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INTEGRATING FINANCING OF VERTICAL HEALTH PROGRAMS: LESSONS FROM KYRGYZSTAN AND THE PHILIPPINES



September 2018

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It was prepared by Jenna Wright, Dasha Migunov, Leizel Lagrada, Iana Provotorova, Sharon Nakhimovsky, Marjan Inak, Heather Cogswell, and Rena Eichler for the Health Finance and Governance Project.

The Health Finance and Governance Project

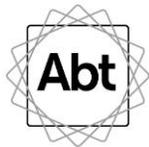
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this six-year, \$209 million global project increases the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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Abt Associates Inc. | 6130 Executive Boulevard | Rockville, Maryland 20852
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
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DISCLAIMER

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ACRONYMS

BTL	Bilateral tubal ligation
DOH	Department of Health (the Philippines)
DOTS	Directly Observed Treatment, Short Course
EPCMD	Ending Preventable Child and Maternal Deaths
FP	Family Planning
GOK	Government of Kyrgyzstan
GOP	Government of the Philippines
HFEP	Health Facilities Enhancement Program (the Philippines)
HFG	Health Finance and Governance
IUD	Intrauterine Device
LGU	Local Government Unit (the Philippines)
LMIC	Low- and Middle-Income Country
MCP	Maternal Care Package
MDR	Multi-drug Resistant
MHIF	Mandatory Health Insurance Fund (Kyrgyzstan)
MOH	Ministry of Health
NDHS	National Demographic and Health Survey
NGO	Non-governmental Organization
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
PFPP	Philippine Family Planning Program
PHC	Primary Health Care
PHIC	Philippine Health Insurance Corporation
POPCOM	Population Commission (the Philippines)
RPRH	Responsible Parenthood and Reproductive Health Program (the Philippines)
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization



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I. INTRODUCTION

Low- and middle-income country (LMIC) governments are making choices today that will affect their pathways to universal health coverage (UHC) and their ability to reduce maternal and child deaths. These choices, especially those made in the early phases of developing UHC strategies, matter because they can have long-lasting effects. For the many LMIC governments establishing new health financing schemes to pool resources across large populations, one choice relates to the historical legacy of “vertical” programming. Under vertical programming, financing, governance, and service delivery may all be organized around an individual disease such as tuberculosis (TB) or category of health service such as family planning (FP). In contrast, the packages of services financed through these new financing schemes, sometimes called national or social insurance, are intended to provide a broader set of services, basic or comprehensive, to meet health needs of the population.

Stakeholders continue to debate the benefits and weaknesses of vertical programming. Proponents point out that vertical programming has some benefits – for example, vertical programs have become a functional platform that delivers good health outcomes and strong accountability for certain diseases or categories of health services prioritized by the global health community, in the context of otherwise weak health systems (Rao 2014). Others argue that vertical programs distort processes for allocating resources, so that actual funding does not align with the preferences or needs of the population and may instead reflect the preferences of the donors who introduced them. Vertical programs create fragmented financing flows that influence provider and patient behavior in unintended, sometimes perverse, ways and create duplicative processes that are wasteful and burden the workforce (Msuya 2005; Atun et al. 2008). Furthermore, because vertical programs are not organized around the whole patient, they miss opportunities to promote access across the continuum of care.

For better or worse, many LMICs inherited vertical programs, and governments must now decide whether a new government-managed financing scheme such as national or social health insurance will assume the functions currently performed through vertical programs. Specifically, governments may decide that services previously purchased through vertical programs will be either i) incorporated under the consolidated purchasing structure of the new financing scheme; ii) excluded from the new scheme and continue to be purchased by vertical programs; or iii) purchased through both institutional structures.

To support governments facing these decisions, the United States Agency for International Development (USAID) commissioned the Health Finance and Governance (HFG) project to conduct this study. The study is intended to help health system stakeholders better understand why some LMIC governments have made the decision to integrate services into the purchasing mechanism of a new health financing scheme, and how they have operationalized it. To explore these questions, HFG conducted case studies in two countries, Kyrgyzstan and the Philippines, where governments have been implementing large-scale and broad-based health financing schemes (Kyrgyzstan’s Mandatory Health Insurance Fund (MHIF) and the Philippine National Health Insurance Program managed by the Philippine Health Insurance Corporation and commonly known as PhilHealth) for more than a decade and have grappled with the policy and operational challenges. The case studies focus on the fate of single vertical programs: TB in Kyrgyzstan and FP in the Philippines. This study is the third in HFG’s series, *Pathways to UHC*. The first explored the role of evidence in designing benefit plans (Nakhimovsky et al. 2015) and the second explored strategies for expanding coverage for informal workers (Nakhimovsky et al. 2017).



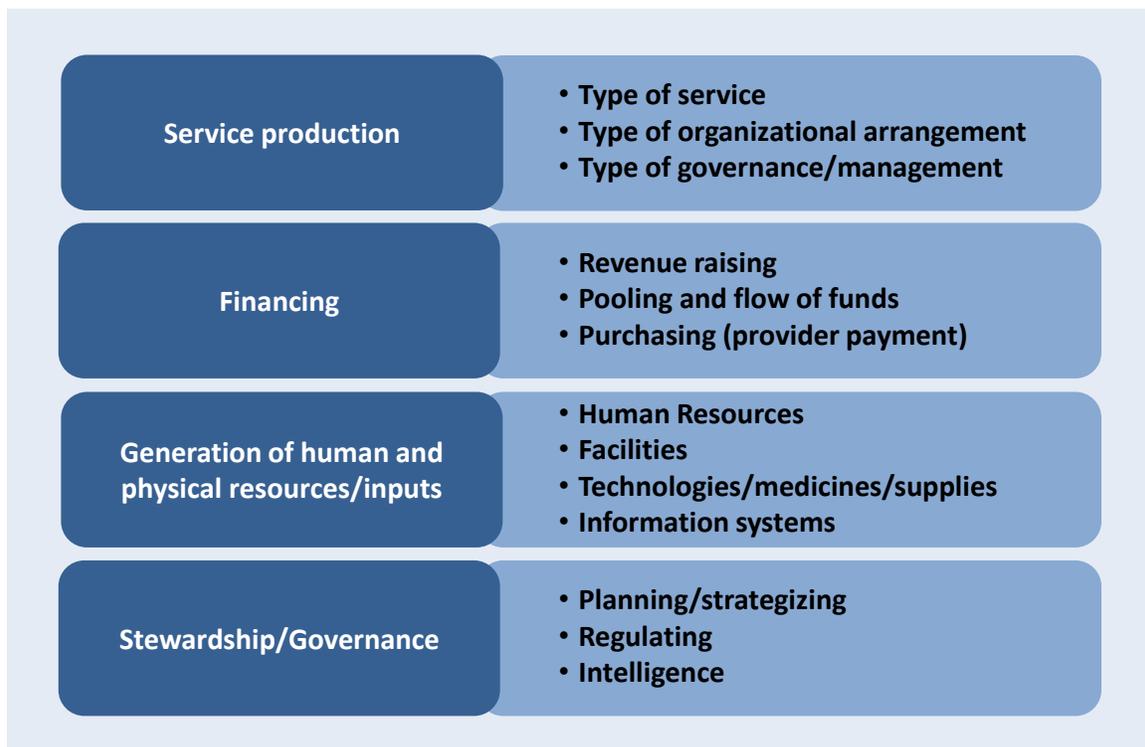
This report begins with a summary of the framework and methods for the case study research. Section 3 presents key findings for the Philippines and Kyrgyzstan, and Section 4 shares cross-cutting implications for other LMIC governments anticipating similar situations. Annexes A and B present the full case studies for Kyrgyzstan and the Philippines, respectively, including details of the country's reform process and the perspectives of key informants.

2. METHODS

2.1 Framework and Definitions

This study seeks to enhance understanding of why and how countries have integrated financing of previously vertically financed services into national or social financing structures that pool resources and pay providers for delivering a broader package of health services. Drawing on key informant discussion (phone conversation with Susan Sparkes (2018)), Sparkes et al. (2017) and the *World Health Report 2000* (WHO 2000), this study considers four health system functions that are implicated in the process of integration. Figure 1 presents each function, or groups of activities and tasks, along with sub-functions that make up each one. This study uses the terms “integration” and “inclusion” interchangeably.

Figure 1: Functions and Sub-functions for Integrating



Source: Sparkes et al. 2017

2.2 Case Study Methods

This study focused on countries whose governments have already established health financing schemes that pool resources and purchase a package of services for large populations. It excluded countries whose governments only finance and deliver health through line ministries. Other papers, including Sparkes et al. (2017), consider some of the issues around integration in these other contexts.

HFG purposively selected two USAID-supported countries, Kyrgyzstan and the Philippines, which have a legacy of vertical programs and also have large-scale health financing schemes that have been in operation for several years. Through a preliminary literature review, HFG identified specific health services – TB in Kyrgyzstan and FP in Philippines – that were previously financed in a vertical manner but have since started integrating under the broader health financing scheme. The experience of this integration has potential to contain lessons for other countries related to integrating vertical services into new health financing schemes that purchase a package of services, such as national or social health insurance.

In each country, HFG conducted a comprehensive desk review and 10-15 key informant interviews, led by 1-2 in-country interviewers. HFG purposively selected key informants based on their expertise and experience with relevant reforms. Key informants included high-level policymakers and program managers from governmental and non-governmental organizations. They also included decision makers, program managers, and private sector actors who experienced the shift of financing from vertical programs to the new health purchasing scheme. Annexes A and B contain more details on each country's key informants. By collecting narrative data through interviews, the study team captured how actors understood the evolution, current organization, and operations around how services of interest (TB in Kyrgyzstan and FP in the Philippines) are financed, purchased and managed.

HFG developed and pre-tested semi-structured interview guides (see Annexes C and D) in both countries before using them to conduct interviews with study participants. The research protocol and interview guide received approval through Abt Associates' institutional review board and the local ethical review boards in Kyrgyzstan and the Philippines. Each interview lasted about one hour. Interviews were conducted in English and Russian in Kyrgyzstan and English and Tagalog in the Philippines. Interviews were audio recorded and the recordings were transcribed, cleaned, and reviewed for quality purposes. Interviews were coded by topic and analyzed to identify themes and key information. Coding and analysis was conducted by two researchers for the Kyrgyzstan case study and one researcher for the Philippines case study.

3. KEY FINDINGS

3.1 Overview of Reforms in Kyrgyzstan and the Philippines

Transitioning from vertical program financing to pooling and purchasing these services under large-scale health financing schemes in Kyrgyzstan (MHIF) and the Philippines (PhilHealth) is an ongoing process occurring within a broader context of health system reform.

3.1.1 Transition of TB services in Kyrgyzstan

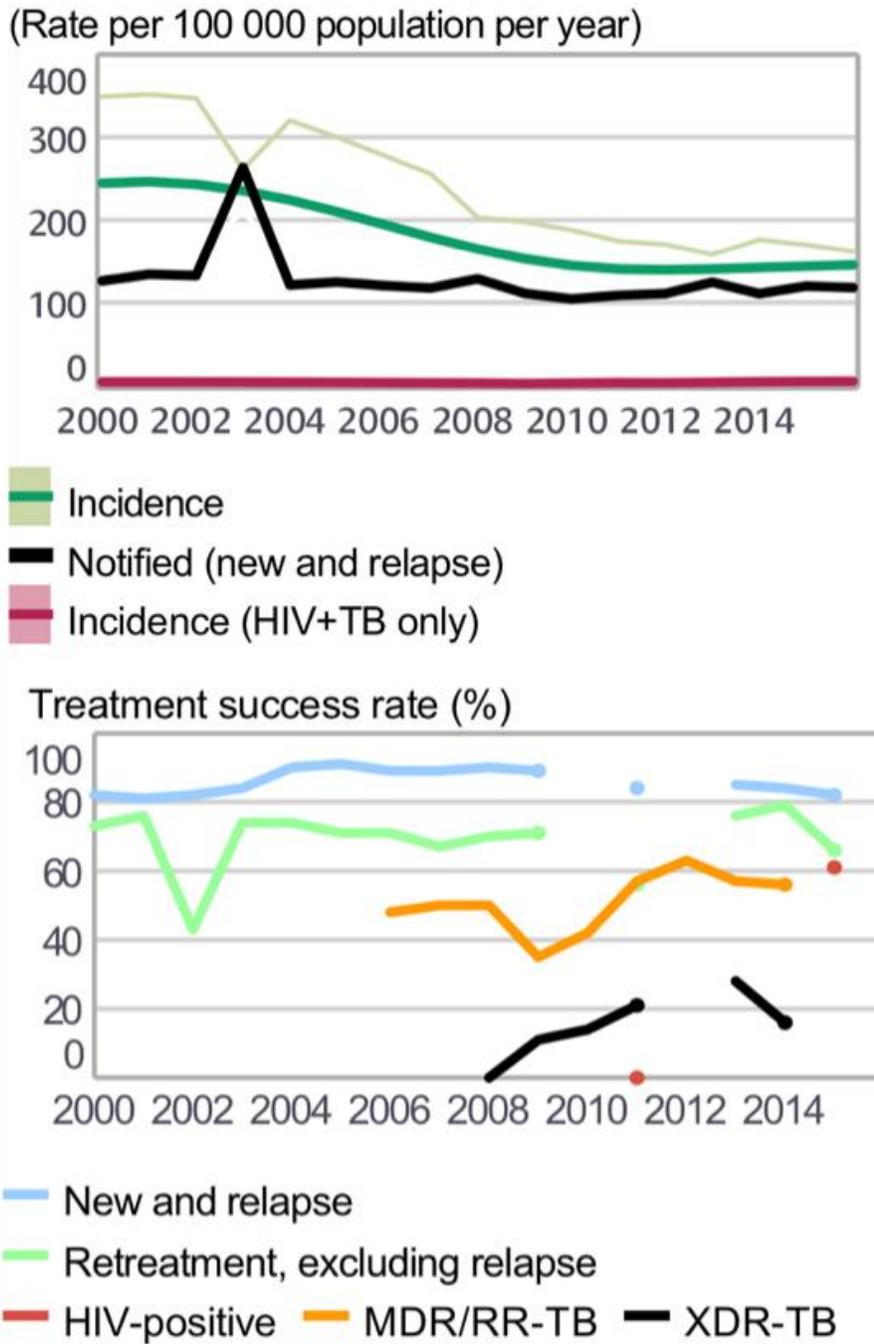
The government of Kyrgyzstan (GOK), independent from the Soviet Union since 1991, inherited a highly developed inpatient hospital network and a very weak outpatient and primary health care (PHC) facility network from the Soviet system. This structure affected the delivery of all categories of health services, including TB, which was largely furnished by specialty TB hospitals as inpatient care.

In the late 1990s, the GOK initiated a far-reaching reform of the health system: mandatory enrollment under a health financing scheme that pooled payroll taxes, premium payments, and other government funding to purchase a broad package of health services for enrollees. As part of the reform process, the GOK established the MHIF to administer the national financing scheme, developed an explicit benefits package, and developed norms and standards for care. Among other changes, these new norms and standards stipulated shorter hospital stays for TB inpatient care and shifted many types of health services to lower-level facilities located closer to communities. The GOK also began restructuring the service delivery system by strengthening the PHC level and closing or repurposing underused inpatient hospitals.

