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A critical analysis of purchasing of health services in the Philippines: A case study of PhilHealth

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A Critical Analysis of Purchasing
of Health Services in the Philippines:
A Case Study of PhilHealth

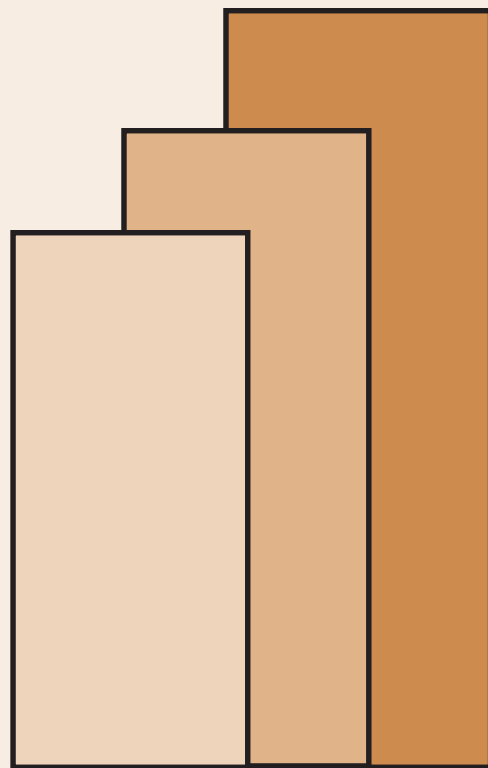
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Ida Marie Pantig, and Beverly Lorraine Ho*

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PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES

A Critical Analysis of Purchasing of Health Services in the Philippines:

A Case Study of PhilHealth

Oscar F. Picazo, Valerie Gilbert T. Ulep, Ida Marie Pantig, and Beverly Lorraine Ho

11/30/2014

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Abbreviations and Acronyms

ABTC – Animal Bite Treatment and Care
AHMOPI – Association of HMOs in the Philippines, Inc.
CARES – Customer Assistance, Relations and Empowerment Staff
CPG – Clinical Practice Guidelines
DBM – Department of Budget and Management
DOH – Department of Health
DSWD – Department of Social Welfare and Development
EMR – Electronic Medical Record
GAA – General Appropriations Act
HIV – Human Immunodeficiency Virus
HMO – Health Maintenance Organization(s)
HTA – Health Technology Assessment
KP – Kalusugan Pangkalahatan
LGU – Local Government Unit(s)
MCP – Maternity Care Package
MOVES – Mobile Orientation, Validation, and Enrolment Scheme
NBB – No Balance Billing
NCP – Neonatal Care Package
NG – National Government
NHIP – National Health Insurance Program of the Philippines
NHTS-PR – National Household Targeting System for Poverty Reduction
OFW – Overseas Filipino Worker
OOP – Out-of-Pocket
OPB – Outpatient Benefit
P/A – Principal/Agent
PCB – Primary Care Benefits
PHIC – Philippine Health Insurance Corporation or PhilHealth
PHP – Philippine Pesos (in July 2014, PHP43.3=US\$1.00)
Q1 – Quintile 1, the lowest-income quintile, also known as poor in the parlance of health financing in the Philippines
Q2 – Quintile 2, the second lowest-income quintile, also known as near-poor in the parlance of health financing in the Philippines
RA – Republic Act
RUV – Relative Unit Value
SP – Sponsored Program
THE – Total Health Expenditures
UHC – Universal Health Care

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Abstract

This study is a critical analysis of health services purchasing undertaken by PhilHealth which implements the National Health Insurance Program of the Philippines. Purchasing is about how an institution should determine, negotiate for, and obtain health services on behalf of a group of people which has contributed resources, either through taxes, premiums, or point-of-service payments, in exchange for anticipated health services.

The study employs a principal/agent framework for analyzing three critical relationships: that between the purchaser and health care providers, between the purchaser and citizens (or members of Philhealth), and between the purchaser and the government, both as regulator and as funder of services, at the national government and local government levels.

In analyzing these three relationships, the study compares three states: the ideal or theoretical arrangement of purchasing as determined by economic theory; the “design” arrangement as written in laws, implementing rules and regulations, executive and administrative orders, circulars, and other policies; and the actual arrangement or practice as culled from reports and interviews of stakeholders. Thus, the study is an analysis of the key alignments and variances of purchasing practices vis-à-vis the “design” and the theoretical ideal in each of the three relationships. To do this, the study employs an extensive document review as well as key informant interviews of decisionmakers and other stakeholders, including PhilHealth management and staff, the DOH, provider representatives, and consumer representatives.

The study is part of a multi-country analysis of purchasing of health services in selected African and Asian health financing organizations. The study provides key findings and policy implications.

Key words: purchasing of health services, Philippines, PhilHealth, strategic purchasing, active purchasing, health care financing

Executive Summary

This study is a critical analysis of health services purchasing undertaken by PhilHealth which implements the National Health Insurance Program of the Philippines. Purchasing is about how an institution should determine, negotiate for, and obtain health services on behalf of a group of people which has contributed resources, either through taxes, premiums, or point-of-service payments, in exchange for anticipated health services.

The study employs a principal/agent framework for analyzing three critical relationships: that between the purchaser and health care providers, between the purchaser and citizens (or members of Philhealth), and between the purchaser and the government, both as regulator and as funder of services, at the national government and local government levels.

Introduction

Buying services on your own is quite simple: you just choose what suits your needs and what is within your budget. But one party (the principal) buying services on behalf of another (the agent) engenders difficult problems. The principal may overspend or underspend the entrusted funds. It may be too stringent or too liberal with the purchased services. This is the case with health services purchased by a third-party (PhilHealth) on behalf of members who collectively contribute in order to obtain services from contracted providers, all under the stewardship of the government dispensing this function through policy and regulation. In health care, buying services on behalf of others is made even more complicated by information asymmetry in which one party in the transaction (the provider) may know more about the disease the other party (the patient), and where the both the patient and the health insurer find it difficult to measure the service quality of the provider.

Under this arrangement, three relationships emerge which need to be managed closely: (a) between PhilHealth and members, (b) between PhilHealth and service providers, and (c) between PhilHealth and the government. This note analyzes PhilHealth as a purchaser of health services in terms of these relationships. To assess the purchasing performance, health systems analysts from Asian and African countries formulated the set of standards to be used during a meeting from May 14 to 16, 2014 in Chiang Mai, Thailand.

Purchasing of health services is particularly relevant to achieve effective coverage under the *Kalusugan Pangkalahatan* (KP) program. PhilHealth, the country's social health insurance, has focused on expanding membership but as its population coverage approaches 75-85 percent, this should shift to increasing the reimbursement rate so that health insurance indeed reduces households' risks of falling into poverty due to illness. Doing this requires PhilHealth actions revolving around purchasing of health services: determining the services that members need, accrediting providers, ascertaining the cost of services and negotiating with providers on a reasonable price, and paying them expeditiously with minimal out-of-pocket payment from members.

Purchaser-Member Relationship

This relationship focuses on effective mechanisms to reflect people's needs, preferences, and values in decision-making.

- To engage actively with members on their health needs, preferences, and values – PhilHealth does this function unevenly, but in the case of the Primary Care Benefit (PCB+) expansion, it did extensive focus group discussions (FGDs) to inform benefits design.

- To ensure there are mechanisms for identifying eligible beneficiaries – PhilHealth has no problem identifying paying members but has difficulty with Sponsored Program (SP) members whose premiums have been paid for by the National Government (NG) but have not been enrolled. The Department of Social Welfare and Development (DSWD) identifies households eligible under the conditional cash transfer program, which PhilHealth uses as basis for SP coverage. The Department of Budget and Management (DBM) then directly transfers the premium subsidies covering Quintile 1 (poor = 5.2 million families) and Quintile 2 (near-poor = 5.6 million families) to PhilHealth. Coordination and data problems, however, have resulted in large variance between PhilHealth’s claim of population coverage (75 percent in 2012) and the households’ self-reported coverage of PhilHealth insurance (60.3 percent), per 2013 National Demographic and Health Survey (NDHS).
- To ensure awareness of members to their entitlements and obligations – FGDs indicate that members know PhilHealth in general but they are not aware of their specific benefits. In 2013, a World Bank evaluation showed 36 percent of SP patients were unaware of their coverage, a problem being addressed by Community Health Teams (CHTs) and PhilHealth’s CARES program that helps patients navigate the health system.
- To develop entitlements reflecting health needs of members and protecting them against financial catastrophe – In 2013, 60.3 percent of confined patients were covered by PhilHealth, significantly higher than the 37.7 percent in 2008. In 2011, PhilHealth reformed the provider payment by changing from retrospective fee-for-service (FFS) to prospective case rates which placed providers at risk for going over the rates for 23 conditions. Comparison of data pre- (2011) and post- (2013) reform show that almost all these case rates showed lower average costs and lower average lengths of stay compared to the FFS figures. PhilHealth expanded this case rate system to all inpatient conditions in 2013, and also introduced catastrophic financing for 9 conditions (Z benefits). However, real resource costing needs to be done as the current case rates involved averaging the claims of providers with some adjustments. In terms of public health interventions, analysis shows that the reimbursement rate for Maternal Care Package has been generous but TB DOTS has been inadequate. Finally, average support value in 2013 represented only 31.5 percent of hospitalization cost, leaving the balance of 68.5 to be funded mostly out-of-pocket.
- To ensure that members can access entitlements – In general, access is increasing: the percentage of treatment-seeking households rose from 7.9 percent in 2008 to 10.7 percent in 2013. However, the distribution of PhilHealth-accredited facilities is very uneven across provinces and regions, as is utilization. Moreover, there is no pattern between coverage and benefit utilization across regions. Finally, PhilHealth accreditation of doctors has lagged much behind the growth of membership. Patients per accredited doctor has more than doubled from 1,190 in the mid-1990s to 3,240 in 2011.
- To establish effective mechanisms to listen to complaints, views and reflections of members – Established procedures exist for settling complaints and resolving disputes. However, PhilHealth needs to have an active hotline, a webpage with same-day response, and an active social media.
- To report on purchaser performance to promote accountability – This function is not well developed and requires further institutionalization. No entity performs a watchdog function. PhilHealth’s annual reports feature positive achievements but gloss over issues, problems, and challenges; also, the indicators change from year to year. PhilHealth’s ‘Dashboard’ is still in its infancy.

Purchaser-Provider Relationship

This relationship underscores the use of policy and regulatory tools by the purchaser to incentivize the responsiveness and efficiency of providers.

- To take active decisions on which providers to purchase services from, with consideration of quality, ability to provide services, and location – PhilHealth has been too stringent in accrediting government hospitals and public health clinics, reducing access to these services. Only 67 percent of all licensed hospitals have been accredited. For TB DOTS, only 59 percent of all licensed TB DOTS clinics have been accredited after ten years. Although a more accommodative accreditation policy has been specified in the General Appropriations Act of 2012, this has not been implemented fully. More facilitative arrangements with providers to improve quality of care are yet to be institutionalized.
- To extend services to under-served areas – PhilHealth has no geographic equalization (or equity) fund. PhilHealth reimbursement rates are uniform and do not provide additional incentives for geographically isolated and depressed areas (GIDA).
- To improve health system efficiency through rational provision and use of services – Gatekeeping and referral systems are very weak because patients tend to go to the nearest health facility, referral bypass fees are not imposed, and many cities do not have city hospitals or filter clinics, forcing patients to clog DOH-owned regional hospitals located in these cities. On the positive side, payment reform from FFS to case rates has shown good results. The Generics Law has been in force for decades but providers still find ways to prescribe branded drugs. Not all clinical guidelines are available. Finally, because PhilHealth accounts for only 11 percent of total health expenditures, it has not evolved as a major payor and is largely unable to exercise its monopsony power to lower health care costs and reduce out-of-pocket spending.
- To monitor provider performance, including quality of care – Quality standards are mostly ex-ante through accreditation. Concurrent quality monitoring is not yet in place. De-accreditation of erring providers is rarely resorted to as it penalizes members just as it does the erring providers.
- To enforce contractual agreements with qualified public and private providers – PhilHealth outpatient benefit packages evolved in a fragmented fashion, requiring repetitive accreditation and monitoring. Hospitals usually complain of payment delays, although payment has been expedited under case rates. Also, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.
- To implement and adjust provider payment methods that enhance quality and efficiency – Under case rates, providers know in advance their reimbursements. A No Balance Billing policy is in force and compliance has improved. In June 2013, 93 percent of surveyed hospitals practiced balance billing; by June 2014, this has been reduced to 59 percent.
- To ensure mutual accountability between purchaser and providers through timely payment – On average, turn-around time fell by 21-24 days when PhilHealth changed provider payment from FFS to case rates.
- To manage finances in a transparent and accountable way – PhilHealth has adopted an accounts-management approach to ensure all collectibles are collected. PhilHealth has an internal audit unit that investigates fraud. Revenues have always been aligned with expenditures, but reserve management has been conservative. The ratio of reserves to benefit payments and operating costs

reached as high as 3-4 years' worth from 2004 to 2009, though this has been reduced to 2.2 years in 2013, closer to what the law prescribes at 2 years.

Purchaser-Government Relationship

This relationship focuses on government stewardship to ensure that public health priorities are linked to resource allocation and purchasing decision-making.

- To establish policy and regulatory framework for the purchaser and providers – PhilHealth is a government owned and controlled corporation with an independent governing board. The government, however, is overly represented in the board, and members/providers are generally under-represented. The PhilHealth executive committee provides technical direction, but there are skill deficits in certain areas (e.g., actuary, health technology assessment, and business analytics). Policies are issued through circulars, but these are often fragmented as benefit expansion is not underpinned with a long-term vision of social health insurance in the country.
- To promote equitable access to needed health services by investing in delivery capacity in under-served areas – PhilHealth does not invest in capacity infrastructure although its predecessor (Philippine Medical Care Commission) did so. PhilHealth's tool is financing, which hopefully will incentivize providers to locate in underserved areas.
- To ensure adequate resources are mobilized to purchase services – Government has mobilized sin taxes for the Quintile 1 and Quintile 2 premium subsidy program. However, collection efficiency (for paying members) is only 67 percent. Increasing premium among paying members is highly politicized. The premium rate of 2.5 percent of employee earnings is one of the lowest in emerging economies.
- To implement mechanisms to ensure accountability of purchaser to government – Audit is institutionalized. However, neither the Executive nor the Legislative branches have exercised stewardship roles proactively. DOH, as mother agency, does not have enough staff with health-financing skills to provide technical support to PhilHealth.

