Facilitators and Barriers to Engaging Private Primary Care Providers in the Delivery of Family Planning Services in the Philippines

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Strategic Purchasing for Primary Health Care

INTRODUCTION

Demand for FP outstrips supply, leading to inequity

Use of modern contraceptives among married women increased between 1993 and 2018 (Fig 1) however **modern contraceptive prevalence rate (mCPR) in the Philippines lags behind other ASEAN countries** (Fig 2).

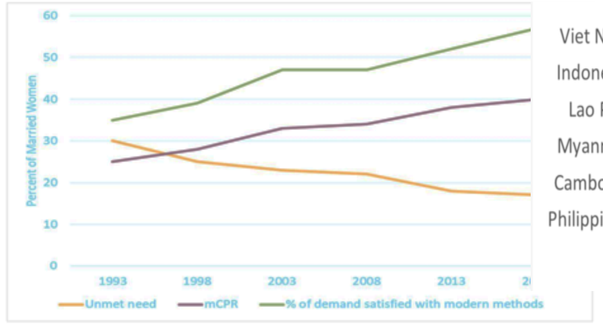


Fig 1: FP Indicators, 1993-2017 (Source: DHS, 2017)

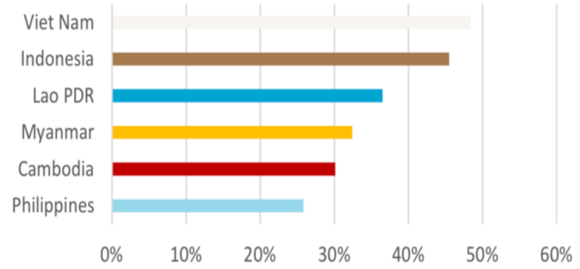


Fig 2. % WRA using modern contraception (Source: WHO SEARO, 2016)

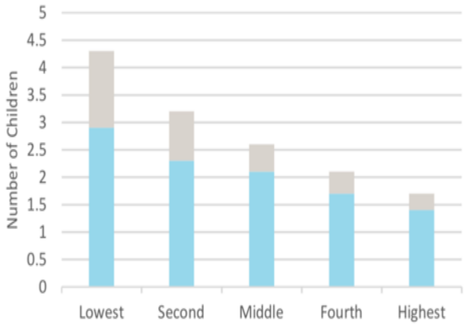


Fig 3: Wanted vs Actual Fertility by Income, 2017 (Source: PSA, ICF, 2018)

Amidst changing social norms, mCPR trend is influenced less by religious opposition and **driven largely by increasing demand outstripping supply, especially for the poor.**

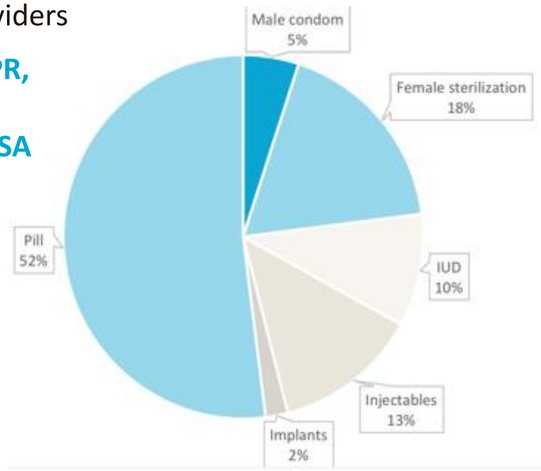
Gap between actual and desired number of children is widest among the lower socio-economic groups (Fig 3). They also have shorter median birth intervals (31.2 mos) compared to the wealthiest households (52.6 mos).

FP services concentrated in the public sector, bias for short term methods

The Philippines has a relatively **imbalanced method mix, with a preference for short term methods** (Fig 4). LARCs , despite the benefit of being convenient, cost-effective over time, and generally acceptable to users, are underutilized as these methods require higher initial financial output.

