Original Article

Access this article online

Quick Response Code:

Website: https://journals.lww.com/pjhrd

DOI: 10.4103/PJHRD.PJHRD_6_25

Bridging policy and practice: A qualitative study on PhilHealth claims and financial processes in public hospitals

Meljun R. Banogon, Geremiah Edison Daniel C. Llanes[1], Juan Maria Pablo R. Nañagas[2], Jaime Z. Galvez Tan

Abstract:

BACKGROUND: PhilHealth serves as the Philippines' national health insurance provider and is central to implementing the Universal Health Care (UHC) Law. Despite this, existing gaps and ongoing challenges in claims and financial management systems continue to affect public healthcare facilities' operations and sustainability.

AIMS AND OBJECTIVES: This article examined the effectiveness and challenges of PhilHealth's claims and financial management systems in public healthcare facilities, focusing on accreditation, claims processing, reimbursements, and financial governance.

MATERIALS AND METHODS: A qualitative multiple-case study design was employed in Quezon City and the provinces of La Union, Sorsogon, Leyte, and Bukidnon, with data collected from 2022 to 2023. Prior to data collection, a certificate of exemption was granted by the Department of Health – Single Joint Research Ethics Board (DOH-SJREB). Data were collected through key informant interviews with healthcare facility heads, claims processors, and PhilHealth personnel, supplemented by document reviews and facility observations. Thematic analysis was employed to examine the implementation of national health insurance policies at the facility level.

RESULTS: Accreditation standards are uniformly defined, yet compliance varies widely, directly influencing reimbursement outcomes. Facilities with compliance gaps often face provisional accreditation, downgrades, or suspension, resulting in reduced revenue. Although the Universal Health Care (UHC) Law guarantees patient access to PhilHealth benefits, the efficiency of claims processing remains uneven and highly dependent on administrative capacity, staffing adequacy, and digital infrastructure. Systemic inefficiencies at both PhilHealth and facility levels contribute to delays and claim denials. Reimbursements are further constrained by outdated case rate ceilings, inconsistent financial practices, inadequate recordkeeping, weak information systems, and poor storage conditions—particularly in lower-level hospitals and rural health units.

CONCLUSION: Reforms in claims processing workflows, information system integration, and financial management capacities are crucial to enhance reimbursement efficiency. Strengthening these systems is fundamental for supporting sustainable, equitable, and high-quality healthcare delivery in the public sector within the Universal Health Care (UHC) framework.

Keywords:

Claims processing, Financial governance, PhilHealth, Public hospitals, Reimbursements, Universal Health Care (UHC)

Health Futures Foundation, Inc., Quezon City, Philippines, [1]Department of Psychiatry and Behavioral Medicine Philippine General Hospital, Manila, Philippines, [2]Asian Eye Institute, Makati City, Philippines

Address for correspondence:
Mr. Meljun R. Banogon, Health Futures Foundation, Inc., Quezon City, Philippines.
E-mail: meljunbanogon@gmail.com

Received: 08-07-2025
Revised: 19-09-2025
Accepted: 03-10-2025
Published: 21-11-2025

Introduction

Since its founding, PhilHealth has taken pride in its ability to extend population

How to cite this article: Banogon MR, Llanes GE, Nañagas JM, Tan JZ. Bridging policy and practice: A qualitative study on PhilHealth claims and financial processes in public hospitals. Philipp J Health Res Dev 2025;29(3):79-90.

coverage. PhilHealth Annual Reports indicate that coverage was 35% in 2000 and has progressively grown since then.[1] With the passage of the Universal Health Care (UHC) Act, which mandates that all Filipino nationals be automatically enrolled in the National Health Insurance Program (NHIP), PhilHealth's coverage rate has reached 100%.[2-4] PhilHealth was also stated to have improved access to primary health care in 2016 through its packages and accreditation system.[1] PhilHealth's purchasing strategy has been fee-for-service from its beginnings. However, the corporation saw this strategy as inflationary and unsuccessful. In 2013, they implemented an all-case-rates system.[5] Despite adjustments in purchasing strategy and an increase in coverage, concerns about persistently high out-of-pocket (OOP) expenses and PhilHealth's small proportion of the country's overall health spending persist. From 2014 to 2021, PhilHealth's contribution remained consistent, not exceeding 18.30%, while OOP spending continued to make up the bulk of the country's total health expenditure.[1] In 2021, PhilHealth contributed 12.90%, whereas OOP spending was 41.5% and government financing was 37.40%.[1] Although the share of OOP has decreased, this may be attributed to increased participation from national and municipal governments. However, the COVID-19 pandemic may have significantly influenced the decline in PhilHealth contributions and OOP spending, as restrictions reduced the number of individuals able to access health care.[6] Moreover, PhilHealth's potential has been hindered by a combination of low healthcare spending, a limited benefits package, and internal institutional issues.[6] Findings reveal underlying issues in PhilHealth's case rate system that have affected its function within the healthcare delivery system.[7] Increased claim-filing procedures have added strain on both health institutions and PhilHealth, requiring more staff, funding, and resources. In addition, retroactive payments and per-patient processing contribute to inefficient budgeting and inconsistent reimbursements. Consequently, in 2019, the average PhilHealth reimbursement as a percentage of overall healthcare costs was 22.6% for hospitals and infirmaries and 4.42% for Rural Health Units/City Health Centers. This low ratio is due to outdated case rates that only cover direct care expenses, as well as a growing reliance on government assistance and support.

