ADOPTION OF A MIXED REGULATORY MODEL FOR HEALTH FACILITIES

BACKGROUND

Currently, patients can only access benefit packages from PhilHealth-accredited health facilities. Prerequisite to PhilHealth accreditation is a DOH License to Operate or a Certificate of Accreditation. However, this setup may pose challenges to health facility owners, and ultimately, to patients. While this mechanism ensures that only health facilities compliant with safety and quality standards are qualified for reimbursements, the purely prescriptive licensing standards are difficult for some health facilities to comply with. Non-compliant facilities are subsequently not accredited by PhilHealth. This may then limit access to PhilHealth benefit packages.

Hospitals are required to fully comply with all four components of regulation: physical plant, equipment, personnel, and service capability. This is known as the "all-or-none" approach. This is based on the clinical services and ancillary services specified in Section 8 of Republic Act No. 4226, also known as, "Hospital Licensure Act." Ancillary services, such as clinical laboratory, blood service facility, x-ray facility, and pharmacy, are packaged together to complement the level of care of the clinical services. Failure to comply with all the requirements may result in non-issuance of a license to operate or downgrading to next lower hospital classification (Table 1). In addition, some hospital owners perceive that the current classification of hospitals makes it difficult or impossible for them to innovate due to limited flexibility in services.

The regulatory goals of hospitals and other health facilities must align with the health goals of DOH's FOURmula One Plus (F1+) for Health. It should ensure responsiveness of health facilities to the needs of public, help improve better health outcomes by ensuring safety and quality of services, and help ensure financial risk protection by licensing.

Thus, it is imperative that DOH adopt a more responsive regulatory model for hospitals to address the inefficiencies of the current strategy.

TABLE 1. NEW CLASSIFICATION OF GENERAL HOSPITAL

Hospital Service	Level 1	Level 2	Level 3
Clinical Services for In-Patients	Consulting specialists in, but not limited to: Medicine Pediatrics Ob-Gyne Surgery	All of level 1 plus the following:	All of level 1 and Level 2 plus, the following:
		Department Clinical Services	Teaching/training with at least any two (2) accredited residency training program for physicians in any medical/surgical specialty and/or subspecialty
	Emergency and Out-patient Services	Respiratory Unit	Physical Medicine and Rehabilitation Unit
	Isolation Facilities	General ICU	Ambulatory Surgical Clinic
	Surgical/ Maternity Facilities	High Risk Pregnancy Unit	Dialysis Clinic
		NICU	
		Dental Clinic	
Ancillary Services	Secondary Clinical Laboratory	Tertiary Clinical Laboratory	Tertiary Clinical Lab with Histopathology
	Blood Station	Blood Station	Blood Bank
	1st Level X-Ray	2nd Level X-Ray with Mobile Unit	3rd Level X-Ray
	Pharmacy		

*Based on AO No. 2012-0012-A

SHIFT FROM "ALL-OR-NONE" TO FLEXIBLE, RATIONALIZED AND RESPONSIVE REGULATION

Three regulatory models were considered and reviewed for feasibility and alignment with the goals of F1+ for Health.

- **Modified Service Capability Model**

  This model is based on the current strategy in which health facilities are classified and regulated according to capability. Compliance with the minimum standards are still prescribed for licensing.

  The Modified Service Capability Model has the following features:

  1. Shift from "all-or-none" regulation to rationalized licensing. A weighted assessment of licensing requirements is done and a minimum passing score is set.
  2. Shift of some of the "input" licensing requirements to "output or outcome" licensing requirements
  3. Streamlining of licensing requirements
  4. Rationalizing of licensing standards, violations, and sanctions

- **Service Level Allocation Model**

  This is an implementation strategy based on a list of services allocated to different levels of facilities. It categorizes disease conditions based on risk grade. (Figure 1) The higher the risk grade, the higher level of facility it is assigned to. It requires that there is a defined package of clinical services assigned to a particular facility level.

