Strategic Purchasing in China, Indonesia and the Philippines

Ayako Honda, Di McIntyre, Kara Hanson and Viroj Tangcharoensathien, Editors
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Chapter 1: ‘Strategic Purchasing’ – definition and analytical framework used in the multi-country study
Ayako Honda, Kara Hanson, Viroj Tangcharoensathien, Dale Huntington, Di McIntyre
Background – Why focus on the purchasing function of health financing?

Universal health coverage (UHC) is currently at the centre of global policy debate. Since the 58th World Health Assembly that endorsed UHC (World Health Organization, 2005), and the 2010 World Health Report, which recognized the critical role of health system financing (World Health Organization, 2010), many low- and middle-income countries (LMIC) are considering reform of their healthcare financing systems to offer better financial protection and access to needed healthcare for all.

A country’s decision on how to transform its health financing system should not only be guided by decisions on revenue collection and fund pooling but also on healthcare purchasing (World Health Organization, 2005, Carrin et al., 2008). In the health system, purchasing refers to the process by which funds are transferred to healthcare providers to obtain health services for the population. Purchasing can be strategic or passive (World Health Organization, 2000): strategic purchasing involves the on-going search for the best means to optimize health systems performance by deciding which interventions should be purchased, how they should be purchased and from what providers, while passive purchasing occurs by following a pre-determined budget or simply paying bills when presented (World Health Organization, 2010). Strategic purchasing can improve health systems performance by promoting quality, efficiency, equity and responsiveness of healthcare service provision and, in so doing, facilitate progress towards UHC (World Health Organization, 2010, Figueras et al., 2005).

Despite the important role that purchasing plays in health systems performance, there is very limited empirical work on purchasing arrangements in LMICs. The RESYST (Resilient and Responsive Health Systems) consortium, in collaboration with the Asia Pacific Observatory on Health Systems and Policies (APO), undertook a multi-country study to critically examine how purchasing mechanisms are functioning in a range of LMICs from a strategic purchasing perspective; and contribute to filling gaps in the literature relating to purchasing arrangements.
What is strategic purchasing?

Purchasing involves making three sets of decisions: (1) identifying the interventions or services to be purchased while taking into account population needs, national health priorities and cost-effectiveness of those interventions; (2) selecting service providers, giving consideration to service quality, efficiency and equity; and (3) determining how services will be purchased, including contractual arrangements and provider payment mechanisms. A critical factor in health systems performance is the extent to which purchasers are able to influence providers to pursue equity, efficiency and quality in health service delivery (RESYST, 2014).

In strategic purchasing, a purchaser is an organization that buys health services, using pooled funds, for certain groups or the entire population. The purchaser can use levers to influence the behavior of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers. However, purchasing mechanisms operate within each country’s policy framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear policy framework and appropriate guidance to ensure that resource allocation and purchasing decisions are linked to public health priorities. As the purchaser buys health services for people, it is important for the purchaser to ensure that there are effective mechanisms in place to determine and reflect people’s needs, preferences and values in purchasing, and hold healthcare providers accountable to the people. The key strategic purchasing actions are shown in Figure 1.
The analytical framework used in the multi-country purchasing study

To understand the various components of strategic purchasing and the organizational environment within which they operate, the study employed the multiple principal-agent relationship model suggested by Figueras et al. (2005), which provides a framework for examining relationships between different actors.
An agency relationship refers to one in which a person or organization (the agent) acts on behalf of another (the principal). The principal has objectives that they want to accomplish and delegates tasks to agents in order to achieve these objectives. If both the principal and the agent seek to maximize their own utility or benefits, there is good reason to believe that they may have divergent objectives and that the agent will not always act in the best interests of the principal (Pratt and Zeckhauser, 1985). The challenge facing the principal is in creating institutional arrangements for the agent so that the agent’s best interests, given those arrangements, lead to desirable outcomes for the principal. Institutions refer to rules, laws, norms and customs to which an organization is subject (Ben-Ner and Putterman, 1998), and govern the way in which organizations can cooperate and/or compete (Williamson, 1996).

In strategic purchasing, the multiple principal-agent framework can be used to define the relationships between: (1) purchasers and providers, (2) government and purchasers, and (3) citizens and purchasers:

- For purchasers and providers: In the principal-agent relationship, the purchaser, as principal, uses financial, contractual, regulatory and monitoring mechanisms as levers to ensure that the health provider, as its agent, delivers an appropriate mix of quality healthcare services, at an agreed price. In this relationship, it is important to consider: (i) the criteria used to select providers; (ii) the form of contract that is employed; (iii) the mechanisms by which providers are paid; (iv) how prices are set, and whether prices are affordable and realistic; and (v) the mechanisms put in place to monitor performance. The organizational environment in which providers operate (e.g. the number of purchasers and healthcare providers, etc.) and the internal management systems they use for operation are also critical.

- For the government and purchasers: In this principal-agent relationship, the purchaser acts as an agent for the government (principal). The government must play a stewardship role to ensure that public health priorities are linked to resource allocation and purchasing decisions. In
the context of purchasing, three defined stewardship tasks exist: (i) formulation of health policy to define the vision and direction of the health system; (ii) exertion of influence, including approaches to regulation of the health sector; and (iii) collection and use of intelligence to monitor health system performance.

- For citizens and purchasers: A principal-agent relationship exists between the citizen (the principal) and the purchaser, who acts as the citizens’ agent in purchasing healthcare services. A key question in this relationship concerns the extent to which the purchaser represents the needs, preferences and priorities of citizens when determining service entitlements; and monitoring mechanisms for ensuring quality, equity and responsiveness in health service provision (Figueras et al., 2005).

The framework applied to this study is limited to principal-agent relationships that directly involve purchasers. While a number of other principal-agent relationships exist in healthcare financing mechanisms and these may also provide valuable insight into purchaser performance, this study focuses on the roles and functions of purchasers in their relationships with providers, Government and citizens as purchasers undertake strategic purchasing.

Figure 2 presents an outline of the principal-agent relationships in strategic purchasing and serves as the conceptual framework for the study.

**Fig.2. The three key strategic purchasing relationships**

![Diagram showing the three key strategic purchasing relationships: Providers, Citizens, Government]  

Source: Authors’ summary
Using the framework based on agency theory, the multi-country study critically examined the functioning of strategic purchasing in 10 Asian and African countries, which comprised seven RESYST countries (India, Kenya, Nigeria, South Africa, Tanzania, Thailand, Viet Nam) and three APO countries (China, Indonesia, the Philippines), and identified factors influencing that performance. Specifically, the study aimed to: (1) describe the selected purchasing mechanisms using a framework of the three core purchasing relationships (i.e. what groups of actors are involved in purchasing and how are they structured/organized/related); (2) for each relationship, identify key design and implementation gaps by comparing the ideal strategic purchasing model (Figure 1), the policy design, and actual purchasing practices (i.e. determine how the purchasing relationships are functioning); and (3) identify factors that enable and/or hinder effective purchasing, and assess what can be done to produce the desired actions/performance (i.e. determine why the purchasing relationships function in certain ways and provide recommendations to improve purchasing performance).

Case study approach

The study employed a case study approach to investigate the research questions. The purchasing mechanisms in a range of countries are the ‘cases’ in this study and the three core purchasing relationships which exist in the purchasing mechanisms are the units of analysis. An embedded case study design, that is one which incorporates more than one unit of analysis in an individual case (Yin, 2008), is used to analyze the three purchasing relationships and address the research questions.

Each country study team selected between one and three existing purchasing mechanisms on which to undertake the study. These purchasing mechanisms are grouped according to type of healthcare financing arrangement:

- The public integrated model: government budget financing of healthcare provision with healthcare providers that are part of the government sector
The public contract model: public purchasers contract healthcare providers. The purchasers can be either a state agency or social security funds.

The private contract model: private purchasers (insurance schemes) contract healthcare providers (Docteur and Oxley, 2003).

Data were collected through review of policy and other related documentation, semi-structured interviews, group discussions and secondary data analysis. Each case, or purchasing mechanism, was separately analyzed and the study results were compared to produce robust theoretical inferences. The type of healthcare financing arrangement was considered in the cross-case comparison in order to identify common or contradictory patterns.

**APO country purchasing studies**

The APO countries that participated in the purchasing study have each studied one purchasing mechanism that operates in the country, with China examining the New Rural Cooperative Medical Scheme; Indonesia examining Jaminan Kesehatan Nasional (National Social Security); and the Philippines examining the National Health Insurance Program.

The New Rural Cooperative Medical Schemes (NCMS) in China is a mandatory insurance scheme for the entire Chinese rural population, which accounts for one fifth of the world population. NCMS has been in operation for more than 10 years and currently covers 98% of China’s rural population. Approximately 80% of the funds for the scheme come from national, provincial and county government subsidies, and 20% from individual premium contributions. Funds are pooled at the county level and, therefore, there are a large number of separate, county-level pools currently in existence. Purchasers are county-level governments that purchase health services both from public and private health providers. A combination of fee-for-service and case-based payment is used as the provider payment mechanism under the NCMS.

In Indonesia, Jaminan Kesehatan Nasional (JKN), National Social Security commenced in 2014 and currently covers 52% of the total population. JKN is
a single pool, mandatory health insurance scheme for state government and company employees, with expansion planned to reach the entire informal sector. The poor are financially supported by publicly financed premiums. JKN is funded using the central government budget and some local government budget; payroll contributions by employees and employers; and premiums from community members. BPJS Healthcare (the Agency for Social Security) is the purchasing organization. JKN uses capitation for primary healthcare; INA-CBG (DRG type) for hospital care; and provider claims for referral services.

In the Philippines, the National Health Insurance Program, a single pool, mandatory health insurance scheme for the whole population, was established in 1995 and currently covers 74.9% of the total population. Multiple funding sources include: fully subsidized premiums for the poor; income-related premium contributions by public and private sector employees and fixed annual premiums for the informal sector. The Philippine Health Insurance Corporation (PhilHealth) is the purchasing organization in the country. Provider payment is largely made on a fee-for-service basis, moving towards capitation for indigent members, with fixed co-payments for outpatient care and case-based payments for selected procedures. Balance billing is allowed only for the non-poor.

The three purchasing mechanisms examined in the APO country studies all use social health insurance (SHI) and apply the ‘public contract model’. While the three purchasing mechanisms have a number of common features, variations are seen in the design of the purchasing mechanisms and the context where they operate. In terms of target population, while the Chinese NCMS targets the rural population and has achieved 98% coverage of that population, the Indonesian JKN and the Philippines National Health Insurance Program are targeted at the entire population and are yet to achieve 100% coverage of the population. Implementation of the Indonesian JKN has just commenced and will gradually increase coverage to reach the entire population. The Philippines National Health Insurance Program has faced challenges in expanding coverage to informal sector workers and the poor, as enforcing that the informal sector pay annual premiums is problematic and local government subsidies for the poor are subject to local political leadership and fiscal space in the local area. The Indonesian and
the Philippines SHI models have established a single pooling mechanism, with a central SHI purchaser, while the Chinese NCMS, which pools funds at the county level, has established multiple pools with no mechanism for cross subsidization between counties with different socio-economic status and county-level governments act as purchasers in this scheme. The level of government subsidy provided to the mandatory health insurance schemes varies between the three countries. All three mechanisms purchase healthcare services from both public and private healthcare providers, with public healthcare providers receiving supply-side funding from Government through annual budget allocations.

**Strategic purchasing in the public contract model – key messages from the APO purchasing studies**

While the key findings from the three country studies vary due to differences in the design of the health financing mechanisms and the context in which the mechanisms operate, there are a number of important, common themes identified in relation to strategic purchasing in the three countries. These include: (1) the use of specific policies to encourage efficiency; (2) measures to ensure healthcare quality; (3) equity – reaching the disadvantaged; (4) the relationship between the public purchaser and the Government; (5) public awareness of entitlements and engagement in monitoring and accountability.

**Use of specific policies to encourage efficiency**

Both China’s NCMS and the Philippines’ National Health Insurance Program employ a number of levers to contain costs.

In China, policies such as mixed provider payment methods, ‘clinical pathways’ and provider claim auditing have all been introduced experimentally or at study sites to improve the efficiency of fund use. However, some aspects of the innovations should be enhanced, including the requirement for more accurate and methodological calculation of global budgets and case-based payments, and use of cost-effectiveness evidence in designing benefit entitlements.

In the Philippines, while the patient gate-keeping and referral system is yet to be strengthened, provider payment reform that introduced a case-based
The payment system has improved efficiency, reduced the average cost and length of stay in hospital for each case and improved payment timeliness, although the actual use of case-base payment is still low. The incidence of balance billing has also declined. Further improvement could be made by introducing a DRG system to take account of co-morbidities and clinical complications. In the context of dominant, for-profit, private healthcare providers in the Philippines, the limited health expenditure by PhilHealth and a restricted benefit package with no comprehensive primary care benefits, no outpatient pharmacy benefits, and limited support for inpatient services, have prevented PhilHealth from becoming an influential purchaser of care and from utilizing economic power in purchasing to promote efficiency in healthcare service provision. The Philippines National Health Insurance Program could also benefit from the introduction of clinical guidelines and national guidelines for health technology assessment.

**Measures to ensure healthcare quality**

A lack of mechanisms to encourage healthcare providers to improve healthcare service quality is seen in all three countries, although some efforts have been made. Key challenges to improving healthcare quality include the capacity of purchasers to accredit healthcare providers and monitor service quality, the delegation of authority given to purchasers to enforce healthcare quality measures, and the absence of third party organizations to monitor quality in healthcare service provision.

In China, quality control and improvement strategies have been designed and implemented through contract agreements between purchasers at the county level and accredited providers. The contracts specify quality and performance assessment criteria and the performance assessment determines whether the contract will be renewed. In addition, purchasers endeavor to improve healthcare quality through various tools such as adoption of clinical pathway management systems, implementation of standard treatment guidelines and reporting systems. However, the system lacks a clear mechanism to monitor the quality of healthcare providers and services by purchasers. Due to a lack of capacity in purchasers and current delegations of authority to purchasers – purchasers have supervision authority to health providers, but does not have the right to
penalize them for poor performance – it is the health administrators who have enforcement authority, supervision of healthcare service quality by purchasers becomes somewhat ineffective. Furthermore, the current system does not encourage providers to improve quality.

In Indonesia, BPJS does not have adequate levers in the form of accreditation, negotiation, contract management and monitoring to ensure quality in healthcare service provision. There is a strong need to address healthcare quality at the PHC level using measures such as the accreditation of primary healthcare centers and hospitals and institution of standardized clinical guidelines for entry-level care. The capacity and authority of purchasers to monitor health-service quality is limited, especially in relation to government providers.

In the Philippines, quality-of-care mechanisms are limited and mostly pre-determined and imposed through a PhilHealth in-house mechanism. De-accreditation of providers is rarely undertaken, as it would cause severe disadvantage to the members relying on the providers concerned.

**Equity – reaching the disadvantaged**

Coverage of the population for financial protection when accessing healthcare services does not necessarily mean that all of the population has the same level of access to quality healthcare services. All three countries face problems with scarce availability of healthcare providers in geographically difficult to access areas.

In spite of the fact that insurance premiums are covered in full by national and local government subsidies, the Philippines National Health Insurance Program has encountered challenges in enrolling the poor population in the programme due to a lack of information provided to potential beneficiaries on entitlements and benefits.

In China, the Government and purchasers have implemented policies and taken action to promote equitable access to healthcare services, particularly through greater allocation of resources to underserved areas by central and local governments and the provision of financial protection to the rural population when they access healthcare services. Equity has gradually
improved, and member satisfaction with NCMS increased with members believing that NCMS alleviates their own financial burden when accessing healthcare. Around half of inpatient costs are reimbursed to members and members receive additional compensation for certain serious illnesses. For ‘five-guarantees families’ and low-income groups, other financial assistance is used to exempt them from premiums and subsidize their medical costs. The availability of healthcare providers in a number of remote areas remains a challenge and, in spite of improved coverage of financial protection, ensuring equitable access to healthcare services is difficult.

Similarly, the Indonesian Government faces financial constraints in developing new health service infrastructure and in deploying adequate human resources for health in geographically difficult to access areas, which affects the ability of Government to reduce inequity in access to services across the diverse geographical areas found in the country. In spite of efforts, marginalized populations in hard-to-reach areas do not receive the same benefits as citizens in areas that are easier to access.

In the Philippines, a similar issue has manifested in a slightly different manner. Provider accreditation by PhilHealth is stringent, which can severely reduce access to and utilization of hospital and public health services by the National Health Insurance Program members in underserved areas due to a lack of healthcare providers in these areas. There are currently no effective policies in place to ensure quality of care in these underserved areas. Although a more liberal accreditation policy is specified in the General Appropriations Act of 2012, the policy has not been widely implemented to date. Also, in the Philippines, serious problems exist in the identification and enrolment of Sponsored Program members, whose premiums are paid by the national Government. Many Sponsored Program members are unaware of their entitlement to benefits and steps should be taken to remedy this situation. PhilHealth has recently introduced a system to allow health facilities to identify poor patients who are automatically registered as PhilHealth members and can immediately take advantage of the benefits that are available through the programme.
The relationship between the public purchaser and the Government

In strategic purchasing, government actors and regulatory authorities are expected to provide guidance and stewardship to allow purchasers to undertake strategic purchasing and to ensure public health priorities are addressed in purchasing decisions. The case studies from Indonesia and the Philippines found that the role, capacity and delegation of authority between the Government and public purchasers need to be clarified and that the government stewardship function needs to be strengthened in order to facilitate strategic purchasing.

Specifically, the Indonesian case study identified that unclear organizational roles and accountability lines between BPJS (as purchaser for JKN) and the Ministry of Health and district health offices act to undermine the function of JKN as a purchaser. It is important to strengthen government stewardship to ensure health equity and establish an integrated regulatory framework for quality standards, payment systems, price regulation, and monitoring, evaluation and accreditation of providers. Also, the Ministry of Health and local government health offices have problems monitoring purchaser performance, as government policy design does not include mechanisms for monitoring the performance of BPJS. The inability of district and provincial health officers and local government authorities to access BPJS data limits the effective monitoring of BPJS. There is also confusion about the role of district health offices in local government.

The Philippines case study also found that government stewardship, including that by Department of Health, Congress, the Office of the President, Presidential Management Staff and the Cabinet, is limited due to a lack of appropriate technical skills. An “arms-length” attitude of higher-level bodies has led to an on-going lack of reports, assessments, strategic plans and similar documents that could inform the public of the current state of the National Health Insurance Program. As a result, PhilHealth often acts as a self-regulating organization.
Public awareness of entitlements and engagement in monitoring and accountability

Engagement between the purchaser and those on whose behalf services are purchased, is one area that requires careful consideration in all three country cases.

In China, while accountability mechanisms, such as reporting systems, complaints systems, supervision and information transparency, have all been established to allow members to comment on the healthcare that they receive, some mechanisms do not function effectively and further improvement is required if members’ needs and preferences are to be met and concerns to be heard. Furthermore, systems for member participation in monitoring NCMS are not well established and there is a lack of public awareness of the processes for commenting on the quality of the services given by healthcare providers, purchaser performance and the entitlement to input into purchasing decisions.

In Indonesia, no clear mechanism exists, either in policy design or in practice, to reflect the needs, preferences and priorities of citizens when determining service entitlements and there is no citizen representation on the governing body of BPJS. Legislation relating to patient rights is limited. Legislation should also be put in place to ensure that members from civil society organizations are represented on the governance structures of purchaser organizations so that citizens’ views are represented, their concerns are listened to and the preferences considered in purchasing decisions on benefit packages.

In the Philippines, systems to allow members to articulate preferences, needs and complaints are not well established. Benefits are largely determined from the top down, although benefits are increasingly being vetted through focus-group discussions with members. While PhilHealth premiums are far lower than those in other middle-income countries that have achieved UHC, PhilHealth provides less comprehensive benefits. The ability to expand entitlements and increase both inpatient and outpatient care is limited by a lack of income from premiums. While the political sensitivity of premium increases has been recognized, there is a need for PhilHealth and the government to engage people in the country
in consultations on premium increases and the expansion of benefit entitlements. Members in the Philippines National Health Insurance Program are not formally organized and no independent watchdog exists to ensure the programme operates as intended. Local health insurance offices could be used as key contact points for members, but this does not currently occur. While there is a website where citizens can voice concerns, the response to concerns is infrequent and delayed and should be improved.

The APO publication

As outlined in the previous sections, a number of common themes were identified in the three APO country case studies on strategic purchasing. There are also a number of case-specific issues identified in the studies. The following chapters on the studies undertaken in China, Indonesia and the Philippines provide critical analysis, using rich field data, on the challenges and facilitating practices specific to each case as well as the issues common to the three cases.

The multi-country study team hopes that this publication will enrich understanding of how China, Indonesia and the Philippines translate the concept of strategic purchasing into actual practice, their successes and barriers, and areas for improvement. The results of this study will strengthen the ability to undertake strategic purchasing, and show how strategic purchasing is a critical instrument for use in progress toward UHC and can assist countries to achieve their commitments to the UN General Assembly Resolution on Sustainable Development Goals.
References


Chapter 2: A critical analysis of purchasing mechanisms in China’s rural health insurance scheme

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Abstract

Since the end of 2008, rural residents of China have been universally covered by the new rural cooperative medical scheme (NCMS). This insurance scheme has provided substantial financial protection and mitigated medical costs to protect rural patients against impoverishment due to catastrophic health problems. The purpose of this study, which uses the RCOST-SHARESYST generic research protocol, is to describe the current purchasing mechanism and organizational structure, critically assess purchasing performance by comparing purchaser behaviour with expected strategic purchasing, and explore barriers to effective purchasing in NCMS.

A case-study approach was adopted in this study, with qualitative analysis of interviews with focus persons. Two counties from Qinghai province and two from Henan province were selected as the study sites. Operational data on NCMS and data from health institutions were collected with a specially designed questionnaire. Key informants were interviewed, including 88 key interviewees (doctors, patients, researchers and health administrators).
The major findings include the following.

- Government and purchasers have implemented policies and taken action to achieve the equity outcome, and equity has gradually improved.
- Innovations such as mixed provider payment methods, clinical pathways and provider claim auditing have been adopted at study sites to control costs and improve quality of healthcare.
- Mutual accountability and governance mechanisms have been established through a reporting system, complaints system, supervision, and information transparency, but some aspects need to be enhanced in practice.
- Quality control and improvement strategies have been designed and applied through contracting arrangements, quality and performance assessment, adoption of clinical pathway management and the reporting system.

Recommendations include the following.

- Promote equity through responding to citizens’ health needs and preferences, raising reimbursement rates, and creating effective incentives for the allocation of resources to underdeveloped areas.
- Improve efficiency by modifying pricing negotiation mechanisms and by introducing more cost-effective services into the NCMS benefit package.
- Encourage enrollees to participate in monitoring and evaluation of the NCMS purchasing performance.
- Establish a unified health information system across different hospitals and provinces for quality control and supervision; quality improvement plans should be drawn up and implemented.
A critical analysis of purchasing mechanisms in China’s rural health insurance scheme

Acronyms

APO    Asia Pacific Observatory on Health Systems and Policies
DRG-PPS diagnosis-related group-prospective payment scheme
NCMS   New Rural Cooperative Medical Scheme
PC     purchaser-citizen relationship
PG     purchaser – government relationship
PP     purchaser – provider relationship
RESYST Resilient and Responsive Health Systems
RMB    Renminbi (official currency of the People’s Republic of China)
Introduction to NCMS

Overview of progress of NCMS

NCMS funding and premiums

Both individual contributions and government subsidies for NCMS have increased over time. At the beginning of its implementation, the annual individual contribution per capita was about 10 RMB while the Government provided an annual subsidy of 20 RMB per capita. In 2013, the annual individual contribution per capita was about 90 RMB, while the Government provided an annual subsidy of 280 RMB per capita.

Pooling and funding

The rural county is the unit which manages the NCMS fund. Using guidelines and policy instructions from central and provincial government, county governments develop and implement operational policies, work plans and management. Individual funds and subsidies from governments from at all levels are pooled in a fund at the county level. Premium collection and enrolment management are usually conducted by the township governments and village organizations, using the arrangement drawn up by the county government.

From 2004 to 2012, the number of people covered by NCMS increased from 68 million to 805 million, accounting for 72.6% and 98.3% of the total rural population, respectively.

The NCMS fund covers both outpatient and inpatient care. About 70% of the fund is used for inpatient care and the rest for outpatient care. A catastrophic-insurance scheme, using part of the NCMS fund, has recently been established to reimburse medical expenditure on selected diseases with high medical costs. Cost-sharing mechanisms for insured people include deductibles, co-payments and ceilings. Table 1 shows the progress made in the NCMS.
Table 1. Basic information on NCMS

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of counties implementing NCMS</th>
<th>Number of enrollees (x 100 million)</th>
<th>Enrolment rate (%)</th>
<th>Annual funds raised (x 100 million RMB)</th>
<th>Per capita fund (RMB)</th>
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<td>2005</td>
<td>678</td>
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<td>75.7</td>
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<td>98.3</td>
<td>2484.7</td>
<td>308.5</td>
</tr>
</tbody>
</table>

Source: China Health Statistics 2013

County NCMS administration

An NCMS administrative committee in each of the counties decides administration issues. This committee acts as a board of governors, consisting of members from relevant county departments, including health, finance, civil affairs and agriculture. The Vice-Mayor of the county usually chairs the committee. The responsibilities of the committee include making decisions on the following:

- The benefit package; this follows guidelines determined at province level but there are variations depending on local situations;
- policies for the selection of contractor hospitals; criteria and policies are decided by the committee in the light of proposals from the NCMS office; and
- provider payment systems; the NCMS office prepares proposals for implementing these systems for consideration by the committee.

NCMS purchasing organization

The NCMS purchaser is the NCMS office, representing the county NCMS administrative committee. The NCMS office is hosted by the county health bureau, with financial support from a specific government budget. Its major responsibilities include the following:

- Appraisal and approval of contracted hospitals;
- ensuring the proper financial balance of NCMS funds;
- everyday management of NCMS fund accounts;
- auditing and reimbursing medical expenses;
- managing the information system for enrollees and medical expenditure;
- reviewing and monitoring health services provided by health providers contracted by NCMS;
- making the NCMS fund transparent to the general public;
- participating in the design and adjustment of the NCMS plan; and
- coordinating fund collection.

Relevance to universal health coverage

China has achieved a high level of population coverage in some aspects of health insurance schemes and public health programmes, but needs more efforts to improve service coverage and cost coverage (Meng and Xu Ling, 2014). While the NCMS has improved access to healthcare, its effect on financial protection has not been significant, mainly because of the rapid increase in medical costs. In addition, with the current financing mechanism, sustaining the scheme with limited financial capacity is a big concern for low-income counties. With the current premium collection policy, which states that all rural people in the same county should pay equal premiums, poor families will find the scheme more difficult to afford. Even though the provider payment system was introduced a long time ago, its implementation is not optimal, because the NCMS administrators are not fully familiar with the strategic purchasing concept and knowledge.

Conceptual framework

This study employs the conceptual framework developed by the RESYST team (RESYST, 2014).

The study uses a policy analysis framework to understand the relationship between the organizations involved in a purchasing mechanism, i.e. the structure of the organizations involved in the purchasing mechanism and identification of the role that each organization plays within that structure. There is interplay between organizations and institutions (rules, laws,
norms and customs) and, in fact, institutions which link organizations shape the behaviour within organizations and/or govern activities in organizations. Consequently, the institutional arrangements created for organizational structures provide information that helps the observer to understand the reasons for certain organizational behaviours, including the arrangement of resources, information, decision-making, delivery mechanisms and accountability, that are considered to be the central issues affecting institutional and organizational solutions to principal-agent problems. The principal-agent relationship in NCMS purchasing is illustrated in Figure 1, below.

**Fig.1. The principal-agent relationship in NCMS purchasing**

**Government**
(at national, provincial, and county levels)

- Ensure NCMS is well organized and operated according to government policies
- Decide NCMS benefit packages considering the requirements from government

**Citizens**
(the rural population covered by NCMS)

- Decide NCMS benefit packages considering the needs of the NCMS insured
- Ensure needs and preferences of insured are reflected

**Purchasers**
(county NCMS office)

- Decide contractual arrangements and payment system
- Deliver appropriate healthcare services

**Providers**
(hospitals, township health centres, village clinics)

Source: Authors' adaptation from RESYST 2014
Methods

Study design

The case-study approach is the main method used in this research. Selected sample cases are studied in a qualitative way and key people are interviewed for analysis.

Qinghai and Henan provinces were selected as the places for our research for the following reasons: different economic situations, with the former falling behind by comparison while the latter advanced; different progress in medical reform, with the former adopting a two-way referral method which achieved greater efficiency while the latter experimented with comprehensive payment systems reform aiming to control medical costs and improve the quality of healthcare. Three towns in each county were selected, covering Yiyang and Xi counties in Henan province, and Huangzhong and Hualong counties in Qinghai province.

Data sources

Sources of information

The analysis of present policies focuses on the policies of the central government, information on policy design, and implementation in the two provinces to illustrate the policy design of strategic purchasing of medical services by NCMS. Interviews with key figures aim to obtain specific information on implementation in local areas through face-to-face interviews with health administrators, NCMS management, administrators of medical institutions, medical practitioners and hospitalized patients, in order to understand the actual situation in practice, assess the gap between the ideal model and policy design, and explore the reasons behind it. The analysis of NCMS statistical reports is a quantitative analysis of reports dating from 2009 to 2014 to enable an objective assessment of the functioning and effect of NCMS.

NCMS purchasers have to report to the Government about fund expenditure monthly, quarterly and annually. The NCMS report information can be used not only to monitor the utilization of NCMS funds,
but also to reflect the performance of the strategic mechanism of health services purchasing by NCMS.

**Data collection**

Data collection was conducted through the cooperative efforts of teachers and students of the China Centre for Health Development Studies and the Centre for Health Management and Policy of Shandong University between June and September 2014. This involved gathering policy documents and conducting key figure interviews.

Data about organization and arrangement of purchasing were obtained by a review of policy documents and interviews with relevant personnel.

Documents included *policy documents* of the central government and provincial governments, NCMS supervision files, contracts signed by county offices and service providers and a database provided by county offices and major service providers.

**Individual interviews:** Key informant interviews were organized. Table A2 shows the number and origin of interviewees. Questions used in the interviews came from the project, adapted to include the NCMS characteristics and local settings. Interviews were recorded and the contents transcribed into Microsoft Word files for further analysis. All the converted texts were carefully verified to guarantee high quality.

Selected interviewees come from the following levels:

- **provincial level** – two personnel in charge of policy research from each of the two provincial health departments and one expert; and
- **county level** – from each county, one government official, two management personnel, one head of county hospital, one head of village hospital, three doctors and two hospitalized patients.
### Table 2. Number and origin of interviewees

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Henan province</th>
<th>Qinghai province</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors of provincial health bureau</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>NCMS researchers</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Directors of county NCMS offices</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Directors of hospital</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Doctors</td>
<td>18</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Patients</td>
<td>12</td>
<td>16</td>
<td>28</td>
</tr>
</tbody>
</table>

*Source: Authors’ summary*

### Analysis

To ensure full compliance with the aims of the research, qualitative data analysis was undertaken by means of deduction and induction. There are three major steps. First, based on the main structure, the policy files were categorized with unified codes; converted texts were coded by Max QDA. Second, on the basis of the transcriptions, the contents were extracted and interpreted. Finally, the key messages from the interviewees were summarized.

### Major results

#### Description of the purchasing mechanism

The key participants in the design and implementation of the NCMS purchasing mechanism are the county health bureaus, county government agencies, NCMS contracted medical institutions and rural residents. The county health bureau, as a branch of the county government, is responsible for the design of the system, policy-making and fundraising, and plays a leading role in system operation and purchasing practice. The county NCMS management office, as the operative agency and subject to the county government, is responsible for the specific operational work, which mainly involves management and disbursement of funds, design and implementation of the purchasing mechanism, approval and supervision of contracted medical institutions, auditing of medical expenditure and compensation, etc. Contracted medical institutions are providers of NCMS medical services, participants in the design of the mechanism, consultants for the price and compensation system and contractors, which are subject
A critical analysis of purchasing mechanisms in China’s rural health insurance scheme

to supervision and assessment by the management. The rural residents involved are the beneficiaries and are encouraged to participate in the design and implementation as well. Since the price mechanism and level of reimbursement directly affect rural residents’ enthusiasm for enrolling in NCMS, their opinions and preferences are supposed to be given full consideration.

Others involved in this purchasing mechanism are higher-level health administration departments (Ministry of Health, provincial health department and municipal health bureau), government financial departments at all levels, departments in charge of price, etc., which focus on different areas of management in accordance with their own responsibilities. Health departments, as the main leaders, take on the tasks of management and policy instruction. Financial departments supervise and audit fundraising and spending. Agricultural departments help with publicizing and promotion. The Department of Civil Affairs provides medical aid for the poor and disadvantaged groups, and the Department of Supervision of Food and Drugs regulates drugs contributing to the development of NCMS.

The central government and local governments play different roles in the operation of the NCMS. There are four major areas embodying the role of central government: planning and policy-making; arranging subsidies from central finance for the provinces involved; setting up and coordinating managing institutions, clarifying their duties, giving general instructions, prompting and coordinating the implementation of policies; and supervising the operating system to ensure safe operation of NCMS funds.

Local governments have other, more relevant duties: helping the implementation of central policies based on local economic situations and social development; publicizing NCMS policies and collecting and raising funds; setting up, managing and supervising institutions to assess and supervise the implementation of NCMS policies and giving advice on how to improve it; and auditing for safe operation.

Nowadays, NCMS fund pooling is conducted at county level in most parts of China. It is the responsibility of the county management office to manage and use this money, draw up specific policies, supervise and assess its
operation, gather data and information and conduct other daily operational work of this kind. With the development of the society’s economy and promotion of the new medical reform policy, management has been transferred. In the two provinces sampled, the NCMS management offices were transferred to the Department of Human Resources and Social Security in Qinghai province in 2011, while the health departments offered assistance with the daily work of administering the NCMS.

As for the design of the system, the NCMS management offices, on behalf of the governments and rural residents involved, purchase needed services from the medical institutions with the funds, which symbolizes their core position in this purchasing mechanism and thus exerts a direct influence on the efficiency of spending and benefits the rural residents involved through the identification of the relationship of NCMS with governments, service providers and rural residents.

**Purchaser-government relationship (PG)**

Using analytical instructions from RESYST, the purchaser-government relationship was analysed from four aspects (PG1-4).

- **PG1.** Content and clarity of the policy and regulatory frameworks within which purchasers and providers operate, including explicit expectations of purchasers, governance structures and mechanisms, purchaser autonomy for day-to-day management, reporting requirements for purchasers, purchaser obligations and autonomy to take action on poor performance and financial protection of the population.
- **PG2.** Mechanisms by which government contributes to promoting equitable access to needed health services by investing in service delivery capacity in currently underserved areas.
- **PG3.** Mechanisms by which government ensures that adequate resources are mobilized and available to purchase services to meet citizen entitlements.
- **PG4.** Mechanisms to ensure the accountability of purchasers to government.
Content and clarity of the policy and regulatory frameworks

Policy design

The responsibilities of each level of government are defined by central government in the NCMS policy. Governments at all levels are responsible for their own implementation plans for designing and implementing NCMS. Table 3 summarizes the main content of policies in this area.

Table 3. Policy design for the purchaser-government relationship

| Ideal theoretical model                                                                 | Establish clear policy and regulatory frameworks within which purchaser(s) and provider(s) will operate, including explicit expectations of purchaser(s), governance structures and mechanisms, purchaser autonomy for day-to-day management, reporting requirements for purchasers, purchaser obligation and autonomy to take action on poor performance. |
| National policy design                                                                   | Regulations for purchasers and providers and measures for implementation and management, supervision and assessment systems should be established by counties, including: |
|                                                                                         | 1. Management system for contracted medical institutions; |
|                                                                                         | 2. appraisal and supervising system for contracted institutions; |
|                                                                                         | 3. annual assessment system for contracted institutions; and |
|                                                                                         | 4. super vision system for services and prices. |
| Policy design in Henan                                                                    | 1. Based on the clinical pathway quality control system, establish the chief quality controller system and leading group for medical quality management. |
|                                                                                         | 2. Set up the achievement assessment system, in which experts are employed to assess the hospitals involved, with city experts working on county hospitals and county experts working on town hospitals. |
|                                                                                         | 3. Combine administrative supervision, peer supervision and third party supervision. Hospital performance will affect the allocation of NCMS funds. |
| Policy design in Qinghai                                                                  | Establish management system for purchasers. County administrative offices are supposed to report revenue and expenditure of the funds, which also need publicizing in the form of notices etc. on a regular basis. This ensures the right of the rural residents involved to participate, be acknowledged and supervise, thus securing the openness, fairness and justice of NCMS. Purchasers are expected to report the spending, management and operation of funds. |

Source: Authors’ summary

Actual practice

NCMS management offices are the operative agencies, which are subject to the health department administrations. In the two provinces sampled, the NCMS management offices were transferred to the Department of Human Resources and Social Security in Qinghai province in 2013, while the health departments offer assistance. Social security bureaus entrust the
management offices with administering NCMS funds, and the latter bear the corresponding obligations and responsibilities.

Both the health departments and the social security departments are in charge of NCMS, commissioning the NCMS offices to purchase services from the contracted institutions with the aim of achieving complete implementation of NCMS policies and deriving the maximum social and economic benefit from NCMS funds, thus ensuring benefits for the rural participants.

The obligations of purchasers are: (1) to regularly report on the implementation of policies and the cost-effectiveness of expenditure to the departments in charge through monthly, quarterly and yearly reports analysing payment and operation; and (2) to submit reports about problems, and to correct them promptly – otherwise they will be investigated and the purchaser will be penalized. Supervision and assessment are conducted by government departments including the Chinese People’s Political Consultative Conference, financial bureau, price department and auditing bureau. Supervision includes day-to-day and annual supervision, and assessment includes both special and comprehensive assessments.

To make better use of NCMS funds, a contract mechanism has been put forward, in which NCMS offices and medical institutions are supposed to sign contracts based on government policies. Negotiations on clinical pathways and prices are subject to the direction, support and participation of government, although they are conducted by NCMS offices and medical institutions. Based on the contracted purchasing mechanism, a system of medical institution management and a quality control system have been set up, and basic medical service packages have been introduced. A supervision system has been introduced, thus reducing pressure and improving efficiency. See Box 1 for quotes from interviews on the policy and regulatory framework.
Box 1. Findings from interviews on the policy and regulatory framework

_Health bureau chief from Yiyang county_: Contracts are actually put forward by our government. The Government is the designer and organizer, the NCMS office is the operator. Contracts should be signed between the NCMS office and medical institutions. There is content like allocation of funds to hospitals, NCMS offices’ implementation of policies, supervision of hospitals and information reports. Negotiations of contracts and compensation have been conducted within the present framework of NCMS.

_NCMS office director from Xi county_: We are supposed to report to the health bureau, which is our leader. We fill out statistical reports every month. Whenever problems come up, we must report to the health bureau and [send] our stage report. The communicative mechanism is very prompt, for we are to be investigated and punished for not correcting mistakes.

_NCMS expert from Qinghai province_: The reimbursement plan, which is the result of negotiations among multiple parties, and NCMS policies are designed and approved by government administrative departments. The implementation of policies is conducted by NCMS offices, as are the auditing and supervision of the medical institutions. Communication between government and NCMS offices aims at improving security level of all civilians and maximum benefits of the spending of NCMS funds.

_Health bureau chief from Xi county_: NCMS is commissioned by the government to purchase services on behalf of the people. NCMS offices are bound to report to us how the funds are spent and we approve of it after careful considerations. We supervise and assess the purchasing of services and implementation of policies, which mainly involves whether compensation is on time, if it is there, if it abides by our regulations, if the service provided is of good quality, if the service is provided in the right procedure, and so on.

_NCMS office director from Huangzhong county_: Communication between the NCMS office and the security bureau about the NCMS purchasing is actually the release and notification of information. And meetings were held when there were changes in policies. Their functions are to supervise and direct us. There are day-to-day inspections and a final assessment every year. Inspection can be targeted as well as comprehensive. When we fail to follow the rules, the inspector will point it out and we will correct it accordingly. Inspections from the security bureau are mostly on procedures. If we don’t follow the regulations, we will be punished. Regulations are there in policy files.
Gaps between theoretical model and policy design

The ideal health services strategic purchasing mechanism should establish a clear system of policy and regulation by government between purchasers and providers. In the NCMS policy design, government, as a client, establishes the policy framework and control system between NCMS and the medical establishment in purchasing and providing services; and clarifies the aims, and management structure, daily management autonomy, job information reporting system, responsibility and financial protection of participants. There are no gaps between the theoretical model and policy design.

