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PERSPECTIVE

Comprehensive Primary Care PhilHealth Benefits for the Filipino People. *Ngayon Na*! Perspective Study on the Universal Health Care Law Implementation

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ABSTRACT

The implementation of the Universal Health Care Law in the Philippines has significantly stalled, with health financing and service coverage remaining heavily skewed toward expensive hospital-based care rather than cost-effective primary care. Despite increased government spending on health, out-of-pocket health expenditures remain high at 43 percent. Even with PhilHealth's *Konsulta* (recently rebranded as *YAKAP*), primary care utilization remains strikingly low. To jump-start UHC implementation, we assert that the strategic way forward is the immediate rollout of a comprehensive primary care services package. The way to do this was proposed during the 2013 DOH *KP* assessment, six years before the enactment of the UHC Law. All we need

Transactions NAST PHL Vol. 48 (2026)
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now is for the DOH and PHIC to have the political will to implement it. And the Filipino people, having experienced how their primary care needs have been met comprehensively and compassionately, consistent with health as a right rather than a politicized *ayuda* [assistance], will now demand the same quality care at all levels of the health system and call for UHC *Ngayon Na* [Right Now]!

Keywords: Universal Health Care, health financing, social health insurance, primary care

Abbreviations: *BUCAS*, Bagong Urgent Care and Ambulatory Services; CHE, Current Health Expenditure; CHED, Commission on Higher Education; DOH, Department of Health; *GAMOT*, Guaranteed and Accessible Medications for Outpatient Treatment; HCPN, Health Care Provider Network; HFEP, Health Facility Enhancement Program; HRH, Human Resources for Health; IRR, Implementing Rules and Regulations; *KP, Kalusugan Pangkalahatan; Konsulta, Konsultasyong Sulit at Tama*; LGUs, Local Government Units; NBB, No Balance Billing; NCDs, Noncommunicable Diseases; OOP, Out-of-Pocket; PCB I, Primary Care Benefit I; PCB II, Primary Care Benefit II; PCPN, Primary Care Provider Network; PHIC, Philippine Health Insurance Corporation; PIDS, Philippine Institute of Development Studies; RHUs, Rural Health Units; SHI, Social Health Insurance; UHC, Universal Health Care; WHO, World Health Organization; *YAKAP, Yaman ng Kalusugan* Program

Introduction

The implementation of the Universal Health Care (UHC) Law has significantly stalled. UHC was enacted into law in February 2019 (Republic Act 11223 2019) and its Implementing Rules and Regulations (IRR) (DOH 2019) were issued in October 2019. The COVID-19 pandemic, which erupted in 2020, disrupted implementation timelines and resource availability for three years while reinforcing the law's urgency and importance. To date, the rollout of integrated provider networks has remained largely at the pilot stage.

The UHC Law and its IRR recognized the centrality of outpatient primary care benefits and mandated the Philippine Health Insurance Corporation (PHIC) to come out with comprehensive outpatient benefit within two years of its enactment. The comprehensive outpatient benefit should include, but are not limited to, services of health professionals, diagnostic, laboratory, dental, and other medical services, personal preventive services, prescription drugs and biologicals, in accordance with the recommendations of the Health Technology Assessment Council (IRR Rule Sec 6.3). Seven years have passed since the enactment of the UHC Law and its IRR, but a truly comprehensive primary care benefit remains to be realized.

At this point, it is good to recall the words of former Department of Health (DOH) Secretary Alberto Romualdez Jr. and convenor of the UPM UHC Study Group, who said in 2011, eight years before the UHC Law was passed: "All of us began with the promise of Universal Health Care. If it's still not there, I think we should start getting impatient. … we should start convincing our people that they should not be too patient. They should start demanding their rights because the people who are running things are not part of the communities that are deprived… It is urgent for people who have no voices" (Pharmaceutical and Healthcare Association of the Philippines , 2011).

The Universal Health Care Study Group (UHC SG) aims to identify and discuss one major opportunity and the challenges to accelerate the implementation of the UHC. In this article, we assert that the effective implementation of comprehensive primary care benefits is the strategic way forward.

