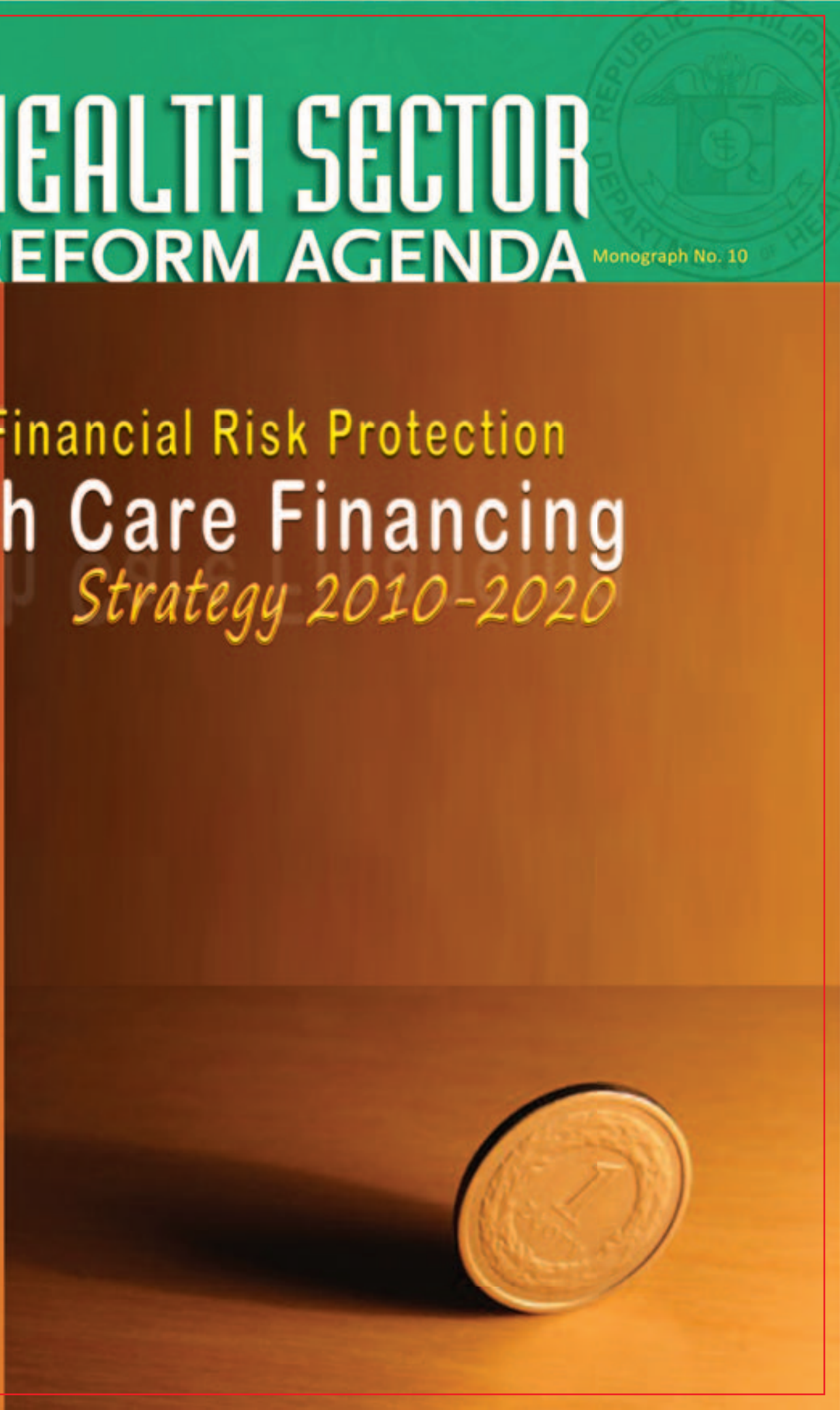
HEALTH SECTOR REFORM AGENDA

Monograph No. 10

Toward Financial Risk Protection

Health Care Financing Strategy 2010-2020



HSRA MONOGRAPHS

HSRA Monograph No. 10

TOWARD FINANCIAL RISK PROTECTION

HEALTH CARE FINANCING STRATEGY OF THE PHILIPPINES 2010-2020

DEPARTMENT OF HEALTH
Republic of the Philippines

Toward Financial Risk Protection: Health Care Financing Strategy of the Philippines 2010-2010

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FOREWORD

The Department of Health has identified equitable health care financing as one of the three health system goals to be pursued to guarantee equitable, sustainable, and quality health care to all Filipinos. Initiatives for reforming the health financing in the Philippines have been undertaken to secure higher, better, and sustainable financing for health. Initial gains have been achieved through increasing government budget for health, improving efficiency in its utilization and improvements in social health insurance in terms of expanding membership base especially among the poor, increasing benefits and expanding the accredited providers. However, major challenges remain to be addressed in order to provide financial risk protection for the population, including among others, underspending in health, inequitable health financing, inappropriate incentive measures for providers, and fragmentation of health financing.

Cognizant of these challenges, the Department of Health, with support from its partners, has developed the Health Care Financing Strategy 2010-2020 that will provide the roadmap towards attaining the strategic goals of increasing overall level of health spending, promoting universal coverage, improving allocative efficiency, and promoting technical efficiency.

The Department of Health together with the Philippine Health Insurance Corporation, along with Local Government Units, development partners, and other stakeholders in health shall endeavor to implement the health financing reforms articulated in this Strategy paper so that all Filipinos can access health services without becoming impoverished by it.

Francisco T. Duque III, MD, MSc
Former Secretary of Health
Civil Service Commission

Health care financing has long been recognized as a key component of our country's health sector reform efforts. This publication is the first attempt to craft a strategy that focuses on health care financing over a ten year timeframe.

The 2010-2020 Health Care Financing Strategy of the Philippines has one, clear direction: to safeguard all Filipinos from the financial risk of poor health. It is a strategy that has been developed by the two major actors in health care financing of our country: the Department of Health and the Philippine Health Insurance Corporation. They did not develop it alone. Over the past three years, consultations have been held with other health stakeholders from local government units to health care providers to civil society.

Harnessing ideas into a collective, coherent strategy for health care financing contained in this publication was a giant step. The next giant step is equally daunting. It calls for all stakeholders to support and engage in the successful implementation of the strategy.

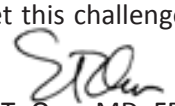
Let me offer this challenge to everyone because only when we take it up can we finally achieve.

Esperanza I. Cabral, MD
Former Secretary of Health

The 2010-2020 Health Care Financing Strategy of the Philippines: Toward Financial Risk Protection is the blueprint for meeting the challenge posed to us by President Benigno Aquino III of *"serbisyong pangkalusugan sa tulong ng PhilHealth para sa lahat sa loob ng tatlong taon*." This challenge is one of the five marching orders of the President to the health sector.

This document presents the key steps for meeting specifically the challenge of Universal Health Care. Stronger mechanisms must be set in place to mandate and compel everyone to enroll in the National Health Insurance Program. PhilHealth members must know their entitlements and responsibilities. Accredited facilities and providers must understand their roles and obligations. Quality health care should be provided at the point of health service with manageable out-of-pocket expenses. And, in doing all these gigantic tasks, we have to institute the highest level of governance in health in terms of good public financial management and the appropriate administrative infrastructure.

If met, this challenge will provide each Filipino access to quality care and adequate financial protection. I am happy to commit the resources of my office to meet this challenge.



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ABBREVIATIONS AND ACRONYMS

APIS	Annual Poverty Indicator Survey
AVPC	Average value per claim
BHFS	Bureau of Health Facilities and Services
BSP	Bangko Sentral ng Pilipinas
CFO	Commission on Filipinos Overseas
CHD	Center for Health and Development
CO	Capital outlay
DBM	Department of Budget and Management
DILG	Department of the Interior and Local Government
DOF	Department of Finance
DOH	Department of Health
DRG	Diagnosis-related group
DSWD	Department of Social Welfare and Development
EU	European Union
EHP	Essential health package
EXECOM	Executive Committee
FAPs	Foreign-assisted programs
FFS	Fee-for-service
FIES	Family Income and Expenditure Survey
GDP	Gross domestic product
GNP	Gross national product
GOP	Government of the Philippines
GSIS	Government Service Insurance System
HCF	Health care financing
HMO	Health maintenance organization
HPDPB	Health Policy Development and Planning Bureau
HSEF	Health Sector Expenditure Framework
HSPSP	Health Sector Policy Support Program
HSRA	Health Sector Reform Agenda
IMF	International Monetary Fund
IP	Indigenous people
IPP	Individually paying program

IS	Information systems
LFS	Labor Force Survey
LGC	Local Government Code
LGU	Local Government Unit
LHA	Local health accounts
LICT	Local Implementation and Coordination Team
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
ME3	Monitoring and evaluation for equity and effectiveness
MOOE	Maintenance, operating, and other expenses
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NG	National government
NGO	Non-governmental organization
NHA	National health accounts
NHIP	National Health Insurance Program
NOH	National Objectives for Health
NSCB	National Statistics Coordination Bureau
NSO	National Statistics Office
ODA	Official Development Assistance
OFW	Overseas Filipino workers
OOP	Out-of-pocket
OPB	Outpatient benefit
OWP	Overseas Workers Program
PBG	Performance-based grant
PCP	Primary care physician
PH	Public health
PHC	Primary health care
PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial health office
PHP	Philippine peso
PIP	Phased implementation plan
PIPH	Provincewide Investment Plan for Health
PMT	Proxy means test
PNHA	Philippine National Health Accounts
PPM	Provider payment mechanism

PPP	Purchasing power parity
PRO	PhilHealth regional office
PS	Personnel services
RA	Republic Act
RHU	Rural health unit
RICT	Regional Implementation and Coordination Team
RTD	Round table discussion
SDAH	Sectorwide Development Approach to Health
SHI	Social health insurance
SP	Sponsored program
SS	Sentrong Sigla
SSS	Social Security System
SWAP	Sectorwide approach
SWS	Social Weather Stations
TB DOTS	Tuberculosis directly observed treatment short-course
TGE	Total government expenditures
THE	Total health expenditures
TWG	Technical working group
UC	Universal coverage
ULAP	Union of League of Authorities of the Philippines
USAID	United States Agency for International Development
USD	United States dollars
WB	World Bank
WHO	World Health Organization

DEFINITION OF TERMS

Access - Ability to utilize available health services without any significant barriers or obstacles

Allocative efficiency - Method of allocation where resources are distributed among multiple activities within a sector or program in a way that maximizes a specified outcome

Average value per claim - Total reimbursements over total claims

Benefit - Services covered under a health insurance contract or a medical scheme

Capitation - Payment mechanism where a fixed rate, whether per person, family, household, or group, is negotiated with the health care provider who shall be responsible for delivering or arranging for the delivery of health services required by the covered person under the conditions of a health provider contract

Case mix - Relative complexity and intensity of services required to treat patients in a hospital due to diagnosis, disease severity, and patient characteristics

Case-based payment method - Hospital payment method that reimburses hospitals a predetermined fixed rate for each treated case; also called per-case payment

Contract - Agreement between payer(s) and provider(s) which defines in advance the health services to be purchased, their quantity, quality, and price

Co-payment - Fixed peso amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by service provided and by health plan.

Cost containment - Set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Coverage - Coverage of a population for health services often represented in three dimensions: breadth, or the extent of the covered population; depth, or the types of services covered; and height, or the level of cost sharing

Curative care - Personal health care or hospital-based services

Diagnosis-related group - Classification of hospital case types into groups that are clinically similar and are expected to have similar hospital resource use. The groupings are based on diagnoses and also on procedures, age, sex, and presence of complications or comorbidities.

Efficiency - Use of energy, time, and money to produce maximal outputs. It involves dimensions of technical efficiency (generating a specific output at least cost) and allocative efficiency (selecting the right mix or set of outputs to get the best results out of resources).

Essential health package - Minimum set of health care services recommended for the intended beneficiary

Fee-for-service - Traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Financial protection - Ultimate effect of health financing schemes that eliminate or greatly reduce the amounts patients must pay out of pocket

Fiscal autonomy for health facility - Capacity to manage and keep the funds allocated to/ generated by health facilities

Fiscal impact - Burden that different groups (national and local government, social health insurance, individual, and other private groups) must pay to finance health system costs. It is closely linked to financial risk protection and is a function of how key groups contribute to financing a specific health product or service.

Health equity - Defined alternatively as equal health status for different income groups, equal access to care, equal payment for health care, equal uptake of public subsidy, etc.

Incentive - Economic signal that directs individuals or organizations (economic entities) toward self-interested behavior

Indigent - Person who has no visible means of income, or whose income is insufficient for the subsistence of his family

Inpatient support value - Reimbursement over total hospitalization cost

Local economic enterprise - Restructuring of LGU hospitals into a corporate setup as embodied in the 1991 Local Government Code

Means test - Protocol administered to determine the ability of individuals or households to pay varying levels of contributions to the National Health Insurance Program, ranging from the indigent in the community, whose contributions should be totally subsidized by government, to those who can afford to subsidize part but not all of the required contributions for the program

National Health Insurance Program - Compulsory health insurance program of the government as established in the National Health Insurance Act of 1995 (RA No. 7875), which shall provide universal health insurance coverage and ensure affordable, acceptable, available, and accessible health care services for all Filipinos

Out-of-pocket payment - Amount that a family is required to pay for health care. This could arise because the family has no social health insurance cover or has to pay user fees in public facilities. Even if the family has health insurance, OOP could arise as a result of co-payments, deductibles, or benefit limits or exclusions, or from the use of medical savings account which individualize family health expenditure.

