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HFG RAPID ASSESSMENT OF TB PAYMENT AND PFM SYSTEMS IN THE PHILIPPINES: LESSONS LEARNED AND POLICY IMPLICATIONS



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This publication was produced for review by the United States Agency for International Development. It was prepared by Matt Kukla and Chris Lovelace of the Health Finance and Governance Project.

The Health Finance and Governance Project

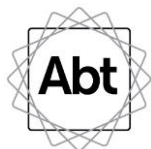
USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, \$209 million global project will increase the use of both primary and priority health services, including HIV and AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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I. BACKGROUND

I.1 Problem Statement

Despite substantial funding for TB prevention and treatment over the last 10 years, both by donors and governments, the world-wide incidence of TB remains troubling. Across lower- and middle-income countries, access to TB services is limited, and the quality of TB services is often substandard. Many countries face questions over the long-term financial sustainability of their efforts to prevent and treat the disease.

In the Philippines, there are roughly 290,000 new TB cases per year (WHO, 2016). Meanwhile, donor funding for TB has declined, health care costs are rising, and out-of-pocket spending accounts for roughly two-thirds of national TB expenditures. The Philippines needs to identify mechanisms to improve the efficiency of TB spending (i.e., mechanisms for spending money wisely). In the short term, this may mean finding ways to improve outputs—such as access, use of services, and quality—for a given level of spending on TB. In the long term, the Philippines and countries facing similar challenges may be interested in finding ways to achieve better outputs with fewer resources.

Global evidence suggests that increased TB costs, inequitable access to care, lower rates of case detection and case holding, worse treatment outcomes, and an increased burden of disease due to TB—including the increasingly prevalent multi and extremely drug resistant TB (MDR-TB and XDR-TB)—are often tied to gaps in the continuum of TB service delivery, inadequate coordination of policies across payers, and weak financial incentives for health care providers (Figueras et al. 2005, Langenbrunner et al. 2009).

I.2 General Activity Description

The HFG-TB strategic purchasing activity is intended to better target country health budgets and national health insurance funds towards priority TB services and the poor. The three health financing functions are revenue collection, pooling, and purchasing. Revenue collection concerns the source of funds and level of funding. Pooling is the accumulation of pre-paid revenues on behalf of a population, and purchasing is the transfer of pooled funds to providers on behalf of a population. Strategic purchasing focuses on the purchasing function, specifically provider payment and public financial management (PFM) systems. While not discounting private investment, the activity focuses on public funding, as it is critical for public health services (such as TB services). Public funding can be used to buy services from both public and private providers, and is best suited to increase access for the poor.

The HFG-TB strategic purchasing activity contributes to increasing technical efficiency—that is, achieving the maximum possible improvement in outcomes from a set of resource inputs—and allocative efficiency, which refers to allocating resources in a way that maximizes the welfare of a society. The strategy achieves this by identifying ways, both globally and within countries, to improve financial incentives to providers, reduce PFM barriers, and increase provider autonomy. If the nature of provider payment and PFM systems creates conflicting financial incentives, or barriers to spending money wisely and improving TB service delivery, those conflicting incentives and/or barriers should be removed.

2. OBJECTIVES AND METHODOLOGY

2.1 Country Objectives and Outcomes

The Philippines was the subject of one of several country case studies linking strategic TB purchasing with improved efficiency and better outcomes. In April 2016, HFG conducted a brief but in-depth assessment of health purchasing/provider payment and PFM systems in the Philippines, to identify rigidities and barriers. The assessment had a twofold purpose:

1. HFG would observe and learn from key stakeholders in the Philippines, with the aim of synthesizing information on PFM barriers and provider payment bottlenecks.
2. Where these issues were not already being addressed, HFG would make recommendations for removing barriers and bottlenecks.

The following outcomes were to be achieved through this assessment:

PhilHealth

1. HFG would learn from PhilHealth about:
 - The benefits and limitations of PhilHealth's existing provider payment system as it pertains to primary, outpatient, and inpatient health care services
 - The extent to which PhilHealth's provider payment mechanisms are aligned for contracted public and private providers
 - Gaps in TB service delivery that PhilHealth is currently targeting or would like to
 - Improvements that PhilHealth is looking to make in TB service delivery, and mechanisms by which providers are being incentivized to make these improvements
2. HFG would assess whether and to what extent:
 - There is potential to refine PhilHealth's provider payment system and engage in dialogue with PhilHealth on options for improving purchasing of TB services.
 - Improvements in PhilHealth's provider payment mechanisms are needed so as to coordinate and align incentives for public and private providers.
 - There is potential to improve PhilHealth's information and operating systems, which, through the collection of patient/provider data, are used to purchase TB services.

Department of Health

1. HFG would learn from the Department of Health (DoH) about:
 - TB services that are purchased by DoH only, PhilHealth only, or both DoH and PhilHealth
 - The benefits and limitations of TB financing in the Philippines, with a focus on PFM barriers to purchasing public or individual TB services; this would include purchasing mechanisms, level and flow of funding, budget formation, payments to and contracting of providers, and financial management
2. HFG would assess whether and to what extent improvements could be made in how TB services are financed, with a focus on budgeting processes and purchasing.

Both PhilHealth and DoH

- I. Through meetings with development partners and health care providers, HFG would provide both PhilHealth and the DoH with insight into:
 - Conflicting roles of and relationships between the DoH and PhilHealth as they pertain to purchasing of TB services
 - The extent to which TB service purchasing mechanisms of the DoH and PhilHealth create gaps in the TB continuum of care and possible solutions for filling these gaps
 - The extent to which conflicting financial incentives stem from differences in the DoH and PhilHealth's purchasing mechanisms and payment systems
 - Public and private providers' satisfaction with existing payment mechanisms and rates for TB services
 - Obstacles providers face with regard to existing payment mechanisms and information systems
 - PFM and purchasing improvements that could incentivize health care providers to deliver higher-quality TB services more efficiently and effectively

Local Government Unit

- I. HFG would provide the representative Local Government Units (LGUs) with observations on:
 - The extent to which TB service purchasing mechanisms of the DoH and PhilHealth create gaps in the TB continuum of care, and possible solutions in which the LGUs could fill these gaps
 - PFM improvements that can be made or barriers that can be removed to improve how TB services are purchased

2.2 Methodology

Data for this assessment came from three sources:

1. Key informant interviews
2. Policy documents
3. Secondary data

Key informant interviews were conducted with the DoH, PhilHealth, and development partners. Since public health and TB services are devolved in the Philippines and flow through LGUs, LGUs were also seen as a critical component of HFG-TB's assessment. Public and private providers were also interviewed so as to better understand how issues associated with TB financing have an impact on TB service delivery. Annex A provides the complete list of interviewed stakeholders.

Policy documents included guidelines and circulars published by the government or PhilHealth; assessments conducted by development partners; and peer-reviewed journal articles related to TB purchasing in the Philippines. Sources of secondary data included TB and health expenditure data published in National Health Accounts reports as well as publicly available data from the World Health Organization and World Bank.

