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AWARENESS OF HEALTH INSURANCE BENEFITS IN THE PHILIPPINES: WHAT DO PEOPLE KNOW AND HOW?

DISCUSSION PAPER

MARCH 2017

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WORLD BANK GROUP
Health, Nutrition & Population

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Health, Nutrition and Population (HNP) Discussion Paper

Awareness of Health Insurance Benefits in the Philippines: What do People Know and How?

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Abstract:

Objective: This paper assesses how people who are eligible for government-subsidized (free) health insurance through Philippines Health Insurance Corporation (PhilHealth) find out about their eligibility and their benefits, and also how well people know the PhilHealth benefits.

Data: A panel of household survey data (2011 and 2015), collected by the UPEcon Foundation and the World Bank, as well as administrative data.

Findings: First, we find that *barangay* officials and staff of the Department of Social Welfare and Development (DSWD) are the most important source of information on eligibility for government-subsidized health insurance, emphasizing the role played by local governments and other non-health national programs in informing people of their health insurance coverage. Second, we find that, overall, there is considerable room to improve people's knowledge of the PhilHealth benefit package (i.e. which health services are covered and that the extent of knowledge varies by benefit type. Awareness of coverage of various types of hospital care is high and around 75 percent of the poor know about the no-balance billing policy. By contrast, only a minority of poor people know that their PhilHealth coverage includes a free primary care consultation. Third, we find that most people learn about what health services are covered by PhilHealth from their social networks (that is, friends, neighbors, families, and relatives), followed by PhilHealth staff deployed in health facilities, and then the mass media; by contrast, only a small share of people appear to learn about their benefits from PhilHealth or DSWD outreach programs specifically designed to inform communities of benefits.

Recommendations: Recommendations include to (a) make better use of the DSWD's "family development sessions" (FDS) to provide relevant information on the full range of PhilHealth benefits, especially primary care, (b) train and incentivize members of the local community to share information on PhilHealth benefits, (c) reassess the design and implementation of the Philhealth *Alaga Ka* outreach program, and (d) sustain, and even scale-up, mass media campaigns on Philhealth benefits.

Keywords: health insurance, benefit package, universal health coverage, conditional cash transfers, PhilHealth

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I. INTRODUCTION

In recent years, the Philippines has seen a rapid expansion of health insurance coverage, especially among the poor. In particular, the implementation of the 2012 Sin Tax Law, which increased tobacco and alcohol excise tax and earmarked most of the incremental revenues for PhilHealth premium subsidies for indigent households, contributed to an increase in the number of families receiving government-subsidized health insurance from 5.2 million to 15.3 million poor families and senior citizens between 2012 and 2015 (Kaiser, Bredenkamp, and Iglesias 2016).

However, it cannot be taken for granted that households whose PhilHealth coverage is subsidized by the national government necessarily know of their membership entitlement and the full range of helath services that are included in the PhilHealth benefit package. The reason is that families whose insurance coverage is subsidized by the national government are 'automatically enrolled' in PhilHealth. They do not have to actively enroll with PhilHealth Rather, have coverage because their households are listed on the National Household Targeting System for Poverty Reduction (NHTS-PR) or *Listahanan* as being poor and eligible for free health insurance.

In response, PhilHealth and other Government entities — at both national and local levels — have put in place a number of measures to inform households of their entitlement (coverage) and benefits. For those subsidized households who are also beneficiaries of the conditional cash transfer (CCT) program (known as the *Pantawid Pamilyang Pilipino Program* [4Ps]) of the DSWD, there is the CCT program's "Family Development Sessions" (FDS) where health, education, and other topics are discussed. In addition, CCT beneficiaries can use their CCT cards to access health services without any additional documentation (such as a PhilHealth card or the PhilHealth member data record)[1]. A major PhilHealth initiative is the PhilHealth Customer Assistance, Relations and Empowerment (CARES) program, initiated in 2012, through which PhilHealth deploys nurses in PhilHealth-accredited hospitals to provide information and assist members with determining their eligibility, understanding their benefits, and claims inquiries (PhilHealth Circular No. 12 series of 2012). The *Alamin at Gamitin para sa Maayos na Buhay* (or *Alaga Ka*) roadshows, launched in March 2014, are a partnership of PhilHealth, the Department of Health, and local government units (LGUs) aimed at informing indigent members of their entitlement (through the distribution of the member data record) and explaining to indigent members how to avail of basic primary care benefits. PhilHealth also uses mass media, in particular television, to reach a wider audience with information on its programs and benefits.

