

Operationalizing a Mobile Philhealth Service Office for Expanding Coverage and Service Delivery in Underserved Communities

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ABSTRACT

In many remote barangays and coastal villages in the Philippines, families continue to struggle with access to basic health services. Enrollment in PhilHealth or filing claims often requires long travel, lost income, and navigating bureaucratic systems, creating barriers rooted in geography, poor infrastructure, and administrative red tape. This study, *Operationalizing a Mobile PhilHealth Service Office for Expanding Coverage and Service Delivery in Underserved Communities*, explores the feasibility of bringing PhilHealth closer to the people through mobile service offices. Using a mixed-methods approach, surveys and interviews with community members, leaders, and PhilHealth personnel captured both community perspectives and practical considerations of cost, sustainability, and scalability. Findings reveal that while most respondents are registered, utilization of benefits remains moderate due to distance and poor communication. The concept of the Mobile PhilHealth Office received strong support, with expectations for regular visits, comprehensive services, compassionate staff, and integration of digital tools. The study concludes that enrollment alone does not guarantee equitable access, as distance and communication gaps remain the most significant barriers. Respondents emphasized that success depends not only on proximity but also on service quality, staff attitude, sustainability, and modernization. To address these, the study recommends institutionalizing the Mobile PhilHealth Office with consistent schedules coordinated with barangay officials, expanded services for enrollment, renewals, claims, and orientations, and prioritization of vulnerable groups such as senior citizens, persons with disabilities, and low-income families. Continuous staff training, digital innovations, adequate resources, and enhanced information dissemination are essential to ensure accessibility, accountability, and alignment with health system reforms. Ultimately, the Mobile PhilHealth Office must serve as a holistic interventions that advance equity, dignity, and inclusive governance in rural health service delivery.

Keywords: Public Administration; Philhealth; Mobile PhilHealth Office; Healthcare Accessibility; Underserved Communities; Universal Health Coverage; Service Delivery; Equity; Inclusive Governance; Feasibility Study; Mixed-Methods Research; Cebu Province, Philippines

INTRODUCTION

Internationally, mobile service delivery has been recognized as a viable strategy to overcome barriers in healthcare access. For example, in India, mobile governance (m-governance) initiatives have utilized mobile offices and ICT frameworks to enhance citizen engagement, reduce bureaucratic barriers, and democratize access to essential services (Misra & Kalra, 2011). Similarly, in Kenya, mobile health clinics

have been deployed to reach rural and underserved populations, demonstrating how mobility can bridge geographic and financial gaps in healthcare delivery (Ouma et al., 2018). These global experiences affirm that mobility is not merely logistical but a transformative modality for ensuring equity in public service delivery.

In the Philippines, health care is one of the basic needs that all our families possess. For communities living in such remote barangays, in isolated islands and in highland sections, PhilHealth-based care is a daily struggle. The nearest office might take hours to reach, requiring significant travel and time off work. The internet isn't stable, and benefits are often misleading or hard to locate. These common challenges leave many families uninsured or delay their claims when they do get sick and need the benefits they are owed.

Take, for instance, a farmer earning only ₱400–₱600 per day. To process his PhilHealth concerns, he must leave his work and travel more than 2–3 hours to the city, spending ₱220 for a one-way fare (₱440 round trip) and another ₱150 for food. In total, that is ₱590 in expenses just to reach the office and sustain himself for the day. When combined with the ₱400–₱600 in income he loses by not working, his effective loss ranges from ₱990 to ₱1,190 per day. This means that accessing PhilHealth can cost him two to three times his daily wage, a sacrifice that discourages many from pursuing the benefits they are entitled to.

