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An assessment of provider payment reforms in the Philippines health sector

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Abbreviations

ACR	All Case Rates
ADB	Asian Development Bank
AFP	Armed Forces of the Philippines
AFP-PN	Armed Forces of the Philippines, the Philippines Navy
AFP-PA	Armed Forces of the Philippines, the Philippines Army
AFP-PAF	Armed Forces of the Philippines, the Philippines Air Force
AIDS	Acquired Immune Deficiency Syndrome
ALLMAP	Acute Lymphocytic Leukemia Medicine Access Program
AO	Administrative Order
BCMAP	Breast Cancer Medicine Access Program
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHS	Barangay Health Station
CBR	Crude Birth Rate
CO	Capital Outlay
COA	Commission on Audit
ComPack	Complete Treatment Pack
CPG	Clinical Practical Guidelines
CPI	Consumer Price Index
DBM	Department of Budget and Management
DHS	Demographic and Health Survey
DOH	Department of Health
DPRI	Drug Price Reference Index
DRG	Diagnostic-related Group
DSWD	Department of Social Welfare and Development
EMR	Electronic Medical Reporting
EPI	Expanded Program on Immunizations
FFS	Fee-for-service
FHSIS	Field Health Services Information System
FIES	Family Income and Expenditure Survey
GAA	General Appropriations Act
GCG	Governance Commission for Government-owned and Controlled Corporations
GDP	Gross Domestic Product
GOCC	Government-owned and Controlled Corporation
GSK	GlaxoSmithKline
HFEP	Health Facility Enhancement Program
HFS	Health Financing Strategy
HMO	Health Maintenance Organization
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IAP	Insulin Access Program
ICD	International Classification of Diseases
IEC	Information, Education, and Communication
ILHZ	Interlocal Health Zone
IRA	Internal Revenue Allotment
KDI	Korean Development Institute
KP-UHC	*Kalusugan Pangkalahatan* Universal Health Care
LGU	Local Government Unit
MAP	Medical Assistance Program
MCH	Maternal and Child Health
MCP	Maternity Care Package

MDG	Millennium Development Goal
MFO	Major Final Output
MOOE	Maintenance and Other Operating Expenditures
NBB	No Balance Billing
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHA-SHA	National Health Accounts-System of Health Accounts
NHTS	National Household Targeting System for Poverty Reduction
NSD	Normal Spontaneous Delivery
OFW	Overseas Filipino Worker
OOP	Out-of-pocket
OPB	Outpatient Benefit Package
PCB	Primary Care Benefit
PCSO	Philippines Charity Sweepstakes Organization
PHIC or PhilHealth	Philippines Health Insurance Corporation
PhilPEN	Philippine Package of Essential Non-Communicable Disease Interventions
PIDS	Philippine Institute for Development Studies
PIPH	Province-wide Investment Plan for Health
PNDF	Philippines National Drug Formulary
PNHA	Philippines National Health Accounts
PNP	Philippines National Police
PS	Personnel Service
PSA	Philippines Statistical Authority
RDMAP	Rare Disease Medicine Access Program
RHU	Rural Health Unit
RVU	Relative Value Unit
SHA	System of Health Accounts
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB-DOTS	Tuberculosis-Directly Observed Treatment Short-course
UHC	Universal Health Care
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

Overview

The Philippines Health Financing Strategy (HFS) 2010–2020 aims to ensure financial protection by reducing out-of-pocket (OOP) health spending by Filipino households. As the HFS approached the midpoint of its implementation, the Department of Health (DOH) initiated a process to review progress on the strategy and, as part of this process, asked the World Bank to undertake an assessment of the health financing reforms. The World Bank's assessment is published in two reports: the first report focused on the pillar of the HFS associated with the risk-pooling function and the expansion of health insurance through PhilHealth (Bredenkamp, Bales, and Gomez 2017), while this second report focuses on the pillars associated with provider payment reforms.

This report reviews the current provider payment arrangements and policies of the Philippines, and the extent to which they have contributed to the achievement of the HFS goals. It focuses on the pillars of the HFS that center on provider payment issues, including what is paid for and by whom (pillar 3) and how it is paid for (pillar 4). Because the HFS envisages that pooled sources of health funding, such as payments by the Philippines Health Insurance Corporation (PHIC or PhilHealth) and the government budget, should progressively replace OOP spending as the source of financing for health care, the extent to which this shift has occurred is a recurring theme. In addition, the assessment looks at how the purchasing arrangements improve allocative and technical efficiency, equity, and quality. It takes a sectoral approach to purchasing, looking not only at the purchasing arrangements of PhilHealth, but also purchasing of health services by the DOH and local government units (LGUs). The assessment concludes with concrete recommendations for the next five years and beyond.

Current purchasing arrangements

Who are the purchasers?

The Filipino people are the most important purchasers of health care through the money that they spend out-of-pocket on health care. Indeed, in 2016, OOP spending accounted for 54 percent of total health spending. This heavy reliance on household OOP spending threatens financial protection goals and is estimated to push 1.5 million Filipinos into poverty each year. There are also multiple pooled purchasers and their share of health spending has shifted quite substantially over time. PhilHealth is the most important of these, with its share of health spending rising from 9.4 percent to 17.4 percent of the total between 2011 and 2016. During the same period, the DOH and LGUs have maintained their shares, each at around 7–8 percent of the total. The share of external assistance has risen slightly to 2.2 percent of the total. The share contributed by other national agencies, private insurance, and health maintenance organizations (HMOs) has fallen.

What is purchased?

PhilHealth is constantly developing new benefit packages, most of which are for curative care. The PhilHealth inpatient benefit package covers nearly all inpatient services that are available, at both public and private facilities, and accounts for the bulk of PhilHealth payments. PhilHealth also pays for select ambulatory care services, a comprehensive set of maternity and newborn care services, a primary care benefit (PCB) package (although, unlike most other PhilHealth benefits, this is only for indigent and sponsored PhilHealth members and only available at government primary care facilities), outpatient services for diseases considered to be public health priorities, and packages for medical conditions considered to be economically and medically catastrophic. PhilHealth tries to reduce inappropriate or low-value care by imposing requirements that limit (reimbursable) services to providers who have the technical capacity to deliver them (through a process of facility accreditation) and to patient groups for whom the services are most effective.

The DOH funds curative care indirectly through transfers to PhilHealth (36 percent of the DOH budget) and to the medical assistance funds of hospitals (1 percent). It also spends directly on curative care (15 percent), preventive care, and public health (9 percent), in addition to spending on other health system functions like enforcing regulations, training, and investing in physical facilities (22 percent). Spending on curative care is primarily through the purchasing of service inputs (rather than through the direct provision of health services), for example, through centralized drug procurement and distribution, blood services, and also supply-side subsidies to DOH-retained (i.e. non-decentralized) hospitals to cover labor and some operating costs. For preventive care, most DOH spending goes to the expanded program on immunizations (EPI) and infectious disease control, with additional amounts for the family health program (including maternal and child health [MCH], family planning, nutrition, and other services), public health measures, and noncommunicable disease (NCD) control.

LGU budgets fund both curative (28 percent) and preventive care (45 percent) provided by LGU hospitals, rural health units (RHUs) and their urban equivalent, and barangay health stations (BHSs), mainly to cover the payment of labor and operating costs. In addition, LGU budgets cover various local regulatory functions. LGUs also exercise control over the funds that PhilHealth transfers for LGU-owned facilities (such as LGU-owned hospitals and RHUs). PhilHealth payments are paid into facility-specific trust fund that are managed by the LGU on behalf of LGU health facilities and used to purchase other inputs into curative care.

From whom are services purchased?

Health services are purchased from a wide range of government and private health facilities and professionals. These include licensed hospitals, infirmaries and dispensaries, freestanding hemodialysis centers, birthing homes, and ambulatory surgical facilities, as well as government primary care outpatient facilities (RHUs or the equivalent in urban areas) providing modern or traditional medicine services and BHSs. The extent of purchasing from the private sector is quite substantial: PhilHealth purchases services from more private hospitals than public hospitals. Regardless of whether public or private, PhilHealth only purchases services from facilities that have met PhilHealth's accreditation requirements (which are specific to each benefit package). The accreditation process relies mainly on documentary verification of requirements and signing of performance commitments.

For whom are health services purchased?

All Filipinos using health services in government facilities or obtaining medicines through the DOH's medicines access programs benefit from the DOH and/or LGU subsidies. All Filipinos with health insurance through the PhilHealth, currently equivalent to 91 percent of the population, are covered for services purchased by PhilHealth. Indigents and other vulnerable groups are granted special entitlements beyond those of the average Filipino in that their premium contributions to PhilHealth are 100% subsidized by government, a 'no balance billing' (NBB) policy applies when they seek care, and they are eligible for additional benefit packages (focused on diseases that disproportionately affect these groups) for which other groups are not eligible. The DOH also provides additional support to vulnerable groups through the Medical Assistance Program (MAP), a supplemental safety net scheme to cover additional costs incurred by people using government hospital health services.

How are health services purchased?

Several different provider payment mechanisms are used to purchase services and inputs, each with their own inherent (dis)incentives. For inpatient care and some specialist ambulatory procedures, PhilHealth has switched from the fee-for-service (FFS) payment system to a system known in the Philippines as 'all case rates' (ACR) that pays for bundles of care defined by diagnostic groups. The

ACRs were first introduced in 2011 for 23 case types, then expanded to all case types in 2013. The PhilHealth primary care package is paid by a form of blended capitation including a 'per family payment' and a withhold that is paid once certain components of the care package have been provided. PhilHealth bundles the costs of medicines into the case rates, PCB per family payment, and other packages, rather than paying for it separately. When it comes to DOH and LGUs, they purchase inputs to services through budget appropriations, mainly in the form of line-item budgets for recurrent costs (such as personnel or operating budgets) or for capital expenditure on infrastructure and equipment.

Assessment of progress on Pillar 3 on allocating resources according to the most appropriate financing agent

The HFS identified fragmentation among purchasers as a source of allocative inefficiency and proposed to eliminate uncertainties in purchasing responsibilities by clearly assigning responsibility for various areas of care and categories of expenditure to specific pooled purchasers. The Philippines uses three categories of expenditure (or input type), namely personnel services (PS), maintenance and operating expenditures (MOOE), and capital outlays (CO). By 2020, the vision was that PhilHealth would fully cover all PS and MOOE for curative care and personal preventive services, LGUs would fully cover these costs for public health services (community-level preventive care), and the DOH and LGUs would continue to share responsibility for CO for DOH-retained and LGU-owned facilities, respectively. Consequently, the report assesses whether spending by each pooled purchaser (PhilHealth, DOH, and LGUs) for each service (public health/preventive, curative/personal, outpatient medicines) and category of expenditure or input type (PS, MOOE, and CO) has evolved in line with these directions.

Public health/personal preventive services: According to the HFS, MOOE and PS costs associated with public health would shift to LGUs, while MOOE and PS costs associated with personal preventive services would shift to PhilHealth. The share of LGU funding in public health showed almost no increase between 2011 and 2014 (which is the most recent year for which data are available), while the LGU share of funding for preventive care varied from year to year. Responsibility for the funding of various personal preventive services and public health programs remains shared between the different purchasers because the system lacks a mechanism to allow some of the items currently financed by the DOH and LGUs to shift to PhilHealth responsibility, particularly bulk procurement of vaccines and some types of drugs. In addition, the payment of professional fees by PhilHealth for personal preventive services seems to be supplementing LGU allocations for PS, rather than replacing them as was envisioned by the HFS. At the same time, the fact that some LGU facilities have not yet succeeded in meeting PhilHealth accreditation requirements for primary care packages hinders the transition from LGUs to PhilHealth as financing source for personal preventive services.

Curative care/personal health services: The HFS envisioned a shift between the pooled providers so that the MOOE and PS costs associated with curative care would eventually all be paid by PhilHealth. Indeed, between 2011 and 2016, PhilHealth's share of total health expenditure increased by 8 percentage points. However, the OOP share dropped by only 3.5 percentage points. This suggests that PhilHealth seems to be supplementing, rather than replacing, DOH and LGU budget spending. Moreover, it is only making a limited contribution to the overarching HFS objective of replacing OOP spending with pooled sources of funding. In general, though, fund flow and adequacy of funding are difficult to assess due to the multiple and overlapping sources of payments and also complicated (and often unclear) rules about how different sources of funding can be used. Importantly, the HFS failed to define the roles of non-DOH central agencies and private insurance in the financing of curative care despite their importance as financing sources.

Outpatient drugs: Pharmaceuticals are a large health expenditure item in the Philippines, funded mainly by household OOP spending. The high OOP spending on drugs and materials should be a cause

for concern, not least because individual patients are at an informational disadvantage when it comes to purchasing them. PhilHealth has designed an expanded PCB package (*Tsekap*) which, among other things, expanded the list of medicines provided at RHUs to include select non-communicable diseases, and thus had the potential to shift more pharmaceutical spending from OOP to pooled purchasers. However, and despite the new package's formulation being in line with the HFS vision of shifting MOOE for personal preventive care to PhilHealth, its implementation was halted. The remaining pooled financing for outpatient drugs is through the DOH's complete treatment pack (ComPack) program, but it fails to integrate the drug dispensing with comprehensive disease management services (like the expanded PCB package would have).

CO: The DOH appropriations for CO tripled between 2011 and 2016, mainly due to the expansion of the Health Facility Enhancement Program (HFEP) of the DOH, which was initiated as part of the Philippines Universal Health Care (UHC) strategy to improve access to quality government health facilities through upgrading physical infrastructure and equipment, especially of LGU-owned facilities. In conflict with the HFS vision that the CO of LGU-owned facilities should be borne by LGUs, the DOH's HFEP budget increased rapidly starting in 2011. Moreover, the local infrastructure projects that were financed by the HFEP financed were implemented centrally (by the DOH working with its regional offices). This decision was justified by the experience that centralized implementation was faster than LGU implementation and that economies of scale could be achieved through centralized procurement. That said, the actual facilities to be financed by HFEP were proposed by LGUs who also made a commitment to provide co-financing. Despite the considerable spending on CO by DOH, though, a number of LGU facilities are still not accredited to provide PhilHealth packages, while other LGUs have been unable to allocate adequate budget for complementary inputs or sustainable financing to maintain and operate accredited facilities.

Cross-cutting issues

The resource shifts between the various pooled purchasers that were envisioned in the HFS involve important tradeoffs whose implications may not have been fully appreciated at the time that the HFS was drafted. However, with the rapid increase in coverage of PhilHealth between 2011 and 2016, and thus the volume of funds flowing through PhilHealth, the HFS vision is feasible. It is true that, as funds shift to PhilHealth, the DOH and LGUs will lose substantial financial leverage and there is also a risk that the low-price advantage of centralized procurement might be diminished. At the same time, if these shifts are fully accomplished they will likely lead to improvements in the responsiveness of facilities because PhilHealth pays in a way that motivates improvements in performance. Finally, because the shift from supply-side to demand-side payments will result in an inevitable redistribution of resources across facilities and localities, close supervision will be needed to ensure that facilities that receive less do not attempt to compensate for lost income by charging patients more (through balance billing or excess charges).

Have the goals been achieved?

Despite some movement toward the HFS vision, progress has been less than was anticipated when the HFS was drafted. The expected improvement in allocative efficiency that would come from reducing duplication and overlap in "who pays for what" has not been achieved. The vision of shifting MOOE and PS budget responsibility from the DOH and LGUs to PhilHealth has not been effectively implemented. The DOH also continues to play a strong role in capital investment and procurement of materials and drugs, rather than supporting the devolution of financing to LGUs. While the HFS implied—and is correct—that choosing the appropriate purchaser would improve allocative efficiency, additional strategic direction beyond that provided in the HFS is needed to define more clearly the package of services to be paid by the government (DOH and LGUs) and by PhilHealth.

Assessment of progress on pillar 4 on shifting to new provider payment mechanisms

Pillar 4 of the HFS focuses on the provider payment mechanisms used by PhilHealth and how these payment mechanisms can better incentivize provider behavior and, in so doing, improve technical efficiency (achieving more with existing resources) and reduce OOP spending. The emphasis in the HFS is on shifting away from FFS payments toward a case mix system for inpatient and specialist care and capitation payments for primary outpatient care that also include outpatient drugs. This report assesses the extent to which these two new payment mechanisms have been implemented and, also, how well they are functioning to reduce OOP payments, improving efficiency, and enhance quality.

Case rate payments

The underlying theory of case rates is that when a hard budget constraint is imposed on the provider/facility for a given case type, the provider/facility will have an incentive to ensure that average costs per case fall below the case rate. However, the effectiveness of the Philippines' case rates in achieving technical efficiency – and also financial protection – was seriously undermined by allowing facilities to set their own service charges (just as they did with FFS) and then bill whatever share of the service charge is not covered by the PhilHealth case rate payment to the patient. Because providers have the "safety valve" of billing any charges not covered by PhilHealth to patients, they face almost no financial risk and have very little incentive to provide care more efficiently. By contrast, when it comes to poor patients, the ACRs function more like what theory would predict: because PhilHealth's NBB policy prohibits balance billing of poor patients, providers face a hard budget ceiling when it comes to the care of these patients. Unfortunately, this potential is undermined by the fact that, in practice, the NBB policy has been poorly enforced. In sum, the fundamental shortcoming in the way that the case rate payment mechanism has been implemented in the Philippines is that it functions exactly the same way, and creates the same incentives, as the FFS mechanism, with the PhilHealth ACR payment serving merely as a discount off the hospital's service charge.

There are additional challenges related to information systems, lack of clear treatment guidelines, and poor stakeholder understanding of case rate payments. First, even though the combination of ACRs and balance billing creates basically the same incentives for over-servicing as FFS did, when ACRs were implemented PhilHealth stopped collecting the detailed resource utilization data (e.g. on service and drugs) which had been used under FFS to detect over-servicing or inappropriate treatment, and potentially deny claims. This is unfortunate because it eliminated important information that could have been used to hold providers accountable for the appropriateness of care provided under ACR, and also could have served as the basis for updating the rate at which cases are paid (and convincing providers of the fairness of those rates). Second, most case rates, including many of those with the most frequent claims, lack accompanying evidence-based treatment guidelines. Without these guidelines, PhilHealth case rates cannot reach their potential as a mechanism for improving and standardizing quality of care, promoting evidence-based medicine, and controlling pharmaceutical use and spending. Third, it seems that the PhilHealth case rate policy is still largely misunderstood by a number of key stakeholders. Not least among these are the national audit authorities with the consequence that there are often unnecessary audit queries into PhilHealth payments that potentially could have been avoided if case rates were well understood.

Capitation payments

The blended capitation payment for primary care, consisting of a fixed payment per family enrolled and additional payments for performance, is theoretically well grounded. It provides an important

complement to the LGU health budgets, ensuring a basic income to the facility based on enrollments while also incentivizing the provision of key elements of the essential package of primary care services.

Despite the careful design, the PCB package has several shortcomings. First, and most importantly, the PCB package is currently only available to the poor population. New legislation looks set to change this, though, and would certainly be a move in the right direction. Second, private providers are not permitted to be accredited to provide the PCB package. This limits patient choice when it comes to finding a trusted primary care facility and inhibits the development of an effective gatekeeper system to more effectively ration hospital care. Third, the number of services included in the PCB package is fairly narrow, thus limiting the potential impact that it could have on population health and health system efficiency. The expanded PCB (or *Tsekap*) package included more services (including for management of non-communicable disease), but was not eventually implemented. Fourth, the well-designed provider incentives in the capitation payment are diluted by the cumbersome arrangement whereby, instead of paying facilities directly, PhilHealth transfers the capitation payment into an LGU trust fund which then only disburses funds to facilities based on purchase orders for consumables. That said, LGUs tend to pass the professional fee portion of the capitation payment almost directly to health workers, thus maintaining a good share of the intended incentive effect. Finally, an effective means of incorporating outpatient drugs into the PCB package is yet to be found. The proposed *Tsekap* package had included an expanded outpatient drug package that would include drugs dispensed by pharmacies that are independent from prescribers, but would have likely been hampered by logistical difficulties. On the other hand, it is not clear that the alternative of continuing to supply primary care drugs through vertical programs is a better solution. No matter what arrangements for drug purchasing and provision are used, though, unless patients and medical personnel can be convinced of the quality of generic drugs, most solutions for cost-effective outpatient drug packages will fail to achieve objectives.

Cross-cutting issues

Successful implementation of provider payment reforms will also require appropriate supporting reforms in related areas of health policy. These include policies related to ensuring quality of care, balancing increased provider autonomy with appropriate oversight mechanisms, addressing the incentives create by the persistence of state subsidies, and ensuring service prices that are fair to both patients and providers. When it comes to quality of care, there are both gaps and duplication in responsibility for health care quality that arise due to fragmented responsibility across the DOH, PhilHealth, and LGUs. In addition, the periodic licensing (by DOH) and accreditation (by PhilHealth) may not be sufficient to ensure that the actual daily provision of care follows guidelines and quality standards for every patient and for every episode of care. Second, the limited operational and financial autonomy of government facilities inhibits them from fully responding to the incentives inherent in these different payment modalities. Policies to enhance provider autonomy, as envisaged in the HFS, could be pursued, but increased autonomy should be accompanied by changes in oversight mechanisms. In addition, the continued reliance of hospitals on state subsidies is a challenge when it comes to attaining the goals envisaged in the HFS because it reduces the financial pressure to improve efficiency and cost control that case rates are intended to exert on facilities. Finally, reasonable and fair prices are needed throughout the system—both for patients who continue to pay a large share of health costs out of pocket and also for providers who need to procure inputs (including labor) at a fair price to deliver services within their budgets. Right now, charges for medical services vary across facilities for treatment of the same disease or for implementation of the same procedure in ways that do not necessarily reflect differences in underlying cost. Regardless of the payment mechanism used, oversight of PhilHealth purchasing and provider behavior is extremely important.

Have the HFS goals been achieved?

When it comes to case rates, the cost containment goal is unlikely to have been met because case rates have not been implemented in a way that imposes a hard budget constraint on facilities. The goal of promoting fairer risk sharing among contributors, financing agents, and providers has also not been achieved because facilities can still charge whatever they want (by billing either to PhilHealth or to the patients). PhilHealth faces a predictable risk (because it is only liable for the ACR amount) and providers bear little to no risk (because they can charge to patients what PhilHealth does not pay), but the patients face substantial risk (through potentially large balance billing). Nevertheless, some goals were achieved. These include an initial reduction in turnaround time for PhilHealth payments, shifting care from inpatient to ambulatory care facilities for some specialized services, and improving the standardization of care and cost control for select PhilHealth packages (such as the Z-benefits).

With respect to capitation payments, the cost containment and productive efficiency goals are unlikely to have been achieved given their current design and implementation. On the other hand, improvements in allocative efficiency are likely to have occurred due to the expansion of health insurance coverage among poor PhilHealth members who would then be eligible to use the PCB package to prevent and manage disease and, thus, avoid acute episodes which could require higher levels of care. It is reasonable to expect that there might also have been an associated reduction in OOP payments among poor members as a result of the utilization of the PCB package and its associated drug benefits.

Recommendations

Pillar 3: Allocating resources to the most appropriate financing agent

The main challenges faced in the implementation of HFS pillar 3 are a lack of a clear division of responsibility for funding across the main financing agents, inefficient purchasing arrangements, and excessive OOP spending. Overcoming these challenges will require a political solution. Political agreement needs to be reached, first, on which items patients should be responsible to pay for out of pocket and which items should be paid by pooled purchasers. Then, political agreement will be needed to clarify what each of the pooled purchasers—the DOH, LGUs, and PhilHealth—should be responsible for. We recommend that the direction envisioned by the HFS, namely to continue to shift recurrent costs from government budget subsidy to PhilHealth payment for services (which will imply maintaining the inpatient benefits while expanding the various PhilHealth outpatient benefits package services to ensure greater financial protection and more value for money through strategic purchasing) is a sound one. Current policies should be adjusted in line with that vision. It would also be important to ensure that PhilHealth payments actually do replace, rather than supplement (as is currently sometimes the case), payments by other financing agents, thus avoiding (current) duplicate payments and inefficiencies.

Pillar 4: Shifting to new provider payment mechanisms

The main challenges faced in the implementation of HFS pillar 4 include the persistence of FFS incentives and balance billing (despite the shift to ACRs), lack of financial or other incentives for patients to seek care at the appropriate levels of the system, controversies about how to implement an outpatient drug benefit, insufficient reliance on evidence-based treatment guidelines, lack of facility autonomy in operations or finance, and inadequate oversight mechanisms to ensure quality and performance of health providers. The general direction in which the DOH and PhilHealth would need to move to resolve these challenges includes several measures. First, revise the ACR payment mechanism so that it constitutes a hard budget ceiling for providers and eliminates uncontrolled balance billing. This will need to be done through a consultative process between PhilHealth, DOH,

and providers. Second, and to complement the first measure, formulate a fixed co-payment policy not only to help create the hard budget ceiling, but also to strengthen financial protection of patients. The co-payment policy could also differentiate between levels of care to help incentivize the use of primary care facilities as gatekeepers and encourage appropriate upward and downward referral. Third, ensure that any new proposed outpatient drug benefit can be feasibly implemented and also try to create better incentives to encourage the use of generic drugs. Fourth, clarify who should be responsible for ensuring quality of care and develop quality assurance mechanisms that go well beyond basic licensing and accreditation. Fifth, develop a clear vision and road map for facility autonomy to enable providers to better respond to the incentives inherent in the provider payment reforms. Sixth, strengthen monitoring and oversight of quality and costs, both for packages reimbursed by case rates and for primary care services paid through blended capitation payments and to ensure that any increases in facility autonomy lead to the intended objectives rather than adverse outcomes. Specific measures that will help to realize these directions are discussed in the recommendations of the main report.

1. Introduction

Between 2011 and 2016, the health policy direction in the Philippines was defined by the *Kalusugan Pangkalahatan* Universal Health Care (KP-UHC) Strategy 2011–2016 of the Department of Health (DOH). The KP-UHC Strategy consists of three main 'thrusts', namely (a) financial risk protection through expansion of the National Health Insurance Program enrollment and benefit delivery; (b) improved access to quality hospitals and health care facilities; and (c) attainment of health-related Millennium Development Goals (MDGs), together with control of emerging diseases and noncommunicable diseases (NCDs).

The KP-UHC Strategy was accompanied by a Health Financing Strategy (HFS) 2010–2020 whose overarching objective was to ensure financial protection from out-of-pocket (OOP) health spending for all Filipinos. The HFS is built on five strategic pillars with important interdependencies. These pillars are creating more fiscal space for health (pillar 1); sustaining membership in the Philippines Health Insurance Corporation (PHIC or PhilHealth) pooling (pillar 2); who pays for what (pillar 3); provider payments (pillar 4); and fiscal autonomy of health facilities (pillar 5). The HFS is carefully justified and aligned with the overall sector goals of enhancing financial protection, as well as achieving efficiency gains, and ensuring access to quality care. It also contains a set of indicators for tracking progress, with policy targets for 2016 and 2020.

As the HFS approached the midterm of its implementation, the DOH engaged in a process of reviewing progress on the strategy to inform its strategic direction for the subsequent period. Indeed, during the first five years of implementation of the HFS, a number of rapid policy changes occurred, some of which were in line with the directions of the HFS—and others not. Consequently, decisions needed to be made as to whether the HFS still reflected the vision for the financing of the health sector and, if so, which additional policy changes were needed to achieve that vision. If, on the other hand, the vision was considered outdated, then a new set of strategic directions and an accompanying policy road map would be needed.

