Executive Summary

Background

The National Economic Development Authority (NEDA), in coordination with the Philippine Statistics Authority (PSA), and University of the Philippines Manila-National Institutes of Health (UPM NIH), is mandated to validate the performance of the Philippine Health Insurance Corporation (PhilHealth) in implementing the National Health Insurance Program (NHIP) as per Section 31 of RA 10606, also known as the National Health Insurance Act of 2013, that amended RA 7875 and RA 9241. The Institute of Health Policy and Development Studies of the National Institutes of Health was tasked to head an independent validation of PhilHealth's performance. The objectives of this validation were established through meetings among the involved agencies.

Objectives

1. To compare the financial performance of hospitals pre- and post- NBB roll out
2. To describe the implementation of the NBB in selected hospitals
3. To collect best practices in implementation of NBB in selected hospitals
4. To describe the difference between total bill of selected NBB cases versus estimated bill as per standard of care and total bill of selected NBB cases versus corresponding PhilHealth case rate

Methods

This was a mixed methods study that involved the following activities: (1) facility survey (2) documents review and (3) case studies that involved key informant interviews (KIIs) and/ or focus group discussions (FGDs) in sampled government hospitals which implement the NBB nationwide. Seventeen (17) NBB hospitals of different levels covering the 17 regions of the Philippines were selected to be part of the case study. Seven top and five poor performing hospitals were selected from those with available financial statements. Additional, five hospitals were selected from those who did not submit financial statements. The selection of hospitals was done together with NEDA, PSA and PhilHealth.

Results and Discussion

Four hundred thirty-one (431) hospitals were contacted, while 185 hospitals responded, however, majority of these hospitals submitted financial statements of their LGUs, claiming that there were no separate financial statements for their specific hospital. Thus, only 50 hospitals submitted complete and useable financial statements.

Financial ratio analysis of the pre- and post- NBB roll out periods of the 50 hospitals showed a 58.36% decrease in Total Margin, with a steady Salaries Expense as a proportion of Total Expenditures, on a nominal basis. There was a simultaneous 65.33% increase in Current Ratio, and a 4,671.14% decrease in Debt Service Coverage.

In most hospitals, while the medical social service office heads the implementation of the NBB program, it is the admitting unit that usually begins the process of enrolling patients into the NBB program by triaging and initially assessing their eligibility. Eventually, all NBB patients are screened and enrolled through the Health Care Institutions' (HCI) PhilHealth portal by the medical social service office. Even as the PhilHealth Customer Assistance Relations and Empowerment Staff (PCARES)'s primary role is to monitor the NBB program, they also inform patients of the documentary requirements for enrollment. The pharmacy office also has a significant role in NBB implementation by assuring that prescribed medicines and medical supplies are provided free of

charge to NBB patients. In addition, they are in charge of forecasting of drugs and medicines, and medical supplies to ensure continuous availability. NBB compliance of hospitals is monitored through: (a) PCARES monthly report, (b) customer satisfaction surveys, and (c) Individual Performance Commitment Review under the Strategy Review for its Performance Governance System. Results from these reports aid hospitals in identifying specific departments and or staff who deviate from NBB policies.

Patients learned about their rights and benefits in the NBB program from: (a) hospital staff verbally informing them of free hospital services during confinement, (b) hospital pamphlets and posters, (c) hospital provided "bantays' class" which include weekly activities such as lectures on health and wellness and NBB policy, (d) group orientations led by ward nurses, (e) pre-recorded audio material that is played every morning and afternoon in the wards, (f) other NBB patients, and or (g) 4Ps classes led by their LGUs.

Because of RA 10606, government hospitals are compelled to deliver free health services to eligible NBB patients. As a result, most hospitals put in place different strategies to address implementation issues such as unavailability of (a) beds, (b) drugs and medicines, (c) diagnostic tests and (d) blood products. Strategies included provision of makeshift beds, expansion of hallways as rooms, bed-sharing, outsourcing of medicines, diagnostic tests and blood products, referral of patients to LGUs for assistance or inclusion of "discharge medications," which is a euphemistic term for medications and supplies needed during the convalescence at home, into the hospital bill.

