SP4PHC
Strategic Purchasing for Primary Health Care

STRENGTHENING PHILHEALTH'S ROLE IN PURCHASING PRIMARY CARE SERVICES

THINKWELL

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 (FP) and maternal, newborn, and child health. The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell 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 governments to strengthen health purchasing policies and practices in support of the implementation of the Universal Health Care (UHC) Law enacted in 2019. To demonstrate applicability, incubate innovative ideas, and generate evidence, ThinkWell supports UHC Integration Sites (UIS) in the provinces of Antique and Guimaras.

The Philippine Health Insurance Corporation (PhilHealth) implements the National Health Insurance Program (NHIP) with the goal of providing financial protection to Filipinos when accessing health care services. The Philippine UHC Law provides an opportunity to strengthen PhilHealth's role in purchasing PHC services by mandating the development of a comprehensive outpatient benefit (COPB) package. This brief provides an overview of PhilHealth's role in financing primary care services and identifies challenges and opportunities to strengthen its role with the implementation of the UHC Law.

INTRODUCTION

Patients in the Philippines access PHC services in both public and private facilities. The Local Government Code mandates municipalities to manage rural health units (RHUs) and *barangay* health stations that deliver PHC services, including preventive and promotive health services (Congress of the Philippines 1991). While PHC services are available at the municipal level, patients are free to choose their health service providers and may opt to proceed directly to higher-level public facilities or to private facilities. Bypassing public primary facilities is common due to patients' dissatisfaction with the quality of care, which is an important factor in their decision to seek care at other facilities (Romualdez, Rosa, Flavier et al. 2011).

Financing is an important determinant of access to good-quality PHC services. By virtue of devolution, local government units (LGUs) are mandated to finance basic public services, including local health programs. However, due to variable financial capacities of LGUs, the Department of Health (DOH) provides for additional inputs, including augmentation of health human resources; capital expenditure; and commodities. As part of its mandate to administer the NHIP, PhilHealth also offers benefit packages to purchase services and augment funding for health at the LGU level (Romualdez, Rosa, Flavier et al. 2011). A lack of demarcation and harmonization of tax-funded services versus premium-funded benefits has led to fragmentation and duplication of service delivery (Dayrit, Lagarda, Picazo et al. 2018). Nevertheless, private household spending remains high, with out-of-pocket (OOP) payments representing 47.9% of the country's current health expenditure in 2019 (PSA 2020). High OOP spending leads to inequity in access to services. In 2017, 63% of the poorest

income quintile cited money as one of the main barriers to accessing health care (PSA and ICF 2018).

The Philippine UHC Law mandates PhilHealth to be the strategic purchaser of individual-based health services,[1] including those delivered as PHC. The UHC Law requires PhilHealth to cover more comprehensive outpatient care and to establish gatekeeping and referral mechanisms to access comprehensive care within health care provider networks (HCPNs). To achieve this goal and to support local health systems in prioritizing primary care, PhilHealth was mandated to develop a COPB package within two years of enactment of the law (Congress of the Philippines 2019).

METHODOLOGY

This brief provides an overview of PhilHealth's current capacity to finance PHC services and identifies lessons and recommendations for developing the COPB package. ThinkWell used both quantitative and qualitative data to develop this brief. As part of this, the team conducted a desk review of PhilHealth policies as well as academic and grey literature related to PhilHealth's benefit packages for primary care, in addition to its benefit claims and accreditation data for primary care services. First, the team describes the evolution of benefit packages for primary care and outpatient specialist services offered by PhilHealth. Then challenges and opportunities for the development and implementation of these benefit packages in terms of service, financial, and population coverage, as well as monitoring and evaluation, are discussed. Finally, some observations and lessons are presented, specifically from the pilot implementation of the new Konsulta package—the latest iteration of PhilHealth's primary care benefit package—in the province of Guimaras in 2021, one of the UIS provinces supported by ThinkWell.

EVOLUTION OF PHILHEALTH PRIMARY CARE BENEFIT PACKAGES

PhilHealth has expanded its PHC benefits package several times over the last 20 years (Table 1). PhilHealth assumed responsibility for the former Medicare program in 1997.[2] Medicare benefit packages primarily covered inpatient services, but in 2000, PhilHealth introduced the first Outpatient Consultation and Diagnostic Package, also known as the Outpatient Benefit (OPB) Package. PhilHealth paid public primary care facilities, or rural health units (RHUs), an annual capitation rate of 300 Philippine peso (PHP), about US$6, for every household of a sponsored member.[3] The benefit package covered select services, including consultations and a limited set of diagnostic examinations (PhilHealth 2000). At this time, LGUs were encouraged to pay for the premiums of sponsored members. PhilHealth's strategy was to market OPB capitation payments as a rebate for LGUs for every indigent sponsored (Panelo, Solon, Herrin et al. 2017), encouraging the sponsorship of the poor by the LGUs (Silfverberg 2014).

In 2012, PhilHealth rebranded OPB to the Primary Care Benefit 1 (PCB1) Package. Through PCB1, PhilHealth linked payment more directly to services, paying only for members empaneled at each facility. The annual capitation rate increased to PHP 500 (US$10) per family of sponsored members and other member types. The rebranded package covered more diagnostic examinations, services, and medicines (PhilHealth 2012a). PhilHealth attempted to increase its benefits by including outpatient medicines for specific noncommunicable diseases through the Primary Care Benefit 2 (PCB2) Package. This package was only piloted in 2014 to allow for implementation systems to be developed, but it was not successfully rolled out (PhilHealth 2014a).

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[1] Individual-based health services are defined in the UHC Law as health services or goods that can be definitively traced back to one beneficiary, such as PHC, inpatient services, medicines, diagnostics, laboratory tests, and so on (Congress of the Philippines 2019).

[2] Established by the Philippine Medical Care Act of 1969, the Philippine Medical Care Program (Medicare) aimed to provide total coverage of medical services according to the needs of Filipinos. The program was overseen by the Philippine Medical Care Commission, which began operations in 1971. It had two basic programs: Program I for the members of national social insurance programs (Social Security System and Government Service Insurance System), and Program II for the rest of Filipinos (Congress of the Philippines 1969). However, although operations for Program I started in 1972, implementation of Program II never took off.

