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*Surian sa mga Pag-aaral  
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# Policy Notes

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## New ideas to help the Aquino administration achieve its health agenda

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One of President Benigno S. Aquino's inaugural commitments is to ensure quality and affordable health care for each and every Filipino during his term. Indeed, a healthy citizenry makes for a healthy nation. But trekking the road toward this goal is not easy. For despite the gains in many areas in the country's health care situation, certain bottlenecks remain. As such, the Aquino administration must work hard on its health agenda and come up with a strategic plan to address the constraints.

This *Policy Notes* offers a few new ideas that may help the new administration achieve its health agenda. Three major areas are discussed, namely: (a) access to primary care; (b) upgrading of the hospital system; and (c) focus on province-wide health systems. In each of these areas, certain schemes are being proposed.

### **New ideas offered**

*Ensure access to primary care for all Filipinos.* A potential step in attaining the Department of Health's (DOH) universal health care is to assign every individual to a primary care provider which will be paid by PhilHealth through capitation. In areas where public health units cannot service all patients, private providers could be contracted to provide the service.

There are several advantages to this scheme. One, it would solve problems in terms of access since a defined primary care provider is accountable for each individual. This would address the breakdown of the referral system because primary providers can serve as the gatekeeper of the health system. Patients should be allowed to access higher-level

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facilities only after securing referrals from their primary care provider.

Two, it would help address some issues in financing. While the National Health Insurance Program (NHIP) was passed way back in 1995, universal coverage is still far from being achieved.<sup>1</sup> The varying degrees of local government unit (LGU) participation in the Sponsored Program (SP) subject the poor to catastrophic expenditure during episodes of illness. The national government (NG) should therefore guarantee the coverage of the poor by taking the responsibility of paying for the health insurance premium of the poorest of the poor, particularly those who are recipients of the Pantawid Pamilyang Pilipino Program (4Ps). The responsibility of LGUs should be shifted toward enforcing the mandatory enrollment of the informal sector. Uninsured individuals primarily come from the informal sector.<sup>2</sup> This sector comprises a wide spectrum of people ranging from professionals (i.e., lawyers), self-employed entrepreneurs, contractual workers, and jeepney drivers.

Among the reasons cited in focus group discussions as to why those in the informal sector do not enroll or sustain their membership in PhilHealth is the perception that they do not get anything from the insurance program unless they are very sick (PIDS 2009). If every enrolled member will have one primary care provider

<sup>1</sup> While PhilHealth reports 85 percent coverage, the 2008 National Demographic Health Survey (NDHS) reports only 38 percent coverage.

<sup>2</sup> All those who are formally employed are mandatory members of PhilHealth.

assigned to and responsible for them, the members will feel the tangible benefit of joining PhilHealth. These primary care providers could be tapped for health promotion and delivery of public health programs, ensuring that DOH programs are delivered even to far-flung areas. And by acting as the gatekeeper of the health system, the current practice of bypassing lower level facilities for simple ailments could be curtailed and hospitals could shift their focus to patients who really need higher level of care. This will lead to a more cost-efficient health care system.

Lastly, the proposed scheme would address issues on monitoring and quality of care. It would be easier to collect health information since there is an assigned provider for each person. The information collected would also solve the reliability problem of the Field Health Service Information System (FHSIS) since reporting would be based on the actual status rather than reported incidence of diseases. There should also be expected improvements in the quality of care since the patients would be able to “vote with their feet,” that is, if they feel that the quality of service by their assigned providers is not at par with others, they can opt to be taken out of the providers’ registry and go to other providers. This could spur competition among health workers.

This option is viable because there is already an existing primary care network composed of rural health units (RHUs), city health offices (CHOs), and barangay health stations (BHSs). The barangay health workers (BHWs) could be

mobilized for registration of those who live in far-flung areas. PhilHealth, through its SP, also has the experience with the capitation approach. The private sector would also be expected to join the scheme since the setup is similar to health maintenance organization (HMO) physician networks that currently exist in major urban areas. The scheme will be particularly attractive for fresh graduates because this implies guaranteed clients. Health worker deployment would also be easier since there are incentives to locate in areas where the number of registered clients is high but health worker penetration is low.

