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A Comparative Analysis of PhilHealth Reimbursement for Common Illness Claims in Selected Government and Private Hospitals in Albay

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ABSTRACT

The National Health Insurance Act of 1995 created the Philippine Health Insurance Corporation (PhilHealth), a government-owned and -controlled corporation (GOCC) under the Department of Health, with the mandate to provide health insurance coverage and ensure that healthcare is affordable, acceptable, and accessible to all Filipinos. Both government and private hospitals share this responsibility but differ in the extent to which they utilize PhilHealth benefits, leading to variations in hospitalization claims. This study examined and compared PhilHealth hospitalization payments for common illness claims, timeliness of claims processing, and adequacy of coverage in selected government and private hospitals in Albay using quantitative data sourced from the PhilHealth database. Findings revealed that a government hospital classified as Category A performs at par with private hospitals in terms of PhilHealth payments, though significant variances in claims exist due to differences in claimant access, hospital resources, and service utilization. Factors such as the availability of medical personnel, facilities, hospital reputation, and infrastructure also shape patients' choices and influence the patterns of PhilHealth hospitalization claims.

Keywords: *common illness claims, government hospitals, private hospitals, health insurance, PhilHealth*

INTRODUCTION

The right to the highest attainable standard of physical and mental health is fundamental to every person, regardless of any status, and it is a clearly guaranteed right. Indeed, the World Health Organization (WHO) affirms this, making it the foundation for countries' social legislation and health policies, with the promise that every citizen should have equitable and affordable access to quality health services.

In the Philippines, the evolution of the health system reflects a steadfast pursuit of this right. These ranged from the establishment of the Philippine Medical Care Act of 1969 and the Philippine Medical Care Program of 1971 up to the decentralization of health governance in 1991. The most notable undertaking is the National Health Insurance Act of 1995 signed by Fidel V. Ramos which institutionalized an innovative financing scheme aimed at breaking down access barriers and addressing rising costs of care. These steps led to the creation of Philippine Insurance Corporation (PhilHealth) which became the cornerstone in the nation's path toward equitable and sustainable health coverage.

Successive administrations continued to build on this foundation, for example, when Rodrigo Duterte signed the Universal Health Care Act (RA 11223), which automatically enrolled every Filipino in

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the national insurance program, and when the administration of Ferdinand R. Marcos Jr. prioritized the creation of specialty centers outside Manila so that provincial patients could access care locally. Through all these, PhilHealth continues to embody the UHC vision, that is ensuring that every Filipino, regardless of background or economic standing, can access quality health services and financial protection.

The effectiveness of our universal healthcare system relies heavily on the functioning of PhilHealth, which must meet the healthcare needs of all Filipinos by guaranteeing equitable and affordable access. To fulfill this mandate, substantial yearly appropriations from Congress, combined with regular premium payments from contributors, ensure that members receive the medical attention and preventive care they deserve. These financial mechanisms help support service delivery and uphold the promise of universal health coverage for every Filipino.

Several studies have examined the financial implications of PhilHealth's payment schemes, highlighting the persistent gap between reimbursement rates and the actual costs of hospitalization. For instance, research conducted at Batangas Medical Center revealed that PhilHealth payouts were insufficient to cover expenses for the five most frequently performed general surgical procedures—appendectomy, open cholecystectomy, initial repair of inguinal hernia, total thyroidectomy, and modified radical mastectomy (Ilagan et al., 2024). This finding contrasts with the conclusion of Ramos and Untalan (2020), who reported that the PhilHealth case rate system effectively reduced out-of-pocket expenses for patients in the non–No Balance Billing (NBB) category who underwent thyroidectomy. Moreover, broader analyses of hospital financing show that while private hospitals tend to maintain profitability, they remain vulnerable to financial distress when reimbursements are delayed, whereas public hospitals often rely on government subsidies to stay operational. These trends indicate that PhilHealth, though envisioned as the national purchaser of health services under the Universal Health Care framework, continues to struggle in achieving equitable, timely, and sufficient financing support for both public and private healthcare institutions (Uy, et.al., 2021).

Researchers have highlighted that while PhilHealth plays a critical role in reducing the financial burden of healthcare, there remains a persistent mismatch between what is reimbursed and what hospitals actually spend on patient care. This discrepancy has been observed to vary significantly between government and private hospitals, reflecting differences in resource allocation, cost structures, and administrative efficiency. Several studies have also evaluated the implementation of the All-Case Rate (ACR) payment system, which was designed to standardize reimbursements and promote efficiency, yet its effectiveness remains debatable due to inconsistencies in claim processing and coverage adequacy. Moreover, evidence suggests that PhilHealth's contribution to public hospital financing is not uniformly distributed across local government units (LGUs), resulting in uneven financial support and service delivery capacities among hospitals nationwide. On the other hand, private hospitals face challenges in maintaining operational sustainability because of delayed or partial reimbursements, which affect their revenue flow and service quality.

Despite these institutional and policy-level analyses, there remains a critical need to understand how these financial dynamics directly affect patients—the intended beneficiaries of universal health coverage. Few studies have comprehensively explored the patient perspective regarding PhilHealth's capacity to provide genuine financial protection, particularly for common and frequently claimed illnesses. Understanding the extent to which reimbursement gaps translate into out-of-pocket expenses can shed light on the real-world affordability of healthcare in both public and private hospital settings. Thus, examining the comparative hospitalization payments under PhilHealth for common illness claims becomes essential in assessing not only the financial efficiency of the system but also its equity and responsiveness to the healthcare needs of all Filipinos.

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Literature Review

The establishment of the Philippine Health Insurance Corporation (PhilHealth) was primarily intended to deliver universal health insurance coverage for all Filipinos (PhilHealth, n.d.). This initiative aligns with the World Health Organization's (WHO) global call to make healthcare accessible, available, and affordable to all citizens, particularly the vulnerable sectors of society. Upholding its vision, "*Bawat Pilipino, Miyembro. Bawat Miyembro, Protektado. Kalusugan ng Lahat, Segurado*," and mission, "*Benepisyong pangkalusugang sapat at dekalidad para sa lahat,"* PhilHealth seeks to provide comprehensive and quality healthcare benefits through effective collaboration with healthcare providers and the development of responsive policies. Both its vision and mission reflect the Corporation's mandate to ensure that healthcare services remain affordable, acceptable, available, and accessible to every Filipino. Moreover, the implementation of its programs is guided by the core values of integrity, innovation, agility, commitment, compassion, equity, and social solidarity, which collectively serve as the foundation of PhilHealth's role in realizing the country's goal of Universal Health Care.

Funding scheme and health financing mechanisms

The effectiveness of the universal healthcare system depends largely on the mechanism provided by PhilHealth itself as it traverses to the needs of all Filipinos for universal access to equitable and affordable healthcare programs. To safeguard these needs, the programs raised substantial annual allocations from Congress and regular payment of premiums from all contributors to ensure that they will receive the medical attention and preventive care they deserve.

This individual financing scheme is sorted into social solidarity where each member contributes financial resources to a pool that will pay for every member's health care. This mode of support depends on the income group, age groups, differing health status individuals, and residence in different geographic locations. As an exemplification, the healthy subsidize the sick, those who earn more subsidize those who have less, and the premium contribution of the poor families identified by the National Household Targeting System for Poverty Reduction is subsidized by the government. These same beneficiaries are also covered in the No Balance Billing Policy, where no other fees and expenses shall be charged and paid for indigent patients above and beyond the package rates. On the other hand, for those without visible means of income, the national government and the local government unit share the payment of premiums. To generate funds, the government in 2012 utilized additional tax revenues from alcohol and tobacco products or the earmarked revenue source (sin taxes) to increase the health care spending and the number being covered by PhilHealth upon the implementation of Republic Act No. 10351 (Sin Tax Reform Act of 2012) (philhealth.gov.ph) which makes this subsidy through tax-based financing.

Despite these schemes, members of PhilHealth still pay out of pocket (OOP) for medical services (PIDS) which can be attributed to voluntary use of non-designated service providers (DSPs), benefit design, and lack of product knowledge (Cairncross, et al, 2013). The main culprit for this OOP is medicines accounting for almost two-thirds of total health spending and three-quarters among the poor (Bredenkamp and Buisman, 2016) which accounted to approximately 44.7 percent of the current health expenditure in the Philippines (Statista, 2023).

The population-based health services, as mandated, are sourced out from the national government through DOH and provided free of charge at the point of service for all Filipinos in coordination with line agencies enumerated in the Universal Health Care Act also referred to as Kalusagan Pangkalahatan (KP). This is in consultation with LGU, the health care providers, and partners in identifying the milestones for the transition of other sources of financing health facilities to improve the mechanism of PhilHealth.

The revenue for health is generated from four main sources, namely: (1) national and local government; (2) social health insurance through PhilHealth; (3) out-of-pocket (OOP) spending; and (4) other private spending, which may include private health insurance and donor funding, among others. The

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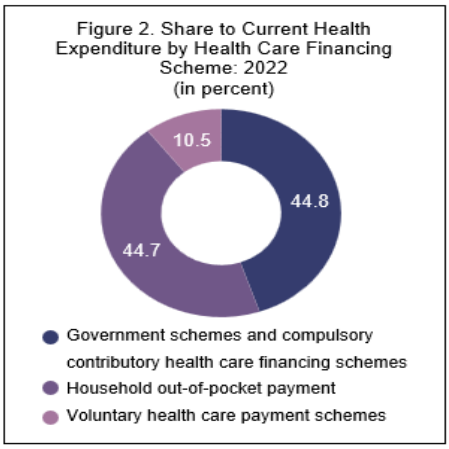
government schemes and compulsory contributory health care financing schemes made the highest contribution in 2022, with 44.8 percent or PhP 502.95 billion share to the total Current health expenditure (CHE), followed by Household out-of-pocket payment with 44.7 percent or PhP 501.79 billion share and Voluntary health care payment schemes with 10.5 percent or PhP 17.62 billion share as reflected in the Figure given at the right (PSA, 2023).

