Lynchpin of Targeting:
Understanding the role of street-level bureaucrats in nationwide targeting for social health insurance

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Marie Elaine A. Ceralde
(Philippines)

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Andrew Fischer
Erhard Berner

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Disclaimer:

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Inquiries:

International Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

t: +31 70 426 0460
e: info@iss.nl
w: www.iss.nl
fb: http://www.facebook.com/iss.nl
twitter: @issnl

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

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List of Acronyms

4Ps	Pantawid Pamilyang Pilipino Program
BCC	Barangay Community/Characteristics
CBMS	Community-based Management System
DOH	Department of Health
DSWD	Department of Social Welfare and Development
DSWD-CCT	Department of Social Welfare and Development – Conditional Cash Transfer
FAF	Family Assessment Form
HIV-AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
IT	Information Technology
LGU	Local Government Unit
LVC	Local Verification Committee
MPDO	Municipal Planning Development Officer
MSWO	Medical Social Welfare Officer
NBB	No Balance Billing
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NGO	Non-Government Organization
NHIP	National Health Insurance Program
NPT-TPT	Near-Poor Threshold to Poverty Threshold
PCB	Primary Care Benefit
PCSO	Philippine Charity and Sweepstakes Office
PHDO	PhilHealth Desk Officer
PhilHealth	Philippine Health Insurance Corporation
PMT	Proxy Means Test
SWDO	Social Welfare Development Officer
SHI	Social Health Insurance
SOP	Standard Operating Procedures
TB-DOTS	Outpatient Anti-Tuberculosis Directly Observed Treatment Short-Course
UCS	Universal Coverage Scheme
VUP	Vision 2020 Umurenge Programme
WHO	World Health Organization

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Abstract

The Philippines' social health insurance, administered by Philippine Health Insurance Corporation (PhilHealth), was able to achieve almost universal coverage of the entire population. However, despite its commendable population coverage, it is still being underutilized, especially by the poor. This research investigates the effectivity of using targeting systems on social policies with universal nature by taking the case of social health insurance. Among other factors, eligibility criteria of the program are crucial in effectively translating coverage to utilization of benefits. The research uses the lens of street-level bureaucrats who are put in a critical position to identify eligible patients, and act as pseudo-targeters for PhilHealth. This is done by conducting literature review on academic debates and desk review of studies conducted on targeting in social health insurance, triangulated with interviews of street-level bureaucrats as key informants. A framework is proposed to analyse the role of street-level bureaucrats in targeting, while also looking into the factors affecting how they operate and its impact to benefits received by the poor. Using the framework, this research suggests that the street-level bureaucrats can be considered as a "lynchpin of targeting" in implementing social protection programs targeted to the poor. Due to the inefficiencies of Listahanan as the official targeting system, street-level bureaucrats make discretionary actions in order to cater the needs of their clients. By taking advantage of their discretionary measures together with relative autonomy they can exert, street-level bureaucrats are able to significantly influence targeting to the extent that they, in principle, *make* policies they are tasked to merely implement.

Relevance to Development Studies

In developing countries, social provision of goods and services are exceptionally challenging because of limited resources they have to work with. Nonetheless, this does not mean that they cannot and should not implement universal approach to social policies. Targeting mechanisms are believed to efficiently allocate available resources and is thus often used in universalistic systems of provisioning by the State, such as social health insurance in providing universal healthcare. However, the effectiveness of targeting systems remains in question. Eligibility should allow for equitable distribution favouring those vulnerable and marginalized in the country. Street-level bureaucrats are among the important actors in targeting beneficiaries for social protection programs. This research contributes to explaining why a social health insurance having been able to achieve universal coverage and committed to provide universal access by equitably targeting the poor with the assistance of street-level bureaucrats, still does not translate to optimal utilization of its benefits.

Keywords

Targeting, street-level bureaucrats, social health insurance, eligibility, PhilHealth, Philippines

Chapter 1
Introduction

This Chapter provides the context within which the research is conducted. This includes presentation of the Philippines' national health insurance, its targeting and implementation, and then focuses on the impact of street-level bureaucrats' participation in targeting. After which, the research question is presented; followed by the methodology which discusses methods, scope and limitations, ethical considerations, positionality and lastly, the structure of the paper.

1.1 PhilHealth: the irony of *targeted* national health insurance *for all*

The National Health Insurance Program (NHIP) is the Philippine's social health insurance that is designed to provide health insurance for all Filipinos. The institutionalization of NHIP in 1995 is complemented with the establishment of the Philippine Health Insurance Corporation (PhilHealth) to administer the program. The law[1] mandates PhilHealth to provide universal financial access to healthcare by giving a basic minimum package of benefits (RA 7875, Sec. 1, b.) to the identified beneficiaries.

Over the past decades, the system seems to have improved in terms of population coverage, expansion of benefits and accreditation of health facilities where patients can avail their PhilHealth benefits. Population coverage is almost universal at 98 percent coverage reported by PhilHealth in 2018 (from 79 percent in 2013), while National Demographic and Health Survey (NDHS) shows 66 percent in 2017 (from 60 percent in 2013).

In 2013, PhilHealth adopted the official list of poor people in the country from Listahanan[2], and started its targeted programs for the poor. Before this, program coverage is only at 84 percent of the entire population, wherein 45 percent of which are the poor in 2012. In 2014, the total program coverage increased to 87 percent where more than half (53 percent) of its enrolled members are poor (PhilHealth Stats & Charts).

However, healthcare needs of people, especially the poor, remain highly underserved (Cabalfin 2016). The targeted poor are enrolled in PhilHealth either as Indigent members or Sponsored Program members. Out of the population sample studied (Faraon 2013:70-71), more than a third of the household has still at least one case of PhilHealth underutilization, wherein the Sponsored Program members have the most instance of underutilization.

Moreover, despite the almost universal coverage, the utilization rate of PhilHealth benefits remains low at eight percent in the 1st quarter of 2018, even lower than 12 percent rate in 2017 (PhilHealth Stats & Charts). Such level of utilization is deemed low compared to the improvement of healthcare use in Thailand after its implementation of Universal Coverage Scheme (UCS). Since implementation of UCS in 2001, out-patient utilization rate increased by 31 percent, from 2.45 visits per member in 2003 to 3.22 in 2010; while in-patient utilization increased by 23 percent, from 0.094 in 2003 to 0.116 in 2010 (WHO 2013:13; McManus 2012:75-76).

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[1] RA 7875, "National Health Insurance Law of 1995" as amended by RA 9241 in 2004, and RA 10606, "National Health Insurance Act of 2013"

[2] Listahanan is a targeting system that uses proxy means testing to identify the poor. Further discussions in Chapter 3.

1.1.1 Street-level bureaucrats in PhilHealth

Despite PhilHealth's universal coverage and targeted programs for the poor, the country has yet to achieve its health targets and indicators because of the issue of underutilization. Several studies show that the program implementation still faces challenges in effectively providing PhilHealth benefits to the people (NEDA et al., n.d.; Quimbo et al. 2008; Diosana, n.d.; Faraon 2013). In particular, Querri et al. (2018) highlighted that the effect of inaccurate targeting of the poor using Listahanan does not guarantee equitable access to PhilHealth programs. Because of the deficiencies in the system (i.e. inclusion/exclusion errors, over-counting the poor), the most vulnerable (i.e. homeless, families in far-flung areas, workers in the informal sector) are left without PhilHealth coverage.

Several studies have been conducted assessing the effectivity of Listahanan in reaching the poor, and eventually extending PhilHealth benefits targeted to them (NEDA et al., n.d.; Quimbo et al. 2008; Cabalfin 2016; Dayrit et al. 2018; Manasan 2011; Picazo et al. 2015). However, there had not been any research solely focusing on how the targeting of the poor are conducted –more so on the role of street-level bureaucrats in targeting schemes. This research will focus on the process of targeting of PhilHealth members at the local level, where street-level bureaucrats such as the Barangay Captain, barangay health workers and PhilHealth desk officers designated in health facilities play a crucial role in the identification of eligible members of PhilHealth both in Indigent Program and Sponsored Program. Barangay officers are responsible in the enrolment of their workers, scholars and volunteers. Health workers and PhilHealth desk officers are actors that the poor interact with on a daily basis. They are involved in the end-to-end process starting with information dissemination on benefits, guidance on enrolment process, until claiming of benefits. Barangay-level officials, together with the DSWD-CCT staffs are among the top sources[3] of information of the poor with regard to PhilHealth and their benefits. PhilHealth officers deployed in health facilities are the second source of information by the poor (Bredenkamp et al. 2017). Thus it is important to investigate the implementation at their level if they really are the "lynchpin of targeting" because they are the first line of service providers that the poor goes to for healthcare needs, as well as the first line of 'targeters' who determines their eligibility.

1.2 Research objectives and questions

The main objective of this research is to understand the role of street-level bureaucrats in targeting the poor. Specific objectives include assessment of effectivity of targeting systems used in PhilHealth to identify the poor –highlighting the effect of street-level bureaucrat participation in the process; and then further understand the factors that influence street-level bureaucrats' behavior in the performance of their duties.

[3] Both the local level officers (Barangay officer, Community health team) and the DSWD staff with CCT program (Municipal link, CCT members, Parent leaders, announcement in Family Development Sessions) are the top sources of information on PhilHealth coverage and benefits. Other sources include PhilHealth sources (staff in health facility, upon release of MDR) and social network (friends, employer, relatives, neighbor).

To achieve these objectives, I will answer the main research question and sub-questions stated as follows:

Research question:

To what extent can street-level bureaucrats impact targeting systems in social programs?

Sub-questions:

1. How effective is the targeting system implemented in PhilHealth?
2. What are the factors influencing street-level bureaucrats' ability to attend to their clients' needs?
3. How do street-level bureaucrats influence the targeting in social health insurance for the poor?

In this paper, I will attempt to answer these three sub-questions to understand how significant is street-level bureaucrats' impact in implementing PhilHealth programs for the poor. First, knowing if the targeting system works well in identifying targeted poor beneficiaries of PhilHealth helps understand if the selection process and the categorization of members affect program effectivity. Second, having a clear comprehension of the reasons behind how street-level bureaucrats operate establishes the significance of their role in catering appropriately to the poor's needs. Lastly, upon validating their vital role, I will look into how they influence who gets what, as well as how they impact the breadth and depth of benefits the targeted beneficiaries get from the participation of street-level bureaucrats in the targeting for PhilHealth programs.

1.3 Methodology

1.3.1 Desk review, meta-analysis of relevant studies and interview with street-level bureaucrats

In able to answer the aforementioned questions, I have employed qualitative approach to explore interactions, processes, and lived experiences among individuals, institutions and systems in which they are a part of (O'Leary 2004:113). Specifically, thematic analysis (2004:196) was done to organize the information gathered from different sources. Base from literature and interviews, themes emerged such as eligibility gained via targeting tool, and discretionary behavior of street-level bureaucrats. It helps explain the bigger dilemma on why despite universal coverage, utilization remains low –specifically through the lens of street-level bureaucrats. To ensure triangulation of data and findings, three methods were employed: desk review of policy and program documents and reports, meta-analysis of relevant studies, and key informant interviews.

Policy documents such as Republic Acts, Implementing Rules and Regulations, PhilHealth Office Circulars[4], Department of Health (DOH) reports, PhilHealth Citizens Charter are reviewed. Publicly available national database such as the NDHS, and reports such as administrative data from PhilHealth and local government are also reviewed. These documents are vital in answering the first sub-question on effectivity of targeting in PhilHealth, as well as understanding policy goals and program design.

[4] See Appendix 1 List of PhilHealth Office Circulars reviewed

Meta-analysis of qualitative studies is "the aggregating of a group of studies for the purposes of discovering the essential elements and translating the results into an end product that transforms the original results into a new conceptualization" (Schreiber et al., in Timulak 2009). In this regard, it differs from secondary data analysis which uses existing data from other studies to analyse a new research question (Popay et al. 1998 in Heaton 1998). I have compiled and assessed the evidence of related studies on effectivity of Listahanan in targeting Indigent beneficiaries of PhilHealth, to inform the first sub-question; and studies on how street-level bureaucrats *make* the policy as they implement it in such a way that is in line with the policy goals but with modified approach adjusting to their capacity and their clients' demands, informing second and third sub-questions. Literature reviewed include health insurance studies, PhilHealth performance evaluation reports, academic debates on targeting, universal provision and street-level bureaucracy.

