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**Research Report**

## Rapid Assessment of Strategic Purchasing in the Philippines: A Country Case Study

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# Rapid Assessment of Strategic Purchasing in the Philippines

A Country Case Study

Thematic Working Group on Strategic Purchasing  
The Collectivity

# Rapid Assessment of Strategic Purchasing in the Philippines

A Country Case Study

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## Abbreviations and Acronyms

BOD – Board of Directors

DOH – Department of Health

DRG – Diagnosis Related Groupings

DSWD – Department of Social Welfare and Development

HMO – Health Maintenance Organization

LGU – Local Government Unit

LHIO – Local Health Insurance Office

NBB – No Balance Billing

NDHS – National Demographic and Health Survey

NHIP – National Health Insurance Program

NHTS-PR – National Household Targeting System for Poverty Reduction

OOP – Out-of-Pocket Payments

PAGCOR – Philippine Amusement and Gaming Corporation

PCB – Primary Care Benefit

PCSO – Philippine Charity Sweepstakes Office

PFPR – Per Family Payment Rate

PhilHealth – Philippine Health Insurance Corporation

PNHA – Philippine National Health Accounts

POC – Point of Care

POS – Point of Service

RHU – Rural Health Unit

SHI – Social Health Insurance

THE – Total Health Expenditure

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The usual disclaimer about errors and omissions applies.

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## Executive Summary

For many resource-constrained settings, challenges in financing mainly revolve around how to mobilize more resources for health, ensure that there is proper allocation of these resources, and use it as a leverage to shape provider behavior.

Health financing in the Philippines has evolved through the years since the introduction of a health insurance system in 1969 under the Medicare Program. Its coverage was limited to the formal sector workers until its expansion into a single payer system in 1995 with Philippine Health Insurance Corporation (PhilHealth) as the sole administrator. However, health financing remains fragmented with multiple funding streams that sometimes overlap and run separately from and independent of each other. These pools vary in the way they are funded and in the services they finance.

While PhilHealth is the single biggest purchaser of health care services in the country, it has not yet fully utilized its health financing role as a lever to drive health sector development. Global experience shows that a strong purchaser can act as a key change agent in the health sector encouraging improved performance and accountability from the providers and ensuring equitable access to health services.

PhilHealth is uniquely positioned to centralize health financing and use this to shape the health market behavior. This is even more important, as the Philippines finally moves closer to its goal of universal coverage. The existing economic and political support offers a window of opportunity to create that leverage. A step forward in that direction is taking stock of the strengths and weaknesses in its current purchasing situation, which could provide a strong basis for developing an action plan or enhancing existing reform initiatives moving forward.

The rapid assessment guide for strategic purchasing which was co-produced by the collaborative learning initiative led by the World Health Organization (WHO) and the Institute for Tropical Medicine – Antwerp (ITM) was used for this purpose.



## Overview of Health Financing in the Philippines

The Philippines is a lower middle-income country located in South East Asia with an estimated population of 104.5 million in 2018. It is an archipelago of about 7,106 islands and consists of three major island groups: Luzon, Visayas and Mindanao. The key social and economic indicators suggest that the country is economically performing well but the growth has not been inclusive with poverty still persisting and health disparities widely evident.

Health financing was expected to drive health sector development since the introduction of health insurance system in 1969. But even after two decades of operation, the Philippine Health Insurance Corporation (PhilHealth) – the state-run social health insurance agency, being the biggest single purchaser of health care services in the country, still failed to utilize its purchasing capacity as a lever to improve health sector performance and overall health outcomes.

While the health status of the country has improved over the past decades with notable gains in some areas. It is also undergoing demographic and epidemiologic transition characterized by decrease in fertility, increase in life expectancy and substantial changes in risk factors that presents new health challenges alongside the growing burden brought about by rapid urbanization, high population density, and climate disruptions. These factors created additional demands for PhilHealth to take an active role and become more strategic in its purchasing function.