PhilHealth was established to protect Filipinos from high health care costs. It is described as a safety net — providing the guarantee that no one would have to choose between getting medical care and earning enough money to eat. But in actuality, the system often appears unattainable for those who need it most. Farmers, fisherfolk, indigenous peoples, and informal workers are among those who face significant hurdles in accessing PhilHealth services within the country, and they are all critical parts of its economy. Governments worldwide have attempted to deliver mobile services to address similar issues. Mobile clinics, mobile libraries, and mobile government vans have shown that when services are delivered directly to communities, they can be impactful. That's already happening in the Philippines with mobile blood donation and civil registration services. These are clear examples that mobility can break down barriers, reduce inequities, and foster trust between institutions and people.

The Mobile PhilHealth Office idea aligns with this notion: taking services right to people. Imagine a vehicle driving into a remote barangay, with personnel and tools to register for membership, handle claims, and orient people to the benefits they may receive. Instead of families taking a day's wage to travel a few miles to the city, PhilHealth would be there, available as needed. And beyond an administrative space, it would be a platform to educate communities about health and empower them with knowledge of their rights and benefits under this program.

This is the vision borne out by this study. The research aims to test the viability of a Mobile PhilHealth Office from financial, technical, and social standpoints, as well as its potential role in enhancing access to and delivery of services in underserved areas/communities. The investigation aims at exploring this concept so that actionable recommendations can be proposed and addressed by policy makers, PhilHealth personnel, and local municipalities and government, but more than that, to give a face to common struggles of plain Filipinos who simply have to be able to get healthcare without regard to where they are.

RELATED LITERATURE

Universal health coverage requires more than enrolling citizens in a national health insurance program; it also requires ensuring that members can conveniently understand, access, and use their benefits. In the Philippines, the Universal Health Care Act mandates equitable access to quality and affordable health

services while protecting Filipinos from financial hardship. It also emphasizes a people-centered approach that considers the different needs and circumstances of communities (Republic Act No. 11223, 2019). However, Flaminiano et al. (2022) found substantial geographical differences in PhilHealth population coverage, service coverage, and financial protection. This suggests that high membership or enrollment rates do not necessarily translate into the effective utilization of benefits, particularly when accredited facilities and service offices are unevenly distributed. Consequently, expanding PhilHealth's administrative presence in underserved communities is necessary to convert formal insurance coverage into meaningful access.

Geographic isolation, transportation limitations, and low household income strongly influence people's ability to access healthcare and insurance-related services. Geographically isolated and disadvantaged areas are characterized by barriers involving distance, difficult terrain, weather conditions, and insufficient transportation (Republic Act No. 11148, 2018). The Philippine Institute for Development Studies reported that only about half of Filipinos could reach primary healthcare facilities within the government's standard travel time of 30 minutes, demonstrating continuing inequalities in timely access (Ulep & Casas, 2021). Rural and lower-income Filipinos are also more likely to experience out-of-pocket health expenses, further increasing the burden placed on farmers, fisherfolk, informal workers, senior citizens, and other vulnerable groups (PIDS, 2023). In addition to transportation expenses, residents may lose an entire day's income while traveling to and waiting at a distant office. A Mobile PhilHealth Service Office could reduce these direct and indirect costs by bringing enrollment, record updating, claims assistance, benefit inquiries, and orientation services closer to barangays.

Mobile and outreach-based service delivery has been recognized as a practical intervention for populations that cannot regularly access permanent facilities. The World Health Organization explains that mobile clinics provide flexible and viable means of reaching isolated and vulnerable populations, particularly where distance prevents people from receiving essential services (WHO, n.d.). Although a Mobile PhilHealth Office would primarily provide administrative rather than clinical services, the same outreach principle applies: an essential public service is transported to communities instead of requiring disadvantaged residents to travel to urban centers. Philippine law also recognizes the value of mobile delivery by authorizing mobile health services that provide healthcare and disseminate health information, especially to poor and underserved citizens (Republic Act No. 10354, 2012). PhilHealth's own outreach activities have demonstrated the usefulness of community-based operations by registering individuals with primary-care providers, updating membership records, and explaining available benefit packages (PhilHealth, 2023). These experiences support the operational feasibility of a scheduled Mobile PhilHealth Office coordinated with local government and barangay officials.

