Chapter 4: A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

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Abstract
This study is a critical analysis of health services purchasing undertaken by PhilHealth, which implements the National Health Insurance Program of the Philippines. The study employs a principal-agent framework for analysing three critical relationships: that between the purchaser and healthcare providers, between the purchaser and citizens (members of PhilHealth), and between the purchaser and the Government, both as regulator and as funder of services, at the national Government and local government levels.

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

The study provides the following key findings:

- PhilHealth’s effort in responding to its members’ needs, preferences and values in decision-making are recognized, however, more work needs to be done to make sure that they are actively engaged and are aware of their entitlements and obligations. Protection from financial hardship is another area that needs work. Accountability and feedback measures exist but are not further explored to improve performance.
- PhilHealth’s ability to influence providers’ responsiveness and efficiency through policy and regulatory tools is inadequate. Although automatic accreditation is in
place, only 67% of government hospitals are accredited. Gatekeeping and referral systems are weak; quality standards are not monitored. However, the shift in payment mechanism from fee-for-service to case rates has shown positive results and a no-balance billing policy is in force and compliance has improved.

- Government has ensured resources for PhilHealth through earmarked sin taxes and audit is institutionalized, but no proactive stewardship role exists. Although investments in delivery capacity in underserved areas is ideal, PhilHealth’s tool is financing, which it is hoped will incentivize providers to locate in underserved areas.

As PhilHealth approaches universal population coverage, the key remaining tasks are as follows.

- **Purchaser-member link** – to identify the remaining members whose premiums have been paid for by government but who are not aware of their entitlements.

- **Purchaser-provider link** – to improve benefits by significantly expanding the PCB+ package and giving members a choice of provider (public or private); to loosen up on the accreditation of public health programmes (especially TB-DOTS) with a significant impact for poor Filipinos; to fine-tune the case rate payment system by conducting costing exercises; to expand Z benefits using objective burden of disease and cost-effectiveness principles.

- **Purchaser-government link** – to undertake strategic planning on the role of social health insurance, focusing on the need to improve collection efficiency and to increase the premium so that benefits can be expanded and sustained. To strengthen the stewardship and regulatory functions by investing in skills needed to manage a modern health financing system, including actuarial science, health technology assessment and medical informatics and business analytics.
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

**Acronyms**

- CARES: Customer Assistance, Relations and Empowerment Staff
- DALY: disability-adjusted life year
- HMO: health maintenance organization
- KP: Kalusugan Pangkalahatan (universal health)
- MDG: Millennium Development Goal
- MOVES: Mobile Orientation, Validation, and Enrolment Scheme
- NHTS-PR: National Household Targeting System for Poverty Reduction
- OPB: outpatient benefits
- PAGCOR: Philippine Amusement and Gaming Corporation
- PCB+: expansion of primary care benefits
- PCSO: Philippine Charity Sweepstakes Office
- PHIC: Philippines Health Insurance Corporation
- PhilHealth: Philippine Health Insurance Program
- PHP: Philippine peso (PHP 43.3 = US$ 1.00 as at July 2014)
- Q1: quintile 1, the lowest-income quintile, also known as “poor”
- Q2: quintile 2, the second-lowest-income quintile, also known as “near-poor”
- RESYST: Resilient and Responsive Health Systems
- RHU: rural health unit
- SHINE: Social Health Insurance Educational Series
- TB: tuberculosis
- TB-DOTS: Philippines directly observed treatment, short course program (tuberculosis)
- Z benefits: catastrophic illness benefit programme
Overview of healthcare financing and health service purchasing in the Philippines

Healthcare financing

The country’s total health expenditure increased in nominal (current) terms from 198 billion Philippine pesos (PHP) in 2005 to PHP 417 billion in 2011 and PHP 468 billion in 2012 (see Table 1). Correspondingly, nominal per capita health expenditure increased from PHP 3759 in 2009 to PHP 4392 in 2011 and PHP 4847 in 2012. Total health expenditure represented 4.3% of gross domestic product in 2011 and 4.4% in 2012. This compares favourably with Thailand (4.2%) and Singapore (4.1%), better than Indonesia (2.5%) and Myanmar (2.1%), but lower than Viet Nam (6.9%).

The distribution of health expenditures has not changed much during the past decade. Private sources, mostly out-of-pocket spending, accounts for more than 60%, while government expenditure has consistently been below 30%. Social health insurance, represented mainly by PhilHealth, with a small fraction from the Employees’ Compensation Commission, has consistently been below 10%. Donor expenditure accounts for 1-2%. Household out-of-pocket spending remains inordinately high as a proportion of total health expenditure in the Philippines.

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

Table 1. Key indicators of health expenditures, 2012

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure</td>
<td>PHP 467.8 billion</td>
</tr>
<tr>
<td>Total health expenditure as % of gross domestic product</td>
<td>4.4%</td>
</tr>
<tr>
<td>Total health expenditure per capita</td>
<td>PHP 4847</td>
</tr>
</tbody>
</table>
Table 1. Key indicators of health expenditures, 2012 (Con’t.)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of health expenditure</td>
<td></td>
</tr>
<tr>
<td>National and local government as % of total health expenditure</td>
<td>18.5%</td>
</tr>
<tr>
<td>Social health insurance (PhilHealth) as % of total health expenditure</td>
<td>11.4%</td>
</tr>
<tr>
<td>Household out-of-pocket spending as % of total health expenditure</td>
<td>57.6%</td>
</tr>
<tr>
<td>Others (donors, private institutions)</td>
<td>12.8%</td>
</tr>
<tr>
<td>Uses of health expenditure</td>
<td></td>
</tr>
<tr>
<td>Curative/rehabilitative care</td>
<td>52.3%</td>
</tr>
<tr>
<td>Medical goods directly purchased by households from retailers</td>
<td>30.4%</td>
</tr>
<tr>
<td>Preventive healthcare</td>
<td>9.4%</td>
</tr>
<tr>
<td>Administration</td>
<td>6.7%</td>
</tr>
<tr>
<td>Not elsewhere classified</td>
<td>1.2%</td>
</tr>
</tbody>
</table>


PhilHealth as purchaser of health services

PhilHealth was selected as the focus of this case study because it is the social health insurance programme in the Philippines. It is also one of the pioneers in the developing world. PhilHealth was established in 1995, following on from the Philippine Medical Care Commission which was created in 1969. The Philippine Medical Care Commission and PhilHealth were intended to carry out the National Health Insurance Program of the Philippines.

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

PhilHealth’s contribution to total health expenditure is currently small (11% in 2012), a figure dwarfed by sizeable out-of-pocket payments, mainly for over-the-counter drugs and prescription pharmaceuticals, especially those used to treat noncommunicable diseases. If this existing pattern and volume of out-of-pocket health spending can be pooled through premiums, this will transform PhilHealth into a large strategic purchaser of health services, lowering costs and significantly improving the overall efficiency of the health system. This potential remains to be realized, and this study’s primary interest is to see how it can be achieved.
PhilHealth has embarked on an ambitious reform programme involving the expansion of population coverage (corresponding to universal health coverage “width”), increasing benefits (corresponding to universal health coverage “breadth”) and changing the provider payment system to reduce, if not eliminate, out-of-pocket payments (corresponding to universal health coverage “depth”). Analysing these reforms through the lens of strategic purchasing can pinpoint current weaknesses and gaps in the reform programme and help PhilHealth achieve its target of universal health coverage.

Organizational characteristics of PhilHealth

Legal status

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

Vision, mission, and mandate

The vision and mission statements of PhilHealth are written in short Filipino phrases in line with its desire to communicate them to every Filipino. The vision is “Bawat Pilipino, miyembro; Bawat miyembro, protektado; Kalusugan natin, segurado” or roughly translated as “Each Filipino is a member; each member is protected; our health is secured”. The mission is “Sulit na benepisyo sa bawat miyembro; dekalidad na serbisyo para sa lahat” or “Optimal benefits for every member; good quality service for all”. Its values are innovation, good quality service, utmost integrity, equity, social solidarity and holistic care.
The vision, mission and values are consistent with its mandate to provide full health insurance coverage and ensure the delivery of good quality health services to every Filipino. As a social health insurance scheme, the National Health Insurance Program is a sustainable way for healthy Filipinos to support those who are sick and in need by making benefit packages available. However, its powers are limited to supporting officially enrolled members under the National Health Insurance Program, and it is prohibited from participating in the direct provision of health services, such as procurement of medicines, hiring of staff in hospitals or owning and investing in health facilities (Congress of the Philippines, 1995).

Funding sources and amount of funding
PhilHealth’s funding comes solely from health insurance premiums. It does not receive any budget subsidy from the national Government for running its operations. In 2013, 69% of funding was sourced from premiums paid by workers in the formal and informal economy, and the remaining 31% from the premiums of sponsored programme members. Total 2013 contributions amounted to around PHP 55 billion.

Regular contributions come from the formal and informal sectors. The employed sector contributes 2.5% of the employee’s monthly salary, which is automatically deducted from the payroll. Half this sum is paid by employers, and the other half by employees. Members of the informal sector contribute on a monthly or quarterly basis. Members of the informal economy sector who do not qualify for the sponsored programme are sponsored by the local government unit where they are registered or through other forms of cost-sharing mechanism (Congress of the Philippines, 2013a). Premiums of Sponsored Program members identified by the Department of Social Welfare and Development are paid by the Department of Health. Househelpers (domestic workers) are fully sponsored by their employers under the Domestic Workers Act (“Batas Kasambahay”, Republic Act No. 10361) (Congress of the Philippines, 2013b).

Establishment details
A national health insurance programme was set up by President Ferdinand Marcos through the Philippine Medical Care Act of 1969 (Republic
Act No. 6111, more commonly known as Medicare) (Congress of the Philippines, 1969), with the Philippine Medical Care Commission tasked to oversee implementation. However, it covered only the employed sector.

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

The National Health Insurance Act has been revised twice, first in 2004 through Republic Act No. 9241 (Congress of the Philippines, 2004), then in 2013 through Republic Act No. 10606 (Congress of the Philippines, 2013a). Key revisions in the first amendment include changes in accreditation requirements for health service providers and inclusion of two more representatives, one from the Basic Sectors of the National Anti-Poverty Commission and another from the overseas Filipino workers’ sector, on the Board of Directors. Aside from the strengthened mandate to cover 100% of the population, the 2013 amendment reflected the removal of accreditation fees for registered healthcare professionals under the Professional Regulatory Commission and the inclusion of Department of Health licensed hospitals as accredited healthcare providers. There is also an increasing shift from a fee-for-service payment mechanism to case-based payments.