[3] Sponsored members are those who have insufficient income to pay premiums themselves; their contributions are paid by another individual, government agencies, or private entities.

In 2014, PhilHealth attempted to further expand its coverage for primary care services. The TSEKAP package, which stands for *Tamang Serbisyo sa Kalusugan ng Pamilya*, attempted to expand PCB1 to include more diagnostic examinations and medicines to address conditions with a high burden of disease. The package offered an increased annual capitation rate of PHP 800 (US$16) per family. PhilHealth also planned to accredit private primary care providers (PCPs) to increase access points for its members. The package was meant to cover sponsored members and other select member types, but was also intended to include formal economy members; its pilot implementation planned to cover Department of Education (DepEd) personnel. However, the implementation of the package was deferred for no clear reason (PhilHealth 2014b, 2015a, 2015b, 2015c).

With the similar intention of expanding service coverage, accrediting private PCPs, and covering members of the formal economy, PhilHealth introduced the expanded Primary Care Benefit (ePCB) Package in 2019. The tariff rate for ePCB was increased to PHP 800 (US$16) per family to cover a number of free services offered by accredited providers (PhilHealth 2019). Meanwhile, PCB1 continued to be implemented for sponsored members accessing services in RHUs. The ePCB package was also the first to explicitly allow co-payment. The OPB did not have rules on co-payment, while PCB1 and TSEKAP included the implementation of the No Balance Billing (NBB) policy[4] as part of accredited providers' performance commitments. Because of this, facilities had variable practices for co-payment. While there were public facilities that did not charge user fees, some municipalities created policies that supported user fees, especially for non-PhilHealth clients (DOH 2013). In the ePCB, PhilHealth set fixed co-payment rates per beneficiary for certain services, while still following the NBB policy (PhilHealth 2019).

In 2020, PhilHealth released implementing guidelines for Konsulta, a primary care benefit package that integrates and expands upon PCB1 and ePCB. Through Konsulta, PhilHealth aims to provide all Filipinos with financial access to an assigned PCP who will deliver basic essential services at every life stage. Konsulta has an annual capitation rate of PHP 500 (US$10) for public facilities and PHP 750 (US$15) for private facilities per individual and not per household or per family, as in the case of previous packages (PhilHealth 2020a and2020b). Although Konsulta covers more services and medicines, it remains to be seen if this capitation rate is sufficient, especially as PhilHealth moves toward a more comprehensive benefit package design. Delays in approval and challenges due to the COVID-19 pandemic slowed its implementation from 2020 to 2021, but pilots at some sites started in January 2021 and have scaled up to nationwide implementation in July 2021.

PhilHealth also offers outpatient benefit packages paid through case rates for specific conditions (Table 2). Conceptualized to incentivize interventions to achieve the United Nations' Millennium/Sustainable Development Goals (M/SDGs), SDG Benefit Packages are paid through a case rate payment mechanism.[5] These packages cover various diagnostics and medicines for specific conditions or services, such as malaria, HIV/AIDS, tuberculosis (TB), FP, animal bites, and maternity care delivered at accredited specialist health facilities (PhilHealth 2014c). The NBB policy is applied to these benefits in all government facilities, as well as private facilities for TB, FP, and maternity care services (PhilHealth 2017a).

[4] The NBB policy states that no other fees beyond package case rates can be charged to sponsored members (PhilHealth 2011). The NBB policy was extended to domestic workers in 2014 (PhilHealth 2014) and to senior citizens and lifetime members in 2017 (PhilHealth 2017a). As of 2017, this policy covers all accredited government facilities and select private facilities as PCB providers, TB-DOTS centers, birthing homes, and infirmaries or dispensaries.

[5] Previously named Millennium Development Goals (MDG) Benefit Packages.

Table 1. *Major iterations of PhilHealth benefit packages for primary care services*

Benefit Package	Tariff	Eligibility	Providers*	Services covered†	Payment terms
OPB (2000)	PHP 300 (US$6) per household annually; no co-payment rules	Sponsored‡ and their dependents	Government health facilities (RHUs)	Consultation; primary preventive services§; 5 diagnostic examinations	Quarterly payment based on payment of premiums and submission of reports
PCB1 (2012)	PHP 500 (US$10) per family annually; NBB policy applied as part of performance commitment Maximum PHP 100 (US$2) incentive for electronic reporting	Sponsored; organized groups¶; OFWs; and their dependents	Government health facilities (RHUs)	Consultation; primary preventive services; 7 diagnostic examinations; drugs & medicines for 4 conditions	Quarterly payment based on performance on registration (or empanelment) (50%) and profiling (50%)
TSEKAP (2014)#	PHP 800 (US$16) per family annually; NBB policy applied PHP 1000 (US$ 20) for medicines pooled nationally to form a global budget	Sponsored; organized groups; OFWs; DepEd personnel; and their dependents	Government health facilities (RHUs); government hospitals OPD; private facilities	Consultation; primary preventive services; 12 diagnostic examinations; drugs & medicines for 10 specific conditions	Quarterly payment based on performance on enlistment (50%) and profiling (50%) Direct payment to pharmacies per unit of medicine
ePCB (2019)	PHP 800 (US$16) per family annually; fixed co-payment schedule per beneficiary; NBB policy applied**	Sponsored; organized groups; OFWs; formal economy††; lifetime members‡‡; senior citizens; and their dependents	Government and private hospitals OPD; ASCs; primary care facilities; private outpatient clinics	Health screening & assessment; consultation; follow-up specific conditions; 10 essential services; 18 drugs & medicines	Payment upon registration of new members (60%, monthly) and upon completion of PhilHealth's performance targets (40%, yearly)
Konsulta (2020)	PHP 500 (US$10) for public facilities or PHP 750 (US$15) for private facilities per individual annually; maximum of PHP 500 (US$10) co-payment per beneficiary for private facilities; NBB policy applies	All Filipinos§§	Government and private hospitals OPD; ASCs; primary care facilities; private outpatient clinics	Initial & follow-up consultations; health screening & assessment; 13 select diagnostic services; 21 drugs & medicines	Payment upon registration of new members (40%, monthly) and upon completion of PhilHealth's performance targets (60%, yearly)

Sources: Compiled by authors from relevant PhilHealth circulars (see **Annex A**)

Abbreviations: PHP = Philippine peso; NBB = No Balance Billing; OFW = Overseas Filipino Workers; DepEd = Department of Education; OPD = outpatient department; ASC = ambulatory surgical clinics

* Providers must be accredited by PhilHealth.