### Trends in Health Spending

A closer look at the trend in health expenditure in the Philippines, suggest that the resources earmarked for health financing in the country remains inadequate. Total health expenditure (THE) as a percentage of GDP, which now stands at 4.7%, has not changed significantly. Although, the THE grew consistently over the past decade, it is still considerably low compared to other regional economies (i.e. China, 5.6%; Cambodia, 5.7%; and Vietnam, 7.1%).

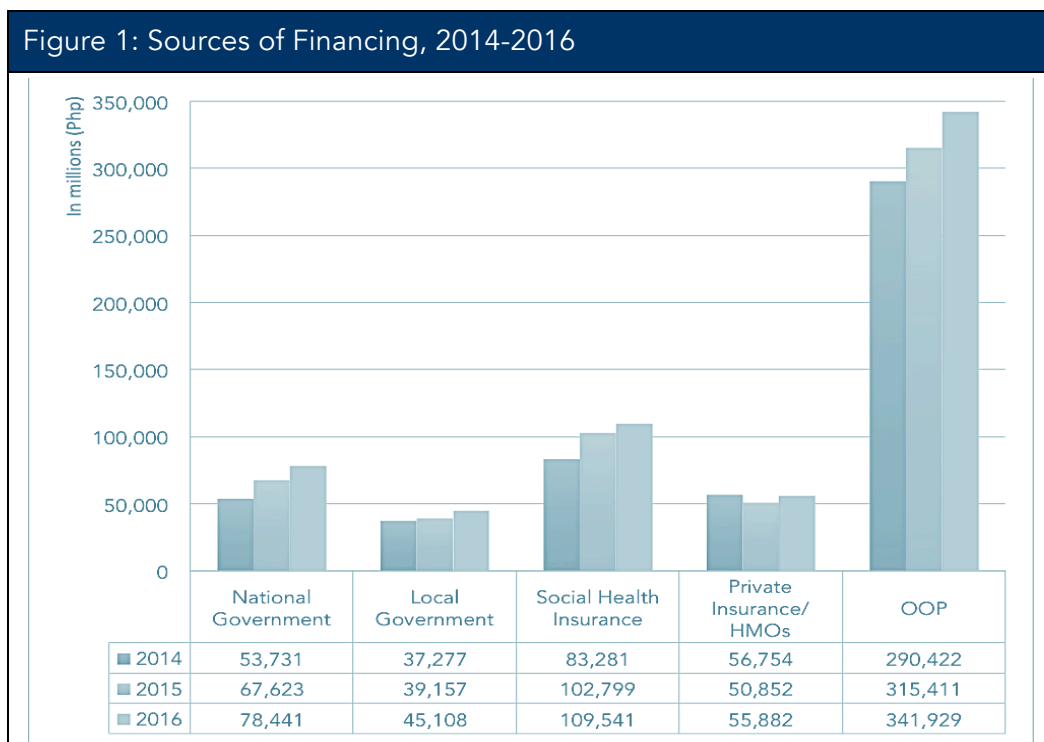
The state participation in THE is also low compared to private sector share. The strong reliance on private sector financing means that a high proportion of out-of-pocket (OOP) spending is necessary to gain access to health care services making it a significant source of health inequity. OOP continue to stand out at 53.7% of THE, which means the burden of paying for health care is predominantly shouldered by individual families. However, THE per capita in 2014 (in US\$ PPP) has increased to 328.9 from 241.6 in 2010, which positively indicates relative improvement of coverage in the provision of health services.

Table 1: Key Indicators on Health Expenditures, 2014	
Indicators	Figures
Total health expenditure (% of GDP)	4.7
Total health expenditure per capita, PPP (2011 constant prices)	328.9
Public expenditure on health (% of THE)	34.3
Private expenditure on health (% of THE)	65.7
Out-of-pocket payments (% of THE)	53.7

Source: World Health Organization

### Revenue Sources and Purchasing Mechanism

Pooled financing in the country mainly comes from four sources: (1) the national government through the Department of Health (DOH); (2) local government comprised of cities, municipalities and provinces; (3) PhilHealth who administers the social health insurance; and private insurance, health maintenance organization (HMO) and micro-health schemes.