**Organizational structure**

The Board of Directors oversees all the activities of the organization. The Board of Directors includes the President/Chief Executive Officer, who is the head of the corporation. There is an Internal Audit Group that conducts the financial and operations audits, and a Corporate Secretary. Under the President/Chief Executive Officer are various administrative offices, including the Office of the Executive Vice-President/Chief Operating Officer. Under this office are departments with specific functions for the delivery of health insurance, including fund management, member management, and health finance policy. This office also manages all the heads of regional offices across the country. In every department, vice-presidents and senior managers are in charge. Area vice-presidents
handle clusters of regions that are managed by regional vice-presidents, who handle regional managers in every suboffice.

Management and leadership
The Board of Directors is composed of members that represent various interests in the delivery of health insurance, including the President/Chief Executive Officer of PhilHealth. Representing the national government are secretaries of the Departments of Health, Interior and Local Government, Social Welfare and Development, Labor and Employment, and Finance, as well as the Chairperson of the Civil Service Commission, the President and Chief Executive Officer of the Social Security System, the President and General Manager of the Government Service Insurance System, and the Vice-Chairperson of the Basic Sectors of the National Anti-Poverty Commission. There are representatives from every member segment, which are the Sectors of Healthcare Providers, Employers, Labor, Self-Employed, Local Government Units, and Formal/Informal Economy. Also included is the Independent Director of the Monetary Board (PhilHealth, 2014a).

Financial management and auditing
The National Health Insurance Fund draws contributions from programme members, other appropriations earmarked by the national and local governments for this purpose, such as those for the Sponsored Program, subsequent appropriations provided under the filing of claims, donations and foreign aid grants, and any subsequent accruals (Congress of the Philippines, 2013a). For the financial year 2013, PhilHealth’s total assets stand at PHP 131 billion, and the reserve fund is around PHP 115 billion.

As with any other national government agency, financial management is restricted to rules and regulations applicable to the use of public funds. Moreover, annual total costs (which include administrative and operations costs) until 2018 must not exceed 5% of the sum total of total contributions, total reimbursements and investment earnings generated during the immediately preceding year. After 2018, annual total costs must not exceed the sum total of 4% of total contributions and reimbursements and 5% of investment earnings generated during the immediately preceding year (Congress of the Philippines, 2013a).
PhilHealth has an internal auditing department, but is also subject to independent audit by the Commission on Audit in accordance with International Standards on Auditing (Commission on Audit, 2013). Consolidation of financial statements from regional offices, where benefit payments and operating expenditures are decentralized, has been done through the Home and Branch Accounting System since July 1999. In this system, the central office consolidates individual accounting reports prepared by the regional offices at the end of every financial year (Commission on Audit, 2013).

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

**Other health financing and purchasing arrangements**

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

**National Government**

The national government is represented by the Department of Health, the highest policy-making body for health and the reporting or attached agency for 72 of the largest retained public hospitals. The Local Government Code, enacted in 1991, devolved all primary and secondary facilities to some 1400 local government units in 1992, leaving the largest apex hospitals, regional hospitals and other higher-level health facilities retained under the Department of Health (Congress of the Philippines, 1991). Four of these hospitals have autonomy via their own special charters while the rest do not, and are effectively a hierarchical extension of the Department of Health.

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

The purchasing of health services varies by facility. Purchasing is largely passive, as indicated by the following observations: (a) there is no clear identification of patients as clients or customers – public hospitals are supposed to cater more to the poor, but technically, everybody has a right to access the facilities and utilize the services there; (b) the roles of the purchaser and the provider are not clearly delineated, i.e. there is no purchaser/provider split; (c) there is no clear delineation between the budgets that health facilities receive and the outputs or outcomes that they are supposed to deliver.

**Local government**

Local government units consist of 80 provinces and some 1300 cities and municipalities. Under the Local Government Code, provinces own and manage provincial and district hospitals; cities own and manage city hospitals and city health units; and municipalities own and manage rural health units and barangay (village) health stations. These local health facilities are funded from each local government unit’s internal revenue allotment, as well as internally-generated funds from PhilHealth, private health insurance and user fees. There is no uniform financing or purchasing arrangement for these health facilities, and each local government unit is left very much on its own in deciding how to manage them. Very few of the health facilities have autonomy (La Union Medical Center is one); most are managed as hierarchically funded budget-receiving entities.

**Private health insurance and institutional spending**

The private health insurance industry in the Philippines is small, accounting for only 2% of total health expenditure in 2011. There are two main types: health maintenance organizations (HMO), which number fewer than 20, and life insurance companies offering indemnity health insurance as a product. Private institutional health spending includes the health expenditure of private schools and private establishments. These are school-based or work-based health programmes to which students or employees are entitled as a benefit.
Purchaser-member relationship in PhilHealth

Characteristics of PhilHealth members

There are five PhilHealth programmes, each with its own type of member: sponsored, formal, individually paying, overseas Filipino workers and lifetime (retirees). In general, the classification is based on the type of employment or the agency paying the premiums. Table 2 shows each membership type based on the old and current National Health Insurance Program laws.

Table 2. PhilHealth membership types

<table>
<thead>
<tr>
<th>Membership type</th>
<th>National Health Insurance Act of 1995 (Republic Act No. 7875)</th>
<th>National Health Insurance Act of 2013 (Republic Act No. 10606)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsored</td>
<td>A person who has no visible means of support, as identified by the local health insurance office and based on specific criteria set by PhilHealth.</td>
<td>A person who has no visible means of support, as identified by the Department of Social Welfare and Development following specific criteria (NHTS-PR²).</td>
</tr>
<tr>
<td></td>
<td>Contributions are subsidized partially by local government units and national Government, though PhilHealth provides counterpart financing equal to the local government unit’s subsidy.</td>
<td>The national Government subsidizes the full premium payment of indigent members identified under NHTS-PR.</td>
</tr>
<tr>
<td>Formal</td>
<td>Workers in both government and private sectors, as well as household employees and sea-based overseas Filipino workers; employees pay half the premium and the employer the other half.</td>
<td>Workers in the government and private sector; half the premium is paid by the employee and the other half by the employer.</td>
</tr>
<tr>
<td>Individually paying</td>
<td>Self-employed; contributions are based on household earnings and assets.</td>
<td>Individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, or as a career, but do not belong to the informal sector, e.g. movie actors. Contributions are based on household earnings and assets.</td>
</tr>
<tr>
<td>Overseas Filipino workers</td>
<td>Documented/undocumented Filipinos engaged in remunerated activities in another country (Republic Act No. 9241); member pays premium in full.</td>
<td>Documented/undocumented Filipinos engaged in remunerated activities in another country (Republic Act No. 9241); member pays premium in full.</td>
</tr>
</tbody>
</table>

² NHTS-PR = National Household Targeting System for Poverty Reduction.
Ideal versus actual functions in the purchaser-member relationship

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

Table 3. Ideal functions of the purchaser in the purchaser-member link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To engage actively with members about their health needs, preferences, and values</td>
<td>PhilHealth fulfils this function unevenly, but in the case of the Primary Care Benefit expansion (PCB+), it conducted extensive focus-group discussions to inform the design of the benefits.</td>
</tr>
<tr>
<td>To ensure there are mechanisms for identifying eligible beneficiaries</td>
<td>PhilHealth has no problem identifying paying members but has difficulty with Sponsored Program members whose premiums have been paid by the national government but who have not been enrolled. The Department of Social Welfare and Development identifies households eligible under the conditional cash transfer programme, which PhilHealth uses as basis for Sponsored Program coverage. The Department of Budget and Management then directly transfers the premium subsidies covering Quintile 1 (poor = 5.2 million families) and Quintile 2 (near-poor = 5.6 million families) to PhilHealth. Coordination and data problems, however, have resulted in large variance between PhilHealth’s claim of population coverage (75% in 2012) and the households’ self-reported coverage with PhilHealth insurance (60.3%), in the 2013 National Demographic and Health Survey.</td>
</tr>
</tbody>
</table>
Table 3.  Ideal functions of the purchaser in the purchaser-member link and assessment of PhilHealth’s performance (Con’t.)

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure awareness of members of their entitlements and obligations</td>
<td>Focus-group discussions indicate that members know of PhilHealth in general but they are not aware of their specific benefits. In 2013, a World Bank evaluation showed that 36% of Sponsored Program patients were unaware of their coverage, a problem being addressed by community health teams and PhilHealth’s CARES programme, which helps patients navigate the health system.</td>
</tr>
<tr>
<td>To develop entitlements reflecting the health needs of members and protecting them against financial catastrophe</td>
<td>In 2013, 60.3% of inpatients were covered by PhilHealth, significantly higher than the 37.7% recorded in 2008. In 2011, PhilHealth reformed the provider payment system by changing from retrospective fee-for-service to prospective case rates, which placed providers at risk for going over the rates for 23 conditions. Comparison of data pre-reform (2011) and post-reform (2013) show that almost all these case rates showed lower average costs and lower average lengths of stay compared with the fee-for-service figures. PhilHealth expanded this case rate system to all inpatient conditions in 2013, and also introduced catastrophic financing (&quot;Z benefits&quot;) for nine conditions. However, real resource costing needs to be done, as the current case rates involved averaging the claims of providers with some adjustments. In terms of public health interventions, analysis shows that the reimbursement rate for the Maternity Care Package has been generous, but that for TB-DOTS has been inadequate. Finally, the average value of support in 2013 represented only 31.5% of hospitalization costs, leaving the balance of 68.5% to be funded mostly out-of-pocket.</td>
</tr>
<tr>
<td>To ensure that members can access entitlements</td>
<td>In general, access is increasing: the percentage of treatment-seeking households rose from 7.9% in 2008 to 10.7% in 2013. However, the distribution of PhilHealth-accredited facilities is very uneven across provinces and regions, as is utilization. Moreover, there is no pattern linking coverage and benefit utilization across regions. Finally, PhilHealth accreditation of doctors has lagged greatly behind the growth of membership. The number of patients per accredited doctor has more than doubled from 1190 in the mid-1990s to 3240 in 2011.</td>
</tr>
<tr>
<td>To establish effective mechanisms to listen to complaints, views and reflections of members</td>
<td>Established procedures exist for settling complaints and resolving disputes. However, PhilHealth needs to have an active hotline, a webpage with same-day response and an active social media presence.</td>
</tr>
</tbody>
</table>
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

Table 3. Ideal functions of the purchaser in the purchaser-member link and assessment of PhilHealth’s performance (Con’t.)