Performance-based grant - Transfer of resources, normally from government or development agencies, linked to achievement of performance targets

Persistency rate - Active members of current year over active members of previous year

Provider payment mechanism - Method used to transfer resources from the payers of health care services to the providers

Proxy means test - Statistical formula used to approximate income to determine the poor, using socioeconomic variables that would predict household income and allow for objective ranking, classification, and prioritization of poor households

Public health services - Science and practice of protecting and improving the health of a community, as by preventive medicines, health education, control of communicable diseases, application of sanitary measure, and monitoring of environmental hazards

Quality - Compliance of goods and services with a prescribed standard. The standard may involve dimensions of quantity (number), structure (facility, equipment, supplies, or drugs used), or processes (skill or practice, "decision making"). Compliance with quality standards result in improved health outcomes, financial risk protection when such quality standards are linked to payment of benefit packages, and client satisfaction.

Risk pooling - Pooling health risks among young, healthy people, and older and more illness-prone people in an insurance scheme in order to lower the average financial risk to the insurer

Technical efficiency - Proper allocation of services such that waste and unnecessary use of medical services are minimized

Total health expenditure - Total amount of financial resources spent on health related issues, regardless of source or agent

Universal coverage - Means providing all citizens with the mechanism to gain financial access to health services through the National Health Insurance Program, which shall provide the entire population with at least a basic minimum package of health insurance benefits

Utilization - Percent of number of claims over beneficiaries per sector

EXECUTIVE SUMMARY

The following critical factors impelled the formulation of the 2010–2020 health care financing (HCF) strategy for the Philippines:

- First, the total health expenditures (THE) in the country remain low and stagnant by international standards, resulting in underinvestment in health and the potential erosion of any gains in health status.
- Second, while the devolution of health services to local government units (LGUs) brought planning and management of public health services closer to the people, it has also unintentionally splintered health services and financing. Thus, the country's health financing system is extremely fragmented, leading to major coordination problems, aggravated by inadequate regulation.
- Third, the system is highly inequitable and provides weak protection to households from the financial consequences of getting sick.
- Fourth, at the facility level, some institutional structures and incentives are inappropriate and inadequate to yield good service performance.

Past reform programs dealt with these problems incrementally and have not dramatically improved the health financing picture. As the country expects to move into the higher ranks of middle-income economies, higher levels of consumption as well as financing of health services are expected.

The urgent need for an integrated HCF strategy is evident, one that will be guided by the following principles:

- **Solidarity in funding health services.** The cross-subsidy function of social health insurance has to be enhanced. Solidarity can only be brought about by the membership of each Filipino in the Philippine Health Insurance Corporation (PhilHealth), from the richest to the poorest.
- **No grey areas.** Responsibilities and roles of every player must be clearly identified, understood, and carried out. The HCF strategy must define who pays for what in terms of type of resources and package of services.
- **Less choice, more protection.** In the Philippines, the higher-income groups are used to choice of services and freedom to choose among providers is perceived as a basic right. However, choice can jeopardize the gatekeeping function, and ultimately the efficiency of a health system. In order to stress the importance of overall system efficiency as a goal, this principle will be applied. Users who use the preferred provider system will enjoy higher protection than those who want to retain the freedom to choose.
- **Protection for the most vulnerable groups.** Equity must be ensured and financial risk protection guaranteed especially for the poor and the marginalized Filipinos who do not have the resources to pay for health services.
- **New rules, more efficient transactions.** Providers who go into contracting arrangements with PhilHealth and government agencies will be paid better and faster.

They will also address the following goals:

- **Resource mobilization.** Increase the overall level of health spending until the THE reaches about 5.0 percent of the gross domestic product (GDP), the norm prescribed by the World Health Organization

(WHO), or until the Philippines catches up with the THE/GDP and per capita THE of neighboring countries.

- **Universal membership.** Strengthen financial protection and achieve equity by sustaining the membership in health insurance among the formal, informal, and indigent populations and by linking premium levels with households' ability to pay.
- **Allocative efficiency.** Improve allocative efficiency by defining an essential package of health services for government budgetary commitment, defining the PhilHealth benefit package that complements the public health package, and clearly delineating who pays for what services.
- **Technical efficiency.** Enhance overall system efficiency by reforming the provider payment system, providing or increasing the autonomy of retained hospitals, managing local government unit (LGU) health facilities as economic enterprises with the authority to retain income, and strengthening the functional local health system through accreditation.

Within the context of the critical factors in Philippine health care financing, the principles to be followed, and the goals to be achieved, the 2010–2020 HCF Strategy: Toward Financial Risk Protection Health Care Financing Strategy proposes five strategies. It should be noted that health financing reform cannot move alone. Other parts of the overall health sector are important to its implementation and therefore have to move alongside it. In the area of human resources, the problems of low-paid staff, migration of health workers, and the use of the maintenance and other operating expenses (MOOE) budget to complement poor salaries have to be addressed. In the area of service delivery, facilities must be given the opportunity to retain income gained from efficient management. Accreditation of nonhospital health facilities must also be fast-tracked. In the area of drugs and technology, the regulation and availability of affordable quality drugs, as well as of medical equipment needed to provide services for the population and designed as part of the PhilHealth benefit packages, require attention. In the area of information systems, financial resources have to be committed to develop systems, especially in PhilHealth as the organization that will carry the burden of health financing initiatives. Finally, in the area of governance, efficient resource allocation within the system can only take place if resources are concentrated instead of fragmented and managed by hundreds of decision makers at different levels of government.

The five strategies follow:

Strategy One
Increase resources for health

2010	2016	2020
THE at 3.3% of GDP	THE at 4.0% of GDP	THE at 5.0% of GDP
Government spending on health at 5.5% of total public spending	Government spending at 6.0% of total public spending	Government spending on health at 7.0% of total public spending
OOP as major financing source for health expenses: 48.0% of THE as of 2005 NHA	OOP spending at 45.0% of THE	Average premium level of PhilHealth to increase by 5 times the 2009 level in real terms PhilHealth as major financing source for health expenses OOP spending at 35.0% of THE

STRATEGY TWO
SUSTAIN MEMBERSHIP IN SOCIAL HEALTH INSURANCE OF ALL FILIPINOS

2010	2016	2020
Formal sector (including casual and contractual): payroll contributions		
OFWs: Fixed premium	OFWs: Premium payment as requirement prior to migration	OFWs: Continuous premium payment
Informal sector: Voluntary	Informal sector: Partial subsidy from LGU with contributions linked to administrative licenses/permits/ documentation	Informal sector: Some on partial subsidy from LGU; others fully paying members
Indigents: Sponsored program as a shared subsidy between LGU and NG	Indigents: Sponsored program fully subsidized by NG	

STRATEGY THREE
ALLOCATE RESOURCES ACCORDING TO MOST APPROPRIATE FINANCING AGENT

2010	2016	2020
PhilHealth: Main payer of personal care		
DOH: Subsidies for salaries and MOOE of retained hospitals, subsidies and distribution of drugs for national priority programs	DOH: Subsidies for salaries of retained hospitals	DOH: Main funder of capital outlay for tertiary hospitals; limited role in public health funding
LGUs: Subsidies for salaries and MOOE of primary and secondary facilities	LGUs: Subsidies for salaries of all primary facilities and some secondary facilities	LGUs: Main funder of capital outlay of primary and secondary facilities and community-focused public health interventions
		PhilHealth: One of the funders of public health interventions through outpatient packages

Strategy Four
Shift to new provider payment mechanisms

2010	2016	2020
Capitation for outpatient benefits for sponsored program beneficiaries		Capitation as a major tool to pay for primary health care services for all Filipinos
Fee-for-service for inpatient care	DRGs for inpatient care	Per-case payment under a case-mix system Benefits to include outpatient drugs
Per-case payment for maternity care package and selected medical and surgical procedures	Per-case payment for case-mix system for preferred providers	

Strategy Five
Secure fiscal autonomy of facilities

2010	2016	2020
DOH-retained hospitals with income retention	DOH budget funding salaries of DOH-retained hospitals' personnel	DOH-retained hospitals fully corporatized and autonomous; not receiving subsidies
LGU health facilities without income retention	Majority of LGU health facilities with income retention	LGU health facilities receiving minimal subsidy
	DOH and LGUs fund capital outlay	DOH and LGUs fund capital outlay

To evaluate the HCF strategy, the Department of Health (DOH) Monitoring and Evaluation for Equity and Effectiveness (ME3) will be used as the framework.

The HCF strategy's final outcome will be measured in terms of improving the financial risk protection of households from sickness as reflected in the overall health status of all Filipinos, financing that is not driven by out-of-pocket (OOP) expenditures, and client satisfaction and responsiveness to the Philippine health care system.

The intermediate outcomes of access, quality, and efficiency directly impact on this final outcome and are embodied in the HCF strategy. The intermediate outcome of access is met through universal membership in PhilHealth that will help to reduce financial barriers. Physical barriers will be addressed by LGU and national government (NG) spending. The intermediate outcome of quality is met through licensure and accreditation standards, current acceptable standards of practice for health service delivery, and provider payment

mechanisms. The intermediate outcome of efficiency, both allocative and technical, involves the allocation of resources to the most appropriate financing agent as well as the organization of public health facilities into economic enterprises that are able to manage their budgetary and extrabudgetary resources so that they become less dependent on budgetary subsidies.

The final outputs of the HCF strategy will have an impact on the four dimensions of health sector reform: financing, governance, service delivery, and regulation. These outputs are: increased resources for health, sustained membership in social health insurance of all Filipinos, allocation of resources according to the most appropriate agent, shift to new provider payment mechanisms, and fiscal autonomy of facilities.

Through the final outcome, intermediate outcomes, and final outputs of the HCF strategy, equity for all Filipinos in health systems will be achieved.

Two time horizons or cycles will be used for the M&E plan for the HCF Strategy of the Philippines: 2010–2016 and 2017–2020. Each cycle will have a phased implementation plan (PIP) that will give more details about the activities to support the strategies. Both plans will undergo continuous review and revisions so that they are always updated to be responsive to any change that may affect the successful implementation of the HCF strategy.

An HCF Oversight Committee involving the DOH and the PhilHealth, with participation from the Union of League of Authorities of the Philippines, representatives from academe and nongovernmental organizations, as well as all other pertinent bureaus, offices, and persons, will be created to take the lead in the implementation and evaluation of the HCF strategy. The Health Policy Development and Planning Bureau (HPDPB) will serve as the secretariat of the committee.

Proper implementation of the HCF strategy requires the engagement of all the stakeholders involved. With the support of the HPDPB, policy forums will be held to introduce and disseminate the strategy to partner agencies and institutions, together with the distribution of pertinent materials. Manuals for specific partners, whose roles are crucial to the HCF strategy and its implementation, monitoring, and evaluation will also be prepared. Said partners include the Centers for Health Development (CHD), the PhilHealth regional offices, the provincial/city/municipality LGUs nationwide, and health care providers.

INTRODUCTION

Work on "Toward Financial Risk Protection: Health Care Financing (HCF) Strategy of the Philippines 2010–2020" was carried out in response to the following factors: First, Article XIII of the 1987 Constitution of the Republic of the Philippines, which clearly states that the State shall adopt an integrated and comprehensive approach to health development and shall endeavor to make essential goods, health, and other social services available to all the people at affordable cost. Second, the achievement of the Millennium Development Goals (MDGs), which require the strengthening of health systems, including health financing, in order to meet and sustain the targeted health outcomes. Third, the recognition of health financing as one of the four pillars of the DOH reforms intended to improve the performance and responsiveness of the Philippine health system to all Filipinos. Fourth, the need for a single, focused, and integrated strategy to address health care financing issues that are at present dealt with in a limited manner in the National Objectives for Health (NOH), the Health Sector Reform Agenda (HSRA), and the *FOUR*mula One Policy Framework.

The HCF strategy paper was prepared by a technical working group (TWG) from the Department of Health and the Philippine Health Insurance Corporation, with technical assistance from the European Union Technical Assistance to the Health Sector Policy Support Program (EU-TA HSPSP) and additional support from the World Health Organization. The paper has benefited from presentations to United States Agency for International Development (USAID) and EU-TA HSPSP consultants, TWG round table discussions, and consultative meetings with other government agencies, local government units, nongovernmental agencies, civil society, and other stakeholders as well as presentations at DOH executive committee and national staff meetings, PhilHealth executive committee, and meetings with National Economic and Development Authority (NEDA) and Department of Budget and Management (DBM). Overall coordination of the work to develop the HCF Strategy was provided by the DOH Health Policy Development and Planning Bureau.

Potential users of the HCF strategy paper are (1) the Department of Health, (2) the Philippine Health Insurance Corporation, (3) the national government, (4) local government units, (5) government agencies involved in health care and health financing, (6) legislators, and (7) other public and private partners in the health sector.

The HCF strategy paper consists of four major sections. The first part presents the rationale of the paper, including the background as well the critical factors that impelled its formulation. The second part enumerates health care financing principles and goals that give shape to the strategy and also examines the possible options to be taken. The third part identifies and discusses the five major health care financing strategies for the Philippine health sector. Finally, the fourth part outlines an implementation and monitoring plan for the HCF strategy, consisting of a monitoring and evaluation framework, indicators and sourcing/collection methodologies, and an implementation plan. The paper also includes a definition of terms, a list of references, and appendices.

I

RATIONALE

BACKGROUND

In developing the health care financing strategy of the Philippines, it is important to remember that health financing reform cannot move alone. Other parts of the overall health sector are important to its implementation and therefore have to move alongside. In the area of human resources, the problems of staff with low salaries, migration of health workers, and the use of MOOE to complement low salaries have to be addressed. In the area of service delivery, facilities must be given the opportunity to retain income gained from efficient management. Accreditation of nonhospital health facilities must also be fast-tracked. In the area of drugs and technology, the regulation and availability of affordable quality drugs, as well as of medical equipment needed to provide services for the population and designed as part of the PhilHealth benefit packages, require attention. In the area of information systems, financial resources have to be committed to develop systems, especially in PhilHealth as the organization that will carry the burden of health financing initiatives. Finally, in the area of governance, efficient resource allocation within the system can only take place if resources are concentrated instead of fragmented and managed by hundreds of decision makers at different levels of government.