The GOK took another large leap forward in the early 2000s by implementing health financing reforms that aligned provider payment with the norms and standards. Specifically, the GOK shifted financing from input-based line item budgeting to capitation at the PHC level, which pays a set rate per year for each person in a facility's catchment population, and case-based payments at the hospital level, a set rate for all services delivered for an episode of care. In 2009, the GOK continued to strengthen the health service purchasing function by making the MHIF independent of the Ministry of Health, which oversees service delivery. Through this process that separated financing from provision of services, the MHIF gained more flexibility to use strategic purchasing tools.

The vertical TB service delivery system, and by extension its financing and management, remained largely intact during the broader health system reforms described above. While incidence of TB declined during that time, the rates of drug resistance among new and previously treated TB cases became a growing concern (Figure 2). By 2012, there was momentum to reform the TB delivery system in a similar manner. In that year, the government shifted purchasing of TB services from the Ministry of Health to the MHIF. All TB services are now financed through capitation for the PHC level and case-based payment for hospitals, just like other services in the MHIF package.

Figure 2: Trends in Incidence of TB and Treatment Success in Kyrgyzstan



Source: WHO 2018

Note: Data are as reported to World Health Organization

This integration of TB services into the MHIF system produced dramatic changes. Some TB specialty hospitals no longer operated at full capacity after imposition of guidelines for shortened hospital stays, prompting the government to close some of them. The effort to shift much of TB services to primary care and outpatient settings continues to the present day. These facilities felt that they were not sufficiently compensated for the increase in workload that came with integrating TB into MHIF; furthermore, it has taken time for the population to increasingly seek and accept outpatient TB treatment. In response to these challenges, in 2017, MHIF began a pilot in one *oblast* (region) to pay monthly bonuses to PHC facility staff for successfully treated TB cases in addition to the capitation payments the facility received for the same patients.

The transition in care delivery for TB patients continues today under the MHIF's purchasing scheme, with stewardship of the National TB Program under the Ministry of Health.

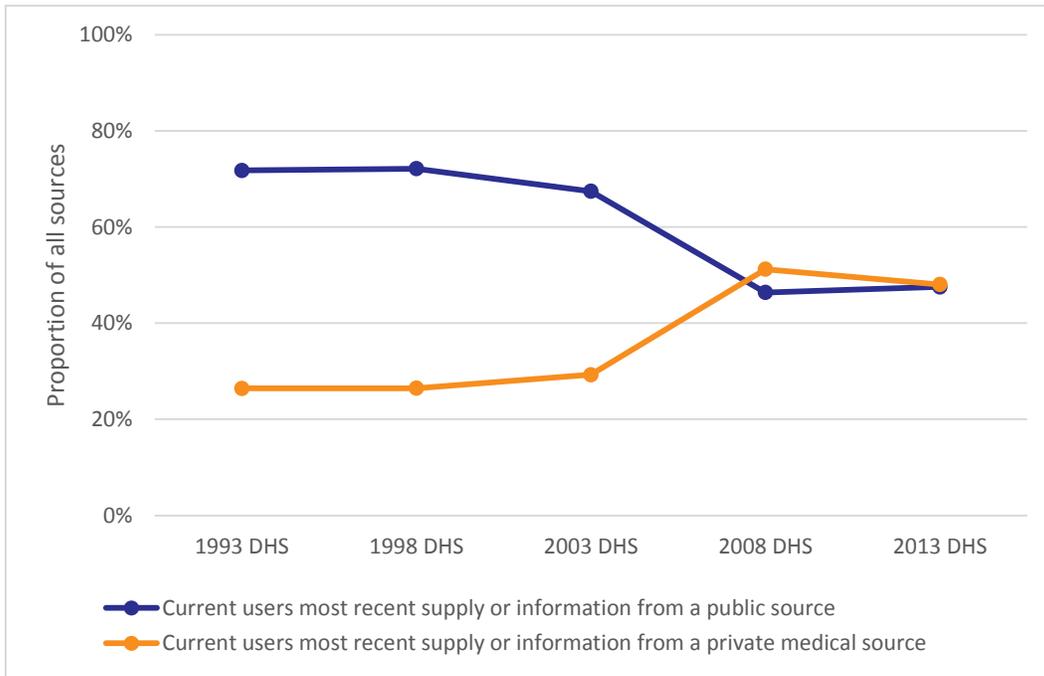
3.1.2 Transition of FP services in the Philippines

The Philippine government established the legal framework for UHC in the 1987 Constitution, building on capacity gained by administering Medicare, a social health insurance program that had covered formal sector employees since 1969. In 1995, to increase equity in the health system, PhilHealth was established to take over Medicare and expand population coverage. Additional reforms in 2012 helped create a sustainable, consistent source of financing for subsidizing premiums for the poor, elderly, and other vulnerable groups. By 2016, PhilHealth was reported to cover more than 90 percent of the population.

However, benefits remain narrow and financial coverage thin. PhilHealth spending accounts for only 14 percent of total health spending, while household out-of-pocket spending is above 50 percent. PhilHealth began by covering only inpatient care, which only enabled access to hospital provided FP services. By 2018, PhilHealth covered bilateral tubal ligation, vasectomy, intrauterine device insertion, and the subdermal implant.

For decades, FP services and commodities had been provided for free through the Department of Health (DOH) FP program. Local government units (LGUs) assumed responsibility for providing health care (including FP services) through public facilities in the 1990s. In spite of these policies, the proportion of FP users obtaining FP information or commodities from the private sector grew over this time period. (Figure 3).

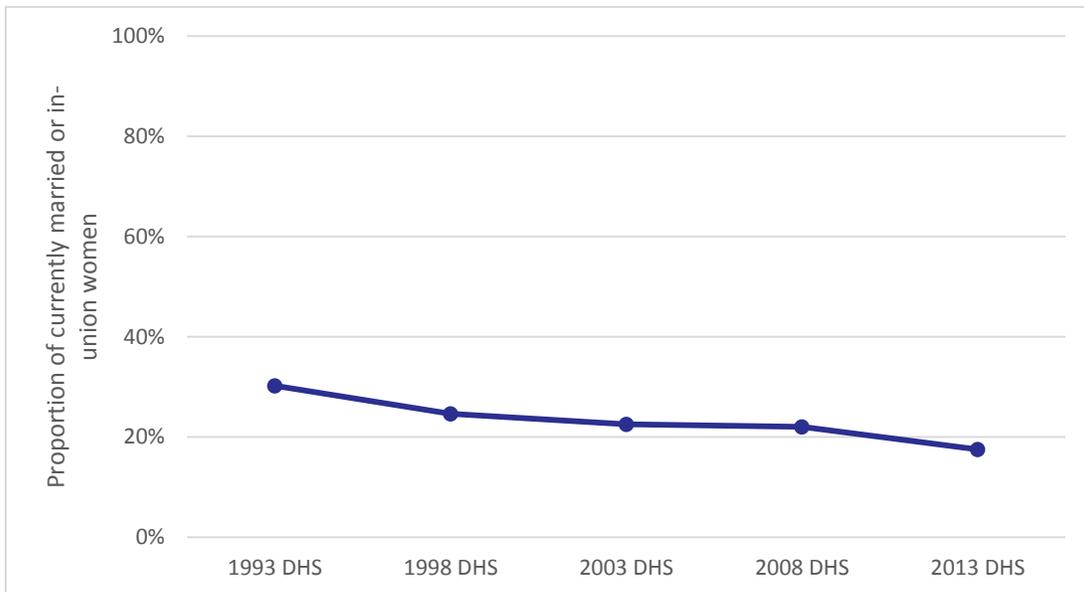
Figure 3: Trends in Source of FP Supply or Information in the Philippines



Source: Data from ICF 2015

In the 2000s, efforts to ensure FP service coverage faced political and financial challenges. USAID phased out funding for FP commodities, after having provided substantial funding since the late 1960s. At the same time, political momentum grew among groups opposing comprehensive FP coverage. Some LGUs stopped procuring commodities. Partly due to these factors, an unmet need for modern FP methods in the Philippines persists (Figure 4).

Figure 4: Trends in Unmet Need for FP among Currently Married or In-union Women in the Philippines



Source: ICF 2015

Since 2010, government administrations reestablished this commitment to strengthen access to FP services, although opposition remained. By 2018, PhilHealth added several outpatient benefits, including for maternity care and TB directly observed treatment, short course (DOTS). There are plans to increase this outpatient benefit package to include FP. Operationalizing this expansion of benefits is scheduled to take place in 2019-2022.

3.2 Reasons for the Transition

Through key informant interviews, the case studies explore the key factors that contributed to the decision to include TB and FP services under the benefit packages of MHIF and PhilHealth, respectively.

3.1.3 Kyrgyzstan

Reason #1: Improve efficiency of TB spending

Decision makers recognized that transitioning the purchasing of TB services to the MHIF would bring benefits similar to those that inspired the country's broad health system reforms. Reforms to TB financing and service delivery were expected to make the system more effective at controlling TB in Kyrgyzstan with the same financial resources. Key informants cited efficiency gains from shifting a portion of TB testing and treatment services to PHC and outpatient providers, and away from more resource-intensive inpatient care.

Additionally, shifting a significant portion of provider income to output-based financing for many services, including TB services, helped realign financial incentives and bolster efforts to fully implement the service delivery shift. Moving the purchasing function from the Ministry of Health (which owns the health facilities) to a separate purchaser facilitated the shift to payment mechanisms that aligned better with health sector goals.

Reason #2: Improve quality of care and patient-centeredness

Quality and coverage of TB services in Kyrgyzstan were demonstrably poor before reforms. A main reason for implementing reforms related to TB financing and service provision was to improve health outcomes. The legacy system enabled over-provision of inpatient care, poor infection control, and poor treatment completion rates, all of which contributed to a high burden of multi-drug-resistant TB. By shifting a larger portion of TB testing and treatment services to the PHC and outpatient facility level, treatment became more convenient for many patients and reduced their time in the hospital, where they are at higher risk of infection. By shifting purchasing of TB services to the MHIF, the GOK clarified the role that PHC and outpatient facilities should play in delivering TB services.

Reason #3: Increase domestic financing as external financing is reduced

Over the past five years, donor funding has accounted for approximately 30-60 percent of the budget for TB services in Kyrgyzstan (WHO 2017). The Global Fund to Fight AIDS, Tuberculosis and Malaria has financed the majority of TB drugs and equipment there for many years. As this funding decreases, the GOK has been able to allocate some of the savings from increased efficiency in the TB delivery system to increase domestic funding for TB drugs and equipment.

3.1.4 The Philippines

Reason #1: Help ensure availability and increase access to FP services

PhilHealth is better positioned to pay private providers, which are a large source of FP provision, than is the vertical FP program, which must abide by public procurement management regulation. PhilHealth

also has a routine process for accrediting and paying both public and private providers; the Population Commission (POPCOM) sometimes provides grants to private providers, but not as a routine part of operations. Thus, PhilHealth is the better financing vehicle to achieve more comprehensive access through a total market approach. Also, when LGUs did not allow or were restricted from purchasing FP commodities and services in the 2000s due to political opposition to FP, PhilHealth could still reimburse for FP delivered at private facilities. This ensured some level of access to FP.

Finally, historically, the FP vertical program in the Philippines has been underfunded and unmet need remains high. In 2000, for example, only 8.3 percent of the Philippine Population Management Program budget went to FP and counseling services; the majority funded reproductive health services and counseling, excluding FP (Racelis and Herrin 2003). This financing imbalance remained as donors departed and political forces that opposed FP access gained momentum during 2001-2010. In part due to these factors, unmet demand for modern FP is high: according to the Philippines National Demographic and Health Survey data for 2017, around 30 percent of demand for modern FP methods remains unmet (PSA and ICF 2018).

Reason #2: Align capabilities with responsibilities, clarify institutional roles and responsibilities, and streamline

Neither the DOH nor LGUs have sufficient strategic purchasing capability. While PhilHealth also has to improve its capacity, it is set up to lead health care purchasing as the Philippines advances towards UHC. So keeping LGUs (with support from the DOH) as service providers, and PhilHealth as the purchaser, while gradually expanding PhilHealth’s outpatient benefits, will help streamline operations, remove duplication, and clarify roles and responsibilities across institutions. This institutional structure will also help free up program managers in the DOH and LGU to focus their efforts on regulation and service delivery quality. A large range of key informants – public and private providers, and managers of other vertical programs that already transitioned purchasing to PhilHealth – all agreed that this division of labor would help all stakeholders more productively contribute to the program’s objectives.

Reason #3: Demand-driven approach will reduce wastage of commodities

Current DOH procurement of FP commodities results in wastage of FP commodities because forecasting is inaccurate, resulting in overstocking in some LGUs and stock-outs in others. There were also reports of delayed deliveries, with some commodities nearing expiry when they are delivered to LGUs. Under a demand-driven approach, it may be that such wastage is reduced because PhilHealth only pays for the FP method that the beneficiary uses.

3.3 Operationalizing the Transition of Financing

Operationalizing the transition of financing functions away from vertical programs to broader health financing schemes is a long process. Key informants in both countries mentioned challenges they are experiencing or anticipate confronting as more services move in this direction. Table I summarizes key operational considerations identified by stakeholders.

Table I: Key Informants’ Perspectives on Operationalizing the Transition

Kyrgyzstan	The Philippines
<p>Service production</p> <ul style="list-style-type: none"> • Need to re-train providers and create incentives to deliver care differently at PHC, outpatient and hospital levels 	<p>Service production</p> <ul style="list-style-type: none"> • Not all providers registered to provide FP services through the DOH program are accredited by PhilHealth. There are significant

Kyrgyzstan	The Philippines
<ul style="list-style-type: none"> • Need to build capacity and willingness of providers to operate under different payment models and norms • Longer transition period can help ensure quality of patient care continually improves throughout the transition period, and avoid disruptions in care from shocks to the system 	<p>hurdles to pass for them to get accredited; not all of them will want to go through the process.</p> <ul style="list-style-type: none"> • Burden for small public health facilities, which are mandated to provide the same public health programs as larger health facilities
<p>Financing</p> <ul style="list-style-type: none"> • Need to realign financial incentives at the PHC and outpatient level to accompany increase in workload 	<p>Financing</p> <ul style="list-style-type: none"> • PhilHealth still needs to strengthen purchasing operations across its package and address existing challenges, including: <ul style="list-style-type: none"> • Insufficient technical capacity to change case-rate payment to global budgets for PhilHealth’s inpatient FP services. Stakeholders want to make this change to give more flexibility to hospitals and better align payment with true cost given each hospitals’ different case mix. • Payments to providers are often late. • PhilHealth needs to update its reimbursement rates; these rates are considered to be below the cost of provision. This may tempt many providers to charge patients the difference, despite legislation forbidding this practice. • Still need to expand outpatient benefits under PhilHealth, including services related to FP, and the corresponding increase in premium and capitation payment rates
<p>Generation of human and physical resources</p> <ul style="list-style-type: none"> • Mitigation strategy may be helpful to address job uncertainty for TB specialist physicians and staffs of TB specialty hospitals created by task-shifting • Mitigation strategy may be helpful to address increase in workload at the PHC and outpatient level 	<p>Generation of human and physical resources</p> <ul style="list-style-type: none"> • DOH and LGUs need to ensure adequate number of health providers skilled in FP is available, especially in isolated and hard to reach localities • DOH needs ensure health facilities are equipped to provide quality FP services, whether through upgrading/constructing local health centers, or by enjoining private providers as provided in the law • PhilHealth needs to be more purposive in engaging providers, including leveraging its accreditation and benefit packages to ensure quality, affordable FP services

Kyrgyzstan	The Philippines
<p>Stewardship/Governance</p> <ul style="list-style-type: none"> • Separating the purchaser from the Ministry of Health enabled better leveraging of strategic purchasing tools • The National TB Program under the Ministry of Health retained its stewardship and governance role 	<p>Stewardship/Governance</p> <ul style="list-style-type: none"> • Need to increase investment in information for the population: enrolled individuals don't know about their benefits, and do not know about options and guidance for spacing children, modern methods, etc. • Need to clarify the institutional roles of DOH, including Population Commission, and PhilHealth in financing FP as provided in the Responsible Parenthood and Reproductive Health Law of 2012 • PhilHealth needs to more strategic in purchasing health services for example by expanding outpatient benefits, negotiating for prices of health services and commodities, using provider payment to control health spending • PhilHealth needs to collect and use information effectively in designing benefits and monitoring service provision, including to strengthen fraud detection processes, and ensure informed and voluntary choice of FP • LGUs need to ensure health staff are trained on FP, necessary for accreditation. LGUs (which manage facility financing from PhilHealth and other sources) need to direct and support facilities to use PhilHealth payments to procure commodities and improve FP services rather than relying on DOH supplies

Source: Key informant interviews

4. DISCUSSION

This study used in-depth case studies and cross-country analysis to analyze how the governments of Kyrgyzstan and the Philippines have moved to integrate priority public health services into the governments' national health financing schemes. Findings are relevant for other LMIC governments, which are experiencing or will experience similar processes in the future.

