Is Universal Health Care Possible?

The Coverage of the Informal Workers in the National Health Insurance Program in the Philippines

A Research Paper presented by:

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Philippines

in partial fulfillment of the requirements for obtaining the degree of

MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Social Policy for Development

SPD

Specialization:

Poverty Studies

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The Hague, The Netherlands

December 2015

Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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Acknowledgements

This study would not have been possible without the help, guidance and valuable assistance of the following:

To my ***parents, sibling and relatives***, for supporting all my decisions and for always believing in me;

To my dear ***friends in the Philippines***, for giving me all the encouragements to finish this paper;

To ***Sam***, thank you for loving me and pushing me forward to fulfil my dreams;

To my supervisor, ***Dr. Karin Astrid Siegmann***, for sharing her expertise and for her untiring support in this study; and

To my Second Reader, ***Dr. Mahmood Meskoub***, for his suggestions to further improve this paper;

To all my ***teachers in the ISS***, who imparted their knowledge and experiences;

To my ***classmates***, for the laughter, memories and unforgettable moments in the ISS.

To ***NEDA*** and ***Nuffic***, for the opportunity you've given to me to fulfil my Master's degree;

Special thanks to the ***people who helped me in doing my field work***, and to all my ***respondents*** who participated in my research;

To all those friends and colleagues I fail to mention here, dankjewel!

Lastly, to the **LORD JESUS CHRIST**, for teaching me to trust in Him and for giving me wisdom, strength and courage every day.

Maraming Salamat po!

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List of Acronyms

APIS	Annual Poverty Indicator Survey
CCT	Conditional Cash Transfer
CHD	Centers for Health Development
CSWD	City Social Welfare and Development
DOH	Department of Health
DOLE	Department of Labor and Employment
FGD	Focus Group Discussion
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
ILO	International Labour Organizations
KASAPI	Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance
KP	Kalusugan Pangkalahatan
LGU	Local Government Unit
MFI	Microfinance Institution
NBB	No Balance Billing
NGO	Non-Government Organizations
NSCB	National Statistical and Coordination Board
PHIC	Philippine Health Insurance Corporation (PhilHealth)
PSA	Philippine Statistics Authority
RA	Republic Act
SSS	Social Security System
UHC	Universal Health Care
UN	United Nations
UNRISD	United Nations Research Institute for Social Development

Abstract

The Philippine government tried to cover the informal workers in the National Health Insurance Program of PhilHealth, which aims to provide financial and health risks protections to all towards achieving the goal of Universal Health Care. However, despite of the promising legislation and progressive health reforms, it is still a big challenge for the government to cover the informal workers in the program. The study investigates the extent of the coverage of the NHIP among the workers in the informal economy and the factors that can adversely affect the demand of the informal workers to participate in program, which could impede the achievement of the UHC. Mixed methods and various sources of data were used in the study.

The study found out that PhilHealth coverage (both estimates and actual coverage) among the informal workers is still low and far-off from the universal target. Following are some of the significant reasons identified that can adversely affect the demand and the effective coverage of the program among the informal workers: a) lack of awareness about the program; b) limited and different benefit packages offered across membership categories; c) negative perceptions of the informal workers on the targeting mechanism used by the government in selecting the households to be fully or partially subsidized in the program, and others. To improve the coverage of the NHIP, some of the recommendations of the study are: improve the targeting mechanism used for selecting the sponsored and indigent beneficiaries; focus more on the coverage of the non-indigent or non-sponsored members; strengthen the policies of the government that aim to provide the overall security (work, employment and other securities) for the informal workers; intensify information dissemination about the program and ensure the involvement of the informal workers' associations, organizations and even the female member of the household (i.e wives) in the awareness campaigns; expand the benefit packages of the program; and treat informal workers as heterogeneous group with varying level of needs to come up with appropriate strategies to reach and cover them in the program. In this regard, universal health care coverage and protection for all Filipinos against healthcare financial risks, particularly among the informal workers, could be more possible and attainable.

Relevance to Development Studies

This paper contributes to the growing literatures on universal health care coverage, however, focusing on the universal coverage of the informal workers in the social health insurance program. The paper appreciates the significance of the informal workers in the economy and the importance of integrating them to any social policy like the insurance program, which can improve, protect and develop their well-being, particularly in the areas of health care.

Keywords

Informal Economy, Universal Health Care, Social Health Insurance, Coverage, Access, Indigent

1. Covering the Informal Economy: A Challenge to Universal Health Care

1.1 Background, Relevance and Justification of the Study

Nowadays, workers in the informal economy comprised a huge portion of the labor market worldwide. Based on the International Labour Organization (ILO) statistics (2012), the Philippines' share of persons employed in the informal employment and in the informal sector are 70.1% and 72.5%[1], respectively. In general, informal workers are more exposed to different insecurities and vulnerabilities due to their living and working conditions. They have higher chance to be sick and ill, since most of their works are exposed to diseases and different health risks (Lund 2012: 15). For instance, in the Philippines, it is reported that more than fifty percent (50%) of the injuries are being experienced mostly by the self-employed workers (Rockefeller Foundation 2013: 7), the workers which comprised the huge part of the labor market (DOLE 2011: 7-8). The Rockefeller Foundation report on Health Vulnerabilities of the Informal Workers (2013) provides the health-related issues and the magnitude of health risks being experience by different type of informal workers. The report shows that, in general, agricultural, construction, domestic, manufacturing and transportation workers have the higher exposure to occupational health risks and hazards (i.e risk of death, serious injury or disease). On the other hand, the home-based workers, street vendors, and waste pickers have risk of acute illness and chronic non-fatal conditions (Rockefeller Foundation 2013: 8). In addition, due to unstable and relatively low income, most of the informal workers including their families have inadequate nutrition and do not have the capacity to visit and consult doctors or medical practitioners during sickness (Lund 2012: 15). Thus, it is important for the informal workers to have an access to health services and protect themselves from sickness and health risks.

The international organizations and institutions, such as the United Nations (UN) and the ILO, are now recognizing the importance and contributions of the informal work-

[1] The figures refer to non-agricultural activities/employment and the latest year of data available for the Philippines is 2008.

ers in the economy and their needs and rights to be protected from different vulnerabilities through social security and protection programs (ILO and WHO 2009; Caracciolo 2014). In addition, the ILO broaden the scope of informality by shifting the concept from the informal sector to informal economy. This means that when dealing informal economy, one should consider not only the informal employment in the enterprises but also recognizes the employment relationship and the nature and conditions of works in both formal and informal sectors (ILO 2003; Chen 2005: 1).

In line with the international agenda of social protection floor and decent and productive employment, the Philippines in its Labor and Employment Plan 2011-2016 also provide an enhanced social protection program for the informal workers that aims to increase the coverage, expand the benefits and improve the access of the informal workers to different social protection mechanisms that will protect them against risks such as the social health insurance (DOLE 2011: 20).

The key strategy of the national government on improving the health status of all Filipino is the Universal Health Care (UHC) or the "*Kalusugan Pangkalahatan*" (KP). Under the strategy of UHC, the National Health Insurance Program (NHIP) of the Philippine Health Insurance Corporation (PhilHealth) has been implemented to provide social health insurance to all Filipinos and to provide quality health care services. Workers in the informal economy were integrated in the program since 1995 (DOH 2010; National Health Insurance Act 2013). However, government identified bottlenecks and gaps in covering the workers in the informal economy in the program. Given the nature and the working condition of most of the informal workers such as irregularity of work and unstable income or earnings, they tend not to register at all in the program or if they were already registered, they could not sustain their membership in the program (Jowett and Hsiao 2007: 95). In response, reforms have been made to improve the coverage of the said sector of the economy (National Health Insurance Act 2013).

For instance, PhilHealth introduced new strategies to expand the coverage of the program among the informal sector workers, which includes the iGroup Program (formerly known as the "*Kalusugan Sigurado at Abotkaya sa PhilHealth Insurance (KASAPI)*" or the "Health is Secured and Affordable with PhiHealth Insurance". In iGroup Program,

PhilHealth partnered with different organized groups (i.e cooperatives, rural banks, microfinance institutions and non-government organizations) that provide flexibility in the payment scheme of the insurance premiums and promote group enrollment amongst the workers in the informal economy who pays their own insurance premium. In return, PhilHealth provides incentives to their partnered organizations who maintain or exceed the agreed minimum number of enrollees in the program. Incentives include lowering the monthly premium contribution of the members of the organized group (Manasan 2011: 16; PhilHealth 2012). However, despite of the promising legislation and progressive health reforms, it is still a big challenge for the government to cover the informal workers in the program.

Hence, this paper investigates and focuses on the extent of the NHIP in covering the workers in the informal economy towards achieving universal health care and to uncover the reasons behind the lack of effective coverage on the said sector of the economy.

Relevance and Justification of the Research

Most of the social policies and programs such as in health and education sectors are universalistic in principle (Mkandawire and UNRISD 2005: 2). However, "universal" in this sense usually refers to "universal coverage", in which Fischer (2012: 11) argued as a necessary but not a sufficient condition of a universal social policy. Noting that universalistic principle of a social policy should not only focus on covering the whole population but should also look into the universal access (Fischer 2012: 12; Aday and Andersen 1974: 208), which is defined as equity and equality on the access to the services provided, and these services should be available and delivered of same quality across different groups (Fischer 2012: 12). Thus, it is necessary to take into account whether all Filipinos are covered and can access the quality health care services being provided by both public and private providers, for it to be considered as universal. Hence, for this paper, both the ***coverage*** and the ***effective access*** are considered.

In the study of Manasan (2011) on Expanding Social Health Insurance Coverage, it is suggested that reforms in the health programs are necessary to expand the coverage of the program for the entire population in the Philippines. On the other hand, in this

paper, the focus is mainly on the workers in the informal economy, who are considered as one of the most vulnerable and unsecured sectors of the economy. The study used and analysed recent data such as the 2014 Annual Poverty Indicator Survey (APIS) and the latest data extracted from PhilHealth, which are relevant to use since the health reforms has been implemented in 2013. This paper pinpoints key issues on program's designs and implementation and other factors affecting the effective coverage of the informal workers in the program. The paper also considers the household characteristics of the informal workers to determine whom amongt them are covered by the program, and those who are not covered that need to be prioritized and targeted by the government to achieve UHC. This particular information is not included in the study of Manasan (2011). The study was conducted to provide recommendations for consideration of the program designers and implementers on how to further improve the NHIP in terms of covering the said essential sector of the economy.

1.2 Objectives, Research Question and Sub-questions

The objective of this paper is to investigate and evaluate the effectiveness of the NHIP under the new health reforms in covering and providing effective access of the health care services among the workers in the informal economy, towards achieving universal health care. The research aims to uncover the possible reasons for the lack of effective coverage of the informal workers despite of the progressive health legislation and reforms being implemented. With this, recommendations were formulated to further improve the program towards achieving universal health care access and coverage.

In this regard, following main research question and sub-questions are formulated:

Research Question:
To what extent does the National Health Insurance Program cover the workers in the informal economy in the Philippines?

Sub-Questions:

a) Whom among the workers in the informal economy are covered by the Program?
b) What could be the reasons behind the lack of effective coverage of the NHIP among the workers in the informal economy?

1.3 Scope and Limitations of the Study

In order to capture the extent of the coverage of the program for the workers in the informal economy and to have clearer understanding on why the NHIP is effectively or ineffectively covering the workers in the informal economy, secondary data such as the 2014 Annual Poverty Indicator Survey (APIS) data and data from PhilHealth; and the primary data from the qualitative interviews were used in the study.

The 2014 APIS is a household survey data that provides sufficient national estimates (PSA n.d.). On the other hand, data from PhilHealth provides the actual coverage of the population in the program. Results from these data sources can be generalizable, particularly at the national level. However, there are limitations in using these dataset. For instance, some of the variables of interest are not available in the 2014 APIS data. Hence, only relevant variables that have indications of coverage to PhilHealth and informality are included in the analysis.

Due to the limitations of the quantitative method of collecting data, the focus group discussions (FGDs) with the informal workers and interviews with the concerned persons who are involved in the implementation of the program were employed in order to complement the results of the quantitative analysis. This will be further discussed in the methodology part. Note that the results of the FGDs are non-generalizable and could only be limited to the views and insights of the particular groups of informal workers who were considered and participated in the group discussions.

1.4 Structure of the Research Paper

This paper is consists of seven chapters. The first chapter presents the research problem and the relevance of conducting the study. The next chapter, Chapter 2, discusses about the NHIP of PhilHealth including the benefit packages and the insurance financing and health system. Chapter 3 discusses the conceptual and analytical framework used in the study to answer the research questions. In addition, Chapter 3 also includes related literatures that provide empirical as well as theoretical evidences on the supply and demand factors that can affect the coverage of the public in a social health insurance program.