This article presents the qualitative results focusing on how stakeholders perceive and experience the role of PhilHealth claim payments or reimbursements in relation to the overall revenues of government health facilities. The article also explores other sources of revenue for government hospitals and examines stakeholders' perspectives on the potential for PhilHealth to integrate or manage these funds as a strategic purchaser of health services. In particular, it investigates how healthcare providers and facility managers perceive the contribution of PhilHealth reimbursements to the overall revenues and financial operations of government health facilities. This study explores and describes how PhilHealth claim payments influence the day-to-day operations of government health facilities, for example, enabling the acquisition of additional assets, the purchase of laboratory equipment, and the replenishment of medicine and supply stocks. It also examines stakeholders' accounts of how the "pooled PF" from PhilHealth reimbursements is allocated among health-facility personnel. The qualitative strand of the research provides a detailed analysis of participants' insights into the effects of PhilHealth reimbursements on facility income. Rather than calculating ratios, the study draws on interviews and focus group discussions (FGDs) to capture healthcare providers' perceptions and experiences of how PhilHealth reimbursements shape the financial capacity and service delivery of their institutions.

Materials and Methods

Study design

To capture diverse contexts and perspectives, a stratified random sampling strategy was used. The country was first grouped into five broad geographic clusters. From each cluster, we identified one province or city, and within each selected area, we purposely included a mix of facilities: a Level 3, Level 2, and Level 1 hospital, an infirmary, and a Rural Health Unit or City Health Center that provides PhilHealth-reimbursable services. Data collection was conducted from 2022 to 2023, with the analysis and conclusions reflecting only the conditions and information available during this timeframe.

To enrich the range of viewpoints, two national specialty hospitals—one Department of Health (DOH) Government-owned and Controlled Corporation (GOCC) and one DOH non-GOCC facility—were

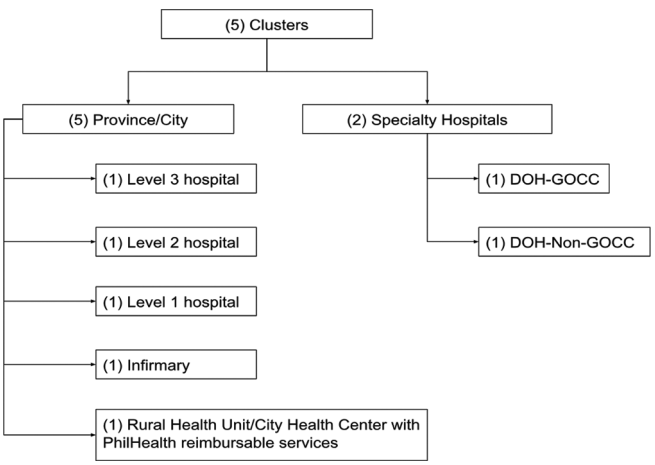

Figure 1: Sampling design

also included so that experiences from both local and national levels were reflected in the study. This process resulted in a total of 27 facilities that formed the basis for the interviews, document reviews, and on-site observations [Figure 1].

Information from the PhilHealth online databases, the National Health Facility Registry, and the Department of Health's Health Facilities and Services Regulatory Bureau was triangulated to compile a comprehensive list of PhilHealth-accredited facilities in each province or city. From this list, a varied set of sites was identified to capture perspectives across different levels of service delivery: One Level 3, Level 2, and Level 1 hospital, an infirmary, a Rural Health Unit or City Health Center, and – at the national level – one DOH–GOCC specialty hospital and one DOH–non-GOCC specialty hospital. For each planned facility type in every cluster, two alternative sites were preidentified to serve as backups in case the initially selected facility could not participate, for example, if it was unable to provide the required records or faced difficulties in arranging interviews or FGDs.

Ethical clearances

Ethical clearances for hospitals requiring their own reviews were handled by the Research Assistant (RA) in-charge of the hospital. Ethical clearance was obtained from the following: DOH Single Joint Research Ethics Board (SJREB) approval code number: 2022-60, Lung Center of the Philippines, LCP-CS-016-2022, East Avenue Medical Center EAMC IERB 2022-82, Ilocos Training and Regional Medical Center REC Protocol 2022-30, and Bicol Regional Hospital and Medical Center (exempted from review). Other study sites did not require additional ethical clearance from their institutions, as the DOH-SJREB approval was deemed sufficient.

Participants and procedures

The key informant interviews (KIIs) were done with the Chief of Hospital, Finance Officer, Budget Officer, and PhilHealth Officer. In Rural Health Units (RHUs) and CHCs, FGDs were done with at least five (5) senior staff. KIIs were conducted for the Municipal Health Officers or Physicians-in-charge of RHUs and CHCs to avoid bias. Before the interview/discussion, the researchers obtained informed consent forms from the target participants. Interviews/discussions were done via the platform most convenient for the participants. The team also visited the study sites and conducted interviews face-to-face. A list of topics was given before the interview/discussion. The interviews/discussions were recorded via a voice recorder (when done face–to-face) or via Zoom (when done virtually). Only the participants and the interviewer were present during the interviews/discussions. Data collection was done until the data were saturated or once there was no more new information being brought up.

To ensure that respondents feel their participation in the research study is valued, interviewers take care to conclude each interaction in a cordial and uncomplicated manner, fostering an atmosphere of trust, cooperation, and mutual respect.[8] After the interview, the researchers transcribed, translated from *Bisaya* and *Tagalog* to English, and began substantially analyzing all the data gathered.