Source: Philippine National Health Accounts, Philippine Statistics Authority

The latest available data from the Philippine National Health Accounts (PNHA) shows that, even years after the devolution of health services in 1991, the level of local health spending has not caught up with that of the national government. Similarly, social health insurance is only contributing a little over 17% of THE, with the rest of the expenditure coming from private sources.

The Philippines started a social health insurance scheme under the Medicare Program that serviced only the formal sector workers. This was later expanded into the National Health Insurance Program (NHIP) in 1995, extending insurance coverage to the rest of the population. Consequently, PhilHealth was established to be the sole administrator of the NHIP, gradually integrating the various health insurance components previously administered by different government agencies into a single fund.

PhilHealth is designed as a single payer system primarily financed through contributions. The formal sector members are mandatorily covered through payroll deductions at a rate of 2.75 to 5.0% of the basic salary, shared between the employee and the employer. Premiums of indigent members, identified through the National Household Targeting System for Poverty Reduction (NHTS-PR)<sup>1</sup> and the elderly aged 60 years old and above are fully subsidized by the national government at PhP 2,400 (approx. \$45 USD) with annual renewal of funds sourced from alcohol and tobacco revenues. The rest of the population including self-earning individuals and informal sector members are required to pay a minimum of PhP 2,400 or 3,600 (approx. \$65 USD) if monthly salary is over PhP 25,000 (approx. \$455 USD).

Over the last two decades, insurance coverage dramatically increased with over 93% of the country's population who are now eligible to avail of health services purchased by the social health insurer, although PhilHealth claims that 100% of the population is technically covered because of the Point of Care (POC) and Point of Service (POS) policy<sup>2</sup>. The largest increment in aggregate membership has come from covering the poor and the senior citizens. Today, PhilHealth boasts to be the biggest purchaser of health care services in the country paying a little over PhP 2 billion in benefit payments per week and yet its contribution to THE is but minimal.

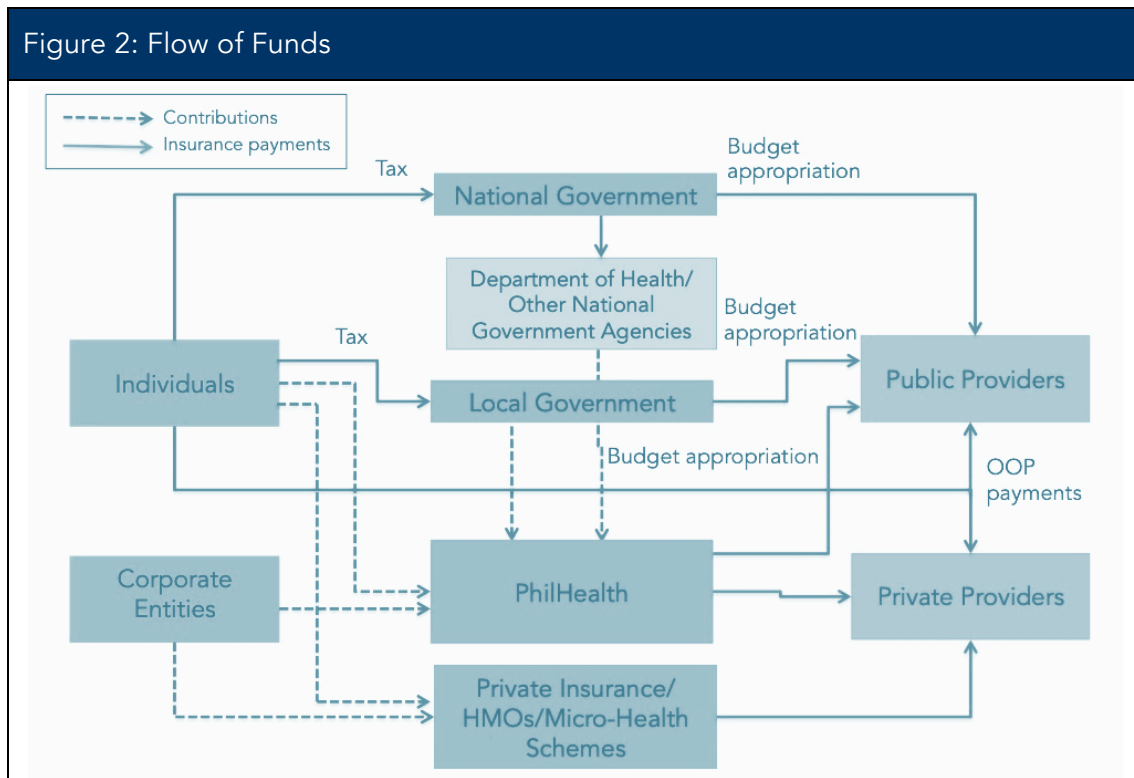
On the other hand, privately pooled funds from voluntary insurance programs operated by private insurance companies, health maintenance organizations, and even micro-health schemes are gaining substantial market with a growing economy and increasing demands for quality health services. These programs also found a business advantage in PhilHealth being the first-peso payer of the hospitalization cost.

