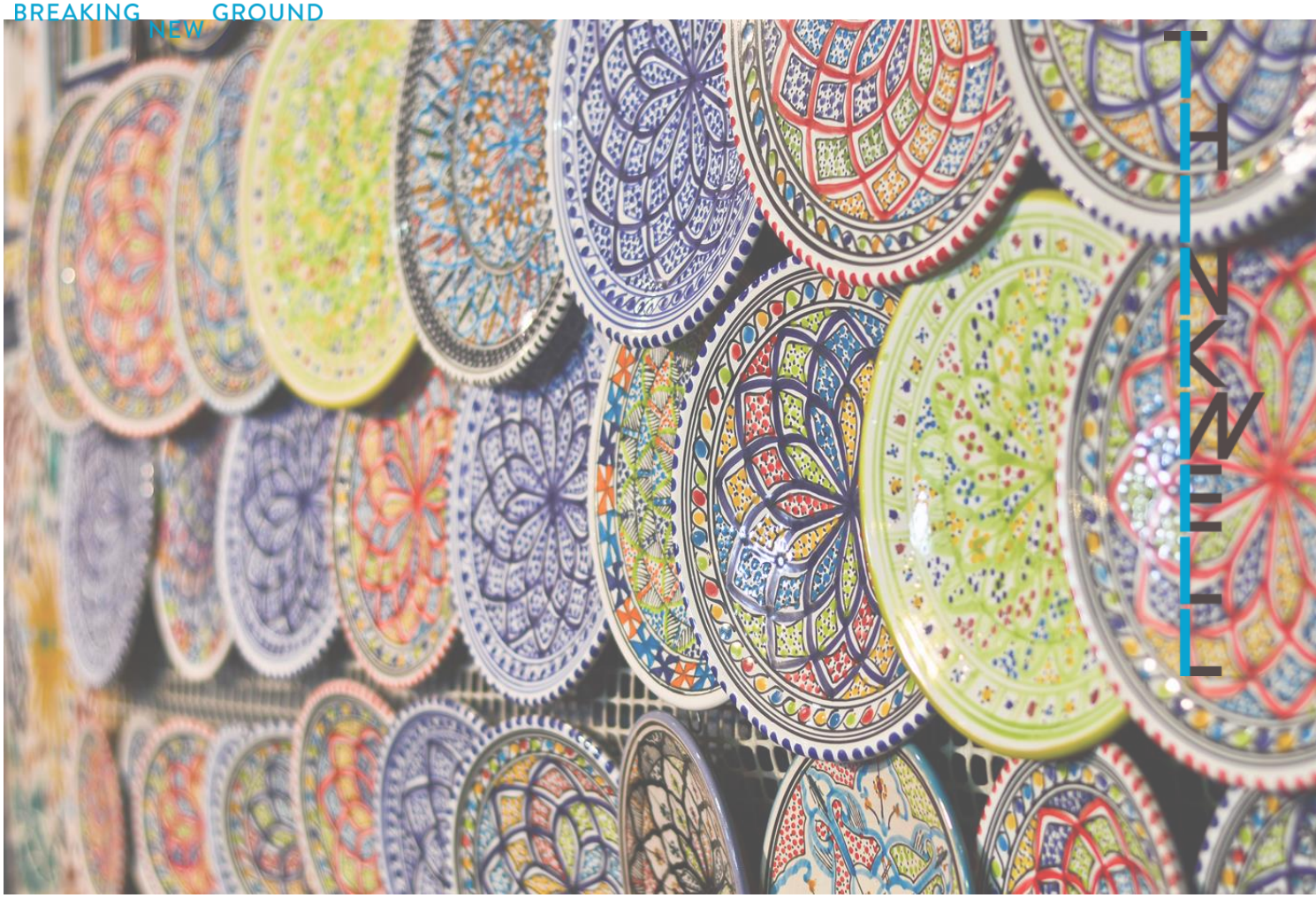
MONOGRAPH

SP4PHC
Strategic Purchasing for Primary Health Care

Policy and Implementation Insights on Provider Payment Reforms of the Philippine Health Insurance Corporation

June 2021

BREAKING NEW GROUND



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ACKNOWLEDGMENTS

The authors would like to express their sincere gratitude to all individuals who contributed their time and insights to this monograph. In particular, the team would like to acknowledge Dr. Mel Santillan and the PhilHealth Benefits Development and Research Department for their openness to take part in the learning sessions and for coordinating the participation of key stakeholders in PhilHealth; Ms. Paula Monteith for generously sharing her time to participate as technical expert in a number of the learning sessions; Ms. Celina Gacias and Ms. Julienne Lechuga for providing additional technical support in presenting the content on select topics; Mr. Matt Boxshall for the opportunity and guidance in engaging the technical experts; and Dr. Pura Angela Wee Co and Dr. Maria Eufemia Yap for the technical guidance in the overall conduct of the learning sessions.

Recommended citation:

Dredge, Robert, Christian Edward Nuevo, and Antonio Ramon Paterno. 2021. *Policy and Implementation Insights on Provider Payment Reforms of the Philippine Health Insurance Corporation.* Manila: ThinkWell.

ThinkWell produced this report under the Strategic Purchasing for Primary Health Care (SP4PHC) grant from the Bill & Melinda Gates Foundation. ThinkWell is implementing the SP4PHC project in partnership with government agencies and local research institutions in five countries.

For more information, please visit our website at **https://thinkwell.global/projects/sp4phc/**.

For questions, please write to us at **sp4phc@thinkwell.global**.

FOREWORD

The Philippine Health Insurance Corporation (PhilHealth) remains steadfast in its commitment to provide comprehensive and responsive financial coverage for health services for all citizens of the Philippines. The institution and its people aspire for all its members to have the best experience by ensuring all healthcare providers are committed to providing affordable, equitable, and quality services. With the tall order of Universal Health Care (UHC), there are extreme challenges that face PhilHealth - administratively, politically, and financially. However, the UHC Act also provides the legitimate basis and considerable opportunity to bring forth the reforms needed in financing health in the country. This further motivates and supports our deep desire to see PhilHealth efficiently reform the way it operates in the health sector. Our mission to provide members financial protection when accessing health care is very clear. PhilHealth is the only agency in the government that has that noble mandate.

ThinkWell was thoughtful and generous enough to give PhilHealth the privilege of interacting directly with two highly respectable world-renowned experts in health care financing: Mr. Robert Dredge and Ms. Paula Monteith. Toward the latter part of the second semester of 2020, our Friday afternoons were never as purposeful as we anticipated the learning sessions. The learning sessions accorded clarifications on the theoretical aspects of provider payment, while the sharing of global experience contributed to how we can effectively put to use the theories. It was an honor for us to have had the chance to discover more and understand better the intricacies of provider payment methods through the learning sessions with Bob and Paula.

Our question on what makes for an effective purchaser of health cannot be ascertained until we do it and continue doing it. We have to be rigorous, and we have to be practical. This monograph is a valuable reference for PhilHealth and a practical resource for anybody interested in gaining insights on PhilHealth provider payment schemes with good comments and helpful guidance from international experts on health care financing.

Dr. Mel Santillan
Senior Manager, Benefits Development and Research Department
Philippine Health Insurance Corporation

PREFACE

The Philippines health sector has embarked upon, and has begun to implement, an ambitious program to make healthcare available to all citizens. It has set a realistic timescale to make this a success. Integral to this will be the alinement of the various funding and payment methods that give the correct incentives to all involved in the system. Much progress has been made on these. That this is a recognized priority for all is reflected in the involvement of so many key individuals and Institutions throughout the series of learning sessions, and technical discussions that followed. If this commitment can be maintained, then the reforms will be a success, and it has been a privilege to be a small part of the development and clarification of them.

Robert (Bob) Dredge

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ABBREVIATIONS

ACR	All case rates
COBP	Comprehensive outpatient benefit package
DOH	Department of Health
DRG	Diagnosis-related group
FFS	Fee-for-service
HCPN	Health care provider network
ICD	International Classification of Diseases
NBB	No balance billing
NHSO	National Health Security Office
PHC	Primary health care
PhilHealth	Philippine Health Insurance Corporation
PPM	Provider payment mechanism
PCB	Primary care benefit
RA	Republic Act
RHU	Rural health unit
SP4PHC	Strategic Purchasing for Primary Health Care
TCMC	Thailand Case Mix Center
TDRG	Thailand diagnosis-related group
UHC	Universal health care

EXECUTIVE SUMMARY

The Philippine Health Insurance Corporation (PhilHealth) was established in 1995 with a primary role of ensuring financial risk protection for all Filipinos when accessing the health care they need. The full materialization of this mandate remains challenged to date. In fact, in 2019, the share of PhilHealth in the total health expenditure of the country remained low at only 22% (PSA 2020). This is a stark contrast to out-of-pocket spending, which accounted for around 54% of total health expenditure. PhilHealth has faced heavy criticism over the years for inefficient payment mechanisms, inadequate package rates, lack of transparency, and even poor technical capacity to fulfill its function.

The recently passed Philippine Universal Health Care Act 2019 aims to revitalize and strengthen PhilHealth as part of the overall agenda of health systems reform. In order to become the national strategic purchaser of health services in the country, PhilHealth is envisioned to shift its provider payment mechanism towards a blend of diagnosis-related groups (DRGs) and prospective global budget payments, supported by proper costing methodologies. Primary care is also a key area of focus particularly through the development of a comprehensive outpatient benefit package that will have gatekeeping and patient navigation features that integrate comprehensive care within health care provider networks (HCPNs).

In 2020, ThinkWell facilitated learning sessions with PhilHealth representatives to help inform the development of health financing and provider payment policies. These were either input sessions where key concepts and global best practices were presented, or policy consultation sessions where representatives of PhilHealth and/or ThinkWell presented analytics and policy developments for discussion. ThinkWell conducted eight learning sessions from June to November 2020, attended by PhilHealth representatives from various technical and operational units at the national and local offices.

After the learning sessions, ThinkWell circulated technical summaries to all participants containing key discussion points and recommendations. Cross-cutting insights and reflections include: (1) creating and engaging champions to generate buy-in for reforms, (2) transparent and participatory relationship with stakeholders, (3) deliberate designing of PPMs and supporting components to address existing issues and achieve desired goals, and (4) managing transitions to work with realistic capacities of health care providers and the system as a whole.

PhilHealth adopted the recommendations from these learning sessions as shown in policy drafts, technical briefs or presentations, and actual activities conducted. These include: (1) stakeholder consultation on the costing framework and methodology with the pilot health care provider, (2) linking of costing with the development of the DRGs and co-payments, (3) implementation of facility-based global budget payment as an interim strategy prior to full contracting of HCPNs, (4) blended payments as either interim or final payment designs, and (5) designing of global budget mechanism supported by clear end-goals and governance mechanisms to facilitate the transition. ThinkWell provided support to PhilHealth in these activities particularly by co-developing technical materials for the stakeholder consultations, designing the estimation approach to translate anticipated cost data to actual DRG rates, as well as drafting policies and implementation strategies across all provider payment reform directions.