Key Remaining Tasks

As PhilHealth approaches universal population coverage, the key remaining tasks are:

- Purchaser-member link – To identify the remaining members whose premiums have been paid for by government but are not aware of their entitlements.
- Purchaser-provider link – To improve benefits by significantly expanding the PCB+ package and giving members the choice of provider (public or private). To loosen up on the accreditation of public health programs (especially TB DOTS) with significant impact on poor Filipinos. To fine-tune the case rate payment system by conducting costing exercises. To expand the Z benefits using objective burden of disease and cost-effectiveness principles.
- Purchaser-government link – To undertake strategic planning on the role of social health insurance, focusing on the need to improve collection efficiency and to increase the premium so that benefits can be expanded and sustained. To strengthen the stewardship and regulatory functions by investing in skills needed to manage a modern health financing system, including actuarial science, health technology assessment, and medical informatics and business analytics.

Chapter I. Background and Introduction

A. Objectives and Rationale of the Study

Objectives – This study is a critical analysis of the purchasing of health services undertaken by PhilHealth which implements the National Health Insurance Program (NHIP) of the Philippines. Purchasing is a new word in the lexicon of health care financing, although the concept is practiced by health organizations through their various tasks and functions, often in a fragmented fashion. Purchasing is not about procurement of commodities, supplies, civil works, or technical services for use in the health sector. Nor is it about the recruitment of health workers or managers. It is more encompassing than these, and more strategic. Purchasing is about how an institution should buy health services on behalf of a group of people which has contributed resources, either through taxes, premiums, or point-of-service payments, in exchange for anticipated health services. This study is an attempt to explain this concept in its entirety using PhilHealth as a case study.

The study is a part of a multi-country analysis of purchasing of health services in Africa and Asia. It is funded by the Asia Pacific Observatory of Health Systems and Policy (APO) while the other country studies were funded by the RESYST Project of the London School of Hygiene and Tropical Medicine. All the studies used a common conceptual framework, methodology and terminology.

The objectives of this case study are: (a) to provide an overview of health care financing and thereby situate the context of purchasing of health services in the country; (b) to explain the nature of purchasing of health services and identify the key purchasing mechanisms operating in the country; (c) to analyze and understand how purchasing of health services is practiced in the National Health Insurance Program (NHIP), as implemented by PhilHealth; and (d) to cull key lessons, policy implications, and recommendations (Chapter VI).

Rationale – Universal health care (UHC) has taken center stage in the global and local health arena. The 58th World Health Assembly endorsed UHC and the 2010 World Health Report recognized the critical role of health system financing in low- and middle-income countries (WHO, 2005; WHO, 2010). In 2010, when President Benigno Aquino III assumed office, his administration took on the challenge of UHC and committed to achieve nationwide membership coverage by 2016. This vision was contained in the Department of Health's program on *Kalusugan Pangkalahatan* (KP, the translation of UHC in the national language) which has three thrusts: (a) financial risk protection through the provision of premium subsidies to the poorest two quintiles of the population as well as reforms in provider payment, (b) strengthening of the public health system to meet the Millennium Development Goals (MDGs), and (c) massive infrastructure rehabilitation and construction through the Health Facilities Enhancement Program (HFEP).

Purchasing of health services is particularly relevant in KP's thrust of financial risk protection. The focus of social health insurance in the Philippines has long been on expanding membership, but as coverage approaches 80-90 percent of the population, this should shift to increasing the reimbursement rate (or the so-called "support value"¹) so that health insurance indeed reduces a household's probability of falling into poverty due to a member's illness. Doing this requires a combination of actions from PhilHealth, all revolving around purchasing of health services – determining the health services that most members need, identifying and accrediting providers, ascertaining the true cost of health services and negotiating with providers on a reasonable price, and paying these providers the reasonable amount, with minimal, if not zero, out-of-pocket payment from members.

¹ Support value (%) = (Total PhilHealth reimbursement in PHP/Total value of claim in PHP) x 100

These tasks, bundled together and called “purchasing,” seem simple, but get complicated in the design and practice of social health insurance for many reasons. First, the design of social health insurance such as PhilHealth may not incorporate the best practices as informed by economic theory, institutional theory, and the theory of incentives. This may be due to poor information; the political negotiation that usually occurs in the formulation of legislation and policy; historical inertia or mere tradition. Second, the practice of social health insurance may vary from the design of the enabling laws and subsequent rules and regulations due to inadequate understanding or interpretation of the law, circulars, and executive or administrative orders; shortcomings in governance and oversight structure; weak institutional capacity to enforce the laws and circulars; uneven application of such laws and circulars; and lack of monitoring and evaluation. Third, the purchasing functions themselves may be fragmented across institutional units, and infrequent communication and poor coordination among units can reduce the effectiveness of even the best-designed rules and regulations.

This study, therefore, is important as it provides a detailed analysis of each of the functions of purchasing and how Philhealth is performing according to both the theoretical ideal as well as to its written design as reflected in its enabling laws, circulars, and orders. The results of the analysis, in turn, can provide inputs (policy and programmatic implications) on how the purchasing functions of PhilHealth can be improved so that it meets its goals pertaining to UHC.

B. Conceptual Framework and Methodology of the Study

Buying services on your own is quite simple: you just choose what suits your needs and what is within your budget. But one party (the principal) buying services on behalf of another (the agent) engenders difficult problems. The principal may overspend or underspend the entrusted funds. It may be too stringent or too liberal with the purchased services. This is the case with health services purchased by a third-party (PhilHealth) on behalf of members who collectively contribute in order to obtain services from contracted providers, all under the stewardship of the government dispensing this function through policy and regulation. In health care, buying services on behalf of others is made even more complicated by information asymmetry in which one party in the transaction (the provider) may know more about the disease the other party (the patient), and where the both the patient and the health insurer find it difficult to measure the service quality of the provider. Under this arrangement, three relationships emerge which need to be managed closely: (a) between PhilHealth and members, (b) between PhilHealth and service providers, and (c) between PhilHealth and the government.

The conceptual framework of the study underscores two related ideas that will be explored in this study. The first idea is that there is a set of theoretical ideal purchasing functions that must be dispensed by purchasers of health services. The second idea is that there are three key principal-agent (P/A) relationships in the purchasing of health services which must be analyzed based on how well they reflect the theoretical ideal set of functions.

Ideal or Theoretical Arrangements – These are the P/A arrangements, functions, or actions predicted by economic theory to be ideal. Two key ideas must be differentiated in this regard: active or strategic purchasing (which is deemed to be the ideal) versus passive or inactive purchasing (which is deemed to be what many purchasers do in practice, unless they know better). In this study, active purchasing of health services refers to the strategy and practice of linking resources mobilized for health with the provision of health services by promoting (a) equity in the distribution of resources, (b) efficiency in the use of resources, and (c) transparency and accountability in order to promote effective coverage of quality health services and financial risk protection and thereby facilitate progress towards universal health care (UHC) (RESYST, 2014). Ideally, an active purchaser (and in some instances, other actors involved in active purchasing) is expected to develop, manage and use information systems to gather information about population health needs, service utilization, and revenue and expenditure.

- Purchaser-member relationship – This relationship focuses on the existence of effective mechanisms to determine and reflect people’s needs, preferences and values in purchasing decision-making. These ideal functions are explained in Chapter III.
- Purchaser-provider relationship – This relationship underscores the use of policy tools by purchasers to improve provider responsiveness and efficiency. These ideal functions are explained in Chapter IV.
- Purchaser-government relationship – This relationship focuses on government stewardship to ensure that public health priorities are linked to resource allocation and purchasing decision-making. These ideal functions are explained in Chapter V.

Given the ideal functions, purchasing arrangements in each of the three P/A relationships can then be assessed by comparing existing arrangements with these ideal set of functions, and with a designed functions as contained in the enabling laws, implementing rules and regulations, and institutional circulars.

Designed or Legal Arrangements – These are the P/A arrangements, functions, or actions explicitly contained in the enabling legislation, implementing rules and regulations, executive or administrative order, circulars, and other relevant policy instruments. These pieces of information were obtained in the review of relevant official documents.

Actual or Existing Arrangements– These are the P/A arrangements, functions, or actions as observed in the actual practice of institutions or their governing boards, management officials, or staff. These pieces of information were obtained in relevant reports as well as key informant interviews (in the form of tacit knowledge).

Based on the conceptual framework, the study’s challenge is to identify the alignments and variations between ideal and design, and between design and actual practice. The succeeding chapters report on these alignments and variations in the three relationships. To undertake the above assessment of the three P/A relationships, the study involved extensive search and review of related literature, both published and unpublished; formulation of a common study instruments across countries, i.e., analytical framework, semi-structured questions, coding scheme for culling responses, and standard report outline; conduct of local key informant interviews (KII) from May to July 2014 with stakeholders; and multi-country sharing of experiences involving country teams in a meeting in Chiang Mai, Thailand on July 14 to 16, 2014.

The respondents for the KIIs included executives and managers of PhilHealth (7), hospital directors (2), hospital coordinator for PhilHealth (1), and patient groups (2).

Chapter II. Overview of Health Care Financing and Health Service Purchasing in the Country

A. Health Care Financing

The country's total health expenditures (THE) increased in nominal (current) terms from PHP 198 billion in 2005 to PHP 417 billion in 2011 and PHP 468 billion in 2012 (see Table 1). Correspondingly, nominal per capita health expenditures increased from PHP 3,759 in 2009 to PHP 4,392 in 2011 and PHP 4,847 in 2012. Total health expenditures represented 4.3 percent of GDP in 2011 and 4.4 percent in 2012. This compares favorably with Thailand (4.2 percent) and Singapore (4.1 percent), better than Indonesia (2.5 percent) and Myanmar (2.1 percent), but lower than Vietnam (6.9 percent).

The distribution of health expenditures has not changed much during the past decade. Private sources, mostly out-of-pocket spending, accounts for more than 60 percent, while government expenditures has consistently been lower than 30 percent. Social health insurance, represented by mainly by PhilHealth and a fraction from the Employees Compensation Commission, has consistently been lower than 10 percent. Donor expenditures account for 1-2 percent. Household out-of-pocket (OOP) spending remains inordinately high as a proportion of THE in the Philippines.

Over the past years, it has stayed at around 53 percent, moving slightly from 53.3 percent in 2009 to 52.7 percent in 2011. However, in 2012 OOP jumped to 62.1 percent of THE. Most of out-of-pocket spending is in the form of medical goods directly purchased by households from retailers. As much as 30.4 percent of THE arise from these types of purchases.

Table 1. Key Indicators of Health Expenditures, 2012

Indicators	Values
Total health expenditures (THE)	PHP 467.8 billion
THE as percent of GDP	4.4%
Per capita THE	PHP 4,847
Sources of health expenditures	
• National and local governments as percent of THE	18.5%
• Social health insurance (PhilHealth) as percent of THE	11.4%
• Household out-of-pocket as percent of THE	57.6%
• Others (donors, private institutions)	12.8%
Uses of health expenditure	
• Curative/rehabilitative care	52.3%
• Medical goods directly purchased by households from retailers	30.4%
• Preventive health care	9.4%
• Administration	6.7%
• Not elsewhere classified	1.2%

Source: Philippine Statistical Authority, 2014

B. PhilHealth as a Purchaser of Health Services

PhilHealth was selected as the focus of this case study because it is the social health insurance program in the Philippines. It is also one of the pioneers in the developing world. PHIC was established in 1995 but it originated from the Philippine Medical Care Commission which was created in 1969. PMCC/PhilHealth was envisioned to carry out the National Health Insurance Program of the Philippines.

PhilHealth has the largest network of facilities and professionals accredited by any risk-pool in the country. Thus, the reach of PhilHealth's policies and its overall influence on the provision of care is large and can be significant.

PhilHealth's contribution to total health expenditures is currently small (11 percent in 2012), a figure dwarfed by sizeable out-of-pocket payments, mainly of over-the-counter drugs and prescription pharmaceuticals especially of non-communicable diseases. If this existing pattern and size of out-of-pocket health spending can be pooled through premiums, they can transform PhilHealth into a large strategic purchaser of health services, lowering costs and significantly improving overall efficiency in the health system. Such potential remains to be seen, and this study's primary interest is to see how this can be achieved.

PhilHealth has embarked on an ambitious reform program involving the expansion of population coverage (corresponding to UHC 'width'), increasing the benefits (corresponding to UHC 'breadth'), and changing the provider payment system to reduce if not eliminate out-of-pocket payments (corresponding to UHC 'depth'). Analyzing these reforms using the lens of strategic purchasing can pinpoint current weaknesses and gaps in the reform program and help PhilHealth achieve its target of UHC.

C. Organizational Characteristics of PhilHealth

Legal Status - The Philippine Health Insurance Corporation (PhilHealth) is a "tax-exempt government corporation attached to the Department of Health for policy coordination and guidance" (Congress of the Philippines 1995). It is classified as Government Owned and Controlled Corporation (GOCC), defined as "any agency organized as a stock or nonstock corporation, vested with functions relating to public needs whether governmental or proprietary in nature, and owned by the Government of the Republic of the Philippines directly or through its instrumentalities either wholly or, where applicable as in the case of stock corporations, to the extent of at least a majority of its outstanding capital stock" (Congress, 2011).

Vision, Mission, and Mandate - The vision and mission statements of PhilHealth are written in short Filipino phrases in line with its desire to communicate them to every Filipino. The vision is "*Bawat Pilipino, miyembro; Bawat miyembro, protektado; Kalusugan natin, segurado*" or roughly translated as "Each Filipino is a member; each member is protected; our health is secured." The mission is "*Sulit na benepisyo sa bawat miyembro; dekalidad na serbisyo para sa lahat*" or "Optimal benefits for every member; good quality service for all." Its values are innovation, good quality service, utmost integrity, equity, social solidarity, and total care.