For over a decade, the governments of Kyrgyzstan and the Philippines have been implementing and refining their national health financing schemes to pool resources and purchase health services for the population. The schemes pool mandatory premium payments from payroll taxes and general tax revenue, among other sources. Literature reviews and key informant interviews revealed several common themes as to why these governments have moved to integrate purchasing of these services from vertical programs into the broader schemes. This integration will mean that the purchasing entity of the more general health services package will also become the purchaser of these priority health services. In both countries, key informants identified opportunities for improving quality of or access to TB or FP services as a result of MHIF and PhilHealth, respectively, assuming the role of purchaser. In Kyrgyzstan, the move is also expected to improve patient-centeredness of TB care by moving services closer to patients and reducing risk of hospital-based infections. Key informants in both countries identified opportunities to improve the efficiency of TB and FP dollars through this shift of purchasers and intentional design of payment mechanisms that reward outputs.

The case studies also help illuminate the operational challenges of transition financing of public health services from a vertical program to the entity that purchases a broader package of health services. Provider budgets in many LMICs are already considered insufficient to expect the provider to deliver the full benefit package. Including another type of service in the benefit package can further strain providers. Kyrgyzstan experienced this situation when the GOK started enforcing the regulation that TB testing and much of the patient's treatment should be completed at the PHC and outpatient facility level. Income of PHC and outpatient facilities was based on a fixed amount per person in the facility's catchment area. When the facilities received guidance to furnish more outpatient services (including TB services) through the capitation payment, some facilities felt this was an unfunded mandate. In response the GOK has continued to refine the capitation payment over time. Additionally, in 2017 the GOK through the MHIF began piloting bonus payments for PHC staff for successfully treated TB cases. While capitation may be operationally simpler than reimbursing providers based on actual output, the latter are often considered better at aligning incentives. Key informants in the Philippines also raised concerns over inadequate reimbursements and weakness in the current provider payment mechanism once PhilHealth expands the benefit package. Decision makers need to consider the implications of adding new services to service providers' responsibilities and assess whether reform of the payment system is necessary for assuring an appropriate incentive environment. Payment needs to be adequate to encourage effort and quality care, while not introducing perverse incentives to over-provide or to skew the mix of delivered services.

In Kyrgyzstan and the Philippines, TB and many FP services, respectively, were initially not purchased through the national schemes. The reason for this initial exclusion is clear in the Philippines: PhilHealth initially covered only inpatient care; as a result, inpatient FP services were covered and outpatient FP services were not. In recent years, the government has moved to expand the PhilHealth benefit package to include outpatient services and this has proven to be a long process. In Kyrgyzstan, the reason for the initial exclusion of TB services is less clear. At the time that the MHIF was created in Kyrgyzstan, a

vertical program under the Ministry of Health purchased TB services (through combined government and external funding) from a state-run, TB-specific service delivery system. Like other vertical health services, vertical TB financing and service delivery remained intact for many years while much of the Kyrgyz health service delivery and purchasing system was restructured. It was not until many years later that the government moved to implement similar reforms for the financing and delivery of TB services. During the first stage, a decision was undertaken to include general health facilities and then gradually include vertical services. This was because during the first stage, clear payment mechanisms for the vertical services had not yet been developed.

This study is intended to inform health system stakeholders as they determine the future of the vertical programs operating in their country. Policymakers around the world will eventually confront the decision of whether to integrate services under the purchasing mechanism of a health financing scheme, such as national or social health insurance, or to keep the purchasing function under the vertical program. This study intends to help those policymakers better understand why two governments made the decision to integrate services under the broader scheme's purchasing mechanism, and how they have operationalized it.

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ANNEX A: CASE STUDY ON TRANSITIONING PURCHASING OF TUBERCULOSIS SERVICES IN KYRGYZSTAN

A1. Introduction

Since the dissolution of the USSR in 1991, the government of Kyrgyzstan (GOK) has progressively reformed the way health care is delivered, financed, and managed within its borders. These reforms have impacted how the country is responding to urgent health priorities such as tuberculosis (TB). TB control has evolved from a largely vertical program with siloed financing and service delivery to one that is integrated under a single payer system.

1.1 Study Objective

This case study presents the evolution of the national TB response in the context of broader health systems reforms, as told by TB program experts and key informants who witnessed or participated in the reform process as policymakers or advisors. Their experience with the reform of Kyrgyzstan's TB system may be of interest to other country governments that are considering reforming vertical health programs such as TB. Like other former Soviet countries, historically, Kyrgyzstan's TB response has been focused on an extensive TB hospital network. While other countries may already have an outpatient-based approach to TB care, lessons from Kyrgyzstan's experience transitioning TB financing to the single purchaser and stimulating TB care through financial incentives may still be relevant to these countries.

A2. Literature Review

2.1 Tuberculosis Burden in Kyrgyzstan

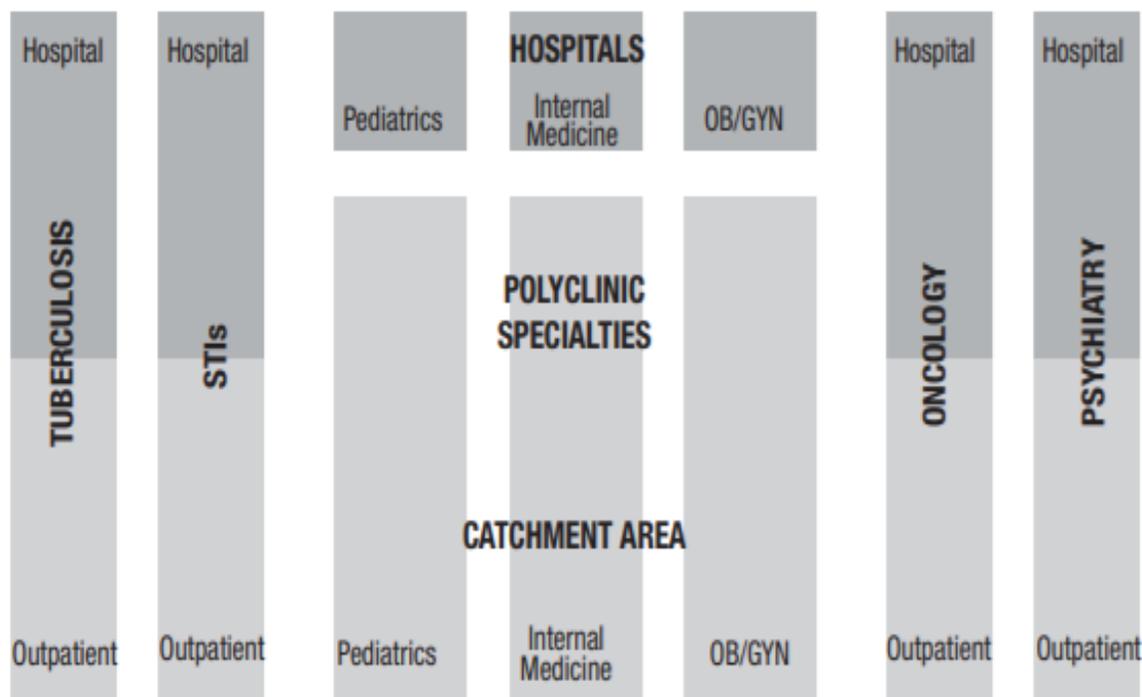
Kyrgyzstan has made substantial progress in responding to its TB epidemic over the past two decades. Between 2001 and 2017, the TB incidence rate decreased by 48 percent (from 168 to 90 cases per 100,000 population) and the TB mortality rate decreased by five times (from 27 deaths to 5.2 deaths per 100,000 population) (National TB Program of Kyrgyzstan 2017). Despite these improvements, some TB outcomes have worsened and the disease remains an urgent health priority for the country. Upward trends in the numbers of multi-drug resistant (MDR-TB) cases (25 percent of new cases are registered as MDR-TB cases) and low MDR-TB treatment success rates (65 percent) make Kyrgyzstan one of the 30 highest MDR-TB burden countries in the world (National TB Program of Kyrgyzstan 2017; WHO 2017).

2.2 The Evolution of Kyrgyzstan's Tuberculosis Control System

Under the USSR, Kyrgyzstan's economy was heavily dependent on the larger Soviet economy. The health system was managed and financed entirely by the state and relied on a wide network of hospitals across various vertical health programs (see Figure A.1). The population received free health care as a basic entitlement. The GOK ran specialty hospitals and sanatoriums to treat TB patients in an inpatient setting for the full course of treatment. Hospital staff salaries and the cost of providing inpatient care (including meals and other basic necessities) were financed by the state through line-item budgets based

on the hospital's bed capacity (Ibraimova et al. 2011). A cadre of TB specialists based in these hospitals were the main providers of TB diagnostics and treatment services.

Figure A.1: Structure of Health Delivery System in the Former Soviet Union



Source: Cashin et al. 2009

With the collapse of the economy in the early 1990s following the dissolution of the USSR, the large, costly public health network in Kyrgyzstan became untenable. Hospital budgets shrank and quality of care declined.

Kyrgyzstan began to reform its health system in the mid-1990s with a series of multi-year comprehensive health reform programs that focused on introducing family medicine, strengthening primary health care (PHC), and restructuring the government-owned health facility network. These reforms helped the GOK overhaul service delivery norms through the introduction of evidence-based medicine, new clinical practice guidelines, norms and standards for health facilities, better pharmaceutical prescription practices and use, and improved medical education. The reforms also changed the distribution of government-owned health facilities throughout the country. The GOK strengthened the PHC and outpatient facility level and closed or repurposed underused inpatient hospitals. These moves helped to align the facility network to the GOK's goal to shift more health services to the PHC and outpatient facility level and reduce the country's reliance on inpatient service delivery (Ibraimova et al. 2011).

Purchasing of health care services also evolved. The GOK introduced mandatory health insurance funds (MHIF) in 1997. A mandatory payroll tax was instituted to partially finance the health system along with premiums from families outside the formal sector, funding from general tax revenue, and external funding. The GOK developed a state-guaranteed benefit package and the Additional Drug Package soon thereafter, making explicit the health services covered by government funds and provided to the

population with co-payments or for free (O'Dougherty et al. 2009). An entity also referred to as the MHIF was established to manage the funding pool and pay health facilities to provide the benefit package. PHC and outpatient health facilities were paid through capitation (a base amount multiplied by the number of people in the health facility's catchment area). Hospitals started receiving case-based payments (a pre-set amount per type of case (i.e., diagnosis) treated by the hospital). Case-based payments for hospitals were considered preferable to input-based financing because they could improve efficiency by better targeting the services covered by the state-guaranteed benefit package (HFG project n.d.). The transition to output-based payments did not happen overnight. In the first few years of the new payment system, hospitals received case-based payment funds for variable costs related directly to patient care, such as drugs, supplies, food, and performance-related staff bonuses. The line-item budget was used for fixed costs (O'Dougherty et al. 2009). Over time, input-based financing from the Ministry of Health declined. Many inpatient hospitals that were not profitable under the new output-based financing model were closed. In a few cases, hospitals in remote areas that were not profitable remained open and received additional financing from MHIF to ensure access to inpatient services in those areas. Similar to the gradual changes to the hospital payment system, the GOK made incremental changes to the payment system for PHC providers. At first, the capitated rate only included salaries and supplies while other costs were covered by a line-item budget. All costs (other than significant capital investments) were then gradually rolled into the capitated rate (O'Dougherty et al. 2009). Between 1998 and 2009, the MHIF operated under the purview of the Ministry of Health. When the MHIF became a separate entity in 2009, it was able to further operationalize the shift from the ministry's input-based financing to output-based financing (Ibraimova et al. 2011).

Experts and scholars credit these reforms with reducing patients' financial burden for accessing hospital care – particularly for the poor – increasing transparency, improving the access to and distribution of outpatient and inpatient health services, and rationalizing the state-owned service delivery network (Jakab and Manjjeva 2008; O'Dougherty et al. 2009). The comprehensive health financing reforms that accompanied the service delivery reforms played an important role to solidify these changes by aligning financial incentives (Dominis et al. 2018).

The TB system in Kyrgyzstan has also undergone a number of reforms. In term of **service delivery**, Kyrgyzstan, like other former Soviet countries, developed national clinical practice guidelines in line with the World Health Organization's recommendations for a significant shift to outpatient treatment and reduced hospital stays for TB patients. Starting in 2003 and continuing today, responsibility for TB testing and treatment has increasingly shifted away from a hospital inpatient-based system. A growing number of TB patients are receiving care at PHC facilities, with the cost of the services covered by the capitation payment mechanism. MDR-TB patients receive care at hospitals for the first couple of months, and then some transition to outpatient care at the PHC level. **Human resources** have undergone changes to reflect this new approach to TB care. PHC workers have received training on outpatient TB care.

Purchasing of TB services has also undergone a major shift that has built on the general health sector reforms and reflects the emphasis on more efficient and effective TB care. In 2012, the government moved TB financing from the Ministry of Health to the MHIF as the single payer and guaranteed that any TB funds saved through increased efficiency would remain earmarked for TB control. These changes gave the MHIF the resources, flexibility, and incentive to introduce new provider payment mechanisms for TB.

In 2016, the MHIF implemented a case-based payment system (or diagnosis-related groups (DRGs)) that pays TB hospitals based on the types of cases they treat. This payment mechanism incentivizes shorter hospital stays and hospitalization only of TB patients who need inpatient care. For example, the MHIF pays a TB hospital a large fee for treating a contagious MDR-TB patient who requires complex inpatient

care and a very low fee for treating a non-contagious, drug-susceptible TB patient who could be successfully treated in an outpatient setting. Since the introduction of the new TB hospital payment system and other restructuring efforts, five TB hospitals have been closed and the number of cases treated in TB hospitals has decreased from 14,068 in 2013 to 8,093 in 2017 (MHIF and National TB Program data 2018).