The Philippine Amusement and Gaming Corporation (PAGCOR), Philippine Charity Sweepstakes Office (PCSO) together with the Department of Finance (DOF), PhilHealth Corporation, and Department of Health (DOH) signed a Joint Circular that will operationalize the efficient and sustainable allocations for individual-based services under the Universal Health Care Program (UHCP) under RA 11223 or the Universal Health Care (UHC). Under this UHC Law, 50 percent of the National Government share from the income of PAGCOR, 40 percent of the Charity Fund, net of Documentary Stamp Tax Payments, and mandatory contributions of the PCSO will be transferred to PhilHealth for the improvement of its benefit packages that will cater to the vast majority of members here and abroad.



Categories of PhilHealth Members

PhilHealth members are those Filipinos defined under the 1987 Constitution and as of 2024, there are 115 million members of PhilHealth (Cabato, 2024), from close to 112M Filipinos are guaranteed prompt access to PhilHealth's benefit packages in the year 2022 (PhilHealth Annual Report, 2022). The ballooning members were due to the inclusion of Informal Economy members who are entitled to the POS program except foreign nationals. This increase in figures is indicative that the Corporation and the State were serious in their advocacy that all Filipinos must be immediately enlisted as eligible PhilHealth members and have an easy access to preventive, promotive, curative, rehabilitative, and palliative care for medical, dental, mental, and emergency health services, delivered as population-based or individual-based health services.

These members are under different membership programs categorized into various sectors of society like employees in private and government entities, workers not covered by formal contracts, those considered as indigents, sponsored members reflected from the contribution done by the other party, those who reach the age of retirement, and the elderly. There are types of PhilHealth members (Kwik. Insure, n.d.) such that formal economy members which pertains to all employed individuals working both in government and private sectors having offices in the Philippines where the employer and the employee will each pay half of the premium; the informal economy members that includes those unemployed, self-employed, migrant workers, informal workers, naturalized Filipinos, and foreigners living in the Philippines who are voluntarily or individually paying their premiums in full amount. On the other hand, the Overseas Filipino Workers (OFWs) are included who follows the formal economy membership and pays a monthly

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contribution. There are also the senior citizens who do not belong to any membership category are automatic members of PhilHealth under UHC Law of 2019 to whom the government covers their annual premiums. The lifetime members and the sponsored members are those 60 years and above and have paid a minimum of 120 monthly premiums with PhilHealth and the former Medicare program; sponsored members and those 60 years and above and have paid a minimum of 120 monthly premiums with PhilHealth and the former Medicare program; sponsored members, respectively. The indigent members categorized as those without a source of income or insufficient household income based on DSWD's specific criteria while the qualified dependents are those contributions are declared and covered by a principal member, either a legitimate spouse, children, or parents.

The Law further reclassifies the types of members under Section 8 of the UHC Act, as simplified into two (2) types based on the source of premium contributions, namely; direct contributors and indirect contributors. This is to give effect to the mandate of the Universal Health Care Act that every Filipino citizen shall be automatically included in the program.

The direct contributors are the qualified dependents as the legal spouse/s who is/are not an active member of the Program; unmarried and unemployed legitimate, illegitimate children, and legally adopted or stepchildren below twenty-one (21) years of age; foster children as defined as Foster Care Act of 2012; and parents who are sixty (60) years old and above, not otherwise an enrolled member. On the other hand, the indirect contributors refer to all others who are not included as direct contributors as well as their qualified dependents. The basis of this PhilHealth contribution rate is the percentage of a person's earnings. Under the UHC Act, the rate is set to go up by half a percent each year, starting in 2021, until it reaches 5% in 2024 and 2025.

In terms of the premium payments, under the direct contributors, the premium payment as of 2014 of the employees with formal employment are 5% of the P10,000 monthly basic salary as the minimum whose premium contribution payments are equally shared by the employee and the employer. The *kasambahays* on the other hand, its premium contributions as stated under R.A. No. 10361 shall be shouldered solely by the household employer. Those earning beyond P5,000, the contribution rate is 3% of their monthly salary and they will pay a proportionate share. While the self-earning individuals and the professional practitioners, their monthly premium shall be computed straight based on their monthly income to be paid wholly and individually by the member following the terms of payments set by the Corporation. The overseas Filipino workers categorized as sea- and land-based OFWs, the premium payment of the former will be computed directly based on the monthly basic salary of the employee to be equally shared between the employee and the employer, while the latter they are required to provide proof of their monthly salary as the basis of the computation for premium payment. For Filipinos living abroad and those having dual citizenship, the premium contribution is pegged at P3,600.00 a year. Advance payment of premiums shall be allowed for a maximum period of two (2) consecutive years only. (PhilHealth, 2017). While the Lifetime members, and all Filipinos aged 21 years and above with the capacity to pay, required monthly premium contributions corresponding to the membership type under the direct contributors.

The indirect contributors such as the indigents identified by the DSWD, shall all be automatically enrolled and covered under the Program. The existing beneficiaries of Pantawid Pamilyang Pilipino Program shall be enrolled and provided with the coverage under the Sponsored Program Component of the NHIP. The senior citizens are automatically covered by the Program while the PWDs will be paid by the National Government but for those employed PWD members, the premium shall be shared equally by their employers and the National Government as employee's share. There is also a component for the Sangguniang Kabataan where the premium payment shall be shared by the barangay as the employer and the official or personnel as the employee. The premium payment equivalent to the Employee Counterpart shall be sourced from the barangay funds. Those previously identified at point-of-service (POS) or during registration, members previously sponsored by LGUs or private entities, and those who are not yet in the PhilHealth database and are financially incapable of paying premiums shall be enrolled and provided

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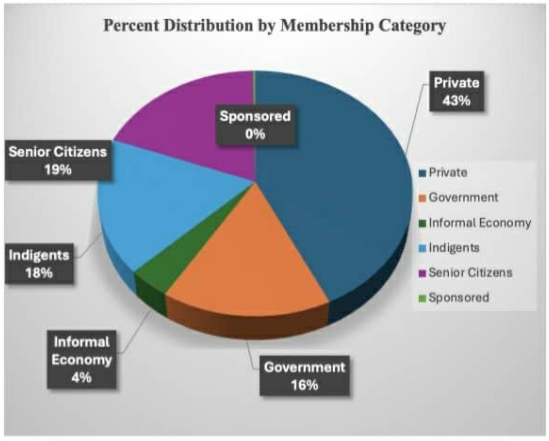
coverage under the Sponsored Program Component of the NI-IIP. Those Filipinos aged 21 years old and above without the capacity to pay premiums and covered under special laws, their premiums are subsidized by the government.

Among these numbers, the changed abruptly increased proportional to the PhilHealth members. In 2022 alone, out of almost 65 million direct contributors, it was the privately employed individuals who topped in the numbers of registered members and dependents with almost 29.5 million or 43 percent. It is followed by those employed in the government having 6.9 million or 16% of registered total members while the informal or self-earning contributed almost 20 million members or 4% of the total members. On the other hand, the indigents consist of 25 million members out of 39 billion which translates into 18% of total indirect contributors. It was followed by senior citizen members with 11.7 million or 19% and the sponsored reaches to 1.8 million or 0.26% at the least.

To operationalize the "individual-based health services", the NHIP set rules and guidelines on the payment mechanism provided in RA No. 7875, as amended. In 2017, the Formal Economy contributed the largest share with a total premium payment of 46% or equivalent to 48.8 billion while in 2022 it reached almost 92 billion from the privately employed and 35.5 billion from the government-employed members. On the other hand, the Indigent and Senior Citizens contributed 32% and 12% respectively, or 46.9 billion premium contributions subsidized by the government through the Sin Tax which dramatically increased to 38 billion and 41 billion in 2022, respectively. Seven percent (7%) are premium contributions from the Informal Economy and the rest is from the Sponsored Program that in 2022 reaches almost 508 million.



A study made by Haw, Uy, and Ho (2020) using national health survey data from 2008 to 2017 found that PhilHealth membership improved access to healthcare, with higher outpatient and inpatient utilization among members. However, the use of PhilHealth was also linked to increased healthcare costs across facility types. These findings suggest that while PhilHealth has expanded service access, its reforms have not effectively contained medical expenses in the Philippines.Benefits entitlement of PhilHealth members under UHC programs. As a member of PhilHealth one is protected under comprehensive benefit packages based on an individual's health, not on the person's ability to pay. These packages are compartmentalized into inpatient benefits availed by those in need of confinement not less than 24 hours; outpatient benefits that require day surgeries and treatment procedures done in accredited hospitals and free-standing clinics and don't require confinement; primary care benefits which are categorized into primary preventive services, diagnostic examinations, and drugs and medicines, that are available to indigent/sponsored members, organized groups, and land-based migrant worker-members, and dependents. This is recently expanded to the DepEd personnel; the Z benefits that are designed for life-threatening illnesses that require prolonged hospitalization, extremely expensive therapies, or other treatments that can

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deplete a family's financial resources, unless covered by special health insurance policies; and lastly, the MDG benefits and other social benefit packages that are in line with 3 Millennium Development Goals of reducing child mortality, improving maternal health and combating HIV and other infectious diseases.

These individuals must be enrolled in PhilHealth for recognition of their membership together with their dependents to receive the same health coverage as their principal members. The availing of this program by these dependents falls into children 20 years old and below but when they reach the age of 21, they can be enrolled as a member of PhilHealth; parents especially those with permanent disability irrespective of age; legitimate spouse provided they are not a member; and children with disability (congenital/acquired) even they are 21 years old and above as long as they have this total disability.

The cited benefits can be availed of by the active PhilHealth members with updated payment. Their needs must be attended to by an accredited doctor and service must be rendered by the PhilHealth accredited Health Care Institution (HCI). These accredited HCI must provide timely, safe, patient-centered, and effective health services in place of incentives provided by PhilHealth such as a recognition and awards system, infrastructure, and quality improvement opportunities. The health care providers are grouped into private and public hospitals wherein 59% of accredited hospitals are from the private sector. In the recent statistics posted by PhilHealth, there are 1,872 accredited hospitals of whom 1,096 are private hospitals and 776 are government hospitals. These hospitals are categorized into Levels 1, 2, and 3 depending on the health services they can provide. Variations in the services depend on these levels of the hospital as well as the hospital type and service capability (general or specialty). Specialty health facilities render clinical care and management, as well as ancillary and support services, for specific conditions. All hospitals have basic clinical, administrative, ancillary, and nursing services.