The effectiveness of mobile services depends not only on physical proximity but also on service quality, information dissemination, digital capability, and operational continuity. The WHO identifies people-centeredness, equity, integration, effectiveness, safety, and efficiency as essential dimensions of quality health services (WHO, 2025). Therefore, mobile personnel should be properly trained to provide respectful, patient, and understandable assistance, especially to older adults, persons with disabilities, Indigenous peoples, and residents with limited educational attainment. Digital systems may further improve operations by supporting paperless transactions, electronic record verification, appointment management, and timely dissemination of schedules and requirements; nevertheless, digital channels should complement rather than replace face-to-face support because internet connectivity and digital literacy remain uneven. The WHO similarly notes that digital health can make health systems more

efficient, sustainable, affordable, and equitable when designed around universal access (WHO, n.d.). Thus, the proposed Mobile PhilHealth Service Office should combine regular community visits, dependable equipment and connectivity, trained personnel, clear communication, and sustained institutional funding. The reviewed literature establishes the policy justification and practical value of bringing public health and insurance services closer to underserved populations. Nevertheless, much of the existing literature concentrates on clinical mobile services, general healthcare access, or national patterns of PhilHealth coverage rather than the operational feasibility of a mobile office dedicated to PhilHealth administrative transactions. Limited evidence is available concerning communities' preferred services, frequency of visits, staffing requirements, technology needs, and concerns about the sustainability of such an intervention in Cebu Province. The present study addresses this gap by examining the perspectives of both community members and PhilHealth personnel and assessing the proposed service in financial, technical, operational, and social terms. In doing so, it may provide a localized basis for institutionalizing an accessible, inclusive, and people-centered Mobile PhilHealth Service Office.

OBJECTIVES OF THE STUDY

This research aimed to establish an operational Mobile PhilHealth Office as a strategic intervention to improve access to health services across Cebu Province in 2025. It examined the demographic profiles of PhilHealth personnel and community representatives, including their age, sex, occupation, educational background, household size, daily income, and relevant work experience. The study also assessed community members' enrollment and use of PhilHealth benefits, distance and transportation to the nearest office, travel expenses, and barriers to accessing services. Moreover, it evaluated their awareness of PhilHealth benefits, sources of information, and confidence in PhilHealth's ability to support their families during illness. Finally, it explored the perceived usefulness of a Mobile PhilHealth Office, the services residents expected, the preferred frequency of community visits, possible concerns, and relevant insights gathered through qualitative observation.

METHODOLOGY

This study used a mixed-methods design to examine the challenges underserved communities face in accessing PhilHealth services and assess the feasibility of establishing a Mobile PhilHealth Office. Quantitative data from surveys measured service use, travel time and costs, insurance status, and awareness of PhilHealth benefits, while qualitative data from interviews and focus group discussions captured the experiences and needs of farmers, fisherfolk, Indigenous peoples, and informal workers. Guided by the Universal Health Care Act of 2019, the Local Government Code of 1991, Service Delivery Theory, Decentralization Theory, and Mobile Governance, the study involved community members, PhilHealth personnel, and local government units. Statistical and thematic analyses were used to evaluate behavioral patterns, community needs, and institutional preparedness, while feasibility was assessed in terms of technical, financial, operational, and social factors. By combining numerical evidence with personal experiences, the study developed people-centered recommendations to improve accessibility, reduce health service disparities, build public trust, and advance universal health care among Filipino families in geographically underserved communities.

RESULTS AND DISCUSSION

PhilHealth Respondents' Demographic Profile

The demographic profile of PhilHealth personnel respondents provides important context for understanding their perspectives on the feasibility of Mobile PhilHealth Office in reaching geographically isolated and disadvantaged areas (GIDAs).