Yet, despite these efforts, analysis of routine household surveys (such as the Demographic and Health Surveys and the Family Health Surveys) consistently show that self-reported health insurance coverage lies well below the coverage rates reported in administrative databases (Bredenkamp and Buisman 2016) — something which is confirmed by analysis undertaken in a companion discussion paper[2] — and that the poor tend to utilize their health insurance benefits less than other groups (Quimbo et al. 2008). In both cases, the authors attribute their findings

[1] The member data record is a document generated by the PhilHealth information system that provides proof of PhilHealth membership. Subsidized PhilHealth members do not receive health insurance cards. They are sometimes issued with a member data record as physical proof of membership during awareness campaigns and can also request one as proof of membership.

[2] Bredenkamp, C., J, Capuno, A, Kraft, L. Poco, S. Quimbo and C.A. Tan. Forthcoming. Expansion of health insurance in the Philippines: Evidence from Panel Data. HNP Discussion Paper. Washington, D.C.: World Bank.

to lack of awareness of PhilHealth coverage and benefits among the poor. In other countries and contexts, the importance of ensuring that people understand their health insurance entitlements and that covered populations are reached through various interventions to elevate public awareness has also been emphasized (World Bank 2008; Bauhoff, Hotchkiss, and Smith 2010; Meng et al. 2010; Acharya et al. 2013; and Kutzin 2013). To date, however, there has been little attempt to explore in-depth the question of benefit awareness in the Philippines.

In this paper, we examine the extent to which Filipinos, and especially the poor Filipinos entitled to free health insurance, are aware of their health insurance entitlement and benefits, as well as how they obtain this information. Specifically, we ask the following questions: first, how do subsidized PhilHealth members learn of their entitlement; second, how well do PhilHealth members (both poor and non-poor) know their benefits; third, where do PhilHealth members obtain information about PhilHealth benefits. Answers to these questions can help policymakers to design interventions that ensure that the eligible population can take advantage of their insurance entitlements. Data are drawn from a nationwide household survey conducted in 2015 as a collaboration between the UPecon Foundation[3] and the World Bank.

[3] The UPecon Foundation is a private, non-profit research institution of the faculty members of the University of the Philippines School of Economics.

II. DATA AND METHODS

DATA

In this paper, we use two data sources. First is a panel of household survey data constructed from two nationally representative surveys, collected in 2011 and 2015 respectively.[4] Our analysis relies solely on the 2015 wave since this was the first time that questions on benefit awareness and information sources was asked. The second is the administrative records of the DSWD, specifically the NHTS-PR list or *Listahanan*.

The 2015 survey analyzed in this policy note consists of 1,780 households (representing 9,177 individuals). These households had previously participated in the January–April 2011 survey which was a nationally representative[5] sample of 2,950 households (including 13,858 individuals), randomly selected through a multistage cluster sampling design. Due to cost considerations, the number of households included in the follow-up 2015 survey was reduced. This also meant that over-sampling among poor and informal sector members, for which disaggregated analysis was anticipated, was needed to ensure sufficient statistical power (sample size) in those groups.[6] While there was some attrition, balancing tests on the baseline characteristics of the two groups confirm that sample attrition does not bias the results. Sample weights were applied during data analysis to correct for sampling design.

The NHTS-PR list (or *Listahanan*) was developed by DSWD in 2011 for the purpose of identifying poor households eligible for the CCT program.[7] In 2011, when funding was secured to provide national subsidies[8] for the health insurance coverage of the poor for the first time, this list was also used to identify the poor eligible for free health insurance (Department of Health Department Order 2011-0188). In 2011, the total national subsidy allotted was sufficient to cover 4.9 million poor families on the NHTS-PR list. In 2012, the budget was further increased to cover 5.2 million families drawn from the NHTS-PR households. With the proceeds of the revenues of the Sin Tax Law, which subsidized health insurance premiums starting in 2014, 14.7 million poor families drawn from the NHTS-PR households, together with 0.6 million

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[4] The 2011 data were collected as part of the Health Equity and Financial Risk Protection in Asia (HEFPA) project by the UPecon Foundation, Inc., in collaboration with the Erasmus University Rotterdam and the World Bank, and cofinanced by the European Union. The collection of the 2015 data was a collaboration between the UPecon Foundation, Inc. and the World Bank, and cofinanced by the World Bank's Poverty and Social Impact Analysis (PSIA) trust fund.

[5] Sampling excluded the Autonomous Region of Muslim Mindanao because of the intensity of the conflict. The Autonomous Region of Muslim Mindanao accounts for 3.5 percent of the population of the Philippines.

[6] The 2015 sample consists, therefore, of two components: component A consists of the poor and informal sector households while component B consists of the formal sector. For component A, 1,980 households classified as poor or in the informal sector were sampled in 2015, but only 1,513 interviews were completed, implying an attrition rate of 24 per cent. Reasons for non-participation include: (a) failure to locate the households, (b) refusal to participate, and (c) transfer of household to a new location outside the survey sites. For component B, attrition was not a concern as the targeted sample size to achieve sufficient power (namely 254) was achieved. The actual size of component A in 2015 was 1,513 households (compared to 1,975 at baseline) while the actual size of component B in 2015 was 267 households (compared to 975 at baseline) for a total size of 1,780 households (or 9,177 individuals).