The vision, mission, and values are consistent with its mandate to provide full health insurance coverage and ensure the delivery of good quality health services to every Filipino. As a social health insurance scheme, the NHIP is a sustainable means for healthy Filipinos to support those who are sick and in need through the availment of benefit packages. However, its powers are limited as they are limited to supporting only those officially enrolled members under the NHIP and are prohibited from participating in the direct provision of health services, such as procurement of medicines, hiring of staff in hospitals, and owning and investing in health facilities (Congress of the Philippines 1995).

Funding Sources and Amount of Funding - PhilHealth's funding comes solely from health insurance premium. It does not receive any budget subsidy from the national government for running its operations. In 2013, 69 percent of the funding was sourced from premium of members of the formal and informal economy, and the remaining 31 percent from the premiums of sponsored program members. Total 2013 contributions amounted to around PHP 55 billion.

Regular contributions come from the formal and informal sectors. The employed sector contributes 2.5 percent of the employee's monthly salary which is automatically deducted from the payroll. Half of this is shouldered by the employers, and the other half by employees. Members of the informal sector contribute on a monthly or quarterly basis. Members of the informal economy sector who do not qualify for the sponsored program are sponsored by the local government unit (LGU) where they are registered or through other forms of cost-sharing mechanisms (Congress of the Philippines 2013). Premiums of DSWD identified sponsored program members come from the Department of Health. Househelpers are fully sponsored by their employers under Republic Act 10361 or *Kasambahay Law* (Congress, 2013).

Establishment Details - A national health insurance program was set up by President Ferdinand Marcos through R.A. 6111 or the Philippine Medical Care Act of 1969 (more commonly known as Medicare), with the Philippine Medical Care Commission (PMCC) tasked to oversee implementation. However, only the employed sector was covered.

The call for a more inclusive health insurance program began in the 1990s, leading to the passing of R.A. 7875 or National Health Insurance Act of 1995. The law established the Philippine Health Insurance Corporation, which assumed the responsibility of the Philippine Medical Care Commission (Medicare) and the Overseas Workers Welfare Administration (OWWA) in providing financial protection to all Filipinos.

The law has since been revised twice, first in 2004 through R.A. 9241, then in 2013 through R.A. 10606. Key revisions in the first amendment include changes in accreditation requirements for health service providers and inclusion of two more representatives, one from the Basic Sector of the National Anti-Poverty Commission and another from Overseas Filipino Workers (OFWs) sector, into the Board of Directors. Aside from the strengthened mandate to cover 100 percent of the population, the 2013 amendment reflected the removal of accreditation fees for registered health care professionals under the Philippine Regulatory Commission and the inclusion of DOH-licensed hospitals as accredited health care providers. There is also an increasing shift from a fee-for-service payment mechanism to case-based payments.

Organizational Structure - The Board of Directors oversees all the activities of the organization. Included in the Board of Directors is the President and Chief Executive Officer (CEO) who is the head of the corporation. There is an Internal Audit Group that conducts the financial and operations audits, and a Corporate Secretary. Under the President and CEO are various administrative offices, including the Office of the Executive Vice President and Chief Operating Officer. Under this office are departments with specific functions to the delivery of health insurance, including Fund Management, Member Management, and Health Finance Policy. This office also handles all the heads of the regional offices across the country. In every department, there are Vice Presidents and Senior Managers in charge. Area Vice Presidents handle clusters of regions that are managed by Regional Vice Presidents, who handle Regional Managers in every sub-office.

Management and Leadership - The Board of Directors is composed of members that represent various interests in the delivery of health insurance. The President and CEO of PhilHealth is included. Representing the national government are Secretaries of the Departments of Health, Interior and Local Government, Social Welfare and Development, Labor and Employment, and Finance, as well as the Chairperson of the Civil Service Commission, the President and CEO of the Social Security System, the President and General manager of the Government Service Insurance System, and the Vice Chairperson of the Basic Sector of the National Anti-Poverty Commission. There are representatives from every member segment, which are the Sectors of Healthcare Providers, Employers, Labor, Self-Employed,

Local Government Units, and Formal/Informal Economy. Also included is the Independent Director of the Monetary Board (PhilHealth 2014a).

Financial Management and Auditing - The National Health Insurance Fund consists of contribution from program members, other appropriations earmarked by the national and local governments for this purpose, such as those for the sponsored program, subsequent appropriations provided under the filing of claims, donations and foreign aid grants, and any subsequent accruals (Congress, 2013). For the financial year 2013, PhilHealth's total assets stand at PHP 131 billion, and the reserve fund is around PHP 115 billion.

As any other national government agency, financial management is restricted to rules and regulations applicable to the use of public funds. Moreover, annual total cost (which includes administrative and operations costs) until 2018 must not exceed 5 percent of sum total of total contributions, total reimbursements, and investments earnings generated during the immediately preceding year. After 2018, annual total costs must not exceed the sum total of 4 percent of total contributions and reimbursements and 5 percent of investments earnings generated during the immediately preceding year (Congress, 2013).

PhilHealth has an internal auditing department, but is also subject to independent audit by the Commission on Audit (CoA) in accordance with International Standards on Auditing (COA, 2013). Consolidation of financial statements from regional offices, where benefit payments and operating expenditures are decentralized, is done through the Home and Branch Accounting System since July 1999. In this system, the central office consolidates individual accounting reports prepared by the regional offices at the end of every financial year (COA, 2013).

PhilHealth has 20 regional offices and 101 local health insurance offices. The regional offices are headed by a regional vice president. Each region in the country has a PhilHealth regional office, with the exception of Region III (which has two) and National Capital Region (which has three). Local health insurance offices, headed by a branch manager, are established in every province and chartered city to coordinate with LGUs in enrolling members, processing reimbursements, and preparing annual reports.

D. Other Health Financing and Purchasing Arrangements

Purchasing of health services in the Philippines can be organized into four distinct groups corresponding to their types of health financing.

National Government – The National Government is represented by the Department of Health (DOH), the highest policymaking body for health and the reporting or attached agency for 72 of the largest retained public hospitals. The Local Government Code, enacted in 1991, devolved all primary and secondary facilities to some 1,400 local government units (LGUs) in 1992, leaving the largest apex hospitals, regional hospitals, and other higher-level health facilities retained under the DOH. Four of these hospitals have autonomy via their own special charters while the rest do not, and are effectively a hierarchical extension of the DOH.

As in most hierarchically funded government entities, these retained hospitals obtain an annual budget from the General Appropriations Act (GAA), which is managed by the Department of Budget and Management (DBM). They also generate, in varying degrees, internally generated funds such as reimbursements from PhilHealth, reimbursement from private health insurance, and user fees.

The purchasing of health services varies by facility. Purchasing is largely passive, as indicated by the following observations: (a) There is no clear identification of patients as clients or customers. Public hospitals are supposed to cater more for the poor, but technically, everybody has a right to access the

facilities and utilize the services there. (b) The roles of the purchaser and the provider are not clearly delineated, i.e., there is no purchaser/provider split. (c) There is no clear delineation between the budgets that health facilities receive and the outputs or outcomes that they are supposed to deliver.

Local Governments – Local government units consist of 80 province and some 1,300 cities and municipalities. Under the Local Government Code, provinces own and manage provincial and district hospitals; cities own and manage city hospitals and city health units; and municipalities own and manage rural health units and barangay (village) health stations. These local health facilities are funded from each LGU's internal revenue allotment (IRA) as well as internally-generated funds from PhilHealth, private health insurance, and user fees. There is no uniform financing or purchasing arrangement for these health facilities and each LGU is left very much on its own on how to manage them. Very few of these health facilities have autonomy (e.g., La Union Medical Center); most are managed as hierarchically funded budget-receiving entities.

Private Health Insurance and Institutional Spending– The private health insurance industry in the Philippines is small, accounting for only 2 percent of THE in 2011. There are two main types: health maintenance organizations (HMOs), which number fewer than 20, and life insurance companies offering indemnity health insurance as a product. Private institutional health spending includes the health expenditures of private schools and private establishments. These are school-based or work-based health programs that students or employees are entitled to as a benefit.

Chapter III. Purchaser-Member Relationship in PhilHealth

A. Characteristics of PhilHealth Members

There are five PhilHealth programs, each with its own type of members: Sponsored, Formal, Individually-Paying, Overseas Filipino Workers, and Lifetime (retirees). In general, the classification is based on the type of employment or the payer of premiums. Table 2 shows each membership type based on the old and current NHIP laws.

Table 2. PhilHealth Membership Types

Membership Types	RA 7875 (1995)	RA 10606 (2013)
Sponsored	A person who has no visible means of income as identified by the Local Health Insurance Office and based on specific criteria set by PhilHealth	A person who has no visible means of income as identified by the Department of Social Welfare and Development (DSWD) based on specific criteria (NHTS-PR ²)
	Contributions are subsidized partially by LGU and NG ³ though PhilHealth provides counterpart financing equal to the LGU's subsidy	NG subsidizes the full premium payment of indigent members identified under the NHTS-PR
Formal	Workers in both government and private sectors as well as household employees and sea-based OFWs; employees pay half of premium and the other half by the employer	Workers in the government and private sector; half of the premium is paid for by the employee and the other half by the employer.
Individually-Paying	Self-employed; contributions are based on household earnings and assets	Individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, or as a career, but do not belong to the informal sector, e.g., movie actors. Contributions are based on household earnings and assets.
Overseas Filipino Workers	Documented/undocumented Filipinos engaged in remunerated activities in another country (RA 9241); member pays premium in full	Documented/undocumented Filipinos engaged in remunerated activities in another country (RA 9241); member pays premium in full
Lifetime	SSS and GSIS retirees and pensioners and members who reach the age of retirement as provided for by law and have paid at least 120 monthly contributions; no premium is	A former member who has reached the age of retirement under the law and has paid at least 120 monthly premium contributions. Lifetime members do not pay premium.

² NHTS-PR = National Household Targeting System for Poverty Reduction.

³ NG = National Government.

collected from Lifetime Members

B. Ideal Versus Actual Functions in the Purchaser-Member Relationship

This relationship focuses on the existence of effective mechanisms to determine and reflect people’s needs, preferences and values in purchasing decision-making. Table 3 shows the ideal functions of the purchaser and an assessment of how PhilHealth has dispensed each of these functions.

Table 3. Ideal Functions of the Purchaser in the Purchaser-Member Link and Assessment of PhilHealth’s Performance

Functions of Ideal Purchaser	Assessment of PhilHealth
To engage actively with members on their health needs, preferences, and values	PhilHealth does this function unevenly, but in the case of the Primary Care Benefit (PCB+) expansion, it did extensive focus group discussions (FGDs) to inform benefits design.
To ensure there are mechanisms for identifying eligible beneficiaries	PhilHealth has no problem identifying paying members but has difficulty with Sponsored Program (SP) members whose premiums have been paid for by the National Government (NG) but have not been enrolled. The Department of Social Welfare and Development (DSWD) identifies households eligible under the conditional cash transfer program, which PhilHealth uses as basis for SP coverage. The Department of Budget and Management (DBM) then directly transfers the premium subsidies covering Quintile 1 (poor = 5.2 million families) and Quintile 2 (near-poor = 5.6 million families) to PhilHealth. Coordination and data problems, however, have resulted in large variance between PhilHealth’s claim of population coverage (75 percent in 2012) and the households’ self-reported coverage of PhilHealth insurance (60.3 percent), per 2013 National Demographic and Health Survey (NDHS).
To ensure awareness of members to their entitlements and obligations	FGDs indicate that members know PhilHealth in general but they are not aware of their specific benefits. In 2013, a World Bank evaluation showed 36 percent of SP patients were unaware of their coverage, a problem being addressed by Community Health Teams (CHTs) and PhilHealth’s CARES program that helps patients navigate the health system.
To develop entitlements reflecting health needs of members and protecting them against financial catastrophe	In 2013, 60.3 percent of confined patients were covered by PhilHealth, significantly higher than the 37.7 percent in 2008. In 2011, PhilHealth reformed the provider payment by changing from retrospective fee-for-service (FFS) to prospective case rates which placed providers at risk for going over the rates for 23 conditions. Comparison of data pre- (2011) and post- (2013) reform show that almost all these case rates showed lower average costs and lower average lengths of stay compared to the FFS figures. PhilHealth expanded this case rate system to all inpatient conditions in 2013, and also introduced catastrophic financing for 9 conditions (Z benefits). However, real resource costing needs to be done as the current case rates involved averaging the claims of providers with some adjustments. In terms of public health interventions, analysis shows that the reimbursement rate for Maternal Care Package has been

	generous but TB DOTS has been inadequate. Finally, average support value in 2013 represented only 31.5 percent of hospitalization cost, leaving the balance of 68.5 to be funded mostly out-of-pocket.
To ensure that members can access entitlements	In general, access is increasing: the percentage of treatment-seeking households rose from 7.9 percent in 2008 to 10.7 percent in 2013. However, the distribution of PhilHealth-accredited facilities is very uneven across provinces and regions, as is utilization. Moreover, there is no pattern between coverage and benefit utilization across regions. Finally, PhilHealth accreditation of doctors has lagged much behind the growth of membership. Patients per accredited doctor has more than doubled from 1,190 in the mid-1990s to 3,240 in 2011.
To establish effective mechanisms to listen to complaints, views and reflections of members	Established procedures exist for settling complaints and resolving disputes. However, PhilHealth needs to have an active hotline, a webpage with same-day response, and an active social media.
To report on purchaser performance to promote accountability	This function is not well developed and requires further institutionalization. No entity performs a watchdog function. PhilHealth’s annual reports feature positive achievements but gloss over issues, problems, and challenges; also, the indicators change from year to year. PhilHealth’s ‘Dashboard’ is still in its infancy.

Source: This study

C. Analysis of the PhilHealth Purchaser-Member Relationship

1. Ensuring that all members are registered – Based on the latest official reports of PhilHealth, the coverage rate is at 75 percent in 2013. Coverage rate refers to the portion of the population who are eligible to receive benefits. Coverage rate estimates is usually lower than enrollment rate, which is defined as the portion of population listed in the PhilHealth database. PhilHealth estimates of coverage rates have been contentious because its information system cannot capture the exact number of members and beneficiaries (spouse and children under 21 years old). In lieu of actual count of principal and dependent members, PhilHealth uses average household size as multipliers to estimate to coverage rate. The assumed multipliers, however, do not take into account households with two or more principal members, the age distribution of members, and the household size. As a result, the coverage rate estimates have been highly varied. PhilHealth once reported an 85 percent coverage rate while estimates from national surveys and external reviews showed less than 50 percent. The 2013 National Demographic and Health Survey (DHS) reported that 62.8 percent of Filipino households had health insurance, of which 60.3 percent had PhilHealth insurance (NSO, 2014).