3. TB POOLING AND FUNDING FLOWS

3.1 Overview

Risk-pooling constitutes one of the three health financing functions. It refers to the consolidation of pre-paid funds by individuals; that is, funds that are pooled prior to the point of service and ultimately used to purchase health services on behalf of that enrolled or covered population. There are several, common modes of risk-pooling for health: social health insurance; private health insurance; publicly financing (via general tax revenues) at national or locals levels; and community-based health insurance (World Health Organization 2010). For many low- and middle-income countries, such as the Philippines, TB financing is also pooled by donors.

Pre-payment is an important component of improving financial risk protection, and is a critical component of Universal Health Coverage (UHC). UHC is intended to display equity in coverage and efficiency in health spending (Boerma et al. 2014; McIntyre and Kutzin 2016). Pre-payment allows consumer payments for health care to be more predictable and spread across time, rather than incurred at the time of illness. Put another way, pre-payment increases the odds that lack of financial resources at the time of need does not cause people to forfeit care (Wagstaff et al. 2015). Pooling can also spread financial risk across population groups and allow cross-subsidy between the rich and the poor, the healthy and the sick, and the employed and unemployed. Pre-payment and pooling can address equity and risk within a single risk pool, or across risk pools if the financing structure allows for this. The degree of equity enhancement and risk reduction depend on the particular arrangements of the financing mechanisms in place. Finally, more-consolidated risk-pooling can improve efficiencies by reducing administrative costs, fragmentation in purchasing, and prices for health services.

Figure 1: Health Expenditures, by Source and Year, in the Philippines

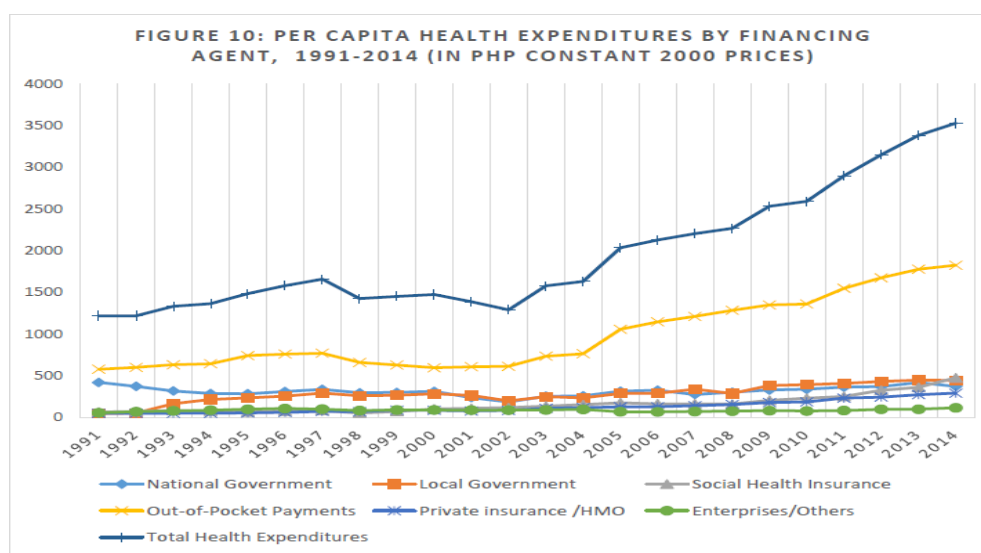
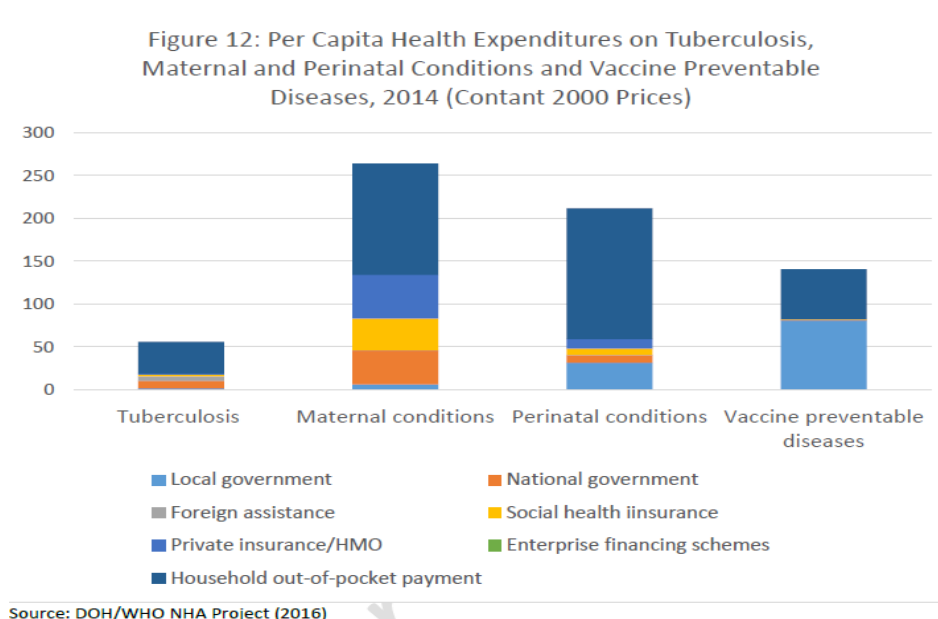


Figure 1 presents total health expenditures and health expenditures by source in the Philippines between 1991 and 2014 (Salon and Herrin 2014). Total health care expenditures began rising dramatically in 2003 following reforms to PhilHealth. Out-of-pocket expenditures also rose over this

period at a similar rate, suggesting that most of the variation in total health expenditures was due to out-of-pocket spending. By 2014, out-of-pocket spending accounted for nearly two-thirds of total health expenditures.

TB expenditures mirror general health expenditures in the Philippines, per Figure 2 (Salon and Herrin 2014). According to 2014 National Health Accounts estimates, household out-of-pocket spending on TB accounted for roughly 66 percent, or two-thirds, of total TB expenditures. The DoH financed another 17 percent of total TB expenditures, while 9 percent came from donors, 4 percent from PhilHealth, 3 percent from local governments, and finally 2 percent from private health insurance.

