# 1. Executive Summary

## 1.1 Introduction

The Philippine healthcare system suffers from inequities in healthcare access in all stages of life, resulting in poor health outcomes especially among the underprivileged. This is attributable to three main problems: 1) shortage of healthcare workers especially in the public sector, 2) administrative fragmentation and 3) health policy fragmentation. To address this, a gradual, systemic and comprehensive strengthening of primary care systems, funded centrally through national health insurance and supported by a holistic set of policy and systems interventions, was proposed. In the resulting strengthened systems, each health consult would be seen by a primary care provider, who would provide holistic and continuing health care and education, referring to an established network of hospitals or specialists for specialized treatment as necessary. This way, costs would be managed effectively, health care and education would be delivered efficiently, and access would be available equitably.

## 1.2 Objectives

In terms of impact, this study aimed to strengthen primary care systems in the Philippines.

The general objective was to measure the effect of strengthening primary care systems on health system performance. Specifically, to measure the effect of a set of health system enhancements at the primary care level in urban, rural, and remote pilot sites, on the following outcome areas:

1) patient utilization,

2) patient satisfaction,

3) primary care provider satisfaction,

4) knowledge of primary care providers,

5) quality of care,

6) health outcomes,

7) financial risk protection and

8) administrative efficiency.

## 1.3 Methodology

A 3-Phased approach (Preparation, Implementation, Evaluation) was used to first develop an ideal PCB scheme and surround it with enabling health system components and processes; then implement and test the entire model in actual clinical settings: corporate/university, rural, remote (geographically isolated disadvantaged area or GIDA), and urban. Finally, the entire process would be evaluated. (See Figure 1)

Through its first pilot study in a university employees' clinic, this program developed the tools and piloted the methods which are the components of the proposed primary care strengthening system. The resulting strengthening 'package', in a manner of speaking, could then be replicated in local health systems all over the country. Two more studies were therefore set up in one rural and one remote setting. Sites were chosen from specified criteria.

### 1.3.1 Preparatory Phase

The Preparatory Phase *health system strengthening* activities fell under seven distinct but inter-related work streams: 1. health financing, 2. primary care provider networks (PCPN), 3. health information systems development, 4. health workforce development, 5. community engagement, 6. monitoring and evaluation, sometimes called assessment, analytics, surveillance, or evaluation, and 7. program management.

Each work stream progressed at its own pace throughout the year in Phase 1.

The Preparatory Phase *research* activities included baseline information gathering mainly through surveys. Questionnaire development and design of indicators preceded this, while encoding and analysis followed. Consultations with health system experts were conducted to inform various activities as needed.

### 1.3.2 Implementation Phase

Each study site therefore piloted an outpatient primary care benefit delivered through a primary care provider network (PCPN) consisting of a primary care facility (mainly the rural health unit [RHU]) and its barangay health stations (BHS) augmented by nearby government and non-government health providers including pharmacies, diagnostic labs, and parts of district hospitals, and by local transportation providers. These PCPNs were also augmented by training the health workforce. The use of multiple sites enabled this program overall to provide a nuanced picture of how outpatient health

benefit schemes can be replicated across the country and what their impacts, challenges, and recommended strategies for success might be.

The Implementation Phase just finished its second year in the first site (urban /corporate clinic'), and first year at the two sites (rural and remote). This phase included the actual health consultations and availing of PhilHealth benefits per consult. Electronic medical records are now being used to record data and ensure its availability and accessibility for review and evaluation. A payment scheme agreed upon during the preparatory phase is now being carried out. The Evaluation phase included analysis of above-mentioned outcomes, as measured using appropriate instruments developed under this project. Descriptive analyses of outcomes are currently being done to ascertain the impact of strengthening or transitioning to a primary care system.

### 1.3.3 Evaluation Phase

The outcomes evaluated aimed to describe a wide range of effects that may result from strengthening primary care systems, specifically the effects on health care delivery, quality and access. The outcomes were categorized into eight pre- and post-study outcome areas (see Objectives), although the study also monitors *utilization of health services* *during* the Implementation Phase.

In the 3 sites, additional analyses will be done looking into 1) health equity across socioeconomic strata, and 2) the use of accessibility interventions like transportation.

## 1.4 Relevant Results

Currently, several study outcome areas had already been reported and may inform national policy, even if the study is still ongoing. Continued grant funding recently approved would ensure the *impact* is documented by the follow-up surveys in 2021. Specifically, survey results particularly in the areas of utilization are reported (see section 14.2), along with intra-Implementation Phase accounting records of health benefit utilization. Although only the two expansion sites were funded, the initial site's results were included when possible to better inform policy. Other outcome areas are reported when relevant and once adequately analyzed.

### 1.4.1 Implementation Phase Utilization of Benefits

A gradual rise in utilization of health services was seen in the rural and GIDA sites. This was faster in the more developed site (rural) than the less developed site (GIDA). In

the latter, some explanatory factors pertaining to accessibility and availability of services were investigated. Although these were not statistically tested, they were found to be temporally related to the observed changes in health care utilization.

Since health expenditure data and other utilization information was derived from the EHR, it describes only users of the system and only expenses covered by the pilot primary care fund. This information was useful for actuarial estimates and for extrapolation to what may happen if the system is replicated in other sites. Extrapolation may be valid to larger scales i.e. provinces, if the scale-up is assumed to introduce little in terms of health system dynamics. That is, if there is little to no interaction among municipalities, and most or all of the health care activity of interest occurs within municipalities.