Chapter 4 describes the methodology used in the research. Justification on the use of mixed methods and various data sources, such as quantitative national household survey, FGDs with the informal workers and key informant interviews, are also included in this chapter. On the one hand, Chapter 5 discusses the demographic features of informality in the country to support the causal dynamics of using the different sources of data in this study. Chapter 6 discusses the extent of coverage of the program among the informal workers and the answers to the research sub-questions posited above. Lastly, Chapter 7 provides the conclusion and the recommendations on how to further improve the program in order to cover the informal workers towards achieving universal health care. Moreover, recommendation for future research is also including in this chapter.

2. The Philippines National Health Insurance Program (NHIP)

The Universal Health Care (UHC) or the "*Kalusugan Pangkalahatan*" (KP) of the Philippines has three strategies to achieve the goal of UHC. These are the: a) scaling-up preventive and promotive public health programs; b) improving quality healthcare facilities and services; and lastly, c) providing financial risk protection by increasing the coverage and benefits of the national health insurance (DOH 2010). With respect to the latter strategy, the government implemented the NHIP under the Republic Act (RA) No. 7875 – "National Health Insurance Act of 1995" that aims to provide social health insurance to the Filipinos (National Health Insurance Act 1995). The program is spearheaded by the Department of Health (DOH) and the Philippine Health Insurance Corporations (PhilHealth), a government-owned corporation (PhilHealth, n.d.).

However, health reforms have been made throughout the years to address the gaps and challenges faced by the program such as difficulty to cover those who are self-employed; lack of quality health facilities, medicines and equipment; inequitable distribution of health workers; inefficient insurance payment mechanism and the like. Reforms for the improvement of the program were stipulated in the amended RA No. 7875 which is now known as RA No. 10606 - "National Health Insurance Act of 2013" (National Health Insurance Act 2013).

In the new law, NHIP categorizes its members to the following: Formal Economy, Lifetime Members, Senior Citizens, Indigent, Sponsored Members and the Informal Economy. These categories are based on the source and amount of the insurance premium contribution and the types of benefits that a particular member is entitled with. Members of the NHIP in the *formal economy* are those with formal job contract and agreement in which the premium contributions of the workers are cost-shared by both the employee and the employer. *Lifetime members* are members who have reached the retirement age of 65 with a minimum of 120 months premium contributions. On the one hand, those under the *Senior Citizens* category are the elderlies (60 years old and above) who do not belong to other membership categories of the program (National Health Insurance Act 2013).

The *Indigent members* are those identified by the national government (Department of Social Welfare and Development) as the poorest of the poor through proxy means test. Indigent households are included in the government's National Household Targeting System for Poverty Reduction (NHTS-PR) list. This list is being used by the government in targeting the households to be prioritized and included in their anti-poverty programs such as the NHIP and other programs including the Conditional Cash Transfer (CCT). This means that all families under the CCT Program are automatically became member of the NHIP through the Indigent Program (National Health Insurance Act 2013; Fernandez 2012). On the one hand, *Sponsored members* are members whose premium contributions are subsidized by their respective local government unit (LGU) based on their own criteria for selection. The LGUs allot Php 2,400 for each of their sponsored household per year (National Health Insurance Act 2013).

Another membership category are those in the *Informal economy.* It includes sector such as migrant workers, self-earning individuals (i.e. professional practitioners), Filipinos with dual citizenship, naturalized Filipino citizens and citizens of other countries working/residing in the Philippines, and the informal sector. Informal sector in the informal economy includes but not limited to street hawkers, market vendors, pedicab and tricycle drivers, small construction workers and home-based industries and services (self-employed). They are the one who are paying for their own premium contributions. The amount of contribution is at least Php 2,400.00 per year, which can be paid in a quarterly, semi-annual or annual basis (National Health Insurance Act 2013). However, it is noteworthy to point out that those under the indigent and sponsored membership categories are more likely to be informal workers who could be considered as the "working poor"[2].

Benefit Packages of the Program

The beneficiaries, both the principal member and their dependents, can enjoy and avail the full health benefits and entitlements of the program if their premium contributions are paid for at least 3 months. The following criteria of a qualified dependents of the principal member of the family set by PhilHealth are: a) spouse (husband/wife) who

[2] Interview with Ms. Remedios Gabuya of PhilHealth (21 July 2015)

is not an active PhilHealth member; b) son/daughter who is below 21 years old, unmarried and unemployed; and c) family member with permanent disability and totally dependent to the principal member (National Health Insurance Act 2013).

Based on RA 10606, all members of the program including their dependents can avail the benefits which include: in-patient care, medical and surgical care, emergency and transfer services, and health education packages. PhilHealth also offers Z package and the expanded Z package that cover catastrophic diseases; Case Rate Packages including medical cases and surgical procedures (*See Appendix A for the list of benefits under these packages*); and the No Balance Billing (NBB) policy wherein "*no other fees and expenses shall be charged and be paid for by the indigent patients above and beyond the package rates*" (National Health Insurance Act 2013). For the meantime, the NBB policy is applicable only for the members under the indigent and sponsored categories who can avail the free health care services in almost all government or public health facilities but to limited and selected private facilities (National Health Insurance Act 2013). The policy is also extended to the domestic workers due to "Kasambahay Law" of the Domestic Workers Act that provide social protection for the domestic workers in the Philippines (PhilHealth 2014).

PhilHealth Accredited Service Providers

Service providers including public and private hospitals, health facilities, and health care professionals, should be accredited by PhilHealth or licensed by the DOH to ensure quality assurance in delivering of health care services to the public. For the public sector, DOH is managing the tertiary hospitals and health professionals at the national and regional level. On the one hand, managing and financing of the provincial, district hospitals, rural health units and barangay health stations are under the LGUs. In the case of private service providers, private hospitals, clinics, and private health professionals provide quality services but with a higher fees compared to public health facilities (Romualdez Jr. et al. 2011: 61). Thus, these services are usually for those who can access and afford their service fees.

PhilHealth Financing System

In terms of financing the program, PhilHealth depends on the following sources of funds to sustain the program operation. It includes: a) premium contributions of the other members of PhilHealth, who are not subsidized by the program (pooled fund); b) out-of-the-pocket expenditures of the household for the health care providers; c) budget allocated by the government; and d) taxation (for budget appropriation), which includes the resources coming from sin taxes (additional tax imposed on buying alcohol and tobacco goods) (Romualdez Jr. et al. 2011: 48; NEDA 2014).

Philippine Health System and the Role of the Local Government Units (LGUs)

In the Philippines, the health system is devolved in which the DOH serves as the national health governing agency that is mandated to develop policies, national plans and guidelines on health. On the one hand, LGUs have an autonomy and is responsible for providing health services in their respective areas including financial management of health interventions in their respective unit. However, LGUs have to make sure that the services they provided and being implemented are in line with the national health policies and guidelines. DOH put up Centers for Health Development (CHDs) to some of the LGUs that will guide the local officials in terms of delivering of health services (Romualdez Jr. et al. 2011: 19).

Other Related Social Security Program

There are other social security programs provided by the government to the workers in the informal economy apart from the NHIP. One example is the Social Security Program of the Social Security System (SSS). The SSS is a government-owned corporation that provide social insurance program for non-government employees, self-employed and voluntary members. The SSS provides the following benefits such as: a) sickness benefit allowance; b) maternity benefit allowance; c) disability pension; d) retirement pension; e) death pension and burial expenses (SSS, n.d.). With this, the SSS program offers more

extensive benefits as compared to the benefits provided by the NHIP which is only limited to health and hospitalization benefits to their qualified member beneficiaries.

3. The Dynamics of Informality and its Effects to UHC: Conceptual and Analytical Framework

3.1 Universal Health Care: *Coverage* and the *Effective Access*

In examining and evaluating the effectiveness of the program in achieving the goal of UHC, the Kutzin's (2000: 2-3) goal-oriented framework, which focuses on the *depth* and *breadth* of coverage, was used. The former is defined by Kutzin as an "extent to which services are available to people without exposure to out-of-the-pocket expenditure", while the latter refers to "the proportion of population that has effective access and financial risk protection". With this, it is necessary to take into account whether all Filipinos, particularly the informal workers, are covered and have equal access to quality health care services being provided by the program, thus, giving them protections from health and financial risks. The framework seems to be related to Fischer's principle of "coverage and access" (2012: 11) which also considers both the breadth and the depth of the coverage of the particular universal social policy or program.

For the purpose of this paper, *coverage* is used to refer to those who are registered in the program and who are eligible to avail the benefits since they are able to sustain paying their premium for at least three (3) months of qualifying contributions. On one hand, those *with effective access* are the covered member beneficiaries who are able to use the insurance and had access to quality health facilities and services during health needs.

3.2 Understanding the Dynamics of the Informal Economy

The Chen's segmentation pyramid (Chen et al. 2004: 40; Chen 2008: 21) is used in the study to investigate the characteristics of informality, such as income and gender, across different segmentations of the informal economy in the Philippines using the data collected from 2014 APIS and the data from the FGDs. Moreover, the pyramid was used to know how these dynamics of informal economy can affect the demand for the social health insurance among the informal workers from the different segments of the pyramid.

The pyramid shows that the segments of the informal economy who are on the top of the pyramid such as the informal employers and employee are predominantly men with relatively higher income. While those on the base of the pyramid are mostly women who work at home or as industrial and casual wage workers with low earnings.

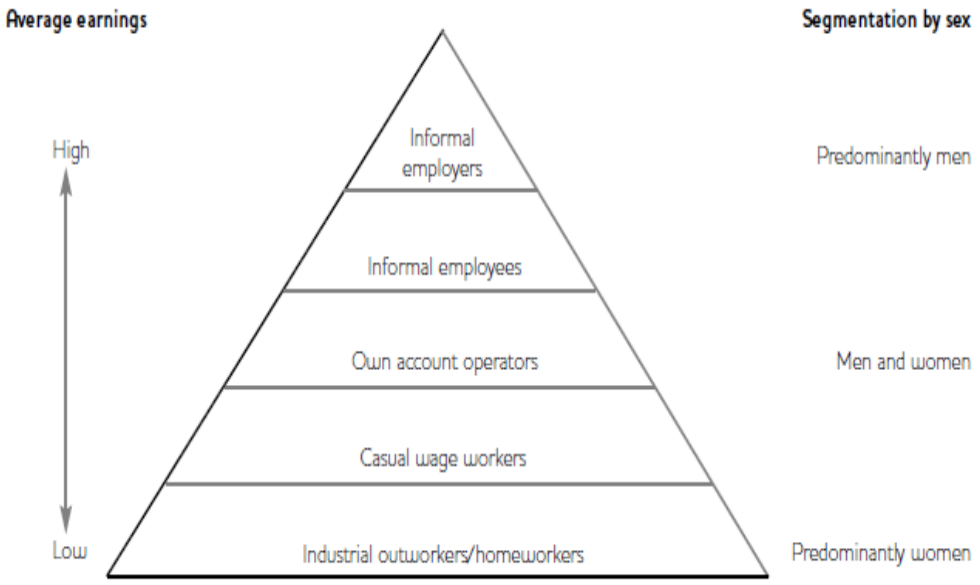


Figure 1. Chen's Segmentation of Informal Employment by Average Earning and Sex (Chen 2008: 21)

3.3 Demand and Supply-Side Factors Affecting the Coverage of the Social Health Insurance

Empirical studies from different countries show the various factors affecting the demand for the health insurance. The figure below was used as a framework to identify the significant demand and the supply side determinants that can affect the coverage of the program among the workers in the informal economy.

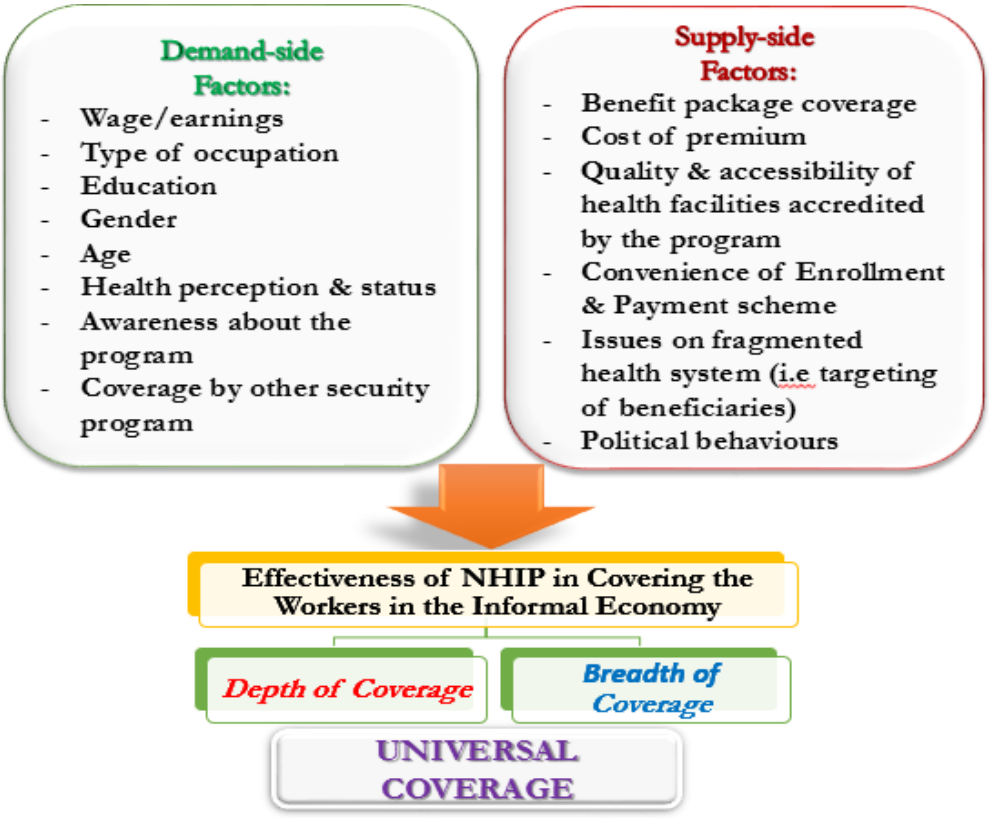


Figure 2. Factors Affecting the Effective Coverage of the NHIP among the Workers in the Informal Economy (Source: Author)

Demand-Side Factors

Demographic and socioeconomic characteristics of the household such as income or earnings, level of education, type of occupation, age and gender of the household head are important to consider in the study to determine the extent of the coverage of the program; to identify whom among the informal workers are covered; and to know the likelihood of the household to be a member in an insurance program given its demographic as well as socio-economic characteristics. It should be noted that the enrollment of the principal member (usually the household head) of the household also means enrollment for his or her qualified dependents, which is part of the benefit packages of the program (National Health Insurance Act 2013).