Gaps between policy design and actual practice

The NCMS policy design has been described above. In practice, NCMS is entrusted by government departments with the purchase of services, but the government has the right of final decision. This relationship prevents the NCMS playing the role of buyer to the full. NCMS has supervision authority over the medical establishment, but does not have the right to penalize the medical establishment for bad performance – that right falls to the health bureau. This weakens the supervision authority of NCMS.

Mechanisms for government to promote equitable access

Policy design

Insufficient provision of health services in some rural counties would constrain the accessibility of healthcare even though NCMS can provide financial protections. Therefore, it is necessary for some remote and poor areas and groups to take pertinent measures with NCMS to promote access to healthcare. Table 4 summarizes the major content of policies in this area.
### Table 4. Policy design of mechanisms for government to promote equitable access

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Mechanisms by which government contributes to promoting equitable access to needed health services by investing in service delivery capacity in currently underserved areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National policy design</strong></td>
<td>Central finance is supposed to provide pertinent aids to supplement the elementary medical service system and network in poor areas and for groups in great need, including the following.</td>
</tr>
<tr>
<td></td>
<td>1. Strengthen the construction of infrastructure and enhance the capability of relevant personnel in poor areas.</td>
</tr>
<tr>
<td></td>
<td>2. Allocate more subsidies to poor areas and the poor population. Reduce premiums for the extremely poor population and/or exempt this group from paying premiums.</td>
</tr>
<tr>
<td></td>
<td>3. Increase medical aid and compensation for the poor and those in great need.</td>
</tr>
<tr>
<td><strong>Policy design in Henan</strong></td>
<td>1. Increase medical aid and compensation for the poor and those in great need. Medical assistant funds from national and provincial financial accounts should be used effectively to help these poor rural residents in need who have relatively great economic difficulties.</td>
</tr>
<tr>
<td></td>
<td>2. Surplus funds will be used as secondary compensation for the larger medical expenditure of these poor people and those with serious diseases who have joined NCMS.</td>
</tr>
<tr>
<td><strong>Policy design in Qinghai</strong></td>
<td>1. Strengthen infrastructure construction and enhance the capability of relevant personnel in poor areas.</td>
</tr>
<tr>
<td></td>
<td>2. Enhance the capability of elementary medical institutions and provide proper support for the construction of medical institutions in the poor middle-west villages. Central finance is supposed to provide pertinent aids to complete the elementary medical system and network.</td>
</tr>
</tbody>
</table>

*Source: Authors’ summary*

### Actual practice

Both central government and local governments have taken measures to promote fairness and accessibility in areas where the medical service is inadequate. In terms of NCMS funding, central finance provides subsidies, dependent on the different economic levels, to cover 80% and 60%, respectively, of funds to the western and the central regions, with subsidies to the eastern region in a certain proportion. Financial assistance has been provided for the construction of an information platform for the central and western provinces.

Measures taken by Qinghai province are as follows:

- County governments increase their input into health service development in agricultural and pastoral areas;
• infrastructure construction in the health system in these areas is strengthened through anti-poverty projects in villages, partner assistance and individual-to-community assistance, etc.;
• cities have provided more help for rural areas in professional health training to enhance service capability; and
• the human resources system in the rural areas has been promoted to resolve the lack of professional personnel and problem of low professional quality.

Measures for the poor who need special care have been taken in both Qinghai and Henan provinces:
• The extreme poor have been helped to join the NCMS with funding drawn from the medical aid funds; and
• families with serious major diseases can apply for medical aid to get secondary compensation for their high medical expenditure if they are still in great difficulty after claiming medical subsidies.

Gaps between theoretical model and policy design
In the relations between purchaser and government, the ideal mechanism should promote basic health service accessibility by providing investment in areas where the current services are insufficient. In the policy design of NCMS, this aspect is involved, but there are no clear measures or mechanisms to follow, and there is nothing to show the degree to which action has been taken or which goals have been met.

Gaps between policy design and actual practice
In some low income settings, especially rural areas, the quality of health services is still poor because infrastructure and health inputs are lacking and economic development is lagging behind. This is particularly the case in the rural and western parts of China. This reduces the efficiency of the NCMS fund usage. It also affects the fairness of health service accessibility. The proportion of NCMS offices supporting the poor is still low. Coverage is still low, and the rescue fund does not play its proper role.
Government funding mobilization for NCMS

Policy design
The policy of central and provincial governments is clear: the government at central, provincial and county levels needs to mobilize financial resources to support the operation of the NCMS. Table 5 summarizes the major contents of the policies.

Table 5. Policy design of government fund mobilization for NCMS

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Mechanisms by which the Government ensures that adequate resources are mobilized and available to purchase services to meet citizen entitlements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>Ensure the equity and accessibility of resources to fulfil the entitlements. Measures are as follows:</td>
</tr>
<tr>
<td></td>
<td>1. Identify the separate duties of governments at all levels and a reasonable proportion of duty for each in the process of fundraising;</td>
</tr>
<tr>
<td></td>
<td>2. Increase subsidies to poor areas and extremely needy populations by way of fundraising; and</td>
</tr>
<tr>
<td></td>
<td>3. Ensure sufficient personnel expenses and management expenses for NCMS agencies.</td>
</tr>
<tr>
<td>Policy design in Henan</td>
<td>1. Subsidies are provided by central finance and are to be allocated to the NCMS special account only when local subsidies in proportion to their own share of duties are there already.</td>
</tr>
<tr>
<td></td>
<td>2. More financial support is provided to the middle-west areas by central finance in the form of transfer payments. Support capital arranged by local finance at all levels and local taxes are used to set up county rural cooperative medical security and aid funds, which are managed by NCMS agencies in special accounts to help the most needy population.</td>
</tr>
<tr>
<td>Policy design in Qinghai</td>
<td>Ensure sufficient personnel expenses and management expenses for NCMS agencies. Personnel of NCMS agencies are within the authorized size of government administrations or government-affiliated institutions and are financially supported by the government finance budget instead of cooperative medical funds, which avoids diverting payments by the rural participants to the cost of personnel, thus reducing the economic burden on rural residents.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice
NCMS financial sources mainly include individual payments, government financial support and interest income from funds. Government financial support can account for 80% of total funds. In order to guarantee NCMS funds, the individual payments are collected by township and village organizations and then sent to the NCMS financial account. The funds will return to NCMS along with three-level government support funds. The central government provides financial aid to provincial government,
provided that provincial, city and country financial support is provided. All levels of funding are received on time because it is a high priority for government. Although some local financial resources are restricted, support for NCMS is relatively strong.

Government provides funds in accordance with the number of NCMS enrollees included in the budget at the beginning of the year. The NCMS belongs to the health or social security bureau. The NCMS does not operate its own account. The health or social security bureau provides all staff and operating funds. See Box 2 for quotes from interviews on government fund mobilization.

**Box 2. Findings from interviews on government fund mobilization for NCMS**

*Director of health bureau from Xi county:* NCMS doesn’t operate its own account. The Bureau of Health provides all staff and operation funds.

*NCMS expert from Qinghai province:* Government provides NCMS operation funds, [based on] the county coverage population, and is included in the budget at the beginning of the year.

*Director of NCMS office from Huangzhong county:* There are two parts of NCMS funds: one part paid by [the] individual, through the township and village levels of government. We collect the money and submit to financial accounts, then it returns to us. Another part is State aid…from the Bureau of Finance. The financial situation of our government is not very good, but the support is strong.

*Health bureau chief from Hualong county:* There are three levels of funds: financial subsidies by the central government, the provincial government and county government. NCMS participants’ money will be collected and placed in the financial account, then the central government will send money to the provincial government in some proportion. The provincial government sends the central government funds and their own [funds] to the county government, in some proportion. The county government does the same to the NCMS.
Gaps between theoretical model and policy design
In the relations between purchaser and government, the ideal model should ensure that sufficient resources can flow and can be obtained, in order to meet citizen entitlements. In the policy design of the NCMS, this aspect is covered, so there is no significant gap between the theoretical model and policy design.

Gaps between policy design and actual practice
The financial base of the NCMS is relatively narrow, with 80% of NCMS being funded by different levels of government. Scarcely any funds come from social or private investment. This may affect the stability and sustainability of fundraising in the future. Besides, in order to maintain the financial balance of the NCMS, it pays more attention to preserving the safety of the funds. This can limit the benefit package/lead to less financial protection.

Ensure accountability of purchasers to government

Policy design
Table 6 summarizes the responsibilities and obligations of each relevant department, agency and contracted institution to protect the legal interests of rural participants and provide them with convenience and good service.

Table 6. Policy design of government accountabilities of purchasers

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Mechanisms to ensure the accountability of purchasers to government.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>To ensure accountability of purchasers to government, the following mechanisms have been set up.</td>
</tr>
<tr>
<td></td>
<td>1. Purchasers are accountable to government through reporting about NCMS funding arrangements and purchasing.</td>
</tr>
<tr>
<td></td>
<td>2. Price negotiation and reimbursement should conform to the NCMS policy framework and government instructions.</td>
</tr>
<tr>
<td></td>
<td>3. Purchasers who break NCMS policy and regulations will incur corresponding penalties.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice
Government entrusts NCMS with purchasing medical services on behalf of government and participants. Government, as the principal authority,
has the right to supervise the NCMS, and the NCMS office is responsible to government for purchasing mechanism design and implementation. The responsibilities of the NCMS are as follows:

- NCMS offices regularly report their operating situation to government and supervisory departments and submit fund payment information statements;
- the agreement signed between the NCMS and medical institutions needs to follow NCMS policy. The NCMS should undertake the corresponding responsibility if it violates the provisions or does not perform well;
- the NCMS is responsible for the supervision of medical institutions which provide services and financial compensation. It is the duty of NCMS to ensure a high quality of service. Only if the standard is satisfied can NCMS money be paid; and
- the NCMS is responsible for the security of fund operation and rational use of funds. It is very important to achieve financial balance. NCMS should make sure that the interests of participants are satisfied.

See Box 3 for interviews on accountability of purchasers.

**Box 3. Findings from interviews on accountability of purchasers**

*Director of Health Bureau from Xi county:* NCMS should have rights to regulate the medical institutions and funds compensation; better regulation, better management. I will not give you money if you cannot meet the standard; the quality of service must be guaranteed.

*NCMS director from Xi county:* NCMS on behalf of the government buys the service, the county government is my boss. We have an information statement reporting to the regulatory authority. This is the regulation for us. If there is no accordance with the NCMS policies, or there are illegal practices, or if we do not perform well, we will be held responsible. The government supervises our efficiency, and we are responsible to them. Funds belong to the Bureau of Finance, and they are only responsible for its safety and reasonable use. NCMS is responsible for spending money, and the Bureau of Finance supervises money trends.
Box 3. Policy design of action to improve health system efficiency (Con’t.)

**Officer of health bureau from Hualong county:** Department of Health and NCMS communicate, outpatient service money is sent directly to hospitals, because hospitals and village doctors form a hierarchy. Township hospital funding that is paid directly to the village doctor is more effective. The NCMS responsibility is to play the role of supervisor, to guarantee the compensation funds.

Gaps between theoretical model and policy design

In the relations between purchaser and government, the ideal model should design and provide a mechanism to ensure that purchasers are responsible to the government. In the policy design of NCMS, this aspect is covered, but there are no clear measures or mechanisms to follow, and nothing to show the degree to which action has been taken or which goals have been met.

Gaps between policy design and actual practice

The governments hardly monitor and evaluate the performance of NCMS overtime. Usually the performance of NCMS is evaluated at the end of the year following implementation, and taken into account in the following year’s policy adjustment. The current government evaluation index for NCMS mainly includes the number of people benefited and the amount of compensation; there is no in-depth assessment of social problems which have been resolved or the influence on health of NCMS activities.

**Purchaser-provider relationship (PP)**

Using the RESYST analytical tools, the purchaser-provider (PP) relationship was analysed from the following aspects.

- **PP1.** Mechanisms by which purchasers take active decisions on which providers to purchase services from, with consideration given to quality, ability to provide an appropriate range of services and location relative to the distribution of the population.

- **PP2.** Mechanisms by which purchasers take action (e.g. through equitable distribution of financial resources and providing
appropriate incentives) to extend services to geographically inaccessible and underserved areas.

• **PP3.** Mechanisms by which purchasers take action to improve health systems efficiency through rational provision and use of services, by means of effective gatekeeping and referral, effective provider payment methods, use of monopolistic purchasing power, use of generic essential drug lists and standard treatment guidelines.

• **PP4.** The process for purchasers to monitor provider performance, including quality of care, and provide appropriate penalties for non-adherence (e.g. quality improvement plans or de-accreditation, being mindful of limited options when the healthcare provider is the sole provider in the locality).

• **PP5.** Arrangements for and mechanisms to enforce contractual agreements with qualified public and private providers that encompass the range of services required, compliance with standard treatment guidelines, quality expectations, payment issues, requirements for information submission, penalties or instituting corrective action for non-performance.

• **PP6.** Arrangements for and mechanisms to implement and appropriately adjust provider payment methods that send signals to enhance and maintain quality and efficiency, and design and monitor user payment policies to prevent financial catastrophe (including control of balance billing, co-payment limits).

• **PP7.** Mechanisms to ensure mutual accountability between purchasers and providers through timely payments to healthcare providers and appropriate audit systems.

• **PP8.** Mechanisms for purchasers to manage finances in a transparent and accountable way, protecting against fraud and conflict of interest, and ensuring that expenditure and revenue are aligned.
Service purchasing

Policy design

Selecting qualified providers is crucial to assure the quality of medical care provided for patients. The entry and exit mechanism for contracted hospitals creates competition and incentives among providers to improve their performance, which is clearly defined in the mechanism of the purchasers for providers, as shown in Table 7.

Table 7. Policy design of mechanism of purchasers for expected services purchased

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Take active decisions on which providers to purchase services from, with consideration of quality, ability to provide appropriate range of services and location relative to the distribution of the population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>Selection of NCMS-contracted hospitals should follow these principles.</td>
</tr>
<tr>
<td></td>
<td>1. Reasonable layout; easily accessible to farmers in NCMS.</td>
</tr>
<tr>
<td></td>
<td>2. Reasonable structure. The medical institutions should be non-profit, comprehensive and specialist, practising both traditional Chinese medicine and Western medicine, satisfying the medical needs of residents.</td>
</tr>
<tr>
<td></td>
<td>3. Rational allocation of health resources, more funding invested in the western region and underserved areas.</td>
</tr>
<tr>
<td></td>
<td>4. Dynamic management. Entry and exit system for the contracted institutions should be established.</td>
</tr>
<tr>
<td>Policy design in Henan</td>
<td>According to the regulations of Henan province, to ensure the quality of medical services, designated medical institutions should satisfy the following requirements.</td>
</tr>
<tr>
<td></td>
<td>1. The hospital should obtain the “Practice Licence for a Medical Institution” and admittance permissions of professional medical services.</td>
</tr>
<tr>
<td></td>
<td>2. A qualified hospital management system, standard diagnosis and treatment guidelines, comprehensive measures to control medical costs, and professional personnel and facilities are required.</td>
</tr>
<tr>
<td></td>
<td>3. An information management system should be established to undertake designated medical services, a network of hospital information systems and new rural cooperative medical information management systems should be created to ensure timely reimbursement to patients.</td>
</tr>
<tr>
<td>Policy design in Qinghai</td>
<td>1. Services for farmers and herdsmen, Tibetan Mongolian medical technology should also be provided.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary
Actual practice

For approval of NCMS-contracted hospitals, the local governments have launched regulations for NCMS-contracted hospitals in Henan province and supervision and management regulations for NCMS-contracted hospitals in Qinghai province according to local economic development and social status. The application procedure and approval process are clearly stated in these regulations.

Gaps between theoretical model and policy design

According to the requirements of the strategic purchasing mechanism, the designated medical institution shall be selected in consideration of its medical quality, range and ability to provide medical services, and the convenience of residents for medical treatment. Detailed provisions are given in the policy of application of the conditions of the designated medical institution, such as hospital size, service content, etc.

Gaps between policy design and actual practice

Implementation of the policy is good, with all counties surveyed able to comply with the management method, selecting both public and private hospitals which meet the requirements. Meanwhile, medical institutions to provide specific services are encouraged, e.g. oral-dental hospital, gynaecological hospital. In Qinghai province, special Tibetan medicine technology is encouraged, which ensures comprehensive medical services for the residents and reduces the burden of medical care. The contract period in Henan province is two years, and in Qinghai one year.

Action for equitable distribution of services

Policy design

To ensure equity and efficiency of medical care, favourable policies including financial subsidy and personnel attraction incentives have been implemented in the western region and underserved areas. Yet inequality still exists and primary hospitals are finding sustainable development challenging in the long run. The content of the policy design is summarized in Table 8.
Table 8. Policy design of action for equitable distribution of services

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Take action to extend services to geographically inaccessible, underserved areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>1. In the economically underdeveloped regions, in order to improve the rate of service delivery in hospital, subsidies are given for normal hospital service delivery by the cooperative medical fund to enrollees.</td>
</tr>
<tr>
<td></td>
<td>2. Setting different deductible and reimbursement ratios, i.e. low deductible and high reimbursement rates, for primary medical institutions.</td>
</tr>
<tr>
<td>Policy design in Henan</td>
<td>1. The growth rate of average inpatient cost overtime in township medical institutions is allowed to be 10% higher than those of county institutions.</td>
</tr>
<tr>
<td></td>
<td>2. For the global budget provider payment, the increase in the amount of prepaid funds for primary medical institutes is higher than for county-level hospitals.</td>
</tr>
<tr>
<td>Policy design in Qinghai</td>
<td>1. Making full use of the “Supporting the Poor” programme to strengthen infrastructure construction and improve medical care facilities in rural areas, with the emphasis on township health centres.</td>
</tr>
<tr>
<td></td>
<td>2. Strengthening management, increasing urban health support and investment, strengthening the professional and technical training of healthcare personnel, standardizing treatment guidelines and improving the quality of services in rural areas.</td>
</tr>
<tr>
<td></td>
<td>3. Advancing the reform of the personnel distribution and promotion system of health institutions in agricultural and pastoral areas, stimulating the enthusiasm of the staff, hiring medical college graduates to work in township hospitals systematically every year, and solving the problem of shortages of technical health personnel and the problem of low technical quality of healthcare in agricultural and pasture areas.</td>
</tr>
</tbody>
</table>

*Source:* Authors' summary

**Actual practice**

In order to encourage medical institutions to provide high-quality medical services for residents from outlying districts, policy-makers encourage residents to access medical care in basic-level hospitals, mainly by setting higher reimbursement rates for medical treatment in basic medical institutions than in the municipal and provincial hospitals.

Policies have been adopted in Henan province in favour of basic-level medical institutions, through a higher growth rate of the global budget payment arrangement and the cost of inpatient care; in Qinghai province,
medical experts and graduate students are encouraged to work in rural areas with higher pay and favourable promotion arrangements, in order to ensure the accessibility of medical services in these areas. But these incentives have not had a major impact in the basic-level medical institutions. First, highly educated young doctors are unwilling to work in the countryside, which leads to a severe loss of expertise in public health centres in villages and towns and an inconsistent quality of care. Also, with the rural residents’ increasing ability to pay and their health requirements changing, they would rather spend more money and go to the provincial hospital than to a hospital near their home. Patients are the source of the hospital’s income, so the long-term development potential of the basic medical institutions is limited.

See Box 4 for quotes from interviews on action for equitable distribution of services.

**Box 4. Findings from interviews on action for equitable distribution of services**

*Doctors A and B from Ganhetan township health centre in Huangzhong county, Qinghai province*

A: But the problem is, we can’t give proper treatment for some diseases because of the limitation of personnel and facilities. So many patients go to more advanced hospitals. That is the reality. Even you, you want to go to bigger cities.

B: The salary is too low in basic-level hospitals. No one wants to stay here.

**Gaps between theoretical model and policy design**

In order to make health services accessible, in addition to providing sufficient financial support for medical institutions in remote areas, purchasers should also create other incentives, such as redefining the function of the basic-level medical institutions to ensure the sustainable development.
Gaps between policy design and actual practice

Various policies are used to encourage graduates and young doctors to work in remote, underdeveloped areas, e.g. providing financial subsidies and priority when changing to formal employee status, but the survey shows that these preferential measures have not solved the problem of brain drain.

Action to improve health system efficiency

Policy design

NCMS is trying to improve health system efficiency by implementing a two-way referral policy and a mixed provider payment method and by designing and implementing an essential drug list and standard treatment guidelines. There are challenges and deficiencies in real practice, and improvements are needed. Table 9 summarizes the policy design for this aspect.

Table 9. Policy design of action to improve health system efficiency

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Take action to improve health systems efficiency through rational provision and use of services, by means of effective gatekeeping and referral, effective provider payment methods, use of monopsonistic purchasing power, use of generic essential drug lists and standard treatment guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>1. Implementing the essential drugs list for NCMS reimbursement, standardizing the use of medicines in hospitals, reducing medical costs and ensuring rational use of drugs.</td>
</tr>
<tr>
<td></td>
<td>2. On the basis of the Guidelines on Promoting the Reform of the Payment Method of the New Rural Cooperative Medical System, a variety of payment methods have been implemented, such as diagnosis-related groups, case-based payments, capitation payments and global budget payments, to encourage the medical institutions to adjust the structure of medical income, to control excessive investigations and to achieve standardized medical treatment and cost control.</td>
</tr>
<tr>
<td></td>
<td>3. Lowering drug prices by implementing drug bidding as a purchasing process. The Government has promulgated the National Medical Service Price Standard.</td>
</tr>
<tr>
<td></td>
<td>5. Establishing a two-way referral system and setting stringent standards for transferring treatment out of the county, setting different deductible and compensation rates for medical benefits in medical institutes at different levels; guiding the patient to the right department and improving the efficiency of services.</td>
</tr>
</tbody>
</table>
### National policy design

6. In 2006, the Ministry of Health issued diagnosis and treatment guidelines for Western, traditional Chinese medicine and for combined Chinese and Western medicine; clinical operational norms and the Chinese National Formulary were also issued, for the reference of medical institutions and personnel.

7. Clinical pathway management for eight diseases has been conducted since 2009. The range of clinical pathway management is gradually growing larger.

### Policy design in Henan

1. Reform of comprehensive payment methods has been under way since 2009. Diseases are categorized into three groups (A, B and C) according to clinical pathway management principles, with the charges varying from group to group, which effectively controls the unreasonable growth of medical expenses and promotes the rational allocation and utilization of health resources, as well as reasonable criteria for assessment of medical care quality.

2. Enrollees who need to be transferred to contracted provincial hospitals for hospitalization should first obtain a referral letter from the county health institute and then undertake the referral procedure through the new rural cooperative agency. For patients who go to designated provincial hospitals for hospitalization without the referral letter from the county health institute, reimbursement will be reduced by 10%. The designated provincial medical institute has an obligation to inform patients of the above policy. For patients who go to designated provincial hospitals for hospitalization without being informed, the 10% of compensation expenses will be assumed by the hospital.

3. NCMS-contracted hospitals should standardize the procedure of purchasing by drug bidding to ensure drug quality. The mark-up percentage and retail price of drugs shall not be higher than the price set by the price control authorities, and the price of medical services shall not be higher than the government guidance price.

4. Editing of Diagnosis and Treatment Guidelines for Diseases in Rural Areas of Henan and 50 Clinical Pathways in the Rural Areas in Henan for reference in later practical work.

5. Price negotiation mechanism: the NCMS office sets the price of single disease categories and the mode of payment. The price should be set through negotiation between medical institutes and the NCMS office using a combination of clinical pathway assessment and average expenses.
A critical analysis of purchasing mechanisms in China’s rural health insurance scheme

Table 9. Policy design of action to improve health system efficiency (Con’t.)

<table>
<thead>
<tr>
<th>Policy design in Qinghai</th>
<th>1. Strict implementation of the medical insurance diagnosis and classification system. Farmers can choose freely among the designated medical institutes in the county. Farmers who go to more advanced hospitals than the county hospital should have a referral letter from the county designated hospital and complete the referral procedures at the county cooperation office.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Strict implementation of the NCMS Essential Drug Catalogue in Qinghai province. Medical personnel should adhere to the rational use of drugs and reasonable treatment in order to control the unreasonable growth of medical costs effectively.</td>
</tr>
<tr>
<td></td>
<td>3. Diagnosis Standards of Disease, Conventions of Treatment of Diseases, Admission and Discharge Standards of Disease and Curative Effects Criteria have been drawn up and put into practice.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice

In order to improve the operational efficiency of the health system, the policy-makers standardized doctors’ prescription of medication, implemented a mixed payment system to control the unreasonable growth of medical expenses, and distributed patients by adopting the mutual referral system. The mixed payment method reform has been under way in Henan province since 2009. Patients are assigned to group A, group B or group C. Patients in group A and group B pay their medical expenses using case-based payment, with the NCMS paying most of the cost. Patients in group C pay using the fee-for-service payment method, with the NCMS reimbursing a fixed proportion of the cost. Although medical expenses in society as a whole are increasing continuously, average hospitalization costs in Xi county hospital from 2009 to 2013 decreased by 1%, showing that medical expenses can be controlled by changing the mode of payment. Most interviewees consider the mixed payment method reform to be an incentive for controlling expenses, while some think that the pathway should be perfected by adjusting prices accordingly, with the influence of basic drug policy taken into consideration. In addition, NCMS also encourages medical institutes to innovate in improving health service quality and controlling medical expenditure. See Box 5 for quotes from interviews on practice in improving health system efficiency.
Box 5. Findings from interviews on practice in improving health system efficiency

*President of Yiyang county hospital, Henan province:* Essential drug list and regulation is implemented by the country, and we have to use essential drugs to follow clinical pathway. If we use drugs that are not included on the list, we will be punished due to excessive medical treatment. The punishment is not reasonable.

*Director of Lianzhuang township hospital:* We now use per diem payment instead of fee-for-services and set the average expenses, amount of drug prescription and number of health examinations, which is put under supervision and audit to control the medical expenses. Because of the high reimbursement rate of NCMS, increase of farmer’s income and change in health consciousness, farmers tend to choose more advanced hospital instead of health clinics in towns and townships. Patients in obstetrical department and department of general surgery in health clinics and township hospitals are getting fewer, with more patients choosing county hospitals for hospitalization.

*Director of Zhaba town health clinic, Qinghai province:* NCMS encourages us to be innovative. For example, we try our best to only prescribe necessary drugs. For common cold, we only prescribe drugs for 3 or 4 days rather than for 8 or 10 days, to avoid prescription of high price. By doing this, we can control the medical expenses and improve the service quality.

*Director of Xiazhuang people’s hospital in Henan province:* NCMS encourages us to take new measures in this field. Our hospital tries to control the medical expenses by including more diseases into clinical pathway.

By applying the classified diagnosis and treatment system and the two-way referral system, the proportion of patients who go to higher-level hospital decreases, and this may lead to the use of the medical resources more reasonably and lowers the patients’ expenses. The two-way referral policy refers to the fact that patients should get official permission from the doctor before they transfer to higher-level hospitals, and doctors should recommend that patients transfer to lower-level hospitals for rehabilitation. However, there exist many difficulties in the implementation of the mutual referral system. For lack of corresponding regulatory measures, the basic-level medical institutes can only provide very limited medical services and the function of medical institutes at all levels needs to be perfected. The
two-way referral system is somehow a mere formality. See Box 6 for quotes from interviews about the referral system.

**Box 6. Interviews on referral system**

*Office administrator of Huangzhong county hospital, Qinghai province:* It’s set by the superior department that the referral ratio of our hospital can’t be more than 30%, which is in favour of county hospital. It means that we should see to it that we have patients in our county hospital. Patients with ordinary disease will stay in county hospital.

*Director of Ganhetan hospital in Huangzhong county, Qinghai province:* Conditions in the basic-level health clinic are very limited. Lots of patients come to us for referral letter after they go to higher-level hospital for medical advice. If we don’t give them the referral letter, they will quarrel with us. I think the mutual referral system put a limitation on patients. They don’t have the freedom to choose which hospital to go to.

**Gaps between ideal model and policy design**

Based on the strategic purchasing requirements, in order to improve the working efficiency of the health system, the purchaser should take measures to encourage a reasonable supply and use of health services. Policy-makers in the country have established the referral system and obtain a reasonable diversion of patients. Meanwhile, the implementation of mixed modes of payment prompts the medical institutes to improve care quality and control the growth of medical expenses. Using purchasers’ monopsony power, the government and the NCMS office set the price of medical services and drugs so that the price of medical services is lowered and the capacity utilization rate is increased. In addition, doctors’ practice is standardized by the enactment and promulgation of the basic drug system and clinical diagnosis and treatment guidance, which also improves health service quality by encouraging rational prescribing. The survey shows that the government is the price-maker, while the NCMS office is the purchaser of the service, but with no right to fix the price. Thus, purchasing power will decrease and cause difficulties in carrying out the policies.
Gaps between policy and practice

First, the Government exercises monopsony power by fixing and adjusting medical prices. However, the process of setting the price of medical services is not adequate. For instance, price-setting does not reflect the technical services and knowledge values, the price of investigations using high-tech medical equipment is too high, and prices are updated too slowly.

Second, the NCMS office controls the price of drugs by means of centralized drug bidding procurement. The price for basic drugs is relatively low and the profits of drug producers and shipping companies are affected, so that some basic drugs cannot be shipped to health centres in towns on schedule.

Finally, the global budget payment method improves the self-control of hospitals, while burying problems of medical quality. If they were acting only in their own interests, hospitals would relax management control over medical quality in the first half-year and reduce the level of services to save expenditure in the second half-year. Moreover, moral hazard may arise, e.g. the hospital may find excuses to refuse patients.

Monitoring provider performance

Policy design

In both Henan and Qinghai provinces, provider performance monitoring and quality control measures have been provided. Yet the standardized medical quality control process within hospital and third-party accreditation is missing in primary hospitals. The content of the policy design is summarized in Table 10.
Table 10. Policy design for monitoring provider performance

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Monitor provider performance, including quality of care, and provide appropriate penalties for non-adherence (e.g. quality improvement plans or de-accreditation, being mindful of limited options when the healthcare provider is the sole provider in the locality).</th>
</tr>
</thead>
</table>
| National policy design   | 1. Contents of supervision: whether prescribing is reasonable and normative; whether the medical charges are reasonable; whether the readmission rate and repeated inpatient rate appear to have increased; whether the essential drug list and clinical guidelines have been implemented; whether the pricing of drugs and diagnosis and treatment items are in accordance with the pricing policy; whether medical document management has met requirements; and whether there has been an obvious increase in average hospitalization expenses, per capita outpatient costs and operating income.  
2. Medical institutes that violate the regulations will not have their contract renewed. |
| Policy design in Henan   | 1. Combination of external control and internal control (Xi county): External control — a healthcare reform leading group at county level has been established, which carries out a performance appraisal of the health-service provider every quarter- or half-year and issues independent evaluation reports. The leading group will decide to reward, punish or censure the service provider on the basis of the appraisal results.  
Internal control — each medical institute sets up a quality-control expert group, performance appraisal group and quality-control staff (at hospital and department level). An internal communication system has been established at department and hospital level.  
2. Performance appraisal (Yiyang) — mid-year and annual appraisals of the designated medical institutes every year. The indicators include the rate of growth of average hospitalization expenses, average hospital stay, actual compensation ratio, medical service quality, evaluation of reform of the mixed-payment method, patient satisfaction survey, etc. |
| Policy design in Qinghai | 1. An evaluation and assessment system is applied to the designated medical institutes. The county health administrative bureaus and social insurance bureaus inspect and evaluate NCMS-contracted hospitals.  
2. Public and private investigations are conducted and third-party inspectors monitor medical service quality and medical charges in the designated hospitals. The evaluation results will determine whether those medical institutes can renew their contract the following year. |

Source: Authors’ summary
Actual practice

To enhance medical service quality, purchasers need to strengthen their evaluation of hospital performance. Purchasers in Xi county have critically assessed the following five aspects of hospital performance for inpatient medical care: organization management, outpatient service management, inpatient service management, outcome evaluation and design of the health information system. Each contracted hospital has to report to NCMS office show well the NCMS policy has been implemented. In addition, NCMS offices will randomly examine the medical case history of each hospital by checking clinical pathway operation, medical examinations, drugs and antibiotics, etc. to identify non-adherence and to impose penalties. After the comprehensive payment method reform has been carried out in Henan, hospitals have to observe clinical pathway management. And each hospital has to designate a quality control officer to ensure the quality of medical care. In Qinghai province, clinical pathway management has also been applied to certain diseases. See Box 7 for quotes from interviews on monitoring provider performance.

Box 7. Findings from interviews on monitoring provider performance

*Director of NCMS office of Xi county, Henan province:* One evaluation index for hospital performance assessment is coincidence rate of clinical pathway which is settled at 95%. According to our evaluation, coincidence rate in county hospital is 92%, and 86% in township hospitals.

*Director of Caohuangling township hospital, Xi county, Henan province:* We have established the medical service evaluation group which is responsible for quality control of medical care. A medical controller checks whether medical treatment is consistent with the clinical pathway for inpatient medical care.

*Director of Lianzhuang township hospital, Xi county, Henan province:* NCMS office takes performance assessments for each hospital, and the assessment process with indicators are clearly specified. The assessment is conducted twice a year, with a mid-year and year-end checking. I think this performance evaluation will play an effective supervision role to our hospitals especially in improvement of medical care and to secure NCMS funding operation. The assessment is based on the result of random case history checking and the hospital will receive sanction for disqualification. The sanction will be public exposure, informed criticism, and 10% funding from global budget will be cancelled.
Gaps between theoretical model and policy design

Purchasers formulate assessment criteria to evaluate medical quality and performance of provider regularly. The explicit sanctions are listed in the contract. The results of performance evaluation will determine contract renewal for each provider. In Henan province, the purchaser tries to control quality of medical care through clinical pathway management and supervision by health administrations, and encourage providers to improve the quality of medical care and control expenses at the same time. However, the standard medical quality control process and internal and external accreditation are lacking. It is highly recommended that a medical control process should be introduced in hospitals.

Gaps between policy and actual practice

It is stated that the NCMS offices examine the medical case histories at each hospital in order to critically assess the hospital’s operational performance. However, in practice, only a small number of medical case histories will be examined owing to the shortage of staff. And this may mean that illegal practices go unpunished.

Second, purchasers are responsible for creating incentives, i.e. rewards and penalties to encourage medical institutions to improve the quality of care and decrease medical expenditure. However, it is surprised to find that weak responses to the incentive, within only a few hospital acting accordingly. The reason is that the incentive mechanisms are not clearly stated in the contract and the rewards have little impact on doctors or hospitals. See Box 8 for quotes from interviews on gaps in policy design and practice.
Box 8. Findings from interviews on gaps in policy design and practice in monitoring provider performance

Director of the People’s Hospital of Huanzhong county, Qinghai: The NCMS office is responsible for monitoring medical care by checking case histories to identify medical services, drugs and other charges. However, because of the lack of capacity, the supervision has not been done regularly.

Chief of paediatrics of the People’s Hospital of Hualong county, Qinghai: How well clinical pathway management is implemented will be checked in the performance appraisal. One point of reward will be given for total accordance with the clinical pathway. But the bonus is only RMB 50 for one point. The purpose of implementing the clinical pathway is to encourage doctors to follow standardized clinical treatment, and we will not care about extra hundreds of bonus.

Finally, hospitals are affiliated with the health administration department; in other words, the provider is subordinate to government. This governance structure will save management costs, but may lead to deficiencies in supervision. The reason for this is that communication, information transfer and policy implementation will operate very smoothly between providers and government and thus save transaction costs. On the other hand, however, government powers of supervision may be weakened because government turns a blind eye to providers’ irregular performance. This has happened occasionally.

Design and enforcement of contractual arrangements with health providers

Policy design

Providers are accountable to purchasers by virtue of the contracts they sign and fulfil, which explicitly state requirements, rights and obligations, as well as penalties for non-fulfilment. Table 11 summarizes the policy content of these contractual arrangements.
Table 11. Design and enforcement of contractual arrangements with health providers

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Design and enforce contractual agreements with qualified public and private providers that encompass the range of services required, compliance with standard treatment guidelines, quality expectations, payment issues, and requirements for information submission, penalties or corrective action for non-performance.</th>
</tr>
</thead>
</table>
| Policy design in Henan  | 1. Critically assess contracted hospitals in management, healthcare quality, expenditure control and enrollee compensation. Make the results public.  
2. Manage de-accreditation of hospitals for not complying with regulations.  
3. Sign contract every two years.  
4. Negotiate prices for the chosen provider payment method. |
| Policy design in Qinghai | 1. NCMS-contracted hospitals sign contract with NCMS offices and follow regulations strictly.  
2. The contract signed by NCMS office and medical institutions clearly states the entitlement and obligations of both sides. Penalties are also clearly defined.  
3. Sign contract every two years. |

Source: Authors’ summary

Actual practice

The medical service contracts of NCMS-contracted hospitals in Henan province were drawn up by the county NCMS office, where the feedback information from various medical institutions was summarized, and contracts were revised and signed. The NCMS office also drew up the policy documents, including those on implementation of clinical pathway management, reform of the mixed payment method and quality evaluation. Implementation of the clinical pathway, case-based payment method and prices paid were decided by negotiation between the county NCMS office and medical institutions. Price negotiation was dominated by the Health Bureau and performed by the NCMS office. Price negotiations did not go smoothly in the beginning. Adjustments were made by the NCMS office after the contracts had been implemented for a year, including increment to disease entities, refinement of clinical pathways and increases or decreases in costs. Contracts were signed yearly and well implemented. See Box 9 for quotes from interviews on practice in contractual arrangements.
Box 9. Findings from interviews on practice in contractual arrangements

**Director of Xiazhuang Hospital, Henan:** The contracts drawn up by the county NCMS office were issued to various medical institutions for discussion and feedback. Directors and head nurses of all departments were organized to have a discussion and suggestions were summarized and submitted to the county NCMS office. After modification by the office, the contracts were formally signed by the two parties. Contracts were well implemented.

**Director of Xi county People’s Hospital, Henan:** For the paid price negotiation, the hospital calculated first, and then negotiated with the county NCMS office, and the prices were finalized. Generally the prices may increase by 5% per year.

**Director of Yiyang county People’s Hospital, Henan:** The negotiation process is not smooth. The hospital hoped the county NCMS office could actively solve their reported problems, and reflect them in the contract modification and formulation. In addition, entity prices could be fine-tuned based on the previous year’s basic data. The main problem in contract implementation was that supervising officers were not professional, and were not quite sure about the punishment standards, punishment forms, and even whether they should punish offenses.

**Director of Hualong county NCMS office, Qinghai:** The NCMS office drew up the contracts and negotiated with the hospital representatives. Contracts were signed after agreement. The whole process may last about half a month. All medical institutions basically could comply with the provisions of the contracts.

The service contracts of designated medical institutions in Qinghai were authorized by the county social security bureaus, drawn up by the county NCMS office, and issued to various medical institutions for advice. Contracts were signed after negotiation yearly, in the first half of the year. Contract negotiation and signing went smoothly. The county Social Security Bureaus also issued Measures for the Management of Designated Medical Institutions of Rural Cooperative Medical Care and Single Disease Payment Reform Plan, and defined rights, obligations and related incentive measures for both service purchasers and service providers, which were required to be strictly implemented by various medical institutions. From interviews, we found that contracts and related policies were well implemented.
Gaps between theoretical model and policy design
Medical service purchasers draw up the contracts, define both sides’ rights and obligations and, after contract signing, make sure that medical institutions comply with the provisions by means of incentive measures. The prices to be paid for medical service are decided after their negotiation, which fully represents the interests of medical institutions and is consistent with the requirements of the strategic purchase model for purchasers. Thus there is no significant difference between policy-making and the ideal purchase model.

Gaps between policy design and actual practice
It was found from the investigation that the key problem in the contracting process in Henan is mainly in the design of pathway management and the final price negotiations. The negotiation often takes a long time. The NCMS office forced the prices down, which put pressure on medical institutions.