To inform this process, the DOH asked the World Bank to undertake an assessment of recent health financing reforms as an input into discussions on the future health financing directions. A joint DOH-PhilHealth technical working group, chaired by the Undersecretary for Policy and Finance in the DOH, led the process of review, consultation, and updating of the new health financing directions. Development partners (including the World Bank, World Health Organization [WHO], United Nations Children's Fund [UNICEF], and Asian Development Bank [ADB]) participated in this process. The World Bank's assessment is published in two reports: the first one focuses on the pillar(s) of the HFS associated with the risk-pooling function and the expansion of health insurance through PhilHealth (Bredenkamp, Bales, and Gomez 2017), and this one focuses on the pillars associated with provider payment arrangements.

This report reviews the Philippines provider payment policies and the extent to which they have contributed to the achievement of the HFS goals. It focuses on the pillars of the HFS that center on provider payment issues, including what is paid for and by whom (pillar 3) and how it is paid for (pillar 4). Because the HFS envisages that pooled sources of health funding, such as PhilHealth or the government budget, should replace OOP spending as the source of spending on health care, the extent to which the measures that have been taken contributed toward this overall objective will be a recurring theme. In addition, the assessment will look at how the purchasing arrangements improved allocative and technical efficiency, equity, and quality. Importantly, it takes a sectoral approach to purchasing, looking not only at the purchasing arrangements of PhilHealth, but also purchasing of health services by the DOH and local government units (LGUs). The assessment concludes with concrete recommendations for the next five years and beyond.

2. Purchasing arrangements

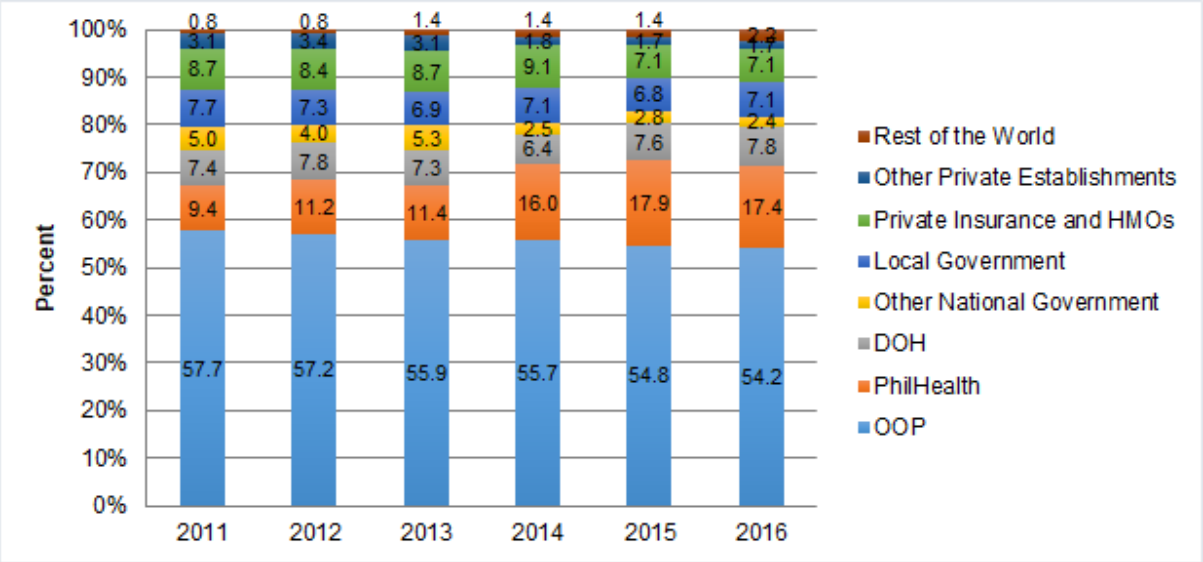
Our analysis of the purchasing arrangements in the Philippines is based on the answers to five questions: 'what is purchased, from whom, how, for whom, and by whom'. Analyses of purchasing arrangements are usually framed around the questions of 'what is purchased', 'from whom is it purchased', and 'how is it purchased' (Figueras, Robinson, and Jakubowski 2005). In addition, and to provide insights into how provider payments contribute to the Philippines Universal Health Care (UHC) goals of providing equitable access to services and financial protection, the question of 'for whom' medical services are purchased was added to the analysis. Finally, because we also assessed which is the most appropriate financing agent to pay for different services and factors of production (because this is the key question in pillar 3 of the HFS), we also added the question of 'by whom' services are purchased. The assessment placed a special emphasis on examining the incentives inherent in provider payment design and implementation, their effect on the behaviors of health system actors, and, consequently, their impact on the attainment of health financing goals.

2.1 Who are the purchasers?

People, through the OOP payments that they make for health care, are the most important purchasers in the health system. In 2016, according to the Philippines National Health Accounts (PNHA), OOP spending by patients and their families accounted for more than half (54 percent) of all health spending in the Philippines (Figure 1). This heavy reliance on OOP payments is of particular concern when it comes to lower-income groups who are most likely to be adversely affected, and even impoverished, by OOP spending. Survey data show that every year, 1.5 million Filipinos are pushed into poverty as a result of OOP spending on health (Bredenkamp and Buisman 2016). This means that successfully achieving the HFS objective of shifting from OOP spending to pooled financing is an important part of an overall poverty reduction strategy for the Philippines.

The HFS envisages a shift away from the current reliance on OOP spending toward pooled purchasing [1] through government subsidies or insurance. Pooled funding in the Philippines is substantial. PhilHealth spent over PHP 102 billion in benefit payments in 2016 (PhilHealth 2017b). The DOH received a total appropriation of PHP 123 billion in 2016, of which a substantial share (PHP 43.8 billion) was transferred directly to PhilHealth. Total LGU and DOH health spending fluctuates slightly over time but remain of similar magnitude, emphasizing the extent to which health financing in the Philippines is devolved. Most importantly, and often overlooked, is the relatively large health spending at the central level by agencies other than the DOH and PhilHealth. In 2013, non-DOH central agencies[2] spent an amount equivalent to about 73 percent of the DOH spending; however, this share has declined to a still sizeable 30 percent in 2016 (Racelis et al. 2016). Data from the PNHA from 2011 to 2016 illustrates a clear shift toward pooled funding by PhilHealth, as the share of total health spending from OOP and other pooled sources (other national government spending and private insurance) declined (Figure 1).

Figure 1. Share of PhilHealth and other financing agents in total health expenditure, 2011 to 2016



Source: PNHA, Philippines Statistical Authority (PSA). https://psa.gov.ph/pnha-press-release/data (January 21, 2018).

Note: HMO = Health maintenance organization; Other social security agency funds are included with PhilHealth, but account for 0.03 percent of the total in that category. International loans and counterpart funding in 2011–2013 are included as part of the DOH, and in 2014–2016, they are not separately reported.

2.2 What is purchased?

Health services that are purchased include personal health interventions—both curative and preventive—as well as public health interventions. It is not easy to obtain a comprehensive picture of which services are purchased in the Philippines, by whom, and how. To do so, one needs to collate a large number of circulars and administrative orders (AOs), as well as their subsequent amendments, many of which are specific to particular services and interventions. In the National Health Accounts (NHA) data, on which we rely for our analysis, personal services include only pure private health goods and services, which are mainly curative in nature. Public health includes both pure public goods and services, as well as goods and services with externalities (for example, information, education, and communication [IEC]; safety and standards regulation; immunizations; and vector control). Curative care focuses on treating disease, whether curing it completely or diminishing its severity, while preventive services focus on avoiding disease, preventing disease progression, and promoting health. These broad categories of services and interventions are paid for through a combination of government budget, health insurance funds, and patient OOP payments.

Various regulations define and constrain what different pooled purchasers can purchase. The 1995 Health Insurance Act stipulates that PhilHealth can pay for health services used by members/beneficiaries or purchase health services within the benefit package (including inpatient and outpatient care, diagnostic tests, preventive medicine, and drugs) on their behalf. However, the Act prohibits PhilHealth from directly providing services to patients or procuring inputs for the purpose of directly rendering care, which means that PhilHealth may not run its own health facilities.

The 2013 Health Insurance Act states that PhilHealth must aim to provide its members with 'responsive benefit packages' and should continuously strive to improve the benefit package to meet the needs of its members. According to Section 37 of the Act, members and dependents are entitled to inpatient care, outpatient care, emergency and transfer services, health education, and other services considered appropriate and cost-effective. The package should be reviewed annually to assess its financial sustainability, relevance to health innovations, mechanisms for quality

assurance, need for increases in the benefits, and its impact on reducing OOP payments. The annual review should include actuarial studies. The Act also stipulates that a no balance billing (NBB) policy (discussed in section 2.5) should be applied when indigent members, or other member groups to be defined by PhilHealth, use government health care facilities. It also states that facilities should provide all necessary services and quality of care to attain the best health outcomes.

The PhilHealth inpatient benefit package, which covers almost all types of inpatient services with only a few exceptions, accounts for the bulk of PhilHealth payments. The inpatient benefit package covered by PhilHealth essentially consists of all the services that licensed hospitals, infirmaries, and dispensaries[3] can provide. In 2016, inpatient payments to hospitals amounted to 71.6 percent of PhilHealth benefit payments, increasing to 86 percent if inpatient services provided at infirmaries/dispensaries (which also often have inpatient beds) are added. PhilHealth claims payment records indicate that, in 2016, only 14 case types accounted for 55 percent of all claims and 37 percent of the value of all claims (see Annex, Table A.1), the majority of which consisted of inpatient care services.

PhilHealth's benefit package also includes certain ambulatory care packages accounting for about 5 percent of all claims in 2016. These are less complex services with low relative value units (RVUs),[4] which can be safely provided on an outpatient basis. Ambulatory care services covered by PhilHealth include day surgery, radiotherapy, hemodialysis at freestanding clinics, outpatient blood transfusion, and voluntary surgical contraception. While PhilHealth allows these services to be reimbursed when provided on an outpatient basis, they may still be provided on an inpatient basis.

In addition, there is a special PhilHealth 'Z-benefit package' that covers a variety of conditions that are considered economically and medically catastrophic. The Z-benefit package has been in place since 2013 to cover illnesses that are life- or limb-threatening and require prolonged hospitalization,[5] as well as extremely expensive therapies or care that could substantially deplete household financial resources. The decision whether to include a specific condition into the Z-benefit package considers whether medical intervention is likely to give the patient a good chance at survival and significantly improve health outcomes. This criterion explains, for example, why the Z-benefit package includes breast cancer treatment, but only up to and including Stage IIIA. The emphasis in the Z-benefit package on providing financial protection can be seen in the fact that there is a detailed list of service components defined for each condition and that a policy of NBB applies to indigents and sponsored groups, along with a policy of fixed or negotiated co-payments for other member categories.

The PhilHealth benefit package also includes a comprehensive set of maternity care and newborn care packages. The maternity care package (MCP) includes antenatal, delivery, and post-partum care at both hospital and nonhospital facilities. Members can use these benefits at licensed hospitals, infirmaries, and dispensaries, or at PhilHealth-accredited birthing homes or maternity clinics. In addition, the general inpatient care package of PhilHealth covers caesarean section (C-section) and other interventions for complicated deliveries in hospitals (see Table A.2). Overall in 2015, PhilHealth claims paid for about 44 percent of all deliveries in the country, or 73 percent of all institutional deliveries.[6] Maternity care services account for a large share of PhilHealth benefit payments. **Error! Reference source not found.** shows that of the total number of PhilHealth claims in 2016, 12.3 percent were for normal uncomplicated delivery, complicated delivery with episiotomy, or C-section. A total of 8.3 percent of all claims was for the normal newborn care package, accounting for about 30 percent of all births. PhilHealth payments for maternal (11.5 percent) and basic newborn care (1.3 percent) amounted to more than 12.8 percent of the total value of claims.

A PhilHealth primary care benefit (PCB) package, provided to indigent and sponsored patients only, covers common conditions for which people often seek outpatient care at government facilities, as well as a limited set of drugs. The PhilHealth PCB package that is currently being implemented, namely

PCB1, includes a range of essential outpatient services such as screening for NCDs and diagnosis and treatment for common infectious disease conditions, including dispensing of some basic drugs (Table A.3). PCB replaced the Outpatient Benefit Package (OPB), which did not include any consultations, diagnostics for NCDs, or any medicines. In 2013, the PCB added risk profiling for hypertension and diabetes, adopting the protocol from the Philippine Package of Essential NCD Interventions. In 2015, a new primary care package, *Tsekap*, came into being, expanding the primary care package to include a broader range of NCD diagnostic services, medicines, and dental care.[7] However, its implementation was deferred for reasons that have never been clearly articulated. The *Tsekap* circular, however, remains in place.

In addition to the PCB package, there are a number of other PhilHealth outpatient benefits for diseases that constitute a threat to public health and/or were priorities under the MDGs. PhilHealth offers outpatient benefits that cover treatment for tuberculosis (TB) (Tuberculosis-directly observed treatment short-course [TB-DOTS]) (since 2003), malaria (since 2008), human immunodeficiency virus /acquired immune deficiency syndrome (HIV/AIDS) (since 2010), and animal bites (since 2012). Tropical infectious diseases like dengue, leptospirosis, leprosy, and filariasis are covered by the PhilHealth inpatient care benefits.

Within each package, PhilHealth limits the types of services that it reimburses, for reasons of patient safety or cost-effectiveness. In the package of services for women about to give birth, for example, at nonhospital facilities, only low-risk vaginal deliveries are covered. The intention is to ensure that nonhospital facilities do not retain patients who need to be referred to higher-level facilities for care. Similarly, in the TB-DOTS package, only TB cases susceptible to first-line anti-TB drugs are covered. In the Z-benefit package, as previously mentioned, the clinical criteria or stage of disease used to determine if a case will be covered by PhilHealth is quite restrictive because the packages are intended to provide services to the groups most likely to fully recover as a result of the treatment package. Patients not meeting these criteria can still receive some of their inpatient care reimbursed by PhilHealth but, unlike in cases included in the Z-benefit package, will likely face substantial excess payments over and above what is reimbursed.

PhilHealth's requirement that members have a minimum contribution record before they can claim benefits is one limit on the conditions under which PhilHealth will purchase services for its members, but the requirement of a contribution history varies by member and service type. For most packages, contributing members (such as those in the formal or informal sector) are required to have made three months' contributions within the previous six months to be able to claim benefits. This policy is intended to address the risk of adverse selection. For Z-benefits, however, these members are required to agree to a three-year membership 'lock-in' to claim benefits. On the other hand, subsidized members who do not pay premiums (such as the poor and the elderly) are immediately eligible to claim benefits. A special policy was developed to ensure that all women who are about to give birth would benefit from PhilHealth coverage (PhilHealth Circular 22-2014). This involves explaining to women during their maternity care visit that the price of the annual PhilHealth premium is much lower than what is reimbursed through the maternity care or normal spontaneous delivery (NSD) case rates and giving them the opportunity to enroll in PhilHealth at their maternity care facility.

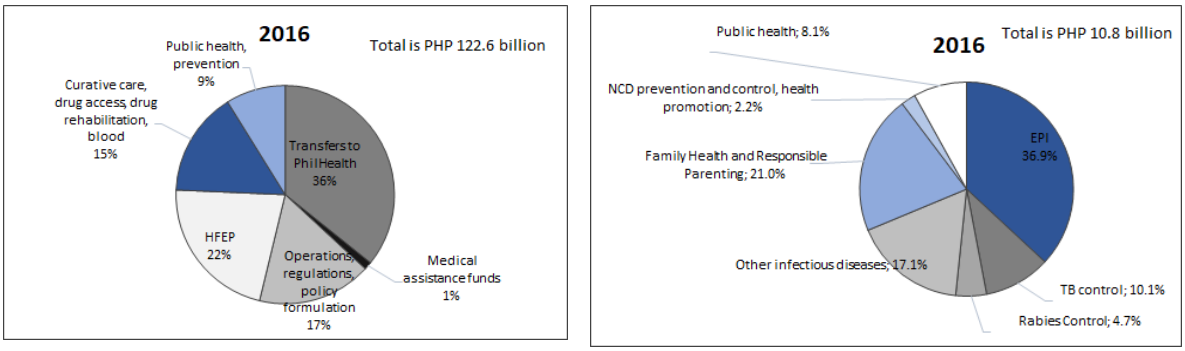
Government purchases of major final outputs (MFOs), as defined in the annual General Appropriations Act (GAA), are the basis for central budget appropriations to the DOH. The first MFO is health sector policy services, consisting primarily of policy formulation but including some purchasing of drugs and medical and dental supplies to make affordable quality drugs available to the population. The second MFO is technical support services and includes financial support to preventive medicine programs, transfers to PhilHealth for indigents and senior citizens, the Health Facility Enhancement Program (HFEP), local health systems development and assistance, and other support

for inputs to health services. The third MFO is hospital services, consisting primarily of subsidies for payroll and operating expenditures of DOH-retained hospitals, blood services, and a few other central facilities. The fourth MFO is health sector regulation services, including the food and drug administration, regulation of medical devices, quarantine, and support for regional health regulations. In addition to appropriations specific to the MFOs, budget is also appropriated for general operations of the central DOH and regional DOH offices and for the medical assistance program (MAP), which is a program of the DOH, intended to provide financial assistance to patients seeking health care or confinement in government hospitals.[8]

While much of the national government purchases of health services are indirect, by subsidizing PhilHealth coverage, infrastructure investment, or regulations, the national government also directly provides health services and medicines through the DOH general appropriations. While the bulk of the DOH appropriations were for transfers to PhilHealth (36 percent); the MAP (1 percent); operations, regulations, and policy formulation (17 percent); and investment in health facility renovation and construction through the HEFP (22 percent), around 9 percent was used to subsidize public health and preventive medicine services and a further 15 percent was used to subsidize curative care services and ensure access to drugs through medicines access programs (Figure 2, left panel**Error! Reference source not found.**). The largest preventive medicine and public health service items subsidized by the DOH are the expanded program on immunizations (EPI) (37 percent of DOH preventive spending) and infectious disease control measures (31.8 percent), followed by family health and responsible parenting (21 percent), public health measures (8.1 percent), and NCD control (2.2 percent) (Figure 2, right panel). Curative care consists primarily of DOH subsidies to DOH-retained hospitals (92 percent of DOH curative care spending) but also includes the provision of drug rehabilitation services and blood services and procurement and distribution of drugs through medicines access programs. In contrast to PhilHealth, which purchases services or medicines from providers on behalf of members, the DOH subsidies are generally used to pay for inputs rather than to purchase services from providers.

Figure 2. Structure of DOH general appropriations, 2016

General appropriations **Public health and preventive care appropriations**



Source: GAA 2016.
Note: GAA line items categorized as 'public health' in the figure consist of epidemiology and disease surveillance, quarantine, emergency management, and environmental and occupational health. The figure on the right breaks down the preventive medicine allocation into its components.

The provision of health services to serve the population within the jurisdiction of various LGUs is also subsidized by the LGU budget. The devolution of public financing for health has shifted control of a large part of government health budget away from central agencies toward LGUs. There are 1,634 LGUs, which may be cities or municipalities. Following a process of devolution in 1991, these LGUs have a considerable degree of autonomy in the financing and delivery of health care. This includes personal health care services and public health services provided by LGU hospitals, rural health units

(RHUs), urban health centers, and barangay health stations (BHSs). According to National Health Accounts-System of Health Accounts (NHA-SHA) data from 2014, 45 percent of LGU health budgets were used to provide preventive care, while 28 percent were used for curative care services, and the remainder went to governance and administration (PSA 2017). While it is not completely clear from the presentation of data in the NHA-SHA, it is likely that preventive care services include the RHU and BHS budgets, even though these facilities also provide curative care services. The LGU financial and audit reports conducted by the Commission on Audit (COA) and the DOF's Bureau of Local Government finance reports provide inadequate details for analysis of other aspects of LGU health financing, including the use of the LGU trust fund into which PhilHealth payments are made.

2.3 From whom are health services purchased?

Health services are purchased from a wide range of government health facilities that provide different types of services. The DOH currently operates 70 hospitals, including four Government-owned and Controlled Corporation (GOCC) hospitals,[9] 12 DOH hospitals, and 54 regional hospitals.[10] PhilHealth's list of accredited hospitals as of December 2016 included a total of 421 government facilities including hospitals run by the DOH, other central agencies, state universities, and LGUs (PhilHealth 2016b). By the end of 2016, PhilHealth had also accredited 337 government infirmaries and dispensaries, 2 ambulatory surgical centers, and 1,802 MCP-accredited facilities (PhilHealth 2017a). For primary outpatient care, municipalities (and component cities) operate the RHUs (or urban health centers). It is not known how many RHUs or urban health centers are there nor how many LGUs lack such facilities. However, in 2016, there were 2,557 government outpatient clinics accredited by PhilHealth to provide the PCB package in 1,578 LGUs (PhilHealth 2017b). In 2015, there were 19,622 BHSs (DOH 2017) providing primary care and public health services close to the population in 46 percent of all barangays.

The private sector is also an important provider of health care services, with more private hospitals than public hospitals as well as a substantial number of outpatient specialist facilities, from which PhilHealth purchases services. PhilHealth's list of accredited facilities at the end of 2016 indicated 782 private hospitals and 355 private infirmaries/dispensaries from whom secondary and tertiary care are purchased. Specialist outpatient care is purchased from accredited private ambulatory care facilities consisting of 237 ambulatory surgery centers, 140 freestanding hemodialysis centers, and 1,465 private birthing facilities. PhilHealth purchases services from many of these private facilities, while some of them are also subsidized by the DOH.[11] The *Tsekap* primary care package also envisaged that PhilHealth would be able to contract with private primary care providers for the first time, but the policy has not yet been implemented. In addition, there is a large but unknown number of private outpatient nonsurgical clinics and traditional medicine clinics from whom patients purchase services through OOP payments.

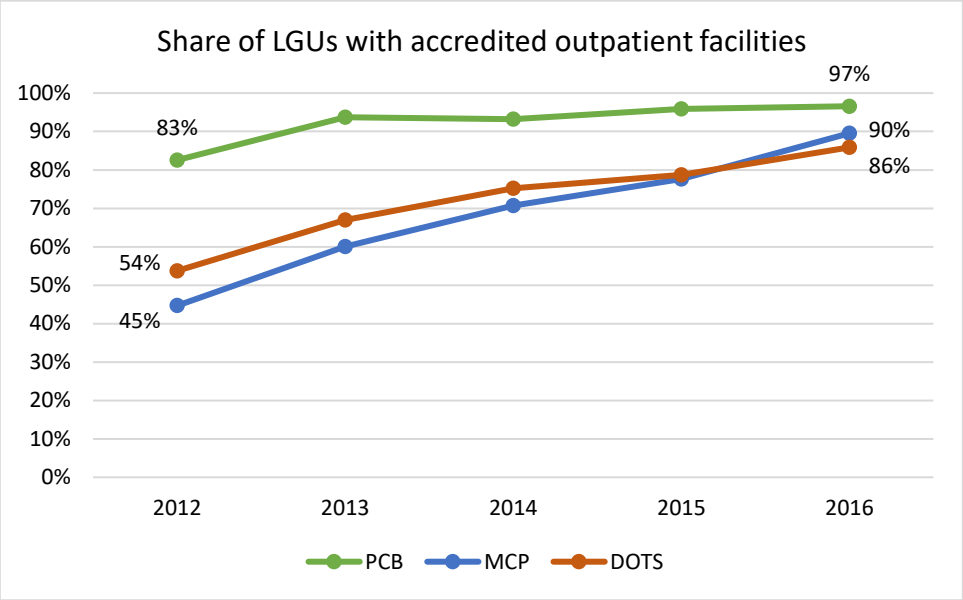
The DOH has a licensing process to certify that all hospitals and certain types of outpatient facilities (both public and private) meet the required standards for providing services, but there is no licensing process for outpatient primary care facilities. The DOH licenses all hospitals, ambulatory surgical centers, and freestanding dialysis clinics, as well as certain technical blocks like laboratories and radiotherapy units. The 16 regional offices of the DOH (still referred to under the former name as Centers for Health Development in the GAA) license infirmaries and dispensaries that have inpatient beds. In addition, facilities that provide certain benefit packages (TB-DOTS, HIV/AIDS, malaria, and animal bite treatment centers; blood centers; newborn screening facilities; and Z-benefits) have to undergo certification that their staff have completed particular training or that they have the necessary equipment needed for that package, such as the certification of Basic Emergency Obstetric and Neonatal Care (BEmONC) for MCP facilities. For example, the DOH certifies maternity care facilities as BEmONC facilities. Some facilities may choose to undergo accreditation by independent accreditation organizations for boosting global competitiveness. By the end of 2016, five private

hospitals in the Philippines have Joint Commission International accreditation. ISO quality management certification has been attained at a number of government hospitals but is primarily related to management aspects rather than clinical quality aspects of hospital quality. A national Hospital Accreditation Commission was set up in 2013, also for making hospital services in the Philippines more globally competitive through accreditation, but no information can be found about its current status and activities. There is no general accreditation or licensing system for the RHUs, urban health centers, BHSs, or private medical clinics. An earlier effort to certify the RHUs, called the *Sentrong Sigla Movement* (DOH 2000), was eventually found to have failed at improving processes needed to achieve better outcomes (Catacutan 2006) and appears to have been halted because there is no information on this movement since the early 2000s.

PhilHealth purchases services by contracting with public and private facilities that have met PhilHealth's accreditation requirements and are willing to sign performance commitments. Accreditation of health care providers to ensure minimum standards of quality has been a key responsibility of PhilHealth since the Health Insurance Act of 1995. PhilHealth's Accreditation Department is responsible for setting 'benchbook' standards[12] and verifying that providers meet the standards required for different PhilHealth benefit packages. Accreditation is typically renewed almost automatically, but can be denied or suspended if standards are not met. This occurs mainly because of fraudulent claims rather than because of problems with the quality of services. PhilHealth can also recommend that the DOH withdraw facilities' licenses. Since 2012, all public and private hospitals licensed by the DOH are eligible for automatic PhilHealth accreditation. PhilHealth accreditation of hospitals, ambulatory surgery, hemodialysis clinics, and MCP providers consists mainly of documentary verification of accreditation requirements and signing of performance commitments.[13] For Z-benefits, PhilHealth goes beyond facility accreditation to actually accredit facility capacity to provide the services needed for each specific disease/package, but due to the nature of the Z-benefit package, this practice is generally limited to a few highly specialized tertiary hospitals.

For most outpatient facilities, like the RHUs and urban health centers, PhilHealth's accreditation of capacity to provide the PCB package serves as the main mechanism to ensure facilities meet minimum quality standards because these facilities are not licensed or accredited by the DOH or LGUs. According to PhilHealth statistics, the share of LGUs with at least one facility accredited to provide the PCB grew from 83 percent in 2012 to 97 percent in 2016 (Figure 3). Substantial growth has also been seen in the share of LGUs with facilities accredited to deliver the TB-DOTS and MCP. However, as many as 10 percent of LGUs still lack accredited MCP providers and 14 percent lack a TB-DOTS provider.

Figure 3. Trends in proportion of LGUs with accredited outpatient package providers, 2012–2016



Source: PhilHealth Stats and Charts 2012–2016.
Note: There are 1,634 LGUs nationwide.

