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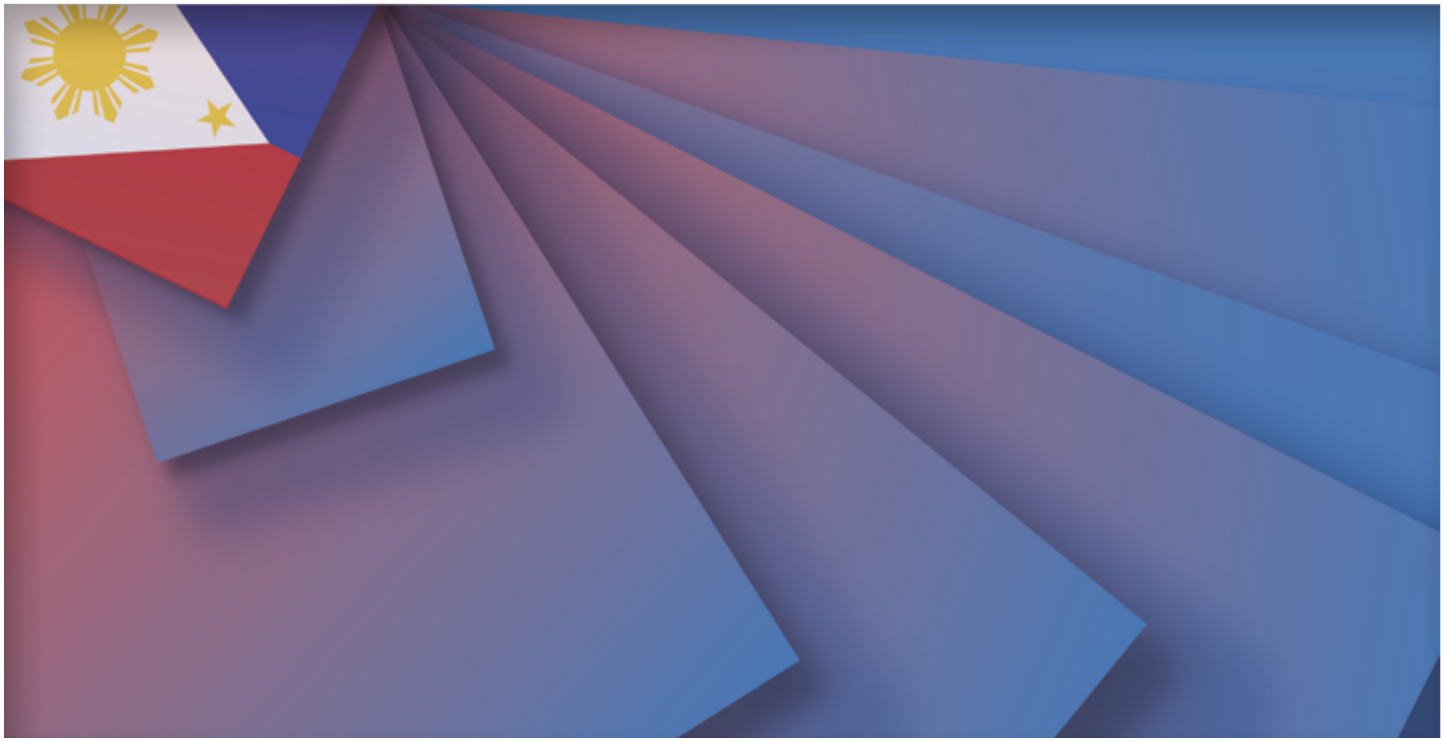

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Contents

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Executive summary

Through the implementation of the Universal Health Care (UHC) Act *(1)*, the Philippines' health system, especially its chief health agency the Department of Health (DOH), has sought to address a triple disease burden and the COVID-19 pandemic. The aim of this case study is to examine key aspects of primary health care (PHC) in the Philippines to inform future policy and practice, incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022.

The devolution of the country's health system places management and implementation of health care under local government units (LGUs). The DOH steers national PHC directives and programmes. Although devolution has allowed LGUs to innovate around models of care to better reach marginalized communities, the health system remains fragmented. This is exemplified by the limited referral and coordination channels among levels of governance and service delivery. The non-profit portion of the private sector helps close service delivery gaps for PHC through partnerships with nongovernmental organizations (NGOs), technical assistance from the academic community, and community-owned projects and patient groups, but these mechanisms often limit individual participation. This is separate from the for-profit portion of the private sector, which functions as a parallel health system not directly under the DOH's management.