† Only drugs and medicines listed in the Philippine National Drug Formulary may be charged to the packages.

‡ The Sponsored (or Indigent) Program includes those who have no visible or have insufficient means of income.

§ Primary preventive services have minimal/no cost implications (health screening, health education, counseling).

¶ Organized groups are legally registered organizations of the informal sector.

TSEKAP was never implemented.

** The NBB policy covers both public and private primary care providers.

†† Formal economy members are public or private workers who have established employee-employer relations.

‡‡ Lifetime members are individuals >60 years old who have paid at least 120 months' worth of contributions.

§§ Under the UHC Law, every Filipino citizen shall be automatically included in the NHIP and shall be granted immediate eligibility for health benefit packages in the program.

Table 2. *PhilHealth benefit packages for select outpatient specialist services*

Benefit Package	Tariff*	Eligibility	Providers†	Services covered‡	Payment terms
Outpatient Anti-TB Treatment through Directly Observed Treatment Short-Course (DOTS) Package (2003)	PHP 4,000 (US$80) per case; NBB policy applies	Members and dependents diagnosed with TB cases that are susceptible to first-line anti-TB drugs	TB-DOTS Centers	Diagnostic examination; consultation services; anti-TB drugs; health education & counseling of confirmed TB cases susceptible to 1st line TB drugs	Reimbursement upon approval of claims
Voluntary Surgical Contraception Procedures (2008)	PHP 4,000 (US$80) per procedure; NBB policy applies	Members and dependents of reproductive age	Government and private hospitals; ASCs; primary care facilities (for non-scalpel vasectomy only)	Vasectomy; ligation; laboratory; room & board; drugs, medicines, & supplies; health education & counseling	Reimbursement upon approval of claims
Outpatient Malaria Package (2008)	PHP 600 (US$12) per case; NBB policy applies	Members and dependents with laboratory confirmed diagnosis	Government health facilities (RHUs)	Consultation; laboratory examinations; drugs & medicines; health education & counseling	Reimbursement upon approval of claims
Outpatient HIV/AIDS Treatment (OHAT) Package (2010)	PHP 30,000 (US$600) per year; NBB policy applies	Members and dependents with laboratory-confirmed diagnosis	DOH-designated treatment hubs	Laboratory examinations; drugs & medicines	Reimbursement upon approval of claims (quarterly)
Animal Bite Treatment (ABT) Package (2012)	PHP 3,000 (US$60) per case; NBB policy applies	Members and dependents with category III rabies exposure	ABT centers	Vaccine; immunoglobulin; local wound care; medicines & supplies	Reimbursement upon approval of claims
Maternity Care Package (MCP) (2015)	PHP 6,500 (US$130) for hospitals; PHP 8,000 (US$160) for other facilities; NBB policy applies	Women about to give birth	Hospitals; infirmaries or dispensaries; birthing homes or maternity clinics	Essential services during antenatal period; labor; normal delivery; immediate postpartum; follow-up visits within one week	Reimbursement upon approval of claims
Intrauterine Device (IUD) Insertion (2015)	PHP 2,000 (US$40) per case; NBB policy applies	Members and dependents of reproductive age	Hospitals; ASCs; infirmaries or dispensaries; birthing homes or maternity clinics	Counseling; IUD device; use of facility	Reimbursement upon approval of claims
Subdermal Contraceptive Implant Package (2015)	PHP 3,000 (US$60) per case; NBB policy applies	Members and dependents of reproductive age	Hospitals; ASCs; infirmaries or dispensaries; birthing homes or maternity clinics	Consultation, follow up, & counseling; insertion; medicines & supplies	Reimbursement upon approval of claims

Sources: Compiled by authors from relevant PhilHealth circulars (see **Annex A**)

Abbreviations: PHP = Philippine peso; NBB = No Balance Billing; OPD = outpatient department; ASC = ambulatory surgical clinics

*For these packages, the NBB policy covers NBB-eligible members (see footnote #4) in all government facilities, and in select private facilities (TB-DOTS centers, infirmaries or dispensaries, and birthing homes).

†Providers must be accredited by PhilHealth.

‡Only drugs and medicines listed in the Philippine National Drug Formulary may be charged to the packages.

CHALLENGES AND OPPORTUNITIES

BENEFIT PACKAGE DEVELOPMENT: GUARANTEEING COMPREHENSIVE SERVICE COVERAGE

There are no clear guidelines and protocols on how benefits should be developed and updated. PhilHealth makes key decisions based on the financial viability of the insurance program instead of the country's health needs (Dayrit, Lagarda, Picazo et al. 2018). Politicians or professional medical organizations seem to influence what services are included in the package development (Obermann, Jowett, Alcantara et al. 2006). Although PhilHealth states that it considers gravity of disease, public health importance, and stakeholder opinion in cost calculation or package development, it is not clear how these considerations are taken into account. With no explicit benefit expansion plan or strategy, benefit packages are prone to duplication or exclusion of covered services and inefficient delivery (Picazo, Ulep, Pantig et al. 2015). The recently released Konsulta package was developed and implemented without a formal prioritization of service coverage but, instead, added on to services it already covered in previous benefits. It was also developed before the institutionalization of the health technology assessment (HTA) process in 2020, even though the UHC Law mandates the use of HTA for the development of PhilHealth benefit packages (DOH 2020a).

PhilHealth primary care benefit packages have been criticized for omitting important services across the spectrum of care. For example, although the PCB covers cervical cancer screening, there is no coverage for cryotherapy at the primary care level, even if this has been shown to be the most cost-effective measure for cervical cancer screening (Guerrero, Genuino, Santillan et al. 2015). For the Outpatient HIV/AIDS Treatment (OHAT) package, although a confirmation test is necessary to be covered, the test is not included in any benefit package. There is no cover for the management of opportunistic infections in this package either, leading to OOP for people living with HIV (Wong, Co, Espinosa et al. 2019).