[7] The 2011 NHTS-PR database was created using a combination of geographic and individual targeting. First, 'poor' municipalities with poverty rates in excess of 50 percent were identified using the 2003 small-area poverty estimates of what was then the National Statistical Coordination Board. Then, within these poor municipalities, a proxy means test (PMT) was used to identify individual households as either poor or non-poor. In municipalities with less than 50 percent poverty rates, the PMT was also administered to households deemed (by the DSWD) to be living in 'pockets of poverty' (DSWD 2010). All enumerated households, both poor and non-poor, are included in the official 2011 NHTS-PR database, but only those below a certain threshold are eligible for free health insurance.

[8] The 2011 national subsidies were full payment of the required premium, while previous national subsidies were partial and only extended to poor households that were identified (and cofinanced) by their local governments.

families headed by senior citizens, were receiving free health insurance by the end of 2015 (PhilHealth 2016).

MEASUREMENT OF AWARENESS OF BENEFITS AND SOURCES OF INFORMATION

Using the survey data, we construct several measures of awareness.

First, we ask those households who report receiving fully-subsidized health insurance (either through the national government's indigent program, senior citizens program, or sponsored by other parties) how they found out about their PhilHealth entitlement/coverage.

Second, among those respondents who have heard of PhilHealth, we ask them to identify, from a list of 18 items, which PhilHealth benefits they have heard of. Read one by one to the respondent, the items in the list include general PhilHealth benefits associated with hospital care, namely, room and board during hospital confinement, medicines at the hospital, laboratory services/laboratory tests, surgical procedures, radiotherapy, and blood transfusion. It also includes PhilHealth benefits that are disease-specific, such as hemodialysis, and treatment of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), malaria, tuberculosis, dengue, breast cancer, cervical cancer, prostate cancer, and leukemia. The treatment of breast cancer, prostate cancer, and leukemia are part of PhilHealth's 'catastrophic Z benefit' package. The list also includes two PhilHealth benefits that are extended exclusively to the poor, namely primary care checkups/consultations and 'no balance billing' by hospitals/facilities beyond what is reimbursed PhilHealth. In addition, the list also contains three items that are not included in the benefit package, namely vitamin supplements, ambulance services, and discounts at grocery stores. For poor households, then, 15 of the 18 items are actually PhilHealth benefits, while for non-poor households 13 of the 18 items are PhilHealth benefits. Scores are calculated based on the number of correct answers given.

Third, we ask survey respondents about their sources of information about specific PhilHealth benefits. Respondents were allowed to provide multiple answers. We tally the responses and classify them broadly into seven types. These are answers related to the DSWD's CCT program (such as the FDS and Municipal Links who are responsible for information-sharing between and among program beneficiaries and program implementers), social networks (families, friends, relatives, senior citizen organizations, coworkers, and employers), PhilHealth activities (such as the *Alaga Ka* campaign and the deployment of PhilHealth staff in health facilities through the PhilHealth CARES program), health care providers, local governments (including *barangay*-level officials), and others.

POPULATION SUBGROUPS

Results are reported for the population as a whole, and also for particular groups of the poor.

- First, we look at the poorest two quintiles of respondent households, ranked by per capita consumption. Since the survey is nationally representative, the poorest two quintiles of respondents are equivalent to the poorest two quintiles of Filipino households.

- Second, we define the poor as those whose annual per capita incomes[9] put them below the official poverty line(s) estimated by the Philippines Statistical Authority (PSA), on a triennial basis using the Family Income and Expenditure surveys (FIES), for the province in which they reside. To estimate the poverty thresholds for 2015, we inflate the 2012 provincial poverty thresholds by the PSA's official consumer price index.[10] We term this group the 'FIES-poor'.

- Third, we define the poor as those whose names can be found on the NHTS-PR[11] list of the poor below the (predicted) income threshold which would make them eligible for free social protection programs, including free health insurance and (subject to other restrictions) the CCT program. We term this group the 'NHTS-PR-poor'.

- Fourth, we look at CCT beneficiaries, who are a subset of the households on the NHTS-PR list who, subject to fulfilling additional program requirements related mainly the age of the children, are eligible for participation in the CCT program.

Since the household poverty rate remains high at around 25.8 percent in 2014 (PSA 2015), there will be quite a lot of overlap between households belonging to the bottom two income quintiles and the FIES-poor group. There should also be substantial overlap between the FIES-poor and the NHTS-PR-poor, but not completely. Indeed, it is well-documented that if the FIES-poor group is taken as reference, the PMT used in the NHTS-PR is known to lead to both inclusion and exclusion errors (Fernandez and Velarde 2012). In other words, the list of NHTS-PR households may include households who are not FIES-poor or exclude some of those who are considered FIES-poor.