Figure 2: Per Capita Expenditures, by Disease and Source

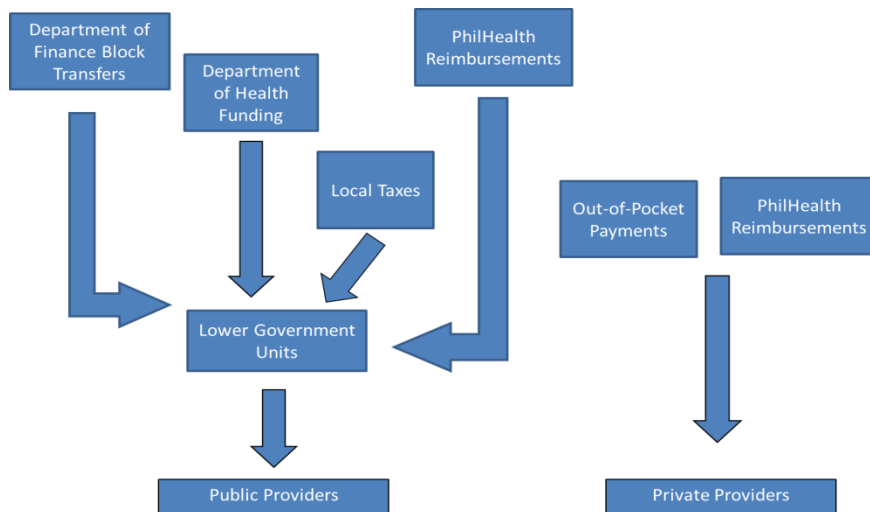


The sources and flow of funding to health care providers for TB are presented in Figure 3, and highlight the fragmentation that exists in risk-pooling for TB in the Philippines. Public health care providers, which are managed by LGUs, obtain funding or non-financial resources that can be used for TB from four sources: the Department of Finance (via block transfers); the DoH; PhilHealth; and local taxes. Block transfers are unobligated funds given by the Department of Finance to LGUs, and LGUs are not required to allocate any of those funds to TB. In 2016, block transfers to LGUs accounted for roughly 16.1 percent of the total government budget, or 428.6 billion pesos (Department of Budget and Management (DBM) 2016). The DoH provides nurses, TB drugs, technical assistance, and limited funding to LGUs. LGUs also receive reimbursements from PhilHealth for TB and general health services delivered by public health facilities. Finally, LGUs can use local tax revenue to finance TB services. Donors accounted for 9 percent of total TB funding in 2014; most of this was used to purchase TB drugs.

Financing flows to private health care providers are less fragmented but absorb near all out-of-pocket TB spending. As such, out-of-pocket payments from patients account for most of these providers' revenue, and come from three sources: uninsured TB patients, who pay out-of-pocket for primary, outpatient, and inpatient TB services and drugs; PhilHealth members, who receive primary, outpatient,

or inpatient TB services and drugs, but are charged at the point-of-service (e.g., balanced billing¹); and non-TB patients (either uninsured or PhilHealth members), whose payments for drugs and services may be used to subsidize uncompensated care delivered to TB patients. Private facilities also receive reimbursements from PhilHealth for members with TB who use primary, outpatient, or inpatient TB services/drugs.

Figure 3: TB Funding Flows, by Source and Destination



TB financing, particularly as it relates to the public sector, is heavily decentralized in the Philippines. In addition to the multiple funding streams for TB from the government, donors, and PhilHealth, the presence of over 3,000 LGUs creates yet another source of fragmentation in the pooling of TB funds. Mayors shape local TB policies within their LGUs, determine what percentage of the total budget will be spent on TB, and prioritize where/how those resources for TB are spent (DoH 2014). Mayors have ultimate authority over these decisions, despite PhilHealth guidelines that stipulate where and how reimbursements to LGUs (and ultimately public health facilities) should be spent. The roles and responsibilities of LGUs will be discussed in greater depth in the Section 4 (see subsection on public financial management); however, this point is relevant for risk-pooling discussions.

3.2 Issues

While risk-pooling is not the focus on this report, the implications of risk-pooling for TB purchasing, care coordination, and health system performance are likely significant. Global evidence suggests that fragmented financing systems, including those involving TB, often result in provider payment systems that are not coordinated across payers (Langenbrunner et al. 2009, Gottret et al. 2008). Moreover, in the case of the Philippines, the total amount and sources (mix) of TB funding differ across municipalities, and each of the 3,000 LGUs has its own unique priorities concerning where and how much of those resources are spent. Funding flows and priorities ultimately have an impact on the relationship that

¹ Balanced billing is a practice by which a health care provider bills a patient the difference between the price of delivered health services and the rate at which those services are reimbursed by a payer

LGUs and public health providers have with private health care facilities, particularly when it comes to TB directly observed treatment, short-course (DOTS) referrals and the coordination of TB service delivery. They are also likely to influence the incentives of public and private health care providers.

These issues could have three effects on health system performance as it relates to TB. First, changes in the relationship between public and private providers, as well as changes in delivery system incentives, can accentuate inequities in access to and use of TB services, both within and across municipalities. Such changes may also account for some of the variation in case detection rates and treatment success rates across municipalities. Second, the issues raised immediately above likely contribute to the growing share of out-of-pocket costs for TB care, which in turn can influence financial risk protection. Finally, the presence of multiple, fragmented funding sources, coupled with differences in LGU priorities, almost certainly creates inefficiencies in TB spending (Langenbrunner et al. 2009, Gottret et al. 2008).

Two examples, based on key informant interviews, illustrate these relationships:

1. If a private health facility refers a TB patient to a public health facility, PhilHealth guidelines may, depending on the case, require the latter to share a proportion of the reimbursement with the former. Yet, because PhilHealth payments flow through LGUs, which in practice control their own reimbursement policies, PhilHealth guidelines may be altered or ignored. If private facilities do not receive adequate compensation for referring TB patients to public facilities, they are less likely to do so in the future. In turn, those patients may end up paying more out of pocket than if they sought care in public facilities, or they may simply forgo care due to costs. Private hospitals raised these issues and supported these hypotheses during interviews with HFG.
2. Efforts by some LGUs to improve TB outcomes could be thwarted by neighboring LGUs that have not prioritized TB financing or coordinated TB financing policies. Without quantitative (empirical) evidence, it is impossible to discern whether spillover effects are the result of intentional free-riding by municipal governments. However, through key informant interviews with LGU mayors and public health officials, HFG was told that some municipalities were experiencing unprecedented rises in TB case detection rates and costs that could be explained only by an influx of TB-positive patients from neighboring municipalities. They also argued that LGU policies aimed at improving access to TB services, reducing out-of-pocket costs, and improving efficiencies through more-coordinated service delivery would have limited effect, because TB populations often seek care outside of their own municipality.

4. PUBLIC SECTOR TB FINANCING

4.1 DoH Roles and Responsibilities

4.1.1 Overview

The National TB Control Program (NTP) is a part of the DoH and tasked with shaping national TB policies. It also establishes TB guidelines, provides financial and non-financial resources to regional/provincial/municipal governments, and offers these governments technical assistance where needed (DoH 2014). Regional health offices play a similar role but have a greater focus on the provincial and municipal governments. The national and regional governments can set regulations but have limited legal authority to enforce regulations on provincial governments or LGUs across the Philippines' municipalities.

Provincial health offices are accountable to provincial governors, while LGUs are accountable to mayors in each municipality. LGUs act as both payer and provider of public health services in their respective municipalities (DoH 2014). As discussed in Section 3.1, mayors shape local TB policies within their LGUs, determine what percentage of the total budget will be spent on TB, and prioritize where/how those resources for TB are spent. LGUs also manage public health facilities, which are required to spend resources strictly by line item; that is, they are not allowed to shift resources across line items. While auditors monitor LGU spending to ensure that the LGUs abide by national policies, this occurs only at the sector level (health, education). Audits do not assess where or how health finances are spent.

4.1.2 Issues

- 1) *Purchaser-Provider Split*: A purchaser-provider split is a joint health financing and service delivery model in which the payer (typically a third-party entity, such as a national health insurer) is kept organizationally separate from contracted health care providers. The purpose of this split is to improve competition among service providers and enhance purchasing incentives. In turn, this can lead to improved service delivery and achieve strategic objectives such as cost containment, better clinical quality and responsiveness, and greater efficiency and organizational/management autonomy (Tynkkynen et al. 2013, Gottret et al. 2008). While often applied to third-party payers, a purchaser-provider split model is equally relevant to public entities such as the DoH. Global evidence suggests that in the absence of this split, weak accountability mechanisms can further hinder the above health system objectives (Svedoff and Gottret 2008). In the Philippines, LGUs lack both a purchaser-provider split and the necessary accountability mechanisms (audits, quality assurance systems).
- 2) *Provider Autonomy*: Because public health facilities cannot currently shift resources across line items, they are unable to efficiently allocate inputs. In turn, this increases administrative and service delivery costs for public health facilities. In addition to these inefficiencies, line item restrictions can prohibit public health facilities from delivering essential TB services and drugs to patients. For instance, if a facility's budget for certain medical supplies has been spent, and demand for TB services that require the use of those medical supplies is high, facilities will not be able to use existing funds to purchase additional supplies for those services. In the absence of organizational and managerial

autonomy, the clinical quality of TB services may decline and patient access to such services may be inhibited (Kutzin et al. 2010).

