



**Report to the Delegation of the European Commission in the Philippines**

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**Technical Assistance to the Mindanao Health Sector Policy Support  
Programme**

***A Situational Analysis of Health Financing in the Mindanao and ARMM***

***Regions***

***Final Version***



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## ***Foreword***

The Mindanao Health Sector Policy Support Programme is part of the European Commission's commitment to supporting the Government of the Philippines in the reforming the health sector. This support is delivered in partnership with the Department of Health of the Philippines in Manila (DOH) utilising the DOH Field Implementation Management Office in Mindanao, the Centre for Health Development at Regional level, and the Department of Health of the Autonomous Region of Muslim Mindanao (ARMM-DOH). Over a four year period from January 2008 to January 2012, the programme aims to engage local governments at provincial and municipal level in the conflict affected areas of Mindanao in support of the implementation of the FOURmula One for Health reform agenda. FOURmula One for Health is a policy framework intended to strengthening health services management and delivery in decentralised operating context. It specifically intends to support the achievement health related Millennium Development Goals and National Health Objectives.

The programme-targeted conflict affected areas are listed in the Financing Agreement between the European Commission and the Government of the Philippines as Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay, Lanao Norte, Lanao Sur, Compostela Valley, Davao Oriental, Maguindanao, Basilan, Sulu, Tawi-tawi, Isabela City, Marawi City and other areas as required. As the conflict affected areas are amongst the poorest and least stable regions in the Philippines, it is hoped that the programme will enhance health governance and health management capacity leading to a general improvement in the health status of these populations. In contributing the health and welfare of the people of Mindanao it is also hoped, to some measure, to enhance the capacity for peace.

This survey was designed to collect baseline information and is part of a series of research studies supported by the Mindanao Health Sector Policy Support Programme (MHSPSP). The research is

designed to bring greater understanding of the situation in the conflict affected areas of Mindanao and provide baseline information for the implementation and evaluation of the FOURmula One for Health initiative in the conflict affected areas.

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## ***Abbreviations***

<b>Abbreviation</b>	<b>Description</b>
ARMM	Autonomous Region of Muslim Mindanao
CAA	Conflict-Affected Areas
DOH	Department of Health
DOH-ARMM	Department of Health – Autonomous Region of Muslim Mindanao
DOMB	Department of Management and Budget
EC	European Community
EC TA-HSPSPS	EC Technical Assistance to the Health Sector Policy Support Programme
FIMO	Field Implementation Management Office
IDP	Internally Displaced Persons
LGU	Local Government Unit
MHSPSP	Mindanao Health Sector Policy Support Programme
OOP	Out-Of-Pocket Payments
PGU	Provincial Government Unit
PhilHealth	Philippines Health Insurance Corporation
PIPH	Provincial Investment Plan for Health
researcher	Short-Term Expert
TOR	Terms of Reference
USAID	United States Agency for International Development
WB	World Bank

## ***Abstract***

*One of the four pillars critical to Formula One for Health throughout the Philippines is Health Financing.*

*This purpose of this situational analysis is to describe the current health financing situation in the Mindanao CAA and ARMM regions and to set forth recommendations for health financing support to be provided under the Mindanao Health Sector Policy and Support Programme (MHSPSP).*

*The situational analysis included site visits with key health financing informants, data and report gathering, and personal interviews with a subset of health system stakeholders in Manila, Davao City, Davao Oriental (Lupon municipality), Cotabato, and Maguindanao (Shariff Aguak municipality).*

*The results of the analysis indicate that the current state of health financing in Mindanao CAA and ARMM is fragmented with a program-driven health financing framework facing significant challenges including high levels of Out-of-Pocket payments (OOP), a lack of regionally-adopted financing strategies and local health accounts, and considerably weak implementation of PhilHealth.*

*Given the limited coordination between health financing entities and lack of health accounts data in Mindanao CAA and ARMM, interventions should focus on improving coordination between key components of the system as well as establishing critical health financing data elements for increasing evidence-based policy decision-making and maximizing resource allocation and efficiency in health .*

# ***Introduction***

## **Purpose**

The purpose of this report is to establish an accurate baseline assessment of the current health financing situation in Mindanao's Conflict-Affected Areas (CAA) which includes the Autonomous Region of Muslim Mindanao (ARMM). This document draws together relevant reports and findings with respect to health financing functionality and capacity as it applies to the Mindanao Region of the Philippines. In addition, this report identifies a program and set of related guidelines for monitoring and evaluating the effectiveness of proposed health financing activities in ARMM and CAA context throughout the term of MHSPSP. Lastly, this report includes a budgeted proposal for health financing support and technical assistance to be provided to government and health facilities in Mindanao CAA during the remaining term of MHSPSP. As one of the main four pillars of the F1 framework is Health Financing, one focus of the project includes supporting the Local Government Units (LGUs) at Provincial and Municipal levels in the implementation of health financing initiatives under the FOURmula One-for-Health Reform Agenda (F1).

## **Scope**

The scope of work included working with the DOH and the MHSPSP to establish baseline data or information to which MHSPSP interventions in health financing can be assessed. More specifically, the STE liaised with DOH Central Office to assure harmonization of TA activity, review health financing mechanisms within Mindanao CAA and ARMM, determine the current functionality of the system, compile a single-source document that draws on the DOH's suite of reports and other relevant literature, and to map health finance allocations across Mindanao CAA and ARMM.

The provinces, municipalities, and barangays supported under MHSPSP are numerous and significant in the Mindanao CAA areas of the Philippines. Excluding the ARMM, the Mindanao CAA consists of eight

(8) provinces, one (1) city and forty-five (45) municipalities while ARMM consists of one (1) city, 5 provinces, and 113 municipalities. The study was undertaken over a two (2) week period in October 2008 to conduct a situation analysis of health financing in the region and provided the opportunity for the researcher to visit Mindanao's CAAs as well as to attend meetings with key informants in Manila. More specifically, in Mindanao CAA site visits were made to Davao City, the province of Davao Oriental, and the municipality of Lupon. Meetings in Mindanao CAA were held with key informants from the Department of Health Field Implementation Management Office (FIMO), as well as government representatives from the municipality of Lupon and staff from MHSPSP. In the ARMM, site visits were made to Cotabato City, the province of Maguindanao, and the municipality of Shariff Agwak. Meetings were held with the DOH-ARMM Secretary Tahir Sulaik, MD and visits were made to one provincial hospital and two rural health units in Maguindanao. Strengths of the mission include the seemingly reliable and consistent insights and reports from key informants with regard to next steps in health financing in the region while limitations of the work include the inconsistent amount of data available for analysis (primarily descriptive data available) among the provinces as well as the tenuous security situation which limited access to some locations.