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To report on purchaser performance to promote accountability</td>
<td>This function is not well developed and requires further institutionalization. No entity performs a watchdog function. PhilHealth’s annual reports feature positive achievements but gloss over issues, problems and challenges; also, the indicators change from year to year. PhilHealth’s “Dashboard” monitoring system is still in its infancy.</td>
</tr>
</tbody>
</table>

Source: Authors’ Summary

Analysis of the PhilHealth purchaser-member relationship

Ensuring that all members are registered

The medical social welfare officers of government hospitals are responsible for classifying patients and automatically enrolling the poor into PhilHealth so that they can receive immediate medical care. PhilHealth reimburses the hospitals and sends the list to Department of Social Welfare and Development for further validation. In 2013, PhilHealth issued implementation guidelines for the point-of-care enrolment programme (Administrative Order No. 2013-31).

The Aquino administration has been proactive in enrolling poor households. In 2011, almost 5 million poor households identified in the National Household Targeting System for Poverty Reduction (NHTS-PR) were already enrolled. The goal of the Government is to enrol the remaining 9 million poor households by 2014. Almost 25% of the total Department of Health budget is allocated to subsidize the premiums of poor households. As a result of this policy, the budget of the Department of Health increased almost fourfold between 2009 and 2014.

Coverage of non-Sponsored Program members is poor. Formal workers are supposed to be enrolled mandatorily in the social health insurance programme. However, poor coverage persists. In a study conducted by Silfverberg (2014a), the estimated coverage rate in the Government and private sector is around 80%, leaving 20% who are not enrolled. This high non-enrolment rate in the mandatory sectors is due to labour issues such as contractualization and casualization of employees. Employers are not obliged to cover the premiums of contractual and casual employees.
The informal sector is the biggest contributor to low coverage. In another study conducted by Silfverberg (2014b), fewer than 40% of informal workers are covered. The composition of the informal sector is extreme in terms of socioeconomic status, as it is composed of both near-poor and affluent households. The design intended to capture the informal sector in the insurance system makes it easy for members to opt out. In terms of premium payments, members in this sector need to pay at least three monthly premiums in the six months immediately before they receive treatment, which is not easy for near-poor households. Based on the latest official reports of PhilHealth, the coverage rate in 2013 was 75% (the coverage rate refers to the portion of the population who are eligible to receive benefits). Coverage rate estimates are usually lower than the enrolment rate, which is defined as the portion of population listed in the PhilHealth database. PhilHealth estimates of coverage rates have been contentious because its information system cannot capture the exact number of members and other beneficiaries (spouse and children under 21 years old). In lieu of the actual number of principal and dependent members, PhilHealth uses the average household size to derive multipliers to estimate the coverage rate. The assumed multipliers do not, however, take into account households with two or more principal members, the age distribution of members or the household size. As a result, estimated coverage rates have varied greatly. PhilHealth once reported an 85% coverage rate, while estimates from national surveys and external reviews showed less than 50%. The 2013 National Demographic and Health Survey reported that 62.8% of Filipino households had health insurance, of which 60.3% had PhilHealth insurance (National Statistics Office, 2014).

As for enrolling poor households, as with most social health insurance schemes, the idea is for the Government to subsidize the premiums of the poor households. Prior to 2013, local government units were responsible for identifying poor households, and their premiums were partly shared by the local and national governments. Identification of poor households has been highly politicized and unstandardized in practice, which led to undercoverage of “true poor” households. Enrolment of “political poor or indigents” was also common in local government units.
Under the new law on the National Health Insurance Program, the responsibility of identifying poor households eligible for the Sponsored Program was shifted from local government units to the national government. Counterpart financing was also removed, as the national government began to pay all premiums for the pre-identified poor households. PhilHealth used the National Household Targeting System (NHTS) of the Department of Social Welfare and Development. NHTS is a targeting tool, also used in several social and poverty reduction programmes of the Government (PhilHealth, 2012a). All households in the bottom 40% of the NHTS list are automatically covered by PhilHealth. As most of the poor households are already covered, the major challenge now for the Government is to locate and inform them about their new benefit entitlement. Problems arise because of errors in the addresses in the NHTS list and geographical constraints. NHTS uses location when identifying poor households. Hence, households without a permanent address (e.g. informal settlers or homeless people) are not included in the NHTS list.

In parallel with NHTS, PhilHealth also rolled-out “point-of-care enrolment”. Although this strategy promoted adverse selection, it was introduced to capture “critically poor” households which have not been included in the NHTS list.

**Ensuring awareness among members of their entitlements to benefits**

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

In 2012, PhilHealth deployed 530 nurses in level 2 and 3 government hospitals to serve as “navigators”. Their main responsibility is to help patients to determine their membership status and inform them of their benefit entitlement. They also perform surveys and studies initiated by PhilHealth. In hospitals retained by the Department of Health, PhilHealthcareS staff are stationed at a designated PhilHealth desk. Private hospitals may opt to hire their own navigators.

Information and education campaigns

PhilHealth has launched numerous programmes such as the Mobile Orientation, Validation and Enrolment Scheme (MOVES) and the Social Health Insurance Educational Series (SHINE) to improve the awareness of both members and stakeholders. MOVES aims to educate its members, especially Sponsored Program members, about PhilHealth and their benefit entitlement by giving lectures and presentation in localities. SHINES is a way to educate and update local executives, municipal officers and policy-makers about social health insurance. The corporation also engages in traditional information, education and communication activities, such as radio and television broadcasts for the dissemination of PhilHealth processes, benefit packages and entitlements. Currently, PhilHealth has a regular time slot on radio and television, where the public can raise queries and voice their concerns.

Despite these attempts to improve awareness, mass education programmes are still limited. In the case of mass educational campaigns such as MOVES, vulnerable population segments are not captured, as most of the lectures are conducted in local government centres or in urban areas. Most poor households in the country are in geographically challenged areas, which it is impossible to reach via the traditional modes of information, education and communication. There is also no mechanism or standard in place to instruct local offices how they should conduct mass education campaigns. As of the time of writing, only a few local government offices have conducted MOVES.
Active engagement of members about their preferences, needs and problems

Ideally, citizens should be involved in major policy decisions of PhilHealth, especially during the development of the benefit package. This is to ensure that the policies in place are for the general good of the population. In terms of benefit design and development, there are no clear guidelines or written protocols showing how benefits should be crafted or how the concerns of the population should be taken into account. There is no benefit expansion plan or strategy. Hence, all the existing benefit packages of PhilHealth might be crafted and approached in an unstandardized and ad hoc environment.

Although health technology assessments were introduced in the past as part of the benefit development process, they have never been institutionalized. Hence, it is not clear how benefits are decided. Ideally, PhilHealth should take into account the economic effectiveness and sociocultural acceptability of the benefit packages prior to rollout. Although PhilHealth admitted that it takes into account the gravity of the disease concerned, its public health importance and public opinion (e.g. use of surveys), it is not very explicit how the corporation used them in the actual cost calculation or in the implementation arrangements for the benefit package. The approval of benefit packages is also prone to political influences, as shown by the inclusion of several packages that are not cost-effective. Ideally, one could study documents developed during the benefit development process, such as minutes of meetings and detailed documentation of benefit packages and other documents. However, such documents do not exist.

Ensuring effective mechanisms for members’ complaints, views, and reflections

There are established procedures for settling complaints and resolving disputes. However, these are not enough; what is needed are well maintained channels of communication between PhilHealth members and providers and the management and Board of Directors, to ensure that members’ and providers’ views are heard, addressed and, it is hoped, taken into account in the decision-making process. Although PhilHealth maintains a website, the queries of citizens are not addressed in a timely manner. PhilHealth has not fully utilized the potential of social media to reach out to members and providers.
Purchaser-provider relationship in PhilHealth

Organizational characteristics of health service providers

Overall trends in health facilities

Health facility investments, both public and private, has stagnated relative to a ballooning population since the 1980s. The bed-population ratio was one of the highest in Asia in the 1970s at 32 per 1000 population but this has declined to only 17 per 1000 population in the 2000s. Average occupancy rates typically exceed 100% in government hospitals, except lower-level ones. Private hospital investments have also been slow. Health facilities are poorly distributed geographically. The devolution of health services since the 1990s may have contributed to the widening disparities in the quantity and quality of these facilities.

Hospitals

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

- Level 1 (formerly Level 2) has a bed capacity of less than 100 and has the following services: consulting specialists in medicine, paediatrics, obstetrics and gynaecology, and surgery; emergency and outpatient services; isolation facilities; surgical/maternity facilities; dental clinic; secondary clinical laboratory; blood station; first-level X-ray facility; and pharmacy.
- Level 2 (formerly Level 3) has a bed capacity of 100-200 and has all the services of Level 1 facilities, with the following additional facilities: departmentalized clinical services; general intensive-care unit; high-risk pregnancy unit; neonatal intensive-care unit; tertiary clinical laboratory; and second-level X-ray facility with mobile unit.
- Level 3 (formerly Level 4) has a bed capacity of more than 200 and has all the services of Level 2 facilities with the following additional facilities: teaching with accredited residency training programme in the four major clinical services; physical
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

medicine and rehabilitation unit; ambulatory surgical clinic; dialysis clinic; tertiary clinical laboratory with histopathology; blood bank; and third-level X-ray facility.

- Hospitals labelled as Level 1 in the pre-2012 classification are now classified as “other health facilities,” which can be any of the following: primary care facility; custodial care facility; diagnostic/therapeutic facility; and specialized outpatient facility.

At present, there are 1810 hospitals in the Philippines, with 726 (around 40%) under public ownership, and the remaining in private ownership (Department of Health, 2012a). The majority of private hospitals operate as for-profit institutions, with a significant concentration in Central Luzon region and National Capital Region, which are relatively wealthier. In fact, 34% of all hospital beds are located in the National Capital Region, where 12% of the nation’s population reside. The establishment of private hospitals in areas with lower poverty rates is commonly seen as a measure to ensure a steady income (Lavado et al., 2010).