Conversely, the utilization of the benefits under the UHC program through PhilHealth deviates from what it is envisioned. For example, PhilHealth's objective is to provide equitable access to quality and affordable healthcare for the poor but these subsidized members are the ones who are unable to fully utilize its benefits (Nisperos MD, Ornos MD, 2022), possibly rooted in their very low awareness (Moore 2019). Another thing, some members' unavailing of PhilHealth in-patient benefits, stemmed from being ineligible for the benefit, numerous requirements before one can claim benefits, and the lengthy processing time of claims (Ricamata and Tandang, 2017). It can be deduced therefrom that PhilHealth is still far from functioning effectively in leveraging purchasing power, steering cost-effective service delivery, and equitable access to resources. (Uy, et al.,2023) and the challenge of reducing the out-of-pocket scheme health spending to which the largest contributor is medicines. is still at par despite the numerous legislation efforts.

Analysis of the accessibility of PhilHealth programs and benefits

Expanding its programs and services, PhilHealth optimized its reach to quality and accessible healthcare and access to all types of medical care, including palliative, curative, rehabilitative, and preventive care. In 2022, there are 10,987 accredited healthcare facilities nationwide, an increase from 9% in 2021. Of a total of 1,872 accredited hospitals nationwide, 59% are private facilities, while the remaining 41% are public facilities. An analogy from this number is that private hospitals invested more than public facilities in terms of their services.

A new classification as to service capability of the hospitals and differentiated on its features includes that Level 1 hospitals or emergency hospitals provide initial clinical care and management to patients requiring immediate treatment as well as primary care on prevalent diseases in the locality; while Level 2 hospitals are non-departmentalized hospital that provides clinical care and management on the prevalent diseases in the locality. Level 3 means a departmentalized hospital that provides clinical care and management of the prevalent diseases in the locality, as well as particular forms of treatment, surgical procedures, and intensive care. Level 4 is mainly on teaching and training hospitals (with at least one accredited residency training program for physicians) that provide clinical care and management of the prevalent diseases in the locality, as well as specialized and sub-specialized forms of treatment, surgical

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procedures, and intensive care (Joson, 2012). Aside from hospitals as healthcare facilities in the Philippines, we have here ambulatory medical clinics. The difference between the two is that hospitals are usually designed to provide inpatient care where patients are admitted to stay in the healthcare facilities depending on their health status and outpatient care is the opposite. While ambulatory clinics are usually designed to provide only outpatient care (Joson, 2012).

Uy, et al. (2021) found that both public and private hospitals span their growth from 2015 to 2020, with public hospitals turning to government capital investment programs, while private hospitals use debts and profits patients to expand their assets. As public healthcare is shared between the public and private hospitals, they differ in their mechanism of rendering services based on the availability of resources especially what PhilHealth may offer to utilize as benefits for this hospital's clientele. The services offered by the public hospitals mainly on preventive and primary care while also taking the lead in educating the public on health issues. On the other hand, private hospitals focus on specialized care for cardiovascular diseases, cancer, pulmonology, and orthopedics (Philippines - Healthcare, 2024)

Hospitals being the core providers of the healthcare system challenged to ensure that such care provides value for money, conserves healthcare resources, and promotes health equity. For instance, the Western Visayas Sanitarium and General Hospital, a Level 1 Hospital, offers numerous services such as Out-Patient Department Service, General Admission, PhilHealth admission, and Emergency Room Care, to name a few. This is indicative that every health facility shall have an adequate number of qualified, trained, and competent staff to ensure efficient and effective delivery of quality services. (dbm.gov.ph, 2022). But things are different from the geographical location of the hospitals wherein healthcare in rural areas is of significantly lower quality due to a shortage of medical facilities and equipment while the best hospitals and clinics are often found in large cities, such as Metro Manila, Cebu, Davao, and Quezon. Likewise, the remoteness of healthcare facilities prevents one from seeking health services.

On the flip side, private healthcare in the Philippines provides more consistent care, and facilities tend to be better equipped than public ones. In the same manner, doctors in private hospitals are on par compared to the public sector where the facilities of the former are much better equipped and treatment is typically faster.

The Philippine Health Insurance Corporation (PhilHealth) plays a pivotal role in the nation's healthcare system, offering insurance coverage to reduce medical expenses for Filipinos. This research focused on understanding how these benefits are utilized in different hospital sectors, which is crucial for evaluating healthcare accessibility and equity.

Access and Utilization of Benefits in Hospitals and Healthcare Facilities

There is a significant demand for the government and the healthcare sector to revolutionize the state of the Philippine healthcare program concerning the ballooning population despite having achieved universal healthcare. It is rationalized by a lack of healthcare personnel and outdated technology remains a challenge to the program (De Guzman, 2018). Parallel to this conclusion, the availability of healthcare resources appears to be an issue in consideration of bed population and health-professional population ratios that are substantial for higher coverage rates and the healthcare resources within proximity eliminate this issue (Silfverberg, 2015), to name a few.

With this immense fact, the policies governing the utilization of the PhilHealth benefits lie in the devolution of the provision of health services from the national to the local government units including the hospitals in provincial and district, and the public health and primary care services to the municipal government same with cities, as deregulated under the Local Government Code of 1991 highlighting the Executive Order No. 138 dated June 2021. Thus, the implementation of the national public health programs became the responsibility of the local government units (LGUs) and these brought substantial variations in hospital governance and health service capacities in LGUs.

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The speck of these benefits' utilization in the perspective of local access underlies the health programs proposed by the health officer to be approved by the governor or mayor which later turned into political gains of the latter (Liwanag & Wyss, 2020). To further conclude (ibid), the critical point is in the decision granting the same for the various functions with adequate capacities and the ability to grasp the importance of health services. Certainly, the strong political will and motivation of local leaders were crucial to their success in improving the health system.

Source: Statista. (2024, February 23)

Nonetheless, the reforms ruptured the referral system and the fragmentation of the financing of health services and the jurisdictional responsibilities delimits into primary and secondary health services, those provided in rural and city health units and barangays health stations vis-à-vis those provided in district and provincial hospitals under provincial governments, respectively, see Figure 2. However, the upper-level hospitals remained under the DOH (Picazo, n.d.) or tertiary health services including medical and surgical diagnostics, treatment, and rehabilitative care provided by the medical specialist. These are just the remaining residual powers and functions that are retained in the DOH (Cuenca, 2018).

Categorically, public hospitals are either DOH-retained or locally owned and controlled, while private hospitals however classified as single proprietorships, partnerships, corporations, missionary/religious or civic organizations/foundations, and cooperatives. The majority of these private hospitals are for-profit corporations. Tangent to this profit consideration is the location as a major important function in the existence of hospitals. For example, highly urbanized cities like Metro Manila, tend to have more hospitals that offer higher levels of care rather than the primary level of care present in less urbanized areas. It can be deduced also that services depend on the level of the hospital, as well as the hospital type either a general or specialty.

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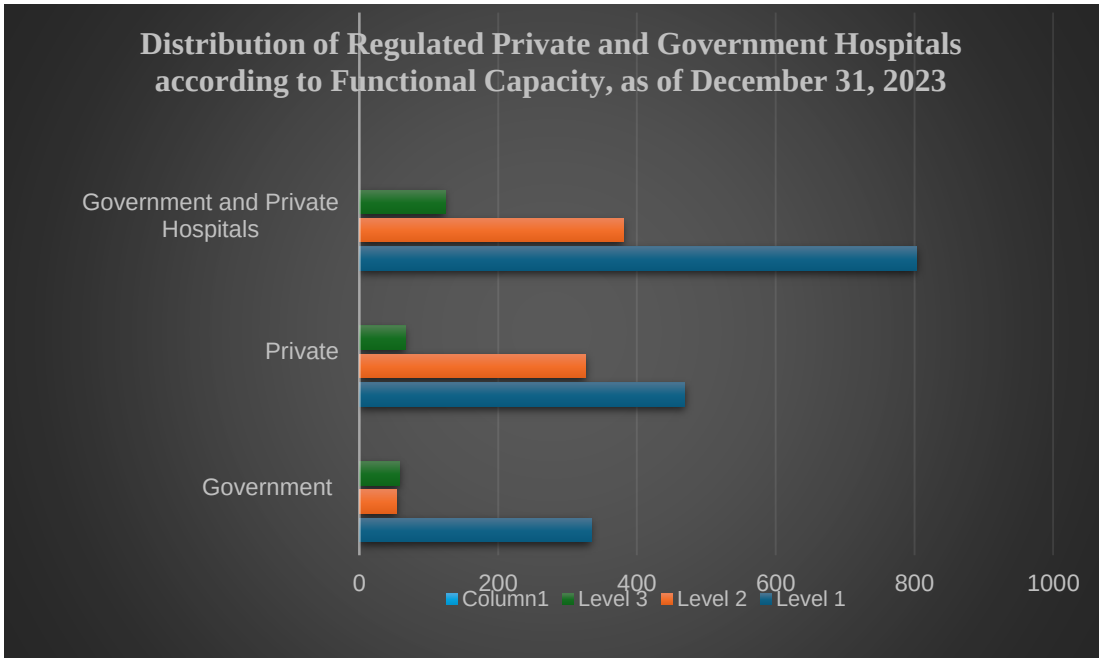

Figure 3. *Distribution of Regulated Private and Government Hospitals*
Source: DOH, 2023

The classification of hospitals is categorized according to ownership (government and private), the scope of services (general or specialty) to functional capacity such as the general hospitals categorized as Level 1, Level 2, and Level 3, the specialty hospitals, and trauma capability hospitals being a trauma-capable facility and trauma-receiving facility. On the other hand, Other Health facilities are classified into Category A: Primary Care Facility; Category B: Custodial Care Facility; Category C: Custodial/Therapeutic Facility; and Category D: Specialized Out-Patient Facility.