## **Background Information**

When the Local Government Code was passed in 1991, the much of the health system of the Philippines became a "devolved system". This law decentralized health services to the 78 provinces, 118 cities and more than 1,400 municipalities nationwide. The Philippines Department of Health sets policy and determines responsibilities of the Local Government Units (LGUs) (Philippine Health Insurance Corporation, 2008-2010 Medium Term Plan). Furthermore, according to DOH Administrative Order No. 23, PhilHealth is expected to aggressively play its role in the current health financing framework adopted for health sector reforms. This Order stated *that "the National Health Insurance Program (NHIP) shall serve as the main lever to effect desired changes and outcomes in each of the four major implementation*

*components, where the main functions of the NHIP including enrollment, accreditation, benefit delivery, provider payment and investment are employed to leverage the attainment of the targets for each of the reform components.”* (Philippine Health Insurance Corporation, 2008-2010 Medium Term Plan).

However, according to the PhilHealth Medium Term Plan 2008-2010 and Provincial Health Investment Plan reports regarding Mindanao CAA and ARMM regions, there are significant limitations in the capacity of provincial and local government agencies to implement critical elements of the F1, including effective health financing initiatives which increase access to appropriate and quality care, that address the needs of the poor, and which establish a framework for efficient and cost-effective resource allocation within both regions (Compostela Valley Provincial Government, 2008, Davao Oriental Provincial Government (2008), Department of Health of the Autonomous Region of Muslim Mindanao, 2008). Furthermore, these reports indicate the absence of a health financing strategy specific to Mindanao CAA and ARMM regions and that overall financial management capacity is limited, especially in overseeing financial flows and resource allocations. Weakened links in governance structures and health system supervision often limit the advancement of a more robust health financing framework.

In addition to the limitations in the capacity of provincial and local government agencies to implement critical elements of F1, currently the largest proportion of revenues comes from out-of-pocket payments, 48.4% (National Statistics Coordination Bureau, 2005). Effective risk-pooling is very limited and the benefits of the Philippine Health Insurance Corporation (PhilHealth) are clearly not optimized because of low enrolment in the plan. In the Philippines, approximately 16 million people were enrolled in PhilHealth in 2007. In the ARMM region, the number of enrolled families increased 4.5 times from in 2004 from 2003 levels, while these numbers returned to 2003 levels in 2005 (ARMM-Wide Investment Plan for Health, 2008-2012). There are also limited incentives for health facilities to become and to maintain PhilHealth accreditation status (ARMM-Wide Investment Plan for Health, 2008-2012). Capitation generally reverts back to LGU central funds and does not necessarily translate to investments

in health. Lastly, these reports also indicate there is limited capacity of program managers to navigate the claims process to receive funds from PhilHealth (ARMM-Wide Investment Plan for Health, 2008-2012). Understanding these issues and identifying the weak links among the various system components is an important and formidable challenge for MHSPSP.

In addition, it is important to review health spending of the Philippines and specifically Mindanao CAA and ARMM in the international context. The table below compares the Philippines with other countries in Southeast Asia on selected health expenditure indicators.

**Table 1: selected health expenditure indicators in some South East Asia countries**

Member State	Total expenditure on health as % of Gross domestic product	General government expenditure on health as % of total expenditure on health	General government expenditure on health as % of total government expenditure
Cambodia	6.7	25.8	11.4
Indonesia	2.8	34.2	5
Lao People's Democratic Rep.	3.9	20.5	5
Malaysia	3.8	58.8	7.5
Myanmar	2.2	12.9	1.4
Philippines	3.3	39.8	6.3
Singapore	3.7	34	6.2
Thailand	3.5	64.7	11.2
Viet Nam	5.5	27.1	5
AVERAGE	3.9	35.3	6.6

Source: WHO, website

Compared with other South East-Asian countries, the Philippines ranks below average on the following two indicators: 1) total health expenditure as a percent of GDP and 2) government expenditure on health as a percent of total government spending. The country is slightly above average for government spending as a proportion of total health expenditures.

## ***Literature and Report Review***

In order to conduct a thorough baseline analysis of the health care financing situation in, an analysis of existing literature and reports from the Philippines and the international context was conducted. The leading health finance reports reviewed from the Philippines include documents from both the national and provincial levels including the Fourmula One Strategy, the Philippines National Health Financing Strategy, and Provincial Investment Plans for Health (PIPH) from Compostela Valley, Davao Oriental, Saranggani, Sultan Kudarat, Zamboanga del Sur. For ARMM, the ARMM-Wide Investment Plan for Health (2008-2012) was reviewed. Moreover, the Medium-Term Plan 2008-2010 for PhilHealth was assessed. In addition, key supporting documents from within the international context include health financing and development reports and studies from Afghanistan and Rwanda, two recent conflict-countries that can provide lessons for Mindanao CAA and the ARMM.

Generally, health financing in the context of development is a “staged” process in which most countries begin with a centralized health financing approach and then seek alternative health financing mechanisms such as social or community-based health insurance that can assist to pool resources and further maximize the efficiency of allocating resources for health (Newbrander et al. 2007; Shepard et al., in press). Moreover, to advance such health financing mechanisms and to examine their impact, it is critical to have reliable data available to examine financial flows and to identify the actual cost of care. Such studies provide the background information necessary for testing the impact of health care financing mechanisms.

The following provides a brief overview of the current health financing elements identified that are necessary for understanding the baseline situation in Mindanao CAA and ARMM. Furthermore, these elements help to identify possible areas for the MHSPSP to support throughout the term of the project.