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

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

Private hospitals comprise around 60% of all hospitals and may be owned
by a single proprietor, a partnership, a family, a religious institution or
a corporation. They also acquire their licence from the Bureau of Health
Facilities and Services and are then accredited by PhilHealth to receive
reimbursements if they meet the standards. Private hospitals receive their
funding from out-of-pocket expenditure, reimbursements from private
health insurers and PhilHealth reimbursements.

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

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

The imbalance in the geographical distribution of Government physicians
is a serious matter, as most are concentrated in big cities. The Department
of Health launched the Doctors to the Barrios programme in the 1990s as a response to this shortage and other problems such as the inability of smaller, rural local government units to support their devolved health programmes fully. However, the programme only requires doctors to stay for two years, and most do not stay with their assigned local government unit when the programme is over (Capuno, 2008). Because of the stopgap nature of this programme and the decreasing independence of the participating local government unit to achieve financial stability in health, the Doctors to the Barrios programme is currently under review by the Department of Health (Crisostomo, 2014).

Department of Health implements other measures to help local government units, such as Doctors to the Barrios–Leaders for Health, community health teams, Rural Health Team Placement programmes and the Specialist to the Provinces programme, all requiring the participation of at least one qualified physician to complete the team (Department of Health, 2010a). Apart from the efforts of some State universities to oblige their students to work in public service after a few years, there is no national legislation requiring health professionals to work in the public sector after graduation; neither are there special incentives for physicians to practise in underserved areas.

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

Stand-alone clinics: birthing centres, renal clinics, etc.
Stand-alone clinics usually provide outpatient and ambulatory care for patients. They do not have the full range of services available in a typical hospital, but specialize in a particular health service. The most prevalent stand-alone clinics are lying-in or maternity clinics, dialysis clinics, clinics for tuberculosis (TB-DOTS), free-standing private clinics operated by a sole proprietor and polyclinics run by a group practice. Physicians who work
in hospitals often operate their own private practice alongside through a clinic. Most are run privately, and the cost of treatment is high. The poor typically seek outpatient treatment in public facilities such as the rural health units or the outpatient ward in public hospitals.

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

**Rural health units and barangay health stations**

Rural health units provide basic primary care, serving mostly the poor. They are the most frequently utilized health facilities (around one-third of visits to all health facilities according to the 2008 National Demographic and Health Survey (National Statistics Office, 2009). Barangay health stations are centres set up in barangays, the smallest political unit in the country, and are managed by rural health units or city health offices.

Rural health units were created in the 1950s so that each municipality could improve access to healthcare. In the wake of the passage of the Local Government Code in 1991, rural health units, city health units and barangay health stations were devolved to the municipal and city local government unit. The Department of Health was left with the task of building capacity at the rural health units and barangay health stations for delivery of the various vertical health programmes, e.g. Expanded Programme on Immunization and TB-DOTS. In general, rural health units and barangay health stations provide health services free of charge, but problems of lack of availability, accessibility and human resources are common. Just like hospitals and clinics, rural health units can be accredited by PhilHealth. As of 2009, there are 843 accredited rural health units to provide the outpatient benefit package (Romualdez et al., 2011).
Ideal versus actual functions in the purchaser-provider relationship

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

Table 4. Ideal functions of the purchaser in the purchaser-provider link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To take active decisions on which providers to purchase services from, with consideration of</td>
<td>PhilHealth has been too stringent in accrediting government hospitals and public health clinics, reducing access to these services. Only 67% of all licensed hospitals have been accredited. For TB-DOTS, only 59% of all licensed TB-DOTS clinics have been accredited after 10 years. Although a more accommodating accreditation policy has been specified in the General Appropriations Act of 2012, this has not been fully implemented. More facilitative arrangements with providers to improve quality of care are yet to be institutionalized.</td>
</tr>
<tr>
<td>quality, ability to provide services and location</td>
<td></td>
</tr>
<tr>
<td>To extend services to underserved areas.</td>
<td>PhilHealth has no geographical equalization (or equity) fund. PhilHealth reimbursement rates are uniform and do not provide additional incentives for geographically isolated and depressed areas.</td>
</tr>
<tr>
<td>To improve health system efficiency through rational provision and use of services</td>
<td>Gatekeeping and referral systems are very weak because patients tend to go to the nearest health facility, referral bypass fees are not imposed, and many cities do not have city hospitals or filter clinics, forcing patients to clog up Department of Health-owned regional hospitals located in these cities. On the positive side, payment reform, i.e. the change from fee-for-service to case rates, has shown good results. The Generics Law has been in force for decades, but providers still find ways to prescribe branded drugs. Not all clinical guidelines are available. Finally, because PhilHealth accounts for only 11% of total health expenditure, it has not evolved as a major payor and is largely unable to exercise its monopsony power to reduce healthcare costs and out-of-pocket spending.</td>
</tr>
<tr>
<td>To monitor provider performance, including quality of care</td>
<td>Quality standards are mostly imposed ex-ante through accreditation. Concurrent quality monitoring is not yet in place. Deaccreditation of erring providers is rarely resorted to, as it penalizes members just as it does the providers.</td>
</tr>
</tbody>
</table>
Table 4. Ideal functions of the purchaser in the purchaser-provider link and assessment of PhilHealth’s performance (Con’t.)

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enforce contractual agreements with qualified public and private providers</td>
<td>PhilHealth outpatient benefit packages evolved in a fragmented fashion, requiring repetitive accreditation and monitoring. Hospitals usually complain of payment delays, although payment has been expedited under case rates. Also, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.</td>
</tr>
<tr>
<td>To implement and adjust provider payment methods that enhance quality and efficiency</td>
<td>Under case rates, providers know in advance their reimbursements. A no-balance billing policy is in force, and compliance has improved. In June 2013, 93% of surveyed hospitals practised no-balance billing; by June 2014, this was reduced to 59%.</td>
</tr>
<tr>
<td>To ensure mutual accountability between purchaser and providers through timely payment</td>
<td>On average, turnaround time fell by 21-24 days when PhilHealth changed provider payment from fee-for-service to case rates.</td>
</tr>
<tr>
<td>To manage finances in a transparent and accountable way</td>
<td>PhilHealth has adopted an accounts-management approach to ensure that all collectibles are collected. PhilHealth has an internal audit unit that investigates fraud. Revenues have always been aligned with expenditure, but reserve management has been conservative. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years’ worth from 2004 to 2009, though this has been reduced to 2.2 years in 2013, closer to what the law prescribes, i.e. two years.</td>
</tr>
</tbody>
</table>

Source: Authors’ Summary

Analysis of the purchaser-provider relationship in PhilHealth

Engagement of providers and provider payment systems

PhilHealth purchases inpatient and outpatient services from various contracted health providers and drug outlets and pays these according to agree-upon provider payment systems.

Ordinary inpatient case packages

Case payment for inpatient care was introduced for the first 23 case rates in 2011, replacing the traditional fee-for-service system. This was expanded in January 2014 to cover all inpatient medical and surgical cases. All members are eligible under this payment system, but only Sponsored Program members utilizing Government hospitals are entitled to the no-balance
billing policy (i.e. zero copayments). Healthcare providers are paid a fixed rate and are responsible for distributing professional fees to physicians.

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

Table 5. Effect of the case rate payment system on average cost of care (PHP), by Sponsored Program and non-Sponsored Program members, 2010* and 2012**

<table>
<thead>
<tr>
<th>Selected case rates</th>
<th>Sponsored Program</th>
<th>Non-Sponsored-Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>Acute gastroenteritis</td>
<td>12 008</td>
<td>8676</td>
</tr>
<tr>
<td>Cataract removal</td>
<td>41 694</td>
<td>18 069</td>
</tr>
<tr>
<td>Cardiovascular accident I</td>
<td>46 255</td>
<td>35 836</td>
</tr>
<tr>
<td>Pneumonia I</td>
<td>27 217</td>
<td>19 370</td>
</tr>
<tr>
<td>Dengue I</td>
<td>69 620</td>
<td>12 956</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>139 679</td>
<td>35 681</td>
</tr>
</tbody>
</table>

* = before introduction of case rates; ** following introduction of case rates.
Source: PhilHealth, 2014.

Table 6. Effect of the case rate system on average length of stay (in days), by sponsored and non-sponsored programme members, 2010* and 2012**

<table>
<thead>
<tr>
<th>Selected case rates</th>
<th>Sponsored Program</th>
<th>Non-Sponsored-Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>Acute gastroenteritis</td>
<td>6.13</td>
<td>4.49</td>
</tr>
<tr>
<td>Cataract removal</td>
<td>1.93</td>
<td>1.16</td>
</tr>
<tr>
<td>Cardiovascular accident I</td>
<td>12.08</td>
<td>9.11</td>
</tr>
<tr>
<td>Pneumonia I</td>
<td>9.81</td>
<td>6.47</td>
</tr>
<tr>
<td>Dengue I</td>
<td>8.22</td>
<td>5.96</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>14.33</td>
<td>6.58</td>
</tr>
</tbody>
</table>

* = before introduction of case rates; ** following introduction of case rates.
Source: PhilHealth, 2014.
Some problems persisted, however. As many as 36% of the Sponsored Program patients did not know about their PhilHealth coverage (World Bank, 2012). A few hospitals resorted to upcoding (charging a patient under a condition reimbursed at a higher rate than the real condition), e.g. paediatric to acute gastro-enteritis (Machinji, 2012). Patients’ out-of-hospital expenditure remained a problem, as some facilities continued to experience shortages of drugs and medical supplies (Maala, 2014); in effect, this is default balance billing. However, the prevalence of balance billing declined from 93% in June 2013 to 59% in June 2014 (Picazo, 2014a).