Exacerbated by the COVID-19 pandemic, challenges to the full implementation of UHC include a scarcity of health care workers, especially in rural areas, and variable health financing schemes resulting in increased out-of-pocket (OOP) expenditure. Efforts to strengthen PHC could address health workforce and financing gaps and seek to harness empowered local structures.

Despite the fragmentation of the health system and limited resources, PHC service delivery is enabled through strong local mechanisms, many of which were created during the COVID-19 pandemic. These mechanisms include ordinances for the implementation of national health programmes, increased buy-in from local leaders for PHC, multisectoral collaboration for health, continual grassroots feedback from patients, and innovations around monitoring and quality assurance of service delivery. PHC-oriented research could enable further innovation at national and local levels, including to support utilization of digital technologies. For example, there may be opportunities to scale PHC innovations such as remote consultations and diversified models of care.

Introduction and national context

The Philippines suffers from a triple burden of disease from communicable diseases, noncommunicable diseases (NCDs) as well as diseases and conditions arising from rapid industrialization and urbanization *(2)*. In 2021, the most common causes of morbidity were primarily due to infectious diseases *(3-6)* and the top-five causes of mortality were related to NCDs *(7-10)*.

Mental health conditions are a growing concern. Prior to the COVID-19 pandemic, depression was the leading mental health disorder, followed by anxiety. Adolescent mental health and substance abuse were also of concern *(11)*. Many mental health challenges were exacerbated during the COVID-19 pandemic *(12)*.

The Local Government Code of 1991 outlines the devolved health system *(13)*. Under this law, policy-making, funding and the implementation of health services are the responsibility of LGUs at three levels: provincial, city/municipal and *barangay* (the most granular local unit of governance). National agencies such as the DOH retain regulatory functions and operational oversight through associated agencies that manage national programmes or key health system components. These agencies include the Philippine Health Insurance Corporation (PhilHealth), the Food and Drug Administration, the National Nutrition Council and the Philippine National AIDS Council. The DOH also operates specialized hospitals and end-referral centres for specific population groups or disease entities *(14–19)*.

The Philippines utilizes a Field Health Services Information System (FHSIS) to monitor morbidity, including infectious diseases targeted for control such as malaria, TB and rabies, as well as NCDs including hypertension and diabetes.

FHSIS data on critical health interventions show fluctuations in service coverage for maternal and child health and nutrition (MCHN) and NCD management during the first two years of the COVID-19 pandemic (2020–2021) *(3, 20)*. Immunization rates for children under 5 years of age in 2021 were below the national target of 95%, and only 63% of infants were considered fully immunized. This represented a drop in coverage from 69% of infants in 2019 *(3, 20)*. NCD management for adults aged 20 and above also declined during the pandemic *(3)*.

Five tracer commodities are monitored through LGU Health Scorecards: PT-HiB-HepB vaccine, combined oral contraceptive pills, Losartan, Metformin and Category 1 TB drugs. In the 2020 Health Scorecard, only 9% of public facilities, including tertiary hospitals and PHC centres, reported no stock-outs of these commodities, although rates varied between facilities *(20)*.

Methodology

This case study examines PHC to inform future policy and practice, incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022. Information was gathered through 10 stakeholder consultations with representatives from organizations and agencies from both the private and public sectors. Stakeholders from the public sector represented national agencies including Central Divisions of the DOH, and health practitioners from LGUs. Stakeholders responded to questions about their roles related to PHC, implementation of UHC, and the mandates, milestones and COVID-19 adaptions. A limitation was that the stakeholder consultations coincided with a transition period following national elections and a nationwide vaccination campaign, thus limiting the availability of respondents.

Secondary data were gathered from a desktop review of official DOH reports from 2020 to 2021. These include the FHSIS report *(3)*, the LGU Health Scorecard *(20)*, the Philippine Health Facility Development Plan 2020–2040 *(21)*, reports from Philhealth, and strategic plans and frameworks. Archival research into previous health agendas and PHC models included DOH publications and records as well as open-access literature on local health systems and UHC. Some sources on PHC implementation were referred to or volunteered by respondents during the stakeholder consultations. Data were synthesized narratively against the five strategic actions from the Western Pacific Regional Framework on the Future of Primary Health Care, namely: i) service delivery models; ii) empowered individuals and communities; iii) fit-for-purpose PHC workforce; iv) PHC financing; and v) a supportive and enabling environment.