Age Distribution

As shown in **Table 3**, the largest group of respondents in terms of age was between **21 and 30 years old (n = 15)**, followed by those aged **31 and 40 (n = 12)**. Smaller proportions were observed among those aged **41–50 (n = 8)** and **51 years and above (n = 6)**, while no respondents were below 20 years old. This distribution suggests that the majority of PhilHealth personnel are in their early to mid-career stages, which may contribute to openness toward innovative service delivery models and adaptability to digital solutions. At the same time, the presence of older personnel provides institutional experience and stability, which is essential for sustaining long-term programs.

Table 3
Age Distribution of PhilHealth Respondents

Age Group	Frequency	Percentage
10-20	0	0%
21-30	15	37%
31-40	12	29%
41-50	8	19%
51 and UP	6	15%
Total	41	100%

Gender Distribution

With respect to Gender, as presented in **Table 4**, the sample consisted of **23 females** and **18 males**, indicating a slightly higher representation of women in the PhilHealth workforce. This gender balance reflects inclusivity and diversity within the institution and may influence perspectives on service delivery, particularly in addressing the needs of vulnerable groups such as indigent families, senior citizens, and women. Such diversity strengthens the alignment between personnel demographics and the community's expectations for compassionate and equitable service, as highlighted in the qualitative findings.

Table 4
Gender Distribution of PhilHealth Respondents

Gender	Frequency	Percentage
Male	18	44%
Female	23	56%
Total	41	100%

Years of Service

Regarding years of service, as shown in **Table 5**, the majority of respondents reported **less than five ye-**

ars of tenure (n = 23), while smaller groups had 5–10 years (n = 8), 11–15 years (n = 5), 16–20 years (n = 3), and 21 years and above (n = 2). This indicates that most personnel are relatively new to PhilHealth, which may explain their strong support for innovative approaches such as Mobile PhilHealth Office. At the same time, the presence of long-serving staff ensures continuity and institutional memory, which is critical for addressing sustainability concerns. This balance between younger, less experienced personnel and seasoned staff reflects the dual need for innovation and stability in program implementation.

Table 5
Years of Service of PhilHealth Respondents

Years in Service	Frequency	Percentage
LESS THAN 5	23	56%
5 – 10	8	20%
11 – 15	5	12%
16 – 20	3	7%
21 – ABOVE	2	5%
Total	41	100%

Taken together, the demographic profile reinforces the conclusions of the study. The youthful and predominantly early-tenure workforce may drive enthusiasm for accessibility, regular scheduling, and digital innovation, while experienced personnel highlight the importance of sustainability and resource adequacy. The gender balance further supports inclusive service delivery, aligning with community expectations for respectful and compassionate staff-client interactions. Thus, the demographic characteristics of PhilHealth personnel strengthen the case for Mobile PhilHealth Office as a holistic intervention, combining accessibility, innovation, sustainability, and inclusivity to bridge service gaps in GIDA communities.

Community Respondents' Demographic Profile

This section presents the demographic characteristics of the respondents, including age, sex, occupation, educational attainment, household size, and daily wage. The profile provides essential context for interpreting the findings of the study, as these variables influence perspectives, socio-economic conditions, and access to services.

Age Distribution

As shown in **Table 6**, the majority of respondents belong to the older age brackets, with 33 percent aged 51 years and above and 29 percent aged 41–50. This indicates that more than half of the respondents are middle-aged to elderly, suggesting that the perspectives gathered are shaped by mature individuals with considerable life and work experience. Meanwhile, 21 percent are aged 31–40, 15 percent are between 21–30, and only 2 percent are within the youngest group of 10–20 years old.

Table 6
Age Distribution of Community Respondents

Age Group	Frequency	Percentage
10-20	2	2%

21-30	15	15%
31-40	21	21%
41-50	29	29%
51 and UP	33	33%
Total	100	100%

Gender Distribution

The Gender distribution of respondents, presented in **Table 7**, is nearly balanced, with 49 percent male and 51 percent female. This equitable representation ensures that the findings reflect both genders' perspectives without significant bias toward one group.