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<sup>1</sup> The National Household Targeting System for Poverty Reduction (NHTS-PR), consist of a set of uniform and objective criteria to identify the poor, this is the main tool centrally designed and implemented by the Department of Social Welfare and Development (DSWD) to improve delivery of social services. The same tool is being used by several government programs including PhilHealth, which reduced the overall cost of targeting, improved coordination and enhanced efficiency and effectiveness of social protection programs. The tool has become the basis for PhilHealth for the automatically coverage of the poor in the social health insurance.

<sup>2</sup> An allocated sum of P3 billion set into motion the Point of Service (POS) Program of PhilHealth in 2017. It granted PhilHealth coverage to Filipinos who do not have the means to pay for health services at the time of hospitalization. A similar policy was implemented in 2013 called Point of Care (POC) Program alongside the massive enrollment of the poor and the elderly, seeks to automatically provide social health insurance entitlement upon hospital admission after an assessment of the potential beneficiary by medical social workers using a set of socio-economic criteria. The POS has actually allowed the state insurance to provide financial risk protection to those who would have otherwise "fallen off the cracks" for not being identified as poor under the proxy means test.

Other sources of financing are the Philippine Amusement and Gaming Corporation (PAGCOR) and the Philippine Charity Sweepstakes Office (PCSO), which are government agencies that manages national charities and casinos, that also set aside funds to be provided as medical assistance grants and financial support for patients undergoing costly medical procedures. However, OOP payment remains to be the predominant source of financing for health. These are spent largely on unregulated fees of doctors, drugs and medicines, and diagnostics. *Figure 2* shows the flow of health funds and *Table 2* provides a summary of the purchasing mechanism in the Philippines.



Source: Adopted from Obermann, Jowett, and Kwon, 2018.

### Key Issues and Challenges

- Resources allocated for health remains inadequate as evidenced by a low public share in health spending.** While the health budget allocation of national government dramatically increased with more infusion from sin tax revenues, the internal revenue allotment (IRA) for LGUs on the other hand are allocated independently of need and capacity to raise local revenues. No portion of the IRA itself is earmarked for health service provision, which is already a devolved function. This leads many LGUs to underfund their health and the very reason for the slow uptake in public health spending.

