, abolishing PhilHealth would seem a very drastic idea, but its dire financial situation may convince even non-radicals that it has outlived its usefulness. In 2021, a PhilHealth executive told a congressional hearing that PhilHealth actuarial life could last up to 2027 only (Cahiles, 2021), unless government subsidy for PhilHealth is increased and/or premium contributions are hiked. Indeed, the pandemic has drastically affected both premium contributions from voluntary members and even compulsory members (especially since the government has allowed OFWs to make voluntary payments, rather than mandatory ones, at least during the pandemic), and has also raised expenses for claims or reimbursements due to the ever-increasing number of COVID-19 cases. Hence, PhilHealth's abolition could even be viewed as a cost-effective measure of terminating the operations of an inefficient agency. Such abolition would instantly free up billions of pesos in operating

expenses: PhilHealth's 2019 "total operating expenses" is pegged at 12,948,749,363 pesos (latest available). In the same year, PhilHealth's collection efficiency rate is at 79% only, which, while numerically better than in recent years, remains far from the ideal 100%, especially since premium contributions are automatically deducted monthly from the salaries of those in the formal sector (private and public employees). There is simply no reason to tolerate a collection efficiency rating below 100%. PhilHealth is also partly faulted by the Commission on Audit (COA, 2021) for the "all case rate payment scheme" which had "sped up (the) reimbursement process but lacked control mechanisms to detect and prevent improper payments" Thus, in abolishing PhilHealth, the savings can instantly be rechanneled to the public healthcare system and the government's huge subsidies (which PhilHealth enjoys then and now) could also be utilized to expand the public healthcare system. For example, just in 2020, the government funneled subsidies amounting to 63,425,436,284 pesos to PhilHealth. Allotting such subsidies to the public healthcare system is more efficient than retaining it as a subsidy for PhilHealth, which in turn spends a huge portion of it for reimbursements to private healthcare facilities, where its support value is less maximized compared to public facilities (see Tables 3 & 4).

Table 3

PhilHealth's National Average Support Value in Various Private Healthcare Facilities (2017)

Member Category	Private Facility Type														
	Level 1			Level 2			Level 3			MCP (Maternal Care Package) Provider			Infirmary/Dispensary		
	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support
National	63%	52%	53%	48%	41%	42%	40%	35%	36%	99%	72%	73%	71%	57%	58%

Legend: USV – Unadjusted Support Value; ASV – Adjusted Support Value
Note. Data from author's FOI request #PH-435443369785. Figures were rounded off.

Table 4

PhilHealth's National Average Support Value in Various Government/ Public Healthcare Facilities (2017)

Member Category	Government Facility Type														
	Level 1			Level 2			Level 3			MCP (Maternal Care Package) Provider			Infirmary/Dispensary		
	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other sup-port	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support	USV	ASV w/o other support	ASV w/ other support
National	84%	66%	67%	74%	59%	60%	71%	56%	57%	99%	72%	73%	85%	67%	68%

Legend: USV – Unadjusted Support Value; ASV – Adjusted Support Value
Note. Data from author's FOI request #PH-435443369785. Figures were rounded off.

House Bill 9515 has one possible immediate drawback: its provision of doing away with the premium contributions, for which the total collected from direct contributors amounts to a whopping 85,569,185,891 pesos in 2020. Admittedly, such abolition of premium contributions will instantly provide additional savings for those who are employed. In lieu of premium contributions, the bill provides for alternative sources of funding for the public healthcare system, such as sin tax revenues, PAGCOR revenues, etc. (Section 33). Laban ng Masa's wealth tax-for-health-care advocacy could help fine-tune and bolster such provision, and ensure that there will be enough funds for the swift expansion of the public healthcare system. Similarly, in the UK, Labour Party-affiliated members of parliament (MPs) call "for a progressive tax on those with assets worth over £5 million" to fund healthcare, in lieu of a national insurance rate hike (Trinder, 2021), a policy also backed by senior Labour Party figures (Helm & Inman, 2021). Back in the Philippines, in the first year of the pandemic, IBON Foundation has also reiterated its call for the imposition of "(a) wealth tax of 1% on wealth above Php1 billion, 2% on wealth above Php2 billion, and 3% over Php3 billion..." which "...will raise Php236.7 billion annually just from the 50 richest Filipinos alone who by any standard are those who can best afford to pay much higher taxes" (Africa, 2020). Another advocacy group, the Freedom from Debt Coalition, also campaigns for a wealth tax in the Philippines (Rivas, 2021), and at least one economist, UP Prof. Solita Collas-Monsod (2021), also favors such a wealth tax.