Service delivery and purchasing reforms of the TB system continue to this day. In 2017, the GOK adopted the *Action Plan for Optimization of the System of TB Services for the Population of Kyrgyz Republic for 2017-2026*, which includes outpatient treatment expansion and optimization and restructuring of the TB hospital network as two of its three main objectives. Using savings from this optimization of service delivery, the MHIF started piloting a program in November 2017 to provide bonus payments to PHC workers for successfully treated TB cases to further encourage outpatient TB treatment.

As part of the PHC bonus payment pilot, the MHIF issues payments to PHC facilities that successfully complete treatment for a TB patient in accordance with new guidelines on outpatient TB case management. The bonus payment amount is determined by the complexity of the case: \$176 for each drug-susceptible TB patient and \$353 for each MDR-TB patient. The amount paid to each health worker directly involved in the TB patient's care is determined by the health worker's level of effort in the patient's care. For example, family medicine providers (nurses and feldshers) receive the majority of the bonus payment (up to 85 percent) because they do the bulk of the work with TB patients. The bonus payments are made on top of the health worker's regular salaries, which are funded through per capita payments to the PHC facilities from the MHIF.

The TB **supply chain** has also undergone structural changes. Kyrgyzstan used savings from optimization to contribute more domestic resources to procurement of TB drugs and supplies. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) had been procuring all first-line and second-line TB drugs for the country. Through the 2015 grant application process, the GOK committed to increasing domestic resources for such procurements. As of 2018, Kyrgyzstan procures all first-line TB drugs and an increasing proportion of second-line TB drugs.

Governance of TB control remains with the Kyrgyzstan National Tuberculosis Program, part of the Ministry of Health. The program is responsible for developing TB strategic plans and guidelines and monitoring TB prevention and control efforts.

2.3 Methods

As part of a multi-country study, the research followed the common analytic framework described in the methods section of this report. The specific methods used for the case study in Kyrgyzstan are detailed below.

The Kyrgyzstan Ministry of Health Scientific Research Preventive Medicine Ethics Committee approved the study on May 14, 2018. A local consultant conducted a literature review of TB and health system reforms in Kyrgyzstan and identified 16 sources from peer-reviewed and gray literature. The results of the literature review informed the interview guide.

A researcher from the Health Finance and Governance (HFG) project and a local consultant conducted semi-structured in-person interviews in Russian with 12 key informants, including policymakers, managers, financiers, and implementers/providers who have direct expertise or experience with the reforms of the national TB response. Two HFG researchers also conducted one interview with a key informant in English by phone. TB patients or current health workers were not interviewed as part of the study. The interviews of key informants were conducted between May 28, 2018, and June 20, 2018.

Table A.1: Types of Key Informants

Type of Organization	Key Informants
Government agencies	6
Provider associations	2
Civil society organizations	1
TB facilities	1
International partners	3

The local consultant involved in the data collection transcribed all of the interviews in Russian. A different local consultant translated the transcripts into English. Two HFG researchers coded the English transcripts and analyzed the data together in a workshop.

It should be noted that Abt Associates, the prime contractor for the HFG project, is also the prime contractor for USAID’s Defeat TB Project and other prior health projects in Kyrgyzstan. One of the HFG researchers and the local consultant had done work for the Defeat TB Project.

A3. Findings

3.1 Why Decision Makers Decided to Change the TB System

Key informants were asked why decision makers decided to reform the way TB services were delivered, financed, and managed. They identified several shortcomings with the prior system, as well as certain triggers, that led decision makers to implement reforms for the health system overall, and eventually with TB service delivery.

3.1.1 Economic pressure was the primary reason for overhauling the service delivery system

Inefficiency was a key driver in the decision to restructure the service delivery system in Kyrgyzstan. The reality of the post-Soviet health budget left the country with no choice but to shrink the hospital sector:

This was mostly the economic pressure. We clearly understand that no matter how much money is given to the system, it will not be enough. Therefore, we need to create an efficient, affordable system and effectively use the funds that give a certain result for small-value investments. The financial deficit and the economic burden and pressure force us to find a way out, having limited resources and achieving great results.

- Key informant

The large, state-funded hospital sector was inefficient due to over-capacity and high cost. The government realized that it could save money by closing underutilized general hospitals. One key informant explained that there were too many hospitals and hospital beds for the need: “There were several assessments with participation of the WHO...that demonstrated that the country needed fewer beds than they had, and that there were potential savings.” In 2012, the GOK realized it could gain

further savings by restructuring TB service delivery in a similar manner – reducing TB hospital bed capacity and shifting more TB care to outpatient settings in line with WHO guidelines.

3.1.2 The previous input-based payment system for TB hospitals incentivized unnecessary hospitalizations

Several factors contributed to the decision to shift the purchasing function for TB services from the Ministry of Health to the MHIF. Before the MHIF assumed this role, the entirety of a hospital's budget was determined centrally based on the hospital's bed capacity. This input-based financing incentivized hospital administrators to maintain the high volume of inpatient care. This practice proved problematic for TB control efforts:

The bed capacity was formed based on the number of beds and unit... Such practice encouraged only one thing – to increase the number of beds and get more money from the State. The weirdest thing is that the beds were constantly occupied with patients. Everyone was admitted, even those who should not have been admitted, and [that led to] TB exposure. Infection control was poor. Both BK+ and BK- sensitive patients were hospitalized. The principal objective was to meet the bed turnover plan, that is, 320 beds a year. That was the objective of the chief physician.

-Key informant

Another key informant agreed that there were unnecessary hospitalizations. “Why deny that in TB hospitals not only TB patients were treated, [but also] patients after surgeries?”

3.1.3 MHIF was better equipped to implement strategic purchasing

Unlike the Ministry of Health, the MHIF had the flexibility to implement output-based payment. One key informant explained why the Ministry of Health ceded the purchasing function for TB services to the MHIF in 2012: “The Ministry understood that it did not have the tools to make the service more efficient. The MHIF had such tools. The Ministry may not apply such efficient financing methods.” Under this new system, providers' budgets also became more flexible. One participant recalled that when the Ministry of Health served as the purchaser, the hospital's budget was broken down by line item such as salary, procurements, and utilities. Hospital managers had to go through a bureaucratic process to move money between line items as needed. Once the MHIF became the purchaser and paid hospitals case-based payments, the hospitals gained autonomy because they could allocate that funding as they needed.

3.1.4 Financing changes complemented service delivery changes

In parallel with these provider payment system changes, the Ministry of Health developed new standard treatment guidelines for TB hospital services based on WHO recommendations. “We developed standards, which specify that patients with [drug-susceptible] TB should stay 30 days, but not more than 40 days in a hospital, and patients with recurrent disease should stay for about 60 days, while MDR-TB patients should be treated for at least 90 days,” explained a key informant.

3.1.5 PHC workers needed incentive to provide proper outpatient TB treatment

The government also started to reform financing of TB services at PHC facilities because PHC staff were not incentivized to provide outpatient treatment to TB patients. Although directly observed treatment, short course (DOTS) and sputum collection was integrated *de jure* into family practice in the 1990s, family practice providers often did not perform those services. As one participant explained, “health

care organizations lacked incentive to collect sputum. Sputum sampling could be done by a manager and if he/she wanted...but if he/she was reluctant to take samples, no one would blame him/her.” Another participant discussed how the initial reforms to standard treatment guidelines and infrastructure changes in the 1990s made some progress, but were not sufficient for creating a high performing system of TB care at the PHC level:

To me, the first reforms at the primary health care level such as DOTS and DOTS+ provided a positive effect; however, for the most part the system has stayed the same. More radical reforms were needed and we could not possibly overcome this barrier.

-Key informant

In light of this need to incentivize better outpatient TB care at the PHC level, the MHIF is using the savings from the new efficiencies in the TB hospital network for a pilot test that pays a bonus to PHC workers for successfully treated TB cases; the pilot, which began in November 2017, is being implemented in one oblast.

3.1.6 Global Fund requirement for increased domestic funding for TB drugs and laboratory supplies necessitated greater financial efficiency

Key informants were mixed on whether donors played a role in prompting the restructuring of the service delivery system. One informant explained, “The key trigger was a simple desire to make the system more efficient; there was no specific pressure to initiate this decision.” However, another key informant thought that funders played a larger role: “...this sort of push from the donors especially has been there for a long time, but because it’s a politically sensitive issue – reducing the beds in hospitals, etc. – it was not moving very fast.” One informant also explained that the Global Fund used the grant application process in 2015 to set a condition that the government increase domestic financing for first- and second-line drugs and essential supplies. Concerns that the Global Fund would significantly reduce its financial support to the country led the government to the reforms to create more financial efficiency to free up funds for drug procurements.

3.2. How the Kyrgyzstan Government Operationalized the Reforms

Key informants were asked how the changes to the financing of TB services were introduced and operationalized. They described the various elements of the operationalization, including the decision-making process, the regulatory documents that guided the changes, the new information system that enabled the new payment mechanisms, and the learning curves, or behavior changes, among stakeholders during the transition period.

3.2.1 Garnering political support for the reforms was a long and difficult process

The Ministry of Health served as the catalyst and leader of the reforms but a number of other stakeholders, including the Ministry of Finance, the MHIF, Parliament, and international organizations, were also involved in the decision-making process. The key informants emphasized that the negotiations leading up to and during the introduction of the reforms were long and challenging due to the politically sensitive nature of hospital restructuring:

Not everything was going smoothly; there were some sensitive issues. We intensively discussed the structural changes and their impact because everyone was scared about the future of hospitals and had concerns about possible social tension and political pressure on the Ministry of Health. But the first step was made and the process was launched.

- Key informant

3.2.2 Government resolutions mandated and shaped the reforms

The decision to move TB services to the single payer system was finalized by a resolution that was drafted by the Ministry of Health and adopted by the government in 2012: *On Transition of Health Care Organizations that Provide TB Care to the Single Payer System*. In accordance with this government resolution, the budget for TB “was reallocated from the Ministry of Health to the MHIF and, thereafter, all [TB] organizations are financed from the Mandatory Health Insurance Fund.” Another key document for implementation of the reforms was the *Action Plan for Optimization of the System of TB Services for the Population of Kyrgyz Republic for 2017-2026*, which was adopted by the government in 2017 as a road map to guide the optimization and restructuring process.

3.2.3 New information systems were key to operationalization of the reforms

Several key informants highlighted the importance of new information systems for the operationalization of the reforms. The Ministry of Health was lauded by a key informant as “quite progressive” for introducing a new accounting software that automated financial reporting by the TB hospitals. The MHIF develops budgets for the TB hospitals based on data such as the number of treated cases, the population subgroups that are entitled to benefits, and the estimated costs of each treated case.

3.2.4 TB hospital managers and staff needed time to adjust to the new payment systems

Many of the key informants described the changes in attitudes and behavior that accompanied operationalization of the reforms. A key informant explained that TB hospital managers and staff were initially “outraged” because they “did not understand what case-based payment is.” The transition from input-based to case-based payment was a gradual learning process for TB hospital managers, who were used to the old financing system and did not initially understand the autonomy that came with the new system:

Managers learned step-by-step that these are the funds of an organization and the organization has the right to spend such funds and set the priorities. So, the irony was that the organization had a budget surplus from procurement of housekeeping commodities and they could spend the surplus to buy other services or goods. But the manager of this organization did not know what to do with the surplus, because in the past, all savings were retained in the budget and, pursuant to the line-item budgeting, the entity was not entitled to spend such funds.

- Key informant

Some key informants noted that the MHIF was able to “prevent collapse” of the system during the transition period by maintaining some flexibility and giving the hospitals a chance to adjust to the new processes. At the same time, as a key informant explained, the MHIF needed to demonstrate that the restructuring was real and the transition period would not last: “...we even asked MHIF to tighten the policy because the TB hospitals didn’t believe [that the consequences were real] and when they don’t believe, they will not move forward with the reforms.”

3.2.5 Population continues to expect hospital-based TB treatment

Medical staff inform TB patients about the outpatient treatment approach upon confirmation of the patient's diagnosis and treatment needs. The Ministry of Health's Republican Centers for Health Promotion also helps to disseminate information about the new approach of outpatient care for TB. While significant work has been done to educate the population about TB, as one key informant explained, this effort is an uphill battle because of the long-held assumption that TB patients should be hospitalized: "When people, relatives, neighbors notice the first symptoms of disease and hear the word 'TB', it is that particular TB stigma, which makes them pose a question 'Why are not you in a hospital?'"

3.3 Pros and Cons of the Reforms

Key informants were asked about the pros and cons of the TB financing reforms for patients, providers, health facility managers, the health system, society, and TB control. The key informants felt that the reforms generally had or will have a positive impact but they noted some negative consequences and were clear that the transition period was difficult for many stakeholders.

3.3.1 TB care is becoming more convenient and patient-centered

Most of the key informants felt that the transition to outpatient care stimulated by the financing changes and other reforms is more convenient for patients because it allows them to stay at home and "live a normal life." As one key informant explained: "It has become better for the patients. Formerly, we sent everyone to a hospital, and staying in the hospital is depressing. They now have the chance to get outpatient treatment, because earlier they might have asked not to be hospitalized."

Some key informants also indicated that patient satisfaction will improve because PHC staff who receive bonus payments for successfully treated TB patients will become more attentive and courteous to these patients: "In my view, the financing system for outpatient level or PHC will change slightly the attitude of medical staff to a patient, because they get money for a specific patient."

However, one key informant noted that the experience of outpatient treatment may not be positive for all patients:

A patient who lives in a remote village and seeks care may get tired of multiple trips and redirections to various places and finally he may want just to be hospitalized and get services in one place. From this point of view, inpatient treatment is convenient for the patient... A patient wants to come to a hospital where a doctor and a nurse take care of him; they make patients' rounds and choose treatment; they bring drugs, and everything should be free of charge and within reach.

- Key informant

3.3.2 Job security concerns for TB hospital staff

The impact of the reforms on health workers is evolving. Several key informants explained that health workers at TB hospitals that are reducing beds due to the new requirements for patient admission are anxious about their job security. "It could be a sort of stress for a medical worker, because he/she needs to be retrained and find another job," said a key informant.

3.3.3 PHC staff resistance to increased TB responsibilities may be mitigated through new bonus payment system

The PHC level is also facing some growing pains as part of the reforms. Some PHC staff have resisted the increase in TB responsibilities resulting from the shift from hospital-based to outpatient TB

treatment because they are not compensated for the increased workload. A key informant summarized the frustration felt by PHC staff: “TB specialists would get bonus payments up to 46 percent and family medicine specialists would feel resentful: ‘Why do I deal with a person who coughs, why do I collect sputum but TB specialists get the bonus and I don’t get anything?’”

The key informants noted that the new pilot of bonus payments to PHC workers for successfully treated TB patients is improving the motivation and performance of these workers. A key informant described the impact of the bonus payments on PHC staff: “We improved the financial status of nurses a little bit and this is good, this is very good. We motivate the Primary Health Care level through payments for successfully treated cases, and this is also very good.”

3.3.4 Mixed impact on health worker reporting burden

Perspectives on the impact of the reforms on health worker’s reporting burden were mixed. Several key informants noted that the automation of some recording and reporting processes makes the job of health workers easier. Others indicated that the reporting burden has increased: “The staff of PHC level mention that more reports should be now produced and they feel higher load.”