Supply of FP services that require a trained provider is concentrated in the public sector (Fig 5), where services are free of charge. **Private provision of FP services is limited**, despite comprising ~65% of all health providers

Fig 4: mCPR, 2017 (Source: PSA and ICF, 2018)



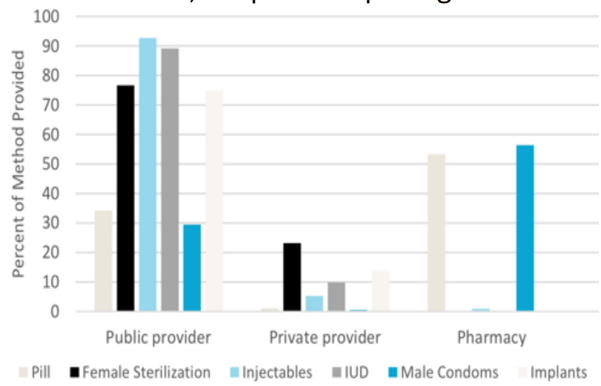


Fig 5: Sources of FP Services, 2017 (Source: PSA and ICF, 2018)

Limited access to financing of FP services through social health insurance

PhilHealth runs the National Health Insurance Program. Membership of all Filipinos to PhilHealth is now compulsory under the 2019 Universal Health Care law (RA 11223).PhilHealth currently offers 4 benefit packages for long-acting and permanent contraceptive methods: IUD insertion, Subdermal Implant insertion, Non-scalpel vasectomy (NSV), & Bilateral Tubal Ligation (BTL). However **only 18.5% (355 out of 3159) of birthing homes (both public and private) are accredited by PhilHealth to provide its FP benefit packages** (that is, one PhilHealth accredited facility to offer LA, RC benefits for every 20,000 women of reproductive age.)

METHODS

Situation analysis on private sector provision of FP services synthesized national health survey data, DOH & PhilHealth reports, policy documents, published and grey literature. Also included are analyses of key legal frameworks, the Universal Health Care Law (RA 11223), and the Responsible Parenthood and Reproductive Health Law (RA 10354).

Quantitative analysis of private provider accreditation and claims reimbursement data from PhilHealth were obtained with permission from the PhilHealth Corporate Planning Department. Statistical analysis done with Microsoft Excel.

Participatory process mapping was done to assess the contracting and reimbursement pathways understood/ encountered by private providers. These were reconciled with the guidelines as imposed and intended by PhilHealth and the Ministry of Health (DOH) using an Implementation Fidelity framework (Intended vs. Implemented vs Achieved)

Key informant interviews (KIIs) and focus group discussions (FGDs) elicited barriers and facilitators to private sector provision of FP services. National and subnational level KIIs included the DOH (2), PhilHealth (3), the Integrated Midwives Assoc. of the Phils. (1), and Private Practicing Midwives Assoc. of the Phils (1). Among private providers, five FGDs engaged 38 midwives and 5 private doctors; two FGDs focused in urban settings, two in a rural/ suburban context and a final discussion with mixed rural and urban providers. . All interviews were audio recorded and transcribed, with the key points summarized in English. Manual thematic analysis was applied to the qualitative data.

Verbal assent to participate (and be quoted) was obtained from the respondents. Anonymity and confidentiality of information were provided upon request

RESULTS

The value that PhilHealth offers to private providers will determine whether the purchaser is strategic in influencing provider behavior. Factors that add value (which would make offering family planning an attractive proposition for providers) must outweigh those that reduce value (which would discourage providers from offering family planning under PhilHealth). Private providers working at the primary care level identify several factors that reduce the value offered by PhilHealth for family planning services:

On Profitability: Private providers do not perceive PhilHealth reimbursement for FP services as a profitable business proposition

While PhilHealth's rates for its FP benefits are significantly higher than those offered by parallel insurance schemes in LMICs, they are low compared to typical prices charged by private providers (Table 1). **Private sector rates are driven largely by steep and variable commodity purchase prices**; additionally, claims may only be reimbursed for implant insertion but not for removal