It is assumed that household with relatively higher income has higher probability to be covered by the insurance program since they can afford to pay the premium contributions compared to those with low income or earnings (Dadoza 2011: 29; Gumber and

Kulkarni 2000: 3608; Hottordze 2008: 56). This assumption is supported by Grossman's "wage effect" (1972: 241) that the higher the wage of the person, the higher the person will demand and invest on health. On the one hand, the type of occupation is also an essential determinant of the insurance coverage since it could be the main source of income of the household which can directly affect the decision of the household or an individual to join the program (Gumber and Kulkarni 2000: 3608; Hottordze 2008: 40), thus, increasing the program's coverage.

Educational attainment is also an important determinant of being covered by the insurance program. It is assumed that individual with higher level of education has higher chance to avail the insurance program since they can comprehend more the importance of having health insurance (Dadoza 2011: 26-27). Another factor is the age, with an assumption that the older the individual the more likely he or she is covered by an insurance program (Dadoza 2011: 26-27; Hottordze 2008: 39).

Gender of the household head is also an important dimension in determining the likelihood of the household to be insured by the program. Women play essential role in the household especially with regard to prioritizing the welfare and survival of the household. For instance, working women usually spend their earnings and income for the whole family rather than for personal consumption or expenditures compared to men (Wit 1996: 38). Since women or wives are usually the one who perceived to provide "care" for the family, it can be assumed that female-headed households have higher probability to enroll in the program, aiming to protect the family from health risks (Hottordze 2008: 39).

The study of Mathauer et al. (2008: 58) in Kenya provides evidence that most people in the informal sector wanted to be insured in the health insurance program, however, due to high premium contributions, it hinders them to participate in the program. Hence, the insurance premium is perceived as an additional burden for the informal workers, instead of providing them protection and health security (Gumber and Kulkarni 2000: 3611).

Factors such as lack of awareness on the benefits of the program and on the enrollment procedures have negative impact on the coverage of the population in the program. It is assumed that coverage of the target group can be improved if the group is knowledgeable and has full understanding about the benefits being provided by the program (Mathauer et al. 2008: 63; Hottordze 2008: 64).

Perception about health and the household health status should also be considered since it can be a common reason for enrolling or not in the program (Jehu-Appiah et al. 2012: 226). For instance, it can be assumed that if the household members perceived themselves as healthy, then there is a higher probability of non-enrollment of the household in the insurance program.

Mathauer et al. (2008: 56) found out that in Kenya, the presence of any other insurance scheme (i.e. community-based insurance) and other informal institutions and mechanisms that can also provide protection against health risk might reduce the demand for the national health insurance. For instance, most of the non-insured informal households tend to depend on their immediate family and relatives in times of emergency (Wood and Gough 2006: 1699) like financing their hospitalization. Another coping strategy of the poor people is to seek for financial assistance to the politicians and other organizations such as charities, religious groups and non-government organizations (Wood and Gough 2006: 1698). Most of the time, the poor find these existing informal institutions and arrangement more reliable and more accessible (Wood 2003: 457) especially during emergency health needs. Thus, poor opt to rely on these for their survival, short-term security which usually lead to clientelist relationship between the supporting group or individual and the poor (Wood 2003: 460; Wood and Gough 2006: 1704).

With this, it compromises their own long-term security (Wood 2003: 457) by being risk averse for not enrolling in the health insurance program and investing for their own health security. It is one of the significant characteristics of the "informal security regime" (Wood and Gough 2006: 1703-1704), in which the people "*rely heavily upon community and family relationships to meet their security needs*", if the government fails to provide the protection and welfare that supposedly reduce insecurity experienced by the people (Wood and Gough 2006: 1699).

Supply Side Factors

The supply-side pertains to different actors and institutions such as the policy makers and implementers who are involved in the program design and implementation, including the government, who is considered as the primary provider of public goods and services at the national and at the local level.

Since the health system in the Philippines is fragmented, issues on the decentralization of health services is included in the framework that can affect the coverage of the program among the informal workers. In Capuno (2009: 2), the rationale of decentralization or the devolution in the country is that it can lead to a more efficient and equitable delivery of services to the public, since the LGUs have the direct contact with the locals and LGUs also know more about the needs of people in the particular area. However, a study shows key issues and challenges with regard to devolution of social services from national to the LGUs. These are as follows: a) difficulty to organize and synchronize public health; b) discretionary health spending by the LGUs; and c) politicization of the system at the local level (Kelekar and Llanto 2013). This might be related to the political theory discussed in Preker et al. (2000: 782) with the presumption that the behaviors of political actors (i.e politicians and officials) are based on their self-interest in which they usually used their power and positions in taking advantage of the situations particularly in implementing the program and delivering of services to the public.

Factors such as convenience in the enrollment, benefits of the insurance scheme and accessibility and quality of healthcare facilities and services being provided by an insurance program can also affect the demand for the health insurance (Thornton et al. 2010: 201; Jehu-Appiah et al. 2012: 229). For instance, in Nicaragua, the government used microfinance institutions (MFIs) to provide informal workers flexibility to pay for their premium contributions. However, the enrollment and retention rate of the informal workers in the voluntary health insurance program is still low (Thornton et al. 2010: 202). Hence, it showed that MFIs and its payment schemes might not be an effective "agent" in expanding the coverage of the informal workers in the insurance program. In addition, convenience in the enrollment process is also an important factor to consider such as

location or distance of the registration office and the waiting time to process the enrollment in the program. In Nicaragua, most of the informal workers prefer not to enroll in an insurance program since for them enrollment in the program is effort, money and time consuming (Thornton et al. 2010: 193-194). In Ghana, studies show that there is a positive relationship between the convenience experienced during the enrollment process and the decision of the household to enroll and sustain their membership in the insurance program (Jehu-Appiah et al. 2012: 226-227; Hottordze 2008: 49).

In terms of the benefit package offered by the program, it can be assumed that insurance program might effectively encourage informal workers to enroll if the benefit package being provided can help them improve their health and protect them from health as well as financial risks. For instance, in the case of Ghana, the out-of-the-pocket health expenditures cannot be removed fully through insurance since the insured still have to pay for other health expenses that are not covered by the benefit packages offered by the insurance program (Nguyen et al. 2011: 6). On the one hand, Gumber and Kulkarni (2000: 3607) point out that households belong in the informal economy would have higher out-of-the-pocket health expenditures, however, only few of them are covered by the insurance scheme and some have tendency to voluntary pay for the insurance premium just to be benefited and included in the insurance program in Gujarat. Moreover, the study also provides evidence that most of the informal workers preferred to have an additional benefits included in the existing insurance program such as the inclusion of life insurance coverage, accident and permanent disability compensations in the benefit package (Gumber and Kulkarni 2000: 3611).

With regard to the accessibility and quality of healthcare facilities and services accredited by the insurance program, the proximity of the accredited hospitals or any health facilities, the availability of health services including medicines and other drugs, and the presence of health professionals in the said facilities are also factors that can affect the decision of a person to enroll or not in an insurance program. (Mathauer et al. 2008: 55; Dadoza 2011: 34). Moreover, these factors are important to evaluate to determine whether the program can provide access to quality healthcare facilities and services for all, to consider it as universal (Fischer 2012: 12).

4. Research Methodology

4.1 Research Technique

For this paper, mixed methods of research were used for data collection. Secondary data on national household survey, FGDs as well as key informant interviews were conducted to uncover the research questions posited above. The rationale of using mixed methods and combining the different sources of data is mainly for complementarity and expansion purposes (Greene et al. 1989: 259). It can enrich the analysis through triangulation of the results generated within and between methods and from multiple data sources, thus, yielding to more reliable and valid results of the research (Jick 1979: 603).

4.1.1 Secondary Quantitative Data

Annual Poverty Indicator Survey (APIS)

For the quantitative method, the 2014 Philippines Annual Poverty Indicator Survey (APIS) was used in the analysis. APIS is a national household nationwide survey that provides data on the socioeconomic profile of Filipino households, including the different variables that indicate the living and working conditions associated to poverty (PSA, n.d.). It was opted to use since it is the latest national survey data available that can capture both the indicators of the informality and the variables on PhilHealth membership. It provides national estimates on the extent and scope of the coverage of the population in the PhilHealth program particularly the workers in the informal economy after the health reforms have been implemented.

However, one of the weaknesses of the quantitative method including the survey is that the data generated from this method might underestimate (Carvalho and White 1997: 11) the totality of the informal workers in the country, since some of the criteria of informal economy listed in the ILO definition were omitted in the statistical definition used in the national surveys (i.e APIS and the Labor Force Survey) of the country. Seven

(7) cases were excluded from the standard definition of informal economy by the ILO. These are the following: a) single proprietorship, partnerships and corporations (including corporate farms, commercial livestock raising, commercial fishing and similar units); b) quasi-corporations; c) units with ten (10) or more employees (unless they satisfy all the criteria); d) domestic helpers hired by households; e) units engaged in professional services (unless they satisfy all the criteria); f) farms managed by cooperatives; and g) farms, regardless of size, keeping sets of accounts separate from the households (NSCB 2002 in Pastrana 2009: 3).

In this survey data, informality was approximated using the variable "type of occupation", with the following categories that are used by the PSA as proxies for the informal economy: a) self-employed without any employee; b) employer in own family operated farm or business; c) worked with pay in own family operated farm or business; and d) worked without pay in own family operated farm or business (PSA 2013).

On the analysis of this data, the descriptive statistics provides the distribution of the respondents by different demographic and socio-economic variables which are indicated in the analytical framework. Logistic regression was also done to predict the likelihood of the informal workers to be a member or non-member of the program based on the household characteristics. Below is the model used in the study:

$$Y = \alpha + \beta i\, Xi + \varepsilon$$

where: Y - 0: NHIP non-member;
1: NHIP member

Xi - Gender (0 – Male; 1 - Female);
Age (1: 15-30 years old; 2: 31-50 years old; 3: 51 and above);
Level of education (1 – no education; 2 – primary; 3 – secondary; 4 - tertiary);
Income/wage (by quintile, 1- lowest to 5 – highest quintile);
Types of occupation (categories were mentioned above);

Proxy Indicators for some of the supply-side factors (indicated in the framework):
Membership in other private insurance scheme (0- Without; 1 - With)
Availment of Loan (0 – No; 1 - Yes)

ε - error term

PhilHealth Data

Other secondary data used in this study came from PhilHealth that provides the 2014 actual coverage of the NHIP by membership category. The actual number of population of the country covered by program was captured from the extracted data from PhilHealth. However, PhilHealth could not be able to provide the number or percentage of the covered informal workers in the program over the total number of informal workers in the country due to lack of the actual figure of the latter. It should be noted that comparing the statistics from PhilHealth and the APIS 2014 data is limited and could generate different results since the former provides the actual and used individual as the unit of analysis while the latter generates the estimates at the household level. However, these two secondary data sources could still indicate and validate the extent of the coverage on achieving UHC particularly in covering the informal workers in the NHIP.

The results from the quantitative secondary data were further validated and analysed using other data sources including the data from the FGDs with the informal workers and one-on-one interviews with the program implementers.

4.1.2 Focus Group Discussions

In determining and explaining the causality between two or more factors and variables, qualitative method over quantitative method is recommended to use (Carvalho and White 1997: 13). The FGDs among the informal workers were conducted to determine the factors affecting their demand for the social health insurance. Through FGDs, the participants can share and compare their experiences (Breen 2006: 465) with regard to the insurance program of PhilHealth and it is also appropriate to use if the time and financial resources are limited (Bertrand et al. 1992: 199).