Service delivery models

An important PHC service delivery model was the development of interlocal health zones (ILHZs) in accordance with the 1999 Health Sector Reform Agenda *(22)*. This system was intended to provide linkages among primary care facilities connected to secondary and tertiary facilities in adjacent localities. ILHZs were designed to facilitate the pooling of resources and patient referrals, but in practice they have been unable to address problems such as patient spillover and weak coordination systems among adjacent localities, resulting in health system fragmentation *(15, 17)*. The most recent iteration of the ILHZ system in the 2019 UHC Act *(1)* seeks to address this gap by creating local health care provider networks (HCPNs) for private and public facilities.

A common challenge both to the ILHZ system and the creation of HCPNs is the limited coordination of LGUs with private providers and facilities, with most lines of communication and referral being limited to the public sector. The Philippines' archipelagic nature also hampers communication and referral especially in geographically isolated communities. Political considerations, especially from Local Chief Executives, which include mayors of cities and municipalities as well as provincial governors, may either strengthen or hamper

the robustness of an ILHZ or an HCPN *(23)*. An additional challenge is the UHC Act ignoring the mechanics of HCPN creation and monitoring within each LGU. Addressing these challenges falls largely to the DOH's Bureau of Local Health Systems Development (BLHSD). The BLHSD has piloted the integration of services and managerial oversight in several LGUs, with the goal of achieving full financial and technical integration by 2025.

There are up to 3900 primary care facilities (PCF) across the country, of which 2593 are public sector Rural Health Units/Health Centres (RHU/HCs). As only 50% of Filipinos have access to an RHU/HC within 30 minutes of their residence, it is estimated that an additional 2400 RHU/HCs by 2025 will be needed to address this gap, with all *barangays* having at least one health station. As of 2022, only half of all *barangays* had at least one health station. The private sector augments PCF capacity for birthing homes and infirmaries. Up to 1071 birthing homes are run by private entities compared to 835 run by LGUs; of 683 infirmaries nationwide, 336 are privately run while 347 are run by the LGUs or the military *(21)*.

Primary care providers should be the first point of contact for patients seeking care, but in practice patients also go directly to hospitals, including end-referral centres, for specialized care. In 2018, there were 1200 licensed hospitals with a total of 105 330 beds. Of these hospitals, 769 were private facilities while the remaining 431 were run by LGUs or the military *(21)*.

On a national level, the Integrated Clinic Information System (iClinicSys), Philippine Health Information Exchange (PHIE) and the PhilHealth e-claims system are undergoing roll-out and improvement with the goal of harmonizing health informatics systems among facilities *(24)*. Claims from the Philhealth system are used as a proxy indicator for outpatient service outputs. At the time of writing in 2022, up to 4550 outpatient facilities had been accredited by PhilHealth to provide medical consultations, maternity care and TB packages under the Directly Observed Treatment Short course strategy (DOTS). However, these comprise less than 10% of the total number of claims paid under PhilHealth. Primary health clinics not falling under these categories accounted for less than 1% of claims in 2021, with a total of 9500 peso (approximately US$ 171) from three visits, suggesting a need for improvement in how PHC claims are categorized and filed *(25)*.

Against this backdrop, devolution and the resulting mandate for LGUs to innovate has enabled PHC service delivery. LGUs can implement measures such as house-to-house consultation teams to provide care for housebound elderly citizens, satellite clinics and onsite facilities in dense urban settlements, and "sundown" clinics for HIV testing and care. Devolution also allows LGUs to initiate the construction of public infrastructure for preventive services such as improved water and sewage facilities *(3, 20)*.

In the absence of strong national mechanisms for HCPN creation, the private sector, including civil society groups and NGOs, augment PHC services in some areas through LGU partnerships to finance basic services such as chest X-rays for TB screening or to provide donations and technical expertise. A key role of some NGOs is in reaching marginalized populations and communities, such as

persons living with HIV. For example, the NGO LoveYourself provides HIV care through a one-stop-shop model that offers preventive services against sexually transmitted diseases, HIV screening and therapy, and mental health services. *(26)*. However, NGO-led innovations often have limited reach across disadvantaged communities.