Table 7
Sex Distribution of Community Respondents

Sex	Frequency	Percentage
Male	49	49%
Female	51	51%
Total	100	100%

Occupation

As shown in **Table 8**, farming and fishing dominate the respondents' livelihood profiles. Farmers constitute 41 percent of the sample, while fisherfolk account for 32 percent. Informal workers make up 15 percent, indigenous respondents 8 percent, and others 4 percent. This occupational spread highlights the rural and labor-intensive character of the community, where agriculture and fisheries remain the primary sources of income.

Table 8
Occupation of Community Respondents

Occupation	Frequency	Percentage
Farmer	41	41%
Fisherfolks	32	32%
Indigenous	8	8%
Informal Worker	15	15%
Others	4	4%
Total	100	100%

Educational Attainment

The educational attainment of respondents is presented in **Table 9**. The majority (46 percent) reached elementary education, while 36 percent completed high school. Only 14 percent attained college-level education, and 4 percent reported having no formal education. This distribution underscores the limited access to higher education within the community, which may influence employment opportunities and income generation.

Table 9
Educational Attainment of Community Respondents

Education Level	Frequency	Percentage
No Formal Education	4	4%
Elementary	46	46%
High School	36	36%
College	14	14%
Total	100	100%

Household Size

As shown in **Table 10**, nearly half (48 percent) of respondents live in households with 4–6 members, while 33 percent reside in larger households of 7–9 members. Smaller households of 1–3 members account for 13 percent, and 6 percent live in extended households with 10 or more members. These figures suggest that most respondents belong to medium-sized families, which is typical in rural Filipino settings.

Table 10
Household Size of Respondents

Household Size	Frequency	Percentage
1–3	13	13%
4–6	48	48%
7–9	33	33%
10 & up	6	6%
Total	100	100%

Daily Wage

The daily wage distribution of respondents is presented in **Table 11**. The largest proportion (42 percent) earns between ₱401–600 per day, followed by 34 percent who earn ₱201–400. A smaller group earns ₱601–800 (10 percent), while 6 percent earn ₱801 and above. Notably, 2 percent reported no daily wage at all. This income profile indicates that the majority of respondents fall within the lower-income bracket, reflecting modest economic conditions consistent with rural livelihoods.

Table 11
Daily Wage of Respondents

Daily Wage (₱)	Frequency	Percentage
0	2	2%
1–200	6	6%
201–400	34	34%
401–600	42	42%
601–800	10	10%
801 & up	6	6%
Total	100	100%

Overall, the demographic profile of the respondents (see Tables 1–6) paints a picture of a rural, labor-intensive community composed largely of middle-aged and elderly individuals engaged in farming and fishing. Educational attainment is generally limited to elementary and high school levels, households are medium to large in size, and income levels remain modest, with most respondents earning between ₱201–600 daily. These characteristics provide important context for understanding the perspectives and experiences of the population studied, particularly in relation to health service delivery and policy interventions.

Accessing PhilHealth Services

The descriptive statistics presented in **Table 12** provide important insights into the accessibility and utilization of PhilHealth services among respondents. Enrollment in PhilHealth yielded a very high mean score ($M = 4.82$, $SD = 0.39$), suggesting that most participants are already registered, with little variation in responses. However, the regularity of benefit use was lower ($M = 3.35$, $SD = 0.70$), indicating that while membership is widespread, actual utilization of services remains inconsistent. Accessibility emerged as a critical concern, with respondents unanimously reporting that PhilHealth offices are located far from their communities ($M = 5.00$, $SD = 0.00$). Travel to these offices was also rated highly ($M = 4.89$, $SD = 0.31$), reflecting uniform reliance on specific modes of transportation.