[9] Notwithstanding the arguments in favor of using consumption rather than income to measure living standards in developing countries (see, for example, Deaton and Grosh 2000), in the Philippines the official poverty rate is measured using income.

[10] In the analysis, we use provincial poverty lines, that is, compare each household's income level to the poverty line of the province in which it resides. However, to give the reader a sense of the approximate level at which poverty lines are set in the Philippines, the average poverty threshold (based on the 2012 provincial poverty threshold adjusted by consumer price index) was PHP 20,450.66 per capita in 2015.

[11] Ideally, we would compare the households in our dataset to the PhilHealth database, but this is not available for research purposes.

III. FINDINGS

HOW DO SUBSIDIZED PHILHEALTH MEMBERS LEARN THAT THEY ARE COVERED?

In general, among those households who report receiving subsidized health insurance (either though the national government's indigent program, senior citizens program, or sponsored by other parties), the two most important sources of information about membership status (that is, entitlement to subsidized coverage) are local government institutions and the DSWD's programs and officials (especially through the CCT program), followed by various PhilHealth sources (see table 1). About 38 percent of subsidized members learned about their PhilHealth entitlement from local government institutions, especially *barangay* officials (35 percent) and also, to a lesser extent, community health teams (3 percent). Equally important was the DSWD's program (39 percent), with the activities of the Municipal Link[12] being the most prominent (25 percent). PhilHealth information sources were less important. Only 16 percent of subsidized households learnt about their PhilHealth membership directly from PhilHealth institutions and activities, with only 1 percent citing the PhilHealth *Alaga Ka* campaign as the source of information. Social networks — friends, neighbors, relatives, families, local parent leaders, senior citizens, coworkers, or employers — were the least important source of membership information.

There are some differences by socioeconomic status, with some sources of information being relatively more or less important for the poorest of the subsidized group. The Municipal Links, for example, while an important source of information on membership for all subsidized members (23.4 percent), are especially important for the poorest quintile (29.6 percent). By contrast, *barangay* officials, from whom 34.8 percent of all subsidized members learn of their PhilHealth coverage, are the primary source of information on membership for only 29 percent of quintile 1, FIES-poor, and NHTS-PR households and for 27 percent of CCT households. PhilHealth staff at facilities were also a more important source of information for subsidized households in general (6.8 percent) than for the poorest quintile (3.1 percent) and CCT members (3.4 percent). Interestingly, as many as 14.3 percent of CCT households learnt about their PhilHealth coverage from other CCT members, likely indicating the importance of peer-to-peer information-sharing within this group and the fact that the CCT card can be used as proof of PhilHealth membership.

[12] The Municipal Link is a DSWD employee who coordinates DSWD programs at the local level, serving as the link between the DSWD and the LGU. The website of the DSWD describes the Municipal Link as follows: "The Municipal Links of 4Ps serve as the link between the Department of Social Welfare and Development (DSWD) and the Local Government Units (LGU). They are in -charge of the over-all supervision in the program implementation in municipalities, in coordination with the Municipal Social Welfare and Development Office (MSWDO), and community facilities, like schools and health centers. They monitor compliance and grievances of all stakeholders in the program. Similarly, they provide training and capability building activities to beneficiaries." (DSWD 2010).

Table 1. Source of Information on PhilHealth Membership Status among Households who Received PhilHealth Premium Subsidies, 2015

Sources	All Subsidized (n=580)	Quintile 1 (n=133)	Quintile 2 (n=137)	FIES-Poor (n=248)	NHTS-PR-Poor (n=237)	CCT (n=261)
DSWD staff and CCT program						
Municipal Link	23.4%	29.6%	18.8%	25.5%	25.4%	24.3%
CCT Member	7.4%	7.4%	10.0%	8.5%	8.6%	14.3%
DSWD Staff	1.9%	3.1%	1.9%	1.7%	1.8%	3.9%
Announced in the FDS	1.4%	3.4%	0.0%	1.9%	2.0%	2.7%
Parent Leader	4.8%	2.2%	6.4%	4.7%	4.3%	5.9%
Subtotal	38.90%	45.70%	37.10%	42.30%	42.10%	51.10%
PhilHealth sources						
When given MDR number	8.4%	7.9%	11.7%	10.5%	10.7%	8.0%
PhilHealth staff at health facility	6.8%	3.1%	9.2%	6.1%	5.9%	3.4%
Alaga Ka campaign	1.0%	1.5%	0.4%	1.0%	1.1%	0.0%
Subtotal	16.20%	12.50%	21.30%	17.60%	17.70%	11.40%
Local government						
Barangay officer/At the *barangay*	34.8%	28.8%	34.4%	28.9%	28.8%	26.6%
Community Health Team	3.2%	2.3%	3.7%	3.3%	3.5%	3.9%
Subtotal	38.00%	31.10%	38.10%	32.20%	32.30%	30.50%
Social networks						
Friends	1.2%	2.0%	1.5%	1.9%	2.0%	1.7%
Company/employer	1.0%	1.1%	0.2%	0.7%	0.7%	0.6%
Relative/s	2.0%	4.6%	1.3%	3.2%	3.4%	3.0%
Group/meeting of senior citizens	1.6%	1.6%	0.6%	1.2%	1.3%	0.7%
Social Security System (SSS)	0.2%	0.0%	0.0%	0.0%	0.0%	0.3%
Neighbor	0.1%	0.3%	0.0%	0.2%	0.2%	0.0%
Subtotal	6.10%	9.60%	3.60%	7.20%	7.60%	6.30%
Others	0.7%	1.2%	0.0%	0.7%	0.4%	0.7%
Total	100%	100%	100%	100%	100%	100%