## National Level Documents

The FOURmula One Strategy of the Philippines Department of Health builds upon lessons and experiences from the major health reform initiatives undertaken throughout the country in the last 30 years -- from the Primary Health Care approach in the late 1970s, the Generics Act in the late 1980s, the devolution of public health system in the early 1990s, the National Health Insurance Act of 1995, to the Health Sector Reform Agenda (HSRA) conceptualized in the late 1990s. F1 provides for a policy framework for bringing about improvements in health financing, regulating, and more efficient delivery of health services especially to the poorer Filipino populations based upon good governance (Department of Health, 2008(a)), (Department of Health, 2008(b)).

Specifically, with regard to health financing, the objective of the F1 reform is to secure greater, better and sustained investments in health. The key strategies for attaining these objectives focus on the improvement of mechanisms for the generation, pooling and utilization of funds from all sources including national and local governments, social health insurance, and private as well as official development assistance. The strategies include (Department of Health, 2008(a)):

- Focusing national government subsidies on priority health programs and adopting performance –based allocation schemes;
- Mobilizing resources from extra budgetary sources;
- Coordinating National and Local Health Spending ; and
- Expanding the reach and coverage of the Philippines Health Insurance Corporation.

In summary, health financing has been proposed under FOURmula One as one of the four primary mechanisms for advancing the health of the Filipino population over the next decade. As a result, specific initiatives to improve the health financing situation, particularly in underserved areas of the country are critical.

As the Philippines Department of Health (DOH) is engaged in reforming the health system one of the primary aims is to improve the performance and responsiveness to the needs of the population specifically with regard to access to services and equity in health financing. Moreover, as indicated in the FOURmula One Strategy, health financing constitutes one of the four primary pillars of DOH reforms. This document describes the current health care financing framework for the Philippines and sets forth a series of proposed reforms. In summary, the strategy suggests that health financing in the Philippines should (Department of Health, 2008(c)):

- Promote equitable use and provision of services relative to need;
- Advance efficiency in the administration of the health financing system ; and
- Advance quality and efficiency in service delivery.

According to the World Health Organization (WHO) website 2007, average per capita spending on health in 2007 was \$40US in the Philippines, compared to \$96 and \$179 US in Thailand and Malaysia respectively. Per capita government expenditure in these countries are also well above Philippines figures. Furthermore, some of the primary health financing issues currently faced by the Philippines includes (Department of Health, 2008(c)):

- a. Limited pooling of resources, leaving Filipinos largely at risk for cost of illness;
- b. Efficient use of resources goes unrewarded;
- c. Significant amounts of out-of-pocket expenditures;
- d. Isolated areas (such as Mindanao and ARMM) are lacking PhilHealth Accredited Facilities
- e. resulting in under-served populations at risk; and
- f. Devolution of health services has led to fragmentation.

Many of these issues present health financing challenges throughout the country but are felt even more significantly in Mindanao CAA and ARMM where in addition to health service provision concerns, the

population is facing important security problems and dealing with the health of displaced persons, effects of war, etc.

## **Mindanao Documents**

The following provides a brief summary of the health care financing situation and needs in several of the Mindanao CAA areas based on their associated Provincial Investment Plans for Health (PIPHs). At the time of this report, PIPHs were available for the following provinces: Compostela Valley, Davao Oriental, Sultan Kudarat, Sarangani, and Zamboanga Del Sur. By the completion of this report, PIPHs were unavailable for Zamboanga Del Norte and Zamboanga Sibugay. The PIPHs provide a useful reference for developing and implementing a supportive health financing strategy. The PIPHs indicated shared issues across the provinces as well as individual provincial concerns.

### ***Compostela Valley***

According the Compostela Valley Provincial Investment Plan for Health 2008-2012 (2008), 20,711 beneficiaries are enrolled under the PhilHealth program as of 2008 while 41,544 households have yet to acquire any coverage.

Voluntary enrollment continues to pose a challenge for the indigent and those employed in the informal sector given limited funds. Absence of client segmentation data has also made it difficult to properly identify enrollees for this program and public-private sector partnership has not been fully maximized as a strategy to expand its coverage. Furthermore, when covered in the plan, the PIPH indicates that the benefits of enrollment are not well understood by beneficiaries. Furthermore, the provincial and municipal LGU budgets for the indigent population remain very low. The Rural Health Units at Montevista, Pantukan and Maragusan are not yet accredited for outpatient benefits under PhilHealth. The PIPH describes Compostela's priorities in the area of facility accreditation. These priorities include accrediting 11 Rural Health Units under the PhilHealth Maternal Health Package,

accreditation of the three Rural Health Units for outpatient benefits, as well as the accreditation of 10 Rural Health Units for TB-Dots. Furthermore, the focus will be on upgrading several hospitals. Lastly, the PIPH indicates that generally PhilHealth beneficiaries prefer to be admitted in the Davao Regional Hospital, as the four accredited hospitals in Compostela Valley do not have enough bed capacity to cater to PhilHealth members and that equipment needs updating and repair.

### ***Davao Oriental***

According to the PIPH for Davao Oriental, health care financing in the province largely relied on financial resources available to the LGUs through their IRA (Internal Revenue Allotment). Similar to the national picture of health financing, out of pocket expenditures and individual purchasing of health services by the patient remain very high. The total number of indigents enrolled in PhilHealth for 2007 in Davao Oriental was 609. Furthermore, the enrolment of indigents continues to be highly political where municipal leaders are given discretion of who is labelled “indigent” for subsidized enrolment in the PhilHealth program. The PIPH calls for greater accountability and fairer means for enrolling the truly indigent population of Davao Oriental (Davao Oriental Provincial Government, 2008).

According to the report, of the three Philhealth accredited Rural Health Units (RHUs) in Davao Oriental, only two (2) (Lupon and Banaybanay) have received capitation funds and applied it for improvement of health services. Mati, is also a Philhealth accredited facility but did not receive capitation funds because there are no Philhealth enrollees in the indigency program.

