



# Technical Assistance Consultant's Report

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Project Number: TA-4647 (PHI)  
December 2008

## **Philippines: Developing capacity for contracting of providers by PhilHealth** (Financed by the ADB and GTZ)

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**Asian Development Bank**



## ABBREVIATIONS

ADB	Asian Development Bank
AO	Administrative order
AQAS	Accreditation and Quality Assurance Section
BEmONC	Basic emergency obstetric and newborn care
CABG	Coronary artery bypass graft
CBHCOs	Community-Based Health Care Organizations
CBHCP	Credits for Better Health Care Project
CEmONC	Comprehensive emergency obstetric and newborn care
CEO	Chief Executive Officer
CHD	Centre for Health Development
CIO	Chief Information Officer
CME	Continuing medical education
COMPAS	Comprehensive PhilHealth Accreditation System
CPG	Clinical Practice Guideline
DBP	Development Bank of the Philippines
DOH	Department of Health
DRG	Diagnosis Related Groups
EC	European Commission
ECP	Electronic Claim Processing System
EIS	Executive information system
FFIED	Fact-Finding, Investigation & Enforcement Department
FGDs	Focused group discussions
FM	Financial management
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HMIS	Health management information system
HMO	Health maintenance organization
HTA	Health Technology Assessment
ILHZ	Inter Local Health Zones
IPAS	Integrated PhilHealth Accreditation System
IRR	Implementing Rules and Regulations
ISQua	International Society for Quality in Health Care Inc
ITMD	Information Technology Management Department
KfW	German Development Bank
LGU	Local government unit
MDGs	Millennium development goals
MDR	Member Data Record
MMR	Maternal mortality rate
MOA	Memorandum of agreement
NCR	National Capital Region
NGO	Non-governmental organization
NHA	National health accounts
NHIP	National Health Insurance Program
NOH	National Objectives for Health
OOP	Out-of-pocket payment
PCSO	Philippine Charity Sweepstakes Office

PHA	Philippine Hospital Association
PHIC	Philippine Health Insurance Corporation (PhilHealth)
PIPH	Provincial Investment Plans for Health
PMA	Philippine Medical Association
PMAIS	PhilHealth Member Account Information System
PRC	Professional Regulation Commission
PREMIS	PhilHealth Re-engineered Membership Information System
PRO	PhilHealth Regional Office
RTH	Return to hospital
SEC	Securities and Exchange Commission
TARS	Treasury Accounts Reconciliation System
TIMS	Treasury Information Management System
TPA	Third party accreditation
UCPS	Unified Claims Processing System
UMID	Unified Member Identification
WB	World Bank
WHO	World Health Organization

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**Acknowledgements**

The Consultants would like to thank Dr. Madeleine Valera, Senior Vice President PhilHealth, her team and her colleagues for their support during the project.

The consultants would further like to thank Ms. Karima Saleh, PhD, Senior Health Economist Asian Development Bank (ADB), who initiated this TA project as part of ADB's broader support for health sector reform in the Philippines and provided indispensable guidance to the consultants as well as forged the close cooperation with GTZ and other donors. Ms. Saleh was succeeded by Mr. Vincent de Wit, Principal Health Specialist on 14 November, 2008.

The consultants would also like to thank Dr. Michael Adelhardt and Mr. Manolito Novales of the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) for their close cooperation in this technical assistance project by not only offering intellectual sparring partnership and the contracting of national consultants but by also offering office space and logistical support.

Generous and continuous support from remote was provided by Prof. Dennis Streveler for the work on health management information systems (HMIS)

Last but not least, the consultants thank Ms. Dussel Ison of ADB for coordinating meetings and Ms. Florence Morales of GTZ and her team for always being there to help with all the logistics and making the team feel at home at GTZ.

## **I. EXECUTIVE SUMMARY**

### **A. General**

Contracting is nothing new to the Philippines, to the Filipinos or to the Philippine Health Insurance Corporation (PhilHealth or PHIC). Many Filipinos have one or more contracts, with e.g. builders, landlords, employers or banks. They all know the concept: agreeing with the other party on what they want, based on articulated needs; conditions and terms of performance of obligations and even pre-termination of the agreement; demandability of rights; and, in the event of non-performance of an obligation under the contract, remedies for rights violated.

To PhilHealth contracting is known as a Memorandum of Agreement (MOA). It is e.g. used in the Warranties of Accreditation that have to be signed by health care providers that want to be accredited and subsequently get reimbursed for their health services to the members.

So, contracting of health providers means for PhilHealth not more and not less an addition to the current system of accreditation warranties or a replacement of these when going to third party accreditation. It is just a matter of deciding what PhilHealth wants to have the health care providers delivering to their members, how they want to see them operating vis a vis PhilHealth and their members, selecting the providers that PhilHealth trust to deliver good services and who will act financially responsible. Then negotiate the terms of the contract which requires give and take.

PhilHealth will need to be attractive for the providers of health services and offer them incentives. The same is expected of the selected providers. They need to have or do something different or do better than their competitors in order to become and remain attractive for PhilHealth as contract partner.

The recommendation, supported by international evidence and by many international and development agencies, is therefore: just do contracting and learn by doing, i.e. gradually expand and adjust the contracting mechanisms and become more sophisticated over time. Contracting is a great tool to improve services delivery and efficiency. So, it has been an excellent decision of the Corporation to embark on it.

Starting from a thorough analysis of current regulations and practices at PhilHealth and providers and against a background of international experience, it is shown in this report:

- how contracting can be done successfully
- what options PhilHealth has in order to gradually develop such contracting system while maintaining accreditation as a condition for a contract
- how the Corporation can get better prepared to deal more effectively and efficiently with providers and members
- what challenges it may face outside of PhilHealth to really make a difference with contracting.

### **1. Relating to Providers**

PhilHealth and providers will need each other as long as health care needs exists and as long as social health insurance is considered an important financing tool for health care to provide citizens access to quality care and to prevent them from impoverishment. This implies therefore a long term relationship between PhilHealth and providers. Such relation, in order to withstand the times, needs to be built on:

- Mutual interests



- Mutual trust
- Consistency
- Continuity
- Transparency and
- Accountability.

The mutual experiences, perceptions and actual behaviour of all three parties, i.e. of the Corporation, providers and members of PhilHealth, matter for the implementation of contracting and for making it effective. These perceptions were explored during focused group discussions and in meetings with umbrella organizations of providers, with providers, with PhilHealth members and PhilHealth staff.

- Members appreciate PhilHealth although they receive relatively little support as compared to their out of pocket payments at the point of service (the provider), which can go up to on average to 40% of the required fee. The membership card is seen as a discount card, raising the question if PhilHealth really is **THE** health care financier in town that services the citizens and pays for most of its health care and who is seen as their champion to guarantee good and timely services in case of need. Or are the citizens on their own to see what they can get and, if they can have to look for money to pay and if they can't have to forego care at all or bankrupt themselves or their families.
- Providers appreciate the reimbursement by PhilHealth but they are not satisfied because of late payments, unexplained deductions and refusals of submitted claims, cumulative policy measures and subsequent AO's and circulars of PhilHealth for which they don't get much explanation and time to implement. An instituted and regular dialogue is missing that would go beyond mutual complaining about claims processing and instead focuses on improvement of services for the members and on improving business support systems and administrative procedures.
- PhilHealth staff notice signs of suboptimal quality care, of lax claims handling and of sometimes defrauding behaviour of the providers while also noticing the tedious procedures both parties have to use to do business. Staff express the need for more training, for better coordination inside PhilHealth and the need for improved business support systems. They expect management to have them, their business processes and support systems well prepared if and when the Corporation moves into a system of contracting.

## **2. Business Processes**

Accreditation, claims handling and review of performance of providers are currently tedious and time consuming procedures of which the effectiveness and efficiency at PhilHealth and providers can be greatly improved by:

- Streamlining procedures at providers and PhilHealth;
- Skipping some of the current administrative requirements (paper attachments to claims);
- Entering into modern provider performance review systems, based on computerized health information and statistics;
- Moving towards integrated and secure computer based business processes in an environment of improved coordination; and
- Leaving as much as possible the direct personal interaction with providers to account managers in the front offices of PhilHealth in the provinces.

### 3. Business Support Systems

PhilHealth is an ambitious organization:

- It wants to become the main health care financier and the main purchaser of health services in the Philippines.
- It wants to get better protection of its members by making its benefits package broader and deeper (i.e. more health services included and less out of pocket payments for the members).
- It wants to enter into new payment systems for its providers, case-based or in a more advanced form, DRG-based.

To realize such ambitions it is absolutely vital for the Corporation to first streamline its business processes and to get its health management information and health informatics systems in order. The corporation cannot even handle today's numbers of claims.

***With expanding numbers of members, expanding benefits and new payment systems, the information systems will collapse and PhilHealth will see its most vital instruments to cease functioning. It will therewith lose its standing, its reputation and credibility vis a vis members, providers, LGU's, DOH and the Government in general.***

The timely implementation of Track 1 (e.g. streamlined procedures, established health data dictionary, eliminated claim attachments) and Track 2 (e.g. N-Claims2 and Supercenters) as described in the reports of Prof. Dennis Streveler is therefore an absolute must.

***Without a Board accepted implementation of these tracks, the Corporation cannot go into effective and efficient contracting.***

This requires the special, focused attention of a relentless Chief Information Officer on SVP level, directly reporting to the President/CEO of PhilHealth with full authority to coordinate and implement the agreed tracks.

### B. The Way Forward

Although PhilHealth could enter into a simple paper based small scale pilot of contracting, such approach would not bring the Corporation much closer to more effectively and efficiently dealing with providers and will not create any other incentives for providers other than extra money.

Only PhilHealth' streamlined business processes, the possibility of online communication and data transfer together with web-based checking of eligibility and claims processing will allow for more cost/effective optimal claims handling and fraud detection/protection by PhilHealth and providers as well as to more timely payments to providers and thus become a big incentive for these providers.

However the need to offer additional financial incentives to preferred providers may not be ignored. **Any future increases in reimbursement rates or extension of the benefits package should be reserved for selected good performing providers therewith creating a powerful instrument for effective contracting and improved services delivery.**

Substantial financial incentives will provide an excellent chance to press the providers to not increase their charges to the patients to the currently existing levels, i.e. to get rid of the practice of balance billing, and to stop defrauding the Corporation.

## **1. Stepwise**

PhilHealth will subsequently have to consider the various options provided and make its decisions, highlighted hereafter:

- Define the policy objectives of contracting for PhilHealth e.g. to achieve a supportive framework in which providers are enabled to deliver excellent services to their patients in partnership with PhilHealth.
- Upgrade business processes to allow for effective and efficient contracting
- Upgrade business support systems to allow for necessary business processes to continue and to be able to absorb the new activities like contracting, benefits expansion and new payment systems for providers, i.e. implement the essentials of the agreed steps in Health Management information Systems Track 1 & 2!

Having accomplished the above, continue with practical contracting preparation steps.

### **a. Gradual implementation (or Pilot)**

This is, of course, based on PhilHealth decisions of the aforementioned topics:

1. Have the contracting policy decided
2. Observe that conditions for effective and efficient contracting are met:
  - Streamlined and upgraded HMIS & efficient business process
  - Splitting Accreditation from (extra) Payment
  - New Unit for Contracting or existing one tasked with contracting
  - On HQ and PRO-level: human resources capacity available and prepared via sufficient training
  - Account managers designated
  - Reshape claims & performance review, especially if pilot will be done together with outpatient benefits expansion and/or case-based payment systems
  - Adjusted legal environment, as far as necessary (dependent of contract policy)
  - Social marketing policy and implementation plan defined
  - Training PhilHealth & provider management & staff
  - Funds allocated for internal and external activities
  - Funds allocated for providing financial incentives
3. Have aims of the pilot defined, e.g.:
  - Testing the tools of contracting (the contract itself and the claims processing & provider performance evaluation)
  - Testing the organization & business processing at providers and PhilHealth
  - Testing communication
4. Have indicators of success of pilot defined, baseline data and data collection secured
5. Eventually have comparators defined to show relative improvements in services delivery, member protection (financially), administration effectiveness and efficiency

6. Choose option for contracting:
  - Contracting on top of accreditation (i.e. leaving accreditation as entitlement to current reimbursement levels and create a preferred provider system)
  - Split accreditation from contracting but use accreditation as a condition and have contracting as the sole venue to getting reimbursement from PhilHealth (this is the more radical, more contentious and more difficult to implement variant, which the Corporation may well wish to postpone to a later date)
7. Choose the providers to enter into a contract pilot with
8. Chose for contracting only or in a combination with:
  - Case based payment system introduction
  - Outpatient benefits expansion and capitation based funding
  - All three together.

Consider to start with case-based payment before entering into contracts.

Throughout the Project, the team has closely coordinated with the EC consultants working on the establishment of an improved outpatient benefits package, combined with capitation based payments, and on the establishment of a case based payment system.

9. Determine contract payment and strategy
10. Write specifications
11. Organize tender or hand-pick providers
12. Alert targeted providers/umbrella organizations (PHA/PMA or Midwives associations)
13. Start dialogue with providers and therewith also institutionalize new dialogue structure and process of communication
14. Explain PhilHealth contracting policy
15. Table contract offer and explain
16. Solicit reaction from providers
17. Negotiate contract: terms and conditions, i.e. compromise
18. Sign
19. Provide training to PhilHealth staff and providers
20. Implement
21. Monitor & evaluate
22. Adjust and
23. Decide to roll out, for what category of providers and in what area etc. etc.

## **2. Indicators of Success**

To monitor the success of the contracting system a number of indicators can be formulated, related to health, financial and administrative issues as being the most important aspects of the system.

The Corporation may want to define the indicators. The following are suggestions:

- Health
  - Access:
    - Geographically (physical access), e.g. travel to RHU: 15 minutes; to 2<sup>nd</sup> level hosp. 30 minutes
  - Health status (MMR down to xxx %);
  - Financial protection of members e.g. OOP down 20%

- Financial: benefits package/admin costs rate
- Administrative: e.g. % RTH; admin costs/claim; filing to payment turnaround time reduced to max 14 days

### 3. Legal Aspects

After extensive review of the relevant laws, other regulatory documents and jurisprudence it is concluded that there are no legal obstacles for contracting by the Corporation. But, PhilHealth's Charter (Section 5 of RA 7875) allows it to contract only within the following parameters:

1. to pay for the utilization of health services by covered beneficiaries
2. to purchase health services on behalf of such beneficiaries.

The Corporation cannot:

1. provide health care directly
2. buy and dispense drugs and pharmaceuticals
3. employ physicians and *other* professionals for the purpose of directly rendering health care
4. own or invest in health care facilities (however, it can offer higher payments for facilities to compensate for their investment costs)

The main text of the final report and the annexes contain also draft amendments of the current regulation as to provide PhilHealth with more choices to better implement its contracting.

**Sample contract:** Ultimately, a contract is a legal document. A sample or model contract is provided (Annex 5), focusing mainly on hospitals and doctors and which is easy adjustable for other providers and types of services. A main feature of this model is also the inclusion of an arbitration mechanism to help solve disputes in a fair, elegant and timely manner.

### 4. Costs

Contracting as such doesn't have to come at much extra costs. When and if the proposed streamlining of the business processes together with the implementation of Track 1 & 2 of HMIS has taken place and subsequently the third party accreditation and case-base payment have been established, then there will be no influence on staff numbers. There will only be a need for upgrading the knowledge and skills of staff, dealing with contracting and the new business processes. Actual piloting and monitoring of costs will definitively learn if there are any extra costs.

### 5. Co-payments

The current system of out of pocket payments by patients at the point of services has been reviewed and some options to improve it were discussed. In any case, collecting co-payments should be done by the providers. But transparency in collecting and accountability in administration can be improved, especially with an eye on the so-called balance billing by the providers.

### 6. Challenges for Successful Contracting

There are several challenges, PhilHealth will encounter. Many of these challenges are outside the direct influence of PhilHealth. But, PhilHealth in partnership with DOH could ask for attention for these challenges and work to solve them, despite the political and legal aspects that currently may seem to be beyond reach:

a. **Stewardship situation in health care**

- i. **Devolution.** This has caused a fragmented system of management of the system with mixed attention of local governments to the health care system, dependent of their political preferences and the capacity of their administrators. The national government tries to recapture some ground via Centres for Health Development (CHD), the Inter Local Health Zones (ILHZ), via the Fourmula 1 approach, via provincial investment plans for health and via conditional cash transfers. How good these measures per se may be, they are not more than sticking bandages to a fundamentally flawed system.
- ii. **Autonomy** is granted for some of the DOH hospitals, however without any performance agreements and monitoring of these by DOH. On the other hand, LGU hospitals have no autonomy, leaving PhilHealth to eventually contract with the Governor or Mayor and not directly with the hospital management. PhilHealth can therefore expect:

***Political interference** in its contracting process, which will make it difficult for PhilHealth to be selective in its contracting with providers. E.g. can it afford to not contract a public hospital, owned by the municipality, and prefer the provincial one in the same city for concluding a contract because of better quality and services?*

***Lack of enforcement will.** Many regulations exist in the health care system but complaints can be heard everywhere about the lack of enforcement and political interference to make legal actions to stop the implementation.*

b. **Fragmented funding** of health care and consequently fragmentation of care.

Health care is funded from the National Budget, LGU budgets, PhilHealth, HMO's, NGO's and donors while leaving the patients with on average 40% to be paid out of pocket. Such a situation leaves PhilHealth with relative little financial clout vis a vis the providers of health services. Some members perceive the PhilHealth membership card as a "discount card".

Health care providers, funded from different sources and having to serve different politicians may be less inclined to cooperate, enter into a referral system and prevent patients from falling through the cracks.

Fragmentation of funding and fragmentation of care also cause **administration costs** to be higher than necessary: in essence a loss of scarce resources.

c. The **sponsored membership program** for the indigents is lacking continuity because of its election driven character and the need for the indigents to take

over the payment of contribution after a year. The program requires separate administration efforts.

- d. **A private hospital system that goes largely unregulated** in its performance. The mandatory beds in charity wards of private hospitals are a contested issue. Some private providers are not even interested in being accredited by PhilHealth because of the hassle they have to go through and because of the little compensation they receive from PhilHealth.
- e. **Overall lack of resources** for the health care system: 3.5% of GDP, while the WHO advised level for middle income countries is 5%. PhilHealth will have to tap into more resources, especially from the high earning informal sector and increase its premium levels while protecting the poor. The National Health Insurance Program is a mandatory program but universal coverage has not been achieved. To cover up this fact, PhilHealth Board has decided that 100% of the population has to be defined as covering 75 % of the population!
- f. **Capacity at PhilHealth.** PhilHealth will have to upgrade its business processes, its business support systems and the knowledge and skills of its work force to make proposed reforms successfully happen.
- g. **Ownership at PhilHealth.** Management will have to work closely together and cordially embrace all renewal activities to make them effective and to synchronize and finance the various actions it will need to undertake to make contracting work.
- h. **Shifting to a reimbursement instead of a benefits-in-kind system.** At present members are not entitled to care, as to be guaranteed by PhilHealth but instead are entitled to limited reimbursement of bills paid, if they can manage to find a provider. This has consequences for the co-payment system.

These challenging factors, mostly outside of PhilHealth are at the same time a constraint for effective contracting, i.e. to really make a difference with contracting. PhilHealth will therefore have to look for those opportunities where it can make a difference with contracting. In the meantime it may want to closely work with DOH and Congress to address the above mentioned challenges which are of a strategic nature.

### **Not rocket science**

Although the above may leave the impression that contracting as such is a daunting task, in essence it is not; at least not from a technical point. The international advice is: just start it and learn by doing, subsequently adjust and gradually achieve what you want. This report and its annexes are supposed to show the way and provide the means for decision making by the corporation and to make a start with contracting.

### **Cost of benefits and of achieving the National Objectives of Health (NOH)**

The consequences of the planned implementation have been considered and costs estimated. These can guide PhilHealth in its preparation of its gigantic tasks in supporting the NOH.

### **Investments in Health: DBP Credits for Better Health Care Project**

Health care providers/borrowers of the Development Bank of the Philippines (DBP) health investment fund, filled with \$ 50 M by KFW and soon with another \$ 50 M by ADB, can greatly profit from being contracted by PhilHealth and rewarded by higher payments for their contribution to better access to improved health services for PhilHealth members. This creates clearly a win-win situation for PhilHealth and the provider. By engaging in this area PhilHealth may also find itself influencing investment choices as to direct them to their priorities, geographically and services-wise.

### **Dialogue with providers**

PhilHealth and providers could profit from a more institutionalized dialogue with each other which systematically discusses not only contracting and the content of contracts but especially the health, administrative and communication policies underpinning the contracts.

### **The report and its annexes**

The above is described in much more detail hereafter. The report provides options and recommendations as well as practical instruments like a sample contract on how to move forward. The report has many separate annexes, i.e. the final reports of the individual consultants of which the main findings and recommendations have been included in this report, technical documents and reference materials. These annexes provide a wealth of information, justification and detailed guidance on many of the activities related to contracting.

Further, all final documents and reference materials have been uploaded on a dedicated website which will be handed over to PhilHealth by end of Project. The earlier produced Inception Report (Supplementary Annex A) and October 2008 Report (Supplementary Annex B) are not annexed to this report but separately made available.

### **Mission accomplished?**

The consultant team considers herewith its tasks to have been accomplished albeit that two areas have not been covered extensively because of the impossibility to timely contract two international consultants, one on HMIS and the other one on provider performance review. However, the consultants have tried to fill in this void as much as they could. For this they have been greatly supported from remote by Prof. Dennis Streveler.



## II. INTRODUCTION

This report summarizes the findings of a team of consultants that worked together with management and staff of PhilHealth from September to December 2008 on the Project in support of PhilHealth to develop and to eventually gradually implement a system of contracting between PhilHealth and health care providers. The report reflects the findings of the team on:

- The relationships of PHIC and health care providers in their many forms.
- The business processes of PHIC and providers.
- The business support systems.
  - The options to use a system of contracting to strengthen the relationship between PHIC and providers.
  - The internal requirements for successful contracting at PHIC and providers.
  - The conditions, challenges and risks in the overall health system to be fulfilled responded to or mitigated as to make contracting a success.

### A. Support from ADB and GTZ

The project was supported jointly by ADB and GTZ, which had contracted the international and national consultants respectively. GTZ also offered office and meeting space, communication and logistics support, on the PhilHealth premises.

### B. Cooperation with EC consultants

Close cooperation existed with the team of consultants of the European Commission (EC), with whom visits were synchronized. The EC team was working on PhilHealth Benefits Package and on the introduction of a new (case-based) payment system for hospitals. Both developments relate to contracting because the object of contracting is the benefits package to be delivered by the contracted provider and the contract would reflect the mechanisms and fees for paying the providers. The team has also provided extensive comments on the EC consultants' work on the above as well as on their Health Care Financing Strategy Paper. These comments are annexed to the October 2008 Report of the team.

### C. Terms of Reference and Approach

The terms of reference, the approach and the planned deliverables are described extensively in Inception Report, which is separately available (Supplementary Annex 1).

#### Visits

The inception visit<sup>1</sup>, which took place from 14 to 26 September 2008, coincided with the appraisal of the ADB supported Credits for Better Health Care Project (CBHCP). The CBHP is creating an investment fund for health at the Development Bank of the Philippines (DBP). This fund will lend money to different categories of providers to support the attainment of health related MDG's, to support access to health care for underserved areas and to prevent impoverishment of patients when in need of health services.

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<sup>1</sup> By the international consultant/Team Leader (Jan Bultman)

The team leader made two more visits, from 15 October to 1 November and from 12 November to 15 December. During his last visit he was joined by the International Consultant for Financial Management and Administrative issues)<sup>2</sup> and two national consultants (on HMIS and FM/Admin).

The team visited Dagupan City and Laoag City and the adjacent areas to get further acquainted with the issues at the PhilHealth Regional Offices (PRO's) and at the health care providers.

The team held numerous meetings with officials and representatives of the various stakeholders including the Philippine Health Insurance Corporation (PhilHealth), PhilHealth Regional Offices (PROs), Department of Health (DOH), Philippine Hospital Association (PHA), Philippine Medical Association (PMA), Asian Development Bank (ADB), the *Deutsche Gesellschaft für Technische Zusammenarbeit* (German Technical Cooperation, GTZ), European Commission (EC), the World Bank (WB), team leaders of other donor-sponsored projects, and providers and members from various provinces nationwide. A list of persons met during the Project is attached (Annex 7).

The team did a number of presentations for PhilHealth management and staff in HQ as well as elsewhere to explain the concept and methods of contracting. The slides for these presentations are annexed separately (Supplementary Annex D).

At the end of every visit a debriefing meeting was held with management and staff of PhilHealth and the discussion subsequently included in the reports of these visits which are separately annexed (Supplementary Annexes E-G). The content of these reports (Inception Report and October 2008 Report) are not included in this final report, except for essential sections that need to be taken into account when entering into contracting.

Unfortunately, it has been impossible to do the timely contracting of two more international consultants: one for health management information systems (HMIS) and the other one for provider performance review. However, the team is very grateful that it could make use of the excellent support from remote by Prof. Dennis Streveler and from his advice on HMIS. Further, the national consultant, Dr. Mary Ann Evangelista, has done an international literature review on modern provider performance review in relation to contracting and paying for performance as well as has provided support in the design of some indicators for the review of contracted providers. This means that it is still necessary to have an international consultant to be contracted for advice on HMIS supported performance review, using statistical tools for profiling of providers. The need for contracting the international HMIS consultant can be determined if and when the planned implementation of the HMIS upgrading advances and his further advice is perceived as necessary and useful.

The next chapter provides the background for starting the upgrading of PHIC contracting system. Then the objective of contracting is reflected. Subsequently the paper is split into Part A and Part B.

Part A providing a description and review of the current systems and the policy environment of PhilHealth against some international experiences.

Part B embarks on contracting and how to make it happen and to evaluate its impact.

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<sup>2</sup> Mr. Ron Hendriks. The other (national) consultants were: Dr. Mary Ann Evangelista (general and quality improvement activities); Ms. Blesilda Gutierrez, CPA (FM/Admin), Dr. Alvin Marcelo (HMIS) and Atty. Ms. Rowena Daroy-Morales (Legal issues)

This report is based on the individual reports of all the team members, which are separately attached (because of their volume) and their direct inputs in this paper. The team leader bears ultimate responsibility for the text of this report and its content.

All reports, annexes and presentation slides can be found at <http://iosn.grouphub.com/projects/2474051/project/log>. A password will be provided for access after turning over the project to the PHIC designated staff.

### **III. BACKGROUND**

The Philippines health sector has to function within heavy cost constraints. Therefore, there is great need to optimize the use of scarce financial resources. Further, the country is facing an exodus of essential health staff, which creates the need for optimizing the distribution and the use of human resources.

The Philippines Health Insurance Corporation (PhilHealth or PHIC) is a major player in the health sector, not so much because of its financial volume but more by its mandate and the tools it has at its disposal to shape the sector and to foster the availability and access to quality health care services for its insured. PHIC does this together with 4 other funding agencies: the Department of Health (DOH), the provincial governments, the municipal governments and the private health insurers or HMO's.

Besides this, there are high out of pocket contributions as well as contributions from donors/charities and NGO's. This creates a complicated landscape with fragmented funding, causing fragmentation of care delivery and decreased options for cost/quality control of providers. It leads as well to high administrative costs for funding and financing health care, complemented/and aggravated by high administrative costs at the provider side.

Private providers receiving payments from PHIC complain about the lack of clarity, bureaucracy, continuous changing and revoking of rules and the late reimbursements/payments.

The payments by PHIC to the providers are just a small part of the total costs of the medical interventions with the remainder being paid by the patients directly out of pocket. Overall, the private providers receive a rather small part of their income from PHIC payments, which leaves PHIC with relatively little clout towards the private providers. This may differ between the small private clinics (more PHIC clout) and the big private hospitals (less clout).

PhilHealth uses a simple form of contracting, i.e. the signing of an accreditation warranty, to obtain the services of private providers. While the "Implementing Rules and Regulations of the National Health Insurance Act of 1995 as amended by Republic Act 9241" offer many good instruments, the instrument of contracting is not used to its full potential.

#### **A. Relationship between PhilHealth and providers**

The relationship between PHIC and the providers is rather asymmetric because the obligations are more on the side of the providers, as imposed by the law, while PHIC does not have many obligations vis a vis the providers. PHIC does neither pay interest to the providers for late payments nor pays advances. There seems to be some lack of trust in PHIC among the providers and PHIC itself lacks credibility among

some of the providers. Further, the administrative procedures for review of claims, quality of services and for paying the providers are complex and tedious. Therefore it is most likely unnecessarily costly.

Such a situation is not very conducive for fruitful cooperation between the PhilHealth and the providers, especially when the country faces a human resources crisis. Doctors and nurses are leaving the country. It seems this is because of low payments in the Philippines and better earnings abroad. The number of medical students, enrolling in family medicine is decreasing. This will further decrease the already alarming low availability of family doctors in the rural areas and decrease the effectiveness of the referral system, thereby, making health care more costly. The ambition to expand on medical tourism will also lead to less availability of health staff for Filipinos, i.e. an internal brain drain.

## **B. Contracting for Better Health Care**

The Government of the Philippines, according to its National Objectives for Health 2005-2010, sees purchasing as a key role in the provision of a package of health services. The Government has announced that a performance based financing system for health will be adopted. It sees the PHIC as the “flagship program in health financing” which it wants to strengthen via expansion of enrolment coverage, improving benefits and leveraging provider payments on quality in health care (page 51). It further wants to “create the appropriate mix of budgeting and provider payment mechanisms that would best influence provider behaviour towards providing quality care and preventing health problems while containing costs” (page 56).

PHIC, as the Government’s and DOH’s most important purchaser of health services has therefore acknowledged that a review and update of its contracting system, its procedures and performance are necessary and have to be complemented by entering into proper dialogue with the providers.

## **C. Contracting for More Investments**

The Philippines is also in need of additional investment in the health sector to upgrade buildings and equipment to at least reach current licensing standards and to expand for essential services to in hitherto underserved areas. The Development Bank of the Philippines (DBP) has therefore established an investment fund for health. This fund is partly supported by the German Bank for Development (KfW) and will also receive support from ADB via its Credits for Better Health Project (CBHCP). This fund will amount to a total of \$ 100 Million.

ADB had agreed with DBP that its support will be mostly used for lending money to different categories of providers to support the attainment of health related MDG’s, to support access to health care for underserved areas and to prevent patients from impoverishment when in need of health services.

It was advised that the borrowers of DBP health loans, who would serve the PhilHealth members should be contracted also by PhilHealth for offering their services. Thus offering collateral for DBP, providing PhilHealth a say in choosing borrowers and investments while offering its expertise to DBP, creating a smooth payment relationship for DBP and giving the potential borrowers long term certainty about the returns on their investment. These borrowers/providers can be the first priority for entering into contracts with PhilHealth. This way, synergy can be created between the contracting project and the CBHCP.

DBP borrowers could be one of the priority categories for contracting, although the category can be very diverse. Such diversity and the eventually wide geographic distribution of borrowers may be difficult to

handle at the start of the implementation. However, the implementation of the ADB financed and DBP implemented Credits for Better Health Care Project will go on for 6 years and the project may start off slowly, giving PHIC enough time to engage with this category of providers.

Other criteria for the prioritization of implementation (categories of providers and/or geographic) are explored hereafter.

#### **IV. PURPOSE AND OBJECTIVES OF CONTRACTING**

PhilHealth sees the purpose and objective of contracting of health care providers as purchasing of efficient quality health care services for its members and their dependents and to protect these members from too high user charges. It places PhilHealth in a strengthened, i.e. more effective and more efficient, role of purchaser on behalf of its insured members, while carefully choosing applicable financing mechanisms and assessment of performance, therewith contributing to good clinical and financial governance (transparency and accountability) on the side of health care providers as well as of the health insurance system.

The essence of contracting is a purchasing mechanism used to acquire a specified service, of a defined quantity (volume of services or number of persons to be served) and quality at an agreed-on price, from a specific provider, for a specified period. Contracting presupposes an ongoing relationship, supported by a contractual agreement. Contracts transfer money from a Government or a health insurance fund/company (contracting agency) as purchaser to an independent public or private provider of services in exchange for specified deliverables. Contracting entails a possibility to review provider performance.

The essential change for PHIC and the providers would be the eventual use of the contracting mechanism as a way to select providers and their services, implying that some providers may not be contracted and that PhilHealth may also select some but not all services of a provider for contracting. The selection of providers will have to be a careful process, based on objective criteria to make it acceptable for providers and to be sustainable in any legal procedure.

#### **V. DESCRIPTION OF CURRENT SYSTEM, COUNTRY CONTEXT AND INTERNATIONAL EXPERIENCES (PART A)**

Hereafter follows a summary of the findings during the Project, based on the meetings held and on the review of Philippine and international documents/literature. These findings reflect current situations, experiences and expectations.

##### **A. General Observations**

Overall, PhilHealth has continued to strongly express its intention to go ahead with contracting but it will decide after it has had a chance to study the final reporting by the team, after weighing the various options provided and the consequences for the Corporation considered. PhilHealth realizes that it will have to work on meeting the conditions for the start of effective and efficient contracting and need to provide the necessary investment funds to upgrade its business processes and its business support processes.

The representatives of PHA and PMA, after having received an explanation of what a system of contracting could entail, have also expressed their interest in the development of a system of contracting. They seem to be willing to discuss such system and the eventual content of a contract with PhilHealth and to play a facilitating role towards their members, of course dependent on the intentions of PhilHealth, of the content of a contract and what this would mean for their members.

PhilHealth is advised to alert providers as soon as possible about its work on a possibly intensified contracting system without nailing down any specifics as to prevent unrest among the providers and to show them PHIC's intentions towards a strengthened dialogue with the providers.

PhilHealth is advised further to explain that the intention of the development of a contracting system is in no way meant to be cost savings operations for PhilHealth but as a system for partnership with selected providers to better serve PhilHealth members and to bring efficiency into the system.

## 1. Current developments in health policy

Many current policy developments are relevant for contracting and vice versa:

- The further **implementation of the DOH Fourmula 1 policy**, on the medium term aiming at:
  - a more secure, better and sustained financing for health
  - Assuring the quality and affordability of health goods and services
  - Ensuring access to and availability of essential and basic health packages
  - Improving the performance of the health system

PhilHealth can play a very important role in the implementation of the Fourmula 1 policy and cause synergy with the implementation of this policy via its planned extension of the benefits package by making it broader (i.e. more covered services) and deeper (i.e. higher reimbursement rates). Contracting can be THE tool for supporting the Fourmula 1 policy in assuring access to improved essential quality health services, by selecting and rewarding providers who are willing to partner with PHIC in such endeavour and pay them for performance (another intention of the Fourmula 1 program):

- **The planned extension of the PHIC out-patient benefits package (OPB)**

Benefits are the object of contracting, i.e. a contract states what the contracted provider is supposed to deliver to PhilHealth members. So, a contract, referring to the OPB, can help PHIC implement the OPB in a sustained and controllable way.