- **Health care financing system in the country is fragmented and inequitable.** The devolution transformed the local governments into providers of primary and secondary health services through their rural health units and LGU-managed hospitals. However, a number of tertiary and specialty facilities were retained under the jurisdiction of the DOH. This fragmentation led to overlaps in the resource allocation and financing of health services, as evidenced by the existing pools of money available from PhilHealth, DOH, LGUs and other government instrumentalities like DSWD, PAGCOR and PCSO.
- **The high OOP expense leaves the poor and low-income group vulnerable to financial and health risk.** Apart from the already high OOP, the reported average support value of PhilHealth or the level of financial support SHI covers against a member's hospitalization cost is only at 33.8 percent. The implementation of the NBB policy is already a laudable effort and a bold departure from decades of a balance billing culture. As a matter of principle, it provides the full insurance coverage sought after by patients, in practice though, the implementation might still be problematic as the policy is currently limited to publicly-run facilities which are hounded by procurement delays.

Table 2. Summary of Purchasing Mechanism in the Philippines

Purchasing Mechanism	Services	Population Covered	Sources of Fund	Purchaser	Provider Payment
<b>General Tax-Funded Health Services</b> Publicly-financed health services; national and local government pools	Public health interventions and commodities	Entire population	Government budget	Department of Health, Local Government Units, Other National Government Agencies (PCSO, PAGCOR, DSWD)	Budget allocation
<b>National Health Insurance Program</b> Mandatory social health insurance; single pool	Inpatient care, limited outpatient services, primary and catastrophic care	93% of total population (2017); 96.97 million	<b>Formal sector:</b> payroll tax contributions by employers and employees (2.75% of basic salary shared equally); <b>Informal:</b> annual minimum premium contribution \$US 48; <b>Poor:</b> fully subsidized by national government	State-run social health insurance agency (PhilHealth)	Case-based payment; Per family payment rate
<b>Private Health Insurance</b> Voluntary schemes open to formal sectors (usually as an employment benefit) and informal sectors; multiple pools	Inpatient and outpatient care	30% of total population (2017); 31.1 million	Premium contributions by beneficiaries (individual and corporate)	Private health insurance companies/ health maintenance organizations	Fee for service at contracted public and private health facilities
<b>Micro-health Insurance</b> Voluntary schemes mainly targeting rural populations; the micro-health scheme is usually bundled with a financial product (e.g. micro-loans) offered by organized groups; multiple pools	Inpatient and outpatient care	25.4% of total population (2017); 26 million	Premium contributions by beneficiaries	Organized groups (e.g. cooperatives, mutual benefit organizations)	Fee for service at contracted public and private health facilities

## Analysis of Strategic Purchasing Functions

The analysis of the strategic purchasing in the Philippines will cover four (4) major domains: payment mechanism, benefit design, information system, and governance.

### Provider Payment Methods

The health service delivery in the Philippines is dominated by the private sector. About 60% of PhilHealth accredited health facilities are private providers. PhilHealth employs an accreditation process assessing the qualifications and capabilities of health care providers against a set of benchmark and standards before health care providers can participate in the SHI program. It also separately accredits providers for its Primary Care Benefit (PCB) package, Maternity Care Package (MCP) and TB-DOTS Package.

Providers	Number
Public hospitals	763
Private hospitals	1,150
Primary care providers	2,455
Maternity care clinics	3,243
TB-DOTS providers	1,996

Source: PhilHealth Stats and Charts, 2017

In 2011, PhilHealth decided to shift a more efficient and prospective case based payment from an inflationary and inefficient and retrospective fee-for-service. It started with 23 conditions that represent about 70% of the claims PhilHealth is paying. This was expanded in 2014 to become the primary payment mechanism until now.