The cost of reaching the nearest office was moderately burdensome ($M = 3.73$, $SD = 0.62$), while barriers to access showed greater variability ($M = 4.09$, $SD = 1.04$), suggesting diverse challenges such as distance, communication gaps, and bureaucratic processes. Taken together, these findings highlight that although enrollment is nearly universal, the practical use of PhilHealth services is constrained by geographic and systemic barriers. This underscores the need for innovative solutions, such as mobile service units, to bridge the gap between policy promises and everyday realities of underserved communities.

Table 12
Descriptive Statistics on Accessing PhilHealth Services (N = 100)

Survey Item	Mean	Standard Deviation
Are you currently enrolled in PhilHealth	4.820	0.3861
How regularly do you use PhilHealth benefits	3.350	0.7017
How far from your locality can we find the PhilHealth office	5.000	0.0000
How does one typically get to the nearest PhilHealth office	4.890	0.3145
How much does it cost to get you to the nearest PhilHealth office?	3.730	0.6172
What barriers exist for you to access PhilHealth services?	4.090	1.0357

Awareness and Perception

The data presented in **Table 13** on PhilHealth awareness and Perception provides meaningful insights into how members perceive their benefits and the institution's role in supporting them. Respondents reported a relatively high familiarity with their PhilHealth benefits ($M = 4.14$, $SD = 0.70$), suggesting that most

members have a good understanding, though there is some variation in awareness levels. When asked where they generally obtain information about PhilHealth, the mean score was lower ($M = 3.25$, $SD = 1.11$), with a higher standard deviation, indicating that sources of information are diverse and inconsistent—some rely on official channels, while others may depend on informal networks. Confidence in PhilHealth’s ability to support families during illness was strong ($M = 4.37$, $SD = 0.85$), showing that members generally trust the institution, though variability suggests differing personal experiences. Overall, the findings highlight that while familiarity and confidence are relatively high, information dissemination remains uneven, pointing to the need for clearer, more accessible communication strategies to ensure all members are equally informed and empowered.

Table 13
Descriptive Statistics on Awareness and Perception (N = 100)

Survey Item	Mean	Standard Deviation
How familiar are you with your PhilHealth Benefits being a member	4.140	0.6966
Where do you generally get information on PhilHealth	3.250	1.1135
Do you feel confident that PhilHealth can support your family during illness	4.370	0.8487

Concept of a Mobile PhilHealth Office

The data on the concept of a Mobile PhilHealth Office, as shown in **Table 14**, reflects strong community support and clear expectations. Respondents overwhelmingly agreed that such an initiative would be highly useful ($M = 4.96$, $SD = 0.20$), with almost no variation, showing near-unanimous recognition of its importance. When asked about the services they would like to access through a mobile office, the mean was also high ($M = 4.25$, $SD = 0.89$), though the larger standard deviation suggests diverse needs—ranging from enrollment assistance to claims processing and information dissemination. Frequency of visits was rated very positively ($M = 4.68$, $SD = 0.63$), indicating that communities desire regular and consistent presence of mobile units. Concerns were also noted, with a mean of 3.99 ($SD = 0.89$), showing moderate worries such as sustainability, reliability, and adequacy of services. Overall, the findings emphasize that while enthusiasm and perceived usefulness are very strong, the success of Mobile PhilHealth Office will depend on addressing varied service expectations and alleviating community concerns about implementation and continuity.

Table 14
Descriptive Statistics on the Concept of Mobile Philhealth (N = 100)

Survey Item	Mean	Standard Deviation
If a Mobile PhilHealth Office comes to your community, would it be so useful to you?	4.960	0.1969
What services would you like to get through the Mobile PhilHealth Office	4.250	0.8919

How frequently should a Mobile PhilHealth Office go to your Community	4.680	0.6337
What worries you about a Mobile PhilHealth Office	3.990	0.8932

Community Insights for Mobile Philhealth

The findings of this study are best understood through both quantitative measures and qualitative insights, synthesized in the **conceptual diagram of community perspectives on Mobile PhilHealth Services**. At the center of the diagram is the proposed mobile office, surrounded by seven thematic clusters: **Accessibility and Proximity, Regular Scheduling, Service Quality, Scope of Services, Digital Innovation, Sustainability, and Information Dissemination**. Each cluster represents recurring community concerns and expectations, visually demonstrating how logistical and human factors converge in shaping health service delivery.