In other cases, the fragmentation of coverage across benefit coverage makes it difficult to ensure continuity of care. Although screening for TB is covered in PCB, there is a mismatch between ensuring availability to provide screening and in the availability of treatment via the TB-DOTS package, as shown by the analysis of the accreditation data. Similarly, even if there are packages for subdermal implants and IUDs, providing advice for FP is not incentivized in the PCB or ePCB. Although PhilHealth's latest Konsulta package covers a wider range of services than its predecessors, it still does not include all individual-based primary care services listed by the DOH (DOH 2020b).

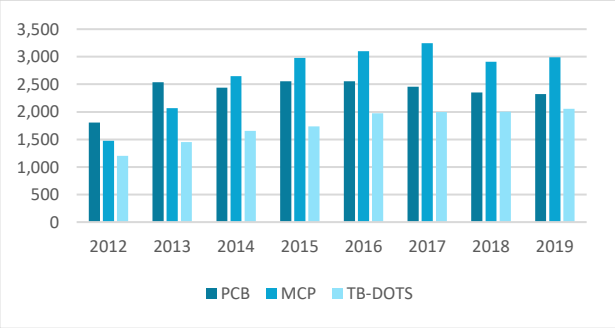
Benefit package development should be more rational. PhilHealth's financial stewardship and regulatory functions should be enhanced by investing in skills needed to manage a modern health financing system, including actuarial science, HTA, medical informatics, and business analytics. To continually improve existing packages, previous development processes should be documented and studied, with the results made available to the public. This process will help identify good practices to emulate and persistent challenges to address. Subsequent expansion of benefit packages leading toward the COPB package should be guided by a clear benefit expansion plan and incorporate appropriate processes, such as benefit prioritization and HTA, for a more cost-effective and financially sustainable package. These processes will ensure that different public health and economic factors, such as the continuity of the spectrum of care and the government's financial capacities, can be considered. To this end, the DOH and PhilHealth are developing a benefit prioritization plan to better streamline the development of benefit packages (Panelo, Stein, Dutta et al. 2020).

ENSURING ADEQUATE PROVIDER MIX: OFFERING SUFFICIENT FINANCIAL INCENTIVES

PhilHealth needs to ensure that there are sufficient accredited providers to deliver high-quality care for its beneficiaries. The number of PCB, maternity care package (MCP), and TB-DOTS providers have fluctuated over the years (**Figure 1**), and gaps in geographical coverage remain (**Figure 2**). As of June 2021, PhilHealth has accredited only 87 Konsulta providers, although implementation is still being scaled up (PhilHealth 2021a). Although the UHC Law

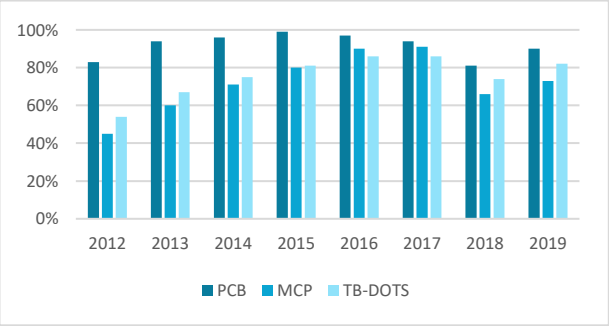
tries to ensure that gatekeeping mechanisms will be established by mandating that every Filipino register with a PCP of choice (Congress of the Philippines 2021), without enough accredited providers, gatekeeping cannot be properly enforced.

***Figure 1**. Number of accredited PCB, MCP, and TB-DOTS facilities, 2012-2019 (PhilHealth 2021b)*



Source: Compiled by authors from relevant PhilHealth stats and charts

***Figure 2**. Percentage of LGUs with accredited PCB, MCP, or TB-DOTS facilities (PhilHealth 2021b)*



Source: Compiled by authors from relevant PhilHealth stats and charts

To increase access, more providers need to reach the standards for PhilHealth accreditation, but as benefit packages expand, PhilHealth accreditation standards become more stringent. In 2017, a baseline study on service readiness of RHUs for seven high-priority conditions showed that, although basic equipment, medicines, and commodities were available, there were problems with infrastructure, occasional stockouts, and lack of diagnostic capacity, especially in less prosperous LGUs (World Bank 2019). These limitations in service readiness will be a problem as PhilHealth demands increased capacity from its providers in order to deliver expanded benefit packages. For example, the minimum requirements for accreditation as a Konsulta provider are higher than the requirements for ePCB in terms of service capacity, technical skills complement, and other supporting systems, such as health information systems (PhilHealth 2020). The pilot implementation of Konsulta in Guimaras has highlighted some of these limitations (**Box 1**).

Box 1: Initial observations from the pilot implementation of the PhilHealth Konsulta benefit package in Guimaras in 2021

As a UHC Integration Site (UIS), the province of Guimaras was included in the pilot implementation of the PhilHealth Konsulta benefit package in 2021. Guimaras is a fourth class island province located in the Western Visayas region, [1] with a poverty incidence of 9.5% per capita as of 2018 (PSA 2020). Guimaras is among the first 33 provinces in the Philippines that committed to being a UIS in 2019. As supporting policies for the UHC Law are still being developed, these sites provide an opportunity to demonstrate applicability, incubate innovative ideas, and generate evidence toward more inclusive and progressive policies by modeling efficient and needs-responsive, province-wide health systems. Observations and lessons learned from the initial implementation of the PhilHealth Konsulta benefit package in Guimaras can provide insights for the improvement of the package and the eventual development of the COPB package.

Public health facilities in Guimaras had difficulties meeting service and human resource standards needed to deliver the Konsulta benefit package. To support the pilot implementation of Konsulta, ThinkWell conducted an assessment of health facilities in Guimaras to establish a baseline. The assessment revealed that there are gaps in the service capacity of public health facilities, contrary to the service offerings required by Konsulta (**Table 3**). RHUs have limitations in ensuring availability of medicines, such as pharmaceutical management capacity and limited autonomy in procurement. Thus, they are often dependent on DOH assistance for their medicine supply. Meeting adequate capacity for laboratory and radiologic services is also a problem. While all municipalities in Guimaras have the required number of support staff (i.e., nurses or midwifes), only one municipality has met the target of one physician to 20,000 beneficiaries (**Table 4**). These gaps are currently being addressed with the continued pilot implementation of the package in Guimaras.