The Status of UHC Implementation Based on the World Health Organization (WHO) UHC Cube

The UHC Law addressed the first dimension, or the breadth of population coverage, by declaring **all** Filipinos covered by virtue of citizenship (Republic Act 11223 2019). The two other dimensions, service coverage (depth) and health financing coverage (height), attest to the stalled UHC implementation. Service coverage remains skewed towards the provision of the more expensive hospital inpatient and specialized care rather

Transactions NAST PHL Vol. 48 (2026)
doi.org/10.57043/transnastphl.2026.6356

than the more cost-effective care, ranging from health promotion and prevention to primary curative services. In an effectively balanced service coverage, most health needs are addressed at the primary care level; the secondary care level manages referred and moderately complex cases; and the tertiary care level provides highly specialized interventions.

Primary Healthcare Service Coverage

In 2024, PHIC's total claims payment was PhP164.5 billion. *Konsultasyong Sulit at Tama* (*Konsulta*) payouts, representing primary care, totaled only ₱3.59 billion, or 2.2 percent of total claims payment. The overwhelming share of PhilHealth spending remains concentrated on hospital-based services, perpetuating a treatment-heavy bias that does little to prevent catastrophic household expenditures (Philippine Health Insurance Corporation 2024b).

Health professional attendance at the time of death can serve as a proxy indicator for primary care coverage. Alarmingly, 48.5 percent of the registered deaths in 2023 were reported to have been without any health professional attendance (Philippine Statistics Authority 2025), suggesting that nearly half of those who died never reached a health facility nor received any form of health care. This could be due either to a lack of physical or financial access.

Financial Coverage

In 2022, when Total Health Expenditure was still disaggregated, PHIC's share was 14 percent, with the national government share at 21 percent, and the local government share at 10 percent. OOP spending accounted for 45 percent of total health expenditure.

For 2024, Dr. Valerie Ulep gave an overview presentation of the Philippine Institute of Development Studies (PIDS) UHC in the Numbers forum (2025) that showed that, even with increased aggregated government health spending at 44 percent share of CHE, OOP share decreased minimally to 43 percent from 45 percent in 2022 (Ulep et al. 2025). Financial risk protection is generally associated with OOP spending below 20% of total health expenditure (World Health Organization & World Bank 2017).

The end goal of population, service, and financial coverage is improved health outcomes. The PIDS UHC in the Numbers forum concluded that increased government spending did not translate to better health outcomes, which continue to lag behind those of our ASEAN neighbors (Ulep et al. 2025).

PHIC's Response to the UHC Mandate to strengthen primary care

PHIC's Primary Care Initiatives

The Philippine Health Insurance Corporation (PHIC) was established in 1995 as the country's national health insurer, following Social Health Insurance principles.

PHIC rolled out its first Outpatient Benefits (OPB) in the late 1990s to early 2000s. OPBs were disease or condition-specific packages such as TB-DOTs, covering only LGU-enrolled indigent families. LGUs provided these services, financed through "capitation" or a reimbursement of P500 from the P1,200 PHIC premium per indigent family enrolled (Obermann et al. 2018).

In April 2012, PHIC repackaged OPB and renamed them Primary Care Benefit I (PCB I), covering doctors' fees and diagnostics, and Primary Care Benefit II (PCB II), covering selected outpatient medicines using voucher payments. Only indigent and sponsored families were covered.

In 2013, the DOH organized a *Kalusugan Pangkalahatan* (*KP*) assessment: focus on Health Financing. The international and local group of health experts recommended a two-year timetable for the declaration of Universal coverage for comprehensive primary care benefits composed of PCB I + and PCB II ++.

PHIC's response was *Tamang Serbisyo para sa Kalusugan ng Pamilya* (*Tsekap*), basically a rebranded enhanced PCB I, covering high burden diseases but without universal coverage (PhilHealth Circular 15 2014) (Oberman et al. 2018)

In July 2020, responding to the UHC Law's mandate, PHIC formally replaced *Tsekap* with *Konsultasyong Sulit at Tama* (*Konsulta*) (PhilHealth Circular 2020-0002), with benefits further enhanced in 2024 (PhilHealth Circular 2024-0013). On July 31, 2025, the Expanded *Konsulta* Program was rebranded to *Yaman ng Kalusugan* Program (*YAKAP*). *YAKAP*'s benefits were expanded

Transactions NAST PHL Vol. 48 (2026)
doi.org/10.57043/transnastphl.2026.6356

to 75 medicines, with more laboratory tests including cancer screening, and each beneficiary would receive up to PhP20,000 worth of medicines per year or GAMOT (Guaranteed and Accessible Medications for Outpatient Treatment) from accredited pharmacies or providers.