Lastly, key informant interviews were conducted to validate and further contribute to the empirical findings of earlier studies. Interview participants include street-level bureaucrats such as Barangay Captains, barangay health workers and PhilHealth desk officer in health facilities. Details of interviewees are coded in Table 1.1 below. Aside from PhilHealth desk officer, all other respondents prefer not to be named in this research.

Table 1.1 List of key informant interviewees

No.	Name / Position of interviewees	Institution	Code of interviewees	Time of interview
1.	Barangay Captain	Barangay Pinagkaisahan	BC 1	August 14, 2019 12:30 pm
2.	Barangay Captain	Barangay Kamuning	BC 2	August 20, 2019 9:00 am
3.	Ms. Elinel Buenaventura / PhilHealth Officer	Clearbridge Diagnostic Center	PHDO	August 14, 2019 9:00 am
4.	Barangay Health Worker	Barangay Kamuning	BHW	August 20, 2019 8:00 am

These community experts have the knowledge and understanding of what is happening and how social programs for the poor works in their community. They are able provide information and valuable insights on rules-in-use practiced at community-level (UCLA, n.d.). With this method, I was able to study the practice of targeting in PhilHealth programs for the poor using the lens of street-level bureaucrats through their everyday experiences in servicing their clients. Interviewees include both Barangay Captains of Kamuning and Pinagkaisahan, one barangay health worker in Kamuning, and a PhilHealth desk officer in a dialysis center. Interviews have been conducted through video conversations with participants using either Viber or Messenger video calls, each lasted for at least an hour. Interviews with the PhilHealth Corporate Planning Department and PhilHealth desk officers from public and private general hospitals were planned and requested, however, their schedule did not permit. Since I was dealing with street-level bureaucrats, I had to go through a bureaucratic process of sending an official request and official approval from the PhilHealth head office with regard to interviewing the PhilHealth regional office and its desk offices. A more political bureaucratic approach was experienced with coordinating with local officers. I had to go through a gatekeeper from these barangays to successfully conduct interview and gain access to their administrative records.

1.3.2 Scope and limitations

This research focuses on the actors involved in targeting for PhilHealth Indigent and Sponsored Program members, instead of the targeted beneficiaries. In understanding how street-level bureaucrats function, this research will explore their role specifically only in targeting poor members for PhilHealth and determining their eligibility to exclusive benefits (NBB, PCB, TB-DOTS[5]) for the poor.

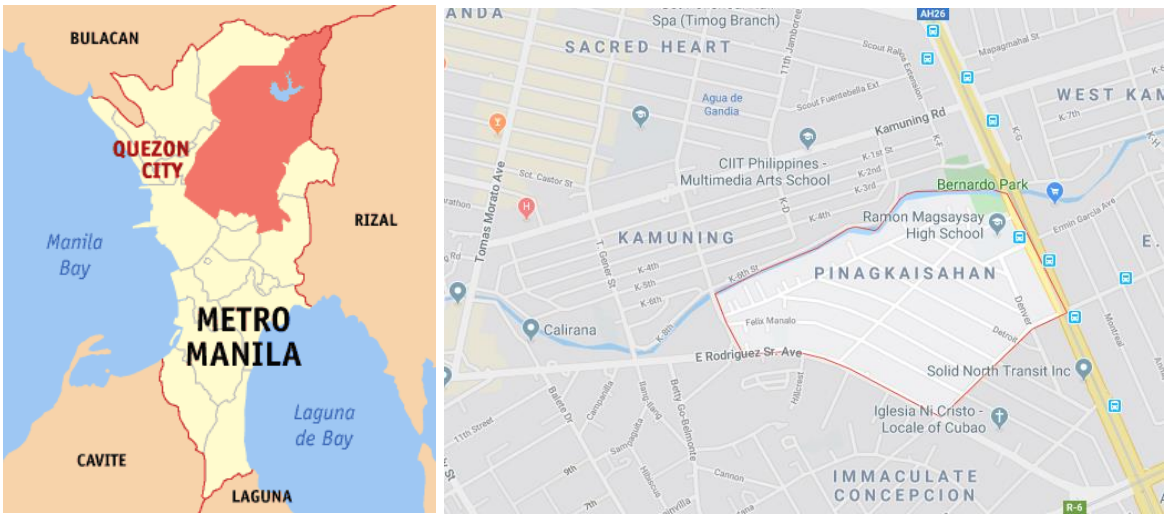
I have decided to focus my research within the urban setting in Quezon City, Metro Manila allowing me to control for geographic and transportation factor causing underutilization. Hospitals and health facilities are concentrated to Metro Manila and neighbouring cities.[6]

Barangay profiles

Quezon City is a landlocked city with land area occupying 25 percent of the National Capital Region with 166 square kilometres, and population of 2.9 million residents[7] representing 23 percent of total population of the region (PhilAtlas). It has young population with median age of 26 years. It is categorized as highly urbanized city with the highest income-earning city in the country in 2007. On the other side of the coin however, the city houses numerous pockets of poverty with 40 percent of its households belong to lowest income deciles (World Bank Assistance to Quezon City), most likely due to economic migration towards the business center.

Within Quezon City, I have chosen two adjacent barangays –Barangay Kamuning and Barangay Pinagkaisahan, as seen in Map 1.1.

Map 1.1 Map on location of Quezon City in Metro Manila,
and map of Barangay Kamuning and Barangay Pinagkaisahan



Source: Wikimedia Commons; Google Maps

These barangays have several accessible public and private hospitals, as well as pockets of poverty, which are two important criteria in this research. Kamuning has a population of

[5] No Balance Billing (NBB) policy, Primary Care Package (PCB), Outpatient Anti-Tuberculosis Directly Observed Treatment Short-Course (TB-DOTS)
[6] See Appendix 2 Heat map of health facilities nationwide
[7] Population count as of 2015 Census

15,000 residents; while Pinagkaisahan has a smaller population of just below 7,000 residents, which are 0.53 percent and 0.24 percent of Quezon City's population, respectively. Majority of the population of both barangays are aged 15 to 40 years, consistent with the city (PhilAtlas). Barangay Kamuning has an estimate of 3,500 residents (23 percent of barangay's population) in identified depressed areas of Bernardo Park Compound, K-6th Silangan and #113 Kamuning Road Compound. There is one general hospital in Kamuning, Dr. Jesus C. Delgado Memorial Hospital, which is a private hospital. Public health facilities include Kamuning Super Health Center, which is a rural health unit and three other clinics (Barangay Profile; National Facility Health Registry v2.0). Barangay Pinagkaisahan has two public health facilities –Bernardo Health Center and Bernardo Social Hygiene Clinic (Community Profile; National Facility Health Registry v2.0). Both barangays have also easy access to at least five nearby public hospitals in their adjacent barangays including National Children's Hospital, Philippine Heart Center and National Kidney and Transplant Institute, Lung Center of the Philippines, and Philippine Children's Medical Center, which are all less than 3 km away from them.

Limitations and challenges

In the conduct of this research, limitations and challenges have manifested in two aspects –data gathering and interviews with key informants.

Disaggregated data at the barangay level is necessary to fully comprehend the level of access of the poor in using PhilHealth benefits targeted to them. Despite the existence of the national official databases such as the National Demographic and Health Survey[8], data at barangay level is not readily available and cannot be produced in time for the research. Unfortunately, even upon request with barangay offices for their local administrative data, information on PhilHealth utilization is also not available at their level. However, Barangay Kamuning was able to give a number of PhilHealth cards distributed, but starting only from 2018. It was because the current Barangay Captain just took over the position that year, and there was no turnover of documents from the previous administration. No data is available regarding PhilHealth from Barangay Pinagkaisahan.

In the coordination and conduct of interviews, there are several logistical and political challenges experienced during the research. I was limited to conduct the research from the Netherlands. The review of relevant studies and academic debates remotely is manageable; but follow-up on data requests, getting key informants to agree for interviews, and actual conduct of interviews with them is a struggle. The bureaucratic process adds another layer of complication, as discussed earlier. It was challenging to coordinate with PhilHealth head office on data requests and schedule video interview considering that at the time of request, the office has been busy with deliberation of budget hearings and is frequently being called to Senate public hearings for management and financial issues. With this, I resorted to sending my interview questions and just get their response. Several PhilHealth desk officers contacted are vocal in their hesitation to participate in an interview worried that they do not know the answer to the questions. Similarly, the Barangay Captains and health workers are also hesitant for the same reason but officials' hesitation is more on the perception that they are being policed and monitored on their operations. During the interviews, I encountered a technical challenge of slow internet connection with my respondents in the Philippines. This affects the flow of our discussion and worse, hampers us from having a decent conversation. Nevertheless, I was able to conduct successful interviews even if I was not able to talk to all of my target respondents.

[8] The NDHS is a national survey that contains PhilHealth utilization and membership among the poor, among others.

1.3.3 Ethical considerations

Considering that my research tackles the workings in the health sector, the doctor-patient privilege is highly imperative. In conducting my interviews, I had been very mindful not to ask specific health conditions about the patient that would identify the person. Instead, I focused on details on instances how a patient become eligible to benefits for indigents and able to gain access on these.

On a broader perspective, I first made sure to establish a respectful environment between the researcher and the participant in conducting my interviews. I have expressed my gratitude for their willingness to spend time and share their thoughts and knowledge on my research. At the beginning of the interview, I explained the purpose of the study to participants, their role in the analysis of PhilHealth targeting for the poor, and how the information gathered from them will be represented in my research. Before recording our conversation, I made sure to get their consent, and also asked if they are comfortable to be identified as key informants. Local officers are comfortable in being identified, while the PhilHealth desk officer prefers not to be named.

The guide questions I used were phrased in a particular tone so that it does not pre-empt the response of key informants. The conduct of interviews was generally flexible to allow respondents' own flow of thought be expressed during the conversation. It also allows to elicit honest insights in their everyday experience at work.

1.3.4 Positionality

Aside from being a researcher, I am part of National Economic and Development Authority (NEDA), a government planning agency that generally supports targeting systems to efficiently allocating limited resources. In conducting this research, I am aware of this prejudicial bias towards targeting. Instead of entirely dropping the government's hat, I have utilized my knowledge of how the Listahanan targeting is designed and envisioned to be implemented, vis-à-vis the actual practice on the ground. This allows me to better establish connection of how the targeting system affects behavior and management style of street-level bureaucrats in managing eligibility criteria on PhilHealth benefits.

Being affiliated with NEDA, I was able to course my initial communications thru official letters to head of agencies requesting for data and interview with their frontline service providers. Official communications gave me advantage that they will not disregard or immediately decline my request. However, as an outside researcher from the two barangays, it was hard at first to convince the local leaders to participate. Utilizing my social capital, I was able to find someone who assisted me in following-up coordination and data requests from them.

Being a public servant, the PhilHealth desk officer are more open to sharing their experiences in servicing their clients. They openly expressed their struggles in SOPs of filing claims in PhilHealth because of the perception that I can somehow help them flag their concern with higher policy makers. However, despite my empathy with their issues, I was conscious not to promise drastic action to address their concerns.

In conducting this study, my appreciation has expanded from just seeing PhilHealth implementation from a policy maker's perspective but also understanding the nuances of policy implementation through local bureaucrats' experiences.

1.4 Structure of the paper

This paper is organized in five parts. Chapter 1 provides the introduction to the research with discussion on PhilHealth and street-level bureaucrats in PhilHealth. Then the research objectives and questions are stated, followed by methodology used including scope and limitations, ethical considerations and positionality of the author. Chapter 2 explains the concepts used in the research as well as discusses the framework constructed in order to analyse the data appropriately. Chapters 3 and 4 presents the analysis on targeting system in the Philippines, and on street-level bureaucrats' role in PhilHealth targeting. Lastly, Chapter 5 states the conclusions of the research and the policy recommendations accordingly.