Certification by the Professional Regulation Commission is a legal requirement for health professionals to practice in their fields and the only form of quality certification for patients using unlicensed and unaccredited outpatient providers. The Professional Regulation Commission oversees the various professional boards that prepare the contents of licensure examinations, determine training curricula, inspect schools, adopt codes of ethics, administer oaths and issue certificates of registration, and investigate violations of professional standards. The Commission can also revoke certificates of registration. It is illegal to practice in the medical and health professions without these certificates. Separate professional boards exist for different medical professions, including medicine, dentistry, optometry, psychology, pharmacy, nursing, midwifery, medical technology, respiratory therapy, radiologic and X-ray technology, physical and occupational therapy, and nutrition.

2.4 For whom are health services purchased?

With PhilHealth coverage at 91 percent by the end of 2016, almost all of the Filipino population potentially benefits from PhilHealth reimbursements to providers for some type of health services. The share of the population covered by PhilHealth has increased from 70 percent in 2010 to 91 percent of the projected population by end of 2016 (PhilHealth 2017b). Many of these people are contributing members and their dependents, including those in the formal sector program (employed in the government, formal private sector, household help, enterprise owners, and household drivers) and informal sector (migrant workers, informal sector, self-earning individuals, and organized groups) together accounting for 43 percent of members and 40 percent of beneficiaries (members plus dependents). A large share of PhilHealth beneficiaries have their contributions fully subsidized by the national government through the indigent and senior citizens' program. As of December 2016, the PhilHealth database showed indigent program membership equivalent to 14.6 million families[14] (for a total of 43.5 million beneficiaries) and senior citizen program membership equivalent to 6.2 million families[15] (for a total of 7.6 million beneficiaries) in a population estimated at 101 million people. Other members are covered by PhilHealth's sponsored program (whose members' premiums are paid by LGUs or third parties such as nongovernmental organizations [NGOs] or churches)[16] or the lifetime member program (where contribution history and age exempt members from premium payments).

Anyone who uses government health facilities for inpatient or outpatient care, or obtains medicines through the medicines access programs, benefits from state budget subsidies. According to the 2013 Demographic and Health Survey (DHS), about 7 percent of individuals sought care at government facilities in any given month and, therefore, benefited from these subsidies. The most frequently used public facilities were the BHSs (30.1 percent of people using a medical facility in a 30-day reference period), RHUs (including urban health centers, 18.0 percent), and public hospitals (15.6 percent). About 55 percent of hospital inpatient stays in any given year are in public hospitals. Among people using health services, reliance on public facilities is higher among the poor. According to the 2013 DHS, among the poorest quintile, 73.1 percent of admitted patients used public hospitals, compared to only 27.4 percent among the richest quintile, who relied predominantly on private inpatient facilities.

Indigents and other vulnerable groups are given priority in both PhilHealth and DOH purchasing. First, and as already noted, about 51 million people benefit from free health insurance through the indigent and senior citizens programs financed by the national government,[17] while most of the 2.8 million beneficiaries in the sponsored program have their premiums financed by local governments or other branches of the national government. Another way in which PhilHealth prioritizes indigents and sponsored members is through the implementation of an 'NBB policy' for inpatient care whereby, unlike other membership categories, the indigent and sponsored members are not supposed to pay extra to providers over and above the amount that is reimbursed by PhilHealth. This policy is discussed further in section 2.5. The GAA 2016 allocated about PHP 1.4 billion in funds for assistance to indigent patients either confined or outpatient in government hospitals, specialty hospitals, LGU hospitals, Philippine General Hospital, or West Visayas State University Hospital through the MAP.[18] LGU budgets generally also have medical assistance funds in the name of various local politicians, and the Philippines Charity Sweepstakes Organization (PCSO) allocated over PHP 9 billion for medical assistance in 2016. Both the DOH and LGU medical assistance funds can be used to cover any individual that mayors, congressmen, and DOH staff wish to sponsor because there are no clear eligibility criteria. Funds are paid directly to the hospital in what seems to be a type of post-payment safety net scheme. The PhilHealth PCB package is another example of the prioritization of indigents and sponsored members; other PhilHealth members are not eligible. Finally, the DOH budget also prioritizes vulnerable groups over others not only through the transfer that it makes to PhilHealth for the premiums of indigents and seniors but also through paying for a number of vertical programs from which the poor are likely to disproportionately benefit. These include programs to combat diseases that are more likely to affect the poor (like TB, tropical diseases, and malaria), medicines access program, and the family health and responsible parenting program, which targets family planning access to poor people and those living in regions with the highest unmet need.

2.5 How are health services purchased?

PhilHealth, as the main health sector purchasing agency, contracts with inpatient and specialist outpatient facilities and reimburses them on what is termed an all case rate (ACR) basis. The ACR policy covers all codes listed in the International Classification of Diseases (ICD-10). Medical conditions of a similar nature or of similar case management type are grouped together, which means that there are only about 330 rates for 4,600 medical case types. It is a fixed payment per episode of care, but does not necessarily cover the full health service fees charged by a given facility and (except in the case of indigent or sponsored members where balance billing is not permitted) facilities typically bill the patient any balance in charges over and above the case rates. Case rates were first introduced in 2011 for 23 case types; then in 2013, the full ACR policy was introduced. The rates were based primarily on historical (two years) PhilHealth claims data from government and private tertiary hospitals (level 2 and level 3 hospitals). For medical cases, an additional percentage was added above the average value per claim to cover any cost components that may not have been incorporated into those claims and also to encourage hospitals to accept the shift from a fee-for-service (FFS) to case rate payment model. For procedural codes, the complexity of procedures and costs of specialist

doctors (surgeon and anesthetist) were considered in setting the rates. The share (amount or percentage) of the case rate payment that should go to professional fees and to facility fees is specified. The policy also allows for special case rates to be assigned to specific medical conditions or procedures to promote equity and rationalize benefit costs given PhilHealth resource limitations, for example, for dialysis, chemotherapy, cataracts, or C-section. This suggests that these special rates may be set at levels higher than or lower than full cost recovery, to achieve objectives of encouraging or discouraging provision of certain services. While case rates do not vary by level of hospital or between the public and private sectors, they are reduced by 30 percent when paid to infirmaries and dispensaries.

Z-benefits, ambulatory care packages, and the maternal and newborn care packages are also purchased on a case rate basis but with more detailed specifications of the exact package content and how they are to be paid than in the case of the ACR. Z-benefits, maternity care, NSD, newborn care, hemodialysis, cataracts surgery, and so on all have their own separate circulars, laying out in detail who is eligible, as well as which service items are mandatory and which are not but should still be included (for the same case rate payment) when needed by the patient. For example, the Z-benefit package requires that any complications arising during the hospital stay related to the primary Z-benefit condition should be considered part of the package and no additional charges are allowed to cover costs. To prevent abuses, pre-authorization is required for some of these benefits. The detailed descriptions in the PhilHealth circulars are intended to ensure greater standardization of the services provided, to minimize under-provision, to improve quality of care and patient safety, to ensure that a given case rate is sufficient to cover service costs, and to reduce upcoding by clearly defining each case type. The detailed specification of which services are included in the package is very different from the regular inpatient case rates, which are defined solely by the ICD code and possibly some level of severity or type of procedure applied and for which no standardized treatment protocols are specified.

The primary care package is purchased using a form of capitation, the 'per family payment', which also involves performance-related pay in the form of withholds, making it a blended payment mechanism. The per family payment for the PCB package is a fixed amount per family that is paid to accredited government PCB package providers and provides a steady supplement to LGU facility budgets. Facilities are paid PHP 50 per quarter in per family payment for members and dependents enlisted at the facility. Another PHP 75 per quarter per family is paid if the facility performs 'health profiling'[19] of individuals in these families. If the profiling is not performed, the facility is not paid those amounts. The *Tsekap* package (which has been passed but not yet implemented) intended to increase the payment to PHP 800 per family, half of which would be paid for enlistment and the other half only if profiling was performed. The PCB package also includes a set of 'obligated' services related to prevention of cardiovascular disease, breast cancer, and cervical cancer.[20] While PhilHealth circulars indicate an intention to include financial incentives for performance on obligated services, this is still being piloted and evaluated,[21] but in the meantime, facilities are supposed to be monitored for compliance. In addition, PhilHealth circulars also intended to provide an incentive of PHP 100 in the payment if the facility submitted its reports electronically and in the correct format—something which has also not yet been implemented. The payments are made quarterly into an LGU trust fund earmarked for use by the PCB-accredited facility, from which the facility can periodically request funds through purchase orders. Because the DOH budget is paid to PhilHealth to cover indigents, and these PhilHealth resources are then transferred to LGUs according to family payments, this effectively constitutes an intergovernmental transfer from the DOH budget to the LGU budget for primary care services for indigent members.

PhilHealth also pays for medicines provided at the hospital level by including them in the calculation of the inpatient case rate, while medicines provided at the primary care (outpatient) level are included in the calculation of the per family payment. The inpatient case rate is set at a level

considered sufficient to cover the costs of all medicines needed in the treatment of that particular case category. The per family payment under the PCB package was calculated such that a minimum of 40 percent of the per family payment should go to covering the costs of drugs dispensed by the facility. A pilot was undertaken in 2012 (known as PCB2) wherein the dispensing of drugs shifted to accredited drug outlets, affiliated with the accredited primary care providers, which are paid directly by PhilHealth.[22] This pilot was the precursor to the medicines benefit design in the (not yet implemented) *Tsekap* primary care package. The *Tsekap* medicines benefit would allow prescriptions to be filled at private drug outlets who would then receive payments directly from PhilHealth for the value of drugs dispensed, independent of the per family payment to *Tsekap* providers. The prices of medicines in the *Tsekap* package are supposed to be negotiated based on the Drug Price Reference Index (DPRI) developed and updated by the DOH.

PhilHealth payment policies for inpatient, specialist, and primary care stipulate that a fixed share of the payments be used for staff in the form of professional fees. For inpatient medical cases, a fixed 30 percent of the case rate reimbursement is to be paid as professional fees, while for procedural cases, the computation of professional fees is relative to the complexity of the procedure as measured in RVUs, with the balance of the case rate payment being paid to the facility to cover other costs. The 2012 PCB1 package stipulated that of the PHP 500 per family payment, 20 percent was to be paid as honoraria for the staff and for improvements in their capabilities, specifically 10 percent for the physician, 5 percent for other health staff, and 5 percent for non-health staff. In addition, a minimum of 40 percent should be allocated to pay for drugs dispensed at the facility (asthma, gastroenteritis, and pneumonia) and a maximum of 40 percent for reagents, medical supplies and equipment, information technology equipment, and staff capacity building. The *Tsekap* primary care package policy intended for 20 percent of the per family payments to be used exclusively as professional fees and capacity building, but allowed these payments to extend also to volunteers and community members of health teams not employed by the facility. The remaining 80 percent was to be used for operational costs, including facility enhancements, information technology equipment and services, encoders, IEC campaigns, capacity building, and diagnostic services (reagents and so on) and to contribute to 'big purchases'.

In 2010, the NBB policy was put in place to enhance financial protection, especially among indigent and sponsored[23] members. According to this policy (PhilHealth Board Resolution No. 1441, s-2010), no other fees shall be charged or paid for by the PhilHealth indigent and sponsored patients availing of services paid on a case rate basis. At that time, the services paid on a case rate basis consisted of only the 23 case types introduced in Circular 11 (2011) (including the maternity care and newborn care packages) and the case rate packages that PhilHealth had developed for ambulatory surgery, radiotherapy, and hemodialysis. When the 23 case rates were expanded to ACRs in 2013 and when Z-benefits were introduced, NBB for indigent and sponsored members was part of those reforms. The NBB is also in place for the PCB package, which was introduced for indigent and sponsored members in 2012, and part of the proposed *Tsekap* primary care package. This means that indigent and sponsored patients should not incur additional charges when using primary care although they may have to pay additional services that are outside the PCB/*Tsekap* package. The maternity care, NSD, and newborn care packages are the only packages where the NBB policy is in place for all PhilHealth members. For non-indigent patients, facilities can bill patients for the balance that is left after payments from PhilHealth are subtracted from their charges. For indigent patients, hospitals must cover any balance between charges and PhilHealth case rate payments from other revenue sources (according to the NBB policy) or find ways to provide effective services more efficiently.

The DOH and LGUs purchase services for Philippines citizens through budget appropriations. The Philippines national budget is moving toward performance-based budgeting. In line with this, the DOH develops its annual plan and budget structured as four MFOs. After deliberations and adjustments, the budget is approved by the Congress and the President in the GAA. Among the MFOs, two are

largely focused on service provision—technical support services (MFO 2), including a large number of public health and preventive medicine programs and hospital services (MFO 3). MFO 2 budget allocations are primarily for maintenance and other operating expenditures (MOOE), most of which go to procure drugs and consumables, while the largest share of the MFO 3 budget allocations is for personnel services (PSs), followed by MOOE.[24] MFO 2 also includes substantial capital outlays (COs) for building and renovating government health facilities. Across all of the government, performance incentives are being put in place to reward agencies and individual staff performance based on the achievement of the targets. There are also attempts to hold LGUs accountable for performance in the health sector. These include the DOH's health-related 'LGU scorecards' that are accompanied by awards for top-performing LGUs and the Seal of Good Local Governance, which is a prerequisite to access certain additional financing streams, including from the Department of Budget and Management (DBM) and the Department of Interior and Local Government.

Different government health facilities have different degrees of autonomy in how they can organize the provision of services and manage their revenues to cover their costs and make investments. A handful of government facilities have been corporatized or transformed into enterprises, such as the four GOCC hospitals under the DOH and the La Union Medical Center, which is under LGU governance. These corporate entities operate with a high degree of autonomy. In addition, the DOH-retained hospitals have been granted the right to income retention (and this right is renewed through the GAA each year) but are subject to some restrictions on how funds can be used. Most LGU hospitals and primary care facilities operate as regular government service providers, with substantial restrictions on the use of funds. The restrictions include strict application of line item budgets (with ceilings on expenditure on capital, operating costs, and PS) and requirements to procure inputs through government procurement agencies. The number of staff positions is capped by the plantilla system, while the ability to hire additional staff (including contractual staff) is restricted by spending caps on different budget lines items—something that will be discussed later in the report.

3. Progress on pillar 3: allocate resources according to the most appropriate financing agent

The HFS identified fragmentation among purchasers of services as a source of allocative inefficiencies, and the third pillar intended to remove grey areas where it is unclear who should be paying for what by clearly assigning responsibility to one of the three payers. Recall that expenditure items can be classified as COs, PSs, and MOOE. The HFS vision is for PhilHealth to eventually be the main payer of personal care, including for PSs and MOOE, and also to contribute to the payment of public health interventions targeted to individuals through its outpatient packages (Table 1). Over time, the DOH is supposed to gradually shift from its role as funder of direct service provision (through paying for PS, MOOE, and CO at DOH-retained hospitals, as well as procurement of drugs for national priority programs) toward a stronger regulatory and advocacy role, with funding for service provision limited to contributing to CO at DOH-retained hospitals and a limited role in paying for some public health interventions. LGUs are also supposed to gradually eliminate their financial contributions to the salary (PS) and MOOE costs of providing personal health care services (curative care and individual preventive medicine interventions) while increasing their budgets for capital investments (CO) in primary and secondary health facilities and continuing to pay the PS and MOOE involved in delivering population and community-level public health interventions. This section will assess whether the health financing system has moved in the direction envisaged under pillar 3 of the HFS and discuss whether any aspects of the vision should be reconsidered.

Table 1. HFS vision of who pays for what, 2010, 2016, and 2020

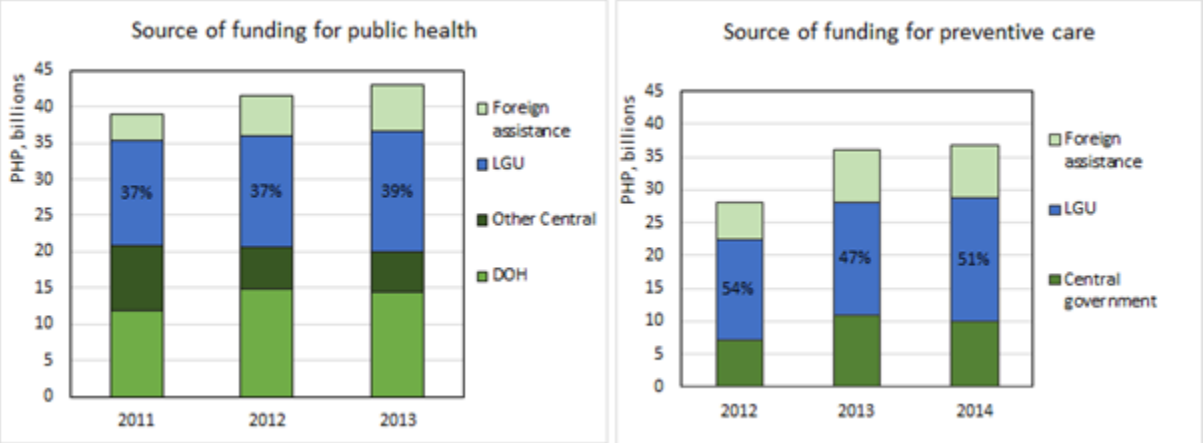
Expenditure Items	Personal Services (Curative Care and Individual Preventive Health Care)			Community-level Preventive/Public Health Interventions		
	2010	2016	2020	2010	2016	2020
PS	DOH, LGU, and PhilHealth	DOH, LGU, and PhilHealth	PhilHealth	DOH and LGU	DOH and LGU	LGU
MOOE	DOH, LGU, and PhilHealth	PhilHealth	PhilHealth	DOH and LGU	DOH and LGU	LGU
CO	DOH and LGU	DOH and LGU	DOH and LGU	DOH and LGU	DOH and LGU	DOH and LGU

3.1 Public health/preventive medicine

The HFS calls for the funding of public health and community preventive medicine to become the responsibility of LGUs and individual-level preventive medicine services to be the responsibility of PhilHealth. Up till 2014, the share of LGU funding in public health and preventive care activities has been relatively stable.[25] In 2013, the PNHA estimated public health spending at over PHP 42 billion (about 8 percent of total health expenditure), while the NHA-SHA estimated preventive care spending at PHP 36 billion (7 percent of total health expenditure).[26] Public health spending grew about 3.8 percent per year between 2011 and 2013, while preventive care spending grew 7.2 percent per year from 2012 to 2014.[27] Despite the HFS vision of shifting responsibility for public health or preventive care to LGUs, NHA estimates suggest that there has not been much movement in that direction. The LGU share of total public health spending remained at around 37 percent to 39 percent between 2011 and 2013 (Figure 4). LGUs accounted for 54 percent of preventive care spending in 2012, but as central

government and foreign aid spending on preventive care increased, the LGU share decreased to 47 percent in 2013 and 51 percent in 2014.

Figure 4. Sources of funding for public health interventions 2011–2013 and preventive care 2012–2014



Source: Left panel: 2011–2013: PNHA - PSA. PNHA.
Right panel: 2012–2014: NHA-SHA - Rachel H. Racelis, Fe Vida N. Dy-Liacco, Alejandro N. Herrin, Lilibeth C. David, Lucille F. Nievera, and Laurita R. Mendoza. Philippine Health Accounts Based on the 2011 System of Health Accounts for CY 2012 (Revised), 2013 and 2014 (Provisional): Tables, Estimates and Analysis (Draft March 2016).

Overlaps in responsibility for the funding of various preventive medicine and public health programs persist, despite the HFS's vision that responsibility would be more clearly assigned. Different public health programs have different sources of funding, and programs may frequently have multiple sources of funding (see Annex, Table A.4). For these programs, the DOH generally procures medical consumables and drugs; these line items consist primarily of MOOE expenditures. LGUs pay the salaries and other facility operating expenditures. Several programs also receive funding from international sources, such as programs against malaria, TB, and HIV/sexually transmitted infections (STIs). However, PhilHealth, in following its mandate and the vision laid out in the HFS, has developed benefits packages that will gradually cover many of these preventive medicine interventions. In the interim, though, if the DOH and LGUs also continue to fund these programs, there may be significant duplication in funding. Further incorporation of preventive medicine interventions into PhilHealth benefit packages is likely to occur in future. For example, the Republic Act 10152, known as the Mandatory Infants and Children Health Immunization Act of 2011, stipulates that "the Philippines Health Insurance Corporation (PHIC) shall include the basic immunization services in its benefit package."

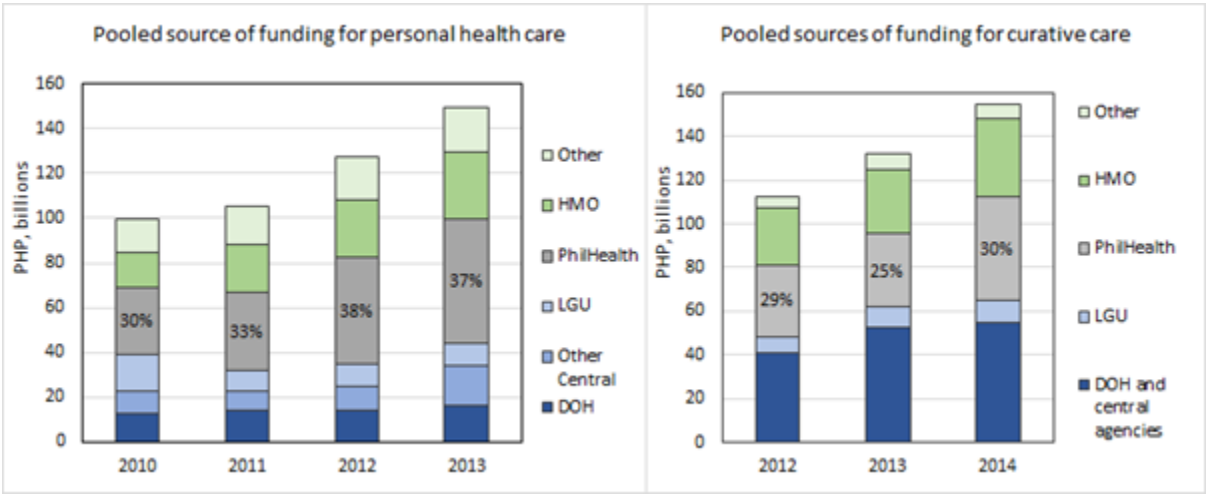
Indeed, the mechanism by which individual-level public health/preventive services that are currently being financed by the DOH or LGUs will shift to PhilHealth is not very clear. One question relates to how DOH procurement of specialized inputs (such as vaccines) through bulk purchasing would be financed; if PhilHealth were to become the main purchaser, there is no mechanism by which PhilHealth reimbursements could flow back to the DOH to pay for the inputs procured. It is also not clear how the PhilHealth payments for professional fees are actually being used by the LGUs; are they being used to replace their own budget outlays for personnel payments (as the HFS envisages), thus freeing up resources for other purposes, or as salary supplements to aid in retaining or attracting health personnel? Also, for geographic areas lacking PhilHealth-accredited providers and, therefore, unable to benefit from PhilHealth payments, there will remain a need for DOH and LGU financing to ensure the necessary funding for the provision of these services. However, there does not appear to be much of an effort to prioritize investments in those localities to help them obtain PhilHealth accreditation and thereby eventually shift to PhilHealth funding to ensure services for the population.

3.2 Curative care/personal health care services

The HFS vision for pillar 3 involves a gradual shift toward a single pooled purchaser of personal health care services, which covers curative care and individual preventive/public health care; by 2020, PhilHealth reimbursements would fully cover facilities' recurrent costs for personal health care services. The DOH and LGU supply-side subsidies are to be gradually withdrawn as PhilHealth takes over the responsibility for MOOE and PS costs. The DOH and LGU programs that provide direct services or goods to the population, such as the complete treatment pack (ComPack) and medicines access programs, would also gradually be incorporated into PhilHealth packages, reducing duplication of funding sources for personal health care services. It must be noted that in this pillar, the HFS focuses on shifting the responsibility for payment among pooled resources to avoid duplication and enhance efficiency, but ignores the larger task of replacing OOP spending with pooled sources of funding, which may explain why progress has been slow in reducing the OOP share of total health expenditure.

There has been a slight shift toward PhilHealth taking on a larger share of pooled health care funding for personal health care/curative care services, but central financing continues to increase, suggesting that PhilHealth spending is not replacing, but rather supplementing, direct budget spending. Total PhilHealth reimbursements in 2015 were 2.75 times higher than in 2010 (adjusted for inflation using consumer price index [CPI]-health). Similarly, per member reimbursements (adjusted for inflation) doubled in the same period, reaching PHP 1,038.4 per member by the end of 2015.[28] Some evidence of a shift can be seen in the fact that PhilHealth spending has grown faster than overall pooled funding for personal care (19 percent per year versus 11 percent per year between 2010 and 2013 [PNHA]) and for curative care (16.6 percent per year versus 13.6 percent per year between 2012 and 2014 [NHA-SHA]).[29] Also, PhilHealth increased its contribution to pooled personal care spending from 30 percent to 37 percent between 2010 and 2013, and its share of pooled curative care spending from 29 percent to 31 percent between 2012 and 2014 (Figure 5). These figures suggest that PhilHealth spending is not gradually replacing central budget funding, as was intended by the HFS, but supplementing it.

Figure 5. Pooled financing scheme spending on personal health services (2011–2013) and curative care (2012–2014)

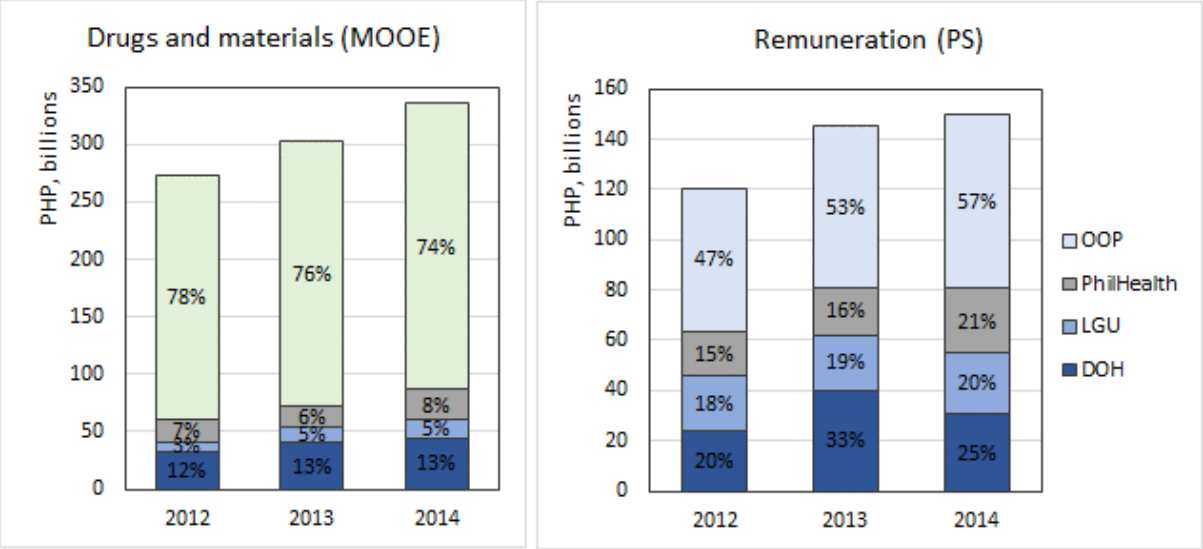


Source: Left panel: 2011–2013: PNHA; Right panel: 2012–2014: NHA-SHA.