Within the Philippine health sector, four critical factors impelled the formulation of this HCF strategy for the Philippines. First, the total health expenditures in the country remain low and stagnant by international standards resulting in underinvestment in health and the potential erosion of any gains in health status. Second, while the devolution of health services to local government units brought planning and management of public health services closer to the people, it has also unintentionally splintered health services and financing. Thus, the country's health financing system is extremely fragmented, leading to major coordination problems, aggravated by inadequate regulation. Third, the system is highly inequitable and provides weak protection to households from the financial consequences of getting sick. Fourth, at the facility level, some institutional structures and incentives are inappropriate and inadequate to yield good service performance.

Past reform programs dealt with these problems incrementally and have not dramatically improved the health financing picture. As the country expects to move into the higher ranks of middle-income economies, higher levels of consumption of health services are expected. The need for an integrated health care financing strategy to address these four critical factors is urgent.

UNDERSPENDING IN HEALTH

In 2005, the Philippines spent only 3.3 percent of its GDP on the health sector while other Southeast Asian countries spent about 4.0–5.0 percent on average (see Table 1). While the percentage-point difference may not look large, it is quite significant in terms of gross expenditures and if one considers that the health sectors of the countries in the region are also underfunded. Indeed, the WHO has recommended globally that countries should spend at least 5.0 percent of their GDP on health. Industrial countries now spend 8–12.0 percent of their total domestic output on health.

Philippine per capita health spending is also significantly lower than its neighbors. In 2005 the average THE per capita was US$199 (in purchasing power parity, or PPP), compared to almost US$300 in nearby Asian countries (see Table 1). Government expenditures on health as a percentage of total government spending were 5.5 percent, slightly below the regional average. Selected macroeconomic indicators of the country are presented in Appendix 1.

TABLE 1.Indicators of Health Expenditures of Selected Southeast Asian Countries, Mid-2000s

Country	THE as % of GDP	GHE as % of TGE	Per capita HE (PPP int. $)	Per capita GHE (PPP int. $)	GDP per capita at PPP in US$ (2008)
Indonesia	2.1	5.1	78.0	36.0	3,990
Malaysia	4.2	7.0	454.0	203.0	14,225
Philippines	3.3	5.5	199.0	73.0	3,539
Thailand	3.5	11.3	323.0	207.0	8,379
Vietnam	6.0	5.1	221.0	57.0	2,774
Average	**3.9**	**6.3**	**299.8**	**111.1**	**6,581**

Sources: WHO and IMF Web sites

Fragmented Health Financing System

Figure 1 depicts the health financing flows in the Philippines according to funding source, financing agent, and health service provider. No indication is given as to the relative size of financial resources; what the figure captures is the fragmentation of the country's financing system. The figure also does not take into account the private sector which constitutes about half of the country's health service providers, causing further fragmentation.

Government health spending is controlled or determined by hundreds of actors (DOH officials, governors, mayors, PhilHealth officials) who have direct control over health resources and different mandates and responsibilities. DOH continues to finance the so-called retained hospitals while LGUs use their internal revenue allocations to operate their own health facilities. Both DOH and LGU health facilities, in turn, receive PhilHealth reimbursements and, sometimes, external support from donors (mostly in kind). In addition, the facilities may or may not have their own fee or other revenue-generating programs. As a result of all these, planning, coordination, and allocation of available resources are highly inefficient. Fragmentation of donor support has also engendered huge transactions costs while awaiting the full implementation of a sectorwide investment program, or a sectorwide approach (SWAP).

The devolution of health services to LGUs was meant to result in a more responsive, as well as more accountable, health system at the local level. However, it has also had the unintended consequence of further splintering service delivery and financing. The Local Government Code of 1991 transferred health services up to the level of provincial and district hospitals to local government units consisting of 81 provinces, 136 cities, and 1,495 municipalities. Devolution resulted in three administrative levels: central DOH in charge of regulation and provision of tertiary care (through retained hospitals), the provincial governments responsible for secondary care (provincial and district hospitals), and the municipal governments in charge of primary care. City governments inherited city health facilities. Some public health activities remained the responsibility of the central level with the support of regional units or Centers for Health Development. Funding, including reimbursements from PhilHealth, was also sourced across all levels.

New challenges have emerged with devolution, in particular the greater need for coordination and

policy monitoring. The DOH, no longer in control of overall planning and resource allocation, has to negotiate with a range of actors to rationalize investments and service delivery, including local government executives with contrary perspectives on health. The splitting of the referral system into local, provincial, and central elements is another major challenge. The current devolved environment with its unclear boundaries, disjointed responsibilities, and fragmented financing can result in unclear accountabilities and substantial administrative workload.

WEAK SOCIAL PROTECTION, EQUITY, AND SOLIDARITY

In general, the health financing system does not provide a safety net for Filipinos from the financial consequences of sickness. Ordinary Filipinos who get sick can easily slide into poverty because of the following reasons:

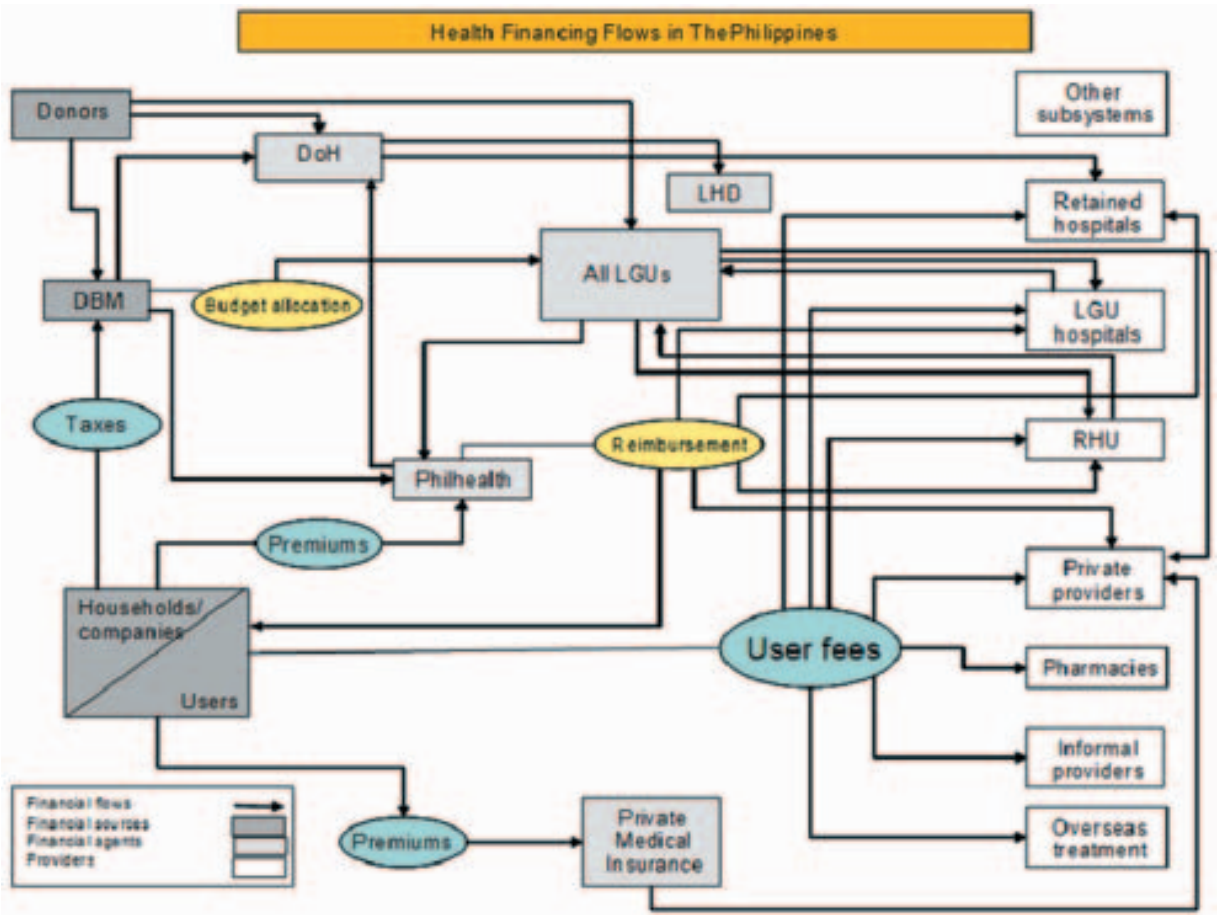
- Prevalence of out-of-pocket health spending. The prevalence of out-of-pocket expenditures as the main source of heath financing points to a serious inequity in the health financing system, since it forces the sick patient's family to cough up the money to pay for care at the point of need, i.e., at the time when they are most vulnerable.
- Limitations of PhilHealth spending for health. These limitations have several dimensions. In terms of membership, PhilHealth mainly covers those employed in the formal sector of the economy. Although inroads have been made in recent years to cover the informal sector workers and those working overseas and provide PhilHealth sponsorship for the poor and the unemployed, sustained universal membership has yet to be achieved. Moreover, membership in the indigent sponsorship program can be irregular and volatile. In terms of support value, PhilHealth reimbursements do not fully cover hospitalization costs since there are no restrictions on balance billing and professional/hospital fees. Reimbursements for outpatient consultations and drugs still have to be set in place, although additional benefits that include outpatient TB DOTS, outpatient care for sponsored program (SP) members, and maternity care are now provided. In terms of contributions, PhilHealth premium levels continue to be regressive since their low ceiling means that those in the upper salary brackets contribute proportionately less than those who earn less.
- Erosion of social solidarity through increasing reliance on voluntary private health insurance. Since PhilHealth cannot provide full insurance coverage, better-off households find it more convenient to enroll in supplemental private health insurance plans while those with little means are left with no choice. If this situation persists, the cross-subsidy function of PhilHealth will not succeed and the promise of social solidarity under this social health insurance program will remain unfulfilled.

INAPPROPRIATE INCENTIVE STRUCTURES

Incentives play a key role in the rational allocation of health services and facilities. Based on the country's present health sector performance, incentives have not played that role well.

First, fragmented decision making jeopardizes the establishment of a health care delivery system based on a long-term facility rationalization plan. Some remote areas have no facilities, restricting access to services. In contrast, other areas have multiple facilities, some of them too big for their catchment population, resulting in underutilization. In fact, LGUs have the freedom and power to make decisions about their health service delivery network with minimal coordination with their neighboring LGUs as well as little regard for the overall national referral system. Moreover, the private sector is guided by market-based motives leading them to where capacity to pay is located, mainly in urban areas.

FIGURE 1
Health Financing Flows in the Philippines



Sources: HPDPB, DOH

Second, supply-side allocations, largely through budgets, do not provide the right incentives for performance, both in terms of quantity and quality. No clear relationship exists between the amount of resources received by public hospitals and their performance. Historical-based budgeting is the main method used to decide how to allocate public money. From the demand side, PhilHealth needs to do more in terms of ensuring adequate health care provision. For instance, PhilHealth reimbursements do not fully encourage cost-effective treatments since the use of generics is not promoted and access to basic services in highly specialized facilities is allowed without referrals from lower levels of health facilities.

Third, the inability to retain income and the lack of fiscal autonomy serve as disincentives since well-managed health facilities do not benefit from possible income gains and earnings.

Marginal Impact of Past Reforms

Past reform programs have dealt with health financing problems incrementally and have not dramatically improved the health financing picture. The current HCF Strategy embodies the principles set in the Health Sector Reform Agenda, echoed in the National Objectives for Health, and restated in the current DOH's *FOUR*mula One framework. Appendix 2 summarizes the goals defined in these documents related to health care financing issues. Appendix 3 highlights government health spending objectives in the NOH, while Appendix 4 presents those of PhilHealth.

The government spending objectives in the NOH indicate mixed progress. Based on the 2005 Philippine National Health Accounts (PNHA), overall resource mobilization goal will be achieved. However, money has not been substantially focused on public health interventions when measured as a percentage of total health spending. The performance-based financing strategy initiated by the DOH in 2005 has yet to be implemented. Also, out-of-pocket spending as a percentage of the THE remains high, mostly to the disadvantage of the poor and vulnerable groups in the country.

The PhilHealth objectives in the NOH also show mixed progress. Equity and financial protection indicators will most likely not be met. PhilHealth enrollment of the poorest households has not been sustained during the period of 2005–2010, despite two years of high enrollment in 2004 and 2006. Also, deficient targeting tools might have led to nonpoor households that are being subsidized, while a big number of poor households have been excluded. The current payment system does not provide enough financial protection to members. Operational issues, such as claims processing, still have to be improved. On the positive side, accreditation indicators show an uptrend and most probably will be met on schedule.

Available data suggest that the current health financing reforms have had limited though positive impact on the major HCF challenges. Out-of-pocket spending represents a hefty and worrisome 48.4 percent of total health expenditures (see Table 2). The share of public spending on the THE has decreased from 41.0 percent to 27.0 percent from 2000 to 2005. Indeed, while PhilHealth spending has increased from 7.0 percent to 11.0 percent over the same period, the increase merely shows that PhilHealth has crowded out and replaced public spending. A comprehensive strategy is needed, one with more visible and effective impact on financial protection, resource mobilization, and allocative and technical efficiency.