Chapter 2
Concepts and Framework

This Chapter explains concepts and framework necessary in the analysis of data gathered from relevant documents on targeting and health insurance, and interviews with implementers. The concepts such as universalism, social health insurance and street-level bureaucracy, are discussed accordingly in relation to the research. With this, I have formulated an analytical framework that will be utilized in the next chapter.

2.1 Debates on universalism and targeting

> "The debate essentially refers to the challenges of treating people the same while at the same time differentiating them in order to redistribute income and wealth across society, and to address disadvantage and discrimination. […] The challenge remains with regard to how to treat poor people the same as anyone else, without stigmatisation or segregation, while at the same time differentially directing resources towards them […]" (Fischer 2018: 221, 223)

As clearly stated by Fischer (2018), these polarized approach in implementing social policy revolves around how to effectively bring about development to the people. The debate emerges because of the ideological shift in perceiving social policy as a means towards poverty reduction instead of achieving holistic development. At its best, social policies should serve not only as an instrument of development, but also as a guarantee that the development process will ensure wide range of "ends" of development. This entails that the pursued development, as well as in its pursuit, benefits everyone regardless of their income level, gender, age, economic contribution (formal or informal sector, reproductive economy), among others.

Social policy with a universalistic approach is highly driven by the ideologies of equality and citizenship. In this case, provision of social programs operates considering the principles of needs, rights, and citizenship. While targeted provision of social services are implemented if social policy is appreciated with having just marginal role in development (Mkandawire 2005). Social programs are directed specifically to the poor, with the logic of maximizing efforts and resources on public provision to ensure the development of the most vulnerable sector in society.

On one hand, the concept of universalism has been interpreted at various levels of 'universality'. As for one, the World Bank takes position that universalism is achieved provided that "everyone has access to something regardless of how it is delivered". Similarly, many countries define universalism as equivalent to coverage, regardless of how generous or equitable the provision is (Martinez Franzoni and Sanchez-Ancochea 2016). Especially in health systems, universal healthcare is tantamount to universal health coverage, wherein entire population is covered and in principle, have access to health services. However, a broader perspective of universalism is suggested at systemic level. Universalism is not just about universal population coverage. Universalism pertains to the interaction among guiding institutional principles of access and coverage, cost of service provided, and financing scheme (Fischer 2018). In terms of access and coverage, universal provision is characterized by integrated systems where public and private does not compete but complement in providing services. The two other dimensions of universalism are highly relevant to PhilHealth as the social health insurance of the country. Both the cost of social services and financing for the system are pooled and internalised so that the cost will be distributed over

time and among users instead of paying exact cost at time of use –as should be the case of PhilHealth system. However, because of the strong evidence on 'crisis of universalism', development partners and international financing institutions have then taken the opportunity to promote targeting schemes to their recipient countries.

On the other hand, targeting or poverty targeting is defined by international financing institutions as the use of policy instruments to channel resources towards a target group within the entire population (Weiss 2005). It is essentially identifying specific recipients of social programs for the purpose of gathering information on their situation, assess their needs, and eventually provide appropriate services for them. Targeting can be done in 4 ways: by activity (i.e. primary healthcare and primary education), by indicator (i.e. income level, asset ownership, and number of children in the household), by location (i.e. residence of target beneficiaries), or by self-targeting (i.e. benefits are attractive only to the poor) (ibid.). The appeal of targeting is hard to resist specially as aid donors market targeting to developing countries with fiscal constraints. Targeting has been persuasive with its promise of accurate and cost-effective mechanism in providing for the poor. Targeting is also perceived as a social policy instrument for the 'redistribution' of resources on society (Mkandawire 2005:5). The state provides for these deserving targeted beneficiaries using public expenditure, which is funded thru taxes. With targeted efforts, there is this perception that there is more poverty-reducing impact if transfers are concentrated to the poorest members of society (Fischer 2018:225). Since the implementation of targeted programs for the poor, targeting schemes seems to be less effective in affecting poverty reduction compared to universal approach to social provision. Hence, the cycle on universalism and targeting continues.

This research is concerned with the seemingly misguided conception of universalism in implementing PhilHealth programs as a tool towards achieving universal healthcare in the country. PhilHealth, as the Philippines' social health insurance, is designed to provide universal healthcare thru universal coverage and access for all. Ironically, despite PhilHealth's universal nature, it provides benefits depending on membership eligibility criteria in delivering benefits and healthcare services.

2.1.1 Critiques on targeting

The critique with regard to targeting errors and institutional capacity of targeting will be thoroughly discussed as these are the most relevant in understanding targeting schemes and role of street-level bureaucrats as local policy implementers. Aside from these two, other important critiques on targeting will be enumerated and briefly explained.

Targeting errors

Targeting involves assessment of individuals with respect to a threshold (usually poverty line) of who are deserving or not deserving (poor or non-poor). Generally, there are two possible types of error: Type I error (exclusion error) and Type II error (inclusion error). Type I error occurs when a poor candidate is excluded from being selected to be in the program, while Type II error occurs when a non-poor candidate is included and hence receives benefits from the program (Mkandawire 2005).

Kidd and Athias' study (2019) on 38 social protection schemes in 23 developing countries shows that proxy means testing is far from accurate and cost-effective in targeting the chronic poor, despite World Bank claims. Furthermore, targeted programs for the poor are not only failing to accurately identify its intended population which the program would cover, but also failing to reach the poorest class in society. Not only that poverty-targeting programmes are not accurate, it further concludes that universal and affluence-tested schemes are more effective. The study boldly claims that universal and affluence-tested

schemes are much more effective than poverty-targeted programmes in reaching both intended recipients and the poor. Affluence-tested schemes exclude the non-poor from the entire population, and considers the residual population the recipients of the social assistance program. Based on the study, there is high inclusion and exclusion errors in creating registries of the targeted category. The best estimate done so far is with Brazil's Bolsa Familia with 44 percent exclusion using simple means-test; while the worst are 97 percent error in Rwanda's Vision 2020 Umurenge Programme (VUP) using community-based targeting; and 96 percent error in Guatemala's Mi Bono Seguro scheme using proxy-means test. More specifically on the lack of effectivity of poverty-targeted schemes, only the Philippines' Pantawid Pamilya were able to reach half of the poorest 20 percent of its intended category. Worst cases are Uzbekistan's Low-Income Allowance and Rwanda's VUP with 98 percent and 97 percent errors respectively. Study result shows that poverty-targeted programs are excluding over half of the poorest quintile of their intended category, is consistent among the countries studied. An alternative approach to targeting was implemented to South Africa's social grant programmes. Instead of targeting the poor population (which is majority of the population), the scheme excludes who are deemed better-off, hence should not be included in the program. The study concludes that semi-universal, or high coverage schemes are much more effective in reducing extreme poverty (at least 90 percent of the poorest 20 percent were reached) than the commonly practiced poverty-targeted schemes.

High errors may be a combination of asymmetric information and weak institutions. Asymmetric information transpires when potential beneficiaries surveyed does not declare their true economic or social status during survey interview (Mkandawire 2005; Weiss 2005). Incorrect data gathered contributes to the targeting errors, and consequently leads to incorrect program design for the targeted population. Mkandawire (2005) declares that the probability of committing these two errors are even greater in developing countries where institutions are generally weak.

Institutional capacity

In this section, I will only discuss thoroughly the administrative institutional capacity of the public sector, considering it is the relevant aspect with regard to the role of street-level bureaucrats in targeting and implementing PhilHealth. Financial institutional capacity will be briefly discussed in the next section together with all other critiques on targeting.

The introduction of targeting schemes, in effect, redirects focus of social policy makers and implementers from directly addressing poverty in general, to establishing a targeting tool first and then just provide assistance to those deemed worthy of the public social assistance. As evidenced by Oxley, Dang, Föster, and Pellizari (2001, in Mkandawire 2005), when using targeting approach, the efforts are more focused on establishing 'appropriate' institutions that can administer targeting, rather than the actual provision of social assistance, which has more impact on poverty reduction. Moreover, efforts are more exerted on improving the accuracy and efficiency of targeting system, rather than directing the time and financial resources to improve the quality (i.e. support value of PhilHealth, and cash grants in conditional cash transfers). Since the launch of Listahanan in 2011, the government had even engaged in development loans[9] for technical assistance to improve the targeting design of the proxy means test being used. This resulted to formulation of two layers of estimates on PMT models for the second round of Listahanan –one for income estimates, another for minimising errors. However, the grants provided to beneficiaries of the Pantawid Pamilya program, wherein the Listahanan targeting was used, have not increased since it piloted more

[9] World Bank Project ID: P082144 (USD 405 million); Asian Development Bank Project Number: 43407-013 (USD 400 million)

than 10 years ago. The grants remained at maximum of Php 2,000 (~Eur 35) per household per month, hence eroding its support value due to annual inflation.

Other aspect of critiques on targeting

Other critiques on targeting include refuting its cost-effectivity, resulting to dual structure and stigmatism, questioning its political feasibility, and promoting perverse incentives. Even if the amount of financing reduces due to smaller number of targeted recipients, additional costs are incurred in order to create 'appropriate' institutions for targeting to work (Mkandawire 2005; Dutrey 2007). Being identified as a recipient of social programs, these beneficiaries are also being labelled and stigmatised as poor and needy, which in some cases adds to their vulnerability. Targeting also creates dual structure, wherein one aimed at the poor is funded by the state and the other for the well-off served by private sector. In effect, poor benefits are provided to poor people (Mkandawire 2005; Sen 1995:14 in Mkandawire 2005; Titmuss 1968), wherein they are not un-serviced but are treated differently (Fischer 2018:222). Targeting also severs cross-class solidarity and interests (Fischer 2018) among different stakeholders in society. Moreover, it is a challenge to gain political support from the middle class to use some of their taxes to provide for the targeted beneficiaries of the program. Such social divide is even exacerbated by the use of foreign aid for its implementation. In reality, targeting exercise became more of an activity to disburse donor funds, rather than utilizing local resources (Dutrey 2007; Mkandawire 2005:8). Lastly, targeted programs are assumed to result to perverse incentives (Mkandawire 2005; Fischer 2018). Perverse incentive is the idea that the support for the poor will encourage indolence and mendicancy among beneficiaries. This also affects the economic contribution of the poor thru availability of their labor in the market. The poor might opt not to work to the point that it increases their income and might go over the threshold and lose the assistance.

2.2 Social health insurance

> "Social Health Insurance (SHI) is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other." (WHO 2003)

While we now appreciate social health insurance (SHI) as the World Health Organization (WHO) has defined it a decade ago, the concept of social health insurance can be tracked back to 1883. It is when Germany integrates all voluntary structures of health financing into a mandatory state-supervised scheme (Saltman and Dubois 2004: 21; Bump 2015: 30).

Over time, there had been shifts in three aspects of social health insurance –coverage, purpose/benefit, and payment schemes. The coverage of initial SHI schemes only includes small number of workers in a particular economic activity, and then eventually expands to almost all residents, or at least those who are below the threshold. The purpose of insurance and the benefits provided transitioned from being wage replacement and death benefit to payment for healthcare services (outpatient treatments and inpatient hospital care) and drugs and medicines. Lastly, payment schemes shifted from voluntary worker cooperatives to mandatory legislation supervised by the state. (Saltman and Dubois 2004)

With the age of development aid, social insurance is packaged as one of the components of social protection which international development organizations are promoting. Social protection aims to protect people from crisis and shocks during their lifetime. Other components of social protection include social assistance/ safety nets and labor market programs. Social insurance is usually contrasted with social assistance. While social insurance is characterized by requirement to pay some amount as premium contribution for the mutual

fund; social assistance is a welfare provisioning for the vulnerable group promoting equity among its citizens (World Bank 2012; ADB 2003; SDC Resolution No. 1 Series of 2007).

The objectives of social health insurance are to achieve population coverage, to provide financial protection at point of need, and to enable access to quality and affordable healthcare services (WHO 2010). During the 2003 Regional Expert Group Meeting on social health insurance, different concerns on social health insurance were raised. Countries without universal coverage struggle with attaining substantial population coverage. While for those countries who have almost reached universal coverage, concerns were about financial sustainability, quality of care, equity issues, among others.