INTRODUCTION

In 2020, ThinkWell facilitated learning sessions with representatives from the Philippine Health Insurance Corporation (PhilHealth) to help inform the development of health financing and provider payment policies. ThinkWell prepared these learning sessions as part of the technical support provided to PhilHealth on strategic purchasing and provider payment reforms towards achieving universal health care (UHC). Specifically, these sessions aimed to:

- Generate feedback on ongoing data analytics and policy development work of ThinkWell and PhilHealth on priority areas, namely diagnosis-related groups (DRGs), global budget payment, primary care, co-payment schemes, and costing of health services;
- Produce technical outputs that will guide continuing development and implementation of policies on these priority areas; and
- Enhance knowledge and proficiency of PhilHealth partners on health financing and provider payment.

The learning sessions acted as platforms for discourse between PhilHealth and technical experts, tackling the key reforms PhilHealth is currently undertaking as part of its role in progressively realizing the mandates of the UHC Act. The discussions in the learning sessions were a rich resource of global experience, knowledge, and insights on health financing, particularly the provider payment reforms that helped shape the health system of select countries to what they are today. As PhilHealth realizes the health financing reforms under the UHC Act, it is envisioned that this monograph can be best maximized as a resource material to guide policies, particularly building upon and learning from the experiences of other countries which accomplished similar reforms. The learning sessions were primarily intended to contribute to the design and implementation of key provisions mandated in the UHC Act, and inputs presented in this monograph are contextual and targeted for application and not meant to be a theoretical reference. Outside PhilHealth, this monograph is intended for the consumption of individuals with foundational knowledge on key health financing concepts like strategic purchasing and provider payment.

This monograph provides a comprehensive technical documentation of these learning sessions on provider payment reform. Each learning session is documented in this monograph as a module that includes brief description of concepts and overview of the policy context in the Philippines. These sub-portions of the modules are primarily included to add conceptual framing to the topic and are made concise since the document does not primarily aim to be a technical resource for concepts on provider payment. Rather, this document aims to focus more on how these key concepts, together with actual global experiences, can be translated to policies cognizant of the context in the Philippines. Thus, a significant portion of the modules highlight the key discussion points and recommendations that were generated during the learning sessions. A synthesis is provided in the end that summarizes the cross-cutting insights across all modules, as well as key recommendations for each. The impact of these recommendations at of time of writing is also included.

CONTEXT

THE PHILIPPINE HEALTH INSURANCE CORPORATION

PhilHealth was established through Republic Act (RA) No. 7875[1] in 1995. This act effectively transformed the 1969 Philippine Medical Care Commission into PhilHealth, a government-owned and controlled corporation. PhilHealth is tasked to implement the National Health Insurance Program, with the goal of providing Filipinos

[1] RA No. 7875 (1995) – An Act Instituting a National Health Insurance Program for All Filipinos and Establishing the Philippine Health Insurance Corporation for the Purpose

financial protection when accessing health care services. This landmark piece of legislation widened the coverage for health to key vulnerable populations and groups such as the poor or indigents, self-employed, and the informal sector. The act also indicates that PhilHealth shall implement different mechanisms to pay providers, in accordance with approaches indicated in the said act. These have remained consistent even through amendments of RA No. 7875 (RA Nos. 9241[2] and 10606[3]).

The mandate and role of PhilHealth is ultimately to ensure that Filipinos do not face further financial risk when ill—which means, no Filipino should be impoverished by seeking care. Given its scale and reach, PhilHealth can maximize many things to achieve this goal, including:

1. Membership of as many or all Filipinos, such that both the healthy and the sick are within the same pool and their health care costs and needs offset each other, following the principle of risk pooling and cross-subsidization.
2. Funds are consolidated such that the institution achieves maximum and strongest purchasing power.
3. A broad range of health care providers (both public and private) are accredited or contracted, such that access and quality of care for its members are maximized, which also puts PhilHealth's payment system in a strong position to influence the cost of health care.

Ultimately, PhilHealth's role is to pay for basic and essential health services on behalf of Filipinos. By pooling funds and bringing in all Filipinos as its members, PhilHealth can leverage significant purchasing power towards the provision of all essential services, pay for these services, equitably re-distribute resources to those most in need, and drive quality provider performance.

International comparisons suggest that there are six general payment methods used to pay providers. These are: (1) line-item budgets, (2) global budgets, (3) per-diem, (4) case-based, (5) capitation, and (6) fee-for-service (FFS). Payment systems can either be prospective, where payment rates are negotiated and agreed upon before the treatment takes place, or retrospective, where payment rates that are determined during or after the service has been rendered. Each of these provider payment mechanisms (PPMs) create different incentives that can be used depending on the situational context and targets of a given health financing entity, or even an entire health care system. These PPMs present various mechanisms of improving efficiency and quality, increasing accessibility, and easing implementation as much as possible. Many middle- and high-income countries use combinations of several methods to contextually achieve goals, particularly to increase productivity, while ensuring patient satisfaction and keeping control over costs (Cashin 2015; Maceira 1998).

In 2012, PhilHealth started transitioning from FFS towards case-based payments for inpatient care, to eventually move to all case rates (ACR) system in 2013. This aimed to ensure efficiency, cost containment, and predictability in coverage (PhilHealth 2011; 2013). Case-based payments are determined by using the average expected cost in an average-performing facility to treat a disease belonging to a given category. This is based on the specific set of health services recommended by local or internationally published and accepted practice guidelines that are deemed essential for management, care, or treatment of the specific condition. Adjustment factors, such as severity of condition, comorbidities, and other patient and clinical characteristics, that may affect care and its costs are factored in (Kazungu, Barasa, and Obadha et al. 2018; Annear and Huntington 2015; Kutzin 2013).

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[2] RA No. 9241 (2004) – An Act Amending RA No. 7875, Otherwise Known as "An Act Instituting a National Health Insurance Program for All Filipinos and Establishing the Philippine Health Insurance Corporation for the Purpose

[3] RA No. 10606 (2012) – An Act Amending RA No. 7875, Otherwise Known as the "National Health Insurance Act of 1995," As Amended, and for Other Purposes

Some improvements were observed during the early implementation of the ACR system. In particular, PhilHealth showed that support value, or the ratio between PhilHealth payment and the total patient charges, increased from 37.7% in 2008 to 60.3% in 2013. The average costs per case and lengths of stay also lowered as compared to when FFS was used. From an average of 60 days, the turnaround time for processing and reimbursing claims was also reduced by around 21-24 days in 2012 (Picazo, Ulep, and Pantig et al. 2015). However, these studies were conducted in specific circumstances (Annex A) and during the very early stages of the policy roll-out. The ACR system has since been criticized heavily for having very low rates vis-à-vis actual medical charges, and also for having slow reimbursement processes (Cabalfin 2016).

UNIVERSAL HEALTH CARE ACT

The recently passed RA No. 11223[4], generally referred to as the UHC Act, bolstered PhilHealth's role and capacity to become the national strategic purchaser of health services in the Philippines, particularly by reforming its PPM. Chapter IV, Section 18b of the said law states that: "*PhilHealth shall endeavor to shift to paying providers using performance-driven, closed-end, prospective payments based on disease or diagnosis-related groups [DRGs] and validated costing methodologies...*" (Congress of the Philippines 2019). It also prescribes that a standard costing methodology shall provide PhilHealth with updated and more comprehensive cost information to inform its benefit rates and make these more responsive to the prevailing costs of health services.

Currently, costing activities tend to be unsystematic because they are done in an ad hoc manner, typically as a reaction to provider pressure and/or as part of the development of benefits for a select few conditions. These are conducted using varying methodologies and thus challenge consistency in the setting of rates. The shift towards DRGs aims to address the issues of the ACR system. The ACR system has been criticized for not fully subscribing to the principles of case-based payment since its rates are not fully calibrated to case severity, and some case rates are meant for individual interventions and not bundles of services for an episode of care. The DRG is a form of case-based payment where cases with homogenous clinical and resource needs are grouped together. To achieve clinical homogeneity, this means bundling appropriate and related diagnoses and major procedures for a specific case. This also translates to economic homogeneity as cases with the same resource needs are grouped together. Lastly, the payment through performance-driven, prospective payments is interpreted as a shift to global budget payments. This aims to enforce financial discipline for providers, improve payment administration efficiency, and, at the same time, allow providers the opportunity to strategize use of their resources. The prevailing piece-meal reimbursement-based payment system has brought forth difficulties in terms of turnaround of payment, as well as fragmentation of the total payout of PhilHealth (Obermann, Jowett, and Kwon 2018; Cabalfin 2016; Picazo, Ulep, and Pantig et al. 2015).

These provider payment reform components all work together in order to address persisting issues of PhilHealth and drive it towards becoming a more effective and strategic national purchaser of health services. Further context for each of these provider payment components shall be discussed in the succeeding sections.

THINKWELL STRATEGIC PURCHASING FOR PRIMARY HEALTH CARE

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning and maternal, newborn, and child health. The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell

[4] RA No. 11223 (2019) - An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor

in collaboration with country governments and local research partners. The SP4PHC project is focused on purchasing reforms in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda.

In the Philippines, the project provides technical assistance to national and local government to strengthen health purchasing policies and practices in support of the implementation of the UHC Act enacted in 2019. To demonstrate applicability, incubate innovative ideas, and generate evidence, ThinkWell supports UHC Integration Sites in the provinces of Antique and Guimaras. At the national level, ThinkWell directly engages with key government agencies, particularly PhilHealth, to provide technical support in shepherding the reforms set forth by UHC Act. ThinkWell is currently providing assistance to PhilHealth in reviewing global literature and evidence, conducting quantitative and qualitative analytics, as well as implementing stakeholder consultations to guide policy development and strengthen PhilHealth's strategic purchasing role. Key reform areas of focus include costing of health services, expanding primary care payment coverage, shifting inpatient payment towards DRGs and global budget, and establishing cost sharing schemes.

LEARNING SESSIONS

The identified priority areas based on the UHC Act provider payment reforms each had at least one learning session allotted to it. Each priority areas had its own specific objectives (Table 1) in order to guide the scope, design, and target participants (Table 2). The sessions followed two specific formats. First was an input session, where conceptual elements and information about the topic were discussed by the technical expert, followed by a plenary question and answer. The second was a policy consultation session, where PhilHealth and/or ThinkWell presented ongoing work on analytics and policy development on the topic, followed by an open discussion with and feedback from the technical expert. To further flesh out the discussion, participants were allowed to send in questions and/or clarifications, which were answered by the technical expert via email (Annex B).

ThinkWell conducted all learning sessions virtually through Zoom. Depending on the session objectives and format, ThinkWell and/or PhilHealth delivered presentations. Presenters and speakers included Dr. Mel Santillan and Ms. Abigail Estrada from the Benefits Development and Research Department of PhilHealth; Ms. Julienne Lechuga, PhilHealth consultant; Mr. Bob Dredge and Ms. Paula Monteith, ThinkWell consultants; Ms. Celina Gacias, ThinkWell data analyst; and Mr. Christian Nuevo, ThinkWell Technical Advisor for Health Financing, who also acted as the moderator for all learning sessions (Table 1).