Enrolling poor households – Like most SHIs, the idea is for the government to subsidize the premiums of the poor households. Prior to 2013, the local government units were responsible in identifying poor households, and their premiums were partly shared by the local and national governments. Identification of poor households has been highly political and unstandardized in practice, which led to under-coverage of ‘true poor’ households. Enrollment of ‘political poor or indigents’ was also common in LGUs.

Under the new NHIP law, the responsibility of identifying poor household eligible for SP was shifted from local government units to national government. Counterpart financing was also removed, as the national government began to shoulder the total premiums of the pre-identified poor households. PhilHealth used the National Household Targeting System (NHTS) of the Department of Social Welfare and Development (DSWD). NHTS is a targeting tool also used in several social and poverty reduction programs of the government (PhilHealth Circular 51-2012). All households belonging to lower 40

percent in the NHTS list are automatically covered by PhilHealth. As most of the poor households are already covered, the major challenge now for the government is to locate and inform them about their new benefit entitlement. Erratic addresses found in the NHTS list and the geographical constraints NHTS uses location in identifying poor households. Hence, those households (e.g. informal settlers or homeless) without permanent addresses are not included in the NHTS list.

In parallel with the NHTS, PhilHealth also rolled-out ‘point-of-care enrollment.’ Although such strategy promoted adverse selection, it was introduced to capture the ‘critically poor’ households who have not been included in the NHTS list. Earlier, the government has adopted the policy of subsidizing fully the premium contribution of households belonging to the two lowest quintiles of the population. The Medical Social Welfare Officers of government hospitals are responsible for classifying patients, and automatically enrolling the poor to PhilHealth so that they can receive immediate medical care. PhilHealth will reimburse the hospitals and send the list to DSWD for further validation. In 2013, PhilHealth released the implementation guideline for point of care enrollment program (AO 2013-31).

The Aquino administration has been aggressive in enrolling poor households. In 2011, almost 5 million poor households identified in the NHTS were already enrolled. The goal of the government is to enroll the additional 9 million poor households by 2014. Almost 25 percent of the total DOH budget is allocated to subsidize the premiums of poor households. As a result of this policy, the budget of DOH increased by almost fourfold from 2009 to 2014.

Poor coverage of non-SP members - Formal workers are supposed to be enrolled mandatorily in the social health insurance program. However, poor coverage persists. In a study conducted by Silfverberg and Silfverberg (2014), the estimated coverage rate in the government and private sector is around 80 percent, leaving 20 percent who are not enrolled. This high non-enrolment in the mandatory sectors is due to labor issues such as contractualization and casualization of employees. Employers are not obligated to cover the premiums of contractual and casual employees.

The informal sector is the biggest contributor of under-coverage. In another study conducted by Silfverberg (2014), less than 40 percent of the informal workers are not covered. The composition of the informal sector is extreme in terms of socio-economic status, as it compose of near poor and affluent households. The design of capturing the informal sector in the insurance system is prone for members to opt out. In terms of premiums payments, members in this sector needs to pay at least three monthly premiums with the immediate six months before confinement, which is not easy for near poor households to comply.

2. Ensuring awareness of members to their benefit entitlements - Coverage does not always translate to benefit utilization. Although supply-side constraints (e.g. scarcity of health facilities) contribute to the low utilization, demand-side problems such as awareness of membership status, eligibility and entitlement play a significant role in poor usage of benefits. Poor awareness is common among SP members who were automatically enrolled by the national government. In the past, poor utilization is also exacerbated by general policy direction of corporation as a pension fund resulted to shallow benefit depth and low benefit utilization. In recent years, a paradigm shift in the policy direction of PhilHealth was observed as more aggressive benefit expansion and awareness campaign were institutionalized.

CARES Program - In 2012, PhilHealth deployed 530 nurses in levels 2 and 3 government hospitals to serve as ‘navigators’. Their main responsibility is to assist patients determine their membership status and inform their benefit entitlement. They also perform surveys and studies initiated by PhilHealth. In DOH-retained hospitals, PhilHealth CARES are stationed in designated PhilHealth desk. Private hospitals may opt to hire their own navigators (*PhilHealth Circular no. 52 of 2012*).

Information and education campaigns - Philhealth launched numerous programs such as MOVES and SHINE not only to improve the awareness of members, but also stakeholders. The PhilHealth MOVES (Mobile Orientation, Validation and Enrolment Scheme) aims to educate its members especially the SP members about their PhilHealth and their benefit entitlement by giving lectures and presentation in localities. While the PhilHealth SHINES (Social Health Insurance Educational Series) is an avenue to educate and update local executives, municipal officers and policy makers about social health insurance. The corporation also embarks in traditional modes of IEC such as radio and television for the dissemination of PhilHealth processes, benefit packages and entitlement. Currently, PhilHealth has a time slot in radio and television, where the public can ask queries and voice out their concerns.

Despite these attempts to improve awareness, mass education programs are still be limited. In the case of mass educational campaign such as MOVES, vulnerable segments are not captured as most of the lectures are conducted in local government centers located or in urbanized areas. Most of the poor households in the country are in living geographically challenged areas, which it is impossible to be reached via the traditional modes of information, education, and communication. There is no also mechanism or standardize in place on how local offices should conduct mass education campaigns. As of this writing, only few local government offices have conducted MOVES.

3. Active engagement of members on their preferences, needs, and problems - Ideally, citizen should be involved in major policy decision of the corporation, especially during benefit package development. This is to ensure that policies in place are for the general good of the population. In terms of benefit design and development, there are no clear guidelines and written protocols on how benefits should be crafted and how to the concerns of the population should be taken into account. There is no benefit expansion plan or strategy. Hence, all the existing benefit packages of PhilHealth might be crafted and approached in an unstandardized and ad hoc environment.

Although health technology assessment was introduced in the past to be part benefit development process, it has never been institutionalized. Hence, it is not clear how benefits are decided on. Ideally, the corporation should take into account the economic effectiveness and socio-cultural acceptability of the benefit packages prior to rollout. Although PhilHealth admitted that it considers the gravity of disease, public health importance and public clamor (e.g. use of surveys), it is not very explicit how the corporation used them in the actual cost calculation or in the implementation arrangement of the benefit package. The approval of benefit packages is also prone to political influences as manifested by the inclusion of several packages that are not cost-effective. It is ideal to study documents developed during the course of benefit development process such as minutes of the meetings and detailed documentation of benefit packages and other documents. However, such documents do not exist.

4. Ensuring effective mechanisms for members' complaints, views, and reflections – There are established procedures for settling complaints and resolving disputes. However, these are not enough; what is needed are well-maintained channels of communication between PhilHealth members/providers and management/Board that ensures members/providers views are heard, addressed, and hopefully taken account in the decision-making process. Although PhilHealth maintains a website, the queries of citizens are not addressed in a timely manner. PhilHealth has not fully utilized the promise of social media to reach out to members and providers.

Chapter IV. Purchaser-Provider Relationship in PhilHealth

A. Organizational Characteristics of Health Service Providers

Overall Trends in Health Facilities – Health facility investments, both public and private, has stagnated relative to a ballooning population since the 1980s. The bed-population ratio was one of the highest in Asia in the 1970s at 32 per 1,000 population but this has declined to only 17 per 1,000 population in the 2000s. Average occupancy rates typically exceed 100 percent in government hospitals, except lower-level ones. Private hospital investments have also been slow. Health facilities are poorly distributed geographically. The devolution of health services since the 1990s may have contributed to the widening disparities in the quantity and quality of these facilities.

Hospitals - The DOH classifies all hospitals according to the size, bed capacity, and types of services offered. The classifications below reflect the latest levels in 2012 (Silvera 2013):

- Level 1 (formerly Level 2) has a bed capacity of less than 100 and has the following services: consulting specialists in medicine, pediatrics, OB-GYNE, surgery; emergency and out-patient services; isolation facilities; surgical/maternity facilities; dental clinic; secondary clinical laboratory; blood station; first level X-ray facility; and pharmacy.
- Level 2 (formerly Level 3) has a bed capacity of 100-200 and has all the services of Level 1 facilities with the following additional facilities: departmentalized clinical services; general intensive care unit; high risk pregnancy unit; neonatal intensive care unit; tertiary clinical laboratory; and second level X-ray facility with mobile unit.
- Level 3 (formerly Level 4) has a bed capacity of more than 200 and has all the services of Level 2 facilities with the following additional facilities: teaching with accredited residency training program in the four major clinical services; physical medicine and rehabilitation unit; ambulatory surgical clinic; dialysis clinic; tertiary clinical laboratory with histopathology; blood bank; and third level X-ray facility.
- Hospitals labeled as Level 1 in the pre-2012 classification are now classified as “other health facilities,” which can be any of the following: primary care facility; custodial care facility; diagnostic/therapeutic facility; and specialized outpatient facility.

At present, there are 1,810 hospitals in the Philippines, with 726 (around 40 percent) under public ownership, and the remaining private (DOH, 2012). Majority of private hospitals operate as for-profit institutions, with a significant concentration in Central Luzon and NCR, regions, which are relatively wealthier. In fact, thirty-four percent of all hospital beds are located in the NCR, where 12 percent of the nation’s population reside. The establishment of private hospitals in areas with lower poverty rates is commonly seen as a measure to ensure steady income (Lavado, et al., 2010).

Government hospitals can either be managed by the LGU where they are located, as is the case for most Level 1 and 2 hospitals, or managed directly by the DOH, as is the case for most Level 3 hospitals. They acquire their license to operate from the Bureau of Health Facilities and Services (BHFS) of DOH and are accredited by PhilHealth to receive reimbursement claims if they meet the standards. Before the devolution of health services to LGUs in 1991, all government hospitals were under the DOH. Devolution gave most of the primary and secondary care, as well as some tertiary care responsibilities, to LGUs while DOH retained control of around 70 general and specialty hospitals.

Some but not all government hospitals have fiscal autonomy. DOH-retained hospital get their funding mostly from DOH and LGU hospitals from their respective LGUs. Depending on how entrepreneurial the hospital director or management is, the public hospital can also rely on PhilHealth reimbursements. Also depending on the ordinance that the LGU has passed pertaining to the local hospital under it, these PhilHealth reimbursements can either be retained at the health facility or not. Indeed, the role of PhilHealth reimbursements in the sustainability of government hospitals is one of the main challenges facing them.

Private hospitals comprise around 60 percent of all hospitals and may be owned by a single proprietor, a partnership, a family, a religious institution, or a corporation. They also acquire their license from the BHFS and are then accredited by Philhealth to receive reimbursements if they meet the standards. Private hospitals get their funding from out-of-pocket expenditures, reimbursements from private health insurers, and PhilHealth reimbursements.

Physicians – Philippine medical education is patterned after the American system. Physicians take a four- or five-year pre-medical course and four years of medical education followed by one year of internship. Upon passing the Physician Licensure Exams, they are qualified for general practice, but have the option for further studies in specialization and sub-specialization in teaching hospitals (Level III). Just like all other health professionals, they are all registered under and regulated by the Professional Regulatory Commission (PRC). Physicians undergo a separate accreditation process in PhilHealth.

Government physicians are hired by the DOH for its retained hospitals, and by the LGUs for LGU hospitals. The entry-level position for resident physicians in DOH hospitals is Medical Officer III, which has a monthly gross salary of PHP 26,878. LGU hospitals offer resident physicians a lower entry-level position, such as Medical Officer I, which has a monthly gross salary of PHP 39,493 (Santos, 2013). Low salary grades of doctors contribute to the increasing number of doctors leaving the country for better opportunities abroad (Trillanes, 2013).

Geographic misdistribution of government physicians is serious, as most are concentrated in major urbanized cities. The DOH launched the Doctors to the Barrios (DTTB) Program in the 1990s as a response to this shortage and other problems such as the inability of smaller, rural LGUs to fully support their devolved health programs. However, the program only requires doctors to stay for two years, and most do not stay with their assigned LGUs when the program is over (Capuno, 2008). Because of the stopgap nature of this program and the decreasing independence of participating LGU to achieve financial stability in health, DTTB is currently under review by the DOH (Crisostomo 2014).

DOH implements other measures to help LGUs, such as DTTB-Leaders for Health (DTTB-LHP), Community Health Teams (CHTs), Rural Health Team Placement Programs (RHTPP), and Specialist to the Provinces Program (STTP), all requiring the participation of at least one qualified physician to complete the team (DOH, 2010a). Aside from efforts of some state universities to mandate their students to work in public service after a few years, there is no national legislation requiring health professionals to work in the public sector after graduation; neither are there special incentives for physicians to practice in underserved areas.

Physicians in private hospitals have higher salaries than in public hospitals, and most supplement their income by doing shifts in multiple hospitals or setting up their own clinic. More specialists are available in private hospitals because of the availability of advanced equipment. For cases of larger tertiary hospitals that function as corporations, most private physicians, particularly consultants, are stockholders in their hospitals. They also usually hold administrative positions.

Stand-alone clinics: birthing centers, renal clinics, etc. - Stand-alone clinics usually provide outpatient and ambulatory care for patients. They do not have the full range of services available in a typical hospital but specialize in a particular health service. The most prevalent stand-alone clinics are lying-in or maternity clinics, dialysis clinics, clinics for tuberculosis – direct observed treatment short course (TB-DOTS), free-standing private clinics by a sole proprietor, and polyclinics run by a group practice. Physicians who work in hospitals often have their own private practice on the side through clinics. Most are run privately; high costs of treatment are associated with these clinics. The poor typically seek outpatient treatment in public facilities such as the RHUs or the outpatient ward in public hospitals.