- **The planned introduction of a case-based payment system for hospitals**

A case based payment system may help in the urgent need to simplify the current reimbursement system by paying a lump sum per case and not for individual diagnostic test, drug or other medical intervention. However, by simplifying, PhilHealth will also lose some information about the performance of the provider. A contract can include the reference to such new system and demand some essential information of the contracted provider to monitor his performance.

A contract can further specify the agreement with the provider on the volume of services to be rendered thereby helping in overall cost-containment and prevention of supply-induced demand.

The effectiveness of a case based payment system could be greatly enhanced by including outpatient care in the cases, i.e. have one lump sum for the whole episode thus leaving it to the provider to economize and to do as much as possible in outpatient care. Herewith becomes the claims processing system even more efficient because less claims will have to be processed. The inclusion of outpatient

care is currently not foreseen. It is however strongly recommended. A contract with a provider to deliver inpatient and outpatient care could support such integrated payment system.

- **Introducing a DRG system?**

At the moment PhilHealth is also considering to implement DRGs (Diagnosis Related Groups) in the hospitals in order to have a case-based payment system. Although DRGs are not within the scope of this assignment a couple of remarks can be made:

- ✓ Do all of the hospitals have an accounting system which makes it possible for them to calculate the costs of a treatment, related to a certain diagnosis?
- ✓ If not, how much time and money will it cost the hospitals to figure out and to implement such a system?
- ✓ Is it worth the extra effort if PhilHealth is only paying a small portion of the costs of a treatment to the provider?
- ✓ Will PhilHealth differentiate between the hospitals, based on differences in costs/treatment, or will it pay the same amount for a certain DRG to all the hospitals?
- ✓ It is almost certain that there will be a big difference in the costs of the DRGs between the hospitals because of differences in investments, in staff numbers, in quality of care etc.
- ✓ PhilHealth could also consider having a benefit in kind system which means that there is an agreement on the price of a DRG and an agreement on how much PhilHealth will pay and the patient will need to pay. With such a system, which is preferable, PhilHealth should be aware of the reallocation effects between the hospitals, which can be quite substantial. Will those effects be acceptable?
- ✓ Would it not be easier for PhilHealth to start with a couple of cases and a case-based payment which could be evaluated before taking next steps? PhilHealth could also start for these few cases with a benefit in kind system with the agreements as mentioned above to get some experience.

- **Investment funds**

The availability of 100M USD for investments in the health care sector, coming from KFW and ADB and made available via the Development Bank of the Philippines (DBP).

Increasing investments in health is also one of the aims of Fourmula 1 and supposed to be guided by the Provincial Investment Plans for Health (PIPH). Close coordination of DOH and PhilHealth with DBP can help to assure that investments will be really beneficial for PhilHealth members by increasing access to quality care in existing health institutions and in hitherto underserved areas, fitting in the PIPH. Contracting is **THE** vehicle to provide certainty to the DBP borrower/provider as well as to DBP itself about the financial viability of DBP investments.

- **A new Health Care Financing Strategy**

The EC consultant team, in close collaboration with DOH, has provided a Health Care Financing Strategy Paper. This paper describes the current situation in health care financing, using a well accepted international framework. It points at the many issues in the system and its implementation. It further stresses the need to gradually increase the percentage of health care to be financed by PhilHealth. If implemented, this would give PhilHealth more, very much needed, financial clout vis a vis the health care providers. Any extension of the benefits package and therewith any increase in the funding of health care services would make PHIC more attractive for Filipinos to register as a member of PhilHealth. This will therewith also generate more financial clout for PHIC. However, with the current

fragmented system of financing (from the National, LGU budgets, by HMO's and others) PhilHealth financial clout will remain limited. It is therefore of utmost importance to mitigate as much as possible the current fragmentation of funding and to consider creating a single payer/purchaser of health care services via PhilHealth. Such single payer could also take care of the public health activities that can be performed by the curative system of family physicians, midwives and hospitals.

All these actions, leading to more financial clout for PHIC would make a contracting system more forceful and effective. However, given the fact that PHIC has a monopoly position, PHIC deserves strong oversight by DOH to make sure that it is fulfilling its mandate in an effective and efficient way and does not start behaving as the monopolist who does not have to care for its revenues and is reluctant to spend its resources and to show concern for its members or for the contracted providers.

## **B. Relationship between PhilHealth and providers**

As of June 2008, PhilHealth utilizes the services of 3,601 institutional providers and 20,961 professionals in providing care for its health insurance members. Many providers operate on what has been passed on as information from the former Medicare program, the precedent of PhilHealth in managing the national health insurance program, since there is no marketing mechanism in place to enjoin newly-licensed providers to become partners in providing health care to its insurance members.

By way of the warranties of accreditation, the providers are granted the privilege of providing care to PhilHealth members and the right to reimburse payment for such services from the Corporation. In this partnership between PhilHealth and provider, there seems to be an implicit assumption that the mere act of applying for accreditation means that the provider swears to abide by all rules and policies of the Corporation. This creates problems when providers do not agree with specific provisions of issuances, e.g. the rates paid for services rendered<sup>3</sup> or more recently, with the requested submission of receipts for professional services.

There appears to be a gap in dialogue between PhilHealth and its providers. Circulars are routinely sent out to providers with the assumption that they would know what to do thereafter. The Focused Group Discussions, held with providers (separate Supplementary Annex C3) as well as meetings with individual providers, with PHAS and PMA show that this is not the case. The legalese that is intrinsic in such documents is often interpreted in various ways by the providers. Medical clerks in-charge of claims processing receive the issuance(s) from the management of the facility usually without further guidance. When problems arise, PhilHealth troubleshoots by conducting clarificatory meetings with providers as a group, or through individual meetings at their respective facilities.

As there is no regular dialogue for these issues<sup>4</sup> between parties, these grey areas are not immediately clarified. Consequently, providers find ways to implement the circulars to the extent of their understanding, sometimes leading to claims returned to hospitals or denied outright; or to delays and denials in accreditation.

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<sup>3</sup> To some extent PhilHealth does engage its providers in setting fees, i.e. development of the Relative Value Scale (RVS) was done with extensive interaction with specialty societies. What is not done is negotiation with individual professionals and/or institutions for fee rates.

<sup>4</sup> A number of PhilHealth Regional Offices (PROs) have initiated annual or semi-annual dialogues with providers mainly for claims processing concerns. If other topics are covered it is deemed insufficient for their needs, hence the general impression of providers still is that not enough dialogue happens between them and PhilHealth.



## 1. Payment of providers

According to the information provided in the FGDs as well as in separate meetings with the providers, delay in claims processing and payment by PHIC is their main concern in their relation with the Corporation. On average, it can take between 2 to 7 months of waiting for payment after a claim is submitted to PhilHealth. “Good” claims are those claims that reflect reasonable management of cases and have complete supporting documents and are thus processed faster; while those with deficiencies usually have documents missing or have inconsistent information and have to be returned at least once to the provider for rectification necessarily leading to an additional waiting period.

After a patient’s discharge from the hospital it takes, on average, between 16 to 42 days before the claim is submitted to PhilHealth for processing. Providers report that the lag between patient discharge to claim submission is usually due to doctors’ slow provision of a discharge diagnosis and signature to the forms.

Another cause of delay of submission is the verification of member eligibility, wherein a copy of the member data record (MDR) needs to be secured from one’s employer or proof of premium payment has to be provided by the member.

Participants in the FGD’s estimate that up to 20% of their monthly claims reimbursements get deductions. Outright denials are few and are usually due to filing after the 60-day cut-off period. Participants report that they submitted letters of appeal for denied claims, most of which end up still denied for “lack of merit”, a term which is vague to most providers.

Most providers report that they have an internal process of reviewing claims prior to submission to PhilHealth to ensure compliance with requirements. Often it is still the same claims clerk that goes over the set of documents twice.

Given this combination of delay in payments, deductions and denials of claims coupled with fees that are often perceived as quite low compared to the actual costs, many providers feel that none of their investments may be recouped through PhilHealth reimbursements. To offset lost income, some resort to increasing the volume of their private patients while some increase the fees in other service areas.

Providers feel that PhilHealth circulars are not adequate to convey information about new policies and guidelines. They are quick to note however, that it is fairly easy to ask PhilHealth to provide clarification about issuances, when needed.

A particularly sore area is that doctors are not informed if and when their professional fees have been denied for whatever reason. Many doctors feel that PhilHealth should at least call them to verify why a certain case was managed as such before payment is denied or disallowed.

In view of this ongoing cycle of claims being returned to hospitals, deductions and denials, providers have taken initiatives to make internal changes to improve claims processing such as:

- Have regular staff meeting to delineate and clarify tasks of staff, claims processing and requirements
- Hire additional staff or ask the doctors to check the claims
- Provide training on claims processing, usually with invited speakers from PhilHealth
- Procure new equipment (computers and printers)

- Provision of performance bonuses when staff are able to process a certain number of claims within a target period
- Require the claims clerk to submit a written affidavit every time a claim has deficiencies
- Require a regular written test for staff on PhilHealth rules on claims processing

**Recommendations of the providers** for improvement can be clustered into the following categories:

- **Create an interface between PhilHealth and providers** to allow access to eligibility information (payment of premium, dependents, use of the maximum 45-day confinement, etc) for faster processing of claims.
- **Regular dialogue with PhilHealth** to clarify issuances, to provide further guidance on specific issues, and to have a venue to bring concerns to the attention of the Corporation.

Overall, provider sentiment is still positive. Despite continuing problems with claims reimbursement, respondents agree that having a national health insurance system is a good way to help many Filipinos gain access to health care.

## **2. International examples of dialogue between third party payers and providers**

In many countries, e.g. Germany, the Netherlands, Bulgaria, the health insurance agencies or representatives of insurance companies have a regular and institutionalized dialogue with the health care providers, on the national, on the regional level or with the individual providers. On the national level it is mostly with the umbrella organizations to agree on sample contracts, on fee schedules, on benefits packages on performance and on general partnership or to discuss policies. At the provider level it is mostly about the performance of the provider, the services to insured and the plans for the coming period.

Such dialogue helps in seeing each other not as adversaries but as partners in establishing mutual trust, sharing of mutual concerns and creating of mutual trust about the policies and the implementation of health insurance and in making it easier to live up to the requirements of a contract.

Some countries have established a national health council with representatives of the main stakeholders to discuss health policies, including health financing, and the implementation of such policies.

### **C. International examples of contracting**

The stage for elaborating on contracting is nicely set in a quote from an article “Trends on contracting in health care” using India as an example (Joshi and Chandra 2006).

**The United States of America.** In the USA, contracting of health care providers by health care insurers is common practice. Sometimes there is no negotiating power balance between both parties and the health care insurer take the lead. It is remarkable that recently a book is issued with the title “Managed Care Contracting Survival Guide for Healthcare providers” (Kirsner 2008) stating: *“Managed care contract terms have a direct impact on your organization’s bottom line, in terms of patient volume, revenue, and cash flow—not to mention staffing and business planning. Those contracts have a major effect on the profitability, and even the success or failure of your organization. So it’s crucial that you have a plan in place for your contracting and reimbursement strategy”*

### The Netherlands

Contracting has been a cornerstone in the Dutch health insurance system, which guarantees all its citizens all the essential health care services in case of need. In this system, the health care insurers negotiate the contracts with healthcare providers. The contracts consist of a general part and a specific part. The general part is the same for every healthcare provider belonging to a certain category. The specific part differs per provider. For example the agreed remuneration and the other terms of payment are in the specific part. Although the insurers can negotiate about the price or fee, it is not possible to agree on a price or fee higher than the maximum level set for the whole country by a governmental body, the Dutch Healthcare Authority.

Members and dependants can also choose for an insurance contract with their insurer which allows them go to a healthcare provider not contracted by their healthcare insurance company. Instead of receiving the health services of the chosen provider for free (except for paying the occasional required copayment) as common in the benefit in kind system, the insured patient pays the provider himself first and subsequently requests for reimbursement by his insurer. However the insurer can put in his contract with the member that this reimbursement will be lower than the price or fee the insurer would pay to a contracted provider. This means that the member has to pay part of the costs from his own purse.

*“The World Health Assembly resolution 2003, recognized the potential of “contracting” to improve health system performance. However, contracting if poorly planned and executed also has inherent risks. India is actively involved on the issue of contracting therefore, the health planners have to pay due attention on the emerging issues and latest trends on contracting health services. The magnitude of inputs required in health systems is enormous. It may not be possible, even in most developed countries to render medical care to whole community free of cost and by one actor, whether public or private. The one viable alternative can be a joint effort both by public and private. The participation may be at the level of provision of inputs in respect of manpower, materials and supply chain management, funding etc. or at the level of management process in rendering the care. It is also true that there is definite risk with the contracting system as well. This risk can be reduced to some extent by performance based contracts, where payments to the contractor depends at least partially on the achievement of the particular outcome.*

*Contracting is a tool that formalizes the relationships and obligations between the different actors in the health system. Contracting is as old as the history of health care. If we take into account the various inputs in the health care organizations, it can be appreciated that the organizations, whether in the private or public had to participate in some form or the other; be it - human resource, materials or equipments, financial resources, irrespective of the size or the type of the health care organization. The delivery of health care in almost every country, involves some form of public private partnership. In countries where care is delivered mainly through the public system, many inputs such as pharmaceuticals and support services are sourced from the private sector. In countries with predominantly privately owned facilities, the state influences their configuration through regulations and financial incentives. In hospitals, the situation is further complicated because of the many functions provided by such institutions: the training of health professionals and research and development, for example, are activities that are publicly funded to varying degrees.”*

**Other international examples** of contracting and a toolkit are provided by Benjamin Loevinsohn (World Bank 2008). This book is at PHIC. Although the context in the Philippines is very different from most countries described in this book, it has very good advice on and attention points for contracting. Its main advice boils down to just do contracting and learn by doing. Most countries that embarked on contracting have seen their services becoming more effective and efficient. Contracting private providers is many times more cost/effective than using public providers. More can be found at <http://www.worldbank.org/hnp/contracting>, including checklist and a contracting plan.

## D. Current payment mechanisms

PhilHealth currently uses 3 payment mechanisms for its various benefits – fee-for-service, capitation and case payment.

**Fee-for-service** means a health care provider receives a payment for each unit of service. At present, most benefits of PhilHealth are paid through this mechanism, unavoidably creating the problem of diagnosis creep and overutilization.

**Capitation** is the payment mechanism used for the outpatient benefit packages for the sponsored program. A fixed rate – Php 300 (US \$6)<sup>5</sup> -- per family is negotiated with the local government unit for arranging for the delivery of health services required by the covered person under the conditions of a health care provider contract.

*SECTION 46, PhilHealth IRR (2004). Payment Mechanisms – Payment of a health care provider shall be made through any of the following mechanisms:*

- a. Fee for service;*
- b. Capitation payment to health care professionals and institutions or networks of the same including HMOs, cooperatives, and other legally formed health service groups based on capitation rate guidelines set by the Corporation;*
- c. Such other mechanisms as may hereafter be determined by the Corporation.*

**Case-based payment** means a fee is set for a certain range of services. PhilHealth currently has CBP for cataract extraction, maternity care package for normal spontaneous delivery, newborn package and voluntary surgical sterilization. New packages are being developed for in-patient services and for chronic care including diabetes and hypertension.

## E. Claims processing

The N-Claims System has 13 major steps from receipt to release of payment to providers. For CY 2007 the average processing time of 50% of the PhilHealth Regional Office is within the 60 days requirement of the law. As of June 2008, with the full implementation of the New Claims (N-Claims) processing system, the average processing time of 94% of the PROs is within 60 days period. The Operations Sector Monthly Report of Claims processed for the month of September showed that there were 65,604 claims “returned to hospital” (RTH) or denied claims. This represents 22% of total claims processed. The report however did not provide how many of these claims were RTH or denied. Records from the Office of the Vice-President for Area II-South Luzon and Visayas provides that for Area II, 88% of the total RTH/Denied claims are RTH and 12% are denied claims.

<sup>5</sup> US\$1=Php 49

The report also shows that only 6 or 32% of the PROs were able to process claims equivalent or more than the average claims received per day thus accumulation of backlogs. And 11% of to the total claims processed is beyond 60 days. Further, the report shows that 12 out of 19 or 63% of the PROs have a backlog of more than one month workload (22 working days per month).

Records from the Office of the Vice-President for Area II-South Luzon and Visayas show that the top three reasons for RTH are as follows:

- Incomplete attachments/lack of documentary requirements
- Claims filed are beyond the 60 days from discharge date
- Claims forms are not properly accomplished

## 1. Analysis of cost/effectiveness and absolute costs of claims processing

The Operation Sector Monthly Report of Claims processed shows that for the month of September 2008, there were 65,604 claims RTH/denied claims. The report however did not provide how many of these claims were RTH or denied.

Records from the Office of the Vice-President for Area II-South Luzon and Visayas provides that 88% of the total RTH/Denied claims are RTH and 12% are denied claims. Details of which are as follows:

PRO	RTH	Denied	Total
4-A	10,434	1,699	12,133
4-B	2,667	217	2,884
5	1,313	170	1,483
6	1,975	486	2,461
7	6,426	730	7,156
8	2,381	119	2,500
Total	25,196	3,421	28,617
Percentage	88%	12%	100%
	57,761	7,843	65,604

Assuming that these figures are representative of all other PROs, the **PhilHealth could have saved PhP 7,578,875.13** had these dirty claims been returned immediately.

## 2. Costs of accreditation and claims processing

For costing purposes, the PRO-NCR process flow was used, since it described in detail the different steps in accrediting healthcare providers. Currently there are 26 steps from receipt of application to issuance of certificate of accreditation to institutional providers and 24 steps to accredit Independent Health Care Providers. Labor cost of accrediting institutional Health Care Providers are as follows:

Category	Without Deficiency	With Deficiency
Primary	₱ 6,422.17	₱ 7,760.55
Secondary	7,314.42	9,321.99
Tertiary	11,329.56	14,006.31

The following data are being used for calculating the absolute costs of claims processing:

- Number of claims 2007: 3.023 million
- Total costs of reimbursed benefits: 18.5 Billion Pesos
- Average amount per claim: 6,103 Pesos
- The average labor costs for processing claims are calculated to be 140.11 Pesos per claim
- This includes the costs for medical evaluation of 9.86 Pesos per claim
- The annual report (2007) of PhilHealth shows that operational expenses, excluded the personal and remuneration expenses, are 35% of the total operational expenses of PhilHealth
- The number of Return to Hospital (RTH) and denied claims in September 2008 was 22% of the total number of claims in September 2008. claims (based on the analysis of the national FM/Admin consultant)

Given the above figures the costs of claims processing in 2007 are calculated to be 571.8 million Pesos ( $3.023 \times 140.11 \times 1.35$ )

### 3. Cost effectiveness of claims processing

A cost-effectiveness analysis is a technique to compare the relative value of various procedures or strategies (American College of Physicians 2001). A new procedure is compared with the current procedure in the calculation of the cost-effectiveness ratio. (CE ratio).

CE ratio = (Cost new procedure – Cost current procedure) divided by (effect new procedure – effect current procedure) or

$$\text{CE ratio} = (\text{Cnp} - \text{Ccp}) : (\text{Enp} - \text{Ecp})$$

The result might be considered as the price of the additional outcome. If this price is low enough, the new procedure is considered “cost-effective”. It does not mean however that the new procedure saves money. The notion of cost-effectiveness requires a value judgment which means that the opinions can differ from person to person. Cost-effectiveness should also be judged taking into account the policy and other procedures within an organization.

It is not easy to calculate the CE ratio because the costs of the alternative process and the effect of the new procedure are not known.

However this does not prevent from providing the following observations on the cost effectiveness of the current process:

- The handling of claims is a very tedious process.
- It takes a long time for the hospitals to generate the claims.
- In the hospitals it takes, in a considerable number of claims, more than 60 days (the maximum term set by PhilHealth) after discharge of the patient to produce the claim, due to administrative requirements.

2001	1,417,124	
2002	1,574,954	
2003	1,831,786	
2004	2,148,633	
2005	2,646,352	
2006	2,419,682	
2007	2,688,412	
2008	1,388,530	First semester 2008

- This means that in a lot of cases the hospital send the claim to PhilHealth just to make sure they stay within the required time of 60 days; they know on forehand that this type of claims will be returned but they have another term of 60 days.
- A backlog exists which means that the providers are complaining about the late payments of claims
- The number of fraudulent claims is rising 1)
- The gathered information is not manageable 2)
- The number of claims is developing as follows:

- 1) PhilHealth estimates the number of fraudulent claims as about 4% of the total number of claims. The number of claims may change due to the following factors:
  - a. If PhilHealth succeeds in enrolling the indigents and the Informal Sector, the number of members and therefore also the number of claims will rise.
  - b. The number of claims will also rise if the benefit package is extended. These two factors may lead to an increase in the number of fraudulent claims, but not necessarily to an increase of the total percentage.
  - c. The third factor is a new claims processing system with better possibilities to detect fraud.

It is easy to predict that a combination of these three factors will increase the detection of fraudulent claims.

- 2) The claims give a lot of information. However processing by hand does not make it possible to make adequate statistics and to use these statistics as a tool for provider performance review.

It is not necessary to be a clairvoyant to predict that without rapid changes the present system for claims processing of PhilHealth will collapse.

To present the current system of PhilHealth as not cost-effective is an understatement. The current system presents a threat for the continuing existence of PhilHealth, especially if more activities are going to be added, without a fundamental overhaul.

### Claims processing delays<sup>6</sup>

Claims processing per PhilHealth Regional Office (PRO) in 2007; January to June 2008:

	Average Process. days		Number of claims		Average payment	Total payment
	2007	2008	x 1000	x1P	x1000 P	
PRO VIII	31	17	55.5		5352	297,036
PRO NCR-South	41		173.7		6882	1,195,403
PRO NCR-Central	42		239.9		7736	1,855,866
PRO I	48	39	141.1		5844	824,588
PRO XII	55		205.1		5003	1,026,115
PRO XI	59		232.1		5358	1,243,592
PRO IV-A	59	48	202.7		5734	1,162,282
PRO IV-B	59	46	111.2		5428	603,594
PRO II	60	31	78.2		5309	415,164
PRO X	66	40	249.4		4920	1,227,048

<sup>6</sup>Blesilda Gutierrez and Mary Ann Evangelista reports (Supplementary annexes C4 and C3, respectively) include description of the claims processing flow.

PRO NCR-North	69		216.6	9260	2,005,716
PRO IX	69	59	83.5	4727	394,705
PRO III	72		242.4	6354	1,540,210
PRO CARAGA	73		67.6	4764	322,046
PRO VII	81	50	225.3	5531	1,246,134
PRO CAR	74		62.6	5421	339,355
PRO V	83	35	130.3	5416	705,705
PRO VI	84	52	178.5	7096	1,266,636
<b>Total</b>			<b>2895.7</b>	<b>6103</b>	<b>17,671,195</b>

In 2007 half (50%) of the regional offices of PhilHealth had a claim processing time of 60 days or less. This means also that about 50% of the total number of claims (1,439,500) was paid within 60 days. The total number of claims was 2,895,700.

There is a difference in the number of claims shown in the different statistics which could mean that the different departments of PhilHealth are using different data bases or estimate part of the numbers themselves. There is also a difference between the total amount paid on benefits as shown in the table above and the amount showed in the financial report 2007 of PhilHealth, 17.7 billion Pesos vs. 18.5 billion Pesos.

Based on the data from January until June 2008, there seems to be an improvement in claims handling. All the PRO's of which data were available, had a faster processing time than in 2007. This can be seen as a good development.

#### **Claims returned to hospital (RTH claims)**

If a claim is returned to hospital, due to documentary requirements or missing of an ICD10 code the claim has to be evaluated and accomplished in the hospital and sent to PhilHealth for payment again. It could take than another 60 days (or longer) before the claim is paid.

Returned to hospital claims (Fajardo 2007).

- In 2006, 613 government hospitals were accredited ( September 30<sup>th</sup> 2007: 695) of 702 licensed;
- Government hospitals comprise 39% of all hospitals and they get 28% share of PhilHealth's reimbursement;
- They earned P4.8 billion from PhilHealth;
- The private hospitals earned P 12.4 billion from PhilHealth;
- There were 29,640 RTH claims to government hospitals (4 out of 10 RTH claims).

This means that:

- The total number of RTH claims in 2006 was 74,100 (government hospitals 29,640, private hospitals 44,460);
- The number of private hospitals was 1800 (61%);
- The average amount per claim from a government hospital is lower than the average amount in a private hospital although the maximum benefits are the same (39% of the government hospitals get 28% of the share);
- The performance on claims in government hospitals and private hospitals is not very much different. (39% of the hospitals are producing 40% of the RTH claims)



The example of the Valenzuela Medical Centre shows<sup>7</sup> that there are all kinds of reasons for RTH claims:

- incomplete attachments
- incomplete Form 3 data
- incomplete Form 2 data
- incomplete Form 1 data
- un-reconciled charges
- incomplete Operating Room forms
- no time of admissions and discharge on the claims form

This raises three questions:

1. Is it really necessary for PhilHealth to request all the information they are asking for at the moment?
2. Is it possible to improve the handling of claims in the different hospitals and at PhilHealth?
3. Is it possible to collect the data for claim processing other than by hand and have claim processing in a much faster way?

From the content of this report it will become clear that the answer on the first question is no and on the second and third question the answer is yes.

The Implementing Rules and Regulations of the National Health Insurance Act (R.A. 7875) as amended by R.A. 9241 Title IV Section 47b. gives some rules about the payment of claims:

- All claims for payment of services rendered shall be filed within sixty (60) calendar days from the date of discharge of the patient.
- If the claim is sent through mail or courier, the date of mailing as stamped by the post office of origin or date received by the courier service shall be considered as the date of filing.
- Claims returned for completion of requirements should be refilled within (60) calendar days from receipt of notice based on the date the returned claims were received by the health care institution.

#### **4. International practices concerning claim processing delays**

##### **United States of America:**

Prompt pay laws<sup>8</sup> have been established since the late 1990s by states to relieve delayed payments. As many as 49 states and the District of Columbia have prompt pay laws under their insurance codes that are enforced through sanctions in the form of penalties, fines and sometimes restitution. Most commonly used are interest penalties that are as high as 18% per annum on unpaid or untimely paid claims. Most of the current pay laws require payment within 30 to 60 days from the insurers to the providers. (American Dental Association<sup>9</sup> and the American Medical Association<sup>10</sup>).

<sup>7</sup> Valenzuela Medical Center, LMA 2008; [http://erc.msh.org/leadernet/award/LMA2008\\_en.pdf](http://erc.msh.org/leadernet/award/LMA2008_en.pdf)

<sup>8</sup> Prompt Pay Laws by State, October 2003: <http://www.donself.com/documens/prompt-pay.doc>

<sup>9</sup> American Dental Association  
<http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=2382>

<sup>10</sup> American Medical Association  
<http://www.ama-assn.org/ama1/pub/upload/mm/368/claims-checklist.pdf>

However these laws apply only to “clean” claims or claims submitted to third party payers without any missing or wrong information. Industry data shows that for the dentists for example 93% of all dental claims are paid within 10 days.

#### **The Netherlands:**

The healthcare insurance companies and the healthcare providers in the Netherlands have an agreement that every claim sent to the insurance company before the 12<sup>th</sup> of a month will be paid before the end of the month. If this is not possible an advanced payment will be given before the end of the same month.

If it takes too long for an insurance company to pay, the provider can request the company to pay within a certain period of time and also proclaim the interest rate (set by law) over the money which still has to be paid. This can end up in a court case in which the judge will decide what is reasonable.

### **F. Provider performance review**

#### **1. Financial**

It is presumed that the providers want to have their money as soon as they have accomplished their medical intervention or admission of a patient.

It takes some time before the clerks in the hospitals etc. have filled in the necessary forms for PhilHealth or have collected all the necessary documents. A rough estimate is that on average 2 clerks are working in a hospital (1 clerk per 50 beds) to get all the paperwork for claim processing done. Then these claims are sent to PhilHealth. A relative large part of them (22%) are going to be returned to hospital (RTH claim). On average it takes PhilHealth 63 to 64 days to handle the claims. This does not look that bad considering a claim should be handled within 60 days but this is about an average. The outliers are important.

It is advisable that the Grievance and Appeal Review Committee has members independent from PhilHealth. The CEO of PhilHealth and/or the President could be a member of this committee also but only in an advisory capacity. The recommendations for the other members should not be made by the CEO but by the Government or the Department of Health. It could also be considered to give the Philippine Hospital Association and/ or the Philippine Medical Association the possibility to recommend members to the committee.

#### **2. Medical appropriateness & Quality of provided care against standards**

Assessment of medical appropriateness and the quality of provided care against standards is currently done at PhilHealth through health technology assessment, utilization review and peer review. These processes are managed by the Standards and Monitoring Department (SMD) under the Quality Assurance Group (QAG).

1. Utilization review - formal review of health resource utilization or of the appropriateness of health care services on a prospective, concurrent, or retrospective basis. Data from the HIS on professionals are routinely reviewed for outliers by the SMD or in response to referrals from other units. The output of utilization review goes to the Peer Review Committee for deliberation and action.

2. Peer review - process by which the quality of health care provided to NHIP members or the performance of a health care professional is reviewed by professional colleagues of comparable training and experience either within the professional organization or hospital or within the Corporation itself when commissioned by the Corporation to undertake the same.

A *Peer Review Committee* composed of representatives from various specialty societies and representatives from the HFP Sector (SMD and Accreditation) meets on a monthly basis for 2-3 hours to discuss (1) referred cases from Claims Processing about appropriateness of care for complicated cases; (2) referrals from the Protests, Appeals and Review Department regarding denied claims; and (3) results of utilization review.

Decisions of the Peer Review Committee take the form of a resolution. Written feedback is sent to the provider in question. Unfortunately, the findings and decisions are not routinely shared with the Claims Department or Fraud. If the committee feels an administrative case needs to be filed against a provider, the resolution is sent to Fraud for action.

In cases where the findings point to a breach of warranties, PhilHealth Circular 10 series 2008 states that providers are given warning up to 3 offenses after which their accreditation status is denied.

On a case to case basis a provider may be invited to join the deliberation. If the provider wishes he/she may file an appeal to the Committee to contest their decision.

*National Health Insurance Act  
(RA 7875 as amended)*

**SEC. 38. Safeguards Against Over and Under Utilization.** – *It is incumbent upon the Corporation to set up a monitoring mechanism to be operationalized through a contract with health care providers to ensure that there are safeguards against:*

- a) over-utilization of services;*
- b) unnecessary diagnostic and therapeutic procedures and intervention;*
- c) irrational medication and prescriptions;*
- d) under-utilization of services; and*
- e) inappropriate referral practices.*

3. Health technology assessment – evaluation of health resource that includes drugs, devices, equipment, medical, diagnostic and surgical procedures as well as organizational, administrative and support systems.

An *HTA Committee*, composed of an expert panel on evidence-based medicine and division staff, provides technical assistance to the PRSD. It meets once a month for about 3 hours to evaluate drugs, supplies, procedures, clinical guidelines and other health technologies to identify which ones would reflect best practice and ultimately be advocated by PhilHealth among its providers.

As needed, providers and representatives from various specialty societies are invited to join specific meetings of the HTA. To date, the HTA has been instrumental in the selection of the 10 CPGs advocated by PhilHealth and in the selection of drugs for inclusion in the Drug Price Reference Index. The HTA also issues a newsletter, The HTA Forum, as a reference for providers on best practice care.

Clinical practice guidelines are systematically developed statements based on best evidence, intended to assist practitioners in making decisions about appropriate management of specific clinical conditions or diseases. PhilHealth and its HTA committee appraise guidelines developed by various local specialty

societies and also those from international sources. To date, PhilHealth has endorsed ten (10) clinical guidelines.

While these CPGs are clinically sound, PhilHealth's difficulties have been in getting its providers to use the guidelines in managing their patients. From the time the guidelines were endorsed, the issue of clinical autonomy has been put to fore. Many specialists insist that PhilHealth's paper evaluation would not be able to capture the actual range of decisions that went into a care process leading to a deviation from the recommendations of the CPGs.

This is further aggravated by the fact that the medical evaluation process is still manual across the PROs and is done by doctors (non-specialists are majority) who have been out of clinical practice for some time and have not much chance to regularly update their own knowledge to international standards.

**10 Clinical Practice Guidelines endorsed by PhilHealth**

1. *Paediatric Community Acquired Pneumonia*
2. *Acute Appendicitis*
3. *Hypertension*
4. *Dyspepsia*
5. *Acute Bronchitis*
6. *Adult Asthma*
7. *Community Acquired Pneumonia in Adults*
8. *Urinary Tract Infection*
9. *Acute Gastroenteritis*
10. *Maternity Care*

The creation of an ad hoc expert panel of peer reviewers from various specialty societies in 1998 was an attempt to troubleshoot this gap. This group was later integrated into the claims processing unit. With the subsequent reorganization of the Corporation, the unit was taken out of claims processing and has taken its current position as ad hoc to the Standards and Monitoring Department.

### 3. Licensing of providers

Licensing of public and private institutional health care providers is the mandate of the Department of Health (DOH). Licensing of professionals, on the other hand, is the mandate of the Professional Regulation Commission (PRC). By law, none of these institutions (R.A. 4226) and professionals (R.A. 8981) can start operation/practice their craft anywhere in the Philippines if a license is not issued.

The DOH requires compliance with its basic infrastructure (building, equipment and supplies) and manpower requirements as well as the requirements for fire and radiation safety, food sanitation, and laboratory competence. There are no explicit standards for quality of care in the hospital license requirements. The licensing paradigm works by the principle that quality can be assured if the inputs are in place. Evidences from international experience do not support this belief. This license to operate is renewed annually. Re-inspection is required as a policy; however, this is not always the case especially in areas with civil unrest and where security of staff becomes a problem when they do inspections. There have been very few reports of licenses being denied.

The PRC requires its professionals to pass a national board examination before a license to practice is issued. This national examination is supposed to evaluate the knowledge of the professional in his field. No skill testing is done at these examinations. This license is renewed every 3 years provided the professional complies with a minimum number of continuing education units. The Philippine Medical Association (PMA) accredits meetings or conferences for which CME points may be earned, through its CME Office. However, evaluation of the CME requirement is not stringent at the point of license renewal, the Professional Regulation Commission (PRC), such that a professional need only to submit certifications of attendance to various conferences or forum as proof.

#### 4. Accreditation

PhilHealth's accreditation process involves verification of qualifications and capabilities of health care providers in accordance with the guidelines, standards and procedures set by the Corporation.

Beginning 2009, PhilHealth plans to implement its Benchbook standards (PhilHealth 2004). It aims to replace the current standards which are enhanced DOH licensing standards with additional standards/criteria on quality improvement for reimbursement purposes.