Quantitative results reinforce these themes. Enrollment in PhilHealth was nearly universal ($M = 4.82$, $SD = 0.39$), yet regular use of benefits was moderate ($M = 3.35$, $SD = 0.70$), reflecting the accessibility gap highlighted in the diagram's **Accessibility and Proximity** cluster. Respondents unanimously rated PhilHealth offices as distant ($M = 5.00$, $SD = 0.00$), directly aligning with calls for mobile units stationed closer to barangays and sitios. Similarly, the very high perceived usefulness of a mobile office ($M = 4.96$, $SD = 0.20$) and strong demand for frequent visits ($M = 4.68$, $SD = 0.63$) correspond with the **Regular Scheduling** cluster, where communities stressed the importance of predictable, consistent deployment.

The qualitative emphasis on **Service Quality**—kind, patient staff and shorter waiting times—complements the quantitative finding of high confidence in PhilHealth's support during illness ($M = 4.37$, $SD = 0.85$), though variability suggests uneven experiences. Barriers to access ($M = 4.09$, $SD = 1.04$) mirror qualitative concerns about bureaucratic processes, long travel, and inconsistent communication, captured in the **Information Dissemination** cluster. Calls for **Digital Innovation**, such as mobile apps and paperless systems, also resonate with quantitative evidence of moderate familiarity with benefits ($M = 4.14$, $SD = 0.70$) and diverse information sources ($M = 3.25$, $SD = 1.11$).

Taken together, the conceptual diagram and narrative explanation provide a holistic framework: quantitative data offer measurable evidence of accessibility and utilization gaps, while qualitative insights humanize these numbers by revealing lived realities and practical solutions. Both strands converge to affirm that Mobile PhilHealth Office—designed with accessibility, regular scheduling, digital integration, and empathetic service—can significantly enhance equity and inclusivity in health service delivery for rural communities like Tuburan, Cebu.

CONCLUSIONS

The study found that PhilHealth enrollment did not necessarily result in the consistent use of benefits because of accessibility and communication barriers. Distance was the primary challenge, particularly for residents of geographically isolated and disadvantaged areas who lived far from PhilHealth offices. Respondents strongly supported establishing a Mobile PhilHealth Office that would provide regular visits and comprehensive services in their communities. However, its success would depend on service quality, positive staff attitudes, sustainable operations, effective communication, and the integration of digital tools. Therefore, the Mobile PhilHealth Office should be a holistic and people-centered intervention that combines accessibility, consistency, compassion, sustainability, and innovation.

RECOMMENDATIONS

The study recommended establishing Mobile PhilHealth Offices and a fully equipped Mobile PhilHealth Bus to provide equitable health insurance services to residents of geographically isolated and disadvantaged areas. These mobile units should visit communities monthly or biweekly in coordination with barangay officials and offer enrollment, membership renewal, ID or MDR printing, claims processing, and orientation services, prioritizing senior citizens, persons with disabilities, and low-income families. Personnel should receive continuous training in compassionate, respectful, and patient-centered service, while adequate staffing, equipment, resources, and extended operating hours should support sustainable operations. Digital applications, paperless processes, and partnerships with agencies such as the SSS and Pag-IBIG Fund should be integrated to simplify transactions and reduce documentation requirements. Furthermore, schedules, requirements, and available services should be communicated through barangay announcements, text alerts, and community leaders, while mobile service delivery should be institutionalized within PhilHealth's operational framework to ensure consistency, accountability, and alignment with broader health system reforms.

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