The BHFS licenses stand-alone clinics except outpatient clinics as currently, there are no standards for these yet. They can also be accredited by PhilHealth providers and receive reimbursement claims. As of 2009, there are 19 dialysis clinics, 406 TB-DOTS clinics, 288 maternity clinics, and 42 ambulatory service clinics accredited by PhilHealth (Romualdez et al., 2011). With the recent expansion of PhilHealth benefits for outpatient care, the poor have the option to access these clinics at a lower cost.

Rural health units and barangay health stations - RHUs provide basic primary care, serving mostly the poor. They are the most frequently utilized health facilities (around one-third in proportion with other health facilities according to the 2008 NDHS (DOH, 2009). *Barangay* health stations (BHSs) are centers set up in *barangays*, the smallest political unit in the country, and are managed by RHUs or city health offices.

RHUs were created in the 1950s for each municipality to improve access to health care. In the wake of the passage of the Local Government Code in 1991, RHUs, CHUs, and BHSs were devolved to the municipal and city LGU. The DOH was left with the task of building capacities of the RHUs and BHSs in delivering the various vertical health programs, e.g., Expanded Program on Immunization and TB-DOTS. In general, RHUs and BHSs provide health services free of charge, but problems of lack of availability, accessibility, and sufficient workforce are common. Just like hospitals and clinics, RHUs can be accredited by PhilHealth. As of 2009, there are 843 accredited RHUs to provide Outpatient Benefit Package (Romualdez, et al., 2011).

B. Ideal Versus Actual Functions in the Purchaser-Provider Relationship

This relationship underscores the use of policy tools by purchasers to improve provider responsiveness and efficiency. Table 4 shows the ideal functions of the purchaser and an assessment of PhilHealth’s performance.

Table 4. Ideal Functions of the Purchaser in the Purchaser-Provider Link and Assessment of PhilHealth’s Performance

Functions of Ideal Purchaser	Assessment of PhilHealth
To take active decisions on which providers to purchase services from, with consideration of quality, ability to provide services, and location	PhilHealth has been too stringent in accrediting government hospitals and public health clinics, reducing access to these services. Only 67 percent of all licensed hospitals have been accredited. For TB DOTS, only 59 percent of all licensed TB DOTS clinics have been accredited after ten years. Although a more accommodative accreditation policy has been specified in the General Appropriations Act of 2012, this has not been implemented fully. More facilitative arrangements with providers to improve quality of care are yet to be institutionalized.
To extend services to under-served areas.	PhilHealth has no geographic equalization (or equity) fund. PhilHealth reimbursement rates are uniform and do not provide

	additional incentives for geographically isolated and depressed areas (GIDA).
To improve health system efficiency through rational provision and use of services	Gatekeeping and referral systems are very weak because patients tend to go to the nearest health facility, referral bypass fees are not imposed, and many cities do not have city hospitals or filter clinics, forcing patients to clog DOH-owned regional hospitals located in these cities. On the positive side, payment reform from FFS to case rates has shown good results. The Generics Law has been in force for decades but providers still find ways to prescribe branded drugs. Not all clinical guidelines are available. Finally, because PhilHealth accounts for only 11 percent of total health expenditures, it has not evolved as a major payor and is largely unable to exercise its monopsony power to lower health care costs and reduce out-of-pocket spending.
To monitor provider performance, including quality of care	Quality standards are mostly ex-ante through accreditation. Concurrent quality monitoring is not yet in place. De-accreditation of erring providers is rarely resorted to as it penalizes members just as it does the erring providers.
To enforce contractual agreements with qualified public and private providers	PhilHealth outpatient benefit packages evolved in a fragmented fashion, requiring repetitive accreditation and monitoring. Hospitals usually complain of payment delays, although payment has been expedited under case rates. Also, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.
To implement and adjust provider payment methods that enhance quality and efficiency	Under case rates, providers know in advance their reimbursements. A No Balance Billing policy is in force and compliance has improved. In June 2013, 93 percent of surveyed hospitals practiced balance billing; by June 2014, this has been reduced to 59 percent.
To ensure mutual accountability between purchaser and providers through timely payment	On average, turn-around time fell by 21-24 days when PhilHealth changed provider payment from FFS to case rates.
To manage finances in a transparent and accountable way	PhilHealth has adopted an accounts-management approach to ensure all collectibles are collected. PhilHealth has an internal audit unit that investigates fraud. Revenues have always been aligned with expenditures, but reserve management has been conservative. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years' worth from 2004 to 2009, though this has been reduced to 2.2 years in 2013, closer to what the law prescribes at 2 years.

Source: This study

C. Analysis of the Purchaser-Provider Relationship in PhilHealth

Engagement of Providers and Provider Payment Systems – PhilHealth purchases inpatient and outpatient services from various contracted health providers and drug outlets and pays these according to agree-upon provider payment systems.

(a) Ordinary Inpatient Case Packages – Case payment for inpatient care was introduced for the first 23 case rates in 2011 to replace the traditional fee-for-service (FFS) system. This was expanded in January 2014 to cover all inpatient medical and surgical cases. All members are eligible under this

payment system, but only SP members utilizing government hospitals are entitled to the No Balance Billing policy (i.e., zero copayments). Health care providers are paid a fixed rate and are responsible for distributing professional fees to physicians.

An assessment of the case rate payment system for the 23 conditions shows that relative to the FFS, it has led to lower average cost per case and lower length of stay. Out of the 23 case rates, all except pneumonia II recorded lower average costs in 2012 compared to the average FFS costs in 2010. Table 6 shows selected declines in average costs of care. Similarly, all except pneumonia II recorded lower ALOS in 2012 compared to the ALOS under FFS in 2010. Table 5 shows selected declines in average length of stay.

Table 5. Effect of the Case Rate Payment System on Average Cost of Care (PHP), by Sponsored and Non-Sponsored Program Members, 2010 (Before Case Rate) and 2012 (After Case Rate)

Selected Case Rates	Sponsored Program		Non-Sponsored Program	
	2010	2012	2010	2012
Acute gastro-enteritis	12,008	8,676	15,123	8,454
Cataract removal	41,694	18,069	41,827	18,713
Cardio-vascular accident I	46,255	35,836	56,369	33,765
Pneumonia I	27,217	19,370	39,679	18,414
Dengue I	69,620	12,956	24,176	12,433
Caesarian section	139,679	35,681	306,736	35,170

Source: PhilHealth, 2014

Table 6. Effect of the Case Rate System on Average Length of Stay (in Days), by Sponsored and Non-Sponsored Program Members, 2010 (Before Case Rates) and 2012 (After Case Rates)

Selected Case Rates	Sponsored Program		Non-Sponsored Program	
	2010	2012	2010	2012
Acute gastro-enteritis	12,008	8,676	15,123	8,454
Cataract removal	41,694	18,069	41,827	18,713
Cardio-vascular accident I	46,255	35,836	56,369	33,765
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Dengue I	69,620	12,956	24,176	12,433
Caesarian section	139,679	35,681	306,736	35,170

Source, 2014

Some problems persisted, however. As many as 36 percent of the SP patients did not know about their PhilHealth coverage (World Bank, 2012). A few hospitals resorted to upcoding (charging a patient under a higher reimbursing condition rather than the real condition), e.g., pediatric to acute gastro-enteritis (Machinji, 2012). Patients' out-of-hospital purchases remained a problem as some facilities continued to experience shortage in drugs and medical supplies (Maala, 2014); in effect, this is default balance billing. However, the prevalence of balance billing has declined from 93 percent in June 2013 to 59 percent in June 2014 (Picazo, 2014).

Catastrophic Case Packages (Z Benefits) – These cover disease conditions that are deemed economically and medically catastrophic using PHIC criteria. A reference hospital is first contracted to assist PHIC in setting the practice standards and costing of the package. Other providers are then selectively contracted based on capability to render the package. Currently, providers are limited to public tertiary hospitals. Health care providers are paid a fixed rate and are responsible for distributing

professional fees to physicians. SP members are eligible for zero co-payment while non-SP members are entitled to a maximum copayment of 50 percent. In 2013, Z benefits package was expanded into Z MORPH (Mobility, Orthosis, Rehabilitation, and Prosthesis Help) to support the treatment of disabled persons as indicated by Republic Act 7277 or the Magna Carta for Disabled Persons. Assessment of the Z benefits (Table 7) shows low utilization so far mainly because of the limited number of providers, quite stringent eligibility criteria, and limited patient information on this package.

Table 7. PhilHealth’s Z Benefits, by Amount Paid (PHP) and Number of Patients, as of June 30, 2014

Conditions Covered by Z Benefits	Amount Paid (PHP Million)	Number of Patients
Acute lymphocytic leukemia, standard risk, for children	4.3	28
Early breast cancer	17.8	211
Prostate cancer, low to intermediate risk	1.1	11
Kidney transplant for end-stage renal disease, standard risk	80.7	136
Coronary artery bypass graft surgery, standard risk	54.4	99
Total correction for tetralogy of Fallot, for children	32.0	100
Closure of ventricular septal defect, for children	18.0	72
Cervical cancer, stage I to IV	-	-
Z MORPH	-	-
Total	208.1	657

Source: PhilHealth, 2014

Other conditions are being considered under this benefit, including colon and rectum cancer; liver cancer, hepatitis B, and hepatitis C; other cancers and blood disorders, premature newborn, and pediatric surgical conditions. Presentation to the PhilHealth Board for their approval has been slated.

Outpatient Benefits and “MDG” Benefits – The evolution of PhilHealth outpatient or “MDG” benefits is shown in Table 7. These cover a range of services delivered by outpatient clinics, birthing centers, free-standing dialysis clinics, ambulatory surgical centers and outpatient departments of hospitals. Some examples are the maternity care and newborn package during normal delivery (MCP), packages for tuberculosis (TB DOTS), malaria, HIV-AIDS, severe acute respiratory syndrome (SARS), avian influenza, hemodialysis, chemotherapy and radiotherapy, animal bite, and voluntary surgical contraception. All members are eligible to avail of these packages. Health care providers are paid a fixed rate and are responsible for distributing professional fees to physicians. Sponsored program and indigent members are entitled to zero co-payment through the No Balance Billing Policy.

Table 8. Evolution of PhilHealth’s Outpatient and “MDG” Benefits

Year	Benefits	Providers
2000	Outpatient Benefits (OPB)	RHU only
2003	+ Maternity care package (MCP), TB DOTS	RHU + birthing centers (public & private) + TB DOTS centers (public & private)
2006	+ Neonatal care package (NCP)	RHU
2008	+ Malaria	RHU
2010	+ Animal bite treatment and care (ABTC)	RHU
2012	+ HIV/AIDS treatment	Treatment hubs (usually gov’t regional hospitals)

2014	+ IUD insertion	RHU
2014	+ NCD drugs (pilot)	Pharmacy
2015	+ Other primary care	RHU + private clinics

Source: PhilHealth, n.d.

Table 8 shows the number of providers and payments to providers under this benefit from 2009 to 2013. No data are available on the number of patients seen. No assessment of each of these packages is available. However, a consultancy for the feasibility of PhilHealth financing of multiple drug resistant TB showed the following performance of PhilHealth’s TB-DOTS package (Picazo, et al., 2014): (a) While TB patients are overwhelmingly poor, most of them are not included in the government anti-poverty program of conditional cash transfers (CCT/4P) and therefore are not automatically covered as SP members, as stipulated under the law. (b) After ten years (2003 to 2013), PhilHealth has accredited only 59 percent of the 5,084 licensed TB-DOTS centers. The non-accreditation of TB DOTS providers, even those operating under the DOH’s National Tuberculosis Program, means that many of them are not benefiting from PhilHealth reimbursements for TB care. Indeed, 499 LGUs in the country do not have PhilHealth accredited TB DOTS providers. (c) Compared to the total cost of TB diagnosis and treatment per patient of PHP 9,030, the reimbursement rate represents support value of only 44 percent.

Table 9. Number of Providers and Payments to Providers Under PhilHealth’s Outpatient Benefits (2009-2011) and Primary Care Benefits (2012-2013)

Year	Benefit Name	No. of Providers	Amount in PHP Billion
2009	OPB	n.a.	0.684
2010	OPB	n.a.	1.008
2011	OPB	1,404	1.309
2012	PCB	2,134	3.625
2013	PCB	2,536	3.026

Source: PhilHealth, n.d.

PCB1 covers primary preventive and outpatient consultation services, diagnostics, and drugs for four of the most common outpatient conditions. Government-owned outpatient clinics (rural health units and outpatient departments of government hospitals) are the accredited providers and are paid an annual per family payment rate of PHP 500. This program requires providers to open a trust fund where PhilHealth reimbursements will be collected, and for providers to allocate the PhilHealth revenues as follows: 40 percent for services, 40 percent for drugs and diagnostics, and 20 percent for incentives for professionals is explicitly prescribed.

PCB2 was designed to provide pharmacy benefit for eight drug molecules for hypertension, diabetes mellitus, and dyslipidemia. The benefit guidelines prescribe the following: (a) Only those screened by their PCB1 primary care providers using WHO PEN Guidelines are eligible; (b) Patient can obtain drugs only at drug outlets that agree with set price caps. (c) While there is no limit to the amount of drugs that an individual can avail, only one member per family can use the benefit. (d) Drug outlets are reimbursed monthly depending on the consumption. The program is currently being piloted in Pateros, a municipality within Metro Manila. However, an assessment of this pilot indicates that the sample size is not powered enough to provide robust findings. Indeed, out of the 66,000 total population of the municipality of Pateros, only 80 people were found to be eligible, out of which only 5 accessed the benefit and only 1 is currently using the benefit (Herrera, 2014).

Licensing, Accreditation, and Contracting – Prior to 2012, PhilHealth was criticized for being overly redundant with DOH licensing processes and delays in its contracting (which it called accreditation) procedures. It required “pre-accreditation surveys” which duplicated in part with the DOH

licensing inspections, annual renewals, facility checks, and manual submissions of paper-based applications. This resulted to bottlenecks in contracting (granting accreditation privileges) which occasionally resulted in “accreditation gap” and the subsequent difficulty of providers to be reimbursed for services rendered during the gap period.