The older accreditation standards looked for inputs including specific numbers of nursing and medical staff; number and location of specific equipment and supplies; and completion of required documentation in logbooks and charts. To introduce the concept of continuing quality improvement, PhilHealth also required the creation of an Infection Control committee, whose function was monitored through documentation of meetings. On the other hand, the new standards in the Benchbook will ask for evidence on how these input work together to achieve the desired outcomes for the patients such as cure or less pain. Some examples of these processes to be assessed include the way patients are transitioned from the admitting area to the room all the way up to discharge and even through follow up or community care.

In June 2008, as part of a feasibility study on third party accreditation or TPA (Shaw et al 2008), the Benchbook standards were evaluated against the ISQUa principles for developing standards. Results show that the Benchbook standards comply well in covering quality improvement, focus on the patient, organizational planning and performance, and safety. They are however, weak in the aspects of standards development and measurement. Nonetheless, they are comprehensive enough to allow the shift from input assessment to process and outcome assessments, which PhilHealth aims to accomplish beginning 2009. TPA is still an ongoing discussion in PhilHealth and among stakeholders. While most of them agree that it the way forward for accreditation in the Philippines, progress is slow towards creating a multi-stakeholder committee that will steer the process.

A minimal fee is charged to both public and privately own health care facilities the amount depending on the level of services for accreditation. Presently, the field staff of the Accreditation and Quality Assurance Section (AQAS) at the various PhilHealth regional offices acts as the surveying/inspecting team. The Health Finance Sector, particularly the Accreditation Department, with assistance from GTZ, is continually working on the implementation needs for the transition to the Benchbook standards. A set of indicators were developed in 2005 and refined in 2006-07 for measuring the level of compliance to the various standards. These indicators will be assessed using an assessment tool which is forthcoming in early 2009. Sustained compliance to the standards will be ideally monitored jointly by the Accreditation Department (and the AQAS in the PROs) and the Standards and Monitoring Department using pre-selected indicators which are yet to be identified by PhilHealth.

### Accreditation

*(As of June 2008)*

Facilities	Number Accredited
Hospitals (as of May 08)	1,536
Rural Health Units	1,226
Authorized Hospitals	87
Free-standing Dialysis Clinics	24
TB-DOTs Centers	459
Maternity Care Clinics	278
Professionals	20,961

## 5. Review of the above

Shaw et al (2008) report that PhilHealth's current accreditation program, though laudable in its firm commitment to foster a culture of quality among providers, does not yet meet international standards for an accreditation. Particularly highlighted is the finding that PhilHealth's accreditation program is not representative enough of the full range of stakeholders that should be involved in such a program. Indeed, for many years much of concerns for accreditation, and for quality improvement of health services, has been passed onto PhilHealth alone.

A closer scrutiny of PhilHealth as an accrediting body using the *ISQua International Accreditation Standards for Healthcare External Evaluation Organisations (2007)*, further reinforce the assessment above, that PhilHealth by itself, will not be able to implement a full accreditation program that is in line with international standards. To illustrate, some specific points include, incomplete representation of all relevant stakeholders; weak financial system to track income and expenses generated from the accreditation process such that it is difficult to assess just how much it is costing the corporation to do accreditation; costing of the program is heavily reliant on PhilHealth (i.e. minimal fees charged to providers); communication framework between the corporation and providers is not yet fully functional such that there is limited dialogue between partners and no routine feedback; weak evaluation of human resource needs for the program leading to inadequate number and skill mix of staff; and information system still inadequate for comprehensive monitoring needs.

***The proposal for a third party accreditation (TPA) is a viable option for the selection of providers for contracting. This, however, needs to be developed in parallel with contracting since there is no agency, apart from PhilHealth, that can carry on the task of TPA as required***

The Department of Health (DOH) is mandated to license hospitals and other healthcare organizations. PhilHealth is mandated to accredit those same organizations. Licensing and accreditation help to ensure that these healthcare organizations have the capacity to pursue their vision which is providing accessible, affordable, equitable and quality healthcare to all Filipino citizens.

By 2007, of the 1,872 licensed hospitals, 318 were not accredited.

### a. Accreditation fees, initial and renewal (in pesos), duration of accreditation (in years)

	Initial	Renewal	duration in years
• Infirmary	3,000	2,000	1
• Primary care hospitals	5,000	4,000	1
• Secondary care hospital	8,000	8,000	1
• Tertiary care hospital	10,000	10,000	1
• Rural Health Units/ HC's	1,000	1,000	1
• Ambulatory surgical clinics	5,000	4,000	1
• Free standing dialysis clinics	5,000	4,000	1
• TB-DOTS providers	1,000	1,000	1
• Maternity Care Clinics	1,500	1,000	1
• General Practitioner	1,000	1,000	3
• Dentist	1,000	1,000	3

• Medical Specialist	1,500	1,500	3
• Midwives	500	500	3

#### **b. Renewal of accreditation once per year**

At the moment PhilHealth has the following guidelines:

- The renewal of accreditation of the institutional healthcare providers follows a scheme with renewal dates, different per region;
- All government owned institutional healthcare providers shall be granted a 20% discount on the initial accreditation fees;
- All institutional healthcare providers shall be granted a 25% discount on the accreditation renewal fee provided that all renewal requirements are submitted 60 days ( 10%, 30 to 59 days) prior to the date of expiration of the date of renewal of accreditation.

#### **c. Costs of accreditation (in Pesos)<sup>11</sup>**

	Level 1	Level 2	Level 3
Without deficiencies	6,420.23	7,758.61	12,665.99
With deficiencies	7,981.67	9,320.05	14,004.37

#### **d. Revenue on accreditation fees (in million Pesos)<sup>12</sup>**

2006: 15.636

2007: 18.508

#### **e. Remarks**

Is it necessary for every institutional healthcare provider to be surveyed and to get his accreditation renewal every year? Besides the question of necessity one can wonder about the fairness of letting providers pay for their accreditation without granting them higher reimbursement fees to cover their costs. Providers have to pay for the travel expenses, board and meals of the accreditation team also. Looking at the costs of accreditation and the fees paid, PhilHealth has still a small “loss” on the accreditation fees for institutional providers.

***A suggestion could be to have institutional providers accredited less frequent and start with a renewal interval of every 2 years, combined with the obligation to inform PhilHealth if there are any changes at the provider which are crucial for maintaining its accreditation status and o make them pay a substantial fine if they don't. It will save money on the provider's side and on the side of PhilHealth.***

If PhilHealth decides to have contracting on top of accreditation this could mean that PhilHealth does not need any additional resources to make contracting possible.

The accreditation of professionals is being considered as an administrative procedure.

<sup>11</sup> From the work of the national consultant Blessie Gutierrez.

<sup>12</sup> PhilHealth Statement of Income for the year ended December 31, 2007

#### **f. Review of the above against C/E and international standards**

Accreditation, guarantees that the healthcare providers at the moment of their accreditation do have the skills, personal and equipment to do their job. However it does not say anything about the way they are actually performing. PhilHealth is not evaluating the quality and quantity of the delivered care per provider and per patient on a systematic basis which means that there is in effect no provider performance review. Therefore provider performance cannot be reviewed against cost-effectiveness.

As far as provider performance review exists it could be done a lot more efficient by collecting data systematically from the providers and by aggregating/ constructing statistics, based on the data in the claims processing system.

The accreditation process could be more cost-effective by not doing it every year but with the obligation for providers to inform PhilHealth about changes related to their accreditation and by violating this information requirement to get fined if changes are uncovered by ad hoc visits or otherwise.

#### **G. Co-payments**

In the current system, PhilHealth reimburses a small portion of the fee demanded by the health care provider. It functions like a discount card. The remainder of the payment can come from an HMO or has to be paid directly out of pocket by the patient. Co-payments are collected either by the provider facility cashier or by the professional himself at discharge. Receipts for the hospital charges are issued to the patient. If the professional fee is paid separately to the doctor [or his secretary], a receipt may or may not be given.

PhilHealth does not have a way of tracking these additional payments. The amount of co-pay is not reflected in the claims reimbursement documents submitted by the hospital. Providers are not obliged to inform PhilHealth about the amount of extra payment which they ask their patients to pay.

PhilHealth was established to provide all citizens with a mechanism to gain financial access to health services and to prioritize and accelerate the provision of health services to that segment of the population who cannot afford such services. The National Statistical Coordination Board (NSCB) reported in its 2003 Philippine National Health Accounts (NHA) that almost 76% of health expenditures by Filipinos come from “out of pocket” or personal funds.

Review of PhilHealth reimbursement made in a tertiary hospital showed that for catastrophic illnesses it covers only 14% of the total hospital expenses while for ordinary and intermediate care the coverage is from 14 to 21%.

The following steps are undertaken by providers in handling co-payment collection and administration:

- a. Upon admission of PhilHealth members in a hospital, they are oriented by the Admitting Section on PhilHealth Forms that needs to be filled-up.
- b. Generally deposits are required for hospital admission except for emergency cases.
- c. The Billing Section (or its equivalent) of the hospital regularly updates patient and/or their relative about their hospital bill. Usually most of the hospital set credit limit and in cases that patients'



hospital bill goes beyond the limit, additional deposit is required.

- d. Patients who are not able to provide additional deposit or update bills are either transferred to lower rate rooms or are referred to charity wards. Patients in private hospital without charity wards are referred to government hospitals. While patients in government hospitals who are not able to update their deposits are advised to seek assistance from government agencies, such as the Philippine Charity Sweepstakes Office and from legislators (Senators & Congressman) with priority development assistance funds (PDAP), local government officials (governor, mayor and vice-mayor) including NGOs.
- e. Upon discharge additional payments for the hospital bill and professional fees of doctors are collected and paid at the hospital cashier appropriately covered by official receipts. Patients who are not able to pay their counterpart are required to sign promissory notes. However, most of these account receivables, including disallowance from PhilHealth reimbursement, are no longer paid by patients.

Despite the noble intention of the law, PhilHealth covers only minimal portion of the total expenses. As a result, most Filipinos, when afflicted with serious illness, either die from lack of proper hospital care or become saddled with debts. Members have accepted that they will have to pay something extra every time they use their PhilHealth benefits.

There seems to be an implicit acceptance that benefits from the NHIP will require a certain amount of co-payment from its members. Though some participants in Focused Group Discussions have expressed a wish that PhilHealth would cover 100% of hospital expenses, there was no strong objection to co-payments.

The biggest expense related to members' use of their PhilHealth benefits is in purchasing medicines outside the hospital, either for inpatient use or for continuing medication after confinement. Co-payments range from as little as 150 pesos (US\$3)<sup>13</sup> to a few thousand pesos (US\$1,633) per admission.

*Co-payments range from as little as Php 150 (US\$3)<sup>1</sup> to a few thousand (US\$1,777) per admission... most patients find out about it at or near discharge.*

Payment of professional fees, over and above the fees paid by PhilHealth, is another cost area for members, which easily eats up more than the monthly income of a typical family earning minimum wage particularly for severe cases or surgeries. For many patients, they only find out about the extra charges at discharge.

Members report that they had experienced spending more than the family's monthly income for these out-of-pocket payments. Sources of additional money come from any or all of the following: loans from relatives, friends, credit cards, or donations from charitable institutions such as the Philippine Charity Sweepstakes Office (PCSO).

Members are informed by hospital personnel (administration or finance) or by the doctors themselves about the additional payments. They are informed that the additional fees are collected over and above the PhilHealth benefits since the fees reimbursed are less than the actual charges. The timing of the information however is problematic for most, because they only learn about the additional payments often at or near discharge.

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<sup>13</sup> \$1=Php49

Additional payments for the hospital bill and professional fees of doctors are collected and paid at the hospital cashier and receipts are given to the member in return. Members report that no other fees, gifts or donations are asked of them.

In cases where the hospital bill and /or professional fee were paid in full by the member, he/she is issued a waiver. This waiver can then be used by the member to get reimbursed for the paid fees from PhilHealth directly.

Unavailability of medicines is common and consequently becomes a high-cost area for members as they need to purchase them outside of the hospital facility. Though these can be reimbursed with PhilHealth, it is dependent on whether or not the limit has already been reached at facility level. Once the limit is reached, the member can no longer get reimbursed by PHIC even if he has original receipts.

Currently, the PHIC data base can not generate information on co-payments or out of pocket expense of the patient. Beginning September 2008 providers are required to submit copy of Patient Statement of Accounts; however, these are not yet encoded in the database. Information on the total hospital bill and professional fees must then be included in the electronic summary of claims to be submitted by the provider.

### **1. Adjustments of height and types of co-payment**

At present there is no mechanism or procedure within which co-payments are adjusted either upward or downward. Further, co-payments vary for the different categories of insured/members (and dependents) and/or for different types of benefits, based on the hospital's range of fees for ward or private cases; and based on the professional rates determined by each medical doctor. These fee rates are controlled to a certain extent in the public sector where fees are regulated by the DOH and PhilHealth but are not controlled by any regulatory body in the private sector. In this sector, fees are by demand, varies widely across regions and less so in the major urban areas, and can be changed at will by the providers, despite attempts to get rid of balance billing.

No formal co-payment exists in the health insurance system, meaning there is no formal requirement for patients to pay anything to PHIC (or to the provider) when they avail of benefits, except for membership contributions. Any out of pocket payments at the point of service is given directly to the institutional or professional providers.

The small sampling of PhilHealth members at the FGDs reveals that the amount of co-payment can be as low as Php 150 pesos (US\$3)<sup>14</sup> to a few thousand pesos (US\$1,632) per admission.

### **2. Cost/effectiveness of co-payment collection and member protection**

The providers in the Philippines do not always collect the co-payments before admission with the result that they are confronted with promissory notes of which, as they indicated, quite a lot will never be paid. The process of co-payments can only be cost-effective if co-payments are paid to the providers before admission. There are co-payments in some healthcare systems which are income related. Normally healthcare insurers do not know the incomes of their insured (and they should not, for privacy reasons). In these cases, normally the co-payments are collected by the tax office or by an independent agency mandated by the Government or the insurer with permission from the Government.

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<sup>14</sup> \$1=Php49

### 3. Some international examples of co-payment collection

Three main types of health insurance schemes emerge (OECD 2004), showing that health insurance schemes differ widely on the basis of the contractual relationship between the insurer and the providers, with consequences for co-payments.

Regarding these distinctive health insurance models, the healthcare insurance of PhilHealth can be seen as indemnity insurance. The question is, if this kind of insurance gives financial protection to the insured in catastrophic cases. The answer can be a clear **no**. Another question has to do with the trade-off between access to healthcare and co-payments. Co-payments are supposed to play a role in improving efficient use of healthcare, stimulating the use of healthcare provisions if absolutely necessary and only on the appropriate level of care. However copayments should not prevent the patient from visiting a doctor because he/ she cannot afford it. This would lead to missing opportunities for prevention of diseases or missing a chance of early intervention, therewith just aggravating the disease and its consequences and ultimately increasing the cost of health or worse: the avoidable early death of the patient.

#### Options for co-payment collection

##### 1. Indemnity insurance without contracting.

No contractual arrangements exist between insurers and providers under “pure” indemnity insurance models. Most private health insurers use this model. Indemnity insurance pays compensation to an individual for his/her specified loss according to the terms of the contract, which often may seek to restore the initial financial position of the person prior to the loss (subject to cost sharing or deductibles). Indemnity insurance offers choice of doctors (including specialists), hospitals, and other health care providers. Indemnity health insurance pays their share of the costs after receiving a bill from the insured. Bills are usually paid on a fee-for- service basis but can also be a case based payment or a DRG based payment.

In such a system the patient has two separate contractual relations: one with his provider (who gives care to him on condition of payment by the patient) and one with the insurer (who reimburses his costs for precise described health risk and health interventions in case the patient was in need for this care and he has paid his premium). The insurer has no direct relation with the provider. In order to contain costs, indemnity insurers not only do risk selection (i.e. avoiding high health-risk patients) and demand risk-rated premiums but can also demand the patient to ask for pre-authorization of admissions or for expensive interventions and ask for the medical data in order to review the case on medical necessity and appropriateness.

Although not commonly used it should be noted however that with an indemnity insurance it also possible to have contracts with providers which give the insured or the providers certain advantages above the providers without a contract. E.g. car insurers, which operate as indemnity insurer, have sometimes preferred body workshops under contract and insured can go there for easily processing their claim and get the work done.

##### 2. Selective contracting with institutional and other healthcare providers.

Insurers negotiate agreements with certain doctors, hospitals, and other health care providers to supply a range of services to insured at reduced cost. Selective contracting can free the patient from the need to pay for health care up-front. It also facilitates cost containment by giving the insurers direct purchasing power in relation to providers.

Selective contracting is widely applied by health insurers using managed care options, e.g. in the social health insurance scheme for curative services in the Netherlands.

In practice the healthcare insurers in the Netherlands do selective contracting with for example hospitals for certain procedures. They also have contracts with suppliers (manufacturers) for medicines in order to supply generic medicines. Selective contracting is not a problem in the Netherlands because patients are entitled to go to other

healthcare providers also. By doing so they will be reimbursed by the insurer although it means they have to pay a co-payment. Reimbursement is lower than the price they have to pay.

The Netherlands has a benefit in kind system which means that the insured are entitled to legally defined benefits to which the insurer has to provide access via concluding a sufficient number of contracts. Insurers which cannot give access to care in the Netherlands within a reasonable time have to allow the patient to go abroad if the patient can be treated more timely. Insurers can also conclude contracts with providers abroad. Co-payments can exist with the aim to prevent unnecessary consumption of healthcare or e.g. for admission in nursing homes or homes for elderly people. The latter to compensate for the savings of the patient because he/ she does not have the expenses anymore for his own household.

### **3. Integration with providers.**

Insurers and providers are vertically integrated. Providers are not independent, but are rather salaried workers of the insurer, or may be otherwise integrated under certain contractual arrangements. One example is the staff-model Health Maintenance Organization.

In many European countries selective contracting is used with co-payments tailored to just improve efficient use of healthcare. However most countries are reconsidering their healthcare systems because of the increase in costs due to the developments of medical technology and the ageing of their populations. This could result in higher co-payments as a way of co-financing (and not just an efficiency stimulus) and/ or smaller benefit packages. However this is far away from a system with co-payments that prevents patients from visiting a doctor, like the one in the Philippines.

#### ***South Korea's copayment system***

The system change for co-payments in Southern Korea<sup>15</sup> provides an interesting example of the possible relation between co-payments and contracting:

A Co-payment Ceiling System has been introduced since July 1, 2004 as a health insurance safety net. The system is designed to protect people who accumulate high co-payments. If an insured individual pays for co-payments exceeding the co-payment ceiling threshold currently set at 3 million won within a period of 6 consecutive months, he or she is exempted from any further co-payments occurring. This is to prevent households against catastrophic or high-cost diseases and from bankruptcy. This ceiling system is applicable for inpatient, outpatient, and pharmaceutical services.

The Compensation for Excessive Co-payment is payable when the insured or dependents received treatments at health care institutions and made co-payments exceeding 1,200,000 won within 30 days; the insured will be compensated 50% of the exceeding amount by the NHIC. This compensation mechanism has been introduced to alleviate excessive financial burden of beneficiaries arising from high co-payment.

## **4. Co-payments and benefits package**

Tradeoffs exist between the breadth and depth of a benefits package and the total height of copayments. Especially in a health insurance system with benefits in kind and using contracting of providers it makes sense to have the benefits package as big as possible, because the contracting system supports the patient in controlling the provider in providing appropriate care and setting his fees. For

<sup>15</sup> Soonman Kwon: "Thirty years of national health insurance in South Korea: lessons for achieving universal Health care coverage", <http://heapol.oxfordjournals.org>

any medical intervention or health services offered to the patient, he is at the mercy of the provider unless prices/fees are legally controlled by a state body, which is not the case in the Philippines. However, in order to balance the revenues and expenditures of the health insurer he may have to demand co-payments (besides raising the premiums), which can be dependent of the income of the patient/insured and therewith also a tool for more solidarity between the rich and the poor. The very poor can also be totally exempted from copayment.

Where in effect the patients in the Philippine pay relatively high copayments and the poor are not exempted there is ample financial space to increase the package of PHIC benefits and in return ask for higher but income dependent co-payments as to protect the poor (and higher income dependent contributions), thus increasing at the same time PhilHealth clout vis a vis the providers. Increased clout will help PHIC in contracting.

## **H. Status of PhilHealth HMIS**

This section describes the current state-of-the-art information technology that is being deployed at the Philippine Health Insurance Corporation together with an analysis of the gaps and bottlenecks that exist between its present form and the corporate vision. It will then juxtapose the report of Prof. Dennis Streveler and identify at which point of the Streveler-design the current system stands.

In summary, the PhilHealth HMIS is still struggling at the transactional (PRO) level for membership, claims, contributions and accreditation. A claim is typically processed at an average of 63-64 days. There is no widely accepted health data dictionary, and no integrated view of the corporation's data forcing end users to revert to disparate applications for analysis. Internal attempts to build this integration engine have failed due to lack of leadership and infrastructure.

Juxtaposing this current situation to the proposed transition of Prof. Streveler (Track 2), it can be said that the corporation is, at best, three to five years away from the ideal design. And the longer the Corporation delays taking decisive action on these tracks will only bring it closer to complete information systems collapse. However, there are already steps that can be taken (Track 1) which will bring significant benefits to PHIC but only if they are implemented as soon as possible. The decision to implement Track 1 is an urgent one which needs to be addressed head on by the leadership.

### **1. Analytical framework for review of HMIS**

There are various methods that can be employed in the analysis of information systems. The most popular (and more detailed) is that of John Zachman's Enterprise Architecture ([www.zifa.com](http://www.zifa.com)). In the interest of time however, this initial analysis will employ Heeks ITPOSMO Framework for analyzing health care information systems.

According to Heeks, health care information systems may be analyzed under the following categories:

- Information
- Technology
- Processes
- Objectives and Values
- Staffing and skills
- Management
- Others (funding)

### a. Information

The INFORMATION category delves into the content collected and maintained by the system. Up to this point, the Corporation has accumulated one terabyte of data since encoding started in 1995. These data are shared between those collected from legacy systems and current state-of-the-art systems. Majority of the data pertain to one of the following domains: membership, claims, contribution, accreditation, financial.

Prior to the current **N-Claims system**, there was the Unified Claims Processing System (UCPS) which was built on Clipper. This was followed by the **PhilHealth Member Account Information System (PMAIS)** which ran on Oracle. These two systems were then merged into the N-Claims together with an upgrade to the **PhilHealth Re-engineered Membership Information System (PREMIS)**. These upgrades were implemented in phases such that by August 2008, all PhilHealth regional offices (PROs) had migrated completely to N-Claims.

The N-Claims processing system collects data from Forms 1 and 2. Pertinent data collected are: patient identifiers, member identifiers, diagnosis, diagnosis codes, procedures, procedure codes, and amounts claimed per benefit category (room and board, ancillary procedures, and medications). It however falls short of documenting actual medications, laboratory and ancillary procedures provided to the patient.

The Contribution/Collection system records payments from companies on behalf of their employees/PhilHealth members. This system suffers from the non-use of employers of the member's PhilHealth Identification Number in making their payments.

The Accreditation database stores data about professionals and facilities that are accredited by the Corporation. The rapidly evolving data requirements of PHIC with regards accreditation data places it in a flux making it difficult to merge data from one previous time span to another.

***Bottom-line: The corporation needs a re-assessment of the current data model as well as its documentation. There are presently poor documentation systems for existing applications and future applications, based on these poorly documented predecessors, will only suffer further from this lack.***

### b. Technology

The Corporation boasts of a state-of-the-art technology infrastructure that befits a national agency. It has supercomputers with an expanding storage complement. It runs most of its operations on an Oracle database with Visual Basic or Java applications for the front-end. The ITMD manages a wide-area network running on a synchronous transfer mode/frame relay -- a secure, high-capacity connection between the main office and its PROs nationwide. In terms of hardware, the corporation has state-of-the-art equipment for servers, workstations and network. Preferred operating systems are proprietary with Windows machines being the default installation in the workstations.

***Bottom-line: The Corporation has the necessary technological infrastructure to power its current applications. However, it is at real risk of suffering from complete stoppage unless a disaster recovery and business continuity plan is developed. A backup center (already recommended by Streveler) is a priority task.*** Although the process for this has started (backup center will be in Clark), the process is taking too much time. An attempt to build a data warehouse internally revealed some problems with the current infrastructure if analytics are to be performed using the existing hardware.

### c. Processes

This appears to be the weakest part of the PhilHealth information system. Although there are clear protocols within the ITMD, the same is not evident amongst end users. There is high expectation from end users of the capacity for ITMD to analyze the data from the domain perspective when as a matter of fact, the ITMD is already overloaded with the mere management of the corporation's IT infrastructure.

There is also no standard, widely-accepted definition for many key business terms causing confusion among stake-holders. Something as simple as 'member' can be interpreted many ways. This has been a focus of contention among different departments because their query results will necessarily differ if the definitions for the denominators are not uniform amongst them. The lack of a recognized leader overseeing all these processes contributes to this disintegration. Although the senior vice president has oversight, the technical control and monitoring needs to be managed by a corporate-wide chief information officer.

### d. Objectives and Values

The present information system of the corporation is mostly transactional in nature (operational data store) and does not produce data in a form convenient for analysis. There also seems to be gap between the way the transactional systems are built vis-a-vis the corporation's core strategy which is social health insurance. This is evidenced by the inability of the current data stores to easily produce data to support success in key result areas. It seems as if the information system was built by someone who did not anticipate or understand social health insurance nor the impact PhilHealth can have in the delivery of health services in the country.

### e. Staffing and Skills

The staffing of ITMD continues to decrease with the recent resignation and transfer of key personnel to other departments. Along with the migration are the concomitant deterioration in documentation and technical support. The staff of the other departments (the end users of the data) likewise suffers from capacity to analyze the data by themselves for use in their decision making processes. An attempt to resolve these problems was the Health Analytics Technical Working Group. This is a multi-departmental committee tasked to convert the operational data stores into a consistent data warehouse for the country.

***Bottom-line: PHIC lacks the capacity to maintain its growing data at the management side and at the analytics side, two important skill sets in the evaluation of contractor performance.***

### f. Management

The huge data-set of PHIC is being managed adequately by the ITMD. This is expected to deteriorate however, as ITMD continues to lose its IT personnel to the private sector. ITMD also has failed in going beyond the infrastructure to meet the information requirements of the many end users. As it is presently managed, ITMD will not be able to offer the data warehouse that is desperately needed by the departments.

### g. Others (funding)

The corporation appears to have enough resources to run a robust ITMD and has a slush fund of more than 70 billion pesos. It has the means to create an end-to-end health analytics technical working group that directly addresses institutional requirements.

## 2. HMIS status summary

- The PHIC HMIS lacks robust standards that can make applications inter-operate with one another.
- The PHIC lacks manpower for full support for health analytics.
- PHIC is collecting too much information on paper which requires attachments and prevent automated analysis by predictive algorithms. In effect, the data do not yet translate into better performance by the end users of the data.

***Juxtaposing this present system to that of Prof. Streveler's, and given that the current management structure will remain the same, it will take PHIC another three to five years to be able to definitely respond to the challenge of Prof. Streveler.***

The following two tables (taken from the Streveler March 2007 report) summarize the recommendations:

STUDY REGARDING:	PRIORITY	CONSULTANT MAN-MONTHS
5.1.1 Membership database issues	High	1 month
5.1.2 Streamline claims processing issues	Highest	2 months
5.1.3 Stop entry of old collections data prior to 2002	IMMEDIATE	n/a
5.1.4 Defining "What is a PIN?"	High	1 month
5.1.5 Implementing NO PIN = NO PAY	High	1 month
<b>TOTAL</b>		<b>~ 5 man-months</b>

The Membership database issues are being addressed by the Membership Management Group. This entailed hiring a systems analyst (previously an employee of ITMD). The membership database is undergoing cleanup but there are still about 34,000 records with duplicates (as of November 2008). These duplicates resulted from Plan the 5 million campaign where many indigents were registered hastily into the membership database. ***The current status of the membership database (lots of duplicates and no unique identifier for patients) make it unsuitable for the contracting mechanism.***

The above project proposals are also underway albeit in a non-integrated way. A new Treasury Accounts Reconciliation System (TARS) and Treasury Information Management System (TIMS) are in the process of development. An effort to create a health data dictionary started last June 2008, and has been going around the corporation for comments and validation. The Health Informatics Section is the unit in charge



for the HDD, but not much progress has been achieved since. The security and preparedness module is nearing completion for a cold backup of the whole PHIC system. Backup centres in Clark and Baguio are being considered with the former being established by first quarter of next year.

A special project called the Unified Member Identification (UMID) was launched this year. It aims to design and implement a smart card system (with biometrics) to PhilHealth members where dependents will be registered on the card with their own unique numbers. This UMID is known in concept to ITMD, but so far, there are no integration mechanisms to connect UMID with the rest of N-Claims.

PROJECTS	PRIORITY	LIKELY PROJECT COST (OVER 3 YEARS 2008-2010)
5.2.1. FMIS (financial)	Urgent	US\$ 3 million
5.2.2. PREMIS and PMAIS (membership, collections)	High	US\$ 1 million
5.2.3. NCLAIMS2 (claims processing)	Highest	US\$ 5 million
5.2.4. PNHDD (health data dictionary)	High	US\$ 500,000
5.2.5. SECURITY and DISASTER PREPAREDNESS	Urgent	US\$ 1.5 million
<b>TOTAL</b>		<b>US\$ 10 million</b>

***In summary, the Philippine Health Insurance Corporation suffers from the following problems with their HMIS: a lack of a leader to integrate the whole system, to streamline processes and to see HMIS projects through; a lack of a health data dictionary; and the lack of communications between departments on the HMIS-related developments within their own organizations. With all of these deficiencies, the Corporation definitely has to put substantial attention to the re-design of its whole information systems architecture.***

The Philippine Health Insurance Corporation has maintained databases for accredited facilities and professionals. Originally, this was called COMPAS or Comprehensive PhilHealth Accreditation System. COMPAS contained information about institutions and professionals relevant to their ability to provide quality service to PhilHealth members. However, COMPAS was not accessible via the N-Claims. A more updated version of COMPAS, IPAS (or Integrated PhilHealth Accreditation System) was created and this was connected to N-Claims such that a non-accredited facility or professional will not be available as a look-up in N-Claims if their status in IPAS is invalid. The current method being used by the Corporation is the processing of paper requirements at the PRO level which are then forwarded for final decision at the Central Office. Upon approval (or denial), the Health Informatics Section updates IPAS and this is automatically reflected in N-Claims.

The Philippine Health Insurance Corporation will benefit from a contracting mechanism with selected preferred providers. However, in order to do this successfully, it should re-design its health management information system to make it streamlined and efficient. Previous recommendations have emphasized this as Track 1 (streamlining, data dictionary, eliminate attachments) and Track 2 (N-Claims2 and Supercenters). Unfortunately, progress on these tracks have been very slow, and are not proceeding at a rate required to meet the needs of contracting.

The number of claims will grow due to enrollment of the members and extension of the benefit package. It is not necessary to be a clairvoyant to predict that without rapid changes the present system for claims processing of PhilHealth will collapse. This makes it unthinkable to have contracting on a large scale (besides) pilots because the present system is not capable of handling this.

To say the present system of PhilHealth is not cost-effective is an understatement. The present system presents a threat for the continuing existence of PhilHealth, especially if more activities are going to be added, without a fundamental overhaul.

## I. Framework for Contracting

### 1. Legal

Contracts in the Philippines are generally governed by the general law on contracts as found in the Civil Code, which provides that contracting parties may establish such stipulations, clauses, terms and conditions as they may deem convenient, provided they are not contrary to law, morals, good customs, public order or public policy. A contract is defined by the Civil Code as a meeting of the minds between two persons whereby one binds himself, with respect to the other, to give something or to render some service. There can be no contract unless there is **consent** of the contracting parties who must be legally capacitated; an **object** certain, which is the subject matter of the contract; and **cause**, or consideration.

#### a. Parties to the contract

A party to a contract may be a natural or juridical person. The PHIC, LGUs, institutional health care providers and umbrella organizations or national associations of providers incorporated in accordance with the SEC are juridical persons. They can contract only within the authority and limits set by their respective Articles of Incorporation. The PHIC is authorized, under its Charter and IRR, to enter into contracts with: a) health care institutions; b) health care professionals (doctor of medicine, nurse, midwife, dentist or other health care professional duly licensed to practice in the Philippines accredited by PHIC); c) HMOs; and, d) community-based health care organizations.

The PHIC may also contract with national associations of providers (the “umbrella organizations”) for limited purposes.

#### b. Consent of the parties

To be able to give consent, a party must have capacity to do so. Juridical persons have the capacity to give consent, through their respective Boards. Natural persons give their consent personally or through agents duly authorized for the purpose.

Health care providers, juridical or natural, must be accredited as a health care provider before it can be capacitated as a party to be give consent.

The associations of national providers in representation of its members are legally constrained from entering into contracts with PhilHealth regarding delivery of health services, and to be paid for these services by PhilHealth. As non-stock corporations, they cannot distribute any part of their income to their members<sup>16</sup>. The main purpose of these associations is for coordination with PhilHealth to encourage and ensure cooperation from the provider members as well as to promote compliance with the requirements and conditions for participation in the NHIP<sup>17</sup>.

### **c. Object of the contract**

The subject matter of the contract between the Philippine Health Insurance Corporation and the health care providers is limited to the paying for the utilization of health services by covered beneficiaries or to purchasing health services in behalf of such beneficiaries. It shall be prohibited from providing health care directly, from buying and dispensing drugs and pharmaceuticals, from employing physicians and other professionals for the purpose of directly rendering care, and from owning or investing in health care facilities.

These health services or the benefit package granted to the beneficiaries shall include<sup>18</sup>:

a) Inpatient hospital care:

- 1) room and board;
- 2) services of health care professionals;
- 3) diagnostic, laboratory, and other medical examination services;
- 4) use of surgical or medical equipment and facilities;
- 5) prescription drugs and biologicals, subject to the limitations stated in Section 37 of this Act;
- 6) inpatient education packages;

b) Outpatient care:

- 1) services of health care professionals;
- 2) diagnostic, laboratory, and other medical examinations services;
- 3) personal preventive services; and
- 4) prescription drugs and biologicals, subject to the limitations described in Section 37 of this Act;

c) Emergency and transfer services; and

d) Such other health care services that the Corporation shall determine to be appropriate and cost effective.

**Cause of the Contract.** The cause of the contract is the why of the contract, the immediate and most proximate purpose of the contract. In the case of the Philippine Health Insurance Corporation, it would be to fulfill its mandate under the law. For the health care providers, it may be for the faster payment of the claims, the speeding up of the process of providing services, and the provision of better services.

Under the Leaping Fourward towards Financial Protection in 2010 Resolution approved by the Board of Directors of the Philippine Health Insurance Corporation, there are four steps:

Leap One: Shifting to New Payment Mechanism

Leap Two: Contracting or Preferred Provider Service Agreements

Leap Three: Investing in Health Care Providers, Particularly Public ones

<sup>16</sup> Manila International Airport Authority v. Court of Appeals, G.R. No. 155650, July 20, 2006.