Nearing the midpoint of the HFS strategy, there has only been a slight shift in the share of MOOE and PS costs away from government budget toward PhilHealth responsibility, and again the DOH and LGUs have not reduced their shares. The left panel of Figure 6 shows that PhilHealth is paying a higher share of total drugs and other materials (MOOE), but the DOH and LGUs have not reduced their relative shares, which one would expect if PhilHealth is taking over more of these costs. At least the

OOP share appears to be declining slightly. Similarly, the right panel of Figure 6 shows that PhilHealth is paying a higher share of remuneration/salaries (PS) at facilities, but the share paid by LGUs and the DOH has not declined. In fact, the share paid by the DOH increased by 25 percent compared to 2012.

Figure 6. Trends in sources of funding for MOOE (drugs and materials, and remuneration), 2012–2014



Source: NHA-SHA 2016.

The high share of drugs and materials costs paid out of pocket by households should be a major policy concern. Despite PhilHealth coverage and the DOH medicines access programs, pooled funding sources have not substantially reduced the absolute amount or relative share of OOP spending on pharmaceuticals. In 2014, among central agencies and PhilHealth, only about 20 percent of total spending was for drugs. Among LGUs, the share was slightly lower at 16 percent. What is striking is that 68 percent of household OOP spending is for purchase of pharmaceuticals, and this is even higher among the poorer quintiles (Bredenkamp and Buisman 2016). Of those purchases, 62 percent are from drug retailers, although some of this may be drugs prescribed by physicians. Current data sources do not allow in-depth analysis of the nature of these drug purchases. For example, while the Family Income and Expenditure Survey (FIES) shows what share of OOP spending is spent on drugs, the survey does not provide sufficient information to know whether drug spending is for inpatient care, outpatient care, or self-medication; chronic disease, acute disease, or prevention; or prescription or nonprescription or other important details that could be useful in formulating policies to reduce this burden. The NHAs also do not provide sufficient detail to understand the nature of drug spending.

Due to multiple and overlapping sources of payments, it is impossible to know how much remuneration health personnel actually receive which, in turn, makes it difficult to assess whether health personnel are being paid too little or too much. Currently, the DOH and LGUs pay salaries based on the Salary Standardization Law of 2013. The Law aims to ensure that government personnel across different government agencies are paid on the basis of equal pay for equal work, and that the salaries are also set to be comparable to salaries in the private sector for similar work. The Law aims to provide differentials in pay that compensate for hazardous work, night duty, and other factors where pay differentials would better balance demand and supply of workers. In addition to salaries, though, health workers now receive professional fees as an earmarked share of the PhilHealth case rate or capitation reimbursements to facilities. As PhilHealth coverage and benefits have expanded, so too has the monetary value of PhilHealth benefit payments (tripling from PHP 30.5 billion in 2010 to PHP 97.0 billion in 2015, while the CPI rose only 17 percent over that period) and, therefore, also the real value of professional fees. Many health workers also receive payments from OOP spending that uninsured households make to facilities, in other words, from user fees. Joint Circular No. 1, S

(2012) of the DBM and the DOH provide detailed explanations of the benefits for government health workers but also include a prohibition on double compensation. It appears that there is a policy intention, according to the HFS, to replace state budget payments for health worker remuneration by payments from PhilHealth professional fees and/or OOP payments by households. Yet, there does not appear to be an accountability mechanism to ensure that, on the one hand, health workers actually receive their professional fees and, on the other hand, that these professional fees actually do replace salary so that they are not overpaid at the expense of patients or state budget funds. In short, there is no information available on the actual total remuneration received by health workers.

As with public health/preventive medicine, there are also many curative care interventions where there appear to be duplicate payments by the DOH and PhilHealth, especially when it comes to the drugs/medicines component of these interventions. In 2016, the GAA for the DOH included nearly PHP 9 billion in appropriations for the procurement of drugs, medicines, and vaccines, including medical and dental supplies for distribution to government health care facilities. While the GAA did not lay out the details of which programs were intended to be covered by this procurement, it is known that the DOH runs several medicines access programs for catastrophic or rare diseases and is providing some basic outpatient drugs through the ComPack program (see Table A.5). For catastrophic diseases, PhilHealth has a Z-benefit package that includes the costs of drugs (and other items) needed for the treatment of the diseases in this package. Consequently, once PhilHealth has developed and implemented the Z-benefit for a given disease, the DOH payments for drugs related to that disease should be redundant. There is also potential duplication by PhilHealth and the DOH when it comes to the DOH ComPack program and PhilHealth PCB package. The ComPack program was designed to make low-cost complete-dosage packages for common medical conditions widely available, and the drugs are distributed to LGUs, mainly in primary care facilities. Yet, many of the drugs in the ComPack program are the same drugs that are now covered by the PhilHealth PCB package.[30] Thus, while PhilHealth reimbursements to the RHUs include the costs of these drugs, LGUs receive these drugs for free from the DOH, thus potentially receiving duplicate payments for some items. The design of the *Tsekap* package made a conscious effort to avoid overlap between PhilHealth coverage and the DOH programs.

There is also duplication in funding for equipment and COs, including through mechanisms that alter the original intention of PhilHealth reimbursements. A prominent example is the stipulation in the GAA[31] that the amount reimbursed by PhilHealth to the DOH-retained hospitals (for example, through case rates) should be used for constructing additional health care facilities and providing new equipment, rather than for the payment of PS. This practice, which is supposed to be monitored through quarterly reports posted on the DOH website, effectively converts reimbursements for PSs and operating budget (MOOE) into COs. This is not the intention of the case rates nor the vision of the HFS and ultimately a very convoluted mechanism for allocating capital investment funds that is not likely to result in a rational allocation of funds to facilities in greatest need of upgrading or to localities in most need of new facilities. It also effectively means that the amount of funding going to COs at DOH-retained hospitals may be much larger than it appears from the capital line items in the GAA; it also erodes the availability of financing for MOOE and PS, which is so necessary to deliver quality health services.

The HFS neglected to clarify the intended roles of the non-DOH central agencies and private insurance, who are important funders, in pooled financing. According to the 2016 PNHA, spending by other central agencies, such as the military (PHP 15.1 billion), reached nearly one-third of the level of the DOH (PHP 49.4 billion), while the spending by private insurers and HMOs (PHP 45.0 billion) was almost as high as the spending by the DOH. Yet, the HFS did not mention these important sources of health financing and how any duplication of payments and perverse incentives related to their funding might be resolved. The HFS also neglected to mention how these sources of funding affect overall

health equity and financial protection goals. Further research is needed to understand the role, and impact, of these large health financing agents.

3.3 Outpatient drugs

Pharmaceuticals are a large health expenditure item in the Philippines, funded largely by household OOP spending. Drugs account for more than half of total DOH, LGU, PhilHealth, and household health expenditures.[32] Out of all drug spending in the Philippines, 90 percent is paid out of pocket by households. The rationale for shifting the responsibility for pharmaceutical purchasing from individuals to pooled purchasers lies in the information asymmetries between patients and physicians. Patients are at an information disadvantage relative to physicians when determining which drugs, and how many drugs, they need, making them susceptible to being misadvised to purchase unnecessary and often costly medication. The widespread practice of self-medication, coupled with ubiquitous pharmaceutical advertisements and lack of restrictions on retail purchase of prescription drugs without a prescription, compounds the problem. For the individual, the cost of obtaining information to make correct decisions is high. By contrast, a pooled purchaser, such as the government or PhilHealth, can act in the public's interest to obtain this information and use it to set reimbursement rules to ensure cost-effective and appropriate use of medicines. To date, this shift has not occurred.

Implementation of the comprehensive PhilHealth outpatient drug benefit that was developed as part of the expanded PCB package (*Tsekap*) could help shift more of pharmaceutical spending from OOP spending to pooled purchasers (namely PhilHealth). The expanded PCB package (*Tsekap)* included a more comprehensive list of medicines than is currently provided as part of the PhilHealth PCB primary care package (Table A.3). However, its implementation was halted. Now, the DOH ComPack program continues to provide diabetes and hypertension drugs to a number of localities. However, while bulk procurement of the ComPack drugs may help to ensure low prices, the ComPack program is not integrated into a comprehensive package of services required for the management of these diseases (as would have been the case under the *Tsekap* program), and there is no mechanism for PhilHealth to reimburse the DOH for the costs of these drugs.

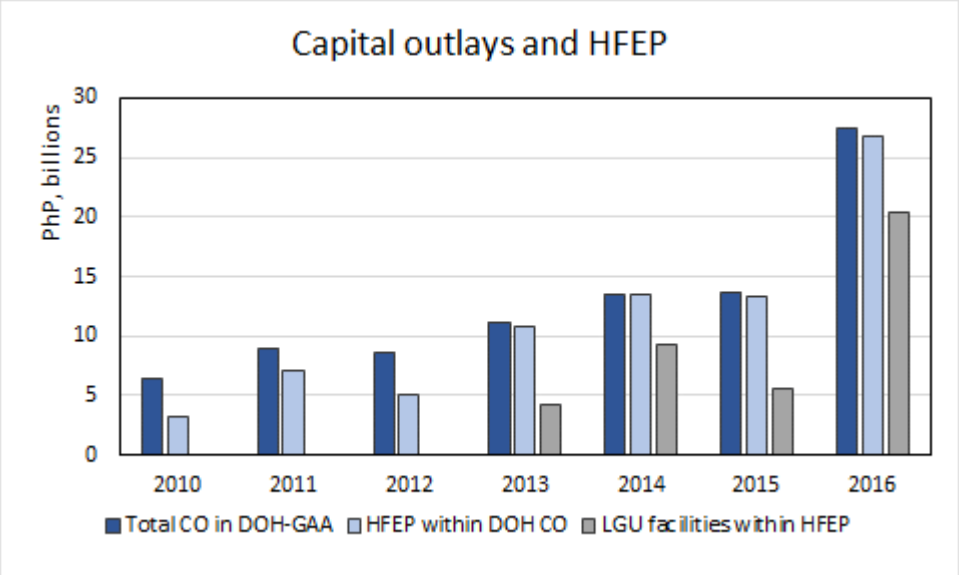
3.4 Capital outlays

The main program for capital investments in the health sector is the HFEP, initiated in 2007 and included as one of the strategic thrusts of the KP-UHC to improve access to quality hospitals and health facilities through upgrading of facilities. In 2010, the HFS called for the DOH to retain responsibility for COs at DOH hospitals on the basis that a central authority was in a better position to ensure the proper mix of availability of facilities that promote access, quality, and equity. It also argued that LGUs should cover COs for primary and secondary facilities in their localities as they would know best where underserved areas exist. One of the objectives of HFEP investments was to expand the number of facilities that meet PhilHealth accreditation standards and can receive PhilHealth payments, particularly in poor areas. Another was to ensure adequate BEmONC-accredited maternity care facilities.

Starting in 2011, however, as the HFEP budget rapidly increased, the DOH decided to recentralize capital investments in the health sector through the HFEP. The decision was based on the argument that HFEP civil works were implemented faster when managed by the DOH regional offices than when managed by LGUs and that there were also potential price and quality advantages of centralized, larger-scale procurement of hospital equipment by the DOH (DOH 2012). HFEP allocations increased from PHP 3.3 billion in 2010 to PHP 13.5 billion in 2014 (benefiting partly from sin tax revenues). In 2016, a dramatic increase was seen in the HFEP appropriations with the total amount allocated reaching PHP 26.9 billion (Figure 7), of which a large share was earmarked for the BHSs, RHUs, and LGU hospitals. These trends and the DOH recentralization are contrary to the HFS vision of LGUs

covering CO costs for primary and secondary care facilities. Nevertheless, there is certainly some merit in having more centralized master planning for secondary and tertiary facility infrastructure. One challenge of decentralized financing of capital, especially for tertiary and secondary facilities, is that many of these facilities are operated by one LGU but serve catchment populations that span multiple LGUs, with the result that there is a risk that devolved capital investments may lead to inadequate service capacity and an undue financial burden on LGUs where the facilities are located, while neighboring LGUs incur no expenses for the services provided to their populations. Central financing of capital could help to address this. It could also help to address equity concerns. However, capital investments in primary care facilities by a central agency lack a clear allocative efficiency rationale, particularly when the main constraint to obtaining PhilHealth accreditation is related to human resources (that is, inadequate staffing) rather than the condition of facilities.

Figure 7. Trends in DOH COs, the HFEP component of COs, and the LGU component of HFEP, 2010–2016



Source: GAA, various years.

Guidelines for rationalizing the health care delivery system based on health needs were issued in 2006 (AO 2006-0029), providing a set of health and non-health criteria to be used in the rationalization process. The basis for the allocation of HFEP funds included the existence of a provincial facility rationalization plan based on health needs, implementation plans linked to the province-wide investment plans for health (PIPHs), and documented intent to use funds to meet DOH licensing and PhilHealth accreditation requirements (DBM 2011). Criteria for allocations include LGU priority as demonstrated by LGU allocation of MOOE and human resources for the project, DOH regional office review (to ensure the project is consistent with PIPH framework and other regulatory requirements), and additional priority for LGUs with more than 85 percent indigent program enrollment and evidence of good LGU management. A Philippine Institute for Development Studies (PIDS) study in 2012, however, found that the HFEP guidelines failed to explicitly mention this AO in its guidelines for allocating the HFEP funds. Evaluation of the HFEP allocations from 2007 to 2010 also indicated that investment fund allocations were not related to need (including poverty incidence, population, or inclusion in the PIPHs) (Lavado et al. 2012). Instead, other—sometimes conflicting—policy goals were set by politicians that diverted investments from filling the gaps, for example, the need for training hospitals for nursing students, and priority investment in primary care facilities to decongest tertiary facilities in some areas. Gaps between need and infrastructure investments were greater for the HFEP funds sourced from congressional and senate initiatives than from DOH general appropriations.

The HFEP may need to be complemented by additional measures to ensure that the capital investment results in facilities actually being able to receive PhilHealth reimbursements for services provided. Despite the intention that the HFEP would help to ensure that facilities meet PhilHealth accreditation standards, field visits suggest that HFEP fund allocations do not always follow the facility rationalization plans developed by the provincial health officials. Rather, allocations are heavily influenced by the wishes of the local chief executives (mayors). In addition, although the beneficiary LGUs are required to sign a Memorandum of Agreement committing them to provide the necessary human resources once the facility upgrading has been completed, the DOH lacks the means to enforce this. The COA's audit of the DOH in 2014 also found that medical equipment procured with the HFEP funds has often gone unutilized, is defective, or was never received by the facilities. While data to substantiate this point of view are lacking, it is often said that many LGUs lack the fiscal capacity and planning skills (and culture) needed to anticipate the recurrent cost implications of new physical investments such as might be provided through the HFEP (World Bank 2013).

The provision in the GAA that allows the DOH budget to be used to procure inputs at DOH facilities, then have these inputs reimbursed through PhilHealth case rates, and then have the reimbursements be used by the facility for COs, is likely to lead to irrational capital investments. This point was made in the previous section but bears repeating. Generally, the basis for determining capital investments in the health sector should be population health care need and current capacity to meet those needs and not equivalent (indirectly) to the amount of DOH-subsidized inputs allocated to a given facility. The convoluted nature of these fund flows is also likely to escape effective oversight of, and accountability for, fund use.

The HFS also points out that private facilities should not receive subsidies for COs, but should rather recover those costs from their revenues. PhilHealth reimbursements to private hospitals were about 2.5 times higher than reimbursements to public hospitals during 2012–2014 (which is the most recent data available). Private hospitals are disproportionately used by the wealthier part of the population. One option would be for PhilHealth to reimburse private facilities at a higher rate than public facilities in order to recover their capital investment costs, but this would further concentrate PhilHealth benefits among the rich. Cost recovery of private facilities could instead be funded by patient co-payments, although safeguards would have to be in place for the poor in areas where there are inadequate public facilities and they are forced to use private facilities for certain services.

3.5 Cross-cutting issues

Justification for continued DOH procurement

The justification for continued DOH and LGU subsidies to the direct provision of curative care and primary care services, that is, MOOE and PS budgets, has been nearly eliminated by PhilHealth coverage expansion. By 2016, the substantial revenues from the Sin Tax Law combined with the point-of-care enrollments[33] had virtually eliminated PhilHealth coverage gaps for indigents, at least on paper. Nevertheless, and contrary to the HFS, the DOH and LGUs continue to allocate state budget funds for supply-side subsidies to most government health facilities. In addition, the DOH subsidizes drug and materials procurement and also continues to fund the MAP.[34] While continued subsidies are required in areas whose facilities have not yet attained PhilHealth accreditation, these should be targeted at those specific locations and additional measures taken to ensure that the LGU facilities indeed meet accreditation standards. Simultaneously, efforts are needed to continue to increase and sustain PhilHealth population coverage. If the reason for continued supply-side subsidies is that PhilHealth reimbursements are too low compared to the costs of providing services, then it might be more efficient to allocate more resources to PhilHealth to ensure their reimbursements are adequate. These demand-side subsidies are better able to target patients in greater need of financial protection

and are paid in a way that motivates higher productivity of providers than supply-side subsidies (which are paid whether services are provided or not).

Bulk procurement of drugs and materials or centralized procurement of high-cost patented items may justify continued centralized, rather than devolved, procurement. Some items such as vaccines, drugs for rare conditions, or chemotherapy drugs may require centralized procurement because of the possibility of obtaining lower prices through bulk procurement, although centralized negotiation with decentralized financing could also help to ensure lower prices. However, it is necessary to have clear criteria for determining when the DOH procurement is justified or when decentralized procurement could be acceptable. There are always tradeoffs between centralized and devolved procurement of pharmaceuticals and consumables. With centralized procurement, complex logistics may lead to long delays and slow responsiveness to local needs. Devolved procurement, on the other hand, may be subject to corruption and inflated prices, requiring other measures to ensure reasonable price levels.

Shifting sources of funding have political implications

Shifting from the DOH and LGU supply-side subsidies to PhilHealth payments based on service provision has implications for the redistribution of resources across facilities. Facilities currently receiving government budget subsidies may not be the same facilities that would receive additional reimbursements from PhilHealth for service provision according to current or future benefit package and reimbursement mechanisms. Potential losers are likely to put up substantial political resistance to such a policy. Medical facilities accustomed to receiving a steady stream of funds for the PS and MOOE budget lines would have to figure out how to manage to cover their operating budgets with the more variable revenue streams that come from service provision, rather than relying on additional requests for budget allocations. There is a high risk that facilities will make little effort to increase efficiency and control costs, when it is easier to simply increase charges to patients to cover any shortfalls, adversely affecting patient financial protection. Financial management skills would have to be improved, particularly at smaller facilities like RHUs and BHSs, if recurrent costs are to be covered by PhilHealth reimbursement. In a limited number of clearly defined remote areas with inadequate patient volume, revenues from service provision may not be adequate to ensure the survival of facilities; so, government budget allocations for operational budgets may need to be continued in those localities.

The DOH would require substantial reorganization and redefinition of functions because its budget for direct service provision would be substantially reduced, as would its ability to use financial (budget allocations) instruments to manage public providers; the same applies to the LGUs. According to the HFS vision, the DOH and LGU budget appropriations would no longer be used for direct service provision, which means that the amount of funds that would need to be allocated to the DOH and local facilities for service provision could be reduced because these resources would have to be allocated to PhilHealth to cover the full cost of service provision. The amount of funds currently paid for PS and MOOE that the DOH would shift to PhilHealth responsibility amounts to 14.5 percent of the 2016 DOH budget appropriations. The LGU direct subsidies for operating general hospitals, estimated in 2014 NHA-SHA at nearly PHP 10 billion, would also shift to PhilHealth. While budgets for direct service provision would be reduced, the DOH and the LGUs would need to make substantial changes in their functions and operations, such as increasing resource allocations for regulatory functions, inspections, strategic infrastructure and equipment investments, training and monitoring, and oversight of PhilHealth—all of which would require substantial investments in information technology systems. The DOH and the LGUs would have to shift from reliance on financial instruments toward a greater use of regulatory instruments in their management and stewardship of the health sector. There is likely to be substantial resistance from the DOH and the LGUs to implementing this

vision because the DOH and the LGUs would lose considerable direct financial leverage over their providers.

Complications of devolution

Some of the biggest challenges in ensuring equitable and efficient health financing, as well as getting alignment of financing with the broader health sector orientation, relate to the devolved relationship between the DOH and the LGUs. The Local Government Code of 1991 aimed to transform LGUs into self-reliant communities and active partners in nation building by giving them more powers, authority, responsibilities, and resources and by giving local chief executives more freedom to carry out programs suitable for their area. A key component of this devolution was the allocation of internal revenue allotments (IRAs) from the central budget to LGUs in an amount no less than 30 percent of the collection of internal revenue taxes to supplement local revenues from taxes and fees. These funds are allocated to provinces, municipalities, cities, and barangays on a quarterly basis, without restrictions, for use at the local chief executive's discretion, with oversight by the COA. While the DOH lays out the broad national health goals and guidelines, LGU resource constraints and local chief executive discretion over resource allocation means that LGU implementation of programs is not always aligned with these goals. While devolution has allowed space for innovation, which has been highly successful in some localities (Picazo 2015), [35]it has also led to fragmentation in financing and health care services, resulting in disparities in the availability and quality of health services (Picazo et al. 2013). The combination of weaknesses in local planning and budgeting and the high degree of discretion of local chief executives (who may be motivated by political interests) means that resource allocation is not always focused on effectively and equitably meeting local health care needs (World Bank 2011).

Devolution of health services to LGUs also complicates the assignment of the responsibility to pay for specialist and hospital services. When it comes to specialist facilities and hospital facilities whose catchment populations span multiple jurisdictions, an undue financial burden is currently being placed on the LGUs in which the specialist facility/hospital is located. To resolve the interjurisdictional problems of service delivery, planning, and finance, interlocal health zones (ILHZs) within which financing and administration would be shared have been promoted as part of the health system reforms of the mid-2000s. The creation of the ILHZs is essentially an effort to reinstitute some of what was lost during devolution, but there has not yet been a thorough evaluation of their effectiveness (World Bank and ADB 2005). Since the recentralization of various elements of health spending and service delivery has not occurred in a systematic or strategic manner, it seems that the DOH has not fully committed to making devolution work – but has also not yet fully committed to renationalization. Thus, many DOH-retained hospitals are not serving to complement existing LGU capacity but instead to substitute for it.

Devolution also broke the established referral networks through which continuity of care was coordinated. Pre-devolution, continuity of care, and referral were assured by the centralized management of the system. Under devolution, with some facilities under the municipality, some under the province, and still others under the DOH, this referral network has broken down (PIDS 1999; World Bank 2011). The referral system has still not been reconstituted, and patients often simply bypass primary care to go straight to secondary or tertiary care facilities.

Devolution also makes it difficult to fully realize economies of scale. This is because the supply-side subsidies now come from individual LGUs where a facility is located, which will want to focus on serving residents of the LGU, rather than expanding the scale of operations to ensure cost-effective laboratory services run at full capacity with specialized staff, which is only possible when services are provided across multiple LGUs.

Lack of data makes it difficult to follow flows of funds and detect duplication

The national and local budgeting processes determine, to a large extent, what is purchased using public funds; yet, assessment of the gaps and duplications is hindered by lack of data. Resources are allocated to different government agencies and local governments through the annual GAA. LGUs allocate their IRA and other funds to different sectoral priorities, including health. The GAA is discussed in Congress every year, and it is easily available to the public and analysts through government websites, but there is little information available about what health services are actually purchased through the DOH regional office or LGU budgets or what is achieved in terms of health outcomes. This is even more complicated when health services rely on funding from multiple sources, such as PhilHealth, DOH, and LGU budgets, with separate accounting systems, which may lead to overpayment or underpayment that is difficult to assess. It is particularly difficult to assess the appropriateness of government budget allocations across localities when they overlap with PhilHealth reimbursements for the same diseases or drugs because gaps or duplications are difficult to detect.

Some prominent data gaps have been revealed in the course of undertaking this analysis. Many of these stem from the devolution of financing and service delivery whereby the national government also lost (or ceded) the ability to compel LGUs to provide certain health-related statistics to the national level. There is no aggregate information on the number of RHUs or urban health centers in the Philippines; the national level does not maintain a database of the number of facilities that are under LGU control. There is no aggregate information on the number of government health workers in the country because the national level does not have information on health workers employed by LGUs. While information on health worker salary scales is available, there is no information available on total health worker compensation, especially the amount of income being derived from PhilHealth professional fees. Given how much of health spending goes to medicines, better information on drug consumption is also needed, either through some revisions to the FIES or perhaps a specialized study. Perhaps most importantly, though, there is no regularly compiled and aggregate information available on how much LGUs spend on health and on which items. This also means that we cannot tell whether the DOH budget allocations need to be adjusted to supplement spending in needy areas. In addition, when it comes to health sector outputs, it seems that the Field Health Services Information System (FHSIS), which contains information on services delivered, is available only with substantial delay; in 2016, the most recently available FHSIS data were from 2014. These data gaps have limited our ability to analyze, as comprehensively as we would have liked, all the angles of the 'who pays for what' question. More importantly, though, these data gaps are an obstacle to the effective stewardship of the health sector. Without comprehensive and up-to-date information on health financing and service delivery, the health system cannot be responsive to the needs of the population.

While substantial efforts have been made to improve public access to information on health service and public finance, including through the Seal of Transparency and posting of financial information at facilities and on agency websites, there remain some obstacles to using these resources. Some sites require security access to view reports, links are broken, and sometimes pop-ups warn that connections to some documents are not secure, dissuading users from accessing such files. Some of the documents are scanned copies that are not very readable, other formats are not amenable to word searches, and data is often contained in PDF files (which are not useful for quantitative comparison and analysis). There is no standard uniform format for much of the important information. For example, while some facilities do provide detailed disbursement reports by item, others just indicate total disbursements for the year. The DBM has created a People's Budget to make the public finance information more accessible to the public, but the information on the health sector is quite limited.

3.6 Allocating resources to the most appropriate financing agent: have the HFS goals been achieved?

There has been some movement in the direction of the HFS vision. However, it is less than had been anticipated by the midterm of strategy implementation. Moreover, substantial impediments to achieving the vision remain.

The overall goal of improving allocative efficiency by reducing duplication and overlap in who pays for what has not yet been achieved. The analysis indicates that there are still a large number of programs funded by multiple sources and with possible duplication in payment. The DOH does not seem to be ceding responsibility for the financing of health programs to PhilHealth as PhilHealth expands the number of benefit packages it offers, particularly for preventive medicine. Instead, there are many instances where there appears to be an overlap in what the DOH and PhilHealth are paying for. If there is an advantage to DOH bulk procurement of certain items, such as vaccines, and the DOH wishes to continue financing those items, then the PhilHealth package design should exclude these costs from the package because they are covered by DOH appropriations. If it is determined that PhilHealth should reimburse the DOH for these costs, the current regulations that inhibit efficient fund flows between agencies will need to be changed.