House Bill 9515's focus on strengthening the public healthcare system is a big leap from past schemes (including the UHCA) that do not explicitly ban privatization and instead even emphasize public-private partnerships, which the bill considers as a form of privatization. This is also the culmination of the decades-long fight of social movements against the piecemeal privatization of aspects of Philippine healthcare, including the presence of private clinics inside government healthcare facilities, for example. In including free oral/dental healthcare, the bill also outdoes the UHCA (which does not provide PhilHealth coverage for oral/dental health services). Mendoza et al.'s recent policy analysis (2020) points out that "(o) utpatient dental health services, which comprise the majority of availed oral health services, are not covered by PhilHealth benefits." Thus, similar to House Bill 9515's advocacy for free oral/dental healthcare, they recommend that PhilHealth consider covering "public oral health services…The dental health team may be compensated for services rendered. This could be an encouragement for dental professionals to be in the public health sector as financial benefits can complement the services they render to the public."

The bill would also want to renationalize currently devolved aspects of healthcare, after decades of a somehow failed devolution process. Its explanatory note remarks that "(t)he system of devolution has done little to address the widening inequalities in access to healthcare in our population," and that "(g)iven the inequitable distribution of health workforce and services…increased development is needed in the countryside where majority of the population are underserved." Related to health equity, a loyal Duterte ally, Sen. Christopher "Bong" Go (2021), current chairperson of the Senate Committee on Health, supports renationalizing a number of local hospitals, pointing out that "we cannot just pass on the cudgels to LGUs at this time especially amid an ongoing pandemic when resources are already scarce. National government must step in…" An early assessment (Grundy et al., 2003) gives evidence that:

> (s)ubsequent to the introduction of devolution, quality and coverage of health services declined in some locations, particularly in rural and remote areas. It was found that in 1992-1997, system effects included a breakdown in management systems between levels of government, declining utilization particularly in the hospital sector, poor staff morale, a decline in maintenance of infrastructure, and underfinancing of operational costs of services. Decentralization aims to widen the decision-making space of middle-level managers, enhance resource allocations from central to peripheral areas, and improve the efficiency and effectiveness of health services management. The findings of the historical review of devolution in the Philippines reveal some consistencies with the international literature, which describe some negative effects of decentralization…

Despite such findings, Grundy et al. (2003) suggested “undertaking a second wave of reform in order to ‘make devolution work.’” Meanwhile, Cuenca (2018) pointed out that devolution has also weak spots in a developing country context, though there are local government units (LGUs) whose positive devolution experiences could become role models for others, and thus opts for a system in which “public health can be a shared responsibility of both national and local government.”

Despite the bill’s far-reaching objectives, however, it still allows private healthcare facilities and health maintenance organizations (HMOs) or private insurance to exist subject to State regulations, thereby leaving some space for the continuous commodification of healthcare, at least in private facilities where OOPPs would certainly be required for most types of treatment (especially after PhilHealth is abolished). Arguably, such reality will not matter if the bill succeeds in expanding the public healthcare system (Section 6 and Section 23) and if the sources of tax revenues listed for the law’s appropriations are retained and even increased (Section 33), as most citizens would theoretically be accommodated in public healthcare facilities where services would become totally free as per the bill’s provisions, and most private hospitals – especially profit-oriented ones – would either go out of business or operate as charitable institutions. However, the 3-month period after the bill’s passage – during which PhilHealth will be abolished (and consequently, government spending for citizen’s availment of private healthcare would instantly be stopped) – could be too short a time to immediately fill the gaps in the public healthcare system and swiftly transition to a system where majority of the citizens will prefer to seek treatment in (and would be accommodated by) public healthcare facilities. Even assuming that the necessary funding for such expansion of public healthcare is fully secured through tax revenues, some aspects of expansion such as putting up additional buildings and hospital beds and ordering imported state-of-the-art medical technologies (not to mention the mass hiring of additional personnel for public facilities in anticipation for an increase in demand) would take longer than 3 months to accomplish. Hence, the transition period should either be extended by a year or two (even 10 years, if necessary), during which PhilHealth would still be allowed to partly shoulder the cost of treatment in selected private hospitals. If such a period is extended, the bill should also include a provision on possibly regulating (towards lowering) the cost of treatment in private hospitals, while ensuring that “reimbursement rates approach the true cost of providing care efficiently in the private sector…” (Dayrit et al., 2018) so as to eventually stop private hospitals from asking patients to cough up OOPPs.