Source: HEFPA Survey, 2015; authors' computations.
Note: Subsidized households include indigent, sponsored, and senior citizen members; MDR is member data record

HOW DO PEOPLE LEARN ABOUT THE VARIOUS PHILHEALTH BENEFITS?

A person's awareness of the services included in the insurance benefit package will influence his/her decision to seek care when he/she needs it. Just as important is the person's knowledge of what is not included in the package. This section describes the results of additional survey questions (asked only in 2015) that probe the respondents' awareness of specific PhilHealth benefits. Recall that the list includes three items that are not PhilHealth benefits for any members, namely vitamin supplements, ambulance services, and grocery store discounts. In addition, primary care checkups/consultation and the application of 'no balance billing' (that is,

no excess payment beyond what PhilHealth reimburses) are only for those covered under the Sponsored Program or Indigent Program. Consequently, in the analysis for households in the poorest two quintiles, as well as households who are classified as FIES-poor and NHTS-PR-poor, checkups/consultations and no balance billing are counted as benefits, while for other households they are not.

More than 95 percent of households understood that PhilHealth covers general inpatient admissions (see table 2), with about 80 percent aware that PhilHealth covers surgical procedures, and around 75–80 percent aware of the coverage of medicines at the hospitals. Awareness that medicines are provided at hospitals was, in fact, slightly higher among the poor than among the general population.

On average, households gave 11 correct answers out of a possible 18. Also, less than half of households were aware that PhilHealth covers radiotherapy, blood transfusion, hemodialysis, or treatment of HIV/AIDS. Only a little over half of respondents were aware of the coverage of laboratory services/tests with not much variation across the subgroups examined. In contrast, the level of awareness of the various cancer treatments included in the Z-benefit package is relatively high among all groups — at 68 to 71 percent for most subsidized groups, including the poor. Around 80 percent correctly identified that grocery store discounts were not part of the package and just over 55 percent correctly identified ambulance services as not being part of PhilHealth benefits, again with not much variation across population groups. Between 64 percent and 68 percent of the poor (depending on the definition) and 73 percent of the general population knew that vitamin supplements were not included. In general, though, the results suggest that there is still substantial room for improving knowledge about the contents of PhilHealth benefit package.

While the patterns among the poorest quintiles, the FIES-poor, and the NHTS-PR-poor are similar to those among the general population, it is notable that benefit awareness among the CCT population is markedly lower for a few of the benefits. These include the cancer treatments in the Z-benefit package (which is 8 percentage points lower) and dengue treatment (which is around 6 percentage points lower).

Two additional findings concern benefits that are made available only to the poor. The first finding is that there is a low level of awareness of the fact that, for the poor, checkups/consultations are a part of the PhilHealth benefit package. In fact, awareness of this benefit is second lowest among all 18 benefits analyzed. This is particularly worrisome since the subsidized poor are the target beneficiaries of the Primary Care Benefit 1 package which includes outpatient consultations in accredited rural health units and city health centers. On the upside, though, nearly three in four poor households are aware of the ‘no balance billing’ policy at hospitals. Together, these two results suggest that there is a strong likelihood that the poor may bypass preventive and curative care low-level health facilities in favor of the higher-level facilities.