Outsourcing experiences of hospitals include: (a) cash-based or credit-based payments with third party supplier; and (b) partnership with NGOs. Hospitals also augment their budget for NBB patients by: (a) requesting additional funds from LGUs and DOH; and (b) creation of petty cash fund that is replenished with LGU emergency funds or part of the professional fees of the PhilHealth reimbursements received by hospitals.

Other challenges in NBB implementation that hospitals face include: (a) lack of documentary requirements such as identification cards, birth certificates, marriage contract of indigenous people or of Filipinos living in geographically isolated and disadvantaged areas; (b) outdated HCI portal or unstable internet connection; (c) lack of manpower for to cope with the higher than 100% bed occupancy rate; (d) patients availing NBB benefits for their admissions despite having exhausted allowable number of consumable days for room and board; (e) patients made to stay longer in the hospital despite being discharged, due to having to wait for the approval of their PhilHealth enrollment and or NBB eligibility; (f) provision of free services, despite inadequate reimbursement values of several case rates ; and (h) violations by physicians on prescribing non-PNF drugs.

Best practices in carrying out NBB implementation include: (a) the giving of coupons or certificates, indicating the patient's membership status, medical social service classification, and eligibility to avail NBB services; (b) establishing a one-stop-shop office to enroll patients into the NBB program, even on weekends; (c) orienting patients to their rights and benefits under NBB by organizing "bantays' classes", playing pre-recording promotional audio on NBB policy in the wards, and LGUs incorporating NBB information in their regular meetings with their constituents and 4Ps members; (d) for easy identification, placing NBB tags in patient charts as early as the process of screening, giving of "NBB passport card", updating and dissemination of NBB admissions list; (e) developing a computer-based system for sending on-line prescriptions from physician to hospital pharmacy; (f) devising strict enforcement of reimbursements of patients OOP expenditures during discharge process and provision of infographics on reimbursement of OOP's; (g) agreement to guarantee

services above and beyond limits of case rates in return for earmarked funds from their respective LGUs; (h) adopting a policy requiring hospital PhilHealth offices to submit claims for reimbursement within 48 hours from the patient's discharge; and (i) initiating a client feedback mechanism through customer satisfaction surveys.

Based on PhilHealth Circular No. 0006 s. 2017 and No. 0022 s. 2012, there are ten requirements for NBB hospitals. Results revealed that overall, on the average, all hospitals were 84.6% adherent to PHIC requirements for NBB implementation. The areas wherein all hospitals were 100.0% compliant were in: Status of HCI portals, Therapeutics Committee, and PCARES office. While the areas that all hospitals are struggling with include: Access to basic comfort (41.0%), Quality of Care assessment reports (77.1%). Hospitals reported that they were not able to comply with several requirements, because they are not allowed to deny patient admission even if they are already at full capacity.

A total of nine hundred twenty-eight (928) NBB and nonNBB charts and eight hundred fifty-eight (858) corresponding NBB and nonNBB bills were reviewed and compared to standard of care practices. Low average percent compliance to standard of care of all case types was observed, specifically, there was low compliance to monitoring, physical assessment and laboratory procedures, thus diminishing the ability of hospitals "to establish definitive, accurate diagnosis and further achieve best possible outcomes for their patients" (PhilHealth Circular No. 22 s. 2012). NBB- and nonNBB- cases were similarly non-adherent to standard of care practices.

Of the 28 case types, there were five instances wherein NBB and nonNBB costs were statistically different. There were three instances wherein NBB costs were higher than nonNBB costs: Acute Respiratory Failure, Normal Spontaneous Delivery (Level 1), and Small for Gestational Age. At the same time, there were two instances wherein nonNBB costs were higher than NBB costs: Hemodialysis, and Urinary Tract Infection.

There is evidence that perhaps the PHIC case rate for Cleft Lip and Hemodialysis may be lower than current market prices, and thus may need to be increased. Similarly, there is evidence that perhaps the PHIC case rate for Acute Gastritis, Acute Renal Failure, Febrile Convulsion, Small for Gestational Age, and Normal Spontaneous Delivery (Level 2) may be higher than current market prices, and thus, can be decreased.