The vision of shifting MOOE and PS budget responsibility from the DOH and LGUs to PhilHealth does not seem to be well understood and has, therefore, not been implemented. As a result, PhilHealth payments are not seen as replacing the DOH and LGU funding as intended in the HFS but rather as supplementing them. In particular, the professional fees portion of the PhilHealth reimbursement is being used to top up salaries in many localities and DOH facilities rather than reducing the financial burden of the payroll on state budgets. Similarly, PhilHealth reimbursements for drugs through case rates become additional capital for facility investments (through the GAA provision previously mentioned), rather than reducing the reliance of facilities on state budget for procurement of drugs. The failure to implement the strategy as intended may be leading to higher financial flows to providers and little increase in financial protection for patients.

The DOH continues to intervene strongly in capital investment and the procurement of materials and drugs for preventive programs, rather than supporting the devolution of public health functions. It may be easier to do things this way in the short run, but it does not serve the longer-term goals of increased responsiveness of LGUs to meeting the needs and demands of their constituencies as intended by the Local Government Code of 1991. The DOH could play a stronger role in monitoring and supervision, master planning, and setting and enforcing standards, rather than direct procurement or provision. Arguments for the DOH to take over the responsibility for COs in LGU facilities have some merit to ensure uniform access to care across localities.

Allocative efficiency requires not only reforms to reduce fragmentation and duplication, such as through the measures laid out in Pillar 3, but also that strategic direction be given as to how to define the package of services to be paid by the government and PhilHealth. Pillar 3 of the HFS implied that by choosing the appropriate purchasing agent for each type of service, appropriate choices would be made about what to purchase. However, it does not provide any direction as to how to define the benefit packages that will be provided by different purchasing agents. With the PhilHealth benefit package focused on inpatient care, there is little incentive for patients to seek care early or to use primary care services to reduce the need for costly inpatient care. Within inpatient care, there are no clear guidelines as to how to select the diseases that should be covered by the Z-benefits package. The general direction that the state budget should fund capital investments and preventive care is inadequately detailed to ensure complementarity with the PhilHealth benefit package, particularly when different entitlement groups benefit from different benefit packages.

4. Progress on pillar 4: shift to new provider payment mechanisms

Pillar 4 in the HFS focuses on the provider payment mechanisms used by PhilHealth and how these payment mechanisms can incentivize provider behavior and, in so doing, improve technical efficiency. The payment mechanisms mentioned in this strategic pillar consist of PhilHealth case rate payments for inpatient care and specialist ambulatory care, capitation payments for outpatient care, and payment for outpatient drugs. The HFS argued that PhilHealth has substantial advantages over the DOH and the LGUs in purchasing health services in a way that can enhance technical efficiency. This may be the reason the HFS did not provide any strategic direction for the payment mechanisms used by the DOH and the LGUs, such as on the implementation of the performance-based budgeting system that was started in 2005.

The HFS made the case for provider payment reform by stressing the need to overcome the shortcomings of the FFS payment mechanism (that was being used by PhilHealth at the time) and reduce OOP payments by patients. The HFS identifies a number of problems associated with FFS and line-item budget provider payment mechanisms, including the lack of performance targets for the quantity and quality of services provided and lack of incentives for providers to increase technical efficiency in service provision. Most importantly, the HFS points out that patients shoulder high costs through their responsibility to pay for any excess costs charged by hospitals but not paid by PhilHealth. The HFS called for provider payment reforms that gradually eliminate FFS payment for PhilHealth benefit packages and the adoption of new payment mechanisms that achieve multiple goals, including enhancing financial protection and cost containment; promoting fairer risk-sharing among contributors, financing agents, and providers; minimizing administrative costs; and promoting good quality of care. In addition, the new payment mechanisms are intended to consider patient's choice of provider, portability of services, and reliability of information systems.

The HFS also pointed out that PhilHealth would need to restructure its core processes to implement the envisaged payment reforms. For all new provider payment mechanisms, PhilHealth would need to establish formal relationships with providers through contracts containing specific details about the quantity and quality of services and payment terms. Restructuring of core processes would include the introduction of computerized payment mechanisms and post-audits. A shift in organizational culture toward setting and meeting targets, as well as setting and honoring the obligations and rights of different parties, would also be needed.

The fourth pillar outlines the following envisioned reforms to PhilHealth payment arrangements. For outpatient care, there would be a shift from paying by capitation (in the form of a 'per family' payment) for the care for indigent members toward capitation payments that cover a broader package of primary care and are extended to all Filipinos by 2020 (Table 2). In addition, by 2020, PhilHealth is supposed to pay for all outpatient drugs. For inpatient care, there was supposed to be a gradual shift from FFS payments to diagnostic-related groups (DRGs) by 2016, and then to per case payments in a case-mix system by 2020. We understand that the 'case-mix system' is what PhilHealth refers to as ACRs. The MCP and specific outpatient medical and surgical procedures referred to in Table 2 were already paid on a per case basis before 2010, and the HFS envisaged that they would be incorporated into the overall case-mix system by 2020. The meaning of the intermediate DRG mechanism is unclear, but it seems that it involves reimbursement for the bundled cost of diagnosis and treatment for a limited number of diagnostic groups with a similar level of resource use, rather than for the full set of medical conditions implied under a case-mix system. The HFS specifies that case rates would be used for preferred providers, implying that FFS payments (which provide less financial protection to patients) would be applied when care is obtained at non-preferred providers. However, the meaning and significance of preferred providers is not clear because there is no gatekeeping role in the system, and PhilHealth does not have special preferred provider arrangements. The fourth pillar of the HFS

also indicates rapid growth in the contribution of PhilHealth to total health expenditures from PHP 22 billion in 2010 to PHP 40 billion by 2016 to as high as PHP 162–234 billion in 2020. This growth would stem from the expansion of coverage for outpatient care from sponsored (indigent) members and dependents to all Filipinos, as well as expansion of the outpatient benefits to cover a full primary care package and outpatient drugs.

Table 2. HFS vision of shift to new provider payment mechanisms, 2010, 2016, and 2020

	2010	2016	2020
Outpatient care	Capitation for sponsored program beneficiaries	Capitation for sponsored program beneficiaries	Capitation for all Filipinos for primary health care services; PhilHealth pays for outpatient drugs
Inpatient care	FFS	DRGs	Per case payment under case-mix system
Specialist care	Per case payments for MCP and selected medical and surgical procedures	Per case payment for case-mix system for preferred providers	
PhilHealth spending	PHP 22 billion	PHP 40 billion	PHP 162–234 billion

While the fourth pillar does not describe any reforms in the way that the DOH pays for services, it does lay out the ways that the DOH is expected to support the implementation of pillar 4 reforms. The DOH's role would be to assist the LGUs in the preparation of their PIPHs, which form the basis of the budget allocation to health and other sectors.[36] The DOH should also use performance-based grants to provide additional resources to poor provinces, encourage fast processing of benefit payments, and conduct information drives to build awareness and understanding of the new provider payment mechanisms. The strategy also states that LGUs should support the implementation of contracts between PhilHealth and LGU-owned primary and secondary facilities, using the new provider payment mechanisms.

4.1 Case rate payment mechanism

Development of the case rate policy

The HFS recognizes that the attainment of UHC and patient financial protection requires improvements in technical efficiency, that is, achieving more with existing resources, and envisaged that this could be achieved by having PhilHealth shift from FFS to case rate payments. Under FFS payments, despite some medical auditing and utilization reviews, it was very difficult to control overprovision by providers due to information asymmetries and provider resistance to PhilHealth interference in clinical decision making. Consequently, the HFS considered it imperative to shift from FFS to case rates to create incentives for efficiency and quality and reduce turnaround time for payments.

The underlying theory of case rates is that when a hard budget constraint is imposed on the provider for a given case type, the provider/facility will have an incentive to reduce costs, which then aligns their incentives with that of the purchaser and the patient. The budget constraint differs across diagnoses (case types) based on the average costs of treating a particular diagnosis, but it is set in advance for a given diagnosis (case type). The uncertainty in costs—due to differences in the severity of disease across patients as well as variation in patient response to treatment within a diagnostic group—will average out across all patients with a particular diagnosis. Patients whose care costs more than the case rate will be balanced by patients whose care costs less than the case rate. Consequently, on average, despite variation in case severity and treatment response, the facility can keep its costs

below the case rate reimbursement levels. Providers maintain their clinical autonomy when it comes to service provision, but the payment mechanism creates an incentive to avoid overprovision of (unnecessary) services.

Experimentation with case-based payments began in 2003 with maternity care. In the Philippines, there is a high demand for maternity and newborn care services (and associated financial protection mechanisms) due to an estimated 2.3 million births each year,[37] of which 62 percent are institutional deliveries. Starting in 2003, PhilHealth introduced a bundled payment rate for the MCP at accredited nonhospital facilities and NSD in hospital settings. In 2006, a case rate for a newborn care package was added. These packages helped move normal delivery out of the hospital setting, freeing up hospital resources for more complicated deliveries requiring C-section or other specialized interventions.

Case rates were subsequently introduced for various outpatient packages, followed by an additional 23 medical conditions and procedures (some inpatient and some ambulatory), and then scaled up to the ACR policy. The outpatient case rates were for outpatient HIV/AIDS treatment, animal bites, malaria and TB-DOTS, chemotherapy, hemodialysis, outpatient blood transfusion per session, and some types of ambulatory surgery (such as cataracts). In 2011, case rates were introduced for 23 inpatient medical conditions and procedures and, very quickly thereafter, scaled up to ACRs in 2013. Circular 31 (2013) pertaining to the introduction of ACRs states clearly that their 'objective is to reduce the OOP expenditures of patient-members'. The evolution of what is covered by case rates is presented in Table A.6 in the Annex.

Case rates were instrumental in shifting care from inpatient to ambulatory care facilities for some specialized services, thus helping to increase the efficiency of the health system. Initially, PhilHealth only covered inpatient care, which created incentives for providers to admit patients to hospital for care that could be provided on an ambulatory care basis. The shift to case rates for certain outpatient procedures and for the maternal and newborn packages expanded the range of facilities people could use and still benefit from PhilHealth reimbursements. The benefit to the health system was the reduced burden on inpatient facilities and greater efficiency by avoiding unnecessary hospital care. In 2013, PhilHealth further increased access to services by identifying benefit packages, procedures, and medical conditions previously only covered when provided in hospital settings but which would become compensable at primary care facilities as long as the facility had met a set of specified requirements. In addition, reimbursement of hemodialysis and chemotherapy services was also expanded to facilities based on their ability to provide the services (PhilHealth Circular 21, s-2013), regardless of whether they were hospital or ambulatory facilities. However, to protect patient safety, Circular 35-2013 indicates clearly that more sophisticated procedures are still only allowed to be provided by higher-level hospitals. In 2014, a consolidated list was issued clarifying exactly which services are compensable through case rates at primary care facilities with inpatient beds, with special provision for facilities in geographically isolated and disadvantaged areas and those with a shortage of health workers (PhilHealth Circular 25-2014).

The Z-benefit packages are also paid on a case rate basis, with some differences compared to the general case rates, including detailed description of the mandatory and potential intervention components and a cap on patient co-payments. These Z-benefit packages reflect a strategic approach to financing catastrophic illnesses through identifying cost-effective mandatory services that follow approved treatment guidelines, protocols, and clinical pathways, which are necessary to achieve optimal outcomes for patients, thus eliminating the high variation in clinical care that patients would otherwise have obtained. Facilities providing Z-benefits must be accredited for each package to ensure that they are sufficiently qualified to provide specialized care for these relatively rare and difficult-to-treat conditions. For prostate and breast cancer, the Z-benefits packages incentivize early detection by including early stage, but not late stage, cancers in the package. On average in 2016, the

reimbursement per claim for Z-benefits was high, amounting to PHP 331,500, compared to just PHP 11,300 per hospital inpatient claim. However, reimbursements for Z-benefits constitute a small share of all PhilHealth reimbursements—about 0.5 percent of total PhilHealth benefit payments (by value) with only 1,573 claims, but this share is up from 0.4 percent of total benefit payments and 754 claims in 2014.[38]

Shortcomings of the current case rate payment mechanism

The effectiveness of the Philippines' case rates in achieving technical efficiency and financial protection is seriously undermined by allowing facilities to charge the patient for the difference between hospital charges and the PhilHealth case rates. The implementation of the Philippines' case rate payment policy is such that hospitals continue to charge patients on a FFS basis for each service item provided, with the various fees listed on the patient's bill. The provider then subtracts the PhilHealth case rate payment (for the patient's diagnosis of procedure case type) from the bill and charges the patient the balance (that is, balance billing). In other words, providers do not face the hard budget constraint that would induce them to take the measures needed to reduce costs and improve technical efficiency and the effectiveness of care. Case rates, as implemented in the Philippines, are not the same as the typical case rates of provider payment theory and, thus, fail to create the incentives that case rate theory predicts. PhilHealth Circular 11 of 2011 touts the advantages of case rates as being simpler to administer than FFS, having a more transparent pricing structure than FFS, allowing members to better predict how much PhilHealth will pay for services provided, and having a faster turnaround time for claims processing and reimbursement—which, in turn, would be more cost-efficient for PhilHealth, accredited providers, and members. However, the two most important expected effects of a (theoretical) case rate policy, namely inducing providers to become more technically efficient and ensuring protection of patients from financial risks when seeking care, are not mentioned and indeed, given the way that the case rate policy is designed, these cannot be achieved.

Allowing hospitals to balance bill was a policy compromise that resulted because case rates were implemented in a context where data to set rates appropriately was missing and convincing hospitals to accept the risks associated with a new payment mechanism was difficult. In general, the level at which case rates are set must be adequate to cover the costs of providing care, on average, across health facilities and patients. However, the database used to set the case rates may have led to underestimates of full cost recovery levels because it covered only previous PhilHealth reimbursements of charges, not necessarily the full cost of providing care. In addition, because public facilities receive subsidies for personnel, operating costs, and COs, the average reimbursements among public and private facilities in the PhilHealth database are likely to underestimate average full costs, particularly for unsubsidized private facilities. The process of developing ACRs has also been criticized for lacking transparency and external (peer) review of the methodology and data (Dalmacion, Juban, and Zordilla 2016). Little time was allocated for the transition from FFS to ACR to allow hospitals to reduce variation in treatment protocols for the same diagnosis. As a result, PhilHealth had difficulty defending the adequacy of these case rates for full cost recovery. That said, an external assessment of the adequacy of 23 case rates found that cost recovery was generally high in the LGU hospitals and for the medical case rates in general, although somewhat lower in the DOH-retained facilities and for procedural case rates (World Bank 2012). PhilHealth no longer gathers the detailed resource utilization data they had under FFS, making it difficult to defend adequacy of rates or to make appropriate adjustments on a routine basis. There is also a need for greater transparency in the process of standardizing protocols, costing, and case rate setting to get facilities to buy into this new payment mechanism and eliminate balance billing. Further research should also assess differential costs when controlling for case-mix severity at different types of facilities to see if adjustments are needed in terms of a finer granulation of diagnostic groups or whether assistance

needs to focus more on helping higher-level hospitals to provide more efficient care through standardized protocols.

To better protect the poor, the case rate policy was accompanied by a NBB policy which, despite some success, has in general been poorly enforced. The NBB policy was initiated in 2010 (by PhilHealth Board Resolution 1441) and applied to all indigent and sponsored members for all conditions. It was also later expanded to lifetime and senior members. According to the NBB policy, no other fees or expenses shall be charged or paid for by the eligible patient-member above and beyond the PhilHealth case rates when seeking care in public facilities. Although 31 percent of PhilHealth claims were made by indigent or sponsored members in 2016, it is likely that far fewer people actually benefited from the NBB policy, not only because the NBB only applies in public wards (and not private rooms) in public facilities, but also because not all facilities comply. While laudable in principle, in practice, the NBB policy is problematic in a number of ways. First, because of ambiguity about whether ACR payment rates are adequate to cover reasonable average service charges for each diagnosis, facilities continue to charge above the ACR rates, then seek supplementary sources of funding to cover the difference. Interviews with hospital staff indicate that facilities do try to recover at least some of these costs through funds from the MAP, but often rely on balance billing to make up the difference. Second, there is a risk that facilities may cut back on services to indigent/sponsored members to stay within the case rate amount but continue to overprovide services to non-sponsored members, leading to real or perceived reductions in quality of care and only partial effects on efficiency enhancement. Third, the enforcement of the NBB policy has been weak. An evaluation of the NBB policy implementation in 2012 showed that 76 percent to 87 percent of patients eligible for the NBB policy were still making OOP payments (Mijares-Majini 2012), so even sponsored patients often have to pay additional charges. The main reason for this was the non-availability of medicines, consumables, and services in the inpatient facilities; lack of arrangements for external subcontracting of these services; and no penalties for noncompliance with this policy (Punsalan et al. 2012). More recent data from PhilHealth in 2016 indicate that the extent of balance billing has subsequently fallen, but is still substantial with 37 percent of eligible sponsored patient claims made still involving OOP payments (PhilHealth 2017b). Fourth, non-sponsored patients continue to face substantial financial risk when seeking care because they are still charged the balance between full charges and the PhilHealth case rates, which is not a predictable or fixed amount.

The PhilHealth case rate policy is still largely misunderstood by a number of key stakeholders, including national audit authorities. After the case rates were applied, a misunderstanding of the policy by the COA resulted in an observation (flag) in the 2012 audit. The COA observed that the fact that the PhilHealth case rate system allowed institutional health care providers to be reimbursed the full amount of the case rates regardless of actual charges defeated the intention of the policy (which was to save money). PhilHealth subsequently met with the COA to discuss the logic of case rate payments, explaining that overpayment for some cases is intended to balance the underpayment of other cases, especially when the NBB policy is applied. That said, the COA does have a point if one thinks about how PhilHealth implements case rates in practice: if hospitals are in practice fully reimbursed for the treatment/charges of more costly patients through a combination of PhilHealth and patient balance billing, why would one need surplus revenues from less severely ill patients whose case rates are higher than charges? Unless case rates operate as a hard budget ceiling (and the NBB policy is strictly applied), the PhilHealth case rate policy is effectively being implemented like an FFS system where patients get a discount equal to the case rate payment and providers are not incentivized toward efficiency goals.

Information requirements for maintaining and refining the case rate system and improving its effectiveness are substantial and may require additional data collection efforts. The data used to determine the ACR came from the PhilHealth claims database. However, because some items paid by patients were not included in the PhilHealth claims data, the rates may underestimate total charges

according to current practice. In some sense, the information requirements under the ACR system could be less than under the FFS system: in principle, an advantage of case rates is that PhilHealth does not need to gather information on hospital charges to make payments, only on diagnostic and procedure codes. This approach may also help reduce the current 'FFS mindset' that still pervades hospitals despite being paid on a case rate basis. Indeed, in many countries, case rate systems rely on hospital cost surveys to gather information on the full costs incurred by hospitals for different diagnoses rather than relying on detailed charge information provided by hospitals in making their claims. Post-audits will always remain essential, though, to detect fraudulent claims, particularly upcoding and unnecessary admissions.

PhilHealth mechanisms for holding providers accountable have shifted away from methods aimed at detecting and denying payment for over-servicing (which were appropriate under FFS), but they have not yet been replaced by alternative mechanisms that effectively deal with the new incentives created under an ACR system. Under FFS payments, PhilHealth, as a purchasing agency, had to tightly control expenditures through utilization review and claims auditing. When PhilHealth switched to case rate payments, it stopped doing detailed claims auditing of resource use for each case, because it was only liable for a fixed payment for a given case type. However, PhilHealth neglected to put in place adequate mechanisms to deal with predictable adverse behavior of providers for increasing the number of cases (as happened in the case of cataract surgery) and for upcoding (as happened in the case of pneumonia) or to nudge doctors toward compliance with evidence-based clinical protocols to improve quality of care. In addition, PhilHealth failed to put in place a cost control mechanism that would address the fact that the case rates with balance billing had essentially the same incentives for overprovision as FFS payments, leaving PhilHealth members vulnerable to high and unnecessary OOP payments.

The Governance Commission on GOCC (GCG) performance scorecard is intended to hold PhilHealth accountable, including with several indicators related to case rate payments, and scorecard performance has improved steadily over time. The 2013–2014 performance agreement between the GCG and PhilHealth included a performance target to reduce the turnaround time for good claims. The 2013 target of less than 40 days was successfully achieved. From 2014, the target was changed to less than 30 days and, although it has not yet been achieved, having this target adds substantial pressure to further reduce claims processing time. Emphasis on this measure may have led to an overemphasis on rapid claim processing (which is to the benefit of providers) while neglecting other performance areas not included in the scorecard, such as fraud detection and ensuring quality and effectiveness of care (which would be to the benefit of the patient). The percentage of DOH-licensed hospitals with PhilHealth engagement is another indicator, which was already substantially achieved by 2013 (96.2 percent), increasing further to 100 percent in 2015. The other performance target relevant to case rate payments is to increase the share of all sponsored program claims that apply the NBB policy to 70 percent or higher. Performance was measured and found to be only at 51.1 percent in 2015, rising to 63 percent by 2016. PhilHealth has substantial (potential) leverage to enforce compliance of health care institutions with the NBB policy because noncompliance constitutes fraudulent behavior (Section 159 of Health Insurance Act 2013) and can be penalized with suspension of accreditation and fines. However, to the best of our knowledge, PhilHealth has never suspended accreditation for violations of the NBB policy, perhaps because it would adversely affect PhilHealth's performance (score) on hospital accreditation. According to the 2016 performance agreement summary, the 2016 NBB performance target is being renegotiated due to changes in some related policies and difficulties that facilities face in ensuring an adequate supply of pharmaceuticals.

The lack of evidence-based treatment guidelines for most case rates (including many of those with the most frequent claims) means that the PhilHealth case rates cannot reach their potential as a mechanism for improving and standardizing quality of care, promoting evidence-based medicine, and controlling pharmaceutical use and spending. Most claims are for inpatient conditions, many of

which do not yet have evidence-based treatment guidelines approved by medical societies or the DOH. PhilHealth Circular 35-2013 states that PhilHealth-accredited health care providers should use the Clinical Practice Guidelines (CPG) adopted by societies and the DOH, or provided by the WHO, or if not available, 'currently accepted standards of care', to support their diagnosis and management. However, there is no clearinghouse of all current clinical guidelines, most of the societies' websites do not have clinical guidelines posted, and, for those that do, the sets of clinical guidelines are typically incomplete (missing important medical conditions). This makes it difficult for the DOH or PhilHealth to implement its quality assurance function of checking compliance with clinical guidelines. It also hinders PhilHealth's ability to define the benefit package guided by cost-effectiveness analysis and health technology assessment, as mandated by Health Insurance Act 2013. Consequently, there is a wide variation across facilities in diagnostic and treatment practices (that is, the concrete package of services provided) and hospital charges for the same diagnostic group. Previous technical reviews provide evidence of inappropriate clinical management of some diseases and nonadherence to clinical guidelines (Mijares-Majini 2012).

PhilHealth, as a major purchaser of inpatient services, has the potential to reduce pharmaceutical spending (including OOP pharmaceutical spending), but current provider payment arrangements fail to realize this potential. The Health Insurance Act 1995 stipulates that drugs for which payments will be made shall be those included in the Philippines National Drug Formulary (PNDF)—a measure which should limit prescribing to essential drugs. However, physicians may still prescribe drugs outside of the PNDF and require patients to pay for them out of pocket. Another circumstance in which patient spending on medicines which should be covered by PhilHealth arises is when physicians prescribe drugs within the PNDF, but for various reasons, the LGU Procurement Unit has not yet obtained the necessary drugs (resulting in stock-outs at hospitals), forcing patients to purchase drugs outside the facility. Finally, because physicians still face FFS-type incentives under the ACR policy (in that they can bill patients for any balance not covered by PhilHealth), they are motivated to prescribe unnecessary and expensive drugs; prescribing these drugs comes at no cost to the physician or facility, and it takes less effort to overprescribe than to determine precisely what the patient needs. At least under the FFS mechanism, PhilHealth undertook medical reviews to examine the appropriateness of services and drugs given to patients because they were liable to pay for those costs. Under ACR, however, PhilHealth imposes few controls over pharmaceuticals used for inpatient care because the payment of a fixed case rate means that the entire risk of overprescribing is then borne by the patient, not PhilHealth. The DOH and the LGUs provide little regulatory oversight to physician prescribing practices. Taken together, these measures (or lack thereof) create an incentive structure that does little to control medicines spending and puts patients at increased risk of OOP spending.

Case rate payments implementation: have HFS and health system goals been achieved?

The cost containment goal of case rates is unlikely to have been met. A 2012 evaluation based on the PhilHealth claims database found that the average hospitalization cost increased after the implementation of 23 case rates (Mijares-Majini 2012). The good news is that it found only a few instances of upcoding and non-compensable claims. However, average length of stay did not decline, possibly indicating a failure of measures to improve efficiency. Cost recovery at hospitals appeared to remain high, often over 100 percent. Overall, between 2010 and 2016, PhilHealth reimbursements increased from PHP 30 billion to PHP 102 billion, exceeding the 2016 HFS target by 2.5 times. Taking into consideration the increase in the share of the population covered by health insurance, the value of PhilHealth reimbursement per estimated beneficiary increased 250 percent (in current price terms), from PHP 436 to PHP 1,089, over that period (PhilHealth 2011, 2017b). If PhilHealth payments were replacing household OOP spending, this might have been acceptable, but from 2011 to 2016, household OOP spending actually increased 140 percent in current prices (although this constituted a 4 percentage point decline in OOP share of total health expenditure).[39] This suggests that health care costs have not really been controlled.

The goal of promoting fairer risk-sharing among contributors, financing agents, and providers has not been achieved. PhilHealth faces low risk because the payments (case rates) are fixed. Providers face low risk because they can still charge what they want; after receiving payment from PhilHealth, they can bill the balance to patients—even sponsored patients because there seems to be no consequence of failing to adhere to the NBB policy. Patients continue to bear the financial risk of health care seeking, particularly the patient groups that are not covered by the NBB policy.

The goal that has been most successfully achieved by the case rate payment reform was reducing turnaround time for payments. Turnaround time was substantially shortened after the case rate policy was implemented (Dalmacion, Juban, and Zordilla 2016; Mijares-Majini 2012). This administrative advantage of case rates was one of the motivations for the rapid switch from 23 case rates to ACR. However, this advantage of case rates also has a downside. The improvement in turnaround time was achieved in large part because the medical evaluation of claims that had been done under the FFS system was halted. It also came at the expense of the amount of information collected on services that are provided to patients—information that could have been useful for assessing quality of care or inappropriate patterns of service provision. Reductions in turnaround time benefit hospitals and other providers but provide little benefit to patients who, are after all, are the main clients of PhilHealth.

4.2 Capitation payment mechanism

Development and features of the policy

PhilHealth has built on its original OPB that focused on five basic diagnostic tests to develop a more comprehensive PCB package. The latest version of the primary care package is named *Tsekap*. In developing the *Tsekap* primary care package in 2014 (see Annex, Table A.2), PhilHealth aimed to cover diseases accounting for a high share of all inpatient medical claims, including community-acquired pneumonia (10 percent of all inpatient benefits paid); gastroenteritis, gastritis, and urinary tract infections (4 percent of all benefits paid); dengue fever (2 percent of all benefits paid); and hypertension and asthma (2.5 percent of all benefits paid) (PhilHealth 2016a). The package includes primary preventive services, diagnostic examinations, and drugs that can easily be provided by the RHUs and other primary care outpatient facilities. It also includes cancer screening (breast and cervical) to aid in early detection of cancer, which could reduce spending under the Z-benefit packages. Services for the diagnosis and management of diabetes and hypertension services (Philippine Package of Essential Non-Communicable Disease Interventions [PhilPEN])[40] are included and adapted from the WHO guidelines for managing NCDs in low-resource settings. Outpatient drug benefits were an important extension of the package in line with the HFS pillar 4, including essential drugs for the treatment of asthma, diabetes, hypertension, dyslipidemia, and ischemic heart disease, in addition to the drugs for treating infectious diseases that have been included in the package since 2012. Nutrition is included in the form of breastfeeding education, weight monitoring, and deworming.