Since 2012, the process has been streamlined. The DOH adopted the PhilHealth Benchbook accreditation standards and incorporated it in the licensing requirements, thus essentially requiring only one survey pre-licensing and accreditation. Henceforth, all licensed providers are deemed accredited upon submission of documentary requirements and a pre-accreditation survey is no longer required. Also, health care providers no longer need to renew on an annual basis; instead, renewal is automatic until it is withdrawn or terminated. The resulting reactions among providers to this new accreditation process have been mixed; some providers felt that PhilHealth was more competent in conducting the accreditation surveys, which encouraged them to perform better.

The above procedures describe the normal engagement process of PhilHealth. It is passive, i.e. only those who apply are engaged and only those who are engaged are in its database. This begs the question: how will PhilHealth know how much leveraging power it has and where? A clear exception to this norm is the way PhilHealth actively sought and negotiated with providers for the Z benefits. After determining the package that will be developed, PhilHealth selected the reference hospital, which then assisted PhilHealth in formulating the guidelines, setting practice standards, costing the package, and assessing the clinical capability of interested hospitals. Once the guidelines were in place, PhilHealth engaged other potential hospitals through selective contracting.

PhilHealth uses the *Performance Commitment* as the main contracting tool. All health care providers must sign this in order to be accredited. It stipulates providers’ “undertakings to provide quality health services, willingness to comply with policies on benefits payment, information technology, data management and reporting, referral, among others.” A section of the tool allows providers to tick the appropriate services it is able to deliver. The tool is comprehensive but provisions are still very general at this stage; details have been left out primarily because these – guidelines, indicators, targets, etc. – are still to be clearly defined yet.

The primary care benefit 1 (PCB 1) program came up with specific provisions for its providers, majority of which are LGUs. PCB1 requires that LGUs set up a trust account for the health facility to ensure that the capitation paid will be retained for the facilities’ use/improvement of the facility, as opposed to the fund being siphoned back to the LGUs’ general funds. This was initially met with a lot of resistance but currently around 84 percent of LGUs have set up trust.

Contract enforcement is highly reliant on a functional monitoring system. PhilHealth intends to track performance on four dimensions: care quality, patient satisfaction, financial risk protection, and fraud using a variety of methodologies which includes electronic Medical Post-Audit System (eMPAS), Mandatory Monthly Hospital Report (MMHR), claims profiling, exit surveys, client satisfaction surveys, facility visits, chart reviews and field validation. While the manpower complement for these activities has yet to be filled, PhilHealth has temporarily tapped the CARES Program. The PhilHealth CARES program deployed 530 nurses initially as patient navigators in hospitals all over the country in order to guide the SP members in utilizing their benefits. In addition their mere presence in hospitals was said to have deterred provider fraud.

Timely Payment - All health care providers are required to submit their claims within 60 days after patient discharge while PhilHealth is required to process the claims within 60 days after claims filing. When filing delays are caused by providers, PhilHealth penalizes them by not processing the claim

anymore. However, if PhilHealth fails to process the claims within the prescribed period, there are no corresponding penalties for PhilHealth or interest payments corresponding to the delay in payment.

Claims processing is still paper-based. Upon receipt at local PhilHealth offices, the claims are manually encoded into the computer system before processing can begin. Claims encoding and medical evaluation are considered the biggest bottlenecks. The shift from FFS to all case rates has rendered the medical evaluation largely unnecessary. An assessment of the shift from FFS to case rates shows that the turnaround time for claims processing has shortened, as expected. All hospital levels, ambulatory services, and maternity clinics recorded lower turnaround time in 2012 compared to the turnaround time under FFS in 2010 (Table 10) (PhilHealth, 2014).

Table 10. Reduction in Days of PhilHealth Claims Processing Turnaround Time from Fee for Service in 2010 to Case Rates in 2012, by Type of Facility

Type of Facility	Reduction in Claims Processing Days
Level 1 Hospitals	22
Level 2 Hospitals	23
Level 3 Hospitals	24
Level 4 Hospital	21
Ambulatory Services	27
Dialysis Centers	23
Maternity Clinics	22

Source: PhilHealth, 2014

No Balance Billing Policy - PhilHealth operates as a first-peso payer, meaning it covers a fixed amount per case and all charges in excess of that amount are to be shouldered by the member or private health insurance, if available. PhilHealth has never regulated user fees before the No Balance Billing policy was introduced in year 2011, the same time the first 23 case rates were launched.

The NBB policy had the goal of ensuring zero out-of-pocket payment for SP members in wards of government hospitals, without choice of attending physician. However, this was met with a lot of trepidation from the providers who questioned the validity of the PhilHealth package rates, knowing fully that except for the Z benefits, the rates were based on averaged-out FFS claims. Thus, monitoring of provider compliance to the policy has been challenging. Claim form documents cannot capture the entirety of the patient’s hospital-related expenses because first, some patients purchase their medicines outside of the facility either because of lack of medicines and supplies in the hospital or because patients opt to seek cheaper alternatives from drug outlets outside of the facility (Majini, 2012). Second, physicians collect additional fees on top of what the package is paying them. Even though PhilHealth requires that all receipts must be attached and reimbursed by the hospital to the patient, there is no way to determine this accurately unless the patient declares so. Thus in the absence of a good information system, the best option is to undertake exit interviews amongst discharged patients. More recently, the PhilHealth CARES nurses were put to the task of monitoring NBB compliance. In June 2013, 93 percent of patients still had out-of-pocket expenses, but this rate has declined to 59 percent in June 2014.

The Z benefits took a different approach. The case package, for which costing was undertaken with the providers themselves, required zero co-payment for SP members and fixed co-payment of 50 percent of the package cost for non-SP members. Because the cohort of Z beneficiaries is still limited, exit interviews were performed in each one of them. This showed 100 percent compliance with the fixed co-payment or NBB billing provisions. Recently, the NBB policy has been expanded to cover all outpatient services rendered in non-hospital institutions.

Geographic Equity – Under the FFS provider payment system, PhilHealth incentivized physicians practicing in sites determined to have shortage of health personnel by adding 10 percent to their professional fee reimbursements and allowing them to perform surgical procedures beyond a certain relative value unit. The adoption of the all case rates provider payment system put forth that special fee schedules be drawn up for geographically isolated and disadvantaged areas and areas with shortage of health personnel. However, the guidelines for this policy pronouncement are yet to be formulated.

In the 1970s, PMCC experimented with constructing its own health facilities in underserved areas, but this did not work, and the health facilities were soon turned over to the DOH, and then to the LGUs when health services were devolved in 1992. Geographic inequity has not solved under devolution; in fact, there are indications it may have worsened. Larger and richer provinces/cities tend to have better health services than smaller and poorer LGUs.

Enhanced Health Systems Efficiency – The Philippines resorts to a mixed range instruments to enhance system efficiency, with varying results. Among the more visible ones are the following:

(a) Use of Drug Formulary – The Philippine National Formulary (PNF) contains the essential drugs list. It is prepared by the DOH’s National Drug Committee upon consultation with experts and specialists from professional medical societies, the medical academe and the pharmaceutical industry, and is updated every year. The general basis for selection of medicines consists of the following criteria: relevance to prevalent conditions, efficacy and safety, quality, cost of treatment regimen, appropriateness to capability of health workers, local health problems and benefit/risk ratio. In addition, preferential factors like “most thoroughly investigated drugs” are outlined and single formulation is preferred. (Maramba, 20xx).

In all benefit programs, PhilHealth is mandated to reimburse only drugs included in the PNF. However, this is not always practiced. Under the all case rates system and PCB benefits, health care providers can go around this rule because they are not required to declare which drug molecules were administered as a requirement for payment. Meanwhile, certain selection criteria for the PNF – drugs for most prevalent conditions, not too costly, and with established evidence – are limiting for programs like Z benefits. The Z benefits cover high-cost conditions but not necessarily high prevalence conditions, and the drugs or devices do not have as extensive evidence base as in other conditions.

(b) Drug Price Reference Index (DPRI) – DOH recently completed the first edition of the DPRI (DOH, 2012) listing 660 drugs, their generic name, dosage strength/form, the range of tender price (PHP), and the drug price reference (PHP). The DPRI thus lists the ceiling prices for government bidding and procurement set by the DOH for all retained hospitals and regional health offices (CHDs) procuring medicines. Winning bid prices of essential medicines shall not exceed the DPRI. The DPRI aims to improve the efficiency in the pricing and procurement of medicines in the public sector. It also aims to guide PhilHealth in setting reimbursement caps for medicines.

(c) Clinical Practice Guidelines – PhilHealth is mandated to support quality improvement and consistency in delivery of health services. It performs this function not by developing clinical practice guidelines (CPG) but by appraising guidelines and translating these into policy statements. The appraisal uses a five-stage process that begins with systematic search for CPGs published locally and abroad. The validity is then screened against the AGREE (Appraisal of Guidelines for Research and Evaluation) tool, and an in-house appraisal checklist. Interventions are then assessed based on local applicability. Finally, drugs are counterchecked against the PNF. The guideline appraisal process is undertaken by at least three technical staff. The findings then become the basis for policy statements. Currently, PhilHealth has

released policy statements for 15 disease conditions⁴ under PCB1, PCB2, and some inpatient and outpatient case packages. However, since adherence to the guidelines is not routinely monitored and is not made a prerequisite for payment, there is no way to determine adherence. In the case of the Z benefits, adherence is mandated as the payment is based on tranches according to guideline-based treatment.

The following system-efficiency enhancing instruments are not yet in place or underutilized:

(a) General expenditure and cost controls – The Philippines has no centralized “resource allocation authority” that sets guidelines on the overall resources in the health system to be spent for a particular year. While the process under hierarchically-organized hospitals of DOH and LGUs exhibit close-ended budget, there is a lot of “gaming” at the facility level as hospital directors play one funding source vis-à-vis other sources (PhilHealth, private insurance, user fees, PAGCOR, PCSO, external donors, and sometimes pork-barrel financing from politicians) and in the case of LGUs, internal revenue allotments.

(b) No effective gate-keeper or referral system – Many higher-level hospitals are clogged with primary-care patients. Some cities do not have city hospitals, and their residents troop to DOH regional hospitals which are supposed to cater to referral cases. There is no referral bypass fee. Philhealth has not been able to influence the flow of patients so that they go to the right level of facility.

(c) No formal process of health technology assessment – While the evaluation of the efficacy and cost-effectiveness of drugs are fairly well-established in the Philippines, a similar process for devices and procedures does not yet exist. Health technology assessment is done very informally. Under Z benefits, the choice of conditions to include in PhilHealth is often based on the cost of treating the condition, rather than the burden of disease and the cost-effectiveness of treating it. There are no established rules and benchmarks for screening such conditions to be covered, e.g., cost of DALY averted as percent of GDP.

⁴ Community acquired pneumonia for adults and children, acute appendicitis, hypertension, dyspepsia, acute bronchitis, asthma in adults, urinary tract infection in adults, acute gastroenteritis, maternity care, dengue hemorrhagic fever, cataract, diabetes mellitus, chronic cough in children, cholecystitis, and the Philippine Essential Package for Non-communicable Diseases

Chapter V. Purchaser-Government Relationship in PhilHealth

A. Organizational Characteristics of Government Actors

There are several government agencies in the health service purchaser-government relationship, the main groups being the following. In this chapter, the focus is on stewardship of and policymaking for PhilHealth.

- Stewards and policymakers – Congress, Office of the President (Presidential Management Staff), and DOH (Secretary of Health is the chair of the PhilHealthBoard);
- Regulator – DOH (licensing, accreditation, quality monitoring) as well as owner of DOH-retained hospitals; Food and Drug Administration (pharmaceutical regulation);
- Financier of premium subsidies to Q1 and Q2 - DBM
- Employer of civil servants – government line agencies, GOCCs, DBM as source of fiscal revenues;
- Owner of health facilities – DOH (retained hospitals), LGUs (provincial, city, municipal health facilities);
- Financiers of catastrophic medical conditions – DSWD, PCSO, PAGCOR.

B. Ideal Versus Actual Functions in the Purchaser-Government Relationship

This relationship focuses on government stewardship (Task 1 and some subtasks of Task 2 above) to ensure that public health priorities are linked to resource allocation and purchasing decision-making. Table 11 shows the ideal functions of the purchaser and an assessment of the performance of PhilHealth.

Table 11. Ideal Functions of the Purchaser in the Purchaser-Government Link and Assessment of PhilHealth’s Performance

Functions of Ideal Purchaser	Assessment of PhilHealth
To establish policy and regulatory framework for the purchaser and providers	PhilHealth is a government owned and controlled corporation with an independent governing board. The government, however, is overly represented in the board, and members/providers are generally under-represented. The PhilHealth executive committee provides technical direction, but there are skill deficits in certain areas (e.g., actuary, health technology assessment, and business analytics). Policies are issued through circulars, but these are often fragmented as benefit expansion is not underpinned with a long-term vision of social health insurance in the country.
To promote equitable access to needed health services by investing in delivery capacity in under-served areas	PhilHealth does not invest in capacity infrastructure although its predecessor (Philippine Medical Care Commission) did so. PhilHealth’s tool is financing, which hopefully will incentivize providers to locate in underserved areas.
To ensure adequate resources are mobilized to purchase services	Government has mobilized sin taxes for the Quintile 1 and Quintile 2 premium subsidy program. However, collection efficiency (for paying members) is only 67 percent. Increasing premium among paying members is highly politicized. The premium rate of 2.5 percent of employee earnings is one of the lowest in emerging economies.

To implement mechanisms to ensure accountability of purchaser to government	Audit is institutionalized. However, neither the Executive nor the Legislative branches have exercised stewardship roles proactively. DOH, as mother agency, does not have enough staff with health-financing skills to provide technical support to PhilHealth.
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Source: This study

C. Analysis of PhilHealth’s Purchaser-Government Relationship

Policy Framework and Institutional Structure – PhilHealth was instituted through Republic Act 7875 and therefore creating the Philippine Health Insurance Corporation as the administrator of the National Health Insurance Program. The law stipulates the powers and functions of the Corporation. Some of these are:

- (1) To set standards, rules and regulations necessary to ensure quality of care, appropriate utilization of services, fund viability, member satisfaction, and overall accomplishment of program objectives;
- (2) To negotiate and enter into contracts with health care institutions, professionals, and other persons regarding the pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing and delivery of health services;
- (3) To determine requirements and issue guidelines for the accreditation of health care providers for the program;
- (4) To supervise the provision of health benefits with the power to inspect medical and financial records of health care providers and patients who are participants in or members of the program, and the power to enter and inspect accredited health care institutions;
- (5) To submit to the President of the Philippines and to both Houses of Congress its Annual Report which shall contain the status of the National Health Insurance Fund, its total disbursements, reserves, average costing to beneficiaries, any request for appropriation, and other data pertinent to the implementation of the Program and publish a synopsis of such report in two newspapers of general circulation;
- (6) To conduct post-audit on the quality of services rendered by the health care providers; and
- (7) To monitor compliance by the regulatory agencies with the requirements of the law and carry out necessary actions to enforce compliance.