Catastrophic case packages (Z benefits)

These packages cover conditions that are deemed economically and medically catastrophic, using PhilHealth criteria. A reference hospital is first contracted to assist PhilHealth in setting the practice standards and costing of the package. Other providers are then selectively contracted according to their capability to deliver the package. Currently, providers are limited to public tertiary hospitals. Healthcare providers are paid a fixed rate and are responsible for distributing professional fees to physicians. Sponsored Program members are eligible for zero copayments, while non-Sponsored Program members are entitled to a maximum copayment of 50%. In 2013, the Z benefits package was expanded into Z MORPH (Mobility, Orthosis, Rehabilitation, and Prosthesis Help) to support the treatment of disabled persons as indicated by Republic Act No. 7277, the “Magna Carta for Disabled Persons” (Congress of the Philippines, 1992). Assessment of Z benefits (Table 7) shows low utilization so far, mainly because of the limited number of providers, quite stringent eligibility criteria and limited information for patients about this package.

Table 7. PhilHealth Z benefits, by amount paid (PHP) and number of patients, as at 30 June 2014

<table>
<thead>
<tr>
<th>Conditions covered by Z benefits</th>
<th>Amount paid (PHP million)</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute lymphatic leukaemia, standard risk, for children</td>
<td>4.3</td>
<td>28</td>
</tr>
<tr>
<td>Early breast cancer</td>
<td>17.8</td>
<td>211</td>
</tr>
<tr>
<td>Prostate cancer, low to intermediate risk</td>
<td>1.1</td>
<td>11</td>
</tr>
</tbody>
</table>
Table 7. PhilHealth Z benefits, by amount paid (PHP) and number of patients, as at 30 June 2014 (Con’t.)

<table>
<thead>
<tr>
<th>Conditions covered by Z benefits</th>
<th>Amount paid (PHP million)</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney transplant for end-stage renal disease, standard risk</td>
<td>80.7</td>
<td>136</td>
</tr>
<tr>
<td>Coronary artery bypass graft surgery, standard risk</td>
<td>54.4</td>
<td>99</td>
</tr>
<tr>
<td>Total correction for tetralogy of Fallot in children</td>
<td>32.0</td>
<td>100</td>
</tr>
<tr>
<td>Closure of ventricular septal defect in children</td>
<td>18.0</td>
<td>72</td>
</tr>
<tr>
<td>Cervical cancer, stage I to IV</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Z MORPH</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208.1</strong></td>
<td><strong>657</strong></td>
</tr>
</tbody>
</table>

Source: PhilHealth, 2014.

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

Outpatient benefits and MDG benefits

The evolution of PhilHealth outpatient or MDG benefits (thus called because of their association with the United Nations Millennium Development Goals) is shown in Table 8. These cover a range of services delivered by outpatient clinics, birthing centres, free-standing dialysis clinics, ambulatory surgical centres and hospital outpatient departments. Some examples are the maternity care and newborn package for normal delivery, packages for tuberculosis (TB-DOTS), malaria, HIV/AIDS, severe acute respiratory syndrome (SARS), avian influenza, haemodialysis, chemotherapy and radiotherapy, animal bites and voluntary surgical contraception. All members are eligible for these packages. Healthcare
providers are paid a fixed rate and are responsible for distributing professional fees to physicians. Sponsored Program and indigent members are entitled to zero co-payments through the no-balance billing policy.

Table 8. Evolution of PhilHealth outpatient and MDG benefits

<table>
<thead>
<tr>
<th>Year</th>
<th>Benefits</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Outpatient benefits (OPB)</td>
<td>RHU only</td>
</tr>
<tr>
<td>2003</td>
<td>+ Maternity Care Package, TB-DOTS</td>
<td>RHU + birthing centres (public and private) + TB-DOTS centres (public and private)</td>
</tr>
<tr>
<td>2006</td>
<td>+ Neonatal care package</td>
<td>RHU</td>
</tr>
<tr>
<td>2008</td>
<td>+ Malaria</td>
<td>RHU</td>
</tr>
<tr>
<td>2010</td>
<td>+ Animal bite treatment and care</td>
<td>RHU</td>
</tr>
<tr>
<td>2012</td>
<td>+ HIV/AIDS treatment</td>
<td>Treatment hubs (usually Government regional hospitals)</td>
</tr>
<tr>
<td>2014</td>
<td>+ insertion of intrauterine devices</td>
<td>RHU</td>
</tr>
<tr>
<td>2014</td>
<td>+ noncommunicable disease drugs (pilot)</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>2015</td>
<td>+ Other primary care</td>
<td>RHU + private clinics</td>
</tr>
</tbody>
</table>

Source: PhilHealth, undated RHU = rural health unit.

Table 9 shows the number of providers and payments to providers under this benefit from 2009 to 2013. No data are available on the number of patients seen. No assessment of the individual packages is available. However, a consultant’s report on the feasibility of PhilHealth financing of multidrug-resistant TB (Picazo et al., 2014) showed the following performance of PhilHealth’s TB-DOTS package: (a) while TB patients are overwhelmingly poor, most of them are not included in the Government anti-poverty programme of conditional cash transfers (CCT/4P) and therefore are not automatically covered as Sponsored Program members, as stipulated under the law; (b) after 10 years (2003–2013), PhilHealth has accredited only 59% of the 5084 licensed TB-DOTS centres – the non-accreditation of TB-DOTS providers, even those operating under the Department of Health’s National Tuberculosis Programme, means that many patients do not benefit from PhilHealth reimbursements for TB care and, indeed, 499 local government units in the country do not have any PhilHealth accredited TB-DOTS providers; (c) compared with the total cost
of TB diagnosis and treatment per patient of PHP 9030, the reimbursement rate represents a support value of only 44%.

Table 9. Number of providers and payments to providers under PhilHealth’s outpatient benefits (2009-2011) and primary care benefits (2012-2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Benefit name</th>
<th>No. of providers</th>
<th>Amount (PHP billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>OPB</td>
<td>n.a.</td>
<td>0.684</td>
</tr>
<tr>
<td>2010</td>
<td>OPB</td>
<td>n.a.</td>
<td>1.008</td>
</tr>
<tr>
<td>2011</td>
<td>OPB</td>
<td>1404</td>
<td>1.309</td>
</tr>
<tr>
<td>2012</td>
<td>PCB</td>
<td>2134</td>
<td>3.625</td>
</tr>
<tr>
<td>2013</td>
<td>PCB</td>
<td>2536</td>
<td>3.026</td>
</tr>
</tbody>
</table>

*Source:* PhilHealth, undated. OPB = outpatient benefits; PCB = primary care benefits.

The Primary Care Benefit 1 (PCB1) package covers primary preventive and outpatient consultation services, diagnostics and drugs for four of the most common outpatient conditions. Government-owned outpatient clinics (rural health units and outpatient departments of Government hospitals) are the accredited providers and receive an annual payment per family of PHP 500. This programme requires providers to open a trust fund in which PhilHealth reimbursements will be collected, and providers must allocate the PhilHealth revenue as follows: 40% to services, 40% to drugs and diagnostics and 20% to incentives for professionals. These proportions are explicitly prescribed.

The Primary Care Benefits 2 (PCB2) package was designed to provide pharmacy benefits for eight drugs to treat hypertension, diabetes mellitus, and dyslipidaemia. The benefit guidelines prescribe the following: (a) only patients screened by their PCB1 primary care providers using the WHO Package of essential NCD interventions for primary healthcare (PEN) guidelines are eligible; (b) patients can obtain drugs only at drug outlets that agree to observe the set price caps; (c) while there is no limit on the amount of drugs that an individual can obtain, only one member per family can take advantage of the benefit; (d) drug outlets are reimbursed monthly, depending on consumption. The programme is currently being piloted in Pateros, a municipality within Metro Manila. However, an assessment of this pilot indicates that the sample size is not large enough to provide robust findings. Indeed, of the 66 000 total population of the municipality
of Pateros, only 80 people were found to be eligible, of whom only five accessed the benefit and only one is currently making use of it (Herrera, 2014).

**Licensing, accreditation and contracting**

Prior to 2012, PhilHealth was criticized for being overly slow with Department of Health licensing processes and causing delays in its contracting (which it called “accreditation”) procedures. It required “pre-accreditation surveys” which overlapped in part with the Department of Health licensing inspections, annual renewals, facility checks and manual submission of paper-based applications. This resulted in bottlenecks in contracting (i.e. granting accreditation privileges) which occasionally resulted in “accreditation gaps” and subsequent difficulties for providers in obtaining reimbursement for services rendered during the period of the gap.

Since 2012, the process has been streamlined. The Department of Health adopted the PhilHealth Benchbook accreditation standards and incorporated them into the licensing requirements, thus essentially requiring only one survey prior to licensing and accreditation. Henceforth, all licensed providers are deemed accredited upon submission of documentary requirements and a pre-accreditation survey is no longer required. Also, healthcare providers no longer need to renew their accreditation annually; instead, renewal is automatic until accreditation is withdrawn or terminated. The reaction of providers to this new accreditation process has been mixed; some providers felt that PhilHealth was more competent in conducting the accreditation surveys, which encouraged them to perform better.

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

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

The PCB1 programme came up with specific provisions for providers, the majority of which are local government units. PCB1 requires that local government units should set up a trust account for the health facility to ensure that the capitation fees paid will be retained for the use and improvement of the facility, instead of the fund being siphoned back into the general funds of the local government unit. The requirement was initially met with a lot of resistance, but currently around 84% of local government units have set up trusts.

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

All healthcare providers are required to submit their claims within 60 days of patient discharge, while PhilHealth is required to process the claims within 60 days of claims filing. When filing delays are caused by providers, PhilHealth penalizes them by not processing the claim. However, if PhilHealth fails to process the claims within the prescribed period, there are no corresponding penalties for PhilHealth, or interest payments corresponding to the delay in payment.

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

Table 10. Reduction in days of PhilHealth claims processing turnaround time from fee-for-service in 2010 to case rates in 2012, by type of facility

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Reduction in claims processing days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 hospitals</td>
<td>22</td>
</tr>
<tr>
<td>Level 2 hospitals</td>
<td>23</td>
</tr>
<tr>
<td>Level 3 hospitals</td>
<td>24</td>
</tr>
<tr>
<td>Level 4 hospital</td>
<td>21</td>
</tr>
<tr>
<td>Ambulatory services</td>
<td>27</td>
</tr>
<tr>
<td>Dialysis centres</td>
<td>23</td>
</tr>
<tr>
<td>Maternity clinics</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: PhilHealth, 2014.