Table 2. Awareness of Specific PhilHealth Benefits, Among all Member Households and Poor Households, 2015

PhilHealth Benefits	All members	Quintile 1	Quintile 2	FIES-Poor	NHTS-Poor	CCT
	(n=1,780)	(n=335)	(n=332)	(n=603)	(n=508)	(n=381)
	Percentage providing correct answer					
Room and board during hospital confinement	95.7%	96.6%	97.3%	96.9%	96.6%	97.5%
Medicines at the hospital	76.4%	80.5%	78.5%	80.7%	80.6%	83.6%
Checkup/Consultation**	31.6%	38.7%	33.0%	37.3%	40.2%	41.4%
Laboratory services/laboratory tests	53.3%	53.8%	55.5%	55.2%	58.1%	57.9%
Surgical procedures	81.8%	81.8%	77.6%	79.0%	77.0%	82.5%
No balance billing/free services for Sponsored Program Members in government hospitals**	74.0%	76.1%	72.1%	74.4%	74.9%	78.9%
Ambulance service*	54.9%	54.6%	56.8%	56.6%	58.8%	57.6%
Vitamin supplements*	72.7%	63.6%	73.5%	67.8%	66.6%	63.8%
Discount at a grocery store*	83.2%	82.9%	80.0%	81.7%	83.1%	80.5%
Radiotherapy	36.7%	34.4%	37.5%	36.5%	38.3%	32.9%
Blood transfusion	41.7%	39.2%	48.1%	43.4%	47.5%	42.6%
Hemodialysis	47.3%	44.0%	50.9%	47.5%	49.4%	42.8%
Treatment for HIV/AIDS	47.6%	39.8%	50.4%	45.5%	46.6%	39.2%
Treatment for malaria	60.8%	54.1%	59.8%	56.6%	56.4%	58.0%
Treatment for tuberculosis	71.5%	69.0%	69.8%	69.0%	70.3%	68.5%
Treatment for dengue	75.7%	74.0%	72.4%	72.4%	73.2%	70.9%
Treatment for breast cancer, cervical cancer, and prostate cancer	71.3%	71.4%	68.2%	69.1%	71.3%	64.6%
Treatment for leukemia	68.6%	66.7%	64.5%	64.9%	66.0%	60.3%
Mean score, correct awareness of existing PhilHealth benefits (Maximum = 18)	11.15	10.90	11.14	11.02	11.21	11.24

Source: HEFPA Survey, 2015; authors' computations.
Note: * Not a PhilHealth benefits for any member; ** PhilHealth benefits for subsidized (Indigent Program) members only; percentages reflect those households that answered correctly, given the benefits to which their subgroup is entitled.

FROM WHOM DO PEOPLE LEARN ABOUT THE VARIOUS PHILHEALTH BENEFITS?

Respondents were asked to recall from whom they learnt about the contents of different services in the the PhilHealth benefit package. In the general population, and consistently across the bottom two income quintiles, social networks—friends, neighbors, families, and relatives—are by far the most important source of information on the contents of the PhilHealth benefit package; they are cited by more than 60 percent of households.

The second most important source of information is PhilHealth, but interestingly not the outreach programs that are designed to inform people of benefits. The PhilHealth *Alaga Ka* campaign, for example, is mentioned by only a handful of households; PhilHealth leaflets and brochures are also seldom mentioned. Rather, it is the PhilHealth staff deployed in health facilities that appear to be the most effective of PhilHealth's information/outreach mechanisms.

The third most important source of information on benefits is the mass media, particularly television. These are likely to be mainly PhilHealth's own television advertisements. Equally important is the local government, particularly *barangay* officials. Interestingly, DSWD's CCT program, which was an important source of information on PhilHealth membership status, seems not to be an important source of information on PhilHealth benefits; neither are health care providers.

There is very little difference in the frequency with which different income groups rely on the different formal sources, such as PhilHealth and *barangay* government officials, for information on PhilHealth benefits. This suggests that the accessibility of these institutions and their programs is quite equitable. The exception is the FDS which, as might be expected since this program targets the poor, is slightly more relevant for the poorer population groups and especially CCT households — but still, even among this group, it is not a very important source of information. Rather, it is the informal information sources, like social networks of friends/neighbors and family/relatives, where income differences are observed, with the poor relying on friends and family somewhat less than those who are better-off.

Table 3. Sources of Information about PhilHealth Benefits, Among all Member Households and Poor Households, 2015