Provider payment system
Policy design
The current payment method for inpatient care is global budget payments, with case-based payment for several diseases of provider payment methods and fee-for-service payments of user payment policy in both of study provinces. The policy of timely reimbursement of inpatient medical expenditure soon after or at patients’ discharge is in place to prevent financial catastrophe. Table 12 summarizes the main content of policies in this area.

<table>
<thead>
<tr>
<th>Table 12. Policy design of provider payment system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ideal theoretical model</strong></td>
</tr>
<tr>
<td><strong>National policy design</strong></td>
</tr>
</tbody>
</table>
Policy design in Henan

Provider payment methods

1. The entities in the diagnosis-related group prospective payment scheme (DRG-PPS – diseases related to the case-based payment system) should be increased on the basis of the global budget. A combined method of payment of DRG-PPS and the per diem system should be explored.

2. Over-expenditure is shared. After comprehensive appraisals, if the designated medical institution cannot meet the requirements of the quality control indicators, a proportion of the prepaid NCMS funds will be deducted.

3. Provider payment method: the global budget payment method has been implemented. The yearly total prepayment fund is paid by monthly appropriation in advance and year-end settlement. The total prepayment is divided up by month. Ninety percent of the global payment amount is deposited to the medical institution at the beginning of each month. The settlement of pooling funds is conducted at the end of the year.

User payment policies

1. Patients are reimbursed when they leave hospital. The part of the hospitalization costs after proportional reimbursement which is payable by the patient is paid to the hospital when the patient is discharged. The fee-for-service payment method has been used.

2. The medical aid system for serious diseases.

Policy design in Qinghai

Provider payment methods

1. Single-disease quality control and the case-based payment method have been implemented by all levels of designated medical institutions: 29 single diseases for county-level hospitals and 14 for town-level hospitals.

2. The global budget payment method with prospective payment system is used. The hospitals bear the excess costs.

User payment methods

1. People enrolled in NCMS can select their hospital at all levels of designated medical institutions within the province, and their medical expenses are reimbursed immediately. The reimbursement rate and deductions are based on compensation standards.

2. Outpatient medical expenses are paid by the family accounts. Twenty-two special diseases and chronic diseases are included in the scope of reimbursement for outpatients. Reimbursements are paid to the patients proportionally, and the settlement is performed at the end of the year.
A critical analysis of purchasing mechanisms in China’s rural health insurance scheme

Table 12. Policy design of provider payment system (Con’t.)

| Policy design in Qinghai | 3. The ceiling for reimbursement of inpatient expenses for 21 very serious diseases is RMB 200,000. Medical expenses are paid according to the case-based payment method. After regular reimbursement and second reimbursement, patients who qualify for assistance from civil ministries are awarded assistance reimbursement according to the Medical Aid Policy.  
4. A one-stop service for NCMS reimbursement and medical aid reimbursement is provided for patients who qualify, paid initially by the designated medical institutions and settled at regular intervals with the NCMS office. |

Source: Authors’ summary

Actual practice

Henan implements a global budget for total prepayment. Ninety percent is paid in advance, and the rest is settled at the end of the year on the basis of the results of the performance assessment. Prospective payments are made to the county-level hospitals twice a month, and to the township hospital once a month. The quality of the medical care provided by the medical institutions is reported every month to the NCMS office, which returns the patients’ records to the hospital after review.

Qinghai uses the global budget payment method. The budget is prepaid every month, and hospitals assume any excess medical expenditure. The inpatient medical expenses of enrollees are reimbursed by the medical institutions when they leave hospital.

Qinghai and Henan allow enrollees to select a hospital themselves among designated medical institutions anywhere in the planning region; inpatient costs are reimbursed immediately after discharge. It was found from the interviews that patients were very aware of their hospitalization costs, and the policy of instant reimbursement on discharge was convenient and transparent. Besides, the reimbursement rate is high, which obviously alleviates the finance burden. See Box 10 for quotes from interviews on the provider payment system.
Box 10. Findings from interviews on practice on provider payment system

**Director of Huanglin town hospital in Xi county, Henan province:** Reimbursement process by the NCMS-designated medical institutions is that the medical records of the patients are handed over to the supervisors of NCMS after signing, and then sent to the NCMS office, which transfers the money to the hospital accounts after review.

**Doctor of Dayuan hospital in Huangzhong county, Qinghai province:** This year’s contract is carried out based on prospective payment system for total prepayment. Medical expense for each patient is not allowed to [exceed] 650 RMB. The hospital has to bear the excess part. Part of the excess expense is deducted from the money in social security, or we are under penalty of equal amount of fine, which restrains us a lot.

**Patient of Ganhetan town hospital, Huangzhong county, Qinghai province:** Now 80% of hospitalization expenses can be reimbursed, much better than before. No reimbursement [was received] before NCMS was implemented. Much of the medical burden has been eased, and we just pay what we should pay, and it’s very convenient.

**Gaps between theoretical model and policy design**
In the strategic purchase mode, purchasers should implement and adjust the system of payment for the medical institutions to improve the quality of medical care and operational efficiency. At the same time, the patients are allowed to select their hospital themselves from the designated medical institutions, and their expenses are reimbursed promptly. By establishing a reasonable medical expenses reimbursement ratio, combined with the medical aid system for serious diseases, it is possible to avoid patients being pushed into poverty because of their illness. The policy is becoming more refined.

**Gaps between policy design and actual practice**
Implementing the global budget payment system is advantageous for controlling unreasonable rises in medical expenses, but obviously there are disadvantages as well. First, it is very difficult to calculate a reasonable budget for each hospital. Both the provinces use the principle of a 5% budget increase in the following year over the previous year. The budget
is fixed using the following indicators: total amount of NCMS funds in the county and the average hospitalization expenses for the previous three years. The reimbursement calculation is not accurate or scientific. Applying the global budget payment method can restrict excessive medical services or investigations, but it will not encourage hospitals to control medical costs reasonably.

Furthermore, some medical institutions do not manage the prepaid medical expenses system efficiently in the first half of the year, and this may lead to over-expenditure. The hospital may cut down on necessary medical tests or even refuse to admit the enrollees in order to save costs before year-end settlement, because of their limited budget.

**Ensure mutual accountability between purchaser and providers**

**Policy design**

The purchaser is accountable to providers by depositing the budget promptly with the hospitals. Meanwhile, providers need to report to and be audited by purchasers. Table 13 summarizes the main content of policies in this area.

**Table 13. Policy design to ensure mutual accountability**

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Ensure mutual accountability between purchasers and providers through prompt payment to healthcare providers and appropriate audit systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>Auditing of claims for reimbursement is consistent with the regulations. The global budget payment is deposited promptly with the hospital, and settlement is conducted promptly.</td>
</tr>
</tbody>
</table>
| Policy design in Henan  | 1. After examining and verifying the reported claim documents from contracted hospitals at the NCMS monitoring platform, the NCMS office should deposit the prospective funds with hospitals within 15 working days of receipt of the documents.  
2. The audit department regularly audits the revenue, expenditure and management of NCMS funds. |
| Policy design in Qinghai| 1. The contract clearly states that county NCMS offices should settle medical expenses promptly with contracted hospitals.  
2. Medical expenses prepaid by the designated medical institutions are balanced regularly with the NCMS office. The report of inpatient expenses paid by the designated medical institutions is sent to the NCMS office in the first five days of the following month, and the account settled before the 20th of each month. |
3. The NCMS office and hospitals should make full use of the NCMS information system and the hospital information management system to pay, evaluate and settle the account in time, thereby improving work efficiency.

4. The one-stop service of NCMS reimbursement and medical aid reimbursement is provided for patients who qualify for assistance, paid initially by the designated medical institutions and settled at regular intervals with the NCMS office.

Source: Authors’ summary

Actual practice

It was found that the reimbursement procedures for the medical expenses paid by the medical institutions of both Henan and Qinghai were virtually the same. Documents were sent to the NCMS offices by hospitals. Funds were deposited promptly to the account for each hospital after examination and verification of the claims. See Box 11 for quotes from interviews on practice in mutual accountability.

Box 11. Interviews on practice on mutual accountability

Director of Huanglin town hospital in Xi county, Henan province: The staff who are responsible for NCMS sort out the documents of the patients before the 22nd of each month, and hand them over to the NCMS supervisors, who, after examination, report to the NCMS office for verification. After correctness has been guaranteed, comprehensive reimbursement [claims] will be submitted to the NCMS accounts in the form of bills.

Director of Hualong People's Hospital, Qinghai: The compensated fund is appropriated directly from the NCMS accounts to the hospital. There was no difference after the NCMS merged with social security. Funds were deposited in place promptly and smoothly.

Gaps between theoretical and policy design

The strategic purchase method requires the purchasers to pay for and audit the medical service providers, thus establishing a mutual trust mechanism. The development of China’s policy reflects the above requirements. First, the NCMS office needs to appropriate full funds on schedule to medical
institutions which have paid the medical expenses for the patients, and the auditing department needs to strengthen the audit of medical funds.

Gaps between policy design and actual practice
It was found from the interviews that the NCMS office faces a shortage of competent staff, which may affect the efficiency and accuracy of examination and verification of documents reported by hospitals. There is a limited number of staff responsible for examining and verifying claim documents from hospitals. Lack of capacity may decrease the accuracy of examining and verifying reimbursement forms. Some violations may be omitted, such as fraudulent reimbursement or unreasonable drug usage, which adversely affect the safety and usage of funds. Also, some of the staff had limited knowledge of medical insurance: in particular, those who came from the Social Security Department to the NCMS agency were not familiar with NCMS reimbursement policies, which affected the efficiency of procedures. Therefore, establishing and perfecting health information systems and aligning the NCMS and hospital information management systems would strengthen external monitoring.

Transparency in fund management
Policy design
As shown in Table 14, the safety of NCMS funds should be guaranteed by ensuring transparency of expenditure and accepting supervision.

Table 14. Policy design to ensure transparency in fund management

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Manage finances in a transparent and accountable way, protecting against fraud and conflict of interest, and ensuring that expenditure and revenue are aligned.</th>
</tr>
</thead>
</table>
| National policy design | 1. Expenditure is determined by revenue.  
2. Transparency of NCMS fund utilization. Reimbursement rate, prices of medical services and medical expense subsidies should be made open to the public at the county (township) NCMS offices and the designated hospitals. In particular, expenditure and revenue in the medical funds of the county NCMS should be open at least once in every three months.  
3. To ensure the safety of NCMS funds, maintain the pay-as-you-go basis and retain a certain amount as a surplus. The surplus should be limited to 10% of total funds. The accumulated surplus should not be more than 25% of the total pooling funds raised in the same year. The sum of 5% or 3% is taken from NCMS funds to form the risk fund. |
4. Adhere to principles — control of total amount, pay-as-you-go, close-ended provider payment and surplus accumulated to the next half of the year for the outpatient pooling funds — and implement the measures — funds used exclusively for their intended purposes, and accounts exclusively managed.

5. Staff who misappropriate NCMS funds should be punished under the criminal law.

6. According to the Audit Law, expenditure and revenue and fund management should be regularly audited by the Auditing Department.

7. Identify staff who have exercised deception in financial management under the Accounting Law.

8. To ensure that all NCMS funds are deposited promptly, simplify the procedure. From 2009, appropriation subsidy funds from central finance are adjusted: pre-appropriation at the beginning of the year, settlement at the end of the year, acceleration of examination and issue of subsidy funds from central finance, and prompt provision of subsidy funds from local finance. Implement strictly the interim measures for centralized treasury payment management of NCMS subsidized funds issued by the Ministry of Finance, ensure that financial subsidy funds are appropriated directly to the county NCMS accounts, and put an end to retention and delay in disbursement of NCMS funds.

<table>
<thead>
<tr>
<th>National policy design in Henan</th>
<th>1. Medical service prices and medical compensation procedures should be published for a considerable period at the designated medical institutions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Expenditure and revenue of medical funds of the county NCMS should be published once a month at the county NCMS offices.</td>
</tr>
<tr>
<td></td>
<td>3. Medical expense subsidies, including hospitalization subsidy and outpatient subsidy for very serious diseases, should be published at the town NCMS offices, county designated medical institutions, village hospitals or village committee offices.</td>
</tr>
<tr>
<td></td>
<td>4. Publication of this information should be monitored and checked by all levels of health departments and financial departments. Institutions which do not comply are issued a notice of criticism, required to rectify the problem within the specified time, or even disqualified as a designated medical institution.</td>
</tr>
<tr>
<td></td>
<td>5. The departments of health, finance and audit should strengthen their monitoring of medical institutions, standardize medical practices, improve service quality, perfect the NCMS payment system, reform the monitoring and evaluating system, and closely monitor inpatient flows, compensation funds for medical institutions and expenditure of funds. They should summarize their experiences, identify problems and solutions in order to perfect payment methods and ensure the smooth reform of the NCMS payment system.</td>
</tr>
</tbody>
</table>
Policy design in Qinghai

1. The county financial bureau sets up a special NCMS bank account, in which the funds and interest should all be used for medical compensation.
2. The county NCMS sets up fund balance, general ledger and subsidiary accounts. The closed operation mode issued, so that the financial department manages the funds but does not use them, the NCMS office uses the funds but does not control them, and the bank pays out the funds but does not manage them.
3. The town NCMS office sets up special accounts to manage the funds; the appropriated compensation funds should be examined and approved by the director of the office.
4. To ensure the security of the NCMS funds, they are used exclusively for their intended purposes, accounts are exclusively managed, and daily and monthly balance of revenue and expenditure accounts are kept.
5. The use of NCMS funds at all levels should be audited and monitored annually by the county audit bureau. The results of auditing and monitoring should be open and supervised by the society and the people.
6. Operational security of NCMS funds should be ensured.

Source: Authors’ summary

Actual practice

To ensure the security of funds and transparent fund management, policies have been laid down in the following areas. First, the principle that expenditure is determined by income has been adopted. The use of NCMS funds is publicized in NCMS offices, designated hospitals and village committees at all levels, as well as medical service prices and expense reimbursement, so that they can be supervised by society. Second, there is a surplus in the NCMS fund, and the risk fund is deducted from this in proportion. In Xi county, the pilot county for reforms of comprehensive modes of payment in Henan province, the yearly fund surplus is 24%, with the utilization rate increased. The reform of comprehensive modes of payment reinforces the security of the funds. In addition, embezzlement of NCMS funds and bogus insurance claims are punished under the Constitution, Audit Law and Accounting Law. Lastly, special accounts for the NCMS fund have been set up in unified fund planning counties. There are designated staffs to maintain the accounts to ensure that funds go to the right place. See Box 12 for quotes from interviews on practice in transparency.
Box 12. Findings from interviews on practice in transparency

Director of the cooperative management office in Hualong county, Qinghai: The financial pressure is huge after the combination of NCMS office and social insurance, in that some policies are not made rationally and need more research. Another reason is that, in recent years, the economic condition of people is getting better and the medical requirements increase a lot. For instance, [previously] they didn’t go to hospital because of lack of money, but now they go to provincial hospitals for minor illnesses, which cost more money and greater financial pressure.

Director of the cooperative management office in Xi county, Henan: The implementation of comprehensive modes of payment improves the efficiency of utilizing NCMS funds and ensures the safety of the funds. As to the repeated insurance of the floating population, in order to prevent bogus insurance claims for repeated reimbursement, the original invoice should be required and examined.

Gaps between theoretical model and policy design
On the aspect of ensuring the safety of NCMS funds and publicity of management, various policies have been adopted, such as a publicity system, setting up special accounts for the NCMS fund and opening an account for risk funds, which embodies the requirement of strategic purchasing.

Gaps between policy and actual practice
It was found that the publicity system performs well in the NCMS agencies and the designated medical institutes. However, at the basic-level health centres, not least of all in the village committee or in the village health clinic, publishing of compensation for hospitalization and serious disease pension needs to be improved. It was found in the interviews that some village committees or village health clinics are not active in publicity because of lack of supervision of the publicity system. What is worse, the publicity system is not known at all in some places. On the other hand, farmers in NCMS lack a sense of supervision and the appropriate level of education. They pay very little attention to publicized information, which reduces the power of social supervision.
Purchaser-citizen relationship (PC)
The following aspects of the purchaser-citizen (PC) relationship were analysed using the guidelines from the RESYST project.

- **PC1.** Mechanisms by which purchasers actively engage with citizens to determine their health needs, preferences and values, and subsequently update this information.
- **PC2.** Mechanisms by which purchasers develop and update service entitlements to reflect the health needs of the population and protect the population against financial catastrophe.
- **PC3.** Mechanisms by which purchasers ensure eligible beneficiaries are identified.
- **PC4.** Mechanisms for purchasers to ensure citizens are aware of their entitlements and obligations.
- **PC5.** Mechanisms by which purchasers ensure that citizens are able to access their entitlements.
- **PC6.** Mechanisms for purchasers to listen to the complaints, views and reflections of members/citizens; take action to respond effectively to these complaints, views and reflections; and manage disputes between patients and healthcare providers, and between patients and purchasers.
- **PC7.** Mechanisms for purchasers to publicly report on their own performance to promote transparency and accountability.

Engagement with citizens

Policy design

Baseline surveys to collect information from citizens have been carried out. The information has been summarized and proposed for policy design. Table 15 summarizes the major policies at various levels of government.
Table 15. Policy design for engagement with citizens

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Actively engage with citizens on their health needs, preferences and values, and update this information regularly.</th>
</tr>
</thead>
</table>
| National policy design  | 1. County health bureau should conduct a baseline survey in order to collect information on health needs, preferences and treatment feedback, and summarize the information to provide reference information for policy design.  
2. NCMS office organizes group discussions by a supervision committee consisting of citizens, director of hospital and community member. |
| Policy design in Henan  | NCMS offices at county and village level should go to primary-care hospital or village to supervise and examine NCMS application status and citizens’ health needs and preferences. |
| Policy design in Qinghai | NCMS offices carry out baseline survey to collect information on health needs and preferences of farmers and herdsmen. |

Source: Authors’ summary

Actual practice

Policy-makers in the country require NCMS offices at county and village level to carry out baseline surveys in order to actively elicit health needs, preferences and recommendations on NCMS policy. The baseline survey is usually conducted once or twice a year so as to update the above information promptly.

Specifically, in Henan province, policy-makers mainly record the incidence of endemic diseases, the baseline survey database of citizens’ health status, and household follow-up studies showing citizens’ health status and needs. Purchase decisions in certain disease services are based on disease incidence. Since the database has been set up and fully implemented, surveys are not conducted as frequently as they were in recent years.

Since economic development is lagging well behind in Qinghai province, policy-makers record citizens’ health status data by means of residents’ health records collected by township hospitals. Before the NCMS office merged with the human resources and social security bureau in 2011, the health bureau organized baseline surveys and updated the information yearly. However, since 2011, they have not engaged in any large-scale investigations. See Box 13 for quotes from interviews on engagement with citizens.
Box 13. Interviews on engagement with citizens

**Director of NCMS office, Xi county, Henan:** We have done two baseline surveys in total. One was before NCMS took place and the second time was before the provider payment reform. In the past, we did the survey quarterly, and in 2013 we have done it twice for provider payment reform. But now we lack capacity to do the survey.

**Director of NCMS office, Hualong county, Qinghai:** From 2005, health bureau would select several staff and took around three months to do baseline surveys including disease, common disease, incidence and inpatient cost in each year, and make timely updates. They are experts in this work, but now we just carry out policies issued by government.

Gaps between theoretical model and policy design

There are no major gaps between strategic purchasing and current policy design.

Gaps between policy and actual practice

First, we assume that doctors could record residents’ health status and health needs when patients come to see the doctor and express specific health demands. Doctors could gather this information and report to policy-makers. However, in reality, only a few doctors would submit suggestions relating to matters such as shortages of essential drugs or deductibles for paediatrics which are too high. They get no response from policy-makers and therefore doctors are not willing to submit the information which gets no action. On the other hand, NCMS offices and policy-makers overlook doctors as a means to engage with citizens’ health needs. Most doctors interviewed indicate that they have not been asked for suggestions for policy-making, and they just implement policies passively.

Second, because of the lack of capacity, the frequency of baseline surveys has declined significantly in Henan province. Moreover, since the NCMS office has been merged with the human resources and social security bureau in Qinghai, the staff did not pay much attention to collecting information on health needs from farmers.
Developing an appropriate NCMS service package

Policy design

Policy-makers at the health bureau introduce and update benefit packages and compensation rates to ensure that farmers participating in NCMS receive their entitlements and that their out-of-pocket medical expenses are reduced to a reasonable amount. Table 16 summarizes the main content of policies in this area.

Table 16. Policy design for developing the service package

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>National policy design</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. The county health bureau should conduct baseline surveys in order to collect information on health needs, preferences and treatment feedback, and summarize the information to provide reference information for policy design.</td>
</tr>
<tr>
<td></td>
<td>2. Provide medical assistantships for five-guarantees families and poor families in rural areas who have serious diseases.</td>
</tr>
<tr>
<td></td>
<td>3. Prompt adjustment of medical compensation rates, deductibles, ceilings and catastrophe subsidies to compensate for the rise in medical costs and protect against catastrophe.</td>
</tr>
<tr>
<td></td>
<td>4. Award secondary compensation to those enrollees who have received serious illness compensation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy design in Henan</th>
<th>Principles behind the NCMS medical compensation scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Encourage residents to see doctors at the primary-care hospital in the first stage.</td>
<td></td>
</tr>
<tr>
<td>2. Combine medical cost compensation with rural medical assistance.</td>
<td></td>
</tr>
<tr>
<td>3. Expenditure to be determined by revenue; balance of revenue and expenditure, allow surplus at around 15% of revenue.</td>
<td></td>
</tr>
<tr>
<td>4. Each county adjusts medical cost compensation rates to match local economic development and level of medical costs.</td>
<td></td>
</tr>
<tr>
<td>5. Maintain stability and persistence of policies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy design in Qinghai</th>
<th>1. Deductible for provincial hospital is 500 RMB; township hospital, 350 RMB; county hospital, 100 RMB; village hospital, 50 RMB.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Reimbursement rate for village hospital is 90%; county and township hospital, 80%; provincial hospital, 70%. Payment for inpatient service delivery is case-based. Ceiling for inpatient compensation is RMB 100 000/year.</td>
<td></td>
</tr>
<tr>
<td>3. The medical assistance fund covers deductible payments for poor residents.</td>
<td></td>
</tr>
<tr>
<td>4. The compensation ceiling for 21 serious diseases is RMB 200 000.</td>
<td></td>
</tr>
<tr>
<td>5. Secondary compensation is provided for people suffering from one of the 21 serious diseases.</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Authors’ summary*
Actual practice

According to NCMS policies issued by provincial government, the medical compensation scheme and benefit package have been updated every year to keep up with local economic development and the rise in medical costs. Patients are satisfied with the compensation rate and medical services obtained from hospitals.

Patients participating in the NCMS did not engage in policy-making discussions in both Henan and Qinghai provinces. The compensation policy has been updated on the basis of population health indicators and information from patient follow-up visits gathered by each hospital. Most of the interviewed patients were fairly or highly satisfied with the medical expenditure compensation they had received, which had reduced their economic burden, and they expect greater improvement in medical service quality. Few patients interviewed had no idea about where or how to complain about NCMS benefit packages and related policies. Almost all of the patients interviewed had not been asked to provide feedback on NCMS by policy-makers. See Box 14 for quotes from interviews on practice in service package design.

Box 14. Interviews on practice in service package design

NCMS expert, Henan: [It is impossible for] patients participating in NCMS to make policies, they mainly provide feedbacks and suggestions, and receive follow-up interview after medical treatment. Policy-makers would not consult with them.

Patient, Xianglushan village hospital, Yiyan county, Henan: NCMS has never consulted with us, they just ensure we know well about NCMS policies.

Patient, Shangxinzhuan village hospital, Huangzhong county, Qinghai: We do not know where to complain if we do have dispute with hospitals.

Gaps between theoretical model and policy design

Under the ideal theoretical model, service entitlements should reflect the health needs of citizens. In this case, it is important to make sure government hears the voices of citizens. We have detailed and clear regulations about recording citizens’ health needs and health status
information; however, the lack of procedures for rewards and penalties creates a disincentive for NCMS offices to follow the regulation. Thus, policy-makers should create incentives to ensure purchasers elicit farmers’ health needs through face-to-face interviews or group discussions and reflect their needs in the policy design.

Gaps between policy and actual practice
Government has not realized how important it is to hear from farmers and learn about their health needs in order to develop benefit packages and entitlements. In addition, primary NCMS offices are lacking in capacity to carry out baseline surveys. Furthermore, farmers do not understand policies comprehensively. Sometimes they are not aware that they should be protecting their own rights to acquire high-quality medical services. Above all, policy-makers regard suggestions from citizens as impractical. Thus regulations and mechanisms should be created to ensure that citizens’ health needs and suggestions reflected in service entitlement.

Identification system for eligible people
Policy design
The health information system should be established across the whole nation to identify beneficiaries. In addition, medical aid programmes have been introduced to assist certain groups of people and for reimbursements in cases of serious illness. Table 17 summarizes the main content of policies in this area.

<table>
<thead>
<tr>
<th>Table 17. Policy design for operation of the NCMS identification system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ideal theoretical model</strong></td>
</tr>
<tr>
<td><strong>National policy design</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Table 17. Policy design for operation of the NCMS identification system (Con’t.)

<table>
<thead>
<tr>
<th>Policy design in Henan</th>
<th>1. Set up medical assistance system. Offer medical assistance to households in rural areas, “five-guarantees” families, and households living below the poverty level.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. NCMS-contracted hospitals should verify NCMS enrollees’ membership to prevent fraudulent use of other membership.</td>
</tr>
<tr>
<td></td>
<td>3. Patients who have not been reimbursed on leaving hospital can return to the office where they enrolled to claim reimbursement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy design in Qinghai</th>
<th>1. Clearly define the following cases which are not covered by the NCMS fund: medical costs due to road traffic crashes, medical negligence, work-related injuries, public health, overseas medical services, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Patients who receive special assistance and are living below minimum living standards should be verified according to the county civil administration membership roster.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice

To ensure that NCMS enrollees receive their entitlements, NCMS-contracted hospitals must strictly verify enrollees’ membership and make sure that patients submit valid identity certificates in order to obtain compensation when they leave the hospital to protect from duplicate enrolment and fraud; purchasers should clearly define what kind of medical costs will not be reimbursed from the NCMS fund; for enrollees who also receive special assistance or live below the minimum living standards, identity information should be verified from the county civil administration membership roster.

From our face-to-face interviews, we see a need to perfect strategies of identification and prevention of cheating on insurance. This is especially true in the case of migrants who are hospitalized in different cities and cannot obtain medical compensation when they leave the hospital; in this case, migrants may re-enrol in another social insurance scheme or cheat the insurance by submitting fake invoices. Furthermore, the national health information system network has not been set up, so a number of insurance cheating cases may be misidentified.
Gaps between theoretical model and policy design

Reimbursement procedures and compensation policy have been developed and implemented effectively in practice. There are no major gaps between the ideal theoretical model and policy design.

Gaps between policy design and actual practice

There are a few sources of insurance cheating during the reimbursement process. First, insufficient staff numbers at the NCMS office prevented them double-checking all reimbursement materials to identify insurance cheating. Second, the national health information system network has not been set up, and this makes it difficult to verify the enrollee’s membership across different provinces. As a result, migrants may re-enrol in another social insurance scheme in order to obtain extra compensation. Although this cheating issue has not been very serious in recent years, as purchasers have implemented punishment policies to avoid moral-hazard behaviours, cheating in medical reimbursement does have passive effects, especially for the safety of NCMS funds. It is highly recommended that a health information system should be set up and enrollees’ information made available across the whole country so as to identify genuine beneficiaries more accurately.

Ensuring citizens’ awareness of their entitlements and obligations

Policy design

As summarized in Table 18, it is clearly stated and well designed in NCMS policies that citizens’ awareness of their entitlements and obligations must be ensured.

Table 18. Policy design for ensuring citizens’ awareness of their entitlements and obligations

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Ensure awareness of citizens of their entitlements and obligations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>1. Right to participate. Ensure enrollees’ right to participate in designing NCMS policies and management work by submitting suggestions.</td>
</tr>
<tr>
<td></td>
<td>2. Right to acquire information about NCMS policies and fund usage. Enrollees should be informed by doctors when they prescribe drugs which are not on the essential drug list.</td>
</tr>
</tbody>
</table>
Table 18. Policy design for ensuring citizens’ awareness of their entitlements and obligations (Con’t.)

<table>
<thead>
<tr>
<th>National policy design</th>
<th>3. Right to supervise. Ensure NCMS supervisory committee is made up of farmers; enrollees have the right of complaint and disclosure to relevant departments.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4. Village NCMS offices carry out propaganda work to ensure that farmers are aware of NCMS implementing regulations and enrollees’ entitlements, benefits and obligations.</td>
</tr>
<tr>
<td></td>
<td>5. Bulletins such as enrollee notices are printed to make NCMS policies much easier for farmers to understand.</td>
</tr>
<tr>
<td>Policy design in Henan</td>
<td>1. NCMS offices at various levels and contracted hospitals should make public the medical compensation rate, essential drug prices and NCMS work performance.</td>
</tr>
<tr>
<td></td>
<td>2. Advocate through the mass media to encourage farmers to enrol in NCMS.</td>
</tr>
<tr>
<td>Policy design in Qinghai</td>
<td>1. County NCMS offices are responsible for NCMS policy propaganda work.</td>
</tr>
<tr>
<td></td>
<td>2. Village NCMS offices help to advocate regulations and ensure a comprehensive understanding of NCMS implementing regulations by citizens.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice

According to the national NCMS regulations, enrollees enjoy entitlements, including the following: receive basic medical care, receive medical reimbursements, monitor NCMS fund management and use, and put forward suggestions for the daily work of the NCMS office. The obligations are as follows: comply with the NCMS regulations, pay insurance premiums on time, coordinate with medical centres to receive medical services, and report illegal medical behaviour to the authorities. NCMS offices at various levels encourage farmers to enrol in NCMS using the mass media, which has obtained favourable results.

By the end of 2012, the NCMS enrolment rate reached 98.3%, which implies that all peasants are covered by the NCMS. This achievement is closely linked with farmers’ recognition and acceptance of the NCMS. In our face-to-face interviews with patients in both Henan and Qinghai provinces, almost all patients were quite clear about enrolment premiums, inpatient medical costs, medical compensation rates and the reimbursement procedure. They were very satisfied with the benefits they received from NCMS. It was also noticed that patients in Henan province know more about NCMS policies than patients in Qinghai province.
However, most of the patients interviewed were not aware of NCMS coordinated fund usage or management performance. A large number of enrollees admitted that they would not put forward suggestions to the NCMS office. First, farmers are satisfied with the NCMS, since it has alleviated their medical costs and catastrophic expenditure and enrollees have received great benefits. And enrollees are concerned with medical compensation and the quality of medical service while neglecting their entitlement of monitoring the NCMS offices’ daily work. Second, the monitor and supervision mechanisms have not been implemented well in practice. For instance, it was noted that an NCMS administration committee, consisting of village leaders, cadres and enrollees, should be founded in each village to monitor and coordinate the daily work of the NCMS. However, most enrollees have never heard of this system. See Box 15 for quotes from interviews on mechanisms for informing citizens.

Box 15. Interviews on practice on mechanisms for informing citizens

*Officer of NCMS office, Huangzhong county, Qinghai*: enrollees have not monitored us and our daily work.

*Patient in central county hospital, Hualong, Qinghai*: I am very clear about medical cost. But the doctor did not tell me about what investigations I have to take and treatment pathway.

*Patient in central county hospital, Yiyan, Henan*: I am quite satisfied with reimbursement procedure. I can obtain medical compensation when I leave the hospital. Doctors have told me about inpatient cost, inspections and treatment. The out-of-pocket amount is around RMB 300.

*Director of health bureau, Yiyang, Henan*: Citizens are not allowed to discuss clinical pathway or participate in price negotiation. This is because peasants do not have enough medical knowledge and they are not capable of participating in decision-making. We are ensuring patients know the facts and details of treatment procedure, diagnosis standard, medical cost and out-of-pocket amount.

Gaps between theoretical model and policy design

There are no obvious gaps between the ideal theoretical model and policy design.
Gaps between policy and actual practice

According to our research, patients in Henan province know more about NCMS policies than patients in Qinghai province, mainly because the economic development of Qinghai province is far behind that of Henan province and this could mean that citizens’ level of education in Qinghai is lower than in Henan province. Also, local government in Henan has implemented a strategy that doctors have to notify each patient about treatment information and related compensation policies before they are hospitalized. This strategy has worked well.

Ensuring citizens’ ability to access entitlements

Policy design

Policies should ensure that enrollees are able to access their entitlements, that reimbursement takes place promptly, and that high reimbursement rates are set. Table 19 summarizes the main content of policies in this area.

Table 19. Policy design of ensuring citizens’ ability to access entitlements

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>National policy design</th>
<th>Policy design in Henan</th>
<th>Policy design in Qinghai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that citizens are able to access their entitlements.</td>
<td>1. Develop and update the benefit package, including raising the compensation rate for inpatient and outpatient medical costs, secondary reimbursement, and free physical examinations to ensure enrollees receive more benefits. 2. Make sure enrollees choose NCMS-contracted hospitals freely to seek treatment and obtain medical compensation promptly when they leave hospital. Simplify the referral procedure to make it convenient for enrollees to seek healthcare within one province. 3. Simplify the reimbursement process for migrants and ensure their entitlement to receive medical compensation. 4. Combine NCMS with the rural medical assistantship system at county level to ensure that enrollees who live in poverty obtain compensation and subsidies promptly.</td>
<td>1. Enrollees freely choose NCMS-contracted hospitals. 2. Patients receive medical compensation when they leave hospital. 3. Explore repayment of medical costs reimbursed in another province.</td>
<td>1. Outpatient medical costs will be paid from the family account, with no deductibles or reimbursement for outpatient medical costs. 2. Explore repayment of medical costs reimbursed in another province.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary
Actual practice

To ensure that enrollees can access their entitlements, purchasers develop and update the benefit package in accordance with citizens’ health needs and preferences and carry out supervision strategies to make sure medical institutions follow the regulations to provide high-quality health services. In addition, the related reimbursement policy and poor residents’ assistance plan have been implemented to protect enrollees against impoverishment due to catastrophic medical expenditure. For migrants who seek health treatment at places different from their original enrolment city, reimbursement schemes have also been developed to guarantee that medical reimbursement can be obtained promptly and conveniently.

Gaps between theoretical model and policy design

There are no obvious gaps between the ideal theoretical model and policy design.

Gaps between policy and actual practice

A number of migrants or enrollees who seek medical services in another province may abandon their reimbursement claim because of the complex reimbursement process. In addition, they have to come back to the place where they were enrolled and submit original documentation. This is very inconvenient for them. Therefore, it is necessary to provide immediate reimbursement for patients, no matter where they received their medical treatment. Instant reimbursement in NCMS-contracted hospitals pays for migrant enrollees first and settles the account with the NCMS office where the migrant patients were enrolled. It also requires collaboration among providers and purchasers indifferent places, using the medical information system.

NCMS public complaint mechanism

Policy design

The mutual accountability between citizen and purchaser should be enhanced by listening to consumers and effectively resolving disputes and complaints. Table 20 summarizes the main content of policies in this area.
Table 20. Policy design of NCMS public complaint mechanism

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish effective mechanisms to listen to complaints, views and reflections of the members/citizens and take action to respond effectively to these, and manage disputes between patients and healthcare providers and between patients and purchasers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National policy design</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hotline in NCMS office for enrollees’ complaints and policy consultants.</td>
<td></td>
</tr>
<tr>
<td>2. Citizens can also complain via mass media.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy design in Henan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Make every health administration department supervision hotline publicly accessible online.</td>
<td></td>
</tr>
<tr>
<td>2. NCMS-contracted hospitals should set up a complaint and suggestion box, make the NCMS supervision hotline and consultant hotline publicly accessible and ensure that staff resolve problems and deal with enrollees’ consultants at all times.</td>
<td></td>
</tr>
<tr>
<td>3. Each county government should establish an NCMS supervision committee, consisting of government officials and enrollees, to monitor NCMS fund usage and management performance.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy design in Qinghai</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Each county NCMS office is responsible for managing complaints and disputes.</td>
<td></td>
</tr>
<tr>
<td>2. A hotline has been set up at the NCMS office for enrollees’ complaints and policy consultants.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice

Each county NCMS office has established a hotline for enrollees’ complaints and policy consultants. The hotline number is printed on the NCMS enrollee notice. Especially in Henan province, local government makes the NCMS supervision hotline and consultant hotline publicly accessible and ensures that staff resolve problems and deal with enrollees’ consultants at any time. From interviews with officials from NCMS offices in both provinces, we learned that most citizens call to ask about compensation policies and only a few calls relate to medical disputes.

From our interviews with patients in both Henan and Qinghai provinces, we realized that hardly any patients have complained to or consulted any administration department before. Most patients were not clear what they could do when they had medical disputes or suggestions for the NCMS. And the majority of them were quite satisfied with inpatient medical
services and medical personnel. See Box 16 for quotes from interviews on the NCMS public complaint mechanism.

**Box 16. Interviews on practice in the NCMS public complaint mechanism**

*Director of NCMS office, Huangzhong county, Qinghai:* The health administration department has to establish a complaint hotline to manage medical disputes. And NCMS office set up a supervision hotline to answer compensation policy questions. We would receive a lot of calls each day. Our staff will resolve complaint and talk to consultants any time.

*Patient at Liuquan village hospital, Xicounty, Henan:* I am quite satisfied with medical service this time. Local government and NCMS compensated a lot of medical cost for us, so I believe in their work. I do not know how to complain and reflect my suggestions.

**Gaps between theoretical model and policy design**

There are no obvious gaps between the ideal theoretical model and policy design.

**Gaps between policy and actual practice**

Every NCMS office or health administration department has already established supervision hotlines and deploys staff to deal with complaints or disputes. However, there are many enrollees who still do not know how to express complaints. One reason is that most enrollees have never had disputes with hospitals and they are quite satisfied with NCMS regulations, so it is not necessary to complain. Another reason is that farmers with a low level of education do not have the awareness required to monitor the daily work of NCMS.

**Public reports on purchaser performance**

**Policy design**

Purchaser performance and reimbursement policies are published in order to promote transparency and supervision from the public. Table 21 summarizes the major content of policies in this area.
Table 21. Policy design of public reporting on purchaser performance

<table>
<thead>
<tr>
<th>Ideal theoretical model</th>
<th>Report publicly on purchaser performance to promote transparency and accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>National policy design</td>
<td>1. County NCMS offices should make NCMS compensation standards, medical service prices and medical cost reimbursement public monthly or quarterly via mass media or on a notice board.</td>
</tr>
<tr>
<td></td>
<td>2. County NCMS supervision committees inspect the situation of notification implementation.</td>
</tr>
<tr>
<td>Policy design in Henan</td>
<td>1. NCMS offices at different levels and NCMS-contracted hospitals and village clinics should make NCMS regulations, such as hotlines, reimbursement rates, deductibles and ceilings, public on a notice board or via mass media.</td>
</tr>
<tr>
<td></td>
<td>2. NCMS-contracted hospitals should make medical service prices and the enrollee reimbursement process public.</td>
</tr>
<tr>
<td></td>
<td>3. County NCMS offices should make the revenue and expenditure of the NCMS fund public monthly.</td>
</tr>
<tr>
<td></td>
<td>4. Township NCMS offices, NCMS-contracted hospitals and village clinics should make public the system for medical compensation, including inpatient medical cost compensation and outpatient serious illness compensation.</td>
</tr>
<tr>
<td></td>
<td>5. Each health administration bureau and financial bureau at different levels should inspect the notification situation. Warn and penalize institutions or contracted hospitals which break the rule.</td>
</tr>
<tr>
<td>Policy design in Qinghai</td>
<td>1. Auditing bureau supervises and audits NCMS fund management performance each year and makes public the results of the audit.</td>
</tr>
<tr>
<td></td>
<td>2. Set up an NCMS supervision committee, consisting of village cadres and enrollees, to supervise NCMS enrolment fee collection and policy implementation.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Actual practice
It was found in the interviews that NCMS-contracted hospitals make public the medical service prices and reimbursement procedures, and NCMS offices publish their performance via mass media.