3.3.5 Greater autonomy for efficient TB hospitals and budget reductions or closure for inefficient TB hospitals

As intended, the reforms have been positive for the health facilities that have enough patients to stay in business. The health facilities that have adapted well to the new financing systems now have more autonomy to focus on their priorities:

A certain freedom, a certain autonomy has emerged for health organizations because under the single payer system, health organizations are financed through one lump sum. In other words, the funds that flow to these organizations allow their managers to independently identify the key priorities [for spending]. This is one of the benefits of the single payer system.

- Key informant

A key informant explained the impact of the reforms on the less efficient TB hospitals: “...when we speak about a provider with a high level of cases which were indirectly associated with TB ...a low level of bed rotation, and long bed days, the budget of such a provider had sharply dropped down.” Many unprofitable TB hospitals were closed or repurposed.

3.3.6 Increased efficiency of TB system and better allocation of resources

The key informants all agreed that the reforms have made the TB system more efficient due to the reduction in unnecessary hospitalizations. The key informants described the savings that have resulted from the reforms and appreciated that these freed-up resources can be reinvested in the TB system for procurement of TB drugs and improvements in TB care at the PHC level:

Since 2016, the country provides all drug-sensitive TB patients with the needed drugs. Since 2017, 10 percent of patients with drug-resistant TB were ensured with the second-line drugs at the expense of the State’s funds. In 2018, KGS 32 million [approximately USD 450,000] were allocated for [TB drugs], including KGS 20 million for the purchase of first-line drugs for treatment of drug-sensitive TB and KGS 12 million for the purchase of second-line drugs for treatment of drug-resistant forms of TB. In addition, about KGS 30 million were distributed for PHC capacity strengthening. These are the savings due to the optimization of TB services.

3.3.7 Improved quality of TB care and positive impact on TB burden

While some of the financing reforms are still in the early stages, several key informants feel that the reforms have already helped improve the quality of TB care and reduce the TB burden in Kyrgyzstan. Speaking of the impact of the PHC bonus payment pilot in one region, a key informant commented on the reduction in inpatient TB treatment: “We compared data for a quarter of 2018 and 2017, and we noted a 40 percent decrease in the admission rate. This is remarkable.” A key informant credited the reforms with the stabilization of some TB statistics: “Inclusion of the financial incentives is a breakthrough. If the country had not accepted changes in 2012, we would remain levelled off [with our TB indicators].”

3.4 What Policymakers in Other Countries Should Consider

The key informants were asked to describe what type of advice they might have for other countries considering financing reforms for vertical services, such as moving financing of the services to a single payer. The key informants were quick to note that they are not necessarily in a position to provide advice to other countries because their TB reforms are still in the early stages but they were happy to share their experiences and lessons learned with other countries. Based on the Kyrgyz experience, the respondents highlighted the importance of the following factors in implementation of reforms: an enabling environment; a focus on patients; financial flexibility to spend on actual priorities; an incremental and steady approach; and mitigation of potential opposition.

3.4.1 Enabling environment is essential

In general, the key informants were enthusiastic or at least cautiously optimistic about the financing reforms in Kyrgyzstan, but they noted that the implementation of these types of reforms may not be appropriate everywhere: “It depends on the readiness of the system. It may not be similar everywhere; everything depends on whether people are ready for changes and to what extent the system is flexible,” explained a key informant. Some of the enabling factors in Kyrgyzstan mentioned by the key informants included the existence of the MHIF, strong political will, and a robust health management information system. “We will not do anything until we have accurate data and it is accessible to every performer of the program,” stated a key informant.

3.4.2 Focus on what is best for patients

Although a primary driver of the reforms in Kyrgyzstan was economic pressure, a number of the key informants emphasized the need to focus on what is best for the patient. As one key informant stated: “The key point is that all of such reforms, strategies/policies should satisfy the needs of patients and the population. Certainly, financing and savings are important matters, but a person and a patient should have a top priority.” This type of focus on the patient can be achieved through financing mechanisms that provide organizations with the autonomy to spend according to their actual priorities:

I would recommend program budgeting, which is presently adopted in the Kyrgyz Republic. Such budgeting assumes that a ministry or an agency sets the target and its indicators, and the target should be achieved with relevant funding. What is the benefit of the program budgeting and pool financing? Every ministry and agency has its problems and they may give priority to meeting certain tasks at any time, as compared to the situation where we appropriated funds for transport only, and there was nothing left for other expenditures. A ministry/agency should decide on its own what the priority is.

3.4.3 Use incremental and continuous approach to reforms

Some key informants mentioned the flow of reforms as another element that policymakers should consider. Kyrgyzstan implemented the reforms step-by-step and did not “destroy everything abruptly.” One key informant emphasized the need to use an incremental approach and maintain momentum, even during challenging periods:

...we should always change something for the better, recalculate, analyze, make decisions and keep moving on. Even if we take small steps, it is better than doing nothing and leave everything stagnated, because over time our population will suffer...we know what it takes to improve the system. Despite certain opposition, which will continue for various reasons, we should anyway continue moving. The decisions may not be right all the time but if the reforms are progressing, the changes will take place and every difficulty can be overcome.

- Key informant

3.4.4 Prepare for potential challenges

Anticipation of challenges and mitigation strategies for those challenges are important considerations for policymakers embarking on financial reforms. A major challenge mentioned by the key informants was stakeholder opposition to the reforms. In Kyrgyzstan, the greatest resistance came from medical workers who were worried about losing their jobs with the optimization and restructuring. A key informant explained this challenge: “The most difficult point is to work with the medical staff who show resistance. Although they understand that these changes should go through, they are worried due to the instinct of self-preservation.” Retraining for dismissed medical staff is an example of a mitigation strategy for this challenge.

It is also important to consider the broader regulatory environment that can influence the progress of the reforms. For example, in Kyrgyzstan, the closed TB hospitals could not immediately be repurposed due to a regulation regarding the use of the facilities. As one of the key informants explained, “Our sanitary norms and regulations provided that [TB] facilities may be used only for treatment of TB patients.” Closed TB hospitals are now starting to be used for other purposes and revisions to the regulation on repurposing of TB hospitals will be adopted next year.

A4. Conclusion

As part of Kyrgyzstan’s broader health sector reform, the GOK shifted the purchasing of TB services from a vertical program in the Ministry of Health to a single payer, the MHIF. This case study presented an overview of the broader reforms and discussed in more detail the TB-specific reforms that led to this shift, and what the shift has meant in practice. It also presented the perspectives of key informants as to why and how these changes occurred. The information here can be compared with that of another case study, on the Philippines’ move to include family planning services under the country’s national insurance scheme. Findings from the cross-country comparison may be helpful to governments as they consider maintaining vertical programs or shifting the purchasing function of the programs’ services to the single payer of a national health financing scheme.

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ANNEX B: CASE STUDY ON TRANSITIONING DELIVERY AND FINANCING OF FAMILY PLANNING SERVICES IN THE PHILIPPINES

B1. Introduction

The Philippines meets the two criteria for study site selection: (1) the country has a long-established social health insurance scheme to support universal health coverage (UHC). Managed by the Philippine Health Insurance Corporation (PHIC, commonly called PhilHealth), the National Health Insurance Program (NHIP) was established to provide all citizens with affordable access to quality health services and to accelerate the provision and uptake of priority health services by poor and vulnerable populations who historically have had weaker health outcomes and less access to services than other populations; and (2) the government has a legacy of “vertical” programs, which are gradually becoming part of the NHIP. Designed to be the main government purchaser of health care in the country, PhilHealth benefits expanded to cover personal health services that have historically been delivered through public health programs.¹ These include TB, maternal and neonatal care, and family planning (FP) services that had or continue to have associated vertical programs.

1.1 Study Objective

The Philippine case study identifies lessons that can be useful for policymakers in that country as well as in other low- and middle-income countries who may need to make similar choices. Specifically, this case study aims to better understand:

1. The driving factors behind the government’s decision of whether to include the services previously provided through vertical programs in the NHIP benefits package;
2. The implementation of the government’s decision; and
3. Any unintended consequences resulting from the decision.

B2. Literature Review

2.1 Evolution of UHC in the Philippines

The Government of the Philippines has long demonstrated a strong commitment to providing affordable, quality care to its people. In 1969, the government passed the Philippine Medical Care Act. This Act set

¹This paper adopts the definition of public health programs as a mix of personal health services (often with externalities) and population-based interventions designed to manage a disease or set of diseases that health authorities consider important. The financing and delivery of public health programmes tend to be vertically integrated and separate from the rest of the health system, thus, the term “vertical programs” (Kutzin, Cashin, and Jakab 2010)

in motion a series of steps ultimately aimed at providing affordable health care to all Filipinos. Medicare I, a risk-sharing social security scheme, provided mandatory coverage for formally employed public and private workers and their dependents. Though it was never implemented, Medicare II was intended to expand coverage to those excluded from Medicare I.

Then, in the 1987 Constitution, the government further emphasized its strong commitment to UHC by outlining a responsive local government structure intended to bring health services closer to the people. Enacted in 1991, the Local Government Code transferred the responsibility for health service delivery from the Department of Health (DOH) to Local Government Units (LGUs), with the provincial governments managing local hospitals and the city and municipal governments overseeing primary care facilities. The implementation of devolution, however, led to fragmented health services and overlapping provision of basic health services, especially in areas where local hospitals were established near health centers (Romualdez et al. 2011).

PhilHealth was created in 1995 to administer the NHIP, replacing the Medicare Program, which, as described above, had never been fully implemented. PhilHealth covers a much larger population than Medicare I did – not just formally employed workers, but also PhilHealth members who have retired, overseas Filipino workers, self-employed individuals in the informal sector, and the poor. Initially PhilHealth covered mostly inpatient care, but its benefits have expanded through the years to include outpatient surgeries (e.g., cataract operation), chronic care (e.g., dialysis), and personal health services provided historically through vertical health programs. PhilHealth accredits the providers, both government and private, and pays for inpatient and outpatient services (Romualdez et al. 2011, Picazo 2012). PhilHealth pays providers a fixed rate per case, which includes professional² and facility fees for many outpatient and inpatient packages.

Table B.1 shows the evolution in PhilHealth service benefits as they relate to FP services and how PhilHealth gradually came to finance an increasing number of outpatient services. Some FP services were incorporated into PhilHealth's maternal care package (MCP) (e.g., postpartum intrauterine device (IUD) insertion), and paid as part of as part of the bundled package, or separately as a stand-alone benefit (e.g., subdermal implants). Expanding FP services under PhilHealth became more explicit after 2010, when the government renewed its commitment to pursue UHC, with PhilHealth as payer of health services (DOH 2010a, DOH 2010b). PhilHealth has also expanded the types of providers who could provide them. For example, a 2018 expansion of benefits allows licensed nurses and midwives at accredited facilities to provide IUD insertion and subdermal implants. The evolution of PhilHealth benefits as they relate to other programs (e.g., for malaria, TB, and integrated childhood illnesses) followed a similar path, whereby outpatient benefits expanded gradually over this period.

² The amended health insurance law (2013) allows payments for professional services rendered by salaried public providers. The payments are retained in the health facility to be pooled and distributed among public health personnel, and to defray facility operating costs, maintain or upgrade equipment, plant, or facility, and maintain or improve the overall quality of service in the public sector.

Table B.1: Evolution in PhilHealth FP Benefits

PhilHealth Benefit Package				Related Public Health Program
Year included	Name of package or service	FP component	Service delivery* and financing	
1995	Surgical contraception (PhilHealth 2000a)	Bilateral tubal ligation (BTL) and vasectomy	Provided by doctors and hospitals Paid based on Relative Value Scale (PhilHealth 2002)	Various donor-supported DOH FP projects, including Integrated FP and Maternal Health Project DOH provided donated FP commodities to both public and private service points FP private providers are authorized to charge fees to non-poor clients (DOH 1990, DOH 1994, DOH 1995, DOH 1993)
2001	Low Risk Maternity Care Package (PhilHealth 2001)	Postpartum care, including FP and counseling	Provided by public and private non-hospital facilities (outpatient clinics, rural health units, and birthing homes) Paid by case rate	Safe Motherhood Program (DOH 2018a) Family Planning Program (DOH 2018b)
2003	Maternity Care Package (PhilHealth 2003)	Postpartum care, including FP and counseling; accreditation requires facility to have oral contraceptives, injectables, and IUDs	Provided by public and private non-hospital facilities (lying-in clinics, midwife-managed clinics, birthing homes, rural health units, ambulatory surgical clinics) Paid by case rate	Safe Motherhood Program Family Planning Program
2006	Normal Spontaneous Delivery Package in hospitals and MCP in non-hospital facilities (PhilHealth 2006) (PhilHealth 2009)	Postpartum FP services	Accredited public and private hospitals and non-hospitals; postpartum FP services Paid by case rate	Safe Motherhood Program Family Planning Program
2008	Package for Voluntary Surgical Contraception Procedures	Vasectomy, BTL	Accredited hospitals (primary, secondary, and tertiary hospitals) and ambulatory surgical clinics, whether done as an out- or inpatient procedure Paid by case rate	Safe Motherhood Program Family Planning Program
2014	Benefits for women about to give birth (PhilHealth 2014)	BTL and IUD insertion	Provided by accredited public and private non-hospital for IUD	DOH regional office/hospital organizes FP outreach services and/or contract FP services

PhilHealth Benefit Package				Related Public Health Program
Year included	Name of package or service	FP component	Service delivery* and financing	
			insertion; public and private hospitals for BTL Paid by case rate	(DOH 2014) Provision of modern FP methods in outreach services, and hospital and non-hospital facilities
2015	IUD insertion: postpartum and interval; postpartum BTL; non-scalpel vasectomy	BTL and IUD	Provided by public and private non-hospital facilities Paid by case rate	Provision of modern FP methods in outreach services, and hospital and non-hospital facilities
2015	Subdermal Contraceptive Implant Package	Insertion of implantable contraceptive, incl. counselling and follow-up	Provided by doctors and trained midwives in public and private surgical clinic and birthing homes Paid by case rate	Inclusion of progestin subdermal implant as one modern method recognized by the National Family Planning Program (A.O. No. 2015-0006)
2018	Free-standing FP clinics	Non-surgical vasectomy, IUD insertion, subdermal implants	Non-surgical vasectomy provided by doctors; insertion of IUD and subdermal implants provided by doctors, nurses, and midwives Paid by case rate	Certification process for private health facilities to provide modern FP services such as contraceptive pills, injectables, and implants, natural FP methods, IUDs and non-surgical vasectomy, excluding BTL and vasectomy; all DOH-certified FP clinics receive FP supplies purchased by the DOH (DOH 2017)

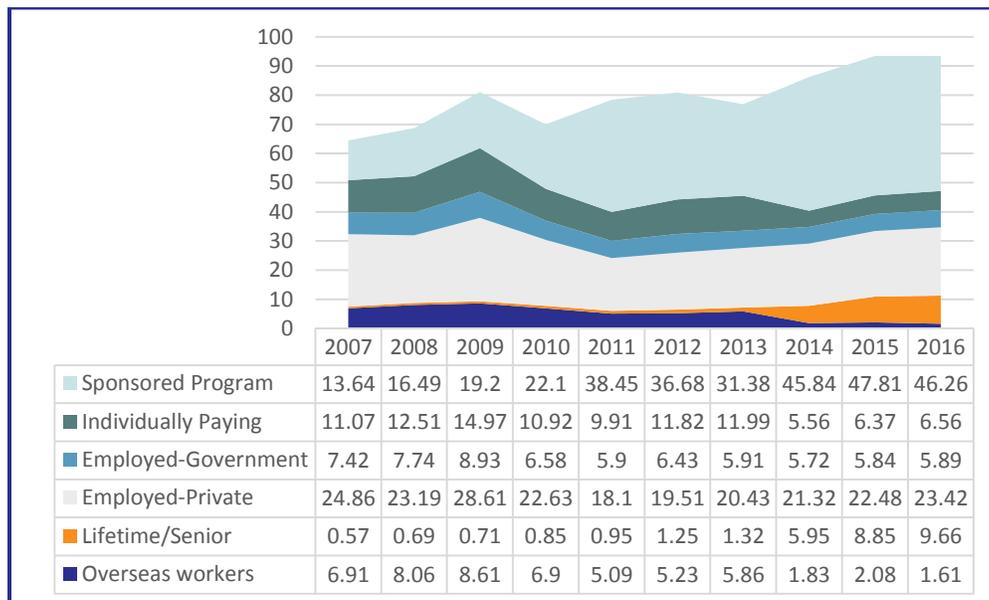
Source: Various PhilHealth Circulars for PhilHealth benefit packages; DOH website for related public health programs

While PhilHealth benefits were expanding, the DOH was pursuing a complementary set of supply-side reforms. The DOH used regulatory measures to improve the availability of essential medicines and control their prices (Solon, Panelo, and Guiafelix 2003, Romualdez et al. 2011, Wong et al. 2013). The DOH also increased capital investments in local health facilities to improve access to health care. For the past 10 years, the Health Facilities Enhancement Program (HFEP) constructed and equipped local hospitals and rural health centers. An assessment of HFEP reported higher rates of facility-based deliveries, outpatient consultations, and inpatient admissions in HFEP-funded facilities compared to non-HFP-funded ones (Lavado et al. 2012, Picazo et al. 2016). Also, the DOH helped strengthen local service delivery systems by hiring and deploying doctors, nurses, midwives, and other health personnel as well as procuring and distributing health commodities crucial in delivering priority public health programs (DOH 2005, DOH 2012).