Data analysis

The thematic analysis was conducted by organizing the data gathered from the interviews, performing an initial read-through of the information, identifying codes and subcodes, and grouping themes to produce the analysis and interpretation. The data were then interpreted and analyzed within the context of the objectives of the study, as well as the researchers' observations and viewpoints, and those of literature-based perspectives. A descriptive content and textual analysis was made. In this thread, codes or categories were formed, as this is the essence of qualitative data analysis.[9] Face-to-face meetings were conducted with the study sites for data validation, feedback, consultation, and recommendations. The meetings were forums arranged by the RA in-charge of the province/city and attended by the research team, the officials of all the study sites of the province/city, the Governor, Provincial Health Officers, financial officers of the province, as well as other stakeholders identified by the study sites. The quarterly progress reports and final publication-format report were submitted to PCHRD and PhilHealth. Upon approval, copies of the final report were shared with the stakeholders who participated in the study. With the consent of the LGUs, virtual meetings or a series of fora were held to present the research findings to PhilHealth, key officials of the DOH, study sites, local government and health units (through the Offices of the Provincial Governor and the Mayor for HUCs), and the expanded provincial or city health boards, particularly those in UHC advanced implementation areas as designated and decided by the DOH and PhilHealth.

Disclosure on the use of artificial intelligence

The corresponding author utilized AI solely to enhance the grammar structure in this manuscript, and no other approaches were employed.

Results and Discussion

This section presents qualitative insights from KII and FGD on how PhilHealth reimbursements affect healthcare facility income, operations, and sustainability. The findings cover six major areas: accreditation, claim processing, revenue generation, financial management, professional fee distribution, and policy perspectives. Respondents emphasized that while accreditation

standards are uniform, the actual experience varies; facilities face delays, documentation issues, and administrative burden during the process. Claim processing remains a bottleneck, with inconsistencies and prolonged turnaround times affecting cash flow and operational stability. PhilHealth reimbursements were reported to significantly influence a facility's income and budgeting decisions. However, the delays and unpredictable release of payments constrain resource allocation and financial planning. Integration with other revenue streams is hindered by unclear policies and insufficient support from PhilHealth, limiting opportunities to diversify income. A recurring theme was the unequal or inconsistent distribution of pooled professional fees. Healthcare workers described discrepancies and a lack of transparency in how shares are allocated, leading to dissatisfaction and mistrust within teams. On financial management, respondents outlined varied practices in handling PhilHealth-related documentation, with common challenges in compliance and reporting due to frequent policy updates and limited staff training. Finally, views on UHC and global budgeting were mixed. While some saw potential for improved equity and planning, others were concerned about reduced autonomy and inadequate preparation for system-wide implementation. In summary, while PhilHealth remains a critical source of revenue, inefficiencies in processes, lack of integration with facility systems, and weak policy support continue to undermine its full potential in strengthening public healthcare delivery.

PhilHealth accreditation

PhilHealth accreditation is a prerequisite for health facilities to participate in the NHIP. This process evaluates a facility's capacity and the competency of its personnel based on the standards set by the Philippine Health Insurance Corporation. Annual accreditation ensures that healthcare providers comply with service, administrative, and clinical requirements.

A respondent from Bukidnon affirmed the routine nature of this process:

"We are monitored here last month by PhilHealth, so ang accreditation namin for this year is already done."

Accreditation is typically completed within 2 weeks of filing. If filed after the year-end but before February, facilities retain their eligibility without operational disruptions. However, missing this February cutoff results in the loss of accreditation and exclusion from NHIP participation. Although reaccreditation is relatively straightforward for previously accredited facilities, delays in certificate issuance – such as those observed in a Level 3 hospital in Quezon City - can affect administrative timelines. Some facilities operate under provisional accreditation due to unresolved violations, either from PhilHealth or the DOH. While this status often does not impact operations, it reflects systemic issues. In Bukidnon, a respondent highlighted: *"They're penalizing us when it's not even our fault that it happened."* This referred to a violation committed nearly a decade ago but only communicated recently, by which time most of the original staff had already left. In another case, a hospital received provisional status in 2021 with no clear explanation. Such ambiguity contributes to administrative strain and staff confusion. Accreditation lapses can also lead to serious operational consequences. In Sorsogon, for instance, several hospitals outsourced laboratory services to a private provider to optimize budgets. However, due to inadequate planning, the private lab lacked a license to operate. This failure led to DOH licensing issues and PhilHealth accreditation problems. One Level 1 hospital was even downgraded to an infirmary, resulting in the denial or return of most PhilHealth claims for that year. Across study sites, Bukidnon, La Union, Leyte, and Sorsogon, respondents agreed that accreditation requirements are standardized. However, the ease of compliance depends heavily on institutional capacity. Lower-level facilities such as RHUs and health centers often face more difficulties meeting requirements due to staffing, infrastructure, and administrative limitations. In summary, PhilHealth accreditation is essential but challenging, particularly for resource-constrained facilities. While the process aims to uphold service quality and accountability, inconsistent communication, bureaucratic delays, and legacy violations can compromise operations. Streamlining accreditation and improving coordination between PhilHealth, DOH, and facilities could enhance compliance and ultimately improve access to reimbursable healthcare services.

PhilHealth claims

The PhilHealth claim process follows a standard sequence across most facilities, beginning with the verification of a patient's membership via the PhilHealth portal.[10] Unregistered or inactive patients may be enrolled through the point-of-service (POS) mechanism. As explained by a respondent in Leyte:

"Yung sa amin po kung wala pong PhilHealth, meron po tayong tinatawag ngayon na point of service (POS), doon natin ini-enroll ang pasyente na unregistered."