Gaps between theoretical model and policy design
There are no obvious gaps between the ideal theoretical model and policy design.
Gaps between policy and actual practice

The purpose of making public NCMS fund management performance is to accept supervision from society. It was found in Henan province that all patients were satisfied with the NCMS offices and their work, because they could obtain medical reimbursement promptly. This indicates that patients pay more attention to medical service prices and expenditure and do not care about how well NCMS regulations are implemented or about offering opinions to enhance the performance of the administration departments. Therefore, it is necessary to make them more aware of the need to protect their interests and make suggestions to policy-makers.

In the interview with the director of the NCMS office in Huangzhong county, Qinghai province, the director admitted that the supervision mechanism for contracted hospitals and NCMS offices had been established, but that channels for citizens to express their suggestions and monitor NCMS work performance need to be enhanced.

NCMS purchasing performance

Indicators for NCMS fund utilization

Five indicators are used to measure NCMS fund utilization: population coverage for inpatient care, average expenses per hospital admission, reimbursement rate for inpatient care, fund utilization rate, and distribution of NCMS inpatient funds by level of hospital. The allocation of NCMS funds to inpatient care is examined because inpatient care accounts for the majority (more than 70%) of total NCMS funds and data on inpatient care are available from the reporting system.

- Population coverage of inpatient care = number of hospital admissions / total number of enrollees ×100%
- This indicator reflects the major benefits which insured persons receive from NCMS when accessing hospital services. Financial barriers were the major factor influencing people’s use of healthcare services before the introduction of NCMS.
- Average expenses per hospital admission = total expenditure on inpatient care / number of hospital admissions
This indicator can be used to show the efficiency of fund utilization per unit of hospital care.

- Reimbursement rate of inpatient care = the amount of NCMS reimbursement / total hospital expenditure $\times 100\%$
- This indicator is the major indicator for reflecting the extent of financial protection that NCMS can provide.
- NCMS fund utilization rate = annual fund spending / total amount of fund collected in the year $\times 100\%$
- Accumulated surplus rate = cumulative surplus amount / total amount of NCMS fund $\times 100\%$

These two indicators are used for measuring the efficiency of NCMS fund utilization.

**Main findings**

**Population coverage of inpatient care**

From 2009 to 2013, population coverage of inpatient care increased gradually in all sample counties (Table 22). The two counties in Qinghai had a higher coverage of inpatient services than that in Henan province.

**Table 22. Population coverage (%) of inpatient care for enrollees in sample counties, Henan and Qinghai provinces, 2009–2013**

<table>
<thead>
<tr>
<th>Year</th>
<th>Henan</th>
<th>Qinghai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xi</td>
<td>Yiyang</td>
</tr>
<tr>
<td>2009</td>
<td>4.81</td>
<td>5.85</td>
</tr>
<tr>
<td>2010</td>
<td>4.91</td>
<td>6.91</td>
</tr>
<tr>
<td>2011</td>
<td>5.20</td>
<td>8.37</td>
</tr>
<tr>
<td>2012</td>
<td>6.83</td>
<td>11.36</td>
</tr>
<tr>
<td>2013</td>
<td>8.10</td>
<td>11.69</td>
</tr>
</tbody>
</table>

*Source: China Health Statistics 2013*
**Average expenses per hospital admission**

From 2009 to 2013, average expenses per hospital admission increased gradually in all sample counties (Table 23). In the same year, the average expense per inpatient for enrollees was lowest (RMB 2015.78–RMB 3707.51) in Hualong and highest (RMB 3147.08–RMB 5028.30) in Xi county.

**Table 23.** Average expenses (RMB) per inpatient in sample counties, Henan and Qinghai provinces, 2009–2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Henan</th>
<th>Qinghai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xi</td>
<td>Yiyang</td>
</tr>
<tr>
<td>2009</td>
<td>3147.1</td>
<td>2588.6</td>
</tr>
<tr>
<td>2010</td>
<td>4322.3</td>
<td>2941.2</td>
</tr>
<tr>
<td>2011</td>
<td>5079.4</td>
<td>3392.5</td>
</tr>
<tr>
<td>2012</td>
<td>5245.4</td>
<td>3814.6</td>
</tr>
<tr>
<td>2013</td>
<td>5028.3</td>
<td>4046.4</td>
</tr>
</tbody>
</table>

*Source: China Health Statistics 2013*

**Reimbursement rate of inpatient care**

From 2009 to 2013, the reimbursement rate for inpatient care for enrollees increased. In comparison, the actual proportion of inpatient reimbursement (about 40%) in Qinghai province was lower than that (about 45%) of Henan province in 2009 and 2010, while the situation was reversed from 2011 to 2013 (Table 24).

**Table 24.** Actual percentage (%) of inpatient reimbursement in sample counties, Henan and Qinghai provinces, 2009–2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Henan</th>
<th>Qinghai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xi</td>
<td>Yiyang</td>
</tr>
<tr>
<td>2009</td>
<td>48.1</td>
<td>45.0</td>
</tr>
<tr>
<td>2010</td>
<td>42.4</td>
<td>44.9</td>
</tr>
<tr>
<td>2011</td>
<td>40.5</td>
<td>49.0</td>
</tr>
<tr>
<td>2012</td>
<td>52.0</td>
<td>60.1</td>
</tr>
<tr>
<td>2013</td>
<td>50.9</td>
<td>50.8</td>
</tr>
</tbody>
</table>

*Source: China Health Statistics 2013*
Annual NCMS fund utilization

In terms of the annual fund utilization rate, there are huge differences in different years in all sample counties. They were lowest (68.63%–81.91%) in 2011. However, the expenditure of NCMS funds exceeded the annual funds collected by about 10% in Yiyang in 2011; Hualong over-ran by about 4% in 2012 and 10% in 2013, and Huangzhong over-ran by about 3% in 2009 and 9% in 2013. Correspondingly, the cumulative surplus rates were highest (30.50%–47.66%) in all sample counties in 2011 (Table 25). From then on, the cumulative surplus rates gradually declined in all sample counties. This shows that the control of annual expenditure for NCMS funds remains to be improved.

Table 25. Annual fund utilization rate and accumulating surplus rate of NCMS (%), Henan and Qinghai provinces, 2009–2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Henan NCMS fund utilization rate</th>
<th>Henan NCMS fund accumulating surplus rate</th>
<th>Qinghai NCMS fund utilization rate</th>
<th>Qinghai NCMS fund accumulating surplus rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xi</td>
<td>Yiyang</td>
<td>Hualong</td>
<td>Huangzhong</td>
</tr>
<tr>
<td>2009</td>
<td>92.9</td>
<td>79.9</td>
<td>94.6</td>
<td>102.6</td>
</tr>
<tr>
<td>2010</td>
<td>93.3</td>
<td>78.5</td>
<td>88.4</td>
<td>92.1</td>
</tr>
<tr>
<td>2011</td>
<td>68.6</td>
<td>73.8</td>
<td>78.1</td>
<td>81.9</td>
</tr>
<tr>
<td>2012</td>
<td>90.6</td>
<td>110.3</td>
<td>104.1</td>
<td>88.0</td>
</tr>
<tr>
<td>2013</td>
<td>87.9</td>
<td>89.6</td>
<td>110.6</td>
<td>108.8</td>
</tr>
</tbody>
</table>

Source: China Health Statistics 2013

Conclusions and policy recommendations

Conclusions

Based on study results and analysis, this study has reached the following conclusions.

Government and purchasers have implemented policies and taken action to achieve equitable health outcomes with the result that equity has gradually improved

To ensure that citizens are aware of their entitlements and obligations, purchasers encourage rural residents to enrol in NCMS through mass media, printing and distribution of brochures, publicity operations by
NCMS funds in village offices, etc., which has obtained favourable results. Currently, the majority of rural residents are covered by NCMS. And this achievement is closely associated with farmers’ recognition and acceptance of NCMS. The interviews also show that almost all patients were quite clear about enrolment premiums, inpatient medical costs, medical compensation rates and reimbursement procedures and are very satisfied with the benefits they obtain from NCMS. However, there is a lack of awareness of purchaser performance monitoring and the possibility of making suggestions about purchasing, since the citizen monitoring and supervisory mechanisms have not been well established and enrollees are generally satisfied with NCMS.

To improve accessibility to needed healthcare, government has issued favourable policies such as position promotion and higher payments to encourage medical experts and graduate students to work in the countryside. But these incentives have not had a major impact on doctors working at primary hospitals. Highly educated young doctors are unwilling to work in the countryside, causing a brain drain in primary healthcare institutions and making it difficult to guarantee the quality of medical services.

To promote the equitable allocation of financial resources, both central and local governments have taken action such as subsidizing most of NCMS funds in western underdeveloped regions and providing financial assistance for the construction of the health information system in rural areas. Besides, higher inpatient compensation rate and outpatient reimbursements are set for primary health facilities to encourage the flow of patients from tertiary hospitals to community hospitals. However, these incentives were not effective enough, as patients prefer higher-level hospitals as their disposable income grows, and certain gaps in the quality of medical care, staff and equipment exist between hospitals at different levels.

Financial protection is another priority of NCMS, as its mission is to protect residents against being impoverished as a result of catastrophic illness. Around half of inpatient costs will be reimbursed and patients may receive secondary compensation for certain serious illnesses. For five-guarantees families and low income groups, other financial assistance will exempt
them from premiums and subsidize their medical costs. The interviews indicated that enrollees are satisfied with NCMS, as this insurance scheme has substantially alleviated their medical burden compared with before.

**Innovations such as mixed provider payment methods, clinical pathways and provider claim auditing have been introduced experimentally or implemented in study sites to improve the efficiency of fund use, but some aspects of these innovations should be enhanced.**

To control medical expenses, mixed payment methods including global budgets, fee-for-service payments and case-based payments have been applied in both Henan and Qinghai provinces. In Henan province, case-based payment methods and clinical pathways have also been implemented so as to improve the efficiency of fund use. The outcome indicates that mixed payment methods have reduced inpatient medical costs to a certain extent. Treatment guidelines and essential drug lists have been developed and implemented to avoid excessive use of medical care and drugs.

The benefit package should be based on cost-effectiveness and evidence, but in practice it is difficult to achieve this. Most benefit packages are formulated by taking into account the total amount of the NCMS fund, a breakdown of reimbursement across hospitals at different levels and the morbidity of the diseases concerned.

Purchasers and providers sign their contracts after negotiation payment methods and pricing, and draw up explicit provider performance evaluation rules to promote the proper use of NCMS funds. The provider performance evaluation is also illustrated in the purchasing contract. These strategies have ensured that NCMS funds have been utilized properly and efficiently. However, the method of calculating medical costs is not scientific. For the global budget provider payment method, in particular, the payment amount is determined by the total amount of NCMS funds, the average medical costs over the previous three years for each hospital and the size of the hospital. For case-based payment, the purchaser does not have the power to set prices for medical services; moreover, the payment for a specific disease should be calculated more accurately. The efficiency of the purchasing mechanisms is low due to these shortcomings.
On the basis of NCMS-contracted hospital approval and management rules, almost all public hospitals will be selected as contracted hospitals, and they therefore have insufficient incentive to improve performance. Private hospitals find it hard to compete with public hospitals, mainly because public hospitals continue to receive supply-side funding. A lack of competition among hospitals may create disincentives for improvements in service quality and performance by contracted hospitals.

Purchasers need to report monthly, quarterly and annually to government with fund expenditure information to monitor the utilization of NCMS funds and the performance of strategic purchasing. Five indicators—benefit rates, average medical expenses, proportion of actual reimbursement, fund utilization rates, and fund flow—indicate that fund utilization efficiency has been gradually enhanced.

**Mutual accountability and governance mechanisms have been established through the reporting system, complaint system, supervision and information transparency, but some aspects need to be enhanced in practice.**

Government, as the principal stakeholder, has set up a policy framework and regulation system that both NCMS offices and NCMS-contracted hospitals should apply. In practice, most regulations and policies have been implemented very well. Purchasers and providers comply with the contract to purchase and provide medical services. However, there are gaps between policy design, actual practice and the ideal theoretical model. For example, NCMS offices have to act in accordance with government instructions and follow government’s leadership; in addition, purchasers do not have the right to impose penalties. In respect of organizational structure, the NCMS office comes under government authority, which indicates that governance and operation have not been fully separated. For this reason, some inspection and regulation effects will not be realized.

Entitlements and obligations for purchasers and enrollees have been explicitly specified in the NCMS scheme. The fund reimbursement information has been made public in villages and county hospitals to ensure that enrollees are aware of the information. However, according to strategic purchasing, policies and benefit packages should reflect the
health needs and preferences of citizens. Although there are channels such as hotlines and supervision committees whose delegates are farmers, audit and inspection department, etc. and which allow consumers to express their health needs, preferences and complaints, the complaint system does not work effectively in practice, since complaints and suggestions are not addressed by policy-makers.

Quality control and improvement strategies have been designed and applied through contracting arrangements, quality and performance assessment, adoption of clinical pathway management, implementing standard treatment guidelines and the reporting system. Quality control and assessment standards can be improved.

 Purchasers formulate assessment criteria for regular evaluation of medical care quality and performance of providers in both Henan and Qinghai provinces. Detailed penalties are listed in the contract. The results of the performance evaluation will determine contract renewal for each provider. Purchasers in both provinces try to control the quality of medical care through clinical pathway management, auditing, monitoring and customer satisfaction surveys, supervision by health administrations, introduction of standard treatment guidelines, reporting and encouraging providers to improve the quality of medical care while simultaneously controlling expenses. However, there is a lack of accreditation within hospitals and by third parties. Due to the lack of capacity, vulnerabilities exist in supervision by purchasers and government. The motivation for quality improvement is not strong.

Policy recommendations
On the basis of the study results and conclusions and to improve the NCMS purchasing mechanism, we make the following policy proposals.

1. Health technology assessments should be introduced and widely used to formulate benefit packages; citizens’ opinions and preferences need to be ascertained and addressed; reimbursement rates and incorporated services need to be expanded to benefit more people, especially poor groups; and effective incentives must
be created and implemented to increase the resources allocated to underdeveloped areas, thereby promoting equity.

2. Modify the pricing negotiation mechanism between NCMS offices and hospitals; strengthen the monitoring and performance evaluation of contracted hospitals; provide favourable policies and funds to support private hospitals, thus encouraging public hospitals to improve their performance; provider payment methods need to be further explored; reimbursement rates and ceiling should be calculated more accurately.

3. Encourage enrollees to participate in monitoring and evaluating of NCMS purchasing performance.

4. Establish a unified health information system across different hospitals and provinces for quality control and supervision; quality improvement plans should be drawn up and implemented.
A critical analysis of purchasing mechanisms in China's rural health insurance scheme

References


Chapter 3: A critical analysis of selected healthcare purchasing mechanisms in Indonesia

Laksono Trismanoto, Julita Hendrartini, Tana Susilowati, Putu Astri Dewi Miranti, Vini Aristianti

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Abstract

Universal health coverage is currently at the centre of global policy debates worldwide. Since the 58th World Health Assembly endorsed the concept of universal health coverage (World Health Organization, 2005) and the 2010 World health report recognized the critical role of health system financing (World Health Organization, 2010), many low- and middle-income countries are considering reforming their healthcare financing systems to offer better financial protection and access to much-needed healthcare services for all. The implementation of universal health coverage in Indonesia began in January 2014 and is widely seen as a significant step forward for Indonesia’s 239.7 million people. Indonesia’s policy-makers are committed to covering every citizen by 2019 in a system managed by Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Healthcare), the implementing agency for healthcare social security.

The aims of the study are as follows.

1. To critically assess the performance of healthcare purchasers in Indonesia, using a framework based on agency theory.

2. To identify factors influencing that performance.

3. To identify factors that enable or hinder effective strategic purchasing.

4. To identify potential mechanisms to address these factors by examining the institutional arrangements which embody principal-agent relationships.

5. To draw conclusions and make policy recommendations to promote effective purchasing arrangements for universal health coverage.

The main conclusions are as follows.

1. Purchasing arrangements in Indonesia do not yet reflect strategic purchasing concepts.

2. The needs, preferences and priorities of citizens in determining service entitlements and monitoring mechanisms are not clearly reflected in policy design or implementation.
3. BPJS has inadequate levers (contractual arrangements and monitoring mechanisms) to ensure that the health provider delivers a high-quality mix of healthcare services at an agreed price. The capacity and authority of the purchaser to monitor health-service quality is limited, especially for government providers. The problem of fraud is not yet under control.

4. In policy implementation for universal health coverage, the government role as steward has a limited impact. Government faces difficulties in developing new health-service infrastructure and deploying adequate human resources for health in order to minimize the inequity gaps in access to services. The Ministry of Health and local government health offices have problems in monitoring purchaser performance. There is no policy design for monitoring the performance of BPJS. In local government, there is confusion about the role of district health offices.
Acronyms

APO        Asia Pacific Observatory on Health Systems and Policies
BPJS Healthcare Badan Penyelenggara Jaminan Sosial Kesehatan (social security agency for healthcare)
DJSN       Dewan Jaminan Sosial Nasional (National Social Security Agency)
DRG        diagnosis-related group
INA-CBG    Indonesian Care Based Groups (diagnosis-related-group system)
Jamkesda   Jaminan Kesehatan Daerah (local health scheme)
Jamkesmas  Jaminan Kesehatan Masyarakat (social health insurance for the poor)
Jamsostek  Jaminan Sosial Tenaga Kerja (formal-sector workers’ insurance)
JKN        Jaminan Kesehatan Nasional (National Social Security System)
KPK        Komisi Pemberantasan Korupsi (Corruption Eradication Commission)
NHI        national health insurance
p-care     primary care software for health information systems in primary healthcare facilities
PBI        Penerima Bantuan Iuran (government subsidized for poor)
Puskesmas  public primary healthcare facilities
RESYST     Resilient and Responsive Health Systems
Overview of healthcare financing arrangements in Indonesia

Indonesia has a complex healthcare financing system, with many financial resources for health. In the following section, the Kutzin financing functions framework (Kutzin, 2001) is used to describe healthcare financing in Indonesia. See also Annex 1 for the healthcare financing mechanism of the social security scheme.

Revenue collection

Public revenue for the health system comes from general taxes (direct and indirect) and non-tax revenues collected by central and provincial/district government, bilateral and multilateral loans (not significant), as well as bilateral grants to government. Sources of public financing of health expenditure in Indonesia include revenues generated by central, provincial and district government, social security schemes and other revenue channelled through the Government budget. Prior to the creation of the JKN, revenue was derived from tax and non-tax income of central and local government. Private sources of health finance are out-of-pocket payments, private insurance and companies that provide health benefits for their employees.

Before the national health insurance system was introduced (in 2014), health insurance in Indonesia covered approximately 72% of the population, an increase from 43% in 2010. The major insurers under the old insurance system providing this coverage included:

- PT Askes Indonesia for civil servants and retirees, jointly funded by employee and employer (national level), covering 7.3% (17.3 million people);
- Jaminan Sosial Tenaga Kerja (PT Jamsostek), covering formal-sector workers, fully funded by the employer (2.20%, 5.1 million people);
- Jaminan Kesehatan Masyarakat (Jamkesmas), covering the poor and near-poor population, funded by the central Government (35% of the population, 86 million people);
• Jamkesda (social security scheme managed and funded by local government to cover poor, near-poor and citizens in certain areas) covering 32 million people (13.5% of the population). However, not all provinces in Indonesia can implement health insurance for their populations, owing to local government policy. In each province and district, Jamkesda has different purchaser mechanisms, beneficiaries, premiums and benefit packages.

The implementation of universal health coverage in Indonesia began in January 2014 and is widely seen as a significant step forward for Indonesia’s 239.7 million people (Republic of Indonesia, 2012). Indonesia’s policy-makers are committed to covering every citizen by 2019 in a system managed by BPJS Healthcare, the implementing agency for healthcare social security. Two key laws that support this system are: the National Social Security System Law No. 40/2004 (Republic of Indonesia, 2004) and the Implementing Agency of Social Security (BPJS) Law No. 24/2011 (Republic of Indonesia, 2011) (see Annex 3). The national health insurance system of Indonesia uses a single-payer system, with BPJS as the sole mechanism, called Jaminan Kesehatan Nasional (JKN) or National Social Security System.

Healthcare financing in Indonesia has changed since 1 January 2014, when the health revenue collection process in Indonesia increased:

1. public funding for the poor community;
2. premiums from members of the informal sector who are not eligible for Government subsidies; and
3. premiums from participants in civil service (PT Askes Indonesia), military/armed forces and PT Jamsostek.

At the policy level, all aspects of health financing reform in Indonesia are complicated by the decentralization of the system. Although the concept initially appears simple, with the districts taking responsibility for implementing health services, there is a complex mix of different financing schemes across the programme. The central Government budget is grouped into centrally managed budget items, such as deconcentration, and budget items transferred to local government, e.g. to the General Allocation
Fund (DAU) and Specific Allocation Fund (DAK). The central Government budget can be used for salary, capital investment in public hospitals and some operational budget items. In strong fiscal local governments, a genuine local fund exists.

Alongside these financial resources, health insurance funds are channelled through BPJS. These funds can be used for paying human resources and also for the operating budget by means of claims and/or capitation fees. There is the possibility of duplication of financing for the same programmes or activities.

**Pooling the risk**

Before 2014, pooling was generally performed from two main sources, namely the central government budget (Ministry of Health) and the local government budget. The central government budget at the Ministry of Health was used to pay premiums for poor people (Jamkesmas) and health programmes. The second source is the local government budget, (either provincial or district/city), which provides a budget for health programmes and the Jamkesda (local health insurance). Since 1 January 2014, the BPJS Healthcare has taken over risk pooling by collecting premiums from the central government budget for the poor community (Penerima Bantuan Iuran, PBI), premiums from civil servants, members of the military/armed forces and workers, and non-salaried members (informal sector). The Ministry of Health allocation to BPJS is used for the poor and near-poor. This is the subsidized participant scheme.

Since 2014, Ministry of Health insurance funds have been directly channelled to BPJS. As a result, the Ministry of Health does not have the authority to set the BPJS budget allocation. The BPJS budget is determined by calculating capitation fees for primary care (mainly) and claims for referral services using INA-CBG (Indonesian Care Based Groups, a diagnosis-related-group (DRG) system).

Pooling in BPJS poses some risks, one of which is that the non-salaried participants are those who are sick, tend to be ill, and are in the upper-middle class of society. This is a characteristic of social insurance called adverse selection. Government policy, aimed at the gradual extension
of membership of JKN at the beginning of 2015, is likely to fail in the aim of social insurance to ensure that richer, healthy people subsidize poor, sick people. This may be because the budget for healthy poor people in the BPJS pool is used by sick but richer people, who pay small premiums in return for big benefits.

**Purchasing**

Before this research was conducted, there were still many different purchasers in the system. Although the Law mandates BPJS to be the single purchaser, in the transition phase the Jamkesda still operates local health insurance for local people by the local government at district level. In addition to that, there are individual citizens who made out-of-pocket payments for services received directly in the community. The purchasing mechanism implemented is varied, as shown in Annex 1. However, by 2016, BPJS Healthcare will be the sole purchaser in Indonesia in anticipation of the achievement of universal health coverage in 2019. As part of JKN policy (social health insurance in Indonesia), Jamkesda will be merged with BPJS Healthcare in 2016.

**Healthcare purchasers operating in Indonesia**

Currently, there are two purchasers: central and local government and BPJS (see Annex 2). The central and local government budget is allocated by political decision, because it is mainly derived from tax. Every year, government and central/local parliaments draw up the central and local government budget, taking into account technical and political considerations. In theory, the allocation is determined by a rationally developed planning system. However, in practice, various political influences affect budget allocation.

In 2014, BPJS-managed funds of around Rp. 40 trillion from various sources (approximately US$ 3.2 billion at rates prevailing in spring 2015) to cover all the benefit, both outpatient and inpatient. The fund is distributed to service providers through a mechanism in BPJS. As a payer, BPJS has the following payment mechanisms: capitation fees for primary outpatient healthcare; and claims for healthcare referrals using INA-CBG for both inpatients and outpatients. The capitation budget is a single rate determined by BPJS
which has an upper limit. However, the inpatient claim system using INA-CBG which is a type of DRG as the base rate. But the total claim for hospitals has no upper limit. The CBG creeping is a cause of no upper limits, as global budget was not applied to the inpatient services. The results is difficult to control cost. The amount of the claim paid by BPJS to hospitals is influenced by the following factors.

1. The number and type of human resources and health facilities for health (i.e. supply-side availability). Technology and medical specialist availability are the main factors determining whether a hospital can perform the highly paid INA-CBG services.

2. Class of hospital. Class A is the highest class of hospital with the most expensive INA-CBG.

3. Demographics and geographical and cultural access. Remote regions have INA-CBG prices which are expensive for their class. Most Class A, and Class B hospitals are in the big cities.

4. The hospital’s administrative capacity for making claims. The capacity and capability of the hospital to make claims is an important factor which influences the speed with which claims are made and their amount.

An area which has a large, densely packed population, a full complement of human resources for health, good healthcare facilities and the capacity to claim properly will obtain a large proportion of BPJS funds. The audit system has not worked yet. So when fraudulent practices are followed in healthcare services in the area, claims will increase.

**Key issues in progressing towards universal health coverage**

Differences in supply-side conditions, infrastructure, decentralization policy and fiscal capacity of each region trigger variations in the implementation of the social security system in Indonesia, causing inequities in healthcare access. Inequality in the availability of health facilities and health workers and in geographical conditions indicates a potential widening of health inequities among population groups. One example is the inequality in infrastructure, facilities and human resources between western and eastern Indonesia. In the eastern region, the number of health facilities and human resources are limited. Therefore, there are limited choices of health-service
provider. As a result, in this region, people do not have many options for medical treatment. In western Indonesia and in big cities with an adequate number of health service providers, the community has access to more services. Without an improvement in the availability of (supply) facilities and human resources in eastern Indonesia, BPJS health funds will be disproportionately utilized by many urban areas and regions of western Indonesia.

Access to healthcare also depends on other infrastructure, e.g. transport in the community. Without infrastructure improvements in rural or remote areas, access to healthcare is difficult to achieve, and the objectives of social health insurance cannot be realistically achieved. At the initial stage, because of the voluntary nature of the scheme, members of the community in the informal sector who register as BPJS members tend to have more sick people in need of medical care among them. They are close to the high-technology healthcare providers and may use the high-cost INA-CBG. Because of the inequality of access, the western part of Indonesia may have higher opportunity rather than the eastern part of Indonesia. Moreover, the group of rich people can take advantage of the portability of JKN. They may move up to the VIP class to get some more convenience, which they will not get when they use only the BPJS basic package. Up to now, there has been no system for quality control or fraud prevention. The half-hearted decentralization policy has had an effect on JKN implementation. BPJS is a centralized body for financing health services and is controlled by the President. At provincial and district level, there is no quality control system for BPJS activities, including data management. This is becoming a big issue for the evaluation of BPJS using regional analysis.

Methods
This study employs a case-study approach to investigate the research questions. The units of analysis are the purchasing arrangements/mechanisms in Indonesia and the three principal-agent relationships, which exist in the purchasing mechanisms are the. In this study, the units analysed are the mandatory social security scheme (BPJS) at the national level in East Kalimantan and East Nusa Tenggara provinces and Yogyakarta Special Territory to give a proper representation of provinces in the country. East
Kalimantan represents the rich provinces in this sampling method and Nusa Tenggara Timur (East Nusa Tenggara) represents the poor provinces. Yogyakarta Special Territory is a medium-fiscal-capacity area. Within each area, this study covers two districts chosen at random. In each district, the study gathered the data required to show the implementation of the healthcare financing system in detail. In-depth interviews were conducted with the Head of the District Health Office, the Head of the BPJS Office, primary healthcare providers and hospitals.

Data on purchasing arrangements were gathered through document review and supplemented by interviews with actors involved in the purchasing arrangements. The qualitative data was collected by interview and focus-group discussion. Individual interviews with the purchasers and relevant actors in government, particularly ministries of health (at both national and decentralized level) and focus-group discussion with provider groups and community representatives were undertaken in order to gather information on current purchasing practices in the countries being examined. Interview with community representative also part of the data collection method.

The study uses both deductive and inductive approaches to analyse the qualitative data in order to ensure that the analysis fully captures the themes in the conceptual framework and any themes outside the conceptual framework that emerge as important during qualitative data collection and analysis.

**Results: BPJS purchasing mechanism**

**Description of the purchasing mechanism**

In this study we will focus on the purchasing mechanism implemented by BPJS, because the National Social Security System Law states that only a single purchaser, BPJS, is allowed to manage social security programmes in Indonesia. According to the roadmap to Social Health Insurance in Indonesia, By the end of 2016, there will be no Jamkesda, as it is a temporary mechanism in the transition towards UHC by 2019. BPJS is the legal entity established to implement social security programmes, as mandated in article 1 of Law No. 24/2011 on BPJS. According to the
JKN road map, there will be no Jamkesda by 2019. In one city in East Kalimantan, Jamkesda was dissolved in 2014. According to the Roadmap towards a national health insurance 2012-2019 in Indonesia (Republic of Indonesia, 2012), Jamkesda will merge with the social health insurance system in 2016.

The mission of BPJS is as follows.

1. To build strategic partnerships with various institutions and encourage public participation to expand the membership of the national health insurance scheme (JKN).

2. To establish and administer a health insurance system that is effective and efficient and provides a high-quality service for participants through optimum partnership with the health facilities.

3. To manage social security programme funds and BPJS Healthcare funds effectively, efficiently, transparently and accountably to support the sustainability of the programme.

4. To build an effective BPJS Healthcare system based on the principles of good corporate governance and improve the competence of employees to achieve superior performance.

5. To implement and develop the system of planning and evaluation, assessment, quality management and risk management for the entire operations of BPJS Healthcare.

6. To develop and strengthen information and communication technology to support the operations of BPJS Healthcare.

In general, funding for BPJS Healthcare in the JKN system comes from three sources: (1) the participant premium from central Government (for poor households); (2) the employer and employee contributions; and (3) contributions by non-salaried members. BPJS can use 6.47% of the total revenue for supporting administrative tasks of BPJS Healthcare. Thus the administration costs are funded by government, and community members who pay premiums.

The amount of national health insurance premiums is stipulated in article 16B of Presidential Regulation No. 111 of 2013 (Republic of
Indonesia, 2013a), namely that premiums for civil servants, members of the Tentara Nasional Indonesia (Indonesian military), members of the POLRI (police), State officials and non civil-servant government employees is 5% of the salary or wages per month, paid on the following terms: 3% paid by the employer and 2% paid by the participant. Premiums for private-sector employees are 5% of the salary or wages per month, on the following terms: 4% paid by the employer and 1% paid by the participant. The private sector premium is lower than civil servants, because most of them have a lower income earners.

The calculation of the maximum contribution of formal sector participants is based upon their taxable income, family status and PRKP K1 status, and has an upper limit of Rp 4.725 million (USD 337). This premium cover the dependents (spouse and children) of civil servants, and for employed members it covers the employee and family (spouse and two children). Non-salaried members (i.e. the informal sector) who are not poor pay their own premium. The premiums for these non-subsidized informal workers are fixed according to the class of service they choose.

- Rp. 59 500 (US$ 4.5) per month for first-class benefits
- Rp. 45 000 (US$ 3.4) per month for second-class benefits
- Rp. 25 000 (US$ 1.9) per month for third-class benefits.

The participant can upgrade to a higher class using their own income or combine the national health insurance with private medical (indemnity) insurance.

In this study, it was found that, during the four months of national health insurance implementation studied, BPJS Healthcare did not act as a purchaser that bears the risks as an assurer should do. As a result, BPJS seems to be merely an administrative institution so that, if it collapses or runs out of funds because of adverse selection, government will provide it with financial assistance to avoid bankruptcy. This means that BPJS Healthcare does not play the same role in cost and quality control as other insurance agencies. BPJS Healthcare’s role as a guarantor of risk has not been laid down in any regulation, thus leading the executing agency to serve only as a fund manager in a purely administrative role. In practice,

1 Note. The premium of Rp. 59 500 for first class benefits is considered too low.
the purchaser, BPJS Healthcare, only implements rules that have been defined in the laws and regulations of the Minister of Health.

Since all premiums are collected into a single-pool (BPJS), excessive use of services and BPJS resources by those (rich or poor) who have better access to health services will disadvantage those (rich or poor) who cannot access them. This may be due to the low health facilities utilization rate and claim ratio among poor community groups, which means that the premium paid by the government for this subsidized group is not well absorbed. In other words, the use of services and BPJS resources by rich (non-salaried) members who have better access to health services will reduce access to BPJS resources by poor people who cannot access services.

BPJS Healthcare and relationship with government

Policy design

A national policy, in the form of a law to manage the operations of both purchasers and providers, was issued in 2004. This law was followed by the implementing regulations in the form of regulations of the Minister of Health. However, the regulations do not explicitly reflect government expectations of purchasers. Ideally, the role of government to drive the active purchaser is: (1) to fill service delivery infrastructure gaps; (2) to ensure that adequate resources are mobilized to meet service entitlements; and (3) to ensure the accountability of the purchaser.

The policy that regulates purchaser and provider operations is laid down in Law No. 24/2011 on BPJS (chapter IV on functions, duties, powers, rights and obligations), Regulation of the Minister of Health No. 71 of 2013 (Republic of Indonesia, 2013) and Regulation of the Minister of Health No. 28 of 2014 on guidelines for the implementation of national health insurance. Regulations governing healthcare quality are contained in Presidential Regulation No. 12 of 2013 (Republic of Indonesia, 2013b), and cost and quality control are regulated by Regulation of the Minister of Health No. 71 of 2013 (Republic of Indonesia, 2013c). Regulations promoting efficient use of drugs are contained in Decision of the Minister of Health No. 159/MENKES/SK/V/2014 on the National Formulary (Fornas).
Recently issued regulations on the prevention of cheating (fraud) in health insurance programme implementation in national social security system are contained in the Regulation of the Minister of Health No. 36 of 2015, as well as the regulation on financial protection provided for in the National Social Security System Law No. 40/2004.

**Actual practice**

In practice, there are no explicit regulations governing the relations between the Ministry of Health and BPJS Healthcare.

According to the law, BPJS Healthcare is a public legal entity responsible to the President. It is domiciled in the capital of Indonesia and has offices at the provincial and district/city level. It has 13 regional offices. This structure shows that BPJS Healthcare is a centralized body. The Board of Directors is an authorized BPJS body and takes full responsibility for maintaining the operations of BPJS in accordance with its mission. Board members come from different professional areas. They are appointed and dismissed by the President, who appoints one of the members of the Board of Directors as the main director.

According to the law, BPJS Healthcare is monitored both internally and externally. Internal supervision is carried out by the supervisory organ of BPJS. There is a supervisory board and an internal supervision unit. The supervisory board consists of various professionals, representing professionals, government, workers, employers and the public. The supervisory board is appointed and dismissed by the President and members have to meet special requirements, such as competence and experience in management and supervision. The chairman of the supervisory board is one of the members, appointed by presidential regulation. The tasks of this supervisory board are to supervise BPJS activities, supervise BPJS management and development of the Social Security Fund by the Board of Directors, and provide advice, counsel and judgement for the Board of Directors. BPJS reports to the President, with a copy of the report going to the Dewan Jaminan Sosial Nasional (DJSN – National Social Security Agency).
External supervision is provided by the DJSN, which is responsible to the President. Its functions are to formulate general policy and coordinate the implementation of the National Social Security System through studies and research related to the implementation of social security, to propose social security fund investment policy and propose the national budget for beneficiaries of social security contributions and the availability of the operating budget to government. It consists of 15 people, representing government, notable figures and/or experts who understand the field of social security, the employers’ organization and workers’ organizations, with the chairman and other members.

Other independent agencies that oversee BPJS are Satgas Profession (Professional Task Force), BPJS Watch, the Otoritas Jasa Keuangan (Financial Services Authority – OJK), the Supreme Audit Agency (BPK) and the Komisi Pemberantasan Korupsi (Corruption Eradication Commission – KPK). The Professional Task Force is a combination of various professional organizations, such as the Ikatan Dokter Indonesia (Indonesian Medical Association – IDI), Ikatan Bidan Indonesia (Indonesian Midwives Association – IBI), Persatuan Perawat Nasional Indonesia (Indonesian National Nurses Association – PPNI), etc. BPJS Watch is a combined committee of workers in social security action. The Financial Services Authority is a state agency which monitors financial agencies. The big challenge for these independent agencies is that they have little knowledge of medical insurance and therefore their role in supervising BPJS Healthcare is very limited.

Article 51 of Law No. 24/2011, (which addresses relations with other institutions), states that, for the purpose of improving the service of the social security programme, BPJS shall cooperate with other government institutions. For example, in terms of quality control, BPJS should collaborate with district/city health offices to evaluate the performance of health providers, since the district/city health office is the agency mandated by law to perform this role. However, the cooperation between BPJS and Government agencies has not been defined in implementing regulations. Coordination between BPJS and the Ministry of Health is important, since the role of the Ministry of Health is to represent the President in the health sector.
At the provincial and district level, there is no policy on the relationship between provincial and district health offices with the branch offices of BPJS. There is no oversight function for provincial health offices, as the decentralized arm of Ministry of Health. There is no formal communication or reporting flow. Communication with the Ministry of Health is still similar to that prevailing during the preparations for the introduction of JKN before 2014. This means that the Ministry of Health functions as a regulator only.

To improve equality of access to health services, which is lacking in remote areas, the Indonesian Government has regulated health services through the 2009 health legislation and the presidential regulation on the national health system. In the implementation of JKN concerning access to health services, government has also stipulated the law’s implementing regulations. Government regulations aim to encourage investment by the purchaser on health service infrastructure, especially in areas with low healthcare coverage, as stipulated in the 2013 presidential regulation on health insurance.

The Government has formed a health technology assessment team and clinical advisory board at national level in order to control the cost and quality of national health insurance services. Meanwhile, BPJS Healthcare has established a Medical Advisory Council, composed of academics, professional associations and clinicians, so that the quality of the profession is controlled by the profession itself.

Besides the two teams formed by the Ministry of Health and BPJS, there is another team to control cost and quality assurance, which is an independent group whose members include professional organizations, medical experts, medical practitioners and academics. This team operates at central, provincial and local levels to control the quality and cost of JKN participants’ health services.

The design and implementation of the mechanisms which ensure the accountability of the purchaser to government have been defined by law. Even some independent bodies, such as the Financial Services Authority and the Corruption Eradication Commission, are involved in ensuring
accountability of JKN implementation, which is managed by BPJS as stipulated in the law. The DJSN also plays a role in the oversight and accountability process of BPJS. DJSN act as the regulator while BPJS act as implementer.

However, as of 2015, the accountability system has not been implemented in the field. There is no independent monitoring of the quality of medical services at the district level. For reasons which are unclear, the fraud prevention and eradication system has not been established. New regulations concerning the prevention of fraud exist as of 2015. These regulations recommend the implementation of a fraud prevention system, particularly through coordination among different key stakeholders.

Data on participation and utilization of JKN participant services are difficult for local government health offices to access. This makes it difficult for district government to establish promotion and prevention programmes or report on the status of public health in the district. BPJS local branches use a centralized institutional purchaser policy. As a consequence, the local BPJS branch is not free to give data access to provincial and district governments. BPJS Healthcare is perceived to comply only with the rules set by the central government and is seen as reluctant to coordinate with local government health offices.

**Analysis of design compared with the ideal**

The Ministry of Health and BPJS Healthcare should share responsibility for the quality control and cost control function. However, in practice, this function is not yet coordinated properly at national, regional or local level.

In the case of physicians and other human resources for health, there is still an imbalance between the ideal and the existing policy. For instance, government has not managed to set up a plan for equitable geographical distribution of medical specialists throughout Indonesia. As a result, specialists are disproportionately concentrated in big cities. The indicator of health facility availability and accessibility has not been adopted as an indicator for regional development.
The imbalance between the ideal and the existing policy lies in the contract between purchaser and provider, which is an important factor in encouraging strategic purchasing. The provision which states that the government provider will automatically and compulsorily serve as BPJS provider is one of the weaknesses of the existing policy. It is a weakness because there is no good credentialing process. For example, both qualified and non-qualified government healthcare providers can act as providers for BPJS members because even those without accreditation can become BPJS providers. Any public hospital can be a BPJS partner, regardless of the quality of services it provides. In remote provinces, only public hospitals operate, such as in East Nusa Tenggara province. In addition, hospital quality control should be performed by not only national level independent agency but also local one.