4.1.3 Recommendations

Policy Recommendations for DoH Roles/Responsibilities

- ☑ The DoH should expand the organizational and managerial autonomy of public health facilities as a critical step towards both output-based purchasing and a purchaser-provider split in the public health sector

Such a move could be achieved by allowing public health facilities to shift resources across line items. Greater financial autonomy would improve the efficiency of health and TB spending by allowing facilities to allocate inputs in a way that minimizes costs while maximizing service delivery outputs/outcomes. As discussed above, such reforms could also lead to improvements in the quality of and access to essential TB services.

The previous Secretary of Health indicated that the Philippines' long-term objective should be for public health facilities to become fully autonomous, compete with private facilities, and contract with PhilHealth for primary, outpatient, and inpatient services. The DoH, at the LGU level, has little capacity for or experience in contracting with private health providers, which explains the rationale for having only PhilHealth contract with private and public facilities. While this vision was shared by many other stakeholders, evidence from other countries suggests that this can be a long and challenging process (Gottret et al. 2008, Bossert et al. 1998). First, such an agenda would go beyond a mere purchaser-provider split within the DoH; it would instead eliminate both of its functions as purchaser and provider. Evidence from developing countries suggests that political resistance to such reforms and institutional challenges as the DoH's roles change can be enormous (Savedoff and Gottret 2008, Bossert et al. 1998). Second, experience shows that public facilities need time to adjust before being forced to compete with private facilities for contracts from either national or private health insurers (Langenbrunner et al. 2009). In the absence of this adjustment period and/or short-term government subsidies, public facilities will struggle financially.

HFG's proposed option, coupled with reforms to PhilHealth's reimbursement system (see section 5.6.3: Claims/Reimbursement) would both introduce public facilities to PhilHealth's output-based payment systems and act as an incremental step towards contracting, without forcing public facilities to immediately compete with private facilities. Nonetheless, even these incremental reforms should be carefully designed and implemented. Experiences from neighboring countries (e.g., Vietnam) suggest that in the absence of adequate regulations, monitoring systems, or enforcement, public facilities with full management autonomy can behave in ways that hinder public health objectives (Somanathan et al. 2014). This includes risk selecting healthy or high income patients, balance billing patients for services that should be free, and allocating inputs for only those health services which bring in the greatest revenue.

4.2 Public Financial Management and Budgeting

4.2.1 Overview

The Department of Budget and Management indicated that budget allocations to the DoH in the current year (t) are largely based on the previous year's budget (t-1) plus inflation. However, the DBM also suggested that a more complex resource allocation model is used to determine budgetary needs and



priorities. The DBM further clarified that high-priority areas, such as those included in the SDGs (in which TB is included), receive a relatively higher proportion of funding. The DoH can also receive bonus funding by the DBM via “external recommendations,” which can include recommendations from senior-level leaders (e.g., the president) or agencies.

As part of the budgeting process, the DBM also requires the DoH to report on percentage liquidation (budget execution rate) and other key performance indicators (KPIs) (DBM 2016). The DoH at all levels (national, regional, provincial, and municipal) is able to select KPIs and collect data on those indicators. Its performance on those KPIs is theoretically used by the DBM to determine the DoH’s budget.

While the DBM began implementing program-based budgets in 2012, ministerial (e.g., the DoH) budgets are still developed by line items, and ministries are not allowed to shift resources across those line items (DBM 2016). The DBM has not yet begun to implement performance-based budgets, even though it developed performance targets and an incentive system in 2012–2013. The DBM is currently designing a pilot for performance-based budgeting that will begin in 2017 (DBM 2016).

According to the Department of Budget and Planning (DBP) within the DoH, budget allocations by the DoH for TB in the current year (t) are also based on the previous year’s budget (t-1) plus inflation. Like the DBM, the DBP highlighted that a resource allocation model is used to determine provincial governments’ needs and priorities. The National Economic Development Authority is tasked with developing and applying this model. Unfortunately, the data used to populate this model can quickly become out of date, particularly in the years leading up to a new TB prevalence survey. The last survey conducted was done in 2005–2006. Furthermore, TB prevalence data are based almost entirely on utilization and encounter data from public health providers.

Like the DBM, the DBP has implemented program-based budgeting, albeit still through line items. Once budgets are released, the NTP and other regional, provincial, and municipal governments cannot shift TB resources across line items. The DBP has not yet implemented program-based budgeting. It will, like the DBM, pilot a performance-based budget in 2018, though this will be for the entire DoH rather than specifically for TB (DoH 2013). A significant challenge for the DoH, as with the DBM, is the availability and collection of data to inform performance- or outcome- based budgets.

4.2.2 Issues

The process by which the DBM determines DoH budgets contains two flaws:

- 1) The DBM monitors the DoH’s overall budget execution rate as well as KPIs to determine (in part) the upcoming year’s budget, but not where the DoH allocates its budget. Auditors also do not evaluate whether the DoH is spending its budget on high-priority areas or areas that offer significant value for money. It was not clear from HFG’s key informant interviews with the DBM whether this will be addressed in the 2017–2018 performance-based budgeting pilot. However, it is troubling that the DBM does not hold the DoH accountable for allocating its own resources inefficiently or to low-priority areas.
- 2) The DoH is able to select KPIs and track data on these indicators, yet the DoH has selected indicators for which it has limited control over their performance. For instance, in 2015 KPIs for TB included 253,381 cases being treated, and 90 percent of those treatments being successful. The DoH, given its functions and resources, cannot influence case detection or treatment outside the public sector (DoH 2014); even within the public sector, the DoH’s ability to impact these indicators is limited. Fortunately for the DoH, the DBM mentioned that it rarely uses these KPIs to determine the DoH’s budget. Put another way, even if the DoH does not meet its KPI targets, it will

rarely be held accountable for underperforming. Again, it is unclear whether performance-based budgeting pilots in 2017–2018 will address these issues.

The DBP faces two challenges with its budgeting process within the DoH. These are as follows:

- 1) It lacks high-quality, timely data to set TB budgets. As mentioned above, the DoH's TB budget is typically a function of prior years' budgets and a statistical model that accounts for need. Data used to populate this model are based in part on case detection rates, which are collected only every 10 years from the public sector. This means that TB budgets will be either underestimated or overestimated each year.
- 2) As with the broader budgeting process, the DBP also allocates budgets by line item (albeit with an upcoming performance-based budgeting pilot in 2018). This means that, at present, the NTP cannot shift resources across line items. If the TB program needs to allocate additional funding for TB drugs and less for technical assistance, it is unable to do so. In turn, this will impact the efficiency/effectiveness of the NTP's spending, budget execution rates, and, in theory, future years' budgets.