The COVID-19 pandemic emphasized the importance of HCPN creation, especially with the creation of the One Hospital Command initiative to help coordinate referral of COVID-19 patients. The pandemic also accelerated a shift towards digital technologies, for example through virtual consultations with health care providers. Prior to the pandemic, the KonsultaMD initiative, a pilot telemedicine service of the DOH, provided private virtual consultations to fee-paying patients. *(18)*. Since 2020, more partners in the public and private sector have used this model to address COVID-19 and mental health concerns by increasing provider access in private networks. This experience shows that the use of digital technology helps address service delivery gaps and should be prioritized even in low-resource settings. Other digital technologies include the building of local databases for patients and the construction of repositories for capacity-building. Despite these innovations, the use of digital technologies is challenged by limited infrastructure and staffing in LGUs *(24, 27)*.

Empowered individuals and communities

Participation of individuals and communities is supported by NGOs, specialized societies of health care workers and the academic community. NGOs are active players in the non-profit portion of the private sector. They played key roles in service delivery, as seen in the long-standing partnerships between LGUs and multinational organizations. These partnerships engage the private sector and civil society to augment LGU resources for services such as water, sanitation and hygiene, alongside taking active roles in policy-making through consultations and the provision of feedback. Some NGOs, such as LoveYourself and the Culion Foundation, collaborate closely with patient communities for advocacy and empowerment. Approaches include training health providers in local languages and customs, developing educational materials that align with Indigenous belief systems, and conducting dialogue in community-based settings.

Also key to empowerment are specialty societies for health care practitioners. These include societies of physicians in a particular field (e.g., oncology, public health) and allied health care workers. These groups empower practitioners through training and accreditation and can provide input as organizations to key processes such as the development of clinical practice guidelines (CPG). The academic community also participates through capacity-building and leadership training. For example, the University of the Philippines Manila's College of Public Health has short courses and training programmes specifically designed for local chief executives.

Community pharmacy projects such as *Botika ng Bayan* (People's Pharmacy) or *Botika ng Bayani* (Heroes' Pharmacy) projects are exemplar community-owned initiatives. These innovative models for community pharmacies provide

essential medicines at affordable prices as well as facilitate ownership of public health programmes and infrastructure.

The organization of patient communities is a key strategy for the empowerment of patients, such as those living with NCDs. Examples of patient communities include senior citizens' clubs, diabetes clubs and hypertension clubs. These patient groups provide patient and caregiver education, regular follow-up and social support. Before the COVID-19 pandemic, these patient groups regularly organized health promotion activities; however the introduction of limitations to curb the spread of the virus limited public mobility and social gatherings. These measures had a particular impact on housebound patients and caregivers. Thus, it falls to LGUs, individual practitioners and advocates to challenge community structures that contribute to patient exclusion from PHC through administrative reforms that eliminate barriers to individual empowerment.

A strength of these community empowerment mechanisms is the emphasis on collective action and shared responsibility. Key to this is the mobilization of community champions and leaders who help the target community to ensure sustainability. This benefits health system devolution, which mandates the participation of civil society organizations. These initiatives provide a means for communities to be consulted and thus provide key inputs for policy-making. Yet, even in many community and organization-based activities, the individual patient is still seen as a passive recipient or beneficiary.

A fit-for-purpose PHC workforce

A scarcity of human resources remains a major challenge. Most physicians are concentrated in cities, wherein 90% of RHU/HCs have at least one medical doctor. However, less than 10% of facilities outside of urban areas have doctors and nurses, although 80% of *barangay* health stations have a midwife and 90% have a *barangay* health worker *(28)*. Another challenge is that about one-fifth of health care workers are working overseas. Salary differences and working conditions are likely to contribute to emigration. This situation was exacerbated by mass resignations among the workforce during the COVID-19 pandemic, especially among nurses *(29)*.

Health care workers are more likely to work in areas with greater earning potential and in areas close to where they are trained *(30)*. As a result of this inequity, health care worker density varies nationwide. Estimates based on World Bank data indicate that there were 5.4 nurses and midwives per 1000 Filipinos in 2019 *(31)*, and a 2020 survey showed that the physician–patient ratio in the country was at 1.2 physicians per 1000 persons at that time *(32)*, with physicians being distributed almost equally between the private and public sectors *(18)*. Around 61% of nurses, 91% of midwives and 53% of medical technologists were employed in the public sector, with higher compensation being a key factor in this distribution *(18)*. Potential applicants for services are either notified through public postings or are referred by local practitioners. Ongoing training is provided through DOH classes and courses, which counts towards performance ratings and promotion.