2.2.1 PhilHealth program design

As a social health insurance, PhilHealth is responsible for the enrolment of all Filipino citizens, collection and management of premium contributions, and purchasing of quality and affordable healthcare services for its clients. PhilHealth implements the social protection program that provides financial aid on health expenses towards achievement of universal access to healthcare. As mandated by RA 7875 (Sec. 3), PhilHealth should administer NHIP to provide all citizens with mechanism to help people pay for health services. However, despite the universal nature of its goal, PhilHealth prioritizes the provision of financial access to the poor, who are those in segment of the population who cannot afford such services; hence, the need for their identification and targeting.

Program details on enrolment process and requirements, eligibility criteria, benefit package, and financing per relevant PhilHealth member sector are presented using Table 2.1 below. The table emphasizes the program design on Indigent and Sponsored Program members by contrasting it with members in the formal economy. Moreover, partner institutions and other options for health financing is also briefly explained.

Table 2.1 PhilHealth program design

Member sectors	Enrolment	Eligibility criteria	Benefits	Financing
Members in the formal sector	Employers	Employed	All regular benefits	50% employer, 50% employee
Indigent members	DSWD/ PhilHealth office	- Included in Listahanan list - Certificate of Indigency	- All regular benefits - PCB package - No Balance Billing policy	Full national subsidy
Sponsored Program members **A. LGU**	Barangay office	N/A	- All regular benefits - PCB package - No Balance Billing policy	National and local government
B. Government hospitals	Point-of-Care enrolment	Assessed by MSWO/SWDO/ PHDO[1] as poor	- All regular benefits - PCB package - No Balance Billing policy	National government and public health facility

[1] Medical Social Welfare Officer (MSWO)/ Social Welfare Development Officer (SWDO)/ PhilHealth Desk Officer (PHDO)

Source: Author's synthesis using RA 9994; RA 10606; RA 10351; Revised IRR of RA 7875; PhilHealth Annual Stats and Charts; PhilHealth OC 2017-0017

Enrolment process

PhilHealth, being a social program, accommodates everyone to be registered and enrolled in their insurance scheme. Enrolment is implemented in several mechanisms using different tools to accommodate the different capacity and health needs of everyone. In general, an individual can apply for PhilHealth membership through the PhilHealth Local Insurance Office in their municipality. Since its establishment, the enrolment of members from the formal economy was the most convenient to implement. Employers in the formal economy applies for the enrolment of their employees. Aside from the regular enrolment process, there are several other ways using poverty-targeted enrolment such as automatic coverage of indigent senior citizens, persons with disability, orphans and Listahanan poor households, sponsored membership under local government unit enrolment, and Point-of-Care enrolment through government hospitals.

In general, all applicants should at least submit the basic requirement of accomplished Member Registration Form[10]. In some cases, supplementary documents are required to finalize the enrolment (Revised IRR of RA 7875).

In 2013, a large scale automatic coverage is conducted with the adoption of the list of poor households as identified using the Listahanan targeting system of the Department of Social Welfare and Development (DSWD). In its first year, 21 million members and dependents were initially enrolled in PhilHealth as Indigent members, which increased to 34 million in 2018 (PhilHealth Stats and Charts). The list of identified poor is endorsed by the DSWD National Household Targeting Office to PhilHealth Head Office, whereby the latter will forward the list to respective regional offices for initial processing (verification as indigent and tagging as new enrolees who are not yet enrolled as sponsored members, or members of informal economy).

Enrolment through Sponsored Program is another tool for improving PhilHealth coverage that is targeted to the poor. Upon enrolment, sponsored membership is only paid for a year of premium contributions. Most of the members under this category is either sponsored by their local government or by the government hospital where they are confined[11].

Sponsored membership through the Point-of-Care enrolment are offered to patients who are not yet member of PhilHealth and is assessed by hospital's social worker as poor, but is not included in the Listahanan. Point-of-Care enrolment is only available in government-owned hospitals and health facilities. Point-of-Care enrolment allowed for 'critically poor' needing medical services to be accommodated even not listed in Listahanan but is assessed by Medical Social Welfare Officer (MSWO) as incapable to pay for services needed (Picazo et al. 2015:21). The MSWO or DSWD Social Welfare Development Officer assesses prospective sponsored member/indigent patient in granting eligibility to be a sponsored member thru Department of Health (DOH)-owned hospitals. Dayrit et al. (2018) notes that the POC is approved by the PhilHealth board in recognition to the limitations of Listahanan in fully covering the poor. The This allows the poor to be eligible to same benefits available to Listahanan-poor, despite being excluded from the list.

[10] See Appendix 3 Member Registration Form

[11] Premium contributions of Sponsored Program members may also be paid for by the DSWD (for vulnerable groups under the care of their institutions or accredited institutions), by another private entity, or by another individual.

Eligibility criteria

In general, any individual can enrol to PhilHealth in order to be covered by the national social health insurance. For the formal economy workers, they are immediately endorsed by their employers for enrolment upon hiring. For a poor person to be enrolled under the Indigent Program, he/she must be in the list of poor households identified in the Listahanan; otherwise, he/she should present a Certificate of Indigency upon application. For LGU-sponsored members, the local government regularly enrols their barangay health workers, nutrition scholars, barangay tanods, and other barangay workers and volunteers (Cabalfin 2016:6). Point-of-Care enrolment requires that the patient is assessed by the MSWO/SWDO as poor, despite not being included in the official list in Listahanan.

Benefits

PhilHealth benefits are divided into two categories: inpatient and outpatient packages[12]. In addition to all the benefit packages available to all members, PhilHealth also offers programs targeted to the poor. This includes Primary Care Benefit (PCB) package and No Balance Billing policy.

The PCB covers conditions such as pneumonia, urinary tract infection, upper respiratory tract infection, asthma, etc. Services covered by PCB includes consultations, blood pressure measurements, clinical breast examination; and diagnostic examinations on blood count, urinalysis, fecalysis, x-ray, etc. The PCB package can be availed by going to a Local Health Insurance Office and be assigned to PCB provider (rural health unit, health center, government hospital).

The No Balance Billing policy launched in 2011 ensures that 'no other fees or expenses shall be charged or paid for by the indigent patients over and beyond the package rates during their confinement period' (PhilHealth Circular 2017-0017). It is further strengthened by the Implementing Rules and Regulations of the National Health Insurance Act of 2013, which emphasizes that 'all necessary services and complete quality care to attain the best possible health outcomes shall be provided to them' (Revised IRR of RA 7875, Sec. 43).

Financing

PhilHealth financing is paid for by premium contributions of its members. In 2017, premium payments from the Formal Economy has the highest contribution of 46 percent, while payments for Indigent and Sponsored Program members contributed 32 percent and 7 percent, respectively (PhilHealth Annual Report 2017).

Premium payments for Indigent members and Sponsored Program members are paid for by the national government and local government subsidies. Funds for indigent members are annually identified and appropriated in the General Appropriations Act, which is the country's national budget plan. Within the Indigent Program, premium contributions of vulnerable groups (i.e. orphans, abandoned and abused minors, out-of-school youths, street children, persons with disability, and battered women) under the care of the DSWD, or any of its accredited institutions run by NGOs or any nonprofit private organizations, are paid using DSWD annual budget (RA 10606, Sec 29-A).

Similarly, the local government unit (LGU) and government-owned hospitals also allocate funds from their annual budget to cover premium payments of their respective sponsored members. Premium sharing varies from one LGU to another. 'In some areas, the province pays for the entire LGU share. In other areas, the province and the

[12] See Appendix 4 Detailed list of PhilHealth benefits

city/municipality divides the LGU share of the premium subsidy between them' (Manasan 2011:9).

Partner institutions and other options on health financing

In order to effectively undertake their function, PhilHealth work together with their partner institutions and individuals. Their partners generally include healthcare providers, service providers, employers and collecting partners. Healthcare institutional providers consist of DOH hospitals and facilities, PhilHealth-accredited facilities, private hospitals, clinics, and other specialty health facilities (i.e. TB-DOTS, drug abuse and rehabilitation, outpatient malaria, outpatient HIV-AIDS treatment); while healthcare professional providers consist of physicians, midwives, dentists and nurses. As of April 2019, there are total of more than 10,400 accredited institutions nationwide wherein more than 100 Level 3 hospitals, almost 2000 primary care benefit providers and 1,700 TB-DOTS service providers. Additionally, there are total of 43,100 accredited professionals nationwide. The Health IT Providers are PhilHealth's service providers, who assists on electronic transactions and information management of PhilHealth. They provide technical support for e-claims and other verification procedures done online. Partnership with employers help ensure that all their employees are covered by mandatory health insurance as mandated by law; while partnership with collecting partners such as banks and non-bank institutions help in making premium payments more convenient to members.

Aside from the PhilHealth, other sources for health expenses financing are also utilized such as voluntary health insurance through Health Maintenance Organizations, or in other cases through direct out-of-pocket payments at point of need. As of July 2018, there are 30 certified and active Health Maintenance Organizations in the country (Insurance Commission 2018). The Philippine Statistics Authority latest data shows that in 2017, 12.5 percent uses voluntary health insurance while out-of-pocket expenses still remain the highest comprising 54.5 percent of health expenditures. PSA (2018) reports that more than half of the out-of-pocket payments are spent on pharmacies, followed by expenses on private general hospitals.

2.3 Street-level bureaucracy

> "I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out. […] Street-level bureaucrats *make* the policies they are charged to implement." (Lipsky 1980, 2010)

Lipsky[13] (1969, 1980, 2010) first conceptualized the idea of "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" as *street-level bureaucrats*. Correspondingly, *street level bureaucracy* is a public institution that "employs a significant number of street-level bureaucrats in proportion to its workforce" (ibid.). The state policies and programs are delivered to the people through them, which in effect their actions are the policies provided by the state to its citizens. They are either service providers, agents determining citizen entitlement, or keepers of public order. Example of those who are service providers include health workers, teachers and social workers; agents determining citizen entitlement includes clerks in welfare

[13] 1969 publication was a discussion paper for the Annual Meeting of the American Political Science Association, Commodore Hotel; while the book was published in 1980; and 6th edition of the book was published in 2010

office and public housing agencies; and keepers of public order are the police workers and judge.

In view of the nature of work of street-level bureaucrats, they gain both political and practical appreciation of policy implementation on the ground, and hence has more realistic assessment of the nature of the problem. However, their assessments cannot be considered as the absolute truth. It is still the system in which they are operating (i.e. criteria within targeting system in identifying the poor for subsidized social health insurance) assess the clients' characteristics (i.e. eligibility to government subsidized benefits). Considering the heterogeneity of their work, they maximize the range of discretionary actions available to them with the relative autonomy they can exert, in able to appropriately deliver policy benefits to their clients. This practice renders them not only as implementers but also as policy makers, wherein they are the ones who ultimately decide what kind of services and benfits policy targets receive instead of the formal policy (Dogaru 2017:53).

Further expanding Lipsky's definition of *discretion* as the various policy options in determining the nature, amount and quality of benefits and sanctions provided by street-level bureaucrats' agencies, Dogaru (2017:53) defines discretion also as the freedom granted to choose among several possible actions to take, or not to take, when interacting with policy targets. Inspired by these definitions, discretion has also been interpreted by Hansson (2017) as the principle of balancing treating all citizens alike (in terms of their claims to government services), while also being responsive to the individual cases, whenever deemed necessary.

Meanwhile, *autonomy* can be better appreciated by comparing street-level bureaucrats and street-level managers (Lipsky 2010: 18-23). Unlike the bureaucrats' concern on accomplishing their work in a manner that is consistent with their own preferences and beliefs, street-level managers prioritize work productivity and effectiveness. Street-level bureaucrats face the burden of doing large amount of tasks within limited amount of time; while their managerial counterparts are pressed into contributing to the achievement of agency goals. In terms of their relative autonomy, street-level bureaucrats strive to maintain their level of autonomy while managers have the tendency to restrain their subordinates' autonomy. However, Evans (2010) pointed out that Lipsky was not able to give attention to the role of professionalism between bureaucrats and managers. He claims that the professional status of street-level bureaucrats influence both the nature of their discretion and the way in which they are managed by their superiors. Nonetheless, the paradox Lipsky (ibid.) emphasized persists that while managers would naturally want to restrain their subordinates (lessen the resistance) to be more effective in reaching agency goals, the bureaucrats' practice of such autonomy is basic to the survival of the agency's policy implementation.