In addition to these functions, PhilHealth also holds quasi-judicial powers to carry out its tasks more efficiently. As an accrediting body, “PhilHealth is allowed to suspend temporarily, revoke permanently, or restore the accreditation of a health care provider [...] after due notice and hearing.” According to the Law, the revocation of a health care provider’s accreditation shall operate to disqualify him from obtaining another accreditation in his own name, under a different name, or through another person.

As a government owned- and controlled-corporation (GOCC), PhilHealth is under the Governance Commission for GOCCs (GCG), a regulatory body with the power and function to evaluate the performance and determine the relevance of PhilHealth. Some of the powers and functions of PhilHealth pertain to how PhilHealth holds authority over providers. The law has given PhilHealth such authority through accreditation of health facilities to ensure the delivery of quality services. Accreditation

for government hospitals are automatic effective April 2012, while private hospitals need to fulfill both licensing requirements and accreditation requirements of PhilHealth.

Equitable Access to Needed Health Services – The health system contributes to the promotion of equitable access to needed health facilities by investing in service delivery capacity in currently underserved areas. Access entails three aspects: physical (geographic) access, economic access, and access to appropriate healthcare. These factors are more pronounced in far-flung rural areas in the Philippines.

To achieve the UHC objective, health facilities should be physically accessible to all. Being an archipelagic country, the dispersion of hospitals is highly uneven, having pockets of concentration in major urban areas. Taking note of this limitation, PhilHealth decided to accredit all government hospitals in the country, following the provision of the General Appropriations Act of 2012. An automatic accreditation is granted to facilities that are providers of primary care benefit package, maternal and newborn care package, TB-DOTS, outpatient malaria package, and providers of special procedures such as ambulatory surgical clinics, and freestanding dialysis clinics.

For facilities that are automatically eligible for PhilHealth accreditation without undergoing the pre-accreditation survey, PhilHealth Circular 13, s. 2012 requires a signed Performance Commitment to ensure the quality of services provided. The Performance Commitment includes the providers' responsibilities and commitments as to service delivery and accountability to PhilHealth.

The government's direction towards making all the necessary providers of care available for all is complemented with the NG subsidy for the premium payment of the poorest segment of the population. In 2013, a total of 31.4 million indigent members and dependents have been covered and are eligible for benefits in a PhilHealth-accredited facility under the PhilHealth's Sponsored Program. The SP members include the nationally-identified poor and those eligible for sponsorship as certified by the LGU. The premium subsidy for the poor identified at the national level will be sourced from the sin taxes while the premium of the rest of the SP members will be shouldered by the sponsoring LGU.

Despite the mandate on automatic accreditation, 67 percent of government hospitals are not accredited based on DOH and PhilHealth data. An interesting story, however, is that PhilHealth reports 31.4 million people are eligible for use of PhilHealth under the Sponsored Program, while only 23.3 million are considered to be below the poverty line according to official poverty results. However, there is no mechanism to determine if the all SP members are aware of their automatic membership and eligibility for health insurance use. The overestimate of the poor may be causing leakage which may result to inequities in access to and utilization of health care by the deserving indigents as the accreditation of government facilities is also incomplete.

The appropriateness of health services is difficult to determine as the country lacks a database for diseases. Also, there is no existing policy on the determination of the service capacity and capability of the hospital sector. There have been DOH initiatives to identify the characteristics of the hospitals in an area through the Survey on the Services and Equipment Available in the Health Facility in 2011, but these efforts have not gained ground. Without this mechanism in place, no strong basis exists for the granting of funds under the Health Facility Enhancement Program for the upgrading and enhancement of government facilities (Lavado et al, 2011). Finally, PhilHealth does not have a mechanism to identify areas with poor hospital accreditation rate.

Ensuring Availability of Resources for Delivery of Entitlements –The law mandates PhilHealth to set aside a Reserve Fund which shall not exceed a ceiling equivalent to the amount actuarially estimated for two years' projected program expenditures. Any amount in excess of this should either be used to increase PhilHealth benefits, decrease member's contribution and augment the health facility enhancement program of the DOH. Should there not be a need to do so, excess funds should be

invested in interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines.

In 2013, 62 percent of total income was sourced from premiums, 27.2 percent from national and local government contribution, 10.6 percent from interest income, and 0.2 percent from other income. The law cited the earmarked taxes for health spending; in 2013, a total of PHP 12 billion allocated for PhilHealth was sourced from sin taxes and used as premium subsidy for Q1 and Q2 households. This mandate, contained in RA 8240, ensures a steady stream of resources for PhilHealth entitlements for this significant segment of the population.

PhilHealth also needs to rethink its reserve management strategy. Because of its origins under two large pension funds (SSS, GSIS), PhilHealth (and PMCC before it) imbibed the mentality of a pension fund, hence the Board's focus on accumulating huge reserves in excess of what is needed for benefit payments. The PHIC's reserve fund has climbed steadily from PHP35.5 billion in 2004 to PHP 115.6 billion in 2013. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years' worth in 2004 to 2009 (Picazo, 2012), but this has gone down to a more reasonable 2.2 years in 2013, closer to what the law prescribes, which is 2 years (PhilHealth, 2014).

The larger development issue that PhilHealth needs to face, however, is its ability to expand its benefits. The current premium contribution rate (2.5 percent of earnings) was calculated on the basis of ordinary inpatient benefits, excluding outpatient benefits and Z benefits. As the clamor for expanded benefits under UHC increase, there is a need for PhilHealth to increase the current level of premiums and to raise if not remove the ceiling on premium contributions, and to improve collection efficiency.

Accountability of PhilHealth to Government –The Manual of Governance of PhilHealth lists the duties and responsibilities of the Board, one of which is to ensure its fiduciary capacity. The Manual also explicit details its disclosure and transparency policy, i.e., PhilHealth shall disclose information on financial and operating results, remuneration policy for the Board and key executives, information about Board Directors including their selection process, issues regarding employees, and governance structures and policies and the process by which they are implemented. PhilHealth is also mandated to maintain a website and post the following, among others: complete compensation package of officers, latest annual audited financial and performance report, audited financial statements, current corporate operating budget, performance evaluation systems, and performance scorecards.

In general, PhilHealth has adhered to its mandate. However, PhilHealth has also figured intermittently from such cases as bloated staff bonuses, arrearages in the remittance of collections by certain agencies, and fraud and conflict of interest committed by a few providers. Under the previous administration, PhilHealth was also used for political ends, as shown by artificial increase in memberships during two previous elections. These are all matters of accountability and governance that the PhilHealth Board and executives – as well as stewards – should keep in mind. So far, there is no entity that acts as a watchdog and advocate, and this might be something worth looking into to avert abuse of the social health insurance fund.

One provision of the National Health Insurance Act calls for a Joint Congressional Oversight Committee to conduct a regular review of the NHIP which shall entail a systematic evaluation of PhilHealth's performance and impact. In addition, the National Economic and Development Authority is mandated to undertake studies to validate the accomplishments of the program. These studies should be done, according to the law, in coordination with the Philippine Statistics Authority and the National Institutes of Health of the University of the Philippines. The validation studies should include an assessment of the enrollees' satisfaction of the benefit package and services provided by PhilHealth. These studies, together with an annual report on the performance of PhilHealth, shall be submitted to the Congressional Oversight Committee. So far, this Committee has been inactive.

PhilHealth has diligently done many of these functions, but the quality of its outputs has varied. For instance, pertinent documents are easily accessible in the PhilHealth website the PhilHealth Stats and Charts are also accessible. However, PhilHealth continues to be unable to produce actual counts of members and dependents, and business analytics are not done on a routine basis. It issues its annual report promptly and regularly, but the indicators used change with each year. Actuarial analysis are not done in greater frequency. Finally, the Joint Congressional Oversight Committee has been inactive.

Chapter VI. Overall Assessment of Purchasing of Health Services Under PhilHealth

A. Assessment of PhilHealth as Purchaser of Health Services

Purchaser-Member Relationship

Registration and entitlement of members – The massive premium subsidy program of the National Government for Q1 and Q2 households engendered a daunting task of identifying each and every eligible primary member and dependent. PHIC claims that 75 percent of the Philippine population is now covered (i.e., paid-for premiums), but DHS data indicate that only 60 percent of households claim they are covered by health insurance, leaving a large proportion of households who have been given subsidy but who do not know their PhilHealth status. To address this problem, more information, education, and communication campaign is needed to inform poor and near-poor households of their status, entitlements, and benefits. PhilHealth has also adopted a “point-of-care” approach of identifying poor patients at health facilities who will then be automatically registered as PhilHealth members.

Articulation of members’ preferences, needs, and complaints – This is a function that is not well established in PhilHealth. Benefits are still determined largely in a top-down manner, although these are increasingly being vetted through focus group discussions with members, as in the case of the PCB+/Tsekap. Members are not formally organized, and there is no independent watchdog body that looks after members’ concerns. The local health insurance offices (LHIOs) can be key points of contact for members, but this is yet to materialize. While there is a website where citizens can voice their concerns, the PhilHealth response is infrequent and much delayed.

Purchaser-Provider Relationship

Strategic purchasing – The low proportion of health expenditures from PhilHealth (maximum of 12 percent), its thin benefit package (no comprehensive primary care benefit, no outpatient pharmacy benefit, low support value for inpatient services), as well as internal institutional deficits (weak IT, weak health technology assessment) have precluded PhilHealth from becoming an influential strategic purchaser of care. PhilHealth is yet to exercise its potential monopsony power vis-à-vis providers (hospitals, physicians, pharmaceutical suppliers), but this can only happen if it becomes a major payor of health services. Despite the Philippines having one of the highest drug-price regimes in Asia and in the developing world, PhilHealth has not made major inroads in direct negotiation with big pharmaceutical firms for lower drug prices. The expanded coverage through Q1 and Q2 subsidies as well as the launching of an expanded PCB+ benefit should increase PhilHealth’s role in the health care market, and should be used as an opportunity to wield market power.

Provider payment system and timeliness of payment to providers – Through the years, PhilHealth it has been mainly a passive payor of health services under an inflationary provider payment system. The change in provider payment in 2011 to a case rate system increased PhilHealth’s influence in the health care market. Indicators show that in general, the average cost per case has declined, the average length of stay per case has declined, and the timeliness of payment to providers has also improved. While there are still cases of No Balance Billing, the prevalence of balance billing has declined from 93 percent in June 2013 to 59 percent in June 2014 (Picazo, 2014). In the future, the provider payment system has to evolve into a DRG (diagnosis related group) system to take account of comorbidities.

Licensing and accreditation of providers – Accreditation of providers was recently moved to DOH which issues their licenses. Accreditation remains a slow and painstaking process, especially for government hospitals and public health programs. As much as 33 percent of hospitals are not accredited;

for TB DOTS, after ten years of accreditation experience, only 59 percent of the DOTS centers licensed by DOH's National Tuberculosis Program (NTP) have been accredited or certified, leaving 41 percent unaccredited or uncertified, thus denying them receipt of PhilHealth reimbursements.

Prioritization of health services – There is yet no formally established process for health technology assessment (HTA) at PhilHealth. The Philippines has an established process for the economic and therapeutic evaluation of drugs (FDA, NCPAM), but a similar process is not in place for devices and procedures. As a result, the determination of the benefit package (especially for costly procedures such as those under Z benefits) is rather unsystematic. WHO has established the guideline that an intervention is cost-effective if the cost per disability adjusted life year (DALY) averted is lower than 3 times the per capita GDP of the country for that year. To operationalize such a rule, PhilHealth needs to conduct analyses of the costs per DALY averted of the most expensive medical and surgical conditions in the country.

Quality of care – Under PhilHealth's Benchbook accreditation program, hospitals were classified according to whether they were centers of excellence, centers of quality, and centers safety. The criteria for these classifications involved not only structural but also process aspects of care as well. However, the generally poor availability of data on hospitals (e.g., infection rates) precluded analysis of whether ex-ante accreditation standards resulted in ex-post quality improvements. Patient satisfaction surveys are not regularly conducted to obtain even perceptions of quality. On individual hospitals' own initiative, and as part of a campaign to attract more patients, some facilities have resorted to obtaining reputable international accreditation such as JCAHO, Accreditation Canada, ISO, and the like.

Information technology – PhilHealth's use of information technology (IT) for business analytics is in its infancy. Because of weak use of IT, key data on patients and providers and payments are not available on a just-in-time basis for decision-making, whether by PhilHealth's own technical staff or by the Board. Efforts are being initiated in this area at the outpatient-end of the spectrum of care (through the OPB and PCB+ benefits), even though the more critical (because more expensive) end is inpatient (especially surgical) care.

Purchaser-Government Relationship

Adequacy of funding to purchase services – Premium rates in PhilHealth are far lower than what prevails in middle income countries that have achieved UHC and which provide more comprehensive benefits. Colombia collects 12.5 percent (8.5 percent from worker and 4.0 percent from employer); Estonia, 13 percent of wages; Turkey, 12.5 percent. The current contribution rate of 2.5 percent among the employed, for instance, does not cover provision of outpatient benefits nor for Z benefits. PhilHealth's goal of expanding the benefit package and increasing support value (reimbursement rate) in both inpatient and outpatient care will inevitably require increasing the premium rate. However, such an increase is politically sensitive, and is not likely to be initiated in an election year (2016) or prior to it (2015). Because of this, the design of benefits is often done in a "reverse process," i.e., fitting the benefits within the given resource envelop, rather than determining the needed benefits, costing them out, and arguing for a needed premium increase. This has been a long-standing dilemma, and unless there is political will to break it, PhilHealth will continue to limp along.