No-balance billing policy

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

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

The Z benefits took a different approach. The case package, for which costing was undertaken in collaboration with the providers themselves, required zero co-payments for Sponsored Program members and a fixed co-payment of 50% of the package cost for non-Sponsored-Program members. Because the cohort of Z beneficiaries is still limited, exit interviews were conducted with all of them. This showed 100% compliance with the fixed co-payment or no-balance billing provisions. Recently, the no-balance billing policy has been expanded to cover all outpatient services rendered in nonhospital institutions.
Geographical equity

Under the fee-for-service provider payment system, PhilHealth introduced incentives for physicians practising at sites determined to have a shortage of health personnel, by adding 10% to their professional fee reimbursements and allowing them to perform surgical procedures beyond a certain relative value unit. The adoption of the all-case-rates provider payment system stipulated that special fee schedules should be drawn up for geographically isolated and disadvantaged areas and areas with a shortage of health personnel. However, the guidelines for this policy pronouncement are yet to be formulated.

In the 1970s, the Philippine Medical Care Commission experimented with constructing its own health facilities in underserved areas, but this did not work, and the health facilities were soon turned over to the Department of Health, and then to the local government units when health services were devolved in 1992. Geographical inequity has not been resolved since devolution; in fact, there are indications that it may have worsened. Larger and richer provinces and cities tend to have better health services than smaller and poorer local government units.

3.3.1.8 Enhanced health systems efficiency

The Philippines resorts to a mixed range of instruments to enhance system efficiency, with varying results. Among the more visible ones are the following.

(a) Use of drug formulary – the Philippine National Formulary contains the essential drugs list. It is prepared by the Department of Health National Drug Committee after consultation with experts and specialists from professional medical societies, medical academia and the pharmaceutical industry, and is updated every year. The general basis for selection of medicines consists of the following criteria: relevance to prevalent conditions, efficacy and safety, quality, cost of treatment regimen, appropriateness for the capability of health workers, local health problems and benefit/risk ratio. In addition, preferential factors like “most thoroughly investigated drugs” are stated and single formulations are preferred.
In all benefit programmes, PhilHealth is mandated to reimburse only drugs included in the formulary. However, this principle is not always observed. Under the all-case-rates system and PCB benefits, healthcare providers can get around this rule because they are not required to declare which drugs were administered as a requirement for payment. Meanwhile, certain selection criteria for the Philippine National Formulary – drugs for the most prevalent conditions, not too costly, and with an established evidence base – are limiting for programmes like Z benefits. The Z benefits cover high-cost, but not necessarily high-prevalence, conditions, and the drugs or devices involved do not have as extensive an evidence base as that for other conditions.

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

(c) Clinical practice guidelines – PhilHealth is mandated to support quality improvement and consistency in the delivery of health services. It performs this function not by developing clinical practice guidelines, but by appraising guidelines and translating them into policy statements. The appraisal is a five-stage process that begins with a systematic search for clinical practice guidelines published locally and abroad. The validity is then screened, using the AGREE (Appraisal of Guidelines for Research and Evaluation) instrument (AGREE Collaboration, 2001) and an in-house appraisal checklist. Interventions are then assessed based on local applicability. Finally, drugs are counterchecked against the Philippine National Formulary. The guideline appraisal process is undertaken by at least three technical staff. The findings then become the basis for policy statements. Currently, PhilHealth has released policy
statements for 15 disease conditions\textsuperscript{3} under PCB1, PCB2 and some inpatient and outpatient case packages. However, since adherence to the guidelines is not routinely monitored and is not made a prerequisite for payment, there is no way to determine adherence. In the case of the Z benefits, adherence is mandated, as the payment is made in tranches according to guideline-based treatment.

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

(a) General expenditure and cost controls – the Philippines has no centralized resource allocation authority that sets guidelines for the overall resources in the health system to be spent in a particular year. While the process under hierarchically organized hospitals of the Department of Health and local government units have a close-ended budget, there is a lot of “gaming” at the facility level, as hospital directors play one funding source off against other sources (PhilHealth, private insurance, user fees, the Philippine Amusement and Gaming Corporation (PAGCOR), Philippine Charity Sweepstakes Office (PCSO), external donors and sometimes pork-barrel financing from politicians) and, in the case of local government units, internal revenue allotments.

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

(c) No formal process of health technology assessment – while evaluation of the efficacy and cost-effectiveness of drugs is fairly well established in the Philippines, no similar process for devices or procedures exists

\textsuperscript{3} Community-acquired pneumonia for adults and children, acute appendicitis, hypertension, dyspepsia, acute bronchitis, asthma in adults, urinary tract infection in adults, acute gastroenteritis, maternity care, dengue hemorrhagic fever, cataract, diabetes mellitus, chronic cough in children, cholecystitis and the Philippine Package of Essential Non-communicable Disease Interventions.
as yet. Health technology assessment is conducted very informally. Under Z benefits, the choice of conditions to include in PhilHealth is often based on the cost of treating the condition, rather than the burden of the disease and the cost-effectiveness of treating it. There are no established rules or benchmarks for screening such conditions, e.g. cost of disability-adjusted life years (DALY) averted as a percentage of gross domestic product.

**Purchaser-government relationship in PhilHealth**

**Organizational characteristics of government actors**

There are several government agencies in the health service purchaser-government relationship, with the main groups shown below. In this chapter, the focus is on stewardship of and policy-making for PhilHealth. The associated functions and the agencies that fulfil them are listed below.

- Steward and policy-maker – Congress, Office of the President (presidential management staff), and Department of Health (the Secretary of Health is Chairperson of the PhilHealth Board);
- Regulator – Department of Health (licensing, accreditation, quality monitoring) as well as owner of Department-of-Health-retained hospitals; Food and Drug Administration (pharmaceutical regulation);
- Financier of premium subsidies to Q1 and Q2 – Department of Budget and Management
- Employer of civil servants – Government line agencies, Government-owned and controlled corporations, Department of Budget and Management as source of fiscal revenues;
- Owner of health facilities – Department of Health (retained hospitals), local government units (provincial, city, municipal health facilities);
- Financier of catastrophic medical conditions – Department of Social Welfare and Development, PCSO, PAGCOR.
Ideal versus actual functions in the purchaser-government relationship

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

Table 11. Ideal functions of the purchaser in the purchaser-government link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To establish a policy and regulatory framework for the purchaser and providers</td>
<td>PhilHealth is a Government-owned and Government-controlled corporation with an independent governing board. The Government, however, is over-represented on the board, and members/providers are generally under-represented. The PhilHealth Executive Committee provides technical direction, but there are skill deficits in certain areas (e.g. actuarial affairs, health technology assessment and business analytics). Policies are issued through circulars, but these are often not coherent, as benefit expansion is not underpinned with a long-term vision of social health insurance in the country.</td>
</tr>
<tr>
<td>To promote equitable access to needed health services by investing in delivery capacity in underserved areas</td>
<td>PhilHealth does not invest in capacity infrastructure, although its predecessor (Philippine Medical Care Commission) did so. PhilHealth’s tool is financing, which it is hoped will incentivize providers to locate in underserved areas.</td>
</tr>
<tr>
<td>To ensure adequate resources are mobilized to purchase services</td>
<td>Government has mobilized sin taxes for the Q1 and Q2 premium subsidy programme. However, collection efficiency (for paying members) is only 67%. Increasing premiums for paying members is a highly politicized issue. The premium rate of 2.5% of employee earnings is one of the lowest in emerging economies.</td>
</tr>
<tr>
<td>To implement mechanisms to ensure accountability of purchaser to government</td>
<td>Audit is institutionalized. However, neither the executive nor the legislative branches have exercised stewardship roles proactively. The Department of Health, as the mother agency, does not have enough staff with health-financing skills to provide technical support for PhilHealth.</td>
</tr>
</tbody>
</table>

Source: This study.
Analysis of PhilHealth’s purchaser-government relationship

Policy framework and institutional structure

PhilHealth was instituted through Republic Act No. 7875, which created the Philippine Health Insurance Corporation as the administrator of the National Health Insurance Program. The law defines the powers and functions of the Corporation. Some of these are as follows.

1. To set standards, rules and regulations necessary to ensure quality of care, appropriate utilization of services, fund viability, member satisfaction and overall accomplishment of programme objectives.

2. To negotiate and enter into contracts with healthcare institutions, professionals and other persons regarding the pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing and delivery of health services.

3. To determine requirements and issue guidelines for the accreditation of healthcare providers for the programme.

4. To supervise the provision of health benefits with the power to inspect the medical and financial records of healthcare providers and patients who are participants in or members of the programme, and the power to enter and inspect accredited healthcare institutions.

5. To submit to the President of the Philippines and to both Houses of Congress its annual report, which shall contain the status of the National Health Insurance Fund, its total disbursements, reserves, average costing to beneficiaries, any request for appropriation, and other data pertinent to the implementation of the Program, and publish a synopsis of such report in two newspapers of general circulation.

6. To conduct post-audit on the quality of services rendered by the healthcare providers.

7. To monitor compliance by the regulatory agencies with the requirements of the law and carry out necessary actions to enforce compliance.
In addition to these functions, PhilHealth also holds quasi-judicial powers so that it can carry out its tasks more efficiently. As an accrediting body, PhilHealth is allowed “to suspend temporarily, revoke permanently, or restore the accreditation of a healthcare provider […] after due notice and hearing” (Congress of the Philippines, 1995). According to the law, the revocation of a healthcare provider’s accreditation shall disqualify him from obtaining another accreditation in his own name, under a different name, or through another person.

As a Government-owned- and controlled-corporation, PhilHealth comes under the authority of the Governance Commission for Government-Owned and Controlled Corporations, a regulatory body with the power and function to evaluate its performance and determine its relevance. Some of the powers and functions of PhilHealth pertain to the way PhilHealth holds authority over providers. The law has given PhilHealth such authority, exercised through accreditation of health facilities, to ensure the delivery of high-quality services. Accreditation for government hospitals has been automatic with effect from April 2012, while private hospitals need to fulfil both the licensing requirements and the accreditation requirements of PhilHealth.

Equitable access to needed health services

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

To achieve the universal health coverage objective, health facilities should be physically accessible to all. As Philippines is an island nation situated in a large archipelago, the distribution of hospitals is highly uneven, having pockets of concentration in major urban areas. In view of this limitation, PhilHealth decided to accredit all government hospitals in the country, following the provisions of the General Appropriations Act of 2012. Automatic accreditation is granted to facilities that are providers of the primary care benefit package, maternal and newborn care package,
TB-DOTS, the outpatient malaria package and special procedures such as ambulatory surgical clinics and freestanding dialysis clinics.