<sup>17</sup> Section 75, Implementing Rules and Regulations of the National Health Insurance Act of 1995.

<sup>18</sup> Section 10, Republic Act 7875

#### Leap Four: Expanding Patient Benefits.

The third leap may be contentious since, the National Health Insurance Program is prohibited from owning or investing in health care facilities<sup>19</sup>. However, PhilHealth can reimburse health care providers, to compensate them for their investment costs. This is relevant e.g. in case the providers borrow from the Development Bank of the Philippines (DBP) to establish health care facilities to serve PhilHealth members in hitherto underserved areas or to upgrade their services.

## 2. Practice of law, court rulings and relevant context

In daily practice, when a conflict between two parties arises, they have the option to go to court. However this may prove to be a time consuming and costly procedure with an uncertain outcome, making a more simple and less time/cost consuming alternative attractive.

**Dispute solving mechanisms.** Under the Philippine Legal System, there are various modes of settling disputes, apart from the judicial process as provided by law. The judicial process of resolving disputes through the court system is governed mainly by the Rules of Court, as promulgated by the Supreme Court of the Philippines. However, other avenues are open to parties so as to sidestep the long and arduous process of litigation. Also, even though the parties are already in the process of litigation, the law still provides for ways to shorten this process. These alternative dispute resolution mechanisms which can be made applicable to PhilHealth and the health care providers and members when it comes to their disputes are provided for under the Civil Code, the Arbitration Law, the Alternative Dispute Resolution Law, *Katarungang Pambarangay* Law and pertinent Supreme Court Circulars on Court-Annexed and Court Referred Mediation.

The Civil Code provides remedies by which parties can avoid the litigation of their dispute. This is done through a compromise. A compromise is defined as contract whereby the parties, by making reciprocal concessions, avoid a litigation or put an end to one already commenced<sup>20</sup>. The Civil Code also provides that courts should endeavour to persuade the litigants in a civil case to agree upon some fair compromise<sup>21</sup>. The following are however not subject to a compromise<sup>22</sup>:

- (1) The civil status of persons;
- (2) The validity of a marriage or a legal separation;
- (3) Any ground for legal separation;
- (4) Future support;
- (5) The jurisdiction of courts;
- (6) Future legitime.

A dispute between PhilHealth and the health care providers, or between PhilHealth and its members can be valid ground for a compromise agreement. It is not a dispute that is included among those enumerated. It is a contract between the parties, and as such, it has the force of law between the contracting parties and should be complied with in good faith<sup>23</sup>.

Republic Act 876, otherwise known as the Arbitration Law provides in Section 2 thereof that two or more persons or parties may submit to the arbitration of one or more arbitrators any controversy

<sup>19</sup> Section 5, Republic Act 7875

<sup>20</sup> Article 2028, Civil Code of the Philippines.

<sup>21</sup> Article 2029, Civil Code of the Philippines.

<sup>22</sup> Article 2035, Civil Code of the Philippines.

<sup>23</sup> Article 1159, Civil Code of the Philippines.

existing between them at the time of the submission and which may be the subject of an action, or the parties to any contract may in such contract agree to settle by arbitration a controversy thereafter arising between them. Such submission or contract shall be valid, enforceable and irrevocable, save upon such grounds as exist at law for the revocation of any contract. A contract to arbitrate a controversy thereafter arising between the parties, as well as a submission to arbitrate an existing controversy shall be in writing and subscribed by the party sought to be charged, or by his lawful agent<sup>24</sup>.

The later law which governs alternative dispute resolution mechanisms is Republic Act 9285, otherwise known as the Alternative Dispute Resolution Act of 2004. Aside from arbitration, it provides for other means of resolving disputes such mediation and other forms the parties may agree on. The objectives of this law are:

- 1) actively promote party autonomy in the resolution of disputes or the freedom of the party to make their own arrangements to resolve their disputes<sup>25</sup>
- 2) achieve speedy and impartial justice<sup>26</sup>
- 3) de-clog court dockets<sup>27</sup>
- 4) reduce delay in the resolution of disputes
- 5) increase access to justice for disadvantaged groups
- 6) reduce the cost of resolving disputes
- 7) help reduce the level of tension and conflict in a community
- 8) increase civic engagement and create public processes to facilitate economic restructuring and other social change
- 9) increase popular satisfaction with dispute resolution
- 10) manage disputes and conflicts that may directly impair development initiatives.

The provisions dealing with the *Katarungang Pambarangay* are found in Sections 399- 422 of the Local Government Code. The Local Government Code provides that there is hereby created in each *barangay* a *lupong tagapamayapa*, referred to as the *lupon*<sup>28</sup>. The *lupon* of each *barangay* shall have the authority to bring together the parties actually residing in the same city or municipality for amicable settlement all disputes except<sup>29</sup>:

- a) where one party is the government, or any subdivision or instrumentality thereof;
- b) where one party is a public officer or employee, and the dispute relates to the performance of his official functions;
- c) offenses punishable by imprisonment exceeding one(1) year or a fine exceeding five thousand pesos;
- d) offenses where there is no private offended party;
- e) where the dispute involves real properties located in different cities or municipalities unless the parties agree to submit their differences to amicable settlement by an appropriate *lupon*;
- f) disputes involving parties who actually reside in *barangays* of different cities or municipalities, except where such *barangay* units adjoin each other and the parties thereto agree to submit their differences to amicable settlement by an appropriate *lupon*;
- g) such other classes of disputes which the President may determine in the interest of justice or upon the recommendation of the Secretary of Justice. The court in which non-criminal cases not falling

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<sup>24</sup> Sec. 4 Republic Act 876.

<sup>25</sup> Section 2, Republic Act 9285

<sup>26</sup> Ibid.

<sup>27</sup> Ibid.

<sup>28</sup> Section 399, Republic Act 7160.

<sup>29</sup> Section 408, Ibid.

within the authority of the *lupon* under this Code are filed may, at any time before trial, *motu proprio* refer the case to the *lupon* concerned for amicable settlement.

PhilHealth is a government corporation, and hence a dispute involving the corporation cannot be settled through the *Katarungang Pambarangay*. Also, where there is a complaint or grievance filed under the IRR of the National Health Insurance Act of 1995, which involves a complaint against an employee of PhilHealth or a grievance against such employee, it cannot be settled if the dispute relates to the performance of the official functions of said employee. The minimum amount for offenses under Republic Act 7875, as amended by Republic Act 9241, is ten thousand pesos, which is above the jurisdictional requirement of the *Katarungang Pambarangay* Law for offenses.

On October 16, 2001, the Supreme Court promulgated A.M. No. 01-10-5-SC PHILJA, which contained the structures and guidelines for the institutionalization of mediation in the Philippines. Under the said circular, the following cases are referable to mediation:

- a) all civil cases, settlement of estates, and cases covered by the Rule on Summary Procedure, except those which by law may not be compromised<sup>30</sup>;
- b) cases cognizable by the *Lupong Tagapamayapa* under the *Katarungang Pambarangay* Law;
- c) the civil aspect of BP 22<sup>31</sup> cases; and
- d) the civil aspect of quasi-offenses under Title 14 of the Revised Penal Code.

In the context of a contract between PhilHealth and the health care providers, and there is a breach thereof, such a dispute is mediatable, because it will entail the enforcement of a breach of a contract. If the money claim of a health care provider does not exceed one hundred thousand pesos, it may be subject to mediation also. A member's claim for reimbursement from PhilHealth or administrative protests pertaining to processing and payment of claims not exceeding one hundred thousand pesos may also be subject to mediation. Criminal offenses arising under Republic Act 7875, as amended by Republic Act 9241, and the IRR, would not be referable to mediation under the circular, as the minimum fine prescribed there under is ten thousand pesos.

Since mediation is part of pre-trial, the court shall impose the appropriate sanction including but not limited to censure, reprimand, contempt, and such other sanctions as are provided under the Rules of Court for failure to appear at pre-trial, or in case both of the parties absent himself/themselves, or for abusive conduct during mediation proceedings<sup>32</sup>. Such other sanctions include the dismissal of the action<sup>33</sup>.

The benefits of court-annexed mediation are:

- **AFFORDABILITY:** Mediation services are typically free or less expensive than other traditional means.
- **TIMELINESS:** Mediation cases are usually heard in a more expedited manner.
- **CONVENIENCE:** Mediation cases do not present the logistical problems found in other methods of problem resolution.

<sup>30</sup> Article 2035, Civil Code of the Philippines.

<sup>31</sup> An Act Penalizing the Making or Drawing and Issuance of a Check without Sufficient Funds or Credit and Other Purposes.

<sup>32</sup> A.M. No. 01-10-5-SC PHILJA

<sup>33</sup> Rule 18, Section 5, 1997 Revised Rules of Civil Procedure.

- **UNDERSTANDABILITY:** Mediators are trained to set the participants at ease, to explain the mediation process, and the mediator's role in the process.
- **PRIVACY:** With few exceptions, mediation sessions are held in private so that the parties need not air their grievance or complaint in a public setting.
- **EFFECTIVENESS:** Nationally, in 75% to 90% of mediation cases mediated in a controlled dispute resolution situation, the parties reach an agreement.
- **SATISFACTION:** Participants report a high degree of satisfaction with the process and the results. The parties maintain control over the outcome.

When the mediation process does not work, the early neutral evaluation under the Judicial Dispute Resolution process is resorted to. It is a series of activities undertaken for failed mediation cases. It is employed as last resort when the parties could not reach a settlement. It is also employed when there is likelihood that the parties would change their minds. At this stage it is already the judge which will act as the conciliator or mediator. This is provided for by A.M. No. 04-1-12-SC, a resolution issued by the Supreme Court which stated the concept of a judicial dispute resolution process. As stated in the resolution, the following models shall be used:

- the use of the pre-trial judge who will conciliate between the parties
- the use of the pre-trial judge as an early neutral evaluator
- the use of the pre-trial judge as mediator
- a combination of any of the above.

### 3. Enforcement effectiveness

To enforce the National Health Insurance Act, the Philippine Health Insurance Corporation in its charter, has quasi judicial powers. It can enforce the law through the appropriate procedures as outlined in its charter and the IRR. The Philippine Health Insurance Corporation can prosecute complaints, has a grievance machinery, and a mechanism for administrative protests.

The enforcement of the contract is made effective by the stipulations of the parties, and more so their will. An arbitration mechanism can be put in place, as well as clauses that serve as coercive measures to ensure its enforcement, like penalty clauses. A penalty clause can provide as follows:

It must be emphasized that under Article 1191 of the Civil Code, the power to

rescind obligations is implied in reciprocal ones, in case one of the obligors should not comply with what is incumbent upon him. The injured party may choose between the fulfilment and the rescission of the

***In the event that the SECOND PARTY incurs a delay in its obligations, damages in the amount of \_\_\_\_\_, per day of delay shall be paid accordingly; provided that the delay is not attributable to FIRST PARTY, and provided further that the delay is not caused by factors beyond the control of the SECOND PARTY.***

***In the event that either parties commit fraud in the performance of its obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.***

***In the event that either parties are negligent in the performance of its obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.***

***In the event that either parties contravene the tenor of their obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.***

obligation, with the payment of damages in either case. He may also seek rescission, even after he has chosen fulfilment, if the latter should become impossible. Much more so, under the Civil Code, those who in the performance of their obligations are guilty of fraud, negligence, or delay, and those who in any manner contravene the tenor thereof, are liable for damages<sup>34</sup>.

Although at the moment the “Implementing Rules and Regulations of the National Health Insurance Act (R.A. 7875) as Amended by R.A. 9241 provides for penalties in case of offenses and misbehavior of healthcare providers and members. The penalties vary from a minimum of 10,000 Pesos to a maximum of 50,000 Pesos and a suspension of the accreditation from 3 months up to the whole term of accreditation. The amount of the penalty and the term of suspension of the accreditation are related to existing mitigating or aggravating circumstances. One could also argue about the maximum fine of 50,000 Pesos. It seems that the maximum fine should be much higher to be effective:

*“More reliance on POST- audit activities of a very small percentage of paid claims would result in the desired compliance rates. Post-audit is extremely important. Severe penalties (at least P100, 000) should attend the detection of outright fraud if they were to act as an effective deterrent. Minor penalties should attend inadvertent errors (P500, P1,000)” (Streveler 2007).*

#### **4. Current contracting practices**

PhilHealth is not totally a novice in the area of contracting. Since 1997 it has been involved in the process, though on a limited scope. For most of its providers, PhilHealth concludes a contract via warranties of accreditation. Providers that comply with the accreditation requirements of PhilHealth are given the privilege to provide a wide range of health care services to PhilHealth members, based on the capability of the institutions and its professionals.

To further expand its number of providers available to their members, PhilHealth has also concluded memoranda of agreements (MOAs) with LGUs for them to manage accredited rural health units (RHUs) to provide outpatient care packages.

In 2005, PhilHealth began its organized group enrolment initiative, the KASAPI programme (*Kalusugan Sigurado at Abot-kaya sa PhilHealth Insurance*), which aimed to include organized groups such as CBHCOs (community-based health care organizations) and cooperatives. PhilHealth signs a MOA with the CBHCO for inclusion of the latter’s members into the NHIP to ensure financial protection for their health care needs. In this partnership, the CBHCO pays to PhilHealth the premiums of its enrolled members.

## **VI. FROM CURRENT SITUATION TO THE FUTURE: DEVELOPING CONTRACTING (PART B)**

Part A described and reviewed the current systems and practices of the relationship between PhilHealth and providers, the business processes and the business process support systems to search opportunities for improvement and for increased cost-effectiveness of those processes and their support systems. Building on earlier work, e.g. by Dennis Streveler and other consultants as well as on international experience.

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<sup>34</sup> Article 1170.



Improvements are recommended in the dialogue between providers and PhilHealth, in claims processing and provider performance review. For all these improvements to happen it is seen as absolutely vital to first get the HMIS and its proper use in the required shape as advised in the Track 1 and Track 2 approaches.

Also the legal environment for contracting has been explored. An inventory of all relevant legal documents has been made and is separately annexed and also made accessible on the contracting website: <http://iosn.grouphub.com/projects/2474051/project/log> . Nothing legally seems to prevent entering into a contracting system, dependent of the modalities. However some changes in the regulations may provide for more effective contracting and for efficient dispute solving between PHIC and providers.

## **A. Concrete steps towards contracting**

In Part B the concrete steps towards the introduction of a contracting system will be explored, the options from which PHIC can choose, the conditions to be fulfilled and the challenges to making the contracting system effective. Therefore the steps to go into contracting will be described one after the other.

### **1. What to achieve with contracting**

- PhilHealth may want to explicitly formulate its objectives for entering into contracting and what it wants to get out of it, e.g. to achieve a supportive framework in which providers are enabled to deliver excellent services to their patients in partnership with PhilHealth. So, PHIC may want to do contracting for getting:
  - Availability of providers in a circumscribed area
  - Providing a defined benefits package to defined population
  - Delivering defined quantity and quality of outputs (e.g. cataract operations, immunizations, screening procedures etc.)
  - Specific health objectives /outcomes to be achieved, lowering maternal and neonatal mortality rates
  - Other?

The specific objectives of PhilHealth contracting could aim to ensure that providers:

- Comply with the terms of their contract and deliver the service in line with the service specification (in compliance with the PHIC benefits package);
- Deliver improved, high quality, effective services that reflect good practice. (The quality specifications should be a key component of the contract);
- Increase geographic and financial access to PHIC members
- Achieve successful outcomes for service users;
- Protect patients from balance billing and overcharging
- Encourage service user (patient) feedback that can be used to inform strategic commissioning decisions of PHIC;
- Focus on the strategic priorities set out in PhilHealth strategic planning;
- Allow risk to be monitored, managed and action to be taken to mitigate risks.
- Meet local and nationally agreed performance targets in health and health care;
- Deliver value for money;
- Provide information that informs wider commissioning and procurement activity;

- Provide performance information to all relevant stakeholders.
- Other?

## 2. What to contract

Although contracts are a flexible instrument, PHIC will be restricted to contract only those health services that are described in the Health Insurance Act and its regulations.

### i. Listed benefits in general

The actual benefits to be included and referred to in a contract will always cover the current range of inpatient packages according to the capacity of the provider. Outpatient packages, as currently included in the benefits package can also be included in a contract. The content of a contract can change if and when the benefits package changes. I.e. a contract cannot go beyond or outside the services as included in the benefits package of PhilHealth.

It depends of the formulation of the benefits package what subsequently can be included in the contract what exactly can be offered by the provider. If the formulation is rather general, i.e. hospital care, than everything that is done by the hospital can be reimbursed unless, specific medical interventions are excluded in the formulation of the benefits package and/or in the contract.

**N.B. the team has not reviewed the benefits package and its formulation, but takes the current formulation as starting point for contracting.**

### ii. Specific interventions/services

PhilHealth can also chose to select specific services, as covered by the benefits package, to be offered by selected providers as it does already for cataract surgery.

- ### iii. In its contracts it can also determine the volume of the services and/or of the specific interventions to be provided. This way, it can use this instrument to eventually concentrate high-tech and/or high-risk medical interventions for cost/effectiveness and quality reasons and compensate with this option for the shortcomings in the health planning system in the Philippines.

So, PhilHealth can insert in the contract precisely the type of benefit(s) and the volume of services it wants to get delivered to its members. See model/sample contract for details (Annex 5).

## 3. Whom to contract

In general, a contract will be agreed with a qualified provider, i.e. a licensed and accredited provider capable of providing the services to be offered in the benefits package. However, the power of contracting is in carefully selecting the providers, assuming there is something to select from and not a monopoly situation where a provider has no competitor. The latter may be the case in rural areas where there is only one secondary or for tertiary care only one tertiary level hospital. The same can be true for individual professionals to eventually be contracted. In all other cases offering a contract selectively can cause providers to offer better services, if these are going to be reviewed by the Corporation.

In order to prevent any conflicts with the providers that will not be selected or from whom specific services will not be selected or only in limited volumes, PhilHealth may want to be explicit about the criteria it will use to select the providers and their service, e.g.:

1. Needs of population to be served
  - a. Epidemiological profile
  - b. Geography

Based on these criteria, PhilHealth may e.g. decide to contract a limited number of providers in the NCR and/or a limited volume of specific services because of the epidemiological profile of a certain medical condition in a certain area (e.g. senile cataracts or angina pectoris caused by partial occlusion of the arteries feeding the heart and in need of angioplasty of CABG)

2. Price of the services offered by the provider

Price will not be the only criteria in most cases, but if the offered quality of care is equal among providers, price can be the decisive issue.

3. Volume of services

PhilHealth may prefer for some specific interventions providers capable of handling high volumes because of better quality and lower prices. However, accessibility for the members needs to be taken into account. I.e. there may be a trade-off between price/quality and accessibility!

It may also prefer bigger hospitals over smaller ones because the smaller ones, and especially the hospitals with less than 50 beds, will have more difficulty in guaranteeing quality of care, multidisciplinary and continuity of care.

4. Quality

Besides using e.g., accreditation, licensure/registration, certification and credentialing as pre-conditions for offering a contract, PhilHealth may also feel the need for further control of quality.

As mentioned above, the size of a hospital may be an issue for quality reasons.

5. Organizational:
  - a. Part of a vertically integrated network
  - b. Part of a horizontally integrated network

PhilHealth may favor the vertical integration of services for getting better services and for the effective use of a referral system. This may be for maternal and child care (including BEmONC and CEmONC) but also for care in general.

The integration of outpatient and inpatient care may be interesting to pursue, especially when introducing a case based payment system covering inpatient and outpatient care. This means that a legal person can offer different benefits and even work in different locations, cities or provinces.

A horizontally integrated network of e.g. midwives or of family physicians may offer advantages over individually organized practitioners as regards continuity of care (substituting for each other), or for offering better opportunities for internal medical audit and peer review as well as for post-graduate education.

6. Practical:
  - a. Certainty the provider can deliver
  - b. Willingness of provider to contract on the conditions offered.
  - c. Other

This will sound obvious but it's nevertheless important.

## 7. Financial/admin

- a) No balance billing
- b) Zero fraud
- c) Timely submitting of claims

This is an obvious set of criteria and very much related (a & b) to member protection

## 8. Ideological reasons

- a. Only, or preferably, public providers
- b. Only, or preferably, private ones
- c. Mixed

In principle, PhilHealth may want to freely choose between public or private providers, dependent of quality and in combination with any of the other above mentioned criteria. However, it may also feel obliged or pressured to contract public providers despite the eventual better quality of services by the private provider in the same area. This is a contentious area. However, PhilHealth primary responsibility is towards its members and not towards public or private providers. The Price/Quality rate and the other criteria should be the only criteria that matter.

## 9. Attracting (private) investments, e.g.

- a. DBP (KFW/ADB supported investment Monies)
- b. Other

As described elsewhere, the Philippines is in need of health investments but not everywhere and not in all places to the same extent. PhilHealth may want to selectively support those investments and those providers that will improve access to quality care for its members, e.g. settle themselves in underserved areas

## 10. Any combination of the above

#### 4. How to contract

PhilHealth can choose to **handpick the providers** it wants to contract, based on its current experience with providers and based on any of the above reflected criteria. The advantage of this method is that it can move slowly and pick one provider after the other for a contract. The disadvantage is that this method may create an image of secrecy by PhilHealth because of lack of transparency in the procedures and the perceived lack of any recourse by the providers who see their neighbours getting nice contracts and better payment for what they may think are equal level services. This method may also be prone to favoritism and corruption.

The alternative method is to **organize a tender** for specific contracts with specific categories of providers, nationally or regionally/provincially. To avoid the disadvantages of the handpicked process (favoritism and corruption) the tender should be organized in a transparent way with in de bid-evaluation committee representatives/observers of umbrella organizations, patients, DOH the league of Governors and the like. Loevinsohn's book provides more details about this option.

#### 5. How to pay

PHIC will have to decide how it wants to pay the contracted providers, i.e. what payment mechanism it wants to use.

- PhilHealth can just stick to its current payment system and eventually add a certain amount per unit (day, intervention, capita) to the current system if going for a preferred provider system.

Besides making the payments faster, the way the payments are being made can remain the same as they are now and as reflected in the IRR and the AO's, until there is the opportunity to go into electronic banking and e-payment systems.

## **6. What incentives to offer**

Providers invited to enter into a contract will certainly want to know what the advantages will be for them. PHIC can consider to offer one or more of the following incentives

- Timely payment
- Support for admin optimization
  - Improve speed of billing process
  - Prevent RTH and deduction/refusal of claims
- Advance warning, dialogue and explanation of changing PHIC policies
- Higher fees, reflecting performance and differences in investment costs
- Status of preferred provider on top of accreditation
- Marketing by PHIC to members of services of preferred providers
- Feedback on comparative performance

## **7. Conditions for selecting providers**

Selecting providers assumes that:

1. PhilHealth has the mandate to select the services it wants to offer its members from the various providers available on the market, i.e. that it can actually
  - a. from public providers, i.e.
    - i. not all may get a contract
    - ii. not all their services may be contracted
  - b. from private providers,
    - i. preferred above public ones, based on explicit criteria (i.e. may include the bankruptcy or abolishment of a public providers
    - ii. not all may get a contract
    - iii. not all their services may be contracted

Such selection may not be appreciated by the public providers and their political bosses, i.e. the Governors and Mayors if they see that the hospital they formally own is not chosen to get a contract at all or that some of the services on offer are not wanted or only in limited numbers while their neighbouring provinces or municipalities have more luck. However, if PHIC is aiming at and can make clear that their picks are the best way to serve its members, and therewith also the population, inhabiting the governor[s]/mayor's province/municipality than this should be acceptable (also in Court).

Selection further assumes the:

2. Existence of oversupply of providers, or of
3. Over-capacity of providers,
4. Existence of anti-monopoly/anti- cartel regulations

## 8. Content of the contract

As mentioned before, a contract is a flexible instrument. The attached model for contracting of hospitals and doctors (Annex 5) can easily be adjusted for the contracting of specific benefits and of services or for contracting different categories of providers. PhilHealth can add to or delete from the model what it deems to fit its objectives and administrative practice.

### B. Future business processes: claims processing

Improving claims processing is already happening: 10 out of 18 PRO's were able to improve the average claim processing time due to strict monitoring of claims processing time in the first half of 2008.

The example of the Valenzuela Medical Centre shows it is also possible to improve the claim processing in the hospitals to a great extent. The Valenzuela Medical Centre is a 100 bed teaching and training hospital under the Department of Health. They won the 2008 Leadership and Management Award from USAID and MSH (Management Sciences for Health). Their Quality Improvement Team implementing their quality program identified seven problem areas of which reducing the number of RTH insurance claims) was identified as the problem area that could have the greatest positive impact on the facility. It is interesting to see that the percentage of RTH claims (in average 22%) could be a proxy of the quality of the hospital.

The team set a challenge of reducing the RTH claims by 50% by November 2006. The team was able to reduce (comparing the month of January to November 2006) the number of RTH by 83.6% greatly exceeding the target of 50%.

This illustrates that:

1. Leadership and management play an important role;
2. The number of RTH claims obviously could be a proxy of the quality of the hospital;
3. Even with the present system it is possible to improve claim handling and claim processing time as the example of PhilHealth (monitoring) and the example of the Valenzuela Medical Centre shows.

A factor which not should be underestimated is the face to face contact between PhilHealth officials and the providers. Talking to each other creates understanding of each other's problems and a common effort to solve the problems. ***PHIC may want to consider establishing positions for account managers in all PRO's and Provincial offices who are the first point of contact for the providers and who talk to the hospital management on a regularly basis (at least twice a year).***

Even with the improvements within PhilHealth and even if all the hospitals follow the example of the Valenzuela Medical Centre the system will remain very tedious. Gathering information by hand means that if you want to use the information for policy reasons, health care management or fraud detection, the data have to be entered into a computer to make it manageable and to make statistics etc.

Claims processing is one of the most important business processes of a health care insurance company. Besides paying the providers it is a "conditio sine qua non" (a condition without the system won't work) to make sure the members and dependants can get the benefits they are entitled to. It is for a health care insurance company (it should be) the main source to get information about the providers, the use of the benefits by the insured and the development of the different diseases. Therefore it should

provide information for a kind of a three dimensional database which can be approached from the patient side, the provider side and from the disease side. This data base should also offer the possibility to track patients, providers and the disease over time. I.e. it gives a longitudinal approach, which also offers the option of long term quality control. However, if the patient does not stick to one doctor or hospital it may be difficult to develop such longitudinal patterns. A referral system helps to avoid this.

Future claim forms of PhilHealth should have no attachments or almost no attachments and included in the n-Claims2 design. Further no information should be asked, on or with the claim form, PHIC already has or should have.

The existing “Form 1” and “Form 2” used now are clearly inadequate to support any form of automated adjudication since “the invoice” which contains the charges actually is an “attachment” to the claim rather than part of the claim itself.

### **Electronic claims processing, provider profiles and fraud detection**

Once an electronic claims processing system is in place it is possible to make provider profiles and to have fraud detection in a structured way. Provider profiles give the opportunity to gather the necessary information about the healthcare system and fraud detection will protect the system against excessive payments.

For fraud protection and provider profiles it is recommended to look at the different systems already available on the market because it could be less expensive than to develop your own software.

Besides back-payment of the claim there are penalties if it comes to fraud. These penalties vary from a minimum of 10.000 Pesos to a maximum of 50.000 Pesos and a suspension of the accreditation from 3 months up to the whole term of accreditation. The amount of the penalty and the term of suspension of the accreditation are related to existing mitigating or aggravating circumstances. One could also argue about the maximum fine of 50.000 Pesos. It seems that the maximum fine should be much higher to be effective.

The Terms of Reference for the PHIC-staff in charge of the administrative part of claims review for fraud detection are described in Annex 3. It should be a position on the level of Vice-President of the organization.

Electronic claims processing could be a result of the upgrading of the system. If electronic claims are completely implemented it could result in a saving on labour costs of 50% or more which in Pesos means a saving of 286 million. It is not necessary to fire PHIC staff because with appropriate training they can be used for other tasks in the changing environment of PhilHealth. Due to lack of data it could not be estimated how much the extra costs for the providers will be in case they don't have the means at the moment for electronic claims processing.

The reduction of costs for claims processing could be used to finance the incremental costs increase for contract implementation.

A future claim form could look like having:

#### **1. A unique identifier of the provider.**

As a result of the accreditation and/or contracting process PhilHealth has all the information about the provider it needs. This information can be stored in a provider database and the provider should have a unique number related to the provider in this database.

There should also be a possibility to put the unique identifier of the provider to whom the patient is referred to or referred by. In the Netherlands this is used as an indicator for quality of care by the medical specialists. There is a system of referral by the General Practitioners to the medical specialists. The referral pattern of the GP's can be used for planning because it tells something about the use of hospitals by patients from different regions. (In the Netherlands almost every medical specialist has his/her practice in a hospital).

## **2. A unique number of the insured persons.**

Everybody should have a unique number in the membership database (the number of the dependants can be related to the number of the paying member). There are countries where everybody has a unique civil service number. As we understood the Philippines is working on this also. If this number is implemented it should be used in claims processing. A unique member/ dependant number makes it possible to have eligibility checking on line.

## **3. A unique code for the different provisions or treatments.**

The concept of treatment has to be defined. What is included and what is not? It should, of course, reflect the benefits package and the agreed benefits to be delivered by the provider. There should also be clarity about the inclusion of imaging, drugs and lab tests as to avoid making the patient pay for this if it is included in the package/ contract and fee.

As supporting system a Health Data Dictionary is required containing also information about the provisions or treatments. A case based payment system should therefore also define what's in the case.

## **4. A unique code for the diagnosis at admission and codes for the final diagnoses.**

This will also give information about the quality of the care provided. Overtreatment or the wrong treatment can not be in the interest of the patient or the health care insurance company. It creates also the possibility to gather information about morbidity and co-morbidity. Co-morbidity should also be coded. The codes for the diagnoses should be in a Health Data Dictionary also.

## **5. Price or agreed fee paid by the patient or others and the price or agreed fee to be paid by PhilHealth.**

Of course the computer of PhilHealth should control this and should calculate the price/ agreed fee also related to the benefit package formulation (either in kind or reimbursement).

## **C. Business support systems**

The above described (future) claims form indicates that there are several business supports systems which not only are used to pay the claims but also support the gathering of health informatics. The claims form is the most important source for health informatics for a health insurance company. The trick of the story is to make data accessible in such a way that it gives you the information you need. Data should be explored by statistics, looking for outliers, looking for patterns, looking for re-admissions for the same disease or for combinations of patients/diseases/interventions which are not possible etc.

The business support systems for claim processing are:

1. A provider database with a unique identifier for the provider;
2. A membership database with the possibility of eligibility checking on line;



3. A Health Data Dictionary which also contains unique codes for the provisions/ treatments and diagnoses (morbidity and co-morbidity)
4. A database with information about the agreed prices/ fees for the different provision/ treatments;
5. A financial system to pay the providers. The computer checks the claims and if approved it should also approve and pay the claims. If there is no approval, return information should be automatically generated by the computer and send to the provider.

A fraud detection system is described below.

### **1. Electronic claims processing**

An Electronic Claim Processing (ECP) System is proposed; Such system supports the processing and control of the claims of the different providers related to the diagnosis and treatment services for outpatients and inpatients, to the medicines/drugs and other healthcare services, in accordance with the various rules of the Department of Health and PhilHealth. Submitting claims over the Internet eliminates expensive software licensing fees and provides faster implementation at much lower cost. (PHIC building its own network will be more expensive).

While, on the one side, the ECP system will keep all structured and coded data related to the healthcare services provided to the patients and will protect confidentiality and privacy of the data as well, on the other side it will facilitate the easy use of evidence based standards in the assessment and repayment of claims in an electronic environment.

It is an essential target to reduce claim payments regarding extra and unethical usage and to analyze the costs and services through ECP. On the other hand, such a system should not only concentrate on cost control but should also support the quality improvement and continuity of healthcare services.

It is also aimed that an ECP system will produce required information for healthcare and health insurance sectors by using various activity statistics, costs and quality indicators related to the healthcare services provided by various institutions. Therefore the ECP system should be designed in accordance with the management information systems.

### **2. Fraud prevention**

Fraud by the healthcare providers becomes more and more a problem at PhilHealth. The PHIC Legal Services Sector has four (4) separate and independent departments namely the Fact-Finding, Investigation & Enforcement Department (FFIED) who conducts investigations and provider visits to detect and prevent fraudulent activities, the Prosecution Department who handles prosecution of cases filed before it by the FFIED, the Arbitration Department who hears and decides cases filed by the Prosecution Department and lastly, the Internal Legal Department who handles the over-all corporate legal requirements of the Corporation.

About 4% of the claims are assumed to be fraudulent. It should be noticed that this percentage is found using the present system of claims processing. It could be quite different as compared to a system of electronic claim processing because a lot of fraudulent claims cannot be discovered by hand.

This means you that you can buy the software and modify it according to your/PHIC needs.

It does not mean that it has to be Rosella's software. It is recommended to look at the different systems already available on the market because it could be less expensive than to develop your own software.