There are huge differences in healthcare access among different regions. According to the law, BPJS should provide a compensation fund in case a member cannot access health services they need because of unaccessible referral healthcare facilities. Although this regulation has been adopted, in practice it has proven to be very difficult to administer / disburse funds because it requires a certificate from the local health department(which in itself may be in accessible to the member).

The imbalance between the ideal and the existing policy occurs because there is no legal framework regulating the harmonious relationship and synergy between local health authorities and the local branches of BPJS, which creates difficulties for coordination in the field. Coordination between BPJS and government seems to exist only at the central level.

**Analysis of design compared with actual practice**

The Government has formed a health technology assessment team and clinical advisory board at national level in order to control the cost and quality of national health insurance services. BPJS Healthcare established a Medical Advisory Council, composed of academics, professional associations and clinicians to oversee the quality of the medical professionals.
The policy for the provision of access services has been drawn up, but in practice there are still many inequalities. Central and local government should invest in the construction of new health facilities and the distribution of health personnel to ensure the availability of health facilities in remote and suburban areas. In fact, in the middle of 2014, the President issued a presidential instruction to reduce the budget of the Ministry of Health by Rp. 5 trillion (approx. US$ = USD 340 999 000 or 3.4 billion; USD=IDR 14 705). The health budget cuts mean that the Ministry of Health has a limited ability to concentrate investment on the construction of health facilities in remote and suburban areas. Moreover, not all regions allocate 10% of local revenue to health development.

Based on the study results, all Government providers, including primary healthcare facilities and hospitals, are obliged to cooperate with the Government, while private providers are not obliged to cooperate with the purchaser and serve BPJS participants. This results in a very long queue of patients in Government hospitals, because these hospitals are not able to accommodate all BPJS participants.

The contract between BPJS and hospitals uses a prospective payment system in which INA-CBG rates are not in accordance with the actual hospital rates. INA-CBG was set by government and does not differentiate between public and private hospitals. Some private hospitals have tariffs that are much higher than INA-CBG figures. This makes some private hospitals reluctant to cooperate with BPJS. However, some private hospitals can adapt their services and make some profit from the BPJS contract.

Since 2007, the DRG payment system has been used to pay the patients in hospitals. There are 1077 INA-DRG classifications for both inpatient and outpatient classes, each with three levels of severity. Aside from these, there are special tariffs for expensive procedures, expensive drugs, implants, and prosthesis.

The National Casemix Centre under the Minister of Health has the responsibility to calculate these rates. Rates INA-CBG is being adapted to implement regionalization consisting of regional 1 (Java and Bali), regional
2 (Sumatra), regional 3 (Kalimantan, Sulawesi, and West Nusa Tenggara), as well as regional 4 (Maluku, Papua and Nusa East). Regionalization associated with the distance and the price difference between regions. There are differences in rates of up to 7 percent for medical consumables.

In the early stages of JKN implementation, capitation payments to primary care facilities did not improve the quality of medical services provided by physicians, owing to the absence of a legal framework that enables payments for human resources (including incentives to medical doctors and other health personnel). However, the current situation is better, owing to a Minister of Home Affairs regulation which has managed to return at least 60% of capitation fees for medical services to medical personnel. However, there are no performance indicators for services funded by capitation. In 2015, a pilot pay-for-performance system was implemented in some provinces.

In the Implementing Agency of Social Security Law No. 24/2011, BPJS is vested with the authority to award and renew the accreditation of primary care organizations that will be serving the participants. This authority should be used well because the standards and criteria for accreditation have been ratified by the Minister of Health. But the reality is that accreditation is only a formality: public health facilities must participate in the JKN programme whatever their conditions are, since not all Government providers are accredited. The “real credentials” process should be conducted for private providers, but the practice is still somewhat flexible because, in some regions, such providers are still limited.

As a matter of fact, the central Government, in this case the Ministry of Health, has been trying to build dozens of Pratama (third-class) hospitals in some remote areas, but without the support of provincial government or sufficient numbers of health workers. Thus, it is very difficult to provide access to health services in remote areas.

The study found a BPJS report showing that the ratio of claim payments to independent participants (non-salaried members/informal sector who pay their own premium) is over 100%. The claim ratio is calculated as follows: claim paid/premium received x 100%. Even in November 2014, the claim
ratio was over 1300%. On the other hand, the ratio of claim payments to poor participants, which are subsidized by the Government, is relatively low owing to access problems.

A premium of Rp. 59 500 for first class benefits is considered too low. Moreover, participants may move to a higher class by paying a relatively small fee. The result is that the rich will obtain more benefits because they are closer to the high technology and medical human resources. There is no clear regulation on this. Capitation payments to the public health facilities have not been used properly. There is no indicator of performance for primary care services. The improvement in the quality of these services, including the availability of drugs to treat 155 primary diagnoses, cannot be assessed.

Compensation policies to reduce inequity, provided by the existing regulations, are not implemented in full. Only ambulance transport between health facilities is in operation so far.

**Critical assessment**

This study found insufficient investment to ensure equitable distribution of health facilities in 2014, especially in remote and suburban areas. The Government has set a target of increasing the number of JKN participants gradually until 2019. However, it does not provide support in the form of adequate health facilities. Therefore there is a problem on the supply side of the healthcare delivery system. The sources of health financing in Indonesia are still not yet run as mandated in the legislation.

The existing policy features a contract between purchaser and provider, which is an important factor in encouraging strategic purchasing. There is no legal framework regulating synergy and a harmonious relationship between local health authorities and BPJS at the local level.

The imbalance between the ideal and the existing policy arises from the fact that JKN enables participants to move up to the VIP class. In western European countries, if participants do this, then they lose their patient rights. But in Indonesia participants do not lose their rights and pay only the difference between their existing entitlement and the VIP price.
BPJS Healthcare and relationship with providers

The theoretical ideal of the purchaser–provider relationship

Ideally, the purchaser will improve health system efficiency through rational provision and use of services, in the following ways.

1. Providing an appropriate range of services and locations relative to the distribution of the population by means of effective gatekeeping and referral.
2. Selecting providers and accreditation.
3. Implementing provider payment methods efficiently (prospective payment system).
4. Making use of monopsonistic purchasing power.
5. Introducing generic essential drug lists and standard treatment guidelines.
7. Ensuring mutual accountability between purchaser and providers through timely payments to healthcare providers and appropriate audit systems.

Actual implementation of the purchaser–provider relationship

Pursuant to the Implementing Agency of Social Security Law No. 24/2011, BPJS has the authority to accredit and reaccredit healthcare providers that enter into cooperation to serve the participants (see section 5.2.4, “Analysis of design compared with actual practice”, above). The Regulation of the Minister of Health No. 71 of 2013 on healthcare services in national health insurance, includes the process of accreditation and reaccreditation. All public providers, including primary healthcare facilities and hospitals, are obliged to cooperate with BPJS, while private providers are not obliged to cooperate with the purchaser to serve BPJS participants.

Provider payment mechanisms used in the JKN programme are capitation fees for primary healthcare and INA-CBG for hospitals. The patient do not have to co-pay at point of service for outpatient and inpatient care. Healthcare services are provided based on referral scheme, which means
hospitals provide services which primary care cannot manage. Hospital services include inpatient and outpatient care.

In contrast, there is no ceiling on the budget for hospital claims by INA-CBG. In practice, the INA-CBG payment system in Indonesia is inefficient because it cannot reduce the hospital admission rate. The implementation of INA-CBG at this early stage is still similar to a fee-for-service system with a package tariff, because regulation of referral, readmission and unbundling is still very limited.

Health professional associations and health facilities have also been involved in negotiating health service tariffs (capitation for primary care and INA CBG for the secondary care) under Presidential Regulation No. 12 of 2013 and other regulations.

In the context of purchasing, the distribution of specialists and health facilities is important because the healthcare referral payment system is based on claims under the INA diagnosis-related groups. These claims refer to medical technical capabilities that can only be performed by specialists. In this process, medical services in BPJS can be regarded as unlimited.

For quality control of the JKN programme, the health services delivered to participants must comply with the standards of medical care and with existing laws and regulations. Meanwhile, to ensure that services for participants have been delivered in accordance with the standards of medical care, the accreditation process is applied, but unfortunately this has not been done optimally, i.e. mainly to Government healthcare providers. As for clinical pathways, these have been recommended in the INA-CBG technical guidelines but, in practice, not all hospitals have a clinical pathway to guide their healthcare. Healthcare providers are supervised by a quality control and cost control team set up by BPJS. But so far the team has not provided a report on the results of monitoring healthcare providers using medical service standards and clinical pathways.

In respect of efficiency, providers are obliged to use drugs based on the National Formulary (Fornas) and follow binding regulations. Now that Fornas has been introduced, all healthcare providers should use it as a
guideline. The reality is, however, that some drugs included in Fornas are not available in hospitals, so that patients often get drugs which are not in accordance with Fornas, which often causes problems in hospitals.

In order for providers to provide health services for participants or become BPJS Healthcare networks, the main requirement is the existence of a contract between the healthcare provider and BPJS Healthcare, preceded by accreditation in line with Government regulations. This contract is only valid for one year before reaccreditation and conclusion of the next contract are required.

The contract between BPJS and Hospitals can also be used by BPJS for controlling the quality of hospitals, so if a healthcare provider breaks the rules in its healthcare services, BPJS will impose a penalty, by giving three warnings followed by termination of the contract.

... If the hospital still doesn’t want to change [for the better], we will break up this [contract]. There are so many complaints that we have given feedback three times. We also have discussed them in local and provincial health department meetings, but there is no response at all. So, we’ll possibly break up the contract ... [Head of the BPJS Branch]

BPJS Healthcare monitors and evaluates healthcare providers by requiring them to submit a report, which is mandated by Regulation of the Minister of Health No. 71 of 2013. Monitoring the quality of health services in primary healthcare facilities becomes easier with the p-care (IT system) installed on primary providers’ premises. Reports on health services in primary healthcare facilities take the form of participant visit reports, for those who use capitation funds and those which do not use non-capitation funds, respectively, with a non-uniform reporting format.

Hospital claims to BPJS follow the coding of primary and secondary diagnosis and procedures (if any). The result of INA-CBG grouping will determine the INA-CBG code and the amount that should be paid under the claim. The hospital will draw up the claim, filling in the patient identification and online disease diagnosis system, and the summary will
be submitted to BPJS. BPJS verification staff will verify the claim and, if it is approved, BPJS will pay the claim at the latest two weeks after approval.

Monitoring and evaluation of the quality of healthcare in hospitals are mostly conducted using internal and external mechanisms. Internal control in hospitals is conducted by controlling drugs and medical supplies for services, for instance using Fornas (mostly generic drugs) and controlling the use of laboratory and radiology services. In addition, clinical guidelines and pathways have been developed for effective and efficient services, and training for health workers is conducted to improve their capabilities and reduce inefficiency.

... For example, we’ve held training programmes, meetings, calls, etc. We also have given some sort of BPJS handbook about the guidelines to treat the visiting BPJS patients. We made the handbook ourselves. But admittedly, it’s less effective because of that less bargaining power ... [Respondent statement, Balikpapan Hospital]

Some regulations stipulate that the accountability of healthcare providers to the executing agency must be ensured. This is done by means of health services’ reports to primary healthcare providers in the case of primary healthcare providers and by means of healthcare claims in the case of referral healthcare providers. In addition, before claims are paid, a BPJS verification team from the branch office will verify the claim by matching it against medical records.

**Gap between theoretical ideal and policy**

Compared with provider payment systems in other countries, the system in Indonesia is slightly different: the purchaser has a very strong bargaining position because BPJS is the only purchaser at the national level that controls primary providers and hospitals. However, there is no limit (ceiling) to the budget for hospital service claims. Therefore there is the potential risk of cost escalation and negative balance of the BPJS Fund.

There is no regulation or policy on the audit system by BPJS Healthcare to control the quality and cost of healthcare. Even the new accountability process is conducted unilaterally by the healthcare provider through
monthly/routine reports to BPJS Healthcare: so far, BPJS has not been able to show its accountability to the healthcare provider. Moreover, there is no regulation for the prevention, detection, investigation or prosecution of healthcare provider fraud.

**Gap between policy and implementation**

The reality on the ground is that credentials are processed only as a formality, since Government healthcare providers must participate in the JKN programme whatever their quality status, since not all public hospitals are accredited. The “real credentials” process should be conducted for private providers, but the practice is still somewhat flexible because, in some regions, the number of private providers is still limited.

The accreditation process is not consistent with existing regulations. Most family physicians, family clinics and hospitals admit that, in the early stages of this national health insurance system, the accreditation process is only loosely implemented. The accreditation process is not conducted appropriately or as strictly as stated in the regulation, especially for primary healthcare facilities in remote areas with inadequate facilities and infrastructure. Moreover, they have not been able to use the p-care system, which is one of the requirements of an accreditation assessment. Not all primary healthcare facilities can use p-care for various reasons, e.g. shortage of health personnel or lack of computer and Internet access. BPJS Healthcare has allowed up to three years for primary healthcare facilities to complete this infrastructure, according to a respondent from a primary healthcare provider.

This study shows that public health centres have not played their role as a gatekeeper, since they all open only from 7 a.m. to 12 noon. Moreover, it seems that public health centres, as government health facilities, do not need to meet the accreditation requirements, which include adequate service hours, because they automatically become part of BPJS network anyway.

To encourage even distribution of financial resources and provision of incentives for healthcare providers, especially hospitals, the Ministry of Health issued a regulation to define the INA-CBG payment tariff for classes
A critical analysis of selected healthcare purchasing mechanisms in Indonesia

A, B, C and D hospitals. However, in practice, the implementation of this system is regarded as unfair by hospital managers. The main argument is that all classes of hospitals give participants the same health services. The tariff regionalization system for INA-CBG and differentiation by hospital class mean that class C and D hospitals tend to make excessive patient referrals to class A and B hospitals because of the low INA-CBG tariffs they would receive for delivering the care themselves.

The absence of a ceiling budget for hospital claims causes various problems. The first is the inequality of process and the large number of claims in some regions of Indonesia. A region with a large, densely packed population, a full complement of human resources for health, good healthcare facilities and the capacity to claim properly will obtain a large proportion of BPJS funds.

The second problem is the absence of upper limits on claim payments, which can increase the possibility of fraud on the part of hospitals (known as “DRG creep”). Healthcare providers tend to increase the claim when there is no cap on the maximum amount. In the current situation, there is a possibility that fraud in hospital care will increase.

According to interview results, for payments for INA-CBG at referral healthcare providers, the INA-CBG tariffs are set at the same level for both public and private hospitals in the region concerned. This leads to difficulties in private hospitals because of differences in financial management. Public hospitals still receive subsidies from central, provincial or district government (for staff salaries, recurring costs and administrative overheads) while the private ones do not get such public subsidies and must manage their finances based purely on the results of the INA-CBG claims.

Although Presidential Regulation No. 32 of 2014 has already been issued, some public health centres were still hampered by the absence of a treasurer and were still waiting for a decree from the district government. This happened because there is little knowledge about the capitation system in the district health office and among physicians and heads of public health centres. Some public health centres have already submitted a report and
plan of action to the regional health office to claim their capitation fees but have still not been paid.

In public primary healthcare facilities, drugs are procured by the provincial government using a budget from the provincial department of health. Obstacles often encountered are the lengthy process required to procure drugs and the need to follow a plan that is not in line with requirements and not implemented on time, which often leads to time-expiry of certain drugs in public health centres.

Monitoring and evaluation meetings are held once or twice a year by BPJS and providers to provide feedback on service performance. Nevertheless, some primary healthcare facilities say that, since JKN was introduced, they have never been evaluated or monitored directly by BPJS Healthcare.

According to BPJS, it has defined a reporting format, but this cannot be used by primary healthcare facilities, since not all of them, especially Puskesmas (public primary healthcare centres), can use the BPJS information system, p-care. The main elements of the report are the participants who visit and the amount involved in referrals, which are provided by the p-care system. In practice, the p-care system, which it is mandatory to apply, faces problems of infrastructure, e.g. access to high-speed Internet connections and computer networks. In addition, the installation of this system has placed an additional workload on the personnel of health centres, since each provincial government has already developed its own health centre information system.

Physicians in several public health centres and private clinics admit that there is no BPJS evaluation or penalties imposed on those which deliver poor services, e.g. if there is overutilization and high referral rates. The primary healthcare do not have to pay for referral services. However, in future, capitation payments will be combined with assessments of primary healthcare physicians’ performance. No detailed indicators for this assessment have yet been determined.
BPJS Healthcare and relationship with citizens

The theoretical ideal of the purchaser–citizen relationship

There are four indicators of the theoretical ideal of the purchaser citizen relationship:

1. To ensure all members are registered;
2. to ensure that citizens are aware of their entitlements;
3. to encourage active engagement of citizens in respect of their preferences, needs and problems and to take appropriate action; and
4. to establish effective mechanisms to listen to the complaints, views and reflections of members and manage disputes between patients and healthcare providers.

Actual implementation of the purchaser–citizen relationship

This study found that the identification of benefit packages adopted a top-down approach, in which citizens are not involved in creating the benefit package. The citizen’s voice is barely heard in the process, because of limited and weak civil society groups which could voice civil society’s preferences, needs and problems. The limited engagement of citizens is due to a lack of understanding about citizens’ rights and a mechanism to determine their preferences and needs. The limited role played by civil society in this area has also led to a lack of citizen participation in the process of determining citizen entitlements. The limited information, education and communication programme in the community is one factor contributing to this problem. Limited resources and limited coordination and networking with other stakeholders are among the other reasons why the information available to citizens is very limited. In respect of payment of premiums, a number of independent members in the informal sector do not pay premiums regularly, but no penalties are imposed on members who do not pay their premiums regularly. There is a fixed timeline for payment of premiums in a particular month. Anyone who falls sick can pay a premium, become a member and use the service after a few weeks’ waiting period, although the rules on waiting periods are changing.

There is no evidence of any mechanism to assess citizens’ health needs. There is no forum or mechanism for changing benefits in the JKN
programme, so it is difficult to do. Moreover, benefits are already defined by law and presidential regulation, so they are hard to change. To resolve this problem, the benefits of the JKN programme should not be determined by the Ministry of Health alone; the process should involve other relevant ministries, e.g. the Ministry of Social Affairs.

The benefit package that should be received by all JKN participants still faces obstacles in terms of geographical imbalances in the availability of health facilities, infrastructure and human resources for health between different regions. If participants require further treatment, a primary healthcare provider can send them to a referral healthcare provider. Participants can only access the primary healthcare provider with which their names have been registered; they cannot go to a different one. At the time of this study was done, for the initial registration, BPJS will identify the closest first-level health facility. After three months, participants can switch to another health facility if they feel uncomfortable with the services provided by the first one; they can move to any primary healthcare physician they want. If members move to another area, they can report to the BPJS office to be registered with a new physician in their new place of residence.

**Gap between theoretical ideal and policy**

There is no policy regarding the participants’ right to renew the benefit package received in accordance with the needs of the population before the research was done. Financial protection against catastrophic illness has not been defined explicitly, but is already reflected in the benefits provided by the JKN programme via a comprehensive health service meeting the medical needs of participants.

The imbalance between ideal and policy is also shown by the lack of Government regulations to manage participant involvement in awareness-raising about their rights and obligations. Such regulations only exist internally within BPJS. There is an imbalance in access between people living in big cities and those in villages or remote areas because of the absence of a Government policy on mandatory work in remote areas by health professionals. Furthermore, there is a lack of national regulations providing financial incentives for specialist to work in remote areas in order to reduce this imbalance. As Indonesia is situated in a large archipelago,
citizens’ needs in Java are different from those in Kefamenano or East Nusa Tenggara.

For members from middle and upper social classes, this is not a problem, because they can use private transport or have funds to pay for public transport. For the poor, it is different. For citizens who live in remote areas, transport costs are much higher and these costs are not covered by JKN, which may make it difficult for the citizen to access services.

There is also no policy on health benefits for people with special needs, e.g. disabled people who have special health needs.

A striking case in the early implementation of JKN in Indonesia was the registration of non-salaried participants (non-poor participants). Most new members who voluntarily register with BPJS were sick people who needed regular treatment, or patients being treated in hospital (a situation which will definitely induce adverse selection). At first, BPJS allowed a member to benefit directly from the JKN programme after registering, with no waiting period, which increased adverse selection. However, BPJS subsequently introduced a regulation imposing a waiting period.

Some members from middle and upper social classes have better access to healthcare because they have no financial barriers in terms of other costs, e.g. transport, accommodation or the opportunity costs incurred by other family members owing to lost work time. In contrast, poor BPJS members who live in remote areas should have the same benefits, but they experience barriers related to these other costs. In practice, the latter cannot obtain treatment.

Gap between policy and implementation

The imbalance between policy and its implementation exists because the active engagement of citizens regarding their preferences, needs, problems and actions is not yet fully realized. BPJS has a call centre to handle patient complaints, but its performance in resolving patients’ problems does not yet meet their expectations, as reflected in the quotation below.

*I called the call centre, which suggest [that I] come to the nearest BPJS office. I need to come three times before getting service because of very long queue, but the problem was not solved....* [patient statement]
There is no evidence that citizens can participate in the process of determining health needs and priorities. In the case of information, there is also a gap between the policy set by the Government and its implementation. Article 16 of the National Social Security System Law (No. 40/2004) states that every member is entitled to receive benefits and information about the implementation of social security programmes in which she or he participates. Although there are regulations and policies regarding the BPJS responsibility to ensure that citizens are aware of their entitlements, there is only a limited information, education and communication programme from BPJS and the Ministry of Health to inform citizens about programmes, benefits, premiums, procedures, rights and obligations. BPJS informs its members even less frequently, especially those in remote areas. Therefore, there are still many people who do not know what JKN is. There is call centre to assist the patients who have difficulties or dispute with providers, however, this call centre usually cannot solve patient’s problem. In most cases, they have to come to the BPJS office branch, which has limited number of staff to handle patient’s problem.

Similarly, in terms of access, there are still many regions which do not meet the community’s needs. The reality on the ground indicates that there is no mechanism to ensure that beneficiaries, especially marginalized groups (poor people, residents of remote areas), can access available services. As regards the availability of health facilities, technology and personnel who can provide specialist medical services, an unbalanced situation prevails in remote and rural areas. Out-of-pocket payments are still incurred by patients, e.g. transport costs for referrals. Similarly, many poor people who become JKN participants cannot access healthcare because of the unavailability of adequate health facilities to meet their needs, particularly in remote areas.

The imbalance between government policies and their implementation in the provision of health facilities and health workers creates inequities in healthcare access throughout Indonesia. If a member from East Nusa Tenggara with coronary heart disease needs surgery, she/he cannot obtain this service because of the unavailability of heart surgeons, medical equipment and other facilities. To bridge the access gap, government policy states that BPJS should pay compensation to participants who cannot
access health facilities, especially in underserved areas. From evidence in the field, the compensation policy has not been implemented. Only limited ambulance transport between health facilities has been provided for members from remote areas, such as East Nusa Tenggara, to attend referral centres in Bali and other provinces. This is the opposite of what happens in Yogyakarta, where almost all levels of healthcare service are available and can be served by Sardjito hospital, which is the top referral hospital for other provinces.

... It is compensated on the local level due to the absence of health facilities, which is set by local health office. But for the compensation, [it] is not funded yet ... [Head of BPJS Healthcare Branch]

There are already regulations, policies and mechanisms regarding complaint handling. Complaints about JKN are handled in one of three ways: directly by BPJS, through the person in charge at the hospital or with the health offices (coordinated personally with the leader of the health office). Other ways are through a free hotline (Halo BPJS, tel. 500400), a direct call to the branch office or a personal visit to the BPJS branch office. It is acknowledged by all respondents that complaint handling, including Halo BPJS, is not optimum and not even functional. The fact is that most complaints are submitted to newspapers and television. It was revealed in the interviews that most complaints from members are about overcomplicated procedures and long waiting times, and they are reluctant to use the BPJS service. All respondents rate BPJS performance as poor, and there are too many requirements to access it. The lack of awareness-raising meant that members did not know their rights and obligations. The factors related to the dysfunctional complaints mechanism include the lack of knowledge among members about the complaints mechanism too. Most of stakeholders (provider, district health office and Ministry of Health) are not actively handling complaints, except when they appeared in the newspaper or television. There is also shortage of manpower in BPJS centres.
**Gender issues in implementation of national health insurance**

Health services for women, including mothers and children are included in the healthcare benefit package in the national health insurance system. Following the launch of BPJS Healthcare in January 2014, the Minister of Health’s maternal and newborn health programme (Jampersal) was closed down, as these services are now a benefit in JKN. It is specifically stated in Presidential Regulation No. 12 of 2013 that reproductive health, including family planning, is a benefit under JKN. Meanwhile, in the circular letter of the Minister of Health No. 31/2014, it is clearly stated that antenatal care be paid under the capitation payment but normal delivery can be claimed from BPJS (reimbursement claim based on special tariff) and other referral to hospital can be claimed by INA-CBG. For pregnancy and delivery, the Government has special package tariffs. For antenatal care, there will be three services amounting to Rp. 25,000 (US$ 2) per visit; for normal delivery attended by a primary provider or midwife, the amount is Rp. 600,000 (US$ 45).

In support of Millennium Development Goals 3, 4 and 5 (promote gender equality and empower women; reduce child mortality; and improve maternal health), health screening for women is already provided under JKN. As described in article 21 of Presidential Regulation No. 12 of 2013, they are included in promotion and prevention services and include cervical cancer screening (Pap smear) and breast cancer screening (mammography).

In the interviews for this study, a board member from central BPJS Healthcare states that most health priorities are already included in the benefit package provided under JKN, especially women’s health, with a package covering delivery, family planning and even abortion using a network of primary healthcare providers, e.g. private midwives, with non-capitation rates which can be claimed separately from capitation fees at a referral centre of the hospital in accordance with the referral provisions.

... If the abortion is due [to a] medical indication, it will be covered; but if they want it, not because of medical indication, it will not be covered ...

[Head of BPJS Healthcare Branch B]
... Medical check-up as well as Pap smear planning will be given only for those who have such risks... [Head of BPJS Healthcare Branch B]

... In addition, we also provide a programme that deals with the detection of cervical cancer for the spouses of JKN participants who are married, but not in the present time. In the future a clinic for a Pap smear examination [will be] prepared as early prevention of the risk of ovarian cancer. Next 1-2 months we will include it in the benefit package ... [Head of BPJS Healthcare Branch B]

This is similar to the statement of the Government through the Ministry of Health that the mechanism for monitoring and evaluation by BPJS in terms of the achievement of the national health policy programme is the responsibility of the Ministry of Health. For example, a bundled package of Rp. 200,000 for antenatal care, as described above, is the responsibility of the health office. The antenatal care package is paid through claims, because it is a non-capitation service. The health office can check whether maternal and child health programmes have been achieved or not. This programme is still to be implemented. Meanwhile, national health policy programmes covering tuberculosis, HIV/AIDS and prevention of disease have not yet been created by the Ministry of Health or BPJS Healthcare.

The health office will be a kind of supervisor for the achievement of the targeted programme (bundling the antenatal care package). So we will give Rp. 200,000 if the programme is achieved. [Ministry of Health]

Maternal and child health is currently treated [as a special case], not included in the capitation. But this [has just been implemented]...the future [goal] is quality of service. [Ministry of Health]
Conclusions and policy implications

Conclusions

Purchaser-government relationship

1. Unclear organizational roles and accountability lines between BPJS (purchaser) and the Ministry of Health/district health offices.

2. Inadequate monitoring and evaluation because data in BPJS cannot be accessed by district and provincial health officers, and local government authority and capacity to monitor the programme are low.

3. Limited budget for developing new health service infrastructure and deploying strategic human resources to reduce inequity in services, especially in remote areas.

Purchaser-provider relationship

1. Purchaser (BPJS) has inadequate authority, accreditation or capacity to contract, especially with respect of government providers.

2. Poor contract monitoring mechanisms to control health services increase the possibility of moral hazard and fraud.

Purchaser-citizen relationship

1. The needs, preferences and priorities of citizens in determining service entitlements are not made clear in policy design and implementation.

2. The large number of regions where community needs are not met indicates that there is no mechanism to ensure that beneficiaries can access available services, especially in the case of marginalized groups.

3. There is no evidence that citizens can participate in the process of determining health needs and priorities.

4. There is no citizen representation on purchasing boards.

5. Legislation on patients’ rights is limited.
Policy implications

The current healthcare purchasing situation may have a negative impact on the health system. Health revenue and the pooled system in BPJS may become an obstacle to achieving the universal health coverage policy objective of social justice. Marginalized citizens in problem areas may not obtain the same benefits as other citizens. It is predicted that the budget-spend gap between the groups will widen. The unclear quality of care and inefficiency of the services purchased may worsen in the current purchasing situation. The roles of the Ministry of Health and local government health offices in developing equitable health services and ensuring good purchasing may become less active. The ultimate result is that the objective of universal health coverage policy in terms of equity and efficiency of health system becomes more difficult to achieve.

Policy recommendations intended to transform the current passive purchasing system into a more strategic purchasing system are as follows.

1. Empower citizens to participate actively in benefit-setting, especially in the case of remote areas, minors and disabled people.
2. Ministry of Health and local government should invest in developing health facilities and human resources and improving equity in access.
3. Strengthen Government stewardship for health equity and establish an integrated regulatory framework for quality standards, payment requirements, price regulations, monitoring and evaluation, and accreditation of providers.
4. Ensure cost-effective contracting between purchaser and providers, including accreditation, negotiation and management and monitoring of the contract. It is also important to set an upper limit on hospital claims in order to control costs.
5. Promote and establish a higher quality of care through accreditation of primary healthcare facilities and hospitals, with standardized clinical guidelines at primary level.
6. Ensure structural or functional integration of public health programmes into purchasing.
7. Split the premium pool between poor people, government-subsidized member and salaried-workers on the one hand, and non-salaried members (e.g. self funded) on the other hand, in order to ensure health equity.

8. Enforce purchaser accountability by making relevant data accessible to the general public and relevant stakeholders.

9. Strengthen quality control in health services as well as fraud prevention, detection and prosecution.
References


Republic of Indonesia (2013c). Regulation of the Minister of Health No. 71 of 2013 on healthcare services in JKN. Jakarta, unpublished.


Annex 1. Healthcare financing mechanism of the social security scheme in Indonesia

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<th>Jamkesda East Nusa Tenggara</th>
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<td>Premium subsidy from central government (tax-funded) for poor people (JKN)</td>
<td>Premium subsidy from central government (tax-funded) for poor people (JKN)</td>
<td>Premium subsidy from central government (tax-funded) for poor people (JKN)</td>
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<td>Premium contributions from employer and employee (formal sector)</td>
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<td>Premium contributions from employer and employee (informal sector)</td>
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<td>Premium contributions from informal sector (voluntary)</td>
<td>Premium contributions from informal sector (voluntary)</td>
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<td>General tax-funded revenue from central government for promotion and prevention programme in public primary healthcare</td>
<td>General tax-funded revenue from central government for promotion and prevention programme in public primary healthcare</td>
<td>General tax-funded revenue from central government for promotion and prevention programme in public primary healthcare</td>
<td>General tax-funded revenue from central government for promotion and prevention programme in public primary healthcare</td>
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<tr>
<td>Pooling</td>
<td>Single pool (at national level)</td>
<td>Three pools: JKN, Jamkesda province and Jamkesda district</td>
<td>Three pools: JKN, Jamkesda province and Jamkesda district</td>
<td>One pool (BPJS/JKN)</td>
</tr>
<tr>
<td>Purchasing</td>
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<td>Limited access, but in some cases can refer to national hospital</td>
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Source: Authors’ summary
## Annex 2. Overview of purchasing arrangements in selected provinces of Indonesia

### Social security schemes

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<td>Local budget</td>
<td>Central budget</td>
</tr>
<tr>
<td>Coverage (excluding civil servant and informal sector membership)</td>
<td>889 813 (24.1% of the population)</td>
<td>3 690 520</td>
<td>333 195 (9.6% from 3 457 491 population)</td>
</tr>
<tr>
<td>Note: some districts have total coverage poor: 381 175 (10.3% of the population) 333 195 (9.6% of the population) 873 274 (25.3% from 3 457 491 population) 942 129 Jiwa (27.2% from 4 899 260 population) 561 164 (11.5% from 4 899 260 population) 2 096 920 (42.8% from 4 899 260 population)</td>
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<td>Poor people specified by Ministry of Social Affairs</td>
<td>Poor, near-poor and certain population groups (e.g. religious leaders, prisoners) not covered by NHI</td>
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<tr>
<td>Benefit package</td>
<td>Comprehensive (no cost-sharing)</td>
<td>Comprehensive (no cost-sharing)</td>
<td>Claim ceiling Rp. 15 000 000</td>
</tr>
<tr>
<td>Provider payment system</td>
<td>Fee-for-service</td>
<td>Fee-for-service</td>
<td>Capitation and INA DRG</td>
</tr>
</tbody>
</table>

NHI: national health insurance

Source. Authors’ Summary
### Annex 3. Summary of national health insurance policy in Indonesia

<table>
<thead>
<tr>
<th>No.</th>
<th>Topic</th>
<th>Legislation</th>
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</thead>
<tbody>
<tr>
<td><strong>Executive Agency (BPJS Healthcare)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Mechanism to assess the health needs of participants</td>
<td>Presidential Regulation No. 12 of 2013, article 20: Every participant has the right to healthcare benefits in a form of individual healthcare service covering promotive services, preventive, curative and rehabilitative, including medicine and medical consumables in accordance with medical requirement. Article 26: New technology application under healthcare benefits shall refer to medical requirements in line with health technology assessment.</td>
</tr>
<tr>
<td>2.</td>
<td>Selection of healthcare providers by participants</td>
<td>To determine healthcare providers Presidential Regulation No. 12 of 2013, article 29, clause 1: Initially BPJS Healthcare will register each participant to one first level healthcare facility which will be appointed by BPJS Healthcare, based on the recommendation from the health department at regency/city level. Presidential Regulation No. 12 of 2013, article 29, clause 2: After the first 3 (three) months, participant has the rights to select their own first level healthcare facility.</td>
</tr>
<tr>
<td>2.A</td>
<td>Policies related to gender issues</td>
<td>Presidential Regulation No. 12 of 2013, article 21, clauses 4−7: (4) Family planning as referred in clause (1) letter c consists of: counselling, basic contraception, vasectomy and tubectomy working with family planning institutions (5) Vaccines for basic immunization and basic contraception materials as referred in clause (3) and clause (4) are provided by the Government and/or regional government (6) Health screening services as referred in clause (1) letter d is provided to [selected] individual[s] to detect disease risk and further impact of certain diseases (7) Regulation on procedure of health screening, type of diseases and schedule of health screening services as referred in clause (6) shall be regulated in a ministerial regulation.</td>
</tr>
<tr>
<td>3.</td>
<td>Selection of benefit package by participants</td>
<td>Presidential Regulation No. 12 of 2013, Chapter IV, Healthcare Benefits, articles 20–26 (essentially, comprehensive benefits unless there are some that are excluded). Chapter VI, Benefit Coordination, articles 27-28 (essentially, participants in healthcare benefit schemes can enrol in additional healthcare insurance).</td>
</tr>
<tr>
<td>4.</td>
<td>Mechanisms to ensure the accountability of the executive agency to participants</td>
<td>Law No. 40/2004, article 4; The National Social Security System is administered on the principles of: a. mutual assistance; b. not-for-profit; c. transparency; d. prudence; e. accountability;</td>
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### Annex 3. Summary of national health insurance policy in Indonesia (Con’t.)

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</table>
| 4   | Mechanisms to ensure the accountability of the executive agency to participants | f. portability;  
g. mandatory participation;  
h. trust fund; and  
i. return on management of the Social Security Fund to be used entirely for developing programmes in the best interests of participants.  
Elucidation of article 4 of Law No. 40/2004 on the National Social Security System and Elucidation of article 4, letter e of Law No. 24/2011 on the implementing agency of social security, that:  
The principle of accountability in this provision is the principle of accurate and accountable programme implementation and financial management. |
| 5   | Types of healthcare provider contracted | Healthcare providers qualified to work with BPJS in Regulation of the Minister of Health No. 71 of 2013, chapter III.  
Cooperation of health facilities with BPJS Healthcare, article 5.  
In order to cooperate with BPJS Healthcare, health facilities referred to in article 2 shall comply with the requirements (this requirement is described in articles 6–8).  
In addition, provisions must comply with the requirements referred to in clause (1). BPJS Healthcare in cooperation with health facilities should also consider the adequacy of the number of health facilities and the number of participants to be served. |
| 6   | Mechanism for selecting healthcare providers | Regulation of the Minister of Health No. 71 of 2013, chapter III, Cooperation of Health Facilities With BPJS Healthcare, article 5:  
In order to cooperate with BPJS Healthcare, health facilities referred to in article 2 shall comply with the requirements (this requirement is described in articles 6–8).  
In addition, provisions must comply with the requirements referred to in clause (1). BPJS Healthcare in cooperation with health facilities should also consider the adequacy of the number of health facilities and the number of participants to be served.  
Article 9:  
In determining the choice of health facilities, BPJS Healthcare shall perform selection and credentialing using technical criteria that include:  
- human resources;  
- infrastructure and facilities;  
- scope of services; and  
- service commitment.  
Technical criteria referred to in clause (1) shall be used to determine the cooperation with BPJS Healthcare, the type and extent of service, capitation, and the number of participants who can be served.  
BPJS Healthcare in establishing the technical criteria referred to in clause (1) shall be based on the Regulation of the Minister. |
Annex 3. Summary of national health insurance policy in Indonesia (Con’t.)