Table 1. Topics and objectives of the learning sessions

Objectives	Date(s) and Session Format	Technical Resource Person	Speakers
Diagnosis-Related Groups			
To describe key principles and global practices on DRGs To present the current draft of the policy on DRGs guiding principles and its accompanying transition plan To discuss latest updates on mapping of DRGs and preliminary results of analytics To identify strategies to better facilitate transition to DRGs in the Philippines	19 June 2020 *Input session*	Bob Dredge	Bob Dredge
	9 July 2020 *Policy consultation*	Bob Dredge	Dr. Mel Santillan Celina Gacias
	25 August 2020 *Policy consultation*	Bob Dredge Paula Monteith	Dr. Mel Santillan Celina Gacias

Objectives	Date(s) and Session Format	Technical Resource Person	Speakers
Global Budget			
To describe key principles and global practices on global budget payment To present the current draft of the policy on global budget guiding principles and its accompanying transition plan	19 June 2020 *Input session*	Bob Dredge	Bob Dredge
To discuss latest updates on estimation of global budget and preliminary results of analytics To identify strategies to better facilitate transition to global budget in the Philippines	16 July 2020 *Policy consultation*	Bob Dredge	Abigail Estrada Christian Nuevo
Primary Care			
To describe PPMs for primary care, supplemented by global practices To define the key principles and gains of capitation as payment mechanism for primary care	26 June 2020 *Input session*	Bob Dredge	Bob Dredge
Co-Payment			
To present the current draft of the policy on co-payment guiding principles and its accompanying transition plan To identify strategies to better facilitate introduction of fixed co-payments in the Philippines	14 August 2020 *Policy consultation*	Bob Dredge	Christian Nuevo
Costing			
To present the current costing framework and methodology of PhilHealth, including results of pilot of tools to select providers	20 November 2020 *Policy consultation*	Bob Dredge Paula Monteith	Christian Nuevo Celina Gacias
To identify strategies to improve the costing framework and methodology, and better facilitate its policy translation and nationwide roll-out	26 November 2020 *Policy consultation*	Bob Dredge Paula Monteith	Christian Nuevo Celina Gacias Julienne Lechuga

The participants across the learning sessions varied since invitations were also targeted based on the topic. The ThinkWell Philippines team as well as the Benefits Development and Research Department of PhilHealth were the regular attendees. The full profile of participants of the learning sessions are presented in Table 2.

Table 2. Learning sessions participants

Organization	Office/unit	Representatives
ThinkWell	ThinkWell Philippines	SP4PHC team
PhilHealth	Health Finance and Policy Sector	Senior Vice President and technical staff
	Finance Management Sector	Senior Vice President and technical staff
	Office of the Actuary	Vice President
	Quality Assurance Group	Vice President and technical staff
	Benefits Development and Research Department	Senior Manager and technical staff
	Standards and Monitoring Department	Senior Manager and technical staff
	Primary Care Benefit Team	Team Lead and technical staff
	Millennium Development Goal Benefits Team	Team Lead and technical staff
	Regional Offices	Regional Vice President, Unit Heads, and technical staff
Commission on Audit	Central Office	Technical staff

MODULE 1: DIAGNOSIS RELATED GROUPS

Key principles

The DRG is a classification system that groups together patient cases that are clinically and economically similar. Variables such as primary diagnosis and procedures performed, as well as demographic, administrative, and sometimes resource-use variables, such as age, gender, and discharge status form part of the patient case classification algorithm (Figure 1). In order to appropriately classify a case into a DRG system, a uniform coding database on the diagnosis and procedures done is needed. The most commonly employed system in DRG classification systems is currently the International Classification of Diseases (ICD)-10 for medical diagnoses, though it is worth noting that several countries are already looking to migrate to an ICD 11-based classification. However, coding for procedure is more variable and dependent on country contexts (Mathauer and Wittenbecher 2012; Annear and Huntington 2015).

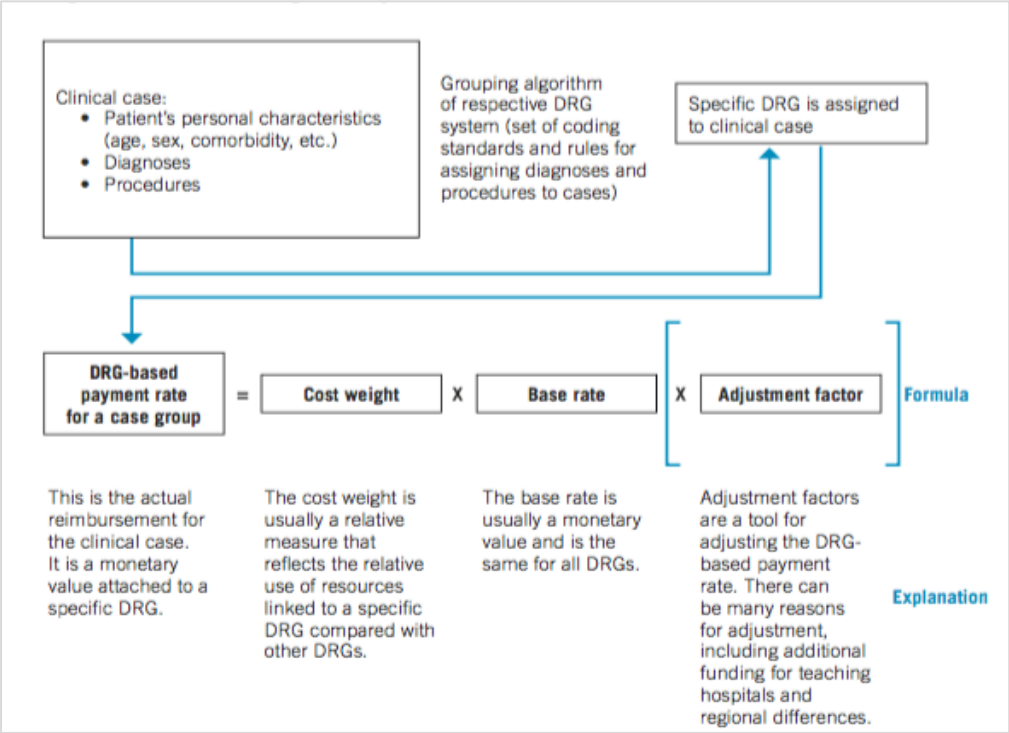

Figure 1. Core Component Design of DRGs (Annear and Huntington 2015)

Payment based upon DRGs is a form of case-based payment, where a payment rate setting system determines the cost of each DRG in reference to the average amount of resources used per clinical case. Rates for each are computed following some determined base rate based on average cost per discharge or percentage thereof of all DRG cases (this can be specific to a hospital or a group of hospitals), cost-weights are determined according to the relative use of resources related to the treatment of a DRG-group, and adjustment factors that allow modification of the price among different types of providers. In a DRG approach, there is greater equity in financing because providers are reimbursed the same amount for the treatment of patients with similar clinical conditions (Mathauer and Wittenbecher 2012; Annear and Huntington 2015).

All in all, DRG-based payment as a PPM sets the correct provider incentives at three levels, namely: (1) to reduce costs per patient treated, generally reflected in reduced length of stay, avoidance of unnecessary care and reduced intensity of care provided, (2) to adjust revenues per patient by proper price-setting given the cost of service provided, and (3) to increase the number of patients by cutting waiting time, improving the quality of care and raising the reputation of the institution (Annear and Huntington 2015).

Country context

The first attempt of PhilHealth into transitioning to a DRG system was around 2009 (Obermann, Jowett, and Kwon 2018). A Philippine case mix system was put together following the Malaysian grouper, in partnership with the Malaysia United Nations University. However, the effort did not materialize into full transition due to logistical and technical difficulties. Therefore, PhilHealth transitioned towards the ACR system.

Efforts to transition again to DRGs were made in 2017 and DRGs were further established as one of the main provisions in the UHC Act. The DRGs is seen as a key component to solve provider payment issues faced by PhilHealth, particularly inefficiencies brought by the prevailing case-based payment. While PhilHealth reviewed and studied multiple grouping systems such as that of the United States, UK, and Germany, certain advantages were identified with the Thailand DRGs (TDRGs). PhilHealth initiated a partnership with Thailand National Health Security Office (NHSO) and Thailand Case Mix Center (TCMC) with support from the European Union

Philippine Health Sector Reform Contract. Under this, technical assistance was provided by the NHSO and TCMC to analyze PhilHealth claims data vis-à-vis version 5 of the TDRG. This was complemented with technical training and consultancy activities, as well as simulation by matching of a subset of claims from a hospital in the Philippines. This partnership demonstrated encouraging results, with a final agreement of allowing the Philippines to adopt the TDRG version 5 as its base grouper in developing the country's own.

Currently, PhilHealth, in partnership with ThinkWell, has completed mapping of the Relative Value Scale used by the ACR procedural coding system with ICD-9-Clinical Modification which is utilized by the TDRG version 5. The ICD-10 used by the ACR medical coding system is also the same one used by the TDRG version 5 and was adopted accordingly. Following this, PhilHealth developed the first iteration of the Philippine DRGs. All grouping logic were re-assembled, and a larger annual pool of 5 million historical claims from 2018 were used to simulate how the grouper would work in the Philippines. This first iteration is currently undergoing further analytics, to be followed by consultation with medical societies to establish a more contextualized grouping logic.

Key learning points and recommendations

Proper contextualization and calibration of both clinical and economic features is a significant and necessary step when adopting existing DRG systems. This should be supported by strong consultation and analytics initiatives. The ongoing analytics work matching the current claims data of PhilHealth with the rules and algorithm of the TDRGs is recognized as a strong starting point, particularly for clinical features. As part of continuing work, the following actions are recommended:

- *Organize and identify champions:* This primarily refers to the clinical features of the Philippine DRGs to be developed. Strategic, inclusive, and comprehensive consultations should be done with medical practitioners (i.e., professional societies) to ensure acceptability and appropriateness of clinical groupings to local practice. In doing this, an effective strategy proven by experiences in other countries is to find and convene an initial roster of credible practitioners to rally behind the initiative and speak of the merits of the system from a relatable standpoint. Other professionals and stakeholders should also be involved in this type of activity to rally wider support for the policy before engaging in wider consultations with all interested parties.
- *Model potential financial gains and potential losses:* This primarily targets the economic features of the Philippine DRGs to be developed. Costing initiatives should be done to capture relevant data to set the actual rates for the DRGs. As part of the initiative to display the merits of the new system, a simulation or a retrospective exercise may be done to compare the status quo (ACR) and the new DRG system. Existing claims and new cost information collected can be used for the simulations to assure providers that data used are sourced from their facilities. Economic gains for the providers following the new system can make for a strong case for the shift. A reasonable transition period for all is also necessary to help providers to familiarize with the new system and be able to comply with its mechanics.

Enabling systems that will facilitate the transition at both the purchaser and provider levels should be put in place and communicated to relevant stakeholders. The backbone requirements of an effective DRG system can be demanding. The current transition plan as well as the set of governing principles are recognized to be well-paced, comprehensive, and thorough. In structuring the implementation details, the following actions are recommended:

- *Establish a robust coding system:* Good coding and record keeping complemented by responsive governance and audit mechanisms are important. Country experiences show that linking these with the implemented DRGs incentivizes providers to report the right diagnosis codes. This is driven by their desire to be paid correctly. Most coding errors documented are not motivated by any fraudulent behavior, but by

human errors interfacing with the system. It has also been shown that in the initial implementation of DRGs, more accurate reporting of diagnosis code can potentially increase overall payment rates by around 4-5% because more of the underlying factors that accurately reflect the clinical interventions are coded. Some countries have deflated their initial rates in anticipation of this, the justification being that providers' cost or true case mix have not changed, but their case mix is now more accurately reported. It is recommended that coding should be done by professionals to achieve this level of rigor. Audits do not need be done for all claims, but only select samples. Independent coding experts may also be engaged for an additional layer of capacity and quality assurance and review.