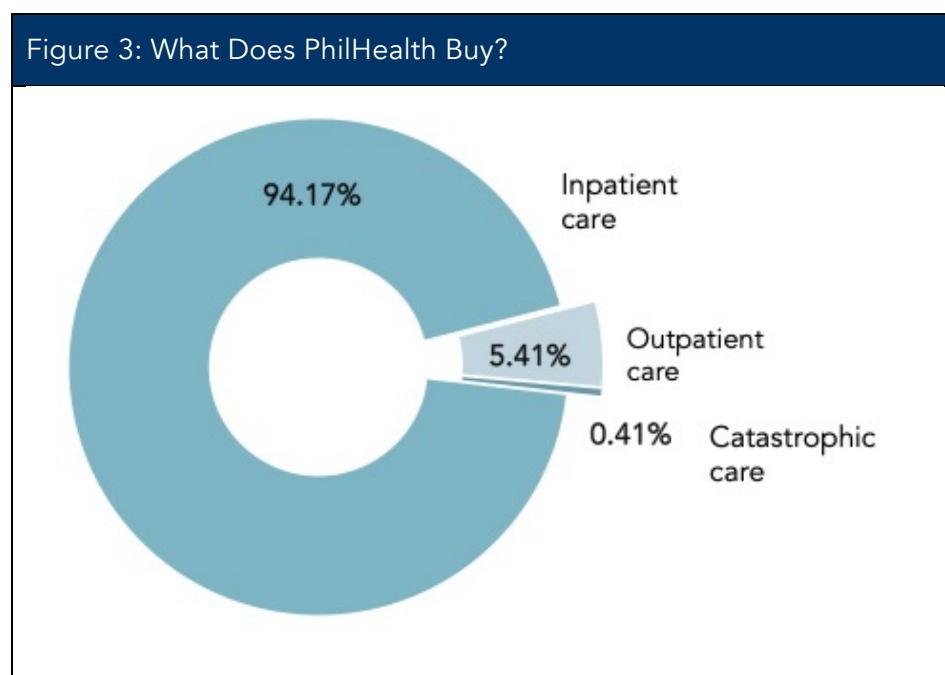
PhilHealth also utilizes a modified capitation payment called a Per Family Payment Rate (PFPR) to pay for primary care services. The payment is tied to a set of performance indicators (e.g. health profiling, provision of obligatory services for those with hypertension, diabetes and dyslipidemia, and electronic submission of data etc.) The capitation amount however is very low that it does not provide incentive for providers to perform.

To improve financial risk protection among vulnerable population, a No Balance Billing (NBB) policy was implemented which guarantees qualified members that they will no longer have to pay any amount beyond what PhilHealth pays for when admitted in ward-type accommodation in government hospitals.

### Benefit Package Design

The services covered by PhilHealth are heavily skewed towards in-patient services. Non-communicable diseases (NCDs) now top the list among the ten causes of mortality and

morbidity in the country. And yet for many of these chronic diseases, outpatient drugs are still not included, dental care, and vision care not covered. Neither are the costs for outpatient care except for a limited number of services and procedures (e.g. cataract extraction, day surgeries, and TB-DOTS) and consultation fees reimbursable. It has even become a practice by health providers to require the patients to be confined even if a more cost-effective outpatient management of care is available because most of the SHI benefits are for inpatient hospitalization. Moreover, outpatient consultation and routine diagnostic services are limited to certain population segments like the poor, elderly and migrant workers to the exclusion of those in the formal and informal sector.



Source: Author's calculation from the PhilHealth Stats and Charts, 2017

In 2012, PhilHealth started to cover disease conditions that are identified as economically and medically catastrophic called Z-Benefits<sup>3</sup>. These packages can be availed by members in selectively contracted providers based on capability using stringent eligibility criteria. With the catastrophic benefit packages, the NBB policy is applicable for poor members and comes with a maximum co-payment of 100% for the rest of the population.