In 2010, the government directed the DOH to ensure effective PhilHealth coverage and the implementation of *Kalusugan Pangkalahatan* (universal health coverage). With the President’s strong political support, three laws critical to sustaining the UHC efforts were passed: (1) the Sin Tax Law in 2012 to raise sufficient sustained resources, in particular, to fully subsidize coverage for the poor; this was particularly important because, although the poor always received subsidized coverage, previous financial support depended in large part on the LGU where they resided, which did not always have sufficient funding to cover the costs; (2) the Reproductive Health Law in 2012 to ensure universal access to reproductive services; and (3) the amendment of the National Health Insurance Act in 2013 to guarantee PhilHealth coverage for the poor and other vulnerable populations through automatic enrollment. The poor and the elderly have PhilHealth coverage if they are listed in the National Household Targeting System for Poverty Reduction (NHTS-PR) database and the Office of the Senior Citizens Affairs, respectively.

As of December 2016, PhilHealth reported 91 percent coverage (Figure B.1). The expansion in membership coverage was complemented with enhanced PhilHealth benefits, including expensive treatment and procedures (called Z benefits) and expanded primary care packages (Table B.1).

Figure B.1: Population with PhilHealth Coverage 2007–2016 (millions)



Source: PhilHealth Corporate Planning Department, April 2017

Despite PhilHealth's progress in expanding service and population coverage since 1995, as of 2018 financial protection remains insufficient in the Philippines. In 2014, 50 percent of total health spending was spent by households paying out-of-pocket (Obermann, Jowett, and Kwon 2018). Also, the percentage of people incurring catastrophic payments increased from 2.5 percent in 2000 to 7.7 percent in 2012, and the percentage of people impoverished by health spending increased by 1.5 percentage points (Bredenkamp and Buisman 2016).

PhilHealth has taken steps to improve financial protection. For many years, patients paid all charges that exceeded the PhilHealth reimbursed amount (i.e., balance bill) to providers either out-of-pocket or through their private health insurance, if they had such insurance. As of 2011, however, PhilHealth changed its payment mechanism from fee-for-service to case rates. It then implemented its No Balance Billing policy, which prohibits providers from charging patients in excess of the case rate for the poor and for inpatient care patients at public hospitals. Several other PhilHealth benefits also feature No Balance Billing for all beneficiaries, including the Maternal Care Package, the Neonatal Care Package, and FP (Picazo et al. 2015). More broadly, the 2012 Sin Tax law has generated a source of stable revenue for low-income beneficiaries that significantly substantiates what LGUs could contribute previously. As funding continues to increase through this source and other domestic resource mobilization initiatives, financial protection of the PhilHealth benefit package can deepen.

2.2 Political, Legal, and Financing Context for FP in the Philippines

The implementation of FP in the Philippines is strongly influenced by politics and depends partly on how the president of the country manages religious opposition to FP (Herrin et al. 2003, Lijauco 2008, Melgar 2010, Acuin et al. 2015).

In 1971, the Population Act of the Philippines created the Population Commission (POPCOM) and launched the Philippine Family Planning Program (PFPP) as an integral part of national development. Public FP and non-governmental organization (NGO) clinics provided FP services. Under the (Corazon) Aquino administration (1986-1992), responsibility for the PFPP was transferred from the POPCOM to the DOH. The PFPP was framed as a rights-based health program and promoted as an intervention to reduce maternal and child deaths. The president's term ended with the Local Government Code in place, directing LGUs to provide reproductive health services and FP. The strong political support for FP continued throughout the 1990s, as the government focused on sustainability measures in preparation for the phase-out of USAID-donated supplies by 2004. The procurement of FP commodities had been funded fully by donors, and 90 percent of them had been purchased by USAID (Schneider and Racelis 2004).

The political climate changed during the Arroyo government (2001-2010). The government revised its vision for FP, limiting it to interventions that prevent high-risk pregnancies, reduce maternal deaths, and prevent abortion. At the same time, USAID phased out donated contraceptives. This decade also saw heightened promotion of natural FP and a neglect of modern methods. Some LGUs, responsible for procuring contraceptives for poor clients, banned modern methods in their jurisdiction (Melgar 2010, Lee, Nacionales and Pedroso 2009). Overall funding was insufficient: of the PHP 17 billion (US\$ 314 million) spent by the program, only 8.3 percent was spent for FP and counseling services (Racelis and Herrin 2003).

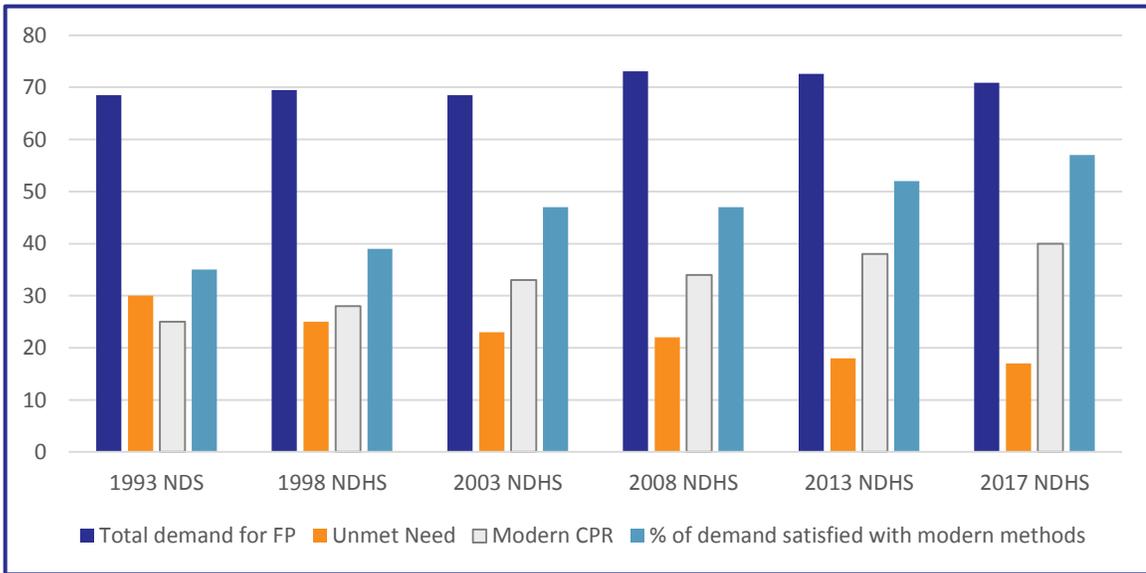
Political tides changed again with the (Benigno) Aquino government (2010-2016), with reignited support for comprehensive access to FP. Specifically, this government used political capital to ensure enactment of the 2012 Responsible Parenthood and Reproductive Health (RPRH) Act, almost 14 years after it was first filed in Congress (Fonbuena 2013). The law guarantees universal and free access to modern contraceptives for all Filipinos, especially poor women. But the Supreme Court suspended its implementation temporarily on March 19, 2013, after church groups filed petitions arguing the law was

unconstitutional. On April 8, 2014, the Supreme Court unanimously declared the RPRH law constitutional but voted to strike down eight of its provisions partially or in full. More than a year later, the court issued a temporary restraining order prohibiting the DOH from "procuring, selling, distributing, dispensing or administering, advertising and promoting the hormonal contraceptive." The order was in response to a complaint filed by the Alliance for the Family Foundation Philippines that alleged that the Food and Drug Administration of the Philippines (FDA) already certified two types of Implanon believed to induce abortion. The Supreme Court then directed the FDA to rule whether the two brands of implants have abortifacient agents. After two years, the FDA ruled these products are not abortifacients and the temporary restraining order on contraceptive implants was lifted.

The Duterte administration (2016-present) reinforced the provisions of the law by issuing Executive Order No. 12 in 2017 to achieve zero unmet need for modern FP (Government of Philippines 2017). In 2017, more than PHP 189 million (US\$3.6 million) was allocated to all 17 DOH Regional Offices to support activities related to the implementation of this order, including capacity-building activities for FP service providers, setting up FP services in hospitals, engaging civil society organizations and private groups in the demand generation and FP service delivery, and supporting transport/delivery of FP commodities and warehousing at the service delivery points. The government also allocated, albeit inconsistently, a budget for FP to implement the RPRH law, for a cumulative total of PHP 4.3 billion (US\$83 million) by 2018 (DOH 2018c).

The inconsistent FP policies over the past 50 years provided FP programming with fewer resources than it needed, especially for modern and effective "artificial" methods. This likely slowed the increase in contraceptive prevalence of modern methods (Herrin et al. 2003). Figure B2 shows the trends of total demand for FP and the demand met by modern contraceptive use for married women of reproductive age based on the Philippines National Demographic and Health Survey (NDHS) data. Unmet need for FP among this population declined from 30 percent in 1993 to 17 percent in 2017 and modern FP use increased 0.63 percentage points per year. Had the FP program continued to create demand for FP and if all married women who expressed a desire to space or limit their children had used FP, the national target of a 65 percent contraceptive prevalence rate could have been achieved in 2016 (DOH 2012, PSA and ICF 2018).

Figure B.2: Trends in Total, Met, and Unmet Demand for FP, 1993–2017



Source: NDHS 2017 key indicators, except total demand, which was from individual NDHS surveys

Note: Total, met, and unmet demand is among married women of reproductive age.

Inconsistencies in policies and roles that govern financing of FP commodities and services have resulted in overlaps and gaps. On the one hand, the RPRH law specifies that the DOH is responsible for procuring and distributing FP supplies to the LGUs, enhancing the capacities of health facilities, and carrying out public awareness activities. On the other hand, PhilHealth is tasked with paying accredited facilities for providing reproductive health services. In addition, the LGUs are mandated to provide FP services and they can procure commodities. This contrasts with the Health Care Financing Strategy (DOH 2010a), which emphasized the need for clearer role definitions among the DOH, LGUs, and PhilHealth with respect to who pays for what services, to avoid duplication, shortfalls, and inefficiencies in funding. The strategy paper identified PhilHealth as the main payer of personal care and to act on behalf of its members to fully exploit its purchasing function to improve the cost-effectiveness of service delivery. To implement this strategy, the DOH has set up a technical working group tasked with overseeing a transition of procurement of public health commodities to PhilHealth.

2.3 DOH Plans to Complete the Transition in Financing FP Services by 2020

Acknowledging the inefficient use of government’s limited resources when services and commodities are financed by the DOH through the supplies downloaded to LGUs and PhilHealth through its benefit packages, the DOH organized a technical working group (DOH 2017) to define the course of action to smooth the transfer of funds from the DOH to PhilHealth. This is intended to remove duplication in FP financing. It is also intended to strengthen PhilHealth as the national purchaser of individual-based services and provide an opportunity for the government to influence prices and improve affordability.

The DOH is committed to transfer to PhilHealth the allocated budget as initial funding for the commodities of 21 public health programs. Commodities in this budget include those needed for FP as well as for basic diagnostic tests, oral health, integrated management of childhood illnesses, and other areas. Legal and political challenges remain, but the DOH remains committed to leading the process to

overcome them and implement the transition plan between 2019 and 2021. The FP annual budget of PHP165 million (US\$3 million) for commodities is scheduled to be transferred by 2020.

2.4 Methods

Given the objectives of this research, the Health Finance and Governance (HFG) project selected the Philippines as a study site because (a) it has a government-run national health insurance program administered by PhilHealth; and (b) several services financed through vertical programs, including FP, have been included in the health insurance benefit package by law. Necessary government approval was secured, including the required ethical clearance from the National Ethics Committee. A comprehensive desk review was done, and key informant interviews were conducted using a standardized questionnaire that was pretested and subsequently modified. Key informant interviews were conducted between June and July 2018.

The 10 respondents included three high-level policymakers from DOH and PhilHealth, three program managers from national and local governments, one of whom is also a public provider, three technical experts from international organizations supporting the vertical programs being transitioned to PhilHealth; and a private FP provider who receives grants from international organizations and is accredited by PhilHealth.

B.4 Findings

4.1 Reasons for Transitioning Financing of FP Services to PhilHealth

As Table B.1 demonstrated, PhilHealth began in 1995 covering a set of inpatient surgical contraceptive services, and since 2011 has expanded its benefits to cover more outpatient services. This section discusses several reasons why decision makers included (or plan to include) FP services in PhilHealth financing. According to key informants, stakeholders who continue to be involved in this decision-making process range from former DOH secretaries and PhilHealth presidents who are well-known UHC champions, to legislators, development partners, advocacy groups, RPRH implementation team members, and the DOH technical working group that is working on the transition of the procurement of public health commodities to PhilHealth.

4.1.1 Decision makers followed historical precedent and were guided by the vision of a single payer system

According to key informants, designers of PhilHealth included surgical contraception (BTL and vasectomy) in the original package due to historical precedence:

To some extent this is also a continuation of Medicare and NHIP, where FP was already a part of the benefit package for members, so its origin probably belongs to the population program policies of the Marcos era.

-Technical expert key informant

Key informants also emphasized the impact of the vision for PhilHealth on the decision. Including surgical contraception in the PhilHealth benefit package made PhilHealth the payer for these services for a larger population of new beneficiaries – not just formal sector workers.

It is pushed by a mindset that says, ‘our vision was to make PhilHealth the ultimate payer, so we should move in that direction.’