Of special concern are communities classified as Geographically Isolated and Disadvantaged Areas (GIDAs), which are often underserved and have fewer resources to maintain the health workforce. To redress this, one mechanism is the Doctor to the Barrios (DTTB) programme, which provides GIDAs and other areas with volunteer doctors, who are then offered continuing education in public health and management *(33)*. A similar programme for public health pharmacists provides technical assistance and monitoring. Similar deployment programmes are extant for other allied health professionals such as medical technologists and public health associates, but these were not as emphasized by LGUs. In addition, the DOH Medical Scholarship Programme aims to increase the availability of homegrown health care professionals in vulnerable communities *(34)*. A recent court ruling that transfers responsibility for basic service delivery to local governments could encourage LGU support for the local health workforce and lead to higher retention rates in rural and underserved areas *(29, 35)*.

To address health workforce shortages during the COVID-19 pandemic, adjustments were made in the public health workforce distribution through task-shifting. LGUs deployed local health practitioners and volunteers to vaccination sites. Contact tracers were also hired by LGUs to facilitate timely case management.

PHC financing

OOP spending has historically been a primary mode of health financing, accounting for 50% of health service funding *(36)*. Families only allocate 2.7% of their annual income to health-related expenses, below expenditures for food and utilities and even durable furniture and special family occasions *(38)*. Accordingly, it is difficult for families to prepare for such health expenses, especially catastrophic ones such as critical hospitalizations *(37)*. The COVID-19 pandemic influenced OOP expenditure. National Health Accounts data from 2019 to 2021 show an increase in the share of total health expenditure to gross domestic product (GDP) from 4.6% in 2019 to 6.0% in 2021. In 2021, government expenditure and compulsory contributions comprised 50.3% health expenditure, and 8.2% came from voluntary payment schemes. The share from OOP expenditure thus dropped to 41.5% in 2021 *(39)*.

All Filipinos are enrolled in PhilHealth, which supports UHC by reducing OOP payments and improving financial access to health care. The No-Balance-Billing policy and expansion of the Health Facilities Enhancement Programme (HFEP) also seek to improve health care access by ensuring availability and continuity of health care services *(37)*. PhilHealth is largely utilized for inpatient care and services *(37)*. Claims decreased in 2020 due to the reduction in inpatient admissions arising from mobility restrictions *(40)*.

However, peculiarities in the categorization of PHC services such as MCHN or outpatient services such as TB-DOTS hinder the proper monitoring and utilization of PhilHealth financing *(25)*. Moreover, around 10% of the population remain unregistered with PhilHealth despite the stipulations under the UHC Act

and thus have difficulty accessing covered services *(1)*. These non-registered persons comprise self-employed individuals as well as poor citizens and persons deprived of liberty *(41)*.

Catastrophic health expenditure is defined as the allocation of 40% or more of a household's non-subsistence income for health expenditure. Although use of the 40% non-subsistence income threshold would show that only 0.8% of Filipino households suffer from catastrophic health expenditure, this is thought to be an underestimate due to factors such as adjusted expenditure on other basic needs whenever a catastrophic health expenditure is imminent or ongoing *(42)*.

Another development that will affect PHC financing is the Mandanas-Garcia legal ruling *(35)*, which prioritizes funding shifts towards local governments. This will result in decreased funding for national agencies, including those involved in PHC service delivery, but place more financial decision-making and integration in the hands of local health systems. At the time of writing, it was unclear how the ruling could be leveraged to empower LGU efforts without compromising the ability of the DOH and attached agencies to fulfil their mandates for national programmes for PHC.

A supportive and enabling environment

Mechanisms to create a supportive and enabling environment are guided by national policies and strategies set at the beginning of each administration or every six years. Several reports summarize previous efforts to expand and improve PHC, including maternal and child health, endemic infectious diseases, impoverished Filipinos, and minority groups (*16, 22, 23, 43-57*). Interventions have included the establishment of local *barangay* pharmacies, establishment of the Health Technology Assessment Council, mandated use of electronic medical records in all health facilities, registration of Filipinos to PhilHealth, and expansion of telemedicine coverage beyond COVID-19 monitoring. At the time of writing, Administrative Order 2022-0033 codifies the health sector's strategy, prioritizing the implementation of UHC and the development of HCPNs *(58)*.