TABLE 2. Percent Share of Health Expenditures by Financing Agents, 2000–2005

Financing Agents	**2000**	**2001**	**2002**	**2003**	**2004[1/]**	**2005**
Government	40.6	36.2	31.0	31.1	30.7	28.7
National	21.2	17.1	15.8	15.2	15.7	15.8
Local	19.3	19.1	15.2	15.9	15.0	12.9
Social insurance	7.0	7.9	9.0	9.1	9.6	11.0
PhilHealth	6.8	7.7	8.8	8.6	9.4	10.7
Employees' compensation	0.2	0.2	0.2	0.5	0.3	0.4
Private sources	51.2	54.5	58.6	58.6	58.5	59.1
Out-of-pocket	40.5	43.9	46.8	46.9	46.9	48.4
Private insurance	2.0	2.5	2.9	2.3	2.5	2.4
HMOs	3.8	3.1	3.6	4.7	4.3	3.9
Employer-based plans	3.7	3.9	4.1	3.4	3.6	3.2
Private schools	1.1	1.2	1.3	1.3	1.2	1.2
Others	1.3	1.3	1.4	1.2	1.2	1.2
All sources	100.0	100.0	100.0	100.0	100.0	100.0

[1/] Revised

Sources: NSCB, NHA 2005

II

Health Care Financing Principles, Goals, and Options

In developing the Philippine HCF strategy, the following principles were kept in mind:

- Solidarity in funding health services. The cross-subsidy function of social health insurance has to be enhanced. Solidarity can only be brought about by the membership of each Filipino in PhilHealth, from the richest to the poorest.
- No grey areas. Responsibilities and roles of every player must be clearly identified, understood, and carried out. The HCF strategy must define who pays for what, in terms of type of resources and package of services.
- Less choice, more protection. In the Philippines, the higher-income groups are used to choice of services, and freedom to choose among providers is perceived as a basic right. However, choice can jeopardize the gatekeeping function, and ultimately the efficiency of a health system. In order to stress the importance of overall system efficiency as a goal, this principle will be applied. Users who use the preferred provider system will enjoy higher protection than those who want to retain the freedom to choose.
- Protection for the most vulnerable groups. Equity must be ensured and financial risk protection guaranteed especially for the poor and the marginalized Filipinos who do not have the resources to pay for health services.
- New rules, more efficient transactions. Providers who go into contracting arrangements with PhilHealth and government agencies will be paid better and faster.

Four goals should be met if the challenges of health financing in the Philippines are to be met:

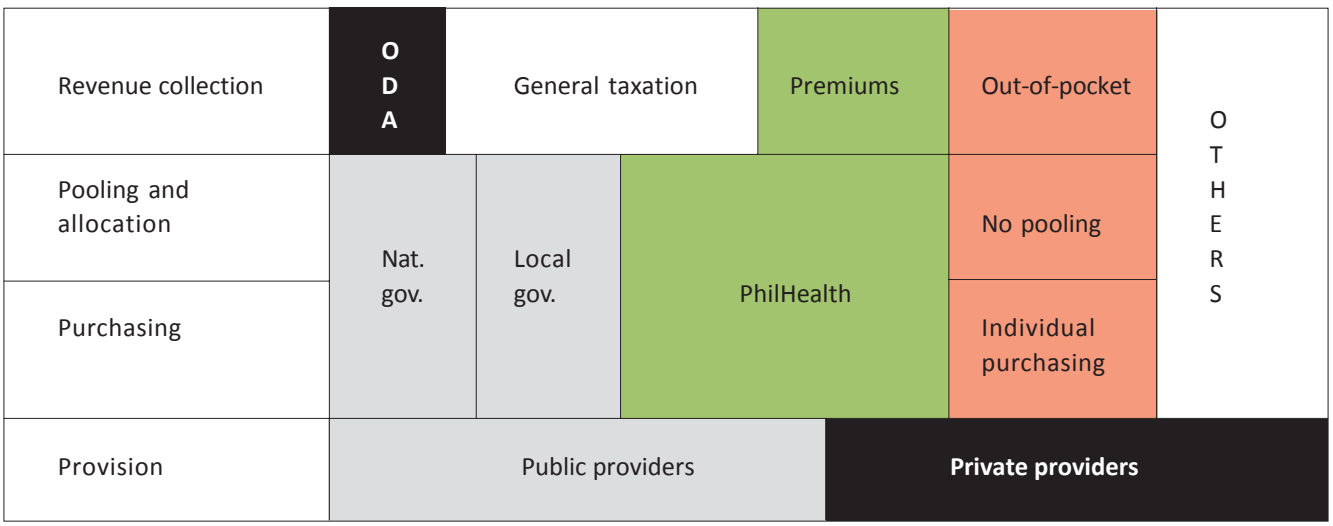
- Resource mobilization. Increase the overall level of health spending until the THE reaches about 5.0 percent of GDP, the norm prescribed by WHO, or until the Philippines catches up with the THE/GDP and the per capita THE of neighboring countries.
- Universal membership. Strengthen financial protection and achieve equity by sustaining the membership in health insurance among the formal, informal, and indigent populations and by linking premium levels with households' ability to pay.
- Allocative efficiency. Improve allocative efficiency by defining an essential package of health services for government budgetary commitment, defining the PhilHealth benefit package that complements the public health package, and clearly delineating who pays for what services.
- Technical efficiency. Enhance overall system efficiency by reforming the provider payment system, providing or increasing the autonomy of retained hospitals, managing LGU health facilities as economic enterprises with the authority to retain income, and strengthening the functional local health system through accreditation.

The interplay of the four goals is best understood with the help of Figure 2, which puts together the various functions, sources, and key players involved in health financing.

Resource Mobilization

According to the WHO regional office recommendation, the Philippine THE should increase to at least 5.0 percent of GDP in 2020 from its current level of 3.3 percent, amounting to an estimated Php 678 billion (at 2008 prices). Since the Philippines is a transitional country in terms of

FIGURE 2
Proposed Restructuring of the Health Financing System in the Philippines
According to the National Objectives for Health



Source: Modified from Figure 5.2, *The World Health Report 2000*

health needs, dealing with both communicable and noncommunicable diseases that require two health system structures, health costs for the country can be expected to escalate.

The small share of government spending relative to GDP, approximately 19.0 percent in 2009, shows the limitation of mobilizing additional resources out of tax-based money. However, the present government allocation for health (estimated at 5.5 percent) is far from its potential. Countries in the region allocated, on average, 6.3 percent of their budget to health in 2005. If the three bottom countries (Pakistan, India, and Myanmar) are removed, the regional average would grow to 8.5 percent. Assuming a fair annual real global budget increase of around 5.0 percent for the next 10 years plus a sustained health allocation of 7.5 percent of the budget to health, the Philippine government could spend around PHP192 billion in 2020 (at 2008 prices) on health, a little more than three times the current figure. Appendix 5 presents the methodology used.

Table 3 presents options that the Philippines can consider for resource mobilization. Setting aside options that do not promote financial protection (i.e., OOP expenditures) or equity (i.e., private health insurance), two options remain. These are tax-based resources and PhilHealth, assessed according to three criteria.

Neither one of the two options can be relied on by itself to generate the additional resources needed; both options have to be used. In the best case scenario, health spending at 5.0 percent of the GDP will remain a target, together with the expansion of social health insurance funds through the increasing membership of Filipinos in PhilHealth. As the number of PhilHealth members increase, so will the financial protection offered by PhilHealth to these members as well as reduction of OOP expenditures for health.

The most important goal is to reduce OOP expenditure from its current size (48.0 percent of the THE) to 35.0 percent in 2020. To reach this target, other funding agents must grow faster than OOP. Considering the limitation of the government budget, extrabudgetary resources from PhilHealth have the greatest potential to supplant OOP with prepaid funds. In order to reach a significant share

of the market (set arbitrarily at one-third of the THE), PhilHealth reimbursement claims should grow at a sustained rate of 20.0 percent per year.

A certain level of the THE will remain as OOP. But much still remains to be done to decrease OOP to this level. In this regard, the following options are recommended:

- Clarify the responsibility for monitoring financial protection and elevating it in the policy agenda. Unclear responsibilities contribute to the poor impact of the policy goal on financial protection. No specific institution is in charge of activities that aim to reduce OOP expenditures; baseline data are not available, while impact evaluation research has not been carried out at all. Existing PhilHealth studies on support value are very aggregative. Moreover, they are based only on PhilHealth claims data and therefore do not take account of patients who did not benefit from PhilHealth and who may have suffered from financial risk of sickness even more. A more robust M&E system is needed to provide timely data to fine-tune the implementation and to adjust relevant policies.
- Increase public spending on health and use a significant part of it for premium payments for the poor. Public spending on health, measured as the proportion of total government spending going to the health sector, should grow from the current 5.5 percent to 7.0 percent. Assuming an expansion of government spending of around 5.0 percent during the next 11 years, between PHP180 billion and PHP190 billion will be available for health. Approximately half of this amount should be allocated to PhilHealth through premium payments for the poorest and partial subsidy schemes for those in the informal economy sector. The other half (PHP80 billion) will fund DOH nonservice delivery functions (policy setting, regulation, etc.) and the remaining operation of public facilities.
- Increase premium levels. To ensure that the above projections are feasible, the average premium value should be increased by five times the current level in real terms by 2020.

Universal Membership

Overall improvement in membership management to achieve universal coverage requires both political will and administrative improvement. The advantages of having all Filipinos enrolled in PhilHealth are compelling. Universal membership makes available far more financial resources for the single payer, strengthening PhilHealth's purchasing power in price negotiations with private providers. It makes cross-subsidization a reality, allowing PhilHealth to become a social safety net for risk of illness, especially catastrophic care. It makes PhilHealth more financially robust, able to cope with the vagaries of illness patterns of its members. Finally, it also favors more homogeneous implementation arrangements and can reduce the present fragmentation among providers of basically the same services.

Official PhilHealth reports state that 86.0 percent of all Filipinos in 2009 had health insurance. The coverage rate is derived using the average family size estimates from the census and other official data sources and disaggregated these by region and type of member. On the average, a family consists of 4.5 persons. The fact, however, is that some families may have more than one PhilHealth member. Thus, the estimation may need further refinement to arrive at a more accurate membership rate.

Sustaining universal membership is not solely the charge of PhilHealth. It requires that all stakeholders be involved, including the national and local governments, central government departments, and nongovernmental organizations (NGOs).

- Membership of the formal sector. The assistance of the Department of Labor and Employment, especially its labor inspection arm, is critical to get all enterprises to abide with Philippine social legislation regarding mandatory pension and health insurance enrollment of workers. Some employers in the formal sector deliberately employ their labor force on a "casual" basis in order to avoid paying for their

TABLE 3. Options for Resource Mobilization

Criteria	Tax-based Resources	PhilHealth
Potential for resource mobilization	The share of government spending in GDP is currently small. In 2020, the government could mobilize between PhP180 and PhP190 billion for health, equal to 7.0 percent of its total spending.	In 2020, PhilHealth could generate PhP160 billion from premiums if more informal economy workers and OFWs become members and if 60.0 percent of all formal economy workers plus OFWs earn a monthly average salary of PhP25,000, out of which 3.0 percent is contributed to PhilHealth.
Equity in raising revenues	The equity of raising resources through taxation depends on the overall fairness of the tax system of the government. Normally, taxation is an equitable way of raising revenues.	The fairness of the system will depend on the capacity of the PhilHealth to set and implement different premium levels according to the member's ability to pay. The PhilHealth has succeeded in achieving equity in raising revenues to some extent; the informal sector continues to be a challenge.
Potential political support (feasibility)	The health sector faces competition from other sectors for budget allocation and may find it difficult to secure an additional 2.0 percent of the total budget. Also, the government's ability to allocate more resources will be limited by its debt service.	Setting premium PhilHealth levels is carried out through policy changes supported by research studies.

PhilHealth premiums. Payment of the correct premium levels using their employees' actual salaries should also be ensured.

- Membership of the informal sector through the individually paying program (IPP). Local governments and local business coalitions can help in enlisting informal sector enterprises and workers in PhilHealth. The subsidy program, now limited to the indigent and unemployed, may have to be expanded to include the poorest informal sector workers. Their membership may have to be supported by a hybrid of premium and tax-based enrollment payment.
- Membership of indigents through the indigent sponsorship program. To ensure program sustainability, different options should be explored. At present, the program is shouldered by LGUs (provincial governor, municipal mayor, or barangay official) or congressmen. However, this arrangement has resulted in a number of problems: the selection process becomes politicized, membership is usually coterminous with the term of the political official, and there is no uniform and robust set of selection criteria for indigents that can be applied nationwide. The assistance of the Department of Social Welfare and Development and LGUs is critical to identify all poor and socioeconomically marginalized populations through the proxy means test (PMT) and then enlist them in the sponsored program.

The 2007 decrease in the members of the sponsored program, estimated to cover 2 million families, provides an important lesson to policymakers. It is clear that the current counterpart system between LGUs and PhilHealth plus weak enforcement efforts have failed to sustain enrollment numbers, despite the increasing number in LGU-funded

enrollment. A long-term agreement among stakeholders, including national government agencies, should be pursued, making universal membership a priority. Turning over the financing responsibility for indigents from LGUs to the national government is highly recommended but would require amendment of the law.

- Role of other health insurance schemes. PhilHealth's new role as main purchaser should not prevent other actors from participating in the system as financing agents. The strategic thrust is to channel the biggest chunk of public and private spending through PhilHealth. However, due to its limitations on benefits, PhilHealth will not be able to—indeed, should not—cover expenses deemed less essential or nonessential services. The coverage of these services, mainly demanded by the richest segment of the population, should rely on supplemental health insurance or employer health programs within a legal framework that ensures fair competition and quality. Moreover, microinsurance as well as community-based insurance programs should not duplicate the services already provided by PhilHealth.

In exploring the options for allocative efficiency, two questions need to be asked. Both are variations of the basic question: Who pays for what? The first question is: Who should pay for what outputs? Although this is a central question in resource allocation, it has not been addressed in a forthright manner. The existing resource allocation system in the Philippines is based on historical inertia. Throughout the years, multiple sources of financing have evolved, resulting in different loci for resource allocation. With devolution, the situation even became more complex as LGUs themselves became payers of health services and owners of local public health facilities.

The lack of clear principles and criteria has led to the duplication of functions. Health managers manifest various forms of adoptive behavior as they seek to extract as much as they can from potential funding sources, whether these be PhilHealth reimbursements, budget requests, donor funding, user fees, or others. This situation is aggravated in areas where private providers have a substantial presence.

Table 4 explores the issue of who should pay for what outputs. It presents the current and potential role of the three financing agents: PhilHealth, DOH, and LGUs. Clearly, PhilHealth emerges as the strongest contender for becoming the main funder of most services. However, at present, until the time that universal membership is sustained, DOH and LGUs have to continue funding certain outputs. In particular, LGUs should continue their role as payers of primary health and hospital services.

The second question is: Who should pay for what inputs? Table 5 presents the advantages of using the main three financing agents: DOH, PhilHealth, and LGUs. Advantages are given in terms of the tools available to them that will improve input efficiency and result in greater productivity.