Specifically, the PIPH report identified the following issues concerning the implementation of PhilHealth in the Province:

- Inability to identify and select “*true*” indigents

- Sustainability of the Sponsored Program requires prioritization and knowledge of program benefits
- Low level of facility accreditation

### ***Sultan Kudarat***

According to the Sultan Kudarat Provincial Investment Plan for Health 2008-2012 (2008), health financing in the province is also below the desired level within the Philippines and internationally. Similar to other Mindanao CAA provinces, the social health insurance through PhilHealth covers only 26.02% (n=10,238) of the 39,515 target indigent families to be enrolled. Out-of-pocket spending in this province accounts for 75-80% of the overall expenditures for health. The report indicates that the budgetary allocation for the health programs as well as procurement of drugs and medicines both in the provincial and municipal levels is also inadequate.

The following is a list of the objectives for health financing in the current Sultan Kudarat PIPH:

- 85% of marginalized populations have access to health services through PHIC Sponsored Program
- 100% of all Health facilities in Sultan Kudarat maintain their PHIC accreditation
- Increase PHIC share in hospital care expenditure from 12% to 20% by 2012
- To increase provincial and municipal LGU health expenditures
- Establish Local Health Accounts (LHAs)
- Capacity building of health financing components and staff

### ***Sarangani***

For the province of Sarangani, global enrollment figures in PhilHealth for the population of 516,412 as of 2007 were unavailable. Data are available for the indigency program. With regard to this population, the province has enrolled 2,785 families (which is equivalent to roughly only half of the total identified indigent families) in the PhilHealth program.

According to the PIPH, sources of LGU funds come from the internal revenue allotment, taxes, grants, borrowings and other sources. The provincial appropriations for the health sector from 2003 to 2006 have remained constant at approximately 15% of the total provincial budget.

The following is a list of the objectives for health financing in the current Sarangani PIPH:

- Increase enrollment in PhilHealth, particularly the indigent population.
- Increase universal coverage
- Increase the number of accredited hospitals in the province. Currently, three out of five government hospitals in the province are PHIC accredited due to inability to meet the standard requirements on physical structure, health personnel and hospital equipment. One primary objective of the province is the PhilHealth accreditation of 50% of all TB-DOTs centers by 2010. At present, the province has one out of seven RHUs accredited as PhilHealth TB-DOTS facility.

### ***Zamboanga del Sur***

The Zamboanga del Sur Provincial Investment Plan for Health 2008-2012 (2008) indicates that 29% PhilHealth coverage of the indigent population in the province. This coverage has expanded since 2000 where the estimates were approximately 5% coverage of this population. Along with further enrolment of the poor into PhilHealth, several issues are of concern in health financing for the province. These issues include enrolment of the informal and formal sectors in the plan, further dissemination of information about PhilHealth, increased accreditation of rural health units (currently 46% are accredited at the LGU level, and 40% at the city level), increased LGU investments in health, and the establishment of local health accounts.

### ***ARMM-Wide Investment Plan for Health***

The ARMM-Wide Investment Plan for Health 2008-2012 (2008) outlines the current health financing situation in ARMM and describes needs in this area for the region. This report indicates that the benefits of social health insurance in ARMM are not maximized given low enrolment in PhilHealth and limited incentives for Local Chief Executive (LCEs) to enroll indigents. In the ARMM region, the number of enrolled families increased 4.5 times in 2004 from 2003 levels, while these numbers returned to 2003 levels in 2005 (ARMM-Wide Investment Plan for Health, 2008-2012). For example, sponsored program enrolled families in Maguindanao alone rose from 2,940 in 2003 to 109,917 in 2004, and then decreased to 9,440 in 2005. Such a fluctuation adds to the difficulty in establishing a sustainable risk-pool within the area. Furthermore, PhilHealth accreditation of these facilities is quite low. In addition, the ARMM-wide plan indicates that no health financing framework is available in ARMM to guide policymakers and program managers on how to allocate resources, mobilize funds, and deliver cost-effective financial management in the health sector.

More specifically, the ARMM-report indicates the following primary concerns regarding health financing in ARMM:

- Limited knowledge and expertise at DOH-ARMM in tracking resources, expenditures, budgets, etc. and data showing the link between resource use and health outcomes.
- A health financing strategy and framework does not exist.
- There are no existing studies and standard guidelines for health financing schemes
- Management information systems are weak regarding financial data.
- PhilHealth is underutilized and under-established in ARMM and;

*.... has yet to put in place human resource, infrastructure and other requirements to institutionalize its operation (DOH-ARMM 2008)*

- Facility PhilHealth accreditation and re-accreditation is quite low.
- Overall health financing relationship between DOH, LGUs, PhilHealth needs strengthening.
- Costing of health services has not been conducted.

It should be noted that given the more centralised system of health operations in the ARMM, this region will most likely require a slightly different approach to health financing strengthening and development when compared to other Mindanao CAAs. Tools and studies to support this component of MHSPSP may need to be adapted to fit the local context.

Reviewed together, the PIPHS indicate a shared need across the provinces of Mindanao for further health financing strengthening. The areas of greatest focus seem to include: development of health financing strategies, development of local health accounts, increased enrolment in PhilHealth (including further coverage of the poor), and increased accreditation of health facilities.

## **International Context Documents**

The following include a series of documents from the international context that might be helpful in expanding research and technical assistance in health financing in the Mindanao CAAs.

The Government of the Islamic Republic of Afghanistan is currently developing a national health financing strategy incorporating the needs of the provincial health sector throughout the country. As a conflict-affected area, Afghanistan is setting forth a strategy similar to Mindanao. Current issues in health financing are focusing on strategy design, development of national and local health accounts, financial management strengthening, and identifying resources needs within a changing health care and security environment. This strategy may serve as a reference for developing health financing strategies within the context of Mindanao (Ministry of Public Health, Afghanistan, 2008). More specifically, Afghanistan has been successful in developing a strong foundation of health financing research (including primary care and hospital cost analyses) necessary for pilot testing user fees and community-



based health insurance approaches. Step-down cost analyses as applied in Afghanistan could be useful to the development of a health financing research arm in both Mindanao CAA and ARMM.