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<tbody>
<tr>
<td>7</td>
<td>Agreement with healthcare providers regarding:</td>
<td>The credentials process is explained in the Regulation of the Minister of Health No. 71 of 2013, chapter III, Cooperation of Health Facilities with BPJS Healthcare, section 2, article 9. The payment method is explained in the Regulation of the Minister of Health No. 69 regarding healthcare standard rates at first-level health facilities and advanced-level health facilities in the implementation of the health insurance programme. The benefit package provided is explained in Presidential Regulation No. 12 of 2013, chapter IV, Healthcare Benefits, articles 20-24, and article 25 regarding the services that are excluded. Article 26 addresses the assessment of service specifications. Supervision of healthcare quality: Regulation of Minister of Health No. 71 of 2013, Chapter VI, Quality Control and Cost Control. Article 33: In order to ensure quality and cost control, the Minister is authorized to conduct:</td>
</tr>
<tr>
<td></td>
<td>• registration/credentials and accreditation;</td>
<td>• health technology assessments; • clinical advisories; • standard rate calculation; and • monitoring and evaluation of healthcare service implementation.</td>
</tr>
<tr>
<td></td>
<td>• payment method and service levelling;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• benefit package provided;</td>
<td>Monitoring and evaluation referred to in clause (1) letter d is to ensure that health professionals who provide healthcare at first-level health facilities and advanced-level referral health facilities have complied with the authority and medical services standard specified by the Minister.</td>
</tr>
<tr>
<td></td>
<td>• monitoring and evaluation of healthcare quality;</td>
<td>Article 37: Implementation of quality and cost control by health facilities as referred to in article 36 shall be performed through:</td>
</tr>
<tr>
<td></td>
<td>• monitoring and evaluation of healthcare costs;</td>
<td>• organization of health professionals’ authority in performing professional practice according to their competence; • utilization review and medical audit; • development of professional ethical and disciplinary standards for health professionals; and/or • monitoring and evaluation of the use of drugs, medical devices, and medical consumables in healthcare, carried out periodically through the utilization of the health information system.</td>
</tr>
<tr>
<td></td>
<td>• reports/information to be submitted by the healthcare providers</td>
<td>Article 38: Implementation of quality control and cost control by BPJS Healthcare referred to in article 36 is performed through:</td>
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</tbody>
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In respect of the implementation of quality control and cost control as referred to in clause (1), BPJS Healthcare establishes a team for quality control and cost control consisting of elements of professional organizations, academics and clinical experts.
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<td>Agreement with healthcare providers regarding:</td>
<td>The team for quality control and cost control as referred to in clause (2) can perform:</td>
</tr>
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<td></td>
<td>• registration/credentials and accreditation;</td>
<td>• awareness-raising of the authority of health professionals in performing professional practice in accordance with their competence;</td>
</tr>
<tr>
<td></td>
<td>• payment method and service levelling;</td>
<td>• utilization review and medical audit; and/or</td>
</tr>
<tr>
<td></td>
<td>• benefit package provided;</td>
<td>• development of professional ethics and discipline for health professionals.</td>
</tr>
<tr>
<td></td>
<td>• monitoring and evaluation of healthcare quality;</td>
<td>In certain cases, a team for quality control and cost control as referred to in clause (2) may request information on the identity, diagnosis, medical history, examination history and treatment history of the participant in the form of a photocopy of the medical records of the health facilities as needed.</td>
</tr>
<tr>
<td></td>
<td>• monitoring and evaluation of healthcare costs;</td>
<td>Monitoring and evaluation of health service costs (fraud): there is no regulation.</td>
</tr>
<tr>
<td></td>
<td>• reports/information to be submitted by the healthcare providers</td>
<td>Report: Regulation of the Minister of Health No. 71 of 2013, Chapter VII Reporting and Utilization Review, article 39.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facilities shall make a monthly report of healthcare activities submitted on a regular basis to BPJS Healthcare.</td>
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<tr>
<td></td>
<td></td>
<td>BPJS Healthcare shall implement a utilization review on a regular and sustainable basis and provide feedback on the utilization review results to health facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPJS Healthcare shall report the results of the utilization review to the Minister and DIJSN.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provisions concerning the reporting mechanism and utilization review as described in clause (2) and clause (3) shall be determined by the regulations concerning BPJS Healthcare.</td>
</tr>
<tr>
<td>8</td>
<td>Financial flows of the executive agency, healthcare providers and related parties</td>
<td>Regulation of the Minister of Health No. 69 of 2013 regarding healthcare standard rates at first-level health facilities and advanced-level health facilities in the implementation of the health insurance programme.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regulation of the Minister of Health No. 19 of 2014 regarding the use of the national health security capitation fund for healthcare services and operational cost support in regional government-owned first-level health facilities.</td>
</tr>
<tr>
<td>9</td>
<td>How the executive agency communicates with the central government</td>
<td>Law No. 24/2011, Part 4 Entitlement, article 12: While implementing its authority as set forth in article 11, BPJS shall be entitled to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. obtain operational funds for the implementation of the social security programme which originates from the Social Security Fund and/or other sources in accordance with the provisions of laws and regulations; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. obtain the monitoring and evaluation results of implementation of the social security programme every 6 (six) months.</td>
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</table>
A critical analysis of selected healthcare purchasing mechanisms in Indonesia

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</table>
Rate of claims: Regulation of the Minister of Health No. 69 of 2013.  
Operational budget of the executive agency: Law No. 24/2011, Part 4 Operating Costs.  
Article 44: Operational costs of the BPJS consists of personnel costs and non-personnel costs.  
Personnel as set forth in section (1) above consists of the Supervisory Board, Directors, and employees.  
Personnel costs include salary or wages and other additional benefits.  
Supervisory Board, Directors and employees receive salary or wages and other additional benefits in accordance with the authority and/or responsibility for implementing the tasks in the BPJS.  
Salary or wages and other additional benefits as set forth in section (4) with due regard to the applicable level of fairness.  
Supervisory Board, Directors and employees could receive incentives in accordance with the performance of BPJS, which is paid from the result of its expansion.  
Provisions regarding the salary or wages and other additional benefits as well as incentives for the employees shall be established by the Directors.  
Provisions regarding on the salary or wages and other additional benefits as well as incentives for the Supervisory Board and Directors shall be established by the President.  
Article 45: Operational funds as set forth in article 41, section (1), letter d shall be determined based on percentage of the received dues and/or from the result of expansion fund.  
Further provision regarding on the percentage of the expansion fund as set forth in section (1) shall be regulated in the Government Regulation. |
| 12  | How government supervises the executive agency                        | Supervision of BPJS: Law No. 24/2011 on the Implementing Agency of Social Security Chapter IX Supervision Article 39  
Supervision towards BPJS shall be conducted both externally and internally.  
The internal supervision of BPJS shall be conducted by the supervisory organ of BPJS which consists of:  
• Supervisory Board; and  
• internal supervisory unit. |
<table>
<thead>
<tr>
<th>No.</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>How government supervises the executive agency</td>
<td>The external supervision of BPJS shall be conducted by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• DJSN; and</td>
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<td></td>
<td></td>
<td>• an independent supervisory institution (in the explanation of the law, it is mentioned that the independent supervisory institution shall be the Financial Service Authority. In certain conditions, in accordance with its authority, the Audit Board of the Republic of Indonesia could conduct the examination.)</td>
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<tr>
<td></td>
<td></td>
<td>The Corruption Eradication Commission (KPK).</td>
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<td></td>
<td>Monitoring and Evaluation Team of the National Health Insurance (JKN): Decision of the Minister of Health No. 046/Menkes/SK/II/2014 regarding the monitoring and evaluation team for national health insurance implementation in 2014.</td>
</tr>
<tr>
<td>13</td>
<td>How government communicates with the executing agency</td>
<td>Law No. 24/2011, Part 4 Entitlement, article 12.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>While implementing its authority as set forth in Article 11, the BPJS shall be entitled to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. obtain operational funds for the implementation of the social security programme which originates from the Social Security Fund and/or other sources in accordance with the provisions of laws and regulations; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. obtain the monitoring and evaluation results of implementation of the social security programme every 6 (six) months.</td>
</tr>
<tr>
<td>14</td>
<td>Rules regarding the benefit package</td>
<td>Presidential Regulation No. 12 of 2013, Chapter IV Healthcare Benefits, articles 20–26 (essentially, comprehensive benefits unless there are some that are excluded):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Healthcare is not guaranteed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health services performed without going through the procedures as stipulated in the regulations.</td>
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<td></td>
<td></td>
<td>• Health services in health facilities which do not cooperate with BPJS Healthcare, except for emergency cases.</td>
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<tr>
<td></td>
<td></td>
<td>• Health services which are guaranteed by the programme of work injury insurance against illness or injury due to accidents or employment relationships.</td>
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<tr>
<td></td>
<td></td>
<td>• Health services carried out abroad.</td>
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<tr>
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<td></td>
<td>• Healthcare for aesthetic purposes.</td>
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<tr>
<td></td>
<td></td>
<td>• Services to overcome infertility.</td>
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<tr>
<td></td>
<td></td>
<td>• Straightening of teeth (orthodontics).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health disorders/diseases caused by drug addiction and/or alcohol.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health problems caused by people accidentally hurting themselves, or pursuing hobbies which endanger them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complementary, alternative and traditional medicine, including acupuncture, shin se, chiropractic, which has not been declared effective by health technology assessment.</td>
</tr>
</tbody>
</table>
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</table>
| 14  | Rules regarding the benefit package             | • Treatment and medical actions categorized as an experiment (experimental);  
     |                                                 | • Contraceptives, cosmetics, baby food and milk;  
     |                                                 | • Household health supplies;  
     |                                                 | • Catastrophic healthcare in emergency relief, extraordinary events/outbreaks; and  
     |                                                 | • Cost of other services that are not related to health insurance benefits provided.  
     |                                                 | Chapter VI Benefit Coordination, articles 27-28 (essentially, participants of healthcare benefits can enrol in additional healthcare insurance). |
| 15  | Supervision and evaluation of the executive agency | Law No. 24/2011 Chapter VIII Accountability  
     |                                                 | Article 37: BPJS shall be obliged to deliver accountability for the implementation of the tasks in the form of programme management reports and financial reports which have been audited by the public accountant to the President, with a carbon copy delivered to DJSN no later than 30 June of the following year.  
     |                                                 | The period of the programme management report and financial report as set forth in section (1) above runs from 1 January to 31 December.  
     |                                                 | The format and content of the programme management report as set forth in section (1) above shall be proposed by BPJS after consulting DJSN.  
     |                                                 | Financial report of BPJS as set forth in section (1) above shall be prepared and presented in accordance with the applicable financial accounting standards.  
     |                                                 | The programme management report and financial report as set forth in section (1) shall be published in the form of exclusive summary through electronic mass media and at least 2 (two) printing media of which have circulation nationally, no more than 31st July of the next year.  
     |                                                 | Format and content of the publication as set forth in section (5) shall be determined by the Directors with the approval of the Supervisory Board.  
     |                                                 | Provisions regarding the format and content of the programme management report as set forth in section (3) shall be regulated by the Presidential Regulation. |
| 16  | Mechanisms to ensure accountability of executing agency | Law No. 40/2004, article 4 on the National Social Security System, is administered on the principles of:  
     |                                                 | a. mutual assistance;  
     |                                                 | b. not-for-profit;  
     |                                                 | c. transparency;  
     |                                                 | d. prudence;  
     |                                                 | e. accountability;  
     |                                                 | f. portability;  
<pre><code> |                                                 | g. mandatory participation; |
</code></pre>
<table>
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| 16  | Mechanisms to ensure accountability of executing agency | **h.** trust fund; and  
**i.** return on management of the Social Security Fund to be used entirely for developing programmes in the best interests of participants.  
Elucidation of article 4 of the Law No. 40/2004 on the National Social Security System and Elucidation of article 4 letter e of the Law No. 24/2011 on the implementing agency of social security, that:  
The principle of accountability in this provision is the principle of accurate and accountable programme implementation and financial management. |
| 17  | Government funding for the executive agency to perform functions in health insurance | From Contributions of PBI and the initial fund of Rp. 2 trillion.  
Law No. 24/2011, Part 4 Entitlement, article 12.  
While implementing its authority as set forth in article 11, the BPJS shall be entitled to:  
• obtain operational funds for the implementation of the social security programme which originates from the Social Security Fund and/or other sources in accordance with the provisions of laws and regulations. |
Supervision towards BPJS shall be conducted both externally and internally.  
The internal supervision of BPJS shall be conducted by the supervisory organ of BPJS which consists of:  
• Supervisory Board; and  
• internal supervisory unit.  
The external supervision of BPJS shall be conducted by:  
• DJSN; and  
• an independent supervisory institution (in the explanation of the law, it is mentioned that the independent supervisory institution shall be the Financial Service Authority. In certain conditions, in accordance with its authority, the Audit Board of the Republic of Indonesia could conduct examination.)  
The Corruption Eradication Commission (KPK).  
Monitoring and Evaluation Team of the National Health Insurance (JKN): Decision of the Minister of Health No. 046/Menkes/SK/II/2014 regarding the monitoring and evaluation team of national health insurance implementation in 2014. |

**Healthcare providers I and healthcare providers II**

| No. | How, and how often, healthcare providers I and healthcare providers II communicate with the executive agency | A communication forum between health facilities is established by each branch office of BPJS Healthcare in accordance with the working area concerned, by appointing a person in charge from each of the health facilities. The task of the person in charge of health facilities is to provide the information needed for referral services (National Health Insurance Implementation Manual of BPJS Healthcare). |
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<td>Agreement with healthcare providers regarding:</td>
<td>The credentials process is explained in the Regulation of the Minister of Health No. 71 of 2013, chapter III, Cooperation of Health Facilities with BPJS Healthcare, section 2, article 9. The payment method is explained in the Regulation of the Minister of Health No. 69 regarding healthcare standard rates at first-level health facilities and advanced-level health facilities in the implementation of the health insurance programme. The benefit package provided is explained in Presidential Regulation No. 12 of 2013, chapter IV, Healthcare Benefits, articles 20-24, and article 25 regarding the services that are excluded. Article 26 addresses the assessment of service specifications. Supervision of healthcare quality: Regulation of Minister of Health No. 71 of 2013, Chapter VI, Quality Control and Cost Control. Article 33: In order to ensure quality and cost control, the Minister is authorized to: • health technology assessments; • clinical advisories; • standard rate calculations; and • monitoring and evaluation of healthcare services implementation. Monitoring and evaluation referred to in clause (1) letter d is to ensure that health professionals who provide healthcare at first-level health facilities and advanced-level referral health facilities have complied with the authority and medical services standard specified by the Minister. Article 37: Implementation of quality and cost control by health facilities as referred to in article 36 shall be performed through: • organization of health professionals’ authority in performing professional practice according to their competence; • utilization review and medical audit; • development of professional ethics and discipline for health professionals; and/or • monitoring and evaluation of the use of drugs, medical devices, and medical consumables in healthcare, carried out periodically through the utilization of the health information system. Article 38: Implementation of quality control and cost control by BPJS Healthcare referred to in article 36 is performed through: • compliance with quality standards of health facilities; • compliance with healthcare process standards; and • monitoring of the outcomes of participants’ health. In respect of the implementation of quality control and cost control as referred to in clause (1), BPJS Healthcare establishes a team for quality control and cost control consisting of elements of professional organizations, academics and clinical experts.</td>
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| 20  | Agreement with healthcare providers regarding: | The team for quality control and cost control as referred to in clause (2) can perform:  
  - awareness-raising of the authority of health professionals in performing professional practice in accordance with their competence;  
  - utilization review and medical audit; and/or  
  - development of professional ethics and discipline for health professionals. |
|     | • registration/credentials and accreditation; | In certain cases, a team for quality control and cost control as referred to in clause (2) may request information on the identity, diagnosis, medical history, examination history and treatment history of the participant in the form of a photocopy of the medical records of the health facilities as needed.  
  - payment method and service levelling;  
  - benefit package provided;  
  - monitoring and evaluation of healthcare quality;  
  - monitoring and evaluation of healthcare costs;  
  - reports/information to be submitted by the healthcare providers | Monitoring and evaluation of health service cost (fraud): there is no regulation.  
  Report: Regulation of the Minister of Health No. 71 of 2013, Chapter VII Reporting and Utilization Review, article 39. |  
Health facilities shall make a monthly report of healthcare activities submitted on a regular basis to BPJS Healthcare.  
BPJS Healthcare shall implement a utilization review on a regular and sustainable basis and provide feedback on the utilization review results to health facilities.  
BPJS Healthcare shall report the results of the utilization review to the Minister and DJSN. |
|     |     | Provisions concerning the reporting mechanism and utilization review as described in clause (2) and clause (3) shall be determined by the regulations concerning BPJS Healthcare. |  
Provisions concerning the reporting mechanism and utilization review as described in clause (2) and clause (3) shall be determined by the regulations concerning BPJS Healthcare. |
| 21  | Accountability mechanism of healthcare providers to the executive agency | Report: Regulation of the Minister of Health No. 71 of 2013, Chapter VII Reporting and Utilization Review, article 39.  
Health facilities shall make a monthly report of healthcare activities submitted on a regular basis to BPJS Healthcare.  
BPJS Healthcare shall implement a utilization review on a regular and sustainable basis and provide feedback on the utilization review results to health facilities.  
BPJS Healthcare shall report the results of the utilization review to the Minister and DJSN. |
|     |     | Provisions concerning the reporting mechanism and utilization review as described in clause (2) and clause (3) shall be determined by the regulations concerning BPJS Healthcare. |  
Provisions concerning the reporting mechanism and utilization review as described in clause (2) and clause (3) shall be determined by the regulations concerning BPJS Healthcare. |
| 22  | Financial flows between the executive agency, healthcare providers and other parties involved in the national health insurance scheme | Regulation of the Minister of Health No. 69 of 2013 regarding healthcare standard rates at first-level health facilities and advanced-level health facilities in the implementation of the health insurance programme.  
Regulation of the Minister of Health No. 19 of 2014 regarding the use of the national health security capitation fund for healthcare services and operational cost support in regional government-owned first-level health facilities. |
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<tr>
<td>23</td>
<td>Executive agency encouragement of innovation by healthcare providers</td>
<td>In accordance with its tasks and functions, the executive agency supervises healthcare providers in cost control and quality control and awards credentials before the contract.</td>
</tr>
<tr>
<td>24</td>
<td>Participants’ opinion about the performance of the executive agency</td>
<td>Law No. 40/2004, article 16: Each participant is entitled to receive benefits and information about implementation of social security programmes in which she or he is participating.</td>
</tr>
</tbody>
</table>
| 25 | Mechanisms to channel the aspirations of the people in choosing healthcare providers and healthcare benefits | Presidential Regulation No. 12 of 2013, article 29, clause 1: Initially BPJS Healthcare will register each participant to one first level healthcare facility which will be appointed by BPJS Healthcare, based on the recommendation from the health department at regency/city level.  
  Presidential Regulation No. 12 of 2013, article 29, clause 2: After the first 3 (three) months, participant has the rights to select their own first level healthcare facility.  
  Participants cannot select secondary healthcare. |
| 26 | Mechanisms that integrate the needs of the participants and the healthcare providers, as well as the benefit package that will be received by participants | Presidential Regulation No. 12 of 2013, Chapter IV Healthcare Benefits, articles 20–26 (essentially, comprehensive benefits unless there are some that are excluded):  
  - Healthcare is not guaranteed.  
  - Health services performed without going through the procedures as stipulated in the regulations.  
  - Health services in health facilities which do not cooperate with BPJS Healthcare, except for emergency cases.  
  - Health services which are guaranteed by the programme of work injury insurance against illness or injury due to accidents or employment relationships.  
  - Health services carried out abroad.  
  - Healthcare for aesthetic purposes.  
  - Services to overcome infertility.  
  - Straightening of teeth (orthodontics).  
  - Health disorders/diseases caused by drug addiction and/or alcohol.  
  - Health problems caused by people accidentally hurting themselves, or pursuing hobbies which endanger them.  
  - Complementary, alternative and traditional medicine, including acupuncture, shin se, chiropractic, which has not been declared effective by health technology assessment.  
  - Treatment and medical actions categorized as an experiment (experimental).  
  - Contraceptives, cosmetics, baby food and milk.  
  - Household health supplies.  
  - Catastrophic healthcare in emergency relief, extraordinary events/outbreaks; and  
  - Cost of other services that are not related to health insurance benefits provided. |
<table>
<thead>
<tr>
<th>No.</th>
<th>Topic</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Mechanisms that integrate the needs of the participants and the healthcare providers, as well as the benefit package that will be received by participants</td>
<td>Chapter VI Benefit Coordination, articles 27-28 (essentially, participants of healthcare benefits can enrol in additional healthcare insurance).</td>
</tr>
<tr>
<td>27</td>
<td>Mechanism to express participants’ displeasure/complaints to the healthcare providers and/or the executive agency</td>
<td>Presidential Regulation No. 12 of 2013, Chapter 10 Complaint Handling, article 45: In case participant is not satisfied with healthcare benefit services performed by healthcare facilities in partnership with BPJS Healthcare, complaints can be raised to healthcare facilities and/or BPJS Healthcare. In case participant does not receive proper services from BPJS Healthcare, complaints can be raised to Minister. Complaint raised as referred in clause (1) and clause (2) shall be handled appropriately and in a short period and shall provide feedback to complaining participant. Raising complaint as referred in clause (3) shall be in accordance with the prevailing law.</td>
</tr>
</tbody>
</table>
| 28  | How the executive agency guarantees its accountability to participants | Law No. 40/2004, article 4: The National Social Security System is administered on the principles of:  
  a. Mutual assistance;  
  b. not-for-profit;  
  c. transparency;  
  d. prudence;  
  e. accountability;  
  f. portability;  
  g. mandatory participation;  
  h. trust fund; and  
  i. return on management of the Social Security Fund to be used entirely for developing programmes in the best interests of participants.  
Elucidation of article 4 of Law No. 40/2004 on the National Social Security System and Elucidation of article 4, letter e of Law No. 24/2011 on the implementing agency of social security, that: The principle of accountability in this provision is the principle of accurate and accountable programme implementation and financial management. |
Annex 3. Summary of national health insurance policy in Indonesia (Con’t.)

<table>
<thead>
<tr>
<th>No.</th>
<th>Topic</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Mechanism for participants to know the performance of the executive agency</td>
<td>There is no such mechanism. However, the laws have mandated as follows: Law No. 40/2004, article 16: Each participant is entitled to receive benefits and information about implementation of social security programmes in which she or he is participating. Law No. 14 of 2008 on public information disclosure; consisting of 64 articles, this law in essence places a liability on any public agency to give access to every public information applicant to obtain public information, except for some specific information.</td>
</tr>
</tbody>
</table>

*Source: Authors’ Summary*
Chapter 4: A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

Oscar F. Picazo, Valerie Gilbert T. Ulep, Ida Marie Pantig, Beverly Lorraine Ho

Philippine Institute for Development Studies
Abstract

This study is a critical analysis of health services purchasing undertaken by PhilHealth, which implements the National Health Insurance Program of the Philippines. The study employs a principal-agent framework for analysing three critical relationships: that between the purchaser and healthcare providers, between the purchaser and citizens (members of PhilHealth), and between the purchaser and the Government, both as regulator and as funder of services, at the national Government and local government levels.

In analysing these three relationships, the study compares three states: the ideal or theoretical arrangement of purchasing as determined by economic theory; the “design” as written in laws, implementing rules and regulations, executive and administrative orders, circulars and other policies; and the actual arrangement or practice as culled from reports and interviews with stakeholders. Thus, the study is an analysis of the key alignments and variances of purchasing practices vis-à-vis the “design” and the theoretical ideal in each of the three relationships. To do this, the study employs an extensive document review, as well as key-informant interviews with decision-makers and other stakeholders, including PhilHealth management and staff, the Department of Health, provider representatives and consumer representatives.

The study provides the following key findings:

- PhilHealth’s effort in responding to its members’ needs, preferences and values in decision-making are recognized, however, more work needs to be done to make sure that they are actively engaged and are aware of their entitlements and obligations. Protection from financial hardship is another area that needs work. Accountability and feedback measures exist but are not further explored to improve performance.

- PhilHealth’s ability to influence providers’ responsiveness and efficiency through policy and regulatory tools is inadequate. Although automatic accreditation is in
place, only 67% of government hospitals are accredited. Gatekeeping and referral systems are weak; quality standards are not monitored. However, the shift in payment mechanism from fee-for-service to case rates has shown positive results and a no-balance billing policy is in force and compliance has improved.

- Government has ensured resources for PhilHealth through earmarked sin taxes and audit is institutionalized, but no proactive stewardship role exists. Although investments in delivery capacity in underserved areas is ideal, PhilHealth’s tool is financing, which it is hoped will incentivize providers to locate in underserved areas.

As PhilHealth approaches universal population coverage, the key remaining tasks are as follows.

- **Purchaser-member link** – to identify the remaining members whose premiums have been paid for by government but who are not aware of their entitlements.

- **Purchaser-provider link** – to improve benefits by significantly expanding the PCB+ package and giving members a choice of provider (public or private); to loosen up on the accreditation of public health programmes (especially TB-DOTS) with a significant impact for poor Filipinos; to fine-tune the case rate payment system by conducting costing exercises; to expand Z benefits using objective burden of disease and cost-effectiveness principles.

- **Purchaser-government link** – to undertake strategic planning on the role of social health insurance, focusing on the need to improve collection efficiency and to increase the premium so that benefits can be expanded and sustained. To strengthen the stewardship and regulatory functions by investing in skills needed to manage a modern health financing system, including actuarial science, health technology assessment and medical informatics and business analytics.
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

**Acronyms**

- **CARES**: Customer Assistance, Relations and Empowerment Staff
- **DALY**: disability-adjusted life year
- **HMO**: health maintenance organization
- **KP**: Kalusugan Pangkalahatan (universal health)
- **MDG**: Millennium Development Goal
- **MOVES**: Mobile Orientation, Validation, and Enrollment Scheme
- **NHTS-PR**: National Household Targeting System for Poverty Reduction
- **OPB**: outpatient benefits
- **PAGCOR**: Philippine Amusement and Gaming Corporation
- **PCB+**: expansion of primary care benefits
- **PCSO**: Philippine Charity Sweepstakes Office
- **PHIC**: Philippines Health Insurance Corporation
- **PhilHealth**: Philippine Health Insurance Program
- **PHP**: Philippine peso (PHP 43.3 = US$ 1.00 as at July 2014)
- **Q1**: quintile 1, the lowest-income quintile, also known as “poor”
- **Q2**: quintile 2, the second-lowest-income quintile, also known as “near-poor”
- **RESYST**: Resilient and Responsive Health Systems
- **RHU**: rural health unit
- **SHINE**: Social Health Insurance Educational Series
- **TB**: tuberculosis
- **TB-DOTS**: Philippines directly observed treatment, short course program (tuberculosis)
- **Z benefits**: catastrophic illness benefit programme
Overview of healthcare financing and health service purchasing in the Philippines

Healthcare financing

The country’s total health expenditure increased in nominal (current) terms from 198 billion Philippine pesos (PHP) in 2005 to PHP 417 billion in 2011 and PHP 468 billion in 2012 (see Table 1). Correspondingly, nominal per capita health expenditure increased from PHP 3759 in 2009 to PHP 4392 in 2011 and PHP 4847 in 2012. Total health expenditure represented 4.3% of gross domestic product in 2011 and 4.4% in 2012. This compares favourably with Thailand (4.2%) and Singapore (4.1%), better than Indonesia (2.5%) and Myanmar (2.1%), but lower than Viet Nam (6.9%).

The distribution of health expenditures has not changed much during the past decade. Private sources, mostly out-of-pocket spending, accounts for more than 60%, while government expenditure has consistently been below 30%. Social health insurance, represented mainly by PhilHealth, with a small fraction from the Employees’ Compensation Commission, has consistently been below 10%. Donor expenditure accounts for 1-2%. Household out-of-pocket spending remains inordinately high as a proportion of total health expenditure in the Philippines.

Over the past years, out-of-pocket expenditure has stayed at around 53%, moving slightly from 53.3% in 2009 to 52.7% in 2011. However, in 2012, it jumped to 62.1% of total health expenditure. Most of out-of-pocket spending is in the form of medical goods directly purchased by households from retailers. As much as 30.4% of total health expenditure arises from these types of purchase.

Table 1. Key indicators of health expenditures, 2012

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure</td>
<td>PHP 467.8 billion</td>
</tr>
<tr>
<td>Total health expenditure as % of gross domestic product</td>
<td>4.4%</td>
</tr>
<tr>
<td>Total health expenditure per capita</td>
<td>PHP 4847</td>
</tr>
</tbody>
</table>
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

Table 1. Key indicators of health expenditures, 2012 (Con’t.)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of health expenditure</td>
<td></td>
</tr>
<tr>
<td>National and local government as % of total health expenditure</td>
<td>18.5%</td>
</tr>
<tr>
<td>Social health insurance (PhilHealth) as % of total health expenditure</td>
<td>11.4%</td>
</tr>
<tr>
<td>Household out-of-pocket spending as % of total health expenditure</td>
<td>57.6%</td>
</tr>
<tr>
<td>Others (donors, private institutions)</td>
<td>12.8%</td>
</tr>
<tr>
<td>Uses of health expenditure</td>
<td></td>
</tr>
<tr>
<td>Curative/rehabilitative care</td>
<td>52.3%</td>
</tr>
<tr>
<td>Medical goods directly purchased by households from retailers</td>
<td>30.4%</td>
</tr>
<tr>
<td>Preventive healthcare</td>
<td>9.4%</td>
</tr>
<tr>
<td>Administration</td>
<td>6.7%</td>
</tr>
<tr>
<td>Not elsewhere classified</td>
<td>1.2%</td>
</tr>
</tbody>
</table>


PhilHealth as purchaser of health services

PhilHealth was selected as the focus of this case study because it is the social health insurance programme in the Philippines. It is also one of the pioneers in the developing world. PhilHealth was established in 1995, following on from the Philippine Medical Care Commission which was created in 1969. The Philippine Medical Care Commission and PhilHealth were intended to carry out the National Health Insurance Program of the Philippines.

PhilHealth has the largest network of facilities and professionals accredited by any risk pool in the country. Thus, the reach of PhilHealth’s policies and its overall influence on the provision of care is large and potentially significant.

PhilHealth’s contribution to total health expenditure is currently small (11% in 2012), a figure dwarfed by sizeable out-of-pocket payments, mainly for over-the-counter drugs and prescription pharmaceuticals, especially those used to treat noncommunicable diseases. If this existing pattern and volume of out-of-pocket health spending can be pooled through premiums, this will transform PhilHealth into a large strategic purchaser of health services, lowering costs and significantly improving the overall efficiency of the health system. This potential remains to be realized, and this study’s primary interest is to see how it can be achieved.
PhilHealth has embarked on an ambitious reform programme involving the expansion of population coverage (corresponding to universal health coverage “width”), increasing benefits (corresponding to universal health coverage “breadth”) and changing the provider payment system to reduce, if not eliminate, out-of-pocket payments (corresponding to universal health coverage “depth”). Analysing these reforms through the lens of strategic purchasing can pinpoint current weaknesses and gaps in the reform programme and help PhilHealth achieve its target of universal health coverage.

Organizational characteristics of PhilHealth

Legal status

The Philippine Health Insurance Corporation (PhilHealth) is a “tax-exempt Government corporation attached to the Department of Health for policy coordination and guidance” (Congress of the Philippines, 1995). It is classified as a government-owned and controlled corporation, which is defined as “any agency organized as a stock or nonstock corporation, vested with functions relating to public needs whether governmental or proprietary in nature, and owned by the Government of the Republic of the Philippines directly or through its instrumentalities either wholly or, where applicable as in the case of stock corporations, to the extent of at least a majority of its outstanding capital stock” (Congress of the Philippines, 2011).

Vision, mission, and mandate

The vision and mission statements of PhilHealth are written in short Filipino phrases in line with its desire to communicate them to every Filipino. The vision is “Bawat Pilipino, miyembro; Bawat miyembro, protektado; Kalusugan natin, segurado” or roughly translated as “Each Filipino is a member; each member is protected; our health is secured”. The mission is “Sulit na benepisyo sa bawat miyembro; dekalidad na serbisyo para sa lahat” or “Optimal benefits for every member; good quality service for all”. Its values are innovation, good quality service, utmost integrity, equity, social solidarity and holistic care.
The vision, mission and values are consistent with its mandate to provide full health insurance coverage and ensure the delivery of good quality health services to every Filipino. As a social health insurance scheme, the National Health Insurance Program is a sustainable way for healthy Filipinos to support those who are sick and in need by making benefit packages available. However, its powers are limited to supporting officially enrolled members under the National Health Insurance Program, and it is prohibited from participating in the direct provision of health services, such as procurement of medicines, hiring of staff in hospitals or owning and investing in health facilities (Congress of the Philippines, 1995).

Funding sources and amount of funding
PhilHealth’s funding comes solely from health insurance premiums. It does not receive any budget subsidy from the national Government for running its operations. In 2013, 69% of funding was sourced from premiums paid by workers in the formal and informal economy, and the remaining 31% from the premiums of sponsored programme members. Total 2013 contributions amounted to around PHP 55 billion.

Regular contributions come from the formal and informal sectors. The employed sector contributes 2.5% of the employee’s monthly salary, which is automatically deducted from the payroll. Half this sum is paid by employers, and the other half by employees. Members of the informal sector contribute on a monthly or quarterly basis. Members of the informal economy sector who do not qualify for the sponsored programme are sponsored by the local government unit where they are registered or through other forms of cost-sharing mechanism (Congress of the Philippines, 2013a). Premiums of Sponsored Program members identified by the Department of Social Welfare and Development are paid by the Department of Health. Househelpers (domestic workers) are fully sponsored by their employers under the Domestic Workers Act (“Batas Kasambahay”, Republic Act No. 10361) (Congress of the Philippines, 2013b).

Establishment details
A national health insurance programme was set up by President Ferdinand Marcos through the Philippine Medical Care Act of 1969 (Republic
Act No. 6111, more commonly known as Medicare) (Congress of the Philippines, 1969), with the Philippine Medical Care Commission tasked to oversee implementation. However, it covered only the employed sector.

The call for a more inclusive health insurance programme began in the 1990s, leading to the passing of the National Health Insurance Act of 1995. This law established the Philippine Health Insurance Corporation, which assumed responsibility for the Philippine Medical Care Commission (Medicare) and the Overseas Workers Welfare Administration to provide financial protection for all Filipinos.

The National Health Insurance Act has been revised twice, first in 2004 through Republic Act No. 9241 (Congress of the Philippines, 2004), then in 2013 through Republic Act No. 10606 (Congress of the Philippines, 2013a). Key revisions in the first amendment include changes in accreditation requirements for health service providers and inclusion of two more representatives, one from the Basic Sectors of the National Anti-Poverty Commission and another from the overseas Filipino workers’ sector, on the Board of Directors. Aside from the strengthened mandate to cover 100% of the population, the 2013 amendment reflected the removal of accreditation fees for registered healthcare professionals under the Professional Regulatory Commission and the inclusion of Department of Health licensed hospitals as accredited healthcare providers. There is also an increasing shift from a fee-for-service payment mechanism to case-based payments.

Organizational structure

The Board of Directors oversees all the activities of the organization. The Board of Directors includes the President/Chief Executive Officer, who is the head of the corporation. There is an Internal Audit Group that conducts the financial and operations audits, and a Corporate Secretary. Under the President/Chief Executive Officer are various administrative offices, including the Office of the Executive Vice-President/Chief Operating Officer. Under this office are departments with specific functions for the delivery of health insurance, including fund management, member management, and health finance policy. This office also manages all the heads of regional offices across the country. In every department, vice-presidents and senior managers are in charge. Area vice-presidents
handle clusters of regions that are managed by regional vice-presidents, who handle regional managers in every suboffice.

**Management and leadership**
The Board of Directors is composed of members that represent various interests in the delivery of health insurance, including the President/Chief Executive Officer of PhilHealth. Representing the national government are secretaries of the Departments of Health, Interior and Local Government, Social Welfare and Development, Labor and Employment, and Finance, as well as the Chairperson of the Civil Service Commission, the President and Chief Executive Officer of the Social Security System, the President and General Manager of the Government Service Insurance System, and the Vice-Chairperson of the Basic Sectors of the National Anti-Poverty Commission. There are representatives from every member segment, which are the Sectors of Healthcare Providers, Employers, Labor, Self-Employed, Local Government Units, and Formal/Informal Economy. Also included is the Independent Director of the Monetary Board (PhilHealth, 2014a).

**Financial management and auditing**
The National Health Insurance Fund draws contributions from programme members, other appropriations earmarked by the national and local governments for this purpose, such as those for the Sponsored Program, subsequent appropriations provided under the filing of claims, donations and foreign aid grants, and any subsequent accruals (Congress of the Philippines, 2013a). For the financial year 2013, PhilHealth’s total assets stand at PHP 131 billion, and the reserve fund is around PHP 115 billion.

As with any other national government agency, financial management is restricted to rules and regulations applicable to the use of public funds. Moreover, annual total costs (which include administrative and operations costs) until 2018 must not exceed 5% of the sum total of total contributions, total reimbursements and investment earnings generated during the immediately preceding year. After 2018, annual total costs must not exceed the sum total of 4% of total contributions and reimbursements and 5% of investment earnings generated during the immediately preceding year (Congress of the Philippines, 2013a).
PhilHealth has an internal auditing department, but is also subject to independent audit by the Commission on Audit in accordance with International Standards on Auditing (Commission on Audit, 2013). Consolidation of financial statements from regional offices, where benefit payments and operating expenditures are decentralized, has been done through the Home and Branch Accounting System since July 1999. In this system, the central office consolidates individual accounting reports prepared by the regional offices at the end of every financial year (Commission on Audit, 2013).

PhilHealth has 20 regional offices and 101 local health insurance offices. The regional offices are headed by a regional vice-president. Each region in the country has a PhilHealth regional office, with the exception of Region III (which has two) and the National Capital Region (which has three). Local health insurance offices, headed by a branch manager, are established in every province and chartered city to coordinate with local government units in enrolling members, processing reimbursements and preparing annual reports.

Other health financing and purchasing arrangements
Purchasing of health services in the Philippines can be organized into four distinct groups, corresponding to their type of health financing.

National Government
The national government is represented by the Department of Health, the highest policy-making body for health and the reporting or attached agency for 72 of the largest retained public hospitals. The Local Government Code, enacted in 1991, devolved all primary and secondary facilities to some 1400 local government units in 1992, leaving the largest apex hospitals, regional hospitals and other higher-level health facilities retained under the Department of Health (Congress of the Philippines, 1991). Four of these hospitals have autonomy via their own special charters while the rest do not, and are effectively a hierarchical extension of the Department of Health.

As in most hierarchically funded government entities, these retained hospitals obtain an annual budget from the General Appropriations Act, which is managed by the Department of Budget and Management.
They also generate, in varying degrees, internally generated funds, e.g. reimbursements from PhilHealth, reimbursement from private health insurance and user fees.

The purchasing of health services varies by facility. Purchasing is largely passive, as indicated by the following observations: (a) there is no clear identification of patients as clients or customers – public hospitals are supposed to cater more to the poor, but technically, everybody has a right to access the facilities and utilize the services there; (b) the roles of the purchaser and the provider are not clearly delineated, i.e. there is no purchaser/provider split; (c) there is no clear delineation between the budgets that health facilities receive and the outputs or outcomes that they are supposed to deliver.

**Local government**

Local government units consist of 80 provinces and some 1300 cities and municipalities. Under the Local Government Code, provinces own and manage provincial and district hospitals; cities own and manage city hospitals and city health units; and municipalities own and manage rural health units and barangay (village) health stations. These local health facilities are funded from each local government unit’s internal revenue allotment, as well as internally-generated funds from PhilHealth, private health insurance and user fees. There is no uniform financing or purchasing arrangement for these health facilities, and each local government unit is left very much on its own in deciding how to manage them. Very few of the health facilities have autonomy (La Union Medical Center is one); most are managed as hierarchically funded budget-receiving entities.

**Private health insurance and institutional spending**

The private health insurance industry in the Philippines is small, accounting for only 2% of total health expenditure in 2011. There are two main types: health maintenance organizations (HMO), which number fewer than 20, and life insurance companies offering indemnity health insurance as a product. Private institutional health spending includes the health expenditure of private schools and private establishments. These are school-based or work-based health programmes to which students or employees are entitled as a benefit.
Purchaser-member relationship in PhilHealth

Characteristics of PhilHealth members

There are five PhilHealth programmes, each with its own type of member: sponsored, formal, individually paying, overseas Filipino workers and lifetime (retirees). In general, the classification is based on the type of employment or the agency paying the premiums. Table 2 shows each membership type based on the old and current National Health Insurance Program laws.

Table 2. PhilHealth membership types

<table>
<thead>
<tr>
<th>Membership type</th>
<th>National Health Insurance Act of 1995 (Republic Act No. 7875)</th>
<th>National Health Insurance Act of 2013 (Republic Act No. 10606)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsored</td>
<td>A person who has no visible means of support, as identified by the local health insurance office and based on specific criteria set by PhilHealth.</td>
<td>A person who has no visible means of support, as identified by the Department of Social Welfare and Development following specific criteria (NHTS-PR²).</td>
</tr>
<tr>
<td></td>
<td>Contributions are subsidized partially by local government units and national Government, though PhilHealth provides counterpart financing equal to the local government unit’s subsidy.</td>
<td>The national Government subsidizes the full premium payment of indigent members identified under NHTS-PR.</td>
</tr>
<tr>
<td>Formal</td>
<td>Workers in both government and private sectors, as well as household employees and sea-based overseas Filipino workers; employees pay half the premium and the employer the other half.</td>
<td>Workers in the government and private sector; half the premium is paid by the employee and the other half by the employer.</td>
</tr>
<tr>
<td>Individually paying</td>
<td>Self-employed; contributions are based on household earnings and assets.</td>
<td>Individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, or as a career, but do not belong to the informal sector, e.g. movie actors. Contributions are based on household earnings and assets.</td>
</tr>
<tr>
<td>Overseas Filipino workers</td>
<td>Documented/undocumented Filipinos engaged in remunerated activities in another country (Republic Act No. 9241); member pays premium in full.</td>
<td>Documented/undocumented Filipinos engaged in remunerated activities in another country (Republic Act No. 9241); member pays premium in full.</td>
</tr>
</tbody>
</table>

² NHTS-PR = National Household Targeting System for Poverty Reduction.
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

Table 2. PhilHealth membership types (Con’t.)

<table>
<thead>
<tr>
<th>Membership type</th>
<th>National Health Insurance Act of 1995 (Republic Act No. 7875)</th>
<th>National Health Insurance Act of 2013 (Republic Act No. 10606)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime</td>
<td>Social Security System and Government Service Insurance System retirees and pensioners and members who reach the age of retirement as provided for by law and have paid at least 120 monthly contributions; no premium is collected from lifetime members.</td>
<td>A former member who has reached the age of retirement under the law and has paid at least 120 monthly premium contributions. Lifetime members do not pay premiums.</td>
</tr>
</tbody>
</table>

Source: Authors’ summary

Ideal versus actual functions in the purchaser-member relationship

This relationship focuses on the existence of effective mechanisms to determine and reflect people’s needs, preferences and values in purchasing decision-making. Table 3 shows the ideal functions of the purchaser and an assessment of how PhilHealth has dispensed each of these functions.