Compared to PhilHealth, DOH and LGUs have fewer tools available to them. They have not yet fully implemented the use of performance-based payment schemes, are constrained by salary structures for public sector personnel, and have inadequate information systems. Again, PhilHealth emerges better positioned to introduce purchasing mechanisms that will promote efficiency and productivity.

There are additional factors to look into in the decision on which of the three main financing agents should purchase health services. In exploring their respective strengths and weaknesses, policymakers should look at their (a) capacity to design and manage contracts, (b) capacity to monitor performance and quality through a reliable information system and a sound auditing function, (c) experience with tools that promote efficiency, and (d) capability of getting political support.

- In terms of the capacity to manage contracts, DOH may not have the needed experience because of its mindset as a public institution. For PhilHealth, the experience is also quite limited and is only in terms of the outpatient benefit (OPB) package for LGUs. However, its

countrywide network of offices with experience in claims management will serve it well. LGUs act more as providers rather than purchasers; most of their contracting arrangements are ad hoc.

- In terms of the capacity to monitor performance and quality, DOH has experience in the area of public health-related benchmarks. PhilHealth has financial resources to support an information system while LGUs generally have uncoordinated and fragmented information systems.
- In terms of available tools that promote efficiency, DOH has a performance-based budgeting scheme that is not fully functional. LGUs have not developed any tools to date while PhilHealth's performance incentives are attached to patient behavior and requirements.
- For the fourth requirement of political will, DOH can strengthen its regulatory functions. PhilHealth has a public mandate to fund health services for the entire population while LGU executives are interested to show their support for health services in order to win more constituents' votes.

In summary, PhilHealth is best positioned as the purchaser. Indeed, the purchasing function will naturally gravitate toward PhilHealth as it pools more resources for its social health insurance program. However, LGUs will not be able to reduce

TABLE 4. Who Should Pay for What Outputs?

Outputs	**DOH**	**PhilHealth**	**LGUs**
Public health interventions	DOH, through the CHDs, supports the implementation of vertical programs.	Until universal membership is sustained, this is not feasible since nonmembers will not be able to avail of these interventions.	LGU-owned facilities provide these services.
Universal package of basic primary health care services	DOH has no mandate for this.	Until universal membership is sustained, this is not feasible since nonmembers will not be able to avail of these services.	LGUs pay for and provide this. Their administrative level is closest to service provision.
Hospital services	DOH provides these through its retained hospitals, which are mostly centers of training and excellence but also include district hospitals in Metro Manila.	PhilHealth pays for these services through its inpatient benefit packages.	LGUs pay for and provide lower level hospital services; they do not have resources for higher level services except for some large cities, such as Manila and Makati.
Outpatient drugs	DOH has no mandate to pay for outpatient drugs and no logistic capacity to handle them.	PhilHealth has the potential to implement a single nationwide program and to wield strong negotiation power in purchasing outpatient drugs.	In general, LGUs' negotiation power is too weak to control prices of outpatient drugs.

TABLE 5. Who Should Pay for What Inputs?

Outputs	DOH	PhilHealth	LGUs
Personnel services (salaries)	Salaries are easy to manage because they follow the government scale but they are generally low.	PhilHealth payments for professional fees serve as a strong incentive for increasing supply.	Salaries are easy to manage because they follow the government scale but are generally low.
MOOE	Allocation through current budget mechanism does not provide incentives for performance and also makes it difficult to track health service costs.	PhilHealth is able to support nonsalary recurrent costs through reimbursements.	Capacity to mobilize resources is limited and the budget does not provide enough incentives for providers.
Drugs	DOH has regulatory powers with respect to drug prices.	PhilHealth can address some of the challenges related to drug costs and rational use through a reimbursement package.	In general, purchasing capacity is limited and the power to negotiate is weak but there are instances of good pooling arrangements.
Capital outlay	DOH can perform sector management and see to it that facilities adhere to a long-term vision	This is not related to the provision of determined services and is difficult to justify for PhilHealth.	LGUs have good knowledge about underserved areas.

their role as purchasers until universal membership is sustained and basic services are funded through PhilHealth reimbursements or other mechanisms.

Current transactions between purchasers and providers are based on budget allocations and reimbursement claims. In both cases, there are no performance targets of quantity and quality of services to be delivered. Also, the lack of flexibility in these transactions results in poor services or higher costs shouldered by patients, since they shoulder any excess cost. Alternative payment methods should be explored as strategic options to the prevailing fee-for-service (FFS) system. Through contractual arrangements, these new provider payment mechanisms can explicitly include clauses that ensure better use of resources.

Five criteria are considered to select the best payment methods among budget allocation, per-case payment, and capitation for institutions on the supply side (DOH and LGUs) and on the demand side (PhilHealth). These criteria are: (a) cost containment, (b) efficiency improvements, (c) implementation arrangements, (d) financial protection, and (e) risk sharing.

- In terms of cost containment, budget allocation is effective for DOH and LGUs. For PhilHealth, budget allocation is not a realistic approach until universal membership is sustained. Per-case payment by PhilHealth is currently being implemented but is limited. Capitation is good for cost containment for PhilHealth and makes planning easier. However, services covered by capitation are not adequately monitored.
- In terms of efficiency improvements, performance budgeting is not on track for both DOH and LGUs. Per-case payments will ease claims processing for PhilHealth and decrease transaction costs. Capitation might result in

decreased services by providers unless clearly addressed by contracting arrangements.

- In terms of implementation challenges, the easiest payment method is through budget allocation. DOH and LGUs may not have enough resources for per-case payments; for PhilHealth, the challenge lies in the required information system. Capitation is easy for PhilHealth to plan and implement.
- In terms of financial protection, DOH and LGU budget allocations provide limited subsidy and usually only for public providers. Per-case payments and capitation will depend on the contracting arrangements and some private providers may actually not agree to the arrangements.
- In terms of risk sharing, the contracting arrangement is the deciding factor although the risk is usually shifted from payer to providers for budget allocations, shared between providers and payer for per-case payments, and shifted from insurer to providers for capitation.

The assessment of the payment mechanisms vis-à-vis the five criteria and the three main players suggests that budget allocations should be replaced by a mix of per-case payments and capitation.

TECHNICAL EFFICIENCY

Funding of primary health care services is fragmented. Financing for rural health units (RHUs) come from the LGU budget allocation, the DOH, donor donations, the PhilHealth capitation fund, and some user fees. Varying priorities for health as well as capabilities to mobilize local resources result in inequities in health expenditure across municipalities. Decision making at different levels, and by different entities, on resource allocation results in inefficiency and higher transaction costs. Decentralization may make sense from a service provision perspective; from a financing perspective, it has caused fragmentation and has virtually eliminated cross-subsidies across LGUs, since each LGU is an independent purchasing and spending entity.

Reducing the number of actors and clarifying the scope of their responsibilities can help build a more efficient and fair health system. The involvement of the LGU in both the supply and demand sides of the market should be discontinued or, at least, made clearer. A related and more daunting reform is the ownership and autonomy of facilities and, by extension, the status of public health workers.

The benefits that accrue to advanced provider payment mechanisms depend on the providers' response to the incentives in these mechanisms. For example, capitation works as a cost-containment incentive only if providers receive the capitation funds and can retain any potential savings from efficiency gains. Otherwise, the expected cost containment and performance improvement will not take place. Thus, the importance of giving providers a degree of autonomy with respect to managing resources allocated to or generated by them.

Autonomy for hospitals can take different forms: letting them retain revenues from fees, giving them the power to hire and fire staff, and allowing them to raise funds through borrowing. As the level of autonomy increases, more demanding reforms will be required. A hospital organized as an autonomous, government-owned and controlled corporation will have a separate budget from the DOH (or LGU) and will be governed by an independent board of directors or trustees. In addition, its civil servant employees will cease being part of the civil service and will have to be rehired by the new autonomous hospital. However, autonomy does not negate the administrative role of the DOH or the LGU in the hospital. In fact, these autonomous hospitals will have to be supervised and regulated by them as parent organizations. In some instances, the parent organization may decide that capital outlay of the autonomous hospital will remain under its control. Whatever form hospital autonomy takes, the DOH or LGU must still be able to influence and shape the local health facility network, to make rational investments in underserved areas, and to ensure that hospital operations are always assessed vis-à-vis health outcomes.

To address the challenges posed by health care financing in the Philippines, which range from underspending in health, a fragmented health financing system, weak social protection and inequity, to inappropriate incentive structures for the entire sector as well as for individual facilities, the goals proposed for a responsive HCF strategy are resource mobilization, universal membership in social health insurance, allocative efficiency, and technical efficiency. Various options can be taken to reach these goals. The options for the Philippines are expressed in the five strategies detailed in the following section.

III

HEALTH CARE FINANCING STRATEGY

The key role that PhilHealth plays in the Philippine health care financing strategy was highlighted in the earlier discussions on rationale, health financing principles and goals, and strategic options to take. PhilHealth has the greatest potential in supplanting OOP as a health financing source as it aggressively works on its membership campaigns for the sponsored program, the informal sector, and the overseas Filipino workers (OFWs) while working on increases in premium levels and support values. Compared to the DOH and LGUs, it is better positioned to be the main funder of most services and also has the most tools to introduce purchasing mechanisms that will promote efficiency and productivity. The power to fund and to purchase can only be expected to grow as PhilHealth works toward universal coverage. Already, PhilHealth has initiated capitation and per-case payments that ensure some measure of cost containment, financial protection, risk sharing, and efficiency improvements.

The role to be played by PhilHealth to meet the goals of resource mobilization, universal membership, allocative efficiency, and technical efficiency is further fleshed out in the five strategies that comprise the overall health care financing strategy for the country. This role can only be performed by PhilHealth if legislative changes take place to support, and in fact, mandate it.

STRATEGY ONE: INCREASE RESOURCES FOR HEALTH

The two main sources of increased resources for health are (1) DOH/LGUs and PhilHealth, and (2) OOP. According to the WHO guidelines, Philippine health spending should increase from the current 3.3 percent of GDP to 5.0 percent by 2020. Assuming a strong annual economic growth of 5.0 percent and an average increase in the THE of around 9.0 percent per year, the Philippines should spend about PHP678 billion in 2020, reckoned at constant 2008 prices. This increases to around PHP1.2 trillion when an annual inflation rate of 4.0 percent is assumed. The estimated per capita expenditure in 2020 of PHP5,900 (PHP678 billion/114 million inhabitants), equivalent to US$125 at March 2009 prices, however, is still way below the average for middle-income countries.

The allocation of around 7.0 percent of total government expenditures to health will bring Philippine health spending closer to the regional average. Assuming a sustained budget increase of 5.0 percent per year in the next decade, the amount available for health will be around PHP191 billion at 2008 prices. The PHP35–51 million to be allocated by the national government to PhilHealth can fully cover 5.5 million poor families in 2020, with premiums estimated at PHP4,500–9,000 at 2008 prices. LGU allocation to PhilHealth, amounting to 50.0 percent to 75.0 percent of premium payments, can partially fund 5 million more families. The national and LGU subsidies for indigents can ultimately be sourced from just the national government and will dramatically ease enrollment efforts and reduce transaction costs. The remaining number of families, estimated at 15 million (including OFWs and excluding nonpaying members), are assumed to fully pay their respective premiums.

For OOP's share in total health expenses to be overtaken by DOH/LGUs, and PhilHealth, PhilHealth needs to increase premium levels. Average premium value should increase by five times the current level in real terms by 2020. Simultaneously, PhilHealth's collection rate should grow more vigorously.

In increasing resources for health, the following steps are to serve as guidelines:

TABLE 6. Steps toward Increased Resources for Health

2010	2016	2020
THE at 3.3% of GDP	THE at 4.0% of GDP	THE at 5.0% of GDP
Government spending on health at 5.5% of total public spending	Government spending at 6.0% of total public spending	Government spending on health at 7.0% of total public spending
OOP as major financing source for health expenses: 48.0% of THE as of 2005 NHA	OOP spending at 45.0% of THE	Average premium level of PhilHealth to increase by 5 times the 2009 level in real terms PhilHealth as major financing source for health expenses OOP spending at 35.0% of THE

Strategy Two: Sustain membership in social health insurance of all Filipinos

Table 7 summarizes the steps toward sustained PhilHealth universal membership. From the current situation, the steps to take include expanded membership among OFWs, an enrollment drive within the formal sector to include casual and contractual employees, better coverage for informal sector workers with the poorer within this group partially subsidized by the local government, enrollment and subsidy of the invisible poor or those without any formal documentation, and full subsidy of sponsored program members by the national government. By 2020, on the assumption that every household has at least one member enrolled in PhilHealth, total PhilHealth membership should reach 28.5 million, approximately 10 million more than the present number.

With all Filipinos enrolled in PhilHealth, the full intent of the PhilHealth law will be met. Social solidarity will be achieved as resources are concentrated that foster cross-subsidies from richer to poorer households, from healthier to sicker members, and from younger to older individuals. PhilHealth's pooling function will be supported by public subsidies and premiums. Membership in PhilHealth will remain mandatory but other insurance schemes will be allowed to compete for services that complement the PhilHealth benefit package, whether these be private health insurance, health maintenance organizations, or provincial health insurance initiatives.

TABLE 7. Steps toward Sustained Universal Membership

2010	2016	2020
Formal sector (including casual and contractual): payroll contributions		
OFWs: Fixed premium	OFWs: Premium payment as requirement prior to migration	OFWs: Continuous premium payment
Informal sector: Voluntary	Informal sector: Partial subsidy from LGU with contributions linked to administrative licenses/permits/ documentation	Informal sector: Some on partial subsidy from LGU; others fully paying members
Indigents: Sponsored program as a shared subsidy between LGU and NG		Indigents: Sponsored program fully subsidized by NG

STRATEGY THREE: ALLOCATE RESOURCES ACCORDING TO MOST APPROPRIATE FINANCING AGENT

Working on Strategy Three requires, first, determining what services should be provided and second, clarifying in broad terms who should pay for what services.