As a post-conflict country, Rwanda has embarked upon several health financing initiatives over the past decade that are considerably improving the efficiency of service delivery and access to services by the general population. This report serves a reference for advancing issues in Mindanao in the areas of local health accounts, identifying the cost of services (particularly in ARMM), examining the variation of health service costs among rural and urban health care facilities. This report also provides detailed methodological information for approaching issues pertaining to health care financing in conflict-affected areas (Beaston-Blaakman, Swerdin, et al., 2006). More specifically, the steps taken in Rwanda to establish detailed service costs and national and local health accounts could be transferrable to Mindanao CAA and ARMM in further developing the health financing system. Lastly, this reports indicates the necessary steps including, research, methodological design, and outlines ways to management limitations in setting up both cost studies and local health accounts.

Newbrander, et al. (2007) article provides a framework for approaching the development of a sound and efficient basic package of health services in conflict-affected areas and specifically provides economic data pertaining to Afghanistan. The study is relevant for other post-conflict countries that are re-establishing health services and seeking to develop cost-effective and equitable health systems as it outlines several of the steps in economic analysis for improving the efficiency of primary care with limited resources. Furthermore, the report is relevant to Mindanao CAA and ARMM in that it discusses how to advance health financing policy-making within a challenging security environment and limited data.

Morgan (2006) provides a unique framework for examining systems of operation including organizational operations and process. This text offers several sophisticated lenses for examining

relationships between various components of an organizational system and has been applied to interpretations of the relationship between public administration and private sector entities. It can be useful for interpreting the health financing relationships in Mindanao CAA and ARMM including LGUs and PhilHealth. This text is useful for assessing the current strengths and weaknesses of health financing organization and operations in Mindanao. Moreover, it provides a lens through which one can examine the gaps between the various stakeholders in the health financing system including Department of Health, PGUs/LGUs, PhilHealth, and the broader population (including enrollees).

## ***Methods***

### **Theories, Models and Hypotheses**

In order to further investigate the current situation of health financing in Mindanao a “systems analysis” framework (Table 1) was developed to examine the contributions and weaknesses of the various components of the current health financing framework and sought to identify applicable datasets to investigate critical issues pertaining to the indigent population, PhilHealth enrolment, health sector spending at the LGU levels, etc. The “systems analysis” framework enables the researcher to identify the various key components or contributors to the health financing system and to identify ways to strengthen this system (Morgan, 2006). In order to explore the current health financing situation in Mindanao CAA and ARMM from a systems perspective, the researcher developed a brief questionnaire (Appendix 1) to explore several baseline aspects of the health financing system with system stakeholders which included the following elements:

- a. Primary components of the health financing system including payers, revenues, and expenditures;
- b. Current strengths and weaknesses of the health financing system to deliver accessible and affordable health care;

- c. Major gaps in the functioning of the health financing system to achieve cost-effective, equitable care;
- d. Equity and coverage of the indigent population in Mindanao CAA and ARMM; and
- e. Identification of key reports to further review the baseline health financing situation

Site visits were conducted and a series of interviews were conducted with a sample of key health financing informants and health system stakeholders in Manila, Davao City, Davao Oriental (Lupon municipality), Cotabato, and Maguindanao (Shariff Aguak municipality).

Key informants include representatives from the Republic of the Philippines Department of Health (DOH), the Department of Budget Management (DBM), the Philippine Health Insurance Corporation (PhilHealth), Lupon Municipality Staff, Autonomous Region for Muslim Mindanao Department of Health (DOH-ARMM), Maguindanao Province, Shariff Agwak Rural Health Units, the World Bank, European Community Technical Assistance to the Health Sector Policy Support Programme (EC-HSPSP) and the Mindanao Health Sector Policy Support Program (MHSPSP).

The purpose of the interviews was to identify the primary themes or issues to strengthen the health financing system in Mindanao CAA and ARMM and that could be addressed under the MHSPSP. These interviews were held primarily in a group format with the exception of a few individual interviews. In total, 27 individuals participated in the interview process. Participants were selected based upon their relationship to the health finance system in Mindanao CAA and ARMM and were part of a sample of convenience. Availability during was also a factor in selection. Twenty-four interviewees participated in a group format, while three participated in individual interviews. The average group size was four participants. Three groups were held in Manila with stakeholders from the DoH and PhilHealth while three additional groups were held in Mindanao (Lupon, Davao City, and Cotabato) with government representatives from Lupon municipality, FIMO, and DOH-ARMM. The interviews were conducted

orally, and the researcher maintained a diary of field observations pertaining to the responses of the participants. The complete list of issues and questions addressed is available in Appendix 1. Some of the questions were used for report gathering and reliability checking purposes. The key focus questions of the interview pertain to items (b-e). Participants were probed for further explanation and details as necessary.

Additional information and reports were accessed as necessary. The researcher reviewed pertinent information regarding health financing in the international context to support the development of recommendations and conclusions in this report. Finally, the current and future needs for health financing studies and support in Mindanao CAA and ARMM.

## **Sources of data**

The key sources of data for this analysis include the reports outlined in the literature review as well as data received during an interview process with key informants. Furthermore, data from various provincial reports provided some information about health finance allocations, but was found to be inconsistent with regard to availability and level of detail. For example, some provinces reported health expenditures down to the municipal level while other did not.

## **Data Analysis**

As part of the “systems analysis” the responses from interview participants in both group and individual formats were collated and basic qualitative data analysis techniques were applied. The qualitative analysis identified and code key factors associated with issues generated during the interview process. For example, the researcher coded and counted the various strengths identified in response to question (b) of the health financing interview (Appendix 1). For each primary question category b-e in the questionnaire (Appendix 1), factors identified at least five times or more throughout the group and individual interviews are indicated in Table 1. Furthermore, the counts/ number of times each element

is addressed or mentioned are listed as well. These factors highlight both the primary strengths in the current health financing system in Mindanao CAA and ARMM as well as the elements to be improved from the stakeholder perspective

## ***Results***

Results from the study can be categorized into three components including the assessment from the literature review, a synthesis of results based upon the interviews held in Manila, Mindanao CAA and the ARMM, as well as interpretation of results from available data including mapping.