With the preceding circumstances, the allocation or distribution of hospitals differs both in private and public hospitals. For instance, the private hospitals outnumbered the government hospitals with 772 hospitals out of 1195 recorded by the Philippine Statistics Authority in 2022. Approximately 40% are in government-run and the remaining is in the private sector. Unlikely, the increase of hospitals that corresponds to an increase in hospital beds is substantially more in the private sector than in government hospitals, and the likelihood of 30% of Filipinos accessing the service of the private healthcare system as their main source of care despite higher consultation fees and drug costs rather than public facilities. The two best private hospitals in Manila like the Medical City and St. Luke's Hospital Philippines Medical Center preferred most Manilla (Phil. Hospitals). Although many public hospitals, especially those in urbanized cities, provide excellent care and diagnostic services (Fran, 2022), patients look for convenience, confidentiality, short waiting hours, and perceived higher quality than the public sector (Sherpa & Yadav, 2019). Therefore, hospitals and other health facilities in the Philippines can be classified according to their service capability. Claims on PhilHealth Hospitalization Payments Made to Common Illnesses in Public and Private Hospitals

The state held Corporation, the Philippine Health Insurance (PhilHealth) is responsible for the reimbursement of the Health Care Institutions and Hospitals and other service providers for the delivery of the healthcare services compliant to all pertinent policies and requirements of the program. Under PhilHealth Circular 2021-0004 issued on 8 April 2021, the use of Debit-Credit Payment Method facilitates the settlement of accounts payable to the healthcare facilities (HCFs) (Cervantes, 2021)

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Per record, the PhilHealth has paid a total of Php166 billion for some 13.6 million claims, or 76.4% of the almost 18 million claims received from accredited government and private hospitals from calendar year 2020 to June 30, 2021 (Philhealth, 2021), P129.6 billion as of December 31, 2022 (PhilHealth, n.d.). From there, the claims of Php 4.22 billion is out from the Php7 billion reimbursed in the National Capital Region Plus area (Cervantes, 2021). in 2022, the PhilHealth paid claims worth Php1.30 billion (GMA, 2023). On the same vein, Tunanan-Mendoza, et al. (2015) made a cost analysis in the conduct of their study in two tertiary private hospitals which assessed the economic burden of community-acquired pneumonia (CAP) among Filipino adults and compared actual treatment expenses with PhilHealth's case rate payments. Findings showed that hospitalization costs for both moderate- and high-risk CAP cases were significantly higher than PhilHealth's reimbursements of ₱15,000 and ₱32,000, respectively. The study estimated the national economic burden at ₱8.48 billion for moderate-risk and ₱643.76 million for high-risk cases, indicating that PhilHealth payments fall short of covering the true cost of pneumonia care and highlighting the need for improved financial protection policies.

The basis of the preceding claims on government and private hospitals are illnesses such as acute respiratory tract infection as the leading illness in the Philippines with hypertension, urinary tract infection, animal bites, skin diseases, acute lower respiratory infection, pneumonia, acute watery diarrhea, bronchitis, and TB in all forms was recorded in the year 2020 (Statista, 2024). Infectious and cardiovascular (CV) is also considered the predominant illness with a stroke that causes hospitalization or worst leading to death (Sison, 2005). It is found out too that from 2011-2020, PhilHealth paid P665.28 billion to HCIs representing reimbursement of 67.95 million claims. It also paid P50 billion worth of previously unsettled claims to hospitals and doctors in the last five months of 2023.

To add, Ang and Fernandez (2024), made an observation that chronic obstructive pulmonary disease (COPD) is a major health and economic burden in the Philippines, with hospitalization costs remaining high despite PhilHealth coverage. A study at the Philippine General Hospital showed that charity patients spent about $75.89 per day, while private patients spent $285.71. Most expenses were from accommodation, professional fees, and medications. The findings highlighted that PhilHealth's support for COPD remains insufficient, and better outpatient care could help reduce overall costs.

Heart failure (HF) remains a major clinical and financial challenge in the Philippines, requiring continuous care and frequent hospitalization. Using a micro-costing approach, the study conducted by Anonuevo, et al (2025) estimated that in 2022 about 914,892 Filipinos lived with HF, resulting in an economic burden of PHP 80.9 billion (USD 1.5 billion), with 90% of costs coming from direct expenses—mainly hospital and medication costs. The study underscored that HF care exposes many Filipinos to financial hardship due to high out-of-pocket spending, emphasizing the need for stronger preventive measures and improved financial protection for patients.

There considered a top ten (10) medical cases from January 1 to December as reimbursed by the Corporation. These includes Pneumonia Moderate and High Risk with a claims account of P 4,969,675,781 corresponding to 321,442 claims count, followed by Dengue Fever (Mild/Severe) with 1,928,575,318 and 202,906 claims account and claims count respectively. Acute Gastroenteritis with 845,595,017 claims account and 156,531 claims count. This followed by Covid-19 Pneumonia Package 27,177,262,519 claims account and 130,136 claims count. Others are Hypertensive Emergency Urgency with 978,098,300 and 118,871 claims account and claims count, the Urinary Tract Infection Admissible having 765,689,750 claims account and 115,355 claims count, Stroke Infarction (Hemorrhagic/ Non Hemorrhagic) with 3,171,897,042 claims account and110,504 claims count. Another one is the Peptic Ulcer Disease with/without Hemorrhage ranging 698,569,051 claims account and 109,917 claims count. Plus a Newborn Sepsis having 750,128, 168 claims account and 58,128 second to the lowest claims count. Lastly the Asthma in Acute Exacerbation with 437,589,529 claims account with the least 55,527 claims count.

PhilHealth also provides coverage for illnesses and their corresponding benefits includes Case Rate for Hemodialysis (per session) (P2,600), Case Rate for Outpatient Blood Transfusion (one or more units)

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(P3,640.00), Thyroidectomy (Total or Complete Cash Benefits) (31,000.00), Ovarian Cystectomy (Unilateral or Bilateral) (23,300.00), Pneumonia in moderate risk pneumonia (P15,000), high risk pneumonia (P32,000), and primary care moderate risk pneumonia (P10,500). There's the noted coverage for Tonsillectomy (Primary or Secondary) (P18,000), Normal Spontaneous Delivery (NSD) in lying in (P6,500), hospital (P5,000) and pre-natal (P1,500).

These benefits are paid to the accredited Health Care Institutions (HCI) through all case rates that is deducted from the member's total bill, which shall include professional fees of the attending physicians prior to discharge. As coined in the study of Ulep, Uy and Casas (2020), a so-called noncommunicable diseases (NCDs) caused about 70% of deaths in the Philippines, with poorer communities most affected. Despite this, the health system remains focused on infectious diseases, leading to fragmented care. Strengthening the Universal Health Care Act to address gaps in governance, financing, and service delivery is vital to ensure continuous and effective NCD management.

PhilHealth Z Benefits

PhilHealth's Z Benefits package provides substantial financial coverage for illnesses such as cancers includes the breast, prostate, and cervical, the kidney transplants, and heart surgeries. It offers high-value coverage, often over P1 million, which designed to minimize out-of-pocket costs for severe, long-term treatments at accredited hospitals. The coverage extended to diagnostics, surgery, chemotherapy, and post-operative care.

In Caballes, Sollner, and Nañagas (2012) study under the Health Systems Development Project in 2010, examined the effectiveness of financial protection mechanisms for indigent and severely ill patients in selected public and private hospitals across Philippine provinces. Based on the data derived from 449 respondents, findings showed that PhilHealth reimbursements and hospital discounts together covered only about 46% of total inpatient expenses. Invalidated PhilHealth claims ranged from 28% to 42%, while discounts provided more support to poorer and sicker patients than reimbursements. The results suggested that although both mechanisms help reduce medical costs, PhilHealth's processes must be strengthened to ensure equitable financial protection for indigent patients.

In the study conducted by Uy, et.al (2022) who analyzed the use of Philippine social health insurance data filed by 1,295 hospitals in 2019 and 2020, the prolonged effects of the COVID-19 pandemic have significantly reshaped the utilization of hospital services in the Philippines, exposing underlying weaknesses in the healthcare system. This situation highlights the risk of a sustained public health crisis in countries with fragile health infrastructures and limited social protection mechanisms. As the nation endured multiple waves of infection and mobility restrictions, the strain on hospitals, healthcare workers, and the financing mechanisms became increasingly evident. In response, policymakers were urged to adopt a whole-of-health approach that not only addressed the pandemic but also safeguarded access to essential healthcare services for non-COVID-19 conditions. Such a strategy required strengthening service delivery networks, sustaining preventive care programs, and ensuring equitable access, particularly for the most vulnerable populations.

In 2025, the Philippine Health Insurance Corporation (PhilHealth) Bicol reaffirmed its expanded benefit packages, significantly increasing coverage for key treatments, including hemodialysis (from ₱4,000 to ₱6,350 per session), severe dengue (from ₱16,000 to ₱47,000), kidney transplantation (up to ₱2,093,000), acute myocardial infarction (up to ₱523,853), and cataract surgery (up to ₱187,100 per eye), with the adjustments aimed at reducing the financial burden on patients.

In this context, the role of the Philippine Health Insurance Corporation (PhilHealth) became even more crucial. During the pandemic, PhilHealth's reimbursement system was tested by the surge in hospitalization claims and the need to expand benefit packages for both COVID-19 and non-COVID illnesses. However, several studies and reports indicated challenges, including delayed reimbursements, varying claim rates between government and private hospitals, and increased out-of-pocket expenditures

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among patients seeking treatment for common illnesses. These issues underscored the limitations of the current payment structure and raised questions about its adequacy in providing genuine financial protection to all members. Post-pandemic recovery efforts thus call for an in-depth evaluation of PhilHealth's capacity to sustain equitable and efficient reimbursement for common illness claims across different hospital types. Such comparative analyses are essential to determine whether the promise of universal health coverage has translated into real and measurable access to affordable care for Filipino patients.

Timeliness of Claims Processing

The Philippine Health Insurance Corporation provides financial protection for both inpatient and outpatient care through its case rate payment system. Members who are admitted for at least 24 hours may avail of inpatient benefits, while outpatient support covers consultations, preventive screenings, laboratory procedures, and essential medicines under the primary care package, including the Yaman ng Kalusugan Program (YAKAP), which aims to improve access to basic health services. Reimbursement procedures in both public and private hospitals follow the standardized All Case Rates (ACR) scheme, where accredited facilities receive a fixed amount for specific diagnoses or procedures. The process typically begins with eligibility verification at the point of service, followed by the automatic deduction of PhilHealth benefits from the patient's hospital bill, and the subsequent submission of electronic or paper-based claims by the health facility.