Taking off from Lipsky's (1969, 2010) discussion on discretion and autonomy as two facets of how street-level bureaucrats perform their role in policy implementation and in reality policy making at the local level, Sevä (2015) further discusses on the factors affecting these two facets. The Sevä's framework proposes the following four explanatory factors: management setting, policy understanding, implementation resources and policy beliefs. In this research, I adopted the factor on management setting as it explains the determinants of the level of discretion and authority in decision-making. The three other factors influence how the official policy is implemented. Two dominant management settings are identified in this framework labelled as Weberian and collaborative. Weberian management is a top-down model of management wherein the people's interests are represented by elected officials in a democracy. In this management type, street-level bureaucrats have limited autonomy because they have to follow higher-level officials, while having restricted discretion in implementing policies with few options to choose from. Collaborative management is characterized by participation of private stakeholders in policy making, and hence political power is relatively

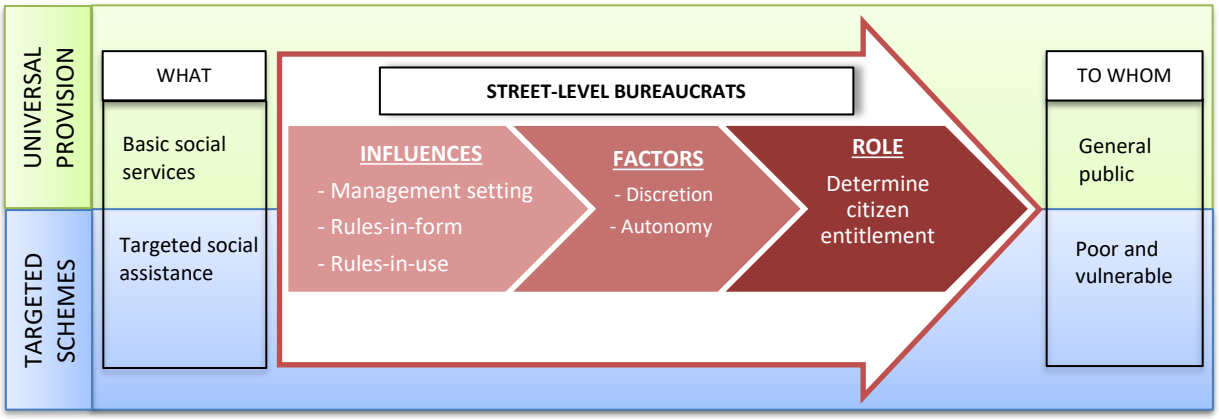
distributed and decentralized from just sole public officials. In this setting, street-level bureaucrats have high autonomy from superiors to effectively respond to stakeholders' demands, but have low discretionary power since they are dependent on other participants to fully implement the policy. Management setting is also discussed by Keiser (2010) in terms of the influence of managers to street-level bureaucrats' as one of the factors affecting their decision in granting eligibility for Social Security Disability Program in the United States.

2.3.1 Street-level bureaucracy in targeting system

Street-level bureaucrats have extensive impact in the lives of the public, considering their function as enablers and providers of public service provision, or keepers of public order. Moreover, Lipsky (2010) emphasized that people's availment of state provision is affected by how street-level bureaucrats perform their task in accommodating needs of their clients in accordance to implementation of a particular policy. In the context of this research, I am particularly interested on the influences affecting how the street-level bureaucrats of PhilHealth (i.e. Barangay Captain, barangay health officers, health workers and PhilHealth desk officers designated in health facilities) grant access to government programs (i.e. eligibility to PhilHealth programs for the poor).

In order to do so, I have structured an analytical framework that acknowledges the critical role of street-level bureaucrats, and in doing so, looks into vital influences and factors shaping the manner in which street-level bureaucrats perform their duties.

Figure 2.1 Analytical framework on street-level bureaucrats' role in social provision



Source: Author's synthesis based on Lipsky 2010; Sevä (2015); Keiser (2010)

Figure 2.1 illustrates that the goods and services that the state provides, are being delivered to citizens thru street-level bureaucrats. From one end, the diagram shows *what* the state provides, while the other end shows *to whom* these benefits and programs are provided. State provision may either be conducted as universal provision of basic social services (i.e. basic healthcare, basic education, etc.) or through targeted schemes of social assistance (i.e. cash transfers, social pension, etc.). Universal provisions are accessible to the general public, that is the entire population; while targeted schemes are aimed to be delivered only to the poor and vulnerable groups in society. The big red arrow shows the process of how *influencing elements* contribute to the level of discretion and autonomy they exercise, which in effect are *factors* that allow street-level bureaucrats perform their *role* in social provision.

For the influencing elements, I have included *management setting* as it directly influences the variety of discretionary actions available to street-level bureaucrats as well as the extent

of autonomy they can exercise (as discussed in the earlier section). Other elements include the *rules-in-form* which are formal laws and policies, rules and regulations that these bureaucrats are subject to follow, and *rules-in-use* such as the norms and practices in their occupational group, including social and policy feedback from other bureaus (cf. Lipsky 2010:14; Polski and Ostrom 1999; Keiser 2010). Both rules-in-form and rules-in-use restricts, structures, and standardizes how bureaucrats –in terms of discretion and autonomy– manage and (re)act appropriately at the issue at hand. For instance, a combination of highly bureaucratic top-down management, too specific regulations stipulated in laws, and conservative rules-in-use norms and practices can result to restricted discretion with low autonomy of street-level bureaucrats.

On one hand, *discretion* is vital to how street-level bureaucrats work because in reality, the situations they face is too complicated and cannot be simply boxed into the formal programmatic rigid categories. On the other hand, *autonomy*, or as Lipsky (2010:16) put it in the context of street-level bureaucrats, 'relative autonomy from their organizational authority', is the capacity of low-level workers to partially modify from how they are expected to accomplish the work towards a manner more consistent to theirs. While at times, this arises when their interests and beliefs do not exactly share their superiors' perspectives or agency goals, the exercise of autonomy makes them more effective in implementing the policy as it becomes more reflexive and appropriate in attending to their clients' needs. To be able to effectively do their task, having several options is not sufficient, and needs to go hand in hand with a certain level of autonomy to be able to fully attend to their clients' concern. The combination of available discretionary actions and the level of autonomy of street-level bureaucrats, as affected by influencing elements, determines the level and/or type of benefits that the people are made entitled to. In this sense, they have the potential to be the "lynchpin of targeting" considering the dynamics of how they do work. Among the three roles of street-level bureaucrats' discussed in Chapter 2.3, I will only focus on their *role to determine who among their clients are eligible to entitlements*, as this is the relevant role in the context of their participation in targeting schemes. In the next Chapter, I have utilized this analytical framework in understanding the role of street level bureaucrats in targeting system in the Philippines.

Chapter 3
Analysis of targeting system in the Philippines

This Chapter aims to discuss the targeting system used in PhilHealth programs for the poor. This will inform the research on the effectivity of the system in reaching the program's intended beneficiaries. First, I briefly introduced the different targeting schemes in the country. After which, the rest of the chapter focuses first on Listahanan method, strengths and weaknesses. Lastly, I discussed the participation of street-level bureaucrats all throughout the targeting process.

3.1 Philippine targeting schemes

Considering the scarcity of resources in a developing country such as the Philippines, the government has been using targeting mechanisms to efficiently and equitably cater to the poor. Among the targeting tools used in the country, the National Household Targeting System or *Listahanan* is the most comprehensive and commonly used in social programs. The Listahanan is implemented by the DSWD, originally to profile the target beneficiaries of the conditional cash transfer program. The DSWD took on the initiative to conduct the survey due to the lack of available comprehensive profile of the poor, when the agency is preparing for the implementation of the conditional cash transfer program.

Another database used in identifying the poor in other social programs is the Community-based Management System (CBMS). The CBMS database is a data collection system that generates updated and disaggregated data necessary in targeting beneficiaries and monitoring impact over time (RA 11315). It is a technology-based system that involves the community in collecting, processing and validating the data generated at the local level. CBMS merges nationwide data from national agencies, geo-tagging, and CBMS data in the local government units. Unfortunately, not all LGUs have CBMS database set up in their locality.

3.2 Listahanan targeting

In 2013, the Listahanan was adopted by PhilHealth for the automatic enrolment of indigent persons pursuant to the National Health Insurance Act of 2013 (RA 10606); also in compliance to Executive Order 867 that mandates the use of Listahanan for all social protection programs. Succeeding discussions in this Chapter will then only focus to effectivity of Listahanan in targeting.

3.2.1 Listahanan targeting model

The Listahanan is an information management system that identifies who and where the poor are nationwide (DSWD 2014). It serves as a database of poor families as basis in identifying social protection program beneficiaries.

It uses a Proxy Means Test (PMT) model that approximates family income based on observable and verifiable income proxy indicators such as housing structure, access to basic services and facilities like water and electricity ownership of specific assets. These indicators are based on the Family Income and Expenditure Survey, Labor Force Survey, and the Census of Population and Housing. Two questionnaires are used to collect information from

households: Family Assessment Form (FAF) and Barangay Community/Characteristics (BCC) Form. The FAF is comprise of 52 questions inquiring about welfare level of the family. The BCC Form gathers information on barangay's street patterns and establishments.

Two Listahanan assessments were already conducted in the country –in 2011 and in 2015. Summary of first and second round of assessments are presented in the table below.

Table 3.1 Listahanan 1 and 2 coverage, targeting result and errors

	Listahanan 1 (2011)	Listahanan 2 (2015)
Proxy means test (PMT)	2 PMT models (1 urban; 1 rural)	2 PMT models (1 for non-NCR; 1 for NCR)
PMT layers	1 layer to approx. income	2 layers (1 to approx. income; 1 to minimize error)
No. of households assessed/surveyed	10.1 million	15.1 million**
Total number of poor identified	5.2 million	5.1 million
Total number of near-poor identified	N/A*	1.4 million
Exclusion error	30 percent	Non-NCR : 6.8% NCR : 19.3%
Inclusion error	24 percent	Non-NCR : 13.9% NCR : 10.7%

*During the implementation of the first Listahanan, the number of near-poor cannot be identified yet

**Of the 15.1 million households assessed, 100,000 of which are interviewed thru 'on demand' assessment

Source: Velarde (2018); Mapa (2016); DSWD (2014).

Compared to one layer estimating the PMT models in the first round, the Listahanan 2 uses two layers of estimates on PMT models to improve accuracy by not only estimating for income, but also for minimizing errors. The target number of households to be assessed also increased to extend the reach of assessment into far-flung areas in the country where poverty is more prominent. The Listahanan 2 can now identify the number of near-poor[14] which was assumed to contribute in the inclusion error in the first round. Using two different PMT models considerably decreased the error rates in the estimates.

3.2.2 Strengths and weaknesses of Listahanan

Although considered as the most comprehensive targeting tool in the country, the Listahanan have been implemented not without criticisms. Having been using the Listahanan for several years already, I have summarized several observations on the strengths and weaknesses of Listahanan as the targeting mechanism for social programs and policies in Table 3.2 below.

[14] The near-poor is estimated by Paqueo et al. (2014) as either 10.87 percent base on Near-Poor Threshold to Total Poverty Threshold (NPT-TPT) ratio of 1.28, and 13.97 percent base on 1.37 NPT-TPT ratio

Table 3.2 Strengths and weaknesses of Listahanan

STRENGTHS	WEAKNESSES

• Efficient allocation of limited resource
• Prioritization of efforts to the vulnerable sector
• Relatively objective by using proxy indicators in survey assessment of households
  ○ Limits bias from political patronage
  ○ Prevents pitfalls of community-based targeting system
• In PhilHealth, enables the disaggregation of Informal sector members into more vulnerable sectors – Indigent and Sponsored Program members
	• 'Efficient' cost savings from less expenditure to welfare programs offset by institutional and administrative costs of targeting
	• Contradict "universal" nature of PhilHealth
	• Circumvention of proxy indicators
	• Over targeting the poor
	• Exclusionary from the start –nationwide assessment is conducted only to identified pockets of poverty
	• Not updated regularly
	• Not able to disaggregate by type of vulnerable groups

Source: Author's interpretation derived from Mkandawire (2005); Conning and Kevane (2000); Velarde (2008).