### 1.4.2 Baseline Household Surveys

Baseline values for the pilot site populations were determined from the baseline surveys; but these would be of greater value in comparison to post-study values. Social gradients were documented within each population in terms of how different socioeconomic strata use health care and health benefits, and how they spend on it. However, the power of these analyses was limited because the survey sample sizes were calculated for whole-population estimates, not sub-population comparisons across strata.

### 1.4.3 Health Worker Knowledge

Health worker knowledge was found to still improve post-training even with the shift to a more innovative, less facilitator-dependent learning format. More importantly, the new format was designed to be applicable to all health conditions; its execution was able to accommodate multiple diseases, in the same vein as the DOH reforms in the area of health workforce training.

## 1.5 Recommendations

1. The study should be continued in ongoing sites, for at least two more years to fully see the effects of a strengthened primary care system.
2. Expansion of the study to support UHC-implementing provinces should be given due consideration, especially but not limited to the host provinces of its current municipal sites.

3. Subsequent funding of the study needs to be considerate of its size, scope, complexity, and significance.
4. The products of this research can be packaged and exported in a replicable way to benefit other localities around the country that need technical assistance in attempting UHC reforms.
    a. The specific learnings of the study as regards the research question are summarized in the Conclusions.
    b. As regards the policy question: Based on these learnings, the Recommendations detail what can therefore be done to improve health systems.

## 1.6 Justification for each Recommendation

### 1.6.1 CONTINUATION OF THE STUDY IN CURRENT PILOT SITES

The Implementation Phase will be continued for TWO MORE YEARS. Funding for this will be coming from DOH-AHEAD-HPSR & PCHRD. The proposed amount, similar to its first year implementation, can bring the study to a three years Evaluation by the end of 2022. This allows ample time for all the post-study surveys and analyses of what would by then be a wealth of data that can be used in relevant health policies.

### 1.6.2 Support for host provinces

The funding application for Phase 2 of this program accommodates a notable development, namely the provincial scale up, by adding a potential stream of work in the Logical Framework: Scale Up (or Scale Out depending on province-level discussions). However, while these provincial arrangements are being formalized, most of the next year's activities will remain focused on the original work streams in the current municipalities to ensure completion of the project.

- Both provinces containing this project's municipality-wide expansion sites are UHC Integration Sites (UIS) – provinces and cities designated by the DOH to innovate ways of providing person-centered integrated health systems, as provided for under the UHC Law. Both provinces and one neighboring province have invited this project to advise or be their UIS development partner.
- The project has adopted UP Health Service as the urban study site. This will essentially position a private clinic as part of a larger public-

private PCPN within the framework of the UHC Law. Funding for such a site will attempt to be through the private partner. The research focus will be to investigate how a private health provider can augment government health services, aiming to help address public health care needs.

### 1.6.3 Additional funding

By design (as implementation research in health policy and systems), this project requires more than one year to execute. Three reasons for this are apparent as of this writing.

1. Systems have many moving parts; anything can go wrong or be delayed beyond the project's control. The ongoing Implementation Phase needed research funding, due to a slight delay in pilot health service funding from another agency that covers the project's pilot PCB scheme. Had there been no delays, the current research funds would still only have lasted until the middle of the first year of the Implementation Phase.
2. The study is multi-disciplinary in scope, real-world in setting, and whole-system in approach. It therefore takes time to prepare and is intended to discover challenges and develop solutions within the funded duration.
   i. Within the current Implementation Phase, customized site-specific solutions are still being attempted such as delivery of medications to barangays, and new EHR features.
   ii. For the additional Implementation Phase, the added advantages would be the ability to 1. account for seasonality of diseases and health behaviors at a societal scale, 2. test the previous year's solutions (essentially a replication study) and 3. solve problems that were detected late in the previous year.
3. The study was designed to address national health system issues. It began from front-line implementation at a university setting to design and test tools and methods, then moved to municipal settings to roll them out cautiously. It is important to scale up or scale out. The timing of going to scale is ideally once solutions are proven to work in smaller settings. In this case, added funding will go to the evaluation of implemented solutions solutions. However, the advent of the UHC Law and its imminent implementation may mean that earlier access to research-based recommendations will be needed by entire

provinces or cities. This circumstance implies that the study sites are valuable even for early detection of challenges and for designing system solutions, albeit untested ones. Added funding in this case would provide the host provinces an “R&D municipality”.

Even if none of these are done, e.g. the study is to be closed, it would only be ethical to leave behind a working system for the pilot municipalities. As they would then be on their own once the researchers exit, there should be enough time for transitioning to implementer-led continuity of the newly strengthened local health systems.

### 1.6.4 Translation of Research

High level discussions were held within UP Manila to consider the options for turning the end products of this research into a replicable form of assistance that can be provided to provinces and cities, in aid of UHC implementation. The envisioned product is a *provincial assistance program for UHC implementation.*

The program consists of the electronic health records system as the lead point, accompanied necessarily by the other components in order to effect lasting and health system-wide change. These other components are health financing design, PCPN formation with transport networking, primary care training, and monitoring and evaluation, all handled by a consultant team in tandem with local counterparts. The package will be offered for a duration of one year, with a second and at most third year as options, because the goal is to empower the client having transformed its health systems and transferred enough know-how for it to manage the system autonomously.

In its current state, the offer has been met with a positive response from the Governor of Sorsogon Province, the host province of our GIDA municipality of Bulusan and in the province of Bataan. A MOA with UP is being sought. Although there may be concerns about efficiency, one reason behind the strategy of lodging this endeavor under UP is the indelible distinction of having the pursuit of UHC for national development as its ‘soul’.