The Rosella BI Platform<sup>35</sup> offers a comprehensive approach to fraud detection:

*Fraudulent healthcare claims increase the burden to society. Therefore healthcare fraud detection is now becoming more and more important. Generally, healthcare frauds are not obvious and thus difficult to detect. The followings are typical examples of healthcare fraud techniques used by health care providers and patients;*

- *Providers billing for services not provided.*
- *Providers administering (more) tests and treatments or providing equipments that are not medically necessary.*
- *Providers administering more expensive tests and equipments (up-coding).*
- *Provider's multiple-billing for services rendered.*
- *Providers unbundling or billing separately for laboratory tests performed together to get higher reimbursements.*
- *Providers charging more than peers for the same services.*
- *Providers conducting medically unrelated procedures and services.*
- *Policy holders letting others use their healthcare cards.*

#### **General Fraud Detection Strategy**

*If you know who trick your organization and understand how they do that, you know how you can perform effective fraud detection! There are two steps to follow to catch fraudulent claims;*

1. *Find out "WHO" and "HOW" they trick your institution; Healthcare frauds are mostly from healthcare providers. By lodging bogus services, they cheat healthcare insurance companies. These claims and providers tend to have some common profiles and patterns. Identify profiles and patterns from known fraudulent cases.*
2. *Find audit rules and predictive models; once you know profiles and patterns of fraudulent providers and claims, develop audit rules and procedures for them. The primary difficulty will be that data that link fraud directly does not exist in claims databases. You will need to identify profiles that link to fraud indirectly.*

*Rosella BI Server offers a perfect platform to implement fraud detection systems with powerful rule engines and advanced predictive analytics. (Rosella's marketing claim).*

#### **D. Statistical healthcare fraud detection techniques**

*The net effect of excessive fraudulent claims is excessive billing amounts, higher per-patient costs, excessive per-doctor patients, higher per-patient tests, and so on. This excess can be identified using special analytical tools. Provider statistics include;*

- *Total amount billed.*
- *Total number of patients.*
- *Total number of patient visits.*

<sup>35</sup> Rosella BI platform, <http://www.roselladb.com/healthcare-frauddetection.htm>

- *Per-patient average billing amounts.*
- *Per-patient average visit numbers.*
- *Per-patient average medical tests.*
- *Per-patient average medical test costs.*
- *Per-patient average prescription ratios (of specially monitored drugs).*
- *and many more.*

#### *E. Analytic Healthcare Fraud Detection Methods*

*Healthcare fraud detection involves account auditing and detective investigation. Careful account auditing can reveal suspicious providers and policy holders. Ideally, it is best to audit all claims one-by-one carefully. However, auditing all claims is not feasible by any practical means. Furthermore, it's very difficult to audit providers without concrete smoking clues. A practical approach is to develop short lists for scrutiny and perform auditing on providers and patients in the short lists. Various analytic techniques can be employed in developing audit short lists. Keep in mind that excessive fraudulent claims lead deviations in aggregate claims statistics. In addition, fraudulent claims often develop into patterns that can be detected using predictive models!*

##### *1. Statistical listings of risky providers*

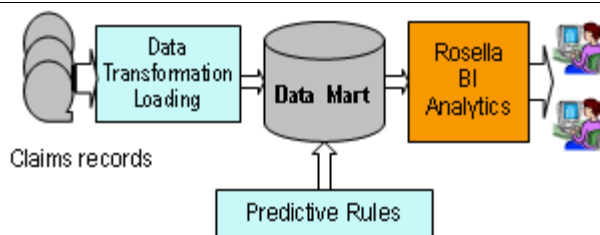
*When abusive claims are repeated frequently, the consequent is higher provider statistics. Various provider statistics can be used to identify fraudulent claims. For instance, audit short-lists may include the followings;*

*Doctors who treated whopping, say 50+ patients in a day.  
Providers administering far higher rates of tests than others.  
Providers costing far more, per patient basis, than others.  
Providers with high ratio of distance patients.  
Providers prescribing certain drugs at higher rate than others.  
and so on.*

*It is noted that statistical analytic techniques can reveal excessive providers who might be outright stupid! But it will be difficult to identify modest level fraud activities. The subsequent section describes how sophisticated techniques can be applied.*

#### *VII. DATA MART FOR HEALTHCARE CLAIMS AUDIT*

*Incorporating the techniques described in previous sections leads to intelligent audit and fraud detection environment. It is noted that healthcare fraud detection requires compilation of potentially huge data, involving complex computation and sorting operations. Our data mart platform for healthcare fraud detection is based on the following architecture. First, claim payment records are transformed and loaded into healthcare fraud data mart. Data is added into data mart, normally monthly or quarterly basis. Summary information is created for providers, doctors and policy holders. Expert systems engines are used to analyze score and detect potentially risky providers and claims, Finally, auditors (and investigators) analyze data.*



#### A. Rosella BI Platform for Healthcare Data Mart

Healthcare claims data marts can contain potentially huge amount of information. In addition, the complexity in detecting fraudulent claims makes fraud detection extremely challenging. Rosella BI Platform can help you with the following features;

##### 1. Fast Rosella DBMS

Rosella is a big main-memory optimized high performance cross-platform database management system. It has very fast sort engine which drives sorting and aggregation operation, using up to 512GB main memory. This is essential for healthcare data marts.

##### 2. Predictive modeling

Rosella BI platform supports a number of advanced predictive modeling methods such as neural network, decision tree, regression, etc.

##### 3. Expert systems

Rule-based expert systems engines are indispensable part of Rosella BI platform. Fraud patterns are transformed into audit and screening rules, and applied in screening and detecting fraudulent claims.

##### 4. Chart and report writing

Rosella BI server has built in charting and report writing engines incorporated with predictive modeling and expert systems engines.

Rosella BI Platform provides all-in-one end-to-end platform for healthcare data mart solutions that you can build. It is available to both value-added solution vendors and in-house developers. Note that it comes with template implementation that you can extend.

### 3. Recommendations

The consultant team strongly advises to follow up on the recommendation of Dennis Streveler made in his report in 2007 for the improvement of HMIS.

He estimated the costs for improvements as follows:

(In million Pesos)	
* Financial Management Information System	150
* Improvement membership and collection system (PreMis and PMAIS)	50
* NClaims 2 ( Claims processing)	25
* Web – enabled PhilHealth National Health Data Dictionary	2.5
* Security and disaster preparation	7.5
	-----
Total	235

It is understood that from HMIS Track 1 the following will be accomplished in the first quarter of 2008:

- Health Data Dictionary;
- Claims processing with accredited providers all real time on line, including a membership data base with an unique patient number and the possibility for eligibility checking;
- Data base with best practices'

Subsequently followed by the following elements of Track 2 to be accomplished:

- National Health Data Dictionary
- N-claims 2;
- Provider profiles;
- Cost-Benefit Analysis;

Although the Cost-Benefit-Analysis of proposed supercenters was not approved by the Board of PhilHealth, the above mentioned improvements are very useful.

Rejecting the concept of supercenters, should however not relax security and disaster preparation.

## 1. Targets

According to Streveler's report, PHIC could consider the following possible targets:

2009: no more than 50% of claims should need any "attachments";

2010 : no more than 30% of claims should need any "attachments";

2011: no more than 20% of claims should need any "attachments";

Nirvana (Final State): no more than 8% of claims need any "attachments".

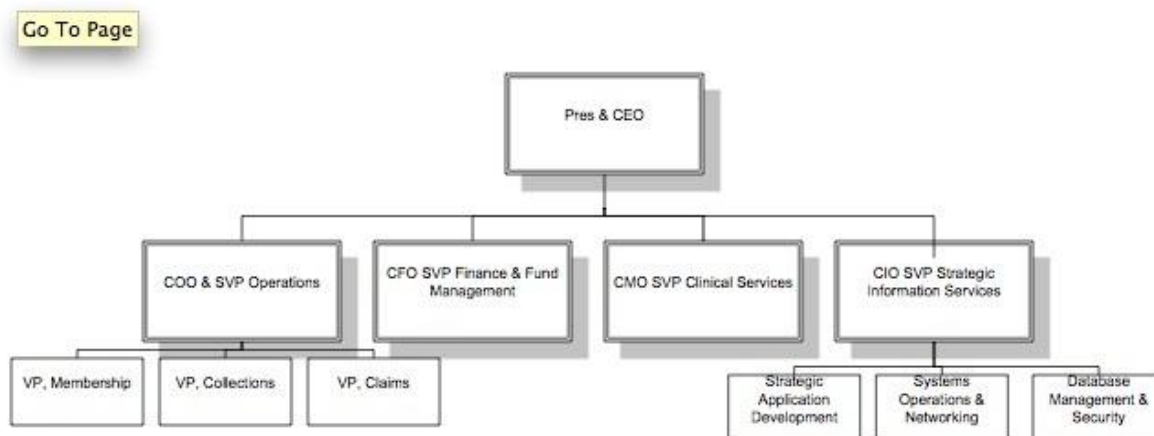
Of course there is a need for ex-post audits based on statistics looking for outliers etc.

## D. Health management information system

### 2. Organizational requirements

A **clear and effective strategy for health insurance** is the first step towards establishing reliable HMIS-based transactions between providers and PhilHealth. *However, this can only be done effectively and*

*efficiently after the implementation of Track 1 and Track 2!* Due to the importance of HMIS and its contribution to the corporate vision, mission, and goals, it should be **championed by the chief executive officer (CEO) and managed by a chief information officer (CIO) directly reporting to the CEO**. The multi-departmental nature of information within the Corporation has made it necessary to appoint a CIO whose role will be to integrate the various agendas of the different departments while maintaining streamlined systems. The following figure shows a sample organogram that places the HMIS under the direct supervision of the CEO through a CIO.



### 3. System requirements and specifications to support contracting

A optimally functioning HMIS is necessary for the **effective management of claims, a core business process of PHIC**. This HMIS will consist of the transaction system which interacts with external systems (provider HMIS) and which also informs the corporate executive information systems (EIS) for decision support.

An important pre-condition for a successful HMIS is the **design of an integrated corporate information systems architecture** where all core processes of the corporation (membership, collection, claims, and accreditation) link to each other to offer just-in-time information.

All in all, this re-design of the information systems architecture must be **led by the chief executive officer and managed by the chief information officer**.

Other features of the HMIS are :

**A database with information on agreed prices/ fees of different services/ treatments.** This database of standard rates is accessible by both providers and PhilHealth and contains contracted fees for pre-defined services. These data must come as an electronic database because it will serve data to all parties in the contract.

**Financial system to pay the providers.** The financial system must exist to ensure that adequately filed claims are processed correctly and reimbursed appropriately by PhilHealth.

**System to measure provider performance.** Both PhilHealth and providers must have access to provider performance data for different reasons; for PhilHealth, to determine where the provider stands among

his/her peers; for the provider, to look for further areas of operational efficiency and quality improvement.

**Fraud detection system.** When data from claims and accreditation are in integrated form, fraud detection can be instigated and automated warnings given by the system using predictive algorithms even before huge fraudulent claims are accumulated.

#### 4. PhilHealth's next steps for HMIS as preconditions to contracting

In order to achieve the ideal HMIS setup, PhilHealth needs to take action on previously recommended activities (Streveler 2007) that were divided into Track 1 (short-term) and Track 2 (long-term) reforms, to wit:

##### a. Track 1 (short term)

1) **The recognition of HMIS as a strategic resource and its elevation directly under the Chief Executive Officer and managed by a Chief Information Officer.** This action stresses the strategic value of HMIS within the Corporation for policy support and for operations. The appointment of a chief information officer will also mitigate the growing functional disintegration and its reflected impact onto the existing HMIS.

2) **N-Claims database cleanup.** The N-Claims database requires some significant cleanup and integration before it can function optimally for contracting. This cleanup needs to be performed at the soonest possible time with a multi-disciplinary team overseeing the process (not just ITMD). It also requires a health data dictionary to inform the team on how to map old data elements to the new cleaned up version.

3) **Fast tracking of online inquiry services.** Once the database has been cleaned, online services may now be offered to members and providers with the confidence that these are sufficient quality.

4) **Elimination of attachments.** Where possible, attachments should be avoided especially those which are already accessible from historical and application data.

5) Start pilot with selected providers. **All of the components of the contracting mechanism may be observed and monitored closely to allow all parties to refine their respective conditions and to understand how the contracting mechanism will actually work on a larger scale. Figure shows how this pilot may be done.**

##### b. Track 2 (long term)

1) **Unique identifiers for patients.** Numeric identifier which uniquely identify patients are important for the new HMIS. This is consistent with the World Health Organization's recommendations in the Medical Records Manual for Developing Countries. In this manual, WHO strongly recommends the assignment of one number per patient for medical records.

2) **Craft N-Claims 2 requirements.** The current system of PHIC will need to evolve from its current patchwork of databases into a more efficient and more automated, integrated HMIS operating in fewer centres around the country.

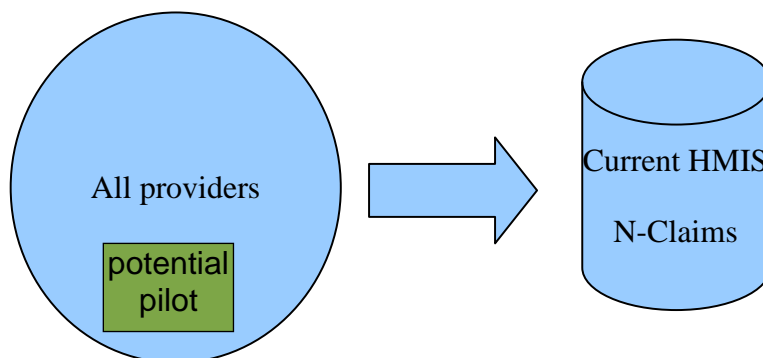
3) **Formalize N-Claims2/Supercenter concept within Corporation.** The improvement of the HMIS, which starts with its elevation as a corporate strategic value, should ultimately result into a corporate-wide redesign of core processes that are more responsive to internal and external stakeholder needs. This

means the HMIS re-design efforts (which will result into N-Claims2 and the Supercenters) should start at the soonest possible time to make the most out of the remaining time and resources of the corporation.

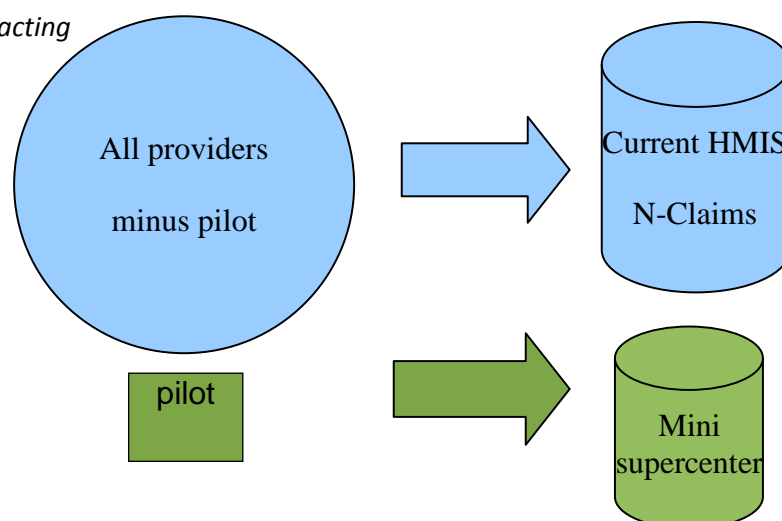
#### Conceptual map of the transition from old HMIS to new

This transition aims to shift contracted providers only into a new HMIS. This new HMIS could be the start of N-Claims2 and Supercenter concept.

*Before contracting*



*With pilot of contracting*



#### b. Priority tasks of the CIO

**Defining of reports to be extracted from clean database and then given to contracted providers.** This entails the design and creation of profile templates which are extracted from PhilHealth's database and are supplied to the providers. The Health Informatics Section has started this activity and is waiting for its formalization.

**Formalization of the health data dictionary (HDD).** This is a structured set of metadata which defines the key data elements for use in the corporate information systems. The HDD is key to cross-departmental communication and will help to avoid misinterpretations of queries. The HDD should become first a corporate standard and subsequently, a transaction standard between PhilHealth and the contracted providers.



**Formalization of the data warehouse within the Corporation.** The N-Claims database cleanup process will open up opportunity for database integration. The data warehouse is a result of the cleanup process and can contribute to the creation of the warehouse which can serve the internal needs of the management for decision making by providing them an integrated perspective of the corporate data..

**Defining standard performance indicators, measuring them regularly, and using them to feedback performance to PROs and providers.** While the new system (N-Claims2, supercenters) is being put to place, current provider operational indicators should be extracted from N-Claims and be used for feeding back performance. This feedback serves several purposes: 1) to inform providers of their status vis-a-vis their peers; 2) to advise PhilHealth of possible outliers based on statistics; and 3) to advise providers on areas for operational improvement.

A template terms of reference for a chief information officer may be found in Annex 4.

**Caveat: Tracks 1 and 2 only list priority action areas for the reformation of PhilHealth HMIS to respond to the contracting mechanism.** Once the CEO and the CIO are involved actively in HMIS as a strategic resource, more items may enter into the picture. The key is to get the leadership to provide mandate to the HMIS re-design as soon as possible. Given that it may take three years at least for the design of N-Claims2 and to introduce the Supercenters concept, we strongly recommend that Track 1 and 2 items be started at the soonest possible time and that their implementation is considered as a necessary condition for the start of efficient contracting.

## **E. Updating provider performance review**

Models of external evaluation include accreditation, peer review, inspection, ISO certification, and evaluation using 'business excellence' or other frameworks (Marquez 2001). Each of these models is evolving to meet changing demands which include public accountability, clinical effectiveness, and improving the quality and safety of services and their outcomes.

Actually there are two types of provider performance review i.e. the financial and administrative review as described in this report and the review of the performance according to standards being the cornerstone of quality assurance in healthcare. Even when appropriate and evidence based standards are available, many doctors do not routinely follow them. Also medical staff of PHIC has difficulties with the interpretation of the standards. This leads to different interpretations of provider performance and may lead to unjustified variations in the outcome of the claims review process with eventually financial consequences for the doctors/hospitals.

Further, the question is: "What is the best strategy to make providers perform according to standards". There is a lot been written about this but one thing is for sure making regulations is not the best way to do it.

The use of obligations through regulations, rules, and requirements is a form of management intervention that is used by governments throughout the world to enforce compliance with input standards (such as training requirements for licensed practitioners and the availability of space and other requirements for healthcare facilities) and to define who is authorized to perform what kinds of medical interventions (such as licenses to prescribe certain medications). In countries where government agencies directly provide healthcare services to a substantial segment of the population or where the government is the primary payer, public sector agencies potentially hold considerable power to influence the delivery of care. In reality, however, regulations are a rather blunt instrument for

inducing behaviour change at the facility or provider level. Moreover, most government health agencies in developing countries have very limited funds and capacity to enforce such regulations. Perhaps for these reasons, regulations have not been applied widely to achieve performance according to standards.

Moulding et al. (1999), drawing on behaviour change theories and the results of many pilots described in articles, proposed a five-step process for successful dissemination and implementation of clinical practice guidelines:

**Step 1:** Assess the readiness to change of individuals within the target population of healthcare providers to determine the appropriate mix of strategies for providers at each stage of readiness

**Step 2:** Identify the specific barriers to performance according to the standards

**Step 3:** Decide what level of intervention (i.e., individual, group, or population) would likely be most effective given the target providers' stage of readiness and the specific barriers to performance

**Step 4:** Design standards dissemination and implementation strategies that match the needs, readiness, and barriers of target groups

**Step 5:** Carry out and evaluate the effectiveness of the strategies

Further, PhilHealth will need to continue its collaboration with specialty societies and leading clinicians in order to update its current set of clinical practice guidelines (CPGs) and add new ones to cover most of the high volume and/or problematic cases seen at medical evaluation. PhilHealth wisely sees the CPGs as a guidance and not as mandatorily to be followed, given the character of standards, i.e. based on clinical probability, on ignoring co-morbidity and other complicating factors (like patient compliance).

The report of the national consultant, Dr. Mary Ann Evangelista, about CPG's (Supplementary Annex 3), further reflects on the problems around CPG's.

## **1. Accreditation of providers**

It is suggested to have institutional providers accredited every 2 years with the obligation to inform PhilHealth if there are any changes in the "crucial" for accreditation during the accreditation period and to make them pay a substantial fine if they don't. It will save money on the provider's side and on the side of PhilHealth. If PhilHealth decides to have contracting on top of accreditation this could mean that PhilHealth does not need any additional resources to make contracting possible.

The accreditation of professionals is being considered as an administrative procedure.

It is further recommended that quality of care provision needs to be emphasized as an accreditation requirement under a contracting mechanism. PhilHealth's processes and capacity to monitor and evaluate its providers according to standards need to be enhanced.

## **2. Profiling of providers**

As mentioned earlier the electronic claims should undergo an almost completely computerized process which gives the possibility to make provider profiles, checking for right accounting of the claims and to be used for fraud detection.

Analysis of care profile patterns should provide PhilHealth and providers with meaningful information on clinical performance to help reduce variations and thereby help improve the quality of the services provided.

Based on the provider profiles, Phil Health's medical staff should discuss with the providers their professional behaviour compared with the agreed standards and should try to change the provider's behaviour if favourable for the patients and PhilHealth. Making statistics and interpreting statistics, gathering the necessary information to interpret is also a process of learning by doing. It needs somebody with an academic degree in mathematics and/ or statistics or well trained public health doctor with a background in clinical epidemiology and medical/ bio statistics.

### **3. Monitoring the performance of contracted professionals and health care institutions**

The contract between PhilHealth and the provider constitutes the basis for the evaluation of performance where actual performance is to be compared with the targets negotiated at the outset of the contract. Differences are then used as basis for discussion, including analysis to determine why targets were not met and what can be done to improve things in the future. Such a process provides the opportunity for both parties to systematically review progress against longer term goals.

This requires formal evaluations and reviews, as well as very regular contact between the parties.

Mechanisms will have to be in place at PhilHealth and at the provider level to identify and assess problems routinely. The current processes of utilization review, peer review and submission of the monthly mandatory hospital reports, while useful, are still quite limited in scope and depth in providing an evaluation of the performance of parties, in great part to their paper based character which does not allow for aggregation of data and profiling of providers, comparing them with their peers.

Having identified improvement opportunities, parties can agree to solutions which are preferably recorded 'at the table' in the form of signed notes and appended to the contract document.

At the outset, contracts should include the description and requirements of the performance review process. It can include a requirement that the provider will generate prescribed data on services activities and quality and in prescribed formats so that performance can be measured against targets as specified in the contract.

Draft Terms of Reference for the staff in charge of performance monitoring are attached (Annex 2)

### **4. Indicators**

As for the evaluation of providers, it depends on the issues agreed upon in the contract and the necessity to measure the outcome. Not everything needs to be or can be measured. However for measuring it is necessary to have good definitions about which both parties agree on. If this is the case a set of indicators can be implemented.

Again, this could be a very tedious task. Non-clinical services are easier to monitor than clinical services. To give another example to make clear how tedious determining a set of indicators could be:

Suppose one of the goals of PhilHealth is to improve the access to healthcare. The first question is: "How to define access to healthcare". This could be the availability of health services as such (opening hours,

geographical or financial access) or the extent to which agreed processes are implemented (e.g. a referral system or CPG's),

It could also aim at improving the impact of services as measured by outcomes. If for example the objective is promoting successful birth outcomes, 3 outcome indicators could be used i.e. neonatal mortality, (low) birth weight and congenital syphilis. The problem with such indicators is that they, for most of the time, reflect not just the performance of one professional or one hospital but of a range of health workers and institutions. E.g. maternal and neonatal mortality are dependent of:

- (i) adequate family planning, preventing pregnancies of very young or rather old women; or leading to a healthy spacing of pregnancies as to allow the woman to recover from the previous pregnancy and to replenish her body iron and to improve her nutritional status in general;
- (ii) the availability of health promotion and condoms to prevent sexually transmitted diseases;
- (iii) the adequacy of prenatal care, which requires healthy behaviour (no use of tobacco, alcohol etc. and adequate nutrition) and active help-seeking behaviour of the mother and requires professional care by midwife, nurse or doctor, predicting the obstetric risks. In case of elevated obstetric risk, women will be need to be timely referred to another professional, halfway during the pregnancy, which makes it difficult to ascribe causality to one or the other professional;
- (iv) professional assistance during delivery and in the period of postnatal care, which can also be done by different professionals. Sometimes adequate and timely transport with well equipped vehicles will be necessary to get the delivering mother or the preterm, immature or distressed newborn at the next level of care. I.e. several contracted professionals and/or hospitals could become involved.
- (v) These factors make it also difficult to track just one professional and measure his performance.
- (vi) The timely availability of safe blood or blood products and/or of pharmaceuticals.

In the end maternal mortality indicator statistics or neonatal mortality statistics can become like bikini's: "what they reveal is tempting but what they hide is vital". So, in these cases, MMR and NMR are only acting as flags indicating that there is a deviation from the aspired level and posing the need to dig deeper and to look where in the chain of events and activities of the various health care providers the care was sub-optimal and where this can be improved. Such approach demands an active quality improvement policy and activities that are commonly stimulated as part of an accreditation system. For PhilHealth in its contracting of professionals it will be important, not only to make sure that providers take part in such quality improvement efforts and requires accreditation as a condition for a contract, but also to formulate such indicator that is really and uniquely related to the contracted provider (professional or hospital and the patients diagnosed and treated by him or it). Further search for such specific indicators!!

Therefore, before determining a set of indicators, define policy, contract goals and performance expectations. If you know what you want, you can define it and try to measure it. The report on Options for Performance Review for Contracting (Evangelista Dec 2008) provides some options for indicators.

## F. A new way to communicate and have dialogue

In general, stakeholders for contracting agree that continuing dialogue between parties is an essential element for smooth implementation. At present, there is no structured dialogue schedule with providers and members.

Nonetheless, a number of PROs have initiated annual, semi-annual or quarterly dialogues with providers [and members] mainly for claims processing concerns. If and when other topics are covered, stakeholders feel that the information provided is still insufficient for their needs. Hence, the general impression still is that not enough dialogue happens between them and PhilHealth.

PhilHealth is also regularly invited by the Philippine Hospital Association (PHA) and the Philippine Medical Association (PMA) to its scheduled meetings for information sharing. The PHA conducts dialogues once a year in each of its chapters and also hosts an annual convention. The PMA also hosts an annual national convention and once a year for each of provincial medical societies. In these meetings, new issuances or troubleshooting tips are shared by PhilHealth in the areas of claims processing and accreditation.

No review meetings are done about the actual relationship of PhilHealth and provider, or PhilHealth and member as partners.

***It is proposed that to effect a new communication dynamic with PhilHealth stakeholders, there should be a pre-determined schedule of dialogue agreed upon by the parties concerned with a structured agenda aimed at assessment how each of them are performing according to agreed parameters. This avoids the usual problem of merely airing complaints and grievances to PhilHealth.***

***These dialogues will be done throughout the year, by area or by PRO; by a team composed of central office and PRO staff; guided by certain indicators for assessing performance within the context of contracting.***

Having a dialogue is not the same as imposing changes. It means that intended changes in e.g. policy or implementation of the health insurance program have to be discussed. This requires a different attitude especially from an organization with Quasi – Judicial powers like PhilHealth. A dialogue however does not mean that if there is no agreement the necessary changes should be stopped. There should always be somebody to take the decisions. However the dialogue can attribute to a more acceptable way of implementing those changes and to actually accept the proposed changes as being reasonable and fair. Where and on what topics do the interests of the providers and PhilHealth meet and what do they want to achieve:

Providers	PhilHealth
<ul style="list-style-type: none"> <li>• to cure patients</li> <li>• a good healthcare system</li> <li>• adequate planning of healthcare facilities</li> <li>• good quality of care</li> <li>• the possibility to earn an adequate income</li> <li>• a fair and timely payment</li> <li>• timely accreditation or contracting</li> <li>• less bureaucracy</li> </ul>	<ul style="list-style-type: none"> <li>• to ensure affordable, acceptable, available and accessible healthcare for all citizens in the Philippines which means:</li> <li>• enough healthcare providers, also in remote areas</li> <li>• enrolment of the population in the system</li> <li>• good quality of care</li> <li>• an efficient healthcare system</li> </ul>

<ul style="list-style-type: none"> <li>• timely announcement and explanation of circulars (changes)</li> <li>• protection against patients who do not pay their co-payments</li> <li>• explanation about returned and denied claims</li> <li>• a fair Grievance and appeal procedure</li> <li>• provider profiles (maybe not in the beginning but after a few years they cannot do without them)</li> </ul>	<ul style="list-style-type: none"> <li>• no more costs and no higher premiums than necessary</li> <li>• no fraud</li> <li>• no balance billing</li> <li>• financial protection for the members</li> <li>• leveraging provider payments on quality in healthcare</li> <li>• to be the key-player in the healthcare system</li> </ul>
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It is clear that both, the providers and PhilHealth have to play an important role in the healthcare system of the Philippines. Combining efforts to make the Philippines a better place as it comes to outcomes of the healthcare system is necessary. One cannot do without the other. Therefore it is absolutely necessary to have an institutionalized system for a dialogue in place. As necessary, a memorandum of agreement may be signed between PhilHealth and PMA/PHA detailing how this dialogue can proceed. Elements of such a MOA are provided in Annex 6.

As mentioned above there are already many situations in which there are contacts between PhilHealth and the providers i.e. accreditation teams, meetings between management and staff of the PRO's with the administrative staff or with medical directors of the hospitals and PhilHealth's "Healthcare Provider Relations Department".

It seems not necessary to have more staff to do the job. It is more about structuring the dialogue. Such systematic and sustained dialogue could be done on national level by establishing a standing advisory committee with representatives of e.g. the Philippine Hospital Association and the Philippine Medical Association. Maybe these representatives can have a seat in the Grievance and Appeal Committee also. This advisory committee could be asked to give their opinion about changes in the system, on forthcoming circulars, on the content of contracts and so on.

Besides on the national level it is advisable to also have an advisory committee on the provincial level (per PRO) with people from the different medical disciplines. In this committee all things important for the healthcare in the region can be discussed. Further, it is advisable to discuss the contracts and administrative matters with representatives of the various medical disciplines in the regions. Working together means trust, and trust has to be deserved and not violated (it comes on foot and goes on horse!).

## **G. Changing regulations**

In order to have PHIC contracting based on a firm legal footing and to allow for an arbitration mechanism, the following amendments are being proposed:

1. Sec. 4 of Republic Act 7875, as amended by Republic Act 9241, is proposed to be amended by inserting the following definitions as follows:

d.) Contracting- a purchasing mechanism used to acquire a specified service or services, of a defined quantity and quality, at an agreed-on price, from a specific provider or providers, for a specified period.

e.) Service Contract- the agreement entered into between PHIC and the health care provider or providers for the health care provider to provide specific health care services, of a defined quantity and quality, at an agreed on price, for a specified period, to beneficiaries of the National Health Insurance Act.

v.) Participating Health Care Provider- a health care provider who under an express contract with the Philippine Health Insurance Corporation has agreed to provide a specified service or services, of a defined quantity and quality, at an agreed on price, for a specified period.

2. Sec. 34 of Republic Act 7875 as amended by Republic Act 9241, is proposed to be amended as follows:

Section 34. Provider Payment Mechanisms. - The following mechanisms for public and private providers shall be allowed in the program:

- a) Fee-for-service based on mechanisms established by the Corporation;
- b) Capitation of health care professionals and facilities, or networks of the same including HMOs, medical cooperatives, and other legally formed health service groups;
- c) Budget based on mechanisms established by the Corporation
- d) Contracting based on mechanisms established by the Corporation;
- e) A combination of those above; and
- f) Any or all of the above, subject to a global budget.

3. Sec. 43 of Republic Act 7875 as amended by Republic Act 9241 is proposed to be amended as follows:

Sec. 43. Hearing Procedures of the Committee. Upon the filing of the (Original Text: complaint) complaint for grievance, the Grievance and Appeal review Committee, from a consideration of the allegations thereof, may dismiss the case outright due to lack of verification, failure to state a cause of action, or any other valid ground for dismissal of the complaint after consultation with the Board; or require the respondent to file a verified answer within five (5) days from service of summons.

Should the defendant fail to answer the complaint within the reglementary 5-day period herein provided, the Committee, *motu proprio* or upon motion of the complainant, shall render judgment as may be warranted by the facts alleged in the complaint and limited to what is prayed for therein.

After an answer is filed and the issues are joined, the Committee shall require the parties to submit, within ten (10) days from receipt of the order, the affidavits of witnesses and other evidence on the factual issues defined therein, together with a brief statement of their positions setting forth the law and the facts relied upon by them. In the event the Committee finds, upon consideration of the pleadings, the affidavits and other evidence, and position statements submitted by the parties, that a judgment may be rendered thereon without need of formal hearing, it may proceed to render judgment not later than ten (10) days from the submission of the position statements of the parties.

In cases where the Committee deems it necessary to hold a hearing to clarify specific factual matters before rendering judgment, it shall set the case for hearing for the purpose. At such hearing, witnesses whose affidavits were previously submitted may be asked clarificatory questions by the proponent and by the Committee and may be cross-examined by the adverse party. The order setting the case for

hearing shall specify the witnesses who will be called to testify, and the matters on which their examination will deal. The hearing shall be terminated within fifteen (15) days, and the case decided by the Committee within fifteen (15) days from such termination.

The decision of the Committee shall become final and executory fifteen (15) days after notice thereof: Provided, however, That it is appealable to the Board by filing the appellant's memorandum of appeal within fifteen (15) days from receipt of the copy of the judgment appealed from. The appellee shall be given fifteen (15) days from notice to file the appellee's memorandum after which the Board shall decide the appeal within thirty (30) days from the submittal of the said pleadings. The decision of the Board shall also become final and executory fifteen (15) days after notice thereof: Provided, however, that the decision of the Board is appealable to the Court of Appeals in accordance with the Rules of Court. (Original Text: Provided, however, that it is reviewable by the Supreme Court on purely questions of law in accordance with the Rules of Court.)

The Committee and the Board, in the exercise of their quasi-judicial functions, as specified in Section 17 hereof, can administer oaths, certify to official acts and issue subpoena to compel the attendance and testimony of the witnesses, and subpoena duces tecum ad testificandum to enjoin the production of books, papers and other records and to testify therein on any question arising out of this Act. Any case of contumacy shall be dealt with in accordance with the provisions of the Revised Administrative Code and the Rules of Court. The Board or the Committee, as the case may be, shall prescribe the necessary administrative sanctions such as fines, warnings, suspension or revocation of the right to participate in the Program.

In all its proceedings, the Committee and the Board shall not be bound by the technical rules of evidence: Provided, however, That the Rules of Court shall apply with suppletory effect.

## **1. IRR amendments**

1. Title II, Section 3 of the Implementing Rules and Regulations of the National Health Insurance Act is proposed to be amended by inserting the following definitions as follows:

Section 3. Definition of terms - For the purposes of these Implementing Rules and Regulations, the terms below shall be defined as follows:

c.) Accredited Provider - a health care provider that has been accredited in accordance with the these Rules.

d.) Arbitration - a voluntary dispute resolution process in which one or more arbitrators, chosen in accordance with the contract entered into between the Philippine Health Insurance Corporation and the participating health care provider, and/or rules promulgated in accordance with Republic Act 9285 and Republic Act 876, resolve a dispute that arose from the contract.

e.) Arbitration Pool- a pool of thirty-five arbitrators, with five representatives from the government sector, five representatives from the institutional health care providers sector, and five representatives from the labor sector, five representatives from the employer sector, five representatives from the self-employed sector, five representatives from the Filipino overseas workers sector, and five representatives from the health care professionals sector respectively, from which the parties to a contract in a dispute choose the arbitrators who shall resolve the dispute.



f.) Arbitration Panel - a panel of three arbitrators chosen by the parties from the Arbitration Pool to resolve the dispute that is the subject of the contract.

f.) Arbitrator - person chosen to render an award in a dispute that is the subject of the contract.

g.) Award - any partial or final decision by an arbitrator in resolving the issue in a dispute.

i.) Contracting- a purchasing mechanism used to acquire a specified service or services, of a defined quantity and quality, at an agreed-on price, from a specific provider or providers, for a specified period.

j.) Contract- the agreement entered into between PHIC and the health care provider or providers for the health care provider to provide specific health care services, of a defined quantity and quality, at an agreed on price, for a specified period, to beneficiaries of the National Health Insurance Act.

rr.) Participating Health Care Provider- a health care provider who under an express contract with the Philippine Health Insurance Corporation has agreed to provide a specified service or services, of a defined quantity and quality, at an agreed on price, for a specified period

2. Rule VIII, Section 46 of the Implementing Rules and Regulations of the National Health Insurance Act of 1995 is proposed to be amended as follows:

Sec. 46. Payment Mechanisms - Payment of a health care provider shall be made through any of the following mechanisms:

- a.) Fee for service;
- b.) Capitation payment to health care professionals and institutions or networks of the same including HMOs, cooperatives, and other legally formed health service groups based on capitation rate guidelines set by the Corporation;
- c.) Contracting based on mechanisms established by the Corporation;
- d.) A combination of those above;
- e.) Any or all of the above, subject to a global budget.

