First Confirmed Case	Population	Confirmed Cases (as of September 29, 2020)	Recovered Cases (as of September 29, 2020)
January 30, 2020	108 Million	309,303	252,930

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Leveraging the existing single payer (PhilHealth) to strategically purchase COVID-19 services

The Philippines, an archipelago in Southeast Asia, is a lower-middle income country with a population of 109.5 million. The first case of COVID-19 was reported on January 30, 2020, and the first case of community transmission was documented on March 4, 2020. COVID-19 cases increased in mid-August 2020 with general lockdown measures being re-instituted in the most populous parts of the country such as Manilla, the capital, where almost all Filipinos have been ordered to stay at home.

In 2014, the Philippine Government established the Inter-Agency Task Force for the Management of Emerging Infectious Diseases to facilitate inter-sectoral collaboration for epidemic preparedness and ensure an efficient government response to assess, monitor, control, and prevent the spread of epidemics. The task force, chaired by the Secretary of Health, was convened in January 2020 to lead an inter-sectoral collaborative response to the COVID-19 pandemic.

The Philippines Health Insurance Corporation (PhilHealth), established in 1995, administers the National Health Insurance Program (NHIP) to provide health insurance coverage and ensure accessible and affordable health care services for all Filipinos. In 2019, the Universal Health Coverage (UHC) law was passed, which expanded access to health care services by automatically enrolling all Filipinos in the NHIP. At the onset of the COVID-19 pandemic, PhilHealth played a pivotal role in financing health care services. This brief documents actions taken by PhilHealth and how it has leveraged existing systems to quickly respond and contribute to the pandemic response.

A strategic purchaser defines what to buy, where to buy and how to buy

In January 2020, PhilHealth developed a benefits package for the isolation and referral of suspected cases at all PhilHealth-accredited facilities — with full reimbursement to health care providers. Meanwhile, PhilHealth continued to collect data to develop new benefit packages, which were launched in April 2020. These explicit benefit packages included health and non-health benefits for COVID-19 testing, community isolation and inpatient case management for mild, moderate, severe and critical case types.

	Community isolation	Testing by RT-PCR	Inpatient case management for COVID-19
Included services	• 14 days admission • Accommodation, food, hygiene kit • Patient education • Monitoring • As needed: medicines, diagnostics, imaging, referral and transport to other facility	• Screening/clinical assessment • Specimen collection • Specimen handling • Conduct of RT-PCR testing • Analysis and reporting	• Accommodation • Management and monitoring of illness • Diagnostics: Laboratory, imaging • Medicines • Supplies and equipment • Professional/readers' fees
Contracted Public and Private Providers	• Accredited and Department of Health (DOH)-certified community isolation units or temporary make-shift isolation centers	• DOH licensed and PhilHealth accredited testing laboratories	• Accredited level 2 or 3 health care provider and Tertiary hospitals for inpatient case management • COVID-19 referral centers for severe and critical cases
Payment modality	Case based payment rates for each benefit package		

The Department of Health (DOH) licenses public and private health facilities, while PhilHealth accredits and contracts health facilities to offer different benefit packages. While guidelines are still evolving and being updated, PhilHealth based their costing for COVID-19 case management on existing guidelines and used the patient's perspective to identify full economic costs. These costing estimates were used to develop payment rates. Rather than use the provider perspective for the analysis — which reflects providers' acquisition costs that are difficult to obtain and capture accurately, and also have wide variances because of differing institutional cost structures — PhilHealth used direct medical costs borne by the patients, which are the costs of services encountered by patients at the point of care. These costs are price signals that reflect provider acquisition costs, that will generate a sufficient margin to support sustainable operations and embodies the health facilities objectives regardless of ownership (public or private).

Reimbursement amounts for the COVID-19 testing benefit package were based on market information on test kits and in consultation with infectious disease experts. Prevailing rates may change in the future as protocols change and with the entry of new test kits. Therefore, PhilHealth is tracking prevailing market conditions and demand for testing services, that will inform subsequent policy reviews.

Buffer payments to protect health providers

When local community transmission began in March 2020, PhilHealth initiated an "interim reimbursement mechanism" (IRM) or advance payment to accredited health care providers. The IRM supported health care providers who were struggling with increasing operational costs coupled with reduced footfall as Filipinos stayed away from health facilities because of stigma and fear of COVID-19. The reimbursement was computed based on historical data of health care provider operations and billing in the previous year.

Monitoring strategic purchasing functions

PhilHealth used their existing monitoring systems to monitor the effectiveness of their purchasing functions. The health care provider assessment system supported the medical audit of submitted claims, which were required to be detailed and itemized with comorbidities listed using ICD coding. This system also tracks utilization of health care services, and is being used to examine quality and appropriateness of treatment. Feedback channels through the regional PhilHealth centers receive patient feedback, such as patients' suggestions, complaints and any cases of informal charges levied by providers. An expert panel is due to review the COVID-19 benefit packages, and their implementation, to inform subsequent revision of the benefit packages.

In conclusion

Despite PhilHealth being designated as the primary channel for resources to health care providers, resources continue to flow directly to providers through other channels beyond input financing — limiting PhilHealth's ability to take advantage of its monopsony power. However, the Philippines presents an interesting example on how a social health insurance program can leverage existing purchasing mechanisms to transfer funds to health care providers rather than use parallel channels to fund the pandemic response as observed in many countries.