The group discussions were done in one of the cities in Cavite, Philippines. The area is selected due to the following criteria: a) Cavite province has the largest number of population which is about 3.6 million (2014 projected population) (PSA 2014); and b) Cavite also has the highest number of informal sector workers (24.7%) registered in the program (as the primary members) compared to the other provinces in Region IV-A,

which is based on the data from PhilHealth[3]; c) Region IV-A (CALABARZON), where Cavite is situated, has the highest projected number of informal workers in 2014 (more than 32% of the labor force), based on the Labor Force Survey (PSA 2013) and is also valid from the data obtained from the 2014 APIS; and d) Cavite is one of the provinces with huge number of in-migrants and booming number of resettlement projects wherein most of the informal settlers and displaced families from Metro Manila, the capital of the Philippines, have been relocated (Provincial Government of Cavite 2013), specifically in the city where the FGDs were conducted[4]. In this regard, the selection of this province is based on the logic of intensity sampling in which it can provide a '*sufficient intensity'* or '*rich examples of the phenomenon'* but not necessarily selecting the unusual cases (Patton 1990: 171-172).

Figure 3. Map of Cavite, Philippines
(Source: https://commons.wikimedia.org/wiki/File:Cavite-map.jpg)

A total of six (6) FGDs were undertaken considering the different groups of informal workers. The table below shows the profile of the different groups:

[3] PhilHealth Membership Database (extracted on February 12-13, 2015). Copy of the extracted data was emailed last 11 August 2015.
[4] Information from the City Social Welfare and Development Office in Trece Martirez City, Cavite

Table 1. Composition of the Groups of the Informal Workers Participated in the FGDs

Type of Informal Works	No. of Participants	Gender
Tricycle Drivers	6	All Men
Domestic Workers (live-in/part-time)	6	All Women
Waste Pickers/Street Sweepers	5	Mixed
Home-based industries/services (small retail stores and vulcanizing/repair shops)	6	Mixed
Small- based construction workers	5	All Men
Market or Street vendors	6	All Women

(See Appendix B for the detailed compositions of each of the informal-type of occupation)

Table 1 shows that the size of the group is 5 to 6 participants as recommended in Cronin (2002: 170), in order to have more in-depth and substantial discussions among group members. Participants per group are selected by the gatekeepers based on the following criteria, however, regardless of their membership status in the NHIP. Gatekeepers were oriented a week before the schedule of the FGDs on the objectives of the research and the criteria for the selection of the participants. All participants are the only one who is working in the family (the '*breadwinner*'). This criterion for selection has been considered since the income earner of the family is usually become the principal members of the in the program, who can pay for the insurance contribution of the household as required by the NHIP.

Each of the participants introduced themselves first for documentation purposes. The discussions were recorded with the consent of the participants of the groups. The researcher also ensures the confidentiality of the identity of the participants. Each participants of the groups were asked about their living and working conditions, health status, support received and strategies during health emergencies and all about PhilHealth (*See Appendix C for the FGD Guide Questions*).

Before analyzing the focus group data, all the audio recordings were transcribed verbatimly and all the proceedings of the discussion done by the note taker were also accounted. This method was done to ensure the completeness of the data gathered from the discussions (Bertrand et al. 1992: 201). In analyzing the data, the following were considered in the analysis of the focus group data: a) essential themes; b) remarkable quotes; and c) unexpected findings, as recommended in Breen (2006: 472).I used content analysis through systematic margin coding method. Codes were assigned per question and use these to code the different points discussed in the transcript per group (Morgan 1988 in Bertrand et al. 1992: 205) particularly on the different reasons or factors affecting the coverage of the informal workers in the program. After the coding process, frequency of the codes within and across different groups of occupations were counted (Breen 2006: 472) to determine the common factors and significant points raised during the discussions. In addition, to ensure the reliability of the data, I also looked into the issues wherein the members of the group agreed or disagreed during discussions (Breen 2006: 472).

4.1.3 Key Informant Interviews

Additional method for data collection employed in this research is the key informant interviews with the program implementers at the national and at the local level. These interviews were conducted to explore the perspectives, motivations and the extent of support given by PhilHealth and the LGUs in covering the informal workers in the program. Moreover, data gathered capture other supply-side factors that could affect the development in the implementation and expansion of the coverage of the NHIP among the workers in the informal economy. Factors include the issues on the program implementation in a fragmented health system, the political behaviours, working relationships and the interactions and behaviours of the different actors at the national and at the local level. *(See Appendices D and E for the Guide Questions used during the interview of PhilHealth official and the City Social Welfare and Development Officer).*

FGDs and the interview with the program implementers were considered in the analysis to validate the results from the secondary data. However, not all demand and supply-side factors indicated in the framework can be captured by both the quantitative

and qualitative methods in order to triangulate the results. Hence, proxy indicators were used to represent some of the supply-side factors. Table below summarizes the data sources for each factor in the framework and the proxy indicators used in the analysis.

Table 2. Summary of the Factors Affecting the Coverage of the Informal workers in the NHIP and the Corresponding Data Sources Used in the Analysis

Factors Identified	**Data Sources**		
Demand-Side Factors	**2014 APIS**	**FGDs**	**One-on-one Interviews**
Wage/Earnings	X	X	
Type of Occupation	X	X	
Education	X	X	
Gender	X	X	
Age	X	X	
Health status and perception	X (proxy - health expenditure)	X	
Awareness about the program		X	X
Coverage by other security programs; Alternative strategy for financial health risk protection	X (proxy- membership in SSS program; availment of loan)	X	
Supply -Side Factors			
Benefit package coverage	X (proxy - health expenditure)	X	X
Cost of premium	X	X	X
Quality and Accessibility of Health facilities and services accredited by the program		X	X
Convenience of Enrollment & Payment Scheme		X	X
Issues on fragmented health system (i.e targeting of beneficiaries)	X (proxy - some of the poverty-related indicators such as income etc.)	X	X
Political behaviours		X	X

Source: Author

Triangulating the generated results from the aforementioned methods and sources can provide a complete picture and better understanding on the extent of the

coverage of the program among the informal workers and the reasons behind the lack of coverage and effective access of the program for the workers in the informal economy that hamper the achievement of UHC.

4.2 Issues and Lessons from Field Work

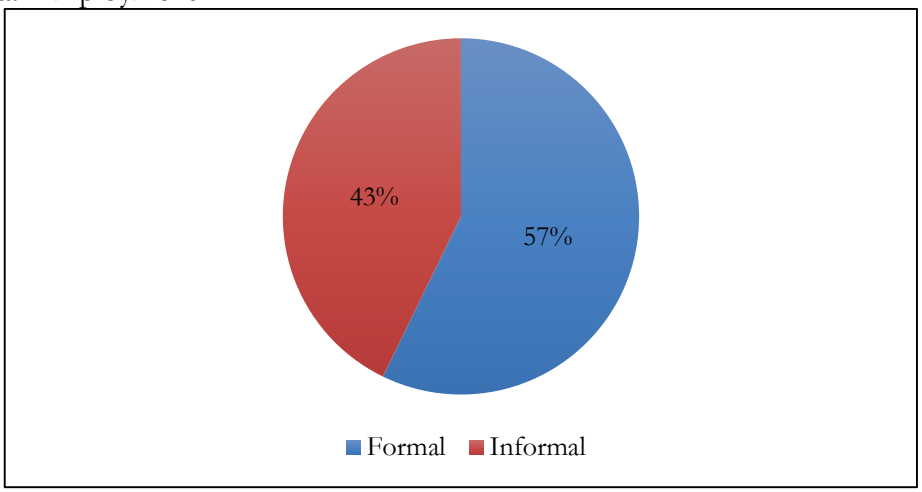
Some of the difficulties I experienced during field work were the coordination with the gatekeepers and searching for the FGD participants who are qualified to the set criteria. The gatekeepers had difficulty in searching for possible participants since most of the informal workers, particularly with the groups of tricycle drivers and vendors, reasoned out that they cannot participate because they need to work and earn money for that day. Therefore, I provided free food and token to the participants just to compensate to an hour absence from their works. On the group of the domestic workers who cannot commit at first to join the discussion since they have work to do during weekdays, I decided to adjust the schedule and do the FGD with the domestic workers on one Sunday afternoon, during their day-off from work.

5. The Demographic Features of Informality

Before assessing the extent of the coverage of the informal workers in the NHIP, it is necessary to examine and show that the demographic features of the informal workers from the APIS (national) data is more or less similar to the features of the informal workers participated in the FGDs. This explains and sheds light on the causal dynamics of using and integrating the different sources of data in the study.

Using the 2014 APIS data and the PSA's definition of informal workers, the graph below illustrates the proportion of household head[5] working in the informal economy over the total employment in the country.

Figure 4. Proportion of Household with Heads Working in the Informal Economy over the Total Employment



Source: Author based on PSA 2014

Figure 4 show that 43% of the households in the Philippines are working in the informal economy. The resulting figure underestimate the totality of the informal employment in the country, since the survey data might not capture some employments outside the informal enterprises and excludes other informal-type of occupations (i.e domestic workers) in their operational definition of informality.

[5] PSA defined household head as "an adult person, male or female, who is responsible for the organization and care of the household, or who is regarded as such by the members of the household". (Source: https://psa.gov.ph/nsoda/index.php/catalog/93/datafile/F9/V132)

Among the informal workers, the distribution of the informal workers by the following demographic characteristics are presented in the Table 3:

Table 3. Distribution of Informal Worker (Household Head) by Different Demographic Characteristics

Demographic Characteristics		% Distribution
Income/Wage		
	Quintile 1 (lowest income group)	50.6
	Quintile 2	15.2
	Quintile 3	14.2
	Quintile 4	9.8
	Quintile 5 (highest income group)	10.2
Type of Occupation		
	Self-employed without any employee	77.3
	Employer in own family operated farm or business	16.5
	Worked with pay on own family operated farm or business	3.9
	Worked without pay in own family operated farm or business	2.4
Gender		
	Men	79.3
	Women	20.7
Education		
	No education	2.7
	Primary Education	46.2
	Secondary Education	44.4
	Tertiary Education	6.7
Age		
	15-20	0.2
	21-30	3.4
	31-40	16.5
	41-50	27.4
	51-60	26.3
	60 and over	26.1

Source: Author based on PSA 2014

Table 3 shows that most of the household heads in the country who are working in the informal economy belong to the lowest income group. With regard to the type of occupation, 77.3% of the informal workers are self-employed. Majority of them are men compared to women. It can also be seen in the table that most of them only finished

secondary education, followed by the primary education. In terms of their age, most of the informal workers are middle aged and above (41 years old and over).

Comparing the features of the sampled participants of the FGDs with the national demographic characteristics of the informal workers, it can be observed that in terms of their age and educational attainment, most of the participants are within the middle-aged group and predominantly have lower level of education, which are the same with the 2014 APIS results (*See Table 4*). On education, the results from both data sources indicate that informal workers predominantly have lower level of education (primary and secondary level of education). This characteristic of the informal workers in the Philippines is consistent with the presumption that in the developing countries, persons (due to surplus labor) with low level of education tend to work in informal employment (Gerxhani 2004: 278) since informal works are characterized with ease of entry (Gerxhani 2004: 274) and cheap unskilled labor (Gerxhani 2004: 282).

With regard to gender, numbers of men and women informal workers are almost the same. This differs with the gender composition of the APIS data wherein majority of the informal workers are men.

Table 4. Distribution of the Informal Workers Participated in the FGDs by Demographic Characteristics (Education, Age and Gender)

Demographic Characteristics		**% Distribution**
Education	No education	0
	Primary Education	18.2
	Secondary Education	69.7
	Tertiary Education	12.1
Age	15-20	0
	21-30	21.2
	31-40	24.2
	41-50	42.4
	51-60	12.1
	60 and over	0
Gender	Men	48.5
	Women	51.5

Source: Author based on the data from FGDs

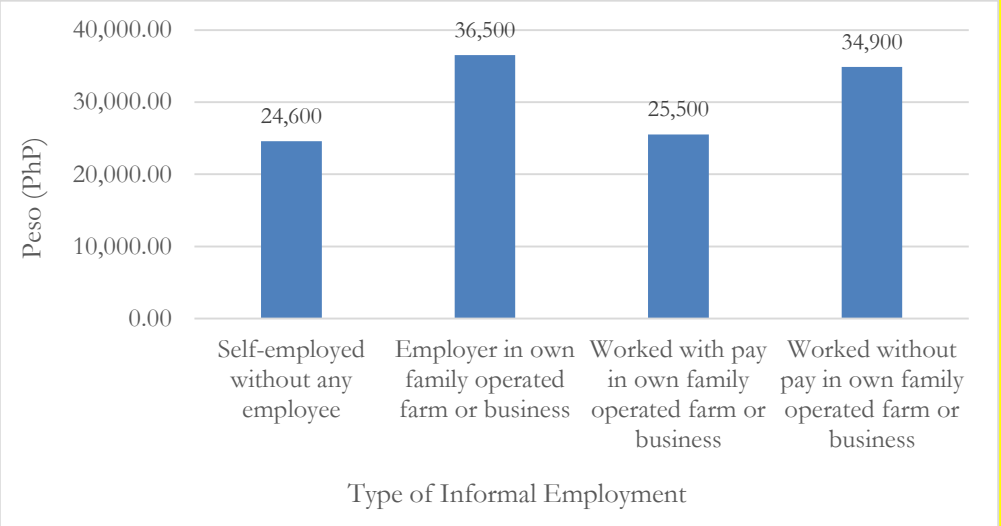
To further examine the features of informality in the Philippines, gender and income across different segments or type of occupations in the informal economy were also shown below. Based on the 2014 APIS, Figure 5 shows that only the self-employed type of occupation registered the higher proportion of women compared to men. On the one hand, informal employers are generally men. This feature could confirm Chen's segmentation pyramid of the informal economy by gender, which shows that women population are predominantly self-employed. This feature is not visibly observed to the sampled informal workers who participated in the FGDs. However, the data from the FGDs still shows that the informal economy is gendered. For instance, most of the domestic workers and street vendors are women while tricycle drivers and construction workers are all men.