House Bill 9515’s provisions would make the Philippine healthcare system closer to both the UK and Cuban models (see Table 5). Government expenditure on healthcare will be increased through tax revenues. With regard to financing healthcare, the bill’s provisions are more like those of the Cuban model (fully tax-funded), in contrast with the Philippine status

quo and the UK system (both partly funded by mandatory national insurance contributions). More recently, the Conservative UK government has passed legislation to increase the national insurance payment by 1.25 percentage points (Alegretti, 2021). Thus, House Bill 9515 would make public healthcare in the Philippines even more progressive than that of the UK's NHS, at least from the viewpoint of taxpayers. Furthermore, out-of-pocket payments under the bill would be zero, except in private healthcare facilities. Operations and "essential and lifesaving" medicines are now also covered. Moreover, even oral/dental healthcare is to be free of charge. In general, House Bill 9515 concretizes the social movement-backed call for free, comprehensive, public healthcare, which has spanned decades now.

Table 5

Illustrative Comparison of the Healthcare Systems of the Philippines, UK, & Cuba

Country	Government Expenditure on Health	Out-of-pocket payments (OOPPs)	Medicines (Prescription Drugs)	Total Hip Replacement	Oral/Dental Health
Philippines (status quo	Low	Big	Not free; Free essential medicines available thru some LGUs; Subsidized medicines (30 drugs) also available to certain sectors 48.5% of OOPPs spent for "drugs, neutraceuticals and medical products" Drug prices historically high (especially when compared with India & Pakistan)	Free for "indigent, sponsored, and kasambahay members"; With "negotiated fixed co-pay" (OOPPs) "for all other eligible members and their qualified dependents," for expenses beyond 103,400.00 pesos (for members who are 66 years old & above); and beyond 160,400 pesos (for members who are 65 years and 364 days old and below)	Partially covered

Country	Government Expenditure on Health	Out-of-pocket payments (OOPPs)	Medicines (Prescription Drugs)	Total Hip Replacement	Oral/Dental Health
Philippines (under House Bill 9515)	High	Zero in public healthcare facilities. Status quo (possibly still big OOPPs in the short term; theoretically could be reduced in the long term) in private hospitals.	Free in public healthcare facilities	Free in public healthcare facilities Government subsidy for private healthcare (PhilHealth coverage) would be stopped, hence, possibly high OOPPs in private health facilties	Covered
UK	High	Small	Free/no charge in Scotland, Wales, & Northern Ireland; Minimal charge in England (£9.35 or 632 pesos per item) but 90% of items are still free of charge	Free	Covered

Country	Government Expenditure on Health	Out-of-pocket payments (OOPPs)	Medicines (Prescription Drugs)	Total Hip Replacement	Oral/Dental Health
Cuba	High	Small	Focus is on preventive healthcare; Prescription drugs for hospitalized patients, free; Shortage of medicines documented in recent years List of subsidized drugs (162 items) retained	Free	Covered

Note. Data from: DOH (n.d.); Picazo, 2012; Dayrit et al., 2018; BBC, 2011; teleSUR, 2020; Ulep & De La Cruz, 2013; PhilHealth, 2014; Cylus et al., 2015; Spiegel & Yassi (2004); Riera (2006); NHS Business Services Authority (n.d.).