Patients or their relatives submit the necessary documents to the hospital, which then compiles and transmits the claims to PhilHealth. Forms such as the Member Data Record are filled during the patient's stay, reviewed at discharge, and submitted electronically via eClaims. Before 2016, claims were submitted physically.

Despite similarities in procedures, disparities exist across facility levels. In Bukidnon, La Union, and Sorsogon, around 90% of patients meet PhilHealth eligibility. In a Quezon City Level 3 hospital, this rises to 91%–92%. In contrast, lower-level facilities in Leyte have only 70%–80% compliance due to weaker administrative systems. RHUs and health centers fare worse; a major QC Health Center reports only 20% PhilHealth membership, with few actively contributing.

Several factors hinder claim submission. Some patients opt out of POS due to documentation barriers or logistical difficulties. Others choose to pay OOP or rely on alternative assistance (MAIP, DSWD, PCSO, and LGUs), especially if their conditions are not covered by PhilHealth case rates. Some are referred to higher-level hospitals where initial stays become ineligible for claims. A respondent emphasized this limitation:

"At the Sorsogon RHU, there is no Point-of-Service and patients must enroll on their own."

"The patient must go to the PhilHealth office in another municipality. they need 3 months' worth of contributions to avail of the benefits."

These barriers reduce membership uptake and discourage claim filing. In contrast, a hospital exploring NSO integration for birth certificate processing aimed to improve enrollment, with the medical chief remarking:

"There's no reason for patients not to file claims, we already have Point-of-Service."

Workforce and infrastructure are decisive factors. Higher-level hospitals, with more personnel and digital systems, perform better in claim processing. They use structured systems – like triple-checking protocols, staff rounds, and form pigeonholes – that reduce errors and denials.

In La Union:

"Pigeonholes were assigned to all doctors for easier signing of claims." In Sorsogon:

"Staff training on PhilHealth compliance decreased RTH and denials."

Lower-level facilities, however, lack personnel and rely on multitasking. At one infirmary, the administrative officer handled everything – from approving and verifying claims to checking compliance across wards.

Insufficient infrastructure computers, Internet, and trained encoders – further impede RHUs in Sorsogon, Barugo, Aringay, Pangantucan, and QC. Even where electronic medical records exist, difficult interfaces and resistance to digital systems hinder use.

Delays persist even after claim submission. While the official deadline is 120 days, the Bukidnon and Sorsogon provincial health offices aim for a 15-day submission postdischarge. Provincial hospitals meet this, but district hospitals take 25–30 days, and infirmaries exceed 30 – again reflecting capacity gaps.

Once received by PhilHealth, claims are anonymized to reduce bias but evaluated inconsistently. Some processors are stricter than others, resulting in identical claims being differently approved. With quotas imposed, some processors rush reviews.

"Due to the quota, processors tend to simply return the claim."

Moreover, e-Claims' systems are slow and documents are hard to read, compounding processing delays. These inefficiencies undermine facility cash flow and disincentivize claim filing. The complexity of the claim process, resource limitations, and availability of alternative support programs reduce the utilization of PhilHealth benefits, especially in lower-level facilities. Streamlined processes, improved infrastructure, and consistent evaluation mechanisms are necessary to boost claim efficiency and equity.

PhilHealth reimbursements and health facility revenue

PhilHealth reimbursements are a vital revenue stream for both nationally-run and locally-run health facilities. For nationally-managed hospitals, reimbursements are pooled with other income sources such as rental fees, Malasakit funds, PCSO support, and training fees. Locally-managed hospitals operate with a general fund (provincial allocation) and a restricted fund, which specifically holds PhilHealth reimbursements.

Reimbursements are automatically credited to dedicated hospital bank accounts – one for facility costs and another for professional fees. A respondent noted:

"It is automatically credited to our respective bank accounts. We have two bank accounts exclusively for PhilHealth reimbursement and for the portion of professional fees."

In nationally-run hospitals, signatories are typically the Chief of Hospital and the Cashier. In contrast, locally-run facilities require signatures from the Local Chief Executive and the LGU Cashier, reflecting differing control over fund disbursement.

Turnaround time and payment behavior

Turnaround times vary across institutions. The fastest is 15–22 days, while some specialty hospitals wait 40–60 days, depending on claim volume and processor availability. While reimbursements are issued almost weekly, they are often partial. As one Mindanao respondent stated:

"Every week, our cashier receives a text from the PhilHealth Office to receive the reimbursement… stating whether it's a hospital fee or professional fee."

Contrary to PhilHealth's 60-day reimbursement policy, funds are only released for processed claims, creating unpredictable cash flow, particularly for higher-level hospitals, which often receive only partial amounts. Lower-level facilities, however, more frequently receive full reimbursements.

Delays and receivables

Delayed payments and unpaid receivables plague many institutions. One specialty hospital continues to receive payments for claims filed years ago. Some RHUs in La Union and Bukidnon have not received reimbursements from claims dating back 5 years.

"PhilHealth requires us to implement the NBB program but does not provide funding for its implementation. We have to spend our own funds to do it."

(Quezon City Level 3 hospital official)

Such delays have severe financial consequences. At the QC Level 3 hospital, Quantified Free Service (QFS) – mandated by the No Balance Billing (NBB) policy – costs the hospital ₱1.07 billion, with some individual cases reaching ₱1.5–2.5 million.