### **Literature Review**

The literature review indicates some consistent themes among those provinces that were able to provide reports during the duration of the short-term assignment. These consistent themes include the following:

1. Need to reduce high levels of out-of-pocket payments and to increase further pooling of risk within the population.
2. Need to increase health facility accreditation by PhilHealth.
3. Need to channel PhilHealth reimbursements directly back into health services as opposed to into the LGU general fund.
4. Need to increase “consistent” enrollment of the poor into PhilHealth annually and move away from a politically motivated process (during election periods).
5. Need to further establish capacity to enable evidence-based decision making for health financing at the local level in Mindanao CAA and the ARMM.

## Interviews

Table 1 Primary Contributing Factors and Identification Counts for Key Health Financing Questions

Primary Contributing Factors and Identification Counts for Key Health Financing Questions (Group and Individual Interviews)					
Interview Question	Category	Factors and Counts (n=number of times addressed)			
		PhilHealth Social Insurance	HSPSP Project Experience in the Philippines	Strong Interest in Health Financing Advancement	
<b>b</b>	<b>Strengths</b>	N=15	N=6	N=20	
		Lack of Coordination	Weak Management Capacity	Low Enrollment in PhilHealth	High Level of Out of Pocket Payments
<b>c</b>	<b>Weaknesses</b>	N=15	N=17	N=20	N=22
		Low Facility Accreditation	Low Financial Data Availability	PhilHealth Claims Processing Concerns	Lack of Equity
<b>d</b>	<b>Gaps</b>	N=14	N=18	N=8	N=15
		Lack of Health Accounts	Weak Data Systems Capacity	Lack of Cost Data to Improve Efficiency	Lack of Guidelines and Specific Strategies for Financial Management
<b>e</b>	<b>Data Availability</b>	N=16	N=14	N=10	N=12
		Political motivation to enroll the indigent population	Need for further identification of the poor		
<b>f</b>	<b>Equity</b>	N=15	N=15		

The data from the 'systems analysis' (Table 1) categorised the key finance related issues under the heading of Strengths, Weakness, Gaps, Data Availability and Equity:

**Strengths** – The primary strengths of the health financing system include the existence of the PhilHealth system (n=15), strong interest on the part of various stakeholders to improve the health financing system (n=20), and data available from the HSPSP project that can serve as a foundation for health financing work in Mindanao CAA and ARMM (n=8).

**Weaknesses** – The primary weaknesses of the health financing system include the lack of coordination between payers and facilities, PhilHealth and LGUs (n=15), weak management capacity (n=17), and low enrollment in PhilHealth (n=20), and high levels of out-of-pocket payments (n=22).

**Gaps** – The primary gaps of the health financing system include low levels of health facility PhilHealth Accreditation (n=14), low levels of financial reports and data availability (including limited detail) (n=18), PhilHealth claims processing concerns including timing, payer work, coding, etc. (n=8), lack of equity in the system due to high levels of out-of-pocket payments (n=15)

**Data Availability** – The primary issues associated with data availability include the lack of local health accounts (n=16) for financial management and linkages to public health data, weak data systems capacity (n=14), lack of reliable unit cost data at the facility level to examine and improve resource efficiency (n=10), lack of adapted health financing strategies to be implemented at the local level (n=12).

**Equity** – The primary equity issues appear to be the continued political motivation behind enrolling a selected indigent population into PhilHealth at the LGU level and the need to identify the “true” indigent population (n=15), and the need for further identification of the “true” poor (n=15).

The interviews with key health system stakeholders in Mindanao CAA and the ARMM also provided critical information for identifying the baseline health financing needs within the health system. Results of these interviews are as follows by key stakeholder:

### ***DOH Manila***

The Department of Health in Manila provided useful information regarding FOURmula One as well as information pertaining to the National Health Financing Strategy. Representatives also highlighted many of the issues outlined in these strategies including the importance of health financing in the FOURmula package, the need to reduce OOP and to expand coverage in PhilHealth, particularly for informal sector and indigent populations in Mindanao CAA and ARMM. The DOH also suggested the need to begin to identify ways to strengthen capacity building for data capture within health financing, particularly in ARMM. (M. Beltran, personal communication, October 21, 2008)

### ***PhilHealth***

Representatives from PhilHealth highlighted the importance of developing a health care financing strategy for Mindanao CAA and ARMM that has a closely defined relationship between the PLGUs/MLGUs and representatives from PhilHealth. It was indicated that specific coordination of claims, processing, and spending should be outlined in the strategy to increase equitable access to services. (M. Rosa-Valera, personal communication, October 21, 2008) Furthermore, representatives reported that technical assistance within the MHSPSP project should focus on increasing facility accreditation under PhilHealth and assisting these facilities with claims processing. (L. Vinyals, personal communication, October 28, 2008)

### ***DOH-FIMO Davao City / Davao Oriental (Lupon)***

Representatives from both DOH-FIMO and the municipality of Lupon in Davao Oriental indicated their interest in learning how the MHSPSP project could assist to strengthen financing in the region.



Furthermore, these representatives expressed an interest in expanding the amount of health spending at the local level. They suggested that the development of local health accounts would enable them to track and review over time expenditures in the health sector by type of service, facility, etc.

Furthermore, it was suggested that a workshop be held to increase the technical capacity in financial management, interpretation of health accounts data, etc. (E Wales, S. Valdez, L. Tejam, personal communication, October 22, 2008), (Lupon Municipality Staff, personal communication, October 22, 2008).