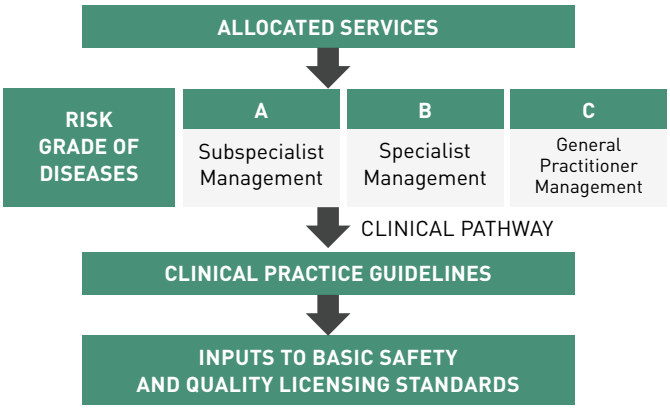

FIGURE 1. SERVICE LEVEL ALLOCATION MODEL

- **Unbundled Services Model**

  In this model, the health facilities will still be regulated according to the four components. (Figure 2) It offers greater flexibility in the kinds of services offered. This can also give rise to arrangements.

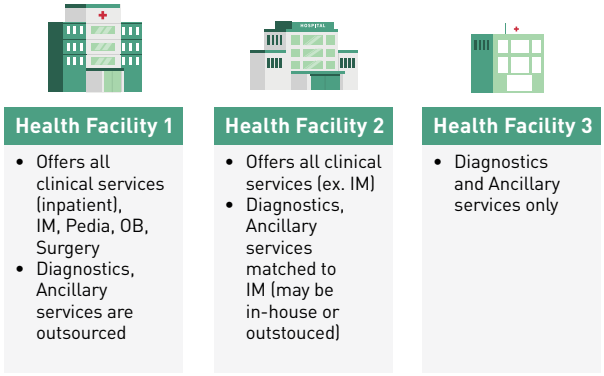

FIGURE 2. UNBUNDLED SERVICES MODEL

To assess these three models, the Health Regulation Team and Health Facilities and Services Regulatory Bureau (HFSRB) conducted a Round Table Discussion with hospital and other health facilities' stakeholders.

- Stakeholders were given a self-administered survey to evaluate the models presented to them using a Likert Scale.

- The criteria used in the survey were designed to evaluate each model according to the goals of F1+ for Health, Healthcare Provider Network, and the goals of regulation of health care.

RESULTS

Based on the inputs of stakeholders, and as verified from the survey, the Modified Service Capability Model was considered the most likely to attain the goals of F1+ for Health and regulatory objectives of health care (94.5% of respondents). (Figure 3)

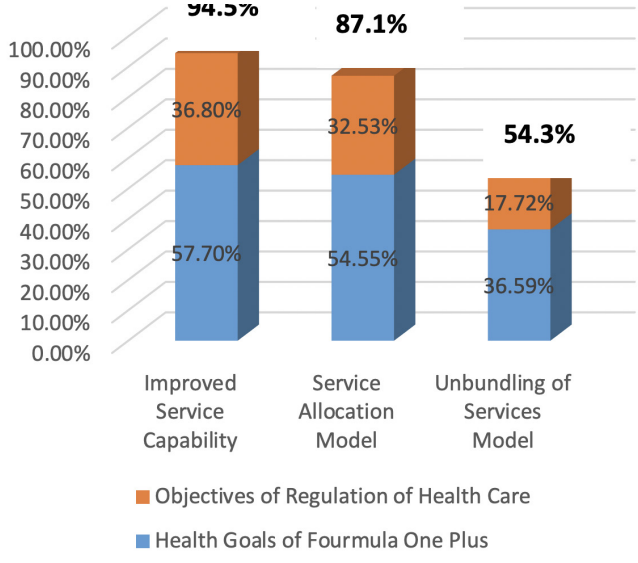

FIGURE 3. RESPONSE OF STAKEHOLDERS ON THE PERCEIVED LIKELIHOOD OF THE REGULATORY MODELS TO ACHIEVE HEALTH GOALS OF F1+ AND OBJECTIVES OF REGULATION OF HEALTH CARE

On the other hand, the Service Level Allocation Model was considered to be the most likely aligned with the model of care of Healthcare Provider Networks (85.81% of respondents).