Case rates and hospital costs

The shift from fee-for-service to case-rate payments significantly reduced hospital revenues. Case rates have not been adjusted in 8–10 years, despite rising healthcare costs. These fixed rates often fail to cover complex cases in higher-level facilities. Many facilities recommend tiered case rates that reflect hospital levels and service intensity.

Return-to-hospital and denied claims

RTH and denied claims represent major financial losses, especially for services already rendered. eClaims has made refiling more rigid, starting the 60-day refiling period from the Email receipt, regardless of acknowledgment. Most rejections are due to clerical errors, such as incomplete data, late submissions, or mismatched information.

At lower-level facilities, rejections frequently cite "noncompliance with standard of care," though facilities report that these judgments are vague.

"PhilHealth does not indicate how the claim did not comply with standard of care." (Infirmary respondent, Sorsogon)

These issues are exacerbated by inconsistent claim evaluations. Identical claims are sometimes approved or denied depending on the processor's discretion. During the pandemic, certain limitations were lifted, but these have since been reinstated.

Technology and third-party issues

Some facilities experience claim denials due to technical issues with third-party transmission platforms. In one case, files transmitted electronically became unreadable, even though the hospital complied with all requirements.

"We are penalized for faults beyond our control." (Hospital staff)

PhilHealth is urged to ensure seamless integration with third-party systems to avoid penalizing compliant hospitals.

Performance and best practices

Some hospitals have significantly reduced their RTH and denial rates. The Level 3 hospital in Quezon City reduced RTH from 8% to under 1% by creating a composite PhilHealth Management Team that regularly coordinates with PhilHealth. In Bicol, hospitals reported <2% RTH rates, While one health facility in Cagayan de Oro had one of the lowest denial rates in the country.

PhilHealth debt

Debt from PhilHealth primarily stems from delayed reimbursements. The QC Level 3 hospital saw its receivables reduced from ₱500–₱600 million to around ₱200–₱300 million. A specialty hospital reported total PhilHealth debt at ₱1.1 billion. However, PhilHealth does not consider denied claims as debt, contributing to discrepancies in financial reporting.

Referral disputes and equity

Referral cases also create reimbursement confusion. If a referred patient has the same diagnosis, only one hospital can claim the benefit – often whichever submits first. In Bukidnon, higher-level facilities report that lower-level hospitals quickly file claims postreferral, leaving them ineligible.

Approaches vary:

- In Sorsogon, referring hospitals claim nothing and rely on MAIP funds
- In Quezon City, referral hospitals receive claims; referring hospitals get a referral fee.

During the pandemic, dual claims were allowed, but restrictions have since returned – renewing the need

for clearer policies and equitable reimbursement structures.

The findings reveal critical systemic issues in PhilHealth reimbursement: delayed and partial payments, outdated case rates, vague claim denials, and inconsistent processing. These disproportionately affect higher-level and more service-intensive facilities. Meanwhile, resource constraints and unclear feedback mechanisms leave lower-level facilities struggling to comply. Improving policy clarity, upgrading systems integration, and adjusting case rates based on facility levels are essential for a more responsive and equitable reimbursement system.

Health facility expenditures and PhilHealth

Differences in financial governance

A fundamental distinction in the financial management of Philippine health facilities lies in their governance structure. Nationally-run hospitals enjoy fiscal autonomy, enabling them to independently plan and mobilize funds. In contrast, locally-run hospitals depend heavily on LGU approvals, resulting in a more layered and often slower budget mobilization process. In nationally-run hospitals, the Medical Center Chief, in coordination with an executive or management committee, oversees expenditure decisions. Each hospital department develops its annual budget plan, which is reviewed against projected revenues and then approved by the executive committee. Meanwhile, locally-run hospitals prepare a project procurement management plan (PPMP) based on projected resources. This plan undergoes review by the local budget officer and local treasurer, and must be approved by the Local Chief Executive. Only after approval can procurement proceed. While emergency purchases outside the PPMP can be subsidized by the LGU, there are instances when such requests are unfulfilled due to a lack of provincial funds.

As one official from Bukidnon noted:

"The annual budget proposal is suggested and decided by us hospitals based on our needs."

Expenditure categories and sources

All health facilities classify expenses under three main categories:

- Personnel Services (PS)
- Maintenance and Other Operating Expenses (MOOE)
- Capital Outlay (CO).

These are primarily funded by the General Appropriations Act (GAA) for national hospitals, or by the provincial/municipal budgets for local hospitals and RHUs. However, PhilHealth reimbursements play a crucial role in augmenting these budgets, especially for MOOE.

Use and allocation of PhilHealth reimbursements

PhilHealth reimbursements are divided into:

- Facility share – typically used for MOOE or PS
- Professional fees (PF)– distributed to medical and nonmedical staff.

While facility shares are not restricted to a specific expenditure type, they are often used for MOOE, which includes utilities, medicines, supplies, and operational costs. In provinces like Bukidnon, Leyte, La Union, and Sorsogon, PhilHealth reimbursements are the primary source of MOOE, held in restricted funds that cannot be accessed by provincial governments.

However, not all provinces enforce this restriction. In other areas, reimbursements are placed in the general fund and are freely used at the discretion of the province – often to cover PS. This variability reflects inconsistencies in fiscal policies, affecting hospital autonomy and financial stability.

Operational impact of reimbursements

Regardless of facility type or share ratio, PhilHealth reimbursements significantly affect operations. Even in a specialty hospital where reimbursements accounted for <5% of total revenue, officials reported it still heavily impacted their MOOE. For locally-run facilities, these reimbursements are often considered a lifeline, given limited alternative income sources.