However, since the bill abolishes PhilHealth, subsidies for treatment in private facilities would be stopped. Thus, in the short term, this may mean big (or even higher) OOPPs in private facilities, except in areas where the private facilities will be given tax incentives, pending the establishment of public ones. This is a pragmatic approach that will ensure no areas are left unserved by healthcare facilities. In the long term, as the public healthcare system is meant to be expanded and strengthened by House Bill 9515, private healthcare facilities could be compelled to reduce OOPPs to still attract patients, function as charitable institutions or donor-funded foundations, or stay out of business.

In remaking the Philippine healthcare system, the country has the opportunity to learn from the experiences of both Cuba and the UK, which at this point, despite funding problems, still offer free healthcare for all, and, at least before the pandemic, can still boast of better health outcomes which the Philippines can only aspire for. The Philippines should ensure that funding problems would not hamper the swift establishment and strengthening of a robust and free public healthcare system. In Cuba's case, it is impossible to gain a valuable insight on financing (except for the fact that a developing country, with a GDP smaller

than the Philippines', can choose to prioritize healthcare and reap good health outcomes for its citizens, despite perennial problems ranging from medical supply shortages to inability to upgrade infrastructure), as their financial problems are a result of a long-term external factor (the US-led economic blockade) which instantly ties its hands on most economic matters. Considering that the Philippines has no such externally induced financial difficulties, the Philippines could easily start providing more budget for public healthcare if its government chooses to do so. Meanwhile, the UK's experiences point to the importance of consistent funding/state investment in healthcare and caution against piecemeal privatization (and hence, commodification) of the public healthcare system.

The Royal College of Physicians' report, Underfunded. Underdoctored. Overstretched. The NHS in 2016, says it all: "The NHS budget has not kept pace with rising demand for services. We need a new NHS budget that: meets the demand for health services; sets realistic targets for efficiency savings; protects funds for transformation; invests in the long-term sustainability of the NHS." Robinson (2002) notes that the NHS has been underfunded for "the past 20 years." More recently, the NHS Support Federation (2020) reveals that:

> "(t)he NHS has experienced a decade of underfunding since 2010, despite cash boosts in 2018 and 2019. Between 2009–2019, the NHS budgets rose on average just 1.4% per year, compared to 3.7% average rises since the NHS was established. The whole NHS budget has not been protected and the result is cuts to frontline services, especially in public health. (n)early half of staff say underfunding stops them doing their job properly—many say it is the worst situation they have seen. There is a crisis in the recruitment of staff across the NHS—including too few doctors, midwives, paramedics, and nurses. Per head, the government spends less on the NHS than many other comparable countries. We have less beds and doctors per head than many comparable countries. Large cuts to social care and mental health have added huge pressure on the NHS, as there are not enough services outside of hospitals."

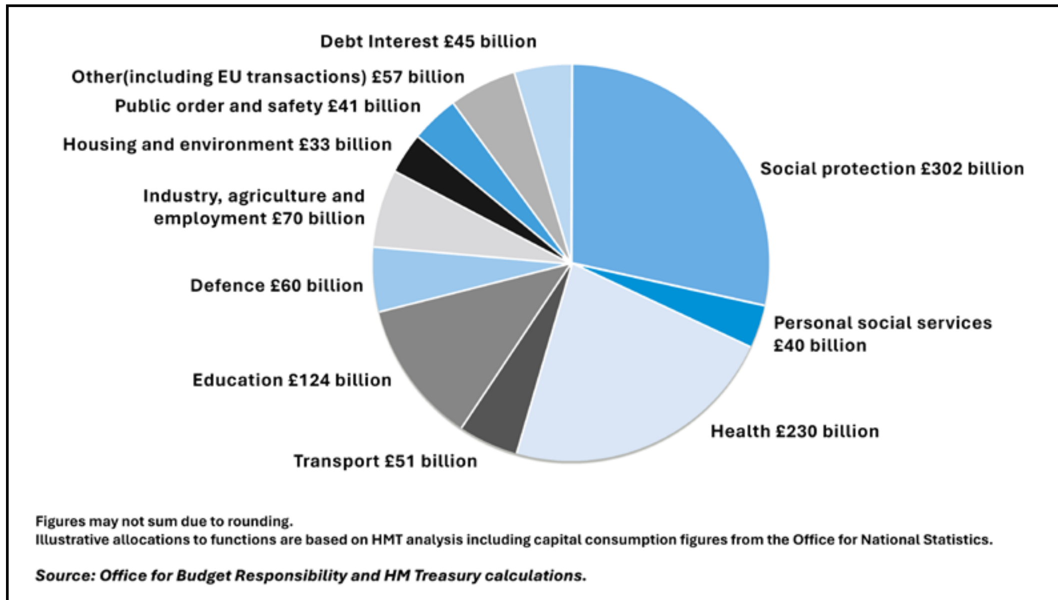
Within this context, underfunding has clearly partly caused