Under existing policy, claims for reimbursement of services must be submitted within sixty (60) calendar days from a patient's discharge, a shorter period compared to the 120-day allowance granted during the pandemic. Encouragingly, by late 2025, the Philippine Health Insurance Corporation was able to process claims in an average of 22 to 25 days—well within the required timeframe—largely due to strengthened digital systems and the use of artificial intelligence in claims management. In regions such as the Davao Region, processing has been even quicker, averaging about 19 days. Despite these gains, the strict filing deadline has contributed to a notable number of otherwise valid claims being returned or denied—around 5.3% in 2024—placing financial pressure on health facilities and revealing operational bottlenecks. In response, the PhilHealth Board issued PhilHealth Board Resolution No. 2995, s. 2025, introducing temporary flexibility in submission deadlines to minimize denials, ensure fair reimbursement of legitimate claims, and strengthen coordination with healthcare providers.

Then President Ferdinand Marcos Jr. directed the Department of Health to extend the filing period for hospital claims with the Philippine Health Insurance Corporation from 60 to 120 days and to streamline documentation requirements, following reports of more than ₱1 billion in outstanding claims. This move aimed at easing delays in PhilHealth payments and helping health facilities recover denied claims of which this amount, approximately ₱786.66 million were denied claims, while ₱298.77 million were classified as return-to-hospital (RTH) claims. A report by the Commission on Audit cited persistent non-compliance with PhilHealth's claims processing guidelines and internal systemic weaknesses within hospitals, warning that these issues hinder the timely recovery of public funds and may ultimately affect the delivery of essential health services.

For the first nine months of 2025, the Philippine Health Insurance Corporation disbursed a total of ₱217.93 billion in claims payments—almost double the ₱112.23 billion released during the same period in 2024—covering both public and private health facilities. Of this amount, private institutions received ₱127.79 billion, while public facilities accounted for ₱90.14 billion in reimbursements. As of September 30, 2025, PhilHealth reported an average claims processing turnaround time of 22 days, reflecting improved efficiency in line with the directive of Ferdinand Marcos Jr. to strengthen institutional performance. The agency noted that the surge in expenditures is largely attributed to payments for catastrophic illnesses under its Z Benefit Packages—such as heart surgery, cancer treatment, and kidney transplantation—as well as the continuing rise in high-cost services like outpatient hemodialysis, underscoring its commitment to providing substantial financial support to members facing life-threatening and complex medical conditions.

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There are considered factors attributed to the delays in PhilHealth claims reimbursements that includes internal operations such as administrative capacity and staffing adequacy of the healthcare facilities as well as digital infrastructure. Added to it is the non-compliance and various violations of existing rules and regulations.

Adequacy of Coverage relative to Actual Hospital Costs

PhilHealth benefits are grouped into inpatient, outpatient, and special packages, all paid through standardized case rates that are remitted directly to accredited facilities. The case rate amount is deducted from the patient's total bill – including professional fees – prior to discharge. Coverage spans a wide range of services: hospital confinement, outpatient services like dialysis and select procedures, maternity care, preventive services, and catastrophic packages for high-cost conditions.

PhilHealth currently administers benefits through the All Case Rates (ACR) system, under which accredited health facilities are paid a fixed amount based on a patient's diagnosis rather than the actual cost of care, meaning each illness or procedure has a predetermined reimbursement rate, separate from outpatient and other benefit packages. While this approach simplifies claims processing, hospitals receive the same payment regardless of the severity or complexity of a patient's condition, often resulting in substantial out-of-pocket expenses for patients despite the promise of universal health coverage. A recent study by the Philippine Institute for Development Studies recommends modernizing PhilHealth's hospital payment system to make it more equitable and financially sustainable, noting that from 2014 to 2023 inpatient service costs increased by an average of 3.4% annually, leading to an estimated 40% decline in the real value of PhilHealth reimbursements over the decade.

The reviewed literature highlights PhilHealth's critical role in achieving equitable and affordable healthcare for Filipinos, with a membership of over 115 million as of 2024 (Cabato, 2024). Anchored in the Universal Health Care (UHC) framework, PhilHealth's mandate as the country's national health insurance provider centers on ensuring financial risk protection and universal access through adequate reimbursement and sustainable funding mechanisms. To realize these goals, PhilHealth relies on annual congressional appropriations and regular member contributions to sustain preventive and curative care services nationwide. However, several studies have pointed out that despite these efforts, the system's effectiveness remains inconsistent across hospital types and regions, partly due to underutilization of benefits (Nisperos, 2022), limited public awareness (Moore, 2019), and membership ineligibility issues (Ricamata & Tandang, 2017).

Empirical findings revealed persistent disparities between PhilHealth's reimbursement rates and the actual cost of hospitalization. Members continue to pay substantial out-of-pocket expenses, which still comprise 44.7% or ₱501.79 billion of total health expenditures (PSA, 2023). Ilagan et al. (2024) reported that PhilHealth payouts were insufficient to cover expenses for the five most common surgical procedures, while Ramos and Untalan (2020) found that the case rate system only moderately reduced costs for non–No Balance Billing (NBB) patients. Broader analyses by the Philippine Institute for Development Studies (PIDS, 2022) further indicate that reimbursement delays place private hospitals at financial risk and push public hospitals to depend on government subsidies. These findings underscored systemic inefficiencies in PhilHealth's payment structure that undermine its financial protection goals.

In 2022, of the 1,872 PhilHealth-accredited hospitals, 59% were private and 41% public—showing a steady expansion of healthcare infrastructure (Uy et al., 2021). However, the services they offer differ significantly: public hospitals often focus on primary and preventive care, while private hospitals tend to deliver specialized and high-cost treatments (Phil-Healthcare, 2024). This uneven distribution results in pronounced disparities in service accessibility and quality, especially in rural areas such as Albay, where healthcare resources remain limited. Urban centers provide superior medical and diagnostic services (Fran, 2020), and private facilities generally maintain higher quality than their public counterparts (Sherpa & Yadav, 2019). Other studies point to additional barriers such as outdated equipment (De Guzman, 2018),

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scarcity of medical personnel and resources (Silfverberg, 2015), and political influences on local health management (Liwanag & Wyss, 2020).

Common illnesses such as pneumonia and chronic obstructive pulmonary disease (Ang & Fernandez, 2024), hypertension and heart failure (Anonuevo et al., 2025), dengue, gastroenteritis, acute urinary tract infections (Statista, 2024), asthma, and stroke (Sison, 2005) continue to dominate hospitalization cases in the Philippines. From 2011 to 2020, PhilHealth disbursed ₱665.28 billion for 68 million claims, yet reimbursement rates still lag behind actual hospital expenses, causing delays and operational strain among health facilities. These ongoing issues make Albay a suitable study area due to its accessibility, diverse population, and balanced presence of both public and private hospitals. Such characteristics allow for a meaningful comparative analysis of PhilHealth's reimbursement mechanisms and their impact on service delivery for common illnesses.

Overall, the reviewed studies acknowledged PhilHealth's progress in improving healthcare accessibility and financial protection. Nonetheless, challenges persist—particularly regarding reimbursement adequacy, timely fund release, and equitable benefit distribution. Existing literature indicates that while PhilHealth's reforms have expanded healthcare access, they have not effectively reduced the financial burden of medical expenses (Haw, Uy, & Ho, 2020). Thus, this study addressed a critical research gap by conducting a comparative analysis of PhilHealth reimbursements for common illness claims in selected government and private hospitals in Albay. The findings aim to contribute to policy development toward a more efficient, equitable, and sustainable healthcare financing system.

Despite the implementation of the Universal Health Care (UHC) Law and the continued expansion of PhilHealth's programs, issues in hospitalization payments remain a major concern in both government and private hospitals. PhilHealth's reimbursement rates are often insufficient to cover the actual cost of medical care, resulting in significant out-of-pocket expenses for patients. This financial gap particularly affects low-income and indigent patients who rely heavily on PhilHealth for hospitalization and treatment. The imbalance in payment mechanisms also causes strain on public hospitals that depend on reimbursements to sustain their operations, while private hospitals experience financial instability due to delayed and inadequate payments.

Furthermore, the inequity between healthcare access in urban and rural areas deepens the problem. Most accredited and well-equipped hospitals are located in major cities, while rural regions continue to struggle with limited facilities and medical personnel. This geographic disparity limits the effectiveness of PhilHealth's universal coverage, as patients in remote areas often cannot fully benefit from their insurance. Given these persistent challenges, there is a pressing need to assess and strengthen PhilHealth's payment system to ensure fairness, efficiency, and sustainability in the delivery of healthcare services across both government and private hospitals.

While numerous studies have analyzed PhilHealth's role in promoting universal health coverage, limited research directly compares hospitalization payments for common illnesses between government and private hospitals. Most existing literature focuses on PhilHealth's overall financial mechanisms, case rate payments, or disease-specific reimbursements, but few have examined how these payments differ in terms of adequacy, timeliness, and patient impact across hospital types. This lack of comparative analysis creates uncertainty about whether PhilHealth's current payment schemes truly achieve equity and efficiency in healthcare financing.

Moreover, prior studies have often emphasized institutional or policy perspectives, leaving a gap in understanding the patient experience — particularly how reimbursement gaps affect out-of-pocket expenses and access to quality care. There is also minimal investigation into how delays or discrepancies in PhilHealth reimbursements influence hospital operations and service delivery, especially in rural versus urban settings. Addressing these research gaps will provide valuable insights for policymakers and healthcare administrators to improve PhilHealth's payment structure and ensure that both public and private hospital patients receive fair and adequate financial protection.

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Objectives of the Study

This study compared PhilHealth hospital payments for common illness claims between selected government and private hospitals in Albay. Specifically, it:

1. Determined the level of PhilHealth hospital payment for common illness claims between selected government and private hospitals in Albay, along:
   a. the number of claims;
   b. the amount of claims; and
   c. the variances in claims and payments;
2. Determined the timeliness of claims processing;
3. Determined the adequacy of coverage relative to actual hospital costs; and
4. Recommended measures to strengthen the adequacy, fairness, and timeliness of PhilHealth reimbursement across healthcare facility types.