5. TB STRATEGIC PURCHASING: PHILHEALTH

5.1 Certification/Accreditation

5.1.1 Overview

A two-step process is required for facilities to contract with PhilHealth: certification (done by DoH) and accreditation (done by PhilHealth). Both processes and quality standards are roughly identical, must be conducted annually, and are administratively and financially burdensome. While this process is the same for public and private providers, PhilHealth requires a separate accreditation process for its primary care benefit package, inpatient benefit packages, and all six outpatient benefit packages (e.g., TB DOTS). However, if a facility is accredited for the outpatient care packages, it automatically qualifies for the primary care package.

The administrative costs and time required to apply for PhilHealth accreditation are burdensome (PhilHealth 2012). Many of the following must be submitted the first year and annually thereafter (except the 1,000 pesos):

- 1,000 pesos fee
- Proof of DoH certificate
- Provider data record
- Photos of facility
- Contracting forms/agreements

In the case of DOTS accreditation (one of the six outpatient care packages), proof of a DOTS accredited physician/provider (photos, license, forms) working at the facility is required.

Roughly 96 percent of public facilities are accredited by PhilHealth for the TB DOTS outpatient benefit package, compared with only 4 percent of private facilities (Health Policy Development Project (HPDP) 2015). A growing number of private facilities are applying for accreditation so as to deliver TB services in house rather than refer patients to the public sector. This behavior is motivated by numerous financial and non-financial incentives, which will be addressed later in the report.

Public facilities must be certified by DoH but can choose whether to become PhilHealth accredited. In theory, public facilities have little incentive to obtain PhilHealth certification, because PhilHealth reimbursements are given to the LGU, which must allocate those resources in accordance with national guidelines. The extent to which LGUs follow these guidelines is not clear. In practice, the DoH provides an annual financial incentive of 200,000 pesos to facilities that become PhilHealth accredited. Data were not available to assess whether these annual accreditation bonuses (and other, non-monetary factors) outweigh the weakened incentives of having LGUs act as a financial gatekeeper.

5.1.2 Issues

- 1) Inefficiencies exist within and across the DoH certification and PhilHealth accreditation systems. Because these processes are nearly identical, health care facilities (public and private) as well as the DoH and PhilHealth face excessive administrative costs. At the same time, the health care system does not gain any benefits, such as improved quality standards, by adding an additional layer of

accreditation. PhilHealth also requires an annual accreditation process for health care facilities, rather than every three to five years. Finally, health care facilities face unnecessary administrative costs by having to apply for multiple clinical benefit packages, rather than applying to meet general quality accreditation standards.

- 2) PhilHealth faces a conflict of interest as both payer and accreditor. As more facilities become accredited, PhilHealth's total expenditures will rise. It is thus to PhilHealth's benefit to delay or prevent health care facility accreditation. Evidence from interviews with health facilities suggests that even when the application paperwork is correctly filed, PhilHealth may delay sending staff to those facilities to conduct inspections or file the paperwork.

5.1.3 Recommendations

Policy Recommendations for Accreditation/Contracting

- The DoH should convert the two-step certification/accreditation process into a single accreditation process for health care facilities;
- The DoH should create a single accreditation process that facilities should be required to pass (e.g., they must meet a range of quality standards), rather than requiring facilities to become accredited for individual benefit packages;
- PhilHealth should increase the length of an accreditation from one year to three or five years, as is standard internationally;
- In the long term, the DoH should create a separate, independent body to conduct facility accreditations. This would eliminate PhilHealth's conflict of interest and, because the supply of facilities eligible for PhilHealth reimbursement would rise, so too should a number of health system performance metrics.

5.2 Benefit Package

5.2.1 Overview

5.2.1.1 Primary Care

PhilHealth's benefit package covers most preventative and primary care services. The package does not specifically mention TB diagnostic services, though the capitated payment should cover TB screenings (PhilHealth 2012, PhilHealth 2014). Only members under the sponsored program (indigent), organized groups, overseas workers, and their dependents are covered for primary care benefits.

5.2.1.2 Outpatient Care

PhilHealth added multiple outpatient benefit packages in 2003, which cover specific conditions associated with the MDGs (Figure 4). The TB DOTS package includes diagnostic tests, consultation fees,

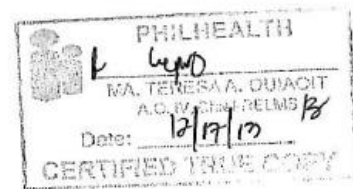
and first-line anti-TB drugs (PhilHealth 2012, PhilHealth 2014). It originally covered only new cases of TB but was amended in 2014 to include both new and old TB cases. All PhilHealth members are eligible for the six outpatient care packages.

Figure 4: MDG Outpatient Benefit Packages

VII. MILLENNIUM DEVELOPMENT GOAL PACKAGES

The following packages shall be paid using case-based payment but will follow the existing rules of reimbursement, payment and claims filing contained in their respective circulars.

1. Maternity Care Package (RVS 59401)
2. Outpatient HIV/AIDS Treatment Package (RVS 99246)
3. Animal Bite Package (RVS 90375)
4. Outpatient Malaria Package (RVS 87207)
5. TB-DOTS (RVS 89221, 89222)
6. Newborn Care Package (RVS 99432)



VIII. EXCLUSIONS

5.2.1.3 Inpatient Care

PhilHealth began with a mandate only to cover inpatient care; the benefit package was expanded to include primary and outpatient care in recent years. Inpatient care is the primary benefit for all PhilHealth members. The number of inpatient “diagnostic conditions” covered is fairly comprehensive and listed in the PhilHealth circular (PhilHealth 2012, PhilHealth 2014). TB inpatient services, including drugs for MDR-TB, are included as a covered diagnostic condition.

PhilHealth benefit packages are identical for public and private health services, so long as the facility is accredited. PhilHealth covered benefits are identical to those offered in the public sector; thus, PhilHealth members receive no “top-up” or supplemental TB benefits for using public care. Publicly delivered TB services, which include primary, outpatient, and inpatient care (and first-line drugs), are theoretically free of charge even if a patient is not a member of PhilHealth.

5.2.2 Issues

- 1) PhilHealth’s primary care package to date is only for the indigent and a few other, small-population, groups; the remaining PhilHealth members do not have access to free primary care, which includes TB screenings in the private sector. Some might argue that PhilHealth members can use free primary TB care in the public sector. The reality is that most do not. This means that most PhilHealth members will be financially unprotected from primary/diagnostic TB service costs when using private care. They are therefore more likely to forgo needed care, and that suppresses TB case detection rates).
- 2) By failing to harmonize its TB benefit package, PhilHealth also fragments TB service delivery for patients and weakens care coordination. In the absence of a benefit package that spans the TB care continuum (from diagnosis through inpatient care), patients are more likely shift care across private and public sectors for TB services/drugs. Multiple providers are unlikely to communicate with one another to ensure that the patient’s care is timely, clinically appropriate, and not duplicated. Such behavior can thus lead to excessive health spending, poor quality of care, loss to follow-up, and possibly even increased MDR-TB rates due to uncompleted treatments.