Figure 5. Proportion of Households by Gender per Group of Informal Employment

Source: Author based on PSA 2014

In term of the average earning by type of occupation, Figure 6 shows that the informal employers group has the highest mean monthly wage, while the self-employed group has the least mean monthly income. This also validates the Chen's segmentation pyramid of informal employment by average earning which illustrates that informal employers (those at the top of the pyramid) have relatively higher earnings than the rest of the workers belong to the other groups of occupation in the informal economy. To examine the relationship between variables wage and type of occupation, the chi-square test of independence was used. The result indicates that there is a significant relationship exists between the wage and the type of occupation (at 95% level of confidence) (*See Appendix F for the generated contingency table and the Chi-Square Test of Independence between the two variables*).

Figure 6. Mean Monthly Wage of Household Head by Type of Informal Occupation



Source: Author based on PSA 2014

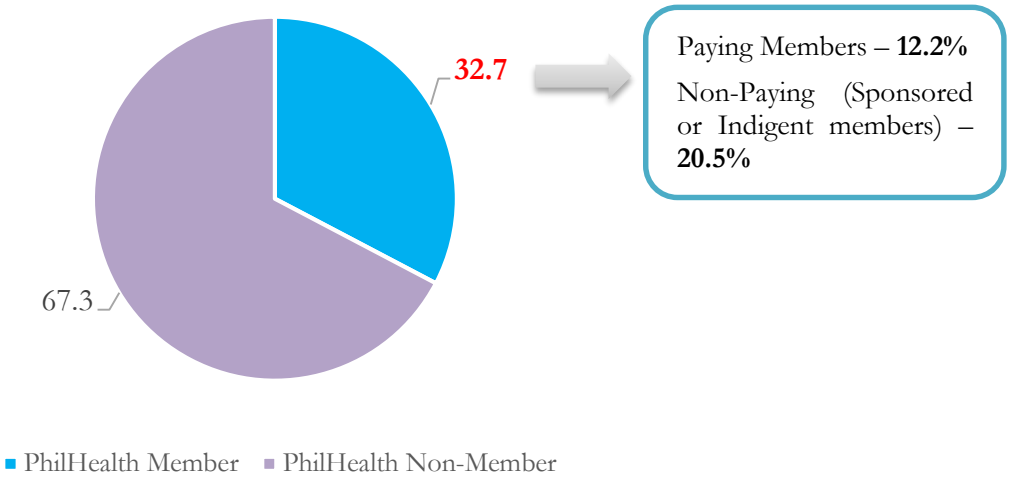
Chen's argument on the segmentation of income across groups of informal works is also supported by the data generated during FGDs. The research found out that the income of the informal worker who participated in the FGDs vary not only across groups of occupation but as well as within the same group of occupation due to different situations and working conditions of the informal workers in terms of their monthly wages.

Hence, based on the 2014 APIS data and from the profiling of the participants who engaged in the FGDs, it can be perceived that the features of informality from these data sources are more or less similar. Hence, it can shed light for the causal dynamics of using these data in this study. In addition, the characteristics of the informal economy in the Philippines seem to validate the arguments of Chen with regard to gender and income across different type of informal works.

6. The Extent of the NHIP Coverage among the Workers in the Informal Economy

Considering the breadth and depth of the coverage, as defined by Kutzin (2000: 2-3), both the proportion of the informal workers who are covered by PhilHealth as well as their effective access to quality healthcare services were examined. In terms of the breadth of the coverage of the program, the graph below shows the coverage rate of the NHIP among the informal workers. Based on the APIS 2014, roughly one-third (32.7%) of the households, whose household heads are working in the informal economy, are covered by PhilHealth insurance (*See Figure 7*). Note that the figure includes both paying members and non-paying-members. Paying members in the informal sector are those paying their own insurance premium contributions. On the other hand, the non-paying members are those members whose contributions are provided or subsidized by the government (either by the national or local government) under the Indigent or Sponsored Program of PhilHealth[6]. Figure also shows that there are more informal workers covered by PhilHealth through Sponsored or Indigent Program.

Figure 7. NHIP Coverage Rate among the Household Heads Working in the Informal Economy



Source: Author based on PSA 2014

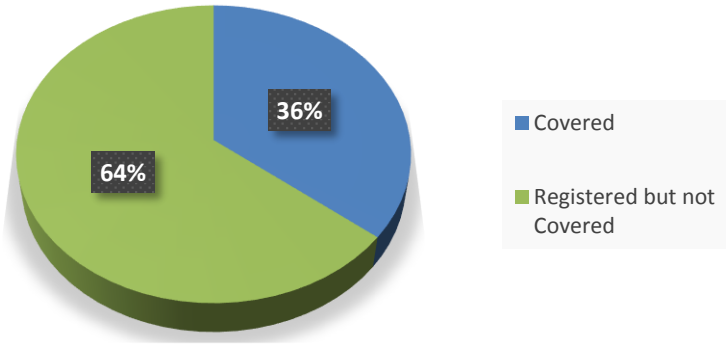
[6] From the email of the Philippine Statistics Authority (dated 08 September 2015) and Interview with Ms. Remedios Gabuya of PhilHealth (21 July 2015)

On the distribution of the informal workers who participated in the FGDs, almost 40% (13 out of 33 participants) of the total number of informal workers are covered by PhilHealth. Among those who are covered by the program, majority of them are sponsored or indigent members, particularly those in the domestic worker group. This conforms to the results generated from the APIS data.

On the one hand, PhilHealth provided data on the actual coverage of the program among the informal economy which is based on the definition of informality stipulated in the RA10606. Since PhilHealth could not be able to provide the number or percentage of the covered informal workers in the program over the total number of informal workers, the Corporation monitor the coverage rate over the total number of registered members based on their membership database[7]. Note that not all registered in the program are covered by the benefits. Members should sustain the required premium contribution for at least 3 months to be totally covered by the program.

As of December 2014, the coverage rate of those working in the informal economy is 36% of the total registered informal economy members in the program, as shown in the Figure 8. It should be noted that this includes only those informal workers or members who pay their own premium contributions (individually paying members) and those who did not qualify under the Indigent and Sponsored membership program of the government through the means test procedure.

Figure 8. NHIP Coverage Rate of the Informal Workers among the Total Registered Informal Workers in the Program



Source: PhilHealth 2015

[7] Interview with Ms. Remedios Gabuya of PhilHealth (21 July 2015)

However, it is also necessary to look into the coverage of the indigent members and sponsored members since most likely they are also working in the informal economy, given that some of the criteria considered for the selection of the indigent (through proxy means test) and sponsored members are related to the occupation and income of the household especially the household heads (Mapa and Albis 2013).

Table 5. Number of Families Covered by NHIP under the Indigent and Sponsored Programs, 2013-2014

Non-Paying Members	2013	2014
Indigent	5.2 million families	14.2 million families
Sponsored	4.4 million families	847,900 families

Note: Only the number of families are reported (and available) not the number of households
Source: PhilHealth 2013; PhilHealth 2015[8]

The table above shows that there is a huge increase in the number of families being subsidized by the national government in the NHIP from 2013 to 2014. The increase in the coverage of the indigents is one of the strategies of the country to bring down the poverty incidence of 25.2%[9] of the population (NEDA 2014: 9). However, number of sponsored families by the LGUs in the program decreased significantly. This can be validated by the data from the FGDs, wherein some of the informal workers were previously members of the NHIP through Sponsored Program of the LGUs, but, currently not covered by the program due to low budget allocated by the LGU for the program or due to variations in the selection criteria for sponsorship. Per the city welfare officer, the number of the sponsored members of the LGU in the program depends on the budget allocation per year. LGU sponsorship is valid for one year only. The officer added that most of the time the allocation is insufficient to cover the growing number of the "poor" families who usually belong to informal economy in their area[10].

[8] PhilHealth Membership Database (extracted on February 12-13, 2015). Copy of the extracted data was emailed last 11 August 2015
[9] 2012 Poverty incidence
[10] Interview with the City Social Welfare and Development Officer (*name undisclosed*) (12 August 2015)

In general, the data generated from the 2014 APIS data, the actual figure from PhilHealth and data from FGDs show that the breadth of the coverage among the informal workers has not yet been expanded extensively, particularly those informal workers who are paying for their own premium contributions to the NHIP. It seems that the universal (100%) target of the program has yet to be reflected on the coverage of the informal workers. However, it can be observed that the government is giving more priority to those indigent by immensely increasing their coverage in the program.

In addition, it is important to note that identifying and measuring the totality of the informal workers in the economy is still a predicament. It can be seen on the differences on the definitions and the limitations in quantification of informality in both 2014 APIS and PhilHealth data. Thus, it might not cover the full range and the different subsectors and categories of the informal works which can affect the coverage rate of the program among the said sector of the economy.

With regard to the depth of the coverage of the program, the views and experiences of the various groups of the informal workers with regard to the quality and accessibility of the healthcare services and benefits provided by the program were considered based on the data gathered from the focus group discussions conducted. In addition, findings from the one-on-one interviews with the program implementers at the national and at the local level were also analysed.

Based on the interview with one of the city officials, the researcher found out that there are instances that the medicines and medical equipment in the health centers and some of the government hospitals situated in the city are not available. This can be confirmed by the experiences of the informal workers who participated in the FGDs. Most of the participants belong to the domestic worker, market vendor and home-based worker groups have almost the same undesirable experiences on the quality of health services given in most of the government hospitals such as lack of rooms and beds for the patients and obnoxious and poor services of some of the hospital workers and staffs. For instance, one of the home-based workers (Alvin), shared his experience – "*I have no choice but to confine my sick daughter in a private hospital because when we went to the nearest government hospital, there are no available rooms and we were not accommodated right away given that it was an emergency".*

This shows that there is still disparity on the quality and accessibility of the health services between the government health facilities and the private facilities. To cross-check, in the 2013 Cavite SEPP Report, it is accounted that the public or government and privately-owned hospitals located in the province increased in number. Based on the report, the entire hospitals in the province have enough beds to cater the population since the bed to population ratio is 1:1,424 that meets the standard ratio of 1:2,000 (Provincial Government of Cavite 2013). However, the bed to population ratio of the public or the government hospitals alone is not reported. Another experience from one of the domestic workers (Evelyn, PhilHealth member, 38 years old) shared that - "*When my son was hospitalized, the doctor prescribed medicines. But, when I asked the hospital's pharmacy, it was not available. I just bought it to the private drugstore near the hospital*". This also shows issue on accessibility of the beneficiaries to health care services including the provision of medicines that supposedly given to the beneficiaries for free or in discounted price, but, not available in the health facilities.

Relating these circumstances to one of the institutional guiding principles of Fischer (2012: 12) on understanding universalism – the dimension of "*coverage and effective access*", it seems that the universalistic nature of the NHIP and the health services attached to the program seem to be weak. On that note, it can be construed that both the breadth and the depth of the coverage of the program still needs enhancement and further improvement in covering the entire informal workers in the economy.

The research tried to uncover the answers to the following sub-questions to further substantiate and validate the claims with regard to the extent of the coverage of the program among the informal workers.

6.1 Whom among the informal workers are covered by the NHIP?

In understanding the coverage disparity, it is expedient to determine whom among the workers in the informal economy are benefitting from a particular social protection program across different informal type of occupations Chen (2008: 25). It is reported above that 32.7% of the informal workers are covered by the program, of which 20.5% are non-paying (sponsored or indigent) members and the 12.2% are the paying members. Distributions of the covered informal workers (paying and non-paying) in the NHIP by demographic characteristics are shown in Table 6.