- *Set clear metrics and targets based on policy goals:* More than just understanding the cost and expenditure landscape of facilities from providers themselves (bottom-up approaches), setting of rates should also consider policy goals and desired outputs of the purchaser. Costing can also be a means to understand resource use, and likewise guide providers in rationalizing their facility costs particularly in relation with other comparable providers. Adjustment factors are not recommended for teaching hospitals (i.e., those that train for specializations) as they are expected to get more complicated cases, and thus naturally claim for the more expensive DRGs relative to other facilities. Adding another adjustment institutionalizes a higher pay for inherent service expectations from these facilities. These other cost items (e.g., teaching, research) which are not directly related to service delivery may be covered by other funding sources (e.g., co-payment) but should similarly be made transparent. Furthermore, it is recommended to set clear and explicit expectations or outputs regarding services. Estimated payments to providers should likewise be calibrated with these service expectations.

MODULE 2: GLOBAL BUDGET PAYMENT

Key principles

A global budget is a prospectively agreed-upon sum of money which the provider can utilize for a given time period. This moves away from the typical line-item budget, which breaks down the funding into individual product lines, such as salaries, equipment, and maintenance. Instead, a global budget can be thought of as a single encompassing budget that simply sets an overall spending limit. It is mainly used to control the total expenditure on a particular product, service, or institution, and motivate providers to improve service delivery through incentives that reward quality, efficiency, and timely clinical practice. It allows providers to structure their resource inputs and costs more flexibly and responsively, in line with their actual needs rather than a predetermined and rigid line-item process (Berenson, Upadhyay, and Delbanco et al. 2016). Global budgets can be set through three broad approaches. The first approach is based on historical expenditures of a health facility, which is used as a nominal starting point to guide estimations and/or negotiations on global budget amount. The second approach is capitation, where an amount allocated for each individual in a particular population group is used to estimate the total budget. This is typically used for municipality level programs or primary care and can be refined/weighted based on factors that may influence health needs within the specific population group and/or area. The third approach is normative, where an external rate is set and applied to service line items that make up the expenditure of the facility. These service line items can be in the form of DRGs, with projected case load informing the volume of each DRG the facility will provide. As a total, this then forms the total global budget (Dredge 2004).

Once the global budget is set, payers can decide between a "soft" or "hard" limit. Under a *hard* cap, the payment is limited to the agreed upon financial limit, which transfers the excess financial risk to the hospital. This set-up is strict because providers are not reimbursed for expenses above the benchmark. On the other hand, dealings are more lenient under a *soft* cap because it permits partial compensation where the payer assumes part or all of the overruns. However, studies have shown that a soft target often fails to contain spending unless the provider is significantly penalized for exceeding the limit (Dredge 2004).

A global budget will influence the behavior of the purchaser and the provider, who in turn, will respond to the constraints, incentives, and penalties of the payment mechanism. The most basic type will place pressure on the hospital to improve unit cost efficiency, as long as there are continuous monitoring systems in place. They may even look for alternative and innovative ways to approach their patients and raise utilization rates. As such, one may see a realignment of existing budgets and a reorganization of resources, such as manpower, infrastructure, supplies, and service, in an optimal way. However, the full potential of the global budget will not automatically materialize, especially if used alone. It will require explicit delegation of responsibilities and autonomy to hospitals. Therefore, measures, tools, and other mechanisms, such as case-based funding, could supplement a global budget in order to provide incentives for cost-effective behavior. All in all, a global budget puts together the ease of administrative execution with the strong incentives to boost performance. As such, it can practically deliver real progress and improve efficiency in a cost-effective way with relatively less and simple resources. It gives providers the incentives and motivation that they need to rethink and realign their systems in order to deliver quality medical service (Dredge 2004).

Country context

The prevailing ACR payment system works by paying providers after services have been provided. This means that providers will have to expend resources first, and then get the payment. While the law allows PhilHealth a window of 30 days for turnaround in payment (Congress of the Philippines, 2012), the current reality is that the retrospective nature of the reimbursement system leads to financial constraints for providers. This makes financing and financial planning for our health providers more difficult, and less strategic.

PhilHealth Circular No. 037-2012 was the first attempt to a prospective global budget payment system. However, implementation of the policy was put on hold even before anything started due to issues with the payment scheme (PhilHealth 2012). In 2013, PhilHealth introduced a more flexible payment mechanism called the Interim Reimbursement Mechanism. Under this mechanism, money is advanced prospectively to eligible facilities and protected by clear agreement terms. Here, money is front-loaded to eligible facilities based on the average value of claims in the past year multiplied by a predetermined time period (PhilHealth 2020). This special payment mechanism that can be taken as a very crude global budget mechanism is only activated during emergencies to aid providers to continuously be operational and resource-ready to provide needed health services. This mechanism has been activated in the past during onsets of catastrophic events such as the 2014 typhoon Yolanda and the 2017 Marawi armed conflict, and more recently as part of the COVID-19 response (PhilHealth 2014; 2017; 2020).

The UHC Act allows PhilHealth to pay prospectively its providers through a DRG-based global budget system. This is also regarded as the main payment mechanism when engaging health care provider networks (HCPNs), essentially paying for comprehensive care from primary to tertiary level with all component facilities taken as one unit within the network.

Key learning points and recommendations

Governance support and mechanisms should enable, facilitate, and enhance the prospective and cost containing features of global budget payment to fully realize its gains. Contracting mechanisms should be put in place to compel accountability from providers paid through global budget. Accordingly, all providers, whether individually or as groups, should ideally be recognized legal entities to be engaged in such contracts. Multi-year contracts are effective in a sense that they give providers certainty of their resources and allow them to plan more strategically. Purchasers—in this case, PhilHealth—are also granted predictability on how much benefits they pay out over a longer period. Thus, risk is better managed for all parties involved. This also contributes to administrative efficiency for both purchaser and provider. Audit mechanisms should balance safeguarding public funds and contributing to achieving the purpose of global budget payment. This means

acknowledgement and operationalization of certain features, such as efficiency gains, incentives, and performance-based payments—all of which may be distinct from traditional line-item passive financing. Including these with clarity in contractual terms can help dispel risks. Given considerable changes in shifting to global budget payments, decision-makers in implementing institutions should be the main champions. The inclusion of provider payment transitions in key management documents, such as the medium-term development plan of PhilHealth, is a good manifestation of commitment to the reform.

Prospective payment and contracting should realistically consider the implementing capacity of the health care system, especially health care providers. Transition strategies to manage the reform are useful to ensure more effective implementation. These include:

- Implementing facility-based global budget in the interim is a good strategy. This is in recognition of the Philippines' lack of strong experience with front loaded payments and network-based contracting, plus the prevailing behavior of providers to act more as individuals rather than system players. However, full transition to global budget payment for HCPNs should be made clear and apparent as early as possible. This can be done through clear transition timelines and better incentives for those that form functional networks.
- Direct shift to a totally DRG-based global budget payment may not be desirable or manageable. A blended approach of current and future payment systems can best facilitate this transition, allowing providers and systems to adjust more easily over a limited number of years (say three or four). Some form of in year transitional support may be desirable for providers who may not benefit or "lose" from the move to DRG based budgets.

Prospective payments for HCPNs are best to achieve integrated care delivery. Regardless of provider composition—public, private, or mixed—what is most important is legitimacy, alignment, and role clarity within these networks. Networks for contracting should be represented by a legitimate governing entity with a recognized mandate to organize providers under it. This can either be public or private in nature, depending on implementation acceptability. In the practice of provider network in some countries, the highest-level facility is identified as the lead by all its component facilities and represents the network to the purchasing entity. Regardless of the model, networks should be formed with the spirit of coalition and not competition. Contracting mechanisms can facilitate this by ensuring fair decision-making, resource sharing, and accountability across component facilities of a network.

Global budget amounts should be carefully calibrated with priority outputs, activities, and even outcomes. Payment design should likewise drive desired provider behavior. To drive true integrated care, funds for primary care should be included in payments for HCPNs. Special mechanisms can be put in place to achieve specific policy goals: where primary care is being championed, protecting minimum levels of spending on primary care and/or other key services within a pooled global budget for networks can be a good strategy. Risk-sharing mechanisms should be put in place as part of global budget payments. In particular, there should be clarity on how savings can be used by providers. This can be linked with national priorities or locally determined needs that might require additional investments. The process for agreement on these should be clearly stated in contracts. Setting absolute hard caps on global budget payments is not a common practice internationally, as this may cause underspending in fear of depleting funds. Some reasonable flexibility is typically awarded to providers through soft caps. The use of a three-year moving average in estimating global budget payments can be done in the initial years of implementation. Once payment systems stabilize and providers become more attune, annualized estimation can be done.

MODULE 3: PRIMARY CARE

Key principles

Primary care is key to strong health systems and has been associated with better health outcomes, equity, less chance of being subjected to inappropriate health interventions, cost-effectiveness, and patient satisfaction. Primary care is a service delivery concept that refers to a *"level of a health care system that provides entry into the system for all new needs and problems, provides person-focused (not disease oriented) care over time, provides for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others"* (Starfield, Shi, and Macinko 2005). The coordinative aspect aims towards integrated care, with effective gatekeeping helping patients navigate access to specialty care, hospital care, and diagnostics (Atun 2004; Greenfield, Foley, and Majeed 2016; Tangcharoensathien, Limwattananon, and Patcharanarumol et al. 2015; Ang, Ho, and Mimi et al. 2014).

Country context

Primary care in the Philippines is provided by both public and private providers. Because of the devolved set-up of the country's health system, public primary care facilities, called rural health units (RHUs), are within the financial and managerial accountabilities of municipalities and cities, and are not linked with any inpatient facility in terms of organization, governance, and/or resources. Private primary care facilities are also typically independent. Preventive and promotive health services (i.e., information and education campaigns, health literacy interventions, surveillance etc.) that relate to primary care are also largely the responsibility of public primary care facilities, with private primary care facilities focusing mostly on direct to patient primary care services. These public and private primary care facilities are currently not licensed by the Department of Health (DOH) and only require a license to operate from the local government. Recent quick supply mapping of the DOH also showed that around 55% (roughly 3,000) of primary clinics are private, with the remaining 45% (roughly 2,500) accounted for by RHUs (DOH 2019). At the DOH, the Disease Prevention and Control Bureau is the main body responsible for primary care services. The Bureau is subdivided into eight divisions, focusing on different vertical disease programs (DOH, 2017).

PhilHealth pays a selective range of primary care and outpatient services. Two capitation-based packages for select primary care diagnostics, medicines, and services are currently implemented: 1) the primary care benefit (PCB) of PhilHealth pays a capitation rate of Php 500 (~US$ 10) per family per year for indigents and sponsored program members of PhilHealth (PhilHealth 2012), and 2) the enhanced primary care benefit which pays a capitation rate of Php 800 (~US$ 16) per family per year for formal economy, lifetime, and senior citizen members (PhilHealth 2018). Separate outpatient specialist packages cover specific conditions such as animal bite, malaria, tuberculosis, family planning, maternity care, and HIV/AIDS (PhilHealth 2012; 2008; 2014; 2015).