- 3) While public TB services are theoretically both comprehensive and free, the reality is that drugs are often not available. TB patients are thus forced to purchase TB drugs in the private sector, which can be very costly (more on this issue below).

5.2.3 Recommendations

Policy Recommendations for Benefit Packages

- Expanding a national benefit package takes time and should be done only when sufficient resources are available to sustainably finance those packages. However, given the above benefits and the limited cost of expanding the primary care TB benefit package to all populations, HFG recommends this as a highly cost-effective option.

5.3 Provider Payment Mechanisms

5.3.1 Overview

5.3.1.1 Primary Care

PhilHealth's primary care package is paid on a capitated per family per year basis (PhilHealth 2013). However, PhilHealth guidelines stipulate that payments should be released per quarter to either the provider (if private) or the LGU (if public). The indigent, toward whom the primary care package is directly geared, must be assigned a public provider. All other population groups eligible for the package can choose a provider (public or private). However, the provider must reside within that individual's geographical area. Individuals can only transfer general practitioners (GPs) if they move to another province/city/municipality. Facilities are required to submit an annual physical/check-up for the PhilHealth member in order to receive the capitated payments; if they do this electronically, they also receive a 100 peso bonus.

5.3.1.2 Outpatient Care

For the TB DOTS package, bundled case-based payments are made to DOTS accredited facilities. This means that the payment includes facility costs, physician/provider costs, and first-line TB drugs. Payments are made for new cases or readmissions due to relapse, treatment lost to follow-up, and treatment failure (PhilHealth 2013). Two payments are made: one after the "intensive phase" and the other after the "maintenance phase." Payments are released only for complete treatments or treatments during which a patient dies, while providers who lose their TB patients will not be reimbursed.

5.3.1.3 Inpatient Care

Bundled, case-based payments are also used for inpatient care, though cases are determined by disease category and ICD-10 code—i.e., diagnostic related groups (DRGs). Again, a bundled case rate is one that includes physician fees, drugs, and facility costs. Payments account for all readmissions under the same condition that occur within 90 days following discharge (PhilHealth 2013). Despite the use of DRGs, PhilHealth sets a ceiling on its members' length of stay within a hospital to 45 days.

There are hundreds of diagnostic codes for inpatient conditions, of which TB is included. PhilHealth guidelines indicate how these case rates should be allocated (e.g., operational, physicians, other staff) once received by the facility. For instance, facilities must give physicians and other staff their proportion of the reimbursement within 30 days or risk being penalized (PhilHealth 2013). Moreover, facilities may claim for up to two conditions when a patient has multiple co-morbidities. This does not apply for all conditions; some secondary conditions may be reimbursed only 50 percent, others 100 percent, and other 0 percent. Finally, only certain facilities can treat and be reimbursed for certain conditions. For example, complex procedures with a relative value unit of 200–500 must be treated in a Level 2 hospital or above, while primary care facilities can be reimbursed for only 70 percent of a standard case rate.

5.3.2 Issues

PhilHealth has designed its capitation-based payment mechanism differently than would be recommended based on global best practice (Langenbrunner et al. 2009). These differences include the following:

- 1) Under capitation-based payment systems, a member is linked to a health care provider either through self-selection or by assignment. Evidence suggests that, when implemented and monitored effectively, capitation can stimulate competition among providers, because more patients translates into greater revenue. Providers thus have an incentive to improve quality (clinical and perceived) and reduce costs. In the public sector, PhilHealth’s capitated payment is not linked to a single provider. Rather it is given to the LGU, which then decides how to distribute those funds. Thus, incentives associated with capitation are diluted or eliminated.
- 2) Capitation is often used for primary care, because primary care services are lower in cost and more predictable compared with inpatient care (World Health Organization 2010). Nonetheless, providers must still be able to assess risk, negotiate a capitated payment rate, determine their cost structure, and manage a patient’s care effectively. For this reason, capitated payments typically occur per member rather than per family, which is how PhilHealth’s capitation system is structured. Families will vary by size substantially, particularly in lower-middle-income countries like the Philippines. Those members will have different medical risks, needs, and preferences. Families also move apart for work, and are thus not confined to the same geographical region. Unless the risk-adjustment formulas driving those capitated rates are very well designed, a per-family method will increase providers’ financial risk. The same can be said for the payment period. Most capitated payments occur monthly rather than annually, because predicting a health care provider’s monthly expected costs is far easier and less error-prone than doing so for an entire year.

5.3.3 Recommendations

Policy Recommendations for Provider Payment Mechanisms

- PhilHealth should reform its capitation-based payment model for primary care

PhilHealth’s outpatient and inpatient payment mechanisms are relatively well designed, but could certainly be improved. PhilHealth even expressed interest in reforming its inpatient payment system to incentivize providers to achieve better health and TB outcomes for their patients. However, at present PhilHealth is most in need of reforms to its capitation-based payment model for primary care, which would be relatively easy to design and implement. Reforms could have a significant, positive impact on

case detection rates, patient out-of-pocket costs and financial risk protection, and quality of and access to TB services, as well as coordinated TB service delivery (Langenbrunner et al. 2009).

5.4 Prices

5.4.1 Overview

5.4.1.1 Primary Care

The primary care capitation rate is 500 pesos per family per year (~\$10) (PhilHealth 2013). This figure is not risk adjusted to account for patient case mix, geography, or facility type. This rate is identical for both public and private providers. According to PhilHealth guidelines, 40 percent of the capitated payment must be spent on drugs, 40 percent on supplies and operational costs, and 20 percent on physicians or staff.

5.4.1.2 Outpatient Care

The outpatient TB DOTS package rate is 4,000 pesos (~\$86) per case, although actual reimbursement rates have averaged 2,000 pesos (~\$49) per case (PhilHealth 2013). This rate was based on a 2003 cost study, and again this figure is not risk adjusted to account for patient case mix, geography, or facility type. The TB DOTS case rate is identical for both public and private providers. Per PhilHealth guidelines, 25 percent of reimbursements should be allocated to consulting services, 35 percent for facility staff, and 40 percent for operational costs of DOTS facilities.

5.4.1.3 Inpatient Care

Inpatient case rates vary by diagnostic code (PhilHealth 2013). It was not possible to identify reimbursement rates for inpatient TB services. Inpatient case rates were also based on the above 2003 costing study, and are not risk adjusted to account for patient case mix, geography, or facility type. Rates are also identical for both public and private providers.

5.4.2 Issues

- 1) Per key informant interviews, payment rates for primary care, outpatient TB DOTS, and inpatient care are far below the cost of delivering those services, particularly for providers in the private sector. This stems from the fact that the most recent costing of health services was conducted in 2003 and was based on a sample of public facilities (whose costs, for any given service, are likely to be below those incurred by private facilities). Private providers have tried to negotiate reimbursements rates with PhilHealth but had little success. This is less of an issue for public facilities, who use PhilHealth payments to supplement public funds. While no-balanced-billing policies are in place for most services, private providers, who rely on PhilHealth payments as a primary source of revenue, must identify alternative revenue sources to subsidize these low reimbursements rates. Key informant interviews found that private facilities sometimes resort (informally) to balanced billing, which increases patient out-of-pocket costs (thus worsening financial risk protection) and hinders access to TB services.
- 2) PhilHealth has not applied any “advanced” modeling techniques to set its payment rates for primary, outpatient, and inpatient care. This includes the lack of risk-adjustment for patient case mix, geography, facility type, or other factors (PhilHealth 2013). Risk-adjustment is a process by which the average price for a given service (e.g., 4,000 pesos for the TB DOTS package) is adjusted to

account for variations in provider costs. For instance, the underlying cost structure for a teaching facility will be higher than the one for a non-teaching institution delivering the same service. Instead, PhilHealth reimburses all facilities the same amount for a service (e.g., the 4,000 pesos). The result is that some facilities have less or little incentive to treat patients or provide high-quality services, while others have greater incentive to do so.

