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).

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.

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.)
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>
<thead>
<tr>
<th>FP method</th>
<th>PhilHealth Case Rates in PHP (USD equiv.)</th>
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<tbody>
<tr>
<td>Copper IUD Insertion</td>
<td>2,000 (40 USD)</td>
</tr>
<tr>
<td>Subdermal Implant Insertion</td>
<td>3,000 (60 USD)</td>
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Table 1: Comparison of PhilHealth Case Rates for LARCS vs Private Sector Rates

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.
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?

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

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

On Payment: Delayed and uncertain payment undermine financial incentives

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.

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.

"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."

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

"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?"

"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?"

"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."

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

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

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 delays 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 expeditiously.
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.

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.

WORKS CITED:
ICF, Philippine Statistics Authority (PSA). 2018. Philippines National Demographic and Health Survey. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.

RECOMMENDED CITATION