At the Level 3 hospital in Quezon City, where the PhilHealth Share Ratio was only 13% in 2022, the hospital chief emphasized:

"We are heavily dependent on PhilHealth reimbursements. The problem is we already spent the money, and we need to recover it to continue serving our patients. Pondo kasi talaga ang essence ng government hospital."

Despite receiving ₱628 million in MOOE that year, this amount covered only 30% of the hospital's needs, reinforcing their reliance on timely PhilHealth reimbursements.

Budget planning under a retrospective payment system

Because PhilHealth uses a retrospective payment system, hospitals must estimate their annual reimbursements. These estimates are often conservative, as actual reimbursements rarely meet projections. This uncertainty leads to inaccurate budgeting and compromises the strategic allocation of resources.

One challenge is that case rate reimbursements do not cover indirect costs such as electricity, water, or Internet – yet these are often the exact expenses that MOOE targets. Thus, health facilities remain dependent on GAA and local subsidies to sustain operations.

"PhilHealth reimbursements have increased, but we still cannot be financially independent." (Provincial Hospital, Sorsogon).

In one instance, the Sorsogon hospital attempted to cut expenses and save funds, only to use them a few months later for basic MOOE, showing the unsustainability of self-reliance under current reimbursement rates.

Rural health units and reimbursements

RHUs receive funding primarily from municipal budgets, with PhilHealth reimbursements used to augment infrastructure or service improvements. For example, one RHU used these funds to procure computers and prepare for eClaims' compliance and the reopening of its lying-in facility.

Professional fee sharing mechanisms

Professional fees from reimbursements are generally split 50–50 between medical and non-medical staff, based on DOH guidelines. In some provinces, local ordinances provide a further breakdown:

- In Sorsogon and Bukidnon, the nonmedical 50% is divided equally between nurses/midwives and administrative staff
- In Sorsogon, the doctors' share is performance based, for example, 50% to the surgeon, 30% to the anesthesiologist, and 20% to the internist.

In nationally-run hospitals with private wards, PFs for private patients are separated, with the remainder pooled and distributed among hospital personnel.

In RHUs, PF-sharing follows municipal ordinances based on the type of PhilHealth-covered service rendered. These findings highlight the centrality of PhilHealth reimbursements in the financial survival of both nationally- and locally-managed health facilities in the Philippines. Differences in financial management, particularly the limited fiscal autonomy of LGU-run hospitals, create structural challenges in fund mobilization and resource allocation.

With reimbursements falling short of total expenses, especially for indirect costs, many hospitals remain dependent on government appropriations. This makes the timely and predictable release of PhilHealth funds critical. A standardized, transparent approach to fund management – especially in handling reimbursements will be essential for sustaining service delivery and expanding access to care across facility levels.

Handling of PhilHealth and other financial records

State of IT infrastructure across health facilities

A consistent challenge across all health facilities is the inadequacy of IT infrastructure, particularly in financial management systems. While some higher-level hospitals have begun implementing digitized systems, no facility is fully automated, especially in terms of handling PhilHealth claims and reimbursements.

Even in specialty hospitals, lapses remain. For example, one facility with wards spread across multiple buildings struggles with information relay because its IT systems were not designed to accommodate such a layout.

There is a clear gradient in IT capacity – as facility level decreases, so does the sophistication of digital infrastructure. This trend reflects disparities in resource allocation. Higher-level hospitals have benefited from earlier and more extensive digitization efforts. In Quezon City, for instance, the Level 3 hospital allocated ₱40 million for digitalization, including:

- Electronic Medical Records (EMRs)
- Radiologic and Laboratory Information Systems
- Human Resources Information System
- Electronic Government Accounting System.

All of these are integrated into Bizbox, a hospital information system. In Region X, digitization started earlier at Level 3 hospitals (2017) than in provincial hospitals and RHUs (2018) with Level 2 hospitals following in 2019.

Persistence of manual recordkeeping

Despite advances in digital processing of e-claims, manual elements remain entrenched in PhilHealth record handling. Claims are submitted electronically, but supporting documents are physically completed, scanned, and stored. As one staff shared:

"Nasa amin po yung logbooks, tapos naka-tago po 'yun."

Facilities are required to retain hard copies for audit, refiling, or appeal of returned or denied claims. However, storage limitations – especially in lower-resourced facilities – exacerbate the burden of maintaining physical records.

Use of iHOMIS and information systems

Most provincial and Level 1 hospitals use iHOMIS, enabling some integration of patient and financial records. However, infirmaries still operate largely manually, with only e-claims processed digitally. RHUs, in most study sites, lack any electronic health information systems.

This technological disparity hampers efforts toward UHC implementation, particularly in establishing efficient referral systems. Referral success depends on interoperability. However, nationally run hospitals often use independent and incompatible systems. In contrast, local governments are better positioned to implement province-wide systems that ensure data continuity across facilities.

In Sorsogon and Bukidnon, for example, the provincial government is actively pursuing integrated information systems that encompass both hospitals and RHUs.

Implications for universal health care and referral systems

The lack of standardized IT infrastructure presents a major barrier to UHC goals, particularly the seamless patient referral and data-sharing necessary for coordinated care. Without integration, health facilities remain siloed, resulting in fragmented service delivery and inefficiencies in tracking patient outcomes or financial performance.

Provincial mandates for unified systems – such as those in Sorsogon and Bukidnon – can serve as models for institutional coordination. These initiatives demonstrate that political will at the LGU level can drive IT system reforms.