The capitation payment for the comprehensive PCB package provides an important complement to the LGU health budgets. The original OPB in 2000 involved a payment of PHP 300 per household to the LGU for a fairly limited package of services. When the service package was expanded in 2012, the capitation payment was increased to PHP 500 and was paid per family rather than per household. This payment amount was later increased to a 'potential' PHP 600 per family, but the receipt of the additional PHP 100 was contingent on the facility doing patient profiling.[41] With the considerable expansion of services to the more comprehensive *Tsekap* package in 2015, the capitation payment increased to a 'potential' PHP 800 per family, with an additional allowance of up to PHP 1,000 per family for outpatient drugs (PhilHealth Circular 002-2015).[42] The term 'potential' is used to indicate

that the amount is the maximum that the facility could obtain, but that part of the payment is conditional—as part of a move toward increased use of performance-based incentives.

The design of PhilHealth's primary care capitation payments for a PCB package reduces the financial risk of primary care facilities. The capitation payments are called 'per family payments' because they consist of a fixed amount per family rather than per individual. This design does not impose much of a financial risk to the PCB provider/facility; the only financial risk to facilities relates to the cost of reagents and other materials used in diagnostic tests and procedures, which is a small portion of the total per family payment amount. The 'per family' payment structure does pose a workload risk, though: larger families or more severely ill patients will take up more staff time than smaller families and healthier individuals.

The blended payment design, consisting of a fixed payment per family and additional payments for performance, is theoretically well grounded. It is a well-known theoretical finding that capitation payments do not incentivize the provider to increase effort to provide essential (and especially preventive) services, which is why theory recommends that capitation payments be blended with performance-based payments to reduce the risk of under-provision or skimping on quality (Robinson 2001). Performance-based payment has been applied or considered for several aspects of the PCB package. In the PCB1 package, performance payments were used to incentivize patient profiling and electronic submission of performance reports. In the *Tsekap* package, they would incentivize provision of a set of so-called 'obligated' services, such as annual blood pressure measurement of adults without history of hypertension and monthly blood pressure monitoring of people with hypertension. A nationwide five-year randomized experiment is currently ongoing to evaluate the effectiveness of tying financial incentives to the delivery of four primary care services and to the quality of health service delivery at the RHUs.[43]

The payment arrangement for outpatient drugs under *Tsekap* involves PhilHealth reimbursement of accredited drug dispensers who are independent of prescribers. This arrangement is in line with the recommended practice that the prescription and dispensing functions should be separated to avoid conflicts of interest where providers would financially benefit from over- or under-prescribing of drugs. Under the structure of the PCB1 primary care package, PCB providers would have had an incentive to prescribe fewer drugs because it would lower their costs. De facto, though, the way that PCB1 was implemented—with many drugs supplied free to RHUs through the ComPack program of the DOH—this incentive was not as strong as it would otherwise have been. To date, the new arrangement, which separates the prescribing and dispensing of outpatient drugs, has not yet been widely implemented (due to the suspension of the implementation of *Tsekap*), but was tested in a small pilot called PCB2.

Shortcomings of the current capitation payment mechanism

The main shortcoming of the PhilHealth capitation payment for primary care is not at the policy level, but at the implementation level: the comprehensive primary care package (*Tsekap*) has not yet been implemented. The reason why the implementation was suspended is not mentioned in the PhilHealth advisory ordering the suspension of implementation. The reason(s) remains unclear. Among the hypotheses are (a) low readiness of the electronic information systems for monitoring performance, (b) disputes about the feasibility and costs of implementing independent dispensing of pharmaceuticals, and (c) concerns that the costs would be too high (at PHP 1,800 per eligible family).

At the policy level, the main shortcoming is that the PCB (and the more comprehensive *Tsekap*), as designed, is limited to indigent and sponsored members rather than available to all Filipinos. The opportunity cost of further delays in implementing the policy for all PhilHealth members is huge: many Filipinos will not be able to obtain essential preventive and primary care services because they cannot

afford them, do not know what services they need, or prefer to use private facilities that do not get reimbursed for this package. Additional opportunity costs stem from families pulled into poverty due to the high costs of purchasing drugs (which would potentially be covered by *Tsekap*) for chronic diseases. Overall health system efficiency is also negatively affected because PhilHealth pays for inpatient but not outpatient care, which distorts patient demand toward unnecessary inpatient care (paid by PhilHealth) rather than more appropriate outpatient care (paid out of pocket by patients).

Another shortcoming is the risk that the LGU trust fund arrangements, whereby incentive payments are paid into an LGU trust fund rather than directly to the facility, mean that the well-designed incentive payments in the PCB policy will not have the hoped-for impact on facility and health worker performance. If the incentive payments for profiling patients are paid to the LGU trust fund, but facilities can only draw from this trust fund using the purchase order mechanism (which is time-consuming and also requires LGU approval), facility staff may see little advantage to putting in the extra effort to profile patients. If per family payments are to be used to reward extra effort or performance, or to improve working conditions, facilities and workers need to be able to access them easily.

The PCB (and *Tsekap*) packages have the potential to introduce a gatekeeping function into the Philippine health system, but the policy does not yet go far enough in this regard. Having a primary care facility that can provide basic services and help guide people toward the most appropriate higher-level institution to seek care and provide appropriate follow-up care after discharge from hospital or to manage chronic illness is an important function in an efficient and integrated health system. While the HFS mentioned this function, it did not lay out a specific strategy for this. The 1995 and 2013 Health Insurance Acts emphasize free choice of providers among accredited health care providers and portability of benefits (defined as enabling members to avail of program benefits in an area outside the jurisdiction of his/her Local Health Insurance Office). However, the Act also stated that this choice would be subject to some limitations based on the area of jurisdiction of the regional PhilHealth office and on the appropriateness of treatment in the facility or provider chosen. Strengthening the gatekeeping function and the referral network should become important roles of the PCB provider and should be used more effectively to achieve improvements in the appropriateness and efficiency of health care seeking.

Low numbers of accredited primary care facilities in some areas may prevent PhilHealth members from accessing benefits, while restricting the package to government facilities may limit utilization of the package even if it is expanded to cover all members. While statistics indicate that 97 percent of the LGUs have at least one PCB provider, there are still 56 LGUs without any PCB-accredited provider and some LGUs are quite large and may need more than one. If the PCB eligibility is extended to all members, as recommended in the HFS for 2020, many will not use the benefits if they must switch from their usual private health care provider. The original design of *Tsekap* included accreditation of both public and private facilities, but the private option was not included in the final circular. Obviously, the main priority is to ensure access to effective health services and financial protection among the poor, but ensuring that the entire population obtains appropriate preventive, promotive, and basic primary care services is important. This could be facilitated by the inclusion of private providers, who serve not only better-off Filipinos but also poorer Filipinos, as PCB-accredited providers.

Logistical difficulties may inhibit the implementation of an expanded outpatient drug package (as intended by the *Tsekap* package), but it is not clear that the alternative of making drugs available through vertical programs is a better solution. Physical and financial access to essential drugs, especially for people with chronic NCDs, is important not only for population health but also for financial protection. As previously noted, pharmaceuticals account for around two-thirds of OOP payments. While the DOH has made substantial efforts to make drugs available through the medicines

access programs, the fundamental problem with that approach is that the drugs are not part of an integrated package of care, including doctors who can reassure patients of the effectiveness of generic drugs (see next paragraph). The current arrangement of PhilHealth paying for services under the PCB package, while the PCB providers dispense drugs subsidized by the DOH for free, lacks sustainability and integration, and (as has been shown) the funding flows remain unclear. At the same time, the arrangement designed in *Tsekap* may not work in all localities due to difficulties in ensuring that accredited dispensing units are available.

No matter what arrangements for drug purchasing and provision are used, unless patients and medical personnel can be convinced of the quality of generic drugs, most solutions for cost-effective outpatient drug packages will fail to achieve objectives. In general, households lack information about which drugs to use and what prices they should pay, and they tend to use the more expensive branded drugs despite wide availability of good-quality generics. The Cheaper and Quality Medicines Act (2007) tried to shift consumption patterns toward cheaper generic drugs by, among other things, requiring that physicians write prescriptions using generic names and imposing financial penalties if physicians did not comply. In fact, compliance with these provisions of the act is quite good: a 2008 study found that nearly 84 percent of prescriptions included the generic name of the drugs (Wong et al. 2016). Nevertheless, there remains a lack of trust among patients and also among doctors (who exert a big influence on patient trust [Wong et al. 2016]) in the effectiveness and quality of cheaper generic alternatives, as well as ignorance of the right to generic substitution. Pharmaceutical marketing also strongly influences patient perceptions of quality and effectiveness of drugs, and people may not be aware that cheaper drugs may be just as effective.

Capitation payment implementation: has the HFS goal been achieved?

Goals of cost containment and productive efficiency (Palmer and Torgerson 1999) goals are unlikely to have been achieved given the design and implementation of capitation payments to date. The HFS had highlighted two risks to achieving the cost containment or efficiency enhancement goals through capitation, and these have only been partially mitigated in implementation. First, the HFS suggested that while capitation would be beneficial to PhilHealth cost containment and makes planning easier, weaknesses in monitoring would make it difficult to know whether services were actually being provided. While PhilHealth has put substantial effort into strengthening electronic medical reporting (EMR) by LGUs as part of the implementation of performance-based incentives, at the time of writing, it had only been tested in one municipality, with subsequent adjustments to the EMR design, and it is difficult to know how well this will work at scale. Without improvements to monitoring, however, PhilHealth will not know accurately how many health services it is buying for its capitation payments and for whom. Second, for capitation to work to achieve cost containment at the facility level, the incentives must be passed on directly to the health care facility and staff. However, the LGU trust fund arrangement still involves PhilHealth paying into the LGU trust fund (based on reports of performance) and the facility having to access resources from the trust fund through purchase orders for the supplies or services it needs to provide services. The ability for this arrangement to reward providers, who achieve savings from cost containment or who increase effort to provide a greater quantity and more effective services to patients, is limited.

On the other hand, allocative efficiency, stemming from the expansion of primary and preventive care to prevent and manage disease and avoid acute episodes, may have improved—although, this has not yet been assessed. Ideally one would want to examine whether the PCB package has helped to increase the rate of NCD detection and management or early treatment among the population and also to assess whether the greater access to primary care has led to reduced inpatient admissions. So far, however, no such evaluations have been attempted.

Equity in health financing—at least in terms of increasing the share of PhilHealth resources spent on indigent and sponsored members—has improved, although it does not appear to have translated into increased equity in financing (or utilization) at the primary care level. The fact that the PCB capitation package is implemented only for indigent and sponsored members is a pro-poor financing strategy. NHA data show an increase in the share of PhilHealth benefits enjoyed by the poorest quintile between 2012 and 2013 (reaching 31 percent in 2013) (Racelis et al. 2016), while PhilHealth data show an increase in the share of claims accruing to indigent and sponsored members from 22 percent in 2010 to 30 percent in 2016 (Kaiser, Bredenkamp, and Iglesias 2016), but primary care specific information is not available. However, the GCG scorecard indicates low performance on enlistment and profiling of the National Household Targeting System for Poverty Reduction (NHTS-PR) families. In 2013, only 57 percent of assigned NHTS-PR members had been enlisted, that is, made contact with local health workers and visited their PCB facilities. In 2014, performance fell to only 51 percent on enlistment among assigned NHTS-PR families. This indicator was subsequently dropped. In 2014, the GCG added a new indicator, namely the utilization rate of the PCB package. The baseline for this indicator in 2013 indicated that 69.6 percent of families assigned to PCB providers had been profiled (as a proxy for utilization); however, performance fell substantially in 2014 to only 41.25 percent. In 2015, this performance indicator was not assessed. By the fourth quarter of 2016, the GCG scorecard for PhilHealth indicated that performance had still not improved, with only 40.25 percent of NHTS-PR beneficiaries assigned to a PCB provider having been profiled, compared to the target of 85 percent.

It is also not known whether the PCB package has helped narrow inequalities in health financing across LGUs. It is difficult to assess whether PhilHealth capitation payments have helped reduce disparities across LGUs in health resources because this information is not aggregated at the national level. What we do know is that since capitation payments can only be made to accredited facilities and only for indigent and sponsored members, LGUs with a high share of indigent and sponsored residents that do get their facilities accredited are likely to receive more financing for primary care from PhilHealth (through capitation) than better-off LGUs which would have fewer indigent residents. At the same time, if poorer LGUs are less likely to have accredited facilities, geographic inequalities in health financing would be exacerbated.[44]

It is reasonable to expect that OOP payments among indigents and sponsored members of PhilHealth have declined because they are covered by the PCB package and its associated drug benefits. While the 2013–2014 GCG interim scorecard does contain some information on the total number of families profiled out of the total enrolled, other standard sources of PhilHealth performance data—such as the semiannual PhilHealth Stats and Charts or the PhilHealth annual report—do not provide any information on the number of people enrolled, profiled, or benefiting from the PCB package. Even the amount of funds spent on the package are unknown. The overlap/duplication of the medicines covered by the DOH ComPack program and the PCB package also makes it difficult to know whether any reduction in OOP or increased access to drugs was a result of the DOH or PhilHealth programs.

The *Tsekap* package policy and its implementing guidelines are consistent with the goals of the HFS and the 2013 Health Insurance Act. The design of the *Tsekap* package is appropriate to help achieve the HFS goals of reducing OOP spending and improving the efficiency of the health system. If it can be effectively implemented—including expanding coverage of essential primary and preventive services to all PhilHealth members, improved and early detection of chronic diseases, and improving access to cost-effective generic drugs for NCD management—there is great potential for not only improving the health status of the population, but also for enhancing system efficiency and preventing cost escalation. Monitoring and evaluation, however, need to be strengthened substantially to ensure that the substantial resources spent on this program are used effectively and that Filipinos truly benefit from the package.

4.3 Cross-cutting issues in provider payment reform

Provider payment reforms do not take place in isolation, and they require supporting conditions to be effective. This section discusses some of the key measures that can support or hinder payment reforms. These include quality of care regulation to counter new incentives for under-provision, financial autonomy, price-setting for drugs and services, oversight by and of PhilHealth, and the role of government subsidies to facilities.

Quality of care

The assignment of responsibility for quality of care is fragmented across the DOH, PhilHealth, and LGUs—and both duplication of responsibility and gaps in responsibility exist. The 2013 Health Insurance Act assigned responsibility to PhilHealth for quality assurance of medical services. This includes responsibility for an accreditation process that not only ensures that health care professionals possess proper qualifications, but also works toward uniform health care standards nationwide and ensures that medical procedures are appropriate and the administration of drugs and medicines is consistent with generally accepted standards of medical practice and ethics. These responsibilities were operationalized through Circular 31 (2014) on the Health Care Provider Performance Assessment System, but many details have yet to be worked out. The Administrative Code (1987) assigns responsibility for standard setting, regulation and operation, and issuing of licenses and permits to the DOH. Within the DOH, the Quality Assurance and Monitoring Division of the Health Facilities and Services Regulatory Bureau is assigned the function of monitoring of licensed health facilities, evaluation of the status of DOH facilities in different regions, surveillance of unlicensed facilities, advocacy around quality improvement guidelines, and implementation of quality management systems.[45] The Regulatory Compliance and Enforcement Division of the same bureau is assigned the function of inspecting facilities to establish compliance with the technical requirements for licensing; issuing permits to construct, licenses to operate, and certificates of accreditation to health facilities; issuing clearances to the HMOs to operate; processing appeals regarding certificate of need for new hospitals; processing Securities and Exchange Commission endorsements; handling complaints against health facilities; and authenticating the medical examination of overseas Filipino workers (OFWs). At the LGU level, the Local Government Code stipulates that health officers should implement the relevant rules and regulations but does not mention a specific role in relation to quality assurance.

Licensing and accreditation may not be sufficient to ensure that patients receive quality care. Licensing and accreditation only ensure the potential for providing effective quality services. As such, it is a prerequisite for quality care but does not guarantee it. What is needed are systems for regular monitoring of processes of care, feedback about medical error, reporting and investigation of adverse medical events, regular reviews of patient records to assess the quality of care provided, learning from good and bad practices, and statistical analysis of patient-level clinical data to identify patterns of effective and ineffective care. This may require better collaboration between PhilHealth, the DOH, and LGU health authorities and hospitals.

Financial autonomy

Different government health facilities have different degrees of autonomy in how they can respond to the incentives inherent in these different payment modalities. A handful of government facilities have been corporatized or transformed into enterprises, such as the four GOCC hospitals under the DOH and the La Union Medical Center, which is under LGU governance. These corporate entities operate with a high degree of autonomy, with oversight from GCG. However, most DOH-retained and LGU facilities have substantial restrictions on their operational and financial autonomy. State budget spending on DOH and LGU facilities is largely input based, through the use of line-item budget allocations, with ceilings on expenditure on capital, operating costs, and PS. In addition, the Salary

Standardization Act requires that salaries be constrained within the civil servant pay scale, rather than responding to health worker labor market conditions. The 2013 Health Insurance Act allowed hospitals to retain income from PhilHealth payments, which are paid based on outputs. However, restrictions are still imposed on the discretionary use of this income: "Such revenues shall be used to primarily defray operating costs other than salaries, to maintain or upgrade equipment, plant, or facility and to maintain or improve the quality of service in the public sector." Enterprising directors find ways around the regulations, like using MOOE budget lines to hire contract staff and finding loopholes in the regulations to pay higher salaries.

The situation is particularly difficult for LGU-owned facilities (including LGU hospitals and outpatient facilities, such as RHUs) because LGU authorities directly control the disbursement of those funds. All funds (including those paid by PhilHealth into an LGU trust fund and OOP payment from households) are held by the LGU authorities. Facility directors must make purchase requests to the LGU to procure inputs, which can lead to delays, or even denials and shortages of inputs in the LGUs where the authorities do not prioritize health. Facilities complain that sometimes when they make purchase request for drugs or consumables, the LGU authorities supply only part of what is requested. Of course, it is likely that the opposite may also occur—facilities may request unreasonable items, but these requests are granted by local politicians due to lack of expertise in health. The current arrangement is very sensitive to the relationship between the health facility and the local chief executive, and the current oversight mechanisms do not prevent abuses or facilitate optimization. Institutions should be set up that are robust and not adversely affected by this relationship. In the LGU facilities, when LGU authorities do not ensure timely procurement of inputs, facility staff must ask patients to buy those items outside the hospital, adversely affecting financial protection. Drug procurement in the LGUs is performed by the LGU procurement agency, which is not specialized in pharmaceutical procurement, which has led to some problems in quality, expiration date, and high prices. The number of staff positions is capped by the plantilla system, while the ability to hire additional staff (including contractual staff) is restricted by spending caps on different budget lines items.

Continued state subsidies

The continued existence of state subsidies to hospitals reduces the financial pressure to improve efficiency and cost control that case rates are intended to exert on facilities. Subsidies from the budget provide a financial cushion to facilities being paid on a case rate basis because, if they cannot push costs below the case rate, they can still rely on state budgets, even for NBB patients. Continued state subsidies provide little incentive to increase effort or performance, although they can be an important financing mechanism to help ensure the availability of facilities (through providing budget for capital investments). However, because supply-side subsidies are paid whether services are provided or not, it is important to ask what health services are actually being purchased with those funds. Are these services that would not be paid by PhilHealth because the patient is not insured? Or would they not be paid because they are outside the benefit package? Or, are these subsidies potentially duplicating payments already being made by PhilHealth? These are important questions which, although beyond the scope of this assessment, should be investigated.

Price setting and regulation

Reasonable prices are needed throughout the system—both for patients who continue to pay a large share of health costs out of pocket and also for providers who need to procure inputs at a fair price to deliver services within their budgets. Drug prices are regulated by the Cheaper Medicines Act, which gave the DOH the authority to establish and initiate a price-monitoring and regulation system for drugs and medicines and to take any other measures necessary to control drug prices. These measures include direct government bulk procurement by the DOH as well as indirect measures

of control such as imposing maximum price ceilings on drugs procured by government entities and PhilHealth.[46] However, high and variable drug prices remain a barrier to drug access, particularly because the PhilHealth PCB package under implementation does not include outpatient drugs. Existing measures have not yet effectively controlled retail drug prices.

The charges for medical services vary across facilities for the treatment of the same disease or for the implementation of the same procedure in ways that do not necessarily reflect differences in underlying cost. Prices charged for medical services at government facilities are set locally by the LGU or by the board of the DOH-retained hospitals, while private medical service prices are completely unregulated. Variation in service charges may partly reflect variation in the underlying costs across facilities. However, much of the variation is due to differences in the number and type of services provided to patients for the same disease, high variation in drug procurement prices across localities, and the fact that charges also reflect different willingness and ability to pay in different localities rather than only differences in cost. This variation in existing facility prices also leads to differences in the extent to which different hospitals would find the uniform PhilHealth payment rates (particularly of ACRs)—that reimburse the same amount for treatment of the same disease at all facilities—acceptable. This practice stands in contrast to one of the key objectives of the move to case rates, which is to reduce the variation in medical care costs and standardize the medical services provided (that is, the protocol) for a given diagnosis. It would be acceptable, however, for private facilities (or even public facilities) to continue to charge additional amounts for nonmedical optional amenities not covered by PhilHealth case rates. However, the patient should know which costs are medically necessary and which are optional.

Oversight

Regardless of the payment mechanism used, oversight of PhilHealth purchasing is extremely important. Over one-third of the DOH's annual budget is transferred directly to PhilHealth to purchase health care for indigent members and senior citizens. The Secretary of Health, as both the one responsible for this transfer and Chairperson of the PhilHealth Board, is in a position to demand accountability for the use of these funds to care for the health of indigents and seniors. PhilHealth reports to the GCG regularly and to the public through its online Stats and Charts, on a large range of indicators, including on the implementation of the NBB policy and enlistment (utilization) of PCB by indigent beneficiaries.[47] The 2015 enhancement of PhilHealth's strategic performance management system added a number of more operational indicators, but external validation of indicators—such as PhilHealth coverage rates or components of OOP spending—using more objective data sources is not yet feasible due to limitations (measurement and timing) in the existing FIES, Annual Poverty Incidence Survey, and the DHS (Paterno 2013).

PhilHealth is also responsible for ensuring compliance with the provisions of the 2013 Health Insurance Act related to fraudulent acts. The regulations state very clearly what constitutes a violation of the Act by members, professionals, institutional providers, and even PhilHealth staff. PhilHealth has the responsibility to detect violations and can impose penalties, such as denying payment or revoking the accreditation of facilities. However, there are often long delays in detecting and resolving contentious claims, even though information systems and processes have been set up for these purposes. This suggests that these systems likely need to be strengthened.

5. Policy options

Building on the analysis in the previous chapters, this chapter presents some options that could potentially resolve the problems, ambiguities, and perverse incentives in the current health financing arrangements. The presentation of the options is structured around the existing pillars of the HFS, but the issues discussed within each pillar may extend beyond the scope of that pillar to other relevant areas of health financing where complementary action is needed.

5.1 Pillar 3: allocate resources according to the most appropriate financing agent

Main challenges

- Lack of clarity of responsibility for funding with significant duplicate payments
- Inefficient purchasing agents or purchasing arrangements
- Excessive OOP spending in the funding mix

General directions for HFS strategy pillar 3

- Obtain political consensus regarding which items should be paid by patients (out of pocket) and which items should be paid for by the pooled purchasers (DOH, LGUs, and PhilHealth), while also strengthening the role of DOH in ensuring the quality and affordability of items that are paid for by patients.
- Clarify, with appropriate justification, which programs, inputs to programs, and localities should (continue to) be funded by the DOH, which should be the responsibility of the LGUs, and which should be covered as part of the PhilHealth packages—and ensure that that the calculation of PhilHealth reimbursements appropriately complements items that are paid for by the DOH or the LGUs. Payments from multiple sources may be continued for strategic reasons, but in those cases, the COA must be made aware of the logic underlying these policy decisions (such as incentivizing the provision of neglected services) to avoid unjustified criticism (and audit decisions) related to the DOH, PhilHealth, or LGUs.
- Continue to shift payment of recurrent costs from the government budget to PhilHealth through subsidizing PhilHealth premiums (known as demand-side subsidies) and, as the PhilHealth packages expand to cover more services, gradually withdraw DOH and LGU funding (supply-side subsidies) for the PS and MOOE budget lines at public facilities.
- Expand the PhilHealth benefit package to include outpatient preventive, promotive, and curative care and a package of outpatient drugs as part of a strategically defined PCB package. This would help to, first, replace OOP payments by patients with prepaid pooled financing and, second, get more value for money out of the health system, given that pooled purchasers (like PhilHealth) have more information and resources than individual patients.
- These directions will need to be supported by complementary policies that fall under other pillars of the HFS, especially pillars 2, 4, and 5. Continued implementation of the actions envisaged under pillar 2 on ‘sustaining membership in PhilHealth’ will complement these directions by ensuring high PhilHealth population coverage and, in so doing, help achieve the goal of PhilHealth becoming the main funding source for

recurrent costs at public facilities. Proposed policy actions/options under pillar 4 on 'provider payments' will complement these measures by improving efficiency and establishing cost controls that will help to reduce the overall costs of health care and contribute to the financial sustainability of PhilHealth. Pillar 5 on financial autonomy of health facilities is also crucial for the success of this strategy, specifically to ensure that PhilHealth payments are seen as contributing to the overall resources available to pay for recurrent spending, rather than topping up payments for inputs (such as salaries).

Specific recommendations

1. Obtain political consensus regarding which items should be paid for by patients and which items should be the responsibility of the pooled purchasers (the DOH, LGUs, and PhilHealth), while also strengthening the role of the DOH in ensuring the quality and affordability of items that are paid for by patients.

- **Using explicit criteria, determine which services and cost components should be paid for by patients/households and which should be paid by pooled funders, namely the DOH, LGUs, and PhilHealth.** These criteria could include, for example, the attainment of equity goals, whether or not the health intervention/service has positive externalities (or is a public good), whether the service is essential or nonessential (elective), and whether there are pooled funder advantages (such as access to information or ability to get lower prices through bulk purchasing). This decision does not need to be uniformly applied to the entire population; distinctions can be made between different groups, such as indigents, seniors, or others. This is ultimately a political process, but should be informed by evidence. Additional information may need to be gathered to fill current knowledge gaps, especially on what patients are paying for (through OOP spending) and what other central agencies (beyond the DOH) are paying for.

- **Even for goods and services that patients must pay for, the government should still be responsible for ensuring that the goods and services that are provided are of good quality and available at a reasonable price, with government action on medicines being one of the most important areas given their large share in OOP spending.** For a start, the DOH could promote, and keep up-to-date, the Drug Price Watch website, which contains information on drug prices, as well as further increase awareness of drug prices by putting links to the Drug Price Watch website on other health-related websites. To complement this price information, the DOH could also make available information on the quality of drugs. In addition, and to reduce OOP spending on pharmaceuticals at the retail level, strategies should be developed to increase the public's confidence in generic drugs as well as to increase doctors' compliance with the generic drug policy. These strategies could include providing information on the clinical efficacy of generic drugs.