For facilities that are automatically eligible for PhilHealth accreditation without undergoing the preaccreditation survey, PhilHealth Circular No. 13, s-2012 (PhilHealth, 2012b) requires a signed performance commitment to ensure the quality of services provided. The performance commitment includes the providers’ responsibilities and commitments relating to service delivery and accountability to PhilHealth.

The Government’s efforts to make all the necessary providers of care available to all are complemented by the national Government subsidy for premium payments for the poorest segment of the population. In 2013, a total of 31.4 million indigent members and dependents have been covered and are eligible for benefits in a PhilHealth-accredited facility under the PhilHealth Sponsored Program. Sponsored Program members include the nationally-identified poor and those eligible for sponsorship as certified by the local government unit. The premium subsidy for the poor identified at the national level will be sourced from the sin taxes, while the premiums of the remaining Sponsored Program members will be shouldered by the sponsoring local government unit.

Despite the mandate for automatic accreditation, 67% of government hospitals are not accredited, according to Department of Health and PhilHealth data. One interesting point, however, is that PhilHealth reports that 31.4 million people are eligible to use PhilHealth under the Sponsored Program, while only 23.3 million are considered to be below the poverty line according to official poverty figures. However, there is no mechanism to determine whether all Sponsored Program members are aware of their automatic membership and eligibility to benefit from health insurance. The overestimate of the number of the poor may be causing leakage, which may result in inequities in access to and utilization of healthcare by deserving indigents, as the accreditation of government facilities is also incomplete.

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

**Ensuring availability of resources for delivery of entitlements**

The law mandates PhilHealth to set aside a reserve fund, which shall not exceed a ceiling equivalent to the amount actuarially estimated to equal two years’ projected programme expenditure. Any amount in excess of this sum should be used to increase PhilHealth benefits, decrease members’ contributions or augment the Health Facilities Enhancement Program of the Department of Health. Should there not be a need for this, excess funds should be invested in interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines.

In 2013, 62% of total income was sourced from premiums, 27.2% from national and local government contributions, 10.6% from interest income, and 0.2% from other income. The law cited the earmarked taxes for health spending; in 2013, a total of PHP 12 billion allocated for PhilHealth was sourced from sin taxes and used as premium subsidy for Q1 and Q2 households. This mandate, contained in Republic Act No. 8240, ensures a steady stream of resources for PhilHealth entitlements for this significant segment of the population.

PhilHealth also needs to rethink its reserve management strategy. Because of its origins in two large pension funds (Social Security System, Government Service Insurance System), PhilHealth (and the Philippine Medical Care Commission before it) imbibed the mentality of a pension fund, hence the Board’s focus on accumulating huge reserves in excess of what is needed for benefit payments. The PhilHealth reserve fund has climbed steadily from PHP 35.5 billion in 2004 to PHP 115.6 billion in 2013. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years’ worth in the period 2004–2009 (Picazo, 2012), although
this went down to a more reasonable 2.2 years in 2013, closer to what the law prescribes, i.e. two years (PhilHealth, 2014b).

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

**Accountability of PhilHealth to government**

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

In general, PhilHealth has adhered to its mandate. However, it has also figured intermittently in such cases as bloated staff bonuses, arrears in the remittance of collections by certain agencies, and fraud and conflicts of interest on the part of a few providers. Under the previous administration, PhilHealth was also used for political ends, as shown by the artificial increase in membership during two previous elections. These are all matters of accountability and governance that the PhilHealth Board and executives – as well as those exercising stewardship – should keep in mind. So far, there is no entity that acts as a watchdog or advocate, and this may be a possibility worth looking into to preclude abuse of the social health insurance fund.
One provision of the National Health Insurance Act calls for a joint congressional oversight committee to conduct a regular review of the National Health Insurance Program, with a systematic evaluation of PhilHealth’s performance and impact. In addition, the National Economic and Development Authority is mandated to undertake studies to validate the accomplishments of the programme. These studies should be done, according to the law, in coordination with the Philippine Statistics Authority and the National Institutes of Health of the University of the Philippines. The validation studies should include an assessment of the enrollees’ satisfaction with the benefit package and services provided by PhilHealth. These studies, together with an annual report on the performance of PhilHealth, shall be submitted to the congressional oversight committee. So far, this committee has been inactive.

PhilHealth has diligently performed many of these functions, but the quality of its output has varied. For instance, pertinent documents are easily accessible on the PhilHealth website, and the PhilHealth statistics and charts are also accessible. However, PhilHealth is still unable to produce an accurate count of its members and their dependents, and business analytics are not performed on a routine basis. PhilHealth issues its annual report promptly and regularly, but the indicators used change every year. Actuarial analyses are not performed frequently. Finally, the joint congressional oversight committee has been inactive.
Overall assessment of purchasing of health services under PhilHealth

Assessment of PhilHealth as purchaser of health services

Purchaser-member relationship

Registration and entitlement of members

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

Articulation of members’ preferences, needs and complaints

This is a function that is not well established in PhilHealth. Benefits are still determined largely in a top-down manner, although these are increasingly being vetted through focus-group discussions with members, as in the case of the PCB+ and Tarnang Serbisyo para sa Kalusugan ng Parnilya (Tsekap), which replaces the PCB1 package. Members are not formally organized, and there is no independent watchdog body to look after members’ concerns. The local health insurance offices could be key points of contact for members, but this has yet to become the case. While there is a website where citizens can voice their concerns, the PhilHealth response is infrequent and much delayed.
Purchaser-provider relationship

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

Provider payment system and timeliness of payment to providers
Through the years, PhilHealth has been mainly a passive payer for health services under an inflationary provider payment system. The change in provider payment to a case rate system in 2011 increased PhilHealth’s influence in the healthcare market. Indicators show that in general, the average cost per case has declined, the average length of stay per case has declined, and the timeliness of payment to providers has also improved. While there are still cases of no-balance billing, the prevalence of balance billing has declined from 93% in June 2013 to 59% in June 2014 (Picazo, 2014b). In the future, the provider payment system needs to evolve into a DRG system to take account of comorbidities.

Licensing and accreditation of providers
Accreditation of providers was recently transferred to the Department of Health, which issues their licences. Accreditation remains a slow and painstaking process, especially for Government hospitals and public health programmes. As many as 33% of hospitals are not accredited; for TB-DOTS,
after 10 years of accreditation experience, only 59% of the DOTS centres licensed by Department of Health’s National Tuberculosis Programme have been accredited or certified. This leaves 41% unaccredited or uncertified, thus denying them receipt of PhilHealth reimbursements.

Prioritization of health services

There is, as yet, no formally established process for health technology assessment at PhilHealth. The Philippines has an established process for the economic and therapeutic evaluation of drugs (Food and Drug Administration, National Centre for Pharmaceutical Access and Management), but a similar process is not in place for devices and procedures. As a result, the determination of the benefit package (especially for costly procedures such as those under Z benefits) is rather unsystematic. WHO has established the guideline that an intervention is cost-effective if the cost per DALY averted is lower than three times the per capita gross domestic product of the country for that year. To operationalize such a rule, PhilHealth needs to conduct analyses of the costs per DALY averted of the most expensive medical conditions and surgical interventions in the country.

Quality of care

Under PhilHealth’s Benchbook accreditation programme, hospitals were classified as centres of excellence, centres of quality and centres of safety. The criteria for these classifications involved not only structural, but also process, aspects of care. However, the generally poor availability of data on hospitals (e.g. infection rates) precluded analysis of whether ex-ante accreditation standards resulted in ex-post quality improvements. Patient satisfaction surveys are not regularly conducted to obtain even a perception of quality. On individual hospitals’ own initiative, and as part of a campaign to attract more patients, some facilities have resorted to obtaining reputable international accreditation such as Joint Commission on Accreditation of Healthcare Organizations, Accreditation Canada, International Organization for Standardization, etc.
Information technology

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

Purchaser-government relationship

Adequacy of funding to purchase services

Premiums in PhilHealth are far lower than those prevailing in middle income countries that have achieved universal health coverage and which provide more comprehensive benefits. Colombia collects 12.5% (8.5% from workers and 4.0% from employers); Estonia 13% of wages; Turkey 12.5%. The current contribution rate of 2.5% for the employed, for instance, does not cover provision of outpatient benefits nor Z benefits. PhilHealth’s goal of expanding the benefit package and increasing support value (reimbursement rate) in both inpatient and outpatient care will inevitably require an increase in the premium rate. However, such an increase is politically sensitive, and is not likely to be initiated in an election year (2016) or prior to it (2015). Because of this, the design of benefits is often done in a “reverse process”, i.e. fitting the benefits within the given resource envelope, rather than determining the needed benefits, costing them out, and arguing for a needed premium increase. This has been a long-standing dilemma, and unless there is the political will to break it, PhilHealth will continue to limp along.

Collection efficiency

Inefficient collection of premiums is a long-standing problem of PhilHealth. For the Government sector, the concerned agencies as employers sometimes make payments lower than the 2.5% contribution required by law. As a result, arrears often accumulate, amounting to as much as PHP 4.6 billion at the end of 2005 (Walker, 2006). Delays in the national government release of cash payments for the premiums of Sponsored Program members have also caused arrears in the past (Walker, 2006).
Stewardship

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

Institutional factors influencing PhilHealth’s performance as purchaser of health services

The legacy of pension-fund origins

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

There is a lack of stronger members’ or patients’ representation on the PhilHealth Board. The PhilHealth Board is dominated by representatives of government departments and agencies performing sundry functions, including Finance, Health, Labour, Social Development, Local Government, Government Service Insurance System and Social Security System. Ranged against them are a few representatives actually involved in health (hospitals, physicians), and then there are representatives of employers and patients. Thus, representatives of members and providers are outnumbered by Government representatives who have little actual knowledge of health service provision and needs. The decision-making is often consensual, tending to be on the conservative side (i.e. stewardship of the fund and reserves position) rather than on the progressive side (expanded benefits to members).