Sources	All	Quintile 1	Quintile 2	FIES-Poor	NHTS-PR-Poor	CCT
	(n=1,556)	(n=335)	(n=332)	(n=526)	(n=443)	(n=381)
DSWD and CCT program						
FDS	1.6%	2.3%	2.6%	2.5%	2.5%	4.6%
CCT leader	0.8%	0.8%	1.2%	0.7%	0.9%	4.1%
Subtotal	2.40%	3.10%	3.80%	3.20%	3.40%	8.70%
Mass media						
Television advertisement/program	13.7%	18.3%	11.7%	15.8%	14.1%	13.4%
Radio advertisement/program	2.3%	1.8%	1.5%	1.8%	1.9%	1.6%
Newspaper	0.2%	0.4%	0.1%	0.3%	0.4%	0.0%
Subtotal	16.20%	20.50%	13.30%	17.90%	16.40%	15.00%
Social networks						
Friends/neighbors	31.5%	24.5%	28.5%	25.7%	27.2%	27.5%
Family/relatives	30.4%	26.0%	28.5%	28.3%	30.6%	24.9%
Senior citizens' organization	0.5%	0.6%	0.7%	0.7%	0.9%	20.0%
Coworkers	3.3%	1.9%	1.6%	1.7%	0.2%	0.2%
Employer	0.5%	0.9%	0.0%	0.5%	0.7%	0.3%
Subtotal	66.20%	53.90%	59.30%	56.90%	59.60%	72.90%
PhilHealth sources						
PhilHealth staff at health facility	19.9%	18.7%	20.9%	18.3%	17.4%	20.0%

Sources	All	Quintile 1	Quintile 2	FIES-Poor	NHTS-PR-Poor	CCT
	(n=1,556)	(n=335)	(n=332)	(n=526)	(n=443)	(n=381)
Alaga Ka campaign	0.1%	0.4%	0.0%	0.2%	0.3%	0.0%
Leaflets/brochures from PhilHealth	1.6%	1.6%	2.1%	1.9%	2.0%	2.1%
Other PhilHealth awareness promotion events	2.1%	1.7%	4.2%	2.8%	3.6%	4.6%
Subtotal	23.70%	22.40%	27.20%	23.20%	23.30%	26.70%
Health providers						
Doctor	0.7%	0.3%	0.3%	0.2%	0.2%	1.1%
Health facility	1.1%	1.2%	0.6%	1.0%	0.7%	1.4%
From other patients	0.3%	0.7%	0.6%	0.7%	0.7%	0.2%
Subtotal	2.10%	2.20%	1.50%	1.90%	1.60%	2.70%
Local government						
Barangay officials	14.6%	13.8%	16.9%	15.7%	16.8%	17.9%
Someone from the municipal/city hall	0.6%	0.5%	0.5%	0.6%	0.4%	0.8%
Politicians	0.1%	0.4%	0.0%	0.2%	0.3%	0.3%
Subtotal	15.30%	14.70%	17.40%	16.50%	17.50%	19.00%
Others	2.5%	4%	3.1%	3.6%	3.5%	3.9%
None (Not aware of any benefits)	0.3%	0.0%	0.0%	0.0%	0.0%	0.3%

Source: HEFPA Survey, 2015; authors' computations.

IV. DISCUSSION AND RECOMMENDATIONS

This analysis yields a number of findings that are relevant to PhilHealth program implementation. They may also be relevant to other countries where specific groups—and especially the poor—are 'automatically enrolled' in government-subsidized health insurance.

DISCUSSION OF KEY FINDINGS

First, of those who are aware of their entitlement to subsidized insurance, most learned of it from their *barangay* officials or through officials of the DSWD, emphasizing the role played by local governments (at the community-level, rather than municipality-level) and other non-health national programs in informing people of the health insurance coverage. Yet, it is disappointing that more people do not mention PhilHealth's outreach activities, such as the *Alaga Ka* campaign as the source of information on their entitlement, especially since the CCT accounts for less than a third of all subsidized PhilHealth members.

Second, there is considerable room to improve people's knowledge of PhilHealth benefits; scores on the benefit awareness index are quite low. While the survey only asked about 18 specific items, the results could be taken as indicative of broader categories of benefits within the PhilHealth benefit package. In this regard, among the specific benefits surveyed, very few people were aware that PhilHealth covers radiotherapy and blood transfusion. On the other hand, knowledge of conditions that are part of the catastrophic Z-benefit package is better and almost three-quarters of respondents knew that the poor/indigent should not be balance billed at hospitals. Of most concern is the finding that so few of the poorer population groups are aware that their coverage includes free primary care checkups/consultations. As noted earlier, the combination of low awareness of free primary care consultations and high awareness of 'no balance billing' increases the likelihood that the poor will bypass the rural health units and urban health centers, going straight to hospitals.

Third, it appears that most households learn about their PhilHealth benefits from their social networks (friends and family) rather than from PhilHealth outreach activities to the general public. That said, one of the most important information sources is the PhilHealth staff deployed in health facilities (that is, the PhilHealth CARES program). While it is reassuring that these staff are highly valued as a source of information on benefits, the problem is that it implies that people only learn of their benefits once they have been admitted to hospital. Since the decision to seek care may be influenced by perceptions of whether the treatment will be covered by PhilHealth, it is critical that this information reach people through other PhilHealth outreach channels, too – and before people get sick. Fortunately, it appears that television advertisements, many of which can be assumed to be developed and paid for by PhilHealth are found to be an important source of information. *Barangay* officials are another important source, emphasizing again the importance of the role played by local governments in benefit awareness. A surprising result was that the CCT program, which is an important source of information on PhilHealth membership status, was not an important source of information on PhilHealth benefits—even among the poorest respondents.