On one hand, the use of targeting system as often marketed by international development partners, allows the government to efficiently manage the limited resources they have into the population group who would have a higher rate of return and impact on poverty reduction in the country. Similarly, Velarde (2008) not only recognizes its efficiency, but also appreciates that proxy means testing is a practical way of measuring economic well-being of the general population. The use of targeting allows the poor to be visible, prioritized, and then effectively understand their needs to appropriately inform social policies. Listahanan is also deemed relatively objective compared to targeting by local officials, by limiting bias from political patronage. It also prevents pitfalls of community-based targeting (Conning & Kevane 2000) which will be further discussed in Chapter 4.1. Lastly, when PhilHealth integrated the Listahanan database with theirs, they were able to identify poor members as Indigent and Sponsored Program members from just lumping them into Informal Sector members, which was done prior to Listahanan.

On the other hand, the 'efficient' cost savings from less expenditure to welfare programs is usually offset by its additional institutional and administrative costs (Mkandawire 2005). Instead of using the budget in establishing institutions and implementing the assessment, resources can be used to augment the benefit provided by these programs. The adoption of targeted programs also contradicts the universal nature of social health insurance, wherein a patient is still subject to eligibility criteria on what benefits are available to them at point of need. Another weakness is the consistent findings on over targeting the poor. This may be due to two reasons: inclusion of near-poor population, or that the beneficiaries of Sponsored Program are not necessarily poor (Querri et al. 2018; NEDA et al., n.d.; Casimiro 2007). Moreover, the use of proxy indicators may be circumvented by interviewees via modifying their answers to the interview questions, that will allow them to be eligible to social welfare programs. For example, the indicator on presence/absence of household appliances may also be circumvented by temporarily transferring these to other households. The conduct of semi-census type survey entails geographic limitations. It is only done in areas with pockets of poverty; hence, those poor in areas where survey was not conducted are automatically excluded from the official list of the poor. Also, because it was conducted by interviewing households (i.e. families living within a physical dwelling), street-sweepers and homeless are also automatically excluded. Moreover, the data base is not updated frequently enough considering the lengthy project cycle (from assessment to data sharing) of Listahanan, the data released would have already been passé and irrelevant. Because of political issues, policy implementers are still using the 2011 Listahanan, despite the existence of the 2015 results. In effect, the new poor have been excluded from the list. Another disadvantage of the

Listahanan is that its original purpose was to identify beneficiaries of the conditional cash transfer in the country. Considering that in 2007, there is no database with detailed profile of the poor, the DSWD took on the initiative to conduct profiling and locating the poor nationwide. This results to the Listahanan being limited to the profiling needs and objectives of the program –targeting the poor. The database has limited information on persons with disabilities, Indigenous Peoples, workers in the informal sector, homeless street families and children, families affected by disasters, among others. This design limits the disaggregation of the information by type of vulnerable groups.

Overall, while targeting helps social policy making identify who and where the poor are, its exclusionary effect also restricts the most vulnerable from accessing social provisions. It can be said that the targeting scheme and implementation in the country have not yet achieved its full potential.

The issue is then not about being selective in allocating resources and targeting beneficiaries of programs, but "how much to push social segregation and discrimination to achieve efficiency, and where to stop" (Sen 1995, in Mkandawire 2005:3). Noting Fischer's (2018:225) contention on universalism, ideally, the Philippines should move towards universalistic social policy (which may entail elements of targeting) that promotes egalitarian and equitable process of social integration and citizenship. With this, the Philippines can either continue using the Listahanan as the official poverty targeting system of government programs; explore other focus of targeting (not only among the poor, but in terms of other vulnerable groups) such as excluding the better-off rather than target certain population category; or entirely do away with targeting and just focus on providing basic universal social services to everyone.

3.3 Role of street-level bureaucrats throughout the Listahanan process

The Listahanan process involves four stages: preparatory, data collection and analysis, validation and finalization, and reports generation (DSWD 2014). In all four stages, involvement of local government and street-level bureaucrats are vital in the effective and accurate identification of the poor.

Preparatory phase includes identification of areas with high incidence of poverty and enumerate the poor households. From this stage, local knowledge of barangay officials is important to saturate pockets of poverty in their jurisdiction.

Data collection involves home visitation and interview with households using the FAF and BCC Form. After which, data are encoded into the database for PMT processing, then compared the estimates to official poverty thresholds to assess if the household is poor or not. At this stage, barangay workers and volunteers help in logistical preparation and conduct of home visitations in target households.

Validation is done by distributing and publicly posting the initial list of poor families in respective barangays for perusal of the community. Velarde (2018:7) acknowledges the essential role of community in validating Listahanan results. During this phase, street-level bureaucrats such as local chief executives (i.e. City Mayor, Barangay Captain) assists in the dissemination of initial list. At this stage, the street-level bureaucrats (i.e. Local Verification Committee members[15]) facilitate feedback mechanism that allows for 'on demand'

[15] Local Verification Committee (LVC) consists of MSWO as chair, Municipal Planning Development Officer (MPDO), and three other members representing civil society organization/ non-government organization (Velarde 2018).

assessment for those who were not visited during regular interview, and accept reports that those in the list is not actually poor. The LVC uses their autonomy to decide who among the 'on demand' applicants can be approved and endorsed accordingly to the DSWD Household Targeting Office, based on the guidelines (rules-in-form), and influenced by their local knowledge of the applicant and the level of strictness/leniency of their co-worker (rules-in-use). Their endorsement and approval however, are still subject to review of the national office. Nevertheless, it is worth noting that at this stage, they are the first line of 'targeters' who decides if the individual is eligible or not.

Finally, when the list is finalized, the DSWD will produce "profiles of the poor" available to be shared with national agencies, local government, non-government organizations and other interest groups (ibid.).

Effect of management setting in the use of Listahanan

Although there is significant improvement on the coverage, estimation and errors of the second round of Listahanan, the second Listahanan had not been released for implementation and use for social protection programs. Unlike the 2015 results, the first Listahanan was well-received by the government and development partners because of its less political nature thru the use of proxy means test method. However, because of the change in leadership of the DSWD and the Secretary's non-confidence on the result of the second round of household assessment, the second set of results were only released to selected government programs. It may also be because the incumbent Secretary then is personally not in favour of targeting recipients in providing social welfare services, but provide assistance to everyone instead. Regardless, the third round of survey has been started in 2018, and is expected to finish by January 2020. In this particular instance, it can be seen that the management setting in the Philippines is more Weberian than a collaborative type of management. The decision of the head of agency superseding the earlier established conduct and use of Listahanan is a clear characteristic of a top-down management setting.

Chapter 4
Findings and analysis on street-level bureaucrats' role in PhilHealth targeting

This Chapter continuous to provide evidence to inform whether the street-level bureaucrats are the primary cause of obstructing utilization of PhilHealth benefits. In this regard, this chapter focuses the assumed role of street-level bureaucrats as pseudo-targeters in identifying enrolees as well as determining their eligibility on what level of benefits can they receive base on membership category. Further discussions include how street-level bureaucrats extend access on PhilHealth programs for the poor, as well as the detrimental pitfalls of street-level bureaucracy in implementing social programs.

4.1 Street-level bureaucrats as pseudo-targeters

Within the targeting system used in the Philippines, local level implementers and street-level bureaucrats are put into position on having to determine eligibility on case to case basis, within their respective jurisdiction. The burden of attending to individual clients' needs is further aggravated by the predicament among street-level bureaucrats' fair treatment to all its constituents. In their own jurisdiction, they are in charge of redistributive as well as allocative function in proving public service to the people. In most cases, their discretionary decisions tend to favour one population category (e.g. poor, whom they share political patronage with) at the expense of the general taxpayers and those whose claims are denied (Lipsky 1980).

The adoption of Listahanan as PhilHealth's targeting tool for reaching and enrolling the poor Filipinos, also resulted to exclusionary effect among the poor who had not been assessed when Listahanan survey was conducted. Hence, because these excluded poor are not included in the 'official list of the poor' they cannot be enrolled as Indigent members, which strips them of the eligibility to avail benefits that their Listahanan-poor counterpart enjoys. Because of this lapse on targeting, street-level bureaucrats have been making discretionary decisions –by utilizing their local autonomy– to provide universal health access to their constituents.

The critical role of street-level bureaucrats is most apparent in the implementation of PhilHealth programs for the poor through the Indigent and Sponsored Program. From the discussion of PhilHealth program design in Chapter 2, Table 4.1 extends the design to show the role of street-level bureaucrats in the selection of beneficiaries for these member sectors.

Table 4.1 Role of street-level bureaucrats in PhilHealth programs for the poor

Member sectors	Enrolment	Eligibility criteria	Role of street-level bureaucrats
Indigent members	DSWD/ PhilHealth office	- Included in Listahanan list - Certificate of Indigency	- Verification of applicant in the list as poor - Issuance of Certificate of Indigency
Sponsored Program members **A. LGU**	Barangay office	N/A	Selection of who to enrol
B. Government hospitals	Point-of-Care enrolment	Assessed by MSWO/SWDO/ PHDO[1] as poor	Determine if applicant is poor

[1] Medical Social Welfare Officer (MSWO)/ Social Welfare Development Officer (SWDO)/ PhilHealth Desk Officer (PHDO)

Source: Author's synthesis using RA 9994; RA 10606; RA 10351; Revised IRR of RA 7875; PhilHealth Annual Stats and Charts; PhilHealth Office Circular 0017-2017

Indigent members are verified by the MSWO/SWDO/PHDO if the patient is in the Listahanan list. Moreover, the Barangay Captain or barangay health worker is responsible for issuing a Certificate of Indigency if they assess that the person is financially incapable of paying for the health expenses.

With respect to LGU-sponsored members, aside from the enrolment of barangay staffs and identified affiliated individuals mentioned earlier, the Barangay Captain has the absolute discretion on who else to give sponsorship to, with respect to their budget and priorities.

Meanwhile, with regard to hospital-sponsored members, the MSWO/SWDO assesses the patient if he/she is financially incapable of paying for the health expenses, using the Intake Survey Sheet as prescribed by the Department of Health. Base on the MSWO/SWDO assessment, the patient will be enrolled either as paying member or as sponsored member.

As reported in the DOH Health Care Financing Strategy 2010-2020, "fragmented decision making jeopardizes the establishment of a health care delivery system. […] In fact, LGUs have the freedom and power to make decisions about their health service delivery network with minimal coordination with their neighboring LGUs as well as little regard for the overall national referral system" (DOH 2010). This finding does not only apply to service delivery but also in PhilHealth targeting across the country. Even if the Philippine public sector practices a highly patriarchal and bureaucratic government, decentralized implementation of social services entails high local autonomy and discretion of the local government which extends to street-level bureaucrats. This setting allows them to be flexible but within tolerable deviation from official policies.

The importance of street-level bureaucrat's role as pseudo-targeters can be emphasized in comparison with the Listahanan as the official targeting system, as shown in Table 4.2.

Table 4.2 Comparison of Listahanan vis-à-vis street-level bureaucrat as pseudo-targeters

Criteria	Listahanan	Pseudo-targeters
Objectivity	✓	
Standardized	✓	
Less politicized	✓	
Reflexive		✓
Local knowledge		✓
Timely		✓

Despite the Listahanan being able to be objective with the use of proxy indicators, is standardized and can be applied to every locality, and less politicized because of limited interaction between the targeted and the targeter, street-level bureaucrats also have advantages in its own respect. Since street-level bureaucrats are able to make discretionary decisions, they can be reflexive and relatively less rigid than Listahanan in granting eligibility to a person on a case to case basis. Also, because they are directly interacting with their clients, they have the local knowledge which they can use to act appropriately to what their clients need. Similarly, since they are aware of the situation in real-time, necessary decision can be made immediately to respond to clients.