Public spending on health should be allocated for services with the greatest impact on health outcomes. The factors that should be considered are population needs, cost-effectiveness, and distribution across all socioeconomic groups. Population needs reflect the epidemiological profile of the country while cost-effectiveness means spending on medical procedures, technologies, and medicines that have proven efficacy. On a broader perspective, cost-effective health spending requires a shift from curative to primary and preventive care interventions. Across all socioeconomic groups, the cost of outpatient drugs is the most inaccessible; public spending for outpatient drugs will ensure access to them by a wider population. Clearer role definitions are needed with respect to who pays for what services, to avoid duplication as well as shortfalls in funding.

As financing agent, the DOH should keep control of capital outlay of retained hospitals in order to enhance capacity and ensure the proper mix of availability of facilities that promote access, quality, and equity. The form of support needed, either in grants or loans, will be decided by each of the retained hospitals.

As financing agent, PhilHealth should be the main payer of personal care, acting as an agent for its members and fully exploiting the power of its purchasing function to improve the cost-effectiveness of service delivery. PhilHealth will fund operations of health facilities, leaving capital expenditures to the DOH and LGUs. A differential between reimbursements paid to private and public facilities might be introduced to reflect the fact that private facilities do not benefit from capital subsidies from government. Because expenditures on outpatient drugs make up a big share of OOP spending, PhilHealth packages covering these are essential for both the financial protection of its members and the rational use of medicines.

As financing agent, LGUs should fund public health interventions in their respective areas until PhilHealth, once its universal membership is sustained, can partially or completely fund them through capitation. Before this point, LGUs should also continue funding the essential health service package. Once universal membership is sustained, resources will shift from paying inputs for facilities to paying PhilHealth premiums. At the final stage of the reform, premiums paid by LGUs will be merged with subsidies from the national government, reducing transaction costs and resulting in administrative ease. At that final stage, PhilHealth also becomes one of the payers of public health interventions and will no longer be limited to its traditional role of paying primarily for inpatient/curative care.

The steps for this strategy are as follows:

TABLE 8. Steps toward Allocation of Resources by Most Appropriate Financing Agent

2010	2016	2020
PhilHealth: Main payer of personal care		
DOH: Subsidies for salaries and MOOE of retained hospitals, subsidies and distribution of drugs for national priority programs	DOH: Subsidies for salaries of retained hospitals	DOH: Main funder of capital outlay for tertiary hospitals; limited role in public health funding
LGUs: Subsidies for salaries and MOOE of primary and secondary facilities	LGUs: Subsidies for salaries of all primary facilities and some secondary facilities	LGUs: Main funder of capital outlay of primary and secondary facilities and community-focused public health interventions
		PhilHealth: One of the funders of public health interventions through outpatient packages

Strategy Four: Shift to new provider payment mechanisms

Table 9 summarizes the steps toward PhilHealth's new provider payment mechanisms. The major strategic shift in the purchasing function is to deemphasize and gradually eliminate fee-for-service payment for the PhilHealth benefit package and to adopt new payment mechanisms that enhance financial protection and cost containment; promote fairer risk sharing among contributors, financing agents, and providers; minimize administrative costs; and promote good quality of care. The new payment mechanisms must also be cognizant of the patients' choice of provider, portability of services, and reliability of the information system.

The table starts off with capitation payments linked to targets and some simple form of case-based payment. By 2014, all preferred providers will be paid per case while fee-for-service mechanisms are retained for nonpreferred providers. By 2020, PhilHealth will use capitation as a major tool to pay for primary health care and per-case payments for inpatient care, and will give benefits to include outpatient drugs. At that point, PhilHealth will be spending PHP162–234 billion.

For all new provider payment mechanisms, PhilHealth will establish formal relations with providers based on contracts with specific details about the quantity and quality of services and payment terms. This strategy requires substantial restructuring in PhilHealth's core processes, introducing computerized payment mechanisms, postaudits, and the culture of meeting targets and setting obligations and rights of parties.

Strategy Five: Secure fiscal autonomy of facilities

Table 10 shows the steps needed to enhance provision of care through changes in facility management and ownership. Pooling resources in PhilHealth implies that current budget allocation to facilities will be channeled to PhilHealth as premium payments. In turn, PhilHealth, through these increased reimbursements, pays for operations of facilities using new payment arrangements that serve as incentives for improved service delivery and performance, as well as cost-effectiveness.

For reimbursements and payment arrangements to truly serve as incentives, the ownership status and management framework of health facilities have to undergo reform as well. For instance, if hospital and clinic managers cannot retain income resulting from efficient management, the positive incentives attached to new paying mechanisms will not be realized.

TABLE 9. Steps toward PhilHealth's New Provider Payment Mechanisms

<table>
<tr><th>2010</th><th>2016</th><th>2020</th></tr>
<tr><td colspan="2">Capitation for outpatient benefits for sponsored program beneficiaries</td><td>Capitation as a major tool to pay for primary health care services for all Filipinos</td></tr>
<tr><td>Fee-for-service for inpatient care</td><td>DRGs for inpatient care</td><td rowspan="2">Per-case payment under a case-mix system

Benefits to include outpatient drugs</td></tr>
<tr><td>Per-case payment for maternity care package and selected medical and surgical procedures</td><td>Per-case payment for case-mix system for preferred providers</td></tr>
<tr><td>PhilHealth spending: PhP22 billion</td><td>PhP40 billion</td><td>PhP162–234 billion</td></tr>
</table>

TABLE 10. Steps toward Securing Fiscal Autonomy of Health Facilities

2010	2016	2020
DOH-retained hospitals with income retention	DOH budget funding salaries of DOH-retained hospitals' personnel	DOH-retained hospitals fully corporatized and autonomous; not receiving subsidies
LGU health facilities without income retention	Majority of LGU health facilities with income retention	LGU health facilities receiving minimal subsidy
	DOH and LGUs fund capital outlay	DOH and LGUs fund capital outlay
GOP spending on supply side: PhP45 billion	PhP60 billion	

Note: Government spending contribution, estimated at current prices, refers to supply-side interventions to pay for hospital upgrades and the regulation function. This is part of the total public spending estimated at 7.0 percent of the total 2020 budget.

From 2010 to 2020, DOH-retained hospitals are expected to undergo the needed changes for full corporatization and fiscal autonomy. By the end of that period, they will no longer receive subsidies. During the same time frame, LGU health facilities will start with income retention and will end with minimal subsidy from their respective local government units. Income earned by both DOH-retained and LGU facilities will fund their recurrent costs (MOOE initially and eventually personnel services, or PS); capital outlay will continue to be funded by DOH and LGU funds. In other words, hospital operations will be funded through the PhilHealth benefit package.

DOH-retained hospitals may become public corporations. Governance can be provided by management boards made up of representatives from provincial government, municipal government, DOH, civil society, and the private sector. Professional managers can be hired to run the hospitals.

LGUs can also corporatize their health facilities within the public domain. They should continue supporting them by enhancing their capacity through regular upgrades. They can maintain ownership in order to ensure that public perspective is present. However, they should guarantee income retention in order to boost efficiency.

IV

Implementation and Monitoring Plan

Monitoring and Evaluation Framework

The existing Department of Health Monitoring and Evaluation for Equity and Effectiveness framework sets the context for the evaluation framework of the HCF strategy. The ME3 system aims to determine whether the government's health reforms are achieving the goals of equity and effectiveness. The ME3 framework defines the performance of any program, project, or activity in terms of a hierarchy of three levels of achievement. At the highest level is the final outcome of financial risk protection as reflected in health status, health care financing, and client satisfaction and responsiveness. Immediately below these are the intermediate outcomes defined in terms of access, quality, and efficiency. The achievement of these intermediate outcomes, in turn, is determined by the completion of major final outputs in the areas of financing, service delivery, regulation, and governance. This hierarchy of performance to be evaluated is summarized in Figure 3.

The HCF strategy's final outcome will be measured in terms of improving the financial risk protection of households from sickness as reflected in the overall health status of all Filipinos, financing that is not OOP-driven, and client satisfaction and responsiveness with the Philippine health care system.

The intermediate outcomes of access, quality, and efficiency directly impact on this final outcome and are embodied in the HCF strategy. The intermediate outcome of access is met through universal membership in PhilHealth that will help to reduce financial barriers. Physical barriers will be addressed by LGU and national government spending. The intermediate outcome of quality is met through licensure and accreditation standards, current acceptable standards of practice for health service delivery, and provider payment mechanisms. The intermediate outcome of efficiency, both allocative and technical, involves the allocation of resources to the most appropriate financing agent as well as the organization of public health facilities into economic enterprises that are

FIGURE 3
Summary of Final Outcome, Intermediate Outcomes, and Final Outputs of HCF Strategy

<table>
<tr><td rowspan="4">E
Q
U
I
T
Y</td><td colspan="3">Health status <<< Financing >>> Client satisfaction and responsiveness

FINAL OUTCOME: Financial risk protection</td></tr>
<tr><td>INTERMEDIATE OUTCOME:
Access</td><td>INTERMEDIATE OUTCOME:
Quality</td><td>INTERMEDIATE OUTCOME:
Efficiency</td></tr>
<tr><td>* Financial access
* Physical access</td><td>* Structural aspects of quality
* Procedural aspects of quality</td><td>* Allocative efficiency
* Technical efficiency</td></tr>
<tr><td colspan="3">Financing, service delivery, regulation, and governance</td></tr>
</table>

able to manage their budgetary and extrabudgetary resources so that they become less dependent on budgetary subsidies.

The final outputs of the HCF strategy will have an impact on the four dimensions of health sector reform: financing, governance, service delivery, and regulation. These are: increased resources for health, sustained membership in social health insurance of all Filipinos, allocation of resources according to most appropriate agent, shift to new provider payment mechanisms, and fiscal autonomy of facilities.

Through the final outcome, intermediate outcomes, and final outputs of the HCF strategy, equity for all Filipinos in health system will be achieved.

MONITORING INDICATORS, DATA SOURCES, AND COLLECTION METHODOLOGIES

The following table presents the proposed indicators for each of the five strategies. The monitoring frame includes only output indicators. Process indicators, including midterm benchmarks, must be defined and included in the DOH, PhilHealth, and LGUs' annual and multiannual plans. Each stakeholder must translate the agreed long-term commitments into operational indicators. HPDPB will provide technical support in the preparation of plans and indicators consistent with the overall HCF strategy.

For each indicator, definitions are given, together with latest available baseline data, data source, collection methodology, and frequency. Targets are also indicated per cycle of implementation: Cycle 1 corresponding to 2010–2016, and Cycle 2 corresponding to 2017–2020. Baseline data range from 2005 to 2016 based on the cycle. Most data can be sourced from the database and official reports of the Department of Health, PhilHealth, and Commission on Filipinos Overseas (CFO), and regular surveys for the Philippine National Health Accounts, National Demographic and Health Survey (NDHS), Local Health Accounts (LHA), Annual Poverty Indicator Survey (APIS), Labor Force Survey (LFS), and Family Income and Expenditure Survey (FIES), although there are others that require surveys and special studies. Whenever needed, special surveys and studies will be commissioned to validate data from secondary sources.

TABLE 11. Indicators, Definitions, Baseline Data, Targets, Data Sources, Collection Methodology, and Frequency
(Philhealth data to be re-estimated based on presidential commitment for Universal Coverage by 2013)

Strategy	Indicator	Definition	Baseline Data (Year)	Target [1]		Data Source	Collection Methodology	Frequency
				Cycle 1 (2010–2016)	Cycle 2 (2017–2020)			
1. Increase resources for health	1. THE as % of GDP	THE ÷ GDP	3.3% (2005)	4.5%	5.0%	PNHA	Desk research	Annual
	2. Government spending on health as % of total government spending	Government spending on health ÷ total government spending	5.5% (2005)	6.0%	7.0%	PNHA	Desk research	Annual
	3. OOP as % of THE	OOP ÷ THE	48.0% (2005)	45.0%	35.0%	PNHA	Desk research	Annual
	4. PhilHealth revenues	Total collections (revenues excluding investment earnings)	26B (2009)	?77B	142B	PhilHealth	Office reports and database	Annual
	5. PhilHealth contribution as % share of family income [2]	PhilHealth family premium payments ÷ family income of upper 70.0%	1.1% for all families (2006)	1.6%	2.0%	PhilHealth, FIES (2004)	Survey/ desk research	Every 3 years
	6. PhilHealth inpatient support value	PhilHealth reimbursement ÷ total hospitalization cost	36.0% (2006)			PhilHealth	Survey	Annual
	7. PhilHealth utilization rate	Number of claims ÷ number of beneficiaries	4.0% (2009)	5.0% across sectors	5.0% across sectors	PhilHealth	Office reports and database	Annual
	8. PhilHealth average value per claim	Total reimbursements ÷ total claims	6,700 (2009)	15,000	25,000	PhilHealth	Office reports and database	Annual
	9. Actively paying members as % of total membership	Actively paying members ÷ total number of members	70.0% (2009)	80.0%	90.0%	PhilHealth	Office reports and database	Annual

[1] Targets are consistent with low scenario in Appendix 5.
[2] Baseline percentage is the result of total claims collection from members (excluding government subsidies) divided by average income of top 70.0 percent of population using FIES data.