To test the viability of this proposal, PhilHealth could expand the capitation scheme in its SP to government employees. Civil servants would provide a good test for the scheme since their membership to PhilHealth is guaranteed by the national government.

*Promote the upgrading and integration of hospitals.* Improvements in primary care should be supported by a parallel effort at improving hospital services. Renationalization of hospitals should not be allowed anymore since this fragmentation in hospital assignments has led to a situation where some provinces free ride in DOH facilities. Delivery of hospital services will be improved if DOH-retained hospitals could serve as a hub of the referral network of the provincial health system.

Patients flock to tertiary hospitals primarily because they are the only facility in the area where physicians are accessible. Since decentralization destroyed the system where all hospitals were

integrated, the career track of physicians was also lost. Thus, a physician with a permanent plantilla position in a primary hospital cannot look forward to being promoted to a higher-level facility. In the same manner, there is no incentive for physicians in tertiary level hospitals to be assigned to lower-level facilities.

The fragmentation in the hospital system is inconsistent with the structure of physician training. Residency training is conducted in teaching hospitals like the Philippine General Hospital and Quezon Medical Center which utilize consultants to be in charge of training residents to become specialists. These consultants normally do not occupy permanent positions and are paid with small honoraria. They pursue private practice outside their work at teaching hospitals and their main incentive is the prestige of being a consultant in their profession. Residents, on the other hand, are the ones staying at the hospitals full-time. These residents stay in the hospital for two to three years and are bound to follow whatever their consultants instruct. This two- to three-year residency period is the window for primary and secondary hospitals to have a chance of having specialists. If the hospitals in a province would again operate as an integrated system, the consultants at the tertiary level teaching hospital could rotate their residents to lower-level facilities. This arrangement is currently being practiced at the Surgery Departments of Davao Medical Center (DMC) and Davao Regional Hospital (DRH). The arrangement ensures that DRH will have ample number of specialists; at the same time, the residents find the arrangement

favorable since the time at DRH provides them breaks from strenuous workload at the DMC.

To address financing problems, all hospitals under the province should be given economic enterprise status so that hospitals will be able to manage their own resources and will have incentives to provide better services. Rather than imposing flat bonuses like the Magna Carta which are unfunded mandates, bonuses should be tied to performance. One possible source of bonuses is through Philippine Health Insurance Corporation (PHIC) reimbursements. Performance-related pay to hospital workers can be sourced from professional fee reimbursements from PhilHealth. While this is already the current practice in most public hospitals, a more standard rule on how professional fees are to be distributed to hospital staff should be issued by the DOH.

Well-run ambulances should be put in place to mitigate problems on access, especially for geographically isolated and depressed areas. A paradigm shift in assessing the adequacy of health facilities is also needed: the more important issue may not be meeting the 1:1000 bed per population ratio but having timely access to health facilities. The experience in Andhra Pradesh in India shows that maternal mortality decreased significantly when the state put its emergency rescue in place. In the Philippines, rather than building more public hospitals, Davao City implemented the Rescue 911 project which led to more patients reaching hospitals during their most critical hours.

*Bring back the focus on province-wide health systems.* The literature on fiscal decentralization

gives four general measures to bridge vertical fiscal gaps, namely:

- 1) expanding local own-source revenues;
- 2) reducing local expenditure responsibilities;
- 3) adjusting the intergovernmental alignment of expenditure responsibilities; and
- 4) providing fiscal transfers from central to local governments (Bird and Villancourt 1998).