Theoretical and Conceptual Framework

This study was anchored on the policy framework established by Republic Act No. 11223 or the Universal Health Care (UHC) Act of 2019, which ensured that all Filipinos had access to quality healthcare services without financial hardships. The law strengthened the country's health system through the expansion of primary care services, improvement of health facilities, and the enhancement of health finding mechanisms. It also introduced automatic enrollment of all Filipinos into the national health insurance program, the establishment of primary care provider networks, and the designation of Philippine Health Insurance Corporation (PhilHealth) as the primary purchaser of healthcare services. furthermore, the law expanded coverage for both preventive and curative healthcare services to promote equitable access to health services.

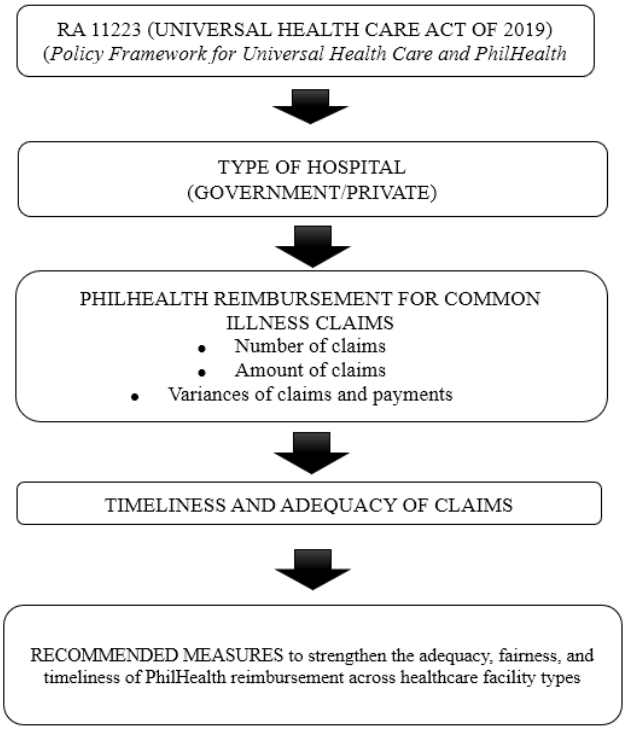

Figure 4. *Theoretical and Conceptual Framework*

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Thus, within the context of the UHC Act of 2019, equitable healthcare financing could only be achieved when PhilHealth reimbursement practices were consistent, fair, and sufficient across both government and private hospitals. This framework served as the basis for examining the differences in PhilHealth hospitalization payments and for analyzing the adequacy and efficiency of the reimbursement system in the province of Albay.

METHODS

Research Design

The study employed a comparative research design, which is an interdisciplinary approach that compares elements that share similarities in some aspects but differ in others (Paisey & Paisey, 2024). This design allowed the researcher to identify similarities and differences in the amounts and numbers of claims, payment variations, timeliness of claims processing, and coverage adequacy across different hospital types. Alongside the comparative design, descriptive-evaluative and descriptive-comparative methods were used to assess the effectiveness of PhilHealth's payment mechanisms and to develop strategies for improving the adequacy, fairness, and timeliness of reimbursements. The study also served as an operational evaluation, examining the impact of PhilHealth's claims processing and payment systems on healthcare access, financial protection, and the overall health outcomes of PhilHealth members. The findings from this evaluation led to evidence-based recommendations aimed at enhancing and standardizing reimbursement practices across both government and private hospitals.

Data Gathering Procedure

A letter requesting permission to conduct the study was prepared by the researcher and was addressed to the selected hospitals through the appropriate administrative officers. A separate letter was also prepared and sent to the PhilHealth Regional Office requesting aggregate data on hospitalization claims for common illnesses, which was coursed through the Office of Planning. Upon receipt, the data was collated, organized, and summarized using tables and charts to facilitate comparison between government and private hospitals. Quantitative data on reimbursement amounts timeliness of claims processing, and adequacy of coverage has been carefully recorded.

Data Analysis

This research utilized quantitative analysis to compare PhilHealth hospitalization payments between selected government and private hospitals, employing descriptive statistics such as percentages, means, and variations to analyze the number, amounts, timeliness, and adequacy of claims. Variance analysis was applied to identify patterns in the number and number of claims, such as the difference in claimants between government hospitals (GH) and private hospitals (PH). The percentage variance was computed by treating PH totals as the reference, highlighting how GH payments compare to PH payments. For payment variance, the study calculated differences in total payments for both government and private hospitals, with positive values indicating higher GH payments. The timeliness of claims was assessed by comparing the number of days to process claims with the statutory 60-day limit. The results, including variance and percentage variance values, provided valuable insights and formed the basis for evidence-based recommendations to improve the adequacy, fairness, and timeliness of PhilHealth reimbursements across different hospital types.

Sources of Data

The study utilized primary data sourced from the PhilHealth office, specifically focusing on the number and amounts of claims for selected common illnesses across government and private hospitals. The data were summarized in tables to enhance clarity for readers, and percentages of variance were calculated

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to facilitate a more accurate comparison. Secondary data from PhilHealth archives, existing records, and official websites were also used, providing additional information on the benefits utilized by both government and private hospitals. Purposive sampling was employed to select PhilHealth-accredited hospitals with active claims processing for common illnesses. The sample included both government and private hospitals in Albay, ensuring that the facilities selected offered comparable medical services. Only hospitals with complete and accessible records were included in the study.

Research Instrument

Data collection was facilitated using a structured data extraction form designed by the researcher. The form captured relevant information, including the number and amount of claims, which reflected the total PhilHealth payment per claim; the timeliness of claims processing, measured by the number of days between claim submission and payment; the adequacy of coverage, determined through the comparison of PhilHealth payments with actual hospital costs; and the type of hospital, whether government or private facility.

Ethical Considerations

This study strictly adhered to ethical standards to ensure the protection of all parties involved. Since the research involved the analysis of PhilHealth hospitalization claim records, privacy was strictly maintained. No personal identifiers such as names, addresses, or other sensitive information will be collected or recorded. All data were anonymized, and only aggregate information related to hospital types and payment amounts was analyzed.

Permission to access the PhilHealth claim records was sought from the appropriate authorities, and the purpose of the study was clearly explained to ensure transparency. The data were used solely for research purposes and were handled with the utmost care to prevent unauthorized access. Furthermore, the study followed ethical guidelines regarding honesty, integrity, and responsible reporting of findings, ensuring that the results were presented accurately and objectively. By adhering to these principles, the study aimed to protect confidentiality, respect the institutions involved, and maintain the highest standar ˆ ethical research practice.

RESULTS AND DISCUSSION

Comparative PhilHealth Hospitalization Payments Made to Common

Illness

For comparative purposes, the government and private hospitals were assigned as categories A and B, however there are no criteria set for the same whether it was pre-determined based on the diagnosis, covering both hospital charges, and professional fees. This was done only to show if there are variances in the claims on common illnesses between government and private hospitals.

To have much clear presentation, the claims paid to the two hospitals – government and private, with assigned categories A and B are added up to arrive at total amount for comparison. The focus on 2024-2025 aggregated PhilHealth data for claims and payments in Albay stemmed from significant shifts in policy, system upgrades, and financial management improvements enacted during this period. The data is collated to reflect the implementation of the Universal Health Care (UHC) Act, increased benefit packages and new payment mechanisms.

Number of Claims

The data in Table 1 presented the number of claimants for selected common illness from government hospitals (GH A&B) and private hospitals (PH A&B). The table also included the computed

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variance and its percentage equivalent, which indicated the difference in the number of claimants between the two sets of hospital types. The variance was calculated using the formula: variance (claimants) = GH A&B Claimants – PH A&B Claimants and to further illustrate proportional differences, the percentage variance was computed as: percentage variance = GH – PH/PH x 100. The positive values reflects that GH had more claimants than PH, while negative values showed that PH had more claimants.

The data revealed notable differences in the distribution of claimants across illnesses. For instance, stroke infarction had the highest positive variance of 89 or 79.46%, indicating that the GH A&B recorded significantly more claimants than PH A&B for this condition. Similarly, perinatal infections and ischemic heart disease with myocardial infarction showed large variances of 150 and 72 and a percentage variance of 2500% and 600%, respectively, suggesting that GH managed the vast majority of these cases, therefore there were more frequently claimed in GH A&B.

Heart failure had a negative variance of -10 and a percentage variance of -6.67%, indicating that PH treated slightly more patients for this illness. illnesses such as hypertensive emergency/urgency and pneumonia moderate risk had small percentage variances with 1.61% and 13.71%, respectively, reflecting similar claimant distribution between hospital groups.

Overall, government hospitals recorded higher claims for most illnesses versus private hospitals and provided a clear comparison of hospital utilization patterns.

Table 1. *Comparative Number of Beneficiaries/Claimants*

Common Illnesses	Gh-A&B No. of Claimants	Ph-A & B No. of Claimants	Variance	Percentage Variance
anemia	87	69	18	26.09
sepsis	69	55	14	25.45
stroke infarction	201	112	89	79.46
heart failure	140	150	-10	-6.67
stroke hemorrhagic	81	16	65	406.25
perinatal infections	156	6	150	2500
ischemic heart disease with myocardial infarction	84	12	72	600
pneumonia high risk	49	34	15	44.12
hypertensive emergency urgency	126	124	2	1.61
Pneumonia moderate risk	398	350	48	13.71

With these observed disparities in the number of claims between GH A&B and PH A&B, it could be attributed to multifactorial. Firstly, the capacity and size of the hospitals likely influenced the volume of patients they accommodated. GH A&B, being larger or more accessible government hospitals, possibly received more patients for certain illness, such as stroke infarction and prenatal infections, resulting in higher claim numbers. Secondly, the availability of specialized services such as hospitals with advanced facilities or specialized departments for cardiac care, neonatal care, or stroke management likely attracted more patients requiring those services, which reflected in the higher claim records. Thirdly, the geographical location and patient demographics played a role. Lastly, the awareness and utilization of PhilHealth benefits that could have affected the number of claims submitted. These factors collectively shaped the claim distribution observed in Table 1.