Strategy	Indicator	Definition	Baseline Data (Year)	Target		Data Source	Collection Methodology	Frequency
				Cycle 1 (2010–2016)	Cycle 2 (2017–2020)			
2. Sustain membership in SHI of all Filipinos	1. PhilHealth beneficiaries as % of total population	PhilHealth beneficiaries ÷ total population	86.0% (2009)	90.0%	95.0%	PhilHealth	Office reports and database	Monthly
	2. Formal sector employees enrolled in PhilHealth as % of total formal sector employees	Formal sector employees enrolled in PhilHealth ÷ total formal sector employees	15.0% (2009)	60.0%	90.0%	PhilHealth	Office reports and database	Monthly
	3. Informal sector workers enrolled in PhilHealth as % of total informal sector workers	Informal sector workers enrolled in PhilHealth ÷ total informal sector workers	31.0% (2008)	65.0%	85.0%	PhilHealth, LFS	Office reports and database Desk research	Monthly
	4. Indigent families enrolled in PhilHealth SP as % of total number of poor families	Indigent families enrolled in PhilHealth SP ÷ total number of poor families	94.0% (2009)	100.0%	100.0%	PhilHealth, Informal Sector Survey	Office reports and database	Monthly
	5. OFWs enrolled in PhilHealth OWP as % of total number of OFWs	OFWs enrolled in PhilHealth OWP ÷ total number of OFWs	49.0% (2009)	69.0%	78.0%	PhilHealth, NSCB	Office reports and database	Monthly
	6. Consistent persistency rates	Active members of current year ÷ active members of previous year		100.0%	100.0%	PhilHealth, CFO	Office reports and database	Annual

Strategy	Indicator	Definition	Baseline Data (Year)	Target		Data Source	Collection Methodology	Frequency
				Cycle 1 (2010–2016)	Cycle 2 (2017–2020)			
3. Allocate resources according to most appropriate agent	1. LGU spending as % of THE	LGU spending ÷ THE	13.0% (2005)	11.0%	10.0%	PhilHealth	Desk research Study	Annual
	2. LGU spending for public health	LGU spending on public health as defined in PNHA ALL is at constant 2006 prices	PhP10.8B, or 46.0% (2005)	PhP29B, or 55.0%	PhP42B,[3] or 60.0%	PNHA	Desk research	Annual
	3. LGU spending for curative care	LGU spending for personal care as defined in PNHA ALL is at constant 2006 prices	PhP6B, or 26.0% (2005)	PhP13B, or 25.0%	PhP15B,[4] or 20.0%	PNHA	Desk research	Annual
	4. National spending as % of THE	National spending ÷ THE	16.0% (2005)	10.0%	9.0%	PNHA	Desk research	Annual
	5. National spending for public health	National level spending for public health as defined in PNHA	PhP9.2B,[5] or 32.0% (2005)	PhP10B, or 20.0%	PhP9B, or 15.0%	PNHA	Desk research	Annual
	6. National spending curative care	National level spending for personal care[6] as defined in PNHA	PhP15.4B,[7] or 54.0% (2005)	PhP28B, or 55.0%	PhP36B, or 60.0%	PNHA	Desk research	Annual
	7. PhilHealth spending as % of THE	PhilHealth spending ÷ THE	11.0% (2005)	19.0%	21.0%	PNHA	Desk research	Annual
	8. PhilHealth spending for public health		Less than 4.0% (2009)			PNHA	Desk research	Annual

[3] Sixty percent (60.0 percent) of LGU spending is assumed to be allocated to public health interventions, the rest going to health facilities.
[4] Twenty percent (20.0 percent) is assumed to be used for administrative and others purposes.
[5] This includes Foreign Assisted Programs (FAPs).
[6] Resources are to be allocated to CO and PS, resulting in reduced resources for MOOE.
[7] This includes FAPs.

Strategy	Indicator	Definition	Baseline Data (Year)	Target		Data Source	Collection Methodology	Frequency
				Cycle 1 (2010–2016)	Cycle 2 (2017–2020)			
	9. PhilHealth reimbursements as % of total budget of public hospitals	PhilHealth reimbursements ÷ total budget of public hospitals				PhilHealth reports	Desk research	Annual
	10. DOH budget as % of total budget of retained hospitals	DOH budget ÷ total budget of retained hospitals				DOH-BHFS	Study of hospital annual reports submitted to DOH	Annual
	11. LGU budget as % of total budget of LGU hospitals	LGU budget ÷ total budget of LGU hospitals	40.0% (2006)	35.0%	30.0%	DOH LHA[8]	Study of hospital annual reports submitted to DOH	Annual
	12. Primary care facilities budget as % of total public spending for health	Primary care facilities budget ÷ total public spending for health	57.0% (2006)	60.0%	65.0%	LHA[9]	Study of hospital annual reports submitted to DOH	Annual
4. Shift to new provider payment mechanisms	1. Benefits paid through capitation as % of total benefits paid by PhilHealth	Benefits paid through capitation ÷ total benefits paid by PhilHealth	2.9% (2009)			PhilHealth	Annual reports Office reports and database	Annual
	2. Accredited facilities paid on per-case or DRG payment by PhilHealth as % of total PhilHealth accredited facilities	Number of accredited facilities paid on per-case or DRG payment by PhilHealth ÷ total number of PhilHealth accredited facilities	2 to 4 (2010)	50.0%	100.0%	PhilHealth	Office reports and database	Annual
	3. PBG spending as % of total DOH budget	PBG spending ÷ total DOH budget				HPDPB		Annual

[8] This is based on LHA of four provinces without retained hospitals (Biliran, Eastern Samar, Negros Oriental, and Capiz).
[9] This is based on LHAs of six provinces (Biliran, Easter Samar, Negros Occidental, Negros Oriental, Iloilo, and Capiz).

Strategy	Indicator	Definition	Baseline Data (Year)	Target		Data Source	Collection Methodology	Frequency
				Cycle 1 (2010–2016)	Cycle 2 (2017–2020)			
5. Secure fiscal autonomy of facilities	1. Retained hospitals with independent Board of Directors as % of total retained hospitals	Number of retained hospitals with independent Board of Directors ÷ total number of retained hospitals				DOH	Study	Annual
	2. % of LGU hospitals with fee (income) retention	Number of LGU hospitals with fee (income) retention ÷ total number of LGU hospitals				DOH	Desk research	Annual
	3. Retained income including PhilHealth reimbursements as % of total MOOE of accredited RHUs	Retained income including PhilHealth reimbursements ÷ total MOOE of accredited RHUs				DOH	Desk research Study	Annual
	4. Retained income including PhilHealth reimbursements as % of total MOOE of all accredited public hospitals	Retained income including PhilHealth reimbursements ÷ total MOOE of all accredited public hospitals				DOH	Study	Annual

IMPLEMENTATION PLAN FOR MONITORING AND EVALUATION

Organization

The Health Care Financing Oversight Committee, to be created by a DOH personnel order, will be chaired by the DOH undersecretary for Sectoral Management and Coordination Cluster and cochaired by the senior vice president of PhilHealth for Health Finance Policy Sector, with the director of the Health Policy Development and Planning Bureau as the alternate chair. The committee's members will come from DOH, PhilHealth, Union of League of Authorities of the Philippines (ULAP), representatives from academe and nongovernmental organizations, as well as all other bureaus, offices, and persons deemed relevant and competent by the DOH-Office of the Secretary. The HPDPB will serve as secretariat of the HCF Oversight Committee.

One of the major functions of the HCF Oversight Committee is to take the lead in the M&E of the HCF strategy and to provide the DOH Executive Committee with updated information accordingly. The Enhanced Philippine National Health Accounts shall be the primary source of information to track the impact of HCF strategy implementation, particularly on the levels of OOP, total health expenditures, and total health spending. The HCF Oversight Committee shall identify and monitor performance indicators that will measure the achievement of the HCF strategy's goals and objectives. In this connection, it will use the data collection mechanisms that have already been institutionalized. Special surveys and studies will also be carried out to generate data that are not routinely collected.

Implementing Arrangements

Proper implementation of the HCF strategy requires the engagement of all the stakeholders involved. Even at the HCF Oversight Committee level, the importance of these stakeholders is underscored by their participation in the committee. With the support of the HPDPB, policy forums will be held to introduce and disseminate the strategy to partner agencies and institutions, together with the distribution of pertinent materials. Manuals for specific partners, whose roles are crucial to the HCF strategy and its implementation, monitoring, and evaluation will also be prepared. These include the Centers for Health Development, the PhilHealth regional offices, and the provincial/city/municipality LGUs nationwide.

Table 12 shows the work to be done at the regional and LGU levels to support the five strategies. Management structures within the region and the LGU, such as the RICT (Regional Implementation and Coordination Team) and LICT (Local Implementation and Coordination Team), will be examined to assess how they can be strengthened and used to generate support.

Implementation Plan and Timeframe

Two time horizons or cycles will be used for the M&E plan for the HCF Strategy of the Philippines, 2010–2016 and 2017–2020. Each cycle will have a phased implementation plan that will give more details about the activities to support the strategies. These plans will undergo continuous review and revisions so that they are always updated to be responsive to any change that may affect the successful implementation of the HCF strategy. Appendix 6 presents an indicative implementation plan for the first cycle.

While the indicative implementation plan identifies activities according to the five strategies, certain crosscutting activities will be undertaken as well. These consist of three types of activities. First, a legislative mapping will be carried out in order to assess which of the strategies are already being addressed by existing and proposed legislation and which strategies may require additional, new legislation, perhaps even an amendment to the original law that created PhilHealth. The mapping will be conducted at both national and local levels. Second, a vigorous information campaign will be mounted to disseminate the strategy throughout the country

TABLE 12. Regional and LGU Support for the HCF Strategy

Strategy	**Regional: DOH CHDs and PhilHealth Regional Offices**	**LGUs**
Increase resources for health	Campaign for accreditation of services Guide PIPH process Maximize claims reimbursements	Increase LGU budget for health (through PIPH counterpart and income retention of facilities Increase LGU subsidy for sponsored program/IPP premiums to cover entire poor population
Sustain membership in social health insurance for all Filipinos	Mount information drive on PhilHealth services Mount information campaign including IEC development and distribution Establish facility-based enrollment system Advocate for IPP enrollment	Promote and sustain membership in PhilHealth of all sectors of the LGU population: formal, informal, sponsored program Increase LGU subsidy for sponsored program/IPP premiums to cover entire poor population
Allocate resources according to most appropriate financing agent	Promote essential health package	Fund essential health package, in particular public health Increase budget for capital outlay of primary and secondary health facilities
Shift to new provider payment mechanisms	Assist LGUs to allocate budget, through the PIPH, that will ensure delivery of the EHP Use PBGs to provide additional resources for poor provinces Negotiate for fast processing of benefit payments Conduct information drive regarding the new provider payment mechanisms	Implement contracts between PhilHealth and LGU-owned primary and secondary facilities using provider payment mechanisms of capitation and per-case payments Allow health facilities to retain income
Secure fiscal autonomy of facilities	Advocate for income retention Work on stricter implementation of the proper use of capitation funds Orient LGUs regarding economic enterprises	Retain ownership of facilities to ensure public perspective Support upgrades, including capital outlay, of primary and secondary facilities Allow health facilities to retain income Transform LGU-owned facilities into economic enterprises

and in so doing, generate the needed support from all stakeholders for its successful implementation. Third, a research agenda will be developed, based on studies already done and studies that are still needed, that can provide evidence-based findings for more informed decisions on how to further refine and hone the health care financing strategy of the country.

APPENDICES

APPENDIX 1

MACROECONOMIC INDICATORS OF THE PHILIPPINES

Indicators	Unit	2005	2006	2007	2008	2009	2010
GDP in current prices	Current billion pesos	5,444	6,031	6,647	7,423	7,669	8,341
GDP in current prices	Current Billion International dollars	98.829	117.534	144.043	167.479	160.991	181.508
GDP per capita	Current Pesos ('000)	63.9	69.3	74.9	82.1	83.2	88.7
Inflation	Percent (%)	6.7	4.3	3.9	8.0	4.4	4.5
Government income	Current million pesos	795.7	882.4	1,136.6	1,202.9	1,123.2	——
Government spending	Current million pesos	963	1,044	1,149	1,271	——	——
Government spending GDP	Percent (%)	17.7	17.3	17.3	17.1	——	——
Exchange rate with USD	Pesos/USD	55.1	51.3	46.1	44.3	47.7	——
Population	Millions	85.3	87.0	88.6	90.5	92.2	94.0

* Underlined figures are projected/estimated.
Sources: BSP, DOF, IMF, NSCB, and NSO Web sites

APPENDIX 2

LINK BETWEEN GOALS OF THE HCF STRATEGY, HCF-RELATED OBJECTIVES OF THE HSRA, NOH, AND *FOUR*MULA ONE FOR HEALTH

Objectives	HSRA 2001	National Objectives for Health 2005–2010	Formula 1 for Health, 2004
Financial protection		Increased coverage of NHIP Increased benefit spending and financial risk protection: - Increased support value - % of claims with zero co-payment Improved allocation of health resources particularly for the poor and vulnerable group	
Equity in funding	Aggressive enrollment of members (SP and IPP)	Improved financial risk protection, particularly through social health insurance Increased coverage of the NHIP Increased benefit spending and financial risk protection Progressiveness of premium contribution	Mobilizing resources from extrabudgetary sources: - User fees for nonpoor - Utilizing assets as "economic rent" - Efficient use of actual resources (technical and allocative efficiency)
Equity in access	Improvement of benefits to make PHIC more attractive	Improved allocation of health resources particularly for the poor and vulnerable group: - Out-of-pocket health spending as percentage of total health expenditures Augmented availability of services: - % of facilities with Sentrong Sigla and/or PhilHealth accreditation - % of facilities offering OPB package	Expanding NHIP: - Benefits - Provider payments - Premiums to increase coverage
Efficiency	Introduction of measures to improve performance	Improved efficiency of health resource utilization: - Established performance-based financing system for hospitals, public health systems, and health regulatory agencies - Established SDAH	Coordinating local and national health spending: - PIPH implementation (one plan with all funds) Focusing direct subsidies to priority programs: - Prioritized programs with performance-based budget Adopting a performance-based financing system: - Revenue-generating institutions to fund themselves and help others
Administrative efficiency	Development of administrative infrastructure that can handle the increased work load	Improved operational efficiency through enhanced internal processes and information systems: - PHIC: % of claims that are fraudulent - PHIC: Increased collection efficiency - Eligibility checking - Customer satisfaction	

Sources: Health Sector Reform Agenda, National Objectives for Health, and *FOUR*mula One for Health Framework, developed by DOH