-Technical expert key informant

New beneficiaries either had access to surgical contraception for the first time, or no longer had to pay out-of-pocket for them.

4.1.2 Financing through PhilHealth can make FP services more affordable and accessible

Most informants believe that transitioning FP outpatient benefits from public health programs to PhilHealth will make FP services more affordable and accessible. One reason for this belief is that PhilHealth pays private as well as public providers, while the public health program only provides ad hoc grants to some NGOs. According to NDHS data (2017), 38 percent of FP contraceptives come from the private sector. While demand for FP care from the public sector exceeds that in the private sector, this percentage is still high. As a DOH key informant explained, “Let PhilHealth be payer; private providers will become access points for FP services since PhilHealth can reimburse. With PhilHealth benefits in place, FP demand can drive increase in utilization.”

Key informants felt that including both public and private providers in the benefits can help achieve health system and FP goals of increased affordability, accessibility, quality, and responsiveness of FP services. First, more providers means there are more service delivery access points, which can be important particularly in areas with little availability. Second, more providers gives patients greater choice in where to access FP services, facilitating more responsive care. Finally, it generates competition

between public and private providers to attract patients, and this can drive improvements in quality of care.

FP services may also become more affordable and accessible given the recent initiative to expand the type of provider who can deliver FP services through PhilHealth. As key informants from PhilHealth explained, as of 2018, PhilHealth is not only accrediting doctors but also nurses and midwives to administer subdermal implants. Also, PhilHealth initially only purchased these FP services from hospitals, but it is now paying accredited primary care facilities and birthing homes for surgical contraception as well.

4.1.3 PhilHealth creates the opportunity for increasing beneficiaries' knowledge of PhilHealth benefits, including FP benefits

Paying for FP through PhilHealth creates a mutually reinforcing cycle between FP access and PhilHealth membership, since providers with FP patients can help those patients enroll in PhilHealth and use their PhilHealth benefits to access FP. An LGU key informant explained how if a patient comes to a health center without a PhilHealth enrollment, “our midwives and nurses assist them to enroll them.” A private provider described how “patients are notified prior to the procedure and their eligibility is checked using the PhilHealth portal...PhilHealth forms are properly filled out.”

On the other side, enrollees in PhilHealth are able to receive information about FP services. As a representative from PhilHealth explained, “...we want now to include FP messages incorporated with our information materials for maternity care and make specific information for women. Like during women’s month, we asked to have an advertisement about FP benefits of women.” A key informant from the DOH agreed that more information about FP is an important step:

Patients must be informed of available FP services. From our review of 23 maternal deaths, we see that lack of information about where to access FP services is one of the main reasons for unmet need; the women who died had an abortion. You know the profile of those 23 women? The mean age is 44 years old. They were all married except for one. I didn't mention they are Catholic...So, that is unmet need, which means they wanted three children, so when they got pregnant with the fourth they decided to get an abortion and they died. I tell health workers it's the lack of awareness that is killing women, we cannot blame them. We should be the ones to blame because why didn't we counsel, why didn't we give them information on FP?

-DOH Key informant

Ultimately, more information about FP and access to services can lead to increased demand for voluntary FP services and can save lives. In fact, one key informant from a development partner believes that PhilHealth will now pay for more FP methods to address “stagnation, if not decreasing CPR and increasing unmet need for FP.” Other key informants shared this sentiment.

4.1.4 Demand-side financing can reduce wastage in commodity procurement and use

Respondents also mentioned that demand-side financing will promote efficiency and reduce wastage by ensuring that valuable FP commodities are used. As one key informant from DOH pointed out: “there would be less wastage from expired commodities since FP will be paid based on patient’s choice.” It will however, require provider capacity: a key informant from PhilHealth acknowledged “We pay the providers the FP benefit. We rely on their capacity to forecast and procure the FP needs of their patients.”

4.2 Operational Challenges to Transitioning FP Financing to PhilHealth

The key informants were asked how changes in FP financing will be undertaken. In their responses, key informants raised concerns about the institutional arrangements, capacity, and policies needed to operationalize this reform.

4.2.1 Different policies send conflicting messages

The informants explained how misalignment between policies made it challenging to understand how to move forward with operations. On the one hand, the 2012 RPRH law increased DOH resources for FP. On the other hand, PhilHealth's outpatient benefits cover an increasing number of FP services, which indicates that the DOH is moving toward financing through PhilHealth. One DOH key informant indicated that the latter is moving forward but did not provide specific information as to when: *“DOH has made a policy direction that all personal services shall be reimbursed by PhilHealth while the public health services shall be budgeted by DOH and LGUs... the timeline for shifting to PhilHealth under FI Plus³ [the current health reform policy] is being developed.”*

The vagueness of key policies may also suggest some conflict in the approach to long-term financing for FP:

The passage of the [2012 Responsible Parenthood and Reproductive Health (RPRH) Act], it seems to me, is back to supply-side financing because the writers of the law do not understand demand-side financing, and they specifically identify DOH and POPCOM. The orientation of key institutions was designed to support [a family planning and reproductive health] nationwide program that is supply side in orientation, rather than saying the goal of this program is for PhilHealth to eventually become the purchaser of commodities or services in FP. There is no vision like that in the [RPRH Act]. It is conceived under a business-as-usual paradigm or mindset. So, it has no broad vision of demand-side financing.

-Technical expert key informant

4.2.2 Overlapping roles and unclear policies create inefficiencies

Several key informants recognized the need to clarify the roles of key organizations as well as the benefit package of PhilHealth in order to improve governance, management, financing and provision of FP services in the Philippines.

Key organizations including the DOH, PhilHealth, POPCOM, and LGUs appear to have overlapping roles and unclear relationships in relation to financing FP services:

- **DOH** purchases capital investments through the Health Facilities Enhancement Program. The DOH purchases FP commodities and gives them to LGUs.
- **LGUs** purchases FP commodities in addition to those they receive from the Health Facilities Enhancement Program through the DOH. They also spend other funding to upgrade health facilities

³ Department of Health Administrative Order No. 2018-0014 “Strategic Framework and Implementing Guidelines for FOURmula for Health Plus (FI+ for Health). With the tagline “Boosting Universal Health Coverage,” this policy has four strategic pillars (Financing, Regulation, Service Delivery, Governance), plus a cross-cutting initiative on Performance Accountability. Implementation of the policy focuses on critical interventions that will produce tangible results felt by Filipinos. Strategies and activities will be carried out by specific institutions according to their mandates and measured according to performance scorecards.

so that PhilHealth accredits them to deliver FP services.

- **POPCOM**, which is under the DOH and responsible for population management, purchases FP services delivered by NGOs and LGUs after doing demand generation.

Certain factors may be incentivizing a shift of service provision and purchasing functions back to the DOH:

The DOH is unwilling to give up some of the service provision functions. Even with devolution, the DOH is unwilling to give up some service provision services, because they see that some, probably many, LGUs are performing below the expectation of the DOH in terms of service provision, budget for health, and stewardship of health services. So little by little, the DOH is gaining back what it has devolved before, like HFEP, like staff deployment programs, like commodity purchases, so little by little all of these things are being done by the DOH.

-Key informant

Key informants indicated that some of the apparent overlap of roles can be traced back to a lack of clarity over what services should be covered under PhilHealth. They differed, however, in their opinions on which organizations should initiate a process to clarify the policies. One key informant suggested that the DOH needed to finalize a policy:

Commodities are placed under DOH procurement by the law, so the decision was also made during the legislative process. To some extent, the DOH must show consistency with public health programs funded by both the DOH and [Philippine Health Insurance Corporation] such as TB where DOH still continues to provide the medicines needed for the program despite parallel [Philippine Health Insurance Corporation] funding. I believe the debate is continuing but has not been addressed by DOH policy-wise. When one can identify where personal care (e.g., HIV meds) ends and public health begins, that decision must be elucidated and put into force by both DOH and [Philippine Health Insurance Corporation].

-Policymaker key informant

Another key informant recommended that PhilHealth show leadership in this decision-making process:

The PhilHealth Board has to make a decision on what the ultimate goal of PhilHealth should be; this is part of a larger problem that covers not only FPRH services, it covers maintenance drugs. What PhilHealth needs to do is to know how many people need personal services in FPRH. We are very clear it is going to be personal services, not public health. By that I understand it to mean permanent methods, implants, modern methods, including pills, injectables, and condoms. Which means if you have listed all these personal services and commodities, you should then have a budget that lists the provision of these things, and PhilHealth should from now on finance these things.

-Technical expert key informant

A respondent from PhilHealth also acknowledged that PhilHealth needs to “review the entire benefits structure, including deliveries” and “rationalize [the PhilHealth benefit packages].” To do so, the respondent explained that PhilHealth would need more provider outlets.

After the DOH and PhilHealth agree on who will pay for what service in promoting and providing FP, some key informants proposed that the budget allocated for FP commodities should be transferred directly from the Department of Budget and Management to PhilHealth. The DOH is presently preparing a three-year transition plan to transfer the funds for public health program commodities to PhilHealth benefits.

Multiple key informants saw that a shift to financing FP through PhilHealth could also help devolution work and make LGUs more responsible in delivering FP services, as it did for the maternal care package (MCP).

There was clamor from the very beginning from other [public health] programs: why do we keep buying commodities when there's devolution. If we want to make the devolution work, we don't do it because we [the national government] keep on buying and buying commodities. But we are really saying to the LGUs – you should be buying these commodities. You have a resource because there's PhilHealth. It really works, look at the Safe Motherhood Program, the LGUs are using MCP.⁴

-DOH key informant

One respondent representing a private provider thought that FP services delivered outside the facility should also be covered by PhilHealth because “accessibility of the facility includes needs mobilization [travel to the facility] costs, time away from family, belief systems that need to be educated while ensuring informed choice and voluntarism. The need for itinerant missions for cases like these is integral and key to the service delivery network.”

Key informants from the LGUs understood PhilHealth financing as an opportunity. They argue that when PhilHealth benefits are implemented correctly, LGU program managers can achieve their service utilization targets faster. LGUs have already done this in other health areas: when PhilHealth held a campaign to have at least one facility per LGU accredited for the MCP, the facility-based delivery increased significantly in a short period of time. According to a DOH key informant, experience in other program areas, like the Safe Motherhood Program, also indicates that LGU providers would still be willing to submit FP program reports even after the DOH no longer provides them with commodities.

Streamlining financing and operations will also allow national program staff to focus their resources on their core strengths. According to a key informant from the DOH, the DOH is keen to transition certain responsibilities: “Historically, the DOH is not good at procurement and we are not good at distribution. ...So why are we [DOH] duplicating [with PhilHealth]? Get rid of duplication and let LGUs, as service providers, buy commodities.” Once responsibilities for procurement have fully transitioned to PhilHealth, a respondent from DOH explained, “[national FP program managers won't] have to deal with procurement... they can focus on monitoring and evaluation of the program, updating the policies and the standards of care...”

Because the DOH is better at supervising service quality, according to a key informant, the long-term vision requires close coordination between the DOH and PhilHealth and iterative feedback to inform policy making in both institutions, to ensure patients receive the required standard of care. According to a DOH respondent, “we work closely with PhilHealth, we involve them in our activities because we want them to hear what our [regional] coordinators are saying about how PhilHealth policies are affecting the program. Not just the national PhilHealth, we also invite regional PhilHealth because sometimes they have a different interpretation of policies [on standards of care].”

As noted above, in 2018, a technical working group was created to address this duplication and determine the appropriate course of action to ensure smooth transition of commodities from the DOH to PhilHealth.

4.2.4 The strategic purchasing capacity of PhilHealth needs strengthening

⁴ The campaign of PhilHealth to have at least one MCP provider in every LGU is considered one of the drivers of increased facility-based delivery. More LGUs are reinvesting PhilHealth reimbursements to improve their health services as well as incentivize their health personnel.

Although a reduction in overlapping roles seemed preferable to many respondents, this sentiment was tempered by respondents' concern over shifting certain responsibilities to PhilHealth. Two key informants highlighted weaknesses in PhilHealth purchasing capacity, and questioned its ability to act as a single purchaser.

According to one key informant, PhilHealth staff lack the right mix of technical skills needed to competently fulfill its function as a strategic purchaser.

When you shift to a demand-side system, you shift health insurance as a strategic purchaser. As a strategic purchaser, what kind of kind of people do you need? The current staff at PhilHealth are primarily marketing people. It's not wrong but you also need people who know how to cost benefits, how to write contracts, to implement, monitor, knowledgeable lawyers who can enforce... you need supply-chain people, people who know how to write work plans for what you're doing with the money. If we just pump more money into the systems, but we do not change the capacity, we have the same problem.

-Key informant

Another key informant expressed a similar observation, and pointed to the need for high-level leaders to facilitate the broad shift in capacity needed at PhilHealth.

The concept of PhilHealth as the ultimate financier of services is still largely lip-service. Maybe they do or do not understand it on technical grounds, but they fear to take the big steps to go in that direction. It takes leadership from the CEO [chief executive officer], COO [chief operating officer], and the board to do these things, but if the board members don't even understand what we are talking about, how could they make these big steps?

-Technical expert key informant

4.2.5 Utilization of FP benefits remains low, in part because of insufficient information for beneficiaries

Although PhilHealth takes steps to inform its beneficiaries of FP services (see 4.1.3), key informants consider these steps as insufficient given the persistent low utilization of FP benefits by PhilHealth enrollees.

As far as long-acting methods are concerned, PhilHealth packages have been there for quite some time, but utilization remains low. Even if you have a package, but you are not paying the providers, nothing happens. Before the nationwide training, most IUD procedures were done on an elective basis, and missed out on a lot of opportunities including postpartum insertion of IUDs.

-Technical expert key informant

Keeping PhilHealth members informed of their coverage is particularly important among those enrolled under the Indigent Program whose premiums are subsidized by the state. One informant pointed out: "there are households that have been paid for with premiums⁵ who don't know that they are members, to the tune of something like 10-15 percent... So, they cannot access FPRH services [because they are not aware of their entitlements]."

⁵ These families are enrolled automatically because they are in the NHTS-PR database. Previous studies reported a discrepancy in coverage between PhilHealth administrative data and household surveys, which may be due to automatic enrollment of the poor and elderly. This discrepancy may explain low benefit utilization among PhilHealth members who are not aware of having insurance (Bredenkamp et al. 2017).

4.3 Risks of Shifting FP Financing to PhilHealth

The respondents identified several potential risks with shifting FP financing to PhilHealth, as well as several lessons that can be taken from the Philippine experience. These include potential changes in providers' behavior as well as LGUs' attitudes that could result in provision of poor-quality FP. Some identified unfavorable effects may be caused by weaknesses in PhilHealth operations.