The pilot implementation of the Konsulta package in Guimaras has provided important lessons that can inform roll-out. Feedback from local stakeholders suggests that network contracting for Konsulta can encourage local health system integration, as mandated by the UHC Law. Discussions with provincial and municipal health officers from Guimaras about the pilot implementation of Konsulta in 2021 have surfaced possible obstacles in implementation, especially when a lot of its processes rely on information technology (IT) systems. As PhilHealth improves the implementation of the Konsulta package, ThinkWell continues to provide support to Guimaras as needed, although implementation has been relatively slow, especially as the province continues to struggle with the COVID-19 pandemic.

Table 3. *Konsulta service delivery standards vs. current capacity of public health facilities in Guimaras, 2020*

SERVICE STANDARDS		5 RHUs	3 Hospitals
Consultation, BP and VS, clinical breast exam, and digital rectal exam		Complete	Complete
Risk profiling for HPN & DM (based on DOH guidelines)		Complete	None
Capability to provide required laboratory and radiologic services	CBC with platelet count, U/A, F/A, sputum microscopy, FBS or RBS	Complete	Complete
	Fecal occult blood, HBA1C, OGTT, lipid profile, creatinine, pap smear	None	Only in DCGNPH
	ECG, chest X-ray	Complete	Complete
Dispense required medicines		Dependent on DOH downloads & MLGU funding/ supply	Complete

Complete Deficient None

Source: Compiled by authors, based on compilation of Konsulta accreditation self-assessment in Guimaras

Abbreviations: BP = blood pressure; VS = vital sign; HPN = hypertension; DM = Diabetes Mellitus; CBC = complete blood count; U/A = urinalysis; F/A = fecalysis; FBS = fasting blood sugar; RBS = random blood sugar; HBA1C = hemoglobin A1C OGTT = oral glucose tolerance test; ECG = electrocardiogram; MLGU = municipal local government unit; DCGNPH = Dr. Catalino Gallego Nava Provincial Hospital

Table 4. Konsulta HRH standards vs. current capacity of public health facilities in Guimaras, 2020

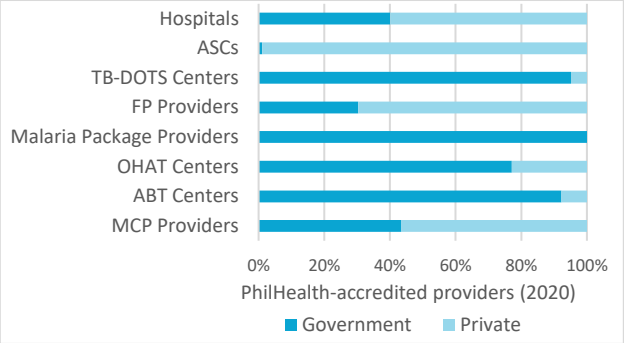
HRH STANDARDS	GUIMARAS MUNICIPALITIES				
	Buenavista	Jordan	Neuva Valencia	San Lorenzo	Sibunag
2020 Projected Population	53,488	38,279	42,218	27,691	23,498
Physician (Target: 1:20,000)	2	1	2	2	1
Gaps	1	1	1	0	1
Support Staff (Target: 2)	2	2	2	2	2
Gaps	0	0	0	0	0

Source: Compiled by authors, based on compilation of Konsulta accreditation self-assessment in Guimara

To engage more providers and thereby expand access, PhilHealth also needs to ensure that its processes are responsive to provider needs. Providers have continually complained of PhilHealth's cumbersome accreditation and claiming processes (Querri, Ohkado, Kawatsu et al. 2018). PhilHealth reimbursements for public primary care providers go directly to the LGUs rather than to facilities, meaning that there is little incentive for these public facilities to engage with PhilHealth. Furthermore, delays in reimbursements have made it difficult for public providers to plan for and use these funds in sync with other funds from the Internal Revenue Allotment (IRA) or DOH.

Contracting more private providers can make an important contribution to expanding access to PhilHealth benefits. There has been a constant 40:60 public-private mix of PhilHealth accredited hospitals (PhilHealth 2014d). Private facilities dominate the provision of some SDG benefits (Figure 3). In the first year of implementation of the ePCB, 58% (118 out of 203) of accredited providers were private providers (PhilHealth 2014c). This shows the willingness of private facilities to be engaged in the delivery of benefit packages.

Figure 3. Comparison of public and private PhilHealth accredited health facilities, 2020 (PhilHealth 2021b)[6]



Source: Compiled by authors from relevant PhilHealth stats and charts

INCENTIVIZING PROVIDERS AND IMPROVING FISCAL MANAGEMENT

It can be politically challenging for PhilHealth to make the increases to premiums needed to cover the costs of more comprehensive benefits. In 2020, ThinkWell conducted a review of previous studies on the costing of PhilHealth benefit packages, which showed that the tariffs paid to providers by PhilHealth were much lower than the implemented rates, especially where payments were expected to cover a more comprehensive package (Annex B). Prior to the implementation of the ePCB, PhilHealth enforced an increase in premium contributions from the formal economy in 2017 (PhilHealth 2017b). With further benefit expansion, the UHC Law mandates continuous increases in premium rates that are scheduled through the years (Congress of the Philippines 2019; PhilHealth 2020d). However, premium rate increases have caused a backlash within certain sectors of the formal economy, especially with the added economic strain of the COVID-19 pandemic; this has resulted in the deferment of the planned premium increase (Cepeda 2020; Ismael 2021). Funding from the national government also continues to be uncertain (Talabong 2021; Laforga 2021).