> "...the worst performance against waiting times targets since the targets were set. This includes the highest proportion of people waiting more than four hours in A&E departments since 2004, and the highest proportion of people waiting over 18 weeks for non-urgent (but essential) hospital treatment since 2008...survey evidence suggests more people are experiencing lengthening delays in getting GP appointments" (Thorlby et al., 2019).

Thus, it must be emphasized that the UK NHS could have achieved way more if its underfunding had been reversed, and even with perennial underfunding, it was able to provide far better services than what the Philippine healthcare system offers. Proposed 2022 national budgets for the UK (Figure 2) and the Philippines (Figure 3) show how much the latter would have to learn from the former to establish a fully functioning free healthcare system. Notice that the UK's spending for healthcare dwarfs its defense spending, while in the Philippines, defense expenditure is bigger than the health department budget. Passing House Bill 9515 without drastically increasing Philippine state spending on healthcare would mean that the country may face long queues in the public healthcare system, possibly worse than what the UK now experiences.

Figure 2

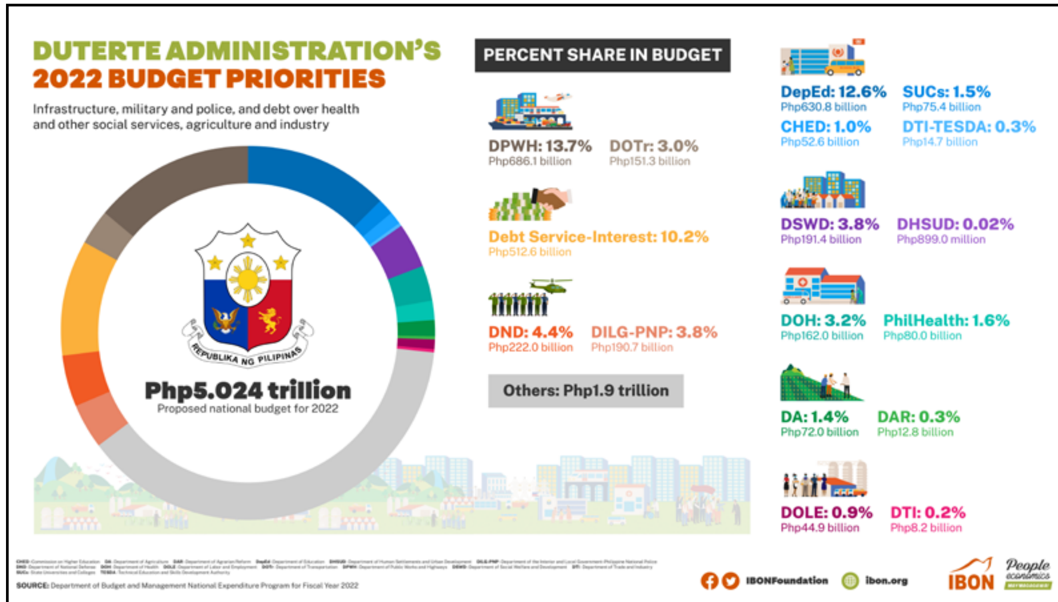
Proposed UK National Budget for 2022



Source: UK Government (2021)

Figure 3

Proposed Philippine National Budget for 2022



Source: IBON Foundation (2021)