- Providers may push for FP methods based on their preference (convenience, higher reimbursement) rather than the patient's choice. *“What if the patient prefers surgical contraception, but the provider forces them to avail services that they are only willing or capable of providing? Right now, providers are saying IUD insertion is harder than the subdermal. IUDs are still available because DOH has a lot of supplies, but if the provider prefers the subdermal, they can just insert it (subdermal implant) within a few minutes.”* -LGU key informant
- LGU providers might prioritize FP over other public health programs that are not included in the PhilHealth benefit package. *“Some health staff might neglect the other public health services and prioritize FP.”* -LGU key informant. On the other hand, smaller, understaffed health centers might not prioritize FP services over other public health programs.
- If FP providers do not seek accreditation to deliver services in the PhilHealth benefit package, patients may end up paying for the services themselves.
- Providers may not seek accreditation because of too many requirements that duplicate DOH licensing or certification. One informant related: *“As of now, a lot of even government providers do not receive reimbursements from PhilHealth for permanent methods, because they have not been accredited. If you are licensed by the DOH as a provider of FPRH services, you should be automatically accredited by PhilHealth. It is absurd to require separate accreditation when you are licensed.”* -DOH key informant

Another informant added: *“accreditation should not be a barrier to entry, because when you insist that this is the standard of care and all providers that deliver FP should meet the standards, whether supply- or demand-side financing, those standards should not change. Even with the way PhilHealth accredits hospitals, accreditation is automatic if you are licensed. You just submit documents to comply with accreditation.”* - Technical expert key informant

- The attitude of PhilHealth personnel may also have an unfavorable effect on FP utilization. *“PhilHealth managers may be more concerned with getting funding (for enrollment) than spending on benefits. Opportunity loss for PhilHealth members may not be on top of their minds.”* -Private provider key informant

4.4 Financing FP through Health Insurance: Lessons from Stakeholders in the Philippines

While the Philippine experience is highly contextual, FP stakeholders offers the following lessons for stakeholders in other low- and middle-income countries:

- I. All diseases, including disease prevention and control programs, should be handled by the government through a public health insurance system. This will benefit the government; it will improve health, reduce economic dependence, and increase available funds for the public's/country's economic development.

2. Any health reform requires strong technical leadership. With competing demands for financial resources, critical decisions must be made in allocating resources to address the health needs of the population and decide who pays for what. Similarly, there is a need for enlightened leadership that understands the technical ramifications of what needs to be done. In moving forward, it is better to include the personal service aspect of other public health programs.
3. Demand-side financing works in a health system that has a large private sector, that can be engaged better through the demand side than the supply side. But if the health concerns are more urgent or epidemic in nature, supply-side financing might be more efficient, because the driving force behind the policy is really control of implementation and protection of the population.
4. Consider the characteristics of health service delivery. A national single payer like PhilHealth can consolidate fragmented health financing and contracts with various providers, public and private, national and local, primary and tertiary, to deliver health care to its beneficiaries.
5. Design the FP benefit vis-à-vis other packages to maximize every interaction between provider and patient, and specify how its provision will be monitored, tracked, and enforced.
6. The benefit design must respond to the health needs of the population and deliver care using effective health technology.
7. Streamline accreditation and claims processing, to avoid unnecessary burden on patients and providers. Ensure timely payments to providers.
8. The health insurance agency must inform members of their coverage and how they can use their entitlements. Other FP stakeholders can complement social health insurance activities with demand generation activities, training for providers, monitoring of progress of the FP program, and generating evidence to update policies and standards of care.

At the end of the day, these lessons will only matter if every woman's desire to space or time her pregnancy is met, without exposing her or her family to financial hardship.

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ANNEX C: SEMI-STRUCTURED INTERVIEW GUIDE USED FOR THE KYRGYZSTAN CASE STUDY (ENGLISH VERSION)

Key Informant Interview Guide

Decision-Making and Operational Considerations Surrounding the Shift of Purchasing of TB services to the Mandatory Health Insurance Scheme

Consent script:

For use with adult professionals who have experience or expertise (i.e., financing, managing or delivering TB services before and after the shift in purchasing of TB services.

Hello, my name is [interviewer name] and this is my colleague [interviewer name]. We are working on a study about the inclusion of health services in national health insurance schemes. This study is being conducted by the Health Financing & Governance Project (HFG), a global project of United States Agency for International Development.

HFG is conducting case studies in the Kyrgyz Republic and the Philippines to explore the decision-making and operational considerations surrounding inclusion of a particular health care service formerly delivered in a vertical manner into national health insurance. As part of this larger study, we would like to ask you a few questions about the Den Sooluk TB financing reforms. The outcome of this work will be a technical report that presents recommendations for decision-makers across all countries that are designing or revising financing for UHC schemes. This research is not intended to be about your performance as an individual or the performance of your organization.

We would very much appreciate your participation in this interview. It will take about 45 minutes to complete. Your participation is voluntary. There is no direct benefit to you for participating. Choosing not to participate will not affect you negatively. You may opt out at any point during the interview and you do not have to answer all questions. There are no right answers; we are just looking for your perspective on these issues.

We will combine the information you provide us with the information provided by about 15 other people we interview. We will keep any personal information about you confidential to the best of our ability. Only authorized researchers will have access to your personal information. We will remove your personal information before we share your de-identified responses with anyone outside of the research team.

If you have any questions or concerns about your participation in this study, you may contact Rena Eichler, the principal investigator or Dasha Migunov, the country manager. I will give you their contact information to write down at the end of the interview.

Do you want to ask me anything about the interview or study?

- Yes [Answer all their questions as best you can]
- No [Move to next item]

Do you agree to participate?

- Yes [Thank them and ask about audio recording]
- No [Thank them for their time, indicate result in spreadsheet]

Can I audio record the interview? Only authorized researchers will have access to the recording for documentation purposes.

- Yes [Thank them and proceed to the interview questions]
- No [Say it is no problem and proceed to the interview questions]

Consent to Participate

(Study Interviewer Signature)

Contact for the Principal Investigator:

Rena Eichler
Phone: +1-202-363-0870
Email: renaeichler@broadbranch.org

Contact for the country manager:

[to be populated based on the country]

Draft Guide for Key Informant Interviews

Respondent's role

- a. Can you tell me about your current position?
- b. How long have you worked there?
- c. What was your role during the design and implementation of Den Sooluk and specifically the financing reforms?

How is the current model for making TB services available to the population different than it was in the past?

- a. How did Den Sooluk, specifically the financing reforms, change the way TB services were provided to the population?
 1. Probe: how did service delivery change (and services provided by whom) and why was that change important?
 2. Probe: how did payments by patients change and why was that change important?
 3. Probe: how are providers paid differently and why was that change important?
 4. Probe: how did the source of financing change?
- b. Did the Den Sooluk financing reforms create winners and losers among TB stakeholders?
 1. Probe: better or worse for patients?
 2. Probe: better or worse for providers (specialist providers lost income)?
 3. Probe: better or worse for managing the TB epidemic?
 4. Probe: better or worse for individuals working for the National TB program?
 5. Probe: better or worse for the MHIF?
 6. Probe: any unintended consequences?
- c. Was there any political resistance from key stakeholders to these reforms? (e.g., TB doctors and nurses, PHC doctors and nurses, patients, Ministry of Health, Ministry of Finance, National TB Program, MHIF?)
 1. Probe: If so, how did the decision-makers handle it

Why decision-makers decided to change the paradigm

- a. Which stakeholders were part of the decision-making process when the decision was made to implement the Den Sooluk financing reforms [e.g., transition TB financing from the MOH to MHIF and using output-based payments / transition TB to being delivered by general hospitals / develop an explicit state guaranteed benefits package]?

- b. Please reflect on the underlying reasons these decision-makers implemented these reforms in 2012.
 1. Probe: was there economic pressure related to funding (e.g., economic recession, pressure related to vertical program funding, etc.)?
 2. Probe: did political leaders support this change?
 3. Probe: did donors advocate for this change?
 4. Probe: who was involved in the decision-making process and how?

How changing the paradigm worked operationally

- c. Please describe the transition process for the following financing reforms
 1. Changing financing of TB services from the MOH to MHIF
 2. Banning informal payments for TB services
 3. Paying providers through output-based payments
 - i. Probe: if providers needed to change their billing, reporting, or other kinds of operations in some way, how was that change handled at provider- and program management level?
 - ii. Probe: how were current TB patients notified?
 - iii. Probe: how did funding streams from donors or government coffers need to shift, from an operational perspective, after the transition of TB financing to MHIF?
 - iv. Probe: how did any policies or laws change?

What policy-makers in other countries should consider

- a. Let's say policy-makers from another country come and ask you whether and how they can improve access to quality TB services through financing reforms. Based on your experience, what advice would you have for them?

- b. Would you have the same advice for all other disease areas? Why or why not?

Is there anything else we have not discussed that you would like to share with us?

Do you have any questions for us?

Thank you for your time!

ANNEX D: SEMI-STRUCTURED INTERVIEW GUIDE USED FOR THE PHILIPPINES CASE STUDY (ENGLISH VERSION)

Key Informant Interview Guide

Consent script (English version):

Hello, my name is _____. I am working on a study about the inclusion of Family Planning in PhilHealth benefits. This study is being conducted by the Health Financing & Governance Project (HFG), a global project of United States Agency for International Development.

HFG is conducting case studies in Nigeria, the Kyrgyz Republic and Philippines to explore the decision-making and operational considerations surrounding inclusion of a particular health care service formerly delivered in a vertical manner into national health insurance. As part of this larger study, we would like to ask you a few questions about the inclusion of Family Planning Services in PhilHealth. The outcome of this work will be a technical report that presents recommendations for decision-makers across all countries that are designing or revising benefit packages of UHC schemes. This research is not intended to be about your performance as an individual or the performance of your organization.

We would very much appreciate your participation in this interview. It will take about 45 minutes to complete. Your participation is voluntary. There is no direct benefit to you for participating. Choosing not to participate will not affect you negatively. You may opt out at any point during the interview and you do not have to answer all questions. There are no right answers; we are just looking for your perspective on these issues.

We will combine the information you provide us with the information provided by about 20 other people we interview. We will keep any personal information about you confidential to the best of our ability. Only authorized researchers will have access to your personal information. We will remove your personal information before we share your de-identified responses with anyone outside of the research team.

If you have any questions or concerns about your participation in this study, you may contact Rena Eichler, the principal investigator or Leizel Lagrada-Rombaua, senior research advisor. I will give you their contact information to write down at the end of the interview.

Do you want to ask me anything about the interview or study?

- Yes [Answer all their questions as best you can]
- No [Move to next item]

Do you agree to participate?

- Yes [Thank them and ask about audio recording]
- No [Thank them for their time, indicate result in spreadsheet]

Can I audio record the interview? Only authorized researchers will have access to the recording for documentation purposes.

- Yes [Thank them and proceed to the interview questions]
- No [Say it is no problem and proceed to the interview questions]

Consent to Participate

(Study Interviewer Signature)

Contact for the Principal Investigator:

Rena Eichler

Phone: +1-202-363-0870

Email: renaechler@broadbranch.org

Contact for the country manager:

Leizel P. Lagrada-Rombaua

Phone: +63915-9503790

Email: leizel.lagrada@gmail.com

Draft Guide for Key Informant Interviews

Respondent's role

1. Can you tell me about your **current position**?
 - a. How long have you worked there?
2. Were you in the **[same/different position]** during the time that family planning (FP) services were included in the benefit package of PhilHealth? If so, can you tell me about your former position?

Note: FP benefits in Philhealth were implemented in various years.

3. How does your **[current / former]** work relate to **Family Planning Program or family planning benefits under PhilHealth?**

Part I: Questions about what's covered under PhilHealth and Why: In what ways has covering target family planning services by PhilHealth changed aspects of their usage and availability, or the governance/operations of their delivery?

We know that Family Planning Program is a nationally mandated priority public health program and an important tool for the improvement of the health and welfare of mothers, children and other members of the family. We sometimes refer to FP program as vertical program, with national government (DOH) providing direction to LGUs in implementing the program.

We also know that PhilHealth has included FP services in their benefit package, initially covering vasectomy and bilateral tubal ligation in 2000 and more recently, covering the subdermal contraceptive implant package.

4. Is it correct that, as just stated, vasectomy, bilateral tubal ligation, and subdermal contraceptive implants are the only FP services covered by PhilHealth?

- a. Probe: does the benefit package have any exclusions related to family planning services? For instance, does PhilHealth pay for condom or pills?
- b. Probe: does the Family Planning program also provide vasectomy, bilateral tubal ligation, and subdermal contraceptive implants services, or just PhilHealth?
- c. Probe: Does Outpatient Primary Care benefit for “consultation” in the PhilHealth benefits list cover a consultation for FP?

Were these services (vasectomy, bilateral tubal ligation, subdermal contraceptive implants) available to the population **before** they were included in the benefit package of PhilHealth?

Probe: who delivered the services?

Probe: what did a person have to pay to access these services?

Probe: who funded the services?

Were there **any barriers or challenges with ensuring these family planning** services were available to the population **[as described in question no. 4]**?

Please describe how these family planning services are made available to the population now that they are included in the benefit package of PhilHealth.

Probe: is there a difference in who delivers these services, i.e., i.e. who used to deliver vasectomy, bilateral tubal ligation, and subdermal contraceptive implants before and after inclusion in the package.

Probe: is there a difference in what people pay to access these services?

Probe: does the benefit package have any exclusions related to family planning services? **For instance,** does PhilHealth pay for condom or pills?

Part II: Why decision-makers decided to change the paradigm

Why was the decision made to include these family planning services under PhilHealth?

Probe: was there pressure related to funding (e.g., economic recession, pressure related to vertical program funding, etc.)?

Probe: did political and Church leaders want this change?

Probe: who was involved in the decision-making process and how?

Probe: was there evidence to support the inclusion of family planning services under PhilHealth?

Why were these services selected to be included in PhilHealth, while other services, including family planning commodities, left to be provided by the Family Planning Program?

If there was debate to include services addressing other diseases under PhilHealth but the decision was made NOT to include them, can you describe why the decision was different for those services?

Part III. How changing the paradigm worked operationally

Please describe the transition process from the FP services as vertical public health program to FP services as PhilHealth benefit package.

Probe: if providers needed to change their billing, reporting, or other kinds of operations in some way, how was that change handled at provider- and program management level?

Probe: how were current patients and/ or Philhealth beneficiaries notified?

Probe: how did funding streams from donors or government coffers need to shift, from an operational perspective?

Probe: how did any policies or laws change?

Probe: in your opinion, what are the mechanisms to ensure no duplication of financing for FP services is happening?

Probe: If government is still budgeting for FP services while PhilHealth is already covering those services, when do you think the transition to health insurance will be completed?

Part IV. Pros and Cons

From your perspective, compared to providing FP services as a vertical program, what other pros and cons of family planning services being included in the benefit package of PhilHealth? Here we refer to both FP currently covered by PhilHealth, and those covered through the Family Health Program.

Probe: Are FP services better (or worse) for patients when covered by PhilHealth? (e.g., more patient-centered care)

Probe: Are FP services better (or worse) for providers when covered by PhilHealth? (e.g., do specialist providers lost income)?

Probe: Is access to FP services better (or worse) when covered by PhilHealth?

Probe: Will the FP Program Implementation be better (or worse) for program managers (in DOH/LGU)?

Probe: Will it be better/worse for PhilHealth managers in-charge of operations?

Probe: any unintended consequences? An unintended consequence may be fewer number of public health centers providing FP services because they are not accredited by Philhealth.

From the **perspective of other stakeholders**, what do you think they might consider to be the pros and cons? Other stakeholders may include the Catholic Church, local politicians, NGOs, legislators, development partners, etc.

Part V. What policy-makers in other countries should consider

Let's say policy-makers from another country come and ask you whether they should include family planning services under their country's national health insurance scheme. Based on your experience, what advice would you have for them?

Would you have the same advice for all other disease areas? Why or why not?

Is there anything else we have not discussed that you would like to share with us?

Do you have any questions for us?

Thank you for your time!



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