Table 1: Comparison of PhilHealth Case Rates for LARCS vs Private Sector Rates

FP method	PhilHealth Case Rates in PHP (USD equiv.)		Private sector rates in PHP (USD equivalent)			
			Commodity Purchase Price	Insertion Service Fee	Removal Service Fee	Total
Copper IUD Insertion	**2,000 (40 USD)**	VS	150-600 (3-12 USD)	500-1,500 (10-30 USD)	400-600 (8-12 USD)	**1050.- 2,700 (21 - 54 USD)**
Subdermal Implant Insertion	**3,000 (60 USD)**		1750-5,000 (35-100 USD)	1,000-2,000 (20-40 USD)	600-1,000 (12-20 USD)	**3350 – 8,000 (67 – 160 USD)**

A key assumption of the PhilHealth rates is that commodities would be provided free of charge to all providers—public or private—through the national FP program, or at heavily discounted prices through public-private partnerships with distributors. As such, the same rates are paid to public providers and private providers. In practice, however, free commodities are provided only to public facilities and rarely to private facilities. **Private providers must purchase commodities individually and are generally unable to procure them at significantly lower than prevailing market prices.** Ad hoc efforts to provide subsidized contraceptives to the private sector have not been sustained.

On Processes: Complex and cost-prohibitive licensing and accreditation process deters many private midwives from contracting with PhilHealth at all

To be PhilHealth accredited, providers must first complete the necessary FP trainings (Fig 7, Step 2). While these trainings are free to public providers, **LARC trainings are not easily affordable for private providers** and may cost between 3,000-5,000 PHP ($60-$100 USD.

"Licensed or not, it doesn't really matter to the patients, as long as you accommodate them, and don't overcharge."

*"I don't understand **how doing all this equates to less maternal deaths** and better quality care."*

After professional accreditation, **few private providers undertake the arduous process of DOH licensing and facility accreditation** (Fig 7, Steps 3a and 4a). The cost burden of attaining the DOH License to Operate (LTO) is high for small businesses and may cost up to 1.5 million PHP ($28,000 USD). This includes construction costs, securing the necessary business permits, and completing (redundant) requirements from various agencies. In contrast, a new birthing home can be constructed and operations commenced without a DOH LTO for approximately 550,000 PHP ($10,000 USD).

Due to weak enforcement and compliance monitoring, many providers are able to operate even without meeting licensing requirements, with obvious implications for service quality.

On Payment: Delayed and uncertain payment undermine financial incentives

In 2018, PhilHealth implemented an electronic claims (eClaims) system for paying its accredited facilities (Fig 8). But even then, **providers continue to raise issues on uncertainties, lack of transparency and significant delays in payment**. Frequent central server breakdown and poor internet connectivity in rural areas are commonly cited reasons. Few facilities also have the capital or sufficient computer literacy to develop their own software; providers must thus hire IT staff, constituting an additional expense.