There appears to be a trend from PHIC's PC initiatives. When Health Policy and Financing experts (those involved with the 2013 DOH *KP* assessment, the 2019 UHC Law and its IRR, and the 2023 NAST UHC paper (Domingo et al. 2023)) recommend that PHIC comes out with comprehensive primary care benefits, PHIC responds with a series of expanding primary care benefits (PCB I to *Tsekap* to *Konsulta*, expanded *Konsulta*, and finally *Yakap*) that continue to fall short of being comprehensive.

Yakap's Limitation as a Comprehensive Primary Care Benefit

YAKAP's limitation can be gleaned from GAMOT's list of 75 essential medicines (242 molecules) (PhilHealth PC 2025-0013). GAMOT's essential medicines cover infections, COPD, asthma, diabetes, high cholesterol, and cardio-vascular conditions, which include some of the top ten causes of mortality, but not necessarily the top 10 causes of morbidity, such as animal bites (#3), urinary tract infections (#4), and skin diseases (#6) (based on the Field Health Services Information System [FHSIS]) (Department of Health 2024b). Significantly, they do not cover mental health conditions such as anxiety disorders, depression, bipolar disorders, and Attention Deficit Hyperactivity Disorder.

GAMOT's PhP20,000 limit per beneficiary is also problematic. A study conducted by Jimeno et al. (2021) found that the cost of managing Type 2 diabetes averaged PhP31,050 (US$621) in a public hospital (Ospital ng Makati) in NCR in 2016. If a beneficiary exceeds her/his GAMOT's PhP20,000 annual limit, she/he has to pay for it from OOP. PHIC, as a Social Health Insurance (SHI) corporation, does not apply the SHI principle of social solidarity, where the well off and relatively healthy who need less medicine subsidize the poor and relatively sickly who usually need more medicine. Medicines should be included within the capitation contract amount for Comprehensive Primary Care Benefits.

Konsulta, rebranded as *YAKAP*, has not had the impact to shock and awe Filipinos to demand the accelerated implementation of UHC. In 2024, PHIC reported that 88 percent of cities and municipalities had *Konsulta* coverage. (PhilHealth 2024b) Actual utilization remained low at just 22.9 percent utilization by those registered and barely 6 percent of the 2024 national population of 112.9 million. *Konsulta* has not translated into broader primary care use.

Effective implementation of Comprehensive Primary Care Services

To fulfill this UHC mandate and jump-start the stalled UHC Law implementation, we recommend the implementation of the comprehensive primary care services proposed in the DOH Philippine Health Agenda 2016 to 2022 (DOH 2020). These comprehensive primary care services address the triple burden of disease in the Philippines, using an all-of-life stage approach. The triple burden of disease is defined as: persistent communicable diseases; rising noncommunicable diseases (NCDs), including malnutrition, and health conditions due to globalization and rapid urbanization. The health conditions due to globalization and rapid urbanization include mental health, drug addiction, accidents, and conditions brought about by climate change.

Using an all-of-life-stage approach means that all Filipinos are assured of being attended to by a health professional from womb (pregnancy and life in utero) to near tomb (elderly) and even being attended to by a health professional at the time of death. Health professional attendance at the time of death does not merely mean having a doctor sign the death certificate. All dying patients and their families deserve the right to have a health professional who guides them physically, mentally, and emotionally through the difficult and complex transition of dying.

Creating a Primary Care Provider NETWORK

A PCPN is a network contracted to provide both population-based services and individually based primary care services.

A PCPN is defined as a coordinated group of public, private, or mixed primary care providers. It shall provide

Transactions NAST PHL Vol. 48 (2026)
doi.org/10.57043/transnastphl.2026.6356

primary care services; serve as the initial contact and navigator to guide patients' decision-making for cost-efficient and appropriate levels of care. It facilitates two-way referrals and removes barriers to health services, enabling patient records to be accessible throughout the health system. A PCPN can implement public health services, as may be determined by the DOH (Rule Sec 17.3.a).

The UHC Law and its IRR provide for both DOH and PHIC to do Network contracting: DOH for population health (Rule Sec 17.2), PHIC for individual-based health services (Rule Sec 18.2). Population health services are defined as those intended to be received by the population or identified groups of people, which contribute to general public health (Rule Sec 17.1.a). Individual-based health services are defined as those that can be definitively traced back to one recipient and have a limited effect at a population level (Rule Sec 18.1).

Two proposed models of PCPNs

The District Health System (DHS)

There are at least two proposed models of PCPNs. In 2013, the joint international and local team of health financing experts proposed a comprehensive package of primary care services to be delivered through a District Health System (DHS). A DHS is a network of Municipal Health Centers or Rural Health Units (RHUs) linked with the District Hospital (DH), providing 24/7 services (DHS = DH + RHUs).