Governance of PhilHealth financial records

In locally-run hospitals, the handling of PhilHealth financial data is centralized at the LGU level, with health facilities granted access only upon request. This limits real-time tracking and oversight at the facility level.

Further, the lack of continuity during leadership transitions adds to the issue. Outgoing officials often fail to endorse or preserve financial records, resulting in lost data and management gaps. This undermines long-term financial planning and weakens institutional memory.

The analysis suggests that ineffective recordkeeping – driven by weak IT systems and governance gaps – impairs accountability, reduces operational efficiency, and can jeopardize claim tracking and compliance with audit requirements. At the same time, some health facilities are transitioning to digital systems, the PhilHealth claim process remains largely manual and paper-dependent. Lower-level facilities suffer the most from IT infrastructure gaps, storage constraints, and limited access to financial data – factors that compromise both daily operations and broader UHC goals.

To move forward, a standardized, interoperable health information system is critical – one that supports both medical and financial records, ensures accurate tracking of PhilHealth reimbursements, and enhances coordination across health facility levels. This transformation will require both national policy alignment and local government leadership, especially in provinces that manage the majority of public health services.

Universal health care

The interpretation and implementation of the UHC Law vary widely across study sites. Health facilities tend to prioritize and focus on the aspects of UHC that most directly affect their operations. This localized approach has resulted in uneven levels of preparedness and implementation.

Understanding and localization of universal health care implementation

In the Mindanao study sites, readiness is demonstrated through efforts to cascade UHC principles to communities:

"We have actually already implemented it as a referral hospital and started to trickle down the information to the communities on how the Universal Health Care will be implemented at the barangay and provincial levels."

Specialty hospitals, being often standalone institutions, have a more complex relationship with UHC implementation. For example:

- One specialty hospital focuses on complying with the 70:30 mandate for bed allocation (70% for service patients, 30% for private)
- Another, being the country's primary mental health referral center, balances its roles as a clinical, research, and policy development institution – especially under the Mental Health Act.

These illustrate the unique challenges faced by specialty facilities in aligning their specialized mandates with broader UHC goals. The findings highlight that a clear institutional understanding of UHC is crucial for effective implementation, especially when mandates overlap with specialized functions.

No balance billing and financial risk protection

Most hospitals assert that they uphold the spirit of UHC through the strict implementation of the No Balance Billing (NBB) Policy. At the Level 3 hospital in Quezon City, a Quantified Free Service (QFS) program absorbs all costs for indigent patients – covering even expenses not reimbursed by PhilHealth. Beyond basic care, indigent rooms are equipped with air conditioning and cable TV, underscoring the commitment to quality and dignified care. These examples demonstrate how creative strategies can operationalize financial risk protection, a cornerstone of UHC, and reinforce the NBB policy's central role in providing equitable healthcare access.

Referral systems: Central to universal health care success

Referral systems are being actively strengthened across study sites to support UHC goals. These systems aim to decongest higher-level hospitals by ensuring patients are treated at the appropriate level of care. However, challenges persist.

In Quezon City, the Level 3 hospital – designated as an apex facility – continues to be overwhelmed by cases that lower-level facilities could handle. Notably:

- Top admissions include normal spontaneous deliveries, pneumonia, and gastroenteritis – conditions ideally treated at lying-in clinics or RHUs
- The hospital had to construct two new wings just to manage normal pregnancies.

This misallocation of cases underscores the urgency of an effective referral system, which would allow higher-level facilities to focus on complex care while strengthening the capacity of RHU and CHC levels.

Coordination challenges due to fragmented facility ownership

A critical barrier to UHC implementation is the fragmented ownership of health facilities, particularly in urban areas like Quezon City. Study sites within the city fall under different entities:

- DOH
- Philippine National Police
- Office of the Mayor
- University of the Philippines
- Quezon City Health Department.

This fractured governance makes it unclear who should initiate coordination, leading to inefficiencies, overlapping services, and congestion.

The Level 3 hospital in Quezon City attempted to improve coordination by initiating interhospital meetings and drafting a Memorandum of Agreement (MOA) for public–private hospital collaboration. However, progress was stalled after submission to the Mayor's Office. Currently,

- The hospital only actively participates in DOH-cluster meetings
- On its own initiative, it liaises with LGUs and other hospitals for patient referrals
- It has bilateral MOAs with other tertiary hospitals to share services, but these arrangements remain ad hoc and outside a formal UHC-aligned network.

This example reflects a common theme: in the absence of a centralized coordinating body, hospitals must take individual initiative, resulting in fragmented and inconsistent integration across systems.

Regional models of universal health care integration

In contrast, regional hospitals – particularly those in Bicol and Northern Mindanao – are more integrated into their provincial health systems. In Sorsogon, prior coordination between the provincial health officer and the Level 3 hospital laid the foundation for an effective referral system, which now serves as the model for the entire province.

Advanced UHC implementation sites like Sorsogon and Leyte demonstrate a higher level of readiness, driven by strong provincial leadership and alignment with UHC goals. Key actions in these provinces include the following:

- Establishing a Special Health Fund (though use is delayed due to the absence of clear national guidelines)
- Registering both hospitals and RHUs to the *Konsulta* Package to expand PhilHealth revenue
- Instituting NBB and Point-of-Service enrollment to minimize OOP payments
- Mandating municipalities to allocate budget for province-wide health programs (e.g., integrated health information systems)
- Establishing effective referral systems even before UHC rollout
- Maintaining strong coordination between the Provincial Health Office, DOH regional centers, and local governments
- Empowering provincial health officers who play hands-on governance roles.