5.4.3 Recommendations

Policy Recommendations for Pricing

- ☑ A third-party agency should conduct a new costing study of TB (or health) services from public and private facilities. This study, coupled with negotiations between payers and providers, would inform new base payment rates for primary, outpatient, and inpatient TB services;
- ☑ PhilHealth should be trained to apply risk-adjustment models to its base payments, to better match payments for health and TB services with the actual costs of delivering those services at different facilities;
- ☑ PhilHealth should initiate efforts to collect new patient and facility level data, as well as use existing data, to inform risk-adjustment models and reimbursement rates.

5.5 Cost Sharing

5.5.1 Overview

5.5.1.1 Department of Health

The DoH states that all TB care is free for patients who seek care with public health care providers. This includes everything: diagnostics and primary care, outpatient TB DOTS, inpatient care services, and drugs (first-line and MDR-TB).

5.5.1.2 PhilHealth

All non-PhilHealth members that use private providers must pay entirely out-of-pocket for TB services and drugs. For PhilHealth members, no formal cost sharing mechanisms exist (e.g., co-pays, co-insurance, and deductibles) aside from their monthly premiums (PhilHealth 2012, PhilHealth 2014). However, PhilHealth members (excluding the indigent and subsidized populations) are eligible for benefits only if they have paid premiums for three consecutive months. While private providers are allowed to balance bill for certain health services, no-balanced-billing applies in the case of public services such as TB services (PhilHealth 2012, PhilHealth 2014).

PhilHealth's reimbursement to public facilities (via the LGUs) is simply an extra source of funds for the respective municipal governments (it supplements existing public health spending). PhilHealth members do not receive any financial benefit for using public health facilities. Put another way, PhilHealth does not act as a secondary form of health insurance to subsidize out-of-pocket costs that its members incur.

5.5.2 Issues

- 1) While TB services are theoretically free for individuals who use public health facilities, the reality is that patients are likely to spend out of pocket for several reasons. The primary reason stems from pharmaceutical procurement issues and the existing “push” system for TB drugs. Under such a system, the NTP procures TB drugs based on expected need and sends them to LGUs accordingly. In turn, TB drugs are then given to public health facilities. In addition to quality issues (e.g., drug expiration), the existing “push” system can result in facilities’ being either overstocked or understocked. This creates major inefficiencies and drives TB patients’ out-of-pocket costs. If the drugs are out of stock, public facilities will tell patients that they can wait (often for extended periods) until those drugs become available; in practice, patients end up purchasing those TB drugs in the private market. Because private health care facilities cannot procure TB drugs at public prices, they are forced to buy them at markedly higher prices. These prices are then passed on to TB patients.
- 2) While 80–85 percent of the Philippines’ population is enrolled with PhilHealth, effective coverage (i.e., members who know they are enrolled and are financially protected from risk) is less (Fabella 2014, Chakraborty 2013). Members can incur substantial out-of-pocket costs for TB services. In primary care, evidence from key informant interviews with private hospitals suggests that those facilities often charge significant co-pays for TB diagnostic services. Moreover, even if low-income individuals enroll in PhilHealth upon arriving at a private facility, this point-in-time enrollment prevents facilities from successfully submitting a claim for that patient. Facilities will therefore find other ways to bill patients to subsidize the cost. For inpatient cases, no-balanced-billing only applies to some diagnostic conditions (of which TB is included); however, because reimbursement rates are so low and regulation weak, anecdotal evidence suggests that facilities may balance bill patients for other (e.g., secondary) conditions. PhilHealth members are also unlikely to know, per PhilHealth guidelines, which conditions do and do not allow balanced billing.

5.6 Claims/Reimbursement

5.6.1 Overview

Claims to PhilHealth must be made within 60 days of discharge/treatment and require a complex set of forms/documents (PhilHealth 2013, PhilHealth 2014). There is an added step for public facilities, who must first submit a claim to their LGUs, who then have the claim reviewed by a technical panel of health care providers, who then submit the claim to PhilHealth. PhilHealth members can file claims for emergency care received at a non-accredited facility, though they must pay up front and file a claim for reimbursement thereafter.

5.6.2 Issues

The total number of claims filed and actual reimbursements received is lower than it should be, according to utilization data on TB services by PhilHealth members. In fact, PhilHealth reimbursements accounted for only 2 percent of the DoH budget for TB in 2012 (HPDP 2014, PhilHealth 2013). Reasons include:

- 1) PhilHealth members have no incentive to present their cards at public facilities, as they will receive no financial benefit (supplemental coverage). PhilHealth members who do present their membership cards will need to fill out paperwork, which in many cases can delay the care and treatment (including drugs) that they receive.

- 2) Similarly, public facilities often do not ask patients for PhilHealth enrollment information. Like the PhilHealth members they treat, public facilities are not guaranteed to receive revenue from the PhilHealth reimbursement (because it goes to the LGU, which then decides where to allocate those resources). Facilities also realize that the total amount reimbursed by PhilHealth is very small, and the odds of PhilHealth accepting a claim relatively low. Public facilities are also required to submit paperwork when submitting a PhilHealth claim, which adds to the facilities' underlying cost structure. This paperwork includes two claims forms, a patient's PhilHealth cards, and a patient's completed NTP card.
- 3) For private facilities, total costs (administrative costs of filing and the service costs) exceed PhilHealth reimbursements. Moreover, the window to submit a claim is short, filing procedures are complex, and facilities often lack dedicated staff to file claims. Note: This does not imply that private facilities have no interest in submitting PhilHealth claims. Such claims offer a greater, more reliable source of revenue than patient out-of-pocket costs.

Moreover, among claims filed in 2012, only half were reimbursed (HPDP 2014, PhilHealth 2013). This actually translated into 20 million pesos in claims reimbursed, compared with nearly 40 million pesos in claims filed. Possible reasons include:

- 1) PhilHealth reimbursements go through LGUs, which do not forward the reimbursements to facilities. The current Secretary of Health acknowledged that this is a problem to be fixed, though it is unclear whether this has happened or will happen.
- 2) There are several requirements involved in submitting claims on time (including getting forms from employers, if patients are formally employed). Claims are rejected if they are not submitted within 60 days, or have errors, or were made using the wrong form. PhilHealth does not inform facilities of errors they have made in filing claims, or how to fix the error.

Because for private providers, case rates are even lower relative to input costs, there is even less incentive to file. Claims have increased since 2008, though claims have only been made for 5 percent of all TB cases nationally (HPDP 2014, PhilHealth 2013).