Collection efficiency – Inefficient collection of premiums is a long-standing problem of PhilHealth. For the government sector, the concerned agencies as employers sometimes make payments lower than the 2.5 percent contribution as required by law. As a result, arrears often accumulate, to as much as PHP4.6 billion as at the end of 2005 (Walker, 2006). Delays in the National Government release of cash payments for the premiums of Sponsored Program members have also caused arrears in the past (Walker, 2006).

Stewardship – PhilHealth is an attached agency of the DOH; the Secretary of Health is the chairman of its Board. DOH stewardship of PhilHealth, however, leaves much to be desired because the technical skills needed to oversee, steward, and monitor PhilHealth are not sufficiently available at DOH. The same can be said of other government agencies supposed to oversee PhilHealth, such as the Congress, the Office of the President/Presidential Management Staff, or the Social Cluster of the Cabinet. Proof of this “arms-length” if not indifferent attitude of higher-level bodies is the absence, for a long time, of commissioned reports, state-of-the art assessments, strategic plans, and similar documents that should inform the public of the state of the National Health Insurance Program. As a result, PhilHealth often acts as a “self-stewarding” institution.

B. Institutional Factors Influencing PhilHealth’s Performance as Purchaser of Health Services

The legacy of pension-fund origins – PhilHealth’s predecessor agency, the Philippine Medical Care Commission (PMCC), was established in the late 1960s under the shadow of two large pension funds, the Government Service Insurance System (GSIS) which collected pension and health insurance premiums from civil servants, and the Social Security System (SSS) which did the same on behalf of private-sector employees. Until 1995 when PhilHealth was established, the PMCC had strong representation from GSIS and SSS. When PhilHealth was established, the PMCC assets were transferred to it and it began to collect premiums independent of the two pension funds. However, the two pension funds continued to be represented in the PHIC Board, wielding strong influence on how it managed its affairs, especially with respect to PhilHealth reserves. Although PhilHealth is a health insurance fund, it is sometimes perceived to be run as a pension fund, and indeed its reserves tend to accumulate to levels far higher than what a health insurance fund should have. For instance, in the mid-2000s, reserves were 3-4 years of benefit payments and operating costs. This pension mentality continues to pervade the organization especially during discussion on benefit expansion.

Lack of stronger members’ or patients’ representation in PHIC Board – The PhilHealth Board is dominated by representatives of government departments and agencies doing sundry functions, including Finance, Health, Labor, Social Development, Local Governments, GSIS, and SSS. Ranged against them are a few representatives actually involved in health (hospitals, physicians), and then there are representatives from employers and patients. Thus, representatives of members and providers are outnumbered by government representatives, with little actual knowledge of health service provision and needs. The decision-making is often consensual, tending to be on the conservative side (i.e., stewardship of the fund and reserves position) rather than on the progressive side (expanded benefits to members).

Use of private health insurance instead of SHI concepts – Until very recently, PhilHealth continued to use health insurance principles borrowed from private health insurance rather than social health insurance. For instance, 3-month waiting periods and exclusions from specified benefits have been the norm. Public-health providers (for TB-DOTS, for instance) have to go through time-consuming and onerous accreditation, rather than being given blanket accreditation since they have been licensed by DOH anyway. The combined effect of the use of these concepts is to restrict utilization (expected of a private health insurance scheme) rather than widen it (expected of a social health insurance program).

Chapter VII. Summary, Conclusions, and Policy Implications

This study is a critical analysis of health services purchasing undertaken by PhilHealth which implements the National Health Insurance Program of the Philippines. Purchasing is about how an institution should determine, negotiate for, and obtain health services on behalf of a group of people which has contributed resources, either through taxes, premiums, or point-of-service payments, in exchange for anticipated health services.

The study employs a principal/agent framework for analyzing three critical relationships: that between the purchaser and health care providers, between the purchaser and citizens (or members of Philhealth), and between the purchaser and the government, both as regulator and as funder of services, at the national government and local government levels.

In analyzing these three relationships, the study compares three states: the ideal or theoretical arrangement of purchasing as determined by economic theory; the “design” arrangement as written in laws, implementing rules and regulations, executive and administrative orders, circulars, and other policies; and the actual arrangement or practice as culled from reports and interviews of stakeholders. Thus, the study is an analysis of the key alignments and variances of purchasing practices vis-à-vis the “design” and the theoretical ideal in each of the three relationships. To do this, the study employs an extensive document review as well as key informant interviews of stakeholders.

A. Purchaser-Member Relationship

Using the framework of an ideal purchaser in the purchaser-member relationship, the analysis of PhilHealth indicates the following:

- PhilHealth’s engagement with its members has been unevenly done, but is improving. In the case of PCB+, extensive focus group discussions were conducted to help in the benefits design.
- Provider payment reforms from FFS to case rates updated the reimbursement rates, but real resource costing of medical and surgical procedures still need to be done. Some public health interventions (e.g., MCP) have generous reimbursements while others (e.g., TB DOTS) do not. On average, support value in 2013 represented only 31.5 percent of hospitalization cost, indicating that PhilHealth has still a long way to go in providing financial protection.
- PhilHealth has no problems in identifying paying members, but it has serious difficulties in identifying and enrolling SP members whose premiums are paid for by the National Government. Many of these members have not been oriented about their entitlement and have not received their PhilHealth cards. Only 60.3 percent of households in the DHS 2013 survey (DOH, 2014) claimed they had PhilHealth insurance while PHIC claimed coverage of as much as 75 percent.
- Focus group discussions done for the design of the PCB+ package indicate that although members know PhilHealth in general, they are not aware of the specific benefits to which they are entitled (FOCI, 2014). In 2013, a WB evaluation showed that as much as 36 percent of SP patients were not aware of their PhilHealth coverage.
- In general, access is increasing: the percentage of households who sought care in the Philippines increased from 7.9 percent in 2008 to 10.7 percent in 2013, according to NDHS data (DOH, 2014). However, access to care is still very uneven across the regions/provinces and within regions/provinces. And access to much-needed and much-desired primary care benefits is limited by the currently very-narrow services included under existing funded benefit (MCP, TB DOTS, and OPB).

- PhilHealth has established procedures for settling complaints and resolving disputes. However, available IT methods (website, e-mail, telephone hotlines, social media) have not been optimally used to respond quickly to member and provider concerns.
- PhilHealth public reporting of performance to promote transparency and accountability is not routinely done. Indeed, it is quite difficult to obtain data from PhilHealth.

The following policy implications and recommendations emerge from the analysis of provider-member relationship:

- To identify and inform the remaining unidentified Q1 and Q2 members – PHIC needs to undertake more pro-active information, education, and communication campaigns. PHIC also needs to make true on its adoption of a “point of care” enrolment whereby patients without PhilHealth cards will be assessed on site and automatically given eligibility if found to be classified as poor or near poor, depending on the criteria to be set by DSWD. PHIC should consider use of civil registration to automatically enroll infants to PhilHealth, depending on the PhilHealth status of the parents.
- To vitalize PhilHealth’s customer service orientation – PHIC needs to revive its customer hotlines, web page, and social media channels to reach out to its members.
- To mandate a stronger PhilHealth membership representation in PhilHealth’s Board
- To encourage and support nongovernmental advocacy groups – Watchdog, research, academic, or labor groups should be supported, especially those focusing on social programs in general and PhilHealth specifically.

B. Purchaser-Provider Relationship

Using the framework of an ideal purchaser in a purchaser-provider relationship, the analysis of PhilHealth indicates the following:

- PhilHealth has tended to be rather too stringent in accreditation, especially of government hospitals and public health clinics. PhilHealth has accredited only 67 percent of licensed hospitals in the country (PIDS, 2014), and only 59 of licensed TB DOTS centers (Picazo, et al., 2014). This severely reduces access to and utilization of hospital and public health services, especially in localities where the licensed but un-accredited facility is the only provider. Although a more liberal and accommodative accreditation policy has been specified in GAA 2012, it has not been widely implemented. PhilHealth is yet to introduce more facilitative arrangements with providers to improve quality of care.
- Unlike in other countries, PhilHealth has no equalization (or equity) fund for GIDA areas, and PhilHealth reimbursement rates are uniform across the board. Thus, there are no additional incentives (aside from normal reimbursements) for providers to locate in GIDA areas.
- Efficiency-improving mechanisms at PhilHealth show a mixed picture. The patient gatekeeping and referral system in the Philippines is very weak (Acuin, 2014). However, provider payment reform from retrospective FFS to prospective case rates has shown positive results. The Generics Law has been in force since 1998, but providers sometimes find ways to prescribe branded drugs

(Wong, 2014). Not all the clinical guidelines are available. There is still no established process and national guidelines for health technology assessment.

- To monitor providers, PhilHealth's has quality of care mechanisms that are mostly ex-ante standards via accreditation. De-accreditation of providers is not usually resorted to because of severe disadvantages it imposes on members relying on the services of the concerned providers.
- PhilHealth signs "performance agreements" with contracted health facilities. However, the performance targets and their accomplishment vary. Hospitals usually complain of payment delays and disallowances in their claims. To deal with these issues, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records (EMR).
- Under the new case rate provider payment system that replaced FFS in 2011, providers know in advance the reimbursements they are going to receive. A No Balance Billing policy has also been in force and compliance has improved, from only 7 percent of surveyed hospitals practicing no balance billing in June 2013 to 41 percent in June 2014.
- PhilHealth's turn-around time (from claims filing to payment) has also improved. For instance, from 2010 to 2012, turn-around time for hospital claims was reduced, on average, by 21 to 23 days (PhilHealth, 2014).
- PhilHealth outpatient benefits have evolved in an extremely fragmented fashion leading to high administrative and monitoring costs and less-than-optimal impact, as shown by TB DOTS and the pilot on PCB 2.

The following policy implications and recommendations emerge from the analysis of purchaser-provider relationship:

- To loosen up on accreditation especially of public health programs – PHIC should consider a blanket accreditation of all DOH-licensed providers of public health programs (TB DOTS, MCP, OPB). This is already mandated under the General Appropriations Act of 2012 but is not yet implemented.
- To update the case rate reimbursements and to move towards DRG system – PHIC should undertake a thorough resource costing of each of the conditions under the case rate system with a view to make them more realistic.
- To expand primary care benefits – The PCB+/Tsekap is currently under design. If approved, this program will have a profound influence on members as it is the first point of contact. It hopefully will rationalize the extremely fragmented outpatient benefit packages. It is also a more palpable benefit, compared to inpatient hospitalization which is rare. Thus, it is deemed more inclusive.
- To institutionalize health technology assessment – The envisioned expansion of the Z benefits should be underpinned with proper analysis of burden of disease and cost-effectiveness. While the Philippines has a fairly developed process for the evaluation of drugs, evaluation of devices and procedures have lagged behind. Burden of disease analyses also need to be strengthened.
- To mandate use of EMRs – PHIC should be able to do just-in-time business analytics, and this can be made possible only with the mandated computerization of its accredited providers. A good

starting point in this regard would be to require electronic medical records (EMRs) of all providers.

C. Purchaser-Government Relationship

Using the framework of an ideal purchaser in the purchaser-government relationship, the analysis of PhilHealth indicates the following:

- The policy framework under which PhilHealth operates is well stipulated in laws. PhilHealth hews to these legal stipulations closely and implements them through regulatory circulars and/or administrative orders of the DOH. The Philippine health financing and service delivery environment, however, is evolving rapidly. Medical technology, IT, global and local professional practices (including medical tourism), and the relationship between private and public sectors are also undergoing rapid changes, as a result of which regulatory instruments are often in a “catch-up” mode to be relevant.
- PhilHealth does not invest in service capacity infrastructure although it did so in the 1970s under PMCC, with varying success. PHIC’s major tool for increasing access in underserved areas is financing; hospital reimbursement was shown in the 1970s to have successfully added hospital stock in rural and peri-urban areas, but since the 1980s this has stalled. The launching of the PCB+/Tsekap package which allows reimbursement of private clinical practices is anticipated to encourage private medical practitioners in rural and poor urban areas.
- Government has mobilized resources from sin taxes to finance a massive premium subsidy for Q1 and Q2 households. However, premium increase among employed and individually-paying members is highly politicized; indeed, it has lagged behind improvement in benefit package. Expanded benefits are contingent upon government’s ability to raise the premium rates and to improve collection efficiency. All industrial and emerging economies that have achieved UHC show premium rates far higher than what obtains in the Philippines at present (Picazo, 2014).
- There remain problems in collection efficiency, and arrears from government agencies have sometimes accumulated. PhilHealth has adopted an “accounts-management” approach in which specific PHIC staff is assigned a specific agency to follow-up on, to ensure all collectibles are collected.
- Financial audit is formally institutionalized in PhilHealth. The Commission on Audit has the constitutional mandate to undertake this function. In addition, PhilHealth itself has an internal audit department that conducts necessary inquiries on how providers are performing their fiduciary responsibilities. A major gap is the lack of more active stewardship role by the Executive (Office of the President) and the Legislative (Congress) branches, as shown by infrequent commissioned reports on the state of the National Health Insurance Program.

The following policy implications and recommendations emerge from the analysis of purchaser-government relationship:

- To brainstorm on and formulate an over-arching national strategy for social health insurance – This is critical as the Philippine economy surges, the population ages and the disease patterns change, and medical and information technology advance.
- To formulate an over-arching national strategy and plan for health facilities expansion – HFEP investments have been identified and provided in an opportunistic, bottom-up fashion. This needs to be corrected with a national health facilities development plan that takes account of economic,

demographic, epidemiologic, and geographic considerations – not only the narrow concerns of LGUs, as is apparent in the HFEP investments.

- To conduct annual external commissioned report on the status of PhilHealth – For its size, importance, and influence, an annual performance report (along the lines of a “white paper”) should be conducted by an external, independent panel to inform the Office of the President, the Congress, and stakeholders on how PhilHealth can be further improved.
- To increase the PhilHealth premium and improve collection efficiency – Political will is needed to increase premium contributions along the lines of other emerging economies’ health insurance programs, and along the lines of the desired benefit package of the population.
- To conduct impact evaluation studies – The implementation of social health insurance requires periodic evaluation of its impact and performance, and identification of key policy and programmatic issues.

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