Following the Philippine Health Agenda of 2016 (DOH 2016), the DOH is moving away from the verticalized view of primary care to an All Life Stages perspective. This "womb to tomb" perspective seeks to ensure that the triple burden of disease is responded to across all life stages, delivering comprehensive and continuing care for all. The prioritization of primary care and re-orientation to an all life stages approach was officially published through Administrative Order 2017-002, or the Primary Health Care Guarantees (DOH 2017). Similarly, the UHC Act also effectively defines primary care as an individual-based health service that should be covered by PhilHealth. The said law specifically mandates PhilHealth to develop a comprehensive outpatient benefit package (COBP) that holistically and comprehensively covers primary care services, with mechanisms for proper gatekeeping with a network of higher-level facilities (Congress of the Philippines 2019).

Key learning points and recommendations

Blended payments are a common best practice in financing PHC services. This means a mix of capitation, FFS, co-payment, and pay-for-performance, determined by the sector and policy objectives of the country. FFS, in practice, are still paid as bundles of services on top of capitation, and not always itemized payments per supply

or service rendered. Effective capitation practices include clear contracts, proper provider engagement, and complementary auditing and monitoring of outcomes and processes. Appropriately designed primary care payment systems can improve outcomes, reduce costs, control prescription patterns, and avoid adverse selection.

Devolved setups benefit from strong alignment with the national level in financing primary care services. Even for devolved health systems, the prevalent best practice is the determination of some basic, mandatory, and nationally determined PCB for the whole population. But in rolling out the benefit, adjustment factors and redistributive mechanisms are enacted based on demographic, geographic, and socio-economic factors, with bias for more marginalized or vulnerable populations. Gatekeeping practices vary across countries based on cultural factors. Considerations on behavioral norms and general acceptability should be balanced with policy goals. Some practices include institutionalization of technical (i.e., requirement of primary care consult prior to seeking inpatient care) and financial (i.e., co-payments for patients that go straight to higher level facilities) impediments to drive the desired gatekeeping effects. Innovation approaches through strong disease management programs are frequently integrated in primary care. Several countries develop a program to manage a specific disease of high prevalence, magnitude, or political interest. In some, ring-fenced money is paid to primary care providers to specifically manage and organize integrated care for patients in this disease group. This allows primary care providers to manage patients in their catchment and avoid unnecessary treatments in higher level facilities. Well-designed disease management programs such as these have been proven to positively impact health outcomes.

MODULE 4: CO-PAYMENT

Key principles

Cost sharing is a mechanism whereby some direct payment of a portion of health care costs is borne by patients, usually relative to the financial coverage provided by an insurer or health purchaser. This can come in many forms, such as deductibles (amount to be paid at initial period before benefits apply), co-payment (a flat fee for a health care service or product), or co-insurance (percentage of the cost of the health care service or product) (Small Business Majority 2017).

Depending on the context of the health system, cost sharing mechanisms may help achieve several goals. First, it can address high health expenditure by distributing costs of health care among patients, governments, and the purchaser. In particular, this can spread financial burden between the purchaser and patients in a controlled manner. Such arrangements can be a means to decrease overutilization, where cost share acts as a disincentive for patients to excessively access health care (moral hazard). This ultimately helps increase patient financial accountability, as well as responsibility over their own health. Calibration mechanisms may include applicability of cost sharing schemes only to select services (not deemed cost effective), providers (usually private providers who may have some profit level target), or population groups (typically those who have capacity to pay) (Zare and Anderson 2013; Luiza, Chaves, and Emmerick et al. 2015). While cost sharing schemes may have these judicious objectives, they may still result in some untoward effects. Cost sharing schemes that require patients some form of payout may sometimes cause a decrease in utilization of both unnecessary and necessary health services. Poor and vulnerable individuals are especially susceptible to this since any form of additional charge may already deter their capacity to access the care. This may lead to delayed access to care and can further cause development to more severe and expensive disease stages (Luiza, Chaves, and Emmerick et al. 2015; Cliff and Fendrick 2018). The design of cost sharing should be mindful of this potential effect, and counterbalances through the calibration mechanisms aforementioned should be put in place as part of the overall cost sharing design.

Country context

In the prevailing payment system of PhilHealth, only a predefined selection of the poor and vulnerable population groups who stay in basic or ward type accommodation are exempt from co-payments, by virtue of the No Balance Billing (NBB) Policy (PhilHealth 2014). In the case of Z-Benefit Packages (a select set of benefit packages for catastrophic illnesses), the same priority groups cannot be charged anything beyond the benefit rate, while others that fall outside the categorization are only allowed a maximum of 100% of the benefit rate as additional charges (PhilHealth 2012). However, monitoring of the NBB Policy has not been strong, and even poor patients still pay out for health services especially when they are asked to purchase medicines outside the hospital due to lack of supplies. The Z-Benefits are also provided by a select set of providers due to service capacity demands. Given that the prices of health services in the country are not regulated in any other way, additional charges remain uncontrolled to the detriment of patients. In fact, the use of PhilHealth benefits to pay for health care is associated with higher average costs. Depending on the facility type, average cost can be higher by 244-865% for outpatient care and 135-206% for inpatient care (Haw, Uy, and Ho 2019).

The UHC Act stipulates that patients who stay in basic accommodation, regardless of economic standing and/or membership type, shall have no additional charges on top of PhilHealth payments to facilities. For those who stay in non-basic accommodation (i.e., semi-private or private rooms), some fixed, pre-negotiated co-pay will be allowed. In the case of outpatient services, only services in private primary care facilities will have the same fixed, pre-negotiated co-pay. All services in public facilities shall not be allowed additional charges on top of PhilHealth payments (DOH 2019).

Key learning points and recommendations

The main goal in setting fixed co-payments should be clearly recognized and articulated to guide its overall design and implementation. Co-payments can be implemented for various reasons. These may include (1) addressing high expenditures, (2) ensuring equity in accessing care, (3) sharing and/or spreading financial risk, (4) controlling or disincentivizing service provision, or (5) revenue raising for providers. Ensuring equity and better spreading financial risk for its members are recognized to be key goals of setting fixed co-payments by PhilHealth. As such, patient awareness should be a key element in the policy design. PhilHealth beneficiaries should be made aware of rules for allowable co-payments so they can also assert this when availing of their benefits. Some consideration must be given to potential disincentives to seek care if co-payments are set too high or are unaffordable for some segments of the population. Similarly, co-payment can be designed in a variety of ways guided by the recognized goal and undergirding rationale of the policy. Co-payment can be designed as annual cap per family, household, or individual; exemptions for selected vulnerable groups; standard co-payment per facility per service category; or co-pay per individual case (recognized to be administratively burdensome and most impractical)

A clear policy decision needs to be made to determine who retains the co-payment as this has significant policy and behavioral implications. Given policy direction of the UHC Act where co-payments are only for non-basic accommodation and should only cover fringe services or additional amenities, collected co-payments may best go straight to the facility. Professional fees are direct medical services and should be within the payments of PhilHealth to the facility. These refer to charges made specifically for services rendered by the attending physician, usually a specialist. Such charges may be outside the total medical bill of the patient, paid separately and/or directly to the doctor. This happens because specialists are typically not employed by hospitals, especially in the private setting, and provide their services within these facilities independently. They are not salaried, and their charges are not within control of the facility. In most instances, the hospitals are not even aware how much these charges are.

Professional fees are not fringe services but are essential to the delivery of health services. As such, these should properly be accounted for and covered by PhilHealth payments, and not shifted towards patients as co-payment. This entails a more formalized relationship between the facility and the specialist to manage and include these fees better. Co-payments for actual fringe services is best consolidated, and used by the facility to fund these additional as additional amenities, and/or as resources to continuously improve the facility (i.e., infrastructure development, new equipment, etc.) These can also be used as incentives for health personnel to attract talent and/or drive performance. Any intended purpose for the co-payments aggregated should follow agreements on a fair and transparent way to allocate them.

Effective calibration of co-payment and/or provider payment adjustment factors should investigate the causes of difference in costs across different providers. Case-based payments, which is the prevailing payment system of PhilHealth, follow the principle of average costs and naturally result in some individual over and under payment. Rates in case-based payment should be regarded as fair pricing for the particular set of services. This means that all clinical and quality elements are deemed achievable within the service bundle and predetermined price. Costs can be influenced by several factors, such as: (1) patient-level characteristics, (2) facility type or level, (3) facility ownership, (4) disease complexity, (5) operational expenses, and (6) profit margins and competition. These factors vary across different areas, and thus affect the experience of providers of being “underpaid” or “overpaid”. However, particularly for the “overpaid”, these variations are generally more a function of efficiency and not deliberate excessive payment. Thus, it can be a way to encourage and enhance overall efficiency of the system.

Adjustment factors based on these parameters can be considered to calibrate the standard case-rate. However, adjustments based for example on level of facility should be done with caution. Higher costs in higher level facilities are not necessarily caused by direct medical services provided, but other specialized functions (i.e., training and teaching). These may not need to be covered in the case payment but are better treated through a separate and transparent funding mechanism. Differences in costs that are caused by case mix of higher-level facilities should naturally be addressed by DRGs as to be implemented by PhilHealth, and do not need additional adjustments. Incorrect adjustments may lead to adverse behaviors such as higher-level facilities taking in simpler cases that cost less, but payments are artificially inflated because of adjustment factors based on facility level.

Governance arrangements, mechanisms, and institutional capacity are key elements in effectively implementing co-payment schemes. The entity that sets and/or regulates health care costs should consider the history and politics of institutions. The mandate of key governance institutions such as the DOH, PhilHealth, and local governments (given the highly devolved set-up in the Philippines) will need to be assessed to find out how each should contribute to the overall goal. Political will and partnerships need to be leveraged across these institutions—i.e., administrative policies on fee schedules from the DOH, local ordinances from local governments, and fixed co-payment agreements with PhilHealth.

Co-payment agreements can be reached and legitimized through contractual agreements between providers and the purchaser. PhilHealth, as part of its strategic purchasing role, can be in a strong position to negotiate and enforce such contracts and agreements. Co-payments should be regarded as part of the minimum compliance standards for contracting, safeguarded by appropriate sanctions instead of incentives (incentivizing for purposes of complying is not strategic). Explicitly defining cost items that providers can use co-payment earnings for may not be a beneficial exercise for PhilHealth, as this dramatically expands the need for understanding facility characteristics and business processes. This can be left to the autonomy of the facility, subject to an overriding agreement on major strategic areas for investment, alongside a process of reporting and audit of their use. To facilitate patient awareness, co-payment rates can be made transparent within institutions and easily available to patients as part of contractual arrangements.

Transaction costs and administrative demands of co-payments schemes should be properly balanced in order to optimize implementation. Negotiations with too many individual providers may present challenges. More so, co-payments differentiated per case, condition, or even cost item shall present the greatest burden and inefficiency. Providers, particularly those from the private sector, may have an advantage in negotiations given their experience. Counter-capacity of managers in the government (PhilHealth) should be at par and may need to be developed. Negotiating with groups of providers is a good strategy to decrease transaction costs. More so, this complements well the idea of HCPNs, where an autonomous committee or network management team can stand in representation of all these facilities during negotiations on co-payment rates. Setting pre-determined national or provincial level standard rates may be an effective way to set co-payments. This approach allows for a more manageable administrative process, while similarly still achieving the goals of the policy.