Amount of Claims

Table 2 shows the actual data gathered, with permission, from the PhilHealth Office. Reflected in the tables are the common illnesses as subject for claims during member's or dependent's hospitalization. These illnesses include perinatal infections, sepsis, stroke infarction, pneumonia moderate risk, heart failure, stroke hemorrhagic, ischemic heart disease with myocardial infarction, pneumonia high risk, hypertensive emergency urgency and anemia.

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Table 2 presented the total PhilHealth case rate payments for selected common illnesses from government hospitals (GH A&B) and private hospitals (PH A&B), as well as the aggregate totals for each hospital group. In addition to absolute variances, the percentage variance was computed to compare payments proportionally, using the formula: Percentage Variance (%) = Total (GH) – Total (PH)/Total (PH) x 100. Positive percentage variances indicated that GH received higher payments relative to PH, while negative values indicated that PH received higher payments.

The analysis revealed substantial difference in proportional payments between hospital groups. Perinatal infections exhibited the highest percentage variance at approximately 2843.3%, demonstrating that GH received significantly more payments than PH for this condition. Similarly, stroke hemorrhagic and stroke infarction had high percentage variances of 65.18% and 34.43%, respectively, indicating that GHs managed more cases or filed claims more efficiently for complex or high-risk conditions.

Table 2. *Total Amount of Claims Paid by PhilHealth on Common Illnesses to Government and Private Hospitals with Percentage Variance for Payments*

Common Illnesses	Gh- A	Gh-B	Total (Gh)	Ph-A	Ph-B	Total (Ph)	Variance (Gh – Ph)	% Variance (Gh - Ph)
anemia	6,400,000	703,000	7,103,000	5,600,000	348,200	5,948,200	1,154,800	19.41
sepsis	15,000,000	18,700	15,015,700	1,700,000	10,800,000	12,500,000	2,515,700	20.13
stroke infarction	14,800,000	523,100	15,323,100	8,900,000	2,500,000	11,400,000	3,923,100	34.43
heart failure	12,800,000	596,900	13,396,900	11,700,000	4,100,000	15,800,000	-2,403,100	15.21
stroke hemorrhagic	14,100,000	107,000	14,207,000	6,400,000	2,200,000	8,600,000	5,607,000	65.18
perinatal infections	19,200,000	56,600	19,256,600	69,600	584,600	654,200	18,602,400	2843.3
ischemic heart disease with myocardial infarction	8,300,000	213,200	8,513,200	2,600,000	282,800	2,882,800	5,630,400	195.3
pneumonia high risk	6,700,000	27,400	6,727,400	3,300,000	571,200	3,871,200	2,856,200	73.79
hypertensive emergency urgency	5,600,000	1,000,000	6,600,000	5,600,000	348,200	5,948,200	651,800	10.95
Pneumonia moderate risk	10,500,000	2,300,000	12,800,000	1,700,000	10,800,000	12,500,000	300,000	2.40

In contrast, heart failure had a negative percentage variance of -15.21%, showing that PHs received higher total payments for this illness compared to GHs. Illnesses such as hypertensive emergency/urgency and pneumonia moderate risk had relatively small percentage variances with 10.95% and 2.40%, respectively, suggesting that payment distributions were similar between the hospital groups.

Overall, the percentage variance analysis provided a proportional comparison of case rate payments, allowing for a clearer understanding of which illnesses generated higher funding for GHs versus PHs. This method complemented the absolute variance analysis and offered insight into hospital utilization, claim patterns, and resource allocation across public and private healthcare facilities.

Furthermore, this analysis demonstrates that government hospitals play a critical role in providing accessible and cost-effective care for common illnesses, particularly among vulnerable populations. Higher claim volumes in these facilities reflect both the affordability of services and the capacity to manage severe and high-risk conditions, such as perinatal infections, sepsis, and pneumonia. Private hospitals, while offering more specialized care and faster service, remain less utilized due to higher out-of-pocket costs,

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highlighting persistent disparities in access. These findings underscore the importance of strengthening government hospital infrastructure, expanding skilled healthcare workforce capacity, and optimizing PhilHealth reimbursement mechanisms to ensure equitable, efficient, and sustainable delivery of care. Policymakers and healthcare administrators can leverage these insights to improve resource allocation, enhance financial protection, and support universal health coverage goals across both public and private sectors.

Variations in Claims and Payments Between the Government and Private Hospitals

The healthcare system in the Philippines is being shared between the public and private medical institutions where the former focus their effort on preventive and primary care while the latter focus on specialized care for cardiovascular diseases, cancer, pulmonary, and orthopedics (Philippines-Healthcare, 2024). The distribution of their medical services distributed among the government and private hospitals as reflected in the number of claims designated to the discharged patients who accessed PhilHealth package benefits. These claims are reflected in the succeeding table as to the variance on the PhilHealth's payments on the common illnesses.

Table 3 presented the total PhilHealth case rate payments for selected common illnesses across government hospitals A and B (GH A+B) and private hospitals A and B (PH A+B). The variance in payment was computed using: Variance (Payments) = Total GH Payments – Total PH Payments. To provide proportional comparison, the percentage variance was calculated as: Percentage Variance (%) = Total GH Payments – Total PH Payments/Total PH Payments x 100. Positive variance and percentage variance values indicated that GHs received higher payments that PHs, while negative values indicated higher payments for PHs. The analysis revealed significant disparities in payments across illnesses. perinatal infections had the largest percentage variance at approximately 2,845.25%, indicating that GHs received overwhelmingly higher payments than PHs for this condition. Other illnesses with high proportional differences included ischemic heart disease with myocardial infarction with 195.26% and stroke hemorrhagic having a 65.17% percentage variance, reflecting the greater concentration of high-cost or complex cases in GHs. These data pose an understanding that the government hospitals bared as the major choice of patients to treat their life threatening illnesses as it requires expertise, high-end facilities, and cost-efficient medical services. Since government hospitals receiving subsidy from the National Government, thus making sense that government hospitals are mainly cost-efficient that attracts more patients during their hospitalization to receive medical care.

Table 3. *Comparative Variances on PhilHealth's Claims and Payments to Common Illnesses made to Government and Private Hospitals*

Common Illnesses	Total Number of Claims		Total Number of Payments		Variance (Payments)	% Variance (Payments)
	GH (A+B)	PH (A+B)	GH (A+B)	PH (A+B)		
anemia	87	69	7,103,000	5,948,200	1,154,800	19.41
sepsis	69	55	15,015,700	12,500,000	2,515,700	20.13
stroke infarction	201	112	15,323,100	11,400,000	3,923,100	34.42
heart failure	140	150	13,396,000	15,800,000	-2,404,000	-15.22
stroke hemorrhagic	81	16	14,207,000	8,600,000	5,607,0003	65.17
perinatal infections	156	6	19,256,600	653,600	18,603,000	2845.25
ischemic heart disease with myocardial infarction	84	12	8,513,200	2,882,800	5,630,400	195.26
pneumonia high risk	49	34	6,727,400	3,871,200	2,856,200	73.77
hypertensive emergency urgency	126	124	5,601,000	5,948,200	-347,200	-5.83
Pneumonia moderate risk	398	350	12,800,000	12,500,000	300,000	2.40

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Conversely, heart failure and hypertensive emergency/urgency recorded negative percentage variances with -15.22% and -5.83%, respectively, indicating that PHs received more payments for these conditions but is at par with the rest of the illnesses covered by cardiovascular diseases.

Illnesses such as pneumonia moderate risk having a percentage variance of 2.40% and anemia with 19.41% had relatively low percentage variances, suggesting similar distributions of payments between the two hospital groups. This is in analogy that these specific illnesses can be accessed both in government and private hospitals any of the PhilHealth dependents for both the hospitals can give arrays of medical services that suited to their illnesses.

The variance and percentage variance analyses provided complementary insights. absolute variances highlighted the raw differences in payments, while percentage variances reflected proportional disparities, allowing a clearer understanding of which illnesses were predominantly treated and claimed in GHs versus PHs. These findings offered a detailed view of hospital utilization, claim patterns, and resource allocation, demonstrating the differential burden of high-cost and specialized illnesses across public and private healthcare facilities.

Amongst the common illnesses, it is the perinatal infections with the highest claims in the government hospitals that range to almost 19,256,600 for year 2023 claims against private hospitals with only 653,600 claims which accorded with 96.61 percent variance. This array of difference is a result of the public health care delivered through public health and primary healthcare centers linked to peripheral barangay which likewise directed their medical access to government hospitals.

The finding that government hospitals received nearly twice the total reimbursement compared to private institutions can largely be explained by structural and systemic factors rather than performance differences. Public hospitals predominantly serve patients from lower socioeconomic backgrounds who rely heavily on insurance support, making them more likely to generate claims. They also function as referral centers, managing more complex and severe cases transferred from primary and community facilities, which naturally results in higher claim values. In addition, government facilities are deeply integrated into the public health network, where primary care benefit packages under PhilHealth direct patients toward public institutions, creating a continuous flow of claims from outpatient consultations to inpatient admissions. Their generally larger bed capacity and higher occupancy rates further contribute to increased claim volumes. Financial considerations also influence patient choices, as public hospitals typically minimize out-of-pocket expenses, while institutional policies in government facilities emphasize systematic claims processing. Taken together, the disparity in reimbursements does not suggest inefficiency on the part of private hospitals; rather, it reflects broader realities such as patient demographics, referral structures, public health integration, and financial accessibility. Ultimately, the heavier claims burden borne by government hospitals highlights their pivotal role in advancing universal health coverage and caring for the majority of insured and high-need populations.

Timeliness of Claims Processing

PhilHealth has significantly improved the timeliness of its claims processing from a maximum statutory period of 60 days which the accredited Health Care Institutions (HCI) are required to filed claims within 180 calendar days from the date of discharge. To get for its variance and the corresponding percentage, the formula utilized to show the difference between the actual processing time and the 60-day statutory limit. The negative values indicate claims were processed faster than 60 days and the positive values would indicate claims exceeded the statutory period.

The table presented below included other hospitals from private hospitals to add more details on the differences among the hospital type.