APPENDIX 3

GOVERNMENT HEALTH SPENDING OBJECTIVES IN THE NOH, 2005–2010

Objective	Indicator	Target	Baseline Data and Source	Likelihood to be Achieved in 2010
Increased mobilization and generation of resources for health	Total health expenditures as percentage of GNP	3.0–4.0 % of GNP	2.9% of GNP (PNHA, 2003)	Yes
	Per capita health expenditures	PhP2,000 per capita health expenditures	PhP1,662 (at current prices) per capita health expenditures (PNHA, 2003)	Yes
	Total government health expenditures as percentage of total health expenditures	50.0% of total health expenditures: 18.0% national 32.0% local	35.0% of total health expenditures: 17.0% national 18% local (PNHA, 2003)	Yes/ No
	Total social health insurance expenditures as percentage of total health expenditures	15.0% of total health expenditures	9.5% of total health expenditures (PNHA, 2003)	No
Increased investments for public health care	Total public health care expenditures as percentage of total health expenditures	20% of total health expenditures: 5.0% national 15% local	12% of total health expenditures: 4.0% national 8.0% local (PNHA, 2003)	No
	Total public health care expenditures as percentage of total government health expenditures	50.0% of total government health expenditures: 20% national 30% local	35.0% of total government health expenditures: 11.0% national 14.0% local (PNHA, 2003)	No

Objective	Indicator	Target	Baseline Data and Source	Likelihood to be Achieved in 2010
Improved efficiency in the utilization of health resources	Established performance-based financing system for hospitals, public health programs, and health regulatory agencies	Institutionalized performance-based financing system	Performance-based financing strategy initiated (DOH, 2005)	No
	Established Sectorwide Development Approach for Health	SDAH system established	SDAH system initiated (DOH, 2005)	Yes
Improved allocation of health resources particularly for the poor and vulnerable group	Out-of-pocket heath spending as percentage of total health expenditures	Reduction of out-of pocket spending to 20% of total health expenditures	45.0% out-of-pocket spending out of total health expenditures (PNHA, 2003)	No, with the current strategy
	Improved financial risk protection particularly through social health insurance	100.0% coverage of health insurance for poor families	70.0% coverage of health insurance for poor families (PhilHealth, 2004)	Yes, but qualitative targeting

Source: National Objectives for Health 2005–2010

APPENDIX 4

PHILHEALTH-RELATED OBJECTIVES IN THE NOH, 2005–2010

Objective	Indicator	Target	Baseline Data and Source	Likelihood to be Achieved in 2010
Improved allocation of health resources particularly for the poor and vulnerable group	Improved financial risk protection particularly through social health insurance	100% of poor have social health insurance Zero co-payment for all sponsored program member claims	100% of poor have social health insurance Zero co-payment for all sponsored program member claims in DOH-retained hospitals (PhilHealth, 2004)	Yes, but no sustained coverage; targeting issues to be fixed.
Increased coverage of the NHIP	% coverage of the total population	85% of total population covered	84% of total population covered (PhilHealth, 2004)	No (at 2008)
	% coverage of indigents out of total eligible indigent sector population*	100% of indigents covered	100% of indigents covered (PhilHealth, 2004)	Yes, but no sustained coverage; targeting issues to be fixed.
	% coverage of informal sector out of total eligible informal sector population	80% of informal sector covered	35% of informal sector covered (PhilHealth, 2004)	No
Increased benefit spending and financial risk protection	Average percentage of benefit support value	80% support value of ward rates	74% support value of ward rates (PhilHealth, 2004)	No
	Percentage of claims with zero co-payment	30% of claims with zero co-payment	20% of claims with zero co-payment for all member types 30% of claims from sponsored program members with zero co-payment (PhilHealth, 2004)	Yes, with changes in PPM
	Progressivity of premium contribution	PhP30,000 salary cap by 2007 for the employed sector Different premium rates for the individually paying program	PhP15,000 salary cap for the employed sector PhP1,200 for all individually paying program members (PhilHealth, 2004)	Yes (salary cap) No, different IPP rates

* Enrollment of indigents to the sponsored program is on an annual basis.

Objective	Indicator	Target	Baseline Data and Source	Likelihood to be Achieved in 2010
	Percentage of accredited health facilities offering outpatient benefit package	Outpatient clinics · Rural Health Units – 80% · Free-Standing Dialysis Clinics – 90% · Maternity Care Clinics – 90% · DOTs Centers – 50% · Private clinics – 50%	Outpatient clinics · Rural Health Units – 731 (31%) · Free-Standing Dialysis Clinics – 18 (66%) · Maternity Care Clinics – 71 · DOTs Centers – 29 (18%) · Private clinics – To be determined (PhilHealth, 2004)	Uncertain
Increased operational efficiency by enhancing internal processes and IS	Collection efficiency	95 % of potential collection Premium contribution posted in 7 calendar days	70% efficiency based on potential collection 94% efficiency based on collection target for year (PhilHealth, 2004)	Uncertain
	Eligibility checking	Processing time for approval of accreditation for health care institutions reduced to 15 days	Processing time for approval of accreditation for health care institutions at 90 days (PhilHealth, 2004)	No
	Customer Satisfaction	80% satisfaction	68% satisfaction, accdg. to the SWS survey (PhilHealth, 2004)	Uncertain
Improved access to safe and quality health products, devices, facilities and services	Percentage of health facilities with Sentrong Sigla and/or PhilHealth accreditation	80% of Rural Health Units and health centers with PhilHealth accreditation	55% of RHUs and health centers with SS/PhilHealth accreditation (PhilHealth, 2004)	Yes
		100% of licensed hospitals with PhilHealth accreditation	89% of licensed hospitals with PhilHealth accreditation (PhilHealth, 2004)	Yes

Source: National Objectives for Health 2005–2010

APPENDIX 5

METHODOLOGY FOR PROJECTING LONG-TERM HEALTH CARE EXPENDITURES FOR THE HCF STRATEGY FORMULATION

by Lluis Vinyals

Long-term projections presented in the HCF strategy were prepared using the following steps:

1. Analyzing the latest officially available Philippines National Health Accounts (2005) by source of resources (left column) and financing agents (top row). See table below (in billion pesos):

	NG	LGU	PhilHealth	HMOs	OOP	Total
National government	13.8		3.0			**16.8**
LGU		23.3	3.0			**26.3**
Donors and loans	12.5					**12.5**
Families/ companies			13.2	21.5	87.5	**122.2**
Total	**26.3**	**23.3**	**19.2**	**21.5**	**87.5**	**177.8**

Note: the 3 billion Pesos difference to 180.7 Billion reported by PNHA 2005 is related to PHIC reserve funds. Reserve funds are resources mobilized but not spent.

2. Preparation of macroeconomic assumptions, based on WHO THE target of 5% of GDP and estimated economic and public spending growth:

Number and Formula	Estimates	2008	2020
1.	Total health expenditure/ Gross Domestic Product (GDP)	3.50%	5.00%
2.	GDP (in billion pesos)	7,423	13,331
3.	GDP growth expected average	5.00%	
4. (2. X (1+CPI)^12	GDP at current price (including estimated inflation)		21,343
5. (2. X 1.)	THE in billion pesos	259.8	667
6. (5. X (1+CPI)^12	At current price, in billion pesos		1,067
7.	Government spending, (budget, in billion Pesos – includes debt services)	1,629 (2009)	2,786
8.	Gov. spending on health in %	4.50%	6.50%
9. (7. X. 8.)	Gov. spending on health, in billion pesos (at constant 2008 prices, no inflation considered)	73	181
10. (9./ Population)	Estimated per capita total health expenditure	3,027	5,639

C. Price Index average for the period: 4%
Average THE increase for the period: 9% (to reach 5% of THE in 2020)

3. Computing growth estimates of each financing agent so that PhilHealth becomes the main health payer and OOPs are reduced while ensuring the feasibility of the options (affordability of premiums). This step is limited to applying the estimated growth rate (see next table) to 2005 data for every financing agent.
4. Adjustment of estimates in two scenarios, consistent with PhilHealth current management projections (low scenario) and more ambitious ones (high scenario) that will make PhilHealth the main health purchaser. This was done in order to accommodate the projections of PhilHealth's Office of the Actuary.

Financing Agent	Average Annual Growth	
	Low Scenario	High Scenario
National government	5%	6%
LGUs	8%	6%
PhilHealth	14%	18%
Out-of-pocket	8%	6%
Private insurance	13%	12%
HMOs	13%	12%
Employer-based plans	13%	12%
Others	5%	5%

The main differences are in the growth rates differential of PhilHealth and OOP expenses. This means that if PhilHealth's share is not growing enough, OOP expenses have to make up for it. Note also that public spending will be almost constant in the two scenarios (as a source of funding). The different growth rates of national government and LGUs parts come about because of their varying roles as financing agents (managers of funds). In the low scenario, a smaller PhilHealth will have less money because both members and the government pay lower premiums. Government will use money from taxes to support the budgets of health facilities.

5. Final result. The following table presents the estimates for the two suggested scenarios.

	2005	2010		2012		2016		2018		2020	
		Low	High	Low	High	Low	High	Low	High	Low	High
National government	28,651	36,567	37,446	40,315	41,678	49,003	51,632	54,026	57,467	59,563	63,963
LGUs	23,271	33,720	30,414	39,113	33,852	52,624	41,936	61,041	46,676	70,803	51,952
PhilHealth	19,899	38,315	45,525	49,794	63,389	84,100	122,898	109,296	171,123	142,041	238,271
Out-of-pocket	87,508	128,685	117,144	150,148	131,641	204,411	166,237	238,505	186,809	278,285	209,926
Private insurance	4,344	8,004	7,656	10,220	9,604	16,664	15,112	21,278	18,956	27,170	23,778
HMOs	7,082	13,048	12,481	16,662	15,656	27,166	24,636	34,689	30,903	44,294	38,765
Employer-based plans	5,755	10,604	10,143	13,540	12,723	22,076	20,020	28,189	25,113	35,995	31,502
Private schools	2,158	2,754	2,754	3,037	3,037	3,691	3,691	4,070	4,070	4,487	4,487
Others	2,102	2,683	2,683	2,958	2,958	3,596	3,596	3,964	3,964	4,371	4,371
Total	180,772	274,381	266,247	325,787	314,538	463,332	449,757	555,057	545,081	667,008	667,014

The total amount corresponds to the THE amounting to 5% of GDP by 2020. The differences are due to the size of each stakeholder.

APPENDIX 6

INDICATIVE IMPLEMENTATION PLAN, 2010-2016

Strategies	Substrategies	Selected Activities	Lead Office(s)
1. Increase resources for health	Increase national and local government spending on health	Conduct legislative mapping	DOH
		Initiate required changes in laws and policy issuances	DOH/PhilHealth
	Expand collection network	Undertake special efforts for informal sector	PhilHealth
	Increase PhilHealth premium levels based on households' capacity to pay	Maximize 3% increase salary cap	PhilHealth
2. Sustain membership in social health insurance of all Filipinos	Provide NG subsidy for SP	Work on full NG subsidy for SP premiums	PhilHealth/DOH
	Segment, expand, and sustain IPP enrollment	Operationalize two-tier system	PhilHealth
		Provide partial LGU subsidy for IPP	PhilHealth
		Estimate number of "invisible" IP	PhilHealth
		Enroll at point of service	PhilHealth
		Secure and allocate NG/LGU funding for prepaid premiums	PhilHealth
	Expand and sustain OFW enrollment in PhilHealth	Continue and strengthen partnership with OWWA	PhilHealth
	Expand and sustain formal sector enrollment to include contractual, casual, temporary, and project-based workers	Conduct pertinent activities with DOLE	PhilHealth
	Enroll the elderly	Link with SSS and GSIS database	PhilHealth
	Engage in marketing activities for all sectors	Develop and implement marketing plans for all sectors	PhilHealth

Strategies	Substrategies	Selected Activities	Lead Office(s)
3. Allocate resources according to most appropriate financing agent	Define essential health package	Identify components of essential health package for RHUs, hospitals, etc. (primary health care)	DOH
		Identify components of complementary package	DOH
	Set NG–LGU subsidy	Identify the services that NG–LGU are subsidizing in their respective hospitals	DOH
		Provide DOH public health funding only for provinces without universal coverage	DOH
		Provide LGU funding for RHU salaries	LGU
	Support capital outlay with DOH/LGU funds	Use DOH funds to provide capital outlay for DOH-retained hospitals	DOH
		Use LGU funds to provide capital outlay for RHUs and their hospitals	LGU
	Shift public health spending from DOH to PhilHealth	Differentiate between community-based and individual-directed public health spending	DOH
		Continue to use DOH funds for community-based public health spending	DOH
		Use PhilHealth funding for individual-directed public health spending	PhilHealth
4. Shift to new provider payment mechanisms	Shift from fee-for-service to mix of per-case payment and capitation	Expand outpatient benefits to other sectors	PhilHealth
		Use capitation for primary health care services	PhilHealth
	Phase out balance billing	Implement cost containment schemes for drugs and medicines	PhilHealth
		Arrange contract with providers	PhilHealth
		Increase support value	PhilHealth

Strategies	Substrategies	Selected Activities	Lead Office(s)
	Arrange contract with providers	Use FFS for inpatient care for nonpreferred providers; and per-case payment for case-mix system for preferred providers	PhilHealth
		Use per-case payment under a case-mix system for all providers	PhilHealth
5. Secure fiscal autonomy of facilities	Fully corporatize and give autonomy to DOH-retained hospitals	Prepare documents and go through process to change organizational structure of hospitals	DOH
		Set up hospital boards	DOH
		Allow hospitals to retain revenues	DOH
		Change sector employment status of hospitals' employees from public to private	DOH
		Provide DOH subsidy for salaries of retained hospitals	DOH
	Fully corporatize and give autonomy to LGU hospitals	Prepare documents and go through process to change organizational structure of hospitals	LGU
		Set up hospital boards	LGU
		Allow hospitals to retain revenues	LGU
		Change sector employment status of hospitals' employees from public to private	LGU
		Provide LGUs subsidy for salaries of their hospitals	LGU
	Allow LGU nonhospital health facilities to retain revenues	Work on needed documents for SB approval	LGU
	Have local health system accredited	Work on accreditation of local health system	PhilHealth

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