MODULE 5: COSTING

Key principles and country context

When PhilHealth moved from FFS to the ACR system, a total of 4,000 case rates were developed. These reflected the ICD codes. To come up with the package rates for each of these case rates, a mix of sources and methodologies were used. A costing study from five participating hospitals in a contracting project accounted for 50% of the source, 30% from average value per case from PhilHealth's historical reimbursements, and the remaining 20% from a case mix tariff from 18 reference hospitals for the 23 initial case rates. This approach presents several problems. For one, the payments from the originating FFS model only accounts for partial costs because only a certain percentage of the cost of service was paid for then. This meant that the proportion not previously paid for was also not accounted in the costing. The costing was also done mostly in public hospitals, resulting to a lack of representation in facility costs particularly for those privately-owned. Lastly, the costing was documented to only include 480 patient charts, which is very limited. In the end, the methodological challenges of developing the ACR translated to underestimated rates. Health care providers and administrators also echoed a lack of transparency on how these costs were processed and used in setting the final rates (Dalmacion, Juban, and Zordilla 2014).

Ultimately, PhilHealth is still left with no standard rate setting policy and costing architecture for its case rates that is technically sound, appropriately incentivizing quality services, and representative of all stakeholders the Corporation wants to engage. As a result, PhilHealth is unable to properly estimate and translate cost of services to actual case rates, leaving providers either underpaid or overpaid, and beneficiaries paying high out-of-pocket payments because of PhilHealth's low support value. Clearly, this poses problems of inequity in spending for all parties involved, detrimental both to individual stakeholders, and arguably the health system as a whole.

The UHC Act stipulates that provider payment reforms of PhilHealth should be guided by proper costing activities that will inform payment rates. Even earlier than the passage of the said act, PhilHealth has started work on developing this standard costing framework and methodology, primarily using the Joint Learning Network Costing Toolkit and Manual (Özaltin and Cashin 2014). Initial costing tools were developed with technical assistance support from external partners and piloted to a cohort of 22 inpatient facilities in Region III. PhilHealth is currently in the process of streamlining and finalizing policy instruments that will institutionalize costing as part of the provider payment ecosystem of PhilHealth.

This costing framework shall inform the DRG rates of PhilHealth, and the global budget payment. PhilHealth payments are expected to cover the costs of providing needed health services for individuals seeking care. As such, the costing framework and methodology comprehensively accounts for all expenditure items of the health facility, including items necessary for providing direct health services such as medicines, commodities,

diagnostics, and health personnel costs, among others. For one, this helps ensure that estimated rates can rationally pay providers. Secondly, this supports the UHC Act direction of PhilHealth financing individual-based health services (i.e., health services that are administered directly to individuals). Currently, financing streams are challenged by huge overlaps and duplications, where several agencies (i.e., national and local) and sources (i.e., budget, reimbursements, user charges, etc.) provide funding for health services. This causes plenty of inefficiencies and lack of accountability in the system. This clarification on financing roles of institutions in the UHC Act steers towards integrated and simplified funding streams, allowing providers more certainty on their fund sources, exacting accountability to agencies on ensuring funding and/or payments, and overall enhancing allocative efficiency in the system. Comprehensively costing facility expenditures ensures that medicines and commodities currently being subsidized by the DOH set for transition to PhilHealth financing will be sufficiently accounted for as part of the costing, and eventually the rates. Inclusion of personnel costs helps ensure that those in private practice/facilities that do not receive government subsidy will be sufficiently paid. Salaries of public health workers will remain part of and financed by budgets of the DOH or the respective local government unit and will not be replaced by PhilHealth payments. This is in accordance with rules set forth by the devolution under the Local Government Code of 1991 (Congress of the Philippines 1991). This overlap may potentially be addressed in contracting details, transforming them into incentives for public workers.

Key learning points and recommendations

Beyond setting responsive rates for benefits and payment systems, costing will help inform better policy decisions, service delivery, and patient outcomes. Accurate costing exercises and data provide tremendous benefits for decision-making and policy at the level of the purchaser (i.e., PhilHealth) and the health care provider. Understanding costs, their structure, and behavior, is a strong tool that can drive efficiency and effectiveness. Utilization of scarce resources can be observed and compared. No hospital would want to be seen as the most expensive (implications on patients), nor the cheapest (may imply some skimping on quality). Clinicians and managers will use the data to understand, challenge and possibly change their practices and identify services that may be under or over resourced.

The cost of conducting costing must be considered and proportionate to expected gains (Pareto principle). Top-down approach to costing is deemed the more practical way forward. Country experiences highlighted during the learning sessions have shown that the added accuracy of a very detailed and tedious bottom-up costing regularly conducted may not add materially to accuracy and will significantly increase the cost of and resource use for the costing process. The costing mechanism should make sense on the ground, particularly to providers sharing the information. There should be clarity on what cost data PhilHealth wants to be collected, how these are processed, analyzed, and used for policy. Methodological implementation of costing should ensure that any bottom-up micro data collected reconcile fully with grand totals used to inform decisions and activities. Initial roll out of costing is recognized to be a practice of recordkeeping (knowing what providers are spending on for the benefit of the facility and of PhilHealth). Consider design of costing information collected, especially given low response rate for certain cost items. While there are no hard and fast rules on direct and indirect costs, it is ideal to be able to attribute as many costs as possible directly to the costed health care activity. Actual cost allocation will depend on the granularity and accuracy of the cost data.

Involvement of health care providers and identifying clinical and medical champions are crucial in pushing for costing. Having clinician-leaders to champion and facilitate better understanding on the ground level, as well as improve participation and response to results of costing activities. Others will believe and commit to the reforms more if they hear it advocated by their peers rather than technocrats. Champion providers can become exemplar or demonstration sites. Some form of incentive or one-off added support for example can be considered. Their clinical knowledge combined with deep understanding on how health care facilities operate should be leveraged in developing complementary IT-based systems or software for costing. Costing activities conducted by PhilHealth in the past included consultations with specialty societies as well as clinical

practitioners in health care facilities engaged in the costing. These should be institutionalized as part of the final costing framework for implementation, possibly through a multi professional or organizational steering or oversight group.

Engagement with providers for costing should be a dynamic relationship where there is continuous interaction until both local and national review and verification of data collected and analyzed, including the resulting conclusions are substantively completed. This shall also provide facilities evidence-based insights to improve their own practices relating to resource use and management. Part of the dialogue should be a process of validation of data and results to concerned health care providers prior to publishing. Data collected should not be adjusted and/or corrected by PhilHealth to maintain fidelity with information from health care providers. Contentious data points and/or results should be vetted with the health care provider prior to finalization. Results of costing should be made transparent through publication and/or direct sharing with health care providers that participated. Cleaned data should be published and available to all interested parties so that they can analyze and understand the full extent of costs. Published data should be anonymized. Data can be graded by type of provider and ownership class so providers may compare and understand individually where they stand in the cost comparisons. Automated validation mechanisms should be embedded in the costing system for efficiency. This should function as a complement to direct provider engagements.

SYNTHESIS

The main goal of the UHC Act in relation to PhilHealth and its financing role is to systematically re-organize the financing landscape in the country such that PhilHealth becomes a dominant, strategic purchaser. To achieve this, PhilHealth must be able to enforce effective financial rules, incentivize good provider behavior, purchase health services on behalf of Filipinos at rational prices, and overall achieve financial risk protection. The learning sessions provided an avenue for interaction and exchange of ideas by all stakeholders with experts in the field based on ongoing analytics and policy development work of PhilHealth and ThinkWell. The participants were able to generate a mix of technical and implementation recommendations towards improving the overall approach to achieving PhilHealth's envisioned role for UHC (Table 3). The cross-cutting insights generated are as follows:

- **Identifying, organizing, and engaging champions is crucial in generating buy-in.** The reforms in PPMs are all going to be interfaced with health care providers and health care facilities during implementation. A good way of obtaining buy-in, boosting confidence and support is to have respected peers rally behind PhilHealth in support of these reforms, establish their merit, and give some stamp of acceptability. Finding clinicians who can help champion the rationale and design of the DRGs can help build credibility and bring more providers to the fold. Similarly, facilities who have experienced the implementation of costing can testify that the activity is both doable and worthwhile.
- **This generation of buy-in necessitates a transparent and participatory relationship with stakeholders.** Historically, the consultative processes of policy development tend to involve stakeholders only towards the end when all the work has practically been done. Identifying and engaging champions will require making sure that stakeholders are active partners in the development stages of the policy such that they themselves will own the process. Medical societies should take part in the grouping of diagnosis to determine what is appropriate in the context of clinical practice in the country. Health care facilities should get comprehensive feedback on costing data collected from them and provide them space to understand the results and its implications. Providers should be brought into the designing of prospective payment mechanisms to ensure it supports resource cycles and needs on the ground. These can also help ensure support across a wider audience base and is similarly an opportunity for PhilHealth as an institution to exact its governance and leadership role.

- **Designing PPMs and its supporting components should be deliberate and targeted towards remedying existing issues and achieving desired goals.** How financing mechanisms are assembled influences what behavior it drives out of the health care providers that receive the payment. As such, the design should be approached with great intentionality. In deciding what costs will be included in payment rates, PhilHealth should be mindful not to pay for inefficiencies (i.e., higher level facilities charging higher prices for simple cases), as well as cost components that may not directly influence quality of care (i.e., having a teaching or training component within the hospital). Cost sharing schemes should also be developed such that it is protective of financial risk for patients, but at the same time realistic also for providers to cover costs not included in payment rates. Adjustment factors for DRGs and even global budget payments should strategically calibrate across varying contexts of health care providers. Those in rural communities may have lower patient volume, but higher cost of supplies due to procurement challenges, or even heavier accountabilities and susceptibility to surges due to being the sole provider in the locality. These elements should be balanced out such that existing challenges are not carried over, and payments actually become responsive.
- **Transitions should manage and work with realistic capacities of health care providers and the system as a whole.** Implementation of provider payment reforms naturally call for improvements both in hard (i.e., IT infrastructure, service capabilities) and soft capacities (i.e., financial management skills, cooperative skills, coding support) of individual health care providers. These should be carefully considered to effectively shepherd the entire system towards the goal. Similarly, capacity of governing institutions both at the national and local levels should be managed. PhilHealth will have to increase its capacity to implement these more sophisticated payment mechanisms. This means enhancing technical proficiencies in analytics, data archiving and processing, stakeholder consultation, and even monitoring. Negotiating skills will also have to be improved and developed to execute new provider engagement mechanisms. Coordination with other crucial agencies (i.e., DOH, Commission on Audit) will also be important in order to create a governance ecosystem with a common understanding of the policies.

Table 3. A summary of the key recommendations for each topic/module

Key Area	Current Situation	UHC Direction	Learning Sessions Recommendations
DRGs	Reimbursement of a fixed payment amount for each inpatient claim based on the declared medical and/or procedure code Select bundled packages for highly expensive and catastrophic conditions (termed Z-Benefits)	DRGs with base rate, cost weights, and adjustment factors generated using data from standard costing exercises and consultations with health care providers Bundled packages for highly expensive and catastrophic conditions	Find and create clinician champions who can support the clinical features of the DRGs being developed. Model financial gains or losses in shifting from ACR to DRGs. Establish robust coding systems and clear metrics.
Global budget payment	Front loaded payment only in emergency or fortuitous events, where historical claims for a specified period of time is used as basis	DRG-based global budget payment for all health care providers and/or HCPNs facilitated by standard estimation methodologies, contracting mechanisms,	Improve governance support and mechanisms (i.e., audit systems and contracting mechanisms) to facilitate introduction of prospective payments systems.