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

**Summary, conclusions, and policy implications**

This study is a critical analysis of health services purchasing undertaken by PhilHealth, which implements the National Health Insurance Program of the Philippines. Purchasing deals with the way an institution should determine, negotiate for, and obtain health services on behalf of a group of people who have contributed resources, through taxes, premiums, or point-of-service payments, in exchange for anticipated health services.
The study employs a principal-agent framework for analysing three critical relationships: that between the purchaser and healthcare providers; between the purchaser and citizens (or members of PhilHealth), and between the purchaser and government, both as regulator and as funder of services, at the national Government and local government levels.

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

**Purchaser-member relationship**

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

- PhilHealth’s engagement with its members has been unevenly conducted, but is improving. In the case of PCB+, extensive focus-group discussions were conducted to help in the benefits design.
- Provider payment reforms, changing from fee-for-service to case rates, updated the reimbursement rates, but real resource costing of medical and surgical procedures still needs to be conducted. Some public health interventions (e.g. the Maternity Care Package) have generous reimbursements while others (e.g. TB-DOTS) do not. On average, support value in 2013 represented only 31.5% of hospitalization costs, indicating that PhilHealth still has a long way to go in providing financial protection.
- PhilHealth has no problems in identifying paying members, but it has serious difficulties in identifying and enrolling Sponsored
Program members, whose premiums are paid for by the national government. Many of these members have not been made aware of their entitlement and have not received their PhilHealth cards. Only 60.3% of households in the National Demographic and Health Survey 2013 survey (National Statistics Office, 2014) claimed they had PhilHealth insurance, while PhilHealth claimed that coverage was as high as 75%.

• Focus-group discussions conducted for the design of the PCB+ package indicate that, although members know PhilHealth in general, they are not aware of the specific benefits to which they are entitled (FOCI, 2014). In 2013, a World Bank evaluation showed that as many as 36% of Sponsored Program patients were not aware of their PhilHealth coverage.

• In general, access is increasing: the percentage of households who sought care in the Philippines increased from 7.9% in 2008 to 10.7% in 2013, according to National Demographic and Health Survey data (National Statistics Office, 2014). However, access to care is still very uneven across and within regions and provinces. Access to much needed and much desired primary care benefits is limited by the currently very narrow services included under existing funded benefits (Maternity Care Package, TB-DOTS and OPB).

• PhilHealth has established procedures for settling complaints and resolving disputes. However, available IT methods (website, email, telephone hotlines, social media) have not been optimally used to respond quickly to member and provider concerns.

• PhilHealth public reporting of performance to promote transparency and accountability is not routinely conducted. Indeed, it is quite difficult to obtain data from PhilHealth.

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

• To identify and inform the remaining unidentified Q1 and Q2 members, PhilHealth needs to undertake more proactive information, education and communication campaigns.
PhilHealth also needs to follow through on its adoption of “point of care” enrolment, whereby patients without PhilHealth cards will be assessed on site and automatically given eligibility if found to be classified as poor or near-poor, depending on the criteria to be set by the Department of Social Welfare and Development. PhilHealth should consider the use of civil registration to enrol infants automatically into PhilHealth, depending on the PhilHealth status of the parents.

- To revitalize PhilHealth’s customer service orientation, PhilHealth needs to revive its customer hotlines, webpage and social media channels in order to reach out to its members.
- To mandate a stronger PhilHealth membership representation in PhilHealth’s Board.
- To encourage and support nongovernmental advocacy groups: watchdog, research, academic or labour groups should be supported, especially those focusing on social programmes in general and PhilHealth in particular.

**Purchaser-provider relationship**

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

- PhilHealth has tended to be rather too stringent in accreditation, especially of government hospitals and public health clinics. PhilHealth has accredited only 67% of licensed hospitals in the country (Philippine Institute for Development Studies, 2014), and only 59 of licensed TB-DOTS centres (Picazo et al., 2014). This severely reduces access to and utilization of hospital and public health services, especially in localities where the licensed but unaccredited facility is the only provider. Although a more liberal and accommodating accreditation policy has been specified in the General Appropriations Act of 2012, it has not been widely implemented. PhilHealth has yet to introduce more facilitative arrangements with providers to improve quality of care.
• Unlike the situation in other countries, PhilHealth has no equalization (or equity) fund for geographically isolated and depressed areas, and PhilHealth reimbursement rates are uniform across the board. Thus, there are no additional incentives (apart from normal reimbursements) for providers to move to geographically isolated and depressed areas.

• Efficiency-improving mechanisms at PhilHealth show a mixed picture. The patient gatekeeping and referral system in the Philippines is very weak (Acuin, 2014). However, provider payment reform, changing from retrospective fee-for-service to prospective case rates, has shown positive results. The Generics Law has been in force since 1998, but providers sometimes find ways to prescribe branded drugs (Wong et al., 2014). Not all the clinical guidelines are available. There is still no established process or national guidelines for health technology assessment.

• To monitor providers, PhilHealth has quality-of-care mechanisms that are mostly ex-ante standards imposed via accreditation. Deaccreditation of providers is rarely resorted to, because of the severe disadvantages it imposes on members relying on the services of the providers concerned.

• PhilHealth signs “performance agreements” with contracted health facilities. However, the performance targets and their accomplishment vary. Hospitals usually complain of payment delays and disallowances in their claims. To deal with these issues, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.

• Under the new case rate provider payment system that replaced fee-for-service in 2011, providers know in advance the reimbursements they are going to receive. A no-balance billing policy has also been in force and compliance has improved, from only 7% of surveyed hospitals practising no-balance billing in June 2013 to 41% in June 2014.

• PhilHealth’s turnaround time (from claims filing to payment) has also improved. For instance, from 2010 to 2012, the
turnaround time for hospital claims was reduced, on average, by 21 to 23 days (PhilHealth, 2014b).

- PhilHealth outpatient benefits have evolved in an extremely fragmented fashion, leading to high administrative and monitoring costs and less-than-optimal impact, as shown by TB-DOTS and the pilot of PCB2.

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

- To loosen up on accreditation, especially of public health programmes – PhilHealth should consider blanket accreditation of all Department-of-Health-licensed providers of public health programmes (TB-DOTS, Maternity Care Package, OPB). This is already mandated under the General Appropriations Act of 2012, but has not yet been implemented.

- To update the case rate reimbursements and to move towards a DRG system, PhilHealth should undertake a thorough resource costing of each of the conditions under the case rate system with a view to making them more realistic.

- To expand primary care benefits – The PCB+/Tsekap is currently under design. If approved, this programme will have a profound influence on members, as it is the first point of contact. It is hoped that it will rationalize the extremely fragmented outpatient benefit packages. It is also a more palpable benefit, compared with inpatient hospitalization, which is rare. Thus, it is deemed more inclusive.

- To institutionalize health technology assessment, the envisioned expansion of Z benefits should be underpinned with proper analysis of burden of disease and cost-effectiveness. While the Philippines has a fairly developed process for the evaluation of drugs, evaluation of devises and procedures have lagged behind. Burden of disease analyses also need to be strengthened.
• To mandate use of electronic medical records – PhilHealth should be able to perform just-in-time business analytics, and this can be made possible only with the mandated computerization of its accredited providers. A good starting point in this regard would be to require electronic medical records from all providers.

Purchaser-government relationship

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

• The policy framework under which PhilHealth operates is well defined in law. PhilHealth adheres to these legal stipulations closely and implements them through regulatory circulars and/or administrative orders of the Department of Health. The Philippine health financing and service delivery environment, however, is evolving rapidly. Medical technology, IT, global and local professional practices (including medical tourism), and the relationship between private and public sectors are also undergoing rapid changes, as a result of which regulatory instruments are often in a “catch-up” mode in the attempt to be relevant.

PhilHealth does not invest in service capacity infrastructure, although it did so in the 1970s under the Philippine Medical Care Commission, with varying degrees of success. PhilHealth’s major tool for increasing access in underserved areas is financing; hospital reimbursement was shown in the 1970s to have successfully added hospital stock in rural and periurban areas, but since the 1980s this progress has stalled. The launching of the PCB+/Tsekap package which allows reimbursement of private clinical practices is expected to encourage private medical practitioners in rural and poor urban areas.

• Government has mobilized resources from sin taxes to finance a massive premium subsidy for Q1 and Q2 households. However, premium increases among employed and individually-paying members is a highly politicized issue; indeed, it has lagged behind improvements in the benefit package. Expanded
benefits are contingent upon government’s ability to raise the premium rates and improve collection efficiency. All industrial and emerging economies that have achieved universal health coverage show premium rates far higher than those prevailing in the Philippines at present (Picazo, 2014b).

- There remain problems in collection efficiency, and arrears from Government agencies have sometimes accumulated. PhilHealth has adopted an “accounts-management” approach in which specific PhilHealth staff are assigned a specific agency to follow up, to ensure that all collectibles are collected.

- Financial audit is formally institutionalized in PhilHealth. The Commission on Audit has the constitutional mandate to undertake this function. In addition, PhilHealth itself has an internal audit department that conducts necessary inquiries on the way providers are performing their fiduciary responsibilities. One major gap is the lack of a more active stewardship role by the executive (Office of the President) and legislative (Congress) branches, as shown by infrequent commissioned reports on the state of the National Health Insurance Program.

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

- To brainstorm on and formulate an overarching national strategy for social health insurance – this is critical as the Philippine economy grows, the population ages, disease patterns change, and medical and information technology advance.

- To formulate an overarching national strategy and plan for health facilities expansion – Health Facilities Enhancement Program investments have been identified and provided in an opportunistic, bottom-up fashion. This needs to be corrected with a national health facilities development plan that takes account of economic, demographic, epidemiological and geographical considerations – not merely the narrow concerns
of local government units, as is apparent in the Health Facilities Enhancement Program investments.

- To prepare an annual external commissioned report on the status of PhilHealth – for its size, importance, and influence, an annual performance report (along the lines of a “white paper”) should be prepared by an external, independent panel to inform the Office of the President, Congress and stakeholders how PhilHealth can be further improved.

- To increase the PhilHealth premium and improve collection efficiency – political will is needed to increase premium contributions along the lines of other emerging economies’ health insurance programmes, and along the lines of the benefit package desired by the population.

- To conduct impact evaluation studies – the implementation of social health insurance requires periodic evaluation of its impact and performance and identification of key policy and programmatic issues.
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