3 A new rule is proposed to be inserted to provide for the contracting mechanism. This rule is to be inserted after Rule VIII on Payment of Claims. The new Rule proposed to be inserted is as follows:

#### Rule IX

##### CONTRACTING OF HEALTH CARE PROVIDERS

Section 50. Scope- This rule shall cover the contracting of health care providers by the Corporation. Only health care providers accredited in accordance with Rule X shall be considered for participation in the service contracting program.

Section 51. Objectives - The Corporation shall implement a service contracting program for the acquisition of specified health care services, of a defined quantity and quality, at an agreed-on price, from a qualified health care provider, for a specified period. The objectives of service contracting program are:

- a.) to optimize resource use and quality of health care services;
- b.) to improve transparency and accountability;
- c.) to improve the processing time for the payment of health care services;

- d.) to provide a flexible platform between health care providers and the Corporation for the provision of health care services; and,
- e.) to maximize the resources.

Section 52. Limitations of Contracting- The Corporation shall contract only under the following parameters:

- a.) to pay for the utilization of health services by covered beneficiaries or;
- b.) to purchase health services in behalf of covered beneficiaries.

The Corporation cannot:

- a.) provide health care directly;
- b.) buy and dispense drugs and pharmaceuticals;
- c.) employ physicians and other professionals for the purpose of directly rendering health care; and,
- d.) own or invest in health care facilities.

Section 53. Contracting- In contracting with providers the Corporation and the providers shall be guided by the following:

- a.) The Corporation shall alert targeted health care providers for the contracting program;
- b.) The Corporation shall explain the policy of the contracting program to the targeted health care providers, with respect to the following:
  - 1.) The intention of the parties
  - 2.) The objective of contracting
  - 3.) The expectations of the parties
  - 4.) The proposed process of contracting;
- c.) The Corporation shall offer to the health care providers the terms of the sample contract, and explain its provisions;
- d.) The parties shall endeavour to negotiate the contract, and arrive at an agreement;
- e.) The parties shall comply with the service contract in good faith;

Section 54. Terms of the Contract - The contract entered into by the Corporation and the health care providers may include the following terms:

- a.) pricing
- b.) design and implementation of administrative procedures;
- c.) delivery of specific health services;
- d.) payment terms;
- e.) arbitration as a dispute solving mechanisms;
- f.) quality control;
- g.) performance monitoring;
- h.) outcomes assessment;
- i.) mechanism for feedback;
- j.) technology assessment;
- k.) conditions for termination and renewal of service contracts;
- l.) enforcement mechanisms; and,
- m.) such other terms the parties may agree on.

Section 55. Criteria for selection of Providers - The Corporation shall set criteria for the selection of participating health care providers in accordance with the following criteria:

- a.) financial viability of the health care providers;
- b.) quality of service provided;
- c.) epidemiological profile of the population to be served;
- d.) geographic location;
- e.) performance history of the health care provider for a given period;
- f.) nature of services offered by the health care provider;
- g.) willingness of health care provider to participate in the program; and,
- h.) such other criteria that the Corporation deems appropriate.

Section 56. Arbitration - All disputes that arise from the contract shall first be resolved through arbitration in all cases. An arbitration panel composed of three arbitrators shall be chosen from the arbitration pool by the parties to the dispute. In no case shall two or more arbitrators be from the same sector. This does not preclude the parties to provide for the selection of arbitrators in the contract and the arbitration process to be followed.

Section 57. Quorum and Votes Required - The concurrence of two votes of the Arbitration Panel shall be required to render an award in all cases.

Section 58. Selection of Members of the Arbitration Pool- The members of the Arbitration Pool shall be chosen by the Board.

Section 59. Applicability of the Arbitration Law and the Alternative Dispute Resolution Act of 2004 - The provisions of Republic Act 9285 and Republic Act 876 shall apply suppletorily to arbitration as provided for in this Rule.

e.) Rule XXV, Section 135 of the Implementing Rules and Regulations of the National Health Insurance Act of 1995 is proposed to be amended as follows:

Section 135. Board Decision Reviewable by the Court of Appeals. - Final orders and decisions of the Board may be reviewed by the Court of Appeals in accordance with the provisions of the Rules of Court. Final orders and decisions of the Board under Title VIII on Administrative Remedies may also be reviewed by the Court of Appeals.

e.) Rule XXXIV, Section 170 of the Implementing Rules and Regulations of the National Health Insurance Act of 1995 is proposed to be deleted. This is because the coverage of this section may be too broad that, there may be no more grievances that can be filed. Also, the exclusionary coverage of this section is not provided for under Republic Act 7875 as amended by Republic Act 9241.

The said section provides:

Section 170. Grievance and Protests Not Covered. - Any action of a program implementor which can be the basis of an administrative or criminal complaint or charge under this jurisdiction of the Office of the Ombudsman, the Sandiganbayan, Civil Service Commission, or the regular courts of justice is neither a grievance nor a protest covered by this Rules and shall be dealt with in accordance with applicable laws.

## **2. Process requirements**

In order to arrive at the agreed stipulations for the object of the contract, there are three stages of a contract: 1) preparation, conception or generation 2) perfection or birth of the contract, which is the

moment when the parties agree on the terms of the contract and 3) consummation or death, which is the fulfilment or performance of the terms agreed upon.

To operationalize the contracting process in the present context, the law and the IRR is proposed to be amended by putting provisions on contracting mechanism. To reiterate, these are the guidelines that can be put in place for the contracting mechanism:

Section 53. Contracting- In contracting with providers the Corporation and the providers shall be guided by the following:

- n.) The Corporation shall alert targeted health care providers for the contracting program;
- o.) The Corporation shall explain the policy of the contracting program to the targeted health care providers, with respect to the following:
  - a. The intention of the parties
  - b. The objective of contracting
  - c. The expectations of the parties
  - d. The proposed process of contracting;
- p.) The Corporation shall offer to the health care providers the terms of the sample contract, and explain its provisions;
- q.) The parties shall endeavour to negotiate the contract, and arrive at an agreement; and,
- r.) The parties shall comply with the service contract in good faith.

### **3. Dispute solving systems**

The Philippine Health Insurance Corporation, to carry out its tasks more effectively, shall be vested with the following powers :

- a.) to conduct investigations for the determination of a question, controversy, complaint, or unresolved grievance brought to its attention, and render decisions, orders, or resolutions thereon. It shall proceed to hear and determine the case even in the absence of any party who has been properly served with notice to appear. It shall conduct its proceedings or any part thereof, in public, or in executive session; adjourn its hearings to any time and place; refer technical matters or accounts to an expert and to accept his reports as evidence; direct parties to be joined in or excluded from the proceedings; and give all such directions as it may deem necessary or expedient in the determination of the dispute before it;
- b.) to summon the parties to a controversy, issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other materials necessary to a just determination of the case under investigation;
- c.) to suspend temporarily, revoke permanently, or restore the accreditation of a health care provider or the right to benefits of a member and/or impose fines after due notice and hearing. The decision shall immediately be executory, even pending appeal, when public interest so requires and as may be provided for in the implementing rules and regulations. Suspension of the rights of members shall not exceed six (6) months.

The revocation of a health care provider's accreditation shall operate to disqualify him from obtaining another accreditation in his own name, under a different name, or through another person, whether natural or juridical.

The Arbitration Mechanism can be provided as follows in the contract:

All disputes that arise from the contract shall first be resolved through arbitration.

The parties shall select three arbitrators from the arbitration pool as constituted by the FIRST PARTY in accordance with its Rules. One arbitrator shall be chosen by the FIRST PARTY, the second by the SECOND PARTY, and the third as agreed upon by both parties. In the event that there is a disagreement as to the third arbitrator, the two arbitrators selected by both parties shall choose from the third member.

The selection of the arbitrators must be made within \_\_ days from the service of the demand for arbitration. The arbitration of the dispute must not exceed \_\_ days. This period may be extended by mutual consent of the parties.

Arbitration shall proceed as follows:

- a) Either party shall serve upon the other party a demand for arbitration. Such demand shall set forth the nature of the dispute, the amount involved, if any and the relief sought, together with this contract.
- b) The demand shall be served in person or by registered mail.
- c) Within \_\_ days from the selection of the arbitration panel, the arbitration panel shall set a time and place for the hearing of the matters submitted, and must cause notice to be given to the parties. Adjournment may be ordered by the arbitrators upon their own motion only at the hearing and for good and sufficient cause.
- d) No adjournment shall extend the hearings beyond the number of days to arbitrate the dispute as stated in this contract.
- e) The hearing may proceed in the absence of any party who after due notice, fails to be present at such hearing or fails to obtain an adjournment. No award shall be made solely on the default of a party. The arbitrators shall require the other party to submit such evidence as they may require for making an award.
- f) Only the parties to the dispute, or their representatives duly authorized in writing shall be permitted to be present during the arbitration.
- g) The parties to the dispute must endeavor to settle the dispute amicably.
- h) The arbitrators shall at the commencement of the hearing ask both parties for brief statements of the issues in controversy and/or an agreed statement of facts. Thereafter, the parties may offer such evidence as they desire, and shall produce such additional evidence as the arbitrators shall require or deem necessary to an understanding and determination of the dispute.
- i) The arbitrators shall be the sole judge of the relevancy and materiality of the evidence offered or produced.
- j) At the close of the hearings as set by the arbitrators, the arbitrators shall specifically inquire of all parties whether they have any further proof or witnesses to present. Upon the receipt of a negative reply from all parties, the arbitrators shall declare the hearing closed unless the parties have signified an intention to file briefs. Then the hearings shall be closed by the arbitrators after the receipt of briefs and/or reply briefs. Definite time limit for the filing of such briefs must be fixed by the arbitrators at the close of the hearing.
- k) The written award of the arbitrators shall be rendered within 30 days from the closing of the hearings. This period may be extended by mutual consent of the parties.
- l) The award must be made in writing and signed and acknowledged by the concurrence of two of the arbitrators. Each party shall be furnished with a copy of the award. The arbitrators in their award may grant any remedy or relief which they deem just and equitable and within the scope of the contract of the parties.

In the event that the parties during the course of the arbitration have settled their dispute, they may request of the arbitrators that such settlement be embodied in an award which shall be signed by the arbitrators. All negotiations towards settlement of the dispute must take place without the presence of arbitrators.

The parties may by written agreement submit their dispute to arbitration other than by oral hearing. The parties may submit an agreed statement of facts, respective contentions to the arbitration panel in writing which shall include a statement of facts, together with documentary proof, or the parties may submit a written agreement. Each party shall provide all other parties to the dispute with a copy of all statements and documents submitted to the arbitrators. Each party shall have an opportunity to reply in writing to any other party's statements and proofs; but if such party fails to do so within seven days after receipt of such statements and proofs, that party shall be deemed to have waived his right to reply. Upon the delivery to the arbitrators of all statements and documents, together with any reply statements, the arbitrators shall declare the proceedings in lieu of hearing closed.

The Corporation shall not be bound by the technical rules of evidence.

The revocation of a health care provider's accreditation shall operate to disqualify him from obtaining another accreditation in his own name, under a different name, or through another person, whether natural or juridical.

Republic Act 7875, as amended by Republic Act 9421, provides a grievance system in which members, dependents or health care providers of the Program who believe they have been aggrieved by any decision of the implementors of the Program, may seek redress of the grievance. The Implementing Rules and Regulations on the National Health Insurance Act provide three different kinds of procedures for the enforcement of the law. These enforcement procedures are for the investigations of complaints against health care providers and members, complaints for grievances against program implementors and administrative protests against decisions pertaining to processing and payment of claims. It must be borne in mind that the rules governing these procedures shall be liberally construed to carry out the objectives of Republic Act 7875, as amended by Republic Act 9241, and to assist the parties in obtaining an expeditious and inexpensive resolution of any case arising under the said Act . The Rules of Court and prevailing jurisprudence may be applied in a suppletory character to all cases brought before the Corporation in the interest of expeditious resolution of these cases.

In the context of a contract, The Philippine Health Insurance Corporation can put in a place an arbitration mechanism to resolve disputes, so as to prevent the long and tedious process of resolving disputes through the court system. The Arbitration Mechanism can also be put in place in the Implementing Rules and Regulations, as proposed, if there is no arbitration mechanism in the contract.

PhilHealth is recommended to have this included in a contract for reasons of easy conflict resolution.

## **H. Conditions for effective contracting**

### **1. General**

Although PhilHealth will be able to do small scale (pilot) contracting but to make it an effective tool, efficiently used, a number of conditions need to be met:

- The adoption of the aforementioned streamlined HMIS & efficient business processes
- Making a split between accreditation from payment. Accreditation by PHIC entitles to reimbursement by PhilHealth. As a first step, selected providers could get higher payments compared with colleagues/competitors who are accredited but not selected for a contract. A follow up step could be to make accreditation a necessary but not sufficient condition for payment by PhilHealth.
- PhilHealth will have to decide if it wants to designate a new Unit for Contracting or to add the job of contracting to one of the existing units. In any case, a close collaboration of the accreditation department, the claims processing department and the eventual unit for contracting is necessary. PhilHealth will have to distinguish between HQ and PRO's. It may further want to consider the position of Account Managers for handling the relation with providers.
- The reshaping of the processes for claims & performance review especially in relation with the planned extension of the outpatient benefits package and the planned introduction of a case-based payment system respectively a DRG-based payment system
- An adjusted legal environment, supporting contracting and facilitating an arbitration mechanism. (Although legally it is possible for PHIC to enter into contracting right now, the proposed adjustments puts it on a firmer footing and provides for a more effective and efficient conflict resolution system
- An active social marketing program to educate the providers, their umbrella organizations, the patients and the public at large on the objectives, processes and impact of contracting.
- Sufficient training of PHIC & provider management & staff.

### **2. Investments**

Although no numeric consequences for staff are foreseen if PHIC takes some efficiency enhancing measures in claims processing and implements its planned HMIS system, in reducing its accreditation frequency from once per year to once in two or 3 years and with moving into third party accreditation, qualitative upgrading of staff are certainly necessary.

### **3. Increasing PhilHealth financial clout**

PhilHealth has relatively little financial clout vis a vis the providers. It finances only about 10% of the health expenditures. To put this percentage in perspective, it does not have to finance public health and the operating costs of DOH and LGU health departments. It does also not finance investments, at least not in a direct way. PHIC pays only for variable, operating, costs of providers. But PHIC payments of direct health care costs are still very limited as compared with the on average 40% out of pocket payments by the patients at the point of services. How to increase PhilHealth clout? Five avenues can be considered:

- Extending the benefits package, by making it broader and deeper, therewith

- Increasing PHIC actual relative payment levels for providers (i.e. less out of pocket payments, OOP)
- Extend coverage of the population, i.e. expand the % members of the population, insured with PHIC
- Increase the contribution levels and therewith PhilHealth's revenues to pay for the increased costs of the extended benefits package
- Change to a benefits in kind system and make co-payments part of the total fee of the providers to be negotiated by PHIC.
- Creation of a single payer/purchaser of health services.

These avenues will be shortly explored hereafter. More details in the report of Ron Hendriks (Supplementary Annex C1).

#### **4. Extending the benefits package<sup>36</sup>, lowering OOP and increasing contributions**

The current benefits package is rather restricted and the burden of paying contributions into PhilHealth unevenly spread. For details see the Report of the International Consultant on financial and administrative management, Dec. 2008 (Supplementary Annex C1). An earlier advice by Hendriks (2007) to expand the package while there were sufficient resources has not been taken. There has been no change in the premiums for 2006, 2007 and 2008 which means that the recommendations in Hendriks report of April 2007 are still valid.

Raising premiums will be an extra burden for poor people and that they cannot afford this. However every medal has two sides. While people have the freedom of choice for paying out – of – pocket for health expenditures there is no guarantee that the majority of the population would be able to afford health care costs through paying out – of – pocket. Actually they have no choice if they want to receive medical care: they have to pay out of pocket. The issue is the high proportion of catastrophic expenses of households. People become poorer or impoverished due to the higher and/ or rising costs of health care.

What people need is financial protection. If people cannot afford to pay higher premiums than these higher premiums should be paid out of taxes (which means more income redistribution). Further the cap can be increased to raise more revenues and the threshold for the poor can be increased under which they pay no premium at all. Also people in the lower income brackets could pay a lower percentage of their income than people in the higher income brackets.

The changes in the package in 2007 and 2008 have been incremental which means that the recommendations in Hendriks' report of April 2007 are still valid.

The Health Sector Reform (HSRA) has two key financial objectives:

1. increase level of health – related expenditure to at least 5% GNP;
2. change current pattern of financing health care by increasing the share of the National Health Insurance Program (NHIP) to 30% and government budgetary allocations to 40% while decreasing household out-of-pocket spending to 20%.

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<sup>36</sup> PhilHealth overview benefit package



Using the figures from the Philippines Health Care Financing Strategy paper (2008-2017) (table 10, page 22) the impact of the two key financial objectives mentioned above is as follows:

The figures of 2005 are converted in figures fulfilling the objectives (in billion Pesos):

	Actually	ff objectives
% GNP	3.2	5.0
National and Local Government	52	113
PhilHealth	20	85
Out-of-pocket expenses	88	57
Others	<u>21</u>	<u>28</u>
Total	181	283

**Conclusion: using the data of 2005 the impact from aspiring the above mentioned key objectives means that Government expenditure should raise by 117%, PhilHealth's benefit package (in money terms) should be expanded by 325% and the out-of-pocket expenses should be decreased by 35,2%.**

## 5. Single payer

The most important question is about the creation of a single payer system: why should the payment for health services by the national and local government (besides the premium payment for the indigents) go separately to the health care providers and not being pooled with the National Health Insurance Program, thus creating more clout for PHIC vis a vis these providers?

If the current fragmentation of funding is not repaired, then PHIC will never have sufficient clout. The country should make a clear choice between a Bismarck (social health insurance) system, financed from payroll contributions and additional funds from the National Budget to subsidize the poor and the non-contributing categories of society (like the elderly and the unemployed) with PHIC as implementing agency and a Beveridge type of system (national health system), financed from the Budget. Now the country has the unfavorable mix of a Bismarck and a Beveridge system, combined with territorial decentralization towards the lower government levels and it lacks therewith a powerful purchaser of health services.

## 6. Moving in the right direction

It should be clear that an objective for PhilHealth as financing 30% of the cost of health care has a very big impact on the benefit package and the premium structure. It is quite clear that if the Health Sector Reform Agenda is a serious issue on the Philippines, PhilHealth should be serious also in extending the benefit package and in adjusting the premiums. The benefit package has to extend up to more than 4 times compared with the figures of 2005 (money 2005).

Taking in mind the above objectives and their consequences, PhilHealth should start moving in the right direction:

- Shift from out-of-pocket payment at the point of services to a pre-payment mechanism should bring higher financial protection.
- Making the enrolment into PhilHealth mandatory, other insurers will only be interested to target the remaining market on top of PhilHealth service coverage. The figures from 2007 are not convincing. The number of insured people decreased with 2.6 million due to a decrease of the indigents of 9.9 million (which is very alarming and a total increase in the other sectors of 7.3 million which can be

considered as a positive development because they are the ones who could afford to pay a higher premium and actually contribute to PHIC's revenues)

- Informal workers and Sponsored Program flat premiums are not promoting a fair contribution to the system. This is still the same in 2007. See figures below.
- Reduce the out-of-pocket expenses to less than 40% in 10 years time. This has everything to do with the possibilities to shift to pre-payment mechanism, to stop balance billing by contracting health care providers, to extend the benefit package and to ask a fair contribution (premiums) from the different sectors of society to the system.
- A growth of 20% per year of PhilHealth financed by premiums and tax based subsidies. In 2007 there was an increase in benefit expenditure of 8.2% (from 17.1 Billion Pesos to 18.5 Billion Pesos which means that more efforts should be put to extend the benefit package (making it broader and deeper, i.e. more services and less co-payment, especially for the poor).

It should also be noticed that the reserve position of PhilHealth increases from 69.5 Billion Pesos in 2006 to 78.0 Billion Pesos in 2007 which is **374%** of the costs in 2007. It depends on the interpretation of the Law if PhilHealth is allowed to have 200% on reserves or 300% on reserves. But most certainly it can be no more than 300% which means that 74% should mandatorily be spend on extending the benefit package or lowering the premiums. 74% means 13.7 billion pesos available for benefits and/ or capacity investment at PHIC. However, 300% reserves is much too high for a social health insurance. In Europe this percentage is 8% for a social health insurer and 26% for a private health insurer.

An extension of the benefit package should go hand-in-hand with an adjustment of the premiums or tax related subsidies and PhilHealth could use part of the reserves also. A good start would be to follow the recommendation of Xavier Modol and his group to extend the Outpatient Benefit Package for the indigents and to raise the payment out of the PhilHealth Capitation Fund from 300 Pesos per indigent member to 650 Pesos per indigent member. Besides this, it could be wise to reconsider the present provision of generic medicines to the population of the Philippines. The focus of PhilHealth should be to provide high quality of primary health care funded through the National Health Insurance System by improving the accessibility to primary health care (doctors and other health professionals) and the provision of appropriate high quality drugs available to all at low prices. Such extended package can not only increase the health status but also prevent unnecessary admission to a hospital.

As the February 2008 report of Xavier Modol, "Evaluation PhilHealth Outpatient Benefit Package", clearly stated the 300 Pesos per indigent member from the Capitation Fund are not only used for the indigent members but for almost everybody. If the others besides the indigents are not members, PhilHealth should make them members also. Paying for people who are not insured is not a good policy for a health care insurance company. Several comments were made in PhilHealth's "Statement of income" for the year ended December 31, 2007 about the (mis-) use of the "Capitation Fund". Because of this, it is not easy to predict how much the costs of an extended OBP will be. Normally if the Benefits are 2.2 times as high as before (650:300) it is easy to calculate that the costs would be 2.2 times as high. In this case however the real costs of the Capitation Fund depend on the efforts of PhilHealth to enforce the rules.

It should also not be forgotten that in a Social Health Insurance System the healthy pay for the sick, the wealthier pay for the poorer, the young pay for the old. This is called solidarity. It seems that PhilHealth is not very successful in enrolling the better off in the Informal Sector. Maybe a law change could help. The law should state that no insurance company working in the Philippines is allowed to insure the benefit package or parts of it PhilHealth is insuring. This will make private insurance in the Philippines an additional insurance as it should be.

It was mentioned that the Executive Committee of PhilHealth took the decision to extend the Benefits package in 2009 with 33% “across the board”. Of course it is wise to extent the Benefit package. **However the planned increase provides also for a good momentum for more effective use of the available extra funds and to use the increase as incentive only for those providers that are willing to comply with PhilHealth requirements for being a preferred provider and willing to enter into a contract with PhilHealth. I.e. it would be create an excellent support for the introduction of a system of contracting with healthcare providers. Such amount may not easily be available in the near future.**

The planned extension of the Benefit package with 33% will costs approximately  $0.33 \times 20 = 6.6$  Billion Pesos. It is not clear yet if there will be a raise in premiums also.

## **7. Capacity at PhilHealth and providers**

In order to implement effective and efficient contracting, the number of PHIC staff seems sufficient but PHIC will have to implement its planned investments in HMIS and to embark on an extensive training program for its staff in the areas of accreditation, claims review, provider performance review, contracting and in the use of its more sophisticated HMIS. Also health care providers will need to receive training in contracting and related processes like claims processing, besides training in new payment systems (case based of DRG systems) and OPB. Attached are terms of reference for a training program on contracting (Annex 2).

### **I. Monitoring and evaluation of the process/outcomes and impact of contracting**

After having started the implementation of contracting, PHIC will want to know if contracting made a difference. It therefore will have to define what it wants to measure as based on the defined goals/objectives it wants to achieve with contracting. Optional objectives have been provided in this paper.

The next step is to define the information necessary for measuring the outcomes. Is this information available? Is it easy to obtain? Does PHIC has to collect other information than before? Is this easy to obtain or to implement? The answer on these questions depends on what PHIC exactly wants to achieve with specific contracts with specific providers.

The evaluation should answer the following questions:

- Is access to services improved (financially and geographically)?
- Are there effects of contracting on quality, efficiency and equity (improved access for the poor)?
- Gave Government and LGU's the necessary support?
- Has efficiency in business processes improved?

The following indicators and information can be used to answer the questions: Member services related

- Improved geographic access:

- e.g. travel to nearest 2<sup>nd</sup> level hospital or midwifery clinic has been reduced to less than 30 minutes. This can be measured in case a new hospital or clinic is established in a hitherto underserved area by using distance and average speed with common transport (bus or tricycle)
- e.g. travel to nearest 3<sup>rd</sup> level hospital reduced to less than an hour.
- Improved financial access
  - Out of pocket payments down with x % due to the following:
    - Balance billing reduced to zero
    - Fraud reduced to zero
    - Inappropriate medical care reduced by half, measured by the reduction in the % denied claims
    - Shift from 3<sup>rd</sup> to 2<sup>nd</sup> level hospital care for a specified population in a circumscribed area (e.g. in case a 2<sup>nd</sup> level hospital is established)
- Health status. This is difficult to measure across the board given the many factors influencing the health status of the population and the eventual parallel introduction of a case-based payment system for priority diseases, unless PHIC contracts for specific interventions like:
  - TB DOTS
  - maternity care, e.g.:
    - MMR & NMR reduced with x % (this can be measured but any reduction cannot directly and causally be related to contracting)
    - deliveries with traditional birth attendants down with x %
  - hypertension prevention/treatment
    - increase in number of persons in specific area, detected with hypertension and successfully treated resulting in systolic blood pressure of less than xxx mm Hg and a diastolic blood pressure of less than xxx Hg
- Administrative efficiency:
  - benefits/admin costs rate

Business Process	Indicators
Claims Processing	<ul style="list-style-type: none"> <li>● ⬇ Number of days to process a claim (provider, respectively PHIC)</li> <li>● ⬆ Number of claims paid</li> <li>● ⬇ Cost to process a claim</li> <li>● ⬇ Number of RTH claims</li> <li>● ⬇ Number of Denied Claims</li> <li>● ⬆ Number of claims processed</li> <li>● Cost of benefits/cost of claims ratio reduced.</li> </ul>
Accreditation	<ul style="list-style-type: none"> <li>● ⬆ Number of preferred providers</li> </ul>

	<ul style="list-style-type: none"> <li>• ↯ Number of days to accredit providers</li> <li>• Number of personnel trained</li> <li>• ↯ Cost to accredit providers</li> <li>• ↱ Proportion of PhilHealth Accredited Hospitals to DOH licensed hospitals</li> </ul>
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## 1. Data collection

As much as possible data should be gathered via PHIC regular data flow, i.e. via claims processing and making use of PHIC internal budget/cost information.

Surveys can be another good source of information e.g. the regular household survey to collect information about the out of pocket payments by patients and the strain this is on families.

Loevinsohn's book (referenced before) presents on pages 37 to 44 also a monitoring and evaluation approach with sound advice on data collection. It reflects also the option of comparison and the use of a control group, especially if and where contracting is a contested policy. In general, making comparisons should not be that difficult for PhilHealth as a monopolist. This is true for the administrative issues and OOP. However finding a similar situation to compare health outcomes is much more difficult, given demographic and morbidity differences in population of the areas without and with contracting.

## 2. Monitoring and Evaluation of the content of contracts and of the process of contracting

PHIC and providers will be interested to learn if the text of the contracts was conducive for achieving the objectives of contracting. i.e. about the sufficiency and clarity of its wording or if any details were superfluous or missing. Monitoring the number of questions asked by providers about the interpretation of a contract or the number of cases submitted to the arbitration panel would be good indicators. Further, of course the content of the questions and disputes is of interest.

PhilHealth and providers will have to separately make up their mind about the efficiency of the contracting process and their internal organization of the contracting process, besides the above mentioned indicators for efficiency of claims processing. This will be a mainly qualitative evaluation although numbers/hours of involved staff and timelines from initial dialogue to signing of contract can be recorded and collected.

All the collected information and the analysis should lead to yearly reporting to the Board of PHIC, eventually leading to adjustments of contracts or of the system and of the internal organization.

## J. Adjustments to co-payment collection and administration

A few options can be considered for adjusting the copayment system:

- Shift to PHIC and include in payment of providers. Shifting the co-payments to PhilHealth and including the co-payments in the payment of providers will improve the financial clout of PhilHealth considerably. This could be an issue in the contracts with providers. The question however is how to do this. All over the world it is common practice to have the collection of co-payments done by the providers (except for the co-payments which are income related, mainly operated in those countries where a good registration and tax collection system exists).

- By contracting the providers, PhilHealth could make an agreement with them that all co-payments exceeding a certain amount should not be paid by the patient but claimed by the providers from PhilHealth. A good example of this is the system of South Korea. This will avoid the poverty trap in a lot of cases. However the total amount of co-payments to be paid as maximum should be related on the social-economic situation in the Philippines, The same amount and conditions as in Southern-Korea ( Pesos 100.000) could be much to much for a lot of indigents in the Philippines. So, the maximum should be related to the income of the insured. This can be done via a system of income brackets and a means test.
- PhilHealth could also consider going to a benefits in kind system. By contracting the providers PhilHealth makes an agreement with them about the total price to be paid by the patient by PhilHealth and the private healthcare insures, like HMO's. This will avoid balance billing and the patient knows beforehand how much to pay for a certain benefit or health service.
- It is advisable however to have the co-payments collected by the providers, before admission of the patient, because they are in the best position to collect these copayments.

National Government	29
Local Government Units	23
PhilHealth	20
Out of Pocket	88
Others	21
	----
Total	181
<i>(year 2005; table 10 page 22)</i>	

According to the Philippines Health Care Financing Strategy 2008 – 2017 (Working paper May 30 2008) the financing of the healthcare system looks like: (source of financing; in billion Pesos)

It means that the Out of Pocket expenses are more than 4 times higher as the contribution from PhilHealth paid for the healthcare system. This most certainly has its impact when considering to shift the co-payment collection and administration to PhilHealth.

Shifting the co-payments to PhilHealth and including the co-payments in the payment of providers will improve the financial clout of PhilHealth considerably. This could be an issue in the contracts with providers. The question however is how to do this. All over the world it is common practice to have the collection of co-payments done by the providers (except for the co-payments which are income related in countries where a good registration and tax collection system exists).

The best time to collect co-payments is when the patient is in the doctor's office. Once they have left the office collections become more expensive and more difficult. In fact with forms, envelopes, stamps, the time spent, not to mention re-billing and eventually legal costs the cost of collection of co-payments after the fact can be nearly as much as the amount of the co-payment itself or even higher.

The collection of co-payments is required before the patient's appointment. It is better to collect in advance of the encounter than as part of the checkout process. Installing an ATM machine in the lobby of a hospital good is a good investment.

#### **There are alternatives however.**

PhilHealth could use a voucher system and ask the patients to buy vouchers in the front offices of PhilHealth. This means that PhilHealth has to know the amount of co-payment. This could be in the contract with providers and could avoid balance billing. The patient gives the voucher to the provider and the provider is claiming the benefit amount from PhilHealth including the amount of the voucher.

There should be a module in the financial system linked to the claim processing system to register the vouchers, to monitor their financial value and to check the vouchers sent in by the providers to see if they are really issued by PhilHealth. Of course it will take time to issue the vouchers and to make adjustments to the financial system.

To calculate the costs the following assumptions were made:

- There are 3 million claims which means 3 million vouchers
- Every voucher takes 10 minutes to produce
- Every working day has 7 working hours
- There are 240 working days a year
- The salary of a Clerk including allowances is 460,000 Pesos a year
- The operational costs excluding personal are 35% of the operating costs
- The adjustment of the financial management system is estimated on 2,500,000 Pesos looks.  
(The financial management system should be adjusted to make it possible to insert the financial transactions in the system).

Using the above mentioned assumptions the total costs are around 188.5 million Pesos (including adjustment of the financial management system) which means 62 Pesos per voucher. PhilHealth is developing a smart card for its members. A card with a chip gives the opportunity to load the chip and to put the co-payment amount on the chip. The patient could pay his/her co-payment to the doctor with this smart card.

The costs will be about the same as the costs for issuing the vouchers.

However one could wonder if this means the financial clout of PhilHealth is also the same because the provider gets the money directly from the patient.

Another possibility could be to transfer the promise of payment from the patient to the provider and subsequently to PHIC. This could be done using the above mentioned smart card but there could be also a permanent promise that PhilHealth will pay the OOP to the providers.

In the first alternative there are the costs of handling at the Front Desk as mentioned above, which will not occur in the second alternative. The problem of both alternatives however is the creation of 3 million debtors for PhilHealth.

PhilHealth has to collect the OOP from the patients which could be a “hell of a job”.

At the moment the system of collecting of out – of – pocket expenses by the providers is not as cost-effective as it could be because the OOP expenses are collected at discharge and not at admission. The result is the providers having a lot of promissory notes from patients, family members and even from politicians who would foot the bill for a certain patient, ending up with many of the promissory notes unpaid).

This problem should not be underestimated. At the moment there is even a law in preparation that punishes hospital officials who refuse to release patients who do not pay their bills.

The biggest issue, if one likes to change the present system, is collecting the OOP money.

However if PhilHealth could manage to handle the OOP expense there could be big advantages like:

- a very much bigger financial clout for PhilHealth
- a stronger relationship with the providers
- the possibility to avoid balance billing
- recognition by the population that they need PhilHealth which could fasten the enrolment (this however could also be negative if people react emotionally thinking they have to pay for their physician to PhilHealth)
- a stronger position of PhilHealth regarding political issues
- a better position for PhilHealth to gradually improve the benefit package

### **Changing collection of copayments?**

There are a couple of possibilities to consider:

1. By contracting the providers, PhilHealth could make an agreement with them that all co-payments exceeding a certain amount should not be paid by the patient but claimed by the providers from PhilHealth. A good example of this is the system of Southern Korea as mentioned above. This will avoid the poverty trap in a lot of cases. However the total amount of co-payments to be paid as maximum should be related on the social-economic situation in the Philippines, The same amount and conditions as in Southern-Korea ( Pesos 100.000) could be much too much for a lot of indigents in the Philippines. So, the maximum should be related to the income of the insured. This can be done via a system of income brackets.
2. Besides the technical issues as mentioned above in this paragraph, PhilHealth could consider to go to a benefits in kind system. By contracting the providers PhilHealth makes an agreement with them about the total price to be paid by the patient and by PhilHealth. This will avoid balance billing and the patient knows beforehand how much to pay for a certain benefit or health service.

A system like this needs regular adjustment due to inflation. This system resembles a case-based payment system. However the difference is that in a system like this, agreements can be made about the price/ tariffs of the different kind of treatments within a defined case.

The mechanism of payment could be adjusted as follows: If PhilHealth is extending its benefits, the co-payments will automatically decrease besides the adjustment for inflation. It could be wise, while extending the benefits, to let this extension in money terms be higher than the inflation. Otherwise there will be no advantage for the patients.