Moreover, overlaps in financing of PHC services among LGUs, DOH, and PhilHealth persist and

[6] There were no PCB/Konsulta providers in 2020 since, although Konsulta governing policies had already been released (replacing PCB and ePCB), COVID delayed implementation to 2021.

undermine PhilHealth's ability to use its purchasing power to improve PHC access and quality. Currently, LGUs are expected to pay for salaries, procure commodities, and pay capital outlay of its facilities. Similarly, DOH has several programs to augment human resources for health (HRH) needs, provide commodities for vertical health programs, and provide capital outlay for facilities in need. These inputs are excluded when PhilHealth costs its various packages. Challenges in budget execution at the national level can also affect the reliability of getting these inputs to the subnational level. These in turn affect the ability to deliver PhilHealth benefits, either because of the facility's inability to meet standards (e.g., lack of equipment, inadequate infrastructure or HRH) or to deliver services (e.g., lack of commodities). Moreover, with the expected increased fiscal space of LGUs starting in 2022 as a result of the Mandanas ruling, [7] there are some uncertainties about delineation of purchasing roles, as more resources are expected to be transferred to the LGUs through IRA rather than through PhilHealth.

The success of the Konsulta package, together with the other mandates of the UHC Law, relies heavily on the continued engagement and satisfaction of its providers. PhilHealth is moving toward a prospective payment mechanism validated by costing methods, which should ensure fair payment terms for providers. The implementation of the Special Health Fund (SHF), mandated by the UHC Law to pool financial resources for province- or city-wide health systems (DOH 2021a), can ensure that PhilHealth payments or reimbursements are earmarked for health services. Furthermore, Konsulta introduces a differential payment scheme, setting tariffs that account for public sector subsidy to public providers. This should help to ensure that sufficient incentives will be given to public and private providers. Differential public and private tariffs will be increasingly important should public providers receive increased subsidy with the Mandanas ruling. To further assist its providers, PhilHealth should reevaluate its payment mechanisms to ensure that they lead to the right outputs and outcomes. DOH and LGUs, on the other hand, can leverage additional funds to provide assistance to facilities that have trouble completing the minimum requirements for Konsulta accreditation.

Under the UHC Law, PhilHealth is mandated to contract networks as opposed to individual facilities, which creates opportunities for better engagement of both public and private providers. Network contracting can reduce barriers to accreditation. Rather than requiring any individual provider to offer the full range of services defined in the benefit package, PhilHealth only requires that the network as a whole be able to offer these services. Therefore, by including facilities at different levels as well as specialist and private sector facilities, networks can ensure that all services in the benefit package can be delivered and are available at the necessary quality. Networks should also improve beneficiaries' access to comprehensive services by linking different types and levels of facilities. There is also potential for cross-subsidization, economies of scale through consolidated procurement, and more cost-effective service delivery. However, challenges remain in contracting networks for primary care; for example, public networks need to be capacitated to manage contracted facilities. To this end, PhilHealth is currently planning to implement a sandbox to test out network contracting for PHC services.

The UHC Law and the Mandanas ruling will together cause significant changes in respective responsibilities of LGUs, DOH, and PhilHealth. The UHC Law aims to clarify which services should be covered by DOH, PhilHealth, and LGUs to help clear the overlaps in funding. Ideally, inputs for services assigned to be covered by PhilHealth, such as primary care, should no longer be included in DOH and LGU budgets. To address this, and together with additional funds expected from the Mandanas ruling, the DOH has developed a devolution transition plan to ensure that LGUs are capacitated to handle these changes and the incoming funds (DOH 2020c; Official Gazette 2021). This plan should also help DOH, PhilHealth, and LGUs to delineate

[7] The Mandanas ruling is a Supreme Court ruling in 2018 in response to the petition that was started by Batangas Governor Hermilando Mandanas. It states that the IRA must come from all national taxes, including tariffs and customs collected by the Bureau of Customs and those from the excise taxes (Philippine Supreme Court 2018).

the inputs and services that they will fund. Full implementation of this plan is expected in 2024. With continuous market fluctuations set to happen due to the COVID-19 pandemic and further policy changes, PhilHealth must ensure that it has data and processes readily available to set reasonable prices for its benefit packages.

POPULATION COVERAGE: PROMOTING EQUITABLE UTILIZATION OF SERVICE

PhilHealth has incrementally increased the population coverage of its PHC benefits over the years. OPB and PCB1 mostly covered only sponsored members, partly due to limitations in fiscal space. PhilHealth only began offering PHC coverage to people in formal employment through the ePCB in 2018. Konsulta will be able to increase population coverage for all Filipinos through the mandate of the UHC Law on immediate eligibility, which ensures that every Filipino citizen is automatically included in the NHIP and is immediately granted eligibility for PhilHealth benefit packages.[8]

However, increased population coverage and immediate eligibility for benefits do not equally translate into efficient utilization. Several studies have shown poor utilization of PhilHealth's primary care benefit packages. For example, a review of the OPB found that the utilization of OPB-related services is extremely low, particularly for preventive or screening procedures that are often provided on request (Modol 2010). **Table 5** shows the mismatch between the number of PhilHealth claims and the estimated number of cases for some conditions covered by PhilHealth in 2020. Supply-side issues already discussed above, such as ensuring the quality of services and adequate number of participating public and private providers, contribute to underutilization of services.

Table 5. *PhilHealth claims vs. estimated number of cases, 2020*

Primary Care Service	PhilHealth Claims	Estimated Cases
TB	30,318	256,541
Contraceptives*	13,000 (40,495.5 CYP)	3,683,189 CYP
Malaria	76	6,120
Deliveries**	908,820	1,281,568

Source: PhilHealth 2021b; DOH 2021b; DOH 2021c; Track20 2020

Abbreviation: CYP = Couple-Years of Protection

* Includes claims for ligation, vasectomy, IUDs, and subdermal implants. CYP for PhilHealth claims through authors' own calculation. Estimated cases are from the Track20 data.
** Number of PhilHealth claims includes claims for MCP, normal deliveries in hospitals, cesarean section, and other types of deliveries covered by PhilHealth. Estimated number of cases includes facility-based deliveries only.

Demand-side problems, such as awareness of membership status, eligibility, and entitlement, also play a significant role in limiting usage of benefits. In 2017, while PhilHealth reported a 93% rate of coverage, only 65% of the respondents of the National Demographic and Health Survey (NDHS) were aware that they were covered by PhilHealth (PhilHealth 2018a; PSA and ICF 2018). Similarly, a study of the implementation of the PCB1 package in 2014 found that only 59% knew about the package (da Walque, Kim, and Basa 2017). A study of the MCP found that only 68% of its respondents were aware of the package's benefit for delivery care, with less than 50% utilizing the package (Reyes, Verdolaga, Wee-Co et al. 2020). A similar survey conducted among persons living with HIV found that only 56% of the respondents utilized the OHAT package (Espinosa 2018).