A Primary Care Study led by Dr. Antonio Dans et al. (Rey et al. 2023) estimated that the cost for providing such a comprehensive care benefit would be about PhP 1500 per capita. PhP 1500 multiplied by 112.9 million Filipinos (2024) would translate to PhP 169.4 billion and would only be 60% percent of PHIC's 2024 reserve fund of PhP280.5 billion, without the PhP 89.8B remitted to the Bureau of Treasury as "unused funds" (PHIC AR 2024). PHIC's "unused funds" should finance comprehensive primary care benefits. Notably, PHIC's *Konsulta* circular 2024-0013 had raised the capitation for primary care benefits to PhP1,700 per year (PhilHealth 2024a; Legaspi 2024).

Advantages of a Capitation Contract for Comprehensive PC Benefits

A capitation contract means that for a fixed capitation amount (PhP1,700), PHIC contracts a PCPN to provide comprehensive primary care benefits for every person registered within a PCPN for an agreed period, usually for a year. This amount covers comprehensive primary care benefits from health promotion, public health prevention, primary care treatment, diagnostic laboratories, and medicines, regardless of the actual utilization of services. This transfers the risk of overprovision of services to the contracted PCPN. It incentivizes spending for health promotion and preventive care versus the more expensive curative care, because whatever is saved from the total capitation amount accrues to the PCPN for use the following year.

The provision of a comprehensive primary care benefit package will address the problem of the 43 percent OOP expenditure for health, of which 36.78 percent is driven by medicines. Medicines remain the single largest item in household health budgets across regions (Program for Health Equity 2025). The all-of-life stage approach ensures health professional attendance from "womb to near tomb" and even at the time of dying to provide the patient and her/his family the physical, mental, and emotional support through the difficult and complex transition of dying. At present, the well-off can avail themselves of these services for making end-of-life decisions.

BUCAS centers as providers of Primary Care Services

The DOH under Secretary Teodoro Herbosa proposed *BUCAS* (*Bagong* Urgent Care and Ambulatory Services) centers providing both Primary and Urgent Ambulatory Care, with the *BUCAS* centers providing 24/7 services. The 24/7 availability of primary care services is crucial for a PCPN because Municipal Health Centers or RHUs, which provide primary care services, are usually open only during office hours.

Limitations of *BUCAS*

Concha, in an early 2024 review of *BUCAS* centers, underscores several limitations that constrain their overall impact. A primary concern is their geographical distribution, with many centers located in accessible areas, from the district hospitals to the Philippine Heart Center in the National Capital Region, rather than in

Transactions NAST PHL Vol. 48 (2026)
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geographically isolated and disadvantaged areas. They serve as the ambulatory urgent care unit of the hospital, relieving the hospital's congested emergency rooms. Thus, they provide urgent ambulatory care rather than comprehensive primary care. *BUCAS* centers generally use the same health human resource of the hospitals. Without a link to the RHUs, *BUCAS* centers lack the forward and back referral from the primary care units to ensure continuity of care (Concha 2024).

Building on Concha's analysis, these limitations suggest that *BUCAS* centers, while effective in improving access to urgent and ambulatory care, may face constraints in fully delivering comprehensive, population-based primary care.

The PCPN and the Health Care Provider Network (HCPN)

PCPNs must be integrated within the Health Care Provider Network (HCPN) to provide a deep and balanced Service Coverage. A PCPN, as the foundation of the HCPN, addresses the primary care needs of the population, but the health care needs of the population go beyond primary care and include tertiary inpatient care.

The HCPN is a province- or chartered city-wide network of public and private providers delivering a continuum of care — from primary to tertiary services — through a functional forward and back referral system (Department of Health et al. 2021a). Note that the UHC Law recognizes the role of private providers. The private sector at present predominates within the tertiary level of health care. It has also initiated networks of primary care clinics. A well-regulated and well-partnered private sector can be a powerful ally in ensuring deep and balanced service coverage.

A Comprehensive Primary Care Benefit Package Requires an All-of-Health System Framework

The implementation, monitoring, and evaluation of the provision of a comprehensive primary care benefit package as proposed by the DOH (DOH 2020) must be within an All of Health System framework (Republic Act No. 11223, 2019 Chapter 1, Sec 2 (c)) to be effective and equitable, leading to faster health outcomes improvement.