### ***DOH-ARMM Cotabato (Maguindanao/Shariff Agwak)***

Representatives from Cotabato expressed a great interest in expanding several of the initiatives proposed in the ARMM-wide Provincial Health Investment Plan. Specifically, they indicated a need to develop the capacity of DOH-ARMM in the financial area, including the development of local health accounts, improving the capacity of staff in financial management, and further understanding the costs of care provided at rural health units and hospitals. Furthermore, it was suggested that a PhilHealth representative be stationed in Cotabato to be able to directly communicate with DOH-ARMM on an on-going basis. (T. Sulaik, personal communication, October 27, 2008)

### ***World Bank***

Representatives from the World Bank expressed their views about the importance of focusing on developing the health financing situation in Mindanao CAA and ARMM. Weaknesses in existing infrastructure and equipment were also identified. The World Bank acknowledged the need to scale up technical assistance and equipment support to the region. World Bank staff also recognized the issue of pooling-risk among the population as a key factor for expanding the role of PhilHealth in the region. (R. Rosadia, personal communication, October 22, 2008)

## ***USAID***

Representatives from USAID outlined the current work they are conducting in ARMM and the basic services provided in the region. They outlined the role of the SHIELD program in the region and described some of the way MSHSPS could be involved in strengthening health financing in ARMM including working directly with DOH-ARMM on developing financial management systems, local health accounts, and augmenting relationships between facilities and PhilHealth. (E. Villate and R. Gonzaga, personal communication, October 24, 2008)

## ***MHSPSP***

Staff from MHSPSP assisted with the coordination of interviews with the various organizations and key representatives from these teams. Furthermore, the team provided reports and information as necessary to conduct the baseline analysis of the health financing situation in Mindanao CAA and ARMM. (M. Guix, E. Arenas, M. Miranda-Poot, S. Delosa, personal communication, October 27-30, 2008)

In summary, interviews with key stakeholders verified much of the information presented in the reports.

In regard to the datasets, detailed data analysis was difficult to fully examine within the limited time-period of the assignment. Although some data was available, information was inconsistent among provinces and mostly available on a case-by-case basis. The intention was to map health financing flows by province down to the municipal level. However, only the provinces of Sultan Kudarat and Sarangani were able to provide this level of detail and their data is shown in Tables 1 and 2 respectively.

**Table 2 FY 2008 Spending for Health in Sultan Kudarat Province by Municipality**

Municipality	Total LGU Budget	Total Health Budget 2008 (Pesos)	Proportion Health Spending
Bagumbayan	66,929,351	5,198,353	8%
Columbio	63,719,993	2,953,530	5%
Esperanza	47,206,684	5,341,416	11%
Isulan	87,669,947	10,093,715	12%
Kalamansig	65,218,951	5,049,964	8%
Lambayong	55,422,687	5,315,186	10%
Lebak	77,440,679	6,753,076	9%
Lutayan	47,238,770	2,903,794	6%
Palimbang	52,822,005	3,419,825	6%
Pres. Quirino	36,019,746	3,608,744	10%
Sen. Ninoy Aquino	40,759,859	2,866,300	7%
Tacurong City	94,194,480	7,558,021	8%
<b>Total</b>	<b>734,643,152</b>	<b>61,061,924</b>	

Source: PIPH Sultan Kudarat, 2008

**Table 3 FY 2006 Spending for Health in Sarangani Province by Municipality**

Municipality	Total LGU Budget	Total Health Budget 2008 (Pesos)	Proportion Health Spending
Alabel	91,121,961	3,681,614	4%
Glan	76,061,921	7,255,983	9.5%
Kiamba	45,689,128	5,131,708	11%
Maasim	54,168,399	2,953,285	5%
Maitum	45,390,984	2,948,407	6.5%
Malapatan	62,028,009	4,180,608	6.7%
Malungon	85,789,341	7,724,424	9%

Source: PIPH Sarangani, 2008

Results from these two provinces indicate that the average proportion of health spending within the LGU budget at the municipal level is between 7.5 and 8%. With the objective of increasing expenditures by LGUs for health, these datasets can offer a benchmark or indicator in moving forward. Tracking and documenting annual spending amounts for all Mindanao CAA and the ARMM should be further developed in the next steps of the project.

## ***Discussion***

In advancing interventions in health financing under MHSPSP, four critical indicators that need to be monitor include:

1. The proportion of spending on health in the LGU
2. The proportion of indigent families enrolled in PhilHealth,
3. The proportion of out-of-pocket spending
4. The proportion of facilities accredited and maintaining accreditation overtime.

As data limitations did not allow for a complete analysis of these indicators, information from the reports do provide some baseline detail and should be noted. For example, data from Sultan Kudarat and Sarangani indicates an average baseline contribution to health among municipalities around 8%, while ranging from 4-12% of the total LGU budget. This data need to be systematically collected and organized at the level of the PGU within Mindanao CAA and the ARMM and will serve as a basis for establishing local health accounts.

Furthermore, the various PIPH reports indicate the average proportion of indigent families enrolled in PhilHealth to be approximately 27%. Subsequently, out-of-pocket spending remains high, approximately 75-80% for example in Sultan Kudarat where PhilHealth coverage of the indigent population is 25%.

Facility accreditation in Zamboanga del Sur is 40% and much less in the ARMM, approximately 10%.

Additional data should be captured to fill-in the gaps and to gather a more complete set of indicators.

These indicators can then be applied to set direct targets for health financing within MHSPSP.