As per its mandate, PhilHealth conducts information campaigns on its benefit packages (Congress of the Philippines 2012). In 2012, PhilHealth launched the Customer Assistance, Relations, and Empowerment (CARES) program, where nurses are deployed to PhilHealth-accredited

[8] Improvements in PhilHealth's population coverage and the immediate eligibility mandate of the UHC Law are discussed in ThinkWell's **Philippine UHC Law Series Brief 4**.

hospitals to educate and assist members to determine their eligibility and understand their benefits (PhilHealth 2012b). In partnership with DOH and LGUs, PhilHealth also launched the *Alamin at Gamitin para sa Maayos na Buhay*, or ALAGA KA, in 2014, a roadshow that aims to inform poor members of their benefits and how to avail them. PhilHealth also uses mass media and social media to reach a wider audience. However, in a 2017 study, only a small share of respondents found these programs helpful. Respondents identified barangay officials, staff of the Department of Social Welfare and Development, and their social networks as the most important sources of information on PhilHealth benefits (Bredenkamp, Capuno, Kraft et al. 2017).

As supply-side issues are addressed, there should be programs created to ensure demand generation as well. PhilHealth continues to conduct its information campaigns, but these strategies should be reviewed and evaluated to better reach appropriate audiences, especially to effectively communicate the immediate eligibility mandate of the UHC Law. PhilHealth is also scaling up its marketing campaign for Konsulta and subsequent benefits, which should be simpler now that benefits are offered to the general public. On the other hand, the UHC Law also mandates the strengthening of the Health Promotion Bureau under the DOH that aims to improve health literacy and health-seeking behavior. In 2019, the DOH launched the **DOH Academy**, which offers several courses on UHC to health workers and other stakeholders. These courses can be further improved to provide health workers with appropriate knowledge that can be used for more accurate information dissemination. On top of these initiatives, DOH and PhilHealth should continuously provide assistance to LGUs and local health workers—the frontliners in the provision of services—to ensure adequate communication of these benefits.

MONITORING, EVALUATION, AND QUALITY

PhilHealth is mandated to conduct a broad range of studies to assess its performance (Congress of the Philippines 2012), but implementation of these studies is inconsistent, and the results are not readily available. Reviews are regularly conducted to assess the financial sustainability of the benefit package, its relevance to health innovations, mechanisms for quality assurance, the possible need for increases in benefits, and its impact on reducing OOP payments (Bales, Bredenkamp, and Gomez 2018). PhilHealth also contracts out a yearly client awareness and satisfaction survey (Rico 2016; Ericta 2020). Previous iterations of the primary care benefit packages also included provisions for annual monitoring and evaluation, including the review of facility compliance as well as implementation and delivery of the package, but there remains a dearth of accessible documents on this.

In the case of Konsulta, PhilHealth aims to utilize its Health Care Provider Performance Assessment System (HCPPAS) to ensure quality of service. The HCP PAS, established in 2019, uses a set of tools to assess the performance of providers using indicators grouped into four domains: quality of care, patient satisfaction, financial risk protection, and detection of offense or compliance to policy. Konsulta offers some performance targets, but these have yet to be validated. Failure to meet any of the performance targets are grounds for close monitoring and for subsequent sanctions and penalties (PhilHealth 2018b, 2020b). ThinkWell is also currently supporting PhilHealth to refine and implement tools to monitor Konsulta.

CONCLUSION AND RECOMMENDATIONS

To ensure that a person's ability to pay does not determine their access to health care, PHC services should generally be funded by public funds (Mathauer, Mathivet, and Kutzin 2017; PHCPI 2019). Over the years, PhilHealth has incrementally improved population, service, and financial coverage for PHC services. The UHC Law mandates the development of a COPB package that will incentivize coverage of all PHC services. As an initial response, PhilHealth developed the Konsulta benefit package, which expanded the previous primary care benefit packages and will provide the basis for further expansion into the COPB package. However, many gaps remain that influence the quality and comprehensiveness of services offered, as well as patient satisfaction and effective utilization of these services.

PhilHealth should continue to improve the design of Konsulta and its benefit packages for PHC. Although the Konsulta package offers expanded service, population, and financial coverage, gaps still remain in terms of meeting the mandates of the UHC Law to provide a more comprehensive benefit package. There are opportunities for DOH and PhilHealth to define what is included in the COPB package that will be available for all Filipinos. Additionally, the UHC Law offers DOH and PhilHealth the opportunity to standardize and streamline their benefit development processes, guided by a unified and responsive benefit expansion plan and important benefit prioritization processes, such as HTA.

PhilHealth should also improve its capacity to implement Konsulta by enhancing its tools and processes. PhilHealth should invest in better IT systems that will ensure responsiveness to the needs of its providers and beneficiaries. Additionally, data systems need to be improved so that data on service and cost, among other things, can be regularly gathered and used as inputs for a more responsive benefit design. Processes, such as accreditation and payment systems, can be streamlined to further incentivize providers to participate in its implementation.

Gaps at the provider level limit the readiness for full implementation of the package, but there are opportunities to meet these gaps with integration among providers. Some providers may lack the capacity to meet the standards for Konsulta accreditation. However, there are opportunities in networking with other types of facilities, especially with the private sector, to ensure that standards can be met and high-quality services can be provided. This presages the development of the HCPNs envisaged in the UHC Law, but providers need to develop the capacity to manage subcontracted facilities as well. On the other hand, better information campaigns are also needed to inform Filipinos of their status, entitlements, and benefits, especially as the UHC Law mandates immediate eligibility of all citizens.

The continuing development of supporting policies for the UHC Law creates more opportunities to improve the financing of PHC and other health services. While the implementation of these policies was hindered due to the health system and financial strains caused by the COVID-19 pandemic, the government must not lose sight of its journey toward UHC. Observations and lessons from pilot implementation of policies in UIS should be gathered and utilized for the improvement or development of more responsive and effective policies. These initiatives, among others, are geared toward the improvement of quality and accessible primary care to all Filipinos, and, ultimately, the achievement of UHC in the country.