Given that options (1) to (3) are difficult to achieve in the short run, some fiscal gaps can be addressed by the DOH by providing transfers to local governments. In Formula 1, DOH linked money to performance through the Service Level Agreement (SLA), introducing a form of performance-related pay. Since the fund is tied only to outcome achievements, SLA is essentially a move toward global budgeting, which many studies have shown to be more efficient than line item budgeting as fund management for the health sector. A closer look at the outcome indicators being tracked reveals that these services are delivered by cities and municipalities. This pay-for-performance scheme might improve further if provinces are also trained to enter similar contracts with their component city and municipalities. Assuming that the scheme where each Filipino is assigned to a primary health care provider is adopted, the role of the LGUs will then be to manage its network of primary health care providers and to ensure the compliance of these providers to DOH protocols. The past experience of the DOH with matching grants had limited success because it was only able to secure the firm commitment of provincial governors but not the mayors of component cities and municipalities (Capuno

2008). To avoid this problem, provinces should be given an option to contract out services (to health providers other than the city health office/municipal health office) when there are areas that refuse to cooperate and are lagging behind. Experience in other countries shows that contracting is efficient for some public health programs such as immunization and nutrition programs (Harding and Preker 2002).

The success of the SLA hinges upon a reliable source of information which tracks achievements. Ten of the 19 indicators of the LGU scorecard rely on the FHSIS, which is accomplished by the LGUs themselves. There appears to be a conflict of interest if the LGU is evaluated based on the data that it generated by itself. The current practice of data collection through the FHSIS is subject to attrition. When one BHW neglects to fill up his/her records, the average for the whole municipality will not be accurate anymore. This problem is aggravated in the aggregation of data at the provincial level because if one municipality opted not to submit its data, the data for the whole province would not be reliable anymore. Generating data through sampling might therefore produce a more accurate report and could help free up time that health workers spend in accomplishing reports. In every province, there are nationally paid DOH representatives called Provincial Health Teams (PHT) who oversee three to five municipalities. These PHTs could be trained to conduct household surveys sampled at the barangay level. To ensure that the data generated by these PHTs are accurate, DOH can commission a third party to validate the results in randomly selected areas.

And finally, as the DOH moves toward performance-related pay, the need for a monitoring and evaluation survey that is sampled at the provincial level is urgent. At present, the health-related surveys conducted by the National Statistics Office (NSO) are sampled at the regional level. Since the health sector is devolved at the LGU level, those surveys could not be used as guides to policy decisions. While it might entail costs to increase sample sizes, one way to rationalize the cost is to consolidate the health surveys into one. Right now, the major surveys that collect health-related information are: Family Planning Survey, Annual Poverty Indicator Survey, National Demographic and Health Survey, and Multiple Indicator Cluster Survey. The DOH and its development partners also conduct surveys for their projects. Rather than having all these surveys, one major health survey sampled at the provincial level and conducted at the right time (before or after elections) might thus even help improve accountability of LGUs. 📄

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### Annex 1. Links of the suggested policy options to the Aquino Health Agenda\*

	Financing	Service Delivery	Aquino Health Agenda		Human Resource	Health Information
			Regulation	Governance		
Expanding PhilHealth coverage and benefit	Universal coverage achieved through - NG enrollment of 4P beneficiaries - mandatory enrollment of informal sector	LGUs to enforce mandatory enrollment of the informal sector	Quality assurance through PHIC accreditation			
Ensuring primary care access for all	PHIC capitation as a source of fund	Gatekeeper of the referral network - reduced cost due to lower incidence of bypassing	“Voting with feet” patients could register with another provider if not satisfied with the service	Foster competition and cooperation among public and private sector providers	Health worker deployment would also be easier: i.e., incentives to locate in areas where the number of registered clients is high but health worker penetration is low.	Easier collection of health information since there is an assigned provider for each person.
Converting provincial hospitals into economic enterprises	User fees and reimbursements could be used for hospital upgrading and Magna Carta payments	Restoration of referral network			Incentives for hospital managers and health workers	
Strengthening the Province-wide Health System	Facilitation of the Sector Development Approach for Health (SDAH)	Contracting with component LGUs to deliver essential public health services	Ensure compliance with DOH standards through performance-based grants	M&E surveys conducted before or after elections to help improve accountability of local chief executives (LCEs)		Consolidation of health surveys into one, sampled at the provincial level

\* DOH Administrative Order No. 2010-0036 dated 16 December 2010, “The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos.”

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