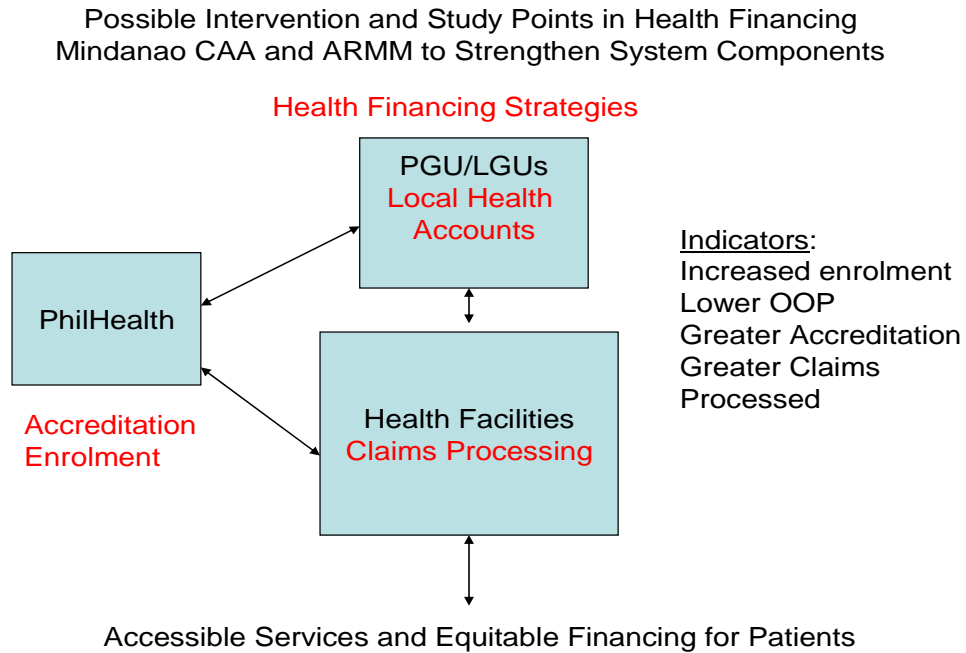
Overall, based upon the reports and interviews, this situation-analysis of the current state of health financing in CAA Mindanao and ARMM indicates:

1. A fragmented and program-driven health financing framework facing significant challenges reinforced by high levels of Out-of-Pocket payments (OOP)
2. A lack of regionally adapted financing strategies and local health accounts
3. Weak implementation of PhilHealth (including difficulties in identifying and providing financial protection to the poor)
4. Facility accreditation problems
5. Local health systems utilizing the resources to not only meet the needs of the local population but internally displaced persons (IDPs) as well.

Despite these concerns and challenges, many of the fundamental structures necessary for advancing a health financing framework in Mindanao CAA and ARMM are in place including willingness on the part of key stakeholders to develop and implement a health financing strategy, the existence of a social health financing insurance plan, PhilHealth, as well as involvement in health financing from LGUs within a partially-devolved funding framework. Results indicate a need to strengthen and coordinate these various components under more localized health financing strategies and to begin to develop a financing system working in concert to increase access and equity, to provide financial protection to the poor, and to improve health care financial management.

Figure 1 below indicates the highlighted areas (within red) that stakeholders agree upon in both the reviewed reports and the key informant interviews for advancing the health financing system in Mindanao CAA and ARMM. Suggested intervention and study points are indicated.

**Figure 1 Possible Intervention and Study Points**



## ***Conclusions***

The local reports outline critical areas where health financing assistance and studies under MHSPSP can play a significant role. Moreover, indicators show low levels of enrollment in PhilHealth, high levels of out-of-pocket payments and accreditation problems among facilities. Interventions focusing on these areas will most likely important contributions and can be monitored once baseline indicators are finalized from all Mindanao CAA and the ARMM.

International reports indicate the need to also consider strengthening the health financing framework by developing the necessary data infrastructure to support more advanced health financing analyses and interventions. This data includes reliable local health accounts and detailed step-down cost analyses<sup>1</sup> of health services at the facility level. Such information can be useful to examine facility efficiency within both local and international contexts.

The interviews with key system stakeholders reflect that interventions should be practical such as working with LGUs to adapt region specific health financing strategies, increasing the role of PhilHealth as a payer of services and working with facilities to obtain and maintain accreditation. The points below indicate specific activities for health financing that, if achieved, will have important impact on the efficient and equitable delivery of health services in the region.

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<sup>1</sup> Step-down cost analysis is where indirect costs or costs that benefit many activity are allocated to services within an agency in a sequenced, or step fashion.

## ***Recommendations (for further technical assistance and studies)***

### **Recommended Health Financing Activities within MHSPSP and Indicators**

**Activity 1** - The adaptation of the National Health Care Financing Strategy for Mindanao CAA and ARMM to guide policymakers and program managers on how to mobilize resources and augment funds.

Indicator – One or two strategies adapted with specific steps for Mindanao CAA and ARMM

**Activity 2** – Identification of financial flows of health resources in (LGUs) in CAA Mindanao and at the level of DOH-ARMM through the establishment of local health accounts.

Indicator – Local health accounts established and institutionalized in each province and municipality as appropriate.

**Activity 3** - Increasing the flow of clients into PhilHealth through social marketing activities, examining incentives for accreditation of health care facilities, and teaching facilities how to submit claims to PhilHealth

Indicators – Proportion of clients enrolled in PhilHealth, proportion of accredited facilities under PhilHealth, number of health facilities trained in claims processing with PhilHealth

**Activity 4** – Identification of the real indigent population and supporting their enrolment in PhilHealth. Continued expansion of the techniques applied by DOH to identify this population in Mindanao CAA and ARMM.



Indicators – Proportion of municipalities with established estimates of indigent population. Proportion of indigents enrolled in PhilHealth.

**Activity 5** - Strengthening the government units (including the LGU Service Officer and PGU Service Officer's financial management capabilities)

Indicators – Number of service officers working autonomously on financial management in health.

**Activity 6** - Conduct a step-down allocation cost study of health services in ARMM.

Indicators – Cost study completed and unit costs of health services identified. Proportion of municipalities in which cost data are used in health budgeting and planning.

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# ***Appendix 1***

## ***Brief Health Financing Interview Questionnaire for Site Visit Meetings***

- a Please describe the primary components of the health financing system including payers, revenues, and expenditure streams.
  
- b What are the current strengths of the health financing system in Mindanao CAA or ARMM to deliver accessible and affordable health care?
  
- c What are the current weaknesses of the health financing system in Mindanao CAA or ARMM to deliver accessible and affordable health care?
  
- d What are the major gaps in the functioning of the health financing system to achieve cost-effective, equitable care?
  
- e What data are available to examine the current functioning of the health finance system in Mindanao CAA and ARMM? What are the future data needs?
  
- f Please describe the issue of equity and social insurance coverage of the indigent population in Mindanao CAA and ARMM. What analyses need to be developed and implement to further identify and enrol these clients in PhilHealth?
  
- g Could you please identify and provide key reports to further review the baseline health financing situation in Mindanao CAA and ARMM?