Key Area	Current Situation	UHC Direction	Learning Sessions Recommendations
		and performance-based incentives	Account for system capacity to absorb prospective payments; pursue transition from facility-based to network-based global budget payments. Drive towards a global budget system that incentivize comprehensive care (primary to tertiary).
Primary care	Fixed annual payment to provider per family in catchment (termed capitation) for basic primary care package with limited coverage Select outpatient specialist benefits	COBP with per person fixed annual capitation per individual in catchment Integration of select outpatient specialist benefits to the COBP, as appropriate	Having blended payments in primary care is a common practice across countries, used to achieve desired policy goals. Even for devolved health systems, having a basic, mandatory, nationally-determined PCB is still a best practice. This can be complemented by other redistributive mechanisms (i.e., adjustment factors, rates calibration, etc.).
Co-payment	NBB (zero co-payment) for select membership types (poor and vulnerable, senior citizens) in ward accommodation in public facilities Fixed co-payment of 100% of benefit rate for Z-Benefits	Zero co-payment for all patients admitted in basic accommodation, and fixed co-payment for all patients admitted in non-basic accommodation	The main goal in setting fixed co-payments should be clearly recognized and articulated to guide its overall design and implementation. Effective calibration of co-payment should investigate the causes of difference in costs across different providers. Governance arrangements, mechanisms, as well as institutional capacity are key elements in effectively implementing co-payment schemes.
Costing of health services	No standard costing methodology Ad hoc costing activities conducted on a per condition basis (typically normative in approach)	Standard costing framework and methodology using a mix of top-down and bottom-up approaches, conducted on a regular cycle	Beyond setting responsive rates for benefits and payment systems, costing will help inform better policy decisions, service delivery, and patient outcomes. The cost of conducting costing must be considered and proportionate to expected gains (Pareto principle). This is important in considering implementation of top-down, bottom-up, or both methodologies.

Key Area	Current Situation	UHC Direction	Learning Sessions Recommendations
			Involvement of health care providers and identifying clinical/medical champions is crucial in pushing for costing. Engagement with providers for costing should be continuous until both local and national review and verification of data collected and analyzed, including the resulting conclusions. This shall also provide facilities evidence-based insights to improve their own practices relating to resource use and management.

These recommendations have influenced the policy development processes by introducing new approaches, re-calibrating approaches, and/or re-affirming initiatives. These include:

- **PhilHealth prioritized re-engaging health care providers that participated in the costing pilot as part of its stakeholder consultation on the costing framework and methodology in order to show results of the data collection.** An anonymized walk through of these results was also done to facilitate better understanding from providers on their costing landscape versus other providers. This activity did not only aim to improve the costing process, but also started a feedback relationship where providers can be more involved in the process and have a new perspective on where they stand compared with other providers in a safe manner.
- **PhilHealth, in partnership with ThinkWell, linked the development of the DRGs and co-payments with the costing activity to ensure that actual provider data can inform payments rates and arrangements.** Initially, there was internal confusion on whether case-specific bottom-up costing will be necessary to set the DRG rates. Presenters suggested to view the DRGs as cost pools to which top-down costing will allocate towards. This was adopted through prioritization of the top-down costing, and development of initial rate setting models from the top-down costing to DRGs. More specific advice was also given to at the outset, separate certain clinical groups (i.e., surgeries, obstetric cases) as these tend to have unique dynamics versus other cases based on experience. In the case of the co-payment policy, the work is still in the very early stages. However, initial frameworks to determine which cost components will be included within payments rates and allowable co-payments have been put together coming from data that can realistically be captured by the costing exercise.
- **PhilHealth has updated its draft policies to reflect that implementation of facility-based global budget payment shall proceed as an interim strategy before full contracting of HCPNs.** This initial plan was affirmed during the discussions. This acknowledges the advantages of moving towards paying networks of providers, but mindfully considers that there is a lack of strong experience in front loaded payments and network-based contracting, plus the prevailing behavior of providers to act more as individuals. The provider payment work plan elevated to the management includes definitive timelines on the start and

end of transitions. This was also echoed by the recommendations as an effective way of helping providers and the system prepare for changes.

- **PhilHealth has indicated in its provider payment technical roadmap that blended payments shall be pursued both as either interim or final payment designs.** Initial discussions on COBP were oriented towards consolidating all primary care and outpatient packages into one. Discussions on global best practices in paying primary care services showed good rationale and options to separate payment for certain outpatient services following disease burden, priorities, and or provider capacity. This blended payment approach for primary care is currently the primary perspective in moving forward with the COBP. In the case of inpatient services, the transition to DRGs shall be guided by interim, parallel implementation of the ACR system. This was advised in order to avoid shocks in the system and create opportunities to troubleshoot and fine tune the Philippine DRGs through actual field deployment. This shall also be used as an opportunity for PhilHealth to clearly show providers how payment rates and/or revenues may change once the DRGs are fully implemented. The transition steps to DRGs currently embed this blended approach with the ACR system.
- **PhilHealth is introducing prospective payment in the form of a global budget with a clear end-goal, and with supporting governance mechanisms to facilitate the transition.** The transition from facility-based to network-based global budget contracting and payment is currently reflected in the work plan. Furthermore, draft guidelines on global budget indicate primary care as part of the payment. A readiness assessment tool and a monitoring and evaluation framework is also being developed to guide both PhilHealth and providers in transitioning to this.

All these documented influences of the learning sessions have been translated in various fronts, such as policy drafts, technical briefs/presentations, and actual activities conducted. It is expected that recommendations from the learning sessions will continuously be re-visited through the reform journey of PhilHealth.

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ANNEXES

ANNEX A. LIST OF FIRST 23 CASE RATES IMPLEMENTED IN 2021

Surgical Case Rates (13)	Medical Case Rates (10)
Cesarean Section	Dengue I (Dengue Fever and Dengue Hemorrhagic Fever Grades I and II)
Dilation and Curettage – Completion and Fractional Curettage	Dengue II (Dengue Hemorrhagic Fever Grades III and IV)
Hysterectomy	Pneumonia (High Risk)
Mastectomy	Essential Hypertension
Appendectomy	Cerebral Infarction (CVA I)
Cholecystectomy	Cerebro-vascular Accident with Hemorrhage (CVA II)
Laparoscopic Cholecystectomy	Acute Gastroenteritis
Herniorrhaphy	Typhoid Fever
Thyroidectomy	Asthma
Radiotherapy	
Hemodialysis	
Cataract	

ANNEX B. QUESTION SETS

Participants sent questions or clarifications to presenters and/or speakers. Below are transcripts of the answers provided.

Diagnosis Related Groups and Global Budget Payment (learning session 1, input session)

QUESTION	RESPONSE
Is there a practical guide to determining soft caps or hard caps? On which instances / circumstances should each be considered for implementation?	This balance is dependent upon where the system determined the risk of any under or over performances-financial and service/volume should lie. It therefore needs to be considered alongside an assessment of which party is best able to manage and mitigate the risk with least disruption to the services provided. Wherever it sits must be very clear to all how it will be managed. The legal entity/ownership and management governance of the provider is also an issue. If the hospital is ultimately owned by the funder-say a [local government]-owned public hospital, then the ultimate risk site with the [local government] as both funder and provider. In this case some form of clear management authority and accountability is necessary to make managers responsible and not simply able to pass on the risk. In practical terms there should be some form of formal agreement or contract between the purchaser and hospital that makes all the above clear. It could describe the balance between the ultimate fact that a global budget has a hard cap and spend must be contained within it. Any variation in activity from the agreed plan could be managed by making adjustments to other hospital budget lines so as to bring back the overall budget to balance, or by agreeing additional payments at marginal rates, or penalties for non-performance at marginal rates. Any additional activities or services instigated by the hospital based upon using savings/efficiency gains must be in agreement with the purchasers strategic policies and priorities and may be best incentivized by an agreed list of desired developments/improvements agreed at the start of the budget year.
How should the provider account for its utilization of the global budget? Should the purchaser require the provider to liquidate the global budget?	Through the formal and hopefully statutory framework for the reporting of public expenditures. I would expect there to be a formal and audited reconciliation of the funds allocated through the global budget showing, and reconciling, the spend to the agreed budget for services/programs. I would also expect that the entire hospital expenditures would be accounted for to International Accounting Standards and subject to formal external and independent audit. Further a process of national public funds audit of all public expenditure should be available. All of these audits should be reported to the appropriate Hospital/Funder (payer) Boards for assurance and confirmation, and a summary be available to the public.

QUESTION	RESPONSE
What types of mechanisms can be put in place to ensure accountability and transparency in the use of global budget payments to providers? How should this link with public finance auditing systems?	See above. I would add that a robust and constructive process of contracts or, if not legally enforceable, Service Agreements, should be signed before the start of the budget year. These would lay out the financing, performance, quality, monitoring and risk/penalty arrangements for both parties. Contracts can vary in complexity but should be kept as simple as allows for proper governance but also as explicit and detailed as satisfies clarity of responsibilities for both parties.
In extraordinary circumstances (i.e., pandemics or outbreaks), how should global budget payments be adjusted? Is it a simple (capped) top-up? Or should another payment strategy be defaulted to under such situations?	In truly extraordinary circumstances then the budget needs to be rapidly refined to refocus on the current priority. It is logical to review and refine any performance and other volume measures and reallocate funds released from these to the circumstance. There does need to be clarity about where the funds will be redirected and to what purpose/output-with sensitive monitoring of their use. Capped top up, along with some review of current expectations is one approach if you can be confident it will be properly applied and is adequate to respond to the new needs. A specific set of line-item type global add-ons, for extra short-term staff, protective clothing, tests, and diagnosis, is more certain to be controlled, but again in the immediate need to respond it must not be overelaborate or delayed. So flexibility between the current budget and the response is needed, but ultimately a cap should be applied. Another order of risk could be an interruption to service by, say a fire in a part of the hospital that means that some activities cannot be delivered. In such cases then penalties on non-performance of activities is not appropriate.
How should efficiency gains (i.e., savings from global budget payment brought by improved operations) be accounted for? Should there be prescribed limits to how much these gains can be, in order to ensure there is no under provision or underutilization of resources? **If [global budget] is not fully spent by the provider (assuming that targets and outcomes are achieved), how best shall this be audited by the auditing body?**	In order to give an incentive to become more efficient and better use the total budget some incentive to share of keep gains from efficiencies should be allowed. The hospital should be able to reinvest any savings made into service areas that are additional to the baseline of activities agreed in any contract. This means that the contract must be monitored in a timely way so the payer can be content that the full range of services intended by the budget are delivered before any of the budget is redistributed. Any savings/efficiencies could then be applied to a set of additional services or initiatives that are agreed by both the hospital and payer and are consistent with the overall strategic purchasing plan. In terms of audit then in year requests for reallocation of the budget should be part of routine monitoring and agreed prior to commitment of the savings. The full budget is then subject to routine audit. If the hospital claims efficiency/cost savings but has not met the full activity targets, then it is legitimate for the payer to withdraw/withhold some of the budget. Again, the scale and scope of this should be set out in the contract.