PhilHealth does not have a written comprehensive benefit strategy or expansion plan and the process for benefit design and development is not explicit. It launches "new benefit packages" incrementally on a yearly basis. New benefits are usually decided by the Board of Directors and in most cases, approached using the research process (i.e. conduct of

<sup>3</sup> Current Z-Benefit packages covers the following: acute lymphocytic leukemia, early breast cancer (stage 0 to IIIA), prostate cancer (low intermediate risk), kidney transplantation for end stage renal disease, coronary artery bypass graft surgery, total correction of tetralogy of fallot, closure of ventricular septal defect, cervical cancer (stage I to IV), lower limb prosthesis, premature and small newborns, selected orthopedic implants, peritoneal dialysis for end stage renal disease, and colon and rectum cancers.



economic evaluation, costing etc.). Although, health technology assessment was introduced years ago, it has never been institutionalized.

## Information Management System

Existing health-related information systems and data sources in the country are highly fragmented. Poor data collection, processing, storage and transfer, and lack of standards and structure for harmonization further exacerbate this situation making access to timely, reliable and complete health information for decision making a real challenge.

While PhilHealth collects what can be considered as the largest health-related information in the country, it has lagged behind in acquiring appropriate technology to meet the demands of processing “big data”, failed to develop the competency to analyze it, and to take stock of the types of data that needs to be collected (e.g. cost of health services) to support operations and decision making.

PhilHealth *Enterprise Architecture* was developed in 2015, as a guide in assessment and integration of existing information systems, and the development of new ones based on needs. Similarly, the health sector developed a *Philippines eHealth Strategic Framework and Plan 2014-2020* as a roadmap towards a more integrated health information system.

## Governance Arrangements

PhilHealth is a government owned and controlled corporation (GOCC) under the policy oversight of the Department of Health (DOH). A 17-person governing council with various sectoral representations comprises the Board of Directors (BOD), with the Secretary of Health as the chair. However, this oversight structure, particularly for strategic purchasing has not translated into adequate stewardship by the DOH. Part of the problem is the existing overlaps in the purchasing of health services between the two agencies and the lack of capacity to provide technical direction. Decision on what provider payment mechanism to use, benefit packages to develop, and the approval of the annual budget for the operation of the NHIP rest with the Board.

The *Universal Health Care Bill*, certified to be a priority measure of the government and is set to be approved within the year, seeks to address current governance issues and particularly aims to transform PhilHealth into a national purchaser of health services. Among the provisions of interests are:

- Clarifying the roles and responsibilities of DOH, PhilHealth, LGUs and other financing agents (e.g. DOH pays for population-level interventions, PhilHealth pays for individual-based interventions, DSWD for non-direct medical expenditures).

- Establishing a Health Technology Assessment (HTA) Council to guide the DOH in the allocation of its health investments and inform PhilHealth of its benefit coverage decisions.
- Adopting an appropriate provider payment method with built-in cost containment mechanism (i.e. global budget).
- Mandating income retention of PhilHealth benefit reimbursements in all government facilities along with strict submission of clinical, costing and price data from all health care providers.
- Enforcing the share of NBB beds (90% of beds in public hospitals, 60% for GOCC hospitals, and 10% for private hospitals) and rigorous monitoring of compliance.
- Streamlining the governance body of PhilHealth with better entry criteria and competency requirements.

### Key Issues and Challenges

- **Lack of prioritization process in benefits development.** There is no formally established process for the inclusion of an HTA. A less transparent and participatory process runs the risk of being political influenced resulting to inappropriate and cost ineffective packages.
- **Cost coverage for both inpatient and outpatient are lopsided.** Contributory to this is the weak monitoring mechanism, inadequate rates, and disproportionate prioritization of benefits, which are largely focused on inpatient than outpatient services. At the same time, resource allocation is severely inadequate and the benefit coverage for primary care services is not comprehensive leading to low utilization and less-than-optimal impact.
- **Gaps in the stewardship of reforms for strategic purchasing.** While PhilHealth primarily has the potential to be a more strategic purchaser, it has not been adequately empowered to enforce this mandate. For example, considerable inroads has been made to increase premiums or adopt a prospective payment mechanism such as the global budget, but has been hampered by constraints in technical capacity or frequent change in institutional leadership resulting to a lag in implementation.
- **Capacity to utilize health information and big data for decision is wanting.** Apart from the highly fragmented information systems, current capacity to analyze, plan and decide based on available health data is still deficient. Adoption of technological advances to process big data and existing research capacity within the institution needs to be strengthened.