As House Bill 9515 opts for a pragmatic approach that retains private healthcare facilities and also incentivizes those in areas where no public facilities are currently available, the Philippines must also ensure that it has learned the lessons on the perils of piecemeal privatization through so-called public-private partnership schemes, which partially commodify healthcare services. This is parallel with Philippine social movements' consistent campaigns against privatization and for greater state responsibility (and funding) for healthcare. Indeed, the bill's Section 34 explicitly bans the "privatization of public health facilities, hospitals and health services…in any form" including "prohibition of transformation to corporate entities, contracting of services to private agencies, public-private partnership, hiring or leasing of equipment and devices from commercial entities." The bill also prohibits the following forms of privatization: "a) Divestiture or outright sale of public sector assets in which the state divests itself of public assets to private owners; b) Franchising or contracting out to private, for profit, or not-for-profit providers; c) Self-management, wherein providers are given autonomy to generate and spend resources; d) Market liberalization or deregulation to actively promote growth of the private health sector through various incentive mechanisms; and e) Withdrawal from State provision, wherein the private sector grows rapidly as a result of the failure on the part of the government to meet the healthcare demands of the people."

An additional lesson from the UK shows how underfunding can lead to privatization by stealth (Shaw, 2003; Lee, 2018). The “deliberate strategy” of underfunding the public healthcare system is “the standard method of privatisation: underfund, make sure it does not work, people get angry, you hand it over to private capital. Then government pays more, for less” (Hyde, 2019). Senior doctors in the UK have also criticized the Conservative-led government for “deliberately underfunding NHS to accelerate privatisation plans” (Forster, 2018). In contrast, the UK Labour Party manifesto (2019) opposed healthcare privatization because “(e)very penny spent on privatisation and outsourcing is a penny less spent on patient care.” Analyzing the impact of privatization on the NHS, Giovanella (2016) explains that “... commodification and fragmentation have produced inefficiencies and major administrative spending hikes (from 6% to 15%)” because of the “multimillion-pound tenders, mergers, and hiring of private consultancies” that it entails. Such a link between privatization and profit-orientedness explains why, under the current setup, PhilHealth support value is less maximized in private facilities, and consequently, why, in general, public healthcare is more cost-effective. In public facilities, administrative expenses are minimized because services are free at the point of use; hence, there is no need for administrative processes related to the marketization of health services. Within the context of perennial underfunding in the UK’s NHS, the Philippines, as a bare minimum, must ensure continuously increasing expenditures for the public healthcare system parallel with the country’s ever-burgeoning population’s needs, on top of the huge initial investment needed to swiftly bring Philippine public healthcare standards closer to the systems that are proven to have good health outcomes (e.g. UK’s and Cuba’s healthcare systems).

CONCLUSION AND RECOMMENDATIONS

Healthcare reform paradigm shifts in the Philippines were partly a result of vibrant and continuous healthcare advocacies of social movements. Inch by inch, grassroots organizations mostly outside the halls of power, but eventually through representatives in Congress too, were able to compel the national government to slowly adopt reforms from the beginnings of healthcare for all aspirations in the 1970s to the automatic enrollment of every citizen in the public insurance system and the partial realization of free healthcare (e.g. for the poorest segments of society) under the UHCA, which was passed more than four decades after the precursor of the current public insurance system was established. House Bill 9515 - refiled by ACT Teachers Partylist Rep. Antonio Tinio and Kabataan Partylist Rep. Renee Louise Co as House Bill No. 205 on June 30, 2025 - intends to reform healthcare financing in the Philippines to make public healthcare free for all, rather than for the poorest citizens only. The bill bans both further privatization and commodification of healthcare but stops short of prohibiting existing private health facilities and private HMOs from operating. Hence, it is

actually a pragmatic measure that wants big changes, yet gives room for some aspects of the status quo, which will be very difficult to abolish right away. If it is passed into law, its success would only be assured if funding for the public healthcare consistently matches the demand for healthcare, and as the UK healthcare system shows, failure to provide adequate funding can affect the quality of service and/or cause policy regression into re-privatization or expanded privatization. Despite recent policy changes, the Philippines' current healthcare system under the second Marcos administration remains far away from social movements' aspirations for a genuinely free (or at least affordable) and universal healthcare system. Future researches may build on the current study to analyze the extent of recent policy shifts.

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