Table 3. Ideal functions of the purchaser in the purchaser-member link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To engage actively with members about their health needs, preferences, and values</td>
<td>PhilHealth fulfils this function unevenly, but in the case of the Primary Care Benefit expansion (PCB+), it conducted extensive focus-group discussions to inform the design of the benefits.</td>
</tr>
<tr>
<td>To ensure there are mechanisms for identifying eligible beneficiaries</td>
<td>PhilHealth has no problem identifying paying members but has difficulty with Sponsored Program members whose premiums have been paid by the national government but who have not been enrolled. The Department of Social Welfare and Development identifies households eligible under the conditional cash transfer programme, which PhilHealth uses as basis for Sponsored Program coverage. The Department of Budget and Management then directly transfers the premium subsidies covering Quintile 1 (poor = 5.2 million families) and Quintile 2 (near-poor = 5.6 million families) to PhilHealth. Coordination and data problems, however, have resulted in large variance between PhilHealth’s claim of population coverage (75% in 2012) and the households’ self-reported coverage with PhilHealth insurance (60.3%), in the 2013 National Demographic and Health Survey.</td>
</tr>
<tr>
<td>Functions of ideal purchaser</td>
<td>Assessment of PhilHealth</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>To ensure awareness of members of their entitlements and obligations</td>
<td>Focus-group discussions indicate that members know of PhilHealth in general but they are not aware of their specific benefits. In 2013, a World Bank evaluation showed that 36% of Sponsored Program patients were unaware of their coverage, a problem being addressed by community health teams and PhilHealth’s CARES programme, which helps patients navigate the health system.</td>
</tr>
<tr>
<td>To develop entitlements reflecting the health needs of members and protecting them against financial catastrophe</td>
<td>In 2013, 60.3% of inpatients were covered by PhilHealth, significantly higher than the 37.7% recorded in 2008. In 2011, PhilHealth reformed the provider payment system by changing from retrospective fee-for-service to prospective case rates, which placed providers at risk for going over the rates for 23 conditions. Comparison of data pre-reform (2011) and post-reform (2013) show that almost all these case rates showed lower average costs and lower average lengths of stay compared with the fee-for-service figures. PhilHealth expanded this case rate system to all inpatient conditions in 2013, and also introduced catastrophic financing (“Z benefits”) for nine conditions. However, real resource costing needs to be done, as the current case rates involved averaging the claims of providers with some adjustments. In terms of public health interventions, analysis shows that the reimbursement rate for the Maternity Care Package has been generous, but that for TB-DOTS has been inadequate. Finally, the average value of support in 2013 represented only 31.5% of hospitalization costs, leaving the balance of 68.5% to be funded mostly out-of-pocket.</td>
</tr>
<tr>
<td>To ensure that members can access entitlements</td>
<td>In general, access is increasing; the percentage of treatment-seeking households rose from 7.9% in 2008 to 10.7% in 2013. However, the distribution of PhilHealth-accredited facilities is very uneven across provinces and regions, as is utilization. Moreover, there is no pattern linking coverage and benefit utilization across regions. Finally, PhilHealth accreditation of doctors has lagged greatly behind the growth of membership. The number of patients per accredited doctor has more than doubled from 1190 in the mid-1990s to 3240 in 2011.</td>
</tr>
<tr>
<td>To establish effective mechanisms to listen to complaints, views and reflections of members</td>
<td>Established procedures exist for settling complaints and resolving disputes. However, PhilHealth needs to have an active hotline, a webpage with same-day response and an active social media presence.</td>
</tr>
</tbody>
</table>
Table 3. Ideal functions of the purchaser in the purchaser-member link and assessment of PhilHealth’s performance (Con’t.)

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To report on purchaser performance to promote accountability</td>
<td>This function is not well developed and requires further institutionalization. No entity performs a watchdog function. PhilHealth’s annual reports feature positive achievements but gloss over issues, problems and challenges; also, the indicators change from year to year. PhilHealth’s “Dashboard” monitoring system is still in its infancy.</td>
</tr>
</tbody>
</table>

Source: Authors’ Summary

Analysis of the PhilHealth purchaser-member relationship

Ensuring that all members are registered

The medical social welfare officers of government hospitals are responsible for classifying patients and automatically enrolling the poor into PhilHealth so that they can receive immediate medical care. PhilHealth reimburses the hospitals and sends the list to Department of Social Welfare and Development for further validation. In 2013, PhilHealth issued implementation guidelines for the point-of-care enrolment programme (Administrative Order No. 2013-31).

The Aquino administration has been proactive in enrolling poor households. In 2011, almost 5 million poor households identified in the National Household Targeting System for Poverty Reduction (NHTS-PR) were already enrolled. The goal of the Government is to enrol the remaining 9 million poor households by 2014. Almost 25% of the total Department of Health budget is allocated to subsidize the premiums of poor households. As a result of this policy, the budget of the Department of Health increased almost fourfold between 2009 and 2014.

Coverage of non-Sponsored Program members is poor. Formal workers are supposed to be enrolled mandatorily in the social health insurance programme. However, poor coverage persists. In a study conducted by Silfverberg (2014a), the estimated coverage rate in the Government and private sector is around 80%, leaving 20% who are not enrolled. This high non-enrolment rate in the mandatory sectors is due to labour issues such as contractualization and casualization of employees. Employers are not obliged to cover the premiums of contractual and casual employees.
The informal sector is the biggest contributor to low coverage. In another study conducted by Silfverberg (2014b), fewer than 40% of informal workers are covered. The composition of the informal sector is extreme in terms of socioeconomic status, as it is composed of both near-poor and affluent households. The design intended to capture the informal sector in the insurance system makes it easy for members to opt out. In terms of premium payments, members in this sector need to pay at least three monthly premiums in the six months immediately before they receive treatment, which is not easy for near-poor households. Based on the latest official reports of PhilHealth, the coverage rate in 2013 was 75% (the coverage rate refers to the portion of the population who are eligible to receive benefits). Coverage rate estimates are usually lower than the enrolment rate, which is defined as the portion of population listed in the PhilHealth database. PhilHealth estimates of coverage rates have been contentious because its information system cannot capture the exact number of members and other beneficiaries (spouse and children under 21 years old). In lieu of the actual number of principal and dependent members, PhilHealth uses the average household size to derive multipliers to estimate the coverage rate. The assumed multipliers do not, however, take into account households with two or more principal members, the age distribution of members or the household size. As a result, estimated coverage rates have varied greatly. PhilHealth once reported an 85% coverage rate, while estimates from national surveys and external reviews showed less than 50%. The 2013 National Demographic and Health Survey reported that 62.8% of Filipino households had health insurance, of which 60.3% had PhilHealth insurance (National Statistics Office, 2014).

As for enrolling poor households, as with most social health insurance schemes, the idea is for the Government to subsidize the premiums of the poor households. Prior to 2013, local government units were responsible for identifying poor households, and their premiums were partly shared by the local and national governments. Identification of poor households has been highly politicized and unstandardized in practice, which led to undercoverage of “true poor” households. Enrolment of “political poor or indigents” was also common in local government units.
Under the new law on the National Health Insurance Program, the responsibility of identifying poor households eligible for the Sponsored Program was shifted from local government units to the national government. Counterpart financing was also removed, as the national government began to pay all premiums for the pre-identified poor households. PhilHealth used the National Household Targeting System (NHTS) of the Department of Social Welfare and Development. NHTS is a targeting tool, also used in several social and poverty reduction programmes of the Government (PhilHealth, 2012a). All households in the bottom 40% of the NHTS list are automatically covered by PhilHealth. As most of the poor households are already covered, the major challenge now for the Government is to locate and inform them about their new benefit entitlement. Problems arise because of errors in the addresses in the NHTS list and geographical constraints. NHTS uses location when identifying poor households. Hence, households without a permanent address (e.g. informal settlers or homeless people) are not included in the NHTS list.

In parallel with NHTS, PhilHealth also rolled-out “point-of-care enrolment”. Although this strategy promoted adverse selection, it was introduced to capture “critically poor” households which have not been included in the NHTS list.

**Ensuring awareness among members of their entitlements to benefits**

Coverage does not always translate to benefit utilization. Although supply-side constraints (e.g. scarcity of health facilities) contribute to low utilization, demand-side problems such as awareness of membership status, eligibility and entitlement play a significant role in poor usage of benefits. Poor awareness is common among Sponsored Program members who were automatically enrolled by the national Government. In the past, poor utilization was also exacerbated by the general policy direction of the corporation as a pension fund, resulting in shallow benefit depth and low benefit utilization. In recent years, a paradigm shift in the policy direction of PhilHealth has been observed, as more aggressive benefit expansion and awareness campaigns were institutionalized.
CARES programme

In 2012, PhilHealth deployed 530 nurses in level 2 and 3 government hospitals to serve as “navigators”. Their main responsibility is to help patients to determine their membership status and inform them of their benefit entitlement. They also perform surveys and studies initiated by PhilHealth. In hospitals retained by the Department of Health, PhilHealthcareS staff are stationed at a designated PhilHealth desk. Private hospitals may opt to hire their own navigators.

Information and education campaigns

PhilHealth has launched numerous programmes such as the Mobile Orientation, Validation and Enrolment Scheme (MOVES) and the Social Health Insurance Educational Series (SHINE) to improve the awareness of both members and stakeholders. MOVES aims to educate its members, especially Sponsored Program members, about PhilHealth and their benefit entitlement by giving lectures and presentation in localities. SHINES is a way to educate and update local executives, municipal officers and policy-makers about social health insurance. The corporation also engages in traditional information, education and communication activities, such as radio and television broadcasts for the dissemination of PhilHealth processes, benefit packages and entitlements. Currently, PhilHealth has a regular time slot on radio and television, where the public can raise queries and voice their concerns.

Despite these attempts to improve awareness, mass education programmes are still limited. In the case of mass educational campaigns such as MOVES, vulnerable population segments are not captured, as most of the lectures are conducted in local government centres or in urban areas. Most poor households in the country are in geographically challenged areas, which it is impossible to reach via the traditional modes of information, education and communication. There is also no mechanism or standard in place to instruct local offices how they should conduct mass education campaigns. As of the time of writing, only a few local government offices have conducted MOVES.
Active engagement of members about their preferences, needs and problems

Ideally, citizens should be involved in major policy decisions of PhilHealth, especially during the development of the benefit package. This is to ensure that the policies in place are for the general good of the population. In terms of benefit design and development, there are no clear guidelines or written protocols showing how benefits should be crafted or how the concerns of the population should be taken into account. There is no benefit expansion plan or strategy. Hence, all the existing benefit packages of PhilHealth might be crafted and approached in an unstandardized and ad hoc environment.

Although health technology assessments were introduced in the past as part of the benefit development process, they have never been institutionalized. Hence, it is not clear how benefits are decided. Ideally, PhilHealth should take into account the economic effectiveness and sociocultural acceptability of the benefit packages prior to rollout. Although PhilHealth admitted that it takes into account the gravity of the disease concerned, its public health importance and public opinion (e.g. use of surveys), it is not very explicit how the corporation used them in the actual cost calculation or in the implementation arrangements for the benefit package. The approval of benefit packages is also prone to political influences, as shown by the inclusion of several packages that are not cost-effective. Ideally, one could study documents developed during the benefit development process, such as minutes of meetings and detailed documentation of benefit packages and other documents. However, such documents do not exist.

Ensuring effective mechanisms for members’ complaints, views, and reflections

There are established procedures for settling complaints and resolving disputes. However, these are not enough; what is needed are well maintained channels of communication between PhilHealth members and providers and the management and Board of Directors, to ensure that members’ and providers’ views are heard, addressed and, it is hoped, taken into account in the decision-making process. Although PhilHealth maintains a website, the queries of citizens are not addressed in a timely manner. PhilHealth has not fully utilized the potential of social media to reach out to members and providers.
Purchaser-provider relationship in PhilHealth

Organizational characteristics of health service providers

Overall trends in health facilities

Health facility investments, both public and private, has stagnated relative to a ballooning population since the 1980s. The bed-population ratio was one of the highest in Asia in the 1970s at 32 per 1000 population but this has declined to only 17 per 1000 population in the 2000s. Average occupancy rates typically exceed 100% in government hospitals, except lower-level ones. Private hospital investments have also been slow. Health facilities are poorly distributed geographically. The devolution of health services since the 1990s may have contributed to the widening disparities in the quantity and quality of these facilities.

Hospitals

The Department of Health classifies all hospitals according to their size, bed capacity and types of services offered. The classifications below reflect the latest levels in 2012 (Silvera, 2013):

- Level 1 (formerly Level 2) has a bed capacity of less than 100 and has the following services: consulting specialists in medicine, paediatrics, obstetrics and gynaecology, and surgery; emergency and outpatient services; isolation facilities; surgical/maternity facilities; dental clinic; secondary clinical laboratory; blood station; first-level X-ray facility; and pharmacy.

- Level 2 (formerly Level 3) has a bed capacity of 100-200 and has all the services of Level 1 facilities, with the following additional facilities: departmentalized clinical services; general intensive-care unit; high-risk pregnancy unit; neonatal intensive-care unit; tertiary clinical laboratory; and second-level X-ray facility with mobile unit.

- Level 3 (formerly Level 4) has a bed capacity of more than 200 and has all the services of Level 2 facilities with the following additional facilities: teaching with accredited residency training programme in the four major clinical services; physical
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

- medicine and rehabilitation unit; ambulatory surgical clinic; dialysis clinic; tertiary clinical laboratory with histopathology; blood bank; and third-level X-ray facility.
- Hospitals labelled as Level 1 in the pre-2012 classification are now classified as “other health facilities,” which can be any of the following: primary care facility; custodial care facility; diagnostic/therapeutic facility; and specialized outpatient facility.

At present, there are 1810 hospitals in the Philippines, with 726 (around 40%) under public ownership, and the remaining in private ownership (Department of Health, 2012a). The majority of private hospitals operate as for-profit institutions, with a significant concentration in Central Luzon region and National Capital Region, which are relatively wealthier. In fact, 34% of all hospital beds are located in the National Capital Region, where 12% of the nation’s population reside. The establishment of private hospitals in areas with lower poverty rates is commonly seen as a measure to ensure a steady income (Lavado et al., 2010).

Government hospitals can either be managed by the local government unit where they are located, as is the case for most Level 1 and 2 hospitals, or managed directly by the Department of Health, as is the case for most Level 3 hospitals. They acquire their licence to operate from the Bureau of Health Facilities and Services of the Department of Health and are accredited by PhilHealth to receive reimbursement claims if they meet the necessary standards. Before the devolution of health services to local government units in 1991, all Government hospitals were under the Department of Health. Devolution gave most primary and secondary care, as well as some tertiary care responsibilities, to local government units while the Department of Health retained control of around 70 general and specialty hospitals.

Some, but not all, Government hospitals have fiscal autonomy. Department-of-Health-retained hospitals get their funding mostly from the Department of Health and local government unit hospitals from their respective local government units. Depending on how entrepreneurial the hospital director or management is, the public hospital can also rely
on PhilHealth reimbursements. Also depending on the ordinance that the local government unit has passed pertaining to the local hospital under it, these PhilHealth reimbursements may be retained at the health facility or not. Indeed, the role of PhilHealth reimbursements in the sustainability of government hospitals is one of the main challenges facing them.

Private hospitals comprise around 60% of all hospitals and may be owned by a single proprietor, a partnership, a family, a religious institution or a corporation. They also acquire their licence from the Bureau of Health Facilities and Services and are then accredited by PhilHealth to receive reimbursements if they meet the standards. Private hospitals receive their funding from out-of-pocket expenditure, reimbursements from private health insurers and PhilHealth reimbursements.

Physicians
Philippine medical education is patterned after the American system. Physicians take a four- or five-year pre-medical course and four years of medical education, followed by one year of internship. Upon passing the Physician Licensure Examination, they are qualified for general practice, but have the option of following further studies in a specialization or sub-specialization in teaching hospitals (Level III). Like all other health professionals, they are registered under and regulated by the Professional Regulatory Commission. Physicians undergo a separate accreditation process at PhilHealth.

Government physicians are hired by the Department of Health for its retained hospitals, and by the local government units for local government hospitals. The entry-level position for resident physicians in Department of Health hospitals is Medical Officer III, which has a monthly gross salary of PHP 26 878. Local government hospitals offer resident physicians a lower entry-level position, such as Medical Officer I, which has a monthly gross salary of PHP 39 493 (Santos, 2013). Low salary grades of doctors contribute to the increasing number of doctors leaving the country for better opportunities abroad (Congress of the Philippines, 2013c).

The imbalance in the geographical distribution of Government physicians is a serious matter, as most are concentrated in big cities. The Department
of Health launched the Doctors to the Barrios programme in the 1990s as a response to this shortage and other problems such as the inability of smaller, rural local government units to support their devolved health programmes fully. However, the programme only requires doctors to stay for two years, and most do not stay with their assigned local government unit when the programme is over (Capuno, 2008). Because of the stopgap nature of this programme and the decreasing independence of the participating local government unit to achieve financial stability in health, the Doctors to the Barrios programme is currently under review by the Department of Health (Crisostomo, 2014).

Department of Health implements other measures to help local government units, such as Doctors to the Barrios–Leaders for Health, community health teams, Rural Health Team Placement programmes and the Specialist to the Provinces programme, all requiring the participation of at least one qualified physician to complete the team (Department of Health, 2010a). Apart from the efforts of some State universities to oblige their students to work in public service after a few years, there is no national legislation requiring health professionals to work in the public sector after graduation; neither are there special incentives for physicians to practise in underserved areas.

Physicians in private hospitals receive higher salaries than those in public hospitals, and most supplement their income by doing shifts in multiple hospitals or setting up their own clinic. More specialists are available in private hospitals because of the availability of advanced equipment. In the case of larger tertiary hospitals that function as corporations, most private physicians, particularly consultants, are stockholders in their hospitals. They also usually hold administrative positions.

Stand-alone clinics: birthing centres, renal clinics, etc.

Stand-alone clinics usually provide outpatient and ambulatory care for patients. They do not have the full range of services available in a typical hospital, but specialize in a particular health service. The most prevalent stand-alone clinics are lying-in or maternity clinics, dialysis clinics, clinics for tuberculosis (TB-DOTS), free-standing private clinics operated by a sole proprietor and polyclinics run by a group practice. Physicians who work
in hospitals often operate their own private practice alongside through a clinic. Most are run privately, and the cost of treatment is high. The poor typically seek outpatient treatment in public facilities such as the rural health units or the outpatient ward in public hospitals.

The Bureau of Health Facilities and Services licenses stand-alone clinics, except outpatient clinics as there are no standards for these yet. They can also be accredited by PhilHealth providers and receive reimbursement claims. As of 2009, there are 19 dialysis clinics, 406 TB-DOTS clinics, 288 maternity clinics and 42 ambulatory service clinics accredited by PhilHealth (Romualdez et al., 2011). With the recent expansion of PhilHealth benefits for outpatient care, the poor have the option to access these clinics at lower cost.

Rural health units and barangay health stations

Rural health units provide basic primary care, serving mostly the poor. They are the most frequently utilized health facilities (around one-third of visits to all health facilities according to the 2008 National Demographic and Health Survey (National Statistics Office, 2009). Barangay health stations are centres set up in barangays, the smallest political unit in the country, and are managed by rural health units or city health offices.

Rural health units were created in the 1950s so that each municipality could improve access to healthcare. In the wake of the passage of the Local Government Code in 1991, rural health units, city health units and barangay health stations were devolved to the municipal and city local government unit. The Department of Health was left with the task of building capacity at the rural health units and barangay health stations for delivery of the various vertical health programmes, e.g. Expanded Programme on Immunization and TB-DOTS. In general, rural health units and barangay health stations provide health services free of charge, but problems of lack of availability, accessibility and human resources are common. Just like hospitals and clinics, rural health units can be accredited by PhilHealth. As of 2009, there are 843 accredited rural health units to provide the outpatient benefit package (Romualdez et al., 2011).
Ideal versus actual functions in the purchaser-provider relationship

This relationship underscores the use of policy tools by purchasers to improve provider responsiveness and efficiency. Table 4 shows the ideal functions of the purchaser and an assessment of PhilHealth’s performance.

Table 4. Ideal functions of the purchaser in the purchaser-provider link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To take active decisions on which providers to purchase services from, with consideration of quality, ability to provide services and location</td>
<td>PhilHealth has been too stringent in accrediting government hospitals and public health clinics, reducing access to these services. Only 67% of all licensed hospitals have been accredited. For TB-DOTS, only 59% of all licensed TB-DOTS clinics have been accredited after 10 years. Although a more accommodating accreditation policy has been specified in the General Appropriations Act of 2012, this has not been fully implemented. More facilitative arrangements with providers to improve quality of care are yet to be institutionalized.</td>
</tr>
<tr>
<td>To extend services to underserved areas.</td>
<td>PhilHealth has no geographical equalization (or equity) fund. PhilHealth reimbursement rates are uniform and do not provide additional incentives for geographically isolated and depressed areas.</td>
</tr>
<tr>
<td>To improve health system efficiency through rational provision and use of services</td>
<td>Gatekeeping and referral systems are very weak because patients tend to go to the nearest health facility, referral bypass fees are not imposed, and many cities do not have city hospitals or filter clinics, forcing patients to clog up Department of Health-owned regional hospitals located in these cities. On the positive side, payment reform, i.e. the change from fee-for-service to case rates, has shown good results. The Generics Law has been in force for decades, but providers still find ways to prescribe branded drugs. Not all clinical guidelines are available. Finally, because PhilHealth accounts for only 11% of total health expenditure, it has not evolved as a major payor and is largely unable to exercise its monopsony power to reduce healthcare costs and out-of-pocket spending.</td>
</tr>
<tr>
<td>To monitor provider performance, including quality of care</td>
<td>Quality standards are mostly imposed ex-ante through accreditation. Concurrent quality monitoring is not yet in place. Deaccreditation of erring providers is rarely resorted to, as it penalizes members just as it does the providers.</td>
</tr>
</tbody>
</table>
Table 4. Ideal functions of the purchaser in the purchaser-provider link and assessment of PhilHealth’s performance (Con’t.)

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enforce contractual agreements with qualified public and private providers</td>
<td>PhilHealth outpatient benefit packages evolved in a fragmented fashion, requiring repetitive accreditation and monitoring. Hospitals usually complain of payment delays, although payment has been expedited under case rates. Also, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.</td>
</tr>
<tr>
<td>To implement and adjust provider payment methods that enhance quality and efficiency</td>
<td>Under case rates, providers know in advance their reimbursements. A no-balance billing policy is in force, and compliance has improved. In June 2013, 93% of surveyed hospitals practised no-balance billing; by June 2014, this was reduced to 59%.</td>
</tr>
<tr>
<td>To ensure mutual accountability between purchaser and providers through timely payment</td>
<td>On average, turnaround time fell by 21-24 days when PhilHealth changed provider payment from fee-for-service to case rates.</td>
</tr>
<tr>
<td>To manage finances in a transparent and accountable way</td>
<td>PhilHealth has adopted an accounts-management approach to ensure that all collectibles are collected. PhilHealth has an internal audit unit that investigates fraud. Revenues have always been aligned with expenditure, but reserve management has been conservative. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years’ worth from 2004 to 2009, though this has been reduced to 2.2 years in 2013, closer to what the law prescribes, i.e. two years.</td>
</tr>
</tbody>
</table>

Source: Authors’ Summary

Analysis of the purchaser-provider relationship in PhilHealth

Engagement of providers and provider payment systems

PhilHealth purchases inpatient and outpatient services from various contracted health providers and drug outlets and pays these according to agree-upon provider payment systems.

Ordinary inpatient case packages

Case payment for inpatient care was introduced for the first 23 case rates in 2011, replacing the traditional fee-for-service system. This was expanded in January 2014 to cover all inpatient medical and surgical cases. All members are eligible under this payment system, but only Sponsored Program members utilizing Government hospitals are entitled to the no-balance
billing policy (i.e. zero copayments). Healthcare providers are paid a fixed rate and are responsible for distributing professional fees to physicians.

An assessment of the case rate payment system for the 23 conditions shows that, relative to the fee-for-service system, it has led to lower average cost per case and lower length of stay. Out of the 23 case rates, all except pneumonia II recorded lower average costs in 2012 compared with the average fee-for-service costs in 2010. Table 5 shows the evolution of the average cost of care in selected cases. Similarly, all except pneumonia II recorded an lower average length of stay in 2012, compared with that under the fee-for-service system in 2010. Table 6 shows the evolution of the average length of stay in selected cases.

Table 5. Effect of the case rate payment system on average cost of care (PHP), by Sponsored Program and non-Sponsored Program members, 2010* and 2012**

<table>
<thead>
<tr>
<th>Selected case rates</th>
<th>Sponsored Program</th>
<th>Non-Sponsored-Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>Acute gastroenteritis</td>
<td>12 008</td>
<td>8676</td>
</tr>
<tr>
<td>Cataract removal</td>
<td>41 694</td>
<td>18 069</td>
</tr>
<tr>
<td>Cardiovascular accident I</td>
<td>46 255</td>
<td>35 836</td>
</tr>
<tr>
<td>Pneumonia I</td>
<td>27 217</td>
<td>19 370</td>
</tr>
<tr>
<td>Dengue I</td>
<td>69 620</td>
<td>12 956</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>139 679</td>
<td>35 681</td>
</tr>
</tbody>
</table>

* = before introduction of case rates; ** following introduction of case rates. 
Source: PhilHealth, 2014.

Table 6. Effect of the case rate system on average length of stay (in days), by sponsored and non-sponsored programme members, 2010* and 2012**

<table>
<thead>
<tr>
<th>Selected case rates</th>
<th>Sponsored Program</th>
<th>Non-Sponsored-Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>Acute gastroenteritis</td>
<td>6.13</td>
<td>4.49</td>
</tr>
<tr>
<td>Cataract removal</td>
<td>1.93</td>
<td>1.16</td>
</tr>
<tr>
<td>Cardiovascular accident I</td>
<td>12.08</td>
<td>9.11</td>
</tr>
<tr>
<td>Pneumonia I</td>
<td>9.81</td>
<td>6.47</td>
</tr>
<tr>
<td>Dengue I</td>
<td>8.22</td>
<td>5.96</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>14.33</td>
<td>6.58</td>
</tr>
</tbody>
</table>

* = before introduction of case rates; ** following introduction of case rates. 
Source: PhilHealth, 2014.
Some problems persisted, however. As many as 36% of the Sponsored Program patients did not know about their PhilHealth coverage (World Bank, 2012). A few hospitals resorted to upcoding (charging a patient under a condition reimbursed at a higher rate than the real condition), e.g. paediatric to acute gastro-enteritis (Machinji, 2012). Patients’ out-of-hospital expenditure remained a problem, as some facilities continued to experience shortages of drugs and medical supplies (Maala, 2014); in effect, this is default balance billing. However, the prevalence of balance billing declined from 93% in June 2013 to 59% in June 2014 (Picazo, 2014a).

**Catastrophic case packages (Z benefits)**

These packages cover conditions that are deemed economically and medically catastrophic, using PhilHealth criteria. A reference hospital is first contracted to assist PhilHealth in setting the practice standards and costing of the package. Other providers are then selectively contracted according to their capability to deliver the package. Currently, providers are limited to public tertiary hospitals. Healthcare providers are paid a fixed rate and are responsible for distributing professional fees to physicians. Sponsored Program members are eligible for zero copayments, while non-Sponsored Program members are entitled to a maximum copayment of 50%. In 2013, the Z benefits package was expanded into Z MORPH (Mobility, Orthosis, Rehabilitation, and Prosthesis Help) to support the treatment of disabled persons as indicated by Republic Act No. 7277, the “Magna Carta for Disabled Persons” (Congress of the Philippines, 1992). Assessment of Z benefits (Table 7) shows low utilization so far, mainly because of the limited number of providers, quite stringent eligibility criteria and limited information for patients about this package.

**Table 7. PhilHealth Z benefits, by amount paid (PHP) and number of patients, as at 30 June 2014**

<table>
<thead>
<tr>
<th>Conditions covered by Z benefits</th>
<th>Amount paid (PHP million)</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute lymphatic leukaemia, standard risk, for children</td>
<td>4.3</td>
<td>28</td>
</tr>
<tr>
<td>Early breast cancer</td>
<td>17.8</td>
<td>211</td>
</tr>
<tr>
<td>Prostate cancer, low to intermediate risk</td>
<td>1.1</td>
<td>11</td>
</tr>
</tbody>
</table>
A critical analysis of purchasing health services in the Philippines: a case study of PhilHealth

Table 7. PhilHealth Z benefits, by amount paid (PHP) and number of patients, as at 30 June 2014 (Con’t.)

<table>
<thead>
<tr>
<th>Conditions covered by Z benefits</th>
<th>Amount paid (PHP million)</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney transplant for end-stage renal disease, standard risk</td>
<td>80.7</td>
<td>136</td>
</tr>
<tr>
<td>Coronary artery bypass graft surgery, standard risk</td>
<td>54.4</td>
<td>99</td>
</tr>
<tr>
<td>Total correction for tetralogy of Fallot in children</td>
<td>32.0</td>
<td>100</td>
</tr>
<tr>
<td>Closure of ventricular septal defect in children</td>
<td>18.0</td>
<td>72</td>
</tr>
<tr>
<td>Cervical cancer, stage I to IV</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Z MORPH</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208.1</strong></td>
<td><strong>657</strong></td>
</tr>
</tbody>
</table>

*Source: PhilHealth, 2014.*

Other conditions are being considered under this benefit, including colon and rectum cancer; liver cancer, hepatitis B, and hepatitis C; other cancers and blood disorders, premature birth and paediatric surgical conditions. Presentation to the PhilHealth Board for their approval has been scheduled.

**Outpatient benefits and MDG benefits**

The evolution of PhilHealth outpatient or MDG benefits (thus called because of their association with the United Nations Millennium Development Goals) is shown in Table 8. These cover a range of services delivered by outpatient clinics, birthing centres, free-standing dialysis clinics, ambulatory surgical centres and hospital outpatient departments. Some examples are the maternity care and newborn package for normal delivery, packages for tuberculosis (TB-DOTS), malaria, HIV/AIDS, severe acute respiratory syndrome (SARS), avian influenza, haemodialysis, chemotherapy and radiotherapy, animal bites and voluntary surgical contraception. All members are eligible for these packages. Healthcare
providers are paid a fixed rate and are responsible for distributing professional fees to physicians. Sponsored Program and indigent members are entitled to zero co-payments through the no-balance billing policy.

Table 8. Evolution of PhilHealth outpatient and MDG benefits

<table>
<thead>
<tr>
<th>Year</th>
<th>Benefits</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Outpatient benefits (OPB)</td>
<td>RHU only</td>
</tr>
<tr>
<td>2003</td>
<td>+ Maternity Care Package, TB-DOTS</td>
<td>RHU + birthing centres (public and private) + TB-DOTS centres (public and private)</td>
</tr>
<tr>
<td>2006</td>
<td>+ Neonatal care package</td>
<td>RHU</td>
</tr>
<tr>
<td>2008</td>
<td>+ Malaria</td>
<td>RHU</td>
</tr>
<tr>
<td>2010</td>
<td>+ Animal bite treatment and care</td>
<td>RHU</td>
</tr>
<tr>
<td>2012</td>
<td>+ HIV/AIDS treatment</td>
<td>Treatment hubs (usually Government regional hospitals)</td>
</tr>
<tr>
<td>2014</td>
<td>+ insertion of intrauterine devices</td>
<td>RHU</td>
</tr>
<tr>
<td>2014</td>
<td>+ noncommunicable disease drugs (pilot)</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>2015</td>
<td>+ Other primary care</td>
<td>RHU + private clinics</td>
</tr>
</tbody>
</table>

Source: PhilHealth, undated RHU = rural health unit.

Table 9 shows the number of providers and payments to providers under this benefit from 2009 to 2013. No data are available on the number of patients seen. No assessment of the individual packages is available. However, a consultant’s report on the feasibility of PhilHealth financing of multidrug-resistant TB (Picazo et al., 2014) showed the following performance of PhilHealth’s TB-DOTS package: (a) while TB patients are overwhelmingly poor, most of them are not included in the Government anti-poverty programme of conditional cash transfers (CCT/4P) and therefore are not automatically covered as Sponsored Program members, as stipulated under the law; (b) after 10 years (2003–2013), PhilHealth has accredited only 59% of the 5084 licensed TB-DOTS centres – the non-accreditation of TB-DOTS providers, even those operating under the Department of Health’s National Tuberculosis Programme, means that many patients do not benefit from PhilHealth reimbursements for TB care and, indeed, 499 local government units in the country do not have any PhilHealth accredited TB-DOTS providers; (c) compared with the total cost
of TB diagnosis and treatment per patient of PHP 9030, the reimbursement rate represents a support value of only 44%.

Table 9. Number of providers and payments to providers under PhilHealth’s outpatient benefits (2009-2011) and primary care benefits (2012-2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Benefit name</th>
<th>No. of providers</th>
<th>Amount (PHP billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>OPB</td>
<td>n.a.</td>
<td>0.684</td>
</tr>
<tr>
<td>2010</td>
<td>OPB</td>
<td>n.a.</td>
<td>1.008</td>
</tr>
<tr>
<td>2011</td>
<td>OPB</td>
<td>1404</td>
<td>1.309</td>
</tr>
<tr>
<td>2012</td>
<td>PCB</td>
<td>2134</td>
<td>3.625</td>
</tr>
<tr>
<td>2013</td>
<td>PCB</td>
<td>2536</td>
<td>3.026</td>
</tr>
</tbody>
</table>

Source: PhilHealth, undated. OPB = outpatient benefits; PCB = primary care benefits.

The Primary Care Benefit 1 (PCB1) package covers primary preventive and outpatient consultation services, diagnostics and drugs for four of the most common outpatient conditions. Government-owned outpatient clinics (rural health units and outpatient departments of Government hospitals) are the accredited providers and receive an annual payment per family of PHP 500. This programme requires providers to open a trust fund in which PhilHealth reimbursements will be collected, and providers must allocate the PhilHealth revenue as follows: 40% to services, 40% to drugs and diagnostics and 20% to incentives for professionals. These proportions are explicitly prescribed.

The Primary Care Benefits 2 (PCB2) package was designed to provide pharmacy benefits for eight drugs to treat hypertension, diabetes mellitus, and dyslipidaemia. The benefit guidelines prescribe the following: (a) only patients screened by their PCB1 primary care providers using the WHO Package of essential NCD interventions for primary healthcare (PEN) guidelines are eligible; (b) patients can obtain drugs only at drug outlets that agree to observe the set price caps; (c) while there is no limit on the amount of drugs that an individual can obtain, only one member per family can take advantage of the benefit; (d) drug outlets are reimbursed monthly, depending on consumption. The programme is currently being piloted in Pateros, a municipality within Metro Manila. However, an assessment of this pilot indicates that the sample size is not large enough to provide robust findings. Indeed, of the 66 000 total population of the municipality...
of Pateros, only 80 people were found to be eligible, of whom only five accessed the benefit and only one is currently making use of it (Herrera, 2014).

Licensing, accreditation and contracting

Prior to 2012, PhilHealth was criticized for being overly slow with Department of Health licensing processes and causing delays in its contracting (which it called “accreditation”) procedures. It required “pre-accreditation surveys” which overlapped in part with the Department of Health licensing inspections, annual renewals, facility checks and manual submission of paper-based applications. This resulted in bottlenecks in contracting (i.e. granting accreditation privileges) which occasionally resulted in “accreditation gaps” and subsequent difficulties for providers in obtaining reimbursement for services rendered during the period of the gap.

Since 2012, the process has been streamlined. The Department of Health adopted the PhilHealth Benchbook accreditation standards and incorporated them into the licensing requirements, thus essentially requiring only one survey prior to licensing and accreditation. Henceforth, all licensed providers are deemed accredited upon submission of documentary requirements and a pre-accreditation survey is no longer required. Also, healthcare providers no longer need to renew their accreditation annually; instead, renewal is automatic until accreditation is withdrawn or terminated. The reaction of providers to this new accreditation process has been mixed; some providers felt that PhilHealth was more competent in conducting the accreditation surveys, which encouraged them to perform better.

The above procedures describe the normal engagement process of PhilHealth. It is a passive process, i.e. only those who apply are engaged and only those who are engaged are recorded in its database. This begs the question: how will PhilHealth know how much leveraging power it has and where? A clear exception to this norm is the way PhilHealth actively sought and negotiated with providers for the Z benefits. After determining the package to be developed, PhilHealth selected the reference hospital, which then assisted PhilHealth in formulating the guidelines, setting practice
standards, costing the package and assessing the clinical capability of interested hospitals. Once the guidelines were in place, PhilHealth engaged other potential hospitals through selective contracting.

PhilHealth uses the Performance Commitment as the main contracting tool. All healthcare providers must sign this commitment in order to be accredited. It stipulates providers’ undertaking to provide quality health services, willingness to comply with policies on benefits payment, information technology, data management and reporting, and referral, among others. A section of the tool allows the provider to tick the appropriate services it is able to deliver. The tool is comprehensive, but its provisions are still very general at this stage; details have been left out primarily because these guidelines, indicators, targets, etc. are still to be clearly defined.

The PCB1 programme came up with specific provisions for providers, the majority of which are local government units. PCB1 requires that local government units should set up a trust account for the health facility to ensure that the capitation fees paid will be retained for the use and improvement of the facility, instead of the fund being siphoned back into the general funds of the local government unit. The requirement was initially met with a lot of resistance, but currently around 84% of local government units have set up trusts.

Contract enforcement is highly reliant on a functional monitoring system. PhilHealth intends to track performance in four dimensions: care quality, patient satisfaction, financial risk protection and fraud, using a variety of methodologies including the electronic Medical Post-Audit System (eMPAS), Mandatory Monthly Hospital Report (MMHR), claims profiling, exit surveys, client satisfaction surveys, facility visits, chart reviews and field validation. Pending the recruitment of the human resources required for these activities, PhilHealth has temporarily tapped the CARES programme. The PhilHealthcareS programme deployed 530 nurses initially as patient navigators in hospitals all over the country in order to guide Sponsored Program members in utilizing their benefits. In addition, their mere presence in hospitals was said to have deterred provider fraud.
Timely payment

All healthcare providers are required to submit their claims within 60 days of patient discharge, while PhilHealth is required to process the claims within 60 days of claims filing. When filing delays are caused by providers, PhilHealth penalizes them by not processing the claim. However, if PhilHealth fails to process the claims within the prescribed period, there are no corresponding penalties for PhilHealth, or interest payments corresponding to the delay in payment.

Claims processing is still paper-based. Upon receipt at local PhilHealth offices, the claims are manually encoded on the computer system before processing can begin. Claims encoding and medical evaluation are considered the biggest bottlenecks. The shift from fee-for-service to exclusively case rates has rendered the medical evaluation largely unnecessary. An assessment of the shift from fee-for-service to case rates shows that the turnaround time for claims processing has shortened, as expected. All hospital levels, ambulatory services and maternity clinics recorded lower turnaround times in 2012, compared with the turnaround time under the fee-for-service system in 2010 (Table 10) (PhilHealth, 2014b).

Table 10. Reduction in days of PhilHealth claims processing turnaround time from fee-for-service in 2010 to case rates in 2012, by type of facility

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Reduction in claims processing days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 hospitals</td>
<td>22</td>
</tr>
<tr>
<td>Level 2 hospitals</td>
<td>23</td>
</tr>
<tr>
<td>Level 3 hospitals</td>
<td>24</td>
</tr>
<tr>
<td>Level 4 hospital</td>
<td>21</td>
</tr>
<tr>
<td>Ambulatory services</td>
<td>27</td>
</tr>
<tr>
<td>Dialysis centres</td>
<td>23</td>
</tr>
<tr>
<td>Maternity clinics</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: PhilHealth, 2014.

No-balance billing policy

PhilHealth operates as a “first-peso payer”, meaning it covers a fixed amount per case and all charges in excess of that amount are to be
shouldered by the member or private health insurance, if available. PhilHealth has never regulated user fees before the no-balance billing policy was introduced in 2011, at the same time as the first 23 case rates were launched.