## Summary Assessment and Proposed Options

The Philippines has already made significant strides in various aspects of health financing but a number of external (low public health spending, weak health sector stewardship) and internal (inadequate benefit process, weak IT systems, deficient technical capacity) deficits have precluded the country, specifically PhilHealth from becoming an active strategic purchaser.

The government has also put forward concrete steps contained in the medium-term health sector agenda. One of the strategic pillars specifically refers to health financing with objectives on: 1) increasing resources for health through payroll, paid tax and pooled funds from overlaps in funding streams; 2) expanding benefits fairly using a fair and transparent system of prioritization in the development and expansion of PhilHealth benefits; and 3) improving financial protection and containing costs through regulatory policies and a more prospective payment mechanisms.

Considering the results gathered from the rapid assessment exercise, the following options were identified as potential points for discussion and/or basis for advancing the strategic purchasing agenda forward:

1. **Negotiate for more equitable and high-impact reforms in the UHC Bill.** Continue to guard the legislative process and ensure that the provisions to transform how health services are budgeted, bought and paid for are followed-through as proposed in the bill. The strong legislative support to reform the health care system offers a very favorable occasion to put the reform agenda on the map and warrants its execution once approved.
2. **Gradually transition from a purely contribution based financing to a largely tax-based system.** The positive economic influence and increasing fiscal opportunity afforded by new revenue streams (i.e. taxes generated from consumption of alcohol, tobacco, and sugar-sweetened beverages, as well as lottery and gaming revenues) provides an enabling environment to push government to continue to take accountability for the health of its people. By adopting a mixed financing system that is largely tax-based, the national government will have been given an increasingly larger role in health sector financing and become a dominant force in expanding the pooled share of health spending through taxes.
3. **Build the backbone of a more responsive benefit package with a robust cost data and comprehensive primary care.** Ensure that cost data from providers are systematically collected and utilized for setting tariffs for benefit

packages. PhilHealth should also move away from a disease-by-disease expansion in benefits development towards a focused approach in building a strong primary health care system. Other than the growing domestic pressure for a comprehensive primary care package, providing it is a more pragmatic expression of concern for health equity and right to health.

4. **Establish the benefit development process around accountability mechanisms.** Efficient allocation of resources driven by members' needs using a set of criteria such as cost effectiveness, merit, risk-protection, cultural nuances and burden of disease is important. But effective reforms are contingent on negotiation rather than technicalities that follows a purely stringent design. The priority setting process for benefits development should be built around existing accountability mechanism that allows for broader stakeholder engagement.
5. **Develop and build capacity for strategic purchasing within the health sector.** As the social health insurance takes on a more bigger role as the national purchaser for health, there is a need to build, strengthen, and deepen the skills and expertise relevant to strategic purchasing. Growing the pool of experts with specialized skills in health economics, actuarial science, health technology assessment among others will provide the needed strategic underpinning for the reforms.
6. **Engaged private sector participation in the overall reform process.** Health reforms must be supported adequately by improvements in the supply side. Building public sector capacity and autonomy is necessary but with a dominant private sector player, with appropriate regulation in place, engaging them to commit and work towards the reform agenda by providing a level-playing field for them to participate is crucial in transforming the health system.
7. **Fast track the integration of health-related information systems.** There is a need to urgently speed up initiatives to reorganize the information system across the health sector making it more seamless and interoperable. The dynamic policy environment demands readily accessible and available data and information that the implementors and stakeholders can use in assessing progress and addressing policy issues.

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