ThinkWell Philippines, through its SP4PHC project, supports national and local government efforts in developing rules and regulations for operationalizing the reforms of the UHC Law. As the team continues to support the implementation of UHC Law policies in its partner provinces, Antique and Guimaras, it hopes to gather lessons and insights from the ground to influence the development and improvement of these policies at the national level. The team has been aiding DOH and PhilHealth to align purchasing schemes for PHC and develop a strategic plan to improve access to high-quality PHC services. Lessons from these pieces of work will not only support the improvement of health outcomes in the Philippines but also contribute to the global discussion of UHC and health systems development.

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

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

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ANNEX A. RELEVANT CIRCULARS FOR PHILHEALTH BENEFIT PACKAGES FOR PRIMARY HEALTH CARE SERVICES

Benefit Package	Relevant PhilHealth Circular/s
Primary care benefit packages	
OPB	**PhilHealth Circular No. 040, s. 2000** Implementing Guidelines for Outpatient Consultation and Diagnostic Package Under the Medicare Para as Masa Program **PhilHealth Circular No. 13, s. 2002** Supplemental Guidelines for the Implementation of the Outpatient Consultation and Diagnostic Benefit Package (OPB), PhilHealth Circular No. 040, series of 2000
PCB1	**PhilHealth Circular No. 10, s. 2012** Implementing Guidelines for Universal Health Care Primary Care Benefit I (PCB1) for Transition Period CY 2012-2013
TSEKAP	**PhilHealth Circular No. 002-2015** Governing Policies on the Expanded Coverage of the Primary Care Benefit Package: Tamang Serbisyo sa Kalusugan ng Pamilya (TSEKAP)
ePCB	**PhilHealth Circular No. 2018-0017** Expansion of the Primacy Care Benefit (ePCB) to Cover Formal Economy Lifetime Members and Senior Citizens **PhilHealth Circular No. 2019-0003** Expansion of the Primacy Care Benefit (ePCB) to Cover Formal Economy, Lifetime Members and Senior Citizens (Revision 1)
Konsulta	**PhilHealth Circular No. 2020-0002** Governing Policies of the PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package: Expansion of the Primary Care Benefit to Cover All Filipinos **PhilHealth Circular No. 2020-0022** Implementing Guidelines for the PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package
Millenium/Sustainable Development Goal benefit packages and other benefit packages for primary care services	
Outpatient Anti-TB Treatment through DOTS Package	**PhilHealth Circular No. 19, s. 2003** PhilHealth Outpatient Anti-Tuberculosis/Directly Observed Treatment Short-Course (DOTS) Benefit Package **PhilHealth Circular No. 014, s. 2014** Revised Guidelines for the PhilHealth Outpatient Anti-Tuberculosis Directly Observed Treatment Short-Course (DOTS) Benefit Package
Voluntary Surgical Contraception Procedures	**PhilHealth Circular No. 16, s. 2008** Implementation of PhilHealth Package for Voluntary Surgical Contraception Procedures
Outpatient Malaria Package	**PhilHealth Circular No. 25, s. 2008** Outpatient Malaria Package
OHAT Package	**PhilHealth Circular No. 19, s. 2010** Outpatient HIV/AIDS Treatment Package **PhilHealth Circular No. 011-2015** Outpatient HIV/AIDS Treatment (OHAT) Package (PhilHealth Circular 19, s 2010) Revision 1
ABT Package	**PhilHealth Circular No. 015, s. 2012** PhilHealth for Animal Bite Package (Rabies Post-exposure Prophylaxis)
MCP and IUD Insertion	**PhilHealth Circular No. 025-2015** Social Health Insurance Coverage and Benefits for Women about to Give Birth (Revision 1)
Subdermal Contraceptive Implant Package	**PhilHealth Circular No. 038-2015** PhilHealth Subdermal Contraceptive Implant Package

ANNEX B. SUMMARY OF COSTING STUDIES FOR PHILHEALTH'S PRIMARY CARE BENEFITS AS OF 2020

Year	Project	Rate	Key Assumptions	Strengths	Weaknesses
2008	Costing of Outpatient Benefit Package	PHP 1,025 (US$20) per sponsored household	Covers preventive and curative interventions, such as reproductive health, vaccination, childhood diseases, TB, maternal health, infectious diseases, and other basic curative services	Defined services and vertical programs	Only costed public health units Limited interventions based on current package
2010	Development of Essential Health Package Costing of the Essential Health Package and Funding Feasibility	Low cost – PHP 500 (US$10) per person Medium cost – PHP 800 (US$ 16) per person High cost – PHP 1,400 (US$28) per person	Covers preventive and curative interventions; contains eight distinct sets of services	Interlocal health zone (ILHZ) model similar to HCPN	Data availability was an issue Limited providers that can provide services costed
2015	Costing of TSEKAP	PHP 615 (US$12) per person PHP 1,440 (US$29) pesos per person	Based on expert consultation	Activity-based costing provided details on interventions	Assumption on utilization needs validation Cost or prices need validation
2017	Guaranteed Health Benefits Costing of Outpatient Packages	PHP 489.65 to 553.87 (US$10 to 11) per person	Top 48 most burdensome conditions; 11% utilization based on NDHS	Covers and prioritizes the top 48 most burdensome conditions in the Philippines	Assumption on utilization needs validation Cost or prices need validation
2018	Philippine Primary Care Studies	PHP 2,000 (US$40; through capitation) Average cost per patient is at PHP 250.71 (US$5); diagnostics at PHP 736.68 (US$15), and medications at PHP 528.48 (US$11) per person	Willingness to pay Comprehensive services available on the site or network	Patient level data Reflects network costs Has data on utilization Both public and private providers Useful electronic medical records data	Data on classification of services needs more analysis
2018	ePCB Costing and Step-by-step Guidelines on How to Set Up the PHC Payment System	PHP 325.00 to 4,966.35 (US$7 to 100)	Covers seven conditions	Facility cost Activity-based costing	No data on utilization that can be used for cost adjustments Only covers seven conditions Diagnosis-based as opposed to service-based