Table 6. Distribution of the Informal Workers Covered by the Program by Various Demographic Characteristics

Demographic Characteristics		**% Distribution**		
		Paying Members	Non-Paying Members (Sponsored and Indigent members)	Both
NHIP Coverage Rate		**12.2**	**20.5**	**32.7%**
Gender	Men	9.1	17.9	27
	Women	3.1	2.6	5.7
Type of Occupation	Self-employed without any employee	8.3	16.2	24.5
	Employer in own family operated farm or business	3.3	2.5	5.8
	Worked with pay on own family operated farm or business	0.2	1.4	1.6
	Worked without pay in own family operated farm or business	0.4	0.4	0.8
Income/Wage	Quintile1 (lowest income group)	6	8.7	14.7
	Quintile2	1.1	5.5	6.6
	Quintile3	1.4	3.6	5
	Quintile4	1.3	1.9	3.2
	Quintile5 (highest income group)	2.4	0.8	3.2

Education	No education	0	0.6	0.6
	Primary Education	2.3	12.1	14.4
	Secondary Education	8.2	7	15.2
	Tertiary Education	1.7	0.8	2.5
Age	21-30	0.2	0.6	0.8
	31-40	2.3	4.2	6.5
	41-50	3.9	6.2	10.1
	51-60	3.7	5.1	8.8
	60 and over	2.1	4.4	6.5

Source: Author based on PSA 2014

On the type of occupation, Table 6 shows that either in paying or non-paying groups, there are more informal workers who are self-employed. It can also be observed that there are more informal employers who are paying members than those informal employers who are non-paying members. Results of the APIS data cannot be validated by FGDs data since number of participants was set and determined before the conduct of the interviews. However, FGDs data show that most of the informal workers participated in the FGDs who are covered by the program came from the group of the street sweepers and domestic workers. From the discussions, it is found out that most of them are covered by the program through subsidization of their insurance premium by the national government and the local government of the Cavite.

With respect to income or wages of those covered by the program, it is found out from the APIS data that there are more non-paying members belong to the lowest income group, while there are more paying members who belong to quintile 5 with relatively higher income among the rest of the income quintile groups. The results could support the effort of the government in prioritizing the poorest of the poor, who belong to the lower quintiles groups, by providing full or partial subsidies for them to be covered by the NHIP. This was also confirmed by the group of the domestic workers during the discussion, where most of them have been identified by the government as poor and have been provided with PhilHealth insurance for free. However, issues about targeting of sponsored and indigent members raised by the non-PhilHealth members during the FGDs are discussed in the later part of the paper.

In terms of gender, there are more men covered by NHIP in both paying and non-paying groups. However, it can be seen in Table 6 that women who are paying members are more than those women who are sponsored or indigent. The result is quite different from the FGDs data, where majority of the non-paying members are women and the paying members are mostly men (*See Table 7*). Based on 2014 APIS *(See Table 6)*, there is high percentage of paying members with at least secondary education, while it is evident that majority of the sponsored or indigent members of the program only have primary level of education.

With regard to age, majority of the covered informal workers, who are either paying or non-paying members, are within the age group of 40 to 60 years old. The same is true with the ages of the participants of the FGDs, as shown in Table 7. There is no specific or certain age patterns observed from those who participated in the discussions who are covered by the NHIP. The results did not necessarily followed the assumption that the older the person, the more likely the person is covered by the insurance program due to more exposure to health risks when getting older.

Table 7. Distribution of Informal Workers Covered by the Program who participated in the FGDs, by Various Demographic Characteristics (Absolute Number)

Demographic Characteristics		Paying Members	Non-Paying Members (Sponsored and Indigent members)	Both
Number of Informal Workers Covered by NHIP		**9**	**4**	**13/33**
Gender	Men	5	0	5
	Women	4	4	8
Education	No education	0	0	0
	Primary Education	2	1	3
	Secondary Education	6	3	9
	Tertiary Education	1	0	1
Age	21-30	0	0	0
	31-40	3	2	5
	41-50	5	1	6
	51-60	1	1	2
	60 and over	0	0	0

Source: Author based on the FGDs data

Further, the study predicted and established the likelihood of the informal workers to be a member or non-member of the NHIP based on the characteristics mentioned above using the binary logistic regression. Table 8 shows the generated odd ratios and the predicted probabilities of the following variables included in the model that can determine the probable characteristics of the certain household in the country to be a member of the NHIP (*See Appendix G: SPSS Output of the Regression Model*).

Table 8. Predicted Probabilities of PhilHealth Membership Status by Various Household Characteristics

Variables	Category	Odds Ratio	Predicted Probabilities	P-value
Wage Quintile	1 (Lowest)	1.07	0.29	0.00
	2	1.93	0.44	0.00
	3	1.35	0.35	0.00
	4	1.16	0.33	0.00
	5 (Highest)*	-	0.30	0.00
Age	15-30	0.57	0.19	0.00
	31-50	1.36	0.38	0.00
	51 and over*	-	0.29	0.00
Type of Occupation	Self-employed without any employee	1.06	0.32	0.00
	Employer in own family operated farm or business	1.17	0.36	0.00
	Worked with pay on own family operated farm or business	1.20	0.42	0.00
	Worked without pay in own family operated farm or business*	-	0.30	0.00
Education	No Education	0.50	0.23	0.00
	Primary Level	0.76	0.31	0.00
	Secondary Level	0.7	0.34	0.00
	Tertiary Level*	-	0.37	0.00
Gender	Men	1.23	0.34	0.00
	Women*	-	0.28	0.00

With/Without Private Insurance	Without Private Insurance	0.38	0.32	0.00
	With Private Insurance*		0.55	0.00
Loan Availment	Yes	1.33	0.38	0.00
	No*		0.31	0.00

* - used as dummy in logistic regression
Source: Author based on PSA 2014

Household (head) characteristics that are more likely to be PhilHealth members are as follows: a) household who belongs to the Quintile 2 (second to the lowest wage quintile group); b) with middle aged household head; c) with household head working with payment in their own family farm or business; d) who have at least tertiary education; e) male headed household; f) household who have private insurance; and g) household who availed loans. With the identification of these household characteristics, the Corporation might want to focus on the households whose characteristics are less likely to be PhilHealth members. Targeting these households could extend the scope and coverage of the NHIP towards UHC.

6.2 Reasons for Lack of Effective Coverage of NHIP among the Informal Workers

Following are some of the significant factors pointed out during the FGDs and interviews that seem to affect the scope of the coverage of the program amongst the informal workers.

Income and the Cost of the Premium Contribution

As discussed earlier, most of the PhilHealth members belong to the low wage quintile groups (APIS 2014) due to subsidization of the insurance premium by the government for the poorest of the poor which includes the working poor. Hence, for them, income and the cost of the premium contribution are not an important factors to consider in order to be included and benefitted by the program. However, per those participants

of the FDGs who are non- indigent and non-sponsored members, income and cost of the premium are essential determinants in availing the health insurance. Informal workers who were interviewed have varying range of incomes or earnings even if they belong to the same group of occupation. For instance, within the group of tricycle drivers, those who have their own tricycle to drive have relatively higher earnings since they can extend their driving (working) hours to earn more money compared to those who only borrow or rent a tricycle who have limited time to drive. In addition, they also have to pay the owner of the tricycle a portion from their earning. Earnings also vary every day. For example, the group of market or street vendors and the home-based workers depend their everyday earnings to the number of clients or customers per day. While other occupational groups have relatively fixed income like the domestic workers, street sweepers and small-based construction workers. In this regard, their ability to pay for the PhilHealth premium contribution can be directly influenced by their earnings.

Erwin (tricycle driver, non-PhilHealth, 28 years old) shared that - *"The premium contribution of PhP200.00 per month is reasonable since the benefits you can have from the program can be extended to your family members. However, our earning per day is not enough because you have to spend it all for your basic needs such as food and for our children's everyday school allowance. Nowadays, it seems that the cost of basic commodities are relatively higher compared before. The government should control the prices of the goods"*. Note that Erwin has relatively lower wage compared to others since he only borrowed the tricycle from someone to earn money for a living. Almost all the non-PhilHealth members across different occupation groups who participated in the discussions also pointed out that they are willing to pay for the premium, however, they do not have the ability to pay for it due to inadequate income and the inflated prices of the basic commodities. In order to validate their statements about inflation, World Bank data shows that the prices of goods and services indeed increased from 2.9% in 2013 to 4.1% in 2014 (WB 2015). Moreover, based on the APIS 2014 data, the ratio of the monthly premium contribution to the monthly income of those who belong to the lowest quintile group (with and average earning of Php 7,900.00) shows that only 2.5% of their monthly income should be allotted to pay for the monthly insurance premium if the household decided to participate in the program. Hence, income and the inflated prices of basic goods and services seem to be significant factors that can negatively affect the demand for the insurance and not necessarily the cost of the insurance premium.

Awareness about the NHIP

Among the groups of the informal workers who took part on the discussions, groups of domestic workers, street sweepers and tricycle drivers are more aware about the PhilHealth program. Most of the domestic workers participated are enrolled under the Indigent Program of PhilHealth, wherein the program are requiring them to attend the Family Development Sessions (FDS) conducted every month. In FDS, the benefits and importance of PhilHealth insurance is being tackled. They became aware about the Indigent Program when the representative from the LGU surveyed them to evaluate whether they should be included or not in the program. With the group of the street sweepers, all of them are informed about the program through the association who enrolled them in the program. It seems that inclusion in the programs of the government or membership in any other associations and organizations can provide more security and protection for the informal workers.

On the one hand, those tricycle drivers who are aware about PhilHealth are currently non-PhilHealth members. However, they used to be enrolled in the program when they were previously worked in private company and industry that provided them PhilHealth insurance as part of the work benefits. It clearly shows that the shift from formal to informal works means losing the membership and entitlement on the NHIP. Based on the discussions, the transition to informal occupation was due to casualization or contractualization practices of the industries and private companies where they were previously worked. They added that even though these companies provided them the PhilHealth insurance, they were not given security of tenure. Hence, this validates that those who work formally are the more likely to be protected against risks (Chen 2008: 22). These scenarios illustrates that providing both employment and work security (and other types of security) is necessary to protect the informal workers from various vulnerabilities and risks (Rodgers and Rodgers 1989).

Majority of the participants of the FGDs who belong to the groups of street vendors, home-based workers and small-based construction workers are the least informed. They pointed out that they do not know the enrollment process, the requirements needed

and the benefits coverage. According to them, they have not seen any information material or heard about campaigns about the program near their working areas (i.e market/street and their home), where they usually spend majority of their time. Hence, lack of awareness about the program can adversely affect the demand for the health insurance.

Moreover, a statement from Alvin (PhilHealth member, 44 years old; employer of vulcanizing shop) was also remarkable - "*I do not know the benefits provided by PhilHealth even if I am a member. My wife just encouraged me to enroll in the program. She said that she will use my name for the registration process since I am the only working and the head of the family. My wife was the one who went to PhilHealth office and enrolled our family*". This case depicts and confirms that most of the women (wives) are usually the one who perceived to provide "care" for the family and give more priority for the welfare of the whole household (Wit 1996: 38). Hence, more involvement of the female members (i.e wife) of the households in the program is suggested to increase the coverage of the program. In addition, it is necessary to target women to participate in the program since they are also the less likely to be members of the NHIP based from the generated results from APIS 2014 data.

Benefit Coverage of the Program

Majority of the informal sector workers from different groups, particularly those PhilHealth members under the Indigent and Sponsored Programs, believe that the program is indeed beneficial and useful. Some of the PhilHealth members were able to use their insurance for the hospitalization of the members of their family. For instance, one of the domestic workers who is under the Indigent Program used her PhilHealth insurance when her son was confined and diagnosed with dengue and pheumonia. All the hospital bills were shouldered by PhilHealth. Other indigent or sponsored members who have also experiences in availing the benefits of the program affirmed the statement. On the other hand, the paying members of the program seems to be satisfied with the benefits, however, they are requesting to be covered by the "no balance billing" policy of PhilHealth, which is only applicable for the indigent and sponsored members. This illustrates that being a member of the program does not guarantee the feeling of inclusion due to variation of the benefits given to each membership categories.

This study examined and compared the health expenditures of the indigent or the sponsored members with the paying members using the 2014 APIS data. The results below show that there is significant difference between the out-of-the-pocket health expenditures of the indigent or sponsored members compared to the expenditures of the individually paying members of PhilHealth. This validates the claims of the participants of the FGDs who are neither indigent nor sponsored members of the program that their health expenditures are higher since they are not benefitting from the *no balance billing policy* of the NHIP.

Table 9. Mean Monthly Health Expenditures by NHIP Membership Category

NHIP Membership	Mean Health Expenditures (in PhP)
Non-Paying members (Sponsored or Indigent)	2,517.34
Paying Members	7,711.45

Note: The mean difference is significant at α=0.05 (with p-value=0.000)
See Appendix H: Means Test
Source: Author based on PSA 2014

Table 9 also shows that the out-of-the-pocket expenditures cannot be removed fully through insurance, even if you are indigent or sponsored members, since the insured still have to pay for other health expenses that are not covered by the benefit packages offered by the insurance program. For instance, two of the participants from the domestic worker group (under the Indigent program) shared that some of the medicines prescribed by the doctors were not available in the hospital pharmacy, in which they supposedly get them for free as part of the benefits for the indigent members. Hence, they ended up buying medicines in leading drugstore

Non-PhilHealth members from the market vendor group blurted that they might encourage to join the program if the benefits given will be the same benefits provided by the Social Security System (SSS). They claimed that PhilHealth is only for hospitalization and they are looking for other benefits such as accident, life and death insurance which can be provided by the SSS. However, based on the APIS 2014 data, there are more informal workers who are PhilHealth members (33%) reported than the SSS members

(20%). But still, PhilHealth might want to study the feasibility of expanding the coverage benefits of PhilHealth to encourage more informal workers to enroll in the program.