- **Similarly, in its role as regulator, the DOH could also take responsibility for informing people about the price and quality of private, as well as public, health care providers.** Patients are likely to think, correctly or incorrectly, that higher-cost private health care providers or 'pay wards' within public hospitals provide better quality health care than public facilities and wards. To inform patients of their full range of options, the DOH could consider developing a website to inform people of the prices and quality of services at different hospitals in or near their locality. This could be similar to the DOH Drug Price Watch website [48] but adapted for hospital services along the lines of international examples such as the U.S. 'Hospital Compare' program, [49] the Joint Commission's Qualitycheck website,[50] or the HealthGrove hospital comparison.[51] These hospital comparison websites allow the patient to type in their postal code to find

hospitals nearby and compare them along different parameters such as quality of care, patient satisfaction, and price charged for specific procedures.

- **The responsibility of providers to provide, and pay for, the drugs whose costs are incorporated into the case rates should be enforced.** Providers need to be monitored, including through patient surveys, to check that all drugs prescribed for PhilHealth members as part of inpatient care and ambulatory care package entitlements are provided by the treating facility and not purchased out of pocket by the patient. This is both a governance issue and a financial protection issue. If drugs are not available in the facility's pharmaceutical department, it is the responsibility of the facility to procure them from the local pharmaceutical market using the funds from the PhilHealth case rate reimbursement. PhilHealth should not pay facilities if patients are having to purchase drugs that are included in the case rates. PhilHealth needs to actively investigate when that occurs to determine who is at fault and impose sanctions.

2. Clarify and justify what should be funded by each of the pooled funders, namely DOH, LGUs, and PhilHealth.

- **By comparing the contents of the existing DOH-funded programs, the LGU-funded programs, and PhilHealth benefit packages—and also adding in the items that should switch from being financed by patients to being financed by pooled purchasers—determine which of the three pooled purchasers should be responsible for which items.** Funding responsibility can be organized by health care service, input type (PS, MOOE, and CO), facility type, and/or even beneficiary group. An example of a beneficiary group could be people living in areas without PhilHealth-accredited facilities where, without PhilHealth demand-side subsidies, facilities may still need some supply-side subsidy. This task may also require gathering additional information on the details of current spending by the DOH, LGUs, or PhilHealth and other central financing agents.

- **Consider whether there is still a need for the MAP program of the DOH (and the LGUs) and for PCSO funding to hospitals, or if these programs can be eliminated and the freed-up funds used to subsidize PhilHealth premiums or other government health programs.** The DOH MAP is funded in the GAA each year as 'assistance to indigent patients either confined or outpatient in Government hospitals' and was allocated more than PHP 1 billion in 2016. In addition, more than PHP 9 billion (in 2016) flowed to hospitals from the PCSO to cover the costs of indigent care (PCSO 2017). First, both these funding sources appear to duplicate what the indigent program of PhilHealth should be covering. With the rapid expansion of the PhilHealth indigent program and related policies (including the provision of full premium subsidies to around half of the population), a clear NBB policy for indigent and sponsored members, and the option of point-of-care enrollment in the indigent program for those that have recently fallen into poverty, there seems little reason to continue other programs intended to provide financial protection to the indigent population. Second, the PCSO and medical assistance funds are not transparently or efficiently allocated nor are there strong enough accountability mechanisms for the use of funds. For example, there are only 37 partner hospitals benefiting from the PCSO funds, they are not spread evenly across the country, and there are no clear criteria for deciding which hospitals should obtain such endowments. In addition, the current accountability mechanism of posting the names and amount of funds received by different individuals is inadequate to ensure the funds are appropriately used to assist indigent patients. All of this said, it would be prudent to do a careful assessment of how the funds of the MAP and the PCSO are currently being used before deciding whether to eliminate these programs and/or determine in which

localities or for which medical conditions they might still be needed. If these funds are retained, they should only be used temporarily in those cases where people have fallen through the cracks in PhilHealth financial protection, such as localities lacking accredited facilities or for (cost-effective) services that have not yet been incorporated into the PhilHealth benefits package, and then these gaps in PhilHealth coverage and accreditation should be quickly filled. Funds freed up by eliminating the MAP of the DOH and the PCSO hospital endowments could be used to augment PhilHealth premium subsidies.

- **Consideration needs to be given to whether the substantial health spending by other central agencies—including the military, police, and state university health systems—can be integrated into PhilHealth purchasing arrangements.** Questions to ask in this regard include the following: 'Do civilians also use these services?', 'Is there a need for improving continuity of care across systems, between these systems and other parts of the public (and even private) system?', 'Are these systems being financed by payment mechanisms that promote quality of care and efficiency?'. Spending by these agencies is substantial—equivalent to about one-third of DOH spending, according to the latest available data (2016 NHA)—and so, these central agencies need to be included in provider payment reforms if the government wants to get more value for money out of the entire Philippine health system.

- **For the LGU-owned primary care facilities, an important decision is the extent to which they should rely on LGU budget allocations versus PhilHealth payments and OOP payments.** There is a need for a public primary health facility in every locality. Even if it does provide many personal health care services (which could be paid by PhilHealth), it still needs financing to perform public health functions (such as health promotion and control of disease outbreaks) and regulatory functions and be able to provide emergency care to stabilize a patient before transportation to a curative care facility. Ensuring sufficient funding for RHUs may be especially challenging in poor LGUs, remote LGUs, or LGUs with small or dispersed populations. In many countries where primary facilities serve small populations, special financing arrangements are made to ensure that they have a minimum basic operating budget so they can continue to exist despite low revenues from service provision (that is, from PhilHealth payments or from OOP spending). Sometimes, these arrangements are complemented by additional payments made for performance. Determining which localities or facilities may require special arrangements, and what those special arrangements should be, is an important (and political) decision.

- **For LGU-owned secondary and tertiary facilities, full cost recovery for recurrent costs through PhilHealth reimbursement and OOP payments, combined with a policy of financial autonomy, would help alleviate the unfair fiscal burden placed on the LGUs where these facilities are located.** Because the secondary and tertiary facilities generally serve the populations of multiple LGUs, the LGU where the facility is located bears the fiscal burden of the recurrent costs of operating the facility while the neighboring LGUs, whose populations use the facilities, essentially free-ride. If the recurrent costs of operating the facility were included in the amount reimbursed by PhilHealth, and could be retained by the facility, then this problem would be eliminated. An additional step, which would be possible if these policies were pursued, could be to devolve the lower-level DOH-retained hospitals to the LGUs, with the remaining DOH hospitals serving a clear function as tertiary referral and training hospitals.

- **The continued LGU responsibility for COs at the LGU-owned secondary and tertiary facilities would need to be accompanied by the strengthening of the ILHZ policy to make the LGU financial burden more equitable, and the option of DOH funding of COs (in line with a regional or national facility master plan) should also be explored.** The vision of the HFS is that the LGUs would fund the COs of all the LGU facilities under their ownership, even the secondary and tertiary facilities that serve multiple LGUs. If this continues to be the vision, then the ILHZ policy needs to be strengthened to ensure that the burden of financing COs is shared fairly across the LGUs. Otherwise, problems of free-riding or inadequate contributions by neighboring LGUs whose populations also benefit from the facilities are likely to persist. Another option is for the DOH, through its regional offices, to centrally allocate CO funds according to a master plan that ensures access for all Filipinos to a network of different level facilities in all regions, avoiding overcapacity and ensuring that gaps are filled. Over time, a continuous master planning process will be needed to coordinate investments across localities to ensure adequate facility coverage while avoiding wasteful overinvestments and helping to better integrate private, public, DOH, LGU and other central agencies' facilities into an effective referral system.

- **A related decision is how private facilities, whose COs are not subsidized by the government, should recover the costs of CO.** One option could be to have PhilHealth reimburse private facilities at a higher rate than public facilities. However, because this would result in PhilHealth effectively paying more for richer people (who are more likely to use private facilities) than for poorer people (who are more likely to use public services which receive state budget subsidies for capital), this would likely be considered unfair—especially if private facilities are perceived as being of better quality. An alternative is for PhilHealth to pay the same amount to public and private facilities and for private facilities to recover their capital costs through additional charges to those patients who choose to use private facilities.

- **A final question is whether COs for primary care facilities (BHSs and RHUs) should be the devolved responsibility of the LGUs (as envisioned in the HFS) or the responsibility of the DOH (as the increasing HFEP allocations imply).** Ultimately, this is a political decision that hinges on central-local roles and power relationships. If the DOH can mobilize resources centrally for COs and can improve the targeting of investments based on clear and transparent criteria, it may make sense for the DOH to take on the responsibility for COs at the LGU primary care facilities, at least where there is considerable need. Criteria for the DOH funding might include, for example, the lack of a PCB-, MCP-, or TB-DOTS-accredited facility in the LGU; the condition that LGUs allocate sufficient recurrent budget to operate the facility; consistency of LGU capital investment plans with the PIPH; and the share of indigent people living in the area. However, for longer-term sustainability of health services, it would be better for the devolved LGUs to take over this responsibility and be held accountable by the DOH through its regional offices and by the local electorate.

3. Continue to shift responsibility for the payment of recurrent costs (PS and MOOE) from the government budget to PhilHealth and address any impediments to implementing this successfully.

- **Continue the original HFS vision that PhilHealth would eventually cover the personnel and operating costs of public hospitals, infirmaries, and dispensaries, including both DOH-retained and LGU-owned facilities.** Based on the decision of what PhilHealth should pay for and what the DOH and the LGUs should pay for (see recommendation 2), lay out a concrete road map for actions to achieve this goal. An actuarial assessment of

this road map will also be needed because it is highly likely that PhilHealth premiums (and, therefore, also government subsidies to PhilHealth) will need to be increased substantially as subsidies shift from the supply side (DOH and LGUs) to the demand side (PhilHealth). Under the recommendations for pillar 5, there will be further discussion of policy actions that can be taken to help facilities transition toward the financial autonomy needed for them to manage within the personnel (PS) and operating (MOOE) funds received from revenues (in the form of PhilHealth reimbursements and OOP payments) once supply-side subsidies are removed. Under the recommendations for pillar 4, a set of complementary provider payment reforms will be discussed.

- **Carefully consider any legal issues and public sector norms that may restrict the extent to which PhilHealth payments may be used to cover recurrent costs on PS or MOOE.** If the Salary Standardization Law does not allow PhilHealth payments to facilities to be used to cover basic salary payments, then this policy must be adjusted. In addition, if the DOH believes that DBM imposes unreasonably low norms for human resources and wages in the highly labor-intensive health sector, then the DOH should provide evidence of the problem and its negative consequences and lobby to change the policy, rather than having LGUs remain understaffed or having MOOE funds used non-transparently to cover personnel costs. It may also be necessary to explain to the LGUs and other stakeholders whether the intention of the 'facility fee' portion of the PhilHealth payment[52] is to replace the LGU budget allocations, supplement the MOOE budget to allow for the provision of more comprehensive services, or cover the cost of COs.

- **Assess the existing legislation that prohibits PhilHealth from reimbursing the DOH for the procurement of drugs and vaccines, and put in place policies to ensure that any procurement by the LGUs is cost effective.** If it is determined that there are advantages to having the DOH directly procure some items (such as vaccines), but that these items should be financed through the purchase of services (as part of the PhilHealth benefit package) rather than through payment for inputs (for example, as part of the DOH or LGU line item budgets), then a mechanism needs to be found by which PhilHealth can reimburse the DOH for these costs. A related point is that there needs to be a clear decision regarding which drugs will be procured by the LGUs and which drugs will be procured centrally through the DOH. Right now, there is overlapping responsibility, and likely duplication, for the financing for drugs. There should also be a (legal) mechanism for the DOH to exert influence over LGU procurement to help ensure that procurement prices are reasonable, that is, in line with the DPRI.

- **Strengthen the DOH information system so that there is stronger oversight of PhilHealth and LGUs' purchasing and service provision.** If a larger share of public funds for health will flow through PhilHealth, as envisaged by the HFS, then PhilHealth internal and external accountability mechanisms will need to be strengthened. Similarly, the DOH will require more information—including on LGU finances, inputs, and services—to better play its stewardship role and protect the health of the population.

4. Continue to expand the PhilHealth benefit package, subject to the above political processes.

- **Once it has been determined which services should not be paid out of pocket by households and then which services should not be paid by the DOH or the LGUs, develop a plan for PhilHealth benefit package development.** This plan should move toward comprehensive coverage and exploit PhilHealth's ability to strategically purchase services in a way that gets more quality and value for money.

- **Important policy choices need to be made with respect to the primary care benefits package and outpatient drug benefit.**

    - **Whether to restrict the PCB to indigent and sponsored members or expand them to all PhilHealth members.** The intention of the 2013 Health Insurance Act, namely 'to give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits', implies that the PCB package should be expanded to all PhilHealth members. A primary care entitlement for all PhilHealth members would have the added advantage of simplifying administration (because providers would not need to distinguish between different types of members when providing care) and facilitate the development of a gatekeeping role for PCB providers. There would also be the longer-term benefits of improved health and reduced use of inpatient care as more people would have access to preventive and basic curative care. However, the expansion of the PCB to all PhilHealth members would also entail a substantial cost to PhilHealth and must be balanced with adequate additional revenues, either from increased premiums and/or some fixed co-payment from (non-indigent) households. It would also require that PhilHealth be able to monitor primary care providers and hold them accountable for effective service provision to avoid under-provision of services (see options for pillar 4).

    - **Whether to limit the primary care package to the short list of items included under the PCB, expand the package to include the services in the *Tsekap* design, or add in even more services (like immunization).** The *Tsekap* package's strong focus on NCD management and effective prevention is appropriate for a primary care package. In terms of additional services beyond those included in *Tsekap*, a political choice has already been made to expand PhilHealth coverage to include immunizations (through the passage of the Mandatory Infants and Children Health Immunization Act of 2011), but this has not yet been implemented. Any revisions to the PCB package would need to go through a process of (technically and politically) determining the contents of the basic minimum package based on clear criteria for inclusion. Any expansion of services would entail an increase in PhilHealth costs, which would in turn necessitate additional resources through increased premiums or fixed co-payments.

    - **Whether to limit the primary care package to public providers or also allow private outpatient facilities/providers to provide the package.** Limiting the package to public providers may help implicitly target the package to indigent and sponsored members who are more likely to use those facilities, especially if the primary care package is expanded to include all PhilHealth members. However, if the government's goal is to ensure population-wide coverage of primary care interventions, then it may be important to include private providers because many people may have an existing relationship with an outpatient or primary care provider (and not be willing to switch) or may find them more convenient. The inclusion of private providers could be achieved through a system of co-payments that would be sufficient to cover private facilities' COs as well as the non-medical amenities that are often available in private facilities and not public facilities.

    - **What steps can be taken to ensure—and possibly even require—that all LGUs have PhilHealth-accredited primary care facilities?** The presence of a PhilHealth-accredited facility in every LGU is crucial to achieving the vision that PhilHealth demand-side subsidies would replace government supply-side subsidies as the

source of financing of recurrent costs at public facilities. Targeted action is needed to ensure that LGUs without an accredited primary care facility do what is needed to get accreditation, including (as necessary) building, equipping, and staffing facilities adequately and applying for accreditation. LGUs that fail to meet the conditions for accreditation are effectively preventing their populations from exercising their right to health services and financial protection. If LGUs face constraints in getting their facilities accredited, then measures are needed to help them to overcome these constraints, whether they are related to human resources, equipment, facility infrastructure, or local political interest.

- **Whether to include an outpatient drug benefit in the PhilHealth primary care package or continue to rely on the DOH for the financing of drugs for primary care.** The inclusion of medicines in the PhilHealth primary care package is in line with the reform directions proposed in the HFS. The HFS states that primary care, including medicines, should be financed by PhilHealth. According to recent proposals this will be achieved through having accredited drug dispensers in LGUs that negotiate prices using the DPRI. However, this is likely to result in somewhat higher prices than could be achieved through bulk procurement and would also require the availability of accredited drug dispensers available in all LGUs. The current arrangement whereby the DOH does bulk procurement should be able to achieve substantial discounts on drug prices, but PhilHealth cannot reimburse the DOH for these costs because regulations are not in place to enable this. In addition, if the current arrangement continues, substantial efforts will be needed to improve storage and distribution logistics to ensure timeliness of drug deliveries to PCB providers. Regardless of the option chosen, patients and doctors need to be convinced that the generic drugs included in the primary care package are effective (Wong et al. 2016) and the choice of drugs included in the package must be determined based on cost effectiveness, through a health technology assessment process. Under the DOH procurement option, the prescribing of these drugs would need to be fully integrated with the set of diagnostic and treatment services included in the PCB package and not be a stand-alone dispensing of drugs.

5.2 Pillar 4: shift to new provider payment mechanisms

Main challenges

- Despite the ACR payment system for inpatient and specialist outpatient care, FFS-type incentives persist; with no constraint on what hospitals can (balance) bill to patients, hospitals are not incentivized to be more efficient and patients pay substantial amounts over and above what PhilHealth reimburses.
- There is inadequate assurance of provider performance under capitation payments.
- There is no incentive for patients to seek care at the appropriate level of the system.
- Outpatient drug benefit implementation arrangements face many challenges.
- There is insufficient use of evidence-based treatment guidelines.
- Rigidities in the rules that hospitals and RHUs have to follow mean that they cannot optimize their investments, inputs, staffing, and remuneration in response to provider

payment reforms, which results in shortages, mismatches, and lack of transparency in fund utilization.

- DOH facilities lack autonomy in the use of funds to pay staff remuneration from their operating revenues, while LGU facilities in many localities face difficulties in using revenues from PhilHealth and OOP payments for timely and adequate procurement of inputs to care.

- Among more autonomous facilities, there are no measures in place to allow for sufficient oversight and regulation of quality and performance.

General directions for HFS strategy pillar 4

- Revise the ACR payment mechanism so that case rates fix the amount that providers receive in advance and eliminate the option of uncontrolled balance billing in public and private facilities. The DOH and PhilHealth should also engage providers in this process to ensure that providers accept the level of case rates as sufficient to cover (reasonable) costs, and also help providers to adjust to more efficient care practices that would enable them to provide care within a fixed budget.

- Apply a fixed co-payment policy to strengthen incentives for users of health services to seek care at the right level, discourage unnecessary care-seeking services, strengthen financial protection, and increase provider efficiency.

- Ensure the feasibility of the (proposed) outpatient drug benefit through measures that increase the availability of the accredited drug dispensers and encourage patients to use generic drugs through, for example, low or no co-payments for generic drugs.

- Clarify the mechanisms and responsibility for ensuring quality of care, including the roles that incentives, regulations, and other quality assurance mechanisms can play and the respective responsibilities of the DOH, LGUs, and PhilHealth in this regard.

- Develop a clear vision and road map for increasing government health facility autonomy, with emphasis on measures that can enhance positive synergies with provider payment reforms. In particular, measures are needed to ensure adequate resources for personnel remuneration in DOH hospitals and to increase LGU facilities' control over the use of their funds so that they can procure necessary inputs.

- Strengthen the monitoring of the blended payment mechanism (capitation plus pay for performance) and outpatient benefits to ensure that the basic primary care (including preventive and promotive) services needed by the population are provided.

- Establish the information systems and oversight institutions that are needed for facility autonomy to work well, balancing autonomy with the need for some control to avoid the adverse effects of provider payment reforms.

- The proposed policies and actions under pillar 4 will need to be complemented by policies under other HFS pillars. Pillar 3 on the most appropriate financing agent complements pillar 4's discussion on provider payment mechanisms by clarifying what patients should be expected to pay out of pocket, including in the form of co-payments.

Specific recommendations

1. Revise the ACRs payment mechanism.

- **Transform the current ACRs into a 'true case rates' payment mechanism by fixing the total amount of funds received by the facility from the combination of PhilHealth reimbursement and fees for each case type.** This means ending the current practice of open-ended balance billing by providers. In so doing, facilities will face a stricter budget ceiling and be forced to become more efficient; facilities with a high cost of provision will be incentivized to reduce costs. It also means having an explicit policy about co-payments (see recommendation 3). The alternative would be to continue as-is, but in that case, PhilHealth would need to implement stricter managed care practices (some of which were in place under the FFS system but eliminated with case rates) such as preapprovals, denials of claims, and substantial restrictions on the clinical autonomy of medical practitioners.

- **The starting point for setting the case rates is to determine the full cost of providing medical care for a particular case type on average across facilities and patients**. The measurement of full cost should include PS, MOOE, and CO cost components. This is the full amount that a facility should receive from all sources for the medical services for that case type. For non-indigent patients, a fixed co-payment or fixed percentage coinsurance payment can be charged to the patient to discourage unnecessary care-seeking services (moral hazard) and promote financial protection goals. Any amount paid by the patient should be deducted from the PhilHealth payment to the facility so that the total amount actually received by the facility remains fixed, thus maintaining the incentives for cost control and efficiency. In this way, PhilHealth will effectively pay more for indigent patients and less for non-indigent patients, but the amount received by the hospital for indigent and non-indigent patients will remain the same.

- **Incorporate the use of the DPRI into drug procurement documentation and into PhilHealth's audits to help bring down prices and lower overall costs.** Ensure that comparisons between the DPRI and winning bids are included in procurement-related documentation and widely disseminated. Investigate for fraud any cases where the prices of the winning bids or claims for PhilHealth reimbursement by facilities reflect prices that are substantially higher than the DPRI. Note that once balance billing is eliminated, true case rates are applied, and facilities are given more autonomy over the use of funds, facilities will want to reduce their drug procurement prices in order to reduce their overall costs. In other words, the incentives and interests of the provider will become more closely aligned with those of the purchaser and patients. If facilities can benefit from the surplus of revenues over expenditures, they will be motivated to keep expenditures low. This means that, over the medium term, strict drug control measures may no longer be necessary but instead serve as a support mechanism to help the LGUs and facilities negotiate lower prices in their drug procurement processes.

- **Update the case rates regularly to ensure that facilities receive sufficient funds to provide cost-effective care.** This should be done by a hospital costing survey that attempts to determine the average full cost of providing services for each diagnostic group. The costing survey would need to be complemented by a system of regular adjustments to reimbursement rates over time using repeated costing surveys and utilization/claims reviews and involving various stakeholders and experts in this process more transparently to ensure buy-in. Updating of the case rates would be easier if the case rates were transformed from a fixed PHP amount to a relative weight that could be

multiplied by a unit price (the base rate) to determine reimbursement amounts each year. For example, if normal delivery has a weight of 1.0, and C-section costs twice as much, then the relative weight of C-section would be 2.0. Female sterilization may cost only half the amount for a normal delivery; so, its weight would be 0.5. If costs of providing medical care in general go up, the base rate is all that needs adjusting. If technologies change, both the unit price and relative weights may need to be adjusted, but this could be done on a rotating basis by focusing on adjusting weights in only some groups of diagnoses each year. Another way in which adjustment of coefficients can be used is to discourage overprovision of some services while encouraging the use of others.

- **Use evidence-based, cost-effective CPG in developing the revised case rates.** The existing CPG of the various Philippine medical societies provide the starting point. However, they should also be validated against international CPG, such as those from National Institute for Health and Care Excellence (NICE-UK), to see where they deviate and to assess whether the deviation is justified. In areas where no Philippine guidelines exist, develop additional evidence-based guidelines for the Philippines, again drawing on international evidence-based guidelines. These guidelines should be used to determine the adequacy of the revised case rates for common medical conditions and can then also be used as a basis to defend the case rates if hospitals complain that the amounts paid are insufficient. The CPG can also be used during claims review to develop criteria to detect unnecessary admissions and upcoding. The approach being recommended here is very similar to the way that PhilHealth went about developing the MCP and Z-benefit package; in both cases, CPG formed the basis of the costing and rate setting. Without these protocols serving as standards, PhilHealth will have substantial difficulty defending its payment rates.

- **Substantial changes will be needed to the monitoring and oversight of service provision to address the new and different incentives that will be created under 'true' case rates.** Areas that will require improved monitoring and oversight include potential manipulation of disease codes by hospitals (upcoding), medically unnecessary admissions, readmissions, medically unnecessary surgeries, and other behaviors that will be incentivized in the case rate system. Appropriate measures for detection—and sanctions—will need to be developed. Substantial international experience with this issue has been accumulated over time and could be adapted to the Philippines. A few examples of initiatives to reduce medically inappropriate admissions and combat fraud and other forms of abuse can be found in the Hospital Payment Monitoring Program (Su 2008), the Medicare Program Integrity Manual (Centers for Medicare and Medicaid Services 2014), and other U.S. programs intended to help physicians avoid fraud and abuse (Centers for Medicare and Medicaid Services 2017). In most case rate systems, detecting manipulation and fraud, and coming up with measures to control them, is an ongoing battle.

- **In the longer run, consider the possibility of combining case rates with a global budget to avoid problems of upcoding and unnecessary admissions.** This is the model used in Thailand's Universal Coverage scheme. The global budget is a prospectively determined amount of funds considered adequate to meet the health care needs of the national population (or regional) population. It is generally determined based on population age-sex structure and the cost of providing care per person in each demographic group, with some upward adjustment each year for technology/quality improvement and inflation. PhilHealth would be responsible for allocating this global budget (consisting of premium revenues plus state budget allocations) to providers proportional to their share in overall

service provision, rather than as a fixed price per case. Facilities keep track of the case rate weights for all their cases, and at the end of a payment period (for example, a quarter), all facilities send the sum of their weights to the PhilHealth office to request payment. Instead of being paid a fixed amount equivalent to the sum of their weights times the rate per weight, facilities would instead be paid an amount equivalent to their share of the total weights of all providers. See Table 3 for illustration. Under this system, PhilHealth spending would never go over budget: if providers collectively provide services efficiently, then the amount per weight will be high, but if providers collectively overprovide, the amount per weight will be low. This system would require major institutional reforms, including transparent reporting and detailed guidelines, as well as substantial managerial autonomy of hospitals.

Table 3. Illustration of global budget allocated using case rate weights

	Traditional Case Rate System		Global Weight with Case Rate Allocation	
	Sum of Weights from Service Provision	**Payment (Assume PHP 100 per Weight)**	**Share of Total Weights (%)**	**Payment (Assume Global Budget Set in Advance at PHP 500,000)**
Hospital A	1,456.5	145,650	26	127,504
Hospital B	3,490.2	349,020	61	305,536
Hospital C	764.9	76,490	13	66,960
Total	5,711.6	571,160	100	500,000

2. Implement a fixed co-payment policy to strengthen incentives to seek care at the appropriate level while enhancing financial protection and improving efficiency.

- **A rapid switch to fixed co-payments at public facilities and removal of open-ended balance billing is needed to impose a hard budget constraint on facilities (which is necessary to achieve the desired effects of case rate payments) and also to provide financial protection to members while avoiding moral hazard.** A political decision is needed on how much PhilHealth members should be paying out of pocket (through co-payment) when using health services. While it is clear from the NBB policy that indigent members should not pay any co-payments, there is currently no policy to limit what facilities can charge to non-indigent patients over and above what PhilHealth reimburses. Options to overcome this problem include fixed co-payments or, alternatively, fixed rate co-payments (known as coinsurance). Fixed co-payments are less financially risky for patients than fixed rate co-payments because the peso amount to be paid remains the same no matter how high the bill is. By contrast, with the fixed rate, say 20 percent, while the share of the bill remains constant, more costly services will translate into more pesos being paid by patients. Requiring reasonable co-payments could also help to discourage patient moral hazard, which can arise when health insurance reduces the cost to the patient to a level that induces excess demand beyond what is medically necessary.

