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PHILIPPINES LIVING HiT UPDATE

3.4.4 Purchasing and purchaser–provider relations

National government and its retained hospitals

In 1991, the management of provincial, district and municipal hospitals, as well as primary care facilities, was transferred to local government units (LGUs), i.e. the provincial and municipal governments, under the leadership of governors and mayors, respectively. However, specialty hospitals, regional and training hospitals, and sanitariums (health facilities for the treatment and recuperation of individuals with leprosy) were retained under the management of the central Department of Health (DOH). Since then, some hospitals that were originally devolved were eventually re-nationalized. To date, there are about 70 DOH-retained hospitals throughout the country.

Since 2001, DOH-retained hospitals have enjoyed a significant degree of management and fiscal autonomy in accordance with a special provision in the General Appropriations Act (GAA), which has been implemented through various guidelines. These guidelines allowed DOH-retained hospitals to retain their income across fiscal years, which can be used for maintenance and other operating expenses (MOOE) and capital outlays (CO) but not for the payment of salaries and 55 other allowances. DOH-retained hospitals were also given the authority – even encouraged – to set and collect user charges. But a DOH directive has set a ceiling for mark-ups at a maximum of 30% of actual cost, so user charges cannot be readily used to cross-subsidize other hospital operational costs. The National Center for Health Facility Development (NCHFD) oversees the implementation of these policies.

DOH-retained hospitals continue to receive budget appropriations from the national government. The size of the appropriations is primarily determined by past (historical) appropriations. A DOH-retained hospital's budget appropriation is also heavily dependent on the amount of "insertions" made by congressmen during budget deliberations. These insertions typically come from congressmen's "pork barrel" funds or their Priority Development Assistant Fund (PDAF) allocations, which are given to legislators by the national government to fund local projects for constituents and are earmarked for expenditure items such as direct

patient subsidies for constituents in specific DOH-retained hospitals. Given the historical approach to setting budgets, these insertions get carried over in future budgetary appropriations, such that hospital budgets bear no resemblance to the original budgets that were based on allocations per bed and per day (see Table 3.10 in the 2011 Philippines HiT for the MOOE allocation versus bed capacity[1]). These insertions also tend to distort the rational basis for the establishment and development of hospitals in the public sector.

PhilHealth and its accredited health-care providers

Since its inception, the Philippine Health Insurance Corporation (PhilHealth) has been responsible for the accreditation of health-care providers and institutions. Accreditation is primarily for purposes of quality assurance – "the verification of the qualification and capabilities of health-care providers prior to granting the privilege of participation in the NHIP (National Helath Insurance Program), to ensure that health care services that they are to render have the desired and expected quality" (PhilHealth, 2004). Both health-care professionals, including doctors, dentists and midwives, and health-care facilities, including hospitals, rural health units (RHUs), TB-DOTS facilities, free-standing dialysis centres and maternity care clinics, undergo independent PhilHealth accreditation processes. Accreditation contracts are renewed annually for facilities and every three years for professionals, but can be suspended or revoked during the period of validity if acts are committed that result in adverse patient outcomes.

However, there is an ongoing process of restructuring to enable PhilHealth to focus more on financing, while leaving regulation and service delivery to other parties (e.g. DOH, LGUs, DOH-retained hospitals, etc.). As a major step in this direction, PhilHealth turned over the accreditation function to the DOH while focusing more on its role as an "active purchaser" of health services (DOH, 2010). PhilHealth Circular No. 54, series of 2012 (PhilHealth, 2012e), includes provisions to enhance provider engagement in achieving universal health care (Kalusugan Pangkalahatan) through various strategies, including automatic accreditation of DOH-recognized institutional health-care providers (IHCPs), as well as decentralization of key functions to regional offices, such as transactions related to processing and updating all IHCP applications. Circular No. 54 also allows extension of such provider engagement to nongovernmental groups, provided that they comply with the terms. An incentive scheme has also been set up for high-performing IHCPs.

One important concern is the uneven distribution of accredited providers throughout the nation, which is a reflection of the uneven distribution of health-care facilities and providers in general (see Table 4.2; compare this with Table 3.11 in the 2011 Philippines HiT). In particular, 35% of all PhilHealth-accredited doctors are based in the National Capital Region (NCR); the number of NCR-based doctors is about eight times more than the average number of PhilHealth-accredited

1 The Philippines Health System Review, available at: http://www.wpro.who.int/philippines/areas/health_systems/financing/philippines_health_system_review.pdf

doctors in regions outside the NCR. Close to 60% of all accredited hospitals are located in Luzon, and over 70% of free-standing dialysis clinics are found in the NCR. PhilHealth accepts any facility that meets its quality standards, but there is little overall planning and management by PhilHealth on the supply side. Moreover, government health institutions are not fiscally autonomous. PhilHealth reimbursements have little impact on health workers as the money the institutions receive goes into the local revenue stream. PhilHealth is currently working on establishing revenue collection at the point of service, as well as encouraging hospital autonomy.

PhilHealth is moving away from the highly inflationary fee-for-service scheme towards a phased-in approach of payments based on case-rates (PhilHealth, 2011c, 2011d & 2011e). Currently, the first batch covers 23 conditions. The next batch will cover an additional 29 common conditions. Together, these 52 conditions account for 95% of all hospitalized PhilHealth cases in the country. As of May 2012, about 59% of the processed transactions at PhilHealth are already case-rate payments, with the balance of 41% still under the fee-for-service scheme. The success of this new payment scheme is contingent upon an efficient monitoring system to avoid errors and catch abusers, as well as the implementation of clinical practice guidelines to ensure patients are received appropriate treatment. The natural next step for a case-rate payment scheme is to move towards global budget payments, an institution-based advance payment calculated on the basis of the hospital's expected number and type of patients. A trial run of global budget-based payments began in December 2012 in selected DOH-retained hospitals (PhilHealth, 2012b).

In line with the implementation of the case-rate payments to providers, PhilHealth began implementation of a "no balance billing" (NBB) policy as a means to reduce medical care inflation, thus preventing catastrophic health expenditures, especially among the poor. NBB effectively eliminates any out-of-pocket payments at the time of service delivery. The NBB policy is currently limited to members of the Sponsored Program. Since its implementation, 64% of all claims of Sponsored Program members are now NBB. The programme aims to progressively expand to include other member categories (PhilHealth, 2011a, 2011b, 2012a, 2013).

PhilHealth is also undergoing an expansion of benefits in two broad areas. First is the programme on primary care benefits, which is an outpatient package, in contrast to the largely hospital-based payment scheme. When completed, this would involve capitations on basic diagnostics, chronic illness drugs and specialty care. The second broad area addresses catastrophic care, or the so-called Z benefit package. This is a case-rate, NBB billing scheme for selected catastrophic illness managed by selected Level 3 and Level 4 government hospitals. Conditions include acute lymphoblastic leukemia, early-stage breast cancer, low to intermediate prostate cancer, and low-risk end-stage renal disease (PhilHealth, 2012d).

The low service utilization rate (6.18% in 2008) is being addressed by institutionalizing customer support centres as well as community health teams, to help members navigate through the system (PhilHealth, 2012c).

Reforms in expanding membership are also under way. As of mid-2012, 4.74 million members were registered for national government premium subsidies in the first quarter and 5.33 million members for LGU premium subsidies in the second quarter.

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