Convenience on Enrollment Procedures (including Payment Mechanism)

Some of the non-PhilHealth members who participated in the discussions still believe that enrolling in PhilHealth is difficult and tedious as more requirements are needed for the registration process. In addition, they pointed out that the enrollment process might be time and effort consuming. However, it seems that most of them based their responses from their experiences from the previous years, before the reforms and changes in the NHIP and the health system have been implemented. There are also some participants who were recently enrolled in the program experienced the ease of the enrollment procedure. According to PhilHealth[11], there are numbers of PhilHealth local offices in the country, where the people can easily register and enroll in the program. In addition, most of the informal workers were registered in the NHIP through iGroup Program, with the help of various organized groups. As of the 1st quarter of 2015, about 10,388 organized groups in the country are working and coordinating with PhilHealth to reach and enroll the informal workers at the local level[12].

However, based from the FGDs, most of the informal workers do not have any idea about these organized groups who offer group enrollment in the program. The group of tricycle drivers and market vendors suggested to tap their respective associations (the tricycle driver association and the market vendors association) for the group enrollment in order to have ease of transaction and registration in the NHIP.

In this regard, the demand for the insurance may negatively affect by the inconveniences in the enrollment procedures, including the payment mechanism, experienced by the informal workers. However, it should be noted that the adverse effect of this factor on the universal coverage of the informal workers in the program also depends on how the workers are aware about the current system of NHIP, the reforms and changes made

[11] Interview with Ms. Remedios Gabuya of PhilHealth (21 July 2015)
[12] Data on the number of organized groups were emailed by PhilHealth (sent on 25 August 2015)

and implemented for the improvement of the enrollment and payment mechanism and processes.

Presence of Informal Schemes and Alternative Strategies for Financial Health Risks Protection

Another essential aspect that has been agreed upon during the discussions by different informal occupation groups is the presence of alternative support and services, which might affect the demand for the social health insurance. Following are some of the identified informal or other survival strategies of the groups of the informal workers during sickness and health emergencies: a) lending groups (i.e associations); b) SSS that can offer loans; c) family and relatives; d) politicians such as the governor of the province, city mayor and barangay captains; and e) City Social Welfare and Development (CSWD) Office of the city who also provide financial assistance to the public.

One of the domestic workers who is a non-PhilHealth member shared that – *"When my eldest son got sick, we went to the Governor's office and asked for assistance. I have a friend working in the office of the Governor and she was able to help us get the financial support for the hospitalization of my son*". From the interview with the CSWD officer, the officer affirmed that several people go to their office and ask for their financial support whenever someone from the family is hospitalized. According to the CSWD officer, the local government unit allots budget for this kind of assistance to the public yearly and the officer noticed that the budget for this fiscal year increased and suspected that it is because of the upcoming election. This statement reveals that there exists clientelist relations at the local level, where the politicians seek patronage and public support for the upcoming election. With this, people tend to depend and rely to these different kinds of short-term supports and security which for them are more accessible and convenient, particularly during health emergencies and needs. From the APIS 2014 data, availment of loans of the household was used as proxy indicator (for the alternative strategy for financial health risks protection) to cross-check whether there are more non-PhilHealth members who avail loans than those covered by the program. However, Table 10 shows otherwise.

Table 10. Percent Distribution of the Informal Workers with Loan Availment by PhilHealth Membership Status

PhilHealth Coverage Status	Loan Availment	
	With	Without
PhilHealth Members	32.9	67.1
Non-PhilHealth	26.1	73.9

Source: Author based on PSA 2014

In this regard, it cannot be construed in general that these short-term supports or alternative strategy provided by different institutions and groups, for instance loans, can negatively affect the demand for the PhilHealth insurance. However, they are still be considered by the informal workers (both PhilHealth and non-PhilHealth members) as provider of immediate support and assistance in times of health need.

Targeting of the Sponsored and Indigent Members

The Indigent and Sponsored Program of PhilHealth were also tackled in the discussions with all the different groups of the informal workers, most of the participants, who are non-indigent and non-sponsored members, reacted negatively and questioned on how the government selected the families to be included in the Indigent and Sponsored Program. Most of the participants are aware about the Indigent and Sponsored Programs and they would also like to be included in the program due to exclusive benefits and services bequeath to the members such as full or partial subsidy of the insurance premium, the *no balance billing* during hospitalization, and the additional benefits that are not available for the other PhilHealth member categories. Most of them claimed that they should also be included since they are also "poor". One of the market vendors, Neng (Non-PhilHealth, 45 years old), pointed out that *"I noticed that in our village, most of the sponsored members are the relatives and friends of the village officials. They told us that they have the criteria for selection but what I've observed is that most of the sponsored members are not deserving to be part of the program because some of them have better lives than the others who were not selected"*. This case shows that the informal workers' feeling of being excluded from the program might be due to the inconsistency and politicization of the selection process (means tests) used by the government in identifying the poor to be prioritized and subsidized. It also shows that the officials might using their powers and positions to take advantage of the situation by including his

or her relatives to the list of sponsored members to be subsidized by the local government in the program. Moreover, means tests used by national as well as the local government might be susceptible to targeting errors such as inclusion of the persons who are undeserving of assistance (Mkandawire and UNRISD 2005: 9).

However, on the discussion with the group of the domestic workers, who are mostly members of the indigent program, shared their experiences on how they were selected. Myrna (sponsored member, 56 years old), explained that someone from the government interviewed them about their livelihood, sources of income, assets acquired (i.e appliances) and the like. In this regard, the study used APIS 2014 data to investigate the claims of both sides of the paying and the sponsored or indigent members with regard to targeting procedure. In Table 11, results shows that in some indicators of poverty such as income, number of appliances and house floor area, the conditions of the paying members are better-off than those identified as the indigent or sponsored members. Results might support the statements of the indigent members on the way they were selected by the government to be subsidized in the program. However, other poverty indicators should still be examined and cross-checked to provide stronger support on their claim.

Table 11. Poverty Indicators by Paying and Non-Paying Membership in PhilHealth

Indicators	Paying Members	Non-Paying Members (Indigent & Sponsored)
Mean Monthly Household Income (in Ph peso)	44, 946	16, 522
Mean Number of Appliances	8	3
Mean Floor Area of the Housing Unit (in sq. m)	81	38

Source: Author based on PSA 2014

Based on the interview with the CSWD officer, it was clarified and explained that the list of the indigent members were selected by the national government using the proxy means test, while the selection for the sponsored members is assigned to each LGU. The officer added that the LGU has their own mechanism of selection. In their case, they are using the household income as the basis for selection. In addition, the CSWD officer also pointed out that the number of sponsored members to be subsidized by the LGU depends on the budget allocated per year and the LGU sponsorship is valid for a year, which may be continued or withdrawn in the following years.

Among the factors in the framework, following are the significant reasons behind the lack of effective coverage of the program among the informal workers identified in the study: a) inadequate income and inflated prices of the basic commodities; b) lack of awareness about the program; c) limited and varying benefit packages offered across groups of beneficiaries; d) low quality and inaccessibility of health facilities and services; e) issues on targeting of the beneficiaries; and f) convenience in the enrolment procedures.

7. Towards Universal Health Coverage of the Informal Workers: The Conclusion and Recommendations

The precariousness of the conditions of the majority of the informal workers in the economy have been observed in the country. This includes the lack of social protection such as the social health insurance. The Philippine government tried to cover the informal workers in the National Health Insurance Program of PhilHealth, which aims to provide financial and health risks protection to all towards achieving the goal of Universal Health Care. Universal principle of any social policy, for instance - the NHIP, does not only refer to the breadth of the coverage of the population in the program but it should also consider its depth, including its effective access to quality health care facilities and services (Fischer 2012: 12; Kutzin 2000: 2-3). In this regard, the study investigates the extent of the coverage of the NHIP among the workers in the informal economy including the factors that can affect the demand of the informal workers to participate in program.

Using the data from various sources, the study found out that PhilHealth coverage (both estimates and actual coverage) among the informal workers is still low, despite of the continuous implementation of health reforms in the country. Following are some of the significant reasons identified that can adversely affect the demand and effective coverage of the program among the informal workers: a) inadequate income to pay for the premium (due to inflated prices of basic commodities); b) lack of awareness about the program (including the enrollment process and the benefits of the NHIP); c) limited and different benefit packages offered across membership categories; d) disuse on the quality and accessibility of the health facilities and services; e) inconveniences experienced in the enrollment process; and f) negative perceptions of the informal workers on the targeting mechanism used by the government in selecting the households to be fully or partially subsidized in the program, thus, can lead to the feeling of the informal workers of being socially excluded in the program.

Having identified the factors affecting the demand for the social health insurance, following are some of the recommendations that might help improve the NHIP coverage among the informal workers in order to achieve the universal health care:

a) Targeting of those who are less likely to be covered based on the characteristics of the household is suggested. The study predicts the likelihood of the household to be PhilHealth member based on their demographic features. Following household characteristics are more likely to be members of the NHIP: *i*) belong second quintile group; *ii*) middle aged; *iii*) working in their own farm or business with pay; *iv*) with high level of education; *v*) male household head; *vi*) with private insurance; and *vii*) those with loans. These might serve as guides for the policy makers and implementers of the program in targeting those informal workers who are still not covered by the program. In addition, government might want to focus and extend their support to those informal workers who are not sponsored or indigent members. It seems that they are the one who are more vulnerable and the least priority of the program.

b) Since the study found out that the shift from formal to informal works could mean losing the coverage in the NHIP, it is recommended to strengthen the policies of the government that aim to provide security to the informal workers, particularly the work security (i.e security of tenure). Objectives of the policies and programs (either social or economic policies) should be consistent and in line with the overall goal of protecting the Filipinos from various vulnerabilities and risks.

c) Intensify the information dissemination campaigns by using different forms of media (i.e. poster or leaflets as suggested by the informal workers) that can be distributed to the areas where most of the informal workers spend most of their time. In addition, information about the PhilHealth enrollment procedures, requirements needed and the benefits of the programs should also be publicized. Information about PhilHealth should be presented in a more creative way to catch the attention of the target audience. The used of the national television and radio can also be an option to spread the importance of PhilHealth insurance, nationwide. Since the wife or the female member of the family is associated to "care" and welfare of the household, they could be targeted to attend the orientations with regard to the importance of

PhilHealth and ensure their involvement in the program. Moreover, various associations of the informal workers (i.e tricycle and vendor associations) can also be tapped to disseminate information about the program to their respective members. If possible, these associations could also be included in the iGroup Program, where PhilHealth can give these associations incentives (i.e low premium insurance) if they were able to encourage and enroll numbers of informal workers in the program.

d) The Corporation might want to review the feasibility of the inclusion of other health-related benefits and services to the program as suggested by the informal workers participated in the discussions. Moreover, it is better if PhilHealth could ensure that the benefits being provided are available and accessible to all and not only to particular groups or membership categories in order to prevent the feeling of being excluded from the program.

e) Discover possible ways on how to further expand the number of indigents and sponsored members to be subsidized by the program. In relation to this, a more reliable and uniform targeting mechanism is needed to establish to all local government units in the country.

f) Informal workers should not be treated as homogenous group. It should be noted that the level of informality they have been experiencing vary and this requires different mechanisms and strategies to reach and encourage them to enroll in the program. Development and implementation of any social policy or program that targeted the group of informal workers should adjust, to some extent, based on the particular contexts, situations and their conditions.

g) Lastly, the PhilHealth, the concerned agencies such as Department of Health, Department of Social Welfare and Development, Department of the Interior and Local Government and the Department of Labor and Employment and the other stakeholders such as NGOs, other organizations and associations of the various groups of informal workers should collaborate and continue to put more efforts towards achieving universal health care coverage among the workers in the informal economy.

In this regard, universal health care coverage and protection for all Filipinos against healthcare financial risks, particularly for the informal workers, could be more possible and attainable.

Due to the limitations of the study, it is recommended for future research to further evaluate the extent of the coverage and access in the program of those working in the informal economy but outside the country (i.e migrant workers). This will also contribute on how the program can achieve the goal of UHC for all Filipinos.