- **Permit all facilities to charge additional co-payments for nonmedical amenities, and permit private hospitals to charge additional co-payments for capital costs.** As is currently the practice, public hospitals could continue to charge patients extra for non-medical amenities (for example, air-conditioning, TV, private toilet, and so on), especially in special 'pay wards'. This allows public hospitals to earn additional income from patients who are willing and able to pay more for certain amenities and for these facilities to compete with private hospitals. However, if this is permitted, it would be critically important to ensure that the quality of medical care is the same in the regular and the pay wards. Private hospitals could charge higher fees (in the form of co-

payments) to cover the higher cost of their non-medical amenities, and also an additional amount to cover their capital costs. For consumer protection reasons, patients should be informed of the basic price, what would be covered by PhilHealth, and what additional co-payments there would be (and what they are for). Patients should know that they have the option of paying less (for fewer non-medical amenities), but that this would not affect the quality of the medical services they receive. To make things absolutely clear, the hospital bill should also lay out the components of the charges and indicate how much will be reimbursed by PhilHealth and how much the patient is liable to pay. These bills should be subject to external audit or verification.

- **Co-payments can also be structured in a way that helps to develop an effective referral system for inpatient and specialized care, thus saving money by restricting the use of secondary and tertiary care to patients who need it.** Many health insurance systems allow patients to choose a facility that will function as the gatekeeper—both providing basic care directly and providing referral to higher-level facilities when necessary. To incentivize patients to use the gatekeeper and follow the referral system, higher co-payments should be required if patients bypass the gatekeeper and seek care directly at higher-level facilities. In the Philippines, this gatekeeping function seems to be missing: patients can go directly to whichever facility they want, and PhilHealth will reimburse at the same rate.

3. Ensure the feasibility of (any future) outpatient drug benefit and encourage patients to use generic drugs.

- **If a decision is made to include medicines in the primary care package, then measures need to be taken to ensure that there are accredited drug dispensers widely available and that patients are willing to use the generic drugs included in the package.** First, a political decision must be made about whether the DOH will continue to supply drugs to the PCB facilities to implement the outpatient drug benefit, with reimbursement from PhilHealth, or whether local drug dispensing facilities will be strengthened to perform this service and directly reimbursed by PhilHealth. If local dispensing is chosen, then it is necessary to assess the geographic coverage of accredited or 'accreditable' drug dispensers. Because the policy has not yet been widely applied, it is not yet known where gaps in coverage may exist. In areas lacking accredited drug dispensing facilities, efforts will be needed to strengthen potential dispensing facilities for eventual accreditation, and in the meantime, alternative dispensing mechanisms would be required. The larger challenge for the implementation of the drug benefit, though, may be related to people's trust in generic drugs (as was discussed above). If it is decided that the DOH should continue to centrally procure these drugs to supply to PCB facilities, then mechanisms for PhilHealth to reimburse the DOH for the costs of these drugs need to be put in place to ensure financial sustainability and avoid duplicate payments.

- **Procuring drugs at a reasonable price will be crucial to the financial sustainability of the primary care package.** The *Tsekap* package, for example, relies on local procurement of generic drugs and requires that negotiated drug prices be below the DPRI levels. It is not yet clear whether this arrangement will be sustainable. Failed bids and subsequent lack of essential drugs could undermine package implementation.

4. Clarify mechanisms and responsibilities for ensuring quality of care and the role of incentives, regulations, and other quality assurance mechanisms in this regard.

- **Under a system of case rate payments and capitation payments that are effective at enhancing efficiency and cost control, measures are needed to mitigate the risk of under-provision of necessary services.** It is, therefore, important that PhilHealth revises its monitoring and auditing processes to focus not only on prices and overprovision, but also on ensuring the adequacy and effectiveness of services that are provided to patients. Current measures are not sufficient. For example, while the process of accreditation certifies the readiness and potential of facilities to provide a full package of services of good quality, it does not guarantee that facilities will provide sufficient quality care to every patient for each episode of care. In addition, while there are clinical protocols that have been approved by the DOH and/or medical boards, they are not formulated in such a way that DOH or PhilHealth can easily use them to monitor the adequacy of care.

- **Responsibility for quality management needs to be clarified, particularly for the quality of services purchased under case rates and capitation.** The DOH seems the logical agency to be responsible not only for setting standards but also for checking compliance with those standards, including by undertaking inspections. However, it may be difficult for the DOH to be objective when assessing its own DOH-retained hospitals. PhilHealth also has the potential for taking on the responsibility for quality control. In order to do so, it would need to reconstitute the detailed claims databases that were in place before the shift to ACRs. These databases could then be used for statistical analysis of the content of care provided, including whether the care was adequate or whether there was over-servicing and balance billing.

Endnotes

[1] The term 'pooled funding' of 'pooled purchasing' refers to funds from government budget, foreign aid, social health insurance (like PhilHealth), and private health insurance (like HMOs and others) but excludes household OOP spending.
[2] These other central entities included military-related entities, namely the Veterans Memorial Medical Center, Armed Forces of the Philippines (AFP) Medical Center, the Philippines Navy (AFP-PN), the Philippines Army (AFP-PA), and the Philippines Air Force (AFP-PAF); law enforcement entities, namely Philippines National Police (PNP), National Police Commission, Bureau of Fire Protection, Bureau of Corrections, and the Dangerous Drugs Board; research entities, namely the Food Nutrition Research Institute, Philippine Council for Health Research and Development; regulatory agencies, such as the National Meat Inspection Service; charitable funding agencies, namely the Philippine Amusement and Gaming Corporation and PCSO; and other central agencies, including the National Council on Disability Affairs, Department of Education, Occupational Safety and Health Center Philippines, University of Philippines System, Department of Labor and Employment, and Department of Social Welfare and Development (DSWD).
[3] Infirmaries and dispensaries are considered primary care facilities with inpatient beds. They do not meet the DOH licensing requirements to be considered as a secondary care facility and are limited to performing services with low levels of complexity.
[4] An RVU is a number assigned by PhilHealth to a surgical procedure to reflect its relative weight or its degree of complexity as compared to another procedure. The more difficult the procedure is, the higher its relative value. For example, a simple appendectomy procedure has an RVU of 100 while the more complex appendectomy for ruptured appendix with abscess or generalized peritonitis has an RVU of 150. PhilHealth. Relative Value Scale 2010. Manual of Procedures (second edition).
[5] By 2015, the Z-benefit packages included acute lymphocytic/lymphoblastic leukemia in children; breast, prostate, cervical, and colorectal cancer treatments; treatment of end-stage renal disease eligible for kidney transplantation or peritoneal dialysis; various heart surgeries, particularly for congenital heart defects; and lower limb prostheses and orthopedic implants. In 2016, an additional package for children with disabilities was added.
[6] It is estimated that there were 2,231,658 births in 2015 (see endnote 37). Of these, 61.1 percent were institutional deliveries, or about 1.36 million births. PhilHealth reports a total of 992,441 delivery claims. Thus, PhilHealth delivery claims as a share of all births is 44 percent and as a share of total institutional deliveries is estimated at 73 percent.
[7] PhilHealth circular 15, S2014. On PCB1 now called *Tsekap* package guidelines for 2014 and PhilHealth circular 002-2015 governing policies on the expanded coverage of the PCB package: *Tamang Serbisyo sa Kalusugan ng Pamilya* (Tsekap).
[8] AO 2014-017. Implementing Guidelines on the MAP of the Department of Health. May 22, 2014.
[9] National Kidney and Transplant Institute, the Lung Center of the Philippines, Philippine Children's Medical Center, and the Philippine Heart Center.
[10] DOH website. DOH Hospitals. http://www.doh.gov.ph/doh-hospitals-directory. Accessed June 22, 2016.
[11] According to the NHA-SHA, Table A.4, private hospitals received PHP 11,783 million (or nearly PHP 12 billion) from central government funds in 2014. However, the DOH GAA 2014 indicates an allocation of only PHP 12,345,000 for private hospitals. It is not clear why these figures differ by a magnitude of 1,000.
[12] PhilHealth benchbook standards include 52 core indicators and a large number of other indicators covering broad categories of Patient Rights and Organizational Ethics, Patient Care, Leadership and Management, Human Resource Management, Information Management, Safe Practice and Environment, and Improving Performance.
[13] Performance commitments consist of a formal letter from the health care institution to PhilHealth covering 45 items, which can be categorized into five groups: (a) formal representation of eligibility for engagement with PhilHealth (license, certificates, and so on); (b) commitment to comply with pertinent laws and regulations; (c) assuring the capacity to provide service packages, willingness to comply with procedures for PhilHealth claims, and proper conduct toward PhilHealth members; (d) warranting that management information system requirements of PhilHealth will be met; and (e) ensuring compliance with PhilHealth requirements to monitor the operations of the facility through surveys, visits, and investigations.
[14] A family consists of the principal member, spouse (if any), and any dependents under the age of 21 years who do not have children of their own; if they have children of their own, they are listed as a separate indigent family.
[15] For the senior citizen program, a family is defined slightly differently in that a spouse of the principal member who is also older than 60 years is counted as a separate family.
[16] Sponsored members include those whose premiums are paid from the budgets of LGUs or legislative sponsors ostensibly because they cannot afford premiums; disadvantaged and vulnerable groups like orphans, people with disabilities, whose premiums are sponsored by the DSWD; barangay health workers, other workers, and volunteers whose premiums are paid by the LGU; and unenrolled women about to give birth, whose premiums are subsidized by one of several government entities.
[17] The expansion of the indigent program from 5.2 million beneficiary families in 2013 to over 14.5 million beneficiary families during 2014–2016, as well as the introduction of the senior citizens' program, was enabled by the passage of the 2012 Sin Tax Law (RA 10351), which earmarked most of the incremental revenues from tobacco and alcohol taxes increased for health insurance coverage of poor and near-poor families, and later also senior citizens.
[18] In the GAA budget line, the amount is listed as PHP 1,428,903,000; however, in Note 9 of the GAA, the amount stipulated for assistance to indigents is PHP 2,783,345,000. It is unclear why this discrepancy exists.
[19] Profiling involves filling in or updating a two-page form that assesses the general health status of the member/dependent. The profile includes basic demographic data, past medical and surgical history, family health history, personal/social history,

immunizations, reproductive health history, and pertinent physical examination findings. The Individual Health Profile is updated annually.

[20] PCB1 obligated services included annual blood pressure measurement for people 18 years and older without history of hypertension, monthly blood pressure measurement for people with hypertension, annual clinical breast exam for females 25 years and older, and annual VIA screening for women ages 25 to 55 years with intact uterus. The PCB2 package included incentives of up to PHP 100 dependent on the proportion of adults ages 25 years and older for whom risk factor assessment for cardiovascular disease was performed. The *Tsekap* package went back to the PCB1 list of obligated services but added body measurement for all family members.

[21] In a nationwide pilot, with the intervention randomized across a nationally representative sample of facilities and assessed by an impact evaluation, PhilHealth, the World Bank, and the Korean Development Institute (KDI) are studying the effect of adding financial performance incentives to the delivery of obligated service and also incentivizing the quality of care.

[22] PhilHealth determines the price cap for each unit of medicine using the DPRI plus an additional 30 percent markup. Drugs prescribed by providers that are not on the PhilHealth list can be dispensed by drug outlets but will not be reimbursed by PhilHealth.

[23] At that time, all poor people receiving government subsidies were termed 'sponsored', regardless of whether their premiums were paid by the national government or local government.

[24] There are essentially three types of line items in national and local budgets, namely COs, PSs, and MOOE.

[25] The PNHA does not allow us to separate out community-level and individual-level preventive care services in the health spending estimates.

[26] The NHA in the Philippines has changed to a new methodology (SHA) with estimates covering 2012–2014. For older estimates going back to the baseline of the HFS, the spending category was public health, while in the NHA-SHA the spending category is preventive care. There is some overlap but much ambiguity in what is included in the scope of each of these concepts, which makes it difficult to compare earlier PNHA with NHA estimates using the new system of health accounts (NHA-SHA) methodology.

[27] To calculate growth in real terms, the CPI for health services was used because there is no gross domestic product (GDP) deflator for health available that would cover prices faced by government service providers.

[28] PhilHealth Stats and Charts 2nd semester 2015 and 2010. The health CPI indicated health prices were 18.9 percent higher in 2015 compared to 2010. It is assumed that PhilHealth is paying the same charges and prices as consumers would be paying.

[29] The CPI specific to health (developed by the PSA) was used to adjust for inflation due to a lack of GDP deflator for health services that could account for prices paid by the government for health services. Personal health care services in the PNHA consists of health care services obtained at public and private facilities and purchase of medical devices and pharmaceuticals but excludes public health spending. For this report, curative and related care in the NHA-SHA estimates includes curative care, rehabilitation, ancillary services, and medical goods.

[30] Specifically, the overlapping drugs between ComPack (A02011-0013) and PCB1 (Circular 010, s2012) include URTI (amoxicillin, erythromycin, cloxacillin) and UTI (cotrimoxazole, ciprofloxacine). If the *Tsekap* package is implemented, it would cover a number of the same drugs as ComPack, including drugs for the treatment of diabetes, hypertension and cardiovascular diseases, hypercholesterolemia (hyperlipidemia), and antihelmintics, and deworming medicines. Currently, both programs indicate coverage of asthma drugs and acute gastroenteritis, but the drugs listed are different.

[31] GAA 2016, Note 14: After describing the amount of funds to be appropriated for the purchase and allocations of drugs, medicines, and vaccines, the act stipulates "The amount of drugs, medicines and vaccines purchased by PHILHEALTH cardholders in DOH hospitals shall be reimbursed by the PhilHealth to the DOH. The amount reimbursed shall then be used exclusively by the DOH for the construction of additional health care facilities." The National Health Insurance Act 2013 stipulates that "reimbursements paid to public facilities shall be retained by the individual facility in which services were rendered and for which payment was made."

[32] NHA-SHA 2014 analyzes expenditures on factors of provision for four financing schemes: central budget, LGU budget, PhilHealth (both as social health insurance and government-based voluntary insurance), and OOP spending. Among these schemes, total health expenditure was PHP 486.7 billion, while total expenditure on drugs was PHP 251.4 billion. Note that spending on drugs and total health spending of foreign assistance, HMO, and other insurance were not included in these calculations because they are not decomposed into the factors of provision.

[33] Point-of-care enrollment is a PhilHealth policy whereby patients who are assessed as being poor by the PhilHealth and DSWD staff at the hospital can be automatically enrolled in PhilHealth if the patient or the hospital pays the annual premium.

[34] The MAP is a fund in the name of various mayors, congressmen, and DOH staff that can be used to cover the excess costs associated with the hospital stays of whomever the mayors, congressmen, and DOH staff wish to sponsor. Funds are paid directly to the hospital.

[35] The Galing Pook awards promote excellence in local governance through recognition, sharing of information, and support of efforts to replicate best practices at the local level, including health sector programs.

[36] The PIPH is a medium-term development plan that serves as the key instrument in building the DOH-LGU partnership, in collaboration with international development partners and other local stakeholders, to attain the health sector reform goals. The PIPH translates national health goals (National Objectives for Health, Medium-term Philippine Development Plan, and MDGs) into specific concrete actions (projects, programs, and activities) at the local levels and forms the basis for budget allocations.

[37] DHS 2013 indicates a crude birth rate (CBR) of 22.1 per 1,000 population and PSA Population Census 2015 indicates a total population of 100.98 million people. This yields an estimate of 2,231,658 births in 2015.

[38] PhilHealth. PhilHealth Benefits Development and Research Department correction of PhilHealth Stats and Charts 2014 and 2015. Utilization Report as of 2017.
[39] PSA. PNHA, PSA. Latest updates for each year.
[40] PhilHealth circular No. 20, s2013 on Adoption of the Philippine Package of Essential Non-Communicable Disease Interventions (PhilPEN) in the implementation of PhilHealth's PCB package.
[41] As described earlier in this paper, profiling involves filling in or updating a two-page form that assesses the general health status of the member/dependent. The profile includes basic demographic data, past medical and surgical history, family health history, personal/social history, immunizations, reproductive health history, and pertinent physical examination findings. The Individual Health Profile is updated annually.
[42] Note that the implementation of the *Tsekap* package was halted (for reasons that are not clear) such that the current capitation payment is PHP 600.
[43] This experiment and impact evaluation are supported technically and financially by the World Bank and the KDI School of Public Policy and Management. The financial incentives provided to health workers are paid for by PhilHealth.
[44] While this information is not publicly available, it is an empirical question that PhilHealth should be able to answer using its administrative database.
[45] DOH. Health Facilities and Services Regulatory Bureau: Profile http://www.hfsrb.doh.gov.ph/index.php/about-hfsrb. (accessed February 21, 2018).
[46] According to the Cheaper Medicines Act, "The Secretary of the DOH shall have the power to implement the fair price of drugs and medicines for purposes of public health insurance and government procurement based on the order of the President of the Philippines imposing maximum retail price."
[47] The PhilHealth Stats and Charts is published online twice per year, and the GCG website contains annual performance assessment reports. The performance agreement between PhilHealth and the GCG calls for quarterly performance reporting. See http://gcg.gov.ph/site/public_files/gcg1405585878.pdf
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[52] PhilHealth reimburses facilities with two amounts, one is the payment for the professional fees for staff providing services and the other component is called the facility fee, which seems to be intended to cover operating costs other than personnel.

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Annex

Table A.1. PhilHealth top medical and procedural claims, 2016

	Medical or Procedural Case Type	Total Claims	Total Amount of Claims Paid (PHP)	Share of Claims (%)	Share of Amount of Claims Paid (%)
1	Hemodialysis procedure	1,517,054	8,084,414,155	15	8
2	Normal newborn care package	818,465	1,318,849,430	8	1
3	Community acquired pneumonia III (moderate risk)	647,340	9,459,906,214	7	9
4	Routine obstetric care for hospitals (NSD package)	469,657	2,454,612,370	5	2
5	Acute gastroenteritis	381,492	2,183,907,050	4	2
6	Routine obstetric care (MCP)	350,312	2,778,408,400	4	3
7	Urinary tract infection, site not specified	261,248	1,837,379,950	3	2
8	Dengue with warning signs	164,404	1,613,909,960	2	2
9	C-section, primary	155,919	3,044,989,320	2	3
10	Bronchial asthma in acute exacerbation	137,144	1,162,199,250	1	1
11	Other acute gastritis	124,373	720,907,950	1	1
12	Vaginal delivery	119,237	1,166,613,910	1	1
13	Chemotherapy administration	117,827	864,741,750	1	1
14	Dengue without warning signs	117,340	1,133,620,210	1	1
	Other case types	4,430,487	63,928,040,081	45	63
	Total of all claims	9,812,299	101,752,500,000	100	100

Source: PhilHealth Stats and Charts 2016.
Note: PCB is not included here because the payment is based on capitation, not claims, and therefore not included in the claims statistics. Therefore, these figures only represent the value of claims, not total PhilHealth benefits paid out.

Table A.2. Claims for PhilHealth maternal and neonatal packages, 2016

	Total Claims for Payment	Share of all PhilHealth Claims (%)	Share of Claim Value (%)	Value per Claim (PHP)
Normal newborn care package	818,465	8.3	1.3	1,611
Delivery claims, consisting of:	1,207,366	12.3	11.5	9,682
MCP (includes antenatal care)	350,312	3.6	2.7	7,931
NSD package	469,657	4.8	2.4	5,226
Primary C-section	155,919	1.6	3.0	19,529
C-section (not primary)	112,241	1.1	2.2	20,001
Vaginal delivery only (with episiotomy)	119,237	1.2	1.1	9,784

Source: Top 10 medical and procedural claims. PhilHealth Stats and Charts 2016.

Table A.3. Evolution of the PhilHealth outpatient/primary care package

	OPB (2000)	PCB1 (2012)	*Tsekap* (2015)
Consultation			
Completion of patient health profile		Yes	Yes
VIA (cervical cancer screening)			Yes
Regular blood pressure measurement		Yes	Yes
Periodic clinical breast exam, digital rectal exam		Yes	Yes
Counselling for lifestyle modification; smoking cessation; breastfeeding		Yes	Yes
Body measurements		Yes	Yes
Risk profiling for hypertension and diabetes (including body measurements)		Yes	Yes
Oral check-up and prophylaxis for children			Yes
Diagnostics			
Chest X-ray, complete blood count, fecalysis, urinalysis	Yes	Yes	Yes
Sputum microscopy	Yes	Yes	Yes
Fasting blood sugar, lipid profile		Yes	Yes
Blood typing, creatinine		Yes	Yes
Electrocardiogram			Yes
Peak expiratory flow meter testing			Yes
Blood glucose monitoring with glucose meter			Yes
Drugs			
Asthma		Yes	Yes
Acute gastroenteritis		Yes	Yes
Upper respiratory tract infection		Yes	Yes
Urinary tract infection		Yes	Yes
Hypertension, diabetes, dyslipidemia			Yes
Deworming			Yes
Ischemic heart disease			Yes

Note: VIA = Visual inspection with acetic acid.

Table A.4. Benefit packages for public health/preventive care and funding sources

Health Programs	Service Delivery	International Donors (Mainly Fund Drugs)	DOH Medicines Access Program	PhilHealth Coverage
Disease-free Zone Initiatives				
Malaria Control Program	BHS, RHU, hospitals	Global Fund through Pilipinas Shell Foundation, Inc.	National Malaria Program (NMP)	Outpatient malaria package
Schistosomiasis Control Program	RHUs, schools, 3 hospitals	United States Agency for International Development (USAID)-Family Health International	Schistosomiasis Control Program (SCP)	Inpatient only
National Filariasis Elimination Program	BHS, RHU, some hospitals	GlaxoSmithKline (GSK) donation	National Filariasis Elimination Program (NFEP)	Not covered
National Leprosy Control Program	Medical centers, DOH and LGU hospitals	—	National Leprosy Control Program (NLCP)	Inpatient only
Rabies Control Program	LGU, hospitals, RHUs	Gates Foundation, Japan International Cooperation Agency	National Rabies Prevention and	Outpatient animal bites package

Health Programs	Service Delivery	International Donors (Mainly Fund Drugs)	DOH Medicines Access Program	PhilHealth Coverage
			Control Program (NRPCP)	
Intensified Disease Prevention and Control				
National Tuberculosis Control Program	LGUs, TB-DOTS facilities	Global Fund (second line drugs)	National Tuberculosis Control Program (NTCP)	TB-DOTS package
Dengue Prevention and Control Program	—	—	Dengue vaccine for school children	Coverage for inpatient care
STI/HIV/AIDS Prevention and Control Program	Treatment hubs, primarily hospitals	Global Fund	National HIV/STI Prevention Program (NHPP)	Outpatient HIV/AIDS package
Control of Diarrheal Diseases and Acute Respiratory Diseases	LGUs, RHUs, health centers, hospitals	—	ComPack	PCB
Soil transmitted helminthiasis control program	RHUs, health centers	GSK	Soil Transmitted Helminthiasis Control Program (STHCP)	PCB includes deworming medicines.
Immunizations	LGUs, RHUs	International Health Partners UK, UNICEF logistics support	EPI	RA10152-Plan to incorporate EPI into PhilHealth packages. Currently, only Bacillus Calmette–Guérin (BCG) and Hepatitis B are in newborn care package.
Food and Waterborne Diseases Prevention and Control Program	RHU, health centers, hospitals	—	Food and Waterborne Diseases Prevention and Control Program (FWDPCP)	PCB1 benefit includes diarrheal treatment too.
Family Health Program				
Family Planning Program	—	NGOs in social marketing of contraception	—	Voluntary surgical contraception package case rate
Nutrition Program	—	—	Micronutrient Supplementation Program (MSP) (Vitamin A, zinc, iron, iodine)	PCB1 has some nutrition education.
New Born Screening Program	—	—	—	Newborn screening package

Health Programs	Service Delivery	International Donors (Mainly Fund Drugs)	DOH Medicines Access Program	PhilHealth Coverage
Oral Health Program	—	—	—	PCB includes child oral health.
Other programs				
Lifestyle-related diseases prevention and control	BHS, RHU, hospitals smoking cessation programs, nicotine replacement	—	National Smoking Cessation Program (NSCP)	PCB includes lifestyle and tobacco cessation counselling.

Source: Adapted from Beverly Lorraine C. Ho. Mapping of medicine entitlement programs of the national government. Consultant report for Medicines Transparency Alliance MeTA. 2015.

Table A.5. Curative care intervention programs and their sources of funding

Health Programs	DOH Medicines Access Program	PhilHealth Coverage
Catastrophic disease programs (Z-benefits)		
Acute Lymphocytic Leukemia Medicine Access Program (ALLMAP)	ALLMAP	Z-benefit
Breast Cancer Medicine Access Program (BCMAP)	BCMAP	Z-benefit
Person with Disability Program	—	Z-morph prosthesis package
Rare Disease Medicine Access Program (RDMAP)	RDMAP	Not covered
Other Health Programs		
Inpatient care at public facilities	GAA bulk procurement of some drugs	PhilHealth inpatient care coverage
Maternal and child health	—	MCP, NSD packages
National Voluntary Blood Service Program (NVBSP)	—	Outpatient blood transfusion benefit
Prevention of Blindness Program	—	Cataract outpatient surgery package paid by case rates
Health Care for Older Persons	HWOPP-Health and Well-being of Older Persons Program vaccines; GHMAP-Geriatric Health Medicines Access Program (free drugs in 1 hospital)	Similar services are available for PhilHealth members.
Mental Health Program	MHMAP-Mental Health Medicines Access Program	Only for inpatient mental health treatment
Common conditions including basic NCDs	ComPack	PCB, inpatient take-home packs
Insulin Access Program (IAP)	IAP, Public-private partnership for insulin consignment by private suppliers	Not covered for outpatient care

Source: Beverly Lorraine C. Ho. Mapping of medicine entitlement programs of the national government. Consultant report for Medicines Transparency Alliance MeTA. 2015.

Table A.6. Evolution of cases covered by case rate payments

	Early Case Rates	23 Case Rates (2011)	ACRs (2013)
Medical case rates			
Dengue (2 rates)		x	x
Pneumonia (2 rates)		x	x
Essential hypertension		x	x
Cerebral infarction		x	x
Cerebro-vascular accident (hemorrhage)		x	x
Acute gastroenteritis		x	x
Asthma		x	x
Typhoid fever		x	x
Newborn care package	x (2006)	x	x
Other case rates			4,563 case types, 327 rates
Procedural case rates			
Radiotherapy		x	x
Hemodialysis		x	x
MCP and NSD (2 rates)	x (2003)	x	x
C-section		x	x
Appendectomy		x	x
Cholecystectomy		x	x
Dilation and curettage		x	x
Thyroidectomy		x	x
Herniorrhaphy		x	x
Mastectomy		x	x
Hysterectomy		x	x
Cataract surgery	x	x	x
Other case rates			4,336 procedural case types, 2,955 rates

Note: In 2016, 12 procedure case types were delisted at the recommendation of specialist medical societies.