5.6.3 Recommendations

Policy Recommendations for Claims/Reimbursement

- The DoH should allow discretionary, non-public revenue, notably reimbursements from PhilHealth, to be given directly to public health facilities rather than to LGUs;
- PhilHealth and the DoH should consider options for eliminating the indirect costs of having TB patients fill out forms after arriving at a public facility. The effect of such policies on PhilHealth member out-of-pocket costs might not be significant, but it would increase the probability that facilities could submit claims, which would increase their revenue;
- PhilHealth policies should be revised so that they offer clear guidelines for health facilities about submitting claims;

- ☑ PhilHealth should advise facilities when claims are filed incorrectly, and the 60-day period should be extended when revisions are required;
- ☑ Both public and private facilities should also earmark resources in their budgets for staff dedicated to filing PhilHealth claims. (Note: During key informant interviews with health facilities, facilities that were most successful at receiving PhilHealth reimbursements had trained staff devoted to filing PhilHealth claims)

Coupled with greater financial autonomy (see Section 4.1.3), by allowing discretionary revenues to be given directly to public facilities, administrators of public health facilities would have both the authority and incentive to use this discretionary revenue to improve the performance of their facilities. Meanwhile, salaries, infrastructure, and supplies could continue to flow through LGUs as needed. Facility administrators could use PhilHealth reimbursements to offer bonuses to health care providers for achieving important outputs or outcomes (e.g., TB case detection or treatment success). As with any private, non-profit health facility, public health facility administrators could also reinvest discretionary revenue into their facilities to improve TB clinical quality and patient satisfaction. Eliminating LGUs from the PhilHealth reimbursement process would have vast implications. First, it would likely improve the efficiency of health spending by reducing unnecessary administrative costs, and further encourage facilities to manage revenues wisely. Second, it would incentivize public facilities to: deliver more care to PhilHealth patients (which could increase case detection rates, case holdings, and treatment success rates), submit a greater number of claims to PhilHealth, and perhaps even begin to compete with private providers. The latter might influence for the better the quality of care delivered in the public sector.

5.7 Referrals

5.7.1 Overview

5.7.1.1 Primary Care

Within the private sector, the GP responsible for a family's primary care is required, per PhilHealth guidelines, to refer patients when necessary. However, there is no indication that the GP responsible for the PhilHealth member must provide a financial incentive to the referral (receiving) provider (PhilHealth 2013, PhilHealth 2014). Public providers do not adhere to PhilHealth referral guidelines, as members are not linked to a specific provider for primary care.

5.7.1.2 Outpatient Care

For outpatient TB DOTS services, PhilHealth guidelines stipulate that only the referring provider can submit a claim; referral providers cannot (PhilHealth 2013, PhilHealth 2014). However, there is nothing in PhilHealth's document citing how much a referring private provider gets paid from the 4,000 peso case rate. The PhilHealth circular states that the actual amount to be shared by the referral and referring facilities must be determined by the facility that actually delivered the TB DOTS services. In short, the referring facility, assuming that it is accredited by PhilHealth, would need to submit a claim, but would not receive any reimbursement for that claim. The reimbursement would go only to the referral (receiving) facility.

5.7.1.3 Inpatient Care

In the private sector, referral facilities (those who receive a patient) are allowed to claim and receive the PhilHealth payments for delivered inpatient services (PhilHealth 2013, PhilHealth 2014). The referring

hospital gets paid 4,000 pesos, regardless of the condition. Both the referring and referral facilities must submit identical claims forms to PhilHealth. Referrals can be made only to a higher-level facility, except among tertiary hospitals, which can refer horizontally. If a PhilHealth member receives inpatient care from multiple facilities, only the first and last facilities are reimbursed.

5.7.2 Issues

- 1) Private GPs who are contracted to deliver primary care services to PhilHealth members have an incentive to refer their patients whenever possible. Referring patients allows them to maximize profits by maintaining the total PhilHealth reimbursement while reducing the costs of delivering primary care services. Conversely, referral providers (those receiving the patients) have an incentive to prevent those patients from accessing needed care or, at the very least, to minimize the inputs used to treat their patients. Systems to regulate and monitor this behavior, for instance through facility audits, are not necessary in place to hold providers accountable for their actions. Patients' access to primary and preventative TB services, financial risk protection, and quality of care can therefore be negatively impacted by the incentives created by this referral system.
- 2) For outpatient care, TB DOTS referrals occur at a relatively low rate (e.g., patients that use private facilities are often not referred to public TB DOTS centers for the outpatient package if/when they are diagnosed with TB). Such TB patients are often not captured by the public system, which in turn depresses national case detection rates. Many stakeholders in the Philippines have expressed concern over how to adequately incentivize private providers to refer patients for TB DOTS treatment. Findings from key informant interviews suggest that private facilities rarely receive a referral fee from LGUs for TB DOTS patients, and many are not even aware that they should receive a referral fee. Once TB patients are referred, they are unlikely to return to that referring facility for additional outpatient or inpatient TB care. Private facilities, despite forgoing substantial revenue from such patients, ultimately refer TB patients out of concern for their health and broader public health objectives. Private facilities are nonetheless beginning to build TB DOTS centers to take on growing patient demand.

5.7.3 Recommendations

Policy Recommendations for Referrals

- PhilHealth should develop or improve systems to monitor the behavior of health facilities and enforce regulations around referrals;
- PhilHealth should consider reforms that strengthen incentives for providers to refer TB-suspect and TB-positive patients without compromising fund solvency and efficiencies;
- PhilHealth should enforce its existing policy that the referring facility receives a share of the total TB DOTS reimbursement (4,000 pesos);
- PhilHealth should also eliminate its policy that requires a referring facility to submit a claim for a service it has not delivered.

- 1) PhilHealth must ensure that systems are in place to monitor provider behavior and enforce regulations, so that patients have access to and are using essential health services, are not incurring excessive out-of-pocket costs, and are not receiving care that is below quality standards. This might include facility audits for quality assurance, or putting in place systems for managing patient grievances or complaints. PhilHealth should also be collecting and analyzing claims/encounter data to track patients, the care they receive, and the costs of delivering those services. If these systems are already in place, PhilHealth must make sure that they are being implemented effectively.
- 2) PhilHealth should consider reforms to its primary care referral system that improve incentives for both the referring and referral providers. For the former, PhilHealth must put in place policies that stop the flow of capitated payments or penalize providers if their patients are referred for services that could be delivered “in house.” PhilHealth should also revise its payment system to ensure that some portion of the total, capitated payment is earmarked to the referral provider (the one receiving a patient).
- 3) HFG recommends that PhilHealth enforce its existing policy that the referring facility receives a share of the total TB DOTS reimbursement (4,000 pesos). However, because the reimbursement rate for PhilHealth’s TB DOTS benefit package is less than the actual cost of delivering those services and filing a claim, this alone would do little to improve private facilities’ incentives to refer patients to public TB DOTS facilities. PhilHealth should also eliminate its policy that requires a referring facility to submit a claim for a service it has not delivered.

ANNEX A: STAKEHOLDERS INTERVIEWED BY HFG

List of Interviewed Stakeholders
Department of Health (National TB Program; Financial Services; Budget and Planning)
Regional Department of Health
Department of Budget and Management
PhilHealth
LGUs (San Juan; Teresa)
Private Providers (De La Salle Hospital; Taytay Hospital)
Public Providers (Rural Health Units in San Juan and Teresa)
European Union
Asian Development Bank
USAID Impact Project
USAID Health Policy Development Project
University of the Philippines School of Economics

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