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Appendix A. List of the Benefit Packages of NHIP to their Members

In Patient Care Benefit Package:

- room and board;
- services of health care professionals;
- diagnostic, laboratory, and other medical examination services;
- use of surgical or medical equipment and facilities;
- prescription drugs and biologicals, subject to the limitations of the Act; and
- health education

Z and Expanded Z Packages:

- Acute lymphocytic leukemia, standard risk (for children);
- Early breast cancer, stage 0 to IIIA;
- Prostate cancer, low to intermediate risk;
- Kidney transplantation for end stage kidney disease, standard risk;
- Coronary artery bypass graft surgery, standard risk;
- Total correction of Tetralogy of Fallot (for children);
- Closure of ventricular septal defect (for children);
- Cervical Cancer, stage I to IV;
- The Z MORPH (Mobility, Orthosis, Rehabilitation and Prosthesis Help)

Case Rate Packages (Medical Cases):

- Dengue; Pneumonia;
- Hypertension;
- Cerebral Infarction;
- Cerebro-vascular Accident with Hemorrhage;
- Acute Gastroenteritis; Asthma; Typhoid Fever; and
- Newborn Care Package in Hospitals and Lying-in clinics, among others.

Case Rate Packages (Surgical Procedures):

- Radiotherapy;
- Hemodialysis;
- Maternity Care Package coupled with the Normal Spontaneous Delivery (NSD) Package and Caesarian Section;
- Appendectomy;
- Cholecystectomy;
- Dilatation and Curettage;
- Thyroidectomy;
- Herniorrhaphy;
- Mastectomy;
- Hysterectomy; and
- Cataract Surgery, among others.

Source: National Health Insurance Act 2013; PhilHealth 2014

Appendix B. Compositions of Each Type of Occupation Group Participated in the FGDs

Type of Occupation	*Name	Age	Educational Attainment	Marital Status	Current PhilHealth Membership Status	Remarks
Tricycle Driver	Raul	48	Vocational Program	Married	Non-PhilHealth	Previously member when he worked for a private company
	Ron	43	College Undergraduate	Married	Non-PhilHealth	Previously member when he worked for a private company
	Harold	32	Highschool Graduate	Married	PhilHealth member	
	Rey	50	College Graduate	Married	Non-PhilHealth	Previously member when he worked for a private company
	Ronnie	56	Elementary Undergraduate	Separated	Non-PhilHealth	
	Erwin	28	Vocational Program	Married	Non-PhilHealth	
Domestic Workers	Dorina	58	Elementary Undergraduate	Widow	Non-PhilHealth	Live-in domestic worker
	Evelyn	38	Elementary Graduate	Widow	PhilHealth member	Through Indigent Program; part time domestic worker
	Shayne	25	Highschool Undergraduate	Married	Non-PhilHealth	Part-time domestic worker
	Lorna	47	Highschool Undergraduate	Widow	PhilHealth member	Through Sponsored Program; part-time domestic worker

	Amor	33	Highschool Graduate	Married	PhilHealth member	Through Indigent Program; live-in domestic worker
	Myrna	56	Highschool Graduate	Married	PhilHealth member	Through Indigent Program; live-in domestic worker
Street Sweepers/Waste Pickers	Luisa	46	Highschool Undergraduate	Separated	PhilHealth member	
	Manuelita	48	Elementary Graduate	Widow	PhilHealth member	
	Resty	52	Highschool Graduate	Married	PhilHealth member	
	Alfredo	45	Highschool Graduate	Married	PhilHealth member	
	Jeorge	42	Highschool Graduate	Married	PhilHealth member	
Home-based industries/services (small retail stores and vulcanizing/repair shops)	Maria	45	Highschool Undergraduate	Widow	Non-PhilHealth	Previously member through Sponsored Program
	Susan	39	Elementary Graduate	Married	PhilHealth member	
	Lita	42	Highschool Graduate	Married	Non-PhilHealth	
	Alvin	44	Vocational Program	Married	PhilHealth member	
	Norman	26	Highschool Undergraduate	Single	Non-PhilHealth	
Small- based construction workers	Freddie	42	Elementary Undergraduate	Married	Non-PhilHealth	
	Noel	32	Highschool Graduate	Single	Non-PhilHealth	Previously member through Sponsored Program
	Jerome	26	Highschool Undergraduate	Married	Non-PhilHealth	

	Raymart	28	Highschool Graduate	Married	Non-PhilHealth	
	Jeff	39	Highschool Graduate	Married	Non-PhilHealth	Previously member when he worked for a private company
Market or Street vendors	Juvy	44	Highschool Graduate	Married	Non-PhilHealth	
	Neng	45	College Undergraduate	Separated	Non-PhilHealth	Previously member through Sponsored Program
	Weng	33	College Graduate	Married	PhilHealth member	
	Glenda	27	Highschool Graduate	Married	Non-PhilHealth	
	Matet	26	Highschool Graduate	Married	Non-PhilHealth	
	Janice	33	Highschool Graduate	Married	Non-PhilHealth	Previously member through Sponsored Program

**Pseudonym- For confidentiality purposes*

Appendix C. Guide Questions used during the Focus Group Discussions

A. Introduction of Participants
Name:
Age:
Educational Attainment:
Number of years in work:

<This was done to know the group characteristics or compositions in order to give us a deeper understanding of the context and the social construct that might affect their responses as a group to the questions during discussions.>

B. Can you describe the typical working day of <*insert type of work*>? (Probe the working conditions such as working hours, earnings, (ir)regularity and safety at work)

<This is to understand the working and living conditions of a particular type of worker and compare their level of informality with other informal works.>

C. What is "*health*" and its importance and relationship with your work? (Probe it through personal experiences regarding health problems/status of the workers and their families)

<This is important to ask to determine whether their perceptions about health and their health status can affect their decision to be a member or not in the insurance program.>

D. How did you deal with your (or your other family members) recent health problems (if any)? Whom did you usually seek for help and financial support?

< This question serves as a follow-up to question C and it was asked to know whether there are existing informal mechanisms and coping strategies of the workers during health shocks and whether PhilHealth insurance is one of their options. It can also identify whom among the participants are PhilHealth and non-PhilHealth members. If some of the participants did not experience recent health problems, then it was asked as hypothetical question to them.>

E. What can you say about PhilHealth Insurance? (Probe the awareness of the participants about the PhilHealth insurance and their experiences with regard to program (if any))

<This question can provide the possible demand and supply-side factors which can affect the coverage of the program amongst the workers in the informal economy.>

F. What do you think the program (implementers) should do to further improve the coverage of the <*insert type of work*> in the NHIP?

<The question was asked to determine the specific mechanisms to improve the program based on the group characteristics (type of informal work).>

Appendix D. Guide Questions Used During the Interview with PhilHealth Officer

1. How and why did you come up with the new membership categories?
2. When did you start covering the informal sector? What is Philhealth motivations in covering this sector?
3. Who are those included under the informal sector? What are their occupations?
4. How does PhilHealth monitor the actual coverage (coverage rate) of the informal workers in the program?
5. Is your definition of informal sector in line with the definition of PSA? If not, what could be the difference(s) with the definitions?
6. In which membership category do the other informal workers (i.e waste pickers, sex workers, farmers) belong?
7. What is the latest coverage rate of the informal workers (over the total number of the labour force)? Is it still low?
8. If yes, what could be the factors that contribute to low/high coverage/access of the informal workers in the NHIP?
9. What are the current strategies of Philhealth to address the low among the informal workers?
10. Can you explain more about the iGroup (formerly KASAPI) Program? How does it work?
11. Does Philhealth conduct information campaigns? When? Where? How and how often?
12. Are there any special benefits of the Program for the informal sector workers and their families? What are those benefits?
13. It is stipulated in RA10606 that those who are poor who belong in the informal sector can be partially subsidized by the LGUs. Do you have any idea on how the LGUs identify whom among the families in the informal sector will be subsidized? Are there guidelines from PhilHealth regarding this?
14. How does PhilHealth monitor the implementation of the program at the local level and ensure that policies are being implemented well?

Appendix E. Guide Questions Used During the Interview with the City Social Welfare and Development Officer

1. What are the roles of the LGU of this city in the NHIP particularly in covering the informal workers in the program?
2. How many families were subsidized by your office in the NHIP?
3. How does the LGU identify their sponsored members (i.e household characteristics)?
4. Can you describe the coordination and working relationship with the PhilHealth office? To what extent does the city government support the implementation of the program?
5. Are there any other projects or programs initiated by the city government that help achieving universal health care particularly on the informal workers and their families?
6. Can you identify issues and gaps in implementing the program in your city that can affect the coverage of the program?
7. Have you heard about the group enrollment program of PhilHealth (iGroup Program) for the informal workers who belong to organized groups?
8. As welfare officer, what can you suggest or recommend on how the NHIP can further increase its coverage for the workers in the informal economy?

Appendix F. SPSS Results: Chi-square Test of Independence between Wage (Quintile) and Informal-Type of Occupations

Head: Class of worker * Wage Quintile Crosstabulation

			Wage Quintile					
			Q1	Q2	Q3	Q4	Q5	Total
Head: Class of worker	Self-employed without any employee	Count	3.264E6	8.133E5	8.241E5	6.053E5	5.710E5	6.078E6
		% within Head: Class of worker	53.7%	13.4%	13.6%	10.0%	9.4%	100.0%
		% within Wage Quintile	82.0%	67.8%	74.0%	78.4%	71.5%	77.3%
		% of Total	41.5%	10.3%	10.5%	7.7%	7.3%	77.3%
	Employer in own family operated farm or business	Count	6.031E5	2.139E5	1.638E5	1.177E5	1.953E5	1.294E6
		% within Head: Class of worker	46.6%	16.5%	12.7%	9.1%	15.1%	100.0%
		% within Wage Quintile	15.2%	17.8%	14.7%	15.3%	24.5%	16.5%
		% of Total	7.7%	2.7%	2.1%	1.5%	2.5%	16.5%
	Worked with pay on own family operated farm or business	Count	4.189E3	1.625E5	9.319E4	2.688E4	1.695E4	3.037E5
		% within Head: Class of worker	1.4%	53.5%	30.7%	8.9%	5.6%	100.0%
		% within Wage Quintile	.1%	13.6%	8.4%	3.5%	2.1%	3.9%
		% of Total	.1%	2.1%	1.2%	.3%	.2%	3.9%
	Worked without pay in own family operated farm or business	Count	1.090E5	9.339E3	3.243E4	2.212E4	1.521E4	1.881E5
		% within Head: Class of worker	58.0%	5.0%	17.2%	11.8%	8.1%	100.0%
		% within Wage Quintile	2.7%	.8%	2.9%	2.9%	1.9%	2.4%
		% of Total	1.4%	.1%	.4%	.3%	.2%	2.4%
Total		Count	3.980E6	1.199E6	1.114E6	7.720E5	7.985E5	7.863E6
		% within Head: Class of worker	50.6%	15.2%	14.2%	9.8%	10.2%	100.0%
		% within Wage Quintile	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	50.6%	15.2%	14.2%	9.8%	10.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.895E5[a]	12	.000
Likelihood Ratio	5.846E5	12	.000
Linear-by-Linear Association	3.367E4	1	.000
N of Valid Cases	7863313		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 18469.95.

Source: Author based on PSA 2014

Appendix G. SPSS Output of the Regression Model

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	WAGE_final			7.621E4	4	.000	
	WAGE_final(1)	.067	.003	579.520	1	.000	1.069
	WAGE_final(2)	.657	.003	4.163E4	1	.000	1.929
	WAGE_final(3)	.301	.003	8.585E3	1	.000	1.352
	WAGE_final(4)	.145	.004	1.700E3	1	.000	1.156
	AGE			5.753E4	2	.000	
	AGE(1)	-.566	.005	1.288E4	1	.000	.568
	AGE(2)	.305	.002	3.452E4	1	.000	1.357
	Type_Occupation			2.910E3	3	.000	
	Type_Occupation(1)	.062	.005	144.060	1	.000	1.064
	Type_Occupation(2)	.157	.005	831.540	1	.000	1.170
	Type_Occupation(3)	.179	.006	763.871	1	.000	1.196
	EDUC			1.918E4	3	.000	
	EDUC(1)	-.684	.006	1.272E4	1	.000	.504
	EDUC(2)	-.276	.003	7.435E3	1	.000	.759
	EDUC(3)	-.135	.003	1.852E3	1	.000	.873
	SEX(1)	.210	.002	1.092E4	1	.000	1.234
	WPI(1)	-.966	.005	4.284E4	1	.000	.381
	Loan(1)	.284	.002	2.805E4	1	.000	1.328
	Constant	-.234	.008	944.205	1	.000	.791

a. Variable(s) entered on step 1: WAGE_final, AGE, Type_Occupation, EDUC, SEX, WPI, Loan.

Source: Author based on PSA 2014

Appendix H. Means Test of the Health Expenditures of Non-Paying and Paying Members

Group Statistics

	PhilHealth_IPP_Sponsored	N	Mean	Std. Deviation	Std. Error Mean
Health (Total)	Indigent/Sponsored	1610760	2517.34	15865.357	12.501
	IPP	959655	7711.45	19687.742	20.097

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Health (Total)	Equal variances assumed	80934.982	.000	-231.611	2570413	.000	-5194.110	22.426	-5238.064	-5150.156
	Equal variances not assumed			-219.458	1.695E6	.000	-5194.110	23.668	-5240.498	-5147.722

Source: Author based on PSA 2014