On most of the questions examined, including those on awareness of specific benefits, there is not much difference between the general population and the poorest income groups. There is some difference in the sources on which people tend to rely on for information on PhilHealth benefits, however, with the poor relying somewhat less on social networks than those who are

better-off. Access to government sources of information (whether organized through local governments, PhilHealth, or DSWD) appears to be similar across income groups.

An important question is what role each government agency does and should play in ensuring awareness of PhilHealth benefits. By the 2013 Health Insurance Law, PhilHealth is mandated to ensure awareness of benefits[13] and, as described in the introduction, has implemented a number of different benefit awareness campaigns. However, there is always the inherent tension (in any system) that the health insurer, as payer, may not be sufficiently motivated to advertise benefits because of pressure to limit payouts and ensure the financial sustainability of the health insurance fund. Consequently, it is important that other government entities also play a role. This policy note has already documented the important roles of DSWD and LGUs, for example, and these are discussed further below. However, there may also be a role for other entities, especially those whose primary objective is to serve the interests of patients, beneficiaries, and the poor. One can think, for example, of the Office of Senior Citizens Affairs (in every LGU), as well as civil society organizations who could potentially be contracted by government to do awareness campaigns, especially in hard-to-reach areas.

RECOMMENDATIONS

Building on these findings, some suggestions for future policy development and program implementation include:

- Make more use of the CCT program to provide relevant information to the poor on PhilHealth benefits. The Municipal Links and the FDS appear to be important sources of information on the entitlement to health insurance coverage through PhilHealth and, so, can likely be better used to give out accurate information on PhilHealth benefits, rules, procedures, and benefits. This echoes the recommendation of the DSWD/World Bank 2014 evaluation of the CCT program which noted that CCT beneficiaries do not use health care more than non-beneficiaries despite having higher health insurance coverage rates, and recommended better use of the FDS to close information gaps on benefit awareness (DSWD and World Bank 2014).

- Identify, train, and incentivize members of the local community to share information on PhilHealth benefits. The fact that *barangay*-level officials are already an important information source of information on PhilHealth benefits suggests that people trust and turn to those that they know at the local level for information. The ideal person for this job would therefore be somebody who is widely known and well-connected to others in the community. Training this person well would be essential to ensure that he/she imparts complete and accurate information about PhilHealth benefits.

- Reassess the design, content, and implementation of the *Alaga Ka* campaign as it is not yet an important source of information of PhilHealth entitlements or PhilHealth benefits. That said, its relatively low impact to date may simply be a

[13] PhiHealth should "Conduct information campaigns on the principles of the Program to the public and private accredited health care providers. This campaign must include the current benefit packages provided by the Corporation, the mechanisms to avail of the current benefit packages, the list of accredited and dis-accredited health care providers, and the list of offices/branches where members can pay or check the status of paid health premiums" (2013 National Health Insurance Act, Implementing Rules and Regulations, Section 6g).

matter of limited scale and time under implementation. It is possible the program has not yet reached a sufficient number of *barangays* for its impact to be felt.

- Mass media campaigns, particularly television advertisements, appear to be an important source of information on PhilHealth benefits, suggesting that they should be sustained and even scaled up. To ensure that future dissemination strategies are well-targeed, though, it would be to examine which media channels Filipinos in different parts of the country (and of different language groups) consider most informative and credible.

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This paper assesses how people who are eligible for government-subsidized (free) health insurance through Philippines Health Insurance Corporation (PhilHealth) find out about their eligibility and their benefits, and also how well people know the PhilHealth benefits.

A panel of household survey data (2011 and 2015), collected by the UPEcon Foundation and the World Bank, as well as administrative data.

We found that *barangay* officials and staff of the Department of Social Welfare and Development (DSWD) are the most important source of information on eligibility for government-subsidized health insurance, emphasizing the role played by local governments and other non-health national programs in informing people of their health insurance coverage. Second, we find that, overall, there is considerable room to improve people's knowledge of the PhilHealth benefit package (i.e. which health services are covered and that the extent of knowledge varies by benefit type. Awareness of coverage of various types of hospital care is high and around 75 percent of the poor know about the no-balance billing policy. By contrast, only a minority of poor people know that their PhilHealth coverage includes a free primary care consultation. Third, we find that most people learn about what health services are covered by PhilHealth from their social networks (that is, friends, neighbors, families, and relatives), followed by PhilHealth staff deployed in health facilities, and then the mass media; by contrast, only a small share of people appear to learn about their benefits from PhilHealth or DSWD outreach programs specifically designed to inform communities of benefits.

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