Fig 8: PhilHealth claims reimbursement process

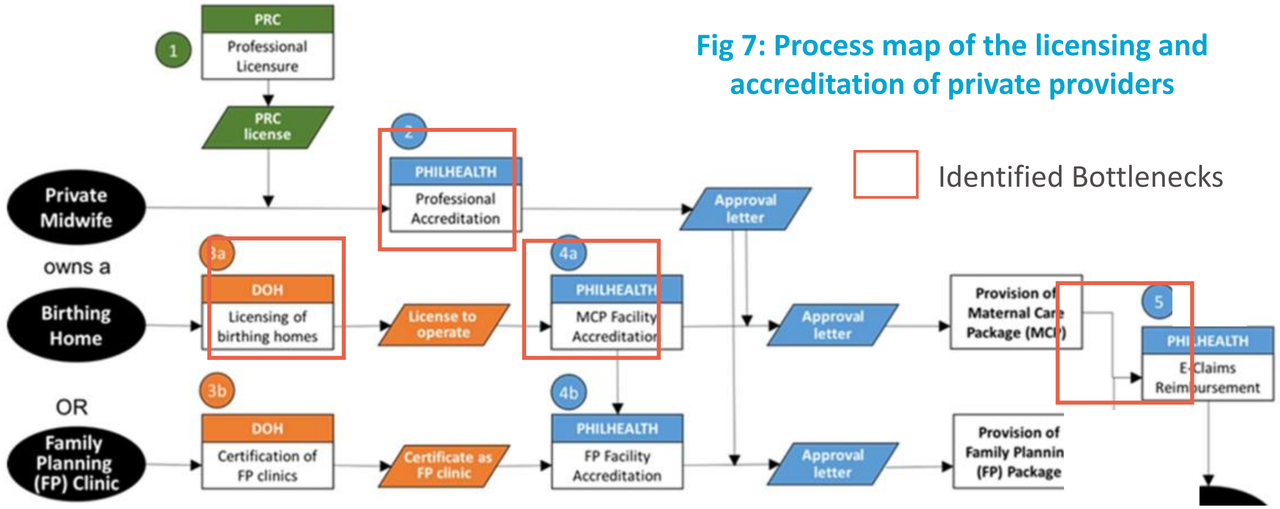


Fig 7: Process map of the licensing and accreditation of private providers

On Professional Identity: Midwives in the Philippines may see offering family planning as being at odds with their professional identity

Private sector midwives tend to define their professional role as centered on attending deliveries rather than providing FP services. This perspective may limit not just their willingness to pursue accreditation but also their intentions to provide FP services at all. **Private midwives are also more accustomed to the business model of a birthing home than an FP clinic which may not only be unfamiliar but can be seen as directly undermining the business itself**: more contraception, fewer babies, less profit. Busy service providers with limited time generally prioritize providing PhilHealth's maternal care package, which is also seen as more directly profitable than the family planning package.

*"I used to be accredited but **it's easier for me to charge out-of-pocket because I get paid ASAP.** PhilHealth, takes two to six months to pay even with the new e-Claims system. Most of the time, it even gets denied."*

*"I am a midwife, I was **trained to facilitate birth, not to prevent it.**"*

*"We **don't know how it [the free-standing family planning clinic] works.** What will the processes be like?"*

*During rainy season, **the internet gets unstable and we cannot submit claims.** And when the internet is good, we still cannot submit claims because their server is not working."*

*"**It's as if they just want to make our lives difficult.** Why can't they simplify or provide assistance at least for the unfamiliar?"*

*"**Giving birth is our bread and butter.** We can only see so many patients in a day, it's more value for the time and effort we pour."*

DISCUSSION

Contraceptive product costs make PhilHealth's current case-based payment rates for LARCs unprofitable for private providers

Profitable rates are the starting point to effectively engage private providers, opening the potential for improving access to family planning services. However, private providers must pay a high price for contraceptives, which drives low profitability of PhilHealth FP claims. Institutional responsibility for government subsidy of contraceptives also remains unclear. This is likely the underlying cause of the disconnect between PhilHealth intention to offer strong value to private family planning providers and its failure to do so.

To increase profitability FP claims for private providers, either contraceptive prices need to be reduced, or payment rates need to increase. Developing packages and adjusting case rates should consider the feasibility of these packages among private providers and the various scenarios they find themselves in. Stakeholders may also consider differential case-based payment rates between public sector (receiving commodities free of charge) and private providers (responsible for purchasing their own contraceptives). Consideration should also be given to the provision of free or subsidized contraceptives to the private sector, perhaps associating access with PhilHealth accreditation.

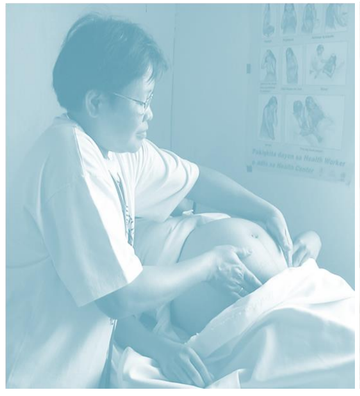


Photo credits: Ana P. Santos 2016

Time-consuming and costly accreditation and licensing procedures prevent and discourage private midwives from pursuing PhilHealth accreditation

The numerous steps required to attain both professional and facility- level licensing and accreditation result in substantial financial and opportunity costs for private-sector midwives. Midwives voice the importance of providing high-quality services and running a viable business, and they perceive that investing in licensing and accreditation translates neither to better service quality nor to increased profitability.