Health financing and primary care

As of 2024, the overwhelming share of PhilHealth spending remains concentrated on hospital-based services, perpetuating a treatment-heavy bias that does little to prevent catastrophic household expenditures (PhilHealth 2024b).

To address this historical bias, the UHC Law's IRR mandates PHIC, as the strategic purchaser, to shift to prospective Global Budgeting from its present reimbursement mode. In the 4th National Health Sector Meeting in 2019, senior PHIC officers presented a conceptualization of prospective Global Budgeting composed of historical payments for inpatient care and for urgent ambulatory care, and a capitation contract for outpatient primary care. Financing mechanisms are different for urgent ambulatory care and outpatient primary care.

The electronic community health information system

Every patient encounter in a PCPN should be captured through standards-based, interoperable electronic community health information systems. These data are used by the local care team primarily to monitor their patients. These data are then submitted routinely to the National Health Data Repository as provided by law (UHC Law, Sec. 31). The ideal health information system, therefore, should first empower community health workers to monitor their PCPN's effectiveness, equitability and health outcomes while allowing the province or chartered city provider network access to the data for population health purposes.

Human resources for health

To ensure the provision of a comprehensive primary care benefit, we need the following:

(1) Immediate full implementation of the Human Resource for Health registry to be used for real-time, equitable HRH distribution decision-making. (2) Massive and widespread urgent training of the current health workforce on their new roles to strengthen the provision of quality primary care services. (3) Establishment of decent work conditions to retain the health workforce in active duty and manage out-migration. (4) Full implementation of the DOH-CHED joint memorandum

Transactions NAST PHL Vol. 48 (2026)
doi.org/10.57043/transnastphl.2026.6356

on the reorientation of current health care professional and health care worker curriculum towards PHC with emphasis on public health and primary care, in the public and private sectors, to produce practice-ready future health professionals (Rule Sec 25.10).

Even now, certain medical schools such as the Bohol Island State University College of Medicine and Cavite State University College of Medicine have adopted a reoriented medical curriculum towards Primary Health Care, with a focus on Public Health and Primary Care to be able to graduate practice-ready PHC practitioners (Commission on Higher Education & Department of Health 2017).

Community Participation

Beyond the strengthening of the health system in its various components, we need the active and meaningful participation of individuals, families (households), and communities in the prevention of diseases and the promotion of healthy lifestyles. For this to happen, improving the health literacy of all Filipinos is of paramount and strategic importance. Health literacy translates to better health outcomes (Ch 1 Sec 2. (a)) (Republic Act No. 11223, 2019), and ultimately Health for All Filipinos.

Conclusion and Recommendations

MOVING FORWARD — Comprehensive Primary Care benefits for ALL Filipinos

We need to implement the comprehensive primary care benefits proposed by the DOH in 2020 (Department of Health 2020), which address the triple burden of disease in the Philippines, using an all-of-life stage approach to achieve improved health outcomes.

The way to achieve this was proposed during the 2013 DOH *KP* assessment, six years before the enactment of the UHC Law in 2019. These proposals have since been incorporated into the UHC Law.

The panel of experts recommended that "comprehensive primary care package (PCBI and PCBII++) be delivered through a District Health System (DHS = DH + RHUs), to reduce OOP share and improve health outcomes. Concomitantly, PHIC should apply NBB to reduce OOP. The DOH Health Facility Enhancement Program (HFEP) Phase II 2014 – 2031, should strengthen the DHS through increased investment" (UHC's PCPN). "The DHS is further strengthened through scaled up 'mandatory' district health services by ALL medical, nursing, pharmacist and dental graduates" in contrast to the present continued reliance on the Doctors to the Barrios Program (UHC Law IRR Rules 25.10 Reorientation of Health Care Professional Education and 26. Return Service Agreement) "Embed 'rural retention' in all health professional education: such as rural recruitment, provincial training, and hometown placement" (UHC Law IRR Rules 25.3.c .d .e) "Implement a five-year HFEP plan (2014-2018) to upgrade provincial/regional hospitals serving as referral backup (UHC's HCPN). For health financing, consider using PHIC's 2-year reserves to front-load investment" (instead of accumulating 'unused funds').

All we need now is for the DOH, as the lead agency of the health sector, and for PHIC, as its attached agency, to have the political will to implement it. And the Filipino people, having experienced how their primary care needs have been met comprehensively and compassionately, consistent with health as a right rather than a politicized *ayuda* [assistance], will now demand the same quality care at all levels of the health system and call for UHC *Ngayon Na* [Right Now]!

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