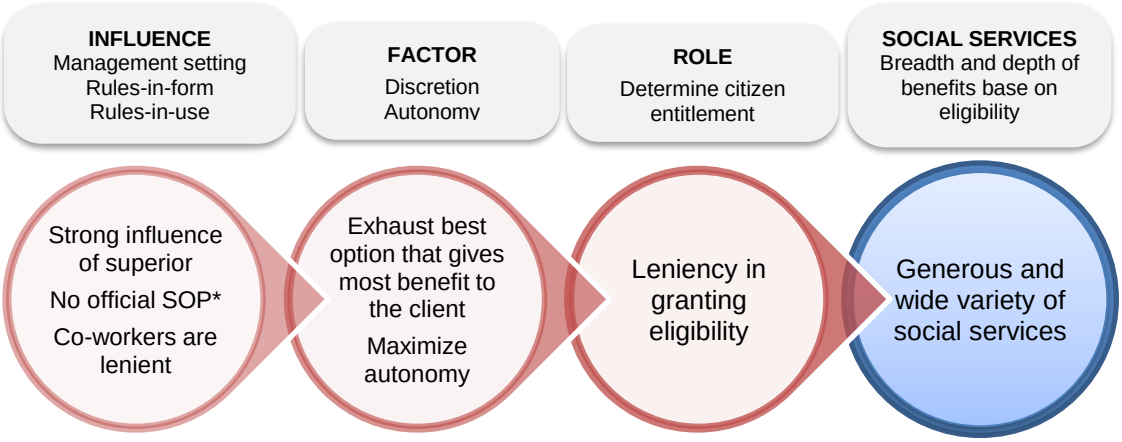
4.2 Street-level bureaucrats extending access on PhilHealth programs

The usual practice of discretionary actions is validated and evidenced by some interview results. Base on the interviews conducted, discretionary decisions done in practice to provide eligibility to the poor who are excluded in the Listahanan include:

a. giving of Certificate of Indigency to non-poor households;
b. granting of Sponsored Program membership not limited to income poor; and
c. looking for other financing options aside from PhilHealth.

Figure 4.1 shows the flow how the influencing elements affect factors –discretion and autonomy, which results to liberal manner of granting of eligibility to clients.

Figure 4.1 Enabling influences and factors affecting how street-level bureaucrats determine eligibility



* Standard operating procedures (SOP)

Source: Author's synthesis based on secondary data and interview results

A top-down management setting wherein there is strong positive influence of superior to the street-level bureaucrat, the latter would likely be motivated to exhaust the best possible option to cater to the needs of their clients.

This was evidenced by the PhilHealth desk officer response,

> "Whenever our patients were about to run out of [dialysis] sessions covered by PhilHealth, I always suggest that they can apply for Guarantee letters from the DSWD, PCSO[16], DOH, or Malacañang. If I have an errand in Malacañang, I even try to follow-up their requests from the staff in charge there." (PHDO)

wherein because the goal of the clinic she is working in aims to fully satisfy their patients, she even facilitates getting other funding sources, which goes beyond her job description. Similar incident also occurs at barangay office where the barangay health worker looks for additional financial aid from politicians, just to provide the need of their client,

> "If the patient is not really eligible [to be enrolled either in Indigent or Sponsored Program], I will just endorse them to a politician who is willing to use their discretionary allowance to help the people in need." (BHW)

In both instances, street-level bureaucrats –PHDO and BHW have high levels of discretion and autonomy in looking for other ways to help their clients.

The absence of strict and enforceable guidelines and SOP widens the available options for street-level bureaucrats' discretionary actions. While BC1 prioritizes children and senior citizens to have PhilHealth coverage, BC2 prioritizes pregnant women in their barangay. This in turn allows for relatively liberal accommodation of these sectors into the Sponsored Program even if they are not income poor, but still deemed incapable to pay for their health expenses.

From the Keiser's theory (2010), the leniency (or strictness) of co-workers in approving application also affects the person's tendency to approve. However, this did not arise from interviews conducted. As per Keiser (ibid.), if the co-implementer is showing leniency in approving applications, the discretion of the street-level bureaucrat would tend to be as lenient.

Considering the outdated information in the Listahanan, it is highly possible that the applicant is not included there not because he/she is rich but because he/she was just above the poverty line ten years ago, and now have fallen into poverty. It should be noted that this discretion and autonomy to do so is not practiced without guidelines. The approval of being eligible through street-level bureaucrats still goes through the process. For example, they may be deemed eligible for the certificate if they live in the neighbourhood that is identified by the LGU as poor community; or if it is commonly known that the person is a street sweeper or homeless[17] (BC1).

As mandated by the law (RA 10606), barangay workers and some volunteers be enrolled in PhilHealth under the LGU sponsorship program regardless of their income level. Apart from this, any constituent who is assessed by social welfare officer or health worker needing the assistance will be enrolled accordingly. In some cases, these are those who are not technically below the poverty line but is assessed as not able to pay health expenses solely with their own capacity –hence rendering them 'worthy' of the sponsorship.

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[16] The Philippine Charity and Sweepstakes Office (PCSO), which provides financial assistance to the poor, is a government-owned corporation mandated to have fundraising activities to support health programs, medical assistance and other charities.

[17] The Listahanan survey was conducted by interviewing households, hence street-sweepers and homeless are automatically excluded from the assessment.

When respondent is asked to what extent do they accommodate the needs of their clients,

> "Even if the patient is not technically poor [based on Listahanan and income level of the household], we will still enrol them under the Sponsored Program because we have seen that the family's wealth had already been dwindling and their entire savings used up because of continuous medical expenses." (BC1)

LGU-sponsored membership, in effect, legitimizes their autonomy and hence expands their discretionary options in the enrolment of their constituents.

4.3 Pitfalls of street-level bureaucracy

Lipsky (2010) acknowledges that street-level bureaucrats may consistently favour some clients at the expense of others, despite official regulation of prohibiting such behavior. Additionally, Conning and Kevane (2002) suggests possible drawbacks if street-level bureaucrats were to conduct a community-based targeting. Although local information and social capital can better inform the accuracy and relevance of targeting, community-based targeting is prone to be eroded by rent-seeking, program capture by local elites, and strategic targeting may be modified to be more responsive to national funding and evaluation criteria, which would all reduce the impact of benefits to its targeted recipients.

As evidenced by interview responses, rent-seeking is present in some PhilHealth-accredited health facilities in order to augment their income wherein,

> "Many health clinics charge 'Other Fees' to patients availing PhilHealth benefits" (PHDO)

Another interview result is consistent with the anecdotal evidence that Querri et al. (2018) was able to gather on 'politically indigent' individuals enrolled under the Sponsored Program that there is no standardized procedure to determine who is eligible to be issued with Certificate of Indigency. When asked how do they assess if the applicant can be granted with certificate, the response was:

> "We personally know our constituents. We know if he/she is poor. We know if he/she comes from a well-off family [or he/she resides in the slum area]. We know if he/she is a street vendor or a street sweeper." (BC1)

Per my respondent, the issuance is solely at the discretion of the social worker approved by the barangay office. However, in this case, even if it is the sole discretion of the officer, there is still rules-in-use (i.e. informal knowledge) guiding the discretionary action. Furthermore, the capture of local elites has materialized with the study findings on the enrolment of non-poor individuals because they have social network with either the person in charge of the enrolment, or with the local official who was given the budget for the Sponsored Program. Another case was observed in Querri et al.'s study (2018) where some areas are not visited by enumerators because of some political agenda.

Although there is no large variation on bureaucratic culture across the country, Querri et al.'s research (2018) only encompasses static assessment of 5 local governments and is not deemed to be representative of all LGUs in the country. Hence I am cautiously adopting the results only applicable to these areas and not claim for its nationwide phenomenon.

Decentralization of social service provision has given the local government almost absolute autonomy in deciding how to manage their resources; while absence of standardized procedure opens up vast opportunity on discretion depends on the policy understanding and personal priority of the implementing street-level bureaucrat.

Another challenge of targeting at the local level is the possibility of multiple enrolment of a poor person as Indigent member –identified thru Listahanan; and as a sponsored member –identified by the local government officers on a case to case basis (Manasan 2011). In congruence to Manasan (2011), even after 5 years, Cabalfin (2016:9) still observes political patronage as one of the challenges in properly targeting beneficiaries of programs. These issues may be haphazardly interpreted as street-level bureaucrats' lack of ability to implement the program. However, their subjectivity and discretionary grant of sponsorship can also be appreciated as resourceful action in response to significant lapses (exclusion and inclusion errors) in the targeting system they are operating in.

Chapter 5
Conclusions and policy recommendations

5.1 Conclusions

In the existence of imperfect targeting systems, this research suggests that the street-level bureaucrats can be considered as a "lynchpin of targeting" in implementing social programs targeted to the poor. This is further substantiated by answering the three sub-questions on: targeting system effectivity, factors influencing street-level bureaucrats' ability to respond to client needs, and experiences of street-level bureaucrat participation in PhilHealth targeted programs. Final conclusions synthesize these three findings in response to the main research question on the extent of impact of street-level bureaucrats on targeting systems.

First, while acknowledging the improvements on Listahanan as a targeting mechanism, it has still some areas for improvement. For one, even from the initial stage of the targeting, the decision to conduct assessment only to areas of extreme poverty already results to immediate exclusion of the poor in those areas not surveyed. Another, is that the use of proxy means indicators makes the system susceptible to errors and inaccuracy considering that it can be circumvented by interviewees. Due to the inefficiencies of Listahanan, other supplementary efforts are created addressing the lapses of the system including 'on demand' assessments, Point-of-Care enrolment, among others. As a result, the design deficiencies of Listahanan allow for street-level bureaucrats to have considerable influence in determining eligibility of targeted beneficiaries.

Secondly, the ability of street-level bureaucrats to serve their clients is affected by the level of relative autonomy they can exercise and the variety of discretionary options available to them –which are both influenced by management setting, rules-in-form and rules-in-use. In the Philippines, wherein social services are decentralized, local governments have high level of autonomy and discretion which extends to street-level bureaucrats. Official guidelines such as Implementing Rules and Regulations and Citizens Charter provides standardization to ensure fair implementation. However, there is apparent lack of standard operating procedures in some aspects of implementation which opens up a vast range of discretionary options to street-level bureaucrats. On one hand, there is the danger that the decision can get highly politicized; but on the other hand, it is also beneficial to allow necessary flexibility in order to cater clients' needs appropriately. Taking advantage of their autonomy, it is common practice among street-level bureaucrats to use their local knowledge in giving eligibility to the poor, despite the limiting formal restrictions if deemed appropriate from one case to another. Using their autonomy and discretion proves that street-level bureaucrats have a vital role in ensuring that client's needs are attended to.

Thirdly, in the case of targeting for PhilHealth, street-level bureaucrats were able to enjoy high level of autonomy and discretion in deciding who among the applicants are worthy to be enrolled under the Sponsored Program as well as who can be given Certificate of Indigency. Although, while being lenient, officers are aware that they should only make special considerations only when deemed necessary. The observed leniency in these two instances result to relatively higher level of welfare benefits (i.e. higher amount of financial assistance) received by beneficiaries compared to those excluded from these programs.

Therefore, with the use of discretion enabled by relative autonomy, street-level bureaucrats have the potential to *make* policies at their level as they implement the formal policies, which is consistent with Lipsky's (2010) theory. Street-level bureaucrats are able to significantly influence the targeting through the Indigent and Sponsored Programs – in terms of deciding who are eligible to what benefits. They can make exceptions from the restricting formal eligibility criteria, if the situation requires them to. However, this freedom can easily be exploited; hence, should always be practiced with caution.

Furthermore, this research also concludes that while the Listahanan, as the official targeting system, is flawed, there are also drawbacks on how street-level bureaucrats operate. The Listahanan, being derived from an econometric model cannot be as accurate as the local knowledge and first-hand experience of street-level bureaucrats. While the discretion of street-level bureaucrats is prone to the dangers of politicization. Therefore, these issues should always be kept in mind in implementing these targeting schemes.

5.2 Policy recommendations

In consideration of the substantial impact of street-level bureaucrats in targeting for social protection programs, the targeting system should fully integrate them in the targeting process. Implementing them hand in hand may improve the reach and accuracy of targeting results as one can validate or contest the other. The targeting system can further capitalize on street-level bureaucrats' up-to-date knowledge on people's socio-economic state, needs, vulnerabilities, among others. Full integration in the targeting system does not only mean that they are tapped once in a while whenever a survey will be conducted. Full integration would entail that they are present in the entire process – from planning and design of surveys to its conduct, verification and finalization. It also means that their professional assessment will be heard and considered in the targeting of beneficiaries.