PhilHealth, and other stakeholders might consider exploring opportunities to streamline, standardize, and rationalize accreditation and licensing requirements for provision of PhilHealth MCP and family planning packages. Redundancies and conflicts between different institutions and the licensing, accreditation, and certification processes could be identified and reconciled through institutional, intersectoral, and interagency dialogue. It would be particularly valuable to identify and resolve redundancies between professional accreditation of private midwives and facility accreditation of birthing homes. For example, it could be possible to consolidate currently separate MCP and LARC accreditation into just MCP, or at least integrate family planning counseling and referral into MCP accreditation.

Perceptions of delayed and uncertain payments undermine financial incentives and further discourage provider contracting with PhilHealth

The recently introduced eClaims system has hastened the process of claims reimbursement. However, processing redundancies, lack of technological infrastructure, and unresponsive prompts on payment status lead to persistence of payment delays.

To reduce reimbursement delays, PhilHealth should continue to invest in improving the usability and end-user experience of its eClaims reimbursement system. Additional investments in server capacity will ultimately reduce submission decays due to server malfunction. The cost-benefit of using electronic signature pads should be explored to address the redundancy of scanning paper-based forms as part of the reimbursement requirements. Enabling more detailed claims error notifications, would enable midwives to address claims errors more expediently.

Midwives continue to identify as birth attendants rather than providers of family planning

The non-inclusion of family planning counseling and service delivery in pre-service training is likely linked to these social and professional norms. Nevertheless, pre-service training is critically important in expanding the range of family planning methods available, and a review of standard midwife training curricula could provide useful additional information. The time may be right to advocate for standardization and the inclusion of more practical FP training in midwifery curricula. **Pre- and in-service training should place increased emphasis on the continuity and complementarity of family planning and maternal health services.** Increased access for private providers to the trainings required by PhilHealth prior to providing the MCP and FP packages could stimulate service delivery, improve quality, and encourage providers to reconsider their professional identity.

As the UHC Law is implemented, PhilHealth will contract with service delivery networks rather than with individual providers

Health care provider networks will be designed to ensure effective geographical coverage, facilitate referral between levels of service provision and between general and specialist providers, and drive efficiency by institutionalizing gatekeeping functions. Networks hold the potential to increase economies of scale, lower procurement costs of commodities, and improve administrative efficiency. They may be composed of public, private, or mixed facilities at all levels of health care. Detailed contracting arrangements are being developed through a roll-out of UHC provisions in selected UHC integration sites.

The government should consider and test the inclusion of small-scale private providers (including midwives and other providers of family planning and MNCH services) within health care provider networks. Networks should contract private providers and connect their practices with government-provided family planning and MNCH service delivery systems. Government-supported network provision of family planning and MNCH services is advantageous for poor women; it increases their options, access, and ability to navigate family planning and MNCH services. But it may also lead to efficient utilization of limited resources (financial, human, knowledge) by allowing for integration of efforts and sharing of resources between the public and private sector (e.g., pooled procurement of family planning and MNCH commodities that maximize volume purchasing, sharing of ambulances and emergency equipment, and sharing of IEC materials).

CONCLUSION

The supply of family planning services has not kept up with demand in the rapidly evolving social context of the Philippines. Political commitment to improving access to family planning is high, and is reflected in policy and regulatory changes. The UHC Law will radically reform the Philippines health sector in the coming years. This reform presents the opportunity to dramatically improve access to family planning by leveraging a vibrant private reproductive health sector that currently offers highly limited clinical family planning services. PhilHealth contracting of private providers has the potential to expand the number of family planning service delivery points, to improve the quality of services, and to increase the choice of family planning methods available at each site. This report presents a series of recommendations that can help make this potential a reality, and ThinkWell will continue to work with partners in PhilHealth, DOH, and elsewhere to develop, test, and learn from these interventions.

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RECOMMENDED CITATION

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