Conclusion and Policy Recommendations

Financial ratio analysis from the 50 hospitals showed varied results in the pre- and post-NBB roll-out trends in terms of the different indicators. In general, there was a 58.36% decrease in profitability of hospitals, while a steady salaries expense as a proportion of total expenditures, on a nominal basis. This may have led to an increase in liquidity (65.33% increase) among the hospitals, and a 4,761.14% decrease in Debt service coverage. This leads us to surmise that the hospitals became more efficient in managing their current liabilities and assets so that they may be able to enter into long term leasing of equipment or financing infrastructure development while accepting lower profitability ratio during post-NBB roll out period. However, while the trends are markedly different between the pre- and post- NBB roll out periods, there was no significant statistical differences noted.

Hospitals encountered different difficulties in implementing NBB, and these have led them to innovate with new policies and enter into new agreements with NGOs, LGUs, and DOH. However, several of these innovations, such as accepting NBB patients beyond authorized bed capacity, extending period of confinement until approval from PHIC is obtained, and diverting some of the professional fee reimbursement of physicians may be risky in terms of hospital acquired infections, non-adherence to standard of care practices, and demoralization of physician morale.

Recognizing the factors that promote and threaten successful implementation of the NBB, we recommend the following policy changes:

I. To improve financial reporting of NBB hospitals:

- **a.** Make submission of hospital specific Financial Statements as an additional criterion for PhilHealth Accreditation
- **b.** PhilHealth should hire or hire the services of, accountants or bookkeepers who shall review all submitted financial statements from NBB hospitals for their completeness and specificity.

II. To improve or sustain compliance of hospital staff:

- **a.** Promote a "no prescription" policy across all NBB hospitals
- **b.** Encourage hospitals to involve all staff to participate and prioritize NBB implementation
- **c.** Continue and strengthen PCARES program as a monitoring system
- **d.** Study the potentially demoralizing practice of NBB hospitals using employee share to PhilHealth reimbursements to fund hospital operations

III. To facilitate enrollment and minimize rejection of claims:

- **a.** Upgrade IT infrastructures to support fast and continuous access by the HCI portals
- **b.** Add additional features to the portal to address issues in enrolment, documentation, and consumption of benefits.
- **c.** Coordinate with PSA, DSWD, and LGU to harmonize data, consider a stronger single registration system instead of continued reliance on hospitals to catch people who fall through the cracks

IV. To ensure quality of care

- **a.** To access the Health Facility Enhancement Program of the DOH should increase engagement with NBB hospitals
- **b.** LGUs should allocate sufficient funds to NBB hospitals
- **c.** LGUs should study the benefits and costs of NBB hospital retaining PhilHealth income
- **d.** PhilHealth should issue Clinical Pathways (CP) or Clinical Practice Guidelines (CPG) for each of its benefit package within the next 12 months. This will empower not only hospitals but also doctors and nurses to know and to intelligently meet quality care expectations that are demanded by the payment of each of the All Case Rate reimbursements.

V. To address threats to sustained implementation:

- **a.** Review the case rates of PhilHealth to better reflect current costs with adjustment including adjustments for hospital's level of cruciality to population health (eg: being the only trauma center within 50 kilometers, or being the only hospital in a financially depressed area, etc).

b. PhilHealth should develop better rules regarding readmissions and their reimbursements.

c. DOH should review and upgrade as needed the authorized bed capacity and allowed plantilla items of all NBB hospitals

d. PhilHealth should investigate factors that lead to hospitals experiencing delays in reimbursements

e. PhilHealth should encourage NBB hospitals to adopt best practices that enhance the implementation of the NBB policy and subsequently improve financial performance.

f. In light of the upcoming implementation of the UHC Law, cash advance arrangements should be granted to NBB hospitals for finance needed upgrades

g. PhilHealth should study how to adopt an "outcomes-based payment" scheme for all NBB hospitals, and eventually for all hospitals when the UHC Law is implemented.