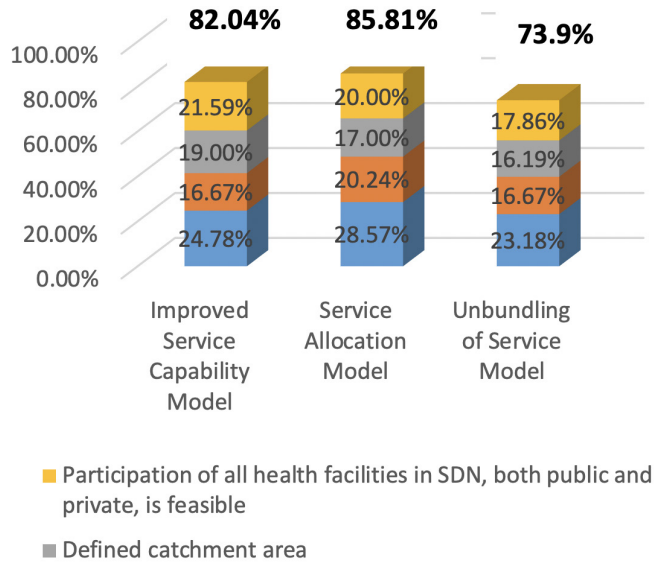

FIGURE 4. RESPONSE OF STAKEHOLDERS ON THE LIKELIHOOD OF THE REGULATORY MODELS TO ACHIEVE MODEL OF CARE OF HEALTHCARE PROVIDER NETWORK

Issues in the Unbundled Services Model were identified by stakeholders regarding its capacity to align with the DOH's health goals in terms of responsiveness and better health outcomes. Since health facilities may select certain services only and may refer ancillary services to other health facilities (ex. diagnostics), concerns were raised on its impact on timeliness of management, credibility and quality of diagnostic results, turn-around time, and handling and ensuring viability of specimens.

RECOMMENDATIONS

1. Consider adoption of a Mixed Regulatory Model for Health Facilities

	Hospital	Specialized inpatient facility and Other Health Facilities* (primary care facility, custodial care facility, and specialized outpatient facility)
Regulatory model	Modified Service Capability Model	Mixed Service Level Allocation and Unbundled Services Model
Advantages	1. Better patient access to services from one health service provider 2. No information asymmetry 3. The health facility can have add-on services 4. Alignment with a legal mandate 5. Improved compliance of hospitals	1. More options/ service providers of specific specialty services 2. May offer lower price point 3. Operational costs can be minimized (outsourced services) 4. They have the flexibility to offer specific clinical services based on their specialty 5. May address HRH issues 6. Licensing requirements are easier to comply 7. Tax revenues from new specialized health facilities

*Based in AO No. 2012-0012

- The unbundling of clinical services and ancillary services cannot be applied to hospitals due to RA 4226. Thus, for the basic framework for the regulation of hospitals it is proposed that the Modified Service Capability Model be utilized.

- For health facilities with selected specialized clinical services and other health facilities (primary care facility, custodial care facility, diagnostic facility, specialized outpatient facility), a mixed model of Service Level Allocation and Unbundled Services is recommended. This mixed model is designed to address the issues in the current strategy being used by DOH in regulating health facilities with selected specialized services by harnessing the best features of the two regulatory models that align with the F1+ goals. It has the potential of providing more flexibility to the health facilities in offering a mix of specialized clinical services. However, the unbundling of ancillary services should be subjected to criteria that ensures safety and quality as well as compliance with clinical practice guidelines. Possible criteria include allocated services, risk grade of diseases, and travel time/distance of health facility to referral diagnostic facility.

2. **Subject the proposed regulatory models to Regulatory Impact Analysis (RIA)**
   This is to ensure that it will truly benefit the patients, and will not cause unnecessary regulatory costs to the hospital owners as well as the government. Based on the RIA recommendations, new regulatory models shall be adopted and there may be possible reclassification of health facilities.

3. **Development of Clinical Practice Guidelines (CPGs)**
   DOH CPGs have to be developed in coordination with specialty societies and other stakeholders. These would be the bases for setting standards for service capability, physical plant, personnel and equipment for each allocated service.

4. **Benchmarking with International Standard Indicators**
   In evaluating licensing indicators for safety and quality, benchmarking with international standard indicators must be conducted. Indicators shall be a mix of inputs and outputs, since there are licensing requirements that are still non-negotiable to ensure safety of heathcare services.

5. **Licensing standards should be weighted depending on risk**
   A scoring system for assessment of compliance needs to be developed. Each licensing standard should be given weighted scores, depending on its risk assessment.

REFERENCES

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The **NHSM BRIEF** is a background document for discussion during the 3rd National Health Sector Meeting prepared by the Health Policy Development and Planning Bureau in collaboration with the Health Regulation Team.

This Brief is written by Dr. Charmaine Ann Rabago and Ms. Steffi Christel Sepe, in consultation with Anne Julienne Genuino & Dr. Anna Melissa Guerrero, edited by Dr. Gloria Nenita Velasco and Dr. Maria Iris Baltazar, and designed by Jake Matthew Kho and Cherie Tan