Whatever the system looks like, it is advisable to have the co-payments collected by the providers, before admission of the patient, because they are in the best position to collect these copayment.

## **K. Social marketing (and public information)**

What is social marketing and why is it been used?



It is necessary for public health professionals to listen to the demands and desires of the target audience and to shape their program according those demands as long as these reflect essential medical needs which cannot be reasonably paid out of pocket. It will give them information for modifying the program and it will strengthen the relation between for example the health insurance plan and the providers (or members or etc.). It will also make decisions more acceptable. The focus on the “consumer” involves in-depth research and constant re-evaluation of every aspect of the program. Research and evaluation together form the cornerstone of the social marketing process.

Within PhilHealth (social) marketing is done by the marketing department, part of the Member Department Group. Targets are set for enrolment for example in the “Kalusugan Sigurado at Abot-Kaya sa PhilHealth Insurance” (KaSAPI) program. There exists also a collection target. This department however is not involved in marketing to the different providers of PhilHealth. The Health Care Provider Relations department is in charge of the relations with the providers. This has more to do with quality assurance than with marketing.

PhilHealth does not sell but tells. This is not an approach that provokes interest, partnership and compliance.

In order to contract the providers it is recommended to review the relation with the providers and to use the instrument of social marketing to improve the relations of PhilHealth with providers and members as regards health care services and to inform these important stakeholders about the ideas, plans, activities and results of PhilHealth. The same is true towards LGU’s given its role as co-financiers and owners of health facilities.

The social marketing process “sells” ideas, attitudes and behaviour; it seeks to influence social, business and government behaviour. Normally there are four (4) P’s for marketing: Product, Price, Place (the way product reaches the consumer) and Promotion. For social marketing four (4) P’s are added: Publics, Partnership, Policy and Purse (Weinreich 2006).

Publics: refers to both, external and internal groups. External groups are the target audience, secondary audiences and policymakers. Internal groups are those who are involved in some way with either approval or implementation of the program. The importance of “selling” to the internal groups is sometimes highly underestimated. People should know how and why.

Partnership: It is important to figure out which organizations have similar goals to yours and identify ways you can work together.

Policy: A behaviour change has to be supported for the long run. For this media advocacy programs can be effective.

Purse: Where will you get the money to develop and create your program?

At the moment the marketing department of the Member Department Groups is in charge of social marketing to the members and the population to be insured at PhilHealth. Their main goal at the moment is to enroll people using the KaSAPI program. The Health Care Providers Relation Department relates with the providers. Besides that, there are meetings with of PHIC with the clerks working in the hospitals (on a regularly basis i.e. 4 times a year) and with the medical directors (1 or 2 times a year) initiated by the management of the Pros’.

Besides the social marketing in order to enroll people it is important for PhilHealth to strengthen their relationship with the providers in order to make them partners and to build together on a social health insurance system. The providers can be ambassadors to tell their patient to use their right on insurance

and to get enrolled at PhilHealth. However a doctor should do this for the benefit of the patient not for the benefit of the doctor.

The question is will there be additional costs: For the moment the necessary staff is already there. The question is however not only: “Are they doing the things right” but also “are they doing the right things”? In 2007 PhilHealth spent 20.1 million Pesos for advertising and 10.7 million Pesos for marketing and promotional expenses, a total of 30.8 million Pesos. A marketing specialist would tell you that it is normal to spend about 3 or 4% of your total money flow on marketing expenses which in the case of PhilHealth would be 3% of 20 Billion Pesos being 600 million Pesos.

We do not advise you to do this but 1% could be a good guideline being 200 million Pesos, i.e. PHIC is recommended to gradually increase its marketing effort and the budget supporting this activity.

#### **L. Implementation of contracting, assumptions and risks, implementation strategy, expected costs and revenues**

Contracting provides the opportunity to have greater control over providers and if used judiciously can improve health system performance. It provides PhilHealth with a management and regulatory tool that creates incentives for improved performance and increased accountability. Contracting can influence access, equity, quality and efficiency of health services, promote public health goals and create an environment conducive to public-private collaboration. It further provides a platform for the introduction of new benefits and new payment systems, i.e. a case-based or DRG based system.

Contracting formalizes the relationship and obligations between PhilHealth and the contracted providers. The process requires well designed contracts, transparent bidding (if any), clear performance obligations and rights for both parties and PhilHealth needs to be able to monitor contracts and should be a trustworthy partner.

Before signing a contract, being an agreement between two parties, the question is always: “What is in it for me”?

The policy objectives for PhilHealth could be to achieve a supportive framework in which providers are enabled to deliver excellent services to their patients in partnership with PhilHealth. The objectives could aim to ensure that providers:

- Comply with the terms of their contract and deliver the service in line with the service specification;
- Deliver improving, high quality, effective services that reflect good practice. (The quality specifications should be a key component of the contract);
- Achieve successful outcomes for service users;
- Encourage service user feedback that can be used to inform strategic commissioning decisions;
- Focus on the strategic priorities set out in PhilHealth strategic planning;
- Allow risk to be monitored, managed and action to be taken to mitigate risks.
- Meet local and nationally agreed performance targets;
- Deliver value for money;
- Provide information that informs wider commissioning and procurement activity;
- Provide performance information to all relevant stakeholders.

Or to put it this way: PhilHealth wants better services, more services, greater access to services, serving the poor, serving remote areas, better financial protection of the insured and lower costs.

The objectives of the providers could be to secure a regular source of revenue and to gain enhanced recognition and credibility.

- Define contract goals and performance expectations;
- Define the contract payments and strategy;
- Make specifications of the desired deliveries;
- Amend regulations if necessary;
- Select providers, or have a bidding process if contracting out;
- Negotiate the contract terms and conditions;
- Mobilize and implement contract;
- Manage contract performance;
- Monitor, evaluate and adjust.
- Define the inherent risks for the provider and PhilHealth and define in the contract how to handle them

Monitoring and evaluation, information, measuring performance is critical but often ignored.

There should be a contracting learning curve for both parties. Besides the monitoring and evaluation of contracted providers, monitoring and contracting should also be done of the overall contracting system, especially during its gradual roll out or piloting. For both types of M&E, indicators should be formulated and a baseline provided. The information needed depends on what you want to achieve via contracting and therefore are interested to know on the provider performance level as well as on the system level.

## **1. Gradual roll-out**

For a gradual roll out, PHIC can consider the following steps:

1. Decide about the contracting policy
2. Check if the conditions for successful and efficient contracting are met
3. Define of the specific aim of the pilot, e.g.:
  - Testing the contract and the tools to implement
  - Testing the organization & business processing at PHIC and providers
  - Testing the communication between PHIC and providers
4. Choose option for a pilot
  - Nationwide
    - For a small category of providers
    - Selected services
  - Restricted to a Region, Province or Municipality
  - Broader category or categories/services
5. Only Contracting, or contracting plus OPB and/or case based payment?
6. Start dialogue with providers
7. Develop contract offer:
  - Determine contract payment and strategy

- Write specifications
8. Organize tender or hand-pick provider
  9. Negotiate contract: terms and conditions
  10. Provide training to PHIC staff and providers
  11. Implement
  12. M&E
  13. Adjust and roll out again, etc. Etc

## **2. Operating costs and benefits (as compared with current system)**

### **a. Costs and revenues**

Before anything can be mentioned about costs and revenues the policy and goals of PhilHealth should be clear and it should also be clear how much money they want to invest to make it happen.

For example reaching the goals of the Health Sector Reform Agenda, PhilHealth should extend its benefit package with 68 Billion Pesos (88 BP instead of 20 BP). If you know what you can offer the other party you can negotiate about what you can expect.

Therefore an estimation of the costs and revenues can only be superficial.

In order to estimate the costs of the adjusted system of PhilHealth it is necessary to look at the following issues:

- Adjustment ICT systems
- Claims processing
- Fraud detection
- Claims review Czar
- Provider profiles, provider performance review
- Accreditation
- Accreditation to 3<sup>rd</sup> party
- Co-payments
- Contracting (on top of accreditation)
- Conditions for effective contracting
- Dialogue with providers
- Premium collection
- Communication and social marketing
- Training
- Extension Benefit package

### **b. Adjustment ICT system**

Before anything else it is absolutely necessary for PhilHealth to upgrade the present ICT systems in line with the recommendations of Dennis Streveler (Report March 2007). He estimated the extra costs on Pesos 235 million.

### **c. Claims processing**

Electronic claims processing could be a result of the upgrading of the system. If electronic claims are completely implemented it could result in a saving on labor costs of 50% or more which in Pesos means

a saving of 286 million. It is not necessary to fire the people because with appropriate training they can be used for other tasks in the changing environment of PhilHealth. Because of lack of data it could not be estimated how much the extra costs for the providers will be in case they don't have the means at the moment for electronic claims processing.

**d. Fraud detection**

It is not necessary to make a fraud detection system. They can be bought and adjusted to the system. A fraud detection system will cost about US\$ 100,000 which means 5 million Pesos.

However at the moment 4% fraudulent claims are discovered. With a system of fraud detection it is very likely this percentage will be higher. Every percent fraud found will give lower costs of 180 million Pesos.

**e. Claims review czar**

It needs a highly skilled claims review Czar to manage the system of fraud detection and making provider profiles. The costs are estimated at 1.8 million Pesos a year. For both processes people not needed for claims processing anymore could be trained and "used".

**f. Provider profiles, provider performance review**

These profiles will be produced in the fraud detection process and can be discussed with the providers in the institutionalized dialogue.

**g. Accreditation and going on to third party accreditation**

A decision has to be made to do accreditation by PhilHealth in the future or by a third party. If it is done by a third party the total savings depend on the way they are going to do it.

If PhilHealth decides to do contracting on top of accreditation the advice is not to do the renewal of accreditation for the institutional healthcare providers every year but once in two years. On one hand accreditation creates income for PhilHealth (2007: 18.5 million Pesos) and on the other hand it costs money.

The accreditation fees are slightly lower than the costs of accreditation:

hospitals	Number of hosp.	Fee initial	Fee renewal	Cost of accred.
Level 1	844	5,000 P	4,000 P	6,400 P
Level 2	701	8,000 P	8,000 P	7,800 P
Level 3	327	10,000 P	10,000 P	12,700 P
Level 4	Included in 3			

By doing renewal of accreditation every 2 years it could be considered to raise the accreditation renewal fee. In other option however is not to let the providers pay for accreditation.

#### **h. Co-payments**

A system like in Southern Korea with a co-payment cap could avoid the poverty trap for people with a low income. It is necessary however to do a means test. At the moment there are no figures available for estimating the number of people who suffer from this poverty trap.

#### **i. Contracting on top of accreditation and dialogue with the providers**

Besides training and education no extra costs are estimated (see below). The people are there on PhilHealth's side and on the provider side. The same counts for the dialogue with the providers.

#### **j. Conditions for effective contracting**

The biggest effort will be the design of the indicators for monitoring and evaluation. At the moment without concrete choices it is not possible to estimate the costs.

#### **k. Premium collection**

PhilHealth should put more efforts in the premium collection especially from the Local Governments. No extra costs are calculated.

#### **l. Communication and social marketing**

The advice is to spend 200 million Pesos every year which is considerably more than at the moment (30.8 million Pesos)

#### **m. Training and education**

It is hard to predict the costs of training and education. A guideline however could be that an healthcare insurance company in Europe spend every year 1% of its operational budget on training and educations which means for PhilHealth 23.9 million Pesos.

#### **n. Extension Benefit Package**

The executive committee of PhilHealth decided to extent the Benefit package in 2009 with 33% across the board with means 6.6 B Pesos.

The advice is also to consider the extension of the Outpatient Benefit Package as advised by Xavier Modol. It would be easy to calculate the extra costs (650 Pesos per indigent member instead of 300 Pesos) but it was also mentioned in the Financial Report 2007 of PhilHealth that the use of the Capitation Fund gives some doubts about the legitimacy of the payments. A better use could lower the costs.

#### **o. Direct costs of contracting**

As already mentioned PhilHealth has enough Staff capacity do contracting on top of accreditation or besides accreditation if accreditation is done by a third party. The staff has to be trained however to do contracting. An estimate of this training costs could be 2.5 million Pesos. However it is not imaginable that PhilHealth can go forward with contracting (besides a couple of pilots) with the present state of the ICT systems. Therefore the investments suggested by Dennis Streveler (235 million Pesos) are necessary

to do the job. One of the first demands of the providers will be timely payment. If PhilHealth has the money, the interest will go to PhilHealth. Every month earlier payment means loss of interest. The monthly payments are estimated on 1.5 billion Pesos. Depending on the interest rate for short term deposits (at the moment almost 3%) it is easy to calculate the lost on interest. These should be considered as direct costs also although even without contracting PhilHealth should consider to pay earlier.

The other costs of contracting are also mentioned above and are dependant of the choices of PhilHealth. What does PhilHealth wants to offer the providers for having a contract?

There are a couple of inherent risks in the contracting process:

- The heavy reliance on donor funds for investments. If there is no donor money available PhilHealth will get stuck unless it manages to use its own resources.;
- The number of providers in rural areas is rather limited, offering little possibilities for selective contracting. Supporting DBP borrowers to establish themselves in those areas may be helpful in creating competition for PhilHealth funding via a contract and therewith improving performance.
- Parties with vested interest may try to gain control over the contracting process;
- Poor monitoring and evaluation mechanisms could ruin the perspective of a gradual roll out and learning by doing.

## **M. Conclusion and recommendations**

### **Introduction of contracting,**

PhilHealth has certainly taken a good decision to opt for a contracting system as a better way to relate to providers and to govern the implementation of the Health Insurance Program. It has the legal basis to start doing it, although some adjustments will provide a better fundament for effective and efficient contracting and dispute resolution. PhilHealth may want to choose for a gradual implementation process for which it is offered a number of options. For a start, going for contracts with selected/preferred providers is the thing to do and then to gradually expand. However, contracting is not only about achieving to have a mutually agreed and signed document but also to make such process effective and supported in an efficient way. Therefore the following necessary actions are briefly repeated.

- **A new dialogue system**

It is recommended to strengthen the dialogue with providers and to create a regular two way communication structure and process on the national and on the PRO or provincial level. Introducing the position of an account manager is also recommended.

- **New ways of claims processing**

It is recommended to streamline the processing, to get rid of the attachments and to introduce as soon as possible a fully e-based process. Such system will allow also for much more efficient provider performance review.

- **Update provider performance review**

It is recommended to continue the strengthening of the review system, using the profiling of providers and reviewing the outliers and spending limited time on minor claims but introducing

the possibility of a post-audit together with much heavier fines for violating the agreed rules of the game.

- **Updating HMIS**

All the above can only happen if an upgraded health information system has been achieved, i.e. after the successful implementation of the relevant activities in the PHIC Board adopted Track 1 and Track2 actions as proposed. The appointment of a Chief Information Officer on SVP level is seen as a must to make this happen.

- **co-payment collection/administration**

Gradually but as fast as possible increasing the depth of the benefits package, i.e. decreasing the out of pocket payments, and the breadth of the package, i.e. adding benefits like outpatient care and drugs, is seen as the best way to help patients/members to cope with the current high financial burden, especially for the poor at the point of services. Some other alternatives are described, which PHIC may want to consider. Out of pocket payments can only be tackled when at the same time the practice of balance billing has stopped. Selective contracting with providers who are willing to stop this practice if in return they acquire the status of preferred provider can provide the basis for this.

- **Legal adjustments**

It is advised to process and implement the proposed amendments of the regulations as to anchor contracting in the Health Insurance Act, the IRR and AO's and to especially allow for the introduction of an arbitration mechanism, to be reflected in the contracts, as a more effective and efficient way of dispute resolution.

- **Organization**

Most important organizational issue will be to decide which unit, existing or new one, will be in charge of contracting. In any case, close cooperation with the claims handling and accreditation department will be necessary.

- **Costs**

Contracting as such does not ask for substantial investments. They will be mainly required for training. More detailed cost-analysis is provided. Assuming that PHIC will adopt the proposed efficiency improvement and moves into third party accreditation, than no numerical consequences for staff positions are foreseen.

- **Implementation**

PHIC is advised to do a gradual implementation or "pilot" of which the scope and extent can be defined by PhilHealth, based on a weighing of the suggestions made in this paper. The careful monitoring and evaluation of the pilot will provide the information for PHIC to eventually adjust its approach, internal organization, the text of the contract and to further roll out over the country.



- **M&E**

It is recommended to pay careful attention to the monitoring and evaluation of the development and gradual implementation of the contracting system and of the accompanying measures like the upgrading of the provider performance review. PhilHealth is recommended, after having decided about the way forward in contracting, to decide also about the monitoring indicators, the unit in charge of monitoring and the establishment of a baseline for the evaluation.

- **Constraints and challenges**

Besides with the internal challenges at PhilHealth, like the upgrading of HMIS, the upgrading of business processes, the training of staff and the effective coordination of management of all contracting-related activities, PhilHealth will be confronted with a number of outside constraints which it may want to see as challenges but which actually may dampen the effectiveness and impact of the implementation of contracting. These constraints have been identified as: fragmentation of funding, fragmentation of stewardship, fragmentation of care, underfunding of the system, parallel running of a budget funded system and a payroll tax funded (health insurance) system and a largely unregulated private sector.

- **Go or no go**

PhilHealth Board will have to decide if all conditions for successful contracting, as described in this paper, are being met before giving the go-ahead for a gradual roll out or a pilot. The implementation of the planned HMIS upgrading will be key for such decision.

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## APPENDIX 1

### **Terms of reference for consultancy to support capacity building for contracting at PhilHealth and providers of health services via training and social marketing**

#### Introduction

Technical assistance is necessary for building capacity at the Philippines Health Insurance Corporation, PhilHealth, and at providers of healthcare services to enter into a more effective and efficient contract relation. In the second half of 2008, policy development work on contracting has been done, in support of PhilHealth, financed by ADB and GTZ. The results of this policy work have been delivered beginning of January 2009. Based on this work, PhilHealth has made its strategic choices and determined its implementation pathway for the contracting of identified categories of priority providers to deliver its benefits package to the insured (i.e. its members). In order to start the actual use of a system of contracts and a more sophisticated system of claims and performance review of providers, sufficient capacity at PhilHealth and providers is a necessary condition. Therefore, next to other activities like investing in health management information systems (HMIS), a training program will need to be developed and implemented.

In parallel to the contracting work, another stimulus to expand the contracting system is emerging: the ADB supported Credits for Better Healthcare Project (CBHP) for the Philippines. The CBHP is creating an investment fund for health at the Development Bank of the Philippines (DBP). This fund, which is supposed to be fully effective and operating at the beginning of 2010, will lend money to different categories of providers to support the attainment of health related MDG's, to support access to health care for underserved areas and to prevent patients from impoverishment when in need of health services. It was agreed that the borrowers of DBP's health loans, who would serve the PhilHealth members, should be contracted also by PhilHealth for offering their services. Thus offering collateral for DBP, providing PhilHealth a say in choosing borrowers and investments while offering its expertise to DBP, creating a smooth payment relationship for DBP and giving the potential borrowers long term certainty about the return on their investment.

So, it will take quite some effort to develop training capacity and to implement the actual training, especially given the parallel developments at PhilHealth, i.e. the planned benefits package extension, the introduction of a new (case based or DRG based) payment system for hospitals and the move towards third party accreditation of health services providers. That's why technical assistance is being requested from all development partners

#### Background

The Philippines health sector has to function within heavy cost constraints. Therefore, there is great need to optimize the use of scarce financial resources. Further, the country is facing an exodus of essential health staff, which creates the need for optimizing the distribution and the use of human resources.

The Philippines Health Insurance Corporation (PHIC) is a major player in the health sector, not so much because of its financial volume but more by its mandate and the tools it has at its disposal to shape the sector and to foster the availability of and access to quality health care services for its insured. To support PHIC in the exercising of its mandate it would like to develop a contracting system for health care providers in order to optimize the services to its members and to increase its potential for cost and quality control of providers and their services.

Although PHIC uses contracting to obtain e.g. IT equipment and other goods for its own organization and, although the "Implementing Rules and Regulations of the National Health Insurance Act of 1995 as amended by Republic Act 9241" offer many good instruments, the instrument of contracting is not used to its full potential in health care purchasing. Further, the relation between PHIC and the providers is rather asymmetric because the obligations are more on the side of the providers, as imposed by the law, while PHIC does not have many obligations vis a vis the providers, and does not pay in time.

The Government of the Philippines, according to its National Objectives for Health 2005-2010, sees purchasing as a key role in the provision of a package of health services. The Government has announced that a performance based financing system for health will be adopted. It sees the PHIC as the "flagship program in health financing" which it wants to strengthen via expanding enrollment coverage, improving benefits and leveraging provider payments on quality in health care (page 51). It further wants to "create the appropriate mix of budgeting and provider payment mechanisms that would best influence provider behavior towards providing quality care and preventing health problems while containing costs" (page 56).

PHIC, as the Government's and DOH's most important purchaser of health services has therefore acknowledged that a review and update of its contracting system, its procedures and performance are necessary and have to be complemented by entering into proper dialogue with the providers.

#### Purpose and objective of contracting of health services

The purpose and objective of contracting of health services is to purchase efficient quality health care services for the Philippine citizens and residents via PHIC in a strengthened, i.e. more effective and more efficient, role of purchaser on behalf of its insured members, while carefully choosing applicable financing mechanisms and assessment of performance, therewith contributing to good clinical and financial governance (transparency and accountability) on the side of health care providers as well as of the health insurance system.

#### Implementation of contracting

The phenomenon of contracting of providers is relatively new to PhilHealth although it uses a Memorandum of Agreement format in case of e.g. a Warranty of Accreditation, to be signed by the health care provider and which obliges the provider to live up to established quality and administrative standards. However, PhilHealth has no wide scale experience with modern contracting and its many options and neither have its health care providers.

After having decided how it would like to use contracting and how it would like to start its introduction, PhilHealth and providers will have to put huge efforts in changing their relationship arrangements, entering into contracts and changing the way claims will be processed and performance reviewed.

The eventual introduction of contracting in 2009 would be complicated by the planned extension of the benefits package and the introduction of a new, case-based, payment system for hospitals at about the same time. However, eventually there can be several policy and practical benefits from a carefully synchronized and simultaneous introduction of all three, especially if the new payment system would lead to a simplification of the current process of claims processing and of provider performance review and would be supported by an upgraded health management information system.

Not only PhilHealth, but also the providers of health care will have to be prepared for these new developments and are in need of strengthening their capacity as well.

Last but not least, the members of PhilHealth will also need to be informed about the developments in contracting, benefits extension and new payment systems as to understand the way this can positively affect the health care they receive as well as the charges they have to pay for actually getting the necessary health care and the way these charges are collected and administered.

To make this happen and to support the smooth introduction of these changes, investments will need to be made in hardware and software as well as in human resources. In parallel, public information campaigns to inform the health care community as well as the public at large will have to be developed and sustained for time to come. In order to support PhilHealth and its providers with the introduction of contracting, the benefits package extension and the new case based payment systems, technical assistance is being requested to create the necessary capacity at PhilHealth and the providers. This assistance is necessary to provide training, for doing social marketing and for building training capacity.

#### Focus of work

Technical assistance (TA) is needed in the following areas:

1. Education of PhilHealth staff and management in principles and practice of contracting and its implementation. This will include the changes in the system of payment for providers
2. Education of PhilHealth management and staff and health care providers in revised health management information systems, in support of contracting and new payment systems and in the new tools to be used. The TOR's for this TA are separately made available.
3. Education of health care providers, i.e. their management and admin staff, in the issues of contracting, to act as a suitable contract partner and to be able to use the newly developed tools. This will include the education of self employed doctors and midwives. As much as possible, their umbrella organizations and associations will be included in the development and conducting of the training for their members, because this would be in the interest of their members.
4. Social marketing or public education, focusing on the health community, on the relevant judicial community and on the public at large. This will include the umbrella organizations of providers and the relevant health authorities at DOH and in the health authorities under MOH in the regions and the Local Government Units, the LGU's.
5. Monitoring & Evaluation of the process, effects and impact of contracting.

For this TA, international and national consultants are to be recruited, individually or via a company.

The aim of the consultancy is to develop core capacity at PhilHealth and at providers (and their umbrella organizations), which can gradually take over from the consultants after the consultants have trained all relevant management and staff of target groups, i.e. when a steady state is reached and maintenance is necessary due to the appearance of new graduates (professionals), managers and staff as well as due to changes in the contracts and payment systems themselves. This is expected to happen 3 years after the



start of the contracting system. In order to institutionalize the training and make it sustainable, the consultancy.

#### Consultancy in detail

Terms of reference for team leader and consultant on education in contracting of health care providers.

1. The international consultant for training of management and staff of PhilHealth and health care providers in the effective and efficient use of a system of contracts will:

- a) Develop training manuals for both target groups, differentiated for managers of PhilHealth and of providers as well as for front and back office staff. The training manuals will clearly state the objectives and learning goals for each target category as regards skills and knowledge and the manual will define the skills and knowledge the trainees will need to master after the training. Training will not only offer lectures but also practical exercises and cases to be discussed and handled by the trainees.
- b) The training manual and plans will include the use of modern provider performance review and profiling systems as well as the revised claims review, new payment systems and accreditation standards and accreditation procedures.
- c) Design a specific simplified module to be used for teaching relevant categories of graduate students of medical schools and colleges as to prepare students for their future professional life.
- d) Develop training materials for the trainees.
- e) In the training manual and training plans, relations will need to be made with the revised PhilHealth benefits package, its proposed case based payment system and the new accreditation standards for providers, including the new procedures for the implementation of the standards and standards review.
- f) Develop detailed training plans for the two target groups, i.e. at PhilHealth and for providers. The training plans should include their implementation, paying attention to numbers of management & staff to be trained, to the time frame, the efficient geographic distribution of training capacity and implementation.
- g) Develop an instrument for the testing of knowledge and skills of trainees, acquired during the training.
- h) Develop M&E indicators and processes to measure the effect of training in the daily practice of the trainees and to improve the training and implementation of the training plans.
- i) Train the necessary numbers of national trainers (consultants and permanent staff) who will take over the day to day training.
- j) Train first batches of management and staff, in cooperation with and in attendance of national staff and of representatives/teachers of medical universities and colleges, evaluate training manual, training plan and implementation.

- k) Evaluate the first year of implementation of training programs and advise adjustments.
- l) Develop a plan for the creation of permanent capacity for training, including the necessary human resources, investment needs in training rooms, training equipment and training materials production. Develop a cost estimate of investment and recurrent costs. The permanent capacity can be divided over the provinces, over independent institutes, located at PhilHealth, at provider associations and at training institutions like medical universities and colleges. The permanent capacity should build on the existing training capacity
- m) In his work, the consultant will have to work closely with consultants on HMIS training, on social marketing and on M&E systems design.
- n) The consultant will also act as team leader of the team of international and national consultants on HMIS, social marketing and M&E

Duration and timing of consultancy: 18 person months over a period of 2 years. It will include 5 visits of 6 weeks each. The remainder of the time to be spend at home/office for writing inception report, training plan, training manuals, test questionnaires, evaluation reports and end-report.

Deliverables: Inception report after 14 days, training manual, catering for the various target categories; learning tools (PPT, prints etc.) and training plan after 10 weeks; M&E plan for training by 12 weeks; Report of country visits by the end of each visit. Evaluation and adjustment report after first training round. Evaluation reports after every 3 months. End report by end of 18 months period.

Required skills: an experienced teacher and curriculum developer with a background in health systems, health services purchasing, contracting and teaching, of at least 10 years national experience and relevant international experience, and an academic background in health sciences, psychology, medicine, public health or health management.

#### Terms of reference for National trainers

The national consultants (10, to be distributed proportionally over the PhilHealth Regions), after having been trained by the international consultant, will:

- a) Provide the training of management and staff of PhilHealth and of health care providers, in accordance with the training plan.
- b) Provide training of permanent staff at PhilHealth, umbrella organizations and teaching institutions for health professionals & management.
- c) Monitor and evaluate the implementation of the training, adjust and introduce any changes in training manual and implementation, necessary because of changes in the contracting and payment systems themselves.
- d) Hand over to designated permanent trainers.

Duration and timing of the consultancy. 50 months, in total, for 10 trainers. The national consultants would get a 5 month contract each, to be implemented over a period of two and a half years. Their start would be 3 months after the start of the team leader and of the consultant on HMIS.

Deliverables of national consultants. evaluation report after every training; yearly reports of progress; adjustments to training manuals, necessary because of changes in contracts, categories of providers and new payment mechanisms.

Skills of national consultants. The national consultant will have a background in teaching and are familiar with PhilHealth systems and operations, including its HMIS and medical informatics system, as well as with the broader health care system. At least 10 years of relevant experience.

Terms of reference for consultant on social marketing.

The consultant for social marketing will:

- a) Develop, test and do a first implementation of a social marketing campaign, aiming at:
  - a. the health care providers (managers and professionals),
  - b. the population at large (as to inform them about the changing way in which PhilHealth and providers will relate with each other and what they can expect about acquiring their entitlements to health care and to reimbursement of paid bills.)
  - c. The teaching institutions for health professionals and managers.
  - d. the relevant judicial officials/professionals/staff, as they may be confronted with the results of new arbitration and appeal procedures, based on contracts, as well as may have to deal with cases in which providers fight decisions by PhilHealth to not contract them.
- b) The work will include the preparation of information materials for the various public media and for the usual information flow of PhilHealth to its providers and members as well as of the umbrella organizations of providers for their members.
- c) In his work and his products/materials for marketing the consultant will have to include the references to the expanded benefits package, the upgraded accreditation system and the introduced case based payment system for hospitals and the interaction between these 4 developments.
- d) Teaching and coaching public information or external affairs staff of PhilHealth and umbrella organizations, which will take over and guarantee the continuity and adjustments to the public information campaign on an as needed basis.

Timing and Duration: 6 person months, divided over a year. Start, immediately at the start of the international consultants.

Deliverables: Inception report after 2 weeks; Campaign plan after 3 weeks; Marketing materials after 4 weeks; Pilot test report, including uptake by the media and receipt by relevant target groups after 8 weeks; Teaching/coaching plan after 6 weeks. Launch of campaign after 10 weeks. Ongoing monitoring of campaign results and monthly reporting and eventually adjusting of campaign and material. Training results and evaluation of training/coaching of national staff after 16 weeks. Final report by the end of the 6 month period.

Skills. An expert with a background and 10 years experience in social marketing and/or public education, external relations and the use of modern media. Experience in the healthcare or healthcare insurance system would be an advantage.

Terms of reference for international consultant for monitoring and evaluation

The international consultant for M&E will:

- a) Develop and start to implement a plan for the monitoring and evaluation of the process and **effects of contracting on:**
- The relationship between Philhealth, providers and their umbrella organizations.
  - The efficiency of claims processing and performance review of providers
  - The establishment and functioning of vertical networks of providers, especially as regards MNCH
  - The DBP supported attainment of MDG's and the improved accessibility and use of health care facilities in underserved areas as being the main objectives of the cooperation between DBP and Philhealth and of the establishment of the investment fund for health at DBP.
- b) In the M&E plan, the consultant will have to include the references to the expanded benefits package, the upgraded accreditation system and the introduced case based payment system for hospitals and the interaction between these 4 developments.
- c) Develop a training plan for staff involved in M&E
- d) Train M&E staff
- e) Evaluate process and initial results of M&E by end of first year after implementation and adjust, if proven necessary, the M&E indicators, the data collection mechanism and reporting format

Duration: 3 months over a period of a year, including 3 visits to the country, of 3 weeks each.

Deliverables: draft M&E plan by 4 weeks, pilot testing, test results and adjusted system after 8 weeks. Teaching, coaching and final report by week 12.

Skills. An expert with extensive knowledge and experience in the design and monitoring of complex healthcare and healthcare financing system changes and their impact on processes, outcomes and impact on healthcare services delivery and the financial protection of insured persons, especially in developing countries. An academic background in public health, health management/administration or health economics is required.

#### General

All consultants will report to PHIC as well as to the donor agency, funding the consultant. PHIC will provide office space and logistic support.

Training supporting equipment like LCD projectors, screens, video cameras, DVD players and monitors need to come from other sources. Same for teaching room rents, per diems for trainees, airtime on radio/TV and printing materials. However, the investment costs will be estimated by the team and the funding sources explored. Some of the teaching rooms and equipment will already be available at PhilHealth premises and some of the costs may already routinely be included in the budgets of PhilHealth and providers, e.g. for per diems and travel.

## **APPENDIX 2**

### **TERMS OF REFERENCE FOR THE DESIGN AND DEVELOPMENT OF CAPACITY BUILDING ACTIVITIES FOR QUALITY HEALTH INFORMATION MANAGEMENT (PROVIDERS/PHILHEALTH/DOH)**

#### **Introduction**

The Philippine Health Insurance Corporation (PHIC) is in the process of developing a contracting mechanism to further improve the benefits accorded to its members. Although the contract itself is not yet final, it is foreseen that a significant amount of capacity building will be needed to prepare the Corporation, the Department of Health, and the providers to understand their role in this contracting system.

One obvious role is to guarantee good data management for quality health care delivery. Contract or otherwise, data management is a pre-requisite for appropriate and adequate health care. This means PHIC, DOH and providers must understand how health management information systems work and how it can help make their operations more efficient and cost-effective.

In the last quarter of 2008, the PHIC started discussions on the revision of the claims forms and of the claims process. The objective is to streamline and enhance the system to make it more responsive to the needs of the corporation and of the providers. This is a most opportune time to integrate capability building for the new claims processing system into many aspects of health education in the Philippines. It is a way to strategically embed social health insurance and good operations management concepts to the upcoming set of health professionals in the country.

This Terms of Reference is for the design and implementation of a capability-building program on quality health information management for PHIC, DOH, and providers that will prepare them to interact with each other effectively and efficiently with the least disruption to their workflow and with maximum impact to their respective organization's performance. The aim of this TOR is to detail the content and methodology of the terms of reference.

#### **Background**

The PHIC over the years has created and implemented electronic systems to address its core processes. This includes (but is not limited to) membership databases, claims processing, contribution/collection databases, and accreditation systems. Unfortunately, the demand for newer more robust systems and requests for strategic information from internal stake-holders had increased as well. The current structure and capacity of the Information Technology Management Department (ITMD) has not been able to meet this demand. The current applications presently in use had been designed as separate modules from the beginning (1995) and each had grown vertically distinct from other modules such that the Corporation is now faced with many disintegrated databases.

From the providers' perspective, concepts of social health insurance, health information management, and specifically claims processing, have not been formally introduced in the undergraduate health education systems (midwifery, nursing, and medical) or to any level for that matter. Such knowledge and skills are learned by trial and error, often by word of mouth, when they reach clinical practice and start submitting claims to PHIC. By far, this learning process has caused much discrepancy in the quality of the claims that have been submitted ranging from the incomplete to the grossly inaccurate and even fraudulent.