Recently, there has been two notable developments in targeting systems in the Philippines, where full integration of street-level bureaucrats may be beneficial. First, the passage of Pantawid Pamilyang Pilipino Program (4Ps) Act in 2018; and second, the passage of Community-based Monitoring System (CBMS) Law. Upon the institutionalization of the 4Ps Act in 2018, its Implementing Rules and Regulations are still being finalized. The 4Ps Act states that the selection of beneficiaries should be based on a 'national standardized targeting system' (Acosta et al. 2019) one of which is the Listahanan, but not limited to it. Hence, there is still the dilemma of what targeting mechanism is going to be used in identifying and selecting beneficiaries. Currently, the 4Ps program uses the Listahanan as its targeting system to identify and reach their beneficiaries. However, the errors and outdated information of the current database raises the concern regarding its effectivity. This instance is a critical point wherein the government can decide to continue the use of Listahanan, or to take the opportunity to explore other means of targeting –wherein the street-level bureaucrats are integrated in the targeting system. The passage of CBMS as a law further complicates targeting social policy in the country, as it can be used as an alternative targeting tool. Although the CBMS is mainly for monitoring and evaluation purposes of social policies, its database also contains information of the poor. Having another targeting database can improve the quality of targeting in the country. The integration of street-level bureaucrats can also be considered in this system.

Finally, the conclusions and recommendations from this research can contribute to theorizing the crucial role of street-level bureaucrats in the effectiveness of targeting systems in social protection policies. By documenting the significance of their role, this research hopes to add empirical evidence rightfully establishing them as "lynchpin of targeting" within an imperfect targeting system.

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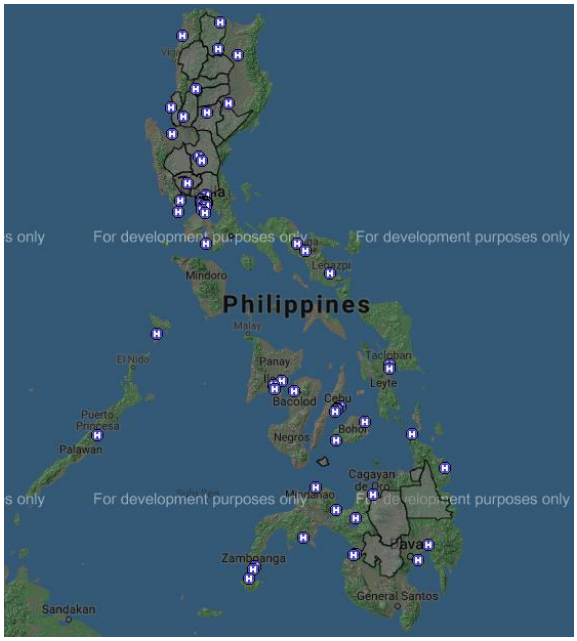
Appendices

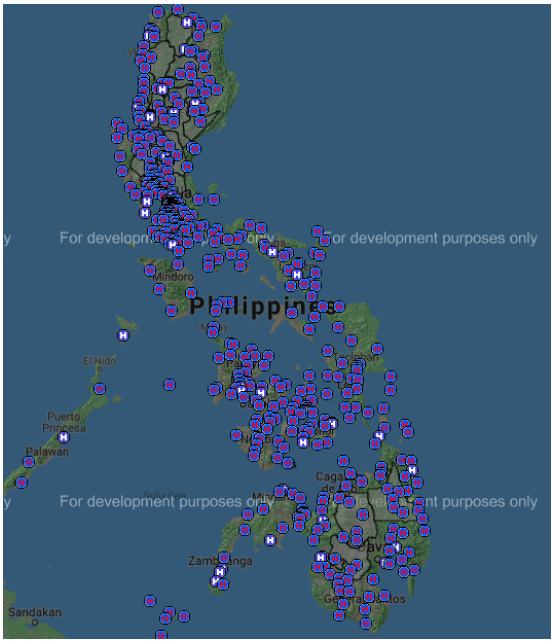
Appendix 1 List of PhilHealth Office Circular reviewed

Office Circular No.	Title
0035-2013	ACR Policy No. 2 – Implementing Guidelines on Medical and Procedure Case Rates
0033-2015	Implementation of the Point of Care (POC) Enrolment Program (Revision 1)
0017-2017	Strengthening the Implementation of the No Balance Billing Policy (Revision 2)
OC's Provided by PhilHealth Corporate Planning Division	
0039-2009	Expanded Normal Spontaneous Delivery (NSD) Package and Maternity Care Package (MCP)
0019-2009	Amendment to the Transitory Provision of PhilHealth Circular No 40, s-2000 re Implementing Guidelines for Outpatient Consultation and Diagnostic Package under the Medicare para sa Masa (Sponsored) Program
0010-2012	Implementing Guidelines for Universal Health Care Primary Care Benefit I (PCB1) Package for Transition Period CY 2012-2013
0007-2013	Guidelines for payment of Primary Care Benefit 1 (PCB1) per family payment (PFP) for 4th quarter of 2012 and CY 2013
0014-2014	Revised Guidelines for the PhilHealth Outpatient Anti-tuberculosis Directly Observed Treatment Short-Course (TB-DOTS) Benefit Package
0040-2015	Entitlement to NHIP Benefits of MCCT Beneficiaries under the Pantawid Program of the DSWD
0010-2017	Clarification on the Health Insurance Coverage of Poor Families as Indigent Members through the Sin Tax Law
0025-2017	Guidelines on the Implementation of Point of Service (POS) and Parallel Implementation of Point-of-Care (POC) –Revision 1
0008-2018	Guidelines on the Implementation of Point of Service (POS) Enrolment Program under the General Appropriations Act (GAA) 2018 Onwards

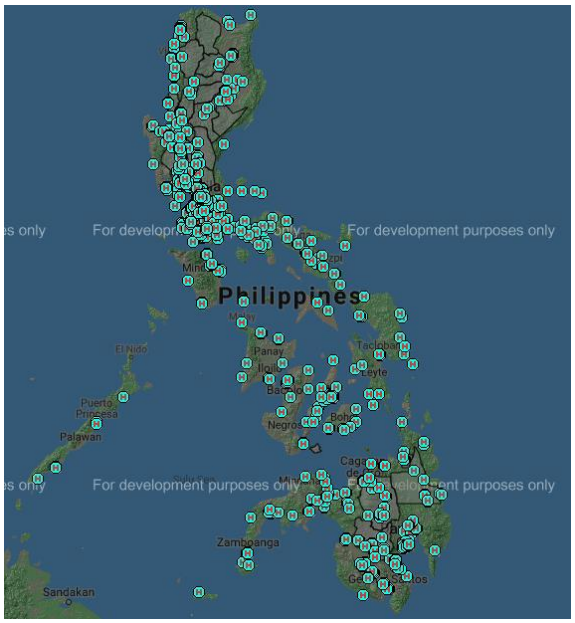
Appendix 2 Heat map of health facilities nationwide



DOH-retained hospitals



LGU hospitals



Private hospitals

Barangay health stations

Source: 'Provincial Profile with Health Facilities' DOH website

Appendix 3 Member Registration Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
(October 2013)

PhilHealth Identification Number (PIN)

IMPORTANT REMINDERS:
1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. The issuance of the PIN does not automatically qualify you or your dependents to be entitled to NHIP benefits.
3. Always use your PIN in all transactions with PhilHealth.

Please carefully read instructions at the back before accomplishing this form.

PURPOSE: ☐ FOR ENROLLMENT ☐ FOR UPDATING

1. MEMBER INFORMATION

Last Name	First Name	Name Extension (JR/SR/III)	Middle Name

If Married Female, please write FULL MAIDEN NAME:

Last Name	First Name	Name Extension (JR/SR/III)	Middle Name

Date of Birth (mm-dd-yyyy)	Place of Birth (City/Municipality/Province)	Sex	Civil Status	Nationality	Tax Identification No.(TIN)
		☐ Male ☐ Female	☐ Single ☐ Widow(er) ☐ Married ☐ Legally Separated		

Permanent Address

Unit/Room No./Floor	Building Name	Lot/Block/House/Bldg. No.	Street	Subdivision/Village

Barangay	City/Municipality	Province	Country	Zip Code

Contact Information

Landline Number (Area Code + Tel. No.)	Mobile Number	E-mail Address

2. DECLARATION OF DEPENDENTS (Use separate sheet if necessary)

2.1 Legal Spouse

PhilHealth Identification Number (PIN)	Last Name	First Name	Name Extension (JR/SR/III)	Middle Name	Date of Birth mm-dd-yyyy	Sex M / F

2.2 Children below 21 years old (unmarried & unemployed) and/or Children 21 years old and above with permanent disability

PhilHealth Identification Number (PIN)	Last Name	First Name	Name Extension (JR/SR/III)	Middle Name	Mark ✓ if with Disability	Date of Birth mm-dd-yyyy	Sex M / F
					☐		
					☐		
					☐		

2.3 Parents' Details

PhilHealth Identification Number (PIN)	Father's Last Name	Father's First Name	Name Extension (JR/SR/III)	Father's Middle Name	Mark ✓ if with Permanent Disability	Date of Birth (mm-dd-yyyy)
					☐	

PhilHealth Identification Number (PIN)	Mother's Last Name	Mother's First Name	Name Extension (JR/SR/III)	Mother's Full Middle Name	Mark ✓ if with Permanent Disability	Date of Birth (mm-dd-yyyy)
					☐	

3. MEMBERSHIP CATEGORY

3.1 Formal Economy
- ☐ Private ☐ Government
  - ☐ Permanent/Regular ☐ Casual ☐ Contractor/Project-Based
- ☐ Enterprise Owner
- ☐ Household Help / Kasambahay
- ☐ Family Driver

3.2 Informal Economy
- ☐ Migrant Worker
  - ☐ Land Based ☐ Sea Based
- ☐ Informal Sector (e.g. Market Vendor, Street Hawker, Pedicab/Tricycle Driver, etc.)
  (Please specify): _____
  Estimated Monthly Income: Php _____
  - ☐ No Income
- ☐ Self-Earning Individual (e.g. Doctors, Lawyers, Engineers, Artists, etc.)
  (Please specify): _____
  Estimated Monthly Income: Php _____
- ☐ Filipino with Dual Citizenship
- ☐ Naturalized Filipino Citizen
- ☐ Citizen of other countries working/residing/studying in the Philippines
- ☐ Organized Group (Please specify): _____

3.3 Indigent
- ☐ NHTS-PR

3.4 Sponsored
- ☐ Local Government Unit (Please specify): _____
- ☐ National Government Agency (Please specify): _____
- ☐ Others (Please specify): _____

3.5 Lifetime Member
- ☐ Retiree / Pensioner
- ☐ With 120 months contribution and has reached retirement age

Date/Effectivity of Retirement: mm dd yyyy

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

_____ _____
Signature over Printed Name Date

Please affix right thumbmark if unable to write.

Please do not write on this portion. For filling-out by PhilHealth Officer:

Received by: _____ Date: _____

Evaluated by: _____ Date: _____

Appendix 4 Detailed list of PhilHealth benefits

In-patient benefits	Out-patient benefits	Z-benefits and SDG-related benefit package
• **subsidy for confinement expenses, medicines, laboratories, and professional fees** • **Surgical cases: maternity care package, to appendectomy, to cataract surgery, among others** • **Medical cases: dengue, pneumonia, typhoid fever, hypertension, asthma, among others**	• Primary Care Benefit (PCB) • Expanded PCB (EPCB) • Day surgeries, radiotherapy, hemodialysis, outpatient blood transfusion, among others	• Z-benefits: leukemia, breast, cervical, prostate, colon and rectum cancer, kidney transplantation, coronary artery bypass surgery, premature delivery, surgery for children, Z-MORPH (mobility, orthosis, rehabilitation, prosthesis help) • SDG-related benefit package: treatment for malaria, HIV/AIDS, TB, animal bite, and those will undergo voluntary surgical contraception procedures