The no-balance billing policy had the goal of ensuring zero out-of-pocket payments for Sponsored Program members in wards of Government hospitals, without a choice of attending physician. However, this was met with a lot of trepidation from the providers, who questioned the validity of the PhilHealth package rates, knowing fully that except for the Z benefits, the rates were based on averaged-out fee-for-service claims. Thus, monitoring of provider compliance with the policy has been challenging. Claim forms cannot capture the entirety of the patient’s hospital-related expenses. This is because, first, some patients purchase their medicines outside the facility, either because of a lack of medicines and supplies in the hospital or because they opt to seek cheaper alternatives from drug outlets outside the facility (Mijares-Majini, 2012). Second, physicians collect additional fees on top of the amount the package is paying them. Even though PhilHealth requires that all receipts must be attached and reimbursed by the hospital to the patient, there is no way to determine accurately that this has been done, unless the patient declares it. Thus, in the absence of a good information system, the best option is to undertake exit interviews among discharged patients. More recently, the PhilHealthcareS nurses were given the task of monitoring no-balance billing compliance. In June 2013, 93% of patients still incurred out-of-pocket expenses, but this rate had declined to 59% by June 2014.

The Z benefits took a different approach. The case package, for which costing was undertaken in collaboration with the providers themselves, required zero co-payments for Sponsored Program members and a fixed co-payment of 50% of the package cost for non-Sponsored-Program members. Because the cohort of Z beneficiaries is still limited, exit interviews were conducted with all of them. This showed 100% compliance with the fixed co-payment or no-balance billing provisions. Recently, the no-balance billing policy has been expanded to cover all outpatient services rendered in nonhospital institutions.
Geographical equity

Under the fee-for-service provider payment system, PhilHealth introduced incentives for physicians practising at sites determined to have a shortage of health personnel, by adding 10% to their professional fee reimbursements and allowing them to perform surgical procedures beyond a certain relative value unit. The adoption of the all-case-rates provider payment system stipulated that special fee schedules should be drawn up for geographically isolated and disadvantaged areas and areas with a shortage of health personnel. However, the guidelines for this policy pronouncement are yet to be formulated.

In the 1970s, the Philippine Medical Care Commission experimented with constructing its own health facilities in underserved areas, but this did not work, and the health facilities were soon turned over to the Department of Health, and then to the local government units when health services were devolved in 1992. Geographical inequity has not been resolved since devolution; in fact, there are indications that it may have worsened. Larger and richer provinces and cities tend to have better health services than smaller and poorer local government units.

3.3.1.8 Enhanced health systems efficiency

The Philippines resorts to a mixed range of instruments to enhance system efficiency, with varying results. Among the more visible ones are the following.

(a) Use of drug formulary – the Philippine National Formulary contains the essential drugs list. It is prepared by the Department of Health National Drug Committee after consultation with experts and specialists from professional medical societies, medical academia and the pharmaceutical industry, and is updated every year. The general basis for selection of medicines consists of the following criteria: relevance to prevalent conditions, efficacy and safety, quality, cost of treatment regimen, appropriateness for the capability of health workers, local health problems and benefit/risk ratio. In addition, preferential factors like “most thoroughly investigated drugs” are stated and single formulations are preferred.
In all benefit programmes, PhilHealth is mandated to reimburse only drugs included in the formulary. However, this principle is not always observed. Under the all-case-rates system and PCB benefits, healthcare providers can get around this rule because they are not required to declare which drugs were administered as a requirement for payment. Meanwhile, certain selection criteria for the Philippine National Formulary – drugs for the most prevalent conditions, not too costly, and with an established evidence base – are limiting for programmes like Z benefits. The Z benefits cover high-cost, but not necessarily high-prevalence, conditions, and the drugs or devices involved do not have as extensive an evidence base as that for other conditions.

(b) Drug Price Reference Index – the Department of Health recently completed the first edition of the index (Department of Health, 2012b), listing 660 drugs with their generic name, dosage strength/form, the range of tender prices in PHP and the drug price reference, also in PHP. The index thus lists the ceiling prices for Government bidding and procurement set by the Department of Health for all retained hospitals and regional health offices (“centres for health development”) when procuring medicines. Winning bid prices for essential medicines shall not exceed the figure stated in the index. The index aims to improve efficiency in the pricing and procurement of medicines in the public sector. It also aims to guide PhilHealth in setting reimbursement caps for medicines.

(c) Clinical practice guidelines – PhilHealth is mandated to support quality improvement and consistency in the delivery of health services. It performs this function not by developing clinical practice guidelines, but by appraising guidelines and translating them into policy statements. The appraisal is a five-stage process that begins with a systematic search for clinical practice guidelines published locally and abroad. The validity is then screened, using the AGREE (Appraisal of Guidelines for Research and Evaluation) instrument (AGREE Collaboration, 2001) and an in-house appraisal checklist. Interventions are then assessed based on local applicability. Finally, drugs are counterchecked against the Philippine National Formulary. The guideline appraisal process is undertaken by at least three technical staff. The findings then become the basis for policy statements. Currently, PhilHealth has released policy
statements for 15 disease conditions\(^3\) under PCB1, PCB2 and some inpatient and outpatient case packages. However, since adherence to the guidelines is not routinely monitored and is not made a prerequisite for payment, there is no way to determine adherence. In the case of the Z benefits, adherence is mandated, as the payment is made in tranches according to guideline-based treatment.

The following system-efficiency-enhancing instruments are not yet in place, or are underutilized.

(a) General expenditure and cost controls – the Philippines has no centralized resource allocation authority that sets guidelines for the overall resources in the health system to be spent in a particular year. While the process under hierarchically organized hospitals of the Department of Health and local government units have a close-ended budget, there is a lot of “gaming” at the facility level, as hospital directors play one funding source off against other sources (PhilHealth, private insurance, user fees, the Philippine Amusement and Gaming Corporation (PAGCOR), Philippine Charity Sweepstakes Office (PCSO), external donors and sometimes pork-barrel financing from politicians) and, in the case of local government units, internal revenue allotments.

(b) No effective gate-keeper or referral system – many higher-level hospitals are clogged up with primary care patients. Some cities do not have city hospitals, and so their residents travel to Department of Health regional hospitals, which are supposed to cater to referral cases. There is no referral bypass fee. PhilHealth has not been able to influence the flow of patients so that they go to the right level of facility.

(c) No formal process of health technology assessment – while evaluation of the efficacy and cost-effectiveness of drugs is fairly well established in the Philippines, no similar process for devices or procedures exists

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\(^3\) Community-acquired pneumonia for adults and children, acute appendicitis, hypertension, dyspepsia, acute bronchitis, asthma in adults, urinary tract infection in adults, acute gastroenteritis, maternity care, dengue hemorrhagic fever, cataract, diabetes mellitus, chronic cough in children, cholecystitis and the Philippine Package of Essential Non-communicable Disease Interventions.
as yet. Health technology assessment is conducted very informally. Under Z benefits, the choice of conditions to include in PhilHealth is often based on the cost of treating the condition, rather than the burden of the disease and the cost-effectiveness of treating it. There are no established rules or benchmarks for screening such conditions, e.g. cost of disability-adjusted life years (DALY) averted as a percentage of gross domestic product.

**Purchaser-government relationship in PhilHealth**

**Organizational characteristics of government actors**

There are several government agencies in the health service purchaser-government relationship, with the main groups shown below. In this chapter, the focus is on stewardship of and policy-making for PhilHealth. The associated functions and the agencies that fulfil them are listed below.

- Steward and policy-maker – Congress, Office of the President (presidential management staff), and Department of Health (the Secretary of Health is Chairperson of the PhilHealth Board);
- Regulator – Department of Health (licensing, accreditation, quality monitoring) as well as owner of Department-of-Health-retained hospitals; Food and Drug Administration (pharmaceutical regulation);
- Financier of premium subsidies to Q1 and Q2 – Department of Budget and Management
- Employer of civil servants – Government line agencies, Government-owned and controlled corporations, Department of Budget and Management as source of fiscal revenues;
- Owner of health facilities – Department of Health (retained hospitals), local government units (provincial, city, municipal health facilities);
- Financier of catastrophic medical conditions – Department of Social Welfare and Development, PCSO, PAGCOR.
Ideal versus actual functions in the purchaser-government relationship

This relationship focuses on government stewardship (the first function and some subtasks of the second function above) to ensure that public health priorities are linked to resource allocation and purchasing decision-making. Table 11 shows the ideal functions of the purchaser and an assessment of the performance of PhilHealth compared with them.

Table 11. Ideal functions of the purchaser in the purchaser-government link and assessment of PhilHealth’s performance

<table>
<thead>
<tr>
<th>Functions of ideal purchaser</th>
<th>Assessment of PhilHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>To establish a policy and regulatory framework for the purchaser and providers</td>
<td>PhilHealth is a Government-owned and Government-controlled corporation with an independent governing board. The Government, however, is over-represented on the board, and members/providers are generally under-represented. The PhilHealth Executive Committee provides technical direction, but there are skill deficits in certain areas (e.g. actuarial affairs, health technology assessment and business analytics). Policies are issued through circulars, but these are often not coherent, as benefit expansion is not underpinned with a long-term vision of social health insurance in the country.</td>
</tr>
<tr>
<td>To promote equitable access to needed health services by investing in delivery capacity in underserved areas</td>
<td>PhilHealth does not invest in capacity infrastructure, although its predecessor (Philippine Medical Care Commission) did so. PhilHealth’s tool is financing, which it is hoped will incentivize providers to locate in underserved areas.</td>
</tr>
<tr>
<td>To ensure adequate resources are mobilized to purchase services</td>
<td>Government has mobilized sin taxes for the Q1 and Q2 premium subsidy programme. However, collection efficiency (for paying members) is only 67%. Increasing premiums for paying members is a highly politicized issue. The premium rate of 2.5% of employee earnings is one of the lowest in emerging economies.</td>
</tr>
<tr>
<td>To implement mechanisms to ensure accountability of purchaser to government</td>
<td>Audit is institutionalized. However, neither the executive nor the legislative branches have exercised stewardship roles proactively. The Department of Health, as the mother agency, does not have enough staff with health-financing skills to provide technical support for PhilHealth.</td>
</tr>
</tbody>
</table>

Source: This study.
Analysis of PhilHealth’s purchaser-government relationship

Policy framework and institutional structure

PhilHealth was instituted through Republic Act No. 7875, which created the Philippine Health Insurance Corporation as the administrator of the National Health Insurance Program. The law defines the powers and functions of the Corporation. Some of these are as follows.

1. To set standards, rules and regulations necessary to ensure quality of care, appropriate utilization of services, fund viability, member satisfaction and overall accomplishment of programme objectives.

2. To negotiate and enter into contracts with healthcare institutions, professionals and other persons regarding the pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing and delivery of health services.

3. To determine requirements and issue guidelines for the accreditation of healthcare providers for the programme.

4. To supervise the provision of health benefits with the power to inspect the medical and financial records of healthcare providers and patients who are participants in or members of the programme, and the power to enter and inspect accredited healthcare institutions.

5. To submit to the President of the Philippines and to both Houses of Congress its annual report, which shall contain the status of the National Health Insurance Fund, its total disbursements, reserves, average costing to beneficiaries, any request for appropriation, and other data pertinent to the implementation of the Program, and publish a synopsis of such report in two newspapers of general circulation.

6. To conduct post-audit on the quality of services rendered by the healthcare providers.

7. To monitor compliance by the regulatory agencies with the requirements of the law and carry out necessary actions to enforce compliance.
In addition to these functions, PhilHealth also holds quasi-judicial powers so that it can carry out its tasks more efficiently. As an accrediting body, PhilHealth is allowed “to suspend temporarily, revoke permanently, or restore the accreditation of a healthcare provider […] after due notice and hearing” (Congress of the Philippines, 1995). According to the law, the revocation of a healthcare provider’s accreditation shall disqualify him from obtaining another accreditation in his own name, under a different name, or through another person.

As a Government-owned- and controlled-corporation, PhilHealth comes under the authority of the Governance Commission for Government-Owned and Controlled Corporations, a regulatory body with the power and function to evaluate its performance and determine its relevance. Some of the powers and functions of PhilHealth pertain to the way PhilHealth holds authority over providers. The law has given PhilHealth such authority, exercised through accreditation of health facilities, to ensure the delivery of high-quality services. Accreditation for government hospitals has been automatic with effect from April 2012, while private hospitals need to fulfil both the licensing requirements and the accreditation requirements of PhilHealth.

**Equitable access to needed health services**

The health system contributes to the promotion of equitable access to needed health facilities by investing in service delivery capacity in currently underserved areas. Access has three aspects: physical (geographical) access, economic access and access to appropriate healthcare. These factors are more pronounced in far-flung rural areas of the Philippines.

To achieve the universal health coverage objective, health facilities should be physically accessible to all. As Philippines is an island nation situated in a large archipelago, the distribution of hospitals is highly uneven, having pockets of concentration in major urban areas. In view of this limitation, PhilHealth decided to accredit all government hospitals in the country, following the provisions of the General Appropriations Act of 2012. Automatic accreditation is granted to facilities that are providers of the primary care benefit package, maternal and newborn care package,
TB-DOTS, the outpatient malaria package and special procedures such as ambulatory surgical clinics and freestanding dialysis clinics.

For facilities that are automatically eligible for PhilHealth accreditation without undergoing the preaccreditation survey, PhilHealth Circular No. 13, s-2012 (PhilHealth, 2012b) requires a signed performance commitment to ensure the quality of services provided. The performance commitment includes the providers’ responsibilities and commitments relating to service delivery and accountability to PhilHealth.

The Government’s efforts to make all the necessary providers of care available to all are complemented by the national Government subsidy for premium payments for the poorest segment of the population. In 2013, a total of 31.4 million indigent members and dependents have been covered and are eligible for benefits in a PhilHealth-accredited facility under the PhilHealth Sponsored Program. Sponsored Program members include the nationally-identified poor and those eligible for sponsorship as certified by the local government unit. The premium subsidy for the poor identified at the national level will be sourced from the sin taxes, while the premiums of the remaining Sponsored Program members will be shouldered by the sponsoring local government unit.

Despite the mandate for automatic accreditation, 67% of government hospitals are not accredited, according to Department of Health and PhilHealth data. One interesting point, however, is that PhilHealth reports that 31.4 million people are eligible to use PhilHealth under the Sponsored Program, while only 23.3 million are considered to be below the poverty line according to official poverty figures. However, there is no mechanism to determine whether all Sponsored Program members are aware of their automatic membership and eligibility to benefit from health insurance. The overestimate of the number of the poor may be causing leakage, which may result in inequities in access to and utilization of healthcare by deserving indigents, as the accreditation of government facilities is also incomplete.

The appropriateness of health services is difficult to determine, as the country lacks a disease database. Also, there is no existing policy on the determination of the service capacity and capability of the hospital.
sector. There have been Department of Health initiatives to identify the characteristics of hospitals in a particular area through the Survey on the Services and Equipment Available in the Health Facility in 2011, but these efforts have not gained ground. Without this mechanism in place, no strong basis exists for the granting of funds under the Health Facilities Enhancement Program for the upgrading and enhancement of government facilities (Lavado et al., 2011). Finally, PhilHealth does not have a mechanism to identify areas with a poor hospital accreditation rate.

Ensuring availability of resources for delivery of entitlements

The law mandates PhilHealth to set aside a reserve fund, which shall not exceed a ceiling equivalent to the amount actuarially estimated to equal two years’ projected programme expenditure. Any amount in excess of this sum should be used to increase PhilHealth benefits, decrease members’ contributions or augment the Health Facilities Enhancement Program of the Department of Health. Should there not be a need for this, excess funds should be invested in interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines.

In 2013, 62% of total income was sourced from premiums, 27.2% from national and local government contributions, 10.6% from interest income, and 0.2% from other income. The law cited the earmarked taxes for health spending; in 2013, a total of PHP 12 billion allocated for PhilHealth was sourced from sin taxes and used as premium subsidy for Q1 and Q2 households. This mandate, contained in Republic Act No. 8240, ensures a steady stream of resources for PhilHealth entitlements for this significant segment of the population.

PhilHealth also needs to rethink its reserve management strategy. Because of its origins in two large pension funds (Social Security System, Government Service Insurance System), PhilHealth (and the Philippine Medical Care Commission before it) imbibed the mentality of a pension fund, hence the Board’s focus on accumulating huge reserves in excess of what is needed for benefit payments. The PhilHealth reserve fund has climbed steadily from PHP 35.5 billion in 2004 to PHP 115.6 billion in 2013. The ratio of reserves to benefit payments and operating costs reached as high as 3-4 years’ worth in the period 2004–2009 (Picazo, 2012), although
this went down to a more reasonable 2.2 years in 2013, closer to what the law prescribes, i.e. two years (PhilHealth, 2014b).

The larger development issue that PhilHealth needs to face, however, is its ability to expand its benefits. The current premium contribution rate (2.5% of earnings) was calculated on the basis of ordinary inpatient benefits, excluding outpatient benefits and Z benefits. As the clamour for expanded benefits under universal health coverage increases, there is a need for PhilHealth to increase the current level of premiums; to raise, if not remove, the ceiling on premium contributions; and to improve collection efficiency.

**Accountability of PhilHealth to government**

The Manual of Corporate Governance of PhilHealth lists the duties and responsibilities of the Board, one of which is to ensure its fiduciary capacity. The Manual also explicitly details its disclosure and transparency policy, i.e. PhilHealth shall disclose information on financial and operating results, remuneration policy for the Board and key executives, information about Board Directors including their selection process, issues regarding employees, and governance structures and policies and the process by which they are implemented. PhilHealth is also mandated to maintain a website and post the following, among others: complete compensation package of officers, latest annual audited financial and performance report, audited financial statements, current corporate operating budget, performance evaluation systems and performance scorecards.

In general, PhilHealth has adhered to its mandate. However, it has also figured intermittently in such cases as bloated staff bonuses, arrears in the remittance of collections by certain agencies, and fraud and conflicts of interest on the part of a few providers. Under the previous administration, PhilHealth was also used for political ends, as shown by the artificial increase in membership during two previous elections. These are all matters of accountability and governance that the PhilHealth Board and executives – as well as those exercising stewardship – should keep in mind. So far, there is no entity that acts as a watchdog or advocate, and this may be a possibility worth looking into to preclude abuse of the social health insurance fund.
One provision of the National Health Insurance Act calls for a joint congressional oversight committee to conduct a regular review of the National Health Insurance Program, with a systematic evaluation of PhilHealth’s performance and impact. In addition, the National Economic and Development Authority is mandated to undertake studies to validate the accomplishments of the programme. These studies should be done, according to the law, in coordination with the Philippine Statistics Authority and the National Institutes of Health of the University of the Philippines. The validation studies should include an assessment of the enrollees’ satisfaction with the benefit package and services provided by PhilHealth. These studies, together with an annual report on the performance of PhilHealth, shall be submitted to the congressional oversight committee. So far, this committee has been inactive.

PhilHealth has diligently performed many of these functions, but the quality of its output has varied. For instance, pertinent documents are easily accessible on the PhilHealth website, and the PhilHealth statistics and charts are also accessible. However, PhilHealth is still unable to produce an accurate count of its members and their dependents, and business analytics are not performed on a routine basis. PhilHealth issues its annual report promptly and regularly, but the indicators used change every year. Actuarial analyses are not performed frequently. Finally, the joint congressional oversight committee has been inactive.
**Overall assessment of purchasing of health services under PhilHealth**

**Assessment of PhilHealth as purchaser of health services**

**Purchaser-member relationship**

**Registration and entitlement of members**

The massive premium subsidy programme of the National Government for Q1 and Q2 households engendered a daunting task of identifying each and every eligible primary member and dependent. PhilHealth claims that 75% of the Philippine population is now covered (i.e. with paid-for premiums), but National Demographic and Health Survey data indicate that only 60% of households claim they are covered by health insurance, leaving a large proportion of households who have been given a subsidy but are not aware of their PhilHealth status. To address this problem, more information, education and communication campaigns are needed to inform poor and near-poor households of their status, entitlements and benefits. PhilHealth has also adopted a “point-of-care” approach to identifying poor patients at health facilities who will then be automatically registered as PhilHealth members.

**Articulation of members’ preferences, needs and complaints**

This is a function that is not well established in PhilHealth. Benefits are still determined largely in a top-down manner, although these are increasingly being vetted through focus-group discussions with members, as in the case of the PCB+ and Tarnang Serbisyo para sa Kalusugan ng Parnilya (Tsekap), which replaces the PCB1 package. Members are not formally organized, and there is no independent watchdog body to look after members’ concerns. The local health insurance offices could be key points of contact for members, but this has yet to become the case. While there is a website where citizens can voice their concerns, the PhilHealth response is infrequent and much delayed.
Purchaser-provider relationship

Strategic purchasing
The low proportion of health expenditure by PhilHealth (maximum 12%), its thin benefit package (no comprehensive primary care benefit, no outpatient pharmacy benefit, low support value for inpatient services), as well as internal institutional deficits (weak IT, weak health technology assessment) have prevented PhilHealth becoming an influential strategic purchaser of care. PhilHealth has yet to exercise its potential monopsony power vis-à-vis providers (hospitals, physicians, pharmaceutical suppliers), but this can only happen if it becomes a major payer of health services. Despite the Philippines having one of the highest drug price regimes in Asia and in the developing world, PhilHealth has not made major inroads in direct negotiation with big pharmaceutical firms for lower drug prices. The expanded coverage through Q1 and Q2 subsidies, as well as the launching of an expanded PCB+ benefit, should increase PhilHealth’s role in the healthcare market, and should be used as an opportunity to wield market power.

Provider payment system and timeliness of payment to providers
Through the years, PhilHealth has been mainly a passive payer for health services under an inflationary provider payment system. The change in provider payment to a case rate system in 2011 increased PhilHealth’s influence in the healthcare market. Indicators show that in general, the average cost per case has declined, the average length of stay per case has declined, and the timeliness of payment to providers has also improved. While there are still cases of no-balance billing, the prevalence of balance billing has declined from 93% in June 2013 to 59% in June 2014 (Picazo, 2014b). In the future, the provider payment system needs to evolve into a DRG system to take account of comorbidities.

Licensing and accreditation of providers
Accreditation of providers was recently transferred to the Department of Health, which issues their licences. Accreditation remains a slow and painstaking process, especially for Government hospitals and public health programmes. As many as 33% of hospitals are not accredited; for TB-DOTS,
after 10 years of accreditation experience, only 59% of the DOTS centres licensed by Department of Health’s National Tuberculosis Programme have been accredited or certified. This leaves 41% unaccredited or uncertified, thus denying them receipt of PhilHealth reimbursements.

Prioritization of health services
There is, as yet, no formally established process for health technology assessment at PhilHealth. The Philippines has an established process for the economic and therapeutic evaluation of drugs (Food and Drug Administration, National Centre for Pharmaceutical Access and Management), but a similar process is not in place for devices and procedures. As a result, the determination of the benefit package (especially for costly procedures such as those under Z benefits) is rather unsystematic. WHO has established the guideline that an intervention is cost-effective if the cost per DALY averted is lower than three times the per capita gross domestic product of the country for that year. To operationalize such a rule, PhilHealth needs to conduct analyses of the costs per DALY averted of the most expensive medical conditions and surgical interventions in the country.

Quality of care
Under PhilHealth’s Benchbook accreditation programme, hospitals were classified as centres of excellence, centres of quality and centres of safety. The criteria for these classifications involved not only structural, but also process, aspects of care. However, the generally poor availability of data on hospitals (e.g. infection rates) precluded analysis of whether ex-ante accreditation standards resulted in ex-post quality improvements. Patient satisfaction surveys are not regularly conducted to obtain even a perception of quality. On individual hospitals’ own initiative, and as part of a campaign to attract more patients, some facilities have resorted to obtaining reputable international accreditation such as Joint Commission on Accreditation of Healthcare Organizations, Accreditation Canada, International Organization for Standardization, etc.
Information technology

PhilHealth’s use of IT for business analytics is in its infancy. Because of weak use of IT, key data on patients and providers and payments are not available on a just-in-time basis for decision-making, whether by PhilHealth’s own technical staff or by the Board. Efforts are being initiated in this area at the outpatient end of the spectrum of care (through OPB and PCB+ benefits), even though the more expensive, and therefore more critical, end is inpatient (especially surgical) care.

Purchaser-government relationship

Adequacy of funding to purchase services

Premiums in PhilHealth are far lower than those prevailing in middle income countries that have achieved universal health coverage and which provide more comprehensive benefits. Colombia collects 12.5% (8.5% from workers and 4.0% from employers); Estonia 13% of wages; Turkey 12.5%. The current contribution rate of 2.5% for the employed, for instance, does not cover provision of outpatient benefits nor Z benefits. PhilHealth’s goal of expanding the benefit package and increasing support value (reimbursement rate) in both inpatient and outpatient care will inevitably require an increase in the premium rate. However, such an increase is politically sensitive, and is not likely to be initiated in an election year (2016) or prior to it (2015). Because of this, the design of benefits is often done in a “reverse process”, i.e. fitting the benefits within the given resource envelope, rather than determining the needed benefits, costing them out, and arguing for a needed premium increase. This has been a long-standing dilemma, and unless there is the political will to break it, PhilHealth will continue to limp along.

Collection efficiency

Inefficient collection of premiums is a long-standing problem of PhilHealth. For the Government sector, the concerned agencies as employers sometimes make payments lower than the 2.5% contribution required by law. As a result, arrears often accumulate, amounting to as much as PHP 4.6 billion at the end of 2005 (Walker, 2006). Delays in the national government release of cash payments for the premiums of Sponsored Program members have also caused arrears in the past (Walker, 2006).
Stewardship
PhilHealth is an attached agency of the Department of Health; the Secretary of Health is the chairman of its Board. Department of Health stewardship of PhilHealth, however, leaves much to be desired because the technical skills needed to oversee, exercise stewardship and monitor PhilHealth are not sufficiently available at the Department of Health. The same can be said of other Government agencies supposed to oversee PhilHealth, such as the Congress, the Office of the President/Presidential Management Staff or the Social Cluster of the Cabinet. Proof of this “arms-length”, if not indifferent, attitude of higher-level bodies is the absence, for a long time, of commissioned reports, state-of-the-art assessments, strategic plans and similar documents that should inform the public of the state of the National Health Insurance Program. As a result, PhilHealth often acts as a “self-stewarding” institution.

Institutional factors influencing PhilHealth’s performance as purchaser of health services

The legacy of pension-fund origins
PhilHealth’s predecessor agency, the Philippine Medical Care Commission, was established in the late 1960s under the shadow of two large pension funds, the Government Service Insurance System, which collected pension and health insurance premiums from civil servants, and the Social Security System which did the same on behalf of private-sector employees. Until 1995, when PhilHealth was established, the Philippine Medical Care Commission had strong representation from the Government Service Insurance System and Social Security System. When PhilHealth was established, the Philippine Medical Care Commission assets were transferred to it and it began to collect premiums independent of the two pension funds. However, the two pension funds continued to be represented on the PhilHealth Board, wielding a strong influence on the way it managed its affairs, especially with respect to PhilHealth reserves. Although PhilHealth is a health insurance fund, it is sometimes perceived as being run as a pension fund, and indeed its reserves tend to accumulate to levels far higher than those a health insurance fund should have. For instance, in the mid-2000s, reserves were 3-4 years’ worth of benefit.
payments and operating costs. This pension mentality continues to pervade the organization, especially during discussions on benefit expansion.

There is a lack of stronger members’ or patients’ representation on the PhilHealth Board. The PhilHealth Board is dominated by representatives of government departments and agencies performing sundry functions, including Finance, Health, Labour, Social Development, Local Government, Government Service Insurance System and Social Security System. Ranged against them are a few representatives actually involved in health (hospitals, physicians), and then there are representatives of employers and patients. Thus, representatives of members and providers are outnumbered by Government representatives who have little actual knowledge of health service provision and needs. The decision-making is often consensual, tending to be on the conservative side (i.e. stewardship of the fund and reserves position) rather than on the progressive side (expanded benefits to members).

Private health insurance rather than social health insurance concepts are used. Until very recently, PhilHealth continued to use health insurance principles borrowed from private health insurance rather than social health insurance. For instance, three-month waiting periods and exclusions from specified benefits have been the norm. Public-health providers (for TB-DOTS, for instance) have to go through time-consuming and onerous accreditation, rather than being given blanket accreditation since they have been licensed by the Department of Health anyway. The combined effect of the use of these concepts is to restrict utilization (expected of a private health insurance scheme) rather than widen it (expected of a social health insurance programme).

**Summary, conclusions, and policy implications**

This study is a critical analysis of health services purchasing undertaken by PhilHealth, which implements the National Health Insurance Program of the Philippines. Purchasing deals with the way an institution should determine, negotiate for, and obtain health services on behalf of a group of people who have contributed resources, through taxes, premiums, or point-of-service payments, in exchange for anticipated health services.
The study employs a principal-agent framework for analysing three critical relationships: that between the purchaser and healthcare providers; between the purchaser and citizens (or members of PhilHealth), and between the purchaser and government, both as regulator and as funder of services, at the national Government and local government levels.

In analysing these three relationships, the study compares three states: the ideal or theoretical arrangement of purchasing as determined by economic theory; the “design” arrangement as written in laws, implementing rules and regulations, executive and administrative orders, circulars, and other policies; and the actual arrangement or practice as culled from reports and interviews with stakeholders. Thus, the study is an analysis of the key alignments and variances of purchasing practices vis-à-vis the “design” and the theoretical ideal in each of the three relationships. To do this, the study employs an extensive document review as well as key-informant interviews with stakeholders.

**Purchaser-member relationship**

Using the framework of an ideal purchaser in the purchaser-member relationship, the analysis of PhilHealth indicates the following.

- PhilHealth’s engagement with its members has been unevenly conducted, but is improving. In the case of PCB+, extensive focus-group discussions were conducted to help in the benefits design.
- Provider payment reforms, changing from fee-for-service to case rates, updated the reimbursement rates, but real resource costing of medical and surgical procedures still needs to be conducted. Some public health interventions (e.g. the Maternity Care Package) have generous reimbursements while others (e.g. TB-DOTS) do not. On average, support value in 2013 represented only 31.5% of hospitalization costs, indicating that PhilHealth still has a long way to go in providing financial protection.
- PhilHealth has no problems in identifying paying members, but it has serious difficulties in identifying and enrolling Sponsored
Program members, whose premiums are paid for by the national government. Many of these members have not been made aware of their entitlement and have not received their PhilHealth cards. Only 60.3% of households in the National Demographic and Health Survey 2013 survey (National Statistics Office, 2014) claimed they had PhilHealth insurance, while PhilHealth claimed that coverage was as high as 75%.

• Focus-group discussions conducted for the design of the PCB+ package indicate that, although members know PhilHealth in general, they are not aware of the specific benefits to which they are entitled (FOCI, 2014). In 2013, a World Bank evaluation showed that as many as 36% of Sponsored Program patients were not aware of their PhilHealth coverage.

• In general, access is increasing: the percentage of households who sought care in the Philippines increased from 7.9% in 2008 to 10.7% in 2013, according to National Demographic and Health Survey data (National Statistics Office, 2014). However, access to care is still very uneven across and within regions and provinces. Access to much needed and much desired primary care benefits is limited by the currently very narrow services included under existing funded benefits (Maternity Care Package, TB-DOTS and OPB).

• PhilHealth has established procedures for settling complaints and resolving disputes. However, available IT methods (website, email, telephone hotlines, social media) have not been optimally used to respond quickly to member and provider concerns.

• PhilHealth public reporting of performance to promote transparency and accountability is not routinely conducted. Indeed, it is quite difficult to obtain data from PhilHealth.

The following policy implications and recommendations emerge from the analysis of the provider-member relationship.

• To identify and inform the remaining unidentified Q1 and Q2 members, PhilHealth needs to undertake more proactive information, education and communication campaigns.
PhilHealth also needs to follow through on its adoption of “point of care” enrolment, whereby patients without PhilHealth cards will be assessed on site and automatically given eligibility if found to be classified as poor or near-poor, depending on the criteria to be set by the Department of Social Welfare and Development. PhilHealth should consider the use of civil registration to enrol infants automatically into PhilHealth, depending on the PhilHealth status of the parents.

- To revitalize PhilHealth’s customer service orientation, PhilHealth needs to revive its customer hotlines, webpage and social media channels in order to reach out to its members.
- To mandate a stronger PhilHealth membership representation in PhilHealth’s Board.
- To encourage and support nongovernmental advocacy groups: watchdog, research, academic or labour groups should be supported, especially those focusing on social programmes in general and PhilHealth in particular.

Purchaser-provider relationship

Using the framework of an ideal purchaser in a purchaser-provider relationship, the analysis of PhilHealth indicates the following.

- PhilHealth has tended to be rather too stringent in accreditation, especially of government hospitals and public health clinics. PhilHealth has accredited only 67% of licensed hospitals in the country (Philippine Institute for Development Studies, 2014), and only 59 of licensed TB-DOTS centres (Picazo et al., 2014). This severely reduces access to and utilization of hospital and public health services, especially in localities where the licensed but unaccredited facility is the only provider. Although a more liberal and accommodating accreditation policy has been specified in the General Appropriations Act of 2012, it has not been widely implemented. PhilHealth has yet to introduce more facilitative arrangements with providers to improve quality of care.
Unlike the situation in other countries, PhilHealth has no equalization (or equity) fund for geographically isolated and depressed areas, and PhilHealth reimbursement rates are uniform across the board. Thus, there are no additional incentives (apart from normal reimbursements) for providers to move to geographically isolated and depressed areas.

Efficiency-improving mechanisms at PhilHealth show a mixed picture. The patient gatekeeping and referral system in the Philippines is very weak (Acuin, 2014). However, provider payment reform, changing from retrospective fee-for-service to prospective case rates, has shown positive results. The Generics Law has been in force since 1998, but providers sometimes find ways to prescribe branded drugs (Wong et al., 2014). Not all the clinical guidelines are available. There is still no established process or national guidelines for health technology assessment.

To monitor providers, PhilHealth has quality-of-care mechanisms that are mostly ex-ante standards imposed via accreditation. Deaccreditation of providers is rarely resorted to, because of the severe disadvantages it imposes on members relying on the services of the providers concerned.

PhilHealth signs “performance agreements” with contracted health facilities. However, the performance targets and their accomplishment vary. Hospitals usually complain of payment delays and disallowances in their claims. To deal with these issues, hospital reports are increasingly being computerized. Under PCB+, providers will be required to have electronic medical records.

Under the new case rate provider payment system that replaced fee-for-service in 2011, providers know in advance the reimbursements they are going to receive. A no-balance billing policy has also been in force and compliance has improved, from only 7% of surveyed hospitals practising no-balance billing in June 2013 to 41% in June 2014.

PhilHealth’s turnaround time (from claims filing to payment) has also improved. For instance, from 2010 to 2012, the
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turnaround time for hospital claims was reduced, on average, by 21 to 23 days (PhilHealth, 2014b).

- PhilHealth outpatient benefits have evolved in an extremely fragmented fashion, leading to high administrative and monitoring costs and less-than-optimal impact, as shown by TB-DOTS and the pilot of PCB2.

The following policy implications and recommendations emerge from the analysis of purchaser-provider relationship.

- To loosen up on accreditation, especially of public health programmes – PhilHealth should consider blanket accreditation of all Department-of-Health-licensed providers of public health programmes (TB-DOTS, Maternity Care Package, OPB). This is already mandated under the General Appropriations Act of 2012, but has not yet been implemented.

- To update the case rate reimbursements and to move towards a DRG system, PhilHealth should undertake a thorough resource costing of each of the conditions under the case rate system with a view to making them more realistic.

- To expand primary care benefits – The PCB+/Tsekap is currently under design. If approved, this programme will have a profound influence on members, as it is the first point of contact. It is hoped that it will rationalize the extremely fragmented outpatient benefit packages. It is also a more palpable benefit, compared with inpatient hospitalization, which is rare. Thus, it is deemed more inclusive.

- To institutionalize health technology assessment, the envisioned expansion of Z benefits should be underpinned with proper analysis of burden of disease and cost-effectiveness. While the Philippines has a fairly developed process for the evaluation of drugs, evaluation of devises and procedures have lagged behind. Burden of disease analyses also need to be strengthened.
• To mandate use of electronic medical records – PhilHealth should be able to perform just-in-time business analytics, and this can be made possible only with the mandated computerization of its accredited providers. A good starting point in this regard would be to require electronic medical records from all providers.

Purchaser-government relationship
Using the framework of an ideal purchaser in the purchaser-government relationship, the analysis of PhilHealth indicates the following.

• The policy framework under which PhilHealth operates is well defined in law. PhilHealth adheres to these legal stipulations closely and implements them through regulatory circulars and/or administrative orders of the Department of Health. The Philippine health financing and service delivery environment, however, is evolving rapidly. Medical technology, IT, global and local professional practices (including medical tourism), and the relationship between private and public sectors are also undergoing rapid changes, as a result of which regulatory instruments are often in a “catch-up” mode in the attempt to be relevant.

PhilHealth does not invest in service capacity infrastructure, although it did so in the 1970s under the Philippine Medical Care Commission, with varying degrees of success. PhilHealth’s major tool for increasing access in underserved areas is financing; hospital reimbursement was shown in the 1970s to have successfully added hospital stock in rural and periurban areas, but since the 1980s this progress has stalled. The launching of the PCB+/Tsekap package which allows reimbursement of private clinical practices is expected to encourage private medical practitioners in rural and poor urban areas.

• Government has mobilized resources from sin taxes to finance a massive premium subsidy for Q1 and Q2 households. However, premium increases among employed and individually-paying members is a highly politicized issue; indeed, it has lagged behind improvements in the benefit package. Expanded
benefits are contingent upon government’s ability to raise the premium rates and improve collection efficiency. All industrial and emerging economies that have achieved universal health coverage show premium rates far higher than those prevailing in the Philippines at present (Picazo, 2014b).

- There remain problems in collection efficiency, and arrears from Government agencies have sometimes accumulated. PhilHealth has adopted an “accounts-management” approach in which specific PhilHealth staff are assigned a specific agency to follow up, to ensure that all collectibles are collected.

- Financial audit is formally institutionalized in PhilHealth. The Commission on Audit has the constitutional mandate to undertake this function. In addition, PhilHealth itself has an internal audit department that conducts necessary inquiries on the way providers are performing their fiduciary responsibilities. One major gap is the lack of a more active stewardship role by the executive (Office of the President) and legislative (Congress) branches, as shown by infrequent commissioned reports on the state of the National Health Insurance Program.

The following policy implications and recommendations emerge from the analysis of the purchaser-government relationship.

- To brainstorm on and formulate an overarching national strategy for social health insurance – this is critical as the Philippine economy grows, the population ages, disease patterns change, and medical and information technology advance.

- To formulate an overarching national strategy and plan for health facilities expansion – Health Facilities Enhancement Program investments have been identified and provided in an opportunistic, bottom-up fashion. This needs to be corrected with a national health facilities development plan that takes account of economic, demographic, epidemiological and geographical considerations – not merely the narrow concerns
of local government units, as is apparent in the Health Facilities Enhancement Program investments.

• To prepare an annual external commissioned report on the status of PhilHealth – for its size, importance, and influence, an annual performance report (along the lines of a “white paper”) should be prepared by an external, independent panel to inform the Office of the President, Congress and stakeholders how PhilHealth can be further improved.

• To increase the PhilHealth premium and improve collection efficiency – political will is needed to increase premium contributions along the lines of other emerging economies’ health insurance programmes, and along the lines of the benefit package desired by the population.

• To conduct impact evaluation studies – the implementation of social health insurance requires periodic evaluation of its impact and performance and identification of key policy and programmatic issues.
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He chaired the negotiation of the WHO Global Code of International Migration of Health Personnel which was adopted by the 63rd World Health Assembly on 21 May 2010. He also chaired the negotiation of the Inter-Government Working Group on Public Health, Innovation and Intellectual Property and a number of WHA resolutions where there are huge conflicts among WHO Member States. He estimated capitation payment rate for the 1990 Social Health Insurance Scheme and 2002 Universal Health Coverage Scheme, and continues support the implementation of Universal Health Coverage in various countries, and heads IHPP research hub for the Asia Pacific Observatory on Health Systems and Policies in 2013-2015. He has published 157 scientific articles.

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