This proposed capacity building program will have three basic modules that build upon one another:

1. General computer familiarity and literacy for managers, claims processors and physicians (E-Health 101)
2. Computer familiarity and literacy regarding hospital information systems for managers, claims processor and physicians (Basic Health Information Systems and Medical Informatics)
3. Improving/streamlining claims production in hospitals, for managers and claims processors (Advanced Health Information Systems: Streamlining Your Philhealth Claims Process)

### **e-Health 101**

This course aims to orient the participants to information and communications technology and how these can play significant roles in improving the health of Filipinos. Without going to detail, the course expounds on the spectrum of e-health (as defined by WHO) and illustrates examples of each band in the spectrum. In that spectrum, special mention will be made on health information systems for PHIC, DOH, and providers and their role in enhancing their respective operations. A thorough discussion on quality health information (complete, accurate, legible, useful, timely) is done at this point.

### **Basic Health Information Systems**

This course provides more detail on health information systems and gives specific case studies of how facilities (local) have benefited from them. The participants learn how HIS are developed and are funded as well as understand the strategic value of HIS in the facility's mandate, especially in decreasing unnecessary operational overhead. At this point, a short session on how contracting works and how health informatics plays a major role in such an environment is given.

### **Advanced Health Information Systems: the Claims Process**

This course specifically discusses how a facility can improve its claims process so it gets the maximum value for its claim. It will discuss the most common reasons for return-to-hospital as well as how to prevent these mistakes. A brief session will be spent on demonstrating how improved claims process can result to a better bottom-line for the facility while increasing the quality of its care. This module includes the following topics: how to fill up a claim form, how to appeal,

### **Purpose and objective of Provider Training for HMIS**

The purpose of this activity is to prepare a program of instruction for PHIC/DOH/providers on how quality health information can improve their operations and enhance services delivered to patients.

The objective is to improve PHIC/DOH/provider performance by equipping them with health informatics knowledge and skills.

### **Focus of Work**

Technical assistance (TA) is needed in the following areas:

1. design of a training program on quality health information for PHIC/DOH/providers

2. pilot testing of the program
3. implementation of the program through a training of trainers

### **Consultancy in Detail**

#### **Terms of reference for team leader and consultants on facilitating the design, testing and pilot of provider training on quality health information program:**

1. Enumeration of international health informatics standards for application in local setting
2. Training needs assessment
3. Definition of terminal competencies
4. Course design
5. Development of instructional design
6. Pilot testing (with providers)
7. Refinements based on pilot tests
8. Creation of manuals
9. Creation of e-learning website (as adjunct to the hard materials)
10. Training of trainers
11. Monitoring

Duration and timing of consultancy: 18 person months over a period of 3 years. It will include an immersion phase of 5 days per week for 6 weeks and the remainder of the time to be spend at home/office for writing inception report, training plan, training manuals, test questionnaires, evaluation reports and end-report.

#### **Deliverables:**

Inception report after 14 days, training manual for developers, catering for the various target categories; learning tools (slides, prints etc.) and training plan after 10 weeks; training plan for training by 12 weeks; Report of country visits by the end of each visit. Evaluation and adjustment report after first training round. Evaluation reports after every 3 months. End report by end of 6 month period.

#### **Required skills:**

International consultant: an experienced teacher and curriculum developer with a background in health informatics and information systems, health services purchasing, contracting and teaching, at least 10 years national experience and relevant international experience, and an academic background in health sciences, psychology, medicine, public health or health management.

National consultant: experienced teacher with track record teaching health informatics at all levels of the health human resource pool (community health workers, midwives, nurses, physicians)

National team members: experience teaching ICT to health workers, skill in using e-learning/e-teaching methodologies, health informatics practitioner.

**APPENDIX 3**

**TERMS OF REFERENCE FOR STAFF IN CHARGE OF MONITORING THE PERFORMANCE  
OF CONTRACTED HEALTH CARE PROVIDERS**

Develop and supervise the initial implementation of a work plan for the review of performance of PhilHealth as contractor and of providers as contracted parties:

1. In relation to existing review mechanisms e.g. accreditation, utilization review, peer review, MMHR
2. In relation to new parameters for contracting, including zero fraud, no balance billing
3. In relation to other clinical and administrative parameters for quality, including but not limited to, those pertaining to emergency care, outpatient appointments and waiting times, elective inpatient admissions, pharmacy waiting times, client relations, information generation (DFID, 2000).

Develop a set of indicators that will be used to assess the performance of PhilHealth, providers, and umbrella organizations as parties to the contract

Develop statistics, profiling the providers on the agreed indicators against their peers to foster attention on the outliers

Develop a training plan and conduct a training of trainers for staff involved in performance monitoring

Evaluate process and initial results of performance review by end of first year after implementation and adjust, if proven necessary, the performance review indicators, the data collection mechanism and reporting format

Effectively communicate (both orally and in writing) the results of performance review to Management

To maintain thorough, objective documentation of all investigative findings, to comply with all reporting requirements and where necessary, to provide assistance the standards monitoring department and accreditation department

To go on occasional business travel as may be required to fulfill these duties

To make recommendations as needed, on specific cases of provider-PhilHealth interactions

Understand and monitor the financial impact of performance monitoring to the Corporation and to providers or their organizations

**Job Requirements:**

1. Academic background in public health, health management/administration or medicine is required
2. At least 5 years experience in the design and monitoring of complex healthcare and healthcare financing system changes and their impact on processes, outcomes and impact on healthcare services delivery and the financial protection of insured persons, especially in developing countries



3. At least 2 years hands on experience with the social healthcare insurance and/ or the health sector itself in the Philippines is preferred.
4. Familiarity with laws and regulations pertaining to healthcare insurance is required.
5. Ability to research, document and present information in an orderly manner is a must.
6. Excellent oral/ written communication skills
7. Problem solving skills to handle conflict situations.
8. Proficiency in MS Excel, MS Word, MS Powerpoint, and SPSS
9. Working knowledge of database, e.g. MS Access

**ANNEX 4**  
**TERMS OF REFERENCE FOR A CHIEF INFORMATION OFFICER**  
(modified from South Georgia Corporation <http://72.14.235.132/>)

**Job Title:** Chief Information Officer

**Department:** Office of the President

**Purpose**

The Chief Information Officer (CIO) will provide technology vision and leadership in the development and implementation of the corporate-wide information technology (IT) program including the health management information system. The CIO will lead PHIC in planning and implementing enterprise information systems to support both distributed and centralized business operations and achieve more effective and cost beneficial enterprise-wide IT operations.

**Nature of Work**

**Essential Duties**

- \* Provides strategic and tactical planning, development, evaluation, and coordination of the information and technology systems for the Corporation.
- \* Facilitates communication between staff, management, vendors, and other technology resources within the organization.
- \* Oversees the back office computer operations of the Corporate-wide information system, including local area networks and wide-area networks.
- \* Responsible for the management of multiple information and communications systems and projects, including voice, data, imaging, and office automation.
- \* Designs, implements, and evaluates the systems that support end users in the productive use of computer hardware and software.
- \* Develops and implements user-training programs.
- \* Oversees and evaluates system security and back up procedures. Supervises the Network Administrator, Database Administrator, and Instructional Technology Specialist.

**Required/Desired Education, Experience and Necessary Qualifications**

Minimum of 5 years of experience with increasing responsibilities for management and support of information systems and information technology, direct management of a major IT operation is preferred. Significant experience in an educational setting is desirable, specifically in technology and information systems planning to support Corporation goals. Experience should also include exposure to both shared and outsourced solutions, as well as support of in-house information and communication systems in a multi-site client-server environment. Specific experience with health insurance data management, financial management and human resource management information systems is a plus. The ideal candidate will also have:

- \* Familiarity with desktop, notebook, handheld, and server computer hardware.
- \* Familiarity with local and wide area network design, implementation, and operation.
- \* Familiarity with operating systems such as Windows, Unix, and Linux.
- \* Knowledge of various office productivity software programs such as word processing, databases, spreadsheet programs, and communications software.
- \* Familiarity with various computer peripherals such as printers, monitors, modems and other equipment.

- \* General knowledge of business processes and their interrelationship gained through five or more years of related experience.
- \* Ability to analyze and resolve complex issues, both logical and interpersonal.
- \* Effective verbal and written communications skills and effective presentation skills, all geared toward coordination and education.
- \* Ability to negotiate and defuse conflict.
- \* Self-motivator, independent, cooperative, flexible, creative.
- \* Current driver's license and access to reliable transportation; ability and willingness to travel when necessary.

Requires a master's degree in Computer Science, Business Administration or a related field or equivalent experience.

#### **Comprehensive knowledge of:**

- \* Data processing methods and procedures, and computer software systems
- \* Systems design and development process, including requirements analysis, feasibility studies, software design, programming, pilot testing, installation, evaluation and operational management
- \* Business process analysis and redesign
- \* Design, management, and operation of managed IT systems

#### **Proven skills in:**

- \* Negotiating with vendors, contractors, and others
- \* Budget preparation and monitoring
- \* Planning and organizing
- \* Management and leadership
- \* Communication

#### **Demonstrated ability to:**

- \* Relate to all levels of the user community
- \* Be a team player that motivates and educates other team members
- \* Plan, implement and support systems in a complex education environment
- \* Set and manage priorities
- \* Comprehend complex, technical subjects
- \* Translate technical language to lay audiences
- \* Link and apply complex technologies to business strategies

#### **Supervision**

The Chief Information reports directly to the President of Philhealth.

**ANNEX 5  
MODEL CONTRACT**

CONTRACT FOR PROVISION OF HEALTH CARE SERVICES

BETWEEN

FIRST PARTY  
(PHIC)

AND

---

(HEALTH CARE PROVIDER)

DATED: \_\_\_\_\_

PLACE: \_\_\_\_\_

KNOW ALL MEN BY THESE PRESENTS:

This contract entered into this \_\_\_\_\_ day of by and between:

I. Parties

- a. The First Party, the Philippine Health Insurance Corporation, a government owned and controlled corporation created by virtue of Republic Act 7875 as amended by Republic Act 9241, with principal address at \_\_\_\_\_ and represented herein by \_\_\_\_\_, hereinafter referred to as the First Party;

and

- b. \_\_\_\_\_, (nature of person contracting and basic legal capacities, and in case of juridical persons, how such personality was acquired); address, (if juridical person, name of representative who must be a natural person), hereinafter referred to as the Second Party;

II. Preambular Clauses

Whereas, the First Party desires to fully utilize its purchasing power in demanding quality care for its members;

Whereas, the First Party, under the Leaping Forward framework is undertaking to step to Leap Two which is the Contracting or Preferred Service Agreements

Whereas, the First Party, in order to fulfill its mandate to provide universal health care coverage, is introducing contracting as a mechanism to purchase health care services from health care providers.

Whereas, the First Party desires to contract with health care providers to fulfill the following objectives:

- to optimize resource use and quality of health care services;
- to improve transparency and accountability;
- to improve the processing time for the payment of health care services;
- to protect the PhilHealth members from high user charges at the point of services; and
- to provide a vehicle for dialogue between health care providers and the Corporation in support of the effective provision of health care services to the members of the Corporation and of the efficient processing of claims and solving disputes;

Whereas the Second Party has the facilities to provide the services needed by the members of the First Party and is willing to extend medical and hospitalization services to the members of the First Party;

FOR AND IN CONSIDERATION of the foregoing, the Parties agreed, as they hereby agree to the following:

### III. Terms and Conditions of Contract

#### A. Obligations of FIRST PARTY

- a.) To comply with the National Health Insurance Act, its Implementing Rules and Regulations, Administrative Orders and Circulars and other pertinent rules and regulations;
- b.) To pay for the specified health care services contained in Annex \_\_\_\_, according to the agreed on schedule of payments without delay;
- c) To provide open source reference implementations of information systems that meet the requirements of the Corporation;
- d) To process claims and pay claims within one month after receipt if in compliance with the above regulations and the terms of this contract; In case the Corporation fails to pay within one month, the Second Party will be entitled to the payment of interest (or an extra bonus) conform the average market rate or the legal interest rate as used by the Government over the said month;
- e) To inform the health care provider on flawed and/or defective claims immediately;
- f) To provide web services such as eligibility checks and other electronic libraries pertinent to claims processing (ICD-10 code, RUV code, PHIC insured PIN, company ID, etc); and,
- g) To timely inform the Second Party about planned changes in its policies and regulations that will affect the second party as to provide the second party the opportunity to express its concerns about the implementation to the Corporation within a month and/or to have sufficient time to prepare for the implementation,
- h) To provide provider with feedback on performance and comparisons with peers.

#### B. Obligations of the SECOND PARTY

- a.) The SECOND PARTY shall comply with the National Health Insurance Act, its Implementing Rules and Regulations, First Party Administrative Orders and Circulars and other pertinent rules and regulations;
- b.) The SECOND PARTY shall in the course of the duration of the contract ensure that it maintains its accredited status in accordance with the accreditation standards of the Corporation so as to participate in the program, and ensure that it complies with the requirements for accreditation as related to its status of health professional or of (primary, secondary or tertiary hospital) at all times; The Second Party will inform the Corporation within one month if it

fails to comply with the standards of accreditation according to its level of accreditation. In case the second party fails to inform the Corporation within the agreed timeframe, the Corporation on discovery of such failure may request the second party to return the payments made by the Corporation for services to its members it has unjustifiably paid during the period of non-compliance.

- c.) The SECOND PARTY shall deliver the specified services as provided for in Annex \_\_\_ to beneficiaries of the National Health Insurance Program without delay, in good faith, and with the highest degree of diligence.
- d.) The SECOND PARTY shall ensure that the rights of the patients under its care are protected at all times.
- e.) The SECOND PARTY shall determine in good faith the eligibility of a beneficiary and substantial compliance with the requirements for availment of health services.
- f.) The SECOND PARTY shall make sure availability of the needed supplies and medicines including diagnostic tests needed by the patient, in like manner they shall ensure against the over-utilization of these services.
- g.) The SECOND PARTY shall not unnecessarily admit the member to inpatient care and not render unnecessary diagnostic and therapeutic procedures and interventions.
- h.) The SECOND PARTY shall ensure against the under-utilization of services.
- i.) The SECOND PARTY shall ensure against inappropriate referral services.
- j.) The SECOND PARTY shall prescribe and administer drugs in compliance with the DOH/PhilHealth issued list of essential drugs that are reimbursable by the Corporation and that are appropriate and necessary for the treatment of the particular member and unquestionably consistent with accepted standards of medical practice and ethics. In case the Second Party considers the reimbursable listed drugs not sufficient for the particular patient, he will explain this to the patient and inform the patient about the financial consequences and will register this in the medical record of the patient for review by the Corporation,
- k.) The SECOND PARTY shall submit mandatory monthly hospital reports and other reportorial requirements, as determined by the FIRST PARTY; The SECOND PARTY shall submit mandatory monthly hospital reports and other reportorial requirements, as determined by the FIRST PARTY

- l.) The SECOND PARTY shall file its claims with the Corporation according to the agreed schedule without delay.
- m.) The SECOND PARTY shall comply with the Management Information System (MIS) requirements of the FIRST PARTY to wit:
  - (1) To maintain a registry of patients;
  - (2) To authenticate the records of the patients;
  - (3) To check the eligibility of the patients;
  - (4) To submit claims electronically using the standard electronic format provided by FIRST PARTY;
  - (5) To maintain a database of all claims filed;
  - (6) To maintain the integrity of a member's digital signature;
  - (7) To maintain the security of its information system;
  - (8) To use the assigned digital signature as per protocol;
  - (9) To keep records relevant to claims for post-audit; and
  - (10) To keep for a period of x years (defined by the legal term for financial data) digital records of drugs and supplies used or prescribed and of medical interventions in the care of the patient for the claimed episode.
- n.) Seek the consent from the FIRST PARTY for the performance of any medical procedure in cases provided in Annex \_\_\_\_\_, except in emergencies.
- o.) Inform the FIRST PARTY of the names and positions of any support staff; and the names and the respective field of health care practice of any health care professional working under his/its management;
- p.) *(In case of health care institution)* Assume liability for the quality of health care provided by any health care professional working under his/its management, including those who practice in the premises of the SECOND PARTY;
- q.) Inform the FIRST PARTY of any change in the place or venue of health care practice;
- r.) In case of an institutional health care provider, inform the FIRST PARTY in any change in ownership or management, or closure or temporary cessation of hospital operation within three months prior to change;



- s.) Shall practice in accordance with the highest nationally accepted medical and care standards, clinical practice guidelines or clinical pathways, fitting with its/his/her specialty and professional competence and in compliance with the applicable Code of Ethics of his/her profession;
- t.) Guarantee, safe, adequate and standard medical care for all patients seeking medical care and shall exercise observance of public health measures in case of communicable diseases;
- u.) Adopt referral protocols, as defined in Annex \_\_\_\_\_, as well as strictly follow guidelines and health resource sharing arrangements of the National Health Insurance Program;
- v.) Strictly enforce a smoke-free policy within the work premises;
- w.) Allow PHIC representative to have access to the medical chart of the patient;
- x.) To allow the entry of the FIRST PARTY's representative to the work premises of the SECOND PARTY for purposes of inspection or investigation; and
- y.) To cooperate in any investigation found to be necessary by the FIRST PARTY by making ready and available when required/summoned, all documents and records pertinent to cases under investigation.

#### C. Common Obligations

- a) The Parties shall both endeavor to improve its health management information systems according to standards agreed upon so as to better implement the service contracting program of FIRST PARTY.
- D. The Parties shall meet twice a year to discuss the SECOND PARTY's plans for improvement of quality and for investments in equipment. The SECOND PARTY shall inform the FIRST PARTY about any investment plans in equipment, worth more than Php \_\_\_\_\_, and shall await the FIRST PARTY's approval before the actual procurement.
- E. The Parties shall agree to meet once a year to have a dialogue to assess the performance of their respective obligations under this contract.

#### IV. Consideration

The FIRST PARTY agrees to pay the SECOND PARTY the amount of \_\_\_\_\_ for the package of services as provided in Section III (B) (c) above, as specified in Annex \_\_\_\_\_, payable as follows:

- a. The FIRST PARTY shall pay the SECOND PARTY 80% amount of claims or To make payment for covered 80% of the total hospital and professional charges within \_\_\_\_\_days from receipt of the Statement of Account from the Second Party, without

prejudice filed within \_\_\_\_ days of such filing, without prejudice to the results of the FIRST PARTY's verification of the veracity and appropriateness of such claims, which shall be completed with \_\_\_\_ days from submission of claims with supporting documents.

- b. The balance of any amount payable during a claim period (as agreed upon by the parties) shall be paid within \_\_\_\_ days from the termination of the verification period.
- c. All medical and hospital accounts not paid as stated in Section IV a & b shall earn an interest of \_\_\_\_% per annum, without prejudice to the right of the Second Party to suspend credit to the First Party. (An interest rate of \_\_\_\_ upon any amount unpaid by the FIRST PARTY after the expiration of the verification period).

#### V. Recording and Billing

The First Party and the Second Party shall exercise diligent coordination on all matters pertaining to any Second Party member or his dependent admitted to the Second Party and both parties agrees to establish mutually acceptable recording, billing and accounting system and procedures;

#### VI. Medical Coordination

It is hereby understood that no employer-employee relationship exist between the First Party and Second Party and/or the latter's medical staff or employee on the account of these agreement.

#### VII. Effects of a Fortuitous Event

In case of a fortuitous event, neither FIRST PARTY nor the SECOND PARTY shall be liable for default or non-performance, provided however, neither of the parties to the contract has committed any negligence, misconduct or in delay that resulted in the default or non- performance;

Upon occurrence of an event considered as a fortuitous event by FIRST PARTY, FIRST PARTY shall immediately send notice to the SECOND PARTY of such a circumstance. The FIRST PARTY shall still comply with its obligations as far as reasonable. The FIRST PARTY shall notify the SECOND PARTY of reasonable alternatives for the performance of its obligations. The alternatives shall be agreed upon by the parties within \_\_\_\_ days from notice.

Upon occurrence of an event considered as a fortuitous event by the SECOND PARTY, the SECOND PARTY shall immediately send notice to the SECOND PARTY of such a circumstance. The SECOND PARTY shall still comply with its obligations as far as reasonable. The SECOND PARTY shall notify FIRST PARTY of reasonable alternatives for the performance of its obligations. The alternatives shall be agreed upon by the parties within \_\_\_\_ days from notice.

#### VIII. Contract Amendments

The terms of this contract may be amended by the Parties, provided, that notice first be given by either party to the other of an intention to amend the terms of this contract. Such notice shall be in writing. The party intending to amend the terms of the contract shall endeavor to negotiate in good faith the terms of the amendment. Such notice however shall not suspend the effects of the contract.

In the event the parties fail to agree on any amendments to the contract within the given time period provided in the notice, the present contract shall continue to be effective. A contract can only be amended once every \_\_\_\_\_, or if both parties agree to do so.

#### IX. Confidentiality

Except with prior consent from either of the parties to the contract, the FIRST PARTY and the SECOND PARTY shall not disclose at any time to any person or entity any information disclosed to them for the purpose of the provision of health care services or for the purpose of reviewing and paying the claims submitted by the Second Party.

#### X. Implementation of the Contract

The contract between FIRST PARTY and the SECOND PARTY shall be effective upon signing. As such, the SECOND PARTY shall commence the services within \_\_\_ days after FIRST PARTY has given notice to the SECOND PARTY to proceed with the implementation of the contract. The notice must be in writing.

#### XI. Penalty Clause

In the event that the SECOND PARTY incurs a delay in its obligations, damages in the amount of \_\_\_\_\_, per day of delay shall be paid accordingly; provided that the delay is not attributable to FIRST PARTY, and provided further that the delay is not caused by factors beyond the control of the SECOND PARTY.

In the event that either parties commit fraud in the performance of its obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.

In the event that either parties are negligent in the performance of its obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.

In the event that either parties contravene the tenor of their obligations, damages in the amount of \_\_\_\_\_ shall be paid accordingly to the injured party.

#### XII. Arbitration

All disputes that arise from the contract shall first be resolved through arbitration.

The parties shall select three arbitrators from the arbitration pool as constituted by the FIRST PARTY in accordance with its Rules. One arbitrator shall be chosen by the FIRST PARTY, the second by the SECOND PARTY, and the third as agreed upon by both parties. In the event that there is a disagreement as to the third arbitrator, the two arbitrators selected by both parties shall choose from the third member.

The selection of the arbitrators must be made within \_\_\_ days from the service of the demand for arbitration. The arbitration of the dispute must not exceed \_\_\_ days. This period may be extended by mutual consent of the parties.

Arbitration shall proceed as follows:

- a.) Either party shall serve upon the other party a demand for arbitration. Such demand shall set forth the nature of the dispute, the amount involved, if any and the relief sought, together with this contract.
- b.) The demand shall be served in person or by registered mail.
- c.) Within \_\_\_ days from the selection of the arbitration panel, the arbitration panel shall set a time and place for the hearing of the matters submitted, and must cause notice to be given to the parties. Adjournment may be ordered by the arbitrators upon their own motion only at the hearing and for good and sufficient cause.
- d.) No adjournment shall extend the hearings beyond the number of days to arbitrate the dispute as stated in this contract.
- e.) The hearing may proceed in the absence of any party who after due notice, fails to be present at such hearing or fails to obtain an adjournment. No award shall be made solely on the default of a party. The arbitrators shall require the other party to submit such evidence as they may require for making an award.
- f.) Only the parties to the dispute, or their representatives duly authorized in writing shall be permitted to be present during the arbitration.
- g.) The parties to the dispute must endeavor to settle the dispute amicably.
- h.) The arbitrators shall at the commencement of the hearing ask both parties for brief statements of the issues in controversy and/or an agreed statement of facts. Thereafter, the parties may offer such evidence as they desire, and shall produce such additional evidence as the arbitrators shall require or deem necessary to an understanding and determination of the dispute.
- i.) The arbitrators shall be the sole judge of the relevancy and materiality of the evidence offered or produced.
- j.) At the close of the hearings as set by the arbitrators, the arbitrators shall specifically inquire of all parties whether they have any further proof or witnesses to present. Upon the receipt of a negative reply from all parties, the arbitrators shall declare the hearing closed unless the parties have signified an intention to file briefs. Then the hearings shall be closed by the arbitrators after the receipt of briefs and/or reply briefs. Definite time limit for the filing of such briefs must be fixed by the arbitrators at the close of the hearing.
- k.) The written award of the arbitrators shall be rendered within 30 days from the closing of the hearings. This period may be extended mutual consent of the parties.
- l.) The award must be made in writing and signed and acknowledged by the concurrence of two of the arbitrators. Each party shall be furnished with a copy of the award. The arbitrators in their award may grant any remedy or relief which they deem just and equitable and within the scope of the contract of the parties.

In the event that the parties during the course of the arbitration have settled their dispute, they may request of the arbitrators that such settlement be embodied in an award which shall be signed by the arbitrators. All negotiations towards settlement of the dispute must take place without the presence of arbitrators.

The parties may by written agreement submit their dispute to arbitration other than by oral hearing. The parties may submit an agreed statement of facts, respective contentions to the arbitration panel in writing which shall include a statement of facts, together with documentary proof, or the parties may submit a written agreement. Each party shall provide all other parties to the dispute with a copy of all statements and documents submitted to the arbitrators. Each party shall have an opportunity to reply in writing to any other party's statements and proofs; but if such party fails to do so within seven days after receipt of such statements and proofs, that party shall be deemed to have waived his right to reply. Upon the delivery to the arbitrators of all statements and documents, together with any reply statements, the arbitrators shall declare the proceedings in lieu of hearing closed.

### XIII. Assignment of the Contract

The SECOND PARTY shall not assign or transfer this contract or any part thereof to any entity without the prior approval of FIRST PARTY.

In the event the SECOND PARTY loses its accreditation during the duration of the contract, the contract shall be assigned automatically to a THIRD PARTY selected by FIRST PARTY to continue the performance of the contract; *Provided* that said Third Party is capacitated and qualified to be party to the contract .

\_\_\_\_\_ (THIRD PARTY) is chosen by the parties of the contract as the substitute in the event of loss of accreditation.

\_\_\_\_\_ (THIRD PARTY) must be accredited as a health care provider at the signing of the contract and must continue to be accredited during the duration of the contract.

#### XIV. Termination of the Contract

In the event any of the Parties fails to comply with its obligations, the injured party may terminate the contract, without prejudice to submission to arbitration in accordance with paragraph 11.. Written notice must be given by the injured party to the other party of the termination of the contract. Notice must be served in person or by registered mail.

The contract shall be deemed terminated within \_\_\_ days of service of the notice.

#### XV. Duration of the Contract

The contract shall be in full force until the services and all payments therefore have been completed and at such time the parties hereto shall be mutually released from all obligations hereunder, provided however, that this does not prevent the parties from extending the Contract under the same or modified terms.

#### XVI. Terms for Renewal

The Parties shall agree to renew the terms of the contract subject to the following conditions:

A.) The provision of health care services by the SECOND PARTY was performed at a level that is satisfactory to the FIRST PARTY;

B.) The FIRST PARTY's compliance with its obligations was satisfactory to the SECOND PARTY; and,

C.) The Mutual Agreement by the Parties that the renewal of the contract would best serve the needs of both parties.

#### XV. Miscellaneous Provisions

- 1.) This Contract shall be governed by, and construed in accordance with, the laws of the Republic of the Philippines.
- 2.) This Contract constitutes the entire agreement between the Parties with respect to the subject matter hereof. All prior agreements or arrangements, written or oral, between the parties relating to the subject matter hereof are hereby canceled and superseded.

- 3.) This Contract may not be amended or modified except in writing signed by the parties.
- 4.) Any notice, request, demand or communications required or permitted to be given under this Contract shall be in writing and: (i) delivered by hand; (ii) sent by postage prepaid; or (iii) transmitted by facsimile to the business addresses first written above. All notices, requests, demands or communications shall be deemed to have been duly received on: (i) the date of receipt if delivered by hand; (ii) the date ten (10) days after posting if sent by mail, whether ordinary or registered; or (iii) the date of transmission if sent by facsimile, provided that if so requested a confirmation copy shall be sent within three (3) days therefrom. Either party shall notify the other party in writing of any change in its address as above written.
- 5.) In the performance of his/her obligations under this Contract, the Parties shall adhere to the principles of good faith, justice and fairness.

IN WITNESS WHEREOF, the **PARTIES** hereto have executed and signed this Contract in the City of \_\_\_\_\_ on \_\_\_\_\_(date).

PHILIPPINE HEALTH  
INSURANCE CORPORATION  
First Party

(name of Second Party)

Second Party

By:

By: (in case of juridical person)

(Name of Representative)

(Name of Representative)

WITNESSES:

-----

A C K N O W L E D G E M E N T

BEFORE ME, a Notary Public for and in the City of \_\_\_\_\_, Metro Manila, personally appeared the persons enumerated below bearing their Community Tax Certificates with the following details:

Name	Government-issued ID No.	Place of Issuance	Date of Issuance

The same persons who are known to me, acknowledged to me, that:

- They are the same persons who executed the foregoing instrument, consisting of \_\_\_\_ pages, including the page wherein this Acknowledgment is contained;
- \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_ are duly authorized to appear in behalf of and bind their respective principals or the companies that they represent; and
- They all executed the foregoing instrument as their own free will and voluntary act and deed, for themselves and/or in behalf of their respective principals.

Notary Public

My commission expires on \_\_\_\_\_

Document No. \_\_\_\_\_

Page No. \_\_\_\_\_

Book No. \_\_\_\_\_

Series of 200\_\_\_\_.

## ANNEX 6

### ELEMENTS FOR A MOA ON CONTRACTING BETWEEN PHILHEALTH AND PHA

1. Institutionalizing of permanent dialogue
  - a. Establishment of a standing committee with 5 permanent representatives of each party with for each member of the committee an appointed alternate
  - b. Chairmanship will rotate on a yearly basis between PHIC and PHA
  - c. Objective of committee:
    - i. Information exchange and discussion on existing and proposed policy developments and implementation arrangements in their respective organizations to provide both organization the opportunity to vent comments and suggestions as regards proposed rules, regulations and AO's
    - ii. To discuss and agree specific policies and actions that will be proposed to their respective Boards and/or members
    - iii. To discuss and agree on the outline and content of a sample contract between PHIC and a hospital, which the respective delegates will present to their Boards and ask for consent.
    - iv. To discuss experiences of the PHA members and PHIC management and staff with the implementation of the contract
    - v. To yearly evaluate the sample contract and agree on necessary adjustments, including the yearly adjustment of rates related e.g. to inflation and other structural factors, beyond the control of the providers.
    - vi. To discuss and make a proposal for the further development of the Social Health Insurance System on the Philippines
  - d. The committee has a permanent Secretariat, consisting of 2 staff of PHIC and 2 of PHA, specifically designated for this secretariat, besides their regular duties in their organizations.
  - e. Mandate of the secretariat of the committee:
    - i. preparation of monthly, by-monthly or quarterly meetings of the official delegations of PHIC and PHA
    - ii. proposing the agenda for the delegates meeting, after consultation with their offices/delegates
    - iii. collecting the underlying documents for the agenda from their offices
    - iv. preparing briefing notes
    - v. preparing the minutes of the meeting
  - f. Costs of the committee: these will be borne by PHIC, except for the staff costs of the PHA secretariat and travel/board & lodging costs of the PHA delegates and except for the internal preparation costs at PHA
2. Evaluation of dialogue: parties will by the end of every calendar year evaluate the process and impact of the standing committee on the implementation of health insurance and on the pursued policies of both parties, especially as regards the concluding of contracts and their implementation and the communication between the two parties and their respective members.



3. Parties will inform their respective members about the planned and actual changes in policies and practices as far as these have an impact on these members.
4. PHA agrees to request its members to participate in efforts to market the Philippine Health Insurance Program to their patients
5. PHIC agrees to inform its members in relevant geographic areas about the health care providers that have been contracted and are PHIC's preferred providers, offering better quality of care and agreed charges to the patients for defined health interventions.
6. Parties will establish an arbitration committee to deal with the issues and conflicts arising from the implementation of the agreed contracts between PHA members and PHIC. (regulation for such committee, including the issues it can deal with is attached).
7. PHA will encourage its Components in the provinces to enter into similar communication as it has itself with PHIC on the national level. Subsequently it will encourage its components to also stimulate the conclusion of individual contracts between its member hospitals and PhilHealth. Mutatis mutandis, PHIC will instruct its PRO's and provincial offices to also enter into a structured dialogue with the PHA Components, with adequate support from the Corporation and fostering information flow, parallel to the flow on the national level.

**ANNEX 7**  
**LIST OF PERSONS MET**

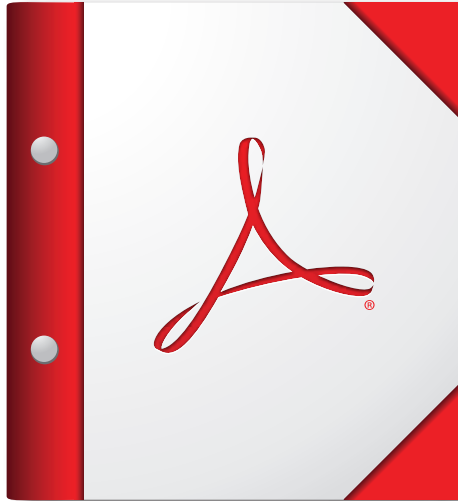
<b>Name</b>	<b>Designation</b>	<b>Office/Organization/ Address</b>
Adelhardt, Michael	Programme Manager	GTZ Pasig City
Ala, Marvie	Director	Bureau of Health Policy Development Department of Health Manila
Alcantara, Arturo	Division Chief	Health Informatics Section Philippine Health Insurance Corporation Pasig City
Aragona, Jovy	Senior Programmer	IMS Department of Health Manila
Arzadon, Maricar	Manager	Benefits Availment Section PhilHealth Regional Office 1 Dagupan City, Pangasinan
Asprer, Leilani	Division Chief	Accreditation Department Philippine Health Insurance Corporation Pasig City
Astom, Fernando A.	CEO	La Union Medical Center
Aurelia, Fidencio	VP for Visayas Chapter	Philippine Hospital Association Quezon City
Bacareza, Walter	Manager	Marketing and Collections Department Philippine Health Insurance Corporation Pasig City
Bacud, Paulus Magnus	Planning Officer III	Corporate Planning Department Philippine Health Insurance Corporation Pasig City
Balog	Vice President NCR	PhilHealth
Banting, Michael Paul	Senior Social Insurance Specialist	Standards Monitoring Department Philippine Health Insurance Corporation Pasig City
Banzon, Eduardo		World Bank
Bauer, Anja	Task Manager, Health	European Commission Makati City
Beltran, Ernesto V.	Senior Vice President Operations	PhilHealth
Beltran, Maylene	Director	Bureau of International H C Department of Health Manila
Bernardo, Irineo	Secretary General	Philippine Medical Association Quezon City
Bumacod, Willy		Comptrollership Department

<b>Name</b>	<b>Designation</b>	<b>Office/Organization/ Address</b>
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