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How Should PhilHealth Set the Case Rates? Lessons from A Costing Study

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Based on the Costing Study of Inpatient Benefit Package for Adult and Pediatric UTI, AGE, and Pneumonia
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FINANCING

KEY FINDINGS

✔ Current benefit package rates for the Pediatric and Adult Urinary Tract Infection (UTI), Acute Gastroenteritis (AGE) and Community Acquired Pneumonia (CAP) are insufficient to cover the estimated costs of public and private patients.

✔ Medical management of the top three disease conditions varies because medical practitioners follow different guidelines.

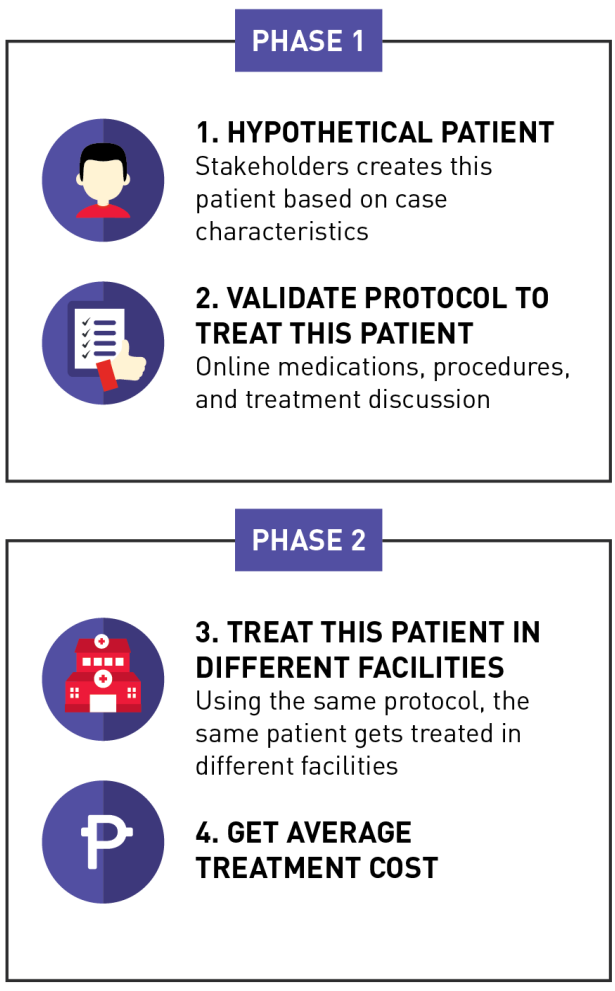
✔ A costing framework that is rapid, practical and scalable demonstrated that private scenario costs were very similar to national average scenario costs. Cost drivers across the scenarios are the diagnostic tests and antibiotic costs.

✔ There are three barriers to undertaking costing exercises:
1) growing reluctance of health facilities to voluntarily participate in the costing exercise,
2) unavailability of encoded data, and
3) unreliable contact information in the PhilHealth facility database.

METHODOLOGY

- A costing survey using the normative approach was developed according to stakeholder-validated clinical practice guidelines to generate the standard cost components required to diagnose and treat the disease.
- The survey was sent to 456 Philhealth-accredited hospital facilities selected through a stratified random sampling of hospitals according to type and level.
- National Average Prices (NAPs) were generated for each treatment input in the master list. Estimated total billing prices were determined, through a cost calculator, from the NAP derived from the facilities.

Figure 1. Summary of the Costing Approach



RESULTS

- The case scenarios were generated through data collected from 117 hospitals (25.7% response rate) over a period of 2 weeks.
- The study provided estimates on true cost of care, i.e. how much an average Filipino patient would spend, using different costing scenarios, with the overall assumption that treatment is in accordance to clinical practice guidelines.

PhilHealth Case Rate (Php)	Case Rate Scenario (Php)	Lowest Cost* (Php)	Highest Cost** (Php)
CAP Moderate Risk 15,000.00	Adult CAP, moderate risk	16,815.88	45,744.78
	Pediatric CAP, type C	16,810.15	37,621.74
CAP High Risk 32,000.00	Adult CAP, high risk, non-ventilated	73,234.30	117,971.57
	Adult CAP, high risk, ventilated	83,652.24	119,661.37
Acute Gastroenteritis 6,000.00	Adult AGE, severe	8,608.40	13,667.07
	Pediatric AGE, some signs of dehydration	5,628.66	15,252.53
	Pediatric AGE, severe signs of dehydration	11,552.39	20,567.67
Urinary Tract Infection 7,500.00	Adult UTI, complicated	9,684.90	70,036.37
	Pediatric UTI, 1st admission	12,519.86	32,424.896
	Pediatric UTI, recurrence	31,546.11	81,623.14

* Lowest cost simulate costing items that are mandatory
** Highest cost simulate costing items that are mandatory and conditional

RECOMMENDATIONS

1. Create a system that will **require institutions to regularly provide** updated costing information specifically to improve accuracy of case rates, and more broadly to support efforts in planning, budgeting, monitoring and evaluation. Additionally, there is value in **mandating electronic medical records** system to facilitate collection of routine data.

2. Ensure **transparency** and **stakeholder participation** in the benefit package development particularly in the rate-setting process. Stakeholders need to be included in reviewing and interpreting costing results at various stages before and during the rate-setting process.

3. Improve case rates design into one that takes into account variations in patient characteristics, i.e. diagnosis-related groupings. Ensure deployment of appropriate **communication strategy** to facilitate understanding by stakeholders of the broader financing system reforms.

Advancing Health through Evidence-Assisted Decisions with Health Policy and Systems Research (AHEAD-HPSR) operationalizes F1+ for Health's commitment to instill a culture of research and strengthen internal analytic capacity in the Department of Health and build health policy systems research capacity within the sector.

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