These examples showcase how political will, proactive leadership, and inter-LGU coordination are essential to UHC success.

Concerns on fund flow and autonomy

Despite progress, some officials prefer direct disbursement of funds to municipalities or health facilities, citing:

- Logistical challenges of centralized provincial fund management
- Difficulty in monitoring fund use at the provincial level
- Belief that facilities understand their patient needs better, and thus should manage their own finances.

This indicates a tension between centralized coordination and local autonomy, which must be carefully managed in UHC fund distribution policies. The implementation of Universal Health Care across the Philippines reflects diverse realities shaped by institutional structure, local leadership, and facility capacity. While some regions have made significant strides through coordination, resource planning, and governance, others are constrained by jurisdictional fragmentation, weak referral systems, and lack of unified health networks.

For UHC to be meaningfully realized, national and local governments must work toward:

- Establishing clear guidelines for fund management
- Promoting interoperable referral and information systems
- Strengthening governance structures across varying ownership models
- Ensuring that facilities are empowered and accountable.

Ultimately, UHC is only as strong as the networks that support it. Its success depends on both system-wide integration and grassroots-level responsiveness.

Conclusion

This article reveals that the effectiveness of PhilHealth systems accreditation, claim processing, reimbursements, and financial management varies significantly across healthcare facilities in the Philippines. While accreditation standards remain consistent, a facility's level of compliance largely determines whether it maintains full accreditation or faces downgrades, provisional status, or even removal. Such consequences directly impact the facility's ability to claim reimbursements and its PhilHealth Share Ratio, ultimately affecting sustainability and service delivery.

Under the UHC Law, access to PhilHealth claims is guaranteed for all patients, and the claim process follows a standardized procedure. However, the efficiency and timeliness of claim processing differ widely, primarily due to resource disparities among facilities. Factors such as staff capacity, system integration, and document handling significantly affect reimbursement turnaround time. Thus, a more comprehensive review of the claim process must go beyond policy compliance to include actual operational bottlenecks from eligibility assessments to benefit utilization and administrative workflows.

Reimbursements remain a lifeline for both nationally and locally-run health facilities, particularly in areas where general appropriations and government subsidies fall short. However, the case rate payment system, which excludes indirect costs such as utilities and infrastructure maintenance, fails to meet the total financial demands of many institutions. This disconnect often leads to reliance on PhilHealth funds for maintenance and other operating expenses (MOOE) despite reimbursements being inconsistent and frequently delayed.

The article also demonstrates that variations in financial management practices, especially between nationally-run and locally-run facilities, contribute to inefficiencies in fund utilization. Locally-run facilities, in particular, often face prolonged approval processes and limited autonomy, delaying procurement and service delivery. Furthermore, handling of PhilHealth and financial records is constrained by gaps in IT infrastructure, recordkeeping systems, and data transfer protocols, particularly in lower-level facilities where digitization is incomplete. Some provinces have made progress through province-wide information systems, but broader adoption remains limited. Taken together, the implementation of Universal Health Care remains uneven across the country. While some provinces, particularly those designated as advanced implementation sites, have demonstrated measurable progress in referral systems, health financing mechanisms, and interfacility coordination, other areas continue to face fragmented governance and overlapping jurisdictions. In settings such as Quezon City, the absence of coordinated healthcare provider networks has contributed to service duplication, overcrowding in higher-level facilities, and underutilization of lower-level facilities. Nevertheless, the adoption of programs such as No Balance Billing, Quantified Free Services, and local referral innovations indicates a gradual convergence toward UHC principles. These findings underscore the need for systematic strengthening of governance, integrated provider networks, and context-sensitive policy implementation to ensure that UHC reforms translate into equitable, efficient, and sustainable healthcare delivery nationwide. Finally, PhilHealth plays a central role in sustaining healthcare operations, particularly for locally-run facilities. However, systemic issues in accreditation, claim processing, reimbursement reliability, and IT infrastructure appear to hinder the delivery of efficient and equitable healthcare. Combined with variations in financial practices and limited integration under the UHC framework, these challenges may constrain healthcare providers' capacity to deliver consistent, high-quality services. Addressing such structural and operational gaps is central to strengthening provider support and facilitating patients' reliable access to timely, affordable, and quality care, emphasizing the broader need for a resilient, data-driven, and integrated health financing system.

Acknowledgment

The authors extend their sincere appreciation to the staff of the Health Futures Foundation, Inc. (HFI), the implementing agency, for their invaluable support throughout the conduct of this study. Gratitude is also expressed to the Department of Science and Technology – Philippine Council for Health Research and Development (DOST-PCHRD), the monitoring agency, for their guidance and oversight, and to the Philippine Health Insurance Corporation (PhilHealth) Central Office for their funding support, trust, and collaboration in making this research possible. The authors acknowledge that quantitative findings and a policy brief based on the full report have also been published in peer-reviewed journals.

The authors also acknowledge the staff of the University of the Philippines Manila - Philippine Journal of Health Research and Development (PJHRD) for their editorial assistance, and the two anonymous reviewers for their constructive criticisms and insightful comments on the manuscript. Any remaining errors or shortcomings are solely the responsibility of the authors. The final language editing, grammar, and structural refinements were made by the journal's editorial staff.

Financial support and sponsorship

Nil.

Conflicts of interest

The authors declare no known political, social, financial, or personal conflicts of interest that could have influenced the conduct or reporting of this research, nor that could be perceived to affect future publications. The views expressed are solely those of the authors and do not necessarily represent the positions of their respective institutions.

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