QUESTION	RESPONSE
What are some of the strategies to create buy-in from private providers, especially given the cost containment feature of global budget payment?	The bonus payment element of funding to public hospitals could be used to pay a higher rate to private hospitals, and it would also reflect a fairer funding system as they do have a different cost base with no public funding support. In higher income countries it is not unusual for the payer to pay the same rate per DRG or FFS to both public and private providers, but some cost base equalization may be needed as well. Another approach is to change the demand side of this, to make enrollees pay a higher co-payment to the private sector and so make the service cost more affordable to the provider, but at some cost to access and equity, especially for the poor. The certainty of a global budget income, with maybe a 3-year rolling funding agreement (revised annually for incremental changes) may help to give some stability to the provider as well.
Are there country best practices in paying integrated care through networks of providers? How is this usually done?	The Netherlands diabetes management system is good for this where networks of providers, led by Primary Care, are showing good results. [Nick Goodwin and Judith Smith listed] these older examples: • **Kaiser Permanente**, a virtually integrated system serving 8.7 million people in eight regions. Health plans, hospitals and medical groups in each region are distinct organisations linked through contracts. A key feature of the Kaiser Permanente model is the emphasis placed on keeping members healthy and achieving close co-ordination of care between providers through the use of electronic medical records and teamworking. • **San Marino**, a republic of 30,000 people on the Italian peninsula, integrates health and social care at an organisational and professional level using a single budget. Care professionals work in multi-disciplinary teams and take both individual and group accountability for service delivery (such as for joint assessment, planning, care management, and care outcomes). Investment is made in the services and skills required to support integrated care, including the fostering of an organisational culture to overcome individual professional interests. San Marino has been rated as one of the best care systems in the world by the [World Health Organization] due to its combination of high life expectancy, low per capita spend, and comprehensive coverage. A more recent comprehensive study published by the EU summarizes the results as: an **analysis of the level of maturity of integrated care implementation** was conducted across 12 selected health systems (Belgium, Bulgaria, Denmark, Estonia, Germany, Greece, Iceland, Italy, the Netherlands, Poland, Spain, Sweden). The maturity assessment was performed using SCIROCCO's online self-assessment tool: 'Maturity Model for Integrated Care'. From the comparison of the maturity self-assessment of the 12 health systems, the health systems in Belgium, Denmark, Germany, Greece, Iceland, Italy, Spain, and Sweden were perceived by their corresponding stakeholders to be more mature than those in Estonia, the

QUESTION	RESPONSE
	Netherlands, Poland and Bulgaria. Germany's Hausach and Haslach areas scored among the highest, while Estonia scored among the lowest.
What are key / non-negotiable adjustment factors that should be accounted for in estimating global budgets? Should these adjustment factors be calibrated annually?	In terms of in year adjustments then this depends upon the approach to risk sharing. If a global budget is to work and contain costs, then the hospital has to accept that there is a limit to funds that it must operate within. In setting and agreeing the budget both parties make clear the funds available and the scope-volume, quality-of services to be covered by the budget. This sets minimum for the operation of the budget. Adjustments are then based on the hard/soft cap balance but there should be some flexibility. If there are factors that are outside the control of the hospital-say nationally imposed price/wage increases, a new policy mandate imposed by national government such as the introduction of a new high-cost drug, then some flexibility should be allowed. The purchaser could hold back an element of the budget as a reserve for this type of cost. Generally, these would be reviewed annually.
In starting a DRG-[global budget] based payment system, how should DRGs be used in estimating the global budget of hospitals? Is "historical basis" simply adding up a hospital's reimbursements for the past years?	My first question - to be a little provocative - is why do you want full blown DRGs, and the complexity that goes with them-for setting a global budget? Cost and activities based on Major Disease Categories (MDC) could be equally effective. They will also be a lot simpler to capture and less volatile. That said DRGs add a high level of refinement and granularity in understanding better hospital performance and indeed in time, individual clinical practice if you can go that far. To the main question. You need to be very confident that the DRG data is sufficiently robust to reflect the actual service profile of the hospital. Similarly, you need to be confident that the cost/price you allocate to each DRG is appropriate to your particular service profile and methods of funding. If you are using another (Thai) system, then there needs to be some data mapping from their base (MCD level) data to your data sets to see if they replicate your activity profiles. You need to check any imported cost/price data or Relative Value units as well. Do they include or exclude any cost elements that you are assuming are covered in the budget-check staff cost funding, Teaching, Research and development, own income treatment, cost of capital/infrastructure to make sue only appropriate cost elements are allowed for. Having done that ideally there should be some modelling of how the new budget will replicate or change the budget allocate to each hospital. I am assuming you want to minimize short term volatility in the funds available to each hospital while the new funding model beds in, and before any real, and appropriate, redirection of funds occur. This can be done by either a full prospective pilot running of the 2 systems in

QUESTION	RESPONSE
	parallel or, if data allows, by a retrospective modelling of what eth DRG based allocation would have been in prior years based upon your DRG model. This has the advantage of allowing for modification to the detailed elements of the allocation model with no service impact. (NOTE-This is what was done very successfully in Indonesia.) Having done this then I suggest a transition and blending of the DRG based budged with the old allocation so that, say in year 1 it is 20% DRG/80% historic, in year 3 maybe 40/60 or 50/50 and so on. This allows for stability, system re-alignment and also managerial and technical capacity to build to run the new budget. Apologies for long answer but a really important topic and a subject in its own right.
What key skills should be built and/or expected from hospitals for effective handling of [global budget] payments?	1. Begin by ensuring key stakeholders in the hospital and hospital sector, especially clinicians, are involved in some of the initial policy and strategy discussions to get their commitment and to establish professional and clinical allies. 2. Use regional and local "workshops" with a consistent message and consistent "cast" of presenters to explain and describe the reason for changes, the technical issues and the timescales. Ensure that there are local or national clinical leaders involved in this. 3. Define clearly and simply the process of budget setting and activity/DRG data collection and reporting that you are establishing, and why you need it. Be mindful of the tendency to overelaborate/complicate this and initially keep high level and simple as allows 4. Be realistic about monitoring and reporting capacity at local level and ensure key competencies are there. Competencies in clinical recording and coding, IT support for grouping, analytical skills and certainly some in house internal audit of case coding is needed (as is some higher-level formal oversight and audit to ensure there is not "up coding". As you know there will be an early years improvement in the volume and quality of clinical coding as DRGs are established as things now done but not recorded will be recorded and coded. Budget deflators of maybe 2-4% to offset this-the hospitals are not treating more complex patients, just recording them better

Primary Care (learning session 2, input session)

QUESTION	RESPONSE
Are there any practices on differential payments between public and private providers (ex. higher capitation rate for private versus public primary care facilities)? Have these been successful?	Generally, systems attempt to pay the same equivalent rate to both. However, in many countries public providers enjoy some elements of "free" services that they do not pay for directly. This could be the provision of facilities and utilities, staff or some consumables and drugs. If this is the case, then some additional compensating payment to private practitioners is justifiable.

It was mentioned that some countries "re-centralize" some funds for primary care at the central level, for redistribution to more targeted or disadvantaged areas. Is this correct? And if yes, is this done after financing for the basic, mandatory, primary care benefit for all the population is secured?	Yes, this is a very common model in EU countries where the national policy is to attempt some form of equitable distribution of the national resource based on a needs-adjusted capitation approach. Generally, there will be a calculation of the Provinces/Districts "fair share' of the national total and an attempt to redistribute based on this. A full redistribution may not be feasible or desirable if it leads to unnecessary destabilization in a local area, and some element of a phased redistribution over maybe a number of years is appropriate here.
For those that practice blended payments, what typically are paid for outside the base capitation - either through fee-for-service or with allowed co-payments?	The usual model for this is for specific targeted programs for areas such as disease management categories, or focused target incentives such as to practice in unattractive/remote locations. Higher co-payments are also used in some countries if a patient does not consult with their registered [general practice]/PHC service or does not use a formal referral gatekeeper system.
What are the most difficult and non-transferrable practices of Kaiser Permanente and Maryland?	In my opinion - and not shared by all commentators - the problem is that many have simply tried to "cut and paste" the entire USA approach and implement it as it stands. They do not take enough regard for local socio-economic, political, cultural and governance when considering how to modify the approach. The systems principles are clearly excellent, but the implementations have been flawed.
Further details on the incentive system implemented by France.	The French incentives are built around 29 indicators in 4 categories-Prevention, Chronic disease management, Cost effective prescribing and Practice Management. Examples include targets to provide 80%+ of diabetic patients with annual screening and monitoring, A full description is available by general web search of: *rémunération sur objectifs de santé publique*
What are some of the more notable practices in terms of pay-for-performance? **In relation to this, are there non-negotiable indicators that should always be tracked for primary care patients? What are these?**	The Quality and Outcomes approach that was developed in England and built on in Estonia has had good results in PHC. With clear correlation between quality gains in PHC as well as reduced referral to secondary care. The French scheme rewards progress in 29 indicators. In both cases the payment is based upon both the achievement of actual target levels of service as well as progress towards targets-this give a clear incentive to the less well performing services that improvement at all levels could be rewarded. Non-negotiable areas must be based upon the circumstances and strategy/policy of the particular country as well as maybe the sub structure/geography of the country. It is not, in my view, appropriate to take the "norms" from one system as simply transfer them. They may be countercultural and more likely unaffordable or unrealistic.

	Rather the domains within which services should be provided should be covered by minimum and measurable standards. These could (should) include access, quality of clinical and personal care, facilities and patient safety and transparency of reporting.
Are you familiar with any best practices in an [low- and middle- income country (LMIC)] setting? **What are some of the effective approaches to setting performance measures in LMICs which can help reduce the risk for overpayment or under delivery of services while accounting for the variability of utilization as can be reasonably expected in a pandemic year? If there are, how have these approaches been designed and implemented (most importantly given the Philippine situation of weaker regulatory capacity and low value for primary care)?**	To be perfectly candid I have only recent LMIC PHC from Indonesia and you may already be aware of their experiences-but see below if a comprehensive summary is useful to you: Primary health care systems (PRIMASYS): comprehensive case study from Indonesia. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. On terms of the pandemic, it seems to me that most countries where it has not been immediately curtailed have essentially made it the number 1 priority at the expense of most other services and redirected resources accordingly until some element of stable response and control is determined. As such most agreed performance targets have been suspended and some form of global budget/grant support has been put in place. The Philippines are not alone in not protecting PHC.
Have there been practices worth emulating in contexts similar to the Philippines on how performance indicators for primary care have been adjusted to account for abrupt changes in utilization due to various disasters, health or otherwise? **Or generally, what should be done in terms of primary care financing during such circumstances?**	See above. The response seems to me – personally - to be the countries response to the balance of “lives verses livelihoods” The case for PHC, and indeed many other secondary care services that have been curtailed by transfer of resource is that of the future health related opportunity cost of this - ill health/ more severe cases in the near future from untreated current existing conditions- against dealing with the immediate health and political imperatives of the pandemic. This is obviously a personal perspective, but the principal should be at least discussed with policy makers before resource transfer.