Local ordinances delineate the mandate of the LGUs' health departments and their PHC functions. PHC programmes are covered by local ordinances include but are not limited to MCHN, TB control, environment and sanitation, substance abuse and control, and gender and development. These ordinances provide a means of operationalizing programmes and campaigns under bureaus such as the Disease Prevention and Control Bureau and are aligned with messaging and strategies developed by the Public Health Services Team. Indicators for these ordinances remain aligned with national health programmes. Such directives are developed by local chief executives and LGU councils.

Strong support from local chief executives is key to service delivery. Local chief executives oversee resource allocation, funding and procurement, which are guided through local departments for finance and general services. Some LGUs have active Local Health Boards to serve as advisory bodies for health policies,

but these are not present in all LGU. Multisectoral involvement is therefore also supported by People's Councils that involve government organizations and civil society groups to support community involvement in policy creation and implementation. People's Councils enable multisectoral collaboration by involving other areas of governance. This model of participative governance has been adapted in cities like Naga and Quezon.

Some LGUs conduct regular multisectoral meetings involving private sector providers, which provide a platform for coordination, the relay of feedback and strategic planning for PHC. However, referral systems between public and private facilities are tenuous or non-existent. The inclusion of private facilities in networks for health informatics and digitalization is also a challenge owing to the limited regulatory oversight of private facilities as well as limited digital infrastructure.

Further input is provided through grassroots or community-centred mechanisms such as consumer satisfaction surveys in *barangay* health stations and other primary care facilities, and social media pages. Mystery shoppers are sometimes used to collect information about health facilities and services, who anonymously report back to local health officers and the local chief executive. More formal accountability measures include individual performance ratings for health providers in government facilities and the disclosure of conflicts of interest. The Philippine Council for NGO Certification also accredits and monitors NGOs to ensure that they are following standards for transparency and accountability, especially when managing external funding.

Monitoring and evaluation is also enabled by the LGU Scorecard, which evaluates local health systems on basic service delivery and resilience indicators. Another measure is the granting of seals of excellence by LGUs to PHC facilities that comply with or exceed metrics for programmes. These qualifications are taken into consideration when prioritizing referrals for PHC services. A shift towards the Performance Governance System for quality management is also promoted in the new Health Sector Agenda *(58)*.

Finally, research oriented towards PHC enables resilience and agility. The National Unified Health Research Agenda 2017–2022 has six themes important for PHC: 1) responsive health systems, 2) research to enhance and extend healthy lives, 3) holistic approaches to health and wellness, 4) health resiliency, 5) global competitiveness and innovation in health, and 6) research in equity and health *(59)*. These themes translate into practical research endeavours such as telepharmacy and other digital avenues for service delivery outside of social media *(60)*.

Conclusion and lessons learned

This case study highlights the strengths of implementing in a devolved health system, while confronting the challenges of health system fragmentation, limited individual engagement and empowerment, and scarce resources for the health workforce and health financing. Devolution allows for the localization of health services and the empowerment of local actors, but these strengths can be challenged by fragmentation. This is apparent in the limited coordination between the public and private sectors, and gaps in provision to underserved communities, especially those situated in remote islands or other isolated areas.

The COVID-19 pandemic highlighted inequities in service provision and health resources but it has also prompted innovation around models of care, especially for housebound or vulnerable population groups such as persons living with NCDs, the elderly and the urban poor.

The private sector and non-profit organizations played a role in bridging service delivery gaps and providing platforms for organized action by patient groups and communities. NGOs played an important advocacy role for patient communities that are marginalized due to geographical factors or persistent stigma surrounding diseases such as HIV. However, individual participation and empowerment in PHC remains limited, even in community-based care, with limited opportunities for meaningful participation especially during the COVID-19 pandemic.

These findings underscore the imperative to address imbalances in human resources for health. Strategies might include providing support for resource-poor LGUs to train and retain public health practitioners and supporters, while addressing drivers of outmigration. There are also opportunities to expand health financing to reduce OOP and allow better out-patient access. This might involve reworking Philhealth policies to increase coverage and would entail broadening avenues for financial protection through other government expenditure.

Finally, findings suggest a need to improve coaching and mentoring of local chief executives and other key figures to prioritize local PHC reforms. There are also opportunities to improve local integration of practitioners and facilities in HCPNs such as the KonsultaMD telemedicine initiative.

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This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Western Pacific (WPRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.