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Table 4. *PhilHealth Claims Processing between Private and Government Hospitals*

Hospital Type	GH/PH	Days to Process Claims	Variance (Days)	Variance (%)
Government Hospital (GH)	GH A	40 days	-20 days	-33.33%
	GH B	38 days	-22 days	-36.6%
Private Hospital (PH)	PH A	37 days	-25 days	-38.33
	PH B	35 days	-25 days	-41.67%
	PH C	35 days	-25 days	-41.67%
	PH D	36 days	-24 days	-40%
	PH E	36 days	-24 days	-40%

In the Philippines, private hospitals received more payments for benefit claims compared to their public counterparts as evidenced by the completed PhilHealth claim processing that took to about 35 days, largely because they have more effectively integrated electronic platforms such as the e-Claims system compared to many government facilities. However, even with relatively quicker processing times, reimbursement delays remain a persistent issue. Payments are often released later than expected, creating cash flow difficulties for private hospitals, with some institutions experiencing backlogs that stretch for several months before they receive compensation for services rendered.

As gleaned from the above given table, both government and private hospitals processed claims considerably faster than the 60-day benchmark. However, private hospitals demonstrated a shorter average processing period (35.8 days) compared to government hospitals (39 days), reflecting a greater deviation from the standard at -40.33% versus -35.00%, respectively. This suggests relatively stronger procedural efficiency among private facilities in claims processing.

To sum it up, all hospitals processed claims faster than the 60-day statutory limit as indicated by negative variance days. PH B and C had the fastest processing times. The GHs were slightly slower but still below the 60-day limit. Percentage variance provides a clear way to compare how each hospital performs relative to the 60-day standard, not just the absolute number of days.

Adequacy of Coverage – comparison of PhilHealth payment against actual hospital costs

In 2025, PhilHealth is significantly increasing its benefit coverage through a 50% adjustment in case rates, aiming to reduce out-of-pocket (OOP) expenses. Despite these improvement, substantial gaps often remain between PhilHealth's fixed payments and the actual, higher costs of hospitalization in many institutions, particularly in private facilities. While PhilHealth increased rates, feedback show that discrepancies still exist, especially in Level 3 hospitals, the "All Case Rate" (ACR) was insufficient, leading to significant out-of-pocket expenses for patients. The key findings from the table above indicate that, in the case of hemodialysis, private hospitals show a modest under coverage of 10.24%, signifying that PhilHealth slightly underpays relative to actual costs. In contrast, for community-acquired pneumonia III,

Table 5. *Comparison of PhilHealth payment against actual hospital costs on Top Paid Benefit Packages among Government and Private Hospitals as of January 2026*

Specified Illness	Philhealth Payment By Hospital Type in Peso	Actual Hospital Costs By Hospital Type in Peso		Variance %	
	GH/PH	GH	PH	GH	PH
Hemodialysis Procedure	6,350 per session	6,350/ session	7,000/ session	0%	+10.24%
Community-Acquired Pneumonia III	15,000 to 32,000	15,000 to 32,000 (under no balance billing policy)	101,248 to 249,695 for 38% medicine, 27% laboratory examinations, 22% bed fees	0%	+269% to +1,565%

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Specified Illness	Philhealth Payment By Hospital Type in Peso	Actual Hospital Costs By Hospital Type in Peso		Variance %	
	GH/PH	GH	PH	GH	PH
Routine obstetric care including prenatal, delivery and newborn services of hospital facilities (maternity care package)	12,675 for normal spontaneous delivery and 2,950 for newborn care package	20,000	18,500 to 52,000	+46.9%	-7.5% to +160%
Caesarian Section. Primary	37,050	25,000 to 30,000 plus 10,000 or more for medicines	24,500 to 100,000	+7.96%	-33.9% to +170%
Expanded Newborn Care Package	5,752.50	5,752.50	5,752.50	0%	0%

the reimbursement gap is substantially larger, with PhilHealth covering only a small portion of private hospital expenses, resulting in variances ranging from +269% at the lower end to +1,565% at the upper end. This highlights the significant out-of-pocket exposure faced by patients in severe pneumonia cases. In routine obstetric care, which includes prenatal, delivery, and newborn services, government hospitals experience costs that exceed PhilHealth payments by 46.9%, while private hospital coverage shows slight over coverage at the lower end (-7.5%) and severe under coverage at the upper range (+160%). For cesarean sections, government hospitals show a modest variance (+7.96%), whereas private hospital variances range widely, from over coverage at the lower end (-33.9%) to under coverage at the higher end (+170%), indicating notable pricing inconsistencies across private facilities. Similarly, the expanded newborn care package aligns closely with actual costs, showing only a 1% variance, suggesting that this package is well-calibrated between reimbursement and service cost. Overall, these findings demonstrate that PhilHealth case rates are not uniformly aligned with actual hospital cost structures, particularly in private hospitals and or high-cost medical conditions.

An Analysis for the comparative difference in the PhilHealth hospitalization payments between Government and Private Hospitals

The integrated analysis of Tables 1-3 confirmed comparative differences in PhilHealth hospitalization claims and payments between government and private hospitals, particularly for high-cost and specialized illnesses. GHs consistently handled larger volumes of claimants for complex conditions, resulting in higher total payments and pronounced percentage variances. These disparities suggest systematic differences in claim volume and payment allocation rather than random variation. Conversely, PHs played a prominent role in certain illnesses with smaller volumes or specialized care. This pattern reflects deliberate systemic allocation: public hospitals primarily manage high-risk, high-volume patients, whereas private hospitals cater to low-risk, elective, or convenience-focused cases.

This comprehensive analysis provided insights into hospital utilization patterns, claim filing efficiency, and resource allocation, illustrating the disparity in hospitalization funding between public and private healthcare facilities in the Philippine healthcare system.

Assessment on how PhilHealth hospitalization payments influence patients financial burden and access to quality healthcare services.

PhilHealth hospitalization payments play a crucial role in reducing the financial burden for patients and improving access to healthcare services, but the impact varies significantly between government and private hospitals. For high-acuity and resource-intensive conditions such as perinatal infections, stroke, ischemic heart disease, and hemodialysis, government hospitals absorb the majority of patients, offering essential care at lower out-of-pocket costs due to subsidies and PhilHealth support. This ensures that even

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the most vulnerable populations can access life-saving treatments, though high patient volumes may sometimes strain resources and extend waiting times. In contrast, private hospitals, while providing faster and more specialized services, often face a mismatch between PhilHealth reimbursements and actual hospital costs, particularly for complex or high-cost treatments. As a result, patients seeking care in private facilities may encounter substantial out-of-pocket expenses, which can influence their healthcare choices and limit access to timely treatment. Routine and elective services, including heart failure management and hypertensive care, are more evenly distributed, reflecting the complementary roles of public and private facilities in the healthcare system. Overall, PhilHealth coverage mitigates financial hardship and improves access, especially for severe illnesses, but gaps in reimbursement highlight the need for a more responsive and flexible payment system that aligns with actual costs and patient needs.

Recommended Measures to Strengthen the Adequacy and Timeliness of PhilHealth Reimbursement across Healthcare Facility Types

To strengthen the adequacy, fairness, and timeliness of PhilHealth reimbursements across both government and private hospitals, several strategic policy directions should be considered. First, reimbursement rates should be regularly recalibrated to reflect actual hospital costs, including inflation, technological advancements, and evolving clinical practices, ensuring that case rates cover the full cost of essential treatments and reduce out-of-pocket burdens for patients. Second, a tiered or risk-adjusted payment system could be introduced, accounting for differences in hospital type, patient acuity, and service complexity, thereby promoting fairness in compensation between high-volume government facilities and specialized private hospitals. Third, enhancing transparency and standardization in hospital cost reporting would allow more accurate benchmarking and equitable allocation of funds. Fourth, the integration of digital claim submission platforms across all facility types can expedite processing, minimize delays, and improve accountability. Finally, prioritizing high-burden, high-cost conditions—such as chronic care, maternal services, and critical illnesses—through targeted supplemental reimbursements or incentive schemes can ensure timely access to quality care while maintaining financial sustainability. Collectively, these strategies would create a more responsive reimbursement system that balances efficiency, equity, and patient-centered access to healthcare across the Philippine health system.

CONCLUSION AND RECOMMENDATION

The findings of this study demonstrated that PhilHealth hospitalization payments play a critical role in shaping patient access to healthcare and mitigating financial burdens, yet notable disparities persist between government and private hospitals. Government hospitals consistently receive higher reimbursements for high-acuity and resource-intensive conditions, such as perinatal infections, ischemic heart disease, and stroke hemorrhagic, reflecting their central role in delivering life-saving, cost-efficient care to vulnerable populations. Private hospitals, conversely, tend to receive higher payments for routine or non-intensive conditions like heart failure and hypertensive emergencies, often coinciding with faster service and perceived convenience, yet patients in these facilities frequently face substantial out-of-pocket expenses due to misalignment between PhilHealth case rates and actual hospital costs. Across both sectors, the All Case Rate payment system simplifies reimbursement but does not fully account for the complexity of certain cases, regional disparities, or the operational realities of different hospital types. While claim processing times are generally within acceptable limits, private hospitals demonstrate slightly faster reimbursements, highlighting potential gains from improved digital integration in government facilities. Overall, the data reveal a complementary healthcare landscape: government hospitals absorb the bulk of complex, high-cost cases, while private hospitals address elective and routine care, emphasizing the need for a more nuanced and responsive payment system that ensures equitable access and financial protection for all PhilHealth members.

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To address these challenges, measures should focus on strengthening the adequacy, fairness, and timeliness of PhilHealth reimbursements. Reimbursement rates should be regularly recalibrated to reflect real hospital costs, technological advances, and evolving clinical practices, reducing the financial burden on patients. A tiered or risk-adjusted payment system could promote equity by accounting for patient acuity, hospital capacity, and service complexity, ensuring high-volume government facilities and specialized private hospitals receive fair compensation. Greater transparency and standardization in cost reporting would improve benchmarking and resource allocation, while full integration of digital claim submission platforms could expedite processing and minimize delays. Finally, targeted supplemental reimbursements or incentives for high-burden and high-cost conditions, including maternal, chronic, and critical illnesses, would enhance timely access to quality care and strengthen financial sustainability. Collectively, these recommendations aim to foster a more efficient, equitable, and patient-centered PhilHealth reimbursement system, reinforcing the Corporation's mandate to provide universal health coverage and improve healthcare outcomes across both public and private sectors.

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